

Head Banging, Thumb Sucking, KST and Chiropractic

by Tedd Koren, D.C.

A young boy, two and one-half years of age....From the time the child was twelve months old, every night, he sat up in bed and repetitively banged his forehead against the wooden crib bars from one to two hours, after which the child went back to sleep....Daytime behavior was described as normal.¹

Head banging has been reported in 3.3 to 15.2 percent of “normal” children,² but is more common in children with cerebral palsy, mental retardation, schizophrenia, autism, otitis media, teething, decreased visual acuity and certain genetic syndromes.³

The medical approach

The medical profession considers head banging a relatively harmless way of releasing tension: “If the sound of your baby’s head banging bothers you, try moving the crib away from the wall. Also be sure to tighten the screws and bolts on his crib regularly.”⁴ A helmet is sometimes recommended.⁵

What causes head banging?

Medically, the etiology of head banging is unknown. The psychoanalytic school believes that head banging is a manifestation of poor ego identity⁶ and even maternal deprivation.⁷ The latter appears related to the discredited “refrigerator mother” school of autism etiology.

From a structural perspective, head banging, head rolling, thumb sucking and other repetitive behaviors may be indicative of cranial subluxations either causing or resulting from meningeal stress. These subluxations/meningeal stresses are often the result of neurological damage caused by pre-natal or birth trauma, accidents, vaccinations, chemical stress and/or emotional stress. Anger and other extreme emotions tighten the meningeal system and increase brain pressure; consequently, head banging is sometimes associated with tantrums.⁸ Repetitive rocking appears to be an attempt to release pressure on the brain and nervous system.

“How could the cranial bones subluxate? Aren’t they fused?”

Do cranial bones fuse?

Italian anatomists always considered the cranial bones to remain non-fused, while the German and British anatomists believe the bones to be fused. Americans learned their anatomy from German and British texts.

Recent research reveals the Italians are correct—the skull bones do not fuse, but remain movable throughout life.

Studies of live monkeys and sections of living human skulls between the ages of seven and fifty-seven demonstrated objectively that the cranium moves in a rhythmical manner and that the sutures, rather than being fused and filled with calcified tis-



sue, contain myelinated and non-myelinated nerve fibers, nerve receptor endings, connective tissue and blood vessels.⁹⁻¹²

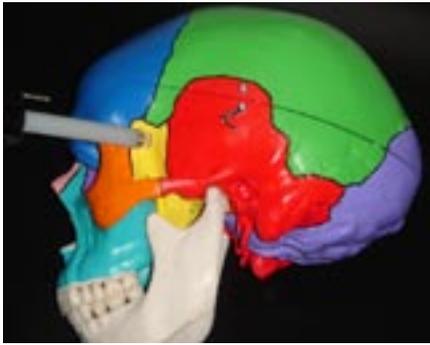
Accommodation to pressure

Cranial movement appears to help the body adapt to changes in air pressure. If the bones of the skull are subluxated, proper accommodation cannot occur and meningeal stress on the brain and nervous system cause pain and discomfort. That’s why children become hypersensitive when a storm is on the way.

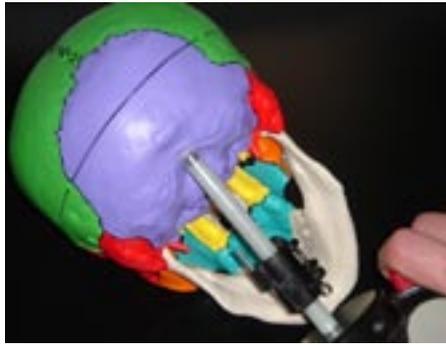
According to an osteopathic source, “Head banging is often an indicator of stresses within the head, and not simply a sign of frustration.”¹³

In Congressional testimony, John E. Upledger, DO, developer of CranioSacral Therapy, reported: *Many autistic children are known to bang their heads, chew on their wrists and/or the bases of their thumbs until deep tissue (tendon sheath) is visible, and/or they may suck on their thumbs so vigorously that the front upper teeth begin to displace forward. Actually, these thumb-sucking children are pressing on the roof of the mouth as hard as they can. We have observed that, when specific corrections of the craniosacral system are successfully carried out, these behaviors spontaneously cease. It is my opinion that the head-banging child is trying to release a compressive force in the head that is quite painful. When we release this compression, head banging stops.*¹⁴

It may be no coincidence that head banging in some children occurs when walking begins¹⁵ since, at that stage, the lower back or lordotic curve forms which adds length to the spinal cord and may increase meningeal tension.



Correction of anterior sphenoid
(line of drive anterior to posterior)



Correction of interior occiput (line
of drive inferior to superior)

What needs to be done?

Head bangers are often trying to relieve cranial/meningeal pain. When meningeal/structural stresses are relieved, head bangers have often responded favorably:

- “Alex was given osteopathic treatment... after the second treatment his chronic head banging stopped.”¹⁶
- A 3½ year-old autistic female compulsive head banger had a “50 percent reduction in head banging” under chiropractic spinal care.¹⁷ Had the child additionally received cranial adjustments, the improvement would have, no doubt, been greater.
- “In over twenty years of practice with thousands of brain-injured children, we have found brain tension due to severe cranial sacral pressure, due to the temporal bones and sphenoid basilar junction being ‘stuck’ in addition to intense myofascial strain. After Koren Specific Technique was added to our protocol, we have seen even more rapid progress in creating good cranial rhythm, reducing fascia strain and elimination of head banging symptoms.” *Matt Newell, Director of Family Hope Center, Blue Bell, PA*¹⁸

What to check for.

All cranial bones may sublaxate; however, using KST analysis procedures, we have found the following sublaxations most common:

1. left and right side of sphenoids anterior (sometimes inferior/superior)
2. occipital bone inferior (sometimes lateral)
3. hard palate inferior
4. left or right parietals inferior (indicative of head trauma)
5. one or both temporal bones anterior.

Please keep in mind that every skull is different. Birth trauma may sublaxate a part of the skull that is not anatomically “supposed” to be sublaxated. That is especially true if there are bumps, ridges, indentations and other unusual landmarks on the child’s skull.

The upper cervical spine should also be checked for sublaxations. We find the following cervical sublaxations most common:

1. atlas C1 right posterior arch lateral and posterior,
2. C2/C3 disc right
3. C5 posterior

Correcting Cranials Using KST

Koren Specific Technique was developed to easily and quickly analyze and correct or adjust the entire structural system, including the cranial bones.

In addition to being able to locate and correct sublaxations to a high degree of specificity with low force on patients, KST practitioners can analyze

and adjust themselves!

For information on Koren Specific Technique (KST), go to www.teddcoreseminars.com.



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