

CranioSomatic Therapy for SOT Categories 1 and 2

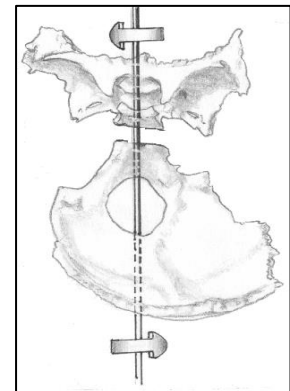
Sacro Occipital Technique is a chiropractic treatment method developed by Major De Jarnette, DO, DC. After years of research he classified his patients' conditions into three categories of problems. Category 1 is described as a lesion of the anterior synovial portion of the sacroiliac joint. Category 2 is described as a lesion involving the posterior ligamentous (weight-bearing) portion of the sacroiliac joint. Category 3 is described as relating to sciatic nerve problems resulting from bulging discs, foraminal compression, psoas muscle spasm, or piriformis muscle entrapment.

The etiology of the first two categories may be the presence of two chronic, perhaps universally-present, cranial distortion patterns: a craniosacral Right Torsion and a Left Lateral Strain.(1) This conclusion is based on years of clinical observations that when these two chronic cranial patterns are eliminated by the CranioSomatic Therapy cranial procedures, the symptoms and indicators of the Category 1 and 2 conditions, and often Category 3, are also eliminated. These include a functional Short Leg, Heel Tension, positive Arm Fossa tests, Dollar Sign test, and the global imbalance in the function of paired muscles described below.

Chronic Right Torsion

The Right Torsion pattern is described in osteopathic cranial literature as a cranial condition in which the sphenoid and occiput have rotated in opposite directions about a hypothetical A-P axis extending through nasion and opisthion.(2) The right greater wing of the sphenoid has moved superior and the right lateral angle of the occiput has moved inferior. The bones of the vault and facial regions have been carried into unique positions by the movements of the sphenoid and occiput.

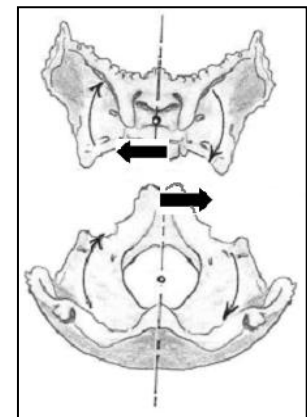
Based on osteopathic quadrant analysis, the bones of the right anterior and posterior quadrants are in external rotation and the bones of the left anterior and posterior quadrants are in internal rotation. This means that the right frontal and temporal bones are in external rotation and the left frontal and temporal bones are in internal rotation. However, multiple sphenobasilar patterns can occur simultaneously; these can offset the chronic patterns. The sacrum is described as tipped inferior on the side of the inferior occiput (right) with the right side rotated posteriorly. These sacral movements result in a compensatory four-opposed rotational spinal scoliosis.



Right Torsion

Chronic Left Lateral Strain

The Left Lateral Strain is described in osteopathic cranial literature as a cranial condition in which the sphenoid and occiput have rotated in the same direction around hypothetical parallel (paired) vertical axes.(2) The axis for the sphenoid passes through the center of the Sella Turcica; the axis for the occiput passes through the center of the Foramen Magnum. The combined movements of the sphenoid and occiput occur in the horizontal plane and result in the left side of the cranium moving anteriorly and the right side moving posteriorly. The sacrum is described as rotating about its vertical axis with the left side moving



Left Lateral Strain

anteriorly and the right side moving posteriorly.

Symptoms

The asymmetry that results from the combination of these two patterns is demonstrated by the following postural and functional evaluations. These evaluations employ a variety of methods of analysis including visual observation, palpation, active and passive ranges of motion, manual muscle testing, static challenge, and therapy localization. They are performed in the standing, prone, and supine positions.

The standing postural evaluation generally reveals that the ears, shoulders, and iliac crests are not level. In the prone position there is generally a functional short right leg with heel tension and a flaccid right gluteal region (SOT 'minor Dollar Sign'). In the prone position, manual muscle testing of the Right Torsion demonstrates that the left posterior shoulder extensor muscle group and the left Gluteus Maximus test strong (facilitated), whereas the same muscles on the right test weak (inhibited). In the supine position, manual muscle testing demonstrates that the left shoulder flexor group and the left hip flexor group appear to be inhibited, whereas the same muscles on the right appear to be facilitated.

In general, if a paired postural muscle tests strong on one side it will test weak on the other. For example, the Psoas tests strong on the right and weak on the left; the Tensor Fasciae Latae tests strong on the left and weak on the right; the Piriformis tests strong on the left and weak on the right; the Sartorius tests strong on the right and weak on the left; and the Latissimus Dorsi tests strong on the right and weak on the left. Based on an evaluation of 40 paired muscles, this imbalance between paired muscles usually holds true for most of the other muscles.(3)

Muscles of the eyes and mandible are also involved in the musculoskeletal imbalance. If any strong muscle (used as an 'indicator muscle') is tested while the patient looks to the right, the indicator muscle will typically weaken. If one eye is covered, the indicator muscle will also usually weaken when the uncovered eye looks superior, inferior, left, or right. The muscles of mastication are also involved. If the patient shifts his mandible to the right, retracts his mandible, or fully opens his mouth, the indicator muscle will also typically weaken.(3)

The Left Lateral Strain is characterized by a series of horizontal rotations. The pelvis is rotated to the right, the dorsal ribcage to the left, the shoulders to the right, and the upper cervical region to the left. The presence of the Left Lateral Strain can be confirmed by the weakening of a strong 'indicator' muscle when the left shoulder and left innominate are pressed posteriorly, and when the right shoulder and right innominate are lifted anteriorly.(3)

The cranial Right Torsion pattern appears to be the source of most of the symptoms of both Categories 1 and 2. If SOT pelvic blocks are placed under the supine patient in the typical positions for treating a right Category 2, with the high block under the right iliac crest and low block under the left acetabulum, most of the weak muscles associated with the Right Torsion will strengthen. Other Right Torsion indicators, such as those associated with eye and mandible movements, will disappear. However, if the patient is retested after becoming weight-bearing and walking for a few feet, the strengthened muscles will again test weak, and the indicators associated with eye and mandible movements will generally have reappeared.(1)

The fact that the symptoms described above disappear with the Category 2 blocking procedure confirms that the pattern is a Right Torsion and that the blocking is able to temporarily correct

the torsion pattern in the pelvis and spine. The fact that the symptoms return upon weight-bearing indicates that the pelvic blocking does not correct the chronic cranial portion which appears to be dictating the Category 1 and 2 spinal and pelvic patterns. Correction of the cranial Right Torsion pattern requires specific cranial treatment procedures.(1)

Treatment Considerations

Chiropractors and osteopaths use a wide variety of modalities to treat cranial, spinal, and pelvic patterns and their compensatory neuromusculoskeletal dysfunctions. However, manual muscle testing and other evaluation procedures from Applied Kinesiology demonstrate that the chronic Right Torsion and the Left Lateral Strain patterns, as well as their compensatory neuromusculoskeletal patterns, are almost always still present in the general and clinical populations. These findings indicate that the treatment procedures currently in general use are not effective in correcting these chronic patterns.

These chronic Cranial Patterns can be considered ‘pseudo-structural’ in the sense that the position and function of the cranial components, and the resulting chronic patterns of musculoskeletal compensation, are both long-standing and require changes to the cranial soft tissue holding elements to release them. The resolution of these patterns requires knowledge of cranosacral treatment procedures. It also involves new concepts and the application of new treatment procedures. These include adequate force (a pound or more for some releases), and a handhold capable of applying and maintaining the forces needed to release the cranial soft-tissue holding elements and mobilize the osseous cranial structures. CranioStructural Integration (CSI), the third workshop in our CranioSomatic Therapy series, provides these cranial concepts and procedures.

CranioStructural Integration treatment procedures generally eliminate the chronic Right Torsion and Left Lateral Strain cranial patterns, as well as the somatic symptoms of the Categories 1 & 2 conditions, in the first 30-minute treatment session. (Contrary to some teachings, it is not necessary to limit the number of procedures performed in each visit.) Once performed, most of these procedures never need to be repeated. A second treatment session is needed to free the 14 facial bones. The patient is rescheduled for a third visit in two weeks to confirm that the muscle imbalances and other indicators have not returned. The two-week break in treatment allows the patient’s body time to adjust to the musculoskeletal changes. At this point, other complaints / problems can be addressed with follow-up visits scheduled as necessary.

The use of pelvic blocking in releasing the two chronic cranial patterns is limited to blocking the Left Lateral Strain on the first visit; no further blocking is used. Because the chronic Right Torsion cranial pattern is removed by cranial procedures, it is not necessary to block the patient for Category 1 or 2. Also, because the Category 2 condition is caused by the cranial patterns described above and is generally not a sprain / strain pattern of the sacroiliac joint as commonly described in sacro occipital literature, it is generally not necessary for the patient to wear a trochanter belt. After the first treatment the patient should be able to jog around the room without the Category 2 or the imbalance in the strength of paired muscles returning. Once the CranioStructural Integration procedures have been performed, the chronic Category 1 and 2 indicators should be gone.

The strength of paired muscles should still be balanced on the patient’s next visit; the chronic Right Torsion release does not need to be repeated. However, there are 10 named sphenobasilar

(SB) patterns, including SB Right Torsion and SB Left Lateral Strain, which are functionally compensatory to postural distortions, shoes, glasses, and activities of daily living. Each SB pattern produces a unique pattern of musculoskeletal compensation by which it can be identified. The functionally compensatory SB Right Torsion and Left Lateral Strain patterns, when they do occur, generally produce the same musculoskeletal symptoms as the chronic Right Torsion and Left Lateral Strain patterns. This means that a return of a global imbalance in strength of paired muscles can be used to identify a functionally compensatory Right Torsion pattern.

SB compensatory patterns are often transitory and are easily corrected by cranial range of motion techniques or pelvic blocking. They may self-correct if the activity which is causing them is terminated. For instance, the SB Torsion pattern may be eliminated by simply sitting on a chair with a level seat rather than one that is tipped. A second example would be to stop wearing worn shoes that may have been distorted by the chronic Right Torsion pattern. The patient should bring shoes to the office on the next visit to be tested in.

References

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