CranioSomatic Therapy for SOT Categories 1 and 2

Sacro Occipital Technique is a chiropractic treatment method developed by Major Bertrand 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 all three of these categories may be the presence of two chronic, almost universally-present, cranial distortion patterns: a Right Torsion and a Left Lateral Strain. This conclusion is based on years of clinical observations that when these chronic 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 test, Dollar Sign and the global imbalance in the function of postural 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. 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 region have been carried into specific positions by the movements of the sphenoid and occiput. 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 rotational scoliosis.

**Chronic Left Lateral Strain**

The Left Lateral Strain is described in osteopathic cranial literature as a cranial condition in which the sphenoid and the occiput have rotated in the same direction around hypothetical parallel (paired) vertical axes. 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 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, which employ a variety of methods of analysis. These include visual observation, palpation, active and passive ranges of motion, manual muscle testing, static challenge, and therapy localization. A 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’).

Working in coordination with the tipped sacrum and compensatory scoliosis created by the Right Torsion, the Left Lateral Strain results in a series of horizontal rotations, beginning with the pelvis. 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. These rotations can be confirmed by the weakening of a strong muscle when the left shoulder or left innominate is pressed posteriorly.

Manual muscle testing in the prone position demonstrates that the left posterior shoulder extensor muscle group and the left Gluteus Maximus test strong, whereas the same muscles on the right test weak (inhibited). Manual muscle testing in the supine position demonstrates that the left shoulder flexor group and the left hip flexor group test weak, whereas the same muscles on the right test strong. In general, most paired postural muscles test strong on one side and 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 left and weak on the right; the Sartorius tests strong on the right and weak the left; and the Latissimus Dorsi tests strong on the right and weak on the left. This imbalance between paired muscles usually holds true for most of the other postural muscles.

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.

**Musculoskeletal Effect of the Chronic Right Torsion**

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 blocking 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 have reappeared.

The fact that the symptoms described above disappeared with the Right Torsion 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 immediately returned 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.

**Musculoskeletal Effect of the Left Lateral Strain**

The imbalances between the right and left paired muscles are mostly associated with the Right Torsion pattern, but because of the integration of the torsion and the lateral strain pattern some of
these muscles may not strengthen after correction of the torsion until the Left Lateral Strain is also released. These include the Psoas, Tensor Fasciae Latae, Pectoralis Major (Sternal and Clavicular divisions), and others. It can be observed that imbalances in these muscles are present in stand-alone torsion patterns but not in stand-alone lateral strain patterns. The Left Lateral Strain does have some characteristic imbalances in paired muscles. For example, the right middle Trapezius tests strong on the right and weak on the left; the right lower Trapezius tests strong on the right and weak on the left; the right Quadratus Lumborum tests strong on the right and weak on the left, etc.3

Treatment

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. On the other hand, both chronic cranial patterns and their associated compensatory patterns can be easily, and permanently, eliminated in several short treatment sessions by applying the appropriate cranial concepts and procedures.3

CranioSomatic Therapy treatment procedures generally eliminate the chronic Right Torsion and Left Lateral Strain cranial patterns, as well as the symptoms of the Categories 1 & 2 conditions, in two short 30 minute sessions using cranial procedures. (Contrary to SOT teaching it is not necessary to limit the number of procedures performed on each visit.) Once performed, these procedures never need to be repeated. 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.

After removing the chronic cranial patterns it is generally not necessary to block the patient for a Category 2 condition. Nor is it generally necessary for the patient to wear a trochanter belt. 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 the SOT literature. Once the CranioSomatic Therapy cranial procedures have been performed, the chronic Category 1 and 2 indicators should be gone. The cranium should not be in any SB pattern.

The Left and Right Torsion patterns and the Left and Right Lateral Strain patterns are now functionally compensatory to shoes, glasses, and activities of daily living (as are the other six SB patterns). However, as functional patterns, these and the other sphenobasilar patterns are often transitory, and are easily corrected by cranial ranges of motion techniques or pelvic blocking. It should be noted that a function SB Right Torsion or functional Left Lateral Strain will produce the same symptoms as the chronic ones.

References