



Standards for Practice

for

Registered Craniosacral Therapist
(RCST)

THE CRANIOSACRAL THERAPY ASSOCIATION
OF NORTH AMERICA

Craniosacral Therapy Association of North America

STANDARDS FOR PRACTICE & CODE OF ETHICS

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Contact information:

CSTA/NA

1110 Birchmont Road, Unit 21

Scarborough, Ontario M1K 1S7

Canada

Membership and Event information:

www.craniosacraltherapy.org

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CSTA/NA CODE OF ETHICSsee Code of Ethics .pdf

STATEMENT of INTENT

It is the role of the Craniosacral Therapy Association of North America (CSTA/NA) to define and maintain professional standards for practice in the model of craniosacral therapy known as Biodynamic Craniosacral Therapy. The purpose of this document is to clearly outline the standards of competency necessary for professional clinical practice of Biodynamic Craniosacral Therapy.

It is written for the use of practitioners, teachers and as a model for course curricula. It is also available for the

Then the Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life, and man became a living soul.

Genesis 2:7

1.0 FOUNDATIONS OF BIODYNAMIC CRANIOSACRAL THERAPY

1.1 Preamble

1.1.a. Biodynamic Craniosacral Therapy is an experiential and theoretical exploration into two fundamental questions:

- What is the nature of health and wholeness?
- How does healing occur in the human body?

1.2 The History of Cranial Work

1.2.a. William Garner Sutherland, D.O. initiated this exploration with two seminal discoveries. His first discovery, that the articular surfaces of the cranial bones are designed to accommodate motion, is well documented. It is based on an inspiration that he had as an osteopathic student in 1899. He was viewing a disarticulated human skull and was drawn to notice the beveling of the sphenosquamous suture. Sutherland reports that he was struck by a thought, that the shape of the sutural surfaces are designed to accommodate motion between the bones of the skull, and that the purpose of this motion was for a primary respiratory mechanism.

1.2.b. In 1899 it was believed that the cranial sutures did not allow for individual bony motion. Based on this initial inspiration, Dr. Sutherland set about through a bold series of personal experiments to prove the immobility of the cranial sutures, as a way of testing the validity of his thought. Dr. Sutherland in fact proved cranial mobility and discovered the therapeutic value of the inherent, motile motion of the cranium and subsequently that of the whole body, from the individual cell to the organism as a whole, and beyond. Dr. Sutherland developed and refined the Cranial Concept continuously until his passing in 1954.

1.2.c. Dr. Sutherland's second discovery occurred almost 50 years after his first. In the late 1940's Dr. Sutherland directly perceived the Breath of Life making a correction to a lesion pattern in the body from the inside without the use of any external force on his part. This completely shifted his paradigm from the use of manipulative techniques in relationship to the membranous and osseous structures of the human body, to an extremely gentle approach. Dr. Sutherland discovered an Intelligence that functions as a health-

maintaining and restoring agent within human physiology. Dr. Sutherland came to appreciate this Intelligence, the Breath of Life, as being subtle in nature, unerring in its ability to heal, pre-existent to our physiology, fundamentally mysterious, and the source of health. Reverence became a primary aspect of the work.

1.3. The Intention of Biodynamic Craniosacral Therapy

It is the intention of Biodynamic Craniosacral Therapy to advance this second aspect of Dr. Sutherland's Cranial Concept. This model focuses on the Breath of Life as the primary expression of well being, and the unfoldments of the Breath of Life as the manifestation of health in and through the whole of human life. This document acknowledges the lineage of this approach from Dr. Sutherland to his student Rollin Becker, D.O., and to present practitioners and teachers in the field.

1.4. The Primary Respiratory Mechanism

1.4.a. Dr. Sutherland's early perceptual and clinical framework was organized around five anatomical and physiological functions of an involuntary mechanism within the human body. His discovery and understanding of the interrelated function of these five aspects of the human body was a unique achievement. In time, Dr. Sutherland saw this system as the means by which the Breath of Life comes into an active relationship with all of our human physiology. The movement he palpated in this system is the primary respiration of the human body, a respiration not of air, but of a force more primary and fundamental. The five aspects of the Primary Respiratory Mechanism are outlined below:

1.4.b. The Inherent Fluctuation of Cerebrospinal Fluid: Cerebrospinal fluid was called by Dr. Andrew Taylor Still, the founder of Osteopathy, the highest known element in the human body. Practitioners of the Cranial Concept have seen that it has vital functions beyond its orthodox functions. Dr. Sutherland described a pulsatory movement of cerebrospinal fluid, which has been called its inherent fluctuation. In this, it is meant that the cerebrospinal fluid fluctuates by a power found within itself and that it is not moved by structures or mechanisms found

outside itself. This power found within the cerebrospinal fluid is the potency of the Breath of Life. This fundamental and essential bioenergy is understood to be an organizing and healing principle of the human body. It is perceived to maintain the vitality, order and homeostatic balance of the human system. Dr. Sutherland considered the fluctuation of cerebrospinal fluid to be the fundamental principle in the Primary Respiratory Mechanism.

1.4.c. The Reciprocal Tension Membrane: The reciprocal tension membranes are composed of the dural membrane lining of the cranium (the inner periosteum), the falx cerebri and cerebelli and the tentorium cerebelli and their continuity with the dural tube below. The reciprocal tension membranes are seen to express their motility and mobility in respiratory cycles driven by the potency of the Breath of Life. Within the CRI level of action, they are perceived to express this motion as a reciprocal tension bi-phasic cycle. The membranes are always under a natural tension as they express the inhalation/exhalation cycles of primary respiration. The natural fulcrum of the membrane system is the anterior aspect of the straight sinus, also called Sutherland's Fulcrum (see 5.2c).

1.4.d. The Motility of the Neural Tube: The central nervous system expresses motility in relationship to the midline organizing fulcrum of the lamina terminalis of the third ventricle. During primary inhalation the midline of the neural tube shortens towards the lamina terminalis and the lateral ventricles coil up and around the Interventricular Foramina (Foramina of Monro). This has been called the ram's horn movement that mimics the embryological development of the central nervous system. The central nervous system is a core organizing system of the human body and is an expression of the ordering and potency functions of the Breath of Life.

1.4.e. The Articular Mobility of the Cranial Bones: Through detailed study of the sutural arrangements of the cranium, Dr. Sutherland discovered that the skull bones are designed to move as part of a respiratory mechanism. He further proposed that the movement of the cranial base is primary, and the movement of the cranial vault is designed to accommodate the motion

of the cranial base. The cranial bones express mobility as reciprocal cycles of flexion/external rotation and extension/internal rotation. Flexion is expressed within the inhalation phase and extension within the exhalation phase of primary respiration. Their dynamic is wholly integrated with that of the reciprocal tension membranes and with the dynamics of the entire primary respiratory mechanism.

1.4.f. The Involuntary Mobility of the Sacrum between the Iliac Crests: The sacrum, and its involuntary motion between the ilia, is classically known as the inferior pole of the primary respiratory mechanism. Its craniosacral motion is called an involuntary movement to differentiate it from the voluntary movements generated via postural mobility. The sacrum is directly and strongly attached to the dural tube at S2. Its mobility and motility have wide ranging effects on the whole of the system. Compressive issues within any of its relationships strongly affect the movement of the dural tube and of the reciprocal tension membranes and also the central nervous system due to its direct connection to the sacrum and coccyx via the filament terminalis.

1.5. Paradigm Shift: A Biodynamic Viewpoint

1.5.a. In Dr. Sutherland's original concept the primary respiratory mechanism was a grouping of anatomical and physiological functions and parts which were believed to be responsible for a primary physiological respiration. In Dr. Sutherland's later work, the emphasis clearly shifted to the primacy of the Breath of Life as the system's motivating and organizing factor. This was in essence a shift from an emphasis on anatomy and physiology, to an emphasis on deeper motive forces within the human system. This is the foundation of a biodynamic understanding of the human system. Biodynamics is the study of living wholeness and the vital phenomena which comprise that wholeness.

1.5.b. In the biodynamic viewpoint, the human system is seen to organize as a unified field around the midline (see 5.1) imperative of the Breath of Life. The concept of the primary respiratory fluid and tissue mechanism is expanded to include the primary respiratory function of the Breath of Life. Hence the Primary Respiratory Mechanism becomes the Primary

Respiratory System (PRS). This includes:

- 1) the Dynamic Stillness;
- 2) the Breath of Life and its unfoldments;
- 3) the organizing and integrating function of the
potency of the Breath of Life within the fluids;
- 4) the relationship of human physiology to the
organizing potency of the Breath of Life;
- 5) the manifestation of these relationships as a unit
of function in primary respiratory cycles of
inhalation and exhalation.

Thus the primary respiratory function is expressed
as a series of unfolding tidal forces and rhythms which
generate the motility and mobility of the potency, fluids
and tissues which comprise the human system as an
open system.

1.6 Embryogenesis

1.6.a. The work of Erich Blechschmidt (1977, 1978) on embryogenesis is profoundly important in understanding the dynamics of the Breath of Life and its unfoldments. This includes the epigenetic and pre-nervous system development of the embryo during the first six weeks following conception. The foundation of the biodynamic principles of this model of craniosacral therapy are to be found in these first weeks of the embryo as the Breath of Life unfolds the blueprint of perfection for the form and function of a human being.

1.6.b. These embryological principles are significant in Biodynamic Craniosacral Therapy:

- 1) The human embryo is distinctly human and whole from the moment of conception. Ontogeny does not recapitulate phylogeny. The human embryo does not go through the evolutionary stages of fish, reptiles, etc. It is a whole and complete human being at each stage of development, from the moment of conception onward,
- 2) The embryo is formed in the first six weeks without the modifying influences of the genes. This is called epigenesis.
- 3) The fluids of the embryo contain the Intelligence of the Breath of Life, as a fluid within the fluid.
- 4) The potency of the Breath of Life generates the form of the embryo with order and precision from within the fluids,
- 5) The physiology of order and precision is carried in the human body throughout life as a biodynamic function.
- 6) All differentiations in the embryo and adult are spatially ordered around the midlines of the notochord and the ventricles.

1.7 Competencies in the Theoretical Foundations of Biodynamic Craniosacral Therapy

1.7.a. The practitioner shall know the theoretical foundations of Biodynamic Craniosacral Therapy. This includes a detailed knowledge of the Primary Respiratory System, its underlying, dynamic forces and their inter-relationships. A practitioner shall have a

clear understanding of the human system as an integrated unit of function.

1.7.b. A practitioner shall have a clear historical perspective of the Cranial concept, from its roots in Cranial Osteopathy through to the emergence of Biodynamic Craniosacral Therapy.

1.8 Competencies in Anatomy and Physiology

1.8.a. A practitioner shall have a working knowledge of anatomy, and to be able to visualize and sense anatomical relationships. A practitioner shall have a clear knowledge of surface anatomy and to be able to locate organs and structures from the surface of the body.

1.8.b. A practitioner shall have a working knowledge of physiology, including the relationships between physiological systems. A practitioner shall have an understanding of how craniosacral therapy impacts human physiology.

1.8.c. A practitioner shall have an understanding of patterns of disturbance from a biodynamic viewpoint, and an understanding of orthodox dysfunction and its relationship to craniosacral therapy. A practitioner shall recognize changes in a client's body, including symptomology, and shall know when to refer clients to other health care professionals.

2.0 GENERAL PRACTITIONER SKILLS

2.1 Overview:

The following is a description of the specific skills to which practitioners are introduced during their training. It is recognized that development of these skills is a lifelong process, and that practitioners are continually growing their abilities in these areas.

2.2 Subtle Listening and Palpation

This form of therapy requires very sensitive palpation, perceptual and intuitive skills. All of the founding practitioners (Drs. Sutherland, Magoun, Becker, Fulford) describe how they gradually developed the capacity to "see" relationships and phenomena which are not directly visible to the casual observer, and to palpate details of anatomy and physiology deep within the tissues, including tissue

and fluid imprints of events from the past. They all emphasize the importance of developing this capacity in order to engage the Intelligence of the client's body. Developing this skill becomes a lifelong learning for practitioners and occupies a substantial part of training time. These perceptual skills are not considered to be extrasensory, but rather the result of thorough anatomy knowledge, long practice in subtle listening with multiple senses, and confidence in the instinctual process.

2.3 Orientation:

2.3.a. The practitioner shall cultivate the quality of orientation, which is the somatic experience of one's conscious sense of place in relationship to time, space and posture during a session.

2.3.b. The practitioner establishes a conscious awareness of him/herself along the following spatial axes:

- 1) Top and Bottom (Sky and Earth)
- 2) Side to Side (Left and Right)
- 3) Front and Back
- 4) Inside and Outside (differentiating inner and outer worlds)

2.4 Practitioner Neutral

2.4.a. The practitioner shall cultivate a neutral within themselves. A neutral is a place of viewing within the practitioner's system that allows witnessing of the client's process with equanimity, a presence of mind that is non-reactive and non-invasive, and an attitude that is free of judgment and expectations.

2.5 Presence

2.5.a. The practitioner shall cultivate the quality of presence, which is the act of placing one's attention in present time and the immediate environment, while maintaining one's orientation.

2.6 Mindfulness

2.6.a. The practitioner shall cultivate the quality of mindfulness, which is the ability to be a fair witness to experience and to skillfully discriminate between self and other. The practitioner can then be present with curiosity and an appropriate interest without merging with the client.

2.6.b. A corollary to this skill is that the practitioner shall cultivate the ability to acknowledge their own inner process, and shall put it aside when they are in a therapeutic relationship with a client.

2.7 The Wide Perceptual Field

2.7.a.. The practitioner shall cultivate a wide perceptual field, in which the senses are opened (seeing, hearing, touching, etc.) into the larger field from which perceptions are received. This is done without losing the perception of oneself at the center of this field. The practitioner's perceptual field then encompasses the client's system without crowding, setting the ground for the perception of therapeutically relevant phenomena.

2.8 Right Distance

2.8.a. The practitioner shall cultivate the skill of negotiation of right distance as a ground for the therapeutic encounter. Right distance is a quality of meeting the client's system that is non-invasive yet provides an appropriate therapeutic contact.

2.9 Stillness

2.9.a. The practitioner shall cultivate a direct, personal experience of stillness.

Stillness and silence are at the heart of healing in Biodynamic Craniosacral Therapy. Slowing down and waiting are essential practitioner skills. The practitioner waits for the Breath of Life to manifest its healing priorities in the fullness of each moment.

2.10 Mutuality

2.10.a. All phenomena are co-emergent and arise mutually. The practitioner shall be aware that the same Intelligence that permeates his or her fluids also permeates those of the client. That Intelligence is an aspect of the Breath of Life which dynamically co-emerges within both client and practitioner and mutually permeates the relationship.

2.10.b. A corollary of this idea is that of co-perception, which is when the client and practitioner have a mutual perception of the Intelligence at work.

2.11 Imaginal Skills

The practitioner shall appreciate the value of images as they appear during a session. Rather than actively visualizing preconceived images, the practitioner waits for images to spontaneously arise and allows them to unfold their relevance in the healing relationship. The practitioner recognizes that images may be linked to sensations in the client's body that have clinical relevance.

2.12 Integrative Skills

2.12.a. The Practitioner shall have the understanding and perception that the human system functions as a unified field. This includes an appreciation of the continuity of tissue, fluid and potency relationships within the system. The practitioner shall recognize self-integration processes as they arise during a session.

2.12.b. The practitioner shall facilitate the integration of session work via stillpoints when appropriate (see 4.1).

2.13 Skills Relating to Trauma and Shock Affect

2.13.a. The practitioner must recognize that inertial patterns within the system are not just physical tissue patterns, but are expressions of past events in which the system experienced some degree of trauma and/or shock. Trauma is a challenge to one's resources and coping mechanisms. Shock is an overwhelming experience that causes reflexive physiological and psychological imprints. The practitioner must understand that while the traumatic event may have long since ended, the system stores the memory of the event in the brain and body, and organizes itself as if the traumatic event were still occurring. Thus the processing of shock and trauma is oriented primarily towards present-time states within the system, rather than the history or story of the past event.

2.13.b. Shock Affect: As part of a traumatic experience, powerful fight or flight physiological responses are generated and these can become frozen within the system and create affects of shock and trauma. These shock affects include imploded central and autonomic nervous system energy and shock, emotional charge, hypo-mobility and tissue contraction. As inertial patterns and fulcrums are accessed, the shock and traumatization held within them may also be evoked. The practitioner shall be aware of these dynamics, be able to create a safe environment for their re-negotiation, and be able to relate to these affects therapeutically.

2.13.c. Tracking: The practitioner shall perceive tissue shock, fluid perturbation, central nervous

system arousal and autonomic nervous system cycling. The practitioner shall perceive and facilitate the discharge of shock affect from the tissues and fluids of the system, while differentiating phenomenon such as tissue shock, fluid perturbation and autonomic nervous system activation. The practitioner shall perceive other significant physiological cues such as eyes glazing over, eyes bulging, sweating, crying, skin color changes, tissue contraction, fasciculations and other body states.

2.13.d. Dissociated States: The practitioner shall have an understanding of and be able to relate therapeutically to dissociative states, fragmentation, hyperarousal, emotional effects and frozen immobile states which are integral aspects of traumatization. As these states may arise when clients access shock affects, the practitioner shall recognize them as part of the healing process. The practitioner shall know when to refer patients to other appropriate health practitioners.

2.13.e. Resources: The practitioner shall facilitate healing resources with a client. A resource is anything that will assist in the successful resolution of the situation at hand. There are many types of resources. Internal resources consist of sensation, thoughts, images, and feelings. External resources include: safe friends, family, and places in nature. Ultimately anything in a client's experience may serve as a healing resource. The practitioner shall help the client observe the elegance and beauty of their survival strategy (ie. dissociation) as a primary resource, without attempting to prematurely take away or remove the strategy that may have saved their life at the time of the trauma.

2.13.f. Containment: The practitioner shall relate therapeutically to shock and trauma issues via containment. The principle of containment involves the practitioner indirectly holding, in the session context, what the client has been unable to process, which are the affects from previous shock and trauma (Emerson, in press). This allows the practitioner to meet the client in a manner which does not challenge the survival resources of the client. The principle of containment consists of four specific functions used by the practitioner:

- 1) Holding: The formation of a receptive container for the client's shock material by being present and remembering the sequence of events through careful listening and observation. The gathering of information on the client's available resources by the use of comprehensive history taking, observing physiological symptoms and movement patterns, along with skilled palpation.
- 2) Protection: Sealing the container through strict confidentiality, the practitioner holds the client's material in their own being. The practitioner holds material the client is unable to hold due to the nature of the experience(s). This includes protecting the client by suspending judgment and advice giving.
- 3) Immersion: The practitioner immerses him or herself in the client's material by contemplating the shocking events. The practitioner silently but consciously names and conceptualizes the shocks and their affects.
- 4) Consultation: The practitioner consults with the client to help initiate lifestyle and behavioral changes to minimize the reactivation of shock patterns. This includes referring a client to other appropriate health care professionals when necessary.

2.13.g. Supervision: It is recommended that practitioners who often work with shock and trauma issues receive professional supervision on a regular basis. Advanced training is highly recommended to provide the skills for competent work in this area.

2.14 Process and Communication Skills

2.14.a. The practitioner shall have basic communications competencies and skills so that they feel confident in relating to the client's arising process and so that the client, in turn, feels heard and held in safety. This includes the ability to be in appropriate verbal contact with the client in order to facilitate the exploration of their arising process. The practitioner shall skillfully dialogue with the patient in sessions to help maintain a safe therapeutic environment. It is also important to know when verbal communication would just get in the way of the arising process and would therefore be inappropriate. The intention of Biodynamic Craniosacral Therapy is to work in

relationship to the primary forces of health in the client, and communication skills support this process.

3.0 THE BREATH OF LIFE: UNFOLDMENTS & PERCEPTION

3.0.a. The essence of Biodynamic Craniosacral Therapy is an understanding of the natural forces which underlie and organize human health. Dr. Sutherland first perceived these forces acting in relationship to cerebrospinal fluid, and borrowed the term "Breath of Life" from the Bible to signify these forces.

3.0.b. In the evolution of Biodynamic Craniosacral Therapy, a conceptual model has emerged to describe various phenomena which are generated by the unfoldments of the Breath of Life. At the level of each unfoldment additional phenomena arise as the Breath of Life manifests in relationship to human physiology.

3.0.c. Each of the unfoldments of the Breath of Life is accessed through a particular perceptual state; a transmutation or shift in consciousness on the part of the practitioner facilitates the relationship and sets the ground for the possibility of change and healing.

3.0.d. Healing in Biodynamic Craniosacral Therapy is understood as a re-emergence of the essential order inherent within the human system. Various experiences and conditions of life can limit the expression of the Breath of Life as it moves in primary respiration. The degree to which primary respiration, as a function of the potency of the Breath of Life, is able to express motion through the whole of the human system, is the degree to which the system is said to be expressing health.

3.1 Perceptual Levels

3.1.a. Sections 3.2 through 3.5 present a thorough description of each of the unfoldments of the Breath of Life, described in terms of the perceptual levels that a practitioner experiences during a craniosacral therapy session. This section is based on the work of Franklyn Sills.

3.2 The Cranial Rhythmic Impulse (CRI)

3.2.a Rate: 8-14 cycles/minute

3.2.b. Palpation: Hands float on tissues, perceptual field narrows to bones, membranes, structural parts, tissue structures, and their relationships.

3.2.c. Mind: Relatively active, analyzing, looking at the relationship of parts and structures.

3.2.d. Emotion: Emotional affects, effects of trauma and experience, emotional fixity. Activation may arise in sessions. Emotional responses are based on past conditioning and defended positions.

3.2.e. Perceptual Experience: Inhalation and exhalation phases perceived as cycles of reciprocal tension motion. Tissue and fluid motion experienced via their reciprocal tension motions. The practitioner commonly experiences tissue motion as the relationship of separate structures in reciprocal tension. Craniosacral motion, flexion and extension of separate parts, predominates one's awareness. Motion is perceived to be organized around automatically shifting tissue fulcrums.

3.2.f. Tidal Unfoldment: The CRI level of motion is generated as an expression of the relationship of parts and structures. It arises as structures and the relationship of anatomical parts form embryologically. Craniosacral motions are not direct expressions of motility, they are outer motions driven by deeper forces. The CRI is an outer expression of motion conditioned by genetics and experiential processes. It is the wave form of our experience, it is not a direct expression of the Tide. The quality of the CRI is directly affected by the state of the autonomic nervous system. Autonomic set points effect CRI expression. The CRI has a variable rate of 8 - 14 cycles a minute which is an expression of conditioned processes. Its rate of expression will change due to the forces of unresolved inertia and the nature of the unresolved experiences held within the system.

3.2.g. Inertial Perception: Within the CRI level of perception, the perception of inertia and unresolved experience is via an awareness of results and effects.

Expressions of inertial processes are perceived via tissue and fluid effects, resistance between anatomical structures and via symptoms and pathology. The

deeper forces at work are not directly perceived. An awareness of lesions predominates the practitioner's perceptual field. These are perceived as tissue and fluid effects, such as tissue resistance, adhesion, compression, pathology, stasis within fluids, and resistance between tissue structures. A perception of activation and fragmentation predominates. These are commonly perceived as tissue compression, adhesion, changes in quality of tissues, strains and fluid fluctuations. Perception is about form and resistance, about how/where we hold unresolved trauma and resistance as CNS hyper- and hypo-states, as tissue and fluid inertia, as resistance between parts, as emotional effects, psychological positions, and as pathological processes.

3.2.h. Inertial Fulcrums: Inertial fulcrums are perceived via tissue lesions, strain patterns, sites of tissue change, loss of mobility, resistance; as fluid congestion and eccentric fluid fluctuation. Inertial fulcrums are located via motion testing, analysis and diagnosis, application of techniques, traction, fluid direction etc. The practitioner actively applies processes to locate and resolve inertial fulcrums which are perceived as lesions.

3.2.i. Organization Perceived: Organization is perceived to be an expression of the relationship and motion of parts. Inertial organization is perceived through motion or fixation around lesion sites, and via tissue and fluid stasis. These are perceived as the results and effects of experience and suffering. The organizing midline is perceived to be a structural axis through the vertebral bodies and cranial base. Automatically shifting fulcrums are perceived to be sites within tissue relationships. Hence, reciprocal tension motion is perceived to be organized around embryologically derived tissue fulcrums, such as Sutherland's fulcrum.

3.2.j. Healing Perceived: Healing processes are based on the acknowledgment of suffering, on a practitioner's relationship to the results and effects of suffering. Healing is perceived as a resolution of CNS activation, emotional effects, symptoms and pathologies and tissue and fluid congestion/resistance.

3.2.k. Healing Modes: Practitioner is active. Work

is lesion, symptom and activation oriented. The practitioner actively seeks neutral states within tissue, fluid and emotional effects. The practitioner is more active in seeking the point of balanced membranous tension. Conversations with tissues and fluids are technique and method based. Processes of decompression, traction, compression, fluid direction, lateral fluctuation of fluid, may be applied to an inertial tissue site.

3.3 The Mid-Tide

3.3.a. Rate: 2.5 cycles a minute

3.3.b. Palpation: Hands immersed/floating within fluid. The practitioner widens his or her perceptual field to include the whole of the person and their biosphere. (The biosphere includes the whole of the physical body, the energy field and the area of environmental exchange around the client's body).

3.3.c. Mind: The mind is relatively still/quiet. The tendencies and conditioning of the mind still may arise. To help synchronize the mind with the mid-tide, allow the mind to settle, finding a still, inner neutral. The practitioner's mind is not interested in parts and relationships per se, but in whole units of function.

3.3.d. Emotion: Emotions are fluid and appropriate to the present experience. Emotional responses and resolutions appropriately arise in present time. Emotional effects and releases are expressed in contained and resourced ways. Emotional activation has the quality of completion, the emotional state does not continue to cycle and is not reinforced.

3.3.e. Perceptual Experience: Potency, fluids and tissues are perceived by the practitioner as a unified field of action. At this level of perception, the practitioner is aware of potency as a transmutation within the fluids. Potency is experienced as a physiological ordering factor within the fluid system. Potency is the organizing factor, fluid is the medium of exchange and cells and tissues organize around its action.

Within the mid-tide, the practitioner is aware of organizing forces at work. These include the biodynamic potency of the Breath of Life and the inertial forces of unresolved experience. The

practitioner is aware of each function of potency, fluid and tissue as a unified and whole tensile field of action. Tissue motility and motion is perceived as a unified tensile field. Individual structures are directly perceived to be part of a unified motility throughout the body. Flexion and extension dynamics are perceived to be a factor of deeper forces at work. An inner breath is perceptible within tissue motility. Flexion and extension of individual bones, of the reciprocal tension membrane and of tissues generally, is perceived to be part of a greater whole. Inhalation and exhalation cycles are perceived as a surge and settling within tensile fields. Motion dynamics are perceived via awareness of unified tensile fields organized around automatically shifting fulcrums. Automatically shifting fulcrums are perceived to be loci or condensations of potency which organize tensile fields of action.

3.3.f. Tidal Unfoldment: Here we have a direct experience of potency within fluids. Potency, fluids and tissues are perceived to be a unified tensile field expressing a tidal rhythm of 2.5 cycles a minute. Tissues, fluids and potency experienced as whole tensile fields of action. The mid-tide is a relatively stable rhythm sensed as an inhalation surge and an exhalation settling within tensile fields.

3.3.g. Inertial Perception: Expressions of inertial processes such as conditioned tissue motion and patterns of inertial motility and mobility, are perceived as distortions within whole tensile fields. The practitioner perceives the whole tensile field distorting around inertial fulcrums. Tissue motility is perceived as a unified field, inertial patterns are perceived as distortions of this field organized around inertial fulcrums. Information within this level of perception is more precise and encompassing than at the CRI level. There is no need to motion test in order to gain clinical information. The practitioner has a direct experience of inertial forces, shapes and organizing fulcrums. The practitioner's mind is more still, less active and the work is less tiring.

3.3.h. Inertial Fulcrums: Inertial fulcrums are directly perceived as sites of inertial potencies. Inertial fulcrums are perceived as condensations of inertial forces within tensile fields of action. Within the mid-tide level of perception, inertial fulcrums are located via

direct perceptual experience. The practitioner is aware of the biodynamic and biokinetic forces at work at the heart of organizing fulcrums. There is an experience of the coupling of biodynamic potencies with inertial forces in order to center and contain the inertial forces. Inertial fulcrums are not automatically shifting fulcrums. They are sites of stasis which do not shift with the intentions of the Tide. Inertial patterns are perceived via distortions within tensile fields of action organized by condensations or concentrations of inertial forces.

3.3.i. Organization Perceived: Organization is directly perceived to be a factor of the potency within the fluids. Inertial organization is perceived as tensile distortions around the condensation of inertial potencies. The forces at work are seen to be the organizing factors. The organizing midline is perceived as the dorsal, or fluid midline, as it is expressed along the neural axis. The fluid tide is perceived to be a manifestation of the potency within the fluid midline.

3.3.j. Healing Perceived: Healing is perceived as a factor of transmutation. Healing is perceived as the resolution of inertial forces and via the reorganization of tissues, fluids and potencies to the primal midline and natural fulcrums. Natural motility is re-established.

3.3.k. Healing Modes: The state of balanced tension is seen to be inherent within the inertial pattern. The treatment plan inherent within the disturbance is perceived. There is an inherent tendency for a neutral to be accessed. At most, the practitioner facilitates state of balance by slowing motion down. Dr. Rollin Becker's three stage healing awareness unfolds:

- 1) Tissues, fluids and potencies naturally seek a neutral. There is a movement towards a state of balance.
- 2) The state of balance is accessed, a functional stillpoint arises. Something happens within the state of balance beyond the conditions present. Biodynamic potencies are liberated, and biokinetic forces are resolved and dissipated. Expressions of Health are perceived. There is a permeation of potency and inertial forces are resolved.
- 3) Tissues, fluids and potencies reorganize/realign

to the primal midline and natural fulcrums.

The Practitioner may offer and engage in conversations about space and history via subtle negotiated intentions of disengagement, space, traction, direction of potencies, lateral fluctuations of potency, etc. offered as conversations rather than as techniques or protocols.

3.4 The Long Tide

3.4.a. Rate: 50 second cycles of inhalation and exhalation (100 seconds total).

3.4.b. Palpation: Hands immersed/floats within potency. The practitioner widens his/her perceptual field towards the horizon. A wide perceptual field is maintained.

3.4.c. Mind: The practitioner's mind deepens and is still, breathes with the Breath of Life within a wide perceptual field. There is still an experience of an observer, although very subtle and still.

3.4.d. Emotion: Expansive emotions predominate, such as joy, warmth, sense of connection and humility.

3.4.e. Tidal Unfoldment: This is the Tide per se. The Long Tide is perceived as a direct organizing intention within and around the patient. At this level of perception, the practitioner has the experience as being in the Tide. The Long Tide is perceived to generate powerful tidal expansions within the body of 100 second cycles (50 seconds inhalation, 50 seconds exhalation). Its intention may also be experienced in a wider field as very slow cycles of expansion (15 - 20 minute cycles). Potency is seen to be an unfoldment of a particular intention to create which carries the universal matrix of a human being.

3.4.f. Perceptual Experience: The Long Tide is perceived to act from the outside in, generating a condensation or concentration of potency expressed as a vortex-like midline, and the bioelectric organizing field which forms around it. Potency is perceived to be a bioelectric field phenomenon. At this perceptual level, the potency of Breath of Life is directly perceived. The practitioner senses potency as a radiance permeating everything. The experience of radiance passes through the practitioner's hands.

There is a light, airy yet powerful experience of radiance. There is a perception of cellular permeation. There is a perception of potency as a field phenomenon. The Original or primal matrix is directly perceived.

3.4.g. Inertial Perception: Inertia is not perceived via fulcrums or inertial motion patterns. Inertial issues are perceived as coalescence and distortions within a matrix, much like Einstein's concept of mass bending the space-time continuum. Inertia is perceived as density and distortion, within a wider matrix. This is similar to how mass is thought to bend space-time in the theory of relativity.

3.4.h. Inertial Fulcrums: Inertial fulcrums are perceived as a density and distortion within an energetic matrix.

3.4.i. Organization Perceived: Organization is perceived as a factor of the radiance of the potency of the Breath of Life and the Original Matrix. The primal midline is more obvious. The geometric precision of the original matrix is perceived. God geometrizes, man cognizes (Randolph Stone, DO). The organizing axis is perceived via the primal midline as an emergent reality.

3.4.j. Healing Perceived: There is a direct experience of the potencies of the Breath of Life doing the healing. Potency shimmers like sunlight on the sea, inertial fulcrums vibrate, inertial forces resolve via permeation, transmutation and a re-connection to the original matrix. Healing is perceived as a shift or resolution within the bioelectric matrix.

3.4.k. Healing Modes: The practitioner's mind is still, potency is directly perceived. Healing is perceived to arise from the without to the within via transmutation and re-connection to the Original matrix. The practitioner is a humble observer holding space and relationship. The practitioner keenly listens to processes of re-connection and transmutation.

3.5 The Dynamic Stillness

3.5.a. Entry: The practitioner's mind stills, settles, deepens and expands, letting go of self-view.

3.5.b. Mind/Consciousness: The practitioner's state of mind is unified, still, expanded, no-self, no self constructs, no subject-object relationship, unity consciousness.

3.5.c. Emotion: Within the Stillness there is no self-other perception. There is only a unified field of compassion. Equanimity and compassion are directly sensed as an illimitable and unified natural state of grace. This state is not personal, but universal.

3.5.d. Perceptual Experience: Within this state there is perception without a perceiver. There are no tides, only an alive, dynamic Stillness. Vibrancy predominates.

3.5.e. Organization Perceived: Organization is an expression of the intention of the divine.

3.5.f. Healing: Healing occurs via direct resonance. Space and time are irrelevant. Healing can be instantaneous.

3.6 Competencies

3.6.a. The following competencies are expected of practitioners in relationship to the unfoldments of the Breath of Life.

- 1) A practitioner shall have a theoretical understanding of the unfoldments of the Breath of Life.
- 2) A practitioner shall have an experiential understanding and recognition of each of the perceptual levels of unfoldment.
- 3) A practitioner shall have the skill to consciously shift perceptual levels during a session.
- 4) A practitioner shall perceive inertial effects at each level of unfoldment.
- 5) A practitioner shall have an experiential understanding of how the system is organized at each perceptual level.
- 6) A practitioner shall perceive and relate clinically to the three functions of potency, fluids and tissues within each of the three perceptual levels and tidal unfoldments.

7) A practitioner shall have an experiential understanding and recognition of the relationship between each level of unfoldment and the particulars of the Primary Respiratory System.

4.0 CONVERSATION SKILLS

4.0.a . Practitioners shall directly relate to the forces and patterns of history held within the client s system. It is the intention of Biodynamic Craniosacral Therapy to bring these forces and their affects back into relationship to the intrinsic potency of the Breath of Life. Conversation skills are the skillful means by which the practitioner can relate directly to the health of the system, as it is expressed through tissues, fluids and potency, in the context of a therapeutic relationship.

4.1 Stillpoints

4.1.a. A stillpoint may be defined as the local or global cessation of the movement of a tidal unfoldment and its attendant tissue motion. A stillpoint may serve as the entry into deeper experiences of stillness which in their turn may catalyze the healing process. A naturally occurring stillpoint is also known as a "functional stillpoint" and should be understood as the unfoldment of the natural healing plan of the system. A practitioner shall understand the therapeutic implications of stillpoint, and shall recognize the arising of a naturally occurring stillpoint within a client s system.

4.1.b . Stillpoints may also occur as the result of a therapeutic conversation. A client s system is encouraged by the practitioner to come into stillpoint so that health and healing may be accessed. A practitioner shall encourage the experience of a stillpoint during a therapeutic interaction. Practitioners shall help deepen the resources of a patient s system and to facilitate their expression via stillpoint processes.

Three types of stillpoints are generally recognized in therapeutic practice; the traditional nomenclature is given below:

1) CV4, compression of the fourth ventricle. A CV4 facilitates the consolidation of potency from the

field into the midline of the body.

2) EV4, expansion of the fourth ventricle. An EV4

facilitates the expression of potency away from

the midline into all the fluids of the body.

3) CV3, compression of the third ventricle. A CV3

facilitates the ignition of potency with the fluid

system as a whole and within the ventricles of

the brain specifically.

4.2 States of Balance

4.2.a. All motion in the body is expressed within tensile fields, it is bi-phasic and limited by a boundary. This is true at the layer of tissues, fluids and within potency itself.

4.2.b. Movement in the system is organized around a fulcrum (see 5.2), as an expression of dynamic forces and their effect on the layers of the system. At each fulcrum there is a place where these dynamic forces balance each other's tendencies, resulting in a state of balance. A state of balance is characterized by the cessation of movement around a fulcrum, accompanied by a sense of settling into a place of dynamic rest and stillness. States of balance may occur at each of the three functions of tissue, fluid and potency.

4.2.c. When a state of balance in the tissue, fluid and potency layers of a fulcrum is achieved, the practitioner perceives stillness. It is in stillness that access to the Breath of Life may occur. Healing arises spontaneously as the potency of the Breath of Life reorganizes the three functions, re-establishing relationship to the natural fulcrums and midlines of the PRS.

4.2.d. A practitioner shall understand the theory and therapeutic implications of states of balance. Additionally, a practitioner shall facilitate states of balance in the tissues, fluids and potency of a client's system,

4.3 Lateral Fluctuation of Cerebrospinal Fluid

4.3.a. The natural expression of fluid motility is longitudinal. There are also lateral fluctuations found within normal body physiology. However, lateral fluctuations can also arise as the fluid effects of inertial fulcrums, they are a fluid response to patterns of disturbance within the system.

4.3.b. The practitioner shall perceive lateral fluctuations of cerebrospinal fluid and of fluid generally in the system. They shall have a clinical understanding of the significance of these motions. The practitioner shall respond therapeutically to lateral fluctuations of fluid.

4.3.c. A practitioner shall initiate lateral fluctuations of fluid and potency to clarify and amplify inertial issues and the forces involved. The initiation of lateral fluctuations begins a conversation with inertial potencies via the fluids and the tensile field of potency as a whole.

4.4 Direction of Fluids and Potency

4.4.a. The practitioner shall facilitate the resolution and re-organization of inertial fulcrums via direction of fluids and potency towards sites of inertia. This skill initiates a conversation with inertial fulcrums and the inertial potencies involved via the fluids of the body. This includes V spread processes and general fluid direction techniques.

4.4.b. A sensitivity to the nuances of the responses to fluid direction is essential in this process. This includes awareness of the echoing and fluctuations of fluids in relationship to dense inertial issues, and sensitivity to the welling up of potency within them as a manifestation of the body's healing processes.

4.4.c. A "V-spread" refers to the position of the practitioner's hands that may be utilized with the direction of fluids, usually in relationship to sutural inertia. One hand is placed over the point of restriction with the index and middle finger forming a "V." The other hand is on a diagonal vector opposite the "V." Fluids are directed toward the "V," which serves to monitor the suture via contact on the articulating bones. The practitioner shall utilize a V-spread and direction of potency in appropriate therapeutic contexts.

4.5 Traction

4.5.a. The practitioner shall initiate conversations about lengthening with membranes and connective tissues via traction. The practitioner shall initiate this conversation from various vantage points, and relate to specific layers of tissue, most importantly the Reciprocal Tension Membrane.

4.6 Disengagement

4.6.a. A practitioner shall initiate conversations about spaciousness via the intention of disengagement. This intention is brought into relationships which have

become compressed, and is essentially a conversation about the space already present within the site of compression.

4.7 Exaggeration

4.7.a. The practitioner shall initiate conversations with effects around an inertial fulcrum by following their direction of preferred movement or direction of ease. Exaggeration of the direction of ease can clarify motion possibilities and provide the practitioner with a clearer sense of how the system has organized around an inertial fulcrum. By following the direction of ease, the path of least resistance, the practitioner reduces the tension around the inertial fulcrum with an intention of accessing a state of balance.

4.8 Direct Action

4.8.a. The practitioner shall initiate conversations with tissue effects around an inertial fulcrum by encouraging tissues to move in the direction against that of their inertial pattern. In this conversation the practitioner reminds the system of other movement options, and additionally offers the possibility of a relationship to spaciousness. The intention of direct action is to access a state of balance.

4.9 Opposite Physiological Action

4.9.a. The practitioner shall initiate conversations with interosseous effects by engaging one component of an articulation in a conversation of direct action (4.8) and the other component in a conversation of exaggeration (4.7). The intention of opposite physiological action is to access a state of balance.

4.10 Intraosseous Motion

4.10.a. The practitioner shall initiate conversations with intraosseous motility- the movement within an individual bone as it expresses primary respiration. Intraosseous motility is dynamic in nature, and may include the release of heat from the bone or a sense of the bone behaving like membrane or cartilage. In this conversation the practitioner is in relationship to patterns held with an individual bone. The intention of this conversation is to access a state of balance.

5.0 SPECIFIC RELATIONSHIPS OF STRUCTURE AND

FUNCTION

5.0.a. It is the intention of this section to outline the relationships within the human system that the practitioner shall understand and be able to relate to therapeutically. The practitioner must understand theoretically and experientially the material outlined in sections 1 through 4 in order to relate therapeutically to the structural and functional relationships discussed below. Thus, when the phrases therapeutically respond to or clinically respond to are used below, they refer to the ability to blend the skills outlined in the sections above with the structural and functional relationships discussed below.

5.0.b. This section has been organized in three parts. The first part presents competencies on core aspects and functions (biodynamics) of the PRS. Following this the outline has been organized in accordance with the five biomechanical aspects of the PRS (5.1 and 5.2). Following the competency outline on each of the biomechanical aspects of the PRS, there are outlines detailing the competencies pertaining to structures and functions which relate directly to these aspects of the PRS (5.3 through 5.18). Finally, several sections outlining competencies for various types of whole body dynamics are found at the end of this section (5.19 through 5.24).

5.1 Primal and Fluid Midlines

5.1.a. The practitioner shall understand and perceive how the Breath of Life unfolds the blueprint of life into human form. It does so around a primal midline, which exists anatomically as the notochord of the embryo, and later as the structures which differentiate from the notochord notably the vertebral bodies, the intervertebral discs, the basi-occiput, basi-sphenoid and ethmoid.

5.1.b. This primal midline is the axis around which the entire form and function of the human body differentiates embryologically. The Breath of Life condenses as an intention in this primal midline and its perfect geometry becomes imprinted on the physiology of the embryo during the first six weeks of development.

5.1.c. The practitioner shall have an awareness of

this primal midline function as the organizing principle throughout life, and shall relate to this function therapeutically. This imprint of perfection is the orientating midline for structure, function and body physiology from the moment of conception until the moment of death.

5.1.d. The practitioner shall know that a second midline called the fluid midline is located in the ventricles of the brain and the subdural space, and shall perceive and relate to this midline therapeutically. The Breath of Life found in the primal midline of the notochord transmutes itself into the Potency within the cerebrospinal fluid.

5.2 Fulcrums

5.2.a. Natural Fulcrums: A fulcrum is the still point in space around which motion organizes. This motion may be perceived in the tissues, fluids and energetic forces of the human system. The architecture of the human body includes natural fulcrums, which are the still points that organize the motion of specific layers of the system. All natural fulcrums are organized in relationship to the primal and potency midlines of the body. A practitioner shall know the natural fulcrums of the body both theoretically and perceptually.

5.2.b. The natural fulcrums of the body include (but are not limited to): the sphenobasilar junction as the natural fulcrum for the movement of the cranial bones, the lamina terminalis of the third ventricle as the natural fulcrum of Central Nervous System motility, and Sutherland's Fulcrum as the natural fulcrum for the movement of the Reciprocal Tension Membrane and connective tissue generally.

5.2.c. Natural Shifting Fulcrums. Dr. Sutherland discovered that a fulcrum may move automatically within a range in space while maintaining its function as a point of organization. Sutherland's Fulcrum is one such fulcrum. It is located at the anterior end of the junction of the falx cerebri and the tentorium cerebelli. Dr. Sutherland called this a suspended automatically shifting fulcrum. These are natural focal points which organize motion and form, and which automatically shift with the intentions of the tide.

5.2.d. Inertial fulcrums: Inertial fulcrums are loci of

inertial potencies which arise out of the interplay of biodynamic and inertial forces. Biodynamic potencies are the potencies of the Breath of Life. Inertial forces occur from overactive genetics, injury, trauma, pathogens and toxins, which restrict the expression of the Breath of Life as motility and mobility in any layer of the system. Biodynamic forces will become inertial in order to center and contain the presence of inertial forces which create an inertial fulcrum. Dr. Rollin Becker called inertial forces biokinetic forces.

5.2.e. Inertial fulcrums are direct, compensatory responses mediated by the health and intelligence of the system (the potency of the Breath of Life) to an individual's life experiences. The potency at the heart of the inertial fulcrum carries the inherent treatment plan for the resolution of a fulcrum, including the dissipation of the inertial forces.

5.2.f. The tissue and fluid worlds organize around inertial fulcrums creating local changes in the state of both fluids and tissues. Tissue effects include: compression, contraction, thickening, shortening, dehydration and/or a loss or increase of tone. Tissue effects and pathology are thus external expressions of the deeper forces and potencies at work within the heart of the fulcrum. A practitioner shall sense how inertial fulcrums create tissue effects in the body, and shall relate therapeutically to tissue effects within the system.

5.2.g. Practitioners shall perceive inertial fulcrums within the system, and relate therapeutically to the forces at work within an inertial fulcrum.

5.3 The Primary Respiratory Mechanism (Biomechanics)

The PRM is classically composed of the anatomical and physiological elements at the core of the body. Its boundary is the dural membrane system and everything that is firmly attached to it. These physical relationships coalesce around the midline function of the Breath of Life, bringing physiology into a relationship with the deeper energies of life. The PRM expressed as a physiological system is involved in the maintenance of order and vitality throughout mind, emotions and the body. The PRM is classically composed of five aspects (see section 1.4, b through

f):

- 1) the inherent fluctuation of cerebrospinal fluid
- 2) the motility of the neural tube (the brain and spinal cord)
- 3) the reciprocal tension membrane
- 4) the articular mobility of the cranial bones
- 5) the involuntary mobility of the sacrum between the ilia

5.4 The Inherent Fluctuation of Cerebrospinal Fluid

The practitioner shall perceive the fluctuation of cerebrospinal fluid and shall sense its expression in the primary respiratory phases of inhalation and exhalation. The practitioner shall be able to perceive the longitudinal fluctuation of the fluid in its tidal unfoldments. The inherent fluctuation of cerebrospinal fluid is driven by its potency, which is in turn disseminated to all of the body's cells and tissues via its fluid systems.

5.4.a. The practitioner shall sense the quality of potency within the fluid system and its fluid drive (vitality). The expression of the potency of the fluid tide is a manifestation of the health of the system, providing a clinical baseline in the analysis of a client's system.

5.4.b. A practitioner shall perceive the longitudinal fluctuation of CSF along the long axis of the body. A practitioner shall perceive longitudinal fluctuations, understand their clinical significance and relate therapeutically to these fluctuations.

5.4.c. The practitioner shall perceive lateral fluctuations of fluids, appreciate the information that these fluctuations communicate and to be able to sense the healing potential in that process.

5.5 The Venous Sinus System

5.5.a. Perception and palpation: The practitioner shall understand and perceive the dynamics of the venous sinus system.

5.5.b. Inertial states: The practitioner shall perceive inertia within the venous sinus system and to relate to its inertia therapeutically. Practitioners shall respond clinically to inertial issues found within the

outlets to venous sinus flow. These include the thoracic inlet, the cervical area in general and the jugular foramen. The practitioner shall facilitate release of fluid congestion in the major venous sinuses: the confluence of sinuses, transverse, occipital, straight, sagittal and cavernous.

5.5.c. Continuity: The practitioner shall appreciate the relationship of the venous sinuses to the reciprocal tension membranes and related cranial bones, and to the PRS in general. This includes the effect of cranial base patterns and intraosseous lesions on the venous sinus system.

5.6 The Motility of the Central Nervous System

5.6.a. Perception and palpation: The practitioner shall sense the motility and mobility of the central nervous system in its inhalation and exhalation phases, in relationship to its natural fulcrum, the lamina terminalis (the anterior wall of the third ventricle). Practitioners shall perceive the spaces within the central nervous system, the ventricles and water beds, and to be able to relate clinically to inertia and congestion within them.

5.6.b. Inertial Fulcrums and Patterns: The practitioner shall perceive inertial patterns within the central nervous system and to recognize the fulcrums which organize them. These include issues of fluid congestion, tissue resistance and cranial structural patterns. Practitioners shall respond therapeutically to these patterns.

5.6.c. Continuity: Practitioners shall have an appreciation and comprehension of the continuity of the central nervous system with the dynamics of the primary respiratory system as a whole. This includes an awareness of the continuity of the central nervous system function with membrane, bone and fluid relationships. Hence, a membranous articular strain pattern within the cranium will be expressed somehow within the central nervous system and vice versa.

5.7 Central Nervous System Facilitation

5.7.a. Perception and palpation: The practitioner shall perceive and comprehend the significance of facilitation in spinal, somatic and visceral dynamics. Practitioners shall appreciate that the spinal cord is not

horizontally segmented, and that facilitation is a dynamic phenomenon within the spinal cord and central nervous system as a whole. Facilitation has repercussions beyond the site of the vertebral segment being palpated. Facilitation within the central nervous system can be the result of peripheral inflammation, hypersensitivity within viscera or soma, vertebral fixations, on-going stress, traumatic events and shock.

5.7.b. Inertial Patterns: Practitioners shall perceive the vertebral zones of facilitation involved, the related area of dorsal horn transduction and their visceral and somatic relationships, and relate to all this therapeutically.

5.7.c. Continuity: Practitioners shall understand the physiological repercussions of facilitation and its implications. These include:

- 1) the relationships of the nervous system to visceral and somatic input and output;
- 2) the relationship of the peripheral nervous system to central processors,
- 3) the relationship of nociception to dorsal horn neurons and spinal cord interneuronal pools; and
- 4) the relationships of the flooding of input via nociception to the dorsal horn neurons, the brain stem nuclei and the hypothalamus-pituitary-adrenal axis.

The role of facilitation shall thus be understood in terms of the general adaptation response and the homeostatic balance of the system.

5.8 The Reciprocal Tension Membrane

5.8.a. Perception and palpation: The practitioner shall perceive the reciprocal motion dynamics of the reciprocal tension membrane (RTM). This includes sensitivity to its flexion and extension dynamics and to its natural fulcrum at the straight sinus.

5.8.b Inertial Patterns: Practitioners shall perceive inertial patterns within the reciprocal tension membranes, classically called strain patterns, and respond to them therapeutically.

5.8.c. Cranial Membranous Articular Strains: Practitioners shall perceive the continuity of bone and dural membrane. They shall sense that inertial patterns within the cranium are always a continuity of bone and membrane relationship classically called cranial membranous articular strains. Practitioners shall sense inertial fulcrums in bony relationships that affect membranous function and shall sense membranous fulcrums that affect bony function. Practitioners shall relate to the whole of a cranial membranous articular strain therapeutically.

5.8.d. Sutherland's Fulcrum: Practitioners shall have an awareness of, and sensitivity to, the dynamics of Sutherland's Fulcrum as the natural organizing fulcrum of the reciprocal tension membranes. Practitioners shall sense changes in its tensile field via an awareness of this fulcrum and its dynamics.

5.8.e. Continuity: Practitioners shall have an understanding and sensitivity to the continuity of the reciprocal tension membranes with the relationships of cranial bones, fluids, neural tube, connective tissues and fascia. Practitioners shall have a comprehension of and sensitivity to the continuity of the dural system from the anterior pole at the crista galli of the ethmoid bone to the most inferior pole at the sacrum and coccyx. An appreciation of the relationships and dynamics of the dural tube is an essential part of this awareness.

5.9 The Core Link

5.9.a. Perception and palpation: Practitioners shall sense the motility and mobility of the dural tube. They shall sense this motion from the superior pole at the occiput and the inferior pole at the sacrum, and from other relationships as well.

5.9.b. Inertial Patterns: Practitioners shall perceive inertial patterns and their organizing fulcrums within dural tube relationships by sensitivity to dural motion, inertia within dural glide, and by sensitivity to the fluid spaces within the dural boundaries. Practitioners shall sense inertial fulcrums within the dural tube via sensitivity to cerebrospinal fluid fluctuation. Practitioners shall relate to these inertial patterns therapeutically.

5.9.c. Pelvic dynamics: Practitioners shall sense the dynamics of the pelvis in its direct relationship to the dural tube. This includes patterns found at the lumbosacral junction, the sacroiliac joints, the coccyx, the hip joints and the pubic symphysis. Practitioners shall relate to these patterns therapeutically. This is outlined in more detail in the section below on the involuntary motion of the sacrum between the ilia.

5.9.d. Vertebral dynamics: Practitioners shall have the ability to perceive and respond therapeutically to the dynamics of the vertebral column and individual vertebra in relationship to the dural tube. Practitioners shall perceive and therapeutically relate to vertebral fixations and the related tissue adhesions and congestion found within dural dynamics. This is outlined in more detail in the section on spinal dynamics below.

5.9.e. Occipital/Atlantal/Axial Triad: Practitioners shall perceive the dynamics of the occipital/atlantl/axial triad and its direct relationship to the dural tube. Practitioners shall perceive inertial patterns within these relationships and respond to them therapeutically. Within this, practitioners shall relate therapeutically to the cervical vertebra and fascia in general. Practitioners shall also be able to therapeutically relate to introsseous lesions of the occiput and its condyles as these affect the dynamics of the atlas and dural tube.

5.9.f. Continuity: Practitioners shall have an appreciation of the continuity of the dural tube with connective tissue and fascia. Practitioners shall perceive overall fascial and connective tissue patterns which affect the functioning and motion of the dural tube and to relate to these therapeutically. Practitioners shall perceive the dural tube and its dynamics as an integral part of the functioning of the reciprocal tension membranes.

5.10 The Articular Mobility of the Cranial Bones

5.10.a. Phases of Motion: The practitioner shall perceive the motility and mobility of the bones of the cranium in respiratory phases of flexion/external rotation and extension/internal rotation. Practitioners shall appreciate cranial bony movement as a unified dynamic and shall sense the individual bony motions of that dynamic.

5.10.b. Natural Fulcrums: Practitioners shall perceive bony motion in relationship to the sphenobasilar junction, the natural fulcrum for the movement of the cranial bones. Practitioners should also be able to perceive the motion of the cranial bones in relationship to Sutherland's Fulcrum at the anterior end of the straight sinus, the natural fulcrum for the integrated motion of the reciprocal tension membranes and related cranial bones.

5.10.c. Inertial Patterns: Practitioners shall perceive inertial patterns within cranial dynamics and their related motion, including the specific inertial fulcrums. On a tissue level, these may include sutural compressions, membranous adhesions and fluid congestion. The practitioner shall respond to these therapeutically.

5.10.d. Continuity: Practitioners shall have awareness and appreciation of the wholeness of the system. They shall recognize that the system expresses motion as a whole and is a unified field. Practitioners shall have an awareness of the continuity of the relationships of the PRS. Hence patterns sensed in cranial bony relationships will be reflected in all other layers of the system. They shall understand and perceive the continuity of bony relationships and patterns with the reciprocal tension membranes.

5.11 The Cranial Vault

5.11.a. Perception and palpation: Practitioners shall perceive the motility and mobility of the cranial vault. This includes a proficiency in perceiving and comprehending the craniosacral motion of each of its individual bones and of the unified motion dynamic of the cranial vault as a whole. They shall be conversant with the individual craniosacral motions of the frontal bone, parietal bone and the vault relationships of the

occiput and temporal bones. Practitioners shall perceive the motion of the cranial bones in relationship to the primal midline and the natural fulcrums of the system. These include Sutherland's fulcrum (the anterior aspect of the straight sinus) and the sphenobasilar junction. An awareness of the midline and the natural fulcrums, gives the practitioner clear base lines to use in clinical practice.

5.11.b. Inertial Patterns: Practitioners shall perceive inertial patterns and their effects within cranial vault sutural and membranous dynamic. Practitioners shall perceive the inertial fulcrums which organize these patterns, which are cranial membranous articular strains (5.8c), and be able to relate to them therapeutically.

5.12 The Sphenobasilar Junction (SBJ) & Cranial Base

5.12.a. Perception and palpation: The practitioner shall perceive and comprehend the motility and mobility of the cranial base and its membranous articular dynamics. Practitioners shall perceive flexion and extension at the sphenobasilar junction in the CRI unfoldment. Practitioners shall perceive the motility and mobility of the cranial bones in relationship to various natural fulcrums, including Sutherland's Fulcrum, the SBJ, and the primal midline.

5.12.b. Inertial fulcrums: Practitioners shall perceive the classical physiological and non-physiological motion dynamics around the SBJ. These include the classical patterns of flexion-extension, side-bending-rotation, torsion, lateral shear, vertical shear and compression. Practitioners shall respond to all of these dynamics therapeutically.

5.12.c. Continuity: Practitioners shall be aware of the unity of function within cranial dynamics. They shall perceive that cranial base patterns, and cranial patterns in general, are reflected in, and are reflections of, both the reciprocal tension membranes and the central nervous system. Practitioners shall relate to this continuity therapeutically. Patterns expressed at the SBJ will also be reflected throughout the body. Practitioners shall sense and relate therapeutically to inertial fulcrums throughout the body that might organize, or compensate for, SBJ patterns.

5.13 The Temporal Bones

5.13.a. Perception and Palpation: The practitioner shall perceive the motility and mobility of the temporal bones and their relationship to the cranial base as a whole.

5.13.b. Inertial fulcrums: Practitioners shall perceive inertial patterns within temporal bone dynamics and to relate their organizing fulcrums therapeutically. Practitioners shall perceive and relate therapeutically to sutural compressions and membranous restrictions, internal and external rotation patterns, fixations in any direction of craniosacral motion, medial compressions and intraosseous lesions. They shall also have an appreciation of the relationship of the temporal bones to the mandible at the temporomandibular joints.

5.13.c. Continuity: Practitioners shall appreciate the continuity of bone and membrane and be aware of the relationship of the tentorium cerebelli to temporal bone dynamics. In this, they shall be aware of reciprocal tension dynamics between the temporal bones, the tentorium and the membrane system in general. They shall respond therapeutically to these. Practitioners shall relate to the whole of the membranous articular strain dynamic of the temporal bones.

5.14 The Viscerocranium (Facial Structures)

5.14.a. Perception and palpation: The practitioner shall have an understanding and appreciation of the motility and mobility dynamics of facial structures. They shall differentiate the three cavities of the viscerocranium: the orbital, the nasal, and the pharyngeal. The practitioner shall appreciate how these three cavities are constructed in relationship to the cranial base, especially the basi-sphenoid, ethmoid and basi-occiput. They shall discern the craniosacral dynamics of orbital and facial structures and shall also be able to discern the specific motions of individual bones. These include the frontal bone, the ethmoid bone, the nasal bones, the vomer, the maxilla, the palatines and zygoma, and their specific relationships.

5.14.b. Inertial Patterns: Practitioners shall

perceive inertial patterns and their fulcrums within the dynamics of the face, the eye orbits and of facial structure in general. They shall respond to the organizing fulcrums therapeutically. Practitioners shall also be able to respond therapeutically to congestion in the nasal sinuses via bony structure and fluid dynamics.

5.14.c. Continuity: Practitioners shall perceive the continuity of facial bone and hard palate dynamics, sense the continuity of structure and function in these relationships, including the reciprocal tension membranes, and be able to respond to this therapeutically (see below for details on Hard Palate Dynamics). Practitioners shall perceive the motion dynamics of the fronto-ethmoidal and sphenovomeromaxillary complex as a unified dynamic (the complex of relationship that includes the sphenoid, vomer, palatine and maxillary bones), and relate to it therapeutically.

5.15 The Hard Palate

5.15.a. Perception and palpation: The practitioner shall have an appreciation and comprehension of the motion dynamics of the hard palate. They shall perceive the unified motion dynamic of the sphenoid bone, the vomer, palatines and maxillae. They shall perceive the unified motion dynamic of the ethmoid bone, the frontal bone and the orbital structures above. Practitioners shall perceive and discern the specific motions of the individual bones that comprise the relationships of the hard palate (sphenoid, vomer, palatines and maxilla).

5.15.b. Inertial Patterns: Practitioners shall perceive and discern inertial patterns and their organizing fulcrums within these relationships. Practitioners shall perceive inertial fulcrums which affect their dynamic and be able relate to them therapeutically. Within the tissues these include:

- a) general compression in hard palate relationships;
- b) the specific patterns of maxillary compression, torsion, side-bending and shear;
- c) inter-maxillary compressions;
- d) the specific patterns of vomer compression, torsion, side-bending and shear; and,

- e) fixations in palatine relationships to the sphenoid and maxilla.

Practitioners shall also be aware of the relationship of the temporomandibular joint to these dynamics and to be able to integrate the dynamics of the mandible into hard palate work.

5.15.c. Continuity: Practitioners shall discern the continuity of the relationships of the hard palate throughout the system. Thus, torsion between the sphenoid and maxilla may be related to torsion patterns at the SBJ and/or torsion between the sphenoid and ethmoid. Further, inertial patterns within facial and hard palate structures may reflect and be reflective of similar patterns in the body as a whole. Specific patterns in remote parts of the body may give rise to, or be reflective of, the patterns in the face and

hard palate. For instance, torsion at the inferior pole of the sacrum may cause or reflect torsion in the hard palate. Practitioners shall perceive these whole body relationships, and relate to them therapeutically.

fulcrums and patterns in the pelvis. Practitioners shall

5.16 The Temporomandibular Joint (TMJ) and its Relationships

5.16.a. Perception and palpation: The practitioner shall perceive the motility of the mandible. They shall relate this motion to the temporomandibular joints and the motility and mobility of the temporal bones. They shall have the ability to perceive the temporal bones, the tentorium cerebelli and the TMJ as a unified dynamic.

5.16.b. Inertial Patterns: Practitioners shall perceive inertial patterns and their organizing fulcrums within temporomandibular joint functioning, and be able to relate to them therapeutically. Practitioners shall be sensitive to TMJ compression and the compressive forces which organize it, both unilaterally and bilaterally, and relate to these compressive forces therapeutically. Practitioners shall facilitate balance in bilateral TMJ function.

respond to all of these relationships therapeutically.

5.16.c. Continuity: Cervical Area: Practitioners shall understand the relationship of the cervical area to TMJ dynamics. They shall understand and be able to perceive the fascial and bony patterns of the cervical vertebra and their relationships to the temporomandibular joints, and relate to them therapeutically .

5.16.d. Continuity: Hyoid bone: Practitioners shall perceive the cranosacral dynamics of the hyoid bone, including the relationship of these dynamics to the temporomandibular joint and temporal bones, and relate to these dynamics therapeutically.

5.16.e. General continuity: Practitioners should be able to perceive whole body dynamics that affect TMJ function. Inertial fulcrums anywhere in the body can affect TMJ function and practitioners shall be aware of the wider issues involved in TMJ function and mobility. These include their continuity with the temporal bones, the tentorium and reciprocal tension membranes, the relationships of the tentorium to the respiratory and pelvic diaphragms, hip joint and pelvic relationships, dural and fascial continuity and inertial

5.17 The Involuntary Mobility of the Sacrum between the Ilia

5.17.a. Perception and palpation: The practitioner shall perceive and comprehend the motility and mobility of the sacrum and of the pelvis as a whole. Practitioners shall perceive the motion of the sacrum in both its flexion and extension phases. Practitioners shall also be able to perceive the motility and mobility of the innominate bones, and their craniosacral motion which is expressed as external and internal rotation.

5.17.b. Inertial Patterns: The practitioner shall perceive inertial patterns and their organizing fulcrums within sacral and pelvic motion, and respond to these therapeutically.

5.18 Specific Sacral Relationships and Pelvic Dynamics

5.18.a. Perception and palpation: The practitioner shall perceive the dynamics of the four joint relationships of the sacrum. These are the lumbosacral junction, the two sacroiliac joints, and the sacrococcygeal junction.

5.18.b. Inertial Patterns: Practitioners shall perceive inertial patterns and their organizing fulcrums within sacral and pelvic dynamics, and respond to these therapeutically. Practitioners shall respond therapeutically to patterns of resistance, restriction and compression, with their organizing fulcrums, at the lumbosacral junction, the sacroiliac joints, the coccyx, the hip joints and the pubic symphysis.

5.18.c. Continuity: Practitioners shall understand and be able to perceive the continuity of sacral relationships with the rest of the primary respiratory system. This includes the reciprocal tension membranes, the central nervous system and the articulations of the cranium. Practitioners shall appreciate and be able to perceive the continuity of connective tissue relationships and sacral dynamics, and relate to these therapeutically.

5.19 Whole Body Dynamics

5.19.a. "Whole Body Dynamics" is a phrase that acknowledges the integrity and unity of the human system. The following sections outline whole body

craniosacral dynamics and the related practitioner competencies.

5.19.b. The core of the human system is considered to be the primary respiratory mechanism as outlined in the sections above. Classically, it is defined by the boundaries of the dural membrane system, the contents of the dural sac, and the cranial bones and sacrum which are directly attached to the dura. Recent anatomical research has established the existence of connections from the dura to numerous vertebrae, further establishing the unified nature of human anatomy and physiology.

5.20 Vertebral and Spinal Dynamics

5.20.a. Perception and palpation: The practitioner shall have an appreciation of spinal and vertebral dynamics. They shall perceive motility and mobility of vertebrae and to be able to perceive their craniosacral and structural dynamics.

5.20.b. Inertial Patterns: The practitioner shall sense spinal and vertebral resistances and restrictions via direct palpation of the vertebrae and via an awareness of the dural tube. The practitioner should be able to sense dural resistances via either occiput or sacrum and perceive the vertebral segment or segments to which the dural resistances are related (see section on the reciprocal tension membranes and the dural tube above). The practitioner should be able to relate to vertebral patterns and fixations therapeutically and to facilitate the resolution of the inertial fulcrums affecting vertebral dynamics.

5.20.c. Classical Motion Patterns: The classical movement patterns of the vertebrae include: forward/backward bending, rotation, side-bending, lateral shearing, anterior/posterior shearing, and superior/inferior compression. The practitioner shall relate to inertial restrictions to these patterns therapeutically.

5.20.d. Embryological Influences: Practitioners shall have an appreciation of the role of embryological somites and notochord in the organization of the anatomy of the vertebral column, and the resulting vertebral and craniosacral dynamics; and also an appreciation of the primal midline as the organizing

axis of vertebral dynamics.

5.20.c. Continuity: Practitioners shall perceive the

continuity of vertebral dynamics with the rest of the

system. This includes the direct relationship with the

dural membranes, cranial base and sacrum.

Practitioners shall respond therapeutically to vertebral

ligamentous articular strains as a unit of function and

to facilitate their resolution.

5.21 Force Vectors and Energy Entrapments

5.21.a. Perception and palpation: The practitioner shall understand the significance of and perceive entrapped force vectors, or energy entrapments, as fulcrums of traumatic origin within the system. Practitioners shall appreciate how force vectors introduce inertial forces into the body which, if unable to be processed, are centered by the potency of the Breath of Life. The tissue and fluid world organize around these inertial fulcrums.

5.21.b. Inertial Patterns: Practitioners shall perceive the fulcrums which result from force vector entrapment and relate to them therapeutically. The practitioner shall have an appreciation of and sensitivity to the nature of trauma and how the memory of trauma is held within the human system. The release of shock affect may accompany the resolution of a force vector and practitioners shall relate therapeutically to this dynamic.

5.21.c. Continuity: Practitioners shall perceive and appreciate the effects of a force vector entrapment on whole body dynamics. Practitioners shall appreciate, and perceive the effects of force vector entrapment, including: local tissue changes, functional changes in the soma and viscera, fluid congestion, nerve facilitation, vertebral fixations and dural resistance. Practitioners shall relate therapeutically to these phenomena.

5.22 Fascial and Connective Tissue Patterns

5.22.a. Perception and palpation: The practitioner shall appreciate and be able to perceive the tissue dynamics of fascia and connective tissue. They shall perceive fascial motility, mobility and be able to sense inertial issues within its expression.

5.22.b. Inertial Patterns: Practitioners shall perceive inertial patterns through the fascial and membranous relationships of the body and perceive the location of related inertial fulcrums. Practitioners shall respond to these dynamics therapeutically. The effects of inertial fulcrums within connective tissue relationships might include tissue adhesions, energy entrapments, dural adhesions, spinal fixation, visceral adhesions, joint and sutural restriction, facilitation

within the nervous system, and fluid and tissue congestion. Practitioners shall respond to all of these phenomena therapeutically.

5.22.c. Continuity: Practitioners shall appreciate and be able to perceive the continuity of fascial and membranous relationships throughout the body as a unit of function.

5.23 Infants and the Birth Process

5.23.a. The birthing process is one of the most formative experiences of life. This can be both a physically and emotionally traumatic process for the newborn and its dynamics are crucial to understand in the context of the Biodynamic Craniosacral Therapy. Many chronic inertial fulcrums can have their roots in the birthing process. All of the classic sphenobasilar and cranial base patterns can arise here and, indeed, all manner of cranial, structural and body patterning can and will occur during the birth process. It is therefore essential for the practitioner to understand this process. It is also important to understand the anatomical and structural relationships of the infant, as they are different from those of the adult. This is not just important in the infant, but also in the adult, as these patterns will persist through life if not treated.

5.23.b. It is important to remember that the birth experience is not just a physical one, but is a process that the infant experiences with all of its faculties. Infants are conscious and register their pre- and perinatal experience fully. It is a psycho-emotional and physical process, all of which will be contained within the central nervous system and tissue memory of the body. It is imperative that the practitioner recognize this when working with infants. Working with infants is a real challenge to the skills of the practitioner. In this work, a safe therapeutic environment is based upon the ability to empathize and resonate with the infant's experience. It is also based upon the ability to maintain contact and communication with a small being who is not able to express itself through linear language.

5.23.c. While the skills outlined above provide the foundation for working with the effects of the birthing process, advanced training is highly recommended to provide the ground for competent work in this arena, especially in working with infants and children.

5.23.d. Empathy and boundaries: The practitioner shall maintain an empathetic contact with the infant and be able to communicate with the infant through

touch and presence. Practitioners shall empathize with the infant's experience of its trauma and work with permission and communication. Practitioners shall have a sensitivity to the infant's boundaries and be able to work with permission and sensitivity in relationship to these boundaries.

5.23.e. Birth patterns: Practitioners shall be familiar with and comprehend the mechanics of, and variations in, the birth process. Practitioners shall recognize these dynamics when expressed as patterns in the infant's system. Practitioners shall recognize birth patterns and their related inertial fulcrums, force vectors and tissue organizations, and be able to relate to these therapeutically. Practitioners shall be sensitive to the expression of shock affects when birth patterning is accessed, and be able to relate to this appropriately.

5.23.f. Intraosseous lesions: Practitioners shall recognize intraosseous lesions in the infant system and be able to relate to them therapeutically. This includes knowledge of the centers of ossification of all the cranial bones.

5.23.g. Infant and adult approaches: Practitioners shall understand and be sensitive to the differences in working with infants as opposed to adults, and must be conversant and sensitive to these principles. Practitioners shall understand and be able to relate therapeutically to the mechanics and anatomy of an infant's system, which differ from that of an adult. Practitioners shall discern these early patterns within the adult system and be able to relate to them therapeutically.

5.23.h. Continuity: Practitioners shall appreciate the direct relationship of birth trauma with the inertial fulcrums and whole body patterns in the infant system. They shall recognize birth patterns in the infant and the related fulcrums and compensations throughout the system. Practitioners shall respond to them therapeutically.

5.24 Adults and the Birth Process

5.24.a. Perception and palpation: The practitioner shall recognize the nature of birth patterns in the adult system and to relate to these patterns therapeutically.

Practitioners shall be sensitive to the expression of shock affects when birth patterning is accessed and be able to relate to this therapeutically.

5.24.b. Intraosseous Lesions: Practitioners shall recognize and relate therapeutically to intraosseous lesions. These may occur in the occiput, the temporal bones, frontal bone, the sphenoid, the sacrum, and the ilia.

5.24.c. Trauma skills: Practitioners shall comprehend, empathize with and create a safe environment for the client's exploration of their birthing process. Practitioners shall be sensitive to the psycho-emotional nature of tissue memory, especially in the context of early life experience and be able to relate to that process therapeutically.

6.0 PRACTICE MANAGEMENT SKILLS

6.1 Practice Procedures, Organization and Management

This section of the Standards Document covers various practical aspects of professional practice. Practitioners shall create an appropriate clinical environment, take case history and clinical profiles, be able to make appropriate referrals to other health professionals, keep on-going records, organize and maintain financial records and manage their practice efficiently.

6.2 Clinical Environment

6.2.a. Environment: The practitioner shall create and have available, a hygienic and tidy clinical environment. This includes appropriate furniture and equipment, temperature control and cleanliness.

6.2.b. Hygiene: Practitioners shall wear appropriate and clean clothing, have clean hands and fingernails, attend to their own physical hygiene and use finger cots, surgical gloves and masks when appropriate.

6.3 Competencies in Establishing a Professional Relationship

6.3.a. Communication: The practitioner shall be

competent in communicating the nature and intentions of the work to the prospective client and the services being offered. They shall clearly communicate their fee structure, appointment system and the commitments required of the client.

6.3.b. Therapeutic environment: Practitioners shall create a caring and listening therapeutic environment, establish and maintain clear and safe therapeutic boundaries and be able to meet the client with a professional and competent ambiance. As part of this, they must maintain the confidentiality of the relationship.

6.4. Competencies in Relationship to Case Histories

6.4.a. Interviews: The practitioner shall be competent in communicating to and interviewing the client. They shall be competent in appropriately questioning the client as to current and past history. Practitioners shall be aware of the non-verbal and body-language clues that the client may be communicating.

6.4.b. Note taking: Practitioners shall be competent in taking a clinical case history and recording their notes in an appropriate manner. They shall note important aspects of that history and to relate it to the present conditions.

6.5 Competencies in Relationship to Record Keeping

6.5.a. Record keeping: The practitioner shall maintain comprehensive and up-to-date records of their client's sessions and progress. They shall keep records securely and treat all records confidentially. Practitioners shall keep records in a form that allows access to them by the client if required.

6.5.b. Storing records: Practitioners shall store records for at least the statutory length of time in an appropriate form. Statutory regulations about computerized information must be adhered to.

6.6 Competencies in Relationship to Communication with other Health Professionals

6.6.a. Other practitioners: The practitioner shall determine if the client is under the care of other health professionals.

6.6.b. Communication: Practitioners shall clearly communicate to other health professionals, with the client's knowledge, when appropriate. All such communications are to be treated with confidentiality.

6.6.c. Referrals: Practitioners shall refer the client to other health professionals when appropriate and to work in an interdisciplinary team when appropriate.

6.6.d. Relationship to colleagues: Practitioners shall dialogue with colleagues and staff when appropriate. They shall enter into supervision and supervisory roles as appropriate.

6.7 Competencies in Relationship to Financial Records

6.7.a. Financial records: The practitioner shall keep clear financial records which comply with legal and professional requirements and needs. They shall keep accurate accounts and receipts for all clients and practice transactions.

6.8 Competencies in Relationship to Time Management

6.8.a. Time management: Practitioners shall manage their time efficiently and keep to their schedule of appointments as closely as possible. They shall efficiently allocate the appropriate amount of time for each client's session and these shall be an expression of appropriate therapeutic intervention.

6.8.b. Appointments: Practitioners shall keep an appointments diary and be able to clearly communicate the frequency and spacing of appointments and the rationale of these to the client.

6.8.c. Scheduling: Practitioners shall schedule their patients in such a manner as to not exhaust themselves or their clients, or negate their client's needs. They shall schedule appointments appropriately in relationship to the clinical needs of their clients.

6.8.d. Cancellations: Practitioners shall have a clear policy as to client cancellations, fees and rescheduling of canceled appointments.

6.9 Competence in managing one's own professional life

6.9.a. Code Of Ethics: The practitioner must adhere to the Association's code of professional ethics and conduct and to be aware of disciplinary procedures.

6.9.b. Role model: Practitioners shall realize that clients may look to them to provide a model of a balanced and appropriate life-style and that their well-being and fitness will affect their work. They shall thus take appropriate care of themselves by attending to their physical and mental well-being and seeking professional help when necessary. Practitioners shall realize that they may need professional, emotional and moral support from time to time and shall have a support network in place that can provide this.

6.10 Competencies in Legal Aspects of Practice

6.10.a. Legal requirements: The practitioner shall comply with any legal requirement for practice. These may include local government requirements, health and safety requirements, local or national planning requirements and local licensing requirements. They shall be aware of any legislation which may be relevant to their practice.

7.0 APPENDIX A: GLOSSARY

ACTIVATION Describes acute or chronic conditions in which autonomic nervous system responses are engaged in response to stress.

BALANCED MEMBRANOUS TENSION - The normal physiological state of harmonious equilibrium in the tensity of the dura mater of the cranium and spinal cord. It is rarely found in any client. Departure from this ideal results from environmental influences. However the mechanism maintains a state of relative balance in any condition, the balance currently found being that which is possible under existing conditions and which may well persist until the present strain is resolved towards a more normal state of function. Balanced membranous tension is that precise point in the range of motion of the cranial articular mechanism where the tension exerted upon it is equalized in all directions. Reciprocal tension is the biphasic movement of the dural membranes in flexion and extension (Magoun 1966, p. 335).

BIOKINETIC Describing forces or patterns produced by the application of external influences. These patterns may be stored in the tissues for extended time periods, as the system compensates and adjusts to maintain an equilibrium which accommodates the force. Biokinetic patterns may be palpated and often reflect physical laws of fluid dynamics, response to gravity, or structural balance compensations, and may relate to individual subsystems of the whole body.

BIODYNAMIC - A biodynamic perspective is one in which the primacy of the Breath of Life is perceived and understood. Biodynamic describes a therapeutic approach in which the Breath of Life and its transmutations are the focus for the work. The perceptual shift to the primacy of the Breath of Life as the system's motivating and organizing factor is the foundation of a biodynamic understanding of the human system. Within a biodynamic viewpoint, the human system is seen to organize as a unified field around the imperative of the Breath of Life. The concept of the primary respiratory mechanism composed of tissue and fluid elements is superseded by that of the primary respiratory function of the Breath of Life.

Biodynamic Craniosacral Therapy is a therapeutic system based on Breath of Life perception and interactions. Biodynamic refers to forces inherent in the blueprint of the system, driving optimum development and efficient functioning. These forces and patterns may be palpated and often reflect embryological patterns preceding the effects of life experience.

Biodynamic forces and their individual expressions (biokinetics) are found throughout nature and are called natural laws. Biodynamics implies an essence or an originality particularly seen in the early stages of embryological development. This originality reveals a beauty and clarity that is rarely seen again in the whole of subsequent development. Thus, biodynamics includes both the kinetic and dynamic features of differentiation.

BREATH OF LIFE - an invisible element, a force within a fluid, that contains an innate Intelligence, a potency; liquid light; bio-electric charge. W. G. Sutherland, D.O. used the term Breath of Life to indicate the original life force and animating spirit of the human organism which can be palpated. The Breath of Life generates the Long Tide, ignites the original matrix within the embryo, and centers developmental movements. This Breath of Life and its unfoldment into the human organism via the ventricular system of the embryo contains a biphasic movement of approximately 6 cycles per 10 minutes. Sutherland originally coined the term from the book of Genesis "and the Lord God formed man of the dust of the ground and breathed into his nostrils the Breath of Life, and man became a living soul" (Genesis 2:7, King James Version).

CEREBROSPINAL FLUID - surrounds the brain and spinal cord, offering protection, support, nutrition and waste removal; is clear and similar to blood plasma except it has less protein, potassium and calcium and has more sodium, chloride and magnesium; "the highest known element" according to A.T. Still, D.O. It is a clear fluid filling the subarachnoid space; approximately 1/2 cup; primary nourishment for the nerves; serves as a protective liquid cushion around the brain; replaces itself every 8 hours.

COMPRESSION an action or force causing tissues to tighten internally (intra-) or in relation to other tissues (inter-) and lose access to their natural capacity for movement and open circulation.

CRANIAL BOWL - Dr. Sutherland's term to describe the inside of the cranial base.

CRANIAL CONCEPT - the idea discovered, investigated and developed by William G. Sutherland, DO, applying osteopathic principles to the skull. It describes the anatomical and physiological mechanisms of the skull that are purported to represent the action of the primary respiratory mechanism as the motivating force relevant to the craniosacral mechanism expressed through the cranial rhythmic impulse, the potency, long tide and the

breath of life. The cranial concept represents the application of the concept of somatic dysfunction to the craniosacral mechanism. Study of the diagnosis and management of the somatic dysfunction as extended to the craniosacral mechanism embraces: (1) introduction and maintenance of somatic dysfunction; (2) the pathological effects of somatic dysfunction; (3) specific methods for palpatory diagnosis and manipulative therapy (Ward 1991, p. 554/121).

CRANIAL RHYTHMIC IMPULSE (CRI) - A term used to describe the timing of the minute rhythmic (cyclic) changes in the primary respiratory mechanism. The CRI is a wave form riding the deeper tidal forces. The cumulative effect of these cyclic changes is expressed as a palpably perceived wave of variable intensity thought to be the consequence of rhythmic fluctuation of cerebrospinal fluid. The impulse occurs throughout the craniosacral mechanism. Rhythmic changes driven by the primary respiratory mechanism can be palpated by a skilled technician throughout the body (Ward 1991, p. 554/121).

CRANIOSACRAL MECHANISM - A term used by W. G. Sutherland, D.O., to describe the synchronous and mechanical movement of the sacral base with the cranial base. This is accomplished by the attachment of the dural tube to the foramen magnum and sacral canal, and probably aided by cerebrospinal fluid fluctuation. It is thought that the foramen magnum moves forward and upward during flexion of the sphenobasilar articulation which through the dural tube pulls the sacral base superior and posterior around a transverse axis at the articular processes posterior to the canal and through the second sacral segment (Ward 1991, p. 554/121).

DEVELOPMENT - the series of changes which an organism undergoes in passing from the embryonic state to maturity. Development implies the work that is done to differentiate. Development implies general growth or increase where differentiation implies specialization and complexity.

DIALOGUING WITH TISSUES/FLUIDS A technique of non-verbal or verbal conversation in which a practitioner poses an observation or question, and can subsequently palpate or sense a response from the client.

DIRECTING FLUID A technique in which the practitioner visualizes fluid connectivity between two places in the client's system, and thereby supports fluidic nourishment via cerebrospinal fluid circulation in an area.

DISENGAGEMENT A technique in which compressed tissues are opened and returned to normal action. Disengagement involves intending space at various levels: CRI (tissues and fluids), Mid-Tide (inertial forces and potencies, coupled fulcrums) and Long Tide (disengagement from within via access to the Breath of Life).

DIFFERENTIATION - evolution towards the more complicated and more specialized in form and structure. It is the specialization of parts of the body or modification of body parts for a particular function.

FACILITATION - an increase in afferent stimuli so that the synaptic threshold is more easily reached; thus there is increase in the efficacy of subsequent impulses in that pathway or synapse. The consequence of increased efficacy is that continued stimulation produces hyperactive responses (Ward 1991, p. 555/122).

FULCRUM - a point around which activity takes place; a means by which influence is exerted; Mechanically it is a point on which a lever turns; a still point around or over which a constantly tense membrane operates. Fulcrums transfer potency from one part of the body to another. They are said in classical osteopathic to be suspended and automatically shifting. Fulcrums are always spatially related to the midline. All motion has fulcrum. Even our mind has a fulcrum. There are moments in time that have fulcrums. Even the Breath of Life has a fulcrum which is found in the Dynamic Stillness. A fulcrum is a function, not a place. The key diagnostic exploration is whether the fulcrum shifts with the tide or if it is static. Fulcrums are natural or inertial.

INERTIAL POTENCY - an emergent property of a whole or biodynamic system such as the human body as an inherent capacity to center or balance disease and pathology by creating potency. Thus any distortion in the body contains inertia and the ability to overcome the inertia by inertial potency. This inertial potency is a function of the Breath of Life. It is one of numerous self-correcting phenomena in the PRS.

INTENDING SPACE A skill in which the practitioner visualizes, and intends via palpation, an expansive opening within tissue or body area, helping the client's system access space already present in the tissues.

MOBILITY The ability to move in relationship with surrounding influences. Mobility of a cranial bone refers to its capacity to flex and extend in concert with its neighboring bones.

MOTILITY - capable of or exhibiting spontaneous motion. A description of the biodynamic movement of the fluid system especially cerebrospinal fluid. Motility is involuntary and moves from the core of the body out to the periphery. Thus motility could be considered the original or animating element of the body.

ORIENTING A skill in which the practitioner cultivates clear self-awareness and self-containment in space, which is a pre-requisite to effective therapeutic relationship with a client.

OSTEOPATHY - a system of primary care based on the theory that the body is capable of healing itself.

POTENCY - strength; force; power; an intelligent force unfolded within the Breath of Life. The power inherent in the cerebrospinal fluid as a body of liquid, which is not compressible and which is contained in the articulated cranium. The hydrodynamic relationship with the rest of the body automatically extends this inherent power throughout the organism and makes it available for use in diagnosis and treatment when the mechanism is understood. It is axiomatic that, if free and unrestricted, body physiology tends unerringly towards the normal. In the cranial concept, if all restrictions are successfully resolved, the same is true as to the action of the cerebrospinal fluid in the craniosacral mechanism. This is a distinct asset in treatment (Magoun 1966, p. 346). There are many types of potencies within the body. They tend to operate in a biphasic motion that has a rhythm of approximately 2.5 cycles per minute. It is potency, called inertial potency by Dr. James Jealous and also called variant potency by Dr. Rollin Becker, that is found at the center of fulcrums of disturbance in the body. Thus, any disturbance or distortion of the body carries with it its own treatment plan in the form of a potency capable of shifting the fulcrum of disturbance back towards a more functional whole.

PRIMARY RESPIRATORY MECHANISM (PRM) - a first or principal grouping of functions and parts which is responsible for physiological respiration; classically it is composed of:

- 1) fluctuation of cerebrospinal fluid;
- 2) function of the reciprocal tension membrane;
- 3) inherent motility of the brain and spinal cord;
- 4) articular mobility of the cranial bones;
- 5) involuntary mobility of the sacrum between the ilia.

Within a biodynamic viewpoint, the human system is seen to organize as a unified field around the midline imperative of the Breath of Life. The concept of the primary respiratory fluid and tissue system is superseded by that of the primary respiratory function of the Breath of Life.

- 1) the Dynamic Stillness;
- 2) the Breath of Life per se, the Long Tide of the Breath of Life and the primal midline;
- 3) the organizing and integrating function of the potency of the Breath of Life within the fluids;
- 4) the organization of the fluid and tissue world to the imperative of the Breath of Life,
- 5) the expression of these in primary respiratory cycles of inhalation and exhalation as a unit of function within the motility and motion of potency, fluids and tissues.

All elements of the PRM are balanced to one another. All layers of the system are enfolded within each other. The PRM arises out of the dynamic stillness. The PRM is dynamic and non-linear. The PRS is an unfolding of the function of the Breath of Life. One of its unfoldments is the

craniosacral mechanism which describes the mechanical interrelationships of the bones and membranes.

RECIPROCAL TENSION MEMBRANE - an interosseous membrane that holds the bones of the neuro-cranium and spine together and allows a range of normal movement at the joints; made up of the dura mater and its reduplications (falx cerebri, tentorium cerebelli, falx cerebelli and medullar dura mater attaching to the sacrum).

SENSING The skill of subtle listening via sensory input supported by deep instinctual awareness. In Biodynamic Craniosacral Therapy, extraordinary capabilities of deep sensing are systematically developed.

STATE OF BALANCED TENSION - A dynamic state of reciprocal tension balance within the whole unit of function of potency, fluid and tissue; a state of dynamic equilibrium.

STILLPOINT - a point at which a part of the primary respiratory system stops and allows for self correction, balance.

TORSION the action or force causing articulating parts to twist in opposite direction in relation to each other.

V-SPREAD A technique in which a practitioner makes a contact with the intention of supporting opening and softening of an area in the client's body. The term derives from the positioning of the practitioner's fingers, which make a V shape on either side of the intended location.

8.0 APPENDIX B:

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