



COLLECTED
PAPERS OF THE MEMBERS
OF THE
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PRESENTED MAY 26th THROUGH 29th, 1982

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CHAIRMAN, I.C.A.K.

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INTRODUCTION

By

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

Chairman

This thirteenth collection of papers by the members of the International College of Applied Kinesiology represents 56 papers written by 41 authors.

These papers will be presented by their authors to the general membership at the Summer meeting to be held in Dearborn on May 26, 27, 28, 29, 1982. The authors welcome comments and further ideas on their findings either in Dearborn or you may write them directly; as their addresses are included 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.

PROTEOLYTIC ENZYME ABSORPTION
BY THE INTESTINES

by

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

Abstract: It has been difficult to understand how ingestion of proteolytic enzymes can affect a distant area systemically, reduce edema caused by either a contusion or hematoma. This is contrary to the normal physiological digestive process we have learned.

Discussion

It has been the author's experience to deal with a hematoma, the size of 1/2 a grapefruit, which failed to respond to aspiration, ultra-sound, heat and cold. After a three-week periodic, it increased in size. It was bound with an elastic bandage to prevent jelly like movement. Ingestion of proteolytic enzyme reduced its size, and within three days the area was normal.

Oral ingestion of proteolytic enzymes must remain intact throughout the normal digestive process. Pass through the intestines, be absorbed into the hepato-portal circulation and survive through the liver without being denatured by this

PROTEOLYTIC ENZYME
G. E. Achilly, B.A., D.C.
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whole process, then go to a localized site of inflammation or edema.

"Systemic absorption has been demonstrated by good scientific studies.¹⁻² The work of Ambrus³, Avakian⁴, Martin⁵ and Miller⁶ all are excellent examples of recent studies which have been published demonstrating that active proteolytic enzymes are taken up across the G.I. epithelial border into the hepato-portal circulation, into the general circulation. These studies indicate that much of the active enzyme principle when orally administered is denatured in the gut, but that enough survives to raise the level of proteolytic activity in the blood considerably."¹ Antigen Absorbtion by the Gut by Hemming also verifies this principle.

Conclusion

A percentage of oral ingestioned proteolytic and other enzymes are absorbed intact through the G.I. tract, transported into the systemic circulation, delivered to a site of edema or inflammation, and digest or reduce fibrin deposits which are carried away by the lymphatic system.

References:

1. Jeffrey Bland, Ph.D., "Glandular-Based Food Supplements: Helping to Separate Fact from Fiction."
2. Jeffrey Bland, Ph.D., "Glandular Based Food Supplement Tapes."

CATEGORY IV

by

John V.N. Bandy, D.C.

T.L. ASIS Bilateral
Bilateral weakness Ant Deltoid 3

ABSTRACT:

There is a fourth pelvic category previously missed. It is common and extremely useful.

Early in 1980 Victor Franks introduced me to an idea he had that there was a better way to fix a Category II. He demonstrated his test and treatment. Investigation has shown that this is not related to a Category II which is an osseous subluxation of an ilium. What Dr. Franks has found appears to be a torque pattern in the pelvis we have chosen to call a Category IV.

The Category IV is seen in the patient as a corkscrew type torque. It is identified by either weakness of the Anterior Deltoid scapular division bilaterally when tested together, or by therapy localization of both of the Anterior Superior iliac spines.

The correction is made by using standard Category II block position (hence Victor's original assumption). The blocks, when properly placed, will negate the T.L. or challenge and the blocks are left until the TL/Challenge returns. This takes between ten and forty-five minutes.

Patients often experience soreness for one or two days following this treatment, but it is an extremely useful technique and I recommend it to you.

TWO POINT THERAPY LOCALIZATION/CHALLENGE

by

John V.N. Bandy, D.C.

ABSTRACT:

As we progress in Applied Kinesiology, the tool of two point (or more accurately multiple point) Therapy Localization/Challenge becomes a more and more useful tool. This is an attempt to familiarize us with some of the parameters of the two point TL/C.

I. We identify body responses to TL/C as a change in an indicator:

- a strong muscle weakens
- a weak muscle strengthens

II. Any variable introduced that changes our indicator can be called a point.

- touching over a joint, organ, or reflex, etc.
- moving the head
- moving the eyes
- moving a bone
- moving a joint
- introducing a nutrient or any other substance
- light or the lack of it
- color/sound
- etc.

III. Each successive point carries with it the qualification of the previous point, thus narrowing the scope of the question we are asking the bodies computer.

THE LIVING COMPUTER

ABSTRACT

This paper considers the relationship between the electronic computer as man has designed and the body which can be considered a biological computer.

The components of each are discussed and how these parts may relate to solving the every day problems of patients of the Chiropractor.

The four different types of computers in the body are discussed and clearing procedure is introduced. A definition of disease is introduced with the understanding of Biocomputer strategy.

BY

ALAN G. BEARDALL, B.A., D.C.

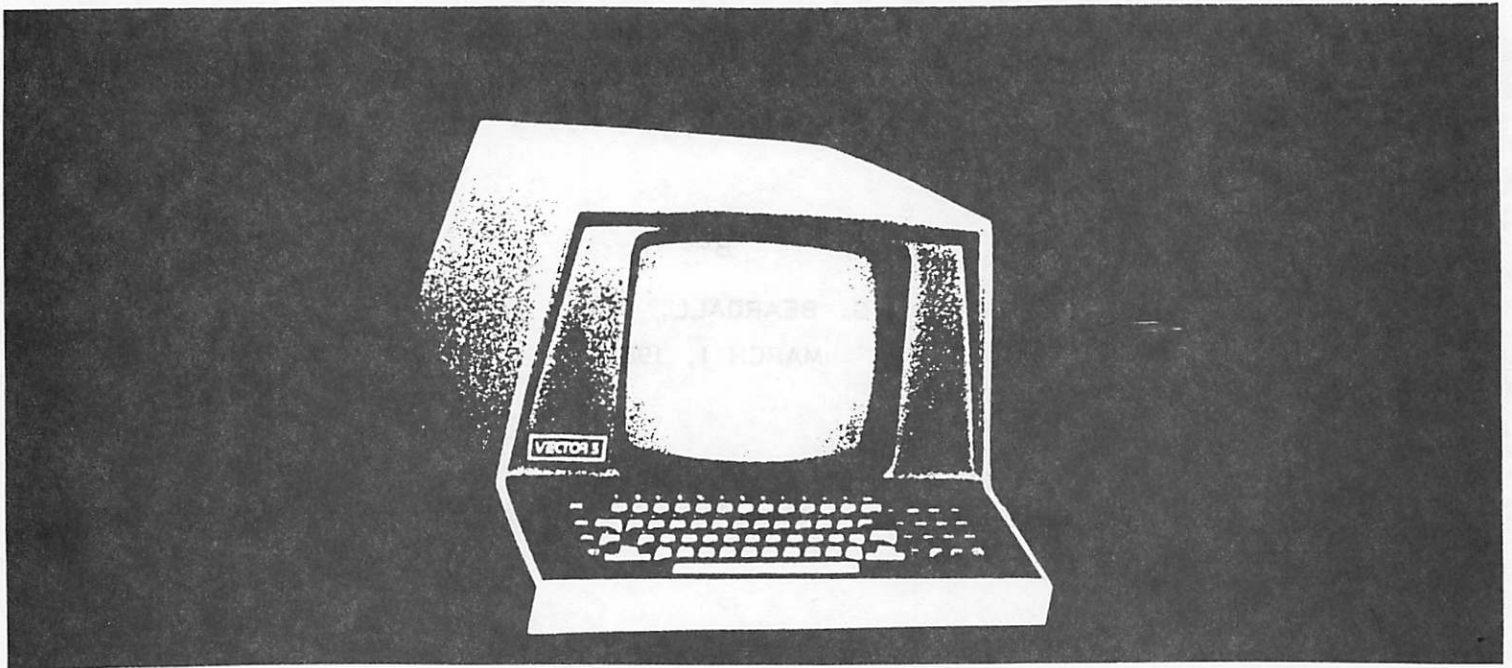
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THE LIVING COMPUTER

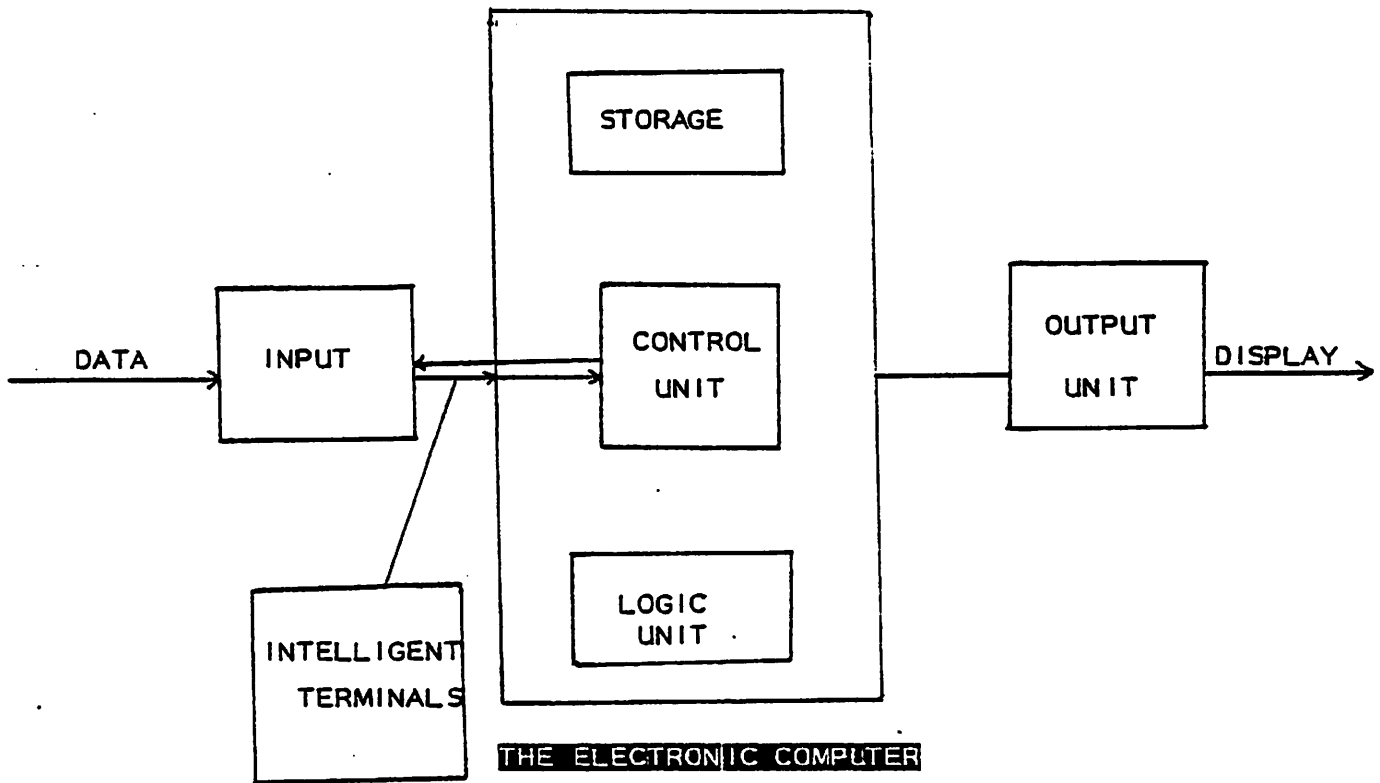
A. THE ELECTRONIC COMPUTER

Our clinical observations at this time lead us to conclude that the body is a biological computer which has an extensive nervous system with processing capabilities similar to that of a computer. To increase our understanding of this biological computer, let us first consider basic computer functions and terminology.

A computer can be defined as an "electronic machine for the purpose of high speed performance of logical operations for the processing of large masses of coded¹ information."² In simpler terms it is "a device that accepts information, processes it and produces meaningful results."³ The computer has three basic functions. They are input, central processing and output.



1. Emphasis ours
2. Computers in Action
3. Ibid.



The input unit is the sensory system of the computer—it gathers raw data and breaks it down into small parts that can be handled simultaneously one item at a time.

The computer contains many intelligent terminals which detect and correct certain operator errors as well as capture and enter raw data. All data must be accurate and properly timed. Aberrant information results in the "garbage in--garbage out" phenomenon.

Information is next sent to the central processing unit (CPU) where all data is coordinated and controlled. Here raw data is transformed into common codes so that the computer can determine whether it recognizes the information received.

Central processing is divided into three parts: the arithmetic or logic unit, the storage unit and the control unit. The arithmetic unit performs logical operations such as the comparison of two items of data. The storage unit stores the data while it is being processed. Whatever is passed on to storage is received in abstract symbolic terms and stored as general facts about the state of the environment. The capability of a computer

to "remember" is one of its most essential aspects as it cannot function unless it can store instructions, facts and figures for retrieval when needed. Stored data remains there until it is called upon by the control unit. The control unit is the most vital for it directs overall functioning of the other units and controls the data flow between them. This unit contains the programmed instructions which must be written in the language of the computer. The central processing unit has a hierarchical arrangement with each level having a number of relatively independent processing elements each pursuing its own job and each trading information with levels above, below or laterally and with each other. Different aspects of problems are handled in different portions of functional sub-systems and are represented potentially at all major levels of the physical system.

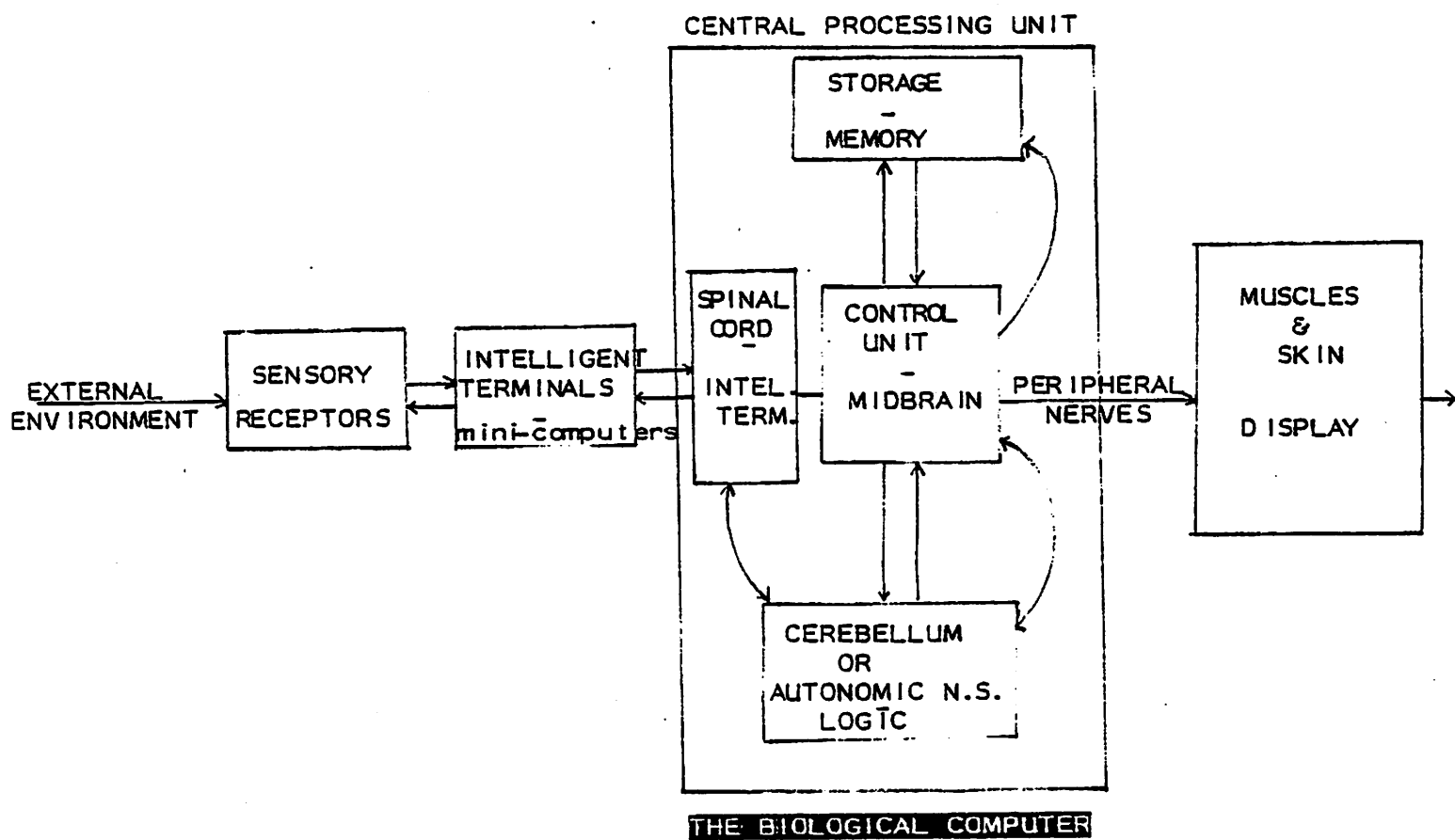
The output unit reports on information from storage and transmits the strategies to the display unit. This unit then reflects the desired actions and computations of the CPU.

In summary, a computer is involved in manipulation of large amounts of sensory data which is processed for input error, monitored, coordinated, controlled, compared, integrated, evaluated and reacted upon to produce adequate solutions to complex problems.

B. THE BIOLOGICAL COMPUTER

With our understanding of the electronic computer, let us now compare these qualities with the biological computer. The human body is a complex combination of different types of organs and tissues. These tissues are involved in a series of inter-reactions both with external and internal stimuli (raw data). This raw data is interfaced with and if necessary reacted upon. These reactions must reflect the "desired action" or will of the primary tissue involved with the problem. The reaction may result in modified behavior or motion, thus the statement "body language never lies."

The human body acts similar to a computer in that it has the same basic functions: Input, central processing and output. The following discussion attempts to correlate these functions into a meaningful relationship.



Our input unit would be our sensory collection system viz. the eyes, ears, nose, taste, touch and also includes many other receptors within our bodies that collect internal data. Adequate irritation of these receptors is called the stimulus (sensory data) and must be reduced to neurological impulses so that the actual physical event can be translated and presented to the nervous

system. These impulses are acted upon by intelligent terminals (synapses), and what can be called mini-computers, where the impulses are detected, corrected, acted upon or entered for processing at other levels of functioning. In essence, information collected by the sensory system must be directed to the proper areas for adequate processing and integration. Numerous intelligent terminals perform many important functions and simple actions are processed entirely at the level of the spinal cord from input to output. i.e. reflex arc. The brain may receive impulses from a simple reflex arc and may cause other systemic reactions (evaluation), i.e. eyes focus on an object, head turns toward the object, etc. The body then places all this information in storage for future reference. What was once a simple impulse can become a systemic reaction that may have many sites of storage or memory.

The CPU is made up of the nervous system and its divisions: A. Peripheral nerves, B. Spinal cord, C. Midbrain, and D. Cerebellum and cerebral tissues.

Once information that was sensory data is reduced to impulses traveling along the nerve, they are acknowledged, integrated, regrouped and prepared for evaluation and storage. "The specific area for storage or memory has not been located, however, evidence suggests that it is incorporated into the structure wherever the stored information is to act."⁴ This would lead us to believe that memory is distributed throughout the body.

Complex data must be reduced to decisions in order to monitor heart rate, temperature, blood and tissue PH, nutritional needs, oxidation rates, thyroid function, muscle tone, spinal positioning and protection of injured or diseased tissue and organs etc.

The output or display function concerns itself with presenting the processed information of the CPU in a meaningful form, for it must reflect the central processing unit's evaluation of the problem. This unit of the biological computer is the

muscles and the skin of the body.

Abnormal muscle function under these circumstances takes on a new and meaningful perspective.

Muscle weakness must be evaluated and interpreted as potentially reflexing the CPU. Thus abnormal thyroid function can be efficiently displayed into the Teres Minor muscle and proper interpretation and treatment can result in resolution of both the thyroid and Teres Minor muscle aberration.

The goal of the organism is to survive a potentially dangerous external and internal environment. Massive data (input) from these areas must be processed, adapted to or reacted upon successfully. Information not received cannot be included in the CPU evaluation.

The complexity of the body necessitates an efficient organization. Apparently, it operates on at least four different levels, each being responsible for organizing and monitoring its particular area of functioning with some overlapping into other areas. We call these areas computers of different complexities. They are: 1. The cerebral computer, 2. The glandular or autonomic nervous system computer, 3. The spinal computer and 4. The local computer.

The first or primary computer relates to cerebral activity. It is by far the most complex for it is capable of evaluation, integration and storage far beyond the other levels of function. The secondary computer is called the glandular computer. It regulates most automated functions as well as monitors the Endocrine system. Next, is the tertiary or spinal computer, which is responsible for communication, integration of information, and the chemistry of digestion. The local computer is the most rudimentary and is found in the motor point of each muscle and thought to be in other types of specific tissue. This functions as the display unit of the CPU. See figure Biocomputer.

INTELLIGENT TERMINALS

The biocomputer contains many intelligent terminals which

are a network of mini-computers or sub-systems in each of the four types of computers - primary, glandular, spinal and local. These terminals are responsible for capturing, correction and monitoring of input information, along with the entering of raw data to primary computers. These terminals also act as mediators between computers, as well as monitors of the cloacals, visual and labyrinthine mechanisms of posture. Information which represents an overload to a more primary computer may be inhibited or put on hold at this level, until this information can be processed successfully. These units are important.

CENTER OF MAN

The bio-computer also has a center from which everything that occurs in the body must be focused. This center is the umbilicus, and has twelve areas that are arranged as a clock and are so labeled. Any changes that occur in any of the computers must be processed through the center of man in order to allow proper integration.

COMPUTER LOCATIONS IN THE BODY

Each computer has a primary site or physical representative area in the body. At this site, analysis of proper function of that computer may take place.

K 27

The primary physical location of the local computers (muscles) is an acupuncture point called K27. It is located at the junction of the 1st rib, clavicle and sternum. The kinetic representative of K27 are the two divisions of the muscle, Sternocleidomastoid. Thus head turning is tied to local computer function and K27 identification. The bones related to local computer are the clavicles.

HYOID

The primary physical location of the spinal computer is

stomach 9, and the hyoid bone. Its kinetic relationship is its primary muscles. They are listed as follows: 1. Anterior and posterior belly of digastricus, 2. Stylohyoid, 3. Mylohyoid, 4. Geniohyoid, 5. Sternohyoid, 6. Sternothyroid, 7. Thyrohyoid, 8. Omohyoid. Muscles that are directly related to the computer (see 1-9 hyoid muscles) record or store all adaptive information. As display units of each computer, they reflect the status of that computer in time and space.

TMJ

The primary physical location of the Endocrine computer is the temporal mandibular joint (TMJ) and associated tissues. The acupuncture point is St 7. The muscles of the Endocrine computer are as follows: 1. Masseter, Superficial division, 2. Masseter, Deep division, 3. Pterygoid Internus Medialis, Sphenoid division, 4. Pterygoid Internus Medialis, Palatine division, 5. Pterygoid Externus Lateral, Sphenoid division, 6. Pterygoid Externus Lateral, Lower division, 7. Temporalis, Parietal division, 8. Temporalis, occipital division.

EYE

The physical location of the primary computer is the eyes and its adjacent musculature. They are as follows: 1. Rectus Superior, 2. Rectus Medialis, 3. Rectus Inferior, 4. Rectus Superior Oblique, 5. Rectus Lateralis, 6. Rectus Inferior Oblique, 7. Upper Trapezius, 8. Longus Capitus, 9. Semi Spinalis Capitus and possibly more. The bones of the cranium are to the primary computer what the vertebrae of the spine are to the spinal column. The acupuncture point of the primary computer is Bladder 1.

TO REVIEW

Each computer represents a level of expression and processing. Each level is capable of input, processing and output. The hierarchy is set so that the most important decisions are

made by computers which are capable of the greatest degree of related computation. Thus problems of an Endocrine nature are handled by the Endocrine computer. Problems of a muscle level are processed at this level also. However, since a muscle is a display unit for the other computers, muscle aberration requires special attention.

KINESIOLOGY

In 1964 Dr. George Goodheart discovered a new diagnostic test for body evaluation. It was called Kinesiology and consisted of muscle testing to evaluate the musculoskeletal status of the patient. Since 1964, the body of knowledge and application of kinesiology has grown to immense proportions.

Muscle testing is computer evaluation. If interpreted correctly, adequate insight into body signs, symptoms and language are easily processed into meaningful information.

ADAPTATION

In the early stages of disease clear relationships exist between muscles and organs. Thus every thyroid dysfunction demonstrated a weak Teres Minor. Every kidney dysfunction demonstrated a weak Psoas muscle, etc. These decisions are generally a reflection of the strategy of the Endocrine computer. Perhaps at this point in time, all elements necessary for healing of the kidney are not available. The stress in the kidney and Psoas muscle are too great and the organism is threatened. This forces the Endocrine computer into a decision or what may be called an adaptation. The adaptation means in a practical sense that the weight or burden is switched to another organ. In a successful adaptation, frequently the pain or discomfort leaves and the patient may feel better even though the kidney problem still exists. In this case, depending on other variables, the Psoas muscle may return to normal tone. Switched means exactly what it says--the burden is delegated to another organ.

or tissue. Generally this results in a hypertonic organ or muscle related to that organ. To be switched, as is often stated in Kinesiology, indicates a successful adaptation. Kinetic diagnosis made in adaptive stages are less significant. This is why switching technic treatment has become so important.

As a disease proceeds in time, generally speaking, the display spreads. The muscle system may show many muscle weaknesses, but many are effects of the adaptation rather than the cause.

COMPUTER CLEAR OUT

Frequent observations by Kinesiologists suggest that the number of muscle weaknesses in an area of complaint appear out of proportion to the number of organs actually involved. Certainly not all muscles are reflecting an organ dysfunction. In painful situations, numerous feed back systems and computer adaptations lead to a mass of overriding neurological output which results in multiple muscle aberrations.

The first step in clearing the area is to perform a computer clear out. This means to activate all computers to remove adaptations, establish order and to see the underlying causative factors. If inadequate diagnostic procedure and treatment follow computer clear out, the organism will return to its prior state.

Central computer clear out is performed in the following manner:

1. The area of complaint is identified.
2. It must demonstrate a positive Palmer therapy localization. (TL)
3. Test all the muscles of this area and record.
4. Retest all muscles and at the same time, place your thumb in the umbilicus.
5. When you find a positive two point to the thumb, test to find if respiration affects the TL. Follow the non-respiratory lesion (NRL) as your priority.

6. Once you have a positive thumb that two points, find a direction in the umbilicus that two points to the muscle. There are 12 possibilities but generally the point will be toward the area of complaint.


7. Retest your muscle and confirm the direction of the umbilicus contact. You are now prepared to diagnose the test of the computer clear out.

8. Challenging the Local Computer - K27. Turn the head to the left and right and test. Follow the positive two point. If the direction of the umbilicus was 1-5, the K27 should be positive on the left with the head turned to the right. If the direction on the umbilicus was 7-11, the K27 should be positive on the right with the head turned to the left. Head turning to the opposite side of the positive K27 is activated by the Ipsilateral Sternocleidomastoid. Note your information and place the head again in neutral.

9. Challenging the Hyoid. The hyoid represents the spinal computer. Most of its adaptations are generally stored in the muscles of the hyoid. The most frequent muscle involved is the Stylohyoid muscle and is therefore challenged primarily R-L or L-R. Note your positive two point from the umbilicus and record. Leave the hyoid in neutral and proceed to the TMJ. The hyoid generally moves the same direction as head turning.

10. Challenging the TMJ-Endocrine computer. The muscles of this computer retain the storage of the adaptation. They may be hypertonic or flaccid depending on the circumstances. Most adaptations appear in the muscle Pterygoid Externus activated by opening the jaw and moving it laterally. Find the TMJ position that has a positive two point to the umbilicus contact. Place the TMJ in neutral and proceed to the eyes. The TMJ usually moves opposite to the hyoid on the same side as the umbilicus contact.

11. Challenging the Eyes-Primary computer. The eye is usually found positive on the same side as the TMJ. Activate each of the eye muscle groups and follow the one which has a positive two point to the umbilicus.



COMPUTER CLEARING TECHNIC (CCT)

1. Hold the proper direction at the umbilicus.
2. Turn the head the opposite side of diagnosed K27.
3. Place the patient's hand on the hyoid bone and push in the proper direction.
4. Move the jaw to the diagnosed position.
5. Activate the eye muscle of the patient in the proper position and hold all of the above.
6. The treating doctor now holds the umbilicus direction and taps or rubs the correct K27 and waits for harmonious pulsations. This should take 30 seconds to one minute and at the most 2 minutes.

PROBLEMS

1. If a harmonious pulse is not felt in one minute, note positions of all computer units and if necessary confirm previous diagnosed positions.
2. Contact acupuncture points or computers and bridge between umbilicus and St 9 (hyoid), St 7 (TMJ) and Bl (eye). Wait for pulsation.

The intent of the CCT is 1. To allow proper regrouping of the individual computers, 2. To allow the CPU the opportunity to reevaluate the output units and properly display the more direct causative factors, 3. Adaptive information is reassessed.

PRACTICAL APPLICATION

A Kinesiology exam of the area of complaint usually results in multiple muscle weaknesses. Following the CCT, the compensatory muscles are normalized and the primary muscles or conditions of malfunction are left to evaluate.

With the above understanding, a new conceptualization of disease may be presented. Disease can be represented as:

1. Breakdown in communications.
2. Conflict in strategies between levels of functions or computers

3. Circuit overload
4. Circuit erosion
5. Inadequate input for adequate resolution.
6. Inadequate transferring of information, nutritional deprivation, RNA, neurotransmitters, etc.
7. Priority of CPU not recognized by treating physicians.
8. Abnormal input from oral cavity, i.e. suppressive drugs, etc.
9. Computer processing at full capacity and therefore data put on hold.
10. Compartmentalization of aberrant tissue.

The CCT has performed miracles in data reduction and has facilitated diagnosis, and therefore patient response. It is presented for your patient's benefit.

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GREATER EFFECTIVENESS AND TIME SAVING IN FINDING AND CORRECTING CERTAIN CRANIAL FAULTS

by
Bruce Beddoe, D.C.

An understanding of which cranial faults tend to be associated with specific other faults, and their vectors of correction in relation to each other, can be very usefull in making the most effective corrections in the least amount of time. Specificity of correction seems to produce faster correction, often corrects multiple faults at once, and produces better results.

When a temporal bulge is found, we can be almost certain that there will be an inspiration assist fault on the same side, if it is carefully checked for. When there is an inspiration assist fault, there is usually (not always) an expiration assist fault on the opposite side. When there is a temporal bulge, we usually (but not invariably) see a parietal descent on the opposite side. Often inspiration and expiration assist faults will not show a muscle weakness with inspiration or expiration unless specific muscles being affected by those faults happen to be tested. Finding these faults by challenging can sometimes be time consuming on patients who require an exact direction of vector challenge before any weakness manifests. This situation is not uncommon. The following will explain a method to quickly find the correct vectors most of the time.

If an inspiration assist is found (or suspected), challenge it basically anterior, but in differing superior/inferior and medial/lateral vectors until the vector is found which causes the greatest degree of weakness in a previously strong indicator muscle. It is usually changes of direction in the inferior/superior plane that will cause the greatest changes in strenth. Then challenge the opposite side. If the direction of challenge for the inspiration assist side was anterior inferior, then the direction of challenge most likely to be fruitful for the suspected expiration assist

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side is posterior inferior. If inspiration assist is anterior superior, then the expiration assist side will usually be posterior superior, etc. There will, according to David Walther, usually but not always, be a medial vector on one mastoid process and a lateral vector on the other¹.

If there is an inspiration assist on one side and an expiration assist on the other side, this indicates that there is twisting or rotational distortion in the skull as well as flexion/extension. It is highly likely in this case, that there will be a temporal bulge (which is a rotational distortion). This, if present, will be on the inspiration assist side of the skull since it is an inspiration assist fault. Of course, the opposite side should then be evaluated for parietal descent.

It should be reemphasized that these correlations are only a guide to finding involvements and each suspected fault should always be challenged individually before correction is attempted.

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MORE EFFECTIVE IDENTIFICATION OF FRONTAL CRANIAL FAULTS
WITH RESPIRATORY THERAPY LOCALIZATION

by
Bruce Beddoe, D.C.

The presence of internal or external frontal bone involvement is usually detected by either therapy localization to the frontal bone just above the orbit, or the zygomatic bone on the side of involvement. It can also be detected by challenging the upper central incisor inferiorly (for external frontal involvement) or challenging the malar surface of the zygomatic bone posterior superior, posterior medial or any vector in-between (for internal frontal involvement). There are, however, problems with these approaches. Therapy localization alone, in this author's experience, often will not reveal frontal involvements. Challenging, especially for internal frontal, must be done in the correct vector, which occasionally must be quite specific. This can necessitate repeated vectoring and testing or risking not finding the involvement. Occasionally when challenging for an internal frontal, the patient will test weak due to a zygomatic sutural fault when a frontal involvement is not actually present.

The following is a technique which I have been using for the past three years on hundreds of patients with great success. The patient therapy localizes (preferably two handed) above the orbit. He is then instructed to breath all the way out and hold his breath. If a previously strong muscle becomes weak and the weakness is then abolished by a full breath in, the patient has an internal frontal involvement on the side of therapy localization. Conversely, if the patient is weak with a full breath in and strenthens with a full breath out, he has an external frontal involvement. At this point it is useful to challenge to make certain the

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therapy localization is actually a frontal involvement and that the respiratory changes are not due to simple inspiration or expiration assists.

I have found this method to be extremely reliable and correlate closely with accurate vector challenge detection of frontal involvements.

CHIROPRACTIC AND WHOLISTIC HEALTH CARE PROGRAMS

THE EPITOME, OR THE RIP OFF

by John W. Brimhall, B.A., D.C.

ABSTRACT: I heard Dr. Gonstead many years ago mention, find it, fix it and leave it alone. Many times since I had heard Dr. Goodheart say the same thing. Our goal should be, to have the ability to find it, as well as fix it when it is there. Sometimes its hard to know when it is all fixed. Kinesiology has given us a tool to help us achieve all of these goals. I plan on showing a need for concentrated care in some individuals and will show slides of pre and post conditions as achieved by the Toftness Method. Most of these conditions on a whole were treated over a period of three months with approximately thirty-five chiropractic adjustments.

I attended a seminar several years ago where the lecturer said that if you want to alleviate symptoms dramatically and be a condition treater, then kinesiology should be your technique. He farther stated that if you wanted to be a total health practitioner, Applied Kinesiology was not the approach. He said many times you were symptom chasing and causing other problems to appear using Applied Kinesiology.

One example that was cited on fixing one problem and causing another, was the half-wit brother. They stated that by adjusting the

5th lumbar the atlas became subluxated. You all know that story as well as I. Although their total concept was not true, it does make one reflect. We know that when we correct a subluxation it does not necessarily cause another one, but Applied Kinesiology knowledge of the "half-wits" lets us check another area to see if it is also subluxated because of their relationship. Another reflection we must look for in the mirror, is when we correct a problem, many times the body will allow another to surface for its correction. An example would be a patient that comes in complaining of low back pain. Through kinesiology, we identify a category two and fix it with the low back pain diminishing. The next day the patient complains that his low back is better but now he has a stiffness in his neck. Our testing methods that day could indicate a weak anterior neck flexor that did not exist the day before. It could also reveal an occiput fixation that was not there the day before. As the person had one problem corrected in the body another surfaced that had been hidden. Many times this is referred to a retracing. As we began to walk around we walk into problems that surface when a previous correction has been made. Dr. Toftness alludes to this in his teachings as well.

I state these things that you already know to be true, only to lay the foundation for what I am about to say. Some say that we should find it, fix it, leave it alone and that should take three or four visits at the most. Some say that we need x-rays for that and others say its not necessary. Some say that we need a complete examination of the entire person to know their total state of health and others say to only quickly evaluate with kinesiology and fix the

existing problem or you are trying to rip the patient off.

Some programs in Chiropractic and wholistic health care extended over many months or years and thousands of dollars. I think its easy for one person to criticize another persons philosophy. In fact, you even hear some chiropractors criticizing the work of other chiropractors. Can you imagine that?

It is not my intent to criticize anyone but to expose us to the idea that we may have the obligation to understand the entire body and watch its working relationship longer than it takes to watch the major initial complaint disappear. It is also my humble opinion that we should examine more than just the area of complaint to understand the total body. A case in point is a fifty year old man that entered our office complaining of back and neck pain. A thorough examination revealed spinal related problems in the region of major complaint as well as a pulsation in the abdominal area that caused us concern. Full spine x-rays showed calcification in the abdominal aorta. His blood pressure was also high at 160/104. I might clarify that this patient had no complaints upon entering our office that were related to any blood vascular disease, blood pressure problems, etc. I had to literally force the patient to receive medical attention at which time they air-vaced him to Phoenix and did emergency surgery. The aneurysm he had was on the verge of rapturing according to the surgeons. The M.D. that I referred this patient to said, "I hope you didn't adjust him, you could have killed him". I told him that I certainly did and that his blood pressure dropped

over twenty points following the adjustment. I also told him that a fellow M.D. in our same town had examined that same patient the week before. He found that he had high blood pressure and told him that it wasn't high enough to worry about with no further follow-up examination even recommended.

You can never assume anyone else has ruled out anything. A short time ago a man entered my office stating he was having cervical pain and headaches. I told him that it had been a couple of years since I had x-rayed him and that I would like to take new x-rays. He stated that wouldn't be necessary because he had spent ten days in the hospital in Mexico following an automobile accident. I told him that I must see for myself before I would adjust anything following an automobile accident. He muttered something to the effect that he would rather not spend the money, he just wanted his neck cracked. Upon examination of the films, prior to the adjustment, my heart stuck in my throat. The patient had an odontoid fracture. Its hard to imagine how a patient could spend ten days in the hospital and not have this discovered, but we can take nothing for granted. I had to refer this one to surgery. He didn't want to do that either because he couldn't afford it.

Only last week a patient entered our office on a referral from a health food store. The lady from the health food store called and said a man came in and wanted to know what he could take nutritionally for a prostate condition. She sent him over for a consultation and it was discovered that he had not only prostate problems but a multitude of weaknesses in the lower extremities, with right foot drop and positive orthopedic findings of disc involvement. The patient already had a

pace maker and multiple signs of vascular insufficiency.

We have all seen a carple tunnel syndrome caused from a ileocecal valve or a re-occurring ileocecal valve caused from an entire acid-alkaline imbalance. I like Dr. Harold Harper's book, titled, "Anything Can Cause Anything". As applied Kineriology Practitioners I feel that we should make as thorough examination as possible to enable us to know what "anything" is.

My major thesis is that after a thorough examination we may know more about the patient than just their primary complaint. I could have challanged the atlas-axis of the odontoid fracture and I'm sure there was a listing to find. I'm glad I didn't!

With a knowledge that there may be more than meets the eye, it may become imparative to correct more than a frozen shoulder syndrome for that patients overall health throughout their life. If we see extreme wedging of the lumbar disc at the posterior, with the weakness of the lower extremities and atrophy of the muscles, we owe it to the patient to explain to them the possible outcome, even if the patient came in only worried about their stiff neck. I would like to show some slides that are pre and post of patient x-rays where the patient received approximately thirty-five adjustments by the Toftness Methods in a three month period. I think that you will be amazed at the correction that was afforded in the length of time. I will also show multiple slides of conditions that responded to nothing more than Toftness adjustments, with no nutritional changes or any other modalities used. These conditions will include many skin conditions, diabetic leisons, Bell's Palsy, blepharoptosis and many more.

As we all know, skin conditions are some of the toughest things to help many times because they reflect the last line of defense being over burdened by impurities. When the body has to use the skin as a kidney for elimination of toxins, the whole system has to be cleaned up to afford permanency in recovery. These slides will demonstrate time after time that this can be done by removing nerve interference only and not having to do anything else. These slides also show to me how much a spine can be corrected through the removal of nerve interference. That also gives me the concept that I must know what the spine is before I begin; so that I know not only what the treatment will be, but how fast I am progressing. I must also be aware of how I am effecting the overall spine for the health of that patient throughout their entire life. I cannot be concerned only about alleviating their symptoms temporarily. We need to use Applied Kinesiology and chiropractic for more than an aspirin approach to health.

We are also finding as years pass by that there were things we missed by not being able to challenge the body deep enough or in the proper method. In others words there were things hidden, that we had no idea of how to bring up. It is my opinion, that by correcting the spine orthopedically and neurological that we are correcting problems that we don't even know are there as well as preventing other problems from happening in the first place.

In summary let me say, we must learn the best and most complete way of finding it, fixing it and leaving it alone. Applied Kinesiology has given us great ammunition for advancing in this field of health care. I pray that our minds my always be open to truth wherever we find it and our goals may be the advancement of our fellowman through better health and awareness.

IMMUNE SYSTEM ENHANCEMENT

Brent W. Davis, D.C.
John W. Brimhall, B.A., D.C.

ABSTRACT

The problem of immune system hypofunction is very prevalent and must be identified and dealt with. IMU-STIM 1, a new phytotherapeutic (herbal) preparation, has recently become available and is very effective in enhancing immune competence. Data are present demonstrating the ability of this substance to abolish A.K. reflexes suggestive of immune deficiency, and also comparing its effectiveness to other immune supporting substances.

INTRODUCTION

In treating the immunodeficient patient the primary procedures of A.K. must be utilized to improve lymphatic and blood circulation and drainage, to align osseous structures, to normalize the cranial-sacral mechanism, and so on. However, in considering the Five Factors of A.K., the nutritional component is often the key for the complete management of immune system hypofunction. Until recently, the only commonly available nutritional support for this problem has been thymus protomorphogen, vitamin C, zinc (and to some extent other minerals), and Superoxide Dismutase (S.O.D.). The authors have been involved in the evaluation of IMU-STIM 1, a new herbal preparation which is very remarkable in its ability to stimulate health immune response.¹

Immune system hypofunction is a problem which is observed clinically more and more frequently (e.g. in pediatrics where there is an increasing incidence of Otitis Media and subsequent ear surgeries, myringotomies), although it has not yet been described in mainstream medical literature as being serious. In fact, medicine is considering it normal since it is so common.

There are myriad factors which contribute to immunodeficiency²: hereditary influence, environmental pollution, dietary inadequacy, and structural and bioenergetic imbalance are just a few. It is possible that medications and

innoculations are causing thymus and immune system imbalance. We submit for your consideration that all of our inoculations may be the reason for the thymus to shrink in the adult, drug induced hypofunction and hypoplasia. Whatever the causes, the fact that this problem is prevalent must be recognized and dealt with. If the immune deficiency is chronic in nature (most are), and is not a severe genetic defect, then the properly equipped Applied Kinesiologist can provide better care than most other health professionals.

PURPOSE

The purposes of this investigation were:

1. To see how IMU-STIM 1 compares with thymus protomorphogen and S.O.D. in the ability to abolish A.K. reflexes suggestive of abnormal thymus activity.
2. To determine the frequency with which IMU-STIM 1 supports thymus function as defined by A.K. tests described below.

METHODS

Three tests were chosen as indicators of immune competence.

1. The strength in-the-clear of the Infraspinati muscles tested bilaterally. If they are bilaterally weak, it generally indicates hypofunction of the thymus.
2. Simultaneous therapy localization to the Infraspinatus NL/NV ("nutritional circuit") only if the Infraspinati muscles tested strong in-the-clear.
3. The change in strength of any strong muscle when the patient simultaneously therapy localizes the thymus and glabella.

If a weakness was obtained by any of the procedures above, then the appropriate substance was placed sublingually and the previously weak muscle

retested. The population involved in the testing consisted of patients (with appropriate symptomatology) chosen by Dr. Davis and Dr. Kathleen Power.

Due to the fact that combined therapeutic modalities were used in treating the patients comprising the test population (i.e. herbal support and varied A.K. procedures), it would not be particularly meaningful to present follow up data on the rate of recovery. We could not say what specifically promoted healing. It is worth noting, though, that the great majority of patients with chronic immunologic deficiencies, who respond positively to IMU-STIM 1 in initial testing, become asymptomatic more rapidly than similar cases in which it is not used.

RESULTS

Table 1. Although the sample presented in Table 1 is not large enough to allow meaningful statistical evaluation, it does give several strong indications.

1. In 8 cases of bilaterally weak Infraspinati muscles, IMU-STIM 1 abolished muscle weakness more effectively than Thymex in 6 cases and more effectively than Superoxide Dismutase (S.O.D.) in all cases.
2. In 4 cases of positive NL-NV therapy localization, IMU-STIM 1 was superior or equal to Thymex in 2 cases and less effective than Thymex in 2 cases.
3. In 5 cases of positive Glabellar-Thymus therapy localization, IMU-STIM 1 was equal to Thymex in 4 cases and superior in 1 case, and was generally equal in response to S.O.D.
4. If 2 units were assigned for each positive response then the following

results were obtained:	<u>IMU-STIM 1</u>	<u>THYMEX</u>	<u>S.O.D.</u>
	+52	+36	+24

Table 2. The test population in Table 2 was different from that in Table 1.

RESPONSE GRADING: ++ very strengthening, + strengthening, 0 no effect, - weakening

TABLE 1

P present, A absent, NT not tested, NA not applicable

CASE #	COMPLAINT	TEST DATES	A		B	IMU-STIM 1		THYHEX		S.O.D.	
			INFRASPINATUS		GLABELLAR/ THYMUS TL	A	B	A	B	A	B
			weak-in-clr.	NL-NV TL							
1	very frequent colds		bilat. P	NT	A	++	NA	+	NA	0	NA
2	chronic ICV incompetence recurrent infections, sinusitis		A	P	P	++	++	0	++	0	0
3	recurring cystitis		P	NT	P	+	+	0	0	0	++
4	debility and undue fatigue		A	P	A	++	NA	++	NA	0	NA
5	cervical, axillary and femoral lymphadenopathy		P	NT	A	++	NA	0	NA	+	NA
6	frequent upper respiratory infections and fevers		P	NT	A	++	NA	+	NA	+	NA
7	frequent influenza		P	NT	P	++	++	++	++	0	+
8	chronic otitis media following myringotomy surgery.		P	NT	P	++	++	0	++	0	++
9	recurring sore throats		P	NT	A	+	NA	++	NA	0	NA
10	frequent runny nose		A	P	A	0	NA	+	NA	+	NA
11	lifelong allergies		P	NT	A	++	NA	+	NA	0	NA
12	frequent colds		A	P	P	+	0	++	0	++	++

TABLE 2

RESPONSE GRADING: ++ very strengthening, + strengthening, 0 no effect, - weakening

P present, A absent, NT not tested, NA not applicable

A B

CASE #	A		B	IMU-STIM 1	
	bil.weak-in-clr.	NL-NV TL	GLABELLAR/ THYMUS TL	A	B
1	P	NT	P	++	++
2	P	NT	P	++	+
3	P	NT	NT	++	NA
4	P	NT	P	++	++
5	P	NT	P	++	+
6	A	P	NT	++	NA
7	P	NT	NT	++	NA
8	A	P	NT	0	NA
9	P	NT	P	++	++
10	P	NT	NT	++	NA
11	P	NT	P	++	+
12	P	NT	P	++	+
13	A	P	P	0	0
14	P	NT	A	0	NA
15	P	NT	P	++	+
16	P	NT	NT	++	NA
17	P	NT	NT	++	NA
18	A	P	A	++	NA
19	A	P	P	+	++
20	P	NT	A	++	NA
21	A	A	P	NA	0
22	P	NT	A	++	NA
23	P	NT	P	0	0
24	A	P	P	++	++
25	P	NT	A	++	NA

(Table 2 discussion cont'd.)

1. In 18 patients having bilaterally weak-in-the-clear Infraspinati muscles, IMU-STIM 1 was very strengthening in 16 cases and had no effect on 2 cases.
2. In 6 patients showing positive NL-NV T.L., IMU-STIM 1 was very strengthening in 3 cases, strengthening in 1 case and had no effect in 2 cases.
3. In 13 patients showing positive glabellar-thymus T.L., IMU-STIM 1 was very strengthening in 5 cases, strengthening in 5 cases and had no effect in 3 cases.

DISCUSSION

IMU-STIM 1 consists of a fresh plant tincture (alcoholic extract) of several species of the healing herb, Echinacea. Dr. Davis became aware of some of the properties of this effective herb about 10 years ago. As time passed, and its therapeutic effects were seen again and again, he became so impressed by it that he decided 2 years ago to research it in depth. A good portion of that research is presented in the IMU-STIM product description pamphlet, and will only be discussed here in brief.

Echinacea affects the immune system on many levels. An analysis of the ash of the plant reveals that it is very high in Ca, Mg, Na, K, and Si. It also contains thirteen trace minerals. The green part of the plant contains vit. C which is complexed with enzymes, organic acids and essential oils. Nutritionally we know that proper levels of Ca, Mg, Na, and K are very important in endocrine balance, metabolic oxidation rate and allergic response³. Also, Ca and Mg are both necessary for complement activation⁴. The role of vitamin C is well known.

Echinacea contains a specific mucopolysaccharide which increases the resistance of ground substance to enzymatic depolymerization by bacterial hyaluronidase⁵. Laboratory experimentation demonstrated that Echinacea has antiviral activity against Influenza, Herpes and Vesicular stomatitis viruses.⁶ The

essential oils in Echinacea have a bacteriostatic effect⁷.

CONCLUSION

The previous information indicates that IMU-STIM 1 is very effective in the prophylaxis and recovery from infections. Its positive effect on the immune system gives it a very wide application. We have used it in place of GSF and found it to be effective in reducing the stress patterns discussed in the article "Stress Without Distress" in the collection papers of winter, 1977.⁸

An interesting case is patient M.K. who had a chronic low resistance and life long low WBC count. On 6-9-81 her WBC was a low 3,800/cmm. With the addition of IMU-STIM 1 and no other additional therapy, one month later on 7-10-81, the lab report reflected a WBC of 5,000/cmm.

Nutristasiometer testing shows that IMU-STIM 1 or Echinacea answered over half of the reflexes that tested positive on 90% of 30 patients tested.

Patients with some types of food allergies also found Echinacea to be effective to reduce symptoms of allergic reaction.

Two point TL to thymus and other organs show the immune system to be responsible for both subjective and objective findings. The herb Echinacea was found to abolish 90% of these two point therapy localization.

Dr. Davis has a special interest in the development and evaluation of new and highly therapeutic herbal preparations and their application to A.K. At this time he is experimenting with a plant which is virtually unknown outside of Central America. The bark of this particular tree appears to be exceptional in the management of hypoglycemia. Continued testing is necessary, and Dr. Davis would welcome response from members who would have an interest in assisting with this and future evaluations. (He is also working on an herbal formulation to support the adrenal glands, something which is difficult to do, on a regular basis, with existing herbal or animal tissue preparations.) Dr. Davis' office address is 453 N. Lake Ave., Pasadena, California 91101.

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We hope you find this herb and others to come to be as helpful as we have.

NOTES AND REFERENCES

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The Amazing Love Pain Treatment

Roger J. Callahan, Ph.D.

Abstract: The severely disruptive pain of romantic rejection is discussed and a highly effective treatment is presented.

Jeffrey is a very successful professional man. For the last three months, however, he has been rendered non-functional. He has had to cope with the most disruptive acute psychological pain that he has ever undergone in his forty-three years of life.

The pain resulted from the rejection he received from the woman with whom he was passionately in love. He had always "played it cool" in his previous romantic relationships. However, as a result of successful psychotherapy, he had significantly reduced his amorophobia (3) so that he was able, for the first time that he could remember, to fall intensely romantically in love. It was great while it lasted.

Unfortunately, Linda had many unresolved problems herself about romantic relationships and she rather abruptly terminated their relationship. This decision, or more precisely, Jeffrey's reaction to this decision, resulted in Jeffrey's severe state of emotional disruption.

The simple treatment described below allowed Jeffrey to receive immediate relief from his severe suffering. Perhaps more importantly, he was able to rationally begin a potentially effective campaign to win Linda back and the latest I heard, it sounds somewhat promising. In any event, Jeffrey knows he will recover nicely even if it shouldn't work out with Linda.

Typically, the treatment described gives immediate significant relief followed by a growing profound relief over the next twelve hours.

Objectively, love pain is not the worst psychological problem that can befall an individual, but it feels like the worst problem while it is active. The recovery rate is usually high although there are often lingering psychological scars which can have considerable impact on a person's personal life.

In my thirty plus years of psychological practice, I have never seen anything cause more disruptive acute psychological suffering than love pain.

This suffering is often at the root of severe depressive disorders. Love pain is no doubt one of the most significant causative factors behind many suicides, especially among younger people, and it is a significant source of homicides (e.g., "The Scarsdale Diet" doctor's murder).

Love pain actually has numerous nuances and facets. Parts of it are an appropriate emotional response to a loss situation and parts of it, the worst parts, are inappropriate neurotic responses consisting of two devastating aspects:

- 1) a feeling of being by nature a romantic loser; not worthy of being loved, and 2) a feeling that it will always be this way.

The love pain treatment is directed toward the neurotic or inappropriate and severely disruptive responses.

Treatment

The treatment consists of the following:

1. Check for a psychological reversal. It is especially common in the romantic realm. Ask the patient to say, "I want to reduce my love pain" and check a strong indicator muscle and repeat for the sentence, "I want my love pain to get worse". Correct the reversal if present (1). I estimate that reversal correction improves success rate by at least 30%.
2. Ask individual to think of love pain and check indicator muscle. Usually it will be weak in the clear. Have patient touch alarm point for bladder and indicator muscle should now be strong when patient thinks about his love pain.

3. Put an acu-aid at bladder 67, or the lateral side of both little toes just behind the nail and to the side (because of the shape of the little toe). Patient will now test strong when thinking of love pain. If acu-aids are not available, any treatment directed toward the bladder meridian will correct the weakness and patient should be instructed on how to provide treatment as needed.

4. If acute love pain returns, it is highly likely that the psychological reversal has returned. Correct the reversal and show patient how to correct it. Have the patient think of the love pain and while continuing to hold that thought have him say, "I accept myself deeply". I also have patient tap the tip of his little finger (P.R. is associated with small intestine meridian) while stating his acceptance of himself.

5. If stomach meridian blows, it is likely that the individual's amorophobia (3) is being evoked and this phobia can be treated like any other phobia (2). Amorophobia is stomach meridian and an acu-aid is placed at stomach 45.

Treatment Response

The response to this treatment has been most gratifying. Over the years I have seen love pain sufferers try all kinds of treatment to get relief from their acute disruptive

psychological pain. I have seen them dose up on tranquilizers, medication and anti-depressants in futile attempts to blot out the pain. I have seen them try huge doses of alcohol to no avail. When the drugs wear off and awareness returns, the horrible unbearable pain comes right back.

Nothing that I have ever seen or heard of gives the relief that this simple natural treatment can deliver. Patients are more appreciative of this treatment than any other that I, as a psychologist, give. That is why I call it "the amazing love pain treatment".

I would greatly appreciate hearing of your experiences with this procedure.

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TEACHING CRANIAL ADJUSTING

Katharine M. Conable

ABSTRACT: An approach to teaching cranial faults is presented, based on a fast testing pattern which covers all of the cranial faults taught in the ICAK 10-session basic syllabus.

I have always considered cranial adjusting both easy to learn and particularly rewarding clinically. It has always been a surprise, therefore, that my students often were reluctant to approach this area and to use the simple and powerful techniques in the 100-hour ICAK syllabus.

Through trial and error, we have discovered that a key to getting students comfortable with new material is to present a smooth testing sequence into which all of the procedures fit. I saw this approach first in Touch For Health Instructor training, where muscle tests were taught in one sequence and drilled over and over until they were easily done. Goodheart's Workshop Procedure follows similar principles. We now use this principle in our presentation of cranial adjusting and have had enthusiastic response from our students, with much greater subsequent application in their practices, than when we organized the material in an anatomical sequence.

We first teach the basic principles of respiratory movement of

skull, spine, and sacrum, with Walter Schmitt's simplified presentations of the motions. We also demonstrate that respiratory changes in muscle function occur. As we teach each specific fault, we fit it into the following pattern, which becomes a very fast scan, through all of the major cranial faults:

Faults identified by respiratory pattern:

<u>Weakness* produced by</u>	<u>Fault</u>
Nasal: inspiration	Expiration Assisted (Mastoid)
deep inspiration	Augmented Expiration Assisted (Sphenobasilar Flexion)
expiration	Inspiration Assisted (Mastoid)
deep expiration	Augmented Inspiration Assisted (Sphenobasilar Extension)
$\frac{1}{2}$ expiration	Temporal or Parietal Bulge (Banana Head)
$\frac{1}{2}$ inspiration	Parietal Descent
Oral respiration: (usually inspiration)	Glabella-E.O.P.
One nostril only	Universal Cranial (Intraosseous)

* Throughout this paper the term "weak" refers to the state of neurologic inhibition of the motor nerve to the muscle, or the "non-intact" state, rather than to any lack of muscle bulk. Similarly, "strong" will be used as short hand for the "intact" or facilitated state.

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3.

Faults identified by challenge:

in on zygomatic arch:	internal frontal bone
down on canine eminence:	external frontal bone
apart, together, side slip, or torque:	sutural: squamosal zygomatrics sagittal lamboidal

In testing this becomes:

"Take a breath in through your nose (test). Take in more air. (test). Let your air out (test), let more air out (test). Take a normal breath and let it $\frac{1}{2}$ out (test). Let it all out and take a $\frac{1}{2}$ breath in (test). Take a breath in through your mouth (test)-(This is for the occasional Glabella fault that shows weak on expiration, Correction is established by challenge- usually side-to-side compression of the head)- Block one nostril and take a breath in (test)." The doctor then systematically challenges all sutures, per the pattern.

Note that on the respiratory-pattern faults, ruling out the earlier faults in the sequence is necessary for positive identification of the later faults, such as Glabella-E.O.P.. The pattern does this for the doctor, and can be used as a review teaching tool- For example, "We know it's not a simple expiration assisted fault because it was not weak on simple nasal inspiration. Nor is it augmented expiration assist because it was not weak on augmented nasal inspiration. Therefore when it weakens on oral inspiration it must be a Glabella E.O.P. fault." Every time we show a new fault, we go through the pattern to that point, showing that the other faults are

not present, and at the same time grooving in the sequence of testing for the students.

On cranial faults identified by challenge, we teach a hard and fast rule: "Adjust in the direction that produces weakness on challenge during the phase of respiration that produced strength (or countered the weakness)." We repeat that over and over and over throughout the ten sessions.

By session #8 in the 100-hour syllabus, we have developed a smooth testing pattern, and can review anatomy, physiology, muscle, organ, and syndrome relationships of the cranial faults. Thus the student feels easily able to use them in practice.

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" CHIROPRACTIC MERIDIAN ADJUSTING "

By Dr. E.J.Cousineau, D.C.

Abstract:

To explore the possibility that spinal adjustment of only the Associated Vertebrae of "involved " Meridian would constitute an "wholistic" approach to the patient's health problems.

Introduction

The five fingered approach to the patient's health problems as proposed in Applied Kinesiology by Dr. David S. Walther (1) and Dr. Fred Stoner (2) includes the challenging and adjusting of the Associated Vertebrae of the Acupuncture Meridians among the five things to be treated or corrected.

The criteria in Applied Kinesiology was always the presence of the weakened muscle which was believed to be contributing to the spinal distortion and recurring vertebral subluxations resulting in the patient's health problems.

The grouping of all the muscles into twelve groups or Meridians appeared in both the manuals by Dr. Stoner and Dr. Walther, and later in Dr. John Thies revised edition of "Touch for Health" (3)

These have been reproduced in the accompanying chart by your author taken from the above-mentioned manuals with the improvements resulting from this author's research into the use of these Associated Vertebrae of the Acupuncture Meridians.

<u>Associated Vertebra</u>	<u>Symbol</u>	<u>Meridian</u>	<u>Muscles Involved</u>
T 4	Lu	Lung	Deltoids, Coracobrachialis Anterior Serratus, Diaphragm
T 5	Cx	Sex-Uterus Prostate	Gluteus Medius, and Piriformis
T 6	Ht	Heart	Subscapularis
T 7	Gv	Governing Vessel Acid-Alkaline Balance	Teres Major
T 8	Cv	Conception Vessel Brain	Supraspinatus
T 9		Pancreas	Latissimus Dorsi, Triceps
T 10	Liv	Liver	Pectoralis Major (Sternal) Posterior Tibialis
T 11	GB	Gall Bladder	Popliteus, Anterior Deltoid.
T 12	Sp	Spleen	Middle & Lower Trapezius
L 1	St	Stomach	Pectoralis Major (Clavicular) Neck Flexors & Extensors Levator Scapularis Biceps brachii, Brachioradialis Opponens Pollicis
L 2	TW	Triple Warmer Thyroid Adrenals	Teres Minor, Infraspinatus Gastrocnemius, Soleus Sartorius, Gracilis
L 3	K	Kidney	Psoas Major, Iliacus Upper Trapezius
L 4	Cx	Ovaries - Testicles	Gluteus Maximus, Adductor Temporo-Mandibular (Switching below the Diaphragm)
L 5	L.I.	Large Intestine	Tensor Fascia Lata, Hamstrings Quadratus Lumborum
S 1	S.I.	Small Intestines	Quadriceps, Abdominals: Rectus, Transverse, Obliques
S 2	BL	Bladder	Sacrospinalis, Anterior Tibialis, Peroneus: Longus, Brevis, Tertius. Rotatores: Longus, Brevis. Levatorum Costorum

Note: Adjusting the vertebral segment in Column One will turn on or strengthen every muscle in the Muscles Involved column. Adjust its spinous process in the direction of subluxation as revealed by the Challenge Method.

Came the Big Idea:

The thought occurred to your author that the spinal adjustment by chiropractors to remove vertebral subluxations, was actually, although unintentionally, strengthening all the muscles in the Meridian group controlled by its Associated Vertebra. How lucky can one be.

The thought further persisted that perhaps the Meridians were a better indicator of where to adjust, when to adjust, and why than were the neurology charts provided the students by their chiropractic colleges. Had not the chiropractors always criticized the medical profession for treating symptoms instead of the "cause" ?. Now here we were given a chart that showed the vertebral segment controlling the muscles to be other than that taught in our schools.

Consulting the accompanying chart, we find the muscles holding the sacroiliac together, namely the piriformis and the gluteus medius, to be controlled by fifth thoracic (T-5) which is the Associated Vertebra for Sex Meridian and associated with the uterus and prostate organs.

Further, the first lumbar is the Associated Vertebra for the Stomach Meridian. I can remember back in my early days in practice, when adjusting the 1st lumbar for lower back complaints elicited comments by the patient as to how much improvement they had in their digestive processes. But when I had adjusted the fifth thoracic for stomach problems, the patient had commented how much better their low back had been.

Testing Procedure:

Your author began in 1978 to test this idea by first testing all the muscles on the patient's first visit according to the examination list of muscles by Dr. Stoner in his manual. Next the twelve Meridians by challenging their Associated Vertebra on its spinous process from left to right and then from right to left, using a p.s.m. (previously-tested strong muscle) as the indicator. When all were listed then only the Associated Vertebrae were adjusted if they showed involvement or weakness of any of their muscles or on challenging. Then all the muscles were retested, as were the twelve Associated Vertebrae. for increased strength if they had tested weak before.

Results:

The results exceeded the fondest wishes of your author. The chiropractic adjustment of the Associated Vertebra of any involved meridian, definitely turned on ALL the muscles of that Meridian, and simplified the whole procedure. Soon we were able to check for involved meridians by challenging only the Associated Vertebra, then checking with only one of the muscles of the group belonging to that meridian, knowing that all were involved or weakened. And post-adjustment all muscles on that meridian grouping would test strong.

In the beginning of the research we also checked the pulses of the Meridians and would find them to be involved also if the Associated Vertebra and the muscles of its group were weak or involved.

Patterns:

On subsequent office visits, the entire list was re - checked both as to muscles and Associated Vertebrae, and pulses. At first on a new patient there were as high as eight to ten of the meridians involved, especially on chiropractors as patients, But later on subsequent visits, the number of meridians would drop to five and then to three and finally to the same ones, which usually were Stomach, Gall Bladder and Sex-(Circulation), which we found due to the stress syndrome.(4)

Results:

This method was the usual procedure in our office for over 1000 visits per year for the last three years. And there were many improvements that made the system workable and rapid. The important thing was the results were so quick in obtaining, as it was almost as if the patient with all his accumulated faults, cranial, pelvic, traumatic, etc. were really "turned on", or "All systems Go". My receptionist was the one who would report back to me their remarks as they left the office, of how much better they felt.

Improvements and Developments:

There have been many developments that were spin-offs from this investigation, each of which deserves a research paper of its own. A few can be listed here:

1. The right elbow-pronation subluxation in place of the carpal-tunnel syndrome as a producer of "switching of left brain activity" (5) reported in 1980 Summer Collected Papers.

2. Pancreas was assigned to T-9 (Ninth Thoracic) with the latissimus dorsi and the Triceps, leaving Spleen on T 12 with Middle and Lower Trapezius.

3. Latissimus Dorsi weakness on ingesting or tasting sugar on the tongue, produced strengthening of the opposite latissimus dorsi which had tested weak before ingestion. This was eliminated by adjustment of T-9, and of C-5. This was previously demonstrated by having patient turn his head to right then to left and noting left head turn corrected sugar mechanism unbalance.

4. Muscles associated with the Adrenal Gland, and which formerly on Circulation-Sex Meridian, were found to respond on Triple Warmer Meridian, where Thies had them in Touch for Health. These were Sartorius-Gracilis, and went with Gastrocnemius-Soleus.

5. Gall Bladder Meridian was more easily checked when using the Anterior Deltoid, along with the Popliteus as an indicator.

6. Rhomboids were found to respond to T10 for Liver Meridian instead of Stomach Meridian.

7. Sex Meridian was found to contain Gluteus Medius-Piriformis associated with Uterus-Prostate organs on T-5.

8. Gluteus Maximus-Adductors associated with Ovaries-Testicles was the biggest discovery. Their weakness would persist when T-5 was adjusted for Sex Meridian. They would produce the Derifield Negative Short Leg which stayed short on flexing the knees while patient was prone, and which were not removed by a cervical adjustment. These were found on Lumbar Four (L-4),

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Developments (Contd.)

which immediately evened the leg shortage of the Negative Derifield Leg Check.

9. Switching below the Diaphragm was corrected by Lumbar Four also. This would reverse weakness in muscles on the Large Intestine Meridian, when the quadratus Lumborum and the Hamstring would be weak on one side of the body, same as the Abdominals and Quadriceps of the Small Intestine Meridian. When they were both on the same side of the body, adjusting the talus and the cuboid subluxation of the right foot would immediately correct this, and L-4 would be present every time. This extremity weakness would cause the left psoas and right adductor to go weak recurrently, until adjusted.

10. The greatest improvement was the ability of the doctor to surrogate test the patient's Meridians and each of the muscles on that meridian, by simply touching it with the fingers of his right hand, similar to T-L or Therapy Localizing by the patient. Testing a convenient patient strong muscle, such as the posterior neck flexors (with patient prone) with the doctor's left hand, and the doctor's right fingers therapy localizing by touching the questioned structure. The left hand fingers are flexed or grounded into a fist to prevent T-L by the Doctor's Meridian Beginning and End Points which are on his finger tips. If his Meridians are "involved" they will reverse the patient's test result. This is a fantastic improvement and a later subject.

Conclusions:Chiropractic Meridian Adjusting IS:

A completely "SFINAL" System of Analysis and Adjusting

A "Corrected" Meric System of Spinal Adjusting.

A Simplified Method of Applied Kinesiology which reduces
the many muscles of Kinesiology to 12 Meridians
each of which is:

Associated with only One Organ and is

Controlled by One (Associated) Vertebra

All Chiropractic;

was discovered by Chiropractors

was developed by Chiropractors

It is all Chiropractic and belongs to the profession.

Summer 1982

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SURROGATE TESTING BY THE DOCTOR
DURING ARTFUL MUSCLE-TESTING OF THE PATIENT

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

Abstract

To reveal a possible error and its correction during artful muscle testing of the patient by the doctor.

Introduction:

The ability of the patient to Therapy-Localize problem areas on his body by placing the extended fingers of his hands either singly or jointly, using either the palmer or the volar sides, is well know in Applied Kinesiology since it was originally introduced as the "Kitty Goodheart "technique, as it was affectionately named after Mrs. George Goodheart after her passing. The method is adequately described by Dr. Walther in his manual on Applied Kinesiology (1). The method of what is called Transference or Surrogate Testing is mentioned in the manual by Dr. Fred Stoner (2).

I am further indebted to Dr. Wallace Gunn, D.C. (3) for his monograph on "How to Treat a Magnetically Imbalanced Body" page 122 of the Collected Papers of the ICAK at their 1979 Summer Meeting in Detroit, Michigan. In it he mentions using the End and Beginning Points of the Meridians to demagnetize the meridian. He further indicated that the treating doctor could accomplish this feat by using the ends of two fingers of the doctor's hands when rubbed across the patients beginning and end points of the patient's imbalanced meridians. Thus was the seed sown for my

further investigations.

The question arose in my mind, that if the patient could therapy-localize by using his finger tips on his own body, then what happened when the doctor placed his hands upon the patient in grasping either extremity to test a strong muscle or using his other hand only for a stabilizer while testing.

Further checking of the beginning and end points of those meridians that begin or end in the finger tips of the hand, revealed that the threemiddle fingers (not thumb or little finger) were those belonging to the meridians most frequently imbalanced. The C.I.F., or middle finger belonged to the Sex Meridian to which the gluteus medius and piriformis, the sacroiliac stabilizers, belong. The Pointing Finger or Index Finger contains the end point of the Large Intestine Meridian, which has the Fascia Lata and Hamstring on its meridian. The Fascia Lata is a favorite intact muscle for testing as a p.s.m. or previously strong muscle. If it goes weak on testing after challenging a particular vertebra or structure, it is considered a valid test.

My investigation has shown that if this finger is placed or touched to a previously tested area of imbalance, an intact muscle will not go weak on muscle testing, since the negative finger will cancel the therapy localization of the involved muscle or area. In other words two wrongs do make a right or they cancel each other out, and no weakness results in the test. This is true only if the owner of the finger has an imbalance in the large Intestine Meridian. The remaining finger of the three belongs to Triple Warmer Meridian (Thyroid-Adrenal), and it becomes imbalanced, but not as frequently as the other two. Mostly, when

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the patient is under some emotional stress involving energy output not of their own choosing. More like an "I gotta", and not an "I want to" type. This produces an energy shut-down, and a hypoglycemia very quickly.(4) If the doctor tests an intact muscle and asks the patient some simple question, such as: "Do I gotta ?", the intact muscle will weaken, if the patient has an imbalance on this meridian.

The point in question is that these are three meridians which are on fingers which are constly and frequently placed upon some portion of the patient's anatomy during the testing of an intact muscle.

Many times the testing doctor takes hold of the patient's forearm at the wrist area and attempts to test the extended arm held out in front of the patient, and uses it as an intact muscle. This is especially noteable in the Sacro-occipital arm test of the patients inguinal fossa along Poupart's Ligament for an indicator of upper or lower fossa involvement. The testing doctor will have the patient's arm grabbed in his hand with the doctors fingers covering the acupuncture pulses. So the results are questionable. If the doctor had an involmnet of any of these three vulnerable meridians he would cancelout possible imbalanced meridians of the patient, and produce others as imbalanced when in reality they were normal. Two involmments can cancel out each other. Hence we would miss meridians needing attention and treat those that are O.K.

Surrogate Testing by the Doctor + Cousineau (Contd) page 4.

Another possible error is the doctors hands holding the leg extended sideways with the patient supine, and testing the fascia lata of the patient. The doctors fingers grip either the inner muscles of the tibia or even the posterior tibialis, which is on liver meridian. If he is grasping the leg to test an adductor, he many times grabs the sides of the fibula where the peroneus muscles of the bladder meridian are present. The bladder meridian contains the sacrospinalis or spinal musculature upon it which is a frequently imbalanced meridian.

The list is getting longer.

The doctor can also have involvment of his meridians that lie on these three fingers. He will then be surrogate testing his own dysfunctions upon the patient and the patient will go weak or strong in response to what the doctor has present.

We are aware of the fact that the Therapy Localizing tells only that a structure is at fault, not what. So when we grasp the patient by either of his extremities, we may be therapy-localizing our own wrist and hand and elbow problems by surrogate test on the patient. I have seen this happen too many times.

Self-Testing or Clearing:

One of the first things we do in our office in the morning, is before we test the first patient for their problems, we have the patient put forth his arm and we test ourselves first, using his arm. We test for switching, using left brain activity. We test for the color pink by thinking of pink, to correct for any sugar imbalance that might exist in us. Then check each of

Surrogate Testing by the Doctor - Cousineau (Contd) page 5:

fingers of the testing hand. We have found that the right hand will not usually be at fault, and is a valid surrogate test on the patient. Our left hand is the problem. The thumb is the Lung Meridian End Point, and seldom is in trouble, unless we know we are having a respiratory problem. Then we know to test it also. The little finger has the Heart and the Small Intestine Meridian End Points on it, the Heart on the inner side, and the S.I. on the external side near the finger nail. The Heart Meridian is seldom in trouble unless there is an imbalance in the Gall Bladder Meridian, which is very frequent, since it follows Stomach Meridian. Stomach is the most frequently found unbalanced meridian of them all, but both of these have their end points on the toes. So these are safe meridians and do not interfere with T.L. or the Surrogate Testing. Test your Stomach and G.B. end points on your face near the left eye.

The Solution:

To prevent the possible unintentional surrogate testing of the doctor's faults or meridian unbalances is simple. All he need do is make a fist of all the fingers of his hand just before he makes the muscle test. He can use his hand to position the patient's extremity, either arm or leg, before testing, but as soon as he applies strength to test, he closes the fingers of his hand into a fist. It works so very nicely. Just try it a few times, and you will find you can change the patient's test at will just by which finger you use to test with. You only have to touch the patient to drain his energy and make him weak.

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Self-Testing

The beauty of this is that the doctor can use the patient or any nearby person to test his own material. He need only find a friendly, strong arm that can be used. Then he can whistle up a tune, count numbers, or use his right hand to T.L. any of the Meridian End Points that end on the face or on the body, and that are handy to reach. He can check all twelve of his meridians, and use upper and lower lip for the end points of Conception Vessel and Governing Vessel. He can hold his face or mouth open or shut, or his jaw projecting left or right, and check his TMJ. In short, there is much he can do for himself.

Handy Muscle Testing.

Another very handy method is to merely test the muscle of the patient that you know lies on that meridian, and when you place the tips of the fingers of your right hand upon that muscle and test an intact muscle with your left hand (fist closed), you will quickly know if that muscle is weak & whether the meridian having that muscle on it, is involved. If weakness ensues upon testing the intact muscle and touching the belly or even the origin or insertion of the muscle, if it is involved, the test muscle will weaken. You can check Spindle Cell or Golgi tendon receptor by this method also.

Spinal Testing

In challenging the Associated Vertebrae, the doctor need only touch or contact the side of the spinous with the tip of a finger of the right hand, usually the index finger, and test an intact muscle, usually the neck extensor with the patient prone, and he will be able to quickly check all the patient's meridians for imbalance.

The doctor can check spinal muscle fixations by either muscle testing, but more simply by straddling the spine with two fingers of his right hand, one finger upon the transverse above on one side and the other finger upon the transverse either below or above that and test an intact muscle. If weakness results on testing, then adjust those structure in the directions they indicated, either with recoil or by the thumbs using the non-force technic, quickly and lightly but firmly. This can restore a thoracolumbar spinal fixation in seconds, and when a bilateral lower trapezius muscle test is attempted, testing both muscles simultaneously, the response is immediate and very strong, when before it is very weak.

Hyperextensions or hyperflexions of the paraspinal muscles on the vertebral segments can be tested by simply using the two fingers to straddle the transverse processes of the segment and applying stress superiorly or inferiorly caudad. If an intact muscle tests weak, then adjust in the direction of weakness with a quick, light thrust and the click will ensue and the post check will test strong.

Conclusions:

We have seen that the test hand of the doctor may contain carpal-tunnel or elbow faults, can be either switched, or contain meridians that begin or end on the middle three fingers that are themselves unbalanced, and may counteract or negate the results of the the patient's therapy localization. The patient's middle three fingers contain meridians that may themselves be unbalanced, and when he contacts his own body surface to T.L., he may neutralize the resultant weakness and cancel out the test. Knowledge of this possibility can prevent false answers and provide much useful data.

The knowledge that the doctor can now T.L. his own body surface, his own meridians, and can be sure that he is not complicating the test results of the patient is a positive step in artful testing by the doctor of his own and the patient's health problems.

I do not know why the right hand's fingers will T.L. properly, and show no meridian imbalance while the left hand and fingers will. But that is the results of my testing.

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BIOLOGICAL AND THERAPUTIC EFFECT OF LASERS

by

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

ABSTRACT: This paper deals with the application and therapeutic effect of laser light applied to the human body and substances taken into the human body. The yard stick measurement used to determine the benefit or detriment of the laser light is standard kinesiological muscle testing.

The word laser is of English origin and stands for Light Amplification by Stimulated Emission of Radiation. The principle of the generation of laser beams is accomplished by subjecting a laser medium; which could be a solid, liquid or gas, to energy from a suitable source, whereby a sufficient quantity of molecular systems are stimulated. The resulting radiation is reflected back and forth between the two resonator mirrors along a fixed axis until it has amplified its own energy sufficiently and it then emerges through the resonator mirror; which is only partially reflecting.

Lasers are divided into solid, liquid and gas lasers according to the type of laser medium employed. For example, helium lasers are gas lasers, liquid lasers are, for the most part, those which employ dyes. At the present time there are a large number of dyes used in suitable solvents. Solid state lasers, such as the ruby laser, are noted for their compactness and high efficiency. Today by varying the laser medium we can generate laser beams of particularly every wave length between ultraviolet and infra-red. The source of energy can, according to the type of laser, be an electrical discharge, a chemical reaction, light energy from a gas discharge lamp, molecular heat or even another laser. A distinction is drawn between permanently active lasers; which produce more or less constant beam, and pulsing lasers which produce a series of very brief but very intense impulses. Modern pulsing lasers can achieve an output in the gigawatt range. While permanently active lasers have an output which varies from a few microwatts to several hundred kilowatts. The beam produced by the above process has three (3) typical characteristics;

which have many interesting applications.

1. THEY ARE MONOCHROMATIC. This means only one particular wave length is reinforced or amplified so that the beam shows only a very narrow line on the spectroscope. Laser beams therefore give colors of a purity, not normally found in natural circumstances.
2. THE BEAM IS COHERANT. Because of the amplifying effect there is a fixed phase relationship between the various parts of the laser beam. Therefore, it is highly resistant to interference. In other words, all the waves in the laser beam oscillate uniformly. They keep in time; which is not the case of ordinary light. This is generated by a number of individual sources emitting their light independently. Laser beams therefore have a high degree of uniformity and coherence; which cannot be achieved by normal light.
3. THERE IS LITTLE SCATTERING. Since only those beams in the vicinity of the axis of the resonator mirror are amplified, the beam emitted is to a large extent parallel. It is therefore possible with the aid of lenses or mirrors to reduce it to a very small focal point.

Because tissue has varying optical properties, laser beams do not proceed in straight lines in our bodies as they do in the air. Any number of scattering processes take place which cause the beam to change direction frequently. This scattering is also greatly dependent upon the wave length and type of tissue, but in general red and infra-red light are scattered less than blue and ultraviolet.

Soon after the first experimental application of laser beams in medicine, a surprising discovery was made. It was found that it was possible to accelerate the healing of resistant ulcers to marked extent by irradiating them with a very low intensity helium beam.¹ Up to the present time no satisfactory physiological explanation of these results have been given. Perhaps the theory recently advanced by ²Fritz Albert Popp may provide a starting point. Popp considers that in addition to the commonly recognized chemical regulating process which takes place in a cell, there is a second system of at least equal importance. According to him, light and sound waves are responsible for the distribution of a greater part of the information

required by the cell system; both internally and externally in the associated organism. Such exchange of information can only take place optically in the red or infra-red range where the cells' substance has the greatest transparency. A cell and its organella have a light and sound spectrum of their individual waves similar to that of a simple regularly constructed crystal chain, such as the sodium chloride crystal. Naturally a cell is a far more complicated structure from a physical point of view than a single crystal. It is therefore understandable that the individual wave spectrum of a cell is a very complexed thing.

Moreover individual wave systems are connected with each other by processes which exchange energy and information. From this point of view, a cell is in a pathologic condition when its oscillations vary or when, for example, they are weakened by the absorption of foreign matter into the cell. A pathological cell is no longer plugged into the common communication system, it is out of step, so to speak, and can actually behave in a harmful way.

We now know these influence the entire relationship of the organism with its environment and can help to counteract the disturbances which arise therefrom. We can regard the meridian system as a kind of defense mechanism against environmental disturbances and it is therefore clear that any irregularities in the system must have a harmful effect on the body as a whole. From what has been said, it is easy to comprehend how laser beams can be used. Because of their coherence and ease of control, and their spectroscopic purity and selectivity. Laser beams can help to restore the wave structure of the cell to its normal healthy state. One can describe the effect as a wave field resonance induced by low powered lasers. In other words, kind of a physical homeopathy.

Other medical applications of lasers include cutting. For example, carbon-dioxide lasers and those with wave lengths of more than five (5) micrometers are very suitable for cutting tissue without loss of blood, as long as only capillary blood vessels have to be severed.

Another application is for use of coagulation. Argon lasers are suitable for trouble free long term deep coagulation. And also in some cases, for the removal of small pieces of tissue. Such laser systems have been used very successfully in endoscopy. In such cases the light conductor is inserted in the biopsy tube of the endoscope. Other important applications are the stopping of bleeding in the esophagus, stomach and bowels.

The most effective method of treating many skin diseases is the radiation of large areas with a red laser beam. The end of the light conductor is angled in such a way that a broad infra-red beam is obtained when the conductor is held a short distance away from the area which is to be irradiated. When the laser's frequency is adjusted to the optimum frequency of the cell, a healing influence can be exerted and wounds resulting from burns, operations, scrapes and cuts can be healed much quicker.

Another application is acupuncture therapy. According to the bio-electric diagnosis, the local resistance of the skin can be used as a yard stick to determine whether certain organs or groups of organs are in a normal or pathological state. By applying a small charge, about .25 volts, for measuring purposes a small electrical current is made to flow between a hand electrode and a point electrode. While normal readings are less than one (1) milliamp, there are certain points in the body where the current rises between four (4) and ten (10) milliamps. These points are, for the most part, those which are known in classical acupuncture. For purposes of bio-electrical diagnosis a current of four (4) to five (5) milliamps is a normal healthy reaction, and any considerable variation above or below this figure indicates a pathological state.

Experiments which have been carried out prove that even weak laser beams can produce a measureable effect. For example, radiation with one (1) milliwatt output of a helium laser can normalize the skin resistance in a few seconds.

What we have seen with patients kinesiologically, is that a substance that the patient is allergic to, can be changed. This is demonstrated by a previously strong muscle going weak when that substance is placed in the patient's mouth.

If we take that substance and apply the laser light to it and then retest the substance in the patient's mouth, no change takes place. But if we have the patient hold the substance while the laser light is applied to it, and then replace it in the mouth we see that the previous weakening does not occur. This would suggest that the substance is now compatible with the patient's body. What has taken place is the previous allergic reaction has been done away with. In an effort to explain why it made a difference, why the patient held the substance, we point to an explanation from the scientist Fritz Albert Popp.³ He claims that the skin emits an ultra weak photon emission. The fact that the skin emits this radiation has been the subject of many experiments for over 20 years. The fundamental biological property of these photons has been disputed. On the other hand, there are grounds for suspecting that they play an important part in cell communication and related phenomena. It is not only believed that this radiation can be utilized for communication within the living system, but that it also transfers genetic information. It is believed that the cells mainly emit photons even before mitosis.

The key assumption here is that ultra-weak photon emission from biological systems is governed by photon storage within the cell population. Provided that biological systems have the ability to store coherent photons they cannot exist in thermal equilibrium. The more the molecules are excited the higher is the spectral emission rate in the corresponding spectrum range. Furthermore, this increases with increasing spectral photon density because of stimulated emissions. The stimulated electromagnetic wave is thereby amplified, hence, the end result is Light Amplification by Stimulated Emission of Radiation; which as previously stated is abbreviated to laser. This boils down to the fact that ultra-weak photon emission must be attributed mainly to the spontaneous emission of excited molecules within the cell population. This fact alone implies the ultra-weak photon intensity can regulate the whole cell metabolism.

The measured intensities can be truthfully interpreted in terms of feedback mechanism within the cell population; which are responsible for stabilizing the

spectral energy density.

So what we think is happening when the patient holds the substance in their hand to be radiated by the laser light, is that the micro laser light beam emitted by the person's skin is penetrating that substance and when that substance itself is radiated by our mechanical laser light, the combination of the two laser emissions (one coming from the skin and one coming from the mechanical laser) are producing a change in the vibratory rate of the substance that the patient previously showed to be allergic to. In effect this neutralized the allergic reaction by tuning that substance to the patient's body. Now this sounds like a great way to treat allergies, but the catch is it only works on the substance that was held at the time. In other words, if the patient is allergic to wheat you can treat the wheat with the laser that is held in the patient's hand and that wheat will no longer show an allergic reaction to the patient, but that patient is still allergic to wheat which has not been treated by laser light. The effect of what we are describing is so pronounced that it becomes beneficial for a person to treat all the substances they take into their body by first holding it in their hand and then having the laser light applied to it. We originally did this by having a patient hold a bottle of vitamins that they would be taking and treat it with a laser while they held it. Then we found that that meant the bottle of vitamins was tuned to their body only and was no longer suitable for anyone else in the family to use vitamins out of that same bottle. We found a better technique is to have the patient use the laser light on the vitamins, after they had counted out the ones to be taken at that time. Which means that the vibratory rate would be tuned to their body at that time assuming that their own vibratory rate may change from day to day. This was an improved method and also did not change the vibratory rate of the vitamins in the bottle, so that someone else in the family could use them. We found out the hard way that this procedure seems to increase the potency of these nutrients substances. We had some bad experiences with actually overdosing some patients, not realizing that this procedure was in effect increasing the strength of the dosage. As a result of this, we now find that the patient actually requires less of the nutrient

substance after it has been treated with the laser light than they did prior to using this laser treatment method.

CONCLUSION: Experiments have shown that biological systems exhibit an extraordinary ability to survive even after they have separated from the complete system.⁴ This is in fact an ample indication of coherence. This means for instance that in optical devices that all structures appear with the greatest contrast or visibility. Consequently biological systems must exhibit holographic properties to an extremely high degree. The successful trials in finding "pictures" of various organs in each other organ, such as the ears, hands and eyes. Examples of this would be acupuncture, iris diagnosis and auricular therapy; which support these conclusions. Our assumption is that the entire genetic information of DNA is stationarily delocalized over the entire body in the form of harmonics, so that the body language speaks to us in many ways, in many locations. Or as we often say, "the body is constantly expressing externally what is going on internally."

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ACKNOWLEDGEMENT:

I wish to express my deep hearted thanks to Dr. Patrick Flanagan for introducing me to laser light principles and to the references contained herein.

DISC CORRECTION OBSERVATIONS
By: GERALD DEUTSCH D. C.

ABSTRACT:

Many techniques have been developed and innovated through the years. Some have withstood the test of time and many fade away through the years. Many of these techniques have merit because they are pain control techniques or very specific corrective methods. They are not complete health management programs. Techniques that have merit are continually used, and gradually through innovative use by our practitioners are upgraded by clinical experience. One technique is the disc retraction as practiced by Cox.

There are many things that come to mind when a paper of this type is done. We think about past papers and the thought comes to mind many times "I should have done that one". One such paper is the one done by Dr. Ken Feder during the spring 1980 I C A K meeting pertaining to the Cox(1) method of disc retraction. Upon reflecting, I don't think I could have done it with the detail that was related throughout the whole paper. I do like to expand on the ideas that are presented in the many fine papers, and refine the concept so that it is more clinically operable, easier and faster. When this is done, we generally find that we have a better technique, and one that delivers possibly more refined results than the original concept. If you do not own a Chiro-Manis table I will try to show how some efficacious results may be obtained without one.

If one carefully reads Dr. Feders' paper, though you may not own a Chiro-manis table you can employ some of the corrective techniques. One reference he names a "FRAMING TECHNIQUE", is a therapy localization(TL)(2) of the vertebrae above and below the lesion, on the side of the lesion. What is happening here is nothing more than a two hand TL of the lumbar spine disc as described by Dr. Goodheart in his earlier papers

of disc lesions. This seems to TL the side of the lesion and the area of would be therapy. Dr. Feder should be commended on this innovation which as I said, only improves the technique. In past conversations with Dr. Goodheart we spoke of Dr. Bonyun(3) of the Canadian Memorial College of Chiropractic and his expertise in disc disorders. His concept is of a wedging of the vertebral disc, the disc bulge, and his method of reducing the lesion. Dr. Goodheart explained a method of detecting and correcting a disc lesion using Applied Kinesiology(AK) and to use the Bonyun correction to correct it. The patient is asked to TL the area of a suspected disc lesion with a two hand contact palms down. This is accomplished by placing hands one over another, or one hand over the fifth lumbar, one hand superior, palms down, and touching the inferior hand at the suspected level of the lesion. Naturally, we can expect a tested muscle to weaken if there is a positive lesion. If there is in fact a disc lesion or a bad nerve root inflammation at the level of the positive TL we can assume that there is need to direct our attention to that vertebral level. The transverse process of the offending vertebra and the one below are challenged, pushing the transverses together and/or apart. A muscle, such as the hamstring, is tested; if it weakens with either challenge the vertebra is adjusted accordingly in the direction that causes weakness. The application of this technique is to be done very carefully. We must remember that we more than likely have a disc herniation, bulging or acute inflammatory problems at the intervertebral foramen.

De Jarnette(4) in his decription of disc lesions gives some very sound advice in correcting these problems. Specifically, he warns against adjusting a patient on the side of sciatica when the body lean, or antalgic position is over the side of the sciatica. The rule was not to adjust into the sciatica. If the antalgic position was opposite the sciatica, a careful adjustment based on the rotation is permissable. One could do a pump on the spinous in the sitting position as described in his manual

with good results in many cases.

Dr. Banyun's correction using the AK approach as described to me by Dr. Goodheart is as follows: With the patient in the prone position, the TL procedures are done to confirm the lesion as described. Next, challenging the spinous of the suspected vertebra will confirm an inferior spinous (I will deal with this correction in the next paragraph), this is one confirmation of the disc lesion. However, the key in this work is to discover the direction of correction by challenging for wedging of the disc. This is done for example by challenging the sacral alar and the transverse of the fifth lumbar toward each other on the suspected side. Repeat on the other side if negative. If those challenging procedures are negative, then challenge apart, in other words pushing the transverses apart, one of these will elicit a challenge. When it is determined which direction challenges, (for example 5L transverse toward the sacral alar when challenged simultaneously toward each other) the patient is then turned on his side with the lesion superior. This is in a similar side roll position that we all have seen, and witnessed many times with poor results. The patient is turned a little more than usual, so that the pressure thrust that is necessary in this technique can be done readily. Position the patient properly, with good control and almost slightly off balance. Contact the transverse of the superior vertebra with the pisiform, and with almost overwhelming pressure is moved toward the direction of the pubes. Pressure contact with the shoulder should be directed superiorly and slightly backwards. The vertebral pair that may have challenged apart is adjusted similarly but the pressure thrust is superior toward the direction of the umbilicus. You will notice that I said pressure thrust not just plain thrust. This is not an ordinary adjustment type thrust, but deep heavy pressure designed to de-torque and level the disc. Do not do too much more than basic neuro-lymphatic, vascular, light fascial or muscular work with these patients

at the beginning of care, as the over-care can can overtreat with dreadful results. The patient is instructed to ice the area for 10 minutes on the hour for 3 hours, then repeating after a few hours for as long as possible until they see you for the next visit. They are instructed to stay in bed and have their meals there. Based on the severity, bathroom privileges may also be withheld in lieu of bedpan techniques. I usually try to have our patients avoid arching their backs while in bed, and suggest using pillows around the bedpan to avoid the distortion that takes place. While in bed I also suggest that they flex the knees to their chest, one at a time every 20 minutes for a few repetitions throughout the waking day. This slightly stretches the muscles of the lower back and helps to maintain a good blood supply to the area because of the slight pumping activity. The patient is instructed to rest in bed with pillows under the knees, and if necessary under the abdomen when abdominal lying.

While Robert Deutsch D. C., now in practice and residing in Burbank, Ca., was associated with me, we observed a phenomenon that challenged a disc lesion when most everything seemed clear, except pain. More sophisticated work was being done in obtaining information on body language, yet we missed many opportunities to adjust a vertebral segment because it didn't challenge. So simple, yet when it's shown to you, it seems that you should have known it all along. Simply challenge, or TL for a disc. At this point there will be no challenge because you have done much for the patient. Now have the patient perform the Val Salva reflex, hopefully without the end result. The tested muscle will now weaken to confirm the correction that has to be performed. You may also have the patient cough; this will react as the Val Salva reaction (causing an intra-dural expansion). I will discuss the Val Salva reflex only, but the cough may be substituted for a more violent reaction at the disc level. Most ICAK instructors are teaching the disc technique using the respiration

technique. The patient is in the prone position and with inspiration the spinous and sacrum are tractioned apart. This is a very safe method of caring for our disc patients. An alternative is using the Cox method of disc care, or other alternatives such as the one described in the forthcoming paragraph. The key is to adjust the spinal segment while the patient holds a deep breath (remember the spinous moves inferior with inspiration). The adjustment is a modified disc pump. To perform the maneuver, you place a double thumb contact at the inferior point of the spinous of the offending vertebra. Thumbs placed inferior of the spinous, with inspiration, and a quick thrust headward. This is done with a little more pressure than with the respiratory effort as currently taught. After challenging, if the muscle is still weak, the following additional measure may be instituted. Simply place the fingers in the same position as before but, with deep inspiration, ask the patient to bear down, this time repeating the Val-Salva reflex. The same thrust follows and the patient is asked to exhale, then inhale to repeat the procedure for a few times.

Those that may own the Chiro-Manis table may utilize the same principle of Dr. Bonyun. Find side of the wedge that challenges for weakness, as previously discussed. Angulate the table in the direction that previously created the weakness. Follow the procedure that is utilized for correction as discussed by Dr. Cox. The same procedure may be utilized with rotation. Challenge for weakness with pressure on one ilium, and with the opposite hand, pressure on the low lumbar spine. The one direction that creates the weakness is the direction that the table is rotated for the correction. Inferior pressure on the base of the sacrum and superior pressure on the upper lumbar simultaneously, indicates the need for traction type care.

This is another example of how other techniques can be integrated within A K. It

also gives the practitioner the opportunity to confirm the efficacy of another technique using Applied Kinesiology.

8/15/81

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LIGAMENT INTERLINK CHALLENGE

By: GERALD DEUTSCH D. C.

ABSTRACT:

The following will describe a method to challenge the ligament insertions for corrections using the ligament interlink technique. This method is an alternative to the physical therapy localization that is ordinarily done to check for the presence of the ligament interlink.

The ligament interlink was developed by Dr. George Goodheart(1) and proven to be an effective method of controlling pain on contralateral related joints. The idea was conceived on studies of decerebrated cats on a treadmill and relating walking motion on contralateral sides of the animal.(2)

The following technique has been applied to hundreds of patients. It was proven to parallel the findings of Dr. Goodheart's technique of therapy localizing the contralateral joints that are related to each other as it relates to ligament interlink. In applying this technique that may be related to ligament interlink, I found that in our office the pattern of therapy localization could be cumbersome and time consuming at times. For instance when one might therapy localize(TL) one knee and contralateral elbow, while testing the quadriceps, or some similar testing pattern, was found to be a little cumbersome. I also found at times that I would like to test a specific area in the posterior aspect of the spine against another area, or relate it to another specific joint in the body. The therapy localization in that matter would be rather difficult for the patient to perform and to be able to have a muscle tested at the same time.

I then felt that many of these areas should therapy localize under certain conditions. Upon experimenting with the original principle I found that the patient may therapy localize a specific area such as the knee if a problem existed in the knee, and of course he may not therapy localize if there is no mechanical problem with the joint. If the

patient therapy localizes to the knee in any event, we would find the problem to fix the mechanics of the joint in trouble. We might treat the spine with a subluxation or a wrist with a carpal tunnel, and so on. However, sometimes the patient complains of pain in a joint or a specific area troubles them. I would then have the patient therapy localize the area of their complaint, and I would directionally challenge the contralateral ligament structure that I may feel is related to the part being therapy localized. At the same time I would test a convenient muscle. The key at this point would be to initialize a specific challenge to a specific direction. The technique is to have the patient therapy localize the pain point such as the shoulder. The doctor may then take the point that he suspects to be involved in the ligament interlink and carefully challenge for direction, or specifically pick the ligament that he feels to be involved with that specific contralateral part. He would then directionally challenge the part while looking for weakening in the tested muscle. The test or challenge would weaken any tested muscle under these conditions. The doctor then challenges the hyoid, either right or left, usually into the treated direction. If the problem is ligament interlink the hyoid will strengthen the tested muscle if tested in a wrong direction. It should cause a weakening once again in the other direction. One direction must weaken the muscle and one must strengthen the muscle in order to be considered a ligament interlink. The doctor can then challenge a ligament either using a rebound type of challenge, such as challenging the ligament in a specific direction and releasing it, following through with testing the muscle, and/or sustaining the challenge. The type of challenge seems to make no difference.

From that point on, the procedure is exactly as described by Dr. Goodheart in his article about ligament interlink. The interesting part about the challenge technique for ligament interlink is that one doesn't have to have the patient place hands onto different aspects

of the contralateral joints. It's possible to very rapidly search for other joints that may be a problem. Once the specific ligament is located simply challenge the suspected ligament directionally. To determine whether this is in fact a ligament interlink simply move the hyoid in one direction or another after the challenge has been executed. If it is a ligament interlink either the tested muscle will remain strong or will weaken as it should in a ligament interlink. We then follow through as before with patient or doctor holding the hyoid into the direction of the manipulation while the part or ligament part is rubbed or manipulated heavily. This by no means should replace the actual therapy localization of the ligament interlink, but could be used as a shortcut to find the problem. Then, have the patient therapy localize as you had before to confirm the therapy localization as a ligament interlink.

This paragraph is an addendum to this article. I had planned on placing it into our collected papers in June 1980 but because of personal problems, I was not able to submit the paper in time, and at that time one of our newer members Dr. E. Mladenoff(3) presented a paper on a ligament interlink concept. He found a crossed arm pattern with the therapy localization on the joints of the same side where before the TL pattern was not present. Upon checking the ligament interlink with this procedure I found that the challenge mechanism worked in the same manner simply by having the patient therapy localize the original problem or the area that you have suspected it to be. Then, challenging the suspected interlink weakened the tested muscle. With this technique, we have confirmed Dr. Mladenoff's findings on this cross pattern therapy localization and find that this pattern is present many times. Those that may use this technique will find it a great time saver in the office. Because of the great variations that could be scanned using the ligament interlink challenge technique. It will then be possible to find more difficult ligament interlink problems.

11/10/82

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THE UVULA REFLEX

By Daniel H. Duffy, D.C.

ABSTRACT: Digital pressure directed towards elevation of the uvula has been found to cause an immediate increase in skin temperature over the sternum and may be another neurovascular control point for the cisterna chyli. Occasionally, the performance of the "uvula lift" had been found to negate all of the findings associated with diaphragm dysfunction, i.e., bilateral lower trapezius weakness, lumbodorsal fixation etc.

Digital pressure on the glomus coccygeum coincidental with expiration causes an elevation of skin temperature over the sternum. This connection, discovered by Goodheart is thought to be the neurovascular point for the cistern chyli. The diagnostic maneuver to uncover this dysfunction is called (by Goodheart) **ANTEROGRADE TECHNIQUE** as opposed to **RETROGRADE TECHNIQUE**. The patient is tested (bilateral pectoralis clavicular) in the supine position and found to test normally however when the table is raised to about the 45 degree position the muscles weaken—this weakness responds to respiration assist by the patient, (deep breath in and held) however correction of the mastoids for inspiration assist does not negate the findings. The correction requires digital pressure to lift the coccyx on expiration for four or five respirations. The contact point is at the glomus coccygeum.

A very chronic and debilitated patient whose main complaint was bilateral axillary pain and fatigue with shortness of breath responded to this correction by Goodheart, however as in all of the previous manipulative efforts on this patient by this writer, the response was shortlived and several days later all symptoms returned. Two more attempts to correct the glomus coccygeum were made and on the third office visit following his trip to Goodheart's research center we decided to try to find another connection. Previous experience with the uvula and its effect on diaphragmatic problems and lymph flow led to the attempt to check the uvula. Sternal skin temperature showed an immediate rise following uvula lift and all of the signs of a diaphragm dysfunction were negated which include lumbodorsal fixation, bilateral lower trapezius weakness, positive therapy localization of the diaphragm, and the "lead effect". On this visit the patient was taught to "belly breath". All patients suffering from anxiety are benefitted by abdominal breathing. The patient for the first time ineighteen months remained asymptomatic for six weeks. Any slight hint of returning axillary pain is negated by abdominal breathing which is a prerequisite to total relaxation in the opinion of this writer. The neurovascular effect of the uvula lift was first experienced by this writer several years ago at an AK meeting wherein Goodheart's diaphragm technique was being taught to an advanced AK class. A doctor suffering overwhelming fatigue and shortness of breath with a very pale and pasty complexion who showed all of the diaphragm signs responded to the uvula lift and in minutes was relieved of his symptoms and exhibited an immediate change in complexion to the typical "rosy red".

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TMJ PAIN AND TRIGGER POINT THERAPY

By Daniel H. Duffy, D.C.

ABSTRACT: Pain related to TMJ dysfunction often yields to intermittent pressure on trigger points located on or near acupuncture points Bladder 36, or 37. Pressure on the correct point will usually cause radiating sensations first into the shoulder girdle, then into the head and finally the ear and TMJ. Sensations are also occasionally felt down the arm and as distal as the foot. The intermittent thrusting into the point must be continued for as long as seven or eight minutes before results are obtained. Rate of thrust varies from 110 to 180 thrusts per minute. This may require supplemental treatment to a trigger point in the belly of the Masseter.

A BASIC RULE FOR THE USE OF TRIGGER POINT THERAPY

TPT is used to relieve any paresthesia or surface symptom and to unmask therapy localization of an affected part. Pain, numbness, tingling, hot or cold sensations are involved and treatment of the proper point will cause these same sensations to appear distant from the point being treated, usually but not always, in a radiating manner from the treatment point into the affected area, and not necessarily reproducing the same sensation as that complained of. The proper point is treated with an intermittent pressure until a sensation is produced in the affected area or in the direction of the affected area and is continued until abatement of the sensation. Quite often the referred sensation becomes intense just prior to abatement. A referred sensation may not arise for two or three minutes following initiation of the treatment. Available guides to TPT and zones are not necessarily accurate nor complete. Occasionally the only sign of success may be change in skin temperature over the affected area. (monitored by instrumentation)

Examples of patient response are "I feel it in my shoulder", "my arm is going numb", "it's going up into my ear now", "it's going into my face", "I feel like my jaw is getting hot", etc. Goodheart demonstrated to me how treatment of a sacroiliac joint point produced a warm sensation behind the knee of the patient and uncovered therapy localization of a posterior os calcis which I had previously corrected unsuccessfully. The patient went on to full recovery following Goodheart's correction. (patient was a champion racquetball player)

To reiterate, the key to TPT is INTERMITTENT PRESSURE that produces a DISTANT SENSATION, preferably in THE AREA OF COMPLAINT until all sensation ABATES or is GROSSLY REDUCED remembering that these sensations, especially of pain will often intensify greatly just prior to abatement. Several disturbing cases of idiopathic chest pain have responded completely to these methods. The mechanism may be acupuncture points effects on axoplasmic flow. All trigger points exhibit exquisite tenderness to the touch.

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FIXATIONS

by

James V. Durlacher, B.A., D.C.

ABSTRACT

The detection and analysis of the type of fixation as described by Goodheart¹, Walther², and Stoner³ is subjective.

At the annual meeting of the I.C.A.K. in Gaylord, Michigan, June 1975, Dr. Robert Stevenson described a simplified method of detecting and analysing the type of fixations without the use of subjective motion palpation. This paper is to substantiate Dr. Stevenson's original observation.

After the doctor has determined that a vertebral fixation is present by finding bilaterally weak muscles in a specific area (indicator muscles) the next process is to determine whether the vertebrae above or the vertebrae below is fixed on the central vertebrae. This is done by pushing the spinus process to the left and to the right observing which offers the least resistance and the most resistance. The side offering the most resistance would be in the posterior position. The next step is to push the relatively posterior and relatively anterior vertebrae along the facet line to determine which side offers the most resistance and if that side is the posterior one, it is termed a posterior fixation. If the anterior side offers the most resistance, then it is an anterior fixation.

If it is a posterior fixation, the top vertebrae is adjusted on the middle. If it is an anterior fixation, the bottom vertebrae is asjusted on the middle.

Dr. Stevenson described a simpler way of analysing the type of fixation. The method is for the doctor to TL with the thumb on one transverse of the verte-

brae and with the forefinger on the opposite transverse process of the vertebrae above or below and test an indicator muscle. If the muscle weakens, contact should then be made on these points and the adjustment made on the exact points that TL'd to reduce the fixation. If the proper adjustment was made and the fixation released, it will no longer TL and the bilateral weakness of the indicator muscle will no longer be present.

CONCLUSION

This procedure has been used in my practice since 1975 in over 15,000 patient visits and I find it to be accurate and reliable without the subjective judgement of motion palpation.

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2
The Use of The X Test As An
Aid In Clinical Research

by

Joseph S. Ellison, D.D.S.

The t test as previously described was used to determine the following:

- 1) whether or not a population mean differed significantly from a constant.
- 2) whether the mean difference between 2 measurements on the same subject differed significantly from each other.
- 3) whether the mean of 2 populations differed significantly from each other.

The t value was determined by taking appropriate measurements of a given variable. Computations were then carried out to determine how much differences between means differed from 0. Obviously the greater the difference, the more likely the measurements were significantly different. The t curve closely resembled the standard curve and was symmetrically shaped about the vertical 0 axis.

Suppose you wanted to do a survey of 100 people, taken at random, who had backaches. You were interested in finding out where they went to seek care. You therefore did a frequency count of their preferences and obtained the following results. (Table 1)

<u>Preference</u>	<u>Frequency Count (f)</u>
Family Physician	24
Osteopath	27
Pharmacist	10
Orthopedic Surgeon	11
Chiropractor	28
	Total <u>100</u>

Table 1: Empirical frequency count of persons seeking care for a backache

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The data in Table I does not lend itself to comparing 2 population means. We are stating our data in terms of a classified frequency and not in terms of measurement data as we did in the t test. It is therefore obvious that the data cannot be plotted along a standard curve. Notice that all persons in a given category have the same score there is therefore no variability within any given category. Numbers will vary with any frequency count. The question we what answered however is do the observed frequencies in a random sample differ significantly from the expected frequencies? The test statistic used in this case is chi square (χ^2).

The data in Table I shows 100 responses in 5 categories. If the responses were equally distributed, the expected frequencies for each category would equal 20 responses ($\bar{x} = \frac{\sum x}{N}$). If O is equal to the observed frequency count and E is equal to the expected frequency count the data can be diagrammed as in Table II.

Preference	O	E	O-E	(O-E) ²	$\frac{(O-E)^2}{E}$
Family Physician	24	20	4	16	0.80
Osteopath	27	20	7	49	2.45
Pharmacist	10	20	-10	100	5.00
Orthopedic Surgeon	11	20	-9	81	4.05
Chiropractor	28	20	8	64	3.20
Total	100	100	0	310	15.50

TABLE II

One way to determine the difference between observed and expected values is to simply subtract the expected differences from the observed differences (O-E) and determine the total as shown in the 3rd column of Table II. Since adding all of the differences always adds up to 0, a more satisfactory procedure is to square each difference and sum the squares as shown in column 4 of Table II. This latter computation yields a positive integer which becomes proportionately larger as the difference between the observed and expected frequency counts increase. It therefore seems that we have a fair statistical measurement of the difference; but suppose we completed another 1000 observations and obtained results as shown in Table III.

Preference	O	E	O-E	(O-E) ²	$\frac{(O-E)^2}{E}$
Family Physician	224	220	4	16	.072
Osteopath	227	220	7	49	.223
Pharmacist	210	220	-10	100	.455
Orthopedic Surgeon	211	220	-9	81	.368
Chiropractor	228	220	8	64	.290
Total	1100	1100	0	310	$\chi^2=1.408$

TABLE III

The sum of (O-E)² is the same for both samples. It is therefore obvious that we have not adequately described the differences between the 2 samples since the proportion of the differences between the 2 samples is different. For instance there was a 50% difference between the observed and expected frequencies of pharmacists in Table I and less than 5% difference in Table II. Therefore since the size of the

squared difference relative to its expected frequency gives us the proportional difference, chi-square is determined by the sum of the quantity $\frac{(O-E)^2}{E}$ as shown in column 5 of Table II to yield a chi-square value of 15.50.

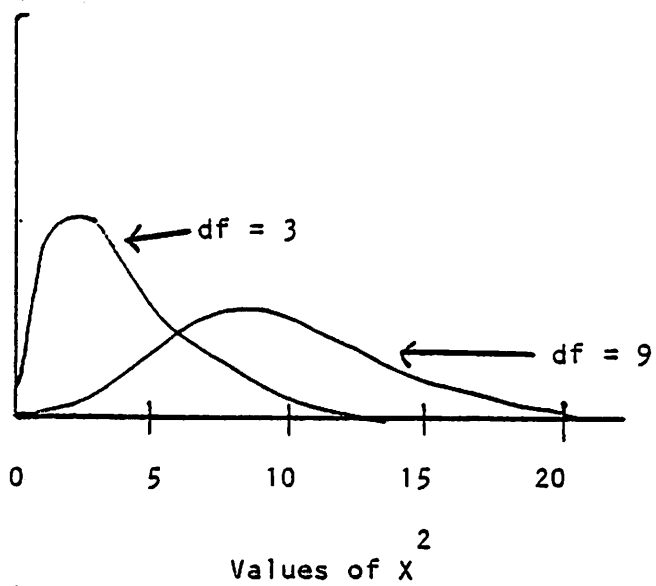
The larger the value of χ^2 the greater is the difference between the observed and expected frequencies. At $\chi^2 = 0$ there would be a perfect agreement between the observed and expected frequencies. Depending on the number of categories, χ^2 is represented by the curve in Figure 1. The level of significance is determined by the investigator and the null hypothesis rejected or accepted according to the computed χ^2 value. This test statistic therefore answers the question: do the frequencies observed by the investigator differ significantly from some theoretical or expected population frequencies?

THE ONE WAY CHI-SQUARE TEST (GOODNESS OF FIT)

For the one-way test a single set of observed frequencies is compared with a theoretical distribution of expected frequencies. The one-way test is illustrated in Table II where the theoretical frequency for each category equalled 20. Since the observed frequency can never exactly match the expected frequency, a chi-square analysis determines if there is a significant difference between what is observed and expected. In table II all observations were equally likely to appear in all categories. At times, observations are made of a population where the expected frequency is different among the categories. For example the expected frequency of blood types of 100 people chosen at random

2

THE USE OF THE χ^2 TEST AS AN AID IN CLINICAL RESEARCH
JOSEPH S. ELLISON, D.D.S.
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could be distributed as shown in Table IV.

Blood Type	Expected Frequency
A	40
B	20
O	30
AB	10
Total	100

TABLE IV

To determine how well the collected data fit the expected distribution, where the expected frequencies are not equal, a Goodness of Fit test is used. The Goodness of Fit test is performed exactly as the One Way Chi-Square test illustrated in Tables II and III. The difference between the 2 tests is the proportion of the expected frequencies. The normal procedure for determining the number of degrees of freedom for the One Way Chi-Square test is to subtract one from the number of categories. In Tables II and III there are 5 categories and since $df = K - 1$, then $df = 5 - 1 = 4$. Table V shows that a χ^2 value of 15.50 under 4 degrees of freedom is significant at the .01 level.

χ^2 P	0.995	0.975	0.050	0.025	0.010	0.005
1	0.043927	0.039821	3.84146	5.02389	6.63490	7.87944
4	0.206990	0.484419	9.48773	11.1433	13.2767	14.8602
20	7.43386	9.59083	31.4104	34.1696	37.5662	39.9968
100	67.3276	74.2219	124.342	129.561	135.807	140.169

2
TABLE V (The χ^2 Distribution)

THE INDEPENDENT SAMPLE CHI-SQUARE TEST (CONTINGENCY TABLE TEST)

This test is also referred to as a Test of Independence or Homogeneity or as a Two Way Test for Association. The test compares two or more variables to determine if they are independent or associated with each other. A contingency table is first set up to display the investigator's observations. Table VI shows results of 2 treatment modalities by way of a 2 x 3 contingency table. The table consists of 2 horizontal rows and 3 vertical columns with 6 cells labeled a through f.

	<u>Recovered</u>	<u>No change</u>	<u>Worsened</u>	<u>Total</u>
Treatment A	a 25	b 19	c 5	49
Treatment B	d 15	e 28	f 8	51
Total	40	47	13	100

TABLE VI

To find the expected frequencies (E) for each cell use the formula:

$$E = \frac{(\text{row total}) (\text{column total})}{\text{grand total}}$$

The expected frequency of each cell is therefore

$$a = \frac{40 \times 49}{100} = 19.6 \quad b = \frac{49 \times 47}{100} = 23.03 \quad c = \frac{49 \times 13}{100} = 6.63$$

$$d = \frac{51 \times 40}{100} = 20.4 \quad e = \frac{51 \times 47}{100} = 23.97 \quad f = \frac{51 \times 13}{100} = 6.63$$

Since $\chi^2 = \sum \frac{(O-E)^2}{E}$, χ^2 is determined as shown in Table VII

Cell	O	E	O-E	$(O-E)^2$	$\frac{(O-E)^2}{E}$
a	25	19.60	5.40	29.16	1.49
b	19	23.03	-4.03	16.24	0.70
c	5	6.37	-1.37	1.88	0.29
d	15	20.40	-5.40	29.16	1.43
e	28	23.97	4.03	16.24	0.68
f	8	6.63	1.37	1.88	0.28
Total	100	100	0	$\chi^2 = 4.87$	

TABLE VII

The number of degrees of freedom for the Independent Sample Chi-Square Test is equal to the number of rows minus 1 times the number of columns minus 1. Since the above sample contains 2 rows and 3 columns, $df = (2-1)(3-1) = 2$. Table VII shows that χ^2 with 2 degrees of freedom must equal or be greater than 5.991 at the 0.05 level. Our computed value of $\chi^2 = 4.87$ is therefore not significant at the 0.05 level.

P	0.995	0.975	0.050	0.025	0.010	0.005
1	0.043927	0.039821	3.84146	5.02389	6.63490	7.87944
2	0.010025	0.050636	5.99147	7.37776	9.21034	10.5966
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.
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.
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100	67.3276	74.2219	124.342	129.561	135.807	140.169

2
Table VII (The χ^2 Distribution)

YATES CORRECTION

In a 2×2 table only, χ^2 tends to understate the probability that chance produced the difference between observed and expected frequencies. It is therefore advisable to subtract 0.5 from the sum of $O-E$ without regard to sign before computing $(O-E)^2$. This correction decreases χ^2 and increases the requirement for significance. If our previous example contained only 2 columns and 2 rows, the problem would be set up as in Table VIII.

Treatment A	25	19	44
	w	x	
Treatment B	15	28	43
	y	z	
Total	40	47	87

Expected frequencies $w = \frac{44 \times 40}{87} = 20.23$

$x = \frac{44 \times 47}{87} = 23.77$ $y = \frac{43 \times 40}{87} = 19.77$ $z = \frac{43 \times 47}{87} = 23.23$

cell	O	E	(O-E)	(O-E)-.5	$[(O-E)-.5]^2$	χ^2
w	25	20.23	4.77	4.27	18.23	0.90
x	19	23.77	-4.77	-4.27	18.23	0.77
y	15	19.77	-4.77	-4.27	18.23	0.92
z	28	23.23	4.77	4.27	18.23	0.78
Totals	87	87	0	0	64.92	3.37
df = (2-1) (2-1) = 1						

Table VIII

Since X^2 must equal 3.841 at the .05 level (Table IX) the X^2 value of 3.37 is not significant. If the Yates Correction was not performed, X^2 would equal 4.21 which would be considered significant.

χ^2	0.995	0.975	0.050	0.025	0.010	0.005
1	0.043927	0.039821	3.84146	5.02389	6.63490	7.87944
.
.
5	0.411740	0.831211	11.0705	12.8325	15.0863	16.7496
.
.
20	7.43386	9.59083	31.4104	34.1696	37.5662	39.9968

2
TABLE IX (The X^2 Distribution)

Another rule used with the X^2 distribution is called the Rule of Five. The rule states that when a cell has an expected frequency of less than 5, that classes with low frequencies are combined to form a pooled frequency that is larger than 5.

Trauma From Occlusion as Related
To Neurologic Tooth Involvement

by

Joseph S. Ellison, D.D.S.

Trauma from occlusion is defined as periodontal tissue injury caused by occlusal forces.^{1,2} Some of the causes of trauma from occlusion include: 1) inflammation of the periodontal ligament with resultant accumulation of fluids, bone loss and shifting of the involved tooth; 2) ill fitting prosthetic devices; 3) abnormal tooth wear; 4) drifting of teeth into spaces created by unreplaced missing teeth. Occlusal interferences have also been shown to increase muscle activity at rest as well as increase the magnitude and frequency of contraction of the jaw muscles.³ The proprioceptors within the periodontal ligament have been shown to detect thicknesses as small as 10 microns.⁴ When occlusal discrepancies are present, a continuous effort is made by the reflex controlled nerve centers to establish a compromised pattern of occlusal contacts to avoid or minimize initiation and injury to the various tissues of the masticatory apparatus.⁵ It has also been shown that tilting forces on the inclined planes of the teeth place greater stress patterns on teeth as compared to axial forces.⁶ Walther⁷ and Blaich⁸ have shown correction of neurologic tooth involvement by applying either buccal or lingual pressure on the involved tooth during the appropriate phase of respiration. Due to excessive drifting of the teeth and other factors

such as enumerated above, many patients present with gross occlusal prematurities requiring more extensive therapy.

In this investigation twenty-seven selected patients were examined for centric prematurities. Some patients were seen more than once to make a total of 52 patient visits. Patients ranged in age from 32-68 years. Sixteen patient visits were made by males. At the beginning of each visit the patient was asked to close along the habitual pathway to the point of maximum occlusal intercuspation. The patient was then instructed to determine the point of first tactile sensation and identify the tooth exhibiting premature contact. The muscle related to the premature tooth was tested and in each case tested weak. The contralateral muscle tested strong. The bite was equilibrated to remove any inclined plane influences and the muscles related to the premature tooth was retested. Forty seven of the 52 muscles tested strong on retesting. Subsequent investigation confirmed that the five teeth where the associated muscle continued to test weak

had a severely destroyed supporting apparatus. These teeth were stabilized by splinting and the muscle subsequently tested strong.

The findings of this paper support the observations by Blaich that neurologic tooth involvement may have important manifestations throughout the body. It also expands the therapeutic modality for treating neurologic involvement. Electromyographic studies have shown that occlusal interferences cause an asynchronous pattern of the masticatory muscles. ^{9,1011} Since muscle disharmony will lead to disharmonious movements of the condyle in the glenoid fossa, it

therefore follows that some cases of diagnosed TMJ syndrome are really symptoms of occlusal disharmony. This explains why biteguards of varying constructions can sometimes negate signs and symptoms of TMJ disturbances.¹² It is probable that in some cases, the biteguard does not directly assist the TMJ but indirectly treats the TMJ by disarticulating teeth in traumatic occlusion, thereby prohibiting aberrant muscle contraction.

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HOLOGRAPHIC TECHNIQUE: A testimonial

David P. Engel, D.C.

Abstract

This paper is a brief narrative description of a successful utilization of holographic technique, elaborated by Dr. Goodheart on Research Tape #68 and in the Advanced A.K. Session #3 in Detroit, November, 1981. The author has found satisfying response in this previously frustrating case.

History: A patient, 61 year old male, presented himself with the primary complaint of pain in the upper dorsal spine. This acute pain had bothered him the previous two days, but seemed to be an outcropping from a more chronic middle dorsal spine soreness which he suspected was the result of a "pulled muscle". This patient is a mechanical engineer, a profession which requires him to remain "hunched over a drawing board" for hours at a time.

Findings: I was not at all surprized to find his ear a full two inches forward of the plumb line. This was accompanied by a high right occiput and right shoulder. Applied Kinesiological exam revealed several findings. Those of which seem most pertinent to his complaints are listed:

- anterior switching
- right Psoas Neuro-Lymphatic weakness
- left Quadratus Lumborum Neuro-Lymphatic weakness
- left Sartorius Neuro-Lymphatic weakness
- left Pectoralis Major Sternal Neuro-Lymphatic weakness
- L.3,4,5 fixation

HOLOGRAPHIC TECHNIQUE David P. Engel, D.C.

- L.3,4 facet Imbrication
- anteriority of D. 3,4,5
- "Pitch" (of P-R-Y technique)
- C.6,7, T-1 fixation

Technique: The above findings were dealt with in the usual fashion, according to standard A.K. technique...with absolutely no diminishment of the symptoms in spite of my best efforts. This patient came well referred to me by his wife who responded well to extensive TMJ and cranial work and I was quite anxious to elicit some degree of satisfactory results. I was fortunate enough to attend Dr. Goodheart's third advanced session where our mentor aptly and to my great interest described the Holographic aspects of our nervous systems.

The concept of correcting the "unfocused, off-center" cranial hemisphere by re-aligning it with the properly aligned, reference hemisphere to correct the memory pattern for, in this case, alignment of certain spinal segments was very interesting and has proven to be very practical, especially in stubborn cases such as this.

The Holographic pattern which elicited the fault occurred during Left-Brain activity (recitation of multiplication table) and the "where it is, it ain't" principle was true-to-form in this instance. Therapy Localization to L-3 on the left was positive only during Left-Brain activity. Resetting the left brain was elicited by tapping the left cranium during Right-Brain activity (humming). After correction of the challenged mechanical subluxation of L-3, Right-Brain activity was performed while tapping L-3 on the left to clear out the Holographic findings.

It seems to make sense that a person immersed in Left-Brain activity (as is this patient) would suffer substantially from that hemisphere being "out of focus". He reported much less restriction of motion on the next visit and was able to lie supine on the adjusting table, with the headpiece

HOLOGRAPHIC TECHNIQUE David P. Engel, D.C.

flat, without pain. This was a notable improvement from previous visits during which it was a major discomfort lying supine, even with the headpiece in a full anterior flexion. Interestingly, the left hemisphere returned to its "unfocused" state, but without recurrence of the L-3 structural or Holographic faults. However, Therapy Localization to the left Quadratus Lumborum Neuro-Lymphatic elicited weakness only during Left-Brain activity. Tapping that Neuro-Lymphatic during humming was performed after the left hemisphere was "reset" by tapping it during humming. The patient was given EBA¹ to hold on his tongue and none of the faults could be re-elicited. Progress since this point has been quite satisfactory.

Conclusion: Since my involvement with A-K, I have been both encouraged and greatly confused by some aspects of the technique; especially the more advanced material. Resisting the temptations to fix only the basics or work only on an advanced level has been a very worthwhile effort and I would like to emphasize how helpful a solid background in the basics has provided a good foundation for understanding and utilizing the more advanced or so-called "exotic" techniques. For this background I owe an unrepayable debt to my dear friend Lance West whose unselfish help has been beneficial beyond description.

¹EBA- Nutri-Dyn Products, Inc. 5705 W. Howard St.; Niles, ILL 60648. This product has been used successfully in balancing left and right brain imbalances of the "electron-poising" concept.

PITCH, ROLL, AND YAW: A Statistical Study

David P. Engel, D.C.

Abstract

The extreme frequency of occurrence of P.R.Y. factors are discussed and a statistical report of this frequency is presented, as well as an organized method for P.R.Y. screening.

Discussion: Since Pitch, Roll and Yaw techniques have been presented, I have seen a notable frequency of occurrence of these imbalances. Drs. Goodheart and Schmidt have presented P.R.Y. in their Detroit Seminars on numerous occasions and the techniques are well described in Dr. Walther's text, Applied Kinesiology Vol 1 (available through Systems, D.C.) on pages 182-189. In addition to the standard P.R.Y. patterns, a Yaw #3 has been shown by Dr. Goodheart (at the annual Ohio Applied Kinesiology Association's meeting in Columbus, 4/81) as well as a new pattern involving Lateral head flexion and necessary coordination of upper Trapezius and Sterno Cleido Mastoideus muscles in a gait pattern which are referred to as "Tilt" and "Walking Gait" respectively.

Except for circumstances prohibiting these exams, all of our patients are screened for P.R.Y., and many are screened frequently if recurrence of the

PITCH, ROLL AND YAW: David P. Engel, D.C.

fault(s) is suspected. Hidden P.R.Y. faults are found with E.I.D. patterns, left and right brain function, etc.

The repeated testing for P.R.Y. patterns has allowed me to develop an organized routine for testing which alleviates patient confusion and allows testing of "Pitch, Roll, Yaw #1, #2, #3", and "Tilt" patterns in 60 seconds. "Walking Gait" is tested with the patient standing and is done separately. It takes about 15 seconds to diagnose and 20 seconds to treat. The following is the organized approach to testing these patterns quickly. The only things this approach "short-cuts" are patient confusion and wasted time:

- 1) Establish a strong indicator muscle. Pectoralis Major Clavicular (PMC) works best. (Patient is supine) In quotations are my instructions to the patient. I have found that the quoted instructions are followed quickly by the patient, with a minimum of confusion. Be sure to remind the patient to keep the elbows straight or they will invariably recruit the Biceps Brachialis. Always watch for recruitment, as it is as common to A.K. testing as is the word "resist". Tell the patient that you will be doing repeated testing with the arms and to keep them in the position until you have instructed him to relax them. This will prevent the task of constantly repositioning the arms.
- 2) "Pick your head up. Put your chin on your chest."
Test the PMC. (This differentiates cervical-occipital flexion faults from P.R.Y. faults)
- 3) "Put your head down. Put both feet on the table."
Test the PMC. (This differentiates lumbo-pelvic faults from P.R.Y. faults.)
- 4) "Now put your chin on your chest, again." Test the PMC. PITCH
- 5) "Keep your head up. Turn your head to the left."
Test the PMC. YAW #3
"Now turn your head to the right."
Test the PMC. YAW #3
- 6) "Put your head down. Tilt your knees to the left." (I usually let go of one arm to manually tilt the patient's knees.) Test the PMC. (This differentiates rotational lumbo-pelvic faults from P.R.Y. faults.)
- 7) "Keep your knees there and turn your EYES ONLY to the right." (I usually point in that direction or tap the patient's right wrist with the testing hand that is holding that wrist. In this case, with my left hand.) Test the PMC. ROLL
- 8) "Now turn your head to the right." (Again, tapping the patient's wrist or pointing right.) Test the PMC. YAW #1.
- 9) "Put your head back to center. Tilt your knees to the right."
The reverse of Step #6.
- 10) Step #7 in reverse.
- 11) Step #8 in reverse
- 12) "Put your knees and head in the middle. Put the left leg down. Tilt your head and put your right ear to your shoulder." (Again, touching or manually

PITCH, ROLL AND YAW: David P. Engel, D.C.

- moving the head, preventing rotation.) Test the PMC. TILT.
- 13) "Reverse your knee positions and tilt your head, putting your left ear to the shoulder." Test the PMC. TILT.

Of course, this procedure will take more time to perform if any of the tests are positive (which my statistics indicate will be very frequent), because of the time required to correct the aberrant pattern(s). It is suggested that correction be done at the time of discovery, then evaluation of correction, followed by the remainder of the P.R.Y. screening. Also, be careful to differentiate P.R.Y. findings from hidden factors. Several patients exhibited an EID 51% NL to the PMC which would otherwise appear as a Roll pattern.

Statistics: The total number of patients screened for this study was 100. These were a random selection of people with a wide variety of ages, complaints, etc., chosen to represent a cross-section of my practice. There were 37 males and 63 females evaluated with the following statistics:

	MALE	FEMALE
TOTAL NUMBER OF SUBJECTS.	37	63
NUMBER OF SUBJECTS WITH NO P.R.Y. FAULTS.	13=35%	20=32%
NUMBER OF SUBJECTS WITH 1 P.R.Y. FAULT.	15=40%	25=40%
NUMBER OF SUBJECTS WITH 2 OR MORE P.R.Y. FAULTS .	9=25%	18=28%

Conclusion: This statistical study has convinced me of the validity of testing each patient, regardless of complaint, age, etc. for all the aspects of P.R.Y. faults. The screening method presented allows, in this author's opinion, a quick and thorough method of testing for these commonly occurring faults.

I would like to take this opportunity to express my appreciation to Dr. Goodheart, whose obviously great contribution to health care has boosted my practice to a level of competence previously undreamed of; and whose patient demonstrations and explanations of Pitch, Roll and Yaw have made this paper possible.

Abstract:

Many patients who present symptoms of Hiatal hernia but display no
(2) T.L. or challenge, (1) are having Pyloric valve dysfunction instead.

These patients may complain of digestive bloating or fullness upon consumption of even small amounts of food. Pyloric valve dysfunction may also be the contributing factor in ulcers and cause the continuing irritation to a Hiatal hernia.

I have found the T.L. point for the Pyloric valve to be at or near
(2) C.V. 10. Dr. Allen Beardall states that the N.L. for the Pyloric valve is
(3) on the right third section rectus abdominis $\frac{1}{2}$ " lateral to linea alba near insertion. Dr. Beardall states the muscle related to the Pyloric valve is the Iliocastalin Lumborum. The 5th thoracic and 4th lumbar are the neurological connecting areas for correction.

To summarize the procedure, have the patient T.L. area of C.V. 10 with
(2) left the right hand and test a previously strong muscle. If weakness occurs, test the Iliocastalis Lumborium left and right. Next with the patient
(3) in a prone position, treat the N.L. and N.V. for weak Iliocastalis Lumborium. T.L. and challenge 5th thoracic and 4th lumbar and adjust.

Then with the patient supine again treat the Pyloric valve reflex. We
(3) have been using this procedure for over eight months and have had good results in chronic and acute digestive problems.

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Privately Published

A SIMPLE SKI CANT TESTING PROCEDURE

By Fatah R. Evans, D.C.

ABSTRACT

A simple procedure to test for ski cants involves the applied kinesiology method of lift testing.

Ski "cants" or wedges are various devices used to change the edge angle of skis. The need may arise because the ski boot design and fit may not allow the skis to flatten on the snow when the skier is in a natural hip width stance. If this situation is present the skier must then compensate effort and energy by using his body to achieve that extra amount of balance and precision his equipment should normally afford him. The compensation then becomes a compromise; unfortunately that compromise may cost the skier a win in competition, as races are won by fractions of seconds.

Ski equipment and the effectiveness of that equipment is as important as the skier's ability. In Warren Witherall's book, HOW THE RACERS SKI, he states, "There is no requirement more basic for an effected ski technique than having your skis change edge simultaneously and having them equally edged at all points in a turn. Proper wedges assure that these requirements are met."

We are all quite familiar with the changes in an athlete's performance after being structurally balanced by applied kinesiology procedures. This then would be our first consideration. The skier should then be evalated for a foot appliance and fitted if there is a need.

The next step would be the testing for cants. The procedure is the same as lift testing presented in Dr. Goodheart's workshop manuals, and in Dr. David Malther's book, APPLIED KINESIOLOGY, THE ADVANCED APPROACH IN CHIROPRACTIC. Simply test for a strong indicator muscle, such as the middle deltoid. The muscle is again re-tested while standing with boots on, either on the skis or on a flat hard surface. The skier should stand as if he or she were in a normal ski stance. A weakness of the indicator muscle would indicate a possible need for cants, all things considered. Now observe whether the skier stands on the inside or outside edges of the boots. If, for example, the skier stands on the outside edge of the boots then place the wedges on the outside edge, but on the skis. The deltoid would be re-tested for a positive response. Duct tape can be used for the cant. Place the appropriate amount of tape layers tested on the heel and toe plates. If the amount of cant is considerable then a plastic cant purchased at any ski shop can be placed under the bindings, so the bindings may be adjusted in order to operate properly. Another approach would be to sand the sole of the boot with a belt sander. The amount of cant will change as the boots, skis, skier and snow conditions change. Quite often only a few layers of tape will make a considerable change in performance. The skier must, of course, be receptive to the changes and adapt to them accordingly. Many skiers are conditioned to ski in a compromising manner and resist changes, even though it is for the better. This is true of many athletes, so they need your assurance as well as a good understanding of the mechanics involved with the testing. Credit must be extended to Clive Bridgman and William Thistle of the Aspen

Ski Academy, whose enthusiasm and desire to improve allowed us to share our resources and observations. This exchange has allowed us to put together the need for cants and the A.K. procedures to test for that need. Though a simple procedure, it has winning possibilities.

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SOUND CURRENTS AND MERIDIAN BALANCING

By Fatah R. Evans, D.C.

ABSTRACT

It has been observed that specific sounds, related to the Coupled Acupuncture meridians, when intoned by an individual, will restore balance in the Meridian System as measured by methods of analysis of Applied Kinesiology. The tonal clearing seems to be another method of Priority Testing.

Many of you may be familiar with the book, THE SECRET LIFE OF PLANTS, by Peter Tompkins and Christopher Bird. In chapter 10, called "The Harmonic Life of Plants", several experiments are mentioned using music to enhance crop growth and yield. As practitioners of Applied Kinesiology (AK) we are aware of the many variables, including sound, that may influence the Energy Systems of the Body. Dr. John Diamond pursued this phenomena, by observing the effect of music on individuals. Then Dr. David Leaf, in a more controlled experiment, revealed that the results were not as consistent. However, we should not discard the possibility of sound vibrations affecting the Energy Systems.

Recently I reviewed some notes taken in 1973, from a class taught by an acupuncturist, Greg Brodsky, who also authored a book called FROM EDEM TO AQUARIUS. Along with other information given of the Five Element Theory, it was mentioned that there were sounds related to each coupled Meridian:

Liver/Gall Bladder- I (ee); Heart/Small Intestine/Triple Warmer/Circulation Sex- E (eh); Stomach/Spleen- A (ah); Lung/Large Intestine- C (oh); and Kidney/Bladder- U (oo). However, in my investigation this order was not correct, or at least not totally applicable. My findings were as follows: I (ee as in feet) - Liver/Gall Bladder; E (eh as in bet) - Heart/Small Intestine/Triple Warmer/Circulation Sex; A (ah as in ah) - Stomach/Spleen; C (oh as in oh) - Kidney/Bladder; and U (oo as in boot) - Lung/Large Intestine.

My original procedure was to only analyze the Meridian System, and by the usual A.K. methods. For example, therapy localization to the Liver-Gall Bladder Pulse Point would weaken a strong Indicator muscle. The pectoralis major sternal muscle would test weak and then respond strongly with therapy localization to the liver alarm point. We would then have the patient repeat the appropriate sound, and in this case (ee). The sound would be sustained for approximately one minute. The muscle and pulse point were then reevaluated and found to be strong. Generally, therapy localization to the 5 IVF factors, to check for 51%^s, would not reveal any further need for treatment.

The procedure may then be reversed, returning to the original weakness. That is, by backing up on the Shen or Ko cycle, the patient would repeat the appropriate sound. In this case, for example, the kidney meridian sound, which is (oh), would be repeated and then evaluated the original muscle weakness and meridian deficiency would return.

Now if the original investigation revealed an excessive meridian, than the sound of that meridian would be used. However, of the fifty persons tested at the time of this writing, only four of the fifty had an excessive meridian. So we have in no way tested the consistency of this finding.

The procedure was then expanded by performing a more detailed analysis. In other words, performing a more complete examination utilizing the standard A.K. procedures. Listings were then made of the findings; for example, muscle weaknesses, subluxations, fixations, and so on. The patient then repeated the appropriate sound current for two minutes, and then the original findings were

reevaluated. Usually most muscle weaknesses were balanced; some aspects of switching were abolished; some subluxations- even cranials- did not show a need for correction when re-challenged.

Again, the sound related to the backed up meridian, when repeated, could bring back the original findings. However, if you correct all that is left to correct after the patient had repeated the sound, then the sound to the backed up meridian should have no affect in reversing the results. Unless of course, you have missed something in the investigation. Then the sound could be used for challenging possible suspect lesions by the combination of therapy localization and the repeating of the sound. This was positive alone and/or in conjunction with EID or Brain Activity.

The results have been interesting and varied. As stated above, some cranial and spinal challenges were eliminated. A reduction of pain and an increase of range of motion were observed in one patient. While demonstrating the procedures to another doctor, he came to notice a sciatic neuralgia and some tenderness of the right upper quadrant over the liver and gall bladder area; but only after he had repeated the appropriate sound.

It is my inclination at this time to downplay the results, until the procedure is further evaluated and criticized. I have no explanation of this phenomena, but I feel it likened to the subtle energies as observed by Dr. George Goodheart concerning Color Therapy, which he presented at the Houston I.C.A.K. meeting. More specifically, I feel we are dealing with energy centers or chakras as explained by Alice Bailey and Shafica Karagulla, and demonstrated by the Pre and Post Ganglionic Technique. Fir Vilayat Khan, in his book TOWARD THE ONE,

refers to these same sounds and their relation to the different chakra levels.

There is much to be explored and explained, so I offer this to you for your scrutiny. And if valid, consistent, and effective, then for your benefit, and by all means, your patients' benefit.

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Dr. Avery H. Ferentz

DEMOGRAPHIC ANALYSIS OF AN URBAN APPLIED KINESIOLOGY PRACTICE

Abstract: The demographic analysis of an urban Chiropractic practice devoted solely to AK provides data which can be used by individuals and research groups. The data reviewed in this survey includes patient age, sex, marital status and location of residence.

In collecting the data for this paper 434 patient files were reviewed manually by the author. The information is taken from the Personal Data Form (Figure 1) filled out as part of the case history¹ of all patients who presented between March 1980 and January 1982 (23 months). The data can be put to various uses including the preparation of a public relations program aimed at a particular segment of the population and determining if the practice is pulling in the type of patient desired. It is interesting to note that over 75% of my practice is under the age of 41 and that just under half of my patients commute to my office from other areas of the greater New York metropolitan region.

The office is located in Manhattan (New York City) on West 57 Street between Broadway and Eight Avenue. This location is on the north west edge of the central "mid-town" business district and is bordered on the north and west by an old residential area which is undergoing a renaissance in both the commercial and residential sectors. The population in this area is becoming ever increasingly made up of young business people and professionals who live and work in Manhattan.

Demographic Analysis. Ferentz
Page 3

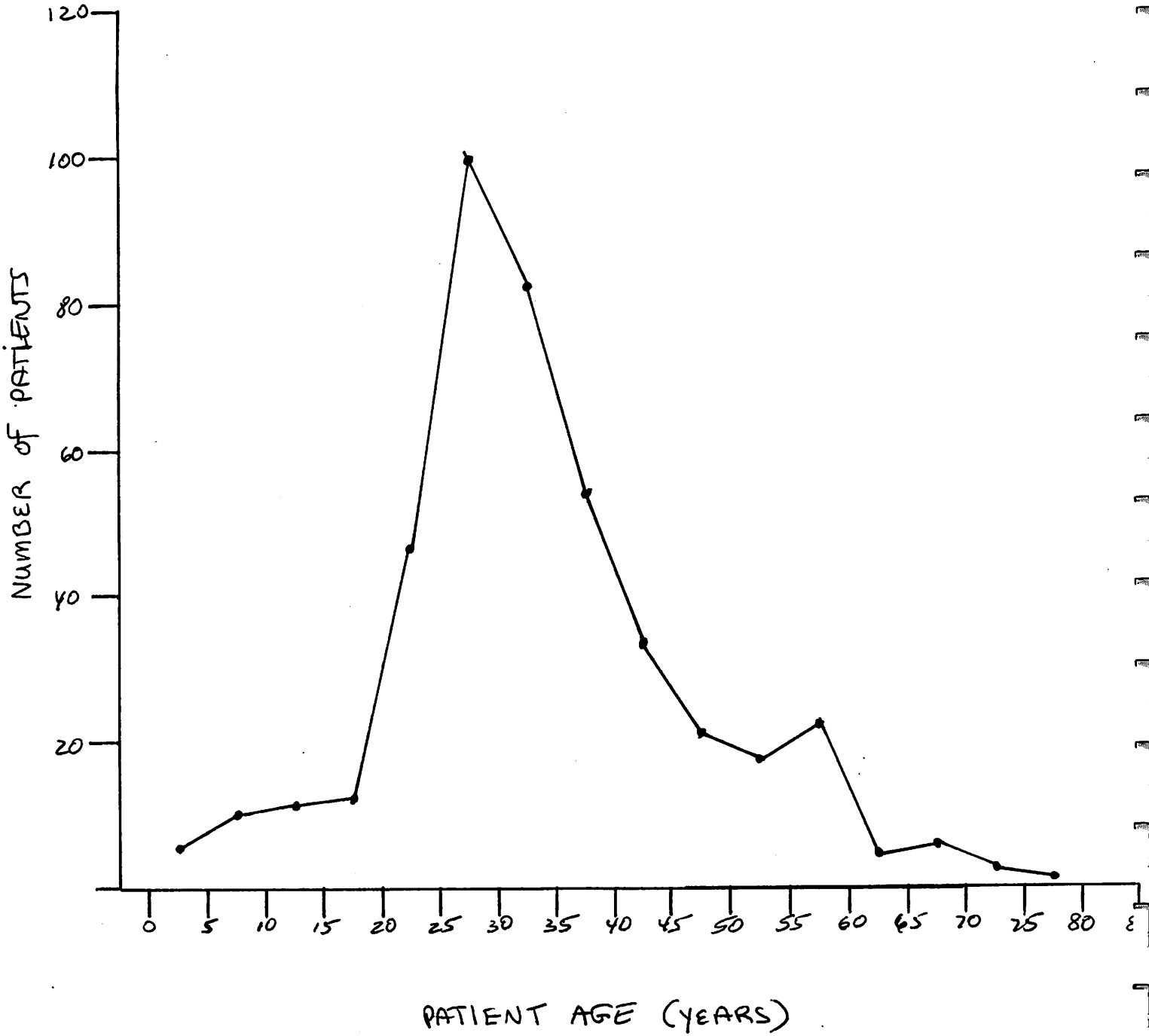
Total	434	
Female	239	55%
Male	195	45%

Figure 2 Patient Population

<u>Age</u>	<u>Patients</u>	<u>Total%</u>	<u>10yr. groups%</u>	<u>20yr. groups%</u>
0-5	6	1.5		
6-10	10	2.3	3.8	
11-15	11	2.5		
16-20	12	2.8	5.3	9.1
21-25	47	10.8		
26-30	101	23.3	34.1	
31-35	82	18.9		
36-40	54	12.4	31.3	65.4
41-45	34	7.8		
46-50	22	5.1	12.9	
51-55	18	4.2		
56-60	23	5.3	9.5	22.4
61-65	4	.9		
66-70	6	1.4	2.3	
71-75	3	.7		
76-80	1	.2	.9	3.2

Figure 3 Patient Age Distribution

DEMOGRAPHIC ANALYSIS FERENTZ
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<u>Female</u>	<u>Male</u>	<u>Marital Status</u>	<u>Total</u>	<u>%</u>
118	87	Single	205	51
70	59	Married	129	32
25	16	Divorced	41	10
11	9	Separated	20	5
7	1	Widowed	8	2

Figure 5 Marital Status (403 patients over age 16)

<u>Female</u>	<u>Male</u>	<u>Location of Residence</u>	<u>Total</u>	<u>%</u>
135	106	Manhattan	241	56
51	42	Other 4 Boros of N.Y.	93	21
10	10	Long Island	20	5
7	12	Upstate N.Y.	19	4
22	15	New Jersey & Connecticut	37	8
10	6	Other states	16	4
4	3	Foreign	8	2

Figure 6a Geographic Distribution of Residence

<u>Location</u>	<u>Total</u>	<u>%</u>
Upper West Side	74	31
Lower West Side	40	17
Upper East Side	48	20
Lower East Side	46	19
Greenwich Village	23	9
Lower Manhattan	10	4

Figure 6b Breakdown of Manhattan Residents

Demographic Analysis. . . . Ferentz
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The age findings of Figure 3, the marital status findings of Figure 5 and the Geographic distribution of Figure 6a and 6b are fairly consistent with the general population trends in the area surrounding my office. Most of my practice (65%) is within the 21 - 40 year old age group, 51% are unmarried and almost 56% live in Manhattan with half of these patients living on the West side. The general sex distribution is fairly even (55% female and 45% male) while single females make up 29% of the total over 18 patient population.

The most positive finding derived from the data is that of patient age distribution and how it will effect the future. As previously mentioned, three quarters of the practice are 40 years old, or younger. Members of this age group are/will become the decision makers of tomorrow in the business and political spheres. Their exposure to Applied Kinesiology and Chiropractic today will only help the profession tomorrow.

¹ICAK Bylaws, Article IV section 5 regarding files and records.

Dr. Avery H. Ferentz

INCIDENCE OF PRESENTING CHIEF COMPLAINTS IN AN URBAN APPLIED
KINESIOLOGY PRACTICE

Abstract: A study of a patient population is presented with incidence of specific chief complaints, sex, and previous Chiropractic experience. Trends in what type of patient is attracted to an urban Applied Kinesiology practice are revealed.

The original chief complaints of the 434 patients seen at my office between March 1980 and January 1982 are included in this study. All information was collected manually by the author from the "complaint" form (Figure 1) which is filled out as part of each patients case history¹.

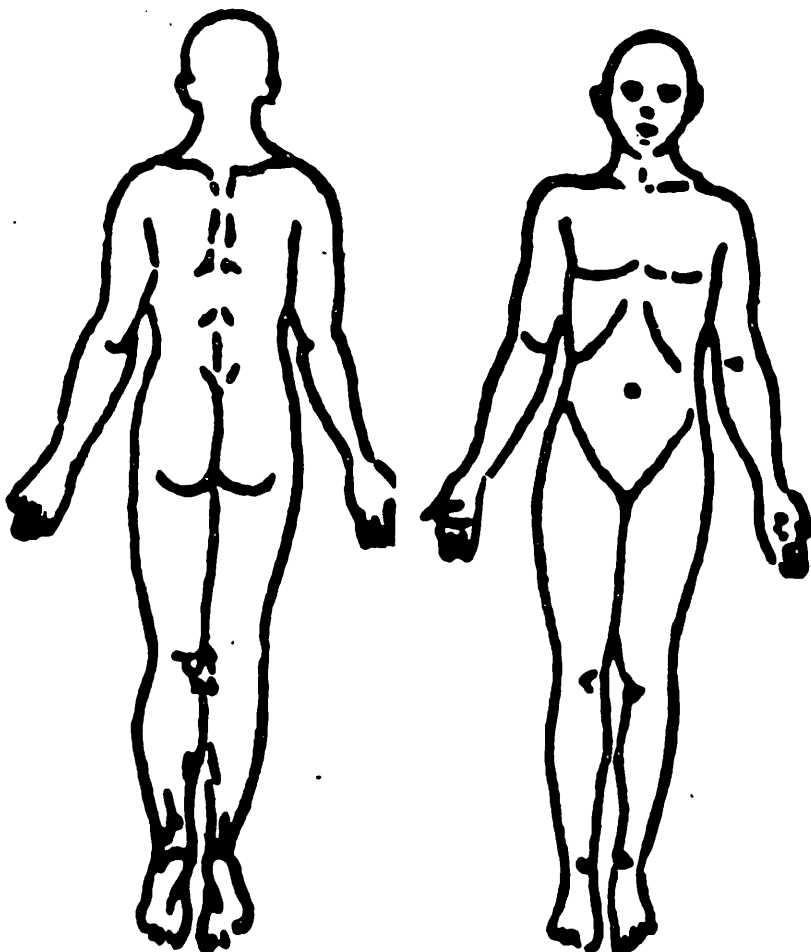
Various correlations between specific chief complaints and the patients sex and previous Chiropractic experience can be drawn from the data presented. In total 38 separate complaints were cataloged. It should be noted that the vast majority of patients had multiple complaints, but the one given the highest priority by the patient was chosen for this study.

My office is located in Manhattan (New York City) on West 57 Street between Broadway and Eighth Avenue. This location is on the north west edge of the central "mid-town" business district and is bordered on the north and west by an old residential area which is undergoing a renaissance in both the commercial and residential sectors.

NAME _____ ADDRESS _____ PHONE _____

AGE _____ SEX _____ OCCUPATION _____

Please describe your present pain fully: _____



When did this pain occur? _____

What were you doing? _____

Have you ever had this pain before? _____

Does this pain hurt worse when you
sit _____ stand _____ move about _____

Does this pain involve a hip _____
leg _____ ankle _____ foot _____

Which one _____

Does your leg become numb? _____

Does your foot feel numb? _____

Does your back hurt worse when in bed? _____

Do you have night sweats? _____

Does it pain you when you bend forward? _____

Is your pain constant? _____

Please outline on the two drawings the exact location and course of your pain _____

Have you ever suffered from this same pain previous to this occurrence? _____

Do heat applications help _____ Worsen _____

Have you been X-rayed during the past six months _____

What medication are you now taking _____

Figure 1

Incidence of presenting chief complaints. . . . Ferentz
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Total	434	
Female	239	55%
Male	195	45%

Figure 2 Patient Population

	<u>Total</u>	<u>%</u>
1- Low Back Pain	98	22.6%
2- Fatigue	36	8.3%
3- Abdominal Pain	28	6.5%
4- Mid Back Pain	26	6.0%
5- Sciatic Pain	26	6.0%
6- Cervico-Dorsal Pain	24	5.5%
7- Head-Neck-Shoulder Pain	21	4.8%
8- Headaches	19	4.4%
9- Allergies	18	4.1%
10- Hyperkinesia	15	3.5%
11- Shoulder & Arm Pain	15	3.5%
12- Knee Pain	13	3.0%
13- Leg Pain	10	2.3%
14- Multiple Joint Pain	9	2.0%
15- No complaint	8	1.8%
16- Upper Cervical Pain	8	1.8%
17- Dysmenorrhea	7	1.6%
18- Foot Pain	6	1.4%
19- Hip Pain	6	1.4%
20- Chest Pain	5	1.2%
21- Upper Respiratory Congestion	5	1.2%
22- Wrist Pain	5	1.2%
23- Hand Pain	4	.9%
24- Temporomandibular joint	3	.7%
25- Eczema	2	.5%
26- Infertility	2	.5%
27- Inguinal Hernia	2	.5%
28- Sore Throat	2	.5%
29- Weight Control	2	.5%
30- Coccyx Pain	1	.2%
31- Constipation	1	.2%
32- Cough	1	.2%
33- Diabetes Mellitus	1	.2%
34- Indigestion	1	.2%
35- Paraplegia	1	.2%
36- Vaginitis	1	.2%
37- Visual disturbance	1	.2%
38- Drug Addiction Withdrawal	1	.2%

Figure 3 Chief Complaints

	<u>Total</u>	<u>Female</u>	<u>Male</u>	<u>With Previous Chiropractic Experience</u>	<u>No Previous Chiropractic Experience</u>
Low Back Pain	98	51	45	70	26
Mid Back Pain	26	13	13	18	8
Sciatica	26	15	11	19	7
Cervico-Dorsal Pain	24	15	9	14	10
Head-Neck-Shoulder Pain	21	14	7	14	7
Headaches	19	9	10	14	5
Shoulder & Arm Pain	15	7	8	11	4
Knee Pain	13	9	4	9	4
Leg Pain	10	5	5	4	6
Multiple Joint Pain	9	8	1	5	4
Upper Cervical Pain	8	2	6	8	0
Foot Pain	6	3	3	5	1
Hip Pain	6	1	6	5	2
Wrist Pain	5	5	0	2	3
Hand Pain	4	0	4	3	1
Temporo-mandibular joint	3	3	0	2	1
Coceyx Pain	1	0	1	0	1
Paraplegia	1	1	0	1	0
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Total:	295	162	133	204	90
% of Total:		55%	45%	69%	31%

Figure 4 Musculoskeletal Complaints

	<u>Total</u>	<u>Female</u>	<u>Male</u>	<u>Previous Experience</u>	<u>No Previous Experience</u>
Fatigue	36	17	19	24	12
Abdominal Pain	28	20	8	19	9
Allergies	18	7	11	12	6
Hyperkinesia	15	1	14	2	13
No Complaint	8	5	3	4	4
Dysmenorrhea	7	7	0	3	4
Chest Pain	5	5	0	4	1
Upper Respiratory Congestion	5	4	1	2	3
Eczema	2	2	0	0	2
Infertility	2	1	1	2	0
Inguinal Hernia	2	0	2	1	1
Sore Throat	2	1	1	0	2
Weight Control	2	1	1	1	1
Constipation	2	2	0	1	1
Cough	1	1	0	1	0
Diabetes Mellitus	1	0	1	1	0
Indigestion	1	1	0	0	1
Vaginitis	1	1	0	1	0
Visual Disturbance	1	1	0	0	1
Drug Addiction Withdrawal	1	0	1	0	1
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
Total:	139	77	62	77	62
% of Total:		55%	45%	55%	45%

Figure 5 Non-musculoskeletal Complaints

Incidence of presenting chief complaints. . . . Ferentz
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<u>Female</u>	<u>Male</u>	<u>Previous Chiropractic Experience</u>	<u>Total</u>	<u>%</u>
154	127	Previous Chiropractic experience	281	65
85	68	No previous Chiropractic experience	153	35

Figure 6 Chiropractic Experience

Examination of the general data on Chief Complaints (Figure 3) shows that almost a quarter (23%) of my patients came to the office because of low back pain and that 74% presented with the 13 complaints at the top of the list while 26% presented with the remainder of the complaints.

Comparison of musculoskeletal (Figure 4) and non-musculoskeletal (Figure 5) groups shows that 68% of patients fall into the former group while 32% fall into the latter. In the musculoskeletal group one third of the patients had low back pain while the remainder were spread mostly over another 12 complaints. This is a distinctly different distribution pattern than the non-musculoskeletal group in which 70% of the patients complained of one of four chief complaints while the other 30% fall into one of the other 16 complaints listed. Another difference between these two groups of patients is the relative amount with previous Chiropractic experience. In the general patient population 65%

Incidence of presenting chief complaints. . . . Ferentz
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had been to a Chiropractor before coming to my office. The musculoskeletal group had a 70% previous Chiropractic experience rate, which is fairly in line with the general patient population. The non-musculoskeletal group, however, had only a 55% experience rate which means that 45% of the patients complaining of non-musculoskeletal complaints had never seen a Chiropractor before. I feel that this is significant in the light of the "back doctor" attitude regarding Chiropractors in New York State. Even though most of the practice is skeletal pain oriented, I am pleased with this trend among the non Chiropractic experience patients.

¹ ICAK Bylaws, Article IV section 5 regarding files and records.

CRANIAL THERAPY

by

Terry L. Franks, D.C.

ABSTRACT:

The following article is a presentation of concepts involving cranial therapy and an overview of procedure.

The actual potential number of different cranial faults is unlimited. There are definite patterns, but the variety appears infinite.

Cranial correction is most effectively done in a proper sequence. This necessitates some form of system such as Applied Kinesiology. Previous approaches have evolved empirically from trial and error, and are done empirically.

Because there are a variety of types of cranial faults, there is a need for a variety of techniques. These techniques consist of three basic approaches. The first is the use of reflexes to attempt to stimulate the body into self correction. The second is to try and assist the body into correction using more external force with or without respiratory assistance. The third is an attempt to make the correction for the body when other approaches have failed, while the indicators remain the same.

Proper technique will involve the use of directional vectors in the proper sequence. This applies to all three approaches.

Using Applied Kinesiology, the now alarm point is a key factor. It is found by therapy localizing the eyes and the appropriate alarm point simultaneously.

A brief overview of procedures is as follows:

1. find the now alarm point

2. find the entry alarm point
3. screen for the cranial compensation
4. clear the compensation using the biocomputer model
5. screen for the primary cranial fault
6. correct it using the appropriate technique

The above procedure allows for the correction of each cranial fault at the proper time (in sequence), with the proper technique, and allows the body itself to determine the amount of correction that is needed.

DIFFERENTIAL DIAGNOSIS METHODOLOGY (D.D.M.)

ABSTRACT: This methodology allows for a more indepth, rational approach to the very complex health problems we are attracting to our offices.

Upon discovering a faulty system in the body, there is a desire on our part to balance the system as totally as possible, not only unto itself, but in relationship to all other systems it may be related to. Therapy should therefore, consist of our taking a look at the neurolymphatic (NL) neurovascular (NV), proprioceptive (cerebellar, hemispheric assistance), neurological (sympathetic, parasympathetic, spinal, cranial, cauda equina [lower neurological] adhesions etc), nutritional (herbs, protomorphogens, homeopathy, vitamins, minerals), emotional (bach, flower Essence Society), and meridan factors. Already the average AK'er is overwhelmed and screaming 'too much', so let me simplify it for you.

- I We get into a body system, by tapping into the alarm point of that system off of an area of pain, the TS line, the pulse diagnosis points, a pathology or lesion; muscle system screening etc.
- II From the active alarm, whether it is over fascilitated or inhibited, our approach is as follows:
 - A. Spinal - alarm point in clear or with pinch
 - B. Sympathetic - alarm point plus palm of fingers on umbilicus plus pinch
 - C. Parasympathetic - alarm point plus dorsum of fingers on umbilious plus pinch
 - D. Cauda Equina - now alarm point and alarm point, hands reversed with pinch
 - 1. to find now alarm point TL eyes plus alarm point which produces weakness of intact indicator
 - E. Cranial - now point and alarm point, hands the same
 - F. Meridian - any two alarm points, hands reversed (may DD opposite meridian)
 - G. Emotional - alarm point plus stomach neurovascular
 - H. Systemic Weakness - TL alarm point while testing specific muscle for that system, plus umbilical tap

As you have noticed, several of the procedures require that a pinch be used while therapy localizing, this is an extension of the Melzack Wall concepts that Dr. Goodheart so wonderfully figured out so that they could be practically applied in practise. Whenever the pinch results in a change of strength it means there is a neurological fault that can be scratched out which is either spinal or a soft tissue adhesion.

My greatest thanks to Dr. Terry Franks for his emmence input in developing this methodology.

CONCLUSION: D.D.M. is a rapid way to differentiate an over fascilitated vs inhibited system and then affords you a multitude of choices from which to approach and more throughly restore it to its homeostatic state.

BASIC CONCEPTS AND PSYCHOLOGICAL REVERSAL

by

JOHN T. HUGHES, DC

Abstract: Validation of Psychological Reversal (PR) is presented. Basic Concepts are discussed in relation to PR.

A concept is a mental image. A basic concept is one that is functional on the subconscious level in such a way as to affect the physiological response of the body.

We instinctively or innately know how to digest and assimilate nutrients, eliminate waste, repair tissue and carry out the basic functions of life.

Through the process of education, we develop ideas or concepts that are impressed upon these innate functions in such a way that the functions are altered - favorably or unfavorably. The unfavorable are capable of producing disease.

The conscious or educated mind reasons both inductively and deductively while the subconscious reasons only deductively. The conscious mind has the ability to choose, to accept or reject an idea. This ability of choice is not present on the subconscious level. If an idea is totally logical to the conscious mind, it is accepted and carried out to its most logical conclusion. This idea or concept may be beneficial or harmful to the body.

For example, a person may have experiences that convince his conscious mind that he cannot digest onions. If this concept becomes totally logical to the conscious mind it is accepted by the subcon-

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scious and becomes a basic concept. Thereafter, each time the subconscious receives the "onion" stimulus, it responds with indigestion.

These induced, faulty concepts may affect only narrow fields, as in the example above, or may be so broad as to affect the whole scope of one's health.

Applied Kenesiology has given us excellent techniques for removing the structural and chemical causes of disease; however, the psychological or third side of the health triangle seems to need improvement.

Now it seems that one of our ICAK Members has given us a physical, A K approach to this psychological, misconception dilemma.

I am referring to the excellent paper by Roger Callahan, PhD, in the winter 1981 edition of ICAK Collected Papers entitled "Psychological Reversal."

Psychological Reversal (PR), according to Dr. Callahan, is present when a person has an indicator muscle go weak after making a statement which he desires and tests strong after making an undesirable statement.

The hypochondriac, who spends considerable time affirming or reciting symptoms, has made ill health so logical that he will test weak when he says "I want to feel good" and will test strong when he says "I want to feel miserable". Dr. Callahan calls this, massive reversal. No matter what is done for this patient, he can never

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respond completely to therapy until the PR is corrected.

It was suggested that there may be some connection between PR and switching. We tested sixty (60) patients and found twenty-six (26) to be reversed on feeling good. Others were reversed on subjects such as headache, high blood pressure, ear noise, overweight and stuttering, to list a few.

All of these patients showed an apparent PR correction when the switching technique of K27, umbilicus was used; however, on follow up, there was frequent return of PR on the same problems. It seemed that we were still not getting into the third side of the triangle.

Dr. Callahan's system seems to work better. The mental activity, the mind chemistry that is activated by thinking of the problem, as the small intestine meridian is balanced, seems to be necessary for satisfactory results.

The patient usually expresses great surprise when they find that they test weak after stating that which they desire.

It seems to be advisable to make it clear to the patient that it is not their thinking that is making them sick but false concepts that have been impressed on the unconscious part of their being via television, parental example, etc.

If the patient thinks you are saying his problem is imaginary or in his head, a barrier immediately goes up and the composite

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personality or doctor-patient relationship is damaged.

In conclusion, I feel that PR is one of the primary causitive factors for which we have been searching. It seems that more research in this direction may bring us an even more effective tool for correcting faulty basic concepts.

Testing for the frequency of occurrence in new patients
for: CLOACALS, HYOID, TEMPORAL MANDIBULAR JOINT. SPHENO
BASILAR PLATE, AND ILIO-CECAL VALVE.

By: Dr. Alex P. Karpowicz, D.C., D.I.C.A.K.

ABSTRACT

My original paper concerning this topic was presented at the summer meeting of collected papers of the members of the International College of Applied Kinesiology, 1979. Patients were taken at random. Some had been under my care before while others had not. It was suggested by a doctor in the audience that I repeat the study using only new patients who had not previously been to a doctor using Applied Kinesiology methods. This report is based on new patients only.

RESULTS

A total of 100 new patients were tested for the five diagnostic tests. Of these, seven showed a positive temporal mandibular joint 4 a hyoid involvement, three had a spheno basilar, twelve exhibited a positive cloacal response, and twenty-five demonstrated the presence of an ilio-cecal valve problem. The original results from a random sampling of fifty patients was as follows 12% showed a positive cloacal, 16% had a positive hyoid, 14% demonstrated a positive TMJ, 30% had a spheno-basilar, and 10% had an ilio-cecal valve problem.

CONCLUSION

The current testing involving only new patients showed an increase in findings for the ilio-cecal valve. the same percentage for the cloacal; and a drop in frequency for the temporal mandibular joint. hyoid, and spheno-basilar, as opposed to the original method of testing patients at random. The ileo-cecal valve definitely should be examined on every new patient, much less those with bizare and pain-related symptoms. It seemed to me that I would have a run on certain problems. That is, five temporal mandibular joint patients in a row, then a dozen without any temporal mandibular joints. It may be what we're attracting or concepting at any given time or perhaps simply coincidence.

RECURRENT HIDDEN CERVICAL DISC AND THE
TENSEGRITY MAST CONCEPT OF SPINAL MECHANICS

by Gary N. Klepper, D.C.

Abstract: Correction of some chronic structural lesions is better maintained if the body is adapted to the corrected position of the segment in question by checking the entire spine while the body is placed in a position of exaggerated correction of the segment.

The use of methods for diagnosing and correcting the hidden cervical disc lesia as recently described by Dr. Goodheart has been of great benefit in the management of a variety of disorders, as we all know. However, when beginning to institute these procedures in my practice, I quickly noted not only a substantial number of patients requiring repeated correction of this lesion, but also a certain pattern to those patients who demonstrated unpleasant side effects to the correction.

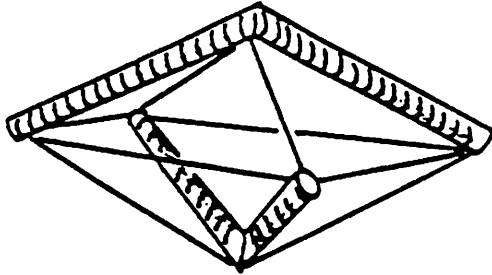
The side effects took the form of moderate to intense discomfort in the mid-dorsal to dorsolumbar junction area or coccydynea which had not been present prior to the correction and which developed either immediately at the time of the adjustment or after a delay time of several minutes to a few days. Examination of these patients usually revealed either dorsolumbar fixation or anterior coccyx which had previously been either undetected or not present. Correction of whatever was responsible for development of the pain brought relief with no further complications. At that time, I explained to the patient that correction of the cervical disc syndrome necessitates an overall lengthening of the spine, and that the pain had occurred in areas which, due to a subtle, undetected

lesion, were preventing the needed lengthening of the spine.

Correction of these complications alone was inadequate insofar as preventing recurrence of the cervical disc in some patients. I therefore continued to investigate any other causative factors that I could identify, such as postural factors involving the carriage of the head anteriorly in relation to a normal weight bearing line due to habit or postural muscle weakness; the tendency of the patient to place himself in a position which creates downward forward pressure on the lower cervicals, such as reading in bed or watching TV with the head propped up on pillows, or doing head or shoulder stands or the plow posture of yoga; adhesions or fascial constriction changes in the anterior cervical musculature; general ligamentous instability; and etc. Correction of all of these factors has been of some value in the prevention of recurrence of the cervical disc, but some patients seemed to be in the frustrating position of needing to have everything corrected which could have the least bearing on postural balance before the cervical disc correction would hold.

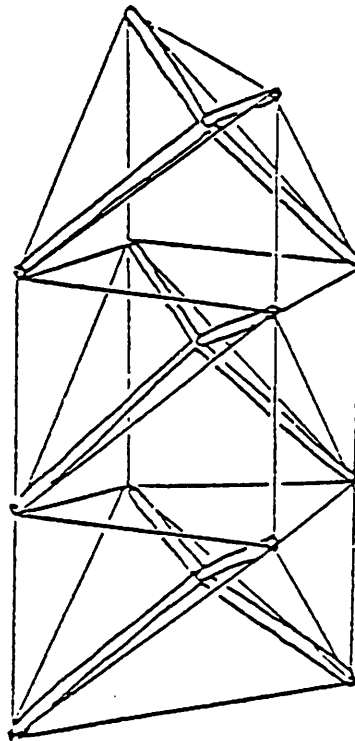
A greater degree of understanding of this problem and a simple means of handling these patients was given to me after reading an article written by Ron Kirkby, Ph. D., entitled "The Probable Reality Behind Structural Integration- How Gravity Supports The Body" in which he likens the mechanics of the spine to the "tensegrity mast", designed by R. Buckminster Fuller. Briefly, the term tensegrity mast (derived from the root words "tension" and "integrity") refers to the design for a tower or mast which utilizes rigid struts as spacers held in place by cables under tension (see illustration). The essential feature of the tensegrity mast is its great strength, which is present by virtue of the fact that tension or stress applied

TENSEGRITY illustrations



Single cell of a tensegrity mast shows two solids stacked on top of one another and held in place by tension in their tensional elements.

Tensegrity mast. Kirkby compares the vertebrae to the rigid struts of the mast, and paraspinal soft tissues to the cables of the mast.



at any point in the mast structure is distributed throughout the entire mast by compensatory tension in all of the cables. The rigid struts are not the weight bearing structures of themselves, but only act as spacers, while the weight of the structure is borne by tension in the cables. Ron Kirkby in this article compares the vertebrae of the spine to the rigid struts of the tensegrity mast, and the soft tissue paraspinal elements to the cables of the mast. He thusly states that the vertebrae and discs of the spine are not designed to be entirely weight bearing structures, but to be spacers and shock absorbers primarily, and that most of the weight bearing of the body should be done by the muscular, ligamentous, and fascial structures. Among evidence produced in favor of this view is the fact that vertebral trabecular pattern predominantly runs horizontally rather than vertically.

On pondering this concept, I began to see the recurrence of cervical disc or any other chronic structural problem in terms of lack of adaptation of the entire body's soft tissue framework to the new position of the vertebral correction which I was attempting to establish.

To put this concept into use, I follow this procedure: After a significant but recurrent subluxation has been corrected, the body is placed in such a position as to increase the position of correction of the subluxation. For instance, in the case of cervical disc, prone correction involves bringing the facet of the vertebra above the disc involved down the plane of the superior facet of the vertebra below the disc. If the correction involved one side more than the other, the head is then placed into rotation to that side, which causes the articular facets to move into a direction similar to the direction of the corrective thrust. It

TENSEGRITY 4

also distorts the surrounding soft tissues into a configuration exaggerating the corrected position of the involved vertebra. At this time, the entire spine, ribs, and pelvis may be scanned for any lesions which are now present, which were not detected with the head in a straight ahead centered position, and these are now corrected.

What has been done here is to adapt the entire spine to the corrected position of the cervical disc, thus allowing it to more easily maintain its correction because the rest of the body is now supporting the segment in its corrected position rather than working against it.

With a little imagination, this technique can also be used to adapt the body to the corrected position of any chronic structural problem.

Special thanks to Dr. Robert Borman of Broomfield, Colorado for introducing to me the tensegrity mast concept of spinal mechanics.

REFERENCE

"The Probable Reality Behind Structural Integration- How Gravity Supports the Body", Ron Kirkby, Ph.D., Rolf Institute, Boulder, Colorado.

Nancy L McBride, D.C.

THE TAP AUDIT

ABSTRACT: By tapping an alarm point being scrutinized along with T-L of the now alarm point or simultaneous T-L of the now alarm with an alarm point in question and tapping of the umbilicus we may have another method of auditing into the visceral functioning and integrity of the body. At Least, perhaps we can get into a deeper level of function.

Last fall during his visit with Dan Gleeson to Los Angeles, Terry Franks shared some of his recent research with me. He has been working on a method to "get into" the different systems of the body especially when the muscle testing was non indicative or "strong in the clear".

I'm not proposing in sharing with you now that I am capsulizing Dr. Frank's research only how I have been utilizing a small part of his work.

I'm sure I am not the only A-K practitioner who experiences frustration when trying to determine when to continue or discontinue a patient's present nutritional support or even if the patient even needs any support.

The basic testing procedure I have been working with is to first identify the now alarm point, if strong in the clear then go on to counter T-L against any other alarm point if this combination is strong in the clear

then while the patient is simultaneously T-L both the now and the alarm point in question tap the umbilicus and re-test the indicator muscle. If weakness is now elicited you must now be into a deeper level of the system. Another variation of this method is to T-L the organ area and counter T-L the organ alarm first and then with the umbilicus tap. At this point when the umbilicus tap demonstrates a weakness you can then begin to audit against this weakness with adjunctive nutritional items.

Many times through preliminary A-K balancing techniques the obvious areas have been corrected and are being maintained. What we don't know is what else is needed to completely regenerate the system.

To illustrate a case in point; a patient had a maturation index report done at the same time she had her Pap smear and the report was very unfavorable with superficial squamous cells at only 10% and parabasal cells at 70% which was exactly opposite of normal. The estrogen output was very low and coupled with the fact that she had had a breast removed due to carcinoma she was not unduly worried. The patient did not want to participate in the hormone program outlined by the Gynecologist and came to my office for nutritional therapy to reverse this pattern.

TAP AUDIT

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Within 4 months of strict adherence to the nutritional program that was outlined for her the patient had completely reversed the original laboratory findings. Now we had to establish whether she still needed the products that she had taken to arrive at this new state of health. Using the procedure outlined herein we are still monitoring the products she was taking eliminating the ones no longer checking with a positive test response and continuing with the ones that do check.

After her initial period of nutritional adjunctive therapy she no longer elicited any system weakness on a muscle testing basis or on T-L of just the alarm points or even with counter T-L of the organ and alarm point for the organs. She did elicit weakness with the tap on the umbilicus.

I have found many patients who have been under treatment still show "system" weakness when using this method of cross T-L and tapping the umbilicus.

We have also begun to use this method to audit for Bach flower remedies with some very interesting results.

I still believe that the organs of the body relate to states of consciousness and when the consciousness is altered the organ system will in time alter also.

APPLIED KINESIOLOGY: DEFINED?

Kerry M. McCord, D.C.

The combined terms "applied" and "kinesiology" describe the basis of this system, which is the use of manual muscle testing to evaluate body function through the dynamics of the musculoskeletal system. "Kinesiology" comes from the Greek word "kinesis", meaning motion, and "ology" meaning the study of a science or branch of learning. Kinesiology then, means the study of the principles of mechanics in anatomy in relation to human movement. The term "applied" puts into perspective this utilization of kinesiology. According to Webster, the first definition of "applied" is: "Put to practical use: engaged in for utilitarian or contributory purpose: concerned with concrete problems or data rather than with functional principles." This certainly describes the use of kinesiology in the practical application known as applied kinesiology.

The above quoted passage is found in Applied Kinesiology Volume I by David S. Walther. The intention of the section in which it appeared was to introduce the reader to the concept of applied kinesiology, its origin, its philosophy and its far-reaching implications.

At the Annual Meeting of the ICAK in May of 1980, a definition of applied kinesiology was developed and ratified. The result of that "lengthy discussion" reads as follows:

The science of applied kinesiology is an organized diagnostic approach of evaluation and physiological therapeutics organized and developed within the chiropractic profession using muscle relationships and muscle organ relationships as determined by manual, mechanical or electronic forms of muscle testing. It allows evaluation and correction of bodily dysfunction and it aids in the prevention of disease and the promotion of health.

As is the case with any proposal, differences of opinion arose and some expressed their discontent with the definition adopted. Upon receipt of the minutes of that meeting, a brief discussion between Dr. Jerry L. Birkett and myself, transpired. We had little criticism with the intended meaning but found the wording somewhat ambiguous and lacking in clarity.

One need only to analyze the definition word by word to realize that its meaning might be expressed more clearly and distinctly. The relative ambiguity might be a function of the circumstances under which it was written and adopted. Perhaps, the fatigue created by prolonged and tedious discussion colored the outcome? Be that as it may, we are left with a definition of applied kinesiology that could stand to be improved.

Our decision, of course, can be to leave it as it is, or, we can create a mechanism by which the definition may be reviewed and recommendations regarding alteration in content and structure may be made.

The latter seems most appropriate. The following is an example of what might develop from even a cursory review and relatively minor alterations in content and structure:

The science of applied kinesiology is a system of diagnosis and therapeutics, developed within the chiropractic profession, using information derived from the observation of neuromuscular and musculo-skeletal relationships, as determined primarily by manual muscle testing, in the evaluation and correction of bodily dysfunction, thereby aiding in the prevention of disease and the promotion of health.

Our purpose must be to provide a solid foundation for the development of applied kinesiology and continue to strengthen its structure through constant revision and a firm commitment to excellence.

COLOR: ITS USE IN RIGHT/LEFT BRAIN FUNCTION
A POSSIBLE KEY TO CELLULAR MEMORY

by

BARBARA D. McQUEENEY D.C.

ABSTRACT:

This is a preliminary report exploring the use of primary colors to influence right and left brain function. A hypothesis on the possible interrelationship of color with the hologramic concept of the brain is presented.

For thousands of years, color has been correlated with acupuncture meridians. Ancient religions have referred to the colors of our chakras. Those gifted with higher sense perception have described their experience of the human body in terms of color. John Ott has enlarged our perspective of the myriad effects of color on different forms of life. George Goodheart has demonstrated the use of color to help a vertebral adjustment hold better. However the actual function of color, a component unifying all the different types of color in the body, has been left unresolved. I feel the concept of the hologram offers a mechanism to explain these phenomenon.

The hologram concept represents an entirely different view of the interaction of mind and body. At the winter

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meeting of 1981, George Goodheart presented a technique utilizing right and left brain activity to uncover faulty bone memory patterns in the spine. These bony segments had basically lost the memory of their correct alignment, but with the mechanical stimulation of tapping during the brain activity that strengthened the area, the memory pattern of the brain and the vertebra were reunited. This concept of a hologram, a far cry from the traditional connectionistic one, involves a perfect image of an area of the body represented in the cells of the brain. That specific area of the body must also have the same perfect image of itself exactly coordinated with the brains' image. Problems arise when these two images are in disharmony.

Is it possible that color serves as an energy link between the various memory patterns of the body? Each area of the body ends up a particular color, but the determination of that color might be influenced by the subtle blending of different shades of color it receives from various regions of the brain. Possibly many discrepancies in color therapies of the past were because

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a certain organ or area of the body begins with a certain tone, but it is enhanced or possibly changed quite significantly depending upon input it receives from the brain.

When clairvoyants see an area of the body that is functioning abnormally and describe it as being muddled and indistinct, are they actually able to visualize the representation of an imperfectly relayed reflection? Poor synchronization between the memory pattern of the brain and the memory pattern of that organ or vertebra could lead to a lack of sharpness or clarity over that region of the body. Throughout history people of all cultures have been interested in colors and pigments. When a warrior smeared himself with war paint, was it strictly to frighten his adversary or could it possibly have stimulated different areas of his brain to actually make him fiercer and more courageous? In our culture is it strictly coincidental that the colored cosmetic preparations that have evolved to such widespread use among women, so closely approximate the meridian

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beginning and end points on the face, fingers and toes that we now use to stimulate the hypothalamus? Possibly the hit and miss success of color therapies of the past were their occasional ability to coordinate and lock in these faulty memory patterns between the brain and various organs in the body.

This is a preliminary report on the use of colored pigments to affect right and left brain activity in the body. At this time however, my subject pool has been too small to draw any definite conclusions. My procedure was rather simple. I bought some natural pigments from Pfanzen Farben Labor in Germany. I got a number of different colors, entirely natural in a crystalline form with a bottle of white emulsion to mix them in. I would apply the pigment to different areas on the skin with a wooden tongue blade. I did not spread it around or rub it in, but would just place a dab of a certain color or just the plain emulsion on the specific area I wished to check and would then retest my indicator muscle. For simplicity's sake I decided to start with the primary colors of red, yellow, and blue. At first

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I was looking for a certain color to strengthen a certain region of the body, but my results were not that impressively consistent. However I noticed that if the particular area of the body strengthened with left brain activity, it would also strengthen if the yellow pigment was applied. When an area of the body strengthened with right brain activity, it would also strengthen if the red pigment was applied. I then started looking for areas of the body that showed a positive therapy localization that was abolished by right or left brain activity; muscles weak in the clear that strengthened with either right or left brain activity; areas of the body that had been treated but re-weakened when therapy localization was combined with left or right brain activity; or basically any area of the body that demonstrated a change of muscle strength with right or left brain activity. The specific areas of the body that strengthened with right brain activity were also strengthened with the red pigment. The weak muscles that strengthened with right brain activity also

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strengthened if red was applied to the general region of the associated organ. The same was true for yellow with left brain activity. When an area was strengthened by both left and right brain activity, blue would strengthen the area. If an individual was switched, the whole pattern was scrambled. It occurred to me on the last few switched patients I worked with, to attempt to unswitch them with color instead of the usual means. Applying blue over K-27 and the umbilicus removed the indications of switching, and the pattern reverted to the normal red-right brain, yellow-left brain. However this may be true only in these few instances. Occasionally other colors would also strengthen at least partially, the indicator muscle but the effect was removed as soon as the color was wiped off. Wiping off the red for right brain activity and yellow for left brain activity had no effect. Once the indicator muscle was strengthened it stayed strong. As previously stated I have used too few subjects to be sure this trend is the correct correlation. However color does seem to have a dramatic effect on right/left

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brain activity and warrants investigation into the possibility of an energy component in the form of color as a complement to the mechanical stimulation of tapping we are presently using.

SUPRAHYOID MUSCLES AND THE PELVIC DIAPHRAGM

by

BARBARA D. McQUEENEY D.C.

ABSTRACT:

A possible relationship between the suprahyoid muscles and the muscles of the pelvic diaphragm is explored in this report. Goodheart's technique of tightening a certain muscle group to influence the tone of a remote area of the body is utilized. A potential implication in the developmental differences of small children is presented.

At the spring 1981 meeting of ICAK, George Goodheart presented a technique to increase the tone of the abdominal wall, and thereby decrease the dimensions of the abdomen, by strengthening the rhomboids. He also demonstrated how weight is basically a function of balancing the forces within the body against those outside the body. By tightening one area of the body, there is an increased ability for the body to maintain its tone in other remote areas of the body. Decreasing the expansiveness of the body is associated with a decrease in actual weight. So both size and weight of an individual are influenced by equalizing this force within the body that is pushing out, with the force outside the body pushing in.

While working with patients having a persistent

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feeling of poor support in their pelvic diaphragm regions, I theorized that this concept might be applicable to the superior and inferior poles of the body, and began investigating a relationship between the muscles of the pelvic diaphragm and other remote muscle groups. After the preliminary research, a correlation seems to exist between the suprahyoid muscles and the pelvic diaphragm.

The patients I selected for this project had already been treated and cleared of any of the usual problems associated with the pelvic diaphragm, plus had been treated for any hyoid imbalances.

My procedure was as follows. First, using a strong indicator muscle the patient would therapy localize to the pelvic diaphragm. This was usually negative. However if the patient would simultaneously bear down increasing the pressure, the indicator muscle would frequently weaken. Cross therapy localization to the suprahyoid muscles was then accomplished to see if this would abolish the weakness. When the pelvic diaphragm did not show a positive therapy localization with bearing down, and yet there was still some indication of a problem, cross therapy

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localizing to the suprahyoid region would often elicit the weakness. Treatment consisted of using spindle cell technique to increase the overall tone of the suprahyoid muscles. The pelvic diaphragm was then evaluated by re-therapy localizing with either bearing down or cross therapy localizing to the suprahyoid muscles, whichever created the initial weakness.

The response in both male and female patients seems to indicate that there is a definite relationship between the suprahyoid muscles and the pelvic diaphragm. However further research should be done to evaluate whether the effect is actually on the levator ani muscles or perhaps the muscles of the perineum. There may be a more specific correlation between individual muscles of the perineum and the suprahyoid muscles.

On a few patients concerned with losing their chin line, I have begun to investigate the possibility that the relationship is reciprocal. The preliminary results give enough positive support to warrant further investigation. As a side note, but an extension of these findings, is the possibility of this phenomena

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being a causative factor in determining skull size in young children. In the growing child, there must be some mechanism that controls the force within their body pushing out against the force outside their body pushing in, and thereby influencing their proportions as they grow. Possibly the sucking reflex plays an integral role. We've all seen two little kids standing next to each other; one with a tiny head and a miniature perfectly proportioned adult body, and the other child with a much larger head and although not necessarily fat, a much softer body. The first child has the force outside his body overpowering the inside force and creating a tiny little old person, and the second child has his inside force too great for the outside force, creating a large soft overgrown body. Results from utilizing these techniques to alter the tone of specific muscle groups to influence the body's dimensions, may prove to be much more dramatic working with individuals in their early formative years.

PRIMARY RESPIRATORY MECHANISM
INHIBITION UPDATE

BY

Richard MELDENER D.C.

ABSTRACT

New procedure for Inhibition of the Primary Respiratory Mechanism (IPRM₂) and how does it contribute to APPLIED KINESIOLOGY diagnosis .

In the 1981 Winter publication of the Collected Papers of the International College of Applied Kinesiology , page 209 , I had the pleasure to introduce the concept of inhibition of the Primary Respiratory Mechanism (IPRM) as a method of investigating subclinical faults .

Different methods were presented & IPRM was attempted by trying either to lock :

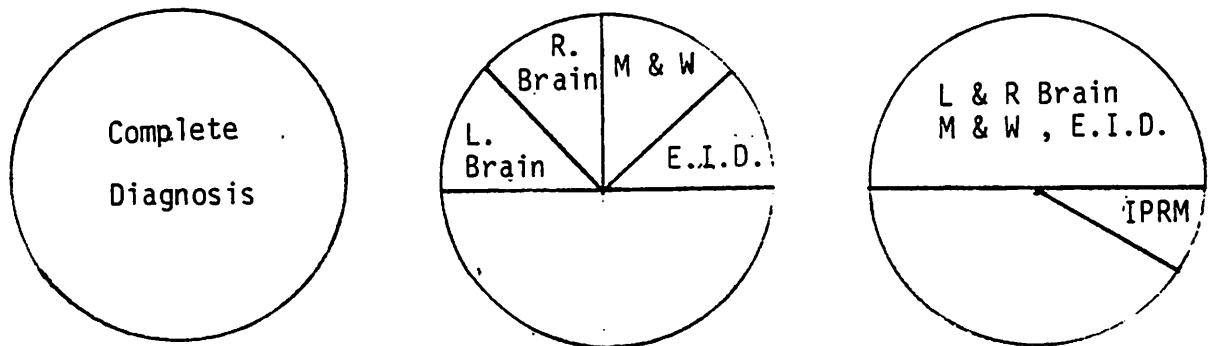
- the sacrum ...: patient was requested for example to bring one knee on top of the other in the sitting or supine position.
- the T.M.J. ...: patient was requested to protrude the jaw
- the respir-...: patient was requested to hold his or her
ation breath without breathing in or out
(procedure previously described by
GOODHEART)

PRIMARY RESPIRATORY MECHANISM

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The diagnostic finesse gained when applying the IPRM method seemed to add up to the diagnostic finesse already gained when using Nervous System activation techniques such as : Right or Left brain activity , E.I.D. cerebellum activity , Melzack Wall activity as described by GOODHEART .



While continuing to investigate the IPRM method I soon started to realize no matter how careful I attempted to lock either the sacrum , or the T.M.J. or the respiration , I sometimes hardly could succeed to inhibit the Primary Respiratory Mechanism .

The purpose of this paper is to present a modified & more efficient PRM locking procedure which I have called IPRM₂

NEW IPRM PROCEDURE
IPRM₂

Instead of attempting to lock one factor intimately related to the Primary Respiratory function ; such as the sacrum or the jaw or the respiration ,

I now attempt to inhibit the PRM by locking simultaneously two factors intimately related to PRM function :

PRIMARY RESPIRATORY MECHANISM

INHIBITION UPDATE

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Simultaneous - Sacrum & Respiration
 locking of - or Sacrum & T.M.J.
 either : - or T.M.J. & Respiration

This new procedure : IPRM₂ has revealed to be much more efficient in attempting to lock the PRM and allows a much wider spectrum in diagnosis than the IPRM method previously described .

USE_OF_IPRM₂ At this time I have found two major capacity to IPRM₂ :

I. Therapy Localization which is informative under specific experimental conditions only , appears to be informative under IPRM₂ alone .

I have observed for example that under IPRM₂ that :

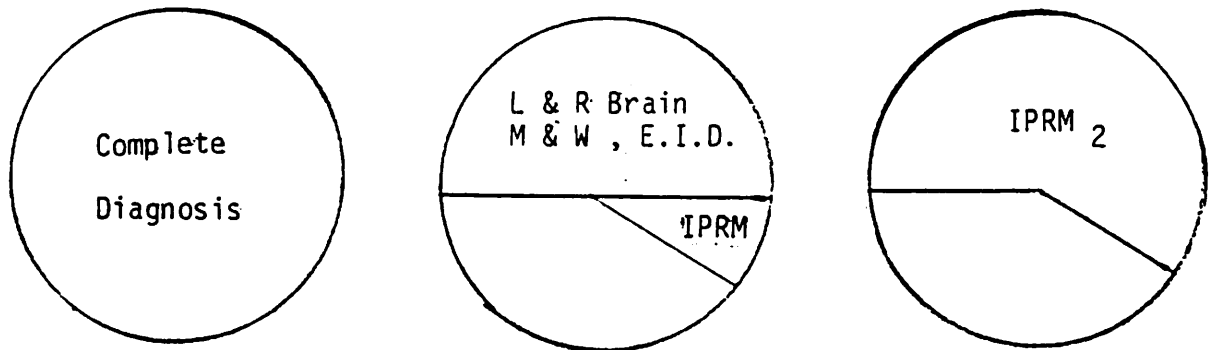
- Fixations TL without motion
- T.M.J. TL without the mouth wide open or tightly closed
- Protruded TL with a single contact instead of TL with a contact & Herniated on the vertebra above and a contact on the vertebra discs below
- Sacrococcygeal TL with a single contact instead of TL with one joint contact on the sacrum and one contact on the coccyx
- Hidden cervical TL without caudal pressure added to the head disc
- Skin TL without challenge
- Hyoid TL without challenge
- Diaphragm TL at the infraxiphoid area without deep respiration

2. IPRM₂ seems to reveal the sum of the spectrum revealed individually by Right & Left Brain activity , EID activity Melzack & Wall activity and IPRM activity :

PRIMARY RESPIRATORY MECHANISM

INHIBITION UPDATE

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Nota : While validating this observation on 100 patients I was surprised to observe that information obtained under memorisation was not obtained under Right or Left Brain activity or Melzack & Wall activity or E.I.D. activity, and was not obtained by either IPRM or IPRM₂

CONCLUSION

I have observed IPRM₂ to be a valuable tool for finding subclinical faults .

The combining of :

- Memorisation and
- IPRM₂

appears at this time to offer the widest spectrum of diagnostic finesse and happens to be a very practical & time saving system to apply .

AEROBIC-ANAEROBIC FASCIAL FLUSH

The fascial flush procedure and the aerobic-anaerobic testing procedures are reviewed. These procedures provide the rationale in establishing the hypothesis of aerobic-anaerobic fascial flush. A small data base is presented.

by Evan Mladenoff, B.Sc., D.C., D.T., F.I.A.C.A.
Diplomate of I.C.A.K.

FASCIA AND FASCIAL DIAGNOSIS

The fascia represents a unique feature of muscle ultra structure. A connective tissue sheath, the epimysium surrounds the muscle and sends septa (perimysia) into the muscle to envelop bundles of muscle fibres. From the perimysia, delicate strands of fine connective tissue (endomysia) pass inward to invest individual fibres.

The connective tissues of the muscle blend with the collagen bundles of the tendon, forming a strong and ultimate union, the myotendinous junction. Connective tissue of muscle and tendon are continuous. They act together as a buffer system against the possibility of too-rapid development of contractile force in the muscle. Without their distensibility the muscle would be in danger of rupturing its fibres or tearing its attachments by a sudden contraction.₁

The muscle and its surrounding and supporting fascia should both be of the same length. When the muscle contracts the fascia should contract, and when the muscle relaxes the fascia should relax. As long as the muscle and fascia operate as a unit the body interprets the muscle and fascia organization as integrated and accepts it as a unit. If the muscle is long and the fascia it serves is short, this creates confusion in the body and the spinal cord accepts these conflicting pieces of information and puts the muscle-fascia organization on hold.

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This conceptualization of muscle and fascia being of different lengths affords a method of diagnosis using the principles of muscle testing. The initial length of the muscle, that is its length at the time stimulation, influences the magnitude of its contractile response to a given stimulus.

Goodheart's original observation was made on a young tennis player who complained of weakness and pain of the posterior deltoid following 2 or 3 sets of tennis. The boy was allowed to play, then his muscles were tested at the time when the complaint was the most obvious. No muscle weakness could be elicited in any of the shoulder muscles by any method of testing.²

Goodheart reasoned that the posterior deltoid could only be weak when the anterior deltoid was contracting. Yet it was obvious that the anterior deltoid was not contracting, since the posterior deltoid was pulling the arm back in preparation for service.

Perhaps the posterior deltoid "thought" the anterior deltoid was contracting. If the fascia were to be short it would give the spinal cord the information that the fascia was short. Consequently, it would produce erroneous information that the anterior deltoid therefore was contracting and this was the reason why the posterior deltoid would weaken on a reciprocal basis -- because of the error of judgement that the body was producing.

.../3

Stretching the anterior deltoid then testing the posterior deltoid produced an immediate weakening. Using a hard deep kneading pressure to the fascial envelope of the anterior deltoid corrected the above muscle pattern. It was soon found that stretching a muscle or any part of it would cause a weakening in that particular muscle or in an adjacent muscle if the fascia were short and did not respond to the stretching of the muscle.

Goodheart found that in gravity muscles (slow twitch-aerobic ie. psoas or gluteus maximus) a relatively slow stretch would produce a weakness response when tested in the usual fashion if there were a fascial shortening involvement. In the non-gravity or fast anaerobic muscles, a rapid stretch prior to testing was indicated.

MODUS OPERANDI

1. Test the muscle in the usual fashion; if weak, fix in the usual fashion.
2. If the muscle tests strong and you suspect corresponding organ or possible muscle involvement, simply stretch the the muscle. If it is a gravity muscle, stretch it slowly; a non-gravity muscle, stretch it rapidly. Retest with the muscle; if the muscle weakens, this is the response that indicates a fascial involvement.

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3. "Iron Out" the fascial covering by hard pressure. For instance, the pressure has no directional indications, but is rather like trying to straighten the accordinian pleats of a folded piece of paper. There would still be evidence of the folds in the paper despite your best efforts.
4. Restretch the muscle in the previous fashion and retest the muscle. The muscle should be strong.
5. Activate the neurolymphatic and neurovascular reflexes for that particular muscle.
6. Recommend the addition of vit. B12 stomach - liver substance 3 times a day for at least 2-3 weeks.

AEROBIC-ANAEROBIC MUSCLE TESTING

There are two types of skeletal muscles that are readily distinguished by speed of contraction and endurance. Ranvier has designated red and white muscles with slow and fast contraction respectively.

The "red" muscle receives its color from myoglobin, the oxygen reserve without the muscle; this tides the muscle over from one contraction to the next. It has a higher oxygen affinity than hemoglobin with an O_2 rate of reaction of less than $1/100$ sec.₃

.../5

The myoglobin starts giving up its oxygen at the instant the muscle contracts and its oxygen still is unreplaced during the resting stage.

These red "slow" fibres (aerobic) have a sensitivity to stretch and that results in sort of a mild tonic activity even at rest. This is why it is said that the postural muscles are hooked up with a tonic neuron in the spinal cord (our postural muscles, the muscles we walk with and the muscles we stand with) ₄

The white fast (anaerobic) muscle fibres have large glycogen stores and high ATP activity. The increased endurance of the red fibres is consistent with their rich blood supply and abundance of mitochondria which supports an essentially oxidative metabolism. ₅

Knowledge of aerobic-anaerobic muscle procedures is important in treating athletes. Often times an athlete indicates the knee problem comes on at about the 12-15 mile mark during training runs and on race day, or the knee problem only comes on during sprinting activities; my shoulder acts up, but only after 2 or 3 sets of tennis.

At the Lake Placid Olympics, a member of the Canadian Downhill Ski Team consulted Dr. George Goodheart regarding difficulty with his "tuck" position in the latter portion of the downhill run. His history indicated that the problem only occurred toward the latter portion of the run. Repeated testing of

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the uninvolved hamstring was negative. Testing the right medial hamstring repeatedly, after 4 or 5 tests, the muscle dramatically weakened. Therapy localization and stimulation of the neurolymphatic reflex at the lesser trochanter for the hamstring neutralized the tendency of the muscle to weaken after repeated contraction.

Goodheart felt that the muscle was not getting its share of required fat with each contraction, since the myoglobin was available for instant oxidation of fat in the muscle.

Aerobic muscles are tested in a repeated fashion of 10 tests in 10 seconds, and anaerobic muscles are evaluated with 20 tests in 10 seconds. Both types of muscles seem to require lymphatic and vascular activity.

The nutritional requirement for the slow fibre is Nutri Fe-Chelate for the aerobic lymphatic fault. The nutritional requirement for the fast fibre is pantothenic acid, 100 mg daily, as an average.

The aerobic/anaerobic muscle testing and treatment briefly described above has far-reaching implications in the field of athletic injuries and performance.

AEROBIC-ANAEROBIC FASCIAL FLUSH

With the two diagnostic features just described, my practise and clinical ability in helping athletes and dancers has been greatly enhanced. However, there is always that patient that

.../7

you just can't seem to find anything wrong with, but you intuitively know that there is something there.

This particular approach to fascial problems is a result of treating many members of the National Ballet of Canada. Ballet dancers are a different breed than athletes. They are mentally driven to be precise and perfect in every movement. This of course requires long hours of classes, rehearsals and performances. One of the habitual problems a dancer lives with is chronic tension, pain, fatigue, etc., of the leg and foot muscles.

I happened to stumble upon the concept of aerobic/anaerobic fascial flush. With the discovery of the cerebellar challenge I began to use it to diagnose difficult fascial flush problems in dancers calves. I began to notice that only occasionally would I find the fascial flush involvement. When I began to stop and analyze my method of testing, I found myself doing 2 stretches of a muscle and sometimes I would use 3 stretches.

Then the thought occurred to me that perhaps there could be an aerobic/anaerobic fascial flush pattern to parallel aerobic/anaerobic muscle testing. If muscles function on an aerobic/anaerobic basis then it seemed that a logical extension for the fascia was to follow the contraction patterns of its muscle. I then began to evaluate for fascial involvement in the following manner:

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- a. aerobic fascial involvement is stretching of the muscle in a repeated fashion at 10 stretches in 10 seconds;
- b. anaerobic fascial involvement is 20 stretches in 10 seconds.

After an aerobic/anaerobic fascial flush involvement was located, an attempt to isolate the nutritional component was made. At present the only nutrition that has been tested is iron and/or pantothenic acid. The results of the testing procedures are listed in the chart below.

Pat.	Muscle	Type of Fascial Stretching	Nutrient
Y.A.	Left gastrocnemius	Aerobic	Iron
C.R.	Right tibialis anterior	Anaerobic	Pantothenic Acid
S.D.	Right and left soleus	Aerobic	Iron
D.C.	Right soleus	Aerobic	Iron
K.G.	Right and left pectoralis major sternal	Anaerobic	Pantothenic Acid
M.G.	Right and left pectoralis major sternal	Anaerobic	Pantothenic Acid
J.O.	Left gastrocnemius	Aerobic	Iron
R.C.	Right and left gastrocnemius	Aerobic	Iron
P.O.	Left gastrocnemius	Aerobic	Iron

.. / 9

DISCUSSION

My first impression is that the aerobic/anaerobic fascial flush does exist, however, there are a number of problems and questions that have arisen:

1. A select patient population is the reason that I stumbled upon the concept. Even in the population though, the ratio of testing to actually finding the fault is in the range of 1 positive finding for every 100 tests. This indicates that in a select population that you might expect to find this fault, it is very rare.
2. The nutritional component may be suspect. As I am writing this report I realize that I have not even considered the nutritional component of the fascia - B12, stomach, liver. Perhaps my assumption of the existence of an aerobic/anaerobic fascial flush included the assumption that iron/pantothenic acid were the ONLY nutrition factors. I hope that my subconscious has been "clear" when testing and not "LOOKING" for an expected result.

CONCLUSION

There is little doubt in my mind that the aerobic/anaerobic fascial flush fault does exist. Although this paper introduces the concept the rationale and testing procedures appear to be

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questionable. In the words of our mentor, Dr. Goodheart, the concept needs to be re-defined and "Run up the flagpole to see if it will fly." I hope that other practitioners interested in this concept utilize the following protocol so that a larger data base may further substantiate my assumptions or disprove them:

1. Aerobic Fascial Flush; stretch the muscle 10 times in 10 seconds. If positive, nutritional challenge with iron, and then with B12 - stomach-liver substance.
2. Anaerobic Fascial Flush; stretch the muscle 20 times in 10 seconds. If positive, nutritional challenge with pantothenic acid, and then with B12 - stomach-liver substance.

.../11

Dr. Evan Mladenoff

APPLIED KINESIOLOGY SUPRA LEARNING ©

This rapid-learning system has been used to learn mainly foreign languages. It is left brain learning where the logical mind is utilized to perform enormous tasks. This can occur because the body and the right brain function are unified and assisting the learning process.

A Bulgarian doctor and psychiatrist, Giorgi Lozanov, is responsible for the research and development of super learning. There are a number of important factors in super learning that he espouses:

1. In order for the mind to perform tremendous mental feats, (supermemory), the body must be in a state of rest. The brain waves should be in a relaxed alpha rhythm. Dr. Lozanov observed that specific music with specific rhythm can induce a relaxed state in the body; but the music-induced relaxation leaves the mind alert.

It is imperative to get in shape for super learning and super memory. The following preliminary exercises should be practised:

- a) relaxation with affirmations;
- b) mind calming;
- c) joy of learning recall;
- d) breathing to a beat.

.../2

- 2 -

2. Super learning uses an 8 second cycle for the material to be learned. The 8 second cycle is 2 bars of 4 beats each at a speed of 60 bpm.

1	2	3	4		1	2	3	4
recite					silence			

Dr. Lozanov found that the mind was kept interested by cycling the tone of the voice, reciting the information using normal, soft, loud, normal, etc., cycle.

3. Dr. Lozanov used classical music with a slow, restful rhythm. The body rhythms of the students zeroed in on this slow beat, relaxing to a more efficient and healthful rhythm. Monitoring with physiological instruments produced the following results:

heartbeat slowed by an average of at least 5 beats per minute; blood pressure was down slightly; brain waves showed decreased beta-waves; brain slowed to alpha rhythm.

All of this was essential, but there was one very important difference. At the very same time the students relaxed, they were also doing strenuous mental work. They had actually learned more than if they'd spent the entire day in tough, fatiguing immersion language courses.

Dr. Lozanov found that we can be relaxed and mentally alert at the same time. As he explains; "A paradox-overwork (supermemory)-- rest."

.../3

With Dr. Lozanov and fellow Bulgarians reporting the following memory in learning languages:

early 1960's	-	500 words per day
1966	-	1,000 words per day
1974	-	1,800 words per day
1977	-	3,000 words per day

it became clearly evident to me that Super Learning was a necessity for me to become an expert in A.K. My good friend Dr. Richard Roy, and I, prepared Super Learning Sessions to study for our I.C.A.K. Diplomate examinations.

Learning was extremely stress-free and enjoyable, that it became, and still is, an obsession. It logically followed that if I was to remove my feeling of being a neophyte every time I attended the I.C.A.K. annual meetings, the only way I could retain the information was the Super Learning procedure.

After successfully completing my Diplomate exams, I decided to teach the 100 hour AK syllabus in the Toronto Area. Armed with the Super Learning technique, I decided to impliment it, thus the birth of Applied Kinesiology Supra Learning ©

The written material was prepared so that with each class, each student received an AKSL supermemory tape.

It was my feeling that new students of AK are often discouraged because of the shear volume of information to be learned. Here was my chance to test the super memory.

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At the conclusion of Class #1 and Class #3 I played the AKSL tape, with the students following the instructions. At the conclusion of listening to the tape, I gave a short quiz to determine memory retention. The 2 quizzes are provided below:

RESULTS

Quiz #1, as shown above, had the following population distribution:

Total number of students	=	37
Total number of students enrolled into AK class for first time	=	25
Total number of refresher students (ie. more than 100 hrs AK study)	=	12

The following results were obtained:

	TOTAL SAMPLE	FIRST TIME STUDENTS ONLY
Score of 75% or better	40.5%	36%
Score of 70% or better	57%	52%
Score of 60% or better	73%	76%
Score of 50% or better	84%	84%

Quiz #2, as shown above, had the following population distribution:

Total number of students	=	30
Total number of students enrolled into AK class for first time	=	24
Total number of refresher students (ie. more than 100 hrs Ak study)	=	6

Questions #1 through 13 represent material that was covered in the previous class. It was not on the tape that was played at the end of the class.

The following results were obtained:

	TOTAL SAMPLE	FIRST TIME STUDENTS ONLY
Score of 75% or better	13%	8%
Score of 70% or better	23%	20%
Score of 60% or better	33%	35%
Score of 50% or better	43%	37%

Questions #14 through 22 represent material that was covered that day in class, and the material contained in the AK Supra Learning tape that was played at the conclusion of the class.

The following results were obtained:

	TOTAL SAMPLE	FIRST TIME STUDENTS ONLY
Score of 75% or better	43%	37.5%
Score of 70% or better	50%	45%
Score of 60% or better	73%	71%
Score of 50% or better	80%	87%

DISCUSSION

Although this is not a classic or pure statistical evaluation, there does appear to be certain tendencies that can be noted. There appears to be an important indicator that at the end of 8.5 hours of class room time, after following

the instructions and listening to an AK Supra Learning tape that 73% of the class achieved a score of 60% or better. More importantly, for those students taking the 100 hour syllabus for the first time, 76% of the population achieved a score of 60% or better. In both samples, 84% of the class achieved a score of 50% or better.

In Quiz #2, the material covered that day in class and listened to on AK Supra Learning tape, achieved similar results; 73% of the total class, 71% of the first time students scored 60% or better. Similarly, 86% of the total class and 87% of the first timers scored 50% or better.

The first half of Quiz #2 does not show very positive results regarding retention of material. However, a number of variable factors enter into the equation; in the 3 weeks between classes, the class was instructed to listen to their AKSL tape at least once a week. A show of hands indicated that less than 10% of the class listened to the tape more than once; however, there does not seem to be a large discrepancy in the amount of material retained by total sample (43%) and the first timers (37%).

It initially appears that a minimum of 60% of material covered in AK class may be obtained, if it is immediately followed up by AK Supra Learning procedures. At this time,

there is no evidence re: the number of times a tape is played to amount of material retained. The super memory capabilities that have been reported by Lozanov and other researchers indicates that this is absolutely possible with respect to AK procedures. It is dependent on the frequency that the AKSL tapes are listened to and the students' capability to develop the ability to utilize right brain and left brain learning in a stress-free exhilarating fashion.

This works a new horizon for studying AK. A horizon that can only expand our mental capabilities; expand our own personal satisfaction, thereby making us better able to serve the public.

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3. Gowitzke and Milner; p.102.
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5. Gowitzke and Milner; p.102.

1. This is my first AK class ever? Yes/No
2. I have had approximately 50/100/150/200 hours of Applied Kinesiology study.
3. List the trid of health-----

4. List the five factors of the I V F.-----

5. Adjusting fixations you
 - a) adjust left hand on right side of spine, right hand on left side of spine.
 - b) adjust right hand on right side of spine, left hand on left side of spine.
6. The Lovett Brother of C5 is:
 - a) T3
 - b) C7
 - c) L4
 - d) T10
7. A bilateral weak lower trapezius is indicative of:
 - a) T12-L1-L2 fixation
 - b) L1-L2-L3 fixation
 - c) T11-T12-L1 fixation
 - d) T10-T11-T12 fixation
8. Bennett's Reflexes are
 - a) neurolymphatic reflexes
 - b) neurovascular reflexes
 - c) acupuncture points
 - d) foot reflexes
9. Chapman's Reflexes are
 - a) neurolymphatic reflexes
 - b) neurovascular reflexes
 - c) acupuncture points
 - d) foot reflexes
10. A bilateral weak neck extensors when tested unilaterally is indicative of:
 - a) occiput fixation
 - b) iliac fixation
 - c) lumbar fixation
 - d) sacral fixation
11. A bilateral weak neck extensors tested together is

(continued on page 2)

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- indicative of:
- a) occiput fixation
 - b) iliac fixation
 - c) lumbar fixation
 - d) sacral fixation
12. To strengthen a weak muscle via the golgi tendon organ you:
- a) approximate the musculo-tendonous junctions
 - b) approximate the belly of the muscle
 - c) separate the musculo-tendonous junctions
 - d) separate the belly of the muscle
13. A bilateral weak psoas is indicative of:
- a) occiput fixation
 - b) iliac fixation
 - c) lumbar fixation
 - d) sacral fixation
14. To strengthen a weak muscle via the spindle cell mechanism you:
- a) approximate the musculo-tendonous junctions
 - b) separate the musculo-tendonous junctions
 - c) approximate the belly of the muscle
 - d) separate the belly of the muscle
15. The teres major is related to which organ:
- a) spleen
 - b) spine
 - c) kidney
 - d) gallbladder
16. The psoas is related to which organ:
- a) spleen
 - b) spine
 - c) kidney
 - d) gallbladder
17. The lower trapezius is related to which organ:
- a) spleen
 - b) spine
 - c) kidney
 - d) gallbladder
18. The popliteus is related to which organ:
- a) spleen
 - b) spine
 - c) kidney
 - d) gallbladder
19. The anterior neurolymphatic for the iliacus is located:
- a) anterolateral thigh

(continued on page 3)

- b) 1 inch above the umbilicus and 1 inch from the midline
 - c) 3rd intercostal space near sternum
 - d) 7th intercostal space on the left
20. The anterior neurolymphatic for the gluteus maximus is located:
- a) anterolateral thigh
 - b) 1 inch above the umbilicus and 1 inch from the midline
 - c) 3rd intercostal space near sternum
 - d) 7th intercostal space on the left
21. The anterior neurolymphatic for the deltoid is located:
- a) anterolateral thigh
 - b) 1 inch above the umbilicus and 1 inch from the midline
 - c) 3rd intercostal space near the sternum
 - d) 7th intercostal space on the left
22. The nutritional requirements for a weak neck flexor is:
- a) vitamin E male/female endocrine extract
 - b) vitamin C, calcium, spleen extract
 - c) kelp, organic minerals, acid-alkaline balance
 - d) niacinamide or niacin, vitamin B6
23. The nutritional requirements for a weak gluteus maximus is:
- a) vitamin E male/female endocrine extract
 - b) vitamin C, calcium, spleen extract
 - c) kelp, organic minerals, acid-alkaline balance
 - d) niacinamide or niacin, vitamin B6
24. The reactive muscle(s) for the deltoids is/are:
- a) sacrospinalis, pectoralis major clavicular
 - b) rhomboids, pectoralis minor
 - c) opposite piriformis
 - d) opposite psoas
25. The reactive muscle(s) for the neck extensors is/are:
- a) sacrospinalis, pectoralis major clavicular
 - b) rhomboids, pectoralis minor
 - c) opposite piriformis
 - d) opposite psoas
26. Therapy localization is
- a) a diagnostic tool
 - b) a therapeutic tool
27. The meridian associated with the neck flexors is
- a) gallbladder
 - b) circulation sex
 - c) stomach
 - d) governing vessel
28. The meridian associated with the teres major is:

(continued on page 4)

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- a) gallbladder
 - b) circulation sex
 - c) stomach
 - d) governing vessel
29. The neurovascular reflex for the deltoids is:
- a) bregma
 - b) medial meniscus
 - c) 1 inch below pterion
 - d) 1 inch above lambda
30. The neurovascular reflex for the lower trapezius is:
- a) bregma
 - b) medial meniscus
 - c) 1 inch below pterion
 - d) 1 inch above lambda

APPLIED KINESIOLOGY SUPRA LEARNING QUIZ #2

There may be more than 1 correct answer.

1. This is my 1st exposure to AK yes/no.
2. I have less than 50/100/150/200 hours of AK before attending this class.
3. Where is the anterior neurolymphatic for the subscapularis located:
 - a) costochondral junction of ribs 8 to 12
 - b) 2 inches above umbilicus and 1 inch from midline
 - c) 6th intercostal space from mamillary line to sternum on the left
 - d) 2nd intercostal space near the sternum
4. Where is the anterior neurolymphatic for the gracilis located:
 - a) costochondral junction of ribs 8 to 12
 - b) 2 inches above umbilicus and 1 inch from midline
 - c) 6th intercostal space from mamillary line to sternum on the left
 - d) 2nd intercostal space near the sternum
5. Where is the anterior neurolymphatic for the rectus femoris located:
 - a) costochondral junction of ribs 8 to 12
 - b) 2 inches above umbilicus and 1 inch form midline
 - c) 6th intercostal space the mamillary line to sternum on the left
 - d) 2nd intercostal space near the sternum
6. Where is the anterior neurolymphatic for the pectoralis major clavicular located:
 - a) costochondral junction of ribs 8 to 12
 - b) 2 inches bove umbilicus and 1 inch from midline
 - c) 6th intercostal space from mamillary line to sternum on the left
 - d) 2nd intercostal space near the sternum
7. The T-S line reveals 3 things, they are:
 - a).....
 - b).....
 - c).....
8. Sacral inspiration assist is treated by:
 - a) pumping sacral base P to A coincident with expiration
 - b) pumping sacral apex A to P coincident with inspiration
 - c) pumping sacral base A to P coincident with expiration
 - d) pumping sacral apex P to A coincident with inspiration
9. Sacral expiration assist is treated by:
 - a) pumping sacral base P to A coincident with expiration
 - b) pumping sacral apex A to P coincident with inspiration
 - c) pumping sacral base A to P coincident with expiration
 - d) pumping sacral apex P to A coincident with inspiration

206. The vertebral levels of the lower horizontal aspect of the T.S. line from P to A are:

- a).....
- b).....
- c).....
- d).....
- e).....

11. To treat a Cranial Inspiration Assist you:

- a) pump mastoid process P to A as patient inhales
- b) pump mastoid process A to P as patient inhales
- c) pump mastoid process P to A as patient exhales
- d) pump mastoid process A to P as patient exhales

12. To treat a sacral wobble expiration assist you:

- a) press sacral apex P to A, pull opposite ASIS A to P as patient inhales
- b) press sacral apex P to A, pull opposite ASIS A to P as patient exhales
- c) press sacral apex A to P, push opposite sacral base P to A as patient exhales
- d) press sacral apex A to P, push opposite sacral base P to A as patient inhales

13. The muscles related to the vertical line of the T-S line, from Superior to Inferior are:

- a).....
- b).....
- c).....
- d).....
- e).....

14. The muscles related to a Category 1 Pelvic fault are:

- a) sacrospinalis
- b) quadratus lumborum
- c) quadratus femoris
- d) piriformis
- e) gluteus maximus

15. A Category 2 P1 ilium has which muscle(s) involved:

- a) piriformis
- b) sartorius
- c) hamstrings
- d) gracilis

16. The cranial faults related to a Category 1 pelvic fault are:
- temporal bulge
 - sagittal suture
 - universal cranial
 - lambdoidal suture
 - parietal descent
17. Lambdoidal suture fault is correlated with:
- open ICV
 - digestive problems
 - protein deficiency
 - whiplash
18. A sagittal suture fault is:
- corrected with inspiration
 - corrected with expiration
 - related to weak abdominals
 - related to whiplash
19. A parietal descent fault is corrected with:
- 1/2 inspiration
 - full inspiration
 - 1/2 expiration
 - full expiration
20. Temporal Bulge is correlated with:
- digestive disturbance
 - protein deficiency
 - allergies
 - hypochlorhydria
21. Teres minor is related to which organ:
- thymus
 - thyroid
 - eye and ear
 - abdominals
22. The upper trapezius is related to which organ:
- thymus
 - thyroid
 - eye and ear
 - abdominals

A GUIDE FOR EVALUATING
MOTOR IMPAIRMENT RATING

H. Louis Obersteadt, D. C.

ABSTRACT: The information in this paper is to offer a guide for measuring permanent physical impairment in relationship to a loss of muscle strength due to injury. Evaluation or rating of permanent impairment has in the past been confusing and inconsistent from the physician's, attorney's, and judge's view. There is also much confusion when there is a considerable difference of opinion as to the percent of whole man impairment from physician to physician. Using the "Guide to the Evaluation of Permanent Impairment", and hopefully this paper, will aid the chiropractor using applied kinesiology to give a more consistent whole man impairment rating.

Permanent impairment is any anatomic or functional abnormality or loss after maximum medical rehabilitation has been achieved and after reasonable period of time has elapsed to permit optimal regeneration, and that the physician feels is permanent at the time. The function of the doctor is to act as an unbiased reporter and state the facts found in an examination for the computation of a percent of whole man impairment. A patient is permanently disabled when his ability to participate in the activities of work, play, social functions, etc. are due to that impairment. Evaluation or permanent impairment defines the

scope of medical responsibility and therefore represents the physician's role in the evaluation of permanent disability. Evaluation of permanent impairment is an appraisal of the nature and extent of the patient's illness or injury as it affects his personal efficiency in one or more of the activities of daily living.¹ It must be remembered that the doctor determines the percent of impairment of whole man and courts and institutions such as insurance companies, determine the percent of disability.

This paper is for evaluating permanent impairment to spinal nerves. There are 31 pairs of peripheral spinal nerves originating from the spinal cord by two routes and they are an intricate conductive system for impulses traveling between the spinal cord and other body parts. The peripheral spinal nerves are divided into three main groups.

- (1) sensory (afferent) fibers
- (2) motor (efferent) fibers
- (3) autonomic fibers

To determine permanent impairment resulting from injury or disease to peripheral spinal nerves we must determine the loss of function due to

- (a) sensory deficit which is pain or discomfort
and/or
- (b) loss of muscle strength

This paper only deals with the latter. In order to do this the physician must determine as accurately as possible which peripheral spinal nerve is involved. Of course, this would include a careful history, orthopedic, neurological and kinesiological examination.

Weakness of the muscle or muscles can be caused by injury or disease to the peripheral spinal nerves, which will also effect the other four factors of the IVF: neurolymphatic, neurovascular, cerebrospinal fluid, and/or the acupuncture meridian connectors. So, with this in mind, the patient will often recruit stronger muscles to accomplish desired motion of the involved muscle. As you can see, careful structural analysis and TS line evaluation is a must. Therefore, we must include strength, aerobic and anerobic testing, EID, and the other techniques used to find hidden problems.

To determine the percent of impairment of the area involved and then the conversion to impairment of whole man, the following steps should be followed.

- (1) Joint motion involved
- (2) Muscle involved
 - (a) action of muscle
- (3) Innervation
- (4) Nerve value (See Tables 4 and 9)
- (5) Muscle grade
 - (a) Normal (0% impairment of strength) - complete range of motion against gravity with full resistance.
 - (b) Good (5% - 25% impairment of strength) - complete range of motion against gravity with some resistance.
 - (c) Fair (30% - 50% impairment of strength) - complete range of motion against gravity.
 - (d) Poor (55% - 75% impairment of strength) - complete range of motion with gravity eliminated.

- (e) Trace (80% - 90% impairment of strength - evidence of slight contractibility, no joint motion.
- (f) Zero (100% MIR of strength) - no evidence of contractibility.
- (6) Calculation of nerve value and muscle grade for upper and lower extremity impairment.
- (7) Conversion to whole man impairment percent.

When you have the above information completed you merely multiply the percent of nerve value with the muscles for a percent of impairment of the upper or lower extremity.

For example, a patient has a full range of motion in the shoulder, but after all attempts of correction the middle deltoid remains weak, but has resistance. Then the joint motion is right shoulder, muscle involved is middle deltoid, innervation is the axillary nerve. The nerve value is 0% to 35%. See Table I. You should give it the whole percentage value. Next, you grade the muscle as Good. To determine this percentage (5% to 25%), the doctor decides how strong the muscle is against resistance i.e. can you push it down easily with one finger or is it fairly difficult to bring out the muscle weakness. If the muscle weakens with little effort, you then grade it at 25%. You then multiply the 35% times the 25% (Good) which is 9%. This then gives you a 9% impairment of the upper extremity. To determine the whole man impairment, refer to Table SIX where you can see that 9% is converted to 5% of whole man impairment rating.

Another example would be a weak left deltoid and a weak coracobrachialis on the right side and the patient is right handed. The deltoid was found to be moderately weak against resistance. The joint motions involved are the shoulders, muscles involved are coracobrachialis and deltoid. Innervations of the deltoid is the axillary nerve whose nerve value is 0% to 35% (see Table 4) and the innervation of the coracobrachialis is the musculocutaneous whose nerve value is 0% to 25% (see Table 4). The muscle grade of the deltoid and coracobrachialis is Good and since it was moderately strong but still was weak against resistance the grade was determined to be 20%, i.e. the doctor determines the muscle grade between 5% and 25% based on the weakness of the muscle. We now multiply the nerve value of the deltoid times the muscle grade of the deltoid which is 35% times 20% which gives you an upper extremity rating of 7%. But since this is the non-preferred side i.e. the patient was right handed, 5% is subtracted from the 7% giving an upper extremity impairment of 2%. The nerve value of the musculocutaneous is 25% and the muscle grade again was good and at moderate weakness (20%). This gives the 5% impairment value on the right side for the coracobrachialis. We now combine the deltoid 2% and the musculocutaneous 7% for a whole man impairment of 9%.

For a final example:

<u>JOINT MOTION</u>	<u>INNERVATION</u>	<u>NERVE VALUE</u>	<u>MUSCLE GRADE %</u>	<u>% OF IMPAIRMENT</u>	<u>WM</u>
Rt. Shoulder	Musc. Cut.	25%	Good 15%	4%	
Coracobrachialis					
Flex. & Adduct					
Deltoid	Axillary	35%	25%	<u>9%</u>	
				Combined Value =	13%
Lt. Elbow	Radial	40%	20%	8%	
Tricep					
Extends					
				Deduction for non-preferred side	- <u>5%</u>
					3%
Combined 3% and 13% = 16%					
(See Table 6)					
Converted to Whole Man =					10%

<u>JOINT MOTION</u>	<u>INNERVATION</u>	<u>NERVE VALUE</u>	<u>MUSCLE GRADE %</u>	<u>% OF IMPAIRMENT</u>	<u>WM</u>
Rt. Hip & Knee	Femoral	35%	Good 15%	5%	
Sartorius					
Flexion					
Gracilis	Obturator	10%	Good 25%	3%	
Adduct & Flex.					
Anterior Tibialis	Deep Peroneal	5%	Poor 75%	<u>4%</u>	
				(Combination of 5 + 3 + 4) =	12%
Converted to Whole Man =					5%
(See Table 10)					

Combined value MIR's for the upper extremity = 16% Converted to W.M. = 10%
 Combined value MIR's for the lower extremity = 12% Converted to W.M. = 5%

FINAL IMPAIRMENT RATING FOR THE WHOLE MAN COMBINED = 15%

CONCLUSION:

As I mentioned earlier, hopefully, with the use of this paper, the "Guide to the Evaluation of Permanent Impairment" and the 36 hour impairment rating course from the chiropractic college of your choice will put you in an advantage that no other health profession has and that is the ability to give an accurate MIR. You must realize that our profession i.e. chiropractors, are the only ones that attempt to take post-graduate studies in impairment evaluation solely to develop a more consistent per cent of whole man impairment from physician to physician. In other words, some one that has the proper training of evaluating (range of motion, peripheral nerve involvement, sensory deficitis) will maintain a consistent finding.

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1 TABLE 4.—SPECIFIC UNILATERAL SPINAL NERVE
IMPAIRMENT AFFECTING THE UPPER EXTREMITY

Nerve	Loss of Function Due to Loss of Strength
Anterior thoracics (pectoral)	0%- 5%
Axillary (circumflex)	0%-35%
Dorsal scapular	0%- 5%
Long thoracic (posterior thoracic n., external respiratory n. of Bell, n. to serratus anterior)	0%-15%
Medial antibrachial cutaneous	0%
Medial brachial cutaneous	0%
Median (above midforearm)	0%-55%
Median (below midforearm)	0%-35%
Branch to radial side of thumb	0%
Branch to ulnar side of thumb	0%
Branch to radial side of index finger	0%
Branch to ulnar side of index finger	0%
Branch to radial side of middle finger	0%
Branch to ulnar side of middle finger	0%
Branch to radial side of ring finger	0%
Musculocutaneous	0%-25%
Radial (musculospiral) (upper arm with loss of triceps) wrist placed in position of function	0%-55%
Radial (musculospiral) (with sparing of triceps) wrist placed in position of function	0%-40%
Subscapular (upper and lower)	0%- 5%
Suprascapular	0%-15%
Thoracodorsal (long subscapular; nerve to latissimus dorsi)	0%-10%
Ulnar (above midforearm)	0%-35%
Ulnar (below midforearm)	0%-25%
Branch to ulnar side of ring finger	0%
Branch to radial side of little finger	0%
Branch to ulnar side of little finger	0%

Found on Page 52, AMA publication "Guides to the Evaluation of Permanent Impairment"

1 TABLE 9.—SPECIFIC UNILATERAL SPINAL NERVE
IMPAIRMENT AFFECTING THE LOWER EXTREMITY

Nerve	Loss of Function Due to Loss of Strength
Femoral (anterior crural) . . .	0%-35%
Femoral (anterior crural) (below iliacus nerve)	0%-30%
Genitofemoral (genito crural)	0%
Inferior gluteal	0%-25%
Lateral femoral cutaneous . . .	0%
N. to obturator internus muscle	
N. to piriformis muscle	0%-10%
N. to quadratus femoris muscle	
N. to superior gemellus muscle	
Obturator	0%-10%
Posterior cutaneous of thigh	0%
Superior gluteal	0%-20%
Sciatic (above hamstring innervation)	0%-75%
Common peroneal (lateral, or external popliteal) . . .	0%-35%
Deep (above midshin) . . .	0%-25%
Deep (below midshin) anterior tibial)	0%- 5%
Superficial	0%-10%
Tibial nerve (medial, or internal popliteal)	
Above knee	0%-35%
Posterior tibial (midcalf and knee)	0%-25%
Below midcalf	0%-15%
Lateral plantar branch . .	0%- 5%
Medical plantar branch . .	0%- 5%
Sural (external saphenous)	0%

Found on Page 55, AMA publication "Guides to the Evaluation of Permanent Impairment"

1 TABLE 6.—CONVERSION OF IMPAIRMENT OF THE UPPER EXTREMITY TO IMPAIRMENT OF THE WHOLE MAN

Impairment of		Impairment of		Impairment of		Impairment of		Impairment of	
Upper Extremity	Whole Man	Upper Extremity	Whole Man	Upper Extremity	Whole Man	Upper Extremity	Whole Man	Upper Extremity	Whole Man
0%	0%	20%	12%	40%	24%	60%	36%	80%	48%
1%	1%	21%	13%	41%	25%	61%	37%	81%	49%
2%	1%	22%	13%	42%	25%	62%	37%	82%	49%
3%	2%	23%	14%	43%	26%	63%	38%	83%	50%
4%	2%	24%	14%	44%	26%	64%	38%	84%	50%
5%	3%	25%	15%	45%	27%	65%	39%	85%	51%
6%	4%	26%	16%	46%	28%	66%	40%	86%	52%
7%	4%	27%	16%	47%	28%	67%	40%	87%	52%
8%	5%	28%	17%	48%	29%	68%	41%	88%	53%
9%	5%	29%	17%	49%	29%	69%	41%	89%	53%
10%	6%	30%	18%	50%	30%	70%	42%	90%	54%
11%	7%	31%	19%	51%	31%	71%	43%	91%	55%
12%	7%	32%	19%	52%	31%	72%	43%	92%	55%
13%	8%	33%	20%	53%	32%	73%	44%	93%	56%
14%	8%	34%	20%	54%	32%	74%	44%	94%	56%
15%	9%	35%	21%	55%	33%	75%	45%	95%	57%
16%	10%	36%	22%	56%	34%	76%	46%	96%	58%
17%	10%	37%	22%	57%	34%	77%	46%	97%	58%
18%	11%	38%	23%	58%	35%	78%	47%	98%	59%
19%	11%	39%	23%	59%	35%	79%	47%	99%	59%
								100%	60%

NOTE: Impairment of WHOLE MAN contributed by UPPER EXTREMITY may be rounded to the nearest 5% ONLY when it is the sole impairment involved.

Found on Page 55, AMA publication "Guides to the Evaluation of Permanent Impairment"

1 TABLE 10.—CONVERSION OF IMPAIRMENT OF THE LOWER EXTREMITY TO IMPAIRMENT OF THE WHOLE MAN

Impairment of		Impairment of		Impairment of		Impairment of		Impairment of	
Lower Extremity	Whole Man	Lower Extremity	Whole Man	Lower Extremity	Whole Man	Lower Extremity	Whole Man	Lower Extremity	Whole Man
0%	0%	20%	8%	40%	16%	60%	24%	80%	32%
1%	0%	21%	8%	41%	16%	61%	24%	81%	32%
2%	1%	22%	9%	42%	17%	62%	25%	82%	33%
3%	1%	23%	9%	43%	17%	63%	25%	83%	33%
4%	2%	24%	10%	44%	18%	64%	26%	84%	34%
5%	2%	25%	10%	45%	18%	65%	26%	85%	34%
6%	2%	26%	10%	46%	18%	66%	26%	86%	34%
7%	3%	27%	11%	47%	19%	67%	27%	87%	35%
8%	3%	28%	11%	48%	19%	68%	27%	88%	35%
9%	4%	29%	12%	49%	20%	69%	28%	89%	36%
10%	4%	30%	12%	50%	20%	70%	28%	90%	36%
11%	4%	31%	12%	51%	20%	71%	28%	91%	36%
12%	5%	32%	13%	52%	21%	72%	29%	92%	37%
13%	5%	33%	13%	53%	21%	73%	29%	93%	37%
14%	6%	34%	14%	54%	22%	74%	30%	94%	38%
15%	6%	35%	14%	55%	22%	75%	30%	95%	38%
16%	6%	36%	14%	56%	22%	76%	30%	96%	38%
17%	7%	37%	15%	57%	23%	77%	31%	97%	39%
18%	7%	38%	15%	58%	23%	78%	31%	98%	39%
19%	8%	39%	16%	59%	24%	79%	32%	99%	40%
								100%	40%

Note: Impairment of WHOLE MAN contributed by LOWER EXTREMITY may be rounded to the nearest 5% ONLY when it is the sole impairment involved.

Found on Page 56, AMA publication "Guides to the Evaluation of Permanent Impairment"

CORRECTION OF THE ANTERIOR
SUBLUXATION OF THE SACRAL BASE

H. Louis Obersteadt, D.C.

ABSTRACT: The sacrum when subluxated anterior at the sacral base can be demonstrated on lateral x-rays and by challenge and can cause various problems that can be corrected using this technique.

It has been demonstrated in many ways that the sacroiliac joint does move¹ and in many different directions, but we only need to look at our x-rays to see proof. It's this movement or subluxation that causes much pain and frustration in doctors trying to reduce that pain. The motion that I observe frequently in my office is the movement of the sacral base anterior. This motion caused much pain in this writer and I have observed it in many of my patients. The correction of this subluxation was demonstrated to me five years ago by my good friend, Dr. Lee Roy Selby, presently Vice-President of the ACA. (I'm sure this is not a new technique to many doctors.) I had been adjusted by other doctors with little relief. Dr. Selby pointed out on a lateral x-ray the sacrum had subluxated anteriorly at the base approximately 6 mm. He manipulated the sacrum and several weeks of low back pain disappeared. Needless to say, I was impressed enough to begin looking closely at x-rays for this type of subluxation in the new patients that were coming to my office

As I mentioned earlier, the sacrum can subluxate in many directions, however, this anterior subluxation of the sacral base is mentioned in only two of the many books I researched. The Logan Basic Methods² and Basic Technique, A system of Body Mechanics³ were the only two books I found that mentioned the subluxation. With this in mind, I started challenging the sacral apex when I found a subluxation on a lateral lumbo sacral view. Of course, not every time was there a positive response, but as I was introduced to the various techniques to find hidden problems (cerebral challenge, EID, right and left brain activity) I found that in most all of the x-rays that demonstrated the problem and many of the patients that didn't show this in x-rays responded to the sacral apex challenge. I found a large percent of the patients regardless of complaint had this problem. At first I thought this to be simple subluxation, then I thought it to be a fixation⁴, then part of the pitch problem, but nothing was successful except the subluxation idea.

I then began a crude form of research on the next 70 patients with this specific problem and found the following:

- (1) 90% had a positive TL to L5 and in 80% of this group the challenge showed PR.
- (2) 100% showed a positive therapy localization to the ileocecal valve.

- (3) 100% had a bilateral weakness of the piriformis. Often a stimulation of the piriformis NL will negate the sacral apex challenge.
- (4) None of the patients showed sacral wobble, pitch roll or yaw patterns, facet imbrication, category I sacroiliac fixation (negative weakness of the neck extensors).
- (5) Five of 70 patients or 7% showed category II.
- (6) Fifteen of 70 patients showed positive therapy localization for disc protrusion at L5 disc space.
- (7) 60% of the patients did not show positive therapy localization, i.e. EID cerebral challenge, etc. were used to bring out hidden faults.
- (8) 100% had a positive inspiratory assist that would temporarily correct the problem, but would not have lasting effect.
- (9) Fifteen of the 70 patients showed occiput cranial fault. Since the occiput is the Lovett Brother of the sacrum, I feel that the occiput is involved 100% of the time, but I have not been able to develop the technique to show that.

Correction of this subluxation is in the same position as Yaw II with the exception that the superior leg is not held against the chiropractor's body, but allowed to drop off the table and the inferior shoulder is rotated to the anterior as far as possible. Contact is made near the sacral apex and direction is determined by challenge. A quick

thrust will produce a gratifying articulation. I have shown this technique to several other chiropractors that were unaware of it and they have reported similar success. Of the 70 patients that we kept track of, only four had to be adjusted a second time. I normally do not re-x-ray a patient unless it's absolutely necessary, but in the few cases I have, there has been excellent change in the lateral lumbo sacral view.

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A SHARING OF NEW VERTEBRAL SUBLUXATION
RESEARCH INFORMATION AND SOME
PERSONAL THOUGHTS

Dean Raffelock, D.C.

ABSTRACT: The purpose of this paper is to share with I.C.A.K. members some exciting scientific community research on vertebral subluxation, chiropractic clinical research, and how this information has changed my practice.

I recently attended a Renaissance International Seminar given by Joe Flesia, D.C. and Easy Reikeman, D.C. I had heard that Renaissance had an exciting perspective of chiropractic and how it relates to the "Predicament of the Species", as well as some very good new research on vertebral subluxation. They also share some remarkably good communication skills and tools to assist chiropractors to relate this perspective and information to the public. I received even more than I expected.

I learned Renaissance was established as a liason organization between the scientific research and chiropractic communities. I was relieved to hear from the start that the chiropractic straight/mixer issue was not on the Renaissance agenda. For the last several years, Renaissance has been gathering, coordinating, integrating and disseminating information on vertebral subluxation. Here are some of the findings:

I. Professor Chung Ha Suh, PhD. and head of the Engineering Dept. at the University of Colorado has been directing research on spinal biomechanics and vertebral subluxation. They have done research exerting pressure on spinal nerve roots and have built a computer

model of the spine. They found that:

- unlike peripheral nerves, spinal nerve roots are highly sensitive to pressure and irritation.
- as little as 45 ml/Hg pressure on a nerve root decreases 60% of nerve function in just a few minutes.
- within a few hours after subluxation takes place, nerve fibers begin to rupture and give off neurotoxins.
- these neurotoxins quickly spread to other nerves along the myelin sheath and cause other subluxations.
- these neurotoxins also start to decay spinal bone structure and the surrounding soft tissue.
- this University of Colorado research is accepted by the National Institutes of Health.

- II. Arpad Denagy, M.D. research neurophysiologist and member of five Nobel prize winning teams, also found that when there is pressure on a nerve root, neurotoxins are produced that destroy nerve, spinal bone and surrounding soft tissues. Dr. Denagy recommends lifetime chiropractic care to everyone from birth.
- III. Ronald Pero, PhD. the world's leading ecogenetic toxicologist, member of the World Health Organization and affiliated with the Sloan-Kettering Cancer Clinic has found vertebral subluxations degenerate genetic coding by loosening the way chromatin material is packed within the cell. Dr. Pero has called vertebral subluxation a "mutational event" and has recommended chiropractic care for the genetic survival of the race.

Raffelock, V.S. Research

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Dr. Pero has accepted a research and consultant position with Renaissance International.

Many other world class scientists, including the prestigious "Club of Rome" members have come out with strong pro-chiropractic statements. One strong personal statement is from Prof. Leandre Poisson, one of the world's leading solar energy researchers who has refused to fly in airplanes or drive cars because of "damage to an already severely poisoned biosphere." The only trip he will take in a car is to his chiropractor.

Renaissance shows and documents four phases of subluxation degeneration. (Incidentally, some of the x-rays and background information are borrowed from the book, Anatomico-Roentgenographic Studies of the Spine by Lee A. Hadley, M.D.)

PHASE I. This phase usually occurs between the ages of 0-20 yrs. Phase I is characterized by initial vertebral malposition with attendant nerve fiber rupturing and neurotoxic production. In the cervical spine, this often looks like a hypolordosis or a complete reversal of the cervical curvature. Besides other subluxations being created by the spread of neurotoxins biochemically, there is also the strong possibility of Lovett Brother subluxations created biomechanically.

Chiropractic clinical research has shown that 95% of children have one or more vertebral subluxations by the age of one, with 100% having at least one subluxation by the age of two.

PHASE II. This phase usually occurs between the ages of 20-40 yrs. Characterized by worsening of the subluxation complex to include severe spinal bone and soft tissue decay. Vertebral disc degeneration is present with the attendant increased pressure on spinal nerve roots and further soft tissue degeneration.

PHASE III. The vertebral subluxation complex goes through further degeneration and vertebral fusion begins to take place. This usually occurs between the ages of 40-65 yrs.

PHASE IV. Complete fusion and complete occlusion of the spinal nerve root take place. This is a terminal condition characterized by a permanent lack of health and an untimely death. Phase IV usually occurs between the ages of 65 and older.

Some good news here. Chiropractic clinical research has shown that Phase I's can usually be returned to normal in $\frac{1}{2}$ - $1\frac{1}{2}$ years with regular chiropractic adjusting. Phase II's can often be brought back to normal in $1\frac{1}{2}$ - $2\frac{1}{2}$ years. Phase III's, if they are going to return to normal (Dr. Flesia says he was a Phase III, now normal) will do so in $2\frac{1}{2}$ - $3\frac{1}{2}$ yrs. Phase IV's have very little chance for reconstruction.

If the earlier phases of subluxation degeneration can not be returned to normal at least the next phase of degeneration can be avoided or greatly slowed down. A key point here is that subluxation degeneration is a progressive condition that is only halted and reversed by frequent chiropractic adjustment.

PERSONAL COMMENTS: This information was and is very enlightening to me. I had to do some deep thinking and reevaluating of some of my priorities with patients. I think many of us A-K practitioners are often too quick to release patients when their digestive, endocrine, neurological disorganization, etc. problems have stabilized. Sometimes I am amazed to receive a referred or dissatisfied patient from another applied kinesiologist's office only to learn that the chiropractor never even bothered to take spinal x-rays. I can now more fully understand our "straight" chiropractic brothers' dismay and, in some cases, disdain about us "mixers" not caring for the spine adequately.

I, for one, feel we who have devoted the time and energy to learn A-K have at our disposal the best of both worlds. I am now setting my patients up on initial short-term treatment schedules with a goal to alleviate pain, endocrine, digestive dysfunction, etc. Then I recommend spinal reconstructive care and then life-long maintenance care.

Renaissance has produced six video cassettes for chiropractic patient education. Dr. Beddoe and I have purchased these tapes and a video cassette player/TV system for our office. We now have one of our seven treatment rooms used for nothing but patient video education. We still do our health care classes but with these tapes I've experienced it much easier to convince patients of the value of spinal reconstructive care and lifelong maintenance care. We now have a good opportunity to see if A-K can shorten the average time it takes to do spinal reconstructive care.

I do encourage all of us to reevaluate whether we have been doing all we can for our patients' spinal structure.

In closing, I hope you have enjoyed the new research information and I hope I have stimulated some of you to reconsider giving patients adequate and lifetime spinal care. Perhaps some who have such busy research practices they couldn't possibly provide reconstructive and lifetime maintenance care will now refer "dismissed" patients to other chiropractors for care and regular spinal check-ups. Or perhaps you can build larger clinics with you the A-K experts and with others doing the spinal reconstructive and maintenance care. As always, we are only limited by our imagination and intention.

I hope to show some of the Renaissance video tapes at the summer's 1982 I.C.A.K. meeting. With the help of multi-media expert Laura-Lea Cannon (who is also my wife) we hope to write and produce new videotapes integrating A-K for use in chiropractic offices, cable TV and who knows, perhaps the larger networks. I welcome your suggestions and comments. Also, I am honored to be a member of I.C.A.K.

REFERENCES:

Renaissance International 830 N. Tejon, Suite 104, Colo. Springs, Colo.
80903 1-800-525-3879

C.H. Suh, PhD., Engineering Center Box 427, Mechanical Engineering Dept.,
University of Colorado, Boulder, Colo. 80309
for Annual Biomechanics Conference on the Spine papers

AN AK VALIDATION OF "COOKBOOK" ACUPUNCTURE POINTS
TO RELIEVE SINUSITIS

By
Dean Raffelock, D.C.

ABSTRACT: Stimulating Acupoint LI 20 seems to relieve sinusitis by strengthening weak neck flexors and correcting frontal bone faults.

In the spring of 1981, I watched Richard Yennie, D.C. confidently demonstrate how to relieve a case of sinusitis within seconds. All he did was to stimulate acupoint LI 20 with a non-piercing spring-action needle. Although a bit skeptical of the cookbook approach, (I don't mean to imply this is Dr. Yennie's only approach) I decided to try these points on my next case of sinusitis. Sure enough, it worked. The patient's nasal breathing improved instantly.

I used these points successfully many times in the next few weeks. The Los Angeles summer smog provided me with ample opportunity to work with sinus problems. Not content with mere results, the scientist within me wanted to know why.

I began correlating LI 20 with neck flexor weakness and frontal bone faults. Whenever I found anterior neck flexor weakness, sinusitis or frontal bone faults, I treated LI 20. In all cases, the neck flexors strengthened and the frontal bone fault was corrected. I have observed these same results well over 100 times, and have not yet seen an exception.

Raffelock, Sinusitis

My partner, and I.C.A.K. member Bruce Beddoe, D.C. has observed the same consistency of results, but has observed a few exceptions. I jokingly asked him if he was truly on LI 20 but, alas, he insists he was.

During this time, we found a respiratory correlation to distinguish between internal and external frontal bone faults. (See Dr. Beddoe's paper this issue of I.C.A.K. papers.)

SUMMARY: I am finding these points (LI 20) useful to quickly relieve nasal sinus congestion in most cases, and am teaching these points to chronic sinusitis patients to do for themselves. Many have found this useful to enable them to let go of their decongestant drug dependency.

Stimulating LI 20 seems to at least temporarily strengthen weak neck flexors and correct frontal faults almost all the time. We, of course, check for further structural, endocrine, digestive and emotional involvements.

Also, I am finding stimulating LI 20 a quick and easy way to assist neck flexors immediately after severe whiplash injuries when manual adjusting may be contraindicated for awhile. Many times cervical subluxations are corrected in the process. The use of the spring needle seems to be less painful than finger stimulation and gives quicker results.

COMMENT: I am once again pleased to see Applied Kinesiology's usefulness as a tool to validate that which works and to let us know why it works.

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Walther, D. Applied Kinesiology, The Advanced Approach in Chiropractic

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CONCUSSION TECHNIQUES USED IN SPINAL THERAPEUTICS---BY---DR. L.E. RAREY, D.C.

ABSTRACT: These concussion techniques demonstrate a specific procedure that can be used as an adjunct to kinesiology methods.

DISCUSSION: Spinal concussion techniques have been used for many years in all of the therapeutic fields. The techniques to be discussed in this paper are but a few that are available (1) Further techniques will be discussed in future papers. The following techniques are based on the findings of Drs. Albert Abrams and George Starr White. (2)

TO EVOKE: To evoke the reflex named, concussion is to be made on the tip or preferably, on both sides of the spinous process of the indicated vertebra.

Successful elicitation of Sympathetic-Vagal reflexes through the stimulation of spinal nerves by concussion, depends largely upon the quality and rate of the concussion-blows. Instead of being delivered as dull thuds, the blows should be rebounding-and-sudden, and must be punctuated by sufficient pause to allow the influenced viscera time to recoil. An average of 60 strokes per minute seems to produce best results. Always adapt both the firmness and the rate of the concussion-blows to the degree of each patients reflex activity. Having selected the indicated spinous process, concuss for about five seconds, pause and equivalent period of time and repeat. The number of repetitions also is to be determined by the quality of the patients reflexes, but treatment on any given center should not be prolonged beyond two minutes, since over-stimulation produces sedation and finally exhaustion.

Whenever two or more centers are to be concussed, pass alternately from one to the other, but avoid miscellaneous or immoderate concussion. Repeatedly consult the below list of reflexes, in order to constantly keep in mind what viscera are being influenced and how. Should any condition not listed be encountered, plan treatment according to the reflexes given. Otherwise concuss origin of nerve-supply to the affected parts. Vertebral concussion is by no means a panacea, but if intelligently employed, will prove a most valuable adjunct to any form of therapeutics

Such eliminative efforts as catarrhal or suppurative discharges must under no circumstances be thwarted by counteractive concussion. Painful symptoms should be palliated with discretion and caution--if at all, for the suppression of pain leaves a false sense of security, and removes the incentive on the part of the system to rectify the causative condition. In short, it interrupts the series of reflex arcs that culminate in "the struggle for existence." The most gratifying auxiliary methods in any diseased condition are those which aim at the promotion of compensation on the part of the eliminating organs. However, even these safe forms of symptotherapy should never lead to the neglect of such measures as will attempt to remove the underlying causes--both primary and secondary.

234 SPINAL REFLEXES EMPLOYED IN THE THERAPEUTIC APPLICATION OF CONCUSSION

FOURTH AND FIFTH CERVICAL-----Lung reflex of Contraction.

SIXTH AND SEVENTH CERVICAL-----Increases Vagal Tone, Contracts Heart, Blood-vessels and
Viscera.

BETWEEN THIRD AND FOURTH

THORACIC-----Diminishes Vagal Tone, Dilates Heart and Blood Vessels.

THIRD THORACIC-----Dilates Cardia, Contracts Pyloris

FIFTH THORACIC-----Contracts Cardia, Dilates Pyloris.

FOURTH TO SIXTH THORACIC-----Contracts and Empties Gall Bladder and Pancreas.

SIXTH AND SEVENTH THORACIC-----Kidney Reflex of Dilatation.

FIFTH TO EIGHTH THORACIC-----Constricts Splanchnic Blood Supply. Dilates Lungs.

NINTH THORACIC-----Dilates Gall-bladder and Duct.

TENTH TO TWELFTH THORACIC-----Dilates Heart, Thoracic and Abdominal Blood vessels,
Increases Erythrocytes and Hemoglobin.

TENTH THORACIC-----Dilates Kidneys and Pancreas. Stimulates Renal and
Pancreatic Activity.

ELEVENTH THORACIC-----Dilates Stomach, Intestines, Liver, Spleen and Uterus.

TWELFTH THORACIC-----Contracts Kidneys, Prostate, Liver, Sphincter of
Urinary-bladder.

FIRST, SECOND, THIRD LUMBAR---Contracts stomach, Intestines, Liver, Spleen and Uterus.

THIRD LUMBAR-----Stimulates Ovaries or Testes, according to Sex.

FIFTH LUMBAR-----Contracts Urinary-Bladder.

- CONCLUSION:
- 1.) Be certain to use sudden blows at 60 per minute.
 - 2.) Check patients reflex response to varify amount of stimulation. (i.e. if heart area concussed check pulse change.)
 - 3.) Don't over-stimulate; usually 2 minutes is adequate.
 - 4.) Use care, skill and judgement , remember this is an adjunct to other therapeutic methods.

- TECHNIQUES:
- 1.) These techniques have been tested and used;
 - a. Rose City Chiropractic Clinic, Portland, Oregon
 - b. Baker City Chiropractic Clinic, Baker, Oregon
 - 2.) Notes compiled from J.T. Du Plessis, N.D. based on findings of Drs. Albert Abrams and George S. White. Seminar, Portland, Oregon, Early 1940's.

The Inconsistent U.M.S.,L.L.L.
(a confused category two)

by

Marc S. Rosen D.C.

Abstract: This paper reviews the bio-mechanics that form the basis for the U.M.S.,L.L.L. pelvic distortions. There is an inconsistency that sometimes occurs. It relates to the mechanics responsible for an inequality in leg length. Stanley Wieczorek D.C. has developed two important concepts. They are referred to as "the confusions", and "reciprocals". Using those concepts it was established that a fixation complex involving the fifth lumbar was capable producing a false therapy localization and challenge of a category two.

A basis for, what is now labeled as a category two, may be found in DeJarnette's discussion of the bio-mechanics productive of a U.M.S.,L.L.L. iliac subluxation. The discussion that I am referring to is contained within DeJarnette's 1952 Sacro-Occipital Technic. Unfortunately this excellent book is out of print.

As stated in 1952, U.M.S.,L.L.L. refers to a posterior or anterior rotation of the ilium. Posterior rotation, of the ilium, tractions the upper aspect of pouparts ligament (also known as the iliac fossa). The upper iliac fossa is found to be painful, upon palpation, in the presence of a posterior ilium. This area also corresponds to the origin of the sartorius muscle. Posterior rotation of the ilium lifts the acetabulum and femoral head to the superior. This results in a short leg finding, when the supine patients lower extremities are compared at the medial malleoli. In addition to tractioning the upper iliac fossa and lifting the acetabulum (producing a short leg), posterior rotation will externally rotate the lower extremity. This is responsible for palpatory pain at the medial knee, corresponding to the insertion of the sartorius.

To review, the U. refers to pain at the upper aspect of pouparts ligament (iliac fossa), M. refers to pain at the medial knee (sartorius insertion) due to external rotation of the lower extremity, S. refers to the short leg finding that was the result of a lifting of the acetabulum when the ilium subluxated to the posterior.

Anterior rotation of the ilium (posterior ischium) will traction the lower aspect of pouparts ligament. This area will be pain-

category two ... Rosen
page two

ful to palpation. Anterior rotation of the ilium lowers the acetabulum and femoral head. Thereby giving rise to a long leg finding, when a comparison is made of the supine patients medial malleoli. Anterior rotation and lowering of the femoral head will result in a internal rotation of the lower extremity. It is internal rotation that is characterized by pain at the lateral knee or over the most inferior aspect of the fascia lata.

DeJarnette also described the first rib as the first area of musculo-skeletal compensation to an iliac subluxation. DeJarnette used the painful first rib head and the three findings of U.M.S. or L.L.L. to diagnose and determine the direction of correction for that iliac subluxation.

If you observe a dry pelvis and separate the ilium from the sacrum, so that you can view the joint surfaces laterally. Then, you would note an anatomical demarcation between the anterior and posterior aspects of the sacro-iliac joint surfaces. The anterior aspect resembles the shape of an "eskimo boot", and so named by DeJarnette. This anterior "boot" is responsible for the respiratory motion and function of the sacro-iliac joint. It is this area that becomes subluxated in a category one.

The posterior aspect of the sacro-iliac joint is further divided into an upper and lower portion. These area's are refered to as "weight-bearing plates". They are of a male female type union, are lined with hyaline cartilage and firmly unite the sacrum and ilium. The hyaline surface gives rise to fibers of cartilage that interdigitate between the sacrum and the ilium. Forming a type of sutural system. As is identified by their name, these weight-bearing plates serve as a means of maintaining an upright biped posture.

A category two is a subluxation of the posterior (weight-bearing) portion of the sacro-iliac joint. A posterior ilium involves the upper weight-bearing plate. An anterior ilium (posterior ischium) involves the lower weight-bearing plate. It is my understanding that, there is a proprioceptive connection between the upper and lower plates and the upper and lower iliac fossa.

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page three

Centrally located is the "membranous bed". An area of synovial tissue. The fluid produced lubricates the anterior "boots" during respiratory motion. The subluxation that is designated as a category two is a sprain type involvement. Not only are the sacro-iliac ligaments involved, but there exists a fracture of the cartilage connections between sacral and iliac weight-bearing plates. The synovial fluid, from the membranous bed, is believed to leak onto the weight-bearing plates. This leads to a less than adequate ability of the pelvis to maintain an upright posture. This is also an explanation as to why a supine block correction is preferred to the side posture adjustment commonly used among Applied Kinesiologists.

It was Goodheart who assigned a muscular significance to the palpatory findings of U.M.S., L.L.L. As you are already aware, it is a functional weakness of the sartorius-gracilis that results in a loss of anterior iliac stability with subsequent posterior rotation of the ilium. The U.M.S. findings follow. It is functional weakness of the hamstrings that permits anterior rotation of the ilium (posterior ischium), the L.L.L. findings follow. Also, with the introduction of the "challenge" and of "therapy localization", there becomes a complete substantiation for the category two.

Wieczorek has introduced us to a concept that he labels "the confusions". He has identified several structural faults that act as "switching mechanisms". They are capable of producing a false therapy localization and/or challenge of spinal, cranial, pelvic, visceral, meridian, or extremity faults. Important to our discussion is the role that "the confusions" play in determining leg length. An accurate determination of leg length is not possible in the presence of a fault that has been identified as a "confusion".

The Wieczorek "confusions" are examined for and corrected prior to any further examination or treatment of that patient. The "confusions" include switching, hyoid, ocular and scanning lock, lateral occiput, lateral atlas-axis, inferior occiput-sacrum, upper cervical fix, limbic fix, and the lovetts and "reciprocals" that may be associated with the listed faults. The time element is between

thirty seconds and one minute. I am referring to the time required to examine for and correct all the faults listed on the previous page. An Activator instrument is an especially efficient means of adjusting these faults, however other mechanical corrective measures are equally as effective.

Reference was made to Lovetts and "reciprocals". It is also research finding of Wieczorek's, that a relationship exists between segments common to the same occipital fiber. That relationship includes both subluxations and fixations. The occipital line that we are concerned with is line two. If you view a chart of the line two segmental relationships that exist between an occipital fiber and its corresponding cervical, thoracic, lumbar, and sacral, you will note that an occipital seven relates to C7, T9, & L5. A subluxation or a fixation, at (for example) L5 may not reveal itself via therapy localization, challenge, or bilateral muscle weakness, until its reciprocal at T9 is returned to normal. If this is the case, then previously negative findings will now be found to be positive, when they apply to L5.

We are familiar with the Lovett concept. The Lovett relationship enters this discussion, in that, if correction of a subluxation or fixation at T9 "opens for correction" a subluxation or fixation at L5, then the correction at L5 will "open for correction" a subluxation or fixation at its Lovett or atlas. To quote Wieczorek "if you adjust one then you must adjust three". Please review Wieczorek's paper on fixations, it is in the Collected Papers winter 1981. As an aside, note that there is a "predictable" subluxation pattern involving the segments common to an occipital area. It is, torque type thrust at the sacral foramina, lumbar spinous right or left, thoracic right or left inferior, cervical rotation.

In the presence of a "confusion" (lateral occiput, lateral C1 etc.) it is not possible to obtain an accurate evaluation of leg length. The block positions, for all three categories, are determined by leg length. Incorrect placement of the blocks (De Jarnette) results in a severe and immediate complication for that

category two ... Rosen
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patient. The success of the therapeutic effort certainly depends on a correct block placement or line of drive when referring to manual adjustment. "The confusions" (switching, hyoid, occular lock, lateral occiput, lateral atlas-axis, inferior occiput and sacrum, upper cervical and limbic fix, and their lovetts and reciprocals) are capable of producing "false positives" when the methods of therapy localization and challenge are employed.

In my practice, several times per week, a patient will present with category two findings that are not consistent with the bio-mechanics of the U.M.S.,L.L.L. By this I mean, a positive one handed therapy localization to the sacro-iliac joint, with a positive challenge for a posterior ilium, however this all exists on the long leg side. That leg length exists both prone and supine. Or, the reverse is often the case. The ilium will challenge as an anterior subluxation (posterior ischium) on the short leg side. Remember that a posterior ilium lifts the acetabulum and femoral head, with a short leg as the outcome. The opposite is, of course, the situation when the ilium subluxates anterior. It is important that I state that prior to category therapy localization, I remove all the faults that have been shown be the cause of the inconsistency in U.M.S.,L.L.L. Recall the idea of "opening for correction" and the lovettt and "reciprocal" relationships. Then if you *challenge for a fixation complex involving the motor units adjacent to and including L5, if that challenge is positive the correction will allow the body a means to express "body language." In this case, the body language would be a positive challenge for an upper cervical fixation. Since L5 is related to occipital seven then T9 must be evaluated, along with C7.

This was the case when I was confronted with inconsistent U.M.S.,L.L.L. findings i.e. posterior ilium on the long leg side. As a rule, there would be a fixation complex involving L5. When adjusted (using an Activator instrument) a previously negative challenge for an upper cervical fixation would now be positive. (as would a bilateral gluteus max. now be weak) It is the upper

*challenge for fixations - contact two segments challenge to the anterior fixations are not assisted by inspiration or expiration

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cervical fixation that was the source of "confusion", the result being a "body language" that tell's you it is a category two when it really wants your attention directed toward the correction of the upper cervical fixation. Should there be a negative challenge at L5, then proceed to it's reciprocal or T9. Adjusting T9 (if involved) will "open" positive findings at L5. You always challenge all the reciprocals and their lovetts. A common distortion pattern that I find in an estimated 30 to 50% of the patients that I see, is a fixation involving C1, C7, T9, T12, L5. (C7 and T12 are lovetts)

After adjusting the fixations within a occipital seven, then the pelvis would no longer exhibit any therapy localization for any of the three known categories. There is always the exception. This would include the patient where the inconsistent U.M.S., L.L.L. would now become consistent, or a pelvis that now therapy localized as a category one or in some cases a sacral wobble. The most common finding is removal of any pelvic therapy localization. (here I may differ with Wieczorek) I will attempt to amplify the therapy localization i.e. r.n.a., weight-bearing, wet fingers etc. the findings usually remain negative.

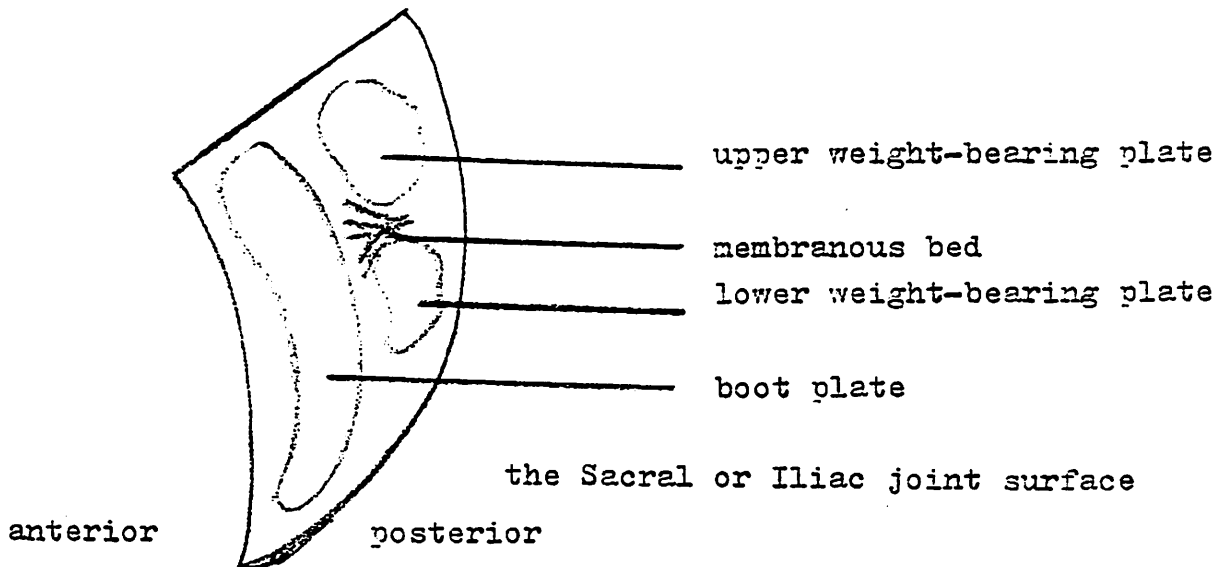
It would be logical to raise two questions. The first is whether I test the sartorius or hamstrings to determine the appropriate muscular explanation for the iliac subluxation. In other words, to determine if the subluxation is a possibility based on muscular weakness. I must confess that I have not tested the sartorius when I find a posterior ilium on a long leg side. Usually I am already using the hamstring as an indicator muscle and it is strong in the clear. You may investigate these muscles as far as the 51%'er idea, but the fact remains that the leg length is not possible if the ilium subluxates in the direction that it does challenge. A short leg requires that you place a block under the P.S.I.S. thereby bringing the ilium anterior. If the challenge is an indicator of an anterior ilium then the block is forcing the ilium further into lesion. Regardless of muscle weakness, the leg length must coincide with the direction of iliac subluxation.

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The second question would refer to whether a system of "priorities" is employed, and that if so, wouldn't failure to be inspiration assisted and pass the "pinch test" reveal that this area is not to be adjusted. I do find patients who, exhibit an inspiration assist for their category therapy localization, and that a pinch of the skin does not abolish the respiratory assist. However upon measuring their legs there still an inconsistent leg length with the direction of iliac challenge.

For a summary, there is a bio-mechanical possibility for an iliac rotation to alter leg length. There are structural faults that Wieczorek has identified as acting as "confusions". If the body reveals itself to be confused i.e. short leg with an anterior ilium you may have to "open for correction" fixations that are of a "reciprocal" relationship, as they are common to an occipital seven.

occipital	1	2	3	4	5	6	7
cervical	1	2	3	4	5	6	7
thoracic	1-2 10	3 11, 12	4-5	6	7	8	9
lumbar			1	2	3	4	5
sacral			1	2		4	



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TEMPORAL TAPPING

Relationship to cranial faults and to switching

by MARIO A. SABELLA, D.C.

ABSTRACT: It has been observed that some patients showed indicator muscle strength changes on temporal tapping regardless of the area of therapy localisation. This was making the validity of the temporal tap as a diagnostic tool somewhat inconsistent. This exercise was initiated to investigate those inconsistencies and allow for better application of the temporal tap.

INTRODUCTION

The first observations were made on a patient who did not seem to respond to temporal tap technique in the usual fashion. Tapping from anterior to posterior on the TS line was producing a weakening of the hamstring muscles while patient was on blocks for a category one correction. Further tests showed that the patient weakened on any muscle when the tap was performed in the clear, i.e. without therapy localisation to any area. This response was unusual and inconsistent with our knowledge of the mechanics of the technique.

PROCEDURE

It has been an accepted fact that the temporal tap correlates

Temporal tap
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in essence to the function of the temporalis muscle and hence stomatognathic involvement could interfere with the function of this mechanism. The first step was to select a strong muscle in the clear. The temporal tap was performed on the left side of the patient using the doctor's right hand, tapping done from anterior to posterior. If the indicator muscle weakened then all spinal involvements were corrected first. In all cases there was no change in the behaviour of the temporal tap pattern. The next step was to clear all possible stomatognathic involvements and then tap. Once again there was no change. However when any cranial fault was found and corrected there was an immediate change and there was no more influence on muscle strength by temporal tapping in the clear.

In the course of the experiment I struck a patient who had a cranial fault and yet did not show weakness on temporal tapping in the classic fashion. However the weakness appeared when the tap was done in reverse, i.e. posterior to anterior. By process of elimination I found that by correcting the switching problem that the patient had I was able to elicit the normal response, i.e. weakening of a muscle on tapping from A to P

CONCLUSION

Based on the above observations the following conclusions can be drawn:

Temporal tap
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1. If any cranial fault exists and patient is not switched, temporal tapping the TS line from anterior to posterior produces a weakening of a strong indicator muscle. Conversely tapping in reverse produces strength in a weak indicator muscle.
2. If a cranial fault exists and patient is switched, temporal tapping of the TS line from posterior to anterior produces weakness of a strong muscle. Conversely tapping in reverse produces strength in a weak muscle.

In all instances the temporal tap was performed on the left side of the patient with the doctor using his right hand and the patient was not therapy localising any point.

RECOMMENDATIONS

It is felt at this stage that it would be advantageous to use the temporal tap both as an indicator for the existence of cranial faults, directly and for switching indirectly when a cranial fault is present. This would allow for more efficient use of the temporal tap for subsequent diagnostic procedures as already indicated in standard Applied Kinesiology techniques.

UPDATE ON ALLERGIES

by

JULIUS L. SANNA, M.S., D.C.

ABSTRACT

When most people hear the word allergy, they immediately think of hayfever (sneezing, runny nose) or asthma. However, allergies also take on many other forms. Cerebral allergies cause hyperactivity, schizophrenia, depression, mania, lack of co-ordination, and many other central nervous system involvements.

INTRODUCTION

Reduced pancreatic function based on stress factors such as addiction, chemical toxins and allergies should be considered as a foundation on which many degenerative diseases are built. A few consequences of the pancreatic deficiency disease process are: 1) a disordered acid base balance; 2) diminished pancreatic proteolytic enzyme in the blood; 3) digestive failure, resulting in poor breakdown of proteins into amino acids; 4) the resulting circulation in the blood of nonusable proteins and peptides which lodge in tissues and evoke kinin-inflammatory reactions; and 5) circulation in the blood of partially digested lipids.

When too much stress causes the pancreas to function improperly, there is first a reduction in the proper levels of pancreatic bicarbonate. Bicarbonate is that pancreatic secretion which creates a necessary alkaline medium for the small intestines.

In pancreatic deficiencies, acute metabolic acidosis usually occurs after the meal because pancreatic bicarbonate now undersupplied and has not neutralized the acid from the stomach as it empties into the duodenum. This reduction of proper bicarbonate levels results in a chain reaction, whereby, the pancreatic proteolytic enzymes, which need an alkaline medium in which to function best, are destroyed. Low production of pancreatic proteolytic enzymes, in turn, has the following consequences; amino-acid deficiency due to a lack of digestion of proteins to amino acids; poorly digested and undigested proteins being absorbed into the blood through the intestinal mucous membrane and evoking kinin-inflammatory reactions throughout the body; and a continual rise in kinin-inflammatory reactions in various tissue and organ targets. More specifically, a low level of the pancreatic enzymes, chymotrypsin and carboxypeptidase, in the blood allows the levels of the tissue hormone kinins to rise; this, in turn, evokes inflammatory reactions in different tissues and organs. Thus, once there is an inhibition of pancreatic function and, especially, the pancreatic bicarbonate, there follows a chain reaction of inflammatory reactions throughout the body (including the brain) due to the fact that these all-important inflammation-controlling enzymes are in low supply. Addiction is described as a state involving withdrawal-phase symptoms of any kind occurring hours or days after contact with a

particular substance. Similarly, these withdrawal-phase symptoms of any kind can be stopped - sometimes only partially - by continued contact with the addictive substance. Foods of all kinds, as well as chemicals, are addictive. Adaptive addiction can be described as a state of relative freedom from symptoms, occasioned when the addictive substance is contacted frequently enough and the biological homeostatic state is in good repair. It is, however, a state of chronic stress, precariously balanced, and paves the way for the emergence of an "illness" - an acute allergic reaction - upon the addition of stress of any kind. Such last-straw stresses may be: 1) an overload of the allergen; 2) the addition of seasonal allergens such as pollens or other environmental stresses; 3) physical stresses such as excessive cold, heat or fatigue; 4) harbored infections; and 5) emotional stresses. The person suffering from adaptive addiction may be likened to one walking a tightrope, from which he may easily fall at any time. If the patient falls from the tightrope - develops an illness - solving that immediate stress, physiological or psychological, merely restores him to the adaptive-addictive tightrope leaving him the prey of any wind of stress that blows in his life. However, if the basic addiction is handled, he then has a broad base from which to handle all stress. The adrenal gland, with its sixty or more corticosteroid hormones, is very important in handling stress. There is evidence pointing

to the clinical conclusion that the stress factors of maladaptive reaction to foods and chemicals produce a state which alters the normal process of all the glands. It can be related to either the overproduction or underproduction of hormones.

Maladaptive allergic and addictive food and chemical reactions in most cases bear a direct relationship to a nutritionally deficient state. More specifically, because the frequent use of only a few foods uses up specific enzymes needed for metabolism and also fails to provide the necessary broad spectrum of nutrients demanded by proper metabolism, such a diet may help to create a nutritionally deficient state within certain cells, tissues and organs of the body.

It has been clinically observed that maladaptive reactions to foods, chemicals and inhalants most often produce localized inflammatory edema and toxicity in specific tissues and/or organs of the body. This reaction compromises the healthy functioning of the local tissue in several ways. First, associated with kinin-mediated inflammatory allergic edema is an often severely lowered oxygen level in the specific reacting tissue. This results in cellular injury, which makes further demands for specific nutrients already in short supply. Such a vicious cycle of nutritional deficiencies, allergic response, localized edema, cellular injury associated with lower levels of oxygen-supply, and consequently even greater nutritional deficiencies encourages locally present and usually dormant opportunist infectious microorganisms to

become active. Once this has occurred, a favorable biological state exists for a flareup of infection. Infectious microorganisms quickly multiply at staggering rates and become toxin producing. This infectious toxicity causes the biochemical system to become even more nutritionally deficient, and the end result is a low level of immunological defense which invites even more infectious invasion, since proper levels of antibodies used in the fight against infections cannot be attained unless optimum nutrition is available; a more severe allergic sensitivity also results.

FINDINGS

The cranial fault evidenced most commonly is the Temporal Bulge. Bilateral pectoralis major clavicular muscle weakness is indicative of an allergic reaction and indicates the need for Betaine HCl. Placing the Betaine HCl sublingually will strengthen the muscle. Applied Kinesiology can also be used to test food allergies by placing a small amount of the substance and using the pectoralis major clavicular muscle (associated with the stomach). A bilateral weakness will occur when the patient is allergic to the food substance.

Sublingual testing of small amounts of extracts of the food and/or chemicals can be used. Here one is looking for a definite response -- sneezing, wheezing, crying, lack of coordination, etc. An elimination diet can be used. When a patient has been off the suspected food for one week, it can be reintroduced and Coca's

pulse testing can be used in conjunction with reaction the patient might be experiencing.

TREATMENT

In addition to usual A.K. procedures described under "Findings", this can be complimented by the following procedures.

Once the food and chemical maladaptive allergic reactions have been diagnosed, the next goal is to establish some kind of control whereby these reactions can be completely avoided. The most reliable method of attaining this goal is a diversified rotation diet.

In order to stop the vicious cycle of addiction, foods that give minor reactions should be avoided for a minimum of 6 weeks; foods that give a major reaction should be avoided for a minimum of 3 months. As an allergic person develops new allergies to frequently eaten foods, all foods should be rotated. The following guidelines should be followed: 1) any one food, whether initially symptom-reactive or not, should be eaten only once in four days; 2) foods are established in families, with only one member of any family eaten during any one day; and 3) one day must intervene between the use of any two members of a family. For example, while wheat would not be eaten more frequently than once in four days, another member of this cereal-grain family, such as oats, could be eaten as a single meal on the third day of the rotation, with wheat again being eaten on the first day of the next cycle, the fifth day of

the program. The smaller the number of foods eaten in a single meal, the less are the chances of a reaction occurring. Several foods may be eaten successfully by most people, but only one, two, or three foods at a meal may be necessary for a few severely sensitive reactors.

SUPPLEMENTATION

<u>NUTRIENT</u>	<u>ADULT</u>	<u>CHILD (50 - 80 lbs.)</u>
Ascorbic acid powder	1 tsp. TID	1/2 tsp. TID
or		
Sodium ascorbate	bowel tolerance	bowel tolerance
Pyridomine	500 mg TID	100 mg TID
Riboflavin	500 mg TID	100 mg TID
Pantothenic acid	500 mg TID	100 mg TID
Thiamine	500 mg TID	100 mg TID
Niacinamine or niacin	500 mg TID	100 mg TID
PABA	500 mg TID	100 mg TID
Folic Acid	400 mcg TID	400 mcg TID
Vitamin E	400 units TID	400 units QD
Vitamin A	10,000 units TID	10,000 units QD
Vitamin D	400 units TID	100 units QD
L-Gluatmine	500 mg TID	500 mg QD
L-Tryptophan	1500 mg at HS if needed for sleep	500 to 1500 mg at HS if needed for sleep
Magnesium	75 mg TID	75 mg QD
Zinc	10 mg TID	10 mg QD
Manganese	10 mg TID	10 mg QD
Chromium	1 mg TID	1 mg QD
Potassium	150 mg TID	150 mg QD
Copper	5 mg TID	5 mg QD
Selenium	100 mg TID	100 mg QD

1. At the beginning of the meal Betaine HCl should be given if gastric acid has been demonstrated to be low.
2. At the end of a meal one or two 225 to 400 mg pancreas compound should be given.

3. Thirty to forty-five minutes after the meal one tablet pancreas compound, one tablet bromelain with papain, ten to twenty grams of sodium bicarbonate or 1/4 to 1/2 tsp. of sodium bicarbonate and potassium bicarbonate (2/3:1/3) should be given.
4. At bedtime: two tablets of pancreas compound; two bromelain tablets with papain should be given.

This program can be maintained two to four months and then reduced according to the patient's needs.

The following supplements should also be considered; alfalfa can be used on the legume rotation day, parathyroid substance, acidophilus tablets and adrenal gland to support the adrenals.

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ABSTRACT: A tool for rapidly identifying the direction of eyes into distortion (EID) patterns is presented. It involves finding a muscle weakness in the clear and moving the eyes through the six positions of gaze until one direction causes the weak muscle to strengthen. This is the eyes out of distortion (ECOD) direction and is exactly opposite to the direction of EID.

The development of eyes into distortion (EID) technique by Dr. Goodheart in 1981¹ yielded yet another tool for the identifying of hidden or covered up faults in the patient's nervous system. One of the problems we have encountered in teaching the eyes into distortion technique is that of identifying the body's major postural distortion when there may be multiple postural distortions in a given patient. Although some doctors are quite adept at immediately identifying the major postural distortion, in many patients, the subtle changes and multiple involvements of muscle imbalance create a confusing clinical picture. We have been able to identify a tool for screening the eyes into distortion technique (EID) based on use of a weak muscle as an indicator and moving the eyes through six standard positions of gaze.

As review by Goodheart,¹ EID may be in one of the six standard positions of gaze, that is, 1) lateral right, 2) up and right, 3) down and right, 4) lateral left, 5) up and left, 6) down and left, or occasionally, straight up or straight down. EID faults are present as an adaptation of the body to compensate for a structural imbalance or other imbalance in the patient's system such that the body may follow Lovett's Law- that is that the body will attempt to maintain the eyes in a level, straight ahead position through a series of compensatory musculo-skeletal changes in light of a primary structural fault.

Many patients with EID problems have postural indications for muscle weakness, as well as TS line indications for muscle weakness, yet the muscle weakness is not apparent on actual testing. The use of testing with EID uncovers this hidden weakness. The use of EID technique with the acupuncture pulses has led to the B & E technique¹. It has given us a tool for identifying hidden acupuncture problems, based on pulse point diagnosis with EID. The clinical usefulness of EID has been well established in its short history, especially for finding these hidden faults.

However, there are present, in most patients, one or more muscles which test weak in the clear, even in the light of an EID fault which commonly covers up most muscle weakness patterns.

In an effort to increase the ease of identifying an EID fault, it was found that if the eyes were into distortion, in an effort to compensate for that structural distortion, that to move the eyes in a direction opposite of the distortion direction, in other words, to move the 'eyes out of distortion' (EOD), would create a strengthening of a muscle which was weak in the clear. For example, if the direction of the eyes into distortion (up and to the left) is an effort of the body to compensate for some hidden fault, then rolling the eyes up and to the left would create muscle weakness for the muscles which were being compensated for by the EID fault. Rolling the eyes in the opposite direction, in this case, for example, eyes down and to the right, would actually increase the body's pattern of compensation and would make muscles which were previously weak in the clear, and therefore escaping the body's compensatory EID pattern, show a pattern of strengthening when the eyes were rolled even farther out of the distortion. This is in fact what we have observed in the vast majority of cases we have tested.

For example, a patient has TS line indicators for a psoas weakness on the left, and a latissimus dorsi weakness on the left, and a pectoralis major, sternal weakness on the right. Testing all the muscles yields strength with the exception of the latissimus dorsi on the left. Using the left latissimus dorsi, (being weak in the clear) in an attempt to investigate a potential EID pattern, the eyes are rolled in the six positions of gaze: that is 1) right, 2) up and to the right, 3) down and to the right, 4) left, 5) up and to the left, 6) down and to the left. One of these six positions will cause the weak latissimus to become strong.

For example, the latissimus is weak with the eyes in any position except up and to the left. That is, with the eyes up and to the left, the latissimus tests strong. This would imply that we are increasing the eyes compensatory pattern to include and hide the weakness of the latissimus dorsi. In this case, the direction of EID would be the opposite direction, or down and to the right. In this patient, rolling the eyes down and to the right would of course bring back the weakness of the latissimus dorsi on the left and would bring out the weakness of the right pectoralis major, sternal, and left psoas.

Oftentimes in the case of acupuncture pulse diagnosis using EID technique, there are very few muscle weakness patterns in the subtle adaptation of the patient. Having corrected all of the muscle weakness patterns before checking for the pulse points makes the identification of EID patterns in the difficult patient a matter of checking all six or eight positions of the gaze

during T.L. to the pulse points on each wrist, a time consuming and frustrating procedure. A much simpler procedure when one intends to investigate pulse points using EID is to, investigate the patient, and second, to identify a muscle weakness in the clear. Using that weak muscle, roll the eyes in the six positions of gaze, until you find a muscle strengthening take place. The direction of EID will be opposite to that direction. In other words, if the eyes up and right strengthen the patient's muscle weakness in the clear, then down and to the left will be the direction of EID, which you may use later in your investigation of the acupuncture pulse points, or other EID investigation.

It must be noted that some patients will have a correction of EID patterns with simple mechanical corrections of the spine or cranium. Initial identification of an EOOD pattern may not contribute to a further understanding of these patients after correcting major structural faults. That is, there will be no EID or EOOD patterns in some patients after correcting major structural (spinal or cranial) faults.

It is also possible that some patients may have muscle weakness which is totally unrelated to any pattern of EID. For example, a patient may have four muscles which are showing up on the TS line, three of which are related to an EID pattern and the fourth one weak due to a traumatic microavulsion of its origin and insertion, which has nothing to do with the EID pattern of the body. In this case, EID will still be present and help you to identify the three hidden muscle weaknesses but there will be no EOOD or EID pattern in the muscle weaknesses which is associated with the EID/EOOD pattern. Fortunately, this is a rare exception, and upwards of 95% of the patients we have seen have shown muscle weakness in the clear to respond to EOOD technique in an effort to help us identify the direction of EID.

Use of EOOD technique is a screening procedure to aid in identifying an EID pattern which may otherwise be difficult to ascertain and has proven to be a very valuable clinical tool in our office. Rapid screening of patients for EID problems through EOOD technique has yielded a high percentage of accurate results, with few false negatives, and occasional false positives due to some underlying structural fault being at the base of the EID/EOOD pattern. It is felt that with this tool of EOOD screening for EID problems, more doctors will be able to employ these procedures in their practices in a rapid fashion, and that this method of teaching EID will increase the rapidity with which doctors learning this material will be able to put it into their own practices. In light of the dramatic responses based on EID patterns, particularly those

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seen by manipulating the acupuncture system with the B & E technique, it is imperative that we advocate the use of EID patterns for identifying faults, particularly in the acupuncture system. It is hoped that this screening system, using EOOD technique, will be a valuable asset toward that goal.

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ANTRONEX - ANOTHER TOOL FOR FINDING HIDDEN PROBLEMS
Walter H. Schmitt, Jr., D.C.

ABSTRACT: The use of Antronex, a natural antihistamine, has been found to be valuable as an aid to enhancing therapy localization and muscle weakness patterns, similar to the methods employed with RNA for finding hidden problems. Antronex caused hidden patterns to become evident after all other AK tools for finding hidden problems had been found negative on the patients discussed.

Some of the most difficult patients seen by applied kinesiologists are those who have all the symptomatic, postural, and TS line indicators for muscle weakness, and yet, upon standard muscle testing, no weaknesses can be found. There is a variety of methods for enhancing therapy localization (T.L.) such as those reviewed by Walther¹ in his text Applied Kinesiology Volume I.

The use of ribonucleic acid for enhancing therapy localization was discovered by Goodheart and is also reviewed by Walther² (Ibid, p. 51). The procedure for using ribonucleic acid (RNA) as an aid in discovering hidden faults is to place one (or more) RNA tablets on the patient's tongue, in an effort to try to enhance T.L. in an area where the doctor thinks it should be positive, but which tests negative. The use of RNA has been a reliable tool in uncovering many hidden faults, especially due to altered chemical states, such as when patients are taking medication.

Recently we have observed a number of patients who demonstrated enhanced T.L. similar to that caused by RNA, but with the use of a natural antihistamine substance, rather than with the RNA. We have found that the use of the product Antronex, (a natural antihistamine produced by Standard Process Laboratories, Milwaukee, Wisconsin) placed on the tongue and insalivated, will cause positive T.L. to be present in some patients who had otherwise shown it to be negative. This therapy localization enhancement using Antronex has been present when the use of ribonucleic acid and all other T.L. enhancement procedures have failed.

The original observation of the use of Antronex as a T.L. enhancement procedure was made on a young female patient who had been diagnosed as schizophrenic by several different mental health practitioners and had been institutionalized at two different hospitals for the care of her schizophrenia. Upon examining this patient, I had occasion to observe that no muscle weakness could be found anywhere in her body. This is not especially unusual in my experiences with treating schizophrenic patients. Very frequently a schizophrenic patient may show incredible muscle strength throughout the body with the exception of possibly one muscle weakness; oftentimes, that muscle being a unilateral sternocleidomastoid weakness relating to the need for niacin supplementation.

This clinical observation has been made in a variety of patients, but in particular some schizophrenics at certain stages of their illness seem to show this incredible muscle strength with no positive T.L. procedures.

Upon encountering this unusual strength pattern in the schizophrenic patient, but realizing that the patient was acutely psychotic and in need of potential care in many areas, I turned to the text Mental and Elemental Nutrients by Carl C. Pfeiffer³. In this text, Dr. Pfeiffer discusses three categories of schizophrenic patients. These are histadelic, histapenic, and mauve factor for pyroluria patients. In an effort to more accurately diagnose this patient, the observations that Pfeiffer had made of the three categories of schizophrenic patients were reviewed. Histadelic patients are those who have an excessive amount of histamine secretion and elevated histamine levels in their tissues. Histapenic patients show abnormally low blood and brain levels of histamine. The third category of schizophrenia according to Pfeiffer has to do with a pyroluria which creates a so-called "mauve" factor in the patient's urine, with normal histamine levels.

The relationship of histamine levels to the diagnosis and classification of schizophrenic patients interested me. The symptoms of my particular schizophrenic patient in this instance seemed to be that of histapenic type patients, that is, those with low histamine levels. When she was tested and showed strength throughout her entire body, again we ran into the puzzlement of 'where to turn next?' Considering the possibility that one of her problems was lowered levels of histamine in her body, the thought occurred that this histapenic situation might be creating some type of cover-up mechanism. This reasoning was that if one of her problems was low histamine levels, the use of antihistamine should aggravate the problem and we might potentially be able to observe some change in muscle testing. This was exactly the case. Upon placing one Antronex pill on her tongue, this patient immediately showed muscle weakness and therapy localization patterns which correlated with her symptoms, and postural and TS line analysis. The patient was then treated in the usual AK fashion, based on the enhanced muscle weakness and T.L. diagnosis made through the use of Antronex in the mouth.

Since that time a number of other patients have been seen who have required Antronex placed on the tongue to bring out muscle weakness and enhance therapy localization. The number of these patients has been six or more in two months time. None of these other patients had schizophrenic symptoms or a history of

schizophrenia, but all had patterns of increased muscle strength and negative T.L. throughout their body, when all symptoms, postural, and TS line signs indicated that there should be muscle weakness patterns present. The usual pattern of the use of RNA and other T.L. enhancement procedures, such as cold or pinching (Melzack-Wall) and cerebellar and eyes into distortion patterns were exhausted before falling back on the fact that Antronex might be of value in these patients. There is nothing in particular in common about the patients who showed Antronex as a valuable muscle weakness and therapy localization enhancing procedure, except that they all had increased muscle strength patterns throughout the body and negative T.L. that defied all other investigative procedures.

The most recent of these patients who required Antronex for positive T.L. was a two year old child who had obvious cranial fault involvement and muscle imbalance based on postural and TS line analysis and showed absolutely no muscle weakness using surrogate testing with his mother. Again, attempting a number of factors to enhance T.L. including RNA yielded no benefit. It was thought that possibly the mother was an inadequate surrogate for this child, and the use of another surrogate was contemplated.

However, the child's history revealed that he had received numerous mosquito bites and subsequent allergic reactions several months earlier, The fact that the patient had had excessive histamine reactions to these multiple bites led me to consider the possibility that there was some imbalance in his histamine physiology. Possibly the patient had been depleted of histamine, because of the excessive history of histaminic responses, or possibly there was some other fault in the histamine metabolism of the patient. This clue caused me to try the Antronex in the patient's mouth. The child was given a piece of an Antronex pill and asked to chew it up. Upon chewing it, immediately the muscle weakness patterns paralleling his postural and TS line indicators were seen in the mother using surrogate testing.

It is felt that there is a pattern of excessive muscle strength and negative T.L. present when there are histamine imbalances in a patient's body. These may be very difficult to diagnose and no attempt has been made at this time to diagnose the presence of excessive or deficient histamine in these patients. However, the use of antronex in the patient's mouth may be of value in those patients where their histamine production is altered from normal. Further research is obviously necessary on this subject. The number of patients

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in this category are fairly few in this author's experience compared to the number of patients who respond to RNA with therapy localization enhancement. The use of Antronex (natural antihistamine) is apparently less valuable than RNA as far as the number of times one will see its need. However, in the individual case who requires Antronex for enhanced muscle weakness and therapy localization, nothing else that we have seen will take its place in aiding the doctor to make an accurate therapy localization diagnosis and muscle testing analysis of the patient.

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2. Ibid, p. 21.

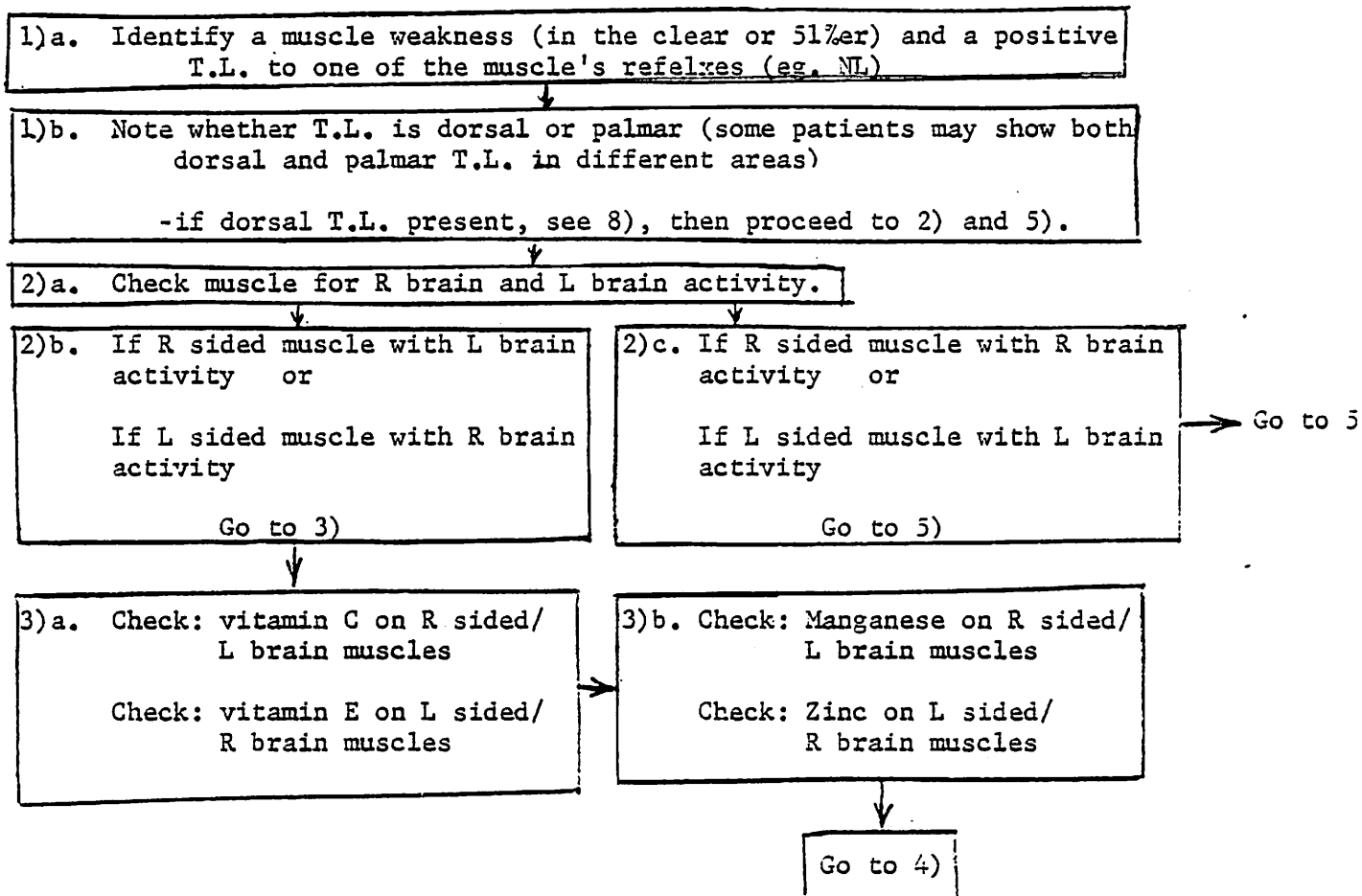
3. Mental and Elemental Nutrients, Carl C. Pfeiffer, Keats Publishing Inc., New Canaan, Conn., 1975, pp. 396-402.

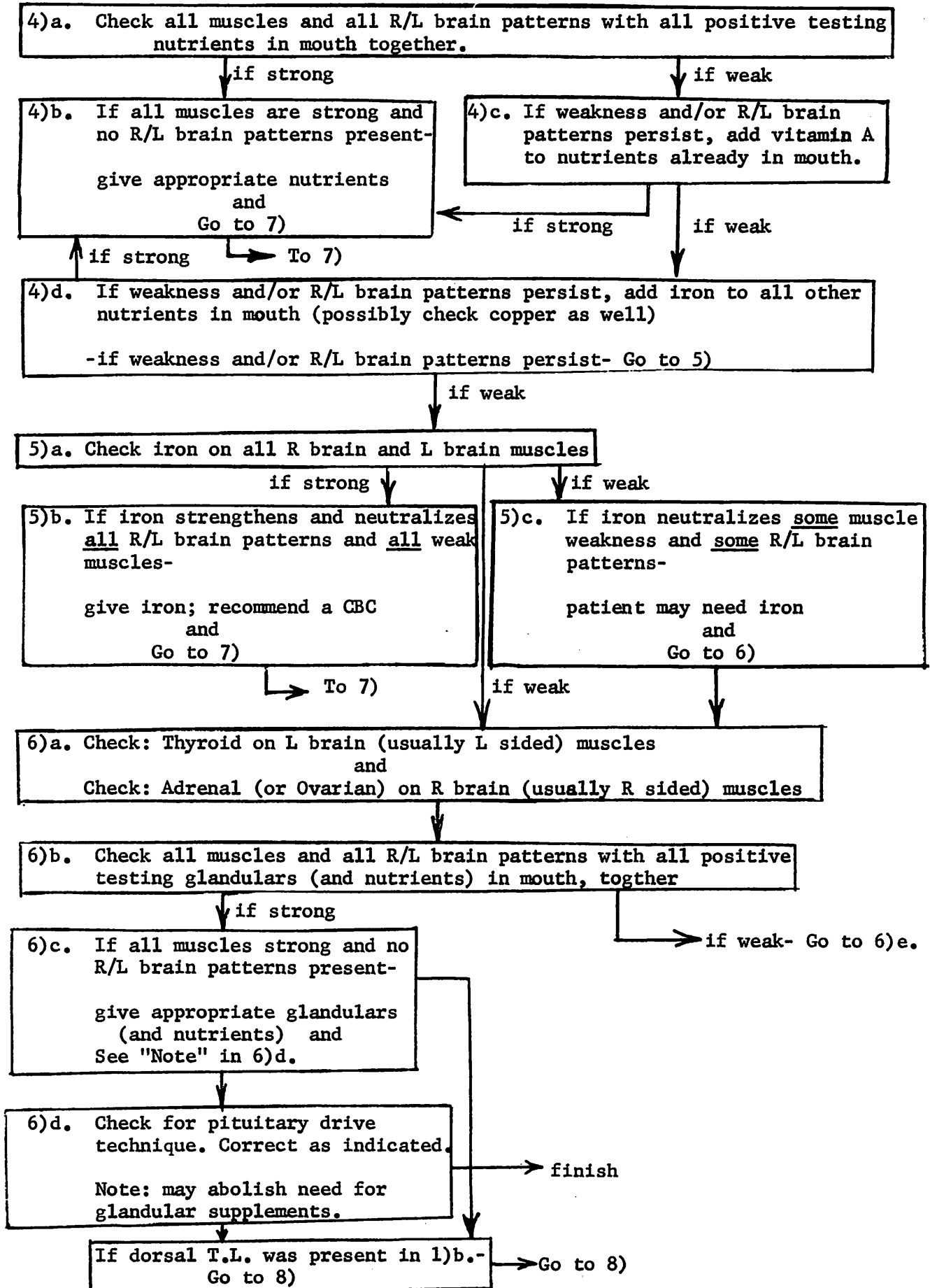
FLOW CHART FOR DORSAL-PALMAR THERAPY LOCALIZATION PATTERNS AND ELECTRON POISING

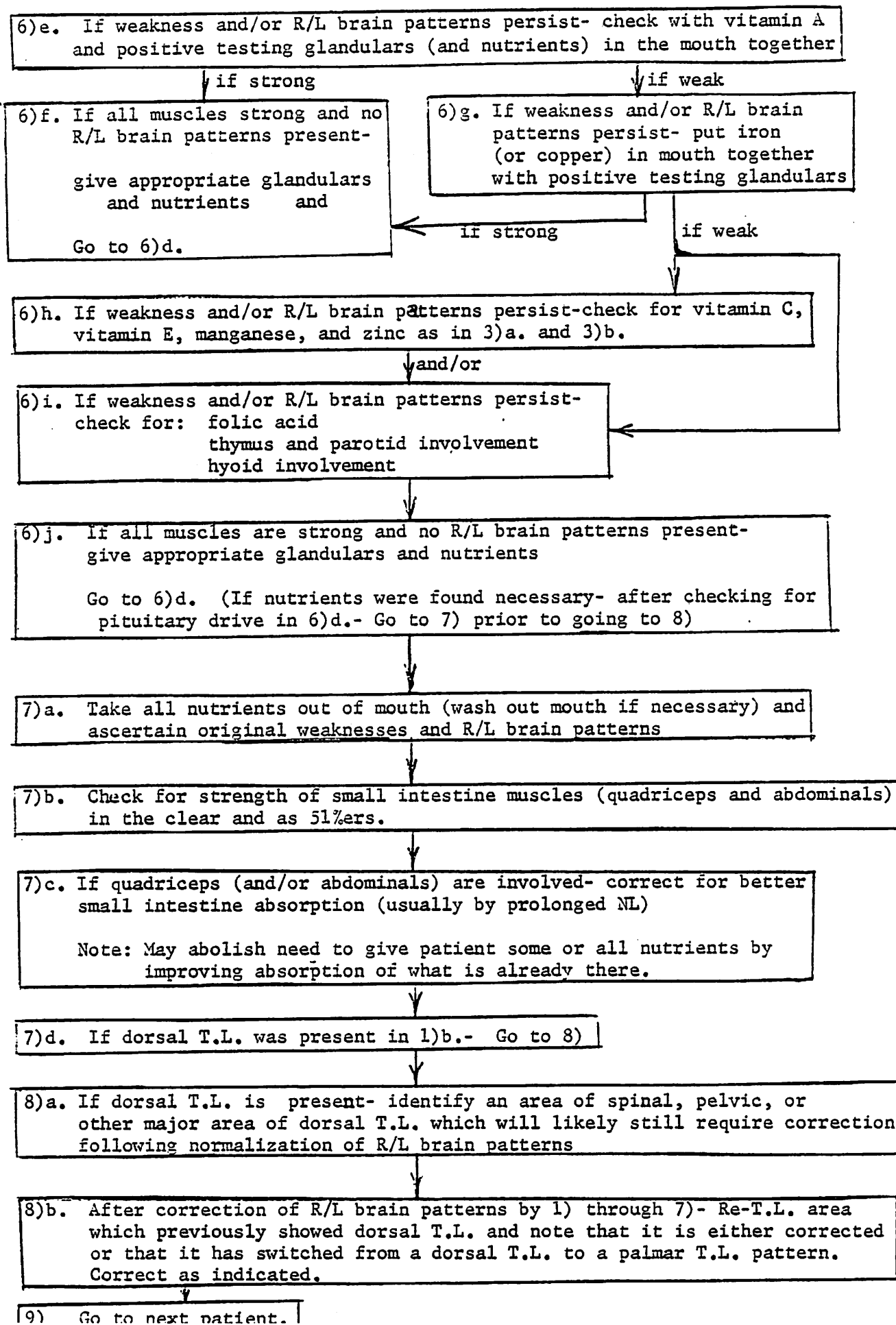
Walter H. Schmitt, Jr., D.C.

Abstract: A flow chart is presented detailing procedures which the author has utilized in dealing with patients who demonstrate right brain/ left brain patterns and dorsal therapy localization.

The following flow chart is based on this author's paper entitled "Clinical Observations Regarding Dorsal and Palmar Therapy Localization" which was presented in the winter, 1981 ICAK Collected Papers in Acapulco. The flow chart may be confusing if the reader has not read the paper first.







THE PSOAS SITTING TEST :
KEY TO HIDDEN LUMBOSACRAL PROBLEMS

Walter H. Schmitt, Jr., D.C.

Abstract: The use of the psoas muscle test in the seated position is discussed, particularly in relationship to hidden occipital, lumbosacral, sacroiliac, and cervical subluxations. The identification of anterior and inferior lumbar subluxations is made possible by T.L. in the seated position using the weak psoas as an indicator. T.L. to the involved lumbar segment in these cases is usually negative in the prone position unless spinal extension (i.e. arching the back) is performed during T.L.

The psoas muscles are the major guy wires of the lumbar spine. Working together, the psoas muscles give stability to the lumbar spine in weight-bearing situations. In low back patients, psoas muscle weakness is frequently seen unilaterally or bilaterally, and often unilaterally with compensatory contralateral psoas hypertonus and/or fascial sheath shortening. Balancing the psoas muscle makes a great deal of difference in these patients, especially in their ability to move the lumbar spine such as getting out of a chair, standing forward flexion (Adam's position), or sitting up from a lying down position.

We have observed a number of patients who appeared to have weakness in one or both psoas muscles based on postural analysis, TS line analysis, and restriction of movement, only to find the psoas muscle(s) strong on testing in the usual supine position. A variety of procedures aimed at finding a hidden psoas weakness were negative, with the exception of testing the psoas in the seated position. Some patients were tested in both the seated and standing positions, but due to the instability of testing the psoas in the upright position when a high-low table was not available,

most patients were readily screened by testing the psoas in the sitting position and a large number were found to have psoas weakness which was present only in this position.

In an effort to identify the cause of this weakness, therapy localization (T.L.) was performed in the sitting position using the weak psoas as the indicator muscle. If the psoas is weak bilaterally in the seated position, the first area of T.L. is the occiput. Very frequently, occipital subluxations which normally create a bilaterally weak psoas pattern will only show up in the sitting position. Correction of the occipital fault in the standard fashion with the patient supine is adequate for correction of the sitting psoas muscle weakness pattern, that is, both psoas muscles again test strong when the sitting position is resumed.

Bilateral psoas weakness may also be associated with lumbar spine or lumbosacral instability, especially when there is a bilateral subluxation of a segment (eg. L-5 straight anterior.) More commonly, however, unilateral psoas weakness will be present accompanied by a unilateral lumbosacral or sacroiliac subluxation on the side of psoas weakness. More often than not, these patterns will only show up with the patient in a seated position. These subluxation patterns which become observable when the patient sits are most commonly, in order of importance, L-5, L-4, sacroiliac, sacral, and other lumbar.

A common pattern of findings in this type of patient would be limited range of motion in forward flexion, lumbosacral discomfort aggravated by forward flexion, with or without radiation into other weight-bearing structures and with or without radiation into the buttock or leg. The patient's pain is usually accentuated by forward flexion in the standing or seated positions. It is accentuated by sitting up from the supine position and by simply sitting for a period of time as is so often the case in disc type problems. A unilateral psoas weakness will be present and T.L. to

the lumbosacral spine will be positive, but usually only in the seated position. Individual T.L. to spinal segments will show a typical pattern of 4th or 5th lumbar subluxation. It is readily evident how and why these patients demonstrate the aggravation of symptoms when sitting in light of the important function the psoas muscles play in supporting the lumbar spine during weight-bearing, and the imbalances which become apparent only in the seated position.

For example, the right psoas is weak in the sitting position only. The patient may have difficulty and pain reaching Adam's position, difficulty and pain on sitting up from the supine position, oftentimes with sciatic type radiculitis which is aggravated by sitting, especially if prolonged. The right psoas is strong in the supine, weak sitting, the right or left straight leg raise may be positive at less than 85 degrees. The patient shows positive T.L. over L-5 while sitting, negating the sitting psoas weakness. However, L-5 T.L. is negative for all other positions and all other muscles (with the possible exception of standing psoas test.) In fact, as is most common in these cases, T.L.ing to L-5 with the patient prone is completely negative.

This pattern misleads many doctors in their effort to identify what appears on the surface to be obvious lumbosacral problems. We have found that by accentuating the lumbar lordosis, we oftentimes enhance T.L. to that area. That is, have the patient T.L. to the suspected area of involvement, for example, the 5th lumbar, while lifting his head and shoulders off the table, arching his back and putting an extra forward strain on the lumbosacral spine, accentuating the normal lordosis. T.L. will usually be positive when employing this hyperextension procedure, and negative with the patient in the prone, relaxed position when the syndrome we are discussing is present.

The typical lesion in the unilateral psoas sitting weakness is an anteriorly rotated lumbar on the side of the weak psoas, or an inferiorly tilted lumbar on the side of the psoas weakness. One can readily see why an anterior lumbar rotation or an inferior lumbar tilt subluxation will not show positive T.L. with the patient prone. The simple pressure of the abdominal contents from anterior to posterior causes support of the subluxation and causes T.L. to be negative. For this reason, we find it necessary to have the patient arch the back in order to find positive T.L. in the prone position.

The recognition of hidden anterior lumbar and lumbosacral problems was first described to me in 1975 by Dr. Terry Franks when we both practiced with Dr. George Goodheart in Detroit. Since that time, literally hundreds anterior lumbar and anteriorly rotated lumbar subluxations have been identified through challenge procedures. However, many of these challengable subluxations eluded T.L. investigation of the lumbar spine with the patient prone. The key to most of these patients is the identification of a unilateral or bilateral psoas weakness in the sitting position which does not show up supine. This weakness is accompanied by positive T.L. to the lumbar (sacral, or sacroiliac, or occipital) areas in the sitting position which negates the psoas weakness and which is negative to T.L. in all other positions. Another clue that a patient has an anteriorly rotated lumbar segment is a long leg on the side of anteriority which appears in the seated position, and which becomes longer as the patient attempts to flex forward while sitting, as if th try to touch the toes.

Correction of the subluxation in the standard fashion for either anterior rotation or inferior tilt on the side of sitting psoas weakness yields immediate strengthening of the psoas, immediate increase in range of motion, immediate normalization of leg length in the sitting position (unless a disc lesion is present), immediate improvement of the patient's

function, and immediate lessening of the patient's discomfort.

A variety of adjusting methods may be employed if L-5 is inferiorly tilted. We frequently use the Bunyon techniques, especially if the subluxation appears to be related to a disc lesion. If a lumbar is rotated anteriorly, we challenge the spinous process laterally, to rotate the side of anteriority toward the posterior by the lateral spinous pressure, such that upon releasing the spinous process pressure, the rebound effect causes the vertebra to rotate even more anteriorly on the side of subluxation and causing weakness in our indicator muscle. Oftentimes, our adjustment of this subluxation parallels the challenge procedure. That is, we adjust the patient with the anterior side down in a side posture position using a spinous process contact which we hook with our finger(s) on the down side, and make a rotary type adjustment pulling the spinous process toward the ceiling in an effort to rotate the anterior side toward the posterior. We are very carefull, of course, not to do these rotary type adjustments in the lumbar spine whenever there is a potential disc involvement.

Therapy localization to the cervical spine with the patient in the seated position may also cause strengthening of a sitting psoas weakness. Often, but not necessarily, if a cervical segment T.L.s under these circumstances, you will find its Lovett brother vertebra in the lumbar spine also showing positive T.L.

The use of the sitting psoas test has allowed us to find many hidden lumbar, sacral, and sacroiliac faults as well as hidden occipital and cervical faults which would have otherwise eluded us. The complementary use of T.L. to the lumbosacral area during spinal extension (i.e. arching the back) in the prone position has correlated well with the sitting psoas test and has given us an extra tool for identifying and correcting the problems of our difficult patients.

THE AFFECTS OF SOUND CUES ON
MOTOR SKILL PERFORMANCE

Sheldon A. Sinett, D.C. M.A.

Abstract:

The affects of sound cues on motor skill performance, to date, have not been studied. Several female ice skaters, active patients, underwent muscle testing while their particular music played. The patients used imagery techniques and the doctor was told when critical points in the freestyle performance occurred.

At the critical points muscles related to problems already known to be endemic to the individual were tested. If the muscle weakened the patient was further tested for total body positioning and eye gaze at this point of the performance.

Temporal tap was found to correct for the musical affect and the patients were taught how to use the tap before a performance.

The results were more than satisfactory in that each skater attained higher scores, each reported a feeling of greater balance and, therefore greater confidence at critical points were achieved.

The affects of music are still being studied for each skater and/or dancer seen in our office. The following is a case study in which the technique was used to increase patient response.

Case Study:

The patient was initially seen for frequent sinus irritation and recent experiences with loss of equilibrium while skating. The patient was treated kinesiologically for thymus, thyroid, PRY, limbic and gait reflexes. While the response was favorable she would still become tired and unbalanced at one

particular point of her performance. Since the patient is an ice skater and takes her cues from music we had her bring in a cassette of the music. While the music played she was instructed on the use of imagery to visualize herself during the performance. Several muscles were tested at points labeled "critical" by the patient, ie: points at which jumps or changes in direction occurred. At one of the critical points it was found that the infraspinatus weakened.

During initial examination and earlier visits it had been determined that the thymus was the target gland. Therefore when corrected kinesiological other involved factors will also balance. The period at which the musical involvement was questioned was a time at which progress had leveled off. There had to be another factor causing the thymus to react, leading to imbalance of musculature. The music is so important that it could be said that a skater has "cochlea-soma" coordination much the same as a tennis player has "hand-eye" coordination.

The correction for this audio involvement was through the use of temporal tap. On the left side, "I will get along fine with my music," on the right, "there is no reason for me not to skate well with my music." This was done in the examination room with alleviation of weakness caused by the music. The patient was then instructed to tap three times per day and before and after skating.

The improvement in performance is reported by the coach as 25 to 30 percent. The alleviation of stress brought about via the music allowed the patient to respond approximately 40 percent greater to treatment than earlier attained.

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THE LAW OF FIVE ELEMENTS
THE TOUCH FOR HEALTH APPROACH

By

John F. Thie, D.C.

ABSTRACT:

A description of utilizing the law of five elements as a method to rebalance the body energy blockages and a plea for the reduction of health care costs by training patients and paraprofessionals to utilize this and other safe AK techniques.

* * * *

The basis of this approach is the assumption that the health of each person is related to the life force flowing through the body in a balanced way. This life force or energy, can be identified by the muscle response to manual muscle testing. The energy in the body must flow from meridian to meridian throughout the entire body entering from the outside through the points on the body called acupuncture points and leaving with the breath. This energy sustains life and then leaves the body in a continuous flow, in and out. Illness in this model occurs when this energy is blocked from flowing into the body, within the body or out of the body.

Points on the body called acupuncture, neurolymphatic, neurovascular, muscle and bony reflex points, when touched, will unblock the flow of the life force or energy. The imbalance is said to be present when, through manual muscle testing of muscles that are related to the energy flow of the 14 meridians (see Table I), do not respond with a locking in the isolated manual muscle test position.

TABLE I

MERIDIAN
ABBREVIATIONS

For convenience, we abbreviate reference to the meridians as follows:

L = Lung	K = Kidney
LI = Large Intestine	CS = Circulation/sex
S = Stomach	T = Triple warmer
SP = Spleen	GB = Gall bladder
H = Heart	LV = Liver
SI = Small Intestine	CV = Central
B = Bladder	GV = Governing

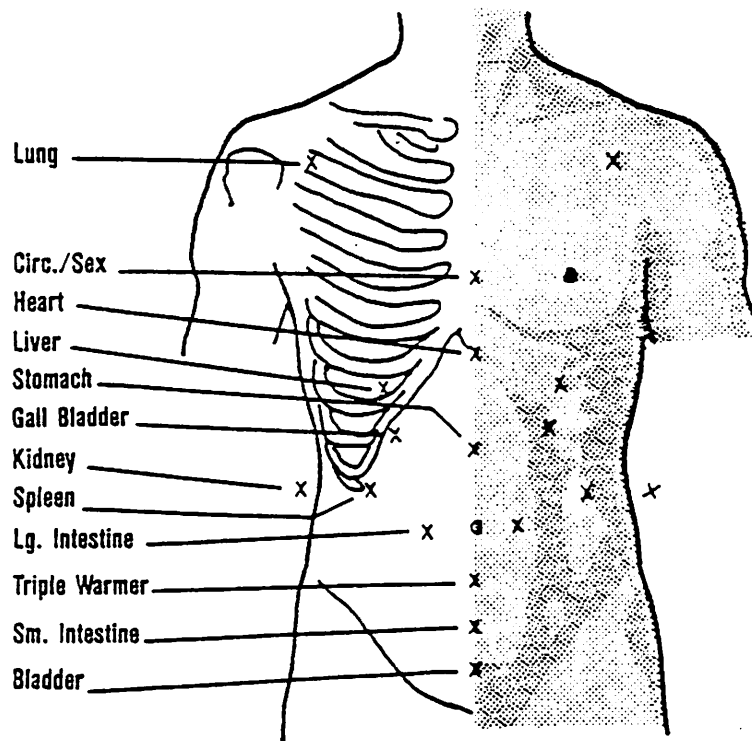
Our findings indicate that most people are under energy flow, indicated by this failure of the muscle in an isolated test position to lock in position and appear to the testor to be unable to sustain this position under pressure, as compared to other muscles in his or her body.

It has been discovered, however, that this inhibition of muscles can also occur when there is an over amount of energy in the particular meridian. One way to determine if that is present, is to touch the reflex points on the body that are traditionally called alarm points. (See Table II and Diagram 1).

ALARM POINT LOCATIONS

- LUNG
Lung 1; the beginning point of the Lung meridian.
- HEART
Central 14; the tip of the xiphoid process below sternum.
- CIRCULATION/SEX
Central 17; level with the nipples.
- STOMACH
Central 12; halfway between the xiphoid process and umbilicus.
- BLADDER
Central 3; just above the symphysis pubis.
- SMALL INTESTINE
Central 4; divide distance between Central 3 and umbilicus with 2 equidistant points — Central 4 is the first point above Central 3.
- TRIPLE WARMER
Central 5; the next point up from Central 4.
- LARGE INTESTINE
Stomach 25; on stomach meridian, level with umbilicus.
- GALL BLADDER
Gall Bladder 24; just below the joining of 9th rib and costal border.
- LIVER
Liver 14; where a plumbline from the nipple crosses the rib cage's costal border.

Diagram 1



ALARM POINTS

The energy flow pattern is traditionally believed to flow during a 24 hour period through each of the 12 paired meridians, in a sequence with each being in dominance for two hours. It has been my personal experience using these methods over the past years, that it is important to begin to rebalance the life force energy by determining the major blockage. One way of doing this is to test an indicator muscle for each of the meridians in the order of the energy flow based on the time of dominance of its function in the body, (see Diagram 2), in time sequence.

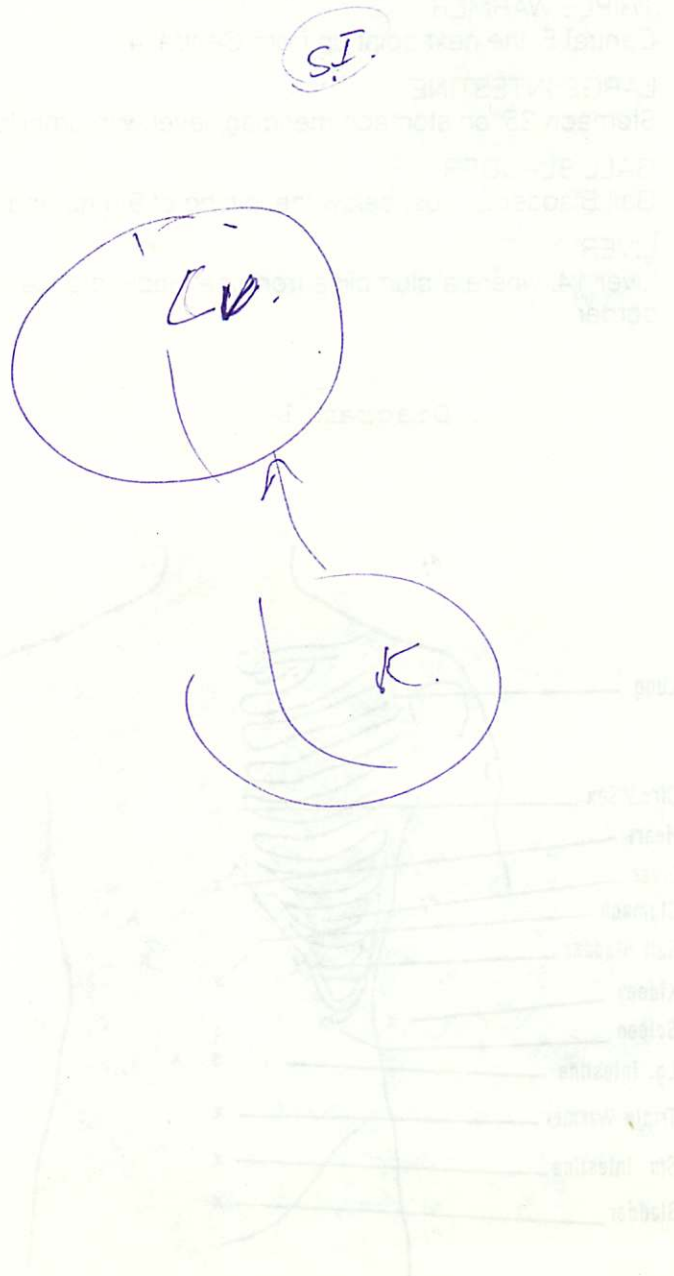
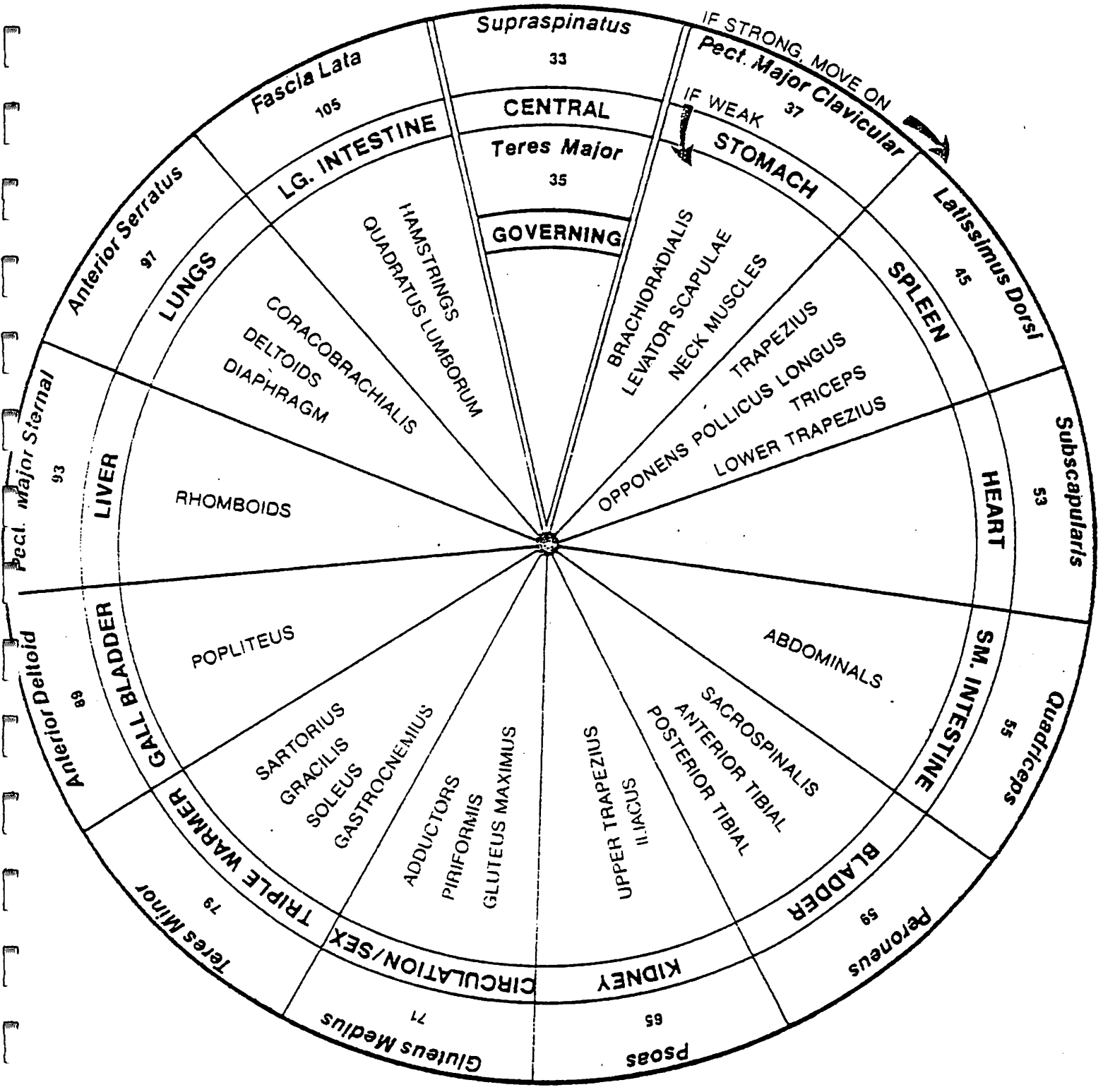
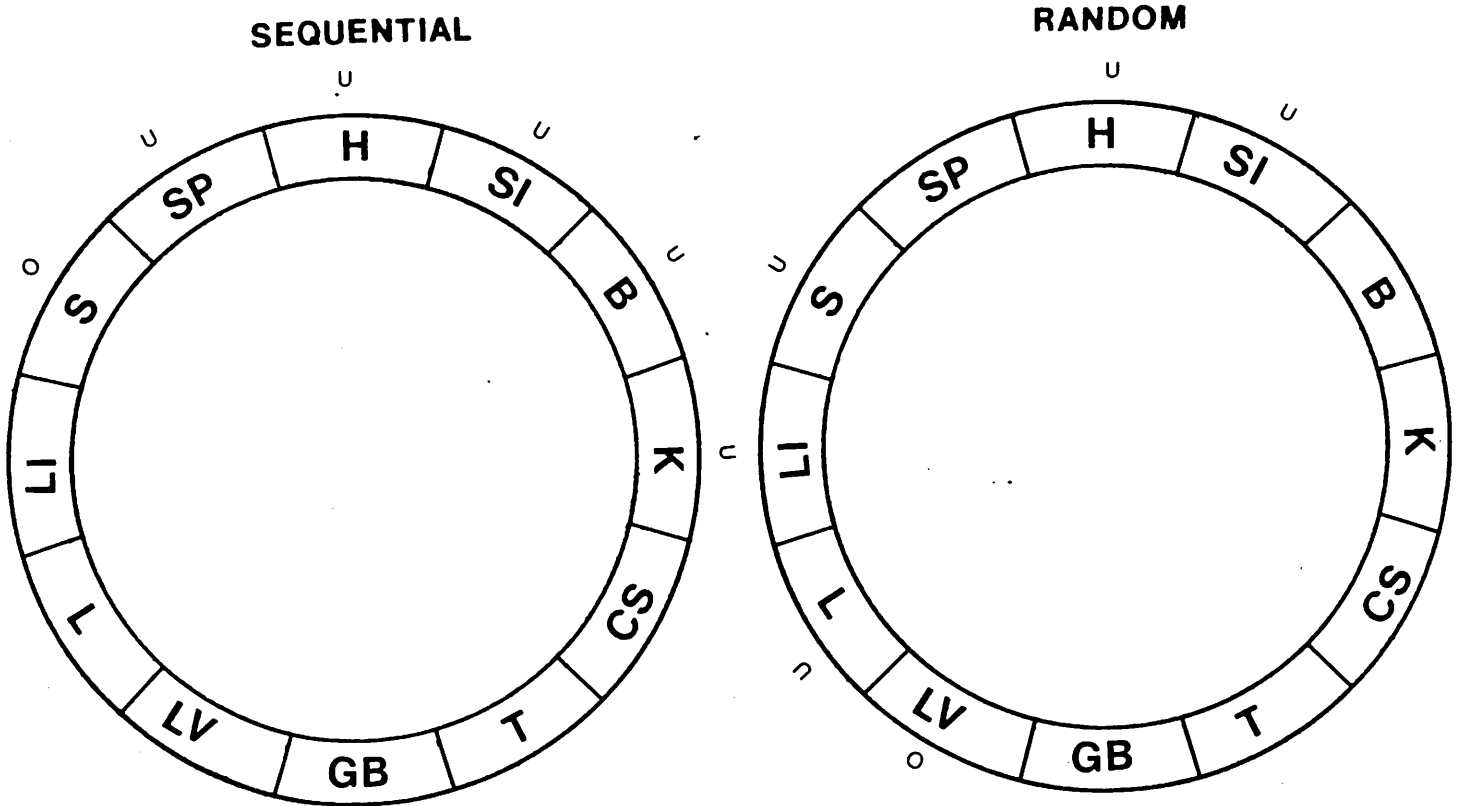


Diagram 2



When four or more muscles are found to be inhibited by manual muscle testing, beginning at the first one found inhibited in a clockwise direction, is the most effective for correction, and will often be the only correction needed. If, however, the inhibitions found appear to be random, using the law of five elements for determination of the starting point, is often more effective as far as the number of corrections to be made. (See Diagram 3)

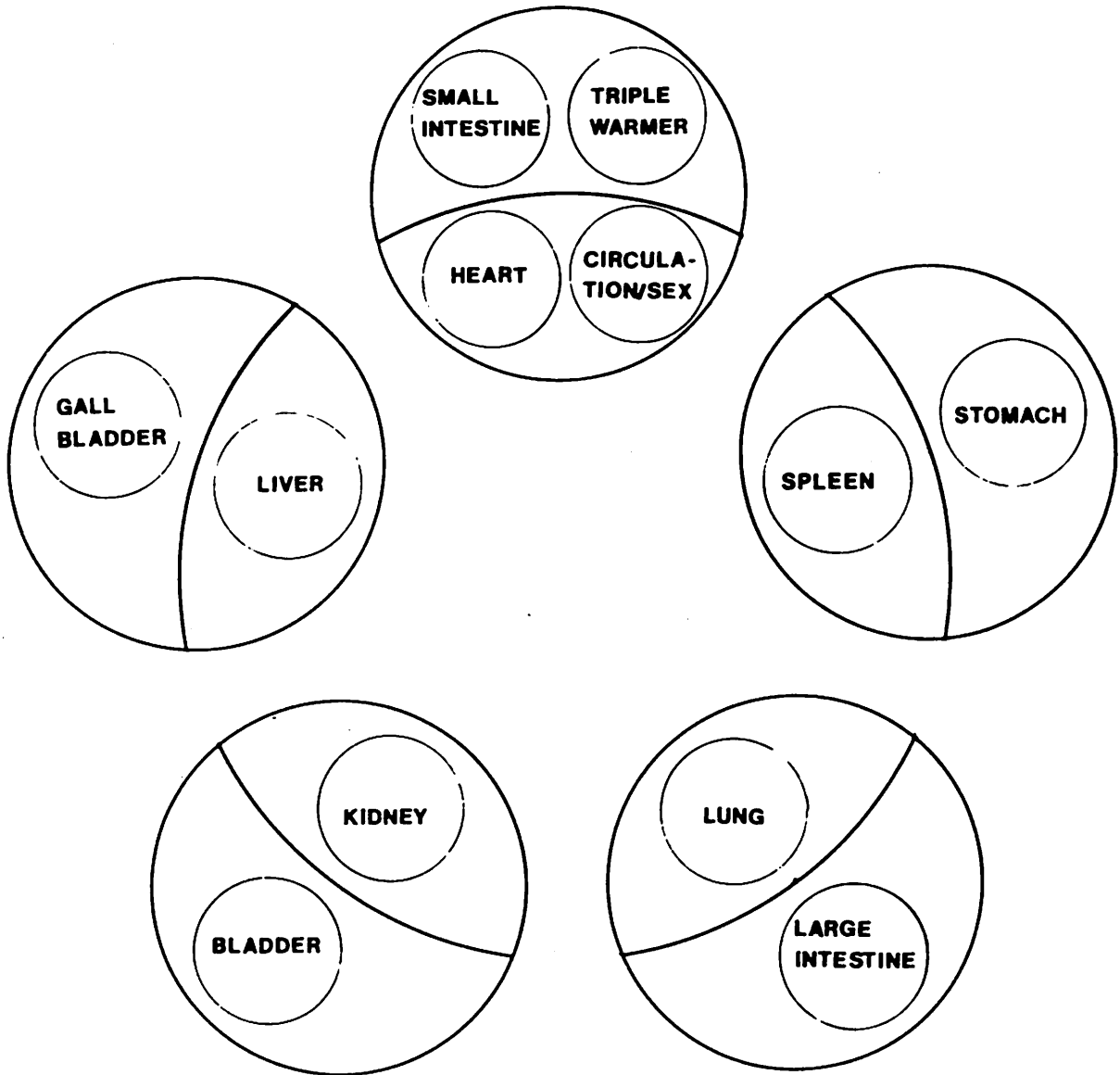
Diagram 3



One way to think about this method is to see the 24 hour clock as representing the flow of energy on the surface, the energy that flows just under the skin, and the five element model as the deeper internal energy interacting between the body's organic functions.

In Diagram 3 sequential, it shows stomach/spleen, heart, small intestines, bladder and kidney muscle indicators all testing weak. Using the alarm points as indicators of over energy, it was discovered that the stomach indicator was found to be inhibited due to over energy. Under these circumstances, the first muscle to be corrected would be the spleen muscles. The rebalancing of the energy would be done using the usual TOUCH FOR HEALTH methods of beginning with the neurolymphatics and challenging, then doing any other rebalancing techniques indicated by the challenge.

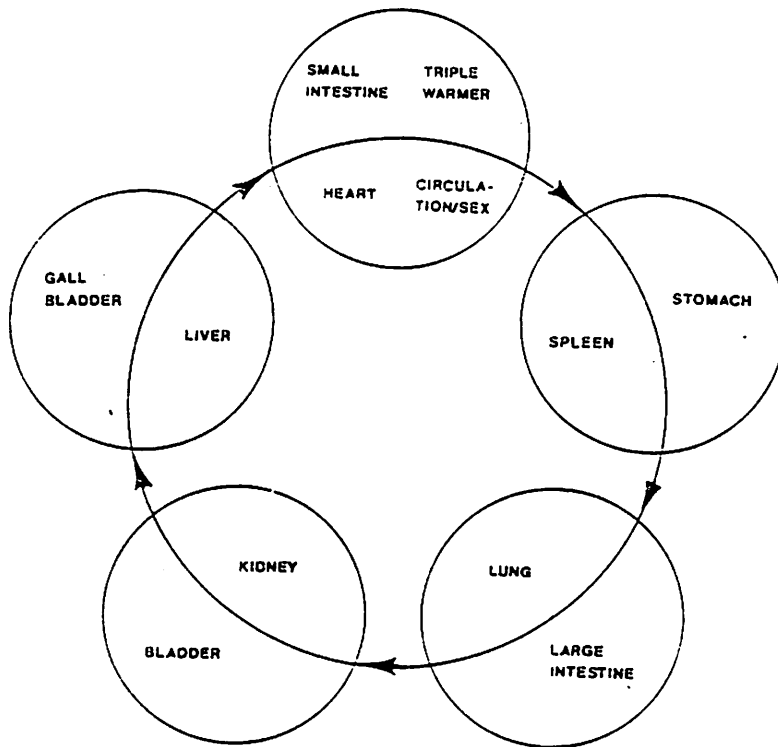
Diagram 4



In the random sequence of Diagram 3, use of the law of five elements would be indicated. That is, grouping the meridians in five categories as shown in Diagram 4. The interaction of these five meridian groups occur in two ways. The first is the cycle traditionally called the generating cycle. This energy flow is circular and clockwise. (See Diagram 5).

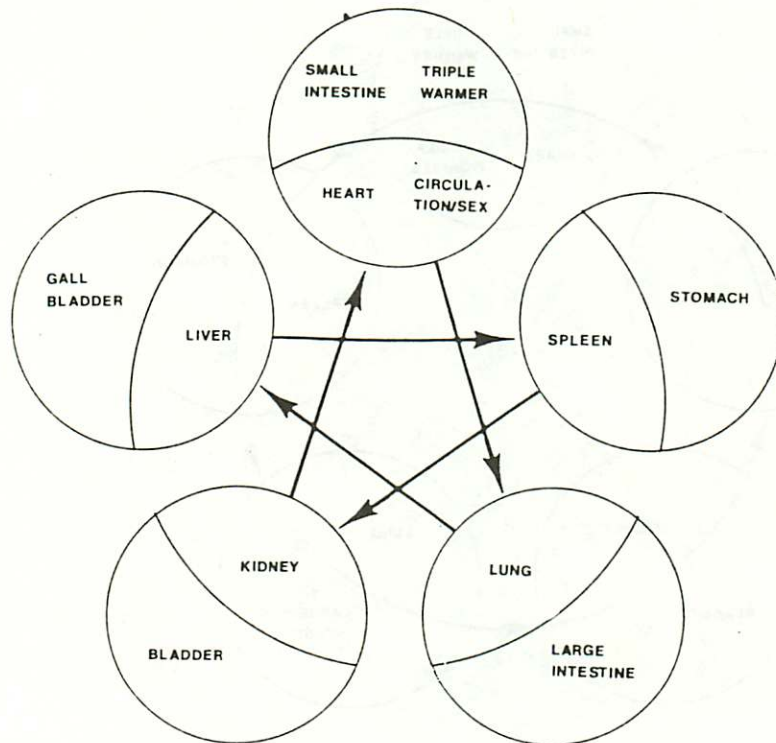
Diagram 5

THE GENERATING CYCLE



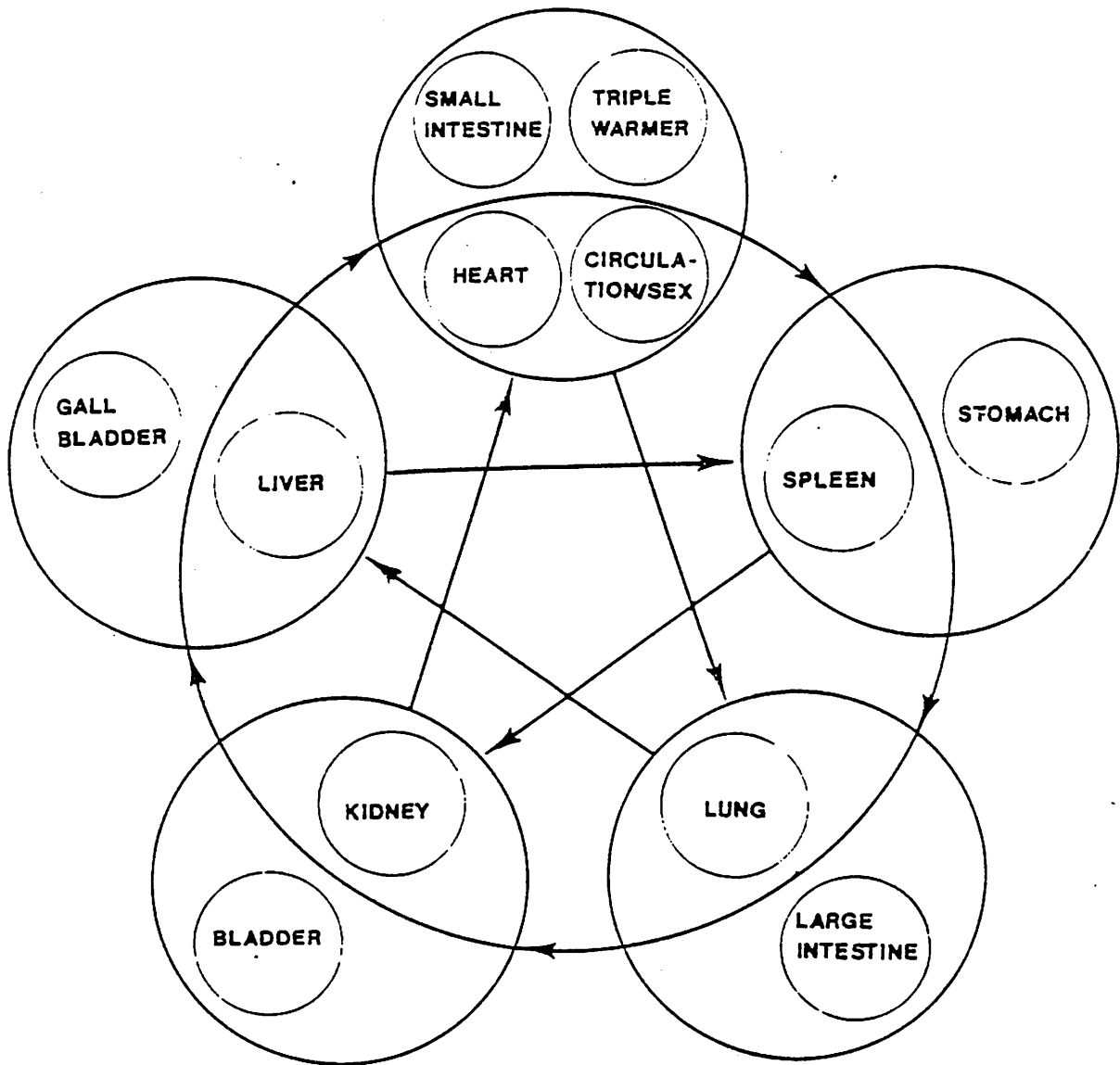
The second is the control cycle, which is represented by the energy flow being in a five pointed star pattern (see Diagram 6). In the model I am using it is necessary to think of the energy flow as one way streets and that the energy can go only in the one direction. The object is to bring the over energy to the under meridian, by the shortest possible route. This can be done by following either the generating or control patterns.

Diagram 6
THE CONTROL CYCLE



Another way to visualize this model and its function is to think about this model (see Diagram 7), representing both the control and generating cycle, relating to the atoms in their orbits and the control relating to the internal atomic particles together and their relationship to each other.

Diagram 7



290 This mode of re-balancing energy blocks requires that you keep both the generating and control cycles in mind and then use, as the starting point, the shortest clockwise distance between the over and under energy, working to correct the under energy.

I will now give you five examples that we use in teaching this method in our Touch for Health program, from the booklet by Gordon Stokes, Training Director for the Touch for Health Foundation.

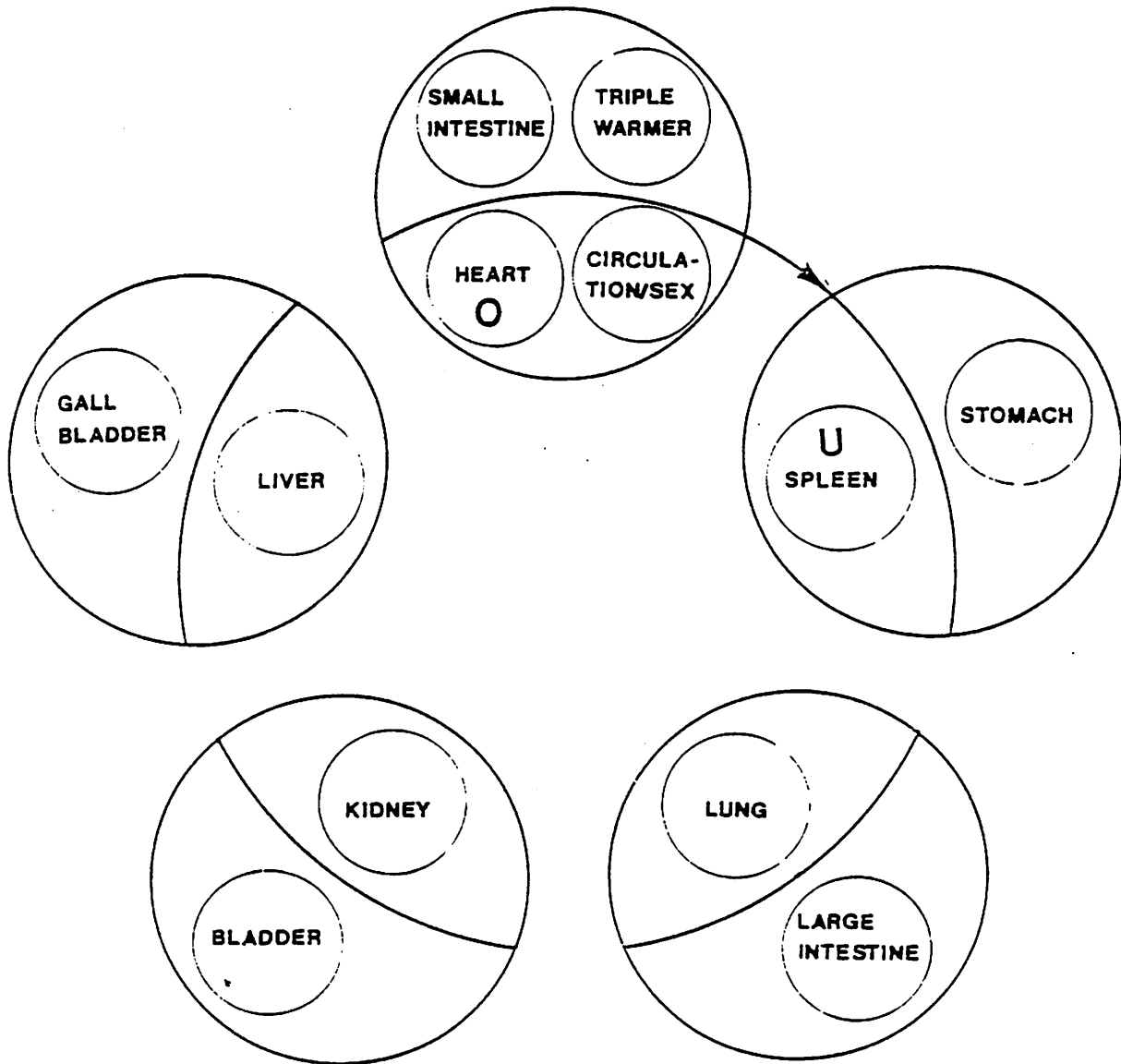
When using this model to assist a person to heal themselves, it is important to remember that the simplest flow should be used first. This, many times, will rebalance the entire energy pattern since God designed our bodies to rebalance whenever possible.

Either the generating or control patterns can be used to start, however, if there appears to be two equally simple patterns, the rule would be to begin with the inner circle of meridians which represent the energy pattern that is working continuously and has to do with the storage and distribution of energy. These are traditionally called the yin meridians.

EXAMPLE #1

USING THE GENERATING FLOW

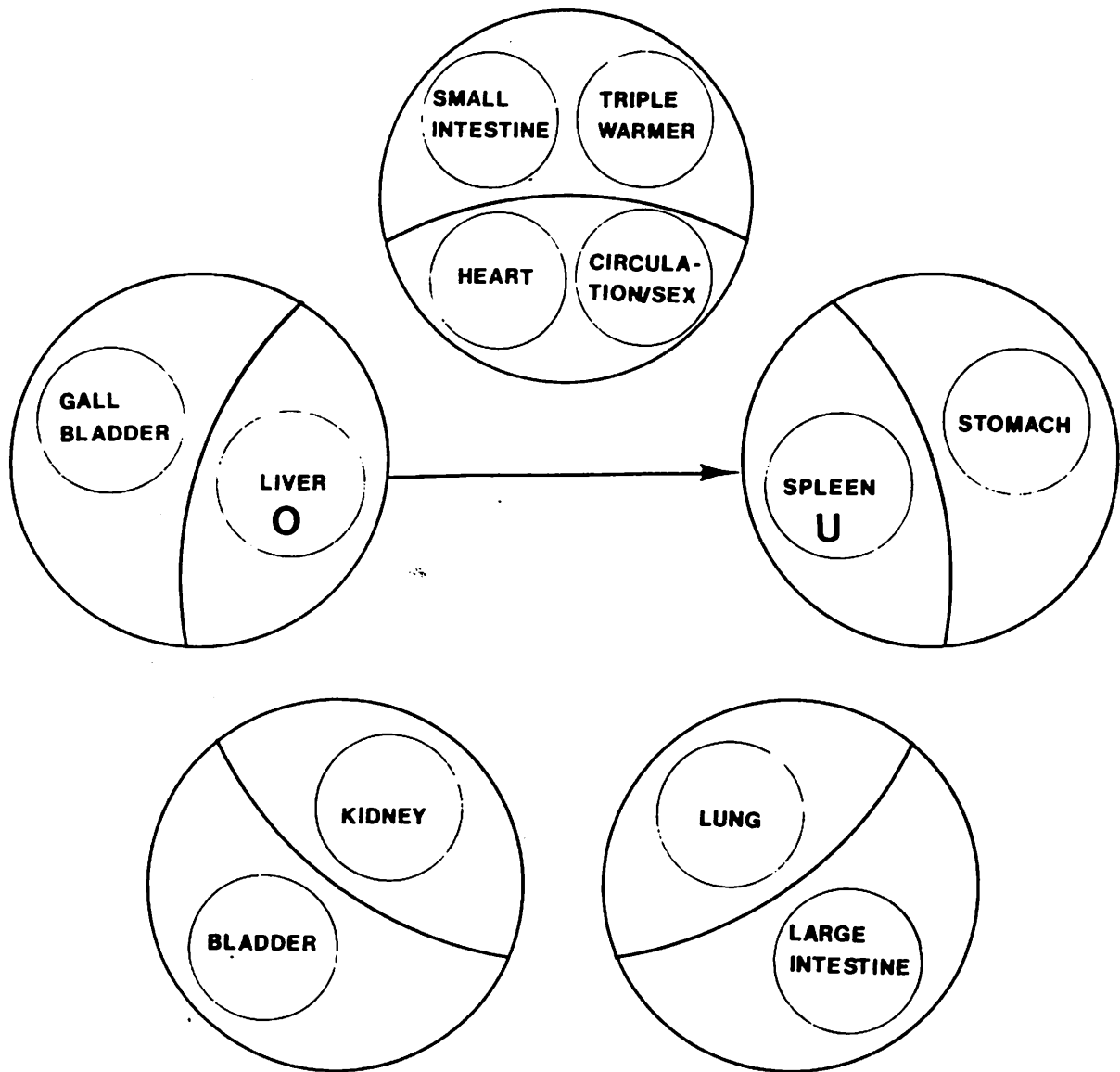
You've tested the 14 muscles and the alarm points. If Spleen is UNDER and Heart OVER energy (see the illustration), you'd use the GENERATING FLOW model. Strengthen Spleen to draw excess energy from Heart. (You'd do this as always, using NL, NV or running the Spleen meridian, of course. Then test the Heart ALARM POINT to double check your transfer of energy.) You always draw from MORE to LESS — and clockwise, remember. Also — using this model, you'll almost always be correcting UNDER energy meridians rather than dispersing the OVER energy.



EXAMPLE #2

USING THE CONTROL FLOW

Another for instance. As in the illustration, Spleen is UNDER and Liver OVER energy. Here CONTROL gives the shortest clockwise distance between the two points, straight across the 5-ELEMENT circle. Using NL, NV (or whatever), you'd strengthen Spleen to draw excess energy from Liver. Now CHALLENGE and check ALL muscles of the affected meridian (as you'd do with any correction). Check the ALARM POINT to be sure the energy's been transferred.

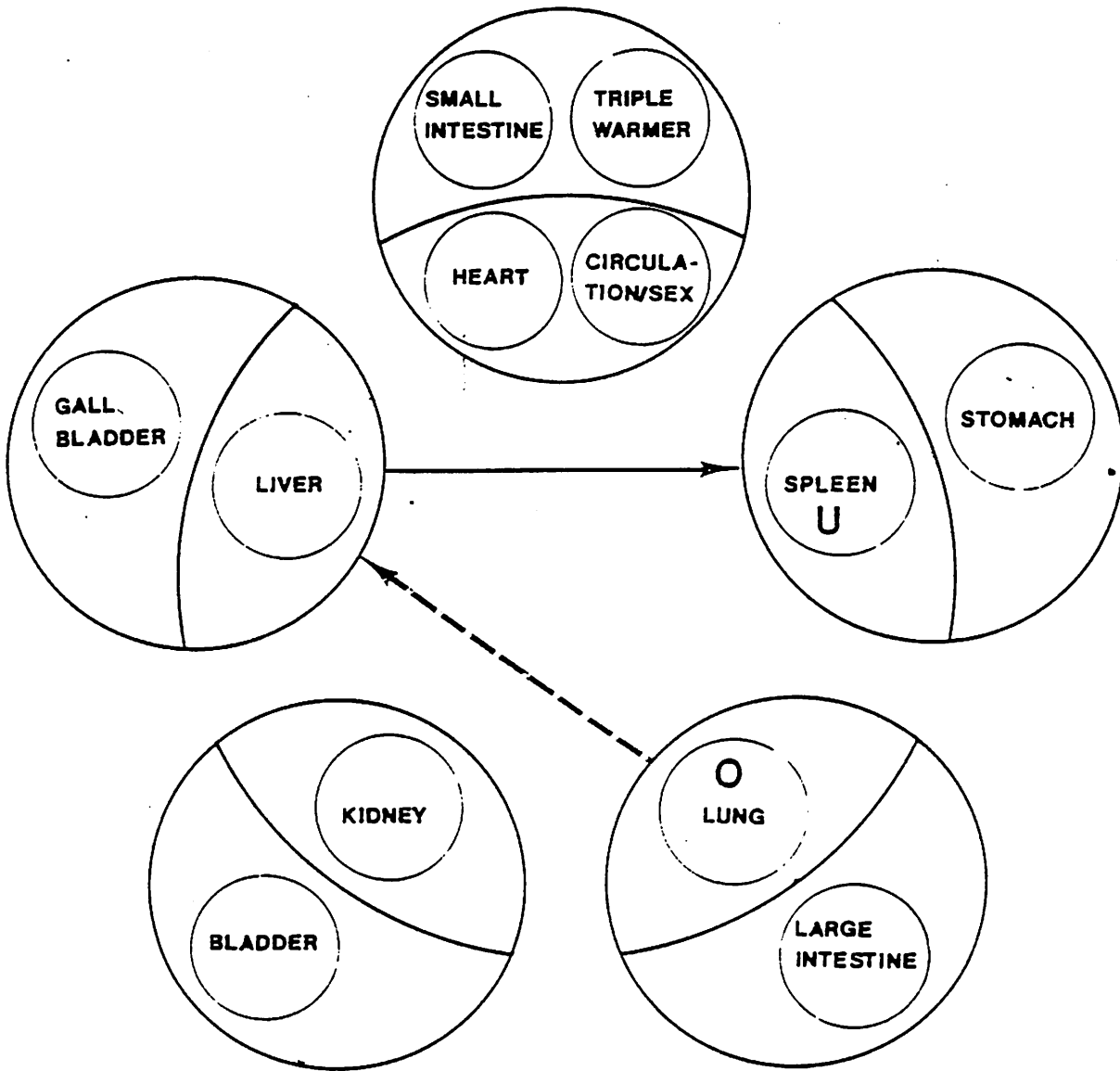


EXAMPLE #3

THE 'BILLIARD BALL' APPROACH USING THE CONTROL FLOW

Now comes expertise. UNDER energy on Spleen and OVER energy on Lungs. In this case — (see the illustration) there's no direct connection between the two points going clockwise on either GENERATING or CONTROL. We need an intermediary and CONTROL's flow gives it to us, using a 'billiard ball' effect. First we strengthen Spleen. This draws energy from Liver (directly across the 5-ELEMENT circle). Now, having created an ARTIFICIAL imbalance in Liver — which you check by testing the Pectoralis Major Sternal (which may show weak) — follow through and strengthen Liver. This draws OVER energy from Lungs into Liver and puts the system back in balance.

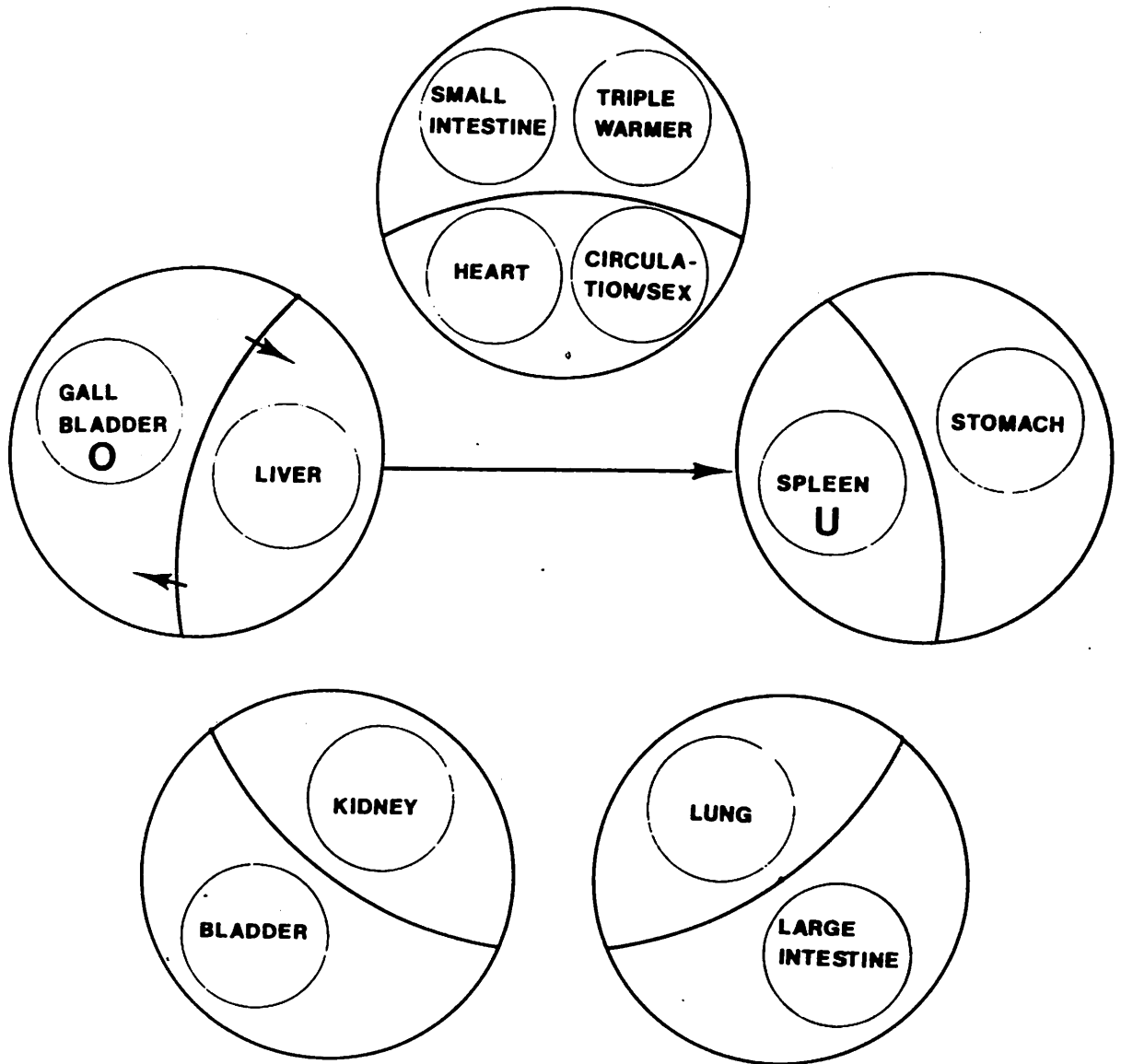
Important rule: whenever you are applying the 5-ELEMENT method always take supplementing action on the Meridian with the deficiency, whether the deficiency has occurred of itself or has been artificially created by you. And remember, surplus energy travels only in the direction indicated by the arrows.



EXAMPLE #4

FROM 'OUTSIDE THE CIRCLE' WORKING INWARD

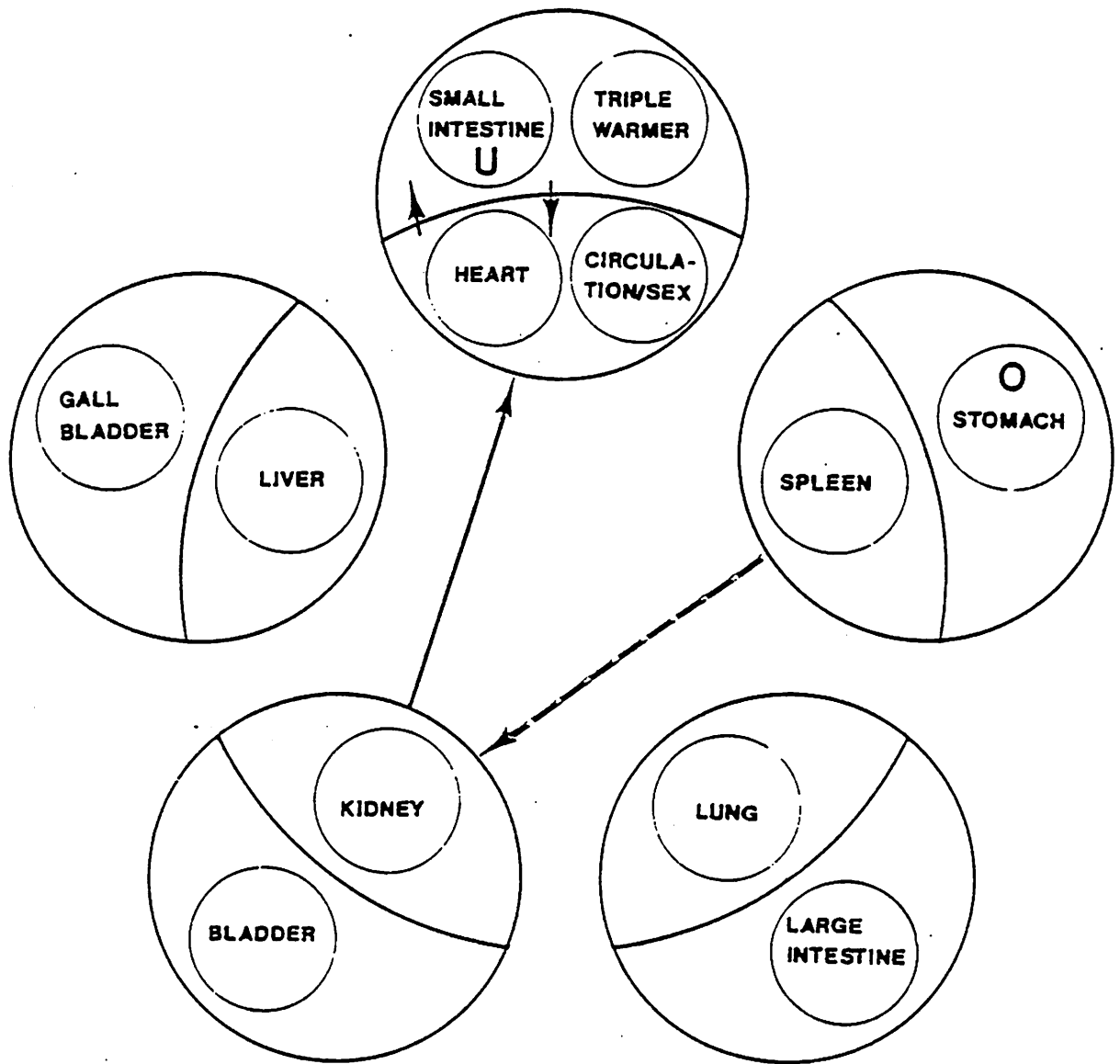
As in the illustration, here's what to do when the OVER energy in one of the ELEMENTS is 'outside the circle,' and the UNDER energy is within it. Gall Bladder is OVER energy, Spleen UNDER. First balance Spleen, then check the Pectoralis Major Sternal to see if Liver went UNDER energy. If so, work on Liver to bring the energy from Gall Bladder to the Liver meridian. Sometimes, the energy travels through the 'wall' in an element without a weakening effect. Since that's likely, and if PMS didn't indicate UNDER energy, check the ALARM POINT to make sure the transfer was made.



EXAMPLE #5

WORKING 'OUTSIDE THE CIRCLE' USING THE CONTROL FLOW

As shown in the illustration, here's how to handle OVER energy on Stomach and UNDER on Small Intestine. Both are 'outside the circle'. The most direct flow is shown by the arrows in diagram. Using your TFH correction techniques, first work on Small Intestine, then on Heart, finally on Kidney. Small Intestine will draw energy from Heart. Then strengthen Heart to draw excess energy from Spleen. NOTE: energy may transfer from Stomach through Spleen WITHOUT WEAKENING Spleen. Check out by muscle testing, each step of the way.)



CONCLUSION

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I have presented a simple model of utilizing a traditional acupuncture law of the five elements, where muscle testing is utilized to determine the over and under energy. This suggest another way to simplify the explanation of illness causations. This method can easily be comprehended by lay and paraprofessional persons and utilized as adjunctive home or office care to the more precise and detailed Applied Kinesiological approach, which is utilized by the licensed health professionals.

I believe that we need to offer the public more and more models that the family can utilize in care of their own members and that assistants can utilize, so that the cost of delivering health care can be maintained at the present level or reduced.

With more and more study required to become a licensed health professional, over longer periods of time, and with more graduate studies required to become competent in the vast specialty areas such as ours, the health professional is entitled to a large sum for his time. The health professional should not be utilized for minor problems that can be resolved by safe, simple techniques. The safe, simple techniques, however, should be indicators for the need of professional help, if they do not maintain the correction or even make the correction desired.

I urge all of you to teach your patients how to help themselves and their families, by utilizing techniques developed out of the original Applied Kinesiological approach of manually testing muscles. Touch for Health is one of these approaches and I welcome all of you to learn more about this program that is now world wide and being learned by many paraprofessionals and lay persons.

NEW METHODS FOR LOCALIZING THE SIDE OF MERIDIAN INVOLVEMENT

by

Michael J. Thomas, D.C.

ABSTRACT

Since George Goodheart (1) first publication of the materials of E.I.D. the eyes have given me a new idea into the concepts of diagnostically shortening treatment time without sacrificing the value of accuracy.

DISCUSSION

Previously, evaluation of the meridians was defined as T.L. to the pulse points and then going to the alarm points to distinguish which of the two pulse points was involved. For the unpaired alarm points of Heart, Circulation-Sex, Stomach, Triple Heater, Small Intestine, and Bladder it was then necessary to make a separate test with either the right or left hand to determine the side of meridian involvement (2). Instead of using "handedness" to define the side of involvement simply use the eyes to "label" whether the meridian involved is right or left.

This is accomplished by T.L. the alarm point previously determined by standard A.A. procedures and then moving the eyes straight in the directions of right or left, checking for the weak indicator to strengthen. Note, that the direction of the eyes should be in a straight horizontal plane.

This paper was originally written for the purpose of defining the side of involvement for meridian therapy, but as a side note the eyes have been used experimentally by myself to distinguish sidedness of involvement whenever the situation of determining sides was appropriate.

CONCLUSION

A faster and easier way of determining the "sideness" of involvement for meridian therapy can be accomplished by moving the eyes right or left in the horizontal plane to "label" the side that is necessary to treat.

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DETERMINING SPINAL INVOLVEMENT IN MERIDIAN THERAPY

by

Michael J. Thomas, D.C.

ABSTRACT

Previous diagnosis of spinal involvement when examining and treating the meridians was accomplished by having the patient roll from supine to prone and then challenging the specific associated level of vertebral involvement. The correction was made in the direction of challenge and the the Lovett Brother was also checked, often times there was no spinal involvement (1).

DISCUSSION

The eyes seem to be a source of energy to the system. After determining the involvement of a meridian, while the patient is T.L. to the pulse point or alarm point instruct the patient to close his eyes, if there is any spinal involvement the weak indicator will strengthen. If there is no spinal involvement the indicator muscle will not change, this seems to be a case of energy imbalance within the meridian only. It was interesting to note that when on some patients there was found to be spinal involvement to a specific meridian that correction of the spinal segment before the meridian was treated negated the positive T.L. to the corresponding pulse or alarm point. Structure seems to dictate function!

Lead eye shields were fabricated and negated the eyes closed concept.

CONCLUSION

A faster and more simple way of determining spinal involvement when treating a meridian is to use the eye as an indicator. By closing the eyes and T.L. an active pulse or alarm point the examiner can test for spinal involvement.

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CORRECTING BILATERAL MUSCLE WEAKNESS

by
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ABSTRACT

This paper discusses an unusual and sometimes perplexing problem encountered in clinical practice. The problem is discovered in routine examination when the patient is found to be strong on epsilateral muscle testing (example pectorals, adductors, G. medius or G. max) but when these muscles are tested simultaneously they are very weak. This paper presents a method to correct this problem.

DISCUSSION

Perhaps I am not the only person who has found that occassionally a patient presents themselves for examination and there is not a strong muscle to be found (or as we say, " a strong muscle in the clear".) Assuming the patient is not paralyzed or in a coma, we have found from experience that the problem is often one of the following: dehydration, iron deficiency, hypoadrenia, or hypoglycemia. This type of weakness responds tremendously when the problem at hand is corrected.

Another syndrome which is encountered in examination is where we find bilaterally the muscles are weak upon testing but if tested individually the muscles are strong and apparently normal. In treating this type of patient we have discovered on of their

chief symptoms is loss of energy and tenderness at T 7-8 between the spinous processes. This can be therapy localized by testing for anterior subluxation of T 7-8. In classical Chinese Acupuncture or Meridian therapy the associated points for the Conception Vessel and the Governing Vessel are T 7-8. One of CV - GV functions is that of storing energy. When the associated point is affected by the anterior spinal subluxation at T 7-8 then the energy storage mechanism does not function properly and one of the resulting physiological phenomena is the weakness of all bilateral muscles. Imagine the effect upon our patient's health and well-being.

CORRECTION

The method we use to correct this problem is to adjust the anterior vertebra by the Dijarnette method or simply to adjust the patient while in the standing posture and use a small roll or cushion placed precisely below the most tender point at either T 7 or T 8 and sometimes T 9 and then give a lift in a cephalad direction. The patient will immediately notice the strength return to the bilateral muscles that were apparently hopelessly weak a minute before the treatment. Immediately the patient will experience a change for the better in their vital energy.

This treatment is especially valued and gratifying to the young athlete whose chance of winning is enhanced on the spot. The feedback has been terrific.

LOCATING THE CAUSE OF NEUROLOGIC DISORGANIZATION

by David S. Walther, D.C.

ABSTRACT

Since Goodheart's original description of switching, [5] it has been an important factor in applied kinesiology examination procedures. It has been noted that problem patients are often those who have repeated switching. A method for finding the cause of switching was previously presented to ICAR. [10]

Presented in this paper is the hypothesis that many individuals demonstrate switching when under specific influence of the structural, chemical, or mental side of the triad of health, yet it may not show in a supine position. A system is offered for determining the basic underlying cause of switching and correcting it.

History

During an applied kinesiology examination, all findings must correlate before a final conclusion regarding the cause of the condition being evaluated can be reached. Failure of this correlation indicates that something is being missed in the examination which could be a contributing factor to the condition; if not found, the examination and treatment will produce only superficial or no results. An example of the failure of correlating findings is for a subject to have a high shoulder on the right with pelvic and spinal balance and no trapezius or pectoralis muscle imbalance. This condition would ordinarily indicate a weak latissimus dorsi on the right, but sometimes an individual is observed to have weakness on the left and strength on the right. To further confuse the issue, the temporosphenoidal (TS) line

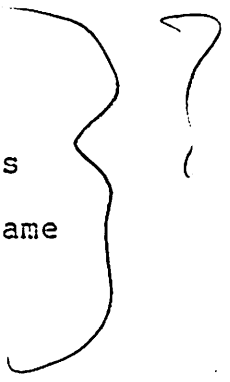
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- or the pulse point diagnosis of meridian therapy - may indicate weakness on the right. Recognizing this correlation failure, Goodheart [6,7] termed the phenomenon "switching" and clinically found various factors which would organize the examination findings.

The factor most often found associated with disorganized examination findings is activity at acupuncture point K27. In classic acupuncture this is considered the "house of associated points," or the master associated point for the body. Goodheart considered the point a master switchboard for the two sides of the body. When K27 is active it will show positive therapy localization, and its stimulation in combination with the umbilicus will dramatically change the disorganized findings. In the example given above, the latissimus dorsi previously found weak on the left will strengthen, and the right latissimus dorsi will become weak after K27-umbilicus is stimulated. Other cases of switching may relate to different systems, such as finding weakness of the right gluteus medius and the left gluteus maximus with only the right circulation sex meridian showing weakness. Since these muscles are related to the circulation sex meridian, they should both be weak on the side of meridian deficiency if there is weakness in both muscles. In this case, if there is a positive K27 indicated by therapy localization, its stimulation will cause the muscle which is weak on the side of the strong circulation sex meridian to become strong, and the opposite muscle will weaken. Stimulation of K27-umbilicus in the presence of disorganized

examination findings has been successfully applied to many types of situations.

In addition to R27-umbilicus stimulation, Goodheart has referred to "auxillary R27 points" which are located on either side of the 11th thoracic vertebra. These points are stimulated in conjunction with the umbilicus in the same manner that the standard R27 point is stimulated.



Other types of switching - such as governing vessel-conception vessel switching, nasal tap, and coccygeal switching - have been clinically demonstrated. In this paper the primary emphasis will be on R27 switching, which was the original type and the one most often found clinically.

Goodheart [5] developed a system of cross patterning modified from the system of cross crawl that Doman and Delacato [3] developed. Use of the cross patterning procedure directed to one side of the body seemed beneficial in keeping the patient from becoming switched again.

Some patients required the unswitching procedure by stimulation of R27-umbilicus or other means only one time; however, in other patients recidivism of switching was a significant problem. Quite often recurrent switching was present in patients with the more difficult conditions to correct.

Dynamic Evaluation for Switching

A dynamic evaluation for switching can be considered as an examination which adds and subtracts various factors which may be the primary cause of switching. A positive R27

may appear when any extra factor related with the triad of health is added. The structural side of the triad of health appears to be the one most often involved. The chemical or mental side of the triad may be the cause, either individually or combined. In most instances, only one side of the triad of health is the primary cause for the switching, but occasionally two or all three sides can be involved.

Evaluation of the types of factors which influence a positive K27 indicates that switching results from stimulation of various types of receptors giving input to the nervous system. The receptors classified by Guyton [8] are mechanoreceptors, thermoreceptors, nociceptors, electromagnetic receptors, and chemoceptors. This classification adequately covers the clinical observations noted below, with the exception of the mental side of the triad of health. Mental aspects obviously give input into the afferent nervous system, but have not been categorized as nerve receptors. Guyton refers to electromagnetic receptors of only one type - the rods and cones of the eye. Those working with applied kinesiology and acupuncture recognize additional receptors which appear to be of an electromagnetic nature relating to the meridian system.

With the accumulation of knowledge in applied kinesiology examination procedures, it has become apparent that many more patients reveal switching - as observed by positive therapy localization at K27 - than was first noted. The original method of therapy localizing for K27 was to have the supine patient touch the right K27 with his right hand

and the left K27 with his left hand. A previously strong indicator muscle was tested for weakening and, if present, a positive K27 was indicated.

Dynamic evaluation for K27 is therapy localization, followed by testing a previously strong indicator muscle while the patient is performing various acts and/or is in various positions. Many patients will not show a positive K27 when in the supine position, but it may show when in a seated or standing position. It may even be negative in the standing position, but positive if the patient holds the therapy localization contact and statically stands in various gait positions. A positive reaction will show even more frequently when the therapy localization is held and the patient walks and then stops; a previously strong indicator muscle is tested while continuing to hold the therapy localization. In some instances, an individual can walk in a straight line and positive K27 therapy localization will not be observed; yet if the patient walks in a figure 8 so that both directions of turning while walking are present just prior to the previously strong indicator muscle being tested, it will be observed. These additional factors to the testing procedure indicate that something in the weight-bearing or gait mechanism is entering disorganization into the nervous system, thus causing evidence of switching.

Some individuals will test negative for K27 therapy localization, and then test positive for it immediately after chewing or if the breath is held in various phases, such as full inspiration, expiration, or on half-phase of respiration, either in or out. There may be a positive indication of switching when K27 is therapy localized and

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the patient simultaneously opens and closes his mouth, activating the TMJ and muscles of mastication. These additional factors causing a positive K27 indicate the stomatognathic system - including the cranial primary respiratory mechanism - is adversely stimulating receptors, causing confusion within the system.

Some individuals will show no evidence of positive therapy localization to K27 in the clear, but they will as a result of chemical changes. A certain type of food, nutritional component, food additive, toxin, etc., may cause a positive K27 when none was present before. This is generally tested by holding a substance in the mouth and testing for a positive K27 in the usual manner. The substance may be inhaled as described by Brimhall. [2]

To complete the triad of health, some individuals will develop a positive K27 by specific thought patterns when none is observed in the clear. It may be a thought pattern that can be successfully treated with the emotional neurovascular contact described by Bennett [1] and modified by Goodheart. [4] An unusual type of positive K27 therapy localization may be observed, which is positive therapy localization when the patient's right hand contacts the left K27 and the left hand contacts the right K27 point. This has been related to schizophrenia and described previously. [9]

Treatment of K27-Umbilicus

The treatment of a positive K27 by digital stimulation

has been of value because it organizes the patient in such a manner that examination findings will correlate. This body organization has been considered necessary so that proper treatment can be provided, rather than treating uninvolved factors or missing those which are involved.

It does not appear that the stimulation of R27-umbilicus by itself is an effective treatment; rather it is a clinically observed, temporary organization of the body's function. This seems obvious because in nearly all instances elimination of the positive R27 is only temporary if no other treatment is provided. For example, it is probable that the positive R27 will return immediately after a patient walks, chews, stands, or stresses the body in any manner. This can be demonstrated in almost all cases where a positive R27 is treated, and it could probably be demonstrated in all cases if the examiner had knowledge of the structural, chemical, or mental factor responsible for the R27 being present.

The consistent return of a positive R27 when no other treatment is given indicates that when a positive R27 does not return it is due to the physician making some correction which was responsible for the positive R27 being present in the first place. It is therefore important to locate the cause of the positive R27 prior to further examination and treatment of the patient.

Treatment of Patient Prior to Eliminating Switching

Switching is characterized by unusual and inappropriate examination findings. It has always been thought that it

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is necessary to eliminate switching prior to treatment of the patient to avoid improper treatment. This paper agrees with this basic principle, but a different view on the method of eliminating switching is taken. It is clinically observed that challenge which eliminates positive K27 therapy localization will be the same challenge present after K27-umbilicus is stimulated to the point of eliminating the positive therapy localization. Other examination findings which show positive challenge but do not eliminate the positive K27 therapy localization may or may not be the same after the stimulation of K27-umbilicus. It is therefore proposed that incorrect information is not obtained if the patient is examined while switched if the examination procedure is directed toward finding the challenge - structural, chemical, or mental - which eliminates the positive K27.

Another principle in this paper is that the vast majority of - if not all - "problem patients" are neurologically disorganized, which is recognized as being "switched." Neurologic disorganization may not be observed by positive K27 in the usual examination; it may be necessary to challenge the body in some other way. A patient may be classified as not being switched and treated accordingly, but in reality he is switched. If the examiner would test for a positive K27 with the patient standing or with some other structural challenge, it would be present. The same is true for various chemical and mental challenges.

Because of the high occurrence of switching in problem

patients, it is obvious that a system for evaluating and eliminating the basic underlying cause of switching is valuable in gaining correction with a minimum amount of time and effort. This can be accomplished by using a positive therapy localization to K27 as an asset in an examination rather than a liability. By routinely stimulating K27-umbilicus, an indicator is temporarily removed which can help locate the cause - structural, chemical, or mental - responsible for the disorganization. In this manner, K27 is considered a monitor for switching or neurologic disorganization rather than a treatment point. By using the diagnostic tools of challenge, therapy localization, oral chemical challenge, and muscle testing the cause of the positive K27 can nearly always be found.

Locating and Removing the Cause of Switching

Structural

If a patient demonstrates a positive K27 therapy localization while supine, the examiner simply challenges various factors or uses two-handed therapy localization to determine what eliminates the situation. Body language can often help the examiner rapidly find the cause. For example, a patient may have symptoms which increase with daily activity. The examiner's questions reveal that the symptoms develop more when standing and walking, but are relieved upon sitting. The indication is structural, probably in the feet or gait mechanism. If the patient indicates that the symptoms continue but are relieved when lying down, there

312 is probability of pelvic or spinal involvement. The feet and gait mechanism are probably not involved if relief is not obtained when sitting. In these examples, the positive K27 therapy localization will be eliminated when the correct challenge is done by the examiner. For example, if the foot is involved, challenging the foot in the direction of correction will cause an indicator muscle weakened by therapy localization to K27 to strengthen. The correction of that subluxation will eliminate the positive K27, and no stimulation is required.

A positive K27 may not be present in the supine position, but appears when the patient stands or walks. Correction of the associated problem - whether temporary as with tape support or permanent - will eliminate the positive K27.

Body language indicating the equilibrium proprioceptors - such as the visual righting reflexes, labyrinthine reflexes, and tonic neck reflexes - suggests probable cranial or upper cervical involvement. Body language indicating equilibrium proprioceptive factors may be evidence of the need for PRY technique, head tilt, ocular lock, and other body language of cranial or upper cervical fault. In these cases if a positive K27 is present in the supine position, having the patient hold various phases of respiration, or using challenge on the skull and upper cervical area, will abolish the positive K27 and indicate the type of treatment needed. When there is no positive therapy localization to K27 in the supine position, it may often develop when a patient holds various phases of respiration, clenches the teeth, wags the jaw,

or turns his head in various positions. Again, these added challenges indicate the type of treatment needed to abolish switching.

Chemical

Chemical causes of switching can be evaluated in a manner similar to that for structural. Body language again indicates the possible presence of a chemical factor. If a patient has exacerbation of symptoms on a monthly cycle along with menstruation, hormone balance is suspect. This can be evaluated by electron poisoning. If an individual shows a positive R27 while supine, testing is done to find the factors of oxidation or reduction which eliminate the positive R27. If R27 is not present with the patient supine, placing in the mouth the opposite factor of oxidation or reduction from that which is needed for treatment may cause a positive R27 to appear.

In some individuals who have body language suggesting endocrine disturbance, a positive R27 will develop when the lights are turned out, indicating pineal involvement. This weakening of an indicator muscle may not be present with the lights out if R27 is not therapy localized. Sometimes specific fruit substances, or chemicals such as fruit additives, may cause a positive R27 to appear. This may indicate that treatment for allergy is necessary.

Mental

The most common mental association with switching is

314 the cross K27 previously described. [9] A positive K27 can also develop when the subject concentrates on specific thought patterns. An interesting two-handed therapy localization may eliminate the weakening. If the K27 is positive when the patient uses only one hand with the thumb on one K27 and the index finger on the other, it may be eliminated by using the other hand to contact the two emotional neurovascular centers.

Summary

The most common indication of switching - a positive therapy localization to K27 - can be used as an asset in an examination to find the cause of neurologic disorganization. Establishing this association enables the physician to purposely correct the cause of the disorganization rather than doing so accidentally. Organization of the nervous system is essential if lasting correction of a patient's symptomatic pattern is to be obtained.

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APPLIED KINESIOLOGY FOR THE DENTAL PROFESSION

This is a proposed syllabus on Basic Applied Kinesiological Procedures as they relate to the Dental Profession. The course consists of four weekends of sixteen hours each.

The syllabus is not presented in the order that it is being taught and the content is adapted, modified and changed to meet the particular needs of the dental profession.

A diplomate working with the dentists must be prepared not only to cover Basic AK procedure, basic AK terminology with his students but must also be prepared to learn dental terminology and dental procedure before he/she can effectively communicate with the dentists.

Ample time must be allowed for both discussion and workshopping.

INTRODUCTION TO APPLIED KINESIOLOGY

Method of diagnosis which can be used by all professions

History of AK

AK Canada and ICAK membership and certification

Discussion of role of Homuncular Nucleus

Triad of Health

1. Necessity of balance in triangle
2. Structural effects
3. Chemical effects
4. Mental effects
5. Interplay of the three sides

The General Adaptive Syndrome and the results of stress

Five IV Factors

1. Nerve Pressure - challenge CI, demonstrate
2. Neurolymphatic points - relationship to muscle and organ
3. Cerebrospinal Fluid Flow
4. Neurovascular points - relationship to muscle and organ
5. Acupuncture Circuits - relationship to muscle and organ

MUSCLE TESTING

- diagnostic tool with 91% reproducibility if done properly

MUSCLE TESTING cont'd.

Factors:

- a) operator's mental attitude
- b) joint stability
- c) direction must be same each time
- d) operator's body and hand position must be same each time
- e) patient's test will be modified by drugs
- f) speed of test must be constant

Watch for patient recruiting:

- a) change body position
- b) jaw clenching
- c) unconscious inspiration assist

Discuss, Demonstrate and Workshop:

Deltoids

Pectoralis Major Clavicular

Psoas

Tensor Fascia Lata

Rectus Femoris

Sartorius

Hamstrings

Anterior Lateral Neck Flexors

Peroneus Longus

Peroneus Brevis

Popliteus

Biceps

Triceps

Upper Trapezius

Subscapularis

Infraspinatus

Discuss the pull down extended arm test

THERAPY LOCALIZATION (TL)

1. Theory and Physiology
2. What can be therapy localized
3. Adding energy to weak muscle
4. Weakening muscle that is strong in clear (51%)
5. Demonstration and workshop on Neurolymphatics, Neurovasculars and TMJ
6. TL to determine length of time to complete correction

TEMPORAL SPHENOIDAL LINE

Theory and physiology

TS line reproduced on teeth

Tooth - Muscle - Organ Relationship - Work of Carpenter et al

- palpation, therapy localization and correlation with teeth - workshop
- cranial - sacral involvement
- screening for tooth involvement
- respiratory correction
- nutritional correction

SWITCHING

- physiology and theory
- ocular lock
- correction

POSTURAL EVALUATION OF PATIENT

1. Check for head tilt
 - low shoulder
 - low pelvis
 - ankle pronation
 - short leg

Discuss Postural Hypoadrenia

Palms foreward

Palms back

Discuss effects of posture on muscle strength and facilitation inhibition, particularly muscles of head, neck and shoulders

CHALLENGE

- theory and physiology
- positive challenge weakens strong indicator or strengthens weak associated muscle
- what can be challenged
 - a) injection of physical force
 - b) foods
 - c) allergy
 - d) psychological stress

NUTRITIONAL TESTING

- theory and physiology
- muscle - nutritional relationship
- 90%+ correlation
- nutrient must be tested in mouth and why
- two point therapy localization with temporal tap to determine hidden deficiencies
- dehydration
- role of RNA in
 - a) balance
 - b) patients on drugs
 - c) patients with recurring symptoms and symptoms that will not leave

INTRODUCTION TO CRANIAL SACRAL MECHANISM

1. Motion of skull bones on respiration
2. Respiration relationship between cranium and sacrum
3. Hypothesis of cerebrospinal fluid flow
4. Review of basic anatomy of skull and its membranes

INTRODUCTION TO CRANIAL SACRAL MECHANISM cont'd.

5. Fascial characteristics

CRANIAL FAULTS

Cranial Inspiration Assist

- breathing pattern
- therapy localization
- challenge
- pain location
- conditions correlating
- correction

Cranial Expiration Assist

- breathing pattern
- therapy localization
- challenge
- pain location
- conditions correlating
- correction

Sphenobasilar Extension Fault (Flexion)

- structural picture
- breathing pattern
- therapy localization
- challenge
- conditions correlating (vision)
- correction
- sphenoid correction

CRANIAL FAULTS cont'd.

Sphenobasilar Flexion Fault (Extension)

- structural picture
- breathing pattern
- therapy localization
- challenge
- conditions correlating (vision)
- correction
- sphenoid correction

Glabella Fault

- structural picture
- breathing pattern
- therapy localization
- challenge
- conditions correlating
- correction
- sacral correction

Internal Frontal Bone Rotation

- structural picture
- anterior neck flexors
- therapy localization
- challenge
- pain location
- conditions correlating
- correction
 - 1) Step #1
 - 2) Step #2
 - 3) Step #3

External Frontal Bone Rotation

- structural picture

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CRANIAL FAULTS cont'd.

External Frontal Bone Rotation cont'd.

- anterior neck flexors
- therapy localization
- challenge
- pain location
- conditions correlating
- correction
 - 1) Step #1
 - 2) Step #2

Universal Fault

- structural picture
- breathing pattern
- therapy localization
- challenge
- pain location
- conditions correlating
- correction
- additional corrections
 - a) sacrum
 - b) atlas - occiput counter torque

Cranial Temporal Bulge

- structural pattern
- breathing pattern
- therapy localization
- challenge for direction
- conditions correlating
- correction
- associated condition
 - 1) Category #1
 - 2) Parietal Descent - opposite side

CRANIAL FAULTS cont'd.Cranial Parietal Descent

- structural pattern
- breathing pattern
- therapy localization
- challenge for direction
- condition correlating
- correction
- associated condition - temporal bulge opposite side

Cranial Sutural Faults

Cranial Saggital
 Cranial Lamboidal
 Cranial Sygomatic
 Cranial Squamosal

- breathing pattern
- therapy localization
- challenge
- pain location
- conditions correlating
- correction

TEMPOROMANDIBULAR JOINT

1. Entire body correlation
 - a) Pennfield and Rasmussen Study
 - b) Willie May D.D.S. jaw equilibration
 - c) Other references

TEMPOROMANDIBULAR JOINT cont'd.

2. Muscles of TMJ and reflexes

- a) Masseter
- b) Buccinator
- c) Temporalis
- d) Internal Pterygoid
- e) External Pterygoid
- f) Neurolymphatic
- g) Stress Receptor
- h) Neurovascular
- i) Nutrition related to TMJ musculature

3. Articulation movement

4. Examination

- a) Pathology
- b) Therapy localization with motion
 - 1) Open Variety
 - 2) Closed Variety
 - 3) Lateral Motion (cross bite)
 - 4) Repeat Rapid Open and Closing
 - 5) Swallowing
 - 6) Phonation
 - 7) Chewing
 - 8) Open to Maximum (Post. fibre of temporalis)

Treatment - Masseter - Buccinator - Spindle Cell - External Pterygoid
GTO and Spindle Cell

ACUPUNCTURE

1. Introduction

- a. Nature of energy
- b. Yin and Yang

2. Meridians

- a) Surface anatomy

ACUPUNCTURE cont'd.

3. Examination

- a) Pulse diagnosis
 - 1) Classic
 - 2) Therapy Localization
- b) Alarm Points
 - 1) Location
 - 2) Challenge
 - 3) Therapy Localization

4. Methods of stimulation

5. Treatment

- a) running meridians
- b) stimulation - sedation points
 - 1) Therapy localization

6. Associated Points

- a) Reflex subluxation
- b) Examine for Lovett Brother

ACUPUNCTURE 2

1. Circulation of Energy

- a) through the body
- b) Time (clock)
- c) Midday-midnight effect
- d) Time and diagnosis
- e) Then and Now Technique for problems that reoccur at same time

2. Law of Stimulation and Law of Deficiency

3. Pain Control Technique

4. SP-21/K-27

5. Connecting or Luo Point

- a) Equalizing energy

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ACUPUNCTURE 2 cont'd.

5. cont'd.

a) cont'd.

- 1) Between coupled meridians
- 2) Between midday-midnight
- 3) Between bilateral counterparts

b) Backing up energy on 24-hour clock

5 ELEMENT CHART

- 1) Energy between Yin and Yang
- 2) Creation cycle
- 3) Centre line divides left and right wrists

BEGINNING AND END (B&E) TECHNIQUE

HYPOADRENIA

- 1. Physiology review
 - a) Cortex (i) Mineraloc s
 - (ii) Andrigens
 - (iii) Glucocort
 - b) Medulla (i) Epinephri
 - (ii) Norepinep
 - c) Neurohumoral (i) Chol c
 - (ii) Adre
- 2. Selye's Triad of Stress ts effects
- 3. Four categories of stress
- 4. Selye's "General Adaptior .drome"

HYPOADRENIA cont'd.

5. Signs and symptoms - Raglans Sign
Ragoffs Sign
Pupil Dilation
6. Associated Muscles
7. Emotional Backache
8. Treatment - removal of stress factors
9. Correlation with Hypoglycemia and Allergies

ALLERGIES

1. Background physiology
2. Relationship to Hypoadrenia
3. Relationship to Hypoglycemia
4. Hydrochloric acid deficiency with
 - a) bilaterally weak Pectoralis Major
clavicular
 - b) calcium deficiency
 - c) temporal bulge
 - d) poor vitamin and mineral absorption

Treatment procedures

HYPOGLYCEMIA

- correlation with hypoadrenia and allergies

Symptom picture

Factors That Produce Hypoglycemia

- a) dietary imbalance
- b) hypoadrenia

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Factors That Produce Hypoglycemia cont'd.

- c) malabsorption
- d) functional hyperinsulinism
- 3) pancreatic tumour

Correction

- diet
- nutritional support
- stress reduction

Physiology

- a) pancreas
- b) adrenals GAS
- c) liver
- d) thyroid
- e) hereditary factors

Hidden Sugars in the Diet

Diagnostic Tests

- a) 6 hour glucose tolerance test
- b) symptom questionnaire
- c) patterns of muscle weakness and response to ingestion of refined sugar

Types of Glucose Tolerance Curves

- a) diabetic
- b) hyperinsulinism
- c) flat curve
- d) dysinsulinism

1. Anatomy of valve
2. Function of valve
3. Valve dysfunction (Open and Closed)
 - a. Open ileocecal valve syndrome
 - 1) Symptoms
 - 2) Indicator muscles
 - 3) Therapy localization
 - 4) Challenge
 - 5) Etiology
 - 6) Treatment
 - a) Neurolymphatic centres
 - b) Neurovascular reflex
 - c) Vertebral involvement
 - d) Acupuncture
 - e) Nutrition supplementation
 - f) Cranial faults correlating
 - g) TMJ correlating
 - 7) Diet Management
 - 8) Constipation
 - 9) Effect of enema
 - 10) Gaining temporary symptom relief (cold pack or pressure)
 - 11) Patient education
 - b. Closed Ileocecal Valve Syndrome
 - 1) Symptoms
 - 2) Challenge
 - 3) Etiology
 - 4) Treatment
 - a) Neurolymphatic centres
 - b) Neurovascular reflex
 - c) Vertebral involvement
 - d) Acupuncture
 - e) Nutrition supplementation
 - f) Cranial faults correlating
 - g) TMJ correlating
 - 5) Diet Management

b. Closed Ileocecal Valve Syndrome cont'd.

- 6) Constipation
- 7) Effect of enema
- 8) Gaining temporary symptom relief
- 9) Patient education

TEMPORAL TAP

Theory of mechanism

Right and Left Brain differences

Procedure - along TS line

- 1) right hand patient's left temple positive suggestions
- 2) left hand patient's right temple negative suggestions
- 3) two handed contact along TS line will accept both types

Uses:

- a) audit mechanism to ascertain whether correction complete
- b) determine presence of hidden nutritional deficiencies
- c) help to change habits eg. smoking
- d) temporarily block involuntary reflexes et. gagging
- e) slow down flow of blood

Proprioception

Neuromuscular Spindle Cell

- 1) Anatomy
- 2) Physiology
- 3) Function - facilitation of prime mover - synergist and fixator
- inhibition of antagonist
- 4) Etiology of dysfunction
- 5) Examination and diagnosis
- 6) Treatment

Golgi Tendon Organ

- 1) Anatomy
- 2) Physiology
- 3) Function - inhibition of prime mover, fixator and synergist
- facilitation of antagonist
- 4) Etiology of dysfunction
- 5) Examination and diagnosis
- 6) Treatment

Ligament Interlink

- Physiology of interconnection between contralateral upper and lower limbs
- interconnection of joint to joint with particular emphasis on TMJ to other joints

Procedure

Role of the Hyoid

Treatment

Reactive Muscles

- Physiology
- Etiology with emphasis on TMJ
- Symptom Picture
- Examination procedure particularly as it relates to TMJ

Treatment

Muscle Stretch Reaction

- Physiology - slow and fast muscles
- Etiology
- Symptomatology
- Examination

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Muscle Stretch Reaction cont'd.

- Examination cont'd.
 - a) fast (white) rapid stretch
 - b) slow (red) muscle fibres slow stretch
- particular emphasis TMJ and neck muscles

Methods of release

- a) fascial flush
- b) nutritional - iron for slow muscles and pantothenic acid for fast muscles
- c) stretch and spray
- d) trigger points

P - R - Y TECHNIQUE

- Physiology of proprioception and facilitation, inhibition and integration of body movement through body on head and body on body reflexes

Pitch

- Examination position
- Correction
- Response to correction

Roll

- Examination position
- Correction
- Response to correction

Yaw

- Examination position
- Correction
- Response to correction

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