COLLECTED
PAPERS OF THE MEMBERS
OF THE
INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY

PRESENTED MAY 27th THROUGH 30th, 1981

SHELDON C. DEAL, D.C., N.D.
CHAIRMAN, I.C.A.K.

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* - Diplomate

INTRODUCTION

By

Sheldon C. Deal, D.C., N.D.

Chairman

This eleventh collection of papers by the members of the International College of Applied Kinesiology represents 53 papers written by 43 authors.

These papers will be presented by their authors to the general membership at the Summer meeting to be held in Dearborn on May 27, 28, 29, 30, 1981. The authors welcome comments and further ideas on their findings either in Dearborn or you may write them directly as their addresses are indluded in the Table of Contents.

These papers do not represent the official educational material of the International College of Applied Kinesiology, but rather areas of special interest to the individual members which have been under research. The papers are presented in an unedited form.

The papers are being mailed out to the members well in advance of the Dearborn meeting. This will allow the membership at large to read the papers in advance which will save time at the Summer meeting and hopefully stimulate more questions from the members and more demonstrations from the individual authors.

We the members of I.C.A.K. can be proud of the amount of research being conducted and feel fortunate to have it at our fingertips in the form of these Collected Papers. It cannot help but be an asset to our health and also to the health of our patients.

CHINESE EYE EXERCISE POINTS

Gerard E. Achilly, B.A., D.C.

Abstract

Observation of eye pressure points used by grade school children of the Peoples Republic of China.

Introduction

During a recent visit to China in October of 1980, we had the opportunity to visit a chinese grade school in Nanking. One class demonstrated the technic of applying systemic pressure to acupuncture points surrounding the eye. According to the instructor, these points are manipulated twice a day during classroom hours. Their main purpose is to improve eye sight, reduce eye strain and prevent any eye aberrations.

The accompanying diagram illustrates the points involved and instruction of their proper use.

Figure 1: Close your eyes, sit, and concentrate. Put your thumbs below your eyebrows and above the corners of your eyes; spread the other four fingers of each hand and curve your fingers like a bow to support your forehead. The surface you stimulate shouldn't be too large. Press and rub the point to 8 beats of the music (or eight counts). Repeat this eight times.

Figure 2. Use the thumb and the index finger of either hand to massage the bridge of your nose. First press (the point) and then squeeze with an upward motion. Each press and squeeze equals one count, eight counts equals one cycle. Complete eight cycles (sixty-four presses and squeezes altogether).

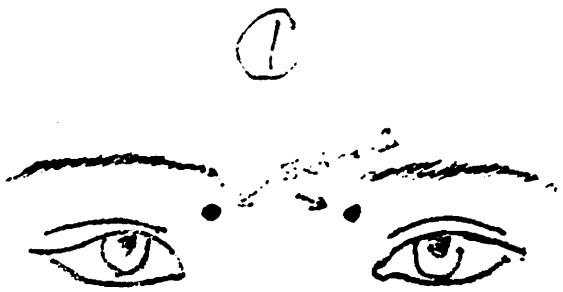
Figure 3: First put the index and middle fingers together, place them against either side of the nostrils, supporting your chin on your thumbs. Take down your middle finger (after you have found the Si Bai point with your index finger). Massage the center part of your cheeks for a count of eight and repeat for eight cycles.

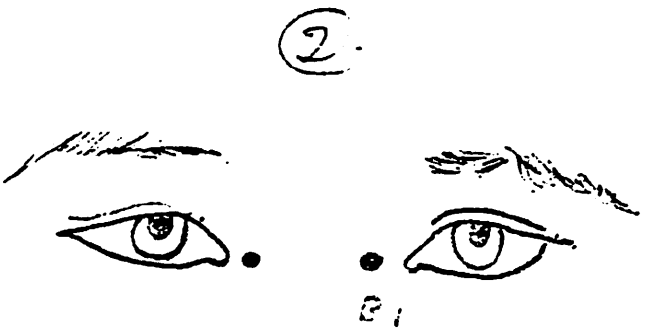
Figure 4: Curl the four fingers of each hand; use your thumbs to press your temples (the Tai Yang point). Following the numbered arrows

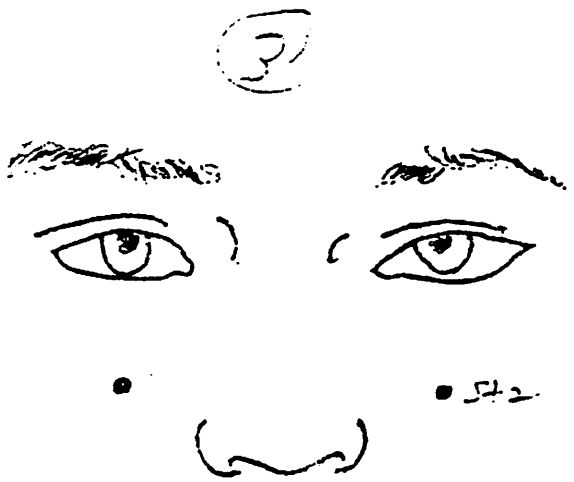
above, bend your index fingers and use the flat part between the first and second joints to stroke in the upper half of a circle along your eyebrows, and then the lower half circle below your eyes creating a full circle. Always stroke from the inner corners of your eyes to the outer. Stroke each full circle to the count of four. Repeat sixteen times.

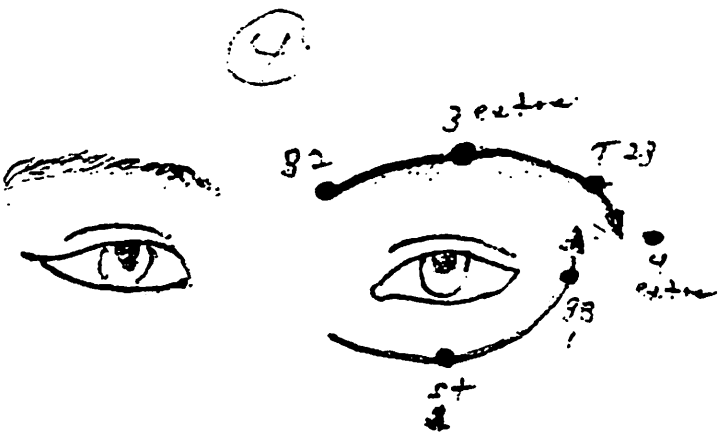
Conclusion

It was the author's personal observation that very few children and young adults wore corrective glasses.









THE TMJ SYNDROME

AND ITS RELATION TO SPEECH PATHOLOGIES

by

Michael D. Allen, D.C.,N.D.

ABSTRACT: This text will help to see how a Tempromandibular Joint, (TMJ), Dysfunction Syndrome and its associated muscular and structural imbalances can cause speech pathologies. Also, how abarations in lingual physiology can cause TMJ Dysfunction Syndromes. Both can be corrected - providing either is a chiropractic problem - with Applied Kinesiological procedures.

INTRODUCTION:

My first exposure to this specific set of syndromes was in mid July 1980, when a regular - and favorite - patient of mine was struck by a high speed truck while she was crossing a street in Laguna Beach, California. After being thrown approximately 20 feet, the unconscious victim required four attempts at CPR and was immediately sent to UCI Medical Center for treatment.

Six weeks of comatose existance for this twenty-one year old female

did not restrict my almost daily trips for chiropractic treatments. These she received while in the intensive care unit. My thanks, as well as the patient's, goes to the hospital for their understanding and cooperation in this endeavor.

Her life was almost lost three times while in the hospital due to a systemic infection, pneumonia and a temporal lobe hemorrhage. In mid October 1980, she was finally released to her family for treatment at home. Her progress has been slow but thorough. I look forward to her recovery of at least 80% of her pre-injury status.

Another patient of mine is a speech pathologist who has been assisting the accident victim since the time she came home - nothing just happens, everything happens just.

While working with the patient, I noticed that she developed a TMJ click syndrome bilaterall- upon opening. The usual procedures were used to correct the problem, but it returned on one side. A day later, the same procedures were used on the still offending side and it cleared up as well. The therapist mentioned an incidental ease in the patient's ability to verbally communicate after this episode, as well as an ease of her breathing patterns with phonation. She immediately went from two words per breath to almost complete sentences with each breath.

ANATOMICAL REVIEW:

There is to date, no new trick to the evaluation of the TMJ with regard to speech pathologies. However, a thorough working knowledge to the anatomical structures to be dealt with is important. A review of the muscles involved in this syndrome is presented:

I. MUSCLES OF MASTICATION

Temporalis
Masseter
Internal Pterygoideus
External Pterygoideus
Buccinator

II. MUSCLES OF THE NECK

A) Cervical
Platysma
Sternocleidomastoideus

B) Suprahyoid
Digastricus
Stylohyoideus
Mylohyoideus
Geniohyoideus

C) Infrahyoid
Sternohyoideus
Sternothyroideus
Thyrohyoideus
Omohyoideus

III. MUSLCES OF THE TONGUE

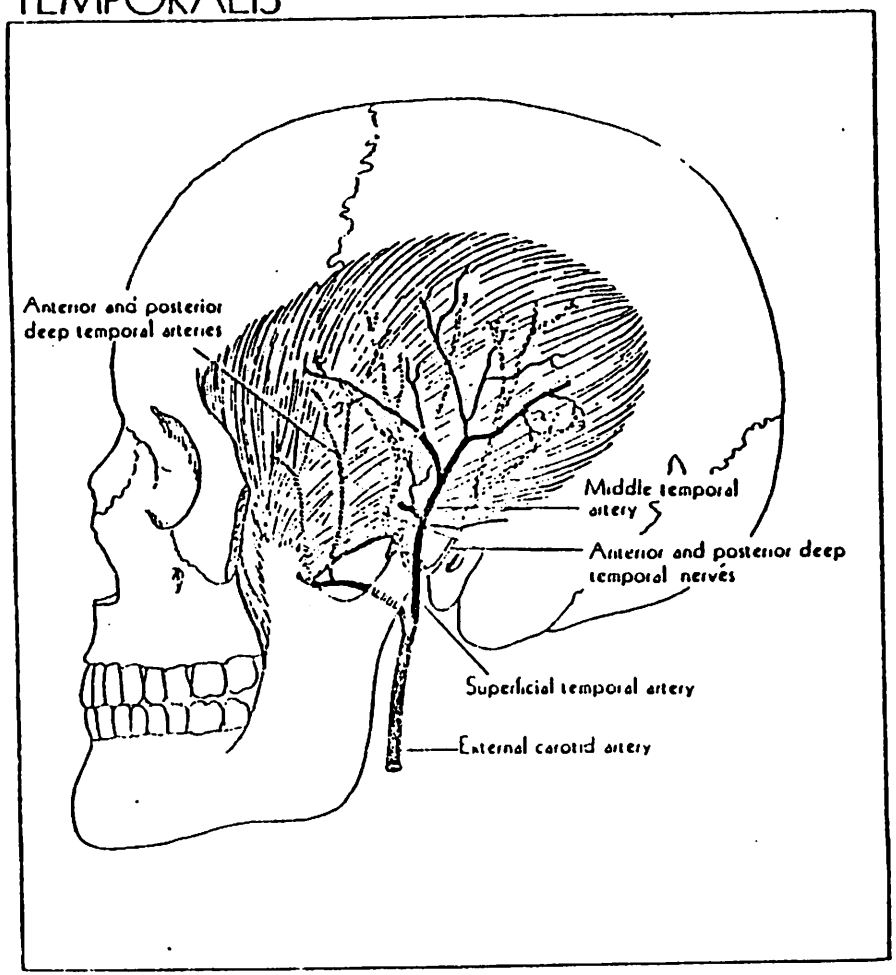
A) Extrinsic
Genioglossus
Hyoglossus (AKA Chondroglossus)
Styloglossus

B) Instrinsic
Longitudinalis linguae (superior and inferior)
Transversus and Verticalis linguae

IV. MUSCLES OF THE PALATE

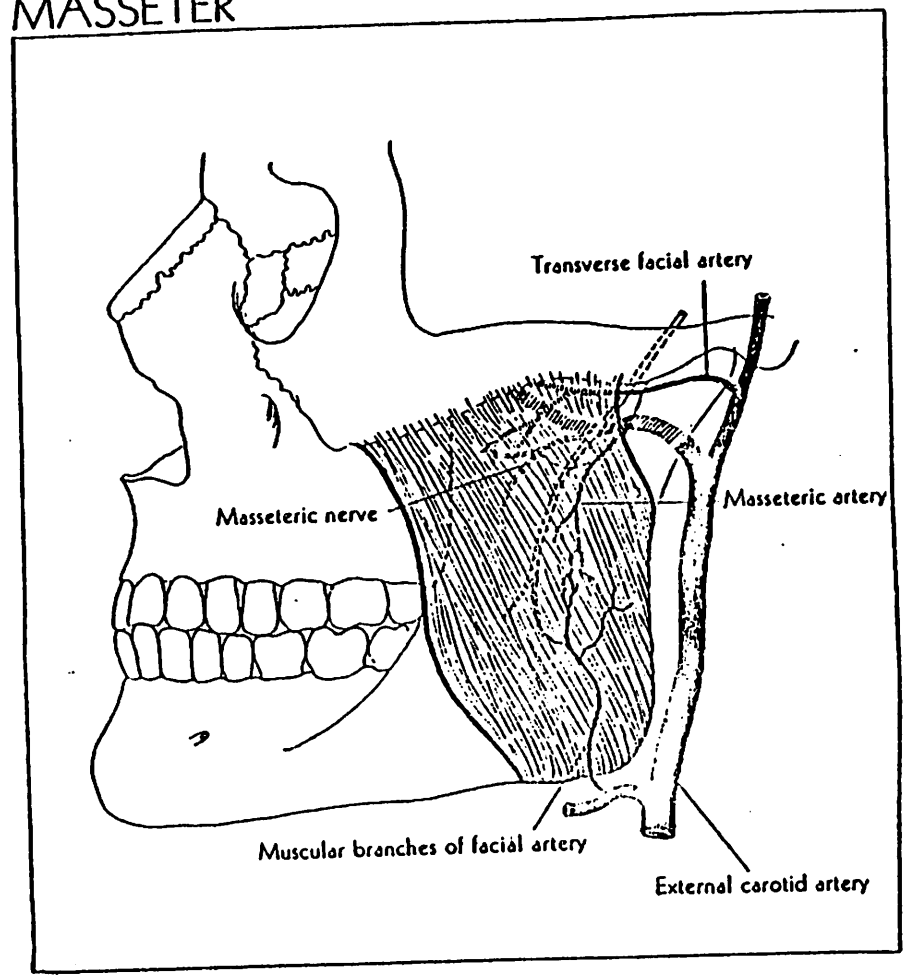
Levator veli palatini (levator palati)
Tensor veli palatini (tensor palati)
Musculus Uvulae
Palatoglossus (glossopalatinus)
Palatopharyngeus (pharyngopalatinus)

TEMPORALIS



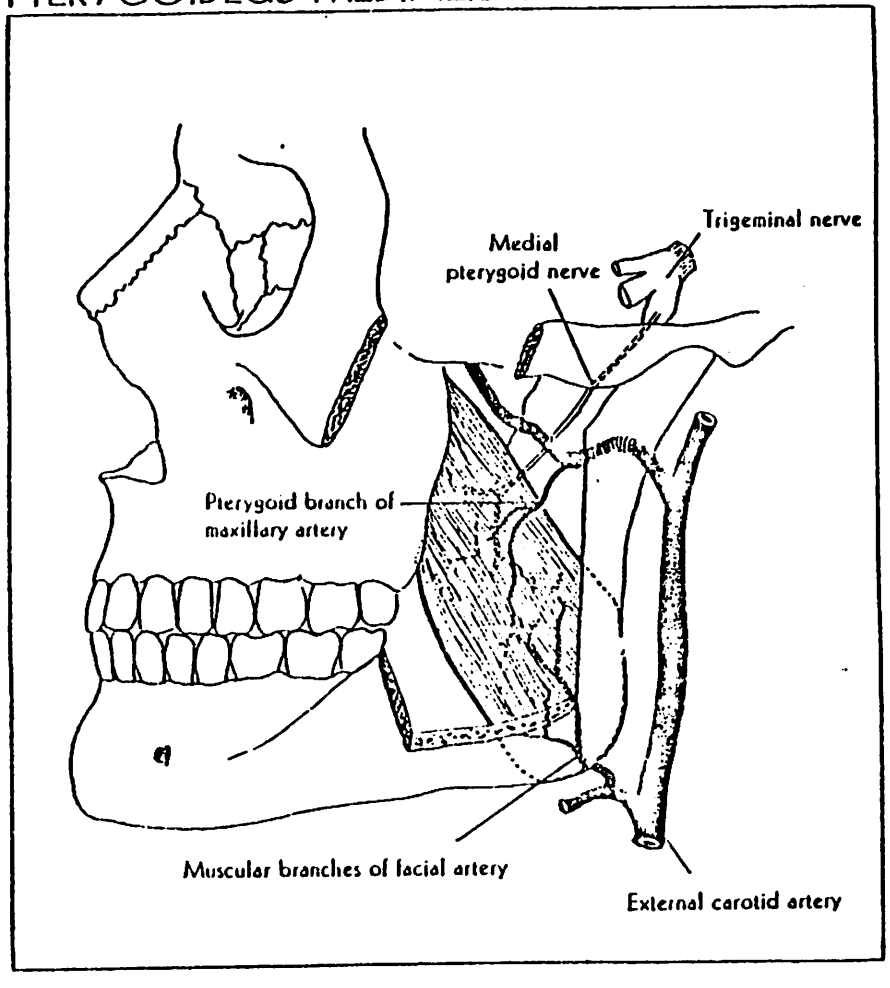
ORIGIN: Floor of temporal fossa and temporal fascia
INSERTION: Anterior border of coronoid process and anterior border of ramus of mandible
FUNCTION: Elevates jaw, retracts mandible, clenches teeth
NERVE: Deep temporal branches of anterior trunk of mandibular division of trigeminal
ARTERY: Middle temporal branches of superficial temporal; anterior and posterior deep temporal branch of maxillary

MASSETER



ORIGIN: Superficial portion from anterior two-thirds of lower border of zygomatic arch; deep portion from medial surface of zygomatic arch
INSERTION: Lateral surface of coronoid process of mandible, upper half of ramus and angle of mandible
FUNCTION: Elevates jaw, clenches teeth
NERVE: Masseteric nerve from anterior trunk of mandibular division of trigeminal
ARTERY: Transverse facial branch of superficial temporal; masseteric branch of maxillary; muscular branches of facial

PTERYGOIDEUS MEDIALIS (Internus)



ORIGIN: Medial surface of lateral pterygoid plate and pyramidal process of palatine bone; small slip from tuberosity of maxilla

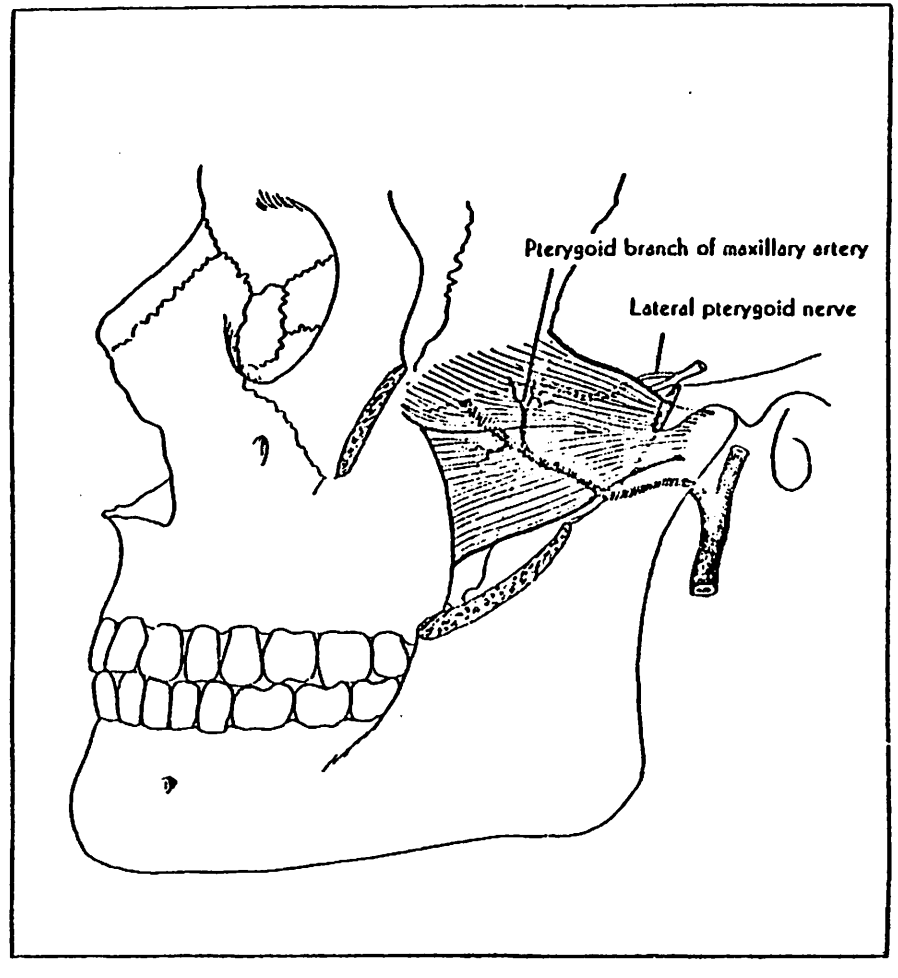
INSERTION: Lower and back part of medial surface of ramus and angle of mandible

FUNCTION: Protracts and elevates lower jaw; assists in rotary motion while chewing

NERVE: Medial pterygoid from mandibular division of trigeminal

ARTERY: Muscular branches of facial; pterygoid branches of maxillary

PTERYGOIDEUS LATERALIS (Externus)



ORIGIN: Upper head from infratemporal surface of greater wing of sphenoid; lower head from lateral surface of lateral pterygoid plate

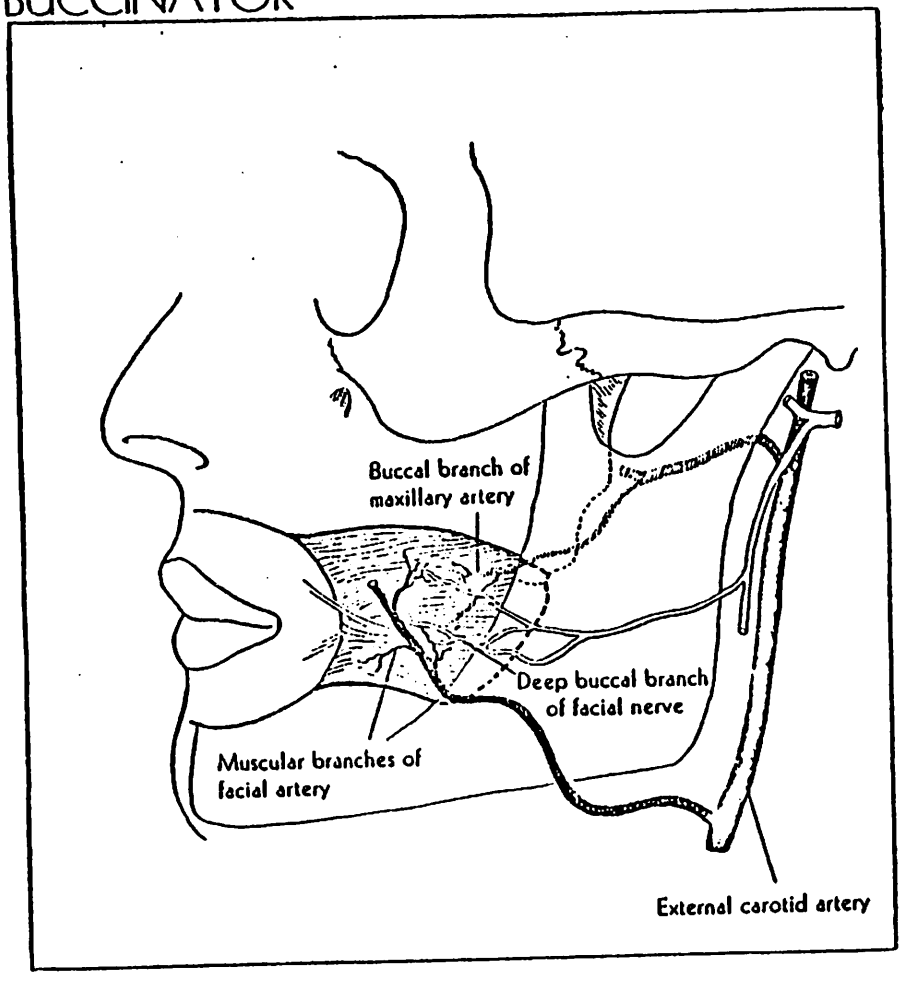
INSERTION: Front of neck of mandibular condyle and capsule of mandibular joint

FUNCTION: Protrudes mandible, pulls articular disc forward; assists in rotary motion while chewing

NERVE: Lateral pterygoid, branch of anterior division of mandibular

ARTERY: Pterygoid branch of maxillary

BUCCINATOR



ORIGIN: Alveolar process of maxilla and mandible opposite sockets of molar teeth; anterior border of pterygo-mandibular raphé

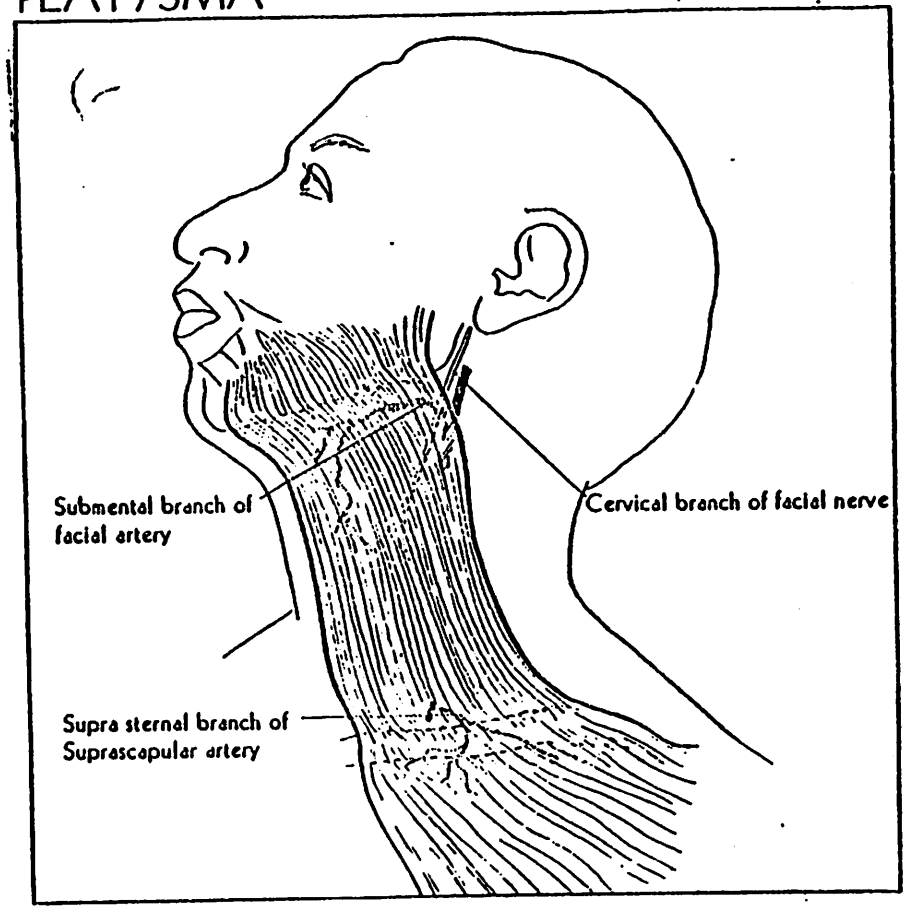
INSERTION: Fibers converge toward angle of mouth, where they blend with orbicularis oris; upper fibers pass to lower segment of orbicularis, lower pass to upper segment of that muscle

FUNCTION: Compresses cheeks, expels air between lips, aids in mastication

NERVE: Deep buccal branches of facial

ARTERY: Muscular branches of facial, buccal branch of maxillary

PLATYSMA



ORIGIN: Upper pectoral and deltoid regions by bundles from superficial fascia. These fibers cross the clavicle and pass obliquely upward and medially along the sides of the neck

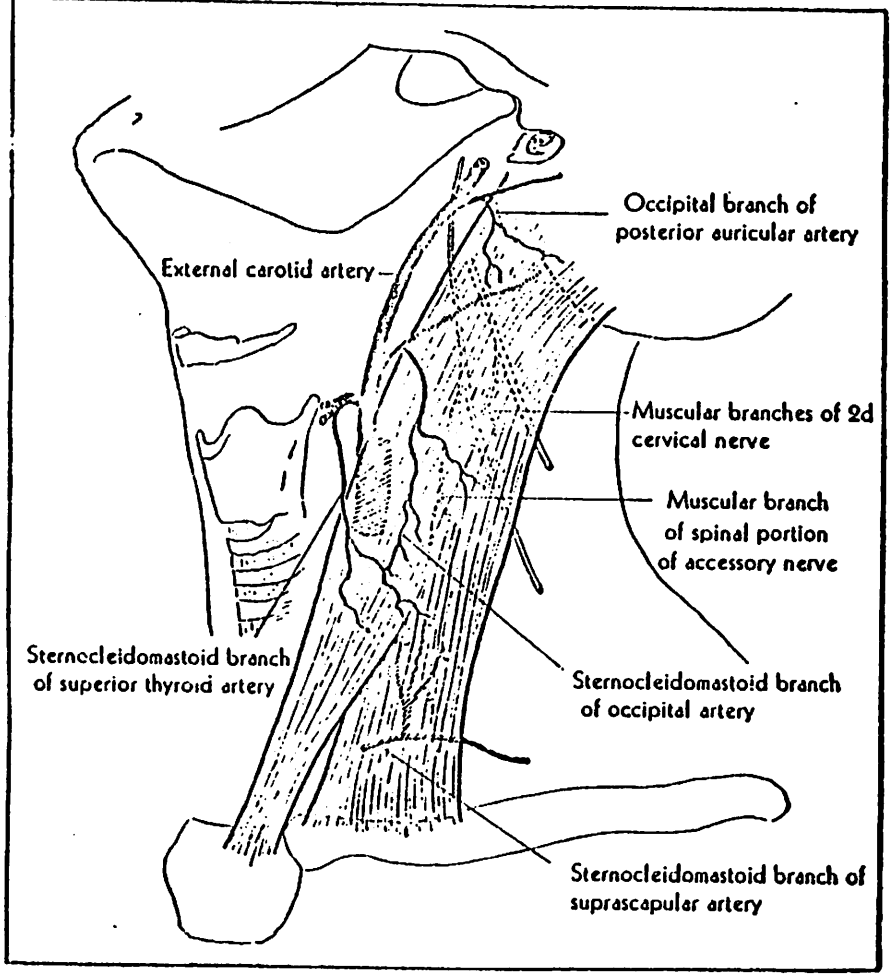
INSERTION: Anterior fibers of one side interlace below the chin with those of the other and connect with depressor labii inferioris and depressor anguli oris. Posterior fibers pass across the angle of the jaw and some insert into the mandible, others pass to skin of lower part of face, many blending with muscles at angle and lower part of mouth

FUNCTION: Depresses lower jaw and lip, tenses and ridges skin of neck

NERVE: Cervical branch of facial

ARTERY: Submental branch of facial, supra-sternal branch of supra-scapular (off thyrocervical trunk)

STERNOCLEIDOMASTOIDEUS



ORIGIN: Sternal head, anterior surface of manubrium; clavicular head, upper surface of medial 3d of clavicle.

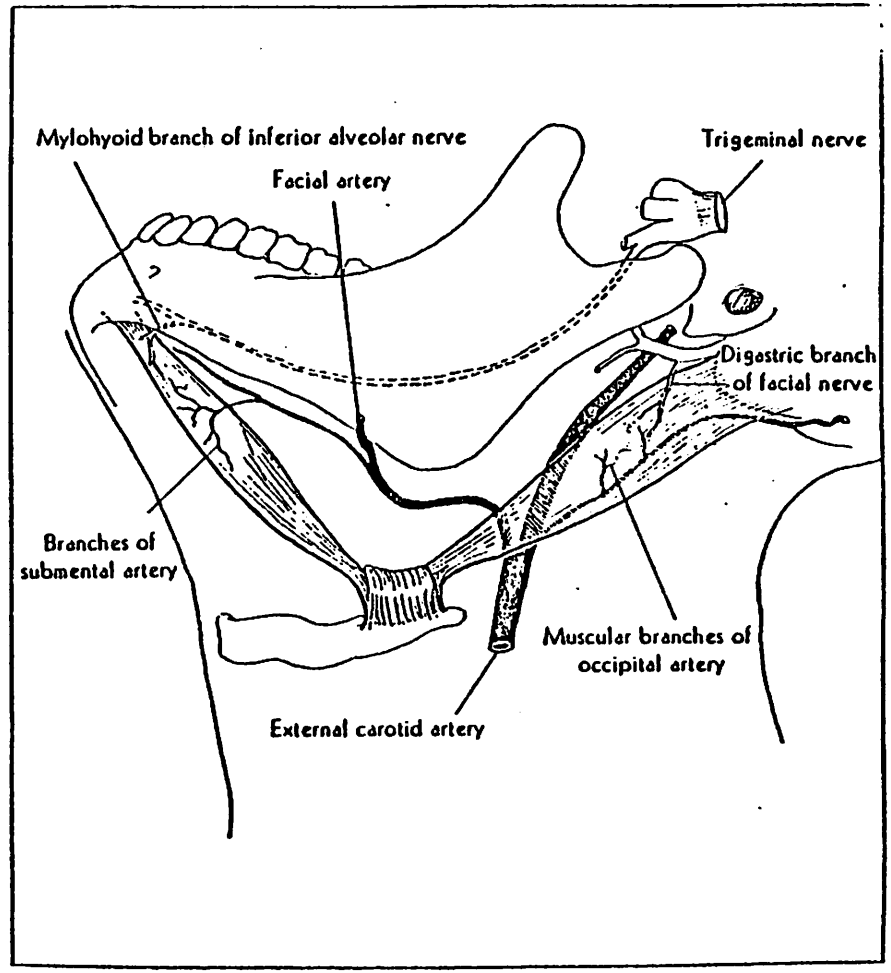
INSERTION: Lateral surface of mastoid process; lateral half of superior nuchal line of occipital bone

FUNCTION: Singly, draws head toward shoulder and rotates it pointing chin cranially and to opposite side; together, flex head; raise thorax when head is fixed

NERVE: 2d cervical and spinal portion of accessory

ARTERY: Sternocleidomastoid branch of superior thyroid and occipital; muscular of suprascapular, occipital of posterior auricular

DIGASTRICUS



ORIGIN: Posterior belly from mastoid notch of temporal bone; anterior belly from digastric fossa of mandible

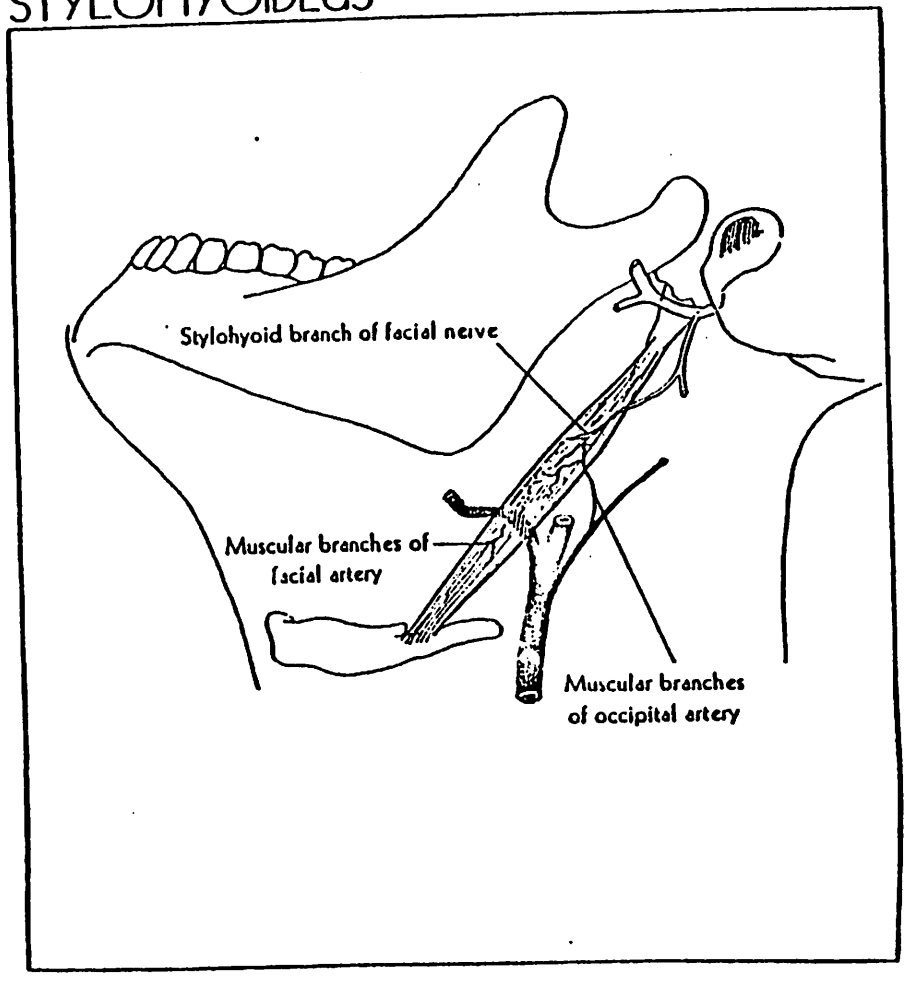
INSERTION: Both bellies by an intermediate tendon which passes through insertion of stylohyoid muscle and is attached to side of body and greater cornu of hyoid bone by a fibrous loop

FUNCTION: Raises hyoid bone and base of tongue, steadies hyoid bone

NERVE: Posterior belly, branches from facial; anterior belly, mylo-hyoid branch of inferior alveolar

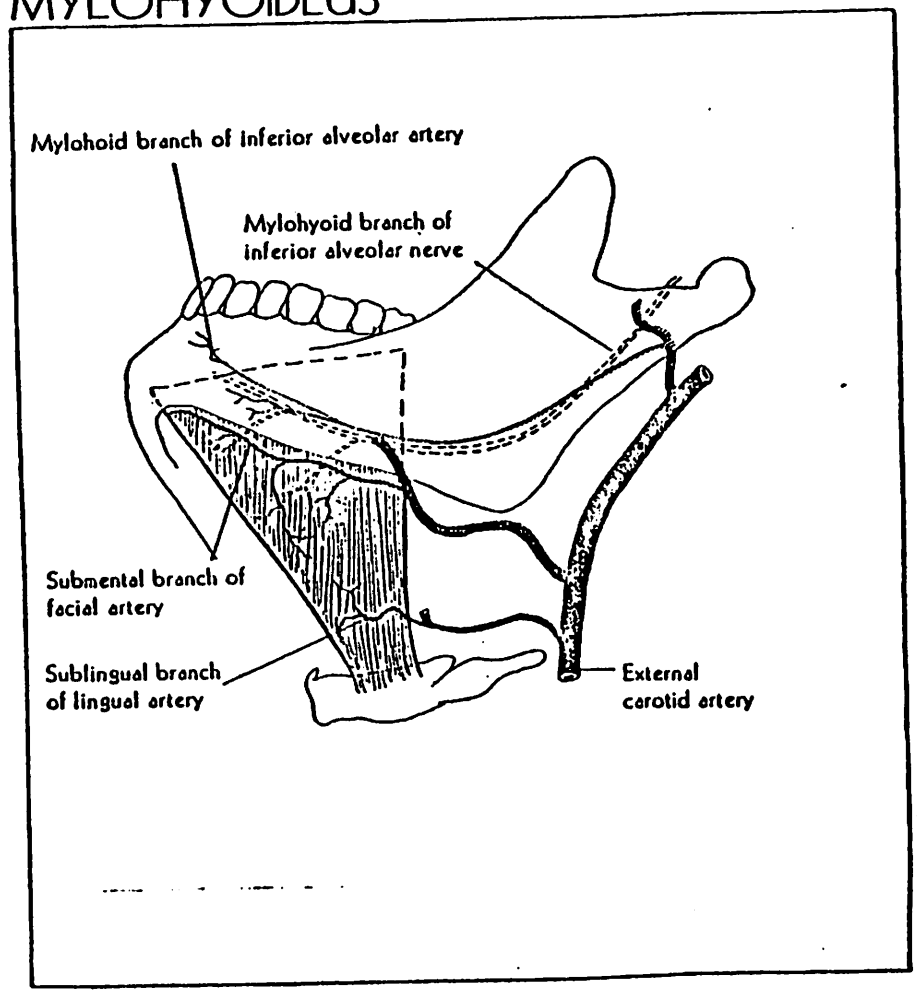
ARTERY: Posterior belly, muscular branches of posterior auricular, muscular branches of occipital; anterior belly, branches of submental

STYLOHYOIDEUS



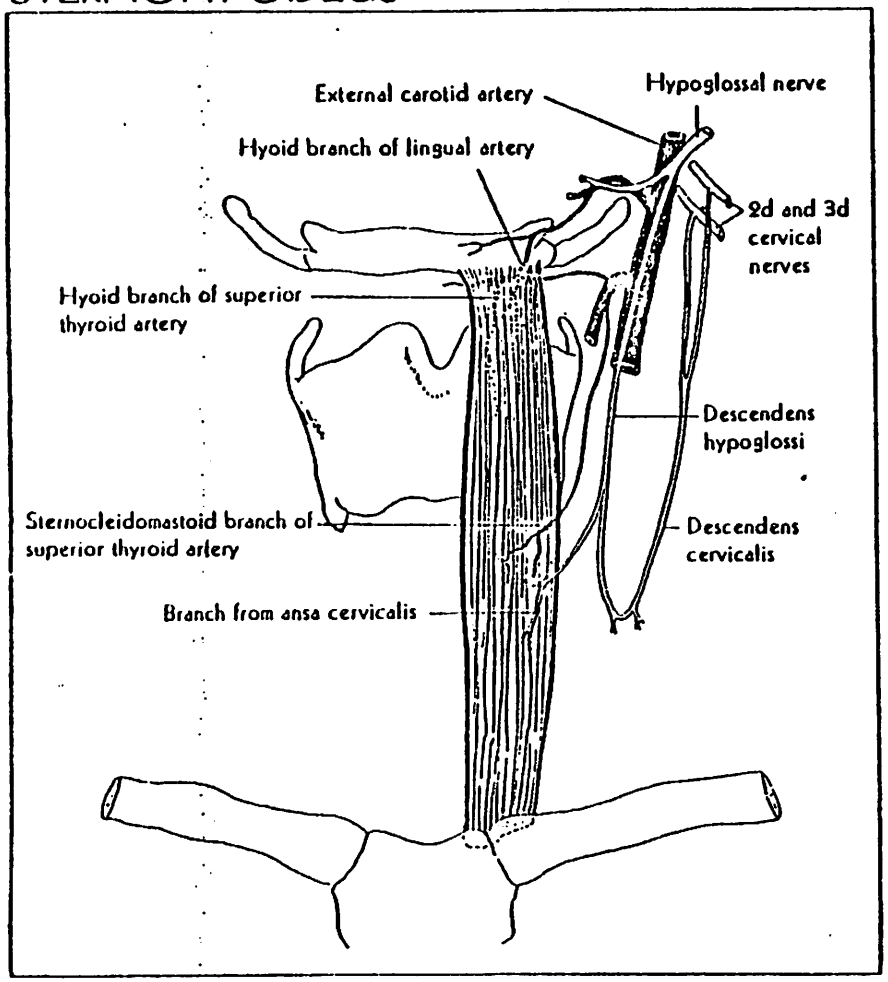
ORIGIN: Posterior border of styloid process of temporal bone near its base
INSERTION: Body of hyoid bone at junction with greater horn, just above omohyoid
FUNCTION: Elevates hyoid bone and base of tongue
NERVE: Stylo-hyoid branch from posterior trunk of facial
ARTERY: Muscular branches of facial, muscular branches of occipital

MYLOHYOIDEUS



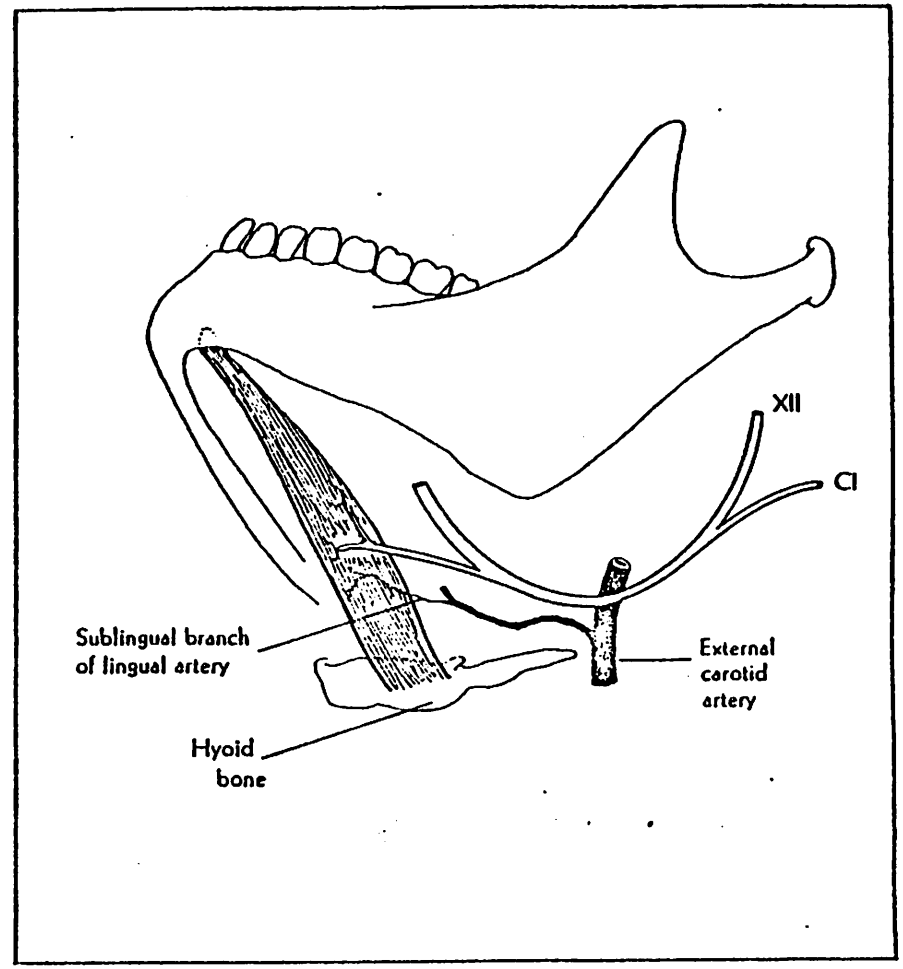
ORIGIN: Line extending from symphysis of mandible to last molar (mylo-hyoid line)
INSERTION: Median raphé from chin to hyoid bone and into hyoid bone
FUNCTION: Elevates hyoid bone and base of tongue, raises floor of mouth; when hyoid bone is fixed, depresses mandible
NERVE: Mylo-hyoid branch of inferior alveolar (branch of trigeminal)
ARTERY: Sublingual branch of lingual, submental branch of facial, mylo-hyoid branch of inferior alveolar

STERNOHYOIDEUS



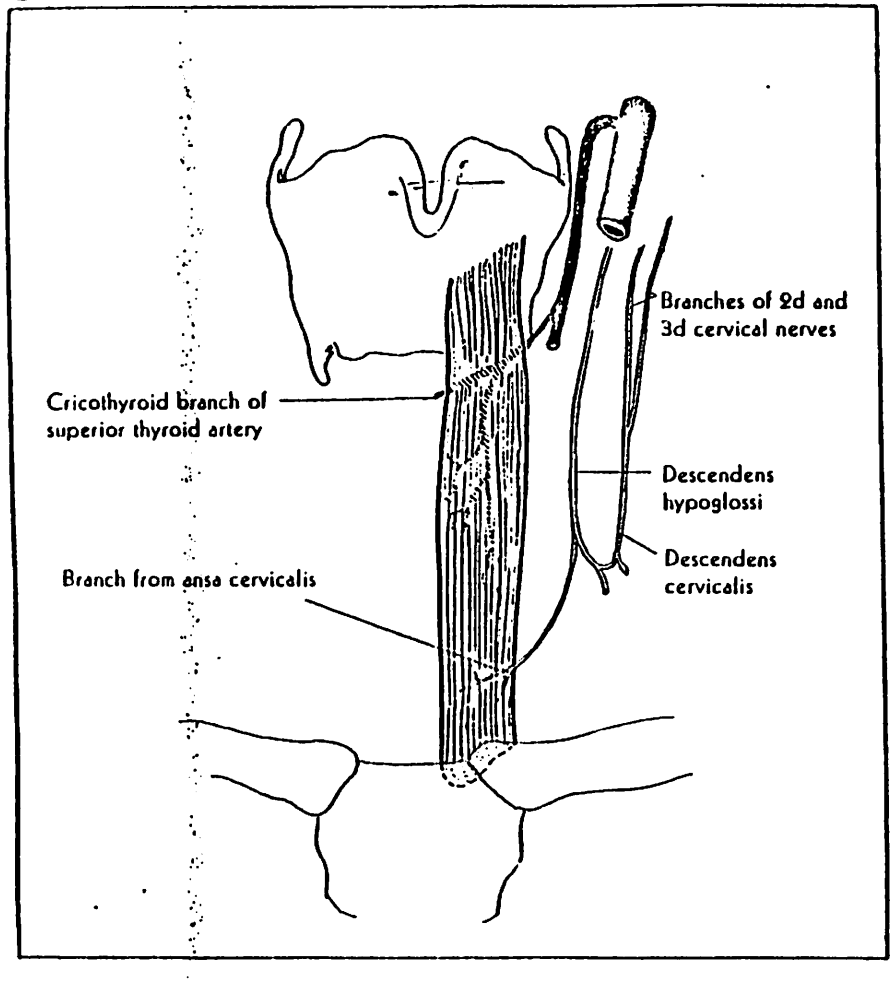
ORIGIN: Posterior surface of manubrium sterni, posterior sterno-clavicular ligament, medial end of clavicle
INSERTION: Medial part of lower border of body of hyoid bone
FUNCTION: Depresses larynx and hyoid bone, steadies hyoid bone
NERVE: Ansa cervicalis
ARTERY: Sternocleidomastoid and hyoid branches of superior thyroid, hyoid branch of lingual

GENIOHYOIDEUS



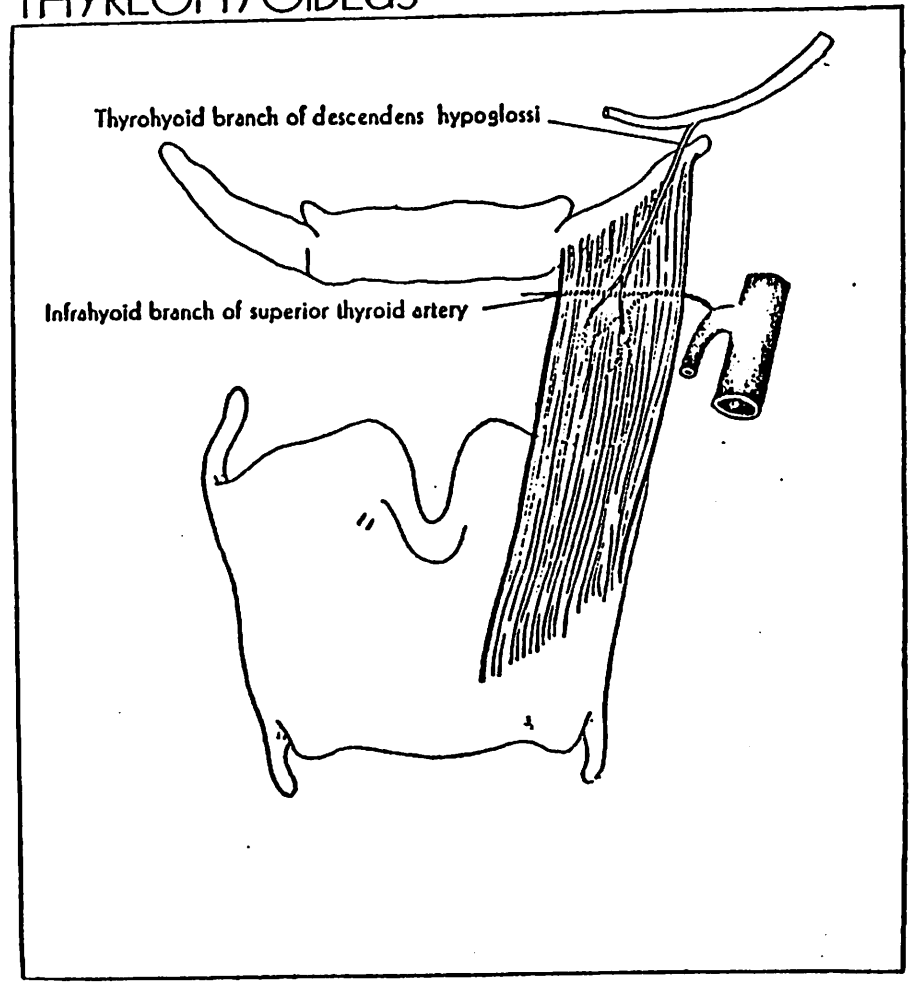
ORIGIN: Inferior genial tubercle on back of symphysis of mandible
INSERTION: Anterior surface of body of hyoid bone
FUNCTION: Elevates hyoid bone and tongue
NERVE: Branch of CI through hypoglossal
ARTERY: Sublingual branch of lingual

STERNOTHYREOIDEUS



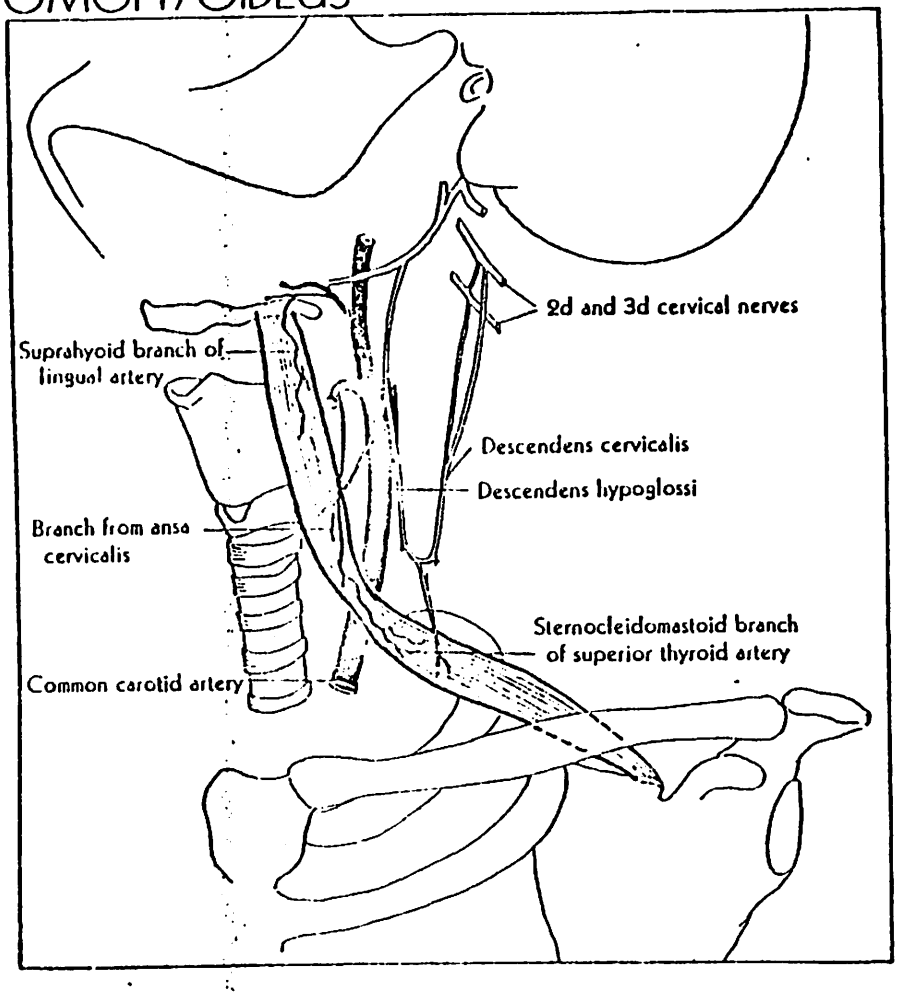
ORIGIN: Posterior surface of manubrium sterni below and deep to origin of sterno-hyoid, edge of first costal cartilage
INSERTION: Oblique line on lamina of thyroid cartilage
FUNCTION: Depresses larynx and thyroid cartilage
NERVE: Ansa cervicalis
ARTERY: Crico-thyroid branch of superior thyroid

THYREOHYOIDEUS



ORIGIN: Oblique line on lamina of thyroid cartilage
INSERTION: Lower border of body and greater horn of hyoid bone
FUNCTION: Depresses larynx and hyoid bone, elevates thyroid cartilage
NERVE: Thyrohyoid branch of C1 through descendens hypoglossi
ARTERY: Infrahyoid branch of superior thyroid

OMOHYOIDEUS



ORIGIN: Inferior belly from upper border of scapula and suprascapular ligament, ending in tendon under sternocleidomastoid muscle; superior belly extends upward from this tendon

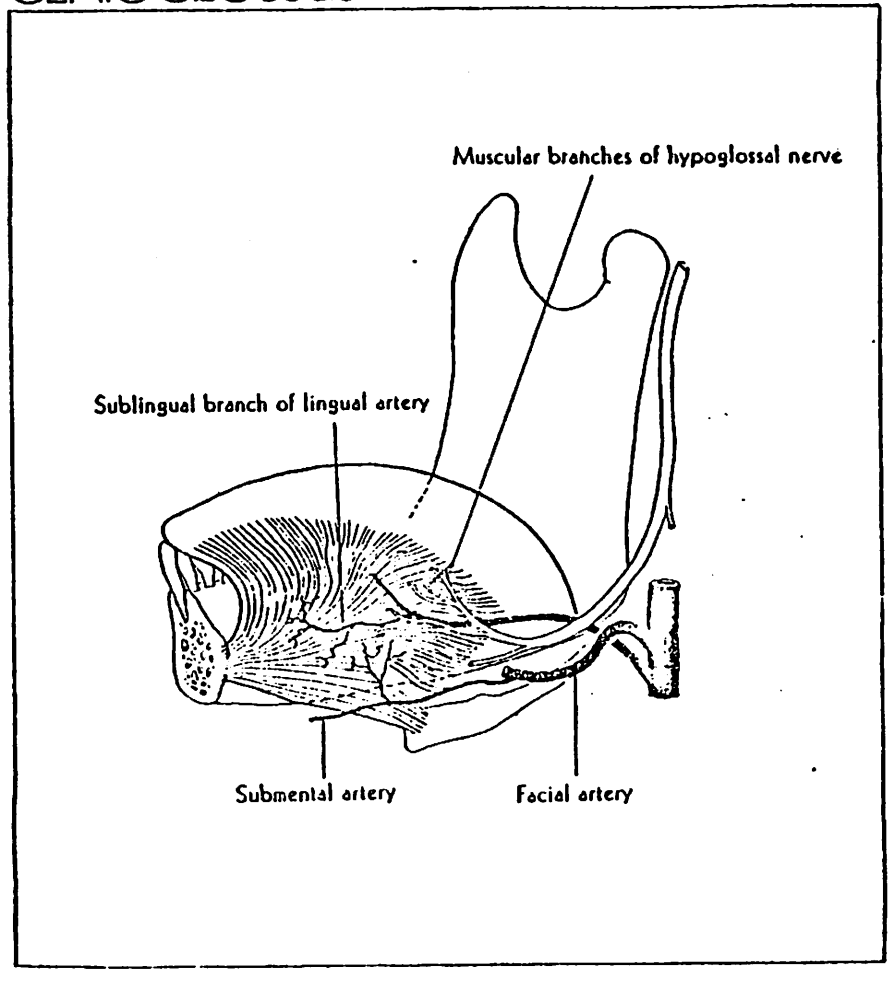
INSERTION: Lower border of body of hyoid bone

FUNCTION: Steadies hyoid bone, depresses and retracts hyoid and larynx

NERVE: Ansa cervicalis formed by medial branches of 2d and 3d cervical and descending ramus of hypoglossal from C1

ARTERY: Suprahyoid branch of lingual; sternocleidomastoid branch of superior thyroid

GENIOGLOSSUS



ORIGIN: This is an extrinsic tongue muscle. It arises from the upper genial tubercle of the mandible

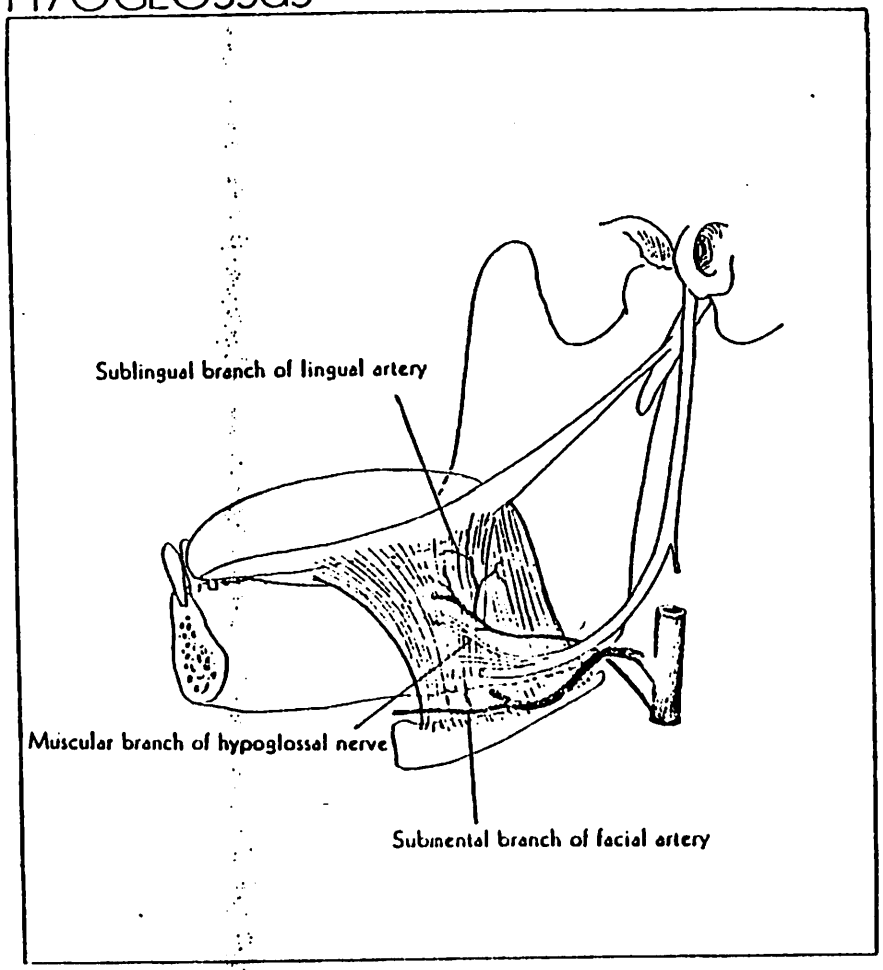
INSERTION: Lowest fibers into body of hyoid bone, middle fibers along whole under-surface of tongue, superior fibers to tip of tongue

FUNCTION: Tongue protruded by posterior fibers, retracted by anterior fibers aided by styloglossus, depressed by genioglossus and hyoglossus

NERVE: Muscular branches of hypoglossal (see intrinsic muscles for sensory innervation of tongue) p. 107-108

ARTERY: Sublingual, submental

HYOGLOSSUS *



ORIGIN: This is an extrinsic tongue muscle. It arises from the sides and body of greater cornu of hyoid bone

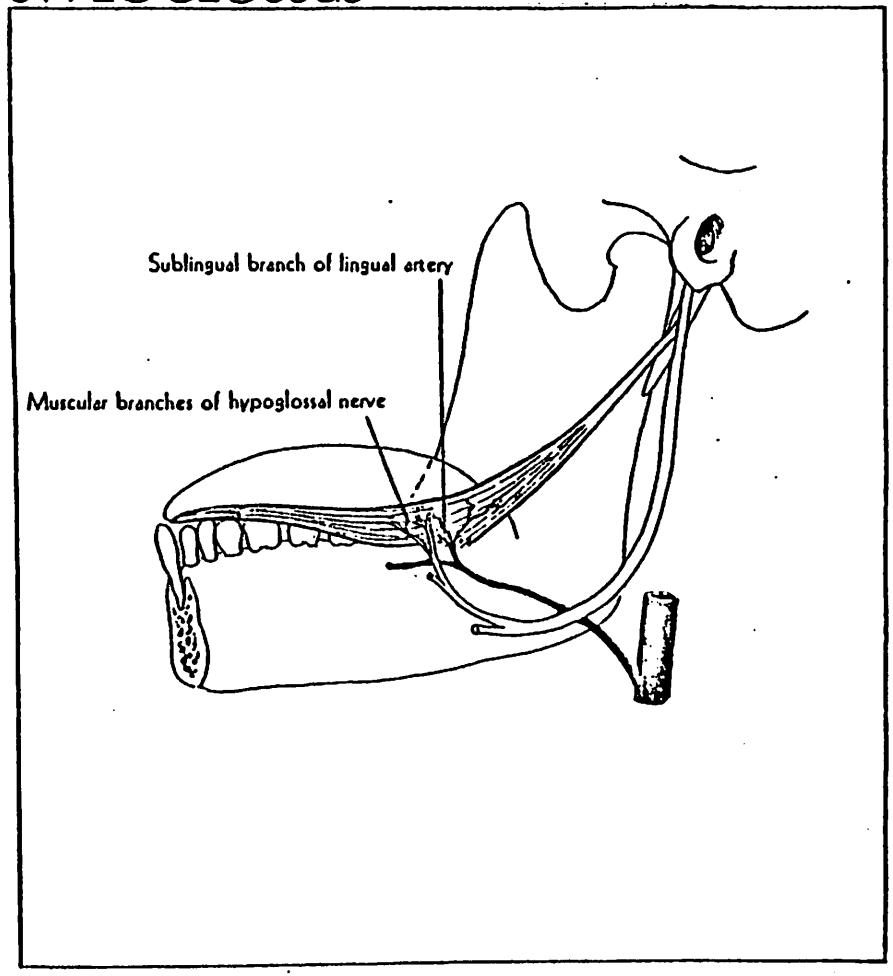
INSERTION: Into sides of tongue, interlacing with fibers of styloglossus and longitudinalis inferior

FUNCTION: Draws down sides of tongue and with genioglossus depresses tongue

NERVE: Muscular branches of hypoglossal

ARTERY: Sublingual, submental

STYLOGLOSSUS



ORIGIN: This is an extrinsic muscle of the tongue. It arises from the anterior border of the styloid process

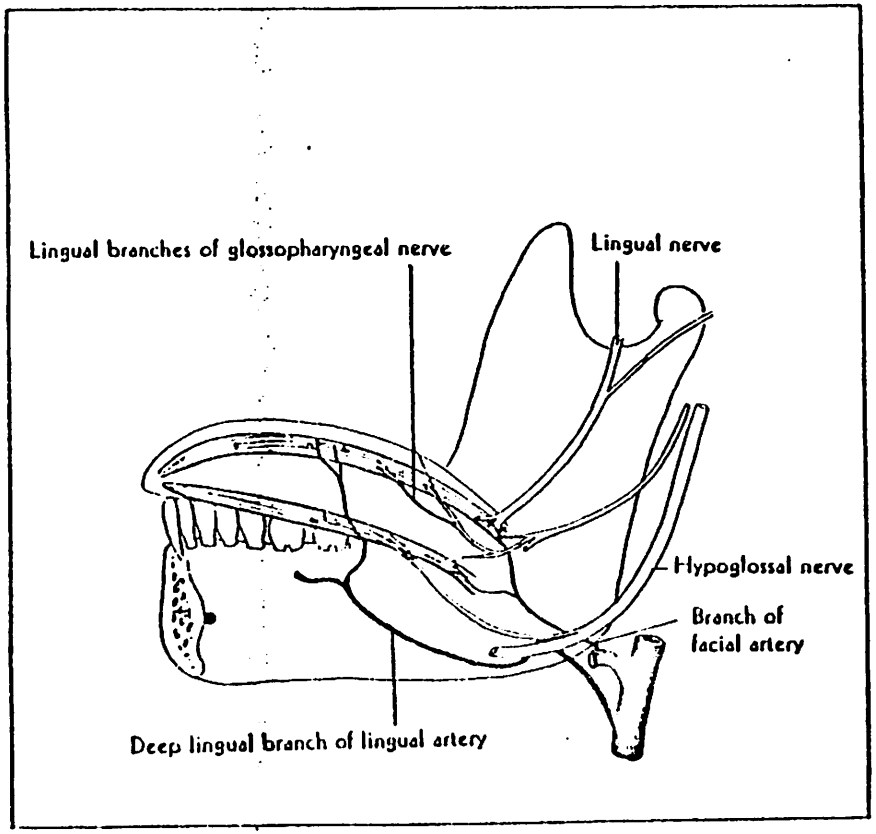
INSERTION: Into the sides of the tongue, its fibers spreading and mingling with the palatoglossus and hyoglossus

FUNCTION: Tongue retracted by styloglossus with aid of anterior fibers of genioglossus, elevated by styloglossus with aid of palatoglossus

NERVE: Muscular branches of hypoglossal

ARTERY: Sublingual

LONGITUDINALIS LINGUAE Sup. & Inf.



ORIGIN: Consists of superior and inferior division; intrinsic tongue muscles; 1) superior from submucous fibers beginning at the back of the tongue; 2) inferior on under surface of tongue between genio-glossus and hyo-glossus

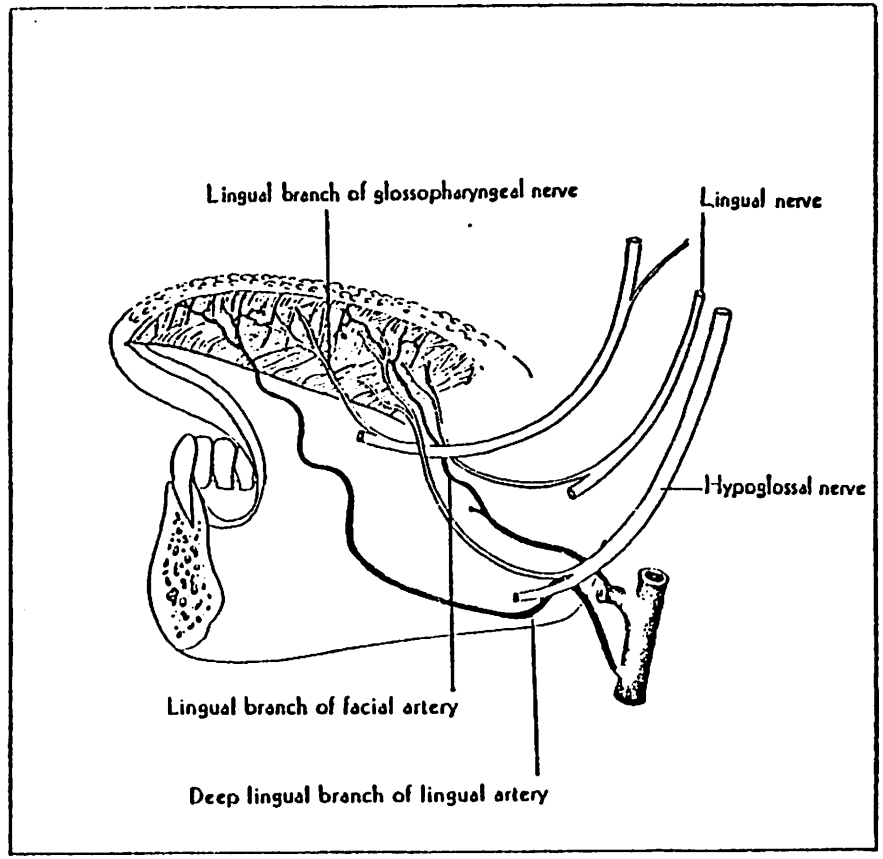
INSERTION: 1) To tip of tongue; unites with muscle of opposite side; 2) to tip of tongue blending with styloglossus

FUNCTION: Modify shape of tongue; 1 and 2 shorten tongue, 1 turns tip and sides upward, 2 turns tip and sides downward

NERVE: Cr. N. V: Lingual branch of V^3—Sensory to anterior ⅔
Cr. N. VII: Chorda tympani branch of facial—Taste, anterior ⅔
Cr. N. IX: Glossopharyngeal—Sensory and taste, posterior ⅓
Cr. N. XII: Hypoglossal—Extrinsic and intrinsic muscles

ARTERY: Deep lingual branch of lingual artery, branches from facial

TRANSVERSUS AND VERTICALIS LINGUAE



ORIGIN: These are intrinsic tongue muscles: 1) transversus from median fibrous septum, 2) verticalis from mucous membrane on dorsum of forepart of tongue

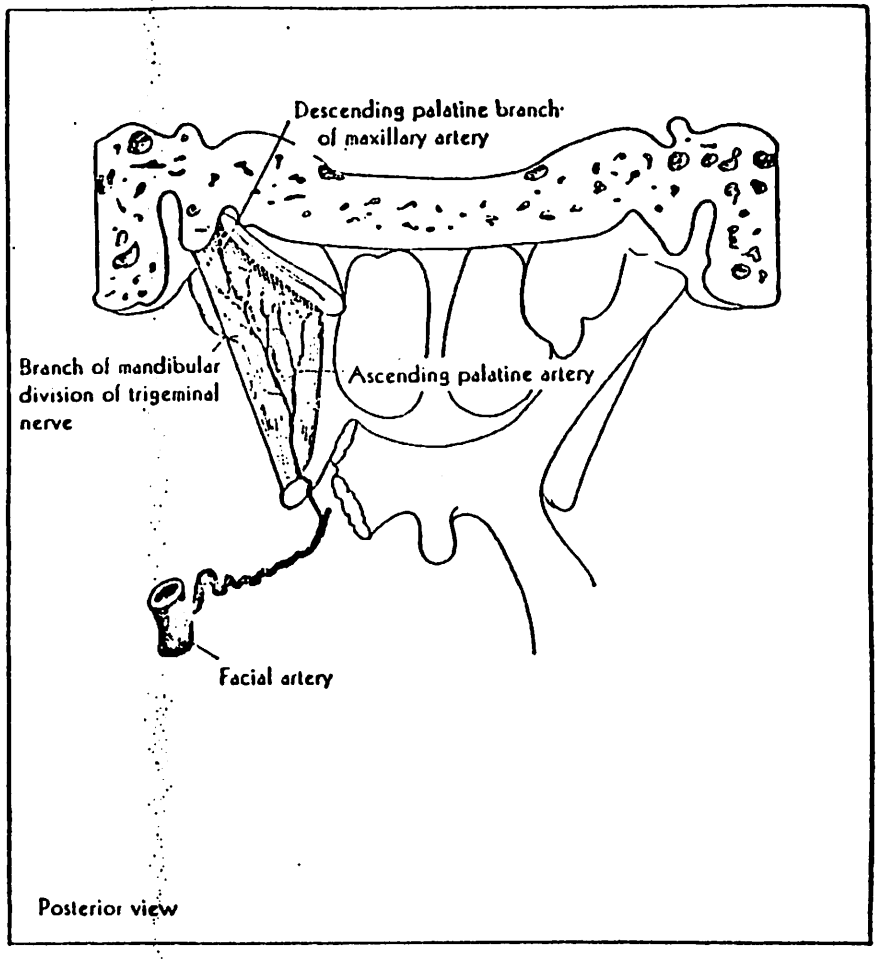
INSERTION: 1) To dorsum and sides of tongue; 2) fibers extend from dorsum to under surface of tongue

FUNCTION: Modify shape of tongue: 1) narrows and elongates tongue; 2) flattens and broadens tongue. Together they form large part of the tongue musculature

NERVE: Cr. N. V: Lingual branch of V^3—Sensory to anterior ⅔
Cr. N. VII: Chorda tympani branch of facial—Taste, anterior ⅔
Cr. N. IX: Glossopharyngeal—Sensory and taste, posterior ⅓
Cr. N. XII: Hypoglossal—Extrinsic and intrinsic muscles

ARTERY: Deep lingual branch of lingual artery, branches from facial

TENSOR VELI PALATINI (Tensor palati)



ORIGIN: Scaphoid fossa and spine of sphenoid bone; lateral sides of membranous and cartilaginous portions of auditory tube

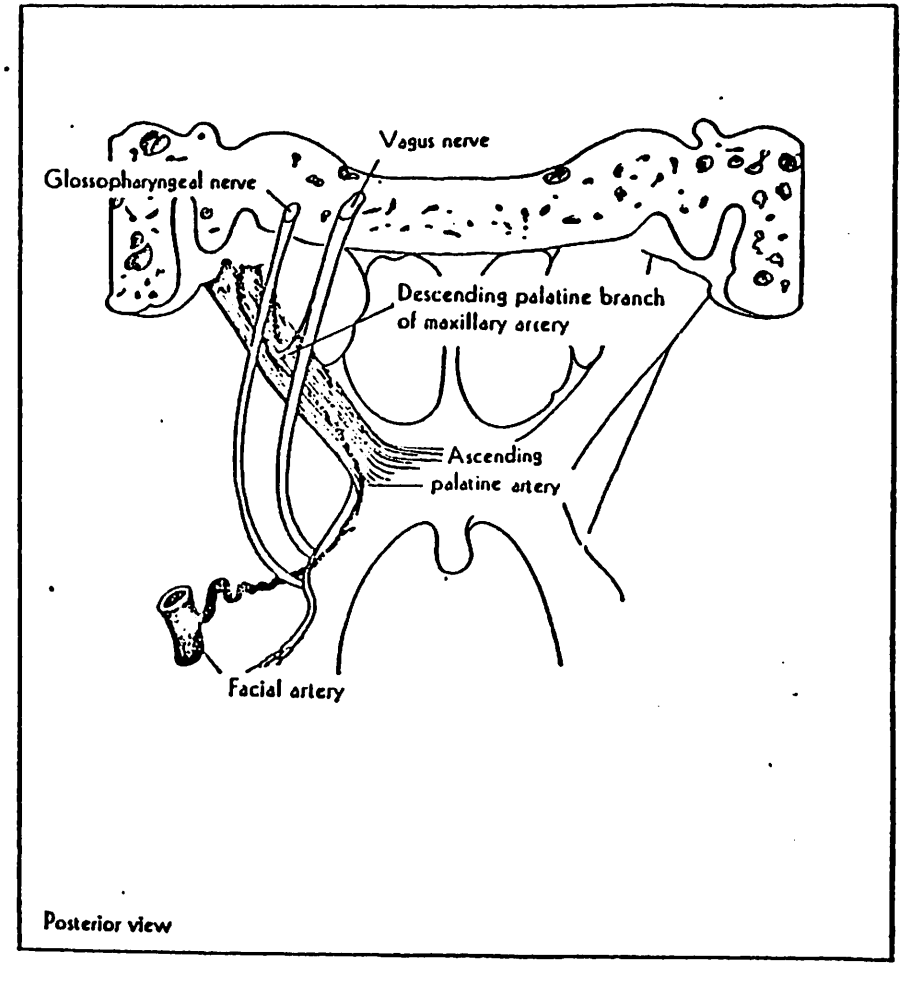
INSERTION: Tendon winds around pterygoid hamulus and into aponeurosis of soft palate; posterior part of palatine bone

FUNCTION: Tenses soft palate; opens auditory tube during swallowing

NERVE: Small branch from mandibular division of trigeminal

ARTERY: Ascending palatine branch of facial, descending palatine branch of maxillary

LEVATOR VELI PALATINI (Levator palati)



ORIGIN: Lower surface of petrous portion of temporal bone; medial side of cartilage of auditory tube

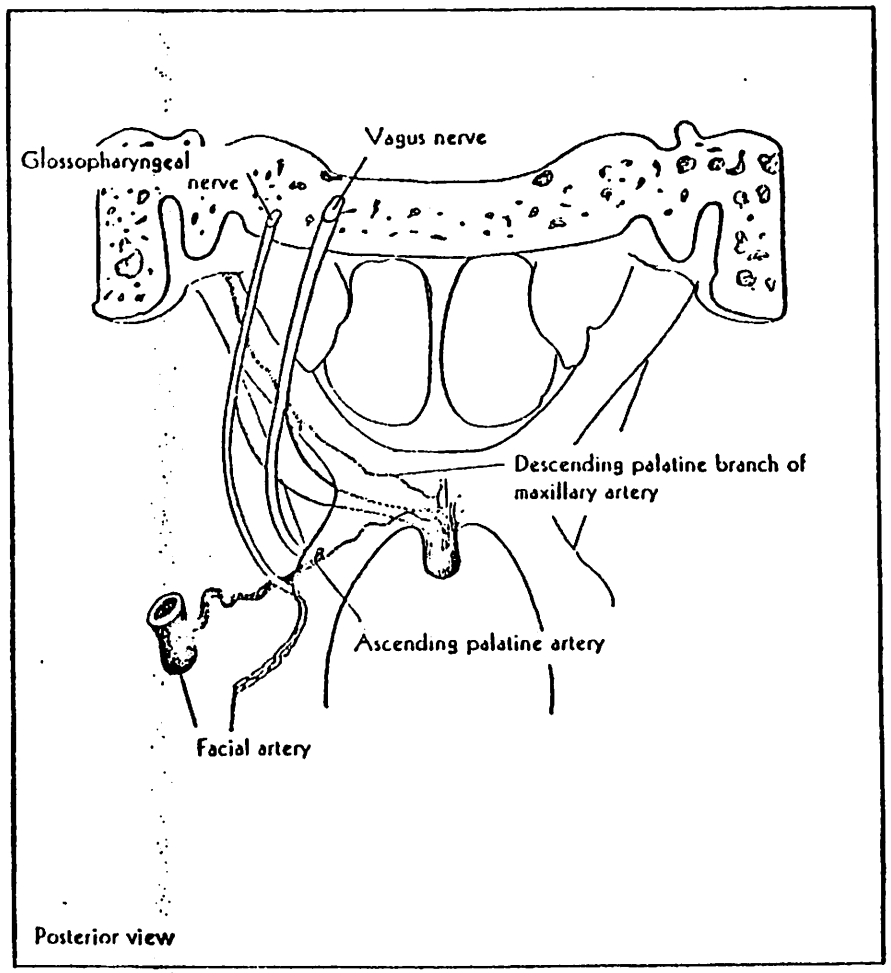
INSERTION: Fibers extend downward and medially to mid-line and join those of opposite side

FUNCTION: Raises soft palate in swallowing

NERVE: Pharyngeal plexus, formed by contributions from sympathetic, glossopharyngeal, vagus and cranial portion of accessory

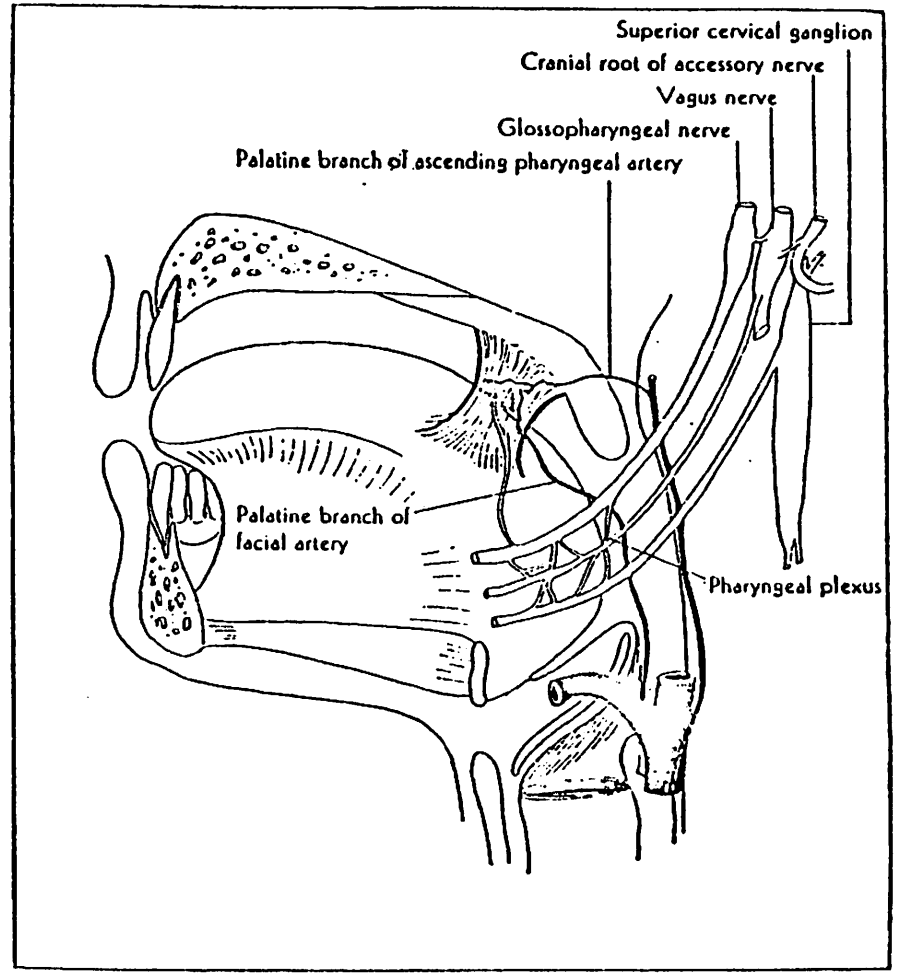
ARTERY: Ascending palatine branch of facial; descending palatine branch of maxillary

MUSCULUS UVULAE



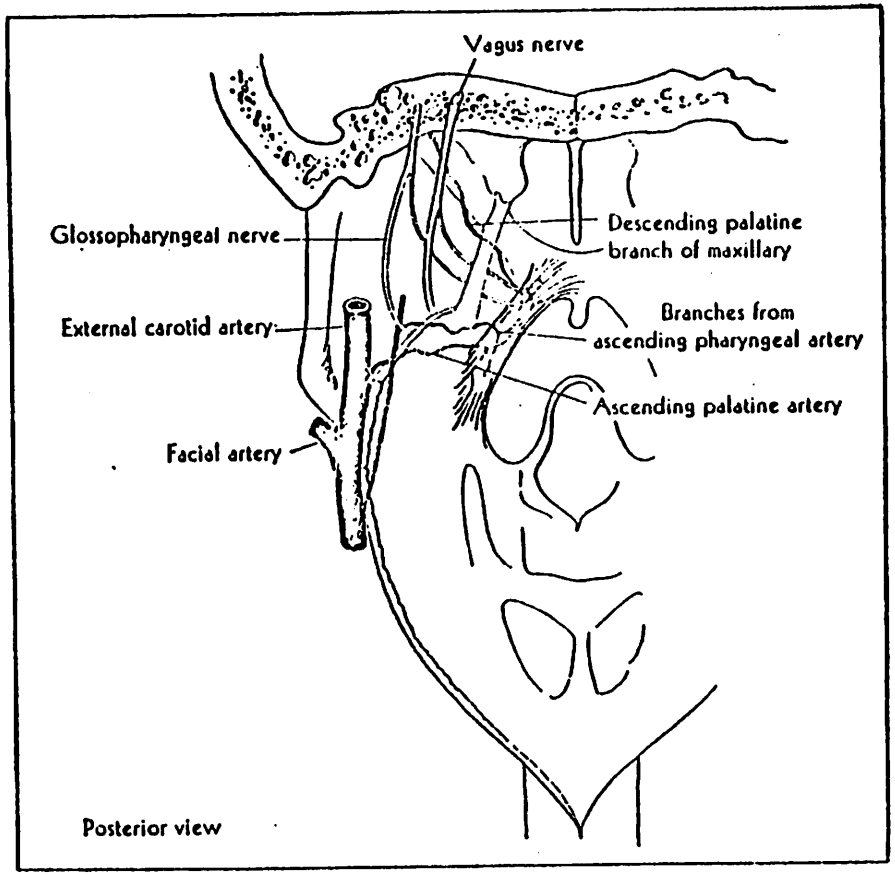
ORIGIN: Posterior nasal spine and palatine aponeurosis
INSERTION: Mucous membrane of uvula
FUNCTION: Raises uvula
NERVE: Pharyngeal plexus, formed by contributions from sympathetic, glossopharyngeal, vagus and cranial portion of accessory
ARTERY: Ascending palatine branch of facial; descending palatine branch of maxillary

PALATOGLOSSUS (Glossopalatinus)



ORIGIN: Anterior surface of soft palate
INSERTION: Dorsum and side of tongue blending with styloglossus and transversus linguae
FUNCTION: Narrows fauces and elevates back of tongue
NERVE: Pharyngeal plexus, formed by contributions from sympathetic, glossopharyngeal, vagus and cranial portion of accessory
ARTERY: Ascending palatine branch of facial, palatine branch of ascending pharyngeal

PALATOPHARYNGEUS (Pharyngopalatinus)



ORIGIN: Extends from soft palate to pharyngeal wall, with mucous membrane forms pharyngopalatine arch; fibers arise from soft palate in 2 layers, the posterior-superior in contact with mucous membrane joins opposite muscle in mid-line; antero-inferior layer passes laterally and downward, joins opposite muscle in mid-line

INSERTION: Posterior border of thyroid cartilage and aponeurosis of pharynx

FUNCTION: Narrows oro-pharyngeal isthmus, elevates pharynx, shuts off nasopharynx

NERVE: Pharyngeal plexus, formed by contributions from sympathetic, glossopharyngeal, vagus and cranial portions of accessory

ARTERY: Twigs from ascending palatine branch of facial, descending palatine branch of maxillary, palatine branch of ascending pharyngeal

Since we are a college of Applied Kinesiologists, and since the word "kinesiology" means essentially, the study of human mechanics or anatomical physics, then a true familiarity with muscular origins, insertions and actions is necessary. It is necessary not only in this one instance, but also in any other kinesiological instance. It is for this reason that the foregoing has been presented.

DISCUSSION:

Musculoskeletal Considerations

Not only can myological dysfunction lead to muscular imbalances - via a malfunctioning golgi tendon organ or muscle spindle apperatus - but also to osteological imbalances.

If two bones stretch a muscle which connects them both, the muscle will be unable to contract as efficiently as it could, thus allowing its ipsilateral antagonist to become abnormally tight.

An example of such an imbalance can be seen in the common origin of the digastricus and the insertion of the sternocleidomastoideus. Possibly one or both of these muscles can affect the function of the hyoid bone, and therefore mandibular function. As well, their contralateral muslces may become hyperkinetic causing other structural problems. This can possibly lead to further imbalances in the ipsilateral stylohyoideus and consequently imbalances in the styloglossus or hyoglossus, (AKA - chondroglossus).

For the purposes of this text, below we have identified twelve bones associated with the tempromandibular joint/hyoidocranial complex. These structures include:

Temporal Bone
Hyoid
Mandible
Clavical
Zygomatic Bone
Maxilla
Palatine Bone
Spheniod Bone
Manubrium
Scapula
Thyroid Cartiladge

The malposition of any one of these structures may cause a concommitant imbalance in the intervening musculature. For example, as stated above, the common point of origin of the digastricus, and the insertion of the sternocleidomastoideus, is the mastoid process of the temporal bone. Specifically, the digastricus has two points of origin. The posterior belly arises from the mastoid notch of the temporal bone and the anterior belly from the digastric fossa of the mandible, and the common insertion of both bellies is by an intermediate tendon which passes through the insertion of the stylohyoid muscle, and attaches to the side of the body, and the greater cornu of the hyoid bone by a fiberous loop.

A consequential weakening of the sternocleidomastoideus which would allow the mastoid process of the temporal bone to rotate posterior, could cause a weakening in the posterior belly of the digastricus and therefore, a malposition of the hyoid bone.

The stylohyoid takes its origin from the posterior border of the styloid process of the temporal bone near its base. The insertion is into the body of the hyoid bone at the junction of the greater cornu just above the mylohyoideus.

Although all three muscles attach to the same bone, their functions are dissimilar, yet intimately integral to the position of the bones, or parts of the bones, to which they take their origin or make their insertion. When the sternocleidomastoideus works singlely, it draws the head toward the shoulder and rotates it pointing the chin cranially, and to the opposite side. When the origin and insertion work together, the muscle flexes the head; as well, it raises the thorax when the head is fixed. The functions of both the diagastricus and the stylohyoideus are to raise the hyoid bone and fix the tongue. The digastricus alone also helps steady the hyoid bone. We could say then that the function of the digastricus is one of precision rather than gross movement.

Since these muscles have different origins and insertions, the position of their origin and insertion dictate the strength with which the muscles can contract. The law of heterometric autoregulation has to do with the ability of a muscle to contract with increased force due to increase stretch. This occurs only within a muscle's physiologic limit. In other words as a muscle's origin and insertion get further apart, the muscle must work harder to pull them together. This means that within physiologic limits the body will strive to maintain balance.

NEUROLOGICAL CONSIDERATIONS

As we know, each muscle contains golgi tendon organs and muscle spindle fibers. At the ends of the muscles, located in the tendon, is the golgi tendon organ. The golgi tendon organ is responsible for detection of the tension applied to the tendon fibers during muscle contraction. If a muscle stretches to its physiologic limit, and beyond, the golgi tendon organ will turn off the muscle. This is the

body's own way of protecting against muscle breakage. In the belly of the muscles are the muscle spindle fibers. They are responsible for detecting momentary length of muscle fibers and the rate of change of these lengths.

Since the golgi tendon organs are primarily tension recorders and respond to active contraction of a muscle and can turn a muscle when it reaches or goes beyond its physiologic limit, the muscle spindle fibers may loose their reference point from which to calculate whether or not a muscle is contracting properly. A very fine tuning mechanism exists between the golgi tendon organs and the muscle spindle fibers to keep a muscle in the proper tonus for its work.

The stretch reflex is the basic neural mechanism for maintaining tonus in muscles. Aside from its role in keeping relaxed muscles slightly active, the stretch reflex is capable of increasing the tension of selective muscle groups to provide a background of postural muscle tonus upon which voluntary movements are superimposed. All is well, considering the structure upon which the muscles are fastened is in its proper anatomical relationship. Should the anatomical relationship become imbalanced, as mentioned above - the sternocleidomastodeus being hypokinetic causing a posterior rotation of the ipsilateral mastoid process of the temporal bone - the neural information becomes chaotic and proper muscular balance cannot be maintained.

Besides the golgi tendon organs and muscle spindle fibers, other neurological considerations must be stated. The muscles intricately involved above also derive their nerve supply form the ansa cervicalis, and cranial nerves V, VII, IX, XI and XII. These areas must not be overlooked in a thorough examination of the hyoidocranial complex.

The usual neurological examination procedures are utilized.

FINAL CONSIDERATIONS

Besides the muscles mentioned so far - the styloidhyoideus, sternocleidomastodeus, and digastracus - another muscle takes its origin from the anterior border of the styloid process. This muscle is an extrinsic muscle of the tongue, the styloglossus. The styloglossus' function is to retract the tongue with the aid of the anterior fibers of the genioglossus, and to elavate the tongue with the aid of the palatoglossus.

The hyoglossus (AKA chondroglossus), takes its origin from the sides and body of the greater cornu of the hyoid bone and is another extrinsic tongue muscle. It inserts into the sides of the tongue interlacing with fibers of the styloglossus and the longitudinalis inferioris. Its function is to draw down the sides of the tongue and with the genioglossus it depresses the tongue.

CONCLUSION:

Because of the intimacy of these muscles with respect to their origins, insertions, and positions in the tongue relative to the mandible, it becomes apparent how important the hyoid muscles are to tempromandibular joint function and speech pathology. An increased tonicity of these muscles on one side of the hyoidocranial complex relative to the opposite side, can cause a concommitant incentric motion of the tongue. This is the cause of speech pathologies such as a tongue thrust, lateral lisp, anterior lisp and many others.

The therapy of speech pathology is proper should the problem be of psychic origin or neurological damage. Should the abnormal lingual physiology arise from myological or structural origin, Applied Kinesiological techniques as an adjunct to chiropractic manipulation is the answer.

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NEURO-CHEMICAL RESETTING

Fourth Dimension Healing

A Research Study Presented To The

INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY

Detroit, Michigan

by: John Andre, D. C.

Fayetteville, AR 72701

ABSTRACT: A principle is described and discussed which helps to explain the way in which the body is healed.

From the beginning of time, mankind has sought relief from the infirmities of mind and body.

Throughout history many perspectives and approaches to healing have been brought forward, tried, and proven or abandoned based upon their respective merits.

Modern Medicine (allopathic/concensus medicine) has proven to be an abject failure at health care, while excelling in crisis therapy. As testimony to this fact, we, the richest nation in the world - who spends most on "health care" per capita - presently rank only number fourteen in infant mortality among the family of nations. The general public is demoralized and rapidly loosing confidence in the present dominant medical system, with its tendancies towards over-drugging, over-cutting, and over-charging - relative to results delivered. Is it any wonder that we, as a nation, are in economic trouble.

Chiropractic has lead the masses towards a more natural, more biologically honest way of life. Chiropractic Applied Kinesiology is progressively exerting a greater influence upon Chiropractice and the populus it serves. Nationwide, skilled A. K. chiropractors are seeing patients travel great distances and have new patients waiting for months to get helped due to very strong popular demand.

The function served by The International College of Applied Kinesiology (I.C.A.K.) has paid large dividends relative to the stimulation, production, and unfoldment of new clinical research findings. Quantum leaps in knowledge and understanding of how to allow the body to be its own research laboratory have been made; each new discovery metaphorically standing upon the shoulders of the prior pooled knowledge.

The potential resultant benefits to doctors of chiropractic are so tremendous as to be difficult of measurement; all they need do is study and learn. Quality instruction is available.

As previously stated, no knowledge stands alone. Many bits of information from various sources provide a mental matrix which functions as a platform wherefrom new thoughts and ideas spring. We eclectic physicians owe so much to so many that it becomes impossible to adequately list them all. It must be noted, albeit, that Dr. Sheldon Deal's discovery of body priority dictates will without doubt go into the history books as one of the most important biologic observations of alltime. Also, the work of the late Dr. Marshall Himes in Segmental Neuropathy opened doors of understanding so profound as to be conspicuous.

While practicing two and a half years ago, this writer stumbled upon a realization - a principle, if you will - that has allowed all the prior studies, complete with all the attendant random information sets, to begin to fall neatly into a well ordered wholeness of vision of the human body/mind (a continuum). Subsequent to stumbling through this door, many other doors have been opened.

The basic observation was a simple one. Much like Newton watching the apple fall from the tree. We have all been brushing so close up against this for so long that it is amazing.

Circumstances were set up to allow for this event by the following train of thought: If one were to analyze a patient at a given place in time, deliver the proper therapy...then, theoretically...said patient should not be in the same place in time where they were previously found. Thus the need to analyze them again. Or, we could say that a dynamic diagnosis is needed and a static diagnosis will not do.

This brought forward the idea that the least one could do would

be to test a muscle pair representing each meridian and major tissue. It was later found that during most office visits testing one side of the body was adequate inorderto determine the necessary direction for therapy. This basic scan can easily be accomplished within two minutes by either the doctor or the assistant.

An example: All basic scan elements check good in the clear except psoas bilaterally weak. Do two hand palm down T.L. to the forehead to distinguish between a higher center and a lower center involvement...it makes psoas strong, place one hypothalplex tablet (V.M. Nutri) on the patients tongue, wait a couple of minutes, have patient chew and swallow. Now re-scan them. We find the psoas has retained its set and we now have all clear except bilateral sartorious weak. Do same forehead T.L. Because it yields the sartorius strong it will most likely be: a.) anterior pituitary, b.) posterior pituitary, c.) pineal, d.) ajna chakra (preganglionic), e.) anterior pituitary/pineal syndrome, or f.) posterior pituitary/pineal syndrome. To sort out one from the other T.L. for the anterior pituitary just above the glabella, for the posterior pituitary at GV-23, for the pineal in between GV-21 and 22, and for the ajna chakra with right palm down on forehead simultaneous with left palm foreward behind the head. In this example the anterior pituitary/pineal syndrome was evident. We reset the circuit with pinealgen-p (V.M. Nutri), did the associated neurolymphatics, and informed the patient in detail relative to the importance of their problem with the occulo-endocrine reflex. This included literature on Vita-Lites, our prescribing full spectrum eye glasses immediately, a John Ott offprint, and the strong suggestion to buy his book: "Health and Light".

We have reset as many as twenty six patterns in a row on one very long office visit. The term "reset" seems to be accurate. Indeed,

when the proper therapy is applied, it works just like an electrical circuit breaker.

This information is not intended to replace any prior knowledge. Rather, it seems to provide a helpful new perspective through which to view the human. And, it helps us a bunch when a doctor new to A.K. asks the question: "but how do we know when to do all these various procedures?"

With this information it becomes clear that the fourth dimension in healing (TIME) is of maximum concern. It is not only important WHAT we do for the patients, but WHEN we do it. As time and circumstances change - so do the patient's needs.

Interfacing this above knowledge with other disciplines has yielded a number of significant understandings. One of which is: It appears as though the human being is only capable of doing one of two things at a time: 1.) either supressing and storing stress within the mind/body, or 2.) unwinding/unwrapping and releasing these deeply stored stresses. It is very exciting to see how a sense of organization in the whole patient progressively developes when one follows the body priority dictate patterns exclusively. Also herein no negative theraputic responses are seen unless a subsequent pattern comes very forcefully to the surface.

Really, what we are doing here is monitoring (conversationally) Innate Intelligence. This is superior to concept analysis (D.N.F.T., et al) in that those doing concept analysis are limited to their own ability to conceive of a problem before they can ask the body about it. Using this Neuro-Chemical Resetting approach allows the body to communicate the problem as it exists through appropriate muscle weakness patterns, thus putting the onus upon the doctor to figure out the pattern then surfaced.

Possibly, the role of the physician engaged in Chiropractice should be to facilitate the progressive release of stress through unwrapping the deep knots in the physiology...much as Transcendental Meditation does in the area of one's consciousness. Actually, the two seem to blend together into the most delicate of overlaps in daily practices. This mode of practice is supported by core chiropractic philosophy, eg. to treat the patient and not the disease. Coincidentally, as these stresses are unwrapped, even the most bizarre of disease patterns fade away. Hans Selye appears to be very correct in pointing to stress as the cause of disease.

Most A. K. chiropractors have gained a level of skill whereby they can well compete with the medical physicians and their practice of crisis therapy. However, it must be remembered that the reason we are even a profession at all today is due to our ability to get sick people well when the entire allopathic medical team has failed. It is entirely possible that the reason for their failure is in large part simply due to a lack of proper knowledge and understanding as to how the body does what it does when it does it.

We have it within our reach today, for many reasons and due to many circumstances, to completely alter the course of health care history. We are already doing it. Consider what the last ten years have brought in the way of growth through increased skill and ability. These times of profound stress and rapid change are working for us and against the inequities of the older less adequate ways. It is pleasant to watch the turning of the public mind towards that which works. It seems that political unity within our profession could be achieved upon a platform of knowledge rather than belief. The key issue appears to be: will we as a profession look for and treat the cause of the subluxation...or?

FUNCTIONAL OCTACOSANOL DEFICIENCY SYNDROME

A Research Study Presented To The
INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY
Detroit, Michigan

by: John Andre, D. C.
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ABSTRACT: A new method for detection and treatment of octacosanol deficiencies is discussed. The presence of a meridian clock block is treated with appropriate protomorphogen therapy, subsequently correcting an overstimulated pancreas which in turn yeilds an homeostatic normalization in octaconasol levels.

INTRODUCTION

Awareness of and interest in the role played by octacosanol in the human body is increasing.

Octacosanol is a solid white alcohol found in wheat oil and from cuticular wax of apples.[1] It is also found most richly in the green blades of wheat (chlorophyll-complex) and in much smaller quantities in wheat germ oil.[2] Octaconasol is fat soluble.[2]

Among the many conditions showing a response to octacosanol are: myoneuropathies, encephalitis, cerebral palsy, and multiple sclerosis.[3]

STATEMENT OF THE PROBLEM

The purpose of this paper is to present an apparent explanation for the probable mechanism whereby octacosanol may be forced away from its normal homeostatic levels through an aberrated physiologic function.

Clinical experience reveals numerous patients with octacosanol deficiencies that fail to exibit lasting response to octacosanol supplementation therapy of customary duration.

Based upon chiropractic philosophy[4] and physiologic knowledge[5] it has long been understood that the human body will, unless interfered with, maintain all systems stable within a field of ever changing environmental stresses (homeostasis). The physician can do only two things for the patient: a.) remove the obstacle to healing, and b.) motivate the patient to be well.[6]

Reason and clinical experience dictate that it should not be

necessary to prescribe any single nutrient for a time longer than needed to achieve the therapeutic goal, mindfully considering that each substance put into the body takes that which is needed from the body for its processing.

LIMITATIONS TO THE STUDY

There were limitations to this study which could affect its outcome. They are as follows:

1. The sampling technique used for this study was not random. Observations were made only on patients seeking care at The Associates Clinic at Fayetteville, Arkansas.
2. Observations were facilitated by strict adherence to body priority dictate patterns presented sequentially.

REVIEW OF THE LITERATURE

The Istuto di Chimica Organica of Pavia, Italy observed rich dominant octacosanol development in the earliest growth stages of bread wheat.[7]

Krulick and Osman reported that sliced potatoe tuber tissue, on incubation, contained large quantities of octacosanol which was not found in comparable unsliced tissue. They also stated that the function of this compound in physiologic processes has not been identified.[8]

Jones, Wert, and Ries found that the addition of octacosanol inhibited the growth response of previously stimulated groupings of rice, maize, and tomatoe seedlings.[9]

RESEARCH METHOD

Duration of Study

This study has been ongoing for three and a half years.

Number and Quality of Subjects

There were in excess of five hundred subjects showing this syndrome during treatment.

The subjects of this study were from a broad distribution of society: sex, age, fitness, diet, and economic backgrounds were mixed. All subjects were patients seeking health care at The Associates Clinic at Fayetteville, Arkansas.

Findings

Manual muscle test findings included fixation-subluxation indicator muscles[10] being weak along with bilateral subscapularis and/or bilateral quadriceps. These were either weak in the clear or in the clear weakness was evidenced upon performing various temporary "unswitching" procedures such as Temporal Tap Audit and K-27/Spl-21 Tap.

DIAGNOSIS

Determination of the presence of this syndrome was made via manual muscle testing[11] following body priority dictates.[12] Testing of selected therapeutic nutrients was accomplished by placing the nutrient in question on the subjects tongue and subsequently re-testing all previously weak indicator muscles to verify a total response.

All subjects were followed up for at least six office visits spread over three to sixteen weeks.

No diurnal variations were observed.

TREATMENT

Treatment consisted primarily of the appropriate therapeutic nutrient (one bottle, usually).

Commonly, the subscapularis (heart indicator muscle) will show up integral to this pattern. When so, a heart protomorphogen (Standard Process Labs, Cardiotrophin) was most effective for correction. On those subjects where a heart tissue concentrate was used, some held their correction while others subsequently required

the protomorphogen therapy.

When the quadriceps surfaced as a part of this pattern, Anti-Gastrin Capsules (Standard Process Labs) was found to be especially helpful along with a small intestine tissue concentrate. Often, it will be found with this phase of this syndrome that the pectoralis major sternal will be strong in the clear with a positive therapy localization to the liver alarm point on the same side. With this finding the subject will do very well with Cholacol II (Standard Process Labs). This product is reported to have a scrubbing effect in the small intestine as well as containing the toxin absorber: montmorillonite.[13]

Upon occasion, other clinical considerations surface in a commanding way requiring additional therapeutic adventures. These all seem to have either the heart or the small intestine as a target site. The following are semi-common along with the customary five factors of the intervertebral foramen:

A. Potassium deficiency or functional potassium deficiency.

B. Parasitic infestation.

C. Clock elemental neuro-chemical resetting pattern (Shin and/Ko Cycle point progressions).

D. Simple meridian neuro-chemical resetting pattern (Source point progressions).

E. Pre-ganglionic involvements.

It is therapeutically imperative that all abnormal intrinsic and extrinsic excessive stress loadings relative to the heart and small intestine be corrected.

HISTORY

It has been reported that octacosanol has an anti-gravity factor and that it is related to fixation-subluxation patterns.[14] It is possible that a deficiency of octacosanol causes a change in

the chemical construct of cerebrospinal fluid. The dural sleeye around each spinal nerve might thereby loose its ability to perform its normal lubricating function, thus potentially causing undue stimulation to the fifth layer muscles and hence the fixation-subluxation pattern.

DISCUSSION

It is herein suggested that an intimacy of relationship exists within the framework of the meridian clock which allows the normal energy transfer mechanism to aberrate, reversing its normal forward motion, this in turn creating a functional clock block. When the block exists between the Spleen/Pancreas Meridians and the Heart Meridian an overstimulation in pancreatic function occures due to an excessive energy loading whose cause is said reversing of normal meridian clock energy flow characteristics.

Your writer has observed that this phenomena, when present, produces muscle weakness indicators associated with the fixation-subluxation syndrome. Simultaneously the pancreas indicator muscle (lat. dorsi) often checks positive for hypertonification. It is also hereby suggested that the pancreas secretes an unknown substance (substance "X") which acts as a balancer to octacosanol in the same way in which insulin is the balancer for blood sugar. This hypothesis appears reasonable in that many liver functions are in a cross balancing relationship with the pancreas and visa versa. It is thought that liver is the primary site of activity for octacosanol.[15]

The role of excessive stress in our society cannot be overlooked. Emotional stress targets many areas of the body. The recounting statement: "so and so broke my heart", reminds us graphically that the heart has an important role in emotional disease.

The small intestine is an important target site for dietary

stresses.

Other clock blocks have been noted at other points on the clock. When present, the same principles of correction appear to apply.

The coincidence of pancreas as involved site in: 1.) Functional octacosanol deficiency syndromes, 2.) Dysinsulinisms, and 3.) Some cancer patterns[16] should be studied. It is possible one function of octacosanol might be to normalize previously overstimulated cell growth in humans similar to that reported in rice, maize, and tomatoe seedlings by Jones, Wert, and Ries.[9]

Symptom Patterns

This writer has observed clinically that an extreme range of symptom patterns is possible when an octacosanol deficiency exists. Among the more common are the following: headaches, stiff necks, a host of mental/emotional symptoms, joint stiffness and pain, fixated and/or "frozen" joints (lack of turgor), localized parasthesia, and some kinds of radicular pain. It is possible that the mental/emotional symptoms might be due to an alteration in the chemical medium bathing the brain.

Hypoglycemia Pattern

The mechanism herein suggested appears to simultaneously be an important, primary causative factor in producing functional hypoglycemia due to the overstimulated state of the pancreas. The coincidence approaches 100%.

Aspirin Mechanism

It has been observed that when this pattern is present, one aspirin on the tongue will clear all muscle weakness indicators. It simultaneously clears an indicator showing liver positive for being in an energy borrowing state.

This causes one to hypothecate that the mechanism whereby asp-

irin effects to body neurochemically is through its ability to effect octacosanol and its balancer (substance "X"). This would very easily explain the tremendous relief many patients enjoy via the two aspirin route. It would also help us to understand why arthritics experience so much help from aspirin; liver being the primary site of involvement in most arthritis patterns.[17]

CONCLUSION

The inability of a major tissue involved in meridian clock dynamics to 1.) accept, 2.) hold, and 3.) pass on the magnetic wave of focus central to said clock dynamics can cause a meridian clock block and subsequently an octacosanol deficiency.

This mechanism may also be responsible for a sizable percentage of the hypoglycemic/diabetic epidemic sweeping the U. S. of A. as well as other less clear commonalities.

The central nature of the systems involved along with the sizable percentage of the populus involved suggests further studies in this area.

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APPLICATIONS OF NEUROLOGICAL TOOTH INVOLVEMENT IN RESISTANT STOMATOGNATHIC PROBLEMS

Robert M. Blaich, D.C.

It has been observed, particularly on "problem patients," that the neurologic tooth involvement may be significantly more common than is generally recognized. Further, it may be involved in the re-creation of cranial faults, vertebral subluxations and muscle and organ dysfunction.

Twenty-five patients were used for this preliminary study. Each of the patients had some particular recurring problem: cranial fault, subluxations, or specific muscle-organ involvement. The common diagnostic factor exhibited by these patients was an applied kinesiology index for the presence of interference in the occlusion. This test was done by simply having the patient bite down gently in normal occlusion while testing any strong indicator muscle. If the strong indicator muscle weakened, interference in occlusion was thought to be present, on either a structural or functional basis. When this criteria was present, it seemed to indicate the need for correction of either a neurologic tooth involvement, a cranial fault, or a major subluxation (usually upper cervicals or pelvic). If the cranial faults had been corrected just previously, it seemed probable that there would be neurologic tooth involvement as a primary problem, which could be causing the cranial faults as a compensation. The procedure then involved scanning the patients gingiva for neurologic tooth involvement by using an indicator muscle while the patient therapy localized two or three teeth at a time at the border of the gingiva and the teeth. When the particular tooth involved was found, it therapy localized, was challenged and adjusted with the usual AK procedure.[1]

Results: In these twenty-five patients, the correction of neurologic tooth involvement allowed a more permanent correction of previously recurring cranial faults, major subluxations, or muscle-organ involvement.

Discussion: Although there is nothing new in this particular procedure, the incidence of neurologic tooth involvement in various types of stomatognathic problems is often overlooked by the practicing applied kinesiologist. The phenomenon which

(cont'd)

(cont'd)

made the greatest impression on this investigator was the situation which occured in a high percentage of these twenty five patients, in which before treatment of cranial faults and subluxations there was no seeming interference in occlusion. However, after structural correction, interference in the patient's occlusion did exist, as evidenced by the weakening of a strong indicator muscle while the patient was biting down gently. This observation seemed to indicate that something else needed to be done to prevent this occlusal interference from re-creating the cranial faults or subluxations as compensations and returning the patient to the condition he was in before being adjusted. Further investigation indicated that a very effective way of correcting this occlusal interference was by locating and correcting the neurologic tooth involvement. Following proper correction, evidence of the interference in occlusion was eliminated, as were the cranial faults or subluxations which had originally been corrected. This particular procedure greatly reduced the need for re-correction of the stomatognathic problems and also the per cent of patients which might otherwise be referred for a dental splint to modify or compensate for the interference in occlusion. On several occasions the interference in occlusion was eliminated by correction of a cranial fault or upper cervical adjustment.

Another interesting aspect in those problem patients where this interference in occlusion then recurred in a future examination was that: 1) zinc is useful in preventing its recurrence (as originally described by Goodheart), 2) treatment to the five factors for the associated muscle and organ of a particular problem tooth was often necessary to prevent recurrence of that tooth involvement. In other words, if an upper left first molar was the tooth that had recurring involvement which re-created occlusal interference, that particular tooth might then be recorrected by treatment to the five factors for its associated organ (the pancreas in this example), 3) ionization problems were found in a high percentage of those people exhibiting the neurologic tooth involvement. The significance of this is not yet understood.

(cont'd)

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Conclusion: In patients with resistant stomatognathic problems, it seems useful to test the patient for interference in occlusion by testing a strong indicator muscle while the patient bites down gently. If this test is positive it is indication of the presence of a cranial fault, neurologic tooth involvement or some major subluxation usually in the upper cervicals or pelvic area. It is useful to test the patients for occlusal interference following all structural corrections to rule out the possibility that aberrant neurologic input from occlusal interference might recreate the structural problems, as a compensation. With the massive input given to the cerebral cortex by the stomatognathic area, it is not illogical to consider that problems could be created elsewhere in the body in an attempt to relieve or compensate for the stress of occlusal interference. Although this is a preliminary report involving a small sample of twenty-five patients, there seems to be indication that this is a valuable procedure.

1. David S. Walther, Applied Kinesiology, The Advanced Approach in Chiropractic, (Systems D.C., 1976) p. 268

John W. Brimhall, B.A.,D.C.
February 5, 1981

THE LEAD SQUARE PRIORITY CHALLENGE

Abstract

Much work has been done in the last several years on showing that the body has a priority in which it should be fixed for maximum results. It has even been shown through AK proceedures when fixing an area out of sequence, it causes it to only return very shortly and it may cause other compensations. We feel the lead square challenge will show you the priority much faster than any other method previously discussed.

As early as 1977 Dr. Beardall was talking about body priorities. He stated that an inspiration lesion or a muscle that's strong when a person inhales was ready to be fixed. A muscle to strengthen while the patient exhaled was not a priority and should be left until the inspiration muscles were corrected. The expiration muscle would then change to inspiration when it was ready to fix. His work has gone on to show other criteria for priority muscle testing and treating.

Dr. Deal in 1978 summer meeting had his article in the collective papers on body priorities as demonstrated by a "dental splint". He stated and showed that the body also had priority mechanisms and by use of a dental splint many other problems would disappear and show that they were compensations and not actually the cause.

It was shown that for a muscle to be fixed or a segment to be set in priority, it must meet the criteria of: (1) it must be weak in the clear, (2) it must therapy localize, (3) it must respond to the inspiration phase of respiration by becoming strong when tested.

In the summer meetings and presented in the collected papers of the ICAK in 1979, Dr. Michael D. Allen branched off on an article called "The Body Knows It - Ask It". His article alluded to one more piece to the puzzle

of determing a primary-priority. That is the same previous three criteria must be used but a fourth can be added which is to pinch the patient anywhere except over the therapy localized area and if the muscle blows weak, it is a compensation. If it remains strong with the other three points in mind, it is a priority ready to be corrected.

It was further shown that when the primary was fixed, then often the compensation would then come up to be the priority and be ready to be fixed. It was further shown that the body would go through a sequence of possible a catagory three and then to possibly a catagory two but would always end up with a category one to be corrected last in the sequence.

On further examination, I think this technique proved very beneficial and we found that a TMJ would sometimes follow the category one before total stabilization would be afforded.

Many doctors have since worked on the priority mechanism and tried to determine the possibility of short cutting this proceedure. And to further prove in their own mind its usefullness.

One complicating factor that has been demonstrated is that more than one segment or muscle may show all of the criteria for a priority mechanism at one time. So which is the real priority. Another complication we found is that it is very time consuming to screen all suspected areas, not to mention the patients weren't overjoyed about our pinching them.

In March of 1980, I went to Cumberland, Wisconsin, and took the Toftness work. Here Dr. Toftness demonstrated amoung many other things, the use of a lead strip to differentiate an occipital reading from a cervical reading. Goodheart's indoctrination has taught us to ask, "Why is that?" and "What

is that?". Further investigation led us to use the Toftness instrument to diagnose the priority. Dr. Toftness has always not only found where the subluxations were with his instrument but has been able to determine which is the maximum area reading and therefore a priority. He always corrects the highest reading or priority first. We found by using the lead strip we could short cut this diagnosis to extreme accuracy and speed.

Further investigation showed us that we could identify priorities according to AK by the same methodology. For example - let's say a patient has a catagory two on the right with a 7th thoracic subluxation with a bilateral gluteal maximus weakness or a cervical fix. How would we know which was the priority? It's even possible that all three of these could meet the other four priority standards. There could also be many compensatory lesions show upon investigation. We found that if the lead strip was placed over the right catagory two and it was the primary-priority, its therapy localization and all other findings would be totally neutralized including the T7, the upper cervical fix and all other compensations upon therapy localization, etc. If the upper cervical fix was not the major problem, it would abolish its therapy localization when the lead strip was placed there but the others would remain to show positive T. L. upon testing.

In summary of the technique, let me reiterate. No matter how many areas of involvement you find, the lead strip placed over the priority subluxation or involvement will abolish all reflexes or therapy localization, etc. If the lead strip was placed over a compensation, it will abolish its reflex but not all of the rest on the body. We also use this to diagnose the major organ disfunction. We feel treating the major body priority first is important here, too.

We hope you find this as useful as we have.

PELVIC BALANCING FLOW CHART

Katharine M. Conable, D.C.

ABSTRACT:

A sequence of testing and treating pelvic imbalances with Applied Kinesiology indicators is suggested, progressing from broadly effective to detailed procedures.

This paper presents a flow chart for correcting pelvic imbalances. It is intended to progress from broadly corrective patterns such as "Pitch-Roll-Yaw" (G. 80 Vol. I p. 1-14) and in-the-clear non-intact muscles to more subtle, hidden-weakness tests. As it is intended for clinical use, I have tried to minimize flipping the patient over. For doctors new to A.K., I suggest doing all the double checks on A.K. patterns. As you gain experience, often time can be saved by relying on challenges alone unless conflicting data arises. The whole pattern can be checked rather rapidly - correcting as you go.

I have referenced the procedures to the more recent presentations in Goodheart's works and the ICAK Collected Papers. Many other references exist.

On subsequent visits I often check only those muscles previously found to be weak and those symptomatically related, given that the patient is progressing well. I suggest reverting to the full pelvic muscle test if there is slow progress. I find that muscles hold much better if all

active reflexes for the particular muscle are treated in one visit rather than proceeding only to the first point of intact functioning on many muscles. Non-intact muscles which recur despite full "five-factor" handling above need to be checked through the full range of aerobic/ anaerobic testing (G. 80 Vol. I p. 31-41), fascial release (G. 79 Vol. II p. 1-8), and "eyes-into-distortion" testing (G. Tape 62). This gives a very good chance that the muscle will stay intact. If there are still problems, more intricate modes of therapy localization can be used. One of the problems seen by doctors new to A.K. is establishing a hierarchy of procedures and efficient testing patterns. I hope this protocol will be of use in teaching, in practice, and for new Applied Kinesiologists.

PELVIC BALANCING FLOW CHART

1. POSTURAL OBSERVATION - standing, prone, supine - I believe that apparent discrepancies in the pelvic pattern observed in different positions may be the result of fixation at the sacro-iliac. Any confusion should be resolved by careful challenging and will clear as correction occurs.

2. PITCH-ROLL-YAW (G. 80 Vol. I p. 1-14).

3. CATEGORY II - therapy localize, one hand to SI joint, supine. Challenge and adjust or block. Challenge ilium for actual position if discrepancy standing to supine, or palpation vs. leg length.

4. TEST PELVIC MUSCLES:

adductors
tensor fascia lata
gluteus minimus (Schroeder ICAK 80W - p. 267)
pectineus
psoas (F)
iliacus
quadriceps - rectus
- vastus
piriformis - 90°
- lower (hyperflexion of hip) (Schroeder ICAK 80W p. 267)
- bilateral simultaneous 90° (C) (Schroeder ICAK 80W p. 267)
sartorius
quadratus lumborum (Beardall Clinical Kinesiology Vol. 1)
abdominals - rectus
- oblique
gluteus medius
hamstrings - central
- medial
- lateral
- "short"-hyperflexion of knee (C) (Schroeder ICAK 80W p. 269)
gracilis
obturator externus (Schroeder ICAK 80W p. 267)
gluteus maximus (F)
popliteus (F)
neck extensors - together (F)
- R or L (F)
- R and L (F)

5. CORRECT FIXATIONS - sacral, iliac, lumbar, cervical or occipital fixations as indicated by bilaterally non-intact muscles ("F" above) (G. 79 Vol. II p. 75-76).

6. CORRECT SPECIFIC MUSCLE-RELATED CRANIAL FAULTS: ("C" above)

A. Challenge and separate vertical occipital suture if short hamstrings non-intact - especially bilateral (Schroeder ICAK 80W p. 269). I have occasionally found a Lovett reactive version of this fault with the same muscle indicator - separation at the midline of the sacrum, per challenge.

B. Challenge and separate symphysis menti if bilateral simultaneous piriformis (90°) is non-intact (Schroeder ICAK 80W presentation, ICAK 79W).

C. Other relationships as published.

7. FIVE-FACTOR CORRECTION ON MUSCLES: pick first muscle or muscles to correct as follows:

A. Are several non-intact muscles on one meridian?

NO YES : Correct these first.

↓

B. Do the meridians of the non-intact muscles form a grouping on the 24-hour cycle of acupunture?

NO YES : Correct muscles of the first meridian in the chain first. (Thie ICAK 79W p. 103)

↓

C. Do the meridians of the non-intact muscles form a pattern on the 5-elements acupuncture chart?

NO YES : Correct the "upstream" muscles first or look for hypertonic meridian further upstream and treat (G. 79 Vol. II p. 69-70, G. 1973).

↓

D. Treat muscles most intimately related to area of pain or instability first.

Treat chosen first muscle or muscles with each major element of the "five factors" that therapy localizes:

Origin and Insertion
N.L.
N.V.
Meridian (Luo point, tonification points, alarm point)
Cranial Stress Center
Hand Stress Center
Muscle Spindle/GTO

Check muscle for fascial release and correct (G. 79 Vol. I p. 79-84). Recheck other previously non-intact muscles. If still non-intact, pick next muscle as above and treat fully. This selection should take only a flash of thought to pick the dominant pattern of weak muscles you are following. Picking the correct first muscle to treat often handles some or all of the other non-intact muscles.

8. SACRAL RESPIRATORY FAULT: hamstrings respond to respiration or positive TL to sacrum (G. 79 Vol. II p. 78-9).

9. SACRAL WOBBLE: Sacral T.L. positive, responds to respiration and positive sacral wobble challenge (G. 79 Vol. II p. 78-9) (G. 1974 p. 45).

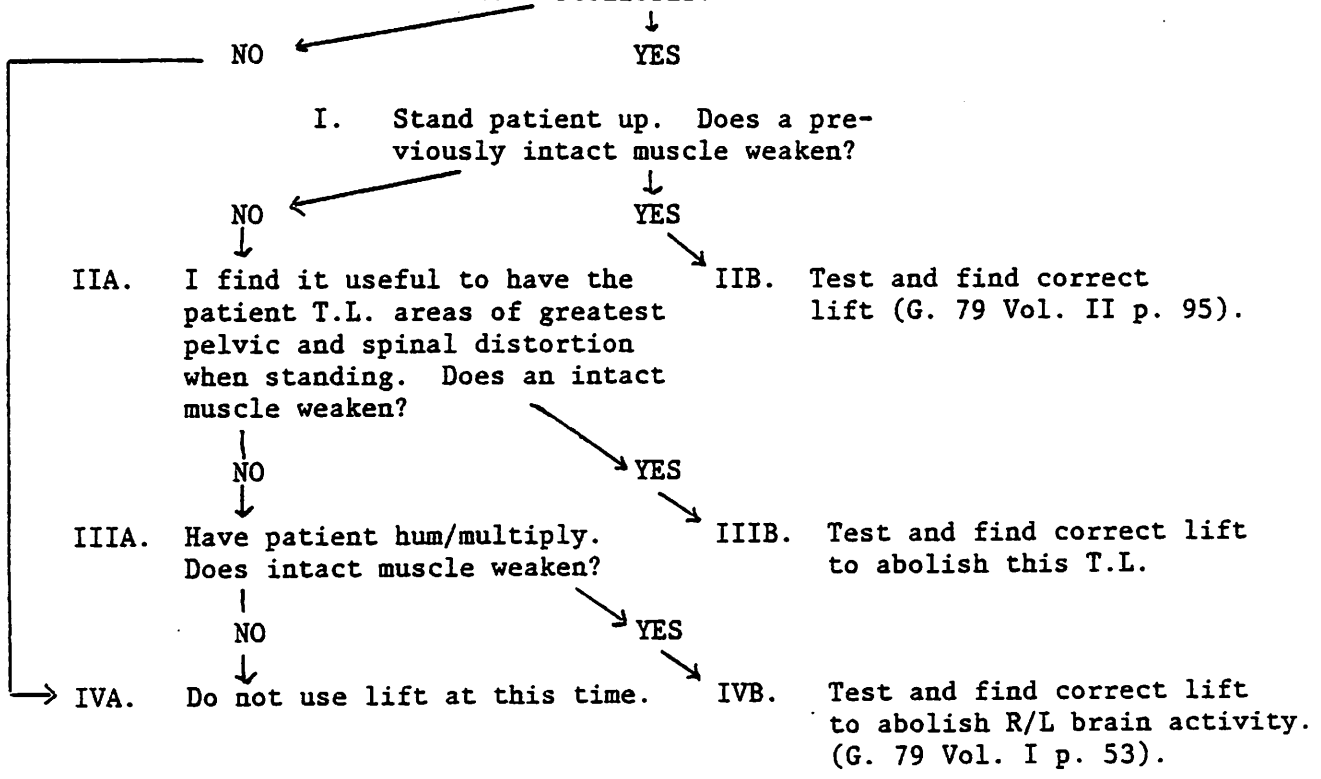
10. CATEGORY 1: T.L. simultaneously to both SI joints. Block or correct with thrusts (G. 79 Vol. II p. 59-63).

11. COCCYX: Challenge and adjust, check respiration. May be done while patient on blocks.

12. C7 - RIB 1 FIXATION: T.L. only positive during head turn. Challenge C7 -rib 1 - separation is positive, (G. 1980 Vol. I p. 14-31).

Items 11. and 12. can be done while patient is on the blocks.

13. LIFTS: Is there:
1. marked short leg while supine?
2. severe pelvic distortion?
3. apparent anatomical short leg while standing?
4. scoliosis?



14. Challenge rest of spine, cranial faults, or other indicated treatment for the day.

RECHECK VISITS

Check as above: Many faults should remain corrected. It may take several visits to cycle through the deeper levels of testing:

1. Are pelvic muscles intact?

   YES ↓

   A. Ia. Test pelvic muscles with eyes into distortion and handle. (G. tape #62). ↓

      II. Use aerobic/anaerobic muscle testing on pelvic muscles. (G. Vol. I p. 31-41). ↓

      III. Test for and handle reactive muscle patterns. (G. 76 p. 1-14).

   → NO

   Ib. Recheck Five Factors and treat very thoroughly, including nutritional support if otherwise appropriate.

   B. Test and correct any fascial flush for pelvic muscles (G. 79 Vol. I p. 73-84).

2. Do needed structural corrections including detailed challenging of pubis and sacro iliacs for any unusual direction of correction, or internal/external ilium (G. 79 Vol. II p. 58-59).

3. Challenge and correct foot, ankle, and knee subluxations using shock-absorber as necessary (G. Tape 26 side 2).

4. Recheck lift and change as needed.

5. Test and treat gaits and cloacals (G. 79 Vol. I p. 117-123) (Beardall ICAK 77W p. 7).

6. Handle TMJ problems (G. 79 Vol. I p. 132-139) (G. 79 Vol. I p. 40-51).

7. Ligament interlink (G. 80 Vol. I p. 73-74, 79 Vol. I p. 98-103) (Mladenoff ICAK 80 W p. 199).

KEY:

G = Goodheart Annual Research and Workshop Procedure Manuals, followed by year and page reference.

ICAK = Collected Papers of Members of International College of Applied Kinesiology, followed by year and "S" for summer meeting or "W" for winter meeting, preceded by author's name.

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3. _____. Monthly Research Tape #62. Detroit, Michigan, 1980.

4. International College of Applied Kinesiology. Collected Papers of Members of the International College of Applied Kinesiology. 1977 Winter - 1980 Winter. Published by International College of Applied Kinesiology. Detroit, Michigan, 1977-80.

" THE GREAT MIMIC " - The Thoracolumbar Spinal Torque

By Dr. Elmer J. Cousineau, D.C., B.S.

ABSTRACT:

To consider the fact that the thoracolumbar spinal torque involves irritation to all nerves below the tenth thoracic emitting from the spinal cord but exiting from the spine at a lower level.

INTRODUCTION:

The thoracolumbar spinal torque has been glossed over so lightly by researchers and educators alike as a source of spinal nerve pressure or irritation contributing to the presence of sciatica, paraesthesia, and leg and back pain. All too often this area has been given only lip service as chiropractic educators and instructors at conventions and seminars have recited the anatomy and origin of the spinal nerves, and have skipped over this area so lightly. It is the area of the lumbar enlargement of the spinal cord and contains all the nerves for those structures below tenth thoracic level, even though they do not emit until a much lower level. The spinal cord terminates at the inferior of the first lumbar vertebra, hence the use of the spinal block in anesthesia and the spinal-tap to examine the cerebrospinal fluid taken from levels just inferior to it. The last nerve said to arise from the spinal-cord and emit at the same level as it arises, is said to be the tenth thoracic. Hence all nerves supplying areas below that must arise from the spinal cord within the space of three seg-

ments, namely the 11th, the 12th and the 1st lumbar levels of the spine.

The muscles associated with this thoracolumbar spinal torque are principally the lower trapezius and the psoas major. The psoas major muscle arises from the anterolateral margins of the bodies of the five lumbars and the twelfth thoracic and even the intervertebral discs between them, passes over the pubes and inserts into the lesser trochanter of the femur. The lower trapezius muscle arises from the spinous processes of the lower six thoracic vertebrae and inserts into the medial end of the spine of the scapula.

The discovery of a consistant pattern of muscle weakness by this author in the use of Applied Kinesiology in his office over the past ten years is the subject of this paper. The consistant presence of a weak <u>left</u> psoas major, and a <u>weak</u> left lower trapezius, would cause or permit a rotation of the lumbar spine away from the weakened left psoas and to the right, while the weakened left lower trapezius would permit the lower thoracic spine to rotate their vertebral bodies to the left or the spinouses to the patient's right, Thus was set up the thoracolumbar torque. This would result in the fixation of the thoracolumbar spine into a hypomobility and refer the necessary motion of the spine to areas above or below it. Hence the resultant stressand strain upon the lumbosacral spine or the mid-thoracics in any bending motion of the spine.

The question arises as to the presence of the weak right lower trapezius muscle instead of the left always being the weak muscle. This was found to be true and present in a great many cases before we discovered the reduction of the subluxation of the right pronated elbow. After that we found the weak right would shift to a weak left lower trapezius, and hence the discovery that is the subject of this paper. This correction was covered in a previous paper by this author at the Summer meeting of the I.C.A.K. in 1980 at Dearborn, Mich, entitled " Is 'Left Brain Activity' caused by an Extremity Lesion ? "

The neglect of correction of this spinal torque could result in the recurrence of the lumbosacral and other spinal subluxations below it. Relief in sciatic cases is so much faster since the discovery of this method in our office.

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NEUROPHONE UPDATE

by

Sheldon C. Deal, D.C., N.D.

ABSTRACT:

During the past year the Neurophone has shown to correct numerous findings of an electromagnetic origin.[1] These findings are items which originally were not known to be affected.

INTRODUCTION:

As the physician goes about "fixing what's wrong" in his patient, he finds that the lesions fall into three (3) categories. Namely: those that respond to a mechanical correction, such as a fixation; those that respond to a chemical correction, such as a calcium imbalance; and those that respond to an electromagnetic change or energy transfer, such as a meridian imbalance. It is with the latter group that the Neurophone has proven to be invaluable. It will correct nearly anything of an electromagnetic nature, provided[2] that it is the next item to be fixed using the priority system to determine what the body wants to have corrected next.

EXAMPLES:

Some of the items that have successfully been treated and corrected with the Neurophone to date are as follows:

- Gait patterns
- Switching, all types
- Cloacals
- Pre and post ganglion
- Reverse polarity
- Meridian imbalance
- Figure eight
- Centering
- Hyoid correction
- Right and left brain
- Hemispheric dominance

In addition to the above items, there is no limit as to a list of other items that may be cleared out as a result of using the Neurophone provided they were only a compensation to one of the above electromagnetic problems. For example, an occiput subluxation is often a compensation to a meridian imbalance.

PRIORITY REVIEW:

The key to having the Neurophone make these corrections is to make sure the electromagnetic lesion is the next step to fix: We determine this by having the lesion meet certain criteria called the Priority System. These criteria are as follows:

1. The muscle or lesion must be weak in the clear.
2. The lesion or body part must therapy localize.
3. The test muscle must now become strong upon the inspiration phase of respiration. (This implies that expiration assist lesions are compensations.)
4. Melzach Wall pinch test must not change the muscle strength found in Step 3.
5. Having the patient move their eyes to their dominant side must not change the muscle strength found in Steps 3 and 4. (If dominant side is not known for sure, the patient may look first right and then left.)

Note: Sometimes Step 1 and Step 2 are the same procedure.

METHOD:

When the patient has met all of the above criteria, the Neurophone may then be used as follows: Have the patient hold one electrode on each temple firmly, this eliminates the need of using a headband and using KY Jelly under the electrodes, and play the pink noise tape through

the Neurophone for a period of 2 minutes.

SHORT CUT METHOD:

After you have found a lesion in the patient's body and you want to know if electromagnetic correction is necessary to clear that lesion or if you just want to know if the patient at hand needs electromagnetic correction period, use the following procedure: While testing an indicator muscle with you right hand, place your left hand on the patient's anterior chest wall so that all five (5) finger tips of your left hand are touching the patient at the same time. If this procedure changes the strength of your test indicator muscle, then the patient requires electromagnetic correction and you can then apply the priority system criteria to see if the electromagnetic correction via Neurophone is the next item to be fixed.

ALTERNATIVE METHOD:

This method is of value when you are checking the patient for a host of conditions. It is called putting the patient into different modes.[3] It will tell you what the patient needs and at what time to do what. In other words, it has the capability to take the place of the priority system while searching for what needs to be fixed. Since this could conceivably cover the whole gamet of Applied Kinesiology, we will only go into the mode that indicates the patient's need for electromagnetic correction. I make no claims to know all the modes available as this is a topic left best to its author, Dr. Alan Beardall.[4]

Once you have located a lesion, let us say you have done so while testing the patient's left PMC while the patient was therapy localizing with their right hand and the TL produced a change of muscle strength. Now have the patient touch the thumb side junction of the distal and middle phalax of the index finger with their thumb of the same hand. This is called a 2-C position and in this case it is done with the patient's left hand. If this position changes the strength of the test myo, then you have established that this patient has an electromagnetic lesion. The next step is for the patient to assume the same position (mode) with the right hand while holding the 2-C position with the left hand. It is very important not to let go of the left hand position until the right hand has assumed the same position. Otherwise, the mode will be lost and you will have to start over. Now with the right hand in the 2-C mode, the left hand is now free to search for what type of electromagnetic problem it is. First have the patient touch the palm of the left hand with their left index finger to see if that position produces a change in the test muscle indicator. If it does produce a change, then the patient needs B and E treatment of the Governing Vessel (Beginning and end). If there was no change, go to the next mode where the patient touches the palm with the middle finger on the left hand. If this produces a change, the patient needs Umbilical K-27 contact. If there was no change, go to the next mode where the patient touches the palm with the ring finger on the left hand. If this produces a change, the patient needs reverse polarity treatment, which is done with the Neurophone. If there was no change, go to the next mode where the patient touches the palm with the little finger on the left hand. If this produces a change, the patient needs the organ treated electromagnetically.

One of the four finger positions (modes) will always show up if the patient originally showed the 2-C mode. The key to tell which mode to treat is once you have found the finger position that produces a change, move that mode to right hand while still holding it with the left hand. If you can assume the same mode with the right hand as the left hand is holding and there is no change in you indicator muscle, you have reached an end point, which means you are now ready to treat it. Using this method, you treat end points only. Obviously the end point takes the place of the priority procedure. If you do get a change in your test muscle indicator when you assumed the left hand mode with the right hand, that means you must search further as that particular mode is not ready to be treated yet and it may be a compensation if you find it to have cleared after you have fixed yet a different mode.

Whether you use modes or just plain follow the priority procedure, you will find that your corrections will hold and you do not have to keep fixing the same lesion over and over again as so many doctors do.

A fringe benefit we have found with the Neurophone is that in rare cases where the lesion meets all the criteria to be fixed next and your procedure will not clear it out, the Neurophone may be used to do this. For example: Blood chemistry shows to be next and tapping on SP-21 and the appropriate K-27 does not work, simply put one electrode on K-27 and the other electrode on SP-21 and turn on the Neurophone for two (2) minutes of pink noise. To date, we have never had this fail to clear out a stubborn lesion like that. It can also be used in place of the tapping for the B and E technic of clearing out a particular meridian.

CONCLUSION:

The use of the Neurophone is a tremendous time saver in treating electromagnetic problems. Obviously, there are doctors who are finding and correcting electromagnetic problems without the use of the Neurophone. But the difference is that it takes 15 minutes to trace it down and fix it without the Neurophone and it takes two (2) minutes to do when you use the Neurophone.[5]

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DIABETES AND APPLIED KINESIOLOGY
THE CHIROPRACTIC APPROACH

By Daniel H. Duffy, D.C.

ABSTRACT: Adult onset diabetes has been found to respond favorably to applied kinesiology (AK) procedures. This chiropractic approach has been effective in over ninety per cent of patients seen in an AK oriented practice with glucosuria.

While the average patient does not seek out the chiropractor for diabetes specifically, the disease is occasionally found on routine urinalysis of new patients and of regular patients not seen for a period of three months or more. (dipstick analysis of all patients are routinely performed every three months)

This short paper will not deal in any of the metabolic involvements or complex derangements pertinent to the problem of diabetes but simply relate my simple approach to eliminating the glucosuria and the subjective symptoms of the patient. There are certainly complex cases that fail to respond to any approach including the conventional use of insulin and oral diabetic drugs.

A good reason for the chiropractor to engage in the treatment of diabetics (aside from the fact that our approach works without doing harm to the patient) is the results of the University Group Diabetes Program wherein a long term scientific study proved that the conventional approach to the problem was worse than the disease and patients fared better overall if they went untreated. Results of this study are available to the lay public in the book "Live Longer Now" (1) and is required reading for all of my diabetic patients.

PRESENTING SYMPTOMS

We are all familiar with the textbook descriptions of symptomatology. I am listing those symptoms complained of by the patients of my experience. They quite often present with pain, burning, numbness or paresthesias in the feet. They also complain of blurred vision, a feeling of being "spaced out", (foggyheaded) are current terms used here. Of course low back pain and sciatica often bring them to our office. They complain of short windedness, dizziness and irritability, pruritus, and impotence. The most common complaint I have seen is foot symptoms, and may involve an ulcer that won't heal. They present at one time or another the entire list of vitamin and mineral deficiency symptoms.

THE CHEMICAL PART OF THE APPROACH

The biochemistry of the diabetic patient is faulty and when one confronts the information on this subject with all of its complexities one tends to become overwhelmed. Most doctors

THE CHEMICAL PART OF THE APPROACH (cont.)

attempt to interfere with these complexities either pharmacologically or nutritionally. I have encountered patients taking over twenty compounds (vitamin) with problems which are steadily worsening rather than improving. My approach to the biochemical aspect of the problem is very simple, I simply restrict the use of all cooked foods and demand especially that the patient not take any milk or bread of any kind. I feel that milk, bread and pastry are the culprits in the cause of diabetes.

When the patient asks if they can have this or that food, I tell them yes as long as it is raw. This immediately solves the question/answer/educational process that is so time consuming otherwise. Further questions on this score are handled by my office assistants. Initially I restrict meat fish and fowl however this is usually not a problem since most people don't want to eat any of it raw. They immediately can take raw eggs which is an excellent source of protein, in fact the best. The raw eggs can be blended in with a small amount of cranberry juice or pineapple juice which are the only two items that depart from the raw food schedule. They are advised to take only the small amount required to mask the presence of the raw egg. Avidin in raw egg white is handled by biotin in the egg yolk, however for those serious students of nutrition who do not accept this can drop the egg in boiling water for twenty seconds and this will deactivate the avidin.

On pulling the cards of the last dozen patients with glycosuria I found that all but two did not respond to the raw food diet and chiropractic treatments. Neither of the patients were able to get fully into the diet. One, a juvenile (11 years of age) reduced insulin from 35 to 4 units per day and was not showing glucosuria, however the parents simply could not accept the program. The child would have responded completely in my opinion. The other "failure" was an adult who allegedly was sticking to the diet but when last seen offhandedly mentioned that he was drinking about a gallon of grapefruit juice a day. (he was a laborer from out of town living in a motel room)

Controlling the juvenile diabetic can be difficult without total parental participation and without it I would not accept the responsibility. The big danger is the patient who shows ketones in the urine, however on the raw fruits and vegetables I have not as yet had any difficulty. The complex carbohydrate seems to take care of this problem nicely, while the raw egg takes care of the protein requirements of the patient. Unfortunately there are still many establichment academicians who still advise against the use of eggs because of "cholesterol" and this makes the average lay person suspicious and unwilling to indulge in this fine protein food.

The only test I run on the patient is the urinalysis and I have not yet found it necessary to rule out kidney disease, or differentiate the types of sugar being excreted etc. since the patients I have seen respond to the simple approach. This I am sure would alarm the academician however we take a good look at the patient clinically and watch the response carefully. The average academician also does not have any idea of the effect of a chiropractic adjustment. (more of that later)

The insulin requirement is reduced to one half immediately following the initial treaetment and workup of the patient. I.e., the patient is simply told to take one half of the amount they have been using. They are then advised to check their urine and continue to halve the requirement as

THE CHEMICAL PART OF THE APPROACH (cont.)

the urine shows negative for sugar. E.g., the patient is taking fifty units when first seen. They cut the amount to 25 units the next day following the treatment. If the second day the urine is negative for sugar the patient cuts the dose to 12 units and continues halving as long as the urine is negative. When the patient gets to ten or so units I usually tell them to stop it completely and await the result. Most patients and doctors are too fearful of diabetes and react to changes in sugar when there are no changes in symptoms. As long as the patient is feeling all right my idea is that we should press on to get them off the drug. Most diabetics in comas do not need insulin, they need sugar. Most diabetics in fact have normal or above normal insulin production.

As far as the patient on oral diabetic drugs, they are immediately taken off all medication. In view of the facts on diabetes I personally consider the use of oral drugs for diabetes a criminal act and consider the patients taking them as not giving informed consent. The harmful effects of these drugs far outweigh their usefulness. There is no rational argument for their use.

I am not really sure about the nutritional requirements of diabetics beyond a natural diet of raw food in the beginning to get the blood sugar down to normal limits as far as recommending this or that routinely. They seem to at one time or another present with symptoms of vitamin deficiency ranging from A to Z so to speak. I do not always find a pancreatic involvement for example. I think that the most common deficiency would be of the B vitamins although I do not recommend high potency but rather the organic doses found in the Standard Process line (B&G). This company also has a compound for diabetic detoxification which I sometimes use. If I use a pancreatic support I use the Sivad whole gland pancreas. It is not so much what the patient takes in the line of nutritional supplements or pharmacologics, but rather what they don't take in the form of man made foods that are totally devoid of natural substances and loaded with artificials.

The effort to maintain a raw food diet is well worth its effects and is a startling revelation to most patients on how well they feel after a week or so. It is the best way to lose weight and gain a sense of well being. I am unable to get as good results with nutritional supplementation and chiropractic treatments.

THE STRUCTURAL PART OF THE APPROACH

While most of the patients seem to respond to the chemical part of the approach, some patients will not respond until the structural component is corrected. The response is delayed in most patients who are not adjusted. The most effective part of the structural approach in my exerience is the tapping technique discovered by Goodheart (2). This technique uses the AK approach to diagnose and treat by tapping, the appropriate points on the spleen and kidney meridians of acupuncture. This produces an immediate normalization of blood chemistries in many patients. In fact the first patient on whom this technique was performed was a refractory diabetic with an unusually high blood sugar. This treatment along with attention to the liver, small intestine and adrenals especially produces good results. Patients often require manipulative treatment

THE STRUCTURAL PART OF THE APPROACH (cont.)

(AK) to the large bowel. I can't recall ever treating a diabetic who did not have some sort of pelvic imbalance requiring manipulative correction and they usually always require correction of the occiput and the upper cervicals. I have purposely held off the tap technique on patients and proved to myself that the return to normal blood sugar is delayed when the technique is not on the initial treatment. These diabetic patients often need prolonged neurolymphatic treatment directed towards digestive centers especially the liver. I recall one patient who had been taking insulin for fifteen years who responded immediately to this approach. (from 45 units/day) She did well and was not seen for approximately a year after her normalization. When next seen she said that her urine showed a plus four suddenly and her bladder would not function. I saw her right away since she was unable to urinate and an AK diagnosis showed a fixation/subluxation of the sacrum and a requirement for tapping of the left spleen 21 point and the right kidney 27 point of acupuncture. Her urine the next day was 2+, down from 4+, the next day it showed a trace and the next day it was clear. Because of the religious convictions of this woman I believe that she had not been violating her diet or she would have admitted it, therefore I can only conclude that in this case it was a subluxation of the sacrum and an imbalance in acupuncture meridian energy that was involved. She was able to empty her bladder five minutes following her treatment. The patient who receives regular chiropractic treatment can also get by with a little cheating on the diet much better than those trying to rely on diet alone. Follow up treatments of the diabetic continue to show a requirement for attention to the digestive tract. I have not seen any effects on the ileocecal valve that may be attributed to too much roughage and do not run into that problem which may be a question of some AK practitioners. In fact last year (1980) I can recall only one ileocecal valve problem which I finally had to take off raw food for a short period of time. We must continue to keep in mind that function arises out of structure and is inseparable from it and to deny the structural part of any physiological problem is to reduce ones effectiveness to that of modern day medicine. The problems of the diabetic are largely a result of the ineffectiveness.

THE MENTAL PART OF THE APPROACH

The psyche can be an all powerful ally or overwhelming enemy to the doctor and the patient and while I personally do not attract patients who possess a strong emotional factor in their illness I occasionally see one as a causative factor in this multifactorial disease. Again the extraordinary talents of Goodheart come to the fore and present us with one of the most powerful tools available for the treatment of the human psyche-the emotional contacts. (3). If this part of the triangle is active and left uncorrected the blood sugar will not maintain its corrections. In my experience the mental side of the triangle is always other person oriented.(God or human) It will help if the doctor tries to ferret out the culprit and then an educational process is necessary. My advice to this type of patient boils down to three simple steps to handle the interpersonal re-

THE MENTAL PART OF THE APPROACH (cont.)

lationship/s that are always involved in the mental stress type of relationships. First they should try to change the situation, secondly they should leave the situation if they can't change it and thirdly, if they cannot change it or leave it (which is the plight of most unfortunates) then they must learn to accept it philosophically so that it does not destroy them. The doctor should offer some instruction in how to begin to cope. Reading the eastern mystics is helpful to some types, transendental meditiation, self help classes etc. are good for others. The most difficult is the misguided religiosos who seem to have a prediliction to self abuse, worry, sadness, and above all great guilt complexes. I have not been successful at all with these types.

We should also be aware of mental conditioning in our present day society. For example a child drinks soda pop, blood sugar elevates abnormally and the pancreas is shocked into pouring out insulin, this drives the blood sugar down-child drinks another soda pop and the situation repeats-soon the child merely sits in front of a television set-sees a coke commercial-and the pancreas secretes insulin. Our senses are being constantly bombarded by commercial sources with most of it injurious to our health. The concept of mental conditioning along these lines can not be underestimated in my opinion.

SUMMARY

Most diabetics respond to the AK approach of chiropractic which includes attention to the diet, psyche and structure. Structural treatment hastens the response to the dietary control and mental control is necessary for lasting corrections. The power of raw natural food is startling to the patient and doctor alike and is the fastest way to better blood sugar control, better weight control and an improved sense of well being. This writer does not consider himself an expert in diabetes but has no doubt about being able to control it. Any doctor who is willing to take the time can learn how to effectively control diabetes and to improve the quality of life of his patients.

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PSORIATIC ARTHRITIS

By Daniel H. Duffy, D.C.

ABSTRACT: A 25 year old female on methotrexate for psoriatic arthritis responded to correction of the ileocecal valve, valves of Houston, emotional center contacts, subluxation of the sacroiliac joint (category two posterior ilium), and limbic technique.

This patient reported having a small patch of psoriasis on the left occipital area since age 19 which worsened during her two pregnancies. She suffered no arthritis until onset of the psoriatic arthritis. Onset was sudden, caused pain in the hands and feet, and psoriatic lesions over the entire scalp. She complained that her fingers seemed to be "frozen". Prior to onset the patient had been beaten severely by her husband and suffered several rib fractures. The pain in the hands and feet necessitated taking hot baths daily in order to produce any mobility to the hands and feet.

Positive therapy localization (PTL) (1) was found at the ileocecal valve and the valves of Houston which was negated by, respectively, traction upwards (closing the valve) and traction downward (opening the junction of the sigmoid and rectum). The patient was constipated and reported bowel movements every four or five days as far back as she could remember. Bowel correction was by neurolymphatic stimulation of the open ICV on the right and for the Quadriceps on the left (2) which succeeded in negating the PTL to the bowel. The pectoralis Clavicular weakened bilaterally when the patient used mental recall of the emotional trauma she experienced at the hands of her husband. This was proof of the emotional factor involved and the emotional contacts on the frontal bosses of the skull were held with a light tugging touch until a pulsation was felt and this was maintained for a period of about five minutes. The iliac was adjusted for a posterior ilium on the right. Limbic technique (4) was used with a left thumb move on the cervicodorsal junction along with a traction move to the same. Constipation technique (5) was performed with right breast reflex superior and left reflex inferior, right buttock superior and Buccal Reflex (6) left and right. A mid dorsal fixation was also corrected as was the neurolymphatics to the adrenal gland. Following the first treatment the patient reported a gross reduction in the pain in the hands and feet which was corroborated by my observation of her improved range of motion and gait fluidity.

Shortly after the first treatment (11 days) the patient reported having the "flu" and diarrhea. Her profile then showed open ICV and flaccidity of the valves of Houston on the next two visits. She was asymptomatic approximately four weeks after the initial treatment. She received a total of ten treatments over a period of thirteen weeks. She was then not seen for a total of four months at which time she reported back with an acute exacerbation of the previous condition. This exacerbation was precipitated by an emotional trauma of having her

boyfriend leave her. The emotional centers were again treated and the bowel was treated for flaccidity on the left and right with an immediate lessening of symptoms. No further treatment was necessary and the patient went on to a complete recovery. Her bowels normalized and she now experiences a normal once a day occurrence. She has presently been asymptomatic for five months.

DISCUSSION

This problem was precipitated by an emotional trauma and was treated initially with a drug that has disastrous side effects. Indeed they should be called "kill effects". The patient was advised to discontinue the drug immediately which she was able to so since the symptoms of pain were immediately lessened by the applied kinesiology techniques. No tests were run, no xrays were taken, no measurements were made of any type, yet this "incurable disease" yielded quite simply to simple kinesiological technique. The fact that an exacerbation was involved with a return of symptoms which again yielded to kinesiological techniques would tend to prove the fact that the situation was not of the "concerned physician" effect. The relationship of the bowels and the emotions are plainly seen in everyday life by anyone who would examine it. These relationships are just as simply diagnosed and proven to the physician and the patient, and as easily as they are demonstrated by anyone, to anyone, they are just as easily corrected and again, demonstrated as being corrected. While the textbooks are full of information about psoriatic arthritis, describing it in detail, none of them tellyou what to do about it unless you would accept the use of methotrexate as being something acceptable to do about it. Applied kinesiology does not have all the answers but we have a lot of basic principles when properly applied can relieve many symptoms and improve the quality of life where the conventional approach fails to do so.

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CAGING THE EYEBALLS

By Daniel H. Duffy, D.C.

ABSTRACT: "Caging the eyeballs" is an expression used in military training wherein the cadet is admonished to defocus the eyes so that he is absolutely without motion while standing in a "brace" which is an exaggerated position of attention. This eye position appears to stop the motion of the mind.

While undergoing aviation cadet training this writer spent a great deal of time in the "brace" position with eyes defocused or "caged". During this time I experienced a great increase in my power of recall and was able to recite entire class lectures from memory without notes. I felt at the time that this had something to do with the long periods of time spent with eyes defocused but was at a loss to explain why. Since the advent of the "EID" technique of Goodheart (1) I thought I would recount my experience in the hopes that it might shed some light or trigger some new ideas.

It seems as though we spend much of our mental time in either the future or the past and this may produce respectively, muscle tension (anxiety) or muscle flaccidity (remorse). When we "cage the eyeballs" (CE) it seems as though our mind stops and we get into the present, so to speak. This CE configuration may be what the meditator is seeking when staring at blank walls, candles, pictures of gurus etc. and defocusing may be what is necessary to attain the alpha state in meditation. I think so. Just as relaxation of the jaw is necessary as some of us found out in Puerto Rico during demonstrations of alpha monitoring equipment. And so it seems that as our eyes stop, our mind stops and when our mind moves, our eyes move or vice versa. I think also that a persons eyes defocus when they are bored and not listening to you and this is subject to some misinterpretation.

In reading the works of the eastern mystics including the subjects of Zen, Tantra, and Buddhism etc., it appears that the underlying idea of all this is to get into the present. Eyeball defocusing appears to be a good way or even a necessary way to do this.

1. Goodheart, G.J. Monthly research tapes, 1981.

THE HIDDEN PARIETAL BULGE CRANIAL FAULT

ABSTRACT: Numerous times patients will have symptoms of hypochloridia and the usual therapy localization for the temporal bulge cranial fault is negative as well as not being able to elicit the bilateral weakness of the pectoralis major clavicular muscles. [1] This paper deals with a method of determining if there is a hidden parietal bulge cranial fault.

INTRODUCTION: It has been very frustrating in numerous cases of patients complaining of hypochloridia symptoms such as excessive belching immediately after meals, various allergies and pain in the epigastric area. These individuals were tested for bilateral weakness of the pectoralis major clavicular and were found to be very strong. Therapy localization to the parietal temporal area was also negative.

METHOD: One of my colleagues that I was taking care of, had frequent symptoms of hypochloridia, which has previously shown bilateral weakness of the pectoralis major clavicular and a positive therapy localization to the parietal temporal area which was corrected, but now continued to have the symptoms but no positive indicators.

In thinking of the various phases of respiration, I then asked him to take $\frac{1}{2}$ breath in and tested the bilateral pectoralis major clavicular with negative results. Then a full breath in with negative results. Then $\frac{1}{2}$ breath out with negative

results, but a full breath out produced a positive bilateral weakness of the pectoralis major clavicular and also a positive therapy localization to the parietal temporal area. Subsequent challenging for the temporal bulge cranial fault was positive and the temporal bulge was corrected in the usual manner. Post check with therapy localization and bilateral pectoralis major clavicular with full expiration was then negative. Approximately seventy five patients have been tested in a similar manner confirming the original findings.

CONCLUSION: If a patient has symptoms of hypochloridia, but does not have the positive indicators, ask the patient to exhale completely and retest.

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USE OF THE BACH FLOWER REMEDIES

by

Terry L. Franks, B.S., D.C.

ABSTRACT:

An attempt is made to systematically use the Bach Flower Remedies to expose deeper emotional levels. The entrance into the emotional side of the triangle is achieved with a combination of neurovascular points and alarm points.

I. Have the patient therapy localize the now-alarm point and systematically screen the neurovascular points until weakness is found when both therapy localize together. The hand on the neurovascular point is always palm down and the now-alarm point contact may show either way. It is usually palmar. The only change in neurovascular points is the gall bladder. It appears to be directly over the lateral wings of the sphenoid. When weakness is found, screen all Bach Remedies. The remedy or remedies found is Level I.

II. Now therapy localize the appropriate alarm point that corresponds to the neurovascular point in Level I. Use the same side of the hand that was on the now-alarm point. Place the other hand (palm down) on the stomach neurovascular. Any weakness produced and then neutralized by a remedy is Level II.

III. With the hands in the same position and the appropriate remedy found for Level II, simply turn the hand over on the alarm point and retest. Any weakness produced and then neutralized by a remedy is Level III.

IV. Place the hand which is on stomach neurovascular back on the origional neurovascular point for Level I. Leave the other hand on the same alarm point found for Level III. Any weakness produced and neutralized by a remedy is Level IV.

The effectiveness of the Bach Flower Remedies seems to be enhanced by two factors. The patient is given an opportunity to interpret his own reactions and feelings, and can also use the remedy to assist him in dealing with himself. So there is both a diagnostic and treatment factor contained within the use of the Bach Flower Remedies.

ANTERIOR CERVICAL SUBLUXATION AND ADHESIONS

BY DAN GLEESON, D.C.
DICAK

For years I have been therapy localizing, challenging and treating anterior cervical subluxations with a variety of results. Not until I was introduced to the concept of challenging and healing cervical adhesions, thanks to Dr. Terry Franks, did I achieve the results I was looking for.

First of all we must recall the muscles that could be involved - sternocleidomastoid; scalenius anticus, medius and posticus; longus colli; longus capitus; also the anterior longitudial ligament; capsular ligaments and local fascial sheaths. It is important for the doctor to go back to his books; reviewing the muscle origins and insertions, because occasionally goading, spindle cell and GTO techniques also need to be done. One should also be aware of the fact that from C1 - 2 junction on down the cervical spine, the facet facings are coronally oblique and that the cervical spine is normally lordotic. All these facts must be put into the mental equation prior to adjusting.

Adhesions, while due to post traumatic tearing are also due to years of postural adaptation and compensation by the muscles, which become habitually: hyper or hypotonic in nature. Ligaments respond to the unstable manner of the vertebra and become tense or lax. Local fascia tends to conflict, with fibers turning at right angles to one another. These inturn results in severe limitation to the flexion-extension patterns of the cervical spine; can result in direct adverse

stresses to-the fascia of the cervical nerve roots and alter normal fascilitation and inhibition activities of the anterior cervial muscles.

METHOD OF CHALLENGING AND CORRECTING ADHESIONS:

Palpate the soft tissues of the cervical spine being careful not to press on any vessels in the area. Be on guard for taught, tender, restrictive sites which when stretched and held in one of many possible directions, result in a previously strong muscle going weak. Treat this finding by maintaining your challenging pressure and in the same direction apply a sharp thrust in an attempt to 'pop' the adhesion. Rechallenge should result in a negative response of your test muscle.

ADJUSTING ANTERIOR CERVICAL VERTEBRAE:

After positive therapy localization, challenge the vertebra in question from an anterior to posterior, slightly superior to inferior direction, depending on the local A-P curvature. Be sure to challenge the opposite side of the vertebra for anterior or posterior subluxation patterns. If anterior and posterior subluxation patterns are found on one segament, do a priority challenge(1) to determine which to adjust first.

This adhesion procedure is not limited to the cervical spine and is used extensively in our office in pelvic, lumbar, shoulder, suboccipital, cervico thoracic etc., myofascial problems.

Effects have been very gratifying. There is often immediate relief of pain for the patient, relief of many possible nerve root compression faults, increased mobility of spinal segments and extra spinal joints.

SUMMARY

I would encourage you to try this technique on your difficult cases. Be sure to do everything else you usually do first, because many of these adhesion faults will be assisted. Ridding the body of adhesions will greatly enhance your therapeutic ability. Good Luck.

(1) Priority Challenging - 1979 Summer Meeting - ICAK
Collected Papers.

A K PUMP EXERCISE

by
Warren Hammer, M.S., D.C.

ABSTRACT: The concept that vertebrae move with respiration is the basis of a new exercise. The patient benefits by relief of spinal pain and increased range of motion.

According to Dr. Goodheart[1] and others, during inspiration the vertebrae move in a caudalward direction; while in expiration, the vertebrae move in a cephalad direction.

A major factor related to respiration and spinal movement is the effect on the cerebral spinal fluid flow. According to Dr. Goodheart[2], "there is an intimate relationship between the lymphatic system and the cerebral spinal fluid system."

Considering the above information, it appeared that a basic spinal exercise could be performed by a patient at home which might alleviate pain, increase cerebrospinal fluid, increase lymphatic flow and increase spinal motion.

Exercise Procedure for Lumbar Spine Involvement:

Patient stands with knees slightly flexed, with one hand above the other hand with the fingers interspersed between the spinous processes of the lumbar and lower dorsal spine.

It is important to maintain a firm grip on the spinous process.

Patient slowly bends backward with flexed knees, inspiring deeply, and presses inferiorly on the spinous processes.

Next, the patient bends forward with knees flexed and presses superiorly on the spinouses, while exhaling. Patient should press inferiorly and superiorly about fifteen times per minute for three minutes.

It is important that the patient presses firmly, as if to attempt to move the bones, with inspiration and expiration.

DISCUSSION: I have given this exercise to hundreds of patients who claim that it is most effective when their spine begins to ache. It is important to review the exercise procedure with patients as they often do not grip the spinous processes correctly or breathe incorrectly with bending.

This procedure could probably also be used for the cervical spine.

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TAPPING of the Temporal Mandibular Joint

(A Preliminary Report)

by
Warren Hammer, M.S., D.C.

ABSTRACT: Tapping an intact T.M.J. while the subject is touching the belly of a muscle or an involved neurolymphatic area may eliminate the need for futher treatment.

Applied Kinesiologists always use tapping for the temporal tap and the stimulation of the meridian system. Tapping has produced results that rubbing, pinching, ultrasonic or static electricity would not ordinarily produce.(1)

The temporal mandibular joint, according to Drs. Goodheart and May, is a computer of vast proportions.(2) Rapid tapping of the T.M.J. bilaterally for at least thirty seconds while the subject therapy localizes seems to be having an effect on this "computer".

Procedure:

1) Clear out the T.M.J. in the open and closed position, checking with the temporal tap or eyes into distortion method.

2) Have subject therapy localize an involved neurolymphatic or neurovascular point.

3) Rapidly tap both T.M.J.'s for 30 seconds. (Sometimes pro-

longed tapping, I.E. 2-3 minutes is necessary.)

4) Retest involved muscle.

T.M.J. tapping has worked for ilieo-cecal valves, and on the belly of muscles that can be touched such as the Pectoralis Sternal, Pectoralis Clavicular, Quadriceps, cervical flexors, etc. Therapy localizing on the belly of a muscle may only be effecting the spindle cells since additional areas may at times have to be treated.

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THE WEAK TENSOR FASCIA LATA MUSCLE VS. THE MEASUREMENTS OF ELECTRO-ACUPUNCTURE

Bert T. Hanicke, D.C.

Abstract:

A study to demonstrate the relationship between the weak Tensor Fascia Lata used as an indicator muscle in Applied Kinesiology for the Colon and the "Indicator Drop" electrical reading of Electro-Acupuncture according to Voll, on the Command Measurement Point for the Colon.

This study was an attempt to see if any relationship could be found between a weak Tensor Fascia Lata Muscle (T.F.L.) and an Indicator Drop (I.D.) found on measuring the same patient using the electrical measurements of a Dematron.[1]

The study was set-up so a student assistant in my office muscle tested the T.F.L. on twenty-five random patients. The students were not aware that a research project was being done. They just did the usual muscle tests routinely conducted at each patient visit and recorded it on the patient's record card. If the T.F.L. was found to be strong, the assistant then had the patient Therapy Localize[2] the Neuro-Lymphatic Reflex[3] and indicated on the patient's record

card if the T.F.L. remained strong, or was then weak. I eliminated from the study, patients who were known to have Colon problems as a major complaint in an effort to rule-out operator prejudice.

Without knowing the results of the muscle test, I measured the Command Measurement Point for the Colon[4], using the Dematron,[1] and recorded this measurement on the patient card, indicating any Indicator Drop,[5] if present.

The Indicator Drop[5] was used as a criterion in this study because it is used in Electro-Acupuncture according to Voll,[4,5] as a definite indication of organ or system pathology. A known electrical stimulus is applied to a point and a maximal reading is obtained, but cannot be maintained, and the reading drops to a new lower level before becoming constant. The size of the difference between maximum and lower reading is recorded as an Indicator Drop (I.D.).

As the table shows, there was high correlation between finding a weak Tensor Fascia Lata muscle and an Indicator

Drop on the same side of the body, or the absence of a weak Tensor Fascia Lata and no Indicator Drop on the same side of the body. Twenty-three out of twenty-five patients showed perfect correlation. A ninety-two percent complete correlation.

The two patients, 5 and 13, who did not show perfect correlation, were examined more closely using the Dematron, and the results show some interesting points to consider when doing muscle tests and evaluating the results.

Patient 5, was found to have an Indicator Drop on the Measurement Point for Rectum, which is located on the Kidney Meridan. Maybe we should consider the possibility of the frequently found weak Psoas Muscle as possibly associated with the Rectum as well as the Kidney.

Patient 13, was found to have an Indicator Drop on the Measurement Point for Terminal Small Intestine. There was no weak Quadriceps Femoris Muscle present, but it is

easy to understand how problems in the terminal area of the Small Intestine could cause aberration of the I.C.V. and a weak Tensor Fascia Lata Muscle on that same side of the body. Perhaps some persistent I.C.V. problems we encounter in practice could be best treated by focusing our attention on the Small Intestine.

TABLE OF RESULTS

\+ in column T.F.L. means the muscle was found weak in the clear.

\- in column T.F.L. means the muscle was found strong when tested.

\+ in the cclumn M.P. - L.I. means an Indicator Drop was found when testing the Measurement Point Large Intestine.

\- in the column M.P. - L.I. means no Indicator Drop was found.

\+ in the column T.L. means the strong T.F.L. muscle went weak when the Neuro-Lymphatic Reflex point was Therapy Localized.

\- in the column T.L. means the strong T.F.L. muscle did not weaken on Therapy Localization to the Neuro-Lymphatic Reflex Point.

Patient	T.F.L.		M.P. - L.I.		T.L.	
	Right	Left	Right	Left	Right	Left
1.	+	+	+	+		
2.	+	-	+	-		-
3.	+	+	+	+		
4.	-	-	+	+	+	+
5.	+	+	-	-		
6.	-	-	-	-	-	-
7.	+	-	+	-		-
8.	+	+	+	+		
9.	-	-	-	-	-	-
10.	-	-	-	-	-	-
11.	-	-	-	-	-	-
12.	-	+	-	+	-	
13.	+	-	-	-		-
14.	+	+	+	+		
15.	+	+	+	+		
16.	-	-	-	-	-	-
17.	+	+	+	+		
18.	-	-	-	-	-	-
19.	+	-	+	-		-
20.	+	-	+	-		-
21.	+	-	+	+		+
22.	-	-	-	-	-	-
23.	-	-	-	-	-	-
24.	-	-	+	+	+	+
25.	-	-	-	-	-	-

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UNLOCKING THE LOCKER

Christopher L. Harrison, D.C.

In this treatise, the author demonstrates the remarkable locking capabilities of of the atlas vertebra and of the even more remarkable locking capabilities of the occiput which when subluxated often locks the highly important C-1 segment and prevents it from being discovered by the chiropractor. The author explains his diagnostic as well corrective procedures.

Mention has been made in numerous chiropractic journals and articles, including articles by members of the I.C.A.K. of the so called locking capabilities of the C-1 or atlas vertabra. Clinicly speaking, what this locking capability means to the proponet of applied kinesiology is often when the atlas is misaligned or in a state of fixation, the clinician will not find other subluxations to show up until the atlas lesion is normalized. This is especially true of the lovett brother and reciprocal occipital-trapezius relationships at L-5, T-1, T-2 and T-10 but also true for other segments throughout the spine. In other words, then, the atlas is somewhat of a master or key vertebra to attend to due to the fact that when it is found to be in a state of fixation or subluxation other segments of the spine which are also subluxated, fail to respond to therapy localization and/or challenge until the atlas lesion is corrected. We have found this to be true in literally thousands of cases over the last several years and other chiropractic researchers have confirmed this phenomenon.

What we have found and also verified in several thousand cases in the last two years is that there is a very definite mechanism that binds or locks the atlas and prevents it from showing a positive therapy localization and/or challenge when it is subluxated or fixated. This mechanism is a subluxation or fixation of the occiput. The major subluxations of the occiput that we have found to lock the atlas vertebra are: 1. The inferior occiput 2. The universal cranial fault 3. The lateral occiput. The diagnostic as well as the corrective techniques are described below.

It is important to remember that the phase of respiration that one uses to test for the occipital subluxations is extremely important as the occiput and sphenoid form the basis for the entire cranial respiratory mechanism. Consequently, we test in the expiration phase. One could test in the inspiration phase, however, we have found as a matter of practicality that almost no lesions show up in the inspiration phase. The descriptions of the techniques for the diagnosis and corrections are given below.

The inferior occiput

Diagnosis

The patient is prone with head face down. A strong muscle indicator is confirmed and one side of the basilar portion of the occiput is pulled superiorward and allowed to rebound. The indicator is immediately tested. This is done for first one side than the next. A weakened indicator indicates an inferior occiput on that side.

Correction

This method is extremely efficient and often reduces multiple cervical lesions as well as the inferior occiput. The patient is prone and the head is rotated so that the lesion side of the occiput is superior. If for instance the right occiput is inferior, the patient's head is rotated so that his face is pointed towards the right side of his body. This places the right occiput in a superior position. The doctor is seated at the head of the table facing the patient and places his left forearm under the patient's face with the fingers cupping the patient's left occiput. The doctors right hand clasps or cups the patient's bilateral mandible with the soft portion of the forearm placed under the patient's right basilar part of the occiput. Firm traction is taken superiorward with both of the

hands so that all of the slack is taken out of the cervical spine and a crisp superiorward thrust is made with the doctor's right forearm so as to move the patient's right occiput superiorward. In approximately 80% of the cases an audible report is heard, however, this does not dictate that the correction has been made. Older patinet's usually do not manifest an audible report and we usually do not use this technique on geriatric patients with degenerative joint disease but rather employ the use of the activator adjusting instrument in a superiorward direction to the basilar portion of the inferior occiput.

The universal cranial fault

Diagnosis

This lesion can of course be found in the usual AK fashion and we have found that one can detect the lesion in the prone position with a challenge with excellent results. The indicator is confirmed and the operator clasps the occiput in a claw type of fashion, rotating the occiput first in a clockwise direction and then in a counterclockwise direction. We have found that this lesion responds better with a steady state challenge. In other words, while the occiput is torqued and held in that position the indicator is tested. In many of the cases, we find that the testing will indicate an inferior occiput on the same side of the inferiority of the universal fault.

Correction

The correction that we have been using with excellent success in terms of permanency is utilizing the Lee Activator adjusting instrument. It is best to use a small pad of rubber or paper to cushion the force of the instrument. The head of the instrument is placed underneath the inferior side of the universal fault and directed towards correction in a circular fashion. We use about 4 to 12 adjustments derotating the occiput to normalcy.

The lateral occiput

Diagnosis

The patient is prone and the head is directed in a steady state challenge first to one side and then to the other. The confirmed indicator is tested simultaneously with the steady state challenge. We have confirmed this type of testing almost 100% with the tongue protrusion method with the patient supine and usually incorporate this method as the patient is already prone.

Correction

The correction that we normally use is the standard chiropractic lateral occiput adjustment with the patient supine and almost always hear a loud audible report with a strong crepitation. In cases where the patient is unable to relax enough the Lee Activator can be utilized by blocking the upper cervicals with the opposite hand of adjustment and placing the padded head of the instrument onto the occiput just posterior to the mastoid on the lateral side and driving the occiput into normalcy. We usually use about 3 to 6 adjustments with the instrument.

Discussion

What has been discussed is probably not new to anyone that has been involved in chiropractic for any length of time. Dr. M.B. DeJarnette has for years advised the D.C. to correct the sacral and occipital lesions before spinal adjusting. Many fine researchers in the I.C.A.K. have been involved in sequence adjusting and have

advised clearing certain segments before going onto the next. What we hope to do in this paper is to specifically demonstrate the intimate relationship of the subluxated occiput to the subluxated atlas so that more lesions can be found to better serve our patients.

Christopher L. Harrison, D.C.

Palo Alto, California

February 1981

INTERRUPTIONS-PHYSICAL AND MENTAL

By Hannes L. Hendrickson, BChE, P.E., D.C.

ABSTRACT: Tapping or repeated muscle tests can interrupt streams of nerve impulses. Also, interruption of continuous thought patterns can bring about profound changes in one's consciousness.

The body is generally in a homeostatic condition wherein there is a constant expiration and inspiration of the lungs and all of the other functions show a constancy. Movement of muscles etc. exhibit efferent and afferant nerve impulse flow from the brain and back to the brain.

Interruption to this nerve impulse flow can by produced by tapping as demonstrated by Goodheart (1). The use of tapping can be also used for removal of pain and to increase mobilization of rigid structures as described by Goodheart (2). A summary of other stimuli was described by Hendrickson (3).

It appears that subconscious programs have been set up to monitor the body's multiple functions and interruption of these programs can be accomplished by physical and other means.

Programs have been set up on the mental side also. A distinct set of steps have been set aside for example in driving a car. At first considerable time is required to manage a car. however, upon repetition of the many steps, a program has been established in the subconscious, making the driving effortless.

Simple as it may seem, even the act of a friendly handshake has a deeply rooted program in the subconscious. Encompassed in this seemingly innocent act is a kinesthetic experience, (continued)

a sensory experience, a visual experience and other sensations. Supposing now that one were to go upon a stage at the request of a hypnotist. And as customary-a hand shake is in order. But instead of presenting his hand, the hypnotist suddenly bends down and starts to tie his shoelaces.

A sudden bewilderment takes over the subject. He is completely confused-at a loss of what to do. His subconscious program of a handshake has been smashed.

Knowing that an interruption of thought has taken place the masterful hypnotist quickly tells the subject to sit down and go into a deep trance. This example of mental interruption was expertly developed by Dr. Milton H. Erickson-a master at hypnosis (4), (5), (6). This example was only the tip of the iceberg in his masterful hypnotic accomplishments.

CONCLUSIONS:

1. Understanding the kinesthetic, auditory, visual and other sensations in the output of a patient can open the door to a better understanding of that individual (4), (5).

2. There is a very fine line between physical and mental, and if we were to listen to Einstein,--there is no fine line-for everything is energy.

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AUGMENTING SENSORY SYSTEMS

TO FURTHER DIAGNOSIS AND TREATMENT

By Hannes L. Hendrickson, BChE, P.E. D.C.

ABSTRACT: Many patients lack the ability to visualize or express other sensory outputs. By improving these deficient senses the doctor can further his diagnosis and treatment of the patient.

Anderson (1) demonstrated that, when the patient assumed the walking gain position, he was able to find a Category II$_d$ subluxation which was previously hidden from convention procedures. Goodheart (2) demonstrated EID (Eyes into Distortion) which enabled the doctor to expedite the healing processes.

The two examples above show the use of the patient's sensory representational systems. The first is the use of the kinesthetic system where the arm or leg is raised. The second example is the use of the patient's visual representational system.

It would seem logical that if the patient had a fully developed representational system, in other words, he had full command of his kinesthetic, visual, imagery, auditory, touching, etc, sensations, this then would assist the doctor in diagnosing as well as promoting the healing capabilities of the patient. This thought is developed as follows:

The walking gait used by Anderson (1) possibly enhanced perhaps another representational system which may have been deficient in patients requiring the walking gait. According to some authors many people exhibit a deficiency in one or more senses.

Bandler and Grinder (3) demonstrated that such possibilities exist. They say that a patient may have a well developed kinesthetic representational system but may have difficulty visualizing. They state that these impoverished systems can be recovered and improved.

This improvement of the deficient system is accomplished by using the patient's most highly valued representational system. For example, if someone had a good kinesthetic system, this individual would be placed before a piano (hobby is playing the piano)-the individual would be asked to close his eyes (deficient in visualization) and look down on the keyboard and move his hands over the keys, listen to the tune internally. The authors state that this combination has assisted deficiencies in visualization.

(CONTINUED)

Erickson (4) used imagery a great amount in his hypnotic inductions to facilitate sensory changes.

Miller (5), a physician, author, director, actor and a stammerer said that if a person visualized himself to be someone else that the stammering could be overcome.

CONCLUSIONS:

1. The sensory representational systems will always continue to play an important role in diagnosing and also will be an invaluable adjunct in healing.

2. Early detection of deficient sensory systems should facilitate patients recovery.

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DEIMBRICATION TECHNIC UPDATE

Arthur R. Holmes,D.C.

"Imbrication Subluxation" has been discussed by several authors. [1, 2, 3, 4.] A technic for correction, entitled "Deimbrication Technic", has been published by this author in several articles. [5, 6.] There have been some changes in the technic over the years. One of the more effective modifications is described in this paper.

In the actual application of the leg deimbrication technic, the superior segment of the subluxation must be anchored with pelvic blocks, so when the sudden traction force is applied, the separation is accomplished. If the traction force is too slow, or if there is no anchoring of the superior unit, the traction force is dissipated with no effective deimbrication accomplished.

There is a tendency for the patient's body to move caudally on the table as the force is applied. The use of chest straps, or the doctor's assistant holding the arms and trunk, or having the patient grasp the sides of the table, are not satisfactory anchoring methods as they are awkward and cumbersome.

If the patient is in the supine table position, with the blocks anchoring the L/5, L/4, L/3 vertebrae, the doctor will attempt to deimbricate the right 5th lumbar sacral imbrication subluxation. He will extend the patient's right leg over the side of the table and hold it between his thighs or knees, at the level of the ankle.

The patient's left leg is flexed at the knee, with the foot flat to the table surface. (See illustration). The doctor braces his right hand on the flexed left knee for support and to prevent the patient's caudal table movement.

The patient's right knee is flexed and straightened quickly with the left hand and legs, producing an instantaneous deimbrication correction in the L/5 sacral area. The doctor's right hand on the patient's left knee allows more control and effective correction in the adjustment.

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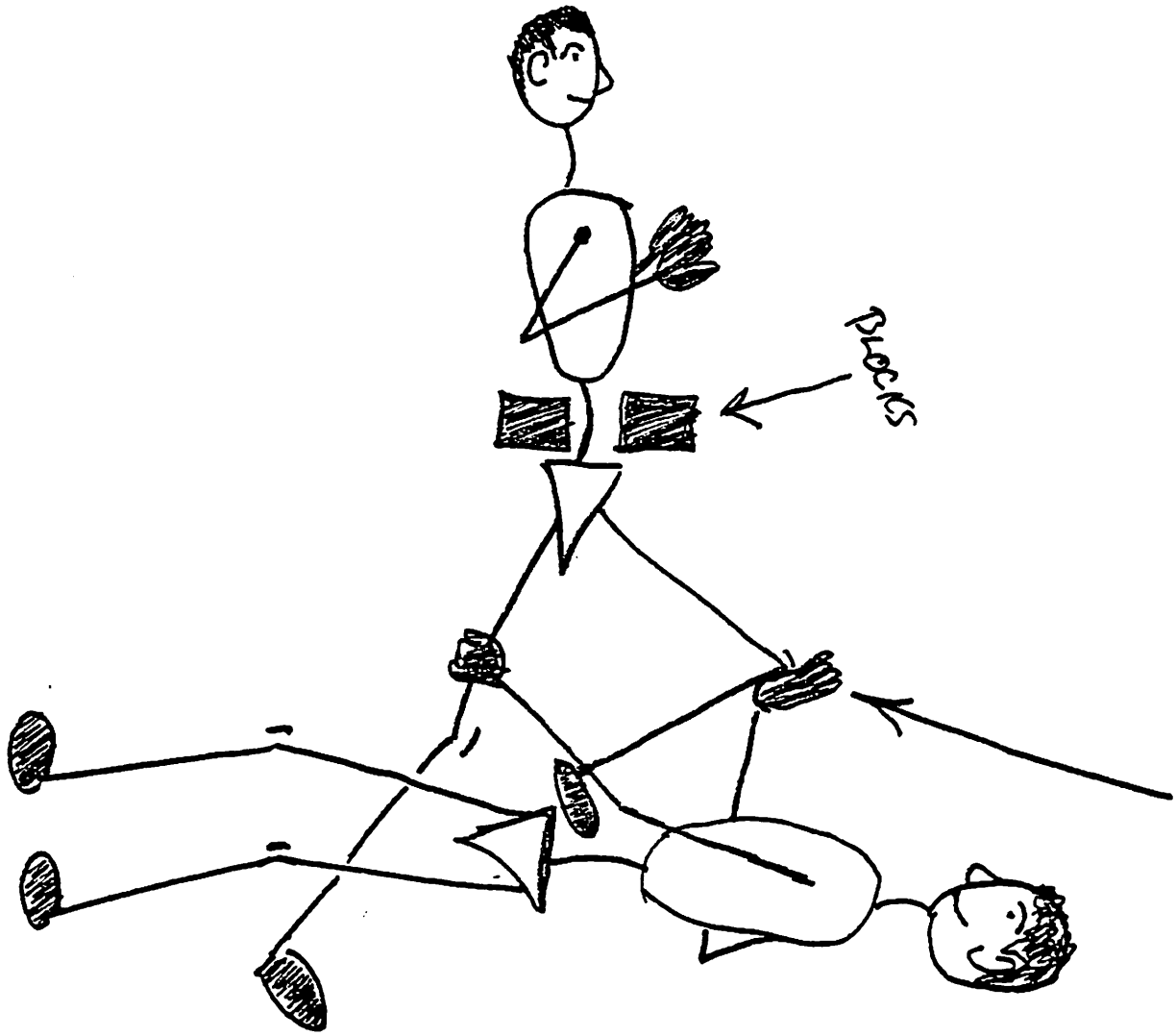

FIGURE 1

REFRAMING: A Neurolinguistic Tool for Reprogramming the Nervous System

by

Katharine Ayers Hovey, D.C.

ABSTRACT: This paper discusses the use of reframing as a tool to communicate with patient symptomatology and to create changes through the use of language and the nervous system which allow misaligned or conflicting patterns of behavior to align themselves with the entire organism.

As Chiropractors most of us have been exposed to the concept of Innate Intelligence and the fact that pain is a warning signal for a deeper process. I find that the reframing procedure, discussed by the various innovators of Neurolinguistis Programming, is a useful tool which can be used to assist the doctor and the patient to gain access to the patient's Innate Intelligence, or unconscious processes, and to change symptomatology or pain into a resource.

A pattern of symptomatology or pain can be regarded as a behavior that "is or was adaptive given the context in which and for which it was establisned." [Dilts et al., 1980, p. 243]. Neurolinguistic programming assumes that

> all behavior is geared toward adaptation and only becomes maladaptive when it is generalized to contexts in which it is not appropriate, or when it is stopped from adapting to changes in the individual or in the individual's ongoing contexts..[and further] that every human being makes the best choices available to them at any given moment, based on the contents of their personal history and their ability to generalize and to make discriminations about their sensory experience of their ongoing context. [Dilts, et al., 1980, p. 245.]

For instance, a small child is "picked on" by the neighborhood bully who punches him in the shoulder. The child's best choice in that context may be to splint the muscles around his shoulder joint to avoid deep bodily injury. If, over a period of years, this incident generalizes to all ongoing contexts in this person's life when he feels bullied, his response may no longer be appropriate. For example, when this individual presents himself in your office with a shoulder problem or "frozen" shoulder that was triggered and expressed through his nervous system in response to feeling bullied by his boss. Obviously the frozen shoulder may be an inappropriate response in this situation. But this person does not consciously know how to create more desirable behaviors or choices, so he comes to you. He does, however, have the resources to create more desirable responses.

As expressed by Dilts et al in Neuro-Linguistic Programming

> every individual has available, at any point in time, the resources needed to make the appropriate changes and choices required to adapt to any situation, if these resources can be accessed and ordered in appropriate sequences. (1980, p.245)

How to access these resources is ourlined clearly and simply in Leslie Cameron Bandler's They Lived Happily After:

1. Identify the symptom or unwanted behavior.

2. Contact the part that generates the identified behavior or symptom. Have the patient go inside and ask, "Is the part of me that generates this behavior (or symptom) willing to communicate with me?" Have the patient pay close attention to any sounds, pictures, feeling or words that come into consciousness. You watch for behavioral responses. If the patient receives a response that is non-verbal, such as a picture, sensation, feeling or sound, have him or her make this communication as unambiguous as possible. Have him intensify the response for a "yes" and diminish it for a "no". If the patient's symptom becomes the vehicle of communication, (i.e. a shoulder pain becomes intensified for "yes" and diminished for "no") this is a preferred response and gives assurance that communication has been established with the appropriate part or unconscious process.

3. Separate intention from behavior. Have the patient ask the part that is creating the symptom or behavior "What are you trying to do for me?" If the answer comes in pictures, sounds, feelings or sensations, rather than a verbal response, build a more complete sensory representation. For instance, if a shoulder pain becomes sharp, while the patient is experiencing the pain, have him let the pain become a sound, a color, a picture, an odor, a taste, a verbalization. This overlaps the sharp feeling (kinesthetic) into visual, auditory and olfactory representational systems and gives you and the patient a more complete representation of the intent of the part creating the symptom. If the intention appears to be undesirable, such as "I'm trying to immobilize you", then clarify the response by asking, "What are you trying to do for me by immobilizing me?" Keep stepping back or clarifying the response until you discover the positive intention of the part. For instance, if the response is "I'm trying to immobilize you to keep you from getting hurt," then the positive intention is identified as being protection and you are ready to proceed to the next step.

4. Find three new ways to satisfy the intention. Ask the patient to "Go inside and ask your creative part to generate three new, more satisfying ways to accomplish the intention." If the patient says he doesn't have

a creative part, build one by having him access a time when he was creative or have him image a creative person he knows generate three better ways to satisfy the intention.

5. Have the originally-identified part accept the new choicesand responsibility for generating them when needed. Have the patient ask the original part if it agrees that the three new choices are as effective as the original unwanted behavior or symptom. If the answer is "yes", then ask if it is willing to accept responsibility for generating the new behaviors in appropriate contexts. If the answer is "no", then have the creative part generate better behaviors.

6. Ecological check. Have the patient go inside and ask if any part objects to the negotiations that have taken place. If there is an objection, repeat steps 2 through 6 until all parts are in agreement. (Bandler,L., 1978, pp129-131)

More details and examples of the reframing process can be gleaned by reading appropriate sections in <u>They Lived Happily Ever After</u>, Volume One of <u>Neuro-Linguistic Programming</u>, <u>Frogs into Princes</u> and <u>Practical Magic</u>.

The basic premise in Neurolinguistic Programming is that every behavior, symptom and communication is useful and meaningful in some way. When a behavior or symptom is inappropriate in a given context, an incongruity exists between conscious and unconscious

behavioral processes. Two conflicting behaviors are being mediated through the nervous system (i.e. an unconscious part is generating the symptom and the conscious part is trying to get rid of it). Reframing is a useful tool for bringing behaviors, parts or various functions of an individual into alignment. This is done through the use of a"meta" system.

> ...the "meta" system is a verbalizing part that can contact and communicate with all other parts at the conscious or unconscious level... it simply acts as a negotiator to bring various factions of an individual or a couple into alignment. In this was all of the inherent resources are utilized to achieve the goals agreed upon by the entire organism. (Bandler,L., 1978, p. 142)

Reframing is designed to create changes that bring misaligned patterns or behaviors that are mediated by the nervous system into alignment with the entire organism.

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THE COLOR PINK AND PINEAL CRANIAL FAULT

by

JOHN T. HUGHES, D.C.

Abstract:

An alternate method of finding pineal cranial faults is presented—muscle weakening in response to the color pink.

In May 1980, John Ott, D.Sc. (Hon.) appeared on the television program "That's Incredible." He demonstrated that the color pink would have a weakening effect on most people. It was stated that some prisons had been painted pink in an effort to make inmates easier to handle.

This program aroused so much interest that an update to the material followed a few months later. On this program it was pointed out that the first fifteen minutes in a pink room had a calming effect on most people, but more than fifteen minutes in such a room would cause the subject to become irritable.

Since a majority, but not all people, were weakened by the color pink, it seemed reasonable to believe that this weakening response is due to some imbalance within the individual.

We know that being neurologically switched or having a thymus deficiency tends to make one more reactive to stress; however this did not seem to apply in these cases.

HUGHES
PINEAL-PINK

Realizing that the pineal gland is light sensitive, we turned our investigation in this direction.

In the 1979 Applied Kinesiology Workshop Procedure Manual, Dr. George Goodheart states that in some subjects muscles that tested strong in the presence of light world test weak with the cessation of light.

Oral absorption of pineal substance abolished the weakening effect.

Dr. Goodheart also found that compression of the wings of the sphenoid bone or compression of the tempromandibular joint bilaterally, pressing . . from lateral to medial, would produce a marked muscle weakening. Oral absorption of pineal substance neutralized this response.

Further investigation indicated the simultaneous spreading of the anterior portion of the ramus and alternate spreading of the pterygoid process was successful in preventing the muscle weakness that related to cessation of light pressure.

In our testing we found subjects who were weakened by the color pink had this response abolished by placing pineal substance on the tongue. It was also abolished by simultaneous spreading of the anterior portion on the ramus and alternate spreading of the pterygoid process.

HUGHES
PINEAL-PINK

Things equal to the same thing are equal to each other therefore it would appear that the weakening to pink response is found in subjects who have the pineal cranial fault.

In our randon testing of subjects we found 62 who had muscle weakness produced by looking at the color pink. 8% of these subjects did not show muscle weakness due to the cessation of light. All 62 subjects had the weakness to pink abolished by correcting the cranial fault as described above.

Beverly Nall, our C.A. and Touch for Health Instructor, did most of our testing.

Comment: The function of the pineal gland on the body is not clearly understood; however, recent studies indicate that it is a biological clock that regulates the activity of the sex glands. In AK research, the cyclic response in terms of menstrual difficulty, menopausal difficulty, thyroid, parathyroid and adrenal difficulty has been very satisfactory after correcting the pineal cranial fault.

Conclusion: The weakening response to pink may be an alternate and perhaps more effective, simpler method of detecting the pineal cranial fault.

PAROTID NEUROLYMPHATIC

BY

Karl O. Hynes, D.C.

ABSTRACT: To examine for the presence of a neurolymphatic or related reflex structure on the anterior of the atlas transverse and it's possible relation to the parotid or other salivary structures.

WEIGHT: 14-28gm.

LOCATION: On side of face immediately below and in front of the external ear. It has deep and superficial parts. The superficial being bounded by SCM, the external ear, Massetter, and the zygomatic arch. The deep area goes in behind the ramus at the jaw toward the pharyngeal area. It has fascial attachments on the styloid process and also extends behind the TMJ.

VESSELS: Arterial - derived from external carotid

Venous - external jugular tributaries

Lymphatic - empty into superficial and deep cervical lymphatics

NERVES: Sympathetic - vasoconstrictors - plexus on the external carotid artery

Parasympathetic - secretory - avriculotemporal derived from glossopharyngeal and possibley from the fascial through the otic ganglion

FUNCTION: Secretes an entirely serous type secretion containing ptyalin - an enzyme for converting starch to maltose as well as serumalbumin, globulin, leukocytes, epithelial debris, potassium thiocyanate (acrystalline salt that acts as a vasodilator), toxins, and a small amount of mucin.

AUTOIMMUNE/RESTORATIVE FUNCTION:

Serves as the vehicle for recycling the RNA, which has been processed in the thymus via the phosphorous/copper reaction and which coats the masticated food and codes it for delivery by priority to the various body parts.

CASE HISTORY:

The patient is a female, 55, presenting a lenthy case history, the most outstanding complaint being nervousness as a result of emotional breakdown in 1957. She has been subjected to various treatment abuses, such as insulin shock, as a result of therapy, electric shock treatments and massive dosed of tranquillizers. She has responded to the Chiropractic AK approach with gratifying results.

A prominent feature on this patient is a parotic gland hypertrophy on the left side of her head and neck which has been developing for a period of approximately ten or fifteen years. The patient has a noticable lack of salvation and some difficulty in swallowing due to the size of the gland. The mass is about the size of a mans fist.

The extreme anxiety of this patient, (she is both paranoid and claustrophobic), made treatment periods initially very short and sweet. There was evidence of upper cervical stress related subluxation which attended to as well as the standard AK and Chiropractic procedures. In palpating the upper cervical area, the writer was aware of an extreme sensitivity on the anterior portion of the transverse of the atlas. The atlas challenged out as a left posterior which was responding well to adjustment.

Investigation was then begun to determine if there was any relation to the area and parotid which was also quite sensitive.

The infraspinatus was chosen as the test muscle because of its relation to the thymus and the thymus' relation to the parotid. This patient had an intact infraspinatus which remained intact when thymus was Therapy Localized but went weak when parotid was TL'd on the left. The right parotid did not TL. Parotid substance was put on the tongue to determine if nutritional factors were present and positive TL was neutralized by the parotid substance. Next the left sartorius was found to be intact to facilitate two handed TL. The Patient was then asked to TL the parotid proper and the anterior portion of the left transverse of the atlas simultaneously in the hope of determining if the transverse was involved. The anterior portion of the atlas transverse would be impossible to TL without simultaneously TL the posterior portion of the parotid. Positive TL to the parotid was neutralized on this patient. Atlas was then challenged in all ways to rule out subluxation, and TMJ was rechecked, having been treated earlier.

The left anterior of atlas transverse was then vigorously stimulated as would be a NL reflex. Single hand TL to the parotid was neutralized after the procedure.

This area was treated four times and the patient has reported greater ease in swallowing and more salivation as well as no sensitivity over parotid or anterior atlas. She is using whole parotid nutritional supplement.

Investigation has begun to verify the usefulness of this NL-like area on other patients. So far results have been encouraging. Our effort has been limited to new patients because of our use of Sivad Raw Adrenal, which contains parotid tissue, on a large number of present patients.

INITIAL FINDINGS:

1. Involvement usually limited to one side.

2. Nutritional factor present more often then NL

3. Those with positive indication for NL are high carbohydrate users.

4. NL area has no effect on positive TL to thymus.

A follow-up report will include figures.

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HAVING BABIES AT HOME

a Slide Presentation

BY

Karl O. Hynes, D.C.

BACKGROUND MATERIAL:

This presentation is of the birth of our third child, son Kris, born January 31, 1980. His appearence was our third successful endeavor to deliver a viable, healthy, pink child into this beautiful world in the comforts of our home.

We began this undertaking of delivering our babies at home when my wife, Marianne, decided, with encouragement from me, that she preferred to give birth to our first child at home. However, her decision did not include doing it without medical assistance. The additional risk of not having a doctor or midwife present came about as a result of the lack of cooperation of the medical personnel in Penna., and the lack of any information regarding alternative birthing services. We had just moved to Penna. from Iowa in October and our child was due in mid - November. It should be noted that nothing could deter Marianne from her decision, especially since she has an intense fear of hopitals.

Our main source of information was a book, Common Sense Childbirth, and a mother of ten, who after having her second child brain damaged as a result of physician mishandling, had the remaining eight at home. She was very helpful.

The labor of the first child, Karl, was 18 hours - after 18 hours of false labor. We were tired and scared much of the time but more tired. Marianne had a lot of back labor and was trying to remember the breathing exercises we learned from the Lamaze classes.

I was terrified when I saw the head of the child present. I did not realize the cranial bones folded over each other so much and I believed we were giving birth to a monster.

Needless to say, after it started to look recognizable, I settled down to delivering. The only real hitch at that point was that Marianne, in her hurry to get it over with, pushed the shoulders out and tore her peritoneum which required repair and was eventfully performed the next day. The people at the hospital treated us like maniacs. Karl was subjected to the usual inhumanities until I got to the nursery and demanded our child. They thought he was staying! We were told how fortunate(lucky) we were, especially since the cord had a square knot in it.

Our second beautiful addition, Yvonne, only took 8 hours and basically went according to plan. Transition is tough on the mother and, if the father is also the deliverer, it's tough on him, too. She's worried and he's re-assuring, even though he might be concerned, too! I took lots of raw whole adrenal. I didn't do a very good job of suctioning Yvonne, so she had a rale for a while. Nor did I tie the string around the cord tight enough. She almost "leaked out" altogether except Mother Nature has almost all the antidotes needed to preserve her favorite species, in spite of excited fathers.

Through all of this Marianne continues to blossom in her maternal beauty, exhibiting all the maternal instincts from nesting to bonding. The main aspect we regret about Yvonne's birth is that Karl Jr. was asleep, napping. He should have been there. We had champagne to toast our new arrival while waiting for the placenta. No pictures on this one - Grandma didn't have film in the camera!

Kris was awaited with great anticipation and consternation. Could we do it again? Could Marianne withstand the pain? This time we hired a professional

photagrapher because I wanted Marianne and everybody to see those cranials! Everything went well, with Marianne enjoying her star status with all the people around and being bothered less with pain this time. The head delivered beautifully and, as I suctional vigorously,(no rales this time), I noticed the head had turned purple. I reached into her vagina and my heart sank as I found the cord wrapped around his neck three times. I quickly reached in and cut the cord and them assisted the lower shoulder out. Kris was out in no time. He was a bloody mess but alive. I found he responded vigorously when I very gently massaged his skin on his chest. He, thankfully, got back to looking pink shortly.

After all the births Marianne had a Rhegam shot to prevent antibody production against our Rh+ children. Our children have not had any shots or medication at all and "Praise God" there will be no future need.

We are planning a feature length production due out in October 1981. The video tape will be screened in Acapulco. Hope to see you there. I know Marianne will demand the vacation.

SUGGESTED READING

1. Gaskin, Ina May Spiritual Midwifery, The Book Pub. Co., 1978

2. Hazell, Lester Dessez Common Sense Childbirth, Berkley Windhover Book, 1969

3. Sousa, Marion Childbirth at Home, Bantam Books/Prentice-Hall, 1976

Bruce C. Jackson, D.C.

The Sore Throat
In It's Relationship to the
Ileo-Cecal Valve Syndrome

ABSTRACT: There is clinical evidence that the "sore throat" complaint of patients is directly related to the ileo-cecal portion of the intestinal tract.

In conducting initial examinations of patients in my office with a major complaint of "sore throat," the following findings were found:

1. Most cases were an acute pharngitis of an influenzal type
   - A. Complain mainly of myalgia, malaise, slightly elevated fever and unilateral swelling of the lymphoidal tissue.
   - B. Remember in viral infections the membranes are only slightly reddened, seldom edematous and seldom exidative. If there are these findings of edema and exudate, follow cultural procedures and treat accordingly.
2. Kinesiological exam revealed:
   - A. Psoas weakness unilateral most often right.
   - B. Bilateral tensor fascia lata weakness
   - C. Anterior neck flexor weakness
   - D. Lymphatic blockage
   - E. Ileo-cecal valve therapy localization (most often open was positive)
   - F. Therapy localization of the ileo-cecal valve negated unilateral right psoas weakness, bilateral tensor fascia lata weakness, anterior neck flexors weakness.

CORRECTION: Correction of the ileo-cecal open valve syndrome is done in the usual manner with prolonged N.L. technique. Adjust in the usual manner for ileo-cecal valve and be sure to check for occipital jamming in febrile conditions.

Nutritional and dietary support consist of restriction of roughage, chorophyll as used in the ileo-cecal open valve syndrome, Vitamin A, Vitamin C, Thymus, and Organic I_2 if heavy congestion is present.*

*Walther, David S., D.C., Applied Kinesiology: The Advanced Approach to Chiropractic, System D. C., 275 W. Abriendo, Pueblo, CO.

USE OF MERIDIAN THERAPY IN THE CORRECTION OF REACTIVE MUSCLE PROBLEMS.

BY ALEX P. KARPOWICZ, D.C.,D.I.C.A.K.

ABSTRACT

In the past some cases involving reactive muscles would return even after fixing by the usual methods. This is of course muscle spindling the belly of the overactive muscle to reduce the setting of that muscle to normal, so when working in conjuction with another muscle, it would not weaken it. One could also use golgi tendon technique to establish normal strength in the overactive muscle. Nutritionally, raw veal bone usually would prevent the reactivity from re-occurring. However, in my experience and that of several others I spoke with concerning the problem, occassionally it would return.

The term "overactive" suggested to me a possible accupuncture type solution. I then decided to sedate the overactive muscle through the usual methods of meridian therapy. That is, I held the four sedation points of the meridian associated with the overactive muscle (holding the lower extremity contact until a pulsation was felt) and then adjusted the associated point on the spine related to that meridian. These are points on the bladder meridian of course.

RESULTS

Currently I have treated twenty-five patients using this approach and have had 100% results. Not only has it worked consistently, but on re-testing, the previously weakened muscle would "lock" strongly when tested in the usual re-active manner. This resulted in remarkable relief of symptoms caused by the reactive muscle problems. Subsequent follow-up with these patients from between 1-3 months after correction revealed no need for additional treatment in respect to that particular reactive muscle problem.

CONCLUSION

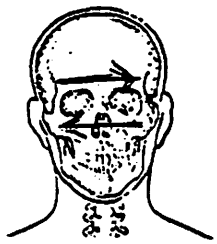
Meridian Therapy again provides us with a valuable tool to treat abnormal function in the body. I think this approach causes less discomfort to the patient during the corrective phase. At this point it eliminates the need for duplicating treatment, and gives the doctor an alternative node of treatment. It must be pointed out to the doctor, the necessity of contacting the exact sedation points on each patient. They can vary somewhat patient to patient, and the doctor can therapy localize to be certain he has pinpointed them. I would appreciate hearing from those of you who use this approach as to your experience with it.

REFERENCES

In accordance with the Index of Goodheart Research Manuals and tapes.

J. Carl Keiser, D.C.

THE FRUIT JAR



I attended a lecture by Dr. Christine Allen, who covered all skull faults known to ICAK (or maybe just me) but, this one was new to me and works quite well.

Hold on to frontal and zygomatic maxillary with thumb and fingers just like opening a fruit jar. Test for FREE movement. A locking on one side or other is quite apparent. Watch Glabella for wrinkling and blanching. Dr. Allen states it is used for migraine, facial pains, and etc; but, watch for side effects and emotional releases like crying or laughing and treat accordingly. Fix what you find. I have experienced none of these in the office and find it quite often a half wit to the universal fault... Correction is made by just unlocking and pushing into locked side. You'll feel it free itself, the whole face moves. Usually tender on locked side at zygomatic.

References

Dr. Christine Allen, Valleywood Med Bldg.....Lecture
40 E. Putnam Ave., Cos Cob, CT 06807

ABSTRACT

STRESS AND THE MENTAL SIDE OF THE TRIANGLE

By Daniel A. Klein, D.C.

DAILY LIFE STRESS

Hans Selye, pioneer of psychosomatic medicine-

Two definitions of stress:

1. The rate of wear and tear within the body
2. The state manifested by a specific syndrome which consists of all non-specifically induced changes within a biologic system.

We were basically designed to cope effectively with our environment.

Psyche's effect on the body untapped powers of mind-- potential healing.

Humanistic emphasis-- promoting health rather than eliminating disease. Delicate interplay between the mind/body/spirit.

Spiritual Stress

Not living in the moments

Future worries

Past perserverating

Lack of meaningful life ritual

World impact-heavy armoring (Primal, Reichien)

Bombardment, excessive stimuli

Noise, mechanical appliances

T.V., papers " bad news " catistrophie

Where is the beauty? (uplift ?)

Time urgency-devastating "no choice" acceptance

(component of Western society)

Adaptation

Late adolescence have accumulated the effects of stress- may manifest into their 40's and 50's.

Slow, developmental process of psychological and physical stress responses throughout life.

People vaguely aware of its heavy toll. (medical and drug bills attest)

General stressor - air, noises, overcrowding, deadlines, constant Sense of competition- (work and domestic life " keeping up with Joneses)

We are all effected

Personal stress- relationships, difficult boss, etc.

Events- financial difficulties, a death, violation of the law, loans

Free floating anxiety, variations of sleeping or eating problems, muscle tension, spasms--numerous others

Even positives are stressors (marriage, promotion, desired pregnancy, outstanding achievement

Transition- frequent in a brief time- stress

Normal adaptive stress occur when source is identifiable/clear

When ambiguous, undefined or prolonged or several sources exit simultaneously, individual does not return to a normal state rapidly. They continue to manifest a potentially damaging stress reaction. This concept is fundamental to understanding psychosomatic disorders.

Stressful day-functioning as if your life is in danger

But since no real immediate threat to life, no real opportunity to identify and recover.

Daily threats are ambiguous-prevent a sufficient recovery from the stress alarm reaction which are induced. This prolonged unabated stress is primarily responsible for the development of stress related disorders.

1 social and health problem of the past decade have been

stress related psychological, physiological disorders

Post industrial nations replaced infectious disese with stress induced disorders.

Four disorders prominent in the United States, Western Europe, Japan

1. cardiovascular disorders
2. cancer
3. arthritis
4. emphysema

Due to: diet, environment, contamination, psychosocial stress

Until you understand the language of their body, you will not protect yourself from excessive stress and the onset of psychosomatic disorders. Identifying stressors and sensitizing to crucial bodily cues are important means to preventative health care. Major changes in attitudes and behavior are necessary for success.

Profound discontinities and splits between mind and body are clearly evidenced in psychosomatic disorders. Integrating mind and body is a trying yet fulfilling task.

Patients with disorders from ulcers to heart problems are constantly advised to relax, but are seldom instructed in how to relax.

Meditative therapies such as autogenic training, progressive relaxation and biofeedback teach people to exercise control over their automatic or involuntary physiological functions. Autonomic control, or voluntary control of the involuntary nervous system was considered impossible a decade ago.

The progress in not to learn actual control of the autonomic system but simply to open channels between the conscious and un-

conscious mind.

Techniques to effect this gives the individual a sense of control over their life and health. Powerlessness can be one of the most insidious effects of excessive stress. Stress weakens psychological resistance and the immunological response as well.

The concept of individual power is essential to Hosistic health . We must see ourselves as active, responsible participants in stress attack rather than passive victims of stress.

Carl Simonton underscores the vital part that an individual can play through visualization in the course of any disease.

Recent research reveals a clear relationship between certain kinds of behavior and a predisposition on the part of individuals manifesting that behavior to develope a particular psychogenic disease.

Typical heart patients at Mt. Zion Hospital, S.F. were noted to be impatient, aggressive, extremely goal oriented, ambitious, restless and always under time pressure, even when " relaxing. "

Can you identify with these traits ?

Cardiologists Ray Rosenman and Meyer Friedman (Mt. Zion) termed this pattern " Type A " behavior and reported their research in Type A behavior and your heart (1974) You may be familiar with their work.

More relaxed individuals were termed Type "B".

Other personality types predispose people to such diseases as cancer, migraines, etc.

Elevated level of neurophysiological activity during exercise or transcent crisis is not synonymous with chronic unabated stress. Periods of illness, stress or crisis in a person's life can be times of profound personal transformation. A breakdown can be a breakthrough.

Both physical and psychological illness are potentially regenerative rather than inherently degenerative.

In early writing, C.G. Young noted that primitive people interpreted illness not as a weakness of the conscious mind, but rather an inordinate strength of the inconscious mind in the process of transforming an individual from one stage of life to another. Symptoms may be an indication of an individual's attempt to undergo a profound self-healing process which may be disrupted rather than enhanced by medication.

The most essential feature of a holistic approach is the profound alteration required in the individuals' belief system.

Once the individual adopts the concept that they are active and responsible participants in the process of stress, they can no longer passively accept the development and reinforcement of stress.

In modern sciences ranging from the neurophysiology of consciousness to quantitative physics, it has become evident that the structure of personal belief systems concerning the nature of the self and the universe governs experience. (Muses & Young, 1972.)

It is a self-fulfilling prophecy what is expected is observed and what is observed confirms the expectations.

An alteration of the belief system opens new realms of possibility.

Most people tend to suppress their stress because of the current norm of social behavior is to tolerate extraordinary high levels of stress. There is a martyrlike quality in this attitude which is not constructive.

Extensive programs are needed to re-educate individuals in stress reduction and health maintainence.

Active participation in identifying and alleviating major stressors through specif attitudinal change, relaxation techniques, and general life examination are the primary focuses toward attacking the stress factors in all our lives.

What would you do if someone randomly walked up to you and kicked you in the shins ?

A. We'd have a real big showdown

B. I'd beat the hell out of the person

C. I think I'd get mad

D. I might hit him

E. I'd want a reasonable explanation for such conduct

F. I'd probably end up doing nothing

If you checked A or B, Dr. Ring would consider you an excessive reactor. Explosive personality, or desires to be.
there is a greater vulnerability to peptic ulcers, cardio-vascular disorders and arthritis.

If you checked C, you would be aware of their anger, but who are indecisive and afraid to express their feelings.

If you checked D, restrained, depending on the intensity or assurance of the respondent.

Persons prone to three psychosomatic breakdowns fall into these categories:

1. Those who suppress their feelings thus blocking natural reactions.
2. Those who overact emotionally or physically.
3. Those unsure of what to do who harbor anxieties about their actions.

Future papers will deal with types of mental disorders and Kinesiolgic approach to illiminating those disorders.

SPINDLE FIBER CHALLENGE AS AN INDIRECT INDICATOR FOR MUSCLE WEAKNESS

Gary N. Klepper, D.C.

At times it is inconvenient or impossible to directly test a muscle for weakness due to either a condition in which the patient is unable to assume a position for the muscle test due to pain, or paresis which prevents the patient from demonstrating a measurable contraction of the involved muscle. In such cases, indirect testing may be desirable in order to measure increased activity in the muscle's motor units.

A simple test which may be useful in these cases involves simply approximating the spindle fibers of the muscle being tested as if to decrease the muscle's strength, then quickly testing a separate strong indicator muscle. Pressure to the spindle fobers in this manner will weaken the muscle to which the pressure is being applied in a normal individual, but should not weaken a separate indicator muscle. Weakness in the indicator muscle induced in this manner is interprested as a problem existing in the muscle to which the spindle fiber pressure was applied. This can then be cross-checked against therapy localization to any factor of the IVF or vertebral levels in order to determine appropriate therapy.

As an example, a patient presents with paralysis of the lower extremities due to an insidious process of questionable nature. Here, challenging the spindle fibers of a major lower extremity muscle such as quadriceps or hamstrings and testing an upper extremity indicator muscle can lead to appropriate therapy in order to encourage re-innervation of the lower extremity muscle thus tested. If spindle fiber challenge to the quadriceps is neutralized by therapy localization to its neurolymphatic point, the neuro-lymphatic activity is used until spindle challenge is negative. Other IVF factors can be checked similarly. Although increased

SPINDLE FIBER CHALLENGE (continued)

function may not be discernable immediately, the doctor knows that appropriate activity has been initiated.

Direct muscle testing should of course be used when possible, because it is more accurate.

EXTREMITY JOINT STRESS TESTING

Gary N. Klepper, D.C.

Due to the difficulty and the time involved in examining extreity joints for problems such as 51% neurolymphatic faults and reactive muscle situations, many times these factors are missed in attempts to correct extreity lesions. For this reason, it is useful to back up the exam by stress testing the joint as described here.

For example, a patient complains of knee pain, but every muscle traversing the joint has been tested in the clear and appears to be strong. Now the joint can be stressed from different angles and a previously strong indicator muscle tested. In the case of the knee, pressure can be exerted at the joint space in a lateral to madial direction as if to test the integrity of the medial collateral ligament, and an indicator muscle tested such as the opposite TFL or any other convenient muscle. This can be reversed with a medial to lateral pressure, with an A-P pressure on the tibia versus the femur, with a P-A pressure in the same way, and with rotatory stress introduced. Compression or distraction force may be added if desired. If, as in the first example, a force testing the medial stability of the knee caused a muscle weakness, this indicates a weakness of some retaining element of the knee which should provide medial knee stability such as the sartorius muscle. This muscle may then be tested on a 51% bais or a reactive muscle basis until the source of the weakness is discovered. Often, this will show damage to a ligament as well as muscles, and appropriate therapy such as ligament interlink technique can be instituted.

A real advantage of this technique is that it will cause the doctor to sometimes investigate a particular muscle more fully because he is able to prove that it is weak even if it is not weak in the clear.

EXTREMITY JOINT STRESS TESTING (continued)

The disadvantage is that this technique of itself will not necessarily reveal all extremity problems, so that if it is used to the exclusion of other examination procedures, failure will often result.

Special thanks to Dr. Terry Franks for demonstrating this technique to me.

MELZACK-WALL AS A MEANS OF RELATING VISCERAL DISORDERS TO STRUCTURAL FAULTS

Gary N. Klepper, D.C.

Melzack-Wall technique checked against a particular involved organ system can reveal certain vertebral problems or cranial faults which may not of themselves be easily detectable by therapy localization.

Classically, it has been a practice to treat visceral dysfunction not only by neurolymphatic activity, nutrion, or other reflexive activities, but also to examine the appropriate spinal segments for any lesions in need of correction. However, sometimes evidence of visceral dysfuction persists even after all muscle indicators have been strengthened and after all structural faults which are detectable by the usual means have been corrected. This may be evidenced by persistent TS line findings along with corresponding symptomatology and physical or lab findings. In such a case Melzack-Wall may be useful in order to detect a significant structural fault which the body has glossed over.

It is necessary to have an indicator of visceral dysfunction. The point at which I will generally institute this technique is when all of the indicator muscles are strong when checked against all of the factors of the IVF. At this point, a weakness can be elicited by any of the forms of augmented therapy localization as described by Dr. Goodheart in his writings and tapes, or it may be useful to create a weak indicator by simply placing one of the patient's hands on the front surface and one on the back surface of the body in such a position that they surround the organ in question. A weakness thus elicited can be neutralized by one quick tap to the associated alarm point as a means of identifying which organ is being therapy localized.

For example, a stomach dysfunction is suspected, but no weakness is able to be elicited. One of the patient's hands is placed over the stomach on the front side of the body and the other behind it on the posterior side of the body. Any indicator muscle is now weak. Maintaining this type of therapy localization, a tap is delivered to the stomach alam point, which neutralizes the weakness in the indicator muscle. However, tapping to any other alarm point does not neutralize the weakness. This establishes that there is some problem or energy imbalance affecting the stomach.

Next, a therapy localization is held at the appropriate alarm point with the patient in a seated or prone position and the skin is scratched over the vertebral levels, ribs, and if necessary the cranial bones until a change in tonus of the indicator muscle is noted. Usually, the localization to the alarm point itself will be negative until checked against the spinal, rib, or cranial level by scratching. On locating the involved level, the segment can be challenged, adjusted, and if successful the original therapy localization will now be negative.

The advantage of this technique is that it can be used to quickly find structural faults that would otherwise be difficult or time-consuming to identify but which may be very significant in their ability to bring about improvement once corrected. Another advantage is that modifications of this technique can be used to advantage when an undetected structural fault is creating a recurrence of problems such as neurolymphatic or acupuncture faults.

One disadvantage is that unless most structural faults and other therapies have already been utilized, there may be so much disturbance or "noise" in the nervous system that the structural faults thus found

would be easily detected anyway by simpler methods such as therapy localization or be of lesser significance, and using an elaborate procedure such as this would then be superfluous. Another disadvantage of this technique is that facilitation of the system involved by structural correction may negate the indication for another simple but needed therapeutic procedure such as neurolymphatic activity or nutrition. Nevertheless. the technique of itself when used at the right time can be enormously helpful.

My thanks to Dr. George Goodheart for his many descriptions of Melzack-Wall applications and therapy localization and to Dr. Terry Franks for his development of the particular applications described here.

LINGUAL BLOOD TESTING

Gary N. Klepper, D.C.

This article is a review of lingual blood testing procedures and their diagnostic significance in certain cases of allergy, poisoning, and digestive problems. Many times it will provide needed diagnostic information in non-responsive cases and presentations of bizarre symptom patterns.

The actual procedure of testing the blood lingually involves puncturing a finger by sterile lancet, placing a large drop of blood thus obtained on the patient's tongue, and testing a previously strong indicator muscle. A weakening of the indicator muscle is a positive response and is interpreted as the presence in the blood of either a toxic factor or a factor which the body is reactive to in a detrimental manner. Classically, the test is done with a bilateral pectoralis major clavicular or a pectoralis major sternal muscle as the indicator, but many times a situation arises in which a different organ system or systems are selectively affected. For that reason, it is sometimes necessary to test a whole series of muscles such as both divisions of the pectoralis major, the quadriceps and/or abdominals, the tensor fascia lata, the middle trapezius, and the latissimus dorsi. Weakening of only one of these muscles would indicate that there is either a selective or a more pronounced detriment to that particular organ related to the weakened muscle.

The next procedural step involves testing a nutrient along with a drop of blood simultaneously to determine what would neutralize the weakening effect of the blood.

Neutralization of the positive blood test by antronex would indicate an imbalance in the histamine-antihistamine levels of

LINGUAL BLOOD TESTING (continued)

the body such as would occur in allergies to food or to other environmental agents or as would occur in certain liver dysfunctions. therapy would involve identification of the offending foods or environmental agents, investigation of all factors related to alllergy such as adrenal function, digestive function, category II lesion, temporal bulge fault, possible need for increase in liver activity, and possible supplimentation with antronex.

Neutralization by a source of zinc such as myelotrophic chelate would indicate either a significant problem of mineral depletion or balance or possibly a heavy metal intoxication. This would be a good indication for a hair analysis to determine if a toxic mineral situation exists, and if so, the source of this intoxication should be identified and eliminated. Chelation with zinc and vitamin C is generally used to displace any toxic menerals already present in the body.

Neutralization by thymus protomorphogen, raw thymus, or thymex would indicate a pseudo-allergy situation. The concept involved here is that the thymus is responsible for differentiating between a normal cellular protein and a foreign invader such as a bacterium which would stimulate the immune responses. In a functional deficit of the thymus, there may be a diminished immune response resulting in frequent infections or there may be an overrectivity of the immune response which could be triggered by exposure to a complex dietary protein such as dairy products or glutin. Often a milk sensitivity cnabe controlled by improvement in thymus fuction. Appropriate therapy here would be supplimentation with thymus material or other appropriate activity for imprvement in thymus function, temporary withdrawal of the offending food, and any therapy necessary to improve intestinal function. This has been very useful in many

cases of chronic dermatitis.

Neutralization by some type of digestive aid such as betaine HCl, zypan, enzymes, comfrey-epesin, or chlorophyll would indicate an intestinal toxicity requiring improvement in digestive or eliminative functionand possibly withdrawal of certain foods such as sweets, chocolate, fried foods, or foods to which a sensitivity or an allergy exists.

In summary, lingual blood testing is as effective diagnostic tool which can help the doctor to get a new perspective on the problem being dealt with and can provide infomation needed to direct proper therapy.

My thanks to Dr. George Goodheart and Dr. Terry Franks for sharing their observatinns on this topic.

POTPOURRI II

By George N. Koffeman, D.C.

Abstract: Four catagories are here presented:

1. Newly discovered allergic response involving sexually related muscles.

2. A surrogate testing procedure for allergy testing of infants and small children.

3. A technique is presented for toning uterine ligaments and the Kinesiological evidence of possible therapeutic value.

4. Operator activated left-brain, right-brain testing together with inspiration/expiration investigation. The response correlation and advantages of its use.

In 1976 I titled my paper Potpourri. It was a collection of observations, none of which I thought worthy of single expansion into a paper on its own merit. Here again I pass out a few remnants from my bin hoping they will fit the mosaic of another's practice.

I. Allergies

My paper for 1979 dealt with organ specificity of allergens, especially foods, supplements, medications, and aromatic substances. I described various combinations of muscle reactions in response to individual sensitivities. At that time I reported that, "We have not demonstrated, at this point, reactivity of any sexually related muscles." I have now found that patients sensitive to coffee will be affected in one or more of those muscles, i.e., gluteus medius, gluteus minimus, abductors, and piriformis.

II. Surrogate Testing for Allergies

Kinesiologists have used surrogates in testing young children for a considerable time now. Perhaps this procedure is used by others. I do not recall having read precisely this method before so will presume to term it my method.

Few things annoy me more than seeing a child with a history of "chronic bronchitis" who has undergone 15-20-25 courses of antibiotic treatment before the age of five. One thing does annoy me more - that is the approval of this practice by a segment of the more "educated" Chiropractors in the community.

Procedure:

1. Select the most prominent symptom - may be rash weals, digestive, etc., but is usually respiratory.
2. Test the mother for muscle competence.

3. Select the dominant system reflex, usually N.L., make sure it is intact by muscle testing mother while she TLs the N.L. reflex.
4. Test foods on child's tongue, recording each blow-out. Test aromatics by inhalation.
5. Reset reflex by bilaterally adjusting skull after each food sensitivity reaction.

I recently tested a two year old girl. Her mother is most careful to provide excellent nutrition for the family. The child reacted sensitively to yogurt, tangerine, and turkey bologna; giving me an opportunity to warn against using processed meats of any kind in the diet. An educational chance which should not be missed.

III. Toning Uterine Ligaments

Somewhere around the '60s, Dr. Maurice Flack, a D.C. in Indianapolis, used to teach a practice management course. One of the techniques he taught was a method, which he maintained would reposition a "tipped" uterus. He stated, as I recall, that even a prolapsed organ that had invaded the vagina could be improved sufficiently to, often, avoid surgery.

I have used this method occasionally on women who have reported area discomfort. Usually they will state that their gynecologist said they have a "tipped uterus". Often the patient will report improvement of symptoms following 1 - 2 or 3 treatments.

Recently I have begun checking the sexually related muscles and have had success in obtaining response when the 5 factors of the IVF would not hold stability. It is easy to use and rapidly accomplished.

Procedure -
1. Place patient supine on the table.
2. Instruct her to relax abdominal wall as completely as possible.
3. Place fingers of both hands along side of uterus, pressing downward and in toward the mid-line of the torso as though to reach under the uterus.
4. Use a quick upward and inward "snap" of the fingers to "flip the ligaments".
5. Repeat two - three times on each side.

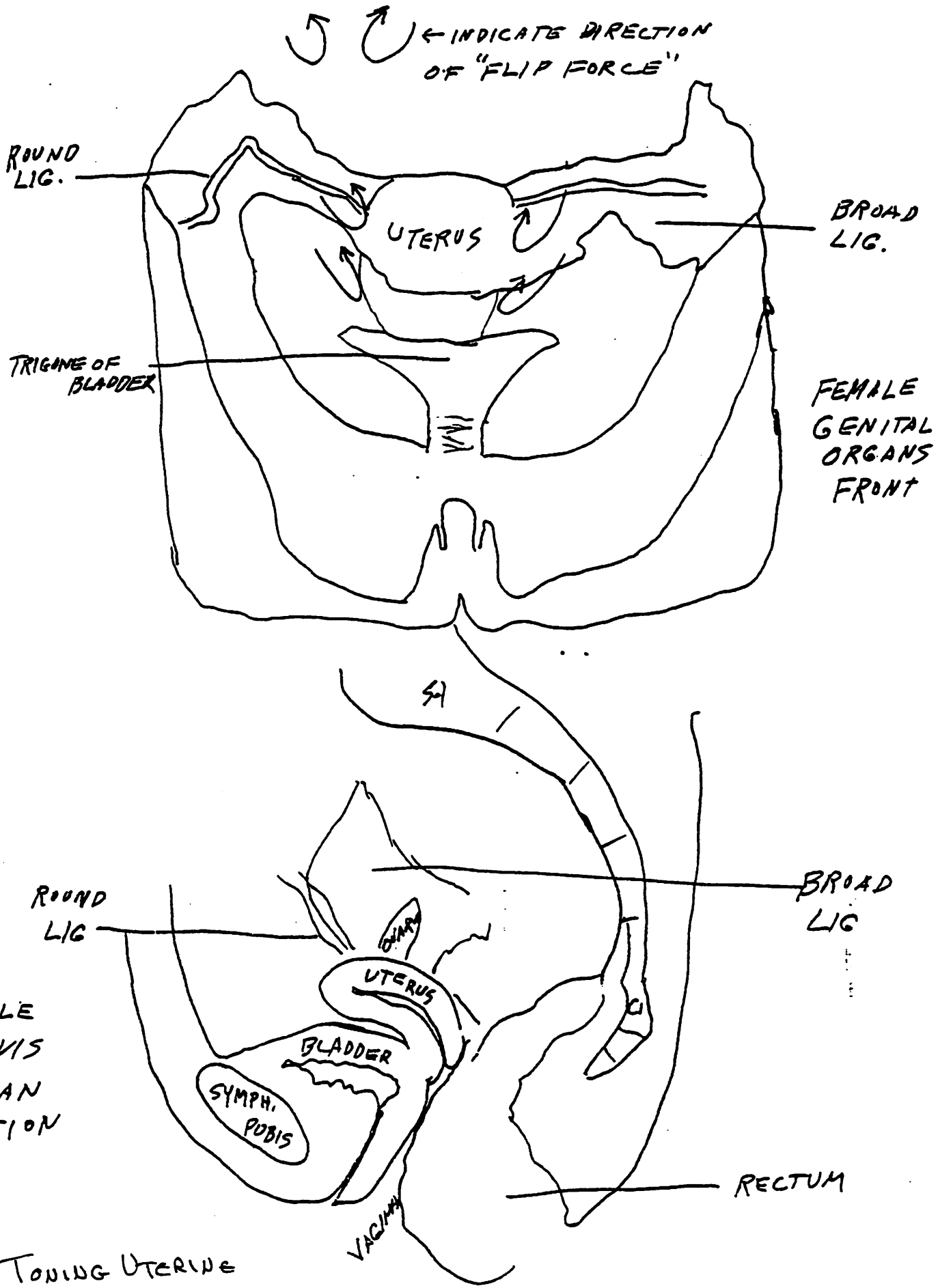
There will be immediate reaction of associated muscles giving some objective evidence for use of this maneuver.

IV. Operator Activated

I have as patients a young couple who are deaf mutes. They have been trained to talk but it is very difficult for one, not of the family, to be sure of complete understanding. Communication is somewhat difficult when the person is prone on the adjusting table.

One day this year, while testing the lady, I discovered that, in my effort to have her understand, I was going through the breathing, counting, and humming for her with no discernible difference in

results. I was surprised by this and so began to test others in the same way. I would, to myself, hum and count, inspire-hold and expire-hold, recording any changes. Then I would have the patient do the same. The results were identical!! Mindful of the warnings of many investigators that when one gets what he expects to find be suspicious of the results. I have tested approximately 75 patients over the past four weeks with a 100% correlation. I have tested both ways - first having the patient breathe and phonate and later retesting unknown to them. After making corrections of problems found and retesting both ways I still get identical results. It is as though this system were a template of the original method. If others find that their conclusions are the same as mine, this should become a valuable tool limited in uses only by the imagination of the doctor.



FEMALE PELVIS MEDIAN SECTION

III. TONING UTERINE LIGAMENTS

CRANIAL ADJUSTING FOR THE NEWBORN

Nancy L. McBride, D.C.

Abstract: The infant who seems very unsettled, unable to sleep soundly, restless, irritable, cries for long periods of time and falls asleep from exhaustion, and just never seems to be contented may be suffering from birth induced cranial faults.

The mother of a four month old baby sat in consultation with me in my office and in tears told me she was becoming thoroughly exhausted since the birth of her daughter. The baby would never sleep more than three hours at any time. The baby would wake up startled and crying and would cry endlessly for sometimes hours at a time and then fall asleep out of exhaustion only to reawaken at the slightest noise or disturbance in the environment. The mother sensed that the baby was never satisfied and never content. She felt that nothing she could do pleased the baby and the mother was close to collapse from frustration and exhaustion. The mother having been a patient in my office for many years for various problems, was aware of the correlation between some of the symptoms her baby was displaying and the possibility of food and/or chemical allergens. She felt there was no observable correlation. My familiarity with the parents and both their respective families led me to believe that since the parents were of highly reactive personalities perhaps this baby was reacting to an uncomfortable emotional environment. With this in mind I called Dr. Terry Franks, I.C.A.K. Diplomate from Minnesota.

Since the 1980 I.C.A.K. Annual Meeting I have been working with Dr. Franks Bach Flower Remedy proceedure which he talked about during that meeting. I was anticipating that Dr. Franks might have some insight, having used the remedies for a longer time, into what might help this infant. During our conversation he asked me, How long was the mother in labor?... the answer 17½ hrs. and then the baby was finally taken Caesarean.. Dr. Franks felt there might be some emotional overtones but that the main problem was a severe cranial fault. He felt from his experience with similar cases that the fault would be mainly with the occiput either bilaterally or unilateral. He said to me,"you will not believe how hard you have to thrust to move that bone, don't be afraid, just do it."

Proceedure:

First clear the mother of all cranial faults so that she can be used for a surrogate. Place the baby on the mother and have her re-therapy localize all the previously checked cranial suture areas. Now when the muscle test reveals a problem area during T-L it can be assumed that this is a fault area in the baby. On first examination the baby revealed a jamming of the occipital bone over the Atlas on the left, an upper cervical fixation and a banana head fault on the left. As soon as I palpated the suboccipital region the baby began violent crying. I held a sustained forceful lifting and pulling motion on the occipital bone until my fingers hurt. I quickly held the banana head fault correction position while the baby continued to scream and then adjusted the upper cervicals by palpation as a straight lateral thrust left to right and right to left.

The baby continued to cry for about ½ hour. The mother called a few days later. The baby began with the night of the first manipulation sleeping through the night and taking regular naps during the day. She also was calm and cheerful during her waking hours. It should be mentioned that the cranial faults previously mentioned were creating an obserable asymetry of this baby's skull.

On subsequent visits other cranial faults have been found and treated on this child. She is definately a different personality. Her mother is now catching up herself as she can now sleep through the night and spend peaceful days with her baby. Since this first experience I have had the good fortune to examine and treat in a similar fashion two other babies with similar case histories although the first child was the most severe. In both the other two cases the results have been equally rewarding. The cranial asymetry so initially obvious in the first baby is almost impercievable after six office visits.

Summary:

Had it not been for my profound respect for the expertise of Dr. Terry Franks I would never have attempted this proceedure. The look on the mother's face while her baby wss screaming in terror was deterant enough. Sometimes we must just believe in what we do and let the FORCE do the rest

AEROBIC AND ANEROBIC MUSCLE TESTING AND DYSFUNCTION

by: Kerry M. McCord, D.C.

ABSTRACT: An attempt is made to simplify and outline the procedures and processes necessary to understand, diagnose, and treat aerobic and anerobic muscle dysfunction.

Histological, Physiological, and Biochemical differences between Aerobic and Anerobic muscle fibers:

Aerobic	Anerobic
Slow	Fast
Red	White
Greater endurance	Rapid fatigue
Large myoglobin content	Large glycogen store
Oxidative metabolism (burns fat and O_2)	Glycolytic metabolism primarily (burns glycogen)
Postural muscles (electromyographically maintain continued activity)	Phasic muscles (produce quick changes in body by rapid movement)

Indications:

Athletic injuries - especially when history indicates muscle failure while in use

Spinal deviation - e.g. standing patient bends forward presenting an observable elevation on one side of the spine - common pattern in lumbar region with psoas or gluteal involvement

Procedure:

1. Test muscle in a serial fashion (repeatedly):
   i.e. if muscle predominantly aerobic
   10 tests in 10 seconds
   if muscle predominantly anerobic
   20 tests in 10 seconds

   Note: occasionally both aerobic and anerobic testing of a particular muscle may be appropriate

2. If muscle weakens when tested in this fashion, TL (therapy localize) to the NL and/or NV reflexes while retesting to confirm analysis and identify the need for lymphatic and/or vascular activity. Therapy localization to the lymphatic and/or vascular drainage centers should neutralize muscle response.

3. Test for nutritional supplementation by use of lingual reception:

   Chelated Iron - aerobic fault
   Pantothenic Acid - anerobic fault

4. Prolonged manipulation of the appropriate lymphatic and vascular reflex centers should now be applied. (up to three minutes of stimulation is occasionally required)

5. Patient should be supplied with the appropriate nutrients(s):

   Chelated Iron - 18 mg. daily
   Pantothenic Acid - 100 mg. daily

Rationale:

Fat not being properly retrieved by the lymphatic system is left in inappropriate quantities in the interstitial tissue resulting in a relative failure of fat delivery to the muscle in need.

Myoglobin (muscle hemoglobin) not abundant enough to insure the release of appropriate quantities of O_2 to accomodate muscle need.

Coenzyme A (a derivative of pantothenic acid) not present in large enough quantity to insure uninterrupted glycolytic metabolism.

Notes of Interest:

90% of ATP (chief chemical agent necessary for muscle contraction) formed by oxidative metabolism

10% of ATP formed by glycolytic metabolism

- with reference to the above and the biochemical differences between aerobic and anerobic muscle fibers it might be reasonable to assume that aerobic faults will be more frequently found

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THE LIGAMENT INTERLINK LESION

Part 1 EXPANDED LESIONS

Part 2 LIGAMENT INTERLINK CLASSIFICATION SYSTEM

by EVAN MLADENOFF B.Sc., D.C., D.T.

PART 1

With the advancement of Goodheart [1] and Mladenoff [2] of a more detailed evaluation of the ligamentous system, it has become apparent that there is a definite and discrete communications network within the ligamentous system. A multiple or complex involvement of ligements seems apparent when dealing with athletic injuries. These injuries usually occur with an increased velocity and the limb(s) positioned at a biomechanical disadvantage. Diagram # 1 illustrates such a particular example where simultaneous ligament stress is incurred at both ankle joints, both knee joints, both hip joints, and some degree of difuse transmission from the waist superiorly.

If the injury is sustained at the right medial collateral knee ligament, then a ligament interlink lesion may further exist at the right lateral ankle and/or the right medial hip. This does not take into account the position of the left lower limb or the remainder of the body. Further possible ligament interlink lesions may also exist with the left ankle and/or the left hip joint. Diagrams # s 2,3 and4 are provided to illustrate the mechanical action that may occur at the involved joint and the possibility of furtherinjury transmitted either superiorly or inferiorly in the same limb.

DIAGRAM # 1

DIAGRAM # 2

Action of the right posterior knee. Arrows indicate the torsional forces developed at the medial knee.

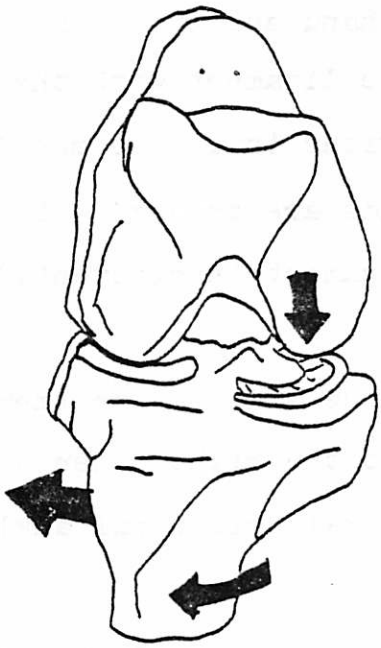
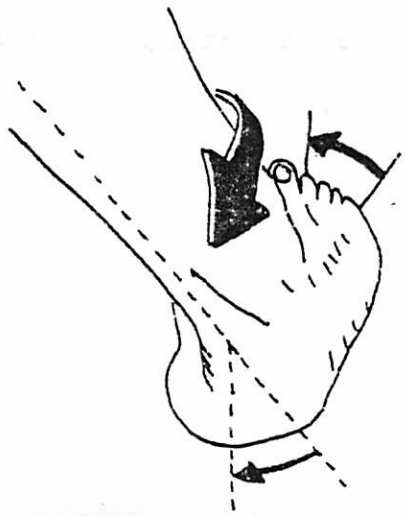


Diagram # 3

Eversion ankle sprain



MODUS OPERANDI

The following modus operandi is offered , however, it has become clearly evident that the priority of these ligament interlinks is secondary to those presented by Goodheart and Mladenoff. For a right medial collateral ligament injury the following may be used to differentially diagnose further ligament involvement.

1) TL the right medial collateral knee ligament with the patients left hand, test indicator muscle,if negative proceed.
2) TL the right lateral collateral ankle ligament with the patients right hand, test indicator muscle, if negative proceed
3) Simultaneously TL right medial collateral knee ligament with the patients left hand and the right lateral collateral ankle ligament with the patients right hand, test a previous indicator muscle (it is imperative that the hands are crossed while TL activity is used to determine ligament involvement.). If positive proceed.
4) Push the hyoid bone to the side of treatment. In the example given, push the hyoid to the right. Then vigorously stimulate the right lateral collateral ankle ligament for 20 to 60 seconds.
5) Repeat steps 3 and 4 until step # 3 produces a negative TL.

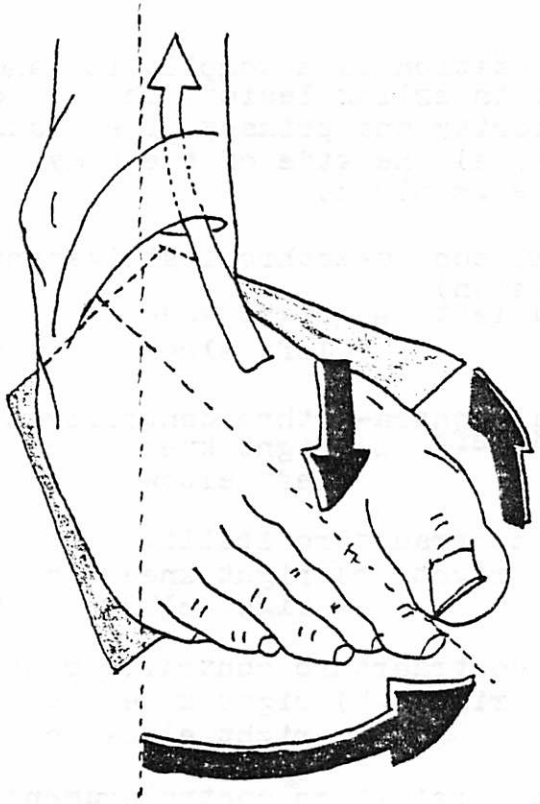


Diagram # 4

Anterior view of eversion sprain

diagrams after Kopandji: The Physiology of the Joints

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1) Goodheart, Applied Kinesiology 1978, 1980 Manuals.

2) Mladenoff,E., Theoretical Extrapolational of The Ligament Interlink Lesion., ICAK Collected Papers Winter 1980.

PART 2

This presentation is a compilation and classification of the ligament interlink lesion. The lesion will be listed in order of priority and primacy. The classification system has three parts, a) the side of the body, b) the joints involved c) the ligaments involved.

1) contralateral contra-arthro ipsiligament (original ligament interlink lesion)
   a) right and left b) right knee c) medial collatral lig.
   left elbow c) medial collateral lig.

2) contralateral contra-arthro contraligament
   a) right and left b) right knee c) medial collateral lig.
   left elbow c) lateral collaterallig.

3) ipsilateral contraarthro ipsiligament
   a) right and right b) right knee c) medial collateral lig.
   right elbow c) medial collateral lig.

4) ipsilateral contraarthro contraligament
   a) right and right b) right knee c) medial collateral lig.
   right elbow c) lateral collateral lig.

5) contralateral ipsiarthro contraligament
   a) right and left b) right knee c) medial collateral lig.
   left knee c) lateral collateral lig.

6) contralateral ipsiarthro ipsiligament
   a) right and left b) right knee c) medial collateral lig.
   left knee c) medial collateral lig.

7) ipsilateral ipsiarthro contraligament
   a) right and right b) right knee c) medial collateral lig.
   right knee c) lateral collateral lig.

This concludes the classification of the original ligament interlink lesions presented in the 1978, 1980 Applied Kinesiology Manuals by Goodheart and the Theoretical Extrapolation presented in ICAK 1980 Winter Collected Papers by Mladenoff. The remainder of this classification is devoted to the presentation in the preceding pages by this author.

8) ipsilateral distal arthro ipsiligament
   a) right side of body b) right knee c) medial collateral lig.
   right ankle c) medial collateral lig.

9) ipsilateral proximal arthro ipsiligament
   a) right side of body b) right knee c) medial collateral lig.
   right hip c) medial hip lig.

10) ipsilateral distal-arthro contraligament
   a) right side of body b) right knee c) medial collateral lig.
   right ankle c) lateral collateral lig.

11) ipsilateral proximal-arthro contraligament
   a) right side of body b) right knee c) medial collateral lig.
                           right hip c) lateral hip lig.

12) contralateral distal-arthro ipsiligament
   a) opposite sides of body b) right knee c) medial collateral lig.
                               left ankle c) medial collateral lig.

13) contralateral proximal-arthro ipsiligament
   a) opposite sides of body b) right knee c) medial collateral lig.
                               left hip c) medial hip lig.

14) contralateral distal-arthro contraligament
   a) opposite sides of body b) right knee c) medial collateral lig.
                               left ankle c) lateral collateral lig.

15) contralateral proximal-arthro contraligament
   a) opposite sides of body b) right knee c) medial collateral lig.
                               left hip c) lateral hip lig.

The establishment of a ligament interlink classification system brings about a highly technical and precise involvement of this type of lesion. It appears in the initial stages of developing this system that it is of an academic nature and may prove to be cumbersum in everyday practise. However, if we are to continue to find additional pieces of the jigsaw puzzle, then we must develop rational anatomical, physiological and biochemical models that are then implimented, investigated and revised.

ANOTHER PIECE IN THE OLD ENIGMA: THE ILEOCECAL VALVE

By

Emil F. Morlock, D. C.

ABSTRACT: Some additional nutritional considerations involving the ileocecal valve.

Everything I have ever heard about the ileocecal valve seems to be true, plus a few observations of my own.

There are a few patients, usually over fifty, who seem to have chronic health problems which reoccur every three to six months. In most cases, I have found a repeated ileocecal involvement. Reviewing all standard treatments, it occurred to me that cleansing of the intestinal tract had not been considered.

As you know, cholocal II (Standard Process)[1], has montmorillonite, which is clay having small amounts of mineral content plus a trace of bile salts. The minerals absorbed into the small intestines cause a positive response to muscle testing. Rationale for using cholocal II was knowing that it is a detoxifying and cleansing agent which removes excess mucus and general debris from the small intestines. Once cleansing is accomplished, the villi in the small intestines are allowed to absorb nutrients more normally and bodily function improves.

In conjunction with cholocal II, it was noticed that lactic acid yeast[1] (Standard Process) also showed positive muscle testing in these chronic cases. Reasoning at this point strongly suggested that once the "house cleaning" was done, or even in the process, the reestablishment of an acid bowl with friendly bacteria would further improve general health.

CONCLUSION: In older patients with chronic gut problems where an ileocecal valve can be demonstrated, consideration of cleansing (cholocal II) and reestablishing of normal intestinal activity (lactic acid yeast) is a factor which merits continuing consideration.

R E F E R E N C E

1. Products Bulletins, Therapeutic Food Company, Milwaukee, WISC. Private papers.

A Technique For The Treatment Of Paranasal Sinuses With Lavage---

By
L.E. Rarey, D.C.

Abstract: This technique demonstrates the use of nasal lavage as an accessory treatment to nutrition and applied Kinesiology in the treatment of chronic sinisitis. The product used is a aqueous solution of chlorophyll.

The patient is seated on a flat table or cot, adjacent to a stack of two or three pillows. He is then bent laterally on the pillows, the lower arm flexed at the elbow and held beneath him, with the body in a strictly sidewise position. The head is now bent downward (laterally) to as nearly upside down as possible. The final position will depend somewhat on the length of the patient's neck, but anyone can flex the head sufficiently to assume a correct position. Be sure that the shoulder remains on the pillow, as there is a tendency for the patient to "ride" over the pillows. Ideally, the head should be exactly vertical. The olfactory area is now down and level.

The patient is instructed to breathe through the mouth so that no fluid enters the pharynx. In this position, any fluid dropped in the nostril will gravitate to the SUPERIOR NASAL areas, in direct contact with the ostia and meatuses of the paranasal sinuses. Using an ordinary medicine dropper, slowly introduce 5cc of chlorophyll into the nostril.

The position as described is fairly comfortable and can be held by all (except the senile hypertonics) for from three to five minutes. Before the patient rises, turn the face downward and allow any fluid in the nostrils to escape. The best method after the solution has been put into the sinus area is to have the patient use kleenex to put over nares and let the solution drain into a sink. This is after the solution has remained in the sinus for three to five minutes. Many times mucus plugs will drain from sinuses, so forwarn the patient of this, as the drainage is usually excessive. If small children are treated, hold the head between the knees. In cases of bilateral involvement, treat each nasal cavity alternately.

Fill right sinus when patient is on right side then drain sinus and have patient turn on left side and repeat procedure. This technique should be repeated two or three times weekly. This technique is useful in involvement of the frontal, ethmoid, sphenoid and posterior ethmoid sinuses. It has the very great advantage that no instruments need be introduced into the sensitive nasal cavity, and, when properly carried out, assures the operator of bringing the antiseptic chlorophyll directly in contact with the involved membranes.

Conclusion: When treating cases of sinus infection be certain to use all other methods of treatment ie; chiropractic adjustments, nutrition, applied kinesiology techniques, and then include the above methods for a complete therapeutic approach.

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2. Clinical Research, Rose City Chiropractic Clinic, Portland, Oregon
3. Clinical Research, Baker City Chiropractic Clinic, Baker, Oregon

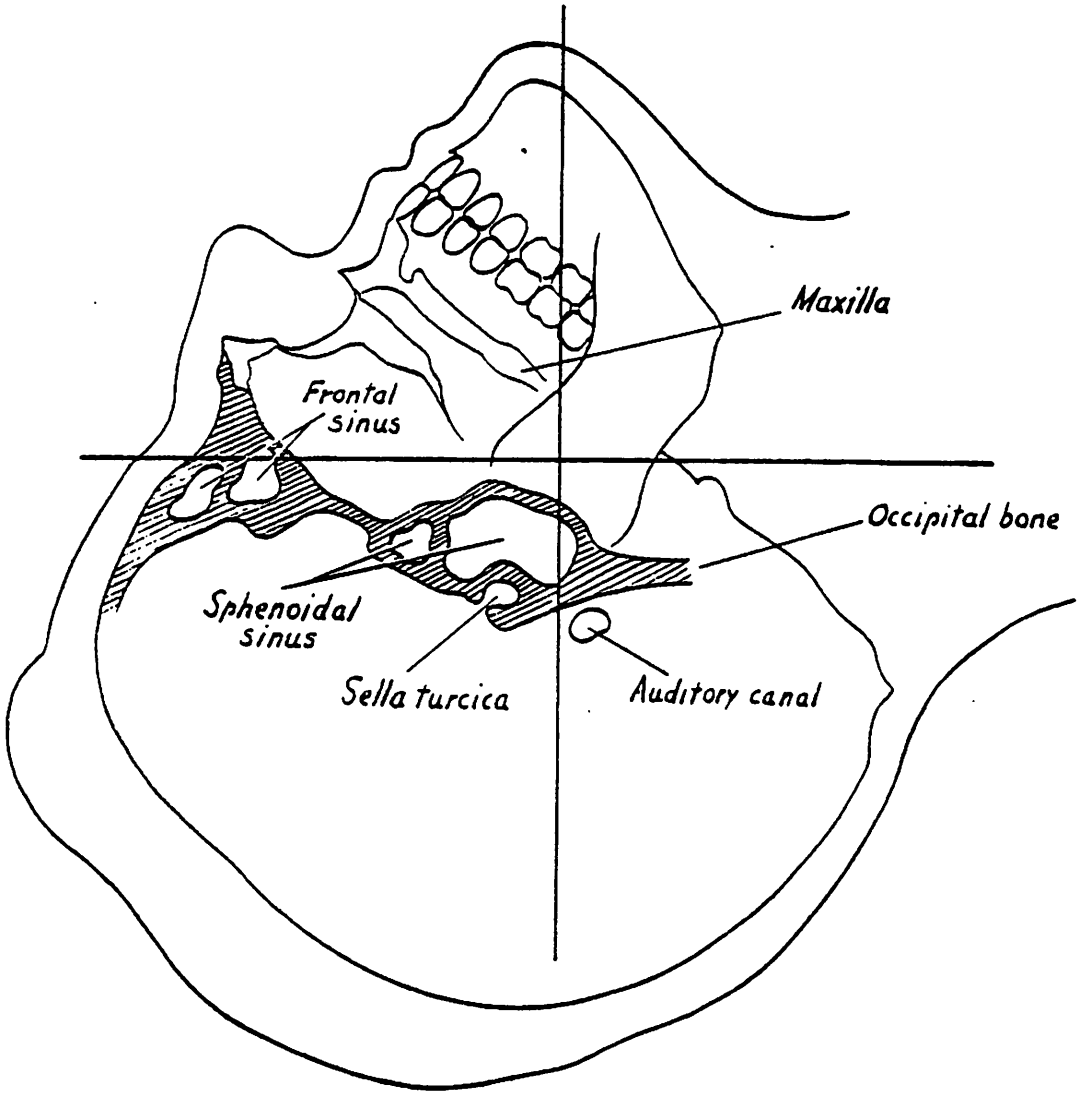

FIGURE NO. 1: The disposition of the anatomical structures in the lateral head-down position.

C1

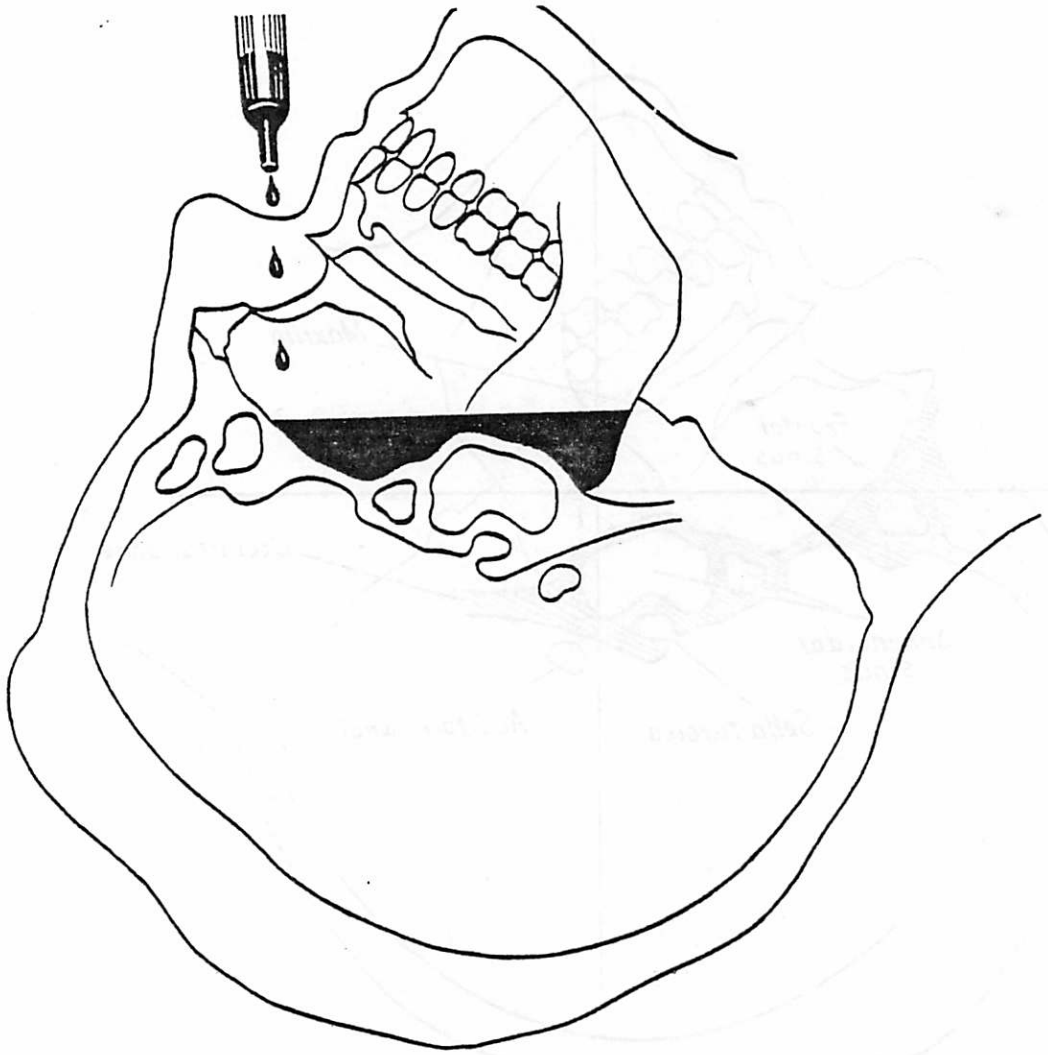

FIGURE NO. 2: In the lateral, head-down position, fluid introduced into the nostrils gravitates to a natural "pocket" which allows intimate contact with the openings of the paranasal sinuses.

Rapid range of motion screening for evaluation of joint involved for routine office use using Applied Kinesiological procedures

by William H. Ripley, D.C.

ABSTRACT: Using similar approach to that of Gerald Deutsch, D.C. in the Collected Papers of the Members of the International College of Applied Kinesiology, summer meeting 1979, entitled "Detection of a 'Movement Subluxation", I found that the following information could be obtained as a quick screening method to help pin-point the area of skeletal trouble by proceeding as follows:

Beginning with the patient in the supine position on the table, I first (after making sure the patient and the doctor are not switched) pick a strong test muscle. I prefer the tensor fascia lata as I stand at the foot of the table facing the patient. I then ask the patient to rotate the head as far to the right as possible (and test the indicator) then reverse to the left, repeat the muscle testing keeping in mind any weakness that shows up. Then posterior flexion (as testing for posterior rocker fault), next full extension of cervical spine (chin on chest). Also right and left lateral flexion asking patient to touch right or left ear to tip of shoulder without rotation. If a direction causes a previously strong indicator muscle to weaken this would be repeated with respiration and the correction is given in the direction that causes weakness on the phase that abolishes that weakness.

I have noted at this point that if a right or left rotation of the skull (full) causes weakness in conjunction with the posterior flexion that correction of the rotation negates the posterior weakness in the majority of cases.

I have also noted that if the patient has any type of arm or shoulder problem that has a vertebral involvement the lateral bending test for cervical spine will indicate weakness. Correction

for this is given from the side that indicates weakness using respiration unless patient has a severe cervical scoliosis at which time it may be wise to adjust from the opposite side using no phase of respiration.
Note: In cases of acute torticolis I have found simply by having the patient look to the right or left as in testing for occular lock will give you the same information as having the patient turn the head in either direction.

Next in routine screening before any correction is made I will have the patient flex the thigh against the abdomen without bending the knee too severely by having them pull the leg up gripping under the thigh above the knee joint then ask them to extend the leg and retest, do both sides; the side that causes weakness is the side of lesion in a category II regardless of whether or not the Ilium is posterior or anterior. I then check to see whether or not the weak side is the side of short or long leg.

The patient may now be blocked and you can determine which is the primary area or the problem by repeating the positive tests above and see if the category correction eliminates the upper weaknesses. I have found as Dr. Stan Wieczorek often mentions, that the category is primary in most cases. For further pin-pointing of extremity problems I have been able to test shoulders by having the patient draw the entire arm back as is used in a swimming backstroke (however find this also may indicate a need for lymphactic drainage as stimulation of anterior neurolymphatic for subclavius will usually eliminate this weakness). Flexion of knee joint, elbow joint, or phalangies three or four times and testing strong indicator will tell you whether or not the problem is in that area or above.

I have found that you may find a weakness in the lateral cervical flexion with an elbow or hand problem or just a weakness in the extremity test without any vertebral involvement. This helps the

examining doctor to quickly know the area to be treated and on subsequent visits can limit his testing to just the area indicated on the previous visit; and also the patient can readily see his or her progress.

This may sound lengthly at first, however, in demonstration with the proper form and an assistant it can be completed in a few minutes and after the first visit the patient is trained and anticipates the next steps.

OVER-UNDER TECHNIC AS APPLIED TO SHOULDER PROBLEM

Presented by:

Richard Roy d.e.c., d.c.

OVER-UNDER TECHNIC AS APPLIED TO SHOULDER PROBLEM

Abstract: Utilizing the Yin-Yang principle in relationship with the six meridians of the arm and its effect on the range of motion of the shoulder.

Any joint can be influenced by unbalanced energy; Dr. Goodheart demonstrated this very well with simple flexion of the spine; when all the energies are brought back into homeostatic balance, the structural work is more efficient and brings faster releif.

When we have a patient with shoulder problem, we utilize the standard method of correction as taught in applied kinesiology including such approaches; ligament interlink, spinal gate pain control, T.M.J., elbow, wrist.

At this point if the range of motion is slow to normalize, we use the over-under technic.

The acu-points that are taken into consideration are, Cv-15, Tw-5, H-5, Si-7, Cx-6, Li-6, Lu-7, except for Cv-15 all the mentionned points are the connector points for each of the meridian of the arm.

This is how we proceed:

1) Pulse analysis is negative.
2) Do the pulse analysis with forced adduction, record the findings.
3) Do the pulse analysis with abduction, record the findings.
4) Do the pulse analysis with adduction and medial rotation at the front, record the findings.
5) Do the pulse analysis with adduction and medial rotation at the back, record the findings.

As each position is maintained, we t.l. the pulse and isolate the meridian that is non-responsive to the turn-off technic. After finding the meridian we tap connector point of the, specific meridian. We also check the associated point to bring a better balance.

This technic was utilized on 15 patients ONLY, IT DOES NEED MORE INVESTIGATION.

Thank you.

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Applied Kinesiology Research Manual, 1978 edition, Dr. George J. Goodheart Jr., 1978, Detroit, Michigan.

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CEREBELLAR ACTIVITY AS APPLIED TO THE MELZACK-WALL PINCH TEST

Presented by:

Richard Roy d.e.c., d.c.

CEREBELLAR ACTIVITY AS APPLIED TO THE MELZACK-WALL PINCH TEST.

Abstract: Utilization of the Melzack-Wall technic applied with the cerebellar concept, as we did with t.l. and challenge.

At this point all of us are familiar with the utilization of the Melzack-Wall technic, especially the scratch and pinch test.

The Melzack-Wall technic as it is used in Applied Kinesiology has different function:

1. Spinal gate pain control.
2. Pinch test to find underlying problem, assist t.l. and challenge.
3. Pinch test to help determine if a problem is primary or secondary.

In this paper the 2nd and 3rd aspect are taken into consideration.

At the present time we have improved the effectiveness of therapy localisation and challenge, in doing repeated challenge and repeated therapy localisation.

Determining a primary problem:

A. Therapy localisation:

1. T.l. to an area under investigation.
2. Test an intact indicator muscle; if the muscle goes weak proceed to step 3; if it remains strong, find why?
3. As the patient does repeated t.l., ask the patient to breathe-in.
4. Test an intact indicator muscle; if the muscle goes weak it is not primary do not continue; if the muscle remains strong go to step 5.
5. Have the patient breathe normally;now as the patient does repeated t.l. ask the patient to breathe-in and do the pinch test.
6. Test an intact indicator muslce; if the muscle goes weak it is not major but it is primary; if the muscle remains strong it is major and primary.

B. Challenge:

1. Test an intact indicator muscle.
2. Do the double challenge.
3. Test the intact indicator muscle; if the muscle goes weak proceed to step 3; if it remains strong find why?
4. As the doctor does the repeated challenge, ask the patient to breathe-in.
5. Test the intact indicator muscle; if the muscle goes weak the challenge is not primary it is preferable to stop and investigate elsewhere; if the muscle remains strong go to step 5.

6. Have the patient breathe normally; now do the repeated challenge and ask the patient to breathe-in and do the pinch test.
7. Test the intact indicator muscle; if the muscle goes weak it is not major but it is primary; if the muscle remains strong it is major and primary.

What we have changed is the following:

On rechecking the t.l. or challenge we used to have 2 steps now we have 4 steps.

Old Way for t.l.:

1. Patient does repeated t.l. and doctor does pinch test.
2. Test an indicator muscle; if it remains strong proceed to another area; if it goes weak something is still wrong at this area keep investigating.

New Way for t.l.:

1. Patient does repeated t.l. and doctor does pinch test.
2. Test an indicator muscle; if it remains strong proceed to step 3; if it goes weak something is still wrong at this area keep investigating.
3. Patient does repeated t.l. and doctor does double pinch test.
4. Test an indicator muscle; if it remains strong proceed to another area; if it goes weak something is still wrong at this area, keep investigating.

Old Way for challenge:

1. Repeated challenge and pinch test.
2. Test an intact indicator muslce; if it remains strong proceed to another area; if it goes weak somethig is still wrong at this area keep investigating.

New Way for challenge:

1. Repeated challenge and pinch test.
2. Test an intact indicator muscle; if it remains strong proceed to step 3; if it goes weak something is still wrong.
3. Repeated challenge and double pinch test.
4. Test an intact indicator muscle; if it remains strong proceed to another area; if it goes weak something is still wrong at this area keep investigating.

In proceeding as such, it has been beneficial in helping to solve many persisting problem.

Thank you.

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Advanced Applied Kinesiology Class, Dr. George J. Goodheart Jr., August 8-9, 1980, Gaylard, Michigan.

Personnal discussion with Dr. Dan Gleeson.

MERIDIAN THERAPY

POINTS LOCATION

RICHARD ROY D.C.

Introduction

This booklet is to help; any one who studies meridian therapy; to find the meridian point with less time. The accompanying chart is designed to be looked at from a certain distance without wondering what number it is we are seeing.

The chart contains the following information:

1. Sedation points
2. Tonification points
3. Connector points
4. Associated points
5. Mid-day mid-night flow of energy.
6. Command points
7. Diagrams showing point location (except associated point).

The booklet contains the following information:
Location of the following points

1. Sedation points
2. Tonification points
3. Connector points
4. Associated points
5. Command points
6. Beginning point
7. Ending point
8. Alarm point
9. Muscles relationship.

Hoping it will help each and every one in better using the meridian therapy.

All yours;

Richard Roy d.c.

Meridian therapy points location

Meridian Therapy
Points Location

Richard Roy d.e.c., d.c.

Privately Published

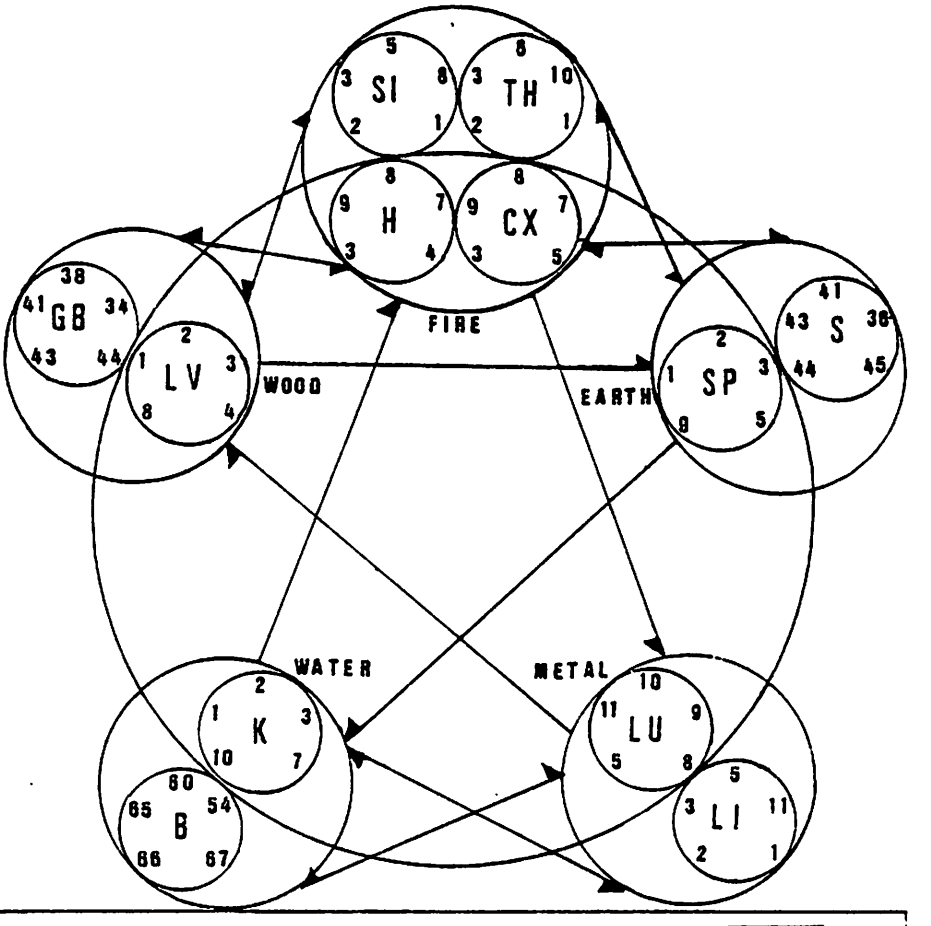
TABLE OF CONTENTS

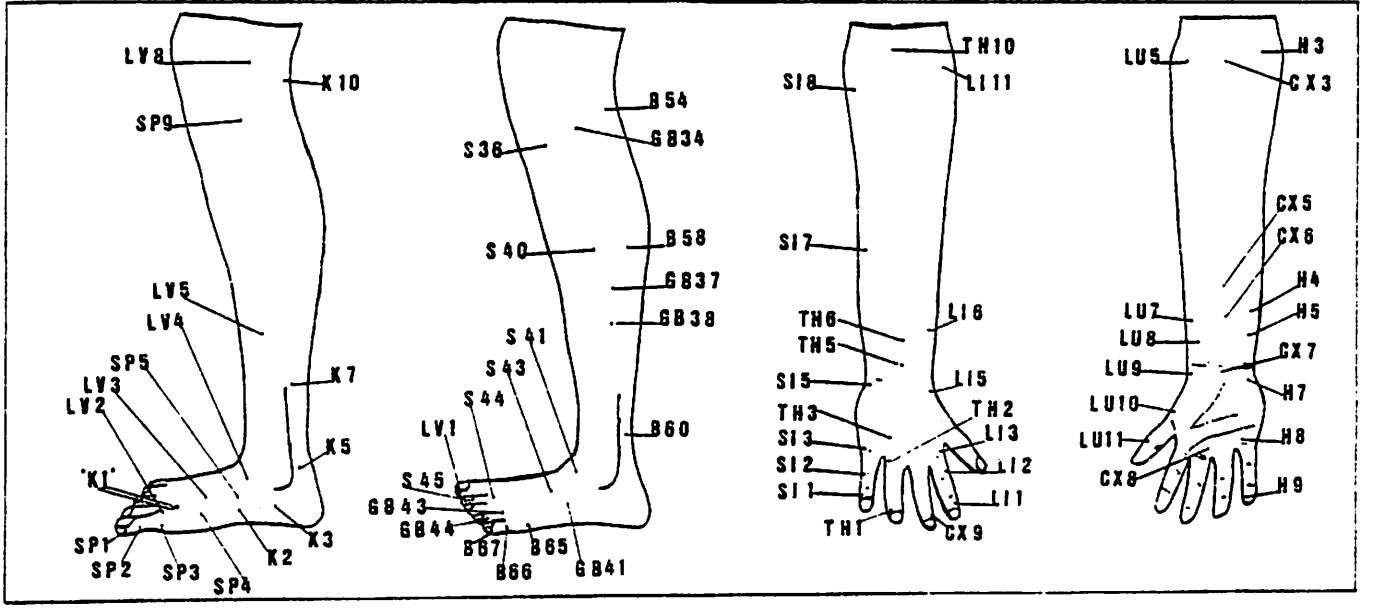
ORGAN	TONIFICATION				SEDATION			
LU	LU 9	SP 3	LU10	H8	LU5	K10	LU10	H8
LI	LI 11	S36	LI5	SI5	LI2	B66	LI5	SI5
S	S41	SI5	S43	GB41	S45	LI1	S43	GB41
SP	SP2	H8	SP1	LV1	SP5	LU8	SP1	LV1
H	H9	LV1	H3	K10	H7	SP3	H3	K10
SI	SI3	GB41	SI2	B66	SI8	S36	SI2	B66
B	B67	LI1	B54	S36	B65	GB41	B54	S36
K	K7	LU8	K5	SP3	K1	LV1	K5	SP3
CX	CX9	LV1	CX3	K10	CX7	SP3	CX3	K10
TH	TH3	GB41	TH2	B66	TH10	S36	TH2	B66
GB	GB43	B66	GB44	LI1	GB38	SI5	GB38	LI1
LV	LV8	K10	LV4	LU8	LV2	H8	LV4	LU8

CONNECTOR POINTS		ASSOCIATED POINTS	
LU 7	B 58	LU·B-13	SP·B-20
LI 6	K 5	CX·B-14	S ·B-21
S 40	CX 6	H ·B-15	TH·B-22
SP 4	T 5	GV·B-16	K ·B-23
H 5	GB 37	CV·B-17	LI·B-25
SI 7	LV 5	LV·B-18	SI·B-27
		GB·B-19	B ·B-28

CIRCULATION OF ENERGY

LU	3·5
LI	5·7
S	7·9
SP	9·11
H	11·13
SI	13·15
B	15·17
K	17·19
CX	19·21
TH	21·23
GB	23·1
LV	1·3





SMALL INTESTINE MERIDIAN

Si 1: Beginning point.
Metal point in the law of the 5 elements.
Located at the medial nail bed of the little finger.

Si 2: Water point in the law of the 5 elements.
First point of the second pair of tonification points for the small intestine, coupled with B 66.
First point of the second pair of sedation points for the small intestine, coupled with B 66.
Located at the posterior medial aspect of the phalanx of the 5th finger at the proximal end.

Si 3: Wood point in the law of the 5 elements.
First point of the first pair of tonification points for the small intestine, coupled with Gb 41.
Located at the postero-medial aspect of the 5th metacarpal at the distal end.

Si 5: Fire point in the law of the 5 elements.
Second point of the second pair of tonification points for the large intestine, coupled with Li 5.
Second point of the second pair of sedation points for the large intestine, coupled with Li 5.
Second point of the first pair of tonification points for the stomach, coupled with St 41.
Second point of the first pair of sedation points for the gall bladder, coupled with Gb 38.
Located at the posterior-medial aspect of the wrist.

Si 7: Connector point.
Located at the posterior-medial aspect of the forearm, one-fourth the distance from the wrist to the elbow.

Si 8: Earth point in the law of the 5 elements.
First point of the first pair of sedation points for the small intestine, coupled with St 36.
Located at the posterior-medial aspect of the elbow.

SMALL INTESTINE MERIDIAN (SUITE)

Si 19: Ending point.
Located anterior to the tragus of the ear.

Associated point: Bl 27, located at the level of S 1.
Alarm point: Cv 4, located 2 inches above the symphysis pubis.
Muscles: Abdominal, Quadriceps femoris.

Notes:

BLADDER MERIDIAN

B 1: Beginning point.
Located at the medial corner of the eye.

B 54: Earth point in the law of the 5 elements.
First point of the second pair of tonification points for the bladder, coupled with St 36.
First point of the second pair of sedation points for the bladder, coupled with St 36.
Located at the medial posterior aspect of the leg, below the popliteal surface.

B 58: Connector point.
Located at the lateral aspect of the lawer leg, halfway between the ankle and the knee slightly to the posterior.

B 60: Fire point in the law of the 5 elements.
Located on the ankle on the lateral aspect, posterior and inferior to the external malleolus.

B 65: Wood point in the law of the 5 elements.
First point of the first pair of sedation points for the bladder, coupled with Gb 41.
Located at the proximal end of the 5th metatarsal on the lateral aspect.

B 66: Water point in the law of the 5 elements.
Second point of the first pair of sedation points for the large intestine, coupled with Li 2.
Second point of the second pair of tonification points for the small intestine, coupled with Si 2.
Second point of the second pair of sedation points for the small intestine, coupled with Si 2.
Second point of the second pair of tonification points for the triple-warmer, coupled with Tw 2.
Second point of the second pair of sedation points for the triple-warmer, coupled with Tw 2.
Second point of the first pair of tonification points for the gall bladder, coupled with Gb 43.
Located at the proximal phalanx of the 5th toe on the lateral aspect.

/4

BLADDER MERIDIAN

B 67: Ending point.

Metal point in the law of the 5 elements.

First point of the first pair of tonification points for the bladder, coupled with Li 11.

Located at the lateral distal aspect of the 5th toe, near the nail.

Associated point: B 28, located at the level of S 2.

Alarm point: Cv 3, located immediately above the symphysis pubis.

Muscles: Sacrospinalis, erector spinal group, peroneus longus brevis tertius, tibialis anterior.

Notes:

KIDNEY MERIDIAN

K 1: Beginning point.

Metal point in the law of the 5 elements.

First point of the first pair of sedation points for the kidney, coupled with Lv 1.

Located on the planter surface of the foot between the second and third metatarsal.

K 2: Fire point in the law of the 5 elements.

Located on the medial aspect of the foot, one to two fingers width distal to the calconeus.

K 3: Earth point in the law of the 5 elements.

Located on the medial aspect of the fact, under the medial malleolus.

K 5: Connector point.

First point of the second pair of tonification points for the kidney, coupled with Sp 3.

First point of the second pair of sedation points for the kidney, coupled with Sp 3.

Located posterior to the medial malleolus.

K 7: Metal point in the law of the 5 elements.

First point of the first pair of tonification points for the kidney, coupled with Lu 8.

Located 4 inches up from the internal malleolus.

K 10: Water point in the law of the 5 elements.

Second point of the first pair of sedation points for the lung, coupled with L 5.

Second point of the second pair of tonification points for the heart, coupled with H 3.

Second point of the second pair of sedation points for the heart, coupled with A 3.

Second point of the second pair of tonification points for the circulation-sex, coupled with Cx 3.

Second point of the second pair of sedation points for the circulation-sex, coupled with Cx 3.

Second point of the first pair of tonification points for the liver, coupled with Lv 8.

Located medial to the popliteal space.

KIDNEY MERIDIAN (SUITE)

K 27: Ending point.
Located at the junction of the first Rib, clavicle and sternum.

Associated point : B 23, located at the level of L 3.

Alarm point: Gb 25, located at the distal end of the 12th Rib.

Muscles: Psoas, illiacus, upper trapezius.

Note: There is some discussion on determining the connector point for the kidney, depending on traditional and modern concept. It varies from K 4, K 5, K 6.

Notes:

CIRCULATION-SEX MERIDIAN

Cx 1: Beginning point.
Located lateral to the aréola.

Cx 3: Water point on the law of the 5 element.
First point of the second pair of tonification points for the circulation-sex, coupled with K 10.
First point of the second pair of sedation points for the circulation-sex, coupled with K 10.
Located at the center of the antecubital fossa.

Cx 5: Metal point on the law of the 5 elements.
Located on the forearm, four fingers width above the palm, in the center of the forearm.

Cx 6: Connector point.
Located on the central aspect of the anterior surface of the forearm, between 3 to 4 inches up from the wrist.

Cx 7: Earth point in the law of the 5 elements.
First point of the first pair of sedation points for the circulation-sex, coupled with Sp 3.
Located at the anterior surface of the wrist at the center.

Cx 8: Fire point in the law of the 5 elements.
Located at the metacarpo-phalangeal articulation of the third metacarpal on the medial side.

Cx 9: Wood point in the law of the 5 elements.
Ending point.
First point of the first pair of tonification points for the circulation-sex, coupled with Lv1.
Located at the lateral nail bed of the m iddle finger.

Associated point: B 14, located at the level of T 5.

Alarm point: Cv 17, located at the xyphoid process.

Muscles: Glut. max. medius, glut. minimus, adductors sartorius, gracilis, piriformis, gastrochemius, soleus, flex. hallucis longus, flex. hallucis brevis.

TRIPLE-WARMER MERIDIAN

Tw 1: Beginning point.

Metal point in the law of the 5 elements.

Located on the ring finger at the medial aspect of the nail bed.

Tw 2: Water point in the law of the 5 elements.

First point of the second pair of tonification points for the triple-warmer, coupled with B 66.

First point of the second pair of sedation points for the triple-warmer, coupled with B 66.

Located at the dorsal aspect of the proximal phalanx of the 4th finger at the proximal end.

Tw 3: Wood point in the law of the 5 elements.

First point of the first pair of tonification points for the triple-warmer, coupled with Gb 41.

Located posterior between the 4th and 5th metacarpal at the distal end.

Tw 5: Connector point.

Located on the posterior aspect of the forearm, on the midline 2 inches up from the wrist.

Tw 6: Fire point in the law of the 5 elements.

Located at the postero-medial aspect of the forearm, three fingers width above the wrist.

Tw 10: Earth point in the law of the 5 elements.

First point of the first pair of sedation point for the triple-warmer, coupled with St 36.

Located at the posterior elbow in the middle.

Tw 23: Ending point.

Located at the lateral border of the eyebrow.

Associated point: B 22, located at the level of L2.

Alarm point: Cv 5, located midway between the umbilicus and the symphysis pubis.

Muscles: Terse minor infraspinatous.

GALL BLADDER MERIDIAN

Gb 1: Beginning point.

Located at the lateral corner of the eye.

Gb 34: Earth point in the law of the 5 elements.

Located on the leg on the superior-lateral aspect at the level of the head of the fibula.

Gb 37: Connector point.

Located at the lateral aspect of the lawer leg, in the midline 1/3 of the distance between the ankle and the knee.

Gb 38: Fire point in the law of the 5 elements.

First point of the first pair of sedation points for the gall bladder, coupled with Si 5.

Located on the lateral aspect of the leg, 3 to 4 inches above the external malleolus.

Gb 41: Wood point in the law of the 5 elements.

Second point of the second pair of tonification points for the stomach, coupled with St 43.

Second point of the second pair of sedation point for the stomach, coupled with St 43.

Second point of the first pair of sedation points for the bladder, coupled with B 65.

Second point of the first pair of tonification points for the triple-warmer, coupled with Tw 3.

Located between the 4th and 5th metatarsal at the proximal aspect.

Gb 43: Water point in the law of the 5 elements.

First point of the first pair of tonification points for the gall bladder, coupled with B 66.

Located between the 4th and 5th proximal phalanx of the toes.

GALL BLADDER MERIDIAN (SUITE)

Gb 44: Ending point.

Metal point in the law of the 5 elements.

First point of the second pair of tonfication points for the gall bladder, coupled with Lv 1.

First point of the second pair of sedation points for the gall bladder, coupled with Lv 1.

Located at the lateral aspect of the diatal phalanx of the 4th toe, near the nail.

Associated point: B 19, located at the level of T-10-11.

Alarm point: Gb 24, located between the 9th and 10th Rib.

Muscles: Popliteus.

Notes:

LIVER MERIDIAN

Lv 1: Beginning point.

Wood point in the law of the 5 elements.

Second point of the second pair of tonification points for the spleen, coupled with Sp 1.

Second point of the second pair of sedation points for the spleen, coupled with Sp 1.

Second point of the first pair of tonification points for the heart, coupled with H 9.

Second point of the first pair of sedation points for the kidney, coupled with K 1.

Second point of the first pair of tonification points for the circulation-sex, coupled with Cx 9.

Located at the lateral dorsal aspect of the great toe, near the nail bed.

Lv 2: Fire point in the law of the 5 elements.

First point of the first pair of sedation points for the liver, coupled with H 8.

Located at the lateral aspect of the great toe.

Lv 3: Earth point in the law of the 5 elements.

Located on the dorsal aspect of the foot between the first and second metatarsal, three fingers width from Lv 2 in a proximal direction.

Lv 4: Metal point in the law of the 5 elements.

First point of the second pair of tonification points for the liver, coupled with Lu 8.

First point of the second pair of sedation points for the liver, coupled with Lu 8.

Located anterior to the medial malleolus.

Lv 5: Connector point.

Located at the medial aspect of the lawer leg, 1/3 the distance between the ankle and the knee.

LIVER MERIDIAN (SUITE)

Lv 8: Water point in the law of the 5 elements.
First point of the first pair of tonification points for the liver, coupled with K 10.
Located on the medial posterior aspect of the knee.

Lv 14: Alarm point.
Ending point.
Located at the costal cartilage of the 8th Rib.

Associated point: B 18, located at the level of T-9-10.
Alarm point: Liv. 14.
Muscles: Pectoralis major sternal, tibialis posterior.

Notes:

LUNG MERIDIAN

Lu 1: Beginning point.

Alarm point.

Located 1/2 inch medial from the humeral head.

Lu 5: Water point on the law of the 5 element.

First point of the first pair of sedation points for the lung, coupled with K 10.

Located on the anterior-lateral aspect of the arm at the level of the elbow.

Lu 7: Connector point.

Located on the anterior-lateral aspect of the forearm between 2 to 3 inches above the wrist.

Lu 8: Metal point on the law of the 5 elements.

Second point of the first pair of sedation points for the spleen, coupled with Sp 5.

Second point of the first pair of tonification points for the kidney, coupled with K 7.

Second point of the second pair of tonification points for the liver, coupled with Lv 4.

Second point of the second pair of sedation points for the liver, coupled with Lv 4.

Located on the anterior-lateral aspect of the forearm 2 inches above the wrist.

Lu 9: Earth on the law of the 5 elements.

First point of the first pair of tonification points for the lung, coupled with Sp 3.

Located on the anterior-lateral aspect of the wrist.

Lu 10: Fire point on the law of the 5 elements.

First point of the second pair of tonification points for the lung, coupled with H 8.

First point of the second pair of sedation points for the lung, coupled with H 8.

Located on the anterior middle portion of the first metacarpal.

LUNG MERIDIAN (SUITE)

Lu 11: Wood point on the law of the 5 elements.
Ending point.
Located on the anterior at the phalangeal articulation of the thumb.

Associated point: B 13, located at the level of T 4.

Alarm point: Lu 1.

Muscles: Deltoid, Serratus Anticus, Coracobrachialis.

Notes:

STOMACH MERIDIAN

St 1: Beginning point.

Located at the infra-orbital notch.

St 36: Earth point on the law of the 5 elements.

Second point of the first pair of tonification points for the large intestine, coupled with Li 11.

Second point of the first pair of sedation points for the small intestine, coupled with Si 8.

Second point of the second pair of tonification points for the bladder, coupled with B 54.

Second point of the second pair of sedation points for the bladder, coupled with B 54.

Second point of the first pair of sedation points for the triple-warmer, coupled with Tw 10.

Located on the antero-lateral aspect of the leg, 3 inches below the patella.

St 40: Connector point.

Located on the lateral aspect of the lower leg, half-way between the ankle and the knee slightly to the anterior.

St 41: Fire point on the law of the 5 elements.

First point of the first pair of tonification points for the stomach.

Located on the anterior midline of the ankle over the talus.

St 43: Wood point on the law of the 5 elements.

First point of the second pair of tonification points for the stomach, coupled with Gb 41.

First point of the second pair of sedation points for the stomach, coupled with Gb 41.

Located between the second and third metatarsal at the proximal end.

St 44: Water point in the law of the 5 elements.

Located two fingers width distal to St 43, between the second and third metatarsal.

STOMACH MERIDIAN (SUITE)

St 45: Metal point in the law of the 5 elements.

Ending point.

First point of the first pair of sedation points for the stomach, coupled with Li 1.

Located at the tip of the second toe.

Associated point: B 21, located at the level of L 1.

Alarm point: Cv 12, Midway between the xyphoid and the umbilicus.

Muscles: Rhomboids, levator scapula, pectoralis major clavicular, biceps, brachioradialis, opponens pollicis, opponens digiti minimn, neck flexors, neck extensors.

Notes:

LARGE INTESTINE MERIDIAN

Li 1: Metal point on the law of the 5 elements.

Beginning point.

Second point of the second pair of tonfication points for the gall bladder, coupled with Gb 44.

Second point of the second pair of sedation points for the gall bladder, coupled with Gb 44.

Second point of the first pair of sedation point for the stomach, coupled with St 45.

Located on the postero-lateral aspect of the index finger.

Li 2: Water point on the law of the 5 elements.

First point of the first pair of the sedation points for the large intestine, coupled with Bl 66.

Located on the postero-lateral aspect of the first finger (index) distal to the first metacarpal.

Li 3: Wood point on the law of the 5 elements.

Located on the postero-lateral aspect of the first finger (index) metacarpal at the center of the metacarpal.

Li 5: Fire point on the law of the 5 elements.

First point of the second pair of tonification points for the large intestine, coupled with Si 5.

First point of the second pair of the sedation points for the large intestine, coupled with Si 5.

Located on the postero-lateral aspect of the wrist.

Li 6: Connector point.

Located on the postero-lateral aspect of the forearm, 1 inch above the wrist.

LARGE INTESTINE MERIDIAN (SUITE)

Li 11: Earth point on the law of the 5 elements.

First point of the first pair of tonification points for the large intestine, coupled with St 36.

Second point of the first pair of tonification points for the bladder, coupled with B 67.

Located on the postero-lateral aspect of the elbow.

Li 20: Ending point.

Located at the nasio-labial fold, at the side of the naries.

Associated point: B 25, located at the level of L 5.

Alarm point: St 25, located 2 inches lateral to the umbilicus.

Muscles: Quadratus lumborum, Tensor fascia Lata, Hamstring, Levator Ani.

Notes:

HEARTH MERIDIAN

H 1: Beginning point.

Located at the center of the Axilla.

H 3: Water point in the law of the 5 elements.

First point of the second pair of tonification points for the heart, coupled with K 10.

First point of the second pair of sedation points for the heart, coupled with K 10.

Located medial to the antecubital fossa.

H 4: Metal point in the law of the 5 elements.

Located on the antero-medial aspect of the forearm, four fingers width above the palm of the hand.

H 5: Connector point.

Located at the medial anterior aspect of the forearm 2 inches up from the wrist.

H 7: Earth point in the law of the 5 elements.

First point of the first pair of sedation points for the heart, coupled with Sp 3.

Located at the medial anterior aspect of the wrist.

H 8: Fire point in the law of the 5 elements.

Second point of the second pair of sedation points for the lung, coupled with Lu 10.

Second point of the second pair of tonification points for the lung, coupled with Lu 10.

Second point of the first pair of tonfication point for the spleen, coupled with Sp 2.

Second point of the first pair of sedation points for the liver, coupled with Lv 2.

Located between the 4th and 5th metacarpal at the distal aspect on the palmar surface.

H 9: Wood point.

Ending point.

First point of the first pair of tonification points for the heart, coupled with Lv 1.

Located on the dorsal lateral side of the little finger next to the nail bed.

Associated point: B 15, located at the level of T 6.

Alarm point: 1 inch below the xyphoid.

Muscles: Subscapularis.

SPLEEN MERIDIAN

Sp 1: Wood point in the law of the 5 elements.

First point of the second pair of tonification points for the spleen, coupled with Lv 1.

First point of the second pair of sedation points for the spleen, coupled with Lv 1.

Beginning point.

Located on the medial dorsal aspect of toe.

Sp 2: Fire point in the law of the 5 elements.

First point of the first pair of tonification points for the spleen, coupled with H 8.

Located at the medial aspect of the interphalangeal articulation of the great toe.

Sp 3: Earth point in the law of the 5 elements.

Second point of the first pair of tonification points for the lung, coupled with Lu 9.

Second point of the first pair of sedation points for the heart, coupled with H 7.

Second point of the second pair of tonification points for the kidney, coupled with K 5.

Second point of the second pair of sedation points for the kidney, coupled with K 5.

Second point of the first pair of sedation points for the circulation-sex, coupled with Cx 7.

Located at the medial-distal portion of the first metatarsal.

Sp 4: Connector point.

Located at the medial aspect of the proximal end of the first metatarsal.

Sp 5: Metal point in the law of the 5 elements.

First point of the first pair of sedation points for the spleen, coupled with Lu 8.

Located at the medial ankle over the talus.

Sp 9: Water point in the law of the 5 elements.

Located at the medial aspect of the knee at the level of the tibial head.

SPLEEN MERIDIAN (SUITE)

Sp 21: Ending point.

Located on the lateral thoracic area at the level of the 9th Rib.

Associated point: B 20, located at the level of T 11, T 12.

Alarm point: Liv. 13, located at the distal end of the 11th Rib.

Muscles: Lower and middle trapezius, latissimus dorsi, triceps, anconeus.

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EFFECTS OF SCLERANTHUS ON SWITCHING

Mario A. Sabella, D.C.

A clinical trial designed to evaluate the effects of Scleranthus on switching. The rationale for the selection of patients for the trial and post treatment results over a period of three months are reported.

1. The phenomenon of switching is predominantly a state of confusion of nerve and energy patterns which may lead to inconsistent postural patterns and musculoskeletal malfunction, in addition to the possibility of learning difficulties in children.
2. Efforts to permanently correct or at least prolong the lasting effect of correction of switching are warranted for several reasons. This problem has been known to contribute to recurrences of subluxations and other structural problems, this in addition to interference with the accuracy of the diagnostic procedures used in Applied Kinesiology. Furthermore the present methods of correction for switching relied to a great extent on the patient's cooperation in carrying out the cross crawl/homolateral crawl exercises for a long enough period of time to allow adequate repatterning to take place.
3. The following hypothesis was posed and tested: Scleranthus is a Bach remedy prescribed to patients who suffer from being unable to decide between two things, in other words comparatively in a state of confusion. Considering that switching is theoretically a confusion of the neurological mechanism responsible for well organised function, then scleranthus should prove beneficial in cases of malfunction of this mechanism.

METHOD

4. The subjects' selection was made from two groups of patients of both sexes and various age groups. The first group of forty four patients was treated by the standard methods of Applied Kinesiology and showed consistent recurrences over a period of nine months. These patients had to be maintained on the cross crawl exercise indefinitely.
   The second group of fifty five patients did not receive any previous treatment for switching.
5. An initial evaluation of the patients included the following standard tests:
   Cross crawl positive. All patients selected for this trial strengthened on cross crawl and weakened on homolateral crawl.
   Occular lock positive.
   Involvement of the conception/governing vessel.
6. After the need for correction of switching was established, a reference indicator muscle was selected, as well as a suitable therapy localisation point i.e.CV24, GV27,K27,SP21. The same criteria were maintained throught the trial.
7. No physical correction was made to eliminate switching. The procedure depended entirely on the use of a solution of scleranthus prepared by adding five drops of the mother tincture to a 25ml volume of distilled water, which was then succused forty times.
8. The patient was given three drops of the scleranthus solution orally and the indicator muscle tested while simultaneously holding the therapy localisation point. The procedure was repeated until a point was reached when therapy localisation did not produce the observed weakness of the indicator muscle. This was considered the point of neutralisation and administration of scleranthus was ceased.

9. The patient was next challenged for switching by the standard tests including homolateral crawl, and confirmed to be free of switching. Patients from both groups were not instructed to do any cross crawl exercises. Scleranthus was not prescribed for continued therapy. All patients were monitored on subsequent visits for a period of three months.

RESULTS AND DISCUSSION

10. Results of the trial are shown in tables 1 and 2.
It can be seen that forty patients (91%) of group one, who had had mechanical corrections on various occasions in the past, stabilised from the first administration of scleranthus, with no recurrence of switching over the period of the trial. Four patients (9%) had recurrences but eventually stabilised for the rest of the period after readministration of the remedy.
Out of the group 2 patients, those who had no previous correction for switching, fifty two (95%) stabilised from the first administration. Three patients (5%) had recurrences, which were eventually eliminated by readministration of the remedy.
The quantity of Scleranthus needed for correction of switching ranged from six to twelve drops.

11. Results of the trial indicate that Scleranthus can be a major factor in the correction of switching.

TABLE 1

Original administration of Scleranthus

	Group 1	Group 2
Age group	No. of Patients	No. of patients
4 - 10	3	2
10 - 20	5	11
20 - 30	5	14
30 - 40	12	9
40 - 50	9	13
50 & over		6

TABLE 2

Recurrence of switching

	Group 1	Group 2
Age	Period from original administration of scleranthus	
5	6 weeks & 10 weeks	
15		4 weeks & 7 weeks
19		3 weeks
28	4 weeks	
37	3 weeks	
42	3 weeks	4 weeks

SUMMARY OF THERAPEUTIC PROCEDURE

12. When switching is detected a strong indicator muscle is chosen. The muscle is then challenged by therapy localisation to any of the accepted points e.g. GV27, CV24, SP21, K27. The patient is then given three drops of the Scleranthus remedy, and while holding the therapy localisation point the muscle is rechallenged. If weakness ensues the procedure is repeated. The end point is reached when therapy localisation does not produce weakness of the indicator muscle.

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ADDITIVES AND FOOD COLORING

by

JULIUS L. SANNA, D.C.

ABSTRACT

The problem of food additives and coloring has long been discussed. The chemistry facet of our therapeutic triangle warrants further research in our endeavor to control the myriad of patterns that confront us.

METHOD

The method of identifying the offensive effects of food additives and coloring agents can be easily demonstrated by using the sublingual response, against an intact muscle. This can be used as a general approach to chemistry imbalances, but I have found this specific to allergic reactions.

CONCLUSION

Recent information has indicated that specific allergic reactions has also been evidenced in Cerebral Palsey, Muscular Dystrophy and Multiple Sclerosis. This has added further emphasis of the intolerable effects on the neuromuscular systems resulting from chemicals external to the body.

The evidence presented should alert us to the inherent dangers in food processing, labeling, distribution and the laws that permit these procedures to exist and their administrative effectiveness.

Food additives are so much a part of our lives today that most of us would find it difficult to put a meal together that did not include them. If you considered a typical lunch, a sandwich, instant soup, and a cola drink, each product contains various additives such as vitamins, emulsifiers, nitrites, as well as food colorings.

No wonder why so many Americans are concerned about food additives -- they seem to be in everything we eat. Are all these substances good for us? Do they serve a useful purpose, or are they just making money for the food industry? My paper explores these many questions and how this situation evolved.

Food additives are not something new. Their introduction into society was not only an important step in man's attempt to control his environment and contribute to the growth of civilization but also an action that was as old as mankind itself. Man has preserved foods by smoking and using spices and herbs to prevent spoilage, and salt was used long before recorded history.

With the changes in the American lifestyle, there are more additives in our food supply than have ever been known in the past. As Americans moved from the farms to the cities, there was a greater need for foods that could be mass produced, distributed

over considerable distances, and stored for long periods of time. As women left the home environment to enter the work place, a new demand was created for more prepared convenience foods.

According to the Committee on Food Protection of the National Academy of Science, food additives are defined as follows:

> In addition to those chemicals that constitute foodstuffs per se, chemicals may be incorporated, either directly or indirectly, during the growing, storage, or processing of foods. These chemicals may be described for convenience as "food additives". When they are purposely introduced to aid in processing or to preserve or improve the quality of the product, they are called intentional additives. Such materials as vitamins, minerals for enrichment, mold inhibitors, bactericides, antioxidants, colors, flavors, sweeteners, and emulsifiers are intentional additives. They are added to the food product in carefully controlled amounts during processing, and the amounts necessary to achieve the desired effect are usually very small.

In addition to the common intentional food additives, certain other chemicals may find their way into foods as a result of their use in some phase of the production, handling, or processing of food products. They are known as incidental additives. Under provisions of the Federal food and drug laws, such foods are permitted in foods only if they cannot be avoided by invoking good production and processing practices and, then, only if the amounts that occur under these conditions are known to be safe.

Chemical additives in themselves may be relatively nontoxic, but may interact with other chemicals of the normal diet to form carcinogenic agents. An example of this is the use of nitrite in

meat preservation and its interactions with amines to form nitrosamines. Another example is diethyl pyrocarbonate, a wine additive that interacts with alcohol to cause levels of 0.1 ppb or so of the carcinogen, urethan. This compound has been banned in various countries.

Natural foods contain thousands of different chemicals, practically none of which have been tested for safety by the usual procedures for food additives. Many of these substances are well known to be toxic at levels only moderately higher than those reaching the consumer. Examples of this are solanine which is present in potatoes, antithyroid substances that are present in the cabbage and mustard family such as broccoli and radishes, tannin found in tea and coffee, and arsenic found in shrimp.

Nitrosamines, which are produced in bacon during frying, have been much in the news lately. Nitrosamines are carcinogenic to various species of laboratory animals at low rates of dosage. They are formed by a reaction between nitrites and secondary amines. Many common vegetables are high in nitrates, especially celery, spinach, lettuce, and beets. A statement by the USDA is interesting because raw tobacco contains far higher levels of nitrosamines than are found in meat or any other food.

Saccharin and cyclamates have raised a great deal of public interest throughout the years. Cyclamates were banned in 1969

because bladder tumors were found in four out of ten rats when fed 10:1 mixture of cyclamate and saccharin in a feeding study that lasted two years. Efforts have been unsuccessful in proving conclusively that cyclamates are indeed tumorigenic.

As a result of the 1960 Color Additive Amendment to the Food, Drug, and Cosmetic Act, FDA keeps a color scoreboard on all additives. Because of adverse reactions in man or experimental animals or presence of questionable impurities in some of the substances, the list had decreased in size to the point in April 1978 in which less than half remained, only a few had been added, all are provisionally listed, and several now are likely to be banned.

The bulk of color additives are obtained from a black substance, coal. About 90 percent of the total dyes used by products are regulated by the FDA and are synthesized from a single, colorless derivative of benzene, called aniline, which in its pure or uncombined form is poisonous. These aniline dyes are also known as coal-tar dyes, because aniline was once obtained from bituminous coal.

Color additives are divided into two categories -- permanent and provisional. Those on the permanent list are colors whose safety has been assured by data the manufacturer has collected from tests in laboratory animals. The provisional list, which will eventually

be abolished, consists of colors in use when the Color Additive Amendments were enacted in 1960 and which have not qualified as yet for the permanent listing because of safety tests required by the FDA.

A color that drew overwhelming attention is FD&C #2 which was used extensively in foods, drugs, and cosmetics for many years. Russia reported that this color, also known as amaranth, caused cancer in rats. This led to a series of tests which resulted in withdrawal of FD&C #2 from the provisional list in 1976. That same year, FD&C #4 was terminated in maraschino cherries and ingested drugs because of unresolved safety questions.

Color additives increase the cost of foods somewhat and can mislead some consumers and give them a false sense of security about a food's safety and economic values. The appearance of a color on FDA's "permanent" list is no assurance that it will not be outlawed if serious questions arise about its safety. Spokesmen for industry replied that the consumer wants foods to be esthetically appealing and appetizing. The food industry's use of color simply gives the consumer what he wants. They suggest that public protest would be loud and long if many uses of colors were discontinued. People would be reluctant to eat margarine without the coloring that makes it resemble butter.

Throughout the past few years, concerns about food additives and hyperkinesis have led to a series of experiments. Hyperkinesis is a term used to describe above the usual amount of activity of children, and the term is often used interchangeably with hyperactivity. It has gained recognition as a problem which may be associated with factors relating to diet, particularly additives. According to some arguments, the ingestion of any of these three thousand substances may alter a child's bio-psycho-social responses. Manifestations such as impulsiveness, irritability, short attention span, restlessness, aggressiveness, excitability, and low frustration tolerance are all ascribed to hyperactive children.

At the annual meeting of the American Medical Association in 1973, Dr. Benjamin F. Feingold presented a paper which correlated children's hyperactivity and their consumption of food additives such as colors, artificial flavors, preservatives, and natural salicylates. He claimed that 30-50 percent of children that he treated with specific additive-free diets had striking behavioral improvements.

Dr. Feingold never submitted his research findings to scientific scrutiny by publication in any scientific journal. His book geared for parents, Why Your Child Is Hyperactive, became a best seller. Parents who considered their children hyperactive beseiged

their pediatricians, asking for special additive-free diets. School teachers also seeked modifications in their present school lunch programs to eliminate those foods on the menu which caused disruptive behavior in their classrooms.

In 1976, the first scientific study designed to test Feingold's thesis was published in The Journal of the Australian Medical Association. Shortly after, another study was conducted by Conners and co-workers in the 1976 issue of Pediatrics. The Feingold theory, stating that food additives caused hyperkinesis, has not been accepted to date. Limiting factors, such as the need for controlled studies and uniformed assessment and diagnosis of hyperkinesis, prohibit total reliance on the role and extent of additives in hyperkinesis. Other correlations must be considered, such as the age of the child and his/her overall diet, if conclusions are to be made about the role of additives in hyperkinesis.

If future studies do indeed indicate an association between food additives and a diverse reaction in children, FDA most likely will increase its regulation of the food industry. Until some action is legislated, normal active children will be continually labeled "hyperkinetic"; and physicians will proceed to place truly hyperactive children on unnecessarily restricted diets which may

not be meeting their nutritional needs. This food additive controversy is far from resolved.

Throughout the past few years, the House of Delegates have considered the question of the Delaney Clause and related provisions of the Federal Food, Drug and Cosmetic Act. This brief paragraph that was added to the 1958 Food Additive Amendment pertains to potential carcinogens used as food additives and reads as follows:

> No additives shall deemed to be safe if it is found to induce cancer when ingested by man, or animal, or if found, after tests which are appropriate for the evaluation of the safety of food additives, to induce cancer in man or animal.

This clause remains a source of controversy and confusion not only to the food industry but also to the consumer.

The Council on Scientific Affairs has considered the problem of food safety throughout the years and has suggested that central questions underlie the debate over the Delaney Clause. The first question is a scientific one -- whether scientific uncertainties that lead to the Delaney Clause have been resolved. The other question is a public policy determination -- whether failing scientific resolution, the public policy judgement made by the Congress in passing the Delaney Clause represents a currently appropriate decision for our society. These questions have not

been resolved, and it's doubtful that these concerns will be resolved in the near future.

The Delaney Clause does not recognize and exempt no-effect level of carcinogens. No one can tell how much or how little of a carcinogen would be required to produce cancer in any human being, or how long it would take the cancer to develop. Another comment against the clause is that we are exposed to many natural carcinogens against which no legal safeguards have been or could be enacted. The term "food additive" is a legal one. Many additives are foods in themselves, and the FDA has pointed out that meat and potatoes would be considered additives instead of food when served in a stew, except they are considered GRAS (generally recognized as safe).

This infers that aflatoxin, a carcinogen often present in peanut butter, is in violation of the Delaney Clause when peanut butter is added to a product such as cookies or candy. The FDA, however, permits 20 parts per billion of aflatoxin in corn and peanuts. The FDA also allows alcohol, a human carcinogen, to be used as a food additive in products such as vanilla extract. It is clear from these examples that the Delaney Clause is not being enforced. Its existence has focused attention on certain food additives, while the nonadditive carcinogenic substances have been set aside.

Throughout my paper an overview of additives has been discussed. Faced with all the confusions of government regulations, consumers may feel helpless in exerting any control over what goes on in their food. The fact is the consumer wields the greatest power of all, the power of the marketplace. Become a concerned consumer by reading labels; exercise your right to choose foods on the basis of convenience, appeal, storage time, or whichever is more important to you.

Lastly, make your views known. Let manufacturers and representatives in Congress know what you want and don't want in your food.

Scientists will never be able to guarantee that anything added to food is absolutely safe. It's up to the consumer to decide what degree of risk they are willing to sacrifice.

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GUIDELINES FOR 10 SESSION SYLLABUS STUDY GROUP PROGRAMS

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The 10 session I.C.A.K. syllabus coordinated with programmed textbooks and slides represents the pinnacle in chiropractic education. Dr. David Walther deserves praise and thanks for his efforts in the development of this program.

Despite the excellence of the 10 session program, there is still a significant drop-out rate in many of the 10 session syllabus classes. This paper presents one idea for decreasing this drop-out rate and further enhancing the AK educational process. It is a program which we plan to employ in the next 10 session class we teach in North Carolina.

In the back of each of the 10 session workbooks there is a plan to implement the newly learned procedures in the individual doctor's office. For the most part, it is left up to the individual doctor to outline a specific plan for review, practice, implementation of the newly learned material.

The proposal of this paper is for the organization of small, local study groups to be held once or twice between each session of the 10 session program. These study groups will be made up of at least three and up to seven or eight doctors from the class who will meet at

a time and place of their own choosing. One doctor will act as the study group leader, arrange the time and place, and remind all members of the group to attend. The location may alternate between any and all of the doctors' offices. The study group leader will also receive the recommended outline of procedures to be reviewed and practiced at each study group session. However, all doctors will participate equally in the study group and there will be no "supervisor" of the group as such; i.e., it will be a self-help group. Therefore, there will be no additional fee for these study group sessions.

The Diplomate instructors will not directly participate in any of the study groups. However, problems or questions which arise may be referred by the study group leader to one of the Diplomate instructors.

It is hoped that these study group sessions will be self-generating and require little of the Diplomate's time after the initial organization at the first session. The study group will serve to aid the doctors in learning correct AK procedures in a standardized fashion. They will also decrease the doctor's frustration at tackling all of the new AK material by himself, and motivate study and review for each study group session as well as regular syllabus session. This in turn should greatly

affect the drop-out rate of the 10 session syllabus classes and help to increase the number of practitioners effectively employing AK procedures for their patients.

The following guidelines are proposed as an outline for topics to be covered at each study group session. Note that for sessions 1 through 8, the material is divided into 2 parts - A and B. The study group may elect to meet twice between each syllabus session, or they may wish to meet once and take a break between part A and part B. This will be left to each study group's own discretion. It is recommended that each study group session last no longer than 3 hours.

Any comments or feedback on the application of study groups in this fashion will be appreciated.

10 SESSION STUDY GROUP GUIDELINES

Study Group
Session #

1-A Check both PMC's and both latissimus dorsi muscles at various stages of gait

Review 1st column of muscle tests (WB p. 23); do tests and watch for errors

-- Apply NL, NV, OI, & nutrient on those found weak, using T.L.

Perform vertebral challenge on several spinal levels

1-B Review 2nd column of muscle tests (WB p. 23); do tests and watch for errors

-- Apply NL, NV, OI, & nutrient on those found weak, using T.L.

Perform fixation analysis (muscle tests & motion palpation) and correction on those identified using T.L.

2-A Test muscles on WB p. 54; watch for errors, apply NL, NV, OI, and nutrient on those found weak by T.L.

Palpate T.S. line; T.L. to T.S. line points to identify their existence.

--Compare T.S. line with postural analysis and check suspicious muscles for weakness and/or 51% involvement with T.L.

2-B Check for switching and K-27 T.L.

Check for cranial and sacral respiratory assistance faults on both strong and weak muscles. Make corrections and then undo corrections by using opposite technique.

Check for Category 1, 2, and 3 pelvic involvements. Review pelvic muscle tests (especially: sartorius, gracilis, adductors, abdominals, gluteus maximus, quadriceps (rectus femoris), piriformis, sacrospinalis)

Review vertebral challenge, especially as relates to pelvic categories and occipital subluxations and fixations

Study Group
Session #

3-A Test all muscles on WB p. 86, T.L.ing for NL, NV, OI and checking for nutrients

Check by T.L. and challenge for ICV open and closed; correct, using reflexes and T.L.ing spine (in prone position for open ICV; using quadriceps for closed ICV) to find related subluxations.

Challenge subluxations, then have patient hold ICV in corrected position AND RE-CHALLENGE to prove whether subluxations are primary or secondary.

Correct and re-challenge primary subluxations.

Do weight-bearing tests, including psoas (for hidden occipital faults), gluteus medius, hamstrings, piriformis, gluteus maximus (for hidden upper cervical fixation)

Check for lift by using different sizes of lifts; try it on people who do and who don't need a lift.

3-B Test again all muscles in 2nd column on WB p. 86 (i.e., foot and ankle muscles)

Check shock absorber technique

Check all adrenal muscles and postural blood pressure, 2nd heart sound, and pupillary reflex

--Use reflexes and nutrients as indicated by T.L. and oral ingestion

Challenge with sugar adrenal muscles, latissimus dorsi, PMS. Fill out hypoglycemia questionnaire.

4-A Check for fascial sheath shortening on major muscle groups. Use fascial flush and spray-stretch technique. Also check for vitamin B-12.

Use muscle spindles to strengthen and weaken various muscles

Use golgi tendon organ to strengthen and weaken various muscles

Check all reactive muscle patterns listed in Walther, p. 22. Also, check for reactive rectus abdominus.

Test for diaphragm function and AK diaphragm technique (T-12/L-1 fixation and psoas-abdominal reactivity).

4-B Check for opponens muscles strength; T.L. and challenge for wrist and elbow subluxations and correct them.

Test muscles on WB p. 98; T.L. for NL, NV, OI and correct

T.L., use respiratory challenge, and use regular challenge for cranial faults on WB pp. 100-104 plus temporo-parietal jamming

Check for blood allergies (using finger prick and blood on tongue) and identify which nutrients neutralize blood allergies (e.g., Thymus, Antronex, Vitamin C, Chelating Minerals, HCl, etc.)

5-A Turn on and off all major (14) meridians using 1) tonify & sedate points 2) meridian tracing

(Review muscle tests of associated meridian muscles. Watch for bad habits.)

Therapy localize all alarm points while testing associated muscle and/or indicator muscle

Palpate the acupuncture pulses - superficial and deep - and observe differences

T.L. acupuncture pulses. Identify meridian involvement by muscle testing and T.L.ing alarm points. Use tapping of 1st tonification point to strengthen. T.L.,challenge, and correct subluxations at associated point on spine. (Pain control technique).

Challenge for hiatal hernia. Correct as needed.

5-B Review neck flexors and neck extensors tests

T.L. and challenge for cranial faults - internal & external frontal

T.L., challenge, and use nasal respiratory challenge for universal cranial fault

Use temporal tap to strengthen and weaken muscles. Block temporal tap with temporalis contraction

Use temporal tap for control of gag reflex

Use right brain and left brain activity with muscle testing. Make manipulative corrections as indicated while patient performs right and/or left brain activity

Check simple nutrient relationships (right brain, vitamin E; left brain, vitamin C, etc.)

T.L. tensor fascia lata NLs along different areas as indicated on WB p. 130.

Study Group
ession #

6-A Review pain control technique
Check for "then and now" technique and law of circulation of energy
Use Luo points and check associated spinal levels
T.L. left Sp-21 and right K-27. Correct as indicated by tapping.
Monitor oral pH before and after correction.
Cover each ear individually with lead. Test muscles on that side of body
T.L. (using wooden swabs) for auricular therapy problems.
Check for emotional recall and emotional NV involvement.

6-B Check for cross-crawl patterns. Practice and learn your own pattern.
Observe the effects of homolateral crawl.
Review the muscles relating to reproductive system function
(gluteals, adductors, piriformis).
Check for the need for uterine lift or prostatic lift. Perform
necessary corrections. Practice the correction if not needed.
Test levator ani muscles.
Check for 2-hand T.L. disc pattern. Challenge for various disc
positions using 2 vertebrae. Use respiratory corrections.
T.L., challenge, and correct with respiration: hand, foot, and
cranial stress receptors.

7-A Review Sp-21/K-27 technique
Find meridian involvements using muscle testing and alarm point T.L.
Use law of 5 elements to identify area of blockage
T.L., challenge, and correct associated spinal area
T.L. acupuncture command points and tap as indicated
Check nutritional relationships as indicated by pattern which
is found (high vs. low dosages)
Check emotional relationships as indicated by pattern which is
found (high vs. low meridians);(i.e., have patient feel
certain emotions and observe muscle strength changes)
Review acupuncture memory keys
Check ligament stretch adrenal pattern. T.L. all adrenal reflexes
one by one and re-check for ligament stretch weakness.

Study Group
Session #

7-B Review teres minor muscle test, fascial stretch, all reflexes, and nutrients.
-- Check axillary temperature. Treat thyroid as indicated and re-check temperature.
Review sacrospinalis tests and reflexes.
Check for and correct all cloacal reflexes
Check for and correct all gait reflexes.
Perform respiratory correction of subluxations; perform subluxation corrections using O and I of intrinsic muscles.
Check for and correct atlanto-occipital rocker, and PRY technique
Fix anterior thoracic subluxation using respiratory rib technique.
Try to decrease spinous sensitivity using CV or GV activity as indicated by T.L.ing lst and last points.

8-A Review all cranial faults using T.L. and challenge (WB pp 200-203).
Review and recheck blood pressure in 3 positions (sitting, lying, standing).
Challenge and correct for all possible hyoid muscle involvements.
Challenge and correct all possible T.M.J. involvements.

8-B Check for RNA in 2 ways: 1) uncovering hidden problems; 2) postural instability and cellular memory patterns.
Check for the effect of simple water in the mouth on weak muscles.
Check for the effect of a simple multiple vitamin in the mouth on weak muscles.
Challenge using imbrication technique. Use both leg challenge and arm challenge patterns.
Review all knee muscle tests. Watch for errors and bad habits.
Check for medial meniscus subluxations.
Review and check orthopedic tests for knee (drawer sign; McMurray's test) etc.

Study Group
Session #

9 Review all shoulder muscle tests. Watch for errors and bad habits.
Practice Yergqson's sign and adjustment for slipped bicipital tendon.
Also practice taping procedure for slipped bicipital tendon (WB p 249).
Practice challenge for AC joint separation and AC joint jamming.
Practice taping for AC joint separation (WB p. 250).
Practice Kocher maneuvers for reducing subcoracoid dislocation (WB p. 252).
Check nasal ionization patterns. Check using a negative ion generator if possible.
T.L. and challenge for: Category 2 internal innominate
Category 2 external innominate
Symphysis pubis subluxation
Check orthopedic tests: LeSegue (SLR)
Fabere Patrick
Adam's position (with 1 leg & 2 legs)
correct using AK methods
Practice taping for sacroiliac and lumbosacral instability (WB p. 270)

10 Check for all factors to enhance T.L. (WB p. 281, etc.)
Review all muscle tests relating to digestive system. Check specific nutrient and enzyme relationships.
Check for sensual skin receptor - bowel T.L. pattern and sensual skin receptor challenge and technique.
Check for problems which show up only during gait.
Review TMJ problems in relation to other joint problems (i.e., sacroiliac, shoulder, hip, knee, etc.)

Note: "WB" refers to the programmed workbook series which has been published by Systems D.C., Pueblo, Colorado as an adjunct to the 10 session syllabus course and as a supplement to Dr. David Walther's textbook Applied Kinesiology-The Advanced Approach in Chiropractic.

METABOLIC CANCER THERAPY

By Jason P. Schwartz, D. C.
Kevin M. McKay, D. C.

ABSTRACT

The use of therapies oriented towards rallying the body's innate ability to heal itself is a philosophy which most Applied Kinesiologists are familiar with. The applications of this philosophy, using natural methods, in treating cancer patients in conjunction with a national research foundation is the topic of discussion.

DISCUSSION

The field of cancer care is filled with an aura of emotionalism and abundant with fallacies. Let us consider the following points:

1) According to the National Cancer Institute: the cure rate for cancer has increased by only one percent in the past 25 years; from eleven percent, up one percent, to twelve percent.

2) Dr. Hardin Jones of the University of California, Department of Medical Physics, has stated, "My studies have PROVEN CONCLUSIVELY that untreated cancer victims actually live up to four times longer than treated individuals. For a typical type of cancer, people who refuse treatment lived for an average of twelve and a half years. Those who accepted surgery and other kinds of treatment lived an average of only three years. Medical treatment seems to interfere with and mess up this natural resistance. You see, it is not the cancer that kills the victim; it's the breakdown of the defense mechanism that eventually brings death."

We can begin to see that the orthodox treatment of cancer patients is not a very reassuring route to have as the only means of dealing with this common disease. (Approximately one out of every three people in this country will die of cancer.)

At our Center, we have recently become research associates with Dr. Harold Manner of Loyola University. Dr. Manner is Chairman of the Biology Department at that prominent University. He has organized a research program through the Metabolic Research Foundation, 8001 N. Milwaukee Avenue, Niles, Illinois 60648, (312) 965-7840. The participating doctors and members of the Metabolic Research Foundation use techniques and therapies which have been shown effective in dealing with cancer patients in centers and clinics throughout the world, including the well known Mexican and Jamacian centers.

To better understand the methods used, let us first examine the premises upon which they are based.

1. What is cancer?

Simply put, cancer cells are differentiated embryonic cells. Everyone has these embryonic cells in their body at all times. They are needed in wound and tissue repair. When some type of carcinogen stimulates these cells they become abnormal cancer cells. Once they differentiate into cancer cells they become significantly different from the normal cells of the body. The body is equipped with a system - the immune system - to eliminate them from the body. However, as a result of poor nutrition, poor health habits, lack of exercise, or other weakening habits, the immune system becomes weak.

2. How do we deal with cancer?

There are different schools of thought based on different premises.

a) Orthodox: Cancer is a local disease with the primary lesion the result of an invading virus, a carcinogen at the site, or trauma such as a blow. Treatment is therefore local, such as surgery, radiation, or chemotherapy.

b) The Alternative Opinion: Cancer is not a local disease, but a systemic one that originates in the entite body. Therefore, to remove the tumor in one area of the body by radiation, surgery or chemotherapy, without first asking the question - what caused this lump or bump to appear? - merely delays the reappearance of the tumor.

TREATMENT: Phase I, First 21 Days

METHODS:

1. LAETRILE or AMYGDALIN or VITAMIN B-17, when taken into the body, circulates around in the blood stream until it meets a cancer cell. At the site of the cancer cell, an enzyme (Beta-Glucosidase), produced by the cancer cell, reacting with the AMYGDALIN, triggers the release of a deadly cyanide compound. This cyanide compound kills the cancer cell. Any cyanide not so used is converted by another enzyme (Rhodanese) found primarily in normal cells, to a safe, harmless compound and excreted in the urine. We will later explain why amygdalin, not used in conjunction with specific enzyme compounds is not effective.
DOSAGE: AMYGDALIN - three 3 gram vials administered intravenously daily or six tablets (2 T.I.D.) daily by mouth (3 grams).
NOTE: for research purposes most supplements used are by Nutridyn- this is done to standardize the products all research centers use. We will thus give dosage and product name using Nutridyn. We feel products of equal quality from other companies may be substituted as long as not being used as research data for Dr. Manner and the Metabolic Research Foundation.

2. Vitamin A in Cancer Therapy
   A. Emulsified Vitamin A is used to avoid the problem of toxic liver due to high amounts (100,000 to 3 million units I.U. per day)
   B. Two mechanisms by which Vitamin A in high amounts can help destroy cancer
      1. Lysomal Splitting
         a) Lysosomes are microscopic organelles located within the cell. They release enzymes which digest particles that enter the cell. The Vitamin A enters the cancer cell, because the cell membrane is not as strong nor

selectively permeable as a normal cell, and causes breakdown of the Lysosome. The autodigestive powers of the Lysosomal enzymes are then freed within the cell to destroy that cell.

2. Vitamin A enhances the immune system of the body which allows the body to attack the cancer as it would the flu or common cold.

DOSAGE: VITAMIN A - this should be given in an emulsified form to prevent liver involvement. Twenty drops of Bio AE Mulsion Forte are given in morning juice and another 20 drops in the evening juice to increase the number of circulating lymphocytes. This will give the patient 500,000 I.U. daily. Every second day an additional 5 drops should be added morning and evening. The skin should be watched. When drying or scaling occurs, discontinue Vitamin A for one week. Return after one week with a two-week on, one-week off routine, employing a dosage 10 drops (5 A.M.; 5 P.M.) lower than that which caused the toxic reaction. 700,000 I.U. daily is the usual toxic level. Lymphocytes are activated by the addition of Thymotrophic Concentrate (6 tablets daily).

3. Enzyme therapy

Tumors have been found to have a protein sheath or coat surrounding them. Laetrile, Vitamin A, nor the body's natural defenses can penetrate this coat. The enzyme therapy is designed to break down this coat so that the other therapies can get to the Cancer cells and destroy them. This is why AMYGDALIN used without the enzymes has been found <u>not</u> to be effective.

ENZYMES USED FOR CANCER TREATMENT:

A. Fractionated from
   1. Beef Pancreas
   2. Calf Thymus
   3. Garden Peas
   4. Lentil Bean
   5. Papaya

B. Administered
   1. Orally
   2. Rectally
   3. Intratumorally (not in the U.S.A.)

C. Used to breakdown tumor protein coat
   (Does not destroy and breakdown all types of protein, it only attacks cancer tissue.)

DOSAGE: ENZYMES - Three Retenzyme E.C. and one Intenzyme tablets are taken together three times daily. These enzymes must be taken witn the digestive tract is most empty. They should be administered mid-way between breakfast and lunch; lunch and dinner; and dinner and bedtime. The 3:1 ratio must be maintained. NOTE: If there is a problem with oral administration of the enzyme, or if it is felt that additional enzyme therapy is required, a rectal form of the enzyme (Retenzyme Aqua+) is available. Two tablets daily are given as a retention enema.

4. Nutritional Supports

A. Vitamin C - helps contain the spread and growth of tumor
   DOSAGE: Fifteen grams of ascorbic acid should be given daily. This amount of ascorbic acid may cause gastric disturbances. For this reason spread the 15 grams throughout the day. The dosage may be increased at the discretion of the physician. Some have recommended dosages as high as 50-70 grams daily. Min-Scorb (1 gram per tablet) will replace minerals while minimizing digestive upset.

B. Vitamin B15 - Calcium Pangmate - Allows cells to use oxygen more efficiently. Cancer cells cannot live in oxygen environment.
   DOSAGE: The salts of pangamic acid will increase the efficiency of cellular oxidation. Organik-15 is available as the zinc and magnesium pangamates. Two of the B-15 tablets should be given with each meal or six per day.

C. Minerals - The minerals of patients are usually out of balance. It is essential that the body be brought back to normal as rapidly as possible. A hair or blood elemental analysis should be performed. Once the mineral deficiencies and surpluses are known, measures should be taken to correct the imbalances.
DOSAGE: Six Exitox daily for a week should effect removal of surplus minerals; heavy metals may take longer. Three to six daily of the "vegetable culture" mineral tablets or of the orotates will usually correct deficiencies.

D. Other nutritional supplements can be considered for individual cases. Selenium, zinc, RNA-DNA and Vitamin E have been used by physicians. There is no supplement which cannot be taken safely with the aforementioned plan. In fact, one should supplement twelve tablets daily of the gland or organ tissue primarily affected. Most patients are hypoglycemic, so the adrenals, thyroid and liver should be supplemented. Six tablets each daily of Sterotrophic Concentrate, Thyrolate and Livatrophic Concentrate should be taken. If there is a past history of radiation and/or chemotherapy, Dismuzyme is recommended (6 tablets per day).

5. Digestive Enzymes - To decrease the stress placed on the gastric glands and the pancreas, one or two Hydrozyme tablets should be taken with each meal. This compound contains hydrochloric acid, pepsin and enterically coated pancreatic enzymes. This will insure the proper digestion of ingested food. The patient should be given a graded litmus paper and instructed to test the first urine in the morning. It should have a pH of about 5.5
DOSAGE: Six Mucozyme capsules should be taken daily to facilitate absorption of nutrients. If nausea occurs at any time during the treatment plan, administer six tablets daily of Enterophic Concentrate and/or Intrinsitrophin.

DIET

CATEGORY	FOODS WHICH ARE ALLOWED	FOODS TO BE AVOIDED
Beverages	Herb teas (chamomile, mint, mint papaya; no caffeine) Fresh fruit juice Fresh vegetable juice	Alcohol, cocoa, coffee, carbonated beverages, canned and pasteurized juices, artificial fruit drinks
Dairy Products	Raw milk, yogurt, butter, and buttermilk in limited quantities Non-fat cottage cheese and white cheese	All processed and imitation butter, ice cream, toppings All orange and pasteurized cheeses
Eggs	Poached or boiled eggs (one per day)	Fried eggs
Fish	Fresh white-fleshed, broiled or baked fish	Non-white-fleshed, breaded or fried fish
Fruit	All dried (unsulfured), stewed, fresh, frozen (unsweetened) fruit	Canned, sweetened fruit
Grains	Whole grain cereals, bread, muffins (e.g. rye, oats, wheat, bran, buckwheat, millet), cream of wheat, brown rice, whole seeds (sesame, pumpkin, sunflower, flaxseed)	White flour products, hullless grains and seeds, (e.g. pasta, crackers, macaroni, snack foods, white rice, prepared or cold cereals, cooked seeds)
Meats	Only occasionally, then limited amounts of lamb, veal or white portion of chicken or turkey	Beef, pork, all prepared meats (e.g. sausage, cold cuts, weiners)
Nuts	All fresh, raw nuts	Roasted and/or salted nuts, especially peanuts
Oils	Cold-processed oils (e.g. safflower, corn), margarine (if safflower or corn oil), eggless mayonnaise	Shortening, refined fats and oils (unsaturated as well as saturated), hydrogenated margarine
Seasonings	Herbs, garlic, onion, chives, parsley, marjoram	Pepper, salt, hot spices
Soups	All made from scratch (e.g. salt-free vegetable, chicken, barley, millet, brown rice)	Canned and creamed (thickened) soups, commercial boullion, fat stock
Sprouts	All, especially wheat, pea, lentil, alfalfa, and mung	None
Sweets	Raw honey, unsulfered molasses, carob, unflavored gelatin, pure maple syrup (in limited amounts)	Refined sugars (white, brown, turbinade), chocolate, candy, syrups
Vegetables	All raw and not over-cooked fresh or frozen, potatoes baked or broiled	All canned vegetables, fried potatoes in any form, corn chips

Additional Recommendations:

Avoid smoke, exhausts, foods which have been sprayed with pesticides, food additives (especially MSG and others ending in -ate), and foods with artificial colors, flavors, and preservatives.

6. Detoxification - Each day a coffee retention enema should be administered. In cases of extreme toxemia, this should be repeated twice a day. One cup of coffee (not instant) should be retained for 15-30 minutes. The caffeine stimulated secretion of bile is an important part of the detoxification plan as it helps to restore the alkaline condition of the small intestine.

DOSAGE: Six Mucozyme capsules should be taken daily to facilitate absorption of nutrients. If nausea occurs at any time during the treatment plan, administer six tablets daily of Enterophic Concentrate and/or Intrinsitrophin.

7. Fast - a two day juice fast should be administered. To allow for taste acclimation to juices, a blend of apple and carrot juice should be taken first. After 2 days, 4-8 oz. glasses of fresh vegetable juice per day.

8. Bowel Movement - It is essential that bowel movements be regular. One and preferably two movements a day must be achieved. Many times the juice fast will initiate this. If not, one teaspoon of Laxadyn in a glass of water taken one hour after each meal should be taken until regularity is achieved. If this still does not achieve results, colonic irrigation should be initiated.

9. Vitamin Mineral Supplement - A therapeutic vitamin-mineral preparation such as Multidyn should be given morning and evening or four per day.

10. Diet - This is the most important component of the treatment plan because it involves a change of lifestyle and eating habits. A juice extracter should be purchases by the patient, and most of the vegetables in the diet should be juiced. In this way all of the naturally-occurring enzymes, minerals and vitamins will be present. (Exception: No meat or daily products of any kind during this period!) The patient should consume at least four 8 oz. glasses of raw vegetable juice a day. Three acceptable brands of juicers are Acme, Champion, and Norwalk.

TREATMENT: Phase 2, 21-Days-to-3-Months

1. DIET. All dietary and therapeutic modalities remain the same except that some meat and coagulated milk product e.g., yogurt, cottage cheese, and acidophilus milk are allowed. No pork, or pasteurized/homogenized milk should ever be re-introduced in the diet.
2. AMYGDALIN. 2-3 gr. vials are administered intravenously twice a week. On non-injection days, 2-500 milligram tablets are given in the morning and 2 again in the evening for a total of 2 grams per day. If the patient started on oral Amygdalin the dosage can be reduced to 2-grams daily.
3. OTHER MODALITIES. All vitamin enzymes and glandular products should remain the same.

OBSERVATIONS

Most cancer patients come to us as a last resort. They have been told they are terminal by their oncologist. Under these conditions it is imperative to work closely with doctors who can render emergency medical treatment. Life threatening complications are common at the advanced stages of cancer.

The social pressures put upon the cancer patient who chooses to take a natural metabolic therapy approach are inconceivable unless witnessed. Often a patient will start the metabolic program but relatives will bludgeon them until they follow the orthodox methodology even if that orthodox route has said there is no hope.

The individual courage needed to step away from the psychological womb of orthodoxy is great, indeed. We are thus left with a special class of patients. They typically are willing to work for their health. They enter a partnership with the doctor and realize that a magic pill alone cannot cure them. Change of life styles are accepted willingly because of this attitude of working together on their health problems.

CONCLUSION

Working with cancer patients brings to the forefront the philosophical difference between treating symptoms versus treating causes. This is dealt with in an arena of emotionalism and mystique beyond what we had ever experienced before. However, using the tools available to us we feel we can offer a viable alternative or adjunct to orthodox cancer care.

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LYMPHATIC DRAINAGE IN LOWER BACK PROBLEMS

by Sheldon A. Sinett, D.C.

Abstract: The use of lymphatic drainage in low back conditions will greatly enhance your results. We have found that the lymphatic drainage is inferior and contralateral to the spinous challenge of the 5th lumbar vertebrae.

Dr. Goodheart has mentioned and demonstrated therapy localization for lymphatic drainage in the spine. We have found that by challenging the 5th lumbar spinous process, the N.L. technique is contralateral to the spinous challenge. For example, if the 5th lumbar spinous is right, the lymphatic drainage would be the left buttocks. If the 5th lumbar spinous is left the lymphatic drainage would be the right buttock. This correlated with T.L for 5th lumbar lymphatic drainage.

In a category I patient, the first thing we take care of is the lumbar spine. We make sure to challenge the 5th lumbar to see what direction it should be adjusted. Before we adjust the 5th lumbar we use the lymphatic drainage technique, which will sometimes correct the 5th lumbar. Lymphatic drainage can take from 15 seconds to 3-4 minutes, depending upon the severity and chronicity of the case. Make sure you use interruption of T.L. and Eyes in Distortion (EID) to see if the whole complex is corrected. If N.L. activity does not correct L5, we then adjust it. The next step is to balance the muscles related to the category I patient, both the piriformis and sacrospinalis. We then block the patient according to short leg. Make sure lesion correlates with 1st ribhead pain. If this is not the case, then the patient is switched. After making the correction of the Category I patient, make sure the 1st ribhead pain has disappeared. We then balance the sacrum and mastoid if necessary. We also check for an upper cervical fixation in the clear or with respiration. We then adjust any vertebrae that is subluxated. To complete the correction of the Category I, the last thing we do is correct the Temporal Bulge.

In the Category II and Category III patient we utilize lymphatic drainage to help maintain our corrections. We have seen better results in our lower back problems in a shorter period of time utilizing this technique.

B I B L I O G R A P H Y

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2. Walther, David, Applied Kinesiology, The Advanced Approach to Chiropractic.

PLACEBO REINFORCEMENT

By:

John F. Thie, D.C.

ABSTRACT:

That "Placebo reinforcement" happens and is dicussed. A plea for more open minded observations realizing that accurate reporting is essential for evaluation of how much placebo affect or reinforcement has contibuted to the results.

* * * * * *

Placebo - - this word is used so many times in medicine and chiropractic. It is often used with derision and contempt when saying that the treatment was primarily placebo in its effect. In doing what some call scientific research, it must be part of the controls. I think that we often fail to define our terms so I would like to discuss with you what are some of the definitions of this word.

1956 - Funk and Wagnalls, New Practical Stand Dictionary, Page 1002

"Placebo noun 1. The opening antiphon of the vespers for the dead in the Roman Catholic Church. 2. Any harmless substance, as bread pills, given to humor a patient rather than as a remedy. 3. Anything said to flatter or please. Latin Placebo - I shall please, verb. placeo - please.

You will notice that the first definition is one that relates to religion. Then the second relates to a harmless substance given to "humor" the patient. That was 25 years ago.

Today, however, the term placebo is receiving much popular press in a much more favorable context. Norman Cousins, in his popular book "Anatomy of an Illness As Perceived by the Patient," 1980, has a chapter on the placebo which is well worth reading.

He states on pages 50 and 51:

> "For a long time, placebos were in general disrepute with a large part of the medical profession. The term, for many doctors, had connotations of quack remedies or "pseudomedicaments." There was also a feeling that placebos were largely a shortcut for some practitioners who were unable to take the time and trouble to get at the real source of a patient's malaise.
>
> "Today, however, the once lowly placebo is receiving serious attention from medical scholars. Medical investigators such as Dr. Arthur K. Shapiro, the late Dr. Henry K. Beecher, Dr. Stewart Wolf, and Dr. Louis Lasagna, have found substantial evidence that the placebo not only can be made to look like a powerful medication, but can actually act like a medication. They regard it not just as a physician's psychological prop in the treatment of certain patients, but as an authentic therapeutic agent for altering body chemistry and for helping to mobilize the body's defenses in combating disorder or disease."

I believe that the placebo affect, as it is now called, really involves the belief systems of the people involved and has a great deal to do with the charisma and personal pride of the people that are doing the therapy. What I believe happens in the minds of those deciding if a placebo has really taken effect, goes something like this.

1. There is a patient that has something wrong, the examining professional is then sought out and agrees that something is wrong, then something is done to correct the perceived wrong in the patient.

2. That the patient and the professional observe that the wrong with the patient has changed.

If the "something" that was done should not have corrected the problem due to the professional and physiological principles, then, from the professionals view, it is a placebo.

Unless we believe that we know all the physiological principles and everything that can happen, we always have to qualify our statements with according to how I understand the physiological functions or according to this or that authority.

When we look back at techniques that we have used in the past, in all professions that allow patients to get well, we will all agree that times have changed and ideas on why things worked have changed.

In medicine, the bleeding of patients for instance. In chiropractic, who among us could not name several past techniques that we could now not say were presumably placebo effect?

Certain physiological principles have gained consensus and are agreed upon and this consensus of ideas becomes scientific proof. What then is part of everything that we do, is the ability of each of us to aid "will to live" of the patient and give the doctor that resides within each one of us a chance to go to work.

Since this placebo has such a powerful effect on the patient, and since our job as doctors is primarily to make the patients as whole or balanced in function as possible, it behooves each of us to do as much as possible to get the "doctor in each of us" to work as efficiently as possible. We can do this by using all our knowledge of the patient and remembering that we are all spiritual, mental, physical and chemical beings and that there are definite laws that govern how we function. We do not know all of these laws of nature but we are finding out more and more ways to be in harmony with these natural laws and in that way, we can advise and treat our patients.

We are learning more and more how we can, and do, consciously affect our physiological functions. Biofeedback now has shown us that functions that we formerly thought were out of the realm of our conscious control can be controlled through training. We can, with this placebo affect, now using the term to please ourselves, do harm or good for ourselves by our belief system or the belief system of the professional that we adopt.

Cousins states on page 61, that:

> "Beecher stressed as long ago as 1955, in the Journal of the American Medical Association, that placebos can have serious toxic effects and produce physiological damage. A case in point is a study of the drug mephenesen's effect on anxiety. In some patients, it produces such adverse reactions as nausea, dizziness and palpitations. When a placebo was substituted for mephenesin, it produced identical reactions in an identical percentage of cases.
>
> "One of the patients, after taking the placebo, developed a skin rash that disappeared immediately after placebo administration was stopped. Another collapsed in anaphylatic shock when she took the placebo drug."

Another study, that is well known in psychological circles, concerns learning in which the expected results occurred when only the teacher was told who were the brightest pupils and could be expected to do better in these circumstances. In fact, the pupils were no more likely to succeed than any other except that the teacher expected them to improve. This would then indicate to me that the belief and attitude of the doctor is, at least or even, more important than that of the patient.

I believe that we, therefore, as a group of what I feel are the most open minded leaders in the healing profession, should take the attitude that "I didn't know that was the way the body, mind and spirit works for you," whenever we are confronted with ideas that are different from our own belief systems. This furthers the idea that "I may wish to investigate that myself, but if I don't I will be happy to hear of your results using that method."

I believe that allowing for differences is essential to our continued growth and development as individual human beings and I believe our continued personal growth is necessary if our organization is to grow, be satisfying and fulfill our purpose of improving our world.

I want to also plead for the use of numbers so we can be exact on the number of different cases that we treat. This should include ages, sex and even greater detail available. There should be case numbers so that another investigator can see the files if desired. When we are reporting our results in the antedotal ways that nearly all of our reports are given, I feel that the use of case histories with details of our examinations, need to be reported, rather than just the general statement on "several cases" or other statements that are over 500 cases when no breakdown is given on whether they are male, female, treated on the classroom demonstration table or in a private treatment room.

The place where the patient is treated makes a big difference, in my experience. I have found that I will get much better "placebo reinforcement" when I ask for a volunteer, if the audience is favorable and I have waited to the end of the explanation for a demonstration, than when I treat a patient in my private treatment room.

The observation that I have just described is one of a gut level feeling on my part. I have not attempted to statistically correlate these results. I have been surprised at the dramatic results that have occurred in chronic conditions, when teaching on the lecture circuit.

I do not want to discount the benefits derived from activating the placebo or doctor within and allowing the physiological changes to take place, but I do want to know when I hear about the results the environment in which they took place so I can evaluate for myself how much "placebo reinforcement" was present in the physiological treatment that was done.

My plea is for better reporting by all of us, of the way in which we discovered our understanding of how our wonderous body works.

* * * * * *

Dr. Otis Thomas
Diplomate, I.C.A.K.

STRESS MANAGEMENT THROUGH APPLIED KINESIOLOGICAL PRACTICE

Abstract: Many patients complaining of very different pain symptoms, both physical and psychological, often have the same group of structural faults. This amazing finding is directly related to "stress-affect" on the human body. This paper discusses the diagnosis of stress and some new healing techniques.

STRESS MANAGEMENT THROUGH APPLIED KINESIOLOGICAL PRACTICE - THOMAS

Over the past few decades, theories and methods of dealing with stressors and stress indicative illnesses have proliferated. Today, stress management techniques range from the 6 o'clock martini administered by the concerned spouse, to the drug prescribing medic, the psychologist and, something new on the scene, the Applied Kinesiologist. The medic and the cocktail dispensing spouse have similar philosophies. They both recognize stress as a real issue and their answer is to mask its effects temporarily with numbing stimulants. The psychologist is much closer to the real answer because he knows that stress has direct effects on the quality of human life and that drugs are not the only answer. His approach is admirable, but does not provide a complete anti-stress program. If neurons are misfiring in the brain and the body is short circuited, the patient finds it difficult indeed to rise to the stress challenge until the structure that is crying out "FIX ME" is properly cared for.

The applied kinesiologist can lay a firm foundation and support the psychological approach by dealing first with the physical damage caused by stress. In order to do this, the A.K. Doctor must redefine his concept of ailments and patient complaints and see modern man as an organism relying on his primal survival equipment of fight or flight to deal with all the intricate assaults of this modern age. The A.K. Doctor must go back to the basics of body structure in order to begin the process of stress management.

In his book, Mind as Healer, Mind as Slayer, Pelletier quotes Simeons:[1]

> "Modern man's cortex, having censored the diencephalic reactions at the level of consciousness, is unable to interpret the bodily preparations for flight correctly. His Cortex cannot understand that his primative diencephalon still reacts in the old way to threats which the cortex no longer accepts as such. When these once normal and vitally important reactions to fear do not reach his conscious awareness, he interprets them as something abnormal and regards them

> as afflictions. He speaks of indigestion when apprehensiveness kills his appetite, and insomnia when fright keeps him awake at night. The increased heartbeat becomes palpitation, the sudden elimination of waste he calls diarrhea, the clenching of the back muscles he calls lumbago, etc. It is man's civilization which prevents him from realizing that such bodily reactions may be merely the normal results of diencephalic alarm and mobilization of those marvelous flight mechanisms to which he owes his existence as a species."

During recent kinesiological examinations at the Thomas Clinic, we have been able to isolate a group of stress-related physical symptoms. These symptoms have appeared with notable frequency among patients coming to us with a wide variety of complaints. By redefining a patient's "civilized" description of his pain, we have been able to help him directly with the effects of stress and to rebalance his fight-flight stasis. When patient complaints were traced to stress symptoms, the body usually showed disturbance in the firing order of the right or left brain and in rare cases, in both right and left brain simultaneously. Most patients who showed a positive misfiring of the right or left brain also had pelvic category problems, limbic system disfuction, T.M.J. problems, occiput or upper cervical subluxation usually accompained by a Lovett brother in the sacrum and lower lumbars, as well as a compensatory subluxation in the thoracic spine. Pulse analysis usually revealed a meridian problem with a concommitant subluxation of the associated point -- for example, the liver meridian will show a subluxation at T-9 or 10 and can be verified by vertebral challenge.

Treatment

Once a list has been made of findings which showed positive therapy localization,[2] the usual priority testing method is followed; asking the body which symptom to fix first.

STRESS MANAGEMENT THROUGH APPLIED KINESIOLOGICAL PRACTICE - THOMAS

In the 1979 edition of the Collected Papers of the Members of the International College of Applied Kinesiology,[3] we reported some amazing effects of the "Pacemaster" on patient treatment. The Pacemaster is an electronic device which acts like a metronome -- sounding rhythmic beats to the patient. The Pacemaster is placed behind the patient's ear like a hearing aid. In the 1979 research, we theorized that the Pacemaster worked on the same principle as a Temporal tapping and served as a synthetic booster to reorder neuronal misfiring in the left and right brain. Further experimentation with the Pacemaster, however, has revealed a much wider effect.

After therapy localization, we applied the Pacemaster to the patient's ear on the side of the brain which had showed neuron firing disorders as a result of stress. We found that the presence of the Pacemaster, with its rhythmic beats sounding in the patient's ear, nuetralized all the symptoms that heretofore therapy localized positive during the diagnosis with the exception of one problem, which we assumed to be the priority structural fault. Upon correction of that priority finding, all other findings disappeared and the patient once again tested strong in all areas.

More research is needed to explain this phenomenon, but it seems reasonable to believe that the Pacemaster or related device is a useful aid in determining which structural faults have priority; and healing those faults which reduce the patient's resistance to stress-debilitation. Dealing with "stress-affects" on the basic structural level is the best care an A.K. Doctor can prescribe. Once the fight-flight stasis has been repaired, the patient can then go on to deal with, and change those elements of his life which cause stress.

Footnotes

1. Pelletier, Kenneth R. Page 44
   Mind as Healer, Mind as Slayer
   Dell Publishing Co. 1977

2. Walther, David Page 7
   Applied Kinesiology
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3. The Collected Papers of the Members of the Page 115
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RE-CURRENT I.C.V., I.C.R., AND COLONIC LAVAGE

Brice E. Vickery, D.C.

Since becoming a serious student of Applied Kinesiology in 1976, the ileo-cecal valve has been promoted from a nebulous phenomenon to one of prime importance in our practice.

The widespread symptoms, well documented and explained by *Nathaniel S. Wirt, Ph.D. as being primarily parasympathetic and sympathetic reactions, are often part or all of the patient's primary complaint.

As we continued our Kinesiological evolution, we noticed that many cases of facett imbrication were due to an I.C.V. and that no permanent correction was made until healing of the I.C.V. took place.

We also observed that many people had frequent recurrences along with *I.C.R. (ileo-colic reflex).

In August 1980, we obtained a Toxygen Colonic unit and began treating these recurrent patients with colonic lavage observing the following criteria:

1. They must have had two or more I.C.V. problems within the preceding year.
2. They must therapy localize from the cecum to at least the hepatic flexure using a. clear, b. brain activity, c. Melzac wall, and now *d. E.I.D. or cerebellum therapy localization.
3. In questioning hundreds of patients, we have learned to dismiss their "regularity" of one bowel movement a day because it is inadequate, and people having three also were found pathologic.
4. Some cases were referred to a Roentgenologist to dismiss the possibility of CA, and to graphically record the colon before treatment.

We were able in every single case to remove the positive therapy localization of the ascending colon, and have not had any recurrences in people with recurrent I.C.V. since we started this program in August 1980.

Two cases, both R.N.'s, illustrate the point:

L.P., age: 42

4/24/78	Facett imbrication - S.I. circuit
11/24/78	Facett imbrication, no I.C.V. (in the clear) sacral apex, small intestine meridian
4/17/80	Same, switched, I.C.V.-open
4/21/80	Improved but still hyperpsoas, TMJ
8/15/80	Category I - Lft., facett imbrication, ICV, Limbic - Rt.

In October, we began a series of twelve colonics. Patient reported that she "never felt better", and has not had a reccurence since that date.

K.A., age: 29

8/27/80	Acute facett imbrication, ICV
9/2/80	Acute facett imbrication, ICV

Ten colonics were done and patient has voluntarily come back monthly. Her lumbar condition has not returned, and her skin, particularly her face, had improved and was continuing to improve (formally only antibiiotics controlled her condition).

Harold K. Marshall, M.D.*, in work done at the East Gardner State Hospital 50 years ago did a study using fifteen thousand colonics in five years. They also included the staff in their study and found some interesting comparisons:

	Mental Patient	Staff
Angulation	48.4%	30.0%
Dilated Cecum	37.2%	46.6%
Ileo-cecal Incomptency	34%	36.8%

"These statistics show that in both the mentally ill and the mentally sound, the three commonest abnormalities are sharp angulation (caused by ptosis) incompetency of the ileocecal valve, and dilated cecum."

"They constitute a triad of findings: angulation, dilation of the cecum and ileocecal imcompetency. This triad gives rise to lengthened evacuation time, pain sometimes intense, or distress in the neighborhood of the cecum, nausea and vomiting, often stimulating appendicitis. Appendectomy should not be delayed in

these cases as chronic appendicitis and ileocecal valve incompetency cannot be easily differentiated." (He didn't know about Applied Kinesiology).

"If, at operation the cecum is dilated and the appendix does not show inflammatory reaction consistent with symptoms, ileocecal incompetency should be suspected."

This probably explains why in Russia and China, the statics for appendectomy are 15% operation, 85% naturally healed while in the United States, they are 85% operation, 15% healed.

Conclusion

The ileo-cecal valve which is routinely treated by Applied Kinesiology has far more significance than previously realized. It denotes a deterioration of the bowel particularly, and the state of the patient's health generally.

It should not be treated with short-cut methods, and has significance in facett imbrication specifically, and we have found it is a hidden part of sway back postural problems.

Colonic irrigation is the most significant therapy in preventing recurrence of I.C.V. because it helps to remove the reactive factors in the colon, and rapidly relieves the liver.

We also state that 95% of all Hypoglycemics and Arthritics have colon problems, and use lavage as part of our standard treatment. Detoxification procedures - such as diet and nutrition - also go hand-in-hand with lavage. We might note here that we include liver concentrate in our treatment as this organ (meridian) shows in the majority of cases. This can be easily understood when the portal circulation, which includes the entire bowel to the rectum, is reviewed.

We realize that improper diet is the start of these conditions and try to impress upon the patient that unless they correct this permanently, we will win this particular battle but they will ultimately lose the war (their health).

* Nathaniel S. Wirt, Ph.D.	"The Ileo-cecal Sphincter & Valve" American Chiropractor · Feb. 1981
* George Goodheart, D.C.	Seminar - Red Jacket Inn - Cape Cod June 1980
* George Goodheart. D.C.	Seminar - St. Maarten - December 1980
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BRICE E. VICKERY, D.C.
February 6, 1981

LACK OF PARATHYROID TREATMENT RESPONSE DUE TO HIDDEN HYDROCHLORIC ACID DEFICIENCY --

Brice E. Vickery, D.C.

Since the introduction and identification of the levator scapulae parathyroid lung meridian relationship by George Goodheart*, we have found more than forty cases among regular and new patients.

The parathyroid mechanism was also found to be instrumental in Limbic system recurrences, another instance of interlocking distortion patterns.

Another variation was found when both levator muscles are weak, the patient does not prevent the characteristic thickening of the shoulder at the lateral trapezius but rather an elongated forward neck.

The most important finding, and the reason for this paper, were failures in patient response to therapy.

Approximately 10% of a group of 45 patients showed inadequate response in the first or second week follow-up. We decided to check calcium (flat of tongue), and were surprised to find positives. We then decided to recheck HCL (bilateral pectoralis clavicular) and using Glabella tapping, brain activity (humming and counting) and E.I.D. (eyes into distortion), found what we felt was the other and may be the primary cause of the patient's calcium problem. Namely, the lack of absorption due to HCL deficiency. These cases then responded to treatment using both Digestyn and Thyrolate together.

We have been very excited by the breakthrough made in this parathyroid mechanism, and have seen one case of high blood pressure, which was consistently over 200, reduced to 170 for the first time in over a year.

We hope these observations are helpful.

BRICE E. VICKERY, D.C.
February 9, 1981

* Winter meeting - 1980 - St. Maarten

Emil S. Zmenak, D.C.
November 26, 1980

ABSTRACT

The muscle-organ relationship has been well established (1). Improper or restricted muscle function may well be a major predisposing factor in both acute and chronic recurring cystitis.

The bladder is highly resistant to infection. Experimentally it is difficult to infect a normal bladder, even by the introduction of pathogenic organisms. If, on the other hand, the bladder is diseased, injured by trauma or unable to empty itself completely because of some associated obstructive lesion, infection readily takes place(2).

Cystitis is thus more often a symptom rather than a disease and primary cystitis is not common. Attacks of acute cystitis are particularly likely to occur among women because of the short urethra and close relationship between the genital and urinary tracts in women. The source of infection is most commonly within the urethra, or infection in Skene's Glands, urethral strictures, diverticuli, urethral caruncles or nephritis.

It is not uncommon for vaginitis or infections of the cervyx or uterus to extend into the urethra and thus into the bladder following intercourse. It has been well established that diabetics or people with sugar problems have poor resistance to bladder infections(2).

The predisposing factors in cystitis are:

1. impaired drainage from the bladder, including prostatitis, calculi or tumor
2. concentrated urine due to low water intake or abnormal pH (normal 5.8 to 6.6) as a result of excess alcohol intake or gallbladder or liver dysfunction(3)
3. anemias
4. introduction of catheters or other foreign objects into the urethra
5. diabetis or sugar handling problems

The clinical manifestations of cystitis include painful and frequent urination with a continual urge to void and pain over the bladder area, fever and occasionally abdominal cramps.

The conventional medical approach to the problem is obviously antibiotic care. However, we have at our disposal an extremely effective kinesiological method of looking after both acute and chronic cystitis. The muscles act as pumps to facilitate the lymphatic drainage from their associated organs(4). Impaired muscle function does not allow adequate drainage of the waste products of bladder and bowel metabolism to take place, and, as a consequence, the pH and the localized chemistry in the pelvic area may become altered, thus predisposing the bladder and the urethra to ongoing recurring infection or causing spasm and stricture of the urethra.

Our clinical experience has shown that the following kinesiological factors are present in many cystitis problems:

1. restricted range of abduction of the legs
2. the presence of a chronic ileo cecal valve problem
3. involvement of the liver and consequently of the pectoralis major sternal and pectoralis minor muscles for lymphatic drainage
4. foot subluxations - usually lateral talus or cuboid (5)
5. alkaline urine and low thymus function

Our approach has been directed towards correcting these factors by:

1. (a) restoring normal pelvic mobility and range of abduction by using the appropriate "Pitch" adjustment i.e. resisted anterior flexion and extension of the head
   (b) fascial flushing of the adductors, particularly at the insertion of the adductors to the pubic bone
   (c) stretch and spray the medial thigh muscles to restore as much mobility as possible.
2. lymphatic drainage of the pectoralis major sternal and pectoralis minor muscles
3. appropriate correction of the ileo cecal valve problem
4. appropriate correction of the foot subluxations
5. acidify urine by having the patient ingest unsweetened cranberry juice or cooked cranberries and provide appropriate nutritional supplementation for the thymus

6. restrict alcohol intake
7. appropriate dietary and chiropractic procedures to handle sugar handling problems

Our response using this approach has at times been almost spectacular, often providing relief of symptoms within minutes. An interesting bonus that a significant number of women have reported has been an increased libido and enjoyment of sex.

References:

(1) Walther's Applied Kinesiology
(2) Essential Urology - Colby 2nd Edition
(3) Therapeutic Foods Manual
(4) Dr. G. Goodheart's Tape #
(5) Dave Walther's Personal Conversation - New York 1978

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$(11{,}400)x + y(3600) = 84{,}000$

$36{,}000$

$22.\overline{00}$

72

$11{,}400$