Cranial Model Comparison

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"Find it, fix it, leave it alone." Dr. Jean-Pierre Barral

"Wait, watch, and wonder." Dr. Jim Jealous

Introduction – Biomechanical vs Biodynamic

Historically, both of the *biomechanical* and *biodynamic* models originated from Dr. Sutherland himself. The five basic principles of Sutherland's work regarding the anatomy and physiology of the cranium and sacrum are still the basis of every model of cranial work. I will make a point in this essay that there were and will continue to be practitioners and teachers who describe their style as opposed to a model differently. Cranial work in general lives in a world of metaphors attempting to describe the indescribable in the therapeutic process. These five principles are still the gold standard for optimizing the central nervous system and body physiology. However, at the end of his career Dr. Sutherland established a sixth, seventh, eighth, and ninth set of principles based on his experience of observing a correction being made in the client's body in 1948 by what he called "the tide" which then became the "long tide" and which is now referred to as "primary respiration" thanks to Dr. Jealous. I'll talk about rates later, but keep in mind that the CRI (Cranial Rhythmic Impulse) was not discussed or discovered until the late 1950s in the osteopathic literature.

Now, the autonomous client self-correction he observed was without any conscious intention of pressure or force into the client. It blew his mind. It might now be called a "senior moment" as he was 75 years old at the time, and yet each of us *spaces out* while giving a session. This is normal. Yet, it is considered to be the experience that ignited the biodynamic model that did not get formally named until the mid-90s. It took fifty years for a name to be given and raise it to the status of a model interconnected with the original. More importantly however, he considered his whole cranial concept to be spiritual. This is because even earlier than 1948 he named phenomena he observed in the client as the Breath of Life from the Book of Genesis in the Bible. The Breath of Life is a fundamental principle of the biodynamic model, "the sixth"

principle. Thus until his death in 1953, he established the biodynamic principles of respect, reverence and afferent hands in addition to the Breath of Life. These are the core principles of the biodynamic model in addition to the *Basic 5*, so to speak. We all tend to start in the same place.

However, most of his students at the time did not like this new direction and the field of Cranial Osteopathy divided into the two camps regarding the teaching of perception and palpation. The early unnamed biodynamic camp became a contemplation by a handful of osteopaths until the 1990s. Over time Sutherland's basic work became the Basic Course in Cranial Osteopathy. It consists of a forty-hour course focusing on the biomechanical basics. It is still taught that way. And since the founder of osteopathy, A. T. Still encouraged all osteopaths to keep digging regarding the study of anatomy, Dr. Jealous, a brilliant mystical osteopath, was able to ignite a much clearer understanding of the biodynamic approach. To him the biodynamic principles fit the Cranial Concept and all the other osteopathic manual arts. He went on to elaborate a critical biodynamic principle from the field of *biodynamic embryology*. This is really the first difference between so-called models at the theoretical level:

- Biodynamic practitioners study embryology and link it to perception and palpation of the therapeutic process.
- Biomechanical practitioners focus on adult anatomy and physiology to enter the therapeutic process.

So, after fifty years the biodynamic model formally became a named model in the 1990s with separate trainings by Dr. Jealous. Dr. Jealous also allowed non-osteopaths to attend his courses and mentored me during my doctoral work in the mid-90s. Biodynamic cranial osteopathy is a root source for Biodynamic Craniosacral Therapy and Craniosacral Biodynamics which also started at that time and made available to non-osteopaths. I transitioned to biodynamic practice then not only with Dr. Jealous but also with Franklyn Sills at his Karuna Institute in England.

Biodynamic Embryology

Fundamentally, Biodynamic Craniosacral Therapy and a companion style using different metaphors called Craniosacral Biodynamics started by Franklyn Sills are based on the study of human embryology and a relationship with the emerging field of trauma resolution therapies and

pre and perinatal psychology. More on that later. Franklyn Sills was the first person to publish teachings on Craniosacral Biodynamics for the non-osteopathic community. My books followed his. It must be noted that the scientific field of biodynamic embryology started coincidentally in the 1940s. It is the field of embryonic morphology, the study of how things move, physically grow and develop when we are barely a speck of dust. Human embryology and its morphology inform not only the perceptual process of the biodynamic therapist but especially different palpation skills. The physical forces forming the embryo are called metabolic fields consisting of areas of naturally occurring compression and decompression inherent to each system of the body to varying degrees of complexity. These embryonic perception and palpation skills are fundamental to the biodynamic model. It is not so much related to the amount of pressure the therapist is using and I will address that shortly.

Emotional Release vs Self-Regulation Difference

Dr. Upledger took the Basic Course in Cranial Osteopathy in 1972. Rolin Becker was one of his teachers. He went on to do significant research on Sutherland's basic principles in the cadaver lab. And he decided that a much wider audience of manual therapists needed to have the cranial osteopathic skill set and thus established the field of Upledger CranioSacral Therapy (CST). That is how cranial osteopathy came to the great masses of manual therapists worldwide thanks to Dr. Upledger. That is how the Upledger *ten step process* came to be for you and me. I started there and so did Franklyn Sills. Although I initially apprenticed with an osteopath in the 1980s who studied with Dr. Sutherland, it wasn't until Dr. Upledger unleashed this potent model to non-osteopaths in 1986 that I became rooted in the Cranial Concept as my career direction.

I received my teacher certification from Dr. John (as he was fondly called) in his first teacher training cohort in 1986. At the time I was also finishing a master's degree in contemplative psychotherapy in Boulder Colorado at the Naropa University. Prior even to Naropa, I already had extensive training and experience in the Gestalt Therapy of Fritz Pearls. At Naropa, I was training to become a contemplative psychotherapist. My time with Dr. John at his beginning brought me closer to my parents who lived down the block from the Upledger Institute. My father died that year, and I had a lot of quality time with him thanks to being in teacher training with Dr. John. Now I say that brief introduction as a way of mentioning a difference between models and specifically to the somatic emotional release (SER) component of

CST. I took all my early cranial training including SER directly from Dr. John. And at the same time I was being trained in a very different psychotherapeutic paradigm rooted in contemplative neuroscience, compassion and mindfulness.

The psychological base of SER derives from a *release based cathartic* (RBC) model of psychotherapy and manual therapy (such as Reichian and Bioenergetic therapies) from the 1950s and even earlier. The research literature I looked at in the 90's regarding RBC did not support the long-term value of emotional release or cathartic work. It is, however, of short term value. During that era of the 80s-90s, Post Traumatic Stress Disorder (PTSD), trauma and trauma resolution therapies were just starting to gain some traction in the manual therapy communities and integrated into CST and biodynamics.

The biodynamic community thanks to Franklyn Sills began to integrate this newer model of therapeutic interaction from the trauma resolution communities. Trauma resolution included Pre and Perinatal Psychology principles around birth based on *affective neuroscience*. This is the science of *self-regulation* and teaching the client how to self-regulate their mind, body and emotions internally with various contemplative practices in conjunction with a variety of physiological and metabolic manual therapeutic interventions. This is now known as the *containment model* in psychology. So I think at the theoretical level that's one of the differences between SER and biodynamics:

- SER works with releasing emotions.
- Biodynamics works towards containing the emotions for inner self-regulation.

And biodynamics does not suppress or deny the clients emotions, it can be a side effect of treatment rather than the goal based on the principle of *seek not, forbid not*. Biodynamic practitioners learn *active listening* when a client expresses emotions. It's more important to help stabilize the autonomic nervous system physiology with active listening than to potentially recapitulate the trauma unknowingly b processing a client's emotions which could retraumatize a client. Active listening and reflecting creates long term ability to *self-regulate*. Self-regulation functions best when a person feels safe, can express a boundary of safety which is recognized by the practitioner.

There are several important therapeutic innovations in the *containment model* that I feel everyone ought to learn based on safety. And not everyone in the biodynamic or CST communities have such training.

- First is to know the principles of *Trauma Informed Care* (TIC). There must be exquisite knowledge and skill with the autonomic nervous system as the principal mediator of trauma and felt sense of safety in the human body.
- Secondly, TIC also involves principles associated with *Interpersonal Neurobiology* (IPNB) another branch of affective neuroscience. Attention must be placed on the therapist's mind, body, spirit *first* and then the client. Yes, the client is second. Place the oxygen mask on yourself first and then your child.
- Thirdly, knowledge and information regarding the structure and function of what Stephen Porges calls the Polyvagal System is essential knowing for every therapist. The Polyvagal Model of Safety involves the vagus nerve and how the client unconsciously determines if he or she is safe with the practitioner. It is now being integrated across many dimensions in the world of psychotherapy, clinical pastoral care, multi-faith ministers, and the international manual therapeutic arts community. This is the way I now teach the emotional component in biodynamic practice. I believe it needs to be the base in all therapeutic and cranial based models.

Altogether SER is quite comprehensive when done skillfully with receptive clients. Many clients have no interest in emotional release. There are different routes to self-regulation and the above points are critical learning. I would like to mention another leg in the base of SER. It is called *fascial unwinding*. The fascial unwinding comes from the osteopathic vision of Viola Fryman in the 1960s. She originated it. And it lends itself to embryonic movements learned in the embryo. In this way it is powerful even without the emotional component.

The biomechanical model is very advanced work. It is like brain surgery, and I feel one's hands and mind need to become much more afferent as Dr. Jealous suggests. Then you will know the appropriate moment to engage the anatomy mechanistically. It is just another tool in your toolkit. As Dr. Jealous once said, "if you've had serious head trauma and been through a windshield, the therapist better know how to disengage a suture in that client's cranium." The corollary to that is to know the right timing for such an intervention.

Rates – Fast vs Slow

Discussion of rates is tricky business even in the biodynamic community because of the *good-bad, better-worse* connotation. Typically three rates are explored: CRI – fast tempo, mid tide – medium tempo, and primary respiration or long tide, slow tempo. In the biodynamic community, the mid tide as named by Franklyn Sills receives a lot of attention as the entry point for a therapeutic process. Primary respiration as taught by Dr. Jealous receives less attention in terms of initial orientation and synchronization with the client's fluid organism. I have had a lot of discussion with Franklyn Sills about the differences between the mid tide and long tide as a model for unfolding the work therapeutically.

- Biodynamic practitioners believe the rates of mid tide and primary respiration give more immediate access to the preexisting health in the body.
- Biomechanical practitioners believe the CRI gives access to the health.

These distinctions are important at the theoretical level but begin to dissolve at the clinical level. Rates are a significant part of all cranial models. The terms CRI, mid tide and primary respiration are based on the perception of movement and its velocity. *Sutherland never discussed rates*. And everywhere now we have rates with their timings and interpretations being taught. And palpation literacy is sometimes defined by the rate you are perceiving in the background of the client's organism. Some have suggested that the CRI is linked to stress states in the autonomic nervous system which of course makes it a valid starting point for a therapeutic process. A biodynamic osteopath will sometimes speak of the long tide from a spiritual and mystical point of view. Dr. Jealous sure did. Dr. Jealous made important distinctions about the various rates that are taught in Cranial Osteopathy courses with a specific focus on the perception of the long tide or what he called primary respiration. That's the term I prefer in my teaching as the entry point to the biodynamic therapeutic process.

So that seems to be a significant difference between models and even within the biodynamic community: which rate do we synchronize with at the beginning of a session and which rate do we end up with in the therapeutic process? Dr. Jealous said that at the end of the session a marker in the therapeutic process would be an increase in the *potency* of primary respiration which he then directly associated with the innate self-healing and self-transcendent intelligences of the human body.

- I learned from Dr. John that we want to feel greater wholeness in the client at the end of a session.
- Dr. Jealous said the opposite and that is that the session must begin with a sense of wholeness.

Biodynamics is a contemplation and not a rule book. These contemplations may or may not have clinical relevance between clients and between sessions with one client.

All rates and rhythms are happening simultaneously, all at the same time. It's a question of the therapist's perception and how each of us got trained by any particular teacher in any model. What are we telling students to look for not only in their own mind-body-spirit complex first, and second how to synchronize with that of the client? Rates are perceived on a spectrum that includes dynamic stillness (biodynamics) and the stillpoint (CST) at one end and the tide at the other. This spectrum depends on the practitioner's aptitude for perceiving inherent movement and inherent biological stillness equated with healing. Many biodynamic trainings show a video made in 1954 at the University of Pennsylvania called The Protoplasm of a Slime Mold. This video clearly shows all rates occurring simultaneously and primary respiration is pointed out several times as well as the stillpoint. There are a lot of doorways to the therapeutic process when practicing the Cranial Concept. When one door closes, pause and remember what Dr. Sutherland said from Psalm 46: Be Still and Know…" I feel that they are all valid and individual practitioners have preferences based on their individual aptitude. I believe the practitioner must allow their attention to be moved by something greater in clinical practice that is beyond rates. And rates can be a doorway to such deeper or greater experience.

Research on rates happened at The University of New England College of Osteopathy in the 1990s. Osteopaths performed cranial sessions on patients with a button on the leg of the table that could be contacted with the osteopath's knee when he or she felt a change in phase of any rhythm they might be perceiving. The button was wired to a computer that included the time intervals between contact with the button. It turns out that the older and more experienced osteopaths tended to contact the button in the slow rate of primary respiration while the younger practitioners contacted the button when perceiving a faster rate such as the CRI. Perhaps it's natural with experience that we slow down our perception and synchronize with a slower therapeutic process. I know that was my career trajectory. After ten years of clinical experience

with CRI, I discovered primary respiration with the help of Dr. Jealous. Preferences regarding rates is an individual aptitude that must be learned and expanded over time. The biodynamic community prefers the slow tide of primary respiration or the mid tide either at the end or beginning of a session, and it takes students some time to perceive it in their own way and at their own pace. I have to laugh because in my second class with Dr. John way back when, he came to my table and asked me if I was feeling the CRI. I lied because I was so intimidated by him at the time. I said yes when in reality I wasn't at that moment. It was later that I could perceive it.

Pacing – More vs Less Steps in a Session

Along with rates it is important to note another difference between models. When I learned CST in the mid-80s everyone received the ten-step process. Gradually overtime and with more experience the ten steps at any given time for any given client became eight steps and then six steps and so forth. It's important to acknowledge that we all tend to work biodynamically in the sense that spending more time at any one hand position tends to have greater value with the contemporary client unless of course we are just tired and falling asleep. I've had that happen too. What I mean by this is that I never know when I'm giving a treatment whether or not the location of my hands will allow access to a deeper therapeutic process that might go on for ten or fifteen minutes. And there are moments when my hands move almost immediately from one location to another. It is important that we do not enter a client session with a goal in mind of the number of hand positions that we will use.

Several years ago I attempted to teach a class on the ten-step process and found that I could not do that. At best, in my sessions that I give I'm using only three or four hand positions. And please don't make that a new rule for your clinical practice. The point is whether or not each of us is willing to enter the therapeutic terrain without a set goal in mind. And in this way it could be said that in biodynamic practice we must "trust the tide" which is a quote from Dr. Sutherland. In other words, rates are not only constantly present in the body, but they are also giving directions to us as we treat our clients especially the pace of the session. One way of describing the difference between models might be:

- The biomechanical model involves more steps is a session.
- The biodynamic model involves less steps.

Palpation Pressure – Passive vs Active Hands

An argument is sometimes made that the palpation skills are different between models:

- Biomechanical are more active.
- Biodynamic are more passive.

Or:

- The biomechanical model involves *more* pressure.
- The biodynamic involves *less* pressure.

That's not always how it functions in clinical practice. Hands are never static. They're floating. They are buoyant in order to be initially afferent. And my hands land on the client's skin with Upledger's "weight of a nickel" metaphor. Our hands are periodically invited to go deeper without triggering the autonomic nervous system (containment). Metabolic kinetic chains of fluid movement particularly within the interstitium and cardiovascular system are included in one's biodynamic palpatory skills. Dr. Jealous called this the *fluid body*. It is the embryonic body prior to anatomical structure and consists of the totality of the biological water in the body then and now with discrete purposeful therapeutic fluid movements. The fluid body is now associated with the metabolically challenged contemporary client and requires afferent hands to relate with in the client. And afferent hands are also going to exist on a spectrum of afferent to efferent.

The clients I had in the 1980s practicing Upledger CST were perfect for that time and method. Over the years I've had a learning progression of "less is more" and "keep it light" as my default mode because of the demands of the metabolically poor health of the contemporary client. I still explore elements of the ten step process but not all at once. Need I say anything more other than nine out of ten Americans are metabolically unhealthy. You cannot imagine the staggering amount of suffering produced by such ill health that comes into all of our offices. Each model is devoted to finding the "Health" in the client. So I feel that the Upledger model and the biodynamic model and all the ways they are being interpreted and taught internationally now are important. The French have a unique cranial manipulation system as does the Chiropractic community in the US. Australian osteopaths are applying the Cranial Concept to the cardiovascular system. So many good teachers are stepping up especially throughout the BCTA-NA, fifty four to be exact.

Biodynamic students spend two to three years together in class which helps establish safety and trust, the cornerstones of any therapeutic process. Those students wishing to go on can assist another training or to become a teacher must complete a third training all together. The teacher certification process is almost a ten year apprenticeship. These guidelines can be found on the website of the Biodynamic Craniosacral Therapy Association of North America (BCTA-NA). I am not familiar with the teacher certification process anymore at the Upledger Institute nor do I know of any of their teachers personally. Yet, Upledger CST has withstood the test of time and provides such relief to so many people. So, if a client asks about the difference between models, develop your own *elevator speech* from all the above bullet points. And if you have not received a session of CST, it is very difficult to talk about differences between models.

Conclusion

All of us teachers and practitioners must unveil our gift, your gift not mine or someone else's, to teach and practice this work in our way. Own it and become who you are. We seek to see the beauty in the inherent healing forces of the body, the "Health." We all help each other recognizing this beauty in life as a result of our combined efforts. All models of cranial work are based on appropriate compassionate responsiveness with our hands, heart, and mind. We need to consider that there is only one model of cranial work. I would say to everyone, keep up the good work. Keep exploring the bright light in your heart. Let the Breath of Life show itself to you as it did to Dr. Sutherland and my teacher Dr. Jealous.

Find it, fix it, leave it alone at a deeper level means to allow primary respiration to find the fulcrum it chooses in the client's body. Allow without interference primary respiration to fix what it chooses and don't chase after primary respiration once it is finished. Rest in the stillness. This is also the deeper meaning of wait, watch and wonder. Wait for primary respiration to show you its intelligence, watch how it functions in its healing cycle and be filled with wonder and awe at the privilege of seeing all this unfold from your heart.