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# Sacro Occipital Technique (SOT):
## Questions and Answers (Q+A)

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Narrative: This paper presents ten questions and answers regarding the Sacro Occipital Technique (SOT) method of chiropractic. My intention in writing this paper is to help readers to further develop their understanding of SOT.

SOT methods are system-based and clinically driven using functional indicators, (4, 5, 6,10) employing techniques that both analyse and adjust three key body systems (categories).

SOT was established and developed by Dr MB DeJarnette, based on over 70 years of dedicated research, study, writing, and teaching.

Indexing Terms: Primary Cranial Sacral Respiratory Mechanism (PCSRM); Systems chiropractic; Lumbar disc lesions; Sitting disc technique (SDT).

## Introduction

This paper imparts my knowledge and experiences, 46 years of practice, in SOT chiropractic, focusing on order, context ('knowledge is information in context'), (5) and the operating principles of the SOT method. (5) It is my hope that these Q&A will address the issues and concerns the reader might have with their understanding of SOT.

> *… 'Continual critical review of all aspects of SOT, in my opinion, is a necessity in the effort to master the work. …'*

## SOT Categories

### *Category One*

Category One pertains to the Primary Cranial Sacral Respiratory Mechanism (PCSRM). The term 'respiratory' refers to the intrinsic motion of the cranial and sacral components of the PCSRM, which facilitates tension on the dura and the subsequent circulation of Cerebral Spinal Fluid (CSF). This process is essential for the protection and nourishment of the central nervous system. (5, 10)

The primary indicator for Category One is heel tension

Heel tension serves as a marker for category one blocking, which aims to enhance the sacrum's respiration while monitoring the resulting respiratory response of the cranium. Additionally, this process anticipates the involvement of the atlas vertebra as it adapts to the needs of the Primary Cranial Sacral Respiratory Mechanism (PCSRM). (5, 19)

### *Category Two*

Category Two refers to the weight-bearing system of the body. It is based on the body's primary neurological principle: its ability to receive sensory input, integrate this input and react through the muscles all while responding to the presence of a category two ligamentous sacroiliac weight-bearing instability. Sacroiliac instability often results from other disturbances in the structural system. (5, 10, 11, 19)

> The key indicator of Category Two is the arm/fossae test

The arm/fossae test monitors the nervous system's sensory/motor response to the instability of the weight-bearing portion of the sacroiliac joint. (1, 3, 5, 7)

### *Category three*

> The primary indicator for category three is the Step Out Toe Out (SOTO) test

Category three pertains to lumbar subluxations, lumbar disc lesions, and conditions of the sciatic nerve, along with functionally necessary adaptations of the *piriformis* muscle, *psoas* muscle, and upper cervical region. (1, 3, 5, 7)

The primary indicator for category three is the Step Out Toe Out (SOTO) test, which assesses the *piriformis* muscles in relation to a lumbar disc lesion or potential entrapment of the sciatic nerve. The *piriformis* muscle initially responds to spinal leans and curvatures created by disc lesions. (5, 14)

## SOT Q & A

Q1: Do SOT adjustment methods help patients in pain?

A1: YES, SOT adjustments help patients in pain in many ways. SOT category three is designed for specific adjustments that address lumbar subluxation, lumbar disc lesions and conditions of the sciatic nerve. Sciatic nerve pain syndromes can be considered as an indicator for category three.

The SOT Sitting Disc Technique (SDT) is an effective method for adjusting any lumbar discogenic syndrome. (1, 3, 5, 14)

All three SOT categories employ stairstep and figure eight analysis and adjustments for addressing cervical issues, while integrating these techniques into the overall framework of each category's adjustment protocol (All parts of a system are in relationship).

Range of motion (ROM) assesments are valuable for conducting pre- and post-analysis to evaluate the effectiveness of the SOT figure-8 and stairstep methods. (3, 15, 19)

Pre ROM > figure-8, stairstep > Post ROM

In addition, the stairstep and figure-8 techniques are developed not only to adjust the cervical spine but also to continuously analyse and assess the progress of these adjustments. (1, 3, 15) DeJarnette remarks, regarding the stairstep and figure-8, that '*these specific cervical techniques combine both analysis and correction*'. (3, 8)

Spinal subluxations can be identified using SOT occipital fibre analysis. This technique comprises three lines of 14 fibres, with seven positioned to the left and seven to the right of the external occipital protuberance (EOP).

The most lateral (fibre #1) is located at the apex of the occipital-mastoid suture. (21, 22) These fibres are organised into three descending lines: line one is palpated as a fibre, while line two is palpated as a small nodule, with the most tender and most prominent fibres being the most significant. Each fibre corresponds to specific vertebrae and particular adjustment procedures. (20, 21, 22)

Vertebrae associated with line one's most tender fibre are adjusted by contacting the spinous tip and adjusting superiorly, whereas vertebrae associated with line two, the most tender fibre, are adjusted at the most sensitive and developed transverse process of the designated vertebrae. (see chart #1) (20, 21, 22) Line two vertebrae are especially notable due to the incorporation of soft tissue therapies, known as Chiropractic Manipulative Reflex Technique CMRT, which, when combined with the stimulation of line two fibres and precise spinal adjustments, achieve a comprehensive and integrated method of care addressing not only for structural related pain but for visceral related pain as well. (20, 21, 22)

Line two stimulation, spinal adjustment, and soft tissue therapy are self-protective processes designed to maintain the relationships between the viscera and somatic systems. (20, 21, 22)

**Chart 1:** Occipital Lines

| Line 1+ 2, Area | Vertebrae Thoracic (T), Lumbar (L) | Related Organs |
|---|---|---|
| One | T,1, 2,10 | Coronary, Myocardial, Intestines |
| Two | T, 3,10,11 | Lungs, Kidneys |
| Three | T,4, L1 | Gallbladder, Gastric, Ileocecal |
| Four | T 6, L2 | Pancreas, Cecal |
| Five | T 7, L 3 | Spleen, Glandular |
| Six | T 8, L 4 | Liver, Colon |
| Seven | T 9, L 5 | Adrenal, Prostate/Uterus |

Q2: Are SOT categories adjusted in numerical order, category one first, category two second and category three third, or in any specific sequence?

A2: No, the number of the category places no preference or order to category adjustments.

The category that is most in need of adjustment is the category that takes priority and is determined by category defining indicators. It is always possible that the indicators may inevitably shift to prioritising a different category. The first two indicator findings listed below (chart two) are done on the plumb line.

All three categories can be clinically defined, with some potential overlaps and with some distinct functional interrelationships. (5)

Chart 2: Indicators

| Indicator | Category one | Category two | Category three |
|---|---|---|---|
| Visual analysis from behind, eyes closed | Anterior/posterior sway | Lateral sway and deviation to one side | No sway, fixed, often with lean or curvature |
| First Rib /Thoracic #1 junction palpated with head flexion | Bilateral movement | Unilateral movement with a unilateral bulging | No movement, fixed |
| Arm/fossae test | Not definable | Definable, Arm reacts to testing (11) | Not definable |
| Heel/tension | Present on same side of leg deficiency | Not present | Not present |
| Step Out Toe Out (SOTO) maneuver | Generally, no unilateral difference | Generally, no unilateral difference | Present unilateral restriction with possible pain. |

Q3: Does cervical pain and/or cervical findings determine the category most in need of adjustment?

A3: No, cervical pain or findings are not a category determining indicator.

As previously mentioned, cervical analytical and adjusting techniques are important aspects of each of the three categories. (8, 15)

In category one, cervical function, particularly upper cervical function (the atlas) responds to the requirements of the PCSRM to maintain optimal function. (5, 10)

In Category two all structural disturbances (inclusive of the cranium) are components of the body's ability to maintain weight bearing stability even though the weight- bearing sacroiliac is primary. (10, 11)

In Category three, head righting reflexes involving the upper cervical vertebrae and related soft tissue are crucial for maintaining balance in the presence of spinal leans and curvatures caused by lumbar subluxations and lumbar disc lesions. (14, 16)

> When the patient presents with cervical pain the indicated category adjustment is essential in addressing the problem as a whole body (system) concern

**Chart 3:** Cervical function

| **Category** | **Function of the cervical spine** |
|---|---|
| One | Maintain the optimal function of the PCSRM. (5,19) |
| Two | Optimize weight bearing stability and alignment. (5,19) |
| Three | Maintaining balance in the presence of spinal leans and curvatures (5,19) |

Q4: Is SOT's Arm/Fossae test a muscle test?

A4: No, the arm/fossae test is not a muscle test.

The arm/fossae uses an arm reaction to assess the nervous system's involvement in sacroiliac weight-bearing instability. The arm/fossae test analyses the body's ability to respond through the muscle system to multiple stimuli, a controlled arm pull, with their eyes open, listening to a command, with stimulation of the fossae (Poupart's ligament of the anterior pelvis) for touch sensitivity.

In the presence of a sacroiliac (SI) weight instability the anterior pelvis (Poupart's ligament) becomes more sensitive to touch in an area corresponding to the area of instability of the sacroiliac. The four areas of instability of the SI are upper, lower, right or left, Poupart's ligament receptor system responds to SI disturbances and become more responsive when stimulated with touch. The upper fossae correspond with the shorter leg length while lower fossae correspond with the longer leg length. Therefore, the arm/fossae test evaluates the presence of a sacroiliac (SI) weight-bearing disturbance while simultaneously identifying its location and where the blocks should be placed. (5, 11, 19)

DeJarnette wrote in his book, *The Philosophy, Science and Art of SOT* that '*The arm/fossae test is the most exacting neurological and myology test a doctor of chiropractic can make and it requires a developing skill constantly renewed*'. (7)

Q5:Are the SOT blocks left in for a specific amount of time and are they placed in a specific manner?

A5: The need for the use of the blocks is dictated by category determining indicators (refer to answer number 2) and are utilised as follows. (5, 6)

### *Category one blocks*

Category one blocks are used to enhance the respiration of the sacral portion of the Primary Cranial Sacral Respiratory Mechanism (PCSRM) with the aim of eventually inducing greater respiration in the cranial portion of the PCSRM resulting in improved dural tension. (1, 3, 5) Improved respiration and dural tension of the PCSRM reduces the need for the atlas vertebrae to adapt to the demands of the PCSRM, ensuring optimal function.

Typically, heel tension is alleviated within the first 30 seconds of blocking, however, the blocks are left in place for an additional five or six minutes to allow the cranial portion of the PCSRM to respond to the enhanced sacral respiration. Crest (#) and dollar ($) signs are monitored to assess the eventual cranial response. Crest signs are found laterally in the lumbar musculature while dollar signs are found in the buttock musculature. The integrity of these muscles are the indicators for the category one cranial adjustment. (1, 3, 5)

### *Category two blocks*

Category two blocks correctly position the weight-bearing portion of the sacroiliac (SI), thereby reducing the sensory response of the fossae tissue of the anterior pelvis (Poupart's ligament) to SI instability. After placing the blocks, proceed with the basic two adjustment to promote cranial sutural motion (flexion/extension) then retest the arm/fossae. The retesting should yield a negative result, after which the blocks can be removed. (1, 3, 19)

### *Category three blocks*

Category three blocks are utilised to correctly position the pelvis, thereby reducing the elongation response of the *piriformis* muscle to the postural demands of a lumbar disc lesion. Block placement, along with the SOTO manoeuvre, helps in identifying the nature of the disc lesion and in some instances, it alleviates or reduces the entrapment of the sciatic nerve caused by the *piriformis* muscle.

These outcomes can typically be achieved within three applications (occasionally two) of the step out toe out (SOTO) manoeuvre, conducted at two-minute intervals, with each manoeuvre maintained for twenty seconds. (6, 14, 16)

**Chart 4a:** Category 3 Plumb Line

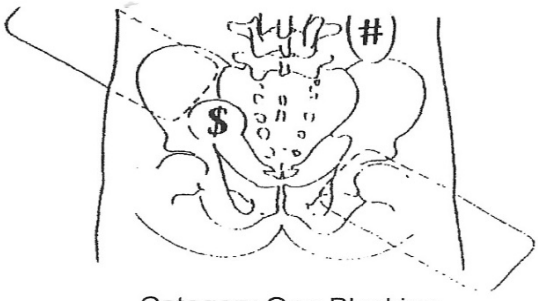
| Plumb Line | SOTO-no blocks | Initial diagnosis | 1-SOTO-on blocks | 2-SOTO-on blocks |
|---|---|---|---|---|
| Lean away from pain | Unilateral restriction | Bulging (lateral) disc | Improvement | Improvement |
| Lean toward pain | Unilateral restriction, with pain possible | Herniated (medial) disc | Limited improvement - if any | Limited improvement - if any |
| Lean, most often away from pain. | Unilateral restriction | Piriformis syndrome | Improvement | Improvement |

Indicators identifies the category most in need of blocks, while the leg length determines the exact placement of the blocks.

**Chart 4b:** Additional considerations

| Category | Additional Block Placement Considerations |
|---|---|
| One | The heel tension side should be the shorter leg length side. |
| Two | Upper fossae on the shorter leg length side, lower fossae on the longer leg length side. |
| Three | To even the leg length while leveling the pelvis |

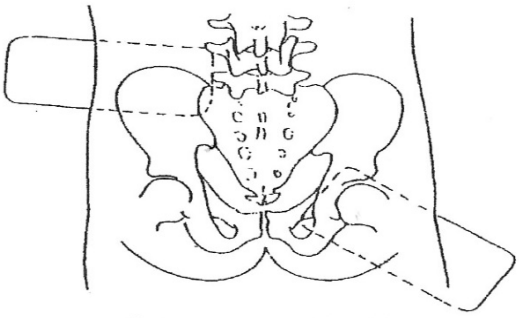
## Category Block Position Right Short Leg




Category One Blocking

***Patient is Prone.***

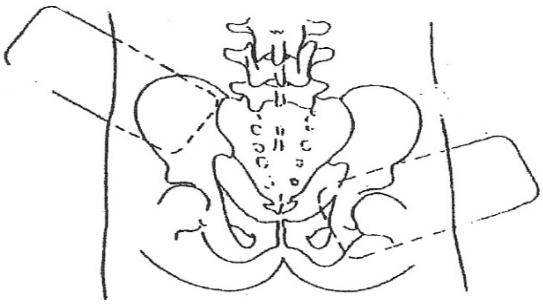
Approximately 6 minutes dependent on # and $ signs and Heel Tension. Heel Tension usually clears within 30 seconds



Category Two Blocking

***Patient is Supine.***

Approximately 1 minute, after Arm Fossae improvement remove blocks



Category Three Blocking

***Patient is Prone.***

2 minute intervals for SOTO
3 SOTO's maximum

Q6: What are the advantages of a system-based method of chiropractic?

A6: It is my belief (not alone) that systems-based chiropractic is crucial not only for the success of chiropractic as a therapy but also as an effective model of care within our entire health care system.

> DeJarnette: *'To bring order out of chaos SOT offers the category system'*. (1, 3, 5)

The body is a functional system made up of a multitude of sub systems, not individual random parts acting independently. In SOT we monitor functional indicators as the primary method of evaluation.

In system adjusting, evaluation continues throughout the adjustment process. Examples include category one crest (#) and dollar ($) signs, which indicate a lack of cranial respiration. As soon as the blocks have cleared heel tension and established respiration of the sacral portion of the PCSRM we begin to evaluate the # and $ sign to determine the state of respiration of the cranium. Another example of ongoing evaluation is the SOTO responses in category three (see Chart 4).

In a system when you affect one member of the system you are affecting all the members of the entire system. An example would be by effectively adjusting the lumbar spine (SDT) in category three you improve the function of the cervical spine, and the function of the *psoas* and *piriformis* muscles which have all been necessary adaptations to a lumbar disc lesion. In turn when you adjust the cervical spine, the *psoas* and the *piriformis* you are influencing the lumbar spine.

Functional indicators allow for making sound judgements, informed choices and recognition of successful outcomes. An example of this is the processing of Category two indicators knowing when you have stabilised the weight-bearing portion of the sacroiliac (SI) along with the balancing the psoas muscle ,the iliofemoral joints, the cervical spine and the cranial sutures all of which aid in the stabilisation of the SI and help neutralise the leg length discrepancy. '*Apply each category two visit until the legs remain balanced*'. (1)

Understanding the patient's symptoms is essential in making a thorough evaluation and most often are addressed in the category adjustment (refer to question one). '*Nothing in SOT is done without a reason and no action is complete until it is re-evaluated, all guided by indicator*'. (5)

Chart 5: Systems

| Qualities of a System | SOT, Systems- Based |
|---|---|
| 1-Can only be defined in the presence of function and process.<br>2-Must coordinate and interface with what is external.<br>3-Objects of a system communicate with each other.<br>4- A system is greater than the sum of its parts.<br>5- A system strives for equilibrium and harmony<br>6- A system is a dynamic process of self-organisation and adaptation.<br>7-A system has a memory which is its basis for response.<br>8- A system self-regulates based on feedback from its environment. | '*DeJarnette addressed the understanding of human function and its identification and treatment by studying basic and primary systems of the body and putting them into three clinically definable but interrelated categories. These categories not only have methods of identification called indicators and specific treatment protocols but give us a model of function for which to strive*'. (5) |

DeJarnette in his SOT 1980 book states '*SOT is a thinking and reasoning procedure. Each thing we do does that which is supposed to be done to remove the patient's problem and promote physiological healing*'. (1)

SOT Categories = A Model of Function + A State of Dysfunction + A Method of Adjustment (18,19)

Q7: Is the SOT sitting disc technique applicable in any of the three SOT categories?

A7: The Sitting Disc Technique (SDT) is primarily used in Category Three adjustments but can also be applied in Categories One and Two. In most instances if there is a lumbar disc lesion that requires the SDT, indicators will suggest the need for category three adjusting.

It has been my experience that the SDT can be extremely effective in decompressing lumbar disc compressions, central to category three. It also has been my experience that the Straight Leg Raise (SLR) can be a useful way of assessing the effectiveness of the SDT adjustment. (5, 14, 16)

In my retrospective study title, '*The Sitting Disc Technique and the Relationship to the Straight Leg Raise*' the following was noted: The SLR appeared to be a helpful method to monitor the functional improvement of the lumbar spine after SDT adjustments. (5, 14, 16) The objective of the SDT is to create space and movement in the posterior aspect of the compressed lumbar vertebrae. Flexion exercises are an important added component in achieving lumbar spinal decompression.

SLR, Pre SDT > SDT adjustment > SLR, Post SDT

The plumb line analysis can be crucial in not only judging the severity of the lumbar disc lesion (refer to chart 4) but also as a post check in assessing the effectiveness of the SDT.

Q8: Should the SOT plumb line analysis be done at each patient office visit.

A8: Yes, Plumb line findings are essential in identifying the category most in need of adjustment and can frequently be an indicator of improvement and change.

Plumb line analysis indicators (refer to charts 2, 4) are important for determining the category and comparing a patient's current findings to their findings from previous office visits:

'Care is seen as a continuum of an ongoing process' (5)

Post adjustment plumb line analysis can be valuable in assessing the effectiveness of that day's adjustment.

The plum line analysis, most importantly, directs you to your next step in the process of analysis and adjustment (note the last column, chart 6 below).

**Chart 6:** Plumb Line, Category Analysis

| | | | | |
|---|---|---|---|---|
| **Plumb Line Analysis** | A to P Sway | Bilateral T1/1st Rib Finding | No Discernable Lean | Place prone on table test for **Heel Tension Category One** |
| **Plumb Line Analysis** | Lateral Sway | Unilateral T1/1st Rib Finding | No Discernable Lean | Place supine on table test for **Arm/ Fossae, Category Two** |
| **Plumb Line Analysis** | No Sway, Fixed | No T1/1st Finding, Fixed | Lean or Curvature Present | Place prone on table test For **SOTO, Category Three** |

Q9: Which category takes preference when there are overlapping indicators? (1,3)

A9: A positive arm/fossae finding makes category two the category of choice no-matter what other finding might indicate. One of the reasons for this is that category one and three blocking can further disturb the weight-bearing portion of the sacroiliac.

It has been my experience that anyone undergoing any type of a lumbar disc disorder can be negatively affected by category two supine blocks. Consequently, when both the arm/fossae and a lumbar disc are present (a SOTO finding) I would suggest blocking supine category two while reducing the level of insertion of the blocks and adding the Sitting Disc Technique to the category two adjusting protocol.

> All three categories can be clinically defined with some potential overlaps and with some distinct functional interrelationships. (5)

Q10: Which of the following are correct statements?

1. Occipital fibres locate primary spinal subluxations, methods of adjusting them and when needed soft tissue therapies to facilitate organ/spine relationships? (20, 21, 22)
2. Even though category three focuses on lumbar subluxations with related disc lesions it is still regarded as a system, with parts that adapt, organise and ultimately self-regulate? (5, 11)
3. The arm/fossae test identifies the presence of a sacroiliac weight-bearing disturbance by evaluating the nervous systems sensory/motor response? (5, 11)
4. The sacroiliac joint has two separate functional portions: a synovial membrane respiratory portion and a hyaline cartilage, ligamentous weight-bearing portion? (11)
5. Subluxated vertebrae can stagnate CSF circulation, identified by line one occipital fibres, inhibiting the function of the PCSRM? (20 ,21, 22)
6. Are all five statements listed above, correct?

## Conclusion

It is my sincere hope that the information presented in this paper has been beneficial in addressing various concerns and providing answers to some of the challenging questions faced by those pursuing SOT.

Additionally, I trust that readers will view this commentary as my personal interpretation of SOT teachings and readings, informed by my over 46 years of experience practicing SOT. Learning and then practicing SOT can be a challenging undertaking but certainly well worth it.

Continual critical review of all aspects of SOT, in my opinion, is a necessity in the effort to master the work. I am grateful to Dr DeJarnette and for the opportunity to gain knowledge about primary functional systems of the body and to be able to develop the skills to analyse and adjust them.

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