

2.-OCULAR LOCK: Cranial fault.
Body into distortion (BID).

3.- CV-GV: Anterior teeth problems
Maxillary bone problems
Jaw problems.

There could also be a false-negative T.L.:

- 1.- Patients with hypertonic muscle(s).
- 2.- Patients with all hypertonic muscles.

Approximately three years ago a book fell into my hands called "Brain Gym Handbook" which mentioned multiple exercises to improve the learning process of the students. Brain Gym is a program of physical activities that enhance learning ability.

These established that coordinated physical movement is necessary for brain development.

Brain Gym consists of 26 easy and enjoyable targeted activities that bring about rapid and often dramatic improvements in concentration, memory, reading, writing, organizing, listening, physical coordination, and more.

One of their many different activities is DENNISON Laterality Repatterning where the patients look at the drawings "X" & "II" for pre-checks and post-checks and anchoring, with these steps:

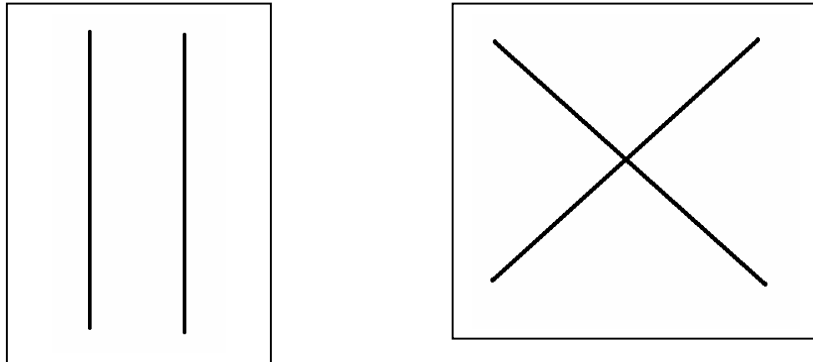
- 1.- Cross Crawl and Looking at an "X" image on paper.
- 2.- Homolateral Crawl and Looking at an "II" image on paper
- 3.- Complete the process with Cross Crawl and looking at the "X".

Their intention of laterality repatterning is to change **trying** to automatic movement and **reflex movement** to conscious choice.

I questioned them about the source of "X" and "II" drawings and their answer was:

"It is the result of years of research. The "X" symbolizes the whole brain working together. The "II" symbolizes reflexive movement and mental (left brain) overriding the physical and the intuitive".

My attention was called to the idea of the **CROSSED LINES** and of the **VERTICAL PARALLEL LINES**, and I initiated my investigation regarding their possible use in Applied Kinesiology.



These drawings are not new since they are also used jointly with other drawings in psychological tests.

PROCEDURE:

I studied 200 random patients, 45% of which were males and 55% were females, who sought consultation for various reasons, and who showed positive therapeutic localization at KI-27. The test for Ligament Stretch Reaction was performed as the initial and final test; hypoadrenia of the suprarenal was discarded as a possible cause of alteration of the reliability of the study.

- 1.- As the initial test I performed a T.L. to KI-27 in supine, seating, and standing positions.
- 2.- In the case of a positive test, T.L. is imparted to KI-27 right, left, bilateral and contralateral to the hand in use.
- 3.- Ocular Lock tests were performed.
- 4.- Visual tests with the "X" and the "II" drawings in supine, seating, and standing position were done.
- 5.- In case of muscle hypertonicity, the indicator muscle was changed.
- 6.- It was confirmed that the black color of the ink and the white color of the paper do not weaken an indicator muscle.
- 7.- Different tests were performed searching for unpredictable muscle function, (simulated gait position, tests related to the patient's problem, etc.).

8.- If positive to "X" & "II" test, this examiner proceeded to evaluate various areas and functions of the body, as indicated by body language until Therapy localization and/or challenge eliminated the positive test.

9.- I treated the problem as usual in AK procedures.

RESULTS:

The following results were found:

The normal responses to the "X" and "II" visual tests were determined to be:

1.-A previously strong indicator muscle becomes weak after viewing the "II" image.

2.- A previously strong indicator muscle remains strong after viewing the "X" image, and in most of the cases weak muscles became strong.

Of the 200 patients with KI-27 positive, unpredictable muscular data was found only in 164 patients. Upon the application of the visual test using the "X" and the "II" drawings (two vertical lines), I found that the 164 patients showed positiveness to the visual response while the other 36 were negative. The group of 164 patients with unpredictable muscular data showed a positive visual "X" and "II" test, meaning that a previously strong indicator muscle remains strong after viewing the "II" image and/or a previously strong indicator muscle becomes weak with "X" test.

It was observed that the 36 patients, those with positive T.L. to KI-27, but with a negative "X" and "II" response, did not have unpredictable muscular tests, and after a more complete check-up the underlying cause of positiveness was found. In other words they could have been misdiagnosed as positive KI-27.

DISCUSSION:

The test by means of visual reflexes with the "X" and "II" drawings is more reliable than using the T.L. in KI-27 due to the fact that positive or negative responses are not shared with other corporal dysfunctions, such as neurolymphatic points, sublaxations, etc. The possibility of more diagnosis exists through the use of different drawings, for which more investigation is recommended.

For the making of the "X" and "II" drawings sheets of white paper were used, and the drawings were in black ink, therefore avoiding any conflict with colors that may cause some positiveness different to switching. It

was confirmed in all the patients that the black and white colors, being neutral, did not cause them any muscular weakness.

DYNAMIC USE OF THIS NEW TOOL AS AN INDICATOR FOR SWITCHING

Routine stimulation of K27–umbilicus clears evidence of neurological disorganization. This is valuable, as described previously by Dr. D.S. Walther, in preventing improper treatment; however, it is also detrimental to finding basic underlying causes of conditions. Over-riding switching eliminates indicators of some conditions which must be treated to eliminate neurological disorganization. For this reason, routine stimulation of K27-umbilicus is self defeating. (Examples of hidden primary problems will be presented as this subject is developed.)

This dynamic approach to switching is similar to the approach used by Dr. D.S. Walther, but now I use the “X” and “II” drawings as an asset in locating the basic underlying cause of the switched condition. This is accomplished with various examination procedures which are used to find what cancels the positive response to these visual reflexes. That factor is then treated, eliminating the positive response to these visual reflexes; this is a more effective method of abolishing the recurrence of switching.

Rather than accidentally making the correction, the dynamic method of locating the cause of switching is purposeful and finds more rapidly the basic underlying causes of an individual's health problem.

Treatment is directed toward the factor that eliminates the positive visual reflexes; if effective, there will no longer be evidence of switching. In this manner, “X” & “II” reflexes serves as a monitor for switching or neurological disorganization without the inconvenience of shared therapy localization response present in common KI-27 T.L., and of course, no misdiagnosed treatments..

CONCLUSION:

The use of visual reflexes has great potential within AK, and needs much more investigation, but I think it will give us a valuable diagnosis and treatment tool for many ailments.

REFERENCES:

1.-Walther, David S., Applied kinesiology Synopsis, Pueblo, Colorado, Systems D.C. 2000.

2.-Walther, David S., Applied kinesiology Volume I, Pueblo, Colorado, Systems D.C. 1981.

3.-Walther, David S., Applied kinesiology Volume II, Pueblo, Colorado, Systems D.C. 1983.

4.-Dennison Paul E., Ph.D., & Dennison Gail, Brain Gym Handbook, Ventura, California, Edu-Kinesthetics Publications, 1989.

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