THE AUSTRALASIAN SACRO OCCIPITAL TECHNIQUE BULLETIN

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CERTIFICATION PROGRAM We have received communication recently from Dr. DeJarnette re. our proposed program. He has suggested some modification as to the conduct of the program, however the material for study will be as outlined and the examinations will be conducted as outlined. The Major has suggested that anyone who wishes certification should not have to attend compulsorily any series of Seminars anyway, it would be simple enough to sort out who knows what at the appropriate time. Other changes will have to be made but these are in the main administrative and concern the selection of certain Seminars for the presentation of advanced material and training of future leaders and teachers in S.O.T.

The main object of this program is not to show how smart we are, nor is it designed to show anybody up as inadequate. We are concerned that a great number of you need help in learning and also help in your clinics in the practical application of S.O.T. efficiently. We also wish to see those who have acknowledged proficiency in this work to have our help and encouragement to reach certain levels in order that others will turn to you and in so doing, you will fulfill that which we have been to you. We started teaching S.O.T. two and a half years ago with the object of improving the Australian chiropractors understanding and knowledge of Sacro Occipital Technique. We believe we have acheived a large measure of success in this. Many of you have learned well, many have come and had a look and then have done no more, others have come to many Seminars and are still not using the work correctly because of a lack of somebody experienced enough nearby showing the way, and others we are sad to say just fiddle about. Simply told both of us cannot be fairy godfathers to everybody. We are somewhat isolated and also have a practice to run. We also feel it is time some of the seedlings (and there are quite a few very healthy ones) to start maturing and to take your rightful place in the profession with us. So you see there is a change going on and now we enter a maturing phase and it is surely up to each one of you who are capable, to enter this program to learn how to help others as we have given understanding to you.

In the future there will be other important announcements relating to the altered course S.O.T. education is to take. In due course you will be informed as to the exciting developements to come.

HYPOGLYCEMIA CONTINUED (Dr C. Curtis Buddingh)

The proper categorizing of patients is the most important and most critical part of S.O.T. The blocks aid and correct the dural tension on the cord via the respiratory motion of the sacral boots.

Let's look at the category system from a different point of view. In a Category 1. there is a loss of normal motion which produces heel tension and pelvic indicators. Now look at the Category 2. as a hypermobility of the sacral respiratory action. In view of hypermobility, this would explain many of the neurological changes in a Category 2. patient. In theory, the hypermobility of the sacral respiratory boot mechanism would have to be proven one way or another just as in any other scientific experiment or application.

Hyperexcitability of the neurological cord reflexes of the sacral foramina via the cord tracts to the sixth dorsal (which previously researched out to be involved similar to dorsal eight) should also show a clinical or sub-clinical evidence of pancreatic hyperfunction and liver hyperfunction. In reveiwing the physiology and pathology, pancreatic hyperfunction would be termed as hyperinsulinism. Hyperinsulinism can be demonstrated by means of a glucose tolerance test of from four to five hours

NOW -- TO PROVE MY THEORY: I had the five hour glucose tolerance blood test done on various Category 2. patients. The test results were all positive hypoglycemic, with some more severe than others in the depth of the glucose tolerance curve. As random studies are not really a true scientific study, I had all my Category 2. patients, acute or chronic, take the glucose tolerance test. Suprisingly enough they all fell into the hypoglycemic blood pattern. Additional observation was made of the different stages and duration of the symptoms of hypoglycemia in relation to the nodular formation of the occipital fibres. These studies showed that the greater the nodulation of all four areas, the lower the blood sugar level went. this was inter-

esting in trying to redirect the curve of the sugar before the results were obtained via the blood tests.
The entire clinical picture of a Category 2. finally came to light and other questions were answered about the previously mysterious Category 2. For instance: The clinical symptoms change after the belt was applied and after the initial correction of the pelvis. In belting the pelvis, what are you doing besides aiding in the support of the sacroiliac ligaments ? First, you are slowing down the hypermobility of the sacral action, which changes the floor of the fourth ventrical - which is controlled by the pancreatic enzymes. Second, you are changing the sympathetic and para-sympathetic balance along with the autonomic nervous system.
If you recall, the attachments of the dura are the intercranial poles, the rim of the neural foramina, the ring of the atlas and the axis and are anchored to the sacrum at the second to fourth foramina. In a Category 1. you have hypomotion of the sacral and cranial cerebral spinal pump. In a Category 2. you have hypermotility of the sacral pump with hypomobility of the cranial function. The reason is that there is a slight inferior dropping of the sacrum which in turn is pulling the sphenoid-basilar mechanism into an extension position. When this takes place, you have an intercranial, neurological problem developing along with hypo-adrenia tendencies and the hyperinsulinism pattern.
In changing the patients diet and supporting the body nutritionally during the course of your Category 2. proceedure, you will find that the pelvis stabilizes twice as fast and recurrence of the position is greatly reduced.
The nutrition used on a hypoglycemic is as follows: Use one A-P Betafood and one pancreattrophin mid-morning, mid-afternoon and evening. If the patients blood pressure drops from a sitting to a standing position, also use one Irenamin mid-morning and mid-afternoon. If the saliva Ph is within normal range, you also support the amino acid and protein pattern with one protefood daily. If the Ph is below 6.8 and protefood is used, tachycardia may develope due to over acidifying the body. The supplements are used along with the dietary change, which means avoiding absolutely the following foods: ALCOHOLIC AND SOFT DRINKS: Club soda, dry ginger ale, whiskies and liquors. Sugar candy and other sweets such as pie, cake, pastries, sweet custards, puddings and ice cream. Caffeine - ordinary coffee, strong brewed tea, beverages containing caffeine. Potatoes, rice grapes, raisins, plums, figs, dates and bananas (starch and sugar). Wine cordials, cocktails and beer. (Alcohol content is a high carbohydrate.)
The above mentioned supplements are used for a period of approximately three weeks with a continued diet change. (Most patients that start changing the diet don't return to eating sweets since this will almost make them sick a few hours later, or the next morning.)
IN SUMMARY:
This is how hypoglycemia is developed when a person enters a Category 2. : The separation of the sacral boots and the weight bearing portion of the sacroiliac produces a hypermobility of the sacral respiratory boot action. This hyperactivity is reflexed to the sixth and eighth dorsals, producing hyperactivity of the associated viscera, pancreas and liver. The hyperactivity of the viscera, pancreas and liver produces the condition of hypoglycemia. If the viscera are not taken into consideration with the entire structural weakness, a reverse stimulation to the sacral area will be produced and prolong the union of the sacroiliac articulation to a normal functioning pattern.

QUESTION (answers to these questions are on the last page)
What is Coxa Senilis Malum ?
What is the difference between infectious arthritis and rheumatoid arthritis ?

TRUTH WILL COME OUT Research is not based upon exploration. If research were based upon science, we would be still riding in chariots. There are always those in all professions capable of being experts at "dispute". They have the faculty of knowing that the thing that someone else does and makes work, cannot work, because science say's it cannot. The bumble bee cannot fly if you believe physicists, but it does fly and well. Chiropractic is a fake if you believe the educated super-duper physiologist and anatomist and neurologist and diagnostician and prognostician. If we believe medicine we cannot believe chiropractic, because each is at wide variance to the other. If a

patient with an inflamed gall bladder responds to chiropractic adjustments, that same patient would not according to the rules, respond to medical care. A migraine patient worsened by chiropractic care, should conversely respond to medical care.
Look at all the physiological, neurological, and even anatomical truisms that have been developed since the advent of S.O.T. Their acceptance by physiologist, neurologist and anatomist does not make S.O.T. more efficient, but it does please the palate of those in S.O.T. who want everything we do to correspond to medical opinions. Your writer is always pleased when he reads a so called scientific tome and it parallels our thinking.
Within the space of 25 years, many things have changed in the world of science. Yet up to 45 years ago, those things then known were stated as facts and acceptable as facts. Change did not destroy the past, but did make the future more acceptable.
The dentist of 40 years ago used to pull teeth with one knee on the patient's chest. The dentist of today is a highly skilled professional because he did not wait for science to dictate his course.
If we in S.O.T. had waited until scientists (and that word is used advisedly) told us we were correct, we would always be fifty years late in every thing we have ever done.
The nameplate on the Apperson Automobile vintage 1912 had these words, " No hill too steep and no mud too deep". I saw an Apperson being pulled up a hill by a team of horses so I lost confidence in that make and bought a Ford.
The dural sleeve, to get back to date, was an unknown term anatomically even 7 years ago, yet it is a common term today. The dura mata was something dissectionists shunned so they did not give it to much attention, yet today it is a prime target of many researchers.
Muscles move bones...that has always been a fact, but when we first began using that statement 50 or so years ago, we were ridiculed. People just don't think to deeply most of the time.
The pelvis has always been a concerned part of man, and many great scientists have given it full attention, yet it was not until 1964 that the pelvis was used to adjust all of man by block placement. That was a wild idea then. It is accepted anatomically, physiologically and neurologically today, and will gain even wider acceptance in another year.
Chiropractors move vertebrae by thrusting onto them. Even D.D. knew we did not do that. Who wants to move a vertebra? Vertebra were not made to be moved. They were made to move to facilitate man's developements and abilities.
Those of us who spent so much time trying to figure out why X-ray films did not show vertebral changes commensurate with results, had many bad years, because we saw hundreds of patients who made marvellous recoveries, yet the listing of the adjusted vertebra did not change. This posed a problem of unbelievable magnitude, and it did drive many hundreds of chiropractors out of chiropractic. It even moved our good Dr. B.J. Palmer from the total spine to the atlas, for the atlas will move.
Vertebrae do not need to move anatomical positions to relieve dural pressure. The processes, the intervertebral cushions, are the things that move to remove dural pressures, but the most important change occurs in the muscles and ligaments that support the vertebra. If we chiropractors are not careful, research just might prove that Oakley Smith, the father of Naprapathy might just have been correct much of the time. We must also remember that the thrust into the vertebral contact, does change blood supplies and that is a very important factor. The osteopaths might have been correct.
When we look at all of man, we know that S.O.T. is correct, yet we also know that with time work and money, S.O.T. will be made better.

CANBERRA A most successful Seminar. We went thoroughly over the basics. It was borne out how correct our assessment of most of you was. You are weak in basics. We have little doubt that those who were in Canberra are ahead of all the rest and this will be on test in the months to come when we begin testing for the certification program. This was a two day Seminar and we are more than happy with a two day Seminar. For it keeps you away from your practice a minimum of time and in two days you get as much as you can absorb. The next introductory Seminar will take place either at the end of May or in June. The next Bulletin will contain details for Seminars scheduled till the end of the year.

NEXT MONTH From next month there will be a change in style of the type face. I am

getting another typewriter and the newsletters in future will be done in capitals just the same as the DeJarnette Bulletins. You should also have noticed that as of last month these Bulletins have grown to 5 pages long. A further change commencing in July will be the introduction of new material that we use in our clinic. We have made a number of wht we think are original findings and we will pass these on to you thru these pages. We hope you like our Bulletin and appreciate the time and effort involved.

OMAHA Dr. DeJarnette has called for an estimate of the number of Doctors wanting to attend this year. For he does not know how many to cater for. We have informed him that 20 Australians will be there. Final details for Omaha will be released by DeJarnette in July when he will call for confirmations. Whilst I do not know his plans yet as to the size of the Seminar we do know that qualified teaching staff are not plentiful. So there has to be a limit as to the number that can attend. This year the Seminar dates are 27-28-29 September (Cranial) 30-September-1-2-October S.O.R.S.I. At present the facilities at Omaha and with the number of competent instructors available only 450 can be handled for the cranial part so the question has been asked of the field as to the total who want to attend. If we have to many then there may be two cranial sessions both the same. The other would be on 24-25-26 September. This at the moment has not been decided however rest assured the dates for the Australians will be 27-28-29-30 September 1-2 October. This year once again there will be a tour arranged and great savings will be the result. So in order that reservations can be handled promptly both for the Seminar and the tour fill out the form at the end of this Bulletin and return. We both feel that opportunities in the future to meet this great man will dwindle so make this your year. Even in his last communication with the field DeJarnette had this to say" In future years, all S.O.T. teaching will be done by S.O.T.O. instructors. The Major knows that he will not last forever, but S.O.T. will, because it is the Alpha and Omega of Chiropractic."

THE S.O.T. ARCHIVES (reprinted from DeJarnette S.O.T. BULLETIN April 1976)
Dreams come true. A red headed young man visited us in Nebraska City some few years ago and he had dreams. Those dreams are materializing, and with Dr. Keith Bastian to sort of keep control over emotions, Dr. Scott Parker is going to make Australia the S.O.T. capitol of the world. Drs. Parker and Bastian now own every printed book available as of March 1976, written by the Major. They are the only persons in the world, other than Dr. M.B. DeJarnette, to be so priveledged. In years to come, those who wish references in S.O.T., will have to look to Australia or perhaps some place in the U.S.A. fortunate enough to be farsighted enough to see the other side of the mountain. S.O.T. is world wide. S.O.T. is a great influence in Chiropractic thinking today. It is perhaps studied more by other teachers of technique than all other techniques combined. S.O.T. is respected everywhere,and even 5 or 6 good D.C's in Nebraska support S.O.T. They may not defend it, but they do support it.

S.O.T. FACTS FOR S.O.T. THINKERS.
Category One block technique does not realign vertebrae, but it does realign dural sleeves.
Category two block technique does realign vertebrae, because it realigns the pelvis. You cannot realign any vertebrae until you align the pelvis. The atlas cannot be stabilized, until the pelvis is stabilized and fixed in adaptable stability.
The Category Three block technique basically opens the intervertebral disc spaces and increases the vascular flow throught the disc empire.
The Category One block position normalizes the legs within 30 seconds if blocks are properly positioned and your categorization is correct.
In Category One proceedure, the first 30 seconds are critical. The neurology has to balance within that 30 seconds if the position is to be maintained for dural sleeve correction. A failing dollar sign within that first thirty seconds is the red light flashing its warning and if you don't heed its warning, then the sirens will go off.
The Category Two block position normalizes the anterior pelvic supports before it begins its work into sacroiliac weightbearing canals. The Category Two block position does not normalize the leg length.
The Category Three block position equalizes the leg length within one minute and begins to open up the intervertebral disc spaces within two minutes. The S.O.T.O. and

posterior ileofemoral add strength to the Category Three block correction. In the Category Three, do not do crest or dollar signs and no cough testing. If the S.O.T.O. and ileofemoral ease the low back and sciatica, then you can complete your Category Three with the S.B. plus block position and patient and Doctor controlled traction and holding.
Give your category techniques time to operate. Don't smack the back every place it hurts, do not add insult to correction by twisting and turning and jerking and knee to back with shoulder lift. Try it once without the "pop" and see how wonderful the response.

CRANIAL TECHNIQUE If you honestly and truly want to render your patients a 100% service you have to know and use cranial technique. Please look at it this way. A man can have a perfect spine and pelvis, yet let one part of his brain go haywire, and that part of his body controlled from that part of his brain simply stops functioning. This man can spend a billion dollars on treatments of all types, but until he gets his brain fixed, he stays status quo. I know a person who had an unfortunate stroke about two years ago. He is paralyzed and he will always be paralyzed until he gets his left temporal bone adjusted properly. I do not care how many thousands of dollars this person spends on auxilary treatments, exercises, chiropractic adjustments; his paralysis will remain unchanged. The instant that temporal pressure is removed cranially that man will begin to function. Until that cranial pressure is removed, he can use his body reserves to conciously perform acts, but he will not recover his automated abilities, and he will begin to degenerate physically and mentally.
Cranial technique is oftentimes a long term care program. It takes a boy or girl twelve years to graduate from high school. That period of time is based upon the average brain's ability to learn just so much each day for a set period of time. If all of that knowledge is suddenly taken away from one of those girls or boys through skull trauma, even when the trauma is corrected, the brain cells that reform have to be retrained.
Cranial technique is not something you give a patient just to be doing something.
It is the most important thing you will ever learn or use as a Doctor of Chiropractic.
Take a human being. Divide him into two parts. Part one is the skull. Part two is all of the rest of this person. Part one controls 80% of that person. The 20% remaining is a transmission or communications system. If the part one fails in vital function. The total man is kaput.
You can spend 99 years in China studying acupuncture, but until you learn cranial technique, you haven't learned what man is all about.
It is totally amazing the influence the cranium has upon man's functions. Simple personality changes which undermine so many human lives, cannot be cured with pills or electro shock or chiropractic spinal adjustment, but it can be cured when the right cranial correction is given.
Ninety Nine people out of every hundred in every city, hamlet and farm in the world, need a cranial adjustment today. They will survive without it and with the help from medicine and chiropractic and diet and religion and love, but they will never truly know what total health is until they get their noodles fixed by an expert.

JOTTINGS A very fine Health Newsletter is now being printed in the U.S.A. and would seem a very worthwhile aiition to your reference library. It is 'THE HEALTHVIEW NEWSLETTER' 2677 State Highway 70. Manasquan, N.J. 08736. 12 Issue subscription (1 Year) to all foreign countries $24.00. U.S.A. & Canada $18.00. Currency stated US$.*
I have been asked for an opinion of Bio Energization which has been developed by a Dr. Morter. It sounds interesting and may well be the link in helping our Category Two patients who have emotional involvement. I have written away to the U.S. seeking any further information which I may be able to pass on to you. For those who would like further information on a future seminar on this work here in Australia then you should contact Dean Lines D.C. in Berri S.A. promptly as the viability of this seminar demands a sufficient number of interested chiropractors. *

I AM A DEFINITE STARTER FOR OMAHA THIS YEAR.
NAME..... ADDRESS.....

I WISH TO GO WITH THE GROUP TOUR..... HOW MANY ARE YOU TAKING WITH YOU?..... (include yourself)
Return this to us promtly please.

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