

**COLLECTED
PAPERS OF THE MEMBERS
OF THE
INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY-U.S.A.**

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*Diplomate

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MESSAGE FROM THE CHAIRMAN

The International College of Applied Kinesiology-USA continues to flourish as a forum in which doctors in the healing professions can present their ideas and their research. By contributing to the collected papers, members have the opportunity to be heard and to be guided in their further efforts through the feedback of their colleagues.

The collected papers include a compilation of research reports, validation studies, case reports and intellectual discourses on various aspects of Applied Kinesiology. Some of the papers represent "seeds" which will grow into powerful diagnostic and therapeutic procedures.

The members of the International College of Applied Kinesiology-USA are to be congratulated, not only for contributing to this collection of papers, but for receiving them, studying them and assisting their authors in the further development of their ideas, concepts and procedures. Through the synergistic effects of helping ourselves and each other to grow, we become a more powerful team, and our contribution to the healing arts and to the health of the world's people multiplies in an exponential manner.

Robert M. Blaich, D.C.
Diplomate
Chairman, ICAK-USA

Instructions to Authors of Collected Papers — ICAK

The *Collected Papers of the Members of the ICAK* are published twice annually, prior to the summer and winter meetings. Manuscripts are reviewed for format, originality, and quality for reproduction. There is no review for authenticity of material. The ICAK recognizes that the usual procedure for selection of scientific papers is a blind review. The purpose of the *Collected Papers of the Members of the ICAK* is to stimulate creative thinking among its members. These papers are distributed only to the members of the ICAK for general evaluation, and for the members to put into perspective the validity of the described approach. The purpose is to put before the membership primary observations that may lead to scientific investigations, new areas of research, and in-depth study, inspiring progress in the field of applied kinesiology.

Statements and opinions expressed in the articles and communications in the *Collected Papers of the Members of the ICAK* are those of the author(s); the editor(s) and the ICAK disclaim any responsibility or liability for such material.

The current *ICAK Status Statement* is published with the *Collected Papers*. It is recommended that procedures presented in papers conform with the *Status Statement*; papers that do not will be published and identified as failing to conform. It is recommended that examination or treatment procedures that fail to conform to the *ICAK Status Statement* be supported by statistical studies, literature references, and/or any other supporting data for the procedure.

Manuscripts are accepted by the ICAK for consideration to publish, with the understanding that they represent original unpublished work. Acceptance of the manuscript by the ICAK does not necessarily imply acceptance to publish. The author may appeal any paper rejected to a committee composed of members of the Education and Research Advisory Committees. The decision of this committee on publishing the paper will be final.

Following are the current requirements that will apply to the Summer 1988 papers:

1. The paper must be an original work and deal specifically with applied kinesiology examination and/or treatment techniques. Various techniques may be discussed if they are correlated with applied kinesiology manual muscle testing examination.

2. The paper must begin with the title, author's name, and an abstract. The abstract should be a brief description of the content of the article.

3. The body of the article should follow the abstract and include an introduction, discussion, research procedure, and discussion of findings. Any or all of these topics may need to be addressed, depending on each paper.

4. The paper is to end with a short summary of the author's conclusions.

5. Quotations should be short, usually no longer than three lines, and should be referenced, giving credit to the original author. All referenced articles, books, or persons other than the author must be properly referenced at the end of the paper, e.g., David S. Walther, *Applied Kinesiology, Volume I — Basic Procedures and Muscle Testing* (Pueblo, CO: Systems DC, 1981). If an article in a journal is referenced, the notation should read as follows: Walter H. Schmitt, Jr., "Fundamentals of Fatty Acid Metabolism — Part II," *The Digest of Chiropractic Economics*, Vol. 28, No. 2 (Sept/Oct 1985).

6. Any quotation of copyrighted material that is longer than that noted above must be accompanied by permission in print from the author and/or copyright holder. The permission must specifically note that the material is to be printed in the *Collected Papers of the Members of the International College of Applied Kinesiology*, copyrighted by the International College of Applied Kinesiology.

7. All art work must be original, or permission to print must be obtained from the author or artist, referenced in the article, and a copy of the authorization sent along with the article at the time of submission for printing in the *Collected Papers*. Photographs must be original black-and-white glossy half-tones.

8. Terminology or procedures that might be unfamiliar to some readers should be referenced at the end of the paper.

9. Any material that is copyrighted by the author must include permission for the ICAK to reproduce the paper and any accompanying graphs, illustrations, etc., at any time and in any manner that the ICAK so choose.

10. The body of the article should be double-spaced on plain paper. No papers typed on office letterhead will be accepted. The manuscript must be clear copy with dark print to ensure adequate reproduction in the *Collected Papers*. The margins on both sides of the paper must be a minimum of $\frac{3}{4}$ " , and the top and bottom margins $\frac{3}{4}$ " when relating to 8-1/2" x 11" letter-size paper. European authors should make note of the copy height of the American standard 11" paper size, which relates to approximately 28 cm. Each page of the paper should be identified by an abbreviated title and the author's last name on the last line prior to the $\frac{3}{4}$ " margin.

11. Manuscripts that do not meet the above qualifications will be returned to the author, with recommendations for bringing the paper under ICAK guidelines for possible future publication.

12. Currently, the articles to be published should be sent to the Education Committee Chairman in triplicate (the original and two copies). The Education Committee Chairman is David S. Walther, D.C., 275 West Abriendo Avenue, Pueblo, CO 81004.

It is planned to establish a Publications Committee in the near future to review all ICAK publications.

INTERNATIONAL COLLEGE OF APPLIED KINESIOLOGY STATUS STATEMENT

The use of manual muscle testing to evaluate body function as expressed through neuromuscular pathways was introduced by George J. Goodheart, Jr., D.C. in 1964. Applied kinesiology knowledge has continued to expand to provide an additional dimension to the diagnosis of human dysfunction.

Early in AK's development, it became obvious that many treatment methods used in chiropractic and other healing arts disciplines improved neuromuscular function as perceived by manual muscle testing. Standard therapeutic approaches comprise the majority of treatment procedures used by applied kinesiologists. Amplification and modification of some of the treatment procedures have occurred as improved approaches have been developed. Some treatment techniques have also been developed which are unique to applied kinesiology.

The most important value of applied kinesiology is its ability as a system to evaluate function via the neuromuscular system to give added dimension to diagnosis. The manual muscle test evaluates the ability of the body's controlling system - the nervous system - to adapt the muscle to meet the changing pressure of the examiner's test. This requires that the examiner be well-trained in the anatomy, physiology, and neurology of muscle function. The action of the muscle being tested, as well as how the body recruits synergistic muscles, must be known. Manual muscle testing is a science and an art, with emphasis on the science.

Many unique observations have been made in applied kinesiology which have given a better insight to body function. It is the International College of Applied Kinesiology's (ICAK) position that the applied kinesiology examination should be combined with approved standard physical diagnosis, laboratory, X-ray, history, and any other special examination procedures of the physician using applied kinesiology as an adjunct to diagnosis. AK examination should enhance standard diagnosis and be enhanced by standard diagnosis.

Applied kinesiology methods add information to an examination, but they should always be used as a part of a multi-faceted investigative endeavor. These procedures - such as therapy

localization, nutritional testing, establishing maxillo-mandibular relationships, the muscle-organ association, etc. - can help the physician determine the major cause of a patient's health problem. They should be used with other supporting evidence from standard techniques in diagnosis. A limited approach, whatever the method, can lead to error.

Therapy localization is a phenomenon which is a reproducible clinical tool. Efforts have been and are being made to better understand the mechanism. When positive therapy localization is present, other examination findings should be used to determine, and finally confirm - the diagnosis. For example, positive therapy localization to a vertebral area indicates further examination by palpation of the intrinsic muscles and the structures innervated by the area. Finally, when all factors are considered and a subluxation or fixation is diagnosed and adjusted, therapy localization (as well as other findings) provides the physician with neuromuscular biofeedback as to whether the corrective effort was successful.

Nutritional and chemical evaluation should only be done with the substance stimulating the subject's olfactory or gustatory receptors. It is also necessary to evaluate other factors which may influence the perceived muscle strength. Confirming diagnostic criteria for the need of any nutrition should be present from the patient's other diagnostic work-up, which may include history, type of dysfunction, laboratory tests, physical diagnosis, and dietary inadequacies. Research sponsored by the ICAK (1) revealed a random response to blind testing of nutrition when the latissimus dorsi muscle was tested. Further research is underway to put into perspective the change perceived in manual muscle testing when nutrition is tested. An adequate educational background is needed in evaluating nutritional needs and manual muscle testing. The use of manual muscle testing by lay salespeople has created problems due to their untrained nature and enthusiasm to sell their products.

The muscle-organ/gland association used in applied kinesiology is referred to as part of "body language." A close clinical association

has been observed between specific muscle dysfunction and related organ or gland dysfunction. This viscerosomatic relationship is but one of many sources of muscle weakness. Placed into proper perspective and properly correlated with other diagnostic input, it gives the physician an indication of the organs or glands to consider as possible sources of health problems. In standard diagnosis, body language such as paleness, fatigue, and lack of color in the capillaries and arterioles of the internal surface of the lower eyelid, gives the physician an indication that anemia can be present. An actual diagnosis of anemia is only justified by laboratory analysis of the patient's blood. Body language indications of AK come from the muscle-organ/gland association and other considerations in applied kinesiology. Further examinations confirm or rule out an association in the particular case being studied. It is the physician's total diagnostic work-up which determines the final diagnosis.

There are both lay persons and professionals who use a form of manual muscle testing without the necessary expertise. There are others who fail to coordinate the muscle testing findings with other standard diagnostic procedures. These are sources of error which may lead to misinterpretation of the condition present and thus to improper treatment, or failure to treat the appropriate condition.

When put into proper perspective, applied kinesiology is a tool for evaluating the impact on the nervous system of a multiplicity of endogenous and exogenous stimuli. It is indeed adding a new dimension to diagnosis. Its greatest value is in functional problems. It helps the physician understand functional symptomatic complexes. Along with the usual diagnostic procedures, it helps differentiate functional from pathological factors when pathology has developed.

The proper use of applied kinesiology requires an appreciation and understanding of anatomy, physiology, and functional neurological relationships. In addition, the physician must have an excellent understanding of muscular synergism to be able to properly administer manual muscle testing.

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A SIMPLE ASSESSMENT FOR MUSCLE IMBALANCE

Louis C. Boven, D.C.

ABSTRACT: A deliberation on a palpatory technique which can be used with posture analysis, temporal sphenoid line and muscle testing for assessment of muscle balance...to give another important piece of information as well as a cross check after completion of therapy to verify successful treatment.

CASE: When first practicing applied kinesiology, I was treating a middle distance runner who was plagued by the ever so popular shin splints. All appropriate muscles were tested and balanced but the patient only enjoyed about 75% relief. The remaining discomfort was located along the anterolateral tibia and the belly of the gastrocnemius. Upon palpation of the origin and insertion of the anterior tibial, muscle tenderness was found. During this period of time, I attended one of Dr. Goodheart's seminars pertaining to the limbic system and it's possible link to the foot muscles. I tested for limbic involvement and it proved positive. After correction, all palpatory pain was

abolished and the runner experienced 100% relief. This led me to palpate the origin, insertion and belly of all muscles testing weak or which showed possible involvement i.e. through postural analysis, temporal sphenoid line etc. What proved universal was that if the muscle tested weak or showed involvement, the origin or insertion, sometimes both, would be tender as well as the belly of the antagonistic muscles if reactive to the imbalance. The tenderness at the origin and insertion area may be nodular, as first described by Dr. Goodheart when discussing Golgi tendon organ technique or may show no nodulation at all.

PRODEDURE: While posturally analyzing the patient, palpate all origins and insertions of muscles appearing to be involved. Palpation should be across the grain of the muscle whenever possible. If involved, tenderness should be present.

2. T.S. line the patient and correlate findings with postural analysis as well as any other diagnostic findings used.
3. Test the appropriate muscles to reveal the weakness

which should be evident. If no weakness appears, palpate origin and insertion for tenderness and, if present, use techniques to uncover hidden weakness.

4. Determine therapies and treat according to applied kinesiology guidelines.

5. Recheck postural analysis, T.S. line and tenderness at origin and insertion. If any show positive, therapy is incomplete.

CONCLUSION: This technique is very useful, but not limited to, muscles which, as of yet, don't have test associated i.e. serratus posterior inferior or superior, some fine muscles of the hands, feet, etc. It is also an effective tool when dealing with hard to test muscles i.e. levator scapula, gastrocnemius, differentiation of scalene involvement etc. This technique will bring the doctor back in touch with basic fundamentals of applied kinesiology such as, accurate knowledge of muscle location and spastic muscle secondary to primary muscle weakness. Most of all, this may make a doctor persevere in a difficult case where no muscle weakness is evident and there are no clinical indicators other than palpatory finding of tenderness.

COPPER STATUS
AND THE COMPRESSIONAL BONE TEST

Anthony Brea, D.C.

ABSTRACT: In the ICAK 1988 winter papers(1) a technique intended to aid in the determination of copper status was presented. In the present paper statistical data collected during the development of this technique as well as several clarifications and additions are presented.

In the 1987 ICAK Winter Papers this author presented the Compressional Bone Test(CBT).(1) The test is design to serve as an aid in determining the need for copper supplementation. Since that time several refinements and additions to the that technique have been made and will be presented subsequently. The procedures that lead to the development of the CBT are reviewed. For a discussion on the prevalence and significance of copper deficiency, please refer to "The Importance of Copper Supplementation...", in the 1988 Summer ICAK collected papers.(2)

METHODS and RESULTS

It was the author's suspicion that any dysfunction in the normal flow of stress induced piezoelectric currents in bone would cause a neurological response detectable by muscle testing. The mode of confirming this hypothesis was simple. A small sample of subjects were use for preliminary testing. The method of testing involved finding an intact indicator muscle. Subjects were then randomly tested by applying a bending force [compressional bone test](CBT) to several long bones. The intact muscle was tested after each compressional test. A large number of those tested weakened regardless of the bone stressed or the location of the muscle used as an indicator. There was generalized muscle weakness caused by stressing the bone. Attempts to determine a

nutritional component to this challenge were made by orally testing those who weakened against different components of bone. The only component that was able to eliminate the response with little or no recidivism was copper.

Following these observations a larger sampling of patients were tested (n=93).

1) Because of an early high number of positive responses (25 of first 30), before CBT was recorded in this larger group these patients were unswitched using standard AK techniques.

2) After switching was eliminated only 20 (22%) of 93 tested showed a positive response (weakened) to CBT. Cross checking against the umbilicus or K27 had no effect on weakness. All 20 responded to copper supplementation. The mineral status (Zn, Se, Mo, and Mn) of those who were unaffected by CBT were challenged by the following methods.

c1) Zn - expiration(3) and inhalation of isopropyl alcohol.(4)

c2) Se - Inhalation of Clorox,(5) oral challenge with desiccated spleen(SPL) and hydrogen peroxide.(4)*

c3) Mo - Inhalation of both formaldehyde and perfume.()

c4) Mn - Inhalation of Ammonia.(6)

c5) Cu - CBT, aerobic muscle test, and oral challenge with ascorbic acid and Mo.

3) Those (73) who did not weaken initially to the CBT were challenged against c1-c4. At least one of these modes of challenges caused weakness in all participants.

4) All those who weakened were cross checked against the umbilicus and K27. Those who were unaffected by cross challenging (umbilicus and K27) were given the appropriated nutrient to chew and swallow. Those who were strengthened by cross challenging were treated by manipulation.

5)Following this all 93 were again challenged with c1-c5(CBT included). 22(24%) who had not originally responded to the CBT now did, and none of the original 20 showed recidivism.

6) Steps 4 and 5 were again repeated until no challenges caused weakness. This procedure in some cases was done all in one day and in others, over a period several sessions.

Some Statistics that were noted during the development of this technique were compiled and are as follows:

	A	B*
a)NUMBER OF PTS. IN STUDY	93 TOTAL	
b)NUMBER WHO REQUIRED COPPER	67 (72%)*	
c)NUMBER WHO WERE RELATIVELY COPPER TOXIC	8 (09%)	
f)NUMBER WHO EXHIBITED INFLAMMATION	38 (40%)	(58%)
e)FIRST MINERAL NEED = COPPER	20 (22%)	(30%)
g)SECOND MINERAL NEED = COPPER	22 (24%)	(33%)
h)FIRST MINERAL NEED = SELENIUM	27 (29%)	
i)AVG. NUMBER OF MINERALS GIVEN/PATIENT OVER A PERIOD OF 5 MONTHS	2.4	
j)TOTAL NUMBER NEEDING ZINC	44 (47%)	
k)TOTAL NUMBER NEEDING MANGANESE	40 (43%)	
l)TOTAL NUMBER NEEDING SELENIUM	47 (51%)	

* Number in column B are percentages of those 66 who required copper supplementation. Column A are percentages of the total 93.

Utilizing this methodology we found that approximately 71% of our patients show need for copper supplementetation.(.) Lebowitz has estimated that 62% of his patient population require copper supplementation.(7)

Analysis of the responses of this larger sampling indicates that disturbances in the metabolism of zinc, manganese, molybdenum and selenium often need to be corrected either by manipulative procedures and/or supplementation before the compressional bone test(CBT) could initiate a generalized muscle weakness pattern. These observations may relate to the presence of relative deficiencies and priorities. In other words, if one is deficient in both zinc and copper, the zinc deficiency may show first (in response to an appropriate challenge) if that deficiency is greater or if the body's biochemical priorities require zinc first. Once that deficiency is addressed then the copper indicators will effect a weakness. A patient can be deficient in both zinc and copper in an absolute sense and at the same time copper toxic in a relative sense. This type of patient, depending upon degree, might need zinc for a period of time to improve his ratio of zinc to copper before the indicators of copper deficient will become evident.

Procedure for compressional bone test(CBT)

- 1) Check K27 and umbilicus. If present eliminate switching.
- 2) Challenge long bone of arms or legs by applying mild bending stress or by percussing bone with a neurological hammer or by hand. If no weakness occurs then go to 3. If weak check against K27 and umbilicus. If muscle strengthens then there is a structural fault in need of correction. If no change then try source of copper.
- 3) Challenge mandible and/or any bone under stress with same methods described in step 2. If no weakness then go to step 4. If weakness check against K27 and umbilicus. If muscle strengthens then there is a structural fault in need of correction. If no change then try source of

copper.

4) Test for disturbances in the metabolism of other minerals (Zn, Se, Mn, Mo) by utilizing the appropriate challenges. Once corrected then return to step 2.

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The Importance of Copper Supplementation
in the Management and Prevention of Free Radical,
Lipid, and Musculoskeletal Pathologies

by

Anthony Brea D.C.

Abstract: In recent years much effort has been focused on determining the affects of trace mineral deficiencies on the human body. Among them copper deficiency has emerged as a significant contributor to the etiology and/or pathophysiology of several degenerative conditions. Associations have been made between absolute and/or relative copper deficiencies, and hypercholesterolemia, ischemic heart disease, rheumatoid arthritis, ankylosing spondylitis and several other conditions. The results of recent studies utilizing direct chemical analysis suggest that as much as 75% of diets in the United States contain subminimal levels of copper.(1) This paper argues that copper deficiency is prevalent and is an important consideration in the management and prevention of many free radical, lipid and connective tissue pathologies. Methods of evaluating and supplementing copper status are also discussed.

The alterations of copper metabolism in chronic inflammatory conditions has been a topic of research for many years. Two major associations that have been studied concern the role that copper deficiency plays in the etiology and/or pathophysiology of free radical pathologies(FRP) and cardiovascular diseases. Recent human studies have been conducted that clearly establish these relationships(2-5) and much evidence now exists that most diets contain borderline or deficient levels of copper.(1,6,7)

Data from recent studies utilizing direct chemical analysis of foods as opposed to food table calculations suggest that as much as 75% of diets in the United States contain subminimal levels of copper (below 2 mg/day). Direct measurements of current foods has revealed 42%-65% less copper than the estimates of current food tables.(7,10) The present level of copper that is considered to be safe and adequate is 2-3 mg/day. Some contend that this level is neither safe nor adequate.(1)

HUMAN STUDIES THAT INDICATE THE NEED FOR SUPPLEMENTATION

LIPIDS AND CARDIOVASCULAR DISEASE

For several decades animal studies have demonstrated that the affects of relative(high Zn to copper ratio) or absolute copper deficiency include ECG abnormalities, high blood cholesterol, cardiac arrhythmias, and degeneration and ischemia of the heart.(8,9) In a recent study Reiser placed human subjects on copper deficient diets containing 1 mg./day of copper for a period of 11 wks.(2) The diet, including the copper level, was considered to be typical of many American diets. In these subjects a 20% fall in serum levels of high density lipoprotein (HDL) with a concomitant 14% rise in low density lipoprotein (LDL) occurred.(3) HDL of course is considered to be protective against cardiovascular disease and LDL the opposite. During copper repletion (Cu = 3 mg./day), which lasted 3 wks. the HDL rose steadily and LDL fell. At the end of the repletion period HDL was 15% higher and LDL was 8% lower than pretest levels.

During the depletion phase of this study (Cu = 1 mg./day), which lasted 11 wks., 4 of the 23 participants experienced heart-related abnormalities.(2) One sustained a myocardial infarction, two experienced

severe tachycardia (tripled heart rate) and the 4th experienced an intermittently occurring, second-degree heart block. As a result, this phase of the study, which lasted 11 wks., was terminated before completion and all 23 subjects were repleted (Cu = 3 mg./day). The 4 subjects with cardiac abnormalities had superoxide dismutase (SOD) levels that were 12% lower than their fellow subjects consuming the same diet. SOD is considered to be a reliable indicator of copper status. Serum copper and ceruloplasmin are considered to be less consistent indicators except in severe states of deficiency.(10) In fact, during the depletion phase (Cu = 1mg./day), of this study, ceruloplasmin increased 15% while serum copper was unaffected. This increase in ceruloplasmin is probably a result of endogenous redistribution triggered by insufficient dietary copper.

In another study hypercholesterolemia was produced in a man fed a diet, made of conventional foods containing a copper level of 0.83 mg/day.(11) This level is believed to represent the lower 15% of daily copper intake in the USA. The depletion period of this study (Cu = .83 mg/day) lasted 109 days and was terminated when several abnormal ECG patterns were detected. Additionally RBC-SOD, plasma copper and ceruloplasmin levels were all decreased. Both cholesterol and LDL levels were increased. Cholesterol rose from 202 mg/dL. to 234 mg./dL. In the repletion phase (Cu = 4 mg./day) which lasted 39 days, copper effected a significant decrease in both cholesterol and LDL levels. By the end of repletion cholesterol fell to 198 mg/dL. These studies clearly illustrate that the level of dietary copper intake can affect lipid, SOD, and cardiovascular metabolism.

Fructose in the American Diet Compounds Deficiency

The affects of fructose on copper metabolism has also been studied in both animals and humans. It has been determined that fructose intake exacerbates the affects of a marginally copper deficient diet in both animals and humans. Intake of fructose levels common in many diets along with a copper intake level of 1 mg./day can cause a 15% reduction in SOD in a period of several weeks.(2) This observation is significant considering the accelerated use of corn sweeteners in the food industry during the past 10 years. In an attempt to address the growing concern over the potential affects of excessive sugar consumption, they have substituted fructose which in the long run, appears to be the fraction in sucrose that is more problematic. In comparison studies, it has been demonstrated that the affects of sucrose on copper metabolism, although present, are significantly less than those of fructose.(12)

As a result of these and other studies a new classification of chemicals has been forwarded.(1) The identity of these agents lies in their ability to simultaneously affect copper and cholesterol metabolism. For instance, ascorbic acid, cadmium, cholesterol plus cholic acid, fructose, glucose, histidine, sucrose, and zinc all are *hypercholesterolemic* and copper inhibiting. On the other hand, calcium, clofibrate (a cholesterol lowering drug), and sodium phytate are *hypocholesterolemic* and copper enhancing. It has been suggested that the principle affects of these agents on cholesterol is mediated through their ability to alter copper metabolism.

THE FACTS ABOUT COPPER AND DIETARY FATS

Dietary intakes of fats and cholesterol has been associated with

increased levels of cholesterol. This has led to the belief by many that high fat foods should be avoided or kept to a minimum. Klevay of the USDA, the author of the copper deficiency hypothesis, was able to induce hypercholesterolemia in rats fed a diet, with a high Zn to copper ratio.(9) Although the absorption of both copper and zinc are actively controlled, these minerals compete with each other for absorption. The present optimum zinc to copper ratio for humans is considered to be approximately 15/2-3, or from 7.5-5.0. Foods that have a lower ratio (below 5.0) favor copper status at the expense of zinc and foods that have higher ratio (above 7.5) favor zinc status at the expense of copper. The ratios of several common foods follow:(13)

FOODS WITH RATIOS BELOW 5.0 (COPPER ENHANCING AND CHOLESTEROL LOWERING)

apples, beef liver, grapes, onions, applesauce, banana, beets, egg whites, squash, walnuts, cabbage, grapefruits, asparagus, pecans, potatoes, lima beans, spinach, peanut butter, watermelon, orange sections

FOODS WITH RATIOS BETWEEN 5.0 AND 7.5 (OPTIMAL)

corn flakes, prune juice, white bread, wheaties, puffed rice, green beans, cantaloupe

FOOD WITH RATIOS BETWEEN 7.6 AND 30 (MODERATELY HIGHER THAN OPTIMAL)

peas, carrots, sherbert, shrimp, wax beans, macaroni, egg noodles, crab, sockete salmon, shredded wheat, broccoli

FOODS WITH RATIOS ABOVE 30

whole egg, american cheese, tuna, cauliflower, swiss cheese, beef rump, white turkey meat

FOODS WITH RATIO ABOVE 50 (CHOLESTEROL INCREASING AND COPPER INHIBITING)

ham, leg of lamb, white chicken meat, bacon, dark turkey meat, beef sirloin, dark chicken meat, whole milk, skim milk, pork loin, beef flank

As you can see, the foods that have been associated with higher cholesterol levels, generally speaking, have considerably higher Zn to Cu ratios. Diets that are considered to be cholesterol lowering have ratios closer to the optimum. Of course it can be argued that they also have lower levels of cholesterol. However in an animal study where diets normally considered to be *hypercholesterolemic*, were fed in conjunction with *hypercholesterolemic* agents, the considerable increases in cholesterol present in the control group of the study, were prevented in the experimental group, by supplementing their diets with extra copper. (24) In effect, the lack of copper or high Zn to Cu ratio in the high fat diet of the control group, negatively affected their ability to properly metabolize the high amounts of fats in the diet. The extra copper supplied to the experimental group provided a more favorable Zn to Cu ratio, thereby allowing them to properly metabolize the high amounts of fat also present in their diets. These effects again demonstrate the control copper exhibits on lipid metabolism.

THE ROLE OF COPPER IN ACUTE AND CHRONIC INFLAMMATION

A common feature associated with acute and chronic inflammatory conditions is an increase in serum copper and a decrease in both serum zinc and iron. (14) These changes in serum metal concentrations are believed to exert a protective role in inflammation. The concentration of serum zinc, which undergoes as much as a 50% decrease, is removed from the circulation by the liver. This reduction is believed to be an

important predecessor to the production of the inflammatory response since zinc is known to inhibit phagocytosis. Additionally, iron is also removed from plasma by the liver. During infections, removal of iron from plasma inhibits the proliferation of bacteria and other microbes. Elevation in serum copper, in the form of ceruloplasmin, occurs approximately 1 day after the fall in zinc and iron levels. This elevation is not representative of a copper toxic state but is the result of an increase need for copper transportation. Excess copper in the body does not increase levels of ceruloplasmin or serum copper.(14) The purpose of this redistribution of copper (from liver into the general circulation) is not well defined, but is believed to involve several non-specific host defenses. Copper *transportation* for the synthesis of cuproenzymes, or modulation of catecholamines and histamine, or superoxide anion production associated with inflammation, are among the most likely reasons for this redistribution. Copper has several central roles in the healing process. Endogenous copper complexes (cupric ions, copper-amino acid complexes, and SOD) are known to have potent anti-inflammatory activity.(15) Additionally copper helps in the formation of collagen and elastin necessary for connective tissue repair.(25) After the condition (infection, fever, trauma, etc...) has been resolved, and the inflammation subsides, the levels of copper, zinc and iron all return to normal.

However, when this return to normal is delayed a *chronic* inflammatory condition may develop. One reason for this delay may be that the absolute amounts of copper readily available for transportation into the area of inflammation are not enough to promote sufficient repair and to subsequently quell the inflammatory response. There is much data that

supports this contention.

For instance, in the acute inflammatory state much of the extra copper needed is replenished or satisfied by increasing copper absorption and decreasing its excretion.(16) Insufficient amounts of dietary copper which is believed to be prevalent in many diets would make the intestinal source of copper during the inflammatory process unreliable. This would lead to varying degrees of endogenous redistribution of copper and/or a poorly protected inflammatory response.(16,17) The acute phase of inflammation is characterized by a small elevation of copper levels in blood cells.(16) In contrast, the effects of *chronic* inflammation appear to be quite different.

In a recent human study, the serum and intracellular levels of various minerals, in 29 patients with *chronic* ankylosing spondylitis, were measured and compared to healthy individuals.(18) As is common in patients with inflammatory conditions, the serum levels of zinc and iron were reduced and the levels of copper were elevated in comparison to the healthy group. However in all 29 patients, *non-detectable levels of copper were found in their RBCs, granulocytes, and platelets.* In comparison, detectable levels were found in the RBCs and platelets of the healthy group. This study taken in the context of what is presently known suggests that a feature of chronic inflammatory conditions is the development of a relative (intracellular) and possibly absolute deficiency of copper caused by prolonged unresolved inflammation.

Observation concerning the mode in which anti-inflammatory drugs and agents function in vivo provide some added insight into the contribution of copper deficiency towards the genesis of the chronic inflammatory

process. First these drugs are believed to be activated by forming copper complexes that improve the mobilization and tissue distribution of copper.(15) Once they enter the area of inflammation they appear to function in the same manner as SOD. Many of these drugs (indomethacin and prednisolone) effect a reduction in inflammation and simultaneously elevate serum copper levels, whereas others (aspirin and copper aspirinate) only reduce the inflammation. The first group of drugs apparently improves the rate of copper transportation to the inflamed area since serum copper levels are increased. However, *copper oxide surprisingly reduces both the inflammation and the elevated serum copper levels.* This is the agent in the proper form that normalizes both parameters. By simply administering a copper salt the inflammation is relieved and in effect the transportation of copper is normalized. The fact that supplementation with copper does this suggest that although copper transport is higher in chronic inflammation, the level is insufficient to completely effect both repair and cessation of inflammation. The above mentioned drugs do not contain copper. They are believed to readily form copper complexes in vivo that are anti-inflammatory in nature, but they do not increase the overall amount of copper in the body. They improve the transportation to areas in need and/or increase the anti-inflammatory activity of copper. On the other hand, administration of copper oxide apparently increases overall levels of copper in the body. The fact that pharmacological agents either raise (improve transport) or have no affect on the already elevated copper levels, combined with the aforementioned data, strongly supports the contention that inadequate endogenous and/or exogenous amounts of copper contribute to the development of the chronic inflammatory state. This is not to say that copper is the only factor involved with chronic

conditions, but that it is a significant contributor that should be addressed.

It has been the authors experience that considerable improvements in inflammatory conditions are consistently effected by administration of copper chelates.(Nutridyn-Coppomin and Standard Process-Copper Liver Chelate) There are no definitive laboratory methods of determining copper deficiency at this time. The methods that are presently being used in research have yet to be perfected for general lab use. The best non-muscle testing method of determining deficiency at this time is dietary evaluation. SOD, ceruloplasmin and cytochrome oxidase are considered to be very sensitive to copper intake, but normal levels vary widely. Decreased copper intake can be accompanied by elevated ceruloplasmin. Intracellular levels of minerals may help identify some copper deficiency states.

A muscle testing technique for identifying the need for copper has been developed by the author (Compressional Bone Test).(19)

THE RELATIONSHIP BETWEEN ESSENTIAL FATTY ACIDS AND COPPER

Animal studies have shown major changes in liver, plasma, cell membrane and organ compositions of lipid essential(EFA) and non-essential fatty acid levels in animals placed on copper deficient diets.(20,21) Similar alterations have been found in humans. Some of these changes include higher levels of arachidonic acid(AA) lower levels of dihomo gamma linolenic acid(DGLA) and higher polyunsaturated fatty acid indexes in cell membranes. The significance of these factors has been discussed by Goodheart and Schmitt.(22,23) Briefly, AA is the precursor to pro-inflammatory PG2 prostaglandins and DGLA is the precursor to anti-

inflammatory PG1 prostaglandins. The situation as outlined above would suggest increased levels of PG2 and decreased levels of PG1. Additionally, the higher polyunsaturated levels would allow greater degrees of lipid membrane peroxidation which of course has been found to occur in free radical pathologies.

Goodheart found that individuals that are deficient or have an increase need for EFA will weaken on repeated muscle testing of multiple muscles. This author found that some individuals already supplemented with the proper dose and type of EFA show recidivism that is non-responsive to EFAs of the omega-3 or omega-6 classes. When challenged with the compressional bone test these individuals will often show weakness that is eliminated when copper is ingested.(19) The weakness caused by multiple muscle challenge is also eliminated. These individuals often respond well to copper supplementation. Muscles burn fatty acids for energy and the final conversion is carried out in the respiratory chain of the mitochondria; the final step requires cytochrome oxidase, a copper containing enzyme that is sensitive to dietary intake.

Along with improvements in aerobic metabolism these individuals may be benefiting from improved levels of PG1 and 2 and lower lipid peroxidation levels that accompany decreases in lipid polyunsaturated indexes.

Conclusion

Some of the current views concerning the role of copper in the etiology and/or pathophysiology of free radical and lipid pathologies has been presented. The importance of considering copper status in these and other related conditions is of considerable importance.

Data from numerous studies utilizing direct chemical analysis of foods indicate that as much as 75% of diets in the United States contain subminimal levels of copper (below 2 mg/day). Feeding copper deficient diets (the same levels present in many American diets) can lead to heart-related abnormalities and unfavorable alterations in cholesterol, high density lipoproteins and low density lipoproteins. The inability to effect healing of acute and chronic inflammatory conditions and subsequently quell the inflammatory response are also affected by dietary deficiency. All of the above effects are compounded by sugar consumption, especially when taken in the form of fructose (corn sweeteners). The correlations between excess dietary fats and increases in serum cholesterol are more a function of the excessively high zinc/low copper ratios present in most high fat foods. Greater amounts of fats in the diet increase the requirement for dietary copper.

The composition of fatty acids in the body are affected by the amounts of copper in the diet. Deficient amounts of copper tend to produce a composition that favors a higher degree of lipid peroxidation.

Copper supplementation aids in the management of acute and chronic inflammatory conditions.

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CHIROPRACTIC - IS ACUPUNCTURE - IS KINESIOLOGY

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Abstract: D.D. Palmer said that disease is too much or too little nerve supply. I see no way to evaluate a person for too much or too little nerve supply without considering the acupuncture system. This should be called the meridian system. Applied kinesiology is necessary to evaluate what is happening in the meridian system. A muscle that is weak in the clear may be too low in energy. A muscle that is over may be strong when tested but will blow weak when touching the alarm point. The meridians may be split right to left with one side being hyper and the other side being hypo. This can indicate serious chronic disease has started or is on the way. In the paper we will discuss many possible imbalances to check for in each meridian or keys and clues. We will discuss multiple ways to approach them and how to use AK as your evaluator.

This past year I have had a real renewed interest in the meridians and their energy flow. What's wrong with AK is what's right with AK. That is that it takes you into almost every aspect of current research known to man at this time. We must be confident in everything from strain counter strain to cranial adjusting. From the meridian systems to miracle points. The list goes on and on. What I have tried to do in this article is to lay out some specific keys in each of the meridians that would give us quick reference to potential problems.

A meridian affects what it is named after or where it courses to or near. For example, the stomach meridian would definitely affect the stomach and therefore, digestion. The fact that it begins underneath the eye shows that it definitely could cause problems with the eye and it goes down the face and therefore, could cause problems or be related to problems in the face and therefore, TMJ and then the neck and then the collarbone and

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then the anterior ribcage and then the anterior lateral portion of the abdomen and right on down through the hip, knee, ankle, and second toe. So how do we know what is important and what is not and what are the common findings one would be suspicious to look to the stomach meridian? I hope the keys and clues that will be discussed will be of as much benefit to you as they have to me.

I am presently taking a course from Dr. John Amaro, D.C., F.I.A.C.A. of Carefree, Arizona. The course is about clinical acupuncture. I would highly recommend this course for any applied kinesiologist. I will give you many of the keys and clues he has given to us and show you how we use these in our office with applied kinesiology. Let me give you the important points of lung meridian and how I would incorporate this with my AK thinking. The lung meridian is on the arm and therefore could be considered in any problems with the arm and shoulder. It's energy is the greatest between 3 and 5 a.m. and therefore, any problem that starts between that period or between it's opposite between 3 p.m. and 5 p.m. would make it suspect. Any muscle on the meridian such as the deltoid will be evaluated. If the muscle was strong in the clear and then when touching the alarm point it became weak, the meridian would be excess in energy. If were weak in the clear, I would touch the alarm point and see if it is strengthened. This meridian would be under active then and should be tonified or otherwise strengthened by the law of 5 elements. The points I would look to to be the most common for potential problems would

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be:

1. LU1 - the alarm point which lies below the end of the clavicle at a definite depression. Very often tender in a patient with respiratory complaints.
2. LU7 - three fingers up from the palmar wrist crease on the thumb side. It is the low point on the LU meridian and a good point for migraine headaches.
3. LU9 - at the palmar wrist crease and is the source point. The source point of any meridian, (and there is one source point for each meridian), is four times more active than any other point on the meridian.
Side note: the source points are the points most commonly used for ryodoraku.

I would consider the lung meridian in any respiratory complaint, in anybody with arm or shoulder pain, and as previously stated on the horary affect. Of course, you would have to consider any place down the arm and even to the thumb because that is where the meridian runs and could cause pain in those areas.

Let us take a second example, the large intestine meridian. It has it's greatest amount of energy between 5 and 7 a.m. and it's least amount between 5 and 7 p.m.. It's horary point is LI2. This meridian starts at the lateral aspect of the index finger and runs up the arm, elbow, and over the shoulder, and ends lateral to the nose. Therefore, anything to do with the large intestine constitutes evaluting this meridian and any area of complaint that

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follows that course could be involved with this large intestine meridian such as G.I. disturbances, hamstring or T.F.L. problems, thumb, wrist, arm, elbow, shoulder, upper trapezius, neck, nose, etc. The key points to remember are:

4. LI4 - (ho-ku) stimulation is always toward the pisiform.

This has a special significance for any problems in the head and neck. It is used in conjunction with many other points.

5. LI11 - it enhances and gives strength to LI4. It is located at the elbow crease, therefore look to it for any elbow problem.

6. LI15 - which is at the tip of the shoulder. When you move your arm up and down a depression comes and goes. This point is excellent for anything to do with shoulder pain.

7. LI20 - at the nasal sulcus and is called by the Chinese "Welcome Fragrance". This affects the pituitary when stimulated and it is used for any major pain. We use it for mothers to deliver at term. (Also consider stimulating SP6 and LI4 at the same time but not until they are full term.

We have found the magnet test to be very effective in screening if points need treatment. You place a donut magnet over a point in question. North or south is indicative of positive or negative. If an acupuncture point is stable, it will remain

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strong. If it is abnormal in yin or yang it will blow a strong muscle weak. I then treat by tapping, electric stimulation, or helium neon laser through the hole in the magnet until it strengthens.

Another very important finding has been that some points need fast tap and some slow. You challenge by doing each and the one that strengthens, I use. That is, if fast tap strengthens and slow weakens, I use fast or vice versa to treat. On rare occasions, some points need both.

8. ST1 - "Receive Tears" just below the pupil of the eye or orbital bone. Anything to do with eye pain, weakness, tearing, etc.
9. ST4 - is the outer corner of the lip - facial pain.
10. ST5.6-7 - around the lower rim of the mandible - facial pain, tic douleroux, bells palsy, etc.
11. ST12 - "Chieuh Pien" (half a bowl) most meridians have a direct contact with this point. It is the vital point for everything.
12. ST17 - the body landmark falls directly over the nipple (sometimes).
13. ST25 - two fingers breadth lateral to the umbilicus. Alarm point for the LI meridan.
14. ST36 - TSUSANLI (stomach three mile) just to the side of the tibial tuberosity of four fingers inferior to the eye of the knee when the knee is flexed at a 45 degree

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angle. This is good for everyting especially abdominal and infectious processes as it increases phagocytosis. Very good combination with SP6 for lowered resistance and infection.

15. ST42 - source point - extreme top of foot. Rydorakv test point major point to affect ST meridian.
16. SP3 - source point behind large toe metatarsal head.
17. SP6 - San Yin Chiao (three yin meeting) four fingers breadth up from the internal malleolus in the midline of leg. Exceptional for female or male, reproductive problems. Hormonal difficulties. Dysmenorrhea, etc.
18. SP21 - the end point under axilla "the Great LUO point" will be used often.
19. HT3 - found just opposite of LI11 on inside of arm at the elbow crease. Very effective in mental depression, anxiety, neurosis, etc. (of course any elbow problem.)
20. HT7 - "Shen Men" (Divine Gate, Spirit Door) sedation point for heart. Source point, Ryodoraku test point. Has an extremely good effect in insomnia.
- 21 HT9 - Tonification point of the heart and is very effective in cardiac disorders. It is on the inside of the small finger, (SI1) is on outside.
22. S13 - At edge of the hand at end of crease when fingers are bend down toward the wrist. Excellent for shoulder pain. When used in combination with BL62 it is very

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effective for low back.

23. SI4 - source point - at dorsal wrist crease small finger side.
24. SI10 - just below the spine of scapula in a definite depression combined with.....
25. SI12 - which is a three finger walk toward the ear. These two points along with SI3 are exceptional for shoulder involvement.
26. SI19 - always treat directly over the TMJ excellent for deafness, tinnitus, TMJ and facial pain. (Treat with mouth open.)
27. BL1 - eyes bright - at the inner canthus of the eye. Exceptional for all eye disorders may be used with laser but do not stare in beam.
28. BL11 - opposite C7-T1 vertebrae master point for any bone involvement. Osteoporosis, assists in fracture healing, two finger breadth (1.5 TSUN) lateral to GV.
29. BL13 thru BL28 - associated points for the respective meridian.
30. BL50 - in crease of buttock used in Sciatica.
31. BL51 - half way between BL50 and BL54.
32. BL54 - "Commanding Center" or "Middle of Man" directly in mid line of popliteal crease. Relaxes muscle spasm throughout the entire spinal column. Excellent in low back, leg and knee pain. It is called BL40 on some

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charts.

33. BL57 - at the bifurcation of the gastrocnemius muscle same indications as for BL54. Exceptional point for constipation.
34. BL60 - between external malleolus and achilles tendon. An endorphin pain relief point second to none. Should always be used especially for anything in the back and lower extremity.
35. BL64 - source point affects entire meridian. Just behind 5th metatarsal.
36. BL67 - head end point very effective in pain, especially headache.
37. KI1 - "Bubbling Spring" "Fowler Point" sedation point for the kidney. In the middle of the two fat pads on the bottom of the foot. One of the most significant points on the body dealing with chronic pain. Patients are not overly joyed by teishin stimulation. Few patients can feel electrical stim on this point. This point lower high B.P.
38. K13 - inside of the leg directly opposite BL60. source point, Ryodoraku test point and affects the entire meridian.
39. K17 - tonification point. Three fingers breadth superior to the internal malleolus not in the midline, slightly posterior.

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40. KI10 - At crease of knee (medial when knee is bent).
Excellent for knee pain. Also the Horary point most effective for conditions aggravated between 5 and 7 p.m.
41. K127 - Home of the associated points stimulate this point to stimulate the entire associated point channel. When used with CV8 (Shrine of God) effective in sedating hyperactive children.
42. P3 - at crease of elbows. Water point on the P meridian. Excellent for any inflammatory process concerning the elbow.
43. P5 - four fingers up from wrist crease (palmar) very effective in psoriasis.
44. P6 - master point for the abdomen, three fingers up from wrist crease. Very effective point for any mental disorder, neurosis, etc.
45. P7 - source point, affects entire meridian. The pericardium meridian deals with circulation of blood and sexual hormonal release.
46. P9 - tonification point. At end of middle finger.
47. TH3 - tonification point for TH meridian. On the back of hand between 4th and 5th finger and two finger breadth behind the web of same. Excellent for hearing.
48. TH4 - in direct center of dorsal wrist crease. Source point. Affects metabolism in general. Ryodoraku test

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point.

49. TH5 - four fingers breadth back from TH4. A master point for the upper extremity. Always add it to any symptomatic treatment dealing with the upper extremity e.g. elbow, wrist, fingers, shoulder, neck, etc.
50. TH10 - just above the olecrenon process sedation point for TH. Excellent for elbow. This point along with ST34 are the only two points of their intensity that are above the elbow and the knee.
51. TH17 - directly behind the ear lobe just superior to lateral mass of the atlas. Excellent for deafness and tinnitus. Since the TMJ cannot subluxate without subluxating the atlas and vice versa, this point is also good for both TMJ and atlas rotary subluxation or when the atlanto axial ligament has been strained resulting in a mal juxta position of the left or right medial border of the lateral mass of the atlas.
52. TH21 - just in front of the ear slightly above SI19. Used in hearing, facial pain, TMJ, etc.
53. TH23 - at the outer limits of the eyebrows indicate in any eye disease.
54. GB1 - at the outer canthus of the eye below TH23 - For eye disease use all of the eye points namely TH23-BG1-ST1-B1 and BL2 (Just above B11) in medial edge of eyebrows.
55. GB2 - just below SI19 (see notes on TH21).

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56. GB14 - in the exact middle of the forehead directly above the pupil of the eye half way between the front natural hairline and the eyebrow. Exceptional for sinus or frontal cephalgia.
57. GB20 - between the external occipital protuberance and the tip of the ear just below the occipital bone. Exceptional for occipital cephalgia and any and all cervical disorders to include acute and/or chronic spasmodic torticollis (wryneck).
58. GB24 - just below the rib cage half way between the side of the body and the C.V.. It is the alarm point for the GB meridian.
59. GB30 - directly over the sciatic nerve notch. Can be considered to be a part of the bladder meridian as well. Always used for any back or leg pain, and is the primary point for any and all coxae (hip) disorder.
60. BC39 - locate at the end of the middle finger when the hand is extended to the side of the leg. Use with GB30 for sciatica, hip pain etc.
61. GB34 - is to the lower extremity what L14 and TH5 is to the upper extremity. Just to the front and a little below the fibula tuberosity. A master point of the body.
62. GB40 - Amaro's hero point. The source point of GB and a Ryodoraku test point. Remember, a meridian affects what it's named after of where it courses to. Take a look at

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the GB meridian it virtually courses everywhere.

63. GB43 - at the web between the fourth (ring toe) and a small toe. When used with HT3 enhances the effect for mental depression. This point is used often especially in sciatica as it is the water point of the GB meridian.

The liver/gallbladder meridian or the wood elements have a special impact on the eyes, muscles, nails, and tendons. It's emotion is anger and is referred to as the wind element and intensifies in the Spring and has the taste of sour associated with it. I have found eye problems that were degenerated to the point where vision was much impaired and two patients were told they were going blind. These cases had a direct correlation to the liver meridian. In testing the pectoralis major sternal, we did normal correction until it was balanced by the five considerations. We then had the patient look into the light over the table and found the PMS's to blow weak. We then dropped mycelized vitamin A under the tongue and allowed for absorption time. The PMS's became strong and remained strong when looking into light. This is a quick test for potential photophobia. The affore mentioned patient's vision improved in a matter of a week. Both patients who were totally losing their vision have had an almost complete restoration. I recommend this simple test to you and possibly mycelized A.

64. LIV2 - at the web between the large and second toe. The sedation point. Relaxes muscle spasm throughout the

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body.

65. LIV3 - two fingers breadth behind LIV2. The Source point of the LIV. Affects eyes and muscle. Any time eyes or muscles are involved check LIV3.
66. LIV8 - tonification point of the liver. When the liver test low on a Ryoidoraku graph, we are generally seeing a seriously ill person or one who has the potential to be. Just inferior and lateral to KI10 an excellent point for knee pain.
67. LIV13 - at the tip of the 11th rib the alarm point for the spleen. Intimately associated with the pancreas, use it for hypoglycemia and diabetes.
68. LIV14 - just superior and medial from GB24. The alarm point for the liver. A vital point.
69. CV1 - in the perineum. An emergency point for drowning. Used often in China. Because of obvious practice considerations, this point has lost popularity in 20th century American and Europe. However, it has shown historically, to be one of the strongest effect points on the body. Its location makes it somewhat undesirable to incorporate into practice. Choose your patient well before using this point. Has a great effect in mental disorder.
70. CV2 - landmark - located at the symphysis pubes. A powerful point in any lower pelvic cavity problem.

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71. CV3 - one human in above CV2. Alarm point for bladder.
72. CV4 - one human in above CV3. Alarm point for the S1.
73. CV5 - one human in above CV4. Alarm point for TH.
74. CV5-6-7 - centers of energy. CV7 is one human in above CV5.
CV 6 is halfway between CV5 and CV7.
75. CV8 - Shrine of God - the navel. It is where Chi energy enters the body at birth and leaves it at death. A very powerful effect point especially in childrens disorders.
76. CV12 - alarm point for the stomach half way between CV8 (navel) and CV15 the xiphoid. Many meridians pass through this point either directly or indirectly. Associated with the solar plexus (seat of the soul). Might not be a bad idea to palpate this point on all patients, if sore, stimulate.
77. CV14 - alarm point for the heart one human in below the xiphoid. Involved when heart disease is present. Also used in hiatal hernia.
78. CV15 - landmark. At the tip of the xiphod.
79. CV17 - alarm point for the pericardium meridian. Affects circulation and sexual hormones. A very effective anti-smoking point. Also used in any respiratory problem two human inches above the xiphoid.
80. CV24 - "Water ditch" below the lips and above the chin in a hollow. Very effective for any facial involvement.

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81. GV26 - between the lips and nose in the philtrum. An emergency point for fainting and shock. A point the Chinese use for high fever.
82. GV25 - at the tip of the nose. Effective in sobering an ineberrated patient.
83. GV23 - two fingers breadth above the front natural hairline. Opens closed sinuses immediately. A point many acupuncture lecturers use for class demonstration to show the immediate effects of acupuncture stimulation.
84. GV20 - at the extreme center and top of the head. Located by drawing an imaginary line straight up from the top tip of both ears. Known as "Cure of 100 diseases" or "one Hundred Meeting Places" the name tells it all. The most singly effective point on the body for hemorrhoids. Use caution in stimulating with a teishen, can cause blackout. Exercise caution in children. Electrical and laser stimulation produces no ill effect.
85. GV14 - just below C7 vertebrae. The vast majority of acupuncture meridians pass through this point. Couple it with ST12 on every patient for remarkable healing response.
86. GV7 - between T11-12 vertebrae the primary point used in the "Mei Hua" system of acupuncture. Where regardless of

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the condition, GV7 is stimulated first then stimulate the "huotuoichiachi" points at the level of the involvement. Extremely effective application.

87. GV4 - between L2-3. A secondary point between L3-4. The most effective point on the body for adrenal stimulation. Always used for low back pain.
88. SP9 - just down from LIU8. An exceptional point for knee pain.
89. L12 - between the first knuckle and the second crease of the index finger on the thumb side. The sedation point for L1. The Europeans use this point for constipation. The Chinese like GB34 and ST40 for constipation and the Koreans like BL57. In a case of chronic constipation or in the elderly with sluggish bowels use L12-BL57-GB34 and ST40.
90. LI10 - a great point for epicondylitis (tennis elbow) located three fingers breadth toward the thumb from LI11.
91. GB25 - at the tip of the 12th rib, the alarm point for the kidney. Any hearing problem or bone problem. Naturally kidney involvement.
92. BL38 - rich for the vitals. Located halfway between the extreme top and bottom of the vertebral border of the scapula. Good for any disorder of the internal organs, thoracic pain or shoulder pain.

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93. "SPERM PALACE" A miracle point three fingers breadth bilateral to GV4 the most effective point on the body for inability to conceive. Treat both the male and female. Use it in combination with -----
94. ---"Palace of the Child" located 3 fingers breadth bilateral to CV3. Has the same effect as sperm palace.
95. "Eyes of Knee" When the knee is bent at a 45 degree angle two "dimples" appear just below the patella, directly over these dimples are the two greatest points for the knee.
96. "Mirale points of the shoulder" located one human in. Superior to the posterior and anterior axillary crease.
97. "PA HSIEH" In the web between 4 fingers 3 points total. Extremely effective in any hand pain, especially arthritis.
98. "Migraine" from ST36 go one HUI. Inferior and one inch posterior. Perhaps the most effective point on the body for instant relief of a full blown migraine.
99. "SEAL PALACE" directly in the middle of the forehead in the exact center between the eyebrows. Extremely valuable in headache (frontal). The "third eye" in physic awareness.
100. "Tai YANG" Just above the zygomatic arch and behind the lateral orbital bone in a definite depression. Great

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for lateral headache and eye strain or pain.

101. GV16 - at the external occipital protuberance used in combination with GB20 is exceptional for neck pain and occipital headache. Also, historically is used to enhance physic awareness and relaxes the body in general.

In summary I hope we have introduced to you some quick reference keys to potential problems a meridian may present. I hope we have shown that the magnet can be instrumental as to showing Yin or Yang disturbance over an alarm point, a regular meridian point and Dr. Deal and Richard Ut have shown that it can be used in reactive muscles. We generally treat right through the magnet over the area that was weakened. We have reviewed the use of mycelized vitamin A in liver disturbance, photophobia and other eye conditions. We hope this has renewed your interest and sparked some new ideas in your meridian understanding. I highly recommend Dr. John Amaro's classes and the tapes and books by Dr. Dave Walther on meridian therapy, etc.

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PSYCHOLOGICAL REVERSAL AND THE TESTING OF SUBSTANCES

Roger J. Callahan, Ph.D.

(c)1988

Abstract:

In order to accurately test nutrients or other substances it is necessary to test for a psychological reversal. If the individual is psychologically reversed to begin with you will not get an accurate reading on the substance. It is also necessary to test for the distinct possibility that the nutrient or substance may, in this particular patient, create a psychological reversal where there was none before. This explains why some patients who should be helped by certain substances or nutrients may actually be worsened by them. The same screening for reversal procedure needs to be done in testing for food allergies or sensitivities.

An extremely difficult psychological patient was found to have a few severe food sensitivities that worsened his condition and resulted in extreme fatigue. As a result nothing was taken into his system without testing it first. There was a gradual marked improvement in energy level and many good days followed.

He came in a few weeks later with extreme fatigue and we checked the only new item that he had ingested which was cherries and they checked out fine.

Over a period of months we observed that every time he had

cherries he felt extremely tired. Cherries were checked again and again and he always tested fine.

Finally, I thought to do the following: I checked him for psychological reversal by having him say "I want to be healthy" and then "I want to be sick". He tested strong on the former and weak on the latter showing that he was not reversed on his health. Then while a cherry was between his lips (and again he tested strong on the cherry) I asked him to mumble, as best he could "I want to be healthy" and he went weak and then he tested strong while mumbling "I want to be sick". When we eliminated cherries his energy level was vastly improved.

The cherry was not only bad for him, but it also caused him to become reversed. Thus we get a falsely negative reading on the food sensitivity test for cherries.

It is always important to have the patient utter both statements (healthy and sick) because it is an extremely interesting fact that if the tester is also reversed the patient will test strong on BOTH statements. (There are fascinating implications about the testing procedure here that demonstrate an interaction effect of the tester upon the subject.) If you only ask a patient to say "I want to be healthy" and he tests strong you don't yet know if he is reversed or not until he tests weak on "I want to be sick". If he tests strong on both statements you know that both of you

are psychologically reversed. If you correct your reversal and repeat the test the patient's reversal will now be revealed.

Various substances may create a reversal where there was none. It is crucial, therefore, to always test for psychological reversal when testing any substance.

A weakness can be falsely made to appear strong when a person is reversed. When a weak muscle appears strong upon the placing of a nutrient or substance in or near the oral cavity, the individual who then tests strong may, in fact, be so stressed by the substance that it reverses him. You then wrongly believe that the substance could help him when it may actually be quite bad for him.

There are some nutrients that will push a person, who is not reversed into reversal. It is therefore recommended that you always test for reversal and ask the patient to say (or mumble when something is in his mouth) "I want to be sick", and then, "I want to be healthy" in order to be sure that you are helping your patient with this substance and not hurting him.

THE ANXIETY ADDICTION CONNECTION

Roger J. Callahan, Ph.D.

(c) 1988

Abstract:

There is a strong relationship between the addictive urge for any substance and the presence of anxiety. The addict may or may not be aware of the anxiety. Anxiety reduction when the substance is taken results in a tranquilizing effect which then sets up a powerful addiction. The addiction is to the tranquilizer whatever form it takes. This psychological addiction is more powerful and difficult to treat than the physiological addiction.

The relationship between the addictive urge and anxiety is very easy to demonstrate using the anxiety treatments I have developed. When the underlying anxiety is treated the addictive urge will completely disappear in 95% of all addicts. The most difficult aspect of treating addicts is not the elimination of the urge which is now very easy but the psychological reversal which every addict has. The addiction itself appears to create a severe psychological reversal. This is why so many addicts are clearly self-destructive and are so very difficult to treat.

Drug addiction is a serious national problem. Any increase in understanding of this little understood problem should be most welcome. Following are some observations regarding various addictions.

In England it is legal to give heroin to cancer patients or others in severe chronic intractable pain. It is a profoundly interesting fact that when the patient no longer needs heroin for the pain and is taken off the drug there are no withdrawal

symptoms.

Cigarette smoking is a very difficult addiction to treat and conventional approaches have an astonishingly low success rate. Experts say that if a treatment program has a success rate of 20% or more it is considered successful.

The physiological aspect of the addiction, the nicotine withdrawal, is over with for most smokers after 48 hours and for a small percentage of smokers, the physical addiction may take, at most, 72 hours. After that time there is no more physical basis for the desire. If you have ever known a smoker who has quit you are aware that he may be "climbing the walls" with intense desire for a cigarette as long as a year or more after quitting. Since the nicotine withdrawal (the physical aspect of the addiction) has been completed within a few days we may speculate what drives the ex-smoker to need a cigarette so strongly long after he is over the physiological addiction.

Some people say that is is "habit" but I like to point out that if dental researchers found the ultimate cure for dental caries it would be very easy to give up the habit of brushing our teeth. We wouldn't be climbing the walls with frustration because we didn't brush our teeth.

All addictions are most difficult to treat. They are the most

frustrating type of psychological problem to treat. The success rate in the treatment of alcoholism, as well as other addictions is dismal.

The biggest problem in the successful treatment of addictions is that after a period of time the addict goes back to the substance. Many smokers who have successfully given up cigarettes for months or years will take them up again. As Mark Twain said, "It's easy to quit smoking, I've done it thousands of times."

Psychologists have speculated for years that addiction is somehow related to the presence of anxiety. I used to wonder about whether it is anxiety or not but it is now possible to demonstrate that all addictive urges are related to the presence of anxiety. With the simple and quick treatment for anxiety that I have developed it is now possible for anyone to investigate the relationship between the addictive urge and anxiety for himself.

The addict discovers, perhaps accidentally, that his anxiety is reduced when he has the substance. This connection between anxiety reduction, or more precisely, the APPEARANCE of anxiety reduction sets up the basis for the addiction. Of course, like all tranquilizers, there is no real reduction in the anxiety; merely a false impression of a reduction. The underlying problem is still there. When someone craves pizza they may not be aware that actually they are feeling anxious and the pizza has become a

tranquilizer. Some addicts are clearly aware of the connection. An easy way to demonstrate to any addict the anxiety base of his addiction is to have him go without his substance for any period of time. The underlying anxiety becomes acutely apparent with the passage of time and his need for his "tranquilizer", intensifies.

It is my position that there is one common factor behind all kinds of addictions and the common factor is anxiety. Any substance or activity which can reduce anxiety, or more precisely, appear to reduce anxiety, is a substance or activity which can form the basis for an addiction. In other words, the substance or activity operates as a tranquilizer. It is irrelevant whether or not the addict is aware that he is receiving a tranquilizing effect or whether he consciously chooses the substance to reduce anxiety.

The patient who takes tranquilizing medication when he is anxious is aware why he is taking the drug. It is a more insidious phenomenon when the addict eats, for example, (when not really hungry) and thereby appears to receive anxiety reduction.

The problem with addictions is that they don't really eliminate or help the original anxiety problem; they merely mask it. Since they appear to reduce the anxiety problem a strong addictive

connection is made between the substance, or the activity, and "feeling good". A more serious result of the addictions is that they create a severe psychological reversal which starts a powerful type of self-destructive process in motion. This destructive process can become so powerful that the addict cannot really help himself.

Activities which can become addictive are limitless. It is not the activity itself which is addictive it is rather what it appears to do for the person engaging in the activity, whether or not he is aware of what it is doing; i.e., appearing to reduce anxiety.

Some of the clinical types of activities which may come under this heading are such things as body picking; obsessively pulling out hair, eyelashes, picking dead skin, finger or toenails, etc.

Following is a simple experiment that you can easily carry out. It will demonstrate that the urge to have a cigarette (or any other addictive substance or activity) is due to the presence of anxiety. The addict is typically not aware that he is anxious but that is irrelevant for our purposes. Despite his lack of awareness of anxiety the treated addict will typically report, however, that he feels relaxed after the treatment which implies that he is now aware that he wasn't so relaxed before the

treatment.

Experiment:

Have the addict quantify the degree of his urge on a ten point scale. If he chooses to go beyond a ten to specify a higher than normal urge (such as 90 or 15), accept his scale and his numbers and then have him tap under his eyes at the beginning of the stomach meridian. While tapping, to emphasize that it is not distraction, ask him to think about how good it would be to engage his particular addiction and keep reminding him throughout the treatment procedure how wonderful it would be to have or do X. For the treatment to work it is necessary for the addict to be thinking about the addictive substance or activity during the treatment; you don't want him to be distracted.

Merely by having him tap a few times under his eyes while thinking of the urge, the urge will reduce significantly. On the ten point scale the urge should go down noticeably or at least 2 points. When the subject reports a 1 point decline it is usually positive thinking at work and not a real reduction. Some addicts will experience a 50% or more reduction in their addictive urge just by tapping under the eyes. In the rare cases where the urge doesn't go down at all it is a function of a reversal. It is very interesting that although all addicts suffer from a severe psychological reversal problem they are rarely reversed on

reducing their urge. When the remainder of the anxiety treatment is given (what I call the "gamut treatment", followed by repeating the tapping under the eyes) the rest of the urge typically disappears. There is no more desire at all for the substance. They can be challenged to try to increase their desire and they are usually unable to do so.

It is typical for them to respond with something like "I'm not thinking about it anymore" even though you are telling them to think about it and they are thinking about it while doing their internal assessment. I hear this all the time and what they mean is that when they think about it the urge is less or not there. They can't imagine thinking about it without their urge being high and so their "explanation" for what is happening is that they are not thinking about it, which of course, is imprecise on their part.

The treatment is part of the procedure that I have developed for curing anxiety problems and phobias. I have found that the same treatment will eliminate the urge in all forms of addictions.

There is much more to curing an addict than temporarily eliminating the underlying cause of his urge but this simple demonstration shows the relationship between the presence of anxiety and the addictive urge and, as you might imagine, it is an important adjunct to the total treatment of an addiction problem.

RIGHT & LEFT BRAIN ACTIVITY

Dr. Earl L. Colum

When using the right brain as in humming or the left brain in saying the multiplication tables and an intact muscle weakens, a cranial correction is needed.

The ability of carrying a tune or using mathematics well is not meaningful as to whether a patient has a short circuit with either R or L brain activity.

Some patients cannot carry a tune as simple as Happy Birthday. Yet show no weakening effect when tested. Others that may multiply correctly may still show weakening when reciting the tables.

Slow learners or those showing poor mental organization frequently will show the need for help with the L brain. After treatment improvement is generally seen. In some cases an instant change for the better is evident.

Percentagewise I have observed when testing it is the L brain that is in need of help. Some cases of R brain. To date I have only seen two patients that were weakened by both humming and multiplication. The first patient that was weakened by both has a history of seizures???

CRANIAL CORRECTION: With the patient seated have the patient hum a tune and test an intact muscle. Then have them do a multiplication table. Both to be done out loud. If multiplying makes an intact muscle weak, have the patient therapy localize (TL) with a knuckle on the suture above the left ear. This will strengthen the weakened intact muscle. The patient maintains the contact and the doctor double TLs to the asterion on the right side. This will again weaken the muscle. The suture contact and the asterion contact to be treated simultaneously with a NS magnetic poles at each point. The knuckle TLion is equivalent to N & S poles together.

For weakness produced by humming TL above the right ear on the suture with a knuckle contact. This contact will double TL with the left asterion with a knuckle or magnetic NS.

Challenge each area with circular movements using NS magnetic poles (together). The intact muscle weakened by the challenge will have an inspiration assist. Treat both areas at the same time using NS poles at each point. Make at least three or four circles, direction of challenge, with the patient holding their breath in.

This will change the NS Tld points to S. Each point can be Tld with a palmar contact and will have an inspiration assist or the points may be tapped with a S pole which will weaken an intact muscle (no resp. assist).

A directional challenge, circular, is made over each point with a S pole. The direction will be opposite of the NS challenge and have an inspiration assist.

Using a S pole at each area treat with the circular direction, determined by challenge. At least three or four circles on at least three phases of inspiration. Treat simultaneously.

Weakness produced with either R or L brain activity is corrected with the same pattern. NS TL to S both challenged and treated with direction and respiration.

When the correction is completed, have the patient repeat the humming or multiplication that earlier had produced weakness. The test will now be negative. After correction of a right brain problem and the intact muscle remains strong, I have never noticed an appreciable change in either tone or rhythm. When a left brain correction has been made there is usually a noticeable improvement in organization and correctness.

Whether a structural or neurological correction is made in using magnetic fields for treatment is not known. Negating the weakness produced by R or L brain activity does have merit. The improved grades of students having L brain correction is most rewarding.

STRAIGHT LEG MUSCLE TESTS

Earl L. Colum D.C.

Standard muscle testing is the foundation on which Applied Kinesiology is based. However, any weakness found in individual or synergistic groups of muscles must be eliminated by finding a corrective procedure. Straight leg muscle testing shows which portion of the rectus abdominus is weak and three levels of spinal fixation.

Six separate tests will be described. Three in the supine position with the leg straight and the knee locked and three in the prone position, two with the knee locked and one with the knee bent.

SUPINE TESTS: 1. The patient raises one leg at a time, six to eight inches up from the table. Pressure is applied at the ankle down to the table. Test other leg. When weakness is found the doctor therapy localizes (TL) with the pads of the fingers over the lower third of the rectus muscle on the side of the leg being tested and retests the leg. The levels of involvement in need of treatment are determined by where it makes the weak muscle strong. The area is now TL with a magnetic pole S,N or N&S together. It is usually the S pole that responds positive. The same TL routine is used on the middle and upper part of the rectus muscle. Use magnet to challenge and treat.

2. The leg is raised half way off the table (22°). Testing direction is down to the table with an ankle contact. TL the middle portion of the rectus.

3. The leg is raised as high as possible with the knee kept

straight. Test down to the starting position. Ankle contact. TL upper third of rectus muscle.

Weakness may be found in any or all positions. Any muscle found weak with its positive TL can be treated by any method that works. I have found to this time a magnetic TL, challenge(direction and respiration) and treat as indicated, to be effective for correction.

If weakness persists or will not TL on only one side, check for and treat a posterior innominate or ischium. If both sides remain weak, check and treat sagittal suture.

An additional straight leg test can be done in the supine position that is associated with the gluteus maximus, not the rectus. The patient attempts to keep the leg on the table. The doctor stabilizes the pelvis with one hand and with the other tries to lift the leg off the table. When weakness is present TL upper cervical or lower lumbar. Challenge and treat.

PRONE TESTS: 1. The patient tries to hold the leg down on the table. With an ankle contact the doctor tries to lift the leg upward, stabilizing the pelvis with the other hand. Test other leg. When weakness is found the stabilizing hand is moved to TL the lower lumbar on the same side being tested, palmar or knuckle. To TL use three or four fingers, spaced to cover the lower three lumbar. When positive use one finger at a time to determine the exact level to be treated. At that level a magnetic pole (S or N) is Tld, usually S positive. The fixation correction will be described later.

2. For an upper lumbar fixation the iliacus muscle is tested. This is best done with the lower leg rotated as far lateral as possible. The testing direction is medial with an ankle contact. TL upper lumbar for the fixation level.

3. The patient lifts the leg off the table as high as possible with the leg straight. Pressure is applied at the ankle or calf, downward. If weakness is present the upper thorasic (2 to 5) area is Tld on the side of weakness lateral to the spinouses. Determine magnetic TL and treat.

Straight Leg Colum 2.

MAGNETIC CORRECTION FOR FIXATIONS: The level of treatment is determined by a positive TL that strengthens the weak leg muscle. Two pairs of contacts for treatment will be found. One pair, lateral to the spinous (R & L) at the TLd area. The second pair contacts will be found, one point, above a spinous, and the second point below that spinous. The same magnetic pole will be used on each pair. The interspinous spaces needing treatment will be found at the spinous level of the lateral TL or the two interspaces above.

Correct the lateral points using the determined magnetic pole, in a challenged circular direction, with the appropriate phase of respiration. At least three sets of circles for three respiratory phases. This will strengthen the previously weak muscles bilaterally.

Now tap the interspinous area at that level and test an intact muscle. (tap with magnet) If the muscle weakens, move and hold the magnet on the interspace above. Do not TAP. This should strengthen the weakened muscle. Challenge the area with a circular movement. If a clockwise direction is positive then the lower space will be opposite or counter-clockwise. Treat the two areas simultaneously with direction and respiration. Tapping alone will reproduce the original weakness until treatment is completed.

Doing the above will correct the fixation and return the strength to the muscles found weak in the prone leg test.

Repeating the rectus tests on later visits revealed some interesting facts. Any muscle weakness was always onesided and never bilateral. TLing on the rectus would only be positive when a knuckle (NS) was used.

To treat this have the patient stand and TL with their knuckles at the same level on the rectus. This would weaken an intact muscle. The doctor TLs to the associated spinal level on the same side with a knuckle contact until a double TL is found to strengthen the weakened muscle. At that point a NS magnetis used to challenge for direction (circular) and

respiratory assist phase. Using NS at the spinal level and NS over the rectus, treat simutaneously with direction and respiration. The spinal level of treatment remains constant while the rectus contact is moved up and down covering four to six inches. This is followed by a single magnetic pole usually S, over each area. Challenge and treat with direction and respiration.

Any time a muscle that is weak and can be turned on and made strong, it is to the patients advantage. The inter-relationship between the rectus muscle and spinal levels is a positive factor for postural integrity. It will effect pelvic balance and is directly related to scoliosis and AP curvatures.

Simple patterns of distortion will be helped by treatment with the S pole. The more distortion that is present will require treatment with magnetic N or NS together. The use of magnets is quite simple once the basic mechanics are known. Remember the patient is always there to help you. Just ask.

PELVIC IMBALANCE IN THE SUPINE POSITION

Dr. Earl L. Colum

In cases of pelvic imbalance, a posterior innominate or posterior ischium, are treated as a single entity. This paper will demonstrate that either condition, a posterior innominate or ischium, is most often a bilateral problem.

In the paper "Correction of Cranial Faults Using Magnetic Therapy" presented in June of 87, it stated there is a connection between the sacroiliac lesions of the posterior innominate with the TMJ, and the posterior ischium with the opposite asterion. Also a palmar therapy localization (TL) to the uninvolved TMJ or asterion would bring out a hidden pelvic fault.

The use of therapy localization with palmar and knuckle contacts has enabled this author to expand the therapeutic effects of Applied Kinesiology.

A palmar TL is equivalent to a magnetic N or S pole. The N pole is always expiration assisted with a specific direction for treatment. The S pole is always inspiration assisted with a specific direction for treatment. The direction of treatment can be challenged and is circular in motion.

A knuckle TL is equivalent to N and S poles together. This NS contact will double TL to another area, also NS. The two areas of contact must be challenged and treated in a circular direction with NS magnetic poles. The intact muscle weakened by the challenge will have a respiratory assist. Treat both areas simultaneously with the determined direction and respiration. Use at least three circular movements for at least one respiratory phase.

This will convert the knuckle (NS) TL to a palmar TL. The areas just treated are tapped with the N or S pole as a challenge to weaken an intact muscle. Either N or S will be positive. The weakened muscle will not show a respiratory assist until a directional (circular) motion is used.

Simultaneously treat the challenged areas with the determined direction and respiration. Use at least three circular movements over each area for at least three respiratory phases. The minimum number of three is essential for proper correction.

When a positive TL is made, either palmar or knuckle, a second contact must be double Tld, challenged for the proper magnetic pole (N,S or NS) with direction and respiration and treated at the same time.

A LEFT POSTERIOR INNOMINATE

The patient complains of pain at the left sacroiliac area and upper groin pain on the same side. Palpating the anterior superior iliac spine shows high on the left or low on the right. The sartorius is weak only on the left with pain on palpation over the lower medial thigh. The left leg is at least $\frac{1}{4}$ inch short. Challenging the lesion by exaggerating the distortion will show positive on the left by weakening an intact muscle, which will strengthen with inspiration.

The inspiration assist indicates that the S magnetic pole will be needed for correction.

The weak sartorius is again tested with the patient Tling to the TMJ (SI 19) on the same side with a palmar contact. If the sartorius is strengthened it shows a relationship between the pelvic distortion and the TMJ. The sacroiliac and the TMJ can be double Tld. With the patient holding the TMJ contact an intact muscle will weaken and show an inspiration assist. The SI joint can be double Tld to find the exact area for treatment using the S pole. Challenge for direction and treat with inspiration, both points simultaneously. This will strengthen the sartorius and eliminate the thigh pain.

The opposite (right) TMJ is Tld with a palmar contact. If negative use a knuckle contact. Either positive TL will have an expiration assist to the weakened intact muscle. With either positive response the right sartorius will weaken with medial lower thigh pain.

Challenging, therapy localizing and treating can be done in any position but I prefer having the patient supine. The doctor stands at the side of the patient opposite the sacroiliac to be worked on. Have the patient bend their knee and place their foot on the table. This will help roll and hold the pelvis off the table (side of lesion). The doctor may need to stabilize the patient with the forearm of the hand treating the SI joint while using the other hand to treat the TMJ or opposite asterion.

Treat by first converting the NS TL to N as described earlier. Complete by using the N pole at each point. Each sartorius will now be strong without medial thigh pain

If the TMJ is involved and not treated magnetically, there will be a continued reoccurrence of the posterior innominate.

POSTERIOR ISCHIUM

A right posterior ischium with associated findings; A low anterior superior iliac spine, sacro iliac pain, medial groin pain, a weak tensor fascia lata, pain over the lower lateral thigh and a positive response to challenging the pelvis by exaggerating the lesion. An inspiration assist is usually found with the challenge.

Test the tensor fascia lata and have the patient TL to the opposite (L) asterion. When positive the weak tensor fascia lata will strengthen. With the same TL an intact muscle will weaken and have an inspiration assist. This indicates to use the S pole when treating. The asterion contact will double TL with the right sacroiliac joint. Using a S magnetic pole over each area (R. SI & L. asterion) challenge for direction and treat with inspiration.

The right asterion is now Tld by the patient. Either a positive knuckle or palmar contact will show a respiratory expiration assist to the weakened intact muscle. A positive TL will cause weakness of the left tensor fascia lata with lateral thigh pain.

With a positive knuckle contact. Double TL the R. asterion and the L.SI or just challenge each with NS for direction and treat with expiration. Complete the treatment using the N pole.

The left tensor fascia lata will strengthen and the lateral thigh pain will be eliminated.

After treating both sides of the posterior innominate or ischium rechallenge the pelvis on each side and test the associated muscles. It is not uncommon to find a patient that has a posterior innominate on one side and a posterior ischium on the other. The body can show a priority with only one lesion in the clear.

The use of magnets for the correction of pelvic faults is not a cure all in itself but is essential for a balanced pelvis and the prevention of reoccurring problems.

There are four spinal levels that may cause similar pelvic distortions. Each will have a NS characteristic needing correction.

The weakness found in muscles either in the clear or exposed by challenge, TL, movement, etc., must all be corrected to attain good health. The knuckle TL with the magnetic correction is a common finding in all patients. If one does not use it, it won't be found. If it can't be found, it can't be fixed.

THE USE OF A SURROGATE
IN MANUAL MUSCLE TESTING

John M. Corneal, D.C.

ABSTRACT

Surrogate testing is employed by most applied kinesiologists at one time or another when direct testing is impossible. The question is often raised as to the accuracy of the test. A sample of twenty-two patients with fifty-five trials involving three surrogates and two doctors yielded mixed results. The accuracy between direct and surrogate testing varied between surrogates from 58% to 100%.

INTRODUCTION

Surrogate testing involves the use of a third party while employing applied kinesiological manual muscle testing. The surrogate holds contact with the patient and the examining doctor manually muscle tests the surrogate. This technique is most useful when conditions (i.e. infancy, dementia, or coma) preclude the direct testing of the patient. (Goodheart 1974)

REVIEW OF THE LITERATURE

Goodheart mentions the use of surrogate testing in the research manuals. He suggests using a surrogate of the same sex. He also points out that the surrogate should be tested first and adjusted if necessary to insure the integrity of the surrogate system. In the case of a small infant, he suggests the surrogate, such as the mother, hold the child but a simple hand-hold contact is adequate in others. Therapy localization, challenge, etc., can be tested using this method. No reliability information was found in the literature. (Goodheart 1974)

TEST PROCEDURE

Two doctors performed the testing at two different office locations using two female and one male surrogate. The surrogates were long-standing chiropractic patients and were adjusted prior to testing. All of the test patients were within the ages of 10 to 50. Patients in ongoing therapy were examined for positive temporosphenoid (T.S.) line indicators. One or more T.S. line indicators were then therapy localized (T.L.) by the patient to verify a positive indicator. The five factors of the involved indicator were then T.L.'d and positives noted. The surrogate was then brought into the room and was tested in the clear using the right supraspinatus as the indicator muscle. The surrogates left hand was used to T.L. the previously positive T.S. line indicators and five factor points while the doctor tested the right supraspinatus. Non-positive points were randomly inserted in the testing as a control. Doctor "A" tested thirteen patients using two surrogates resulting in thirty-six trials. Doctor "B" tested nine patients using one surrogate resulting in nineteen trials. (Table 1)

TEST RESULTS

Doctor "A", surrogate one, involved eight patients and twenty-two trials. Of the twenty-two trials, surrogate testing confirmed twenty-two, yielding a 100% accuracy.

Doctor "A", surrogate two, involved five patients and fourteen trials. Surrogate testing confirmed nine of the trials yielding a 64% accuracy.

Doctor "B", surrogate three, involved nine patients and nineteen trials. Surrogate testing confirmed eleven yielding a 58% accuracy.

DISCUSSION

The ability to reproduce results time after time is the measure of reliability. This test sample indicates a lack of reliability with surrogate testing. In two out of the three surrogates, results were only slightly better than chance. However, the one surrogate was 100% accurate. This would seem to indicate that certain individuals are reliable surrogates but the reason for this is unclear. No affect was noted with regard to the gender relationship of the surrogate and the patient being tested and the accuracy of the test. It was also noted that in an inaccurate response simply reversing the surrogates T.L. to palm-up changed the response.

Future study may reveal the factors that distinguish a reliable surrogate. Until such factors are known, surrogate testing should be reserved for those extreme cases where it is impossible to test directly and corroborative findings are present.

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TABLE 1

<u>DOCTOR "A"</u> <u>Subject</u>	<u>Surrogate 1</u> <u>T.S. Line Indicator</u>	<u>T.L.</u>		<u>Five Factor</u>	<u>T.L.</u>	
		<u>yes</u>	<u>no</u>		<u>yes</u>	<u>no</u>
1	R psoas	x		nl	x	
2	R scm	x		nl	x	
3	R-quadricep	x		nl	x	
4	L-sartorius	x		nl	x	
5	L-pms	x		nl	x	
	R-hamstring	x		nl	x	
6	R-psoas	x		nl	x	
7	L-neck extensor/flexors	x		head stress receptor	x	
8	R Quadricep	x		nl	x	
	P pms	x		nl	x	
	R neck extensors/flexors	x		nl	x	
<u>DOCTOR "B"</u> <u>Surrogate 2</u>						
1	R-pms		x	head stress receptor	x	
2	L-neck extensor/flexor	x		nl	x	
	R-quadricep	x		nl	x	
3	R-psoas		x	nl		x
4	R-sartorius	x		nl	x	
5	R-quadricep		x	nl	x	
	R-popliteus		x	nl	x	
<u>DOCTOR "B"</u> <u>Surrogate 3</u>						
1	Bilateral psoas			occiput	x	
	R anterior tibialis		x			x
2	Bilateral psoas		x			
	L subscapularis		x	head stress receptor	x	
				nl	x	
3	R psoas	x		head stress receptor	x	
4	L-piriformis			nl		x
5	R-teres minor			nl		x
	Bi-psoas			occiput		x
6	Bi-psoas			occiput	x	
7	R-pms	x		R Ilium nl	x	
8	Bi pms			nl	x	
9	Bi psoas			occiput		x

CHIROPRACTIC MERIDIAN ADJUSTING II

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

Abstract:

Chiropractic Meridian Adjusting is a method of Analysis and Adjustment of the Spine to correct unbalance of Acupuncture Meridians.

Introduction:

Acupuncture Meridians may become unbalanced due to an energy drain from the overuse of a particular body organ. This results in a weakness of certain skeletal muscles associated with that overworked organ. This weakness is on only one side of the body, either on the left or on the right. A musculo-skeletal distortion results known as a vertebral subluxation-fixation complex. This is a condition in which two or more adjacent vertebrae lose their ability to perform one or more directions of motion.

The body is then limited in its capacity to perform certain bodily motions to the fullest extent or range of motion. This condition is then evident on observation of the body's posture, either at rest or while it attempts to perform certain motions as in the gait mechanisms on ambulation.

The posture then assumes certain irregular angulations, known as a scoliosis, either laterally or from front to back, and on ambulation the gait mechanism is performed in an aberrant manner.

This condition causes difficulty in carrying out bodily tasks and the resultant stress on its overworked parts produces pain and distress, and even wear and tear of those overworked parts. Those joints carrying the load without the help from the backups may suffer strain or even sprain.

Chiropractic Meridian Adjusting (Cont'd.)

Analysis of Unbalanced Meridians

The method used is known as Therapy Localization. This consists of the doctor touching with his fingertips various parts of the patient's body while testing for a resulting weakness in a previously-tested strong muscle used as an indicator. This weakness acts as a red light telling the doctor of an energy drain in the area.

Since the doctor will be touching the skin of the patient, he is testing whatever structure or tissue that lies beneath that point of contact.

If the patient is touched over a point on the skin known as the Beginning or End Point of an Acupuncture Meridian, and weakness results in the Indicator or Test Muscle, the Meridian is said to be unbalanced. This results in weakness in every muscle associated with that Meridian, when it is tested by the methods of Kendall & Kendall. This weakness or energy leak may be confirmed also by the doctor Therapy-Localizing over each of the muscles associated with that unbalanced Meridian, with resultant weakness occurring in the indicator or test muscle.(1)

PRECAUTIONS to be taken by the doctor while testing: These apply ONLY UNTIL the spinal correction is made. THEN they will no longer affect the test result.

The patient must NOT be touching his body with either hand as he will then be Therapy-Localizing, in addition to the Doctor.

Chiropractic Meridian Adjusting (Cont'd.)

Precautions: (Cont'd.)

1. - Since the fingertips contain the End Points of Meridians, some of which may be unbalanced, this may confuse the test results. The patient's finger tips and even his hands must be at least one-half inch away from any part of his body only while testing the intact muscle for weakness (2).
2. - The patient must be looking straight ahead as the eyes influence the test results. (Eyes into Distortion, Lumbar 4, Medial Calcaneus)(3)
3. - The patient must not cross the arms, legs or feet. (Fifth Cervical)(4)
4. - The weight must be balanced on both feet, if standing. (Lumbar Four)(5)
5. - The doctor must not touch the patient with a finger of his hand that contains an unbalanced meridian. Use another finger, one that will not weaken the strong indicator test muscle.(6)
6. - The patient must not INHALE or EXHALE deeply. (Occipital Fault, Sacral Two (7)).
7. - The lips must be slightly parted (mouth partly open) to separate the End Points of Conception and Governing Vessel Meridians. (Thoracic Seven and Eight).
8. - Metal on the patient's body may influence the results. (Fifth Cervical)(4)

Chiropractic Meridian Adjusting (Cont'd.)

The Strong Indicator Muscle used may be:

- When prone: Neck Extensors (bilaterally) or a Hamstring.
- When supine: A Straight Leg Raise (either leg)
A Straight Arm extended in front of the body.
- When side-lying: An arm extended laterally (Deltoid)

Testing Procedure:

The doctor touches either the Beginning or End Point of a Meridian. If this touching weakens the strong Indicator Test Muscle, this means the Meridian is unbalanced. Every muscle on that meridian should now test weak. Also, it should produce weakness of the indicator muscle, whenever the doctor touches any of those muscles on that meridian.

The doctor next touches the Spinous Process of the Vertebra associated with that Meridian from the left side and then from the right side. Weakness of the indicator test muscle usually results from touching it on the left side of its Spinous Process.

Correcting the Meridian Unbalance:

This is performed by a simple, light thrust on the spinous of the Associated Vertebra into the direction that causes weakness of the indicator muscle when the vertebra's spinous is touched. The spinous is adjusted into weakness.

When retested, every muscle on that meridian should now test strong, as should the Indicator Muscle when either the Beginning or End Point of the Meridian is touched.

CHIROPRACTIC MERIDIAN ADJUSTING II (Con't.)

Associated Vertebra	Meridian	Muscles Involved
T3	Thymus	Second and Third Rib
T4	Lung	Deltoid, Coracobrachialis Anterior Serratus, Diaphragm
T5 *	Uterus/Prostate	Gluteus Medius, Piriformis
T6	Heart	Subscapularis
T7	Governing Vessel	Teres Major
T8	Conception Vessel	Supraspinatu
T9 *	Pancreas	Latissimus Doris, Triceps, Lower Trapezius (Bilaterally)
T10	Liver	Pectoralis Major (Sternal Div.) Posterior Tibialis
T11	Gall Bladder	Popliteus, Anterior Deltoid
T12 *	Spleen	Middle & Lower Trapezius (Individually)
L1	Stomach	Pectoralis Major (Clavic. Div.) Neck Flexors & Extensors (Ind) Biceps Brachii, Opponens Poll. Levator Scapularis, and Brachioradialis (16 in all)
L2 *	Triple Warmer	(Adrenal) Sartorius, Gracilis Gastrocnemius, Soleus (Thyroid) Teres Minor Infraspinatus
L3	Kidney	Psoas Major, Iliacus, Upper Trapezius.
L4 *	Testes/Ovaries	Gluteus Maximus, Adductor
L5	Large Intestines	Hamstring, Quadratus Lumborum, Tensor Fascia Lata.
Sacral One	Small Intestine	Quadriceps and Abdominals: Rectus, Transverse. Obliques
Sacral Two	Bladder	Sacrospinalis, Anterior Tibialis Peroneus: Longus, Brevis & Tertius; Levator Costorum; Rotatores: Longus and Brevis

* Asterik indicates changes made by Dr. E. J. Cousineau, D.C.

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INTRODUCTION

David S. Walther, D.C.
Chairman, Education Committee

This twenty-fifth collection of papers of members of the International College of Applied Kinesiology contains forty-six papers by thirty-two authors. The papers will be presented by the authors to the general membership at the Summer Meeting of the ICAK in Dearborn, MI, June 13-18, 1988. The authors welcome comments and further ideas on their findings. You may talk with them at the meeting or write them directly; addresses are given on the Table of Contents page.

The manuscripts are published by the ICAK as presented by the authors. There has been no effort to edit them in any way; however, they have been reviewed by members of the Education Committee for originality and to determine that they follow the "Instructions to Authors of Collected Papers" published by the ICAK. The primary purpose of the ICAK in publishing the Collected Papers is to provide an interchange of ideas to stimulate improved examination and therapeutic methods in applied kinesiology.

It should be understood that the procedures presented in these papers are not to be construed as a single method of diagnosis or treatment. The ICAK expects applied kinesiology to be used by physicians licensed to be primary health care providers as an adjunct to their standard methods of diagnosis and treatment.

Neither the International College of Applied Kinesiology-USA, its Executive Board, or its Examining Board necessarily endorses, approves of, or vouches for the originality or authenticity of any statements of fact or opinion in the papers. The opinions and positions stated are those of the authors and not by act of publication necessarily those of the International Council of Applied Kinesiology, the Executive Board of the International College of Applied Kinesiology-USA, or the International Examining Board.

THE AMAZING KINESIOLOGY INDICATOR

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

Abstract:

Applied Kinesiology has demonstrated that spinal injuries are produced by the overloading of a particular spinal muscle, when other back-up muscles fail to perform, due to an unbalance of their Acupuncture Meridians.

Introduction:

Applied Kinesiology has repeatedly demonstrated the presence of one or more weak muscles of the body by testing them by the methods outlined by Kendall and Kendall. The weakness is usually unilateral, and only occasionally is it bilateral, involving the same muscle on both sides of the body, as for example, bilateral psoas major, or bilateral lower trapezius.

These muscular weaknesses were strengthened in Applied Kinesiology by treating the muscle's Neurolymphatic, its Golgi Tendon or its Spindle Cell Reflex, and by heavy kneading pressure on its Origin or Insertion at its attachment to a bone, or by treating its Stress Receptor on the skin.(1)

Later methods included treating the organ associated with the weakened muscle, by treating the organ's Neurovascular point on the skull, or by stimulating or inhibiting it via a point on its Acupuncture Meridian.(2)

The Amazing Indicator of Kinesiology

The discovery that ANY (repeat ANY) previously-tested strong muscle could be WEAKENED by the addition of one more stressor, led to the understanding of how the spinal injury occurred in patients suffering distress.

The Amazing Kinesiology Indicator (Cont'd.)

A strong muscle that was being used in a given bodily movement, such as bending forward from the waist, or raising a leg, could suddenly be weakened by the mere touching of the patient's skin by one of the fingers of the patient, or by that of another person, such as the testing doctor (3), by moving the eyes to the inferior and to the side of Spinal Distortion.(4) Thus the burden of effort was now placed upon those muscles that remained to assist in the motion, and distress could result.

This weakening of a strong muscle was also found to occur when an added stress was placed upon an already-stressed joint or articulation, as in the Challenge Method of testing a joint for distress (5). Testing of a wrist or an ankle to determine the presence of a carpal-tunnel, or a tarsal-tunnel syndrome, is an example (6). Walking the patient to test the Gait Mechanism is another example. This includes any spinal articulation, such as the occipital-atlantal, atlantal-axial, lumbosacral, or sacro-iliac articulations (7).

The Overload

The Acupuncture Meridian must have been overloaded or stressed by its organ or one of its muscles to the point where the Associated Vertebra assumed the OFF position, before the addition of the one more Stressor will produce the injury..

The Amazing Kinesiology Indicator (Cont'd.)

The Injury:

The injury occurs **WHEN** the patient adds one more stressor, while performing a bodily motion, such as bending forward, or by raising a leg or an arm, and those muscles that should cooperate in the motion go from strong to weak , just as in muscle testing.

When one or more of the back-up muscles fail to assist in the given motion, then the full load is taken upon those muscles that remain to complete the motion. Thus the injury can occur.

Most treatment is directed toward the restoration of normalcy to the injured spinal segment or muscle. Either heat or cold, or traction or manipulation is used with varying beneficial results

The segment continues to be re-injured when the back-up muscles fail to carry their fair share of the load, because their meridians are unbalanced.(8) Thus healing time is delayed, much the same as knocking the scab off a wound.

The Muscle Inventory via the Acupuncture Meridians.

The fastest method of turning **ON** all the structural muscles is via the Acupuncture Meridians. Every Meridian has a Vertebrae Associated with it that acts as a breaker switch, in case of an organic overload. When it goes to the **OFF** position it weakens every muscle on its meridian. The chiropractic adjustment of the Associated Vertebra turns the Meridian to the **ON** position and restores full strength to every muscle on its meridian.(9)

The Amazing Kinesiology Indicator (Cont'd.)

Instead of strengthening each muscle of the meridian separately, and treating each, the Associated Vertebra of the meridian can be tested for the OFF position. It may be challenged by pressure on the vertebral spinous in one direction, while a strong indicator muscle is tested for weakening. The spinous can be checked for all directions of subluxation. It can then be checked for the phase of respiration that maintains strength in the indicator muscle.

Then it can be turned to the ON position by adjusting it in the direction that causes weakness of the test muscle, but on the phase of respiration that previously would remove the muscle weakness. This will restore strength to all of the muscles on that meridian.(10)

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INNER CLOCKS AND HOUR OPEN POINTS

By

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

ABSTRACT: Herein lies a kinesiological approach to take advantage of the natural rhythms of life that take place in our bodies. These cycles and rhythms are forever present, but only recently have we been able to measure them and thus treat them for the purpose of improving the quality of life in our patients. Once these cycles and points have been identified we can treat them through the acupuncture system.

BACKGROUND:

Modern man lives by the clock, but very often, it is the wrong clock. He times his hours of sleep, work, and play by the mechanical clock he has invented, but the functioning of his body - indeed the functioning of all organisms - is timed by a biological clock or clocks, which regulates sleeping, breathing, living and dying in apparent synchronization with the Universe. Most people cannot hear or obey the ticking of their inner clocks because their lives are run by the artificial clocks of modern society.

It is only recently that science has begun to show interest in these biological clocks. A century ago scientists began to see manifestations of mysterious internal machinery in the cycles of life. Flowers and some plants opened by day and closed at night. Birds knew unerringly when and where to migrate. Some animals knew where and when and how long to hibernate. Later observations of natural changes in plants, animals and men were moved into the laboratory and tested statistically with and without the environmental factors which had been blamed for triggering the behavioral patterns of living organisms.

As a result of these studies, according to Dr. Bertram S. Brown, Director of the National Institute of Mental Health, "Many aspects of human variability in symptoms of illness, in response to medical treatment,

in learning and job performance - are being illuminated. Already some of our changes of mood and vulnerabilities to stress and illness, our peaks of strength and productivity, can be anticipated. Moreover, by the end of this decade, much that is still considered unpredictable in health and human performance may become foreseeable through research into the nature of biological time cycles".⁽¹⁾

I have been fascinated with time and inner clocks ever since the Super 20 Seminar where I used time as the theme for the evening program, where we awarded Dr. Goodheart with the grandfather clock.

Most life cycles seem to fluctuate with the 24 hour period of day and night in the earth's rotation. These are known as circadian (from the latin for "about a day") rhythms. Processes which operate in shorter cycles, down to seconds or micro-seconds in basic cell processes, are termed ultradian. Longer rhythms, such as mood changes occurring at regular intervals of days or illnesses which recur at certain times of year, are infradian.

Of all the cycles in life, the circadian rhythm of organic change from day to night and back again in 24 hours periodicity is most persuasive in living things and was the first such rhythm to attract scientific notice. "That period of 24 hours, formed by the regular revolution of our earth, in which all its inhabitants partake, is particularly distinguished in the physical economy of man," wrote C.W. Hufeland in 1797. "It is, as it were, the unity of our natural chronology."⁽²⁾

In the nineteenth century, the Swedish naturalist Carolus Linnaeus was first to notice that various flowers opened at different hours during the day. The charmingly practical application in formal gardens of Europe were flowers planted to form a clockface with varieties in each

bed blooming and closing at different hours.

One common arrangement started with the spotted cat's ear, which opens at 6:00 a.m., followed by the African marigold at 7:00 a.m., and the Hawkweed at 8:00 a.m. Nine o'clock was marked by the closing of sow thistle, and the nipplewort closed at 10:00 a.m. At 11:00 a.m., the Star of Bethlehem opened, followed by the passionflower at noon. The afternoon was marked by the time of closing of other flowers; childing pink at 1:00 p.m., scarlet pimpernel at 2:00 p.m., hawkbit at 3:00 p.m., bindweed at 4:00 p.m., and the white water lily at 5:00 p.m. The evening primrose opened at 6:00 p.m., completing the 12 hour day.

Many observations have shown internal periodicity at work in insects, animals and sea creatures; as well as plants, although it is only in recent times that biological timing mechanism have been deemed worthy of serious investigation. As we look more closely, we find that precise rhythmicity is a basic key to many vital processes.

Artificial conditioning causes us to think of a time measuring device in terms of springs gears and a windup key. Such conditioning leads us, perhaps unconsciously, to search for a clot of cells or nest of nerves in living tissue corresponding to our limited understanding of the passage of time. The rhythmic core of living organisms may be more analogous to the electric clock, which simply oscillates to a measured beat according to electric signals which it receives from the outside world. Such a concept may help in understanding the grunion and other creatures which behave peculiarly in response to signals others cannot perceive.

We know the vital rhythms of heartbeat and breathing are controlled somewhere in the unconscious nervous system and that abnormal rates are

signals of illness. The heart and lungs also are synchronized rhythmically together. A person at rest has a pulse rate of sixty to eighty beats and respiration of fifteen to twenty breaths a minute. The two functions together show a circadian rhythm rising to a peak by day and falling to a low point during sleep. Dr. Gunther Hildebrandt at the University of Marburh, Germany concludes that a heartbeat to respiration ratio of four to one is a sign of health. A higher or lower ratio may signal that the body is not functioning properly.⁽³⁾

One primary cycle is body temperature, which persistently rises and falls one or two degrees each twenty-four hours.

A person's favorite hours of the day are likely to coincide with the high point, usually afternoon or evening for a person who is active by day and sleeps at night. This cycle may help to explain the difference between people who jump out of bed in the morning, alert and ready for the day's problems, and others who drag around for an hour or two before they begin functioning.

The rate of urine excretion may depend upon several other internal clocks. One is the anti-diuretic hormone ADH, which comes from the posterior pituitary gland on a pronounced 24 hour cycle of its own. Also, excreted in urine is a group of ions, known as electrolytes, including potassium, sodium, chloride, phosphate, magnesium and calcium. Excretion of these substances follows several different circadian rhythms.⁽⁴⁾

There also is circadian periodicity in the production and breakdown of the body's most fundamental energy unit, Adenosine triphosphate (ATP) Studies by Dr. Pittendrigh at Princeton revealed that ATP is transformed to release energy 25 percent faster during time of activity than during rest.

Importance of this cycle was demonstrated at the Lafayette Clinic in Detroit, where a group of people were deprived of sleep. After being awake for 100 hours, the volunteers began to suffer hallucinations and psychosis. They saw fire bursting from the walls and suspected their friends of conspiring to kill them. Their muscle performance and coordination also declined. Blood samples indicated that sources of the basic energy unit were beginning to run down. Once the subjects returned to their normal rhythm of sleep, energy production and behavior also returned to normal. (5)

In animals light stimulates secretion by the hypothalamus and pituitary gland, which in turns increases estrogen secretion by female ovaries and the male's production of sperm. Changing wavelengths of light apparently is important also, and even blind animals respond to light if certain nerves remain to transmit the radiation to a central switching point in the brain. This switching point or central clock coordinator, has been tentatively traced to the pineal gland.

It was Dr. Reinberg and a group of physicians in New York who in 1967 discovered a daily testosterone rhythm in men. Inasmuch as sex hormones frequently are used to treat cancer of the uterus, breast and prostate, knowledge of this natural rhythm may make more precise treatment possible. Other studies have shown that exposure to light at certain times can either delay or speed up ovulation. (6)

It is standard procedure for the U.S. Food and Drug Administration to require a test of new drugs upon laboratory animals before they are approved for clinical test or human use. A lethal dose is determined by measuring the amount which causes 50% of the lab animals to die.

In one such study rats were kept on a steady day night schedule and

injected with potentially lethal amounts of the stimulant amphetamine at two hour intervals. Around 6:00 a.m., when the animals were at the end of their activity cycle, only 6 percent died of the drug. When it was administered at midnight, peak of the rodent's activity, 77.6 percent died.⁽⁷⁾

There are two major theories which attempt to explain the internal biological clocks which govern the periodic rhythms of all living organisms. The first postulates roughly that the cyclic governors are inherited and through countless ages of evolution became so engrained that they are independent of external cues. The second theory states that the internal timers are special sensors (or extensions of our known senses) which coordinate our functioning when triggered by outside forces - light and dark, changing seasons, gravity and electromagnetic waves from the earth, sun, moon and possibly the planets.

A foremost proponent of the second theory is Frank A. Brown, Jr., Professor of Biology at Northwestern University. He and his co-workers have been studying plant and animal rhythms for more than thirty years and have become convinced that there are tides in forces from outer space and that these are the master clocks which synchronize our living time keepers.

This cosmic oscillations, according, to Brown, are bound to phases of the moon, sunspot cycles and perhaps radiation and gravitational force from the planets. Such gentle tides, though not yet measured by scientific instruments, are believed to ebb and flow in hourly, daily, monthly and even yearly rhythms and drive other geophysical forces which surround the earth. These may include barometric pressure, earth's magnetic field, subtle changes in gravity, atmospheric ionization, cosmic rays and weak electromagnetic fields.⁽⁸⁾

ACUPUNCTURE:

In Applied Kinesiology, probably the best example we have of a cyclic rhythm is the 24 hour clock seen in the acupuncture system.⁽⁹⁾ This is where the acupuncture energy flows from meridian to meridian, changing meridians every two hours so that in a period of 24 hours all 12 meridians have been covered. This energy flow follows a set sequence that goes from - heart, small intestine, bladder, kidney, circulation sex, triple warmer, gall bladder, liver, lungs, large intestine, stomach and spleen; whereafter it starts over again in the heart meridian. The fact that the energy flow can be found in one of the twelve meridians at any one time and that the opposite meridian on the 24 hour clock, 12 hours away, has the least amount of energy at any one time, accounts for the midday midnight law commonly referred to in acupuncture.⁽¹⁰⁾

Dr. Goodheart has shared with us the "Now and Then Technic", whereby the now meridian could be identified with the then meridian, meaning the one where the energy is at the time the patient's symptoms occur. By establishing the relationship between the two meridians, the patient's problem could be treated now in the office regardless of the time of day the symptoms occurred. Dr. Terry Franks shared with us that the now meridian alarm point would double therapy localize to the eyelids of the patient. This is a procedure I have found very useful in my practice.

POINT IN CASE:

With all that background, it occurred to me, that to the best of my knowledge no one in AK has ever identified at which acupuncture point the energy is at the moment, even though we know it is moving from meridian to meridian every two hours!

I said to myself, this is another piece of the jigsaw puzzle. Based on all the background of how we are affected by inner clocks and rhythms, it must be significant where the energy was at the time, the accident occurred or the emotion took place or when the problem started, that the patient is now in our office seeking help for.

Whether you ascribe to it or not, the whole practice of astrology is based on the principle that the living organism is influenced its whole lifetime by the position the planets were in at the moment the infant took its first breath.

In herbal medicine there is a practiced theory that the cure for any given disease will be found in a native herb in that part of the world where the disease had its origin. Consequently, much time is spent tracing down the location of the origin of any given disease.

It was facts such as these, plus the vast amount of information available on inner clocks and rhythms that led me to pursue the location of the specific acupuncture point of energy flow at a specific time or event.

It was my good fortune while lecturing in Holland to meet a Professor Alphons van der Burg. He gave me a copy of a book he had written entitled, "Magneet Therapie".⁽¹¹⁾ In the book was a very complicated chart he had made to identify what he called hour open points. Since our meridians vary in the number of acupuncture points they contain. It follows then that the energy must move at different rates of speed if it changes meridians every two hours. This fact alone made the chart complex. But never the less, here was the beginning I needed to hopefully make a Kinesiological correlation.

RESEARCH FINDINGS:

Our research has now led us to believe that there are several energy flows moving through the vast network of our acupuncture system at any one given time. This follows the logic that one of the five major factors of the I.V.F. with its vast network of meridians would not be limited to one energy flow only; just as our vast nervous system would not be limited to transmitting one nerve message only at any given time.

To date, we have identified three such points or cycles in the body relating to the energy flow through the acupuncture system.

First, is the hour open point, hereafter referred to as the H.O.P. This is the acupuncture point where the energy flow is located at the present moment. It is fascinating to see the therapy localization of this point change from one acupuncture to the next as the clock ticks by. Aside from the scholastic interest in locating this point, one of the advantages of knowing its location, is that we can now give the energy flow a boost, not to be confused with changing its rate of travel, but rather just a boost to enhance the strength of the energy flow. This enhances the overall well being of the patient or of ourselves for that matter.

Second, is the complaint open point, hereafter referred to as the C.O.P. This is the acupuncture point where the energy was at the moment the patient's complaint started. This would be the time of the accident, time of the heart attack, time of receiving the emotional affecting news, ect. I believe the location of this point has a profound effect on locating the patient's problem and treating the problem. In some cases, the problem area would not even show up or therapy localize until this point is found first and then the two

of them will two point or double therapy localize.

Third, is the birth open point, hereafter referred to as the B.O.P. This is the acupuncture point the energy was at at the moment of birth, or the time of the first breath of the infant. Since there only are so many points and the energy is consistently moving, it sometimes happens that the C.O.P. is the same point as the B.O.P. I believe this may account for the fact that two patient's can experience the exact same injury and the one patient has minor affects from it while the other patient has major systemic affects from the same injury.

So far we see that everybody has a B.O.P. and a H.O.P., but not everybody has a C.O.P. A critical point in this procedure is the H.O.P. will not show up until the C.O.P. is cleared first. Therefore, one method of being able to distinct whether or not the patient has a C.O.P. is to see if the H.O.P. shows up or not.

CORRECTION PROCEDURE:

I am not so niave to believe that the procedure I am about to describe is the only way the clearing or correction can take place, but it is one way that works for me and other people who have shared this with each other. Aside from just giving someone an energy boost and the fact that I do not do this procedure on every single patient, probably the best indicator for when you should do this procedure is when the patient's problem does not show any need for mechanical correction, chemical correction, emotional correction or electromagnetic correction and you say to yourself, "What do I do now?"

The shortcut of tugging around the navel to show which element of the law of five elements is involved must not show, otherwise, that would be a priority to fix that first, or at least clear it since it may not be the very next thing to fix.

Next you enter a mode for locating these open points on the body's display of muscle indicators. On the left hand, the pad of the third finger is placed on top of the nail of the second finger or index finger. On the right hand the side of the index finger is placed against the side of the little finger. Now the patient's legs are both abducted to lock in the mode on the display and the patient can now let go of the finger positions. This procedure activates the proprioceptive nerve endings in the acetabulum which contains more ruffini corpuscles than any other joint in the body. When you now go back and retest your indicator muscle it still tests strong, but the way that you know that you entered some information is that now tugging around the navel will show which element the C.O.P. is located on. The next step is to enter this element on the display by having the patient hold the tug direction while you close and reabduct the patient's legs. Your test indicator muscle will still test strong, but the way you know that you have entered some additional information is that while testing the indicator muscle, touching the patient with your other hand will now cause the indicator to weaken which did not occur prior to your last entry. Now touch the alarm points related to that element to see which meridian contains the C.O.P. as that will cause the indicator to stay strong as will the exact acupuncture point on that meridian as you search for it by touching the acupuncture points on that meridian by going from the beginning to the end of the meridian. You have now located the C.O.P.

An example of this would be after you have entered the tug of the navel on the display, let's say it was wood, you now touch the alarm points that belong to the wood element. The one that test strong is the one you want because everywhere else you touch the body, the indicator goes weak. Let's say it was G.B. 24 on the right. Now you know that

the C.O.P. is located on the gall bladder meridian on the right side of the body. You now touch the points on that meridian to find out which one allows the indicator muscle to stay strong, as the wrong one will cause a weakness as will touching the body anywhere else. In a case where the alarm point for that meridian is located on the same meridian (which it usually is not, but in the case of the gall bladder it is), then pick the point with the highest numerical value as your C.O.P. as it is possible in the case of the gall bladder that the alarm point could also be the C.O.P. The other two possibilities where this could happen is on the liver and lung meridians.

Take note that this C.O.P. shows up on one side of the body only. This means we are dealing with an energy flow that is different than the traditional 24 hour clock in acupuncture where both of the bilateral meridians have the energy flow going through them at the same time. This particular energy flow moves from the gall bladder on one side of the body to the gall bladder meridian on the other side of the body before it moves on to the liver meridian. In other words, it moves one meridian every one hour instead of every two hours.

Now that you have located the C.O.P. you may close the patient's legs. You understand that this C.O.P. does not change for this complaint that you are working on which is the priority complaint at the moment. You also need to know that this C.O.P. will now not therapy localize in the clear, but it will two point to the area of complaint.

The above example I gave you was for a bilateral meridian of which there are 6 total; gall bladder, liver, lung, kidney, spleen and large intestine. If however, the C.O.P. happens to be on a midline meridian of which there are 6; circulation sex, heart, stomach, triple warmer, small intestine and bladder, then the procedure is a little different.

This designation of bilateral or midline is determined by where the alarm point is located.

Remember that after you enter the tug of the navel the patient tests strong until you touch him with your other hand and then he goes weak. Well, in the case of a midline meridian containing the C.O.P., this phenomenon reverses itself when the patient turns their head to the side of the meridian containing the C.O.P. Have the patient turn his head to the left and retest by touching him again. Then have him turn his head to the right and retest him again. If the C.O.P. is on a midline meridian, after the correct head turn, which identifies which side the meridian is on, now the patient will test strong when you touch him and will only go weak when you touch the correct alarm point and also the correct acupuncture point on that meridian. So now again you have located the C.O.P., but this time on a midline meridian.

For example, if the C.O.P. was on the heart meridian on the left, the patient will test weak when you touch them and after they have looked right they will still test weak when you touch them. But after you have them look left now they will test strong when you touch them. So you now search for which alarm point makes them go weak and consequently which point that makes them go weak on the left heart meridian.

LOCATING AREA OF COMPLAINT:

Now that you have the C.O.P. you need to find the area of complaint. Remember the C.O.P. will not T.L. in the clear, but it will two point to the area of complaint. With the patient touching the C.O.P. test a strong indicator muscle and have the patient look left and then right. The area of complaint will be on the side that went weak. If both sides went weak the area of complaint is on the midline. Now

you know the side of involvement with the patient still touching the C.O.P. and looking straight ahead, touch the patient yourself while still testing an indicator muscle. Use one finger at a time looking for a weakness to occur:

Index Finger	=	Area of Complaint is the head
Middle Finger	=	Area of Complaint is the Upper Trunk
Ring Finger	=	Area of Complaint is the Lower Trunk
Little Finger	=	Area of Complaint is an extremity including the shoulder area or the hip area.

If it turns out to be an extremity, have the patient look up which would mean the arm, if the muscle changes and then look down which would mean the leg if the muscle would change strength. In this case the muscle would come back on strong since your touching with your little finger made it go weak.

Now that you have located the area of complaint, which will challenge but will not T.L., you need to correct it with your normal methods that you usually use. (If you can believe that there is anything normal left after all this). The correction may require nutrition or emotional correction or mechanical reduction of a subluxation, ect., ect.

When the above correction is successfully completed the tug around the navel will no longer show even after you have entered the hand mode for open points.

LOCATING THE N.O.P.:

Remember the N.O.P. will not show until the C.O.P. has been corrected first. It occasionally happens that some other normal everyday corrections need to be made after the C.O.P. is cleared before the N.O.P. will show.

Everybody has a N.O.P. and the meridian it is located on is found by

tugging around the mouth rather than around the navel. To start with tugging around the mouth should not show anything in the clear. If it does, it could be a GV 26 or CV 24 problem which would need to be corrected first. The elements are located around the mouth in the same relative position they are in around the navel. With the five elements being superior, the earth and metal elements being located on the patient's left and the wood and water elements being located on the patient's right. The first step is to enter the open point hand mode by leg abduction which will cause the indicator muscle to still test strong, but you know you have added information because now tugging around the mouth will show which element is involved. Next enter that directional tug on the display by closing and reabducting the legs. The correct alarm point and acupuncture point will test strong when touched by the doctor because touching anywhere else will cause a weakness. The N.O.P. will show bilaterally. Since it does show bilaterally it represents yet a different flow of energy through the acupuncture system because it is moving one meridian every two hours. However, it does not coincide with the traditional 24 hour clock, where the heart starts at 11:00 a.m. and goes to 1:00 p.m. Interesting enough the latter energy flow can be identified also using these methods or the traditional methods mentioned earlier. So that now we have a total of three energy flows running through the acupuncture system that have been identified to date.

Keep in mind the N.O.P. needs no correction as it is normally present in everyone. With the patient in the open point mode you can watch it change from point to point as the time of day passes. If however, you want to give the patient a boost of energy, here is how to proceed. Have the patient T.L. the N.O.P. which will make the indicator muscle go weak and then have them turn their head to the left, if the indicator

muscle goes strong you need to treat a ying acupuncture point. If looking right makes the indicator muscle go strong you need to treat a yang acupuncture point. If the muscle was strengthened by looking left then have the patient look up and to the left if muscle stays strong treat the ying point on the arm. If looking left and down the muscle stays strong treat the ying point on the leg. If the muscle was strengthened by looking right then have the patient look up and to the right if muscle stays strong treat the yang point on the arm. If looking right and down the muscle stays strong treat the yang point on the leg.

N.O.P. TREATMENT POINTS

Ying Arm:	LV-7	CX-6
Yang Arm:	SI-3	TW-5
Ying Leg:	KI-6	SP-4
Yang Leg:	BL-62	GB-41

Only one of the two ying points or one of the two yang points will T.L., but treat that one point on both sides of the body. That one point will T.L. on both sides of the body. You can treat it many different ways by tonifying it. My preference is to use the south pole of a magnet.

If you retest the N.O.P. it should be gone. If you retest the ying or yang points they should be gone. If you cannot find a C.O.P. or a N.O.P. the body needs correction that should show in the clear. Remember not every patient has a C.O.P., but every patient does have a now meridian and also a N.O.P. If the N.O.P. shows in the clear you know that there is no C.O.P.

When you are looking for the area of complaint that two points to the C.O.P. here are some helpful hints as to which areas show up most commonly: Clocks & Open Points, Page 16, Deal

HE =	Shoulder, Elbow
SI =	AC Joint
BL =	Occiput or L-5
KI =	Pubes
CX =	Sterno Clavicular or AC Joint or Pubes
TW =	Clavicle
GB =	SI Joint
LIV =	Hip
LU =	Shoulder
LI =	Shoulder or Clavicle
ST =	Pubes or Sterno Clavicular
SP =	Hip

These are the joints that score the highest on each of the twelve meridians.

CONCLUSION:

The correcting of C.O.P. and B.O.P. has far reaching implications for restoring harmony and health to the human body. Particularly when you consider we may be removing blockages that were heretofore undiscovered. As man learns to live in harmony with his inner clock, as he hears that there is indeed "a season for everything and a time for every purpose under heaven", he will perhaps achieve some of the serenity of what Pythagoras called the "Harmony of the Spheres" and maybe even discover that the classical Greeks were right when they ascribed an influence on human affairs to the heavenly bodies. One possible application is yet another rhythm related mechanism which someday may permit human beings to hibernate as do many lower animals. James M. Lyons and John K. Raison at the University of California at Riverside found that the mix of saturated and un-saturated fats in the membranes of individual cells determines the

temperature below which life processes come to a stop. The mix of these fats, according to the investigators is determined in some way by the periodic cycles of working parts within the cell.⁽¹²⁾ There are few conditions under which the average person might wish to retire into hibernation for long periods of time, but such slowing of the life cycle also could extend the total years of life. It also could be important when man in his space quest ventures beyond the solar system in interstellar trips of many years duration.

ACKNOWLEDGEMENT:

My heart felt thanks goes to Huub Verlinden from Holland whose never tiring inspiration led me to put this paper together. His work and research in fact served as the bulk of the procedure outlined in this paper.

SUMMARY OF PROCEDURE FOR FIXING A C.O.P.:

1. Make sure body is computer clear, nothing shows by tugging around navel.
2. Enter hand mode for open points by abducting legs.
3. Enter tug of element which now shows around the navel by again abducting the legs.
4. Search for alarm point that stays strong in the case of a bilateral meridian.
5. Search for alarm point that goes weak in the case of a midline meridian after the patient turns his head to the same side.
6. Continue to search for the specific acupuncture point on that meridian that changes the muscle indicator strength.
7. This is the C.O.P. which now will two point to the area of complaint.
8. The doctor's other hand can be used to narrow down location of complaint by touching the patient with one finger at a time.
9. Correct area of complaint in the conventional way.

SUMMARY OF FINDING AND BOOSTING ENERGY OF A N.O.P.:

1. Clear the C.O.P. first.
2. Enter hand mode for open point by abducting the legs.
3. Enter tug around mouth that weakens indicator muscle by closing and reabducting legs.
4. Search for alarm point for that element.
5. Search for specific point on that meridian that changes indicator muscle.
6. Have patient T.L. this N.O.P. while looking left or right.
7. Left is ying points. Have patient look up for the arm and look down for the leg. Arm is LV-7 or CX-6. Leg is KI-6 or SP-4.
8. Right is yang point. Have patient look up for the arm and look down for the leg. Arm is SI-3 or TW-5. Leg is BL-62 or GB-41.
9. Treat the point that T.L.'s on both sides of the body using the south pole of a magnet.

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**RAYNAUD'S PHENOMENON
A CASE HISTORY**

Cecilia A. Duffy, D.C.

ABSTRACT: Case history study of Raynaud's phenomenon which responded immediately to merid-
ian therapy and adjustment of the spine.

INTRODUCTION: Raynaud's phenomenon is characterized by periodic episodes of pallor (with
coldness and numbness), cyanosis, and rubor (with pain) in the digits precipitated by cold temper-
atures and stress. It is associated with many disease states such as connective tissue and arterial dis-
orders, as well as effects of drugs. If Raynaud's phenomenon occurs for greater than two years and
no other disease state can be determined, it is termed Raynaud's Disease. (1)

CASE REPORT: A 61 year old white male presented under a worker's compensation injury to the
cervical and upper thoracic spine with pain in those areas and the upper arms. On one occasion he
presented with his left middle finger and right ring finger completely white. He had noticed it turning
white while waiting in the treatment room. The fingers were numb and cold to the touch. There was
no history of previous occurrence or medication. The outside temperature was in the teens.

Examination of the pulse points (2) revealed triple heater/circulation sex to have positive ther-
apy localization. There was a left teres minor weak in the clear that strengthened on TL of the TH
alarm point. Interestingly enough, the left TH3 (tonification point) did not TL, but the right TH3
point did. Tapping of the right TH3 produced immediate color return to the right ring finger.

Examination of the spine failed to reveal a subluxation at the L2 level (TH associated point).
(3) T5 (CS associated point) showed a left posterior subluxation. Adjustment had no effect on the
left middle finger color, however, upon Dvorak and Dvorak tapping of the T6 level (4), the left mid-
dle finger regained full color.

There was no hyperemia or pain upon color return to either finger.

Also found on this particular treatment was a spastic colon at the Valves of Houston.

CONCLUSION: This particular patient exhibited signs of Raynaud's phenomenon, however, diagnosis and treatment by Applied Kinesiology techniques gave immediate relief and produced recognizable changes in circulation. These observations would support the hypothesis that Raynaud's phenomenon can be caused by spinal subluxations and meridian imbalances.

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**DIAGNOSIS OF ADRENAL RELATED TMJ DYSFUNCTION VIA
APPLIED KINESIOLOGY TECHNIQUE**

By Daniel H. Duffy, D.C.

ABSTRACT: Weakness of the sartorius/gracilis muscle related to adrenal dysfunction and induced by ligament stretch technique occasionally will manifest only against the stretch of the TMJ ligaments.

Deutsch discovered ligament stretch technique which is demonstrated by weakening of an intact sartorius muscle being caused by the stretch of any ligament in the body. It is a well validated and highly useful technique.

This writer recently discovered that occasionally only stretch of the TMJ ligaments will cause this weakness.

The weakness will not show on a nonrelated (adrenal) muscle and will be negated by all of the factors relating to the adrenal gland which are in need of correction.

Failure of the corrections in my experience can usually be attributed to failure to correct the neurovascular, acupuncture tonification point and posterior neurolymphatic which are sometimes neglected.

Patients demonstrating this finding usually suffer great pain and deviation from the midline on jaw opening and closing. Following activation of all adrenal factors, the jaw will usually open and close with relative ease. This type of patient has been found to require hourly doses of Drenamin, an aqueous extract of adrenal available from Standard Process Labs. Frequently, a prolonged treatment of the neurolymphatic is also necessary to achieve easy opening and closing. This type of patient is often debilitated and although they test well on whole adrenal, they often react with severe abdominal pain, pallor, palpitations, diaphoresis and anxiety, especially if whole adrenal is taken on an empty stomach. The key to the successful treatment of these patients is discovery and removal of the stressor, be it chemical, physical or mental. Hourly doses of Drenamin may be necessary for three to five days. These are taken only during the waking hours.

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SUBSTANCE ABUSE AND ACUTE LOW BACK PAIN

By Daniel H. Duffy, D.C.

ABSTRACT: A Worker's Compensation patient who continually presented with acute low back pain was found to be indulging in daily chemical self abuse. Total restriction of marijuana, alcohol and refined foods, a limit of six cigarettes per day, and hourly administration of a water soluble extract of adrenal substance resulted in remission of symptoms.

A patient with low back pain and sciatica was rendered asymptomatic by Applied Kinesiology technique. The symptoms would return within a week and the patient would again be seen in an acute low back pain antalgia. This scenario repeated itself several times. The patient was then advised to stop all marijuana, alcohol, and refined food and to limit cigarettes to six a day or forfeit his right to treatment. The alternative would be referral to a surgeon. A considerable amount of time was taken in the explanation of the effects of chemical abuse on the physiology.

The patient agreed to participate properly, was again treated by Applied Kinesiology techniques and placed on an hourly dose of Drenamin, an aqueous extract of adrenal available from Standard Process Labs.¹ The patient continued this dose every waking hour for four days and then was gradually reduced to two tablets at meal time.

In my experience, long term chemical abuse associated with pain will not respond unless near total abstinence is maintained. Patients can usually tolerate six cigarettes per day, one after meals and one between meals. Hard drugs, alcohol and refined foods must be totally eliminated. Upon recovery this patient voluntarily switched to a brand of cigarettes he disliked to help in eliminating the habit, once he recognized the magnitude of chemical effects.

Dosing the patient with large amounts of vitamin and mineral products will not solve these problems. It is more a matter of what they need to STOP taking than what they need to take.

Patients of this nature are often encountered who are taking heroic doses of vitamins and minerals in an effort to reduce symptoms and correct problems, often adding to the chemical insult with synthetics.

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INVALIDATION OF A SCREENING TECHNIQUE

By Daniel H. Duffy, D.C., John M. Heidrich, D.C., Cecilia A. Duffy, D.C.

ABSTRACT: The technique of screening for structural, chemical, and electromagnetic dysfunction by advocates of "Clinical Kinesiology" has been found to be totally ineffective in a series of 200 patients.

200 patients were tested in the three arm positions called for in this technique which have been described as relating to the Leonardo Da Vinci pictures depicting man with limbs at various positions. (1)

The most startling result of this validation study was that there was a total absence of response in these attempts. One would expect to find an occasional effect which would necessitate explanation as to true cause. E.G., every once in awhile a category one pelvis is corrected by simply laying on the wedges. There is usually a shred of truth in most ideas wherein the originator notes an apparent cause/effect relationship and goes on to develop a technique associated with the observation. Such was not the case in these trials, not a single patient responded with changes in muscle strength induced by the arm positions. Our suggestion would be to go back to the drawing board and use the quadricep muscle as an indicator, it is much more difficult to overpower. Other doctors have also invalidated this technique. (2)

The senior author of this paper has also made several attempts to validate the "locking in" concept and also the "advance and lock" concept which also seems to have no validity whatsoever. (3) Since much of this material has never been published in the Collected Notes it is difficult to take a crack at it without going to a great deal of time and expense traveling to seminars, etc.

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DURAL TORQUE AND CROSS CRAWL REVERSALS
David P. Engel, D.C.

ABSTRACT: Investigation of the effectiveness of patients' efforts to eliminate a dural torque or cross crawl findings occasionally reveals a reversal of the original findings which requires the patient to reverse his efforts to neutralize the new version of the pattern.

The idea for this paper came about as a result of several incidences where a patient would display a need for either dural torque elimination, requiring the patient to lengthen the stride of one leg to help neutralize the torque, or performing cross crawl with specific head-turning to eliminate the findings. Occasionally, upon checking the patients' progress in eliminating dural torque (DT) or cross crawl (CC) findings, I would observe that the direction which previously eliminated the DT or CC findings would later exaggerate them, which initially caused me to doubt the accuracy of my original findings or suspect I had inadequately addressed the switching phenomena for these patients.

The frequency with which it happened even in the face of these suspicions and greater care in evaluating these and other patients convinced me that the DT and CC phenomena are either more dynamic than I understood them to be or perhaps they were present on different levels of involvement simultaneously. I'm not sure if either suspicion is more valid, but it seems that the body, being so capable of adapting to stresses, could "bury" a clockwise torque beneath a counter-clockwise torque. Conceivably, elimination of the counter-clockwise torque which is "closer to the surface" might allow the body to now display the hidden or deeper clockwise torque pattern. This could also be the case with CC patterns.

Because I found this frequently enough to recognize it (which I

can approximate to be 20% of all DT and 10% of all CC patients), I decided to carefully monitor all DT and CC patients. For all patients not in their initial stages of care or who didn't need to return within two weeks for treatment of other problems, I rescheduled them for what we call a brief check wherein I assess whether they are correctly following my instructions for eliminating their particular pattern or if their pattern has changed. Of course, the instructions are customized to meet their needs to better understand their task or to change their technique according to their pattern changes.

Because this requires only one or two minutes to accomplish, I don't charge for this service. I have found that patients really appreciate this extra attention and more closely adhere to my instructions. They are better impressed with the importance of eliminating DT and CC and doing it correctly when I observe their progress regularly .

In closing I would like to mention that I have seen DT reverse itself in three different patients three different times each. These patients didn't seem to have any particular switching patterns, but each had been a challenge in balancing their pelvis and one had a mild degree of torticollis. Carefully reversing their lengthened stride when appropriate helped to untangle these challenging cases.

SITTING CERVICAL DISC TECHNIQUE ORCERVICAL CATEGORY III

KENNETH S. FEDER, D.C.

ABSTRACT: The following is a presentation of a cervical disc technique which may be applied while the patient is seated, and assists the correction by flexion and extension of the head.

INTRODUCTION: Having experienced much success with the Flexion-Traction Technique for Lumbar disc protrusion discussed in my paper of the 1980 Summer Collected Papers, I was interested in finding a conservative method for treating cervical disc protrusion and thus have borrowed some of the procedures from the Lumbar technique and applied it to the cervical spine.

TEST AND CHALLENGE PROCEDURE: The challenge is performed with the patient seated and the doctor's contact is on the Lamina or Spinouses of the vertebra above and below the suspected cervical disc. The challenge is made by separating first one side of the vertebra complex and then the other. The Spinouses may also be challenged by separation and if a positive challenge exists, a strong indicator muscle will weaken. There are many occasions where a hidden cervical disc exists and the challenge must be performed with the patient in a B.I.D., E.I.D. or gait configuration. One valuable screening aid to assist in finding the hidden disc has been to have the patient, while seated, advance either the right or left leg in a gait pattern while the challenge to the cervical spine is performed.

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DISC CORRECTION PROCEDURE: The patient is seated and the challenge direction which produced indicator muscle weakness is noted to indicate the side of correction. The correction contact is made on the vertebral area which produced the indicator weakness. If the vertebral Lamina produced the challenge weakness, then the doctor's thumbs are positioned on the Lamina of the vertebra above and below the involved disc. If the Spinouses produced the challenge weakness, then the doctor's thumbs are placed on the Spinouses above and below the involved area.

If the challenge of Lamina C5 and C6 indicates a lesion between C5 and C6 on the right, then the correction is as follows: The patient is seated and the doctor takes a contact on the Lamina of C5 and C6 on the right. The patient is instructed to deeply inhale while slowly flexing the head approximately 20°. The flexion may also incorporate a slight lateral movement away from the challenge side. As the patient is flexing the head 20° and breathing in, the doctor is separating the Lamina of C5 and C6 by pressing downward on the Lamina of C6 while holding C5 cephalward. The patient is then instructed to exhale and slowly bring the head back to the upright position. As the patient is bringing the head back to the upright position, the doctor presses the Lamina of C5 upward while holding C6 in a downward position. The pressure on the Lamina is a pumping action as the patient flexes and extends the head. The procedure is repeated approximately 6 times and

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the area is challenged and evaluated for indicator muscle weakness. If the challenge revealed a weakness with the patient in an E.I.D., B.I.D. or gait pattern, the the correction should be made with the patient in a position which is opposite the one that produced the weakness. If, for example, while the patient is seated and a challenge weakness occurs at C5 and C6 with the patient's right leg forward, then the correction is is made at C5 and C6 with the patient's left leg forward. If B.I.D. or E.I.D. produced the weakness, then the correction is made with the body out of distortion or opposite E.I.D.

DISCUSSION: This paper has presented a conservative approach to assisting in the treatment of cervical disc problems. I have found it to be of great value when more vigorous manipulations cannot be made.

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THE DURAL DEFENSE SYSTEM

Carl Ferreri

ABSTRACT

Man, and all the animal kingdom, was created with basic innate survival systems to be able to exist in a hostile environment, and, for the most part, should be able to survive without any outside administrations. The exceptions to this rule are obvious. It is within these survival systems that we can find the answers to all of the problems that befall the human and animal condition. The primitive or innate survival systems of feeding, fight/flight, and reproduction have been recognized as the basic survival systems for all species. In the animal kingdom the fight/flight system becomes operational, at least to some degree, whenever a stressful situation is encountered. The necessity of protecting the central nervous system and its bony protective enclosure from damage is of first priority. To understand this mechanism more fully we must observe what happens when any animal is put in a dangerous or potentially dangerous situation. The jaws are clenched, the muscles are tensed, the skin and fascia contracts and, in the case of the animal, the tail is pulled down between the legs. What this all means and how it relates to health is the topic of this paper. Most of the information to be discussed comes from the authors observations and clinical experience, as little is found in the literature.

INTRODUCTION

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Most of the therapeutics administered throughout the ages have addressed the effects and/or symptoms of a condition and not the real or basic causes of that condition. Of course, we are not talking of gross injury where outside help, to dress a wound or put together a broken or torn part, may be essential to survival, but rather, the aches, pains and dysfunctions, be they somatic or psychosomatic, in every day life. This is still the case regardless of the therapeutic discipline used. Why you have what you have and not the fact that you have it, is, or should be, the important issue. Unfortunately, almost all of the investigators have lost sight of the self healing, self maintenance and self protection survival features built into the body itself. Medicine and its sub-specialties looks to chemicals and surgery, hot and cold and stretching, Chiropractic, looks, for the most part, to the spine for the irritating effects of the sublaxations or fixations that may be found there, hot and cold and now, machines that stretch or electrically stimulate muscles and structures, possibly acupuncture and diet. An assortment of other disciplines look to herbs, exercise, mental concepts, etc. as the necessary therapeutic modality for restoration of health. When all this fails to produce the desired results, new electronics seems to be the looked for answer. All these applications have had some benefit in some cases but none of these really address the main issue. Why do you have what you have?

THE DURAL DEFENSE SYSTEM

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In the authors paper on the Temporo-Mandibular Joint, the jaw involvements were divided in four main areas for consideration. The first consideration was bilateral therapy localization of the T.M.J., using the gluteus medius muscle as the indicator muscle, with no jaw motion or other function. It should be noted that the gluteus medius muscle is the only specifically reactive muscle to the opposite masseter muscle and therefore the only specific reactive muscle to all T.M.J. functions. This fault, if found, was labeled the Universal Jaw. Just as with the Universal Cranial Fault, if this T.M.J. fault is found, a multitude of problems involving structural integrity of everything from the diaphragm down, including the diaphragm, was at stress. This includes the integrity of the pelvic floor muscles and their involvement in bed wetting, prostate and uterine problems, urine and bladder problems and a host of other conditions. The next consideration was the T.M.J. involvement in the neurologic control of the sequencing of the digestive process and the specific digestion of protein materials and was designates the Digestive Jaw. Swallowing, stomach, small and large bowel function and the function of the valves are specifically involved if there is a fault in this area of the mechanism. The reactive muscle activity of the muscles of the T.M.J. in this sequence relates to specific pelvic muscle stability as another important consideration of this T.M.J. function and its relation to health and structural integrity of the back and pelvis. Skipping the designated third function, we proceed to the fourth consideration, the left T.M.J. with no functional activity involved at the time of test, using the opposite gluteus medius muscle. This is the primary weight bearing or sacro-iliac fault, is found in the Cranial Pelvis, and through structural reactivity is most important in dealing with the chronic back problems seen by both

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Chiropractors and Medical Practitioners alike.

The third classification, mentioned above, the Right Jaw Complex, originally designated as the emotional jaw has been reclassified, by the author, as the Primary Defensive Jaw Complex, and is, with its reactive coccygeal mechanism, the topic of this paper. This, as you will see, is most essential in the basic survival of the organism, as it is the the ultimate adrenal activator and the primary mechanism in protecting the skull and more specifically the brain and with the reactive coccygeal mechanism is responsible for the protection of the spine and the spinal cord from injury.

As was discussed earlier, when observing any animal, including man, when threatened, certain things always happen. First the jaw is clenched, activating the very powerful masseter muscles, causing a number of things to then happen. The teeth are locked together so that they are less likely to be damaged in the event of a blow to the face. The contraction of the masseter muscles initiate the contraction of the buccinator muscles. Although the buccinator muscles can be activated independently, in this case there is an automatic contractile response. In the animal the buccinator muscles are tightened to get the lips out of the way, exposing the teeth to frighten the enemy and also allow for use in defense. In man, however, the buccinator muscles are tightened across the teeth to further help protect them from injury.

The contraction of the masseter muscles initiates the contraction of the temporalis muscles. This, as you will see, is most important in establishing a proper defensive situation for survival. It must be remembered that we are dealing with primitive or innate response systems in a hostile environment. Survival in this primitive setting is life or death. The response mechanism

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must deal with this grave possibility innately, automatically and immediately. It has been demonstrated in Applied Kinesiology that contraction of the right temporalis muscle activates an emotional filtering mechanism. When considering the possibility of life or death [non survival] the emotional response must not immobilize us by fear but must be a controlled response. The contraction of the right temporalis muscle, initiated by the contraction of the right masseter muscle, does just that and at the same time controls the increased adrenaline output. At the same time, under the fight/flight circumstance, the chances are, that we may be physically injured. Applied Kinesiology investigation has shown that the contraction of the left masseter/temporalis muscles activates a sensory input filter mechanism, so that pain will not distract us from the business of survival, at that time. We can deal with the pain later.

Examination of the skull and the cranial bones demonstrates two basic kinds of sutures or joint surfaces. There is a serrated interlock type of suture to which the dura is securely anchored and which actually becomes part of the periostium and an overlap slide type with no firm dural attachment. We find the latter on the sphenoid and temporal bones where they articulate with each other and with the frontal and parietal bones. This type of joint allows for greater respiratory motion in maintaining the various neurological and physiological functions of the brain and skull. In examining these sutures it is apparent that they possess little structural integrity in the event of a blow to the skull. If they are separated past their normal physiological motion, unconsciousness will surely follow. In the jungle, so to speak, this is certainly not survival. If we examine the attachments of the temporalis muscles, we see that they are attached to the skull in such a way that they

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overlap these sutures by a wide margin so that contraction of these muscles will form a locking and stabilizing device for these non interlocked sutural mechanisms. This, then establishes a certain structural integrity to the skull from the outside.

The contraction of the masseter muscles initiates the contraction of the pterygoid muscles, both medial and lateral. The contraction of the medial pterygoid muscles tend to hold the jaw [mandible] in place along with the contracted masseter muscles, establishing a certain degree of structural stability from the inside of the jaw, in the case of the pterygoid, and, the outside of the jaw, in the case of the masseter. The contraction of the lateral pterygoid muscles do two very important things at the same time. Being attached to the greater wings of the sphenoid bone on one end and the mandible on the other end, the contraction of the lateral pterygoid muscles also helps to stabilize the mandible and pulls on the greater wings thus restricting motion. This action tends to lock the sphenoid in place. It, therefore, locks the skull from the inside to further protect its structural integrity in the case of a blow to the head. While exerting a downward pull on the greater wings of the sphenoid the external pterygoids tend to bend or flex this very thin bone downward. The bending or flexing of the bone which makes up the main section of the floor of the cranial vault causes a tightening of the dura. This increased dural tension reduces the possibility of motion inside the skull and causes the dura to act as a sort of trampoline effect to give a resilient wall for the brain to bounce against in the event of a blow to the head. This innate protective mechanism is vital to survival and tends to protect the skull and brain from damage under adverse

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circumstances. But, what about the rest of the central nervous system, the spinal cord, and its protector, the spine ?

When we look at the spine we find a unique combination of bones designed to do many things. It encases the spinal cord, supports the body, allows for all sorts of motion and body positions, allows for the passage of nerves from the cord to the body for communication of data, both into and out of, the central nervous system, is a shock absorber and a protector all at the same time. These spinal bones are highly mobile within a circumscribed range of motion. They are moving all the time either in respiratory or in body activity. The contraction of the intrinsic muscles of the spine and the other muscle groups move the spine in varied activities and tend to hold it together at the same time. The intrinsic and extrinsic spinal ligaments are responsible for the primary stability of this structure but it is still subject to injury and on occasion, either luxation or subluxation.

Additional protective mechanisms are also necessary for survival. The fascia and skin are contracted over the entire body causing the hair to stand up to partly scare the enemy by enlarging its size and to act as a cushion to some degree. We see in a animal the greatest evidence of this contraction over the face, head and spine. We can sense this same contraction in ourselves when in danger, our hair stands on end and we get "goose pimples" along our spines. This contraction also helps to push the blood away from the surface to help increase the supply to the muscles and to help prevent heavy bleeding from superficial wounds and again to hold the body and its parts together. These are, for the most part, observable and documented reactions to danger.

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We also observe that the animal pulls his tail between his legs in time of danger. Why? To get the tail out of the way ? Maybe, but more importantly to increase the tension on the spinal dura to protect the cord and to pull the spinal bones together thereby increasing its strength and make it more resistant to subluxation or luxation, by shortening its length. The human animal also has a tail, it is called the coccyx. It does the very same thing that the animal tail does for an animal. Let us look at this marvelous mechanism and how it works.

The dura is a continuous, very strong membrane, encasing the brain and spinal cord. It attaches in the skull as described above and then to the foramen magnum at the base of the skull, attaches to the posterior 2/3 of the ring of the atlas, is then attached to the odontoid process and posterior wall of the body of the axis or second cervical and to the posterior wall of the body of the third cervical vertebrae and then to the posterior wall of the neural canal of the second and possibly third sacral segment and by the filum terminale into the coccyx. The dura mater is composed of criss cross fibers which pull together or constrict in the case of a tube when a stretching tension is applied to it and actually shortens its length. This accomplishes a number of things in relation to defense and/or survival. The cord occupies a very small space within the neural canal in the first place. Approximately 1/5 the available space. This is reduced further when the dura reacts to tension an stress. The dura is firmly attached to the foramen magnum and then the 1st, 2nd and 3rd cervicals. Tension in this area reduces the dimensions of the cord which help protect it in sudden head movements, particularly blows to the head. The dural attachments allow the atlas to be the only somewhat freely movable vertebrae anteriorly in the spine to act as

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a washer so the head can have full range of motion and yet be securely anchored to the body. The next area of dural constriction is at the area of the 7th dorsal vertebrae. This is the pivot area of the spine for motion and allows for more space between the cord and the bones of the spine. The next area of contraction is at the 5th lumbar and below, again for the same reason.

The length of the spine is shortened by the dural tension to bring the articular fascets closer together and slightly compress the discs, which are considered part of the anterior ligaments of the spine, to increase the tensile strength of the entire spine.

The contraction of the coccygeal, levator ani and pubo-coccygeal muscles are responsible for this entire procedure. These are three rather large muscles in relation to the area and in relation to the function attributed to them in the texts. When they contract they pull the coccyx forward which puts tension on the filum terminale and at the same time pulls the apex of the sacrum forward to dramatically increase the dural tension. If we examine the dural attachment to the sacrum we find a rather efficient lever with good mechanical advantage to accomplish this.

The movement of, and position of, the coccyx has been a wonderment to many in the healing arts. Various techniques were established to attempt to make a change or correction in position and in some cases the coccyx was removed to reduce the dural tension and reduce the compressive force on the discs. Little changes were made, primarily because the technique attempted to stretch the muscle or change the tension in the ligaments without removing the cause. These muscles are directly reactive to the lateral pterygoids and are part of the defense or fight/flight innate reaction.

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On examination, unless there is a specific coccegeal problem, the coccyx will only therapy localize in relation to the sphenoid. The patient touches the lateral masses of the sphenoid on one or both sides of the skull and only then will an anterior challenge therapy localize. The body must always be given the proper and specific information so that it can understand and answer the question properly. Correction is made to the coccyx and the related muscles only after the Defensive Jaw Complex is corrected, as this is the initiating factor.

The Right T.M.J. unilateral therapy localization, utilizing the opposite or left gluteus medius muscle [only], is the indicator of the primary defensive jaw complex. This complex is sequentially reactive and is therefore corrected in its specific sequence. Trigger point activity in the belly and insertion of the masseter muscle is advised and then spindle cell activity to the masseter and temporalis muscles on the right to reduce tension as these muscles have become actively hypertonic, that is, actively engaged in an activity from which it cannot release itself [differs from the usual hypertoniscity which renders the muscle weak on stress]. Only after the right masseter and temporalis are normalized will therapy localization then indicate involvement of the left lateral pterygoid. Rub the left lateral pterygoid in the pterygoid fossa. A T.L. then to the left T.M.J. using the opposite or right gluteus medius, will indicate the involvement of the masseter and temporalis on the left. Spindle cell activity of the left masseter and temporalis, again to reduce tension is then instituted. A T.L. will then indicate a right lateral pterygoid involvement. Rubbing of the right lateral pterygoid in the pterygoid fossa will complete this correction. This is a sequential involvement and will only show in this manner. The left T.M.J. is

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now therapy localized using the right gluteus medius. If there is a positive T.L., test for a spheno basilar fault. If there is no spheno basilar fault indicator, then this is the left pain control defensive jaw complex and is the mirror image, and part of, the defensive right jaw complex. Proceed as above starting with the left masseter and temporalis.

The patient then turns his face to the right while therapy localizing the right jaw [the down jaw]. A positive T.L. requires a repeat of the right jaw correction but with the face turned right. Then have patient turn his face to the left, repeat the therapy localization procedure with T.L. to the left T.M.J. [always using the opposite glutus medius muscle as the indicator]. A positive T.L. will require a repeat of the corrective procedure with the face turned to the left starting with the left masseter/temporalis muscles. Next with the face turned right, bend knees and turn to the left putting the patient into a torque position. Have patient T.L.right T.M.J., because legs are in torque position, use other arm as indicator but put gluteus medius into the equasion by touching it. If positive repeat right correction in that position. Repeat for the left T.M.J.

Turn the patient over and proceed with the coccygeal correction. Have patient T.L. lateral masses of sphenoid and a positive T.L. to anterior stress to the coccyx will now show. Correction is made by firm anterior stress activity either by pumping or held activity through 3 to 5 inspirations, while the patient maintains the sphenoid contact. Then have patient turn face first to one side and then the other while contacting the lateral mass of the sphenoid. A positive T.L. will require the coccygeal correction as above with face turned one side then the other. Repeat with legs bent and turned to one side then the other in a torque pattern.

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All of the T.L. activity should be done with eyes open and closed in the light and in the dark, sometimes sitting and many times standing, as this is a primary defense system. The correction activity, then, will be done in any and all modes found.

On the average, the spine of each patient elongates approximately one to one and one half inches immediately, indicating a dramatic change in the spinal structure with the release of the dural tension.

Although this procedure [the defensive T.M.J. complex] can be done as a specific entity it is intended to be part of the complete neural organization technique protocol. The coccygeal release corrections are best done following the defensive T.M.J. complex [*3 above] corrections prior to the category II correction [*4 above], which is the final step in the basic Neural Organization Technique protocol.

This dural system treatment protocol can be done as an entity even if you do not do the N.O.T. corrections, after the switching and lateral occiput/anterior atlas corrections are made. The full lengthening of the spine will not take place until the complete neural organization technique procedures are completed however, indicating that all segments of treatment are ultimately necessary for proper or full treatment..

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PULSE SYNCHRONIZATION

by Terry Franks, D.C.

ABSTRACT: A concept is presented which is a practical and useful method of testing the objectivity and reliability of muscle testing.

For many years doctors using AK have attempted to find and use a variety of methods to cross check the validity of their findings. Most of the standard medical procedures have been tried, along with a wide variety of chiropractic techniques. It is the opinion of this writer that nothing has worked consistently.

In repeated attempts to validate our findings, it appears as if the doctor and patient were not working together. The goal became the uniting of doctor and patient working together to gain the desired healing and understanding; or, as long as the ego¹ of the doctor and the ego of the patient are in a state of separation², there is no truth³. I am, in this paper, using the definitions of ego, separation and truth found in the Course in Miracles as follows:

Ego-CIM-T63 "The ego is the part of the mind that believes your existence is defined by separation."

Separation-CIM-T63 "Everything the ego perceives is a separate whole, without the relationships that imply being."

Truth-CIM-T35 "True perception is the basis for knowledge, but knowing is the affirmation of truth and beyond all perceptions."

The apparent need for truth can only be satisfied by the doctor and the patient becoming united. As with any new procedure, this concept preceded the practical application.

Two concepts stated in the Bible were helpful. In Matthew 18:20 Jesus stated that "Where two or three are gathered in my name, there am I in the midst of them."

One possible way to achieve this is through touching, which occurs between doctor and patient. The second concept was brought to my attention by Dr. Jerry Lalla of Roseville, Minnesota. From The Living Bible we have:

Hebrews 10:19⁴ " And so, dear brothers, now we may walk right into the Holy of Holies where God is, because of the blood of Jesus."

Hebrews 9:20⁵ "This is the blood that marks the beginning of the agreement between you and God, the agreement God commanded me to make with you."

From King James Bible

1 John 5:6⁶ "This is He that came by water and blood, even Jesus Christ; not by water only, but by water and blood. And it is the Spirit that beareth witness, because the Spirit is truth."

It was thought that a probable manifestation of the blood is the pulse. From these concepts it is postulated that the way to unite patient and doctor is touching the pulse.

The procedure that follows is a direct result of the above concepts.

A. Choose what you want to test and set up the parameters.

Example: Hold TL or lock in display with legs.

B. Contact the patients pulse and your own simultaneously.

C. Wait until there is synchronization of at least one heartbeat between the two pulses.

D. Retest your original indicators based on previous findings.

If pulse synchronization changes a muscle response, this is an indication of error or adaptation. If there is no change in muscle response, this is an indication of a primary finding.

It is relatively easy to use this procedure to improve reliability. It will also

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assist the doctor to be more objective with his testing. As we continue to evolve, the manifestation of lovingness within both doctor and patient will assist the healing process.

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1, 2 and 3-The Course in Miracles

4, 5 and 6-The Bible

SPINAL STRUCTURAL FAULTS - CORRELATIONS

Daniel S. Gleeson

INTRODUCTION

Each organ - muscle system has several potential levels of nerve supply. This compilation of findings allows for a more thorough structural correction of our patients.

In an attempt to effect a more dynamic and lasting therapy for our patients, we have used this list of possible spinal structural faults for the past 2 years as a part of our regular screening. Effects have been positive as this list serves as a constant reminder of what else to look for in general and specific cases. This information was compiled from Drs. Walther, Goodheart and Beardall texts.

MUSCLE	ORGAN	SPINAL N	LOVETT	TSLINE	ASSOC POINT	BEARDALL
ABDOMINALS	SMALL INT	T5-12	C6-T6	T6-7	S1	T12
ADDUCTORS	TESTES	L2,3,4,5, S1	OCC,C1, C2,3,4	L5	T4-5	L3
BICEPS BRACHII	STOM	C5,6	T12,L1	-	T12,L1	T6
DELTOID	LUNG	C5,6	T12,L1	T3	T3,4	T3
GLUTEUS MAX	PROSTATE UTERUS	L4,5,S1 GLANDULAR	C1,2	L5	T4-5	L3 OCC
GLUTEUS MED MIN	TESTES OVARIES	L4,5 S1	OCC,C1,2	L5	T4,5	L3
GRACILIS	ADRENAL GLAND	L2,3,4	C2,3,4	T9	T4,5	T9
HAMSTRING	RECTUM	L4,5,S1,2	OCC,C1,2	L4	L4,5	L1
INFRA- SPINATUS	THYMUS	C5-6	T12,L1	C7	L1,2	T1
LATISSIMUS DORSI	PANC	C6,7,8	T10,11, 12	T6	T11,12	T8
LEVATOR SCAP	PARA THYROID	C3,4,5	L1,2,3	-	T3,4	C7
PECTORALIS MAJOR CLAVICULAR	STOM	C5,6,7	T11,12, L1	T5	T12,L1	T6
PECTORALIS MAJOR STERNAL	LIVER	C6,7,8	T10,11, 12	T8	T9	T1
PERONEUS TERTIUS (LONGAS BREVIS)	BLADDER	L4,5,S1	OCC,CL,2	-	L5-S1	L3
POPLITIUS	GALL BLADDER	L4,5,S1	OCC,C1,2	T4	T10,11	T4
PSOAS	KIDNEY	L1,2,3,4	C2,3,4,5	T11,12	L2,3	T10,11
PYRIFORMIS	REPRODUCTIVE	L5,S1,2	OCC,C1	L5	T4,5	L3
QUADRATUS LUMBORUM	APPENDIX	L1,2,3	C3,4,5	L2	L4,5	L2,3

MUSCLE	ORGAN	SPINAL N	LOVETT	TSLINE	ASSOC POINT	BEARDALL
QUADRICEPS	SMALL INT	L2,3,4	C2,3,4	T10	S1	T12
RHOMBOID (MAJ-MIN)	LIVER	C4,5	L1,2	-	T9,10	T5
SARTORIUS	ADRENAL GLAND	L2,3	C3,4	T9	T4,5	T9
SERRATUS ANTICUS	LUNG	C5,6,7	L1,T12,11	T3	T3,4	T3
SCM	SINUSIS	C2,3 SPINAL ACC CRX1	L3,4	T1	T12,L1	T6
SUBSCAP ULARIS	HEART	C5,6	L1,T12	T2	T5,6	T2
SUPRA SPINATUS	BRAIN	C4,5	L12	-	T8,9	C1
TENSOR FACIA LATA	LARGE INT	L4,5,S1	OCC,C1,2	L4	L4,5	L1
TERES MAJOR	SPINE	C5,6,7	L1,T12,11	-	T6,7	C7
TERES	THYROID	C4,5,6	L1,2,T12	-	L1,2	C6
TIBIALIS ANT	BLADDER	L4,5,S1	OCC,C1,2	-	SAC,S1	L3
TIBIALIS POST	ADRENAL	L5,S1	OCC,C1	T9	T4,5	T9
TRAPEZIUS UPPER	EAR EYE	SPINAL ACCESS C2,3,4	L2,3,4	CRAN FAULTS	L2,3	T10, 11
TRAPEZIUS MIDDLE	SPLEEN	SPINAL ACCESS C2,3,4	L2,3,4	T7	T11,12	T8
TRAPEZIUS	SPLEEN	SPINAL ACCESS C2,3,4	L2,3,4	T7	T11,12	T8
TRICEPS BRACHII	PANCREAS	C6,7,8	L1,T12, 11,10	-	T11,12	T8

CONCLUSIONS

My observations as to frequency of findings in difficult cases has been a high indication of Dr. Beardall's listings followed by the Lovett Brother listings then associated point listings.

I have also found that correction of these faults prior to correcting other reflexive findings often eliminates the need to treat the reflexes.

Respectively submitted to I.C.A.K.

Daniel S. Gleeson, DC

POSTERIOR PONS CONTACT HOLD IN THE TREATMENT OF MENTAL/EMOTIONAL DISORDERS

Richard I. Guidry, Jr. D. C.

ABSTRACT: The Posterior Pons contact hold was discovered, while treating the Psychological Division of the Triad of Health. It has proven to be a very effective treatment procedure and is utilized quite often. The following is my observation of this procedure.

HISTORY

This procedure was discovered where I was using a procedure developed and presented by Dr. Alan Beardal and Dr. John Bandy. The hand modes and the Leg Lock were used to designate that we are treating the Mental/Emotional division of the Triad. Please note that you can just use this technique to diagnose and to treat without the hand mode and Leg Lock procedures. They were part of the history of the discovery.

THE CONTACT

The contact is the posterior cervical region from C1 to C7. The challenge is preformed by the patient squeezing this region with his hand. The mere placing of the hand upon this region does not produce a positive TL.

It has been investigated and it was noted that squeezing the posterior cervical spine is not a TL for a vertebral challenge, is not a TL of neck extensors not is it associated to a Reactive Muscle pattern.

THE PROCEDURE

Once the Posterior Pons contact has been made, two point therapy localization is used to find the associated affected system. The most common region found to be associated is the gonadal system, however any system is capable of the two point therapy localization. One quick way to find the second point is to quickly TL the major anterior neurolymphatic regions or the Mental/Emotional points on the anterior frontal eminence. Usually the associated muscles of the neurolymphatic are the weak indicator muscles but there have been times when an unusual muscle is associated. Hold the two contact points until you feel the pulse synchronize. Retest the weak indicator muscle to verify correction.

CLINICAL OBSERVATIONS

The results have been ultimately impressive especially when this procedure is requested in the first two treatments. The consistency of these mind boggling results has compelled me to write this paper. The healing power of this technique is still effective but the subjective and objective observation are less profound when used after the fourth treatment.

The frequency of using the Posterior Pons Mental/Emotional contact procedure is 1 to 1 in relation to all the other mental emotional procedures used at this time. This is significant enough to mention. This procedure can also be used with Dr. Robert Blaich XK-27 procedure with very favorable results.

I have observed that the etiology of this reflex is usually associated with a Mental/Emotional trauma of 1-3 weeks past. The

profound results however originate in a consistently repeated stress pattern or one very significant incident that has overwhelmingly affected this patient.

CONCLUSION

I present this as an observation and as a possibility to better help your patients. Any feedback in any domain that will help improve the performance or understanding of this procedure would be appreciated.

SACRAL CONTACT POINTS AND THE RELATIONSHIP TO THE SPINAL FIXATION COMPLEX

Richard I. Guidry, Jr. D. C.

ABSTRACT: In the Applied Kinesiology Diagnosis of a spinal fixation it is upon occasion found that the appropriate vertebrae are so tightly jammed that manipulation is impossible. This paper concerns a clinical procedure that has consistently demonstrated the ability to relax the hypertonic muscles holding the fixation thereby making the adjustment possible and pain free.

Diagnose the fixation by the standard AK Muscle test then verified by the different forms of palpation, next, have the patient put his hand over the fixated area and proceed to 2 point TL the sacrum to find the correct contact position and vector of force as follows: The majority of the time the contact points are located on the lower 1/2 of the sacrum along the posterior surface of the Lateral Sacral Crest. The right side is much more prevalent than the left. On occasion the right and left side therapy localize simultaneously, when this happens, the standard pattern is one contact point that is located on the upper half and the other on the opposite lower half. These points are usually painful to touch and resembles the Logan Basic technique in relation to the position on the sacrum where the contact points are located.

The direction of the vector of force for the sacrum contact points are next to determine. The vector could be up, down, right, left or anywhere in between, challenge to find out. The

most common finding is a lateral-superior with a slight A-P direction.

You then go to the vertebral fixation and determine the position to hold your other hand. The contact point is usually located on the transverse process of one of the vertebral and is usually in an anterior and slight superior vector. The point is generally the most tender transverse process. There are times when two vertebrae need to be held but they are rare.

Hold the contact points on the sacrum and vertebrae until you feel the synchronized pulse. Please note that you need only apply a very slight force to your vector. As the pulse appear you will notice that the muscles of the fixation and sacrum will relax and the pain of the contact points will disappear. You should be able to perform the necessary spinal manipulation with an audible release and minimal pain.

Clinical observations note that these contact points are not always present. However they are very common and this procedure most effective.

I present this to you as an observation to help increase your efficiency to correction of the spinal fixation complex.

Clinical Correlations of the Adrenal Glands

By: Lawrence V. Hambrick, D.C.

Abstract: A clinical trial was performed to try to determine the primary cause of adrenal dysfunction. The factors tested were: emotional factor, thymus, pancreas, liver, ileocecal valve, and primary respiratory fault.

Introduction

The adrenal glands play an important role in any A.K. practice. If the patient's adrenals are depleted, he can experience fatigue, low energy, tiredness, and lose his reserve power to react adequately to any additional stress.(1) If the patient is in a hyperadrenic state, he may cover up his weak muscle pattern. This patient is handling the stress presented to him, but this is not a desirable condition. Besides taxing the body's reserve capacity, it presents the doctor with a patient who is suffering from one symptom or another, and no weak muscle to verify the problem. This is what led me to check every patient's adrenals at every treatment. After "fixing" them, I would continue with my usual exam and treatment. It became obvious, after "fixing" the adrenals time after time on the same patient, that I wasn't "fixing" anything, but simply treating the symptoms.

If the adrenals react to any stress as Selye proposes, then the adrenal malfunction is only a by-product of some underlying stress and is the body's attempt to handle that stress. It seems necessary to dig further into the patient's condition to find the real "cause" of the stress reaction. By getting closer to the "cause" of the adrenal malfunction, we should be able to be more effective with our treatment.

But, where do we start? Which side of the triad of health is causing the major problem -- or is it a combination of factors? Is the patient handling the stress and in the adaptive stage; or is he weakening to the

stress and in the exhaustive stage? This study will attempt to answer these questions.

Procedure

I used the first 25 patients that came into my office, who had a positive therapy localization to the adrenal glands. Once the positive TL was located, I checked for cranial problems by testing a strong indicator muscle (usually the PMC) on all phases of respiration. This was done to enhance the reproducibility of the muscle testing.(2)

In order to determine if the patient was in the hypo or hyper adrenic state, I traced the triple warmer meridian with my hand so as to increase the energy - that is, in the direction of energy flow. If this cancelled the adrenal TL, the patient was suspected to be in a hypo-adrenic stage. Again, I traced the triple warmer meridian, but in a direction opposite the energy flow, so as to decrease the energy. If this cancelled the positive adrenal TL, the patient was thought to be in a hyper-adrenic state.

Once it was determined whether the patient was hyper or hypo adrenic, I attempted to find the underlying "cause". While the doctor maintained a TL to the adrenals, the patient Tled to the emotional NV to see if this cancelled the adrenal TL. If it did, an emotional factor was thought to play a role in the patient's stress syndrome. This process was repeated with the patient therapy localizing to the: Thymus - to detect weakness in the immune system, Pancreas NL - for sugar handling problems, Liver - for toxicity or allergy, Ileocecal Valve.(I did not keep statistics whether the I.C.V. needed to be opened or closed.)

See Table 1 for the tabulated results.

Results

Of the 25 patients tested, 80% were in a hypoadrenic condition and

20% in a hyperadrenic state. The emotional component was positive in 60% of the patients. This high percentage surprised me because none of the patients appeared to have any overt emotional strain. It is possible that this percentage is high due to the actual Tling the sinuses - therefore, giving a false positive result. The thymus was positive on 40% of the patients, the pancreas on 48%, the liver on 28%, and the I.C.V. on 32%. Inspiration cancelled the adrenal TL in 64% of the cases. 84% of the patients had more than one reflex contributing to the adrenal dysfunction.

Clinically, once I found what was causing the adrenal TL, I treated the reflexes and/or vertebral segment for that organ and usually the adrenal TL was corrected. Very seldom did I treat the adrenals directly. This makes me feel that I was getting closer to the prime "cause" of the adrenal response.

Suggestions and comments are welcome, so please feel free to write.

References:

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No.	Greater than one reflexes	TL		Emotional	Thymus	Pancreas		Liver	ICV	Respiratory
		Adrenals	↓			NL	+			
1	+	↓	↓	+	-	-	-	-	-	+
2	-	↓	↓	-	-	-	-	-	-	+
3	+	↓	↓	+	+	-	-	+	-	-
4	+	↓	↓	+	-	-	-	+	-	-
5	-	↓	↓	+	-	-	-	-	-	+
6	+	↓	↓	-	+	-	-	-	+	+
7	+	↓	↓	+	-	+	-	-	-	+
8	+	↓	↓	+	-	+	-	-	-	+
9	-	↓	↓	+	-	-	-	-	-	-
10	+	↓	↓	-	+	-	-	-	-	+
11	+	↓	↓	+	+	-	-	-	-	+
12	+	↓	↓	-	+	+	-	+	-	+
13	+	↓	↓	+	-	+	-	-	-	+
14	+	↓	↓	+	+	+	-	-	-	+
15	+	↓	↓	-	+	+	-	-	-	+
16	+	↓	↓	-	+	+	-	-	-	+
17	+	↓	↓	+	+	+	-	+	+	+
18	+	↓	↓	+	-	+	-	+	+	-
19	+	↓	↓	-	+	+	-	-	-	-
20	+	↓	↓	-	+	+	-	+	-	+
21	+	↓	↓	-	+	+	-	+	-	-
22	-	↓	↓	+	-	-	-	-	-	-
23	+	↓	↓	-	-	-	-	+	-	+
24	+	↓	↓	+	-	+	-	-	+	+
25	+	↓	↓	+	-	-	-	-	+	+

Results: #	%	#	%	#	%	#	%	#	%	#	%
21+	84%	20*	80%-Hypo	15+	60%	10+	40%	12+	48%	7+	28%
4-	16%	5*	20%-Hyper	10-	40%	15-	60%	13-	52%	18-	72%
										8+	32%
										17-	68%
										16+	64%
										9-	36%

THERAPY LOCALIZATION WITH EYES OPEN/EYES CLOSED

DARREL W. HESTDALEN, D.C.

ABSTRACT:

A consistent affect of eyes open or eyes closed on therapy localization has been observed. The type of treatment required to correct the cause of the positive therapy localization varies with the state of the eyes that is associated with the therapy localization. The affect has been found with Gamma 1 and 2 muscle testing also.

INTRODUCTION

The affect of eyes open/eyes closed(EO/ECL) on neuromuscular testing has been observed and reported by Goodheart, Beardall, Franks, Ferreri, et al.

The observations include the Neuropeptidal Enteric Holographic Technique, biocomputer clearing techniques, holographic clearing techniques, and neurological dysorganization related to learning disabilities.

DISCUSSION

In treating patients, I have observed a positive therapy localization(TL) become negative and then positive again. I had thought that I had been distracted or the patient had moved the contact, etc.. Further observation revealed a consistent pattern that the TL is influenced by the EO or ECL position.

In evaluating difficult recurring problems I have found TL to be negative but dysfunction is still obvious. TL

with EO/ECL has often uncovered further problems and lead to a satisfactory resolution of the dysfunction.

Beardall referred to EO as the yang state and the ECL as the yin state. The appropriate correction for the yang state is a firm brisk adjustment whereas the yin state requires a gentle slow correction.

I have found the EO open findings generally demonstrate an inspiratory assist and the ECL demonstrate an expiratory assist. Beardall also stated this pattern.

In a Gamma 2 psoas weakness involving an occipital subluxation, I have found that the EO position responds to a brisk occipital adjustment while the ECL position correlates with the tilt pattern of PRYT and the indicated gentle correction.

The Toftness technique utilizes a gentle force held for a length of time. ECL-TL has demonstrate a variance in pressure and vector required to abolish the poistive TL. This was determined by using different force and direction with a static challenge.

It is my opinion that the change in TL with EO/ECL indicates a front brain-hind brain and holographic involvement of the nervous system. In working through complex and difficult cases I have observed the EO/ECL pattern change and reveal new aspects of the problem and indicate a different type of therapy. This can occur during the same treatment session or on subsequent sessions.

SUMMARY

A consistent affect of EO/ECL on TL has been observed in the examination and treatment of hundreds of patients. It appears that the evaluation of an area with therapy localization needs to be done with the patient in both the eyes open and the eyes closed position.

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initiate pressure and continuing the test as answering pressure is felt from the patient.

As mentioned above, I regarded this concept as merely an interesting application of neurophysiology until the concepts of spinal balancing were presented in the summer, 1987 papers ². In addition to being a wonderful technique in and of itself, the spinal balancing paper contained some very practical applications of gamma 2 muscle testing that, although obvious, had just not occurred to me before. Probably the most profound concept to my mind was that a muscle exhibiting gamma 2 weakness was responding to a systemic problem rather than a local one. Thus we now have a great method for finding major or key problems. We have a direct way of asking the body "What should I fix first?". I feel that the discovery of gamma 2 muscle testing will have a profound effect on the course of applied kinesiology. It has already changed the way I practice.

One of the ways in which gamma 2 muscle testing has changed my practice is by allowing me a new method of spinal prioritizing (yes, I'm finally going to get to the technique this paper is supposed to be about). The basic technique Schmitt presented for spinal balancing involved finding a muscle that exhibited a gamma 2 weakness and use that as an indicator to look for the systemic factors causing that weakness. I wondered if it would be possible to reverse this process. Certain problems create systemic disturbances. It seemed to me that if a challenge was made to an area that was producing a systemic disturbance, it might produce a gamma 2 weakness in a previously strong muscle. I have found this to be the case. As the title of this paper implies, the area which I have applied this to most frequently is the vertebral subluxation.

Although subluxations may be viewed as more or less local problems, affecting primarily the distribution of a single nerve root, the inter-communication of spinal nerves as well as the affect of aberrant afferent input to the central nervous system create an obvious potential for systemic consequences to any vertebral subluxation. I found that, starting with a hamstring that was strong on both gamma 1 and gamma 2 testing, I could often find one (sometimes two) vertebral subluxations during a patient visit that would evoke a gamma 2 weakness in that previously strong hamstring muscle. I reasoned that if a subluxation was showing evidence of causing systemic disturbance that it should be cleared first so that the spine could then be re-evaluated free of this systemic influence. This is somewhat similar to the idea behind Schmitts' spinal balancing....to make sure that what you're adjusting is not simply a compensation for a more primary, systemic fault or condition.

To date, I have been using this technique for eight months on over 3,000 patient trials. My basic procedure is to go through the entire spine from C1 through coccyx including pelvic categories and sacral wobble. In about 60% of these cases the more standard spinal analysis is preceded by Schmitts' spinal balancing ². I first analyse the spine using palpation, therapy localization and vertebral challenge against a gamma 1 muscle test. I then instruct the patient that "We're now going to do a different type of testing that will allow me to find the key areas of nerve interference. I want you to start the test by pushing against my hand with your ankle." For this gamma 2 testing I continue using the same hamstring muscle I have been using earlier. I usually do a preliminary test having the patient initiate the hamstring test. Sometimes patients have difficulty figuring out exactly what I want of them and it's a good idea to have the procedure established

The Gamma 2 Vertebral Challenge
a method of spinal prioritization

by

James D. W. Hogg, D.C.

Abstract: The concept of gamma 2 muscle testing as presented by Walter Schmitt, D.C. is extrapolated upon to induce a gamma 2 weakness in an otherwise intact indicator muscle. A method is presented which allows the practitioner to discover areas of spinal nerve interference (subluxation) that are creating aberration at a systemic or supraspinal level.

As you may be aware, a new concept in the art and science of muscle testing was introduced in the Winter edition of the 1985 collected papers ¹. This concept which has become known as "gamma 2" vs "gamma 1" muscle testing was very interesting to me at the time it was presented. It went a long way towards explaining discrepancies that had been noted between machine vs manual muscle testing and many differences in results noted on manual muscle testing between two doctors equally trained and competent in applied kinesiology. A brief overview of the basic concepts contained in that paper are contained in the following three paragraphs.

One of the many things I admire about Wally Schmitt is his ability to take well established principles of biochemistry and neurophysiology and translate those principles into a muscle testing format that is clinically useable and effective. In this he follows in the tradition of our fearless leader. The concept of gamma 2 muscle testing arose out of Wallys' study of the neurophysiology of the neuromuscular spindle apparatus. The spindle cells monitor both the amount and the rate of stretch of a muscle. Thus one aspect of the spindle monitors the absolute length of the muscle while another monitors the rate at which that length is changing. The part of the spindle cell which monitors the absolute (or static) length of the muscle is referred to as the nuclear chain. The part of the spindle cell which

monitors the (dynamic) rate of change of the muscle length is referred to as the nuclear bag. Gamma 1 motorneurons supply the intrafusal fibers of the nuclear bag. Gamma 2 motorneurons supply the intrafusal fibers of the nuclear chain. To quote Schmitt, "Factors which affect gamma 2 motorneuron activity originate in the supraspinal centers" while "...factors which alter gamma 1 motorneuron activity are from sensory receptors which originate at spinal levels." As such, the gamma 1 loop is said to relate to spinal or local level phenomena, while the gamma 2 pathway is considered relevant to supraspinal or systemic level phenomena.

An isometric or concentric contraction as when a patient would push against the pad of a dynamometer, comparative muscle tester or when the patient initiates the muscle test by pushing against the stationary arm of the testing doctor is considered a static or "gamma 2" test. An eccentric contraction as when a patient would have to quickly adapt to the testing pressure initiated by the doctor is considered a dynamic or "gamma 1" test.

To recap my recap, the muscle test that begins as a static, patient initiated test will usually yield information about systemic or supraspinal conditions while the muscle test that begins as a dynamic, doctor initiated test will usually yield information about local or spinal level conditions. To perform a gamma 2 test you would simply instruct the patient to "push hard into my hand" without providing the starting pressure as most of us are accustomed. Once a good, strong pressure is felt from the patient, the test is performed as usual, feeling for weakness as opposed to a good "lock up". If the muscle goes weak under these conditions, it will indicate a systemic or supraspinal problem as a cause of that muscle weakness. The gamma 1 muscle test is performed as most of us are used to by having the doctor

before going on to the next step. I then go back and rechallenge the vertebrae that tested positive earlier, the difference being that this time I have the patient initiate the hamstring test after each challenge thus allowing me to access the effect of the challenge at a supraspinal level. Most of the vertebrae that were previously positive show no response to the "gamma 2 challenge" (eg. the strong hamstring stays strong) but usually one or two vertebral levels will elicit a weakness on the gamma 2 test after challenge. The most common finding is that there will be only one vertebral level which shows positive to the gamma 2 challenge. In over 90% of the cases, adjusting the subluxation that shows a positive gamma 2 challenge will result in a negation of all positive vertebral challenges. In other words, after finding the vertebra that shows a gamma 2 response and adjusting it, I will then go back and re-test the vertebrae that previously showed a gamma I response and find that these levels no longer will challenge or TL. In addition, positive Dierifield findings will clear along with a concomitant improvement in range of motion and symptomology. My theory is that adjusting the "key" vertebra allows the rest of the spine to clear itself of nerve interference in a somato-somato reflex manner.

As I mentioned, the most common finding is that there will be only one vertebra that will show a positive response to the gamma 2 challenge and correcting the subluxation at that level clears the spine of positive findings. I have noted some exceptions. Sometimes there will be no vertebrae that show a positive gamma 2 challenge. In these cases I usually (95+%) I find that there is an uncorrected cranial or lower extremity (usually foot) problem that is primary to any of the spinal problems. After correcting the extremity or cranial problem I re-examine the spine. I then find that either the spine has cleared to both gamma 1 and 2 challenge or

that one of the remaining subluxations will now show a positive gamma 2 challenge and that correcting that subluxation will clear all gamma 1 and 2 spinal findings. The other exception is that occasionally I will find two vertebral levels that will show a positive gamma 2 challenge response. In these cases I simply adjust both vertebrae and the rest of the spine will then test clear.

SUMMARY

The gamma 2 challenge is a logical extension of the outstanding work Schmitt has done in the area of functional neurology and spinal balance. It is a technique that allows me to quickly determine spinal priority using a system that is based in well accepted and established neurological principles. It also allows me (usually) to clear the entire spine with one adjustment. This has a slight time advantage (this advantage could be improved once the technique becomes well tested enough to allow me to simply adjust the first subluxation that shows a gamma 2 challenge and be confident that the spine is clear) but more importantly it allows me to input force into the patients' body only where I'm sure it's needed, allowing a greater benefit to input ratio. I feel that the more healing we can we can allow the bodys' marvelous innate homeostatic mechanism to handle (as opposed to resetting numerous systems manually) the better the results we will obtain. Since I have added the gamma 2 spinal challenge to my technique armamentarium I have observed a gratifying improvement in speed of patient recovery and holding time of my adjustments.

In the concepts behind gamma 2 pathways and testing Schmitt has provided us with the tip of another wonderful diagnostic iceberg, the

exploration of which is sure to provide powerful tools for exploring the wonder and mystery of the human body.

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THYMUS AND VITAMIN C LINGUAL TESTS

Alex P. Karpowicz, D.C., I.C.A.K.

ABSTRACT:

The purpose of this test was to determine if there was a relationship between a positive Lingual Vitamin C test and a Thymus gland involvement. Forty-eight patients were involved, 40 tested normal and 8 were abnormal.

INTRODUCTION:

As we all know the Thymus gland is an important part of our bodies defense. With winter approaching I was interested to see if there was a relationship between an abnormal Vitamin C disappearance time or a positive Lingual Ascorbic Acid test and an involvement of the Thymus gland. We used the standard Lingual Ascorbic Acid test as recommended previously by Dr. George Goodheart. A reagent is mixed in a test bottle and a drop is placed on the tongue of the patient which has previously been dried with the papillae erect with a cotton swab. A stop watch timer is utilized to check and see if the appearance time is 20 seconds or under which would be normal or over 20 seconds going up to 60 seconds which would indicate a relative deficiency of Vitamin C in the person's body.

RESULTS:

Forty-eight patients were tested of which 40 reacted normal, 8 were abnormal. To test the Thymus we used a strong Infraspinatus muscle, therapy localizing against the Thymus which would then weaken in those patients with an over 20 second disappearance time. In all eight positive cases the introduction of a 300 milligram chewable wafer of Vitamin C on the tongue caused the Infraspinatus to strenghten while the Thymus gland was being therapy localized.

SUMMARY:

In conclusion this limited study seemed to indicate a definite relationship between an abnormal or deficient amount of Vitamin C in a persons body and a Thymus gland disfunction indicating a need for Vitamin C. Previously I had wondered why some patients given Vitamin C for colds as a preventative measure responded very well and other patients that it didn't seem to affect at all. Possibly this method and relationship is a means or part of a means to help determine which people are prone to be helped by Vitamin C get over colds quicker and in fact prevent colds.

ANOTHER FACTOR INVOLVING
JOINT INTEGRITY

K.E. KIRCHNER D.C.

ABSTRACT: A discussion of a simple technique used in helping reduce the condition of ligamentous laxity.

As Chiropractors, we all have ran into patients that won't "hold" adjustments. The causes are many and varied, including occupational stresses, poor posture, faulty diets, general stress related environmental stimulants, ovids, other medications, etc. A great many of these patients when tested will show the condition of ligamentous laxity (abnormal elasticity of the ligaments).

As we are all aware, the only time a ligament should demonstrate elasticity is in the last three to four months of pregnancy. At this time the open ovarian follicle of the pregnancy secretes a hormone "relaxin" which produces an elasticity of the ligaments to assist in delivery of the fetus.

We have treated this condition in many ways with nutrition, usually magnesium and or bone meal in some combination with other minerals. This will reduce the condition of ligamentous

laxity in three to six months. In some patients we find that hypoadrenia is present and support of the adrenals will help the condition of ligamentous laxity. We have treated several hundred vegetarians over the years and without exception, patients who have maintained a vegetarian diet for five to eight years will usually demonstrate ligamentous laxity. This I feel is due to an increase in the alkaline base resulting from the lack of "fire foods" in the diet. This increase in alkalinity alters the renal threshold (set point) and allows necessary components of the blood to be filtered out thru the kidneys. We find a very high percentage of vegetarians with the problem of ligamentous laxity.

A short time ago we attended a class on advanced Acupuncture. (Instructor-Dr. John Amaro). He had recently returned from China where a "family" master of Acupuncture had shared several points with indications for treatment with him. In reading the notes I noticed that SP21, "the great Luo point", was listed as causing general joint weakness (see insert). Since my son, Darren, was with me and has had a chronic ligamentous laxity problem for years, I decided to test the premise and had him therapy localize SP21 while challenging the ligament of the 1st. digets. It immediately lost the ligamentous laxity it had always shown. We then tried to stabilize the Point (SP21) bilateral with electrical impulses, lazer, shiatsu, and etc. With each procedure tried, the points would stablilize but

with temporal tap would reoccur.

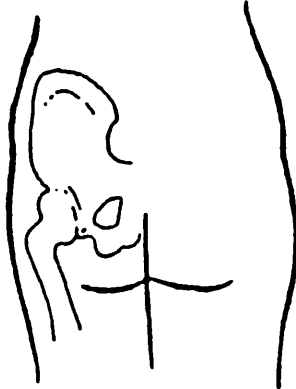
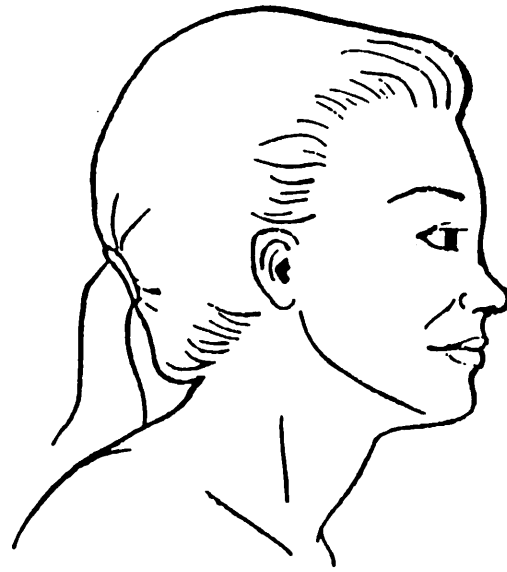
The next day I decided to demonstrate the indications for using this point. I had my son Darren (a known problem) as a subject. We demonstrated the problem of ligamentous laxity and having Darren therapy localize SP21 we demonstrated the correction for the problem. We then described the problems of stabilizing this point. Dr. David Walther was in the class and suggested that we try tapping SP21 bilateral at a slow rate, about 1 hz. for 30 to 40 seconds. This has proved to be the best stabilization to date.

Conclusions

I commend this procedure to all of our practitioners of Applied Kinesiology. While I feel that nutritional support is needed to completely correct the problem of ligamentous laxity, the procedure of tapping SP21 will greatly enhance the correction of this problem. I must apologize for the small statistical base this information is based on. Due to the time factor I have only had the opportunity to test 56 new patients in 20 days and 600 old patients in 20 days time. I have found that the procedure works in a very high percentage of cases to date.

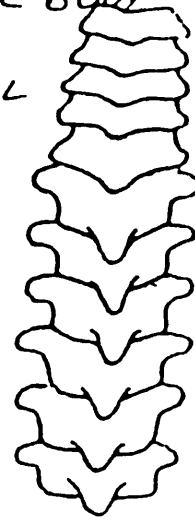
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THE GREAT LUO POINT



* DIFFUSED PAINS SPREADING
OVER THE WHOLE BODY

- LOOSENING OF ALL
ARTICULATIONS
̄ WEAKNESS AND
LOSS OF STRENGTH
IN ALL JOINTS.



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HOLOGRAPHIC CLEARING AS AN APPLICATION OF THE PHASE CONJUGATE

MIRROR CONCEPT

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Abstract: The function of phase conjugate mirrors provides insights into a possible mechanism used in the holographic techniques. A technique is described which is a simple method of removing adaptation so as to cause the body to display more clearly its primary stress patterns.

PHASE CONJUGATE MIRRORS

In 1972, a group of Moscow researchers made a remarkable observation. They passed a laser beam through a plate of frosted glass. The resultant beam, which had become somewhat scattered, was then passed into a cylinder of highly compressed methane gas. The methane gas acted as a mirror with some intriguing properties. It reflected the beam back through the plate of frosted glass, and when it emerged, it had regained its coherent properties.

This type of mirror is called a phase-conjugate mirror, and this phenomenon has been described as time-reversed light, which refers to the fact that a phase conjugate mirror will cause light which enters it to retrace its pathway exactly, and as it does so any aberrations which have been introduced by the medium through which it has been transmitted are then eliminated.

ADAPTATION

The mechanism described above has direct application to the concept of adaptation.

Adaptation is a term which was used by Dr. Alan Beardall to denote the protective mechanism by which an organism deals with a stress which it does not have the physiological reserves to deal with or an injury which it does not presently have the needed components available for repair. Rather than leave the involved tissue under an unacceptable level of stress locally, the body attempts to spread out the stress over several systems so that the organism as a whole can handle easily what the local tissue would be unable to deal with. This adaptive process also prevents the central nervous system from being constantly barraged with noxious stimuli which would overwhelm it.

An example of this would be the dietary use of an incomplete food such as refined sugar. It has long been noticed that with many people, when white sugar is placed in the mouth, a previously intact indicator which has resonance with carbohydrate metabolism such as the latissimus dorsi muscle weakens. However, some people who are utterly abusive of this substance on a routine basis will not display this weakness reaction. This is because the routine use of this substance has induced a defensive adaptation reaction which effectively shifts the stress induced by the offensive agent onto other stress-buffering mechanisms such as supportive aspects of liver and adrenal function as well as altered autonomic activity.

Adaptation mechanisms can and routinely do obscure sight of the true underlying lesions be they structural, biochemical, or electromagnetic in origin. This is the bane of the practitioner

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attempting to diagnose aided by Applied Kinesiology procedures. For this reason, it has been necessary to devise numerous techniques of various degrees of sophistication in order to efficiently read through the superficial display of data which the basic AK exam reveals and grasp an understanding of the strategy that the body has utilized in order to deal with injuries, environmental stresses, and constitutional weaknesses.

SEGMENTATION

If the stress of an injury or another noxious influence causes an adaptation response, and if the body is unable to muster adequate defensive responses, and if proper therapy is not provided to either remove the noxious influence or to strengthen the body's reserves, then a segmentation response tends to occur.

Segmentation refers to the status that has been achieved when the body has put the problem area on hold and essentially insulated itself from the constant noxious impulses generated from that area. Segmentation, like adaptation, is necessary for the survival of the organism as a whole. However, it creates difficulty for the AK examiner in two ways.

First, segmentation makes it very difficult for the examiner to find information in the AK exam related to the patient's real problems. Second and perhaps even more importantly, segmentation causes the organism to shift to a level of function which is out of phase with the electromagnetic impulses which created and which sustain the body. Thus, the body loses its ability to refer to the original blueprints for its repair, and corrections made by the practitioner under these circumstances are of far less significance

because the reference point of optimum function has been lost.

RELATION TO HOLOGRAPHIC TECHNIQUES

The following technique, while not the most far-reaching in effect that can be devised, is presented because it is simple and also it gives the practitioner a chance to observe the shift that occurs in examination findings as the body retrieves a portion of the information from segmented areas.

The procedure is as follows:

1- Perform an examination including the testing of enough muscles to get an overview of the patient's overall kinetic status, a scan for therapy localizations, leg length and arm length measurements. Record findings.

2- Instruct the patient to image themselves in a state of optimum health, or alternately, select their area of major complaint or non-responsive complaint and have them image themselves as functioning free of that particular complaint. Have the patient perform this maneuver both with the eyes open and with the eyes closed. Test indicator muscles during both phases of this challenge. A positive finding is a change in muscle status which occurs in only one of the phases, either eyes open or eyes closed.

3A- If muscle status changed while imaging with the eyes open, have the patient maintain this challenge while you scan for areas of positive therapy localization. Typically, you will find an area of therapy localization over the occipital cortex on one or both sides, and often over the area of complaint and some spinal levels.

3B- If muscle status changed with the eyes closed, have the patient continue to perform the challenge while you scan for areas

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of positive therapy localization. Typically you will find a positive TL over one or both sides of the frontal cortex, and perhaps over the area of complaint and some spinal levels.

4A- If positive challenge was with eyes open, then tap the areas of diagnosed therapy localization with a rapid tonifying percussion while the patient continues their visualization but with the eyes closed.

4B- If positive challenge was with eyes closed, then tap the areas of positive therapy localization with a rapid tonifying percussion while the patient continues their visualization but with the eyes open.

5- Continue percussion until the kinetic status changes to an overall weakness.

6- Perform a computer advance and lock maneuver. For this maneuver, start with the patient supine and with the legs together. Have the patient close the eyes, and with the eyes closed the doctor (using a contact at the patient's ankles) externally rotates both femurs, then abducts the legs till the feet are at the edges of the table, then the femurs are brought into neutral rotation and left in abduction. Now have the patient open their eyes. With eyes open, the doctor momentarily brings the legs back together, then repeats the external rotation and abduction maneuver.

7- Repeat the original examination and note any variation from the original findings. Typically, the examination will now display findings consistent with their more chronic or prolonged complaints, unless the present stress is of sufficient intensity as to require direct intervention at this time.

DISCUSSION

Adaptation and segmentation are phenomena which deserve respect in that they are effective survival mechanisms. Techniques used to retrieve information stored in segmentation or to which the body has adapted are recommended only for the experienced practitioner who is capable of dealing with what the body brings up to the surface as a result. In other words, it is possible to reintroduce the acute phase of a condition that the patient had at one time and that seemed to go away by itself or with treatment. On the other hand, the body is often seen to automatically handle long-standing conditions when they are retrieved from segmentation if the overall status of the patient is better than that at the time that the condition was put on hold, in that now the patient may well have all or most of the needed components for repair to take place and not had those components at the time that segmentation took place.

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A PRELIMINARY REPORT ON
A POSSIBLE CORRECTION OF
POOR VISUAL ACUITY

by DAVID A. KUBICEK, D.C.

ABSTRACT

Ideas regarding the causes and possible corrections of poor visual acuity are investigated. Preliminary results, in developing a procedure utilizing manual muscle testing to determine a cause and treatment, are discussed.

INTRODUCTION

After years of personal experiences and observation, this author has come to the conclusion that poor visual acuity, primarily myopia and hyperopia, are caused by some kind of genetic defect in one or more biochemical pathways that regulates parasympathetic and sympathetic activity, and that by providing the proper nutrients, possibly for an extended period of time to compensate for the genetic defect, one can improve vision.

The poor visual acuity conditions, dealt with in this paper, will all be ones that developed sometime after birth with gradual onset and increasing severity.

This author comes from a family of six children. Three of them have physical characteristics like their father; short, stocky and all with perfect vision. The other three, of which this author is one, have physical characteristics like their mother; tall,

thin, and all with severe myopia. The three of us with visual problems have almost identical prescriptions and began to develop the myopia at about the same age.

It seems that at some point the body's nutritional reserves can no longer compensate for the genetic deficiency. They are eventually depleted and dysfunction begins. Not only may these people have a genetic defect in maintaining a proper parasympathetic and sympathetic balance, but it may be that this imbalance is also more apt to be exhibited in the structures of the eye, as opposed to someone who may exhibit the imbalance in other organs under control of the autonomic system. For example: digestive disturbances, heart conditions or lung disorders.

A PBS television program indirectly helped to solidify this author's conclusions. The purpose of the program was to discuss whether behavior was genetically or environmentally determined. The part that interested this author was when the researchers were interviewing twins, who had been separated at birth and reunited approximately 50 years later. The twins were wearing corrective lens and were asked to trade them one for the other. Much to this author's delight, they could see clearly through each others lens and had nearly identical prescriptions.

DISCUSSION

The two main types of visual acuity problems are myopia (near-sightedness) and hyperopia (far-sightedness).

In myopia the lens of the eye focuses the light rays, which

makes up the visual image, in front of the retina. A negative diopter concave corrective lens that diverges the light is needed in order to focus the image farther back onto the retina for normal vision.

In hyperopia, the lens of the eye focuses the light behind the retina. A positive diopter convex corrective lens that converges the light is needed in order to focus the image farther forward onto the retina.

A diopter is a measurement of a lens ability to diverge or converge light rays.

The lens of the eye has a 15 diopter capability, which should be more than enough to compensate for changes in the shape of the eye itself, excluding major trauma to the head creating severe cranial distortion. One theory regarding myopia is that the eye itself elongates past the point of the lens ability to compensate for it and therefore must focus the image in front of the retina. The elongation is thought to occur by cranial distortion or extraocular muscle weakness. The cranial fault etiology does not seem to fit the gradual onset type of visual disturbances described in the introduction. The increasing extraocular muscle weakness would fit the model, however, this author can not understand why those people with myopia would use their extraocular muscles any less than those with perfect vision. So, in this author's opinion the shape of the eye is a relatively fixed constant, neither elongating or contracting while the process of myopia or hyperopia develops.

The only other structure of the eye with refractive power,

the ability to bend light, is the cornea. Dr. John Rogers an Optometrist described a study that measured the corneal convexity of children with normal vision and compared those measurements to measurements taken of those same children who later developed myopia. The measurements were identical. There appeared to be no change in corneal shape.¹ This proved that the refractive power of the cornea is also a fixed constant.

If the shape of the cornea and the eye itself is assumed to remain constant during the development of myopia and hyperopia, then that leaves only the lens, capable of being the cause of visual dysfunction.

The lens is a transparent structure with an elastic capsule that would assume a spherical shape if not for its ligamentous attachments, that places tension on the lens and therefore decreases its convexity. The ligaments then attach to the ciliary muscle which is a ring of multiunit smooth muscles.

Smooth muscles are divided into two groups: Multiunit and Visceral.

Multiunit smooth muscles consist of discrete or individual muscle fibers; each fiber acting independently and innervated by a single nerve ending as opposed to the visceral smooth muscles which consist of sheets or bundles of fibers that contract in groups. The most important difference is that multiunits are controlled almost entirely by nervous stimulation as opposed to visceral, which are controlled by nervous stimulation, local tissue factors and hormonal action.² This helps to narrow the

possible factors involved in the dysfunction of the lens mechanism.

The ciliary muscle is innervated by both parasympathetic and sympathetic nerve fibers. Parasympathetic stimulation causes the muscles to contract which decreases the tension of the ligaments and allows the lens to assume a more convex or spherical shape. This increases the lens's refractive power, increasing its ability to focus near objects. On the other hand, the sympathetic inhibits the ciliary muscle, which increases the tension of the ligaments and forces the lens to assume a more oval or flattened shape. This decreases the lens's refractive power, increasing its ability to focus distant objects.

No mechanism exists by which the eye can decrease the refractive power or strength of its lens to less than that which exists when the ciliary muscle is completely relaxed.³ But suppose a dysfunction in the lens mechanism did not allow the ciliary to relax. In this case the lens would not flatten to its maximum, therefore, myopia the inability to focus distant objects would occur. Smooth muscles have a specific characteristic, called "tonus contraction",⁴ that allows the muscle to contract indefinitely without fatiguing, as opposed to skeletal muscle which will eventually fatigue and relax.

On the other hand, suppose the dysfunction in the lens mechanism did not allow the ciliary muscle to contract to its maximum. This would not allow the lens to assume its almost spherical shape, therefore, hyperopia the inability to focus near objects would occur.

Drs. Morantz and Schmitt discuss how the parasympathetic and sympathetic balance can be effected at the neurologic level, which relates to the actual amount of the neurotransmitters, and/or at the tissue level, which relates to the response of the tissues to those neurotransmitters.⁵ These individuals will most likely have other signs and symptoms of parasympathetic and sympathetic imbalance as well. Nutrients that increase acetylcholine levels, and/or increase tissue alkalinity will increase parasympathetic activity. Nutrients that increase norepinephrine levels, and/or tissue acidity will increase sympathetic activity.⁶

To support this discussion, this author had to devise a procedure by which one could test the function of the ciliary muscle to determine if in fact it was dysfunctioning and if so, in what way, and to determine what would abolish that dysfunction.

If the problem of myopia is the inability of the lens mechanism to focus from near to far, then activating that process should create a weakness of any strong indicator muscle, and if that inability is related to a biochemical deficiency then that weakness should be of a gamma II or patient initiated type.⁷

If the problem of hyperopia is the inability of the lens mechanism to focus from far to near, then activating that process should also create a weakness of any strong indicator, and again, if that inability is related to a biochemical deficiency, then that weakness should also be of a gamma II type. The above ideas have held true in clinical trials.

MATERIALS AND METHODS

- 1) Find a strong indicator to both gamma I and gamma II muscle tests.
- 2) If the patient is myopic, ask him/her to focus his/her gaze, for approximately two seconds, on the doctor's finger (held approximately 18 inches from the patient's nose), then ask him/her to focus for approximately two seconds on a black dot one inch in diameter located on the ceiling of the treatment room directly above the patient and then evaluate for the creation of a gamma II weakness. If the gamma II weakness is found; evaluate it against the nutrients that increase sympathetic activity as discussed by Drs. Morantz and Schmitt.⁸ The nutrients suggested are: the precursors and cofactors for norepinephrine production [i.e., tyrosine, B-6 and its activators (Zn, Mg, B-2, and phosphorus), folic acid, niacinamide, and Cataplex C (S.P.L.)], Cataplex B (S.P.L.), and Drenatrophin PMG (S.P.L.), whole adrenal tissue and phosphoric acid.
- 3) If the patient is hyperopic, ask him/her to focus his/her gaze, for approximately two seconds on the dot on the ceiling, then ask him/her to focus for approximately two seconds on the doctor's finger (held approximately 18 inches from the patient's nose), and then evaluate for the creation of a gamma II weakness. If the gamma II is found; evaluate it against the nutrients that increase parasympathetic activity also discussed by Drs. Morantz and Schmitt.⁹ The nutrients suggested are: the precursors and cofactors for acetylcholine production

(i.e., choline and pantothenic acid), Standard Process Labs's Cataplex G and Organic Minerals. Supplementation may be required for long periods of time especially in those patients with severe and long standing vision problems. If so, the patient should be monitored very closely for signs and symptoms of vitamin or mineral toxicity.

RESULTS

The discussion involving the possible mechanics of poor vision correlates completely with the clinical trials regarding this author's procedure. 100% of those patients with previously diagnosed myopia weakened to gamma II testing following near to far focusing, and strengthened to one or more of those nutrients that increase sympathetic activity. 100% of those patients with previously diagnosed hyperopia weakened to gamma II testing following far to near focusing, and strengthened to one or more of those nutrients that increase parasympathetic activity. Clinical trials regarding supplementation and possible measurable acuity changes are forthcoming. The results will be reported at a later time.

CONCLUSIONS

The results of clinical trials regarding this author's procedure supports the ideas presented in this paper, regarding a possible cause and correction of poor visual acuity.

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A UNIQUE APPROACH TO THE TREATMENT OF
THE CROSS K 27 FORM OF
NEUROLOGIC DISORGANIZATION

By DAVID A. KUBICEK, D.C.

ABSTRACT

An effective procedure for eliminating the very common, and yet overlooked, Cross K 27 form of neurologic disorganization (henceforth, N.D.) is discussed.

INTRODUCTION

One of the main ideas in all Health Care Professions is that the body heals itself. This process works automatically and continuously unless the level of stress (chemical, mental or structural) placed upon the body exceeds its ability to adapt or deal with that stress. When this ability is exceeded, dysfunction results.

DISCUSSION

In Dr. Blaich's Applied Kinesiology and Human Performance paper¹ he described how people, when pushed beyond their current level of performance or beyond their body's ability to adapt to its new level of stress, would show signs of N.D. in the forms of Cross K 27 and or K 27. The examples described were elite bicyclists training and pushing themselves to improve their endurance and performance, and individuals who were asked to increase their reading rate beyond their current comfort level. Dr. Blaich went on to say that if N.D. developed and was not corrected, the individual would not be able to maintain this new level of performance and would eventually gravitate back to his original athletic ability or reading rate. However, if the N.D. was corrected, the individual could maintain this new level and adapt to the increased level of stress.

It is these original, astute observations by Dr. Blaich that led this author to the following conclusion. If pushing a person beyond his abilities, either physically, mentally or chemically, creates N.D., it is what corrects the N.D. that identifies the body's deficiencies in its ability to adapt to the increased stress and maintain its new level of performance. By identifying and eliminating the N.D. you identify and eliminate the body's deficiencies in its ability to adapt to its current stress.

If the N.D. is not eliminated, the body's inability to adapt will remain, because its deficiencies will remain, and the dysfunction will continue. Therefore, we can use N.D. as a tool to determine the body's deficiencies in its ability to maintain health.

N.D. can be determined by using the standard Applied Kinesiology procedure, which consist of a positive Cross K 27 first described by Dr. Walther in 1980,² and/or K 27 therapy localization. Dr. Walther discovered that all people who weakened with a cross crawl and strengthened with a homolateral crawl, would also show a positive Cross K 27 are known to be present in the Schizophrenic. It is this relationship with Schizophrenia that leads this author to the opinion that the Cross K 27 is a much greater source of confusion or disorganization than the K 27 pattern. This and the fact that 80% of this author's new patients exhibit a Cross K 27 made it extremely important to find a lasting and permanent correction.

The original procedure for treating the Cross K 27 was to have the patient homolateral crawl. This was the best way known at the time, but was only reinforcing an abnormal pattern, so a new way had to be developed. Dr. Walther's soon began to use a static challenge on the mastoids to determine if a specific direction would abolish the positive Cross K 27.³ Correcting the cranial fault in the appropriate direction would then eliminate the Cross K 27.

CROSS K 27 TREATMENT(cont.)

Blaich's procedure described in 1987,⁴ by using different phases of respiration to either bring out a hidden Cross K 27 or abolish a Cross K 27 in the clear, was an extension of Dr. Walther's procedure. In addition, Dr. Blalich evaluated the Cross K 27 against different nutrients and tissue concentrates depending on the patient's history, physical exam and/or lab findings to see what would abolish it. This approach was a major advancement over the original approach in maintaining the correction. The major problem that this author had with the above procedure was that it required the doctor to make an educated guess as to the patient's deficiencies; a hit or miss approach, instead of using the true beauty of A.K., which is to let the patient's body inform the Doctor of these deficiencies and the appropriate corrections. The patient's innate intelligence, instinctive center, or whatever name is used to describe the physical homeostasis mechanism, is far more intelligent than Man's intellectual center or thinking apparatus.

Dr. Goodheart empathically states that patients will tell you what is wrong with them, if you ask the right questions.

Dr. Blaich then expanded his procedure by utilizing the fact that all people that who exhibited a Cross K 27 will also weaken with a cross crawl. He would have the patient cross crawl about 10 cycles with no head turn and check for a generalize weakness.

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CROSS K 27 TREATMENT(cont.)

This weakness will last for several minutes. After finding the weakness he would still determine if a specific phase of respiration would abolish it, but before correcting the appropriate cranial fault, he would then have the patient T.L. the Glabella (representing the Hypothalamus/Pituitary), over the Thyroid/Parathyroid, over the Thymus, over the Liver Neurolymphatic reflex, over the Pancreas/Spleen Neurolymphatic reflex, over the Adrenal Neurolymphatic reflex, over the Reproductive organ Neurolymphatic reflex, and any other organ reflex which could be involved according to the patient's history, physical exam and/or lab findings, to determine which organ or gland would abolish the generalized weakness. This was a much more efficient way of evaluating the causative system, because it freed the patient's hands to T.L. the organ or gland at fault. Dr. Blaich would then correct the cranial fault associated with the cross crawl weakness, which would then return the patient to generalized strength and eliminate the cross K 27. To support the correction he would then evaluate the muscle associated with the organ that abolished the cross crawl weakness for a standard Gamma 1 weakness. If one was found, he would evaluate it against the five factors of the I.V.F. and the standard nutritional supplements related to that muscle. He would fix what he found and supplement the patient with the positive nutrients. This most recent procedure significantly decreased the number of recurrent cross K 27 cases in this author's practice.

Previous procedures had resulted in approximately a 75% recurrence, while this procedure improved upon that to approximately a 40% recurrence. This is extremely significant when one remembers the percent of patients who exhibit the cross K 27 in this practice. However, the percentage of recurrence was still too high.

This author had been admiring and working with Dr. Schmitt's Gamma 2 muscle weakness procedures for several months, when the idea arose to not only do Dr. Blaich's most recent procedure described above, but to evaluate the muscle/organ associated with the cross K 27 for Gamma 2 as well as Gamma 1 weakness. A Gamma 2 weakness, either unilaterally or bilaterally has been found in approximately 95% of all cases tested. The other 5% has shown either a Gamma 2 weakness only or no weakness. Once the Gamma 2 weakness is found, it is evaluated against the basic biochemical procedures outlined in Dr. Schmitt's "Link's Between the Nervous System and the Body Chemistry" seminars. An outline of this author's complete procedure will be given following the discussion. This does not represent all of Dr. Schmitt's procedures and should not be regarded as a guideline or synopsis of his work.

One of the most outstanding features of this procedure is that only the Gamma II weakness associated with the Cross K 27 will reveal all of the malfunctioning biochemical pathways currently described by Dr. Schmitt. Do not stop at the first nutrient that abolishes the Gamma II, but continue until all known pathways have been evaluated.

From one to as many as seven different nutrients have been found to abolish the Gamma II. All other Gamma II's not associated with the Cross K 27 will strengthen to at least one, but not all, of the nutrients that strengthen the Cross K 27 associated Gamma II. So, if the Doctor starts with just any muscle on the T.S. Line that exhibits a Gamma II weakness he may not be able to evaluate all of the malfunctioning biochemical pathways, and therefore decrease his clinical results

MATERIAL AND METHODS

- 1) Patient is supine. Find several strong indicators to both Gamma I and Gamma II tests.
- 2) Have the Patient do approximately 10 cycles of cross crawl, with no head turn, making sure the patient brings arm and leg up at the same time with slow and purposeful motion. Check for generalized weakening of your strong indicators to both Gamma I and Gamma II tests. Every muscle of the body should weaken if the patient in a cross K 27. Weakness will last for several minutes. If cross crawl produces only a Gamma I generalized weakness, then spinal level, gait reflexes, foot problems, subluxations, neurolymphatic, etc.. are involved, and phases of respiration and/or nutritional testing need not be evaluated. If cross crawl produces both Gamma I and Gamma II or just Gamma II weakness, continue with this procedure. If Both Gamma I and II you may evaluate the following procedure using the Gamma I weakness. If only Gamma II, then you must use the Gamma II.

3) Have the Patient then TL to the glabella (Hypothalamus/Pituitary), over the Thyroid/Parathyroid, over the Thymus, over the Liver reflex, Pancreas/Spleen reflex, Adrenal reflex, Reproduction organ reflex and any other organ reflex that may be involved according to the patient's history, physical examination or lab results. One area will show a positive TL, abolishing the generalized weakness.

4) Determine if certain phases of respiration abolishes generalized weakness. If it does, correct the cranial fault related to the specific phase of respiration. If respiration does not abolish weakness, then have patient TL frontals, ocular righting and labyrinthine reflexes, or TMJ. Find what abolishes weakness and correct accordingly. This will return patient to generalized strength.

5) Go to the muscle associated with the organ or gland that abolished the generalized weakness and evaluate it for Gamma II weakness. Once found, use that Gamma II to evaluate the following procedure. (Note: Use supraspinatus for a positive glabellar TL. If TL over Thyroid/Parathyroid is positive, evaluate both teres minor and levator scapulae. If TL over Pancreas/Spleen is positive evaluate both latissimus dorsi and middle trapezius.)

CASE EXAMPLE

A) Cross crawl produces a generalized Gamma I and Gamma II weakness.

B) Have Patient TL to various reflexes. In this example, the liver reflex abolishes the weakness.

C) Determine if phase of respiration abolishes the weakness. In this example, a forced breath in abolishes the weakness. Correct a bilateral sphenobasilar inspiration fault. Patient should now regain generalized strength.

D) In this example, go to pectoralis sternal and evaluate for Gamma II weakness. If a Gamma II weakness is found evaluate it, against the following steps. (Note: If there are structural corrections; sublaxations, cranial corrects, neurolymphatic reflexes etc... that are related to the following steps, make a note of them, but do not correct them until all steps have been evaluated.)

E) Check Gamma II against tissue substances of organ or gland related to that particular muscle. In this example it would be liver tissue, either concentrate or nucleoprotein extract. A high percentage of the time, it will be the nucleoprotein extract.

F) Evaluate Gamma II for Histamine mediated allergy.⁵ See if Antronex abolishes the Gamma II. If it does, identify the causative food allergen and temporarily remove it from the diet for 2-4 weeks. Offensive food will weaken a strong bilateral pec-clavicular. Supplement the patient with Antronex, one with each meal for approximately two weeks to help remove excess hisamines in the tissues.

G) Evaluate Gamma II for Kinin mediated allergy.⁶ See if TL to pancreatic NL abolishes Gamma II. If positive, check Gamma II against Zinc, Pancreatic Enzyme or Pancreatic tissue and supplement patient with substances that abolishes the weakness. Correct NL at end of procedure.

H) Check Gamma II against Thymus NL7. If positive, see if Thymus tissue abolishes weakness. Supplement the patient with the positive nutrient. Correct NL at end of procedure.

I) Check strong Gamma I and Gamma II indicators for weakening, upon inhalation of acetone, aldehyde, ammonia and Clorox⁸. If any of these are positive, check the appropriate nutrients for the inhalant against the Gamma II. Double check the nutrient that abolished the Gamma II by seeing if it abolishes the weakness caused by the inhalant. Supplement the patient with the positive nutrients.

J) Check Gamma II against aspirin.⁹ If positive, determine which essential fatty acid is needed by checking them against the Gamma II. Supplement the patient with the positive essential fatty acid.

K) Check the Gamma II against Glutathione.¹⁰ If positive, check the Gamma II against the individual amino acids; Glycine, Cysteine, and Glutamic acid. If two or three of the three amino acids strengthen, check magnesium, potassium or parathyroid tissue against the Gamma II. If only one of the 3 amino acids strengthen, then check the appropriate nutrient related to that amino acid against the Gamma II. Supplement the patient with the positive nutrient.

L) Check the Gamma II against re-breathing. Have the patient breath into a paper bag or rubber glove about 5 or 6 times. Check the Gamma II for strengthening.¹¹

CROSS K 27 TREATMENT(cont.)

If positive, check the Gamma II against the nutrient related to the Krebs or Citric acid cycle. If this step is positive, you will have to recorrect the original cranial fault found with cross K 27 while the patient rebreaths, but only after all the steps have been evaluated. Supplement the patient with the positive nutrient.

M) Check Gamma II against S.I.19.¹² If positive, check Gamma II against Co-enzyme Q. If strenghtens, supplement the patient with Co-enzyme Q. Correct small intestine neurolymphatic at the end of the procedure.

N) Check the Gamma II against eyes straight superior and then against eyes straight inferior.¹³ If either are positive, check the appropriate nutrients associated with the positive direction, against the Gamma II. Supplement the patient with the positive nutrient. Also check for the structural faults associated with the positive eye position and correct at the end of the procedure.

O) Check the Gamma II against clockwise pelvic torque and then against counterclockwise pelvic torque.¹⁴ If either are positive, check the appropriate nutrients associated with the positive torque against the Gamma II. Supplement the patient with the positive nutrient. Also check for the structural faults associated with the positive torque and correct at the end of the porcedure.

P) Check the Gamma II against convex left and then against convex right.¹⁵ If either are positive, check the appropriate nutrients against the Gamma II. Supplement the patient with the positive nutrient. Also check for the structural fault associated with the positive position and correct at the end of the procedure.

CROSS K 27 TREATMENT(cont.)

Q) Do all the corrections that were associated with the different steps, and supplement the patient with all of the nutrients that abolished the Gamma II weakness. The usual is one tablet or capsule three times daily.

It is not necessary to do all of these steps in one visit. Stop where you want and do all the corrections, and supply all the nutrients that were associated with the steps you performed. Then continue where you left off at the next visit. If on the following visit the patient does not exhibit a cross crawl weakness, then you are finished with this procedure.

There is some overlap of nutrients in the different steps. Therefore, if you find the positive nutrient in a specific step, say in step K, and that nutrient is also a possibility in a later step, say in step O simply try all the other possible nutrients in that later step against the Gamma II first, and if one of those strengthens it, then you need both, that nutrient and the previous nutrient. If the other nutrient does not strength the gamma II, then you just need the previous nutrient for both steps.

When this procedure is completed, Gamma I localized weaknesses may still need corrections. However, they will no longer be influenced by the higher level Gamma II weakness.

RESULTS

This author began using this procedure in December of 1987, on all new patients who exhibited the cross K 27 and all previous patients who continued to have recurrent episodes of this abnormal pattern.

Since that time, I have seen a remarkable reduction in the number of recurrent cases. Approximately 10% of those patients treated with this procedure have had a recurrence of the K 27, and of that 10%, several of those patients had recurrence due to emotional trauma which was easily corrected by holding the emotional neurovascular points.

Not only was the procedure effective in eliminating the cross K 27, but clinical results regarding patient health problems were also positively effected.

Patients seemed to respond much faster to treatment and corrections held longer. Difficult cases have also improved. Results seemed independant of area or type of patient health complaints and the level of severity.

CONCLUSION

In using the aforementioned procedure, this author has been able to significantly reduce the percentage of patients who exhibited a recurrence of the cross K 27 pattern of N.D. This percentage has decreased from approximately 40% recurrence to approximately 10% recurrence. Clinical results regarding a variety of patient health complaints have also significantly improved with fewer treatments and more lasting results. This procedure seems to be an effective tool in eliminating the cross K 27.

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THE THIRTY-SECOND ALLERGY CURE

by Harvey Lang, D.C.

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ABSTRACT: A new clinical method for treating allergies, with applications that can be used in treating phobias, psychological problems, even physical problems, subluxations and fixations. It is suggested that this treatment may be used to "erase" various aberrant brain patterns.

For years, Applied Kinesiology practitioners have tested for allergies by introducing suspected allergens, whether orally or by inhalation, and then tested an intact muscle for weakness. If the intact muscle weakens, it is a sign that the patient is indeed allergic to the substance. The same "weakness phenomenon" occurs with phobias; the patient suddenly becomes weak when reminded of or exposed to a suspected situation.

This paper explains a method for eliminating allergies based upon principles of Neuro-Linguistic Programming (NLP), as well as various principles and procedures used in Applied Kinesiology, especially those of George Goodheart, Carl Ferreri and Roger Calahan. With this technique, allergies are treated as phobias. Just as a person can develop a phobia as a result of traumatic experience, so, too, can a negative experience result in a physical allergy. In one case the result is psychological; in the other, it is physical.

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For example, a person is startled by a snake and filled with terror, leading to a phobia associated with snakes. Any dangerous substance or threatening experience may have the same effect. By association, the fear is then transferred to some other object or set of circumstances, leading to a phobias and even allergies aroused by harmless, non-threatening substances.

In his book Five Minute Phobia Cure, Calahan explains that the immune system in the body serves as a protective defense mechanism to counteract the intrusion of dangerous substances and chemicals. Allergies have been found to be the result of the immune system gone awry. That is, the immune system misdiagnoses what is dangerous to the body, and mistakenly defends the body against harmless substances.

Let us imagine, for example, that a child suffering from chicken-pox is offered an unusually large diet of potatoes. The child's brain might then associate his immune response to the illness with the nightshades in the potatoes. An allergy develops, manifested by the patient "breaking out" whenever coming in contact with nightshades, whether in potatoes or other foods. Eczema, asthma or other problems may result.

In the case of a phobia, a patient may associate a situation or activity with stress, rejection, or unpleasant occurrence. For example, a child is humiliated by being punished while visiting a museum with a large staircase. Years later, the staircase is associated with the stress or feelings of rejection, and triggers an "allergy" to all staircases, or even to walking upstairs.

Initially, it may have been appropriate for the body to shun potatoes or to fear using a flight of stairs. A year later, however, or ten or twenty years later, that response is no longer appropriate. What we find, then, is a principle of association working behind phobias and allergies.

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In NLP, research has shown that the direction in which a person turns the eyes is an indicator of how he is carrying out various types of thought processes. The research on this subject was done by Richard Bandler and John Grinder. Their studies show that the direction a person moves his eyes will indicate how the person is processing or responding to information.

Let us posit six (6) general eye-directions: up, down, and eye-level on both the right and left sides. {Facing a clock, consider the clock's left side (on your right) corresponding to 1:30 (upper-left), 3:00 (middle-left), and 5:30 (lower-left). The clock's right side is then similar to 10:30 (upper-right), 9:00 (middle-right), and 7:30 (lower-right).} See *figure 1*.

Moving the eyes to the upper left (1:30 on the clock) is called "visual-remembered" or "eidectic images." Middle-left (3:00) is "audio-remembered sounds or words." Down to the left (4:30) is "auditory sounds or words."

If moving the eyes to the left side indicates remembering or hearing, moving them to the right indicates creativity. Moving to the upper right (10:30) is connected to "visually constructed images." Moving the eyes middle-right (9:00) is "auditory constructed sounds or words," and lower right (7:30) is "kinesthetic feelings," as well as smell and taste.

In a normal, right-handed person, therefore, remembering what a thing looks like will be accompanied by moving the eyes to the upper left at 1:30 (visually remembered or eidectic images). Ask your patient "What color is your house?" and watch his eyes move upper-left while he thinks of the answer.

Using these principles in allergy testing, I have found that having patients move their eyes to these various directions can "negate" the phenomenon of "muscle-weakening" when the patient is brought in contact

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with the allergen. Then, having the patient taste or inhale while manually directing the eyes will serve to negate the entire allergy.

How is this done? The patient places it in his mouth or inhales it. He is then asked to look clockwise in each of the six directions, from upper left to upper right, while the practitioner tests for muscle weakness. As the eyes move around, the weakness will be dispelled in one (or more) of the directions. Strength returns to the intact muscle.

Now, if you manually push the eyes in the same direction the eyes were pointed in when the strength returned, the weakness will actually reappear. Manual manipulation of the eyes should be gentle, approximately four to eight ounces of pressure directing the eye in the direction that the weakness was dispelled by gazing. This is done four or five times in each direction that the muscle changed from weak to strong. At the same time, the patient breathes in. The procedure negates the allergy.

Upon completing the procedure, you should test again. Have the patient sniff the allergen or place it in his mouth. This time there will not be any muscle weakening, no matter what direction the gaze is directed. This is the sign that the allergy has been negated.

THE "LOOK-DOWN" DOUBLE-CHECK. To verify the success of your testing, have the patient look straight down while you test the muscle. Looking down is usually a neutral position that will normally not cause a change in muscle strength. If your procedure was successful and the allergy has been corrected, the muscle will stay strong even when the patient is in contact with the allergen.

The same type of procedure may be done with phobias and any other type of thought processes that causes weakness. For example, a patient with

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a poor self-image will suffer muscle weakness when saying "I like myself." This problem may be treated in the same manner as we treat an allergy. Instead of the patient holding an allergen, he says "I like myself" while looking in the six directions mentioned above. Usually the muscle will be weak. When we discover the direction in which the muscle gets strong, we make the manual correction. That is, we manipulate the eyes four or five times, gently pushing them in the direction where the strengthening took place, at the same time having the patient breath in and say "I like myself."

Treating psychological problems such as the above is more challenging than treating allergies since, to be successful, one requires the correct verbal input. Using this procedure for the past several months to treat allergies, I can report a near 100% cure rate. In psychological cases, it is difficult to gauge results due to the many variables involved. In addition, it is difficult to determine whether a person is being "cured" or simply given a "placebo." However, random testing has yielded the same positive results as with allergy treatment.

ECOLOGICAL CHECK. When using this procedure to treat allergies, it is important to make sure there is an "ecological check." An ecological check is an NLP term involving a technique called "re-framing." It is a form of "talk-therapy." The procedure aims at changing a patient's action or thought process. However, care must be exercised so that we do not change functional thought processes or actions that are necessary for the patient's well-being.

It is the same with allergies. For example, if a person has a *candida albicans* (yeast) allergy, we make the assumption that the patient has a *candida* overgrowth or *sytemic candidiasis*. The allergy is related to his body's response in fighting the problem. We do not try to correct allergies

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of this sort, for they have a functional purpose. The treatment is rather to kill the *can-dida albicans*, remove the yeast overgrowth, and then allow the allergy to dissipate. (If the allergy persists after the *candida* is gone, then we can use the allergy correction method of eye-manipulation described above.)

We also find that this method of eye-manipulation will work to eliminate subluxations. The method is the same: Have the patient hold or press on a subluxation. Test for weakness. Go through the eye checks and manipulations. The subluxation will be disappear. (This procedure will also work together with "therapy localization.")

Here, too, we must remember to use the ecological check, for some subluxations have a functional purpose, and may in some way be protecting the body. For example, an *Atlas Sublux-ation* or *Atlas Fixation* may often be removed only to reveal a cranial problem which it was protecting. One must always be careful and search for functional purposes.

TESTING WITH ALLERGENS. In allergy testing, I usually use a homeopathic allergy test kit manufactured in Germany and marketed by Seroyal. We also use particular substances and fresh foods: a potato, an egg, etc. For patients with hay fever or grass fever, for example, we test with the Seroyal vials. At times, these are not specific enough, and we have to take the patient in the field or have them bring in the suspected cause of the allergy.

With this treatment we have successfully desensitized people from pollen, feathers, tobacco, milk, cat's fur, and more. Treating milk allergy needs special care, as mentioned above. An intolerance or allergy to milk (lactose) may well indicate the patient's lack of the necessary enzyme (lactase) to break down the lactose into galactose and glucose. This further

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underlines the need to be aware of the ecological reason for an allergy before attempting to eliminate it.

I believe, however, that most allergies are not functional. By the time the patient comes in for treatment, the allergy is a symptom of some associative aberration such as described earlier. Similarly, in treating phobias, we can use this technique to influence the brain functions and "erase" the psychic commands that trigger the negative response.

STRENGTH OF THE UPPER LEFT. We have described how the eye-check technique can be used to eradicate an allergy by manipulating the eyes in the direction that the allergen-induced weakness becomes strong.

It is interesting to note that we also found that in every one of our patients, the muscle strength seems to return when the patient gazes to the upper left (1:30 on the clock), the "visual-remembered" sector. This is regardless of whether the person is right-handed or left-handed (even a person who remembers visual images on the upper *right*, as many left-handed people do). It might be suggested that this phenomenon is caused because the upper-left sector relates to the right hemisphere of the brain. I would further suggest that the right hemisphere of the brain is actually the true dominant in all people, the seat of their Being, the seat of their innermost Self.

Some writers assert that left-handed people have reversed "hemisphere-dominance," but I think that this is only in certain external aspects, such as strength, co-ordination, and conceptual thinking. Regarding his belief system, even a person whose visual processing of information is switched will remain dominated by the right side of the brain. Gazing to the upper-left will therefore always relate to the creative strength of the mind,

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which is on the right. As we have noted, it is always effective in changing the allergy.

Is it better to explore for all areas of strengthening, or to rely on the upper-left? There is not enough data to determine this at present.

One thing to remember is that when you do test for an intact (strong) muscle, the test should be checked with the patient looking straight down, to eliminate any false reactions. In short, the technique is remarkably easy to perform. Any Kinesiologist would be capable of it, and most chiropractors could easily master it.

Long-term effects of this method of allergy correction are unknown. In the three months that I have been practicing it, I have recognized that, when an allergy did return, it was usually quite soon, such as the next day, leading me to conclude that the original procedure was done improperly. After repeating the procedure (on one occasion even a third time), the allergy did not reappear.

Of course, if the original "traumatic" conditions leading to the allergy were to recur, they might re-instigate the allergy.

It is hoped that this method could be used to induce the brain to accept needful "foreign" substances in the body, such as skin tissue or organ transplants. A protocol for this is being developed.

For now and in the future, I believe this method will prove an effective long-term cure for most allergies.

783 Montgomery Street
Brooklyn, NY 11213

December 1987
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The Year of Hakhel

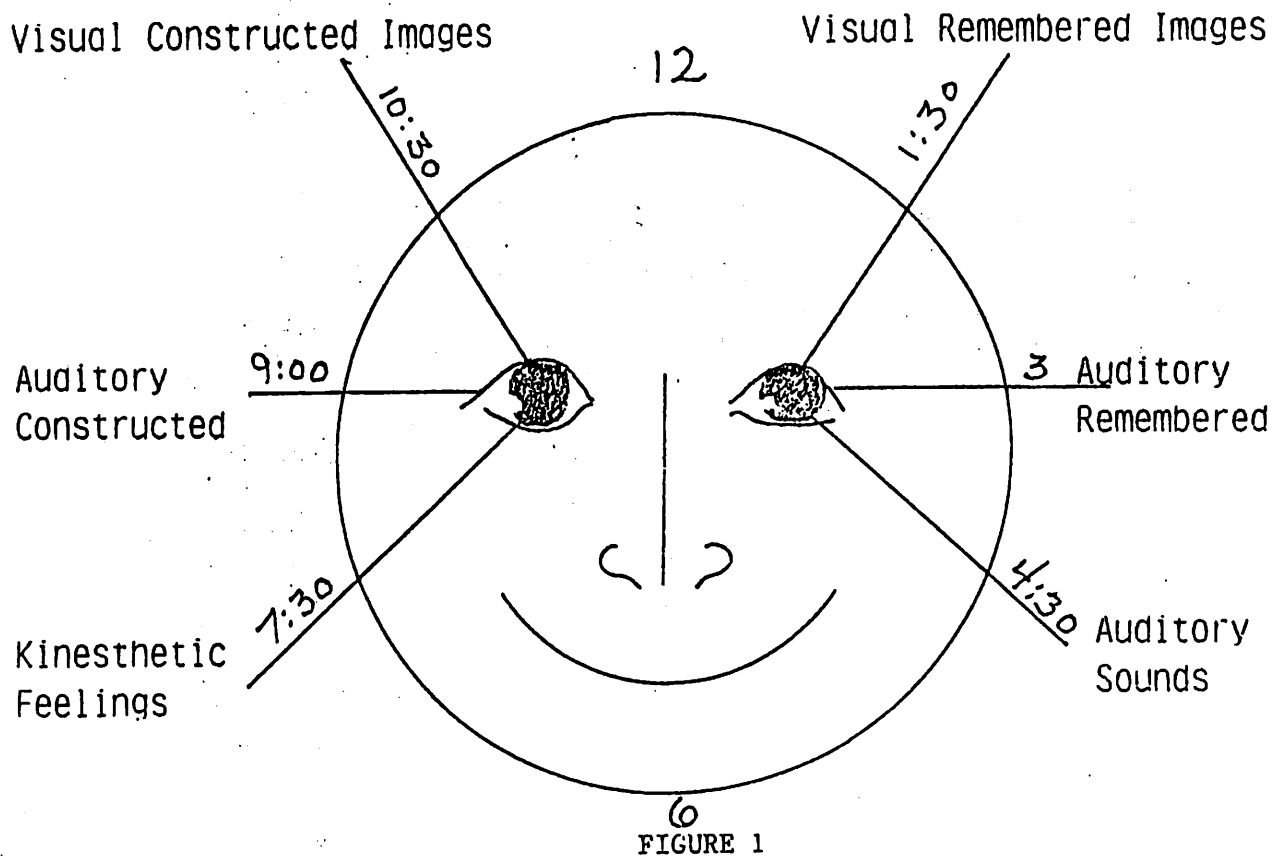
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VISUAL ACCESSING FOR A RIGHT-HANDED PERSON, ("NORMALLY ORGANIZED").



Vc Visual constructed images Vr Visual remembered (eidetic) images.

(Eyes defocused and unmoving also indicates visual accessing.)

Ac Auditory constructed sounds or words Ar Auditory remembered sounds or words.

K Kinesthetic feelings (also smell and taste). A Auditory sounds or words.

A Relationship Between Teeth and Meridians

David Leaf

There appears to exist a distinct relationship between the muscle meridian pain pattern and specific teeth.

The author has lectured for years in Europe and has had lengthy discussions with medical acupuncturists while there. Their opinion is that Applied Kinesiology devotes to little attention to the mouth and the related structures.

In the early eighties, Dr. Goodheart first discussed the existence of muscle meridians and their relationship to structural pain patterns. The procedure at that time was to deeply massage the areas that along the meridian that were tender to palpation.

In 1987, Dr. Goodheart furthered the treatment of muscle meridian imbalances by finding that taping the Beginning and End points of the meridian pair (Ex. Liver - gall bladder) that began or ended on the skull would relieve the pain pattern associated with the muscle meridian imbalance.

The author has observed that when a muscle meridian imbalance is found, the tooth that is related to the meridian will positively challenge. Directional force applied to the tooth will find a direction that immediately stops the pain pattern associated with the muscle meridian.

It appears that tooth imbalances upset the electromagnetic flow within the body. Thus manifesting the imbalance by creating imbalances within the meridian system that can be found with the patient in a gait pattern. Correction of the relative position of the tooth reverses this pattern, immediately relieving the pain and muscle weakness pattern.

The most common finding is of a liver meridian imbalance. Palpation of the liver meridian as it nears the inguinal ligament usually results in severe pain. Have the patient therapy localize to the related tooth (see Dr. Walther's, *Applied Kinesiology Volume II*) and if it therapy localizes find a phase of respiration that negates the challenge. Next, have the patient place a constant pressure in a specific direction against the related tooth based on the standard neurological tooth relationships. Change the direction until one is found that the pain is abolished. Combine these two factors for correction and then recheck after forced occlusion.

Correction of the teeth when found will not only strengthen weak related muscles, but help to balance electromagnetic energy imbalances with in the body.

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George Goodheart, *Applied Kinesiology Workshop Manual*, (Detroit:privately published - 1987)

THYMUS RELATED ALLERGIES: DIAGNOSIS AND CORRECTION

MICHAEL LEBOWITZ D.C.

ABSTRACT: Allergies mediated through the thymus can exist even though screening tests for histamine and kinin allergies are negative. Diagnosis and treatment of these are discussed.

I have been treating chronic severe allergy and ecologically ill patients for a number of years and only a handful have not fully recovered. As a result of this I have become fairly overconfident in my ability. Recently I had a thirty year old female patient with daily severe headaches for as long back as she can remember. This and other symptoms made me suspect a combination of allergies, hormonal imbalances, nutritional deficiencies, and structural imbalances. My initial exam and treatment uncovered cranial faults, some weak TMJ muscles, pituitary dysfunction, prostaglandin imbalance, plus weakness of the levator scapula and upper trapezius. I confidently fixed what I found and gave her appropriate supplementation and dietary instructions and had her return in three weeks. On her return visit all her previous findings were negative, pancreas was positive, some new cranial faults appeared, as did cannabinoid toxicity syndrome¹. No improvement at all was noted in her symptoms. One week later all these findings were negative, thymus was positive and her gamma-2 weakness² strengthened on a 30x dilution of staphylococcus nosode. There was still no relief in the headaches. The fourth visit all her findings were negative though she still had a gamma-2 weakness and no relief with her headaches. I had never been so unsuccessful before. All four visits she had been negative on screening tests for histamine and kinin mediated allergies^{3,4}, but I still had a feeling that allergies were present.

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Out of desperation I started to test foods. Seven different foods that she ate daily plus a prescription medication she was taking all caused universal muscle weakness despite negative screening tests on histamine and kinin allergies. Through trial and error I found that these food allergies were kinesiologyically negated by therapy localization to both the thymus and the thymus neurolymphatic (the one taught by Goodheart and Schmitt just lateral to the liver NL on the right, extending to under the right axilla at nipple level).

Over the next few weeks I had a chance to examine my few chronically ill patients plus many new ones and found that these "thymus related allergies" were very common (at least as common as kinin and histamine allergies).

The thymus was negative in the clear on these patients, and therapy localization to either the thymus or its neurolymphatic did not strengthen a weak gamma-2 muscle. The only way the thymus would show positive would be if a food that caused universal muscle weakness was insalivated (and it was not due to histamines or kinins), the weakness would be abolished by therapy localizing to the thymus or its neurolymphatic.

It appears that in many chronically ill patients their immune systems have a hard time differentiating foods from substances that shouldn't be in the body and reactions such as headaches, brain fog, fatigue, joint pain, etc. are common. Leaving off the offending foods for 3-6 weeks and then retesting and if negative reintroducing the foods on a rotation basis brought good clinical results, but I felt I was missing something. Kinin and histamine allergies still need to be diagnosed and treated, but if the patient is still symptomatic, we initiate food testing to find out if any thymus related allergies are present. I found many chronic

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patients improving dramatically under this protocol. You can either test the foods themselves to see if they cause universal muscle weakness or see if homeopathic allergens to specific foods strengthen a weak gamma-2 muscle.

I was at a standstill for a month or so with this research and was feeling that there must be a way to strengthen the immune system/thymus to get rid of all thymus related allergies at once (like zinc can often negate kinin mediated allergies). All the basic supplementation for the thymus, plus all standard AK procedures were proving ineffective. Avoidance worked well but was inconvenient for many. Providentially on 12-29-87 I received a call from Tony Brea and we had a lengthy discussion on some of his latest research, and the importance of maintaining optimal zinc:copper ratios in patients. Some of my patients had particular sensitivities to certain foods, and if the patient was totally balanced they could eat them. If they had a structural or biochemical imbalance, the food would cause a histamine reaction. After the faulty pathways were corrected, I might find them reacting to the same food or other foods a few months later, but this time it would be causing a kinin mediated allergy. A few months later it would happen again, but this time it would be a thymus related allergy. These foods are stressors to the system only if it is out of balance. We know of the importance of proper levels of zinc in preventing and correcting kinin mediated allergies. After talking to Dr. Brea, I found through muscle testing that thymus related allergies were negated by oral insalivation of copper (I had reported on copper in previous ICAK papers^{5,6}, but not for this type problem). It appears that the particular foods that a person is sensitive to will cause symptoms (usually identical) if the zinc to copper ratio is either too high or too low. The only difference

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will be the target organ (not the symptoms). If zinc:copper is too low, kinin mediated reactions will occur. If zinc:copper is too high, thymus related allergies will occur. You may find a need to alter doses of zinc and/or copper over a few months time as the body is reaching optimum levels. Otherwise you may fix a kinin allergy but cause a thymus one or visa versa.

I now screen my allergic type patients on antronex/histadine, CCK (cholecystokinin), and copper. If antronex strengthens a weak gamma-2 muscle and histadine causes universal muscle weakness, we can assume that histamine allergies are present. Food testing will show that insalivation of certain foods will also cause universal muscle weakness and this weakness will be negated by simultaneous insalivation of antronex. Vitamin B₆ will also negate the weakness caused by the food. A B₆ deficiency makes one prone to histamine allergies and supplementing with B₆ will help correct the condition. We have the patient leave off the offending foods for three weeks- this isn't absolutely necessary but we find that B₆ levels will build faster this way (otherwise part of the B₆ is needed to neutralize the reaction to eating the food). In three weeks the foods are retested and almost always are negative and can be reintroduced into the diet. Occasionally folic acid is needed with or instead of vitamin B₆. If CCK produces universal muscle weakness, we look for offending foods and check zinc the same way we did B₆ above. Attention is also given to the pancreas neurolymphatic and the offending foods are omitted for three weeks as above.

If insalivation of copper strengthens a weak gamma-2 muscle, thymus related allergies are almost always present. We look for the offending foods which will be negated by copper insalivation. Six mg. of copper

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(2 mg. three times a day) appears to be a good dose. My patients that develop sensitivities to most supplements due to their fillers and binders can usually tolerate copper very well though some brands do work better. The symptomatic changes in my most difficult patients has been very gratifying.

As to why so many patients are deficient in copper- most diets are low in copper. Estimates are that over two thirds of the U.S. population get less than the RDA of copper daily⁷. Also there are other considerations. Here in W.V. many homes have galvanized piping. The lining of these has zinc and cadmium in them- both of which are antagonists to copper⁸.

We also have many smokers as patients, which adds cadmium to their system. Vitamin C, iron, and sucrose also are antagonists to copper. I do though also find copper deficiencies in some patients where none of these are factors.

It is estimated that an ideal zinc to copper ratio is approximately 7:1. Most foods are over 7:1, and commonly eaten foods such as milk, pork, poultry, beef (except liver), oats, are at least 50:1. Only apples, grapes, bananas, beets, beef liver, squash, walnuts, and a few others are 3:1 or less.

I have found to date thymus related allergies on over one hundred patients including myself and my son. The responses I have seen in reducing brain fog, increasing energy levels, and calming the disposition have been wonderful. I know that some patients are also copper toxic and I do screen for that too but I find copper deficiency to be more prevalent at least in this part of the country.

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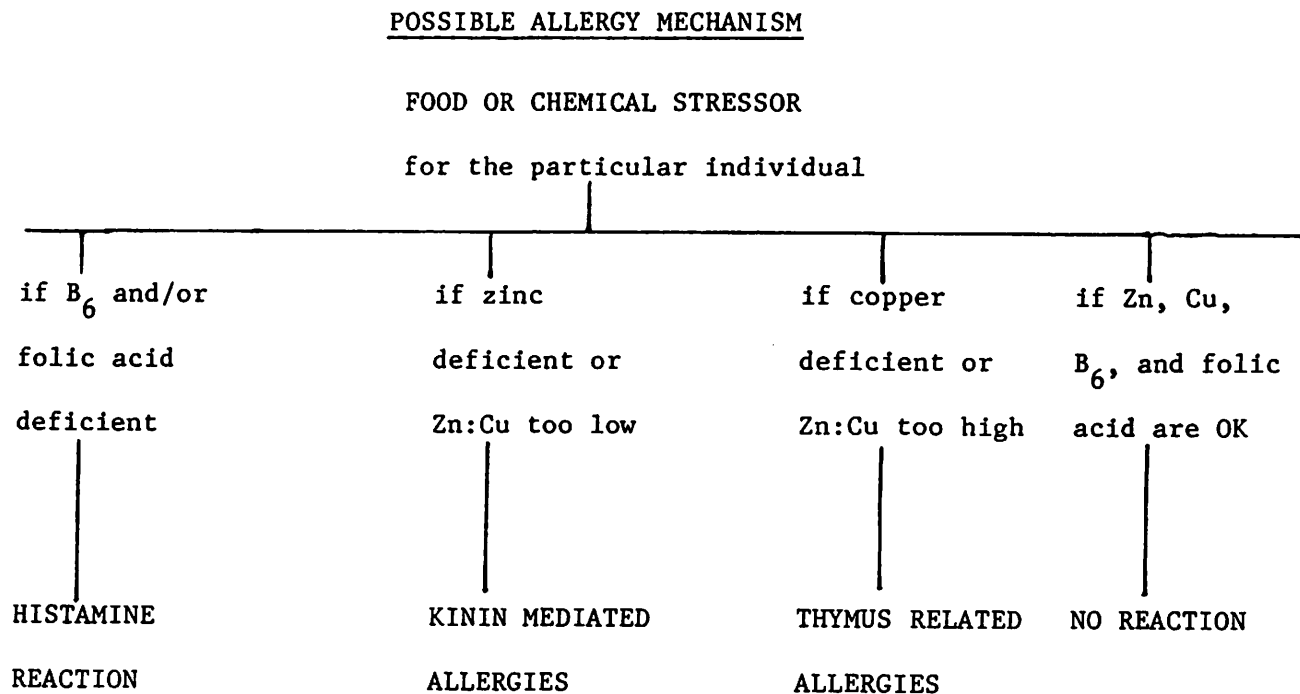
COPPERS RELATIONSHIP TO THE IMMUNE SYSTEM

After finding out the relationship between copper and the immune system on a clinical level, I did a brief literature search to try to understand it better. I found the interrelationships between copper and the immune system are many and varied. I will not hazard a guess as to which physiological pathway is involved, but will briefly list some of what I found:

- 1) Copper deficiency has been shown to cause an impaired humoral mediated response in proportion to the degree of functional copper deficiency⁹.
- 2) Thymic factor activity is decreased by approximately 75% in copper deficient rats¹⁰.
- 3) Copper deficiencies are associated with impairment of cell mediated immunity¹¹.
- 4) Copper deficiencies in rats caused thymus atrophy, and an 80% decrease in natural killer-cell cytotoxicity¹².
- ** 5) Copper deficiency in mice caused an increase in both histamine induced edema and delayed hypersensitivity reactions¹³. Thymus related allergies appear to be of the delayed hypersensitivity type.
- 6) Copper deficiency in sheep inhibited their leucocytes from being able to overcome systemic candidiasis¹⁴.
- 7) Copper deficiency in rats leads to decreased T lymphocyte proliferation¹⁵, and decreased numbers of B cells⁹.
- 8) Copper in adequate amounts is necessary for optimal SOD activity^{16,17}.
- 9) Dopamine-B-hydroxalase, a copper dependent enzyme, is required for norepinephrine synthesis¹⁸. Norepinephrine is the drug of choice to

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suppress an acute systemic allergic response.



SUMMARY OF PROCEDURES

- 1) On any patient with chronic neurological, behavioral, neuralgic, autoimmune, etc., symptoms- allergies must be suspected.
- 2) If histamine causes universal muscle weakness, and antronex strengthens a weak gamma-2 muscle, histamine producing allergies are assumed.
- 3) See if B₆ and/or folic acid negates the histamine weakness. If so, supplement. Also find the offending foods.
- 4) Avoid the offending foods for three weeks. Retest and if negative reintroduce it into the diet. If positive, avoid another 3 weeks and recheck.
- 5) If CCK weakens (universal muscle weakness), assume the patient has kinin mediated allergies. Find the offending foods.
- 6) See if zinc negates the kinin weakness (also check and treat if necessary pancreas NL). If so supplement, then follow step 4.

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7) See if copper strengthens a weak gamma-2 muscle. If so thymus mediated allergies probably exist. Find the offending foods. They should cause universal muscle weakness. This is negated by either copper, TL to the thymus or its NL.

8) Supplement with copper and follow step 4.

9) Patients may have 1,2, or all three types allergies.

Upon further thought and investigation I felt some common structural imbalances must be present in all allergic cases. I have found what appears to be 2 structural faults in common in all allergic patients. When treated they appear to eliminate reactions of all types to all food and chemical sensitivities (even undetermined, undiagnosed ones). Even so the nutrition support and outlined procedures above are critical to make things hold. The structural info will be presented in January on Kauai as I am still compiling data on the results.

CONCLUSION

Zinc:copper ratios are very critical in allergy prevention and treatment. Copper deficiency, either relative or absolute can cause a thymus related allergy that is relieved by copper supplementation.

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SOME TIPS ON TREATING THE SEVERELY ALLERGIC, CHEMICALLY SENSITIVE PATIENT

BY MICHAEL LEBOWITZ D.C.

ABSTRACT: Severely allergic patients may need special care after all the usual diagnostic techniques and therapies are applied. The use of pure vitamin and mineral powders, food testing, and homeopathic nosodes are discussed.

In your severely allergic patient, first fix them structurally, balance their endocrine and immune systems, identify and treat histamine, kinin mediated, and thymus related allergies.¹ Correct candida, prostaglandin imbalances, free radical problems, toxic metals, etc., etc. If they are still symptomatic, there are a few other very useful things to check.

1) Pure Vitamin and Mineral Powders- On many patients, I felt there was a need for B₆, zinc, or other nutrients. These suspected deficiencies would either test negative (even though I tested 3 or 4 brands), or the ones that tested positive would within a few days cause universal muscle weakness, irritability, headache, brain fog, and fatigue (signs of allergies in these patients). This situation which also appeared in myself was becoming incredibly frustrating. In some patients I found no need of nutrients even though I suspected that deficiencies existed. In others, anything they took caused an "allergic" reaction before therapeutic benefits could be realized. I then became acquainted with a company² that sold vitamins and minerals in powdered form with no fillers, binders, wetting agents, etc. I made myself a test kit and started finding numerous deficiencies that never showed up before. Also my patients that usually became "allergic" to their supplements very quickly would now have no problems, if correct doses were given. Using these products has greatly helped these patients.

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One supplement company was kind enough to send me samples of all their fillers, binders, wetting agents, etc. (fifteen in all). Upon testing them I found one in particular that caused universal muscle weakness in 85% of the patients tested. It is used in quantities totalling less than 1% when it is used, so I am not sure whether it is significant or not as the cause of the "allergic reactions".

2) So many of the top allergists and clinical ecologists recommend rotation diets (no food is eaten more frequently than once every 4 days). I and many of my patients would become allergic to any food eaten frequently, though if it was omitted for a week or two it would no longer cause reactions. Using this type of rotation diet recommended by Philpott³, and others has been very helpful (It is no longer needed if instructions in my "Thymus Related Allergies" paper is followed). Other foods would test negative if eaten in small quantities. If these foods were eaten in large quantities and tested after eating them, they would test positive. An allergic reaction would follow. I found on these type patients that when we do food testing, unless the food is still in their system (eaten in the last 48 hours), we may get a false negative muscle test. If you plan a food testing session with a difficult patient, instruct them on what you would like them to eat over the preceeding 48 hours.

3) Homeopathic Nosodes- McBride⁴, and others have advocated using homeopathic nosodes on difficult patients. Many chronically ill patients have long standing low grade bacterial or viral infestations from previous illnesses or vaccinations. These organisms are opportunists and multiply during states of abnormal body chemistry and can cause anything from rheumatoid arthritis to fatigue. They stress our immune systems greatly and aggravate food and chemical sensitivities. I keep a stock of

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about thirty different homeopathic nosodes on hand and on appropriate patients test to see if they strengthen gamma-2 muscle weaknesses⁵. Many times they will and when you tell the patient which organism it is, they can recall having that type infection (sometimes even back at the onset of their now chronic problem) or vaccine. Giving these nosodes gives very satisfactory and sometimes almost miraculous results. Three case histories are briefly given to make you aware of their usefulness and also their possible temporary "cleansing" reactions.

a) One patient had severe rheumatoid arthritis and had been disabled for the past seven years. After the first four visits he was clear on all the usual AK findings. His energy level, state of well being, etc. was tremendously improved but his arthritis was not. On testing nosodes, TB and diptheria were positive. Forty years earlier he was rejected when enlisting for the army due to a positive TB test, tho he has never had TB as far as he knows. After two weeks on the nosode the pain and swelling in his shoulders and knees had completely gone, and was 70% resolved in his hands.

b) I tested positive on smallpox and anthrax (of all things!) and after two days on them, I awoke at 3:00 A.M. with a severe toothache in a tooth that had a root canal 3 years earlier. There was no swelling in the surrounding tissue, no positive therapy localization, so I went back to sleep. In the morning it was 70% relieved but, when I looked in the mirror I saw that the outer layer of skin on my face had peeled off as if I was recovering from a sunburn (this was in Dec. in West Virginia). I feel in my case the bacteria was being eliminated through a weak area (my tooth).

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c)I had a ten year old female patient with chronic diarrhea since birth, and a history of both sexual abuse and chewing tobacco use beginning at ten months old. She had never had a solid bowel movement in her life. Her foster parents had sent her to every specialist imagineable. The only results she ever obtained that were positive were three years previously when they diagnosed her as having celiac disease. Removal of gluten from her diet changed her bowel movements from almost watery consistency to a little thicker liquid. Over two months working on allergies, biochemical and endocrine imbalances, emotional circuits⁶, etc. she was able to eat anything and had normal bowel movements 75% of the time. At this stage we were at a standstill until we tested nosodes. She needed three: V.A.B. (one that Philpott finds routinely in severe cases), Coli bac-cilinum, and D.H.L.P.P. Three days after starting on them she had a diarrhea bowel movement that her mother described as "ten times her normal volume with an odor that made the whole family leave the house". Ever since that episode (three months ago), her bowel movents have been normal 100%of the time.

It appears that properly selected nosodes at the proper time are extremely powerful in their therapeutic action and healing capabilities. Nosodes can be gotten through Boiron⁷, Dolisos⁸, and Standard Homeopathic⁹. Each company has some not carried by the others so I suggest getting from all three. There are some products on the market that are more broad scope and are suppose to eliminate total classes of viruses and bacteria. I have not found these to be nearly as effective therapeutically, and they often also give false negative muscle testing results.

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CONCLUSION

For your severe allergy patients that are still not 100% symptom free, make sure you check the following.

- 1)Pure vitamin and mineral powders without anything added.
- 2)Test foods only while they are still in the system from previous meals.
- 3)Homeopathic nosodes.

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MORE HYPOTHALAMIC SET POINTS

MICHAEL LEBOWITZ D.C.

ABSTRACT:GV-21 coupled with organ neurolymphatics appears to help regulate visceral set points. Diagnosis and treatment is discussed.

After successfully using the hypothalamic set point technique described in these papers¹, I wanted to try and determine if there were any other set point or hypothalamic connections.

Having determined previously that GV-21 was a hypothalamic reflex², I took a group of "problem" patients who had a negative therapy localization to GV-21. They also showed negative therapy localization to all the various organ neurolymphatics. I had the patients 2 point therapy localize with one hand on GV-21, the other on various organ neurolymphatics. In many cases the double therapy localization would weaken an intact muscle (on a gamma-1 and gamma-2 level³). Some patients only had one double therapy localization that was positive, while others had as many as 6 or 7. It appears that there must be multiple pathways of supraspinal input into organ systems and we had "stumbled upon" another one.

Upon experimentation there appeared to be two different methods to abolish the muscle weakness. One would be simply to rub GV-21 and the appropriate neurolymphatic simultaneously for forty seconds. If multiple connections showed positive I felt there must be a common link. About that time I had an Upledger practitioner staying with me. After much discussion and experimentation we found that a sphenobasilar fault and anterior coccyx existed simultaneously on these patients- creating dural tension. We began treating these 2 faults simultaneously- quite

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an athletic feat. It would abolish the multiple weaknesses. These patients were all negative on pretest imaging⁴, so it doesn't appear to be a normal cranial fault. After clearing these set points (the other hypothalamic set points had been cleared previously), no more visceral symptoms or findings occurred.

I have no idea at this point if we have just reached the tip of the iceberg and there are many more hypothalamic connections to be discovered, or if it is fairly complete at this point. Your input is welcome.

CONCLUSION

Hypothalamic set points have what seem to be multiple pathways. One of these can be diagnosed by two point therapy localization to GV-21 and the appropriate neurolymphatic. The technique described will help reset these and thus prevent recurrent problems.

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CLEARING OUT INTERNALIZED EMOTIONS THAT PERPETUATE ILL HEALTH

MICHAEL LEBOWITZ D.C.

ABSTRACT: Internalized fear and anger with their resultant physiological insult can keep us in a state of ill health. A technique to diagnose and treat this is discussed.

Before I even start this paper I would like to give credit to Walter Schmitt D.C. and Roger Callahan PhD. Some of the ideas from this paper were generated from some unpublished ideas of Dr. Schmitt in the sense that they both use imaging and tapping. Dr. Callahan's book¹ also parallels it. Though I can not say his work directly influenced these techniques, they probably indirectly did as I was aware of his techniques.

I received some tapes in November 1987 of sermons of a friend of mine, Pastor Willard Santee. These were entitled "Anger Can Kill You", "Fear Can Kill You", and "Forgive and Be Healed"². I have been aware of the importance of fixing the emotional side of the triangle for quite sometime and have been working on ways to tap into it. We have been using the stomach neurovasculars for quite sometime. My technique using "Emotional Circuit Breakers"³ has also proved very useful. After hearing these tapes, I decided to explore more.

We all know the effects of stress and internalized negative emotions on hormone levels, muscle tension, blood pressure, immunocompetence, etc.

Most negative emotions can be classified as subcategories of either fear or anger. Internalized anger can manifest as any of the following emotional states or characteristics: 1) Bitterness, 2) Envy, 3) Resentment,

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4)Intolerance, 5)Criticalness, 6)Vengefulness, 7)Malice, 8)Complaining/
Demanding, 9)Wrath, 10)Hatred, 11)Jealousy, 12)Gossiping, 13)Sarcasm,
14)Unforgiving.

Fear can be subcatagorized into 1)Anxiety, 2)Doubt, 3)Timidity,
4)Indecisiveness, 5)Superstition, 6)Withdrawal, 7)Lonliness, 8)Over-
aggressiveness, 9)Inferiority, 10)Jealously, 11)Cowardness, 12)Dep-
ression.

After clearing patients out structurally to the point where I could no
longer find a weak muscle, I would ask them to focus on an event that
causes them fear. This would in many cases bring back a weakness of
a muscle I had strengthened. I also would ask them to focus on an
event that causes them anger and that too would often bring back
muscle weakness. In other words, the patients thoughts or emotional
state would cause recurrence of the problem.

I found on these patients that therapy localization to one of the six
pairs of acupuncture points that either begin or end on the head
(SI-19, B-1, GB-1, LI-20, S-1, TW-23) would negate the weakness. Having
the patient focus on the incident that causes fear and/or anger while
tapping the appropriate points would strengthen the muscle weakness.
Retesting the muscle while the patient focused on the incident would
not make the weakness return.

I found though on temporal tapping while having the patient refocus
on the emotion producing incident again, the muscle weakness returned
in about 50% of the patients.

During this time a colleague of mine and I were discussing Bach flower

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remedies. I had dabbled with them back in the late 1970's with mixed results- sometimes they seemed to make changes and sometimes not. On those patients that the muscle weakness recurred with temporal tapping, it would be negated by placing one or more of the appropriate Bach remedies on the tongue (I let the patient read the descriptions of the remedies and pick out ones they thought might apply. I might then add a few based on my knowledge of the patient. We would then test them all.). I found that when giving the remedies to those patients- it resulted in definite personality changes for the better (recognized by the patient and their family members). Most often the changes were recognizable after just a few days and often they were quite dramatic. One patient who for the last four years has taken a standardized "Temperament Inventory"⁴, took the remedies prescribed in this fashion between the third and fourth tests. The first three years the test results were virtually identical. The fourth year the results were substantially different. Her family and friends all saw a metamorphosis of her personality, from being extremely meek and letting people walk all over her, to standing up for herself. Using the Bach remedies with this procedure gives me very consistent and satisfactory results.

SUMMARY OF PROCEDURES

1. Clear out muscle weaknesses.
2. Have the patient think of a fear producing incident in their life. See if it brings back a previously corrected muscle weakness.
3. Have the patient think of an anger producing incident in their life. See if it brings back a previously corrected muscle weakness.

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4. Whichever of steps 2 or 3 is positive (or both), see which acupuncture points that begin or end on the head (SI-19, B-1, GB-1, LI-20, S-1, TW-23) negate the weakness.
5. Tap the points that negate the weakness, while the patient focuses on the emotion evoking thought or event.
6. Temporal tap while focusing on the thought and see if the weakness returns. If not the procedure is complete.
7. If temporal tapping brings the weakness back while focusing, find the Bach remedies that negate it. Give 4 drops sublingually, four times a day.
8. Be forgiving and surrender your problems to God.

CONCLUSION

Removing internalized negative emotions structurally and with Bach flowers can have profound effects on a patients personality and healing ability. Using the techniques described allows us to neutralize these to a great extent and facilitate the healing process.

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HYPOTHALAMIC SET POINT TECHNIQUE

Michael Lebowitz, D.C. and Walter H. Schmitt, Jr., D.C.

Abstract: The concept of set points is presented. Several techniques based on set point theory have been developed based on positive two hand, two point TL to an acupuncture head point and another point somewhere on the patient's body. Tapping of the acupuncture head point while the patient continues to TL to the body point restores normal activity and improves such parameters as temperature and range of motion immediately. Set point techniques are discussed in relation to viscera, vertebrae, muscles, and in relation to sugar and calcium metabolisms. This set point technique appears to be compatible with holographic theory of body function as it regards reference and object beams.

INTRODUCTION

The concept of set points for maintenance of homeostasis of various body functions has been quite popular recently, especially in terms of weight loss and bariatric medicine. Great changes have been achieved in blood sugar rates, rate of weight loss, allergies, etc. via fasting, dieting and other methods designed to alter set points. 1,2

It appears that the hypothalamus monitors most, if not all, systemic body functions. For the purposes of this paper, it is being assumed that the body's set points are related to hypothalamic activity although future research may identify other areas in the nervous system which have set point potential. The hypothalamus seems appropriate, however, for our present state of knowledge.

We could view the hypothalamus as a 200 amp circuit breaker box with each individual circuit breaker serving a different

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organ, vertebra, muscle, etc. If for some reason, the hypothalamus malfunctions and sets, for instance, the sensitivity of the adrenal circuit at 5 amps instead of the normal 20 amps, then even the tiniest bit of sugar ingested might cause the adrenal circuits to blow out and require therapeutic modalities.

The same concept may be held for muscle circuits. We have all had patients who have had one particular muscle weakness that frequently recurs despite our best efforts. Could it be possible that muscles also have a set point and that the recurrent weakness is due to the muscle's set point being altered from normal? If so, the slightest stress could short circuit the muscle. Or worse, an inhibitory resting set point of the muscle may be established at which the muscle thinks it is supposed to be weak.

The same concept appears to be applicable for recurrent subluxations, allergies, biochemical imbalances, nutritional needs, and so on.

We have developed a series of procedures which we feel test for altered set points. Consequently, techniques which return the set points to their normal, homeostatic position have also been devised. Objective changes in oral temperature, range of motion, and other parameters are consistently observed, and are often dramatic. Oral temperature changes in the range of 2° F to 3° F within one minute are commonly seen as are three to four inch increases in lumbar flexion.

Symptom changes can be even more dramatic. One 10 year old

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patient who had vomited daily for five years was treated for a stomach set point dysfunction and after one treatment, has not vomited in six months. Another patient with narcolepsy that occurred while driving five times a day was partially corrected using small intestine NL technique. However, he had total elimination of symptoms when the small intestine set point was reset. One of us (ML) was previously so sensitive to sugar that the mere eating of a few figs or raisins would cause adrenal dysfunction so severe that it would require continued NL activity or supplementation. Now he can ingest "normal" amounts of sugar with no symptoms. We have seen recurrent subluxation patterns, allergies, pain, and numerous symptoms vanish immediately following set point technique. Set point technique is not a panacea, but a very powerful tool when used at the appropriate time.

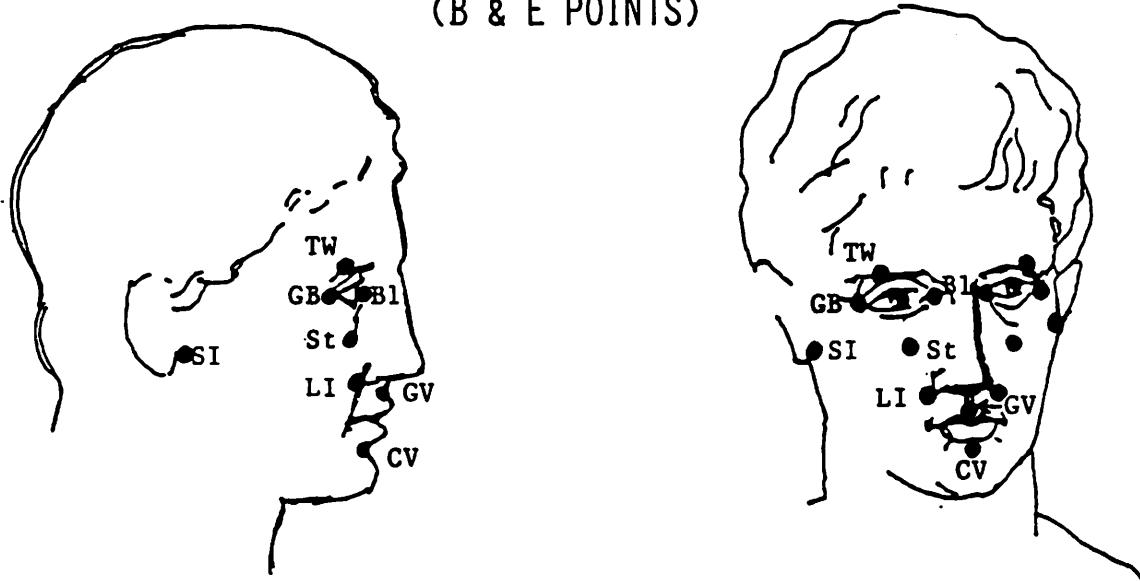
Of the fourteen acupuncture meridians, eight either begin or end on the head: TW-23, LI-21(or 20), SI-19, GB-1, St-1, B-1, GV-27, and CV-24. See figure 1. Goodheart has called these the "B and E" points for Begin and End points and originated the concept that they were related to the hypothalamus.³ These points appear to be our doorway into the hypothalamus, so to speak, for both the diagnosis and treatment of set point problems.

CORRECTING VISCERAL SET POINTS

To change visceral set points, you may use either a gamma 2 weak muscle or a strong indicator muscle. Because the

FIGURE 1

ACUPUNCTURE HEAD POINTS
(B & E POINTS)



SI = SMALL INTESTINE-19
 BL = BLADDER-1
 TW = TRIPLE WARMER-23
 GB = GALL BLADDER-1
 LI = LARGE INTESTINE-21
 ST = STOMACH-1
 GV = GOVERNING VESSEL-27
 CV = CONCEPTION VESSEL-24

acupuncture meridian points which we will use are on the head, they have suprascapular (i.e., gamma 2) as opposed to spinal (i.e., gamma 1) effects. You may suspect a particular meridian because of symptoms, pulse diagnosis, recurrent muscle weakness, or other clinical judgment.

First, TL to the acupuncture head point for the suspected circuit. If negative TL, continue. If positive TL to the head

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point, there will also be positive TL to the associated organ's NL. Treat the NL. If the NL is bilaterally located, the points should be treated ipsilaterally to the head point which TLs. If contralateral TL is present, the patient is switched.

In the case of meridians which do not begin or end on the head, use the coupled yang meridian of that yang-yin pair. These pairs are the same as in the wrist pulse point pairs, as shown in figure 2.

FIGURE 2

<u>Yin</u> -- <u>Yang</u>	<u>Yin</u> -- <u>Yang</u>
H -- SI	Lu -- LI
Liv -- GB	Sp-Pan -- St
K -- B	Cx -- TW

When the head point and the NL are each negative to separate TL, have the patient two hand TL with one hand to the meridian end point and with the other hand to the NL for the associated organ. If a set point problem exists, this two point TL will either strengthen a gamma 2 weak muscle or cause a gamma 2 weakness of a strong indicator muscle.

The treatment to reset the set point requires both doctor and patient participation. The patient must TL to the involved NL (with both hands if possible) while the doctor taps the acupuncture head point fifty to sixty times at a 2-3 times per second (2-3 Hz) rate. Following this correction, the two point TL

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to the point on the head and the NL will be negative, and changes in temperature, range of motion, etc. may be monitored.

Some patients will demonstrate the same two point TL pattern combining TL to an acupuncture head point with an acupuncture point on the body, such as the alarm point or the tonification point. The procedure is the same. The doctor taps the head point while the patient maintains TL to the point on the body. This pattern has shown up on several occasions when the NL for the organ did not show up, yet the patient had symptoms in the given organ.

One such case involved cardiac arrhythmias with no subscapularis weakness, negative TL to the heart NL (both independently and in combination with SI-19), but positive TL to SI-19 and the heart alarm point at the tip of the xiphoid process. Tapping the SI-19 while the patient Tled the heart alarm point immediately stopped the arrhythmias.

Sometimes set point problems show up sequentially. That is, if one set point pattern is corrected, then another pattern which was previously negative will show up. This is often seen to occur between the small intestine and bladder circuits. Each must be corrected as it shows up.

If more than two acupuncture head points TL in the clear, it is likely that there is a cranial fault present. This can be screened for with pre-test imaging ⁴ and challenged and treated accordingly.

Recurrence of the same set point patterns on subsequent

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visits indicates the need for nutritional support. Each acupuncture head point has been related to one or more neurotransmitters and their associated nutrient precursors and cofactors. These will be discussed later in this paper.

CHANGING VERTEBRAL SET POINTS

Vertebral set points patterns are similar to those previously discussed. They should be checked in cases of recurrent subluxations, dermatome or other segmental pain patterns, or in cases of recurrent visceral problems after visceral set points are negative.

Diagnosis is based on a two hand, two point TL, one hand to an acupuncture head point and the other hand to the related associated point vertebra after individual TL to each is negative. For example, the associated point for the large intestine meridian is located at the L-4 and L-5 vertebral levels. One hand will TL LI-21 and the other hand will TL the L-4 and/or L-5 area. In case of the vertebral set point patterns, the acupuncture head point must be Tled on each side while the vertebral TL is maintained before ruling out the problem.

In cases of vertebrae whose associated meridians are yin meridians (eg. H, Liv, K, Lu, Sp-Pan, Cx) which have no head points, the vertebral set points are checked by TL to the vertebra and the paired yang meridian head point. (See figure 2.) The vertebral set points of the cervical spine are checked with the acupuncture head point of the Lovett brother ("half-wit

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brother") vertebra.

You may have to be creative in finding the correct combination of vertebra and acupuncture head point. For example, a recurrent dorsolumbar fixation pattern may be associated with any of four meridians: GB, Sp-Pan, ST, or TW.

Treatment to correct the vertebral set point problem also involves both doctor and patient. The patient TLs to the involved vertebra (with both hands if possible) and the doctor taps the acupuncture head point fifty or sixty times. Recurrent subluxations often vanish for good.

ABOLISHING RECURRENT MUSCLE WEAKNESS

Treatment for the set point for recurrent muscle weakness is similar to that previously discussed. After a weak muscle has been strengthened by standard procedures, the patient TLs the muscle with one hand and the related acupuncture head point with the other hand. This will weaken a strong indicator muscle. The patient holds the TL contact to the muscle while the doctor taps the acupuncture head point fifty or sixty times. The muscle may require TLing to the belly in some cases, and the origin or insertion in others.

SUGAR METABOLISM

Many, if not most, patients show generalized gamma 2 weaknesses when they taste regular table sugar (sucrose). Some patients' weak muscles strengthen when they taste sugar. We have postulated that the normal human response to tasting of sugar is

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no change in muscle strength. If this postulate is true, then any muscle strengthening or weakening reaction to sugar must represent a fault somewhere in the body. Such is the case and it appears that the fault is a erroneous setting of the sugar set point.

A female juvenile onset diabetic patient, 24 years old, had uncontrollable blood glucose levels even though she was injecting as much as 60 to 70 units of insulin a day. The only consistent fault in this patient, besides always reacting to sugar, was the recurrence of thymus involvement, regardless of the fact that the patient was at one time, taking three distinct thymus supplements. Although the thymus would TL and strengthen a gamma 2 weak muscle, there was no apparent infraspinus weakness. The thymus NL was repeatedly manipulated but with continued recurrence.

When this patient simultaneously TLed the thymus area (over the angle of Louis at the level of the second rib on the sternum) and TW-23, strong indicator muscles weakened. Tapping TW-23 while she TLed the thymus area neutralized her reaction to sugar. Her blood sugar became stabilized on a lesser (40 units) daily dosage of insulin.

From that occurrence to this day, every patient (with only three exceptions) who either weakened or strengthened to sugar has had the sugar reaction neutralized by tapping one or both TW-23 points while the patient TLed the thymus area (and/or the thymus NL).

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The effects of this treatment seem to be permanent except when the patient continues to ingest large amounts of refined sugar. When this apparent sugar set point pattern recurs, the patient is counselled regarding refined carbohydrate ingestion. When dietary prudence is exercised, the sugar set point pattern does not recur. However, around Christmas time, a number of patients show a recurrence of the sugar reaction due to dietary indiscretion.

Correction of the TW-23 - thymus pattern results in a much better tolerance to refined carbohydrates. Following treatment, patients can tolerate eating out at restaurants or other peoples' houses without the fear of going into a hypoglycemic and/or hypoadrenic tailspin.

CALCIUM METABOLISM

Calcium metabolism has become of great general interest amongst both professionals and the public due to the concerns over osteoporosis. One of the most important factors in calcium metabolism is the parathyroid hormone. We know that the parathyroid gland is associated with the levator scapulae muscles and that the related NLs are in the bellies of the teres minor muscles. We also know that the parathyroid - levator scapula are related to the lung meridian. ³

When we suspect a calcium metabolism problem, we first check for and correct any levator scapula weakness by the usual methods. When a patient has a calcium metabolism set point problem, he or she will demonstrate a positive two point TL to

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the parathyroid NL with one hand and to the ipsilateral LI-21 with the other hand. (This two hand procedure is occasionally rather awkward.) The two point TL will be neutralized by insalivation of one or more calcium supplements including those containing parathyroid tissue.

Tapping LI-21 while the patient continues TL to the NL in the teres minor belly corrects the two hand TL pattern. However, in a certain percentage of patients, this correction results in the occurrence of a weakness of a right sided flexor muscle which was previously strong which relates to a need for calcium.

In an earlier paper by one of us (WS) ⁵ the need for each of the electrolyte minerals, calcium, sodium, magnesium, and potassium, was shown to be related to a weakness of a muscle in one quadrant of the body (calcium - right flexors, sodium - left flexors, magnesium - left extensors, and potassium - right extensors). Based on these earlier observations, the exposure of a right flexor muscle weakness would represent an actual need for calcium supplementation now that the calcium set point was reset.

Suppose that the patient had a long term calcium deficiency. The body would have to adapt to the long term need for calcium via various mechanisms including resetting the level of parathyroid activity, hence altering its set point. As part of this adaptive mechanism, a previous weakness associated with a need for calcium (eg. right flexor muscle or upper trapezius) would now test strong. When the set point is returned to normal, if the absolute calcium level in the patient is still low, an

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immediate weakness of a calcium muscle, usually a right flexor, again shows up, now that the previous adaptation has been corrected. This mechanism explains how calcium supplementation can occasionally help a patient with back pain, especially if it occurs on the right side. Failure to supplement with calcium in these patients results in a recurrence of the set point adaptation by the next office visit as is seen by the return of the two point TL of the parathyroid NL and LI-21.

There is no accurate indicator of functional calcium metabolism available to the general practitioner at the present time. We are still in the dark ages regarding a simple, diagnostic indicator of this part of the body chemistry. Therefore, we must speculate on the effectiveness of the set point procedure with respect to calcium. But by the same token, what we have found could be as effective as any other tool known to date.

MISCELLANEOUS APPLICATIONS

The applications of this set point technique are as broad as the doctor's creativity. Several ideas are presently being investigated. For instance, heavy metal toxicity may be able to be improved by changing the set point (eg. for the liver) which may affect the absorption and/or deposition of the heavy metal. Weight loss patterns may also be affected by affecting the thyroid or other organ set points. Food cravings, hunger and satiation, and other dietary intake patterns may be normalized. Likewise sleep patterns may be affected. For example, sleep

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pattern problems are usually associated with serotonin and bladder meridian involvement as will be discussed below.

THE CHEMISTRY OF THE ACUPUNCTURE HEAD POINT SET POINTS

Each of the acupuncture head points for the six major yang meridians (SI, GB, B, LI, St, and TW) has been found to be associated with one or more neurotransmitters or other important chemicals. (See Table 1) When a need for set point technique recurs after it has been previously corrected, and there is no apparent cranial fault, the nutritional components of the associated neurotransmitter are checked.

TABLE 1

SI - NOREPINEPHRINE

B - SEROTONIN

TW - SUGAR METABOLISM, POSSIBLY INSULIN

GB - ACETYLCHOLINE

LI - GAMMA-AMINOBUTYRIC ACID (GABA), GLYCINE, GLUTAMINE

ST - HISTAMINE, KININS (EG., CCK, POSSIBLY BRADYKININ)

When a patient shows positive two point TL to an acupuncture head point and a target point (NL, alarm point, vertebra, or muscle), the appropriate neurotransmitter substance may be placed on the tongue and the two hand TL will be neutralized. Further testing with the nutrient precursors and cofactors of the neurotransmitter will usually reveal that one or more of these substances will negate the two point TL as well. When the same meridian pattern recurs, supplementation of the appropriate

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nutrient(s) will stop further recurrence. The major nutrients for each neurotransmitter are listed in Table 2.

TABLE 2

SI - NOREPINEPHRINE: tyrosine, B-6, folic acid, niacinamide, iron
ascorbic acid, tyrosinase, copper

B - SEROTONIN: tryptophan, B-6, folic acid, iron, niacinamide

TW - SUGAR METABOLISM, POSSIBLY INSULIN: check dietary sugar
intake.

GB - ACETYLCHOLINE: choline, pantothenic acid

LI- GLYCINE: glycine, folic acid, B-6, manganese, B-2

GAMMA-AMINOBUTYRIC ACID (GABA): B-6, glutamic acid which
comes from alpha ketoglutaric acid which comes from the
citric acid cycle which requires: B-1, B-2, B-3,
pantothenic acid, manganese, lipoic acid, and several
others. Also zinc which helps to activate B-6.

GLUTAMINE: same as GABA

St- HISTAMINE, KININS (eg. CCK, possibly bradykinin)

CONCLUSIONS

The concept of set points in the nervous system is getting great acceptance, and quite likely, many of our previous clinical successes involving the endocrine system and other visceral involvements are because we were unknowingly resetting altered metabolic set points. It now appears that we can affect set points of many different metabolic functions by using the concepts of muscle testing as functional neurology, two hand,

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two point TL, and the acupuncture system in a framework compatible with the holographic model of body function.

The necessity of the patient TLing a target area in the body while the doctor taps a head point fits perfectly the concept of object beam and reference beam of holography. The reference beam would normally be thought of as emanating from higher, supraspinal neurological level (i.e., the acupuncture head points).⁶ However, it appears that when the set point is altered, the reference beam is giving the body (object beam) the wrong instructions and the body does not know whether to respond to the supraspinal set point (i.e., reference beam) or the lower level (spinal reflex) anatomical and physiological relationships such as local muscle reflexes or local digestive reflexes, etc. The muscle or organ in question must decide between which of its two masters to serve and this creates a great deal of disregulation in the body.

When muscle weakness in the clear has been corrected, the local anatomical and physiological relationships appear to be restored to normal. Now the area on the body (NL, vertebra, muscle, etc.) may be used as the reference beam and the altered supraspinal set point may be treated back to normal in relationship to the normal body area. It is similar to making the tail wag the dog. As the patient focuses on the normalized body area by TL, temporarily making it the reference beam, the doctor resets the higher level set point (new object beam) relative to this "normal" body point reference beam.

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This is the theory upon which our clinical observations are based. Whether or not it is correct, the clinical results of this set point technique are nothing short of dramatic when it is the basis of the patient's problem. We invite your comments and observations.

SUMMARY

ACUPUNCTURE HEAD POINTS TECHNIQUES

A. HEAD POINTS AND NLS & ALARM POINTS (FOR VISCERAL PROBLEMS)

1. TL to head point.
2. If positive, TL to NL or alarm point for:
 - a. associated Yang organ - should neutralize head point TL, or
 - b. associated Yin organ - should neutralize head point TL.
3. Treat NL. Head point TL now negative.
4. Simultaneously TL head point and NL.
5. If positive, tap head point 50 - 60 times while patient maintains TL to NL.

B. HEAD POINTS AND SPINE.

1. TL to a vertebra. If positive, challenge and adjust.
2. Simultaneously TL vertebra and head point for associated meridian.
3. If positive, tap head point 50 - 60 times while patient maintains TL to vertebra.

C. HEAD POINTS AND MUSCLES

1. Test a muscle. If weak, correct using appropriate factors.
2. Simultaneously TL muscle locations and head point for associated meridian: a. origin b. insertion c. belly
3. If positive, tap head point 50 - 60 times while patient maintains TL to muscle location.

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Abstract

The purpose of this paper is to determine if a Therapy localization (TL) reflects a local phenomenon or if it is a reflex relationship from another area of the body. Therapy localization is a term used indiscriminately in Applied Kinesiology however little has been said as to how one is to determine what exactly is being therapy localized. It is the purpose of the authors to determine how frequently a therapy localization is the result of a local problem and how often it is the result of a reflex response displayed as a result of body relationships.

Introduction

Alan Beardall, D.C. developed a very extensive system of measurement to determine malfunction of the human body. He based his system on the very elaborate system of Dr. George Goodheart and expounded his work to measure body function with a great degree of accuracy. One of the major questions Dr. Beardall asked was , "How do we know what we are accessing when we use the technique of therapy localization?" He then began to develop a system of hand modes to enable the physician to be able to determine with a great deal of certainty what was being diagnosed and what was being treated.

The research done in this paper reflects the work of Dr. George Goodheart, Dr. Alan Beardall and Dr. René Espy. The background work is an accumulation of the many fine therapies of Dr. George Goodheart and the organization of Dr. Alan Beardall. Dr. Espy has written a book called "The Body Beautiful" and the technique used to determine what was being therapy localized is based on her work.

*Specific work of Alan Beardall, D.C.

**Specific work of René Espy, D.C.

Definitions

Group Muscle vs. Specific Muscle Test

A group muscle test (sector test) accesses data from a broad spectrum area of the body as opposed to specific data related to an individual muscle test.

A group muscle test is used to access general data applying to the body as a whole.

A specific muscle test is used to access specific information related to the single muscle being tested and its specific body relationships.

Body as a Computer*

Alan Beardall, D.C. developed the conceptualization that the body could be likened to a computer system. This was not to say that the body is a cold, calculated machine but rather it showed the complexity and the precision with which the body functions and the interrelationship of its many parts.

The computer levels were delineated as follows:

1. Local Computer - displayed by the muscle system.
2. Spinal Computer - displayed by the nervous system and the digestive system.
3. Endocrine System - displayed by the organs and glands.
4. Primary computer - displayed by cerebral function.

To test the four computer levels the following sector check is performed.*

1. Check five sector muscle strength. - Local Computer
 - a. If strong proceed to next test.
 - b. If weak, record.

*Specific work of Alan Beardall, D.C.

**Specific work of René Espy, D.C.

2. Check leg length. - Spinal Computer
 - a. If level, proceed to next test.
 - b. If short, record.
3. Check arm length. - Endocrine Computer
 - a. If level, proceed to next test.
 - b. If short, record.
4. Check skin approximation test (Zygoma). - Primary Computer
 - a. If negative, proceed.
 - b. If positive, record.

Body as a Hologram

Dr. George Goodheart developed the conceptualization that the body functions holographically - that is - all parts should know what the other is doing and express the whole in every part.. At first glance one might suspect that the two views are opposed however if one looks closely it is very obvious that the two systems are interrelated. Dr. Beardall's system of measurement diagnoses the reason why the body is not expressing holographically by determining which computer level is not contributing to the equation.

Therapy Localization

Therapy Localization (TL) means touching the body and observing the response of the body in muscle testing, leg length, arm length or skin approximation test measurements.

Procedure: As you TL the body, all five sectors must react by giving the same response if this would be a choice for point of entry. In order to be able to check the 5 sectors, the leg-locking mechanism must be utilized.

*Specific work of Alan Beardall, D.C.

**Specific work of René Espy, D.C.

At this level of entry into the body the TL is always done with the PALMAR surface of the hand.

When therapy is to be applied, the TL should always be done bilaterally, with the hands side by side, not overlapping.

Leg Lock*

Leg Lock: The leg lock is the mechanism by which the energetics of the hand mode can be held in place without the necessity of holding the pattern in the hands. This enables the Doctor to build a series of related patterns to find the proper correction to a specific problems. The leg lock discussed in this paper is called the Straight Lock (SL) mechanism.

Leg Lock: The straight leg lock mechanism is activated by abducting the legs 30 degrees from the midline. The legs are held in this position until it is no longer necessary to hold the mode.

At times it may be necessary to test one leg for muscle tone. The leg lock mechanism is still valid, as long as one leg remains in the abducted position.

Arm Lock*

Arm Lock: The arm lock is the mechanism by which the energetics of the hand mode can be held without the necessity of holding the pattern in the hands. It is used when it is necessary to bring the legs together in order to check for leg length, or whenever it is inconvenient to activate the leg lock.

Arm Lock: The arm lock mechanism is activated by placing the hands in the "praying hands" position and placing them on the center of the top of the head.

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Hand Modes*

Hand Mode: A Hand Mode is a biodynamic electrical pattern of body energy that is manifested by placing the fingers in specific configurations. Once the pattern is activated and placed in both hands, the brain and nervous system hold the display until the hands are opened.

The most common direction of moding is "right to left," following the normal brain dominance pattern. However, there are exceptions to the rule: if information is stored in the right brain and is necessary for processing, then the body will switch polarity and moding will be from left to right until the information needed is brought forth. Some left-handed patients require moding from left to right.

Rules:

1. The hand mode should be placed in the patient's hand whenever possible.

Exceptions:

- a. Patient with severe arthritis
- b. Small child (If possible have parent hold the hands)
- c. Patient with missing limb or digit.

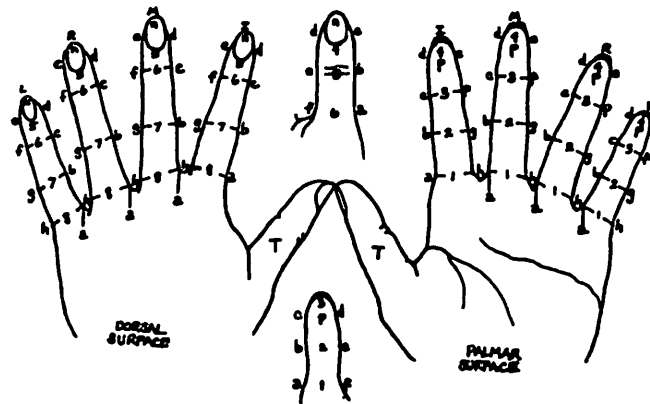
In the above cases, the Doctor or the assistant can place the bilateral hand mode on the body of the patient and have the patient perform the leg lock mechanism to hold the mode within the energetic pattern.

Note: It is important to allow the patient's body to access information, whenever possible, rather than have the Doctor place the mode in their hand and place it on the body of the patient.

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Hand Mode Pattern Code*



2. The hand mode should be held at all times until the correction is made or the leg lock is activated.

Submode Pattern

The following are the finger position submodes.*

1 = Thumb	123 = Thumb/Index/Middle
2 = Index	124 = Thumb/Index/Ring
3 = Middle	125 = Thumb/Index Little
4 = Ring	134 = Thumb/Middle/Ring
5 = Little	135 = Thumb/Middle/Little
12 = Thumb/Index	145 = Thumb/Ring/Little
13 = Thumb/Middle	234 = Index/Middle/Ring in palm
14 = Thumb/Ring	235 = Index/Middle/Little in palm
15 = Thumb/Little	245 = Index/Ring/Little in Palm
23 = Index/Middle in palm	345 = Middle/Ring/Little in Palm
24 = Index/Ring in palm	1234 = Thumb/Index/Middle/Ring
25 = Index/Little in Palm	1235 = Thumb/Index/Middle/Little
34 = Middle/Ring in Palm	1245 = Thumb/Index/Ring/Little
35 = Middle/Little in Palm	1345 = Thumb/Middle/Ring/Little
45 = Ring/Little	2345 = Index/Middle/Ring/Little in Palm

Body Relationship Hand Mode**

This mode reflects the relationship of one part of the body to another. It is positive when an area of complaint is a direct reflex of some other related area of the body.

*Specific work of Alan Beardall, D.C.

**Specific work of René Espy, D.C.

Submode Mode*

This mode links two areas of the body together in a relationship flow.

Sequence Mode*

This mode sets up the sequential flow so the body can access data as it is systematically related.

Vertebral Level Mode**

This mode is positive only when a vertebral level is the area of display when preceded by the Body relationship Hand Mode.

Body Relationship Therapy Mode**

This mode sets up the therapeutic flow to determine what area of the body is to be treated to clear the therapy localization.

One Point/Two-Point

A One Point is defined as TL, a hand mode or a weak muscle in the clear. It is the point at which diagnosis or therapy begins.

A two point is defined as anything that causes a change from the measured response of the one point.

Vertebral Level*

The vertebral level as defined in Clinical Kinesiology muscle correction refers to the nerve supply that is related to the organ reflex phenomena to a muscle.*

*Specific work of Alan Beardall, D.C.

**Specific work of René Espy, D.C.

Myomere*

The myomere reflects the area of normal nerve innervation to a specific muscle.*

Organ Relationship*

Organ Relationship refers to the organs related to the muscle. Dr. Beardall found two organs directly related to each muscle of the body with the exception being the diaphragm sections which have three.

Acupuncture Point*

The specific acupuncture point related to the muscle and is located on the contralateral side of the body. These points act as energizers or circuit overload points throughout the body.*

Procedure**Criteria**

Very specific criteria was used to gather data for the investigation. They are as follows:

1. The area of TL must be reflected holographically, that is, all five sectors, arm length and leg length and skin approximation test must be intact.
2. A bilateral TL must give a two-point response.
3. The Body relationship hand mode gives a positive response and two points bilaterally.
4. The only data measured and collected related to the vertebral level relationships in order to keep the study reasonable and measurable.

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**Specific work of René Espy, D.C.

Procedure

1. Test all five sectors, arm length, leg length and skin approximation. Record data.
2. TL an area of complaint. If the area displays holographically proceed, if not proceed to clearing (not a part of this study).
3. Test the Body Relationship Hand Mode. If positive, insert bilaterally. If negative, test specific local hand modes.(Not a part of this paper).
4. Determine the pattern of display relationship by testing the Sequence Mode. Straight Lock. Mode: T3-Mp, Me-Ld
5. Test the vertebral level hand mode. If positive determine the specific level.**

2 - C2	34 - T6
3 - C3	35 - T7
4 - C4	45 - T8
5 - C5	123 - T9
12 - C6	124 - T10
13 - C7	125 - T11
14 - T1	134 - T12
15 - T2	135 - L1
23 - T3	145 - L2
24 - T4	234 - L3
25 - T5	234 - L4
	235 - L5

Note: The atlas is omitted as it does not have muscle attachments and is under an entirely different system of body relationships.

6. Once the specific vertebral level is determined apply the mode bilaterally. Straight lock.
7. Test the Body Relationship Therapy Hand Mode. If positive apply bilaterally and submode to determine the specific correction.

Patients used in this study were not preselected. The patients measured were regularly scheduled over a seven day period and only patients with a positive TL were documented for this study. The only Body Relationship data that was collected was that relating to vertebral

level relationships for ease in accumulation and calculations. The following charts illustrate whether the areas of TL required treatment of a local nature or whether there was a positive response to the Body Relationship Hand Mode.

T L	Local Therapy	Body Relationship	Hand Mode
Low Dorsals			x
Sacrum			x
Left Scapulax			x
Right Shoulder			x
Left Hip			x
Neck			x
Area Of Infection			x
C-Spine			x
C-Spine			x
Right Ovary			x
Left Shoulder			x
Right C-Spine			x
Right Buttock			x
Right Hip			x
Right Hip			x
Left Upper Trapezius			x
Neck			x
Left Hip			x
Left Upper Trapezius			x
Left Ovary			x
Bilateral Thumbs			x
Kidneys	x		
Liver	x		
Desc. Colon	x		
Midbrain	x		
Bil. Knees			x
Left Temporal Bone			x
Left Knee			x
Left Groin			x
Kidney	x		
C-Spine	x		
Pancreas			x
Kidney			x
Midbrain			x
Lungs			x
Lungs			x
Liver			x
Lungs			x
Low Back	x		
Low Back			x
Right Groin	x		
Liver	x		
Lower Pelvis			x
Lungs			x
Desc. Colon	x		
Midbrain	x		
Liver	x		
Midbrain			x
Parotid Gland			x
Parotid Gland			x

The purpose of the paper was to distinguish between a local phenomena and a body relationship. However interesting results were noticed regarding which areas of the body necessitated treatment.

The areas requiring treatment were as follows:

VL Rel.	VL	Muscle	Cranial	Myomere	Foot	Acupuncture	Nutrient	Organ Rel.
T4				x				
L4		x						
L5				x				
C6							x	
L2				x				
C4			x					
T3				x				
L5					x			
C5					x			
T3				x				
C3				x				
C6			x					
T11					x			
L4		x						
C6					x			
T9					x			
T11				x				
C6							x	
L4								x
T5						x		
T1						x		
L5			x					
L5				x				
T9				x				
L5	x							
T3	x							
T5					x			
T3					x			
C5					x			
T10			x					
C3				x				
T10		x						
L5					x			

Discussion

It was interesting to note that the area of TL was predominantly a body relationship rather than a local phenomena in the majority of cases tested. It was also interesting to note the predominant area of the body that required therapy.

If the Body Relationship Hand Mode was positive the only data accumulated was from those patients with positive vertebral level relationship hand modes for simplicity sake in accumulating data in this study. It is interesting to note that the majority of therapy was not at the level of entry but more frequently a myomere relationship or a foot subluxation.

The supposition that a TL is a display of the area being accessed is possibly presumptuous. The above data leads to the conclusion that we must look beyond the superficial to allow the complexity of the body to express itself rather than the practitioner assuming the burden of proof.

As Dr. Goodheart has reminded us many times, "The body is simply intricate and intricately simple." Dr. Beardall has often quoted Paracelsus, "The mere looking at externals is a matter for clowns, but the intuition of internals is a secret which belongs to physicians."

It is hoped that this paper gives rise to a new awareness of the beautiful body that houses a most complex array of energy that is held together by a force which we have only begun to understand.

BODY RELATIONSHIP PROCEDURE

1. Therapy Localize an area of complaint. Straight Lock.
2. Test the Body Relationship Hand Mode. If positive pass to the other hand and straight lock.

Mode: T3-Ic, Flex Prox. & Distal Phal. 234, L4-Rf.**

3. Determine the pattern of display relationship by testing the Sequence Mode. Straight Lock.

Mode: T2-R4*

4. Test the vertebral level relationship hand mode. Straight lock.

Mode: T3-Mp, Me-Ld**

Submode to the specific vertebral level.

5. Test the Body Relationship Therapy Mode. If positive pass across to the other side. Straight Lock.

Mode: T3-Ic, -IMR, L4-Rf.**

6. Test Submode Mode. Pass across to the other side. Straight Lock.

Mode: T3-Ma, I4-T4.*

Submodes:

- 1 - Vertebral Level
- 2 - Muscle
- 3 - Cranial Bone
- 4 - Myomere
- 5 - Foot
- 12 - Acupuncture Point
- 13 - Nutrient
- 14 - Organ relationship

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Therapy explanation:

1 - Vertebral Level - Submode the positive level. Determine if the adjustment is to be on the right or left by the side of positive submode. Right for right or left for left.

2 - Muscle - Submode the positive muscle. Submode the proper therapy.

Determine Submodes:*

- | | |
|---------|----------------|
| 1 - NV | 12 - Myomere |
| 2 - NL | 13 - Nutrition |
| 3 - VL | 14 - Cranial |
| 4 - MAP | 15 - Foot |
| 5 - VOR | |

3 - Cranial Bone - Submode the positive bone. Adjust .

4 - Myomere - Submode the positive myomere. Adjust. Can be either side. Usually on the side of muscle weakness.

5 - Foot - Submode the positive bone. Adjust.

12 - Acupuncture Point - Submode the positive point. Check for Hyper or Hypo

Hyper - Rapid succession tap/ inspiration - abdominal compression*

Hypo - Tap sequence of eight/expiration - abdominal expansion.*

13 - Nutrient - Submode the positive nutrient. Determine dosage.

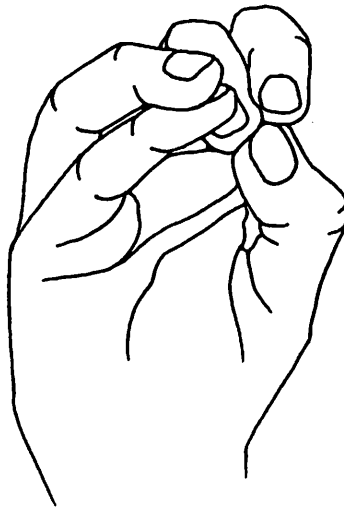
14 - Organ Relationship

a. Submode the Organ relationship

b. Put in Organ Relationship Therapy Mode bilaterally:

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Mode: T3-I4M4,Lp-Mn,Rp-Ln**

Submodes:

- 1 - Organ/Organ Polarity. Pulse positive organs until a synchronous pulse is felt.
- 2 - Organ/Spine Polarity. Pulse positive organ to a specific area(s) of the spine.
- 3 - Specific Nutrient related to the positive organ.
- 4 - Specific Muscle. Determine muscle related to organ. Treat.
- 5 - VL. Submode according to Organ.
- 12 - Cranial. Submode according to organ.
- 13 - Organ Flush (Light, Gentle Massage)
- 14 - Myomere. Submode according to organ.
- 15 - Organ/Tissue Polarity. TL area around organ. Find area of tissue TL. Hold until synchronal pulse is felt.

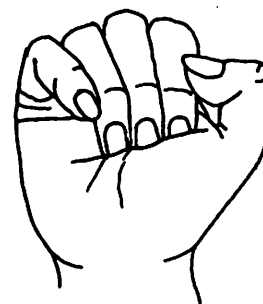
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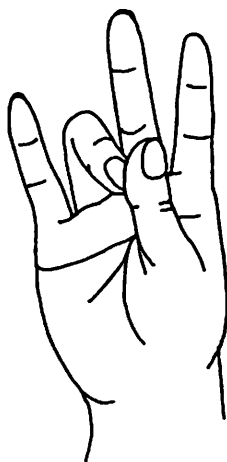
Body Relationship**

Mode: T3-Ic, Flex Prox. & Distal Phal. 234, L4-Rf



Body Relationship Therapy**

Mode: T3-Ic, -234, L4-Rf



Sequence*

Mode: T2-R4



Vertebral Level Relationship**

Mode: T3-Mp, Me-Ld

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Submode*

Mode: T3-Ma,I4-T4

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ABERRANT FIRING OF THE TONIC LABYRINTHINE REFLEXES IN THE PRONE AND SUPINE POSITIONS

Walter H. Schmitt, Jr., D.C.

Abstract: Tonic labyrinthine reflexes (TLR) will facilitate all limb extensors in the face up position and all limb flexors in the face down position. Gamma 2 weakness of any extensor in the supine position or any flexor in the prone position represents an aberrant TLR pattern which is related to a temporal bone fault. The TLR are intimately connected to functional endocrine imbalances. Correction of TLR in the prone or supine positions abolishes many functional endocrine problems. Recurrence of TLR problems may be treated by correcting functional endocrine imbalances.

INTRODUCTION

Most chiropractors spend the majority of time testing and treating their patients with the patients in either the prone or supine positions. Other professionals, such as dentists, also treat supine, face up patients. Applied kinesiologists test muscles in a variety of positions, but the supine position and prone position are the standard positions for most tests.

Much relevance has been made over the distinctions between recumbent and weight-bearing testing, both standing and sitting, but it has always been assumed that there is no particular difference between testing patients in either supine or prone positions. However, nothing could be further from the truth, based on the functional neurology of the tonic labyrinthine reflexes (TLR).

REVIEW OF TLR PATTERNS

The TLR are present at birth and may be seen to manifest themselves by changes in the head positions in relation to gravity in infants up to about the age of four months. After the

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age of four months or so, as other higher centers of the nervous system myelinate, the TLR retreat to a role which is subservient to other reflexes such as visual reflexes, movement reflexes, and eventually righting and postural reflexes. However, the neurological substrate of the TLR remain present throughout life and are constantly active. Because they arise from supraspinal levels, the TLR affect gamma 2 (as well as gamma 1) muscle weakness patterns. ¹ The evidence of patterns of facilitation and inhibition based on TLR activity which may be observed using gamma 2 muscle testing procedures has been the topic of two previous papers by this author. ^{2, 3}

TLR activity monitors the position of the head of the infant (and the adult) in relation to gravity. Since the infant cannot lift the head, these reflexes are concerned primarily with four positions: 1) face up, 2) face down, 3) right ear up and left ear down, 4) left ear up and right ear down. It is the face up and face down positions which are the emphasis of this paper.

FIGURE 1

TONIC LABYRINTHINE REFLEXES

FACE UP
Facilitates Extensors
Inhibits Flexors
(All Limbs)

FACE DOWN
Inhibits Extensors
Facilitates Flexors
(All Limbs)

Figure 1 reviews the patterns of facilitation and inhibition

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associated with the TLR in both the face up (i.e., patient supine) and face down (i.e., patient prone) positions. These patterns result in gamma 2 motor neuron facilitation and inhibition patterns as they originate from supraspinal areas and are concerned with tonic (rather than phasic) muscle activity.

Note that in the face down position, the flexors of all limbs are facilitated and all limb extensors are inhibited. It is this reflex pathway which is the basis for the old axiom about a cat always landing on its feet. That is when the cat is tossed in the air, it first must visually orient its head in the face toward the ground position, and then automatically, due to the TLR, the four limbs' flexor muscles are facilitated to come under the cat so it falls on its feet.

The same pattern is true, or at least should be true for our patients. When our patients are prone, there should be a facilitation of all limb flexors and an inhibition of all limb extensors. Since most of our muscle tests for extensor muscles are performed in the prone, face down position, we are more likely to find an extensor muscle weakness in this position, which is quite convenient.

In a similar manner, in the face up position, all limb extensors are facilitated and all limb flexors are inhibited. Again, we see the lucky coincidence that most of our flexor muscle tests are routinely performed in the supine position making it easier to find these muscle weaknesses.

But by the same token, if the TLR are constantly active in

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our patients, we should never see an extensor muscle weak in the supine position, nor a flexor weak in the prone position. And yet, think how many patients have a weak latissimus dorsi (an extensor) when tested in the supine position! Originally, it was thought that any supine weakness of an extensor or any prone weakness of a flexor was present because the sources of inhibition to that muscle greatly outweighed the TLR source of facilitation. This, however, was an improper assumption!

ABERRANT TLR FUNCTIONING

In fact, any extensor muscle weakness which is present in the supine (face up) position, represents aberrant feedback from the TLR. And any flexor muscle which tests weak in the prone (face down) position likewise represents a problem with the TLR feedback. In other words, the TLR are so powerful that their normal affects on the nervous system will create enough facilitation of flexors when the face is down and the extensors when the face is up that we should never find an extensor weakness with the patient supine, nor a flexor weak with the patient prone.

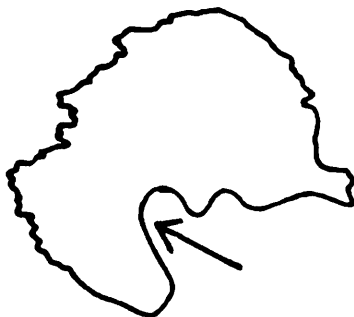
The TLR are initiated in the labyrinthine mechanism in the inner ear which is imbedded deep in the petrous portion of the temporal bone. It was hypothesized that prone flexor weakness and/or supine extensor weakness could originate in temporal bone faults. This hypothesis was tested by therapy localization (TL) to the temporal bones while observing for changes in muscle testing of extensors in the supine position and flexors in the

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prone position.

Careful TL revealed that any gamma 2 weakness of a flexor muscle in the prone position would be neutralized by TL to the most anterior, superior portion of one of the mastoid processes. See Figure 2. Likewise, any gamma 2 weakness of an extensor muscle which is present in the supine position will be negated by TL to the anterior-superior mastoid area on one side or the other.

FIGURE 2
LOCATION OF MASTOID TL TO IDENTIFY TLR - TEMPORAL BONE FAULTS



There has been no apparent correlation observed between side of muscle weakness and side of mastoid TL. Nor has the weak muscle consistently demonstrated a response to either phase of respiration. However, the mastoid TL will only be positive in the position in which the problem exists. The body only recognizes that there is a problem when that problem is accentuated by the prone or supine position. As far as the nervous system is concerned, a weak flexor supine or a weak extensor prone is a part of the "normal" TLR pattern.

Continued observations led to the conclusion that this TLR

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fault is best corrected by respiratory correction of the temporal bone using Walther's method of vector analysis. ⁴ Interestingly, the direction of challenge and the phase of respiration which negates the challenge do not necessarily correlate with predicted AK cranial technique corrections. Likewise, this TLR temporal bone fault is not associated with pre-test imaging which has been proposed as a screening test for cranial faults by this author, and which often reveals actual temporal bone cranial faults. ⁵

Therefore, it is believed that this TLR - temporal bone fault is not a cranial fault as such, but a lack of synchronization between right and left labyrinthine mechanisms which can be phased together by a correction which is typical of a cranial fault.

Example 1: A patient shows a weakness of the right latissimus dorsi in the supine position. Pre-test imaging is negative. Since the lat is an extensor, and as such, should not be weak in this position, each mastoid process is Tled. The left mastoid TL negates the right lat weakness. The mastoid challenge is positive in an A to P direction and this is neutralized by inspiration. The mastoid is then pushed A to P coincident with inspiration six or seven times. The lat is now strong, regardless of position.

Correction of the TLR temporal bone fault must be made in the position where the problem was found. In other words, if a flexor weakness is present in the prone (face down) position, the temporal, must be challenged with the patient prone. If an extensor is weak in the supine position, the temporal must be challenged and corrected in this position. TL and challenge will

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be positive only in the position of aberrant TLR firing.

Example 2: A patient has a right pectoralis major, clavicular (PMC) in the supine position. Pre-test imaging is negative. The patient is placed prone and the PMC is retested and the weakness is still present. TL to each mastoid process at its anterior-superior aspect reveals that TL to the right mastoid neutralizes the PMC weakness in the prone position. Challenge of the mastoid in a direction of P to A with a slight lateral to medial vector is positive. This challenge is neutralized by inspiration. TL and challenge are only present in the prone position. The mastoid is pressed in the direction of positive challenge coincident with inspiration six or seven times with the patient remaining in the face down position. The PMC is now strong regardless of prone or supine position.

The TLR - temporal bone faults often remain present even after cranial fault correction. In fact, as a matter of procedure, it is necessary to first identify (by pre-test imaging, TL, and challenge) any cranial faults prior to looking for TLR patterns. The recommended procedure is to identify and correct any cranial faults, then retest a previous gamma 2 weak muscle or muscles in the face up or face down position which should facilitate them. Presence of weakness of a flexor prone or an extensor supine following any correction (cranial or otherwise) represents the presence of a TLR problem.

Example 3: A patient has a gamma 2 weakness of the right serratus anterior. Pre-test imaging of the muscle causes it to strengthen. TL and challenge to the cranium reveals a right internal frontal fault. Correction of the internal frontal also corrects the gamma 2 weakness of the serratus anterior. However, when the patient is placed in the prone position, the gamma 2

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weakness of the serratus anterior returns. This weakness is neutralized by TL to the left mastoid area. The mastoid shows positive challenge from P to A and from medial to lateral. This challenge is neutralized by inspiration. The correction is made, in the prone, face down position, in the direction of weakness coincident with inspiration, six times. The serratus is now strong in any position of the body and the head.

Correction of the temporal bone with respiration results in a strengthening of the gamma 2 weak muscle(s) in either prone or supine positions. Many spinal adjustments seem to be much easier after this TLR correction. This makes sense since any alteration of flexor-extensor muscle balance would add muscle tone which would make relaxation of the patient more difficult. This is especially true when the position of the head is changed in relation to gravity such as in rotary cervicals or side posture adjustments.

TLR AND ENDOCRINE FUNCTION

Based on an original observation communicated to me by Dr. Dale Sandvall in 1986, we have observed a direct correlation between TLR problems and functional endocrine problems. That is, whenever there is a TLR problem, there is a systemic functional endocrine problem. And whenever a systemic functional endocrine problem is found, there will be TLR involvement.

The only previous basis for this observation is the familiar postural hypotension and associated dizziness which is so often found in functional hypoadrenia. Although we have always attributed this to lack of cerebral circulation upon rapid change

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from recumbent to upright posture, the dizziness must have some connection with the balance mechanism in the labyrinthine system. To date, the neurological substrate for the TLR - endocrine connection has not been identified by this author.

When we find systemic endocrine involvement as discussed in Common Glandular Dysfunctions in the General Practice,⁶ our former procedure was to identify the major organ of involvement and direct our therapies there. The TLR - endocrine connection has taught us two very important new clinical rules to follow.

First, empirically, it has been observed that it is more important in the hierarchy of the nervous system, and for subsequent treatment procedures, to correct the TLR first as this usually corrects all muscle testing indicators of endocrine dysfunction.

And secondly, the corollary to the first rule, if TLR problems recur, the endocrine system must be examined and treated in order to maintain TLR correction.

The practical application of these rules is that, upon finding a TLR problem by identifying a prone flexor or supine extensor weakness, we proceed to TL to each mastoid process, challenge, and make a respiratory temporal correction without even considering the endocrine system. If however, patterns of TLR problems show up repeatedly in the patient, we will then identify the major endocrine involvement by cross TL⁶ and supply the appropriate glandular therapies, both nutritional and reflexes, as well as making the temporal bone correction.

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Only rarely does correction of the endocrine involvement negate the challenge of the mastoid process, although treating the endocrine reflexes will temporarily strengthen the previous gamma 2 flexor or extensor weaknesses which were the indicators of the TLR problem. The temporal correction must still be made and will result in additional improvement in range of motion, temperature, or other objective parameters.

Example 4: A patient has a weakness in the left PMC tested supine. Also weak are the right gluteus medius, right teres minor, and left sartorius. PTI is negative. Each of these three endocrine related muscles strengthen with TL to the left sartorius neurolymphatic reflex (NL). The left PMC is also weak with the patient prone. The PMC becomes strong in the prone position with TL to the right mastoid process. The right mastoid challenges from A to P and this is negated by inspiration. The right mastoid is treated, in the prone position, by pressing the mastoid in the direction of weakness (A to P) with inspiration seven times. The PMC is now strong in any position. None of the previously weak endocrine related muscles are weak, and TL to the NL for the left sartorius is also negative.

COMPLEX PATTERNS

We have observed some patients who show a supine extensor weakness and a prone flexor weakness simultaneously. Each of these problems must be identified in its respective position, and each must also be corrected in its respective position. Occasionally, we have observed the same mastoid process to TL for a prone TLR problem, as well as for supine TLR problems. However, when this occurs, we have usually found that the direction of challenge and the phase of respiratory correction

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are totally different in each position. This observation lends credence to the premise that these TLR problems are not cranial faults, but rather part of a much different neurological integration based on the coordination of body position, respiration, and the balance system mechanism.

CONCLUSIONS

The TLR patterns are excellent examples of how we can use muscle testing as functional neurological evaluation in the clinical setting. Each of us is continuously under the influence of our own TLR and so are each of our patients. A critical look at these inborn reflex patterns and their precise correction when necessary are essential in order for our patients to reach their optimal health levels.

Due to the supraspinal nature of the TLR, we have found the importance of their correction second only to that of cranial faults in the hierarchy of the nervous system. Recurrent subluxations and chronic endocrine dysfunctions will begin to disappear in many patients when the TLR are working as they were designed. When we apply our therapies based on the hierarchy of the nervous system, using muscle testing as functional neurology, our patients respond faster with less efforts on our parts.

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SUMMARY OF PROCEDURES BASED ON THIS PAPER

1. Rule out or correct cranial faults based on pre-test imaging.
2. Test gamma 2 flexors for weakness in the prone position.
Test gamma 2 extensor weaknesses for weakness in the supine position.
3. If either is positive in 2., TL to each mastoid process with the patient in the position which the aberrant TLR pattern showed up.
4. Challenge the TLing mastoid process. Identify a direction of weakness.
5. Identify a phase of respiration which negates the mastoid challenge.
6. Correct the mastoid in the direction of challenge weakness with the phase of respiration which negated the weakness, six or seven times, in the prone or supine position where the aberrant TLR pattern was observed.
7. If any aberrant TLR pattern recurs on next visit, check each endocrine NL reflex by TLing it against any gamma 2 weak muscle which shows the aberrant TLR pattern.
 - a) Treat the related organ and supplement as indicated.
 - b) Also, challenge and correct mastoid process as above.

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THE LINGUAL ASCORBIC ACID TEST AS A SCREENING
TEST FOR OXIDATION-REDUCTION IMBALANCES (OVER-OXIDATION)

Walter H. Schmitt, Jr., D.C.

Abstract: The lingual ascorbic acid test (LAAT) is viewed as more of an indicator of oxidation-reduction imbalances in the body than an absolute indicator of vitamin C levels. Over-oxidation of the tissues will cause a conversion of the active anti-oxidant, ascorbate, into its inactive, dehydroascorbate form. This will result in the LAAT indicating low tissue levels of vitamin C when actually there is plenty of vitamin C, but it is mostly in its inactive form.

INTRODUCTION

The lingual ascorbic acid test (LAAT) was designed to evaluate tissue levels of ascorbic acid, specifically those of the tongue. A LAAT time of 20 seconds or greater implies a deficiency of ascorbic acid of the lingual tissues. The chemistry of the LAAT is based on the disappearance of a blue color on the tongue surface by the inactivation of 2, 6-dichlorophenol-indophenol, sodium salt, a blue colored dye. This blue dye is converted to its colorless form by being reduced by L-ascorbic acid (ascorbate). During this oxidation-reduction reaction, ascorbate is oxidized to dehydro-L-ascorbic acid (dehydroascorbate). In normal tissue vitamin C levels, the blue color will disappear from the tongue surface in less than 20 seconds. 1, 2

Ascorbate is an anti-oxidant by virtue of its ability to become oxidized to dehydroascorbate in the presence of an oxidizing substance or an oxidizing environment. The ascorbate preserves other molecules by sacrificing itself in place of more important molecules, such as cell membranes, enzymes, hormones, neurotransmitters, and so on.

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The use of the ascorbate molecule as a chemical sacrificial lamb is quite efficient in that the oxidized form of the molecule, dehydroascorbate, is normally recycled back into ascorbate. That is, ascorbate is the active form of vitamin C. In its function as an anti-oxidant, it is oxidized to dehydroascorbate, its inactive form, then it is recycled back into its active, ascorbate form.

For years and on hundreds of patients, it has been commonly observed by Goodheart, ³ this author, and others, that many patients demonstrate abnormal LAAT times. McCord documented that 37% of 1112 patients showed abnormal (i.e. greater than 20 seconds) LAATs, and that 19.7 % showed discrepancies of greater than five seconds between the right and left sides of their tongues. ⁴

Further, we have commonly observed rapid changes in LAAT times while treating patients. Sometimes these changes are incredibly dramatic with LAAT's of greater than 50 or 60 seconds returning to the normal range of 20 or below, with absolutely no increase in vitamin C ingestion, and often with no oral nutrient testing of any substance occurring.

In other words, applied kinesiological treatment procedures alone have routinely resulted in normalization, or at least large changes toward normal, of the LAAT when it is performed immediately before and after the treatment procedure.

POSSIBLE EXPLANATIONS

It seems highly unlikely that the body makes more ascorbic

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acid out of nothing, especially since the human body cannot synthesize ascorbic acid. In an effort to understand this phenomena, several ideas have been suggested as possible explanations.

One idea which has been presented is that the body has enough ascorbic acid, but that it is not equally distributed, and that treatment procedures help normalize this distribution with the tongue being a recipient of this process. ^{3, 4} Another idea is that there is plenty of ascorbic acid in the gut, but that it can not be absorbed due to structural imbalances.

Still another observation is that changes in LAAT are most often seen in patients who also display an ileocecal valve (ICV) syndrome, and that the self-intoxication created by the ICV somehow causes the body to rapidly use up its ascorbic acid stores. Correction of the ICV reduces the toxicity and allows better utilization of ascorbic acid by the tissues. As it turns out, this latter explanation may actually be the closest to the truth.

OXIDATION - REDUCTION IMBALANCES (DYSOXIA)

The oxidation-reduction balance of cellular chemistry is maintained via the electron poisoning system. ⁵ This system is an elegant series of chemical steps which serve to assure the cell of an adequate supply of both oxidizing and reducing substrates. The balance of oxidation and reduction around the midpoint of the electron poisoning curve depends on an adequate supply of various vitamins (A, C, E, B-2, B-3), minerals (copper, manganese, zinc,

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selenium, and iron), and hormones (steroids and thyroxine).

A cellular system can become altered from normal when the numbers of oxidizing species (eg., free radicals) produced are greater than the ability of the electron poisoning system to handle them. This is called an over-oxidized cellular environment. Likewise, an excess of reducing equivalents beyond the cells available capacity will result in an over-reduced cellular environment.

Similarly, too little oxidation activity can result in an under-oxidized environment. And too little reducing activity can result in under-reduction of the cell. There is a tendency for over-oxidation and under-reduction to be present together. Likewise, over-reduction and under-oxidation are often different sides of the same coin.

These cellular metabolic imbalances can occur in different tissues of the body at the same time which makes diagnosis difficult. In other words, a patient may be over-oxidized in his liver, but his muscular function may suffer from under-oxidation. Any combination is possible, and as a result, these disregulations of cellular chemistry have been grouped under the heading of "dysoxias" by Dr. Leo Galland. ⁶ Galland discusses two categories of dysoxia: 1. impaired oxidation (i.e., under-oxidation and over-reduction), and 2. oxidative stress (i.e., over-oxidation and under-reduction).

OVER-OXIDATION AND THE LAAT

In oxidative stress, when the cells of the body become over-

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oxidized, this is often reflected in an over-oxidation in the tongue tissues. In an over-oxidized environment, ascorbate will tend to be overworked in its anti-oxidant capacity. If the oxidative stress is excessive and/or of the availability of other anti-oxidant substances is depleted, then ascorbate may be oxidized to dehydroascorbate to such a great extent that the majority of vitamin C in the tissues (eg., tongue) is all in its inactivated form.

In other words, there can be plenty of vitamin C in the tissues, but it can all be in its inactivated, oxidized, dehydroascorbate form in the presence of an over-oxidized cellular milieu. In this case, the LAAT will show a high number (> 20 seconds) indicating what we may erroneously interpret as an ascorbic acid deficiency. However, what the high LAAT really means in this case is that there is not enough activated ascorbic acid.

This model serves as the basis for a rational explanation of the rapid changes seen in LAAT as a result of chiropractic AK therapies. By either increasing reducing activity such as treating adrenal or gonadal systems to increase steroid hormone activity, or by decreasing oxidizing processes by correcting sources of toxicity as the ICV and treating the liver to improve detoxification, the environment of the body can be changed toward normal oxidation-reduction balance. The result is a normalization of the oxidative stress of the cells and the dehydroascorbate can be readily be converted back into the active

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anti-oxidant form, ascorbate. More ascorbate in the active form becomes available and the LAAT test changes dramatically towards normal within the few minutes time which the treatment procedures require.

We have observed an apparent clinical correlation between a positive clorox test ⁷ and a high LAAT. It is interesting to note that small intestine neurolymphatic (NL) activity is one of the manipulative corrections which we make to neutralize the clorox test in some patients. This observation correlates well with Goodheart's observations that small intestine involvement is often seen when there is a right - to - left discrepancy in LAAT times. ^{3, 4} Whenever there is free radical pathology and oxidative stress, one would suspect an over-oxidized environment and a high LAAT. We now use the LAAT together with the patient's diet history to better understand the significance of these tests.

IMPORTANCE OF DIETARY HISTORY

If the patient has adequate supplies of vitamin C in the diet, or is supplementing with vitamin C, and the LAAT is high, we suspect free radical pathology and oxidative stress. When the diet is poor in vitamin C foods, if the patient is a smoker, or on salicylate type drug or a sulfa drug medication which destroys vitamin C, then we consider a high LAAT as a possible indicator of an actual need for more vitamin C. However, we also check the clorox test, ICV, adrenals, and other factors which might contribute to an oxidative stress environment and correct these

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as indicated.

It is important to note that ascorbic acid itself can become a free radical, and some patients who are ingesting thousands of milligrams a day of ascorbic acid are actually harming themselves. When vitamin C supplementation is present in the 1000 mg. or greater range, and the patient shows free radical symptoms, a positive clorox test, or other signs of oxidative stress, the doctor should test the patient against oral insalivation of his or her vitamin C product. Many of the patients who show these characteristics will be seen to weaken on tasting the vitamin C that they think is helping them.

CONCLUSIONS

The LAAT test is an indicator of activated vitamin C in the tongue. High LAAT values (i.e., low tissue vitamin C) may be present for two reasons: 1) an actual tissue need for vitamin C, and/or 2) the presence of oxidative stress and a low level of activated vitamin C.

The latter case is often present when the actual levels of vitamin C are adequate, yet all of the ascorbate has been converted to its inactive, dehydroascorbate form. This situation is the more commonly encountered in our office. On those rare instances where we cannot change the LAAT by AK treatment, we consider supplementation. More often, the LAAT serves as an indicator of the relative oxidation-reduction status of the body (or at least the tongue) and as such gives a valuable tool for the understanding of our patients' physiology.

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THE FUNCTIONAL NEUROLOGY OF PAIN AND PAIN CONTROL

CLINICAL APPLICATIONS AND NEW TECHNIQUES

Walter H. Schmitt, Jr., D.C.

Abstract: The afferent pathways which result in the awareness of pain and other neural connections which influence these pathways are discussed. The difference between mechanical and chemical sources of pain is reviewed. Localization of pain and identification of the nature of pain take place in the somatosensory and viscerosensory cortex. Memory of painful experience resides in the temporal lobe. New techniques for identifying and correcting faults associated with these cortical areas are presented. Since this paper is a review of many recent textbooks on pain, a bibliography covering these sources is presented in place of references. Other references are included.

INTRODUCTION

The Melzack-Wall theory of pain is dead! Long live the new neurology of pain!

Recent advances in the neurology and physiology of pain have greatly changed the way we think about pain and pain control. For example, the original gate control theory of pain control which was proposed by Melzack and Wall in 1965 been shown to be based on erroneous principles as technological advances in neuroanatomy have invalidated the neurological basis for this theory. Newer findings have preserved the idea of a gate type concept for pain transmission and pain control, but in an entirely new light as will be discussed. And recent progress in the neurochemistry of pain has given rise to many new chemical applications for pain control, both pharmacological and nutritional.

Pain is now viewed as an emotional experience rather than a sensory experience. We do not have special sense for pain as we

do for touch, smell, hearing, vision, or taste. We "experience" pain or are "aware" of pain, but technically, we do not "sense" pain. Pain results from an activation of certain neurons in the brain in the emotional areas of the limbic system of the cerebral cortex. But first, the pain must originate somewhere in our sensory nervous system and somehow be transmitted to various areas of the brain where its characteristics are interpreted.

This paper will review the origins of pain in the peripheral tissues, its transmission to the spinal cord and higher centers of the nervous system. Along the way, various pain control techniques, both old and new, will be reviewed in the context of where in the nervous system they seem to have their effects based on functional considerations of the new neurology of pain and pain control. Sections dealing primarily with neuroanatomical aspects will appear in italics.

MECHANICAL VERSUS CHEMICAL ORIGINS OF NOCICEPTIVE DEPOLARIZATION

Those nerve endings which deal with noxious stimulation of the body's tissues are called nociceptors. The afferent pathways of nociceptors may eventually be relayed to the pain awareness areas of the brain, but at their origins in the peripheral tissues, it is improper to call these nociceptors "pain sensing nerves". The messages carried by these nerves may or may not result in pain depending on what happens to their transmission in the spinal cord and at higher levels.

These nociceptor sensory nerve endings which carry messages to the brain which may eventually be interpreted as pain can be

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stimulated by two means: 1. Mechanical deformation of the sensory nerve endings from physical sources (eg., trauma, pin prick, pressure, etc.) will obviously cause some nerve endings to fire off. 2. Certain naturally occurring chemicals are also able to depolarize these nociceptors and cause afferent stimulation. (Excessive thermal stimulation can also depolarize some nociceptors, but this form of nociception is monitored by the same nerve endings which are sensitive to chemical changes and so thermal nociception is not discussed separately.)

There are basically six chemicals which cause nociceptor depolarization. Four of these chemicals are products of the body's inflammatory responses and two are a result of muscle fatigue. The six chemicals, in order of their abilities to depolarize nociceptors, are: 1. histamine, 2. prostaglandins, 3. kinins, 4. serotonin (these four are produced during inflammation), 5. potassium ions, and 6. lactic acid (these two are the results of muscular fatigue). The presence of one or more of these chemicals in adequate amounts will result in the firing of nociceptors regardless of their mechanical deformation. Similarly, these six substances will affect the response from mechanical stimulation of the nociceptors and can create a summated effect with mechanical nociception.

Controlling pain must consider all aspects of the generation and transmission of the nerve impulses that result in pain. This includes an evaluation of the patient's body chemistry to determine whether or not there is a chemical basis for part or

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all of the patient's pain. Muscle testing may be employed to evaluate each of the chemical patterns which affect nociception. It is interesting to note that three of the six chemicals mentioned (histamine, kinins, and serotonin) are putative neurotransmitters in the central nervous system as well as displaying effects on peripheral nociceptors.

Histamine mediated allergies can be a major contributor to chronic pain. These may be screened for by looking for a strengthening of weak muscles when orally testing the natural anti-histamine, yakriton (Antronex from Standard Process Labs or Yakroplex from Enzyme Process). Likewise, excess histamine may be screened for by looking for a generalized weakening of strong muscles upon insalivation of the amino acid, histidine, histamine's precursor. ¹ Patients with excessive histamine often have such increased sensitivity of their nociceptors that merely touching their skin often results in them complaining of pain.

Prostaglandin imbalances may be screened for by having the patient insalivate aspirin, acetaminophen, or other non steroidal anti-inflammatory drugs (NSAID) and observing for a strengthening of a weak muscle or a weakening of strong muscles. Changes in muscle strength induced by tasting one of these substances is associated with prostaglandin imbalances. Since the precursors to prostaglandins are essential fatty acids (EFA), EFA imbalances are at the root of this source of inflammatory problem, at least in the chronic pain patient. Patients who respond to aspirin, etc., must be tested for individual EFA deficiencies and for the

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need for cofactors in EFA metabolism, most notably, vitamin B-6, zinc, magnesium, and niacin. ²

Kinin mediated allergies are a source of excess kinins such as bradykinin or cholecystokinin (CCK). Insalivation of a kinin substance will cause a general weakening in a condition of excess kinin activity. Since kinin mediated allergies are usually associated with decreased pancreatic function, therapy localization (TL) to the pancreas neurolymphatic reflex (NL) will strengthen any weak muscle in excess kinin patients. ³

Excess tissue serotonin may be screened for by having a patient taste its precursor amino acid, tryptophan. Occasionally a patient will be seen to weaken on tryptophan. But as will be seen later, serotonin is also an important neurotransmitter in the central control of pain and it is just as likely to strengthen a weak muscle as weaken a strong muscle in a pain patient.

Histamine, prostaglandins, kinins, and serotonin are all products of a normal inflammatory response in the body. In acute pain patients, there is acute inflammation and this may be controlled by cold, other treatment procedures, or chemicals to decrease the inflammatory response. In chronic pain patients, however, there is often a chronic inflammatory vicious cycle which must be controlled in a general sense first, before attempting to individually balance each of the four chemical responses of inflammation.

The chronic pattern of inflammation can be screened for by

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having the patient sniff ordinary household bleach such as Clorox. A generalized weakness induced by sniffing Clorox is an indicator of the free radical pathology associated with a chronic inflammatory state of the tissues. ⁴ Clorox contains sodium hypochlorite, and hypochlorite is a powerful free radical. Weakening upon sniffing Clorox suggests that the patient has an anti-oxidant need which is perpetuating the inflammatory vicious cycle. Supplying the appropriate anti-oxidant orally will result in a strengthening of weak muscles and a blocking of the Clorox sniff induced weakness.

Chronic patterns of inflammation and tissue oxidative stress begin to improve when the free radical pathology has thus been controlled. Pain which results from one or more of the products of inflammation often improves greatly by correction of the Clorox weakening pattern. However, because there is often a vicious cycle of inflammation and chronic stress, any or all of the four inflammatory chemicals must often be individually treated as well.

Potassium and lactic acid accumulation in the tissues as a result of muscle fatigue can also result in nociceptive depolarization. Chronic functional hypoadrenia often results in a low sodium - high potassium imbalance which can contribute to this pattern. If a pain patient weakens on insalivation of a potassium supplement, this weakness can be negated by TL to the adrenal gland NLs. Correction of functional hypoadrenia is important to the pain patient for this and a number of other

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reasons relating to the tolerance of stress.

Lactic acid will accumulate following muscle activity unless there are adequate pathways to metabolize it into pyruvic acid and on into the citric acid cycle. A need for B vitamins, manganese, and coenzyme Q₁₀ will interfere with normal metabolism and can result in a build up of lactic acid which contributes to the nociceptor depolarization. This fault must also be screened for and corrected as is discussed elsewhere. ⁵

CLUES FROM THE PATIENT'S HISTORY

History alone can be of great value in helping to understand the nature of the patient's pain. The terms which the patient uses to describe the pain can give us diagnostic insight. If the patient describes the pain in mechanical terms (eg., stabbing, grabbing, crushing, pressure, etc.) then the pain is of mechanical origin. If, on the other hand, the patient describes pain as "burning" or "searing", then at least part of the pain is of chemical origin and the patient needs to be evaluated for the chemical factors of inflammation as well as each of six chemicals previously mentioned.

Patients who describe a "throbbing" or "pounding" pain, have mechanical pain which originates from nociceptors located around blood vessels. These nociceptors are picking up the mechanical deformation of the vascular system.

AFFERENT TRANSMISSION TO THE SPINAL CORD

Once the nociceptor has been activated, the message is carried by its afferent neuron to the spinal cord. Here it

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synapses in one of several areas which are the beginnings of the transmission systems to higher levels of the nervous system.

It is in the spinal cord that many pain control techniques have their effects. If the transmission of nociceptive impulses is blocked at this point, then the nociception from the periphery will not result in pain awareness. See figures 1 and 2. If unimpeded, the spinal cord cells stimulate secondary neurons which result in the activation of transmission pathways to higher levels, specifically, the spinothalamic tract, spinoreticular tract, and spinotectal tract.

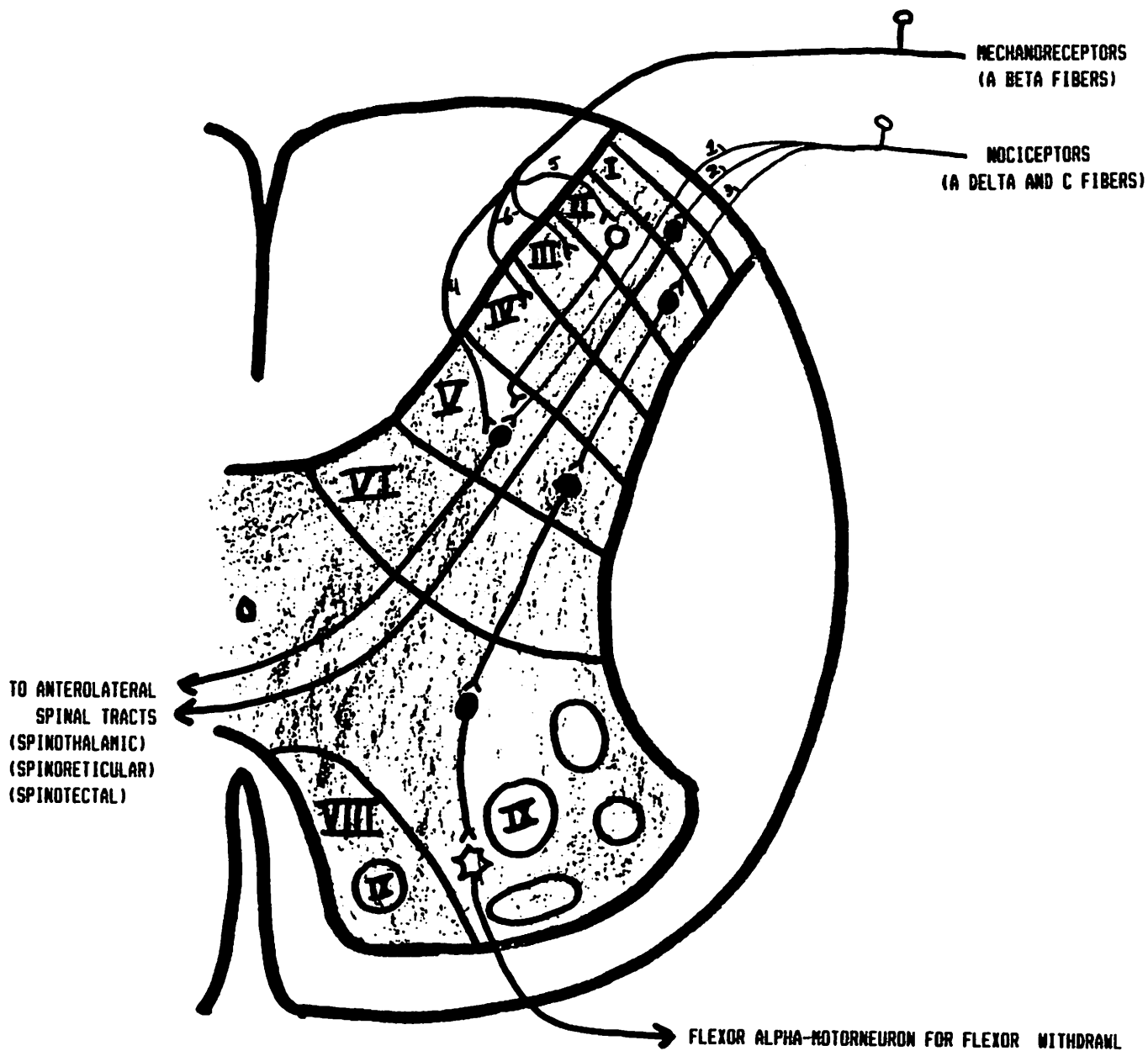
All of these tracts are bundled more or less together as the anterolateral spinal tracts. But before ascending to higher levels, we will look at the pain blocking factors which occur at the spinal cord level.

SPINAL CORD BLOCKING OF PAIN TRANSMISSION

Nociceptive impulses may be blocked from onward transmission at the spinal cord level by two methods. Mechanoreceptors from the peripheral tissues give off collaterals in the spinal cord whose synapses (directly or through interneurons) block the transmission of the nociceptive afferents to higher levels. See figure 1.

Afferents from nociceptors are of two types: small, myelinated A delta (group III) fibers and unmyelinated C (group IV) fibers. Cutaneous nociceptors which give rise to A delta fibers are sensitive to noxious mechanical stimuli in the dermis and epidermis such as pinching, squeezing, and pin pricking.

FIGURE 1
SPINAL CORD EFFECTS OF NOCICEPTORS AND MECHANORECEPTORS



NOTE THREE COURSES TAKEN BY NOCICEPTORS.

1. SYNAPSE IN LAMINA V - GIVES RISE TO ANTEROLATERAL SPINAL TRACT
2. SYNAPSE IN LAMINA I - GIVES RISE TO ANTEROLATERAL SPINAL TRACT
3. SYNAPSE IN LAMINA II - THROUGH INTERNEURONS IN LAMINAE V AND VII FACILITATES FLEXOR ALPHA-MOTORNEURON FOR FLEXOR WITHDRAWAL REFLEX

NOTE THE COURSES OF MECHANORECEPTORS

4. SYNAPSE IN LAMINA V - INHIBITS NOCICEPTION TRANSMISSION CELL
5. SYNAPSE IN LAMINA II - FACILITATES AN INTERNEURON WHICH PROJECTS TO LAMINA V AND THERE, PRESYNAPTICALLY INHIBITS NOCICEPTIVE AFFERENT
6. OTHER MECHANORECEPTOR SYNAPSES

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A delta nociceptors from muscle and deep tissues respond to noxious chemical stimuli and sustained muscular contraction.

Visceral nociceptors are of the unmyelinated, C type.

Cutaneous nociceptors which give rise to C fibers are sensitive to mechanical, chemical, and thermal noxious stimulation. Muscular and deep tissue C type nociceptors respond to pressure and heat.

These two, small fiber types synapse in lamina I (marginal zone), lamina II (substantia gelatinosa), and lamina V of the dorsal horn. At laminae I and V, they stimulate cells which give rise to the spinothalamic, spinoreticular, and spinothalamic tracts, the ascending anterolateral spinal tracts. Nociceptor axons which synapse in lamina II project forward to lamina V and affect transmission via the anterolateral spinal tract by this connection.

Larger, faster A-beta (group II) fibers, which arise from mechanoreceptors in the muscle and skin, are sensitive to touch, pressure, and vibration. These A-beta mechanoreceptor fibers synapse in lamina II, laminae III and IV (the nucleus proprius), and lamina V. In lamina V, they have inhibitory synapses directly on the nociceptive transmission cells that give rise to the ascending anterolateral spinal tract, effectively blocking ongoing nociception. In lamina II, the mechanoreceptors stimulate interneurons which project to lamina V and presynaptically inhibit incoming nociceptors prior to their synapse on transmission cells in this lamina. In laminae III and

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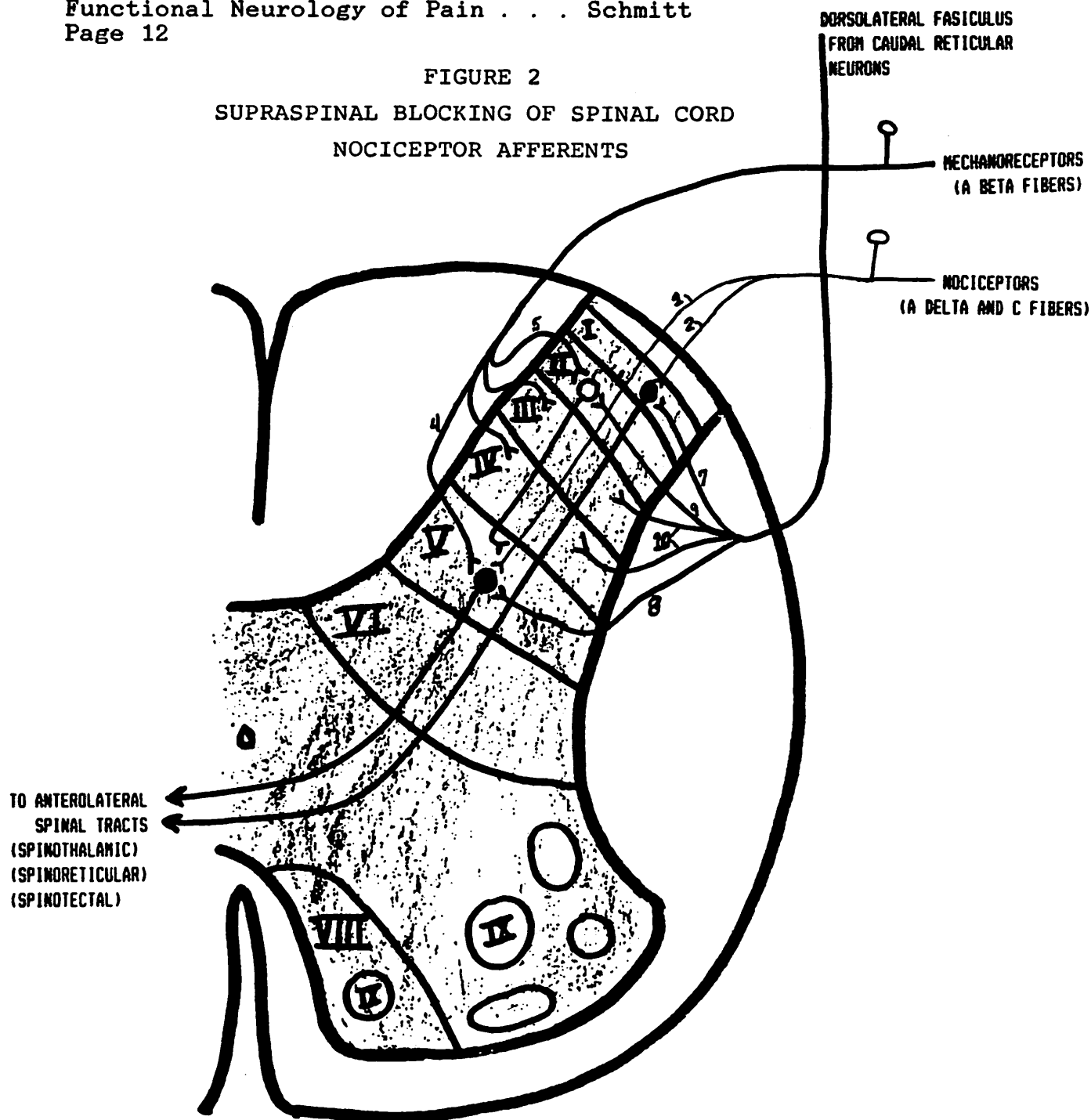
IV, the mechanoreceptors stimulate interneurons which may also be involved in blocking ongoing nociceptive information from laminae I, II, and V. These interneurons employ a number of inhibitory neurotransmitters which include serotonin and enkephalins.

Peripheral stimulation of mechanoreceptor afferents can be quite effective in blocking nociceptive transmission at the spinal cord level. This fact is the basis for why we instinctively rub ourselves over an area immediately after we hurt ourselves. It is also the basis for the use of massage, vibration techniques, and transcutaneous electrical nerve stimulation (TENS). TENS selectively activates A-beta fibers in the tissues over which it is placed and this activation is carried to the cord where the blocking effects occur directly at lamina V and via the other interneuron connections mentioned.

The second pathway which blocks nociceptive activity at the spinal cord level involves fibers which descend from nuclei in the caudal area of the reticular formation. See Figure 2.

The neurons in these caudal reticular nuclei made up of large cells (note their names) and are located in the area of the rostral ventromedial medulla (RVM). The most notable of these is the nucleus raphe magnus (an important serotonin containing tract). Other nuclei which contribute to this effort include the nucleus reticularis magnocellularis, nucleus gigantocellularis, nucleus reticularis paragigantocellularis, and other neurons in the same general RVM area. The locus coeruleus (an important noradrenergic pathway) also sends descending fibers which

FIGURE 2
SUPRASPINAL BLOCKING OF SPINAL CORD
NOCICEPTOR AFFERENTS



FOLLOW THE COURSE OF AFFERENT NOCICEPTORS

1. SYNAPSE IN LAMINA V - GIVES RISE TO ANTEROLATERAL SPINAL TRACT
2. SYNAPSE IN LAMINA I - GIVES RISE TO ANTEROLATERAL SPINAL TRACT

NOTE THE NOCICEPTIVE BLOCKING EFFECTS OF MECHANORECEPTORS

4. SYNAPSE IN LAMINA V - INHIBITS NOCICEPTION TRANSMISSION CELL
5. SYNAPSE IN LAMINA II - FACILITATES AN INTERNEURON WHICH PROJECTS TO LAMINA V AND THERE, PRESYNAPTICALLY INHIBITS NOCICEPTIVE AFFERENT

NOTE THE COURSE OF THE DORSOLATERAL FASCICULUS FIBERS

7. SYNAPSE IN LAMINA I - INHIBITS NOCICEPTION TRANSMISSION CELL
8. SYNAPSE IN LAMINA V - INHIBITS NOCICEPTION TRANSMISSION CELL
9. SYNAPSE IN LAMINA II - FACILITATES AN INTERNEURON WHICH PROJECTS TO LAMINA V AND THERE, PRESYNAPTICALLY INHIBITS NOCICEPTIVE AFFERENT
10. SYNAPSE ON OTHER INTERNEURONS WHICH RESULT IN INHIBITION OF NOCICEPTION BY VARIOUS MEANS

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inevitably inhibit incoming nociception. The neurotransmitters of these cells include serotonin, norepinephrine, gamma-aminobutyric acid (GABA), and enkephalins.

As a group, the caudal reticular neurons give rise to the dorsolateral funiculus (DLF) which descends to synapse in the dorsal horn of the spinal cord (with the exception of those fibers from the locus coeruleus.) Here, by a variety of blocking methods, both direct and through interneurons, afferent nociceptive input can be blocked from further transmission to the ascending tracts which carry the information to conscious levels. Some of the DLF fibers synapse directly on incoming nociceptive afferents in laminae I and V. Others synapse on interneurons which facilitate the same pathways as mechanoreceptors in blocking transmission such as those which originate in lamina II. Still others synapse on other interneurons, which contain enkephalins and other inhibitory neurotransmitters, which block the nociceptive afferent information.

Although higher centers have affects on spinal cord pain transmission, they do so via synapses with the neurons from the caudal reticular nuclei whose fibers descend to the cord in the dorsolateral fasciculus (DLF).

It is important to recognize that the only stimuli which evoke activity in nociceptors are noxious stimuli. The implications of this fact include that it is impossible to block pain transmission at the spinal cord level unless there is first, an ongoing stream of nociceptor activity to block. This is why

it is quite difficult to prevent pain before it happens, although, of course, this can be done through acupuncture and other techniques. These, however, probably affect higher levels in the nervous system.

Nociceptive activity has a built in self-protecting negative feedback motor loop which works through the spinal cord. Just as hitting the patellar tendon causes the foot to kick out in the knee jerk myotactic reflex, so does activity in peripheral nociceptors result in a reflex reaction which causes a muscular reaction. Nociceptor afferents project through interneurons to anterior horn alpha-motorneurons which reflexly results in the affected area being rapidly removed from the noxious stimulus. See figure 1.

The A delta and C fibers which synapse in lamina II project through interneurons to lamina V and then to lamina VII and finally to flexor alpha-motorneurons in the anterior horn. In addition to these connections, other interneuron pathways lead to an inhibition of ipsilateral extensor alpha-motorneurons and facilitation of contralateral extensor alpha-motorneurons.

This is the basis for the "flexor withdrawal" and "crossed extensor" reflexes which we learned about in school. The inhibition and facilitation patterns of flexors and extensors from these nociceptor initiated reflexes can be observed through muscle testing in some pain patients.

Another reflex component of nociceptive activity is a self limiting reflex loop mediated through the caudal reticular

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nuclei previously mentioned. Transmission of nociceptive activity to higher levels via the anterolateral ascending spinal tracts includes spinoreticular fibers which synapse in facilitory endings in the caudal reticular nuclei (i.e., RVM area). These nuclei, by direct reflex activity generated from the peripheral nociceptive activity, facilitates the descending fibers in the DLF which block the nociceptive activity at this level. See figure 2. In other words, through a brainstem reflex pathway, pain turns itself off. And yet, this reflex pathway requires nociceptive activity to generate it in the first place. You can not turn off something which is not turned on to start with.

SUBLUXATIONS AND PAIN TRANSMISSION

The mechanoreceptors in the skin, ligaments, and other tissues can be stimulated to block nociceptive activity as shown in figure 1. This fact also serves as the basis for our clinical observations of the ability of subluxation corrections to alleviate pain. That is, when there is a subluxation of a vertebra or other joint, the normal mechanoreceptor proprioception is altered.

It seems reasonable to assume that in a subluxation, increased mechanoreceptor activity will result on one side of the joint while the other side will show decreased activity. If the normal joint mechanoreceptor activity would be enough to block nociceptive activity from a certain related area of the body, then the decreased mechanoreceptor discharge due to the subluxation could possibly allow the pain to be transmitted.

Manipulation of the joint then, would serve to block pain by at least two mechanisms: the burst discharge of the mechanoreceptors created by the adjustment will barrage the system with potential nociceptive blocking effects. Secondly, the return of normal proprioception to the joint will result in a normal background of mechanoreceptor nociceptive activity through normal ranges of motion which will help to maintain the blocking effects of the nociceptive pathways.

TAPPING FOR PAIN CONTROL

Goodheart introduced a pain control technique based on combining tenets of the acupuncture meridian system and the concepts of manual mechanoreceptor stimulation, specifically, tapping. ⁶ This meridian point tapping pain control procedure has yielded incredible pain control results in many cases of acute and chronic pain. It is summarized below:

MERIDIAN POINT TAPPING PAIN CONTROL PROCEDURE

Testing a strong indicator muscle:

1. Therapy Localize (TL) all four PULSE POINTS on each wrist. One wrist will show positive TL.
2. TL each PULSE POINT individually on positive TLing wrist. One point will show positive TL.
3. TL ALARM POINTS for each of the two meridians at the positive TLing pulse point. One alarm point will show positive TL.
4. TL to TONIFICATION POINT on ipsilateral side of positive alarm point TL. It should show positive TL.
5. TAP TONIFICATION POINT until satisfactory decrease in pain.

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Vary rate of tapping as necessary.

6. TL to ASSOCIATED POINT on spine. If positive TL, challenge and adjust as indicated.

7. If tapping in 5. does not decrease pain significantly, TAP TONIFICATION POINT AND ASSOCIATED POINT simultaneously. Vary rate as necessary.

TONIFICATION POINTS

LEFT WRIST PULSE POINTS

Small Intestine	SI-3
Heart	H-9
Gall Bladder	GB-43
Liver	Liv-8
Bladder	Bl-67
Kidney	K-7

RIGHT WRIST PULSE POINTS

Large Intestine	LI-11
Lung	Lu-9
Stomach	St-41
Spleen-Pancreas	Sp-2
Triple Warmer	TW-3
Circulation-Sex	Cx-9

It is reasonable to assume that this acupuncture meridian point tapping technique for pain control operates, at least in part, by the spinal cord inhibitory mechanisms discussed. The tapping activates mechanoreceptor activity in the skin and underlying tissues which results in a blockade of nociceptive transmission.

THE SIGNIFICANCE OF GAMMA 1 AND GAMMA 2 WEAKNESSES IN PAIN CONTROL

When pulse point diagnosis, alarm point diagnosis, and TL to a tonification point result in a gamma 1 weakness of an indicator muscle, we have been assuming that the major affect of tapping the tonification point was via this spinal blocking mechanism. If, on the other hand, TL of these points, or any other procedure involved with pain control, results in a gamma 2 weakness of an indicator muscle, then we assume that the problem is also

associated with higher, supraspinal levels in the nervous system.

The usefulness of differentiating the gamma 1, spinal involvement from the gamma 2, supraspinal involvement lies in recognizing that the gamma 2 patient may require reinforcement of pain control manipulative procedures by nutritional support. That is, in the gamma 2 involvement, there may be a deficiency of neurotransmitter activity due faulty nutrition which is inadequate to maintain normal production of the neurotransmitter. Or the gamma 2 weakness may indicate that, to control the pain, other supraspinal techniques must be employed such as those involving acupuncture head points that are discussed in this paper and elsewhere. ⁷ Or it may be an indication of emotional reinforcement of the pain perception (anxiety, fear, etc.) which arises at supraspinal levels.

SPINOTHALAMIC AND THALAMOCORTICAL PROJECTIONS OF NOCICEPTIVE ACTIVITY

The thalamus is a way station in the projection of nociceptive activity. Spinothalamic pathways carrying nociceptive messages synapse in several thalamic nuclei, and then further project to four main cortical areas: 1) the hypothalamus, 2) the emotional cortex (limbic system), 3) the somatosensory (and viscerosensory) cortex, and 4) the memory cortex (in the temporal lobe). See figure 3.

The spinothalamic pathways synapse in two separate groups of nuclei in the thalamus, one for projection to the sensory-discriminative areas of the cortex and the other for projection

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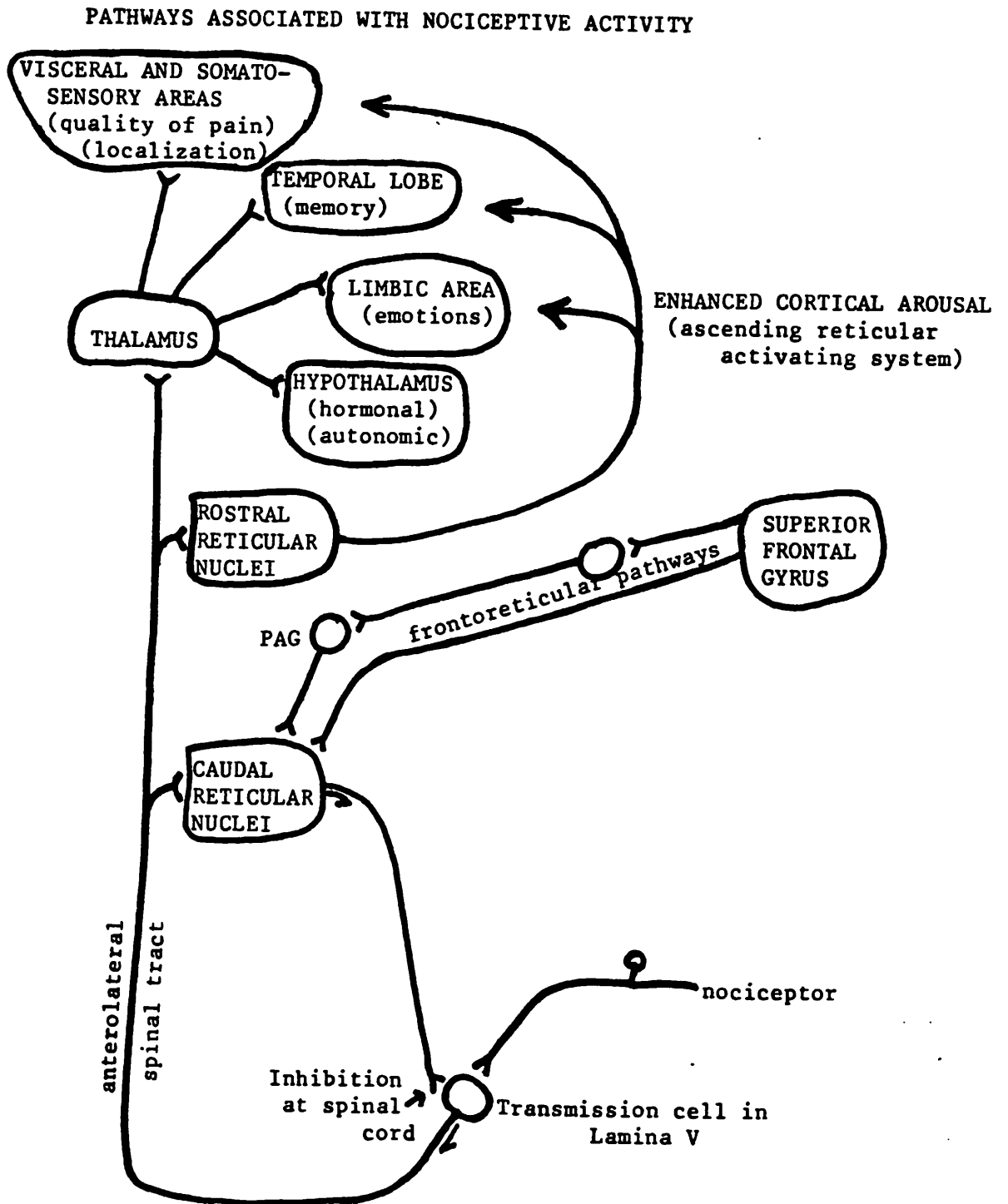
to the motivational-affective system for dealing with pain. The sensory-discriminative area is reached via the neospinothalamic system. This phylogenetically newer system is a rapid transmission system.

The neospinothalamic fibers synapse in somatotopically arranged cells in the ventroposterolateral nucleus (VPL). These cells project to the somatosensory (and viscerosensory) cortex areas in the paracentral and inferior parietal cortex which is also somatotopically arranged for our ability of sensory discrimination. The paracentral cortex is somatosensory I (SS I) area and the inferior parietal cortex is somatosensory area II (SS II). SS I receives contralateral input and SS II receives ipsilateral input. Cortical projections of visceral nociception synapse in the insula, also known as the island of Reil.

The motivational-affective system is reached via the paleospinothalamic system. This phylogenetically older system is associated with affective responses, pain avoidance and escape mechanisms, and autonomic effects of nociception.

The paleospinothalamic fibers which synapse in the medial thalamus and the posterior group nuclei are not somatotopically arranged. These cells project to diffuse cortical and subcortical areas such as the hypothalamus and the limbic system. (Some spinoreticular fibers are part of the paleospinothalamic system and synapse in reticular nuclei. From these cells, they give off fibers which ascend to the thalamus and also synapse in these two thalamic nuclei, reinforcing their ascending

FIGURE 3



All synapses shown are facilitatory except where noted.

projections.)

The limbic system is the area in which the emotional experience which is pain is perceived. This occurs in the orbitofrontal cortex and the cingulate gyrus. Surgery which interrupts these pathways will cause the patient to be unable to identify a problem as pain. The patient may be aware of something different in a part of the body, but the description is not one of pain.

The temporal lobe area is associated with the storage of the memory of the painful experience. This is located in the hippocampal gyrus and inferior temporal gyrus.

It is the thalamohypothalamic projection which explains the stress effects of pain. Increased heart and respiratory rates, sweat gland activity, and other autonomic reactions of the alarm reaction of pain are mediated throughout this pathway.

Likewise, the effects on the endocrine system which are associated with pain, especially chronic pain, are mediated by this pathway. Pain is a stressor and by itself can become a self reinforcing problem by depleting the patient's adrenal cortex and allowing enhancement of any inflammatory process as previously discussed.

These autonomic and endocrine effects are independent of the patient's perception of pain, however. If nociception is ongoing, even if there is natural or drug induced analgesia present at higher levels, the hypothalamic stimulation continues. In other words, factors which block pain at cortical awareness

levels do not block the effects of nociception on the hypothalamus. This can be an important clinical point in the care of medicated patients. The only effective method of insuring that nociception does not affect the hypothalamus is by blocking nociceptors peripherally in the tissues with local analgesics. Blockade of spinal cord transmission of nociception will also work, but it is impossible to determine how effective these procedures are in completely shutting down these pathways.

The thalamic projection to the limbic system is the basis for the emotional activity which is pain. It is in these areas that nociceptive activity is interpreted as pain. We most likely affect this area when we identify and correct the emotional neurovascular reflexes.

In the somatosensory (and viscerosensory) cortex, the localization of the patient's pain and the nature of the pain are interpreted. These areas make us aware that we have a difference in sensation in a given area, and allow us to make an interpretation of the mechanical or chemical natures of pain as described above. However, the fact that the sensation is painful is not interpreted in this area of the cortex, but rather in the limbic regions just mentioned.

The thalamotemporal projection is associated with the memory of painful experience as the temporal lobe is the seat of the memory. The intensity and duration of the impulses reaching this area are the bases for whether or not the pain is remembered. When we stub a toe or prick a finger, the pain often dissipates

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rapidly and we are unlikely to be able to recall the event for very long.

Think now about how many times you have stubbed your toe or pricked your finger. It is difficult to remember all these events. But if you have ever broken your toe, your memory is usually quite distinct, because the pain was more intense and for a much longer duration.

This overview of the thalamocortical projections initiated by peripheral nociceptive stimulation will serve as the basis for several new techniques which will be discussed later in this paper. But first, we will discuss a little more functional neurology of pain in order to explain some of the pain related phenomena with which we are all familiar, but in terms of modern neurology.

ROSTRAL RETICULAR NUCLEI EFFECTS

The nociceptive spinoreticular pathways synapse in both the caudal and rostral reticular nuclei. The latter give rise to the reticular ascending activating system. These fibers project to the areas of the conscious cortex where the other impressions from thalamocortical projections have their conscious impact. The effects of the rostral reticular nuclei on activating the cortex result in enhancement of the cortical awareness of the painful experience. This is, of course, in direct contrast to the effects of the caudal reticular nuclei which we have explained dampen nociceptive input at the spinal cord level.

The reticular ascending activating system (which uses

norepinephrine - NE) will reinforce the emotional experience which is pain, will improve conscious localization of the pain and its nature, and will tend to reinforce imprinting of the pain on the memory of the patient. This cortical arousal affects the entire cortex with the exception of the hippocampus.

Anxiety increases painful experience by its effects of stimulating cortical arousal via these ascending pathways. It is by dampening these effects of anxiety that tranquilizers may have an effect on decreasing pain. Most typical tranquilizers such as benzodiazepines (egs., Tranxene, Xanax, Ativan, Valium, Librium, etc.) stimulate GABA activity which is inhibitory in nature. Also recall that GABA is one of the neurotransmitters used by fibers descending in the DLF for inhibition of nociception in the spinal cord and tranquilizers may help control pain by stimulating GABA activity in this area as well.

So nociception has the ability to both enhance itself (through ascending rostral reticular activity) as well as turn itself off (through descending caudal reticular stimulation). Obviously, there are other factors which influence nociception and allow the manifestations of one of these conflicting pathways to supercede the other. Some of these intervening factors are neurological and others are chemical in nature.

FOCUSING OF CONSCIOUSNESS AND THE PAINFUL EXPERIENCE

One of these other factors is the influence of conscious cortical activity on the caudal reticular nuclei. The superior frontal gyrus is associated with conscious concentration or

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focusing of thought. The superior frontal gyrus stimulates the caudal reticular nuclei by both direct (frontoreticular tract) and indirect (through the periaqueductal gray - PAG) connections. See figure 3. This latter interneuron pathway is one of the sites of endorphin activity. The result of these connections is one which facilitates the caudal reticular nuclei's inhibitory projections to the spinal cord which block the nociceptive input at the cord level.

We have all heard stories, and many of us have had personal experiences, of complete lack of awareness of any pain after severe injury when that injury took place on a battlefield or on the field of sports competition. When a person's awareness is strongly focused on a conscious task, the nociceptive inputs will never reach higher levels because of the superior frontal gyrus activity. Its connections, via the frontoreticular pathways directly and through the PAG connections, to the caudal reticular nuclei inhibit incoming nociception at the cord level.

CHEMICAL AFFECTS ON CNS PAIN TRANSMISSION

The various categories of pain medications have their effects by either facilitating or inhibiting the normal neural pathways with the result of decreasing the conscious awareness of pain. Each of the pain pathways discussed uses one or more neurotransmitters, and most of the modern pain medications affect neurotransmitter activity either directly or indirectly.

Other more common substances such as alcohol, caffeine, and carbon dioxide also affect the transmission and awareness of

nociceptors. Each of these substances has a potentiating effect of the ascending rostral reticular neuron enhancement of pain awareness. In low concentrations, alcohol stimulates the rostral reticular neurons and enhances pain. In high concentrations, these ascending reticular neurons are depressed and pain (and everything else) is diminished.

More than two or three cups of caffeinated coffee per day is enough to stimulate the rostral reticular neurons' enhancement of pain. Caffeine prolongs cAMP activity which is the second messenger inside cells which are stimulated by NE. Therefore, caffeine enhances the activity of the NE containing reticular activating neurons and results in increased pain awareness.

Carbon dioxide affects the rostral reticular neurons firing rates. Lowered pCO₂ decreases these cells activity and decreases pain and increased pCO₂ increases their activity which increases pain. Changes of as little as 2 mm. in either direction from the normal pCO₂ of 40 mm. are enough to change these neurons in their ability to alter cortical arousal.

The effects of tranquilizers, specifically those which increase GABA inhibitory activity and dampen rostral reticular arousal of the cortex, have been previously mentioned. As will be discussed later in this paper, some patients will demonstrate a nutritional need for the precursors and cofactors for GABA or other neurotransmitter related nutrients.

Most neurotransmitters involved in the transmission of pain are simple molecules derived from amino acids. These we can

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readily manipulate with nutrition. Other neurotransmitters in these pathways are more complicated polypeptide molecules and at the present time, there is no known direct nutritional manipulation of these substances.

Substance P which is the neurotransmitter for cells which carry nociceptive information falls into this category. So do the endorphins, the body's natural opiates which have been previously mentioned (eg., beta-endorphin, met-enkephalin, and leu-enkephalin). We can effect the neurons which depend on these larger, polypeptide molecules by manipulative and nutritional stimulation of other neurons which synapse on these polypeptide containing neurons.

TECHNIQUES FOR CLINICAL APPLICATION

In an effort to investigate potential problems based on an understanding of the modern neurology of pain, we have used muscle testing to attempt to identify functional neurological patterns related to these recent findings. Initially, our interest has centered around the higher centers of the brain associated with the awareness of pain, especially the four areas of thalamocortical projections. At the time this new knowledge was learned, a technique had already been developed which is believed to be related to hypothalamic set point activity. Those concepts are the subject of another paper in these Collected Papers entitled "Hypothalamic Set Point Technique" which is the collaborative efforts of this author and Dr. Michael Lebowitz. 7

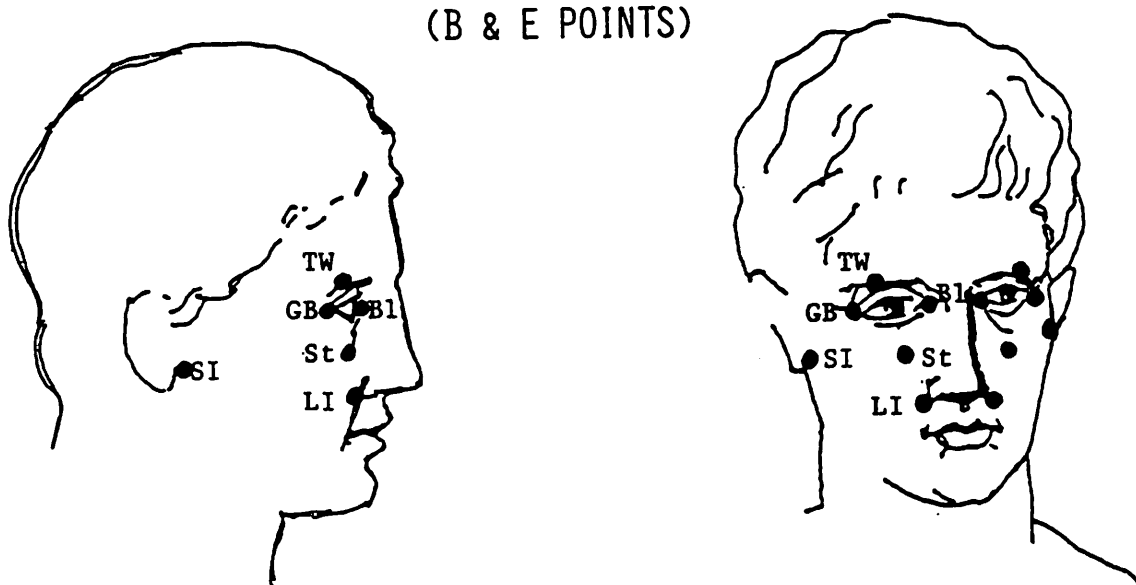
The emotional centers of the limbic system are probably

being addressed by the emotional recall technique and emotional neurovascular techniques of Goodheart which have been established and used for many years (since 1967). The two cortical areas which have not been addressed, are: 1) the somatosensory (and viscerosensory) cortex and 2) the temporal lobe memory areas of the cortex.

Based on the work of Lebowitz and this author, muscle testing is employed in an effort to systematically evaluate these pathways. In the hypothalamic set point technique, the acupuncture head points (those yang meridians which begin or end on the head - see figure 4) are found to be extraordinarily

FIGURE 4

ACUPUNCTURE HEAD POINTS
(B & E POINTS)



SI = SMALL INTESTINE-19
BL = BLADDER-1
TW = TRIPLE WARMER-23
GB = GALL BLADDER-1
LI = LARGE INTESTINE-21
ST = STOMACH-1

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valuable in dealing with number of health problems which seem to be associated with altered hypothalamic set points. These same points are found to be effective in relationship to treating problems associated with the cortical centers for localization, description, and memory of pain.

Although several authors have described techniques which probably affect these cortical areas directly, no previous AK technique has addressed these areas intentionally. The techniques presented here have proven to be consistently effective in dealing with chronic pain, and occasionally, acute pain. Patients are asked to mentally activate the areas of the brain which have been identified to be associated with 1. the location of pain (somato- and viscerosensory areas), 2. the nature or description of the pain (somato- and viscerosensory areas), and 3. the memory of the pain. When patients with pain are asked to concentrate on specific components of their pain, there is often a general weakening of all strong indicator muscles.

With the patient continuing to mentally focus on the particular pain characteristic in question, the various acupuncture head points are Tled with the patient's finger(s) until one is found which negates the mentally induced weakness.

To this point, this technique sounds familiar with the front brain / hind brain technique devised by Goodheart. ⁸ However, the patterns described here take place whether or not the eyes

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are open or closed, which completely differs from the front-hind brain patterns. This technique also sounds similar to "holo-linguistic localization" technique as presented in 1987 by Dr. Gerald Deutsch.⁹ Dr. Deutsch treats an auriculotherapy point and hypothesizes that his technique affects primarily the hypothalamus. Also in 1987, Dr. Sheldon Sinett described a similar technique with mental imagining in athletes.¹⁰ Dr. Sinett has athletes, who have been injured in competition, visualize what they were doing at the moment of the injury and bases treatment on these findings. It is possible, if not probable, that these and other techniques are all dealing with the same mechanism. The ideas in this paper, however, are derived from a conscious effort to identify faults in specific neurological centers using muscle testing as functional neurological evaluation and the results presented are the consequence of a number of trial and error efforts designed to put the modern neurology of pain into a clinical, functional neurological perspective.

An important clinical note must be made at this juncture. The presence of cranial faults may interfere with the findings which are discussed in the remainder of this paper. We always rule out this type of interference by identifying cranial problems by pre-test imaging¹¹ and making appropriate corrections prior to attempting these techniques.

ACTIVATING THE SOMATOSENSORY AND VISCEROSENSORY CORTEX

The somatosensory cortex is the area of the brain which

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localizes sensory inputs from the somatic structures to the brain. Likewise, the viscerosensory cortex, which is located in the same area of the brain, localizes inputs from viscera which reach the cortex.

These cortical localization areas can be activated by having the patient consciously focus attention on a particular part of the body. For example, instruct the patient to "think about your elbow", or "think about your lower abdomen", or "think about your right maxillary sinus area", and so on. Since most patients' anatomical knowledge is quite limited, it is useful to direct the patient to where they should focus their mental attention by touching the area in question and saying "think about this area where I just touched." This is especially useful in the case of areas which the patient cannot see such as the spine or the internal organs.

When the patient activates the somato- or viscerosensory cortex by this method and muscle weakness ensues, there is a fault in the neural circuitry. Weakness induced by this mental focussing method affects virtually all muscles in the body and is of both gamma 1 and gamma 2 types, implicating the supraspinal nature of the origin of the problem. The generalized weakness can be negated by TL to one of the acupuncture head points. As the patient continues to focus on the area of the body which causes weakness, the doctor places the patient's finger(s) on the various head points ipsilateral to the area of the patient's mental focussing. In the case of central pain, the head points

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must be Tled bilaterally in order to find the correct point. If a patient shows TL to a head point of the contralateral side to the problem, the patient is switched.

Correction of the faulty cortical awareness is achieved by having the patient maintain the weakening mental focussing while the doctor taps 50, 60, or occasionally 100 or more times on the appropriate head point. The rate of tapping which has been effective has been about 3 to 4 times per second. Symptom relief, if it is coming, is immediate. Recurrence of the pattern is rare, but will be discussed in later paragraphs.

The nature of pain as the patient describes it (eg., stabbing, pounding, aching, burning, etc.) is also consciously perceived in the somatosensory or viscerosensory cortex. To identify a faulty cortical circuit associated with the nature of the pain, simply ask the patient to think about "what the pain feels like." If the patient is not having the pain at the moment, ask the patient to think about "what the pain feels like when it is present" or "what the pain feels like when it is at its worst."

If focusing on the nature of the pain causes weakness, (a generalized gamma 1 and gamma 2 pattern) the patient is instructed to continue the mental focusing while the doctor directs the placement the patient's fingers on the acupuncture head points ipsilateral to the side of pain. One head point will negate the induced weakness. The procedure is essentially the same as for localizing the pain.

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The correction of this faulty circuit is accomplished by having the patient focus on the nature of the pain while the doctor taps the appropriate head point 50 to 100 times at the 3-4 times per second rate. Again, results, if any, are immediate and recurrence is rare.

ACTIVATING THE TEMPORAL LOBE MEMORY AREAS

Another factor in patients with difficult or chronic pain patterns is that the memory of the pain is so strong, that it initiates the entire vicious cycle of the patient's pain. To address the memory areas which are located in the temporal lobe, the patient is asked to think about the incident which initiated the pain. This is particularly appropriate if the pain was the result of a discrete event such as an accident. If the onset of the pain was insidious, the memory area can be activated in a similar manner to that discussed in the previous paragraphs by having the patient think about when the pain was at its very worst. Sometimes, the correct wording of the question is critically important. For example, you will sometimes find differences in muscle testing by asking the patient such slightly different questions as "think about the accident" or "think about what it felt like right after the accident."

When a patient focuses the memory on a faulty memory circuit, a general, gamma 1 and gamma 2 muscle weakness will occur. Correction of the temporal lobe memory pattern utilizes the same acupuncture head points in the same fashion as already presented. That is, if a patient weakens while focusing on a

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memory factor associated with the pain, the doctor directs the patient's TLing finger(s) to the acupuncture head points. If the pain is unilateral in nature, the TL is to the ipsilateral head points. If it is central or bilateral, the doctor may have to check bilaterally.

When a point is found to negate the memory induced weakness, that point is tapped 50 to 100 or more times at 3-4 times per second while the patient continues to think about the memory of the pain. The correction is usually accompanied by a noticeable reduction in symptoms and the results, if present, are immediate. Recurrence is rare.

**SHORTCUT TO FINDING THE APPROPRIATE ACUPUNCTURE HEAD POINT
FOR TREATMENT**

The head point which negates the mental activation of the cortical areas may be totally random. However, if a patient has shown a recurrent muscle weakness, such as a PMC, from treatment to treatment, it is reasonable to check the St-1 point first. Likewise, if the patient has had severe or recurrent thymus involvement, check TW-23 first. Sometimes, the meridian involved makes sense and sometimes there is no apparent logic whatsoever.

Commonly, a patient will demonstrate weakening on two or three of the cortical awareness factors discussed. When this is the case, each must be corrected individually. Occasionally when two or three cortical factors are all negated by the same head point, correcting one of them will spontaneously correct the other(s). But this is not a hard and fast rule and you must be

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willing to fix what you find and to check and correct each factor separately if that is the way you find the patient.

RECURRENCE

The importance of correcting or ruling out cranial faults prior to employing these procedures has already been mentioned. The factors of recurrence discussed here assume that this has been taken into consideration.

When the cortical awareness factors recur following treatment, they must be recorrected in the fashion presented. However, if the recurrence is associated with the same acupuncture head point, then often the recidivism is due to a neurotransmitter deficiency associated with that head point. In the paper on hypothalamic set point technique by Lebowitz and this author ⁷, each head point was associated with one or more neurotransmitter chemicals. These are reproduced in Table 1.

TABLE 1

SI - NOREPINEPHRINE

B - SEROTONIN

TW - SUGAR METABOLISM, POSSIBLY INSULIN

GB - ACETYLCHOLINE

LI - GAMMA-AMINOBUTYRIC ACID (GABA), GLYCINE, GLUTAMINE

ST - HISTAMINE, KININS (EG., CCK, POSSIBLY BRADYKININ)

If the cortical awareness factor recurs, prior to tapping the head point, test the patient with oral insalivation of the neurotransmitter and its precursors and cofactors. You will find

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one or more of the associated nutrients (See Table 2) will also negate the induced weakness. Continue by tapping the head point while the patient focuses on the weakening thought pattern, but definitely supplement the appropriate nutrient(s).

TABLE 2

SI - NOREPINEPHRINE: tyrosine, B-6, folic acid, niacinamide, iron
ascorbic acid, tyrosinase, copper

B - SEROTONIN: tryptophan, B-6, folic acid, iron, niacinamide

TW - SUGAR METABOLISM, POSSIBLY INSULIN: check dietary sugar
intake.

GB - ACETYLCHOLINE: choline, pantothenic acid

LI- GLYCINE: glycine, folic acid, B-6, manganese, B-2

GAMMA-AMINOBUTYRIC ACID (GABA): B-6, glutamic acid which
comes from alpha ketoglutaric acid which comes from the
citric acid cycle which requires: B-1, B-2, B-3,
pantothenic acid, manganese, lipoic acid, and several
others. Also zinc which helps to activate B-6.

GLUTAMINE: same as GABA

St- HISTAMINE, KININS (eg. CCK, possibly bradykinin)

Another indication to check for the neurotransmitter related nutrients is when more than one cortical awareness factor creates weakness and the head point which negates all the cortical awareness factors is the same. For example, if localization and memory factors were both negated by SI-19, then you should also check to see if they would also be negated by NE

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and one of the NE associated nutrients. When a nutrient factor is involved in this case, treat the patient in the prescribed manner and be sure to supplement the appropriate nutrient(s).

It is important to employ muscle testing as functional neurological evaluation when attempting to supplement patients based on neurotransmitter theory. Shotgun approaches often fall short and can even increase a patient's pain.

One of our chronic pain patients was given tryptophan as a serotonin precursor in the hopes that it would increase serotonin's neurotransmitter activity for its pain blocking effects. However, the therapy backfired and the effect of the tryptophan on the patient was one of increasing serotonin production in the peripheral tissues where its role is as an inflammatory agent which enhances depolarization of nociceptors. The patient's pain got worse, and when we tested the patient with tryptophan, it caused a general weakening of the patient's muscles. Removal of supplementary tryptophan and precise application of the procedures and nutrients reviewed in this paper allowed the patient to make a rapid and complete recovery from his chronic pain.

CONCLUSIONS

If there was no pain, there would be no doctors. Relief of pain is the ultimate physical goal of the doctor practicing to improve his patients' quality of life. And since pain is experienced as an emotion, pain relief is also an important mental goal toward improving the quality of life.

The applications of muscle testing as functional neurology are most suited to the concepts of pain and pain control. Employing muscle testing as functional neurological evaluation permits a most gratifying application of basic sciences to clinical practice. It allows us the opportunity to be at the cutting edge of clinical science as new frontiers are discovered by our basic science colleagues. And we have only barely scratched the surface of these clinical applications of functional neurology.

SUMMARY OF CLINICAL PROCEDURES

I. A. ACCESSING SOMATOSENSORY AREA OF CEREBRAL CORTEX (LOCATION)

1. Have patient focus attention on a specific region in body.
2. If strong muscle weakens: TL to head points while patient continues to think about that part of body. One head point will neutralize muscle weakness caused by focusing process.
3. Tap head point 50 - 60 times while patient continues to focus attention on body part.
4. Recheck 1. and test strong muscle to ascertain correction.

I. B. ACCESSING SOMATOSENSORY AREA OF CEREBRAL CORTEX (QUALITY)

1. Have patient focus attention on the quality of the pain.
2. If strong muscle weakens: TL to head points while patient continues to think about the quality of the pain. One head point will neutralize muscle weakness caused by focusing process.
3. Tap head point 50 - 60 times while patient continues to focus attention on the quality of the pain.

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4. Recheck 1. and test strong muscle to ascertain correction.

II. ACCESSING TEMPORAL LOBE (MEMORY OF PAIN)

1. Have patient focus on:

a. memory of pain when it was at its worst, or

b. memory of incident when pain began.

2. If strong muscle weakens: TL to head points while patient continues to think about than memory. One head point will neutralize muscle weakness caused by memory of pain (or incident causing pain.)

NOTE: No difference if eyes open or closed.

3. Tap head point 50 - 60 times while patient continues to think about memory of pain (or incident causing pain.)

4. Recheck 1.a. or 1.b. and test strong muscle to ascertain correction.

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ACKNOWLEDGEMENT

Although a number of textbooks on pain published beginning in 1984 (see bibliography) were reviewed prior to writing this paper, many of the overview concepts contained herein were gained from listening to a taped lecture by English neurologist, Barry Wyke, M.D. This tape was given to me by a colleague and was apparently presented sometime during the past few years to a group of American physical therapists. I am unable to supply a better reference, but wish to acknowledge Dr. Wyke's presentation for laying the groundwork for and motivating my interest in doing the research involved with writing this paper.

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APPLIED KINESIOLOGY RESEARCH PAPER:BIO-COMPUTER CLEARING (MASTER CLEARING) ACUPUNCTURE POINTSby: HARRY SIMPSON, D.O.

Positive circuits found in patients suffering from chemical-related allergies and neural diseased states.

Clearing techniques of computer clearing with new computer centres plus cloacal and gaiting methodology.

Bio-computer systems evaluation reaffirmed own methods of treating some diseases and further extended the principle of bio-computer utilisation, including four new bio-computer centres, plus additional gait sequences and AP cloacal clearing.

The additional computer centres are secondary and are two nipple S17 ends, and two primary crown bio-computer GV21 and ICV relates to all other centres including cloacals, during priority TLS, in the clear, either by operator or patient.

Entry points may be erratic and inconsistent; when this occurs, treat spinal neurolymphatics. I do this now as a standard process prior to AK testing and treatment, to stabilise AK displays.

Bio-computer centre, cloacal, reflex, AP clearing techniques.

Entry points in clear.

Patient supine, left hand mode priority and in chemistry.

Operator uses patient's right arm, palm facing operator.

SECT.1.

TL I.C.V., NEG. MOVE TO SECT.2.

TL POS., CONTINUE IN SECT.1.

(C)

-2-

TL CV8, SP21, CV17.

TL K27, LEFT AND RIGHT SIDES

TL CV27

TL GV25

GV16

TL GV24.5 ENTRY CLOACAL

TL GV21

- 1) Treat with tapping or 20 seconds white laser.
- b)* Check and treat Hyoid and anterior cranials if priority after Sect.1. is complete.
- c) Test left brain, right brain control and correct.
- d) Gap by lateral parentals.
- e) Check gaits and correct as in Dr Alan Beardall's Instruction Manual, Page 27.
- f) Manipulate I.C.V. or treat with laser if only inflamed.
- g) In chronic cases, use nutritional support and cleansing techniques.

SECT.II. Second treatment pattern, I.C.V. and E.B.V.

Patient supine, prioritise mode in left hand, place it over the umbilicus (CV8).

The operator re-runs Section I.

1. TL I.C.V. SP21 - CV17 - K27 (L & R). C.V.2.
- 2) TL CV24 -GV25 -GV24.5 - GV21 - GV16.
- 3) TL CV14 - for Epstein Barr virus.

Treat a positive TLS by tapping or laser for minimum of 30 seconds while maintaining priority TL over CV8.

SECTION III. Switching I.C.V. and Endocrine.

(C)

-3-

Patient places prioritised left hand mode on K27, bridging left and right hand side.

- 1) Operator TLS CV8 (umbilicus) SP21 CV24 - CV14 - I.C.V. - CV17 - CV2.
- 2) GV25 - GV24.5 (Glaubelia) GV21 GV16.
- 3) GV2 - CV24 - GV25 GV24.5 - GV21.

Treat positive TLS retaining priority over hand mode/TL on K27; retest K27 left then right, retain TL on positive side, re-test through (1) and (2); when positive testing is cleared after treatment, instruct patient to walk around swinging arms for one minute, then return to plinth for re-test through K27, treat if positive, re-test and repeat walking until clear; when clear, test for gaits and cranial fixations.

a) SECTION IV. Reproductive system dysfunction in female and male patients, that contributes to a wide range of endocrine dysfunctions.

b) Entry is through CV8 - I.C.V. - CV2 - K27 - GV21.

c) Clearing is via Section I-II-III. STEP 1.

d) Include in clear, test to ovary/orchic for inflammation.

TL SP13/S28 Both sides CV2. Treat if positive.

TL CV17 -GV24.5 - CV24 - GV25 - GV21 - CV8 - S17.

e) Priority hand mode TL to SP13/S28 or CV2 positive TL by patient.

f) Operator TL CV8-5-4-2

g) Operator TL AP B61-K4-G40 both sides, to test left right ovary/orchic uterus, fallopian tube and penis.

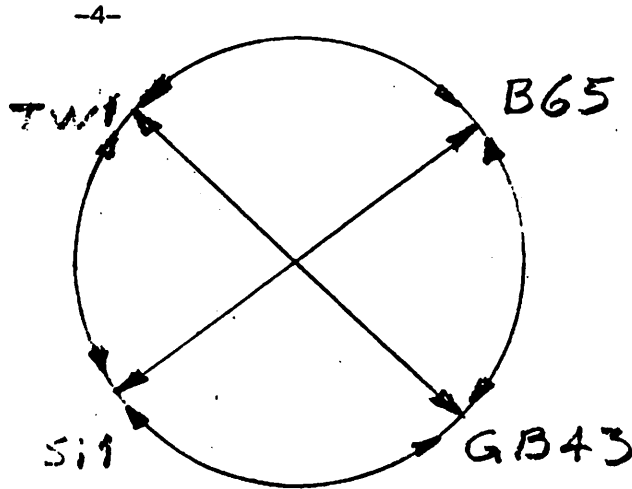
h) Gaits:- TL to positive B65 + GB43.

TL to positive Si.1/H9 + TW1.

i) Treatment:- use tapping, laser, or five element direction with
+
finger polarity - use loop circuits of operator only for gaits,
for 15 seconds.

(C)

j)



Retrieval Step 2.

- k) Patient prioritises hand mode and TLS over CV8 umbilicus.
- l) and re-run Step 1 if positive.
- m) Treat as found for 15 seconds GAIT POINTS all others for 30 seconds.
- n) Retrieval Step 3.

Patient prioritises hand mode placed over pubes S28-K11-CV1.-GV26 test and treat; REPEAT SEQUENCE of test and treat by Prioritised (PTL) CV17/K27/CV24/GV25 GV24.5/GV21.

P.T.L. each MASTER CENTRE, check all other points and treat.

SECTION V.

Patient with known mental stress, phobias, psychosomatic link health problems. Example: 56 year old woman complained of fears and worries. Had Rubella, gave nosode, BP high, poor volumetric capacity of heart pumps, gave homoeopathy and herbal treatment to correct, plus nutritional sequestrene. AK test meridians low output corrected with nutritional balancing.

Retrieval: Bach Flower remedies potentised on patient to take three prescriptions.

Patient continued to improve through each stage of treatment with

(C)

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regressions at each stage of retrieval display. Patient treated in clear and retrieval through stages Sections I and IV and finally V.

Section V procedure: Priority mode, test in clear and correct if necessary. Then patient places left hand (in priority mode) on GV21, TL as in Section I and IV, GV21/K27 switching.

GV21/GV24.5/GV25/CV24.

Priority GV21 to CV2. refers to patterns of phobias and psychosomatic link with lower body centres related to fears and depression.

1. Chemistry: Chemical damage from drugs at concentrated levels.
2. Chemical saturation then takes place (via access routing from 1) through the food chain, cosmetics and air-borne chemicals from industrial processes.
3. The body's chemistry is further disorganised by fad diets, junk foods, microwaved and atomic-irradiated foods which may accelerate glandular deficiencies.
4. Patient counselling is imperative if we are to maintain a systems correction in patients' health standard.

The benefits of treatment may be undermined if the patient fails to protect himself against nutritional deficiencies.

1. Dietary Control for Sections I-II-III-IV.
 - a: Yeast and fungus-free diet for at least the period of dermal or mucus membrane dysfunction.
 - b: Patient must avoid any further use of antibiotic treatment or the prolonged use of any drug.

(C)

-6-

- c: During the treatment period, the patient must drink one litre of water daily for three weeks.
- d: Test for and counteract Lactose intolerance.
- e: AK test all foods, avoid suspected 'E' numbers.
- f: Nutritional balance all meridians.
- g: Avoid all food from the pig.
- h: Avoid skins of all

2. Dietary control for Section IV. Reproductive system.

- a: Consolidation of treatment patterns for controlling further deterioration of the reproductive system is via food allergies - allergies not always detectable by normal AK or electronic testing - whether in the clear or in retrieval, unless they are accessed through S17-S28-K11-B61-K4-G40 or gaits; this may lead to accessing all food allergies more accurately through control points.
 - b: Foods tested which give a positive reading at all levels in this section, provide the ideal repair level, not only benefitting the reproductive system but also showing improved results over many years in P.M.T., rheumatoid arthritis and some types of osteoarthritis, and cranial palsy.
 - c: These foods stress the digestive portion of the reproductive system and reduce the supply of oestrogen.
 - d: Foods to avoid: all poultry and pulses, and foods using them.
3. a: Complex endocrine dysfunction requires a wide range of muscle system displays and will need correcting in the clear.

(C)

-7-

- b: Treat to clear neural muscular pathways; these may vary subject to nutritional, chemical and structural dysfunction.
- c: Test, prioritise in nutrition, lock in hologram and test each muscle and the following lists. (Ref. Dr. A. Beardall, Clinical Kinesiology Instruction Manual.) (1)

Glandular systems to treat

K.4. Uterus. Anterior Pituitary, Bladder Prostate Gonads, Liver*, Thyroid,* Lymphatics of face and neck*, Mammary Gland, Salivary Glands, Submandibular external ear. T5-L3-L5 right hand side.

SP5/K2 Penis. Nose, seminal visicle, sinus (frontal), spleen* urethra (membranes). T5-L2-L3 right hand side.

K5/4 Fallopian Tubes. Parathyroids-Adenoids-Bladder*- Colon Rectal area - colon hepatic and splenic flexure duodenum (descending portion). Liver* - external ear-gonads eustachian tube - lymphatics of duodenum - lymphatics of face and neck* - uterus* - Mammary Gland* sinus frontal* L2.

B61 Ovaries. Urethra membranes* Posterior pituitary - adrenals - Mammary Gland* - Pancreatic duct - Adenoids - Anterior pituitary - Colon rectal* gonards* - duodenum (descending) eustachian tube* - Lymphatics of stomach - Lymphatics of throat thyroid. T5-T11-T12. RHS - L3.

N.B. * indicates priorities.

CONCLUSION

This systematic approach offers satisfactory access to reducing the

(C)

-8-

toxicological effects on and from most disease displays. The treatment of acupuncture stress display centres releases bio-centre functioning and reverses the downside of the patient's health standard. This system minimises AK clearing for best body repair and functional activity.

For many years, I have used a simplified system of detection and correction of most menstrual dysfunctions; now this is accelerated via master acupuncture point clearing. All patients with chronic diseases have so far shown a need for clearing with this system, from whatever origin. I believe that this system will give me access to improve the body's resistance to all forms of toxic saturation. So far, the indication is in:-

1. Arthritis, especially Rheumatoid Arthritis.
2. Menstrual dysfunction, especially in Rheumatoid Arthritis.
3. Palsy, especially Myalgic Encephalomyelitis and Multiple Sclerosis.
4. Candida Albicans - conclusive.
5. Bronchitis.
6. Gall Bladder/Liver portal artery congestion.
7. Correction of switching and food allergies (Master System).
8. Reduced neuro-vascular stress.

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St. Helens, WA11 8AZ, England.

PRELIMINARY RESEARCH IN THE USE OF PHONOCARDIOGRAPHY
IN STRESS RELATED ILLNESSES by Sheldon Sinett D.C.,MA,BA

Abstract;

The purpose of this paper is to see if a correlation exists between an increased second heart sound in the pulmonary area and stress. This paper deals with only a small sampling of people (20).

Introduction:

We all see stress related problems in our offices. I wanted to see if there was a true correlation between the P.C.G. and stress. Everyone with a knowledge of applied kinesiology knows that there is a weakness to the adrenal related muscles (satorius and gracilis) under stress. We are also familiar with the change in blood pressure from a sitting to standing position. However, in stress related conditions, there is no increase in the standing pressure (positive ragland sign).

I have heard Dr. Goodheart speak of the value of P.C.G. in stress related problems many times. I read Dr. Schmitt's articles in the collected papers on the use of phonocardiography. Standard Process Labs has talked about the use of P.C.G. With this knowledge in mind, I established a screening test in my office. We wanted to see people who had untreated stress related problems.

The parameters we used were phonocardiography to confirm the presence of a pulmonary region second heart sound (S2). The size of this second sound is supposed to be one third

the size of the first sound (S1). The appearance of this increased second sound can indicate functional hypoadrenia or pulmonary pathology. Therefore, it's important to differentiate carefully. The second screening procedure we used was muscle testing for the adrenals. We used the satorius muscle for this purpose. The third parameter we used was blood pressure testing from sitting to standing position. The pressure is supposed to elevate 10mg of mercury upon standing. If this does not occur, there is postural hypotension which is a symptom of a stress related condition. These three tests were our indicators to see if a correlation existed between them and stress.

Conclusion:

There was 100% correlation among my twenty patients with the use of P.C.G. and stress. More testing is necessary however because of the size of the initial sample. We expect to conduct this test on at least one hundred patients.

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THE HEEL-TOE TEST

A. J. Woodson, D. C.

ABSTRACT: This paper presents another aspect of simultaneous reactivity in muscles. This phenomenon has been observed in gait testing, and has been the subject of other papers.^{1.2.3.4.} The Heel-Toe Test is a modified prone hamstrings test which first isolates the hamstrings by using a heel contact, and then includes the Gastrosoleus group by using a toe contact. Methodology is described in greater detail, and the implications of a positive test are discussed.

Generally, in testing muscles, the practitioner is attempting to isolate individual muscles or parts of muscles. In testing for reactive muscles, one isolated muscle is tested, and rapidly another isolated muscle. In the case of a positive reactive muscle test, the muscle tested second weakens, but is strong in the clear.

Simultaneous reactivity is the term I have applied to the instance when two muscles are tested at the same time, and one of them weakens. See the previous papers: "The Leg-Pull Test"^{2.}, "The Leg-Push Test"^{3.}, and "The Crossed Leg-Pull Test."^{4.}

(2)

In testing many patients with the presenting complaint of chronic lower back pain (with or without radicular symptoms) I have found a pattern of simultaneous reactivity to occur between the Hamstrings and the Gastrosoleus group. In a typical clinical situation the patient is tested prone, the leg flexed on the thigh, as in the normal set-up for a hamstring test. I tell the patient to "point the heel," and I test the Hamstrings with my pressure directed against the heel. We go on to instruct the patient to "point the toes." The testing pressure is then directed against the ball of the foot in an effort to dorsiflex the foot, while at the same time to push the flexed leg downward to the table. This combined movement puts the Gastrosoleus group into the test along with the Hamstrings.

Most of the time the patient tests strong with both heel and toe pressure. Blocks are then placed under opposite hips and shoulders to torque the spine, and the heel-toe test is performed in each configuration. In many cases the patient will be at a complete loss to control the hamstring group on one side. For example, if a patient with the typical lower back complaint were tested, he would fail the heel-toe test with the blocks positioned under the right ASIS and the left shoulder.

Occasionally a patient will demonstrate a positive test in the clear, that is, without the blocks placed to torque the spine. The blocking brings out the subclinical, borderline cases.

I commend this simple test in that it requires little patient involvement or therapy localization. A positive test is usually

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black and white, and demonstrates to the patient in a dramatic way the implications of gait problems, spinal torque, and upper body involvements.

Since the advent of neurovascular palpation⁵, I have found the typical case in which the heel-toe test is positive, to be very similar to the pattern described in my previous paper, "The Crossed Leg-Pull Test."⁴ There is many times a major involvement in the upper thoracic interspaces of the opposite shoulder. The same nutritional correlations apply.

In the spring of 1987, I took the Clinical Acupuncture series taught by John Amaro, D.C.⁶, which is essentially the ryodoraku acupuncture of Nakatani and Yamashita⁷ put in a chiropractic context. I was intrigued to discover that an old revered formula for lower back pain was SI3/BL62. I recognized SI3 as the appropriate way to sedate the heart meridian (as taught in AK) by strengthening the small intestine meridian. Because I had found many lower back involvements related to what appeared to be heart circuit imbalances, I wondered if this formula might apply in a case where the heel-toe test was positive.

I began to treat BL62, which is at the inferior tip of the lateral malleolus, with the Neuroprobe II instrument I obtained to pursue the ryodoraku studies, on patients who demonstrated a positive heel-toe test. BL62 appeared to be singularly effective in the elimination of the simultaneous reactivity between the Hamstrings and the Gastrosoleus group. I did find that the vertebral involvements had to be resolved first, or else stimulation of

(4)

BL62 did not obtain. In some cases of chronic lower back instability, the treatment of BL62 was the essential ingredient in the final resolution of the problem.

Elimination of the positive heel-toe test is possible without acupoint stimulation. Deep neurovascular-guided pressure at the involved upper thoracic interspaces is sometimes all that is required. Appropriate nutritional supplementation has in some instances been the primary intervention.

(5)

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