Continuing-education workshops conducted by Upledger Institute International (UII) are designed to augment the professional practices or educational programs of healthcare practitioners. Admission requires each participant to hold a current healthcare license or certificate, or be enrolled in an educational program granting licensure or certification. Upon course completion, participants must also assume responsibility for understanding which techniques fall within the scope of their practices.

Special consideration may occasionally be given to laypersons who wish to attend our workshops. In these cases, UII 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 Upledger Institute International.

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 Upledger Institute International, 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.
A Note From the Editor

Welcome! Thank you for choosing the Upledger seminar series. You’ll enjoy many learning opportunities in this CranioSacral Therapy 2 seminar:

- An understanding of the history, principles and neuromuscular basis of CranioSacral Therapy, and its clinical importance.
- The ability to conduct thorough screening evaluations and formulate therapy strategies.
- Supervised practice of CranioSacral Therapy techniques to help normalize common joint 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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SUTHERLAND'S CRANIAL BASE DYSFUNCTIONS

Objectives

1. To gain comprehension of the Sutherland approach to lesions or dysfunctions between the sphenoid and the occiput.

2. To clearly identify the “neutral zone” of the spheno-occipital motion.

3. To gain competency in differentiating and identifying the feel of “osseous” as compared to “membranous” restrictions.

4. To evaluate flexion and extension of the spheno-occipital complex and correct any lesions that may be found.

5. To evaluate for torsion (left and right) of the spheno-occipital complex and correct any lesions that may be found.

6. To evaluate for sidebending (with convexity left and right) of the spheno-occipital complex and correct any lesions that may be found.

7. To evaluate for lateral strain (left and right) of the spheno-occipital complex and correct any lesions that may be found.

8. To evaluate for vertical strain (superior and inferior) of the spheno-occipital complex and correct any lesions that may be found.

9. To be able to detect all of the above lesions during the sphenoid compression-decompression technique which we used in CranioSacral Therapy 2.

10. To understand the probable origin of each of the Sutherland lesions and be able to explain the relationship in terms of spheno-occipital compensation or non-compensation.

11. To integrate the Sutherland concepts into the 10-Step Protocol and apply individual correction techniques when needed.
The Sutherland Cranial Base Lesions
(The Sphenobasilar Dysfunctions)

Notes:
Normal Flexion of Sphenoid and Occiput

Notes:

Normal Extension of Sphenoid and Occiput

Notes:
The Neutral Zone

The neutral zone is the brief pause between the end of the flexion phase of cranial motion as it returns toward the central range and before it enters the extension phase. It also occurs between the end of extension and the beginning of flexion. Therefore, there are two neutral zones per cycle. In the normal cranial rhythm cycle evaluation, the flexion and extension phases should be equal in time. The neutral zone must be perceived in order to evaluate excursion in time and distance into both flexion and extension.

Representation of Craniosacral Motion – Effect of Barriers

Figure 1-1

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Axis of Rotation

Figure 1-2
Third Vault Hold

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The Sutherland Cranial Base Lesions

1. Flexion

2. Extension

3. Torsion

4. Sidebending

5. Lateral Strain

6. Vertical Strain

7. Compression
Facts to Remember:

1. The sphenobasilar articulation is a synchondrosis (a cartilage bar) that does not tend to maintain the lesions.

2. The cranial rhythm, though distorted by the sphenobasilar dysfunctions, continues to maintain its flexion and extension motion cycles.

3. To remember the sphenobasilar you will need to learn the following:
   a. The name of the lesion.
   b. The axis of rotation of the sphenoid and occiput.
   c. The direction of rotation of the sphenoid and occiput on their axis (compensatory vs. noncompensatory).
   d. The potential sites of cause for each lesion.
   e. Clinical significance.

Note: See chart in this section.

4. Sphenobasilar compression and decompression will:
   a. Demonstrate all of the sphenobasilar lesions present in each patient’s evaluation and therapy/balancing.
   b. Normalize 90% of the sphenobasilar dysfunctions.

5. Each sphenobasilar dysfunction is named by testing each range of motion to its maximum distance or time. The greatest range of motion is the named lesion; i.e.: right torsion greater than left torsion = right torsion dysfunction.
6. Except for flexion and extension, any sphenobasilar dysfunction can be tested to its full range of motion by stabilizing the occiput and moving the sphenoid on it.

7. Normalizing each of the sphenobasilar dysfunctions is performed by stabilizing the occiput and moving the sphenoid first into its greatest range of motion (the named direction of dysfunction) and allowing for release.

8. Normalization (a release) occurs when the corrected range of motion moves a greater distance away from the neutral zone or the midline and the feeling of relaxation (widening) occurs.

9. Normalizing each of the sphenobasilar dysfunctions by stabilizing the occiput and moving the sphenoid into the restricted range of motion and allowing for release.
Notes:
Flexion/Extension

A. Named for direction of ease

B. Axis of rotation – transverse

C. Direction of rotation – opposite

D. Origin of dysfunction – compensatory/external to dura mater

E. Evaluation and treatment – Is range of motion greater in flexion or extension? Go in direction of ease and hold.

F. Clinical significance – least severe:
   - flexion – meso to endomorphic headaches
   - sinusitis
   - low-back pain
   - extension – ecto to mesomorphic migraine
   - sinusitis
   - obsessive/compulsive solitary non-team athletes

Figure 1-6
The Sphenobasilar Dysfunctions
The Flexion Lesion

Notes:

The Extension Lesion

Notes:

Figure 1-7
Torsion

A. Named for greater wing cephalad

B. Axis rotation – longitudinal

C. Direction of rotation – opposite

D. Origin of dysfunction – external to the cranial dura mater

E. Clinical significance – more severe than flexion/extension:
   - sacrum mimics occiput
   - head, neck, back pain of varying severity
   - sinusitus
   - temporal bone dysfunction
   - scoliosis
   - eye motor problem

Figure 1-8
Torsion Lesions (Left or Right)

Notes:

Figure 1-9
A. Named for sidebending with convexity left or right (whichever wing is anterior)

B. Axis rotation – vertical

C. Direction of rotation – opposite

D. Origin of dysfunction – external to cranial dura mater

E. Clinical significance – greater than torsion including:
   - headaches
   - endocrine disorders
   - allergies
   - TMJ problems

*Sidebending with convexity right*

*Figure 1-10*
Sidebending Lesions (Convexity Left or Right)

(Top View)

Sidebending With Convexity Right

Sidebending With Convexity Left

Vertical axes of rotation about which sphenoid and occiput are rotated in a sidebending lesion

Figure 1-11

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Lateral Strain

A. Named for direction of ease of sphenoid (side of head that moves anterior most easily)

B. Axis of rotation – vertical (same as sidebending)

C. Direction of rotation – both the same

D. Origin of dysfunction – primary to craniosacral system/intracranial dura mater

E. Clinical significance – severe including:
   - pain syndromes
   - personality disorders
   - endocrine disorders
   - various learning disabilities
   - eye/motor coordination problems
   - reading problems

Right lateral strain

Figure 1-12
Lateral Strain (Left or Right)

Notes:

Figure 1-13
Vertical Strain

A. Named for sphenoid being superior or inferior to occiput at the synchondrosis

B. Axis rotation – transverse (same as flexion/extension)

C. Direction of rotation – both the same

D. Origin of dysfunction – primary to craniosacral system/intracranial dura mater

E. Clinical significance – more severe than lateral strain; manifestations same as lateral strain
Vertical Strain (Superior or Inferior)

Superior Vertical Strain

Sphenoid is elevated

Inferior Vertical Strain

Sphenoid is depressed

Figure 1-15

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**Compression**

A. Named for the problem

B. Axis rotation – none

C. Direction of rotation – none

D. Origin of dysfunction – primary in craniosacral system/intracranial dura mater, sutures, occipital condyle, and L5/S1

E. Clinical significance – most severe:
   - severe emotional problems
   - depression
   - childhood autism

**Sphenobasilar Decompression**

Notes:
### Sutherland Cranial Base Dysfunctions or “Lesions”

<table>
<thead>
<tr>
<th>Sutherland Lesion</th>
<th>Axes Position</th>
<th>Direction of Rotation</th>
<th>Origin of Dysfunction</th>
<th>Clinical Significance</th>
<th>Scale of Severity (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexion</td>
<td>Transverse</td>
<td>Opposite</td>
<td>External to the dura mater</td>
<td>Mesod to endomorphic body habitus is most common. Headaches, sinusitis, low back pain — all chronic and recurrent but seldom disabling.</td>
<td>1</td>
</tr>
<tr>
<td>Extension</td>
<td>Transverse</td>
<td>Opposite</td>
<td>External to the cranial dura mater</td>
<td>Internal to mesomorphic body habitus is most common. “Migraine” type headaches, sinus trouble, may be disabling for a few days at a time. Obsessive-compulsive personality is common, usually into solitary, non-team activities like distance running.</td>
<td>1+</td>
</tr>
<tr>
<td>Torsion</td>
<td>Longitudinal</td>
<td>Opposite</td>
<td>External to the cranial dura mater</td>
<td>Head-neck-back-pain of varying severity, sinusitis, temporal bone of dysfunctions, scoliosis, eye motion problems, sacrum mimics occiput.</td>
<td>2</td>
</tr>
<tr>
<td>Sidebending</td>
<td>Vertical</td>
<td>Opposite</td>
<td>External to the cranial dura mater</td>
<td>Same as for torsion but more severe.</td>
<td>2+</td>
</tr>
</tbody>
</table>

**LESIONS ABOVE ARE USUALLY COMPENSATORY — THEREFORE AXES ARE ROTATED IN OPPOSITE DIRECTION.**

**LESIONS BELOW ARE INTRACRANIAL IN ORIGIN AND ARE NOT COMPENSATED — AXES ARE ROTATED IN SAME DIRECTION**

| Lateral strain    | Vertical      | Same                   | Inside the head, probably in the intracranial dura mater | A wide variety of severe clinical dysfunctions, pain syndromes and personality disorders are common. Various learning disabilities. Eye-motor coordination problems.                                           | 3                      |
| Vertical strain   | Transverse    | Same                   | Inside the head, membranes or sutures, the occipital condyles, L5-S1. Severe emotional distress | Any or all of the above, usually severe. “Endogenous” depression is common.                                                                                                                                              | 4                      |
| Compression       | None          | None                   | Inside the head, membranes or sutures, the occipital condyles, L5-S1. Severe emotional distress | Any or all of the above, usually severe. “Endogenous” depression is common.                                                                                                                                              | 5                      |
The 10-Step Protocol – Version 1

• Listening Stations (Heels, Dorsums, Thighs, ASISs, Ribs, Shoulders, Three Vault Holds)

1. Still Point (CV-4, Sacrum, Feet, etc.)

2. Diaphragm Releases
   a. Pelvic
   b. Respiratory
   c. Thoracic Inlet
   d. Hyoid
   e. Occipital Cranial Base

3. Frontal Lift
   (Vertical Membrane System)

4. Parietal Lift (two parts)
   (Vertical Membrane System)

5. Sphenobasilar Compression-Decompression
   (Horizontal Membrane System)

6. Temporal Techniques
   a. Temporal Wobble
   b. Finger in Ear
   (Horizontal Membrane System)

7. Temporal Decompression (Ear Pull)
   (Horizontal Membrane System)

8. TMJ Compression and Decompression

9. Dural Tube Evaluation (Occiput/Sacrum, L5-S1 Decompression, Iliac Gap, Rock/Glide)

10. Still Point (CV-4)
    V-Spread - Wherever Appropriate

• Listening Stations
The 10-Step Protocol – Version 2

• Listening Stations (Heels, Dorsums, Thighs, ASISs, Ribs, Shoulders, Three Vault Holds)
  1. Still Point (CV-4, Head, Sacrum, Feet, etc.)
  2. Diaphragms:
     a. Pelvic
     b. Respiratory
     c. Thoracic Inlet
     d. Hyoid
     e. Occipital Cranial Base
  3. L5-S1 Decompression, Iliac Gap, Dural Tube Traction
  4. Dural Tube Rock/Glide
  5. Frontal Lift  
     (Vertical Membrane System)
  6. Parietal Lift (two parts)  
     (Vertical Membrane System)
  7. Sphenobasilar Compression-Decompression  
     (Horizontal Membrane System)
  8. Temporal Techniques:  
     a. Temporal Wobble  
     b. Finger in Ear (Circumferential)  
     c. Ear Pull  
     (Horizontal Membrane System)
  9. TMJ Compression and Decompression
  10. CV-4/Still Point  
     V-Spread - Wherever Appropriate

• Listening Stations

* The sacral and dural tube steps have been changed from Version 1. The order of this protocol is structured to free up restrictions that lie within the pelvic and spinal regions before commencing to the head, which some practitioners may prefer.

Note: As you become skilled in the 10 evaluation and correction steps, you may wish to alter the order to better suit your professional style. **What is important to know is the specific procedures and their applications. The order in which the procedures are applied varies among practitioners.** However, the two 10-Step Protocols presented above are recommended by Dr. Upledger and are most commonly followed by Upledger Institute Certified CranioSacral Therapy instructors.
THE HARD PALATE

Objectives:

1. To become familiar with the functional anatomy of the hard palate in relation to the cranial base and the mandible.

2. To localize and restore to normal function any motion distortions in the flexion-extension function between the sphenoid and the palatino-maxillary complex.

   Specifically:
   a. To find and correct any distortions in flexion-extension function between the sphenoid and the palatino-maxillary complex.
   b. To use the nonphysiologic motions of torsion and shear to find and correct functional abnormalities between the sphenoid and the palatino-maxillary complex.
   c. To disimpact the palatino-maxillary complex from the sphenoid.
   d. To evaluate the functional relationships between the vomer and the sphenoid during craniosacral flexion-extension activities and to correct any distortions in motion and/or synchrony.
   e. To evaluate and further mobilize spheno-vomer activities using the non-physiologic motions of torsion and shear.
   f. To disimpact the vomer from the sphenoid.
   g. To mobilize the palatine bones individually.

3. To locate and mobilize any restrictions of individual teeth.

4. To rebalance and align the mandible in relation to the spheno-palatino-vomer-maxillary complex and the temporal bones.

5. To accomplish all of the above without the use of excessive force and without inducing or creating any uncorrected dysfunction of the cranial base.

6. To gain comprehension of the masticatory system and its interrelationship with the whole person.
Protocol for Hard Palate Evaluation and Correction

1. Be sure that all diaphragms, the occipital cranial base, the intracranial membranes, the dural tube and the TMJs have been released and balanced.

2. Nasal bones

3. Zygoma – mobilize individually

4. Maxillary-palatine complex
   a. Flexion-extension balanced and in synchrony with the sphenoid
   b. Torsion – left and right
   c. Shear – left and right
   d. Impaction/compression
   Throughout b, c and d, support the sphenoid so that you do not introduce any dysfunction into the cranial base via the sphenoid-hard palate relationship.

5. Vomer
   a. Flexion-extension with sphenoid synchrony
   b. Torsion – left and right
   c. Shear – left and right
   d. Impaction/compression

6. Palatines
   a. Mobilize cephalad
   b. Mobilize laterally

7. Rebalance the hard palate

8. Temporal bones – decompression

9. Rebalance the mandible and move it anteriorly (TMJ Technique)

10. Spheno-occipital cranial base – rebalance it
Right Orbit: Anterior View

P = Palatine
Nasal Bones and Zygomas

Figure 2-11
Nasal Bones

Notes:
Notes:
The Zygomatic Bones

In some situations, the zygomatic bones can prevent proper functioning of the hard palate and/or the cranial vault. These bones articulate with the maxillae on each side and when these sutures are restricted, the maxillary mobility may be compromised. The zygomatic also articulates with the temporal bone bilaterally. These articulations are relatively small and seldom interfere significantly with temporal motion. However, if the zygomatic does impair temporal bone function, this situation will reflect into the masticatory system and into the cranial vault.

The zygomatic also articulates with the frontal and sphenoid bones and contributes to the inferior and lateral aspects of the orbits. Thus, the zygomatic may be involved etiologically in both vault and orbit problems.

Problems with the zygomatic are usually secondary to facial trauma. These problems are most often corrected as you work through the cranial vault and the mouth. Those restrictions not corrected via these techniques are significant.

The axis of rotation for the zygomatic bone, its evaluation for restriction of motion and the corrective technique will be demonstrated by your instructor.

Notes:
The Functional Anatomy of the Hard Palate

From a practical point of view the CranioSacral Therapist may consider the hard palate as a horizontal template which is connected to the sphenoidal component of the cranial base by three vertical stanchions. The two lateral stanchions are formed by the pterygoid processes of the sphenoid bone and their articulations with the perpendicular plates of the palatine bones and sometimes with the maxillae on each side. For our purposes we may think of these articulations as joints between the sphenoid's pterygoid processes and the palatine-maxillary complex bilaterally. The midline stanchion is formed by the vomer bone, which is situated vertically above the midline of the hard palate (palatine-maxillary complex) and extends upward to connect with the sphenoid bone.

![Diagram of craniofacial anatomy](image)

*Figure 2-1*

Front view showing vertical hard palate-sphenoid relationships. Note that the contact areas of the great wings are superior to the axis of rotation through the sphenoid.
Functionally, the pterygoid-hard palate articulations allow for some hinge action, as does the articulation between the sphenoid and the vomer. This latter joint is formed by the sphenoidal rostrum projecting into the invagination of the vomer on the vomer's superior surface. The rostrum is elliptical in shape and usually penetrates the vomer about a quarter inch. The alae of the vomer articulate with the sphenoid on each side of the base of the rostrum.

The inferior margin of the vomer articulates with the superior surface of the hard palate. Here the vomer covers the length of the midline suture from front to back. This inferior aspect of the vomer widens to cover the prominence which is formed at the sutural junction.

![Figure 2-2](image)

A sagittal cutaway section at the midline showing sphenovo-mer-palatino-maxillary relation. Note that the rostrum of the sphenoid penetrates the vomer. This allows for independent rocking of the two bones. It also makes impaction of the two bones a serious consequence of many head traumas.
From Figure 2-3 we can view the hard palate as four parts joined together at sagittal and transverse suture lines. The two anterior contributions come from the maxillae. The two posterior contributions are from the horizontal plates of the palatine bones.

**Inferior View of the Hard Palate**

![Diagram of the inferior view of the hard palate](image)

*Figure 2-3*
Normal Movements of the Spheno-Palatino-Vomero-Maxillary Complex

During the flexion-extension movements of the craniosacral system, the following movements are perceptible in the hard palate. It is assumed that you have at least partially corrected all dysfunctions of the cranial base and vault before evaluating the hard palate, and that you are aware of any dysfunctions which are not totally corrected.

1. The transverse dimension of the hard palate widens during the flexion phase of the craniosacral rhythm. This dimension narrows during the extension phase.

2. The vomer is reflected through the midline of the hard palate. The posterior midline moves inferior and the anterior midline goes up during the flexion phase of the craniosacral motion. The reverse is true during extension of the system.

Notes:
Hard Palate Evaluation and Balancing

1. Flexion

2. Extension

3. Torsion

4. Shear

Figure 2-4
Flexion-Extension of the Hard Palate

1. With one hand, tune in to the flexion and extension activity of the sphenoid, either by direct contact with the great wings or through the frontal bone.

2. Place two fingers of the other hand upon the biting surfaces of the upper molars (or gums if the teeth have been extracted). Tune in to the widening (flexion) and narrowing (extension) of the transverse distance across the hard palate as indicated by the movement of the teeth.

3. Evaluate motion synchrony between the sphenoid and the hard palate.

4. Evaluate symmetry (or asymmetry) of motion between the sphenoid and the hard palate.

5. Make appropriate corrections as described by your instructor.

6. Be sure you reinforce the natural movement of the sphenoid as you induce corrective forces into the hard palate. This avoids iatrogenically induced cranial base dysfunctions.

Notes:
Hard Palate Techniques
Hand Position

Lateral View

Inferior View
Torsion and Shear of the Hard Palate

**Torsion**

Torsion of the hard palate in relationship to the sphenoid bone is a nonphysiologic motion that you induce to test for its presence as an abnormal condition. When present, it has usually been traumatically induced. Since it is a nonphysiologic motion, you must very gently induce the motion and then wait patiently for the hard palate to comply while you stabilize the sphenoid with your other hand. If you do not stabilize the sphenoid as you induce the torsion movement into the hard palate, you may induce a dysfunction into the cranial base.

In the test for torsion, your hand positions are the same as testing for flexion-extension. Visualize a vertical axis through the cruciate suture of the hard palate extending upwards through the sphenoid. Now stabilize the sphenoid and rotate the hard palate one way around this imagined vertical axis. Wait for the response. Return to the neutral position and induce the torsional movement in the opposite direction. Wait for accommodation and return to the neutral position. Which way did the torsional movement go the furthest and the easiest – to the right (using the anterior palate as the reference point) or to the left? If it went further and/or easier to the left, we call it a left torsion of the hard palate. The opposite is true for a right torsion.

Begin your motion testing for hard palate torsion at either the beginning of craniosacral flexion or extension, but be consistent for both left and right testing.

Your instructor will demonstrate the motion testing and the correction techniques used when a torsion dysfunction of the hard palate is found.

The corrections are done first indirectly (in direction of ease), then directly (in direction of barrier).

After correction has been made, you should reevaluate for improvement in symmetry of accommodation in both tested directions with the craniosacral rhythm. There should be a minimum of a 50% improvement.

![Figure 2-4-a](image-url)
The Vertical Axis Used to Test
Hard Palate Torsion

Vertical Axis

Sphenoid

Hard Palate

Direction of Hard Palate Rotation Around Vertical Axis

Figure 2-5
Notes:
Hard Palate Shear

Sphenomaxillary Shear

Normal Relationship

Shear
(Note intraosseous strain in vomer)

Figure 2-6

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Shear

The test for shear between the hard palate and the sphenoid makes use of the same hand positions as the tests and treatments described for torsion. This time there is no rotational component. Frequently, the hard palate will tend to rotate as you apply your shearing force. Resist the temptation to go along with this tendency. Shear is visualized as a lateral displacement of the hard palate in relationship to the sphenoid. The sphenoid must be stabilized with one hand. With the other hand contacting the biting surfaces of the upper molars, apply a very gentle force in a straight lateral direction. Be sure the sphenoid does not follow the hard palate. Allow time for accommodation to this nonphysiologic motion. Test in both directions. Begin each test at the beginning of either the flexion or extension phases of craniosacral motion – be consistent. Compare the distance and ease with which the hard palate travels to the left and to the right. The dysfunction is named for the direction of greatest excursion and ease.

Corrections are made first indirectly, then directly. Reevaluate for effectiveness of correction. You should see at least a 50% improvement. If not, repeat the correction.

Your instructor will demonstrate the technique for you.

Notes:
Disimpaction of the Hard Palate
From the Sphenoid

Disimpaction of the palatino-maxillary complex (hard palate) from the sphenoid is carried out by stabilizing the sphenoid with one hand and applying anterior traction to the hard palate with the other hand. The traction may be applied via the contact on the biting surfaces of the molars (or gums if the teeth are absent). An alternate method is to grasp the anterior alveolar ridge between the thumb (on the external surface) and the two fingers on the internal surface, and apply traction in an anterior direction.

The first method places your force closer to the pterygoid processes, thus acting more directly upon them. The second method position is less specific. A response of the sphenoid to the anteriorly directed traction on the hard palate indicates the presence of impaction. Continued easy traction is the therapeutic technique for impaction between the sphenoid and the hard palate. This impaction may be either bilateral or unilateral. Your instructor will demonstrate the technique.

Notes:
Sphenoid-Hard Palate Disimpaction Technique

Figure 2-7
Vomer Finger Balancing

Flexion

Axis of Rotation

Torsion

Shear

Figure 2-8
**Vomer-Sphenoid Relationship**

The vomer-sphenoid relationship is evaluated for synchrony of flexion and extension. It will also be tested and treated for torsion and shear. When there has been a torsion or shear dysfunction of the hard palate, the vomer will usually manifest a similar situation. Finally, the vomer is tested and treated for impaction of the sphenoidal rostrum into its invagination. There may also be a compression dysfunction between the distal vomer and the roof of the hard palate.

The vomer is a very delicate bone. Usually, the evaluation procedure alone makes the correction, especially for torsion and shear dysfunctions.

In testing the vomer for flexion and extension you should first tune in to the movement of the sphenoid with one hand. Then place either your middle or your index finger of the opposite hand in the patient's mouth so that the volar surface of your finger overlies the hard palate's sagittal suture, which separates it into two halves. Now tune in to the vomer movement at the same time that you continue moving with the sphenoid. Are the two bones moving in synchrony through the flexion and extension phases of craniosacral motion? Refer to Figure 2-2 (page 33) in order to determine which movements occur in flexion and which occur in extension. Your instructor will demonstrate the evaluation and correction techniques.

**Flexion/Extension of Vomer**

Vomer moves about a transverse axis located in midregion.

Posterior aspect moves inferiorly (pedad) in flexion.

Posterior aspect moves superiorly (cephalad) in extension.
Vomer Torsion and Shear

The tests for torsion and shear of the vomer in relationship to the sphenoid are very similar to those carried out for the hard palate. However, the finger placement in the mouth is different. Your instructor will demonstrate these techniques. Remember two things: First, the evaluation process will usually correct the torsion and/or shear dysfunction if it is carried out gently and patiently. Second, the vomer will usually have the same torsion and/or shear dysfunction as the hard palate. Correction of the hard palate may also correct the vomer, but don't count on it. Go through the procedures for the vomer even if you think that it has corrected during the hard palate procedures.

Figure 2-8-a
Notes:
Sphenoid-Vomer Impaction

Impaction between the vomer and the sphenoid is a common problem that frequently underlies rather severe symptoms including pain, vasomotor and/or allergic problems and pituitary dysfunction. The impaction usually occurs secondary to trauma.

**Typical Force Which Causes Sphenoid-Vomer Impaction**

![Diagram of impaction](image)

Example: A child on a tricycle crashes and the handlebar traumatizes the base of the nose.

When this type of vomero-sphenoidal impaction occurs, the vomer feels like a semirigid projection from the sphenoid rather than an independent bone with a functioning hinge.
Sphenoid-Vomer Disimpaction

Therapy for this impaction and for mobilizing the vomer in relationship to the hard palate is to provide an anterior-inferiorly directed midline traction on the vomer to move it slightly away from the sphenoid. The indication that you have succeeded is the sensation of a changing relationship between the vomer and the sphenoid. Your instructor will demonstrate the technique.

Notes:
The Palatines

After you have completed the mobilization and correction of any dysfunctions of the hard palate and vomer, it is time to pay attention to the palatine bones. See Figure 2-3 (page 34) for the location of these bones in the hard palate. The technique for testing and correction of the palatine bones must be done very gently. Trauma to the palatine due to overzealous evaluation and/or therapy can cause significant pain or nervous dysfunction, which may be difficult to correct.

The palatine bone is like a washer or spacer between the maxilla and the pterygoid process. Usually, minor problems of the palatine are corrected before you focus individually on that bone. Any remaining problems are significant. Your instructor will explain and demonstrate the techniques that we recommend for the evaluation and correction of palatine bone dysfunctions.
The Individual Teeth

After completing your work on the hard palate, lay your fingers along the biting surfaces of the upper and lower teeth. If a tooth sort of “jumps out at you” and begs for attention, go ahead and release it. The tooth may unwind for what seems like a long time. The release usually feels like the tooth is moving slightly out of the jaw.

Notes:
The Finishing Touches

Before you are finished with the mouth, it is necessary to go back to the hard palate. Be sure it is synchronized in flexion and extension activities with the sphenoid and that it is moving with maximum freedom.

Next you must rebalance the mandible in relationship to the “new” upper jaw. Go through the TMJ compression-decompression technique. During decompression, encourage any torsioning or repositioning that it may want to do. Then encourage the mandible to move anteriorly after it is decompressed (especially if you had previously corrected a hard palate impaction).

Temporal Bones Decompression

Notes:

Sphenobasilar Technique

Notes:
MacLean's Triune Model of Brain

Figure 2-12
The Masticatory System as a Part of the Whole Person

MacLean's Triune Model of Brain Development

Notes:
The Reticular Alarm System, the Trigeminal System and the Mammalian Brain – Interrelated and Interdependent

Notes:
Objectives:

1. To develop an awareness of the highly sensitive palpatory skills needed to work with infants and children.

2. To be able to adapt CranioSacral Therapy techniques as appropriate for the differences in the anatomy of infants and children.

3. To be able to incorporate previously learned CranioSacral Therapy techniques into an effective and appropriate protocol for infants and children.
Cranial Evaluation for Children

Protocol:

As you evaluate each of the following areas, correct them when indicated.

1. Evaluate craniosacral synchrony, checking for quality and range of excursion.

2. Evaluate the cranial vault motion and correct to create good quality flexion-extension synchrony and maximum movement.

3. Frontal lift.

4. Evaluate and mobilize the parietals.

5. Sphenobasilar lift (decompression).

6. Evaluate and mobilize the temporals. Ear pull if necessary.

7. Cranial base, condylar part decompression, with the atlas, and then with the occiput away from it in a cephalad posterior posture, holding the atlas.

8. Evaluate the cervical area, especially with rotation at C1, C2 and other cervical segments bilaterally.

9. Evaluate the sacrum. Mobilize the dural tube.

10. Palpate the lower extremities, pelvic and respiratory diaphragm. Evaluate the arms and thoracic inlet.

11. Recheck the quality of the vault motion and compare it to your initial findings. Reevaluate any sutural problems previously noted, and look for any changes which may have occurred.

Note: As you become more confident in your skills and in working with children, continue to blend and apply whatever CranioSacral Therapy techniques you feel are called for at that time; e.g., mouthwork or deeper sphenoid work.
Dysfunctions of Children

Notes:
Cranial Evaluation for Newborns and Infants

Protocol:

As you evaluate each of the following areas, correct them when indicated.

1. Hold newborn. Evaluate craniosacral motion, particularly quality, amplitude and synchrony.

2. Vault hold with vomer flexion/extension and sucking reflex.

3. Cranial base (adapted technique).

4. Sacrum and dural tube mobilization.

5. Diaphragms.

Note: The ability to palpate the subtle craniosacral rhythm and structures of an infant is necessary to be able to apply these techniques.
WHOLE-BODY EVALUATION

Objectives:

1. To evaluate general vitality, motivation, emotional status and/or biochemical dysfunction using the quality of the craniosacral rhythm.

2. To locate specific areas of dysfunction in the body and recognize them as cause or effect.

3. To differentiate active from inactive (or residual) lesions.

4. To develop skill in the use of dural tube evaluation, arcing and fascial mobility (glide and craniosacral symmetry/asymmetry techniques).

5. To use craniosacral rhythm to locate nerve-conduction problems.
Concept of Arcing and Its Clinical Use

Notes:
Facilitated Segments

Notes:
The Craniosacral System

Each person has a craniosacral rhythm. This is caused by the increase and decrease of cerebrospinal fluid produced and reabsorbed at a regular rate within and around the central nervous system (brain and spinal cord). It is palpated with the hands.

The subtle rhythm can be felt by a practitioner trained in CranioSacral Therapy. This regular rhythm (6-12 cycles per minute) can be felt all over the body. It is similar to the rhythms that can be felt when the pulse of the heart and respiration of breathing are evaluated.

The craniosacral rhythm, when felt in different parts of the body, can be used to diagnose asymmetry or unbalanced motion.

When unbalanced motion is found, especially when related to the head and sacrum, it suggests to the practitioner that normal body functions may be disturbed.

When body functions are disturbed, symptoms may develop. A practitioner in CranioSacral Therapy can usually help the body reestablish balanced motion with gentle, subtle techniques, thus assisting the body to return itself to normal function.

Notes:
Use of the Craniosacral Rhythm to Evaluate General Physiological and/or Emotional Status

Notes:
Fascial Glide

Asymmetry/Symmetry of Motion in Response to Induced Glide

Notes:

Differentiation of Active From Inactive Lesion Using the Above Techniques

Notes:
## Summary of Whole-Body Evaluation

1. **Arcing**
   - Discovers active (energy-producing) problem – no residual arcing after resolution – use it to evaluate the effectiveness of your therapy.

2. **Dural tube evaluation**
   - Facilitated segments – caused by active problem which may still be present or which may have been resolved. After resolution, facilitation may be self-perpetuating.

3. **Fascial glide**
   - Fascial mobility – active problem or residuum of resolved problem.

4. **Craniosacral rhythm**
   - Symmetry, Quality, Amplitude, Rate
     - Active problems or residuum of resolved problem. General vitality, evaluate paravertebral musculature to assess innervation of tissues.
THE ENERGY CYST AND SOMATOEMOTIONAL RELEASE®

Objectives:

1. To gain a functional conceptual framework upon which to place the energy cyst model.
2. To gain clinical experience in the techniques of Energy Cyst Release.
3. To gain a functional understanding of SomatoEmotional Release concept.
4. To observe and/or participate in the process of SomatoEmotional Release.
The Energy Cyst

The present model used by Upledger Institute International in its training programs is the result of many hours of interdisciplinary observation of clinical work and discussion between Zvi Karni, Ph.D., D.Sc.; Jon Vredevoogd, M.A.; Elmer Green, Ph.D.; Ernest Retzlaff, Ph.D.; and John E. Upledger, D.O., O.M.M.

It involves the traumatic input of energy into the subject's body, the retention of that energy as opposed to its dissipation, localization of that traumatic energy within the subject's body as an alternative defense against a more generalized negative effect, and the methods of inducing its release.

Notes:
Regional Tissue Release

Notes:
Significance Detector

Notes:
Energy Cyst Formation

This concept is based on the belief that physical forces which are put into a victim's body at the
time of an accident or injury may be dealt with by that victim's body in one of two ways:

1. The injured body may immediately begin dissipating these forces and the natural healing
   process will follow.
2. The physical forces imposed upon the victim's body may be retained rather than
dissipated.

If these forces are retained, the victim's body must adapt to this deposit of abnormal physical
force. The adaptive response is to isolate or “wall off” the abnormal force so that a sort of energy
cyst is formed.

This energy cyst represents a localized area of increased particle activity which is synonymous with
increased entropy. By this we mean that the ions and molecules are moving in a disorganized and
chaotic way so that they are not performing usual work and serving the whole body efficiently.

The energy cyst becomes an area of dysfunction as normal body energy must detour around the
energy cyst. The dysfunctional area does not cooperate with normal and vital tissue and fluid
motion, and thus the energy cyst inhibits normal body function.

A reasonably healthy body can adapt to and work around these energy cysts. However, extra
adaptive energy is required to carry out bodily function with this area of disorganized and un-
cooperative activity in its midst. As the years pass, the adaptive energy required for function is
spent, and the adaptive pattern of the body begins to lose some of its effectiveness. Symptoms
and dysfunctions begin to appear which become more difficult to suppress and ignore.

What Makes Injury Force
Result in Energy Cyst Formation?

The most powerful determining factor which causes energy cysts to form is the emotional status
of the victim at the time of the injury. When powerful negative feelings are dominant in the
victim at the time the external injury forces are imposed, these forces will probably be retained
and energy cysts will result. We have seen over and over again that those people who retain the
effect of injuries and accidents are those same people who harbor anger, resentment, fear, etc.,
regarding the incident. Once these negative feelings are discovered and released, the bodily
dysfunction with its attendant symptoms are free to leave the victim's body.
SomatoEmotional Release

SomatoEmotional Release is based on the concept that the whole body as well as each of its cells, tissues, viscera and systems have independent and yet integrated consciousnesses. A system of releasing obstructive emotional energies from the consciousness of any and all of these areas has been developed using this model. Therapeutically, the system is very effective. Yet as with all of our material, the model is subject to change as new information and concepts are obtained.

Energy Cyst Release is the precursor to SomatoEmotional Release. The former is focused upon more localized problems while the latter is global in focus.

Techniques will be demonstrated.

SomatoEmotional Release

What is it?

SomatoEmotional Release is a therapeutic process designed to rid your body of the residual effects of past injuries and negative experiences.

Where did it come from?

The concept of SomatoEmotional Release was developed during a three-year period (1977-1980) when Dr. Zvi Karni and Dr. John Upledger were working together as researchers in the Department of Biomechanics at Michigan State University in East Lansing, Michigan. Dr. Karni was a visiting professor on leave of absence from his position as Chairman of the Department of Biological Engineering at the Technion Institute in Haifa, Israel. Dr. Karni holds doctoral degrees in both biological engineering and biophysics.
How Does SomatoEmotional Release Work?

Since we began to develop this therapeutic process, we have observed that the victim's body seems to be of two “minds.” Part of the victim wants to maintain the status quo. After all, life is present and the body is working even though that work may be inefficient and painful. Why risk a change?

Another part of the victim is striving for improvement, which means that the energy cyst must be dissipated, thus ridding the body of the need for adaptation and discomfort.

During the therapeutic process of SomatoEmotional Release we act as facilitators in cooperation with the part of the body-mind that wants to get rid of the abnormal energy cyst formation. In order to do this, we encourage the positive aspects of your body-mind and discourage the negative aspects. We will help to expel the energy cyst from your body by facilitating the body's memory of the injury and thus ending the suppression.

This facilitation is accomplished by touch, tuning in to what your positive body would like to do and assisting in this process. The usual result is that your body will assume the position it was in when the external forces were imposed upon it. As this occurs, we can feel the tissues of your body relax as the energy cyst is expelled. We can also feel heat radiating from the areas that have been retaining the injury forces, and we can frequently sense a force leaving your body along the same direction line from which it entered.

You have probably guessed by now that the SomatoEmotional Release process requires extreme sensitivity on the part of the therapist and an attitude of trust and positivity on the part of the patient/client. It is a very mystifying experience for both parties involved. It is very difficult to describe in words, but once the release of an energy cyst has been experienced, it is clearly understood without need for verbal description.
Next Workshop in the CranioSacral Therapy Series:

SOMATOEMOTIONAL RELEASE® 1

In this workshop, CranioSacral Therapy techniques are integrated with various creative and dialoguing methods. Emphasis is on wholeness and self-healing. In this four-day course, participants learn how to assist the patient/client in physically identifying and expelling the energy cyst, and in resolving negative emotional experiences from the body. The goal of SomatoEmotional Release is a comfortable, holistic, body-mind approach to the resolution of problems and obstacles related to an individual's progress. This workshop also introduces the physiological mechanism of disease. Participants must complete CranioSacral Therapy 2 before attending this course.

Required reading; SomatoEmotional Release and Beyond by John Upledger, and a review of CranioSacral Therapy 2: Beyond the Dura.
The following references were used for this Level 2 study guide, as well as the CranioSacral Therapy 2 Study Guide. General Contributions by Clyde W. Ford, D.C.


Upledger, J.E. “CranioSacral Therapy Slide Series” (K4662-KCOM-Library Media Center) This slide set contains a life-sized model of human intracranial membrane, 36 colored 35mm slides and script. Upledger Institute, Education & Research, Palm Beach Gardens, FL.


Upledger, J.E., Vredevoogd, JD. *CranioSacral Therapy*. Easland Press, 1983


UPLEDGER INSTITUTE INTERNATIONAL
AND
ITS EDUCATIONAL CURRICULUMS

Continuing Education and Complementary Care

Upledger Institute International (UII) is a health resource center dedicated to the advancement of innovative techniques that complement conventional care. It's recognized worldwide for its groundbreaking continuing-education programs, clinical research and therapeutic services.

Founded in 1985 by John E. Upledger, DO, OMM, UII has trained more than 80,000 practitioners worldwide in CranioSacral Therapy and other gentle healthcare modalities. Today it conducts hundreds of workshops each year educating healthcare professionals of diverse disciplines.

The cornerstone of our educational training is CranioSacral Therapy, a gentle, hands-on, whole-body method of releasing restrictions around the brain and spinal cord to enhance central nervous system performance and allow the body to self-correct.

Developed by Dr. John E. Upledger after eight years of clinical research and testing at Michigan State University, CranioSacral Therapy has proven effective in aiding individuals with a wide range of medical challenges, including migraines, neck and back pain, fibromyalgia, chronic fatigue, TMJ syndrome, motor-coordination impairments, autism, central nervous system disorders, colic, learning disabilities, brain and spinal cord injuries, emotional difficulties, stress-related problems, neuro-vascular or immune disorders, post-traumatic stress disorder and post-surgical dysfunction.
CranioSacral Therapy
Developed by John E. Upledger, DO, OMM

CranioSacral Therapy (CST) is a gentle, light-touch method of evaluating and enhancing the craniosacral system, the environment in which the brain and spinal cord function. An imbalance or dysfunction in the craniosacral system can cause sensory, motor or neurological disabilities. These problems may include chronic pain, eye difficulties, scoliosis, motor-coordination impairments and learning disabilities, as well as other physical and psychological problems.

The CranioSacral Therapy curriculum begins with the entry-level workshop CranioSacral Therapy 1, which provides the critical foundation necessary to understand the functioning of the craniosacral system. Using palpatory skills to detect subtle biological movements, and fascial and soft-tissue release techniques in a 10-Step Protocol, participants learn to evaluate and work with the entire body.

CranioSacral Therapy Certification
Upledger Institute International offers certification in CranioSacral Therapy at two levels: a CST Techniques certification for those who have completed CS2, and a more advanced Diplomate level for Advanced CST alumni. Examination for certification at each level is a multi-tasked project including written, oral and hands-on testing.

CranioSacral Therapy Courses
- CranioSacral Therapy 1
- CranioSacral Therapy 2
- Unwinding Meridians: Applying Acupuncture Principles to CranioSacral Therapy
- Clinical Application of CranioSacral Therapy
- CranioSacral Dissection
- Therapeutic Imagery & Dialogue™ 1
- SomatoEmotional Release® 1
- Clinical Application of SomatoEmotional Release
- SomatoEmotional Release® 2
- The Brain Speaks™
- CranioSacral Therapy for Pediatrics™ 1
- CranioSacral Therapy for Pediatrics™ 2
- CranioSacral Therapy and the Immune Response
- CranioSacral Applications to Obstetrics 1
- Advanced 1 CranioSacral Therapy
- Clinical Application of Advanced CranioSacral Therapy
- BioAquatic Explorations
- Advanced 2 CranioSacral Therapy
- Advanced Preceptorship
- Advanced 2 Preceptorship
- CranioSacral Techniques for Estheticians
- ShareCare®
- Clinical Application of Cranio-Sacral and SomatoEmotional Release for Pediatrics
- CranioSacral Therapy and the Reversal of Pathogenic Processes
- Clinical Application of Advanced CranioSacral Therapy for Pediatrics
CST TECHNIQUES CERTIFICATION

Synopsis:
Earn your certification in CranioSacral Therapy from Upledger Institute International – and assure patients your training comes straight from the source.

Highlights:
• Ensures a keen understanding of anatomy, physiology and CranioSacral Therapy techniques.
• Opens opportunities in Preceptorship Programs with approved practitioners worldwide.
• Helps preserve the right of qualified healthcare professionals to practice CranioSacral Therapy.
• Paves the way to future healthcare legislation, licensing and insurance reimbursements.

Techniques Certification: Allows you to use the professional designation “CST” in your title.

Requirements:
• Complete a Techniques-level essay exam, objective exam and practical/oral exam that tests your ability to understand and apply CST techniques.
• Complete 75 10-Step Protocol Sessions

Prerequisite: CranioSacral Therapy 2

To register for Techniques Certification, call 800-233-5880/561-622-4334, ext. 2.
Here is a sample of our Techniques-Level Essay Exam
(One of our entire exams will be provided upon registration.)

CRANIOSACRAL THERAPY TECHNIQUES CERTIFICATION
Essay Exam A

This exam was designed with two major concepts in mind. The first is to test your understanding of the information presented in the CS1 and CS2 seminars, the study guides and the Craniosacral Therapy and Craniosacral Therapy 2: Beyond the Dura textbooks. As you study, please keep in mind that the techniques presented in the textbooks have been refined over the years. When reviewing the actual applications, you should refer only to your study guides and class notes.

The second concept is intended to inspire your thinking process. Some questions require an integration of your seminar experience, reading and patient/client experience. Remember, the patient is your teacher. Please answer each question using your own words and experience.

In order to pass the essay portion of the process, you need a minimum 80% grade on the essay.

Take as much time as you need and use whatever reference material that will help you to answer the essay questions. We do require the answers be typewritten or computer printed (we cannot accept e-mailed exams). You must include the complete question and number of the question at the beginning of each answer. We request that the printed font be large enough for the examiner to read easily and the pages numbered.

T1A2. Describe the anatomy of the intra-cranial and dural tube membrane system; include the clinical and physiological significance of each part of the system. (10)

T2A2. Describe the 10-Step Protocol from start to finish including specific techniques and their therapeutic significance as well as the chronological importance. (15)

T3A2. Describe a treatment scenario where you might divert from the 10-Step Protocol and how you would determine where to treat and with what techniques. (10)

T4A2. What is a release? (7)

T5A2. How would you respond to each of these patient/client questions and why would you respond in that way?

a. What is CranioSacral Therapy? (2)
b. How can it help me? (2)
c. How many sessions will I need for my ________ problem? (2)
d. I didn't feel much, why not? (2)
e. How come I feel pain in my _____ when I didn't feel it at the beginning of the session? (2)
The International Alliance of Healthcare Educators (IAHE) is a cooperative of Continuing Education providers who offer other workshops in alternative healthcare modalities.

The current modalities available through IAHE include:

- Brain Curriculum
- CranioSacral Therapy
- Feldenkrais Method
- Healing From the Core
- Heart Centered Therapy
- Lymph Drainage Therapy
- NeuroMuscular Therapy
- Process Accupressure
- Qigong T’chings
- Self-Corrective Mechanisms
- Visceral Manipulation/Nervous System
- Zero Balancing

The International Alliance of Healthcare Educators®
- Website: www.iahe.com
- E-mail: iahe@iahe.com

Find a Practitioner:
International Association of Healthcare Practitioners®
- Website: www.iahp.com
- E-mail: iahp@iahp.com

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- E-mail: upledger@upledger.com

All courses listed are intended to be taught as modalities for licensed healthcare professionals. Some courses may require prerequisite training.
SUBMITTING YOUR NEWS RELEASE TO LOCAL PUBLICATIONS

• Type the news release sample from the following page onto your letterhead, filling in the blanks as indicated. Be sure to include your name and a telephone number where you can be reached during business hours.

• Develop a mailing list of publications — daily and weekly newspapers as well as local magazines. Telephone these sources and ask for the name of the news editor. Your press release should be addressed by name to these individuals at their respective media outlets.

• Don’t forget to mail releases to any local professional organizations that publish newsletters, as well as to your school if you studied locally. Be sure to mention that you are an alumnus of that school.

• Include a 5x7 black and white photograph, if available, with your release. Be sure to put your name on the back and include a sturdy piece of cardboard in the envelope to keep the photograph from bending. It’s a good idea to print “Do Not Bend” on the envelope, too. Photographs often will not be returned.
FOR IMMEDIATE RELEASE:  CONTACT: Public Relations Manager (561) 622-4334  (insert today’s date) or (insert therapist’s name and phone number)

(INSERT HOMETOWN AND THERAPIST PROFESSION) PARTICIPATES IN UPLEDGER INSTITUTE CONTINUING EDUCATION WORKSHOP

(WORKSHOP CITY) – (Therapist name, professional title and hometown) recently participated in the CranioSacral Therapy (insert 1 or 2) workshop offered by Upledger Institute International, an innovative healthcare organization that offers continuing education courses to medical professionals worldwide.

The course is designed by osteopathic physician John E. Upledger, who developed CranioSacral Therapy and has taught the technique internationally.

CranioSacral Therapy is used to detect and correct imbalances in the craniosacral system, which may be the cause of sensory, motor or neurological dysfunction. The craniosacral system consists of the membranes and cerebrospinal fluid that surround and protect the brain and spinal cord. It extends from the bones of the skull, face and mouth — which make up the cranium — down to the sacrum, or tailbone area.

The therapy has been successfully used to treat headaches, neck and back pain, TMJ, chronic fatigue, motor coordination difficulties, eye problems and central nervous system disorders.

For information on CranioSacral Therapy or Upledger Institute International, please call 1-800-233-5880. Ask for priority code G-CSII.

###
MODEL FOR RESEARCH CASE STUDY
OR SINGLE-SUBJECT DESIGN

Introduction

Following are suggestions for a simple yet concise research case study or single-subject design. You can utilize sections 5 and 7 to expand on philosophy or constructs. Sections may even be omitted as appropriate. When most of this information is incorporated on an intake evaluation and discharge form, then only minimal effort is needed to make a publishable single subject design or case study format.

The submitted report will:
• Support the effectiveness of the therapy that was used in the study.
• Open opportunities to validate concepts and techniques within various professional forums.
• Reinforce the depth of your knowledge and skill as a published practitioner.

Report Format

A report could be divided into the following sections:

1. **Introduction**: What is the problem/diagnosis?
2. **Review of Literature**: Past medical history, etiology of the problem, date of onset, social history, previous treatment including surgeries for this problem (and results), and any diagnostics done.
3. **Procedure/Treatment**: Include all treatment procedures, modalities, exercise (home and office) treatment time per session, plus total treatment span (including frequency). If modalities were used, be specific as to any particulars. Mention specific treatment positions if appropriate for further classification.
4. **Outcomes/Analysis of Results**: Both functional and structural outcomes should be listed here, i.e., pre- and post-tests if applicable. (Try to get 2-3 measurements each pre-and post-test as it improves reliability and validity of treatment.) Measure outcomes functionally, also. (Most clinics/practitioners are obtaining this information from patients as well as the “objective” data.) Include patient’s self-assessment as well as therapist’s patient assessment. Rate a percentage of improvement (usually a scalar measurement).
5. **Discussion**: What do your findings mean? How do they add to the established body of knowledge? Where do you go with your results? Make recommendations for change for further analysis of the same subject.
6. **Summary**: An abstract. Summarize points 1-4 (for potential publication).
7. **Conclusions and Recommendations for Further Study**: Was the treatment successful? If so, how did you measure success? If not, what would you do differently with this individual?
8. **Appendices**: May include subject consent form (if appropriate), technical data, date of birth, treatment dates. (If no-name submission, use an identification process other than abbreviations or initials.)
9. **References**: If appropriate or beneficial for further research. Format as:
**UII-Approved Study Groups**

Following the completion of your class, you will be eligible to participate in an Upledger Institute-sanctioned study group that corresponds to the coursework you studied. Study groups offer a small-group environment where you can network, reinforce your skills and discuss case histories with similarly trained colleagues.

Study-group leaders may charge members a nominal fee.

**To locate a study group in your area:**

- See your class facilitator. A list of active study groups is available at the product tables at all workshops.
- Call Educational Services at 1-800-233-5880.
- Log on www.upledger.com. Go to “work with us” and click on the “study groups” tab on the left or cut and paste this url [www.upledger.com/content.asp?id=16](http://www.upledger.com/content.asp?id=16) into your web browser.

“**Study groups are worth their weight in gold. They build practitioners' confidence and help them remember the technical details. They're invaluable in terms of providing good, guided practice time. And practice is what really makes a good practitioner into an excellent one.**”

– Suzanne Scurlock-Durana, CMT, CST-D
Welcome... to the Upledger Institute International - Alumni Association! We are the world’s largest network for CranioSacral Therapy.

Alumni Benefits:
- As an alumnus of any Upledger CST course, you are part of the most respected group of CranioSacral Therapy-trained practitioners in the World
- Strength and support from being part of the World’s largest CranioSacral Therapy global network, with practitioners trained in over 100 countries
- Complimentary listing on the World’s largest CranioSacral Therapy practitioner referral and networking site
- Support through legislative efforts to increase awareness, recognition, insurance reimbursement and protect the right to practice
- Professional Liability insurance available at a discount
- Continued efforts to support recognition through various research projects

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