

Name _____

Date _____

Advanced I Workshop Manual

Language Processing and Brain Integration

Developed by Dr. Carl A. Ferreri
&
Additional Concepts by Dr. Charles Krebs

Expanded by

Dr. Mitchell Corwin
2914 Domingo Ave
Berkeley CA 94705
(510) 845-3246
drcorwin@prado.com
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Foreword

As a protégé of Dr. Ferreri since 1983, Dr. Mitchell Corwin has added many new dimensions to neural organization technique that are outlined in this and future manuals. It is Dr. Corwin's belief that one can learn this work in a fashion that is exciting, well organized, and mentally challenging. It should not be taken as a cookbook protocol to healthcare but as an eclectic approach, that shares the wisdom and expertise of many practitioners.

This manual represents an abridged version of the original work of Dr. Carl Ferreri. It incorporates all the basic concepts of neural organization technique with emphasis on understanding the theory and application. Although there are some differences in description, application, and emphasis, the basic philosophy remains the same. For those that have taken prior instruction from Dr. Ferreri and / or other instructors, differences in opinion will exist. This work should not be construed as a separate entity from the original concepts of Neural Organization Technique but a natural outgrowth.

Advanced workbooks will include methodologies in immuno-therapy, deep level switching, and emotional clearing techniques. Deep level switching and deep hidden switching represents advancements and new concepts developed by Dr. Charles Krebs that have been incorporated into this work. The immuno-therapy advanced workbook II is the latest enhancement of this work and allows a methodology of tissue and cellular repair and activation of the immune system on many levels. It represents an organized approach for the practitioner to actively address health issues in a fashion that restores the original design and inborn wisdom of the nervous system.

The manuals are written in a format that assumes one is familiar with basic kinesiology concepts and knowledgeable of the location of many of the common neurolymphatic and neurovascular reflexes. While this manual can serve as a reference and study aid there is no substitution for a live lecture.

Acknowledgements

I would like to express my gratitude to the many colleagues that shared their knowledge, asked the right questions, and patients for presenting with challenging health conditions.

As with all new developments, a learning curve requires the meticulous process of pattern recognition and correlation with the commonality of reflex patterns of aberrant physiology and illnesses. This manual represents a culmination of two decades of clinical work and study with Dr. Ferreri.

Dr. Mitchell Corwin
2914 Domingo Ave
Berkeley CA 94705
(510) 845-3246
drcorwin@prado.com

Dr. Carl Ferreri
3850 Flatlands Ave
Brooklyn NY 11234
(718) 253-9702
notint1@aol.com

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Thinking" 1998 Australia
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KINESIOLOGICAL APPROACHES TO LEARNING DISABILITIES

Recent breakthroughs in “alternative” kinesiological-based medicine have made available new approaches to learning disabilities and its related disorders. The primary focus is about identifying and removing many of the underlying neurological deficits in the central nervous system that impede normal language skill development.

This kinesiological-based approach identifies three primary physiological factors utilizing therapies comprising of sequential brain integration re-patterning using eye movement, skin surface reflexes (acupressure like techniques), and soft tissue manipulation of the head, neck, and jaw.

These primary components are:

- 1) Unique cranial bone fault patterns that are generally agreed upon by most cranio-sacral practitioners.
- 2) Vestibulo-ocular deficit (inner ear malfunction) that has received some attention in researched based medical models.
- 3) Specific eye muscle faults commonly addressed by behavioral optometrists and psychologists.

These three factors plus diagnostic and therapeutic tools of Applied Kinesiology will often facilitate a swifter resolution and reduce many of the hindrances encountered in remediation-based therapies for learning disabilities.

Key contributors are Drs. Carl Ferreri, George Goodheart, and Charles Krebs. Dr. Ferreri outlined the kinesiological foundation of learning differences in the early 1980's with the introduction of his book called “Breakthrough for Learning Disabilities and Dyslexia.” This contribution called Neural Organization Technique, made available a practical approach for kinesiological-based practitioners worldwide. All of these historical advances would not have been possible without the practical applications of applied kinesiology.

Dr. George Goodheart, the founder of Applied Kinesiology in 1965, developed an entire health care system to evaluate the structural, nutritional, and mental components of health and disease. A foundation contribution was an immediate biofeedback response tool called “muscle testing.” Muscle testing remains today as a primary assessment tool in nearly all alternative based therapies.

Dr. Krebs' work in his recent book called, “A Revolutionary Way of Thinking” opened up new ways to view and understand the emotional overlays through the amygdala (part of the brain that stores our key emotions). This insight has led to a greater understanding of attention deficits and right-left brain integration.

Combining these strategies in my clinical practice of 23 years, I have been able to obtain successful results in treating children and adults with learning disabilities and related disorders. It has been gratifying to assist many in the learning challenged community often in as few as 4-6 one-hour therapy sessions.

Dr. Mitchell Corwin is an LDA member and integrative healthcare practitioner of 23 years experience, practicing under the license of Chiropractic. He maintains a private practice at 2914 Domingo Avenue across the street from the Claremont Hotel in Berkeley and can be reached at 510-845-3246 or by email if you have additional questions at drcorwin@prado.com.

KINESIOLOGICAL APPROACH TO LEARNING DISABILITIES

By Mitchell Corwin

East Bay Learning Disability Association newsletter 2004

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PART ONE: CRANIALS

1. Lesser Wing of Sphenoid

This is an indication of eye muscle imbalances and will always be present with any eye muscle problem. Essentially this is indicative of either your primary eye tracking and teaming or auditory processing deficits in steps 10 & 11 on pages 7 & 8.

Evaluation: Positive therapy localization of lesser wing of sphenoid (always right and often left) using any indicator muscle.

Correction: Lifting with pumping action of 3-5 lbs of pressure, the right and left lesser wings of sphenoid with at least six repetitions.

- a) Place index finger on palatine bone (directly under eye) while pumping the same side mastoid anteriorly.
- b) Repeat procedure on other side.

2. Maxillary Spread Fault

This fault is indicative of (hesitant) speech problems. It will always activate a left homolateral gait disturbance both anterior and posterior. It can be placed after step three.

Evaluation: Spread maxilla internally and observe a left homolateral gait disturbance both anterior and posterior.

Correction: Correct gait reflexes in the standard method.

- a) Simultaneously correct left anterior cloacae and ocular reflexes then posterior left cloacae and labyrinthine centering reflexes (eyes open and closed).
- b) Rub K-27 bilaterally
- c) Spread maxilla internally
- d) Lift parietals with six respirations.

3. Spheno-Basilar Fault

Spheno-basilar fault is the most common cranial fault and its motion appears to be the initiator of all cranial movement and cranial / spinal C.S.F. circulation.

Evaluation: Positive bilateral therapy localization of lateral masses of sphenoid.

Correction: Lift with gentle traction and slight pumping action of occiput and frontal bone for at least six repetitions.

- a) Lifting movement should cover at least six respirations.
- b) Release lateral pterygoids bilaterally.

4a. Sphenoid Tilt (simple presentation)

The Sphenoid tilt represents the critical cranial fault specifically related to learning disabilities. It appears to be responsible for the suppression of left-brain activity and lateralization problems.

Evaluation: Therapy localization of the inferior aspect of the left greater wing of sphenoid and the superior aspect of the right greater wing of sphenoid.

Note: It is understood that the frontal bone will descend over the depressed sphenoid. Following every correction of sphenoid one should lift frontal on same side.

Correction: Reestablish normal respiratory motion of greater wings of sphenoid.

- a) Release left lateral pterygoid and lift the lesser wing of sphenoid (at the speno-maxillary junction). Next, initiate the opposing movement on the right side with right lesser wing tractioned laterally.
- b) Reinforce steps (a & b) externally by tractioning left greater wing superiorly and right greater wing inferiorly for minimally six respirations.
- c) Lift left descended frontal bone.
- d) Correct redundant presentation of sphenoid tilt.
 - 1) Release right lateral pterygoid and lift the lesser wing of sphenoid while externally reinforcing the movement with the operators other hand.
 - 2) Lift right descended frontal bone.
 - 3) Release left lateral pterygoid and lift the lesser wing of sphenoid while externally reinforcing the movement with the operators other hand.
 - 4) Lift left descended frontal bone.

4b. Sphenoid Tilt (complex “X” presentation)

This unique Sphenoid tilt fault represents an emotional overlay presenting itself as a bilateral “X” type fault. It corresponds with emotional and often physical immaturity.

Evaluation: Therapy localization of the superior aspects of both the right and left lateral masses of the sphenoid or as a double “X” pattern (if one therapy localizes the inferior lateral wing of sphenoid).

Correction: Unlock the depressed position of sphenoid wings bilaterally.

- a) Release right and left lateral pterygoids and lift both lesser wings of sphenoid while externally reinforcing the movement with the operators other hand.
- b) Reinforce step (a) externally by tractioning right and left greater wings superiorly.
- c) Next, lift both right and left descended frontals.
- d) Next implement sphenoid tilt simple presentation as listed above in step 4a-c.

Note: The presence of the above, step (4b) is a strong indicator for deep level switching described at the end of this section.

5. Temporal Bone Fault

The temporal bone fault essentially is the vestibular deficit as it relates to disequilibrium.

Evaluation: Therapy localization of the temporal bone by placing a finger in the ear canal.

Correction: Gently traction the ear lobes pulling down and out bilaterally with 3lbs of pressure for at least 12 respirations.

6. Ventricle Pump

The step is to facilitate C.S.F. flow between the third and fourth ventricles.

Evaluation: Two point therapy localization of the temporal bone and frontal bone. This finding is bilateral.

Correction: Pump the frontal and temporal bones for 20 respirations.

- a) Pump frontal bone as previously discussed in correction of an ocular reflex and pump mastoid forward on same side.
- b) Repeat same on opposite side.
- c) Gently traction greater wings of sphenoid in a 45 degree angle cephalad and up for twenty respirations.

Comments: _____

7. Parietal Descent (A.D.D. component)

Bilateral parietal descent found at this point in the protocol is indicative of attention deficit disorder (A.D.D.). If there is an additional hypersensitivity / allergy reaction then the term hyperactive disorder is added (A.D.H.D.). This condition will often result in uncontrollable behavior and activity with marked difficulty in concentration.

Evaluation: If absent reset *Cranial Stress Center* below and proceed to step (9). Positive therapy localization (two handed contact) of parietal descent fault. This is a bilateral cranial fault.. Lift with a quick gentle traction and release parietal bone at the parietal-temporal suture. Then observe a left homolateral gait disturbance both anterior and posterior.

Correction: Lift Parietals as described above. Identify and correct gait reflexes in the standard method.

- a) Simultaneous correction of left anterior cloacae and ocular reflexes and left posterior cloacae and labyrinthine centering reflexes (eyes open & closed).
- b) Rub K-27 bilaterally.
- c) Spread maxilla internally.
- d) Lift parietals with six respirations.

8. Cranial Stress Center: The cranial stress center for steps 1-7 above is located at the mental foramen on the right jaw. This is generally a self-resolving reflex over time but efficient to correct at this point.

Correction: Reset Cranial Stress Center by a simple skin stretch over the foramen omale on the right jaw.

Note: Step (7) above represents a quick and simple version. One has the option to proceed with an **enhanced version** or an **extended enhanced version**.

Enhanced Version: This additional protocol is a shortened attempt to normalize laterality and brain chemistry imbalance and will be discussed on page 10.

Extended enhanced version: This additional protocol is an extension of the enhancement version and is found on page 11. Note the concepts will be discussed in greater depth in another section called "*Deep Level Switching.*"

Comments: _____

PART TWO: V.O.R. SYSTEM

9. Vestibulo Ocular Reflex System

This section is similar to the cranial injury complex. It represents the beginning of the neuro-physiological corrections of brain integration. It encompasses many brain functions believed to be related to processing and interpreting information, self-image, self worth, decision-making, concentration, time consciousness confidence, distractibility, directionality, equilibrium, and procrastination.

Evaluation: Positive therapy localization of labyrinthine to ocular reflexes.

Correction: Essentially the same as in cranial complex.

- a) **Labyrinthine - Ocular:** Simultaneous correction of bilateral labyrinthine to ocular reflexes eyes open and closed.
- b) **TNRR:** Rub TNRR (tonic neck righting reflexes) bilaterally with eyes open and closed.
- c) **Vestibulo-Ocular:** Stimulate right vestibular reflex (ear pull) with bilateral ocular reflexes utilizing eye movement right-left-up-down (*RLUD*).
- d) **TNRR-Vestibular & Ocular:** Rub TNRR while simultaneously activating right vestibular and bilateral ocular reflexes utilizing eye movement.
- e) **TNRR-Spheno-Basilar:** Rub TNRR while activating spheno-basilar motion eyes open and closed
- f) **TNRR-Pterygoids:** Rub TNRR while activating lateral pterygoid muscles bilaterally with eye movement and eyes closed.
- g) **Palatine-Vestibular:** Palatine to vestibular reflexes as found. While placing light pressure over palatine suture, stimulate vestibular reflexes (*RLUD*) with respiration.
- h) **Palatine-Ocular:** Palatine to ocular reflexes as found. While placing light pressure over palatine suture, stimulate ocular reflexes (*RLUD & Closed*) with respiration.
- i) **Sphenomaxillary-Vestibular:** Spheno-maxillary to (bilateral) vestibular reflexes as found. While placing light pressure over spheno-maxillary area, stimulate vestibular reflexes (*RLUD*) with respiration.
- j) **Sphenomaxillary-Ocular:** Spheno-maxillary to ocular reflexes as found. While placing light pressure over spheno-maxillary area, stimulate ocular reflexes (*RLUD & Closed*) with respiration.
- k) **Vestibulo-Cloacal:** Activate (anterior & posterior) cloacal reflexes (*RLUD & Closed*) while holding vestibular reflexes bilaterally.

PART THREE: PROCESSING DEFICITS

Primary Deficits:

10. Auditory Processing

Auditory processing represents the most common primary deficit. It essentially manifests itself as an auditory delay and or an inability to focus on sounds (differentiating between the spoken word and background noise). This deficit will always trigger step (1), an eye muscle fault.

Evaluation: Positive therapy localization of the auditory branch of the eight cranial nerve (vestibular nerve). To accomplish this therapy localization, have the patient must place their index finger in the ear canals bilaterally and gently pull anteriorly while checking with the left anterior deltoid (indicator muscle) with eyes looking in any of the deficit vectors from 1:30 thru 7:30 while practitioner speaks.

Correction: Stretch eye muscle fascia for 20 seconds in each vector.

- a) While the practitioner places middle finger in ear canals bilaterally with a gentle pull cephalad and speaking (counting 1-20), and correct with eyes looking in vectors 1:30→7:30.
- b) While patient holding a card saying “*short term verbal memory*”, stretch eye muscle fascia for 20 seconds in each vector from 4:30→7:30.
- c) While patient holding a card saying “*short term auditory processing*”, stretch eye muscle fascia for 20 seconds in each vector from 4:30→7:30.
- d) Identify if there is an emotional charge related to this deficit by (TL) to skin reflexes or TFL muscle. Correct in usual fashion.
- e) Reset memory by stretching eye muscle fascia up-to-left & up-to-right. Note that a minor memory reset will just be up-to-the-right.

Comments: _____

PART THREE: PROCESSING DEFICITS

Primary Deficits:

11. Eye Tracking and Teaming

This deficit is most commonly referred to as dyslexia and represents an inability for the eyes to track and team as an integrated pair. This primary deficit will always be present because of the sphenoid bone “*tilt*” distortion. It essentially manifests itself as an inability to read for extended periods. This deficit will always trigger step (1), an eye muscle fault.

Evaluation: Positive therapy localization of the cranial nerves 3,4,6 (oculomotor, trochlear, and abducens). To accomplish this therapy localization, have the patient look in any of the deficit vectors from 1:30→7:30 while holding reading material and checking any indicator muscle (*IM*).

Correction: Stretch eye muscle fascia for 20 seconds in each vector.

- a) While reading material is placed on patient’s body, stretch eye muscle fascia with eyes looking in vectors 1:30 → 7:30.
- b) While the patient holds reading material, stretch eye muscle fascia in vectors 4:30→7:30.
- c) While the patient holds reading material with legs crossed, stretch eye muscle fascia in vectors 4:30→7:30.
- d) While patient holding a card saying “*short term visual memory*” stretch eye muscle fascia for 20 seconds in each vector 4:30→7:30.
- e) While patient holding a card saying “*visual reasoning*” stretch eye muscle fascia for 20 seconds in each vector 4:30→7:30.
- f) Astigmatism, check for need to polarize eyes by placing positive and negative finger polarity over eyes individually and check (*IM*). Correct as found by maintaining contact for 20 seconds. Next repeat procedure while rubbing/stimulating visual centers.
- g) While the patient holds a “*lined*” card determine which is the deficit pattern, lines vertical or horizontal. Correct as found by stretching eye muscle fascia in vectors 4:30→7:30.
- h) Identify if there is an emotional charge related to the above deficits by (*TL*) to skin reflexes or TFL muscle. Correct in usual fashion.
- i) Reset memory by stretching eye muscle fascia up-to-left & up-to-right. Note that a minor reset will just be up-to-the-right.

Comments: _____

PART THREE: SECONDARY PROCESSING DEFICITS

12. Academic Skills

This group of deficits is grouped together as secondary in that their deficiencies will not cause step (1) eye muscle faults to fail. One can add to the list any number of processing faults as one sees fit. The list below represents the most common and should represent your minimal list.

Evaluation: Positive therapy localization of any deficit (academic activity, skill, etc. which is age appropriate) while patient is looking in any of the deficit vectors 4:30→7:30 while checking any indicator muscle (*IM*).

Correction: Stretch eye muscle fascia for 20 seconds in each vector (4:30→7:30). Remember to check for emotional charge and memory reset at conclusion of each step as performed early.

- a) Holding a writing utensil in ones hand.
- b) Spelling, a card with the word spelling on it.
- c) Spelling card, while holding a writing utensil.
- d) Math, a card with mathematics (age appropriate) on it.
- e) *Brain Integration:* Hold a card representing music score (gestalt processing) in left hand and math or spelling (representing logical processing) in the other hand. May need to reverse this for true left handed people. Check for deficit in usual fashion. Note this finding is an indication of **Deep Level Switching (DLS)** and will need to be addressed further.
- f) Directionality, a card with the words right, left, up, down.
- g) Directionality, a card with the words east, west, north, south.
- h) Timed Test written on a card.
- i) Peripheral motion. While patient looks straight ahead, move hand or object in their periphery. Initial correction is always in all four cardinal directions. During correction, eyes must be focused straight ahead and open.
- j) Evaluate for low self-esteem by saying one's name aloud. A simple correction would use the standard eye muscle reset (4:30→7:30). An enhanced version would include the (*DHS*) protocol outlined in section VI page (1).
- k) _____
- l) _____
- m) _____
- n) _____
- o) _____
- p) _____
- q) _____
- r) _____
- s) _____

ATTENTION DEFICIT DISORDER

ENHANCED CORRECTION:

Following the correction outlined on page 5 of this section, one can proceed with the following steps to further reduce the neurological deficits of ADD.

Discussion: Therapy localize to the gallbladder [with patient's left hand] will illicit a weak response, which will be negated by therapy localization to right jaw (defensive jaw) with patient's right hand.

Correction: Utilizing eye muscle memory correction by have patient raise one leg, tap sagittal suture then raise opposite leg and make eye muscle memory correction up to the left then up to the right.

- a) While patient is contacting right jaw with right hand and touching gallbladder with left hand, proceed with eye muscle memory correction.
- b) Next, have patient therapy localize SP-21 and repeat eye muscle memory correction
- c) Next, have patient touch jaw with two hand contact representing (universal jaw) and repeat eye muscle memory correction
- d) Next, have patient therapy localize left pec-major sternal representing (endocrine system) and repeat eye muscle memory correction
- e) While patient is maintaining contact with SP-21, the following organs will now therapy localize as deficient:
 - 1) Gallbladder
 - 2) Brain (right & Left hemispheres & midline)Utilize same eye muscle memory correction to reset these organs.
- f) Parietal descent will again show. Repeat correction again as outlined on page 5 corrections steps (7a-d).

Comments: _____

ATTENTION DEFICIT DISORDER

EXTENDED ENHANCED CORRECTION:

This extended procedure is a combination of the concepts of *DLS* (deep level switching) outlined in Section V Pages 1-3 and the prior section, enhanced correction.

- Correction:** Begin deep level switching protocol summarized below:
- a) Reset Reticular Activating System
 - b) Reset Corpus Callosum.
 - c) Reset Amygdala.
 - d) While patient is maintaining contact with SP-21, the gallbladder will now therapy localize as deficient:
Utilize same eye muscle memory correction to reset (eyes L-R).

 - e) Clear emotion anchor utilizing the five basic steps;
 - 1) Conscious emotional anchor.
 - 2) Subconscious emotional anchor.
 - 3) Conditioned reflex.
 - 4) Skin reflexes.
 - 5) Learned response eye correction.

 - f) Final Reset (eyes R) ...Continue with Section IV Page 6.

Comments: _____

EMOTIONAL OVERLAYS

Emotional overlays are frequently present in the learning disabled (*LD*) client. Often several may exist however they generally only cause momentary sabotage in brain integration even though it may appear as though there is a return of *LD* behavior patterns. It is important to distinguish emotional overlay(s) from transient emotional stressors. Emotional overlays have a unique emotional trigger such as homework, reading, math, going to school, writing a report, etc.

Evaluation: Upon completion of the primary deficits auditory processing and eye tracking and teaming, a positive (*TL*) of the visual centers with the basic cranial fault indicators are seen. Commonly one evaluates the greater wing of sphenoid or right labyrinthine-ocular reflex with the visual centers. Alternatively, activating the unique emotional trigger will result in a transient return of the primary cranial faults with the core emotional component indicators outlined in section (6) Deep Hidden Switching.

Note: Commonly several emotional overlays may exist, however it will be up to the practitioner to prioritize its potentially (negative) effect on academic processing skills and personality characteristics. The comprehensive approach would involve the neutralization of both physiological and emotional components one at a time. It appears one can obtain a successful outcome by neutralizing the emotional trigger however it is unknown at this point if the physiological (memory pathway) trigger will self correct.

Correction: To facilitate correction of emotional overlay, one should activate it by verbal or non-verbal client recall. It may be possible to call it up via visual centers only. Upon activation of the emotional trigger, there will be an immediate general indicator muscle weakness that is negated by touching any of the primary cranial faults, ESR points (stomach *NL*) or deep hidden switching indicators (amygdala or corpus callosum reflexes in Section VI). A key finding to note is the immediate presence (recall) of the X sphenoid presentation.

Comments: _____

Correction: Corrections of steps 2-5 below utilize the concepts of accessing memory via the eye muscle corrections of (up-to-the-left & up-to-the-right) with sagittal suture tap to coordinate bilateral activity of the brain hemispheres.

- 1) Reset Atlas.
- 2) Defensive Jaw (right).
- 3) Limbic (SP-21) circuit.
- 4) Occasionally the digestive jaw will show on a child.
- 5) Endocrine circuit.
- 6) Cranial complex faults as outlined in Section IV pages 2-4.
 - a) Note steps 2, 4a, & 7 will be absent.
 - b) It is imperative to identify and correct the X sphenoid pattern fault followed by a single left (common presentation) *LD* sphenoid tilt.
- 7) V.O.R. Faults (labyrinthine-ocular with *TNRR*)
- 8) Reset Eye Muscle Fascia in vectors 4:30 → 7:30 (the aberrant trigger or academic skill).
- 9) Address the emotional component by either a short or long version:
 - a) Clear emotional anchor in the usual fashion as described in Section VI page 3 step 4 or
 - b) Utilize Deep Hidden Switching protocol in Section VI.

Comments: _____

SECTION FIVE: DEEP LEVEL SWITCHING

Introduction

Deep Level Switching (*DLS*) is a term coined by Dr. Charles Krebs. It represents a methodology to unravel the emotional imprints of the amygdala and its negative influence on the reticular activation system of the brain stem. Although this represents only a fraction of his work, its effectiveness coupled with learning disability protocols or applied independently has resulted in a marked and swift improvement in emotional diffusion techniques.

Evaluation: There is no one simple objective method to evaluate Deep Level Switching (*DLS*). One can evaluate it energetically or simply by applying it. The beginning point in ones evaluation and treatment can be an indicator of its severity. This procedure generally only needs to be done once. It is believed to be caused by an inappropriate emotional/neurological memory imprint to the amygdala during early childhood ages 1-3.

Note: Unlike prior steps outlined in this manual, this protocol is wholly energetic in its application. It is assumed that the practitioner acknowledges this and recognizes the need to maximize concentration and maintain a physical contact during these steps.

1. Reticular Activation System

The reticular activation system (*RAS*) is being addressed here relative to its functional role in consciousness. Its influence also extends to motor, sensory, and visceral control throughout its complex network of dendritic connections. Specifically, the ascending projections of the *RAS* terminating in the mid brain nuclei play a significant role in informational processing (lead function) to the right and left hemispheres of the cerebral cortex.

Our concern is how sensory information is interpreted in the *RAS*, the role of the amygdala, and its final termination in the right and left cortical hemispheres for either gestalt or logical processing. When this system breaks down due to the inappropriate influences of core emotional patterns within the amygdala, neural disorganization is dramatically experienced.

Evaluation: Bilateral therapy localization of the juncture of the temporal, parietal, and occiput behind the ear bilaterally. This *TL* represents the functional role of the *RAS*. Commonly there will be an immediate weak *TL* response or a weak response on tongue thrust indicating the *atlas* (main circuit breaker) as the starting point. If the starting point is elsewhere (Cat I or defensive jaw), this is indicative of a lesser degree of involvement.

Comments:

Correction: Corrections utilize the concept of accessing memory via eye muscle corrections of up-to-the-left & up-to-the-right (*LR*) and sagittal suture tap to coordinate bilateral activity of the brain hemispheres by:

- a) Reset Atlas (manual reset often requiring minimally 3-4 attempts).
- b) C-3 ...representing Cat I.
- c) TNNR ...representing cranial injury complex.
- d) Right Jaw ... representing defensive jaw complex.
- e) R-Jaw & Coccyx ...representing Coccygeal release.
- f) Left Jaw ...representing Cat II.
- g) SP-21 ...representing Limbic system.
- h) Bilateral Jaw ...representing universal jaw.
- i) Left PMS ...representing endocrine system.
- j) While contacting SP-21, reset right-sided *RAS*, left-sided *RAS*, and its cross-linked fibers individually with eyes *LR*.
- k) Master reset of *RAS* (hold points bilaterally) with eyes *RLR*.

2. Corpus Callosum

The corpus callosum is being addressed here relative to its functional role in integration of right and left-brain hemispheres necessary for optimal brain function. Loss of integration of the corpus callosum is believed to be relative to the level of inappropriate influence exerted by the amygdala.

Evaluation: Therapy localization of the corpus callosum is performed by interlocking the fingertips on the top of the cranium. This *TL* represents the functional role of the corpus callosum. Commonly there will be an immediate weak *TL* response and the starting point will be the same as in the prior step (1).

Correction: Corrections utilize the concept of accessing memory via eye muscle corrections of up-to-the-left & up-to-the-right (*LR*) and sagittal suture tap to coordinate bilateral activity of the brain hemispheres by:

- a) Reset Atlas (manual reset often requiring 3-4 attempts).
- b) C-3 ...representing Cat I.
- c) TNNR ...representing cranial injury complex.
- d) Right Jaw ... representing defensive jaw complex.
- e) R-Jaw & Coccyx ...representing Coccygeal release.
- f) Left Jaw ...representing Cat II.
- g) SP-21 ...representing Limbic system.
- h) Bilateral Jaw ...representing universal jaw.
- i) Left PMS ...representing endocrine system.
- j) While contacting SP-21 with one hand, correct the three components;
 1. Spread fingers of other hand across the sagittal suture (representing corpus callosum midline fibers) reset eyes *LR*,
 2. Reset front-to-back fibers (bilaterally)
 3. Vertical columns (bilaterally).
- k) Master reset of corpus callosum function with eyes *RLR*.

3. Amygdala

The amygdala is being addressed here relative to its functional role as gatekeeper of our core survival emotions. Its functional capacity although important to our basic survival can often play a negative role in causing loss of brain integration. If an over-reactive amygdala inappropriately tags afferent information from our primary sensors as a threat or potential threat to our survival, it will cause a cascade of neurological activity slowing down the transfer of information to higher brain processing centers.

Evaluation: Bilateral therapy localization of the juncture of the temporal, parietal, and occiput behind the ear bilaterally. This *TL* represents the functional role of the amygdala. Commonly there will be an immediate weak *TL* response and the starting point will be the same as in the prior steps (1&2).

Correction: Corrections utilize the concept of accessing memory via eye muscle corrections of up-to-the-left & up-to-the-right (*LR*) and sagittal suture tap to coordinate bilateral activity of the brain hemispheres by:

- a) Reset Atlas (manual reset often requiring 3-4 attempts).
- b) C-3 ...representing Cat I.
- c) TNNR ...representing cranial injury complex.
- d) Right Jaw ... representing defensive jaw complex.
- e) R-Jaw & Coccyx ...representing coccygeal release.
- f) Left Jaw ...representing Cat II.
- g) SP-21 ...representing Limbic system.
- h) Bilateral Jaw ...representing universal jaw.
- i) Left PMS ...representing endocrine system.
- j) While contacting SP-21, reset right-sided amygdala, left-sided amygdala, and its cross-linked fibers with eyes *LR*.
- k) Master reset of amygdala (hold points bilaterally) function with eyes *RLLR*.

4. Gallbladder Circuit

Correction: *TL* gallbladder:

- a. While maintaining contact on SP-21
- b. Reset: Gallbladder via eye mode correction (*LR*).

5. Emotional Anchor Clear emotion anchor in the usual fashion (see section VI step 4). Note, it will always start from 9:00 and sleeping dreaming will be absent, as this protocol is about consciousness.

6. Master Reset Final reset, while holding any reflex point representing *RAS*, corpus callosum, or amygdala, with eyes up-to-right only.

SECTION SIX: DEEP HIDDEN SWITCHING “Emotional Clearing”

Introduction

Deep Hidden Switching (*DHS*) is a term coined by Dr. Charles Krebs. It represents a methodology to unravel acquired emotional imprints in the amygdala and its negative influence on the corpus callosum. Although this represents only a fraction of his work, its effectiveness coupled with learning disability protocols or applied independently has resulted in a marked and swift improvement in unraveling many core emotional issues.

Evaluation: Unlike (*DLS*) Deep Level Switching in section five, there are multiple techniques and methodologies available to evaluate emotional stress. Too numerous to list, and the simplest one being the emotional stress reflex (*ESR*) (Stomach *NL*) points, the agreed causative factors are generally inappropriate emotional memory imprints. Also, unlike (*DLS*), one may have many emotional issues and thus the need to repeat this protocol for each significant emotional memory uncovered.

The key is to differentiate between deep-rooted emotional issues and minor ones. To accomplish this, call up an emotional issue and determine if the weak muscle response can be negated by therapy localizing to the amygdala or corpus callosum. I believe this is one of the unique factors of this protocol in addition to it being a non-verbal.

Note: Unlike prior steps outlined in this manual, this protocol is wholly energetic in its application. It is assumed that the practitioner acknowledges this and recognizes the need to maximize concentration and maintain a physical contact during these steps.

1. Corpus Callosum

The corpus callosum is being addressed here relative to its functional role in integration of right and left-brain hemispheres necessary for optimal brain function. Loss of integration of the corpus callosum is believed to be relative to the level of inappropriate influence exerted by the amygdala.

Evaluation: Therapy localization of the corpus callosum is performed by interlocking the fingertips on the top of the cranium. This *TL* represents the functional role of the corpus callosum. Commonly there will be an immediate weak *TL* response or a weak response on tongue thrust indicating the *atlas* (main circuit breaker) as the starting point. If the starting point is elsewhere (Cat I or defensive jaw), this is indicative of a lesser degree of involvement. If neither of these therapy localize, the emotional issue is relatively minor and a simpler technique may want to be employed. At the very least, one can hold the *ESR* points or do the emotional anchor release described below.

Correction: Corrections utilize the concept of accessing memory via eye muscle corrections of up-to-the-left & up-to-the-right (*LR*) and sagittal suture tap to coordinate bilateral activity of the brain hemispheres by:

- a) Reset Atlas (manual reset often requiring 3-4 attempts).
- b) C-3 ...representing Cat I.
- c) TNNR ...representing cranial injury complex.
- d) Right Jaw ... representing defensive jaw complex.
- e) R-Jaw & Coccyx ...representing Coccygeal release.
- f) Left Jaw ...representing Cat II.
- g) SP-21 ...representing Limbic system.
- h) Bilateral Jaw ...representing universal jaw.
- i) Left PMS ...representing endocrine system.
- j) While contacting SP-21 with one hand reset corpus callosum via:
(midline fibers, front-to-back fibers, and vertical columns).

2. Amygdala

The amygdala is being addressed here relative to its functional role as gatekeeper of our core survival emotions. Its functional capacity although important to our basic survival can often play a negative role in causing loss of brain integration. If an over-reactive amygdala inappropriately tags afferent information from our primary sensors as a threat or potential threat to our survival, it will cause a cascade of neurological activity slowing down the transfer of information to higher brain processing centers.

Evaluation: Bilateral therapy localization of the juncture of the temporal, parietal, and occiput behind the ear bilaterally. This *TL* represents the functional role of the amygdala. Commonly there will be an immediate weak *TL* response and the starting point will be the same as in the prior step.

Correction: Corrections utilize the concept of accessing memory via eye muscle corrections of up-to-the-left & up-to-the-right (*LR*) and sagittal suture tap to coordinate bilateral activity of the brain hemispheres by:

- a) Reset Atlas (manual reset often requiring 3-4 attempts).
- b) C-3 ...representing Cat I.
- c) TNNR ...representing cranial injury complex.
- d) Right Jaw ... representing defensive jaw complex.
- e) R-Jaw & Coccyx ...representing coccygeal release.
- f) Left Jaw ...representing Cat II.
- g) SP-21 ...representing Limbic system.
- h) Bilateral Jaw ...representing universal jaw.
- i) Left PMS ...representing endocrine system.
- j) While contacting SP-21, reset right-sided amygdala, left-sided amygdala, and its cross-linked fibers.

3. Gallbladder-Heart Circuit

Correction: TL gallbladder:

- a. While maintaining contact on SP-21
- b. Reset:
 - 1) Gallbladder via eye mode correction (*LR*).
 - 2) Heart (right & left sides) via eye mode correction (*LR*).

4. Emotional Anchor

Emotional clearing technique, utilizing a five-step protocol adapted from neural linguistic programming (*NLP*) and modified by Dr. Carl Ferreri and associates.

Note: Being derived from (*NLP*), an eye-vectoring pattern is used, i.e. recalling a memory, such that the face is overlaid with the numbers of a clock. Thus a common sequence may be from 9:00 to 7:30 to 6:00 to 4:30 to 3:00 to 1:30 to 12:00 and ending at 10:30 (always one vector past noon).

A correction beginning at 9:00 represents the deepest emotional anchor; 1:30 represents a minimal anchor, and 12:00 representing a present issue only; minutes to hours old. In the latter scenario, one will note step (c) below is omitted since it will be absent.

Correction: Identify correct starting point for clearing.

- a) Conscious emotion anchor: clearing counter clockwise.
- b) Subconscious (eyes closed) emotion anchor clearing counter clockwise.
- c) Sleeping / dreaming: same as step (b) always starts at 9:00.
- d) Catalogue procedure.
- e) Skin reflexes.
- f) Learned response: clearing clockwise.

5. Master Reset

Final reset: while holding SP-21, contact any reflex point representing corpus callosum, or amygdala, and reset with eyes *RLR*.

SECTION SEVEN: DEPRESSION

Discussion: Depression, when seen in its chronic state will demonstrate a unique readily identifiable cranial fault pattern. Many of its cohorts ranging from anxiety, mood swings to mania fall into this category. Transient emotional stress can be distinguished, as it does not show the unique cranial fault pattern described below. Common additional findings include; right “emotional” jaw, active *ESR* (stomach neuro-vascular) point, endocrine/cardiac back stress pattern, and its associated finding of bilateral weak hamstrings.

Evaluation: The unique cranial fault pattern recognizable in depression is the right sphenoid tilt. This is the mirror image distortion as seen in learning disabilities. Right jaw activation and cardiac-back often accompany it in its acute phase. Stomach *NV* points (*ESR*) will always be present.

Note: Appropriate psychotropic medication such as SRI’s (serotonin reuptake inhibitors) will effectively neutralize the above-described cranial finding.

Correction: If right jaw activation is found, it must be released. If cardiac-back is found and time permitting, it should be corrected. Note, that in the latter case: it occasionally will self-resolve leaving only a weak (*PMS*) endocrine system reflex.

- a) Lift right depressed sphenoid tilt by first releasing the lateral pterygoid and lift lesser wing internally, while externally reinforcing the movement with the operators other hand over the greater wing.
- b) Lift frontal bone on same side.
- c) Spheno-basilar pump (release lateral pterygoids).
- d) Lift parietals and correct left anterior and posterior homolateral gait, K-27, maxillary spread, and parietal lift.
- e) Correct temporal bone fault.
- f) Correct left labyrinthine & ocular reflexes.
- g) Correction tonic neck righting reflex (*TNNR*).
- h) Right & left sphenomaxillary-vestibular reflexes.
- i) Reset Gallbladder-Heart-Brain circuit:
While *TL* gallbladder;
 - Release defensive jaw via eye mode correction *LR*.
 - Limbic (SP-21) via eye mode correction *LR*.
 - Universal Jaw via eye mode correction *LR*.
 - Endocrine via eye mode correction *LR*.
 - Next, while maintaining contact on SP-21
 - Reset:
 - 1) Gallbladder via eye mode correction
 - 2) Heart (right & left sides) via eye mode correction
 - 3) Brain (right& left &mid-line) via eye mode correction.
- j) Release emotional anchor usually starting from 9:00.

DEPRESSION (ENHANCED VERSION)

The enhanced version includes a more comprehensive emotional clearing protocol as outlined in Deep Hidden Switching in section VI.

Correction: If right jaw activation is found, it must be released. If cardiac-back is found and time permitting, it should be corrected. Note, that in the ladder case: it occasionally will self-resolve leaving only a weak (*PMS*) endocrine system reflex.

- a) Lift right depressed sphenoid tilt by first releasing the lateral pterygoid and lift lesser wing internally, while externally reinforcing the movement with the operators other hand over the greater wing.
- b) Lift frontal bone on same side.
- c) Spheno-basilar pump (release lateral pterygoids).
- d) Lift parietals and correct left anterior and posterior homolateral gait, K-27, maxillary spread, and parietal lift.
- e) Correct temporal bone fault.
- f) Correct left labyrinthine-left ocular reflexes.
- g) Correction tonic neck righting reflex (*TNNR*).
- h) Right & left sphenomaxillary-vestibular reflexes.

- i) Implement Deep Hidden Switching Protocol (Section VI Step 1-5).
 - 1) Corpus Callosum
 - 2) Amygdala
 - 3) Emotional Anchor
 - 4) Gallbladder-Heart Reset
 - 5) Master Reset

Comments: _____

