

## Reactive Muscle Correction Via HYPERTON-X

by Frank Mahony

A reactive state is said to exist when activation of one muscle causes other muscles to malfunction. Symptoms include:

Pain, weakness, and/or restricted range of motion.

These are the same symptoms that we use in HYPERTON-X to define the hypertonic state of muscles. Therefore, employing the concept of guilt by association, a reactive muscle is also hypertonic. Most often the reactive state is corrected by the HYPERTON-X correction:

Isometric contraction (25% of force) in extension, for six seconds while exhaling. Repeat until muscle has reached full range of motion.

When this does not totally correct the symptoms noted above, the muscle may be reacting to another hypertonic muscle, just as we learned in Touch For Health, except that we may not have used the term hypertonic. We may have used the term, "over-energized," or, "set too high." The TFH correction was to test the symptom-aware muscle (SAM), and then activate other suspect muscles, and retest SAM. If SAM went weak, the muscle in activation (MIA) was identified as the culprit. The spindle cells of the MIA were jammed together, and/or the Golgi tendons pushed away from each other causing the muscle to weaken, and SAM was quickly retested in contraction. If everything went right, SAM's symptoms disappeared. However, sometimes the correction was not accomplished, was partial, or was temporary.

Possible reasons for this include:

1. The therapist did not effectively stimulate the belly of the muscle, hence, did not affect the spindle cells

to a meaningful degree, nor the Golgi cells in the tendons, which can be elusive.

2. The MIA had a parallel muscle (PAL) that assists in spindle/Golgi cell activity of the MIA, and the PAL spindle cells were not affected in the correction.

3. The TFH/AK method deals with the muscle in a contracted state only, which may not evoke the reactive response.

In the first case, the therapist may have worked on the geometric center of the muscle, but the belly of the muscle was not in the center of the total muscle, such as in the tensor fascia lata, where the muscle is short, and the muscle mass is near the origin at the ilium, with a long tendon inserting below the knee. Manipulation half way between the hip and knee would have no effect on this muscle. Or, the muscle may consist of an array of muscles with multiple origins and insertions such as; the sacrospinalis, anterior serratus, hamstrings, et al. Also, the muscle may not have been clearly accessible, such as with the subscapularis, and psoas. Golgi tendon cells are known to be elusive. In either case, if the muscle is hypertonic, the spindle and Golgi cells may not totally respond to this type of manipulation, and there may also have been some trauma-memory involved as well.

The second example speaks for itself. In the third instance, it is my experience that we need to focus more on working with muscles in the extended state, as this has greater impact on the muscles. Therefore, SAM should also be tested with the MIA in extension as the shortened (contracted) position may not evoke the reactive state.

ALSO KEEP IN MIND THAT AS WE SHORTEN ONE MUSCLE IN CONTRACTION, WE ARE EXTENDING ITS ANTAGONIST, WHICH MAY BE THE REAL CULPRIT.

HYPERTON-X offers a refinement to the standard TFH procedure. The HYPERTON-X correction involves putting either, or both muscles (SAM/MIA) into maximum extension and isometrically contracting, with 25% contractual force, for six seconds. This is repeated until the muscles reach full extension and both/all hold strong in contraction when the other muscle is activated or extended. This offers the benefits of being able to affect all the cells related to the muscle, as well as the PAL and synergistic muscles, and muscles that present the problems of accessibility, etc., as noted above. Also, extension effects more muscle motor units, and has a more dynamic effect on the spindle cells, as they are relatively inactive in shortened contraction.

**Common Reactive Combinations**

Reactive muscle possibilities are endless, so we will deal with some common reactive combinations, keeping in mind that any muscle may be reactive with any other muscle, no matter how distal, and that there may be a chain of reactives involving more than one muscle. A more complete chart of possible reactive combinations are found at the end of this paper. Following are some rules of the reactive road that have proven helpful in identifying reactive combos. Look for:

Muscles that work together in a specific activity

Related opposite body parts, same muscle on the opposite side, and back to front combos, such as:

Fingers	Toes
Neck	Foot
Forearm	Lowerleg
Upperarm	Thigh
Shoulder	Hip
Biceps	Triceps

**Quadriceps**

**Hamstrings**

Muscles whose grain go in the same relative direction:

Vertical, diagonal, horizontal

Muscles that have common, or near common, origin or insertions

Examples of vertical interaction include:

Sternocleidomastoid, abdominal erectus, quadriceps, tibials, quadriceps, hamstrings, gastrocnemius, sacrospinalis

Examples of diagonal similarities include:

Pectoralis major sternal, transverse/oblique abdominals, rhomboids, gluteus maximus/medius, and latissimus dorsi

Horizontal orientation include:

Transverse abdominals, diaphragm, piriformis, pelvic diaphragm

For the sake of demonstration we will focus on a few key muscle groups that are often chronically hypertonic, and in that state usually create a reactive condition in an array of other muscles. These muscles are :

Upper Trapezius, Hamstrings, and Diaphragm

Although the standard reactive correction procedure is to make all weak muscles strong before correction, I prefer not to do so as it may be the reactive state that is causing the weakness. Therefore we may lose the necessary indication of the reactive problem. After correcting the reactive state the weak muscle may become strong, which tells us that the reactive state was the primary cause of its weakness.

**UPPER TRAPEZIUS**

1. Test muscles ala TFH in the shoulder and upper torso, such as:

Deltoid and anterior deltoid, pectoralis major clavicular and sternal,

teres major and minor, rhomboids,  
levator scapula,

subscapularis, anterior serratus,

sternocleidomastoid, anterior-  
posterior neck,

latissimus dorsi

Note weaknesses.

2. Place Upper Trapezius into contraction and retest above muscles, noting weaknesses. Repeat with Upper Trap in extension and note weaknesses.

3. Put Upper Trap into extension and contract gently for six seconds.

#### CORRECTION

Head is turned and brought forward and toward the opposite shoulder as if to place the check on the shoulder. Contract as if to bring the head up and back to center. Repeat until muscle has reached its maximum range of motion. Do both sides.

4. Repeat holding tests of muscles that tested weak with Upper Trap in both positions.

#### HAMSTRINGS

1. Test muscles in the pelvic area for weakness

Psoas, gluteus maximus and minimus,

piriformis, fascia lata, quadriceps,

quadratus lumborum, abdominals

Note weaknesses

2. Retest above muscles with the Hamstrings both in a contracted and extended state. Note weaknesses.

3. Correct Hamstrings via HYPERTON-X and retest weak muscles.

#### CORRECTION

Knee is straight. Therapist cups the heel in his hand and raises leg forward toward the shoulder to maximum range of motion. Contract as if to bring leg down. Also contract as if to bend knee with knee and ankle

stabilized. Repeat until full range of motion is acquired.

4. Retest weak muscles with Hamstring in both contraction and extension.

#### DIAPHRAGM

This unique muscle can cause reactive havoc throughout the body. But because of its location it is not easily dealt with making it awkward to effectively test for reactivity. Testing may also require holding the breath, which in itself may color the results. Also, determining if the muscle is in either a fully extended or contracted state is pretty much a judgement call, and may require some assumptions. An indicator muscle test is helpful here while the subject takes a deep breath, extending the abdomen, and holding the breath while firm pressure is applied to the abdomen. If the indicator goes weak, the diaphragm is a likely candidate as a trouble maker. The diaphragm may still be so even if the IM doesn't test weak, as it may not have gone to full extension. Therefore there are several ways of getting the tests accomplished.

1. Have the individual do some deep breathing for several seconds to activate the diaphragm to full extension and contraction.

2. Begin muscle testing (forty-two or fourteen, or what ever you wish), preferably while the deep breathing continues. If the therapist has a good sense of timing, he will be able to test both on maximum exhalation and inhalation without the breath being held.

Note weaknesses

For the abdominals, since it is nearly impossible to test them while breathing deeply, use deep breathing for several seconds and then perform tests with several 'breath breaks' until all abdominals are tested.

3. CORRECTION

A deep breath is taken and the abdomen is extended to maximum. The therapist applies firm pressure to the diaphragm for six seconds. Repeat three times.

4. Retest weak muscles.

NOTE: In all cases there may be some emotional involvement with a particular muscle position, or tension. If muscles do not respond fully to correction, test the Indicator Muscle (IM) while the person thinks of the body in the muscle test position (then muscle that has been identified as the rogue muscle). If the IM goes weak, hold ESR points, then retest the muscle while the person again focuses on the body position. Repeat if necessary. Also, the person may "recall" a life experience related to the body position, and may have an emotional release as well. Hold the ESR points (your own as well) and be supportive.

**Asking the Body Questions (ABQ)**

Test the Indicator Muscle while asking simple Yes and No questions. If the person has a physical complaint such as pain, weakness, or loss of range of motion, (SAM) ask:

"Is there a reactive muscle involved?"

"More than one reactive muscle?"

If "Yes," test IM as you count up:

"How many muscles: 2, 3, 4, etc."

Determine which muscle is priority and which muscle, or muscles, are involved. Sometimes the muscle demonstrating the symptom (SAM) is not involved in the corrective process. Ask for the muscles in their reactive order. Then test them in order and retest the SAM. What questions you ask are determined by your area of knowledge. For instance, if you are well grounded in Five Elements, ask:

"On which element is the prime muscle: Fire? Earth? etc. Is it a Yin muscle? Yang?"

Another way is asking for body location: Front of the body/Back. Above the waist/Below. Arms. Between shoulder and elbow. Legs. Between hip and knee. Torso. Between hips and ribs. Skeletal Support. Movement muscle. Fast muscle. Slow, etc., whatever will quickly help you identify what muscles are involved, and in what order they should be tested and corrected, which will be the

same order. Sometimes the muscle(s) are unknown to us. In this case ask what the function of the muscle is:

"Does it close the hand? Raise eyebrows? Pucker lips?" etc."

Correct the muscles in order via HYPERTON-X (Isometric contraction in maximum extension for six seconds while exhaling. Repeat until muscle reaches full extension). Re-evaluate SAM for symptom change. Repeat corrections if necessary.

**Summary**

A reactive state exists when one muscle, or group of muscles can cause a malfunctioning of another muscle. Symptoms of the SAM (Symptom Aware Muscle) include pain, weakness, and/or restricted range of motion, which are the same symptoms of a hypertonic state of muscles. Therefore, correcting the hypertonic state of muscles can be a valuable additional method of correcting reactive states. Sometimes the SAM muscle is not directly involved in the corrective procedure as its symptoms are corrected by correcting the reactive state of other muscles. There may be a multiplicity of muscles in a reactive chain that may have to be corrected in a specific order, but often one HYPERTON-X correction may correct all. Reactive muscles are often involved with muscles whose fibers run in the same direction, have common insertion or origin points, are antagonistic, or have a body counterpart relationship: Fingers-toes, hand-foot, ankle-wrist, leg-arm, shoulder-hip, front-back, etc. Three muscles that have a reactive commonality from person to person include, Hamstrings, Upper Trapezius, and Diaphragm. These muscles can cause a widespread reactive condition, so by correcting them via HYPERTON-X major areas of the body are affected with positive results.