Sensory Integration for CranioSacral Therapists

Study Guide

800.233.5880
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Special consideration may occasionally be given to laypersons who wish to attend our workshops. In these cases, The Upledger Institute carefully evaluates personal and/or professional circumstances. If granted a waiver of our licensure/certification requirement, the layperson must sign a consent form stating that completion of an Upledger workshop will not, by any means, provide licensure or certification for hands-on bodywork.

The modalities taught in these workshops demand a solid anatomical and physiological working knowledge. Therefore, all participants must assume responsibility for advance preparation.
Policies, Procedures and Code of Ethics Relating to the CranioSacral Therapy Curriculum

We are pleased to provide you with this training opportunity. We hope that you benefit greatly from this experience and that you apply the concepts and techniques with success in the future.

It is essential that the purity of this work and the high-quality teaching standards that have been established for this curriculum are maintained. As such, if you wish to present or teach any portion of the copyrighted material from this workshop, you must first undergo the required training and/or obtain written permission from The Upledger Institute.

Upon course completion you are invited to take advantage of the Institute’s many ongoing programs and resources. Information is currently available to help you successfully:

- Submit a press release on your continuing education experience and clinical practice
- Get articles published on techniques, applications, client cases and more
- Form a study group
- Sponsor workshops in your area
- Train to become an instructor or presenter
- Network as a technique demonstrator at trade shows

Please let us know your area(s) of interest. We will gladly assist you in determining the most productive use of your assets, as well as support you in organizing presentations, etc. Working together will ensure that the information presented is current, correct and professionally supported with collateral materials.

As a practitioner using therapies taught through The Upledger Institute, Inc.*, you are expected to adhere to the highest professional standards. Among these are the commitment to provide quality therapy to all persons without discrimination, to seek educational opportunities to enhance therapeutic skills, to respect each client’s right to privacy, and to accept the responsibility to do no harm to the physical, mental and emotional well-being of self, clients and associates.

Insurance reimbursement policies vary for manual therapies. If insurance reimbursement is an integral part of your practice, we encourage you to verify insurance acceptance for your profession in your state/locale.

Finally, attendance at this training is not intended to be used as a hands-on license. You must work within your professional scope of practice and abide by the rules and/or laws that govern healthcare practices in your applicable region (i.e., city, state or province).

If you have any questions about these or other issues, please contact Educational Services at 1-800-233-5880. Ask for priority code G-SICS.
A Note From the Editor

Welcome! Thank you for choosing this seminar. You’ll enjoy many learning opportunities in this CranioSacral Therapy course:

- Explore the history, principles and neuromuscular basis of CranioSacral Therapy, and its clinical importance.

- Learn to conduct a thorough evaluation using the craniosacral rhythm as a guide.

- Formulate therapy strategies.

- Perform CranioSacral Therapy techniques to help normalize common restrictions and dysfunctions.

Thanks again for attending this seminar. We hope this will be an enlightening and productive experience for you.
ACKNOWLEDGMENTS

I would like to thank all the therapists, students and patients/clients who have contributed to our work. Their combined efforts help make the CranioSacral Therapy program a great success.

— Dr. John Upledger
Preparing to Learn

Upledger seminars offer a helpful mix of theory and practical work. This workshop will provide you with many concepts and skills that will enhance your assessment and therapeutic capabilities. Rather than subtracting from your existing knowledge or skills, it will serve to build upon it.

1. **Efficiency Factor**
   - Knowledge
   - Action
   - Wisdom

2. **Paradigm** (i.e., frame of reference)
   “Each of us tends to think we see things as they are, that we are objective. But this is not the case. We see the world, not as it is, but as we are — or as we are conditioned to see it.”
   
   *Stephen R. Covey*

3. **Belief System** (i.e., frame of reference based on a feeling of certainty)
   “Remember, as long as you believe something, your brain operates on automatic pilot, filtering out input from the environment and searching for references to validate your belief, regardless of what it is. People with beliefs have such strong levels of certainty they are often closed off to new input.”
   
   *Tony Robbins*
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COURSE OBJECTIVES

This course was designed to help you, the CranioSacral practitioner, gain greater insights into how the nervous system processes all the information which comes to it every moment of every day: the process of Sensory Integration. Through a basic understanding of this complex central nervous system (CNS) integration, we can come to realize that for all of us our ability to focus, maintain attention (sit still, listen, focus on one thing at a time) and perform any motor task (read, write, tie our shoes, follow directions) is dependent on how well this integration takes place. Furthermore, you’ll discover (uncover) that the AROUSAL STATES manifested by our sensory processing often govern our behaviors. This explains why we sometimes feel the need to “flee” certain situations, feel like “fighting” at other times, or feel deeply “frightened.”

If we can understand, and at least partially identify, the signs and symptoms of Sensory Processing Disorders (SPD) we can adapt ourselves, our environment and our CranioSacral treatment to the needs of each individual and MEET THEM IN THEIR WORLD, WHERE THEY ARE. We can learn new tools to help organize and calm the CNS and facilitate the ability of those with SPD to participate in CranioSacral Therapy. We can combine the principles of Sensory Integration with CranioSacral Therapy to help our clients function in life.
What is Sensory Integration

Sensory Integration is the child’s ability to feel, understand and organize sensory information from his body and his environment. Such information is received through the sensory systems which include vision, touch, smell, taste and hearing, as well as systems for knowing about gravity, position of body parts and movement.

For most children sensory integration develops in the course of ordinary childhood activities. Motor planning ability is a natural outcome of the process, as is the ability to adapt to incoming sensations. But, for some children, sensory integration does not develop efficiently.

What is Sensory Integrative Dysfunction

When a “glitch” occurs in the central nervous system, the brain cannot analyze, organize and connect – or integrate – sensory messages. The result is Sensory Integrative Dysfunction or “Sensory Processing Disorder” (SPD). Somewhere in the circuitry of the sensory processing machine, there is a “short.” What may occur is: 1) inefficient sensory intake, 2) neurological disorganization, and 3) inefficient motor language or emotional output. Therefore, the child will not respond in an ordinary way to ordinary sensations.
What are some signs of Sensory Processing Disorder (SPD)

- Overly sensitive to touch, movement, sights or sounds
- Inability to unwind or calm self
- Easily distracted
- Activity level that is unusually high or unusually low
- Impulsive, lacking in self-control
- Poor self concept and emotional insecurity
- Under-reactive to touch, movement, sight or sound
- Social and/or emotional problems
- Poor postural control/stability
- Physical clumsiness or apparent carelessness
- Difficulty making transitions from one situation to another
- Delays in speech, language or motor skills
- Delays in academic achievement

Typically, a child with sensory integrative disorder will show more than one of these signs with frequency, intensity and duration.
What are some signs of SPD That you may see during CST treatment

- Not on an even keel, becomes upset easily - once upset, may have difficulty recovering
- May need to feel in control of people, objects and experiences because he does not feel in control of himself
- Exhibits sometimes-on, sometimes-off processing
- Overreacts to nonverbal cues
- Distressed by changes in routine, changes in position, loud noise, crowded settings
- Misinterprets a casual touch (especially unexpected) as a life-threatening blow
- May feel he will fall off the face of the earth
- Reacts negatively and emotionally to the anticipation of being touched
- Reacts with fight-or-flight response when approached from the rear, or when touch is out of his field of vision
- Strongly dislikes being touched on the face or head
- Unable to identify which body parts have been touched without looking
- Rubs or even bites his own skin excessively
- Uses his mouth to investigate objects, even after the age of 2 years
- Prefers sitting or standing to laying down in order to ensure visual control of his surroundings
- Distracted, inattentive and fidgety when quiet concentration is expected
- Exhibits behavior that seems willful or difficult when it is actually an adverse response to sensory stimuli
- Aggressive, hostile or “pushy” verbally or physically for no apparent reason
- Has difficulty forming warm attachments
History of Sensory Integration Theory

About 37 years ago Dr. A. Jean Ayers, an occupational therapist with advanced training in neuroscience and educational psychology, developed the sensory integration theory to explain the relationship between problems in interpreting sensations from the body and the environment, and difficulties with academic or motor learning.

“Sensations flow into the brain, like streams flowing into a lake. Countless bits of sensory information enter into our brains every moment…the brain locates, sorts, and orders sensations – somewhat as a traffic policeman directs moving cars. When sensations flow in a well organized or integrated manner, the brain uses those sensations to form perceptions, behavior and learning. When the flow of sensations is disorganized, life can be like a rush hour traffic jam.”

— Dr. A. Jean Ayers, Sensory Integration and the Child

So it is that sensory integration, or “sensory processing,” theory and practice has continued to evolve just as Ayres predicted it would. “Truth, like infinity,” she said, “is to be forever approached but never reached.” Her primary objective in developing the theory was to explain the underlying cause of the problems seen in SPD so that an appropriate type of intervention could be used. I wonder if she had any idea that a treatment modality form the osteopathic profession called CranioSacral Therapy would be one such intervention?
“If the human brain were so simple that we could understand it, we would be so simple that we couldn’t.”

— Lyall Watson

• The Sensory Stimuli: odor, taste, touch, position/body in space, sound, light
• The brain’s first registration of sensory stimuli: olfaction (smell), gustation (taste registration), tactility, proprioception (heavy touching pressure), audition, vision
Integration of the Senses

“Over 80% of the nervous system is involved in processing or organizing sensory input, and thus the brain is primarily a sensory processing machine.” —Dr. A. Jean Ayres
Integration of the Senses

- Self Esteem
- Social Ease
- Concentration/Organization
- Creativity
- Abstract Thought

**VISION**
- Reading
- Math
- Visual Perceptual Constancy
- Visual/Motor Integration
- Visual/Spatial Constancy
- Binocularity

**AUDITION**
- Speaking
- Receptive Language
- Auditory/Spatial Integration
- Auditory/Linguistic Integration
- Auditory Sequencing

**PROPRIOCEPTION**
- Oral Motor
- Proprioception
- Kinesthesia

**VESTIBULAR FUNCTIONS**
- Muscle Tone
- Olfaction
- Vestibular Functions

**TACTILITY**
- Gustation

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Sensory Integration: Hearing (VIII)

- Acoustic area of temporal lobe cortex
- Medial geniculate body
- Midbrain
- Medulla oblongata (brain stem)
- Cochlear division of vestibulo cochlear nerve (VIII)
- Reticular formation
- Hair cells

Afferent Pathways (Input)
Sensory Integration: Hearing (VIII)

Efferent Pathways (Response)
The positioning and extents of the reticular formation are depicted in the illustrations. The reticular formation integrates a wide variety of neural activities both afferent and efferent. Stimulations that are going into the cerebral cortex, the hypothalamus, the limbic system, etc. are also activating the reticular system. The reticular formation appears to have strong influences upon every system in the human body from cardiovascular to endocrine gastrointestinal and including emotional systems.
TYPES OF SENSORY DYSFUNCTION

Very generally speaking, Sensory Processing Disorders (SPD) can be categorized into three (3) basic areas of dysfunction.

A. Over Sensitivity

B. Sensory Deprivation
C. Sensory-Scrambled

WHERE the “glitch” occurs:
1. Registration: problems with the sensory receptor(s)
2. Processing/Integration: problems with the connections in the CNS
3. Modulation: a “power struggle” of the senses

The Relationship of Arousal to Sensation

Inverted U-Shaped Curve: The relationship of arousal to sensation follows an inverted U-shaped curve. As the level of environmental stimulation increases, arousal increases. At a certain level of stimulation arousal begins to decrease. At very high levels of stimulation individuals begin to show signs of stress or even shut down.
Arousal, in general increases with:

- Intensity
- Complexity
- Unexpectedness
- Incongruity
- Affective meaning
- Novelty

Arousal generally decreases with:

- Constancy
- Repetition
- Familiarity
- Neutrality

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A Model for Understanding Sensory Modulation

Sensory Overload

Optimal Range of Arousal

Low Arousal

Sensory Events

J. Wilbarger, 1991

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Wilbarger, P.L. and Wilbarger, J.L.
Sensory Defensiveness In Children Aged 2-12
Recognize CNS state changes as indicators of stress:

- Change in breathing patterns (like excessive yawning in babies)
- Change in facial color
- Reddening of the ears
- Complaints of nausea, dizziness, disorientation or other body concerns
- Change in visual focus
- Change in muscle tone
- Inability to maintain organized behavior
- Reverting to more “primitive” play
IDENTIFICATION OF SENSORY PROCESSING DISORDERS (SPD)

Sensory Integration therapists (generally OTs, PTs, and STs) are trained to investigate, like detectives, the systems which are the source of problematic symptoms/behaviors their clients display. Once these initial discoveries have been made, SI therapists then cluster these systems into diagnostic categories; for example: sensory-defensiveness, gravitational insecurity, developmental dyspraxia, bilateral integration and sequencing, or modulation/registration disorders. (Classical explanations have been included for you below.)

Like SI therapists, we CST therapists explore the systems at the core of manifestations our clients present. We need not be concerned with these diagnostic labels except to communicate with other health professionals. We need only palpate the systems with our hands.
TOWARD A DEEPER UNDERSTANDING OF SPECIFIC SENSORY SYSTEMS

- Self Esteem
- Social Ease
- Concentration/Organization
- Creativity
- Abstract Thought

VISION
- Visual Perceptual Constancy
- Visual/Motor Integration
- Binocularity
- Ocular Motility
- Oral Motor

AUDITION
- Auditory/Spatial Integration
- Auditory/Linguistic Integration
- Auditory Sequencing

PROPRIOCEPTION
- Muscle Tone
- Kinesthesia

VESTIBULAR FUNCTIONS

GUSTATION

TACTILITY

OLFACTION
A. The processing of SMELL:

The sense of smell = “OLFACTION”

- Developed early in utero (in 2nd month)
- ONLY sense that connects DIRECTLY to the limbic system of the brain
- Its information is NOT processed through the Reticular Activating System (RAS)

Problems seen with poor registration and/or integration of this sense could include:

- Behavior changes related to specific odors
- Seizures triggered by specific odors
- Distraction caused by specific odors
- Strong need to leave an area due to specific odors
- Allergic reactions to specific odors (may be manifested as above)
- Increased awareness of specific odors
- Tendency to identify elements and articles in one’s world by smelling objects and individuals with which one interacts
- Overly emotional behaviors
- Rare displays of emotion, maintenance of a flat or even affect
- Sinus infections
- Upper respiratory infections
- Rhinitis (constant runny nose)
- Paranoid sense in regard to things not visible in the environment
- Sleep problems, such as sleeping many hours yet not feeling rested
- Lack of concern for personal grooming, especially body odor and halitosis

Notice that…

1. Dulled sense of smell may lead to dulled/flat emotions (lack of emotions)
2. Over sensitivity to sense of smell may lead to over-reactive emotionality
3. Child with decreased proprioceptive sense may revert to the use of smell to feel safe (smelling everything they touch)
B. The processing of TASTE:

The sense of taste = “GUSTATION”

- Together with SMELL, it warns us of noxious substances in the mouth
- Digestion begins in the mouth - taste triggers the brain to have the right gastric juices ready in the stomach

Choice of foods is seldom just about taste, consider …

- Auditory sensitivity
- Tactile sensitivity
- Muscle tone
- Gut dysbiosis
- Allergies
- Trigeminal nerve problems
- Issues with smell
- Issues with visual perception

Problems with poor registration and/or integration of this sense may include:

- Dislikes sweet, salty, sour, bitter, spicy, cold or hot
- Is a fussy eater in general
- Eats mostly refined/simple carbohydrates
- Refuses crunchy foods
- Swallows food without chewing
- Appears disinterested in food
- Will eat only soft or blended foods
- Eats huge amounts but stays thin
- Will only take liquids
- Needs each food item separated from one another
- Dislikes fresh tomatoes but likes ketchup or tomato sauce
- Must have sandwiches cut in small triangles

Notice that …

1. Chewing non-food items can be CALMING because the taste is constant.
2. Chewing and swallowing EQUALIZES the pressure in the middle ear.
C. The processing of TOUCH:

The sense of touch = “TACTILITY”

- The first sense to develop (the skin is the first organ to develop in utero)
- A basic human need
- Touch sensations are processed through the Reticular Activating System (RAS)
- Must be relearned at birth in a dry environment

Problems with poor registration and/or integration of this sense can result in:

- Extreme ticklishness
- Dislike of (or lack of notice of) being sticky, dirty, sandy …
- Aversion to being physically guided (having someone take his/her hand or give gentle guidance with a hand on his/her back)
- Tendency to touch other people or objects
- Unusual pencil grasp (e.g. with the tip of the thumb off the writing implement)
- Dislike of (or even allergic reaction to) synthetic fabrics
- Avoidance of touch (by hands or mouth) of anything “mushy” or “slimy” or having mixed textures
- Intolerance of haircuts, hair brushing, face washing, finger nail cutting
- Unusual reaction to the application of lotions
- Intolerance of socks with seams, loose threads, loose elastic
- Need to remove tags from shirts or other clothing
- Inability to sleep with a top sheet on the bed, or with a top sheet that is not tucked in military style
- Sensitivity to elastic waistbands, belts, starched or stiff clothing
- Acceptance of long sleeves and pants, and short sleeves and pants with great difficulty making a transition to the other
- Preference for only loose and soft clothing
- Insistence on wearing a jacket even inside and on warm days
- Inclination to disrobe totally, or to remove specific pieces of clothing
- Consistent use of backs of hands (or fists) to push off the floor or to catch self when falling
- Established food preferences based on the texture of the food
• Tendency to rub food and other substances or items (possibly including feces) on self and other surfaces
• Resistance to hugs, snuggling, being held
• Apparent lack of sensation of pain, or extremely high pain tolerance
• Presence of self-injurious behavior such as picking insect bites and scabs until they bleed
• Tendency to slap, push and punch others in attempts to show affection
• Tendency to hold arm poised just above the table when writing
• Accustomed tension in arm at shoulder, elbow or wrist to avoid the sensation of muscles, tendons and skin layers rotating over one another
• Scoliosis (if the Galant Reflex has not been integrated)

Notice that …
1. Tactile defending = Anticipating a threat not necessarily obvious/perceived by others.
2. Often hypo-sensitivity to touch is actually hyper-sensitivity in “shut down” (“flight” inward) mode.

D. The processing of MOVEMENT:

The sense of movement = “VESTIBULAR function”
• Completely formed by the 6th month of gestation
• Located in the inner ear to give us awareness of our movement and position related to gravity
• Has connections to the cerebellum and influences the Autonomic Nervous System (ANS) and DURA MATER
• Regulates ALL MOVEMENT directly or indirectly
• Directly governs other functions including: auditory, visual tracking, binocularity, muscle tone, equilibrium and proprioception

Problems with poor registration and/or integration of this sensory system may include:
• Excessive seeking of certain movement (e.g. only quiets with jumping or swinging)
• Avoidance of movement except as absolutely necessary
• Avoidance of head movement; compensation made with other body parts
• Excessive rocking

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• Head banging
• Motion sickness
• Avoidance of carnival rides, merry-go-rounds, swings
• Excessive watching of things spin, or excessive spinning of self
• Dizziness or nausea caused by watching things move
• Reports of never having felt dizzy or nauseated, even when all others in the same situation have
• Inability to read or write in cursive
• Inability to sustain listening without moving or rocking
• Problems of vertigo and/or balance
• Hearing problems, auditory processing difficulties
• Difficulty walking on uneven ground
• Need to move fast
• Difficulty maintaining static balance

Notice that …
1. Smell, tastes and touch are relatively unaffected by vestibular function.
2. Vestibular function must support ALL OTHER SENSORY SYSTEMS in order for us to achieve attention and focus.
3. When an individual’s vestibular system is over-stimulated, they may seek increased amounts of touch, taste or smell inputs.

E. The processing of BODY-IN-SPACE

The sense of body-in-space from joint receptors and muscle = “PROPRIOCEPTION”
• Is necessary in the development of “kinesthesia” (the awareness of movement in space)
• Works with four (4) other systems to help us determine where WE are in relation to our environment, and where our body parts are in relation to each other: vestibular, visual, tactile, olfactory and auditory
Problems with registration and/or integration of this sense may result in:

- Need to be held, swaddled, snuggled
- Unusual need to have physical contact with another person; clinging
- Hysteria over pulling tee shirts over the head
- Avoidance of eyes-closed activities (such as “Pin the Tail on the Donkey”)
- Discomfort or disorientation in the shower
- Difficulty falling asleep and staying asleep
- Falling out of bed
- Feeling as if he/she is floating in space or tipping in space while in bed or seated
- Extreme restlessness while sleeping
- Difficulty getting up and moving after sleep (as if the “strings” were cut)
- Need for heavy covers or clothing, or a back pack to feel grounded
- Need to have light on to sleep
- Fear of the dark
- Avoidance of team sports
- Aversion to crowds
- Preference for, and greater skill in, swimming than in other sports
- Hysteria when laid down as a baby, even if already asleep
- Clumsiness, tripping over own feet, bumping into things
- Swinging between pieces of furniture
- Unusual degree of stretching and yawning
- Difficulty grasping mathematical concepts
- Difficulty with prepositions and pronouns
- Inability to accept physical (and social) boundaries
- Accident prone behaviors
- Insecurity going up stairs
- Difficulty writing, getting dressed, etc., especially if eyes are closed
- Pushing, pulling, playing too rough
- Running hand down wall as walking
- Breaking toys
- Clumsiness in eating

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Notice that…
1. Proprioception is a prerequisite to FEELING SAFE in different spaces.
2. SEEING as well as PROPRIOCEPTION are requisite abilities for math. Without these, children use memorization and rote skills.

F. The processing of **HEARING**:

The sense of hearing = “AUDITION”
- Involves receiving and interpreting sound through air and bone conduction
- Other cranial nerves and developmental functions have influence on hearing

Problems with registration and/or integration of this sense may include:
- Delayed language development (receptive and expressive)
- Dislike of crowded and noisy environments
- Placing hands over ears
- Difficulty falling asleep or staying asleep if there is any noise, or what most people perceive as “no noise”
- Asking for repetitions of words in conversation
- Misconstruing words
- Having difficulty modulating speaking voice
- Delayed and laborious decoding for reading
- Lack of appreciation of music
- Avoidance of chewing

Notice that…
1. Many people who are hyper-sensitive to sounds make their own “white-noises” to mask the bothersome sounds.
2. We normally hear ourselves through bone conductions. If a person always speaks loudly, they may be relying on air conduction.
3. Most people in the autistic spectrum are hyper-sensitive to sound.
G. The processing of SEEING:

The sense of seeing = “VISION”

• “Ocular motility” (visual tracking) is the ability of the eyes to move in all directions
• “Binocularity” is the ability of the eyes to coordinate their activity so they can merge the visual field into one distinct image
• Is dependent on the muscles and cranial nerves that service the eyes, as well as on the VESTIBULAR SYSTEM
• Is the last sense to develop in utero and is not fully developed for many years
• Requires light to stimulate it

Problems with registration and/or integration of this sense may manifest as:

• Inability to hold head still while tracking
• Dizziness and/or nausea when required to track
• Reporting that objects blur or are lost in the field of vision when required to track
• Rubbing eyes after use
• Frequent headaches after visual work
• Frequent stomachaches after visual work
• Eyes move with a jerky or bouncy pursuit when tracking
• Eyes stop tracking an object that continues to move
• Overflow movements to other parts of the face or body when attempting to track
• Inability to read aloud, although can grasp meaning from silent reading
• Difficulty going down stairs
• Poor eye-hand coordination
• Eye pain, watering or discomfort when required to perform visual work
• Inability to read without losing place
• Difficulty copying from the board
• Generalized light sensitivity (photophobia)
• Poor three-dimensional perception
• Difficulty in sustaining eye contact

Notice that…

1. A person must have neurological readiness to comply with the command “look at me!”
2. The SUCKING REFLEX strongly influences the development of binocular vision.
3. If vision is not well-developed and we are still relying on our lower senses, it will be difficult for us to go out beyond ourselves (i.e. reach out/be outward-focused).

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THE “TOOLS”: APPLICATION OF SI TO CST

• Deep touch feels good and actually helps suppress sensitivity to light touch.
• Provide soothing and comforting tactile experiences (unique to each child, but generally surfaces like cuddly stuffed toys, fuzzy blankets, smooth objects).
• Give child something to hold in hands.
• Provide play dough, therapy putty, thera-band or theratubing to offer resistance for heavy work muscles.
• Place heavy pillow, bean bag, heavy soft toy on abdomen or legs to provide calming proprioceptive input.
• Provide toys for chewing or blowing to modulate the CNS through the mouth.
• Use vibrating toys as oral stimulators for those children who calm with vibrating stimulation.
• Adapt treatment area to floor or standing beside the table with an activity on it for those children with gravitational insecurity.
• Use dim, indirect lighting and subdued colors in the treatment room.
• Give the child frequent opportunity to “regroup” sensory/neurological processing BEFORE arousal level reaches a “point of no return.”
• Restrictions of any kind represent boundaries. Boundaries help us feel safe. The feeling of SAFETY comes first in any situation.
RECOMMENDED READING LIST

Raising a Sensory Smart Child – Bell & Paske
What’s Going on in There? – L. Elliot
Visual Thinking of a Person with Autism – T. Grandin
Autism and Sensing – D. Williams
Too Loud, Too Bright, Too Fast, Too Tight – S. Heller
Quirky Kids – Klass & Costello
Problem Child or Quirky Kid – Sommers & Flannigan
The Goodenoughs Get in Sync – C.S. Kranowitz
Building Bridges Through Sensory Integration – Yacht, Achilla & Sutton
Understanding the Nature of Sensory Integration with Diverse Populations – Smith Roly, Blanche & Schaaf
Nobody Nowhere – D. Williams
A Thorn in My Pocket – E. Cutler
Smart Love – Pieper & Pieper
The ADHD-Autism Connection – Kennedy, Banks & Grandin
Children with Starving Brains – J. McCandless
Kids in the Syndrome Mix of ADHD, LD, Asperger’s, Tourette’s, Bipolar and More – M. Kutscher
Allergy Busters – Chara, Chara & Chara
The Out of Sync Child Has Fun – C.S. Kranowitz
Sensational Kids – L.J. Miller
*Special appreciation is given to the helpful insights and information from Judith Bluestone, developer of the HANDLE Method.


Notes: