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Advanced I Workshop Manual

Language Processing and Brain Integration

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

Expanded by

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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.

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Charles Krebs Ph.D.
*"A Revolutionary Way of
Thinking" 1998 Australia
Hill of Content Publishing
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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 spheno-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: _____
