THE BODY KNOWS - ASK IT

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ABSTRACT: The purpose of this test is to show another factor to be used in understanding the priority mechanism dictated by the body for the correction of those problems elicited by Applied Kinesiological methods of diagnosis.

INTRODUCTION: At the summer 1978 meeting of the ICAK, a paper was presented on Body Priorities as Demonstrated by a Dental Splint. In that paper, several guide lines were established whereby the procedure for correction of a multitude of symptoms found on a patient, were dictated by the patient's body. When the sequence to establish a primary lesion or a secondary lesion was followed, the body said "fix me now", or "fix me later".

The advantages to following this sequence are tremendous because: (1) Symptoms which show up may be shown to be compensatory rather than primary. (2) Much more time may be saved in daily practice and, (3) A mechanism by which the patient "unwinds" from a "disease" may be viewed with logical sequence.

PROCEDURE: The procedure established in the 1978 paper on body priorities still is effective and should be followed step by step to lead you to the next factor in differentiating problems.

Let us review the sequences in the procedure to determine if a problem is a primary or a secondary one. A primary lesion will:

1) be weak in the clear - or weak when tested by itself.
2) therapy localize
3) respond to inspiration assist - the indicator muscle changes when everything else stays the same and the patient takes a deep breath, and holds it.

A special note is necessary here to alleviate any possible confusion. The first and second parts above may be the same in some cases - the ileocecal valve is an example. You could, of course, use the ileocus muscle as the muscle weak in the clear, and the therapy localization of the valve area as the second step if you choose.

The secondary or compensatory area would do one or two of these, but not all three. This says that the secondary area is possibly being caused by the primary lesion or problem.

After the above information has been established, we use the pinch to elicit further information.

After the indicator muscle - which was weak when tested in the clear - and the therapy localized area makes a strong indicator muscle go weak, have the patient take a deep breath. If this makes this indicator muscle become strong, pinch the patient anywhere except over the area being therapy localized while everything else remains the same. If the indicator muscle remains strong, the area in question is the next one to be corrected - it is considered the primary problem. If the indicator were to go weak, this would mean that you have isolated a seondary or compensatory area, and you should continue looking for a primary lesion.

The use of the pinch in the priority sequence makes it necessary to define some new terms. These terms make it easier to communicate to the patient how the problem started and the sequence of its correction. This may not become apparent at the outset, but practice will bring about this understanding. Each term also has a shortened note for convenience sake when keeping records.

1) A primary - primary $1^{o}1^{o}$) lesion - All rules apply and the body says "fix me now"
2) A secondary - primary lesion ($2^{o}1^{o}$) - The last step - the pinch - makes the previously strong indicator muscle go weak. The body says "You are on the right track, but you are not quite there".
3) A primary-secondary lesion ($1^{o}2^{o}$) - The indicator muscle strength does not change with inspiration or to any challenge above that. The body now says "fix me later".
4) A secondary-secondary lesion ($2^{o}2^{o}$) - This lesion is the one found only when the area in question is therapy localized or shows up when the pinch alone is used. The body says, "Wake me up later - I'm still sleeping".

It should be kept in mind that, at any time, any one of the other lesions may become a $1^{o}1^{o}$ lesion after the original $1^{o}1^{o}$ lesion has been corrected - even the $2^{o}2^{o}$.

A special note on priorities of the pelvis is in order here. It should be remembered that a pelvis lesion continues to exist and the pelvis is not lesion-free until a category I is elicited as a $1^{o}1^{o}$ and corrected. Also, keep in mind that the category I may be present only as a compensation to a more complicated series of manipulations leading back to another category I. This is very common.

To make sure you are finished with the pelvis after reduction of a category I, pinch the patient while he T.L. to the category I area. If a strong indicator remains strong, you have corrected the low back stability.

EXAMPLE CASE: To explain this procedure a bit further, let us imagine a patient who has therapy localized to the PSIS bilaterally, and nothing shows up. When the patient is then pinched, retesting the strong indicator now elicites a category I is present. Some have interpreted this as "the body misinterpreting information", or that, "the body has become confused".

I would like to sugguest that since we as Chiropractors work with what we call innate intelligence, the body does not misinterpret this information nor become confused, but rather it is we who have misinterpreted the information and become confused, and it is the body which is telling us what we are not hearing.

Keeping this in mind, we are directed to look elsewhere for the primary lesion. It could be anywhere, but since a category I is the last problem to be corrected in the pelvis, continue the examination in that area.

As we therapy localize other areas, it is noticed that a pelvic flare exists on the right as well as a sacral respiratory fault which responds to inspiration and a PL-L3 (category III).

Since the sacrum responded to inspiration, let us follow that to find a primary-primary lesion. The next step is to see if the indicator muscle strength changes when the patient is pinched. When a pinch does not cause a strong indicator muscle to weaken while the patient is holding his breath, the result may be interpreted as saying, "fix me now", and that this is the primary-primary lesion. The only other lesion which had significance, let us say, was the PL-L3 which responded to inspiratory assist, but the indicator muscle

weakened after the pinch, which indicates a seoondary-primary or "fix me later".

After correcting the sacral respiratory fault, the $2^{O}1^{O}$-PL-L3 now becomes a $1^{O}1^{O}$, and its correction also fixes the sacral flare in this example. Now return to the category I, and it has now become a $1^{O}1^{O}$, and is ready to be corrected. Keep in mind that the primary lesion could be quite remote from the secondary lesion, but when it is found, its existence becomes very logical in the sequence of "unwinding" back into a state of "ease".

DISCUSSION: When the explained procedure is followed precisely, the body will direct you when to correct a given area. If the area in question follows the rule that a 1) primary-primary lesion will have a strong indicator muscle remain strong when a patient takes a deep breath and holds it, 2) while therapy localizing to the area and 3) is pinched by the examiner, then it is ready to be corrected, and not until. If any part of this test fails, the body says, "look further".

CONCLUSION: This technique is advantageous in cases where a chronic patient comes in time after time with the same problem has not been cleared out completely. Something is still causing their problem. This technique will help find the cause.

Also, many things which we correct now in the office can be seen to be compensatory and most of the time these secondary lesions are corrected when their underlying cause is found and corrected.

Following the procedure of:

(1) weak in the clear.
(2) therapy localize.
(3) respond to inspiratory assist
(4) pinch with breath held.

will lead the investigator to the area of correction each and every time.

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