

SNEAKY REACTIVES

by

Elizabeth Barhydt and Hap Barhydt

Elizabeth and Hap Barhydt are Touch for Health instructors and life members of the Touch for Health Foundation. They live full time on a motorhome and are currently touring the country. They would like to visit and share experiences with other Touch for Health instructors as they travel through their areas. They may be contacted by writing to:

3037 Grass Valley Hwy. #8084, Auburn, CA 95603

Introduction: Reactive muscles have a habit of sneaking in when we are doing other Touch for Health procedures and confusing the results. Frequently we may think we are testing and correcting one thing when in reality all we are doing is seeing reactive muscles at play.

Sneaky #1: Very early in our use of Touch for Health concepts we found it to be not uncommon for a person to be consistently "out of balance" on the same muscles over and over again in "balance as you go" 14- and 42-muscle balancing. On comparing notes with other Touch for Health instructors and practioners, we found the same experience. In fact we found that this was causing discouragement for quite a few people in the continued use of Touch for Health.

So in the fall of 1982 we started to look more closely at what was happening. The results of these preliminary investigations were reported and demonstrated in the paper Hap presented at the 1983 Touch for Health Convention (printed in the July-August 1983 Touch for Health Journal). Here he showed that a muscle testing "weak" during a conventional 14-muscle balance may actually just be reactive to the muscle tested just previously, if that muscle tested "strong". This is a particularly likely situation if a muscle tests weak on one side only. Typical examples are the left Pectoralis Major Clavicular being reactive to the right, the right quadriceps being reactive to the left Subscapularis, etc.

The sneaky part is this: If you do not recognize this as a reactive muscle combination and use standard "balance as you go" 14-muscle balance technique, that is, go ahead and "strengthen" the "weak" muscle with neurolymphatics (or other meridian type correction) and retest only the previously "weak" muscle, then that muscle will probably test "strong", and you will think that you have fixed the situation. But if you go back and do the 14-muscle balance again, you will find the previously "weak" muscle "weak" again, i.e. the balance didn't "hold".

What actually happened is that the time taken to work the neurolymphatics (or other correction technique) was sufficient to allow the reactive muscle combination to reset. The correction technique was superfluous; you could have merely stood there and counted to ten slowly and achieved the same result. If you had checked the result

by testing both muscles in the same sequence, rather than just the muscle that had been "weak", you would have caught the problem immediately.

The bottom line is to suspect all unilaterally "weak" muscles and repeatedly "weak" muscles encountered in routine muscle balancing as being "weak" to due reactive combination rather than due to meridian under energy.

Sneaky #2: On a person we were balancing regularly twice a week we found the Piriformis to be consistently weak whenever we checked it, even just after balancing and even though the wrist pulse test (see Hap's paper referred to above) and the thumb to little finger screening test (see below) confirmed that all meridians are in balance and thus the Piriformis should test "strong". Since this person was being balanced regularly, she was learning to "help" by moving her leg into position for the test. Watching a little bit more closely, we discovered the Piriformis was "weak" if we tested it immediately after she moved the leg into the test position, but was "strong" if we waited for about 10 seconds before testing or if we lifted the leg into the test position while she remained completely relaxed. The bottom line turned out to be that the Piriformis was reactive to the quadriceps and that whenever the testee used her quadriceps to move her leg into position to test the Piriformis, the Piriformis went "weak".

Thus we find that reactives can also sneak in when the testee assists the testor by moving their arm, leg, or whatever is being tested into position for the testor. Another common combination of this type is any of several muscles tested with the arm extended, the Deltoid, Supraspinatus, or Pectoralis Major Clavicular, for example, being reactive to the Anterior Deltoid; so again when the testee lifts their own arm into the test position the muscle tests "weak".

The best cure for this problem is to work slowly and deliberately with the testee remaining totally relaxed while the testor gently moves the testee's limbs into the test position and, if there seems to be a problem, to wait about 10 seconds after the limb is in position before testing.

Sneaky #3: One day when Hap was testing Elizabeth, using the Deltoid as an indicator muscle with the thumb to finger screening tests and the wrist pulse tests, he was getting very inconsistent results. Then he noticed that whenever Elizabeth looked down at her hand to see what was happening the Deltoid tested "weak", but when she didn't look the Deltoid tested "strong". Upon further testing we found that the Deltoid was reactive to the Front Neck Flexors so that whenever the Front Neck Flexors were activated by turning the the head down and to the side the Deltoid became "weak".

The bottom line here is that reactives can also be triggered by postural changes during the testing. Sometimes a muscle which tests "strong" while lying down will test "weak" when standing up. A little bit more sneaky is the curious testee who wants to watch everything the testor is doing. Turning or lifting the head to see

what is happening may trigger a reactive combination that will make the muscle being tested test "weak".

The cure for this problem is similar to the last: the testee should remain relaxed and not be looking around. Postural reactives are less likely to be triggered if the muscle testing is done in a supine or prone position on a table.

Screening Tests: There are two screening tests useful for helping to determine if reactives are sneaking in: one for determining if there are any muscles "weak" due to meridian under energy and one for determining if there are any muscles "weak" due to reactive combinations.

To assure the accuracy of these screening tests we have found it important to first check for Central Meridian Reversal, Switching, and Centering and to correct as necessary. Central Meridian flow can be checked by testing the Supraspinatus while running the Central Meridian backwards and forwards. The Supraspinatus should test "weak" and "strong" respectively. The tests and corrections for Switching and Centering are described in Hap's paper referred to above.

The first screening test is to test a strong indicator muscle, such as the Deltoid, while the testee touches the thumb and little finger together. If the indicator muscle tests "weak", this is an indication that there are "weak" muscles present due to meridian under energy. On the other hand if the indicator muscle remains strong, this is an indication that there are no muscles presently "weak" due to meridian under energy and thus that any muscles found to be "weak" are "weak" due to a reactive muscle combinations.

The second screening test is to test a strong indicator muscle while the testor places their other hand over the top of the testee's head about 1/2 to 1 inches away. If the indicator muscle remains strong, there are no "weak" muscles present at that moment due to reactive muscle combinations. If the indicator muscle becomes "weak", there are "weak" muscles due to reactive combinations present.

Do not actually touch the top of the testee's head when doing this test because a "weak" muscle may then be a response to other indicators located at the top of the head. Perhaps the most common is jamming together of the parietal bones in the top of the skull. (See pages 25, 28, and 57 in the Touch for Health Handbook.) This condition may be corrected by rubbing the neurolymphatic points for the abdominal muscles or separating the top of the skull as shown on page 57.

It is important to note that this test only indicates for reactive muscles that are "weak" at the moment of test. The test does not screen for latent reactive muscles. If you initially get a "strong" response to the top of the head test, indicating no muscles "weak" due to reactive combinations, have the testee actively move as many muscles as possible, particularly in the area where reactives are suspected. Then retest. Now a "weak" indicator muscle is an indication that there are indeed reactive

muscles present triggered by the movement.

Conclusion: We have two important points to make with this report:

1) Many "weak" muscle responses obtained during various muscle tests are actually reactive muscle responses rather than what we think we are testing. It is important to critically watch what is happening any time a "weak" response is obtained from a muscle test, particularly a "weak" response that repeats on later testing, to make sure that the response is not due to a sneaky reactive.

2) Reactive muscle combinations must be activated to find them. A person with latent reactive muscle combinations may test to be clear of reactive muscles if these combinations are not activated.

Acknowledgements: We thank Gordon Stokes for his encouragement and suggestions and for being willing to present this paper in our absence.