DVD 2

„ Place your hands on the head. Wait. Wait until the head tells you what to do. If the head tells you not to do anything then don't do anything…" Denis Brookes

The perceptual world surrounding us, including the tissues of the body which we as osteopaths touch, are not rigid, but rather temporary appearances and expressions of interrelated conditions and forces. Everything depends on an endless number of other dependences and factors.
The capability to perceive patterns of interacting dynamic dependences and movement patterns, and to interpret them diagnostically, as well as the capability to synchronize with homeodynamic forces, are major factors for successful therapeutic actions.

Technical skills are important. However, to limit the healing potential through an over-focussing on the technical action should be avoided.
Healing is not a process aimed unilaterally from the therapist to the patient. It seems to be of great importance that all participants consciously take part in the healing process and that there is an empathetic insight into the relation of signs of disease, as well as into the connected interrelation of all living things.
(nature photos)

Ü (Exercise): Palpation

1.1 The position of the therapist during the palpation is of great importance. Through a good contact with the feet on the floor one feels the grounding. The feet form a triangle with the ischial tuberosities on the chair, making it possible to have an upright position toward the sky.
1.2 The therapist should neither support himself on the patient nor lose contact. The therapist can move back and forth slightly, like a pendulum, to establish an optimal contact and to find the optimal position slowly. An upright position of the body also enables a relaxed awareness.
The therapist relaxes his body as much as he can.
1.3
Calvaria handhold according to Sutherland
The elbows are placed onto the treatment table, the index fingers directly behind the lateral edges of the eyes on the greater wings, the middle fingers on the temporal bones in front of the ear, the ring fingers on the temporal bones behind the ear and the little fingers on the side of the occipital bones. If possible, the thumbs should touch above the head. They serve as an external point of fixation.
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Occipito-sphenoidal palpation according to Becker
The elbows are on the treatment table, the thumbs on the greater wings of both sides, the index fingers behind the ear, on the mastoid process, the middle fingers behind the ear on the mastoid portions, the ring fingers

behind the occipito-mastoid suture on the occipital bone and the little finger on the occipital squama.

Occipito-sphenoidal palpation according to Upledger
It is a slightly changed form of the occipito-sphenoidal palpation according to Becker.
The elbows are on the treatment table, the thumbs on the greater wings of both sides and the
little fingers and ring fingers are on the occipital bones on both sides.

Spheno-occipital palpation according to Magoun
Therapist: At an angle at the head of the patient
Handposition:
-thumbs and middle fingers (or index fingers) of the upper hand take hold of the greater wings from lateral
-The bottom hand takes the occipital bone into the palm of the hand, the fingers pointing laterally.

Fronto-occipital Palpation according to Sutherland
The upper hand is placed on the frontal bone; the middle finger is on the metopic suture above nasion, the others fingers laterally next to it.
The bottom hand takes hold of the occipital bone with the palm of the hand, the fingers pointing caudally.

2. E: Diagnostic principals

Each osteopathic diagnosis does not only include the case history, inspection, tests and palpation but can also include further examinations by specialists.

For didactic reasons, the following patient examination is limited to the palpation of the cranial system.

2.1 E:Diagnostics: Thermodiagnosis according to Barral

With the palm of the hand – usually with its centre – the dominant hand does this examination.
Determination of the height of the hand: The relaxed, slightly bent hand is placed onto a thermal zone almost on the skin and is then lifted up to the point, where one most feels the heat radiation. From there the hand is slowly lowered up the point where one perceives a slight resistance, usually about 10cm above the skin. The hand should adjust to the contours of the body during the thermal diagnosis.
The hand moves like a pendulum, slightly from one side to the other. It is very important for the diagnosis, that the hand does not remain at one point for too long.
One searches the general contour of the skull for the warmest parts. These are indications for possible dysfunctions.

2.2 E:Diagnostics: Palpation of the form

One can look at the form of the cranium for the differentiation of pathological and functional disturbances. It is also an indicator for the severity of a dysfunction. One can judge the course of the therapy in little children, by looking at the form of the skull.

2.3. E:Diagnostics: Palpation of the Elasticity of the tissue

The hands are quickly placed onto the different parts of the body moving from the feet upwards. The hands give a gentle short pressure onto each body part, which is then quickly released, as in a gentle recoil. The therapist perceives the resistance of the tissue to the pressure (softness/hardness), as well as the reaction of the tissue when releasing the pressure (resilience).

2.4 E:Diagnostics: local pressure pain

Pain caused by pressing is an indicator for possible sutural or intraosseal dysfunctions.

2.4. E:Diagnostics: Palpation of rhythmical tension variations

The natural disengagement during each inspiration phase and the natural compression during each expiration phase are assessed.

The therapist perceives the symmetry, frequency, amplitude, and strength (or potency) of the primary respiration in general and at the respective tissue of the body. A change of the quality at a certain part of the body is an indication for a disturbance in that area. One can become aware of pulling tensions, which inhibit the free expression of the primary respiration.

The reaction of the pulmonary respiration in the tissue can also be palpated. Deep breathing increases the movement.

2.5.1 E:Diagnostics: Mobility tests

Sutures and tissue can also be examined with mobility tests. The mobility tests can be done synchronous with the primary respiration or independent of it.
For example, the therapist gives a small impulse at the coronary suture in the direction that he wants to test, and then perceives if the movement is accepted or restricted.

E:Diagnostics: Fascial tension

2.6 Dysfunctions can create fascial tensions. With that the therapist perceives a tension toward the dysfunction.

2.6.1 If one gives a gentle traction, the fascia gives slightly and then glides along. This fine gliding movement is reduced if there are adhesions, fibrosis, inflammation, or other dysfunctional processes.
One can find a dysfunction in the legs, hips or sacro-iliac-joint by pulling actively on the legs. One compares the symmetry of the flexibility and feels at which part the fascial movement is restricted. Closer to the disturbed part the restriction increases. Each part of the body can be examined in this manner.

2.6.2. E: traction at the dural sleeve from cranial

One can test the spinal dura mater in a way, that's similar to what we've just described.
The occipital bone lies in the palms of both hands. One gives a gentle traction at the occipital bone in a cranial direction.

With his awareness, the therapist follows the fine movement, induced by his traction, of the dural sleeve in the spinal cord canal.
-If the movement stops in the dural sleeve, the therapist registers at which level in the spinal cord canal he perceives the restriction.

E: traction at the dural sleeve from caudal

The therapist sits at a sacral level at the side of the patient.

- The palm of the hand is under the sacrum, the fingertips pointing cranially.
- The spinous processes lie between the fingers, elbow supported on the table.

Procedure:

- One gives a gentle, caudal traction at the sacrum.
- The diagnosis is continued in the same way as the traction at the dural sleeve from cranial.

The further procedure is the same as the one just shown.

2.7. E:Diagnostics: Palpatory differential diagnosis of the dysfunctional level

The osteopath differentiates whether the restricted movement and hardened tissue originates from the bone, from the dura, from brain tissue or from the fluids. A resonance could also be made with electromagnetic fields.

2.8. E:Diagnostics: Palpatory differential diagnosis (new movie made in april)

With the following differential diagnosis it is possible to examine whether the movement restriction of a certain structure (for example spenobasilar synchondrosis) is caused by a different tissue of the body (for ex. The Hyoid).
The osteopath supports one of the two structures (for ex. The hyoid) and brings it to a point of balcance.
(……)
After that he examines, whether the inherent movement or mobility at the sphenobasilar synchondrosis has changed. A normalisation or improvement suggests that the hyoid bone has restricted the sphenobasilar synchondrosis.
(……)
A decrease in movement or mobility suggests that the sphenobasilar synchondrosis has used the hyoid bone as a compensation.
(……)

2.9. E:Diagnostics: Palpation of the fluid movement

The osteopath focuses his attention toward the fluid-colloidal qualities of the organism. The contact is similar to a hand resting on the surface of water. Perceive a gentle current or a direction in which the hand is pulled. This depends on the direction from which the traumatic forces hit the body.

2.10. E:Diagnostics: Gaining a feeling for the organisation in space

Gain a feeling for the organisation in space
How is the structure organized, for example the temporal bone in its intraosseal elasticity?
How is the temporal bone organized in reference to its local surroundings?
How is the temporal bone organized in reference to its regional surroundings?
How is the temporal bone organized in reference to the rest of the organism?

2.11 E: Palpation of the potency

E: Treatment

Some remarks about osteopathic treatment: Technical Skills are important. However, to limit the healing potential by over-focussing on the technical procedure should be avoided. Equally important is the intention, "to be" with the patient, instead of "doing" something to him or to his tissue, and to enable the patient to rejoin with his inherent health.
Healing is not a process aimed unilaterally from the therapist to the patient. It seems to be of great importance that all participants consciously take part in the healing process and the empathetic insight into the relation of signs of disease, as well as into the connected interrelation of all living things.

3.1. E: Treatment: The Neutral according to Jealous

The osteopath places his hands on the head or on a different part of the body. With a gentle awareness the osteopath acts as a passive observer and avoids any kind of following of movement or dysfunctional patterns.
At a certain moment the different movement impulses and tensions in the tissues of the patient come to rest. The different tissues of the body, the fluid and the potency are perceived as one undistinguishable, homogenous density. An integration of body, mind and spirit arises with a momentary best possible balance.

3.2 ----------
3.3 . E: Treatment: Point of balanced tension (PBT): PBMT, PBLT, PBFT
The establishment of a point of balance leads to a release of the tied up forces in a dysfunction, by enabling the tissues to clarify their relation to each other.
In the point of balance the participating joints are in the best possible balance to each other.

Parnormrot)
In the present example we see a free and symmetrical rhythmical tension-adaptation or movement of both parietal bones at first.
Pardysrot)
Then we see a restriction in expiration/internal rotation of the right parietal bone. The membranous, ligamentous, fascial tension is not in balance.
Pardysbalance)

The changed tension creates a tension (pulling) on structure B in direction A. If one does a movement test it is easier to move the parietal bone toward A, while its mobility in the direction of C is restricted.

Pardysbalance 2).
In the treatment one establishes a point of balance for the right parietal bone. The point of balance is reached by testing the movement parameters and following in the direction of ease or passively following (without previous movement tests). This position lies between the normal range of motion of one direction, marked with “A” and the restricted motion of the other direction, marked with “Pr rot”. The point of balance of the membranous, ligamentous and osseous structures is then balanced with the fluid point of balance.

-Allow inherent movements
-a kind of functional stillpoint develops
-Movement becomes palpable again and a new balanced tension has been established

E: Treatment: Point of balanced tension through synchronisation with the primary respiration

A point of balance can also be established by synchronizing with the primary respiration. In the following this is shown with the example of a dysfunction at the parietal bone at the sagital suture. According to Jealous, about 90% of the awareness should rest in the primary respiration, while about 10% of the awareness should be focused on the tensions that

are present. Usually one follows the expression of the tension and augments it minimally in the inspiration phase. A spontaneous disengagement can occur at the end of the inspiration phase.
In the following expiration, inherent forces lead the affected tissue out of the dysfunction.

E: Treatment: balanced fluid tension according to Jealous

-Resonance to the fluid patterns in the dysfunction: One does not address restrictions or barriers of the tissue. The hands follow and remain in the physiological "movement" of the fluid.
-Synchronisation of the hands of the therapist with the fluid and the velocity of the fluid movements and with the inherent spontaneously appearing disengagement. A balance point of the fluids establishes.

E: Adjusting a local, regional and global point of balanced tension:

At first, a point of balance in the intraosseous structure is established, for example the temporal bone.
Then a local point of balance of the temporal bone in relation to its surrounding bones is established. The dural membrane, the brain and the fluids are integrated into this point of balance.
A regional point of balance between the temporal bone and the head follows, and lastly a global PBT between this structure and the whole body.

3.3 E: Treatment: Methods for reaching a point of balanced tension

The following manoeuvres are a **kind of invitation** to the tissue and part of a dialogue with the tissue. The tissue is not forced into a certain direction. Instead one presents certain possibilities to the tissue and the therapist has to respect whether or not these are accepted by the tissue.

Diagram:

Exaggeration technique
Direct technique
Opposite to physiological movement
Compression
Decompression, disengagement
molding

3.4.1 E: Treatment: Exaggeration technique (Ani direct/indirect and then exaggeration technique)

(Pardysbalance) Again the movement of the right parietal bone is easier in the direction of A and is restricted in the direction of C. Pr rot shows the restricted direction of movement of the right parietal bone.

With the exaggeration technique one goes with the tissue or the bone in the opposite direction of the restriction, which means into the direction of the greater mobility (A).

The therapist waits for a relaxation of the tissue with the consequence of a greater mobility and then leads the tissue to the new physiological barrier.
This procedure is repeated up the point where no new release of tension is perceived.
Relative contraindications are children before the age of 5-8 and acute trauma.

3.4.2. E: Treatment: direct technique.

Direkt Technique
With the help of a direct technique the parietal bone is brought in the direction of C, meaning into the direction of the restricted mobility. One should use very, very little force, staying below the threshold where the participating structures start resisting (contracting).
Indications for this technique are, for example, children younger than the age of 4-7, acute dysfunctions of traumatic origin. Indirect and direct approaches can also be combined.

3.4.3. E: Treatment: Opposite to physiological movement using the example of the occipito-mastoid suture

At first one sees the normal biomechanical movement.

This opposing physiological movement is indicated for some very severe traumatic dysfunctions.
In this example, one goes with the occipital bone, as in an indirect technique, into the direction of the greatest mobility, meaning into flexion. At the same time, the temporal bone is brought or held in internal rotation

(=direct technique). A point of balance is established in this position.
This principle of treatment can also be done synchronous with the primary respiration. The flexion of the occipital bone is augmented during the inspiration phase, while the temporal bone is held in internal rotation. During the expiration phase one just follows both bones passively into extension and internal rotation.

3.4.4 E: Treatment: Disengagement

With this technique, two structures are gently separated. This should be done in harmony with the primary respiration, if possible.
Afterwards the point of balance becomes possible.

1st Alternative procedure: One joint partner – in this case the right parietal bone – is held and the left parietal bone is gently separated and a point of balance is established.
Afterwards the left parietal bone is held and the right one is gently released.

2nd Alternative procedure: The only therapeutic induction is focusing ones attention on the disengagement during the inspiration phase and on the accompanying inherent correcting forces. This disengagement does not happen to limit the acting forces, but rather to experience their action and their inner order, to make the according fulcrums visible and to let the acting forces arise in the point of balance.

This treatment principle is indicated, if, because of the underlying trauma, the existing forces have created an immense density and compactness, preventing the point of balance from releasing the forces from their restriction.

Diagram

Indikation:
Compression at the sutures - - especially at the pivot points of the denticulate suture - - at the joints of the extremity - - traumatic and severe chronic restrictions - - fibrosis at the dural membrane - - stretching of fascial or muscular structures - -

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3.4.5. E: Treatment: Compression:

With the help of compression one can create a surrounding, in which the relationship between the tissues is intensified, thereby making hidden conflicts visible.

Two adjoining joint partners are gently approximated. This should be done in harmony with the primary respiration if possible. Afterwards the point of balance becomes possible. The awareness (attention) is focused on the acting of the inherent homeodynamic forces.

1st Alternative procedure: One joint partner – in this case the right parietal bone – is held and the left parietal bone is gently approximated and a point of balance is established.
Afterwards the left parietal bone is held and the right one is gently approximated.

2nd Alternative procedure: Focusing ones attention on the converging movement during the expiration phase and on the accompanying inherent correcting forces is the only therapeutic induction.

E: Treatment: Combination of Compression and decompression:

At first the joint is compressed, moved into the lesion, and afterwards it is decompressed in the opposite direction. The indirect is combined with the direct technique. One can imagine this procedure by comparing it with a stuck (jammed) drawer. To get the drawer out, one pushes is back in first, in order to then get it out without force.

3.4.6. . E: Treatment: Molding

By molding, one tries to influence the shape and the flexibility of the bone, by giving pressure or traction from the outside.
For example the parietal eminence can seem too flat or too prominent on one side. If one uses molding, one gives impulses to flatten a too prominent part of the bone and to make a too flat part more prominent.

This is mainly indicated for intraosseal dysfunctions in early childhood, but also for adults.

(Graph) Fluctuation of the cerebrospinal fluid, secondary respiration (breathing) and the myofascial system can support Molding.

3.12

E: Treatment: V-spread / Fluid Impulse

In the V-spread-technique even severe restrictions are released in the most gentle way with the help of the inherent forces of the fluid fluctuations. The fluid-crystalline characteristics of the body tissue form the basics for this technique.

Text in the picture: Localisation of the exact finger position

The middle finger and the index finger are positioned in a V-shape at the restricted (fixated) suture or at the suture to be tested. At the opposite side one can feel a soft pulsation, at the point where the vector of the fingers lying in a v-shape leaves the skull. This is the optimal point from which to give an impulse toward the restricted suture.

Text in the picture: Testing of a suture

At the beginning of the inspiration phase, one finger of the hand lying on the opposite side sends a fine fluid impulse into the suture to be tested.

The suture is free if the fingers lying in a v-shape feel an opening of the suture, comparable to the feeling of a wave washing up on a sandy beach.
If one doesn't feel an opening of the suture, similar to the feeling of a wave hitting a rock, the suture is restricted (blocked, fixated).

Text in the picture: Release (Freeing) of a suture
(pulsating arrow) During each inspiration phase, the finger lying opposite to the restricted suture, sends a gentle fluid impulse toward this suture.
(arrows at the fingers) In addition, the fingers lying in a v-shape spread the suture with a minimal amount of force.
(arrow standing still) One can also give a continuous impulse toward the restricted suture, independent of the inspiration phase.

E: Further treatment possibilities (new live scenes)
Not only the hand, but also other parts of the body, for example the belly, can send this fluid impulse.
A fluid impulse can also be given from the feet or from the sacrum, to release restrictions at the skull.
Each part of the body, for example the shoulder, can be treated with the help of a fluid impulse.
Also two, three, four or more people standing behind each other and touching one another can send a bundled wave of fluctuation together.

Sutherland mentioned, that even pure willpower, without direct body contact, would be capable of influencing body fluids.

E: Fluctuation techniques

2.1.1. E: Fluctuation techniques – stillpoint induction

The induction of a Stillpoint can be done at each part of the body. Either a global stillpoint, encompassing the whole organism, can appear, or a local stillpoint, which is accompanied by a balancing of the tension of the concerned tissue.

Usually one follows the internal rotation and extension in the expiration phase and gives resistance to the external rotation and flexion.

As the therapist gains more experience, a different procedure starts to prevail. If the therapist synchronizes with the inherent homeodynamic forces and rhythms, it promotes the spontaneous appearance of a stillpoint in the organism, for example in the form of a CV-4 or an EV-4. This approach does not require the meeting or confronting of tissue resistance. It is also not necessary to give a resistance in a phase of primary respiration, but rather the inherent forces in the organism lead to a stillpoint.

E: Fluctuation techniques : Compression of the fourth ventricle (CV-4)

1st and 2nd lateral ventricles
3rd ventricle

4th ventricle
aquaeductus sylvius
interventricular foramen of monro

A CV-4 has a homeostatic effect

Effects of and indications for a CV-4

Tone reduction of the sympathetic nervous system
Tone reduction of the entire connective tissue
For acute and chronic muscle disturbances, degenerative disturbances of the joints, menstrual pain
Fever –reducing
Blood pressure reducing
Pulse reducing
For edema caused by venous drainage problems
For inflammations and infections
For mal-calcification of the bones (promotes ossification)
For depressions
For neuroendocrine disturbances
For hyperthyroidism
Epilepsy (However, one has to consider that an epileptic attack can be triggered)
Promotes the start of labour
Acts as a lymphatic pump
Universal technique and “forgiveness technique”
Reduces blood sugar
Reduces activity of sweat glands

Contraindications
Danger of brain haemorrhage, acute stroke, aneurysms, malignant hypertension
Fractures of the base of the skull
Head injuries
Fractures of the occipital bone
Fractures of the cervical spine

Relative Contraindications
Epilepsy, since it can trigger an attack
Pregnancy, starting with month 7, since it could induce contractions

- The hands are placed into one another in a shell kind of way; the tips of the thumbs are touching and forming a V.
- The thumbs are pointing distally and are placed at about the level of the 2nd or 3rd cervical spinous process.
- The thenars are lying medially along the occipital squama. It is important, that they are not placed over the occipito-mastoid suture.

- During the expiration phase the thenars follow the narrowing of the occipital squama.

- In the inspiration phase the thenars prevent the external rotation or the widening of the occipital squama.
- In the next expiration phase the hands follow the occiput further into internal rotation and resist its widening in the inspiration phase
- This procedure is repeated until external rotation/internal rotation have come to a standstill: a stillpoint
- The hands follow the micro-movements that might appear from the neck muscles.

- A deeper breathing, a slight sweat on the forehead and a reduced muscle tone can take place at a successful stillpoint.

At the end of the stillpoint one feels a strong, even pressure at the occipital bone towards external rotation. The therapist follows this impulse passively and focuses his attention on the quality of the rhythm.

Comment:
Different ways of doing this procedure are possible:

1. The osteopath takes an influence on the fourth ventricle via the bone and the dura. While doing this, the osteopath feels the changing of the elasticity of the bone during the inspiration- and expiration phase and the consequences of his action on the dura, or, to be exact, the tentorium cerebelli.
2. The osteopath focuses his attention directly on the intracranial fluids. The skull and the fourth ventricle are perceived as a balloon filled with

water, and one gives a compressive pressure directly onto these fluids.

3. The osteopath focuses his attention onto the region around the fourth ventricle, however, he experiences the synchronous effects on all levels of density. The osteopath slightly assists the expiration and retraction, without changing the tempo of the "movement" and without hindering the inspiration or expansion; one follows the inspiration passively. This procedure is continued until a stillpoint starts.
4. The osteopath only follows the existing tissue qualities, and it is the decision of the inherent regulatory system, or the "primary respiration", if a CV-4 or an EV-4 occurs. The osteopath "only" functions as a fulcrum to follow these processes.

E: fluctuation techniques:
Expansion of the 4th ventricle (EV-4) according to Jealous

(add to picture: Effect, indication and contraindication: see CV-4 technique)

-The occipital bone is in the palms of the hands.
- The finger tips meet in the middle and point anterior.

-During the inspiration phase the therapist follows the occipital squama into external rotation.
-In the expiration phase he prevents the extension and internal rotation of the occipital squama by giving a gentle anterior pressure with his fingertips in the midline of the occiput.

-In the next inspiration phase the hands follow the occipital squama further into external rotation.
- Continue as in the description of the CV-4 technique.

E: fluctuation techniques: compression of the 3rd ventricle (CV-3) according to Jealous

The CV-3 technique is primarily used for restriction in the 3rd ventricle, asymmetries of the rhythmical coiling and uncoiling of the cerebral hemispheres, disturbed tissue tension in the region of the hypothalamus, the pituitary, the pineal gland and the lamina terminals.

During this technique, the attention is especially focused on the lamina terminals. This is a fulcrum point for the central nervous system, or for the rhythmical coiling and uncoiling of the cerebral hemispheres.

The index finger and/or middle finger are on the greater wings.
The thumb lies on the coronal suture.
Procedure:
-At first one feels and differentiates the movement or restriction at the floor (hypothalamus and infundibulum), the roof (pineal gland) and at the anterior boarder of the third ventricle.
- During the expiration phase the therapist follows the greater wings superior, posterior and medial.
- In the inspiration phase he prevents the external rotation of the greater wings by giving a gentle pressure superior posterior and bilaterally medial.

- In the next expiration phase the hands follow the greater wings further into internal rotation.
-the attention should always be focused on the third ventricle at the restricted level and on the lamina terminalis.
-After several cycles the pressure against the fingers in the inspiration phase decreases and a stillpoint occurs.

E: fluctuation techniques: compression of the lateral ventricles

For example, this technique is indicated for restrictions in the lateral ventricles as well as rhythmical variations of tension in the cerebral hemispheres

- The wrist (carpus) is supported on the treatment table.
- The ringfinger and the little finger are lying above the zygomatic process on the temporal squama at about the level of the cornu temporalis.
- The middle- and index fingers lie above the squamous suture on the parietal bone, approximately at the cornu frontalis and the pars centralis.
- The palm of the hand is about on the level of asterion, about on the level of the occipital cornu.

- During the expiration phase the therapist follows the skull into internal rotation.

- During the inspiration phase he prevents the external rotation of the skull, by giving a gentle pressure medial, bilaterally.
- The attention should always be focused on the fluids in the lateral ventricles.
- After several cycles the pressure against the fingers in the inspiration phase decreases. The external-/internal rotation, flexion-/extension movement has come to a stillpoint.

E: fluctuation techniques: Rotation of the temporal bones

-The thenars of the thumbs lie bilaterally on the mastoid portion of the temporal bones.
- The thumbs lie on the anterior tip of the mastoid process.

-One follows the external- and internal rotation of the temporal bones.
During the external rotation the thumbs move posterior-medial on the mastoid processes.
During the internal rotation the thenars move posterior-medial with the mastoid portion.
-According to the palpatory findings one can gently promote either only the external rotation movement and not the internal rotation or vice versa: only the internal and not the external rotation movement.
-The contrary movement should not be hindered, but just followed passively.

It is also possible to slow the movement down gently.

The external rotation movement of the temporal bones is slowed down by the thenars at the mastoid portion giving a gentle resistance posterior and medial at the start of each inspiration phase.
The internal rotation of the temporal bones is slowed down by the thumbs at the mastoid processes giving a gentle resistance posterior-medial at the start of each expiration phase.

E: fluctuation techniques: Pussy foot technique

The thenars lie on the mastoid portions bilaterally.
The thumbs lie bilaterally on the anterior tip of the mastoid processes.
Both elbows are supported on the table.

-By shifting weight from one elbow to the other one initiates opposite movements of the temporal bones.
-The temporal bone of one side is brought into external rotation by shifting the weight onto the elbow of the same side. This causes the thumb at the mastoid process to move medial and posterior.
-By taking weight off the other elbow, the other temporal bone is moved into internal rotation. Because the hand automatically moves in such a way, that the thenar on the mastoid portion gives a medial-posterior pressure.
-internal rotation of the right temporal bone is accompanied by an external rotation of the left temporal bone, and an external rotation of the right temporal bone is accompanied by the internal rotation of the left temporal bone.

- one changes the direction in the rhythm of the primary respiration.

-Once this opposite movement induction is taken over by the primary respiration, the osteopath just follows passively and waits until these opposite movements have calmed down.
After a short resting phase, a symmetrical rhythm will reappear. Otherwise the osteopath gently promotes the reappearance of a symmetrical movement.

E: fluctuation techniques: Diagonal fluctuation techniques

The thumb and the index finger take hold of the zygomatic process. The middle finger lies in the external meatus of the ear. The little finger and the ring finger take hold of the mastoid process.

- One temporal bone is rotated anterior, while the other temporal bone is rotated posterior.
- Once these opposite movement inductions are taken over by the primary respiratory mechanism, the osteopath just follows the movement passively until the opposite movements have come to rest.

After a short resting phase, a symmetrical rhythm will reappear. Otherwise the osteopath gently promotes the reappearance of a symmetrical movement.

E: Venous-sinus- techniques according to Fryman

The venous drainage from the inner skull depends on the dural and sutural tension relation.

Superior sagital (longitudinal) sinus
Straight sinus
Confluence of the sinuses
Transverse sinus
Lateral sinus
Internal jugular vein
Inferior petrous sinus
Cavernous sinus
Superior petrous sinus
Inferior sagital (longitudinal)sinus

Indications

Very restricted hard skull
Severe dysfunctions of the base of the skull
Numerous sutural compressions
Signs of intracranial drainage problems
High intracranial pressure
Retro-orbital pain
Migrane attacks
Behavioural and psycho-motor functional disturbances

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E: venous-sinus-techniques: Atlanto-occipital release

Contraindications
Fractured dens of axis

danger of intracranial bleeding (haemorrhage)
Fracture in base of skull

Effect
Release of the atlanto-occipital joint
Release in the area of jugular foramen

-Both hands lie under the occipital bone
-The occipital squama lies in the palms of the hands.
-The fingers are placed in right angles, so that they're pointing strictly anterior.
-The finger tips lie directly underneath the lower occipital edge (rim).
-Through the weight of the head, the neck muscles relax increasingly using the fingers as a lever. No additional pressure is given with the fingers.
- If the fingers start slanting due to the relaxation of the neck muscles, they are repeatedly placed at right angles.
-With increased relaxation of the neck muscles, one can start feeling the bony arch of the atlas
-Towards the end of the treatment, the head does not lie in the palms of the hands anymore, but is only supported by the fingers on the atlas.
- After the relaxation of the neck muscles the occipital condyles are released from the atlas. The middle fingers fixate the arch of the atlas while the ring fingers and little fingers gently pull the occiput cranial.

- After that, one does a transverse decompression of the occipital condyles. For that, the fingers are placed in a 45° angle toward the foramen magnum. For an intraosseal decompression, the therapist brings the elbows closer together, causing the fingers at the occipital condyles to move apart. (still turn)

E: Venous sinus techniques: Confluence of the sinuses

-The finger tips of both middle fingers are placed on the external occipital protuberance.
-the fingers are in a vertical position and follow the intraosseous tensions. The weight of the head is on the fingers.

When a "softening" of the bone and the sinus is perceived and an even inherent movement is felt, one can move on to the next step of the treatment.

E: Venous sinus techniques: Occipital sinus

- The fingers are moved one finger's width caudally from the external occipital protuberance.
- After perceiving a softening of the tissue, both middle fingers can be moved one finger's width caudally again, along the occipital sinus.
- This procedure is repeated until the fingers can not be placed closer towards the foramen magnum.

E: Venous sinus techniques: Transverse sinus and straight sinus

- The fingertips of both little fingers are on the external occipital protuberance, while the tips of the

other fingers are placed along the superior curved line (linea nuchae superior) at the occipital bone.
- The weight of the head is on the fingers again.
- The thumbs are placed on top of each other at the sagital suture.
- A connection is visualized from the thumbs to the anterior end of the straight sinus.
- There is a perpetual contact of the fingers until a softening of the tissue is palpated.

E: Venous sinus techniques: Superior sagital (longitudinal) sinus

-The overlapping thumbs are placed above the external occipital protuberance.
-The palms of the hands are lying on the external surface of the head.
-The thumbs are putting a gentle spreading pressure on the tissue at the level of the superior longitudinal sinus.
-After a softening of the tissue the thumbs are moved one finger's width anterior-cranial.
This procedure is repeated along the sagital suture up to Bregma.

- Following this, the fingers of both hands are placed along the metopic suture on the frontal bone. The index fingers are anterior to bregma, the little fingers are above nasion. The other fingers are lying in-between.

-We follow the same principle as above.

E: Dural techniques: Release of the falx cerebri

E: Frontal spread technique

-The ring fingers hook around the zygomatic process of the frontal bone and use it as an attachment.
-The little fingers support the ring fingers.
-the middle fingers and index fingers are next to the medial line of the frontal bone.
-One thumb is under the hand, one thumb is over the hand.

-the index fingers give a slight pressure posterior at the midline of the frontal bone. This decreases the anterior-posterior diameter of the falx and reduces its membranous tension.
-Once no further relaxation takes place or a stillpoint has appeared, one can move on to the lift technique.

E: Frontal lift technique:

-The ring fingers give a gentle pressure medially at the lateral edge of the frontal bone, so that the frontal bone is brought into internal rotation and is released from the sphenoid bone.
-As soon as the frontal bone starts moving anterior, the medial pressure from the ring fingers can be reduced.
-Now one gives a gentle anterior traction, caused by the therapist moving his body weight onto his elbows.

With each release of the tissues, one searches for the new movement barrier of the frontal bone moving anterior.

All fine movements of this membrane taking place during this traction are permitted.
-After the release of the tension patterns, the traction can slowly be reduced (released).
-The hands should never be taken off the bone suddenly.

Alternative hand hold for the lift technique of the frontal bone

- The balls of the little fingers are attached behind the temporal line of the frontal bone.
- The fingers are hooked together and the elbows are supported on the table.

The medial compression is achieved by pulling the fingers apart laterally.
The anterior traction is initiated by straightening the fingers.
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E: Parietal spread technique:
-The hands are lying on the parietal bones.
-The thumbs are overlapping and lying on the opposite sides of the parietal bone.

→The thumb tips give a gentle caudal pressure at the parietal bones, so that the sagital suture sinks and the tension of the falx is reduced.

E: Parietal lift technique:
The hand position: It is similar to the spread technique, with the difference, that the thumbs are not overlapping, but instead are touching each other above the sagital

suture. The other fingers are above the parieto-squamous suture.

-The fingers give a gentle medial pressure at the lower rim of the parietal bone. This releases the temporal bone from the parietal bone.
-The bones of the skull have released, when the parietal bones start moving cranial and start drifting apart.
-Then one gives a cranial and slightly posterior traction at the parietal bone.
-One continues as in the description of the frontal lift technique.

E: Dural technique: Relaxation of the tentorium cerebelli

E:SBS Compression

-The thumbs are lying on the greater wings, posterior to the lateral rim of the eye.
-The ring- and little fingers are touching the outer areas of the occipital bone.

-The thumbs give a posterior tensile force at the greater wings until a reduction of tension in the tentorium cerebelli is perceiveable.

E:SBS Decompression

-The thumbs give an anterior tensile force at the greater wings.
-One continues as described in the frontal- lift technique.

E: Internal rotation of the temporal bone

The thenars of the thumbs are lying on the mastoid portion bilaterally.
-the thumbs are lying bilaterally on the anterior tip of the temporal bones' mastoid process.
-the thenars give a posterior and medial pressure from both sides at the mastoid portion.
This internally rotates the temporal bones and the tension of the tentorium is reduced.

E: Ear pull technique

-the thumbs are lying at the meatus auditorius externus.
-the index- and middle fingers are lying behind the earlobe, as close as possible to the temporal bone.
-The thumbs and the fingers take a hold of the anti-tragus and the earlobe.

-One gives an oblique lateral, posterior and cranial traction in the course of the petrous part.
-The force used is increased gently and very slowly.
-While doing the traction, the direction of pulling might constantly change slightly, according to the tension patterns of the tentorium and the sutures.

E: Anterior dura girdle according to Jealous

The anterior dura girdle stretches along the posterior edge of the lesser wings and along the posterior part of the coronal suture up the greater wings. This term is usually just used in the early stages of embryological development.
Its function is unknown. One assumes, that, as a fluid membranous structure, it has an integrating function on the anterior cranial structures and, for example, participates in dysfunctions of the spheno-squamous pivot point.

E: Anterior dura girdle – mandibular rami (anim. And scene)

The therapist is at the side at the head of the patient.

Thumbs and index finger of the cranial hand take a hold of the coronal suture.
The caudal hand takes hold of the mandible.

4 The osteopath builds up a resonance to the fluid and membranous matrix of the mandible.
5 The awareness is focused on the interchange between the anterior dura girdle and the mandible
6 Possible forces pointing anterior, posterior, Superior, and inferior or rotating, translatory (shifting), compromising and decompromising forces are perceived.
7 These are brought into balance in a dynamic fulcrum between the anterior dura girdle and the membranous ring of the mandible.
8 This enhances the flow of the Potency in this region.

9 The release of inhibiting tensions is usually accompanied by an expansion of the participation structures.

E: Anterior dura girdle – maxillary arch (picture and scene)

The therapist is at the side at the patient's head. The therapist is usually standing, so that the fingers can relax as much as possible.

Thumbs and index fingers of the cranial hand take a hold of the coronal suture.
Middle finger and index finger of the caudal hand are on the palatine processes of the maxillae.
If the space at the gums is not large enough, the middle- and index finger can also be placed on the maxillae's rows of teeth.

E: Anterior dura girdle – Tentorium cerebelli (picture and scene)

The therapist is in a slightly diagonal position at the head of the patient.

Thumbs and index finger of one hand take a hold of the coronal suture.
The other hand is on Inion and at the level of the transverse sinus, corresponding to the posterior area of attachment for the tentorium cerebelli.
The procedure corresponds to the one described above.

Note: No pressure should be put on the occipito-mastoid suture

E: Anterior dura girdle – sphenoid bone

Indication: Dysfunction at the spheno-squamous pivot point (SSP) and at Pterion. The therapist is at the side at the head of the patient.

Thumbs and index fingers of the cranial hand take a hold of the coronal suture.
Index- and middle fingers of the caudal hand take a hold of the greater wings of the patient.
Again we proceed as previously described.

E: Spinal dura mater

E: Spinal dura mater: Traction of dural hose

The spinal dura mater has a relative longitudinal gliding capability from the upper cerviacals to the sacrum.
The dural hose traction can be used for diagnosis as well as for treatment of restricted movement of the spinal dura mater.

If tractioning from the occipital bone, the atlanto-occiptial joint should be especially released and when giving a traction from the sacrum, the lumbo-sacral junction should be released.

E: Spinal dura mater: Tractioning of the dural hose from cranial

The occipital bone is lying in the palms of both hands. The therapist is doing a gentle traction in a cranial direction at the occipital bone. (scene real Torsten)

For a diagnosis the therapist, with his awareness, follows the fine movement of the dural hose, induced by the traction. (also still the scene with real Torsten)
-If the movement of the dural hose stops, the therapist registers at which level of the spinal canal the resistance is perceivable. In this example it is shown by an arrow. (animation 1 + 2 (with and without arrow)

- For therapy the gentle traction is held and the tensions in the tissue are allowed to unwind, so that the restriction can release.
- A V-spread-technique or a technique to relax the diaphragm can promote the release.

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E: Spinal dura mater: TRactioning of the dural hose from caudal

The therapist is sitting on the level of the sacrum, at the side of the patient.
-The palm of the hand is lying underneath the sacrum, the finger tips are pointing cranial.
-The spinous processes are lying between the fingers; the elbow is supported on the table.

- One gives a gentle traction at the sacrum.
- The diagnosis and treatment is done as described in the dural hose traction from cranial

E: Spinal dura mater: rocking of the dural tube according to Sutherland

The patient is lying in a relaxed sidelying position. The knees are bent.
The therapist is sitting behind the patient, in the middle between the sacrum and the head.
One hand is at the occipital bone, the other hand is at the sacrum.

- One gives a gentle, even, diverging traction at the occipital bone and at the sacrum. The occipital bone is tractioned cranially, the sacrum is tractioned caudally. This traction is achieved by leaning the body forward.
- The intensity of the tension stays below the threshold at which the tissue starts to resist. (animation sacro occipital 1)
- All the occurring “unwindings” are permitted.

- Once a relaxation has established in the dural tube, the osteopath begins to follow the flexion- and extension movement of the occipital bone and the sacrum in a kind of rocking movement of both bones. (animation sacro occipital 2+3)

-this rocking movement can gently be promoted in synchronicity with the primary respiration, by giving a gentle impulse in the according direction of movement at the beginning of each inspiration- and expiration phase. Two different ways of doing this are shown. (freezw scene with arrow)

E: rocking of the dural tube, alternative procedure

The patient is supine.
The therapist is next to the patient, in the middle between the sacrum and the head.
One hand is lying sideways under the occiput, the other hand sideways under the sacrum. Turn.