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Bilateral Muscle Weakness Correction 92

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Abstract: A description is given for correction of bilaterally inhibited muscles

In chiropractic applied kinesiology circles the generally accepted method for correcting bilateral muscle weakness found in the muscle examination described by Goodheart, Walther, Stoner and others has been to correct a fixation subluxation. The reason for the bilateral weakness has been generally thought to be a fixation in a group of three vertebrae. The the restoring of facilitation has been demonstrated to be a special chiropractic adjustment of the spine by hand. These chiropractic adjustments for the fixation subluxation did indeed correct the bilateral muscle weakness, in most cases. Conable showed in a paper presented to the ICAK that the description of the correction was not the same by different authors.

In Touch for Health circles the correction was made by use of the neurolymphatic, neurovascular, meridian tracing, origin/ insertion, golgi cell, or spindle cell technics.

I have found that another method of correction which has been effective for me and others that have been shown this method.

The method is very simple and can be used safely by the patient/student/client at home having a member of the family or friend help him/her by testing the previously found inhibited muscles and applying the reflex correction methods. The bilateral weakness problems which I have found, tend to recur with fatigue of the patient regardless of the original method of correction and strengthening of the muscles, that is fixation adjustment or the method I will describe later in this paper.

The spinal fixation subluxations did not appear to follow the spinal nerve pathways to the muscles that were involved in the pattern of subluxations. The fixation of the upper cervicals were discovered by a bilateral weakness of the gluteus maximus muscle and bilateral hamstrings were associated with fixation of the occiput. My observation also indicate some other pathway of communication seems to be involved in at least some of the situations where bilateral weakness are discovered by manual muscle testing.

When I was observing Bruce Dewe, M.D. making corrections for a bilateral psoas weakness, I observed that he did not use an osseus thrust but just moved the skin on the occiput with respiration in the direction of the indicated by evaluating the tongue stress procedures. I experienced this correction on myself and found that I had at least as much benefit from this correction as I had from rapid thrust adjustments of the occiput for the correction. In my own personal experience of the bilateral psoas muscle weakness and in patients I have examined this alternative correction is very more effective than the rapid thrust of the occiput. I have since advocated this method to others, and they also have found that the light pressure moving the skin is very effective and very safe.

I then attempted a similar correction of moving the skin over the spinous processes in a headward to a footward direction for other bilateral weaknesses when I found them in my patients. I have used this procedure now for four years and have found that is is very effective and much easier to correct the problems. The indicators for fixation subluxations are usually gone following the correction and retesting of the bilateral muscles and finding the weakness abolished.

Not every time did I find both muscles of the previously inhibited muscles strengthened by the movements of the skin in a repeated cephalad-caudal motions, sometimes a unilateral muscle weakness would remain and would be corrected by neurolymphatic reflex massage or other reflexes such as neurovascular, meridian tracing or golgi tendon/spindle cell methods. Occasionally I found it necessary to use more than one or

more of the other reflexes to complete the corrections.

I felt that my patients and others needed to know how to help themselves and test the muscles so I worked out a mapping procedure whereby I have been able to map all the muscles and their spinal areas that I have used in my book Touch for Health.

The procedure I found is that a lateral motion over the spinous tips of the appropriate vertebra(e) will inhibit bilateral muscle function and that vertical motion moving the skin will facilitate the same muscles if bilaterally weak. The lateral movement of the skill will not weaken muscles unilaterally in my experience.

I would be interested in any other findings that members of the college have regarding bilateral muscle weaknesses.

The accompanying chart taken from my manual Touch for Health gives the location of the vertebrae that I have found to be associated with the various muscles. These are also listed on the TFH reference chart and the TFH Folios that have been revised early in 1992. The spinal level for correction is found in the upper right hand corner of the picture of the muscle test.

This method can be used in the fix-as-you-go method or in using the five-element corrections, or the 24 hour clock methods, with good results.

Conclusion:

A method which corrects bilateral muscle inhibition, which can be utilized by paraprofessionals and lay persons as well as professionals in the course of their manipulation of family/friends/clients or patients is an important addition to Touch for Health Synthesis methodology.

Procedure:

1. Make TFH muscle assessment.
2. Discover any muscles that are found weak on both sides of the body (both Pectoralis Claviculars, as example).
3. Look at Chart, Folio, or attached reference for Spinal level
4. Massage skin over the spinous process (the center portion of the bone in the spine) at the level indicated moving the skin over the bone in a headward to footward fashion for 10-20 seconds.
5. If not sure of exact location on spine, use two vertebrae above and below the indicated area on chart for the massage. Doing more levels does not affect the results. The correct level needs the massage.
6. Recheck the previously weak muscles. The bilateral weakness should be now eliminated.
7. If one muscle is still weak, use NL, NV, meridian methods for correction
8. Continue with assessment if necessary for procedure you are following.

References

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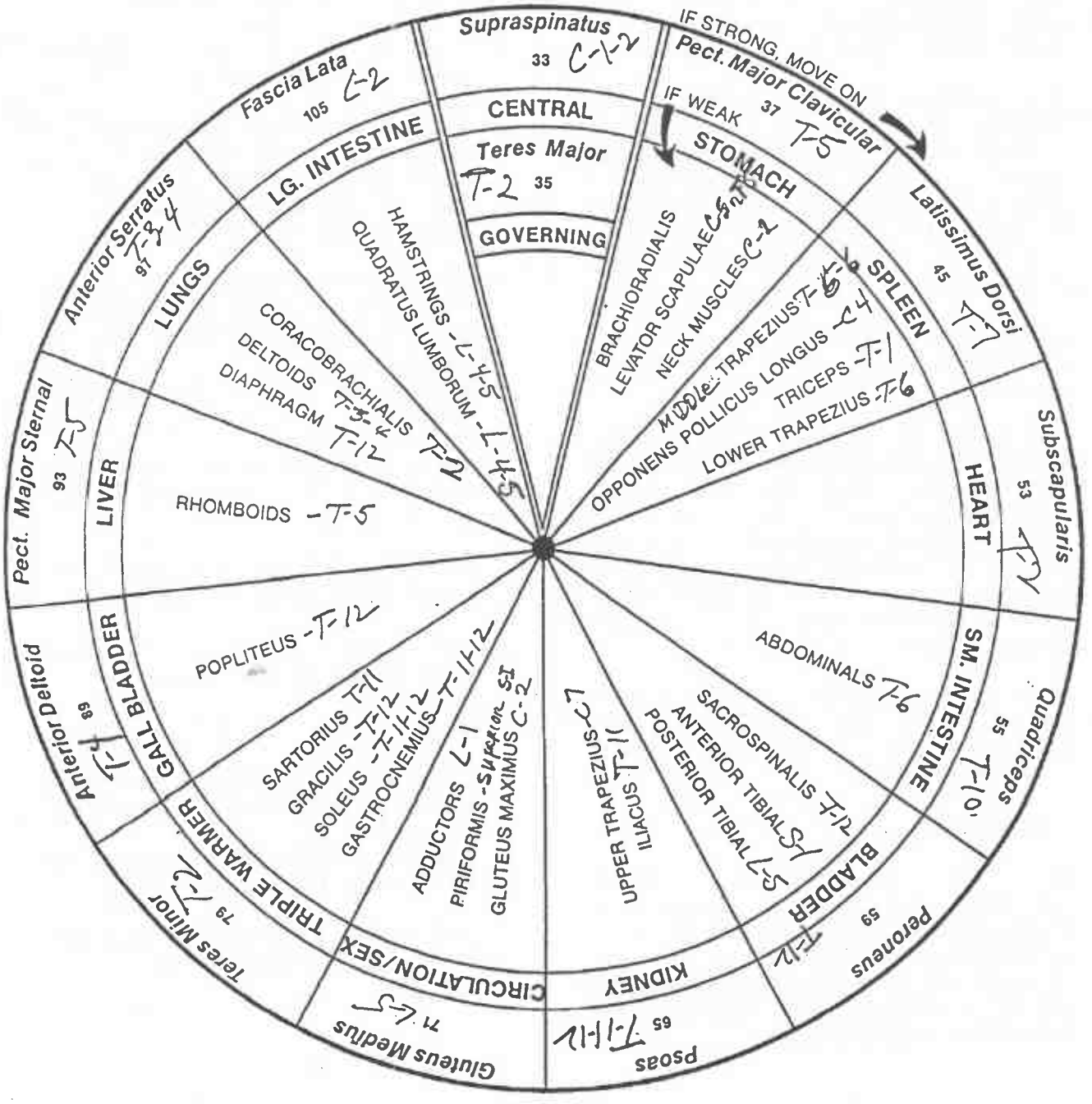
2. Stoner, Fred, D.C. Eclectic Approach to Chiropractic, F.L.S. Publishing Co
3. Walther, David S., *Applied Kinesiology Volume 1*, D.C.Systems, 1981


Supraspinatus 33 C-1-2
IF STRONG, MOVE ON
Pect. Major Clavicular 37 T-5
IF WEAK
CENTRAL
Teres Major T-2 35
GOVERNING
STOMACH
Fascia Lata 105 L-2
LG. INTESTINE
Anterior Serratus 97 T-3-4
LUNGS
Latissimus Dorsi 45 T-7
SPLEEN
Subscapularis 53 T-7
HEART
Quadriceps 55 T-10
SM. INTESTINE
Peroneus 59 T-12
BLADDER
Psoas 65 T-11-12
KIDNEY
Gluteus Medius 71 L-5
CIRCULATION/SEX
Teres Minor 79 T-2
TRIPLE WARMER
Anterior Deltoid 69 T-1
GALL BLADDER
Pect. Major Sternal 93 T-5
LIVER
HAMSTRINGS - L-4-5
QUADRATUS LUMBORUM - T-12
CORACOBRACHIALIS T-3-4
DELTOIDS
DIAPHRAGM T-12
RHOMBOIDS - T-5
BRACHIORADIALIS C5-6
LEVATOR SCAPULAE C-2
NECK MUSCLES C-2
MIDDLE TRAPEZIUS T-5
OPPONENS POLLICUS LONGUS T-1
TRICEPS T-1
LOWER TRAPEZIUS T-6
POPLITEUS - T-12
SARTORIUS T-11
GRACILIS - T-11-12
SOLEUS - T-11-12
GASTROCNEMIUS T-11-12
ADDUCTORS L-1
PIRIFORMIS - Superior S1
GLUTEUS MAXIMUS C-2
UPPER TRAPEZIUS C-7
ILIACUS T-11
ABDOMINALS T-6
SACROSPINALIS T-12
ANTERIOR TIBIAL S1
POSTERIOR TIBIAL L-5