

AN ADJUSTMENT (D.J. 1975)

A D.C. friend of this writer has a Chiropractic practice that used as much electrical energy as does the Ford garage in the same city. This friend values the Chiropractic adjustment on the same level as knuckle cracking. His theory is that if you hit all of them you will hit the one in trouble. To prove his point, he charges \$3.00 for the adjustment, then \$5.00 for the short wave, another \$5.00 for the long wave, yet another \$5.00 for the ultrasound, and to cap it off, \$10.00 for the sine and galvanic. It costs you \$28.00 to be adjusted and treated in his office. I like this friend, because I get alot of his patients. I suppose he gets some of mine.

Your writer has great respect for the chiropractic adjustment, because when indicated, when administered with skill, it does perform a true miracle. The big problem with the average chiropractic adjustment is that it is given to an area of pain to cause that pain to go away. It is the only system of therepeutics that punishes the thing that hurts. Chiropractic has the greatest therepeutic weapon at it's command. The vertebral adjustment is that weapon. It is the miracle of the ages, yet how many chiropractors actually understand what that adjustment is or what it does.

Force is nothing until it meets resistance. A bullet travels from the muzzle of a powerful gun. It is nothing until it strikes an object and it's identity from that point depends entirely upon the makeup of the stricken object. Suppose that object is water. In all probability the bullet will ricochet off the water and travel until it strikes a hard object or is spent by it's own lost power. Water does not offer a total challenge to the bullet.

The chiropractic thrust is nothing until it meets some part of man's skeleton or a brick wall. You can thrust all day into a brick wall and very little gives that you are aware of, but if you could measure the total impact, you did create motion somewhere in that wall. When you thrust into a vertebra, the size of your contact point determines the depth of the total potential. The larger the contact point, the less localised the force. If you are thrusting into an atlas, the point of a lead pencil is about correct. The result of your thrust meeting resistance is force. That force is either neutralised or it moves through or causes something to move away from it's line of drive.

The chiropractic thrust given by respiration and controlled by the DeJarnette block system is an altogether new system of alignment of body parts. This system takes into consideration all of the basic principles of mechanics, direction, force and resistance and ads torsion leverage. It is the torsion leverage which does the miracle. If every chiropractor using the DeJarnette block system of adjusting could visualise the total vertebral alignments that occur, and the process of releases that accompany this alignment, he would be amazed and bewildered. The blocks used correctly as to category do make adjustments that no hand contact could ever make. The blocks are the only means at our command that will release dural port closures and dural torques. All in all, nothing in the past 100 years has their equal when used correctly.

The only problem in using the blocks is knowing at which instant the total person has responded. We do have the dollar and crest signs for the category one and the arm fossa for the category two. If we could charge a fee that would let us stay beside the patient always during block correction, we could keep testing and we would know instantly and exactly

When all responding structures aligned.

Why will a family almost happily contract to spend \$3000.00 with an orthodontist to have a child's teeth straightened, and then expect to spend \$10.00 with a D.C. to have the spine straightened? It must be vanity, and of course the dentist does have the almost perfect public relations setup.

We have made many of our own rules and some of those rules are in need of replacement. A vertebra correctly adjusted, does not need adjusting again, yet some D.C.'s in intensive care practices hammer on those vertebrae several times a day.

Your writer cannot in his wildest dreams visualize a patient ever paying to much for that one chiropractic adjustment so badly needed. He can shiver however, when he recognizes that millions of adjustments are given that are not needed, and the sooner that we face up to this fact the sooner we will orient into a skilled profession. Give me the kind of an adjustment that I may need and you can ship all the acupuncture needles back to China.

FAR TO MANY CHIROPRACTORS HAVE SPENT FAR TO MUCH TIME AND MONEY TRYING TO FIND A SUBSTITUTE FOR THE KIND OF CHIROPRACTIC ADJUSTMENT THEY SHOULD KNOW HOW TO ADMINISTER.

SACRO OCCIPITAL TECHNIQUE. S.O.T. in it's research had to accomplish two things.

1. Collect data...data is what is written on case history cards and what is written on the treatment side of the case record...what you adjusted and how it was adjusted. What else did you adjust and how? What did you do other than adjust? All of this has to be written on the case record card each visit and it is essential that you miss nothing. A little data is no good...accurate and complete data is essential.
2. Correlation of data...you put together what the 1000 case histories show and what the case records show. You begin to segregate and isolate specific things responding to specific application. You finally develop one formula and then another and keep right on going. You solve one problem and create ten new ones. You give up many times and go right back and begin again.

It took 40 years to get S.O.T. well organized. In that period many beautiful and new pieces of technique were developed and constituted. An addition to chiropractic, yet the final picture did not appear until we got the Categories separated and the triangles arranged and the blocks developed and their positions finalized.

Correlation is the most difficult of all things in any project. You dream of a new building and you draw plans and more plans, and each is better or worse and finally you come to an understanding and up goes your building. You no more than move in and you see need for changes and you eternally see need for change.

Sacro Occipital Technic is very stable...it is a conclusive science in chiropractic, yet its author sees need for change, but not without great study and correlation. What changes may be needed are not going to be found in some other technique or some book. Those changes needed are not yet on paper.

WHY CATEGORIES? The cause of a pain is seldom located at the site of the pain, and pain is the big thing that brings patients to the chiropractors office. Where the patient puts his hand to designate his pain is where it hurts, but it would be much easier for the chiropractor if the patient

Physics teaches that if you alter any part of a triangle, you alter all parts. To correct the triangle, it would be good to know what part was initially altered. Man is a system of triangles and man is altered when any part of any triangle is altered.

The three muscles that play major roles in altering man from a state of health to a state of disease and pain would be the latissimus dorsi, the piriformis and the psoas. If those three muscles could always be kept in perfect balance, man would be a pretty tough subject to alter. You also have to recognize that through life man must balance his skull and face upon a small series of bones named the cervical column. This balancing, is done, not by muscle or ligament or tendon strength, but by a mechanism of orientation in space. If the head and face had to be carried around as a dead weight by that cervical column, man wouldn't spend much time upright. When that orientation mechanism goes haywire, much of man goes right along with it and man becomes sick or riddled with pain.

To try and sort out man's different triangles and reorganize them would take much time and skill and be very costly. That is why some chiropractors settle for the atlas as a specific. It is the closest moveable joint to the orientation mechanism, and it can oftentimes do much to re-orientate man and make him feel better. Some settle for the pelvis and that is good because the pelvis controls the dura and the dura controls man's nervous system. Some say to heck with being specific and hit everything. That isn't all bad because they are bound to hit something important, but the ratio of success is small compared to the specific application of skill. Some resort to physiotherapy and that isn't all bad. Physical properties exist and they can be used to control some major problems.

I know chiropractors who use category one, two and three on every patient. They do not take any chance on missing something, and their results are about what you would anticipate...zero to 20. Nature does select, and in selection, if given a choice, the choice may prove remedial.

Categories put man into three distinct areas of human problems and offers three distinct and specific corrective measures. This is specific and if man could just co-operate and always be a specific one, two or three category, our troubles would all be ended. Man will not co-operate, and we therefore do come up against the problem of mixed categories and what to do about them. Some patients will not be totally a category one, and some will not be totally a two and some even refuse to totally be a three. It is this lack of totality that drives man to do other things, and that isn't all bad.

Recognizing that man is a contrary creation, we have cranial technique, C.M.R.T., extremity technique, and chiropractic first aid. Accountability teaches us that S.O.T. gets along with other procedures if applied at the proper time. We know that a category one can accept cervical correction, extremity correction, C.M.R.T. and cranial. This category is hungry for help and it is difficult to offer too much help if it is of the acceptable type. We know the category one is ashamed of it's difficulties and will try and shift those disabilities into another category, so a big sciatica develops. We have correlated over the years that the one great big point in category one analysis is the rocking of the torso. This is a major point and if you can count the rockings back and forth, then following your technique, you will find improvement in the ratio of 1 to 14.

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the closer to fourteen per minute, the more perfect your correction.

First rib palpation in the analysis is important and can be differentiating. The category one has rocker motion because he has bilateral first rib fixation and pain on palpation. This fixation produces the rocker mechanical ability. The leg lift in the supine is a good physical test as to muscle tone, but it is not a differential except in cervical compaction testing. We still use the leg lift, because patients are often made aware of their very poor muscle response.

The arm fossa test is perhaps the finest neural test ever developed in the healing arts. This test tells us many things, and it also specifically tells us that the patient needs a category two blocking technique. A slow response to the arm-fossa command tells us that the patient has a very poor upper neuron reflex mechanism. A "pull backward" effort by the patient tells us that the spinal neurons overpower and are much swifter in reception than the cranial. The arm that moves then stops with a jerk, tells us that the condition is very chronic and is mixed with a category one and is in future need of that blocking technique. The very weak arm reaction tells us that the patient is a serious cranial problem, and perhaps the cranial should be investigated before we proceed with the category two blocking. Judgement is needed in all diagnostic workups.

The category three is a very safe category providing you do what is indicated and nothing more. This category survives and gets well when not burdened with technique. If you are ever in doubt about a category three, just palpate the psoas muscle area and if very painful you have a pretty good idea that this is a category three. Many category three patients have their beginning without the spinal incline or sciatica, and if we learn to recognize a category three before it bends, our recovery is far superior.

ARCHITECTURE OF THE PELVIS. A study of the pelvis brings forth several needed points of information. The union between the innominate and the sacral border, commonly known as the sacro-iliac union, has no normal motion in adult life.

This is a rough articulation, constructed for membranous tension, not articular movement. The sacro iliac union would not support man in the upright position if it were permitted motion. A detailed of the sacral surface and the iliac surface of this compression union shows that no type lubricant exists in life to permit motion of this union without extreme friction. A study of the boot of the sacrum and the comparable boot of the ilium shows that their bearing surfaces do not match as would a motion type articular surface. There is no support for this union on the anterior or inferior portion of either the ilium or the sacral part. The posterior superior margin has a shelf which is composed of material making up the posterior superior iliac spine.

A study of the iliac surfaces from the anterior shows that they are not positioned for weight bearing in relationship to the sacrum. The only plausible excuse for believing that this articulative surface can support weight is the concavity of the sacral border. The wedge part of the sacrum does not comprise the surfaces of the sacroiliac area. The concave depression between the ilium and the sacrum contains the membranous bed which permits sacral extension and flexion in respiration, and gives the sacrum the responsibility of maintaining spinal health. This union is a respiratory union, affording a small amount of thrust movement of the sacrum, controlled by a membrane mechanism such as we see in the tentorium

The sacral boot in relationship to the iliac boot has three components. First, it is a weight bearing union without muscular control. Secondly it is a membranous pump to regulate the cerebro spinal fluid. Thirdly it regulates respiration through the total action of the spinal cord on the ventricles of the brain through the dura mater.

The sacral boot proper could not be weight bearing, membranous movement and bearing point control all in one mechanism, so the boot has to be divided into its components for proper function. The weight bearing part is the so-called sacroiliac strain point. This point does suffer overloads and strains and when such happens, pain is felt in this area and all the category two signs being evident. The membranous pump and the boot mechanism have no relationship to weight bearing, for if they did, they could not serve the vital functions of respiration and cerebrospinal fluid control.

Lumbar five in it's relationship to the sacrum is the pivotal point for much of the respiratory mechanism we attribute to the sacrum and sphenobasilar regions. It is the flexibility of the sacro lumbar spine in extension and flexion which enables the sacral boot to perform its function of membranous impulsion. The sacrum is always a part of respiration be that respiratory effort normal or abnormal. Sacral fixation perhaps predisposes to more cases of fatal pneumonia than do the infections causing the inflammatory lung congestion and solidification.

The membranous bed is capable of minute sacral extension and flexion upon the immobilized ilia. This immobilization of the ilia is essential for normal respiration, and for that reason the so-called sacroiliac subluxation or separation would directly predispose to pneumonia or other serious air exchange diseases. The sacrum can be over extended in relationship to the ilia and thus produce severe localized pain with disability. The ilia can be overextended in relationship to the sacrum and likewise produce disability.

The three components of the sacral articulation move in respiration and are important from a tension membrane and weightbearing standpoint, but the respiratory boot of the sacrum is the vitally important area as it maintains the dura mater tension and controls the pressure of cerebrospinal fluid. Whilst it may be considered that a sacral base at 35 degrees Ferguson's angulation may be in the optimum position this may not be so in differing positions that man puts himself, and all components of the sacrum may not be in perfect mechanical position. Disease, fractures and anomalies can alter function even with supposedly perfect position.

The sacral base line alters it's position radically from vertical to prone and so does the function of the sacrum. In the vertical position the total sacrum is involved, namely, respiratory, postural and membranous bed functions. In the prone position, the respiratory is involved solely and the other components are at rest, in so far as weight is concerned. The membrane part is involved in the prone position as a trigger mechanism. It is essential that the Doctor of Chiropractic understands the sacral respiratory mechanism before he can possibly understand the sacroiliac articulation or the sacro lumbar articulation. Many assaults have been made upon the pelvic region of multitudes of patients and it is a wonder that man survives. Perhaps these words will give a little understanding. (Ed. We may delve a little deeper into this subject later.)

There will be a Seminar in Melbourne in November full details next month.