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# THE UPLINK

Merging Contemporary Chiropractic Neurology and Nutritional Biochemistry in the Tradition of Applied Kinesiology

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Issue No. 13

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## STOP THE PAIN NOW!

In this issue of *THE UPLINK* we will discuss the three pain and injury related techniques which are represented by G-2 submax (Type 3) weaknesses. Correcting these first clears up many other problems.

Testing a weak muscle for the three types of muscle weakness continues to be the most important first step in guiding the doctor to the most efficient treatment strategy. When all three types of muscle weakness (G-1, G-2, and G-2s, or Types 1, 2, and 3) are present, you must consider the following:

- Injury or trauma - recent or ancient (In this issue.)
- Centering the Spine problem (Pituitary NL TLs or tonic labyrinthine reflexes are dysfunctional; emotional NVs positive) (See previous issues.)
- Immune system involvement (See previous issues.)

## SCREENING FOR INJURIES' EFFECTS

In this issue we will focus on IRT (injury recall technique), NSB (nociceptor-stimulation blocking technique), and SP (set point technique.) One or more of these techniques is indicated when there is a history of major injury or trauma, either recent or ancient. The need for IRT, NSB, and/or SP will persist (even for years) until the proper correction is made. But one correction is usually permanent.

There is a simple decision making process for deciding which technique is most appropriate:

- 1) *G-2s (Type 3) weakness present*
- 2) *Autogenic Facilitation-AF-muscle spindle stretching*
  - a) *No response: IRT*
  - b) *Strengthens: NSB or SP*
    1. *Activating pain causes general weakness: NSB*
    2. *No pain or activating pain = no weakness: SP*

## LOCATING THE PROBLEM AREA

*In IRT, rubbing over injury site strengthens.*

*In NSB or SP, pinching over injury site strengthens.*

Once you have determined that there may be a history of injury problem by G-2s and AF testing, you must determine which areas of previous injury are involved. It may be quite obvious, especially in the acute post-trauma period. But often, there are numerous potential areas of previous injury to consider, especially in untreated patients. As discussed in Issue 6 of *THE UPLINK*, the location for IRT is determined when a weak muscle strengthens with *rubbing* the skin over the site to be treated.

In NSB or SP, the opposite is true: *pinching* the skin over the site in need of treatment will strengthen a weak muscle. The only exception to this rule is when pinching the skin over an acute injury creates excessive pain. (These patients always need NSB.)

NSB and SP utilize acupuncture head points (AHPs) also called B & E points. See AHP chart in Issue 8 of *THE UPLINK* for locations.

## NSB TECHNIQUE

Used immediately after an injury up to days or weeks after an injury. It is used in conjunction with:

- a) An area which hurts immediately after an injury
- b) An area which hurts when pressure is applied
- c) Pain on movement

### PROCEDURE:

- 1) Presence of pain causes general weakness. The weakness from pain may be present immediately after injury, induced by direct pressure or by movement.
- 2) Pain induced weakness is negated by patient TL to or doctor tapping to an ipsilateral AHP.
- 3) To relieve pain immediately after injury, tap the related AHP until the pain is reduced.
- 4) If weakness is induced by pressure or movement, tap related AHP while intermittently activating pain (about once every 2-3 seconds.)
- 5) Tap until pain reduction is maximized.

## SET POINT TECHNIQUE

- 1) Area of previous injury may be recent or ancient. Pain may be present or absent.
- 2) TL to area is negative.
- 3) TL to associated **AHP** is negative.
- 4) Simultaneous TL to area of injury plus TL to or tap to an ipsilateral **AHP** is positive.
- 5) Tap 50 to 100 times on **AHP** while patient maintains TL to area of injury.

Case histories using IRT, NSB, & SP follow.

■ **CASE HISTORY #1:** A middle aged woman was seen three weeks post-surgically following a tibial plateau fracture. She had much pain with any movement to knee. A weak PMC was found with all three types of weakness. AF did not strengthen. Rubbing the medial tibia and infrapatellar areas strengthened. IRT was performed to these areas. The PMC was still weak, but AF now strengthened. Pinching over the medial tibia (pes anserinus) as well as the lateral tibia and the popliteal fossa area strengthened. Pressure to the medial tibia caused general weakness, negated by TL to GB-1. NSB was performed. Pressure to the lateral tibia and popliteal areas caused no weakness. SP was performed by tapping St-1 while the patient Tled the lateral tibia, and by tapping BI-1 while Tling the popliteal area. The patient was pain free on all movements and also had greater ranges of motion.

■ **CASE HISTORY #2:** A teenage girl presented five months post-auto accident in which she hit her head, elbow, knee, and hip, and had whiplash. She complained of continuous dizziness, headaches, and neck pain since the accident. Chiropractic adjustments and basic AK had given temporary reduction of symptoms. The right PMS showed G-1, G-2, and G-2s weakness but AF strengthened. Pinching over each of the injured areas strengthened the right PMS. Pressure to each of the injured areas caused no change in muscle strength. SP was performed for each of the injured areas, each responding to a different **AHP**. An internal frontal cranial fault was also corrected. Immediately following these corrections, she reported no dizziness, no headache, and no neck pain for the first time since the accident.

■ **UPDATING TERMINOLOGY:** The different types of muscle testing have been discussed for years in ICAK papers, in our seminars, and in one of our free audio tapes. In 1985 we called these "gamma-1" and "gamma-2." Later we added the third type of testing and changed the terms to G-1, G-2, and G-2s (G-2 submax). In attempt to bring these terms to a higher level of acceptability, we have introduced the terms "Type 1" (G-1), "Type 2" (G-2), and "Type 3" (G-2 submax). Type 1, Type 2, and Type 3 have been used in an upcoming paper which has been accepted for publication in a peer reviewed journal. This publication will establish the new terminology in the scientific literature. As we have done in this issue of *THE UPLINK*, we will use the old and new terms interchangeably for a long period of transition.

■ **NSB TO TEETH:** In issue 3 of *THE UPLINK*, we discussed three techniques for treating tooth involvement: neurological tooth, IRT tooth, and tooth set point. To these techniques we must add NSB to a tooth. Some patients have tooth pain, or referred pain from a tooth, or tooth related TMJ problems. The tooth might TL but correction of the three above techniques does not resolve the patient's problems. Try the following: tap (or have the patient tap) the tooth in question 3-4 times with the finger nail. (If NSB is indicated, this will activate the nociceptors which are creating the problem.) Immediately test a strong indicator muscle. If it weakens, this is an indication for NSB tooth technique. Find an **AHP** which negates the weakness induced by tapping the tooth. Tap the **AHP** continuously while intermittently tapping (or having the patient tap) the involved tooth. Tap the **AHP** until tapping the tooth no longer results in weakness. Since our teeth touch every time we swallow (about 100 times an hour, 24 hours a day) you can imagine the aberrant neurological barrage that an NSB tooth can create and why it is the cause behind many TMJ problems.

**TWO NEW SEMINAR TAPES AVAILABLE:**

■ **A NEW PEER REVIEW REFERENCE:** An AK oral nutrient response study has been published for the first time. The reference is: Schmitt, WH, Leisman G. Correlation of applied kinesiology muscle testing findings with serum immunoglobulin levels for food allergies. Intern. J. Neuroscience. 1998, Vol 96, pp. 237-244.

**1) "NUTRITIONAL ALTERNATIVES & ADJUNCTS TO COMMON MEDICATIONS" SEMINAR TAPES**

Dr. Schmitt's March, 1998 seminar  
**Audio tapes** plus extensive notes: \$175

**2) "PRACTICAL TOOLS EVERY CLINICIAN NEEDS"** Includes clinical correlations of TLR, IRT, cranial, TMJ, and tooth techniques as well as Dr. Schmitt's complete discussion of "The Neurological Basis of AK and Chiropractic." **Video tapes** of the one day seminar in the Chicago area in September, 1998. \$175 includes notes.