SACRO OCCIPITAL TECHNIC BULLETIN

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Category One

How many Category One patients do you adjust per day? In some offices, probably not any. In other offices, probably several Category One patients are seen. The Category One is about as elusive as a $20.00 gold piece, but we must remember that you are born as a Category One if you are born correctly, and you leave this world as a Category One unless the leaving is a sudden, accidental demise. We are often impressed by the amount of pain a patient has, and in such instances, we seldom think in terms of a Category One. You must recognize that the act of living a normal day is the result of a normal Category One state of the total body. When your day is interrupted by a pain here and there, you probably think of a Category Two if the pain involves the lower back…or a Category Three if the pain involves the lower extremities. We must remember that the Category One can be involved in the pain of a gall stone or kidney stone attack. It certainly is involved in the acute coronary or anginal attack. The headache that sends a patient home from work is often a Category One problem. The cold or influenza can be due most often to some part of the Category One other than a Category One failure.

The Category One is a failure of some system of the body that interrupts function and distresses structure. In 60 years of chiropractic practice, I have never seen a case of allergy that was not a Category One, interspersed at times with a Category Two or even Three. I have never seen a case of constipation that was not a Category One, unless I happen to see that person when he or she had an acute Category Two. Remember that every person alive is a Category One when they do not feel up to par. We often attend seminars when all we hear is some new wrinkle on Category Two. Category Two is the most abused of all the human functions we are asked to repair. Category Two is truly the playground for the muscle testers and the leg pullers.

Circulatory problems are prone to be Category One problems in that they complain of so many structural problems that we often fail to investigate for Category One.

Guiding Answer

Remember, whenever a patient has an occipital fiber that is woefully painful to testing, that person is a Category One…maybe not today, but soon. The occiput can portray many structural deviations. It is truly miraculous when we finally get around to a Category One and take the problem seriously enough to see the patient every third day until resolution takes place. Remember, Category One is total man… everything he has or wears, occupation, family, kids…it is all there and has to be sorted out. Category One should be spelled EMOTIONS.

We must remember that Category One is primarily concerned with degenerative diseases such as M.S, A.I.S., Parkinson's, senility, etc.

Most SOTers look upon Category One as something to do when they cannot get results with any other procedure. Category One is the primary concern of the human systems, and when any system is deranged, all systems are dysfunctioning to a greater or lesser degree.

Category One Analysis

This should be part of your office routine for every patient every time you see that patient. A category diagnosis today does not mean that the same routine is in order the next time, without proof of that same need. Don't look at the case history sheet and make your procedure fit that which you did last visit.

Visual Analysis

The Category One has a locked pelvis because the boot part of the sacroiliac articulation is out of reciprocity with its opposite boot. This causes the pelvis to lock so normal sacral respiratory motion can

be obtained as a compensating factor. By *normal* we mean as nearly normal as possible under the present circumstances. A locked pelvis is man's most abnormal problem.

Distortion Analysis

You should have a distortion analyzer in every treating room and you should use it on every patient every time you see that patient. In the Category One, the sacral crest does not move during respiration except for the maximum compensation, which would be about 1/8 inch right or left.

First Rib Test

The Category One has motion when the cervicals are placed in flexion and extension. This is the only category in which this occurs. This is merely a respiratory compensating factor. Place patient prone in Category One with pelvis on table board.

Heel Tension Testing

Grasp both heels and traction with thumbs across calcaneus bones. One heel should be more rigid than the other.

Correct Heel Tension

If heel tension is in the right heel, have patient grasp the left headpiece of the table, and the doctor, using both hands, grasps the heel with thumbs across calcaneus bones. On each deep breath the patient pulls with the left hand as the doctor tractions the right heel.

Measure the Internal Malleoli

When heel tension is corrected and both heels feel equally pliable, place the internal malleoli together and determine which is superior. The superior internal malleolus is the short leg. Make a note of this on the case history sheet.

Blocking

Block according to the 1984 SOT manual. It is very important that this blocking be accurate. Here is where we actually correct the pelvic structures. The posterior ilium is the short side, the anterior ilium the long leg side. Following placement of the blocks, of your previous procedures were correct, the legs will balance within thirty seconds. This is how you determine the compatibility of your blocking. If you did not do the heel tension correctly, or measure the legs correctly, the legs will not equalize, and in fact, will worsen, and the patient will react badly to the blocking. If all goes well and the legs balance, or the short leg becomes the longer leg, this is normal. Blocking time up to this point is from 5 to 15 minutes depending upon the response to your testing of the crest and dollar signs. When either the crest or dollar signs improve, you are then ready for the crest or dollar sign adjustment. It is now very important that you distinguish between the two crest and the two dollar signs as to which is the major. By major, we mean normal. Tension returns to the dollar signs and relaxation to the crest muscles. You can test them for pain qualities if this is easier for your. The minor crest or the minor dollar sign will be the more painful.

Selection of Crest or Dollar Sign Major

The crest sign is an indicator of muscle imbalance and the dollar sign is an indicator of neurological imbalance. It is essential for health that the muscular and the neurological systems balance because one commands and the other performs. If you balance the crest and dollar signs, you have accomplished a therapeutic goal that will bear fruit down through the years. The problem is that in SOT we look for Category Twos when we should be normalizing Category Ones. Category One is your life and how you feel each day. Category Two is that "down in the back" that worries you but does not destroy you, except if neglected it will so enervate you that life seems impossible. We feel that most of us devote more time to Category Two trying to fool nature, when we should be trying to improve nature by correcting as best as possible, the hidden Category One system.

When you have completed the adjustment of the major crest or dollar sign, you are ready for that most critical period in this patient's day, the cough test and the flexion and extension technique.

The Cough Test

This is the only test ever devised that actually tells the doctor if the patient is being disabled by an over-flexion or extension of the dural membranes. It is a fact that few humans past the age of 30 years are ever totally in flexion or extension and such must take place nineteen times per minute normally. This is respiratory motion of facilitation. As your dura flexes and extends, so does your day. Cough technique is explained in SOT 1984 manual on pages 93, 94, 95.

It is essential that you do this cough test as described. Flexion is equally important to extension because without flexion you cannot have extension. Being narrow minded in this regard is being unwise.

The Vasomotor Subluxation

Here is where the chiropractor selects that one vertebra that is the primary cause of all subluxations. This is it and it needs to be precisely accomplished. Spinal manipulators never adjust specifically because they do not know how to adjust specifically. That one vertebra has torqued the spinal cord dura and until it is correctly adjusted, we will have a complaining patient. When it is correctly adjusted, live force flows in a true rhythm.

Placing Blocks for S.B. Minus

Blocks are placed under the ischium, right and left…doctor's right hand over the sacral base. We must place the dura in total flexion in order to un-torque it. As the patient pulls with hand and takes a deep breath, the doctor presses anterior on the sacral base. This is done until that one area of the vertebral system blanches clearly and concisely. This is the crucial subluxation. This is all explained in the 1984 manual on SOT…pages 96 through 100.

Placing Blocks for S.B. Plus

Both blocks under the anterior superior iliac spines (A.S.I.S.)…doctor's right hand over the sacral apex. Patient tractions and takes a deep breath. Doctor presses anterior on sacral apex. Repeat until that specific vertebral area blanches. This is the subluxation that torques the dura…explained in SOT 1984, pages 96 through 100.

Research

SOT dares you to research what we teach. Teaching and writing is like laying your soul bare before the board of the judgment society that determines your fate after you are gone. We welcome research. In reality, those doing research on our research are reaping the benefits of our research. We most often suffer the tears of failure. A technique must live by criticism and when such is well meant and constructive, it is useful. Often in the past it was totally destructive by intent. All mankind resists improvement.

Category Two

Category Two is a slip, separation, or inflammation of the "e" part of the innominate as it joins the sacrum. The weight-bearing part has no motion in the adult normally, has no muscle support, and is totally dependent upon tendons and ligaments for support.

The Arm/Fossa Diagnosis

Until the advent of the arm/fossa test for the Category Two (Sacroiliac articulation dysfunction), the tests in use were cumbersome and indefinite. The arm/fossa test gives those in SOT a definitive upper and lower motor neuron test which defines the weight-bearing part of the sacroiliac articulation is either capable of performing its functions or is incapable.

Prior to the advent of the arm/fossa test, we in SOT used the upper and lower fossae as palpating areas to determine tension as indication of abnormality of support and function. Tension is a process of determined tone, not pain. We found a relationship between tension in the upper fossa and position of the innominate as being posterior at the P.S.S…Tension in the lower fossa as being associated with the ischial area being anterior of normal. Associated with the upper fossa, we find tension on the medial side of the knee and a short leg. Tension in the lower fossa shows stiffening and tension of the iliofemoral region of the lateral femur and a long leg. This was technically known and described in SOT as the UMS and the LLL.

This was the era before the invention of the DeJarnette blocks and his system of blocking for realignment of structure.

The manual adjustment was precise and was described in Dr. DeJarnette's publications prior to 1966.

Many things occurred in the period from 1962 to 1966. In research, you either have a bountiful harvest or you have a crop failure. The harvest was good during that period described above and out of that research came the greatest improvement in the history of non-invasive therapeutics, namely, the pelvic blocking and the categorization system that indicates the type blocking that will be the most useful.

The Arm/Fossa Test

This test originated from many years of research on the upper and lower motor neuron systems of the body which are so important that life and motion depend upon their reaction to everything you come in contact with or do.

The arm/fossae technique is fully described in the 1984 SOT manual, pages 143 through 210.

The arm/fossa test must be used as described or it is unreliable. The use is a three phase maneuver… namely…arm to be tested is upright, grasped at the wrist by the doctor. The free hand is the fossa hand and it is used to excite the reflex that controls the outcome of the test. The inguinal fossa is a very sensitive area on both men and women and the test involves a touch, not a palpatory pressure. This touch is similar to using a pain wheel on any part of the body. The command that excites the neural reflex is "Hold," and immediately the doctor pulls on the arm, footward. This is a timed reaction test and must be done in strict order. The upper fossa on the test side is first and involves the upper half of the fossa. The lower fossa is then tested with the same technique. *(To be continued in the May SOT Bulletin)*

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