WHOLISTIC HEALING PUBLICATIONS

THE INTERNATIONAL JOURNAL IJHC OF HEALING AND CARING

WHOLISTIC HEALING WHP PUBLICATIONS

WHOLISTIC HEALING WHR RESEARCH

January, 2007 **Volume 7, No. 1**

GERIATRIC APPLICATIONS OF CRANIOSACRAL THERAPY: Established allied health professionals' use of a complementary modality

Edith G. Walsh, PhD, RN

Abstract

While use of complementary and alternative medicine (CAM) is well-documented in the elderly, little is known about the use of specific modalities other than chiropractic and acupuncture or of practice patterns of allied health professionals who integrate CAM into their clinical practice. Craniosacral therapy (CST), a derivative of osteopathy, was selected for study as over 50,000 health professionals have received training in this modality. On average, the registered nurses, physical, occupational and massage therapists interviewed were in clinical practice for 20 years, incorporating CST for an average of 13 years. Approximately one third of their clients are 60 years of age and older and seeking treatment for a wide range of conditions — most commonly for chronic pain. The therapists interviewed consider CST their dominant treatment approach, integrating it with standard rehabilitation and health care practices and other alternative therapies. Therapists report CST is effective for decreasing pain and associated use of narcotics, improving functional status, and to a lesser extent, decreasing symptoms associated with neurological problems such as Parkinson's and dementia. Regardless of the presenting problem, the therapists reported older adults frequently experience improved relaxation, sleep patterns and stress tolerance. These therapists are working in private practice; as staff or directors of rehabilitation therapy groups; in long-term care facilities; and in hospice. While receiving referrals from other therapists, physicians, and chiropractors, word of mouth among clients is their most common source of referrals. Except for those working in established rehabilitation therapy group practices or integrating care into their work as facility staff, few reported accepting third party payment. In summary, well-established allied health professionals are integrating CST into their care of older adults and report problem-specific and global benefits to these patients. Given the lack of clinical trials related to this modality, the results of this exploratory study suggest that controlled studies of CST as an adjunct to regular care may be worthwhile, particularly for chronic pain.

Keywords: Complementary and alternative medicine, Integrative medicine, Craniosacral therapy, Geriatric rehabilitation, Pain management

INTRODUCTION

The use of complementary and alternative medicine (CAM) by the elderly in the U.S. is widespread, with estimates ranging from 30 percent (Eisenberg et al, 1998) to 87 percent (Ness, et al., 2005). National survey data provide some information about the types of CAM services elders are using and the conditions for which they seek alternative therapies. For example, in a subsample of the 2000 Health and Retirement Study (Ness, et al., 2005), 46 percent of respondents 65 years of age and older reported use of chiropractic care, 20 percent use of acupuncture, and 24 percent massage therapy. While there is a growing literature about the use of acupuncture, chiropractic, vitamin supplements, and herbal remedies, substantially less information is available about other individual types of therapies that elders pursue. The goal of this paper is to provide a preliminary look at use of one alternative modality by the elderly, which was selected because of the fast-growing number of practitioners in the U.S. Over 50,000 health professionals have received training in this modality.

Craniosacral therapy (CST) is a light-touch, hands-on therapy derived from osteopathic techniques,. Recipients of therapy remain clothed, making it easier and more accessible for some older adults than standard massage therapy. Cranial osteopathy, taught in some osteopathic schools and through continuing educations programs sponsored by the osteopathic Cranial Academy, is restricted in the US primarily to doctors of osteopathic medicine, medical doctors, and dentists. The number of physicians practicing cranial osteopathy is small — only a few hundred osteopathic physicians are members of the osteopathic Cranial Academy. In contrast, CST has become widespread, practiced by a wide range of health professionals. In a two-state survey of 226 massage therapists, Sherman et al. (2005) found that 14 percent had training in CST, and that CST was emphasized in 15 percent of the 2000 treatment sessions researches analyzed in the study. In Canada and England CST is practiced as a specialty of its own, often in combination with osteopathic treatment by non-physician practitioners.

The Upledger Institute, the main training program in CST in the US, has trained over 52,000 individuals in the U.S., and a growing number in other countries.This estimate is conservative, based on the number of individuals who were listed on the Upledger Institute Web site in September, 2005. Others may choose not to be listed, or may have been trained prior to implementation of the web postings. Smaller programs in the U.S., Britain, and Australia provide related trainings. Because it is the dominant source of training in the US, this paper focuses on CST as taught by the Upledger Institute and practiced by therapists trained through the institute.

According to Upledger Institute materials (Web site and brochures), CST is used to detect and correct imbalances in the craniosacral system, which is defined as the membranes and fluids that surround and protect the brain and spinal cord (the dural membranes and the cerebral spinal fluid). Releasing restrictions in the connective tissue (specifically the fascia) throughout the body is another component of treatment. Fascial restrictions are thought to create or contribute to sensory, motor or neurological dysfunction by limiting movement; by interfering with the flow of lymph, blood, cerebral spinal fluid or interstitial fluid; or by creating pressure on nerves (directly or through the effects of swelling). Practitioners interpret softening of the tissue and enhanced tissue mobility as signs of tissue release.

CST is used throughout the lifespan for a range of developmental, musculoskeletal, and neurological problems, as well as anxiety, depression and post-traumatic stress disorder. The Upledger website identifies a wide range of conditions as amenable to craniosacral therapy: “headaches and migraines, chronic neck and back pain, motor coordination impairments, colic, autism, central nervous system disorders, orthopedic problems, traumatic brain and spinal cord injuries, scoliosis, infantile disorders, learning disabilities, chronic fatigue, emotional difficulties, stress and tension-related problems, fibromyalgia and other connective tissue disorders, temporal mandibular joint syndrome, neurovascular or immune disorders, post-traumatic stress disorder and post-surgical dysfunction.”
In a typical treatment, the client lies on his or her back on a massage table, although treatment can be provided in any position. Therapists use gentle touch, usually no greater than 5 grams of pressure. This induces relaxation in the tissues directly under the practitioner’s hands, and hence releases restrictions in soft tissue. Therapists also gently mobilize joints including the cranial sutures which have a small range of motion available to accommodate subtle changes in intracranial pressure.

Therapists use bioenergetic techniques to enhance the effects of their gentle touch, to treat those who find hands-on techniques too intrusive, and to identify areas of restriction. Therapists are taught to palpate a subtle cranial rhythm as an evaluative tool, feeling for symmetry, quality, amplitude and rate. This cranial rhythm, which normally expands and contracts 6-12 times a minute, is hypothesized to relate to the production and reabsorption of cerebral spinal fluid. Therapists may purposely induce "stillpoints" in the perceived cranial rhythm. These stillpoints are thought to have many beneficial effects including restoring flexibility of the autonomic nervous system (Upledger and Vredevoogd, 1983). Craniosacral therapists are taught to maintain a neutral presence and intention in order to foster self-healing. Advanced practitioners are taught dialoguing and positional techniques that may facilitate the release of emotional distress associated with tissue memory. This process is called somatoemotional release (SER), building on the principles of CST to help rid the mind and body of the residual effects of trauma. While new therapists are taught a standardized 10 step protocol, advanced practitioners treat what they find at each session, "listening to the body and following" the tissue as they blend with it and monitor the cranial rhythm.

METHODS

This paper is based on two data sources: review of publicly available information on the Upledger Institute Web site and in-depth telephone interviews with 20 advanced CST practitioners. The Web site was used to gather background information about CST and trained therapists. Using a simple protocol (essentially the list provided in the next paragraph, in question format) approved by the Research Triangle Institute International Institutional Review Board, I interviewed 20 advanced practitioners of CST by telephone, using a snowball approach to sampling. I chose to interview individuals in community practice as this is the dominant mode of practice, not those working at the Upledger Institute clinic. However, some of the respondents are or were instructors for the institute. Starting with several personal contacts (course instructors or teaching assistants), I asked respondents to recommend other experienced therapists for interviews. Efforts to recruit respondents without a personal contact or referral from another respondent, were minimally successful.

Selection criteria included regularly seeing older adults in their practice, advanced level CST coursework and either seven years or more of CST practice or several years' practice focusing on older adults. The number of respondents interviewed was determined by availability during a 4-week interview period spanning August and September of 2005 (17), and later supplemented with three additional nurse therapist interviews to round out the sample. I piloted a draft of the instrument with two volunteers. The results of the pilot interviews are not included as the respondents had substantially less practice experience than the target sample. The interview covered demographics, practice setting, referral sources, reasons why older adults (60 years of age and older) seek treatment, use of other modalities with CST, outcomes of treatment, and reimbursement. I circulated materials derived from the interviews to the respondents for comments and to ensure accuracy of the case examples and of quotations.

RESULTS

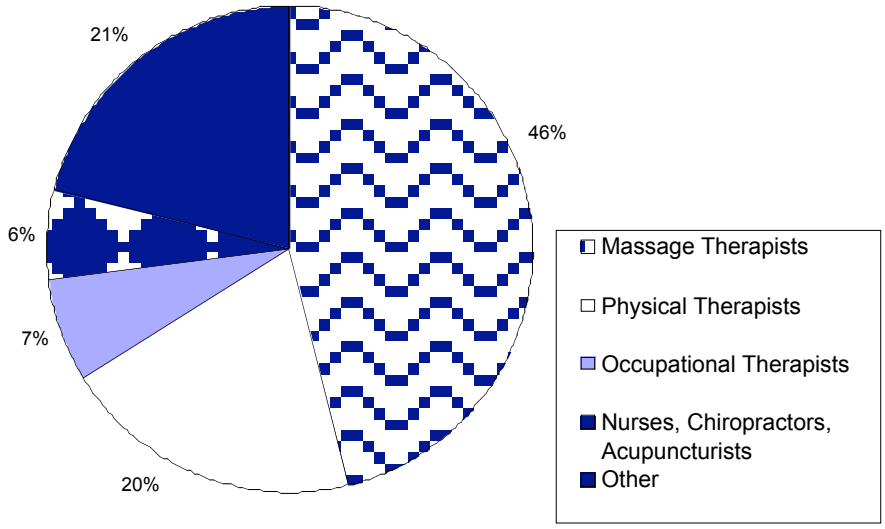
Who practices CST in the US?

The 52,000+ individuals listed on the Upledger Institute Web site (www.upledger.com) have a wide range of prior professional training, including various allied health professions (e.g., massage therapists, physical therapists, occupational therapists, nurses), acupuncturists and chiropractors, physicians (both MDs and DOs), dentists, and those who list themselves as certified in other techniques such as Feldenkrais, the Alexander Technique and hypnotherapy. At this time, CST is not licensed or certified by individual states. Individuals apply these techniques within the context of their prior training and the professional licensure regulations in their states.

Experienced therapists are able to apply for Techniques Certification, or to be further recognized as Diplomates, based on passing written and oral examinations and hands-on demonstrations. This certification process is relatively new, and as of September of 2005, only 324 individuals were listed as Techniques Certified, and of these, only 60 are Diplomates of the Upledger Institute. Information is available on the Web site about each listed practitioner's training, but it is not possible to search that Web site by profession.

For a glimpse of the distribution across professional affiliations of CST practitioners I tallied those of the 324 individuals certified at the Techniques and Diplomate levels. As seen in **Figure 1**, the most common professions represented are massage therapy (46%), physical therapy (20 percent) and occupational therapy (7 percent). Chiropractors, acupuncturists and registered nurses each represent only 2–3 percent. Various other health professionals together represent 11 percent. This last group is diverse, ranging from medical doctors, osteopaths, licensed psychologists, and speech pathologists, to certified physical and occupational therapy assistants. Eight percent did not list any specific health licensure or certification along with their contact information and CST course experience, although some listed graduate degrees. Many listed more than one professional training, most often combining massage therapy with another licensure, such as a master's in social work. I classified these individuals by the licensure that encompasses hands-on care (e.g., massage therapy rather than social work), or in the case of two clinical certificates or licenses, by the licensure typically requiring a longer training period (e.g., registered nurse rather than massage therapist).

Figure 1: Professional background of Techniques Certified Therapists (n=324)



Characteristics of the survey sample

Table 1 shows the professional training, practice settings, demographic information, and any formal affiliation with the Upledger Institute of the survey respondents. The 20 respondents reside in 14 states and included those practicing in urban, suburban and rural areas. The practice settings reported in Table 1 are not mutually exclusive. For example, one therapist who is a member of a group rehabilitation practices primarily sees clients in a long-term care facility.

Table 1: Sample characteristics and practice settings

Professional training		
Physical therapists		7
Occupational therapists		3
Massage therapists		6
Nurses		4
	Total	20
Demographics		
Mean age (range: 36–67)		51
Men		2
Practice experience and settings		
Mean years in clinical practice		21
Mean years practicing CST		13
Advanced certification (Techniques or Diplomate level)		7
Upledger Institute instructors		7
Solo practitioners		16
Group rehabilitation practices		4
Long-term care facilities and hospice		2
Inpatient rehabilitation		1

As seen in Table 1, the respondents were experienced allied health professionals in clinical practice as physical therapists, occupational therapists, massage therapists or registered nurses for an average of 21 years. They had been incorporating CST techniques into their practices for an average of 13 years. Respondents included a former director of physical therapy at a university, a professor emeritus in Health and Sports Science who has accompanied athletes as a massage therapist to four Olympic competitions, and a physical therapist who had previously run an inpatient rehabilitation department. Six of the respondents teach for the Upledger Institute on a part-time basis and another previously taught an advanced level course for several years. All but two were women. Their mean age was 51, ranging from 36–67.

Practice settings and patterns

Most have solo practices; however, four are either the directors or staff of group rehabilitation practices that specialize in combining CST with physical, occupational, and massage therapies, located in Michigan, New Hampshire and New York. One of these individuals primarily treats residents of a veteran's home, evaluating all new admissions for rehabilitation needs and responding to referrals from the nursing staff. One of the registered nurses in the sample had previously worked in private practice but was employed in a long-term care facility at the time of the survey. There she provides brief treatments in the course of her day to both residents and staff. This nurse had also used CST techniques in caring for a hospice caseload, and others reported receiving referrals to treat individual clients in hospice care. One of the physical therapists reported applying CST techniques previously in an inpatient rehabilitation setting in conjunction with standard physical therapy techniques.

CST is applicable throughout the lifespan, and most of the interviewees see clients in various age groups. On average, about a third of their clients were sixty or over, ranging from 5 to 99 percent for those working in long-term care settings, with clients as old as 96. The practitioners unanimously reported that most of their older clients were far along in their disease process or had long standing problems with pain that had not been adequately addressed by conventional approaches. As one practitioner put it, "I'm last on the medical food chain." However, therapists also see older clients who seek this treatment to maintain a sense of well-being or for recent injuries. For some of the massage therapists and nurses this type of client is a substantial part of their practice.

Word of mouth from previous clients (including the adult children of the older adults) was the most common referral source, but the practitioners also reported receiving referrals from other rehabilitation therapists, chiropractors and to a lesser extent, physicians. Many reported physician referrals often start with self-referrals, i.e., patients requesting their physicians to order physical therapy from a pre-identified CST-trained provider the patient learned about through friends or relatives. Over time, the positive results observed by these referring physicians led to further referrals. For example, all of the OT referrals for residents of a veteran's home came from the facility's medical director, based on his observing positive outcomes for previous patients. Several had ongoing professional relationships with orthopedic surgeons who send them patients who are healing slowly. One massage therapist receives referrals (and grants to cover treatment for those unable to pay themselves) from the speech pathology department of a local hospital for patients with dysphagia (difficulty swallowing).

Practice approaches

CST, like massage therapy, requires one-on-one, hands on treatment for each treatment session, in contrast to standard physical therapy and occupational therapy approaches which often involve setting patients up with exercises and enabling practitioners to manage treatments of multiple clients simultaneously. Most of the sample members reported providing 45 minute to 1-hour treatment sessions. Among these practitioners, there appear to be four basic patterns of frequency and duration: three to six sessions provided at weekly intervals until a problem had resolved or substantially improved; two to three visits per week for several weeks or months, followed by decreasingly frequent visits until rehabilitation goals are met; previously treated clients returning periodically for "tune-ups" or as chronic problems flared; and ongoing routine care, much as massage therapy is used, on a weekly, biweekly or monthly basis for general wellness. In contrast, the nurse working in long-term care usually applied CST techniques for only a few minutes at a time to calm agitated residents or address minor aches and pains. Although most of the sample members consider CST their major modality, all of them combine CST with their standard clinical practice, with other complementary modalities they have studied, and frequently share cases with other CAM providers such as acupuncturists or chiropractors. Several reported routinely sharing cases with chiropractors, "softening the tissues" so the chiropractors' adjustments would be more effective and hold longer.

What conditions are craniosacral therapists treating?

Pain was by far the most common reason given for older adults seeking out CST. The locations of the pain varied, including degenerative disk problems and other sources of back, neck and should pain, joint pain (hips and knees most frequently), and chronic headaches. The causes of pain included arthritis, osteoporosis, trauma (including falls), oncologic (cancer) pain, and pain associated with the hypertonicity of Parkinson's disease. The therapists reported these were often long-standing pains for which their clients had not received adequate relief from conventional medicine and therapies. Many described their pain patients as having tried everything including medications, standard rehabilitation, pool exercises, and standard massage. Some of their older clients seek treatment because their physicians do not consider them appropriate candidates for surgical intervention, while others are hoping to avoid surgeries. In other cases, their clients did not like the side effects of their pain medications, or their physicians wanted to see a decrease in pain medication use.

Older adults also seek out these craniosacral therapists for neurological problems, like Parkinson's, vertigo or vestibular problems, and functional deficits resulting from stroke. Therapists reported treating a wide range of other conditions including plantar fasciitis (a painful heel condition caused by inflammation of the tough connective tissue on the bottom of the foot) symptoms of hiatal hernia and gastric reflux, difficulty swallowing post-stroke or post-radiation therapy treated by decreasing swelling and tension in the surrounding tissue and restoring normal swallowing , and agitation (in dementia). They also seek treatment prior to surgery to reduce physical tension and anxiety and after surgery to promote healing. Nurses and some physical therapists in the sample spoke about treating

post-operative pain. This pain sometimes relates to surgical scar tissue holding misalignments of the tissues or to pain resulting from positioning and immobility during surgery. For example, hip replacement surgery is performed with the patient side lying and bent over a frame, which can result in thoracic, lumbar, neck and shoulder pain.

Outcomes: Targeted and nonspecific

The practitioners were careful in reporting outcomes and conservative in taking credit for changes. As one physical therapist explained, “CST does not cure or heal anything. It helps the body heal itself by promoting homeostasis, increasing circulation, decreasing tone, increasing circulation of the cerebrospinal fluid, and allowing improved nutrition to the brain and nervous system. It increases efficiency of movement and function and comfort.” In addition, the therapists were able to report outcomes for only some of their clients because they did not know whether those who did not return had improved or had not benefited from their treatment. They were aware of several reasons clients did not return. Some did not perceive the difference, even if it was visible to others (e.g., being able to bend more easily, decreased need for cane/walker). Others were deterred by the cost or because they needed someone to bring them. Some older clients came with unrealistic expectations, such as being cured of Parkinson’s disease. Others were satisfied with the symptom relief they were getting from medications and chose not to pursue additional treatment.

For those who returned for several visits, called back later to report how they were doing, or came back weeks or months later for a new problem, the practitioners reported a range of positive outcomes.

Pain reduction and improved function

The practitioners reported their clients frequently experience substantial pain reduction. Their clients were able to discontinue or substantially reduce their reliance on pain medications, including narcotics. The occupational therapist working in a veteran’s home reported her clients usually have some pain relief, varying from decreasing two to three points on a 10-point pain scale or going to zero by the end of the session. Lasting pain relief occurs in some cases, and her clients’ use of narcotics often decreases substantially, for example from several doses each day to two to three doses a week. A physical therapist reported his older clients typically achieve a 50 percent reduction in pain. Several respondents spoke about a shift in focus common in their older clients that accompanied pain reduction, away from total absorption with their pain and physical problems, even when pain is not completely eliminated. This change in focus improves their quality of life, providing them the energy to engage with their families and activities more fully. The therapists attribute this both to the actual pain reduction, but also to the hope clients feel after getting relief from a chronic problem they previously thought was inescapable. One therapist provided a poetic description of this process: “Like an older tree given fertilizer — some new leaves start to come out. Life continues instead of some part being dead.”

Physical and occupational therapists reported the diminished pain allowed their clients to more fully and willingly participate in the strengthening exercises necessary to achieving their rehabilitation goals. They reported functional improvements, varying in level and degree in part by how severely impaired the clients were at the outset of treatment. Their clients were able to return to their usual activities, ranging from golfing and tennis, to shopping or just being able tolerate sitting again. They report assisting clients to increase their levels of independence in activities of daily living such as transfers, bed mobility and ambulation, or to improve their range of motion. One physical therapist described common outcomes for his older clients as a 40 to 70 percent increase in range of motion of major joints. In some cases, while no increase in function could be measured, the clients experienced improved ease of motion, within their current level of function, leading to enhanced quality of life. Those in long-term care settings reported CST results in decreased agitation and increased

responsiveness in their patients with dementia. The therapists reported less consistent success with other symptoms, for example only achieving positive outcomes with dizziness about 50 to 60 percent of the time.

Here, and following other sections of this discussion, I share observations from therapists who were interviewed:

> *" I can accomplish much more incorporating CST than I could using standard Occupational Therapy (OT) techniques alone. When I was a traditional OT, I was always looking for ways to reduce pain. OT training focuses a lot on motivation and on splinting to address pain. My assumption was that if I could allay the pain, people would increase their function and participate in exercise. [This is part of what CST addresses.] Combining CST and standard OT with older clients requires longer sessions and sustained change takes a longer period of time[compared to younger clients] — because they have more history and more damage — but it results in increased function, decreased pain and decreased use of pain medication."*

Parkinson's disease

Most of the respondents treat clients with Parkinson's disease, reporting several benefits. They found that it decreased pain and increased relaxation, allowing patients to be more comfortable, though none reported that treatment could permanently change high tone or rigidity. Others reported that treatment resulted in improved balance and mobility, and increased ability to express themselves. In general, the practitioners believe CST magnifies improvements that can be achieved with standard rehabilitation therapies. Their clients report improved function and an improved sense of well-being. Caregivers reported positive impacts on cognition and lucidity and a perception that CST treatment slowed decline, contributing to longer stays in the community. For those more severely impaired, therapists reported treatment decreases rigidity sufficiently to allow passive range of motion, slowing the progression of contractures.

Post-stroke and transient ischemic attacks (TIAs)

Therapists spoke about treating clients who have completed their standard rehabilitation post-stroke, and others who have experienced TIAs. The outcomes they reported included improved communication, including articulation, as well as improvements in movement, balance and stability standing, expression, sleep patterns, and elimination. Sometimes the results were striking; one therapist described a client who took 15 minutes to walk 20 feet to the treatment room making the return trip after treatment quickly.

Gastrointestinal problems and dysphagia

Several therapists also mentioned that many of their clients present with gastrointestinal problems, although these are rarely the reason they seek treatment. They reported resolution or decreased symptoms with hiatal hernias and gastric reflux, irritable bowel syndrome, and Crohn's disease. One massage therapist reported frequently treating people with dysphagia, in some cases resulting in the removal of feeding tubes.

Nonspecific outcomes

Regardless of the presenting problem, the practitioners reported their clients experienced a fairly consistent set of additional benefits of treatment: improved sleep patterns, relaxation, stress tolerance, general well-being, focus, energy levels, and appetite. They observed their clients being able to take

deeper, longer, more relaxed breaths. Their clients often reported their doctors have reduced or eliminated their antihypertensive medications. Clients also reported improvements in secondary problems, including depression and anxiety, as well as physical and functional problems.

> *"The one on one attention, and opportunity to relax in a safe, quiet place, in a comfortable place and a comfortable position where they can concentrate on their bodies in itself is beneficial. It allows the person a chance to feel their body and think about how their body feels, and an opportunity to come to the awareness that they way they think has a tremendous effect on the tone of their bodies. So, sometimes in one session a person can come to understand the way they think and change it, with direct beneficial physical effects."*

Case examples

The following two entries were contributed to describe the personal experience of craniosacral therapy. These were selected from several solicited by two of the therapists interviewed for this study. Many thanks to each of the individuals who took the time to write down their experiences and to the therapists who requested and forwarded them to IJHC.

Louise

> I am 70 years old and still working. I do an hour swim therapy program five days a week. I sought craniosacral treatment first for spondylosis, which caused me intense neck and head pain which radiated down my right arm. [Spondylosis is a deformity of the joint of two vertebrae, particularly of the neck, where as the space between the two adjacent vertebrae narrows; this results in pressing upon the nerves emerging from the spinal cord and results in severe pain in the neck, shoulder and upper limbs etc., (Wikipedia entry 10/25/06)] My arm and hand had become so weak that I could not push a light plug into a socket without using both hands. The effort to avoid pain meant I tended to hold myself unnaturally. I'd lost touch with how it felt to move in a relaxed way. The doctor said my only recourse was surgical removal of two vertebrae. I tried acupuncture, which I'd used for years for other conditions but probably the prescribed pain medication interfered with any benefit. I stopped the medication and went for a craniosacral treatment. I returned from the first treatment in great pain, from the effort of the 45 minute drive home combined with a sensation that my body had worked very hard, which was unexpected since the treatment had been so gentle and non-intrusive. Once home, I lay down to rest before going to work, and found one hour later that I had slept deeply and woke more relaxed than I had been in six months. I recalled that acupuncture treatments often cause a temporary increase of discomfort as toxins are released. Anyway, this gave me hope. For the following two years I have had regular craniosacral treatments, at first every week then twice monthly or even once a month. I can now lift a snow tire with my right arm. I no longer experience discomfort after treatments, only a sense of total well being followed by a splendidly deep sleep that night. After 5 weeks without treatment my neck becomes stiff again. I use the still point inducer perhaps every other night for about 20 minutes. (*note*: Still point inducers are used to temporarily stop the craniosacral rhythm mechanically and thought to improve homeostasis and sympathetic nervous sytem tone. Several styles are available commercially, one can also be made at home by tying two tennis balls into a sock. Proper placement should be taught by an experienced therapist.) I was born premature which may account for my weak lungs and COPD condition. Craniosacral treatments have allowed me to half my daily asthma medication (Advair). I used to also need an inhaler (Atrovent) at least once a month, usually more often, but now I use it at the most once every 5 months.
>
> A displaced patella and arthritis in my left knee also prompted my doctor to recommend surgery, which may eventually be necessary, but meanwhile for the last 2 years my healer has been able to improve how I walk and remove pain by working on my pelvis. This treatment, combined with

swim therapy to strengthen muscles means I can be pain free in my leg for about a month. I am deeply grateful for having found craniosacral therapy.

Bonnie (edited to take out the name of the therapist)

My first appointment for craniosacral therapy was in May 2006 as a result of a friend's referral. I had experienced acute and chronic back pain since the Fall of 2003 and was made very at ease during my first visit. I had fallen and it was difficult for me to sit, lie, stand or walk when I came that day. I felt a great sense of relief from the very first time the therapist used craniosacral therapy to assist in decreasing the intense level of pain. Although I previously experienced some decrease in pain from the massage therapy that I received earlier, it was the craniosacral therapy that provided me with the most relief. I began to experience less and less pain as a result of each session. The therapist placed his hands under my head and my vision opened up. I had not seen a beautiful plant that was in the therapist's office and one day after a CST treatment I experienced an overall view of his entire office for the very first time. He will never know the gift he has given me by treating me with CST. My world has become broader and my vision has become much clearer. With each session, my back progressively improved.

There was a period of two-and-a-half years when I had a very difficult time sleeping due to such intense back pain. I would wake up at night having to turn on my side, using every bit of effort to change position. Today I am not aroused by pain, and when I awaken I can easily turn over. I previously had a very difficult time when needing to get a drink of water, use the bathroom and then return to bed. My back would begin to burn and my legs would proceed to ache. It was impossible to remain in the lying position, forcing me to get up although it was merely 4 or 5 am. Today when I wake up at 4,5, or 6 am, I can go back to bed with very little pain and I am able to fall back to sleep with ease. Without the craniosacral therapy, I would not be feeling as well as I do today and would surely be unable to participate in many everyday activities. I have sought help from many other therapeutic treatments over the past three years, however, it was CST that helped heal my back.

Furthermore, CST is responsible for opening up the additional areas within my body that stored a large extent of the trauma that I had experienced during childhood years. I will be forever grateful to the therapist and the therapeutic technique of CST. I have not only been given the ability to lie, sit and stand for longer periods that I have in the past three years, but CST has been instrumental in healing my body, soul and mind as well.

Table 2 provides several further case examples showing a range of presenting problems and effects of CST. Some of these are also examples of the types of long-standing or severe problems older adults encounter without successful treatment by conventional methods. The therapists sometimes referred to being “last on the medical food chain” or their clients’ situations being “the worst of the worst” as people sought out unconventional treatments as a last resort.

Table 2: Case examples of CST results

Stroke patient with long-standing bursitis in the unaffected shoulder — the combination resulted in functional limitations. Ultrasound treatments gave temporary pain relief for the bursitis. CST achieved similar levels of pain relief, but also improved shoulder mobility leading to increased function.
80-year-old WWII vet with severe bilateral foot pain secondary to multiple fractures and persistent back and neck pain years after being thrown from a jeep in an explosion during the war. Able to walk further and experienced substantial pain reduction after six weekly visits. Continues to come monthly.

Table 2 (Continued)

72-year-old hospice patient with metastatic lung cancer, experiencing extreme anxiety and inadequate pain control. Client fell asleep after 15 minutes of treatment and slept for several hours.
74-year-old woman with back pain who had extensive back surgery during which she experienced cardiac arrest, five years prior to coming for CST. Since that surgery she had problems with mental clarity, as well as continued pain and reliance on a cane. Her pain has decreased, but is not eliminated. Her daughter reports, “She finishes a sentence now, stays on topic, and remembers what she wanted to say.”

CST as prevention

One of the interviewees, the director of a group rehabilitation practice integrating CST with physical therapy and other modalities, hypothesized that his work with older adults serves as a sort of secondary prevention related to an “accumulation of hypomobilities” that he sees as the core issue for older adults. In older men, he reported advanced fascial restrictions in the pelvic area set the stage for prostate problems. In older women, the increased risk of hip fracture may be secondary to pelvic restrictions coupled with postmenopausal demineralization of the bone. Hence, by releasing fascial restrictions in the pelvic area, he suggested that CST could prevent future problems.

Sources of payment and affordability

Private pay is the predominant source of payment in this sample, either paid by the clients themselves or their adult children. For some, this was a personal preference, as in “I gave back my Medicare provider number.” Treatment by massage therapists and nurses is generally not eligible for reimbursement. Some of the physical and occupational therapists — primarily those in group practices — accept third party reimbursement, including Medicare. Few accept Medicaid. The therapists commonly provide receipts for clients to submit for insurance reimbursement (e.g., as an out of network rehabilitation therapy provider for HMO members, or for use with retiree health benefits) or for use with flexible spending accounts.

These practitioners were concerned about affordability and utilized several strategies to help their older adult clients access treatment. Many provided reduced rates or sliding fees, which they saw as preferable to the administrative burden associated with third party reimbursement. Those who do not accept Medicare referred clients to other craniosacral therapists who do accept Medicare. Others shared cases with rehabilitation therapists providing conventional treatment, for example, having a client come to the craniosacral therapist for one visit out of three or four. All practitioners provide receipts that some of their clients use to access tax deductions. One massage therapist receives grant funding from a local hospital, provided on an individual case basis for elders with dysphagia who are unable to afford treatment.

DISCUSSION

Craniosacral therapists are practicing in varied settings and treating a wide spectrum of problems for older adults. Their older clients range from very active to severely impaired. The therapists interviewed report evidence of therapeutic value in the older population for a range of problems. Based on these interviews, several areas appear promising for further investigation including, pain management, facilitating rehabilitation outcomes, dysphagia, agitation, and hypertension.

The techniques applied are gentle and along with specific therapeutic benefits, CST provides an opportunity for older adults to receive bodywork as clients remain clothed, thereby avoiding the physical and social challenges associated with undressing. However, the findings indicate financial and insurance barriers to access for CST for older adults.

This exploratory study does not establish evidence of the effectiveness CST for any specific medical condition, but it does suggest that there may be substantial benefits for older adults worthy of further investigation. In addition to describing a range of possible clinical applications, the study is interesting in revealing how well-established allied health professionals are integrating a complementary modality in both private practices and facility settings.

References

Eisenberg, D. M.; Davis, R. B.; Ettner, S. L. et al. (1998). Trends in alternative medicine use in the United States, 1990–1997: Results of a follow-up national survey. *Journal of the American Medical Association, 280,* 1569–1575.
Ness, J.; Cirillo, D.J.; Weir, D.R., et al., (2005). Use of complementary medicine in older Americans: Results from the Health and Retirement Study. *The Gerontologist,* Vol. 45, No.4, 516–524.
Sherman, K.J., Cherkin, D.C., Kahn, J., et al. (2005, June 14). A survey of training and practice patterns of massage therapists in two U.S. states. *BMC Complementary and Alternative Medicine* (5):13.
Upledger Institute Web site, found at *http://www.upledger.com*
Upledger, John E. and Jon D. Vredevoogd (1983) Craniosacral Therapy, Eastland Press, Seattle Washington.

The author would like to thank the therapists who generously gave their time for these interviews and Dan Benor and an anonymous reviewer for their comments on the initial draft. This research was supported by RTI International and the protocol was reviewed and approved by the RTI International Institutional Review Board.

Edie Walsh is a senior researcher at RTI International with a focus on aging, disability and long-term care. She has also studied CST through the Upledger Institute and served as a teaching assistant to introductory level classes.

Edith G. Walsh, PhD, RN
RTI International
1440 Mail Street, Suite 310
Waltham, MA 02451-1623
(781) 434-1754
ewalsh@rti.org