

## Fight / Flight Survival System

The Fight / Flight (F/F) survival system in relationship to N.O.T. protocols represents the body's physical response primarily to external threat(s). The focus is on the centering reflexes of the cranial and pelvis in relationship to (walking/running) gait and the reactivity of Jaw muscles (arming mechanism of the spinal dural and fascial defense). Hence, this section is most appropriate for dealing with neuro-musculo-skeletal issues.

The fight/flight reaction is generated by Limbic System structures located on top of the brain stem in response to a survival threat or perceived threat. In this work, references to the fight/flight reflexes involve the neural pathways and corresponding proprioceptors relating to the sympathetic response of the peripheral autonomic nervous system.

For the most part, once the centering reflexes of the F/F system are completed the recidivism rate is rare. There are only two causes for causes of reoccurrence:

- The most common cause would involve practitioner error or omission. Failure to complete the scoliosis protocol (if a VOR deficit was identified) within 3 months of initial treatment of the gait reflexes or substantial in completing the F/F protocol.
- A less common cause must involve significant physical trauma(s) to the CNS whether they are external or internal. In these situations there will be a history that clearly delineates physical trauma such as a moderate to a severe motor vehicle accident, cranio-facial trauma or spinal /coccyx injury. Additionally, significant internal stressor(s) such as a cerebral vascular accident, severe heavy metal toxicity, brain tumor and acute microbial infection of the CNS will also trigger a reoccurrence.

Please note the examination and treatment procedure outlined below are the critical concepts representing the most common presentation of the new (virgin) patient. At the end of this section a discussion will follow on the most common practitioner errors and updates that may need to be implemented on past patients

When working with, infants and moderate to severely handicapped children, there will be a need to modify and or add additional steps not listed here. There is no substitute for a hands-on seminar!

**Comments:** \_\_\_\_\_

---



---



---



---



---



---

## EVALUATION and TREATMENT

The **first Neurological Unit** involves clearing Category I through posterior and anterior centering reflexes of the body. The starting point always involves the atlas vertebrae (C-1) as the enabling factor (always found on the virgin patient) and a mid-cervical (C-3/C-4) fixation. This fixation presentation is the body's attempt to stabilize the primary lesions of Category I especially if previous chiropractic/manipulative has previously been performed.

*begin in the supine position*

- I. Cervical Fixation correction:** Stair-step mobilisation of cervical spine to clear the common C1-2 and C 3-4 fixation pattern. Standard applied Kinesiology (AK) techniques can be used to verify this finding.



- II. Atlas Anterior correction:** Neutralize anterior atlas via a quick thrust to C-1 bilaterally on the anterior lateral ring of the atlas. This correction will facilitate the unlocking of the atlas if not cleared in step I as well as the correction of the anterior atlas.



- III. Atlas correction:** Either a rotation or lateral malposition. A left atlas rotation lesion is most commonly found. On infants and toddlers the atlas malposition may present on the right.



- IV. C-3 vertebral correction:** Manipulation of C-3 on the right in any fashion that neutralizes the lesion.

**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## *prone position*

### V. **Posterior Switches correction:**

Represents a way to decrease lymphatic congestion of the CNS including spinal cord. Rub tip of coccyx and K-27 bilaterally.



### VI. **Category I corrections continued:** Category I is the primary neural deficit found in all neuro-musculo-skeletal conditions (also known as the sacral respiratory dural fault). At this point in the treatment protocol, Category I has been activated and an inhibited right hamstring can easily be identified.

- Manipulate right posterior Sacral wing (S-2)
- Manipulate right inferior occiput
- Clear reactive lumbar vertebrae L-3 & L-5
- Fascial flush piriformis



Upon completion of Category I, the right hamstring must test strong in the clear.



Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VII. Posterior Gait Reflexes correction:** Represent the combination of posterior cloacal reflexes and labyrinthine reflexes. Cloacal reflexes are believed to be located adjacent to mid-sacrum bilaterally but best accessed within the bony matrix of the Ischial tuberosity and the Labyrinthine reflexes within the bony matrix between the occipital-temporal suture. Stimulation can be either exaggerating the normal respiratory movement of the bone(s) or by vigorous rubbing. Both methods of correction are dependent upon exaggerated respiration and with eyes open and closed. As a general rule 5 or more respirations are required. Eyes open and closed appear to represent time conscious (present time and recent past).

Note: Cloacal and labyrinthine reflexes are corrected individually and then corrected again together. Bilateral labyrinthine reflexes will always be present in the virgin patient representing external or internal trauma to the CNS believed to be the primary cause of the Cat I phenomena. Bilateral cloacal reflexes if present are indicative of pelvic injury addressed later in the protocol.

Note the correction pattern found in eyes open will be duplicated in eyes closed or vice-a-versa. A cloacal reflex cannot be present without a corresponding labyrinthine. Once individual cloacal/labyrinthine reflexes are corrected the combination of both will become evident and can be treated without the need for therapy localization to identify it.

- Cloacal reflexes are corrected individually
- Labyrinthine reflexes are corrected individually
- Cloacal and labyrinthine reflexes are then corrected simultaneously



**Comments:**

---



---



---



---



---



---



---

## *Supine Position*

### **VIII Universal Cranial (Anterior Atlas) Fault correction**

- Anterior Atlas correction has already been completed in step II.  
Note: In situations where an individual suffers subsequent trauma and Cat I reoccurs, a lateral occiput will be found and will need to be corrected at this point. In infants and toddlers a lateral occiput may also be present in lieu of the anterior atlas.

### **IX. Anterior Switches correction:**

Represents master anterior lymphatic congestion reflexes and home of the association points of all acupuncture meridians (also temporarily clears switching).



### **X. Femur Head correction:**

Femur Head integrity is necessary for proper muscle testing of the lower extremity.

Note: If bilateral cloacal reflexes have previously been identified then there will be a need to correct femur head bilaterally. If bilateral cloacal reflexes have not been previously evaluated then there will be a unilateral femur head lesion.

Evaluation: Straight leg quadriceps muscle test or a modified Gluteus Medius tested at 45° of abduction will show weakness in the clear or imbrication test of hip.

Note: This modified femur head challenge was originally demonstrated by Dr. Alan Beardall



Correction: Externally rotate leg (Femur) and reset ilio-tibial band and with clenched fist apply a sharp blow to greater trochanter or any other method that resets femur head in acetabulum.



### **XI. Sutures correction:**

Cranial sutures need to be decompressed.

- a) Gently spread all sutures with exaggerated respiration.
- b) Parietal (squamous) suture correction requires an additional steps:
  - 1) Lift parietals bilaterally.
  - 2) Correct left homolateral gait: (anterior - simultaneously correction of cloacal and ocular reflexes with eyes open and closed). (posterior - simultaneously correction of cloacal and labyrinthine reflexes with eyes open and closed).
  - 3) Rub K-27 bilaterally.
  - 4) Spread maxillary suture.
  - 5) Lift Parietal suture bilaterally.

Note: Step (a) can be repeated as need following any head trauma especially in toddlers.

**XII. Anterior Gait Reflexes correction:** Represent the combination of anterior cloacal reflexes and ocular reflexes. The reflex pattern found posteriorly will be duplicated anteriorly. Cloacal reflexes lie within the bony matrix of the superior lateral border of the pubic bone and ocular located within the supra orbital notch.

- Cloacal reflexes are corrected individually
- Labyrinthine reflexes are corrected individually
- Cloacal and labyrinthine reflexes are then corrected simultaneously



## Completes Neurological Unit One

**Comments:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_