Disclaimer

Although persons and companies mentioned herein are believed to be reputable, neither the Touch for Health Kinesiology Association nor any of its officers or employees accepts any responsibility for conditions or circumstances resulting from use of this information. Any reader using this information does so at his or her own risk. The Touch for Health Kinesiology Association is not a clinic and does not give treatment.

The papers presented in this Journal reflect the opinions of the authors. Some articles may not conform to the policies set forth by the Touch for Health Kinesiology Association.

This Journal is intended to provide educational and research information on vital energy balancing techniques that have been successfully used to reduce stress and pain. This Journal is not intended to provide medical diagnostic information, and the exercises presented herein are not intended to replace medical treatment where such is indicated.

Copyright Notice

Touch for Health
Kinesiology Association

408 North Main Street, PO Box 392
New Carlisle, OH 45344

It's been 30 years since the *Touch for Health* book first hit the market. Thirty years!

It truly is amazing what can happen when a good idea, based on sound fundamental principles, and a heart-song that is truly compassionate and altruistic, hits the market. In the early 1970s when *Touch for Health* was germinating and coming out on the market, things moved quickly. Within a few short years the book had been translated into several languages, and by the mid-eighties, there were 15 satellite offices throughout the world, each bringing the *Touch for Health* skills to their communities.

Flash forward to today and the *Touch for Health* world, although different, still emulates the original *Touch for Health* seed. We have grown into an international college, and the various Kinesiologies germinating from the *Touch for Health* fundamentals have grown into the hundreds. Today we are in millions of people touched by the heart-song sang not so long ago.

This year's journal has brought together 30 years of growth in *Touch for Health* findings. We have gathered the finest authors and healers our community has known. Especially rewarding is the contribution by Dr. George Goodheart, the man who inspired Dr. John Thie to write *Touch for Health* in the first place.

I agree with Dr. Bruce Dewe, "All you need is a pair of loving hands." That is the heart of energy healing. The science is found within this journal. I can only hope that the reader benefits as much as those in attendance at the conference where these papers were presented.

Keep practicing. Make it daily. And tomorrow *Touch for Health Kinesiology* will be here with you, teaching "wellness to the world."

Robert Aboulache
President,
Touch for Health Kinesiology Association

Teaching wellness to the world

TABLE OF CONTENTS

SCHEDULE
Wednesday, July 13, 2005

Speakers:

Reflexes Underlying ADHD by Brendan O'Hera

The Science, Art and Ethics of Muscle Testing by Arlene Green

Research and Kinesiology by John Thie

The Primitive and Postural Reflexes

...and their effect on our physical, mental and emotional development

by Brendan O'Hara

Just what is ADHD?

Well, modern research tells us that for some folk the neurotransmitters are not doing their job. This can lead to a number of 'symptoms' and the adhesion of the label ADHD (Attention Deficit Hyperactive Disorder): The good news is, it's not a life long sentence.

Children (and many adults) are given the label of ADHD because they exhibit some or all of the following:

- Have difficulties concentrating, reading, writing and learning in general
- Often fidgeting with hands or feet, or squirming while seated
- Having difficulty remaining seated
- Being easily distracted by extraneous stimuli
- Having difficulty awaiting turn in games or group activities
- Often blurting out answers before questions are completed
- Having difficulty in following instructions
- Having difficulty sustaining attention in tasks or play activities
- Often shifting from one uncompleted task to another
- Having difficulty playing quietly
- Often talking excessively
- Often interrupting or intruding on others
- Often engaging in dangerous activities without considering possible consequences
- Often not listening to what is being said
- Often forgetting things necessary for tasks or activities
- Lack of awareness of physical and social boundaries

Now, **the Primitive and Postural Reflexes (PPRs)** are involuntary movements present before proprioception develops. It is through and because of the PPRs that proprioception is developed. These involuntary movements are triggered by either sensory input or by movement of the head. There are many of these reflexes, the majority of which 'emerge' in utero. They emerge, develop, peak, perform their task and then integrate into, and help to develop the whole being. The infant is born with an innate desire to walk and talk.

The PPRs encourage certain and specific movements and actions. The continued repetition of the action/movement 'teaches' the being how to perform the action voluntarily, at will. For example the Sucking reflex causes us to suck. The infant sucks and sucks and by so doing learns how to suck. Having learned how to suck, the infant no longer requires the assistance of the reflex and the reflex 'integrates'.

Problems arise when the PPRs are:

- weak
- early
- late
- retained; i.e., do not integrate

In fact, as you will see, many of the 'symptoms' of ADHD can be the result of retained reflexes. In this lecture we address four of the PPRs and the ramifications if they are retained.

The Moro Reflex is the startle reflex, the early 'flight/fight' response; it is the infant's first form of defense. When startled the infant throws out its arms and legs and screams; then it recoils into the fetal position. The Moro has three main components: visual, auditory and kinesthetic. It assists the development of our breathing reflex and is crucial in the first breath at birth.

If the Moro retains:

- concentration will be poor; the child always on edge, on the alert to danger perceived or real.
- a nervy disposition can result with adrenalin and cortisol almost constantly running through the body. This results in a poorly developed immune system.
- whenever a bird flies past the window the child unconsciously has to investigate; any sound draws the attention as it too could be a threat to his or her safety.
- visual and auditory systems remain immature.
- child exhibits hyper-sensitivity and hyper-reactivity, impulsive behavior.
- child can be socially and emotionally immature.

The Spinal Galant Reflex assists with the birthing process. In conjunction with the womb it helps us to 'wriggle' down the birthing canal.

If the Spinal Galant retains:

- the child cannot sit still; this is the 'Wriggler'
- child fidgets
- bedwetting is often a problem
- often the cause of social isolation
- concentration is poor

The Asymmetrical Tonic Neck Reflex (ATNR) generates the first 'kicks' that the mother feels when 18-20 weeks pregnant. It helps to develop vision, balance and the auditory system. It teaches the infant to roll and brings the individual to the lateral midline.

If the ATNR retains:

- vision can remain monocular
- a homolateral state remains
- swimming is nigh on impossible
- handwriting and written expression is poor
- hemispheric integration can be at a low level
- there is 'clumsiness' with poor balance and stilted gait
- the midline remains a barrier to learning and good co-ordination
- the individual can experience anxiety due to indecision

The Symmetrical Tonic Neck Reflex (STNR), as with all the neck reflexes, adds strength and integration to the neck muscles. It teaches us to rock as a pre-cursor to crawling. Whilst rocking the infant is developing binocular vision, balance and the vestibular system and integrating all this with the large muscles that run the body; developing strength and co-ordination against gravity. Integrating: vision, balance and movement.

If the STNR retains:

- hand-eye co-ordination is poor
- reading is inhibited
- balance is poor
- spatial awareness doesn't develop
- concentration and focus are below par
- binocular vision and depth perception will not mature
- poor posture will result; with slumping at the desk
- the individual is slow on the uptake and at copying tasks

When we compare the traits and symptoms of ADHD with the effects of retained reflexes the similarities are evident. The reflexes fall into the physical side of the triangle. They are an important facet of assisting children (and adults) to become wholly integrated beings. Until the reflexes are integrated physical and emotional imbalances will continue to occur.

In your handouts you will find some simple activities to assist the integration of the Primitive and Postural Reflexes described above. They are helpful not only when dealing with ADHD. In other words these activities help with any of the above ramifications of the above 'retained' symptoms.

Over the years, in clinic, I have found when working with the reflexes that it is great to integrate and balance the reflexes but the individual still needs to do the movements to complete and consolidate the balance.

Brendan O'Hara
The F Sharp Music Company, Australia
Phone: +61 (0)3 5988 6988
Fax: +61 (0)3 59 885 299
Email: fsharp@satlink.com.au
Web: www.movementandlearning.com.au

Notes:

The Science, Art and Ethics of Muscle Testing

by Arlene Green

Muscle testing as an assessment tool can guide the practitioner to determine the nature of imbalances and the therapeutic priority. The art and skill of muscle testing is important in having consistent, accurate and replicable results. Being a skill that underlies all the energy kinesiology methods, learning precision muscle testing is an essential ingredient in having successful results. This workshop will teach not only the basics, but will also fine tune the art of muscle testing with hands on instruction of the physical skill and the art of communicating the process. We will also explore some of the key factors in assuring a high level of quality, consistency and accuracy in muscle testing.

Background

Muscle testing is a kind of body biofeedback that can be used to evaluate changes in the body's subtle energy field. Manual muscle testing has been used for over 50 years by doctors and physical therapists to evaluate muscle function. In the 1960s, Dr. George Goodheart utilized muscle testing as a diagnostic tool to assess muscle, nerve and meridian energy connections. More than just a diagnostic procedure his discoveries led to the creation of a new system of healing that we now know as Applied Kinesiology.

In addition to assessing the strength of an individual muscle's response, muscle testing can be used to assess the body's energetic response to specific stimuli. All types of stress (biochemical, electromagnetic, physical, emotional, mental) impact on the body's energy field and subsequently register on the nervous system, creating a change in muscle response, which we can monitor through muscle testing. That can be useful information when one wants to personalize a session to show someone their individualized response to stress or potential corrective technique.

The technique of muscle testing involves applying slow, gradual pressure against the body. Specific muscles are tested starting in contraction and pushed towards extension; that is the opposite direction of how they normally function. The degree or amount of pressure applied is not as critical as the gradualness and consistency of the pressure. Smooth, gentle pressure will give one the greatest clarity of results. The amount of time applying pressure is approximately 2-3 seconds. This seems to be the optimal amount of time to see if the muscle is able to hold that position or whether it "gives", without fatiguing the muscle. The purpose in muscle testing is to be able to see the difference in muscle strength and performance. It is often used as a measure of feedback on how the body is responding to a specific stimuli.

Communication

After one understands the purpose of muscle testing and how to do it, it's important to be able to successfully communicate that to others. Using kinesiology is like speaking a new language which many students may not discover until they get outside of the classroom when they try to explain it to their friends and family. Explaining the process and how you want the other person to respond when being tested is as much an art as the actual physical technique.

When one muscle tests someone for the first time, in addition to explaining the purpose of muscle testing and how it is done, it is also important to let that person know what is expected of them. Letting them know that its their job to "hold" the position as the muscle receives pressure against it, but that if the muscle "gives" that "its ok to let it go." Personally, I never use the word "resist" unless you intend to engage in a contest of strength. Showing them what the muscle will feel like when it unlocks by pushing together the spindle cell in the belly of the muscle is a useful way to help them sense the difference in muscle response ahead of time.

You can also teach someone how to muscle test you. One of the most important things to remember when coaching someone, especially if it is their first time, is to always give positive feedback. Instead of "don't push so hard" say "push more gently and smoothly." Be sure to reframe what they're not doing right, into what or how they could do it better. Always keep your feedback supportive, as that will help to engender confidence and enthusiasm.

In the early stages of learning muscle testing it is quite helpful to get hands on supervision by an experienced kinesiology teacher. Not all kinesiologists practice the same nor do they test the same, so be aware of that. Look at their background and skill level if you are looking to learn from them. Those who have mastery with the skill will test with smooth, consistent pressure and show a refinement in their skill. Taking some classes where muscle testing is taught, not just used, is important if you are serious to learn the skill well. Repetition and getting feedback in the early stages will help one learn the basics without having to unlearn any bad habits later. My personal recommendation would be to take a class in Touch for Health Kinesiology that focuses considerable time on the actual skill of muscle testing as a part of its basic curriculum.

Testing Procedure

The following is a procedure that can be used when muscle testing to help assure a greater level of accuracy and consistency.

A. Preparation

1. Rub K-27 point- The 27th point on the kidney meridian is located on the underneath side of the collarbone at the junction of the breastbone. It is involved with neurological disorganization problems, sometimes referred to as 'switching'. Rub with medium pressure for about 5 seconds while holding the other hand over the navel. Also, rub above and below the lips (end points of the central and governing meridian which can affect neurological organization).
2. Check for water. A tug on the hair or skin will assess whether the hydration level of the person is optimal in the moment. If the indicator muscle unlocks after tugging it indicates the

person may be somewhat dehydrated which can potentially affect consistency in results. Invite them to drink water and retest

B. Testing

1. To keep it simple one can check the arm held in two positions.

   a. Hold the arm at 45'angle in front of the body keeping your elbows straight. Testing is to push it straight back towards the body.

   b. The second position is with the arm held straight out in front of the body palm down, shoulder level, elbow straight, arm parallel to the floor.

2. Tester places his or her hand above the wrist and applies slow, steady, gradual downward pressure against the forearm. Gentle to medium pressure works as well, if not better, than heavier pressure. The key is in the smoothness of the pressure, not necessarily the amount of pressure.

   a. Using a cue word like 'hold' or having the subject say 'push' helps to synchronize the testing. Using the word 'resist' is not advisable, as it will make it harder to assess if the muscle is letting go.

   b. Keep eyes in one position when testing and breathe normally.

3. We are looking for the muscle to give a 'locked' or strong response (to be able to maintain steady position against pressure being applied to it.)

4. Let the person being tested know that what we are looking for are differences in muscle strength and performance. Tell them, that "Its ok to let the muscle go or relax" if they feel it give or are struggling to hold it in that position.

5. If the muscles lock easily then go to step C. If the muscles give or feel spongy then:

   a. Rub firmly the spaces between the ribs, next to the breastbone (rib spaces 3-4-5) and on the back (T 3-4) for about 10 - 20 seconds with medium to firm pressure. The person being tested can rub their own front points.

   b. Retest the muscle. The muscle should now 'lock' when tested.

C. Check for a Clear Muscle Circuit

After assessing that the muscle can give a locked or strong response, you want to make sure that the muscle can also give an unlocked response. Occasionally, a muscle has a blocked circuit that does not allow a feedback response from the nervous system. If this occurs, then the muscle will stay strong all the time regardless of what you are testing. Therefore, its necessary to determine before you do any testing with it that is has a clear muscle circuit. To check for a clear muscle circuit:

1. Test the muscle. It should be strong.
2. Push your thumbs, or thumb and index finger, together towards the belly (bulging part near the center) of the muscle going with the length of the fibers. On retesting, this should now turn the muscle OFF. To strengthen the muscle, pull apart from the belly toward the ends.
3. If the muscle does not turn off (weaken) then put the muscle in the testing position. Push up firmly against resistance and then push down against resistance (like an isometric exercise) for just 2-4 seconds.
4. Recheck step 2. The muscle should now turn off.

Note: Different systems of kinesiology will probably have some variations in their muscle testing protocols. There is no one standard way of setting up the testing procedures. This way works well for me and for the most part is what is taught in Touch for Health Kinesiology and the PKP (Professional Kinesiology Practitioner) trainings. It helps assess some of the variables, like dehydration and switching, which can affect accuracy and consistency. It also addresses what to do if a muscle does not respond to a stressor (i.e. checking for clear circuit).

Again, my recommendation for learning the art of muscle testing is find an experienced kinesiology teacher who takes time to teach all these refinements and can give you 'first-hand' feedback. This is a subtle skill that requires lots of hands on training and supervision in the early stages of learning.

Variables that can affect Muscle Testing

1. Skill
2. Intention
3. Confidence
4. Dehydration
5. Drugs and Alcohol
6. Blood sugar
7. Neurological disorganization (i.e. switching)
8. Severe emotional stress
9. Fatigue
10. Blocked circuits (see procedure step C.)
11. Inappropriate use of muscle testing
12. Having a bias to the results or expectation
13. Polarity imbalance

Intention and Ethics

Once a person has taken a class or classes and has gained knowledge of techniques, communication skills, and even a level of confidence, perhaps one of the most important and yet subtle keys to success in accurate muscle testing is intention.

The role that intention plays in affecting results in muscle testing may not be as obvious as the techniques used, but it can be as profound. Both unconscious intention and conscious intention can effect muscle testing. An example of where one's unconscious intention could influence results would be in the relationship between consistency and accuracy, and the degree of confidence a tester has. Novice muscle testers often miss the subtle muscle imbalances when testing, and though that is partly due to lack of experience with the physical technique, confidence seems to play a

role too. New people are more likely to have a greater level of inconsistent and therefore inaccurate results. The more confident the practitioner, the more likely they are to stay focused on 'allowing' for the process to happen; and less distracted by their self doubts. Keeping in mind the adage "energy follows intention" one can see how a person who is having self doubts or confusion on an inner level might find their muscle testing results less than optimal. The more confident and skilled the practitioner can remain during the process, the more likely they are to get clear, consistent and accurate results with muscle testing.

There are numerous examples that show the effect that conscious intention has when using kinesiology. A person's thoughts create an energy pattern that can influence muscle response. We can see that very simply when we ask a person to think of something stressful and it turns off a muscle that was previously strong. Holding an intention or setting a goal, creates a specific energetic pattern in the body. That specific pattern can be assessed through muscle testing, or you can simply ask the person their sense of how they 'feel' about that issue or stressor. Doing some intervention can release that pattern quickly and easily. Reassessing that pattern through the person noticing any feeling change or muscle testing their body's response to that stress can evaluate how things have shifted. The intention calls up the pattern, the intervention releases that pattern.

In the same way that conscious intention on the part of the person being tested has an effect on the energy of the body, so too can the tester's intention cause an effect upon the person's energy response. Aside from people testing with an obvious extra push when they are trying to make a point, testers can potentially skew the results if they have an agenda to prove. If the tester has a strong bias to what they feel the results should be, whether its conscious or not,the muscle testing results will be less than optimal. Testers need to stay very neutral in their intention when testing subjects. The more that the tester can 'get out of the way,' the easier it is for them to access the body/mind wisdom and get consistent and accurate results. Staying neutral when muscle testing means not having any preconceived ideas about muscle responses. Letting go of any ideas of how we think the results of the testing should look and staying unattached to the outcome both in the muscle testing and in the intervention is very important. Keeping in mind that while we may have a specific goal or intention for the session, the ultimate goal in the process is to seek clarity and allow for that which is in their client's greatest good to unfold.

Muscle testing is a wonderful tool that can help in the assessment of imbalances and evaluation of therapeutic options. It can help one to determine an individualized program tailored to the needs of the person. It is an art that requires a certain amount of physical skill both in its application and interpretation. The real challenge is in the subtle areas of inner communication. Confidence and clarity as well as accuracy and consistency come with practice and experience.

Since muscle testing is used by different systems and people use it for a variety of reasons, the issue of ethics is something to consider. Some people have expressed the belief that one can muscle test anything. Muscle testing was first used in the context of assessing muscle imbalances of the actual muscle used. However, since we can assess energy imbalances through it, and everything is energy (physical substances, sounds, thoughts, emotions, etc.) then the assumption was made by some, that we can muscle test everything. While that may be true (though I've never had much luck balancing my car or computer), one also needs to consider whether it is appropriate to muscle test something. In my own experience, if I have any reservations about muscle testing something it usually ends up compromising my accuracy. Therefore, if I have any question whether it is an appropriate issue or question to be muscle testing I either first ask, 'Is this an appropriate question?' or I just choose not to muscle test, since I know my results will be less than best. I may even ask if it is useful or beneficial or in the person's highest good when testing. If its not, then why bother? If one muscle tests oneself with any emotional attachment or charge to the issue the results may be less than optimal. I think muscle testing or balancing someone without their consent, even with good intentions, is questionable ethically. These and other issues are certainly something to consider when using muscle testing. Muscle testing requires more than just skill. It also involves a conscious intention to leave one's ego out of the process and not have any agenda or bias on the outcome. Keeping one's intentions pure and for the highest good of all, brings a level of consciousness to the process that will lead toward more optimal results with this artful skill.

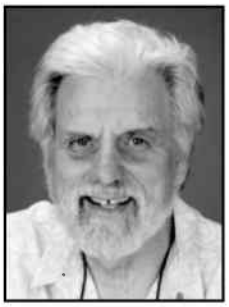
Arlene Green is the director of the U.S. Kinesiology Training Institute. She is a faculty member of the International Kinesiology College and one of the main trainers for TFH and also PKP kinesiology in the U.S. Contact Arlene at the:

U.S. Kinesiology Training Institute
7121 New Light Trail
Chapel Hill, N.C. 27516
(919) 933-9299
greentfh@mindspring.com
www.uskinesiology.com

Notes:

What is Research and why do we want to do it?

by John F. Thie



What is research in the field of touch kinesiology? What do we know? What do we want to discover? What would be the value of our findings? Research is the careful, patient, systematic study and investigation in TFHK undertaken to establish facts or principles that allow us to give more efficient, effective and safe interventions in our self-care and care for others.

In our field of health enhancement that is very new, despite the rush of other disciplines to use it we are somewhat impoverished. We do not have the advantages of some of the more established fields of knowledge that are affiliated with Colleges, Universities, Foundations and Government's Disease and Health care organizations. Naturally, these groups have the advantage of a long track record. In every new field of knowledge the pioneers need to make the necessary sacrifices to attract the more conventional sources of funding. This means we must fund our own research first.

What do we know?

From a scientific research standpoint we know almost nothing. The criteria for knowledge in science is public knowledge. Not only public knowledge, also that the information has been published in peer-reviewed journals. This has been done in Applied Kinesiology to a very limited extent. It has not been done in TFHK.

We do not have the names or total numbers of teachers/practitioners who are teaching TFH worldwide. We do not know the outcomes of TFH interventions as reported in peer-reviewed journals. We do not know how many benefits are derived from TFH interventions which are placebo responses, that is responses that come about to please the person rather than the actual intervention. We no not know if TFHK interventions have a nocebo response that is causing negative outcomes based on the factors surrounding the TFHK intervention. We do know that placebo and nocebo, which relate to the positive and negative responses unrelated to the therapies, are facts in the interventions with drugs and surgeries.

We do not know the amount of education needed to use TFHK safely. We assume that it is safe for everyone because that has been my personal observation and we have not heard of negative outcomes that would change our minds about that assumption.

We do not know who are the best responders to TFHK interventions, or, do all people respond equally?

So where do we start? We need to start locally and expand outward to the world in finding out about ourselves. Who else in your community is doing muscle testing/monitoring? Who can you refer your students or clients to when you do not want or are unable to see them when they would like to have more information or help with TFHK?

Where else do we start at the same time? We need to continue to keep and expand carefully written records of those we are helping, what we are teaching, the protocols we are using and the outcomes of what we have done. We then learn how to present individual case studies for publication. First we publish these in our own publications and then in peer-reviewed publications with which some of us are affiliated. These publications may accept our paper if written as a carefully done case study.

From these case reports we can then develop some hypotheses that could be tested in carefully designed studies. These then could be published in peer-reviewed scientific journals. By following these procedures we could present our methods as one of the safe, efficient methods of enhancing health and preventing disease as well as helping change the present model of disease care that appears to be failing. As evidence of this failure the United State Government through its National Institutes of Health has established a Center for Complementary and Alterative Medicine whose task it is to investigate those methods that are being used increasingly by the American public that are not taught in Medical Schools today.

In the United Kingdom their National Health Service UK issued, in March 2005 a report

by the House of Commons Health Committee on "The Influence of the Pharmaceutical Industry." This is called the Fourth Report of Session 2004–05 Volume I Report, together with formal minutes Ordered by The House of Commons to be printed 22 388.

It stated in part:

> "Pharmaceutical companies cannot be expected to undertake in-depth research into these areas. In the absence of other sources of funding this research must be financed by the Government. We recommend that the Government fund: A multi-disciplinary investigation of existing medicines, combinations of medicines and medicines use where there is a reluctance of the industry to fund such research; Research into the adverse health effects of medicalisation; Trials of non-drug approaches to treatment.
>
> #390. There are a number of specific measures which may help to focus on health priorities. The World Health Organization has recommended that all countries adopt a National Drugs Policy to encourage the availability of medicines to all types of patients, the safety and efficacy of these medicines and their rational use. We recommend that the Government adopt a National Drugs Policy to encourage the availability of medicines to all types of patients, the safety and efficacy of these medicines and their rational use and to ensure that medicines are compared to non-drug approaches.
>
> #391. The NHS, despite its size, has no policy on the evaluation of drugs in treatment relative to non-pharmacological approaches. We recommend that the NHS adopt a policy regarding the role of drug

> treatment in relation to non-drug treatment, emphasising the importance of both approaches. (my emphasis added in bold)."

Can the people using TFHK in the UK be part of this program? Locally they will need to be organized and have a single "Kinesiology Approach" to the government if it is to be possible based on my previous observations with the chiropractic approach to government agencies.

It is hazardous to start talking about the clinical condition of the patient rather than the person who is presenting themselves to us in the clinical condition. One of our approaches to avoid this is to stay with the self-responsibility model of asking the person what they want better in their lives rather than only concentrating on what is wrong with the person. In presenting an individual case study we must never present the study as a way of intervening for a particular problem or disease. What we need to always focus on is the person who is presenting themselves to us with all their multifactorial possibilities. This will mean that in our individual case presentation we must always be very careful to include the personal story of the individual who has the complaints and goals. The entire whole person in the context of their lived life needs to be considered.

We must never lose the value, satisfaction and excitement of helping individual people to have happier and healthier lives in reaching their goals and fulfilling their missions and destinies.

We do not yet know if there is a place for TFHK in the Integrated Medical practices that are developing throughout the world. We do know from personal communication that many licensed health practitioners who have studied TFH do offer these interventions in their practices; we do not know the numbers or the frequency of the use of TFHK by these practitioners or in what situations. There are no peer-reviewed articles about this subject in publications of which I am aware.

Also, what additional training is ideal for a licensed practitioner in TFHK in order to integrate these methods into their licensed profession?

Again, I ask the question," Where do we start? " We start with ourselves, being willing to pay for our own advancement in the scientific world of today. We first, are the yeast; the starter-then the rise of information will attract others with the financial means to grow the field. We need to be aware that some of us want to be the scientists of TFHK. We especially need to encourage and recruit these people to use their investigative interests and talents to do the simple research projects. Keeping good records and developing individual case studies that can be published is the task. We need to note here that there is a difference between testimonials and case studies. Testimonials are a way people can let us know of their appreciation. Appreciation in all things good is vital. Case studies, however, are much more the hard facts recorded of a person's history, interventions taken and outcomes and much more.

We have been developing tools that will assist us in being the scientists of TFHK. One of the tools is the eTouch for Health CD, which allows you to keep careful accurate records of the interventions you do. Another tool that has been developed is the Gateway to TFHK on the Internet, which allows you to post to the Internet TFHK research site the outcome of your interventions. With these tools you have the ability to begin to learn about being a TFHK scientist and reporting your results as careful case studies and reports.

I envision thousands of people worldwide using the TFHK CD and the Gateway to gather the information needed for individual case studies. When we have this compiled information on the Internet it will be available to qualified researchers to develop. The researcher studying the TFH Internet data could submit individual papers and develop hypotheses. We could open the floodgates for more people everywhere to learn how they can better their health and experience joy of living through TFHK. I hope all of you will see the possibilities here and get started on keeping better records and reporting to the TFHK Internet Gateway Research site. And now I want to demonstrate tonight how we can get started with an individual by using both the TFH CD record keeping and how it can be reported to the Internet research site.

SCHEDULE
Thursday, July 14, 2005

Speakers:

30 Years of Growth and Development of TFH by Matt Thie

Four Dimensions of Being by Dale Schusterman

Switched on Selling by Jerry Teplitz

Balancing the Metaphysical Body by Adam Lehman

The Instrinsic Energy by Maurizo Piva

Managing Blood Sugar by Jan Cole

New Science Explanations by Denise Gurney

Elevating Sexual/Life Force Energy by Irene Yaychuk & C. Charleton-Fitchett

Intuition in Kinesiology by Bruce Dewe

30 Years of Growth and Development Touch For Health & Energy Kinesiology

by Matthew Thie, M.Ed., Vice President, TFH Education, Inc.

Who is your primary care provider? **YOU are your primary care provider.** You are the one most qualified to assess your own experience of life and health. To care for your whole self, your whole Soul, you need to find ways to remember what Wellness is for you in the context of your own unique lived life. You can then make the shifts in your energies, the changes in your postures, attitudes, choices and actions that will allow balance among the various aspects of your life. This means embarking on a journey of self discovery which includes responsibly requesting assistance, counsel or therapy from others, whether your friends, your family, professional health practitioners or other "experts".

For over 30 years, Touch For Health (TFH), *developed by chiropractor, Dr. John F. Thie, has provided a way for people to work together to assist themselves, their family, friends, and clients* **to reclaim the central role in the creation of their own Wellness.**

We remain committed to the idea **that many of the techniques used by professional health care practitioners can easily and safely be shared with lay people for their own participation and empowerment in their self-awareness and self-care,** even as TFH is adopted by more and more health care professionals and professional TFH training become available.

When we first began teaching lay people as part of the Applied Kinesiology (AK) program, there were two principle objections. One was that the AK techniques would be dangerous in the hands of lay people, and the other was that we were liable to create a new profession that would be in competition with chiropractic and other categories of physicians who are licensed to diagnose.

Since that time TFH, and so many other Kinesiology systems which have grown out of or in parallel with the TFH or Energy Kinesiology model, have been shared with hundreds of thousands of lay people with great success, satisfaction and safety. The fear that sharing with the public would be dangerous has proved unfounded. TFH is very consciously designed in a holistic, non-diagnostic, energetic model that is safe to learn and apply without any prior specialized training, yet very effective in helping people to feel better and enjoy their lives more.

TFH in particular has developed philosophy, ethics and protocol which not only make it a clearly different model than that practiced by biomedical physicians (a truly holistic, vitalist/energetic model rather than a disease treatment model) but also has proven to be an extremely beneficial complementary approach to working with human beings. TFH focuses on facilitation of optimum performance and satisfaction in life, and does not compete with medicine, but integrates with all aspects of health and Wellness care, encouraging prevention and self-care, including proactive and timely consultation with physicians and other health care experts. The TFH model of kinesiology is non-invasive, honoring of the individual, hopeful and positive (which in itself has a powerful healing influence, even before we apply our gentle energy balancing techniques). TFH & Energy Kinesiology represent the cutting edge in health maintenance, being positive and safe interventions, reducing unnecessary medication and surgery, and optimizing medical care, recovery, adaptation and rehabilitation.

Today it is very clear that the sharing of TFH has indeed resulted in the creation of a new profession of (Energy) Kinesiology. As we celebrate our accomplishments and plan the future growth and development of this new profession of Kinesiology, it is important to consider the foundational program of Touch for Health and the principles that have created this distinct and particularly beneficial profession.

Touch for Health Purposes

VITALITY: Enjoy Life. Improve posture, attitude, energy, balance, harmony and Wellness.

Develop awareness and presence to appreciate and enjoy what is happening in YOUR life. Focus on the creation of optimum performance and personal best. This process of greater awareness leads to growth on all the levels of human functioning.

TELOS: Develop your *Reason for Being.* Find and fulfill purposes and goals that contribute to your sense of participating and loving life. Identify the types of environments, roles, careers and activities in which you will naturally thrive. Create and expand opportunities for all people to discover and utilize their natural healing abilities. Encourage the natural healers to practice the healing arts.

HEALING & RECOVERY: Optimize function of the immune system and healing system. Harmonize mental, emotional, physical and behavioral aspects of each person's life for relief of symptoms, enhanced adaptation and coping, and improved quality of life and Wellness.

Create practical and accessible processes, practices and habits that are proactive, preventative and life-affirming.

In 1973 the book *Touch for Health* was published with the hope that the maximum number of people could help each other to understand and FEEL that there is always HOPE, no matter what their age or physical conditions. All that is needed is a pair of loving hands to improve healing, quality and meaning in life. The original vision was to train patients to use the fundamental principles of assessment and balancing of muscular posture and subtle (meridian) energies through muscle testing and acupressure. Patients were able to bridge the gap between feeling "not well" or imbalanced and feeling "sick enough" to consult a professional. They improved their own preventive self-care habits and increased the benefit of professional health care. This was so successful that lay people who experienced the benefit of TFH wanted to "pass the word" as TFH instructors. This was the beginning of the TFH training program in the educational model.

Since that time thousands of lay people have become effective instructors of TFH and shared these simple, safe, yet powerful techniques throughout the world, in more than 100 countries and 23 languages. Many people have found a career as

TFH instructors, and even TFH practitioners without any prior background in healthcare. Most importantly, thousands upon thousands of people have been helped in subtle or dramatic ways to function better and enjoy their lives more, through the grassroots sharing of TFH as well as in clinical settings.

An untold number have benefited simply by reading the book and trying it out. We have had many letters and reports that suggest that thousands have benefited through their own independent study and experimentation.

Experts have developed and adapted the Touch for Health system in the specific contexts of their professions, which include religious ministry, psychological counseling, education, personal coaching, and more. Within the health-care field, TFH has proved beneficial across the spectrum in the context of traditional Western biomedicine, nursing, chiropractic, massage therapy, Traditional Chinese Medicine, acupuncture, psychotherapy, physical therapy, sports medicine, personal training, etc. The TFH Energy Kinesiology model has also been embodied in a wide range of other kinesiology systems, many of which are based on the foundation of the TFH system, so that this kind of work is becoming more and more known and accessible throughout the world, especially in Europe, Australia and New Zealand.

Important Developments in the Growth of TFH and Energy Kinesiology

The Touch for Health Foundation & Association established 1975
The TFH Foundation was established in Pasadena, California in 1975 (together with the International College of Applied Kinesiology- ICAK) to train instructors to teach the TFH system and administer the TFH Association whose membership includes TFH instructors and interested members of the public. It was set up as a not-for-profit educational foundation accredited in the state of California as a vocational training school. The Foundation also organized and sponsored the first TFH conferences which for many years were the only international kinesiology conferences in the energy model, and to this day embrace speakers and attendees from across the kinesiology spectrum and from around the world. Many of our current leaders in the field of Energy Kinesiology and faculty members of the IKC remember the early days in San Diego, California.

TFHF and ICAK divide and develop separately
Though founded together, and originally coming together in a joint conference, the two organizations soon separated. The ICAK has since focused on training physicians who are licensed to diagnose, using AK in a clinical setting, while the TFHF emphasized the holistic, personal development approach.

TFH Foundation closes, TFH/KA and IKC established 1990
In 1990 drastic changes occurred in California law related to vocational schools, and Dr. Thie retired from his chiropractic practice (which had in part subsidized the TFHF during its 15 year existence) and he donated the Thie Chiropractic Clinic to the Los Angeles College of Chiropractic. It was decided that the time was right to pass the authority for continuing the certification of TFH Instructors to the existing Faculty of the TFHF who then formed the International Kinesiology College in Switzerland. The IKC has now been legally reestablished in Australia, but remains as always a "college without walls", existing wherever TFH classes are taught, consistent with an international standard of instruction and content.

Responding to the needs of lay people, as well as to professionals studying the TFH syllabus, more levels, hours and details have been added to the curriculum, so that now we have a minimum 60-hour training as well as an Advanced Skills Workshop as a pre-requisite to the Instructor Training Workshop. In addition, many related Kinesiology programs and further professional trainings in kinesiology have been developed which are in keeping with the principles of TFH and the standards of the IKC.

It has been a joy to see so many and diverse opportunities to study for those who are passionate about the principles and techniques of this work.

The IKC Faculty continues to expand making TFH ever more available throughout Europe as well as Australia, New Zealand, The United States, Canada, Mexico, Puerto Rico, Central and South America, Japan, Hong Kong, and Indonesia. And the IKC continues to develop means and strategies to fulfill the mission of making TFH available to all people, whether families and friends, lay instructor/practitioners, Professional TFH Kinesiologists, or professionals of other disciplines.

Aims and purposes of the IKC (excerpted from the website, www.ikc-info.org)

The following are just a few elements of the IKC aims and purposes:

- **To teach and disseminate TFH and make TFH available to the widest possible range of people.... in all walks of life and all nations of the world....**
- **To promote research to show TFH works....**
- **To define kinesiology as a method of personal evolution, using precision manual muscle testing only for biofeedback.**
- **To actively support and create the worldwide development of kinesiology as a professional discipline in its own right.**
-

A Unifying Mission

We share these same goals, in terms of the promotion of a professional discipline of Energy Kinesiology, with several other international associations, quite a few national associations, many Kinesiology Institutes, and thousands of individual practitioners throughout the world. The TFH Kinesiology Association in the U.S. continues the mission of an international association, and promotes research and the establishment of TFH Kinesiology as a professional discipline, in addition to its role as an IKC national association. The Energy Kinesiology Association (formally ASK-US, the Association of Specialized Kinesiology of USA) is dedicated to a parallel mission, including the establishment of professional standards, except without as much special emphasis on TFH. The IASK (International Association of Specialized Kinesiology) also has much the same mission, though without the same authority to certify TFH Instructors.

The principle of unity in diversity encourages us to see the opportunities for synergy amongst these similar but separate organizations. The first step is greater awareness of each other and cooperation in common goals. We are happy to report that this process is under way as board members compare notes and find ways to at least work in parallel, if not always directly together.

There are now also many Kinesiology Institutes that offer up to 3-year professional trainings in Kinesiology, with government recognition and even funding of student education. The demand for these trainings is only growing, and I think there is a public need for professionals trained in this way. For that reason we are particularly pleased to see the development of a Professional Touch for Health Kinesiology Training program.

Right now in several countries the governments have recognized the Touch for Health Energy Kinesiology model as useful for their citizens and have recognized it in various ways. In many countries Touch for Health Kinesiology courses and seminars are recognized as continuing education for many of the licensed and registered health professions as well as by organizations and associations for unlicensed or government registered groups. Governments and insurance companies are authorizing payment for kinesiology consultations.

This official recognition of TFH and Energy Kinesiology is a wonderful development and will contribute tremendously to the awareness and availability of TFH. However, with this recognition comes a pressure to conform to more familiar healthcare models and training structures, potentially changing fundamental aspects of TFH.

A Professional Touch for Health Kinesiologist must be a fundamentally different kind of "therapist", with a primary emphasis on **teaching people to be aware of their choices and care for themselves,** while also offering expertise and experience in the specific techniques and applications of energy balancing with kinesiology, **to assist people in relieving their distress and realizing their full potential Wellness and enjoyment of life.**

We still believe in keeping TFH Kinesiology as accessible as possible, while we also develop additional and diverse opportunities for learning (more and different workshops and training programs) and target specific groups (whether segments of the lay public or particular professions). Part of our original purpose in providing a minimal lay training was to allow instructors to be able to share TFH with a minimum investment of time and money, so that those with a gift or passion or calling could discover it, and those who would be happier in a different career field would discover that too.

As was the case when we started TFH, there are many people today who have trained for many hours and years to be health care professionals without first discovering if they have a gift for healing, or a genuine calling, passion, or even any enjoyment in helping other people with their health and Wellness. This is unfortunate for the professionals who are stuck with debts and a personally unsatisfying career as well as for their clients who may not benefit as much from the attention of someone whose "heart is not in it".

One of the great joys of TFH is to observe so many people with no previous training of any kind discover a natural gift or interest in energy balancing and healing. An untold number of people have simply picked up the TFH book and discovered for themselves a way of using the TFH principles to help themselves, their family and friends feel better and improve their lives. Many have taken the basic weekend course, or the entire TFH training and gained a useful tool for their self-care. And many have been inspired to share this help either informally within their circle of family, friends, etc. or formally as TFH instructors, becoming certified through the Instructor Training Workshop and passing on the knowledge with the tried, true and standard protocol codified by the International Kinesiology College for worldwide consistency.

And a percentage of TFH students are continually inspired to become health care professionals, either by going on to study in a traditional profession– massage, chiropractic, naturopathy, acupuncture, biomedicine, psychology, etc.– **or by becoming experts through their own experience and development of the same philosophy, principles and protocols of the TFH synthesis: self-responsible, non-diagnostic, holistic, energy balancing.** This has resulted in a flow of enthusiastic and passionate people into the health care field for the right reasons.

From early on, we have also found that, although TFH is designed to be completely safe and accessible without any medical training, there has been an enthusiastic response from people who are already professionals, or who already have the intention of becoming professionals. Health care professionals are often in a better position to truly appreciate the power of energy balancing, because they are familiar with the limits of the biomedical approach. Many medical doctors, nurses, massage and physical therapists, chiropractors, acupuncturists, psychotherapists and counselors have seen surprising positive results, either in conjunction with standard treatment, or as an alternative in situations where there is no "treatment" or even identified "cause" to treat. Many of these professionals have seen growth in their practice, and more importantly, increased personal and client satisfaction. The focus is transformed from disease treatment to Wellness enhancement, functional improvement and greater joy in life.

There are already existing professions and training programs that have pathology as their primary focus. In fact, the biomedical model is so dominant, availability and access to many safe and effective alternative approaches is often quite limited. While TFHK may be very useful as an adjunct to the biomedical approach to healthcare, it is not necessary, nor even desirable that all practitioners of TFHK be trained in the biomedical disease model and the detailed science of pathology.

There is a great need for a primary focus on the holistic function of the person in the context of his or her own life, and on the powerful yet safe modality of postural and energetic balancing through Touch for Health Kinesiology. Many of those trained in TFHK may indeed wish to continue their study of anatomy, physiology, pathology, psychology, etc., yet many people with a natural gift of healing will find the basic fundamentals of TFHK are sufficient tools to be able to safely help people become more aware of themselves, and to lead healthier, happier, richer lives.

It is perfectly okay, and even desirable to be a Professional TFHK Practitioner having studied "only" Touch for Health, in keeping with the holistic, energetic model and staying within the safe range of Wellness assistance and self-responsibility. Where a TFH Kinesiologist is effectively acting in the role of a Primary Care Provider, it is important to have some first aid training and a knowledge of Red Flags or Warning Signs which indicate an emergency or need for referral. When acting as an instructor, coach, or lay assistant in a model of self-care through self-awareness and postural/energetic balance, we can rely on common sense and other health care resources.

Because so many professionals are involved in the study, teaching and practice of Touch for Health, and so many TFH'ers become professionals, there has been an ongoing evolution of the TFH curriculum towards professionalism. While we support the development of opportunities to enhance professional Kinesiology skills and practices, arbitrary professionalization may be counter-productive.

Professionalism – Expanded and improved teaching materials and curricula, increased opportunities for training, additional support for students through practice and competency assessment and the promotion of excellence in professional practice – is a positive development.

Professionalization – The arbitrary application of standards from other professions in order to look professional such as required prerequisites, breadth studies, hours of training, licensing and regulation (in some countries the use of TFH/K has been restricted to licensed professionals). We must consider carefully whether ever-increasing "standards" might become counter-productive to the goal of sharing these safe techniques with the widest number of people for the maximum benefit.

Dr. Thie originally opposed the increasing requirements for chiropractors in the United States as a barrier to students, yet the result seems to have been an increase in enrollment. Perhaps more worrisome has been the shift away from the vitalist, holistic traditions of chiropractic towards a more biomedical training and philosophy. Similarly massage therapy is approaching a national standard of 1,000 hours of training for certification. How much is too much required training? More importantly, we need to guard against professionalization resulting in the neglect or even elimination of the lay model of individual empowerment with TFH. Awareness and demand for access to the techniques and benefits of TFH among the general public is what will ultimately bring TFH kinesiology to its full potential as a benefit to humanity.

In California, as of January 1, 2003, we now have the **"Health Freedom Law"** which we feel is a much better way to manage TFH and Energy Kinesiology than legislation, restriction and professionalization. The law basically defines the practice of medicine in narrow terms and liberalizes the practice of all the various safe, non-medical therapies. This type of freedom has existed in some parts of Europe and Asia for years with a track record of safety and great benefit, yet the laws in the EU in general and in some specific countries are currently changing and need to be monitored.

Excerpted and paraphrased from **California Senate Bill SB577,** available on the internet.

SECTION 1.

The Legislature hereby finds and declares all of the following:

(a) Based upon a comprehensive report by the National Institute of Medicine and other studies…it is evident that millions of Californians… are presently receiving a substantial volume of health care services from complementary and alternative health care practitioners. Those studies further indicate that individuals utilizing complementary and alternative health care services cut across a wide variety of age, ethnic, socioeconomic, and other demographic categories.

(b). … practitioners could… be subject to fines, penalties, and the restriction of their practice under the Medical Practice Act **even though there was no demonstration that their practices are harmful to the public. [our emphasis]**

(c) The Legislature intends… **to facilitate access** by Californians to complementary and alternative health care practitioners who are not providing services that require medical training and credentials. The Legislature further finds that these non-medical complementary and alternative services ***do not pose a risk to the health and safety*** of California residents, and that restricting access to those services … is not warranted.

SECTION 2.

… Business and Professions Code... :

.... a person who discloses to a client that he or she is not a licensed physician shall not be in violation of Section … unless that person does any of the following:

Conducts surgery … punctures the skin or harmfully invades the body… [Prescribes or administers] x-ray… legend drugs or controlled substances… Recommends the discontinuance of legend drugs or controlled substances prescribed by an appropriately licensed practitioner. Willfully diagnoses and treats a physical or mental condition of any person **under circumstances or conditions that cause or create great bodily harm, serious physical or mental illness, or death.** Holds out, states, indicates, advertises, or implies to a client or prospective client that he or she is a physician, a surgeon, or a physician and surgeon.

Informed Consent and Full Disclosure
The law also requires full disclosure about the practitioner's level of training, the theory and evidence related to a given procedure and about the risks, benefits and alternatives. This will highlight those who have had more extensive training, while not preventing the gifted healer from helping people with TFH as soon as possible. Interestingly, the law also opens the doors for physicians to use alternative therapies that are not within the scope of traditional biomedicine, and may also require the acknowledgement that 80% of standard medical procedures have not been scientifically proven, and other less dangerous, approaches are available.

Under this new law it is now clearly legal to be a TFH practitioner, yet the training of TFH Instructors or Practitioners is potentially subject to demanding California requirements for secondary education! For this reason, TFH Education Inc. is beginning to explore the possibility of partnering or cooperating with existing vocational institutions in California to seed a TFH Instructor/Practitioner program in a variety of schools such as massage, acupuncture, and chiropractic. It has long been a goal to make TFH and/or AK more available to chiropractic students. Currently, although probably all chiropractic campuses have an AK club, almost no colleges make it an official part of the curriculum because it is "not scientific".

Touch for Health is scientific, but lacks orthodox evidence
We know that Touch for Health is real and effective because we have experienced and witnessed the changes in our muscles, postures, energy and in our improved experience of life. Each of us uses the scientific method of observation, hypothesis, experimentation and confirmation in daily practice, and we find that our techniques are easily transferred, and the outcomes are consistently repeatable. In this sense, Touch for Health is one of the most scientific methods available for improvement of wellness and personal best performance. At the same time we lack the traditional documentation of evidence that is required for acceptance within the scientific establishment.

We need to clearly document WHO is doing WHAT, and what kinds of outcomes are resulting. Although we do not treat named diseases, we need to document how use of TFH as an integral part of health care enhances wellness, effectiveness of treatment, compliance, relief from symptoms and reduction of dan-

gerous medication or surgical procedures for people who do have diagnosed conditions. And we need to publish our findings in Peer Reviewed Journals that are listed in the cumulative indexes and are available for research via the internet.

Currently there are a number of newsletters and journals, most notably ***Kinesiology Forum*** and ***The Journal of Applied Kinesiology and Kinesiologic Medicine***. We need to support these journals by encouraging everyone to subscribe, by submitting articles, and by supporting research projects that can be published in the journals. But we need to know what kind of research is appropriate to our model of TFH and Energy Kinesiology.

The reductionist scientific model of orthodox pharmaceutical medicine which seeks a "one drug for one bug", "magic bullet" approach to disease is almost diametrically opposite to the holistic, Wellness model which seeks to take into account a maximum of significant factors which contribute to an integrated sense of well-being and good living. Where the holistic model places the greatest importance on the subjective perceptions of individuals in the context of their lived lives, the allopathic model seeks the "objective" and discretely quantifiable measures of controlled experiments, isolated from any contextual influence, epitomized in the special ritual of the Double or Triple Blind Randomized Controlled Clinical Trial (RCT).

Valid research in TFH and Energy Kinesiology requires TLC not RCT!

RCT is inappropriate for our use. It assumes the ability to eliminate many factors of human experience that cannot be eliminated, and in any case, are fundamental to the theory and practice of TFH/K. We cannot provide an equal initial state in any two human beings, or even in the same human being in a second trial. A blind, false or placebo "balancing" is hardly practicable, is of questionable ethics, and contrary to our purposes. (We are in favor of comparing outcomes of different approaches, or combined approaches to see which seem to produce the most favorable outcomes in general, and for people with specific conditions or symptoms).

Notes:

The Four Dimensions of Being

by Dr. Dale Schusterman

The number four is common to many schools of thought when it comes to understanding the human being. It is the basis of nature, consciousness, and the human body. This paper will explore how to use this quad pattern in the body for the treatment and diagnosis of patterns that have deep roots and might be overlooked without this knowledge. One of the reasons behind switching is that we are an overlay of four separate energy systems. Using this method will quickly get past much of the neurological disorganization that we spend so much time trying to clear before we can effectively work on someone.

The number four is found in all cultures as a metaphor, or symbol, for understanding reality. Native cultures talk of the 'four corners of the earth,' 'the four directions (N, S, E, W), or the 'four winds.' Many of the healing rituals of indigenous peoples involved honoring, invoking, and balancing the four 'spirits.'

All living systems are based on the carbon atom, which creates four bonds to form tetrahedral shapes. The tetrahedron, the simplest of the Platonic solids, is the most compact of all shapes (four faces and four points) and is the building block of nature.

Early medicine talks of the four humours (blood, yellow bile, phlegm, and black bile). A proper mix of these four humours, which relate to the four elements (air, fire, water, and earth), was required for optimum health. Disease was seen as an imbalance, excess or deficiency of the humours. They were said to give off vapors, which ascended to the brain. Here they would form the temperaments (sanguine, choleric, phlegmatic, and melancholic), which describe basic human personality characteristics.

It may sound like nonsense to us now when we hear of such things, but it would be wise not to dismiss outright the knowledge of the ancients. Certainly, they did not have the perspective of our scientific knowledge of the body and mind. But, it is also possible that scientific arrogance has overlooked some of the truths of previous paradigms, which are still valid.

Most wisdom traditions talk about the four dimensions of man/woman. The most common names for these dimensions are the physical, astral, causal, and spiritual planes of existence. We are said to have a garment in which we inhabit each of these four planes. They are called bodies or sheaths—physical body, astral body, causal body, and spiritual body. There are special names for each of these dimensions in the Hindu, Buddhist, Sufi, Jewish, and Taoist systems, but for consistency, we will use the English equivalents. What they all agree on is that there are four basic stages of existence set within a larger backdrop of reality (which is why some systems talk of 5 elements).

Dr. Alan Beardall based his system of Clinical Kinesiology on his observation that there are four 'biocomputers' in the body. He called them the Local, Spinal, Endocrine, and Primary computers. They are the mechanisms in the body that adapt and process all information that come into the system.

First, let us look at the form of the human body. It consists of four extremities—two arms and two legs. The four fingers and toes on each hand and foot are also an example of the four-pattern in the body. There is also a five-fold pattern, but the fifth 'wheel' is different from the other four. The thumb is in a different plane from the fingers, much as the head is different from the arms and legs. The four chambers of the heart is another area where we see the number four manifesting. Other examples could be given, but these are the most obvious areas that reflect the four-fold nature.

As kinesiologists, we can test the four dimensions in the body in a straightforward fashion. We can do this by testing muscles on the four extremities. Each arm or leg represents one of the four dimensions.

In my book, *Sign Language of the Soul: A Handbook for Healing* [1], I describe a complete system of energy healing, based on the Kabbalah (Jewish mysticism), which incorporates an in depth way to explore these four dimensions. The four dimensions or 'worlds' as they are known in the Kabbalah are part of the explanation of the Tree of Life. The Tree of Life (Figure 1) is a model used to describe the anatomy of human consciousness, but it also is an excellent representation of the physical body. Indeed, one of the central tenets of the Kabbalah, which is common to all wisdom traditions, is that the body and human consciousness are cut from the same mold. The symbol of the Tree of Life consists of ten major energy centers connected by twenty-two gates. These 32 pathways express in each of the four dimensions. The correlation in the human body is the four extremities. Each extremity consists of 32 bones, which is a direct correlation to the structure of consciousness.

Lower extremities	14 phalanges, 5 metatarsals, 7 tarsals, tibia, fibula, femur, ilium, ischium, pubis
Upper extremities	14 phalanges, 5 metacarpals, 8 carpals, radius, ulna, humerus, clavicle, scapula

Table 1

Table 2 shows the four dimensions as they correlate with the four extremities. This information will form the basis for the simple testing technique that follows.

Left Arm	Spiritual Body
Right Arm	Mental Body
Right Leg	Emotional Body
Left Leg	Physical Body

Table 2

There are many other such correlations between the body and the Tree of Life, but they are not pertinent to this discussion. However, one other important relationship needs discussing. There are four places in the body which act as doorways, in consciousness, to

these four dimensions. When you focus upon one of these doorways, it brings the body/mind to the frequency of that dimension. The four doorways are the area several inches below the umbilicus (Tan Tien), the thymus/heart area, the third-eye, and the atlas (Table 3). Following is a brief summary of these doorways.

Tan Tien
The area several inches below the umbilicus and several inches into the body is know in Eastern philosophy as the Tan Tien, which means 'the elixir field.' In martial arts, and other similar systems, this area is known as the center of the being. All movement centers from this point and the Tan Tien is a power point that gives great bodily control and strength. This is the center of Qi or Chi in the body; therefore, it is here that one focuses to enhance his or her physical power.

Thymus/Heart
The area of the upper to mid sternum is the next doorway. This is the area of the thymus gland and also covers the heart. This area is the center of emotion, love, and the sense of self. When we talk about ourselves, we point to our thymus. All wisdom traditions talk of the importance of love and opening the heart. This is the doorway to the astral world and by focusing on the heart/thymus area it brings one into awareness of his or her feelings.

Third Eye
The third eye is important in many traditions as the seat of consciousness. Many people focus here during meditation. It is common to look upwards to visualize something or to see with the mind's eye. Looking upwards 20 degrees also shifts the brain rhythm towards the alpha state. This doorway brings one to his or her mental, or visual, state of awareness.

Atlas
The fourth doorway is located at the lower occipital bone and the atlas. This is an area of higher Self awareness. When one concentrates from this place, it is a meta position in which one sees him or herself from a place of objectivity, or from a witness perspective.

Focusing or concentrating on these areas causes a subtle shift in consciousness, which we can use to our benefit as we muscle test the body. There are ways to activate these four doorways in the body to access deeper levels within the being/nervous system, but that is beyond the scope of this paper. What we can do with this knowledge, however, is to combine focusing on the doorway with muscle testing its corresponding extremity.

Left Upper Extremity	Atlas
Right Upper Extremity	Third Eye
Right Lower Extremity	Thymus/Heart
Left Lower Extremity	Tan Tien

Table 3

For example, test all of the major muscles in the left lower extremity and fix any imbalances that you find. The muscles that connect the torso to the left leg (psoas, quadratus lumborum, etc.) should also be considered. Then have your client focus on his or her Tan Tien, *while* you retest the muscles of the left lower extremity. It can help your client to focus if you to touch the Tan Tien, or place one of their fingers on the area. Often you will find one muscle that now tests inhibited. Fix this muscle according to your findings; however, the client must remain focused on his or her Tan Tien while you apply the correction (NL, NV, respiratory adjustment, etc.). There does not appear to be any connection between focusing on the Tan Tien and the muscles of the other three extremities.

Repeat the same procedure with the right lower extremity while the client concentrates on his or her thymus/heart area. Often muscles that test quite strong in the clear, on the right lower extremity, will inhibit with this change of focus. Then test the right shoulder, arm, and hand muscles while the client focuses on his or her third eye (1/2-1 inch above the center of the eyebrows). Finally, have the client focus on his or her atlas area (touch the area to help them focus) while testing muscles of the left upper extremity.

You will often find inhibited muscles in each extremity when you test with the client focusing upon the doorways. Remember, that the client must maintain his or her focus upon the doorway during treatment of the inhibited muscle.

The next time you have a client with a lot of switching, try this method first and fix a few of the imbalances you find. Then go back and see if the client is still switched. Instead of taking the time to unswitch the client, just balance what you find through the four doorways/extremities. Use your time to treat instead of getting them ready to treat.

It is possible for someone to think of a specific injury or emotional issue, or to hold a contact localization while focusing upon each doorway. This will enable you to find new patterns that relate to the client's problem in each of the four dimensions. Do not assume that all right arm problems are related to the mental body, and so on. That would be too simplistic an explanation. A right knee problem might show imbalances in all four extremities when you contact localize the knee, while the client focuses on the doorways, and you perform the muscle tests.

With this procedure you have engaged the consciousness, or attention of the client, hence specific areas of the nervous system, as part of the diagnostics and the treatment. There are many parts to a person, physical, emotional, mental, and the inner sense of 'I.' With this simple procedure you can begin to incorporate these parts into your muscle testing and treating protocol.

Summary of Procedure

1. Test the muscles in each extremity and fix them in your customary way.
2. Have your client bring his or her attention to the doorway that corresponds to one of the extremities, while you retest the muscles.
3. Fix any muscles that inhibit when the client focuses on the doorway. The client must maintain focus on the doorway while you perform the correction.
4. When everything is clear, have your client localize a problem area and repeat steps 2 and 3.

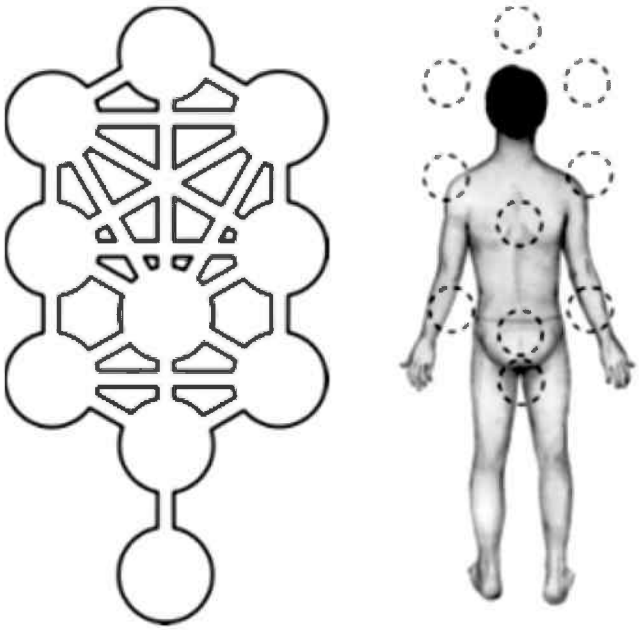


Figure 1. Tree of Life

Notes:

[1] Schusterman, Dale, (2003). *Sign Language of the Soul: A Handbook for Healing, Cranston*, RI: The Writers' Collective.

Switched-On Selling Seminar for Touch for Health

by Dr. Jerry Teplitz

SEMINAR PURPOSE

The purpose of this presentation is to take you through several of the processes that I've developed in my Switched-On Selling Seminar and discover wherever you are "switched-off" in your brain so that you can switch yourself on for the several aspects of the selling process that we will be covering today. At the end of our time together you will be able to do things that were a struggle for you in relationship to prospecting for new clients and being prosperous. You will leave with a set of tools using Brain Gym® to keep yourself switched on. We are not going to teach selling techniques like 101 ways to close a sale. What I want to do in this presentation is to switch your brain on to whatever sales knowledge you have and turn it into a usable and effective information system on selling.

RESULTS

What kind of results can you expect from this experience? While I am doing a very shortened version with you, most of our research and anecdotal evidence has been for the one day version of Switched-On Selling. Here are examples of changes that people have experienced:

1. A Life Insurance Salesperson went through the course and had not closed a major contract in the three months prior to taking the seminar. In the three weeks after the course, he closed 8 major contracts.

2. We had a Realtor who had been in the business for about 6 months and she had 6 personal listings and had not sold a single one. A week after the course she sold 5 out of the 6.

3. We had another Insurance Agent who had been averaging one contract every three weeks prior to the course. We tracked her for over a year after the training. For the first 9 months afterwards she averaged two contracts a week. She changed companies after 9 months, because she didn't really like where she was and in this new company she has been averaging 3 contracts a week, which is about a 500% increase. In her first month with this new company she became the top salesperson in the company.

4. We had a Web Designer who had been attending a conference three times without making a sale for his services. He took SOS the day before the next conference. After the first day of the conference he had 7 contracts. At the end of the conference he had closed 18 contracts.

5. We also have a Life Insurance Company in South Carolina where we installed this program for their salespeople and we have four month's of statistical research comparing before and after figures using last year's figures verses this year's figures. The people who went through the course averaged 39% above last year's figures. People who didn't go through the course had no improvement. People who took the seminar increased premiums 71% versus those who did not take the seminar.

RESEARCH

I've also published a research study with over 350 sales people who took the Switched-On Selling Seminar. I gave participants a pre-questionnaire at the beginning of the seminar and a post-questionnaire at the end of the day. I collected the forms from the participants and mailed them back a month later for them to fill out a third time. Doing it a month later was meant to get over the concepts that the result was just a seminar high or just a placebo effect. Let me share with you some of the results.

I asked 18 questions of the attendees. One of the questions was "I handle rejection well". At the beginning of the day, 54% responded "no" I do not handle rejection well. At the end of the day only 5% were on the negative side. A month later it was even less, it had dropped to 3%. Even more interesting to me was the change on the Strongly Agree side. Only 3% responded Strongly Agree at the beginning of the seminar. At the end of the day over 34% selected Strongly Agree and that number moved up to almost 56% on the one month later forms. All this occurred with no techniques taught at the seminar. All this occurred by using Brain Gym to create new brain rewiring.

I've also conducted a pilot study of the Switched-On Network Marketing Seminar with 25 participants. I discovered even more dramatic changes with these people as compared to the Switched-On Selling participants. The reason for this increased level of improvement is because people don't get into Network Marketing because they want to sell. They get involved because they have a dream and network marketing is the way to meet it. That's why there is such a high drop-out rate in Network Marketing because people immediately hit their blocks and limitations and simply quit.

As an example of the research results, on the Pre-Seminar Questionnaire 88% of the participant's responded either Strongly Disagree or Disagree to the question "I Easily and Effectively Make Calls to Potential Customers and Associates" while only 12% responded Agree. Not a single person said Strongly Agree.

On the Post-Seminar Questionnaire, those responding Agree increased from 12% to 56% while 40% responded Strongly Agree. This means an amazing 96% responded Agree or Strongly Agree to this statement.

Conversely, the number of attendees Disagreeing or Strongly Disagreeing with the statement dropped from 88% at the beginning of the seminar to only 4% at the conclusion of the day.

Since it was only 25 participants, we have not received enough responses to apply these figures to the one month later concept. However, because Switched-On Selling and Switched-On Network Marketing are so similar, I believe we can safely project the same outcomes, which is that the changes held.

THE TRIANGLE

The way to understand what we will be doing today is to look at this triangle. Most seminars will focus on teaching you techniques that will lead to your taking action and getting results. Overall this concept doesn't work very well. Have you ever been to a seminar,

learned a new technique, left excited and three days later you're back doing exactly what you were doing before. The reason for this is the seminar didn't create change at a deep enough level.

Now some seminars will focus on your attitudes and a few seminars will focus on your beliefs and values. Where Switched-On Selling differs is it starts with your brain wiring. That becomes the key to the success of this seminar. By beginning with changing the core wiring, we can then impact your beliefs and values and from this your attitudes are created. Finally you can move into your taking action and you wind up getting your improved results.

KINESIOLOGY EXPLANATION

As we will be using Kinesiology to check what you need to be doing I want to give you the explanation as to why it works This is the explanation that I give to business people so they can buy into these concepts. First, in the early forties, a method of photography was discovered called Kirilian photography. When a person's finger was photographed on a plate with a slight electrical charge, an aura, or an energy band, appeared around the finger. It has since been discovered that everything has its own energy band. We are literally all electromagnetic fields. One electromagnetic field can interact and interfere with another. We actually produce 25 milivolts within our bodies and it's measurable.

You've experienced this when you're walking into a meeting and no one has said a word yet and you know it's going to be a difficult meeting. You've also experienced this If you've ever been working intensely at something and sensed the presence of another person behind you and you turn around and the person is there.

Now where did this muscle checking come from? I think you'll be surprised to learn that the first report in the medical literature was in 1912 by a Dr. Robert Lovett from Harvard Medical School. It was taken further in the 1920s and 30s all by medical people. It got lost in 1941 when World War II hit and we moved into battlefield medicine which is using surgery and drugs. In 1960, Dr. George Goodheart, a chiropractor who is presenting at the conference, rediscovered Kinesiology and developed Applied Kinesiology. Dr. John Thie broke off and started Touch For Health. I initially studied with Dr. John Diamond, who developed Behavioral Kinesiology in 1960. Finally Dr. Paul Dennison developed Educational Kinesiology and Brain Gym in the 1970s.

PERCEPTUAL AND MOTOR SKILLS

There was a study published in 1999 in the Journal of Perceptual and Motor Skills validating the concept of muscle checking. In the study the researchers had volunteers say a truthful statement, which was their real name, and their arm stayed up. They then said a false statement, which was some other name, and their arm went down. Using sophisticated equipment, the researchers found that on the false statement the person's arm went down 59% faster and needed 17% less pressure to push it down.

THE AMYGDALA

Let's examine what's going on in the brain when something happens. There is a part of the brain called the amygdala. When all of our senses see, hear, feel, taste or smell, the signal is immediately sent to the amygdala which can be viewed as a vast computer hard drive. The amygdala is searching for any files stored on its drive from our past where your survival has been threatened. If it finds a file, it will send a signal to the part of the brain called the reptilian brain, which is the brain that first evolved millions of years ago. In the reptilian brain there is an area that is related to our survival; it's where our automatic stress response is located. When you experience a stressful situation, the reptilian brain is the area of the brain that overrides the rest of the brain because this part of the brain controls survival. There's another area that has developed more recently, and that's called the cerebrum which is located towards the top of the head. This is where the concept of choice is located.

Choice is what makes us different from other species on the planet. It's where we can choose to do something or not.

Now, let's assume that you are in a sales situation, and all of a sudden you're under some stress. Your brain quickly reviews and sees if there are any past files in the amygdala that relate to this current experience. If it finds one in the amygdala, it, in effect, presses a button and triggers your automatic response. For example, the file it found may have occurred when you were 6 years old and someone rejected you when you asked for something you wanted. So your not wanting to make cold calls as an adult is actually your responding as if you were still a 6 year old child. You may think you're choosing not to cold call, but when this file kicks in you have no choice.

One of the things that physiologically happens when the flight or fight response kicks in is that blood flow to the cerebrum is shut off so you have no choice in your response.

The choice area is what we want to be able to make operational. The Brain Gym work we will do today is designed to switch off the amygdala's flight or flight response and switch on the choice area so that you can then go to the phone, pick it up and easily make cold calls.

Let me give you an example: We had a woman who was in life insurance, who went through the Switched-On Selling seminar. A week or two after the seminar she was about to make cold telephone calls to prior clients that had fallen through the cracks in order to get appointments with them. She picked up the phone, put it down, picked it up and put it down at which point she realized she was blocked. She took two minutes and did two techniques taught in that course. In those two minutes, two things happened; first, all that negative energy was gone, and second she realized she did not know what she was going to say to the person when they picked up the telephone. She immediately wrote out three lines of script. She made forty calls that day and got 35 appointments, because she was now operating out of choice. That's our purpose today, to flip you into the choice mode.

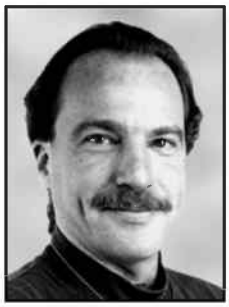
Today I will be taking you through two balances to switch you on to several aspects of selling. The first balance I'll lead you through is prospecting and the second is prosperity.

If you need the handouts for the class that took participants through the two balances, you can email me at Jerry@Teplitz.com.

Notes:

The Chakras – A Bridge Between The Physical and Metaphysical Bodies

by Adam Lehman, ND, En.K.



Abstract: The purpose of this paper is to introduce concepts about the full range of connections between the energy system of the chakras and the physical body. This includes the integrity of the energy system itself, as well as the effects on the physical, emotional and energetic aspects of the physical body. A means of integrating this information into a comprehensive balancing process is discussed.

Introduction

The Chakra system, based in the Eastern Indian culture, is a system that transduces energy between the metaphysical and physical bodies. As *the* major energy system that is largely perpendicular to the body's alignment, it flows through all layers of the aura, and then connects to the body at the deepest level – the spinal cord. This structural composition has broad implications on the nervous system, the endocrine (glandular) system, and most of the other energy systems of the body.

While this topic is big enough for a book (or several books, and there are many already written), I will try to offer some basic concepts here and focus on one chakra as an example of how to utilize information culled from many sources. I will then examine how to apply that knowledge in an Energy Kinesiology session.

What is a Chakra

The word Chakra comes from Sanskrit, and means "wheel" or "disk". And energetically, that's what chakras are – wheels of energy that project in a conical shape from the body. The philosophical concept behind them is that they transduce etheric energy down into physical form, a process known as *manifestation.* But this energy transduction is a 2-way street. So the energy also moves out from the body to the metaphysical in a process known as *liberation.*

Their connections in the body are to the nervous system, specifically different *plexuses* (large bundles of nerves, such as the solar plexus). As well, they relate to the organs and glands associated with the particular plexus. As an example, the heart chakra connects to the cardiac plexus, and is associated with the thymus gland, which is located just behind the sternum near the heart.

There are considered to be 7 "major" chakras that connect to the midline nerve plexuses of the body. The crown chakra enters in through the top of the head and ultimately connects to the root chakra that enters through the perineum – between the anus and the genitals. If you draw a line down through the center of the body, the other 5 chakras extend perpendicularly off that line at different levels: the brow chakra from the glabella (between the eyebrows), the throat chakra at the throat, the heart chakra from the chest, the solar plexus chakra from the upper abdomen, and the sacral chakra from the lower abdomen. These 5 chakras project both from the front and the back.

Chakra Attributes and Properties

The chakra system has been in use for thousands of years. Each chakra has certain attributes associated with it. For instance, each chakra has a color, a sound or note, emotional characteristics, and an element associated with it, as well as the physical correspondences of the glands and their function. As an example, the throat chakra is considered to be blue in color, is related to communication, and the element of sound or ether (different sources may offer different correspondences) to go along with its physical relationship to the thyroid gland.

One of the most fascinating aspects of chakras is their ability to store information. They are like life recorders in this manner, storing everything that happens or has happened in your life, good or bad. As well, chakras contain information about your past lives, and, as a result, may have an affect on your current circumstances resulting from prior events.

Chakras also have their own structural properties. A chakra is conically shaped, with several cones inside the larger outer cone. Each chakra has a different number of these cones. The cones themselves respond to the energy that is around them, as well as to the energy of the information that they store. Some of these properties include: ***spin*** – whether a chakra spins clockwise, counterclockwise, is stagnant, or oscillates like a washing machine; ***projection*** – how far the cones project out of the body through the aura; ***density*** – how well the individual cones within the larger cone are balanced in their distribution. As well, these cones might ***hook*** in on themselves or break off from their connection near the spinal cord, disrupting the energy flow in the chakra.

The chakras are also connected to each other through a system of channels known as *nadis,* and therefore communicate with each other and can affect each other. This presents a holographic aspect where everything affects everything.

The end result of all this is that the chakra system is a dynamic, fluid system that may have profound affects on the physical body based on circumstance. If a person has experienced trauma in his life, then the nature of that trauma has had an effect on one or more chakras. Due to a chakra's ability to record and store information energetically, and subsequently transduce that energy down into the physical body, trauma can continue to have negative consequences on the physical body and emotional state of the person involved. By balancing a chakra relative to a particular traumatic event, it may help to prevent further negative consequences from re-occurring. When a person's chakra system is in balance and flowing, then their life and health is very likely to be the same.

As you now begin to see, the chakra system can be very complex in nature, but at the same time, offers a lot of information and the opportunity to assist the healing process in a variety of practical and creative ways.

Chakras and Healing

Religion, philosophy and healing have had very close ties since the beginning of known culture. The chakras are very much a part of the Eastern Indian culture in all these respects, and therefore have been used in healing for thousands of years. Only recently has this system started to be used in western cultures.

The underlying philosophy of the chakra system provides a model for lifestyle that can assist one to know better where their challenges lie, and where they need to work in order to become happier and healthier. When a chakra is determined to be out of balance, then there are many ways in which to affect that chakra. This has led to many healing modalities based on chakra balancing.

Because chakras are an energy system, various means of affecting energy are often used to balance a chakra. For instance, using colored light to affect the color of a chakra – to make it brighter, change its hue – is a common approach. Another is to use sound, or maybe elaborate spreads of crystals placed on the body. Because crystals have many of the same storage and energetic properties as chakras, this can be an interesting approach.

The importance of using the chakra system in healing cannot be understated. Whether working with a physical injury or an emotional trauma, the record of these events is stored in the chakras. If one works only with the physical nature of these, without caring for the energetic storage in the chakras, then the distortion in the energy field may have the ability, through the process of manifestation, to continue to create disruptions in the future. By integrating the healing process in both the physical and metaphysical bodies, a more complete healing process is accomplished, with better and longer lasting results.

In western culture, without the cultural background, and therefore an in-depth understanding of the system, it has been more difficult to assess the chakras for their healing properties. Unless a person can actually see a chakra (which we have the ability to do, but most cannot), then one must use their knowledge and awareness of the meanings of the chakras to best know how to proceed. However, this is where Energy Kinesiology can play a significant and meaningful role.

Chakra Balancing and Energy Kinesiology

By using muscle monitoring while contacting each chakra area, the body has the opportunity to respond and alert the practitioner where an imbalance exists. Because of the dynamic nature of the chakra system, this is often based on the issue that a person is working on. Change the issue, and the chakra picture changes as well.

Several Energy Kinesiology modalities have protocols for working with the chakras. The One Brain system uses a guided visualization technique to balance the chakras; Applied Physiology uses the meridian/acupuncture system to balance the chakra; Transformational Kinesiology uses Theosophical approaches based on the writings of Alice Bailey and others work with the chakras. Whatever the approach, the important thing is to actually include them in the balancing process.

There are, of course, many other means of energetically affecting the chakra energy fields, such as palming. The nice thing about Energy Kinesiology is that it provides a means for the person being balanced to express specifically which chakra(s) need(s) attention, and how they would like to be balanced. This opens the door to using more than one balancing method in combination.

The more you know about the chakras and their attributes, the more you can bring that information into your balancing as a means of going deeper into an issue. While it is beyond the scope of this paper to provide this kind of information about all the chakras, I would like to focus on a single chakra, examine the meaning of that chakra and how to use that information to go deeper into an issue, and then offer possibilities for balancing.

The Throat Chakra The Personal

The first thing that comes to mind, perhaps obviously so, is that the throat chakra relates to communication. However, our first inclination is to think about that in terms of our own voice. What is often overlooked is that communication is a two-way street. So the throat chakra also is related to *listening*.

With this understanding, combined with our observation and knowledge of the person we're working with and their issue, it is possible to delve further into the matter by asking questions, or simply relating to them about the characteristic of the chakra as a means of soliciting further discussion about their issue.

For instance, if the client is soft spoken and/or easily intimidated, maybe one who avoids confrontation, then the practitioner might ask how the client's ability to communicate their feelings is involved, and how it might be different if they spoke up for themselves.

Perhaps the person is more extroverted, and with a booming, loud voice. How might this assist in their understanding? Is it because they have a feeling of "needing to be heard"? Or maybe the problem is listening, and they overpower the other person as a defense mechanism.

> "Is there something you're afraid to hear?"
>
> "What is misunderstood in this issue?"
>
> "What would happen if you spoke your truth?"
>
> And another important question might be, "How are you not listening to *yourself*?" "To your inner voice?"

Your approach is, of course, going to be based on the context of the session you're in and of the person involved, as well as the chakra you're working with. However, bringing in this understanding can be very enlightening to the person being balanced, providing insight and awareness that, by itself, may be extremely healing. It may also bring up more "stuff" to add to your circuit, increasing the depth of the balance by making connections to other events that the person may have never considered as being related to the issue they're working on. This might also bring up stress in another chakra. By elaborating in a similar fashion, connections between the two chakras are made, providing a further, deeper understanding.

The Physical

Physiologically, the throat chakra is related to the *thyroid gland*. This gland is located behind the throat, just above the sternal notch (at the top of the breast bone). The thyroid is involved in metabolism, and as a result, may be involved in certain types of digestion problems, as well as overall energy levels. For example, a person with *chronic fatigue syndrome* will almost always have an under-active thyroid gland. The main hormone secreted by the thyroid is thyroxin, and the two versions of it that are most paid attention to are T3 and T4.

While medical tests exist to check for thyroid function, they are notoriously less accurate in identifying imbalance than other medical tests. For this reason, in my experience, there are a lot of people who have been told, due to a medical thyroid test, that their thyroid is normal, and yet *function* as a person with an under-active thyroid, or *hypothyroid*. This often results in sluggish metabolism (and hence, poor digestion), and can be part of a scenario of weight gain

– even when not eating too much, constipation, and low energy. Headaches can also result from this. The thyroid's connection to the digestion is further exemplified by the fact that it is part of the *parasympathetic nervous system*, or "rest and digest". This as opposed to the *sympathetic nervous system*, commonly known as "fight or flight".

How is this information useful relative to the chakra?

I'm glad I asked!

When working with a person around communication issues, there might be an effect on the gland that, due to Energy Kinesiology, is easy to find out and include in the circuit if appropriate. One possibility is to use *gland mode* (hand in a fist, pad of thumb to pad of extended middle finger) while touching the sternal notch and monitoring an indicator muscle. An indicator change, whether through under- or over-facilitation, lets you know that the thyroid is involved.

Knowing that the muscle related to the thyroid gland is *teres minor*, a practitioner might monitor this muscle to see how it responds. The muscle being the direct, neurological link to the gland represents the actual energy imbalance. If the mode above indicates an imbalance, always go to the muscle and add that to the circuit. More information = more stress in circuit = better balance.

If you use homeopathic test kits in your sessions, you might check the T3 and T4 vials to see if it's appropriate to add them to the circuit. After the above checks, this is a way to get more specific and add more information.

As well, the practitioner might ask questions with an "energy" metaphor.

For example:

> "Are you putting too much energy into making sure you're being heard?"
>
> "How's your energy for speaking out in this situation?"
>
> Or maybe the client says things like, "Just the sound of his voice drains me." "I wanted to say something, but I didn't have the energy."

Combining these metaphors with the previously mentioned ways of checking the thyroid gland adds valuable information to the circuit.

The other side to this is if you are specifically working on a thyroid issue with a person. Knowing that the thyroid is related to the throat chakra, it may be important to find out how communication is involved with the person's thyroid issue. Developing these kinds of insights may provide clues that your client has never considered before to be related to their lack of energy and slow metabolism.

The Energetic

A chakra itself may have its own energy imbalances related to the structure and function of the chakra. These imbalances have broad ranging effects on the physical and emotional aspects of the body, as mentioned above. As well, they also affect other energetic systems of the body. Because the chakras connect deep into the body at the spinal cord, with their related nerve plexuses, the nervous system (the primal physical energetic system of the body) is affected by the chakras.

The other major physically based energetic system of the body, the meridians, is in relation to the chakras. Acupuncture points themselves, located on or near the surface of the skin, are like little miniature chakras, acting as windows between the physical and metaphysical bodies.

Outside of the body, the Figure 8s and spiral energies of the body are affected by the chakras. With their perpendicular orientation to the body, the chakras actually run through these other energy systems. So, as you can see, the chakras are an incredibly important system to use due to their pervasiveness throughout the physical and metaphysical structures of the individual.

Going even further, we've simply been speaking about the 7 major chakras. There are also many "minor" chakras in important locations throughout the body. As well, the chakra system extends further out of the body, connecting the individual to a more universal consciousness and energy source. By working with this system, the effects may be extremely far reaching in ways we don't fully understand yet.

Returning to the 7 major chakras, let's look at some examples of imbalances that may be examined. For instance, a chakra has spin and projection characteristics. While different sources will say how a chakra "should" spin, more important is how it *is* spinning relative to the individual's normal state. As well, the cones of a chakra project from the body. While certain people's cones might project differently, the important thing is that the cones of all the chakras project about the same distance.

Another chakra characteristic is density – how evenly distributed the smaller cones of the chakra are within the larger cone that holds them together. If the inner cones are concentrated more on one side of the larger chakra structure, this may have an effect on the overall function of the chakra, as well as it's shape and spin.

Because chakras project from both the front and the back, there is a point at which they connect. If there is a disruption at that point, you might find a "broken" cone. Consider this to be like a downed power line, sparking and trying to connect to its other side being so nearby.

These particular characteristics all have their effects on the body and emotional state of the person involved. One Energy Kinesiology modality, Applied Physiology, actually has specific balancing procedures for each of these disturbances. However, even if you don't know the Applied Physiology technique, it is still useful to check for these imbalances and add them to your circuit for more specific balancing results (I'll tell you how in a minute!).

Other useful checks that I like to use are for shape of the chakra – elliptical vs. conical – which will affect the density, but is a slightly different issue. Another is for the synchronicity between the front and back of the chakra, to make sure that the communication is flowing properly between the two aspects. Still another is to check for color disturbances, though this is more often a result of other imbalances that will correct when you do your other balancing techniques.

What follows is a list of checks for chakra characteristics:

1. **Density:** In Applied Physiology (AP), the practitioner begins with a hand in the middle of the chakra field, and then flicks out from the center in 12 directions (like going around a clock), and checking the indicator muscle. Any indicator change (I/C) should be pause locked (P/L). If you don't know AP, and

wish to check this, you might simply check 8 positions, splitting the clock into 8 pieces of pie.

2. **Spin:** Again from AP, place your hand in the center of the chakra field and twist your hand in a clockwise direction. Check the IM. Repeat in a counter-clockwise direction. If one hand spin creates an I/C, P/L.
3. **Projection:** From AP... For outward projection imbalance, hold all five fingertips together and start in the center of the chakra field close to the body. Quickly draw your hand straight out from the body, staying within the chakra field. For inward projection issues, start away from the body and quickly push your hand into the chakra field, straight down towards the body.
4. **Broken Cones:** Circuit Locate (C/L, or touch) the point *on the **opposite** side of the body from the chakra you're checking.* Then connect that point to the original chakra indicator point. For example, if you wish to check the front throat chakra for broken cones, touch the point on the *back* of the throat, then connect it to the front point (in the sternal notch). Check your IM. If I/C, then you know a broken cone is involved. (Either person can hold these points, so you can hold the back point, have the client hold the front point, and then check the IM. Or you can hold both, P/L, and check the IM.)
5. **Shape:** Using your hand, draw an ellipse (a slightly "squashed" circle that is longer in one plane, rather than being perfectly round) in the chakra field. You can do this in 4 different fields – going side to side, up and down, and in the two "x" planes. An I/C indicates which shape is the problem.
6. **Synchronicity:** A technique of my own is similar to checking for Broken Cones, except you must touch the front and back points *simultaneously.* If you get an I/C, P/L. This technique checks for the flow between the front and back of the chakra being in tune with each other. I'll share the correction with you shortly.
7. **Color:** Use color mode. This is from AP – thumb pad over the proximal knuckle (the one closest to the hand) of the middle finger.

While there are other types of imbalances one might check for in a chakra, this list offers a reasonably comprehensive set to check for.

Balancing Chakras

As mentioned previously, there are many ways of balancing chakras. While it is beyond the scope of this paper to go into great detail about many of these methods, I'd like to offer a couple of techniques that I use that are not from a specific Energy Kinesiology modality. However, the main point I'd like to make is that, whatever method(s) you've learned from various sources can often be combined in some interesting ways to increase the effectiveness of your balancing.

One of the most powerful methods I've come across is the 7 Chi Keys, from Applied Physiology. It addresses several specific types of chakra imbalances, and does so quickly and effectively. I believe a certain part of this to be due to the use of the acupuncture system, as well as integration with tuning forks and crystals. This combining of methods provides for extremely effective balances. Nevertheless, I often will look to bring in further support from other techniques. For instance, while holding certain acupuncture points, or affecting those points with tuning forks, I might also lead the person through a visualization technique from the One Brain system, or visualize doing an action that represents the nature of the chakra in relation to metaphorical issues that were previously discussed.

For those of you that don't have any tools for balancing chakras, a simple energy technique used for centuries is to simply "palm" a chakra. This involves holding your hand over the body in the field of the chakra you're working with and focusing your energy through your palm and into the chakra. It is important to remember, when doing this, to act as a channel. Don't exhaust your own energy by transferring it, but rather channel the energy through your own chakras or other energy systems from the universal energy source, and into the chakra field of the person you're working with. If you're working with Broken Cones, you might palm with both hands; hold one hand over the front, the other over the back of the chakra. Try to connect the energy between the two.

Another common balancing technique is to use a good quality light source and a set of good quality color gels. There are many sources of information about the colors related to chakras. Use the light going through the gel and into the chakra field to balance.

Sound is also a powerful healing tool. Applied Physiology uses its own Meridian Tuning Forks in several ways to balance the chakras. However, there are other methods here as well. If you don't have tuning forks, there are notes associated with each chakra. "Toning" – the use of the voice – to sing into a chakra, or have the person sing a particular note can be very balancing to a chakra. The person can even sing the note outside of the office to continue to work with the out-of-balance chakra for themselves. Of course, having an instrument or other generator of sound is useful here to determine the pitch.

The following are balancing techniques I use for two of the above imbalances:

Shape: If you find an elliptical chakra, in my experience, Figure 8s work very well to bring the chakra into balance. Within the field of the chakra, challenge which direction to draw your 8. It is usually either an up-and-down 8 (from foot to head or v.v.), or a lazy 8 (from side-to-side).

Synchronize: If you get an I/C after simultaneously touching the front and back points of a chakra, then balance them using acupressure on the Luo Points of the meridians related to the chakra.

The specific procedure is as follows:

1. Touch the point in the middle of each chakra, first on the front, then on the back. I/C = P/L. This tells you which chakra is out of balance.
2. With the chakra in circuit, now simultaneously touch the front and back points for that chakra. If I/C, then P/L. (If no I/C, then this technique does not apply, but you still must determine how to balance the chakra that showed in step 1).
3. Determine which meridian's Luo Points to hold. Use the list below, with the following criteria: If the chakra that originally showed in step 1 was on the *front* of the body, use the

yin meridian's luo point. If the chakra that originally showed was on the *back* of the body, use the *yang* meridian's luo point. Bilaterally hold these points with a neutral polarity touch (thumb or two adjacent fingers).

To determine which meridian's luo points to use, refer to the following chart:

Crown Chakra – Central and Governing Meridians

Brow Chakra – Pericardium and Triple Heater

Throat Chakra – Spleen and Stomach

Heart Chakra – Liver and Gall Bladder

Solar Plexus Chakra – Lung and Large Intestine

Sacral Chakra – Kidney and Bladder

Root Chakra – Heart and Small Intestine

4. Hold the bilateral luo points until you feel a pulsing. Then try to have the two points synchronize in their pulsing. Sometimes, this might take several minutes.

Conclusion

The chakras provide a fascinating system of insight and information to the history of our physical, emotional and energetic makeup. As well, their actual effect on various aspects of our being make them a critical tool in any Energy Kinesiologist's toolkit. By not working with the chakras in virtually any session, you may be missing an important piece that has the ability to increase the depth of the balance and help integrate the other work you've done throughout the physical and energetic body. In doing so, your balances will last a lot longer.

With this awareness, and armed with some of the techniques offered in this presentation, I hope you will be inspired to include the chakras in your Energy Kinesiology work, as well as to look further into other means of chakra balancing. Certainly, the information provided here merely scratches the surface of a complex and centuries-old system of healing and philosophy.

For those of you who already use the chakras, my hope is that you were able to pick up a tidbit or two, particularly in the concept of combining techniques you may already know. It is through this holistic approach to the chakras that a system in and of itself emerges, and can be applied in creative and meaningful ways to any Energy Kinesiology session.

Thanks so much for your kind attention.

Bibliography:

Hands of Light. Barbara Ann Brennan. Bantam Books. 1987.

Wheels of Light. Rosalyn Bruyere. Bon Productions. 1989.

Eastern Mind, Western Body. Anodea Judith. Celestial Arts.1996.

The 7 Chi Keys. Richard Utt, L.Ac. Applied Physiology. 1986.

Advanced One Brain. Gordon Stokes and Daniel Whitesides. Three in One Concepts. 1989.

Adam Lehman, N.D., En.K.

Adam has private practices in Berkeley and Sonoma, CA, and travels in both the U.S. and abroad teaching Energy Kinesiology workshops. He is co-founder and co-director of the Institute of Bioenergetic Arts and Sciences in Sonoma. He is a Touch for Health Instructor, One Brain Facilitator, and the Applied Physiology Advanced Instructor and Instructor Trainer. Adam is also the founder and director of the Energy Kinesiology Awareness Council, dedicated to increasing the awareness of the North American public to the benefits of Energy Kinesiology.

Please feel free to contact Adam at:
adam@kinesiohealth.com

Institute of Bioenergetic Arts & Sciences
19210 Sonoma Hwy
Sonoma, CA 95476

707-939-8800
707-328-2838

Information about classes and schedules, as well as Energy Kinesiology in general, is available at his website: *www.kinesiohealth.com.*

Notes:

Intrinsic Energy

by Maurizio Piva, Kinesiologist, Naturopath

What it is

The intrinsic energy is the amount of energy available to our body for the functions of all the body systems. It is a functional energy, that modifies its quantity in relation to the lifestyle and the personal tasks or purposes of each individual. The appropriate contribution of this energy is fundamental in order to allow the body to activate its self-healing ability, to maintain its balance during the stress phases, to bring vitality to the body cells and to the individual constitutional elements. The values of intrinsic energy are tested through specific acupuncture points.

How it was discovered

The first discoveries date back to 1995, when I began to study, classify and experiment with the different types of muscle response to the kinesiology test. I developed an initial classification that divides the acupuncture points applied into two categories respectively called *test points for normal muscular states and test points for neurological muscular states.* A third category has been defined for *states out of standard.*

The first category tests the variations of standard muscle response, the second one tests the compensations or the adaptations localized in two or more muscles of an articulation and the third category, not entirely understood in its whole function when discovered, tests broader compensations, often time referring to one side or to the whole body. At the beginning of 1998 I discovered a greater interrelation among the different points and developed a higher understanding of their functions. In 1999 I found out an additional combination among the points, that was developed and classified during the following years, until obtaining a full classification of the possibilities at the beginning of the current year.

There are two main categories of points, called *"states of muscle response"* and *"stress cycles"*. The first one allows activation of the self-healing principles of the body and the second one keeps the balance during the stress phases. The two main categories are divided into seven subcategories, forming a total of one hundred and twenty two possible applications or combinations of points.

Experimentation

I have used the points and their applications with at least two thousand cases, getting in almost all of them extremely satisfying results.

The primary effects are:

- creating and optimizing a self-recovering response of the body, in relation to what will be later applied with the client.
- in a small number of cases, the response to the self-healing principle evoked by the rebalance of the points is in itself enough to help manifest the health potential of the individual.
- an ability to release the energy engaged in containing stress or trauma, allowing its use to manifest an expression of health.
- optimizing the muscle response.
- kinesiological enhancement of concealed imbalances.

The life and death cycles

The basis of the energetic movement of intrinsic energy can be found in the *life and death cycles.* The energetic model used in these cycles is the one of the five elements. The *life cycle* originates and ends in the lungs and represents the expression of the individual's essence; the *death cycle* originates and ends in the kidney and represents the manifestation of energy. One of the two cycles (usually the death cycle), is continuously and actively expressed within the intrinsic energy structure. Both cycles do manifest themselves through the same intrinsic energy structure, and while one is at sleep during the normal daily activities (usually the *life cycle*), the other is active. When the intrinsic energy expresses itself through the life cycle for normal daily activities, we observe a manifestation of deep imbalances, usually autoimmune ones. The subtle balance between the two cycles allows the body to maintain and regenerate itself; a reverse manifestation of the two cycles leads the body to destroy itself. The optimization of this energetic balance in the kinesiology session therefore allows a better individual response to the expression of health. Those who have clinically used the points of intrinsic energy ascertained a restoration of the energetic balance of their clients, quicker than the previous average.

The meridians of intrinsic energy

Numbering two on each side of the body, the meridians of intrinsic energy are functionally related to the Conception Vessel and Governing Vessel. They collect the energy unused by other meridians and send it to these two meridians. This is facilitated with the support of the pulmonary respiration. It is no accident that the two meridians circulate around the lung. Hence it follows the importance of a good functioning of these two meridians, which allow the body to reduce its waste of energy. Unlike the recognized meridians, it doesn't appear that there is a definite direction of the energy circulation, maybe just because in this case the energy must simply be collected and sent to Conception Vessel and Governing Vessel.

I have named these two meridians respectively *nervous system meridian and endocrine system meridian.* The first one is the functional meridian of Conception Vessel and it surrounds the lung on the anterior part of the body, the second one is the functional meridian of Governing Vessel and it surrounds the lung on the posterior part of the body. The points of these two meridians, just like the extraordinary meridians, belong to other meridians. The points of the nervous system meridian are the ones used for the rebalance of the intrinsic energy and have been widely tested. The points of the endocrine system meridian are at an advanced experimental stage after about four years of study.

Notes:

A Growing Epidemic: Taking Aim at Managing Blood Sugar with TFHK and Nutrition

by Jan Cole, M.Ed.

"Diabetes, perhaps more than any other chronic disease, must be managed in large part by the patient."
Gretchen Becker,
biologist, medical writer
USA Today April 16, 2002

Our family has a propensity towards diabetes and blood sugar problems, with three of my dad's brothers and his father afflicted with the disease, all treated conventionally with drugs, some with dietary considerations. My grandfather and one uncle lost their lives to diabetes and its complications. Since heredity can be one of the causes, (there is such a thing as "hypoglycemic families"), and with my own tendencies toward low blood sugar, an interest was generated to research this escalating cultural disease and the management of blood sugar. It's heartening to learn that as with most "hereditary diseases", diabetes and its corollaries, also depend on one's diet and way of life (both nurture and nature) and can be changed.

While visiting my Uncle and Aunt several years ago, I was showing them for the first time some of the techniques we use in Touch for Health, using the various "switches" to weaken and strengthen the latissimus dorsi. My uncle wasn't feeling well from something he'd eaten; he was sure that his blood sugar level would be higher than usual, as it normally was when he didn't feel up to par. To his amazement the reading was lower than it had been for more than a week. Could it have been the neurovasculars, neurolymphatics, the meridian movements that made the difference?

About a year ago, my friend's mother, hadn't seen Anita for several weeks so I offered to drive Mrs. R to Fargo, where Anita was recovering in the Merit Care Medical Center from her second stroke. When her mother and I arrived, a nurse was taking Anita's blood sugar reading. It was a dangerously high 330 level. I asked the nurse if she would be willing to take another reading after I did a bit of Touch for Health intervention with Anita. To our great surprise, my friend's blood sugar **dropped 111 degrees** after 3-5 minutes of intervention!

It led me to question how someone might help themselves with a few simple Touch for Health interventions even though they hadn't taken a TFH course or had access to a TFHK practitioner for full balances. What could a person do beyond the usual plethora of information given regarding diet, nutrition and drugs? In addition to general information, this paper will present nutritional options, as well, as suggestions and insights using our Touch for Health techniques and related goal balancing statements to aim at managing blood sugar and diabetes.

Midst of an Epidemic

According to C. Ronald Kahn, M.D., President, Joslin Diabetes Center, the US and the rest of the world, is in the midst of an epidemic, with more than 18.2 million Americans living with diabetes. 15 million are yet undiagnosed, with an economic cost of $100 billion plus yearly. Over time complications develop and lead to various diseases, including heart and kidney disease, stroke, blindness and amputation. Diabetes, the third leading cause of death in the US after heart disease and cancer, unfortunately has no cure. However, the right diet, nutritional supplements and other interventions can help support healthy blood sugar levels. Over the past decade, the U.S. Centers for Disease Control and Prevention, reports a 40% increase in diabetes in the United States, with this trend predicted to climb at this astonishing rate unless something is done to change its course. It will be helpful to have background information in addition to what we could do or teach someone to do to help manage their blood sugar levels with Touch for Health.

Definition

Diabetes mellitus is a chronic disease condition in which the pancreas no longer produces enough insulin or when cells stop responding to the insulin that is produced, so that glucose in the blood cannot be absorbed into the cells of the body. The treatment includes changes in diet, oral medications, and in some cases, daily injections of insulin.

The pancreas, a small organ behind the stomach, has two main jobs:

1. **to supply pancreatic digestive enzymes to** break down our food for use. Foods such as pastas, sweets, breads contain carbohydrates that must be **changed into glucose, a simple sugar** which gives the body energy.
2. **to produce pancreatic endocrine hormones** (e.g., insulin, gastrin, somatostatin, and glucagon) which **help regulate metabolism, maintain blood sugar/fluid,/salt balances** and **move the glucose from the bloodstream to cells** throughout the body. Insulin allows glucose to leave the bloodstream and helps it into the cells. When functioning properly, a person has energy and growth. With no insulin, glucose can't move out of the bloodstream… thus the disease diabetes.

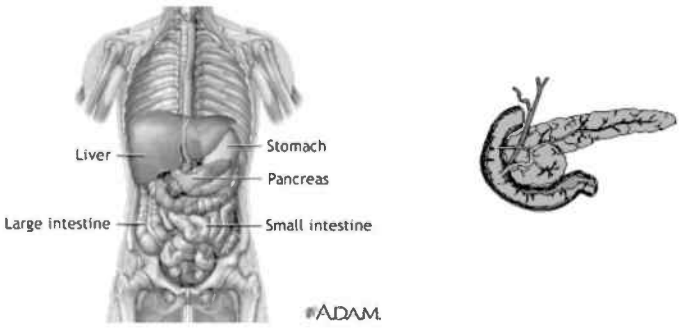


Figure 1. The Pancreas

Approximately 5 liters of blood travels around in our blood vessels and heart at any given moment. In these 5 liters, about one tsp of sugar is all that's needed for all your regular activities.

At Risk

Anyone can get diabetes, but at particularly high risk, especially for Type II, are people who have **close relatives** with diabetes, are **overweight** (over 20% of ideal body weight), the **elderly, African Americans, Hispanics, Native Hawaiians, Native Americans and Asian Americans**; have **high blood pressure** (140/90 mmHg or above), have a **high density lipoprotein cholesterol level** (< or = to 35 mg/dL) and/or a **triglyceride level greater than or equal to 250 mg/d.** Also at risk: **low-birth-weight babies, women who had babies weighing more than 9 lbs.** (4kg) or who were **diagnosed with gestational diabetes** are more likely to develop Type II later in life. Those who have **migrated to Western cultures from East India, Japan and Australian Aboriginal** cultures are more likely to develop Type II diabetes than those remaining in their original countries. Also those who have had **impaired glucose tolerance or impaired fasting glucose**. Several studies, including an 821 Finnish children study, found early introduction of cow's milk formula feeding associated with increased risk of developing Type 1 diabetes. [26] *Diabetes Care* 1999;22:1961–5.

Types of Diabetes

1. **Pre-diabetes** - before developing Type II diabetes, people nearly always have "pre-diabetes" – blood glucose levels higher than normal, but not high enough to be diagnosed as diabetes. At least 20.1 million people in the United States (21.1% of the population), ages 40 -74, have pre-diabetes. The good news is recent research shows some long-term damage to the body, especially to the heart /circulatory system, may already be occurring during pre-diabetes. Actions can be taken to control it and delay or prevent Type II from ever developing.
2. **Type I** - more serious form, occurs when the insulin-producing cells have been destroyed; called insulin-dependent diabetes because of need for daily insulin injections. In Type I diabetes, also called juvenile diabetes, as usually begins in childhood or adolescence, the body produces little or no insulin. Referred to as an auto-immune disease, body mistaken-ly attacks its own good cells. Characterized by a sudden onset it occurs more frequently in descendents from N. European countries (Finland, Scotland, Scandinavia) than from other countries. In the US, approximately 3 people in 1000 develop it.
3. **Type II** - pancreas produces some, but not enough insulin or the cells ignore the insulin. Because of slow onset and ability to control with diet, medications and sometimes insulin injections, it is considered a milder form. The most common form, it occurs in approximately 3-5% of Americans under 50 years; increasing to 10-15% over 50. More than 90% of the diabetics in the US are Type II... also known as age-onset or adult-onset diabetes. The consequences of uncontrolled/untreated Type II, however, are as serious as for Type I. Known as noninsulin-dependent diabetes, when glucose builds up in the blood instead of going into cells, it can cause: a.) cells starving for energy and b.) over time, high glucose levels may harm your eyes, kidneys, nerves and/or heart.
4. **Brittle diabetics** - subgroup of Type I, frequent and rapid swings of blood sugar levels between hyperglycemia (a condition where there is too much glucose or sugar in the blood) and hypoglycemia (a condition where there is abnormally low levels of glucose or sugar in the blood). These patients may require several injections of different types of insulin during the day to keep the blood sugar level within a fairly normal range..
5. **Gestational diabetes** - can develop during pregnancy and generally resolves after the baby is delivered. Develops during the second or third trimester of pregnancy in approximately 2% of pregnancies. Usually treated by diet, however, insulin injections may be required. Women with diabetes during pregnancy are at higher risk for developing Type II diabetes within 5-10 years.
6. **Secondary diabetes** – caused by several common medications which can impair the body's use of insulin and glucose absorption. Includes: treatments for high blood pressure (furosemide, clonidine, and thiazide diuretics); drugs with hormonal activity (oral contraceptives, thyroid hormone, progestins, and glucocorticorids); anti-inflammation drug indomethacin; drugs to treat mood disorders (such as anxiety and depression) including haloperidol, lithium carbonate, phenothiazines, tricyclic antidepressants, and adrenergic agonists. Other medications that can cause diabetes symptoms include isoniazid, nicotinic acid, cimetidine, and heparin.

Treatment for diabetes includes insulin shots, medications, wise food choices, exercise, and controlling blood pressure and cholesterol. The most effective strategy against the degenerative effects of high blood sugar is an integrated approach.

Diabetes Management

Aim: keep blood glucose levels as close to normal (nondiabetic) range as safely possible.

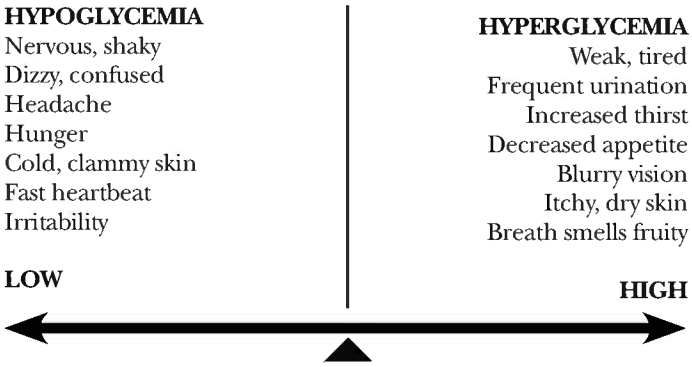
Ideally:

- **Before meals** - 80 and 120 mg/dl (Normal 115)
- **After Meals** - less than 160 two hours (Normal less than 140) *with a glycated hemoglobin level less than 7%*
- **Bedtime** - less than 100-1409 mg/dl (Normal less than 120)

Balancing insulin injections, healthy eating, regular exercise and constant monitoring of blood glucose levels helps to achieve this. A large number of factors influence blood glucose levels, including stress, food intake, periods of growth, hormonal changes, duration and type of physical activity, alcohol, medications, illness, infection, fatigue and menstruation.

When blood glucose levels swing too far in either direction, two emergency situations can develop: **hypo**glycemia (low blood glucose) or **hyper**glycemia (high blood glucose).

Hypoglycemia
Low blood sugar results when too much insulin is secreted by the pancreas in response to certain foods. Proper diet is essential for the hypoglycemic to maintain blood sugar levels. Frequent, (6 to 8) small wholesome meals throughout the day seem to work best. Frequent starchy snack meals (e.g. sandwiches, cereal, etc.) would only aggravate the problem, since all forms of carbohydrate are absorbed quickly. Slowly absorbing protein and fats, however, don't trigger the sensitive insulin apparatus. Small regular meals of protein or fats serve to stabilize the blood sugar, avoiding sudden rises and falls in the glucose levels.



Treat Hypoglycemia
The quickest way to raise your blood glucose and treat hypoglycemia is with some form of sugar, such as 3 glucose tablets, 1/2 cup of fruit juice, or 5-6 pieces of hard candy. After checking your blood glucose and treating your hypoglycemia wait 15-20 minutes and check your blood again. Repeat if glucose is still low and symptoms haven't gone.

Several types of chronic hypoglycemia exist, reactive hypoglycemia and fasting hypoglycemia being the most common. The following synonyms may be used in literature to denote the syndrome: postprandial hypoglycemia, postprandial syndrome, idiopathic reactive hypoglycemia, functional hypoglycemia, spontaneous hypoglycemia.

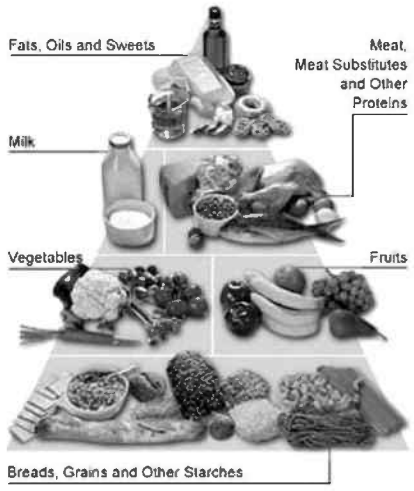
Hyperglycemia
Another of the serious problems diabetics must deal with occasionally is hyperglycemia. If left untreated, it is a major cause of many complications. Hyperglycemia happens when the body has too little or not enough, insulin, or when the body can't use insulin properly and blood glucose (sugar) is high. The problem could be that you ate more than planned or exercised less than planned. The stress of an illness, such as a cold or flu, could also be the cause. Other stresses, such as family conflicts or school or relationship problems, can also cause hyperglycemia.

Treat Hyperglycemia
At times, you can lower your blood glucose level by exercising. However, if the blood glucose is above 240 mg/dl, check your urine for ketones. If you have ketones, do NOT exercise. Exercising when ketones are present may make your blood glucose level go even higher. Cutting down on the amount of food you eat might also help.

When your body breaks down fats, waste products called ketones are produced. The body can't tolerate large amounts of ketones and will try to get rid of them through the urine. Unfortunately, it can't release all the ketones and they build up in your blood which can lead to ketoacidosis.

Diabetes Food Pyramid
…divides food into six varying sized groups. The largest group -- grains, beans and starchy vegetables – is on the bottom, meaning you should eat more servings of grains, beans and starchy vegetables than of any of the other foods. Fats, sweets and alcohol, the smallest group – at the top of the pyramid tells you to eat very few servings.

The Pyramid gives a range of servings. Following the minimum number in each group would equal 1600 calories; eating at the upper end of the range, about 2800 calories. Most women would eat at the lower end and active men in the middle to high end. The exact number of servings needed depends on "diabetes goals", calorie and nutrition needs, life style and pre-ferred foods. It is suggested to divide the number of servings you should eat among the meals and snacks eaten each day.



The Diabetes Food Pyramid is slightly different than the USDA Food Guide Pyramid because it groups foods based on their carbohydrate and protein content instead of their classification as a food. To have about the same carbohydrate content in each serving, the portion sizes are a little different, as well. For example: potatoes and other starchy vegetables are in the grains, beans and starchy vegetables group instead of the vegetables group. Cheese is in the meat group instead of the milk group. A serving of pasta or rice is 1/3 cup in the Diabetes Pyramid and ½ cup in the USDA Pyramid. Fruit juice is ½ cup in the Diabetes Food Pyramid and ¾ cup in the USDA Pyramid. This difference is to make the carbohydrate about the same in all the servings listed. *www.diabetes.org/nutrition-and-recipes/nutrition/foodpyramid.jsp*

Diets for Diabetics, Hypoglycemia
For most hypoglycemics, symptoms can be successfully suppressed or controlled by following a diet. Of the many diets proposed, all are blood sugar regulating diets with the following in common:

- frequent small meals/snacks, depending on your needs 1.5 to 2 hours;
- no sugar, honey, or products containing sugar (check food labels);
- no adrenal stimulants as caffeine (found in coffee, coke and diet-coke, black tea), no alcohol, no chocolate (cacao is a stimulant too), no nicotine;
- be careful with fruit juice (no more than 1 glass diluted) and high-sugar fruit as dried fruit, bananas or grapes,
- no other simple carbohydrates, as white bread and white flour.

Causes - Diabetes / Hypoglycemia / Hyperglycemia
The exact causes of hypoglycemia are yet unknown. Several factors are involved in developing the hypoglycemia syndrome. It is clear that extra risk is present in case of:

Diabetes Mellitus	**Type I**	**Hypoglycemia (multicausal)**	**Treat Hypo**	**Hyperglycemia**
heredity - common genetic markers	unknown cause, certain genes makes person more susceptible	heredity	adapt your way of living to your state of health	if have Type I diabetes, may not have given self enough insulin
environmental	triggered by virus of other micro-organism destroy pancreatic cells	weakened immune system; problems with nutrient absorption and gastro tract	take the nutritional supplements	if Type II, your body may have enough insulion, but not as effective as should be
		tumors		
	complex inter-action between genes + some environment, as having enteroviral infections	wrong eating habits; esp. sugar intake; not eating enough food; skipping or delaying meals	diet that regulates your blood sugar level	stress of illness: such as a cold or flu, could be the cause
	Coxsackie B infections may increase risk of developing disease	prolonged use of refined foods	use several smaller meals, equally spaced over the day	eating wrong things or too much of right things
		prolonged use of drugs like antibotics; alcohol	avoid drugs that influence the blood sugar level	illness, infection, surgery, heart attack
		hormonal disorder		
		chronic stress, body & mental	avoid excess stress	physical stress
		old infections		pain
		pancreas overload		some medication
		excess physical exercise or doing more physical activity than usual	adequete exercise helps to balance your endocrine system	lack of exercise
		food intolerance, allergies		

- avoid adrenal boosters as coffee, black tea, coke and cacao are well-known too increase blood glucose levels.

To slow absorption and even out blood sugar values even more: use mixed meals, i.e. combine carbohydrates with proteins/fat, e.g. cracker with cheese/peanut butter; use high fiber food (whole grains, vegetables); snack before going to sleep. People who try to control their hypoglycemia symptoms generally are on one of the following diets (in random order):

1. **Diabetes Diet** – fairly high in carbohydrates, 50-60% carbohydrates, no sugar allowed, use complex instead of simple carbohydrates: brown bread/rice, etc. Frequent meals.
2. **Krimmel Diet** – akin to standard diabetes diet, but limits starchy foods as bread, pasta, rice, potatoes and corn; recommends non-starchy foods as carbohydrate source instead. 'Food ethic' that is low protein (10-12%), high *complex* carb (50-65%), and low fat. (20-30%) maintained in a structured fashion. *Low Blood Sugar Handbook* and *Low Blood Sugar Cookbook*, by Patricia and Edward Krimmel
3. **HAI Diet** – The Diet of the Hypoglycemia Association, Inc.…adequate (fairly high) in protein, limits carbohydrates; slightly more fat. Daily initial phase 100 g of complex carbohydrates + 100 g of protein, Complex carbs from vegetables, nuts/seeds and a limited amount of fruit, not from starchy foods like bread, pasta, rice, etc. After 3-6 months, rice, bread, etc. can be gradually added.
4. **Dr. Atkins Diet** – very low carbohydrate and high fat. Goal: to reach and maintain ketosis, the state of fat burning. Eating less than 30-50 g carbohydrates daily ketons, a side-product of fat burning, instead of glucose, provides body with fuel. Urine test strips can test the level of ketosis.
5. **The Zone Diet** – *The Zone* by Barry Sears, a biomedical researcher. In his book Sears promotes a diet with a 40% carbohydrate, 30% protein and 30% fat ratio.
6. **Fit for Life Diet** – Harvey & Marilyn Diamond, *Fit for Life* authors – support food combinations. A meal should exist of (complex) carbohydrates (lettuce + potatoes **or**

Symptoms: Diabetes / Hypogylcemia / Hyperglycemia / Ketacidosis
Prolonged symptoms weaken the immune system. If defense system is weakened existing symptoms may worsen.

Diabetes	**Diabetes Type I**	**Diabetes Type II**	**Hypoglycemia (not a disease)**	**Hyperglycemia**	**Ketoacidosis (diabetic coma)**
pancreas (energy output device) is exhausted	insulin - dependent life-long autoimmune disease	age-onset or adult-onset diabetes, any symptoms of Type I	low blood sugar (glucose) wide variation among individuals; energy banks empty	high blood glucose	common in Type I, serious hospitalization needed
unable to produce insulin		obesity strong risk, 80% are overweight	shakiness, trembling hands, rapid heartbeat	dry itchy skin, skin infections common	not enough insulin
	inherit risk from both parents	inherit predisposition	concentration/ attention disorders, memory problems	high sugar levels in the urine	restlessness
frequent urination	frequent urination	frequent urination	dizziness, vertigo	frequent urination	nausea and vomiting
	sugar in urine	urinary tract infection	sudden sweating, pale skin color	deep, rapid breathing	short of breath, rapid breath
excessive thirst	increased thirst	extreme thirst	headache	increased thirst	dehydration
tired & sick	lethargy	tiredness	fatigue, weakness, drowsiness	fatigue	extreme tiredness, drowsiness
unexplained weight loss	sudden weight loss	sudden weight loss	intestinal disorders	weight loss	abdominal pain
	heart attacks/strokes can occur	slow wound healing	sudden mood or behavior changes, anxiety depression crying for no reason	slow wound healing	flushed cheeks, hot, dry skin
gum disease		chronic gum infections	*Candida Albicans* (yeast infections)	frequent infections	a very dry mouth
blurred vision	blindness	blurred vision	visual disturbances; blurry vision	blurry vision	loss of appetite
excessive hunger	increased appetite		constant feeling of hunger, extreme hunger	extreme hunger	due to starvation
peripheral neuropathy-pains feet & hands, need B vitamins	nerve damage	numbness in the feet and legs	sleep problems, nightmares, feel cold clammy	stomach cramps	or uncontrolled diabetes
			clumsy or jerky movements, seizure		sweet/fruity breath odor
constipation - up to 60% affected		genital itching (women)	menstration disorders	wounds, sores on legs and feet easily infected	lack of interesting usual activities
	confusion		confusion, irritability, indecisiveness	dizziness	untreated can lead to kidney failure and
	coma		tingling around mouth, nausea, vomiting	nausea, vomiting	coma or death

vegetables + bread), or proteins (bacon + eggs). Only natural sugar in fruit and vegetables are allowed, no added sugars.

7. **Dr. Carlton Frederick's Diet** – Low Carbohydrate Diet, consists of high protein, low carbohydrate, no sugar. .. an early version of the HAI-diet.
8. **Pritikin's Diet** – consists of no fat & only 3 oz (100 g) of protein and primarily carbohydrates, helps hypoglycemia as well.
9. **Protein Power Diet** – by Drs. Michael and Mary Dan Eades …a protein-rich, moderate-fat, low-carbohydrate diet designed for weight

lose and to bring insulin levels into balance. Diet consists of Intervention Part I: 30 grams of carbohydrate per day and Intervention Part II: 55 grams of carbohydrate per day. Once at desired weight and/or stable insulin levels begin Maintenance, where carbohydrate level is 30% more than protein intake.

10. **Carbohydrate Addict's Diet** – by Heller and Heller, MD"S. This addict is one, who suffers from hyperinsulinism, i.e., body produces too much insulin when consuming carbohydrates regularly. Strong cravings for carbohydrates. One to two meals low carb, with no more than 4 g carb per serving. Second or third meal, (Reward Meal): 1/3 low carb veggies, 1/3 protein and 1/3 carbs (anything liked).

Dietary Guidance

As we age maintaining healthy blood sugar levels is critical to good health. Again, high levels of blood sugar are associated with adverse affects on ones vision, heart/circulation, kidneys and nervous system. Julian Whitaker, M.D. in *Reversing Diabetes,* states:

> *"Nutritional sup-plements are a must for anyone with diabetes. Vitamins, minerals, essential fatty acids and herbs are naturally occurring compounds that, if used rationally and in a balanced manner, can have profound-ly positive effects on blood glucose levels. They can also offer protection against the debilitating consequences of diabetes, from eye and kidney problems to heart disease and premature death. This isn't conjecture–its fact. The annals of medicine are filled with thousands upon thousands of studies examining these natural agents and their beneficial effects on all manner of health challenges..."*

Current medications can have serious side-effects including nausea, diarrhea, skin rash, weight gain, respiratory infections, liver damage, and headaches. There are possible alternatives with vitamins/minerals and herbal products.

Vitamins / Minerals

The loss of insulin sensitivity can be decreased with the right nutrients. Numerous vitamins, minerals, herbs and antioxidants have been studied for their efficacy at promoting healthy blood sugar and protecting cells from the damage of elevated blood sugars with favorable results. These include:

Anthocyanic acid- also called blueberry extract, lowers blood sugar (blueberries)

B-Complex (B1, B3 and B6 at 10 - 100 mg daily plus B12 at 100 - 2,000 mcg daily - methylcobalamin is a far superior form;) B's influence healthy nerve/heart function. A lack of vitamin B-6, which helps you absorb other B's, may cause carpal tunnel syndrome, painful neuropathy in your hands. B-12 helps nerves function and avoid damage. Lack of both B-12 and folic acid can cause leg and foot pain. Other B's:

Inositol - found in lecithin; is helps protect the nerves from damage by high sugar levels,

Niacin - important to help potentiate the effects of chromium. Take it in the middle of meals; high levels of niacin can be harmful, especially to people with diabetes. **(B vits.-whole grains, legumes, beans, raw nuts, seeds, mushrooms, deep sea fish, eggs, dark green vegetables, bee pollen, organ and lean meats, nutritional yeast, fruits, for B12- soy, seaweed, algae and kelp.)**

Chromium GTF (glucose tolerance factor) (200 - 1,000 mcg per day – ChromeMate Picolinate forms are superior) Rare mineral plays a major role in enhancing sensitivity of cells to insulin. Levels in tissues decrease as we age. Over 20 clinical studies show chromium: • Improves glucose tolerance and can restore it to normal • Enhances insulin secretion, lowers insulin levels • Decrease fasting glucose and insulin levels in gestational diabetes • Promote healthy HDL cholesterol and triglyceride levels • Encourages the loss of body fat and promotes muscular gains. An estimated 90% of Americans have a serious Chromium shortage. (Reversing Diabetes); (The Pill Guide Book to Natural Medicines). **(Brewer's yeast, beef, liver, whole wheat, rye, chilies, potatoes w/skin, eggs)**

Flavonoids (100 - 500 mg per day - Quercetin is the most powerful at preventing sorbitol damage to cells) **(fruits and vegetables)**

Lutein - antioxidant found in many plants; beneficial for promoting healthy blood sugar levels. Doctors have reported excellent results using 6-20 mg per day of Lutein to promote healthy vision. Recent studies also indicate Lutein may promote a healthy cardiovascular system. **(Dark green leafy vegetables, fruit, corn, egg yolks and marigold petals)**

Magnesium (300 - 500 mg daily - chelated forms such as taurate and citrate are best), influence healthy nerve/heart function. Major studies suggest those with highest levels have lowest risk for developing diabetes. **(wheat bran/germ, almonds, cashews, pecans, walnuts, soy flour, millet, brown rice, chocolate, dark green leafy vegetables, avocados, dried apricots, legumes)**

Vanadyl sulfate – (10-2000mcg per day) - the active form of vanadium, a trace mineral that mimics the action of the hormone insulin. Studies report it's effectiveness in normalizing blood sugar levels and controlling insulin resistance; showing benefits for both Type I and II. Results of one study: Type II, noted an average 20% reduction in fasting blood sugar; Type I required less insulin.

Vitamin E (400 - 1,200 IU per day - a natural blend is up to 3 times more powerful) **(wheat germ oil, almonds, sunflower seeds and oil, hazelnuts, peanut butter, peanuts, spinach, broccoli, soybean, corn, safflower oils, kiwi, mango)**

Vitamin C (500mg - 2,000 mg per day - Ester-C is a superior form) **(peppers, kale, parsley, collard, broccoli, broccoli, brussel sprouts,**

tomatoes, bee pollen, citrus fruits, kiwi, cabbage, cauliflower, berries, papayas, spinach)

Zinc - multiple roles, needed to help the pancreas produce insulin, to work more effectively and to protect insulin receptor cells. If levels are low: 1.) pancreas may not secrete adequate amounts of insulin, so glucose levels remain high. 2.) insulin released may be ineffective, then glucose can't enter cells and remains elevated in the blood. It's helpful for immunity and tissue repair. Pico-linate or gluconate form is best. **(calf liver, lamb, dark green vegetables, squash, yogurt, pumpkin seeds)**

Herbs

Bilberry extract - widely used as a preventive treatment for complications of diabetes and blood sugar imbalances. It improves night vision, strengthens capillaries, reduces blood clotting and has antioxidant action. Research, primarily from Italy, has uncovered its potential for treating retinal problems from poor blood circulation, diabetes-caused glaucoma, and day blindness. (*Journal of Longevity* - Volume 5/No. 8) (*New Encyclopedia Vitamins, Minerals, Supplements, & Herbs*)

Bitter Melon / Karela / Bitter Gourd (Mormordica Charantia Extract) – tropical fruit from Asia and SA. contains polypeptide p or p-insulin (p- for plant). The blood-sugar-lowering action of the fresh fruit or extract of the unripe fruit, is clearly established in human clinical trials and in experimental models. One study: glucose tolerance increased in 73% of Type II diabetics. In another, the extract produced a 17% reduction in glycosylated hemoglobin A1c after 7 weeks of use. (*The Pill Book Guide to Natural Medicines* pgs 547 & 548); (*The Healing Power of Herbs* pgs - 357 & 358)

Cinnamon - the spice, (not the flavoring), ground bark of an Asian tree - researchers Beltsville (Maryland) Human Nutrition Research Center discovered cinnamon–made fat cells more responsive to insulin helping to control blood sugar levels. It's most active compound--methylhydroxy chalcone polymer (MHCP)–was isolated showing increase in the conversion of glucose to energy by 20 times and blocked the formation of dangerous free radical activity, thereby reducing or slowing the progression of diabetic complications. (*Diabetes Care*, Dec 2003). Significant reductions in blood sugar, ranging from 18 to 29% were reported in a similar study. (*Men's Health Magazine*-December 2000 - pg 40); (*Natural Treatments for Diabetes*-pg 19)

Don Graves, Santa Barbara UC molecular biologist, and colleagues report that cinnamon's a potential treatment for diabetes because of its molecular similarity to insulin. Taken regularly with water, it behaves remarkably like insulin; a natural version far cheaper than primarily, synthesized insulin. It's a promising alternative to insulin shots for Type II / "adult onset" diabetes who require injections, but can't afford them.

Fenugreek extract - significant anti-diabetic effects demonstrated in experimental and clinical studies in the *European Journal of Clinical Nutrition* reports improves glucose tolerance in both Type I and II diabetes. Pancreatic function is stimulated with consistent intake of the herb; significantly reducing both fasting and post meal glucose levels with relatively mild diabetics. Healthy subjects experienced no change in glucose levels. (*Natural Treatments for Diabetes* pg 19); (*Clinical Applications of Herbal Medicine* - pg 19); (*Syndrome X* - pg 223)

Gulvel - also known as Tinospora Cordifolia, a multi-faceted plant, widely believed not only to help restore vital energy body, but also to help revive the pancreas. Indeed, it has been found to help balance levels of both blood fats and blood sugar. (*Journal of Longevity*-Vol. 7/No. 12 – pg 41)

Gymnema sylvestre - one of most powerful herbal agents for blood sugar control, has therapeutic value for both Type I and II diabetics. Recent U.S. clinical study showed that the extract reduced the average fasting glucose by 11%, post-meal glucose by 13% and A1c by 6.8%. Another study reported Type I diabetics, average insulin requirements dropped by almost 30%. In another study Type II diabetics, A1c levels were reduced from 12 – 8.5%. (A1c test is an indicator of the average blood sugar control over the last 2-3 months). There is evidence that Gymnema extracts may possibly regenerate or revitalize the pancreas' insulin-producing beta cells.

Jambolan - a species of cloves used in Ayurvedic medicine, used to treat diabetes because it quickly reduces blood sugar without side effects. It may also decrease the risk of a diabetic developing atherosclerosis, since it contains oleanolic acid, which short-circuits the chemical reactions that make toxic free radicals. (*Natural Treatments for Diabetes* - pg 21); (*Prescription for Herbal Healing* - pgs 84- 85)

Pterocarpus marsupium - has a long history in India as a treatment for diabetes. A potent flavonoid in this tree has been shown to help regenerate beta cells in the pancreas. Researchers in India studied the effects of this herb and were amazed to find it helped control blood sugar levels in 69% of individuals with blood sugar problems. (*Natural Treatments for Diabetes* - pg 43); (*Journal of Longevity*-Volume 7/No. 12 - pg 41)

Vasant Ksumakar Ros - extremely useful for diabetics. It overcomes debility and weakness faster and ensures prompt improvement in blood sugar levels.

Glycemic Index

The **Glycemic index**, a ranking of carbohydrates, is **the measure** of a food or beverage's ability to raise your body's blood glucose (blood sugar) level. GI refers to the **relative amount** the blood sugar is raised, **compared** to a standard (100 grams of sugar). For example, if a particular food raises blood sugar only half the amount of pure glucose, that food is given a glycemic index of 50. Carbohydrates that breakdown quickly during digestion have the highest glycemic indexes; blood glucose response is fast and high. Carbohydrates that break down slowly, releasing glucose gradually into the blood stream, have low glycemic indexes. The index of a food is governed by several factors, such as the form of carbohydrate, the amount and form of fiber it contains, how much processing and cooking it's been subjected to and the presence of other substances such as fat and protein.

European researchers first brought attention to the effects of various foods on blood sugar levels in the early '70's. The glycemic index was conceived in the early '80's by Dr. David Jenkins, University of Toronto nutrition professor, establishing the best type of foods for people suffering from diabetes. He found that foods such as potatoes — traditionally defined as a complex carbohydrate — actually led to a rapid rise in blood sugar.

Glycemic load refers to the amount that a typical serving of food will raise your blood glucose. It compares carbohydrates gram for gram.

High glycemic levels	**Low glycemic levels**
Obesity	Reduces insulin resistance
Diabetes, Type II	Helps control appetite
Heart Disease	Improve weight loss
Some Cancers	Enhance blood sugar control
Increases levels of LDL	Lowers levels of total LDL
Lowers levels of HDL	Raises blood levels of HDL
Insulin resistance syndrome	Decreases oxidative stress
Hypoglycemia	Blood pressure, systolic & diastolic improve, serum triglycerides improve, C-reactive proteins improve

To test the food "index", 50 grams of carbohydrate of the food portion is used. The difference between glycemic index and glycemic load: a food may have a relatively high glycemic index, but an average serving size might only have a slight impact on blood sugar.

Glycemic load is calculated by multiplying the glycemic index of a food by the amount of carbohydrate contained in a typical serving of the food. It may be more reliable than glycemic index as a predictor of how a food will affect the blood sugar level because some foods with a high glycemic index (such as *carrots*) contain such a small amount of carbohydrate in a normal serving that they wouldn't raise the blood sugar level very much. However, carrot juice, which contains a relatively large amount of carbohydrate, would produce a substantial increase in the blood sugar level.

Ex. **Carrots** - fair amount of carbohydrate; glycemic index of some carrots approaches 60 (less than 55 is considered good), but the glycemic load is only 1 to 3 (less than 10 is good). Ex. **Grapefruit** - the juice has a much higher glycemic index and load than the whole fruit.

It isn't necessary to completely avoid high-glycemic-index foods since when these foods are combined in a meal with low-glycemic-index foods, proteins or fat, the overall glycemic effect is reduced. The basic rules: a.) reduce intake of concentrated sugars and most potatoes, b.) increase consumption of legumes and most vegetables and fruits and c.) choose grain products made by traditional methods (pasta, stone-ground flour products, old-fashioned oatmeal) rather than those produced with modern technology (highly refined flour products, low-fiber flaked breakfast cereals, quick-cooking starches, etc.).

A recent study in *Diabetes Medicine* indicated that people with the best glycemic control had the lowest level of oxidative stress. Important to note because many chronic diseases a re a result of oxidative stress; an excess of free radicals can lead to the development of them and also contribute to the aging process.

Glycemic Index Range			**Glycemic Load Range**			**Glycemic Load Daily**	
LOW	**MEDIUM**	**HIGH**	**LOW**	**MEDIUM**	**HIGH**	**LOW**	**HIGH**
55 or less	56-69	70 or more	10 or less	11-19	20 or more	< 80	> 120

Ups and Downs of Blood Sugar Levels

The rate at which food sugars enter the blood should be a consideration when eating– especially for people with diabetes or hypoglycemia. High glycemic index foods demand a rapid secretion of insulin to balance the consequential rapid rise in blood sugar levels.

HIGH GLYCEMIC FOODS (avoid) **(70 or more)**	MODERATE GLYCEMIC FOOD **(56 – 69)**	LOW GLYCEMIC FOODS **(55 or less)**
puffed rice	brown & basmati rice	Soybeans
corn flakes, cheerios	whole grain breads, etc.	Cherries
white flour	whole grain pasta	Pears
white rice	Pineapple	grapes
Rice, rice cakes	apple juice	Apples
over ripe bananas	Bananas	Peaches
millet	orange juice	oranges, limes
raisins	muesli, grape nuts	grapefruit, lemons
most breads, snacks,	shredded wheat	oat bran, All-bran
cakes, pies, candy and	ice cream	Yogurt
desserts of refined flour	Oatmeal	Carob
parsnips	pinto beans	lima beans, kidney beans
carrots	Beetroot	sea vegetables
potatoes (except new potatoes,	sweet potatoes, yams	green beans
sweet potatoes, yams)	Spinach	Lentils
honey	popcorn	nuts/seeds
glucose, white sugar	pita bread, rye, oatbread	fructose, lactose
watermelon	tropical fruits, mango, guavas,	whole wheat
graham crackers	Kavli crispbread	multigrain crackers
Soft and sports drinks	bran muffins, biscuits	sugar free sweets, jams
sweetened fruit drinks	Ceres juices-mango, peach, etc.	milk, water, tea

Glucose and the Immune System

> *"It is important to note here that even moderately elevated blood glucose can lower your resistance to infection over time, since it impairs the functioning of the white blood cells. As a result, certain types of bacteria and fungi that rarely cause serious infections in other people may plague you if your blood sugar is poorly controlled."*[1]
>
> - Milton Hammerly, M.D., *The New Integrative Approach to Diabetes*

One of the diabetic complications, seldom mentioned, is its detrimental effect on the immune system, often having begun before the detection of diabetes. Immune problems are worsened by poor blood sugar control, putting the diabetic at risk for serious infections or complications of simple infections. Eating sugar (sucrose) reduces the body's ability to fight infections.

In 1908, researchers noted that **diabetics were more susceptible than non-diabetics to infections**. It took until 1942 to discover that the bacteria-engulfing white blood cells of diabetics were essentially sleeping on the job. High concentrations of glucose reduces the activity of white blood cells as much as 50%, with an effect lasting for five hours, and decreases the production of protective antibodies adding to poor infection resistance from bacteria and viruses. Subsequent studies also confirm that high glucose concentrations reduced the ability of white blood cells to capture bacteria.

At Loma Linda University, CA, researchers found that **white blood cells** from people who ate the equivalent of a candy bar and a soft drink could capture only one tenth of the bacteria, compared with people who ate only half of the candy bar. The reduced immune responsive-ness occurred within only 45 minutes, meaning that sugar greatly reduces a person's ability to fight infections. An example of impaired immune function: diabetics are far more likely to develop secondary pneumonia when recovering from the flu.

In similar experiments, researchers at Utah State University, tested the effect of different diets on **antibody production** in laboratory rats. Antibodies are very complex immune compounds designed to combat specific bacteria and viruses. They found that as little as a 10% decrease in the nutritional quality of the diet (e.g., 10% more sugar and 10% less protein, vitamins and minerals) decreased antibody production by an incredible 50%. When the amount of sugar in the diet was increased to 75% and other nutrients decreased to 25%, antibody production dropped by 90%. Such changes, in people, would greatly increase susceptibility to infection. Several large studies have confirmed that many Americans who are 55 and over have compromised immune systems due to a deficiency of one or more key nutrients in the diet.

Eating carbohydrate-containing foods, including some fruits, temporarily raises blood sugar and insulin levels. On the other hand, a diet rich in the **soluble fiber** found in fruit may lower the risk of Type II diabetes, despite the high carbohydrate content of most

fruit. High-fiber supplements, such as pectin from fruit, have improved glucose tolerance in some studies. A review of the research revealed that the extent to which moderate amounts of fiber help people with diabetes in the long term is still unknown. The lack of many long-term studies has led some researchers to question the importance of fiber in improving diabetes. Still most doctors advise people with diabetes to eat a diet high in fiber.

"Diabetics tend to develop **yeast infections more** because yeast thrives in a high-sugar environment," says Ronald Hoffman, MD. "**Garlic** suppresses yeast. Also **Acidophilus** helps keep the intestinal flora away from flavoring yeast multiplication."

Brushing and flossing are crucial. "A diabetic has to maintain an absolutely immaculate mouth," says Roger P. Levin, DDS. "Because diabetics are much more susceptible to infection, they are also more susceptible to gum disease which is a bacterial infection."

High Cholesterol, High Triglyerides and Diabetes
Those who have diabetes are two to four times more likely to have a stroke or die of heart disease than non-diabetics. High blood sugar damages the blood vessels and affects triglyceride and cholesterol levels. High triglyceride levels, as well as, low levels of protective HDL cholesterol are common in diabetics.

A diet abundant in **fish, borage and flax seed oils** is associated with lower rates of diabetes, heart disease, high blood pressure, rheumatoid arthritis and other inflammatory conditions. Such a diet reduces insulin resistance, lowers the risk of Type II diabetes and protects against diabetic neuropathy. Fish oil is rich in Omega 3 fatty acids called EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid). DHA nurtures the brain and has been shown to improve memory and brain function. Flax seed oil is a plentiful source of an essential fatty acid called alpha linolenic acid (ALA).

Most of the research on EPA has involved its effects on the prevention of heart disease; this is important, as the risk of this disease dramatically increases for diabetics. EPA works to enhance cardiovascular health by first, promoting the burning of fats in the liver, thereby lowering cholesterol and triglycerides. Significant for diabetics, because excess fats in the bloodstream interfere with insulin sensitivity. When triglycerides are elevated, blood sugar levels often go up as well. It's a priority for any diabetic with elevated cholesterol and triglycerides to get them into normal range. Second, EPA reduces dangerous blood clots that may lead to heart attack or stroke.

The most important of the Omega 6 fatty acids for the diabetic is gamma linolenic acid (GLA) form borage oil. They are frequently deficient in GLA, since they often have problems converting dietary fats into GLA. It can also be an effective therapy for diabetic peripheral/ neuropathy, caused by an inflammation and deterioration of the peripheral nerves, usually in the legs and feet. Characterized by numbness, tingling and sometimes severe pain, the disease gradually destroys the nerves and the legs become more susceptible to ulcerative sores and infection. Nerve damage can impair digestion and sexual function, as well as, cause weakened muscles and loss of muscle tissue.

Peripheral Neuropathy
About 15 million Americans suffer from this nerve problem that can damage the nervous system and cause unrelenting aches and pains. In particular, 60 to 70% of diabetics, 60 to 70%, may suffer peripheral neuropathy when the sugar in their blood reaches and remains at dangerous levels. One theory: sugar leads to chemical reactions around nerves that cause swelling and pinching. If not relieved, nerve death can result. Because nerves send impulses throughout the body, this condition can leave a host of discomforts: pain in your face, hands and feet; digestive troubles and incontinence. Taking extra nutrients may help soothe nerves and relieve pain by repairing and rebuilding the protective structures that protect nerves. (Source: *Energy Times Magazine*, Feb 2001)

PN is prevalent among diabetics who not only have difficulty controlling glucose levels, but also is a problem for those with high lipid levels (cholesterol and triglycerides), those over 40 and among smokers. Various toxins and metallic poisons (such as arsenic, lead and mercury), certain chemicals (especially solvents and some insecticides), excessive alcohol intake, vitamin deficiencies (particularly B12) or vitamin excesses (B6), nutritional imbalances, and a number of drugs can cause peripheral neuropathy, as well. (*Numb Toes and Aching Soles: Coping with Peripheral Neuropathy*) by John A. Senneff

All members of the B vitamin family play crucial roles in promoting and insuring nerve health: **Thiamine (B-1)** and **biotin (B-7)** promote healthy nerves. **Riboflavin (B-2)** aids in nerve insulation. **Niacin (B-3)** assists nervous system function, **pyridoxine (B-6)** helps absorption and use of niacin while **Cyanocobalamin (B-12)** helps nerves function and avoid damage. A lack of B-6 may cause carpal tunnel syndrome, painful neuropathy in your hands that may make it impossible to type or grip heavy object. Both B-12 and **folic acid (B-9)** deficiency can create neuropathic leg and foot pain.

Japanese researchers found that B vitamin supplements helped nerves repair themselves and transmit their vital information (*Gen Pharmacol* 1996;27(6)995-1000). A German study found similar benefits (*Ex Clin Endocrinol Diabetes* 1996;104(4):311-6). Another study discovered that taking B-6 can relieve nerve pain (*Adv Perit Dial* 2000; 16:308-12). French scientists administer high doses of biotin to folks suffering from severe peripheral neuropathy noting marked pain relief within a couple of months. Concluding that biotin is crucial for proper nerves function, they suggest that biotin be used routinely for prevention and management. (*Biomed Pharmacother* 1990; 44(10):511-4). Further proof of B vitamin help for nerves: in the 1990s Cubans suffered an epidemic of nerve pain. When medical experts gave them riboflavin and antioxidant nutrients, their problems decreased (*Am J Clin Nutr* 2000; 71:1676-81S).

Skin
The body's largest organ is also its most vulnerable one; skin can fall victim to threats from both outside (sun, dry air, sharp objects) and inside (high glucose levels, dehydration). Having healthy skin requires caring for its environment both inside and out. Diabetes can add to skin problems. High glucose levels are one reason; many bacteria thrive on sugar, making infections easier to get and harder to cure. Diabetic nerve disease and blood vessel disease are

two other reasons; both can interfere with blood flow to the skin. In addition, nerve damage may dampen your ability to sense irritations and wounds, making it easier to injure yourself and not even notice.

Eye Problems
Diabetic retinopathy, glaucoma and macular degeneration are the leading causes of irrever-sible blindness according to a recent article in the *FDA Consumer*. Diabetic retinopathy, blood vessel damage in the retina, is the leading cause of new cases of blindness ages 20 to 74. It will occur in 90% of people with Type I diabetes and 65% with Type II diabetes approximately 10 years af-

ter the onset of the disease. These eye problems can progress initially without symptoms before the damage becomes apparent.

Two-three million Americans, age 40 and over, have glaucoma, including half of those who are unaware they have the disease. A common problem for diabetics, they are nearly twice as likely to get glaucoma as other adults. Because of the potential complications, those with diabetes are 25 times more likely to become blind than those without the disease.

The brain and visual system while accounting for only 2% of your body's weight use up to 25% of our nutritional intake. Because the eyes are so metabolically active, blurred vision may be one of the first symptoms of diabetes in an undiagnosed person. Studies show that diabetics not only develop cataracts at an earlier age, but they are twice as likely to develop cataracts as a person without the disease

As visually driven creatures, 80% of what we learn comes in through our eyes. Since there is no known treatment for many causes of blindness, prevention is crucial to ensure a protective supply of antioxidants, phytonutrients, bioflavonoids and targeted herbs for eye health. Good blood sugar control is important, as well as, a diet rich in antioxidants, including **lutein, bioflavonoids, quercetin and rutin, alpha-lipoic acid** and the herbs **bilberry** and **eyebright**.

In a clinical trial study sponsored by the National Eye Institute (*Archives of Ophthalmology*, Oct. 2001), 3,640 people at high risk of developing Age-related Macular Degeneration (AMD) lowered their risk by 25% when given antioxidants.

Exercise
People with blood sugar problems need to play close attention during strenuous activity. A lot of exercise, too much insulin or not enough food can make blood sugar levels drop too low. The need for sugar may be immediate or if too low, they may experience insulin shock, may pass out. Physical or mental exercise without proper food compensation can become a hypo situation. Generally, eat 30 to 60 minutes before exercise.

In many ways exercise is as or more important than proper food. Exercise tones up muscles, improves digestion and circulation; well-toned muscles and a decrease in body fat will help decrease the symptoms of hypoglycemia. The higher the level of oxygen your body receives, the better you feel and function, since oxygen intake increases when exercising. Both aerobic and anaerobic exercise help muscles metabolize sugar more effectively, resulting in a long-term improvement. Walking is best for diabetics, as it's by far the safest and least stressful.

Additional Studies
Decrease Your Sleep and Increase Your Risk for Diabetes
Sleep loss, just as poor diet, sedentary lifestyle, chronic stress and aging, is a risk factor for Type II diabetes. Research shows that a lack of sleep causes a "sleep debt" increasing insulin resistance and causing the release of more stress hormones. The result: higher blood sugar levels which can raise the risk of obesity, high blood pressure and diabetes.

According to a University of Chicago study, Dr. Eve Van Cauter, found that chronic sleep deprivation (6.5 hours or less of sleep a night) had the same effect on insulin resistance as aging. Healthy adults who averaged 316 minutes of sleep a night (about 5.2 hours) over 8 consecutive nights secreted 50% more insulin than their more rested counterparts who averaged 477 minutes of sleep or about 8 hours. As a result, "short sleepers" were 40% less sensitive to insulin. Sleep deprivation, which is becoming commonplace in industrialized countries, may play a role in the current epidemic of Type II diabetes. *American Diabetes Association's Annual Meeting* June 25, 2001 Philadelphia

Daily Soft Drinks Double Diabetes Risk
Did you know…drinking just one sugar-sweetened soft drink a day will double your chances of contracting diabetes, according to a Harvard study published in *The Journal of the American Medical Association (JAMA)*. Conversely, drinking a soft drink only once a month reduces the risk to half that of the daily drinkers. The study followed the habits of 91,000 nurses as a part of a much larger study at Harvard University on diet, health and disease.

Recent Developments
Islet transplantation / Stem cell research
Because stem cells are primordial all-purpose cells from which all tissues of the body develop scientists and entrepreneurs working with them have high hopes of generating insulin-producing cells for diabetics. The islet regeneration program at the Strelitz Diabetes Institutes in Norfolk, VA, conducted by research director Aaron I. Vinik, MD and his team discovered a protein called islet neogenesis-associated peptide (INGAP) that stimulates stem cells to grow and transform into cells that can make insulin. Surprisingly, INGAP, appears to target very specifically the pancreas cells in regenerating pancreases and no other

"Our laboratory is using human fetal pancreatic cells in efforts to develop a cell line which is glucose-responsive," says Director Alberto Hayek, M.D., Whittier Institute for Diabetes in La Jolla, CA. "We have found that cells from human fetal pancreatic tissue, when transplanted into diabetic mice...give rise to insulin-producing cells, which reverse the diabetic state."

CytoTherapeutics Inc. of Lincoln, RI, has an exclusive license to allow it to patent stem cells to treat diabetes. Its key technology is based on islet progenitor stem cells (IPSC), a technology that allows the growth of substantial numbers of islets from stem cells derived from adult donors and can lead to a supply of islets for transplantation therapy, novel growth factors, or both, to treat diabetes.

Touch for Health and Other Interventions
What did we do in those very few moments with Anita in the hospital bed?

We: 1.) corrected switching with K27's only 2.) held NV (Neurovascular) for spleen/pancreas above the ears for a few minutes 3.) massaged front NL (Neurolymphatics) for the latissimus dorsi 4.) held ESR for a two or three minutes while visualizing healing colors. The nurse immediately retook the blood sugar reading. **It had dropped 111 points!**

In the interest of research, several diabetic friends were willing to "prick their fingers before and after" using the Latismussi Dorsi NL's, NV's, K27's, spleen meridian and/or ESR points. Some are also trying different nutritional diets, supplements and herbs. Results we've determined so far:

a. Massage the K27's and correcting for switching is important as some of the readings would increase if only the NL's or NV's were used.

b. Stimulating the NL only, raised the blood sugar reading slightly for one person each time, so he was encouraged to correct for switching and to test whether to use the NL, NV, ESR, the meridian and/ or repattern a declaration statement.

c. For one friend, the reading was 164 the day we began – with demonstrating muscle checking and the different options for "corrections." The next morning it was 129 … an unusually low, but good morning reading for her. For this same person, stimulating the **K27's only** would drop the before/after reading 5 – 9 points…without taking the usual medication, the numbers were all in an acceptable range except one which was slightly high and was lowered by 5 points after massaging the K27's.

There is definitely a need for more research in using selected simple TFHK techniques. Of course, it would be best to have a complete balance which would include testing the alarm points for "over energy". It may be that a hypoglycemic state is over energy, that hyper-glycemia may be "under energy" or vice versa; that Type I and II may also test differently, as to whether over energized or under energized thus determining which correction to use. The main point in the research, was to show how using a "medical monitoring device" can measure a before and after result using our Touch for Health techniques with or without declarations and to find simple non-invasive ways for a diabetic or person with other blood sugar problems to help themselves naturally.

Possible Declarations (Goal) Statements
The following are some of the "tools" we use with TFHK balances or repatterning work. Possible declaration (goal) statements after each book or chart information related to blood sugar problems will follow the descriptions. After many years of using declarations with students, clients, we feel it is important to use all of person's given names in creating a present tense, 1st person, **declaration**, declaring what you'd like to be **positively** true, contradicting "the way it is" currently…in other words "the way you'd like it to be."

EX. 'I, Tweety, Tweet, Twee Bird, feel calm comfortable and secure around Sylvester Cat." (all names positive way you'd like it to be contradicts current time)

(from *PKP Energy Wheel Emotions Chart* by the Dewes, Bruce and Joan) Spleen: Empathy, Rejected, (Dis)approved, Faith in the future

(list from **Feelings Buried Alive**, Karole Truman, '91)

Diabetes: Judging self or others severely, Disappointed in life, Ongoing feeling of sorrow, Emotional shock, Joy of life is gone, Obsessed with wanting to control, Feeling it should have been different.

Blood disorders: Feeling powerless in some area of life, Feelings of deep anger, Feelings of longstanding ill well, Intense depression

Blood Problems: Not feeling joy in life, Stagnant thinking, Unable to flow with life, Feelings of fear

Hypoglycemia: Feelings of overwhelmed burdens, Feelings of lack of joy in life

Pancreas: Feelings of judgment, Incorrect use of ego, Feelings of guilt, Not allowing joy, Low self-esteem, Suppressing laughter

****Possible declarations** (goal) statements related statements you might use in your balances, or repatternings, or

I, _____, believe in myself, have self-confidence, high self-esteem, a positive self-image and value, accept, honor, respect and trust myself.

I, _____, feel and embrace joy in my life, and no longer feel ongoing sorrow and disappoint with life.

I, _____, accept and appreciate myself and others, and no longer severely judge myself and others.

I, _____, flow with life and no longer am obsessed with control or wanting to control.

(from the *Behavioural Barometer* by 3 in 1 concepts)

Other words on the chart certainly may apply; I found the predominant one for diabetes and blood sugar problems:

Conscious Resentment/Interest
Hurt/ Fascinated and Embarrassed/Tuned-in

(from *Chakra Awareness Guide* by AMI)

Solar Plexus: pancreas, adrenals, stomach, liver, gallbladder, nervous system, muscles

Qualities/lessons: will, personal power, authority, energy, self control, radiance, warmth, awakening, humor, laughter, transformation

Negative quality: taking in more than one can assimilate and utilize; too much emphasis on power and recognition. Anger, fear, hate; Digestive problems

(from *Charter Life Statement* list by Malcom and Sue Chaffer of Sydney; Carol Albee of US)

Predominant statement found for diabetics/ blood sugar problems from the Charter list of 194:#117 "I can be appreciated."

I, _____, can, am and feel appreciated.

(from *Core Belief* list)

Pancreas/Blood Sugar/Diabetes: Love and approval (I must have the love and approval from all the people I find significant in order to be worthwhile.)

I, _____, know, feel and am a worthwhile person and no longer must have the approval from significant people in my life in order to be worthwhile.

(from *Attitudinal Awareness Chart*)

Pancreas - the capacity to take in, assimilate and balance the sweetness of life. The balance of giving and receiving love. uncertainty, worry, mental confusion, anger, hostility, bitterness, and/or resentment can take the "sweetness" out of one's life

and blood; resulting in imbalances. Problems in this area may indicate issues of rejection and abandonment, feeling unaccepted, self-pity and/or sorrow, feeling deprived of the "sweet" things in life; inability to handle/assimilate the sweetness/beauty of the life; loneliness, holding onto life too tightly.

Possible declarations:

I, _____, am clear, certain and safe, knowing all is well and that everything is working out for my highest good.

I, _____, am and feel accepted.

Other related areas to you might want to create declarations for would be: Exercise issues, Weight issues, Sleep issues, Immune system issues, Dieting and eating pattern issues. I encourage you to share any results you might discover if you balance anyone to help manage their blood sugar problems.

References:

Brand-Miller J, Wolever TM, Foster-Powell K, Colagiuri S. *The New Glucose Revolution*. 2003

Budd, Martin, ND, DO, LicAc.; *Low Blood Sugar (Hypoglycemia) The 20th Century Epidemic*

Challem, Jack, Burton Berkson, MD., PhD., Melissa D Smith, *Syndrome X*

Greenwood-Robinson, Maggie, PhD; *Control Diabetes*

Juvenile Diabetes Research Foundation in Australia, *www.jdrf.org*

Kim, Dr. Ben, *Essential Information about Blood Sugar and Insulin* (article), *Life Essentials Health Clinic*

Ludwig DS. *The glycemic index: physiological mechanisms relating to obesity, diabetes, and cardiovascular disease.* JAMA 2002;287:2414-23 [review].

McCool, Martha and Sandra Woodruff, *My Doctor Says I Have a Little Diabetes*, 1999

Pi-Sunyer FX. *Glycemic index and disease. American J Clinical Nutrition* 2002;76:290S-8S [review].

Thie, John F. Dr., & Matthew Thie, M.Ed., *Touch for Health Pocketbook with Chinese 5 Element Metaphors*

Tufts University Health & Nutrition Letter, 6/04, *For Warding off Diabetes, Magnesium*

University of Sydney, *www.glycemicindex.com*

Vander Hook, Sue; *Understanding Illness, Diabetes*, Smart Apple Media, Mankato, MN 2001

Walker, John, M.D., Gastroenterologist & Scientific Advisory Board Member, *Your "Diet's Critical Need to Monitor Blood Sugar Levels (Glycemic Load)"* 02/18/2005

Whitaker, Julian M.D., *Reversing Diabetes*

www.diabetes.org/type-1-diabetes/hypoglycemia.jsp

www.flourishwellness.com

http://huizen.dds.nl/~hypo/faq, Hypoglycemia Homepage Holland, Copyright (C) 1996, 1997, 1998 by Lars Idema, The Netherlands

www.LibraryforDiabetes.com

www.msnbc.com Newsweek Health Center

Notes:

The Duffer's Guide to New Science explanations of what we do

by Denise Gurney, professional kinesiology practitioner, RK (UK), MBRCP (Energy Med.), BA.

"Quantum mechanics, that mysterious,confusing discipline, which none of us really understands, but which we know how to use" Physicist M. Gell-Mann.

Substitute the word kinesiology for the "quantum mechanics" and you have the start of a discussion I have had many times with clients and friends. In this conference paper, I would like to propose having a dialogue to discuss some of the new science theories which might explain what we do when we use kinesiology. **"Dialogue is shared exploration towards greater understanding, connection or possibility"**. (A bit like a balancing session I would like to venture!). In the break out session we will have a dialogue to discuss some of our ideas about what may be happening in kinesiology balances.

For now I will present some of my own musings from part of my PhD in the hope that they may get your own creative juices flowing.

The conundrum:
It has been challenging enough over the past 30 years to even describe the methods that kinesiologists use, but when faced with the question of "How does it work?, it becomes more difficult.

Some scientists do not think it is possible to take theories about quantum events, or things that happen at sub-atomic level, and to apply them to the physical and metaphysical event. Physicist Roland Omnès talks of speculation, or "twaddle" and "balderdash", for those who look to quantum theory for explanations of consciousness, or for support for a new participatory metaphysics. (Clarke,2002).

However, classical physics cannot explain healing encounters and that leaves much of complementary medicine still an enigma, but not all that we do can continue to be written off as the 'placebo' response. Stephen Hawking admits: "We have no idea how the world really is. All we do is build up models which seem to prove our theories". So here are a few theories which I would like to offer up for discussion:

Goal setting.

1. When a person has a symptom or pain, it is just one possible response to the set of circumstances which caused it. There are other possible responses which are waiting in potential form to be brought into (being) matter in the body. When we create a goal before muscle balancing, we aim to create one of the other potential responses which will be healthier for us, or will make us feel better. This is the message of quantum mechanics : "the world is not determined by initial conditions, once and for all. Every event of measurement is potentially creative and may open new possibilities" (Goswami, 1993).
2. One of the central ideas in quantum theory is of complementarity: that light functions either as particles or as waves, but when it is not observed, either function is only a possibility. It is in the type of observation that the light 'collapses' into either a wave or a particle. Bohr said : you can decide what to look for, either the atom, or the speed it is moving at, but not both. I wonder if by helping the client to take their focus off the physical problem and put their intention onto the potential improvement, we help them create a wave of possibility for themselves.
3. Once they see (observe) the wave of possibility and choose a goal for the balance, the wave collapses and the manifestation of a new reality is now probable. According to physicist Amit Goswami (2002) the collapse of the wave function can affect any of several probabilities: by which he means the vital body (energy body), the mental body, the intellect, or the physical body. This reminds me of our Touch for Health triangle of health model.

Pretesting muscles:
Getting a readout of the bio-computer before the balance shows the client their posture over the situation, and how the muscles are holding up under the stress of their problem. When the bodymind is fragmented in this way, no healing can take place, as healing requires the body to be receiving coherent signals. (Oschman, 2003. Emmons, 2003. Bohm & Peat, 1987). Mixed up (incoherent) intentions prevent us from choosing healing thinking; as it is the mind that fragments, we cannot use mind as healer, we need to contact the supra-mental.(Goswami, 2002).

Balancing the muscles:

1. Whatever method of kinesiology we use, however big or small our toolbox, the aim is to restore muscle strength to muscles that are under-functioning. In Touch for Health we use the challenge technique to determine if the muscle imbalance has been corrected at all levels, in PKP we use finger modes and age recession to make sure the balancing is complete.
2. Physicist David Bohm describes the Implicate/ Explicate order which I suspect may be what we are tapping into with our challenges and finger modes. The Implicate order means that everything is enfolded into everything: The Implicate order of matter, (both the living and non-living), along with the unseen world of our thoughts, feelings, urges, will and desires is enfolded into the world that appears to our senses, the Explicate order. (Bohm, 1980). Both implicate and explicate move along in a seamless whole, which

Bohm refers to as the holomovement. It is not possible to access the Implicate order through thought, only through insight.

3. Each time we do a challenge, or do another finger mode we tap into another part of the implicate order, working our way back to the source of the imbalance. In Touch for Health, the client will start to talk about things that have happened to them, or how they feel about someone or something in their life, and often they have an insight, an 'aha' moment when they 'know' something differently. This place of choice, where they can now choose to look at something from a new perspective, is the place where the quantum wave collapses, and the new probability emerges.

Client/kinesiologist interaction.

1. We already know that light particles that are observed function differently from those that are not observed. This puts the observer into the role of a participator in the interaction. It is a participatory universe. (Wheeler). When a person with consciousness looks, the possibilities collapse and become unique actualities, or consciousness chooses one possibility out of all of them. (Goswami, 2002). The client becomes a participator, observing their own universe.
2. New quantum theories of entanglement, specifically global entanglement theory, offer some explanations for the beneficial interactions between the client and the kinesiologist. In specific entanglement theory, the therapist's pattern heals the patient, but global entanglement theory pre-supposes that systems are naturally self-healing, and therefore the patient self-heals, according to the pattern of the patient or of the system in which the patient is a part. (Hyland,2004). Global entanglement theory fits more with kinesiology teaching that the body is a self-healing mechanism.
3. The concept of an entanglement prone personality is key, and I suspect that effective kinesiology practitioners are high in entanglement proneness. Goswami states that we need to intend an entanglement then we will get an intentional move to the Supramental level where healing occurs.

If you have any further thoughts and would like to talk more about these ideas, I can be contacted at *info@sustainableself.com* +1144 161 433 571

References

Bohm, D and P, F.D. (1987). *Science, order and creativity.* 2nd ed. Routledge, London.

Bohm, D. (1980). *Wholeness and the implicate order.* Routledge, London 220-249.

Clarke, C. (2004) "Entanglement – the explanation for everything?" *Network Review: Journal of the Scientific and Medical Network.* 86, Winter 2004.

Clarke, C. (2002). *Living in connection: theory and practice of the new world-view.* Creation Spirituality Books, Warminster.

Emmons, R A. (1999). *The psychology of ultimate concerns: motivation and spirituality in Personality.* The Guilford Press, New York. 116-117.

Goswami, A. (2002) Notes taken at the Science and Consciousness Conference, Albuquerque.

Goswami, A., Reed, R.E. and Goswami, M. (1993). *The self-aware universe: how consciousness creates the material world.* Jeffrey P. Tarcher, New York.

Hyland, M E. (2004) "Does a form of entanglement' between people explain healing? An examination of hypotheses and methodology." *Complementary Therapies in Medicine.* 12, 198-208.

Oschman, J.L. (2003) *Energy medicine in therapeutics and human performance.* Butterworth Heinemann, Edinburgh. 208-209.

Tiller, W A, Dibble, W E, Kohane M J (2001) *Conscious acts of creation: the emergence of a new physics.* Pavior Publishing, California.

Notes:

Elevating Sexual Energy for Passionate Living

by Catherine Carleton-Fitchett, DNM and Irene Yaychuk-Arabei, PhD

SEXUAL ENERGY is our Life Force Energy. Our life force is expressed by our passion in the living of life. All life is created from and is an expression of sexual energy. Our true nature is to be loving, intimate sexual beings. While we start out in this divine state, we acquire and accumulate manmade blockages that prevent us from realizing our full potential. We can describe health as free-flowing sexual life force energy and illness as blocked sexual energy. To live a healthy, inspired and passionate life, blockages need to be identified and defused.

This workshop provides information to help transform and direct sexual energy towards better health, more fulfilling relationships, purposeful life work, longevity and spiritual advancement.

One need not be in a sexual relationship to benefit from elevated sexual energy.

Everyone has a blueprint for wholeness embedded within them. The Life Force Energy Body represents this blueprint in Figure 1.

The Sexual Life Force Energy body is always healthy, vibrant, and in balance and harmony. It immerses or floods the physical body with energy, and as long as we are bathed in this force, we are healthy and in balance on all levels. The energetic body does not depend on the physical body, but the physical body does depend on the energetic body.

Since the energetic body is never ill, why does our physical body become sick and out of balance?

If the energy flow from the Life Force Energy body to our physical body gets blocked, we become ill. The more it is blocked, the sicker and less animated we become. Pollution and toxins clog our receptor sites creating blockages that prevent our physical body from receiving information from our life force.

The Life Force energy body is represented by the elements of AIR and FIRE. The physical body, manifested by Life Force energy, is represented by the elements of EARTH and WATER. Toxins distort all of the elements creating potential for life force energy interference and subsequent blockages making us more susceptible to disease.

Typical toxins that we deal with are: Earth toxins such as heavy metals; Water toxins such as pesticides, drugs, and xeno-estrogens; Air toxins that we breathe such as dust, molds, asbestos, plastics; Fire toxins such as radiation, psychic pollution, and constricting emotions. Any kind of stress that undermines our nervous system such as loud music, deadlines, heavy traffic, and poor lifestyle is part of psychic pollution.

Now that we have a visual aid in understanding the flow of Sexual Life Force Energy into our Physical Body, we can look at how our society creates barriers to this energy flow. Many of us are taught from early childhood that sex is sin, setting us up to fight against our own sexual energy. We create a monster consciousness that expresses itself in our world. It shows up as the distorted and twisted aspect of violence and abuse through pornography and sexual exploitation.

Through wrong cultural teachings we come to believe we are defective and not enough as we are. In the world of advertising, sex sells! It can be subtle and subliminal or it can be very blatant. Body image is an example of using sex to control our value, worth and beauty through the concept of "body perfect". It especially affects vulnerable young people at puberty creating ugly distortions such as eating disorders, unnecessary cosmetic surgeries and negative body image presentations. Sexual promiscuity is encouraged through inappropriate advertising and music.

Healthy Sexual Life Force Energy is foundational to life and permeates every aspect of our being; yet we suffer from obsession, either through indulgence or through repression. We are a society heavy with sexual hang-ups, self-image, self-worth and self-esteem problems, filled with anxiety and fear. As energy workers and healers, our job is to elevate life force sexual energy by releasing blockages through clearing inner obstacles.

AURIC BODIES

Sexual life force energy must flow freely through all the auric layers of the body for optimum health. Blockages in au-

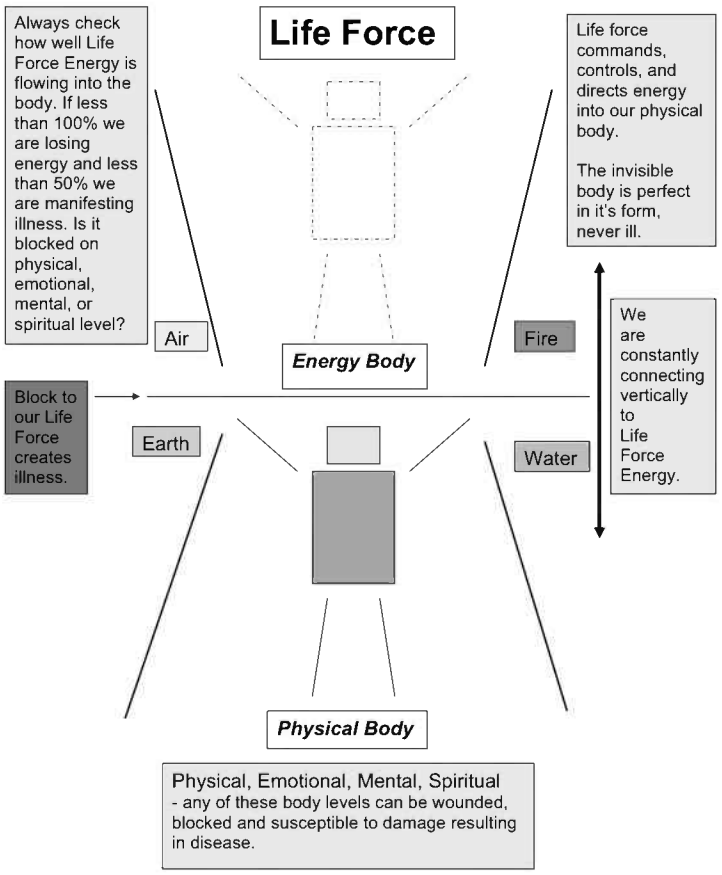
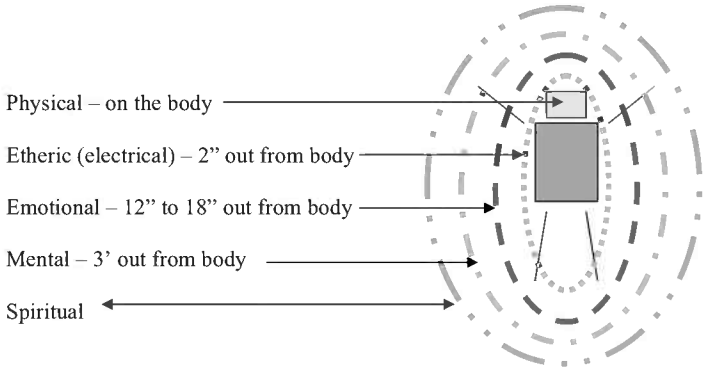


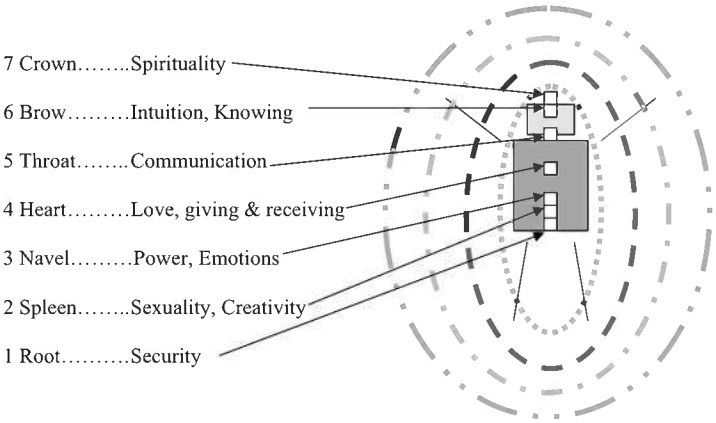
Figure 1. Life Force

ric bodies will manifest as disharmony. If the spiritual auric body is affected, it results in wounded spirit. Blockage in the mental body produces mental illness, and in the emotional body creates emotional baggage. The etheric body, when blocked, produces nervous system and electrical imbalances, and in the physical body blockage results in pain and disease.



THE SEVEN CHAKRAS

To maintain optimum health and establish a flow of energy between the invisible, sexual life force energy and the visible physical body, we need to also balance and cleanse the portals between the two bodies, which are the chakras.



Sexual Life Force Energy gives us our youth and vigour at every age. It's involved in all cycles of life: birth, growth, pregnancy, aging, and death. It is impossible to propagate if sexual energy is undeveloped, and longevity is all a matter of sexual energy.

Passionate living is the outcome of free flowing sexual life force energy. Passion results from an intimate energetic interplay with this sexual life force energy. "Passion lives in all of us and only need be triggered in us. It encompasses boundless love, unbridled enthusiasm, insatiable yearning, and endless longing." (Lazaris)

How do we recognize a person with vibrant sexual life force energy who is living life passionately?

You can sense a hum around them. They walk, but their step has a dance in it. They talk, but their words carry a subtle poetry in them, they look at you, and they really look; it is not just lukewarm, it is really warm. When they touch you, they really touch you; you can feel their energy moving into your body, a current of life being transferred because their Life Force Energy is not repressed. They are loving, intimate sexual beings.

The most profound way to live passionately is to heal repressions, opening up to our Sexual Energy Life Force.

These and numerous other questions hold a tremendous charge within our psyche.

- What does sexual energy mean to me?
- How comfortable am I with my sexual energy?
- Where am I restricting the flow of my sexual energy and why?
- Do I live my life passionately?
- Do I have a passionate relationship with my spirituality?
- How much am I able to love?
- How well do I receive love?
- Am I able to love for no reason at all?
- Am I really comfortable with intimacy? (not just sexual intimacy)
- Am I OK with self-disclosure? (intimacy is self-disclosure)

As Energy Kinesiologists we can diffuse beliefs, attitudes, thoughts, traumas, emotions on a deep cellular level by working with blockages, scripts, hurdles, payoffs or any past patterns that no longer serve us. Our purpose is to create clearer communication between the Sexual Life Force Energy body and all body levels, thus allowing Sexual Life Force Energy to flow and elevate our consciousness into passionate living.

FOUR MAIN CATEGORIES FOR POTENTIAL BLOCKAGE

There are four main categories for potential sexual life force energy blockage and diffusion: Physical, Emotional, Mental, and Spiritual.

PART 1: PHYSICAL BLOCKAGES -Identification and Diffusion

1) BIRTH & PREGNANCY – inherited tendencies
2) GLANDULAR SYSTEM

   The vitality of the glandular system reflects our Life Force Energy. Using "Touch for Health" muscle/meridian testing, we can test and calibrate the vitality and energy flows of the glands. The testing puts the information on our bio-computer screen, and we can use the modality we work with (such as lymphatic massage) to implement change.
3) SEX ORGANS & HORMONES
4) AGING AND PHYSIOLOGICAL CHANGES
5) DISEASE
6) POOR DIET
7) LIFE-STYLE – cigarettes, alcohol, recreational drugs
8) LACK OF EXERCISE
9) MEDICAL INVASIVENESS
10) POLLUTANTS - heavy metals and other toxins
11) OTHER

PART 2: EMOTIONAL BLOCKAGES - Identification and Diffusion

1) FEAR OF INTIMACY – inability to trust
2) COMMUNICATION -negative thoughts and speech diminish vitality and so diminish us and others
3) LONELINESS AND ABANDONMENT
4) POOR BEHAVIOUR, ADDICTIONS - any thought or action that causes you or someone else pain
5) FAMILY AND FRIEND PROBLEMS – quality of relationships
6) EMOTIONAL PAIN FROM PHYSICAL PAIN
7) RECURRENT BAD DREAMS
8) ENVIRONMENTAL INFLUENCES - cities hold increased stress and negative behaviours, weather, barometric pressure
9) FINANCIAL INSECURITY - fear of losing what we have - job, house, identity
10) FEAR FOR PHYSICAL SAFETY, VIOLENCE
11) FEAR OF DEATH AND DYING
12) OTHER

PART 3: MENTAL BLOCKAGES - Identification and Diffusion

1) WRONG TEACHINGS - cultural values, attitudes, beliefs & thinking

   The mind is like a computer chip that only plays back what's programmed in.

   We are a product of wrong cultural principles repeated and reiterated down the centuries.

   a) *Sexuality* - from early childhood we are taught that our bodies are shameful.

   b) *Body Image* – few feel satisfied with their appearance measured against cultural ideals.

   c) *Hardness* – strength (distorted to hardness) is praised, softness is considered weak.

   d) *Illness as a Self-fulfilling Prophecy* - we are conditioned psychologically to expect to be ill.

2) UNSKILFUL THINKING PATTERNS - Unskilful thoughts attract negative energy and outcomes

   a) *Unrealistic Optimism* - prone to creating fantasies that will not come true

   b) *Depression, Fearful, Gloom* - regular such mental states create isolation and addictive behaviours

   c) *Material Gain Focus* - controlling money, career, and relationships - feel they have no value

   d) *Obsessive Physical and Sexual Activities* - feel loss of spiritual connection to self and world

   e) *Consumed with Spiritual, Artistic, or Religious activities* - denies material world

   f) *Mental ignorance* - the basic cause of suffering and of all bodily illnesses

3) CARRYING THINGS FROM THE PAST – stored negativity, resentments
4) INCOMPLETE EXPERIENCES – accumulated unlived moments
5) OTHER

PART 4: SPIRITUAL BLOCKAGES - Identification and Diffusion

1) DEATH
2) REBIRTH
2) REINCARNATION
3) KARMA
4) FREE WILL
5) CONSCIOUSNESS
6) TRANSFORMATION
7) TRANSCENDENCE
8) DIVINITY
9) OTHER

LOVE AND INTIMACY

Let us examine the issue of love and intimacy, one of our most significant emotional blockages. Love cannot exist without intimacy, and intimacy cannot exist without love.

Everyone is afraid of intimacy, yet everyone wants intimacy. The word intimacy comes from the Latin root " intimum" which means " your innermost core". Intimacy is exposing yourself to self, others and the stuff of our reality. We must drop all our defences, only then is intimacy possible. We are all hiding a thousand and one things, not only from others, but also from ourselves. (Osho). Without intimacy, we become closed and isolated, cutting off our Life Force. To live life passionately, we must be open to love and intimacy.

The 7 actions of Love and Intimacy are similar. The 14 states are slightly, yet profoundly different.

Love/Intimacy Chart

The Seven Actions	
Love is: 1) To give 2) To respond – responsible to self/others/reality 3) To respect all we love 4) To know – self & others 5) To have humility to be intimate from a position of knowing 6) To have courage to be committed 7) To be caring	Intimacy is: 1) To give 2) To respond – responsible to self/others/reality 3) To respect all we are intimate with 4) To know - self & others 5) To have humility to be loving from a position of knowing 6) To have courage to be committed 7) To be caring
The seven actions of love produce security and reduce the fear of loss.	The seven actions of intimacy produce closeness, and reduce fear of humiliation.
The Fourteen States	
Loving Relationships produce: 1) Security 2) Pleasure 3) Sense of honesty/vulnerability 4) Trust 5) Caring & intimacy 6) Attempt to reduce the fear of loss 7) State of knowing	Intimate Relationships produce: 1) Closeness 2) Tenderness – vulnerability 3) Allowing space for the state of knowing 4) Trust 5) Caring and loving 6) Attempt to reduce the fear of humiliation 7) State of empathic understanding
To be in a truly loving, intimate relationship, we must do the 7 actions to produce the 14 states 100% of the time.	

We must do the 7 actions to produce the 14 states 100% of the time freely in order to have love and intimacy.

Seven action statements of LOVE and INTIMACY
Test the 7 Actions of love / intimacy

Test in relation to one of the following: Self, Others, Things, my Spirituality

Find the priority statement.

1) I give selflessly.
2) I respond responsibly.
3) I respect that which I love
4) I know myself /others/things
5) I have the humility to be loving/ intimate from a position of knowing
6) I have the courage to be committed
7) I am caring

Seven states of LOVE
Test the states of love in relation to one of the following: Self, Others, Things, my Spirituality

Find the priority statement.

1) I produce security
2) I create pleasure
3) I am honest and vulnerable
4) I produce trust for self/ others/things
5) I am caring and intimate
6) I attempt to reduce the fear of loss
7) I create the state of knowing.

Seven states of INTIMACY
Test the states of intimacy in relation to one of the following: Self, Others, Things, my Spirituality

Find the priority statement.

1) I produce closeness
2) I allow tenderness and vulnerability
3) I allow space for "being"
4) I produce trust
5) I am caring and loving
6) I attempt to reduce the fear of humiliation
7) I create a state of empathic understanding

POSSIBLE RESISTANCES TO INTIMACY

A. Everybody desires intimacy.

It is part of passionate living. We can't be passionate about someone or something if we are not connected.

Test:

I want intimacy in my life. (Y/N)

I am open to allowing intimacy in my life. (Y/N)

If NO for either statements, F/O hold while tapping LU1 points on thumbs and affirming the above statements three times.

B. Everybody is afraid of intimacy.

The next thing is that we need to be willing to admit that there is fear around intimacy. This must be cleared now in order to proceed.

Test:

I am willing to admit I am afraid of intimacy. (Y/N)

If NO, correct with F/O points, while tapping K 27 and rubbing front or back lymphatic for kidney simultaneously, while repeating: "I am willing to admit I am afraid of intimacy."

C. Fear Blockages

- I am afraid of intimacy because it must involve sex and romance./ I am OK with intimacy because it doesn't have to involve sex and romance.
- I am afraid of intense emotion that intimacy may bring up./ I can handle the intense emotion that intimacy may bring up.
- I am afraid of commitment./ I embrace commitment.
- I am afraid that I will lose my sense of self./ I trust that I will retain my sense of self.
- I am afraid of closeness./ I am at ease with closeness.
- I am afraid of allowing another to know me./ I am OK with being transparent.
- I am afraid to know myself. I am OK with discovering myself.
- I am terrified of vulnerability and humiliation./ I am safe with vulnerability.
- I am afraid that I'm not able to love good enough./ I trust that I am able to love good enough.
- I am afraid of having to give up my pay-offs of self-pity and importance./ I am ready to embrace my power and strength.
- I am terrified because I have no guarantee as to the outcome of this intimacy./
- I am willing to take a chance as to the outcome of this intimacy.

D. Projected Past

This has to do with wrong teachings. The mind is like a computer chip that only plays back what is programmed in. We are a product of wrong cultural principals repeated and reiterated down the centuries. This encompasses values, attitudes, beliefs and thinking passed on to us by culture, society, parents and religion.

- I release all religious programming that limits intimacy.

- I release my ancestors beliefs that do not enhance my intimacy
- I am worthy of having intimate relationships.
- I allow myself to enjoy intimacy.

E. Entanglement with the past

If we are stuck in entanglements with past relationships, our future relationships are jeopardised. We carry an attractor pattern where we re-create the same negative outcome. We project the past onto another relationship and expect it to make up for past wounds.

- I release all past hurts from problematic relationships that suppress intimacy.
- I forgive myself for knowingly and unknowingly hurting myself.
- I forgive myself for knowingly or unknowingly hurting others.
- I forgive and release all others for knowingly or unknowingly hurting me.

Getting Started: Practitioner/Client Trust & Touch Response
A trusting practitioner and client relationship is essential to getting started. Clients must be comfortable with their health care practitioner, if they are to fully open up their wounds. Suppressed wounds cannot heal and without healing, blockages cannot be defused. Any repressions or inhibitions must be dealt with up front.

a)"Touch Response" is important to our healing, loving and intimacy. If there is stress with being touched and touching, our ability to receive healing may be affected. Even appropriate loving touch may be rejected. Fear of intimacy - beyond sex- the tenderness, caring, vulnerability and trust is one of our greatest fears. Life force cannot flow if we are paralysed by fear. Testing and defusing the stressors for "touch response" can allow greater success for both client and practitioner.

b)"Gender Bias" is another area which greatly impacts relationships. We should be able to say: *"I am comfortable, peaceful and at ease with the opposite gender, and with the same gender."*

If this statement is true, then we are we are equally comfortable working with either gender and the relationships and practitioners we choose. We come from an empowered choice rather than a fear choice. Clearing gender bias for both the practitioner as well as the client allows for stress free healing and augments the life force.

The Balance:
Pre-Evaluation: Intimacy Stress statements on Touch Response

1) Have Testee think about "sexual energy", what it means to them. Note IM change.

2) Testee strokes own face lovingly. (test)

3) Tester strokes Testee's face lovingly. (test)

4) Testee says:

- It is safe to be touched appropriately. (test)
- It is safe to be touched for health. (test)
- It is safe for me to touch others for love. (test)
- It is safe for me to touch others for health. (test)

Once all the touch issues and gender bias are dealt with, we are able to move on to identifying and clearing blockages to sexual life force energy.

Evaluation: We will work with the priority statement of Section C – Fear Blockages

1) Think about your priority fear blockage statement from section C. Test both negative and positive statements.

2) Find the % of stress towards the fear blockage.

3) Find the % of SEXUAL LIFE FORCE ENERGY towards the fear blockage while touching thymus.

4) Find the emotion.

5) Check which level of the auric field is affected. If more than one, find priority.

6) Check each of the 7 main chakras on the body. One or more will be out. Find priority.

7) Test for one of the 7 chakra colours. (red, orange, yellow, green, blue, indigo, violet)

8) Test which of the 10 sacred geometric shapes are needed. Find the priority if more than one.

Correction:
1) Hold F/O while testee looks at the geometric shape while visualizing it in the colour that they tested for in number 7, above.

2) Have the testee then visualize bringing the shape to the priority chakra with their eyes closed while slowly and deeply breathing in the colour. (The most intimate contact we make with our environment is through our breathing.)

3) Now affirm the positive statement of the fear blockage three times.

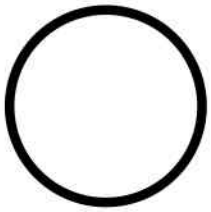
4) Now have the testee imagine touching a baby animal or a baby human. Have them bring a beautiful flower to their face and stroke their face with it, or other intimate touch experience of their choice. Affirm: "It is safe to be appropriately touched. It is safe to appropriately touch others."

Challenge:
Re-test touch response, fear blockage statement, emotion, auric field, and chakras. Check the percentage of stress and sexual life force energy on the goal.

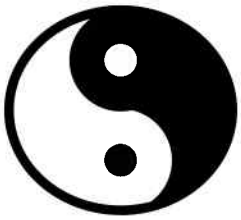
Conclusion:
The release of sexual energy brings us to mastery in whatever is at hand. It may appear that this is applicable to some people some of the time, but in fact we've found it applies to all people all of the time.

9 SACRED NUMBERS

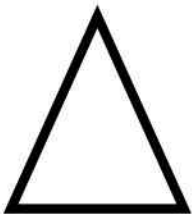
0 is not a number. It corresponds to that which is not nameable or measurable, that which precedes our origins, our CREATOR



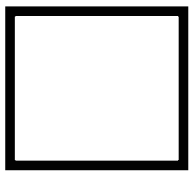
1 (symbol - circle) - corresponds to FORCE, relating to unity as well as TIME. 1 is in the manifested and encompasses the totality and unity we find in all creation.



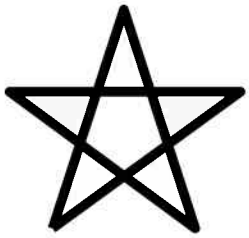
2 (symbol - yin/yang) - corresponds to CREATION. As with all sacred numbers, 1 is contained in 2. The number 2 represents a duality, but because number1 is the supreme force, creative energy had to split into two parts to manifest itself. Out of this "CHI" energy was created, the complimentary polarity of yin and yang, which create the unity.



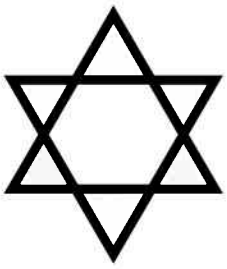
3 (symbol - triangle) - represents the sacred notion of usable LIGHT in creation. It relates to earth and human beings and how human beings perceive their Creator. It also represents heaven, earth and humanity. It allows humanity to bring light to creation.



4. (Symbol - square) - represents the notion of SPACE in a limited world subject to the laws of physics. This imprisonment can be transcended as consciousness changes. It represents the 4 elements of earth, water, air and fire: two yin elements of earth and water and two yang elements of air and fire. All healers work with the laws of nature and the number 4.



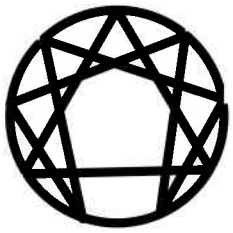
5. (symbol - pentagram or 5 pointed star, used by Traditional Chinese Medicine in the Law of 5 Elements) - in relationship to all that is SACRED through the energy of elevated LOVE. Five is the kingpin that holds everything in place. It is in between all that was (1- 4) and all that will be, or who we are becoming. (5 - 8).



6 (symbol - known as Star of David) - Represents the CELESTIAL FORCE or VITALITY. We are spiritual beings evolved in matter. It is the responsibility of humankind to respect the laws of nature, to transform and illuminate others. We become conscious creators of our reality. The triangle pointing down represents the laws of heaven being applied to earth, or Divinity moving towards mankind. The triangle pointing up represents the energy of humanity moving up to the heavens. In three-dimensional representation, it is the star tetrahedron, our light body used to travel to ascension.

7 (symbol - heptagon) representing the energy of WILL. We are the only beings gifted with fee will and free choice. If we combine our love (5) and the knowledge of creation (2) , we create will (7) and the ability to choose harmony and balance in time and space of the material world.

8 (symbol 8) - SPIRITUAL consciousness and knowledge of our origins and transcending the laws of creation into spiritual laws. This is the energy of immortality, and can only be achieved if we are elevated in the seven previous numbers.



9 (symbol, spiral or enneagram) - FAITH, TRANSCENDENCE from a state of conscious faith based on conviction. The elevated state of dancing around the wheel of all 9 numbers of the enneagram.

References:

Chang Stephen Thomas, *The Complete Book of Acupuncture*, Celestial Arts, 1976.

Chia Mantak and Oellibrandt Dirk, *Taoist Astral Healing*, Destiny Books, Rochester, Vermont, 2004.

Chopra Deepak, *The Book of Secrets*, Harmony Books, New York, 2004.

Gerber Richard, M.D., *Vibrational Medicine*, Bear and Company, Rochester, Vermont, 2001.

Griscom Chris, *Feminine Fusion*, Simon and Schuster, New York, 1991.

Hansard, Christopher, *The Tibetan Art of Living*, Atria Books, New York, 2002.

Hawkins R David, M.D., PhD. *Power vs Force*, Hay House Inc., 2002

Hendricks Kathlyn, Ph.D, Hendricks Gay, Ph.D., *The Conscious Heart*, Bantam Books, New York, 1997.

Johnson Karen, M.D., Ferguson Tom, M.D., *Trusting Ourselves*, Atlantic Monthly Press, New York, 1990.

Lazaris, Workshops and Audio Tapes, *Concepts Synergy*, Orlando Florida, 1986-2005

Ludzia F. Leo, *Life Force, The Secret of Empowerment*, Llewellyn Publications, 1987.

Melchizedek Drunvalo, *The Ancient Secret of the Flower of Life*, Volume 1, Light Technology Publishing, 1998.

Osho, *Intimacy*, St. Martins Griffin, New York, 2001

Osho, *Sex Matters*, St. Martin's Griffin, New York, 2002.

Resnick Stella, Ph.D., *The Pleasure Zone*, Conari Press, CA., 1997.

Notes:

The Sixth Sense - Intuitive Awareness in Kinesiology

by Bruce A J Dewe MD MICAK NZRK, Chancellor, Kinesiology Practitioners Accreditation Board, NZ

Intuition is estimated to be right only about 15% of the time. Does intuitive awareness have a place in Kinesiology? If it does, what is that place? What are the indications and contraindications of using intuition in the kinesiology process?

How and when do we integrate its strengths and weaknesses in our use of standard protocols? Hubert Dreyfus said, *In What Computers Can't Do: The Limits of Artificial Intelligence,* "experience cannot be deconstructed into expert systems".

Cognitive psychologist Gary Klein studied professionals who make do-or-die decisions. His advice, 'Forget analysis paralysis. Trust your instincts'. Does this apply to Kinesiology? If so, should we abandon all Protocols?

What is Intuition?
Webster's dictionary says: The immediate knowing of something without the conscious use of reasoning.

Collins dictionary says: Unexplained feelings that you have that something is true even when you have no evidence or proof of it.

Random House dictionary says: Direct perception of truth, fact, etc., independent of any reasoning process; immediate apprehension.

Most definitions stress that the intuitive process is itself unconscious. Intuition is:

- A keen and quick insight
- Knowing without knowing how you know.

The opposing opinion is:

Intuition is the accumulation of experience converted to flash-fast thinking. Gary Klein, Cognitive Psychologist and author Sources of Power: How People Make Decisions

People call Intuitive Awareness by many names:

- Hunches
- Gut feelings
- Sensing
- Insights
- Revelations
- Dreams

Mona Lisa Schultz MD PhD in *Awakening Intuition* says "Intuition occurs when we directly perceive facts outside the range of the usual five senses and independent of any reasoning process."

Back in 1938, K. W. Wild in *Intuition* said,

> *"An intuition is an immediate awareness by a subject of some particular entity, without such as from the senses or from reason as would account for that awareness. There is an intuitive awareness on which reason and all other forms of knowing are dependent. Intuition is not an alternative to reason or to senses; its minimum function is to form a basis for reason, and its wider functions (if any) to deal with what is inaccessible to reason."*

Intuition in relation to Science, Philosophy
Pitirim A. Sorokin in *The Crisis of Our Age* says, "In regard to scientific and philosophical systems of truth - the truth of the senses and of reason - this is hardly questioned nowadays. The systems are admitted with their sources of truth: the dialectic of human reason and the testimony of the organs of the senses. Mathematics and logic are mainly the system of truth of human reason; and the natural sciences are mainly the depository of the truth of senses. More questionable nowadays is the truth of faith derived from such a source, which is called by diverse names as: "intuition," "inspiration," "revelation," "extra-sensory perception," "mystic experience," and so on. Does such a source, as distinct from discursive dialectics, or testimony of the organs of senses, exist?"

Intuition and the Truth of faith
We admit we do not know exactly the nature of this source of truth. However, we also know scientific observation, in all its forms (experimental, statistical, clinical), & reasoning, does not always guarantee the truth.

The psychologist Carl Jung said, "Intuition is tapping into the collective unconsciousness."

The scientist Robert Sheldrake said, "Intuition is tapping in to the morphogenic fields (invisible fields that connect matter and communicate growth and change.)

The poet John Keats said, "Intuition is touching the face of God".

Intuition and History
Can we reject the existence of such a source of truth, with its great and positive contributions to the history of human thought, science, art, philosophy, religion, ethics, technology, truly creative cultural values, and even economic and practical creative values?

Mathematics and Intuition
In an article, "Intuition, Reason and Faith in Science", in *Science* magazine, Dec. 30, 1938, the mathematician Birkhoff said that intuition and faith serve as "the foundation for the rational superstructure erected by means of deductive and inductive reasoning, and as heuristically valuable, more general points of view, which are beyond reason and of supreme importance."

Back in 1908, Henri Poincaré said,

> *"It is by logic that we prove, but by intuition that we discover"*

Christianity, Philosophy and Intuition
St. Thomas Aquinas called intuition "divine revelation", "the truth of faith" or "wise ignorance" that "goeth beyond all knowledge." (St. Thomas, Summa contra Gentiles, 1924).

Plato said, "Intuition is, Divine madness."

Philosopher F. Nietzsche said, "That which happens can only be termed revelation, that is to say, that suddenly, with unutterable certainty and delicacy, something becomes visible and audible and shakes and rends one to the depths of one's being."

Science and Intuition
Albert Einstein said, "I never came upon any of my discoveries through the process of rational thinking."

M. R. Westcott said, Intuition is the process of reaching accurate conclusions based on inadequate information.

Ernest Ross in *The Psychobiology of Mind-Body Healing,* said "Gut feelings: you are picking up cues and getting molecular responses."

Candace Pert, NIH Chief of Brain Biochemistry and author of *Molecules of Emotion* said, The specific molecule is a neuromodulator in your brain called CCK (cholecystokinin). CCK may be the signal for what we call gut responses. CCK is a hormone that is active in the digestive process but it also connects with a nerve that modulates learning and memory in the brain.

How reliable is Intuitive Awareness?
How much should we depend on gut-level instinct rather than rational analysis when we play the stock market, choose a mate, hire an employee, or assess our own abilities?

David Myers, in *Intuition: Its Powers and Perils* says, "While intuition can provide us with useful-and often amazing-insights, it can also dangerously mislead us."

However, Mona Lisa Schultz MD PhD says, in *Awakening Intuition,* "Intuitive hits are sudden, immediate and unexpected ideas. They seem illogical and have no clear line of thought. They frequently come out of the blue. Nevertheless they bring with them a feeling of confidence and a certainty of their absolute indisputability. Often when we are not outwardly confident about our intuition, when we are devaluing it, our bodies are still expressing confidence in it."

Intuition and the body
Intuitive insights involve emotion.

The body has a language of intuition. It speaks through: health and disease, dreams, visions and voices, body sensations and emotions. No two people experience intuition the same way.

Types of Intuitive Awareness
Clairvoyant- clear seeing, clairaudient - clear hearing, clairsentient - clear feeling, clairsavorance - clear taste, and clairscent - clear smell.

Also there is perception of vibration or energy which takes many forms, telepathy - thought transference, aura perception - which Cayce called the 'emanation of the soul, perception of other realms - spirit guides, angels, nature spirits, etc, psychometry where by holding an object in one's hand, it is possible to pick up intuitive information about the object and/or the person to whom it belongs.

Then there is intuition through time: precognition - the ability to know about something before it actually occurs and retrocognition - the ability to know details about something that has taken place in the past without having been told or having read about it. (past life awareness is included here).

The major expressions of intuitive awareness in more detail.

Clairvoyants receive intuitive information in visual images. They may see a movie about the life of the person or they may see brief images, more like snapshots. Images can sharp, clear images that last several minutes or simply fleeting images with a daydream-like quality. One type of image is not better than another, they are just different. When interpreting the images, they may be symbolic or literal: e.g., a red rose may mean love coming to you or a red rose may mean you are a gardener.

Clairaudients receive intuitive information as sounds. Sounds can be words or music, waves breaking, birds singing, a person crying, any other type of sound. The receiver needs to know how to interpret this information because this knowledge is often received as a flash of instant insight. It is not received logically by thinking things through.

Clairsentients experiences can be physical or emotional. They can vary from smells to tastes or from pains to cramping or as emotional feelings such as happiness or fear. They can have more than one feeling at the same time.

If you experience this, how do you know the pains you begin to feel aren't your own pains? Two good clues are 1) experiencing a feeling (or pain) you don't usually have and 2) the pain goes away after you give the message to the person.

Intuition Network
Dr. Mona Lisa Schultz says we are all intuitive. She says that we all have a brain: a right hemisphere, a left hemisphere, a temporal lobe. We all have dreams. Therefore we are all intuitive.

When intuition comes, the brain releases endorphins and neuropeptides to all nerves, blood vessels the heart, the lungs, the GI tract and all other organs. A systematic organization of specific emotions is being transferred to specific organs in the body.

This, says Schultz, is our intuition network or intuitive guidance system. The right hemisphere is our intuitive receiver. The right temporal lobe is the heart of the intuitive network.

The temporal lobe is important to what we see, hear and dream as well as to intense emotions. It assigns meaning and significance to experiences. It tells us how we feel about something and what we ought to do about it.

Benefits of improved Intuitive Awareness

1. **Improved communications**
   When we learn to use our intuition in positive ways, a greater understanding of the motivations, thoughts, and feelings of others may result. This allows us to become more tolerant, accepting, and loving toward them.
2. **Unleashed creativity**
   Intuitive insights motivate us to grow closer to the creative source, thereby igniting our own creative spark and expression, which is the essence of our true self.
3. **Healing of others and ourselves**
   As we attune to the highest within ourselves and feel motivated to help humanity, we

open ourselves to the One Force and allow its healing energy to operate through us.

What place does Intuition have in kinesiology?
First we must acknowledge that the term 'kinesiology' covers a very diverse group of manual and non-manual therapies. Kinesiology is both an art and a science.

When asked to define kinesiology I say, "Kinesiology is the most holistic of all the natural therapies" or "Kinesiology is the science of energy balancing and is grounded in the study of anatomy and physiology".

Kinesiology uses muscles as monitors of stress and imbalance within the body.

Kinesiology enables people to detect and correct various imbalances that may relate to stress, nutrition, learning problems, minor injuries, and other issues they meet in their daily life.

Kinesiology is a communication tool that enables a person to assess and upgrade their performance in all areas of their life.

Some kinesiologies - educational or energy model
Kinesiologies like Touch for Health, PKP, Edu-K, Three-in-One Concepts fit an educational or energy model. In these kinesiologies, the concept of facilitation of the client on a journey is to the fore.

The ICPKP logo incorporates the essence of this kinesiology: Learning, Growing, Embracing Life. In these client-centred kinesiologies intuition, the process is free-flowing because their protocols include more involvement of the client in the balancing process. The combined intuitive networks (client and kinesiologist) are involved.

Some kinesiologies use the medical model
Other kinesiologies are very much in the medical model. In this model the practitioner decides what is wrong (out of balance) and sets about make corrections with little or no active participation or awareness on the part of the client. In this group I include: Structural Kinesiology, Applied Kinesiology, from which kinesiology as we know it grew, Applied Physiology, Kinergetics and N.O.T. In these practitioner-centred kinesiologies, the kinesiologist is in charge - but they can still make intuitive leaps.

The science of kinesiology (regardless of the stream) includes a protocol (procedure) which is followed. However, many of you will have experienced balances where the kinesiologist 'knew intuitively' what your issue was all about - and they were coming from their own 'stuff' and were entirely 'up the wrong tree'. As David Myers says, our intuition can be way off the mark.

The discipline of kinesiology means being prepared to work by the structure of a protocol (or procedure sheet) and within that, allowing your intuition to flow and develop.

Many times I have taken a history, and known exactly what was going on. Next I have performed several pre-tests and pretest activities and proven that I am absolutely right.

However, I then find that the finger-modes that show are not the ones related to the pre-tests I have done. The client's innate body wisdom is following a different pathway than I would have explored either based on 25+ years experience or intuition.

The art of kinesiology involves a humbleness of spirit which acknowledges that the client's body memory has more information than the client has told me, or I have observed and then to allow the 'person' to direct the balancing process.

Intuition is allowed to flow within the 'modes' that show. However, it is not just the practitioner's intuition, especially if we ask the client of an emotion, 'What does that mean in you life right now?" and of age recessions "Why do you think the body went back there?" or "Why do you think the body opened that old file?".

The client's intuition is especially strong during ESR when we use dialoguing skills like "making it up"; if our client is age recessed into the genealogy – a great grandmother, for instance. Many clients are amazed to later find that the story they 'made up' turns out to be very close to what happened to this distant relative.

We ask clients, "What is your awareness", or " What is the relevance of then to now" or "How will you be different now that you are no longer holding that stress from age 7" or "In what way will your behaviour change in the future".

Each time we do this, we are creating new awareness pathways that strengthen the client's intuitive awareness. Each time we ask a question that leads to a client gaining important awareness, we strengthen our own intuitive processes.

It is OK not to feel intuitive
Kinesiology can be practised by someone who thinks they have no intuition. However, we say in PKP, "Do the process, trust the process, because the process works".

But, you say, "how could the mode for breast lymph release possibly be related to the balance I am doing on this 19 year old with typing and spelling difficulties". Yes, that happened to me. And I asked that question too. I was so 'sure' it could not be that I handed over the balance to my wife, Joan, to continue. As she did the breast lymph release, out came the story of being first girl in the class to develop and the mortification of uneven breast development being giggled over by classmates as she stood at the from of the class doing a spelling test. What was the outcome? Next day, the girl's typing went from under 20 words a minute to over 40/ minute with over 95% accuracy.

I use intuition within the PKP protocol
I have learned to trust the intuitiveness of the finger-moding process even when the client is "blank" in relation to a mode. I now can trust and say, "So one scenario could be .... How does that sound?"

If my intuition is "on", they get awareness. If not, they can say, "No, that's not it" and either they or I, or between us, we intuit another scenario they can play with.

Taking turns at being creative in this context helps both the Kinesiologist and the client access their intuitive network as both are on the same network.

What about a finger mode for Intuition?
Yes, Here is. Self #14b

How do we use Self #14b?
When the mode shows, you have options as to how to proceed.

1. You can use one of the following five lists to help the client gain insight:

   a) The seven emotional centres from Dr. Mona Lisa Schulz's book *Awakening Intuition.* Schulz looks at the balance between power and vulunerability.

   b) When you need to make a decision. A checklist from psychologist, Penney Peirce's book, *Maintaining Open Intuition: A Checklist for the Future.* Get this book.

   c) Making an Intuitive decision. The five decision making steps in psychologist, Gary Klein's book, *Sources of Power: How People Make Decisions.*

   d) When you need personal guidance. A second checklist from psychologist, Penney Peirce's *Maintaining Open Intuition: A Checklist for the Future.* Get this book.

   e) The seven tips for improving intuition in Penney Peirce's *The Intuitive Way: A Guide to Living from Inner Wisdom.* Get this book.

2. Use the PKP protocol from the last page of this paper.
3. Combine any or all of the above as you wish!

Five Helpful Lists

a. The seven emotional centres

The seven emotional centres from Dr. Mona Lisa Schulz's book *Awakening Intuition.* Schulz looks at the balance between power and vulnerability. Test to find the involved centre. You will need her book.

b. When you need to make a decision:

1. Feel for your body's subtle truth and anxiety signals.
   - Do you feel contracted, cold, repulsed, off center, or dense?
   - Do you feel expanded, warm, bubbly, leaning forward, or perfectly aligned?
2. Trust your 'first thoughts' and pay closer attention to events and commentary that arise unsolicited from your own mind and in the environment around you.
   - What is the slightly cloaked message that's trying to get through to you?
3. Practice 'direct writing', pretending to be someone you admire, an expert, an old wise person, or your 5-year-old self.
   - What do these aspects of you have to say about the situation?
   - How do they feel about various solutions?
   - Ask for their opinions.
4. Think about your need to solve the problem and program yourself before sleep to have a dream that will give you insight.
   - What does your deeper consciousness associate with a successful resolution and the experience that would come as a result?
5. Use your nondominant senses to find hidden aspects of the issues you're dealing with.
   - Pretend the various solutions are kinds of odors, sounds or music, tastes, textures, or temperatures.
   - What visceral experience does the response generate in you? Which ones do you lean toward?
6. Invite colleagues to try any of these techniques with you as a group.
   - When the results are in, ask them to help interpret, too.

Adapted from: *Maintaining Open Intuition: A Checklist for the Future* by Penney Peirce

c. Making an intuitive decision

Cognitive Psychologist, Gary Klein PhD who interviewed firemen, nurses, and others who are paid to make up their minds in just seconds, says in his book, *Sources of Power: How People Make Decisions,* 'People are afraid of making decisions because they're trying to find the perfect answer, and there is no perfect answer'.

People make decisions in one of two ways:

a. they analyze the pros and cons
b. they go with their gut instincts.

When making a decision, Klein recommends a combination of several methods, in this order:

1. Get in touch with your gut first.

Remember, once you start listing pros and cons, your rational mind will drown out your intuition.

Check your body language – discomfort could be warning you off.

e.g., Ponder that new job – think about the way you were treated at the interview and it may colour your reaction.

You can even flip a coin to uncover your intuitive point of view. It is not meant to make the decision for you, but to gauge your gut reaction to the result.

How do you feel when one option drops out?

If you're disappointed, ask yourself why.

2. Open up the options and visualize each one.

Doing research is obviously valuable. However, the fear of making a mistake can keep you researching beyond the point of productivity.

On the flip side, the hunger for the relief of making a decision, any decision, can keep you from doing enough legwork. Brainstorm a lot of options.

Think creatively about combining the best pieces of each one by compromising or going the whole hog, e.g.,you could buy both the red and the black sweater.

3. Banish vague fears, such as 'It may be a mistake'.

Instead try to see yourself in specific scenarios.

Ask questions about each possible outcome. Visualize how each option would turn out. Ask:

What's the worst that could happen?

What would I do then?

Could I live with that?

4. Let go of the idea of the perfect answer.

You cannot possibly get all the info, nor can you foretell the future and calculate all the risks.

Chill out. 'The harder a decision is to make, the closer the outcomes are to each other, and the less it matters.'

There is never a guarantee that you're making the right decision. Just accept that.

5. Trust yourself.

Examining your decisions after you've made them helps improve your intuition.

Ask yourself whether you would do it the same way again.

Adapted from: *Sources of Power: How People Make Decisions.* Gary Klein PhD

d. When you need personal guidance:

1. Practice "direct writing" by phrasing the question carefully, then answering from your Soul's point of view, or imagining a spiritual teacher is addressing you.
   - What does the higher part of you already know about the issue?
2. Keep a journal to explore and track the meaning of your dreams and waking reality.
   - What is the deeper meaning in the daily events in your life?
3. Look to your night dreams and daydreams for underlying themes.
   - Is your inner consciousness preoccupied with something that your waking mind overlooks?
4. Watch for synchronicity and omens as a sign of flow or blockage; learn to correlate your inner and outer realities.
   - How can you dissolve the boundaries between yourself and the world, and thus become One?
5. Stop trying, shift out of your head and willpower, and do something involving your senses.
   - How do you feel when you let yourself "indulge" in and be absorbed by a physical experience where your mind isn't in control and where you lose track of time?
   - What comes to mind right after that?
6. Ask for help - from the unseen realms, and from those around you in the physical world.
   - What comes to you soon after you ask?
7. Form a council of people and ask for their first thoughts and gut impressions.
   - How do they interpret their cluster of answers as parts of a more comprehensive response?

Adapted from: *Maintaining Open Intuition: A Checklist for the Future* by Penney Peirce

e. Seven tips for improving your intuition

1 a)Learn to identify your prevailing beliefs, judgments, and attitudes about the way the world works and who you think you are, or ... how it "should" be—and ...

b) be able to suspend those ideas temporarily. Maybe there are other ways to be!

c) Maybe life could teach you something new if you let yourself become innocent, like a child again—with "beginner's mind."

d) Make space for surprises.

2 a) Become friends with your feelings. Just as there is no such thing as failure—there's only feedback—there are no "bad" emotions. Emotions are simply energy and information coming from your body.

b) Be willing to experience every feeling that emerges in your body, without labeling it (I'm angry) or putting a value judgment on it (anger is bad).

c) Just notice and describe the physical sensations of expansion or contraction, hot or cold, density or lightness, and let them move through your body and evolve to their next level of expression.

d) Intuition percolates up from the body via sensation and feeling—nonverbally. Don't block or distort that flow in any way. Eventually it will turn into an Ah-ha!

3 a) Remember to consciously pause between actions. Throughout the day, remind yourself to drop into the here-and-now and feel the world from your body's simple perspective.

b) Be with what's happening in each present moment, without needing to shape, change, or vote on it. It is the way it is. Life is proceeding in harmony. There's something "just right" about each situation.

c) Life is comprised equally of masculine (doing) and feminine (being) energy and awareness. Make sure you have a balance of both.

4 a) Cultivate the habit of appreciating and acknowledging yourself and others for good deeds, successes, uniqueness, and beauty.

b) Speak words that benefit others and the world—what you're interested in rather than what you dislike, what you're actually doing instead of what you don't want to do, how you choose to be rather than how others prevent you from being.

c) Notice what's right with the world. Intuition flows when you see the glass half full rather than half empty.

5 a) Develop the "warrior's attention." Like a great samurai, be alert and present 100%, in each moment, and 360 degrees around you.

b) Be ready to act, without any biases.

c) Practice "engaged indifference."

6 a) Learn to check with your body and your "reptile brain" to see what you instinctually want to do next.

b) Don't assume that once you've decided, the choice will last forever. The currents of insight and creativity can shift and weave into new pathways in the twinkling of an eye.

c) Check in many times throughout the day, "Now what feels right? Am I totally comfortable, at the deepest level, with this course of action?" Intuition occurs in the NOW, in the body, and what's true always has "juice."

7 a) Let go of needing things to be nailed down in advance. You can still have a vision and goals, you can still make plans, but let it all be fluid. Visions and plans evolve constantly.

b) Affirm to yourself: "I know what I need to know exactly when I need to know it." In any given moment, there's just one piece of information, one urge, one action, that's a perfect fit.

c) Develop trust in your own higher awareness to bring you pertinent and accurate insights in a timely way.

d) Act on the information you get and thank yourself for planting the right curiosities, motivations, insights, and physical reactions in your mind, in a way that directs you effortlessly to your next step.

Taken from: *Penney Peirce The Intuitive Way: A Guide to Living from Inner Wisdom,* Beyond Words: 1997

Self #14b
Intuitive Awareness

Dr. Mona Lisa Schultz MD PhD claims we are all intuitive. She says that we all have a brain: a right hemisphere, a left hemisphere, a temporal lobe. We all have dreams. Therefore we are all intuitive. When intuition comes, the brain releases endorphins and neuropeptides to all nerves, blood vessels, the heart, the lungs, the GI tract and all other organs. A systematic organization of specific emotions is being transferred to specific organs in the body.

This, says Schultz, is our intuition network or intuitive guidance system. The right hemisphere is our intuitive receiver. The right temporal lobe is the heart of the intuitive network.

The temporal lobe is important to what we see, hear and dream as well as to intense emotions. It assigns meaning and significance to experiences. It tells us how we feel about something and what we ought to do about it.

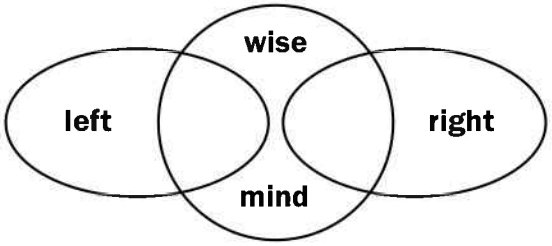
When we dream, brain activity shifts. Scans show that the frontal lobes, which are most active when we are awake, shut down and the remainder of the brain (especially the right temporal lobe) lights up.

This, claims Schultz means that the critical analysis and judgement centres on the frontal lobes of the brain are no longer over-riding other brain activity with messages such as "you can't do that" or "that's not possible" as soon as they perceive non-logical, non-rational insights or awarenesses. This why 'sleeping' on a problem often provides a solution in the morning.

We also need to remain aware of the need for integrated brain activity. We all know that the left hemisphere is logical and rational and that the right hemisphere is intuitive and emotional. To get correct answers to questions, the left hemisphere takes the long path of a series of logical steps. The right hemisphere uses hunch and trial and error. Perhaps surprisingly, the latter (which is more intuitive) is the fastest, especially in emergency situations.

Neither hemisphere is better than the other, and it certainly would not be wise to just work from the right hemisphere. We would be full of emotion and intuition but unable to talk about it or put it into an intelligent framework. Equally as bad is the dominant left hemisphere denying the value or input of the right.

Psychiatrists use the expression "wise mind" to describe the balanced state where both brain hemispheres work in tandem.



True geniuses have a more fluid partnership between the hemispheres than most people. This is important because the left hemisphere tends to pick up on positive words like love, joy, happiness and cheer while the right hemisphere picks up negative-toned ones.

We live in a left hemisphere dominated lifestyle. Developing right hemisphere activity is healthy and healing. However, over-activity of the right hemisphere leads to the state of borderline personality disorder where the person is paralysed by their emotion and intuition.

Here the client's intuition may say, 'I want to die, my life is over' and the person may say 'why can't I just go with it and follow my gut feeling and go with my intuition?' They are lacking the balance of the rational mind, the left hemisphere.

Our next consideration is that ESR, which we traditionally have said is increasing the blood flow to the 'new light' centres in the front brain, is probably decreasing front brain activity and allowing right brain intuitive creativity to flow without the usual paralysing critical, judgmental analysis. We are getting the right result but not for the reason we thought we were.

Evaluation:

1. Check for which hemisphere is over-active and which of the following is involved:
   a) Left hemisphere over-activity (commonest)
      i. acknowledge you have intuition
      ii. tap into your intuition
      iii. listen to your intuition
      iv. honour your intuition
      v. trust your intuition
      vi. act on what your intuition is saying.
   b) Right hemisphere over-activity
      i. acknowledge need for 'common sense'
      ii. acknowledge need for logic and reason
      iii. acknowledge need for systems & protocol.
2. Find the emotion involved.

Balance: (for left hemisphere over-active)

1. Do an integration balancing activity from your 'flavour' of Kinsiology. e.g., ESR or F/O hold.
2. Help the person find awareness, resolution, recognise their trigger factors and plan a strategy.

Balance: (for right hemisphere over-active)

1. Do an integration balancing activity e.g., Cook's hook-ups, R-L polarity, switching etc.
2. Or, put all in circuit and DD with age recession etc.

Checking the changes:

1. Mode and emotion are clear.

   (There will be homework. This is not a once-only thing.)

Notes:

SCHEDULE
Friday, July 15, 2005

Speakers:

Understanding Switching by Charles Krebs

Brain Formatting by Hugo Tobar

Using Emotions to Balance the Heart by Wayne Topping

Transforming Relationships by Mary Jo Bulbrok

Kinesiology Research by Susan Hall

EFT: Emotional Freedom Techniques by Gary Peterson

The Biology of Perception by Sheldon Deal

Understanding Switching in the Body and the Brain
What Does It Mean?

by Dr. Charles T. Krebs

Abstract
The concept of *switching* has been around in kinesiology since its early days, but few kinesiologists have an in-depth understanding of either the nature of switching or the different types of *switching*. The original concept of switching came from Applied Kinesiology or AK. In the AK model, *switching* was perceived as neurological confusion, usually related to cranial imbalance. In later Kinesiologies, *switching* was perceived as a polarity problem so that when switching was "on-line," there was a reversal of the body's polarity, and this reversal of polarity led to a reversal of signals sent out to the body, and a reversal of mental orientation. So if a person was switched, they would often point to the Right as they said turn Left. Likewise, when a muscle on the top part of the body was sedated, it would switch off the homologous muscle (muscle that does the same function) in the lower part of the body.

From a neurological perspective there are two distinct types of switching: 1) A cortically based Projection Switching, and 2) A brainstem-limbic based *Survival Switching*. *Cortical Projection Switching* is more superficial and results from "stress," either physical, emotional or mental stress, causing a reversal of the output of cortical processing such that sensory input correctly processed in a specific cortical area is then "projected" to the wrong, and usually opposite part of the body; or the brain reverses its orientation relative to the body, e.g. confusing right and left. This *switching* is normally transitory, and only exists for the duration of the stress, e.g. you're very tired one day and *switched*, but well rested and not *switched* the next; or the emotional situation stressing you one day has been resolved the next day so you are no longer *switched*.

In contrast, *Survival Switching* is a much deeper level of *switching* caused by psycho-emotional factors that exceed your personality's ability to cope. You cannot live long in a non-coping state, so the subconscious must do something to survive psycho-emotionally. It must somehow reduce stress levels to allow your personality to cope with your life's circumstances once more. This *Survival Switching* occurs deep in the brainstem and limbic areas involved with survival, and since these areas are totally subconscious, we are unaware of their existence. However, once a survival program has become *switched*, it totally controls our overt behaviour, particularly in stress situations, because the survival system neurologically fires first before conscious cortical areas are activated.

How these types of switching can be accessed using Kinesiology, what they are neurologically and what they mean behaviourally is fully discussed below.

Introduction
The concept of *switching* or neurological confusion in body and brain processing was originally developed by Dr. George Goodheart in Applied Kinesiology (AK). Even though the *switched* behaviours have been observed for a long time, there had been no coherent explanation for these "confused" behaviours. For instance, all kinesiologists are familiar with the phenomenon of someone saying – "Turn right!" while pointing vigorously to the left, or when you ask the client to lie down on their back and they lie down on their stomach instead, thinking they are doing exactly what you asked them to do. These are clearly confused *switched* behaviours.

From the perspective of AK, this neurological confusion was the result of cranial faults that then perturbed the neurological flow to or from the brain. When the cranial fault was corrected, the associated *switching* was observed to disappear in most cases. In later Energetic Kinesiologies, switching was considered an energetic polarity reversal that then resulted in neurological confusion. When this energetic reversal was corrected by stimulating specific acupoints, such as Kidney 27s, the associated *switching* disappeared, and the person would now say, "Turn right!" and point to the right.

It was not until the late 1980s that a new concept of *switching* appeared. Hap Barhydt proposed that there was a deeper level of switching associated with the phenomenon of "transposed hemispheres." With "transposed hemispheres" people demonstrated Logic functions in the right hemisphere and Gestalt functions in the left hemisphere. This is the opposite of the majority of people whose Logic linear, sequential and analytical functions are located in the left cerebral hemisphere, and Gestalt visuo-spatial, simultaneous and global functions are located in the right cerebral hemisphere. However, in the 1980s many Edu-K practitioners, including myself, observed that up to 30 % of people with learning problems demonstrated a transposition of the location of Logic and Gestalt functions as determined from muscle monitoring.

This was puzzling to me, as based upon my research, only non-right handed people, that is ambidextrous and left handed people, have truly transposed Logic and Gestalt functions. Non-right handed people actually do have their Logic functions predominately located in their right hemisphere, and their Gestalt functions predominately located in their left hemisphere, and thus do test as having "transposed hemispheres" from the perspective of the majority, the right handed people. All right handed people, 90% of the population, have Logic left, and Gestalt right. From neurology we know that only 10% of the population is non-right handed and only 2% to 3% of the population have their language centres located in their right cerebral hemisphere. So how could kinesiology show 20% to 30% of children with learning problems to have transposed hemispheric function?

What Hap had discovered is that when he corrected switching in a novel way – by holding the AK Law of Five Elements Navel Mode, that is holding all five fingers around the navel, and then simultaneously rubbing the traditional electromagnetic switching points, Kidney 27s for Right-Left Switching, Governing Vessel 26 and Central Vessel 24 for Top-Bottom Switching and Governing Vessel 1 and Central Vessel 8 for Front-Back Switching, the apparent "transposed hemispheres" suddenly reversed and were now "normal" with the Logic left and Gestalt right. He termed this new type of *switching*, Deep Level Switching, as it was clearly a different type of switching from the more superficial confusion of orientation. Also, normal Superficial Switching was usually transitory, being present during states of stress, but absent other times, and for most of the people being absent most of the time. In contrast, this Deep Level Switching was very persistent, and would be present constantly over time until it was corrected.

When I applied Hap's new Five-Finger Quick Fix to my clients demonstrating Deep Level Switching, indeed all except a small percent suddenly showed reversal of the location of their Logic and Gestalt functions. With few exceptions, children demonstrating this Deep Level Switching usually showed the most severe Specific Learning Disabilities (SLDs), and a common pattern of developmental delay. Most of these children were delayed in the development of language to some degree, took longer than average to understand the concepts of time and colours, and usually had difficulty with concentration, staying on task, and problems with maths. Furthermore, when I made kinesiological corrections, these corrections very often did not "hold" and had to be repeated a number of times, and then were often still not stable. In contrast, other children with similar SLDs, when treated with exactly the same corrections, consistently held these corrections and progressed normally through my LEAP program for correcting SLDs.

I then discovered another way of activating this Deep Level Switching using Applied Physiology formatting, and found when this was entered into circuit and corrected by identifying the underlying psycho-emotional issue and causal age, which was usually between one and a half and five years of age, this Deep Level Switching disappeared in the "clear" and did not return except in a small percentage of cases. Once this Deep Level Switching was corrected, these children then progressed normally through the LEAP program; so clearly correcting this Deep Level Switching was important for long-term results with these children. I also observed the same phenomenon with adults who had difficult issues that just did not resolve with my usual treatment procedures – with few exceptions, these people demonstrated Deep Level Switching, which once resolved, permitted on-going resolution of their original problems.

But what is this Deep Level Switching and why did the person's subconscious create this "problem" in the first place? The answer to these two questions and a full understanding of the phenomenon of switching has taken the last twenty years of my life.

The Neurology of Switching

As pointed out above, switching comes in two distinct forms: Superficial Switching and Deep Switching. However, the neurological substrates of these two types of switching are totally different, as are their effects upon your function and behaviour.

Superficial Switching:

Superficial Switching results from how the brain processes sensory information. All sensory input starts as a nerve impulse at a sensory receptor, and then goes via the peripheral nerves to the dorsal root ganglia of the spinal nerve just outside the spinal segment receiving that spinal nerve. From there the axons of the dorsal root ganglia go up the spinal cord to the thalamus. Relay neurons from the thalamus send the nerve impulse to the area of the cortex, which then processes these impulses and turns them into a conscious perception of that sensory experience. However, this conscious perception is not perceived as being located in the head, but rather is "projected" mentally back to the receptor that originally fired.

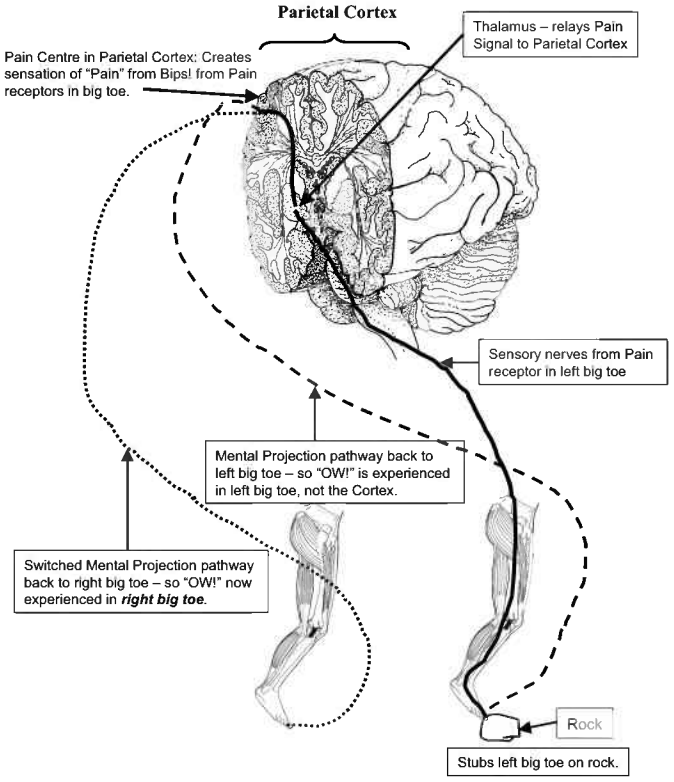
To understand sensory processing, you first have to understand that all nerve impulses are identical no matter what receptor creates them. Thus, the Bip! (sound of a nerve impulse) of the photophore in the retina, the Bip! of the hair cell in your inner ear, or the Bip! of a pain receptor in your toe are the same until they reach the primary sensory cortex where each Bip! is then interpreted as the type of sensory experience processed by that part of the cortex. Thus when a Bip! arrives at the part of the parietal cortex processing pain, the conscious experience is "pain." So pain Bips! go to the pain association cortex of the parietal lobe and elicit the conscious sensation of pain.

A simple example will clarify what may seem a very complicated system. When you are walking along and suddenly stub your left big toe on a rock, the nocioceptors (pain receptors) in your big toe fire a stream of nerve impulses up the peripheral nerves to the spinal nerve where the Bip! Bip! Bip! is relayed into the spinal cord and up the spinal cord to the thalamus of the brain, from which the Bip! Bips! are once again relayed to the association area processing pain in the right parietal cortex. It is only in the parietal cortex that the OWWW!!! – the pain of stubbing your toe – actually exists. However, people do not say, "OWW!, OWW!, my right parietal cortex hurts," but rather, "OWW!, OWW!, my left big toe hurts!"

Why? Because the OWW! is "projected" mentally back to the pain receptor in the big toe that created the Bips! in the first place. The same is true of all other senses. So when I look at you, the "you" I see out there is merely a "projection" of the "you" created in my occipital cortex from Bips! from my retinal photophores (light-sensitive cells).

This is the basis of Projection Switching. Information enters the brain from a receptor, is delivered to the correct cortical association area to be processed, is processed correctly to create the conscious perception, but is then incorrectly projected to the wrong place in the body, or the wrong place with respect to the body orientation. For example, I mean to tell you turn right, and when I mentally referenced my body orientation, my right was correctly referenced as my right side, but due to a polarity reversal in my orientation, I find my mouth saying, "Turn left!". I may immediately recognise my error, or be totally unaware I said the wrong direction. (See Figure 1 below)

Figure 1. Schematic Diagram of Projection Switching. Note solid line is nerve pathway to cortex, and dashed lines are Mental Projection pathways back to receptor: — Normal; ……*Switched.*



An excellent real life example is the following: I was once sharing a house with several people, and one morning one of my housemates came out of her room and said, "Charles, this is really strange. I've just woken up. I can see from the welts on my left arm that I have been sleeping on my left arm, but it feels normal. It's my right arm that is asleep. How the hell could that happen?" I told her to massage her Kidney 27s, which she said were indeed tender, until the sensitivity disappeared. This took only 30 to 40 seconds. She then said, "This is weird! As the tenderness of the points disappeared, suddenly my right arm felt normal and now my left arm has needles and pins."

What this demonstrates is the true nature of brain function, which is to project back to the source of stimulation the nature of the experience the brain is having. In this case the sensory receptors in her left arm were sending a stream of impulses to areas in her right parietal cortex that then interpreted this as a feeling of needles and pins. In the normal course of events, it would have correctly projected this sensation back to her left arm. But due to confusion on the part of the brain, a polarity reversal, the signals of the feeling were switched and projected to the wrong side of the body; so she was consciously feeling the sensation in the wrong arm.

This illustrates how the brain references itself and may become confused with respect to itself. Right becomes left, top becomes bottom, and front becomes back and vise versa. A sensation coming from here is perceived as coming from another place. In fact the brain creates its own reality from the sensory information it receives. Its creation may be true to the world of the sensory input, or it can just as easily be an illusion based on its confusion.

A well-known phenomenon that exemplifies this propensity for illusion is the case of the "phantom pain" in amputated limbs. People who have lost an arm or leg will often still feel sensory events in that missing limb. One of my clients, who had lost his left leg above the knee, was still feeling pain in his left foot. The nerves that had gone to his left foot were clearly still firing sensory information into his brain after the amputation, perhaps due to the physical trauma and the scar tissue formed in the stump of his leg. His brain then correctly projected the "pain" back to where the pain receptors of his missing foot used to be, the original source of nerve impulses in that nerve; but because the foot was no longer there, this pain appeared to be only an illusion of pain – hence the name "phantom pain." When I used kinesiology to locate the active acupoints on his stump, and balanced them, his phantom limb "disappeared," probably because the "stress" of the trauma or scar creating the stream of nerve impulses to his parietal cortex ceased.

While it is important to recognise and rectify Superficial Switching because it perturbs the responses, or "answers," the body gives a kinesiologist through muscle monitoring, it is usually a transitory state of confusion that will correct itself over time. Clearly if I want to muscle monitor you right now, and you are switched, I must clear this switching to get clear and correct responses from your body. However, there is an even deeper and more profound type of switching that went unrecognised until discovered by Hap Barhydt in the late 1980s, and which has been extended and developed further by myself since that time – it is known as Deep Switching.

Types of Deep Switching

In the introduction I described one type of Deep Switching, Deep Level Switching discovered by Hap Barhydt. From further investigation and research I discovered where this Deep Level Switching occurred in the brain, and that this was but one type of Deep Switching. A discovery by Ian Stubbings, the developer of the Stress Indicator Point System, allowed me to understand that Deep Level Switching represented only a specialized case of Deep Switching that occurs as a survival response from deep within the brainstem and limbic system.

Ian discovered that a Circuit-localisation of Central Vessel 10 (CV 10) when active, that is gave an Indicator Change when Circuit-located, was always associated with one or more of the dimensions of Superficial Switching. Thus, when CV 10 gave an Indicator Change, and this was entered into Pause Lock or Circuit Retaining Mode, then one or more of the traditional switching points would give another Indicator Change, indicating that this type of switching was present. For example, if CV 10 was active, and Pause Locked, and then Kidney 27s were Circuit-located, and there was a reciprocal Indicator Change, this indicated confusion about the Right-Left dimensions of the body, which is normally associated with reversal of directions or reversal of letters when writing. Likewise, when CV 8 and GV 1 gave an IndicatorCchange, there was confusion about the Front-Back dimension with people lying down on their stomach when asked to lie down on their back. And when a Circuit-localisation of GV 26 and CV 24 gave an Indicator Change, there was confusion about the Top-Bottom dimension, with people often lifting their arm when asked to lift their leg, and some letters often written upside down.

While I had an effective way of checking for Deep Level Switching using AP formatting, it was a bit complex to explain to people who did not have an AP background. So in my first ever LEAP workshop in Melbourne in 1994, I was having difficulty explaining to the students how to test for Deep Level Switching. A strange phenomenon is that when you mention switching in a class, many people immediately switch, and then trying to explain switching to a switched person is very difficult as they are mentally confused! Fortunately Ian Stubbings had attended this workshop, and he suggested that since CV 10 when touched normally indicated that one or more of the 3-dimensions of switching was active, then perhaps deep touch on CV 10 would show when Deep Switching was present. Indeed it did, so now instead of the lengthy AP formatting procedure to check for Deep Level Switching, you could simply apply Deep Touch to CV 10, and an Indicator Change indicated this type of switching was present.

The use of Deep Touch on CV 10 to check for Deep Switching did two things. First, it now made checking for Deep Level Switching far easier; and second, it showed me that Deep Level Switching, this transposition of the location of Logic and Gestalt functions, was not the only type of Deep Switching in the body. Now I suddenly realised that there could be four types of Deep Switching. Not only was there the Deep Level Switching discovered by Hap, but there could also be Deep Switching in the 3-dimensions observed in Superficial Switching as well! Thus, there is Deep Top-Bottom, Deep Front-Back and Deep Right-Left Switching as well as Deep Level Switching.

But what did these different types of Deep Switching mean? And where in the brain did these different types of Deep Switching occur? Little did I know that an understanding, and probably only a partial understanding, of these two simple questions would take me over a decade to grasp.

Deep Level Switching: What It Is

As discussed above, Deep Level Switching is the confusion of the location of Gestalt and Logic functions in the brain. Incoming sensory data and information can be of two basic types: linear, se-

quential data, or simultaneous, global data. Depending upon the type of data-stream, the information is directed to either the areas of the brain performing the Logic functions that process linear, sequential data, or to the areas performing Gestalt functions that process global, simultaneous data. So when Deep Level Switching (DLS) is present, incoming data is routed to the wrong areas of the brain for efficient processing – the linear, sequential data stream is sent to the Gestalt functions and the global, simultaneous data stream is sent to the Logic functions.

As an analogy, it is as if there are huge cables, one carrying all the Gestalt information to the Gestalt processing centres and one carrying all the Logic information to the Logic processing centres. With DLS it is as if these two cables have been switched and all the Gestalt information is routed to the Logic processing centres and vice versa, resulting in massive confusion in all mental processing.

Using this analogy, in normal processing Logic information goes to the thalamus, and then is relayed straight into the appropriate Logic processing centres, where it is processed, and the decision or answer is sent out to be acted upon. If DLS is present, the Logic information is sent to the Gestalt processing centres instead, which then gives the brain two choices: 1) to send it across the Corpus Callosum (CC) to be processed in the appropriate Logic centre in the other hemisphere, and then sent back to the Gestalt centre before being sent out to be acted upon; or 2) to attempt to process the Logic information in the Gestalt processing centres, which is very inefficient and highly stressful. If the CC is fully accessible, the subconscious will make choice 1) and only incur a time-delay in processing. On the other hand, if the CC is "blocked," then the brain has only choice 2) available, creating inefficient and stressful processing in the wrong hemisphere. Many people with serious learning and performance problems do indeed display both DLS and a "blocked" CC.

A major consequence of this profound confusion in subconscious processing is poor development of both Gestalt and Logic functions, often resulting in language delay and severe deficits in many areas of functions. Another equally important consequence of this deep-seated confusion is that all kinesiological corrections performed to rectify these performance problems will often "not hold." DLS appears to "undermine" all this good work and little change is observed in the original problem, even after many hours of treatment by perfectly competent practitioners.

Deep Level Switching: Where It Occurs in the Brain

For a number of years I did not know where DLS occurred in the brain, but it most likely had to be at the level of the Thalamus, because for the in-coming data stream to be analysed as either linear or simultaneous, it could take place only at this level. For it is the Thalamus that relays all incoming sensory data to the cortex, and thus it would seem it must be here that DLS created the confusion in processing. But where in the Thalamus? This remained unclear until very recently.

Reading a paper on the Thalamic Nuclei, I came across the probable location of DLS. I say probable, because until I can show via brain scanning that this is true, the following discussion remains only a hypothesis, albeit a logical hypothesis. The Reticular Nucleus of the Thalamus is not part of the well-known Reticular Formation of the brainstem, but rather an integral part of thalamic processing. The Thalamic Reticular Nucleus surrounds the Thalamus proper, and is richly and reciprocally connected to the various Thalamic Nuclei. Of the many connections to the Thalamus, one type caught my attention. All sensory data, except smell, comes from the brainstem directly to the specific Thalamic Nuclei that then relay this specific sensory data to the cortex for sensory processing. For instance, all visual information goes from the retina to the Lateral Geniculate Nucleus, and then is relayed to the Primary Visual Cortex in the occipital lobes; likewise all somatosensory data relating to touch goes to the Postero-lateral Nucleus and is then relayed to the Primary Somatosensory Cortex in the parietal lobes.

However, the data is not just passively relayed to these cortical areas, but rather undergoes various types of thalamic processing before relay. One type of thalamic processing of sensory data is to send it out to the associated area of the Thalamic Reticular Nucleus where it appears the data stream is analysed not for content, but rather to identify the nature of the data stream – linear or simultaneous – and then the result of this analysis returns to the sameThalamic Nucleus that sent the data.

I propose that it is upon the basis of this data stream analysis that the receiving Thalamic Nucleus then relays the data to the cortical areas performing either Logic processing or to the cortical areas performing Gestalt processing. In other words, the Thalamic Reticular Nucleus determines to which hemisphere the data will go to be processed!

Clearly Right-Left Switching in the Thalamic Reticular Nuclei would result in DLS, as all linear, sequential data would now be sent to the Gestalt cortical areas for processing, and all global, simultaneous data would now be sent to the Logic cortical areas for processing – hence DLS. Now knowing the probable neural substrate for DLS, I chose to rename DLS, a fairly meaningless name, to Thalamic Reticular Switching or TRS to emphasise its neurological location.

The data stream entering the Thalamic Reticular Nucleus from its associated Thalamic Nucleus is sent directly back to the Thalamic Nucleus it came from, which then sends it directly out to the cortical area processing this type of data. When the linear sequential data stream enters the right Thalamic Reticular Nucleus, and is then returned to the associated Thalamic Nucleus, it is relayed to the cortical area linked to this nucleus. However, if the data stream does not match the type of processing in that cortical area, it is immediately sent across the Corpus Callosum to the homologous cortical area in the opposite hemisphere that does specialize in this type of data processing. This is the major data stream pathway from the Thalamic Reticular Nuclei to the cortical areas. However, there also exists a much smaller minor pathway from the Reticular Nucleus on one side directly to the same Reticular Nucleus on the opposite side by which data may also be transferred, providing some degree of compensatory processing.

Normally when working with specific types of information (e.g. a math problem), the information is either primarily Logic or Gestalt in nature, and hence the data stream entering both right and left Reticular Nuclei is linear, sequential or visuo-spatial, simultaneously. In these cases the Reticular Nucleus on the same side as the relevant cortical processing (e.g. Logic processing areas for maths) relays its incoming data stream directly to the cortical area processing this data. In contrast, the Reticular Nucleus on the opposite side assesses the nature of the data stream, and then relays this incoming data stream to the homologous cortical area in the hemisphere on the same side as the Reticular Nucleus. From here it is immediately transferred via the Corpus Callosum to the correct cortical areas in the opposite hemisphere, along with the data from the same side Reticular Nucleus, for processing (See Fig. 2B).

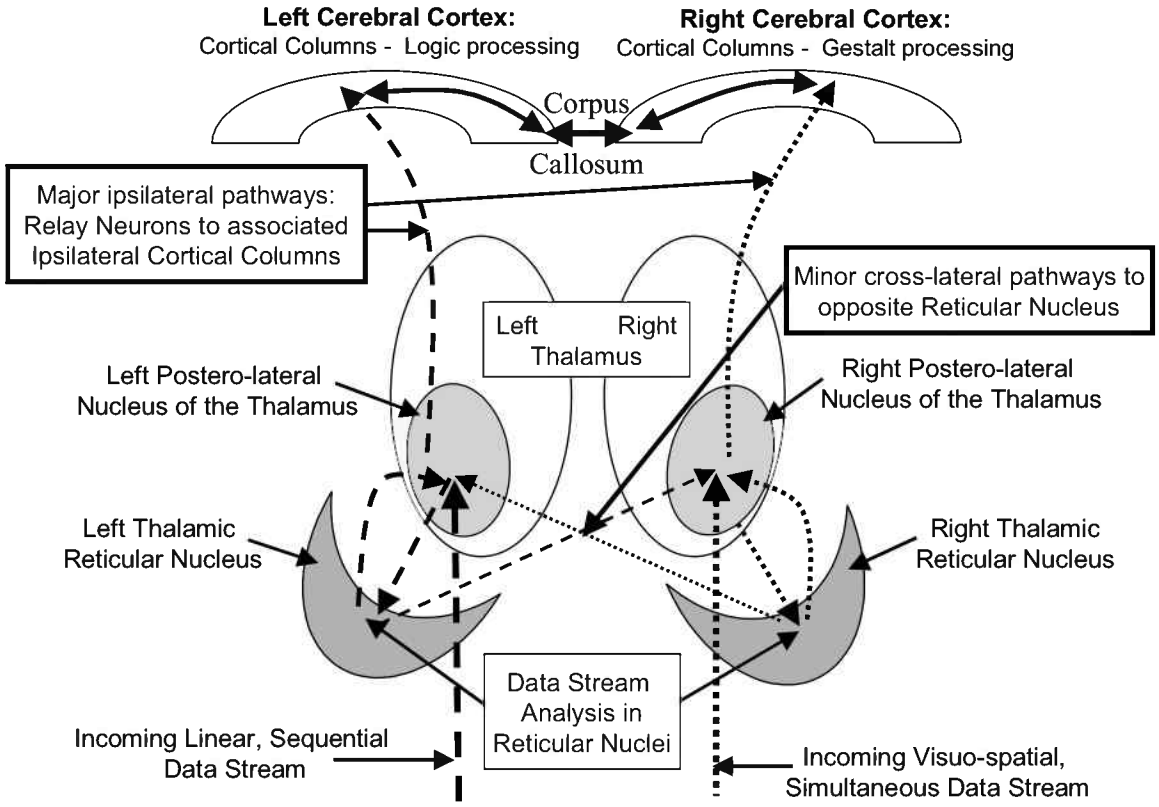


Figure 2A. Schematic Diagrams of Thalamic Reticular Processing of Incoming Linear-Logic and Visuo-spatial-Gestalt Data. Note the critical role of the Corpus Callosum in transferring data to the correct Cortical Area for processing.

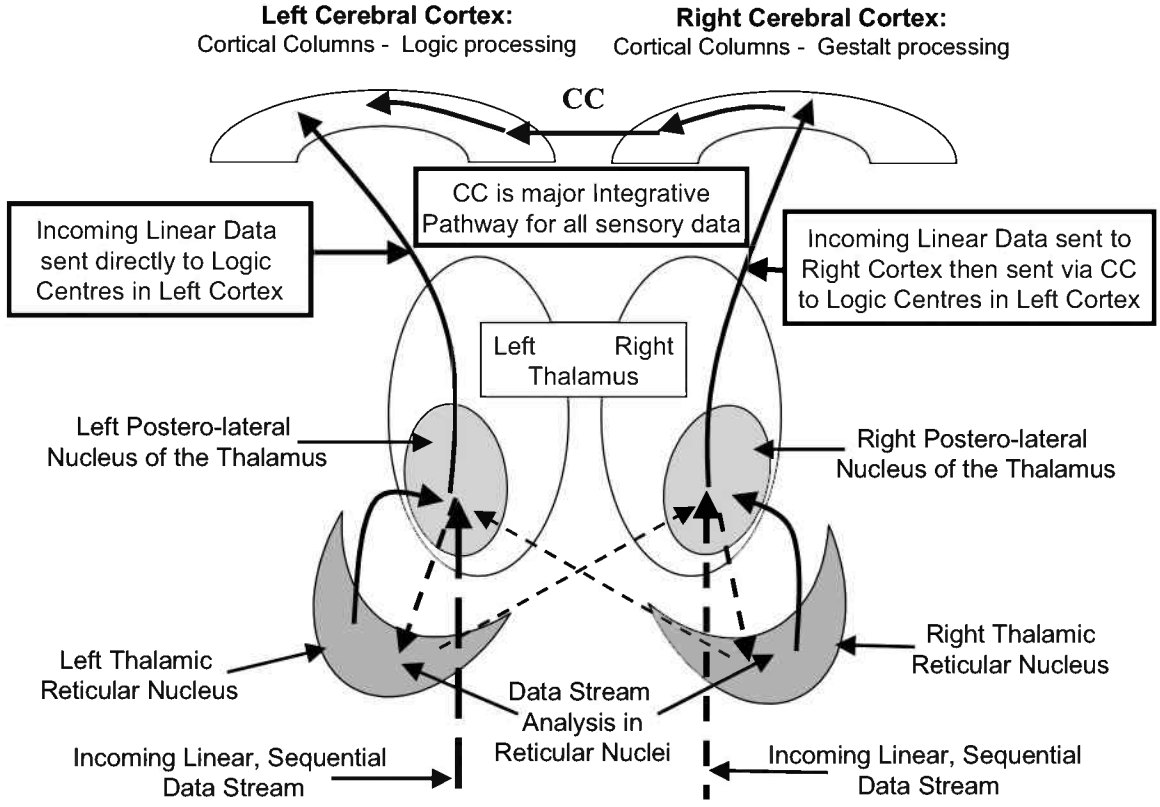


Figure 2B. Processing of Linear, Sequential Data by both Reticular Nuclei. Note that the linear data stream sent to the right cortical areas was immediately transferred via the Corpus Callosum to the Logic processing centres in the left hemisphere.

Therefore, when there is switching in the Thalamic Reticular Nuclei or TRS, the incoming data from one Reticular Nucleus or both Reticular Nuclei may not be sent to the correct cortical area for processing this type of data by the major pathway. Instead, because the major relay pathway is blocked this data may be sent directly to the opposite Reticular Nucleus by the minor pathway, and then relayed to the "wrong" cortical area for processing. This often results in major confusion and poor processing of the switched data.

Because there are both a right and a left Thalamic Reticular Nucleus, TRS may occur in two ways. The TRS may occur in both Thalamic Reticular Nuclei or only in one. If the TRS is in both Thalamic Reticular Nuclei, then there is a complete transposition of data such that both Logic and Gestalt data streams are sent to the "wrong" cortical areas to be processed (Fig. 3A.); and if the Corpus Callosum is "blocked" the brain just has to do the best it can to process the data in the wrong processing centre. This results in profound confusion of virtually all types of data processing, and usually results in delayed development of colour recognition and understanding basic Logic concepts such as relationship of numbers to each other (e.g. Which is bigger – 15 or 50?), or the sequence of the days of the week and months of the year, and often even delay in language development.

If, on the other hand, the switching occurs only in only one Thalamic Reticular Nucleus and the Corpus callosum is "blocked," then only the data from the switched side will be sent to the wrong side for processing. In these cases, the people appear to have one type of processing – either Logic or Gestalt – that is relatively "intact," but the other type of processing is very difficult or confused. Thus while the person may be very good with spatial relationships, they may be "hopeless" at math or vice versa, depending on which side is switched. (See Fig. 3B. & C. on the following page)

If the Corpus Callosum is fully open, either type of TRS may show little effect in overall processing, because the person can effectively compensate for the disturbed data flow by shunting the data from the wrong cortical processing area to the correct area across the Corpus Callosum. However, because there will now be more neural steps in this compensated processing, and each neural step takes real time, the person will be slightly slower than another person without switching processing the same data. In these cases because of the time delay, the person processes the information correctly, but just gets the correct answer slightly after other people with no switching have already gotten it.

Survival Switching and Deep Survival Switching

But what about the other three types of Deep Switching? What do they mean and where do they occur in the brain? Again, at first I had little idea where these might be located in the brain or exactly what they meant, so I called these new types of Deep Switching, "Deep Hidden Switching While these

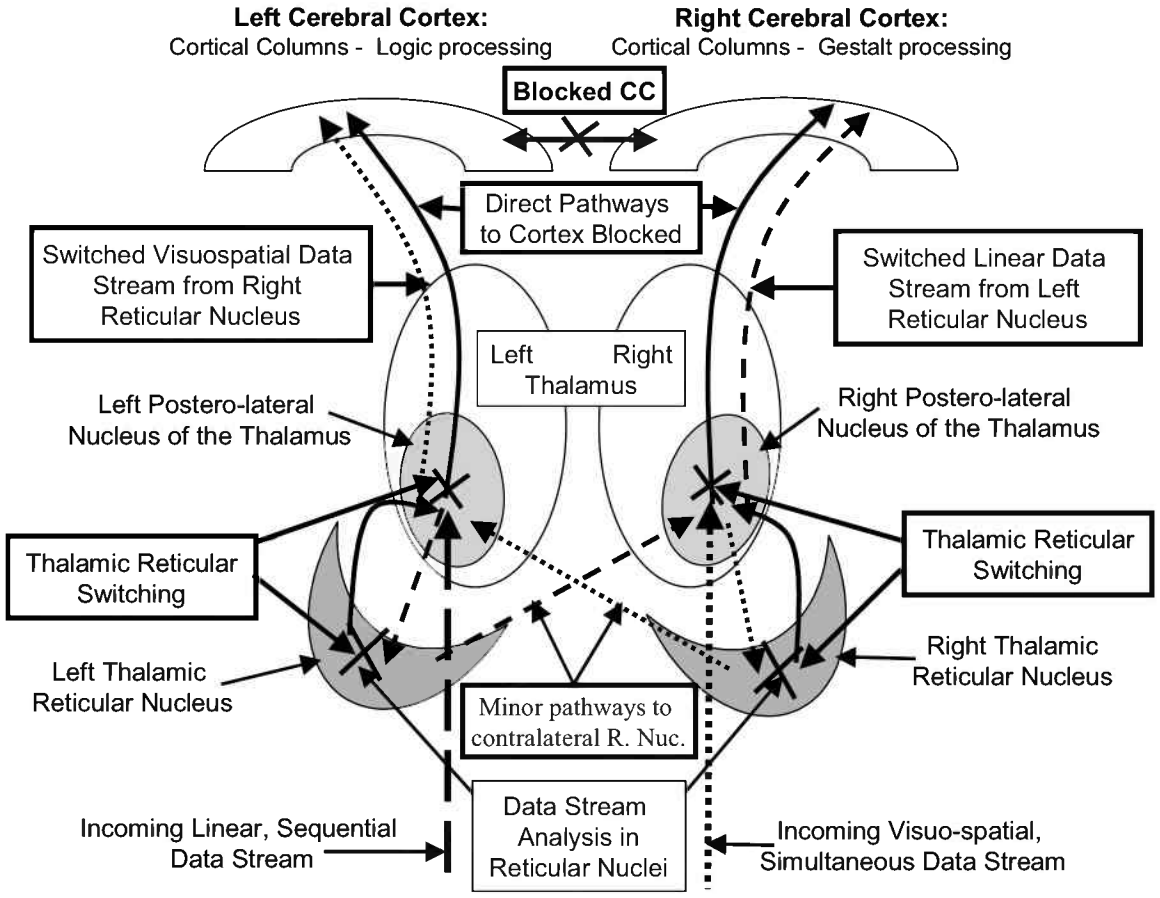


Figure 3A. Thalamic Reticular Switching or TRS in both Reticular Nuclei. Note how the linear data stream is sent to the Gestalt cortical areas and the Visuo-spatial data stream is sent to the Logic cortical areas for processing. If the Corpus Callosum is blocked, then the wrong type of data has to be processed in both cortical areas resulting in profound confusion in mental processing.

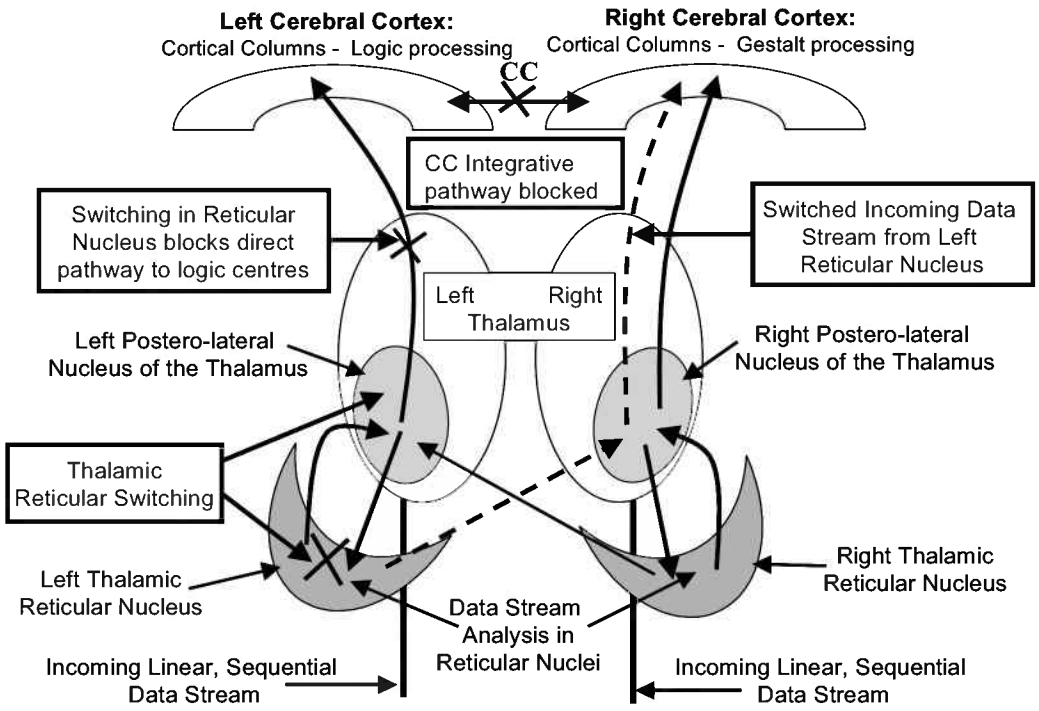


Figure 3B. Thalamic Reticular Switching or TRS in the Left Reticular Nuclei. Note how the linear data stream is switched to the Gestalt cortical areas for processing, but because of the "blocked" Corpus Callosum, it cannot be sent back to the Logic cortical areas.

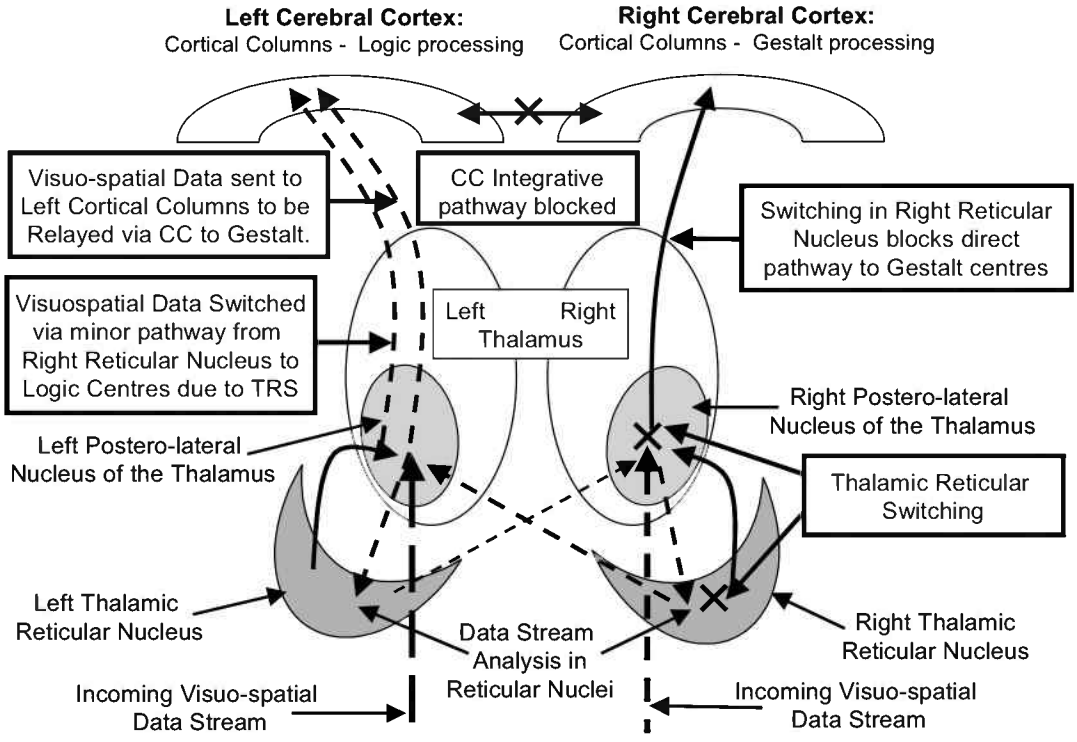


Figure 3C. Thalamic Reticular Switching or TRS in the Right Reticular Nuclei. Note how the visuo-spatial data stream is switched to the Logic cortical areas for processing, but because of the "blocked" Corpus Callosum, it cannot be sent back to the Gestalt cortical areas.

Other types of Deep Switching apparently related to Right-Left, Top-Bottom and Front-Back dimensions of function, these were no longer simple directional confusion resulting from a cortical projection problem located by normal switching procedures. Rather, these switchings are something far more profound, relating to deeper subconscious psycho-emotional processing.

Because these types of switching were not detected by the typical Switching Tests, but remained present yet "hidden" from testing, I had called this type of switching Deep Hidden Switching. However, when deep touch was applied to CV 10, and this caused an Indicator Change, this indicated the presence of Deep Hidden Switching. Once the CV 10 Indicater Change was entered into Pause Lock, then the typical switching points for the three dimensions of switching would now indicate which type of Deep Hidden Switching was present.

But where do they occur in the brain and what did they mean? Once Hugo Tobar had developed brainstem formatting in the late 1990s, I finally had the keys I needed to unlock this mystery. What I discovered was that these three types of Deep Hidden Switching occurred in the deep Survival Systems of the brain. The Survival System has two primary components: 1) A Brainstem Survival System activated largely by the Amygdala in the medial temporal lobes that orchestrates the Fight or Flight reactions related to Physical Survival; and 2) A Limbic Psycho-Emotional Survival System controlled largely by the Anterior Cingulate Gyrus that orchestrates Ego survival, that is defends our sense of "I" and how I see myself to be. However, once the Limbic Survival System has been activated, its output operates through the same Fight or Flight Survival Systems located in the Brainstem, as do threats to physical survival.

The Physical Survival System has four primary circuits or systems that are "hard-wired" into the brainstem for physical survival. The existence of these survival systems and their related neurology have been scientifically demonstrated and compiled into a paradigm changing model by the imminent neuroscientist, Dr. Jaak Panksepp, in his recent book Affective Neuroscience, to which you are directed for a much more in-depth discussion of this topic. This survival system had to be "hard-wired" because higher level processing like "thinking" is just too slow to ensure survival. The animals, including our early ancestors that "thought" first and reacted to dangerous stimuli second did not leave many offspring. So all vertebrates including humans inherited brains that react first to survive, then "think" about how to survive better the next time, that is if they had enough cortex to "think" at all, as this survival system is located in the totally unthinking, unconscious associative processing of the brainstem.

The Survival Systems of the Brainstem

There are four primary Physical Survival Systems. The first is the Fear System, designed to detect Threat or Danger, and then orchestrate a rapid reaction within the organism to survive. These reactions are of two basic types: Fight or Flight. The Flight mechanism is a sub-system of the Fear System that orchestrates "Escape" from dangerous or threatening stimuli, like a lion running after you. There are however, three types of Escape responses: 1) the Freeze reaction, as by freezing and not moving the predator may not "see" you and you escape detection, because most predators' vision is acutely sensitive to movement, but far less so to the detail of static objects. 2) If freeze doesn't work and the predator attacks, you switch to Escape reactions such as the Fear-Withdrawal reaction, and you turn and run for the nearest shelter for safety. 3) If the attack is from a member of your species, then there is a third option, and that is to submit to the more dominant animal – show them your throat so to speak. The Submission reaction then deflects the attack and you survive.

The second brainstem survival system is the Rage System, the Fight of the Fight or Flight, that co-ordinates the physiology and behaviour to Fight to stay alive. This system is also activated by the Amygdala, but largely controlled by the Periaqueductal Gray matter (PAG) in the Midbrain and the Periventricular Gray (PVG) and Perihypothalamic Gray (PHG) matter of the Diencephalon. The PHG largely controls the physiology of Fight or Flight, releasing adrenalin that increases the power of muscle contraction, and restricting blood flow to the digestive system and frontal lobes while at the same time increasing blood flow to the heart, lungs and muscles, and releasing sugar into the blood to provide the energy to fight with. The PVG and particularly PAG provide the behavioural reactions guiding our survival, such as attacking in a rage with nails and teeth if need be.

The third survival system is called the Seeking-Motivation System, and its primary job is to provide the motivation to seek the necessities of life such as food, water and shelter. It used to be called the Reward System, but this is now recognised to be yet another system in the brain related to enhancing motivation. The Seeking System gives you the motivation to "seek" what you need for physical survival, and once you are alive, to seek a mate to help the species survive. However, once you have actually found what you seek, the Seeking System turns off, and the Reward System turns on to ensure that you will be motivated to seek again the next time the Seeking System turns on.

The fourth survival system is called the Panic System because it was described from animal models where the behaviour appeared to be dominated by what we would call Panic. The more accurate, if more awkward, name is the Separation Distress System. This system serves survival in two ways, one primarily when you are a small child, and the other as you mature. Initially, it is the Panic System that reunites a young child or animal with its mother should they become separated – hence the name Separation Distress System. So if a small child becomes separated from his/her mother, or if a chick becomes separated from the hen, or a kitten from its mother, they at first run around in a "panic" emitting what scientists call Distress Vocalisations; or as normal people would say, crying out for mother – "Mummy? Mummy?", "Peep? Peep?", "Meow!, Meow!".

If these Distress Vocalisations (DVs) are successful, the mother and young are reunited, and the Panic System turns off. The stroking and holding of the young when the parent is reunited with the "lost" infant releases oxytocin, the bonding neurotransmitter, which turns off the Panic System. At the same time, opioids are also released into the brain by the caring touch, soothing the infant and making them "feel good."

However, if the DVs do not immediately bring the parent, then the young animal stops moving, crouches down and becomes silent, as it's not a good idea for an unprotected, defenseless young animal to make noise and run around. Later in life, it is activation of the Panic System that generates the feelings of Grief, Sadness and Loneliness when we lose someone close to us. It is also these feelings that drive us to seek companionship and act as social glue to help us maintain relationships with other people. In its extreme form, it can become depression in which you feel totally separate from others – listless, and hopeless.

The Amygdala activated survival emotions of each system are: Fear System – Fear, Terror; Rage System – Anger, Rage; Seeking System – Motivation, Curiosity, Frustration, which fires the Rage System; and Panic System – Anxiety, Panic, Grief, Sadness, Loneliness, Depression.

The Nature of Survival: Survival First, Think Second

Why would the "body," our "innate intelligence," do something as apparently so "stupid" as creating Deep Switching in our mental-emotional processing that actually "blocks" our ability to resolve the issues creating this switching on an on-going basis, particularly as the presence of this switching largely sabotages our best conscious attempts to resolve these issues once we become aware of them? Have you ever become aware of a behaviour you want to change, even understand where it may have come from, and yet not be able to change it? Likewise, why would the "body" block the Corpus Callosum, creating loss of brain integration and creating life-long learning problems that take an enormous toll on our self esteem and self-confidence, and severely restrict our ability to express our true potential?

These questions niggled at my consciousness for years, as my scientific background stated that evolution did not create behaviour or actions in an animal to create problems for them, only to block the animal's ability to solve these problems. Yet from a functional point of view, Deep Switching appeared to only create distress for the person, and impede their ability to demonstrate their best – Why? Why would you continue to repeat behaviours that you had become consciously aware were not in your best interests and you did not want to repeat?

To understand why Deep Switching should exist you have to understand the nature of the Survival Systems, first at the level of Physical Survival, and then at the level of Psycho-emotional (Ego) Survival. The Physical Survival System has two basic parts: 1) the Amygdala that acts as the "Sentinel" of this system, ever-vigilant for potential Danger or Threat; 2) the Periventricular Survival System of the Brainstem, the system that responds with survival physiology and behaviours to the danger and threats detected by the Amygdala. All senses go first to the Thalamus, and then directly to the Amygdala before being relayed to the Cortex to be processed into conscious perceptions, except for smell which is sent directly to the Amygdala before being relayed to cortical areas.

The Amygdala then, in a few neural links, rapidly processes the sensory experience, producing only a coarse-grained image or perception to decide if the stimuli or object "might" be dangerous. It errs on the side of caution, and if it "might" be dangerous, then it treats the stimulus or object as "dangerous" and fires the "Fight or Flight" system for survival. Activation of the Fight or Flight system then actively inhibits the frontal lobe "Thinking System" because thinking is too slow! During evolution, the people who "thought" first and reacted second didn't leave a lot of offspring, so we inherited the brains of people who "reacted" first and then thought second. People who survived used the rapid processing of the Amygdala to activate survival reactions first; then once they had survived physically, thought about how to survive better the next time they were in this situation – the true value of thinking.

However, while the Amygdala is busy activating the Fight or Flight System, the sensory information is being relayed to the cortex for fine-grained processing and comparison with your previous experience. If on the basis of this fine-grained cortical processing you decide the stimulus or object that fired the Fight or Flight system is not really dangerous, you then "turn off" the Survival System, as continuing to activate this energy consuming system when it isn't necessary for survival uses precious resources better used for other survival purposes.

For example, you are walking through the woods, and as you step forward, there is a sudden rustling sound and movement not far from your right foot. The Amygdala processes the sound and makes a rapid coarse-grained image from which it perceives the object "might" be a snake. So while you are still turning your head to look more closely at what the object is, and performing more fine-grained detailed cortical processing, the Amygdala has fired the Fight or Flight system initiating a Fear-Withdrawal Reflex, and you jump back – or flee from the object. While this survival reaction was happening, your eyes focused more clearly on the object and you made a detailed image of the object, as well as having compared the detail of the object with similar objects in your memory based upon your past experiences. Three outcomes are possible: 1) Your cortical processing says, "It's a rattlesnake – Watch out!"; and you continue your flight reaction; 2) Your cortical processing says, "It is a snake, but only a harmless garter snake," in which case you turn off your flight reaction; or 3) Your cortical processing says, "It's only a twisted piece of vine, and I just stepped on the other end," in which case you usually laugh (releasing pent up energy), and proceed to walk by the vine as your consciousness inhibits your Survival System (See Fig. 4 below).

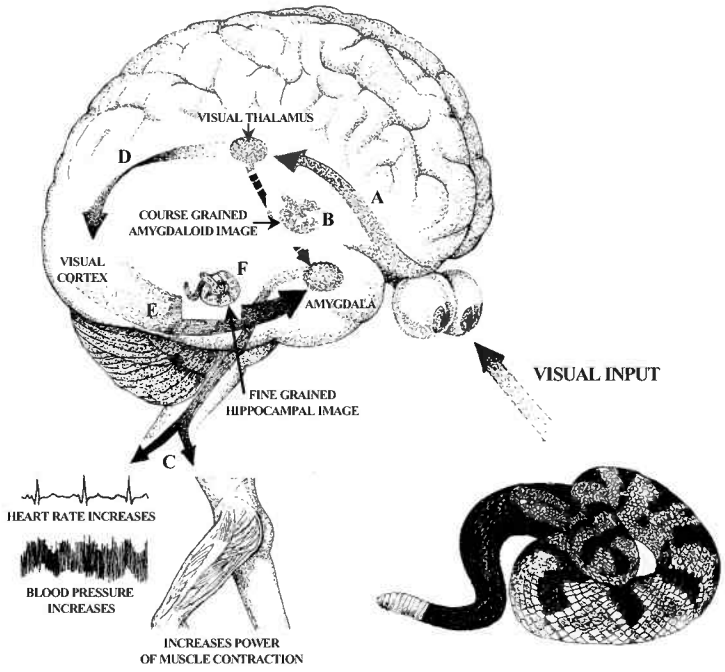


Figure 4. Dual Visual and Memory Systems in the Brain. Visual information goes straight to the Amygdala via branches of the Optic Nerve (A), which forms only a coarse-grained image based on rapid processing involving only a few neural links, and then immediately references subcortical memory of similar objects with special emphasis on potentially dangerous objects of similar shape. The Amygdala "sees" a twisted object on the ground (B), references "snake" – danger – and sends signals to the Periventricular Survival System initiating the "Fight or Flight" response. Signals are then sent to the adrenals (C) to release adrenalin – increasing heart rate, blood pressure, and the power of muscle contraction -- and you may jump back to avoid the object. At the same time, visual information also travels via the Optic tracts (A) and Optic Radiations (D) from the Visual Thalamus back to the Primary Visual Cortex, and undergoes multi-step and multi-level processing involv-

ing many neural links, to form a fine-grained image of the object (E). Cortical memory areas are then accessed for final conscious identification at the level of the Hippocampus, your short-term memory centre (F). If your consciousness says the object is dangerous, you continue Survival reactions; if not, they are turned off.

Psycho-Emotional Survival: The Origins of Deep Switching
Clearly the human Survival System works very well for Physical Survival, witness the almost nine billion people in the world today. However, humans are different from animals in that we have two Survival Systems, the Physical Survival System based in the Amygdala and Periventricular System of the brainstem, the same system possessed by all animals; and a uniquely human Psycho-Emotional Survival System that "protects" our image of ourselves, our Ego. This Psycho-Emotional Survival System is located in the newer limbic system that arose in mammals to handle the complexities of social interaction involved with rearing young that are born helpless and rely on mother's milk for their survival.

While other mammals have a limbic system, it is only once an animal becomes "self-aware" that it sees itself as a separate ego-structure, that the Psycho-Emotional Survival System becomes fully developed. Probably only humans, the higher apes and cetaceans (porpoises and killer whales) have a well-developed sense of Self that we could call an Ego. Once the Ego exists, it then controls the actions of the animal to maintain its existence. So powerful is the human Ego control on our behaviour, that we will risk our physical lives to maintain the Ego intact. Witness the slap in the face with the glove, and pistols at ten paces in which one person risks certain death just to protect his (it's usually a him) Ego against humiliation or embarrassment. How absurd from the Physical survival point of view, because whatever the other person said or did, he was not truly threatening your "physical" life!

When we are born, we have little sense of self as a separate being, but usually between one and one and a half years old, we "suddenly" realise we are indeed separate from other people with separate needs and wants that must be fulfilled to survive. As a separate "me" develops, I recognise that I must modulate my overt survival behaviour to be "accepted" and supported first by my parents and then by my social group. I can't just take another child's food because I'm hungry and want what they have. I have to ask first and share what I have with others – difficult and stressful lessons for two- to three-year-olds to learn. I also live only in the eternal "Now," and thus cannot understand concepts such as "You can have the cookie later!", because "later" does not exist for me! And not getting what "I" want "Now" is very stressful for me – witness the tantrums thrown by children this age.

Tantrums result from activation of the Rage System either from the Fear System, or from Frustration. They're either afraid they will not get what they need (or feel they need), or cannot get what they want. When the Seeking System is activated, you want something, but when you are "blocked" from getting what you seek, it creates the psycho-emotional state of Frustration. Frustration then neurologically fires the Rage/Anger System and initiates rage/anger behaviours. Children throwing a tantrum are not just trying to manipulate adults, but are truly "stressed out" to the point of no longer being able to "cope" with the psycho-emotional stress of the situation!

Once your ego has reached a point of not being able to "cope," you have to do something to survive, because you cannot live for very long in a state of not coping psycho-emotionally. Your Ego must make some type of usually psycho-emotional compensation to allow you to cope with the situation once more!

This is the origin of Deep Switching. Deep Switching is a perturbation of the balance of our survival system to permit us to cope with an untenable situation – the Ego must do this to survive "now," even if it creates a problem in the future!

Deep Switching does not occur in our cortex, but rather in our subcortical, subconscious limbic and brainstem survival systems, and thus we are unaware of its existence, or reason for happening in the first place. It is because of this location in the subconscious survival systems of the brain that I now call Deep Switching, Survival Switching. Survival Switching is created as a compensation for our Ego to survive a situation that it feels challenges its existence.

These same Ego challenges appear to underlie the brain "shutting down" free flow across the Corpus Callosum, often creating a double whammy – Survival Switching and loss of integrated brain function. While these are coping strategies on the part of the Ego, they often "backfire" in the long term by creating more "stressful" situations in your life, for which your Ego has to make further compensations.

Types of Survival Switching: What Each Type Means
Survival Switching comes in four types, depending upon what part of brain function was perturbed as a compensation to cope. I have discussed the first type of Survival Switching, Deep Level or Thalamic Reticular Switching (TRS), above from a functional point of view. TRS is always Right-Left Switching in which Logic data is incorrectly sent to the Gestalt processing centres of the cortex, and Gestalt data is incorrectly sent to the Logic processing centres of the opposite hemisphere. While this results in considerable confusion in mental processing and usually results in learning difficulties, it was created as a mechanism for the Ego to survive an unresolved deep-seated issue.

The other three types of Survival Switching relate to the three types of integration between the different brain regions, and are based on the three types of integrative neurons in the brain: the Commissural fibres (running Right Left), the Association fibres (running from Front Back) and the Projection fibres (running from Top Bottom). Commissural fibres connect the two hemispheres of the brain, the Corpus Callosum being by far the largest, making up 10% of the weight of the cerebral cortex.

Right-Left Survival Switching: Laterality Confusion
Commissural fibres permit the integration of sensory information received by the right and left ears, eyes, nostrils, hands etc. so we are conscious of our total surroundings, and integrate our Gestalt and Logic processing, allowing us to think effectively. When commissural information flow is blocked we have difficulty with visual and auditory integration and have difficulty performing many academic functions like spelling, reading and math.

However, when there is Right-Left Survival Switching, there is an ongoing confusion about laterality – which side of the body is "right" and which is "left." People with Right-Left Survival Switching commonly do not know their right hand from their left hand, and really have to "think" about it to move the correct hand when instructed to do so. Children with this type of switching have great difficulty following directions that involve laterality, e.g. if you say touch your right ear with your left hand, they get confused and often touch their left ear instead, or don't know which hand to move.

I had a girl friend with this type of switching, and although a highly intelligent PhD student, she never knew which was her right hand. She said she did know until she was 11 because her left hand had a wart on it. But the wart fell off when she was 11, and

since then she never knew which hand was which without having to think about it. So while Right-Left Survival Switching can be annoying and create problems, people usually compensate for it quite successfully, and it does not usually impact negatively upon their social or personal relationships. For example I had another friend with this type of switching who would just tell you when you got in the car with him, "Do not tell me to turn Right or Left as I'll get it wrong every time; just point this way or that way."

The other two types of Psycho-Emotional Survival Switching have far more profound effects upon our thinking and our relationships.

Top-Bottom Survival Switching: All Mental or All Emotional, Never the Twain Shall Meet

Top-Bottom Survival Switching is switching between the top and bottom of the brain. More specifically, switching between the Frontal Cortex where we "think" (rationalize and understand), and the deeper Limbic and Brainstem Survival Systems where we "feel" and "react." The Brainstem Survival System is totally associative, it does not think or reason. It only associates an event or stimulus with previous activation of one of the basic Survival Systems: Fear, Rage, Seeking or Panic.

It is indeed this associative nature of the Brainstem Survival System that leads to "Conditioned Learning" like Pavlov's dog. The presentation of a steak just after Pavlov rang a bell rapidly "conditioned" the dog, so when the bell was rung and no steak followed, the dog still salivated because the brainstem system had "associated" the bell to the delivery of food. Likewise, a child before they can reason and understand the concepts of heat flow and hot, soon learns to "associate" a hot stove with pain, often by one-trial learning.

While these are positive examples of the Amygdala-brainstem associative conditioning, phobias are examples of when it goes wrong. In some way "fear" becomes associated with a neutral, harmless stimulus in this brainstem survival system. Because this system does not reason or think, this harmless object creates extreme "fear" every time it is presented and treated by the person as if it is extremely dangerous. This mis-association may then persist, often for a lifetime.

Normally when in balance, the neural flows between the "thinking centres" of our frontal cortex and the "feeling centres" of our Limbic areas, sometimes called the Emotional Brain, allow us to "feel" our emotions and be consciously aware of our emotional states, but yet modulate them by our thinking for social circumstances. So while you may say something that makes me "feel" angry, I can use my conscious thinking to still respond in an appropriate way and not just yell at you. Furthermore, after our altercation, I can use my mental powers of rationalization to "understand" why you responded the way you did, or why what you said made me so angry, and even perhaps why I felt anger because of what you said. From this rational understanding I am able to defuse my anger so I can then behave differently with you the next time we meet.

For mental balance and personal growth it is essential that I be able to not only "feel" and "express" my emotions, but then be able to consciously evaluate them in the light of my experience to understand them with my "thinking." This Top-Bottom integration requires maintenance and synchronisation of neural flows along the Projection fibres between my cortex and my limbic brainstem systems. When a situation exceeds our ability to cope, the psycho-emotional self creates a compensation to survive, which in the case of Top-Bottom Switching is to go either all up and only "think and rationalize," or go all down into your emotions and only "emote"!

Neither of these choices allows you to integrate this stress experience into your life's experience, and thus the original situation maintains its emotional charge. More importantly, whenever a related situation activates this Top-Bottom Survival Switching, you once again can only "think" or "feel," either acting cool and mental with no ability to "feel" the emotions involved, or go all emotional with no ability to think and understand. In either case, this Top-Bottom Switching prevents you from truly resolving the issue.

So you may have had a traumatic situation in your life as a young child, that because of your limited emotional and mental resources at the time, you could not cope with. To survive you shut down or suppressed your emotions and went all mental. When you were older, and now did have the resources to both feel the emotions and understand why you felt them, the on-going Top-Bottom Switching "blocked" your ability to do so. As an example, you are a young child who unfortunately has a violent, alcoholic father. You soon learn it is dangerous to express your emotions because you will be abused either physically or psycho-emotionally, a stress situation your Ego cannot cope with, so it creates a Top-Bottom Switch to cope. You now stuff or suppress your rage/anger and only relate at a mental level, to "protect" yourself and survive. However, this survival mechanism that permitted your Ego to survive your abusive childhood then causes endless stress in relationships, because other people expect you to relate to them both emotionally as well as mentally, but this switching blocks access to your emotions.

Front-Back Survival Switching: It Just Keeps on Happening Again and Again

Perhaps the most profound type of Survival Switching is Front-Back Switching because it keeps you psycho-emotionally "stuck" in the past. When we are confronted with trauma that our Ego cannot cope with, another survival response is to create Front-Back Survival Switching. For the brain, the Frontal lobes are our "Now Time" awareness, where we can appreciate the "now moment," but understand it by accessing similar experiences in our past. The event happening now is experienced by both the conscious and subconscious as happening now.

When in balance, the association fibres carrying our memories stored largely in the back of our brain, and projection fibres carrying our emotional reactions to these memories, are well integrated with processing in our "thinking" frontal lobes. So what happened in our past can be used by the frontal lobe thinking and reasoning centres as a "reference" to understand what is happening "now." So even if a past experience was unpleasant, it only provides a point of reference for what is happening now; the brain clearly understands that this referent "happened" in the past.

However, when Front-Back Survival Switching comes "on-line," we do not move permanently into our Frontal lobes and live in the eternal "Now," but rather our memories of our past trauma switch us into the past. So from the switched brain's perspective, what happened (that is in the past) is now happening again. We enter once more into whatever survival response we adopted at that time, and just suffer through the experience, or if Flight was on-line, run away from this new experience as if it is the same as our past experience. We are totally "stuck" in our past behaviours, sometimes even decades after the original trauma.

When Front-Back Survival Switching is on-line, all new experience is in effect "filtered" through the lens of the past traumatic experience. From this perspective, the same thing appears to be happening again. This is why a 38 year-old women who was raped by her fa-

ther when she was eight years old, still reacts to situations with men as if it is happening again, even though it has not happened in reality for three decades. Until this switching is resolved, the person will continue to demonstrate the same "stuck" behaviour, even after considerable effort to change this behaviour and often many hours of therapy from skilled practitioners. Every Kinesiologist has had clients who, no matter how well you worked and no matter how hard they tried, the same problem persisted over time, often with these clients going from practitioner to practitioner for years.

I consistently found that these "recalcitrant clients" had Front-Back Survival Switching, which once resolved now allowed them to progress in their therapy like other people. I treated a German woman who had been sexually abused as a small child, and had done years of psychotherapy, as well as many other therapies to resolve this issue. She said, "I've cried buckets over this, but nothing has really changed." I first cleared her Top-Bottom Survival Switching, and then the next week cleared her Front-Back Survival Switching. The next day she called me to say that this was the first time in all her therapy that she truly felt something deep inside her had changed and her issue was resolved. I am sure that all of the previous therapy had set her up for this rapid change, but it was not until her Front-Back Survival Switching was cleared that she could step out of the past into the present.

Psychological Reversal Deep Survival Switching: Why I Need to Keep This Problem

Even though the discovery of Survival Switching allowed me and many other LEAP Practitioners around the world to resolve deep-seated problems for many people, there was still a small percent that I and other very competent practitioners and therapists could not appear to help. Or there were people who I would clear Survival Switching one week, and it would be back again the next week. With its return, all the good work we seemed to have accomplished the week before seemed to be to no avail, as the same problem resurfaced yet again. Why couldn't these people "hold" a balance, and why did the Survival Switching constantly reappear, even after what seemed like powerful, deep balances?

This question went unanswered for years until I went to the United States and attended a Thought Field Therapy or TFT course with its founder, Roger Callahan. One of Roger's seminal discoveries was the concept of Psychological Reversal. You have the person state, "I want to get over this problem!" and test an indicator muscle; the muscle indicates "No"! You now test "I want to keep this problem!" and the muscle indicates, "Yes!". This reversal between the outcome the consciousness wanted – to get over the problem, and the outcome the subconscious wanted – to keep the problem, Roger called Psychological Reversal or PR.

Indeed this is a good name for this apparent contradiction in body response, as clearly the person's consciousness does not want the problem, but why is the subconscious stating it needs the problem? I discovered that immediately before the person stated the PR statement, I could not find any Survival Switching, but as soon as I entered the responses to the two PR statements into Pause Lock or Circuit Retaining Mode, and tested again, bingo! – now the Survival Switching showed! Somehow the "challenge" of making the statements brought this highly compensated Survival Switching to the surface where it was now overtly "on-line." In TFT, the person just taps their Small Intestine 4 acupoints together, and the PR is gone with the person now testing, "I want to get over this problem – "Yes!", and I want to keep this problem – "No!".

When I checked people who had made this tapping correction, and for whom the issue now seemed to be clear, I consistently found the survival emotions in the Amygdala to be active, but just suppressed for the time being. Indeed, one of the biggest problems for TFT is that the same problem often returns after a short time, and needs to be treated again. However, I found that I could now resolve this Deep Survival Switching once I challenged with the PR statements to activate this switching, and then directly accessed the associated Amygdala survival emotions. This correction usually required age-recession to early childhood or beyond. Following this correction, the Deep Survival Switching then appeared to be totally resolved and the PR and Survival Switching did not return again in the clear. By in the clear, I mean with no particular issue on-line.

Interestingly, a former neurobiologist and LEAP Practitioner in the UK, Dr. Richard Beale, made a similar discovery at the same time, and for the same reason. Richard just could not understand why some clients could not hold their balances and their deepest problems kept returning. He discovered that when this was the situation, and Survival Switching as accessed via CV 10 Deep Touch did not show, Governing Vessel 5 Deep Touch would often be active. When GV 5 Deep Touch was entered into circuit, then suddenly the traditional switching points would now be active! When these points were entered into circuit along with the Amygdala survival emotions, normal kinesiology balancing then produced long-lasting corrections, and further balancing appeared to truly resolve the previously "stuck" problem.

I now call this Psychological Reversal Switching, Deep Survival Switching, to denote that it is deeper than normal Survival Switching, yet it may have the same three dimensions as normal Survival Switching: Right-Left, Top-Bottom and Front-Back. I now also access this PR Switching directly through GV 5 Deep Touch as both Richard's research and my own confirmed that GV 5 provides consistent access to this Deep Survival Switching, such that whenever GV 5 is active, Deep Survival Switching is always present, and if the PR Statements are tested, they always show PR. In contrast, when normal Survival Switching is on-line as indicated by CV 10 Deep Touch giving an Indicator Change, there is never Psychological Reversal.

These different types of Survival Switching are summarised in the Figure 5 on the following page.

Survival Switching in the Clear and in Context: What This Means

There are two quite distinct forms or ways you may have these different types of Survival Switching. One is in the "clear," that is it is present as an on-going condition – the context is your life. The other form is in a particular context, e.g. only when you are addressing a specific difficult issue in your life; at other times this switching is absent. Survival Switching in the clear obviously has more direct impact on your life because it is present every moment of every day, and provides the subcontext of all of your interactions and experiences.

Deep Survival Switching or Survival Switching that exists in the clear normally has an early childhood origin or may even be karmic, a pattern in your energetic structure created before your birth and transmitted from life to life either in your genes or energetic body, depending upon your belief system. Most commonly the origin of this type of Survival Switching is a childhood trauma with which you just could not cope, and to cope you developed this particular Survival Switching or Deep Survival Switching to survive psycho-emotionally. Since this switching was developed at a point in time when

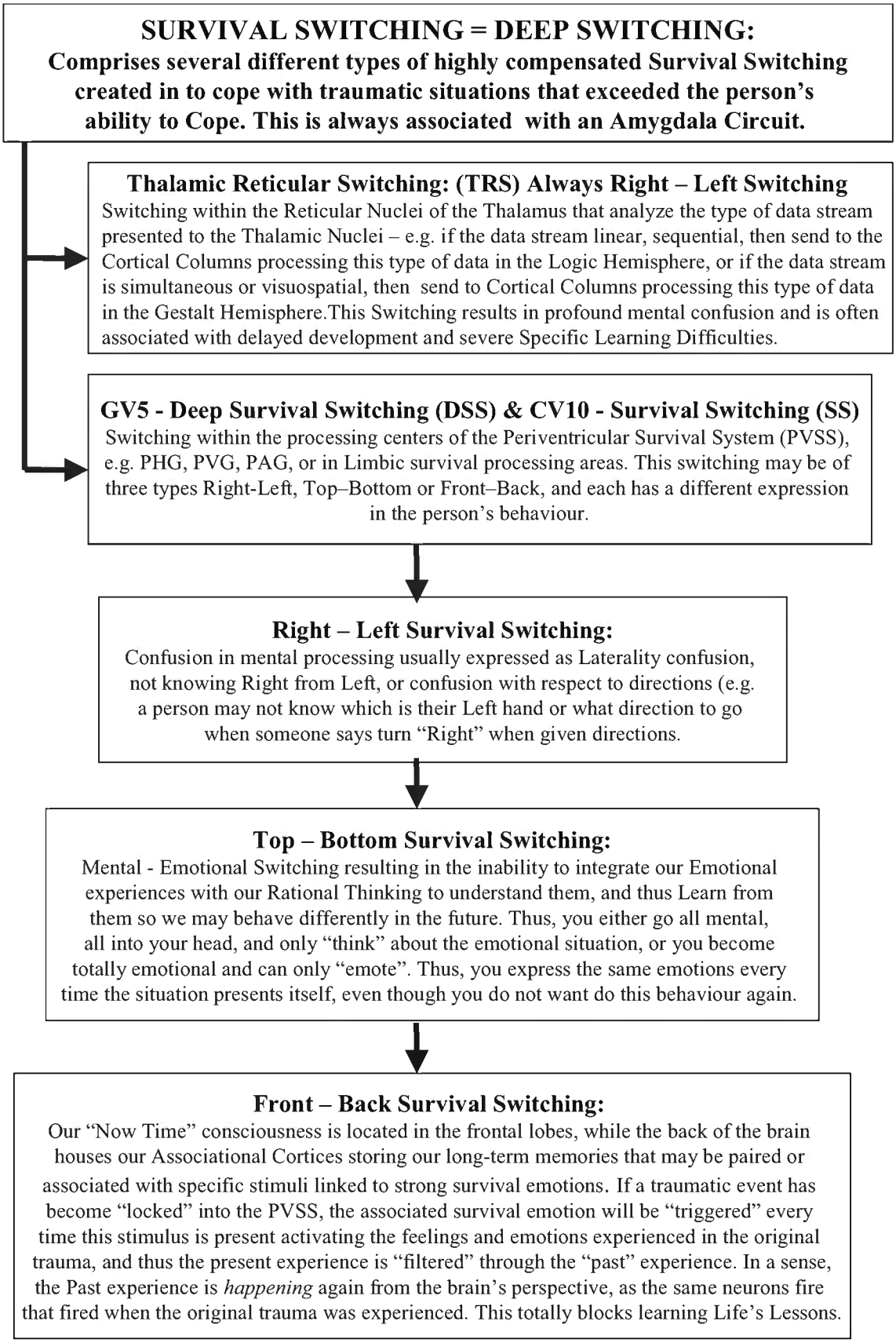


Figure 5. Types of Deep Switching and Their Meaning in Behaviour.

introspection and rational reasoning were not available, it persists over time until it is located and balanced. Once balanced, this switching has now been integrated into your life's experience like other traumas you have survived, and provides a valuable reference to help you cope with and understand future situations.

In contrast, contextual Deep Survival Switching or Survival Switching is dependent upon a specific situation or context to be activated. When that context or situation is not present, you do not express this switching. For example, I check you for Survival Switching and find it is totally clear. Then I ask you to access a difficult issue in your life, one that you have not been able to resolve to this time, and check for Survival Switching again. A very high percentage of the time you will now demonstrate Survival Switching. However, if I now have you think of a pleasant day and check once more for Survival Switching, it does not show. This is the nature of contextual Deep Survival Switching and Survival Switching: it is only expressed when that specific issue is on-line.

The human subconscious is very much like a biocomputer in that all of the information about your life is stored in many different files in a number of directories and subdirectories. Like its physical counterpart, the biocomputer can only access the information in the "files" that have been "opened," not the thousands of other files on your hard-drive. As you are aware if you use a computer, it is only the open files that you can revise or change. So, entering an issue into Pause Lock is very much like "opening" a file, which now brings that data or information – the memory of this experience in all of its sensory dimensions – on-line to be worked with.

Files on the biocomputer do not open to file names, but rather to "trigger stimuli" that activate retrieval of the memory of the previously stressful event or issue into now time consciousness. The most powerful "triggers" are those activating the survival emotions in the Amygdala and Limbic-Brainstem Survival Systems, because these emotions are most related to our physical and psycho-emotional survival.

Like a real computer, the biocomputer also has two types of memory access: Read Only Memory (ROM) and Random Access Memory (RAM). ROM files are protected, that is they cannot be opened by just any user of the computer to which they are "off-limits," so to speak. These are like the primary default settings of your computer that are ROM to prevent untrained people from messing up their basic computer functions and operating programs. In contrast, RAM files are accessible to anyone who knows how to turn on the computer, and to which you have total access to revise and save the updated files at will.

The body's ROM circuits are those circuits involving survival programming that need to be conserved over time for the survival of the individual, both physically and psycho-emotionally. You must remember that the part of the brain that created these files is non-rational and does not think, but rather, it only associates a stimulus with a survival emotion. So if this "association" was made spuriously as in the case of a phobia, incorrect and often debilitating survival responses are now linked to neutral stimuli. But to "disassociate" this false linkage of survival emotion to neutral stimulus, you first have to open the ROM processing of the survival centres like the Amygdala.

Defusing Survival Switching: Set-up Provides the Key to Successful Resolution

Access to the Amygdala survival programming and survival emotions is much more like ROM than RAM. That is, it is much more difficult to "open" these files to revise and update them, but if activated by a trigger stimulus, your biocomputer "reads" them easily, and activates the associated Fight or Flight reactions and related survival emotions. While just being able to turn your computer on does not give you access to your ROM files of the operating of your computer, it does allow these files to be read to operate your computer. However, a competent computer technician can make changes to your default programming because he knows how to "open" these ROM files, and once opened they can now be revised or reset. Likewise, once you can format for the Amygdala survival emotions directly, you "open" these files, and these emotions then become part of the circuit you are balancing.

Release or revision of these survival emotions then permits the person to effectively resolve the Deep Survival Switching or Survival Switching that had blocked the person's ability to make changes in their life that they had consciously desired to make, often for some time. So to make long-term changes in many issues that you have found difficult to resolve, you often have to first access the specific "context" that acts as the "trigger" to activate these highly compensated "defense" or "survival" mechanisms, the Deep Survival Switching or Survival Switching. This Set-up allows these switches to "show" and thus be Pause Locked or held in Circuit.

Then you need to be able to "open" the ROM circuits holding the protected Amygdala survival emotions that drive the Fight or Flight reactions. The Set-up for the Amygdala survival emotions then "opens" these ROM files so they may be entered into circuit. Very often, accessing these powerful survival emotions will over-facilitate the Indicator Muscle, that is, the muscle "Jams" which blocks further indicator muscle response. There are a number of techniques, from spindle cell sedation to SIPS (Stress Indicator Points), to Modes of Processing, to Stomach 3 (right and left) that can then download all of the associated stress, returning the indicator muscle to homeostasis.

Once the type of Survival Switching has been identified and entered into circuit and the Amygdala survival emotions behind this Survival Switching have been "opened" and also entered into circuit, then you may proceed to identify the causal issue or issues that originally generated the Survival Switch in the first place. Often this requires Age-Recession, as these basal survival programs were often created to cope with childhood traumas the developing Ego could not cope with at the time. Dr. Bruce Dewe so correctly said long ago – "The brain is a marvelous biocomputer, but it suffers from one major drawback – emotionally it was largely programmed by a 3-year old!"

To understand why this might be true, consider the following facts: 1) By about the age of two years old, your psycho-emotional self is now guided by a new found sense of "I," the developing Ego. So now "I" want something!; 2) However, this newly developed "I" suffers from a major problem or deficit in awareness – that there are other Egos in the World who also have desires, often in conflict with their own egocentric "I"; and 3) Their "I" lives in the eternal "now" as there is as yet no sense of Time, so if "I" want something, "I" want it NOW! And when "I" cannot have it now, I feel that my needs are not met, or that I am not approved of, or simply that my "will" is over-ridden by another "I," that from this infantile perspective may seem like an annihilation of my "I"!

This normally activates my survival emotions of "Fight or Flight" to survive, and "I" may lash out at the one "blocking" my Ego's desires – How often have you seen a young child hit his mother in this situation? Or the child may attempt to run away from

the situation! Social survival emotions of "Shame and Blame" may also be activated that affect my sense of "self-worth," because if "I" am "guilty," how can "I" be worthy of love and support?

However, once formatting has opened all of the Survival Systems of the Brainstem and Limbic System, and the survival emotions have been "down-loaded" into the circuit, then application of any type of effective balancing technique can resolve the original issue. In so doing, the associated Amygdala survival emotions are defused, and thus eliminate the associated Survival Switching.

While the updated and revised "survival files" are now "stored" back into your memory hard-drive, they no longer contain the Survival Switching or original Amygdala survival emotions. So the next time you encounter a similar context or situation, there is nothing to "trigger" you into your switched state or activate your Fight or Flight programming. You now stay in your frontal lobes with access to your creative problem-solving abilities, permitting new choices rather than your previous knee-jerk Fight or Flight reactions.

NOTE:
For more information on how to work with the Amygdala Circuit and the Brainstem Survival Systems you are referred to the AP and the Brain workshop, the LEAP Brain Integration 1 and 2 workshops, and Hugo Tobar's Neuro-Emotional Pathways workshops. Taking these workshops in this order is highly recommended, as each of these workshops delves deeper into these systems than the one before.

Dr. Charles T. Krebs
Melbourne Applied Physiology Pty Ltd
P.O. Box 71, Learmonth, Victoria
Australia 3352

Notes:

Brain Formatting, Accessing Stress, Consciousness and Awareness

by Hugo Tobar

Abstract: Richard Utt, in Applied Physiology, developed the notion of formatting. In Neural Systems Kinesiology, I have developed these concepts further. Formatting accesses stress states by taking an energetic stress picture using acupoints and finger modes. I have also developed a unified theory of consciousness. This is a model that explains not only the Eastern transpersonal view, but also fits in with current knowledge of neurology and Western science.

To understand formatting better, I have developed a model of formatting and the treatment triangle. This model states that formatting captures an energetic imprint of stress on a particular structure. The treatment triangle enables the practitioner to access and balance the stress very precisely.

Part 1 THE TREATMENT TRIANGLE

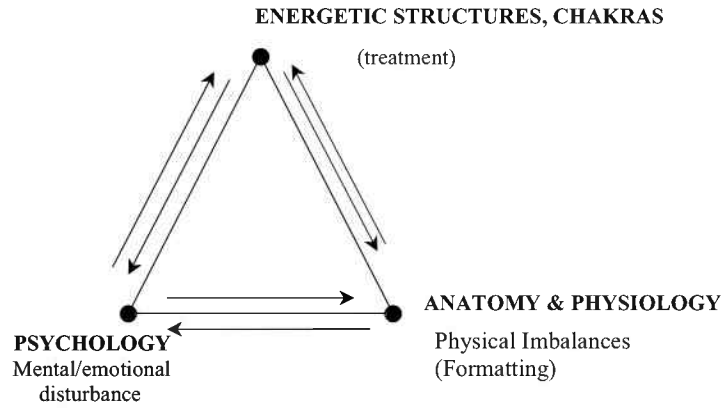


Fig 1: The Treatment Triangle. Source: Tobar 2002, Brain Formatting

Every psychological imbalance has a physical imbalance. The psychological imbalances can appear as temporary mental/emotional imbalances or as more chronic mental disorders. An example of the range of imbalance is from feeling sad or lonely, to having a full blown panic disorder. These extremes, in fact, have the same underlying neurology. They are just different degrees of innervation.

The physical imbalances associated with both psychological disorders are in the anatomy and physiology. Every psychological disorder, whether it is a temporary feeling or a chronic condition, has a neurological imbalance. This manifests in the neurotransmitters and the endocrine system. There is also an imbalance in the Chakra system that accompanies this. The Chakras, in fact, are where the imbalance is held.

For me, in Kinesiology what we do is remove stress. This allows clients to adjust and deal with the stressor and heal themselves. This raises the question, "How exactly do we remove the stress?" Well, the first step is to access the stress. "How is this done?" There are many ways of doing this, and some of them require the practitioner to have a high degree of expertise and personal development.

Part 2 FORMATTING

Richard Utt, in Applied Physiology, developed a major breakthrough for the Kinesiologist called 'Formatting'. This has turned out to be, for me, the greatest gift that Kinesiology has to offer, because it allows the practitioner, no matter how well they are trained, to access the stress on a particular piece of anatomy or physiology. It also allows the practitioner to assess just exactly where the stress is held in the Chakra system.

Formatting uses a combination of acu-points and finger modes. This draws on the Chinese tradition of Acupressure and the Meridian system, and on the Indian tradition of Finger Modes that are derived from mudras. Using a combination of these, the energetic stress pattern of any anatomy and physiology can be accessed

Using music as an analogy, the finger modes and acupoints are notes and the format is a chord.

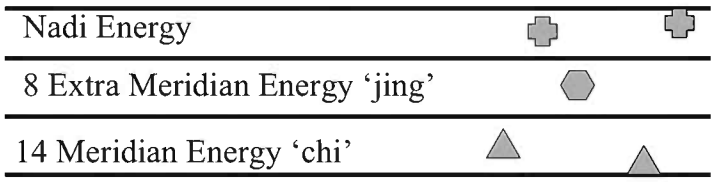


Fig 2: The format 'chord', a format is made up of individual 'notes' of acupoints and finger modes'. Source: Tobar 2002, Brain Formatting

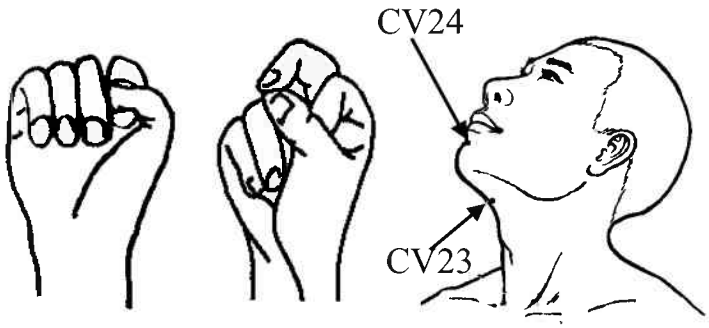


Fig 3: The Limbic Format, which uses the Finger Modes for Anatomy and Gland, and the Acu-points CV23 and CV24. Source: Tobar 2002, Brain Formatting

The origin of consciousness in the East and West or a UNIFIED THEORY OF CONSCIOUSNESS.

Consciousness can be looked at in many ways. It is the foundation of our existence. It makes us who we are and who we think we are. We can consider consciousness from our everyday waking perspective. It is "our" experience from when we wake up to when we go to sleep. There is also consciousness when we are asleep. Indeed, we have the dreaming sleep state and the deep sleep state.

There is also expanded consciousness, the consciousness of meditation, spiritual ecstasy of prayer – that which "up-

lifts the soul". There is also the state of "oneness" or the void of Wolinksy. This is samadhi, the deep state of meditation. All of these could be considered as a form of consciousness. So what is the mechanism of this? Do we consider it as purely a function of neurology? What about all of the Eastern views of it?

What I propose is a model that explains not only the Eastern transpersonal view, but also fits in with current knowledge of Western science. Firstly, let's look at waking consciousness. It is known that lesions in the brainstem reticular formation or in the intralaminar nuclei of the thalamus are enough to cause an irreversible coma.

If we look at the spiritual aspects of consciousness we have "physical" consciousness "awakened" consciousness and "enlightened" consciousness.

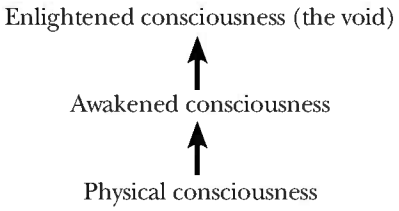


Fig 4: The Pathways for the expansion of consciousness

What is important is that there are no clear lines between each state. One state should lead to the next. In the search for the mechanism in the nervous system, it leads us to some very interesting places. The thalamus seems to be the key for this.

The above diagram is about the expansion of consciousness. Wolinksy talks about the contraction of the "void of undifferentiated consciousness" to form the "I am". He also refers to the expansion of it. The "I am" is the contraction of the "void of undifferentiated consciousness". Wolinsky in The Way of the Human Part III explains it with a diagram as such:

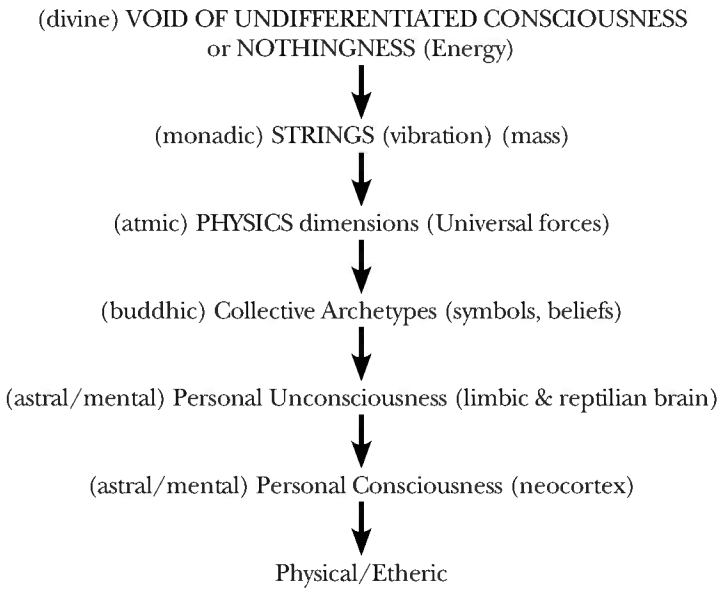


Fig 5: The Contraction of the Void of Undifferentiated Consciousness of Wolinsky

Strings comes from super string theory which says all matter known or unknown is made up of vibrations. These vibrations can be visualised as vibrating strings, hence super strings. So according to Wolinsky the void contracts to vibrations which contract to the physical universe which contracts into archetypes which then contract into the personal unconsciousness and then the personal consciousness.

Next, we need to look at the neural mechanisms of these. The physical consciousness is made up of the 3 parts, which are analogous to the three states of waking, dreaming sleep (REM sleep), and deep sleep (slow wave sleep or NREM sleep).

Personal consciousness relates to WAKING

Personal unconsciousness relates to REM

Collective archetypes relates to NREM

For personal consciousness to exist, we need structures such as the hippocampus. Without the hippocampus we cannot bind one waking experience to the next.

I find Wolinsky's concepts of the physics dimensions very interesting. Looking at this from a purely physical dimension, we understand the concepts of forces such as gravity, electromagnetism, acceleration etc. These are forces that shape our physical world. In fact these forces bind our world, right down to the quantum level, where quantum forces keep atoms together.

So Wolinsky's "physics dimension" (which I call the universe) is shaped by forces both known and unknown. These unknown forces are very interesting. In physics they refer to them as being from other dimensions. To me, in comparisons of Wolinsky's work and that of theosophy, striking similarities can be found. They refer to the physics dimension to that of the atmic plane. Alice Bailey refers to the forces of Astrology as being from the atmic. While they certainly are, there are more than just the astrological influences. The forces which are a contraction of vibration then can shape us on the buddhic plane, which in theosophy is the intuitional plane. According to Wolinsky it is the realm of archetypes. It is these archetypes that make up who we are. Wolinsky has very interesting ideas on this, and in fact it is these archetypes that shape our thoughts, emotions and actions. All of who we think we are exists through archetypes.

Archetypes are symbols, if we have forces of the universe (atmic plane) working through these symbols of the buddhic (archetypes). Then this is called an "imprint of consciousness" by some commentators.

Harish Johari refers to Yantra as an "imprint of consciousness". This is in fact a principle of radionics, where you can use a known physical force through a symbol to make a radionic "imprint".

While it is nice to say this is an "imprint of consciousness" I would prefer to call it an "imprint of psychology", for these archetypes exist on the buddhic dimension of intuition. It is from here that the "imprint of psychology" can effect our mental and emotional realms or the "personal unconsciousness" and "personal consciousness" as expounded by Wolinsky.

The mechanism of the three states that relate to the "personal consciousness", the "personal unconsciousness", and the "archetypal intuition" are well documented.

At this point I would prefer to rename the personal unconsciousness as the "personal unconscious psychology" and re-

name the "personal consciousness" as the "personal conscious psychology" or "personal psychology" for both. It is the expansion of awareness (which people often confuse with consciousness) beyond these realms lead to interesting new ideas.

For me, my new theories first started after reading a book called *DMT – the spirit molecule* by Rick Strassman. DMT is the endogenous hallucinogen produced in the pineal gland at times of expanded awareness like birth, death, sexual ecstasy and deep meditation.

Strassman calls it the spirit molecule because it leads to expanded awareness. He conducted the only legal studies of DMT in the USA. The "problem" is that we have an active enzyme that breaks it down very quickly.

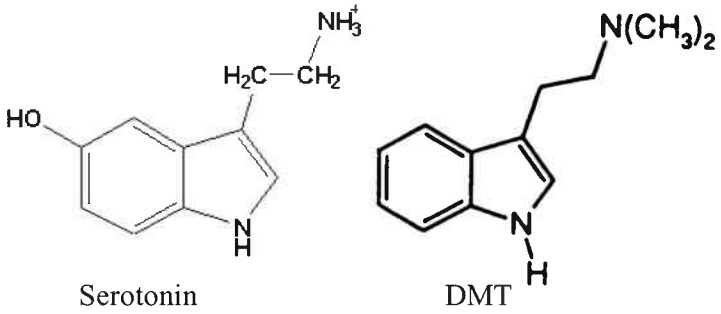


Fig 6: The Chemical structures of Serotonin and DMT

In South America, the Native Americans of the Amazon have a drink called Ayahuasca. The active ingredient of this is DMT (Di Methyl Tryptamine). It also contains a chemical that stops the enzyme that breaks down DMT from working. The Shamans of South America use this drink to do their Shamanic Journeying.

DMT acts on certain receptors of a neurotransmitter called serotonin. Most hallucinogens act on these serotonin receptors (for example, LSD does). So this meant that for me to understand this I had to study serotonin receptors. So then I came across the perfect book called Serotonin Receptors and their Ligands by Oliver et al (eds). This is a book on the study of drug interactions with the different serotonin receptors.

Of particular interest to me became athe 5-HT_4 serotonin receptor. This receptor does have DMT bind to it. These receptors are found in the caudate nucleus, globus pallidus, putamen, nucleus accumbens, ventral pallidum and the substantia nigra pars reticulata of the Basal Ganglia. All of these make up different parts of the Basal Ganglia. These receptors are also found in the Dentate Gyrus, CA1, CA3 and the entorhinal cortex of the hippocampal formation.

These receptors are also found in the frontal and parietal lobes of the cerebral cortex. The other areas in which they are found are the Intralaminar thalamic nuclei and the peripheral cholinergic neurons. These receptors are very interesting because they are thought to be involved with a form of long term plasticity in the brain. Or simply putting it, they can change the way the brain functions.

They are interesting because they are involved with long term inhibition of neurons not firing, which means they fire for a long time. This is more and more interesting when you consider that they are involved with cognition, learning, memory, emotional processes and reward. All that stuff that is completely tied up in our archetypical and personal psychological realms.

So if DMT is able to take our awareness beyond this and even take our awareness beyond the "physics dimension", maybe what it is doing is taking our awareness to the level of vibration. In meditation terms this is called "presamadhi". This is an interesting theory – when I tried my kinesiological techniques on Stephen Wolinksy, who experiences samadhi, he said it felt like a presamadhi. But Stephen pushed me further, he asked me "what about samadhi?" How does that interface with the nervous system? What an interesting concept. I had not thought about that.

Obviously the awareness of the person experiencing samadhi has to be act a high level, though similar to the mechanisms of deep sleep. The mechanism of deep sleep that shuts down the cortex begins in the reticular nucleus of the thalamus. There is an intrinsic system that causes this within the nervous system.

I propose that awareness turns on the reticular nucleus of the thalamus which shuts down the thalamus and therefore the cortex. This simply is the mechanism of samadhi.

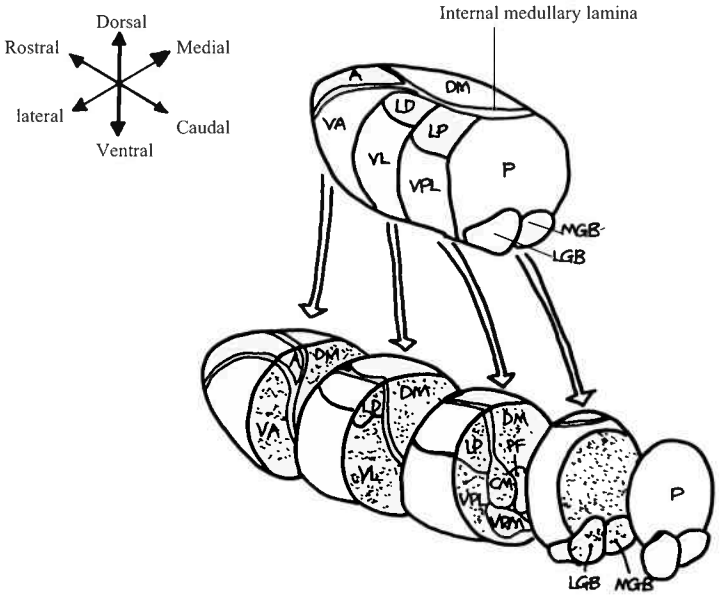


Fig 7: Exploded view of the dorsal thalamus, illustrating the organisation of thalamic nuclei. Source Mihailoff & Haines 1997

Kinesiology

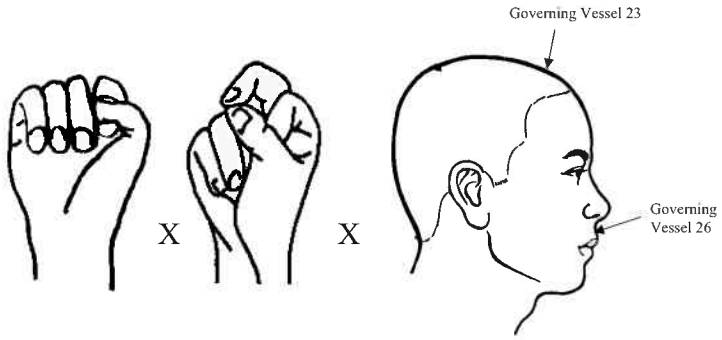
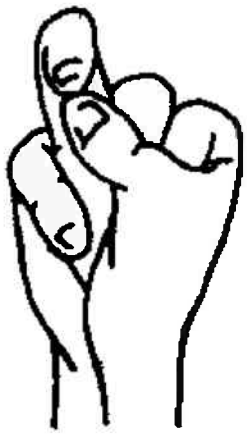


Fig 13: Format for the diencephalon, Source: Tobar 2002, Brain Formatting



Hormone

F*ig 14: Mode for Hormone, holding this mode deep touch, then it is the mode for neurotransmitter. Source: Tobar 2002, Brain Formatting*

Procedure for balancing awareness

1. Test and correct Teres Major
2. Pauselock Diencephalon Format Anatomy x Gland x GV26 x GV23
3. Retest Teres Major
4. Correct as necessary
5. Pauselock Neurotransmitter mode.
6. Temporal Tap "Dimethyl tryptamine"
7. Retest Teres Major
8. Correct as necessary
9. Temporal Tap "5-HT4 Serotonin Receptor"
10. Retest Teres Major
11. Correct as necessary

Bibliography

Callaway, J.C., *Phytochemistry and Neuropharmacology of Ayahuasca,* in, Metzner, R.,(ed) Ayahuasca, *Human Consciousness and the Spirits of Nature,* 1999, Thunder's Mouth Press, New York.

Dumuis, A., Ansanay, H., Waeber, C., Sebben, M., Fagni, L., & Bockaert, J., *5-HT4 Receptors,* in Oliver, B., van Wijngaarden, I., & Soudijn, W., (eds) *Serotonin Receptors and their Ligands,* 1997, Elsevier, Amsterdam, The Netherlands.

Goddard, S., *A Teacher's Window Into the Child's Mind,* 1997, Fern Ridge Press, Eugene, Oregon

Haines, DE. (ed) *Fundamental Neuroscience,* 1997. Churchill Livingstone, New York, NY, USA

Johari, H., *Tools for Tantra,* 1986, Destiny Books, Rochester, Vermont.

Krebs, C.T. & Utt R.D., *Anatomy and Physiology of the Brain and AP Formatting for Brain Anatomy and Physiology,* 1994, Melbourne Applied Physiology, Melbourne, Australia.

McFarlane, K., & Tobar, H.O., *The Chakra Hologram,* 1998, Esoteric Kinesiology, Melbourne, Australia.

MacLean, P.D., *Triune Concept of the Brain and Behaviour,* 1973, University of Toronto Press, Toronto, Canada

Metzner, R.,(ed) Ayahuasca, *Human Consciousness and the Spirits of Nature,* 1999, Thunder's Mouth Press, New York.

Mihailoff,G.A., & Haines, D.E., *The Diencephalon,* in, Haines, DE.(ed) *Fundamental Neuroscience,* 1997. Churchill Livingstone, New York, NY, USA.

Oliver, B., van Wijngaarden, I., & Soudijn, W., (eds) *Serotonin Receptors and their Ligands,* 1997, Elsevier, Amsterdam, The Netherlands.

Panksepp, J., *Affective Neuroscience – The Foundations of Human and Animal Emotions,* 1998, Oxford University Press, New York, New York.

Paramhansa Yogananda Autobiography of a Yogi, Original Edition reprint, 1997, Jaico publishing house, Mumbai, India.

Powell, A.E., *The Causal Body And The Ego,* 1992, Stellar Books, Manilla,

Powell, Arthur E., *The Etheric Double,* 1969. The Theosophical Publishing House, London.

Schmahmann, J.D., (ed) *International Review of Neurobiology Volume 41 – The Cerebellum and Cognition,* 1997, Academic Press, San Diego, California

Strassman, R., DMT – *The Spirit Molecule,* 2001, Park Street Press, Rochester, Vermont

Swami Sivanada Radha, *Kundalini Yoga* 1st Ed. 1992. Motilal banarsidas, Dehli, India.

Swami Sivananda *Spiritual Experiences* 6th ed 1995, The divine life society, Shivanandanagar U.P. India.

The Academy of Traditional Chinese Medicine, *An Outline of Chinese Acupuncture,* 1979. Foreign Languages Press, Peking, China.

Tobar, H.O., *Brain Hologram,* 1999, Kinesiological Institute of Neurological Systems, Melbourne, Australia

Tobar, H.O., *Neural Emotional Pathways,* 2nd ed, 1999, Kinesiological Institute of Neurological Systems, Melbourne, Australia

Tobar, H.O., *Brain Hologram 3 – The Cerebellum Hologram,* 2000, Kinesiological Institute of Neurological Systems, Melbourne, Australia.

Tobar, H.O., *Neural Emotional Pathways 2 – Sleep, Sexuality, & Emotion.* 3rd ed, 2001, Mt Warning Kinesiology, Murwillumbah, Australia.

Tobar, H.O., *Sacred Physiology,* 2001, Mt Warning Kinesiology, Murwillumbah, Australia

Tobar, H.O., *The Primitive Reflexes and the Brainstem,* 2nd ed, 2001, Mt Warning Kinesiology, Murwillumbah, Australia

Tobar, H.O., *Brain Formatting,* 2nd ed, 2002, Mt Warning Kinesiology, Murwillumbah, Australia.

Tobar, H.O., *Neural Emotional Pathways 3 – Stress, Addiction, Consciousness & Emotion*, 2002, Mt Warning Kinesiology, Murwillumbah, Australia

Tobar, H.O., *The Primitive Reflexes and the Brainstem 2*, 2002, Mt Warning Kinesiology, Murwillumbah, Australia

Wolinsky, S.. *The Way of the Human – The Quantum Psychology Notebooks Volume III, Beyond Quantum Psychology*, 1999, Quantum Institute, Capitola California

The procedures and techniques described in this publication are solely for informational purposes. This publication is for research purposes only. HUGO TOBAR and Mt Warning Kinesiology are not dispensing advice, diagnosis, or prescriptions, either directly or indirectly. There are no representations suggesting that the materials presented relate to the condition of the reader. Persons using the kinesiological procedures and techniques given here do so at their own risk.

Hugo Tobar –
Dip.HSci. Holistic Kinesiology
Hugo Tobar has spent 5 years training with Dr Charles Krebs and has been involved in Kinesiology for 10 years. He spent 3 years in India studying Eastern Philosophies and 4 years studying Civil Engineering in both Australia and Ecuador. He has also done two years of Denise Crundall's Reiki volunteers program, which gives an extra dimension to his Kinesiological development.

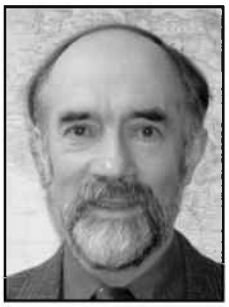
Hugo is a registered level 3 practitioner with the Australian Kinesiology Association (AKA). He is also an accredited member of the Australian Traditional Medicine Society (ATMS).

Hugo Tobar.
Tel: +61 2 6672 7544
Fax: +61 2 6672 7545
P.O. Box 904
Murwillumbah 2484
Australia
e-mail: HugoTobar@aol.com
web: www.kinstitute.com

Notes:

Using Emotions to Balance the Heart

by Wayne W. Topping, Ph.D., LMP



Abstract

Two techniques from Biokinesiology—muscle monitoring with the palm over the flexed wrist and circuit localizing with the nerve endings beneath the fingernails—can be used to increase the accuracy of your muscle testing. In Touch for Health, we have one muscle test (subscapularis) related to the heart meridian. In Biokinesiology we have at least 54 different muscles, tendons, ligaments and discs related to the heart meridian. A fast method is shown to identify which of these are out of balance.

I. Improving the Accuracy of Your Kinesiological Assessment

In 1981, I took a 290-hour training course in Biokinesiology from John Barton that has greatly influenced much of my subsequent work in kinesiology. First we'll describe two procedures we learned that are simple yet can improve your ability to detect energy imbalances within your client or yourself.

A. The Flexed Wrist Experiment

Ask for a volunteer who cannot wear a wristwatch because it creates pain, stops, speeds up or otherwise malfunctions. Have the person extend their arm out to the side horizontally so that you can monitor the middle deltoid muscle. Use spindle cells and/or the central meridian to check to make sure the muscle is in proper balance. Monitor the muscles in the following ways:

a) using fingers over the lower forearm

b) using fingers over the wrist joint

c) using palm over the wrist joint

d) using palm over the flexed wrist joint

If all remain locked, repeat all four tests while holding a wire coat hanger around (without touching) the arm. Test d) is most likely to unlock showing the negative influence of the coat hanger. Test c) is the next most likely to unlock the muscle. Test a) is least likely to unlock.

Explanation

The metal coat hanger is a stressor that is introduced into the person's energy fields, or aura, to show that certain ways of monitoring an indicator muscle are more sensitive than others. Asking for a volunteer who cannot wear a wristwatch pretty much guarantees that you have someone whose system will be sensitive to metal around the arm. This stressor often cannot be detected with test a), sometimes with test b), often with test c) and most easily with test d). The stressor thus proves that testing with a palm over the flexed wrist gives you the most sensitive test.

In Touch for Health, we teach the student to place the testing hand over the lower forearm. Why? Because for some people the muscle unlocks when we push over the wrist. In TFH there aren't fast ways to correct this imbalance. However, in Biokinesiology, we can circuit localize into such a wrist joint to detect the imbalance, then determine the nutrients and emotions required to restore it to balance.

B. Using the Nerve Endings Beneath the Fingernails to Detect Energy Imbalances Experiment

Find a volunteer that has an area of skin out of balance, e.g. a rash. Muscle monitor while pointing your fingertips directly down into the skin. Then muscle monitor while pointing the palmar surface of the finger pads across the skin. Finally, muscle monitor while the fingernails on the dorsal side of the hand are in contact with the imbalanced skin. Usually only the latter method of circuit localizing causes the indicator muscle to unlock.

Explanation

Unless the skin imbalance has sufficient "depth" to it, pointing fingertips at right angles to the skin has minimum contact with the imbalance. By contrast, a wart does have enough "depth" to it. The third test does detect the imbalance. Here the nerve endings underneath the fingernails are going right across the skin surface for maximum contact and most opportunity to detect any frequency given off by the imbalanced skin surface.

This means of circuit localizing allows more types of energy imbalances to be detected in the body than using pads of fingers, e.g. underneath the fingernails to CL the peripheral nervous system on someone who has multiple sclerosis.

II. Balancing the Heart Meridian

In Touch for Health, we have just one muscle related to the heart meridian—subscapularis. In the PKP (Professional Kinesiology Practitioner) program there are the subclavius and extensor pollicis longus muscles associated with the heart meridian.

By contrast, in the Biokinesiology Institute book *Quick Ready Reference*, John Barton has data on 54 muscles, tendons, ligaments, discs, etc., associated with the heart meridian.[1]

Two of these muscle tests were described in the *International Journal of Touch for Health* 1987[6]—Serratus Anterior #8 and Latissimus Dorsi—together with neurolymphatic and neurovascular reflexes that I researched for them.

How do we determine which one or more of these 54 tissues is required to be balanced to balance out heart energy?

In *Take Care of Yourselves Naturally*, John Barton has described two specific response locations for the heart: [2]

22. HEART—in the center of the breastbone 3/5 the distance down from the top to the bottom of the breastbone. Approximately in line with the nipples on a man.
23. HEART—second location, immediately to the sides of the breastbone in between the 3rd to the 5th ribs. An area about 1" wide and 2 ½" long.

In his *Quick Ready Reference* a method is described whereby the reflexes above are circuit located (CL). If the indicator muscle (IM) unlocks, then the practitioner would CL all 54 tissues on each side of the body to determine which are out of balance, determine which has priority, then balance that tissue with emotions, nutrients, and biokinetic exercises. However, there is a faster way which I describe in Topping 1985.[4]

To see how this works, let us consider the full emotional program for two of these 54 tissues. (Note: underlined words indicate most important emotions for the specific system and the heart meridian respectively.)

Serratus Anterior #8

Lymph System	Confused	Confident
Throat Plexus	Unrespected	Respected
Heart	Bitter	Forgiveness
Thymus	Neglected	Cared for
Liver	Helpless	Powerful
Adrenal Cortex	Irritated	Tranquil
Small Intestine	Ungiving	Cooperative

Latissiumus Dorsi

Blood System	Unkind	Kind
Blood System	Discouraged	Encouraged
Bone Marrow	Insufficient	Sufficient
Heart	Bitter	Forgiveness
Kidney	Intolerant	Understanding
Pyloric Valve	Resentful	Appreciative
Pineal	Empty	Fulfilled

Each of the 54 tissues has a series of negative emotions that can cause the imbalance and a corresponding series of positive emotions that can restore the tissue to balance. Included within that list of emotions is **a system emotion**:

Blood	Unkind	Kind
Lymph	Confused	Confident
Nervous	Nervous	Restful

and **a heart emotion**

Insecure	Secure
Bitter	Forgiveness
Brokenhearted	Loved
Unloved	Loved
Defeated	Success, Successful
Sour	Agreeable
Disgusted	Empathetic
Forgotten	Remembered

Each of the positive heart emotions has between 7 and 15 tissues associated with it. We have 21 tissues associated with the blood system, 18 with the lymph system and 16 with the nervous system. Thus, by seeing which of the positive system emotions temporarily balances the heart reflex, we can eliminate about two-thirds of the possible tissues from consideration. The combination of system and heart emotions that temporarily balances the organ reflex will eliminate approximately 90 percent of the tissues. We can then CL each of those muscles, tendons, etc., to see which one or more are out of balance. Or, we can see which unique sequence of positive emotions changes the indicator muscle then verify it by CLing that tissue.

Balancing that tissue with nutrients, biokinetic exercises, and the emotions (Topping, 1985, 1990) should balance the heart organ reflex. [4,5,7]

III. Referred Pain and the Heart

There are three areas of referred pain associated with the heart, as illustrated in Figure 15-2 of Tortora and Anagnostakos 1978.[9]

1) **Upper thoracic spine:** Chiropractic would recognize this as the location where nerves leave the spine to travel to the heart.
2) **Under surface left arm:** We recognize this as the heart meridian. Energy may backup along this meridian up to three days before a heart attack. Biting or putting pressure on the end of the small finger, end of the heart meridian, has successfully pulled people out of a heart attack (Carl Ferreri, personal communication).
3) **Chest area:** This is the pectoralis major muscle where people experience pain when they have angina. In Biokinesiology, the pectoralis muscle is correlated with the heart meridian. When someone is experiencing angina, have them place their arms forward as for pectoralis major clavicular or sternal. Attempt to push the arms out laterally. They will unlock. Touch the heart reflexes and say "you feel secure" and the muscles usually lock, verifying the correlation with the heart meridian.

Ironically, medical science has discovered the underlying basis of applied kinesiology without recognizing it. Placing nitroglycerine or digitalis under the tongue meant rapid absorption into the system and a decrease in angina pain. Then doctors began putting the medications as a patch right over the pectoralis muscle. Balancing out the muscle improves heart function at the same time. They have a correlation between muscle, organ function and the meridian (referred pain) that feeds them both. This muscle-organ-meridian correlation is one of the major platforms of applied kinesiology as developed by Dr. George Goodheart.

References

[1] Biokinesiology Institute. *Quick Ready Reference.* Shady Cove, Oregon. Biokinesiology Institute, 1981.

[2] Biokinesiology Institute. *Take Care of Yourselves Naturally.* USA, 1984.

[3]Dewe, Bruce A.J., and Joan R. Dewe. *Professional Health Provider I: Advanced Specialized Kinesiology Methods.* Professional Health Practice Workshops, 1990.

[4]Topping, Wayne W. *Biokinesiology Workbook.* Bellingham, Washington. Topping International Institute, 1985.

[5]Topping, Wayne W. *Stress Release.* Bellingham, Washington Topping International Institute, 1985.

[6]Topping, Wayne W. "Two Further Muscle Tests for the Heart Meridian". *International Journal of Touch for Health,* 125-8, 1987.

[7]Topping, Wayne W. *Success Over Distress.* Bellingham, Washington. Topping International Institute, 1990.

[8]Topping, Wayne W. *Working with Emotions.* Bellingham, Washington. Topping International Institute, 2002.

[9]Tortora, Gerard J. and Nicholas P. Anagnostakos. *Principles of Anatomy & Physiology.* 2nd Ed. New York, NY: Harper & Row, 1978.

Wayne Topping, PhD, LMP, is a former geology professor who became a TFH instructor in 1977. He has training and certifications in many kinesiologies including extensive training with John Barton at the Biokinesiology Institute. Wayne has taught in 22 countries and written 23 books and workshop manuals. He is founder of Wellness Kinesiology with its 17 courses and is a Touch for Health faculty member for the United States.

Topping International Institute, Inc.
2505 Cedarwood Ave., Suite 3
Bellingham, WA 98225
1-360-647-0164
FAX: 360-647-0164
email: topping@wellnesskinesioilogy.com
website: www.wellnesskinesiology.com

Notes:

Transforming Relationships Through Energy Medicine

by Dr. Mary Jo Bulbrook, RN, CEMP/S/I, CHTP/I, Certified Energy Medicine Practitioner/ Specialist;Transform Your Life through Energy Medicine Program (TYLEM); Founder & Program Director; Energy Medicine Partnerships, Inc., President

Description: Who we are and who we become is shaped by energetic experiences from our families and relationships both in the past as well as the present. Learn how these energies affect us and what can be done to become free, empowered and healed. Examples from teaching this material in Australia, New Zealand, Canada, South Africa, Peru, Chile and throughout the USA will be shared, illustrating concrete ways to change our lives and the lives of those we serve.

Ways to enhance light and love in family relationships with energy dynamics will be covered through blending Energy Medicine and the work of Virginia Satir, renowned family therapist. As conflict and stress challenge heart connections between family members, over time the energetic response blocks love and light, limiting family members' capacity to grow and change.

The Transform Your Life through Energy Medicine (TYLEM) Program originated in 1985 at the International Nursing Diagnosis Conference in Alberta, Canada under the title "Healing From Within and Without." It focuses on personal transformations and the healing of body, emotions, mind and spirit, using a psycho-spiritual emphasis as well as Virginia Satir's model of family change and Touch For Health. Dr. Bulbrook and Dr. Thie were colleagues of Virginia Satir and both shaped their training programs with the influence of Virginia's "Person To Person Model of Care."

Goal – Work through your personal family heart issues while learning to help others using family centered energy dynamics. Learn to plan a sustainable life through living the following spiritual virtues (appreciation, caring, cooperation, excellence, forgiveness, helpfulness, joyfulness, love, peacefulness, respect, service and unity) while achieving balance in family, community, work with holy silence, play and renewal.

This presentation includes:

1. Describing how to transform family relationships using energy medicine, with the theoretical framework of Virginia Satir's process.
2. Experiencing family energy dynamics.
3. Exploring how energy modalities can be used with healing family issues to enhance light and love between and among family relationships.

Presentation Objectives – The participants will be able to:

Objective 1 – Define how energetic experiences shape our past, present and future.

Objective 2 – Describe ways to become free, empowered and healed from those experiences.

Outline: Satir communication styles, family sculpturing, ways of expressing change; Energy Medicine interventions for personal transformations and change.

Presenter: Dr. Bulbrook is a medical intuitive, energy psychotherapist, founder/director of the Transform Your Life through Energy Medicine Program, and president of Energy Medicine Partnerships. In 1980 Mary Jo launched Virginia Satir's first training of Avanta Network which is a process for becoming more fully human. Through Mary Jo's leadership, Healing Touch and Energy Medicine were brought to Australia, New Zealand, Peru, Chile, South Africa, Canada and throughout the USA. Her work includes partnerships with the Aborigines of Australia, Maori of New Zealand and Sangomas, or traditional healers of South Africa.

Mary Jo presented energy dynamics at the 21st Quadrennial Congress of Nurses in Vancouver, Canada (1997), Sigma Theta Tau, International Nursing Honor Society in Australia (1990, the International Society for the Study of Subtle Energy and Energy Medicine (2002) and the European Energy Psychology Meeting (2003). Her other international presentations over the years included: International Transactional Association, Association for Humanistic Psychology, International Touch For Health meeting, International Healing Touch Meeting, Australia Holistic Nurses Meeting, American Holistic Nurses Meeting, Canadian Holistic Nursing Meeting and Virginia Satir's Avanta Network. She has a 20 year distinguished career in university teaching, administration, clinical practice, and research in the USA, Canada and Australia.

Testimonials from other presentations

Satir community – Mary Jo is a mover and shaker. When she starts the ball rolling it makes headway through several generations back. It is like watching Virginia Satir all over again!

Presented at the International Nursing Diagnosis Conference in 1985
This work revolutionizes health and health care to a new dimension. It is good to find someone who can see a broader perspective.

Healing Touch International Annual Meeting January 2003
The combination of these two systems takes energy work to a whole new level. I have opened my heart to my family in a new way. I will never be the same. This work goes to a level deeper than merely psychological talk therapy.

Presentation:

Welcome to the experience of blending
Energy Medicine & Virginia Satir's work
The journey begins…

Virginia Satir's system of helping individuals and families heal is a holistic approach to health and well-being. It is a natural extension embraced in the language of energy psychology. As a psychotherapist and educator of psychotherapists and energy healers, I have found these systems are a natural fit.

How does Virginia Satir help individuals and families heal?

The key aspects to the Satir system are articulated in the conceptual language:

1. Making contact through communication that goes beyond words.
2. Exploring the unique dance between what we give out and what we take in energetically.
3. Experiencing energy's role in body, emotion, mind and spirit health.

Quotes from Virginia's work illustrate these points:

"Look at all ways that we communicate with each other that has nothing to do with words, and allow ourselves the freedom to explore these kinds of communications."

"It is the dance between what we give out and what we take in that is the repository, the laboratory, the resource that we connect inner and outer."

(Memorial Series: ***The Teachings of Virginia Satir*** *1989, Side B, Tape 9)*

"Be aware of your energy coming from the center of the earth, coming from the heavens, coming from your contacts with other people. Feel all that energy blending within you." (Virginia Satir's ***Meditations & Inspirations****, 1985, Celestial Arts. p. 57).*

"Be aware of the energy coming to you from the center of the earth. All you have to do is to be aware of it; it's always there. It is the energy of groundedness that comes from the center upward through your feet and legs. It's like the energy of the heavens, which is always there and comes down through your head, face, neck and arms to join with the energy of the groundedness. That energy from the heavens is the energy of inspiration, of sensing and of feeling one with all life. Accept that beautiful energy of inspiration and ground-ness; let them come together and create still a third energy. This is the energy of connectedness with fellow human beings."

"Let yourself go to that beautiful place deep inside yourself where you find the resources that allow you to use this energy of inspiration, connectedness, and grounded-ness. This is your ability to see, not only with your physical eyes, but also behind your physical eyes. This is your ability to hear the sounds of words and of music, the music of laughing and agony of crying…the ability to hear, behind the physical ear, to what is intended. This is your ability to touch, taste and smell and to touch behind the touch, to smell behind the smell. This is also your ability to speak, to put thought into words – to use that grand evolver of words, your words – to use that grand evolver of words your left-brain. It has these beautiful codes and definitions, the ability to do mathematics, to analyze and to rationalize. And to use the other side, your right brain, which gives you your juices, your awareness and to you joy or pain in living.

*(****Virginia Satir's Meditations & Inspirations****, 1985, Celestial Arts. p. 65-67.*

Summary of Virginia's magic:

- Communicate beyond words, taking into consideration the interaction of the self-other-context. The energies of two people who came together to create a third (this is the connectedness of people). Ordinary conscious communication was complemented by subconscious (slightly below consciousness), unconsciousness (deeply buried data) and super consciousness (beyond five-sense data.)
- Take risks in one's own behalf. Her openness of the self helped another to open. The healing process occurred as contact was made.
- Grow and change based on a learning/education/spiritual model, not an illness model.
- Touch souls together at very deep levels.
- Create a whole person environment to facilitate change, regardless of whether she was doing clinical, teaching and/or a combination of both.

Through meditation she helped people get centered – to connect with all of their parts representing the Self Mandela…tapping into inspiration to help people to make choices for their life…freeing the self from all that binds them from others' expectations.

Virginia Satir's philosophy is combined with Energy Medicine developed by Dr. Mary Jo Bulbrook through her years of experience helping individuals and families change and grow.

The Energy Medicine Program focuses on personal transformations and healing through the Energy System. It is designed to:

Reduce Stress	Promote Relaxation
Heal Relationship Issues	Reshape Family Dynamics
Relieve Pain	Change Unhealthy Beliefs
Assist Others to Heal	Increase Energy Flow
Address Health Challenges	Recover from Trauma & Wounds

Transform your Life!

The goal in Energy Medicine is
To empower individuals
To achieve health and healing.

By working with the energy system, we are capable of changing our own course in life, as well as facilitating healing in others. Through this process our relationships, family dynamics, health, and well-being are improved. Discover how your life can change to a more fulfilling and balanced state of living through working with energy medicine.

Energy Medicine: Stories & Process

Pain and suffering is held in us energetically as well as emotionally and mentally. The word used to describe this is called "soul memory" in the Transform Your Life through Energy Medicine (TYLEM) training program. At times our families are the cause of this imprinting as well as the solution for removing this imprinting. How does this happen?

Story 1. *Gerry, age 50, was on the healing table receiving treatment in a classroom setting as the Energetic Reparenting process was in place. The healer who was working on her became ill in the middle of the treatment and had to leave the client unattended. I walked over to her and intuitively just held the space for Gerry. On debriefing, Gerry reported she had been abandoned by her mother at age 3. This healing session created another "parent abandonment" experience for her. By working in the energy field, an unresolved issue that had been long out of awareness was brought up and healed through the Energetic Reparenting process.*

Story 2. *Sam was in the hospital critically on the edge of life and death. The family had gathered to the bedside with one exception, a daughter Jennifer who lived out of the country. While trying to get home in time to say goodbye to her dad, Jennifer missed her airplane on the last leg of the trip. As her counselor and energy medicine therapist, she called hysterically*

for help. Focusing on the bedside drama, the energetic pattern of each family member in that family system began to be played out. Jennifer was guided to connect energetically with her dad with the anticipation that she may not be able to get home and connect with him before his death. This long distance energetic process shifted Jennifer's energy to come to peace with her dad and use the separation time for her healing of family dynamics.

What do these two stories have in common? Each situation was addressed with an energy medicine approach rather than a classical psychotherapy one.

In addition to being composed of physical organs, cognitive systems, and emotional aspects, we are all beings of light. The Energy Field is part of the spiritual aspect shaping who we are and who we become. Mental and allied health personnel have a role to play in assisting individuals and families grow spiritually. This role includes providing energetic healing and support through both verbal shifting of energy in the therapist/client relationship as well as using healing hands (on or above the body) to provide therapeutic interventions in the energy system. This emerging paradigm shift will require mental health professionals to either become knowledgeable about the field of energy medicine or team up with energy workers to work along side of them. This new frontier calls each of us to step up to the plate and become co-creators of this new way of helping families heal. A model of the energy centers and energy field follows. It is this part of our energy system that interacts with the energy system of others as illustrated in Figure 4.

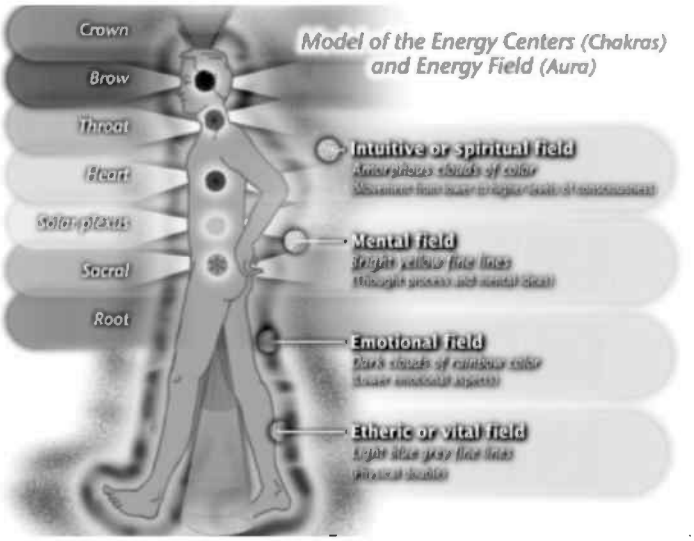


Figure 4. Model of the Energy Centers and Energy Field

The relationship between individuals is dynamic and fluid. The interactions are represented by Figure 5. What occurs is energy flow between and among the chakras as well as fueled by cords that pass between the chakra systems of individuals. The dynamic interplay of energies requires the therapist/practitioner/clinician to register how to assist the client and each person become healed and cleared.(?) –meaning unclear—(and all become healed and cleared?)

Trauma and life experiences are stored in the energy system – the field, the meridians and the chakras. Learning how to assess these blocks to energetic flow requires training and practice. It is as if the practitioner is clearing muddy water to provide a passageway for the light to flow between and among people.

This presentation will offer theory, demonstration and experience with the blending of Virginia Satir's work with energy medicine. It is taking both works to a new level.

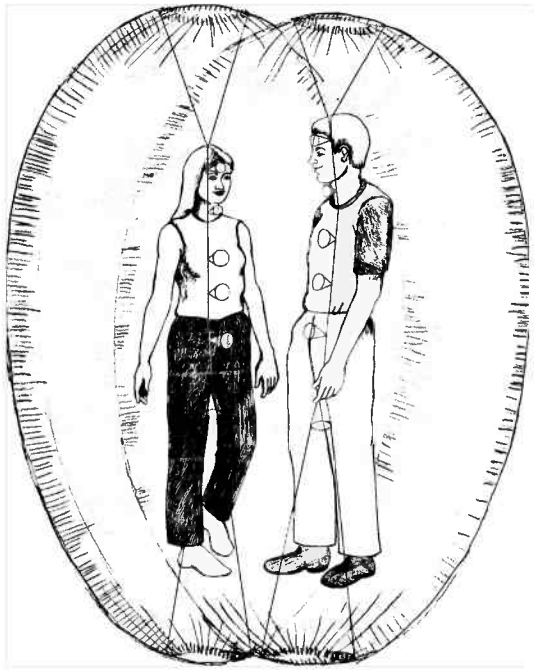


Figure 5. Model of the Energetic Connection between People

In the workshop, some simple interventions will be demonstrated and practiced as well as demonstration of more complex interventions. The Family Energy Vortex will be experienced so that all participants will have the opportunity to transform their families.

There are cord-like structures that come out of the charkas that link us to people as well. These cords sometimes need to be cleared, severed, or repaired as the family interactions are greatly influenced by these experiences. By experiencing the severing of toxic cord- like experiences, one can understand the difference this makes in a general feeling of health and well-being. Cutting the ties that bind us to people are important resources. In addition, energetic reparenting is sometimes needed to correct severe dysfunction in individuals and families.

Life is a journey. Learning about the dynamics of the energy system will provide a roadmap for the adventure, assisting a person on their path toward achieving balance in body, emotion, mind, and spirit.

Join us on this journey and see what the possibilities are!

Dr. Mary Jo Bulbrook, RN, CEMP/S/I, CHTP/I, President
Energy Medicine Partnerships, Inc.
413 Waterside Drive, Carrboro, NC 27510, USA
1 (919) 942-5214 ph (919) 968-0994 fax
Email maryjo@energymedicinepartnerships.com
www.energymedicinepartnerships.com

Notes:

Kinesiology Research – Why Bother, We All Know It Works!

by Sue Hall

But do we really know?

- Can we say for certain that it is the kinesiology techniques we've learned that are having an effect?
- Perhaps it is purely how we are with our clients that 'works'?
- Is it a combination of techniques, expectation and 'bedside manner'?

Does it really matter?

If we decide that we know it works and that's enough for us, then kinesiology is destined to remain amongst the plethora of therapies unrecognised and unvalued by governments, healthcare departments, health insurance companies and many private individuals.

I would argue that remaining on the fringe would be unhelpful for our profession, and that sound research to show that kinesiology has a specific efficacy and an effect over and above other interventions will give us a respected place in healthcare.

At the moment, objective evidence that 'subtle energy' exists is sparse, and therefore a lot of what kinesiology does is 'not possible' in the biomedical framework. However, we all have our own empirical evidence that what we are doing as kinesiologists is often very helpful to our patients. When faced with hostile criticism of our profession, it's little wonder that we tend to opt out of the argument, shrug and say, "Well we know it works."

But do we really?

- What makes a good kinesiologist or a not-so-good kinesiologist?
- Is it something to do with being better healers?
- What about the placebo effect and the non-specific effects common to all healing professions, medical or otherwise?
- How much of the 'healing effect' can be attributed to kinesiology techniques rather than to our caring attitudes and desire to help our patients?

At this stage actually, we really don't know; and until we do have some idea of what is happening, we are not going to be seen as credible professionals – a good reason to do research.

Research is also intrinsic to professional development and should be internal and self-critical to gain feedback about how to be better kinesiologists. This in itself is another very good reason for research to matter.

The need for kinesiology to provide evidence of efficacy is fueled by the fact that it embraces many concepts and treatments for which little scientifically acceptable or plausible mechanisms of action are currently available.

Some of the more modern concepts of physics, in particular those strange notions of quantum theory like entanglement and non-locality, may well prove to be the key, e.g nature's mysterious ability to reach instantaneously across the universe and even through time itself, to ensure the separated but entangled parts of a quantum system are made to match. (Denise Gurney's presentation will take this discussion further.)

So in order to advance the acceptance of kinesiology as a useful alternative medicine, an appropriate scientific foundation is important; and this means good quality, evidence based research, properly supported by a high level academic establishment.

Up to now, research in kinesiology has concentrated on validating muscle testing by looking at changes in muscle response to stimuli, comparing test results to objective measures of strength or neurological function, and inter-examiner reliability studies. The fact that non-AK kinesiology is a whole systems medicine really lends itself to pragmatic studies designed to show an overall effect (if there is one to be found).

Interim results from a clinical trial of Professional Kinesiology Practice (PKP) and back pain, supported by the University of Southampton, UK, will be presented, including a discussion of the methodology underpinning the project and related issues.

- Quality criteria for clinical research
- Model validity
- Issues for clinical research in kinesiology
- Interaction of non-specific effects
- Outcome measures
- Randomisation
- Non-locality
- Unconscious expectancy
- Therapeutic growth
- Power and statistical tests

Sue Hall, MA. , MSc , RK(UK), MBRCP. 2005.
Founder & Principal: British Kinesiology Centre
European Examiner & Senior Faculty: International College of Professional Kinesiology Practice
Assessor /Advisor: Institute for Complementary Medicine
Board Member: European Kinesiology Practitioners Accreditation Board
Board Member: New Zealand Kinesiology Practitioners Accreditation Board.Research Fellow: University of Southampton
Tel: (+44) 1252 722 246
Email: office@britishkinesiology.co.uk
Tel: (+44) 2380 241 072
Email: ssh1@soton.ac.uk

Introduction to Emotional Freedom Techniques

by Gary Peterson, MD; Southeast Institute for Group and Family Therapy; Chapel Hill, NC

This paper will describe some of the basis of the new healing method Emotional Freedom Techniques (EFT). I will outline the process of EFT and make some comparisons between EFT, Thought Field Therapy and Touch for Health.

Emotional Freedom Techniques is an amalgamation and simplification of energy healing methods that is rapidly gaining popularity in many areas of the USA and beyond. (See Gallo, 2002.) Compared to many other energy healing methods, EFT is easy to learn and can be rapidly applied. EFT is a meridian-based system that employs tapping on each of the 12 major meridians and the Conception and Central Vessel. Scaling of the disturbance of the target problem or event is done before, during and at the end of the balancing/treatment procedure.

Retired businessman, Gary Craig, has been the prime developer and promoter of EFT. In 1991 Craig began to study the method of Roger Callahan, Ph.D. called Thought Field Therapy (TFT) (Personal communication, April 3, 2005). TFT builds on the ideas of George Goodheart, DC in Applied Kinesiology and John Diamond, MD in Behavioral Kinesiology. Craig simplified the TFT method and brought into EFT what he considered the necessary elements to obtain beneficial results.

Some of the differences of EFT from TFT are that in EFT 1) no muscle testing is required, 2) there is no routine assessment for or correction of neurological disorganization, and 3) there is no requirement for a specific sequence of acupoints to be stimulated in relation to a specific problem. EFT uses none of the information about specific meridians and their association with specific emotions; rather, it simply describes 15 anatomical points that correspond to acupoints and provides a logical descriptor word or words to designate each balancing point.

EFT is like TFT in that it uses the same acupoints and preserves the use of the 9-Gamut sequence. While TFT was developed with the psychotherapist in mind, like Touch for Health (TFH) (Thie, 1994), the intention of the developer of EFT is it is a method for the lay public as well.

EFT has the same theoretical basis promulgated by Callahan for TFT - that the cause of all negative emotions is a disruption of the body's energy system. Anecdotal information seems to indicate that EFT and TFT are relatively equivalent in efficacy.

EFT PROCEDURE

The method for implementing EFT is called "The Basic Recipe" and is deceptively simple. The Basic Recipe involves four procedures: 1) The Setup, 2) The Sequence, 3) The 9 Gamut Procedure and 4) the Sequence (again). After The Setup, steps two, three, four are repeated until the disturbance is resolved.

Over time the EFT procedure is continuing to evolve as Craig modifies the process based upon results. EFT method information in this article comes from the most recent version of *The Manual* (Craig, 2004).

Prior to The Setup, several steps are indicated:

IDENTIFY TARGET

The practitioner discusses the issue with the subject, clarifying the essence of the disturbance.

ADDRESS RESISTANCE

(While Craig does not address resistance in the Basic Recipe, I have found that this step seems to increase the likelihood of success in resolution of the process.) After the disturbance is identified, ask the subject if there is any reason to maintain the disturbance. Help the subject explore where there is any reluctance to let go of the disturbance and from where the reluctance stems. If you identify any reluctance, talk through the reluctance or target the reluctance for treatment/balance. I ask "Is there any reason you can think of that if you lost this disturbance, it would be harmful to you or others?" and "Is there any benefit that you can think of for maintaining this disturbance?"

IDENTIFY EMOTION AND SCALE DISTURBANCE

Ask the subject to attune to the problem and associated distress.

Ask what is the associated emotion. (While not a part of basic training in EFT, I believe identifying affect is useful in promoting the anticipated outcome. This step serves a similar function to muscle testing for the emotion associated with a goal in TFH.)

Ask for and record a Subjective Units of Disturbance (SUD) rating (Wolpe, 1991) on the target issue. ("On a scale of zero to ten where zero is no disturbance and ten is the highest disturbance you can imagine, how disturbing does it feel to you now?")

1) THE SETUP

The Setup serves the function of addressing potential psychological reversals (PRs), PRs stop progress to resolution of the disturbance during the balancing procedures.

DEVELOP THE REMINDER PHRASE

The practitioner asks what is the worst part of the target event and works with the subject to decide on a reminder phrase for the target event. (The reminder phrase should be short and contain the kernel of the disturbance. Its purpose is to help the subject maintain a psychoenergetic disruption of life energy during the period of the treatment/balance processes). Sometimes the reminder phrase will be self referential like a negative cognition in EMDR (Shapiro, 2001), such as "I'm helpless" and sometimes it will be an emotion, a word or a phrase to remind the subject of the incident, such as "what my uncle did." related to an abuse incident.

CORRECT THE ASSUMED PSYCHOLOGICAL REVERSAL

About 40% of the time there is a psychological energy block (in EFT called a polarity reversal) (Craig, 2004, p 21). This phenomenon is also called psychological (or psychoenergetic) reversal (PR)). Rather than do muscle testing for a PR, in EFT, the practitioner assumes there to be a PR. A simple procedure is done to correct or balance the assumed psychological reversal.

EFT suggests the subject correct the PR by firmly rubbing a neurolymphatic reflex on the upper chest (this is the NL in TFH that is associated with the neck flexors and extensors) or by tapping on SI-3.You can also treat the assumed PR by tapping TW-3, GV-26, or CV-24. (Muscle monitoring (testing) for psychological reversal may be substituted here.) See Figure 1 "Selected Chinese Meridian Acupoints and Associated Emotions."

Place "Figure 1 Selected Chinese Meridian Acupoints and Associated Emotions" about here.

Have subject repeat the affirmation including the reminder phrase aloud three times while tapping or rubbing. (Practitioner tapping with the subject models the movement for the subject, increases the subject's comfort and allows the practitioner to support the process and act as a surrogate for the subject.)

PR Treatment	Say three times:	Optional Muscle Test
Tap side of hand (SI-3)	I deeply and profoundly (love and) accept myself **even though I have** *this problem*	I want to **get over** *this problem*. [versus] I want to **continue to have** *this problem*.

With this procedure, the vast majority of the time, any PR is cleared as confirmed by the fact that the treatment/balance proceeds to diminish the negative emotional attachment to the target incident, i.e. the SUD level drops.

2) THE SEQUENCE

The Sequence is the main part of the treatment/balancing process and most likely to be associated with a decrease in SUD level. *The Manual* suggests to firmly tap the acupoints while stating the problem reminder phrase aloud. I find that tapping lightly 5 to 7 times (or gently touching) at each acupoint while stating the problem reminder phrase aloud does the job and is less likely to be disconcerting to the subject.

The sequence of the tapping and how many points you tap are not critical. Most of the time in demonstration workshop, Craig uses only the first seven acupoints (on head and torso) (Craig, 2004, 2005). In 1998, he added a point at the top of the head that corresponds to the crown chakra (Personal communication, April 3, 2005). He dropped using Lv-14 for a while because of its anatomical position. However, he has resumed using this point in the basic protocol and uses it occasionally in his workshop demonstrations. In order to avoid the anatomically sensitive Lv-14 acupoint and to include the liver meridian in the treatment, I use Lv-8, just below the knee on the medial aspect of the leg. See "Location of EFT Treatment Acupoints." How many points that are tapped each time is a matter of clinical judgment.

Roger Callahan, Ph.D., coined the term "thought field" to embody the concept that thoughts can disturb the life energy fields (ch'i) of the body. This thought field is maintained by the practitioner's repeating of the reminder phrase and having the subject also repeat this phrase, while tapping on selected acupoints. The practitioner should shift the phrasing, addressing a variety of aspects of the disturbing event that have been described by the subject. The practitioner can interject ideas that the practitioner thinks would likely be associated with the disturbance even if the subject had not previously reported the ideas.

3) THE 9 GAMUT PROCEDURE

The "9-gamut procedure" is a series 9 short exercises that can be applied whenever the disturbance level does not seem to be dropping as quickly as expected. It is a standard procedure for The Basic Recipe. However, in Craig's current practice, it is seldom used (Craig, 2004, 2005).

Ask subject to tap at Triple Energizer (Triple warmer)-3 (Gamut Point, Back of Hand) throughout the exercises.

Clinician leads and instructs subject:

1. Close your eyes	4. Look down to the left	7. Hum a note**
2. Open your eyes	5. Move eyes clockwise*	8. Count 1-3-5-7-9***
3. Look down to the right	6. Move eyes counterclockwise*	9. Hum a note**

*It is best to lead this maneuver, slowly moving your finger in a wide circle near the perimeter of the subject's range of eye motion. Look for "catches" in the smooth movement around the arc and "smooth out" these spots.

**The Basic Recipe uses "Hum a tune" to activate the right brain. I believe that sequencing of a tune might also active the left brain, so I ask the subject to "Hum a note."

*** The Basic Recipe uses "Count rapidly from 1 to 5." I believe that "1-2-3-4-5" may be rote and very automatic, while having the subject count odd numbers requires more thought in this step to activate the left (sequential) brain.

4) THE SEQUENCE (AGAIN).

Repeat The Sequence as above. If the subject smiles or laughs, it is a clue that a new insight is being experienced and the SUD is probably decreasing.

Emotional disturbance about an event rarely abates completely after only two sequences of tapping.

EVALUATE PROGRESS

After tapping through The Basic Recipe, ask subject to attune to the problem and request a SUD level. If the SUD drops two or more points, repeat tapping of treatment points. After the first round, vary the reminder phrase to address different aspects of the problem, add emotion and state issues that might be relevant. Using humor helps.

ASPECTS

CHECK FOR TARGET SHIFT

If the SUD hasn't dropped, or if it has increased, inquire as to whether the target has shifted. If the target has shifted, you can clear for an assumed psychological reversal again and treat/balance as above. If the target hasn't changed, treat again for assumed psychological reversal. (TFH practitioners can muscle test for psychological reversal.) Then again attune to the problem and treat/balance as above.

CORRECT MINI-REVERSAL

If progress is being made and the SUD rating drops less than two points after a period of tapping, assume a psychological reversal for the remaining problem (called Mini PR by Callahan), and treat with the affirmation and tapping (or touching) acupoints as follows:

Mini PR Treatment	Say three times:	Optional Muscle Test
Tap side of hand (SI-3)	I deeply and profoundly (love and) accept myself even though I still have some of this problem	I want to get completely over this problem. [versus] I want to continue to have some of this problem.

Keep repeating these procedures until the problem is resolved (SUD = 0). Practitioners who have learned anchoring procedures and procedures to enhance the desired outcome can apply those methods.

LOCATION NAME	ACUPOINT	DESCRIPTION OF ACUPOINTS[2] (One cun = width of the thumb, about an inch)
Eye Brow	BLADDER-2	Medial extremity of the eyebrow, or on the supraorbital notch.
Side of Eye	GALL BLADDER-1	0.5 cun lateral to the lateral eye canthus, in the depression on the lateral side of the orbit.
Under Eye	STOMACH-1	On the infraorbital ridge directly below the center of the pupil, with the eye looking straight ahead.
Under Nose	GOVERNING VESSEL-26	Between nose and upper lip, a little above the midpoint of the philtrum.
Chin	CENTRAL VESSEL-24	Depression in the center of the mentolabial groove. Depression between lower lip and chin
Collar Bone	KIDNEY-27	In the depression on the lower border of the clavicle, 2 cun lateral to the CV (Ren) Meridian.
Under Arm	SPLEEN-21	On the mid-axillary line, 6 cun below the axilla.
Optional - **Below Nipple**	LIVER-14	Directly below the nipple, in the sixth intercostal space.
Optional - **Inside of Knee**	LIVER-8	With flexed knee, the depression at the posterior medial epicondyle of the femur, on anterior insertion of the vastus medialis and the sartorius
Thumb	LUNG-11	Radial (thumb side of hand) side of thumb, about 0.1 cun posterior to the nail.
Index Finger	LARGE INTESTINE-1	Radial (thumb) side of the index finger, about 0.1 cun posterior to the nail.
Middle Finger	PERICARDIUM (CIRC-SEX)-9	Radial (thumb) side or center of the tip of the middle finger.
Baby Finger	HEART-9	On the radial (thumb) side of the little finger, about 0.1 cun posterior to the corner of the nail.
Karate Chop Point	SMALL INTESTINE-3	Ulnar (little finger side) edge of hand at crease from palm when loose fist is made.
Gamut Point	TRI-HEATER (TRIPPLE WARMER, THYROID)-3	Dorsum (back) of hand between the 4th and 5th metacarpal bones, in the depression proximal to the metacarpo-phalangeal (hand-finger) joint, about an inch medial (toward the body) from the web of the hand.

Table 1. Location of EFT Acupoints

FOLLOW-UP ON RESULTS While not a part of The Basic Recipe, it is recommended that the practitioner recheck the SUDs level at the session following the balance. If a desired behavioral outcome was agreed upon, results should be inquired about.

CASE EXAMPLE

The client, Mrs. A, is a retired health care professional with a disability due to PTSD. On the morning of the day scheduled for therapy, her husband called to cancel the appointment because Mrs. A was bed ridden with a severe headache. Headaches were a rare complaint for this patient. I asked to speak with her and encouraged her to come to the session in spite of her headache.

In session, she reported she had awoken with a headache at 4:30 a.m. and shortly after arose for a small breakfast and started to feel anxious. "It happens when I am going to get bad news" she reported. The headache had waxed and waned throughout the morning. She'd feel fine and "then get a scared sensation in my chest and stomach. It stays for a while and then goes away." She could attribute no particular meaning to the symptoms.

We muscle tested for permission to work with the issue of the headache and for which method to use. The result of the muscle testing was to use what I call "Central Tapping," using only four acupoints for the balance (GV-24.5, GV-26, CV-24 and K-27). We used muscle testing to establish that the emotion of anger was involved with resolution of the problem. SUD was 4/10. She associated her anger with her feeling towards extended family members resulting from a phone call she had from her sister who lived outside of the country. Her sister's family members were not being helpful in spite of her sister's potentially severe illness.

We cleared the assumed the psychological reversal (The Set Up) with "disturbance about my anger." It took only one round of The Basic Recipe for her headache to resolve and for her disturbance level to drop to zero. I followed up with an anchoring procedure (elaborated eye roll) to increase the likelihood of the benefits lasting.

She left the session free of her headache and had no recurring symptoms during the following week.

This case is an example of preparing for the EFT method with kinesiology procedures to choose the correct target. Only a few acupoints were chosen. With the choice of the relevant target and adequate preparation for the procedure, the disturbance (headache and anger at family) was effectively resolved. Preparation for the procedure took about 30 minutes; the procedure took less than ten minutes.

CONCLUSION

Emotional Freedom Techniques is a system of healing procedures that is relatively simple to learn and easy to apply. It can be a useful adjunct for the practitioner of Touch for Health.

REFERENCES

Craig, G. (2004). *The Manual* (5th ed.) The Sea Ranch, CA: Author

Craig, G. (2004, June 21-23). *Nutrition and EFT workshop.* Chicago, IL

Craig, G. (2005 March 12-14). *Mastering EFT workshop.* Costa Mesa, CA

Diamond, J. (1985). *Life Energy: Using the Meridians to Unlock the Hidden Power of Your Emotions.* St. Paul: Paragon.

Gallo, F. P. (Ed.). (2002). *Energy psychology in psychotherapy.* New York: Norton.

Goodheart, G. J. (1967). *Applied kinesiology,* 4th Ed. Detroit, MI; Author.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing* 2nd Ed. New York: Guilford.

Thie, J. F. (1994). *Touch for Health.* Marina del Rey, CA: DeVorss.

Wolpe, J. (1991). *The practice of behavior therapy* (4th ed.) New York: Pergamon Press.

Xinnong, C. (Ed.). (1987). *Chinese acupuncture and moxibustion.* Beijing, China: Foreign Languages Press.

Notes:

The Heart of Stress Management

by Jon Seskevich, RN, BSN, BA

In my job as a full time nurse, stress management educator and guide, I devote my time to helping patients cope with the stresses of illness and their treatments. At my presentation at the conference I will share my "jewels of stress management" I have culled from over 20,000 inpatient contacts in a major academic medical center in Durham, North Carolina since 1990.

A couple of examples of the jewels I share are relaxation practice and spirituality. In the hospital everyone tells a patient to relax and don't worry! but seldom is the patient (or family member) effectively taught how. I teach them how. To help focus the relaxation sessions I do, I perform a spiritual assessment. Frankly, if spirituality is important to a patient or client, it can be a valuable tool in stress management. It is easier than you think to include such an assessment in your care giving. Let me begin first with the relaxation I teach patients to use when they are dealing with an unwanted health problem or if they are in the limbo of waiting and not knowing.

The relaxation technique, involves 3 simple steps. The first is what I call, soft belly breathing. There are many names for conscious breathing relaxation, including relaxation breathing, abdominal breathing, soft abdominal breathing, mindful breathing, etc.

To get the idea, place your hand on your abdomen and softly breathe into it, so that it rises with the inhale and falls with the exhale. I encourage soft belly breathing because many, when they learn breathing techniques, make a lot of effort and push the abdominal muscles out. There is more force and effort than what is simply needed. Soft belly breathing, softly aims the breath into the belly, fully expanding the lungs and the palm of the hand and abdomen gently rise.

The second step of the relaxation involves, consciously feeling the contact with the bed (or the chair and floor) and let the surface support your weight. Let the bed or chair do the work, you don't have to. Try this out.

The final step of the technique involves silently repeating a word or phrase to your self. Each patient is instructed to kindly and gently return to the word or phrase when they notice the mind wandering to thoughts, images, sounds, etc.

To assess the interest in spirituality, I ask, "Is religion or spirituality important to you? For some people it is and for some it isn't. How about you?"

I find that I invariably get one of four answers to this assessment:

1. Yes. Or, yes, it is important to me.
2. Well, I don't go to church but I do believe in God.
3. I'm not sure about God but I think there is something spiritual or a higher power. Or, a statement that recognizes personal spiritual feelings.
4. No, not really.

The right phrase

As part of this relaxation practice, I typically encourage the patient to select a soothing phrase to concentrate on. If the patient told me religion was important and they were Christian, I might suggest concentrating on a phrase like, "the Lord is my shepherd" or perhaps "God is with me." I always ask if they are comfortable with any phrase I suggest.

Naturally, the key is to posit a phrase that fits his or her particular religion. If the person is Jewish, I suggest a Hebrew phrase. Shalom, (peace) or Shema Israel. (Hear Oh Israel). If the patient is Muslim, I suggest a Muslim phrase like La Il Allah ha. Il Allah hu. (There is no God but God.). And so on.

On the other hand, if the patient isn't religious or spiritually inclined, I suggest a positive phrase such as Easy does it. Or I might ask the patient to choose a phrase that would be comforting, relaxing, and supportive. I have had many teenage patients choose the phrase I love my mom.

It is important to be very sensitive ethically about encouraging spirituality! Above all, it is best to avoid making any efforts to push a vulnerable patient or client to go along with your religious belief system or to shame a person who isn't religious. I never challenge beliefs that a person finds to be of comfort. The goals are to relieve suffering, improve quality of life and improve physical functioning through stress management, not to convert or convince someone.

The only challenge with this spiritual assessment during my 15 years of clinical practice was from two patients who informed me they belonged to the Church of Satan. How would you respond? For each of these individuals, I suggested the phrase, "Easy does it." They both liked that. I have had a couple of hospital chaplains who suggested I could have offered the phrase, "Go to hell," as an option.

As I continue the stress management teaching after relaxation teaching and practice, spirituality as a coping strategy is encouraged based on the patient's answer to the spirituality assessment. I practice in the Bible belt, so 90% of the patients I see say that religion or spirituality is important to them. Many have simply said God is the best stress management. For those who have little or no spiritual or religious inclination, as well as those that do, I have many other jewels of stress management to share, including behavioral medicine approaches, a listening ear without taking on the pain, compassion and clinical expertise gleaned from my 30 years of hospital work.

Jon Seskevich, RN, BSN, BA can be contacted through his website http://managestressnow.com or email to Jon.Seskevich@duke.edu

Notes:

The Biology of Perception

by Sheldon C. Deal, N.M.D., D.C.

In the world in which we live, we have spirit and we have matter. The difference is that spirit is homogeneous, spirit is permanent, spirit is without change, there never was a time spirit did not exist, there will never be a time in the future when spirit will cease to exist, spirit is a permanent substance. Matter is made up of atomic structure, and because matter is made up of atomic structure, it is an ever-changing substance.

There are some schools of thought out there that would have us believe that the physical world is not real, that the physical world is an illusion, and it just appears that we are here, that we are not really here, it is just one big hallucination. That is not true; the physical world is very real. It is definitely real. We are here attending school, but it is an ever-changing world because that is the nature of atomic structure. Atoms make up molecules, molecules make up compounds, and everything of a matter nature vibrates at a certain rate of speed. So it is an ever-changing substance and it is true that physical structures do not last forever, that the strongest bridge or the tallest building, no matter how well they are constructed, will decay over a period of time. So the physical world does change but it is not because it is not real. It is definitely real. It is just the nature of things made up of an atomic structure that that is the case.

My favorite example is that when you examine the cadaver in the morgue there are no missing parts. You cannot say that that body is dead because a certain part is missing, because all the parts are there that are in the live body. What is missing is the spirit. The spirit has left the body and that is why that body is no longer alive. But the spirit is somewhere. The spirit does not just disappear; the spirit does not end; only the body ceases to be a vehicle for the spirit. So that is the basis of our philosophy, the spirit is constantly occupying bodies of a finer and finer nature, progressing on an evolutionary scale, and that is the whole name of the game, that we come here to attend another day in school, hopefully taking up where we left off last time and that progress is recorded as soul growth.

Now this body that we occupy as a means of transportation on this physical plane of existence is obviously made up of matter. The physics definition of matter is anything that occupies space and has weight. There is a famous experiment that was done in 1906 in Massachusetts General Hospital where Dr. McDougal put dying patients on a Libra scale and at the exact moment of death the weights that were used to counterbalance the body weight went crashing to the floor, proving that something that had weight had left the body. No matter how many times they repeated the experiment, it always happened the same way; at the exact moment of death the weights would go crashing to the floor. So the headlines at the time read, "Dr. McDougal Had Weighed the Soul." But he did not really weigh the soul because the soul is not matter, spirit is not matter. What ever left the body had to be matter. Only matter is subject to the law of gravity. That is why the weights went crashing to the floor. For years and years I told that story thinking that it was only the reporters who thought that Dr. McDougal had weighed the soul. But then Cindy found that article on Art Bell's web site and printed it out for me, and it turns out Dr. McDougal himself thought he had weighed the soul. But what he really weighed was the four (4) ethers that had left the body. The four (4) ethers are part of the physical world, each world has seven (7) subdivisions, solids, liquids, and gases, and the four ethers make up the (7) subdivisions of the physical world. So when the ethers, which make up a certain amount of weight, left at death, that is why the weights went crashing to the floor. So what he was really measuring was the etheric body. But he thought he was measuring the soul.

Some other things that have happened: Candace Pert, a PhD. in neurophysiology, and her associates did some experiments where they found out that the brain cells were communicating with each other by secreting a neuropeptide, and when the one brain cell secreted a neuropeptide, that same neuropeptide would be picked up by the receptor site of an adjacent brain cell and that is how the message would get from one nerve cell to another nerve cell. Now that was a new concept at the time, because prior to that we thought that such a transmission was of an electrical nature, and now we know that it is of a chemical nature. We now have a new explanation of how the nervous system works. What is so significant to our topic is that when they tried to figure out what made the first brain cell secrete the neuropeptide in the first place, it was a thought. When you have a thought, a notion, an idea, a hunch, that act is what causes the neuropeptide to be secreted in the first place. Then that creates the neuropeptide to be picked up by any other cell that has a receptor site that matches that neuropeptide. That was a fantastic breakthrough.

The next discovery was that they found that these exact same receptor site on a white blood cell called a monocyte, and a monocyte is one of the main white blood cells of your immune system. So now whatever the person is thinking, therefore creating neuropeptides, the immune system is eavesdropping on that dialogue. Because the white blood cells are picking up the exact same neuropeptides and so the immune system knows what you are thinking. So we have a thinking immune system. This would explain why psychoneuroimmunology works, why people have success when they practice visual imagery and there are certain clinics that teach visual imagery as a method of treating disease, and the percentage of results at those clinics is increasing more and more as we become more proficient at this process.

A friend of mine tore his Achilles' tendon and he was told that he would never heal if he did not have surgery on it, and if he did not have surgery, he would have a limp the rest of his life. He chose to practice visual imagery. He got out the anatomy books to help him visualize what an intact Achilles' tendon looks like. He practiced that visual imagery over and over and over again and he went on to a complete healing. This just happened to be someone we know whose name is Dr. Jerry Morantz. And he has absolutely no limp, a complete healing, and no surgery. It just was an example of what can be accomplished by practicing visual imagery to bring about the healing. Therefore, thoughts are very powerful. We will go on to describe how incredibly powerful they are even though our mind is in its infantile stages of development.

We have an immune system that is eavesdropping in on our internal dialogue, and the next discovery that Candace Pert and her as-

sociates made was that they found these same receptor sites on other organs of the body, such as kidney, lungs, heart, and intestines. So that means that the rest of the body is also eavesdropping in on our internal dialogue and knows what we are thinking.

The final discovery was that these other organs that have these receptor sites, heart, kidney, lungs, etc., were also secreting neuropeptides, just like the white blood cells were secreting neuropeptides. So what does all that mean? It means we have a thinking body. The mind is no longer confined to the brain. It has escaped and occupies our entire body. It was just an erroneous concept that we had in the first place. We just thought the mind was confined to the brain. Through our ignorance we thought that. Now we know that the thought process is a product of the whole body, and the immune system is scattered over the entire body. The entire body is capable of creative thoughts, and that being the case, it makes us all that much more aware of how powerful our thoughts are, why we need to be careful of what we think, because the rule is, "Think about what you want but make sure you want what you think about." We have all been guilty of that at one time or another, thinking thoughts that we really do not want. But that process is impartial. You attract to yourself that which you think about, whether it is good or not. So we are all on the same boat as far as being affected by our thoughts.

Now, some other research has been done which helps explain how this works, in physics. In Newtonian physics, named after Sir Isaac Newton, everything was viewed as particles and the particles made up everything. But then when they were able to break down the atoms into smaller things than electrons and neutrons and protons, they found out that the particle theory really did not hold up. So there became a new form of physics called Einsteinian physics, which is now superseded by quantum physics. Quantum physics is a fascinating study, and they have particle accelerators nowadays where they can actually break down the atom into smaller particles. Ten (10) years ago they thought atoms were made up of electrons with a nucleus that consisted of protons and neutrons. There were an equal number of protons to the electrons; therefore the atom would have a neutral charge to it. But when they put these atoms in a particle accelerator and bombarded the atoms with high energy, they found out that the neutrons and protons were actually made up of smaller particles called subatomic particles. These subatomic particles were so tiny that you could not see them, you could not weigh them, and you could not measure them. Well then you say, if that is so, how do you even know that they exist? Well, in the particle accelerator, where they are breaking up the atom into smaller particles, they have a viewing screen where they are watching what is going by. They are recording this on film, and although they could not see the particle itself (the subatomic particles) they could see the evidence of it going by because it would leave a streak of photons. Which means a streak of light would go by, that is how they knew subatomic particles existed and they were able to break down the protons and neutrons into something smaller called quarks. They found out the quarks are grouped into groups of three (3), and the quarks are named up quarks and down quarks. A proton has two (2) up and one (1) down, and a neutron has two (2) down and one (1) up. The fascinating thing about this –and this is what makes quantum physics so unusual – the particles were able to be identified with the investigator viewing the screen looking for them, but as soon as the investigator turns his or her attention away, they disappear! They only appear when you are looking for them!

The significance of that is horrendous. It means the investigation of quantum physics is influenced by the investigator. The investigator himself becomes a part of the investigation. His looking, his intent, influences the result. So that takes it out of the previous definition of what comprises something scientific if you are influencing the results of the experiment. Well, in quantum physics you cannot help but influence the results of the experiment. The way that they are able to verify this, well, first of all it was discovered serendipitously, is that when they would view the film of what was recorded of these streaks of photons going across the viewing screen that is when they noticed that the screen went blank. By backtracking, it was at the same time that the investigator turned his attention away from the screen, and the subatomic particles only appeared when the investigator was looking for them.

The most significant point of this is, our minds, in looking for subatomic particles, make them appear, and the subatomic particles make up the neutrons, protons, electrons, which in turn makes up atoms, which makes up molecules, which makes up compounds. Do you see where I am going with that? We are creating with our minds. We are literally creating with our minds. All of this is on a very elementary scale, it is significant, it ties into our philosophy which says our mind is in its first stage of development but later we will be creating fully with our minds. Just like with the Lords of Minds are presently creating with their minds; we humans will have developed to that stage.

In quantum physics, a quantum unit of light is a photon, a quantum unit of electricity is an electron, a quantum unit of gravity is a graviton, and a quantum unit of your body is a thought.

So that is extremely significant, that in this infantile stage of the development of our minds, they are able to show already that the mind can make these subatomic particles appear. It is extremely significant in my opinion at the risk of forcing that on you. A historical point that relates to this concerns Charles Darwin's log book. He had a sailing ship called the Beagle. He sailed to the remote areas of the planet; he investigated nature that was developing on remote islands. When he went to the island of Patagonia and he dropped anchor in the bay, his men got in their life boats that they lowered over the sides of the sailing ship Beagle and they rowed to shore, there where natives who lived on the island who rode out in their dug out canoes to meet them. In communicating with the natives, the natives said, "How did you get here? We are familiar with these parts. We have never seen you before. We are familiar with all of the surrounding islands. Where did you come from? How did you get here?"

And Darwin's men said, "Well, we came on the Beagle." It turned out that the natives could not see the Beagle anchored in the bay because they had no concept that such a thing existed. It was beyond their imagination a sailing ship so big could bring these men from a distant place. It was not until Charles Darwin's men took these natives into their row boats and took them onto the deck of the Beagle and explained to them this was a "Big Canoe", that only then could they see it. So the moral of that story is all of our lives that we have been told that seeing is believing, and it is not true. It is the other way around. Believing is seeing. We only see what we believe. If we do not believe in it then we will never see it. And so that is another concept that we have learned about thoughts and our perceptions.

Another example of the power of thought is the power of intention. Intention is so powerful we need to be mindful about our own intention. Because again it goes back to the rule, Think about what you want and be sure you want what you think about. Let me give you some examples. In our home, we have three (3) cats, about two (2) cats too many. They are lovable, affectionate cats, and they love to be petted and they are constantly rubbing up against us

and they are constantly butting us with their heads because they want to be petted. But when we have company come, and one of Cindy's sisters is very allergic to cats, we gather up the cats and we lock them up in the laundry room. So when we get ready to lock up the cats in the laundry room, we go to approach the cat, like we would normally approach it, now the cat runs from us. We did not say to the cat, "Hey, I am going to lock you up in the laundry room." We did not speak to the cat, but because our intention was to take the cat and lock him up in the laundry room, evidently that intention transferred, because now the cats run from us.

I have heard stories about people who raise chickens. Every day they go out in the chicken pen to feed the chickens, gather eggs, and the chickens gather around them, and the chickens follow them to get the food. But should the person go out their with the intention of picking out a chicken out for Sunday dinner, the chickens run from them. The person does not do anything different than when he goes out to gather eggs. He did not physically do anything different and yet those chickens now run from him when his intention is to pick out a chicken for Sunday dinner. So intentions, therefore, are a very powerful force of thought and perception.

We live in this world that influences our intentions and our thoughts and it controls our perception of what is going on. Here is a truism for you; "Your perception determines your reality." However you perceive it, that is what is real to you. When someone else has a different perception, they see it differently. It is not a matter of one person being wrong and one person being right, the point is it is your perception that determines your reality.

Your perception influences your thoughts, your ideas, your morals, your standards, your job performance, your mental health, your relationships, and because there is a collective consciousness of the planet, if we have some erroneous perception of how it really is, it influences the development of the whole dang planet. If our perceptions are eschewed, then the evolutionary development is affected accordingly.

Our perception of how things are is literally affecting our biology. There are lots of examples of that. People can worry so much that they make themselves sick. Not because something physical happened to them. Not because they took in some toxic poison. Not because they had something physically harm them. Just their thoughts can make them sick. So their health was the result of those thoughts and when it happens collectively affecting the universal consciousness, then the development of our planet can be affected. Some metaphysical organizations teach that everything is karma; everything is due to the law of cause and effect. If something good happens to you it is because you set in motion a good cause earlier. If something bad happens to you it is because you set in effect earlier something that you did and that is the cause of the affect of that. What they do not take into account is epigenesis. Epigenesis means that we, as free-thinking individuals have the ability to come up with something new. Everything is not predestined. Everything is not due to cause and effect. We can institute epigenesis at any given moment; we can set something new into motion. And epigenesis basically falls into two (2) categories: we can think or we can have a perception that is constructive, which activates attraction. The best example of that is love; or we can have the perception of protection and activate repulsion, thus we become defensive. The best example of that is fear. So we can have attraction or we can have repulsion. Those are the two (2) main categories that we can generate.

I want to give you a quote. This is from Dr. Francis in Las Vegas, Nevada. He says, "Human nature is the epigenic rules that bias cultural evolution in any one given direction. It is the summation of individuals' most basic beliefs that determine our attitude toward each other. If our basic belief systems are reversed, then across evolutionary time the composite choices of many individuals determine the fate of the planet, the human species, culture and all other life as we know it towards eventual extinction." Of course the reason we talk about all of this, is so we do not follow in that track and rather get our heads screwed on straight. Another example of that is: worry is the misuse of imagination. We see the world not as it is (remember I said perception determines your reality), we see the world as we are. It can be no other way. You can not see the world differently than what you are. You have heard about so-and-so wearing rose colored glasses, well, the truth is we are all wearing glasses of some color. We all see the world according to our internal makeup. We cannot do otherwise. So the idea is to try to get a perspective that is correct, get a perspective that is constructive, get a perspective that is positive.

Perception controls your genes, via gene expression. Genes do not self-activate, they respond to our environment. The behavior of the cell is not preprogrammed. 95% of all cancer has no hereditary connection. Beliefs are altering our biology constantly. The DNA is only a blueprint so the cell can duplicate itself. Random mutation is an old theory from Darwin. Rather we adjust our genes to fit our environment through our perception of the environment. Our beliefs are the filters between our perception and our biology. Life has everything there is to offer but you only get and see what you perceive!

SCHEDULE
Saturday, July 16, 2005

Speakers:

The Beginnings of AK by George Goodheart

Heart Health: Asprin Is Not a Vitamin - Margarine Is Not a Food by Walter Schmitt

That Reminds Me of a Story by Richard Utt

You'll Be Better, Why You'll Be Better — The Story of Applied Kinesiology

by George Goodheart

Chapter 1 : THE BEGINNING

I graduated from the National College of Chiropractic in Chicago, Illinois in 1939, and previously attended pre-chiropractic at the University of Detroit. I began practice in association with my father late in 1939. However, the advent of World War II didn't give me much time to practice. I went through the Air Corps Cadet Program in 1941, during the early war years, but through a happy series of fortunate events became involved in innovative air operations research, so my active practice really began in 1946 following my release as a Major from the United States Air Force. Having left the Air Force in 1946, I resumed active practice in association with my father until his death in the early '60s.

Because of my father's background in general practice, ours was a general practice, and we saw many patients with many problems. As is usually the case, the further along I got in practice the more intelligent my father seemed to become—the obvious fact being that I became more aware of my inadequacies and his excellent qualities; and I grew in stature and development because of my association with his very, very practical and superb diagnostic and clinical work.

My time in the Air Force had given me a taste for innovative opportunities, and also had taught me a practical method of dealing with problems, and this was to stand me in good stead later on.

Not long after my father's passing, a young man presented himself at the office complaining of a relatively common problem, although at a very early age. He was losing his hair. He had a rapidly receding widow's peak, and at the age of 24 seemed quite concerned. He was a stocky young man who was quite well built, and had recently been discharged from the paratroopers, but despite apparent good health he was suffering from a rapid hair loss.

Examination revealed a hyperthyroid problem, and at that time we were measuring the thyroid function as we still do, by measuring the speed of the achilles tendon reflex. The achilles tendon is put on a stretch and tapped with a testing hammer; then the speed of the achilles as it moves, just as your knee would jerk under the knee jerk test, is measured by its path through a photo-electric beam. This impulse is transferred electrically to an EKG, which then gives a printout to the degree of functional capacity of the achilles tendon to respond to the tap.

The normal time is 330 milliseconds, and his was abnormally fast, approximately 220 ms. 220 milliseconds was quite fast, and nutritionally I had learned that natural amounts of Vitamin A and a source of Thymus, a small gland around the windpipe which is associated with auto immunity, were practically specific for hyperthyroid problems, along with regular chiropractic care. Upon administering this nutritional support and the proper treatment mechanically, he showed a tremendous response in about two weeks. His hairline stopped receding, for which he was very grateful and pleased, and he asked me advice about another problem.

He mentioned that he couldn't get a job in any of the factories in our town because he was unable to pass the physical—and the reason he was unable to pass the physical was his inability to press in a forward direction with one of his arms. One of his shoulder blades stuck out in a rather unusual fashion, protruding from the chest wall. He asked me if I could do anything about it. I said, "Well, probably it's some type of anomaly, a variation in a probably normal function." We did some x-rays to prove this potential which revealed no abnormality, and I could offer him no further advice as to why this particular condition was present.

Either fortunately or unfortunately, depending upon your point of view, I was able to procure a job for him with one of the companies in the building where we had our offices, a nutritional company with whom we did a lot of business. He would come into our office, and quite often in a crowded waiting room would ask me in a loud voice, "When are you going to fix my shoulder?" This embarrassed me somewhat, and I motioned him to come into the inner office quickly, away from the sight and scene of my embarrassment, and I would tell him that there wasn't much I could do about it.

Having been embarrassed for the last time by his frequent inquiry, I resurrected a book that had been given me by a colleague of mine, Dr. Raymond Koshay, a very fine chiropractor in Port Huron, Michigan whom I had been able to help with a knee problem; and for Christmas he had given me a copy of the book. I remembered that there was a muscle that pulled the shoulder blade forward so that it would lie flat on the chest wall, but something like the old adage—what you don't use you lose—I knew the muscle existed but I wasn't sure of its actual origin and insertion. When I applied myself to the book he had given me, "*MUSCLE TESTING*" by Kendall & Kendall, I soon found the muscle that pulled the shoulder blade forward on the chest wall was the anterior serratus. There was a method for testing it which involved placing the patient's hand on the wall, and then pressing on the spine in a forward direction, and the shoulder blade immediately stuck out.

In an effort to identify the cause of the problem I palpated the muscle. He said he had the condition as long as he could remember—15 or 20 years—yet when I palpated the muscle left and right, on the side of involvement, I found no atrophy of disuse—the usual pattern of inactivity that occurs, for example, if you keep your arm in a cast and the muscles wither from lack of activity.

Upon palpating the muscle I felt an unusual nodulation at the attachment of the muscle to the anterior and lateral aspects of the rib cage, which I didn't feel on the other side. The small nodulations were quite apparent to the palpating finger, and in an effort to identify their nature I pressed on them. They were not painful other than minimally so, and they seemed to disappear as I pressed on them with my palpating pressing finger.

Encouraged by the apparent disappearance of the first one or two, I continued to press on all of the small areas which we later learned to be avulsive in character, a tearing away of the muscle from the periosteum. The attachment of the muscle to the covering of the bone, the periosteum, was producing a nodula-

tion which is characteristic in these cases of micro avulsion. They are small tearings away of muscles from their attachment.

Having palpated and pressed on all the small nodulations which coincided with the attachments of the muscle to the rib cage, I then surveyed the muscle. It felt the same, but this time I noticed his scapula (shoulder blade) was lying in a normal position on the posterior chest wall.

Surprised but pleased, I repeated the test, having him place his hands in front of him against a plywood panel that separated one section of the office from another, and I pressed hard on his spine. The shoulder blade did not pop out, and he looked at me with an inquiring glance and said, "Why did you not do that before?" I looked back at him, serious of face and direct of eye, and said, "Well, you have to build up to a thing like this. You didn't get sick over night." It was an automatic response, but all I could think of at the time.

He was pleased, I was delighted. It was an unusual thing to see this quick a response. In an effort to identify this unusual reaction, yet not reveal my surprise, I requested him to return to the office the next day so I could check his hair loss. He advised, surprised, that he hadn't lost any hair in six months. I mentioned that he could never be too sure, so he showed up the next day. I looked at his hair and said it looked fine. Then I said "By the way, let's test that muscle." I tested the muscle, and it remained strong—and it has remained strong ever since! I have seen this patient from time to time since that first incident, which occurred in 1964.

Emboldened by this unusual success, I began to test muscles by the method of Kendall & Kendall, a method which is used by military, civil and government agencies to rate disability and is a standard method of diagnosis. I found many patients showed muscle weakness. Many patients also denied a history of trauma, but many patients responded to the hard heavy pressure at the origin insertion, although many did not.

Fundamentally, my rate of success with patients was rising and I had communicated this method of testing along with the rather primitive method of treatment to my colleagues. One of those colleagues, Dr. Pat Finucan, sent me a patient who had an unusual type of sciatic neuritis, a painful problem involving the lower limb that would cause severe pain if he were to stand, sit or lie down, but would disappear when he would walk. Dr. Finucan had found a weakness of the fascia lata, the muscle covering the lateral portion of the thigh associated with movement outward of the leg.

Despite efforts to correct it mechanically at the spine and locally, using the origin insertion technic, he had been unsuccessful in relieving the patient's pain or changing the disability which was diagnosed by the pattern of muscle testing. The muscle would test consistently weak on the side of involvement: tested by requesting the patient to abduct, moving the leg sideways, and then requesting the patient to resist the pressure to take it medially. This was accomplished while the patient was in the supine, back lying position.

Because of the unusual history, I felt that this was an involvement of the lymphatic system, which is the sewer or drainage system of the body. It is drained by a variety of modes, but fundamentally it is drained by the squeezing action of the muscles on the lymph system. Because walking relieved it, indicating this possibility, I palpated the lymph glands on the lateral aspect of the thigh and felt nothing unusual in comparison to the uninvolved left side.

I palpated also for the potential of any sacroiliac disturbance, because occasionally we get lymph nodulation in the region of the sacroiliac joint if there is a sacroiliac disturbance. I found none of these, and the patient was in a great deal of distress while lying on his back. After palpating for diagnostic information, which I did not find, the patient looked up at me and said, "That's the first relief I've ever gotten." I looked at him and said, very bravely, "That's what you came here for," indicating that it was not the surprise to me that it was.

Astonished by this rather quick success and yet not understanding the basis, I continued to initiate the palpation which I had accidentally used to relieve his pain. He remarked that the pain which he had experienced for many, many months was now completely absent, and subsequent investigation and diagnosis revealed a complete disappearance of the long-standing and chronic irritation of the sciatic nerve.

My secretary, who had been with me for many years and who was a very fine German woman, had quite a bit of sinus trouble and would consistently show a head tilt when she would have a sinus disturbance; and despite the fact that I could find a weakened muscle which I associated with the head tilt, the original technic that had been used on the young man with the hair loss did not produce any muscle strengthening, nor did it affect the sinus involvement.

Thinking that one had to simple palpate and treat the muscle, such as had been done to the sciatic patient earlier that afternoon, I tested her neck flexors by having her raise her head and turn it slightly to one side, and they showed immediate weakening on testing, I attempted to repeat the procedure that had helped the sciatic patient, running my hand along the lateral aspect of the muscle, the sternocleidomastoid muscle that runs from the back of the head bone to the collarbone. I felt nothing different on palpating and testing the muscle, using the technic that I had palpated and tested earlier on the gentleman with the sciatic neuritis.

I tried triumphantly to test her neck muscles again, and to my chagrin her neck muscles were possibly even weaker than before, and I almost injured her head by the sudden collapse of her neck to the testing direction of my hand. I said rather despairingly, "It sure seemed to work on that fellow this morning. I can't understand why it doesn't work on you now."

Then I thought, perhaps what I pressed on was something unassociated with the muscle itself, but associated with, possibly, some lymphatic circuit breakers which had been postulated by an osteopath named Chapman. This had later on been discussed in a text, "*AN ENDOCRINE INTERPRETATION OF CHAPMAN'S REFLEXES*," the second edition, which had been reprinted by the Academy of Applied Osteopathy, copyrighted May 6, 1946. It had originally been copyrighted in 1937 by Charles Owens, D.O., and was a book on the diagnostic and therapeutic application of neurological reflexes that had been the work of Frank Chapman. Both Dr. Chapman and Dr. Owens had postulated the existence of a reflex called the neurolymphatic reflex—a cutaneous visceral reflex that had been under investigation at the Kirksville College of Osteopathy and Surgery.

"The surface changes that are present in a Chapman's reflex are palpable." Dr. Owens spoke of the changes found in the deep fascia as well as the superficial tissues located at specific points (loci) and consistently associated with the same viscera. These little tissue changes, which began in the form of contractions, are located anteriorly in the intercostal spaces between the ribs near the sternum. They may vary in size from a half of a BB shot to that of a

small shot gun pellet, and are generally multiple. This type of tissue change is apparent in some of the reflexes found in the pelvis; but the ones found in the lower extremity, associated with the colon, broad ligament and prostate, vary in character.

By trial and error, testing muscles and then comparing areas that Chapman had originally talked about, we found which circuits affected which muscles. Then, by trial and error and also by examination of a particular patient who had Hodgkin's Disease, and who exhibited nodulations and lymphatic gland characteristics inherent as characteristic of Hodgkin's Disease, we found that many of the nodulations corresponded precisely to the areas that Chapman had originally postulated; and by trial and error, and also by the discovery of nodulations in areas that Chapman had not discussed, we were able to find the neurolymphatic reflexes for most muscles.

By now I was becoming convinced that there was a relationship between muscles and particular viscera or organs. A moderately weak muscle on testing appeared to be associated with a weak viscera or organ, but every time I could see evidence of a weak pancreas, or a weak stomach, or a weak liver or a weak kidney dysfunction—of those organs which would be measured by x-ray or by biochemistry or by some other accepted biological test—I would find a corresponding weakened muscle. This relationship, although rather tenuous at first, became more and more evident as time went on.

This began to explain, at least somehow, the visceral response that occurred from muscular skeletal corrections and made a little more sense out of the observations that patients used to make following treatment for a muscular skeletal problem, and with the spontaneous resolution of the visceral or organ problem. I found a strong relationship to exist between the spinal level of neurolymphatic activity and structural aberrations of the spine, but this was not always the case.

It was just as if there might have been an original subluxation or lesion of the spine, a functional disturbance of the spine that somehow was either self corrected spontaneously or corrected by manipulation; but the long term effects of that disturbance continued to remain. For example: if you have a home washer-dryer and perhaps place a heavy object such as a rug in it, as it starts to spin it dry, the rug's eccentric position in the spinning washer causes a vibration, then the vibration sensor in the washer turns the washer off to prevent damage from the eccentric rotation. This usually sets an alarm going as well as turning the washer off, and the housewife then attends to the problem by opening the panel on the washer, and seeing the rug in an eccentric position rearranges the rug. Then she closes the panel on the washer and many times must then reset a circuit breaker if closing the panel did not already do so. In other words, she would have to do two things: rearrange the rug structure, so to speak, and then also set a circuit breaker.

We postulated that the lymphatic centers were circuit breakers in this sort of analogous context. This proved to be a valuable system of analysis and the response rate continued to rise in patients, and we started to see more and more patients upon whom we did more and more muscle testing.

An Italian woman came to see me and complained of a headache for 30 of her 49 years, and on testing the muscles I observed some muscles to be weakened on both the right and left sides of her body. I noticed that in an effort to maintain a response to testing of certain muscles, if she took a deep breath some muscles, for example on her right side, strengthened; but the same deep breath seemed to weaken the muscles on her left side. But instead of taking a deep breath and producing strengthening on her left side, letting the air OUT seemed to strengthen the muscles on her left side.

She also exhibited a rather unusual configuration in terms of analysis of the level of her head. Looking at the position of her ears in relationship to her head, her ear was lower on the right than it was on the left, as was her occiput, the bones of her skull. Looking at her from the rear confirmed this position, lower on the right, but looking at her on a face view, head on, an anterior look showed her eyebrow and eye to be higher on the right and lower on the left, just the opposite of what I had observed looking at her from the posterior view. Thinking perhaps that her ears were in an altered position, I compared her ear position by measuring down from the vertex and I found that the ears were equally spaced on her head measuring from the top down, yet there was an obvious discrepancy between the level of her ears and the level of her eyes, instead of making a parallel pattern they made a wedge pattern, which was very confusing.

I had been aware of the work of William Garner Sutherland, an osteopath who had postulated the concept that the bones of the skull move as you breathe like the gills of a fish. He developed the concept that there was a vestigial gill mechanism in the skull, and by long experimentation with himself, using many ingenious devices, had attempted to limit the motion. He observed his own response, and published an original text based on his observations entitled, "*THE CRANIAL BOWL*," by William Garner Sutherland. His work had later been documented and revised by Harold Magoun, D.O., entitled "*OSTEOPATHY IN THE CRANIAL FIELD*." Both the first and second editions of Dr. Magoun's books are available.

The concept that the bones of the skull had motion seemed contrary to my anatomical and osteological training, yet in an effort to understand the problems produced by the patient I was examining, I attempted to move the mastoid process on one side of her head in a forward direction while she took deep inspirations, and at the same time moved the mastoid process in a backward direction while she took a deep expiration—in other words, using a counter-torque motion with the fleshy part of my thumbs, the thenar portion of the palm of the hand—and the forward motion and the backward motion were accomplished simultaneously on this 49-year-old Italian woman.

After 4 or 5 deep inspirations and expirations, despite the fact that she had attempted these before, but not with the concomitant skull pressure, she looked at me and her eyes widened, and she said, "That's the first relief I've ever gotten." I looked at her, again serious of face, and with true sincerity said, "Well, that's what you come here for," to again disguise my surprise at her rapid response.

We then began to test muscles against phases of respiration, and we found many muscles responded to inspiration, some responded to expiration, and interestingly enough some responded to half a breath taken out, some responded only to a breath taken only at the nostrils and some responded to a breath taken only at the mouth. Some responded to breathing through one nostril as opposed to the other, and some responded in an opposite fashion. We soon found fourteen basic cranial faults which will be discussed later, but the primary investigation method was to find a weakened muscle.

We had the patient take a deep breath in or out. If the muscle was found to be weak and responded to inspiration, the mastoid process on the side of the skull that the muscle weakened was located and pressed forward at the temporal bone mastoid pro-

cess with the thenar eminence of the hand, with about 4 or 5 pounds of pressure coincident with 4 or 5 deep inspirations.

If the muscles found weak responded to expiration, the thenar eminence of the hand was placed anterior to the mastoid process of the temporal bone and the mastoid process of the temporal bone was pressed backward towards the occipital coincident with 4 or 5 deep expirations using 4 or 5 pounds of pressure.

This resulted in many, many cases improving from many, many conditions, and they postulated a concept of a cerebral spinal fluid flow rate something like a dual irrigation ditch—with someone turning the rheostat down on the pump, and the tomato vines withering somewhat, and then when someone turned the rheostat up on one side or the other, the tomato vines thriving due to an increased flow of the irrigation fluid.

Investigation revealed that not only did the bones of the skull move in a predetermined fashion, but so also did the vertebral segments in which vertebrae went through a rocking type of motion—the tip of the spinous process of a vertebra involved moving in an inferior direction towards the feet with inspiration and a superior direction with expiration. The spinous process moves inferior, footward, with inspiration and headward with expiration.

We soon found there was also a sacral motion, the tip of the sacrum at the coccyx moving forward with inspiration, toward the front of the body, and moving backward, toward the back of the body, with expiration. We found a reverse movement to exist in the coccyx, a counter movement between the sacrum and the coccyx. We also found a counter movement between the total pelvis, the pelvis moving backward as the sacrum moved forward and the pelvis moving forward as the sacrum moved backward, coincident each time with phases of respiration.

This new cranial finding coincident with a method of diagnosis aided greatly in the application of the cranial concept. The original Sutherland concept, as well as those that followed, used topographical, anatomical changes for cranial corrections; but the addition of respiration added a measure of diagnostic certainty and also safety to this relatively new science.

Time has shown that a respiratory relationship exists in the spinal fluid flow rates, and a critical factor in the production of routine cranial correction was to correlate muscle weakness to strengthen with respiration. More of this will be discussed later on in chapters on cranial technic.

By now we had the original methods of muscle testing with the concept of micro avulsion origin insertion technic; we now had the possibility of lymphatic blockage—in other words, the muscle couldn't flush its own lymphatic toilet; we now had the concept of cranial technic, respiratory systems; and we also had, prior to the development of cranial technic, the system which we call neurovascular response.

I was lecturing in Rochester, New York discussing the original method of hard, heavy pressure at the origin insertion of the muscle in case of weakness caused by micro avulsion, and also demonstrating the lymphatic technic for finding the source of blockage in the lymphatic range of muscles. I was asked to treat a young boy with asthma who was having an acute attack and who did not respond to the usual medications. He was having some response to chiropractic technic by a young chiropractor attending the lecture, but he was suffering an acute asthmatic episode at the time of the lecture, during the lunch period.

By now we had found that the adrenal glands were responsible to a great extent for failure to produce adequate adrenalin, agreeing with the medical approach—the crisis care type of approach to asthma seemed time honored, at least pharmaceutically. We would find a weak sartorius gracilis muscle which time had shown to be related to potential failure of the lymphatics of the adrenal gland to flush its own toilet, so to speak—its lymphatic toilet. But investigation of the neurolymphatic reflexes and treatment for them did not change the weakness that we found on testing of the sartorius muscles.

The young boy was lying on his back, one foot pointing straight up and the other foot lying loosely to one side. In an effort to correct the problem I had already used the neurolymphatic reflex and had attempted an origin insertion technic without any success. I knew that occasionally the lymph system was sluggish because of failure of the lymph system itself to drain, and I was using what was called a lymphatic pump. The operator's fist first was placed on the sternum of the individual and moderate pressure was exerted spineward while the patient attempted to lake a deep breath. At the middle of the attempt to take a deep breath the fist was suddenly removed, causing the succussion of the chest, changing the pressures within the chest, and literally shaking the thoracic duct, allowing better lymphatic drainage potential. This too was unsuccessful, but at that time I was aware of a primitive cranial technic of simply spreading the cranial sutures as advocated by Dr. James Alberts, Sr., a very fine chiropractor in the southwest.

In attempting to spread the cranial sutures in a very simplified fashion, I did not see any change, and in an effort to evaluate the problem I sat down and re-attempted to spread the sagittal sutures. From experience I had learned that this was of some value occasionally in lymphatic blocks. My index fingers were resting on the posterior fontanel area with the rest of my fingers spreading the sagittal suture which runs vertically along the top of the skull, separating the two halves of the skull and joining the parietal bones of the skull together. I felt that insistent pulsation, very faint at first, at the posterior fontanel; and despite the fact that his carotid arteries were beating at the rate of about 120 and his respirations were at least 40, I noticed that the pulsations that I experienced with my fingertips were at the rate of 72 beats per minute.

Thinking the beating was perhaps in my own fingers; I removed my fingers and placed them on a wall to identify if the 72 rate beating was in my own fingers. I noticed no change. I reapplied my fingers to the posterior fontanel and felt the continued pulsation, which became more insistent and more persistent and more evident in strength, until finally the young man gradually stopped his labored breathing, took a deep breath, began to breathe easily, and simultaneously his foot rotated up into a parallel position with its opposite member. The doctor attending the youngster, who had asked me to see the patient, looked at me and said, "Good gracious, Doctor, that's marvelous." And I looked at the doctor, very serious of face, and said, "That's what you come here for. "We now had developed another method, called the neurovascular technic, for the correction of muscle weakness.

In the embryo there is no heart, and for the first three or four months the mother's placental circulation is augmented by a network of vascular circuits which, as the tissues grow, ex-

ert slight traction on the blood vessel which then causes the blood vessel's muscles themselves to pulsate in an augmented fashion, aiding the mother's placental circulation.

At about the fourth month the heart is formed, and many times the mother is delighted to hear the heart beat that her obstetrician allows her to listen to. At the advent of the heart beat, the heart takes over part of the burden of supplying circulation to the growing embryo, and the neurovascular circuit of supply and demand circuitry goes on a standby basis—something like a generator behind a hospital in case of power failure, which can be turned on for emergency use.

These neurovascular receptors were first discovered by a chiropractor in California named Terrence Bennett, who developed a foundation for teaching his material and who wrote extensively in the early '30s and '40s of their use. Upon his departure from active practice, and upon his death, Dr. Floyd Slocum, one of the early pioneers in the American Chiropractic Association, took over his activity and the Neurological Research Foundation continues to be active under the auspices of Dr. Martin King from California.

When a light tugging touch was applied to the vascular circuits a pulsation was felt beneath the finger. The light tugging touch is maintained for 20 or 30 seconds minimum time, the muscle is tested before and after, and many times this coincides with the need for cranial fault correction. But in any event, the light tugging touch is maintained for a variable period of time, a minimum of 20 or 30 seconds, and the muscle tested before and after to ascertain the return of strength.

It is just as if the neurovascular receptor acts as a thermostat. If the thermostat is set too low the muscle doesn't get its proper circulation and the muscle's lactic acid and other products of mechanical contraction of the muscle are not flushed or washed out, and the muscle therefore is clogged with its own waste products and shows weakness.

Roger Bannister, who ran the first four minute mile, became a vegetarian - not through embracing of the vegetarian concept, but because the vegetarianism put less of a load on his liver and he was able to oxidize excess lactic acid produced by the increased effort to run the four minute mile. Lactic acid, as it is produced by the muscle in function, causes the capillaries to dilate, and finally there is a status quo reached by the lactic acid level producing the greatest amount of capillary dilation. When the lactic acid reaches higher levels, there is no further capillary dilation until the liver goes into "overdrive" and attempts to oxidize off the excess lactic acid; and here, then, the muscle can resume a normal function.

We find that many muscles lack a "thermostatic" configuration which allows them to function when under stress, and attention to the neurovascular receptors by a light tugging touch allows much better circulation to the muscle. We continue to observe the muscle-organ relationship and we were becoming increasingly convinced of the reasonably frequent relationship between weak organ-weak muscles, although we were not convinced of the contrary relationship of the weak muscle-weak organ.

We now had four options for strengthening weak muscles. We had the hard heavy pressure described earlier, the activation of the lymphatic reflexes, the application of cranial technic, and the use of neurovascular receptors.

The subject of acupuncture has long been a point of interest, but not much was known of this concept until the early work of Bennett Cerf, who published in Random House publications the book, "*ACUPUNCTURE, ANCIENT CHINESE ART OF HEALING*," by Felix Mann, an English physician. Some of the early Jesuits who had been missionaries in China had spoken of the unusual responses that were obtained in many instances from the practice of acupuncture, the insertion of tiny needles of metal or bamboo into prescribed areas on the skin of the sick patient. To quote Felix Mann in his acknowledgements at the beginning of his book, "*ACUPUNCTURE, ANCIENT CHINESE ART OF HEALING*" now published by James Heineman Company, Medical Books Ltd., London, "All European acupuncturists owe Soulie de Morant a debt for his original translations of Chinese treatises. He developed much understanding of the subject and its practical application during the time he associated with Dr. Ferey Rolles. Those who read Chinese are few, but many may be greatly benefited by the French and German books on acupuncture mentioned in the bibliography."

Acupuncture is an ancient Chinese system of medicine in the practice of which a fine needle pierces the skin to a depth of a few millimeters and is then withdrawn. The only thing of real importance in the study of acupuncture is to know at what point to pierce the skin in relationship to which disease.

The notion that a pin prick, often in a part of the body far removed from the seat of the disease, can cure ills is alien to conventional thinking. It is unfortunately the case that many doctors, even when faced with several former patients who have been cured by acupuncture where other efforts have proved fruitless, have refused to believe the evidence.

Acupuncture is not the exclusive possession of the Chinese. The papyrus ebers of 1150 B.C., one of the most important of the ancient Egyptian medical treatises, refers to a book on the subject of muscles which would correspond to the 12 meridians of acupuncture. The Bantu sometimes scratched certain parts of the body to cure disease. In the treatment of sciatica some Arabs cauterize with a hot metal probe a part of the ear. Some Eskimos practice simple acupuncture with sharp stones. An isolated cannibalistic tribe in Brazil shoots tiny arrows with a blow pipe at certain parts of the body.

A patient, and a good friend, had returned from Hawaii and brought me one of the first copies published by Random House of Felix Mann's book. By now we have become pretty well convinced of the relationship between viscera and muscle. In the chapter of Fefix Mann's book entitled "The Five Elements" on page 92, he spoke about an organ relationship which included many of the aspects of acupuncture, giving four points to tonify or stimulate the area and four points to sedate if the organ was overactive.

In an effort to relate these points to kinesiological parameters, we attempted stimulating the points for tonification and found occasional responses in muscles. We attempted to sedate other points and found occasional responses in muscles. Insertion of a needle at the so-called "first point" invariably would produce a strengthening of a muscle if found weak on testing, and insertion of a needle at the first point of sedation would invariably cause weakness of the muscle if the muscle was strong. We soon found that touching the first two points for tonification would result in strengthening of a weak muscle. The converse was also true. Touching the first two points for sedation and simultaneously the second two points for sedation would weaken the muscle.

We wrote the first book on acupuncture in 1966, showing its relationship kinesiologically, and this was the only research manual that did not go through a second reprinting, because the concept was too new at the time. However, since that time it has grown to be a standard portion of Applied Kinesiology and forms a basis of much of the information we have been able to identify about acupuncture.

We now have five arrows, so to speak, in our quiver. We could shoot the arrow along the origin insertion, the neurolyrnphatic, the neurovascular, the cranial, and now the acupuncture path. Each of these develops their own special set of rules and special set of circumstances.

How The Body Heals Itself

Applied Kinesiology is based upon the fact that body language never lies. The opportunity of understanding the body language is enhanced by the ability to use the muscles as indicators for body language. The original method for testing muscles and determining function, by the methods of muscle testing first advocated by Kendall and Kendall, is a prime diagnostic device. Once muscle weakness has been ascertained, a variety of therapeutic actions are available which are too numerous to enumerate here. The opportunity to use the body as an instrument of laboratory analysis is unparalleled in modern therapeutics because the response of the body is unerring. If one approaches the problem correctly, makes the proper and accurate diagnosis and treatment, the response is adequate and satisfactory both to the doctor and the patient. The name of the game, to coin a phrase, is to get people better. The body heals itself in a sure, sensible, practical, reasonable, observable, predictable manner. "The healer within can be approached from without." Man possesses a potential for recovery through innate intelligence or the physiological homeostasis of the human structure. This recovery potential with which he is endowed needs the hand, the heart, and the mind of a trained individual to bring it to potential being, and allow the recovery to take place which is man's natural heritage. This benefits man. It benefits him both individually and collectively, but it also benefits the doctor who has rendered the service and allows the force that created the structure of the body to operate unimpeded. This benefit to man can be compounded by knowledge with physiological facts and with predictable certainty.

Chapter 2 : NUTRITION AND BODY LANGUAGE

Why nutrition is a hit and miss sort of thing

By now my practice was growing at a rate I found difficult to maintain, together with attempting to teach this new material, and I was fortunate to have as my first associate Dr. Terry Franks, who was able to "watch the store" while I was gone. It was also during these initial lecture periods that my next door neighbor's son, now Dr. Walter Schmitt, came to hear me lecture and observe me treating a rather apprehensive female physician, and my making the particular corrections aided in stimulating him to enter chiropractic college

By careful comparison of the facts—what I now could observe in the patients of Dr. Franks and myself, as well as the assistance of the student doctor, Walter Schmitt—we were able to investigate many different features of problems that involved muscle testing and treatment, and we were well into the production of research manuals and research with an ever-increasing amount of knowledge.

I had a patient and a good friend who was attempting to go through Wayne University at the age of 45, having raised a family. She was hypothyroid and hypoadrenic, and her hypoadrenia I was able to help. While taking 3 grains of thyroid a day, she continued to show symptoms of hypothyroidism; i.e., increased weight, easy fatigability, loss of the outer third of the eyebrow, greasy sort of skin, and poor memory—which was not conducive to being a good student at a relatively late period in life. Because of the three grains of thyroid a day and failure to respond, I thought perhaps it would be interesting to observe what happened if she took thyroid in a different fashion.

Many years before I had observed a young boy who had swallowed the contents of an orange crush bottle thinking it contained the beverage, but instead it contained lye and it chemically perforated his esophagus. His esophagus was being reconstructed by a series of maneuvers designed to use a portion of his small intestine, and there was a stoma, an opening in his stomach, where properly vitamized and calorized food was placed. This young man was losing weight despite an adequate caloric intake, developing kidney signs, and also arthritis, at the age of seven. I thought I knew my father's wisdom, but did not understand it totally when my father told me to tell the young boy to chew the food he could not swallow, and then insert it into the artificial stoma. On following this request I observed a decrease in the arthritis, the disappearance of the kidney stones, and an increase in weight. This greatly impressed me—that somehow our salivary digestion and mastication was a factor in the production of proper food assimilation.

With my own children growing I had observed that if they were crying because of being hungry and if I gave them a piece of cheese they stopped crying immediately, when I knew how long it took to digest the cheese. If I were the child involved I wouldn't stop crying until some stage of digestion had developed. I found it difficult to understand how they could stop crying in anticipation of digestion. I also had been doing a test for Vitamin B on the saliva of patients involving the combination of starch and iodine which produces a blue color on the level of ptyalin. Ptyalin in the saliva is an indicator of the amount of Vitamin B; the more ptyalin the more Vitamin B, and the faster the starch-iodine blue color disappeared the greater the amount of Vitamin B. Therefore, judgment could be made as to the need or lack of need for Vitamin B supplementation in a particular patient.

In addition, I was aware of the fact that the parotid glands deiodinated the food we ate. So, with this background material regarding salivary digestion and absorption, I asked this particular patient to chew on the thyroid tablets—she had already taken one that morning—she took three grains of thyroid a day. She chewed one of the grains of thyroid and promptly went into a deep syncope. By this time I was not dismayed by this sudden turn of events and I checked her vital signs, found them all to be normal and sat there with crossed hands waiting for her recovery. After four or five minutes she fluttered her eyes, looked at me. and asked, "What happened?" I said, "You fainted," and she asked, "From chewing the thyroid?" and I said "Yes." She said, "I never did that before," and I said, "Well, you never chewed it before."

The teres minor muscle, the muscle at the back of the shoulder, can be tested easily with the arm flexed 90° and the wrist pushed toward the umbilicus, while the patient attempts to externally rotate the arm, pressing against the doctor's thrust. This muscle I found associated with thyroid, and I had always found it consistently weak in her case, despite efforts to treat it by the previous methods we have discussed. This muscle now tested very strong, and she looked at me and said, "Could I possibly have felt better from that, that you gave me?" I looked at her, serious of face and sincere of purpose and said, "That's what you come here for." This was the first patient we attempted to have chew on the nutrient without swallowing it down.

That afternoon our next door neighbor's father had been to a Mexican party at one of our local hunt clubs and had been tipping a tequila bottle with some frequency and was suffering quite a headache. Emboldened by the experience I had earlier that morning I had him chew some bile salt tablet material. I had tested his pectoralis major sternal division, the muscle associated with liver, and found it to be weak. I then had him chew the bile salt material combined with some Vitamin A. There was an immediate increase in strength of the tested muscle and he looked at me with a question in his eyes and asked, "Could that have helped my headache that quick?" I said, "That's what you come here for," and proceeded to explain what had happened that morning. We then, by trial and error, started testing muscles against nutrients, and have developed the rationale and the pattern of activity which we will discuss later on in this particular text.

We found that certain food could be tested and they would either strengthen or weaken certain muscles. We found certain contaminants in our environment could be tested by inhalation or by contact. We found ration and reason and sense to the rather nebulous concepts of allergy and sensitivity.

Nutrition is a hit or miss sort of a thing because people take nutritional products for symptoms, and depending on which issue of which magazine they have read, people will be taking the currently fad-interest nutritional product, many times with good results.

The body has a unique system of identifying its needs both in terms of food and nutritional supplementation, as well as medication, and the nutrient in question can be tested against any of the patient's muscles upon ingestion of the material on the patient's lingual receptors on the tongue; a muscle is tested, and if the food is good or neutral the muscle will not weaken. If the food, although very appetizing and well liked, is detrimental to the patient the muscle will weaken. The same is true of a nutrient or any medication. This makes sense out of a hit-or-miss sort of nutritional thing, and rather than listening to symptoms alone, we depend on body reaction, a much more effective technic.

It is possible also to test the combinations of foods. For instance, occasionally beef by itself and rye bread by itself may test in a positive fashion, but if you combine them they will test poorly indicating that certain foods should not be combined with others. The point is that one can test any food, any medication and get a body response if the lingual receptors are allowed to be activated by the substance in question. This does not require skill and training. The husband can do it for the wife or vice versa, or any member of the household can be readily trained to do this. It readily improved the management of allergy and food sensitivities, as well as finding foods which are quite compatible with the individual, the biological makeup of the person, as well as increasing their energy balance.

Nutrition as a science is in a sort of chaos because people keep finding out small bits of information about large and major problems. It's like pieces of a jigsaw—when you happen to get the right piece for the right jigsaw puzzle it completes it, but that's not the piece we needed in another person's jigsaw, even though they may have the same desire to accomplish the same problem, and perhaps have similar problems.

Nutrition requires some type of evaluation, both in a positive and minus situation, and the ability to make valid clinical observation of a nutritional requirement requires standardized testing of muscles. Here lies the key to proper nutrition. If a patient needs a certain nutrient, it should at least not weaken any muscle. If the muscle is weak on testing in the "clear," that is no testing without any further action on the part of the patient's body (simply testing the muscle), then the appropriate nutrient should produce quick strength when placed on the lingual receptors of the tongue, and this produces safe, effective and proper use of the science of nutrition on a lingual receptor basis. This same lingual receptor activation may be used to test the food the individual consumes, and many times foods themselves should be tested as well as the nutrients.

I can recall a very famous person in show business who was taking 60 different nutrients and who required only 12 of the 60 she was taking, and 48 were doing her harm. She had a severe allergy and because of her unique voice had no understudy. She did very well following this procedure.

The failure of the science of nutrition to properly evaluate the need or lack of need for a person's nutritional support can only be based on the usual technic of symptom stopping or a "pill for every ill," whether it be a nutrient or pharmacological product. There is a better way, and the better way is to evaluate the patient kinesioiogically and test the nutrient singly against the patient's response. A recent book entitled "*THE FOOD CONNECTION*," by Schecter and Scheinken, speaks of Applied Kinesiology technic in brain sensitivity. There is a new theory of biology as advocated by James Isaacs in his "*COMPLEMENTARY IN BIOLOGY*," published by the John Hopkins Press, and this will also be discussed in further pages.

Chapter 3 : FURTHER DEVELOPMENTS IN BODY LANGUAGE
How the left and right brain function affect the body when trouble has taken place in the body

Our practice had grown to such an extent by this time that I found it necessary to have another associate, and we were fortunate to have Dr. Walter Schmitt join our group following his graduation from the National College of Chiropractic. He had always been of much assistance in developing new concepts. While a champion swimmer at Duke University, North Carolina, from which he had graduated, he would often enter long distance swim meets looking and feeling quite well, and come out of the pool quite distorted and naturally quite exhausted. We found, again by trial and error, that his method of swimming, turning his head to one side while doing the Australian Crawl or its equivalent, was producing a certain pattern activity of unbalance, repeated function which we felt was compromising the natural balance between the right and left sides of his brain.

By taking the work of Doman and DeLacato, who had developed the brain dominance concept, we found that we could exert what we called a cross crawl or homolateral crawl—a pattern of activity using rhythmic muscular activity combined with alternating arm and leg position—to effect consistent and long term structural correction. It was just as if by using repetitive contralateral movements with proper hip position we could put a final coat of varnish on twenty coats of "decoupage" that our efforts in correcting the patient's problem could produce. This could readily be abolished by using a homolateral crawl and this will be discussed in the section on Brain Damage and Cross Crawling.

We then developed the concept that there was a "tape recording" of the patient's problems within the body's nervous system, and proper exercise could produce the facilitation of correction and improper exercise could produce deterioration. This allowed a penetration of the body's nervous system in a manner never before experienced.

The ability to cause a return of 4 or 5 or 10 or 20 different functional problems by simply changing the action of certain muscles and

their rhythmic function was phenomenal. We walk with a contralateral motion, moving one arm and the opposite leg, alternating contralaterally, and by identifying residual areas of our remaining areas of muscle contraction and simply turning the head away from that side of residual contraction or remaining muscle contraction and then performing contralateral motions such as walking, we were able to eliminate many areas of difficulty that had a tendency to recur.

By the same token, we could briefly revive the old concept of a "sick" tape pattern in the body, and by doing a homolateral crawl pattern we could cause a return of highly specialized and definite patterns of activity associated with illness that had previously been documented in that particular patient. The section on Cross Crawl and Brain Damage will further develop these concepts.

About this particular time I was treating a young patient approximately five years of age who had been brain damaged at birth. We also found he had repeated convulsions and many, many problems with his development, especially with his teeth, digestion, elimination—all the patterns of activity of normal function were disturbed. He had been referred to me by another doctor and we were able to help the youngster with the frame of reference that we had open to us.

After the child had progressed quite well, we had a long conference with the mother discussing prognosis limitations, and she asked me if I could help her with a shoulder problem. I said, "Well, if you don't have an appointment I can't do it, but I can check something indicated quite quickly. Accordingly, I tested the teres minor muscle and found it to be quite strong. I went on to treat the child and had several absences from the treatment area with phone calls, and when I returned to finish treating the child, she asked me again about her shoulder, and I said, "Well, I can test a couple of things and if it's something simple I might be able to help you, even though you don't have an appointment."

I tested the teres minor muscle again and because of the numerous interruptions I questioned the mother and asked, "Hadn't I been in here and tested that just a few minutes ago?" because this time in testing I found the muscle weakened. She was holding her child. She said "Yes," and I then had her place the child flat on the table and tested the muscle again and it was quite strong. I then asked her to pick the child up again, and the muscle was weak.

This perplexed me, and I said, "Well, it's probably how you're holding the child. Simply let the child rest on the treatment table and simply touch him." On touching him with one hand the muscle weakened. I thought I was taking leave of my senses and called in my young assistant, Dr. Franks, and had him repeat the same pattern. He found it to be true and looked at me questioningly, and asked, "Why is that?" I said. "Well, Terry, I don't know, but it seems to be sort of transference of muscle weakness." This is what we call surrogate testing, and in most cases where the patient is unconscious or unable to cooperate, contacting one patient with another person who is otherwise normal will reproduce temporarily the muscle weakness that cannot be found easily in the first individual.

The methodism of this mode of investigation is not known at this particular time other than the fact that it is an effective technic under the rather narrow conditions that we set forth above. In other words, if the patient cannot cooperate, or if the patient is unable to cooperate, if she is comatose or unable to respond, this is an effective technic. The use in this regard, and with a very narrow parameter of action, is a useful technic and allows for much therapy in an otherwise difficult situation.

Because of the complexity of man's nervous system, we found a variety of situations, all of which had a time date in that they developed over a period of time. Those studying Applied Kinesiology then sort of grew up with the technic and the technic sort of grew up with them.

We soon found that touching an affected joint or area by the patient would produce an immediate muscle weakening of any tested muscle. We called this Therapy Localization. Therapy Localization did not say "what the trouble was," but simply indicated "where it was. "The *ALL OR NONE* nervous system rule here seemed to be the factor—Therapy Localization would make a strong muscle weak, or conversely a weak muscle strong. This is extraordinarily useful in holistic healing.

We then found that Therapy Localization with palms against the body had a counterpart. If the back of the hands were placed at a critical area, we would also get positive responses. We found Therapy Localization of the thyroid, for example, would be negative, and Therapy Localization of the spleen would be negative, but testing the spleen against the thyroid would be positive. We found a whole host and variety of factors that involved the use of Therapy Localization.

The advent of the Malzack Wall spinal gate theory, which was described in *SCIENCE* for November, 1968, followed a new dimension to Therapy Localization in that, by using a scratch or a pinch we would evoke the touch fiber response and would change Therapy Localization from negative to positive or positive to negative, showing that we were using a spinal gate pattern for Therapy Localization. This also led to the combination of acupuncture circuits with Melzack Wall for the relief from pain, especially post traumatic pain, which has become a very dramatic part of Applied Kinesiology.

As experience developed throughout this entire area of Therapy Localization, one of the prime values in its use has been the identification of structural subluxations, no matter how minimal in character. This had made the muscular skeletal portion of the practice very practical and has stood the test of time.

We have found, as mentioned, that in Therapy Localization we make strong muscles weak and weak muscles strong. Sometimes a muscle which should show a potential weakness on postural observation, such as a high shoulder on one side which is usually a weak latissimus dorsi, would not show this weakness until the patient Therapy Localized the neurolymphatic reflex for the pancreas.

Therapy Localization has allowed us not to tell WHAT something was, but to tell us WHERE it was. Therapy Localization does not tell what something is but where it is, and as a result you can use other methods of examination to identify what the problem is.

The concept of vertebral challenging, 4 or 5 pounds of pressure exerted on a vertebra or some other portion of the skeleton, would cause a rebound phenomenon to occur and muscles would weaken when skeletal areas that were in lesion were pressed upon. This would allow a much better conceptualization of the body's response to structural abnormalities and has proven to be a very practical and very useful technic for changing the osseous relationships that exist in the body. In other words, in finding various segments that are out of position both in static weight bearing positions and in motion, the vertebral challenging has proven to be of great value.

Heart Health: Aspirin is Not a Vitamin – Margarine is Not a Food

by Walter H. Schmitt, D.C., D.I.B.A.K., D.A.B.C.N.

Abstract: Healthy essential fatty acid (EFA) metabolism, which is a prerequisite for a healthy cardiovascular system, depends on proper dietary intake of essential fatty acids and avoidance of trans (partially hydrogenated) fats. This can be demonstrated by unique muscle testing screening procedures.

There are good fats and bad fats which affect our cardiovascular systems, and in fact, all systems in our bodies. The worst of the bad fats consumed in our society are those which have been processed from their natural state by a method called partial hydrogenation. Regarding these partially hydrogenated fats, in a paper by this author published in 1995[1]and 1996[2], the following was stated:

HYDROGENATED or PARTIALLY HYDROGENATED FATS OR OILS - Do not eat these.

If the label contains the words HYDROGENATED or PARTIALLY HYDROGENATED - do not let your family eat it.

If the label contains the words HYDROGENATED or PARTIALLY HYDROGENATED - do not let your friends eat it.

If the label contains the words HYDROGENATED or PARTIALLY HYDROGENATED - do not let your patients or clients eat it.

If the label contains the words HYDROGENATED or PARTIALLY HYDROGENATED - get it out of your family's kitchen.

HYDROGENATED or PARTIALLY HYDROGENATED FATS OR OILS - Read labels and avoid these substances like they are poisons...which they are.

Nothing has changed in subsequent years to alter this position. In fact, even more data implicating the harmful effects of partially hydrogenated (trans) fats has come to the public eye.

Partially hydrogenated fats and oils are processed versions of naturally occurring fats and oils. In nature, most dietary fats and oils exist in a structural form that is called the "cis" form. When these natural fats are processed by bubbling hydrogen gas through them at high temperatures, they become partially hydrogenated, changing their structure to the "trans" form. Cis fats have a bend in them; the processing that produces trans fats removes that bend. See figure 1. Partially hydrogenated oils do not exist in nature. (Some short chain trans fatty acids do exist in nature, in milk products, for example, but are not naturally occurring long chain trans fatty acids.) Therefore, although they start out as "natural" fats, this processing changes them into unnatural substances.

Differences in the shapes of the cis form and trans form of the same fat are of major significance. Cis form fats and oils are easily metabolized by our bodies. On the other hand, the body cannot use fats and oils in their trans forms. When eaten, fats and oils are incorporated into cell membranes altering the composition of these delicate structures. When they interact with normal essential fatty acid metabolism, they disturb function in a most deleterious manner. As described below, these substances meet the definition of a "poison."

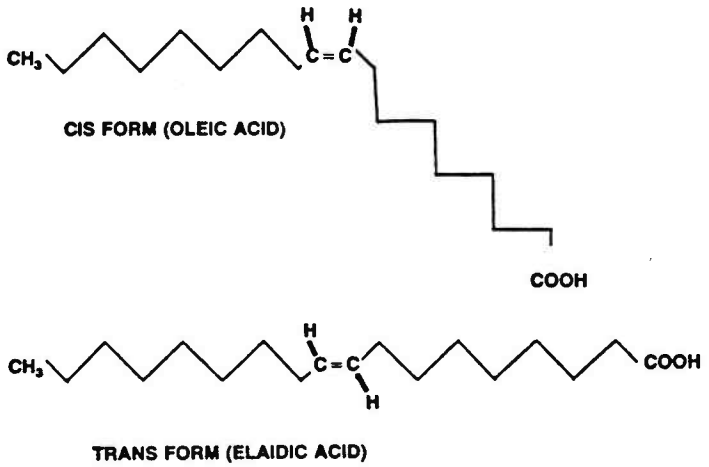


figure 1. CIS and Trans Fats

"POISONS" IN OUR DIETS

In Dorland's Medical Dictionary "poison" is defined as "any substance which, when relatively small amounts are ingested . . . has chemical action that may cause damage to structure or disturbance of function, producing symptomatology, illness, or death."[3] As described in the paragraphs above and below, trans fats damage structure (in cell membranes), disturb function (inhibit enzymes) and lead to health problems. They certainly meet the definition of poison.

Trans fats and oils are not inert. In fact, they interfere with important, normal functions by acting as enzyme inhibitors – inhibiting enzymes that are necessary for the body's normal metabolism of fats. Whereas the half-life of normal cis form fats in the body is 18 days, the half-life of partially hydrogenated trans fats is 51 days. This means that half of the trans fats in the potato chip or French fry that you might eat today will still be inhibiting essential enzyme systems in your body 51 days from now. [4]

Essential fatty acids are naturally occurring cis fatty acids that are converted to the important substances called prostanoids which includes prostaglandins (PGs), leukotrienes, and thromboxanes. We will focus on the three major groups of PGs in the body: PG 1, PG 2, and PG 3 families. See figure 2. (Figure 2 also shows the leukotrienes (LT) and thromboxanes (TX) from the PG 2 family. These have harmful effects.)

One of the major enzymes in our essential fatty acid metabolism is called delta-6-desaturase (D6D). D6D is inhibited by trans fatty acids. The D6D enzyme is necessary for the body to produce the normal prostaglandins of the PG 1 and PG 3 families. See figure 2.

A MAJOR SOURCE OF CHRONIC DISEASE

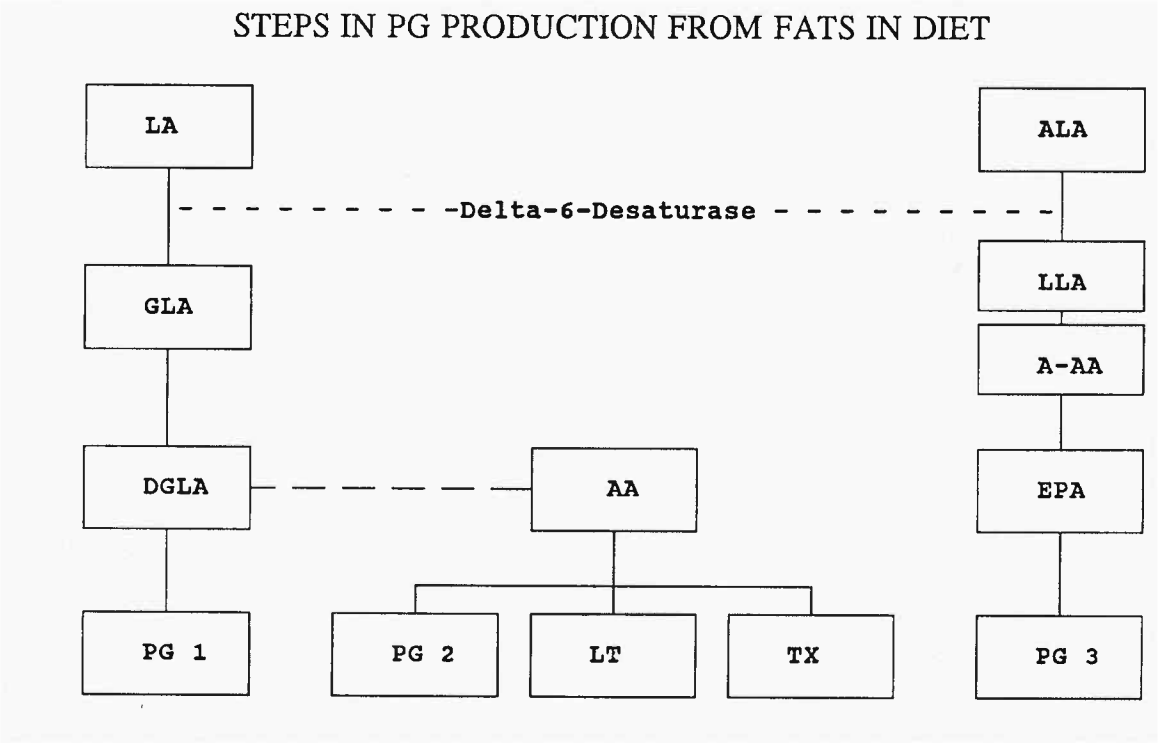
In our society most of the ill effects of chronic disease are caused by or contributed to by the PG 2 family. This includes heart attacks and cardiovascular disease, cancer and inflammatory conditions including arthritis and autoimmune diseases. The PG 2 family is derived directly from naturally occurring fat, arachidonic acid (AA), found in red meat, shellfish and dairy products. The body converts AA directly into the PG 2 family.

PG 2 family reactions include: increasing blood clotting,[5] increasing blood pressure,[6] increasing cholesterol and causing other heart attack risk factors to be made worse.[5] PG 2 family substances increase inflammatory activity thereby perpetuating free radicals and the tissue destruction associated with everything from trauma to autoimmune diseases[7,8,9]PG 2 family chemicals also cause a decrease in natural killer cells that are part of our body's anti-cancer protection. Because of this fact, tumors increase in size under the influence of PG 2.[10,11]

Our bodies also have naturally occurring substances, the PG 1 and PG 3 families that counteract the bad effects of the PG 2 family. The PG 1 and PG 3 families decrease blood clotting,[12,13,14]decrease blood pressure,[5, 12] decrease cholesterol[15,16,17]decrease inflammation,[8, 9,] and increase natural killer cell activity that is necessary to fight tumors[5,]

In one sense, you could think of the PG 1 and PG 3 families as the good PGs and the PG 2 family as the bad PGs, at least in our present society. Of course, there are not really good and bad PGs. But when an imbalance in the PG 1, 2 and 3 families exists in our Western world, it almost always favors excess production of the PG 2 family.

Unlike the easy conversion of AA to the PG 2 family, the body requires several chemical steps to convert other dietary fats into the PG 1 and PG 3 families. One of these essential steps is the D6D enzyme, mentioned earlier, which is blocked by partially hydrogenated (trans) fats and oils from the diet. When we eat these bad, trans fat containing substances, they block the PG 1 and PG 3 production, and by default, PG 2 substances are produced without opposition. The PG 2 imbalance created by the consumption of partially hydrogenated fats contributes to the production of chronic disease that is the enigma of our modern society.



LA = linoleic acid (most food oils)
GLA = gamma linoleic acid (black currant seed oil, evening primrose oil, borage oil)
DGLA = dihomogammalinolenic acid (precursor to PG 1)
AA = arachidonic acid (red meat, dairy, shellfish, mollusks: precursor to PG 2)
ALA = alpha linolenic acid (walnut oil, linseed oil, canola oil, other "cold weather" oils)
EPA = eicosapentaenoic acid (cold water fish oils: precursor to PG 3)

figure 2. Simplified Essential Fatty Acid Flowchart

Many studies now exist demonstrating these negative effects of trans fats, especially in relation to heart disease.[5,20,21,22] Trans fats consumption also increases the risk for diabetes[23] breast cancer,[22] and multiple sclerosis.[24] There are scores of peer reviewed papers documenting the ill effects of trans fatty acids. It is often difficult to convince people to change their habits for preventive benefits; the extensive references now available in the scientific literature are helpful in this effort.

ACUTE SYMPTOMS

There are also acute symptoms that are created by the PG 2 family. Headaches (including what people call "normal headaches"), joint pain including back pain and arthritis, and menstrual cramps are just a few of the symptoms that are related to PG 2 imbalances created by eating partially hydrogenated fats and oils. Millions of people take aspirin, acetaminophen and other non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or naproxen to alleviate these symptoms. (This group also includes the COX-2 inhibitors that have recently been limited from public consumption due to increased cardiovascular events associated with their use.) A discussion of the harmful effects of these medications will be presented later in this paper. Avoidance of partially hydrogenated trans fats and consumption of natural fats and oils can often turn these symptoms around in as little as 3 to 4 weeks without any other intervention.

It has been said that in the history of the world, there has never been an aspirin deficiency or an NSAID deficiency. But there are millions, maybe billions, of people with essential fatty acid deficiencies of the PG 1 and PG 3 families who are suffering the ill effects of unopposed PG 2. This is due to either poor dietary intake of good fats and/or their consumption of partially hydrogenated fats and oils. In fact, if you, your family or friends, your clients or patients achieve symptom relief with aspirin, acetaminophen, or any other NSAID, it is almost certain that there is a fatty acid imbalance in the person's system.

It is often useful to supplement people who have any of the previously mentioned chronic or acute symptoms using essential fatty acids. This is especially true if symptom relief is achieved by aspirin or similar NSAID substances. The PG 1 family can be supplemented with black currant seed oil (BCSO), evening primrose oil (EPO) or borage oil (BO). BCSO, EPO and BO contain gamma-linoleic acid (GLA) which supplies PG 1 family fats beyond the effects of D6D enzyme.

BCSO has about 17% to 19% GLA content; EPO has 7% to 9% GLA and BO has over 20% GLA content. This author prefers to use BCSO due to its higher GLA content, as well as its relatively good taste. The PG 3 family can be supplemented using flaxseed (linseed) oil and/or fish oils such as those containing EPA (eicosapentaenoic acid.) These are readily available from the health food and professional suppliers.

RELIEF OF "NORMAL" HEADACHES

Although supplementation with good EFA is useful, return to normal function will not be seen until the partially hydrogenated fats and oils are eliminated from the diet. I had a patient who I had been regularly treating for many years. I had explained these concepts of good and bad fats in the diet thinking that he understood. Somehow, however, he had never grasped the importance of avoiding partially hydrogenated fats and oils.

After explaining these principles to him one more time, he finally got it. One month later he told me that the daily headaches he had experienced for over twenty years had stopped three weeks after totally eliminating these processed fats from his diet. I told him that I never knew he had daily headaches. He replied that he never told me about them because he just thought that they were "normal" headaches. Of course, "normal" headaches do not exist. Even years of regular treatment were ineffective at relieving his daily headaches as long as he continued daily consumption of the partially hydrogenated poisons that were causing them.

Likewise, many women with menstrual cramps and premenstrual syndrome have been helped by totally avoiding partially hydrogenated fats and oils and/or by supplementing with the appropriate good fats. This is also true for many women with menopausal hot flashes. People with arthritic symptoms (stiff and achy muscles and joints) also improve when avoiding trans fats. When combined with supplementation of essential fatty acid products, results are even more dramatic. People are elated to find out that their daily nagging symptoms are not "normal," nor due to "normal aging" or "just getting older."

One must be both diligent and patient for the changes to take place due to the prolonged half-life of trans fatty acids. Within a few weeks to a couple of months, however, the results are usually noticeable and quite gratifying.

READ LABELS AS IF YOUR LIFE DEPENDED ON IT

Read labels. Read labels as if your life depended on it, which it does. As people say when they first look to avoid these poisons, "These fats are in everything on the grocery store shelves!" Well, not quite everything. But partially hydrogenated oils are found in margarines, vegetable shortenings, most chips, cookies, candy, cakes, popcorn and other similar snack foods, and are used in food preparation by most fast food companies. , Typical ingredients sections of labels include such names as "partially hydrogenated soybean oil," "hydrogenated vegetable oil," "partially hydrogenated cottonseed oil," and so on.

Far too few family doctors, internists or cardiologists are aware of the massive recent research evidence indicting trans fats as increasing their patients' risk of heart disease, much less the other adverse effects of consuming these poisonous substances. In fact, although the abundance of new literature is slowly changing these old attitudes, many doctors still recommend margarine instead of butter for patients trying to prevent or improve heart disease. The fact is that trans fats increase cardiac risk factors twice as much as saturated fat in the diet![22]

Still, many patients blindly follow their misinformed doctors advice and are unwittingly consuming foods thinking they will decrease their risk for heart disease when these foods will actually significantly worsen their cardiac risk factors, not to mention the other problems they create. We must stop the insanity of slowly poisoning ourselves and our society by replacing natural fats with processed trans fats. There are now consumer advocates who are devoted to removing these dietary poisons from out food supply. (See resources at end of this paper.)

ADVERSE EFFECTS OF NSAIDs

There has been much recent concern about the cardiovascular effects of the COX-2 inhibitor NSAIDs that have been removed from the market place. However, there are many other adverse effects of aspirin and all of the other NSAIDs on the market. These medications are often called pain killers, but they are really anti-inflammatory drugs which decrease pain by decreasing tissue inflammation.

Common NSAIDs are listed in the following chart with their generic names followed by their product names in parentheses:

NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)

GENERIC NAME (*PRODUCT*)

DICLOFENAC (CATAFLAM, VOLTAREN)

DIFLUNISAL (DOLOBID)

ETODOLAC (LODINE)

FENOPROFEN (NALFON)

FLOCTAFENINE (IDARAC - CANADA)

FLURBIPROFEN (ANSAID)

IBUPROFEN (ADVIL, CRAMP END, DOLGESIC, EXCEDRIN IB, GENPRIL, HALTRAN, IBREN, IBU-200, IBUPRIN, IBUPROHM, IBU-TABS, MEDIPREN, MIDOL, MOTRIN, NUPRIN, PAMPRIN, Q-PROFEN, RUFEN, TRENDAR)

INDOMETHACIN (INDOCIN)

KETOPROFEN (ACTRON, ORUDIS, ORUVAIL)

MECLOFAMATE (MECLOMEN)

MEFENAMIC (PONSTEL)

NABUMETONE (RELAFEN)

NAPROXEN (ALEVE, ANAPROX, NAPROSYN)

OXAPROZIN (DAYPRO)

PHENYLBUTAZONE (BUTAZOLIDIN - CANADA, COTYLBUTAZONE)

PIROXICAM (FELDEDN)

SULINDAC (CLINORIL)

TENOXICAM (MOBIFLEX - CANADA)

TIAPROFENIC ACID (ALBERT TIAFEN - CANADA, SURGAM - CANADA)

TOLMETIN (TOLECTIN)

NSAIDs decrease inflammation by blocking PGs. These drugs block PG production for all three of the PG families. In fact, aspirin and acetaminophen act by the same PG blocking mechanism. PG 1 and PG 3 normally block the adverse effects of PG 2 family substances in the body in the

presence of a balanced EFA metabolism. NSAIDs, aspirin and acetaminophen will only have a symptom lowering effect if there are more PG 2 precursors in the body than PG 1 and PG 3 precursors. The logical conclusion becomes that these drugs are only useful when there is an EFA imbalance in the first place.

Among the adverse effects of NSAIDs is gastrointestinal hemorrhage.[27] This occurs even at the lowest doses. The internal bleeding effect might be microscopic creating no symptoms, but it does occur. Consider the following statistics that are taken from the website of The American Gastroenterological Association and American Pharmacists Association. (See resources list at end of paper.)

- EACH YEAR 103,000 PEOPLE ARE HOSPITALIZED WITH SERIOUS SIDE EFFECTS FROM TAKING NSAIDs
- EACH YEAR 16,500 PEOPLE DIE FROM THE SERIOUS SIDE EFFECTS FROM TAKING NSAIDs
- MORE PEOPLE DIE FROM NSAID SIDE EFFECTS THAN FROM AIDS EACH YEAR
- MORE THAN 4 TIMES AS MANY PEOPLE DIE FROM NSAID SIDE EFFECTS AS FROM CERVICAL CANCER EACH YEAR
- ONLY 1 IN 5 PEOPLE WHO HAVE SERIOUS PROBLEMS FROM TAKING NSAIDs HAVE WARNING SYMPTOMS

There are many other significant adverse effects of consuming NSAIDs that include the following:

- DECREASE FOLIC ACID ACTIVITY
- INTERFERE WITH VITAMIN C ACTIVITY
- DECREASE GUT IMMUNITY AND INCREASE LEAKY GUT 27, , ,
- ENHANCE LEUKOTRIENES (WHICH ARE MORE INFLAMMATORY THAN THE INFLAMMATORY PGs)
- DECREASE THE AVAILABILITY OF SULFATES AND INTERFERE WITH THE SYNTHESIS OF GLYCOSAMINOGLYCANS / PROTEOGLYCANS (THE BASIS FOR CARTILAGE REPAIR) ,
- SLOW FRACTURE HEALING , , ,

These drugs may be of value immediately following a trauma to limit inflammatory destruction of tissues and set the stage for healing. However, they should not be used for more than two or at most three days, even in post trauma situations. A clinical response to these drugs that lasts longer than several days suggests that the person has an underlying EFA imbalance as the primary problem that should be addressed, not just covered up with these medications.

MUSCLE TESTING SCREENING PROCEDURES FOR EFA IMBALANCE

Due to the fact that aspirin, NSAIDs, and acetaminophen provide symptom relief only in the presence of an EFA imbalance, people who tell of being helped by these drugs will certainly have an EFA problem. The only time that aspirin, NSAIDS, or acetaminophen can help a person is if there is an EFA imbalance in the first place (with the exception of acute injuries mentioned above.) By applying this concept, we can use muscle testing and gustatory receptor challenging to identify those people who have an EFA imbalance. Although this procedure is merely a screening procedure and does not apply 100 % of the time, it is still an excellent screening test for routine use.

We know that people will show a muscle strengthening response on oral testing with substances compatible with their needs. We also know that muscle testing weakening responses will occur when an offending substance is placed in the mouth as has been shown with food allergies.

We can apply these principles to EFA imbalance by testing orally with a mixture of aspirin, ibuprofen (or other NSAID drug) and acetaminophen. The only times these artificial substances will cause a strengthening response of a previously weak muscle is when there is an EFA imbalance. Further, some people

will demonstrate a weakening response of a strong muscle when they taste this mixture (although this is a much smaller number of people than those who will strengthen on the mixture). Either a strengthening response or a weakening response to oral challenge with the aspirin, ibuprofen, acetaminophen mixture is an indicator of an EFA imbalance and a need for EFA.

PROCEDURE

If a muscle is weak (inhibited) "in the clear" – test with oral challenge using aspirin, and ibuprofen, and acetaminophen mixture.

1. If aspirin, etc. mixture facilitates the weak muscle, wipe off the tongue and then test for EFA by placing EFA in the mouth and retesting the inhibited muscle.
2. If aspirin, etc. mixture weakens a strong muscle, wipe off the tongue and then test for EFA by placing EFA in the mouth and retesting the weak muscle.
3. Test for strengthening with oral PG 1 and PG 3 precursor oils and cofactors.

   a.) PG 1: Black Currant Seed Oil, Evening Primrose Oil, Borage Oil

   b.) PG 3: Flaxseed Oil, Fish Oils (EPA-DHA).

   c.) Test with cofactors for EFA conversion into PGs: B-6, magnesium, zinc and niacin.
4. Strengthening responses suggest that the strengthening substance may be beneficial to add to the person's dietary intake if there are other indications from the person's history, laboratory or examination to corroborate the usefulness of the substance. Never recommend any dietary substance based on muscle testing response alone.
5. Instruct the person to read labels and avoid hydrogenated and partially hydrogenated fats and oils.

CONCLUSIONS

Many of us, our family members, friends, clients and patients have nagging symptoms or major degenerative problems that are more or less take for granted. We refer to these symptoms as "normal" or "typical", which they are not. When they recur, we feel victims of an imperfect world. Or we write them off to the aging process. Or suppress the symptoms with aspirin, NSAIDs or acetaminophen and pay the price with side effects, consciously or otherwise.

There are tangible reasons for most everything we experience. The ingestion of hydrogenated and partially hydrogenated fats and oils contributes to the common aches and pains of daily life, as well as to slow degenerative processes and life ending illnesses. These symptoms can be changed and the quality of life improved by simply avoiding hydrogenated and partially hydrogenated fats and oils.

Now you can see why we say, "Get these out of your family's kitchen" and FRIENDS DON'T LET FRIENDS EAT PARTIALLY HYDROGENATED FATS!

SUGGESTED WEB RESOURCES

1. *www.2reduce.com*: a site of the The American Gastroenterological Association (AGA) and American Pharmacists Association (APhA) that offers information and data concerning the overuse of NSAID drugs.

2. *www.bantransfats.com*: a consumer advocacy group working toward eliminating trans fats in the American diet.

3. *http://www.cfsan.fda.gov/~dms/transfat.html*: US Food and Drug Administration site on new labeling laws for trans fats as well as other consumer information on the ill effects of trans fats.

REFERENCES

[1] Schmitt, Walter H., "Get These Out of Your Family's Kitchen". *Chiropractic Journal of North Carolina*, Nov/Dec 1995; 78(6):26-29.

[2] *Journal of the Nutrition Council of the American Chiropractic Association*, October, 1996.

3 *Dorland's illustrated medical dictionary*, 28th ed. WB Saunders, 1994

[4] Schmitt, Walter H., Jr. Compiled notes on clinical nutritional products. Mahopac, NY: David Barmore Productions, 1990

[5] Dannenberg AJ, Redienberg MM. "Dietary fatty acids are also drugs." *Clinical pharmacological therapeutics* 1994; 55:5-9

[6] McGiff JC et al. "Arachidonate metabolites in kinins in blood pressure regulation." *Hypertension* 1991;(Suppl.3):18(supp III):III-150-III-157

[7] Saloman P, et al. "Treatment of ulcerative colitis with fish oil N-3-w-fatty acid: an open trial." *Journal of clinical gastroenterology* 1990; 12(2);157-161

[8] Sperling, RI. "Dietary Omega-3 fatty acids: the effects on lipid mediators of inflammation and rheumatoid arthritis." *Nutrition in rheumatic diseases/rheumatic disease clinics of North America/ nutrition and rheumatic diseases* May 1991; 17(2):373-389

[9] Callejari PE and Surier, RB. "Botanical lipids: potential role in the modulation of immunologic responses and inflammatory reactions." *Nutrition and rheumatic diseases/rheumatic disease clinics of North America* May 1991; 17(2):415-425

[10] Narisawa, T; et al. "Relationship between blood plasma prostaglandin E2 and liver and lung metastasis in colorectal cancer." *Diseases of colon and rectum* Oct 1990; 33(10):840-845

[11] El-Hakm IK, et al. "Leukotriene B4 and oral cancer." *British Journal of Maxillofacial Surg* 1990; 29:155-159

[12] Axelrod L; et al."Effects of a small quantity of w-3 fatty acids on cardiovascular risk factors in NIDDM." *Diabetes care* Jan 1994; 17(1):37

[13] Zhu B; et al. "Is the reduction of myocardial infarct size by dietary fish oil the result of altered platelet function?" *The American Heart Journal* 04/94;127(No.4/part 1):744-755

[14] Goodnight, SH. "The effects of n-3 fatty acids on atherosclerosis and vascular response to injury." Archives of pathology and laboratory medicine Jan 1993; 117:102-105

[15] Engler MB. "Vascular effects of omega-3fatty acids: possible therapeutic mechanisms in cardiovascular disease." *Journal of Cardiovascular Nursing* 1994; 8(3):53-67

[16] Nordoy A; et al. "Individual effects of dietary satuarted fatty acids and fish oil on plasma lipids and lipoproteins in normal." *American Journal of Clinical Nutrition* 1993; 57:634-639

[17] Parkinson A. "Elevated concentrations of plasma omega-3 fatty cids among Alaskan eskimos." *American Journal of Clinical Nutrition* 1994; 59:384-388

[18] Brzeski, M et al. "Evening primrose oil in patients with rheumatoid arthritis and side-effect of non-steroidal anti-inflammatory drugs." *British Journal of Rheumatology* 1991; 30:370-372

[19] Roitt, Ivan M., Brostoff, Jonathon, Male, David K. *Immunology.* St. Louis: C.V. Mosby, 1985

[20] Ascherio A; et al. "Trans-fatty acids intake and risk of myocardial infarction." *Circulation* 1994; 89:94-101

[21] Willett WC; et al. "Intake of trans fatty acids and risk of coronary heart disease among women." *Lancet* 03/06/93; 341:581-585

[22] Byers, Tim, M.D., M.P.H., "Hardened Fats, Hardened Arteries?" *The New England Journal of Medicine* November 20, 1997; 337(21):1544-1545.

[23] Salmeron J, Hu FB, Manson JE, Stampfer MJ, Colditz GA, Rimm EB, Willett WC, "Dietary Fat Intake and Risk of Type 2 Diabetes in Women", *American Journal of Clinical Nutrition* 2001; 73:1019-1026.

[24] Zhang SM, Willett WC, Hernan MA, et al, "Dietary Fat in Relation to Risk of Multiple Sclerosis Among Two Large Cohorts of Women," *Am J Epidemiol,* 2000; 152(11):1056-1064.

[25] Hurley J, Schmidt S. "Movie theater snacks." Nutrition action, May, 1994; 1,9

[26] Litin L, Sacks F. "Trans-fatty acid content of common foods." *New England Journal of Med* Dec 23, 1993; 329(26):1969-1970.

[27] Gomes JA; Roth SA; Zeeh J; Bruyn GAW; Woods EM; Geis GS; "Double-blind comparison of efficacy and gastroduodenal safety of diclofenac/misoprostol, piroxicam, and naproxen in the treatment of osteoarthritis." *Annals of Rheumatic Diseases* 1993; 52:881-885.

[28] Baggott JE; Morgan SL; Ha T; Vaughn WH; Hine RJ; "Inhibition of folate dependent enzymes by non-steroidal anti-inflammatory drugs." *Biochem* J 1992 Feb 15; 282 (pt 1): 197-202.

[29] Bjarnason I, Williams P, et al. Gut, *International Journal of Gastroenterology and Hepatology* 1986; 27(11):1292-7.

[30] Bjarnason I, Zanelli G, et al. Scandinavian *Journal of Rheumatology* 1987; 64:55-62.

[31] Jenkins AP, Trew DT et al.Gut 1991; 32(1):66-9.

[32] Vaananen PM; Keenan CM; Grisham MB; Wallace GL; "Pharmacological investigation of leukotrienes in the pathogenesis of experimental NSAID gastropathy." *Inflammation* 1992 Jun; 16(3):227-40.

[33] Jung U. Yoo, Robert S. Papay, Charles J. Malemud. "Suppression of proteoglycan synthesis in chondrocyte cultures from canine disc." *Spine,* Vol. 17, No. 2, 1992. 221-224.

[34] P. M. van der Kraan, Elly L. Vitters, Bernard J. de Vries, Wim B. van den Berg. "High susceptibility of human articular cartilage glycosaminoglycan systhesis to changes in inorganic sulfate availability." *Journal of Orthopedic Research,* Vol. 8, No. 4, 1990. 565-571.

[35] Varghese, D, Kadakat, S, Patel, H. "Non-steroidal anti-inflammatories should not be used after orthopedic surgery." *British Medical Journal* 1998; 316: 1390 (Letter)

[36] Dimar JR II, Ante WA, Zhang YP, Glassman SD. "The effects of non-steroidal anti-inflammatory drugs on posterior spinal fusions in the rat." *Spine* 1996; 21: 1870-1876.

[37] Altman RD, Latta LL, Keer R, Renfree K,Hornicek FJ, Banovac K. "Effect of non-steroidal anti-inflammatory drug on fracture healing: a laboratory study in rats." *Journal of Orthopaedic Trauma* 1995; 9(5): 392-400.

[38] Mizano H, Liang RF, Kawabata A. "Effects of oral administration of various non-steroidal anti-inflammatory drugs on bone growth and wound healing in mice." Meikai Daigakuy Shigaku Zasshi. *Journal of the Meikai University School of Dentistry* 1990; 19: 234-50.

[39] Schmitt, W.H. Jr. & Leisman, G. "Correlation of applied kinesiology muscle testing findings with serum immunoglobulin levels for food allergies." *International Journal of Neuroscience* 1998, 96, 237-244.

Powers of Stress

by Richard Utt

When a muscle is monitored and observed to be in any of the states of stress other than homeo-sta-stress, it is impossible to immediately determine exactly how far the muscle is away from the homeo-sta-stress condition. It is possible that a single correction - perhaps a spindle organ squeeze technique - will return the muscle to homeo-sta-stress. When a muscle is returned to homeo-sta-stress by a single appropriate spindle organ technique, then the muscle was at the threshhold stress level or, in other words, exhibiting 1 power of stress. The other possibility is that the muscle will require a number - 2 or 20 or 200 - of spindle organ stimulations (or other modality stimulations) to return the muscle to the homeo-sta-stress state. Each of these manipulations takes the muscle one power of stress closer to homeo-sta-stress. These powers of stress represent degrees of muscular chemo-electro-magneto polarity that must be reduced in amplitude bit by bit before the muscle can be returned to homeo-sta-stress. Long before a tissue or organ demonstrates anatomical or physiological changes that are obvious, it will manifest powers of stress that an Applied Physiology (AP) practitioner can observe and work on.

In a real sense, the complex and coordinated tissues and cells of the body - including neurons, synapses where neurons meet, and motor end plates where neurons meet muscles - can be compared to spark plugs. The internal combustion engine in our prize automobile will not run at peak performance if all the spark plugs in all its cylinders are not firing correctly. In order for an electrical charge to travel across the poles of a spark plug, the poles must be appropriately spaced, or "gapped". If the gap is too wide, no spark will jump across it and the spark plug won't fire at all.

How does this relate to muscle function? It can be compared to the condition when a muscle is underfacilitated or overinhibited. When we ask the muscle to respond to commands from our central nervous system, it is unable to contract appropriately and play its part in the "team" of muscles that work together to create graceful, purposeful movement. At its extreme, this condition can be observed as flaccid paralysis, when the muscle does not respond at all!

If, on the other hand, the spark plug gap is too narrow, the jumping spark will be uncontrolled, and the plug will overheat. This is often compared to the states of stress called overfacilitation or underinhibition, where the muscle being observed is unable to relax appropriately during extension - this may result in pain and certainly results in movements that are less graceful and efficient than possible. At its extreme, the muscle may be unable to relax at all, a condition called spastic paralysis.

Even though this analogy to a spark plug, its "gap" width, and its optimal function may seem to be comparing apples and oranges, there are many interesting parallels with living tissues. Within the motor, sensory, and autonomic nervous circuits of the body are motor end plates and synapses that represent real "gap" sites in these nervous circuits. The width of the "gap" between a neuron and an extrafusal muscle fiber, for example, must be within a certain width tolerance (homeo-sta-stress) or the nervous impulse will either be very weak or will not "jump" across the gap at all. The muscular circuit connecting an agonist, the spinal cord, and antagonists will not function optimally because of this constriction or dilation (see the Chapter on the Histology of Stress) of the cells at the neuromuscular junction. When an Applied Physiologist applies the appropriate interventions to the system, he or she is reducing the powers of stress that have created distorted tissues, incorrect "gapping", and observable states of stress.

Sometimes the entire circuit, including the afferent and efferent nervous cells that carry information from the big toe to the brain and back, is compared to the action of a transistor. In a transistor, a small voltage change at one place in the circuit (the sensor or dimmer switch) is used to control or regulate much larger voltages elsewhere in the circuit. In this model, the "dimmer switch" represents the neuromuscular spindle organ (NMS) in a muscle which sends sensory information to the central nervous system (brain and spinal cord). This sensory information informs the brain about the overall tone, action of contraction, and action of relaxation in the muscle itself. The circuit is completed as the central nervous system sends motor impulses back to the muscle which cause it to contract (facilitation) or relax (inhibition).

In this "transistor circuit model" the output voltage (which generates the nerve cell "voltage" that stimulates muscle actions) is adjusted by changing the input voltage (at the NMS). Let's consider the agonist muscle first. If the input voltage is too low (+0.1 mV to +0.38 mV) then the output voltage will also be too low (+1 mV to +38 mV), and the agonist muscle will be unlocked and underfacilitated (see Figure 2 on pg. 34). The muscle is capable of movement but not a solid lock. In that critical moment when we call upon that particular muscle to support us or lift a fragile object, it fails to give us adequate stability.

On the other hand, if the input voltage is too high (+0.6 mV to +1 mV), then the output voltage will also be too high (+60 mV to +100 mV) and the agonist muscle will be overfacilitated (see Figure 3) and it is capable of movement but is tight and rigid, like a weight lifter who is "muscle-bound". While we may not notice this rigidity during large muscle movements - perhaps driving our car - we certainly experience limitations as we try to carefully adjust the tiny screws in our sunglasses.

In the homeo-sta-stress state, the range of input voltages (+0.39 mV to +0.59 mV) creates a range of output voltages (+39 mV to +59 mV) which allow the agonist muscle to contract (locking firmly into positions 1-7) optimally and appropriately so that the muscle accomplishes tasks accurately and gracefully (see Figure 4).

In this model, the agonist muscle exhibits spastic muscle paralysis when an output voltage of +101 mV or more exceeds the range of values we associate with overfacilitation . Flaccid muscle paralysis is observed when the output voltage is 0 mV (see Figure 5).

Remember that an agonist muscle always works as part of a muscle "team" which includes at least one antagonist muscle. In this "transistor" model, hypothetical positive millivoltages are used to represent the chemo-electro-magneto events in the agonist. In order to expand the model to include antagonist activities, we use negative

values for the millivoltages (see Figure 1 for a summary of these circuits). All these voltage values (positive or negative) are hypothetical and are only used to represent the different and varied chemo-electro-magneto events in the neuromuscular circuitry of this model.

Let's consider the antagonist muscle now. If the input voltage is too high (-0.1 mV to -0.38 mV) then the output voltage will also be too high (-1 mV to -38 mV), and the agonist muscle will be weak and overinhibited (see Figure 6). The muscle is capable of movement but not a solid lock.

On the other hand, if the input voltage is too low (-0.6 mV to -1 mV), then the output voltage will also be too low (-60 mV to -100 mV) and the agonist muscle will be underinhibited (see Figure 7 on pg. 35) - it is capable of movement but is rigid and will not unlock. Once again, we may not notice this rigidity during large muscle movements but fine, accurate movements are difficult.

In the homeo-sta-stress state, the range of input voltages (-0.39 mV to -0.59 mV) creates a range of output voltages (-39 mV to -59 mV) which allow the antagonist muscle to relax (unlock) optimally and appropriately so that the muscle team accomplishes its tasks accurately and gracefully (see Figure 8). In this model, the antagonist muscle exhibits spastic muscle paralysis when its output voltage of –101 mV or more exceeds the range of values we associate with underinhibition (-101 mV or more). Flaccid muscle paralysis is observed when the output voltage is 0 mV or less (see Figure 9). A summary of this model is shown in Figure 10.

If the output voltage remains consistently too high, then this creates a situation which can be compared to a circuit in which there is too much current flow and a fuse (or other electronic device, such as a transistor) burns out. In human tissues, this "overheating" may take place over short time periods (perhaps one second) or long periods (maybe 20 years) and culminate in the "burning out" of an organ that will need to be replaced in a heart or kidney transplant! It is important to remember that there are a range of values which represent homeo-sta-stress (39 - 59 mV in our example). When the voltages are regulated within optimal range, the circuit behaves according to design. It is also important to remember that there are a range of values associated with either overfacilitation or underfacilitation - the individual voltage values (+61, +62, +63, etc) can be compared to the powers of stress exhibited in overfacilitation . If the model voltage value (perhaps +63 mV) is only a few mV (or powers of stress) away from the homeo-sta-stress range, then the muscle circuit can be restored to homeo-sta-stress with a small number of NMS manipulations. If, on the other hand, the model voltage value is many mV away from the homeo-sta-stress value (perhaps +93 mV!), then a much larger number of NMS manipulations are required. In an extreme example, when many hundreds or thousands of powers of stress are affecting muscle function, spastic paralysis may occur.

Changes which occur in the "voltage" of this anatomical and physiological circuit may have several different causes. They may be due to chemical events, including our individual reactions to the many different foods - sweets and meats and vegetables - we eat or the alcoholic or caffeinated drinks we consume. Environmental toxins may be inhaled as we wait for the bus on a smoggy intersection, or ingested along with our polluted tap water. Mechanical events, such as sports injuries or strains related to over-exercise or under-exercise may create powers of stress in these body circuits. Finally, our complex mental processes - all of our thoughts, attitudes, and feelings - including happiness, sadness, fright, grief, or anger can contribute to the voltage in these neuromuscular circuits and create powers of stress.

The result in both of these cases is that tissues become distorted and the polarities which create neuromuscular homeo-sta-stress are disturbed. As the powers of stress increase, the amplitude of this tissue distortion and polarity disturbance increases. Individual cells are unable to do their "job" in the cellular community as they have problems receiving nutrients and ventilating wastes through constricted or dilated blood vessels. Neurons cannot transmit impulses effectively along their axons and dendrites. Neurotransmitters flood across overly narrow synaptic gaps or are lost and diluted in overly wide gaps. The nervous messages which coordinate and create appropriate muscle actions are not transmitted accurately. The AP practitioner observes these departures from homeo-sta-stress and understands the appropriate methods using body hardware to create changes in the polarity and chemo-electrical condition at the cellular level which restores the entire muscle to homeo-sta-stress.

In AP we quantify the Powers of Stress by understanding that each Fac/Inh balancing technique we apply is counted as one power of stress. It is important to be aware that when we begin to build a muscle's chemo-electrical condition toward the homeo-sta-stress state that we do not know how many powers of stress it is manifesting. The AP practitioner understands that he or she must be persistent in applying appropriate spindle organ techniques or other interventions until a sufficient number of powers of stress are removed to enable the muscle to accept the final spindle organ technique applied. It may be necessary to be extremely patient and persistent as we manipulate spindle organs multiple times, store the information from these manipulations in Pause Lock, and slowly adjust the chemo-electrical condition of the the muscle towards the homeo-sta-stress state. Ultimately, our repeated use of spindle organ technology will allow the muscle to accept this information and return to the homeo-sta-stress state and stored in Pause Lock. The P/L is now holding the gravity of the powers of stress and we have successfully created a hardware circuit that may be worked on by using an appropriate indicator muscle. The modality of correction is only limited to the expertise of the practitioner at this point. Whatever modality is used, the subsequent release of endorphins and enkephalins by nervous tissues in the brain will affect the motor and sensory components of the multiple nerve circuit that were created in the original P/L, including its powers of stress (Amplitude of Circuit). After all corrections have been made, close the Pause Lock and recheck the original OF/UI/UF/OI circuit observed.

Notes: