



BODY PRIORITIES AS DEMONSTRATED

BY A DENTAL SPLINT

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ABSTRACT: This paper deals with the methods of determining the priorities that the body exhibits in the sequence with which corrections should be made. The use of a dental splint shows us that many of our kinesiological findings are really nothing more than compensations for more basic problems. Herein the guidelines are laid down for the sequence in which the body corrections should be made.

INTRODUCTION: Since the inception of applied kinesiology we have seen the kinesiologist go through a series of phases in the clinical application of AK (Applied Kinesiology). The early kinesiologist found that through the application of his or her newly learned techniques, he could, for example; make an acute pain go away that the patient was experiencing, plus other demonstrations which bordered upon being considered parlor tricks. As the field of applied kinesiology grew and grew, we were able to discover reflexes and syndromes that, heretofore, had gone unnoticed, although, obviously, they were present in our patients' bodies all along. In more recent years, we have been able to demonstrate the presence of subclinical conditions in our patients' bodies, conditions that would only appear or be evident by using such methods as: challenging, temporal tapping, therapy localization, pinching, breath holding, and methods of eliciting reflexes that, heretofore, had been unknown to us. (1)

As a result of this ever-increasing knowledge in applied kinesiology and our ability to probe deeper and deeper into the vast amount of information stored in the body in computer proportions, it no longer was a question of the doctor not being able to find indications of things that needed to be fixed in his patients. Now it became a problem of finding enough time to be able to check in each individual patient all of the things that we are now proficient in discovering and bringing to the surface.

Most recently, the advancements in applied kinesiology have enabled us to uncover problems that we would have never dreamed existed previously. Due to this increase in our clinical armamentarium, when it comes to treating our patients, we now see patients with more difficult type problems, problems that previously would have completely baffled us. The rule seems to be that the more proficient we become in techniques with which we are familiar, the more difficult type of patient we seem to attract to our offices. While treating a patient who has previously defied the efforts of our colleagues, and, perhaps, has stymied the efforts of health professionals in other branches of the healing arts, it many times becomes apparent that we are chasing symptoms.

For example, we may fix a sequence of indicators only to find at the end that one of the original indicators we fixed is now back again, or worse yet, in a more difficult type of patient, we may find ourselves going down in flames by not being able to fix something that has been so easy to fix in the average type patient. We believe this to be due to the fact that many of our findings are compensatory, that the body wants to be fixed, and must be fixed, in a sequence if permanent results are to be obtained.

THE USE OF A DENTAL SPLINT: One such method of determining which of the findings are primary and which of the findings are compensatory is the use of a dental splint. Here within, we have the tabulated results of 23 patients with whom we used the dental splint technique of determining the body priorities. The patients were all tested for what we call the baseline muscles. This includes a bilateral reading on the following 20 muscles:

<i>LATISIMUS DORSI</i>	<i>PMS</i>	<i>FASCIA LATA</i>	<i>ILEOCECAL</i>
<i>SUPRASINATUS</i>	<i>PMC</i>	<i>HAMSTRINGS</i>	<i>HYOID BONE</i>
<i>DELTOIDS</i>	<i>ABDOMINALS</i>	<i>GLUTEUS MAXIMUS</i>	<i>TMJ</i>
<i>TERES MINOR</i>	<i>PSOAS</i>	<i>MID. TRAPEZIUS</i>	<i>UPPER TRAPEZIUS</i>
<i>NECK FLEXORS</i>	<i>SARTORIUS</i>	<i>QUADRICEPS</i>	<i>GLUTEUS MEDIUS</i>

In the case of ileocecal valve, we were checking for open versus closed valve. In the case of the hyoid, we were checking the digastric muscle, on the left and on the right. The strength of these 20 muscles was recorded for left and right and then a dental splint was used, the height of which was adjusted to make a weak indicator muscle become strong. Those patients with an obvious overbite were selected. The fulcrum used was the first molar. Once the adjusted height of the dental splint has been achieved, we would then go back and check the previously weak muscles.

We found on the average a 72% reduction in the number of weak indicator muscles now showing up. What is even more significant is what happened by correcting only those indicators which remain weak with the dental splint in place. After the correction of those and removing the dental splint, all of the previously weak indicator muscles would be strong. In other words, this not only showed us which ones were primary and which ones were compensatory or secondary, but it also saved us a great deal of time in treating a patient.

In the accompanying chart of 23 patients used for purposes of this experiment, where we show zero muscles weak with the splint, it simply indicates that the primary problem was the TMJ itself.

Once it was determined that the patient needed a dental splint, the patient was then sent to a dental kinesiologist. The exact height of the splint was determined by the use of an intraoral screw device made by Swissdent or a modified jack screw or just by temporal tapping. In all cases, the lower arch was used. First a negative alginate impression was made followed by a positive plaster mold and then an acrylic negative overlay covering the posterior teeth connected by a lingual arm. The acrylic splint was then ground and polished to the desired height.

<u>PATIENT</u>	<u>TOTAL BASELINE MUSCLES WEAK</u>	<u>PRIMARIES WEAK WITH SPLINT IN</u>	<u>% OF REDUCTION</u>	<u>MUSCLES WEAK WITH SPLINT OUT AND PRIMARIES FIXED</u>	
C.S.	11	3	75%	0	
A.R.	15	3	89%	0	
B.P.	27	15	45%	0	
C.W.	7	0	100%	1	*
P.F.	5	0	100%	1	*
S.M.	5	1	80%	0	
R.R.	8	4	50%	0	
E.W.	7	3	58%	0	
P.H.	10	2	80%	0	
V.R.	10	0	100%	1	*
E.S.	5	0	100%	1	*
J.M.	14	10	29%	0	
F.S.	4	0	100%	1	*
E.H.	10	0	100%	1	*
J.R.	7	2	72%	0	
H.A.	11	8	28%	0	
M.G.	9	2	78%	0	
A.W.	7	0	100%	1	*
B.B.	17	3	83%	0	
C.S.	21	12	43%	0	
D.C.	16	0	100%	1	*
I.C.	8	0	100%	1	*
<u>D.B.</u>	21	5	77%	0	
TOTALS	255	73	72% (AVG.)	100%	*

*One remaining muscle that had to be fixed with the splint out was the TMJ itself

Not only did we have to correct only the remaining weak muscles with the splint in, which would make

all the previously indicators go strong, but we found that the body wanted the remaining weak muscles to be fixed in a certain order. In fact, with some of the more difficult type patients you are not able to make a single muscle strong unless you fix them in a specific order.

In Dr. Beardall's cloacal synchronization technique (2) he states that the cloacal reflexes is the most basic place to start to fix the patient. We have found that even among the cloacal reflexes that some will not fix, nor will they therapy localize to the correction contact point if that is not the next one in sequence to be fixed. Sometimes a hyoid or gait reflex must be fixed before the cloacal. Regardless of what our total list of indicators may show that need to be corrected, we may not be able to correct a single muscle weakness if we do not follow the proper sequence and first fix the one that the body priorities demand be fixed first. This is so often depicted in the more difficult type patient.

Not always does the body dictate that you may now fix one thing only, as most of the time there may be several things you may fix, the sequence of those particular muscle indicators not being important. We have found that the criteria of whether something can now be fixed or not, can be based on three requirements. In other words, in order for us to permanently fix a specific finding sequentially, it must meet the following criteria:

1. It must be weak in the clear.
2. It must therapy localize.
3. It must respond to the inspiration phase of respiration.
4. Pinch.
5. Eyes left and right.

Using the above criteria, we many times have had to back down on the sequence which we previously had thought was the correct order to fix a specific problem.

CONCLUSION: The body has specific requirements for the sequence in which findings should be fixed if permanent results are to be obtained. This sequence can be ascertained with the use of the dental splint, which will then show which findings are primary and which findings are secondary or compensatory. The 23 patients used in this particular survey all had plastic dental splints, made in the dental office, which could be progressively decreased in size as the patient continued to improve. The goal being that once everything was holding, the dental splint was no longer necessary.

REFERENCES:

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