THE AUSTRALASIAN SACRO OCCIPITAL TECHNIQUE BULLETIN,
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November 1974.
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MELBOURNE. Surely this was one of the greatest Annual Conventions ever. The organisation was handled superbly by Graham Hunt our new President who richly deserves our thanks for a great effort. The Old Melbourne was a great setting for our funtions. Dr. De Rusha gave us all a lesson in Anatomy and Physiology, he opened our minds to many things. We were glad to welcome so many fine NZ Chiropractors this year and we hope that meaningfull discussion co-operation etc. will continue for they were a fine group.
Keith and myself were priveledged to present a short introduction to SOT. at this Convention, a first we believe. For always traditionally an overseas speaker only has been used. We fully believe that Australia has within it's borders many Chiropractors who can add something to our Convention each year.

OMAHA CRANIAL 1974. All saw SOT at its best as represented by the ultimate in the healing arts, DeJarnette Cranial Technique. All of those present saw things happen in seconds that nothing else could make happen in a lifetime. We saw what happens when you turn on the brain currents. We saw the new thing in totality as it relates to man's management of his nervous systems. Done painlessly and for good, however it could go the other way. We must all learn to respect and manage that great force in life... your total nervous system.
We saw Doctors and students in Omaha that will reach the top in skills because they will accept principles, and develope the skills required to manage those principles. We saw others who will sit for ages and ponder the movements involved in Flexion and Extension, and will end a life of doubt sinking into more despair. THE INFANT DOES NOT QUESTION HIS ABILITY TO LEARN TO SIT UP, STAND UP, WALK AND TALK. HE DOES AS HE IS TOLD TO DO. WHEN HE REACHES SCHOOL AGE, HE BEGINS TO DOUBT BECAUSE HE REFUSESPRINCIPLES UPON WHICH HE CAN BUILD. FEW PEOPLE ACTUALLY OPEN THEIR MINDS TOTALLY TO ANY PRINCIPLE. THEY FOG THE ISSUES WITH OWN INTERPRETETIONS.
If your life is dedicated to non principles, it is dedicated to total failure in all things. When you grow big enough to build on principles, then you can begin to ask why principles do certain things. You cannot understand why stepping on a banana peel is a liability untill you step on one, and or see some other person step on one, and they accept principles.
Sacro Occipital Technic is taught on principles. DeJarnette Cranial Technique istaught on principles. If we taught you all of the why's before we taught you the hows you would be 90 years old before you were ready for the hows, and the whys will never make you even 1% of what the hows will make you. Do you want to be poor with whys or rich with "hows". Choose your goal.

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ANSWERS The October question found only one correct answer of those sent in.
Always block on the heel tension side. The leg which is not the heel tension side will always get longer with cough test.
QUESTION. Category 2. (New System) The arm test is weak on the upper fossa on the left. The right leg however is short. Is the patient blocked this visit or do you wait for another day when the upper fossa and the short leg coincide ?.

THINK ABOUT CATEGORIES. Can you think of a better way to handle sick and injured humanity than by the category system? Those who stick to the categories get results and keep out of trouble. A category is a position for certain patients with certain manifestations. The category system was built out of a study of thousands of case histories. A category is not a patient with a disease, but rather a disease that has a patient locked into a pattern. We often think of categories as patients with a sciatica but not a spinal incline, or a patient who cannot cross his legs in comfort, or a patient who is dizzy as a goose with a twisted neck. we think to often of what the patient looks like, or complains of, as being more important than the patterns he fits into.
You would anticipate that a patient had the itch if he kept on scratching day after

day. Would you consider the itch or category most important?
A patient who sat and held his head as if he were afraid to let the force of gravity contain it, would be presumed to have a migraine if he kept his eyes closed, or a stiff neck if he kept looking around to see that no one would run over him. You see a patient with 'psoriasis' and you say, " you have psoriasis". You could be wrong. Perhaps the psoriasis has the patient because the patient fits a pattern psoriasis likes. Suppose the patient with psoriasis has sciatica. Now the whole picture changes. You now think of the sciatica because that is what the patient is going to pay you to remove.
It would be a miracle if every patient could be placed into a positive category and then a step by step procedure prescribed. If this were possible, we could set up computers and mechanize all of chiropractic.
Basically, categories cover three typical patterns, but patterns are not always typical when they breathe and communicate. Way back in 1934, we had the typical and atypical distortions. We had the acute, the subacute and the chronic distortions. We knew categories existed, but it took until 1968 to get them organized, and then to fit the correct proceedure to their component subluxations.

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CATEGORY ONE AND TWO. A category 1 patient as you understand one from S.O.T., suddenly stoops to pick up a shoe. A sacroiliac weightbearing surface slips. It has been 2 years since you saw this patient as a category 1. The patient has gone through many episodes in the past two years. There have been two deaths in the family...a pregnancy no one wanted to happen...a divorce...three jobs...two automobiles and a complete new living room furnishing. You cannot look at your two year old case record card and order a procedure today for today's problem, without doing some exploratory analysis. You have to begin all over again. (Hands up those who follow this thoroughly.)
We have spanned two years in this illustration, but here is a case that covers less than one hour.
This patient came to our office with a severe shoulder problem. The category analysis shows us a category two. This was carried through nicely with almost total relief from pain, but in going home, the patient missed one step slipped and fell. I saw the patient at that time, and she had a typical category one problem. She was dyspneic, her lips were bluish, she was emotionally in semi shock. Her pain was localized into her right hip. She knew she had a hip fracture. Her blood pressure was 86 over 64...pulse 140. The family wanted to call the rescue squad and did. While waiting for the rescue unit I used two books,got her face down...got the PSS., used the books properly and in less than four minutes my patient was talking and smiling. This is a miracle. I was called ...Kept my cool...looked the situation straight on and solved the problem. This accidental category 1. problem was corrected so quickly that it did not even upset the category 2. problem.
We often make the statement that a true catagory 2. will not have a sciatica affecting the posterior buttock and leg. This is true, but we also must remember that a category one or three patient with such a sciatica may have a category 2 problem on the way to the forum. The way to tell is to test...Category 2 testing has been changed and here is a summary of the important changes. These changes make identification of a 2 much easier and will improve your results manyfold.
STEP. 1. Supine patient...arms to side...small pillow for head. Place hands over patients pubes,and ask the patient not to use any part of his body headward of this pubic hand. Patient is now asked to extend both legs and lift them off the table as one unit.(Fig. 1.) All persons without cranial or pelvic structural faults can perform this total leg lift with ease. The aged as well as the young have this lift ability. Remember, use nothing but intra-abdominal and leg lifting muscles. Failure is a Category 2. indicator.
STEP. 2. "CEREBRAL FAILURE"...Doctor sits at head of table with hand placed to side of skull as follows. Index and middle fingers in front of ears...ring and little fingers back of ears...thumbs to temporal lines (Fig. 2.) Press into skull with both hands, bearing your major pressure into the posterior temporal-anterior lateral occipital region. As this pressure is held tightly, ask patient to lift his legs. Should the patient succeed then we have our Assistant place 10 pounds hand pressure on the legs. A leg collapse in this case is a further indication of a Category 2. Patient resistance

is a strong cranial indicator.
STEP 3. Arm-fossa testing for coordination of upper and lower motor neuron function. Remember the challenge is by word of mouth to the patient. The upper motor neurons respond when you say the word "resist" and suddenly pull the arm footward. The patient ideally responds by resting quickly ie. it is a reflex action. The lower motor neurons respond when you touch the fossa. Just the word'resist'arm tug and the fossa touch and you challenge both upper and lower motor neurons.
THE TEST. Pouparts Ligament from the anterior superior illiac spine to the pubes is divided into equal halves. (Fig. 3.) Each fossa tested with arm command and finger pressure. To test right fossa stand to right side of patient. Grasp patients wrist, and bring fingers near to the fossa to be tested (Fig. 4.) Command patient to "resist" with the arm in the straight vertical position simaltaneously tug the arm footward with the other fingers touch the upper fossa with 3 pounds pressure. ALL MUST WORK TOGETHER. If neuron failure due to category 2, arm loses resistance immediatly upon Doctors effort to lower arm. This is the most positive indicator of category 2. we have. Repeat test of all fossa's. Should the arm remain in resistance then the test is negative and upper motor and lower motor neurons are coordinated. (Fig. 5.)
CATEGORY TWO PROCEDURE. Should you have sufficient indicators for Category 2.(4c. thenar knee., Plumbline, leg lift, rib head, arm fossa etc.) then you should proceed as follows. Lay the patient supine. Measure the legs by measuring with gentle traction into the calcaneus. Having decided the short leg you then place the superior block on the short leg side. This superior block is placed at right angles across the body not digonally as previously. Half the block is on the iliac crest and the other half is beneath the lumbar muscles (sacrospinalis quadratus lumborum). The inferior block is placed as previously angled toward the superior block. At 30 sec. check to see that the legs are leveling. At one and a half minutes commence the foot movements. (Fig. 6.) Patient draws the toes headwards then downwards every two seconds. (Up 1,2, down 1,2, etc.) At two minutes recheck the weak fossa's if they are strengthening leave the patient on the blocks. Should the desired strengthening not be taking place then commence the cross crawl techneque (as demonstrated at Melbourne). Immediately the arm fossa test is normal take out the blocks, commencing with the inferior block first. Continue to handle this Category two patient as you have been previously been taught or follow the 1974 Notes.
(N.B. This proceedure is for the straight forward patient. We have many variations in proceedures for different types of Category 2. patients. For instance the cross crawl. Who remembers exactly what to do? These things and many others could be covered should you desire it. How about you the reader letting us know what you would like to know more about. We will be only to happy to fulfill your requests. Letters please)
It is not unusual that a category 1. patient responding slowly after 2 category 1. blockings suddenly shows 2. signs which had remained hidden then responded phenominally. Unfortunately, not all patients are normal. Today, the leg lift, arm fossa etc. are routine check in our office each visit.
The basic category system is fundementally sound because it gives us things not to do as well as to do, and the the things we are not to do are just as important as the things we need do.
One subluxation can kill one person, and untill that subluxation is located and corrected it will kill that person...many names will be used to describe the progress the subluxation makes, but the route is definite and the end is sure.. unless some D.C. intervenes and the subluxation is corrected. When a true subluxation exists in your spine, it is there for no good purpose, and whenever you think subluxations are easy to find and correct you had better get a new brain, because the one you have isn't working.

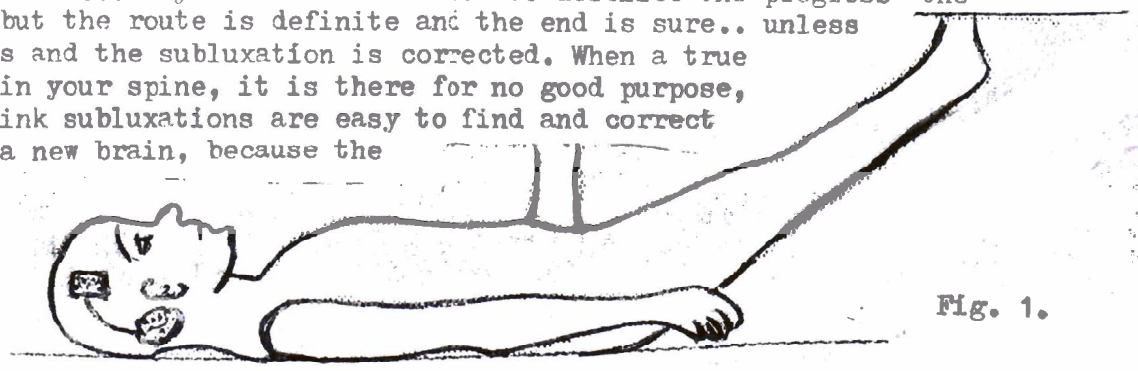

Fig. 1.

STEP TWO.

Fig. 2.

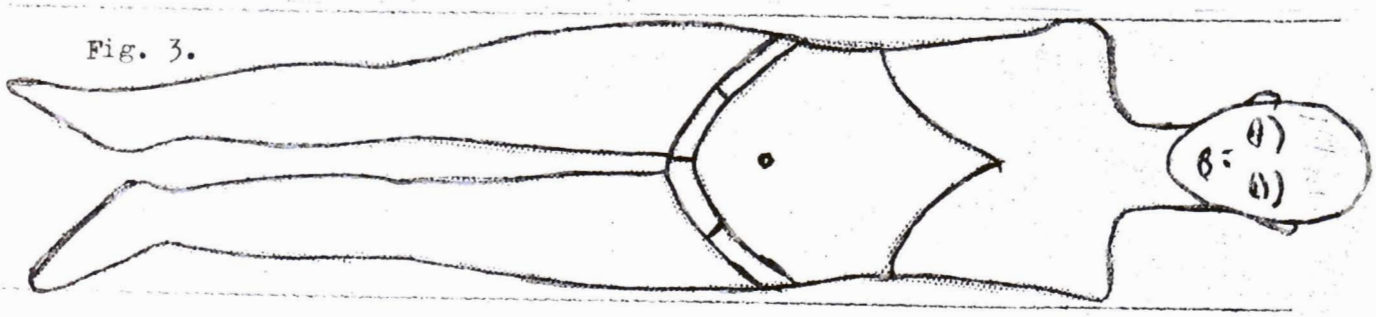

Fig. 3.

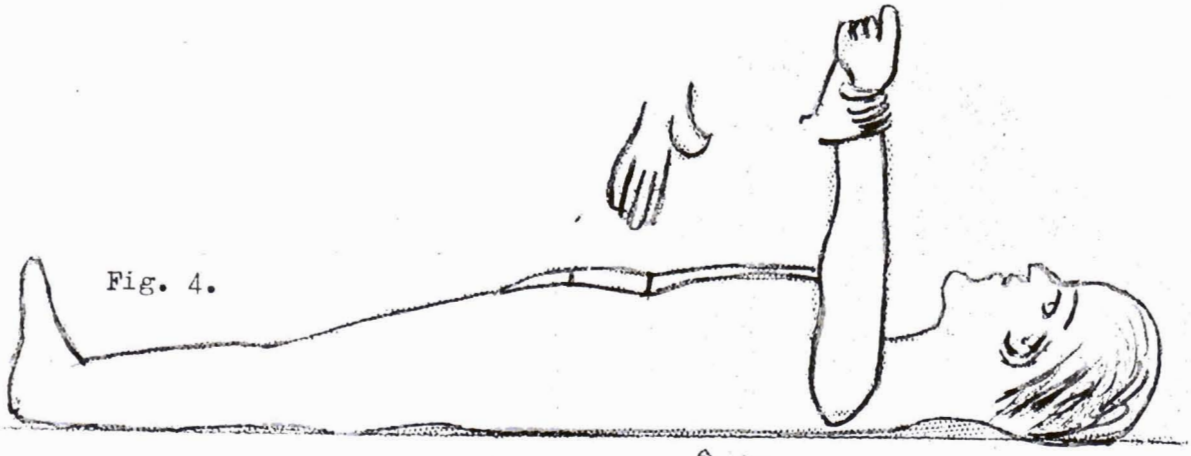

Fig. 4.

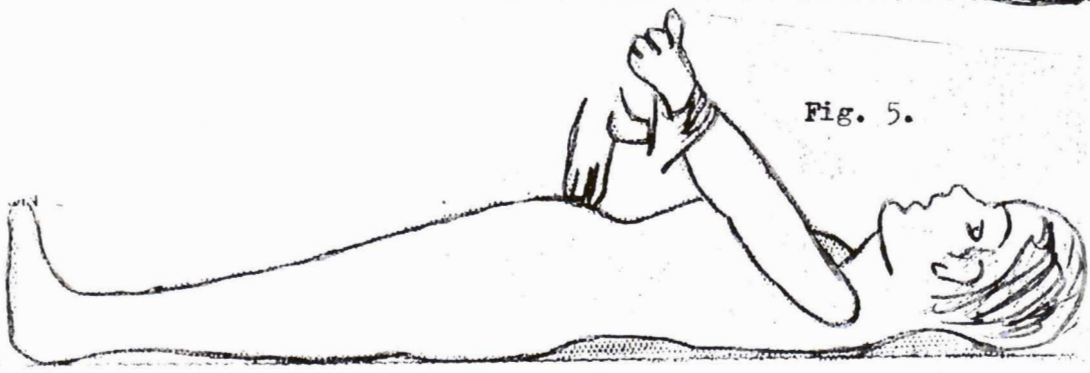

Fig. 5.

Fig. 6.

Dr. M.B. DeJarnette will be 75 years of age on December 23rd. 1974. How about a card from each of you to congratulate him and thank him for the years of service to the sick of the world he has made.