DVD 5

1 Ethmoid bone

Biomechanical and biodynamic palpation and mobility tests

Biomechanically there's supposed to be a posterior (and superior) movement at the level of glabella and an anterior movement on the level of the internasal suture during the inspiration phase.

Biodynamically one should perceive a force in an anterior and inferior direction during the inspiration phase.

1.1 Palpation

The therapist is at the side at the head of the patient.
-the middle finger and index finger of the cranial hand take a hold of the greater wings.
-The index finger is between the arches of the eyebrows on glabella.
The middle finger of the caudad hand is below nasion, that means below the fronto-nasal suture on the internasal suture.

Mobility test
The hand position is the same as described before.
-At the beginning of the inspiration phase the index finger on Glabella gives a slight posterior and minimally cranial impulse to induce a flexion of the

ethmoid bone. The anterior surface of the ethmoid bone should move anterior accordingly.
-the middle finger on the internasal suture feels a minimal anterior movement as a reaction to this pressure.

-At the beginning of the expiration phase, the middle finger on the internasal suture gives a slight posterior impulse to induce an extension of the ethmoid bone.
-The index finger on Glabella feels a minimal anterior movement as a reaction to this pressure.
The therapist compares the amplitude of the movements, the ease of the movements or the force that is necessary to induce the movement.

1.2 Flexion - / Extension dysfunction
Flexion dysfunction: The movement of the ethmoid bone into extension is reduced.
The therapist is at the side at the head of the patient.

-One hand is sideways at the occipital bone, so that the squama is lying in the palm of the hand.
One finger is lying on Glabella, one finger is below nasion on the internasal suture.

Abdominal bandage: indirect technique
-One follows the occipital bone into flexion during the inspiration phase.
-To establish a point of balance, one follows the ethmoid bone into flexion until one palpates the best possible balanced membranous tension.

-Help through breathing:
One can help the treatment by letting the patient hold his breath at the end of the inspiration, as long as he can, while his feet do a plantar flexion. This is repeated for several breathing cycles. (Anim)

Abdominal bandage: Alternative procedure in dynamic synchronisation with primary respiration

-One follows the occipital bone into flexion during the primary respiration.
-At the same time the index finger gives a gentle pressure on Glabella, to promote the flexion movement of the ethmoid bone.
-In addition one can promote the expression of all occurring aberrant tensions or movements during inspiration.
-During the primary expiration phase the therapist only passively follows the movement of the occipital bone and the ehtmoid bone.
-This procedure is continued until the dysfunction has released. (Anim)

The extension dysfunction can be released as shown.

-A fluid impulse can be given from the occipital bone toward the ethmoid bone.

1.3. External rotation dysfunction. See frontal spread an lifting technique and maxilla lift and spread technique

1.4.Lamina cribrosa : See frontal spread and lift technique

1.4.**1 Direct technique for the lamina cribrosa,** 61

The thumb takes a hold of the middle- and/or index finger of the frontal bone by hooking around the outside of the frontal bone's zygomatic process.
The metacarpo-phalangeal joint of the index finger is on Glabella.

Middle finger and index finger of the caudad hand take a hold of the Maxilla's frontal process. The thumb and the ringfinger are on the antero-lateral faces of the maxilla.
One follows the frontal bone into external rotation and flexion during the inspiration.
-At the same time one induces an external rotation and an inferior traction on the maxilla with the caudad hand.
-A point of balance is established.

1.4.2 **Unilateral, 62**

Unilateral direct technique for the lamina cribrosa, left (fig. 2.13)
Indicated for a dysfunction of the lamina cribrosa, ethmoidal incisure and ethmoido-maxillary suture.
The therapist is at the side at the head of the patient, contra-lateral to the side of the dysfunction.
The thumb takes a hold of the frontal bone with the middle finger and index finger by hooking around the frontal bone's zygomatic process.

The index finger of the caudad hand is on the left frontal process of the maxilla.

The middle finger is on the left anterior face of the maxilla

The ring finger is on the left zygomatic process.

One follows the frontal bone into external rotation and flexion during the inspiration.
Index finger and middle finger of the caudad hand bring the maxilla into external rotation.
The ring finger brings the zygomatic bone into external rotation.
(For didactic reasons we show this procedure as one after the other in the animation)
A point of balance is established.

1.5 Lamina perpendicularis : see external rotation dysfunction of the ethmoid bone or frontal spread and frontal lift techniques

1.6 **Lateral parts**

This technique is indicated for restricted movement of the lateral part and for sinusitis.
The therapist is at the side at the head of the patient.

Abdominal bandage: indirect technique

The thumb with the middle – and/or index finger take a hold of the frontal bone by hooking around the frontal bone's zygomatic process.

The index finger of the caudad hand is intraoral on the posterior median palatine suture, the transverse palatine suture.

During the expiration phase one gives an impulse onto the frontal bone toward internal rotation and extension. That means, that the index finger's metacarpo-phalangeal joint gently follows Glabella anterior, while the thumb and the middle finger move the external, lower parts of the frontal bone posterior and medial and the whole frontal bone into a more slanted position.

At the same time the index finger of the caudad hand gives a superior pressure with the intention to give an impulse on to the lateral portion of the ethmoid bone via the vomer into extension and internal rotation.

As an additional aid, the patient can hold his breath as long as possible after the exhalation. This is repeated for several cycles.
-A point of balance is established at the frontal bone, the vomer and the ethmoid bone.

Abdominal bandage: direct technique

Flexion and external rotation of the sphenoid bone, the frontal bone and via the vomer the ethmoid bone are promoted in the direct technique. In this technique the index finger of the caudad hand is intraoral on the anterior median palatine suture of the transverse palatine suture.

Abdominal bandage: drainage of the ethmoidal sinus

1.7 Drainage of the ethmoidal sinus (+ alternative hand position). 67

This technique is indicated for sinusitis.
This technique is a combination of the last two procedures, except for several slight variations.
The index finger is intra-oral on the median palatine suture, in front of the transverse palatine suture, while the middle finger is behind the transverse palatine suture.

It is also possible, to place just the index finger on the whole median palatine suture. This requires the skill of the osteopath to perceive and induce the flexion and extension of the vomer.

During the inspiration, flexion and external rotation is promoted and during the expiration, extension and internal rotation of the structures named above, especially of the ethmoid bone, is promoted.

Abdominal bandage: Opposite physiological movement

A movement opposite to the physiological is also possible. Doing this, one follows the frontal bone into external rotation in the inspiration phase while one induces an extension at the ethmoid bone via the vomer. During the expiration phase one follows the frontal bone into internal rotation while inducing a flexion at the ethmoid bone via the vomer.

1.8 Unilateral drainage of the ethmoidal sinus

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

The cranial palm of the hand is on the frontal bone.
The thumb is sideways on the frontal bone, contra-lateral to the side of the dysfunction.
The other fingers are lying at the same side of the dysfunction.
The index finger is lying on the frontal process of the maxilla.
The middle finger is on the anterior face of the maxilla.
The ring finger and little finger are on the zygomatic bone.

The index finger of the caudad hand is intra-oral on the median palatine suture in front of the transverse palatine suture.
The middle finger is intra-oral on the median palatine suture behind the transverse palatine suture.
It is also possible, to place just the index finger on the whole median palatine suture.

During the inspiration phase the therapist promotes the external rotation at the frontal bone, at the maxilla and at the zygomatic bone.
At the same time one promotes a superior movement infront of the transverse palatine suture. This induces a flexion of the ethmoid bone via the vomer.

The opposite happens during the expiration phase. The therapist promotes the internal rotation at the frontal bone, at the maxilla and at the zygomatic bone.

At the same time one promotes a superior movement posterior to the transverse palatine suture. This induces an extension of the ethmoid bone via the vomer.

-This procedure is repeated for several cycles of the PRM-rhythm.

2 Vomer

Biomechanical and biodynamic palpation and mobility tests

Biomechanically, the posterior edge of vomer should sink (or move inferior) during the inspiration phase. Biodynamically one should perceive a force with an anterior and inferior direction during the inspiration phase.

2.1 Palpation

The therapist is at the side at the head of the patient.
-the cranial hand takes a hold of the greater wings with the middle finger or index finger and the thumb.
-The index finger of the caudad hand is at the median palatine suture of the maxillary bone and the palate bone.
It is also possible to lay the index finger and middle finger on the suture. The index finger on the anterior

part and the middle finger on the posterior part of the median palatine suture.

(The hand position is the same as previously described)

Testing of flexion and extension via the sphenoid bone
During the inspiration phase one follows the sphenoid bone into flexion via the greater wings, or one promotes this movement.
This should cause a flexion of the vomer. The index finger on the posterior part of the median palatine suture should feel a minimal caudal movement as a reaction to this pressure.

During the primary expiration phase one follows the sphenoid bone into extension via the greater wings or one promotes this movement. This should cause an extension movement of the vomer. In this case, the index finger on the posterior part of the median palatine suture should feel a minimal cranial movement as a reaction to this pressure.
One can also induce a movement directly at the vomer.

Testing of flexion and extension via the ethmoid bone
Vomer can also be tested via the ethmoid bone.
One induces and follows a flexion and extension movement at the ethmoid bone with the cranial hand and palpates the reaction at the vomer.

2.2 Flexion and Extension Dysfunction (handhold as in 8.1)

This technique is also used to treat at the spheno-vomerian suture.
The hand position corresponds to the one just described.

Indirect technique for a flexion dysfunction

19 During the inspiration phase one follows the sphenoid bone into flexion.

- At the same time, the finger lying anterior to the transverse palatine suture gives a cranial impuls to promote the flexion movement of the vomer.
- A point of balance is established.
- It can help, if the patient holds his breath as long as possible at the end of the exhalation. This is repeated for several breathing cycles.

direct technique for a flexion dysfunction

-During the expiration phase one follows the sphenoid bone into extension.
-At the same time the finger posterior to the transverse palatine suture gives an impulse in a cranial direction to promote the extension movement of the vomer.
A point of balance is established.
-help through breathing: The patient holds his breath as long as possible at the end of the inspiration. This is repeated for several breathing cycles.

-One can give a fluid impulse from inion.

The treatment of an extension dysfunction is done accordingly.

2.3 Torsion dysfunction and lateral shift of the Vomer (hand hold as in 8.1)

-The cranial hand takes a hold of the greater wings with the middle finger or index finger and the thumb.
-The index finger of the caudad hand is along the median palatine suture of the maxillary bone and palate bone.

Testing of the torsion movement:

The vomer is rotated left and right, while the greater wings are held in a neutral position.

Testing of the for right torsion

-The index finger on the median palatine suture gives an impulse in the direction where the torsion has the greater mobility; in this case to the right.

- A point of balance is established.

For a direct technique, vomer is brought into the direction of the restricted torsion and a point of balance is established.

2.4 Lateral shift of the Vomer

Testing of the lateral shift

The vomer is moved to the left and to the right while the greater wings are held in a neutral position.

Indirect technique for a lateral shift

-The greater wings are held in a neutral position.
-the index finger on the median palatine suture gives an impuls in the direction of the lateral shift with the greatest mobility, in this case to the right.

- A point of balance is established.

2.5 Vomero-maxillary suture, for an internal rotation of the maxilla

Suture edge: The anterior inferior part of the vomer is connected to the nasal crest of the maxilla.
The therapist is at the side at the head of the patient.

Thumb and middle- or index finger take a hold of the greater wings.
The middle finger and index finger of the caudal hand are on both sides of the maxilla's rows of teeth.
-During the inspiration phase one promotes the tension adaptation of the sphenoid bone in flexion.
-At the same time one spreads the fingers on the upper row of teeth to follow the external rotation of the maxilla.
-In the expiration phase one follows the movement of the cranial bones passively
-This procedure is repeated for several cycles until an increase of the vomer's mobility in the vomero-maxillary suture is perceived.

2.6 Decompression of the vomer

The therapist is at the side at the Patient's head.
The thumb and the middle or index finger take a hold of the greater wings
-caudal hand:
the index finger of the caudal hand is intra-oral on the median palatine suture. The thumb is external, below the nose, on the inter-maxillary suture.

-the greater wings are held in a neutral position.
-the index finger and the thumb of the caudal hand give an anterior-inferior traction in an angle of approximately 45 degrees.

2.7 Vomer Pump technique

Indicated for Sinusitis
-the cranial hand takes a hold of the greater wings with the middle or index finger and the thumb.
-Caudal hand: the index finger or index and middle finger of the caudal hand are along the median palatine suture.
-It is also possible to use the index and middle finger; the index finger on the anterior part and the middle finger on the posterior part of the median palatine suture.

Closing of the Sinus

For the closing of the sinus, the vomer and the sphenoid bone are lead into extension in the expiration phase.
-the vomer and sphenoid bone are held in extension and the patient is asked to hold his breath as long as possible at the end of the exhalation. This procedure is repeated several times.

Opening of the Sinus

For the opening of the sinus the vomer and the sphenoid bone are brought into flexion during the inspiration phase.
-The vomer and the sphenoid are held in flexion and the patient is asked to hold his breath as long as possible

after inhalation. This procedure is also repeated several times.

Opposite physiological movement:
During the primary inspiration phase one follows the sphenoid into flexion.
-At the same time one brings the vomer into extension by giving a cranial pressure with the index finger on the posterior part of the palatine suture.
During the expiration phase one follows the sphenoid bone into extension.
-At the same time, the vomer is brought into flexion by giving a cranial impulse on the anterior part of the palatine suture.

This procedure is repeated several times.

At the end, the movement of the vomer should be synchronized with the movement of the sphenoid bone.

3 The Nasal Bone

Biomechanical and biodynamic palpation and mobility tests
In the inspiration phase the nasal bone goes into external rotation.
The nasal bone is influenced by the frontal bone and by the maxilla and therefore by the sphenoid bone. These bones should also be considered in the treatment.

3.1 Palpation

- The index fingers are on both sides of the nasal bone.
- The other fingers are passively on the skull.

3.2 fronto-nasal suture, see frontal bone

3.3 Internasal suture, disengagement

The therapist is at the side at the patient's head.

The cranial hand is on the frontal bone. The middle finger is on the metopic suture, directly above the fronto-nasal suture.
The index finger and ring finger are next to the middle finger.
The thumb and index finger of the caudal hand are on both sides on the nasal bones.
-One gives a cranial traction at the frontal bone or follows the frontal bone into flexion and external rotation during the inspiration phase.
-This promotes the natural disengagement of the internasal suture.

4 lacrimal bone

Biomechanical and biodynamic palpation and mobility tests

During the inspiration phase the lacrimal bone goes into external rotation. It should rotate externally slightly in relation to the nasal process of the Maxilla. The tear duct becomes wider.

The lacrimal bone is influenced by the maxilla, the frontal bone, the ethmoid bone and indirectly by the sphenoid bone.

4.1 Palpation

The therapist is at the side, at the head of the patient; at the side to be tested.
-The cranial hand is sideways on the frontal bone near the fronto-lacrimal suture.
-The index finger of the caudal hand is on the lacrimal bone.

4.2 Global Technique

This technique can also be done at the nasal bone.
The hand hold is the same as the one just described.

-The cranial hand registers and follows the movement at the frontal bone.
-At the same time the external rotation at the lacrimal bone is promoted during the inspiration phase and the internal rotation in the expiration phase.

Alternative procedure

-During the inspiration phase one goes into flexion and external rotation with the frontal bone and then holds it there, while giving impulses at the lacrimal bone into external rotation and internal rotation, synchronous to the primary respiration.

4.3 Fronto-lacrimal suture, see frontal bone

5 Facial skull

Biomechanical and biodynamic palpation and mobility tests

5.1 ----------

5.2 General harmonizing of the face

-The thenars of the thumbs are both lying on the frontal bone.
- The thumbs are on both sides on the frontal bone, near the metopic suture and also on the nasal bones.
-the index fingers are on the frontal process of the maxilla, the middle fingers are on the maxillary bodies, the ring fingers are on the zygomatic bones and the rami of the mandible.
-The little fingers are on the TMJs
- In each inspiration- and/or expiration phase the rhythmic tension adaptation of the facial skull bones is gently promoted, synchronous with the primary respiration.

5.3 Harmonizing of the upper third of the face

This is indicated for example after a fall or a blow onto the frontal bone, as well as for sinusitis, orbita dysfunctions, behavioural disturbances and emotional disturbances in relation to the pre-frontal cortex.
The therapist is at the head of the patient.

-The ring fingers are on the outside at the zygomatic process of the frontal bone.
-The little fingers are next to the ring fingers.

-the middle fingers and index fingers are lying next to the midline of the frontal bone.
-One thumb is over the hand, one thumb is under the hand.
In each inspiration- and/or expiration phase the rhythmic tension adaptation of the frontal bone is gently promoted, synchronous with the primary respiration.

5.4 Harmonizing of the middle third of the face
-The thenars of the thumbs are on the frontal bone.
-The thumbs are next to the midline of the frontal bone.
-Index fingers, middle fingers and ring fingers are on the alveolar arches of the maxillae.
-The little fingers are on the zygomatic bones.

-In each inspiration- and/or expiration phase the rhythmic tension adaptation of the maxillae and the zygomatic bones is gently promoted, synchronous with the primary respiration.

5.5 Harmonizing of the lower third of the face
The balls of the hands are lying on both sides on the temporal bones, the fingers on the mandible.
In each inspiration- and/or expiration phase the rhythmic tension adaptation of the mandible is gently promoted, synchronous with the primary respiration.

5.6 Harmonizing of the lower third of the face, alternative

Alternatively, the thumbs can take a hold of the mandible from above the chin and the other fingers from underneath the chin.

5.7 Harmonizing of the frontal bone, the maxilla and the zygomatic bone

The therapist is at the side at the patient's head, contra-lateral to the side of the dysfunction.

-the cranial hand takes a hold of the frontal bone.
-The index finger of the caudal hand is on the frontal process of the maxilla. The middle finger is on the zygomatic bone and the ring finger on the alveolar arch of the maxilla.

-Alternatively, it is also possible to place the middle finger and ring finger on the zygomatic bones and the little finger intra-oral on the alveolar arches of the maxillae.
In each inspiration- and/or expiration phase the rhythmic tension adaptation of the frontal bone, the maxilla and the zygomatic bone is gently promoted, synchronous with the primary respiration.
After that, the other side is treated.

5.8 Harmonizing of the frontal bone, the sphenoid and the zygomatic bone

The therapist is at the side at the head of the patient, contra-lateral to the side which is to be treated.

-The cranial hand takes a hold of the greater wings with the middle finger and thumb. The index finger and the knuckle joint of the index finger are on the frontal bone.
20 The thumb and index finger of the caudal hand take a hold of the zygomatic bone, the thumb being intra-oral on this bone.
21 In each inspiration- and/or expiration phase the rhythmic tension adaptation of the frontal bone, the sphenoid bone and the zygomatic bone is gently promoted, synchronous with the primary respiration. After that, the other side is treated.

5.9 Harmonizing of the zygomatic bone, the temporal bone, the sphenoid bone, the frontal bone and the maxilla

The zygomatic bone is an integration place for influences from the occipital bone (via the temporal bone), the sphenoid bone and the facial skull.
The therapist is at the side, at the head of the patient, conta-lateral to the dysfunctional side.

Cranial hand:
The thumb and index finger of the cranial hand take a hold of the zygomatic bone. The middle finger is in the external ear canal.
The ring finger is on the mastoid process, the little finger is on the mastoid portion.

-The index finger of the caudal hand is on the frontal bone, the middle finger on the sphenoid bone, the ring

finger on the zygomatic process and the little finger on the maxilla.
In each inspiration- and/or expiration phase the rhythmic tension adaptation of the named bones is gently promoted, synchronous with the primary respiration.
After that, the other side is treated.

5.10 harmonizing of the facial skull and the Neurocranium, indirect technique

The therapist is at the side, at the head of the patient. The thumb on one side and the index-/middle finger on the other side take a hold of the zygomatic process of the frontal bone and the greater wings of the sphenoid bone.
The thumb and index finger of the caudal hand are intra-oral on each alveolar arch at the level of the premolars and molars.

-the caudal hand follows the rhythmic tension adadpations of the maxillary bones and the other facial bones, while the cranial hand gently holds the frontal bone and the sphenoid bone.
-Afterwards the cranial hand follows the tensions/movements of the frontal bone and the sphenoid bone, while the caudal hand gently holds the maxillary bones and the other facial skull bones.
-A point of balance is established between the facial cranium and neuro-cranium.

12.1 Treatment of the pterygo-palatine ganglion,

In general, one should decompress the upper jaw complex at the pterygo-palatine suture. This technique has been previously described with the maxilla techniques. One should also examine the sphenoid bone, the maxilla, the palate bone, the ethmoid bone, the temporal bone, the TMJ and the upper cervical spine. It is assumed, that this technique has a stimulating effect on the pterygo-palatine ganglion.

The therapist is standing at the side at the patient's head, contra-lateral to the side that is to be treated.

-the cranial hand is lying at the side on the calvaria and is only there to perceive.
-the index finger or the little finger of the caudal hand is intra-oral.
It is placed along the outer edge of the maxilla's alveolar process toward the ear hole. The palmar side of the finger is facing medial.
-It might be necessary, that the patient moves his lower jaw to the side slightly, so that the therapist can move his finger in between the upper jaw and the ramus of the lower jaw.
-The finger is brought to the most posterior end of the external side of the upper jaw and is placed on the connective tissue in the pterygo-maxillary fissure. This is located between the maxillary tuberosity and the pterygoid process.

-The finger tip of the index finger gives a gentle medial and slightly cranial pressure towards the pterygo-

palatine ganglion. The finger follows the movement of the tissue as it is doing this.
-The pressure should be held until one feels a relaxation of the tissue tone in the fissure.
The patient should be informed, that this technique could be painful and that it could cause tears to flow.
-Additionally, the cranial hand at the calvaria can give a fluid impulse towards the ganglion.

Midline according to Jealous, modified (lines in picture)

The orientation of the cranio-caudal and lateral development of the embryo occurs along an electrical tension (or voltage) gradient.
Within this median electrical voltage gradient the fluid membrane matrix of the embryo is supposed to be oriented. For osteopaths there is a Potency in this matrix, which functions as a sort of fulcrum, not only for the embryonic development, but also for the entire life.

Midline from Vertex to tip of the Coccyx

4 Handposition: Index and middle finger of the caudal hand take a hold of the coccyx
5 At first, one perceives the midline, the space around this “midline” and the “potency” in this “midline” (picture)
6 After that, one perceives the connection between the vertex and the tip of the coccyx.
7 A point of balance is established between the two.

8 If there is a lack of Potency in the Midline, the therapist focuses his attention on the tip of the coccyx. (picture)

9 Ascending from the coccyx, one promotes the flowing of the potency and the inherent movements of the tissue that accompany the potency.

10 The freer movement parameters are increased (indirect technique).

11 (picture) The attention is focused on the ascending of the potency from the tip of the coccyx to the "midline around the region of the former chorda dorsalis (=notochord) up to the third ventricle in the CNS. At the end one can perceive how this potency spreads through the entire body. (energy man)

12 A new orientation of the vertex and the coccyx to the primary midline is established.

Sacro-coccygeal-lumbo-sacral or thoraco-lumbar "midline"

The therapist is sitting next to the patient at the level of the pelvis.

Index finger and middle finger take a hold of the coccyx.

The other hand is on (or takes a hold of) the spinous processes at the level of the lumbo-sacral or thoraco-lumbal junction.

6 At first, one perceives the midline, the space around this "midline" and the "potency" in this "midline"

7 The relation of the participating structures to the primary midline is perceived.

8 After that, one perceives the relation of the sacro-coccygeal and lumbo-sacral or thoraco-lumbar structures to each other. The awareness is focused on the expression of the primary respiration of the membranous fluid aspects of the participating structures. One assesses the synchronous expression of the primary respiration at these structures.

9 While the osteopath continues to focus his attention on the primary respiration, he also starts to follow the tissue tensions and increases the freer movement parameters.

10 A dynamic point of balance is established

11 A fulcrum is established between the participating structures in order to bring both structures into balance.

12 The resonance of the forces within the fulcrum can release the fixed potency, making it accessible again.

13 Potency flows into the affected structures.

14 One perceives an increase of synchronicity.

Sacro-coccygeal-sternal midline

The cranial hand is on the sternum.
The caudal hand takes a hold of the coccyx from both sides.
The procedure is the same as in the last description.

Inion-SBS-midline

The therapist is at the head of the patient.

The thumbs are placed on the greater wings. The finger tips of the middle finger and ring finger are on inion. The further procedure corresponds to the described principles.

Nasion-Inion

The finger tips of the index finger and middle finger of one hand are placed on nasion.
The finger tips of the middle and index finger of the other hand are on inion

Bregma

The thumbs are on bregma. The other finger tips are lying on the squamous margo of the parietal bone.

Bregma-Inion

The finger tips of the middle- and ring finger of one hand are on bregma. The finger tips of the other hand are on inion.

Atlanto-occipital midline

Both hands take a hold of the occipital bone. The middle fingers, ring fingers and little fingers are touching at the median line of the occipital squama, inferior to inion.
The index fingers are touching at the posterior tubercle of C1.

Midline from vertex to C1

The cranial hand is on vertex

The fingers of the caudal hand are touching the posterior tubercle of C1.
The further procedure is the same as before.

Occipito-cervical midline

The fingers of the cranial hand are in the midline of the occiput. The fingers of the caudal hand are touching the spinous processes of the cervical spine.
-We follow the same principle as before.

Atlanto-occipital-thoraco-lumbar midline

The fingers of one hand contact the median line of the occipital bone. The fingers of the other hand are in the midline at a region of increased tissue tension.
-We follow the same principle as before.

Occipito-sternalal midline

The cranial hand is on the occipital bone. Index finger, middle finger, ring finger and thumb are … [?????]
The caudal hand is on the sternum.

Navel-Occipital (Vertex) midline

This technique is important for birth trauma and emotional trauma.
One hand is on the navel.
The other hand is resting on the back of the head or on the vertex.

4 At first, one palpates the tension at the level of the navel and creates a resonance.
5 After that, one perceives the midline and the space around this midline.

6 And then the navel and midline are connected with each other.
7 A point of balance is established between the midline and the navel.

Chorda dorsalis technique according to Jealous

Indication: For example a vertebral dysfunction
The therapist is at the side of the patient at the level of the affected vertebra.
One takes a hold of both of the participating vertebra.
The cranial hand is at the upper vertebra.
The caudal hand is at the vertebra underneath.
-According to the embryonic development of the vertebra, the lower half of the upper vertebra is gently compressed with the upper half of the lower vertebra.
-After that one establishes a point of balance between the two vertebras.

Axes of the orbit and the petrous portion according to Fryman

Geometric patterns in the body are supposed to act as leading tracts for energy, which is circulating in the organism and for nerve innervation.

The axes of the orbit go from the orbit to the contra-lateral side to the region around the occipito-mastoid suture. The axes cross each other posterior to the sella turcica.
Shifting of the orbital axis if there is a right lateral strain.

The axis of the petrous portion starts at the petrous portion, crosses the midline anterior to the crossing of the orbital axes, and runs to the orbit.
Shifting of the petrous axis if there is a right lateral strain.

Pre-, peri- and postnatal influences, as well as later trauma may disturb the normal development of the described axes, with consequences for the nerve function.

Diagnosis of the orbital axis

One finger is placed on the orbit or eyeball of one side. The other hand is on the opposite occipito-mastoid suture.
A fluid impulse is given from the orbit in a posterior, contra-lateral direction toward the occipital bone.
If the described axes are disturbed, one feels the fluid impulse external to the occipito-mastoid suture.

Diagnosis of the petrous portion axis

One finger is in the meatus auditorius externus. The other hand is on the opposite side on the orbit and the zygomatic bone.
A fluid impulse is given from the meatus auditorius externus in an anterior direction toward the opposite orbit and zygomatic bone.
If the described axes are disturbed, one feels the fluid impulse external to the orbit and the zygomatic bone.

Therapy for the geometric patterns

Part 1:
The patient is asked to imagine looking toward one side, without actually looking that way.
Afterwards the patient is asked to look in the direction he had previously visualized.
One explains to the patient, that the head will be turned in that direction and that he should remain completely passive, while that is done.
The therapist turns the head in that direction up to the physiological movement barrier.

Once the head is there, the patient is asked to relax his eyes (or his glance). Then he should imagine looking in the opposite direction, but without actually looking that way.
Afterwards the patient is asked to look in the direction he had previously visualized.
One explains to the patient, that the head will be turned in that direction and that he should remain completely passive, while that is done.
The therapist turns the head in that direction up to the physiological movement barrier.
This procedure is repeated several times, until a relaxation of the tissue is perceived and the head is brought back to the resting position.

Part 2:
The patient is now asked to imagine looking toward one side.
Afterwards the patient is asked to look in the direction he had previously visualized.

One explains to the patient, that the head will be turned in the opposite direction and that he should remain completely passive, while that is done.
The therapist turns the head in this direction up to the physiological movement barrier.

Once the head is there, the patient is asked to relax his eyes. Then he should imagine looking in the opposite direction, but without actually looking that way.
Afterwards the patient is asked to look in the direction he had previously visualized.
One explains to the patient, that the head will be turned in the opposite direction and that he should remain completely passive, while that is done.
The therapist turns the head in this direction up to the physiological movement barrier.
This procedure is repeated several times, until a relaxation of the tissue is perceived and the head is brought back to the resting position.