

CATEGORY 1 AND THE TOWNSEND TEST

Each year in our SOT seminar series, the basics of the category systems, CMRT and cranial work are presented in a standard, teachable form with a main instructor and a team of table instructors. The objective is that those doctors and students attending receive a thorough, practical, hands-on exposure to the sixty-plus years of clinical enquiry and technical innovations of Major Bertrand De Jarnette.

Having stated this, one or two of you may have noticed that in our last few articles, we have included some concepts of sacro-occipital analysis from other SOT practitioners. This has not been with the intention of detracting from the works of De Jarnette, but rather to present some clinical observations of some very skilled SOT practitioners.

Long time SOT lecturer and researcher, Dr David Denton summarized his experience of seeing SOT in its progression, thus:

“At one time, there was a class of blind students that went to the zoo, with their teacher, for a lesson in observation and learning. In one of the stalls was a baby elephant. All of the students were allowed to pet and experience the animal at hand. When the students returned to their classroom, the teacher asked each one to give his description of the elephant and indeed each was vastly different.

In SOT, our experiences are pretty much the same. Even though Dr De Jarnette has done a fantastic job of researching, preparing and presenting his concepts from infancy to today's maturity, those of us who have watched the growth, probably see it in many different ways.”

At the 1984 Las Vegas SOT Seminar, another long time SOT practitioner, Dr Gordon Townsend of Redmond, Washington presented a most useful additional test for the Category 1 patient analysis. SOTO Australasia's then chairman and bulletin editor, Dr Scott Parker (our current SOT Expression editor, Dr Scott Wustenberg is Scott Parker's nephew) was so impressed with Townsend's work that he encouraged Dr Townsend to publish a paper in our SOT Australasia bulletin.

The paper entitled 'The Townsend Hyperextension Test' and the commentaries which followed, appeared in the September, October and November 1984 bulletins. We are of the opinion that the test deserves the attention of today's SOT chiropractors and thus the writing of this article.

As previously stated, Dr Gordon Townsend is a practitioner from Redmond, Washington who was named SORSI's 'International Chiropractor of the year' in 1999. Dr Townsend received the award at that year's Omaha, Nebraska Symposium, recognized for his outstanding contributions in research and teaching. (2)

The Townsend test addresses one of the areas of possible confusion in the Category 1 testing, that being the area of Category 1 blocking, heel tension and upper cervical involvement.

A review of our current SOT teachings on the subject is in order. For those who have the last written manual of De Jarnette, 1984 Sacro Occipital Technic, pages 54-59 are the relevant pages. (SOTO Australasia has this final SOT manual for sales. For the serious SOT student, someone who wants to research De Jarnette's works, development of ideas and techniques, SOT manuals of previous years are available for loan (via Averil Grebbins).

The heel resistance is determined by the heel tension test. One conflict that can arise in the Category 1 analysis is when the heel tension and the short leg are not on the same side. Over 90% of the time the heel tension will be on the side of the short leg but that leaves us with up to 10% of the time with a situation opposite. De Jarnette explained the finding by stating that “the short leg may not be involved with the atlas but heel tension always is” (3).

Following the determination of the short leg side and the side of heel tension, the cervical rotation test is performed (4). The four statements concerning the findings here are:

“When the face is turned to the left, if there is no atlas interference, there will be no change in leg length”.

“When the face is turned to the right, if there is no atlas involvement, there will be no change in leg length”.

“When the face is turned to the left, if there is no atlas involvement, the short leg may become the long leg”.

“When the face is turned to the right, if there is no atlas involvement, the leg lengths may change”.

De Jarnette made a statement about the atlas involvement and its effects on change of leg length. (the use of his term ‘switching’ is not to be confused with the neural organization term which is handled by cross-crawl and K-27 procedures, part of Applied Kinesiology protocol).

“Switching is avoided when heel tension is considered in leg measurement. When the atlas is subluxated, creating cord pressure, turning the head will cause a leg differential and that is always a problem in switching” (6).

The current SOTO Australasia seminar notes summarized the upper cervical involvement as: (7)

‘leg length alters-may be an upper cervical involvement’ and the notes from the early 80’s state: (8)

‘When the face is turned to the left (or right), if there is atlas involvement, the short leg may become the long leg’ and ‘when the face is turned back to the other side, the leg length may or may not change because of the atlas involvement on the opposite side’.

THE TOWNSEND HYPEREXTENSION TEST:

The patient is positioned prone, having been determined to be category 1 from five step analysis. The patient is checked for leg length. For the purpose of explanation, let's assume that our patient has a right short leg. (Also, practically, it is easier to determine the short leg with shoes on, that is, the patients, yours are optional).

Have the patient place his arms under himself on the table. Ask him to lift up on his elbows, as if to watch TV while laying on the floor, making sure to tip the head back. While the patient is going through this effort, the doctor is watching to see what kind of motion is going on with the feet. (leg length stays the same, long leg lengthens, short leg shortens).

Understand that this is a relative motion and we need to know which leg actually moved. The leg which shortens becomes an indicator for an atlanto-axial subluxation. The involvement will be on the same side as the shortening leg.

The leg which appears to lengthen is the second situation. The leg which lengthens is the indicator for an occipito-atlantal problem, but it switches over and involves the occiput on the opposite side of the leg which lengthened.

The third situation is that we had the patient hyperextend and there was no change in the leg length, thus, for our patient who showed a right short leg, at the end of the hyperextension effort you still see the right leg short to the same degree, then the primary subluxation is the sacroiliac (9).

Townsend has stated that the reason the test was developed was to determine the ascending and/or descending subluxation priorities (10). Thus, in practice, what the test offers is a method of determining the primary lesion and a means of following the body's progressive compensation relative to the sacroiliac, occiput or atlas.

The value of the test is that it tells you where a first, second and sometimes a third priority exists.

A very common finding is that the first test will show an occiput problem (leg lengthened). The occiput is corrected and more often than not the uneven leg length will not be seen. However, in some instances when the second test is performed a secondary problem will show up. In most cases this will be the atlas involvement (short leg shortening). When this is corrected you will have come back to a short leg, long leg relationship.

Many times the findings will ‘oscillate’ on subsequent visits, thus on one visit occiput will indicate, next it’s a primary atlas, back to occiput on the third visit and then to the primary sacroiliac and straight onto the blocks.

Clinically, the Category1 patient who is adjusted with this Townsend procedure has been found to require less blocking time at the time of the blocking visit.

In the SOT Category 1 protocol you have a choice to make once you have included Townsend’s procedure. If you have found an occiput first priority and that has cleared you can let the patient go for that day or you could then continue with the SB+ test and vasomotor adjustment.

TOWNSEND HYPEREXTENSION TEST SUMMARY:

LONG LEG LENGTHENS	=	OCCIPUT
SHORT LEG SHORTENS	=	ATLAS
NO CHANGE IN LEG LENGTH	=	SACROILIAC

Upon hyperextension, measured short leg gets longer or shorter you have
An upper body primary problem associated with the occiput or atlas. If
You have a leg length difference that stays the same, you have a
Sacroiliac problem.

In 1984, De Jarnette was asked his opinion of the test. He wrote: “The Townsend hyperextension test is worthy of thought but have you ever tried it on an 80 years old patient or a 20 year old patient with a bad back?” (11)

Dr Scott Parker, the first person who was sent this test for field testing, replied: “The Townsend Test I feel is just as valid as any of the De Jarnette tests. I have looked at it deeply and it is valid as long as the patient can do the test. I have also checked it by just having the patient raise the head straight up and in the case of the aged this works quite well. There are many cases in the SOT check that cannot always be performed by the 80 year old or the 20 year old with a bad back as well”.(12)

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