

LANGUAGE PROCESSING

Introduction: Learning disabilities, often described as dyslexia, attention deficit, deep level switching or learning challenged etc. is a complex multifaceted neurological disorder with many ramifications and presentations. The work described here falls under the category of "functional" neurological correction not "educational" remediation. The medical and educational approach has been to balance brain chemistry via pharmaceuticals and the later to retrain aberrant brain function by utilizing many various academic and cognitive processes. Although there has been great strides made in remediation within the last several years and there will always be new pharmaceuticals to modify brain chemistry, it behooves the holistic practitioner to be both creative in one's work and knowledgeable of present day brain medicine and educational remediation. Often this will require a team approach with neural organization work leading the way to successful remediation efforts.

Description and Theory: This protocol represents a functional neurological approach to reestablish optimal integration and organization of upper brain function by addressing three primary causative deficits by:

- 1) Correction of predictable cranial faults.
- 2) Correction of the vestibular-ocular reflex deficits.
- 3) Correction of the primarily deficits of auditory processing and eye tracking and teaming.

A secondary and often non-avoidable component will be the emotional impact. This will manifest itself primarily in a subconscious fashion called deep level and deep hidden switching.

It is also understood that there needs to be stability of the basic survival systems as outlined previously. The necessity is correction of the structural faults of Category I through II. As one proceeds with this work, it should be understood that our knowledge base is only what is currently known and will be periodically updated.

Initial Evaluation: Although a vestibular ocular reflex deficit and neurological scoliosis have been previously identified, it will not assist you in determining if a learning disability is minimal, mild, moderate, or severe in nature. The practitioner can gather insightful clues as to the full expression of this condition by careful evaluation of the three basic components listed above, identifying emotional components (deep level and deep hidden switching), and personal observations.

Note: If one is attempting to screen an individual for learning disabilities, the cranial faults listed in section one are an excellent starting place. Observation for gait aberration and its neurological component, the vestibulo-ocular deficit should also be identified. In moderate to severe cases of learning disabilities and often combined with Downs syndrome, Cerebral Palsy, Autism, etc. one will commonly see an absence of cumulative old stress patterns representing an inability to disperse stressors beyond present time. A reactive left and or right jaw may also be found representing physiological overload and emotional overload.

Comments: _____

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: _____

