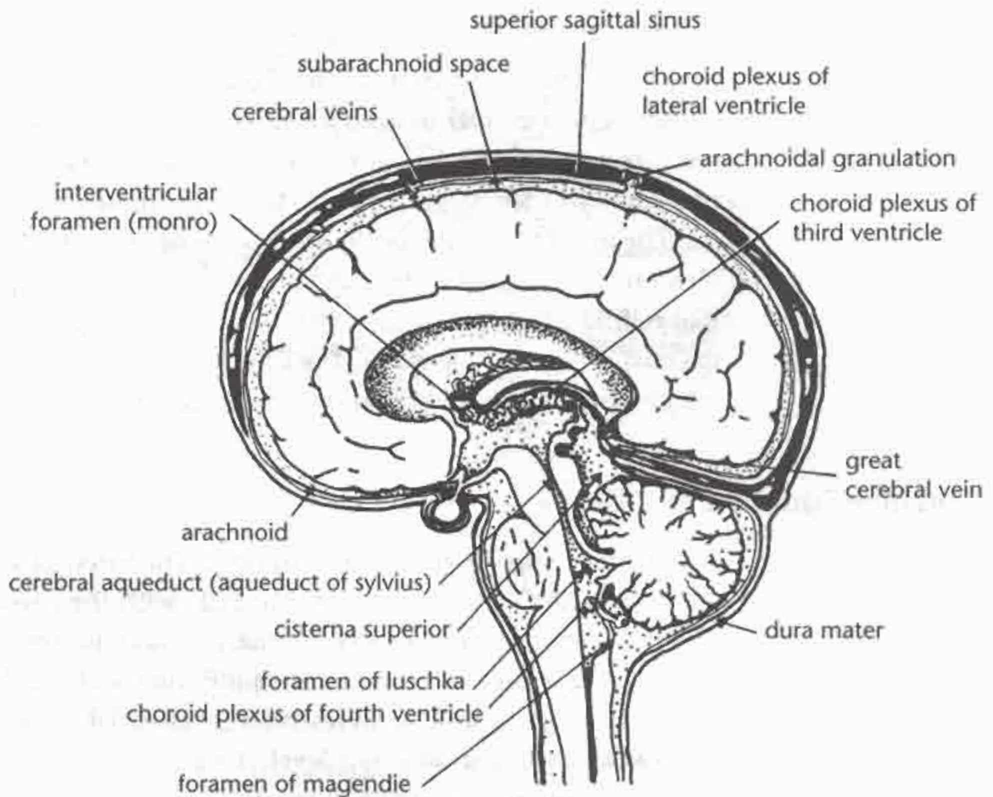
Figure 9: Flow of CSF



From here it flows through the subarachnoid space upward over the cerebrum and downward over the spinal pia. The subarachnoid space empties into the venous blood circulation via the arachnoid villi in the superior sagittal sinus, but first the CSF must pass through the small tentorial opening around the mesencephalon.

Diffusion Between CSF and the Ependymal and Meningeal Surfaces

The surfaces of the cerebral ventricles are lined with a thin cuboidal epithelium, the ependyma, and the CSF is in contact with this surface at all points. In addition, CSF in the subarachnoid space is in contact with the pia. The pia-glial and ependyma-glial membranes are freely permeable and diffusion occurs continually between the brain ECF and CSF. While the membranes are permeable, in both directions, there is directional net flow outward; ventricular (internal) CSF diffuses into brain ECF, and brain ECF diffuses into the subarachnoid space, joining the external CSF. In this manner the CSF continually washes through the brain parenchyma.

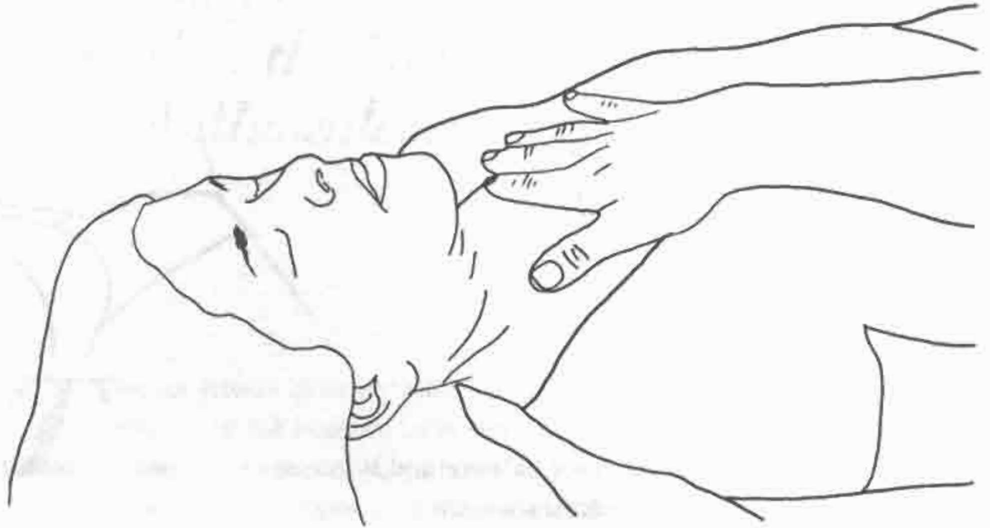
Stress Storage in the Membrane System

It's well known that mental and emotional issues usually involve somatic tension. It has been observed clinically that body tension often has mental and emotional implications. Sometimes in releasing somatic tension patterns a patient will encounter significant emotion that may (or may not) be associated with memories of past experience. Often these memories are painful, and he may be surprised by them, indicating that the memories have until now been blocked from active recall. In these cases the patient may come to the realization that his body symptom is somehow related to the suppression of the experience and the feelings associated with it. The observation of these phenomena raises questions as to the nature of stress storage in the body.

We commonly use the term "stress" to imply "distress," but "stress" really implies any demand for processing or adaptation on the part of the organism, including demands which we may find enjoyable. Because "stress" refers to the non-specific response on the part of the body in its mobilization to action, even pleasure can be perceived as distress by the organism if it presents a significant demand for autonomic response at the wrong time (the "Nelson Rockefeller Syndrome"). In general, only "distress" will be stored by a body, signifying that the organism was unsuccessful in satisfactorily processing or adapting to a challenge. This stress is therefore stored in the tissues as potential energy which may be experienced and palpated as tissue tension and its effects.

With one hand beneath the cervical-dorsal junction and the other over the sternal notch, approximate your hands and follow the torsion as you have done at the lower two diaphragms. Again, encourage the tissue to choose a new pattern of behavior. You are relying on the homeostatic mechanism innate to each body.

Figure 30: Thoracic inlet release



Occipital Decompression

Having cleared the three torso diaphragms, you are now ready to proceed to the occipital cranial base. Cup the head in your hands and place your fingers

Figure 31: Occipital decompression

The Ten-Step Protocol

The ten-step protocol was formatted by John Upledger for the purposes of teaching the basics. It covers a lot of territory and is an effective basic treatment procedure as you teach yourself to work with the cranio-sacral system. As your skills develop, and you naturally abandon the ten-step in favor of a more intuitive, unformatted treatment, the elements of the ten-step will remain ever at your fingertips.

The basis of the ten-step protocol is your palpation. Sit down, place your hands at your station, and listen.

1. Still point induction
2. Transverse diaphragm releases:
   a. Pelvic diaphragm release
   b. Thoracic diaphragm release
   c. Thoracic inlet release
   d. Occipital decompression and dural tube traction
3. Frontal lift
4. Parietal lift
5. Temporal ear pull
6. Temporal rock
7. Sphenoid lift
8. Mandibular decompression
9. Sacral decompression and dural tube traction
10. Still point induction