

## SET TALK

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### THE CRANIAL CONNECTION TO HEADACHES – A PERFECT FIT!

If you are a massage therapist who treats clients with headaches, but are not including the cranium in your treatment, you are missing a significant cause of your clients' headaches and may not be able to achieve long term resolution.

Many times when people think of cranial motion they don't think of soft tissue, they only think of the movement of cranial bones. What's missing in this line of thinking is that soft tissue plays a part in the movement that takes place in every joint and suture of the body, and the cranium is no exception. Any mobilization of a cranial bone will entail mobilization of soft tissue related to it, and any mobilization of soft tissue related to a cranial bone will produce greater mobilization of the cranial bone. When you understand this it becomes obvious that you need to mobilize the cranial bones by treating the soft tissue in the cranium to be most effective in treating headaches.

The first relationship we will discuss is the relationship of the occiput and C1. When the occiput or C1 are restricted in movement the restriction puts pressure on the brainstem which causes severe headaches. These headaches can last for days. Sometimes these restrictions have been present for years in people with chronic headaches which are often diagnosed as migraines.

If we look at this relationship more closely we can see that the soft tissue of the entire back of the neck and top of the shoulders relates directly to the occiput and C1. In addition the occiput along with the sphenoid is the core of the movement in the cranial motion at the Sphenobasilar Synchondrosis (SBS). Normal cranial motion allows a freely moving occiput with little or no soft tissue restriction. So if the soft tissue is restricted along the occiput the cranial motion is also restricted. This reduces the amount of cerebral spinal fluid (CSF) that pumps into the brain. The jamming puts pressure on the brain stem. These interfere with the homeostasis of the brain, normal mental function is reduced, and pain is produced with the added pressure on the brain stem.

A perfect example is Charlene who came to me asking if I could help with her headaches that were so severe she couldn't work. These headaches first appeared when she flew home for Thanksgiving. She went to the ER and was given an injection for pain which temporarily

lessened the headache but it came back full strength. Further medical workup could not find a cause for the headaches, so she was given a prescription for a strong pain killer that she took daily. She came for treatment after being in constant pain for 10 weeks and was afraid she would be addicted to the pain killer. A structural evaluation revealed the head and neck was thrust forward with the chin raised up showing a significant shortening of soft tissue at the base of her cranium around her occiput.

The first treatment was to release the holding pattern of the soft tissue using a combination of trigger points, acupuncture points, and a modified atlas/occipital (A/O) release (Quick Release Technique). The tissue was contracted, swollen and quite painful to touch. As it released and lengthened the curvature of the neck was reduced taking pressure off the occiput and C1. When the modified A/O release was applied it not only freed the occiput from the soft tissue restrictions of the neck but also expanded the cranial motion and the pumping of the cerebral spinal fluid. Applied kinesiology revealed that an additional soft tissue release of the anterior muscles connected to C1 was needed and was applied. Within 15 minutes of the completion of the C1 soft tissue mobilization the headache disappeared entirely and did not return. This case history is typical of a severe C1/occiput headache and its successful treatment.

Another very important cranial relationship to headaches is the occipital/mastoid suture (OM). When this suture is restricted on either the left or right side it creates a cranial imbalance and compression on cranial nerves. If only one side is jammed it often leads to vertigo and an accumulation of amyloid beta and other waste products in the corresponding temporal lobe of the brain. What is also important is that when the OM suture jams the range of motion of the temporal bone is limited and the soft tissue covering it tightens which puts pressure on the trigeminal ganglion. This can cause facial headaches, or in worst case scenarios Bell's Palsy. Headaches from a restricted OM suture are usually one sided on the side of the restriction. Again since the occiput is restricted as part of the OM suture there is less pumping of CSF and diminished homeostasis of the brain.

**Jack**, a 40 year old computer consultant, developed a severe headache on the left side of his head while meeting an extremely stressful deadline. After three days Jack went to his doctor and was given muscle relaxants and pain killers. Two days later the left side of his face was numb and starting to droop. The doctor diagnosed Bell's palsy and put Jack on stronger medication. They told him it usually disappears within six months. Needless to say Jack was very concerned and came looking for other answers.

At Jack's initial visit a structural evaluation revealed his head forward and tipped to the left, part of the core distortion. Using kinesiology to evaluate Jack's cranium and neck it became apparent that Jack's occiput and mastoid were restricted in motion, and there was a spiral twist that ran throughout his body (the core distortion). The QRT was applied to release the tightened neck tissue which reduced the forward curvature of the neck and left tilt of the cranium. Freeing the occiput and stretching the dura allowed a return of normal flow of the CSF with the cranial motion.

The Cranial/Structural Core Distortion Release (CSCDR) was then applied to release the spiral twist in the cranium and throughout Jack's body. Applied kinesiology testing revealed an OM suture restriction so an additional Cranial/Structural technique to mobilize the OM suture was applied which involved rocking and synchronizing the temporal bones. The soft tissue of the neck, shoulders and cranium was then released with specialized myofascial techniques. Special attention was paid to the trigeminal ganglion and the drooping left side of Jack's face.

When Jack left his headache was gone and there was tingling in the part of his face that had been numb. After three more sessions that included mobilization of the cranium using Cranial/Structural techniques followed by soft tissue therapy Jack was out of pain and the symptoms of Bell's palsy were gone. If the cranium had not been included in the therapy Jack's condition would probably have persisted for the estimated six months and would likely have returned because the spiral twist and distortion of the cranium would not have been addressed.

One sided headaches with pain behind the eye are often referred to as ocular migraines. The cranial relationship to these headaches is a jammed palatine bone which can be evaluated with applied kinesiology. This puts pressure on the ocular nerve, and also causes an imbalance in the C7/T1 relationship which tends to rotate in opposite directions causing tightening and spasming in the muscles of the neck and shoulder. Mobilizing the Palatine and associated facial bones will usually release the C7/T1 rotations and get rid of the headaches without medication.

**Jeanie**, a 12 year old middle school student, developed painful headaches behind her right eye when studying at school. Her mother took her to the doctor who sent her to an ophthalmologist, and both agreed she was having the symptoms of ocular migraines. The recommendation was to stop reading especially under stress for three months.

Jeanie's mother brought her for treatment. Structural evaluation revealed a spiral twist of the core distortion, and applied kinesiology showed that her palatine bone was jammed on the right side. The QRT was applied to take care of the tension and stress in the tops of her shoulders and neck. The CSCDR was applied to take the spiral twist out of her cranium and her structure. The jammed palatine was then mobilized along with other associated facial bones. Jeanie's headaches went away after one treatment and did not return.

These are three common examples of how cranial bones are an integral part of the cause headache pain, and how mobilizing the cranial bones can release even severe and chronic headache conditions. The cranial techniques used were Cranial/Structural techniques to specifically mobilize the cranial bones responsible for the headaches.

See the article in the Convention issue of *Massage Message* for the 16 CE Certification class on treating headaches which will be taught by Don McCann at the 2016 FSMTA Convention

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