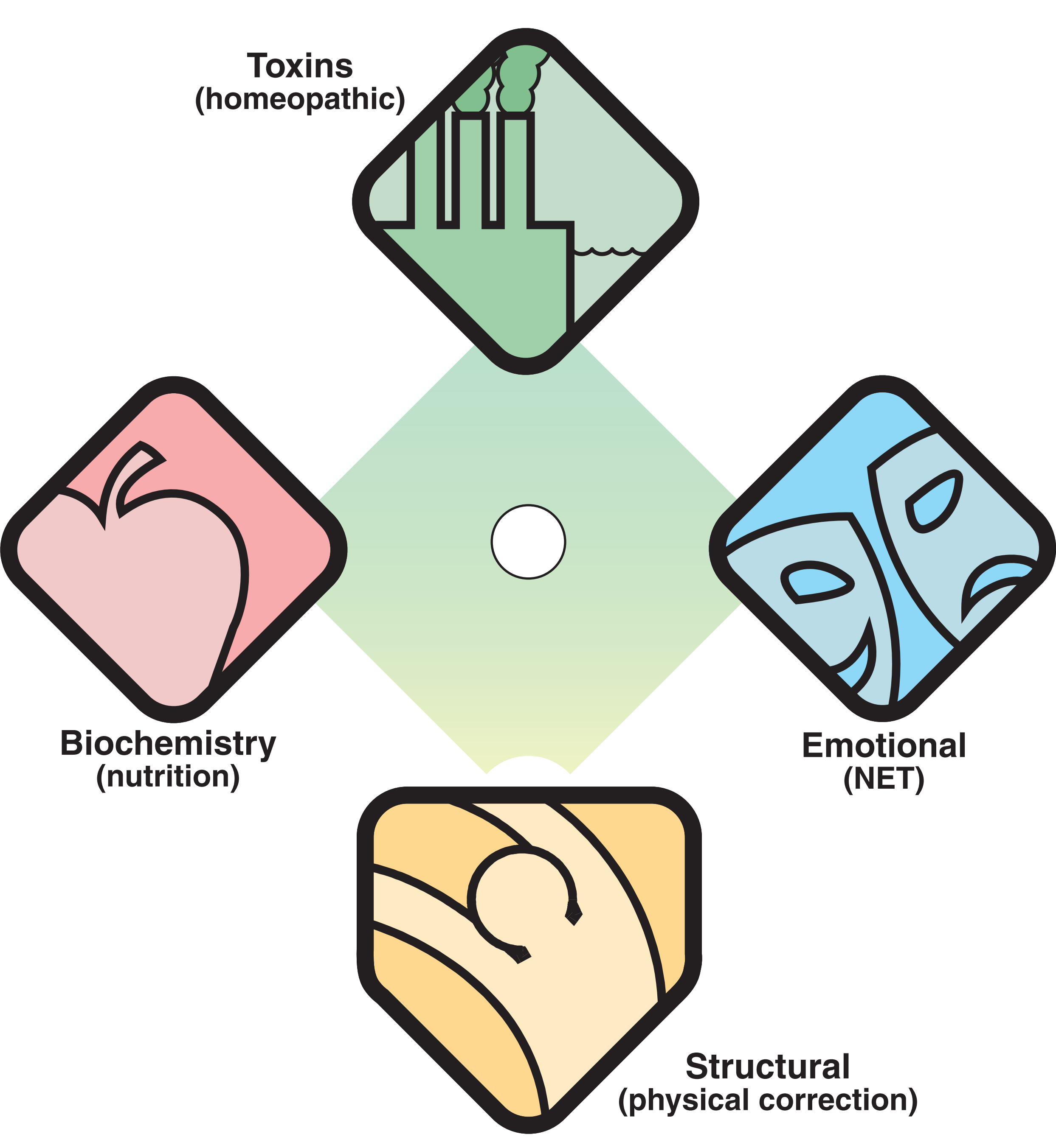
# NET Advanced



*Neuro Emotional Technique®*

# NET Advanced Seminar Manual

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***This book belongs to*** ______________________________

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# A WORD ABOUT THE CONTENTS OF THIS MANUAL

When using the Neuro Emotional Technique® (NET), the correction of a Neuro Emotional Complex (NEC) is a *physiological* versus a psychological phenomenon. Because emotions prior to the 1970s were generally assumed to be psychological in nature, patients may assume NET likewise treats emotional aberrations psychologically. However, NEC treatment is not a substitute for psychological or psychiatric therapy. Patients that show a possible need for psychotherapy should prudently be referred to psychological or psychiatric professionals for evaluations and/or treatment. The techniques contained herein are based on personal experiences in taking care of thousands of patients. Their value is to be determined by the practitioner utilizing the techniques in the manner described in the NET seminars. This manual is to be used as a supplement to the seminar and not as a stand-alone manual. Likewise NET was not designed as a stand-alone technique, but rather as one that dovetails with the practitioner's other techniques.

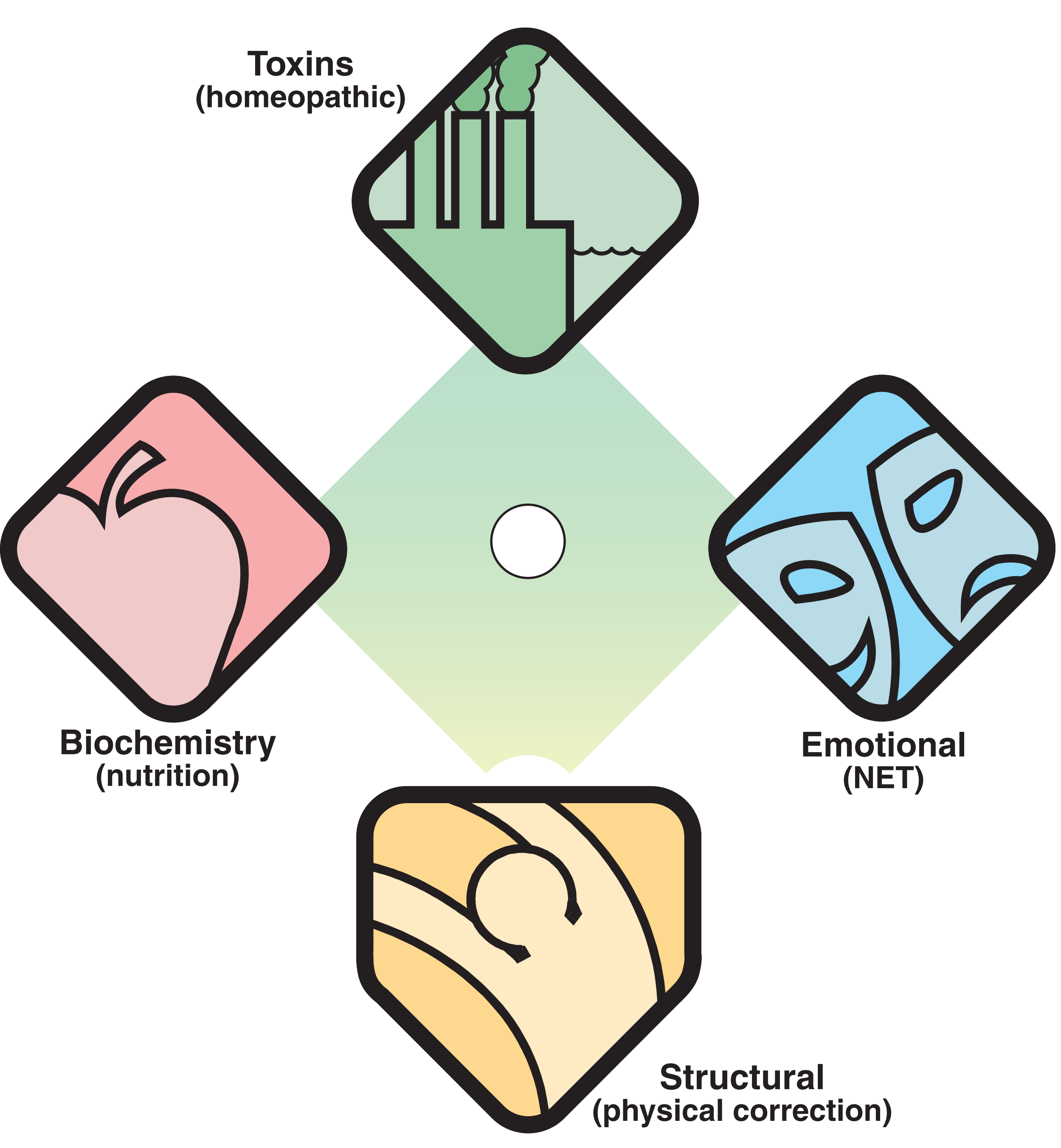
In addition, the following pages having references to NET Remedies® and homeopathic remedies in general are based on personal experience with various case histories and do not necessarily represent any application to a generalized group of patients. All reflexes are non-diagnostic. As always, homeopathic remedies should be recommended based on Materia Medica indicators that reflect the indications for use on the bottle label in addition to a competent case history and examination. The NET Remedies are registered with the United States Food And Drug Administration (FDA) as a Homeopathic manufacturer in accordance with Current Good Manufacturing Practices (CGMP). All NET Remedies formulas are carefully prepared according to the quality standards of the Homeopathic Pharmacopoeia of The United States (HPUS). The HPUS is recognized by the Federal Food Drug And Cosmetic Act (FDCA), which is the Federal Legislation that officially classifies and defines all drugs.

Thank you,

*Scott Walker, D.C.*

*The Walker*

# Home Run Formula



# THE SEVEN DYNAMICS OF NET

## To understand how NET works, or to explain it, you need to understand its component dynamics. There are seven main dynamics.

**1. Muscle Testing.** It has been demonstrated that muscle testing can access the physiology of the body, including the physiology of emotions (see 2), and that muscles—which initially test strong in the clear— will test as being inhibited (weaker) when saying a non-congruent statement (as John saying, “My name is Mary”). This dynamic has been scientifically validated by Monti, et. al.

**2. Emotions are physiologically based.** Emotions are based on minute proteins in the body called Information Substances (IS). These IS are comprised of neuropeptides, hormones and other specialized information molecules which permeate our entire body, including our DNA. This dynamic has been scientifically validated by Pert, et. al.

**3. Pavlovian Responses.** While most think in terms of Pavlovian Responses as applying to animals, humans too are conditioned—sometimes by one event (this is termed a one time trial). While conditioning is normal under most situations, so is the physiological counterpart (the fading or elimination of a conditioned response) called “extinction.” Simply, sometimes extinction does not take place, and we utilize NET to allow the body to carry on with this process. This dynamic has been scientifically validated perhaps more than any other in psychology starting of course with Pavlov, et. al.

**4. Emotions / meridian system correlations.** This is a 1,500 to 4,000-year-old principle. An acupuncture theory, known as the Five Element Law, has been clinically validated for over 1,500 years linking specific emotions to specific meridians. An example is the link between “Anger” and the Liver meridian. This dynamic has not been scientifically validated as yet.

**5. Repetition Compulsion.** One of Freud’s contributions was that of repetition compulsion, which essentially notes that once we have been emotionally traumatized (and also in our view, conditioned), we will non-consciously seek to repeat a like trauma in the future. This dynamic has probably been scientifically validated, but Dr. Walker has not found the references as yet.

**6. The role of memory and physiology.** When we remember a traumatic event, the body replicates the physiology that occurred at the time of the event. This dynamic has been scientifically validated by Hassan, A.M., et. al.

**7. Semantic Responses.** The physiology of the body can not only be reactive to say the sight of a spider, but also the word “spider” or a picture of a spider. This dynamic has probably been widely scientifically validated, but Dr. Walker has not found the references as yet except for Monti, et. al., which did indeed validate it at least as far as muscle physiology.

Taken altogether, the NET Practitioner can use the above seven dynamics—and with the patient’s full involvement—can, with pinpoint accuracy and unprecedented speed, find the origins of emotional trauma. Resolving the trauma only requires entering into the psychoneuroimmunological complex through either spinal or acupoint avenues. This safe and quick intervention allows for the extinction of the emotionally laden conditioning.

# UNDERSTANDING THE NEURO EMOTIONAL COMPLEX (NEC)

Note: In a healthy circumstance, anytime a healthy cellular or organismic unit of life encounters a change in its internal or external environments, the reactive dynamics of that cellular or organismic unit are initiated and engaged until a healthy dynamic homeostasis is again achieved. However, due to various psychophysiological inadequacies within the cellular or organismic units, this dynamic homeostasis is sometimes not achieved. In these cases an NEC is formulated.

I. An NEC is the name given to an interrupted, suspended and congealed phase of any mind/body psychophysiological process or processes that would normally occur within the organism when it encounters a change in the internal or external environment.

1. An interruption, suspension and congealed psychophysiological manifestation occurs when the systems within the organism are overwhelmed by a constellation of factors (see factors listed within the definition of the NEC) which render the individual to be unable to healthfully process emotions and related thoughts concerning any (internal or external environmental) event without a resulting cathexsis. Thus there are a number of physiological factors causing this inability to achieve healthful homeostasis as well as psychological factors.

2. From a strictly psychological viewpoint the individual is unable to process emotions and thoughts because to do so would be i) UNSAFE and/or ii) IMPOSSIBLE. This is in keeping with the principle that the supreme reflex in a living organism is protection/survival, which overrides all other drives, inclinations, and thoughts. Let's take these two factors individually.

i. UNSAFE.

a. There would be a consequence to the normal emotional response, e.g., a beating.

b. The cognitive reality of the event is so overwhelming that it would be life-threatening. For example, the hopelessness associated with being hated by one's mother might be so painful that it is incompatible with living (i.e., makes one suicidal). Therefore, at times when the event is too overwhelming to endure, the NEC (interrupted process resulting now in suspension) is a protective mechanism. Events too painful to endure can include deep shame, hopelessness, and overwhelming grief. Recall the story of the young chimpanzee who died of a broken heart following the death of his mother.

ii. IMPOSSIBLE.

a. Emotional trauma occurs at an age (and the collective experiences thereof) when one cannot cognitively process it. Note that "UNSAFE" and "IMPOSSIBLE" are intermingled and are separated here only for the sake of clarity.

II. Nervous system components of an NEC. Each of the three brain levels is involved. Moreover, the entire physiology is involved via the neuropeptide system. Let's begin with the three brain levels.

1. Reptilian—home of the basic protective and survivalistic reflexes. One of the reasons NEC's usually need to be discovered (via a non cortical – muscle testing mode) is because at the time of trauma, the organism found it to be protective to remove part or all of the given event from conscious awareness. Thus when in a survival mode, the primitive, reptilian brain will engage biochemical processes in order to disconnect from higher cortical functions to variable degrees. Remember, even though the NEC creates problems in present day, at one time it was an adaptive necessity.

2. Mammalian—traditionally, where the basic emotions are housed.

3. Neocortex—the least active part of the brain during NEC formation. As stated above, this part of the brain often gets shut down automatically at times when the organism is in danger. Therefore, the neocortex is least active when NEC's are triggered in the present day. That is why these patterns of reactivity often are unconscious. In other words, they are not in the primary domain of the logical, rational neocortex. Furthermore, if these patterns are simply brought to

one's attention, that is usually not enough for resolution. This is because the neocortex might deduce that given behavior is illogical or unhelpful, but the deduction often stays disconnected from the primitive reflexes of the reptilian brain. This is different than the NET approach. Among other things, the re-engaged physiology promoted by the NET intervention promotes an engagement of all three brain structures and their subsystems.

Therefore, during the NET intervention, it is important for the neocortex to be activated, which is why attempts of non verbal "psychic clearing" by the practitioner are insufficient.

III. The NEC is present throughout the system.

Neuropeptides—as defined in previous text, are the chemical messengers or "information substances" that constitute the "liquid" nervous system throughout the body. Neuropeptide receptors are found in every cell of the body.

Illustrations:

To help illustrate the intricacies of the protective/adaptive neuro-emotional system, we might loosely compare it to the protective/adaptive functions of the immune system. For example, there is an almost immediate response in the immune system on several cellular and biochemical levels when a foreign substance is detected (e.g., bacteria, virus, etc.). This usually efficient process allows for potentially harmful pathogens to be isolated and removed. In addition, our B-lymphocytes act as memory cells, circulating the bloodstream for future detection of a warded off pathogen. That is, if a similar pathogen enters the system in the future, the B-lymphocytes "remember" it and signal an immediate immune response to the rest of the system. This mechanism is the basis of vaccine research. Like emotional responses, immune responses are good, natural, and adaptive. However, sometimes the immune system remembers and launches an immune response to things that are not a threat to survival in the present day. An example would be allergies. It might be that an allergy forms for reasons similar to why an NEC forms, stimulus (allergen) overload, or physiology in a weakened state during stimulus presentation. Like an NEC, allergic responses can range from uncomfortable to life threatening.

Analogous to the immune system, information received through the senses is neuro- chemically mediated throughout all neural and physiological systems. When incoming stimuli resembles previous dangerous events, the "memory cells" of our survival system are activated (likely the amygdala), sending hard-wired (nerves) and neuro-chemical (neuropeptides) signals throughout the body to respond to the threatening stimuli in the SAME way that was previously learned (because it was adaptive at the original time). Also, it is postulated that certain cytokines (neuropeptides) are released in response to specific emotional activation. We assume that the receptor sites for those peptides are concentrated in places that reflect the body's emotional anatomy, e.g., when a stimulus evokes an NEC with a significant anger component, the neuropeptide(s) associated with anger are secreted into the system and attach to receptors all over the body (presumably, the liver and gall bladder).

Finally, we must keep in mind that energetic physiology reflects what is going on in our physical physiology. A disturbance in chi energy flow occurs when an NEC is formed. When the NEC is activated, part of the dysfunction of the NEC is the blockage in that meridian and the cells and tissues mediated by that meridian. In summary the NEC involves all levels of the nervous system, the neuropeptide system, and the energetic system. NET is an intervention that attempts to engage all of these.

IV. Understanding the NEC in the context of repetition-compulsion and stimulus generalization.

Homeostasis is another primary motivating drive in the organism. Conscious, unresolvable conflict puts the individual in a physiologically compromised state. It is defensive, or in other words, adaptive/survivalistic to detach the conscious mind from some or all of the intense feelings and thoughts while in the midst of highly charged, unresolvable conflict. However, we are not computers where we can press the "delete" button and the things we adaptively removed from conscious awareness evaporate into space. Rather, they are still very alive in our physiology in what we call the NEC. But, although the NEC is adaptive in this sense, it is not optimal once the original event is no longer an active issue. As in the immune system, the "memory cells" are still in attendance. If an NEC has formed, it then becomes a physiological

glitch so to speak. Whenever stimuli occur that re-minds us enough of the original event, survival reflexes in the brain engage the nervous system to "survive" (whether or not survival is actually an issue NOW) the present day "danger" (whether or not there is actual danger). The result is either a reaction to the stimulus in the same manner that allowed survival originally, or avoidance of the perceived danger altogether.

In addition to Pavlovian conditioning, there is often a stimulus generalization associated with an NEC. An example is post-traumatic stress disorder, which afflicted many Vietnam War veterans. During the war, soldiers had to face overwhelming physical and emotional hardships, often running for their lives and witnessing horrific events on a daily basis.
Later, back at home where there are no bombs, land mines, etc., the sound of a fire engine siren (stimulus), can trigger the body to react as if an air raid were coming. The sympathetic nervous system goes in overdrive, and the person might even reflexively take cover (conditioned response). Note that this response was originally adaptive and survivalistic. PTSD is a complicated problem with several levels of symptoms, including stimulus avoidance.

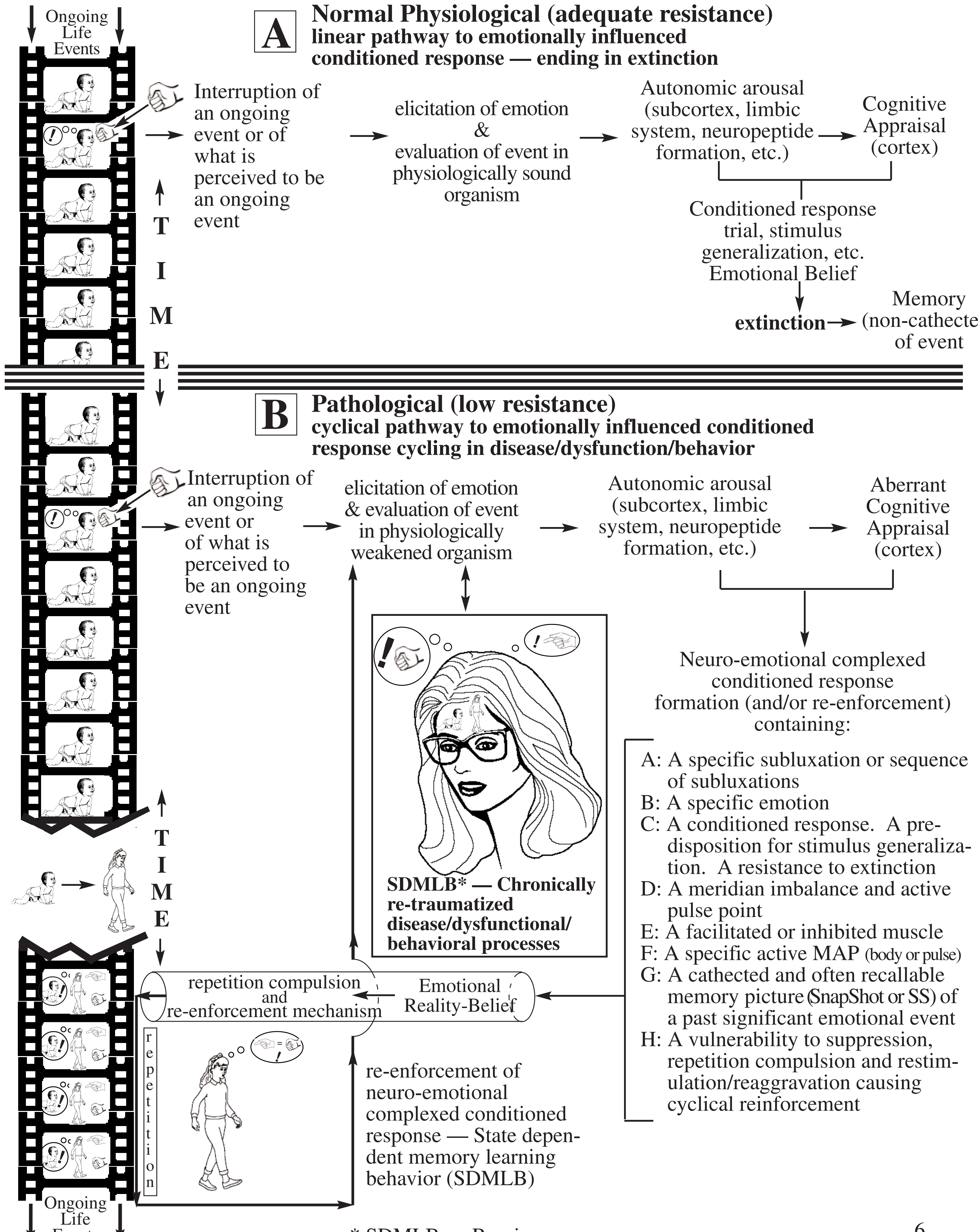
Another kind of stimulus generalization might occur in a young boy who has a harsh father. In this case, the boy might learn that whenever father seems displeased or raises his voice, that the best way to avoid a beating is to find a way to pacify and please. This is the survivalistic response. Later in life, whenever there is a potential conflict with another person (stimulus generalization), the conditioned response is to pacify and please. This conditioned response within the NEC prevents the now grown man from expressing himself and having needs met in relationships. Thus this is also a good example of how an NEC can involve Pavlovian conditioning, stimulus generalization, and repetition compulsion. The repetition compulsion in this case, might manifest as a tendency to migrate to those who will treat him harshly (see below).

A final word on repetition compulsion. When there is deep unresolved need, it is part of the body's homeostatic drive to find a way to have the need met. When there is significant unmet biological need, such as attachment and bonding, the organism is not in optimal physiological balance. Death has been known to occur when the unmet need is severe enough. For example, it was shown in wartime orphanages that babies who were given nourishment only, but were not held, often died from failure to thrive. Similarly, feeling unloved by one's mother can cause a painful, but less dramatic response (NEC formation). Homeostatically, we attempt to resolve these painful NEC's by continually trying to get the love, acceptance, etc., from the desired object (parent) or object representation (i.e. boyfriend, teacher, spouse, etc.). Object representations are chosen based upon their resemblance to the original desired object, thus allowing the possibility of resolution of need. Unfortunately, in their resemblance to the original object, they often have the same limitations, unable to give the person what is needed. For example, a little girl with an alcoholic father might get beatings instead of the love she desperately needs from him. Later in life, she migrates to men who trigger the possible resolution of this unmet need (i.e. men who on some level remind her of her father). Somehow, she repeatedly ends up with a man that beats her, even if it takes several months to years for that behavior to manifest. But, even if the object representation is one that can give love and nurturing, it usually does not feel like enough and generally does not give a sustained resolution of the cognitive distortions and stuck emotions of the NEC.

Most often, when there is a repetition compulsion, there is a negative distortion in perception of self, e.g. pathological shame. For example, a young child who feels unloved by his mother might have several emotions associated with an NEC, for example, anger, abandonment, grief, etc.. However, perhaps the most damaging part of that NEC is the conclusion by the child that there must be a reason that has to do with the child trying to account for why mother is hateful, abandoning, etc.. Hence, " Mommy does not love me because I'm unlovable, not enough, flawed, etc.". Since this belief is literally enough to kill a child, the body defenses protect the individual as much as possible from being consciously aware of the intensity of the belief, which is why shame is often the deepest and last emotion to be discovered in this type of NEC-generated theme.

The foregoing is not intended to represent an exhaustive scholarly discussion of the NEC, but rather a more relevant and concise outline for the NET clinician.

# NORMAL vs. PATHOLOGICAL PHYSIOLOGICAL PATHWAYS




* SDMLB — Rossi

# VERBAL SUPPOSITIONS

## Descriptions, Explanation, and Usage for the Advanced Practitioner

The skillful use of Verbal Suppositions is an extremely valuable tool to uncover the essence of a patient's Emotional Reality (ER). Among the various Verbal Suppositions are Concept Phrases, Test Statements, Personal Laws and Personal Declaratives:

• **Personal Declaratives** (PDs) are complete sentences (often deliberately and carefully pre-meditated with the assistance of the practitioner), which the patient verbally articulates as a complete sentence. The spoken declaration is one the patient believes to be true or would like to be true. PDs serve the practitioner's objective of determining the presence or absence of an NEC relating to the semantics utilized within the PD.

• **Concept Phrases** (CPs) are incomplete sentences that may have emotionally laden NEC contaminated content. CPs are always spoken by the practitioner and are only used AFTER entering an NEC related issue. These phrases frequently include the preamble, "the concept of."

• **Test Statements** (TSs) are best used after finding an NEC related issue. They are usually prompted and suggested by the practitioner and uttered by the patient with the objective of determining the extent to which the patient's emotional reality has impinged upon the day-to-day cognitive perceptions the patient usually relies on. TSs are not used in the NET Mind flow chart, but are merely an emotional "reality check."

• **Personal Laws** (PLs) are usually concise statements that accurately reflect a conceived synthesis, a synopsis, a paradigm or a construct incorporating the emotional realities by which the patient lives (consciously or non consciously) at a core level. They are usually a condensation and essence of much earlier material as brought to light by PDs, CPs, and TSs.

The grammatical use of suppositions in NET is like mathematics. A newcomer to mathematics might assume 2 + 2 = 4 is the same as 2 x 2 = 4. No harm done, one may think, he got the right answer. However as he attempts to advance in mathematics, unless he is told of the significance of the difference of the "+" and the "x", he will later find troublesome errors later on when he interprets 3 x 3 as being equal to 6. And then there are the – and ÷ and the other functionally different processes these symbols represent. Similarly, within NET, there are functionally different semantic processes vulnerable to subtle errors with mathematically precise consequences, and which can occur when (mis)interpreting the muscle test. Turned around, if the tools herein are used properly, the practitioner will likewise find and fix problems with mathematical precision.

The word "supposition" derives from "suppose." Suppose is defined by the Wordsmyth Dictionary as, "to consider as a possibility." We consider as a possibility that a certain Personal Declaratives may test positive, but only as a possibility. We don't mind being wrong. We use the muscle test to determine the result of what we lightly suppose.

In NET, Verbal Suppositions are usually groups of words meeting certain defined parameters that are presented by the practitioner or the patient as the case may dictate, for evaluation by the patient's emotional appraisal system. Words, of course are consciously "heard" via the patient's neocortex and are also mediated into non-verbal concepts, which, in turn, are processed by various aspects of the limbic system which houses memory and emotion.

The limbic system and its ramifications appraise the newly presented concept by comparing it to previously experienced similar concepts (and their survival value) while considering the current needs of the body. Under most circumstances, if the net appraisal of the presented concept is deemed emotionally congruent, the muscle test will be facilitated or strong. If on the other hand, the net appraisal of the presented concept is deemed emotionally incongruent, the muscle test will be inhibited or weak.

# MUSCLE TESTING A VERBAL SUPPOSITION

What does the muscle test mean? Many practitioners seem to get confused as to what a weak versus a strong muscle "means." Two people can see the same thing and interpret it differently. In the past we have discussed that the meaning of a weak or strong muscle is definitely NOT "yes" or "no." Or a "true" or "false." Essentially, in semantic testing, a weak or strong muscle corresponds to either emotional congruency or emotional non-congruency. However, with the variety of verbal suppositions at hand, and with the interpretation/meaning of a weak and strong muscle superficially appearing to be opposite in some cases, a number of clarifying distinctions must be made. The following dialogue is designed to make these distinctions by example.

## Hypothetical Dialogue in a NET Practitioner's Office

1. Practitioner: Mary, Please say, "I am a woman."

2. Patient: "I am a woman." TS STRONG

3. Practitioner: You are testing well. How can I help you?

4. Patient: I want to get well.

5. Practitioner: Great let's check it. Please say, "I want to get well."

6. Patient: I want to get well. PD WEAK

7. Practitioner: Please say, "I want to stay sick."

8. Patient: I want to stay sick. TS STRONG - congruent.

9. Practitioner: Please say, "I want to get very sick."

10. Patient: I want to get very sick. TS STRONG - congruent.

11. Practitioner: Please say, "I want to get deathly sick."

12. Patient: I want to get deathly sick. TS STRONG - congruent.

13. Practitioner: Please say, "I want to get so sick I actually die."

14. Patient: I want to get so sick I actually die. TS WEAK

15. Practitioner: Please again say, "I want to get deathly sick."

16. Patient: I want to get deathly sick. TS STRONG - congruent.

17. Practitioner: We both realize you don't really want to get sick let alone deathly sick. But what non-rational line of thinking would lead you to want to get deathly sick?

18. Patient: I don't know... maybe so I have an excuse for not doing well at work...

19. Practitioner: The concept of something to do with work. CP STRONG

20. Patient: I don't know...

21. Practitioner: The concept of something to do with your family. CP WEAK

22. Practitioner: The concept of something to do with your husband. CP WEAK

23. Practitioner: If this had something to do with your husband, what would that be?

24. Patient: Well he gives me so much attention when I am sick...

25. Practitioner: The concept of something to do with your husband giving you attention. CP WEAK

26. Practitioner: The concept of you wanting his attention. CP WEAK

27. Practitioner: The concept of you wanting his attention so you will feel loved. CP WEAK

28. Practitioner: The concept of you being sick so you will feel loved. CP WEAK

29. Practitioner: The concept of you being sick as the only way you can feel loved. CP WEAK

30. Practitioner: Say this, "The only way I can feel loved is to be sick."

31. Patient: The only way I can feel loved is to be sick. TS STRONG

32. Practitioner: Say this, "I can feel loved and be healthy."

33. Patient: I can feel loved and be healthy. TS WEAK

34. Practitioner: Say this, "I can feel loved more the more my sickness increases."

35. Patient: I can feel loved more the more my sickness increases." TS STRONG

36. Practitioner: Say this, "I can feel loved the most if my sickness brings me near death."

37. Patient: I can feel loved the most if my sickness brings me near death. TS STRONG

38. Practitioner: Say this, "I'd rather be sick than unloved."

39. Patient: I'd rather be sick than unloved. TS STRONG

40. Patient (continuing): You know what? The only time I could tell my daddy & mom ever loved me was when I got sick!!

41. Practitioner: Say this, "I can be loved if I'm just fine."

42. Patient: I can be loved if I'm just fine. TS WEAK

43. Practitioner: The concept of you being naturally lovable. CP STRONG

44. Practitioner: The concept of you feeling naturally unlovable. CP WEAK

45. Practitioner: Say this, "I am naturally unlovable."

46. Patient: I am naturally unlovable. PL STRONG

47. Practitioner:  Say this, "I am naturally unlovable, so I want to get and stay sick so I can then become lovable because I want to feel love more than I want to be healthy."

48. Patient:  I am naturally unlovable, so I want to get and stay sick so I can then become lovable because I want to feel love more than I want to be healthy.  So therefore I want to be sick. Building A Case - TSs  STRONG

49. Practitioner:  Say this, "I can be naturally lovable."

50. Patient:  I can be naturally lovable.  TS  WEAK

51. Practitioner:  Say this, "I am naturally lovable"

52. Patient:  I am naturally lovable.  TS  WEAK

53. Practitioner:  Hmmm. Let's check that again.  Say this again, "I am naturally lovable."

54. Patient:  I am naturally lovable.  PD  WEAK

55. Practitioner:  [Does the NET procedure and follows up with . . .]

--- Validating after poising (correcting) ---
56. Practitioner:  The concept of you being naturally lovable.  CP  STRONG

57. Practitioner:  Say these 2 sentences, one at a time:  "I can be naturally lovable." and "I am naturally unlovable."

58. Patient:  I can be naturally lovable.  TS  STRONG

59. Patient:  I am naturally unlovable.  TS  WEAK

60. Practitioner:  Please say, "I want to get sicker."

61. Patient:  I want to get sicker.  TS WEAK

62. Practitioner:  Say this, "The only way I can feel loved is to be sick."

63. Patient:  The only way I can feel loved is to be sick.  TS  WEAK

64. Practitioner:  Say this, "I can feel loved and be healthy."

65. Patient:  I can feel loved and be healthy.  TS  STRONG

66. Practitioner:  Say this, "I can feel loved more, the more my sickness increases."

67. Patient:  I can feel loved more the more my sickness increases."  TS  WEAK

68. Practitioner:  Say this, "I can be loved if I'm just fine."

69. Patient:  I can be loved if I'm just fine.  TS  STRONG

70. Practitioner:  Very good.  Let's go back to the beginning.  Please say, "I want to get well."

71. Patient:  I want to get well.  PD  STRONG- congruent.  Cycle completed.

# PERSONAL DECLARATIVES (PDs)
## Discussion & Rules

Declare: To make known formally or officially. To state emphatically or authoritatively; affirm. To make a full statement of.

PDs are somewhat familiar to the average NET practitioner. Let's first go over the rules for PDs and then discuss them at length.

### THE RULES FOR PDs

**All PDs:**

1. Are positively formed, i.e., "I want to be slim," versus "I don't want to be fat." Or "I want to have more money," versus "I don't want to be poor."

2. Are something the patient subjectively feels is true or would like to be true. For example, a sick patient may say, "I want to be healthy.", versus "I am healthy." (something they do not feel to be true).

3. Are always verbally articulated by the patient (as opposed to a Concept Phrase which are spoken by the practitioner).

4. Always carry the patient's honest intention and the volition of wanting to be emotionally congruent with it.

5. Are complete sentences.

### SOME DISCUSSION ON PDs

PDs are the most popular form of verbal supposition. Personal Declaratives are complete sentences (often deliberately and carefully pre-meditated with the assistance of the practitioner) which the patient verbally articulates as a complete sentence. The spoken declaration is one the patient believes to be true, or would like to be true. Think of the Declaration of Independence.

The PD thus carries the patient's honest intention and the volition of wanting to be emotionally congruent with it. This is the practitioner's intention as well.

PDs serve the practitioner's objective of determining the presence or absence of an NEC relating to the semantics utilized within the PD.

Ideally, a PD is a positively formed, simplistic statement used to temporarily rule out the presence of an NEC on any one particular issue. The window to the issue is generally fairly obvious. For example, a patient who has tried many practitioners of good reputation, yet does not gain their health, could easily have a PD of, "I want to get well." -- a classic PD. This declarative is positively formed, simplistic and refers to something the patient wants to be true.

# THE STRUCTURE OF PDs

## — Ions, Atoms, and Molecules

**Personal Declaratives (PDs)** are statements which engage the speech/language localization areas, the memory, and in cases of NECs, the prefrontal cortex/limbic system and all other components of the NEC. PDs can be used diagnostically.

In NET, PDs are generally classified as:
**Ion Personal Declaratives**,
**Atom Personal Declaratives**, and
**Molecule Personal Declaratives**

— **"Ion" Personal Declaratives**

Ion PDs are those PDs which are of an identification nature, and have the subject speaking with an identification with, or intimate knowledge of, their immediate reality.

Ions are particularly valuable in a NET GET SET type fundamental poising.

— **"Atom" Personal Declaratives**

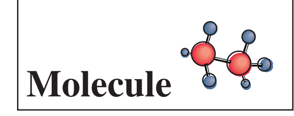
Atom PDs are those PDs that usually have the speaker as the subject, a verb, and a singular object in the sentence.

Atoms are the fundamental PD structures for the mind-entry form of NET (aka NEAT).

— **"Molecule" Personal Declaratives**

Molecule PDs are those PDs that usually have the speaker as the subject, a verb and multiple objects.

Molecules are used in advanced Free Styling and when fundamental Ions and Atoms have not been fully effective.

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**Ion Examples:**

"I [subject] am a [object of identification] male."
"I am a woman."
"My name is Norman."
"It is 1992."

---

**Atom Examples:**

"I'm OK being rich."
"I'm OK with poverty."
"I'm worthy of a sincere relationship with a woman."
"I want to be healthy."
"I can be healthy."

---

**See next page for Molecule Examples.**

# HOW TO BUILD MOLECULES

*"Sodium (Na) is Sodium. Clorine (Cl) is Clorine. But NaCl is an entirely different matter." — Scott Walker, D.C.*

Rule: Important Atoms Build Effective Molecules

Individual congruent atoms when joined together are called molecules.

**The Rational for Molecule Construction:**
Even though the atoms making up the molecule are congruent when tested individually, the resultant molecule may have a Hidden Affect (HA). If an HA is present, the resulting molecule will test as being non-congruent.

**The General Method:**
When building molecules, we are using the acronym **WITH**: **W**hat's **I**mportant **T**o **H**im/Her.

Ascertain the patient's values. Build a molecule by combining one *congruent* atom **WITH** another congruent atom.

In forming Personal Declarative atoms, the usage of "I can..." from the Surround the Dragon "short list" has been found to be the most effective PDs when building molecules.

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**EXAMPLE 1**

Atom Example A: "I'm OK with getting rich."
"I can get rich."
Atom Example B: "I'm OK with being a spiritual person."
"I can be a spiritual person."

Combine **A** **WITH** (What's Important To Him/Her) **B**
Molecule example: "I can get rich and (can) be a spiritual person."

[This person's Emotional Reality (ER) may be that rich people cannot be spiritual. Although he may want to be rich, he subconsciously wishes to avoid feeling apart from God because of his wealth. Any emotion connected to feeling unspiritual is his HA.]

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**EXAMPLE 2**

Atom example A: "I'm OK with losing weight."
"I can lose weight."
Atom example B: "I'm OK with being a good mother."
"I can be a good mother."

Combine **A** **WITH** (What's Important To Him/Her) **B**
Molecule example: "I can lose weight and (can) be a good mother."

[This person's Emotional Reality (ER) may be that good mothers are plump. She may wish to avoid feeling like a bad mother. This is her HA.]

# CONCEPT PHRASES (CPs)
## Discussion & Rules & Attributions

Concept: Something formed in the mind; a thought or notion.

Phrase: A sequence of words intended to have meaning. A characteristic way or mode of expression.

CPs are incomplete sentences, which may have emotionally laden NEC contaminated content. CPs are always spoken by the practitioner. These phrases frequently include the preamble, "the concept of." They are used only AFTER entering a NEC related issue through any MODE (and before correcting it) and in which more contextual information is desired.

Hopefully, and most often, this new information leads the practitioner and patient to a more fundamental or underlying NEC and its accompanying snapshot. Whether a new and more fundamental NEC snapshot is uncovered or not, CPs do discover the more detailed circumstances of the discovered NEC contaminated "Dragon's Den" thus "fleshing it out" (we must remember that the Snapshot is just that, an individual momentary picture of the patient's life, not the whole movie). Additionally, this "fleshing it out" procedure helps take advantage of mobilizing additional patient affect (increasing the specific neuropeptide flood – see NET Basic glossary for SDMLB). Relevant CPs always test weak. Any CP which tests strong should be considered to be irrelevant to the NEC at hand, disregarded and a new CP tested.

CPs are only usable, as mentioned, after a primary NEC issue has been surfaced or "opened", because CPs are only testable in that sensitized state. If a CP tests weak, the CP is deemed to be "hot on the trail". Without the patient's having some primary knowledge of the NEC issue, CPs can have no contextual semantic value, and thus do not work in isolation.

THERE ARE NO "NEGATIVE" OR "POSITIVE" CPs or TSs (including PLs).

NOTE: The results of testing CPs and TSs are not termed (in the traditional fashion) as "negative" or "positive" findings. The findings themselves are neutral, just facts. As the great bard Wm. Shakespeare said, "There is nothing either good or bad. But thinking makes it so." The resultant findings however may be used within the construction of a PD, which may then be found to be positive or negative – because NOW we have a declaring subject who has an emotional reality behind the "thinking [which] makes it so."

THE RULES FOR CPs

**CPs are:**

1. Always spoken by the practitioner.
2. Used only AFTER uncovering an NEC related issue.
3. Always test weak when they are "hot on the trail."
4. Always relevant to the issue at hand.
5. Always made plausible, tangentially related and integral to the issue at hand.
6. Are incomplete sentences.
7. Used when more contextual information is desired.

**ATTRIBUTIONS OF CPs**

If tested strong, should be considered to be irrelevant to the NEC at hand and disregarded.

# EXAMPLES OF "STRONG" & "WEAK" CPs

**STRONG CPs** are those CPs (which contain a concept, spoken by the practitioner, in the contextual proximity of just previously triggered emotional incongruent NEC issue) that muscle test as STRONG when they fail to elicit further re-triggering of that non congruent material. Example of a strong-testing CP: "The concept of something to do with work." (See the example in line 19 of dialogue — The practitioner spoke a concept that was in the contextual proximity of just previously triggered emotional incongruent NEC issue [lines 6 through 18], but failed to elicit a weak muscle.)

**WEAK CPs** are those CPs (which contain a concept, spoken by the practitioner, in the contextual proximity of just previously triggered emotional incongruent NEC issue) muscle test as WEAK when they elicit a re-triggering of that non-congruent material. See example in line 22 — The practitioner spoke a concept which was in the contextual proximity of just previously triggered emotional incongruent NEC issue [lines 6 through 21] elicited a weak muscle.)

CPs CAN BE USED SINGLY OR SUCCESSIVELY.

Sometimes it's effective to use a succession of CPs. Returning to our hypothetical dialogue we notice that a single CP was used at 19 and successive CPs were being used from 21-22 and also 25-29.

17. Practitioner: We both realize you don't really want to get sick let alone deathly sick. But what non-rational line of thinking would lead you to want to get deathly sick?

18. Patient: I don't know . . . maybe so I have an excuse for not doing well at work . . .

19. Practitioner: The concept of something to do with work. CP STRONG

20. Patient: I don't know . . .

21. Practitioner: The concept of something to do with your family. CP WEAK

22. Practitioner: The concept of something to do with your husband. CP WEAK

23. Practitioner: If this had something to do with your husband, what would that be?

24. Patient: Well he gives me so much attention when I am sick . . .

25. Practitioner: The concept of something to do with your husband giving you attention. CP WEAK

26. Practitioner: The concept of you wanting his attention. CP WEAK

27. Practitioner: The concept of you wanting his attention so you will feel loved. CP WEAK

28. Practitioner: The concept of you being sick so you will feel loved. CP WEAK

29. Practitioner: The concept of you being sick as the only way you can feel loved. CP WEAK

Thus CPs can be used in a time efficient manner, eliminating time consuming cognitive and error prone sleuthing.

# EXAMPLE OF ASSEMBLING A SNAPSHOT

Snippets of information are gathered through dialogue and muscle testing and assembled into a SnapShot.

An example of a single woman (and unknown to the practitioner) whose company just down-sized and she is now moving to a less than desired neighborhood. She complains about anxiety but not exactly sure why. The practitioner uses MODE Feeling and finds LUNG—SAD.

**SHORT DIALOGUE**
**Practitioner**: "We're finding 'sad.' Sad is usually correlated with a loss of 'what is' or 'might have been.' Does that make any sense?"
**Patient**: "Well, not really, but maybe, yeah I was a little blue this weekend."
**Practitioner**: "Let's test it.

**TESTING**
**Practitioner**: "The concept of you being sad at a loss of some kind."
**Tests weak.**
[**Patient**: "Well I'm moving away from my friend, John, who is a wonderful neighbor and friend."]

**SHORT DIALOGUE**
**Practitioner** (looking for some familiar romantic type paradigm): Is this a romantic relationship?"
**Patient**: "No he's just a sweetie pie, he helps me a little and I can call on him if I need him."
**Practitioner** (moving on): "OK."

**TESTING AGAIN**
"The concept of you being sad because of moving away from John."
**Tests weak.**

[Abstracting for LCD]
"The concept of an original event in which you were sad because of being separated from someone you cared about."
**Tests weak.**

[Indexing for time and finding age 6]
"The concept of you being sad at age 6, because of being separated from someone you cared about."
**Tests weak.**

**DIALOGUE DIGRESSION**
**Practitioner** (after engaging muscle test): "Did you move at age six?"
**Patient:** "No."
**Practitioner:** "Were you being separated from anyone you cared about, say a teacher you liked as you graduated or a grandmother who died, or even a pet?"
**Patient:** "Well we were worried about Dad dying, he was hospitalized...."

**TESTING AGAIN**
"The concept of you being sad about something about your Dad's health."
**Tests weak.**

"The concept of you being sad about something about your Dad's health because you didn't want to lose your father."
**Tests strong.**

"The concept of you being sad about something about your Dad's health because you didn't want your mom to lose your father."
**Tests strong.**

"The concept of you being sad about something about your Dad's health because you didn't want to lose something he provided for you."
**Tests weak.**

"The concept of you being sad about something about your Dad's health because you didn't want to lose the income he provided for you."
**Tests strong.**

[Again to recheck the positive **TESTING** premise just prior to the above negative test]
"The concept of you being sad about something about your Dad's health because you didn't want to lose something he provided for you."
**Tests weak.**

[Re**TESTING** income]
"The concept of you being sad about something about your Dad's health because you didn't want to lose the income he provided for you."
Still **Tests strong**.

# EXAMPLE OF ASSEMBLING A SNAPSHOT

[Back to the last positive **TESTING** concept again]
"The concept of you being sad about something about your Dad's health because you didn't want to lose something he provided for you."
**Tests weak.**

[Temporarily breaking down the above positive **TESTING**, but cumbersome concept]
"The concept of that "something" he provided for you was love."
**Tests strong.**

"The concept of that "something" he provided for you was a role model."
**Tests strong.**

[**Patient** suggests... "companionship"]
"The concept of that "something" he provided for you was a companionship."
**Tests strong.**

**DIALOGUE DIGRESSION**
[**Practitioner** seeks background asking what the general situation was at the time. **Patient** relates two older brothers, going to Catholic church, mom was working, etc. This is duly noted and the practitioner goes back to the last positive **TESTING** concept again.]

**TESTING AGAIN**
"The concept of you being sad about something about your Dad's health because you didn't want to lose something he provided for you."
**Again Tests weak.**

"The concept of that "something" he provided for you had something to do with church."
**Tests strong.**

"The concept of that "something" he provided for you had something to do with the rest of your family."
**Tests weak.**

"The concept of that "something" he provided for you had something to do with your mother."
**Tests strong.**

"The concept of that "something" he provided for you had something to do with your brothers."
**Tests weak.**

[**Practitioner** seeks more background on the two older brothers which it turns out, abused her when Dad was out of the house. This is duly noted and the practitioner goes back to the last positive testing concept again.]

"The concept of that "something" he provided for you had something to do with your brothers."
**Again Tests weak.**

"The concept of that "something" he provided for you was protection from your brothers abuse."
**Tests weak.**

[Now, loading the other snippets back into the mix.]

"The concept of you being sad about something about your Dad's health because you didn't want to lose his protection of you from your brothers."
**Tests weak.**

**SHORT DIALOGUE**
**Practitioner:** Does a mental picture come to mind which represents that scene?
**Patient:** "Yes."

**Practitioner:** "Let's test it."
Patient holds the Snapshot while the practitioner tests it.
**Tests weak.**

**SHORT DIALOGUE**
**Practitioner:** "OK, please tell me a little more about just how that looked, what was happening?"

Practitioner now listens carefully noting the Patients Own Words (POW). He then prepares the patient for correction by giving instructions on the correction process and restating using POW, the Sanpshot just described, and makes the correction.

# TEST STATEMENTS (TSs)
## Discussion and Examples

Often it is clinically valuable to probe the depths of a patient's Emotional Reality (ER). CPs as described above help this process. TSs do not replace CPs, but are more far ranging. Most often both CPs and TSs are used in tandem. What is a TS?

A TS is a sentence positively formed, simplistic and most often carefully conceived by the practitioner - and is quite often deliberately and purposefully and decidedly non-rational (unlike a PD). Apart from that quality, a TS looks and sounds much like a PD.

A TS is best and usually used after finding NEC material through any MODE including PDs. It is usually prompted and suggested by the practitioner, uttered by the patient, with the objective of determining the extent to which the patient’s emotional reality has (less than consciously) impinged upon the day to day cognitive perceptions the patient usually relies on. Of course the ER influences behavior too.

TSs are suggested to the informed patient (the practitioner having explained the context of the test). The informed patient may well regard the practitioner suggested TSs as counterfactual to his rational experience, but nonetheless venturesomely allows that there may be some plausible and below consciousness NEC driven validity to an opposing or contrary emotional reality based "belief."

TSs are not used in the NET flow chart, but are merely an emotional "reality check," specifically an Emotional Reality check. Emotional reality plausibility causes the test to be integral. TSs are necessarily contextually conceived.

We do not attempt to poise TSs, only PDs.

**TS RULES**

**All TSs are:**

1. Only to be done on a patient who is fairly comfortable with the NET process, has rapport with the practitioner, and is specifically informed about this process.

2. Exclusively exploratory in nature.

3. Positively formed whole sentences, i.e. "I want to be in pain," versus the negatively formed, "I don’t want to feel good." Or the non-sentence, "concept of being in pain."

4. Simplistic and most often deliberately and carefully premeditated by the practitioner.

5. At least tangentially related to the obvious issue at hand. For example, if the issue is health, the best TSs will be led by that issue. To illustrate, a sick patient may be asked to say the TS, "I want to prove my practitioner is going to fail with me.", versus "I want to be a penguin." (a subject lacking any integrity with the issue at hand).

**TSs may:**

A. Often be irrational.

B. Carry content which the patient subjectively thinks to be untrue or would like to be untrue. For example, a practitioner may ask a patient may say, "I want to be sick.", versus "I want to be healthy." (A condition they actually seek or want to be true.)

C. Never poised or fixed.

D. Often suggest new CPs and eventually new PDs, and even PLs (which are discussed below).

E. May become a PD.

**TSs IN ESCALATING DEGREES**

TSs can be effectively used in sequentially escalating degrees. Ever probing the emotional reality perimeter.

Example A:

8. Patient: I want to stay sick. TS STRONG - congruent.

This sentence is positively formed, simplistic and refers to nothing the patient wants to be true. It is irrational. It is a TS. It is at least tangentially related to the information in line 6. It is following the rules of TSs. It establishes a new extended perimeter of the patient's ER. It tested positive and the practitioner elected to try example B.

Example B:

9. Practitioner: Please say, "I want to get very sick."
10. Patient: I want to get very sick. TS STRONG - congruent.

This sentence is also positively formed, It establishes an even more expanded perimeter of the patient's ER. If positive the practitioner may try example C.

Example C:

11. Practitioner: Please say, "I want to get deathly sick."

[Note how this TS is different from a PD. Certainly no sane person would want to get deathly sick. PDs are always something the patient wants to be true or believes is true. Not necessarily so for an TS. Of course the practitioner will not attempt to poise the patient on this statement.]

12. Patient: I want to get deathly sick. TS STRONG - congruent.

This tested weak and the practitioner may, and did, try example D.

Example D:

13. Practitioner: Please say, "I want to get so sick I actually die."

14. Patient: I want to get so sick I actually die. TS WEAK

This sentence tested weak. The practitioner may note that this person is emotionally congruent with being deathly sick, yet not want to die. Thus, in this case, a portion of the patient's ER parameter was established in Example C.

The next option may be to return to the TS in Example C, and, using CPs, find the "Why?" this person could want to be very sick. For instance the practitioner may start with

15. Practitioner: Please again say, "I want to get deathly sick."

16. Patient: I want to get deathly sick. TS STRONG - congruent.

17. Practitioner: We both realize you don't really want to get sick let alone deathly sick. But what non-rational line of thinking would lead you to want to get deathly sick?

18. Patient: I don't know . . . maybe so I have an excuse for not doing well at work . . .

19. Practitioner: The concept of something to do with work. CP STRONG

20. Patient: I don't know . . .

21. Practitioner: The concept of something to do with your family. CP WEAK

22. Practitioner: The concept of something to do with your husband. CP WEAK

23. Practitioner: If this had something to do with your husband, what would that be?

At this point or any point the emotional suppositions can stop and some cognitive questions begun. [In the diagnostic practice of NET, the term "supposition" always refers to investigations of the subcortex (limbic system-body), and the "term" question refers to investigations of the cerebral cortex.] One question can lead to the formation of a new CP, which is what happened in our example.

23. Practitioner: If this had something to do with your husband, what would that be?

24. Patient: Well he gives me so much attention when I am sick . . .

25. Practitioner: The concept of something to do with your husband giving you attention. CP WEAK

TSs and CPs and even Questions can then be intermingled at will with the goal of ending at a fundamental belief system and finally finding a PD at odds with that belief system and then poising it. See Personal Law below.

[Clinically, in these cases, it is worth noting, the patient who is testing strong while saying an NEC related TS will immediately test weak when simultaneously touching the emotional points or an associated Body or pulse MAP – it is extremely easy to accidentally contact the pulses when doing the muscle test. Therefore, like other semantic testing, the patient's and practitioner's hands should be off these areas during the testing.]

# PERSONAL LAW (PL)

## A Special Category of Test Statements

A variation of the TS is the Personal Law. PLs are usually concise statements which accurately reflect a conceived synthesis, a synopsis, a paradigm or a construct incorporating the emotional realities by which the patient lives (consciously or non consciously) at a core level. They are usually a condensation and essence of much earlier material as brought to light by PDs, CPs, and TSs.

An example may be, "I'm no good". Other examples are: "I am unlovable." Or "I don't deserve anything." These fundamental and foundational PLs are underlying many subsets of the patient's ERs and color and influence his/her perceptions and subsequent behaviors. This personal legislation is laid down in moments of high emotional duress. Say at the loss of a twin, or when daddy and mommy get divorced and daddy is leaving the house, birth, molestation, early failures, and other significant events.

Note: Theoretically, PLs are not necessarily NEC impacted. It is possible someone may have a PL of, "God loves me." If that construct incorporates the emotional realities by which the patient lives (consciously or non consciously) at a core level.

This is very rarely found, perhaps, as clinicians we are not looking for it. It is stated here for the record and mostly for clarification: Provisionally, all PLs will test strong whether there is an NEC contamination or not.

A PL Example from line 46 of the dialogue:

46. Patient: I am naturally unlovable. PL STRONG

**TWO MAJOR POINTS**

1. In this dialogue, ALL the preceding suppositions, cognitive questions, CPs, TSs finally boiled down to this major issue, a major issue with its essence stated in a PL.

2. PLs are the root source of the numberless yet less precise NEC leaves on a mighty beanstalk.

The practitioner converted this PL to a PD which was, "I am naturally loveable." [WEAK] and then fixed it.

**MORE ON PLs**

A PL is always stated by the patient. A PL, being a TS, is always stated by the patient. Again, PLs are not used in the NEAT flow chart, not fixed, but are an emotional "reality check", which can suggest a PD, which then in turn be processed through the use of the flow chart. How can a PL suggest a PD?

In a PL example, a patient may non-consciously "believe" he is stupid. Why?

He may have had an NEC formation event in which he neglected to shut the door on the chicken coop, where he kept his beloved pet chickens, but which was then raided by the fox.

His precious pet chickens died. In his despair (grief, crying, dogmatically positioned, etc.) and distress, he may have unconsciously "concluded" or formulated a "rational" explanation – "I am stupid." For him, this is an unconscious and self legislated Personal Law.

The emotional pain caused by his "stupidity" – thereafter it seems, stupidity was to be avoided at all costs. This same patient may, in fact, have attained high intellectual achievements (again driven by his desire to avoid the emotional pain engendered by the concept of stupidity – and not EVER wanting to be "stupid" again). He may have much empirical evidence (degrees and awards of all sorts – "proving") that he is, in fact, intelligent.

Nonetheless he will (kicking and screaming - to avoid) live by the unconscious PL of, "I am stupid.", and indeed, sooner or later (by the repetition compulsion mechanism) he will do something which is subjectively stupid.

He attends a conference of his peers in San Francisco. In obsessively concentrating on the speech he is about to give to his peers (and wanting to appear intelligent – certainly NOT stupid at any cost) he may forget to put the parking brake on his rented automobile when parking on the steep streets of that city. The breakaway vehicle may have caused bodily injury to others attending the conference.

He may present himself to an NET practitioner years later in order to get relief from his unremitting chest pain. The practitioner may eventually find an NEC related to the lung/diaphragm. At age 43 (the conference incident) and then, originally, at age 8 (the chicken coop).

Instead of fixing the grief related NEC, the advanced practitioner may elect to see if there is a deep or profound PL involved. Using CPs and TSs he may eventually find his Personal Law "I am stupid." After uncovering the PL, the practitioner may well choose therapeutically to use a PD, such as "I am OK with being stupid." – within the grammar flow chart.

# REVIEW OF THE CLASSIFICATIONS OF SUPPOSITIONS

Again, Verbal Suppositions are divided into groups of words meeting certain defined parameters, which are presented by the practitioner, or the patient, as the case may dictate, for evaluation by the patient's emotional appraisal system.

**The main Verbal Suppositions are:**

- Concept Phrase **(CP)**
- Personal Declarative **(PD)**
- Test Statement **(TS)**
  and a heavily condensed version of the TS, the
- Personal Law **(PL)**

**What are the Specific Functions of these various Classifications?**

| | |
|---|---|
| Sentences that originally help FIND an NEC. | PDs |
| Words or sentences that PROBE the boundaries of an NEC issue. | CP, TS |
| Words or sentences that VALIDATE the boundaries of an NEC issue. | TS |
| Words or sentences that VERIFY the foundations of a belief system. | TS |
| Sentences that CLARIFY the result of a belief system assumed, Adopted and lived by the patient as fundamentally true. | PL |
| Groups of sentences that BUILD a rational case within a Non-rational NEC issue. | TS |
| These can then be used to CONDENSE a summarized, Yet essence-bearing case sentence. | PL |
| Words or sentences that CONFIRM successful intervention Of an NEC issue. | PDs, TSs & PLs |

# PRINCIPLES AND EXAMPLES

## Categorized by Muscle Strength from Within the Hypothetical Dialogue

As you can see from the Hypothetical Dialogue, various types of suppositions were used. The following are extended principles of the "What Muscles Do" section (in the NET Basic Book).

For clarity, listed below are some principles and examples of Verbal Suppositions based on two different criteria.

1. The resultant muscle strength found using various verbal suppositions (and in reverse)

2. The verbal supposition type and the muscle result found

Perhaps the most common question encountered from new NET practitioners (outside of the "yes" and "no" flawed paradigm) is, "When is the muscle supposed to be strong and when is it supposed to be weak?" The practitioner is finding both weak and strong muscles, but is unsure how to interpret what either means at particular junctions within the NET process.

Below are examples. The examples relate only in context to the above hypothetical dialogue and in the context of that dialogue. Please refer back to the dialogue so that you can be sure you understand these verbal supposition mechanics.

**STRONG:**

Muscles remain facilitated (STRONG) if they:

1. Encounter emotional congruence (as in a PD) spoken by the patient
Example of a negative PD: "I am a woman." -see line 2

2. Encounter a phrase spoken by the practitioner (in context after entering the NEC material) which does NOT relate to their NEC Material (as in a strong-testing CP)
Example of a strong-testing CP: "The concept of something to do with work." -see line 19. This is known (in this case NOT) as being "hot on the trail." See the NET Basic Manual.

3. Encounter a statement spoken by the patient (in context after entering the NEC material) which is congruent with their emotional reality or "ER" (as in a strong-testing TS or PL).
Example of a strong-testing TS: "I want to get very sick." -see line 10
Example of a strong-testing PL: "I am naturally unlovable." -see line 46

**WEAK:**

Muscles inhibit (WEAKEN) if they:

1. Encounter emotional incongruence (as in a positive PD) spoken by the patient
Example of a positive PD: "I want to get well." -see line 6

2. Encounter a "hot" issue which embodies emotional incongruence (as in a weak-testing CP) spoken by the practitioner .
Example of a weak-testing CP: "The concept of something to do with your husband." -see line 22

3. Encounter an issue which embodies emotional incongruence (as in a weak-testing TS) with their ER when spoken by the patient .
Example of a weak-testing TS: "I want to get so sick I actually die." -see line 14

# PRINCIPLES AND EXAMPLES

## Categorized by Verbal Supposition Type Within the Hypothetical Dialogue

For clarity, and still using the examples in the hypothetical dialogue above, let's review what we have just learned, but this time by categorizing by the type of verbal supposition instead of by muscle strength or weakness:

**PDs**

PDs muscle test as STRONG if the PD:
contains emotional congruence (as in a negative PD) spoken by the patient

Example of a negative PD: "I am a woman." -see line 2

PDs muscle test as WEAK if the PD:
contains emotional incongruence (as in a positive PD) spoken by the patient

Example of a positive PD: "I want to get well." -see line 6

**CPs**

CPs muscle test as STRONG if the CP:
contains a phrase spoken by the practitioner which does NOT relate to their NEC material (this is a strong-testing CP)
Example of a strong-testing CP: "The concept of something to do with work." -see line 19

CPs muscle test as WEAK if the CP:
contains a "hot" issue which embodies emotional incongruence (as in a positive CP) spoken by the practitioner
Example of a weak-testing CP: "The concept of it having something to do with your husband." -see line 22

**TSs**

TSs muscle test as STRONG if the TS:
contains a statement spoken by them which is congruent with their ER (as in a strong-testing TS or PL).

Example of a strong-testing TS: "I want to get very sick."
-see line 10

Example of a strong-testing PL: "I am naturally unlovable."

TS muscle test as WEAK if the TS:
contains an issue which embodies emotional incongruence (as in a weak-testing TS) with their ER when spoken by the patient

Example of a weak-testing TS: "I want to get so sick I actually die."
-see line 14

**MAKING THE DISTINCTIONS EASY**

It is worth noting that essentially the same semantic individual elements will test differently under different circumstances, and in different contexts. Water (at the equator) tests warm. Water (at the Bering Strait) tests cold. When someone tickles you it is different than when you tickle yourself.

Try to follow along for now with possibly unfamiliar terms, which will be fully defined later. Or please feel free to read ahead for their explanation now.

Distinguishing between the responses of the TS and CP:

Note in lines 29 and 31 below the similar semantic elemental contents ("sick" and "loved") and the opposite semantic response (first WEAK then STRONG).

29. Practitioner: The concept of you being sick as the only way you can feel loved. CP WEAK

30. Practitioner: Say this, "The only way I can feel loved is to be sick".

31. Patient: The only way I can feel loved is to be sick. TS STRONG

The elements of SICK and LOVED are present in both lines 29 and 30. Yet lines 29 and 30 have opposite semantic response muscle tests.

Let's elucidate – again using these same examples:

29. Practitioner: The concept of you being sick as the only way you can
feel loved. CP WEAK

In line 29 the practitioner advanced the concept to the patient – of only feeling loved if she was sick.

I present here a more material analogous example: This would be like presenting a rubber snake to a snake phobic person. Result – WEAK.

In line 29, the practitioner did not present anything physical prop like a rubber snake, only a semantic concept. That of only feeling love under a certain condition - and he presented it in a Concept Phrase.

**IT'S ALL ABOUT RELATIONSHIPS.**

To the snake phobic patient he could have said "The concept of a snake on your lap." Same result - WEAK. The relationship of a snake on her lap is a relationship she is not congruent with.

30. Practitioner: Say this, "The only way I can feel loved is to be sick".
In line 30 the practitioner asks the patient to state this concept as a sentence, a TS (not a PD because this is something she does not want to be true). In addition, the practitioner's purpose here is to probe boundaries, the function of a TS. In line 31, the patient carries out his request.

31. Patient: The only way I can feel loved is to be sick. TS STRONG
In line 31 the patient states that "The only way I can feel loved is to be sick." In this case she is emotionally congruent with her test statement. Result –STRONG

This would be like a snake phobic person stating, "I am afraid of that snake". She is emotionally congruent with that statement. By making the statement she brings herself and her feelings (afraid) into a different relationship with the snake than the relationship in line 29. By the use of the words "I am" and "afraid", she has constructed a relationship of her, her feelings and the snake, which supports and is congruent with her emotional reality.

That is why it matters who says what.

Thus we can easily distinguish between a CP and a TS, even if the semantic elemental contents (words) are the same.

**Comparing two TSs with different muscle test results:**

Lets look to another sequence later in the dialogue, this time comparing two TSs with different muscle test results:

50. Patient: I can be naturally lovable. TS WEAK

31. Patient: The only way I can feel loved is to be sick. TS STRONG

In line 50, the patient is not emotionally congruent with this test statement. This would be like our snake phobic patient stating, "I like snakes." – she would not be congruent.

In line 31, the patient is emotionally congruent with this test statement. This would be like our snake phobic patient stating, "I only like to be far away from snakes." – she would be congruent.

**Making a distinction between a TS and a similar PD:**

Now lets make another distinction. This time, between three similar sentences from our dialogue, two being TSs and one being a PD.

50. Patient: I can be naturally lovable. TS WEAK

51. Practitioner: Say this, "I am naturally lovable."

52. Patient: I am naturally lovable. TS WEAK

53. Practitioner: Hmmm. Lets check that again. Say this again, "I am naturally lovable."

54. Patient: I am naturally lovable. PD WEAK

55. Practitioner: [Does the NET procedure and follows up with . . .]

Lines 50, 52 and 54 look very similar don't they? In fact 52 and 54 are exact.
Why are Line 50 and Line 52 both classified as TSs? And yet the identical sentence in line 54 classified as a PD?

For clarity, I'll present these lines again with explanations. Again:

50. Patient: I can be naturally lovable. TS WEAK
This line could have become a PD - IF the practitioner choose to use it for the poising process, run the flow chart on it. But he didn't. He choose to use this sentence as a boundary-seeking tool, thus it is termed a TS. It's about intention – probing boundaries or gaining entrance on an NEC.

51. Practitioner: Say this, "I am naturally lovable."

52. Patient: I am naturally lovable. TS WEAK
In this line the patient states a slightly different sentence. The practitioner chose to use "am" instead of "can" - still seeking boundaries, thus a TS.

Again this line could have become a PD - and actually in line 53, the practitioner is thinking this may very well be a bottom line for this patient. In fact he uses it in line 54.

53. Practitioner: Hmmm. Let's check that again. Say this again, "I am naturally lovable."

As he starts to double check his muscle test, the practitioner is musing as to whether this sentence feels bottom line enough to use it as a PD and if so to run the flow chart.
54. Patient: I am naturally lovable. PD WEAK
In this line the patient states the exact sentence of line 52 with the same result WEAK. What is the difference. In 52, he was still searching for boundaries. In 53, The practitioner chose to do a double check on the muscle weakness and decided to poise the patient using that sentence and by that choice, and by virtue of the fact it now meets all the criteria of a PD, it then became a PD in line 54. And he follows up . . .

55. Practitioner: [Does the NET procedure and follows up with . . .]

Thus, some TSs can become PDs. But not all. Here in line 12 is an example of a TS which cannot become a PD.

12. Patient: I want to get deathly sick. TS STRONG - congruent.
It can not become a PD because she does not believe it to be true or want it to be true.

**ANOTHER PD & TS COMPARISON**
When using PDs we are comparing a first found intellectual conception with the emotional state. When using TS, we are comparing a first found emotional state with various intellectual conceptions.

When using PDs, the patient has already defined for himself, and is intellectually integral with, a certain concept. "I am OK with being rich." Here he can verbalize to the practitioner what it is he wants to be true or believes to be true. We use TS only after we have some idea of what the general propensity of the emotional state is.

**Establishing Emotional Reality Perimeters Using Test Statements**
To repeat, when using TS, we are comparing first the emotional state with various intellectual conceptions. However, unlike knowing the well-defined intellectual conception when using PDs, we only know the general directional propensity or inclination of the emotional issue at hand. What we do not know is to what extent the boundaries of the emotional state or ER pervades the subconscious ideation and behavior of the patient. However using the tool of TSs (and CPs), we can find out. For example:

6. Patient: I want to get well. PD WEAK
The practitioner now finds the patient has some aberrant emotional boundary limiting her from getting to wellness. He now compares - using a TS -how this emotionality lines up with various intellectual concepts of boundary in line 7.

7. Practitioner: Please say, "I want to stay sick."

8. Patient: I want to stay sick. TS STRONG - congruent.
The practitioner now finds the patient has some emotional congruency within the boundary of staying sick.

Later in line 12 he is still pressing the boundary . . .
12. Patient: I want to get deathly sick. TS STRONG - congruent.
The practitioner now finds the patient has some emotional congruency within the boundary of getting deathly sick.

Later in line 14 he is still pressing the boundary ever outward . . .
14. Patient: I want to get so sick I actually die. TS WEAK
The practitioner now finds the patient has some emotional congruency at least up to the boundary of getting deathly sick, but that boundary does not exceed death.

# BUILDING A CASE

Building a Case is one of the most valuable topics discussed here, yet requires the least explanation. Building a Case has at least three products.

• It provides another opportunity to double-check your muscle test.
• It provides a rationale for your correction.
• It provides a model which is common to the practitioner and the patient at the same time which engenders affinity which builds rapport.

Building a case is similar to building molecules. In the construction of molecules, especially the complex molecules, our construction materials are first intellectual realities. They are made up of individually tested and poised PDs.

In Building a Case, our construction materials are first made up of tested Emotional Realities. We are constructing first out of emotional reality versus out of intellectual reality. As a brief review on how we construct molecules here is a modified section from your NET Basic Book.

"I'm OK with marrying a woman. A PD
"I'm OK with marrying a woman with a terrific figure." A PD Molecule
"I'm OK with her losing a breast through mutilating surgery." A PD
"I'm OK with marrying a woman with a terrific figure AND her losing a breast through mutilating surgery." A PD Molecule

"I'm OK with becoming rich." A PD
"I'm OK with possibly losing it all and becoming poor." A PD
"I'm OK with becoming rich" AND possibly losing it all and becoming poor." A PD Molecule

Building a compound molecule from these Poised PDs would look like this:
"I'm OK with becoming rich" AND possibly losing it all and becoming poor AND marrying a woman with a terrific figure AND her losing a breast through mutilating surgery."

This type of molecule is, "Less common, less applicable, more bulky, but we must mention, and only rarely recommended . . ." Thus, molecules such as the one in the above example are, in truth, used very little. It's a bulky mouthful isn't it?
On the other hand, Building a Case is easy, less cumbersome and more -- much more – widely used.

We Build A Case from TSs and CPs. If you refer to the lines above line 47 in our hypothetical dialogue, you will see the various components of line 47 being gathered together by the practitioner.

47. Practitioner: Say this, "I am naturally unlovable, so I want to get and stay sick so I can then become lovable because I want to feel love more than I want to be healthy."

48. Patient: I am naturally unlovable, so I want to get and stay sick so I can then become lovable because I want to feel love more than I want to be healthy. So therefore I want to be sick.
Building a case - TSs STRONG

In the end the practitioner and the patient are in harmony with this new construct. In reality, the new construct still falls short of being THE new "string theory" of the patient's emotional life. Picture a big tree and looking at a tiny clump of twigs on one of its many branches. The patient is not an artichoke, but a tree of artichokes.

# PERSONAL LAW RULES

Personal Law Rules (being a sub category of TSs) generally (one exception) follow all the rules of other TSs and are repeated here for convenience:

**All TSs (including PLs) are:**

1. Only to be done on a patient who is fairly comfortable with the NEAT process, has rapport with the practitioner, and is specifically informed about this process.

2. Exclusively exploratory in nature.

3. Positively formed whole sentences, i.e., "I want to be in pain.", versus "I don't want to feel good." Or the phrase, "concept of pain.

4. Simplistic and most often deliberately and carefully premeditated by the practitioner.

5. At least tangentially related to the obvious issue at hand. For example, if the issue is health, the best TSs will be led by that issue. To illustrate, a sick patient may be asked to say the TS, "I want to prove my practitioner is going to fail with me.", versus "I want to be an ostrich" (a subject lacking any integrity with the issue at hand.)

**TSs may:**

1. Often be irrational.
2. carry content which the patient subjectively thinks to be untrue or would like to be untrue. For example, a practitioner may ask a patient may say, "I want to be sick.", versus "I want to be healthy." (a condition they actually seek or want to be true).
3. never poised or fixed
4. often suggest new CPs and eventually new PDs, and even PLs (which are discussed below). This is the exception.

The Exception – TS rule 9 which states: "TSs may often suggest new CPs and eventually new PDs." It will suggest a PD, but not a new CP. Why?

Because PLs are a bottom line product, and all the CP suggesting for this PL has been done. Thus, PLs will not generate an interest in doing new CPs, but rather, CPs may well have been used to find the PL. However, PLs will generate a suggestion for a PD. Example: The PL, "I'm no good.", may spontaneously suggest the ion PD of "I'm good."

# DEATHLY VERBAL SUPPOSITIONS (DVSs)
## DO NOT USE—For clarification purposes only

This term is used here simply and only to make a distinction between properly and improperly formed suppositions. The reason for delineating and elucidating these differences, is because of the overabundance of practitioners misunderstanding the mechanics of the above suppositions. Deathly – refers not to the patient, but rather to the practitioner's choice of words.

First consider a conspicuous DVS example: "I can eat a school bus every day." Ridiculous isn't it?

A DVS is a corruption of both a Test Statement and a Personal Declarative. It is a sentence is used without any contextual rational belief or emotional reality plausibility, thus without a context of integrity. It is not tangentially related to anything. Thus a DVS is not a TS or any other form of viable Verbal Supposition at all – it is a perversion, a distortion.

By knowing a statement to lack rational integrity and considering, but rejecting, emotional reality plausibility, non-integrity and to nonetheless request a patient to make this kind of statement, is ludicrous, as would be to ask a patient to fill a sieve with water.

An example: Consider a patient who does not believe they are a purple horse (has not dreamed they were a purple horse, were not upset when told they were a purple horse, etc.) or otherwise has no plausible reason or affect to suspect they are a purple horse. A DVS could then ask of them to say "I'm a purple horse."

**NO INTEGRITY**
Another example would be having a patient say a similar sentence to the following for testing, "My ligamentum denticulatum wants to be adjusted to, the left."

Note that this is a sentence that is used without any contextual rational belief and the patient in this case has NEVER heard of "ligamentum denticulatum" thus it is impossible for them to have a "contextual rational belief" or "emotional reality plausibility". There is no semantic relevance. Thus it is without a context of integrity.

Remember, muscles test weak in those instances in which there is a non-congruency between rationality and emotionality. In the ludicrous "ligamentum" test just described, the patient has no rational or emotional reference point. Having neither, it is impossible to have congruency OR non-congruency. As certified practitioners, you need to be able to be able to discriminate and elucidate the difference between a DVS and, for example, a PD, if challenged by a muscle testing skeptic.

Since the cerebral cortex does not know what the ligamentum denticulatum is, it cannot have an emotional non congruency (or congruency) with the concept. And even if it did know what a ligamentum denticulatum was, it doesn't intimately know (has not seen, felt, touched, etc.) it's own unique ligamentum denticulatum. And even if it knew it's own unique ligamentum denticulatum, the cortex is asked to make an intellectual judgement as to what direction it should move. And then that decision would be presented to the patient's emotional reality to test for ONLY emotional congruence – not an answer - and NOT the Absolute authoritative answer of the high and omniscient Absolute who alone knows all.

Thus the DVS is not tangentially related. Thus it is not a TS. It is a corruption, a perversion of any kind of Verbal Supposition. While the muscle may very well test weak, it will be because of the context of the testing being done, not the subject matter of the test. The naive practitioner may

well believe a weak (or strong) muscle indicates a "yes" or "no" rather than demonstrates a congruency or non-congruency. This naivete poses much deathly peril for all. Experimentally, it has been interesting to note that the subject may well test weak to ridiculous statements and if followed through with the normal NEAT procedure, it will be found that they have some emotion relating to their own break with their own integrity, often being angry or vulnerable for having even consented to such a ridiculous test.

Also note again for clarity, the corrupted or false "purple horse" statement example is an entirely different supposition than the PD, "I'm OK with being a purple horse.", which might be used if in an extremely rare case in which there was some rational or emotional plausibility (a dream, a bizarre insult, an assigned acting role, etc.) context. In this case it would be "tangentially related."

**The DVS RULES**

DVS are characterized by:

1. the absence of both rational and emotional plausibility
2. causing the test to be non-integral or not being tangentially related
3. irrelevant and subversive of Verbal Supposition viability

A higher technology requires an expanded vocabulary. By participating in this higher vocabulary you are contributing to the preservation of the technology.

# QUICK LOOK TABLE

| | PDs | CPs | TSs | PLs | DVs |
|---|---|---|---|---|---|
| Always a diagnostic aid | yes | yes | yes | yes | no |
| Always an intention to test the Perimeter of a patient's ER | no | yes | yes | yes | no |
| Can be used to test the perimeter Of a patient's ER | yes | yes | yes | yes | no |
| Always used when poising | yes | no | no | no | no |
| Always desired congruency | yes | no | no | no | no |
| Always believes to be true | yes | no | no | no | no |
| Always wants to be true | yes | no | no | no | no |
| Always rational statements | yes | no | no | no | no |
| Always verbalized by the patient | yes | no | yes | yes | no |
| Always complete sentences | yes | no | yes | yes | no |
| Always verbalized by the practitioner | no | yes | no | no | no |
| Exclusively exploratory in nature | no | yes | yes | no | no |

# POLISH THE APPLE (PTA)

PTA is a procedure that is technically a variation of Surround The Dragon (STD). Unlike STD, which is primarily an exploratory procedure, PTA is primarily a confirmatory procedure used to strengthen and validate the patient's new neuro-physiological state. After STD, the practitioner may round out and finish the office visit with PTA.

Purposes of PTA:

1. primarily confirmatory
2. secondarily exploratory

**1. Confirmatory**
Because the patient's body is the ultimate biofeedback unit, the patient subjectively feels and notes the muscle's facilitation in a confirmatory way to all PDs that are congruent within his or her nervous system. PTA PDs are purposeful and slight (or enormous) **exaggerations**. of the probable.

**2. Exploratory**
the aspects of any NEC are theoretically infinite in number. Thus, no matter how confident the practitioner or patient is about the new status of the nervous system, there is always the possibility of a lurking NEC ready to spoil the soup.

**Practical example: Patient can't lose weight.**
Candidate PDs might include: *"I'm OK with my weight the way it is, " "I'm OK with losing weight (looking sexy, being attractive, having less protection, etc.)."*

**STD** PDs may include: *"I'm OK with my weight the way it is," "I'm OK with feeling thinner than my sister," or "I'm OK with needing to buy a new wardrobe."*

**PTA** PDs may include (slight or enormous exaggerations of the probable): *"I'm OK with having the trimmest figure in the whole office building," "I'm OK with having the trimmest figure in the county," "I'm OK being interviewed by The New Yorker magazine about my incredible weight loss," "I'm OK with strangers turning their heads in the street in wild admiration or me," or "I'm OK with admiring myself in the mirror for hours."*

If you happen to hit (find positive) one of the PTA PDs, simply reduce it to a a higher level of abstraction and correct in the usual way. Example: *"I'm OK with having the trimmest figure in the office."* Reduce to *"I'm OK with being trimmer that one of my office peers."* If positive, test to see if it is any one particular peer: *"I'm OK with being trimmer than Bob (Doris, Lynn, etc.)."* If you find, for example, the original conditioning event concerned a high school rival, correct the NEC, then STD. Then PTA again with something like, *"I'm OK having thousands of rivals who may dislike me being thinner than they are."*

At this pint, the patient will often fully get into the mood and self-suggest some PTA PDs, which, while lighthearted, contain some realistically relevant subject matter: *Doc, let's try, "I'm OK with my spouse bragging on my figure to his friends in public places."*

**The patient's candidate PDs are always the best candidate PDs.**

# MOST BASIC ASSUMPTIONS (MBA)

Most Basic Assumptions (MBA) often lead to otherwise generally accepted premises. Invalid premises lead most generally to erroneous conclusions.

Just because the rational mind holds something to be true, it does not necessarily follow that the emotional reality (sub cortical) is likewise holding it to be true.

Example: "I'm OK being a male." This may test positive (weak) on even a very masculinized adult male. It may turn out that his parents always wanted a girl at the time he was born, or even thereafter. He may have felt vulnerable or even unloved as a male. He, as an adult, has absolutely no thought at all about being a male—in fact, it is totally accepted if you were to ask him.

One example of MBA is the story of a strikingly attractive young lady, who was distressed over a botched haircut she had just received. Her shoulder muscles were in spasm and she was in pain. After testing for and fixing many NECs associated with her tension and getting absolutely no tangible results (getting her OK with the cosmetologist, spending the money on a poor job, the time it would take to grow her hair back, etc.), it was decided to backtrack and check all premises. It was found that she was not OK with being pretty!

Consciously, she felt being pretty was a desirable state (although she communicated that she never truly felt she was, and indeed she did spend considerable time and money in pursuit of a condition of beauty).

The original event was a story about being attractive to her stepfather at a young age and a subsequent molestation. She apparently found, on an emotional level, that it was not good to be attractive. After correcting her NEC, her musculoskeletal condition improved.

It helps in doing NET to assume nothing. Especially do not assume that the "emotional mind" is logical. Often, the more basic the assumption (that tests weak), the bigger the result (after correcting the NEC).

# SOME UNFINISHED BUSINESS (SUB)

SUBs are merely conscious or subconscious memories of past events that have a cathexis[1] (NEC) attached and are subconsciously *expressed in conversational material.* SUBs are important because, when engaged, the neuro-homeostasis and fluid decision-making process is interrupted.

To the aware practitioner, patients/clients (or for that matter anyone) can often be observed skillfully working the related SUB material into becoming the main topic of conversation. Topic making can also take place in a raw form without a casual lead in, which when identifiable, makes the advent almost laughable.

SUBs are repetitive themes that are often irrelevant to whatever conversation the person is having. SUBs appear in casual conversations without any discernible stimulation on the part of the casually listening second party.

Examples:

- The elderly acquaintance who has never been in a conversation of any length without relating how, as a youth, she was a beauty queen.

- The person who can never complete a social encounter of any length without relating how he used to make $52,000 a year as an art agent before he became an advertising man (he now makes less).

You probably have known many people who have similar tendencies.

Theoretically, there are an infinite number of subjects in existence which could be talked about. Why, then, do some people so frequently, and almost invariably, bring up in conversation a particular outdated or irrelevant ongoing topic? Muscle testing may reveal that it is because they have NEC-generated SUBs.

They are apparently subconsciously attempting to get the unfinished business finally *FINISHED* by stimulating someone else to say or do something that will at last relieve them of their cathexis.

If the NEC containing the SUB is corrected (and the Dragon Surrounded), the subconscious obsession to talk about their topic should diminish. The healthy result is the cathexis is discharged allowing the body to move closer to homeostasis. This also allows for more uncluttered decision-making ability, and, of course, an increased freedom to engage in present-time topics of conversation.

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[1] **CATHEXIS** The investment of psychic energy, or drive, in an object of any kind, such as wishes, fantasies, persons, goals, ideas, a social group, or the self (from Greek *cathexo*, "I occupy"). Such objects are said to be cathected when we attach emotional significance, or affect (positive or negative), to them. In NET all NEC.s have a cathexis, but a cathexis does not require an NEC to exist.

# GUIDELINES FOR GOOD RAPPORT
## The NET Practitioner-Patient Relationship

1. UNCONDITIONAL POSITIVE REGARD. As described by Carl Rogers, this refers to the attitude the practitioner has towards the patient. Regardless of the patient's life circumstances, bad habits, personality characteristics, or physical appearance, the practitioner should always aim to maintain a loving consciousness towards the patient. When that does not occur, the practitioner-patient relationship invariably suffers. Roadblocks to having unconditional positive regard with a particular patient include: frustration with the patient's progress, transference behaviors of the patient (see Transference document), counter-transference reactions in the practitioner (see Transference document), and life-style behaviors of the patient which are highly incompatible to the practitioner's psyche. Sometimes the last category is unfixable. In such cases, the practitioner should refer the patient elsewhere.

2. RESPECT and DO NOT JUDGE the patient's views, beliefs, lifestyle choices, etc., even though they may differ from your own. This goes along with number 1, above. For example, you may have a patient who needs to work through some NECs related to a recent abortion. You may be morally opposed to abortion, but it is important not to pass judgement onto your patient.

3. HAVE NO NEEDS OF YOUR OWN. The NET session is about the patient only. It is important to work hard at putting personal needs aside, such as the need to be right, the need to be affirmed as a great healer, the need to have a particular outcome for the patient, the need to be liked or loved by the patient, etc. Also, do not be enticed to give special treatment to "V.I.P." type patients who have some position of power or authority. The tendency to do so is always subtly related to a need of your own, which ultimately is counter-productive to the treatment. Finally, do not skew the borders of your relationship with the patient to satisfy a need of your own, e.g., if you have a patient who is a stockbroker, don't ask for a stock tip. When you allow yourself to need something from the patient, it takes you out of the role of healer-helper and into the role of someone who wants something from the patient, thus, diminishing on some level the safety of the relationship.

4. Maintain NANOSECOND CONSCIOUSNESS. As defined by Walker, this is a voluntary state of mind in which the practitioner puts his/her full attention on the patient who is in front him or her in the consultation session in each instant that it occurs; a very high form of concentration and attention. Numbers 5 and 6 below enhance nanosecond consciousness.

5. MAINTAIN GOOD EYE CONTACT. Doing so will engender a sense that you want to listen and care about what is being said. Try not to page through notes and charts or watch the clock too much.

6. LISTEN, LISTEN, LISTEN. It is important to have a good feel of the Patient's Own Words (POW) to describe the feelings and events that surround a particular NEC. This will help you in effectively poising the NEC.

7. MAINTAIN A SAFE HOLDING ENVIRONMENT. The consultation room should be as free as possible from distractions, disruptions, and interruptions.

8. REMIND THE PATIENT OF HIS/HER STRENGTHS. Even though there might be numerous NEC's to work through, associated with all kinds of trauma and disappointments, the fact is that the patient had the internal strength and fortitude to make it to the present point in life, as well as has the good sense to sit there with you and try to work things out. To point out the person's strengths can be very empowering to the patient. Let the person know how brave he or she has been and continues to be.

9. EMPATHIC COMMUNICATION. Acknowledge and appreciate how difficult it can be to broach sensitive, highly charged experiences.

10. As healing arts professionals, it serves us well to maintain an internal feeling of gratitude that someone has honored us by entrusting us with his or her internal world.

# PDs TO ENHANCE RAPPORT AND THE THERAPEUTIC RELATIONSHIP

"I'm OK with patients/clients who _______ (insert the behaviors that really get under your skin)."

"I'm OK with patients/clients who react angrily towards me."

"I'm OK with patients/clients who react lovingly towards me."

"I'm OK with having a loving attitude towards my patients (you might want to use specific names)."

"I'm OK with patients/clients progressing at their own rate."

"I'm OK with patients/clients progressing at their own rate, even if I would prefer it to be quicker."

"I'm OK with patients/clients getting better quicker than I anticipated."

"I'm OK with being wrong."

"I'm OK with my patient's/client's needs coming before my own."

"I'm OK setting appropriate boundaries with patients/clients."

"I'm OK with setting the boundary of_____ (insert the ones you sometimes have a problem with).

# SIGNIFICANT EMOTIONAL EVENTS (SEE)

The formation of NECs is especially vulnerable at times of transition. Remember that emotions are evoked when there is an interruption of what a person perceives as happening or what they infer to be an ongoing process.

Some of these more common times are:

**Mother's environmental history at conception and pregnancy**

**Birth history**

**Birth of siblings**

**Toilet training**

**Baby-sitters**

**Perceived abandonment**

**Death of a pet**

**1st year of school**

**Significant teachers**

**Jr. High transition**

**Peer relationships in Jr. High**

**Onset of puberty**

**Onset of sexual relationships**

**Fights**

**Romances**

**High School**

**Peer acceptance in High School**

**Illnesses, accidents, operations, etc.**

**Parental conflict/separation/divorce**

**Graduation High School and College**

**Abortions**

**Any betrayal**

**First indifference to life/suicide contemplation /attempts**

**Moving**

**Attending college**

**Financial disruptions**

**Any romantic failure**

**Any job failure**

**Malpractice lawsuit threat**

**Illness of loved one**

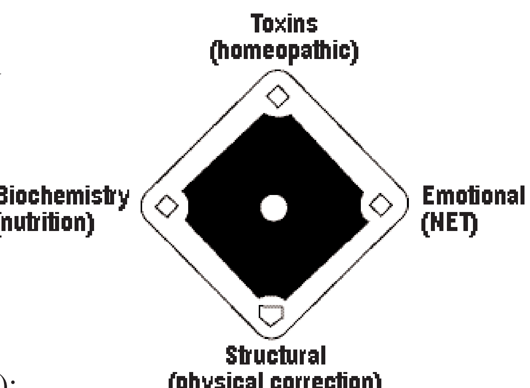
**Learning of a morbid diagnosis**

**Death or illness of a loved one**

Remember that emotion is evoked during any (perceived) interruption of what is happening or expected to happen. The above are, of course, common transition times. If emotion is evoked when the mind/body is in a condition of lowered resistance, NECs may well develop. These very common transition times are only guidelines of which the accomplished practitioner will be aware when indexing for NECs.

# TOO MANY NECs

Evaluate for the following conditions listed below when you have a patient who seems to be having an abnormally high number of NECs — especially of recent origin.




Patients can be predisposed by the Toxic, Biochemical, and Structural sides of the Home Run Formula.

In their approximate order of occurrence (incomplete listing):

**Histamine formation ...................** Allergy or food (or chemical, enviromental) sensitivity. Evaluate and fix in your usual way, eliminate food sensitivities, consider Antronex by Standard Process and/or NET Remedies #8 Allergy.

**Low blood sugar...........................** Evaluate and fix in your usual way. Consider Cataplex B and Paraplex by Standard Process and/or NET Remedies #4 Wood and #1 Earth.

↑

**Vitamin B deficiency....................** Evaluate and fix in your usual way. Consider Cataplex B by Standard Process. Silicon (via oat straw tea) has also been sccessfully used as a catalyst for B uptake in difficult cases and/or NET Remedies #1 Earth.

**Thyroid dysfunction.....................** Evaluate and fix in your usual way. Consider Simplex F and Livaplex by Standard Process and/or NET Remedies #5 Fire and #4 Wood.

↑

**Trace mineral deficiency..............** Evaluate and fix in your usual way. Consider Allorganic Trace Minerals - B12 by Standard Process and/or NET Remedies # 1 Earth.

↑ ↓

**Hypoclohydria (low HCL)..........** Evaluate and fix in your usual way. Consider Betaine HCL by Standard Process and/or NET Remedies #1 Earth (stomach).

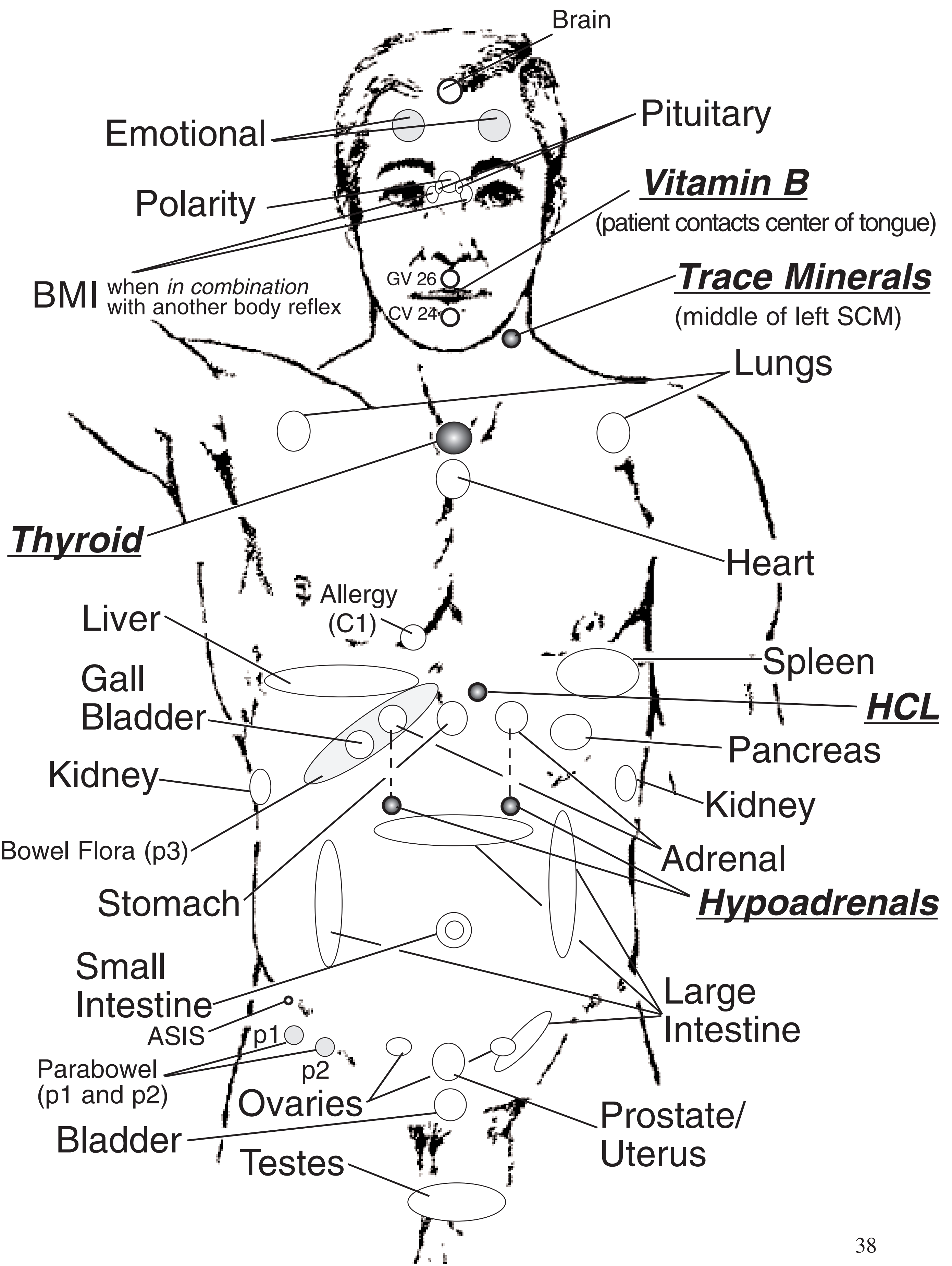
**↑'s = direct influence on another factor**

On the Structural Side of the Home Run Formula, the cause may be some variation of dural torque. Please check:

| **Atlas** | **Axis** |
|---|---|
| **Cranial** | **Sacrum** |
| **Occiput** | **Category 1 (SOT)** |

See "Where to go for What" page in this book to order nutritional supplements, homeopathic remedies, and seminars which may help you learn more about correcting the above nutritional and structural factors which allow for "Too Many NECs."

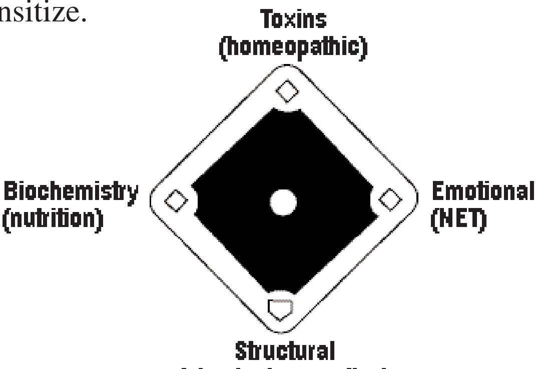
## BODY MAPs FOR "TOO MANY NECs" (see underlines)



# HOME RUN FORMULA EXAMPLES OF "TOO MANY NECs"

**For Histamine formation**, check the *Allergy Point* — If this point is continually active, practitioner needs to determine allergen and desensitize.

1st Base: If active, do NET procedure.
2nd Base: If active, test for #8 Allergy or #9 ER 911.
3rd Base: If active, test for a natural anti-histamine.
4th Base: Check C1.

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**For Low blood sugar**, check the *Hypoadrenal Points* — Test with a bilateral contact.

1st Base: If active, do NET procedure.
2nd Base: If active, test for #5 Fire or #9 ER 911.
3rd Base: If active, test for Vitamins C, Sodium, Potassium and B6.
4th Base: T7, T9 and T11.

---

**For Vitamin B deficiency**, check the *Vitamin B Point* — Have patients contact the center of their tongue to test.

1st Base: If active, do NET procedure.
2nd Base: If active, test for #8 Allergy or #9 ER 911.
3rd Base: If active, test for which Vitamin B.
4th Base: Check active point in combination with an organ MAP to find one which makes it strong.

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**For Thyroid Dysfunction**, check the *Thyroid MAP* — Three-finger contact in the episternal notch.

1st Base: If active, do NET procedure.
2nd Base: If active, test for #5 Fire and #9 ER 911.
3rd Base: If active, test for Iodine, Thyroid PMG, Copper, Vitamins C.
4th Base: C1, C4 and C7.

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**For Trace Mineral deficiency,** check the *Trace Mineral Point* —

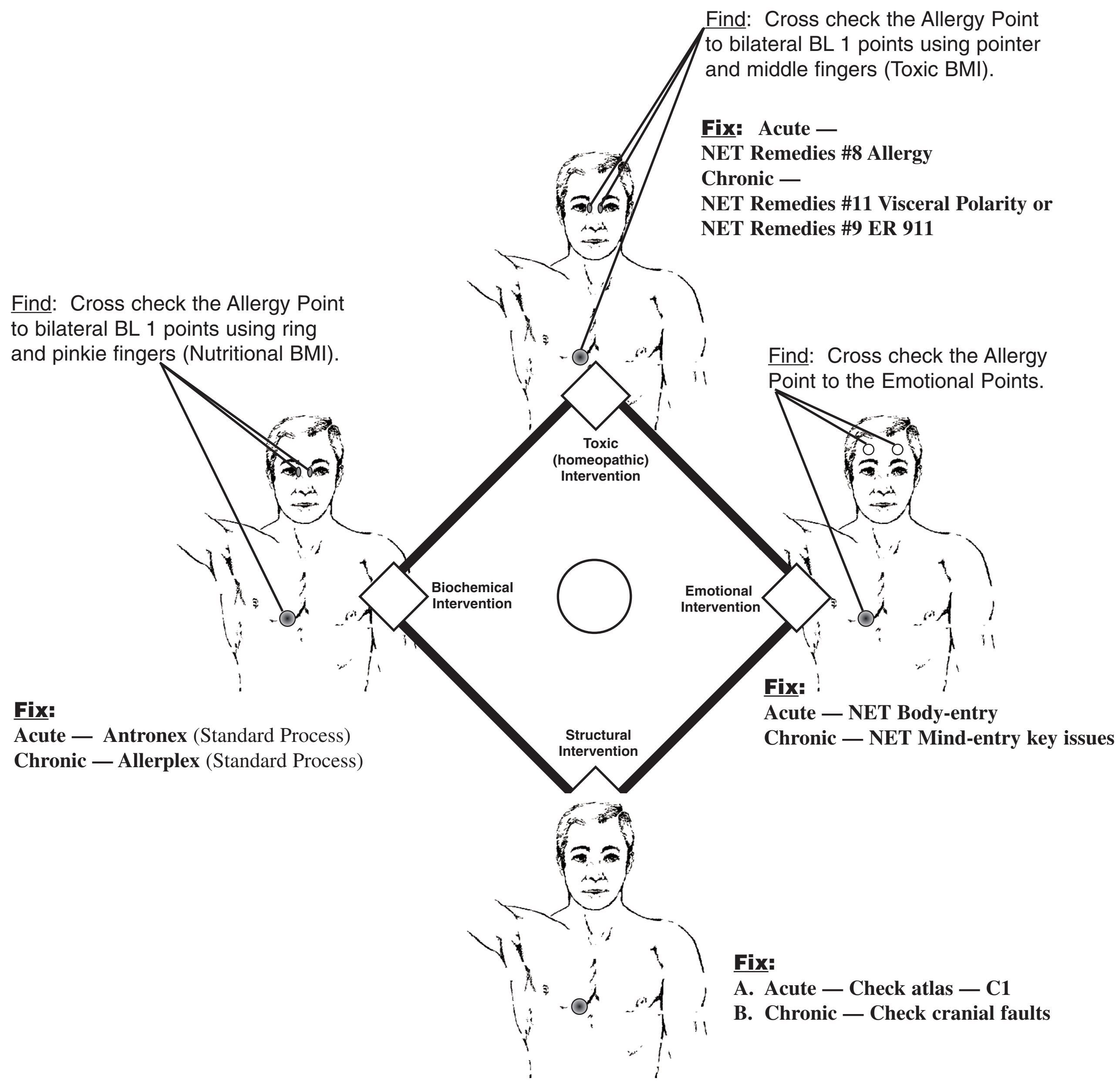
1st Base: If active, do NET procedure.
2nd Base: If active, test for #1 Earth and #2 Metal.
3rd Base: If active, test for Allorganic Trace Minerals, Calcium, Iron, Magnesium and Potassium.
4th Base: Check active point in combination with an organ MAP to find one which makes it strong.

---

**For Hypochlorhydria (low HCL),** check the *HCL Point* —

1st Base: If active, do NET procedure.
2nd Base: If active, test for #1 Earth and #9 ER 911.
3rd Base: If active, test for Betaine HCL.
4th Base: Check active point in combination with an organ MAP to find one which makes it strong.

# HOME RUN FORMULA FOR THE ACTIVE ALLERGY POINT




**NOTE —** If the Allergy Point is continually found active on subsequent office visits, it is recommended that the practitioner identify the offending allergic substance(s). Then use the Home Run Formula to desensitize the substance(s) or refer patient to a practitioner who can address this issue.

# IDENTIFYING OFFENDING ALLERGIC SUBSTANCES

## ***Identifying an allergic substance:***

**After finding an active Allergy Point, semantically test** (without touching the Allergy Point) **for the offending substance — ABCDE:**

"*Something you*: **A**te,
**B**reathed,
**C**ontacted,
**D**rank,
**E**lectromagnetic"

**Have the patient avoid the substance (if possible) that semantically tested and ask him/her to bring a sample of that item in on the next office visit so it can be physically tested.**

***Use Caution with Allergic Substances!***

***Some patients are prone to severe allergic reactions. Take a thorough history. If indicated, only use episternal notch for testing, instead of sublingual testing.*** *Also, some substances, of course, can not be placed under the tongue (such as poisonous chemical cleansers, gasoline, pet droppings, hair, etc.). These substances can be placed in a glass container or 'zip lock' bag on the episternal notch and the Home Run Formula procedure can be performed yielding excellent results.*

**CORRELATION OF APPLIED KINSIOLOGY MUSCLE TESTING FINDINGS WITH SERUM IMMUNOLOGOBIN LEVELS FOR FOOD ALLERGIES**

WALTER H. SCHMITT Jr. and GERRY LEISMAN

Abstract: the pilot study attempted to determine whether subjective muscle testing employed by Applied Kinesiology practitioners, prospectively determine whose individuals with specific hyper-allergenic responses. Seventeen subjects were found positive on Applied Kinesiology (A.K.) muscle testing screening procedures indicating food hypersensitivity (allergy) reactions. Each subject showed muscle weakening (inhibition) reactions to oral provocative testing of one or two foods for a total of 21 positive food reactions. Tests for a hypersensitivity reaction of the serum were performed using both a radio-allergosorbent test (RAST) and immune complex test for IgE and IgG against all 21 of the foods that tested positive with A.K. muscle screening procedures. These serum tests confirmed 19 of the 21 food allergies (90.5%) suspected based on the applied kinesiology screening procedures. This pilot study offers a basis to examine further a means by which to predict the clinical utility of a given substance for a given patient, based on the patterns of neuromuscular response elicited from the patient, representing a conceptual expansion of the standard neurological examination process.

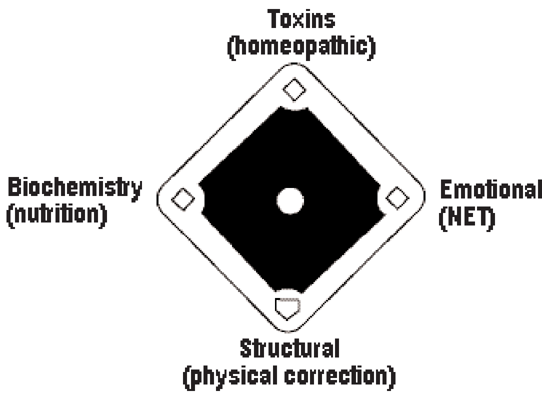
Keywords: Applied Kinesiology; muscle testing; allergies; hypersensitivity; provocative testing; IgE; IgG; immune complexes; functional and neurological assessment.

# HOME RUN FORMULA FOR ALLERGIC SUBSTANCE

***Use Caution with Allergic Substances!***

***Some patients are prone to severe allergic reactions. Take a thorough history. If indicated, only use episternal notch for testing, instead of sublingual testing. Do not use oral ingestion.***

*Also, some substances, of course, can not be placed under the tongue (such as poisonous chemical cleansers, gasoline, pet droppings, hair, etc.). These substances can be placed in a glass container or 'zip lock' bag on the episternal notch and the following procedures can be performed yielding excellent results.*




***Place substance under patient's tongue or on episternal notch and check all four bases of the Home Run Formula:***

**1st Base**: Check substance in combination with emotional points. If active, run the 15 steps using the NET Body entry.

**2nd Base**: Check substance in combination with Toxic BMI. If active, test candidate remedies under the tongue: #8 Allergy, #11 Visceral Polarity, #9 ER 911, #5 Fire, etc.

**3rd Base**: Check substance in combination with Nutritional BMI. If active, test candidate nutrition under the tongue: Antronex, Allerplex, etc.

**4th Base**: Use the following Desensitization Steps*:

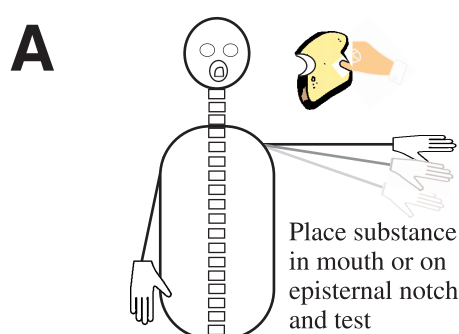
**Step A**. Place substance under patient's tongue or on patient's episternal notch and test. Patient will test weak if sensitive to the substance.

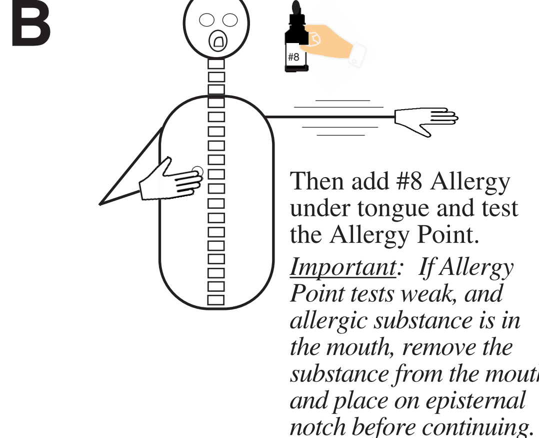
**Step B**. Add #8 Allergy under patient's tongue and test the Allergy Point.
Important note: If Allergy Point tests weak, and allergic substance is in mouth, remove the substance from the mouth and place on episternal notch before continuing.

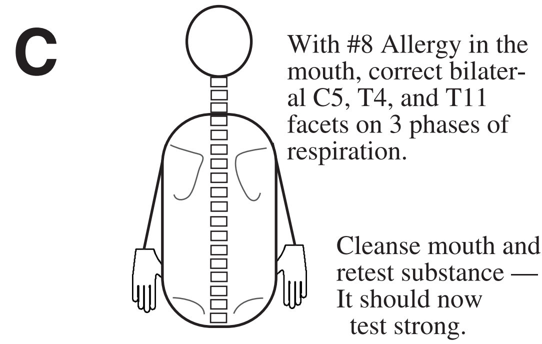
**Step C**. Correct bilateral C5-T4-T11 facets on three phases of respiration. Rinse out mouth and retest substance (it should now test strong).

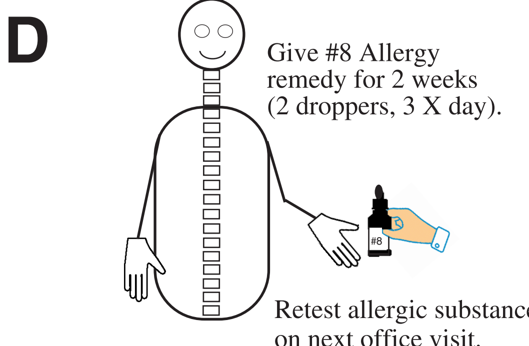
**Step D**. Recommend patient take #8 Allergy— 2 droppers, 3 X day for 2 weeks. Have patient avoid the allergic substance for 24 hours, if possible, and retest substance on next office visit.

## 4th Base Desensitization Steps*




*** The 4th Base Desensitization Steps were developed by Dr. Wayne Braddock of Arvada, CO.**

# PHYSICAL OBSERVATIONS OF THE PATIENT

The following Physical Observations of patients will often appear before, during and after the NET intervention with the Pulse correction method. These observations serve the practitioner to track and monitor the internal processing anticipate their next intervention, and otherwise stay in rapport with the patient. In their approximate order of frequency, they are:

**Before processing:**
Pupillary changes

**During Processing:**
Eyelid closure
REMS
Blushing of face
Blushing of face with irregular blanching
Respiration changes including
    Irregular diaphragmatic contracture rhythm
    Intermittent cessation of breathing (verbally encourage deep breathing)
Tears (usually best not to help dry eyes)
Lip movements and other facial expressions
Slightly involuntary body shifts and stretching, writhing
Yawning
Paling of face

**Toward end of processing:**
Diaphragm regularity
A more homogeneous complexion
REMS reduced
Other affective signs above (under "During Processing") softening

**After Processing:**
Facial features relaxed
Pulse slowing
Comfort
Movements calm and slow
Relaxation
Smiling
Sensory enhancement "Things are brighter"
Enhanced cortical responsiveness
Sense of well being
Exhaustion
Cortical "racing" to catch up with new emotional reality
Sense of increased balance

**On Post Treatment inquiry of *subjective* impression of processing phase:**
Feeling distant, "I was out there," or "I went away."
Time distortions, "How long was I 'gone'?"
Spontaneous self statements occurred such as "I'm no good."
"Ocean" sound in ears
Spontaneous, but not necessarily chronological, SnapShots of the past

# THE NECs OF LOVE

NECs of love can be categorized as follows:
- *Can't fall in love* (narcissistic or avoidant)
- *Can't stay in love* (histrionic or borderline)
- *Can't fall out of love* (dependent or masochistic)
- *Can't be loved*

This last one is to some degree inherent in all of them.

Each of these issues can manifest in different characteristic ways. If the problem is extreme, it can present as a frank personality disorder. For example, somebody with a borderline personality might display a lot of number 2 ("can't stay in love") by having numerous brief, intense relationships, which ultimately end with disappointment and a sense of betrayal (real or perceived). This repeating theme of fleeting relationships usually originates in the primary parent-child relationships. However, for the purposes of this paper, we are not focusing on persons with severe personality disorders, as such individuals require very specialized treatment. That aside, many people can relate to some element of the "NECs of love."

ACTUAL CLINICAL CASE AND RESULTS USING THIS PROCEDURE:
Betty B. is an attractive 36-year-old. business woman who owns several successful computer franchises. She is recently divorced from a man who "just adored me." She stated that her relationship with him was very good and that he was highly committed to her. However, she encountered the same problem with him that she had with others in the past, namely, it began to feel like the relationship wasn't enough. When asked to explain further, Betty basically relayed that whenever a level of stability is achieved in a relationship, then the conquest is over and she must move on to a new one. The "conquest" is not about sex for her. Rather, it is about getting someone to fall in love with her and adore her. She does feel in love with the person initially, but over time that is no longer enough and she tends to fall out of love rather quickly. The NEC in this case was about her "fall from grace" as a child when her younger brother was born. At that time, she felt like she went from being the apple of her father's eye to an insignificant entity. She spent considerable energy from that time on trying to get her father to "fall in love with her" again. Every "love" relationship became about fulfilling this need. After working through this NEC, Betty B. had an improved sense of self and new perspective on relationships.

STEP-BY-STEP:
1. Identify a patient who has relationship issues.
2. Muscle test for the NECs of love, using a personal declarative, e.g.:
    a. I'm OK with falling in love with another person
    b. I'm OK with having a long-term romantic relationship
    c. I'm OK leaving a relationship that is bad or harmful to me
    d. I'm OK with another person loving me
    e. I'm OK having needs in a relationship
3. Find the MAP for the statement that showed an inhibited muscle test.
4. Use concept phrases and test statements to probe the bounds of the NEC.
5. Try to arrive at a personal law. You will almost always find that NECs of love are about personal laws that one is UNlovable. Also, the shame emotion is often involved.
6. Poise the NEC.
7. Re-check the entry statement, then surround the dragon. Use polish-the-apple procedure when appropriate.

# TRANSFERENCE

TRANSFERENCE can be a normal facet of many types of relationships. When it is not pathological or exaggerated it can be benevolent, even helpful. For example, a long-standing patient whom you have helped through many difficult situations might have a mentor/teacher/guide type transference reaction to you. Historically, transference is a psychoanalytic term introduced by Freud to describe certain reactions to the therapist by the patient, which are based upon earlier life experiences with significant others, especially parents. This projection of earlier others onto the therapist occurs unconsciously. Transference feelings can be positive or negative. For example, the patient might unconsciously respond to the practitioner AS IF the practitioner were the cruel father, judgmental mother, punitive teacher, etc., resulting in defensive, perhaps hostile, behavior towards the practitioner. On the other hand, the patient might unconsciously view the practitioner as the early fantasized "ideal mother" who comes to the save the day, resulting in an exalted, savior-like image projected onto the practitioner.

Following the rules of rapport can minimize negative transference reactions. However, sometimes that is not enough. Occasionally, patients with certain intra-psychic disturbances will act out their unresolved conflicts (NECs) by violating the basic boundaries of a respectful relationship (e.g., not show up for appointments, use overly aggressive language towards you, etc.). It is the responsibility of the practitioner to gently insist that respectful boundaries be maintained. If you encounter patients who cannot comply with this basic principle, NET is not an appropriate intervention for them. If the practitioner has difficulty setting appropriate boundaries, the practitioner may have an unresolved NEC on that issue that needs to be worked out with a NET buddy. Some suggestions for PD's to pose are offered at the end of the "Guidelines for Good Rapport" document.

Positive transference reactions by the patient may certainly feel much better than negative ones, especially in the beginning. In fact, they are often ego boosters and can actually feel quite good. It is rather affirming to be told, "You are the best doctor in the world!" However, intense positive transference must be taken quite seriously and can be potentially more problematic in the long run than negative transference reactions if the practitioner is not sensitively aware of the dynamics behind them.

It is important to re-emphasize that transference reactions are quite common and not necessarily pathological. Everyone, to some degree, projects their past experiences with others onto present day situations. However, Healing Arts practitioners are particularly vulnerable to being the recipients of intensified transference reactions. The patient is in some way wounded (physically, mentally, emotionally, etc.) and presents to the practitioner in a weakened state and in need of help. This can trigger an unconscious reminiscence of the child-parent relationship, where the child is vulnerable and inferior to the parent and in need of the assistance and guidance of the parent.

As NET practitioners, the transference phenomenon can be further intensified by the close physical proximity and touching that is inherent in the treatment procedure. Additional intensification can occur from the magical quality of the procedure, which furthers the concept of the "all powerful" parent. It is the responsibility of the practitioner to be aware of transference phenomenon and to help the patient work through exaggerated transference reactions. Demystify NET as much as possible for the patient (which requires that the practitioner be as knowledgeable as possible about NET). Always follow cardinal rule #3 from "Guidelines for good rapport", which states, "HAVE NO NEEDS OF YOUR OWN". For example, if a practitioner subtly encourages an exaggerated positive transference because it is fulfilling the practitioner's unresolved NEC about

acknowledgment, then a disservice is being done to the patient that could ultimately lead to trouble. What happens when you fall short of being a hero, are less than perfect, or disappoint the patient in a given situation? When you fall from the pedestal that you helped to construct, the crash can be devastating for you and the patient. The result can be a severed relationship, which can be painful for the both of you; possibly a lawsuit; and most importantly, a lost opportunity to help someone who desperately needed it. Remember, your results as a practitioner can only be as good as the internal resources of your patient. You are only partly responsible when good results occur. NET healing is a partnership between you and the patient. It is important to always honor the patient's role. Acquiring a high skill level as an NET practitioner is critical, but insufficient in itself.

Kent Bennington, Ph.D., a seasoned psychologist and NET practitioner, previously outlined 5 basic points to keep in mind regarding transference and the patient-practitioner relationship, in general:

1. Bonding is a powerful, often subtle process with the underlying purpose of helping the patient become ultimately more upright and self-regulating;
2. Patients tend to see in you what they do not see in themselves;
3. The practitioner must regard positive attribution from the patient with some sense of neutrality and/or inner appreciation of the process described above;
4. The patient may be seeking more from you than having an NEC poised. In fact, the correction of NEC's, as dramatic as that often is, may very well be a minor aspect of what the patient is seeking in you as a healer. The patient may be seeking a life-affirming bond to sustain an internal developmental process.
5. Keep the interpersonal boundaries clear by being honest with yourself (and with the patient) about what you know and do not know for sure. The beauty of a procedure like NET is that it frees you from being an expert on somebody else. Your job is to apply NET to the best of your ability, not to take or even share credit for the results.

COUNTER-TRANSFERENCE. Just as patients can project their pasts onto the practitioner, characteristics of the patient also can trigger unresolved NEC issues of the practitioner. When this occurs it is called counter-transference. For example, Sally psychologist had a mother who obsessively doted over her as a child. This made young Sally feel constantly constricted and constrained. She still has some unresolved anger towards her mother for thwarting her freedom while growing up. This anger is not something she consciously thinks about. However, whenever patients with obsessional personalities come in to the office, she tends to be more irritable and less empathic towards them. Dr. Sally is having a counter-transference reaction. Since she is an introspective person and a responsible NET practitioner, she notes this behavior to her NET buddy, after realizing that several patients have triggered this reaction in her. A good place for Sally's NET buddy to start would be the PD "I'm OK with obsessional patients." The skilled NET buddy could then use concept phrases and test statements to elucidate the particular characteristics that trigger Sally, and how that makes her feel about herself.

# SOME NET DO'S AND DON'T'S

## WHEN TO DO NET

1. When there is reasonably good rapport between you and the patient.
2. After receiving permission from the patient.
3. After giving the patient a brief description of the procedure, including that it entails light touching by you, the practitioner.
4. When the patient feels safe with you, and you feel safe with the patient.
5. After verifying with the patient that he or she would actually like to be congruent with whatever personal declarative you are about to pose.
6. When the patient has the ego strength to engage in the procedure (see below).
7. When the practitioner has a level of comfort and expertise with the particular therapeutic issue at hand.
8. When the patient is physically well enough.

## WHEN NOT TO DO NET

1. When the patient is intoxicated.
2. When the patient is in a highly agitated state.
3. When the patient is actively psychotic.
4. When the practitioner is unclear about the congruency issue.
5. When the patient feels unsafe with the practitioner.
6. When the practitioner feels unsafe with the patient (e.g., when there is serious personality pathology).
7. When the therapeutic issue, NEC, etc., is/are beyond the practitioner's level of comfort or expertise.
8. When the patient feels too physically compromise to explore emotional issues.

## ARE THERE ANY GROUPS OF PEOPLE WHO WE SHOULD NOT DO NET WITH?

For a chiropractor working with someone who has a complicated psychiatric diagnosis, sessions should be very brief (less than 30 minutes), very focused with constant reminders of the concepts of congruence and emotional reality, and in consultation with the patient's primary therapist. The focus should also be about the emotional component of whatever physical issues the chiropractor is treating the patient for, and not psychotherapy-related issues. Also, please refer to the NET do's and don'ts above, which makes it clear that patients who are agitated, psychotic (which borderlines can sometimes be), or intoxicated are not candidates for NET. That document also reminds the practitioner to only do NET with problems that are within the professional qualifications and comfort level of the practitioner.

For psychotherapists, NET is a tool that can be utilized to assist and enhance the therapeutic process. Therefore, the therapist needs to use his or her professional judgement as they would for any technique they would utilize with a particular patient.

Overall, the practitioner must keep in mind that NET helps alleviate the present day effects of an unresolved event. It does not cure primary neurological degenerative disorders like schizophrenia, and it cannot create psychological sophistication or intelligence. It is a tool, and like all tools, it must be determined if it is appropriate for the given task.

# IMPORTANT WORDS TO NET PRACTITIONERS

The following editorial from the L.A. Times underscores what we have been teaching in the NET. Seminars over the last 6 years. Always be sure to instill in the patient that the only reality we claim to find is an *Emotional Reality* (ER), versus a historical reality. If you explain the ER concept clearly and ROUTINELY (courts seem to like "routinely"), and hand out the NET Patient Education brochure (which mentions ER), you may save yourself a lot of trouble later.

SUNDAY, MAY 22, 1994 LOS ANGELES TIMES

EDITORIALS of THE TIMES

## Fictitious Memories?

*Tighter regulation is needed in psychotherapy community*

The real message sent by a jury in Napa goes well beyond the $500,000 in damages it ordered two psychotherapists to pay Gary Ramona. The verdict was a ringing call for leaders of the mental health community to police their profession better, and for state legislatures nationally to enact new laws to bring more verifiability and more forensic science to the use of psychological evidence in court.

The case marked the first time that a non-patient was allowed to sue a therapist for monetary damages suffered incidentally as a result of treatment of another person. Ramona, once a $400,000-a-year winery executive, charged that the two therapists had elicited from his adult daughter false memories of his raping her as a child. After she sued him, he lost his job, his home and his marriage. The defendants were a psychiatrist and a marriage and family counselor.

The case is perhaps the most dramatic among a rising number of painful family confrontations stirred by recovered-memory techniques. Most often, the patient is a woman who enters treatment for bulimia or other psychological disorder. The therapist–employing various aggressive memory-enhancement techniques such as hypnosis, the drug sodium amytal, dream analysis and even body massages–often recovers "repressed" memories of childhood abuses, sexual and otherwise, some in great and lurid detail.

Undoubtedly, memories of childhood incest can be repressed, and thousands of people have been helped by such therapy to regain psychological balance. And undoubtedly sexual abuse of children is real and widespread. But evidence grows that many of these memories are, in effect, implanted by therapist's suggestions. They are wreaking considerable damage on families, as the jury in Napa seemed to have agreed.

The False Memory Syndrome Foundation in Philadelphia claims that 12,000 families have been disrupted by this problem. That number is difficult to verify, but clearly the psychotherapeutic community must confront the issue. In some parts of the country, public crime victims' funds are going to these "victims," leaving little for true victims.

California alone has 75,000 licensed psychotherapists, including psychiatrists, psychologists, psychiatric nurses, family counselors, social workers and others, not to mention all manner of unlicensed free-lancers. Few of them engage in recovered-memory methods. But they operate largely in privacy, without the supervision and peer review common in other professions. It is time for the California Psychological Assn., national groups, state licensing boards and other authorities to take a stronger hand in monitoring these practitioners.

The most obvious reform is to require therapist to use the same informed consent asked by doctors when they perform routine surgery, spelling out the risks and alternative therapies. The mental health professions are notoriously underregulated; state licensing boards are largely empty shells that discipline only the most egregious offenders and do little to enforce minimum standards.

Beyond that, though, the time has come for more concerted legal efforts to distinguish real from false memories. A model for national adoption comes from the Minnesota State Board of Psychology. It requires that any oral testimony or written reports by therapist include descriptions of the limitations of the techniques used and any reservations about their reliability and validity. In addition, states must re-examine the recent trend toward extending the statute of limitations on bringing charges of childhood sexual abuse from the date of alleged crime to the date of recall.

Critics of the Ramona suit say it is part of a backlash against recent legal gains made by women in punishing men who rape and abuse women as a means of domination. We agree that sexual abuse is a serious matter that deserves stern punishment by the courts. But both the courts and therapists must be careful not to find it where it does not exist, nor to ruin families on the basis of unproven and unreliable evidence.

# PROPER POSTURE GUIDELINE

Use this guideline with the NET Posture Enhancement Technique (PET). Two-thirds of the body weight should be transmitted through the calcaneus. Above that, a lateral plumb line should pass through the center of the knee. On this plumb line, directly above the knees, should be the center of the femur head. The plumb line should pass through the center of the shoulder and through the external auditory meatus. See outline below. This places the atlas in the "driver's seat." The atlas has a beautiful geometric relationship with the mandible and the TMJs. In short, proper posture (structure) expedites efficient function.

Some say that good posture is determined by the feet, and others say it is determined at the atlas or even the symphysis menti. As far as the NET Posture Procedure is concerned, it doesn't matter. The point is that we align the patients with all body parts in proper relationship, and in that new position, check the bases of the Home Run Formula . Keep this in front of you when you do PET in the workshop. Feel free to make copies of the Posture Guidelines below for each treatment room.

---

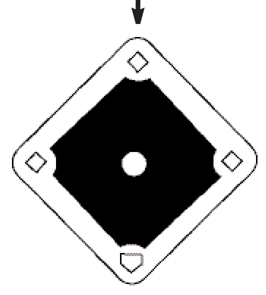
**Posture Guideline — Profile:**

- **Two-thirds of weight through the heels.**
- **Above the heels, a center line through the knees.**
- **Above the knees, a center line through the femur head.**
- **Above the femur head, a center line through the shoulder.**
- **Above the shoulder, a center line through the E.A.M. of the ear.**
- **Elbows slightly bent, with the center line just anterior to the hollow of the elbow.**

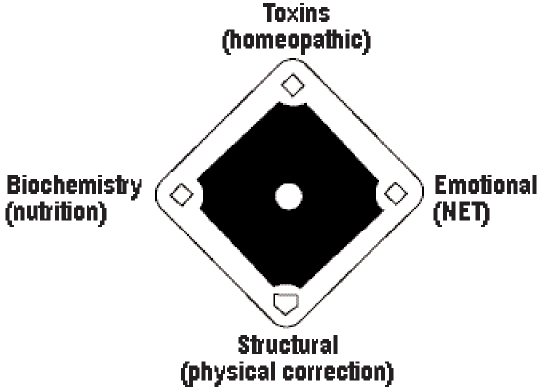
**Posture Guideline — Front-to-Back View:**

- **Toes rotated slightly lateral, 20 degrees from straight ahead.**
- **Knees straight ahead.**
- **Hips level at iliac crests.**
- **Elbows slightly bent, with hands/thumbs turned slightly in.**
- **Shoulders level.**
- **Neck parallel with plumb line.**
- **Ears, mastoid processes and eyes level.**

**Emotional, Toxic, Nutritional, and Structural factors can influence one's posture.**



# POSTURE ENHANCEMENT TECHNIQUE (PET)




## I. PET using NET Body-entry

Ask the patient to assume a posture (standing, sitting, bending, etc.) that feels natural. Observe the patient in a profile and front-to-back view. Note areas that deviate from standard "proper posture guidelines." Gently shift the patient into a more proper posture (which would allow the body to be more biomechanically efficient) and test a previously strong indicator muscle.

Test and correct using the Home Run Formula:
**1st Base**: If active, do NET procedure.

**2nd Base**: If active, test for #10 Scars-Adhesions, #11 Visceral Polarity, #4 Wood or #9 ER 911.

**3rd Base**: If active, test for calcium, ligaplex, etc.

**4th Base**: Evaluate for traditional mechanic distortion causes using your primary structural techniques.

Now ask the patient to again assume a posture that feels natural, and note improvement.

Special note: When testing postures that have an element of vulnerability, it is wise to have an assistant in the room to help the patient feel more safe and comfortable.

## II. PET using NET Mind-entry

### — Option I

Use NEAT — MODE "Feeling" — as an entry.
Ask the patient to note the feeling of his/her posture.

Have the patient concentrate on the feeling and test a previously strong indicator muscle. If the patient tests weak, do the NET Mind-Entry procedure with MODE "Feeling"— patient continues to concentrate on the feeling and thus continues to test weak, while the practitioner counters with a MAP, etc. Follow the regular NEAT procedure and correct in the regular fashion.

### — Option II— Mind-entry PDs

Test Personal Declarative issues related to posture. If charged, correct using the NET Mind-entry procedure.
Example: "I'm OK having good posture," etc.

# EXTRA SUPPORT NOTES

# AND

# BACKGROUND INFORMATION

# TOUCHDOWN — Making Somatic Complaints Relevant To Emotional Reality Through Increased Cognitive and Affective Awareness

Touchdown (TD) is a simple procedure to meaningfully demonstrate to patients how an outer behavior immediately impacts their body. This is about the cognitive-emotive interface in the patient management setting.

**SUMMARY OF THE NET PROCEDURE**
TD is a procedure used to facilitate the cognitive and affective awareness of the patient's specific and personally relevant mind-body connection. This awareness, in turn, allows the patient to focus on the key area of his/her life. The patient can then provide more salient feedback and, thus, help the practitioner to focus on addressing this key area. By doing so, TD ultimately reduces the need for repetitive and thematically-linked NECs.

**STEP-BY-STEP**
TD is a procedure done within the traditional classic NET procedure. In order to contextualize it, a traditional approach example will first be reviewed, followed with an example that incorporates TD.

**Traditional Approach:**
A female patient, mother of two and aged approximately 33, presented herself with a moderately severe bowel disturbance and femur head pain. On examination, a positive ileocecal valve (ICV), along with a weak iliacus muscle, was found. [Note: the iliacus is normally found with a positive ICV, and it inserts into the femur head.] The ICV reflex was negated by two-pointing to the emotional points. In addition, the previously weak iliacus muscle strengthened with the two-point to the emotional points.

The NET discovery process, utilizing the standard deductive “Money, Love, or You” protocol, was run with the emotion being resentment in some association with her dog. Her emotional reality was that she resented not easily being able to be in close proximity to her beloved dog. [The dog was a messy dog that shed its fur all over the carpet, and the mother/employee/wife/dog-owner/patient found it impossible to maintain the household while having the dog in the carpeted areas of the house.] She also felt paralyzed in her will to do anything about the circumstance. Thus, the beloved dog was relegated to the tiled floor of the laundry room and garage, and it was identified that she resented not being able to be close to her dog because of these circumstances. This repetition compulsion enactment related to age seven when her parents got divorced. Normally at this point the SnapShot is recalled, and the structural intervention is initiated.

**Example Incorporating TD:**
Here we will remember that each NEC has many positively testing ELEMENTS making up, or relating to, the developing SnapShot: the MAP element, the “Money, Love, or You” element, the emotional element, etc. And in this case, some elements were: the dog, being apart from the dog, resentment at being apart from the dog, resentment at being apart from her father at age seven, etc. Each of these elements, when contemplated on or mentally held, will then cause a related previously weak muscle to strengthen. This is called countering.

When countering, the practitioner can then state, “*This is connected to that.*” And then after countering one or two times more, the practitioner can be even more explicit saying, “*The dog has something to do with this muscle, and the muscle has something to do with the femur head pain*.”

With the discovery of yet another element, say the validating of resentment, the practitioner can ask the patient to contemplate/ruminate on resentment and demonstrate that this emotion has something to do with this muscle, saying, “*Resentment has something to do with this muscle*.” This same sequence can be done with other associated elements (such as resenting being separate from the dog) and even the composite of all the elements in the final SnapShot. In this case the practitioner might say, “*That picture (SnapShot) of your father being away from you is related to this muscle, and this muscle is related to your femur head pain.*”

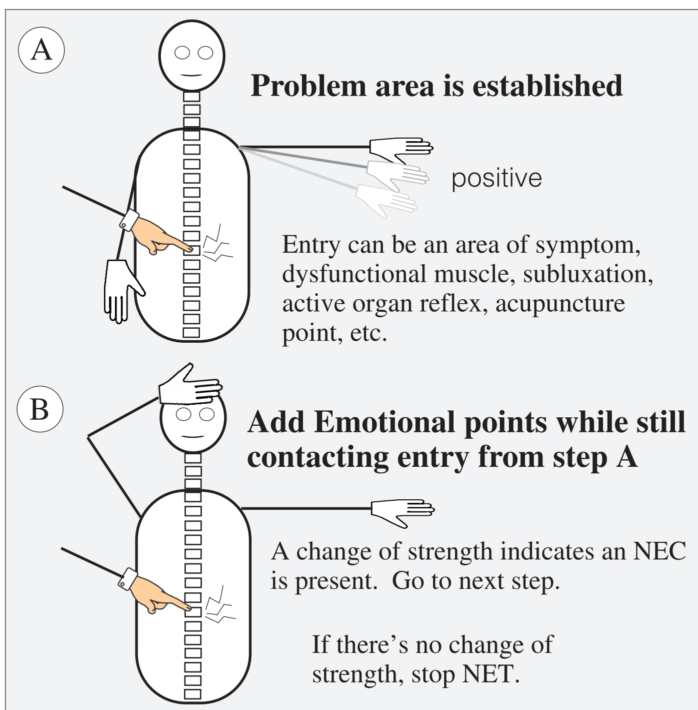
**RECAP OF THE TOUCHDOWN PROCEDURE**
When a positive-testing element of the NEC is found:

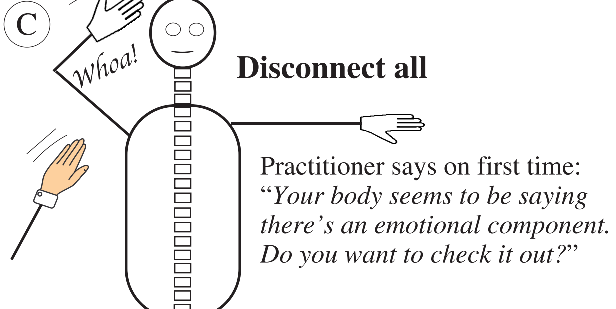
1. Pause.
2. Have the patient think of something neutral (i.e., NOT mentally hold the previously held element).
3. Retest the previously weak muscle. It’s still weak, of course, but now you can demonstrate and, thus, remind the patient of its weakness.
4. Now, while repetitively testing the weak muscle , ask the patient to feel/think of the newly discovered element. Point out to him/her the connection of his/her contemplation of this element and the strengthening of the muscle. In fact, it is most powerful to dramatize this relationship over and over until the patient fully understands that the affective state, generated by his/her personally experienced elements, is directly related to this muscle's physiology (i.e., its ability to contract).

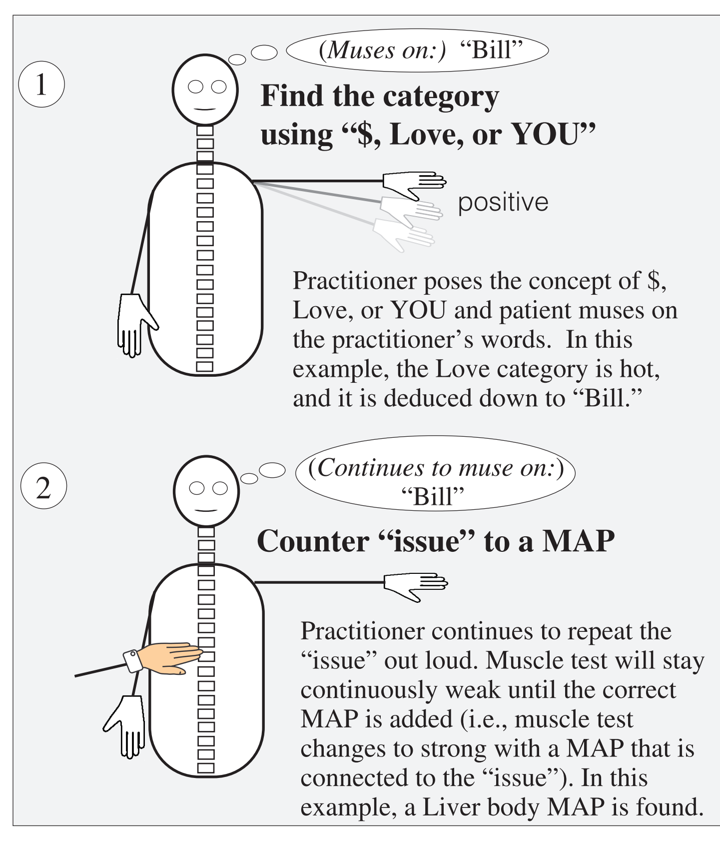
---

Although it may seem so redundant and obvious to you, it is not to the patient. For him/her to truly understand, it must be dramatized. In summary, find a positive-testing element and dramatically counter that element to the patient’s complaint, the affected part.

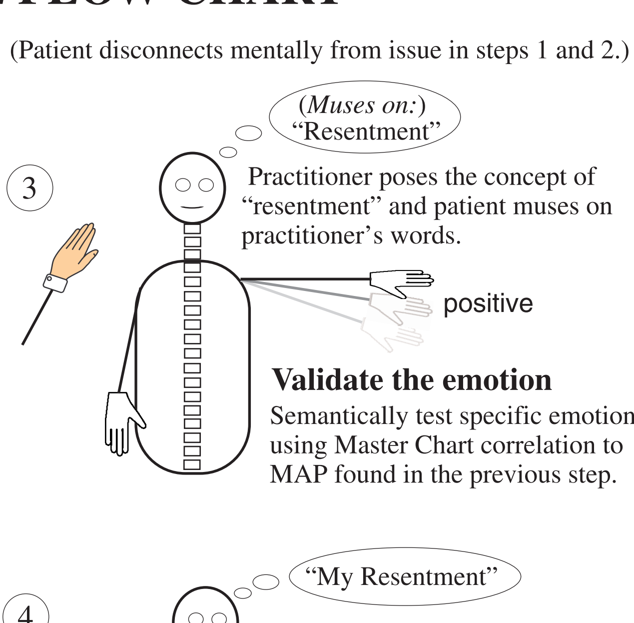
# BODY-ENTRY PICTURE FLOW CHART

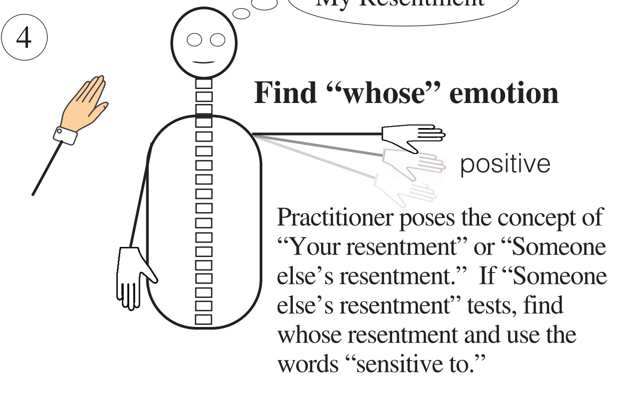


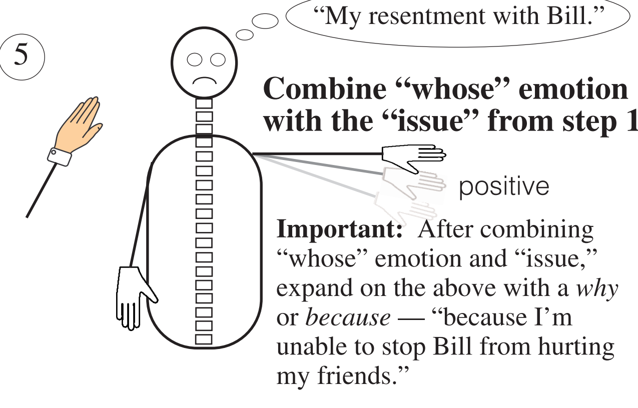



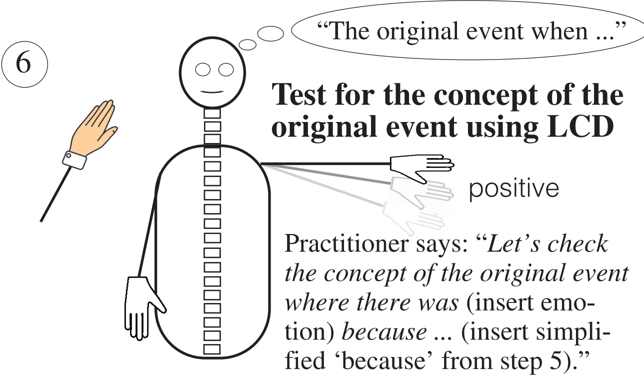




(Patient disconnects mentally from issue in steps 1 and 2.)

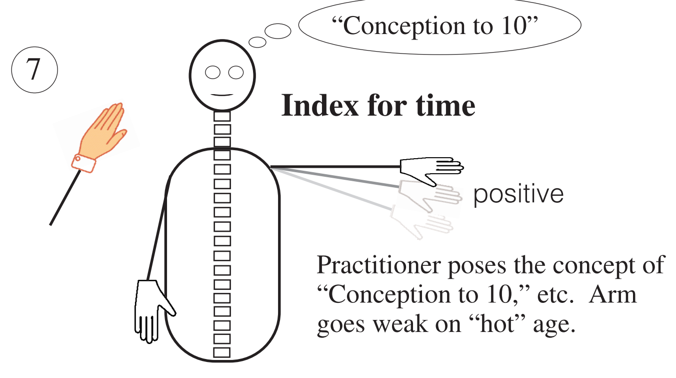


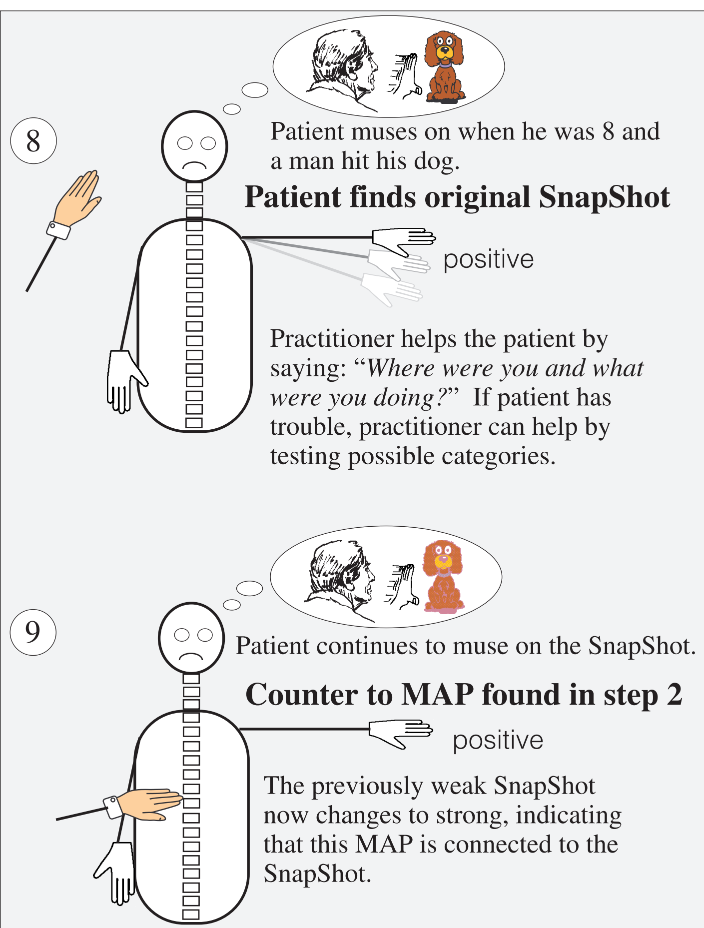



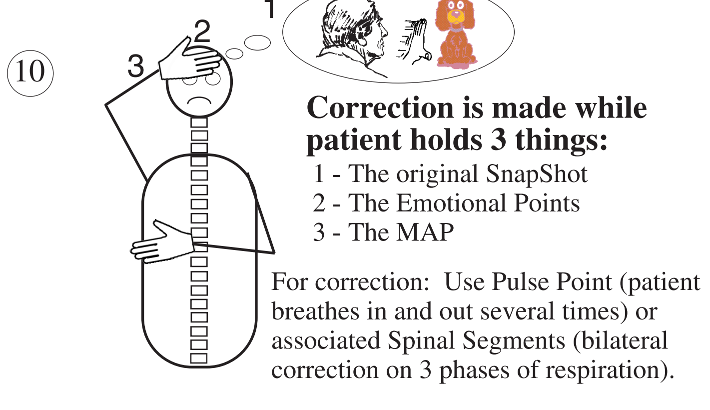



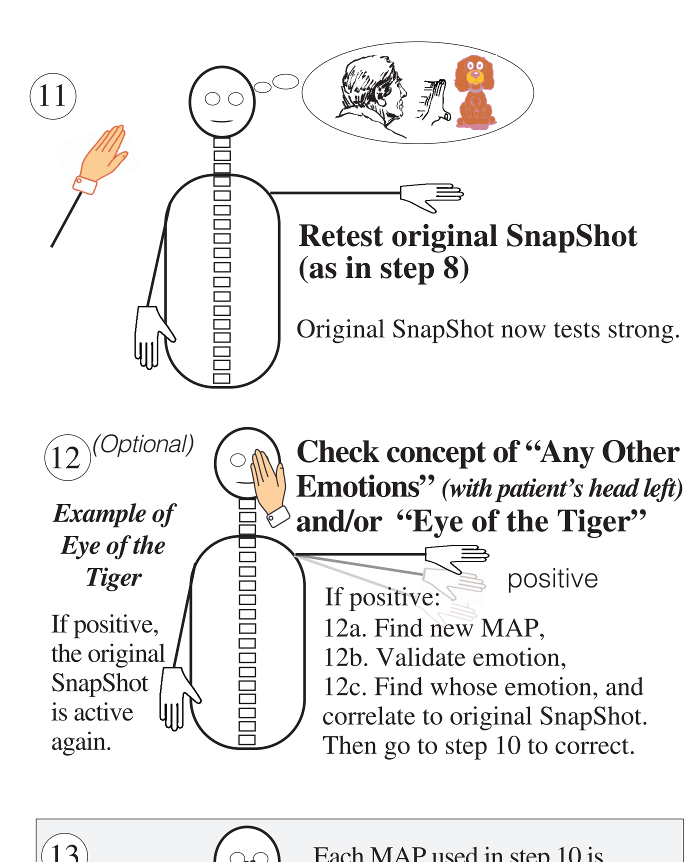



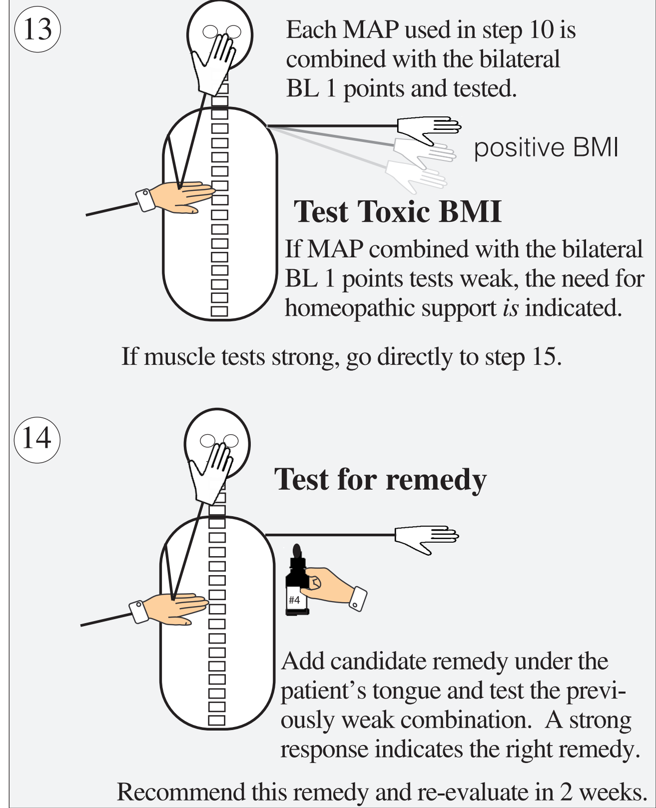

If strong muscle stays strong, go directly to step 9.

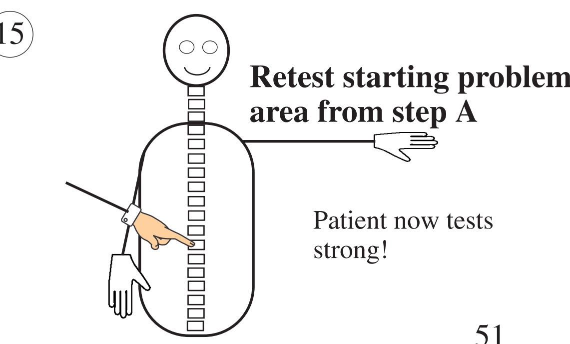

7
"Conception to 10"
Index for time
positive
Practitioner poses the concept of "Conception to 10," etc. Arm goes weak on "hot" age.


8
Patient muses on when he was 8 and a man hit his dog.
Patient finds original SnapShot
positive
Practitioner helps the patient by saying: "*Where were you and what were you doing?*" If patient has trouble, practitioner can help by testing possible categories.
9
Patient continues to muse on the SnapShot.
Counter to MAP found in step 2
positive
The previously weak SnapShot now changes to strong, indicating that this MAP is connected to the SnapShot.


10
1
2
3
Correction is made while patient holds 3 things:
1 - The original SnapShot
2 - The Emotional Points
3 - The MAP
For correction: Use Pulse Point (patient breathes in and out several times) or associated Spinal Segments (bilateral correction on 3 phases of respiration).


11
Retest original SnapShot (as in step 8)
Original SnapShot now tests strong.
12
(Optional)
Check concept of "Any Other Emotions" *(with patient's head left)* and/or "Eye of the Tiger"
*Example of Eye of the Tiger*
If positive, the original SnapShot is active again.
positive
If positive:
12a. Find new MAP,
12b. Validate emotion,
12c. Find whose emotion, and correlate to original SnapShot.
Then go to step 10 to correct.


13
Each MAP used in step 10 is combined with the bilateral BL 1 points and tested.
positive BMI
Test Toxic BMI
If MAP combined with the bilateral BL 1 points tests weak, the need for homeopathic support *is* indicated.
If muscle tests strong, go directly to step 15.
14
Test for remedy
#4
Add candidate remedy under the patient's tongue and test the previously weak combination. A strong response indicates the right remedy.
Recommend this remedy and re-evaluate in 2 weeks.


15
Retest starting problem area from step A
Patient now tests strong!

# THE NET MIND-ENTRY APPROACH

In the Mind-entry of the Neuro Emotional Technique, we often use the Neuro Emotional Anti-Sabotage Technique (NEAT) to make certain that the patient is **congruent** with whatever it is that he/she has defined for himself/herself as being desirable.

**One of the most common forms of the NET-mind Entry approach is to use Personal Declaratives (PDs)**. PDs are sentences in which the patient speaks with the objective of determining the presence or absence of NECs relating to the semantics utilized. Ideally, it is simplistic statement of something the patient subjectively feels *is true* or *would like to be true*. For example, the practitioner might request the patient to say: "**I'm OK having a bigger practice.**" This statement, which the patient would like to be true, contains a subject (usually the patient), a verb (the emotion) and an object (to whom the emotion is directed).

The patient may or may not be emotionally congruent with the above statement. But, even assuming that the patient is congruent, this statement is very different from "**A bigger practice is good for me**," or "**A bigger practice is good for others**," or "**I'm deserving of a bigger practice**," or "**I'm willing to have a bigger practice**."

As one can easily imagine, the potential for NECs exists at many junctures. The skill of the practitioner at this point lies in creative, discerning, common sensible imagination. Keep in mind that the accomplished practitioner will be very aware of language intricacies as the NET-mind Entry approach is applied.

**SURROUNDING THE DRAGON**
The following is a 90%er short list, also known as "Surrounding the Dragon" for important or hot issues:

**I'm OK* with _____________**
**I'm ready, willing and able to ______ (if positive, analyze which)**
**It is safe to ______________**
**I want to ________________**
**I believe I can ____________**
**I can honor ______________**
**I am worthy of ___________**
**It is good for me to ________**
**It is good for others for me to _____________**
**I can be supported by others for me to ______**
**I can have the energy to __________________**

**Important reminder: All statements should only be used if the patient believes it to be true or would like it to be true.**

*N.B.* Although NET can allow for emotional congruence, it does **NOT**:

- Make one intelligent about their decisions
- Make one philosophically sound
- Create spiritual enlightenment
- Create motivation or volition
- Provide skills

*** 'OK' defines a state of *near* neutrality with a situation, yet still allows for a different feeling of preference.**

# THE NET CONCEPT OF "OKNESS"

Re: The NET Mind-entry 90%er Personal Declarative, **“I'm OK with __________”**

When doing the Mind-entry approach, the practitioner is ultimately trying to achieve a healthy state—a relatively homeostatic condition within the patient's nervous system. Inwardly this condition allows for a greater bodily economy—health! Ideal outward signs of this homeostatic condition express a quality of poise, coolness, composure, and self-possession. The first step in this direction is to work with what we call a state of “OKness.”

Definition of **OK:**
***—An assenting to or agreeing to***. From an abbreviation of *oll korrect*—***all right.***

The state of OKness includes having a relatively comfortable disposition or attitude about a particular event or circumstance that has *happened in the past, or is presently happening or is imagined to occur in the future*. It is a state of near neutrality, yet is still allowing for feelings of preference.

In other words, in a state of OKness, the attitude or disposition may indeed embody preferences *for or against* the event or circumstance, but devoid of strong, unhealthy emotion. Thus, OKness allows for (in an ideal sense) the patient to retain preferences, yet at the same time be somewhat dispassionate or detached—i.e. in a state of near equanimity.

| In NET, the desired state is to be **OK with "what is."** |
|---|

One would want to be OK that it is raining, if it is raining, or be OK with sunshine, if the sun is shining. One would want to be OK with a runny nose, if the nose is running, or be OK with pollution, if things are polluted, or OK with wealth, if there is wealth, or OK with death, if there is dying. Someone once said that the great saints of the world really tried to accept the world more than to change it. The distinction to be made here is that to be OK with something is not necessarily to ***prefer*** it.

NOTE: When making PDs, it is best to avoid using the “not” word. Try substituting: avoid, without, less than, fail to, etc.

EXAMPLES: (I want to wash my automobile and it is raining.) “I’m OK with the fact that it is raining.” “I’m OK without sunshine.”

(I prefer that Mrs. Jones get well, but she is not getting better.) PD: “I'm OK even though Mrs. Jones has been unable to get well.”

It is very helpful for the patient wanting to lose weight to be tested on the Personal Declarative: “I'm OK with my present weight,” before going on to: “I want to lose weight,” etc. This often uncovers the major NEC regarding the weight issue. Please note that the practitioner would not have the patient say “I want my present weight,” as this is not a true statement for him or her.

NECs are aberrant physiological patterns within the body. Among other components, they contain emotions, meridian imbalances and subluxations. These bodily distortions prevent a harmonious evaluative relationship with both our inner and outer world. They also prevent OKness. NECs can be discovered by analyzing what we are not OK with in our cognizable world. By using the procedures of NET, we can find the associated subluxation and/or meridian imbalances. Correcting the subluxation and/or meridian imbalances allows us to move back toward **OKness** and, perhaps, even into harmony with the universe in which we live.

# PREDICT, PRETEND, AND PORTEND

*To Predict is OK*
*To Pretend is just fine*
*But to Portend is just pure wasteful time*

**Predict**: to conjecture.
**Pretend**: to draw an inference from slight or inadequate evidence.
**Portend**: to tell something before it happens or as if through special knowledge or occult power.

### Predict

According to the great psychological thinker, Kelly[1] we are all little scientists going through life learning and building personal constructs (theories of life, how it works, our personal philosophy) so that we may predict the future based on our acquired knowledge. Predicting is OK.

### Pretend

It is best to view these personal constructs as pretending rather than Gospel truth. This approach allows for flexibility and not taking ourselves too seriously. Pretending is better because it allows for greater latitude in imaging multiple possible outcomes of congealing events. Pretending is just fine.

### Portend

In the presence of NECs we tend to portend, rather than predict. An environmental situation is generalized and perceived by us to look similar to an event that took place in our past. Additionally, our NEC reaction is to reflexively portend an upcoming emotionally charged event with a feeling and outcome that will be (experienced) like (emotionally speaking, *exactly like*) the one we experienced before.

When thus engaged, portending just doesn't feel right. In the presence of NECs, portending is the natural knee-jerk reaction. The options of predicting and pretending are involuntarily bypassed and the "victim" is stuck with only the emotional reality of the original sensitizing event projected onto the present circumstance.

When a distressed patient "just knows" such-and-such is going to happen, they are likely portending. To those of us who have tried to talk patients into entertaining other possibilities (pretending), the degree of the emotional reality fixation of the portended event outcome has been only too obvious. Ministers, counselors, and psychologists the world over have exhausted themselves trying to talk people out of what their body is telling them.

### Practical self-application (Ex: Relationship issue)

When experiencing any disproportional unpleasantness in dealing with a primary relationship, ask yourself or your patient (rationally), "What is the worst possible outcome this could bring?" If you have any inkling that this outcome or your reaction to this outcome is even slightly beyond reason, the event you are sharing/experiencing is a good candidate for a NET examination.

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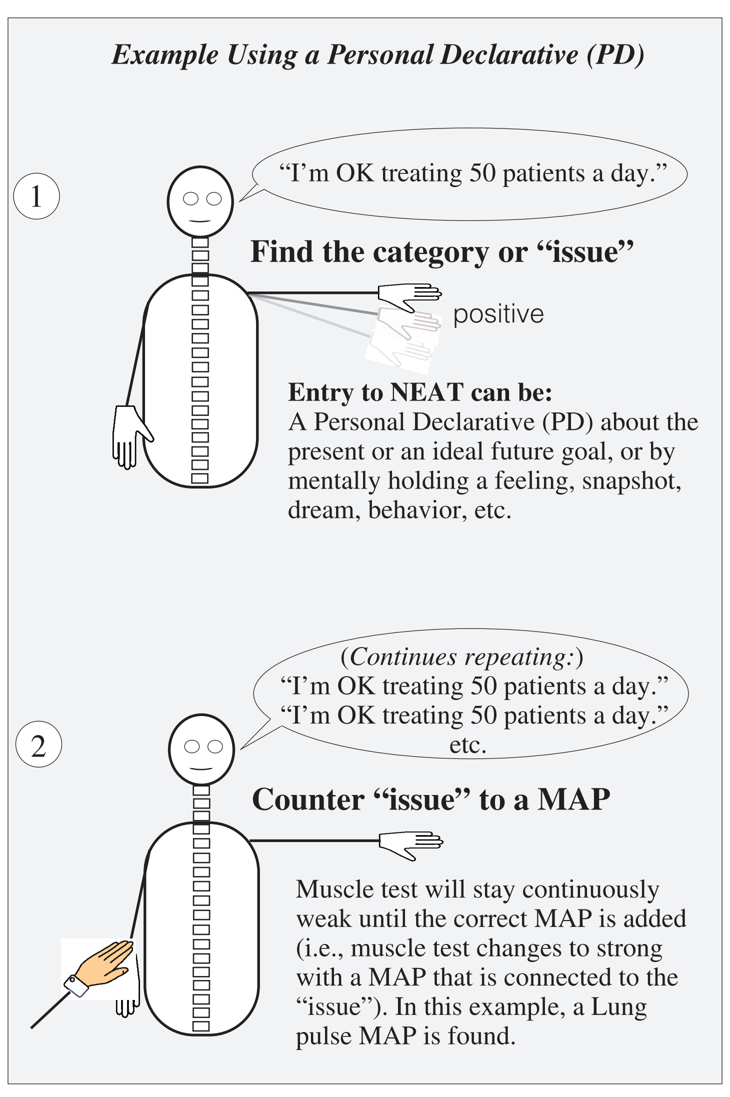
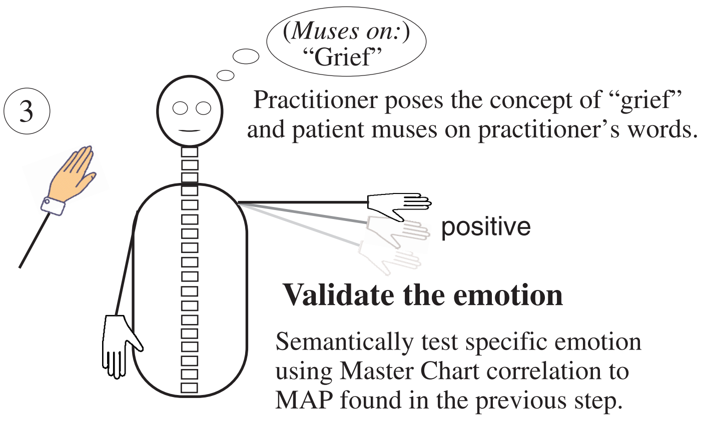
[1] (Kelly, G.A. (1955). The psychology of personal constructs (2 vol).

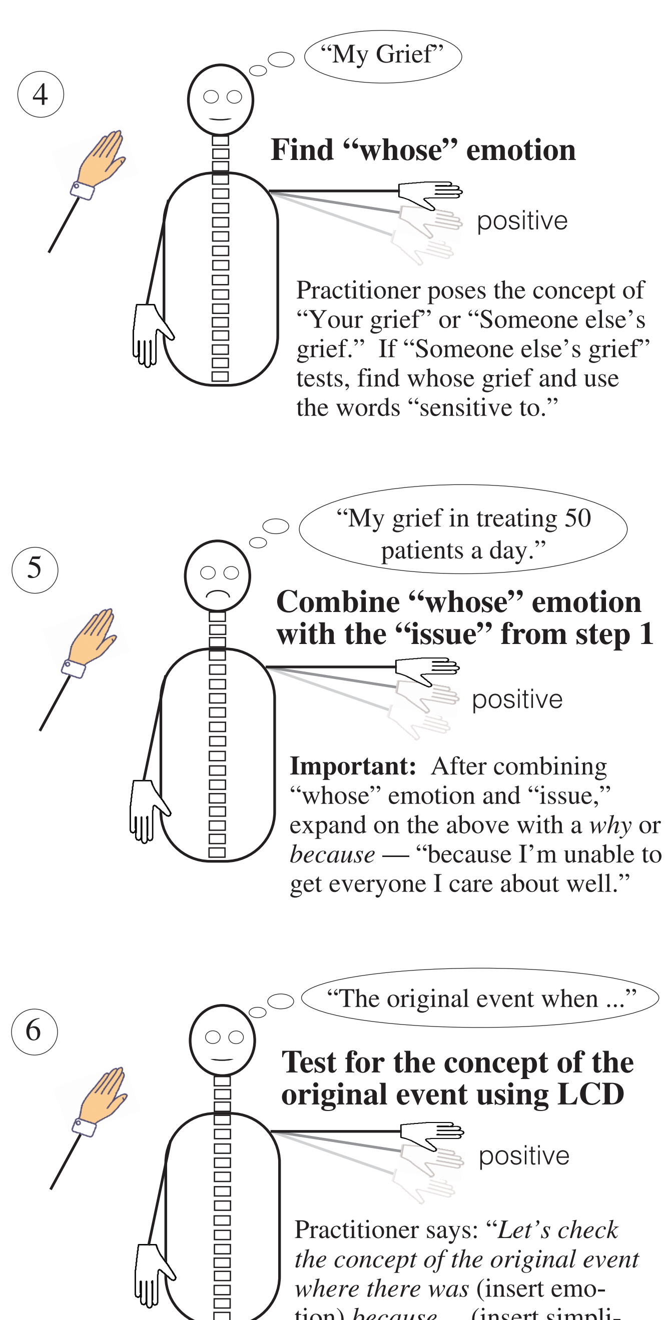
# MIND-ENTRY PICTURE FLOW CHART

## A.K.A NEAT (Neuro Emotional Anti Sabotage Technique)

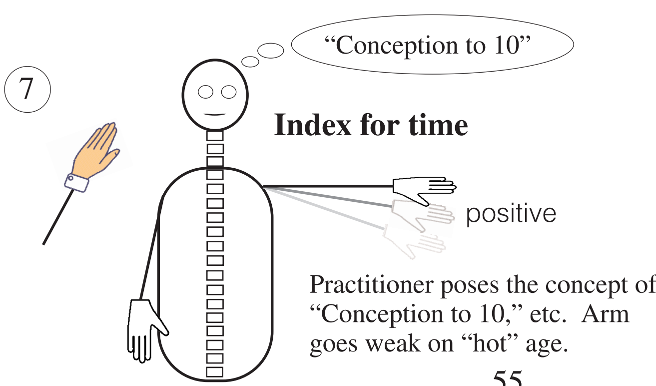


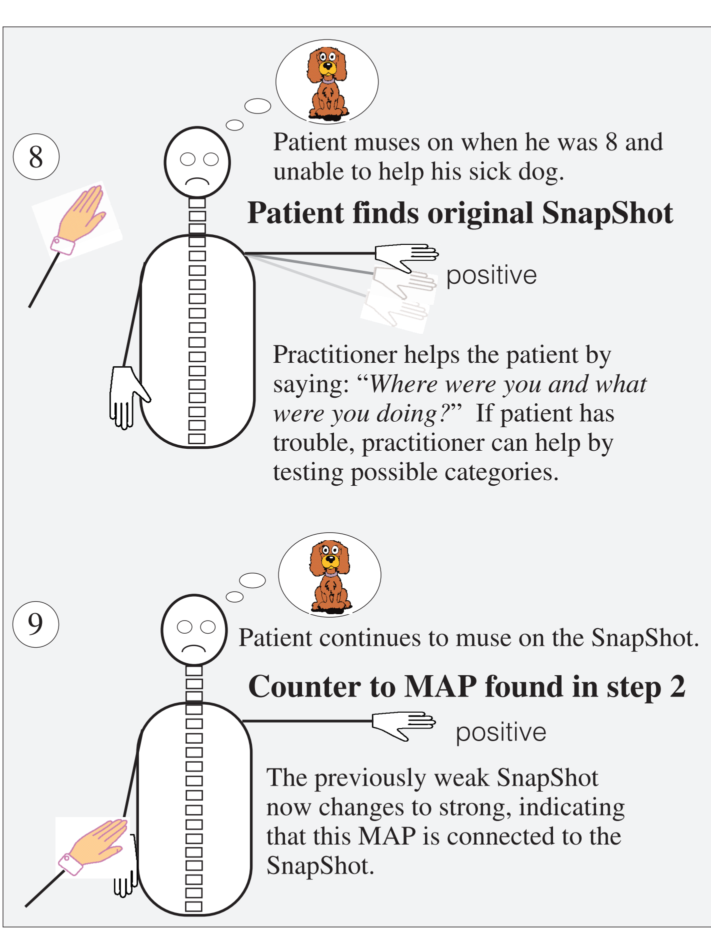

(Patient disconnects mentally from issue in steps 1 and 2.)



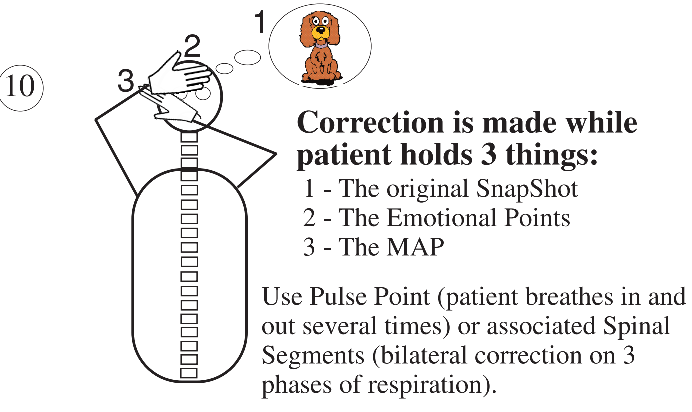




If strong muscle stays strong, go directly to step 9.

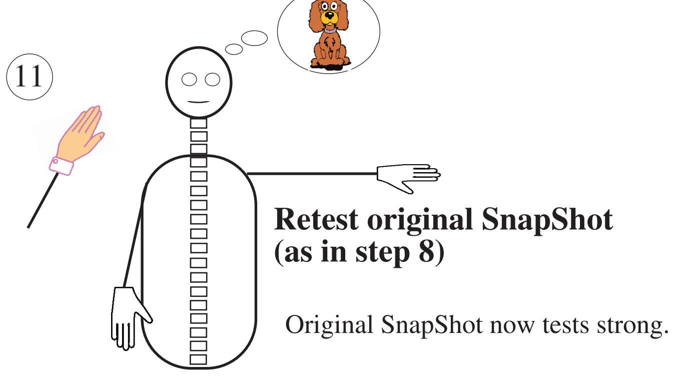




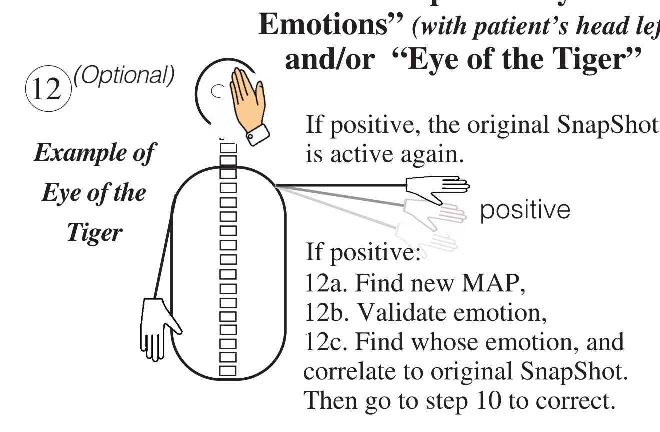
8
Patient muses on when he was 8 and unable to help his sick dog.
Patient finds original SnapShot
positive
Practitioner helps the patient by saying: "*Where were you and what were you doing?*" If patient has trouble, practitioner can help by testing possible categories.
9
Patient continues to muse on the SnapShot.
Counter to MAP found in step 2
positive
The previously weak SnapShot now changes to strong, indicating that this MAP is connected to the SnapShot.

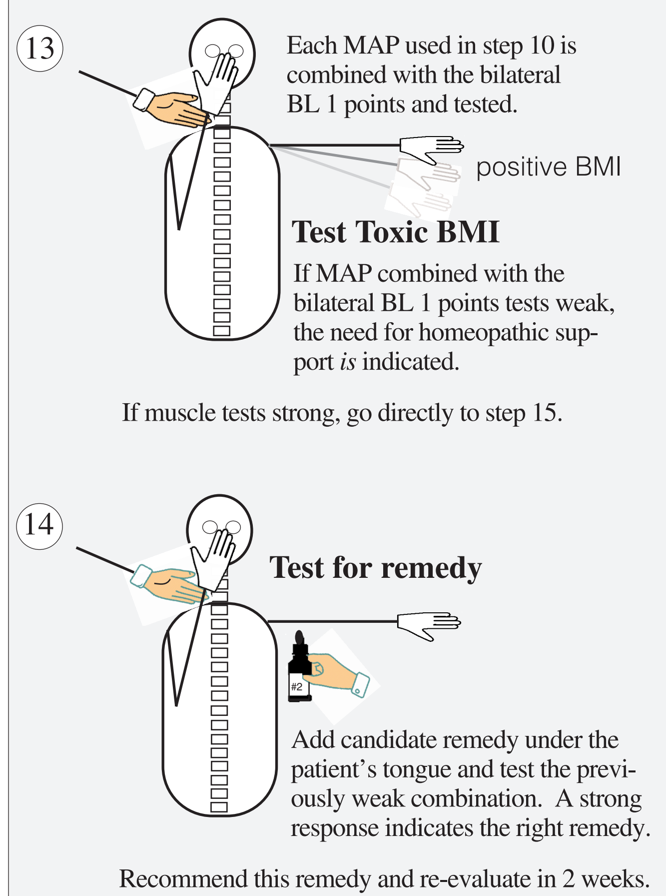
10
1
2
3
Correction is made while patient holds 3 things:
1 - The original SnapShot
2 - The Emotional Points
3 - The MAP
Use Pulse Point (patient breathes in and out several times) or associated Spinal Segments (bilateral correction on 3 phases of respiration).

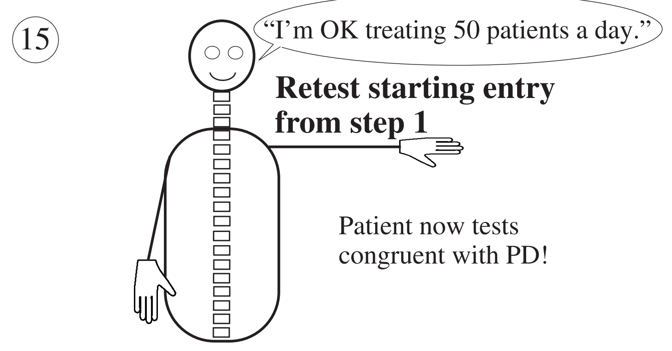
11
Retest original SnapShot (as in step 8)
Original SnapShot now tests strong.

Check concept of "Any Other Emotions" (with patient's head left) and/or "Eye of the Tiger"
12 (Optional)
Example of Eye of the Tiger
If positive, the original SnapShot is active again.
positive
If positive:
12a. Find new MAP,
12b. Validate emotion,
12c. Find whose emotion, and correlate to original SnapShot.
Then go to step 10 to correct.

13
Each MAP used in step 10 is combined with the bilateral BL 1 points and tested.
positive BMI
Test Toxic BMI
If MAP combined with the bilateral BL 1 points tests weak, the need for homeopathic support *is* indicated.
If muscle tests strong, go directly to step 15.
14
Test for remedy
#2
Add candidate remedy under the patient's tongue and test the previously weak combination. A strong response indicates the right remedy.
Recommend this remedy and re-evaluate in 2 weeks.

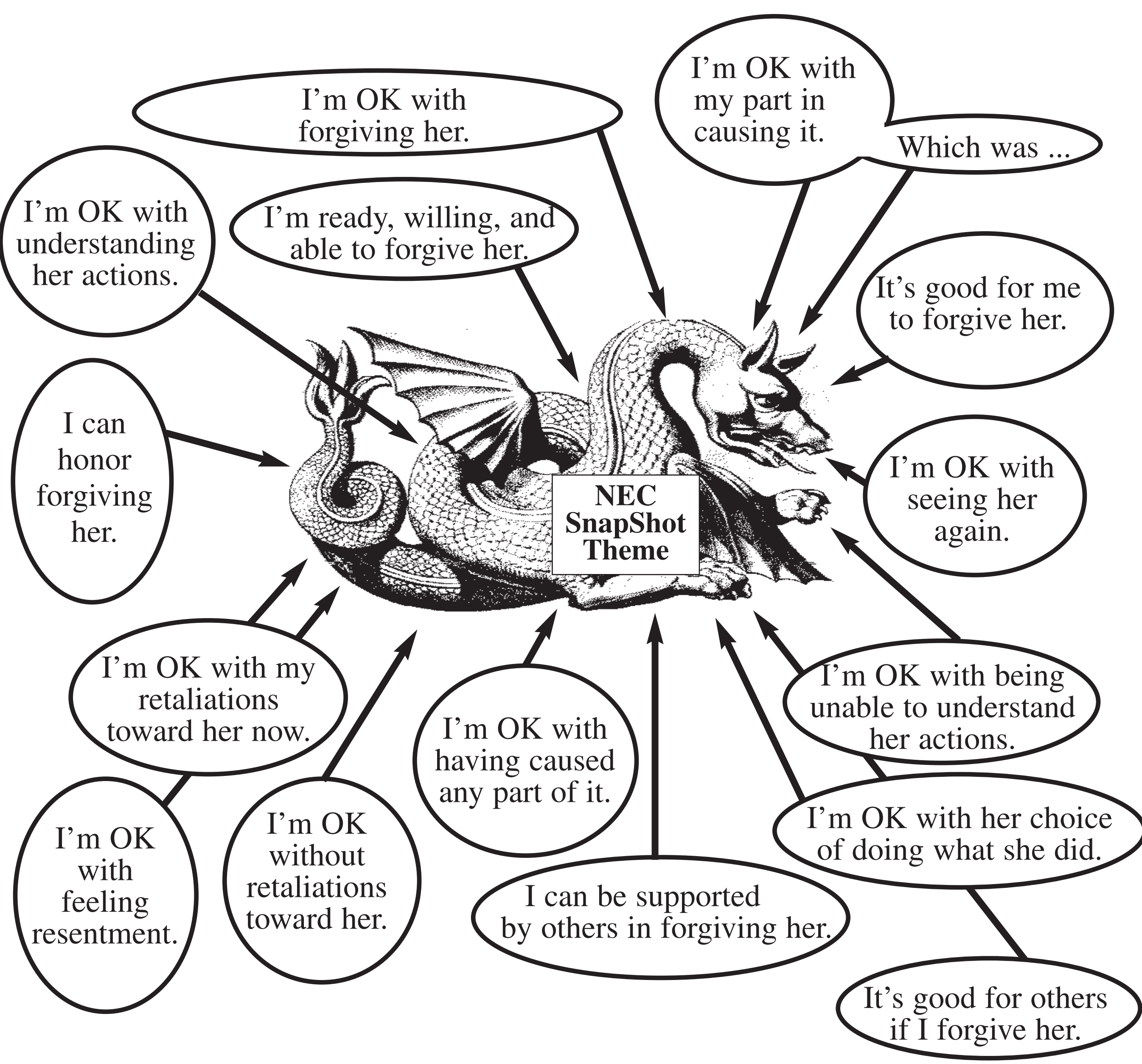
15
"I'm OK treating 50 patients a day."
Retest starting entry from step 1
Patient now tests congruent with PD!

# SURROUNDING THE DRAGON

In Chinese Acupuncture there is a technique known as Surrounding the Dragon. The Dragon is the foci of pain and needles are inserted in key acupuncture points in the nearby vicinity.

In NET, there is also a need for Surrounding the Dragon. In this case, the "Dragon" is the NEC.

For example, if a man has a SnapShot containing an NEC about resentment over a perceived jilt from a former girlfriend, we may wish to Surround the Dragon like this:




This is used to make sure the patient is emotionally congruent with all aspects of all avenues of volition.

***Surround the Dragon!***

# USING NET REMEDIES IN A CONSULTING SESSION

Usually the client will only end up needing one of the Elemental NET Remedies at the end of a session. The exception might be with the addition of ER 911, which may be given to mitigate any excessive emotionality during the session (also for the client who has been under stress prior to the session). Also, it is not necessary to look for BMI activity until the last few minutes of the session. See your notes for "'Apparent' and 'Hidden' BMI Combination Tests" document. You will mostly be testing for the "hidden" variety, because you will have just "fixed" most, if not all of the client's active MAPs, in the session.

Near the end of the session:

1. Have patient contact the bilateral BL 1 points. See "**Toxic Body Memory Indicator**" document.

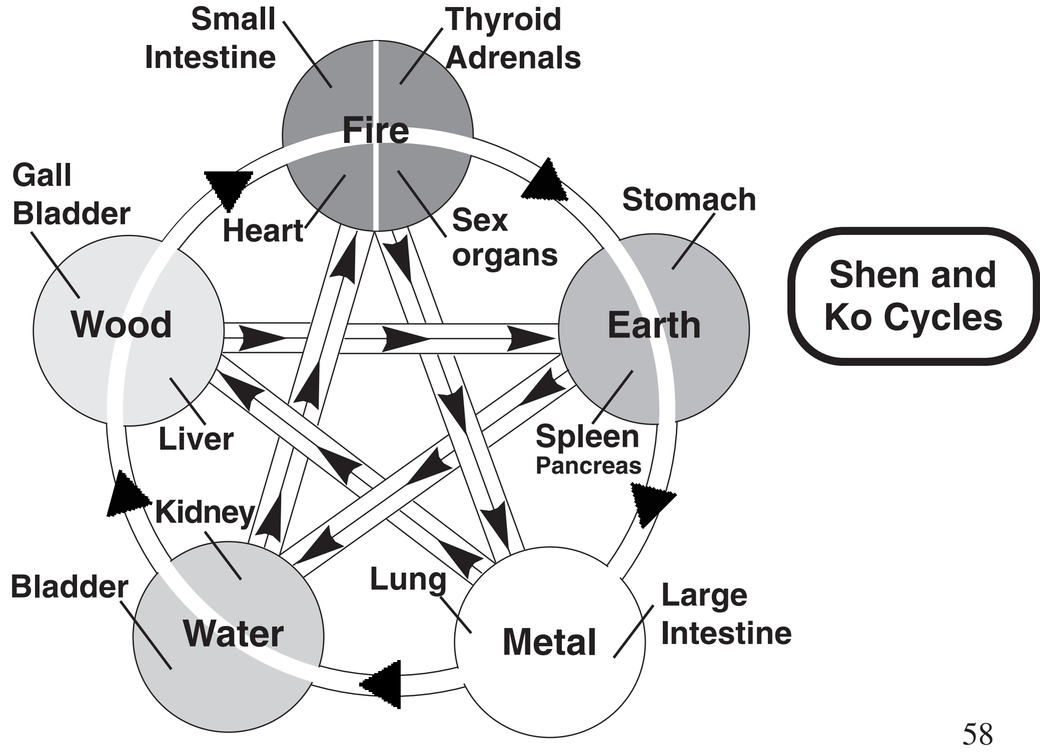
2. While patient maintains the contact above, the practitioner contacts, in turn, one Meridian Access Point (MAP) of each element. [For example: Right lung point (metal), stomach (earth), bladder (water), gall bladder (wood) and heart (fire).]

3. Note which, if any, BMI combinations are active. [For example: stomach (earth), bladder (water) and liver (wood) test positive.]

4. Test to see if any one remedy will negate (change BMI combination weaknesses to test strong) all of the individual active BMIs. [For example: NET Remedies #4 Wood might negate – liver (wood), stomach (earth), and bladder (water).] This was accomplished via the Ko cycle below. You may want use the Shen and Ko cycles below to guide you in a
logical system, although the body can sort it out quickly if you elect to use a trial-and-error method.

5. *Briefly* correlate/explain the need for the Remedies to the client's condition, fill out the recommendation slip and attach it to the client's time/data sheet.

> Note: The clients seem to intuitively know they are processing all the physiological/emotional changes made in the session and are generally very grateful to have the ongoing support of the Remedies.



# POLLUTION, ADDITIVES AND PESTICIDES

**Why do the Allergy and "Toxic" BMI points frequently test positive?** It is widely thought that pollutants effect the immune system's ability to respond adequately. Some of the chemicals which cause immunosupression are: PCB**s, lead, benzene, aldicarb, carbofuran, mirex, nichel, parathion, DDT, dioxins, ozone, asbestos, arsenic, cocaine, marijuana, carbon tetrachloride, glycol ethers, tributyltin, clordane, dieldrin, formaldehyde.** The inefficiency of the immune systems's memory cells (generated by the "B" and "T" prototype cells) may come into play here. The term "Body Memory System" is proposed to describe the whole integration of the memory cell mechanism.

There have been enormously increasing numbers of synthetic versions of organic chemicals in the US environment (including pesticides). The overwhelming majority of all of these chemicals have never been tested for environmental or health effects. 1940=1 Billion pounds, 1950=30 Billion pounds, and 1980=450 Billion pounds.[1]

Just the pesticides alone used in 1984 totaled 1 Billion pounds (double that used in 1964).[2]

The average American eats their weight in food additives every year.[3]

500 Billion gallons of hazardous waste materials are improperly disposed of each year. Every day 50 Billion gallons of liquid hazardous wastes are deposited in disposal sites, 85% of which are located above aquifers or water storage areas. Of 800,000 underground storage waste tanks, about a third are considered structurally impaired (leak). Every year 100 Billion gallons of liquid wastes are absorbed into our ground water. The EPA has set standards for only about seven of the currently used 70,000 toxic chemicals.[4]

"Pollution is wreaking havoc with wild animals' immune systems, scientist suspect. European seals, Canadian whales and Maryland oysters are being killed by diseases they used to fight off."[5]

"In the St. Lawrence estuary near Quebec, snow-colored whales called Belugas contain so many chemicals that when they die, their carcasses are considered hazardous waste. Their hearses are specially equipped trucks; their burial grounds are toxic waste incinerators."[6]

"Human Immune Systems May Be Pollution Victims – Health: Contamination seems to lower resistance to diseases. Theory is bolstered by growing body of evidence."[7]

**Physicians interested in environmental medicine estimate that the number of children and adults who have allergies exceeds 75%.**[8]

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SAMPLE POLLUTANT EFFECT: Sperm Count (world wide)

Re: Some pollutants possibly causing reduced sperm count, "...PCBs used in the manufacture of electronics, pesticides such as endosulfan and atrazine, polycarbonate plastic found in many baby bottles and water jugs, chlorine compounds that bleach paper, resemble the sex hormone estrogen."[9] On commenting on the dramatically reduced sperm counts the world over, Neils E. Skakkebaek, a Danish pediatric endocrinologist, "...computed on the basis of the world literature that the average sperm count in 1940 was about a hundred and thirteen million per millimeter, and that fifty years later it had fallen to sixty-six million."[10]

Re: Unprecedented reduced sperm count, "We thought in the past these toxic substances would act on a target – an enzyme or DNA or the cell membrane, or something like that. But what these endocrinologists have suggested to us is that industrial chemicals can actually mimic hormones...But this century we have generated all these new chemicals and injected them into the environment, and suddenly the body is exposed to new substances...The human species is totally unprepared for this, because it has never happened before...."[11]

"Every man in this room is half the man his grandfather was."[12]

"Commenting on the rate of sperm decline in French men (89 million in 1973 to 60 million in 1992) Pierre Jouannet, reproductive biologist gravely said, "it will take seventy or eighty years before it goes to zero."[13]

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[1]Dr. Samuel Epstein, Toxicologist/Cancer specialist.
[2]The Kellog Report. 1989.
[3] Business Week / May 6, 1996 referring to material from *Food and Safety* by Julie Miller Jones (Eagan Press ($89).
[4]Is This your Child?, Doris Rapp, M.D., Quill, William Morrow, New York. 1991.
[5]Headline in Los Angeles Times, May 12, 1996.
[6]Article in Los Angeles Times, May 12, 1996.
[7]Article in Los Angeles Times, May 13, 1996.
[8]Is This your Child?, Doris Rapp, M.D., Quill, William Morrow, New York. 1991.
[9]Newsweek, March 21, 1994.
[10]The New Yorker magazine, January 15, 1996 article "Silent Sperm".
[11]The New Yorker magazine, January 15, 1996 article "Silent Sperm". Phillipe Grandjean, a professor of environmental medicine at Odense University, in Denmark as quoted by Lawarence Wright.
[12]Newsweek, March 21, 1994 Louis Guillette, a University of Florida researcher in addressing a congressional panel on the alarming reduction of sperm counts.
[13] The New Yorker magazine, January15, 1996.

# MIND-MEMORY AND BODY-MEMORY

**Memory** [L. memoria]

1. General term for the recollection of that which was once experienced or learned.
2. The mental information processing system that receives (registers), modifies, stores, and retrieves informational stimuli; composed of three stages: encoding, storage, and retrieval.

Having patients recall the memory of a specific emotionally traumatizing event (Snap Shot) engages their nervous system and the physiology of the body.

By *remembering* an emotional event, *important somatic and visceral modifications can take place*. Hassan and Ward write,

> "**The role of memory in emotion can hardly be overemphasized.** The perceptual process involved in emotion become part of the memory store. The recollection of perceptions, which implicates neocortical processes, may evoke (through descending connections via "limbic system", hypothalamus, brain stem, and spinal cord) the somatic and visceral motor **changes which occurred in the original situation.** [NET's emphasis]"[1]

The limbic system by some classifications, contains the amygdala, thalamus, caudate nucleus, hippocampus, hypothalamus, septum, and mesencephalon. It is linked by connected fibers. It is the traditional locus of emotions and is also very intimately associated with memory storage.

Having memory and emotion occupy the same anatomical housing makes great economical sense in that our immediate survival is very much dependent on quick reflexive responses to any threatening (thus affective) environmental stimulus.

Body oriented practitioners who deal in the structural world of height, width and depth can now intervene by the virtue of memory, the fourth dimension of *time*.

Rossi, who has done spectacular work regarding memory and emotional trauma, writes,

> "The memories of these traumatic events are said to be deeply imprinted as physiological memory, tissue memory, or muscle memory. We propose that all these designations are actually metaphors for the special state-dependent encoding of memories by stress released hormonal information substances."[2]

**State Dependent Memory, Learning, And Behavior (SDMLB)**

Rossi eloquently writes on an expanded and updated view of conditioning, one that he developed in great detail and much care. A small section of his wonderful work referring in part to memory reads:

> "... conditioning actually involves an important element of state dependent memory, learning, and behavior (SDMLB) that frequently is not recognized by researchers. The pioneers in animal conditioning during the early part of the century, for example, were not aware of the **role stress hormones of parasynaptic cellular modulation** played in the learned association between the sound of the bell and the shock the experimental animal received...A psychobiological model (Rossi, 1986) of memory and learning that includes the state dependent nature of physiological homeostasis as well as of memory and learning will be required for a more complete understanding of the clinical phenomena of depth psychology and psychosomatic medicine." [NET's emphasis][3]

We will discus body memory and the immune system below.

What is "memory?" *Physically*, it is a pattern of neurons in selected brain localities from the basal ganglia to the prefrontal cortex. It is estimated that there are 10 to 15-billion linked cells composing approximately 1.3 kilograms of brain tissue, which include the cerebral cortex, cerebellum, thalamus, and limbic system. The

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[1] Hassan, A.M. , Ward, P.S., *On the Primacy of the Brain* The University ofLeeds, Psychology: Research and Reviews, Spring/Summer 1991, Vol. 10, Nos. 1 & 2, pg. 103-111.

[2] Earnest L. Rossi and David B. Cheek, *Mind-Body Therapy, Methods of Ideodynamic Healing in Hypnosis*, Norton1988 pg. 7.

[3] Earnest L. Rossi and David B. Cheek, Mind-Body Therapy, *Methods of Ideodynamic Healing in Hypnosis*, Published by Norton ©1988.

limbic system contains the amygdala, caudate nucleus, thalamus, hypothalamus, hippocampus, menencephalon and septum. The limbic system controls emotion and is the basic structure for memory storage and recall.

Of course, you and I probably feel that "memory," recallable or not (and our emotionally charged or uncharged opinions of its contents), is always "on" — consciously or non-consciously. Thus, the QUALITY modulation of the body's physiology is always "on" (for better or worse).

But does the body itself have a memory? Here is a story that suggests it does ala Rossi's SDMLB.

From the book, *Conditioned Reflex Therapy* – Andrew Salter (1949, 1961 rev.)

> "The misguided and the well-meaning have tried to talk people out of their bodies for centuries. It can't be done."
>
> "Sometimes impotence seems to involve only simple association. Meignant presents the case of Mr. R., aged 35, who had become impotent six months earlier. All medical assistance had been in vain, but significantly he remained potent with his wife in hotel rooms and whenever they traveled. Six months earlier they had moved to a new apartment. Mr. R. thought there was something familiar about the bedroom, but he couldn't decide what. Meignant, however, found that prior to his marriage Mr. R. had been caught in bed with a woman by a third person who suddenly walked in and found them *flagrante delicto.* It seems that the pattern of the wallpaper in the bedroom of the new apartment was almost identical with that of the bedroom in which he had been discovered. Mr. R. had the bedroom of the new apartment redecorated, and his potency became normal."

So the question — Did Mr. R.'s "brain" remember, or did Mr. R.'s body remember?

**Body Memory**

NET proposes that a Body Memory System or systems exists in which a prioritized "healing list" is kept and followed when the system is uninhibited and that this system can be overwhelmed, clogged or otherwise distorted due to pollutants and other body stressors. This is a term given to the theorized mechanism by which the body heals after a homeopathic remedy is given.

Chopra very vividly emphasizes that our entire body, every molecule, is almost certainly fully replaced every 5 years. This leads us to poses the question — If this is the case, how can we remember something that happened 20 years ago?

The logical answer must be — We are not our memory, but have *access* to our memory. We may indeed have access to something *immaterial*!

Chopra says it this way, "Your body is just the place your memory calls home."

There are at least two major categories of memory. The one we are most familiar with is the cognitive memory; the one that (sometimes!) lets us know where our car keys are. There is another memory that we and others call "body memory." Body memory is non-conscious and is similar to physiological memory.

**Physiological Memory Defined**

"A memory for somatic experiences outside of conscious awareness, e.g., the memory of a conditioned-automatic-system response; also, storage of memory traces by means of RNA". – *Longman Dictionary of Psychology and Psychiatry.*

Of course, body memory is probably not yet recognized *as we conceive it*, although immunologists recognize what they call "memory cells" within the immune system. When an antigen invades the body, the body intelligence starts a time consuming chain of events ending up with a production of antibodies. While this time consuming chain of events is happening, the body (sensing this may indeed happen again in the future) forms memory cells. These memory cells have the capacity to form these same (it remembers) antibodies quickly — less time consuming. Thus, after an initial exposure to a specific antigen, memory cells are stored, lying in wait, remembering the specific type of antigen should that same antigen try to harm the body at a future date. Of course, this body memory cell, like mental memory, is likely to be a molecular "receiving station"—when all is working right.

Body memory lets the body's intelligence know what's next on the healing list. Like the conscious memory, it is not part of the intelligence itself, but rather a matrix (for lack of a better word) through which it works.

Some of us have had the experience of being in a pressing social situation where we are busily re-cognizing various faces and names of the people present. Suddenly, we are called upon to

introduce someone we are familiar with and a memory block occurs! We can't recall our friend's name! We "know" it, but can't recall it.

Similarly, the body "knows" what to do for healing but can not recall what healing duties are on it's agenda. This is especially true if there are many body duties needing to be carried out, as we often see in our chronic patients. Others have also described this type of body memory.

“The energy cyst and tissue memory are two useful concepts related to this body memory. An energy cyst is a place where disorganization in the tissue prevails. It is a pattern that carries the imprint of the body's movement during the fall or impact, for example. Tissue memory is another way the body stores experience and expresses it through the quality of the tissue and the surrounding electromagnetic field.” – *Dianne L. Woodruff, CMA, PhD ISMETA conference presentation 8 June 1996, Toronto.*

“Heredity and past experiences have some trace, some "tissue memories,' which influence the way we react to things.” – *Hans Selye, M.D. in The Stress of Life 1976 McGraw-Hill Co. pg 123.*

**Body Memory and Homeopathy**

There are many theories as to how homeopathy works. The fact that it does work has been confirmed clinically and with many double blind tests. However, the "how" has been elusive. For now, the "body memory" concept is at least a good patient management metaphorical tool, which can be used to explain the "why" of taking homeopathics. It now appears I am not alone.

Two MDs, Bellavite and Signorini, wrote in a book *Homeopathy – A Frontier in Medical Science 1995*, regarding the healing crisis which sometimes follows homeopathy intervention saying,

> "Recognition of such phenomenon might suggest that the disease *history* of each individual patient is somehow related to a single pathobiological or *chronopathological* pathway and that there exists some kind of biochemical or neurohormonal "*biological memory*" persisting in the context of homeostatic disorders."

They also discussed cell activation and modification saying,

> "A number of the modifications are transient and easily reversible, while others are longer lasting, or even permanent, thus constituting a sort of *memory of the biological history of the cell*." *pg 115.*

In the early days of NET, it was found in those "too many patients" who seemed to have received good NET, nutrition and structural corrections, yet still didn't have a full *healing* response, that there was a positive pair of reflex points which were later named the Toxic Body Memory Indicator (BMI)— a faulty memory system. Testing with the Toxic BMI suggested that certain meridians within certain elements (wood, fire, etc.) had gotten their respective *elemental memory systems* jammed or clogged or dysfunctional. Elemental memory systems may seem to be a big jump in faith at first, but let's look at memory.

Memory is such a BIG thing. Imagine having no memory. If we are stripped of it, we lose so much of what we conceive ourselves to be. Memory comes from the Greek "mneme." The term, as used in English, was coined by Richard Semon to denote the ability to remember, which he believed ***all living cells possessed***.

Mental memory has medically recognized (physiological and pathological) categories of dementia, eidetic memory, affect memory, anterograde memory, short and long-term memory, remote memory, retrograde memory, hypo and hypermnesia, screen memory, selective memory, senile memory, and subconscious memory, along with the somewhat accepted "collective unconscious memory" of Jungian psychology, in which the combined engrams or memory potentials inherited from an individual's phylogenetic past are present.

Body Memory also seems to have categories or systems. There are almost surely five. We call these Earth, Metal, Water, Wood and Fire, which correlate with the acupuncturist's five-element viewpoint.

**Body Memory and the Immune System**

The immune system is concerned with what “is” the body and what “is not” the body. Body memory, like mind memory, can be imperfect — apparently both are non discriminating at times.

**A classic demonstration of the non discriminating body memory**

A gigantic shock was sent through the immunological community by someone outside their field. In the 1970s, Robert Ader, a

psychologist, had been doing some experiments involving a variation of Pavlovian type conditioning on rats. This particular type of conditioning is now known as taste aversion learning. Typically, a distinctively flavored solution (water flavored with saccharin, garlic and coffee are examples) is given to water-deprived rats and immediately (in some experiments) afterward a pharmacological agent that produces gastro-intestinal upset is injected.

Interestingly, only a one-time pairing was sufficient to induce a conditioned avoidance to the flavored water. Thereafter, when exposed to repeated presentations of the flavored water, the rats demonstrate aversion.

Ader's experiment involved creating a conditioned aversion to water flavored with saccharin. The choice of drug for the immediate follow-up injection was cyclophosphamine (CY), which has the property of producing nausea. The experiment was done on a "one-time trial" basis (meaning only a single pairing of the saccharin flavored water and the nausea producing CY were done). As expected, the rats demonstrated a conditioned response aversion to the saccharin water stimulus alone (without the CY injection follow-up). So far so good, but there was one unexpected problem.

Observations during the extinction trials continued, testing every few days to note the time required for the conditioning to abate or extinguish. During this time, only the saccharin water was presented (with no CY injections) and a very surprising thing was happening. Some of the previously healthy rats were dying. Later investigations with the help of an immunologist revealed that aside from inducing nausea, CY also had a property of immuno-suppression. By subsequent exposure to the saccharin water (without the immuno-suppressive CY) the conditioned rats' nervous systems (body memory) had fatally suppressed their immune system solely through conditioning!

Hence "psychoneuroimmunology" or PNI (coined by Ader) was off and running. Well, it walked at first because of skepticism, which was later reduced due to many successful replications and variations of Ader's experiments.

And, isn't it a body memory problem when we have an extreme allergic reaction? Probably a faulty memory system with the afore mentioned immune systems memory cells. Are not immunoglobulins and neuropeptides both peptides? Even monocytes have receptors on their surfaces (actually *every* neuropeptide receptor the scientists have searched for has been found there). Additionally, they are themselves capable of making neuropeptides.

Microscopic material, allergens, bacteria, viruses, molds, etc., are, of course, undetectable by the senses (but are detected by at least the monocytes). In light of this and the fact that the immune system can detect what the senses do not, Dr. Edward Blalock was prompted to call it the "sixth sense," and Argentine researcher Hugo Besedovsky called it a "peripheral receptor organ" (of the brain), which notifies the body about these small, but possibly virulent, survival threats. He was the first researcher who demonstrated increased brain activity when the immune system was actively engaged in fighting virulent organisms.

So properly, we should begin thinking in terms of mind / body. And mind-memory / body-memory. Or just an all inclusive *BIG* Memory?! Nomenclature always follows discovery. We'll get it down sometime. Maybe when we are not so cerebrocentric.

In NET, we maintain that it is the lack of normal physiological extinction of a "conditioned response" that causes the problems we encounter in NECs. You could call it a memory problem, or a body memory problem. Memories stimulated by generalized stimuli. We rely on memory to elicit the snapshot within the NEC. The snapshot recalls the physiological body memory. The physiology of the body now replicates to some extent the physiology present at the time of the original event (SDMLB). Conditioned responses imply a memory of some sort — call it body memory or whatever. Anniversary events. Body memory. So if this is correct, we must do all we can to enhance the memory system of the body and make it work better.

So it was, that certain specific homeopathic (energetic) remedies were found to "unjam" at least several types of body memory (call them Earth, Metal, Water, Wood and Fire for now), allowing for fuller body-wide conditioned response extinction with better results and fewer NECs.

Let us now fully engage the body memory to carry out and complete the physiological healing.

# NEUROPEPTIDES AND OTHER INFORMATION SUBSTANCES (IS)

**Peptide**

A compound of two or more amino acids in which the alpha carboxyl group of one is united with the alpha amino group of another, with the elimination of a molecule of water, thus forming a peptide bond, –CO–NH–. Peptides are polymers of amino acids that occur naturally in living tissues and play an important role in many biological processes.

**Neuropeptide**

Any of a variety of peptides found in neural tissue; e.g., endorphins, enkephalins. (1975) An endogenous peptide that influences neural activity or functioning. Now numbering over 100.

**Descartes**

Because of the popular acceptance and subsequent handing down of the philosophical concepts generated by Descartes (17th century), most of us have been educated to think in a "mind as distinct from body" paradigm. For nearly 300 years the concept that the mind and body are surely separate has been largely unchallenged until recently. All western scientists have been educated to think and conduct research using this model, and the general culture has generally embraced and therefore allowed the philosophy to influence its thinking.

"The single sure fact from which his investigations began was expressed by him in the famous words Cogito, ergo sum, "I think, therefore I am." From this postulate that a clear consciousness of his thinking proved his own existence, he argued the existence of God. God, according to Descartes's philosophy, created two classes of substance that make up the whole of reality. One class was thinking substances or minds, and the other was extended substances or bodies." *Funk & Wagnalls Encyclopedia.*

Thus, the split between mind and body was formally born. Emotion since Descartes has been seen as a hindrance to pure and sound reasoning. Although there are some merits to this proposition, in generalized terms this, too, has been shown to be false. Damasio[1] demonstrated that an individual devoid of any emotionality also relinquished effectual rationality. Groen sums up the more current view,

> "*Modern research has not supported the distinction between somatic and spiritual emotions and the whole dualistic concept is now regarded by most researchers as operationally not useful anyway.*[2] "

Marc Barasch colorfully describes the fall, the discovery that caused it, and also introduces Candace Pert, Ph.D., in the heroine's role,

> "...if anyone could be credited with shutting off the refrigeration on Descartes' mortal remains and letting the aroma of a paradigm gone bad reach science's stuffed nostrils, it is Candace Pert, Ph.D., former chief of the Brain Biochemistry Section of the National Institute of Mental Health and codiscoverer of the brain's opiate receptors. Subsequent revelations that similar docking sites for "information molecules" (or neuropeptides) were myriad as stars scattered through the bodily firmament have launched the branch of medicine known as psychoneuroimmunology (PNI), which is busy codifying a self-evident truth: Mind and body have their hands so deep in each other's pockets it's hard to tell whose car keys are whose.
>
> So-called messenger molecules are suddenly turning up everywhere-in the brain (particularly in the centers governing emotion), throughout the immune system, and in organs from gut to gland. Our thoughts and feelings are mediated by neuropeptides; diseases secrete neuropeptides; neuropeptides may be crucial to the healing response. What Pert proved once and for all is that brain, nervous system, and immune system, far from being incommunicado, are at this very second hunched elbow-to-elbow at the espresso bar of the Chatterbox Cafe, animatedly sharing your most intimate particulars."[3]

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[1] Antonio R. Damasio, M.D., Ph.D., *Descartes' Error – Emotion, Reason and the Human Brain* G.P. Putnam's Sons ©1994.

[2] (*Emotions-Their Parameters and Measurement*, J.J. Groin, edited by L. Levi, Raven Press, New York, 1975).

[3] Barasch, Marc, *Welcome to the Mind-Body Revolution*.., Vol. 26, Psychology Today, 07-01-1993, pg. 58.

In fact Pert, herself, admitted to the aforementioned mind bias saying,

> *"In the beginning of my work, I matter-of-factly presumed that emotions were in the head or brain. Now I would say they are really in the body as well. They are expressed in the body and are part of the body. I can no longer make a strong distinction between the brain and the body."*[4]

Much of the neurophysiology of emotions is based on various chains of amino acids called *peptides*, which travel throughout the entire body by extracellular fluids to distant, larger "catcher" amino acid chains called *receptors*.

Pert describes her astounding revelation,

> "In the beginning, like many other neuroscientists, I was secretly interested in consciousness, and thought that by studying the brain I would learn about the mind and consciousness. And so for most of my early research I concentrated from the neck up.
>
> But the astounding revelation is that these endorphins and other chemicals like them are found not just in the brain, but in the immune system, the endocrine system, and throughout the body.
>
> These molecules are involved in a psychosomatic communication network...Information is flowing. These molecules are being released from one place, they're diffusing all over the body, and they're tickling the receptors that are on the surface of every cell in your body... if you can imagine millions of satellite dishes all over one cell. The cells are being told whether they should divide or not divide, whether they should make more of this protein or that protein, whether they should turn on this gene or that gene.
>
> Everything in your body is being run by these messenger molecules, many of which are peptides."[5] [NET's emphasis]

[4] *Whole Earth Review,* 27 Gate Five Road, Sausalito, CA.94965, Summer 1988, Page 109.

[5] Moyers, B., *Healing and the Mind*, Public Affairs Television Inc., Productions Inc. Doubleday. 1993 pg 178.

If you are asked where emotion "is," Pert provides a succinct answer:

> *"The old barriers between brain and body are breaking down...The chemicals that mediate emotion and the receptors for those chemicals are found in almost every cell in the body."* [6]

Pert relates,

> *"People sometimes say they are overcome with this or that feeling. Biochemically speaking, we would say that they are overcome with this or that peptide. What we are dealing with in neuropeptides, we believe, is a body-wide system, or, to put it differently, a system that simultaneously includes brain and body. Conventional scientific wisdom tends to see a clear distinct difference between brain and body. When talking of neuropeptides, the distinction, for all practical purposes, virtually disappears. We are talking about something that can "grip" the whole organism.*
>
> *This is one reason we contend that this "whole body" system—the system of neuropeptides, the system of emotions—can play a critical part in matters of health and disease."*[7]

In 1988 Pert related,

> *"The concept of "emotion" took me out on a limb. Even today, the word is slightly disreputable in many scientific quarters; a half dozen years ago its use smacked of the scandalous."*[8]
>
> "*Emotions*," Pert says, "*are neuropeptides attaching to receptors and stimulating an electrical change on neurons*."[9]

Pert believes joy, grief, love, etc. all have a biochemical basis and that they may be responsible for our mood state,

[6] Candace Pert with Bill Moyers Body and Soul pg 48 Spring 1993.

[7] Pert C., with Dienstfrey, H., *The Neuropeptide Network*, Annals New York Academy of Sciences, 1988 pg. 189.

[8] Ibid pg. 189.

[9] National Geographic, *Quiet Miracles of the Brain*, June 1995 pg. 25.

> "The striking pattern of neuropeptide receptor distribution in mood-regulating areas of the brain [limbic system], as well as their role in mediating communication throughout the whole organism, makes neuropeptides the obvious candidates for the biochemical basis of emotion"[10]

> "Experiments show that the spleen, thymus, bone marrow, lymph glands, and dorsal horn of the spine also produce neuropeptides."[11]

Pert actually argues that the spinal cord should be *considered part of the limbic system*. She reasons,

> "If our reasoning is correct – that the presence of a heavy density of neuropeptide receptors identifies a part of the limbic system – our research suggests that the usual picture of the limbic system should be extended to include the spinal cord... It was Freud, of course, who drew our attention to the possibility that the brain has a conscious part and an unconscious part. Normally, one thinks of the conscious part on the top and the unconscious part toward the back. But we would go further back (or down) and say that the subconscious is in the spinal cord and even "lower."[12]

Says Pert,

> "Now we realize that synapses are not as important as we thought. They help control some kinds of information flow, particularly muscle contraction. But the largest portion of information coming from the brain is kept straight not by the close physical juxtaposition of nerve cells, but by the specificity of the receptors. What was thought of as a highly rigid system appears to be one with far more complex patterns of distribution.

> "When a nerve cell squirts out opiate peptides, the peptides can act "miles" away at other nerve cells. The same is true of all peptides. At any given moment, many neuropeptides may be floating along within the body, and what enables them to attach to the correct receptor molecules is, to repeat, the specificity of the receptors. Thus, the receptors serve as the mechanism that sorts out the information exchange in the body."[13]

The network of interactions is astounding. Says Pert,

> "Peptides, receptors, cells. The receptors are dynamic. They're wiggling, vibrating energy molecules that are not only changing their shape from millisecond to millisecond, but actually changing what they are coupled to. One moment they're coupled up to one protein in the membrane, and the next moment they can couple up to another. Its a very dynamic, fluid system."[14]

**MORE TERMS:**

**Ribonucleic Acid**
A macromolecule consisting of ribonucleoside residues connected by phosphate from the 3 hydroxyl of one to the 5 hydroxyl of the next nucleoside. RNA is found in all cells, in both nuclei and cytoplasm and in particulate and nonparticulate form, and also in many viruses; polynucleotides made in vitro are generally called such. Various RNA fractions are identified by location, form, or function.

**Messenger RNA** ( mRNA ), **informational RNA; template RNA**; the RNA reflecting the exact nucleoside sequence of the genetically active DNA and carrying the "message" of the latter, coded in its sequence, to the cytoplasmic areas where protein is made in amino-acid sequences specified by the mRNA, and hence primarily by the DNA; viral RNAs are considered to be natural messenger RNAs.

**Informosomes**
Name suggested for the bodies composed of messenger (informational) RNA and protein that are found in the cytoplasm of animal cells.

**Naloxone Hydrochloride**

[10] C. Pert, *The Wisdom of the Receptors: Neuropeptides, the Emotions, and Body-Mind*, Advances 1986, 3(3), pg. 12.

[11] Pert C., with Dienstfrey, H., *The Neuropeptide Network*, Annals New York Academy of Sciences, 1988 pg. 194.

[12] ibid. pg. 191 and 193.

[13] C. Pert, *The Wisdom of the Receptors: Neuropeptides, the Emotions, and Body-Mind*, Advances 1986, 3(3), pg. 10.

[14] Bill Moyers, *Healing and the Mind* © Public Affairs Television Inc., and David Grubin Productions Inc. Doubleday. 1993 pg 186.

A potent antagonist of endorphins and narcotics, including pentazocine; devoid of pharmacologic action when administered without narcotics.

**Study**

Effects of MorphineBehavNeuro Vol.100No.5 <86> 647#

Effects of Morphine, Ethylketocyclazocine, and N-Allylnormetazocine on Classical Conditioning of the Rabbit Nictitating Membrane Response

Charles W. Schindler, Marvin R. Lamb, I. Gormezano, and John A. Harvey
University of Iowa

The rabbit's nictitating membrane response was classically conditioned to tone and light conditioned stimuli presented for 800 ms before delivery of a 100 ms unconditioned shock stimulus. Both the mu receptor agonist morphine (S mg/kg) and the kappa receptor agonist ethylketocyclazocine (I mg/kg) significantly retarded the acquisition of conditioned responses (CRs). The retardant effects of both morphine and ethylketocyclazocine on CR acquisition could still be detected when the rabbits were tested 5 days after cessation of drug injections. At the dose employed in this study (S mg/kg), the sigma receptor agonist IV-allylnormetazocine had no effect on acquisition. :Ihe retardant effects of morphine and ethylketocyclazocine on acquisition were significantly antagonized by both naloxone (I mg/kg) and N-allylnormetazocine (5 mg/kg). It was suggested that mu and possibly kappa receptors are involved in the retardant effects of opiates on the acquisition of classically conditioned responses.

**Study**

The Placebo Effect
The Amazing Brain by Robert Ornstein and Richard F. Thompson
HOUGHTON MIFFLIN COMPANY/BOSTON

From pages 177-178

What should be wondered about is how we manage to stay as healthy as we do in our complex environment. Most people who are under stress do not get sick, most people who smoke do not get lung cancer, most people who grieve do not die quickly, most people who move and live entirely new lives remain healthy. Our body temperature remains constant, our heart makes billions of beats on time, our glands receive the correct chemical messengers, and millions of other regulatory processes go on, almost automatically. The brain is designed primarily to run the body and to keep it healthy. The countless extensions of the brain's sensory systems, the internal nervous, chemical, and regulatory systems, all serve to keep us out of trouble.

The brain is our largest organ of secretion—it produces the most chemicals of any organ in the body—and it is the organ of health, our own internal health maintenance organization.

Some of the most recent discoveries in brain sciences have enabled us to get a glimpse of how elaborate our innate healing network is, and how much we might be able to accomplish were we able to develop drugs and procedures that allowed this innate network to flourish.

In one important study at the University of California at San Francisco, under the direction of Jon Levine, a large number of dental patients were given one of several drugs before dental work.

Some were given painkilling drugs, as usual, but others were given a placebo—an inert substance that is believed by the patient to produce genuine physiological effects. Both groups reported little or no pain while in treatment. This finding, so far, is similar to many throughout the world— that inert substances can, if they are believed genuine, influence the body.

This "placebo effect" has often been maligned in medicine, as if nothing "real" is accomplished. This is similar to the experience of Robert Esdaile, the first person to demonstrate hypnosis to the Royal Society, the esteemed British scientific organization. Esdaile, in front of an assembled society committee, sawed off the gangrenous leg of a patient, on stage, without anesthesia. But his treatment was not accepted.

Members of the Royal Society alleged that Esdaile had merely hired a "hardened rogue" to appear. So, too, is the placebo ignored, and it is often considered trivial by those interested in "hard" medicine.

But Levine's experiment was different. After administering the placebo to some patients,

Levine did something else, something quite innovative. He gave half the patients a dose of naloxone, which, as we have seen, is a drug that blocks the effects of endorphins by filling the receptor sites so that the endorphins cannot operate. If the placebo were merely foolery, then naloxone should have no effect. But if the placebo activates our endorphins, naloxone would have an effect. The results were astonishing to many in neurochemistry: those patients who were given naloxone did not produce the placebo effect; they found the dentistry painful. This means that the placebo effect, in this experiment anyway, may have involved the production of endorphins by the dental patients, owing to their belief that they were going to be relieved from pain.

So the brain may be able to relieve pain by producing chemicals on demand that block transmission of the pain signals. Endorphin production has been reported to influence weight, memory, schizophrenic like symptoms, and many other bodily functions. Even more tantalizing, the immune system has endorphin receptors. So the brain seems to possess capacities for healing and self-repair beyond the dreams of researchers only a few years ago. It seems to be able to regulate our health far beyond anything that could be done consciously: Norman Cousins reported that laughter helped him over come a mysterious disease; Augustin De La Pena has hypothesized that the excessively bored brain may be responsible for some cancers; Alan Frey has found that emotional tears may contain substances the body needs to expel; and there are numerous new ideas about how "mental" health and physical health are similar.

**Study**

Endogenous Opiate System and Systematic Desensitization

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In a double-blind study, phobic patients received intravenous infusions of either naloxone or saline *prior to systematic desensitization.* Saline-infused subjects significantly demonstrated the predicted symptom decrease in response to systematic desensitization, whereas naloxone-infused subjects showed no change.

Subject reports and psychophysiological measures of arousal indicated no discriminable awareness of the naloxone versus saline condition. The findings appear to be consistent with the hypothesis that activation of the endogenous opiate system (EOS) plays a role in the effectiveness of systematic desensitization. Implications for a common mechanism underlying behavioral and pharmacological treatments are discussed.

"After the discovery in 1975 of enkephalins and endorphins (natural pain inhibitors in the body), some neurophysiologists suggested that the needles may trigger the release of one or more of these substances, which inhibit pain signals by blocking their pathway through the spinal cord. This view is supported by both American and Chinese studies showing that placing acupuncture needles in certain parts of the brain of dogs causes a rise in the level of endorphins in the spinal fluid. Scientists in the U.S. have also shown that acupuncture analgesia is at least partly reversible by naloxone, a drug that blocks the action of morphine and morphinelike chemicals such as endorphins."– Funk & Wagnalls Encyclopedia.

**Learning Implications**

Quigley comments on levels of learning saying,

> "Learning has been demonstrated in reptiles, fish and it even appears in the lowly and primitive flatworm. Horridge ( 1962) has clearly demonstrated learning can occur in the single nerve ganglion of a cockroach! Thus it appears most likely to occur in the infinitely more neurologically complex spinal cord. Guyton (1966) comments on this possibility when he states, "Most of this storage of information occurs in the cerebral cortex but not all, for even the basal ganglion of the brain and perhaps the spinal cord can

store lesser amounts of information." Now **it is important to establish that memory, especially of traumatic events**, is unconsciously expressed through motor behavior. Thus conscious or unconscious **retention of stressful experiences can be disturbing both physiologically and psychologically**." [NET's emphasis][15]

Malik Slosberg has investigated spinal learning. Commenting on spinal cats (those with spinal cord transected) he writes,

> "...conclude that in spinal animals, involved spinal reflex arcs respond to pairings of CS-UCS [conditioned response-unconditioned response] in a way which seems to parallel some aspects of learning in the intact animal. Further research supports this belief... The authors concluded that **the site of associative learning is within the interneurons of the spinal reflex pathway."** [NET's emphasis][16]

Noxious stimuli can produce spinal learning with motor affects. Can the memories, conscious or non conscious, of emotional traumas do the same and be manifested in spinal subluxations? This would likely be facilitated by neuropeptides. At least one neuropeptide, substance P (which Slosberg discusses below), is elicited by emotion[17] and in compressed nerve roots.[18] In any event, if unpleasant emotional stimuli have any effects similar to those of chemical noxious stimuli, the implications are enormous. The following work by Frankstein strongly suggests "memory" and learning are not always in the brain. However, he also states that significant cortical labor is needed to compensate for unresolved aberrant spinal learning. Slosberg writes,

> "Frankstein reported that injecting turpentine into the footpads of cats produced typical inflammatory and behavioral responses characteristic of pain, including a flexion withdrawal reflex. These initial reactions gradually subsided and normal locomotion returned. However, with decerebration, after the inflammatory injury induced by the turpentine was healed, the flexion returned. This suggests that while the peripheral irritation which induced the flexion had stopped, long-lasting alterations had occurred in the spinal reflex circuits which were compensated by the cortex to produce normal locomotion. With the cortical compensation gone, the abnormal reflex pattern was restored.
>
> Frankstein interpreted this to indicate that the injury produced "pathological excitation" in the nervous system which persisted **even though the peripheral irritation which initiated it had ended.** Moreover, the evidence indicated that the organism was "forced to compensate to conceal the traces of excitation in the nervous system". This compensation was removed with decerebration and the afferent-induced excitability returned. Frankstein interpreted these findings to indicate that neural pathways may become excited by noxious stimulation producing **long-term alterations in their response characteristics which may persist though the noxious stimulation has ceased**." [NET's emphasis][19]

If emotional trauma does act in a similar way to the chemical stimuli described above, and if the human organism is also "forced to compensate to conceal the traces of excitation in the nervous system," we can have new appreciation for the saying, "he is carrying quite a load (emotional burden)."

Actually, if we accept that emotions are carried by neuropeptides, it is interesting that Slosberg finds a neuropeptide, Substance P, involved in spinal learning. He states,

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[15] Quigley, W., *Physiological Psychology of Chiropractic*, n Mental health and Chiropractic edited by Herman S. Schwartz Sessions publishers 1973 pg. 108-109.

[16] Slosberg, M., *Spinal Learning: Central Modulation of Pain Processing and Long-Term Alteration of Interneuronal Excitability as a Result of Nociceptive Peripheral Input,* Journal Manipulative and Physiological Therapeutics, Volume 13, Number 6, July/August. 1990 pg. 326.

[17] Shaikh, M., Steinberg, A., Sielgel, A., *Evidence that substance P is utilized in medial amygdaloid facilitation of defensive rage behavior in the cat*, Elsevier Science Publishers 1993 pg. 283-294.

[18] Cornefjord, M., Olmarker, Farley, D.B., Weinstein, J.N. and Rydevik, B., *Neuropeptide Changes in Compressed Spinal Nerve Roots*, Spine, Vol. 20, No. 6, 1995, J.B. Lipponcott Company pg. 670-673.

[19] Slosberg, M., *Spinal Learning: Central Modulation of Pain Processing and Long-Term Alteration of Interneuronal Excitability as a Result of Nociceptive Peripheral Input,* Journal Manipulative and Physiological Therapeutics, Volume 13, Number 6, July/August. 1990 pg. 329.

> "...and release of substance P may result in prolonged facilitation of interneurons. Such change, which may endure long after the noxious input has subsided, may affect the involved interneurons response to subsequent input. Patterson has termed such an alteration within the spinal cord as a 'neural scar."[20]

And some of that "subsequent input" with an affected "interneuronal response" may well be the laborious and short lasting adjustments given by a chiropractor to a segment that is "emotionally" compromised. The end result is a recurring subluxation.

Could all traumas, including chemical irritation as described above, have an affective/emotional component? Most, but not all, of these emotional components are self resolving. However, those which are not self resolving are usually significant factors in the recurring problems. We refer to these "neural scars" or bodily held emotions as Neuro-Emotional Complexes (NECs).

Clinically, we have found that by having the patient engage a particular emotional event (memory) *just prior to and during* the correction, the patient's nervous system is uniquely engaged and as a result provides a similarly unique opportunity for a greater physical-emotional resolution. It is proposed that the reason for this observably increased benefit is that the pattern of neuropeptides and receptors – via the mechanism of memory – are physiologically engaged, and thus, we are correcting a patient with a more able-to-respond nervous system. Neuropeptides, neurotransmitters, hormones, etc. are all classified as informational Substances (IS).

**The Immune System**

To think Information Substances (ISs) could influence the immune system (they do) seemed a more improbable idea than the notion that emotions were physiologically based. Skepticism abounded as the old paradigms crumbled.

Just twenty-five years ago, the very concept of neuroimmunology was preposterous to some. As Locke states,

> "To suggest that the immune system was regulated by anything other than itself was to utter the medical equivalent of blasphemy."[21]

Pert related the slow acceptance of science in an interview,

> "When people discovered that there were endorphins in the brain that caused euphoria and pain relief, everybody could handle that. But when they discovered they were in your immune system, too, it just didn't fit, so it was denied for years. The original scientists had to repeat their studies many, many times to be believed. It was just very upsetting to our paradigm to find mood-altering chemicals in the immune system and not just the chemicals, but the receptors as well."[22]

Even monocytes have receptors on their surfaces (actually *every* neuropeptide receptor the scientists have searched for has been found there). Additionally, they are themselves capable of making neuropeptides! Mind-Body.

Physiologist Clive Wood pondered the psychosomatic connection (the unseen feeling information in neuropeptides influencing the observable cell) writing,

> "How does our psychological state affect our physiology, (in a phrase attributed to the distinguished American physician Thomas Lewis) 'how does unhappiness get in to [sic] a cell?'... Until recently, the nervous and immune systems were thought of as being completely separate. But the discovery of these lymphocyte receptors means that immunity is to some degree under mental control. What we think and feel is likely to influence our immune responses. So unhappiness gets into our cells by way of receptors."[23]

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[20] ibid pg. 332.

[21] Steven Locke, M.D. and Douglas Colligan, *The Healer Within, The New Medicine of Mind and Body* (E.P. Dutton, 1986).

[22] Moyers, B., *An Interview With Candace Pert*, Body & Soul, Spring 1993.

[23] Wood C., Journal of Alternative & Complimentary Medicine, October 1990 pg 15-16.

## Additional Reading: *Neuropeptides in the Spinal Cord*

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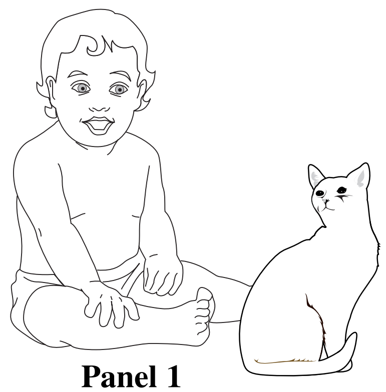
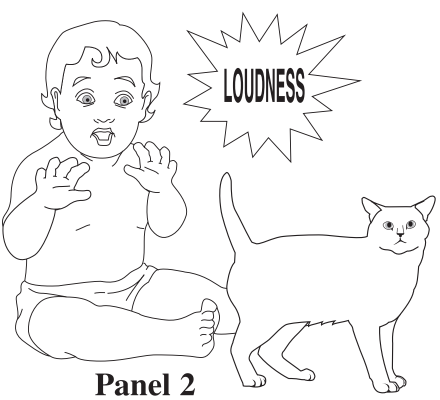
# CLASSICAL CONDITIONING & STIMULUS GENERALIZATION

**In Panel 1** the cat is approached by the child, who shows no signs of fear or upset. The child probably even enjoys the presence of the cat.



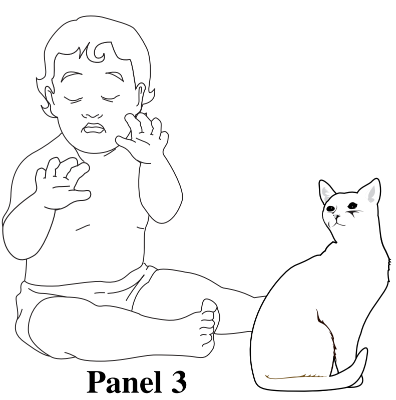
Panel 1

**In Panel 2** the child is scared by a loud noise, which he associates with the cat.



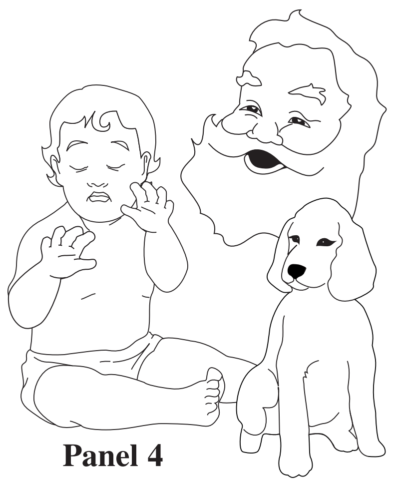

Panel 2

**In Panel 3** the cat alone (without the loud noise) now elicits fear in the child. This is known as a **Conditioned Response**.



Panel 3

**In Panel 4** the child may now also be afraid of other furry (or somehow similar) things, such as a furry dog or even a man with a furry beard like Santa Claus! This is known as **Stimulus Generalization**.



Panel 4

# PAVLOVIAN CONDITIONING

Before we discus conditioning and conditioned responses so integral to the theory of NET, let us remember the "normal" *unconditioned* response.

If a dog is presented with a piece of meat, it naturally responds with salivation, which aides it's natural deglutition and digestion. Just like the normal sucking response in the newborn, this response is not dependent or conditional on anything other than the bare essential basics of life. Thus it is said to be unconditional, or an unconditional response. Fair enough. But it was Pavlov who discovered the conditional response meaning it was conditional or dependent on certain environmental *conditions*.

**Pavlov**

Ivan Petrovich Pavlov, b. Sept. 26, 1849, d. Feb. 27, 1936, was a Russian physiologist – not a psychologist as is sometimes thought. The son of a priest, Pavlov was educated at the Ryazan seminary and at the University of Saint Petersburg in science and medicine. After graduating, he spent two years in Germany with Karl Ludwig and Rudolf Heidenhain studying the nerves of the heart.

As professor of physiology at the Military Medical Academy, the Institute of Experimental Medicine and the Academy of Sciences, Pavlov investigated the physiology of the cardiovascular system, the digestive system and the central nervous system. In 1904 he was awarded the Nobel Prize for his work on digestion. In his experimentation, Pavlov used live animals and studied each system as a continuing process.

The term "conditioned reflex" was first used by him to describe a reflex which is *acquired, rather than inborn*, or *peculiar to the individual, rather than to the whole species*.

**Pavlovian Conditioning**

[Note: Associative learning has been the focus of much research on learning. It is usually — although not unanimously — divided into two forms: Pavlovian (classical, or respondent) conditioning, and instrumental (operant) conditioning. The former primarily involves modification of innate reflexes. The latter involves modification of behavior by reward and punishment — think of a person playing a slot machine or a hen pecking on a keyboard — both seeking a reward. Variations using pain or shock, thus causing avoidance rather than reward, are also used. This is interesting; however, we will not entertain operant conditioning here.]

**Abbreviations**

There are some variations of a number of abbreviations widely used in discussing the various components of conditioning.

They are:
Unconditioned Stimulus = **UCS**
Unconditioned Response = **UCR**
Neutral Stimulus = **NS**
Conditioned Stimulus = **CS**
Conditioned Response = **CR**

Pavlov would present two stimuli to his dog subjects at the same time. One stimulus was food or a shock (both unconditioned stimuli), which produced an unconditioned response (UCR) such as salivation or avoidance— think of a dog lifting its leg off a suddenly electrified grid, immediately after feeling the shock. Salivation or the lifting of the foot are normal responses to these respective stimuli and are thus said to be unconditioned.

The second stimulus was a bell tone, that *when presented alone evoked little or no response*. Thus, it is a neutral stimulus (NS). Presenting the UCS (meat or shock) and the NS (bell tone) together, however, gradually caused the dog to have a response to just the bell tone alone. At this point we say the bell tone has become a *conditioned* stimulus (CS). Now the CS (the bell tone) *by itself* can evoke the response of salivation or avoidance. The response of salivation or avoidance when elicited by a CS (in this case, the bell tone) would then be called a conditioned response (CR).

Thus the UCR and the CR could be the same event—salivation. When this salivation was produced by the UCS (meat) it had an UCR (salivation). However, when salivation is produced by the CS (bell tone)
then the salivation is (conditional on the sound of the bell) a CR.

**Conditioning and One Time Trials**

How often does the conditioning process need to be repeated before conditioning usually occurs? It depends on the nature of both the stimulus and response. If conditioning occurs after just one UCS pairing with a NS, it is termed a *one time trial*. This is important to remember in understanding the dynamics of NET.

## SOME DEFINITIONS

**CONDITIONING**

The process by which a conditioned response is learned, that is, a response to a stimulus that did not originally evoke it.

**CONDITIONED RESPONSE**

In classical conditioning, the learned or acquired response to a conditioned stimulus, that is, to a stimulus that did not elicit the response originally. (Also see Stimulus Generalization.)

**EXTINCTION**

The gradual diminution in the strength or rate of a conditioned response when the unconditioned stimulus or the reinforcement is withheld. In normal neurophysiology, there is a progressive decrease in excitability of a nerve to a previously adequate stimulus until it becomes completely inexcitable. Extinction for visual and tactile stimuli occurs in occipital-parietal lesions. Extinction of most conditioned responses is normal, however, those responses within the NEC are seemingly insulated from, or unreceptive to, this normal physiological process. Restoring normal nervous system function by acupuncture point intervention or spinal adjustment allows extinction to occur.

**SEMANTIC REACTION (SR)**

Term used by Alfred Korzybski to denote the response of the organism, as a whole (including its physiology) to symbols, and, especially, words. This is used in NET to index and isolate the SnapShot by muscle testing. Korzybski successfully experimented using the skin galvanometer to measure SR.

**SEMANTICS, GENERAL**

The science of human responses, as used by Alfred Korzybski, to signs and symbols, including the meaning of words, signals and gestures. It also includes the psychological and sociological aspects of language in the expression of thought and feeling and in exerting an influence on individuals or groups.

**SEMANTIC CONDITIONING**

A variety of classical conditioning, in which a concept in the form of a word, phrase, or sentence functions as a conditioned stimulus as a result of pairing with an unconditioned stimulus or as a result of generalization. E.g., the word *delicious,* when paired with actual food, will eventually elicit the response of salivation. After *delicious* is established as a conditioned stimulus, related words or phrases may elicit the same or similar responses through generalization.

**More on Semantic conditioning**

When lemon juice touches the tongue, saliva is secreted—this is an unconditioned reflex (UCR). However, saliva may be secreted at the mere sight of a lemon or at the sound of the word “lemon"—this is a conditioned response (CR).

The difference is that the sight of a lemon and the sound of the word “lemon" have not always evoked a flow of saliva in the

individual we are studying, and may not do so in all members of the species. These stimuli acquire their power to elicit a response when they occur at about the same time as stimulation with lemon juice or a similar substance. The sight of the lemon or the sound of the word “lemon" then becomes a conditioned stimulus (CS), which can later act as a substitute for the lemon juice (UCS).

**SEMANTIC GENERALIZATION**
A type of Mediated Generalization in which one makes use of what has already been learned as to the meaning of one word in order to relate it to another word. Thus, someone conditioned to respond to the word "tree" may also respond to the word "shrub." Semantic generalization is believed to be one of the mechanisms responsible for the clinical response to the clinicians words as used in the NET procedure. Also see Semantic Reaction.

**STIMULUS GENERALIZATION (SG)**
The tendency for a conditioned response to be evoked by stimuli that are similar to the conditioned stimulus. E.g., if a dog is conditioned to bark when a particular bell is sounded, he tends to make the same response to a wide range of bells; and a child who nearly drowns in the bathtub may develop a fear of wading and swimming. In experiments, alternate stimuli are employed to determine the extent of SG by noting which stimuli produced the same response.

## BACK TO PAVLOV:

### Pavlov's Techniques.

Pavlov's techniques required special soundproof rooms in which the environment could be controlled, a special stand and harness for the experimental animal and the automatic presentation of food without any warning. Stimuli of many different sorts (tones, flashing lights, etc.) could be administered as needed.

By performing a slight operation on the dog's cheek, Pavlov was able to lead the salivary duct to the outside where saliva could be carefully collected and measured. In a typical experiment, a moderately hungry dog was placed on the stand in a soundproof room for several experimental periods until it was well adjusted to the situation and free of emotional disturbance. During this period all saliva flows were measured, and they were usually negligible.

A stimulus was then presented — a tone was sounded. This may have evoked some slight salivation (as part of Pavlov's “investigatory reflex"), but after several presentations the dog usually became neutral or indifferent.

The conditioning process could then be started. The tone was sounded, and a few seconds later food was dropped into the dog's dish. As the dog ate, the flow of saliva was recorded, and when the flow ceased, the tone was again presented followed by food. After a few such combined presentations of tone and food, a test was made presenting the tone alone.

This previously neutral stimulus now evoked salivation — a conditioned reflex. In this example, the food is the “unconditioned stimulus," the tone is the “conditioned stimulus," and the combined presentation of food and tone is called “reinforcement."

### Pavlov's Findings.

Pavlov was able to show how conditioned responses develop to many different types of stimuli and under many different types and conditions of reinforcement. He also studied the process of “extinction," [see above] in which the conditioned stimulus is repeatedly presented but not reinforced. In such cases, the response grows weaker, often in a rather irregular fashion, until the conditioned stimulus ceases to evoke a response.
Pavlov also demonstrated related behavioral processes. For example, after salivation was established as the conditioned response to a

tone of a given pitch, it was found that salivation was also stimulated by different pitches; or, to cite another experimental example, a salivation response, conditioned to a scratch at a particular spot on the leg, was also elicited by scratches on neighboring spots. In each case, the degree of response to the new stimulus depended on how similar to the original the new stimulus was. A slightly different tone or a scratch on a spot very close to the original spot would yield almost the same flow of saliva as the originals, but a different tone or a scratch farther away would yield a smaller amount.

This effect, called “generalization,” could be counteracted by reinforcing the original stimulus, at the same time ceasing reinforcement of the others. The animal then develops “discrimination;" it makes a full response to the original conditioned stimulus and a reduced response or none at all to the others. Thus, Pavlov was able to investigate the smallest differences in stimuli discernible by a dog.

**Studies in Humans**

*Emotional behavior, too, is a field in which the conditioned reflex figures prominently. Conditioned reflexes that have been studied in man include the blink reflex, salivation, the secretion of sweat, the contraction and dilation of the pupil of the eye, and the contraction and relaxation of smooth muscle in the walls of blood vessels...*

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**The Developing SnapShot**

One way in which forms of learning can be categorized is as either associative or non-associative. At present all learning is considered associative to some degree. For example, if a person repeatedly rings a bell at a dog indoors, the dog will habituate. That is, it will cease to prick up its ears and look at the bell. However, if the dog is taken outside and the bell is rung again, it will probably again notice the sound. This suggests the dog's earlier habituation was caused by its association of the bell sound with the **background, or context, stimuli of the room**. This is part of the State Dependent Memory Learning Behavior (SDMLB) elucidated by Rossi.

# OUR THREE BRAINS OR OUR TRIUNE BRAIN

The first brain is an ancient, primitive **reptilian** brain.

The second and next oldest brain is the limbic, or **mammalian** brain, which registers rewards and punishments, is the seat of emotion, and controls the body's autonomic nervous system.

Finally, over the limbic brain lies the **neocortex** or "thinking cap."

In 1973, Dr. Paul MacLean (MIT/NIH) identified three separate components of the ‘brain’ and coined the term “triune brain.” The **reptilian brain**, or brain stem, connects directly to the spinal cord, controlling the basic and instinctive responses of the body, such as sex drive, breathing, hunger, heart rate, etc. It is of ancient design. The second and next oldest portion, the limbic or **mammalian** brain includes structures such as the hypothalamus and pituitary gland and is the seat of emotion. The mammalian brain controls emotions, sexuality and pleasure. The third and newest brain is the **neocortex** and “contains” the cognitive processes we associate with thinking and learning. MacLean writes of these in *The Triune Brain in Evolution* (1990).

Anatomists focus on separation and localization of function within the brain. Yet globalization or holographism is also prevalent. Functionally, the brain will not be confined to anatomy. So MacClean’s model also eventually breaks down, although it has been found to be very useful conceptually.

Although many problems arise because of a lack of coordination between what were originally three different brain systems, MacLean stressed that these structures are not separate, but rather are three systems integrated into one – hence, tri-une. He argued that all the old structures were active in determining behavior, and that from these different, but connected brains, came not only different behavior, but also many of the problems humans face daily.

## I. Reptilian Brain

The Reptilian Brain contributes genetically preprogrammed behavior patterns: aggression (physical), territoriality, ritual, and dominance (establishment of social hierarchies). Much modern human behavior is influenced by these basic drives. We use the reptilian brain to explore our environment, responding to danger with the "fight or flight" instinct.

spinal cord — relays messages.
medulla — basic life support systems.
pons — links cerebellum with cortex, controls some facial expressions and eye movements.
midbrain — controls reflex responses.
cerebellum — kinesthetic senses.

**Basic characteristics**
Primary motor functions
Instinctive or genetically-programmed behaviors
Primitive sensations
Aggression, territoriality, and dominance
Reproductive behaviors
Instinctive Responses
Hunger
Self Preservation
Reproduction

Breathing
Heart Rate
Primitive Muscle Reflexes
Survival Instinct.
Sensory Motor Functions
Concerns Are
Food
Shelter
Reproduction
Territory

**Use**
Explore Our Environment
Responding To Danger
with The "Fight Or Flight" Instinct

## II. Mammalian Brain

The Mammalian Brain is also known as the visceral brain and the limbic system. It deals with health, emotions and learning feelings like anger, hopelessness, and sadness. It also deals with functions like heart rate, blood pressure and sexuality and is linked to memory.

hippocampus — emotions, conditioning, memory storage.
amygdala — emotions, smell.
hypothalamus — physiological functions, hormone levels —when damaged, will produce global retrograde amnesia.
pituitary gland — produces hormones, under direction of hypothalamus.
thalamus — processes perceptions (except smell), and sends information to the cortex.

**Basic characteristics**
Emotions and Altruism
Religious tendencies
Sexuality
Complex sensation and perception
Short Term Memory and storage (into Long Term memory)
Timeless—no Today, Tomorrow Or Yesterday. All That Ever Was Simply Is.
Hormones
Temperature Control
Emotion, Memory Formation.
Aggressive Behavior
Long Term Memory
It tries to re-create the childhood (for the purpose of healing old childhood wounds)

## III. Neocortex

The neocortex contains the intellect that we normally associate with thinking and learning.

cerebral cortex — outer layer or covering of the cerebrum controls thought and language.
corpus callosum — connects the two hemispheres of the cerebrum.
cerebrum — is the largest part of the brain and is divided into two hemispheres. The cerebrum is concerned with interpretations of sensory impulses and is also the center of the higher faculties such as memory, learning, reasoning, judgement and intelligence. The principal lobes of the cerebrum are:
**frontal**—language processing and complex thinking, ability to consider the future (anticipation and planning), deliberation, regulation of action, cognitive concerns and anxieties, and bipedal posture

**parietal**—perceptual processing and information exchange between the brain and the rest of the body
**temporal**—hearing, expression, and memory
**occipital**—vision
**central**—insula or island of Reil

Note: Language behavior is global although it has a nexus in the parietal lobes). Some smell (which is primarily limbic) and most memory (long-term) is neocortical. **Conditioning is thought to be primarily limbic**. Higher aspects of learning are neocortical.

**Basic characteristics**
Reasoning
Composition
Invention
Understanding
Coordinates All Voluntary Muscle Movements
Decision-making
Purposeful Behavior
Language
Voluntary Motor Control
Nonverbal Ideation
Mathematics
Spelling
Grammar

**The Neocortex – Two for the Price of One**

In the 1960's and 1970's, Roger Sperry and Robert Ornstein described the brain as composed of two hemispheres or cortices, left and right. Through a massive bundle of nerves called the corpus callosum, each hemisphere connects to the other. Each of these areas deal primarily with different cerebral activities.

Generally the left brain works with math, logic, reasoning, analysis, words. It is linear, sequential – doing one thing at a time. More detailed.

The right brain works with, art, spatial relationships, intuition, visualization, creativity, puts information into massive wads, holds the big picture.

**Metaphor I**
Plato's Phaedrus metaphor "likens the human soul to a chariot drawn by two horses — one black, one white — pulling in different directions and weakly controlled by a charioteer."

**Metaphor II** to be continued...
Someone at UCSD pointed out that man has always tried to explain the brain in terms of the highest technology available to him at the time. The loom, the calculating machine, the camera, the computer, and now the hologram.

# DREAM WEAVER

Dreams have been a source of mystery and intrigue since the days of antiquity. Originally dreams were thought of in a supernatural way or as direct communications from the gods. There are recordings from ancient Egypt, as early as the 12th dynasty (c. 1991-1786 BC), on the interpretations of dream symbols. It was also the ancient Egyptians who were thought to introduce the process of "dream incubation", which involved putting a person who was distraught or needed guidance from the gods in a temple until sleep was induced, and the priest or Master of Secret Things would interpret the dreams that ensued. The ancient Greeks also believed dreams to be messages from the gods, of which there are several examples in Homer's Iliad (8th century BC). The old testament of the bible is filled with dreams thought to be supernatural communications of some sort, such as Jacob's famous dream of a ladder that extended from earth to heaven.

The Greek philosopher Heraclitus (c. 544-483) is one of the earliest known contributors to "modern" dream interpretation. He suggested that the dream world is unique to the person experiencing it and not influenced by the outside world—even the gods. A century after Heraclitus, Aristotle (384-322 BC) tried to study the dream process in a rational way, suggesting that dreams were fragments of recollections of events of the day. He taught that to understand dreams one must understand metaphor, in which one image describes another. Aristotle also promoted the idea that dreams were a reflection of the bodily state, and that doctors could use a patient's dream as a means of diagnosing an illness. This idea was supported by Hippocrates (c. 460-357 BC), and later by Galen (AD 129-99). As an example, Galen recorded that a wrestler he was treating dreamed that he was standing up to the crown of his head in blood; Galen inferred that he "was in need of a liberal bloodletting, and by this means the pleurisy under which he labored was cured."

In 1900, Sigmund Freud (1865-1939) published his landmark work The Interpretation of Dreams, where he theorized that although dreams may be prompted by external stimuli, wish fulfillment was at the basis of most of them. Accordingly, dreams reflect our deepest desires; they are rooted in our infancy and always hold a serious meaning. As such, there is libidinal energy associated with dreams. Dreams were considered the result of concealed desires, which express themselves in a concealed manner in the dream content. Freud suggested that dreams have a manifest content (what happened in the dream) and a latent content (what is behind the manifest content, i.e., the repressed issues that fueled the formation of the dream). Freudian theory would contend that in most cases the dreamer is unable to solely interpret the dream; the observations and insights of a psychoanalyst are usually required.

Carl Gustav Jung (1875-1961) studied with Freud for several years, but eventually broke away to develop his own theory of the psyche. Although Freud significantly influenced Jung's work, there are some notable differences. One is Jung's tendency to dismiss the importance Freud placed on libidinal forces. Another is Jung's concept of the collective unconscious, which suggests that a part of the mind contains information that is common to all humans. This was his explanation for the fact that people from widely different cultures could have dreams in which specific symbols occur and appear to have the same meaning. Jung considered his view of dreams to be broader and more expansive than Freud's. For Jung, dreams revealed our deepest wishes and longings, which might be 'incongruent' with the persona we feel the need to present to the outside world. Jung suggested that dreams are important messages from ourselves to ourselves, and that people could and should learn to interpret their own dreams.

Regardless of the theory ascribed to, most professionals agree that dreams are important. In my own practice, I found it difficult to be the dream interpreter, as I was not confident about the reliability of my interpretations. Likewise, trying to engage patients in their own interpretation of the dreams often was problematic, and usually they were looking to me for the answer. In the end, I began to dread any mention of dreams because I found the entire topic to be too frustrating and too low in therapeutic yield. However, all of that changed when I began to use the dream as the entry point to the NET procedure.

From the early days of NET, Dr. Walker suggested that dreams were effective for NET "mind" entry (also referred to as NEAT). However, none of the courses had provided a formal didactic on using dreams in the NET procedure. During the past year I began to focus some time on this topic both in my practice and in the NET Advanced seminar. The results have been encouraging and at times dramatic, as the dream often reveals highly significant NECs.

STEP-BY-STEP:
Consider encouraging patients to record the details of their dreams as soon as they awaken, otherwise details will surely be forgotten.

Have the patient relay the contents of the dream, including feelings and perceptions experienced during the dream. Then, begin the basic 15 steps of NET, sequentially using the content of the dream as entry points. Consider the example below (note the abbreviation MT stands for "muscle test"):

*Scenario 1.*

> Practitioner: Now that you've described the dream to me, I'd like you to reiterate each aspect of it from start to finish.
>
> Patient: Well, as I said, I was walking down a long, winding path…(the practitioner stops the patient from continuing further and performs a MT, which shows an inhibited or "weak" muscle).
>
> Practitioner: Your body is reacting to the path; does the concept of a path have any significance for you?
>
> Patient: I'm not sure, maybe it has something to do with some path I'm on in my life?
>
> Practitioner: O.K., let's test that, "the concept of some path you're on in your life" (MT-weak). We seem to be on track, let's try to get more specific.
>
> Patient: Maybe it has to do with a spiritual path, since I just started studying Yoga?
>
> Practitioner: Let's test that, "the concept of a spiritual path" (MT-strong). That doesn't seem to be it, anything else come to mind?
>
> Patient: How about something to do with work; I have been dissatisfied lately with the direction on my career.
>
> Practitioner: O.K., "the concept of a work or career path" (MT-weak).

The practitioner then finds the MAP and emotion, identifies the "why" or "because" associated with the emotion, and finds the original event. Once the original event is worked through, the practitioner re-checks the entry point of the path. If MT is strong, then practitioner has patient continue with next aspect of the dream and repeat above procedure.

Scenario 2.

Same dream, but let's consider the patient who is unable to make associations to the content.

> Practitioner: Your body is responding to the 'path', any ideas about what the path might be representing?
>
> Patient: I have no idea.
>
> Practitioner: Well, there are three categories in life (and you know what they are!), let's see which one is involved. The practitioner will arrive at career, find the MAP, and continue on with the 15 steps.

The beauty in using NET for dreams is that you don't have to be the grand interpreter, you don't have to over work; you are getting the information from the patient, which means that the patient is physiologically engaged in the process, and most importantly, NET provides a means of resolving the conflict held by the NEC involved. After working through an entire dream and all of the NECs it brings up, it is often apparent what the dream symbols meant. On the contrary, trying to mentally figure out the dream symbols without engaging the rest of the body can be a daunting task that may be frustrating and unfulfilling for patient and practitioner alike. Freud and Jung felt that dreams were the gateway to the unconscious and a necessary requirement for self-exploration. Dreams are often the manifestations of very significant NECs. Most patients really enjoy and benefit from this procedure.

# FREEING THE SHADOW FROM WITHIN

Sometimes we need to look at our shadow, the darkness, to bring forth our light. Being "OK" with our shadow can help us balance the polarity between our conscious and personal unconscious awareness. Even though we may not presently be exhibiting a certain trait in our life, we do want to be neutral with any possible traits that we may have exhibited in the past or traits we could potentially exhibit in the future if our circumstances were to change.

Psychologist Carl Jung originally coined the term shadow. The definition of shadow according to the Longman Dictionary of Psychology and Psychiatry is, "according to Jung, an archetype that represents instincts inherited from lower organisms, mainly sexual and aggressive instincts, which tend to be unacceptable to the conscious ego and are therefore repressed into the personal unconscious where they may form complexes."

Shadow is often defined as that portion of self that we fail to bring to conscious awareness and is formed in a parallel fashion to the development of our ego. In life we are constantly viewing the world through an overlay of our "emotional reality," editing what fits into our ego's ideal. More often than not, that which does not fit into our ideal model is moved into the shadow part of our personal unconscious. And, it seems that the more we seek our ideal (usually the light, the good, etc.), the darker our shadow can become.

Jung gave great importance to the concept of integrating the shadow into our consciousness and felt it was necessary to do so in order to reach a healthy sense of self-realization. Jung stated, "Realization of the shadow is an eminently practical problem which should not be twisted into an intellectual activity, for it has far more meaning of a suffering and a passion that implicates the whole person."

In using NEAT, we already know how important it is to be OK, or neutral, with both sides of an issue. We know the value of using the concept of OKness in the construction of positive Personal Declaratives (PDs), as well as being OK with a negative thing that has happened in our past, is currently happening now or could be imagined to happen in the future. We also know there is an incredible amount of transformation possible when we are congruent with both the "Surround the Dragon" format of the positive side of the issue, as well as being OK with the negative side of what is or could be.

In being human, is it possible that all of us contain good and bad, light and darkness, love and hate, courage and fear, beauty and ugliness, etc.? Debbie Ford bases her book, The Dark Side of the Light Chasers, on this very premise, using the holographic principle that we do contain everything—both good and bad—in us. Most of us are raised to be "good." In this process, many of us believe that we need to get rid of the "bad" parts so we can be liked and accepted by our family and friends. From this kind of scenario, as well as many other life experiences, we individually build our own unique shadow.

By using the tool of NEAT, we can remove a cathexis (or charge) from a part of our self—conscious or unconscious—which will then allow us to more freely choose how we express ourselves. Our ultimate goal is to move closer to wholeness and, thus, be more free to create what we really desire.

STEP-BY-STEP:

One of the exercises in Ford's book is to look at a list of negative words and identify if you have a resultant emotional feeling or charge. Using the following words from her book, we can uncover potential NECs by testing OK PDs with any suspicious words:

*Greedy, liar, phony, cheap, hateful, jealous, vindictive, controlling, nasty, possessive, bitchy, wimp, evil, geek, prudish, womanizer, angry, secretive, codependent, alcoholic, predator, drug addict, gambler, sick, fat, disgusting, stupid, idiot, fearful, unconscious, masochistic, bulimic, anorexic, unimportant, shyster, compulsive, frigid, rigid, abuser, manipulator, victim, victimizer, egocentric, better than, foolish, emotional, pompous, ugly, sloppy, loud mouth, big mouth, passive aggressive, smelly, lame, coward, jerk, inauthentic, offensive, inappropriate, wild, dead, zombie, late, irresponsible, incompetent, lazy, opportunist, lush, stingy, unfair, dumb, traitor, weasel, immature, gossip, snippy, desperate, childish, floozy, shrew, pansy, golddigger, hormonal, cruel, insensitive, scary, dangerous, explosive, perverted, psychotic, needy, energy sucker, shit disturber, mean, defensive, man-hater, sad, frail, impotent, insipid, castrated, mama's boy, nervous, arrogant, miser, spinster, slut, deceitful, judgmental, imposter, superficial, violent, thoughtless, martyr, hypocrite, love buyer, sneak, grudge carrier, condescending, competitive, power hungry, wasteful, insane, sinister, bigot, white trash, anxious, stuck, hot shot, goofy, woman-hater, sadistic, nose picker, loser, worthless, failure, envious, critical, flabby, neglectful, whore, shameful, dirty, bitter, shameless, bossy, inflexible, old, cold, withdrawn, soulless, heartless, has-been, cagey, resentful, racist, unenlightened, snob, elitist, faggot, dominating, sleazy, overbearing, inflexible, bad, ignorant, thief, cheater, scammer, pushy, classless, trashy, devious, conniving, groupie, insecure, depressed, hopeless, not good enough, beggar, whiney, asshole, ballbuster, frugal, unlovable, delinquent, scared, hyper, nosy, intrusive, perfectionist, anal, know-it-all, ass-kisser, malicious, resentful, righteous, freak, useless, middle class, resistant, withholding, betrayer, inferior, destructive, thick-headed, confrontational, weak, impatient, full of shit, dyke, self-destructive, imperious, idiot, ruthless, oversensitive, pigheaded, tightass, tasteless, uninteresting, lifeless, empty, diabolical, ridiculous, wretched, pain in the ass.*

Example:
Let's say the word "liar" is a possible hot word. We could test:
"I'm OK with the fact that I have been or could be a liar," or "I'm OK with being a liar."

In either of the above PDs, we just want to be free of any charge. If we are non-congruent, we simply run the 15-steps of classic NET and remove the charge.

In developing the NEC, it is often important to consider that there is some aspect of this characteristic (being a liar) that has served you in some way. To do this we may need to consider what lesson we could learn or have learned from this quality. It is sometimes helpful to ask, " What is the one good or beneficial thing about this aspect?" "What could possibly be positive about this situation?," or "How did this aspect save me in some way?"

Of course, we would also want to build PDs on the positive form of this concept by "Surrounding the Dragon" with the opposite of being a liar:
"I'm OK with being truthful."
"I'm ready, willing and able to be truthful."
"It is safe to be truthful."
"I want to be truthful."
"I believe I can be truthful."
"I can honor being truthful."
"I am worthy of being truthful."
"It is good for me to be truthful."
"It is good for others for me to be truthful."
"I can be supported by others when I am truthful."

If there is a non-congruency, we know what to do. As you can see, there are many possibilities when using the negative (shadow) and the positive PD approach as an entry.

# EMOTION and FACIAL EXPRESSION

Emotion and expression are intimately linked in a network of communication. This paper will discuss the option of adding a specific facial expression during the NET procedure.

Specific response patterns in the body are naturally triggered (such as facial expression, posture, internal chemistry changes, etc.) when a definable stimulus activates a reaction. We use our sensory processing systems — *sight, movement, sound, taste, smell, and/or touch (pressure, vibration, texture, heat, cold, pain)* — to appraise our internal and external circumstances and react accordingly. As an emotion (positive or negative) is set in motion, feelings associated with the emotion instantly follow. The experience is normally compounded with the addition of experiences from memory of a *similar* nature that have been associated with the emotion by way of learned conditioning.

Antonio Damasio, M.D., describes the complex process of emotions in his third book Looking for Spinoza — Joy, Sorrow and the Feeling Brain. The following is a brief overview of the built-in reaction of emotion:

**A**. There is an object or situation (the object or situation can actually be present or can be recalled from memory) that starts the process via one or more of the sensory processing systems.

**B.** Then signals from the sensory system stimulate "emotional-triggering" sites in the brain.

> Some of the regions in brain now identified as being "emotional-triggering" sites are the amygdala and the ventromedial prefrontal region of the brain. These regions are especially associated with the more complex "social" emotions and are also associated with experiences that are re-stimulated based on life experiences stored in memory.

**C.** The emotional-triggering sites then activate "emotional-execution" sites.

> The basal forebrain and hypothalamus are some of the regions now identified as being "emotional-executing" sites and, interestingly, also control the movement of the face, tongue, pharynx and larynx.

**D.** The emotional-execution sites immediately cause an emotional "state" to occur in the body and the brain.

**E.** The initial stimulus often leads to the memory recall of other similar stimuli, which can trigger more chains of reactions (i.e. step A above is set into new layers of reaction).

**F.** The emotional process can cascade into parallel chains of reactions and re-stimulations, keeping the body in various stages of "the experience," or it can come to resolution and complete the process.

### Using Facial Expression in the NET Process

Emotional feelings and facial expression are definitely linked. A specific stimulus causes the body to react in a defined pattern. This pattern includes a specific facial expression, although it can often be very subtle and hard to see as we learn to socially suppress the display. The fact that emotional expression has the power to cause an emotional feeling — *even if one is only "acting"* — is clearly demonstrated in a research study by Paul Ekman, Ph.D. ("An Argument for Basic Emotions," *Cognition and Emotion* 6 (1992): 169-200).

In this study participants were asked to move specific facial muscles in a certain sequence. Although the participants in the study were not informed as to which emotion was associated with their expression, they did report the experience of specific feelings. These feelings correlated with the emotional pattern of the facial expression they were portraying — i.e. the facial expressions brought up the feelings that were learned associations of those emotional expressions.

By optionally adding the facial expression associated with a specific emotion that's "up" during the NEC process, we can add a facial expression to the process when we feel it might be beneficial to the situation.

The following facial expressions (associated with emotional affect based on the work of psychologist Silven A. Tomkins) can be used in correlation with the emotions found on the NET Master Chart — see photos at the end of this paper:

The facial expression of ***Disgust*** *with*
- **Stomach, Spleen, Pancreas — Earth Emotions**

The facial expression of ***Distress / Anguish*** *with*
- **Large Intestine, Lung — Metal Emotions**

The facial expression of ***Fear*** *with*
- **Bladder, Kidney — Water Emotions**

The facial expression of ***Anger*** *with*
- **Gall Bladder, Liver — Wood Emotions**

The facial expression of ***Surprise / Startle*** *with*
- **Small Intestine, Heart, Thyroid, Adrenals, Sex Organs, Pituitary—Fire Emotions**

The facial expression of ***Shame*** *with*
- **Governing Vessel, Conception Vessel — GV/CV Emotions**

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And, occasionally (although not consistently) the facial expression of ***Dissmell*** *with*
- **Governing Vessel, Conception Vessel — GV/CV Emotions**

  and / or
- **Stomach, Spleen, Pancreas — Earth Emotions**

**STEP-BY-STEP:**

Do the classic 15-step NET procedure using the Facial Expression procedure when needed.

The Facial Expression procedure is often helpful at:

- step 5 of the NET procedure— when patients are having trouble associating the emotion with their entry issue or
- step 8 of the NET procedure— when patients are having trouble identifying the details of the "original event."

Step-by-step for Facial Expression procedure:

1. Tell patients you are going to show them a photo of the facial expression that is generally related to the emotion that is testing.
2. Briefly explain that when we mimic the associated facial expression, we are sometimes able to consciously identify a related issue.
3. Show patients the appropriate photograph and briefly point out the main facial characteristics using the words described under the photos.
4. Ask patients to slightly mimic the facial expression while they think about the emotion and issue that tested as being active. (Try to refrain from staring at the patient, as they may feel a little self-conscious.)
5. Continue with the classic NET procedure.

*Note*: You can also use the facial expressions (positive and negative) by themselves to check for congruency with the affect displayed on the face.

**A Special "Extra" Procedure:** After you've cleared any "hot" issues, you can also test the idea of "keeping one's internal joy" should this issue or situation arise again by using the facial affect of Joy / Enjoyment. In other words: even if this happens again, you can still find a place of joy or peace inside yourself.

To test, have the patient make the *positive facial affect of Joy / Enjoyment* while thinking about the specific issue or situation that he/she wants to be OK with while maintaining his/her internal joy. If there is a non-congruency, do classic NET. This is *very* powerful.

**Suggested Helpful Phrases**

"*Jane, I'm going to show you a photo of a facial expression associated with the emotion that's testing as active for you*."

"*It's scientifically validated that when someone makes the facial expression of a specific emotion, even when they're just pretending, they also change their physiology and associated memories surface more easily*."

"*While you think about the issue that just tested, please try to slightly mimic this facial expression."* (The practitioner can softly read the words under the associated photo at this point to help the process).

## The Facial Expression of *Disgust*

*Associated with MAPs of:*
**Stomach, Spleen and Pancreas (body); Earth (pulse)**

*and*

*NET Master Chart* — ***Earth*** (yellow) emotions of:

| | |
|---|---|
| **Over sympathetic** | Disgust, expanded importance of self, obsession, egotistic, despair, nervous, stifled |
| **Low self-esteem** | Lives through others, over concern, hopelessness, lack of control over events, worried, distrust |

# Earth Related Expressions

**Moderate**

**More Exaggerated**

**Associated facial characteristics:**
The head is forward, the tongue is protruded; the lower lip is pushed down as if trying to expel something from the mouth.

# **The Facial Expression of** ***Distress / Anguish***

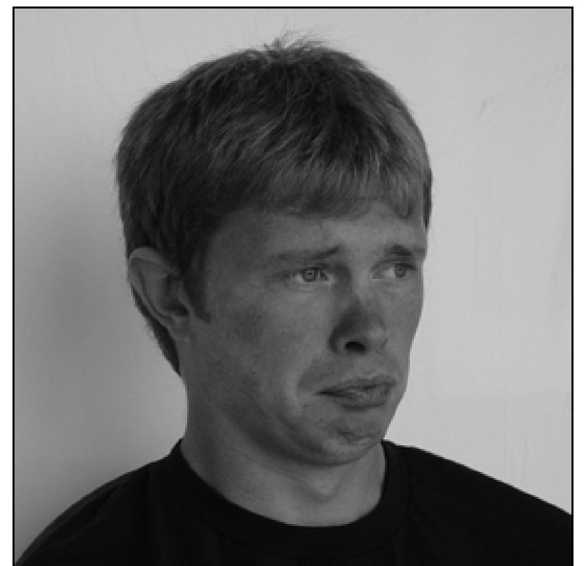
*Associated with MAPs of:*
**Large Intestine and Lung (body); Metal (pulse)**

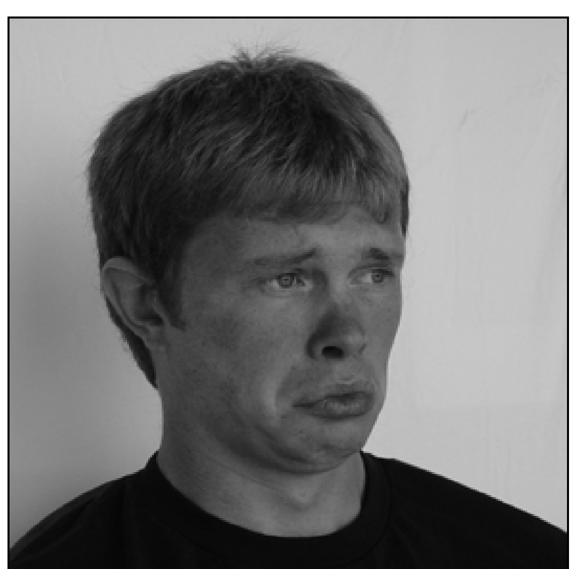
*and*

*NET Master Chart* — ***Metal*** (white) emotions of:

| | |
|---|---|
| **Dogmatically positioned** | Crying, compelled to neatness, defensive, obsession, egotistic, despair, nervous, stifled |
| **Grief** | Sadness, yearning, cloudy thinking, anguish |

## Metal Related Expressions





**Moderate** **More Exaggerated**

**Associated facial characteristics:**
The corners of the mouth are pulled downward, there may be a wrinkling or trembling of the upper lip and the eyebrows are arched upward. In the infant, crying begins with tears and rhythmic sobbing (this is known as the "omega of melancholy").

# The Facial Expression of *Fear*

*Associated with MAPs of:*
**Bladder and Kidney (body); Water (pulse)**

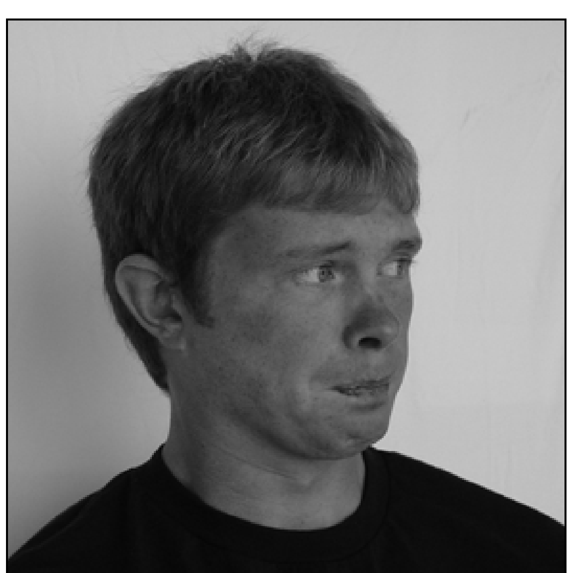
*and*

*NET Master Chart* — ***Water*** (blue) emotions of:

| | |
|---|---|
| **Paralyzed Will** | Miffed, timid, inefficient, wishy-washy, comme ci – comme ca |
| **Fear** | Dread, bad memory, contemplated, impending doom |

## Water Related Expressions

**Moderate**



**More Exaggerated**

**Associated facial characteristics:**
A stare with a fixed gaze at (or just to the side of) whatever might be the source. The face becomes cold, pale, sweaty and uncharacteristically immobile.

# The Facial Expression of *Anger*

*Associated with MAPs of:*
**Gall Bladder and Liver (body); Wood (pulse)**

*and*

*NET Master Chart* — ***Wood*** (green) emotions of:

**Resentment** Galled, stubborn, emotionally repressed**,** depressed, indecisive

**Anger** Irrationality, frustration, aggression

## Wood Related Expressions

**Moderate**

**More Exaggerated**

**Associated facial characteristics:**
The mouth and chin are tight, the jaw is clenched; there is a furrowed brow, and the eyes are narrowed (the face of rage).

# The Facial Expression of *Surprise / Startle*

*Associated with MAPs of:*
**Small Intestine, Heart, Thyroid, Adrenals, Sex Organs and Pituitary (body); Fire (pulses)**

*and NET Master Chart* — ***Fire*** (red) emotions of:

| | |
|---|---|
| **Lost, Vulnerable** | Abandoned, deserted, absent mindedness, insecurity, profoundly deep unrequited love |
| **Frightfully Overjoyed** | Abnormal (inappropriate) laughing, lack of emotion, rapid mannerisms and speech, talkative |
| **Muddled Instability** | Paranoia, muddled thinking, emotional instability, up and down, can't figure it out |
| **Non-thinking, Non-emotive** | Depleted, suppressed, sluggish memory, vivid dreaming |

## Fire Related Expressions

**Moderate**

**More Exaggerated**

**Associated facial characteristics:**
Eyebrows are raised up, the eyes are wide open (there may also be a blink) and the mouth is open.

# The Facial Expression of *Shame*

*Associated with MAPs of:*
**Governing Vessel and Conception Vessel (body); GV/CV (pulses)**

*and*

*NET Master Chart* — ***GV/CV*** (lavender) emotions of:

| | |
|---|---|
| **False Pride** | Arrogance, disdain, disdainfulness, haughtiness, loftiness, false self-assuredness |
| **Shame** | Humiliation, disgrace, dishonored, infamy, embarrassment, awkwardness, confusion, bashfulness, self-consciousness, mortification wounded pride, bullied |

## GV/CV Related Expressions

**Moderate**

**More Exaggerated**

**Associated facial characteristics:**
The head is dropped, the eyes are cast down and averted, the shoulders begin to slump and there is often blushing (sometimes all the way down the chest). There is a temporary sense of confusion with a brief moment where there seems to be an inability to speak.

# The Facial Expression of *Dissmell**

*Occasionally associated with the emotions related to the MAPs of:*

**Stomach, Spleen and Pancreas (body); Earth (pulse)**

And / Or

**Governing Vessel and Conception Vessel (body); GV/CV (pulses)**

## Optional Earth and/or GV/CV Expressions

**Moderate**

**More Exaggerated**

**Associated facial characteristics:**
There is a wrinkling of the nose and a lifting of the upper lip with the head drawn back.

**Dissmell is not found in any dictionaries. It is a new word coined by psychologist Silven A. Tomkins and is one of the innate mechanisms he describes as the Affect System — Affect/Imagery/Consciousness (Volumes 1, 2 and 3 in 1961, 1962 and 1991).*

# <u>Example of the Positive Affect</u>

## Facial Expression of *Interest / Excitement*

*Note: This facial expression (by itself) can be used to check for congruency with the positive affect displayed on the face.*

*Special Extra Procedure: This facial expression can also be checked for congruency in combination with a specific issue or situation the patient wants to be OK with while maintaining his/her interest or excitement.*

## Interest / Excitement Expressions

**Moderate**

**More Exaggerated**

**Interest / Excitement associated facial characteristics:**
The eyebrows are lowered, and the face turns on the attitude of rapt attention as if tracking something. The mouth is partially open and often the tongue is thrust to the corner of the mouth.

# <u>Example of the Positive Affect</u>

## Facial Expression of *Joy / Enjoyment*

*Note: This facial expression (by itself) can be used to check for congruency with the positive affect displayed on the face.*

*Special Extra Procedure: This facial expression can also be checked for congruency in combination with a specific issue or situation the patient wants to be OK with while maintaining his/her internal joy.*

## Joy / Enjoyment Expressions

**Moderate**

**More Exaggerated**

**Joy / Enjoyment associated facial characteristics:**
The muscles of the face are relaxed, the lips are open and wide (smile), and the face is described as bright and shining.

# NET GLOSSARY

**ABREACTION**
A therapeutic technique, originated by Josef Breuer, in which the patient discharges repressed emotions by reviving and reliving painful experiences that have been buried in the unconscious. A. refers to the process; catharsis to the end-result, the discharge of tension.

**ACUPUNCTURE**
Ancient healing art of working with meridian energy (often uses needles for counterirritation).

**ADVOCATE CONSCIOUSNESS (AC)**
A voluntary state of mind in which the Practitioner puts forth, without reserve, an attitude dedicated to advocate the patient's highest stated ethical ideals and overall welfare. To otherwise support, champion, endorse, uphold and affirm the patient, as a mother would a faltering child.

**AFFECTIVE-AROUSAL THEORY**
The theory of D.C. McClelland that motives derive from changes in affective states. This is important to remember when patients asks why their behavior has improved after they have been treated using NET or NEAT.

**ANNIVERSARY EXCITEMENT**
A term introduced by Breuer to identify episodes of agitation or other mental disturbances that end or occur on the anniversary of a significant date in the life of the patient. The event usually is related to the cause of the patient's conflict.

**ANNIVERSARY REACTION**
The unconscious revival of symptoms, or the aggravation of a psychophysiologic illness (e.g., arthritis), on the anniversary of a disturbing event such as the death of a loved one or a severe disappointment. Sometimes useful when searching out the S.E.E. (see below).

**APPROACH-APPROACH CONFLICT**
A conflict situation involving a choice between two almost equally desirable, but incompatible goals. E.g., when a child is torn between separated parents, both of whom he loves. Also called **double-approach conflict.**

**APPROACH-AVOIDANCE CONFLICT**
A conflict situation involving strong attraction and strong repulsion toward the same goal. E.g., when a highly desirable job requires long separation from one's family.

**ATOMS**
Those Personal Declaratives that have the patient speaking as the subject, a verb and a singular object in a sentence. Atom Examples: "I am OK being rich." "I am OK with poverty." "I am worthy of a sincere relationship with a woman." "I want to be healthy." See Ions, Molecules and Personal Declaratives below

**AVOIDANCE-AVOIDANCE CONFLICT**
A conflict situation involving a choice between two equally objectionable alternatives. E.g., when a pacifist must choose between going to jail or leaving the country in time of war. Also called **double-avoidance conflict.**

**BODY MEMORY INDICATOR (BMI)**
The body has a memory. It works as a total body system of memory. There are some points that allow us to access the status of this system. These points are the bilateral Bladder 1 (BL 1) points, which are always held simultaneously, either by the practitioner or the patient, in combination with another body point when testing the Body Memory Indicator (BMI). When the bilateral BL 1 points are simultaneously tested using the pointer and middle fingers in combination with another body point, this is known as the Toxic BMI—a scan for homeopathic need discovered by Scott Walker, DC. When the bilateral BL 1 points are simultaneously tested using the ring and pinky fingers in combination with another body point, this is known as the Nutritional BMI—a scan for nutritional need discovered by Tim Francis, DC.

**BODY-MIND PROBLEM**
The question of the relationship between mental and physical processes, between psyche and soma. The major concepts are (a) interactionism, or mutual influence, (b) parallelism, or separate processes with a point-to-point correspondence, (c) idealism: only mind exists, and the soma is a function of the psyche, (d) double -aspect theory: body and mind are both functions of a common entity, (e) epiphenomenalism: mind is a byproduct of bodily process, (f) materialism: body is the only reality and the psyche is non-existent, and (g) dualism: mind and body are distinct entities, each functioning according to its own principles.

**BREUER, JOSEF**
(broi'er) Austrian physician, 1842-1925. Breuer was an early collaborator of Freud and introduced the "cathartic method" in which the patient talked out sexual feelings under hypnosis. He published *Studies in Hysteria* with Freud in 1895, recognized as the first book on psychoanalysis.

**CATHEXIS**
The investment of psychic energy, or drive, in an object of any kind, such as wishes, fantasies,

persons, goals, ideas, a social group, or the self (from Greek *cathexo*, "I occupy"). Such objects are said to be cathected when we attach emotional significance, or affect (positive or negative), to them. In NET, all NECs have a cathexis, but a cathexis does not require an NEC to exist.

**CHIROPRACTIC**
Healing art used to restore normal function of the nervous system by manipulation and treatment of the structures of the human body, especially those of the spinal column.

**COGNITION**
A general term for all forms of knowing and awareness, such as perceiving, conceiving, reasoning, judging, and imagining. Cognitive processes are often contrasted with cognative processes (striving, willing) and emotive processes (feeling, affect).

**COGNITIVE DISSONANCE**
A term applied by L. Festinger to a state of conflict and discomfort occurring when existing beliefs or assumptions are challenged or contradicted by new evidence. The individual usually seeks to relieve the discomfort by such means as denying the existence or importance of the conflict, reconciling the differences, altering one of the dissident elements, or demanding more and more information. This frequently occurs among smokers who are faced with evidence that cigarettes are hazardous to health.

**COGNITIVE REHEARSAL**
A behavior-modification technique in which the patient rehearses those situations that tend to produce anxiety or self-defeating behavior while practicing positive coping statements designed to reduce the anxiety. E.g., if public speaking is the target situation, the individual envisions the setting of the speech and repeats statements such as "One thought at a time; speak slowly and clearly; it's going fine." In NEAT we have the patient visually rehearse the situation in order to ascertain the presence of NECs.

**COMPLEX OF IDEAS**
A system of ideas closely associated with emotions and other psychic factors so that when one of the ideas is recalled, the associated experience is recalled with it.

**CONDITIONED AVOIDANCE RESPONSE**
A conditioned response that anticipates and averts the occurrence of a harmful or unpleasant stimulus. In the c.a.r., the organism successfully avoids exposure to the painful stimulus, whereas in the conditioned escape response, the organism is already exposed, but maneuvers away from the stimulus or finds a way to stop it.

**CONDITIONED EMOTION**
A feeling or affective state acquired as a result of conditioning, that is, an emotional response. E.g., fear elicited by a previously ineffective stimulus (a buzzer) that has come to be affective by virtue of its association with an unconditioned stimulus. In the NET model, all emotions contained within the NEC are conditioned emotions.

**CONDITIONED ESCAPE RESPONSE**
A conditioned response by means of which an organism ends its exposure to a harmful or unpleasant stimulus, either by flight or by managing to stop the stimulus.

**CONDITIONED RESPONSE**
In classical conditioning, the learned or acquired response to a conditioned stimulus, that is, to a stimulus that did not elicit the response originally. (Also see Stimulus Generalization.)

**CONDITIONED STIMULUS (CS)**
A previously neutral stimulus repeatedly associated with an unconditioned stimulus to the extent that it comes to acquire the power of the unconditioned stimulus to elicit the same response or some aspect of that response. E.g., in Pavlov's experiment, the tone associated with the food is the conditioned stimulus.

**CONDITIONED SUPPRESSION**
A combination of painful and neutral stimuli that decreases the strength of the neutral stimulus acting alone.

**CONDITIONING**
The process by which a conditioned response is learned, that is, a response to a stimulus that did not originally evoke it.

**CONSCIOUS**
Pertaining to or characterized by awareness.

**DESTINY NEUROSIS**
A compulsive unconscious need to arrange life experiences in such a way that failure and defeat are bound to occur. Neurotics of this type blame an unkind fate for their reverses and are unaware that they are, themselves, responsible, or that they are "paying the piper" for guilty impulses or behavior. Also called fate neurosis; neurosis of destiny.

# NET GLOSSARY

**DISPONESIS**
A reversible physiopathologic state consisting of noticed misdirected neurophysiologic reactions to various agents (environmental events, bodily sensations, emotions, thoughts) and the repercussions of these reactions throughout the organism. These errors in energy expenditure, which are capable of producing functional disorders, consist mainly of covert errors in action, potential output from the motor and pre-motor areas of the cortex and the consequences of that output.

**EMOTION**
A complex reaction pattern of changes in nervous, visceral, and skeletal-muscle tissues response to a stimulus. The type and intensity of the reaction is appropriate to the stimulus, which may be of a pleasurable, threatening, or other nature. As a strong feeling, emotion is usually directed toward a specific person or event and involves widespread physiological changes, such as increased heart rate and inhibition of peristalsis. In psychoanalysis, emotions are states of tension associated with instinctual drives, such as sex and hostility. *From the Longman Dictionary of Psychology and Psychiatry.*

**EMOTIONAL EXPRESSION**
The behavioral display of emotions by such means as smiling, laughing, and gesturing; also the somatic changes, such as rapid heartbeat and muscular tension that constitute an integral aspect of emotional reactions.

**EMOTIONAL REALITY**
An emotionally charged concept or memory which may or may not have a corresponding historical reality. E.g., A child whose parents are going out to a movie may have an emotional reality of being forever abandoned. The NET procedure may surface a SnapShot in which this scene is related. Historical reality, in this case, does not correspond to the E.R. N.B. Ethical office procedure dictates that all NEC memories are identified only as E.R.s and that some may also be historical realities, as to be determined by a psychotherapist. This is especially important in molestation and incest E.Rs.

**EMOTIONAL SABOTAGE**
A somatopsychic state in which an individual is sabotaging himself in one or more areas of his life. Usually because of NECs.

**EXTINCTION**
The gradual diminution in the strength or rate of a conditioned response when the unconditioned stimulus or the reinforcement is withheld. In normal neurophysiology, there is a progressive decrease in excitability of a nerve to a previously adequate stimulus until it becomes completely inexcitable. Extinction for visual and tactile stimuli occurs in occipital-parietal lesions. Extinction of most conditioned responses is normal, however, those responses within the NEC are seemingly insulated from, or unreceptive to, this normal physiological process. Restoring normal nervous system function by acupuncture point intervention or spinal adjustment allows extinction to occur.

**FIRST SIGNALING SYSTEM**
A term used by Pavlov to refer to the system of immediate environmental stimuli that are responsible for evoking animal and human behavior. According to Pavlov, the f.s.s. forms the basis of the SECOND SIGNALING SYSTEM (see this entry).

**GRAMMAR**
The distinctive features and structural principles of a language, especially the construction of words (morphology) and sentences (syntax). A system of basic rules by which the words in a language are structured and arranged into sentences. This is important in NET because the body testing often delivers the building blocks of a sentence out of order (Ex: anger - mother - drunk father), and it is the task of the patient with the guidance of the doctor to rearrange the components into a sentence which finally tests as positive. The positive testing sentence, in turn, suggests a SnapShot (see below).

**GENETIC STORAGE**
A theory that learned information—e.g., fear of poisonous snakes, or ability to recognize family members—may be stored by the nervous system at the synaptic or metabolic level. See GENETIC MEMORY.

**HIDDEN AFFECT (HA)**
Any unconscious affect (approach or avoidance in nature) which is a factor in influencing perception and ultimate choice. Individual PD (Personal Declarative) Atoms which test positive (weak), do so because of a Hidden Affect (HA). (The affect in the HAs of positively stated personal declaratives will be of a negative or a void quality.)
Example: "I'm OK with sleeping," may or may not have an HA. The Hidden Affect will eventually be found in the patient's explored Emotional Reality. Perhaps a woman patient complains to the doctor that she has insomnia and wishes to sleep, as her sleeplessness is seriously affecting her job,

health and general enjoyment of life. Of these factors, she is very much aware. They are not hidden, but rather, very much on her mind. Perhaps the NEAT procedure reveals the woman awoke one morning to find her husband dead. Emotionally speaking, she may feel that if she sleeps, another death may occur, which she seeks to avoid. If she was previously unaware of this unconscious feeling (fear?, resentment?, dogmatic position?) concerning sleeping, these affects are called hidden affects. When the patient is poised, the HA is eliminated and the patient is congruent. HAs may also be present in ions and molecules (see below).

**HOMEOPATHY**
System of healing founded by Dr. S.C.F. Hahnemann (1755-1843). This system has been persecuted since its inception by allopathic medicine. Like traditional chiropractic, Homeopathy recognizes an inborn vitalistic principle which is credited with the actual healing.

**HYPERCATHEXIS**
An excess of psychic energy invested in an object (person, activity, goal).

**HYPERESTHETIC MEMORY**
A memory that is abnormally sensitive to past associations, a condition that Freud and Breuer regarded as a causative factor in hysteria cases.

**IMAGERY CODE**
The encoding of an object, idea, or impression in terms of its visual imagery. E.g., if the item "typewriter" is stored in memory via a mental picture of a typewriter, an i.c. is said to have been employed in the memory-storage process. See Semantic Code.

**INDEXING**
A process used in General Semantics. In NET, the process (utilizing muscle testing) to find the time and place circumstances contexting the NEC SnapShot. Since his body and emotional state was and is always in a state of flux, Jones in 1951 is not the same Jones in 1991. Jones 1991 may, however, feel he is the same person by identifying with the ongoing memory of Jones 1951. Elements of memory 1991 may possess similar elements to those indexed in memory 1951 and even invoke emotions from 1951 when retriggered in 1991. (See Stimulus Generalization)

**IONS**
Those Personal Declaratives (see below) which are of an identification nature, and have the subject speaking with an identification with their immediate reality. Ion Examples: "I [subject] am a [object of identification] male," "I am a woman," "My name is Norman," "It is 1992."

**LCD or LOWEST COMMON DENOMINATOR**
The net amount of similar elements in the contents of any two indexed memories. Extraneous elements are discarded. LCDs are used to assist the patient in the indexing of earlier memories associated with the NEC SnapShot. (See Indexing)

**LINGUISTICS**
The study of speech habits; the study of languages and their structure and origins. Linguistics includes phonology, grammar (morphology, syntax), lexicology and, in a wider sense, phonetics and semantics.

**LOCUTION**
A particular form of expression or a peculiarity in phrasing. Important in the composition of Personal Declaratives (PDs) used in NEAT.

**MEDIATED GENERALIZATION**
A type of conditioning in which a generalized response follows a stimulus that is dissimilar to the original stimulus. E.g., Responding in the same way to a banana as to the original stimulus, apple. Thus, learning is involved; learning apples and bananas are similar. See Semantic Generalization.

**MEMORY**
The ability to revive past experience, based on the metal processes of learning or registration, retention, recall or retrieval, and recognition; the total body of remembered experience; also, a specific past experience that is recalled.

**MEMORY AFFECT**
The emotional element recurring whenever a significant experience is recalled. Steadman's Medical Dictionary.

**MEMORY BODY**
A term given to the theorized mechanism by which the body heals after a homeopathic remedy is given. Scott Walker, D.C. proposed a Body Memory System or systems exist in which a prioritized "healing list" is kept and followed when the system is uninhibited. He further proposed this system can be overwhelmed, clogged or otherwise distorted due to pollutants, and other body stressors.

# NET GLOSSARY

**MEMORY - EIDETIC IMAGE**
Mental imagery which closely resembles actual perception; usually vivid and detailed memory images.

**MEMORY GENETIC**
A theory that information based on experience or learning may be stored in a DNA or RNA molecule, which might in turn be inherited as part of a chromosome. Also see GENETIC STORAGE.

**MEMORY PHYSIOLOGICAL**
A memory for somatic experiences outside of conscious awareness. E.g., the memory of a conditioned-automatic-system response; also, storage of memory traces by means of RNA. *From the Longman Dictionary of Psychology and Psychiatry.* See BODY MEMORY.

**MEMORY TRANSFER**
The transfer of acquired information from one individual to another by transplantation of brain cells. Experiments attempting to demonstrate that memory traces in RNA molecules might be transferred among flatworms and mice have produced conflicting results.

**MODE or METHOD OF DIAGNOSTIC ENTRY**
Usually relating to the avenues of approach when using NEAT Emotional non-congruence can be discovered, and its physiological response elicited, by any one of several methods or modes. If a woman reports having migraine headaches following an abortion, the practitioner, in attempting to discover if there is a correlation between this event and the migraines, may ask the patient to (MODE 1) visualize the event, and/or (MODE 2) recall the feeling at the time of the event, and/or (MODE 3) make a PD about the event. E.g., "I'm OK with the abortion."

**MOLECULES**
Those **Personal Declaratives** that have the subject speaking as the subject, a verb or multiple verbs and <u>multiple</u> objects. Molecule Examples: "I am OK being rich ***and*** being charitable" -- "I am OK being [rich] (object one) ***and*** being [charitable] (object two)." "I am OK being [rich] (object one) ***and*** being charitable (object two) and being [humble] (object three)." See Ions, Atoms and Personal Declaratives.

**MOST BASIC ASSUMPTIONS (MBA)**
Those basic subjective assumptions which are so frequently taken for absolute facts, to the extent that to think otherwise is irrational...which it is. However, we are not referring to a logical orientation, but rather to a feeling or emotional orientation. A rational assumption of "wanting to live," may or may not be emotionally congruent with a person who vehemently affirms this is so. Used to check basic premises in doing NEAT.

**NEAT or NEURO EMOTIONAL ANTI-SABOTAGE TECHNIQUE**
A technique in which the aberrant physiology of emotion is discovered by the engagement of the patient's complaint or observation of feelings, dreams, behaviors or symbols including grammar. The grammar, locution and syntax pattern, including their personal semantics, can give rise to (see below) semantic reactions.

**NANOSECOND CONSCIOUSNESS (NC)**
A voluntary state of mind in which the practitioner puts his/her full attention on the patient that is in front of him or her in the consultation session in each instant as it occurs. A very high form of concentration and attention.

**N.A.C. or NANOSECOND ADVOCATE CONSCIOUSNESS**
Abbreviation compounding both Advocate Consciousness (AC) and Nanosecond Conscious-ness (NC) and used to denote a state of mind employing the qualities of both.

**NEC or NEURO EMOTIONAL COMPLEX**
A subjective maladaptation syndrome adopted by the human organism in response to a real or perceived threat to any aspect of its survival. The individual's unique NEC (syndrome pattern) contains:

A: A specific subluxation or sequence of subluxations
B: A specific emotion
C: A conditioned response. A predisposition for stimulus generalization. A resistance to extinction
D: A meridian imbalance and active pulse point
E: A facilitated or inhibited muscle
F: A specific active MAP (body or pulse)
G: A cathected and often recallable memory picture (SnapShot or SS) of a past significant emotional event
H: A vulnerability to suppression, repetition compulsion and restimulation /reaggravation causing cyclical reinforcement

[Note: All Neuro Emotional Complexes (NECs) have an emotion incorporated in the complex, but not all emotions are incorporated in NECs].

**NET or NEURO EMOTIONAL TECHNIQUE**
NET is used to help establish homeostasis in the human organism by adjustment of the spine or acupuncture points to correct NECs. NET makes

use of the neuro-mechanisms of speech, syntax, locution, emotions, acupuncture meridian system, cutaneous reflex points, principles of traditional psychology and general semantics and chiropractic. It resolves "fixations of emotions" held within the body. These "fixations of emotions" are vulnerable to retriggering under specific conditions relating to the original formation of the NEC. It is a structurally-oriented system of dealing with the internal and external manifestations of aberrant emotions. The end product of a successful treatment is an organism more neurologically integrated.

**NET as DISTINGUISHED FROM PSYCHOTHERAPY**
NET is distinguished from psychotherapy in that it is not a directed therapy to the psyche or for "mental healing." It does not employ counseling, nor does it advise behavioral changes. It does not have a goal of insight for the patient. It is not a "talking" cure. It does not suggest or have a goal of self-regulation. It does not teach anything. It does not show one how to learn from one's life experiences.
NET is directed at achieving homeostasis of the human organism. Its method of correction is through the spine or acupuncture point(s). As part of its diagnostic methodology, it requests of the patient, at times, a neuro-emotional case history to assist in uncovering the presence of a Neuro Emotional Complex (NEC). Once discovered, the correction is given, and the treatment cycle is ended. Any case history which reveals a need for psychotherapy is discussed with the patient, and an appropriate referral is made.
In short, NET deals with those weakened physiological states which have ultimately made the body vulnerable to the formation of an NEC. NET does not treat emotions, but rather the bodily complex (NEC) in which an emotion (and a subluxation) is a component part.

**NET SUCCESS**
A life booster experience for the practitioners (who have completed NET Basic) and their spouses or significant others. Five days of planning, goalizing, learning and many hours of workshops designed to eliminate the NECs, which have been paralyzing the attendees efforts to get the results they want out of their life. Usually held in a beautiful natural setting, so as to promote a balance of fun and work. Considered by hundreds of doctors to be the ultimate NET Experience.

**NEUROSIS, TRAUMATIC**
What features are common to all Neurotic symptoms? Here we may note two important points. The effects of the trauma are twofold, positive and negative. The former are endeavors to revive the trauma, to remember the forgotten experience, or, better still, to make it real—to live through once more, a repetition of it; if it was an early affective relationship, it is revived in an analogous connection with another person. These endeavors are summed up in the terms "fixation to the trauma" and "repetition compulsion." Thus, a man who has spent his childhood in an excessive and since forgotten "mother-fixation" may all his life seek for a woman on whom he can be dependent, who will feed and keep him...It may remain an open question whether the aetiology of the neurosis should, in general, be regarded as a traumatic one. The obvious objection is that a trauma is not always evident in the early history of the neurotic individual. Often, we must be content to say that there is nothing else but an unusual reaction to experiences and demands that apply to all individuals; many people deal with them in another way which we may term normal. Where we can find no other explanation than a hereditary and *constitutional disposition*, we are naturally tempted to say that the neurosis was not suddenly acquired, but slowly developed.

Freud - Dictionary of Psychoanalysis -
Edited by Nandor Fodor and Frank Gaynor
Moses and Monotheism, Part III

**NEUROGRAM**
The imprint left on the brain by past mental experiences.

**OCCAM'S RAZOR**
The scientific maxim that the simplest hypothesis or explanation is always preferable. That is, given an alternative between two hypotheses, the one accompanied by the fewer assumptions should be chosen. The term is derived from the maxim of a 14th-century Franciscan monk, William of Occam. Also called principle of economy; law of parsimony. It is interesting to me that this scientific maxim is, in actuality, a philosophic concept.

**ONE UP, ONE DOWN**
A short expression describing the limited concept of dealing with one's relationships in either a superior or inferior feeling of esteem. People having this orientation seem to do so out of an inability to access the present time quality and genuineness of a relationship, and, thus, revert to one of an above or below disposition. They then

fall into some degree of either an appeasing or condescending attitude. In patient/practioner relationships, this dichotomous attitude is to be identified and remedied.

**ORIGINAL NEURO CONDITIONING EVENT (O.N.C.E.)**
A term sometimes used in place of O.S.E.E. to emphasize the inclusion of an N.E.C. and its component conditioning aspect in the S.E.E. or O.S.E.E.

**ORIGINAL SIGNIFICANT EMOTIONAL EVENT (O.S.E.E.)**
An original S.E.E. It is opposed to a secondary S.E.E. that is similar in nature to, and actually a restimulation of, the O.S.E.E.

**PAVLOV, IVAN PETROVICH**
Russian physiologist, 1849-1936. Pavlov was trained in physics, chemistry, physiology, and medicine, and his major interest was in the physiology of digestion and the manner in which it is controlled by the nervous system. In the course of experiments with dogs, he noted that gastric and salivary secretions occurred in connection with noise made during the preparation of food. This observation led to further experiments that yielded the concepts of unconditioned response, conditioned reflex, discrimination of stimuli, extinction of response, and production and elimination of experimental neuroses in animals. He later focused on human neuroses, developing the theory that they are due to an imbalance between the excitatory and inhibitory functions of the cortex and advocating treatment by prolonged sleep, sedatives, and verbal and environmental therapy.

**PERSONAL DECLARATIVES (PDs)**
Sentences (often deliberately and carefully premeditated with the assistance of the practitioner) which the patient speaks with the objective of determining the presence or absence of NECs relating to the semantics utilized. Ideally, a positively formed, simplistic statement of something the patient subjectively feels is true or would like to be true. E.g., "I want to win the championship." This statement contains a subject-(85% of the time the patient), a verb-(the emotion), and an object-(to whom the emotion is directed). See Ions, Atoms and Molecules.

**POISE**
The result of being successfully treated with NET. Equilibrium, balance, the ability to experience genuine present-time emotions versus retriggerings.

**POISING**
The process and art of treating NECs with NET.

**POLISH THE APPLE (PTA)**
Primarily a confirmatory procedure used to strengthen and validate the patient's new neuro-physiological state. PTA is a procedure that is, technically, a variation of STD (Surround The Dragon). After STD, the doctor may round out the session in a primarily confirmatory and secondarily exploratory way by PTA.

**PRESENT OBSERVABLE CIRCUMSTANCE (POC)**
The known circumstance(s) in which a patient now finds himself, especially those he may want to change. POCs are important in that it is often possible to find the key to changing these circumstances in and by the process of getting the patient congruent with them. It is apparent that when any patient strongly does or does not want a particular circumstance, they will usually and eventually attract and get it. Thus, removing the negative charge on the POC often allows for its removal. At the least, when one is emotionally congruent with the POC, the basis and underfooting for change is in place. Thus, the accomplished practitioner will always get the patient "OK" with the patient's desired PD, such as, "I'm OK with being wealthy," only after getting him congruent with the PD that gets him "OK" with his present reality (perhaps in the case above), "I'm OK with now being bankrupt." (See TAD.)

**PSYCHOLOGY**
The scientific study of mental processes and behavior.

**PSYCHOTHERAPY**
Generally, psychotherapy refers to any method that facilitates "mental" healing. At last count, there were over 543 specific types of psychotherapy being practiced in the United States. Many of these still fall loosely into broad categories, such as psychoanalytic, cognitive-behavioral, existential, humanistic, family systems, neurolinguistic, to mention only a few. Insight-oriented therapies no longer enjoy their former prominence. "The talking cure" has gradually given way to action-oriented strategies designed to help patients achieve increased levels of *self-regulation*. Many of the modern psychotherapies teach patients, in one way or another, how to learn from their life experiences.

# NET GLOSSARY

**RATIONALIZATION**
In psychology, a rational or plausible explanation to justify behavior or belief determined by some process other than reason.

**REPETITION-COMPULSION**
A term used by Freud used to describe the unconscious need to reenact early traumas in the attempt to overcome or master them. In repetition- compulsion the early experience is repeated in a new situation symbolic of the repressed prototype.

**RETRACING**
The course of restoration from disease back to health. When a case retraces, it passes back through successive steps, in reverse order, that it passed through in getting worse (in an ideal instance).

**SECOND SIGNALING SYSTEM**
A term used by Pavlov to refer to the system of human language and symbolic knowledge that is based, according to Pavlov, on the first signaling system. The s.s.s. derives from individual experience within a culture. It depends on language, abstraction, generalization, analysis, and synthesis. See FIRST SIGNALING SYSTEM.

**SEMANTIC**
Relating to or of meaning.

**SEMANTIC CODE**
The encoding of an object, idea, or impression in terms of its conceptual or abstract components. E.g., if the item "typewriter" is remembered in terms of its functional meaning or properties, a semantic code is said to be employed. In contrast, an imagery code would encode "typewriter" in memory as a mental picture. See Imagery Code.

**SEMANTIC CONDITIONING**
A variety of Classical conditioning, in which a concept in the form of a word, phrase, or sentence functions as a conditioned stimulus as a result of pairing with an unconditioned stimulus or as a result of generalization. E.g., the word *delicious,* when paired with actual food, will eventually elicit the response of salivation. After *delicious* is established as a conditioned stimulus, related words or phrases may elicit the same or similar responses through generalization.

**SEMANTIC GENERALIZATION**
A type of Mediated Generalization in which one makes use of what has already been learned as to the meaning of one word in order to relate it to another word. Thus, someone conditioned to repond to the word "tree" may also respond to the word "shrub." S.G. is believed to be one of the mechanisms responsabe for the clinical response to the clinicians words as used in the NET procedure. See Mediated Generalization in which all stimuli are of a physical quality as opposed to a "meaning" quality as in S.G. Also see Semantic Reaction.

**SEMANTIC REACTION**
Term used by Alfred Korzybski (see Semantic Therapy) to denote the response of the organism, as a whole (including its physiology) to symbols, and, especially, words. This is used in NET to index and isolate the SnapShot by muscle testing. Korzybski successfully experimented using the skin galvanometer to measure s.r.

**SEMANTIC THERAPY**
A form of psychotherapy in which the patient is trained to rectify faulty word habits and distorted ideas so that he can think more clearly and critically about his aims, values, and relationships. This approach is based on an active search for the meaning of the key words the patient uses and, on practice, in the formation of clear abstractions, as well as on uncovering of hidden assumptions and increased awareness of the emotional tone behind the words he has been using. Chief exponents of this approach are Alfred Korzybski and Wendell Johnson. Also see Semantics, General.

**SEMANTICS, GENERAL**
The science of human responses, as used by Alfred Korzybski, to signs and symbols, including the meaning of words, signals and gestures. It also includes the psychological and sociological aspects of language in the expression of thought and feeling and in exerting an influence on individuals or groups. See Semantic Therapy; Semantics.

**SIGNIFICANT EMOTIONAL EVENT (S.E.E)**
Any event that excites an emotion and alters an individual's values— may or may not be implicated in an NEC.

**SNAPSHOT (S.S.)**
The mental image that almost always is formed instantaneously with the NEC An individual with an NEC carries this specific S.S. in his memory most vividly, at first, as a maladaptive aide in recalling real or perceived threats to his survival. After an NEC correction, the S.S. is less vivid but, nonetheless, remains in memory as part of his life experiences. The S.S. is extremely valuable

in its usage and ability to reactivate all parts of the NEC for the NEC correction.

**SOMATOPSYCHIC**
Pertaining to both body and mind.

**SOME UNFINISHED BUSINESS (SUB)**
SUBs are merely conscious or subconscious memories of past events which have a (NEC) cathexus attached and are subconsciously expressed in conversational material. SUBs are important because, when engaged, the neuro-homeostasis (the clear decision-making process) is interrupted. The cathected subject matter causes a patient to frequently speak about issues which are seemingly not easily related to the present conversational or social setting. SUBs are most easily detected when there are a series of conversational encounters in which the patient brings up the same seemingly unrelated themes or issues.

**STIMULUS GENERALIZATION**
The tendency for a conditioned response to be evoked by stimuli that are similar to the conditioned stimulus. E.g., if a dog is conditioned to bark when a particular bell is sounded, he tends to make the same response to a wide range of bells; and a child who nearly drowns in the bathtub may develop a fear of wading and swimming. In experiments, alternate stimuli are employed to determine the extent of SG., by noting which stimuli produced the same response.

**STRANGULATED AFFECT**
In psychoanalysis, an inhibition or retention of the normal discharge of emotion, which leads to a substitute discharge in the form of physical symptoms. This theory was advanced by Freud and Breuer in 1893 to explain the dynamics of conversion hysteria, but the concept of s.a. was later supplanted by the concept of Repression.

**SUBCONSCIOUS**
Imperfectly or partially conscious, yet capable of being made conscious by an effort of memory or association of ideas.

**SURVIVAL, MENTAL**
The preservation of our mental equilibrium and sanity by extension of those we love.

**SURROUNDING THE DRAGON (STD)**
The procedure by which any NEC theme is explored in order to find any additional NECs related to that theme.

**SURVIVAL, PHYSICAL**
The preservation of our bodies by extension of those we love.

**SURVIVAL, SPIRITUAL**
The preservation of our soul often by extension of those we love.

**SURVIVAL VALUE**
Refers to our strongest instinct... survival...and to the quality thereof. B.J. Palmer said, "These are the two most important words to mankind."

**SYNTAX**
The rules for the combination of words into grammatical sentences; the way words are combined in this manner.

**SYNTAXIC MODE**
A term used by H.S. Sullivan for the highest stage in experiencing the world. Syntax mode is characterized by consensual validation, the development of rational or "syntaxic" thought, and the expression of ideas in a commonly accepted language. *From the Longman Dictionary of Psychology and Psychiatry.*

**SYNTAXIC THOUGHT**
H.S. Sullivan's term for the highest level of cognition, which includes logical, goal-directed and reality-oriented thinking. *From the Longman Dictionary of Psychology and Psychiatry.*

**SUBLUXATION**
A vertebral mis-alignment vs. a complete dislocation of the vertebrae.

**TRANSMUTED ATOM DECLARATIVE (TAD)**
An atom containing an identifiable theme, which has been changed to form a new atom with the same recognizable, although altered, theme producing a modified semantic outcome (meaning) in the form of a PD. If a slightly chubby person were to make the PD of "I'm OK with being slim," the transmuted value may be "I'm OK with being in my present shape" (see POC). Another transmuted atom containing an antithetical and possibly unpleasant value may be "I'm OK with being obese."
(The recognizable theme is the person's anatomical configuration. The "present shape" or "obesity" are mutations of the original content "slim" and change the semantic outcome of a statement.)

**TRAUMA**
An injury (Greek, "wound"), either physical or psychological. Psychological traumas include emotional shocks that have a more or less

permanent effect on the personality, such as rejection, divorce, combat experiences, civilian catastrophes, and racial or religious discrimination. These are often referred to as traumatic experiences. Plurals: traumas; traumata.

**TRAUMATIC EVENT**
A physical or psychic injury that is the immediate cause of an emotional or mental disorder, traumatic neurosis, or psychosis.

**UNCONSCIOUS**
Without perception; the part of mental activity, including primitive or repressed wishes, which are concealed from the consciousness by the psychic censor.

**VISUAL MEMORY**
The capacity to remember in the form of visual images what has previously been seen.