

# A Few Common Errors in Gonstead Adjusting & Tips to Avoid Them

By the Monterey Bay Gonstead Clinical Studies Society  
Update of an article published in the 1999; Vol.10 #2 issue of the GCSS International Journal of Chiropractic

That first time you feel and/or hear the vertebra move, it is an exciting event. After that, sometimes you feel you successfully adjusted the segment and other times not. You are not certain of what was different between the attempts. Those of us who have taught the Gonstead System for many years have noticed certain consistent errors that impede mastery of this highly specific adjusting system. A few are presented here.

## General Adjusting Tips

- σ The importance of static and motion palpation cannot be overemphasized. Both help to prepare you for adjusting the patient (and prepare the patient for the adjustment). In addition to their role in finding the subluxation, they also help you determine tissue texture, joint motion, resistance, etc. For the patient, they get some idea of how you handle and adjust them—if you are nervous and hesitant or if you are confident and assured, they will perceive it.
- σ Have a clear concept of what you are going to accomplish before setting up on the patient. Don't try to figure out what you are going to do during the set-up.
- σ Prior to adjusting the patient, do not move him around excessively. If in pain, excessive

movement only exacerbates it and won't endear you to him.

- σ Many people learning the technique are very tense when setting up. When you are tense, you transmit your intentions to the patient who is then able to anticipate the adjustment. Being relaxed increases the speed and depth of your adjustment.
- σ Never forget that you are dealing with a live human being and not simply a subluxation. You are also correcting a subluxation and not simply trying to achieve an "audible."

## Pelvic Bench

- σ In the low back push adjustment, many begin by standing too far down the table (caudalward to the patient). Unless the patient has significant lower extremity joint problems, flex the patient's knee up to you. When you are standing too low (caudal) relative to the subluxated segment, it is difficult to stabilize the patient's hip or have the correct line of drive. You end up almost lying on the patient. This can affect your own back and makes a good adjusting thrust difficult to deliver. [Figures 1 & 2]



Figure 1: Doctor is too low and cannot properly stabilize the patient's hip nor achieve the correct line of drive.



Figure 2: Doctor is properly positioned and can stabilize the patient's hip properly, achieve the correct line of drive, and maintain a straight-back posture. Notice the difference in the location of the doctor's tie between figures #1 and #2.

- The body drop and thrust in the push move are important in the push adjustment, but too many have the ratio reversed. Often there is dramatic body drop, but the thrust is negligible. In other words, the doctor flexes rather than extends the elbow during the adjustment. It is necessary to contract the triceps and pectoralis muscles and not the biceps in the thrust. It is a “PUSH move”.
- In the push adjustment, both of your feet should remain parallel. It is common to turn the foot closest to the patient’s head outwards (toe out or parallel to the edge of the table). You can injure your knee (tibia P-EX) if you continue to do this.
- Limit rotation of the patient’s torso. The stabilization shoulder must be pushed cephalically not posteriorly. Too much rotation of the patient’s torso tends to cause a “scissoring” rotational adjustment—the “million dollar roll”. In a very flexible patient, ask the patient to push their stomach forward as a means of taking out the slack.
- The thrust is P-A. It is difficult to get a P-A thrust if your shoulders are anterior to the patient. Your episternal notch of the sternum should be posterior to the patient. In this way, the force that you put in the thrust will be directed entirely in the P-A direction, rather than part of it dissipated by reaching with your arm over the patient.
- Stand up. You tell your patients to keep their back straight. You need to do the same. Don’t flex at the waist over the patient. Bend or extend your knees to accommodate the patient’s size and make certain that the table is the right height for you (the top of the table should be in the vicinity of the inferior aspect of your patella). Save your own back so that you can adjust for many, many years. [see photos in the technique section in *Int Jrnl Chiro*, 1999; vol.10 #1]

## Cervical Chair

- The finger contact should be as small as possible on the segmental contact point. That is the reason for the “rathole”. The “rathole” is the space formed between the thumb and index finger on the contact hand when contacting the segment. The contact point tends to be smaller when there is a well-formed “rathole”. Without it, there is a tendency to have a broad contact. [*Figure 3*]
- Line of drive is very important in the cervical spine. P-A and I-S for vertebrae from C2 to C7 are the primary directions of correction. The I-S or “lifting up” of the segment upon the subadjacent segment is crucial. A S-I line of drive can shift the segment more posterior and inferior.
- Improper positioning of the patient’s head and neck is a common error. The most common positioning error is too much extension and/or lateral flexion of more than the subluxated segment. Extension is done by slightly raising chin rather than extending the entire neck. Lateral flexion is done only at the involved segment, not the entire cervical spine. Excessive extension or lateral flexion will not only be uncomfortable for the patient, but will not allow you to give the proper P-A, I-S (“lifting” of the vertebra) line of drive. In some cases, the patient’s neck is maintained in slight flexion in order to separate adjacent vertebrae. [*Figures 4 & 5*]
- “Scissoring” the adjustment can cause an injury. “Scissoring” occurs when the stabilization is not secure and the stabilization contributes to the thrust with a counter-thrust. The patient’s neck typically laterally flexes further to the side of contact during the thrust. This can affect segments below the subluxation being adjusted. The key to preventing it is firm and immobile stabilization. Make certain that the segments inferior to that which is being adjusted are stabilized by your fingers. Raising the elbow of the stabilization hand superiorward and

anteriorward tends to immobilize the stabilization arm and prevent counter-thrust. Use of the cervical chair strap to help stabilize the patient.

- Do not “crowd” the patient. Standing too close behind the patient pushes the head forward, tenses the neck muscles, and

approximates the spinous processes. This will create difficulty when “taking out the slack”. The opposite is also true. Do not stand too far behind the patient as it is difficult to control the patient’s head.

[Figures 6-8]



Figure 3: The “rathole” on a C7 PLS.



Figure 4: There is excessive lateral flexion and extension of the patient’s neck.



Figure 5: Lateral flexion is only done at the segment being adjusted.



Figure 6: The doctor is “crowding” the patient by pushing the patient’s head too far forward.



Figure 7: The doctor is too far back and has difficulty stabilizing properly.

Figure 8: The correct position. The doctor is relaxed and can stabilize the neck properly and provide an effective thrust.

- σ Standing too far to the side of the patient tends to reduce the P-A line of drive and increases the lateral to medial direction. In many cases, this results in a medial-to-lateral or rotational line of drive. The primary direction is P-A, I-S. The side of segmental contact reduces the laterality. Remember to thrust up onto the disc and through the vertebral body.
- σ The use of the cervical chair strap helps to stabilize the patient.
- σ The cervical chair is where many have difficulty delivering the adjustment despite a perfect set-up. It requires a combination of strength, dexterity, timing, and, most importantly, speed. You develop this by practicing over and over again on a variety of patients.

order to become a master. To master subluxation analysis and specific adjusting takes the same dedication.

### **Thoracic Spine (Knee Chest)**

- σ The line of drive is very important. Careful study of a dry spine and lateral x-rays will help you visualize the correct line of drive and the exact location of the segmental contact point. Your segmental contact point on the long, imbricated thoracic spinous process must be caudal and immediately inferior to the spinous above in order to approximate the level of the vertebral body.
- σ Pre-torquing prior to delivering an adjustment is not only unnecessary but may cause you to slip onto the wrong segment. For instance, if you are setting up on T6 spinous process for a PRS-sp. Prior to the thrust, some may add a clockwise pre-torque. This may dislodge the contact point from T6 spinous onto the right transverse process of T7 with a resultant and unwanted PLI-T adjustment of T7. Torque is only added during the thrust, not before.
- σ The thrust in all Gonstead adjustments is sustained. Do not recoil—i.e., an instantaneous reflex-like removal of the contact after the thrust. This can be very painful to the patient. The resulting “whipping” effect may also cause further joint strain. The Gonstead adjustment thrust is always "set and hold."

### **Practice**

- σ The key to mastering the Gonstead System is to practice, practice, practice and get good feedback. The late Andre Segovia did not become a world-class classical guitarist by occasional practice. As he told one young admirer, you need to practice every day in