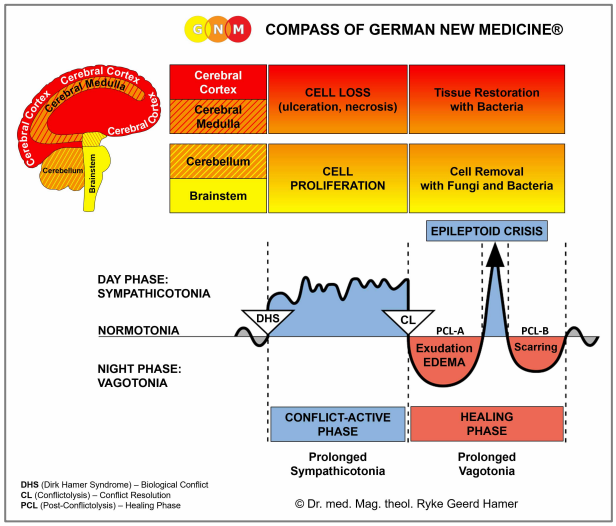
BIOLOGICAL SPECIAL PROGRAMS

SKELETAL MUSCLES

written by Caroline Markolin, Ph.D.



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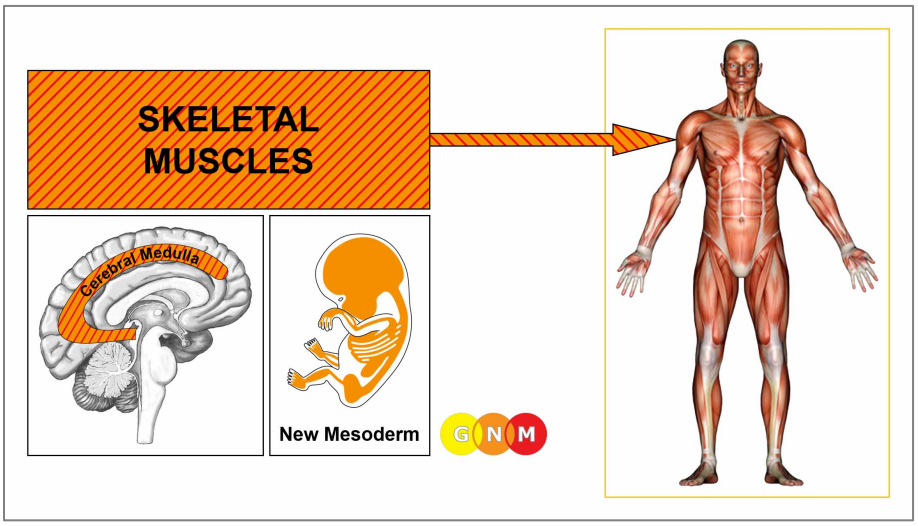
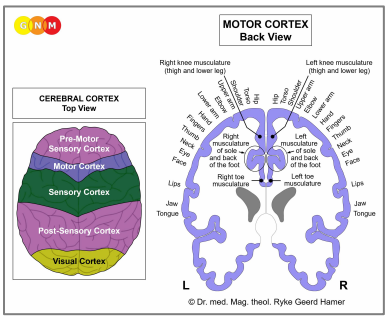
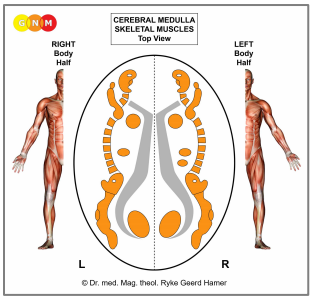


DEVELOPMENT AND FUNCTION OF THE SKELETAL MUSCLES: The musculoskeletal system provides form to the body and allows the body to move and maintain its posture. The muscles are connected to the bones and joints through tendons and ligaments and are endowed with connective tissue, nerve tissue, and blood vessels. The skeletal muscles are composed of bundles of fibers that are organized in a striped pattern; this is why they are called striated muscles. Skeletal muscles vary considerably in shape and size. They range from extremely tiny strands such as the stapedius muscle of the middle ear to large masses like the muscle of the thigh. The skeletal muscles originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The skeletal muscles have two control centers in the cerebrum. The trophic function of the muscle, responsible for the nutrition of the tissue, is controlled from the **cerebral medulla**; the contraction of the muscles is controlled from the **motor cortex** (part of the cerebral cortex). The muscles of the right side of the body are controlled from the left side of the cerebrum; the muscles of the left side are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ (see GNM diagram showing the motor homunculus).



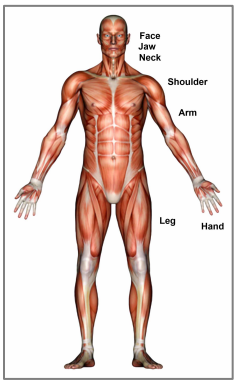
In the cerebral medulla, the bones, skeletal muscles, lymph vessels and lymph nodes, blood vessels, connective tissue, and fat tissue share the same brain relays and therefore the same biological conflict, namely a self-devaluation conflict. The control centers are orderly positioned from head to toe.

BIOLOGICAL CONFLICTS

The **biological conflict linked to the skeletal muscles** is a **moderate self-devaluation conflict**. The specific self-devaluation conflicts are the same as for the bones and joints.

> In line with evolutionary reasoning, **self-devaluation conflicts** are the primary conflict theme associated with cerebral medulla-controlled organs deriving from the new mesoderm.

The **conflict related to the movement of the muscles** is a **motor conflict** of **"not being able to move"** or **"feeling stuck"**. The conflict can be associated with the entire body (generalized motor conflict) or with a single muscle or muscle group (localized motor conflict).



Facial muscles: losing face (loss of a status, reputation, respect, honor, prestige, dignity; disgrace, humiliation, shame), being exposed, feeling ridiculed, foolish or stupid

Jaw muscles: not being able to bite (see bite conflict)

Neck muscles: not being able or allowed to move or turn the head

Shoulder and back muscles: not being able to get out of the way or step aside

Arm muscles: being forcefully held down (physical abuse, sexual abuse, during a vaccination, in a fight or "play"), not being able to hold or embrace someone or hold someone back (flexor muscle), not being able to push someone away, fight somebody off, or defend oneself (extensor muscle and muscles around the elbows)

Hand muscles: not being able to hold on to someone or hold someone back (a loved one who is leaving or dying); not being able to grab something; any distress associated with the hands (work, hobby, or sports-related)

Leg muscles: not being able to escape, flee, or run away (literally or figuratively, e.g., from a workplace or a relationship), not being able to leap aside, not being able to follow, feeling rooted to the spot (petrified), feeling trapped (literally or figuratively), not being able to keep up, not being able to climb up (e.g., not being promoted), not being able to kick somebody away (extensor muscle), a fear of not being able to walk (wheelchair image).

Motor conflicts can also be experienced **with or on behalf of someone else**, particularly, when "feeling stuck" concerns a loved one. The belief that conditions such as ALS or MS are hereditary makes a family member more susceptible to conflicts of the same kind (see GNM Article "Understanding Genetic Diseases").

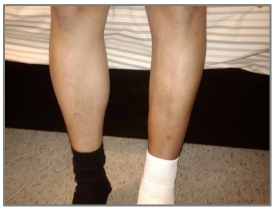
A fetus might endure the conflict of "not being able to escape" when the mother is in danger or because of threatening noises in the immediate environment (jackhammers, chainsaws, lawn mowers, grass trimmers), loud kitchen equipment such as blenders held close to the womb, or screaming and yelling (fights between parents, mother yelling at her children). In this case, the baby is born with (partial) paralysis of the legs with motor disabilities, if the conflict is not resolved. The "loud noises" of ultrasound examinations can be highly traumatic for the unborn (see Down syndrome). A "feeling stuck" conflict could be activated during a difficult delivery or the way the baby is handled immediately after birth. The motor disabilities seen in **cerebral palsy** (according to conventional medicine caused by "brain damage" that occurs to the developing brain) is the result of motor conflicts experienced by the fetus in the womb or during the birth process (see also epileptic seizures and ataxia related to a falling conflict).

Animals suffer motor conflicts as well, for example, during a fight with another animal, when they are "stuck" in a kennel, tied to a chain, locked in a car, trapped in a cage, or held down by the vet during an examination or vaccination.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of muscle tissue (controlled from the cerebral medulla) and, at the same time, **muscle weakness or muscle paralysis** (controlled from the motor cortex). With the impact of the conflict in the motor cortex, less nerve impulses are transmitted to the corresponding muscle causing a loss of muscle function (compare with sensory paralysis related to the epidermis and the periosteum). The **biological purpose of the paralysis** originates in the fake-death reflex (prey animals "play dead" when they face a predator or danger – watch this video). The muscle weakness might be noticed as clumsiness or heaviness, when the legs are affected.

> **NOTE:** The striated muscles belong to the group of organs that respond to the related conflict with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteum and thalamus).

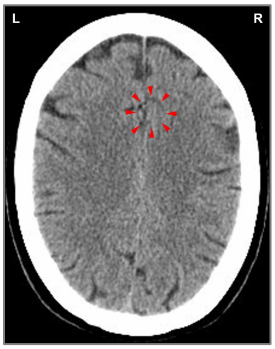
Prolonged conflict activity leads to **muscle atrophy** (muscle wasting) *without* paralysis if the conflict is experienced solely as a self-devaluation conflict. The pelvic floor muscles become weak because of a difficult pregnancy, sexual humiliation, chronic constipation, or urinary incontinence making the person feel "worthless" *there*.



Muscle atrophy in the left leg, as seen in this picture, originates in a localized self-devaluation conflict ("I am not good with my left leg"). For someone unfamiliar with GNM, the condition itself can create a chronic condition.

With a motor conflict muscle atrophy and muscle paralysis occur together, particularly when the distress of not being able to move an arm or leg (or both) causes a self-devaluation conflict.

Muscle weakness and muscle paralysis were formerly diagnosed as **paralytic poliomyelitis**, or **"polio"**, purportedly a "viral infection" that mainly affects children (the scientific evidence of the existence of a "polio virus" has never been provided!). Today, at least in the Western World where polio is supposed to be eradicated by vaccination, the same symptoms are called **ALS** (Amyotrophic Lateral Sclerosis, also known as **Lou Gehrig's disease** or **motor neuron disease**), **Multiple Sclerosis**, or **Guillain-Barré syndrome** (see also renaming of smallpox to pustular eczema after the performance of mass vaccination programs). "Movement disorders" as presented in Parkinson's and Huntington's disease are considered inherited "neurodegenerative diseases" (see GNM Article "Understanding Genetic Diseases").



This brain CT shows the impact of a motor conflict. The center of the Hamer Focus is on the right brain hemisphere (para-central), precisely, in the area of the motor cortex that controls the left leg (view the GNM diagram). The partly edematous ring (dark) indicates that the healing phase is interrupted by conflict relapses (sharp borders); hence, the continued weakness of the legs, predominantly of the left leg.

> **NOTE:** Whether the muscle atrophy or muscle paralysis occurs on the right or left side of the body (or on both sides) is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the muscle or muscle groups that are associated with the self-devaluation or motor conflict.

Conventional medicine is unable to explain why the alleged “polio virus” affects the right leg rather than the left or why the condition occurs at a certain time in a child’s life.

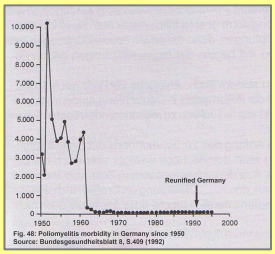


Fig. 48: Poliomyelitis morbidity in Germany since 1950
Source: Bundesgesundheitsblatt 8, S.409 (1992)

This diagram shows the incidence rates of poliomyelitis in Germany between 1950 and 1992. Source: Bundesgesundheitsblatt 8 (1992)

The statistics demonstrate that the vaccination program started in 1962, well after the peak of the polio epidemic (see also tetanus vaccination program and measles vaccination program).

“Polio has not been eradicated by vaccination, it is lurking behind a redefinition and new diagnostic names like Guillain-Barré syndrome” (Viera Scheibner, *Hiding Polio*).

“Health officials convinced the Chinese to rename the bulk of their polio to Guillain-Barré Syndrome (GBS). A study found that the new disorder (Chinese Paralytic syndrome) and GBS was really polio. After mass vaccination in 1971, reports of polio went down but GBS increased about 10 fold … In the WHO polio vaccine eradication in the Americas, there were 930 cases of paralytic disease all called polio. Five years later, at the end of the campaign, roughly 2000 cases of paralytic disease occurred but only 6 of them were called polio. The rate of paralytic disease doubled, but the disease definition changed so drastically that hardly any of it was called polio any more” (Greg Beattie, *Vaccination*).

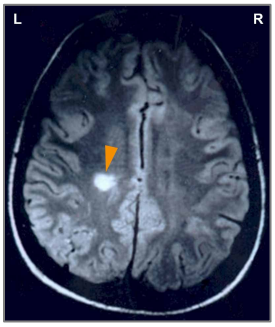
Multiple Sclerosis (MS)

Muscle weakness and a loss of sensitivity in the feet, legs or arms (see sensory paralysis related to the epidermis and the periosteum) is considered as one of the first symptoms of multiple sclerosis.

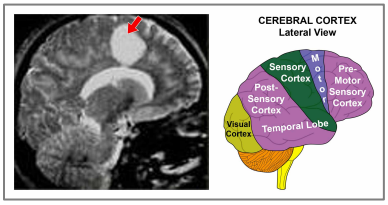
Dr. Hamer: “The big danger is that the patient suffers a **motor conflict due to the diagnosis shock**, since he has been told that he will most likely be in a wheelchair for the rest of his life.”

Without the knowledge of GNM, an MS diagnosis causes great panic. The same holds true when a person is diagnosed with ALS. The fear of not being able to walk and ending up in a wheelchair ("feeling stuck") is so overwhelming that the motor conflict which had given rise to the first symptoms often becomes irrelevant. With the progression of the paralysis the muscle atrophy also advances leading to clumsiness, difficulties walking, and frequent falls (see also "falling conflict" and vertigo). This activates additional motor and self-devaluation conflicts with the result that the mobility becomes more and more impaired and the prognosis becomes a self-fulfilling prophecy. The belief that MS, ALS, or Parkinson's are hereditary makes a person whose parent has the condition more vulnerable to suffer a motor conflict (conflicts can also be experienced *with* someone). The subsequent symptoms lead quickly to the same diagnosis (see GNM Article "Understanding Genetic Diseases").

In conventional medicine, it is assumed that multiple sclerosis is caused by a "degradation of the myelin sheath" concluded from MRI brain images (the myelin sheath is an insulating layer that envelops nerves, including nerves in the brain and spinal cord). The "myelin destruction" is thought to be an "autoimmune response" where the immune system "mistakenly" destroys the myelin sheath covering the motor neurons in the brain. Like the immune system theory, the concept of "autoimmune disorders" that supposedly damage healthy body tissue is an academic construct that has no scientific basis. The claim that MS is the result of a "destruction" of the myelin sheath is therefore highly questionable.



On this MRI, the suspected "demyelination" (called "MS plaque") shows in the cerebral medulla, specifically, in the area that controls the muscles (trophic function) around the right hip (view the GNM diagram). Neurologists consider "the abnormal white area" as the reason for the paralysis. In reality, the "MS plaque" is an accumulation of neuroglia indicating that the person is trying to heal a self-devaluation conflict that was *caused by* the motor paralysis (controlled from the motor cortex – view the GNM diagram)! **NOTE:** The myelin sheath is controlled from the cerebellum and linked to a touch conflict.

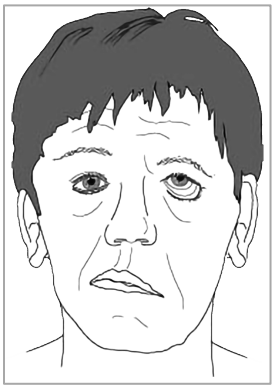


If a build-up of neuroglia is found in the motor cortex, then the "MS plaque" is diagnosed as a "brain tumor", usually followed by an excision of the lesion (see also "brain tumor seizures").

> **Dr. Hamer:** "MS, as we have formerly seen it, never existed. In GNM we therefore speak no longer of 'multiple sclerosis' but rather of motor and sensory paralyses that correlate to very specific locations in the motor and sensory cortex."

Vision impairments, which are quite common in people with MS, arise when a brain edema (in PCL-A) or a large glia buildup (in PCL-B) compresses the optic nerve that runs from the retina of the eye through the cerebral medulla to the visual cortex. Optic neuritis, an inflammation of the optic nerve, is therefore often associated with multiple sclerosis. Other vision problems (see retina) are brought on by the *fears* evoked by the "disease" rather than by the "disease spreading to other organs", as claimed.

Bell's Palsy



Bell's palsy with paralysis or weakness of the muscles on one side of the face occurs in the conflict-active phase of a "loss of face"-conflict (see also stroke and facial paralysis). Facial twitching or **facial tics** typically occurs during the Epileptoid Crisis.

The facial muscles are supplied by the facial nerve (seventh cranial nerve) that also innervates the front two-thirds of the tongue, the upper eyelid muscle, the tear ducts, and the stapedius muscle of the ear. Symptoms of Bell's palsy therefore include tongue weakness affecting speech and swallowing (tingling or numbness of the tongue and a loss of taste originate from the sensory branch of the facial nerve), incomplete lid closure, excessive tearing, and a heightened sensitivity to sound (hyperacusis).

> **NOTE:** Facial paralysis can also occur when a brain edema in close vicinity to the control center of the facial muscles is expelled during the Epileptoid Crisis, for example, a large swelling in the brain relay of the inner ear. Whether the facial paralysis is caused by a biological conflict or the result of a brain edema located close to the brain relay of the facial muscles can be easily determined through a brain CT.

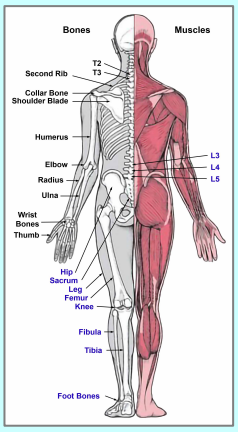
HEALING PHASE: During the healing phase, the atrophied muscle is reconstructed through cell proliferation with swelling due to the edema (fluid accumulation). Concurrent water retention (the SYNDROME) increases the swelling considerably. In conventional medicine, a large swelling is often diagnosed as a **muscle sarcoma** (myosarcoma) or "soft tissue sarcoma" (see also connective tissue sarcoma).

Muscle hypertrophy, an enlargement of the muscle, is the result of a continuous healing process (hanging healing).

> **NOTE:** All organs that derive from the new mesoderm ("surplus group"), including the skeletal muscles, show the **biological purpose at the end of the healing phase**. After the healing process has been completed, the organ or tissue is stronger than before, which allows being better prepared for a conflict of the same kind.

The swelling makes the **muscle stiff and tense** with **pain** ranging from mild to severe, depending on the intensity of the conflict-active phase (a "cold" muscle pain points to an involvement of the periosteum; a "hot" muscle pain indicates that the muscle itself is healing). A **sore or stiff neck**, for instance, reveals an intellectual self-devaluation conflict with difficulties turning the head to one side (see also cervical spine). Which side is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. **Fibromyalgia** is the medical term for widespread muscle pain; with an inflammation the condition is called **polymyalgia** or "polymyalgia rheumatica". In GNM terms, fibromyalgia and polymyalgia indicate a long-lasting healing of a generalized self-devaluation conflict affecting the whole person. In conventional medicine, overall muscle pain is also considered a symptom of "chronic fatigue syndrome" (myalgic encephalomyelitis). The persistent tiredness is believed to be caused by an infection with the "Epstein Barr virus" that has also been made responsible for mononucleosis presenting as swollen lymph nodes in the neck. Based on the Second Biological Law, "chronic fatigue" is a symptom that occurs in *any* prolonged healing phase (vagotonia).

NOTE: The swelling of a healing bone or joint might cause pain in the overlying muscle tissue.



ARM SEGMENT: The musculoskeletal segment of the arm, including the thumb, wrist bones, radius and ulna, elbow, humerus, collarbone, shoulder blade, upper part of the sternum as well as the second rib and second and third thoracic vertebrae (T2 and T3) are a functional unit.

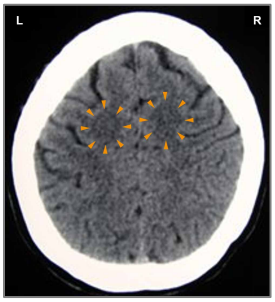
LEG SEGMENT: The musculoskeletal segment of the leg, including the foot bones (ankle, heel bone, toe bones), fibula and tibia, knee, femur and femoral neck, hip and sacrum as well as the third, fourth, and fifth lumbar vertebrae (L3, L4, L5) are a functional unit.

In case of a self-devaluation conflict, the muscle necrosis or osteolysis might take place in the entire segment. The corresponding Hamer Focus in the cerebral medulla reaches either over the whole segment or shows single foci. Accordingly, healing (recalcification of the bone with swelling or muscle pain) occurs either in the whole segment at once or successively.

The arm and leg segments are supplied by the spinal cord (see Embryonic Development).

The brain edema that develops in the motor cortex during the first part of the healing phase stretches the synapses between the neurons, which delays the transfer of nerve impulses to the affected muscle(s) even more (see conflict-active phase). As a result, **in PCL-A the paralysis remains and the muscle weakness increases**! For the uninformed, the further loss of muscle function usually leads to additional motor conflicts and a worsening of the condition. If the conflict-active phase was moderate, the muscle weakness might only be noticed in the healing phase.

NOTE: A loss of motor function can also have mechanical causes (paraplegia), toxic causes (poisoning), or surgical causes (excision of a “brain tumor”).



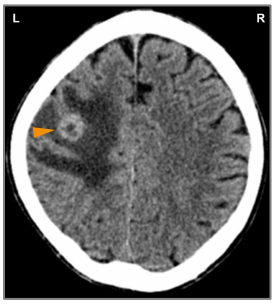
On this brain scan we see an edema (fluid accumulation) on each side of the motor cortex in the areas that control the right and left hand (view the GNM diagram), revealing that a conflict of not being able to hold someone or not being able to defend oneself (with both hands) has finally been resolved. At this point, the hand muscles are still weak. This, however, changes after the Epileptoid Crisis.

During the **Epileptoid Crisis**, a sympathicotonic surge (visible on an EEG as an electrical discharge) expels the edema in the motor cortex. The sudden reconnection of the affected nerve cells causes **rhythmic convulsions**, **muscle spasms**, **muscle cramps**, or **muscle twitching**. The exaggerated muscular movements are a positive sign that the muscle function is striving to get back to normal.

Epileptic Seizures

An intense Epileptoid Crisis manifests as an **epileptic seizure** with tonic-clonic convulsions and rapid muscle contractions. A localized or **focal seizure** with spasms or jerking of a single muscle or muscle groups is confined to the conflict-related muscles, for example in the leg(s) or arm(s). In a **grand mal seizure,** the convulsions involve the muscles of the whole body, typically with tongue biting, foaming at the mouth, and involuntary urination (see bladder sphincter). Contrary to common beliefs, seizures do not destroy brain cells. However, recurring seizures lead to a scarring of the corresponding area in the brain.

Epileptic seizures that occur with **"paralytic rabies"**, whether in animals or humans, are caused by a motor conflict of "feeling stuck" evoked by the bite of an animal. Animals often suffer also a bite conflict ("not being able to bite" the opponent) showing a dropped jaw due to the paralysis of the jaw muscles.



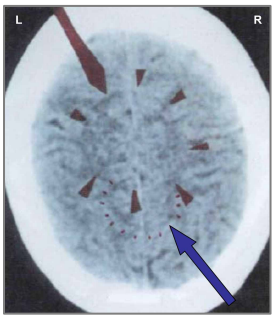
This is the brain CT of a man with a history of generalized epileptic seizures. The seizures arise from the left side of the motor cortex, precisely, from the area that controls the right hand (the hand associated with the motor conflict – view the GNM diagram). The glia buildup (showing white on the scan) indicates that the person is already in PCL-B. The edema located in the cerebral medulla (showing dark – view the GNM diagram) relates to a self-devaluation conflict.

NOTE: In conventional medicine, the proliferation of neuroglia is interpreted as a "brain tumor". If the person happens to be an epileptic, then the "lesion" is diagnosed as "brain tumor seizures", suggesting that the seizures are induced by the "brain tumor". A surgical removal of an "epileptic focus" bears the risk of irreversible paralysis.

NOTE: An epileptic seizure can generalize from anywhere in the motor cortex. This includes the brain relays of the bronchial muscles, laryngeal muscles, or the myocardium (see "heart epilepsy"). An epileptic attack is therefore not necessarily preceded by weakness or paralysis of a skeletal muscle.

Recurring seizures are triggered by conflict relapses through setting on a track that was established when the motor conflict first took place. The "warning signs" preceding a seizure, called an epileptic aura, can become additional tracks, prompting further seizures. At that point, the original motor conflict might already be irrelevant.

A loss of consciousness during an epileptic seizure, called an **absence seizure,** reveals that the Epi-Crisis of the motor conflict concurs with the healing phase of a conflict related to the sensory, post-sensory, or pre-motor sensory cortex, for example with a separation conflict, that generates an "absence" (fainting) during the Epileptoid Crisis. In a **petit mal seizure**, the zoning out only lasts a few seconds.



This brain CT belongs to an 8 year-old boy who suffered simultaneously a motor conflict and a severe separation conflict involving the periosteum. The conflicts happened when the parents were out for the evening and the boy was watching with his older cousin a scary movie, where children were kidnapped from their home while they were asleep.

On the scan we see two central conflicts overlapping into both brain hemispheres, which indicates that the conflicts are equally related to his mother and his father. The lower Hamer Focus (blue arrow) located in the post-sensory cortex is linked to the separation conflict (the fear of being taken away from his parents, like the children in the movie). The upper Hamer Focus (red arrow) located in the motor cortex is linked to the motor conflict (not being able to escape). The partly edematous ring (dark areas) points to conflict relapses causing recurring epileptic seizures with fainting during the Epileptoid Crisis.

Febrile seizures or **febrile convulsions** with tonic-clonic motor activity (twitching of the arms and legs), a loss of consciousness ("absence"), and fever (greater than 38 °C/100.4 °F) occur for two reasons: A) the motor Epi-Crisis coincides with a healing phase that is accompanied by fever, for instance with a middle ear infection, bronchitis, mononucleosis, or a sore throat ("strep throat"). The related conflicts are most likely linked to the same conflict situation. B) a brain edema located close to the motor cortex, for example in the bronchi or larynx relay, triggers the seizure during the Epileptoid Crisis due to the pressure on the motor cortex. In this case, the high fever is caused by the intense healing process on the correlating organ. The encounter with a conflict track prompts instantly a febrile seizure episode with muscle convulsions and a rapid rise in body temperature.

The differentiation between "simple febrile seizures" (lasting less than 15 minutes) and "atypical febrile seizures" (exceeding 15 minutes) points to the intensity of the corresponding conflict(s). Like absence seizures (brief lapses of consciousness) febrile seizures are most common in small children. Febrile seizures in newborns indicate that the conflict, for example a separation conflict, territorial fear conflict or scare-fright conflict happened in utero or during delivery.

Parkinson's

Parkinson's with tremors in one hand or both originates in a motor conflict associated with the hand(s). The tremors might also occur in the neck or in just one arm or leg, depending on the nature of the motor conflict. The typical muscle stiffness (rigidity) and slowing of movements (bradykinesia) are symptoms of a prolonged healing phase while the **tremors occur during the Epileptoid Crisis**. Permanent tremors, for example in the hands, are a sign of a continuous healing crisis due to constant motor conflicts of not being able to use the hands properly. In other words, the tremor itself is a track leading to a chronic condition. Conventional medicine considers Parkinson's a "progressive neurodegenerative brain disorder" (a lack of dopamine is made responsible for the onset of the disease). Like with MS and ALS, the real reason why the condition advances is the negative prognosis and the fear of becoming completely disabled leading to additional motor conflicts and a worsening of the symptoms. Speech problems and voice changes are brought on by scare-fright conflicts.

Focal Dystonia

Focal dystonia is a **sustained muscle contraction** (lasting Epileptoid Crisis) with repetitive movements of a specific muscle. In **focal hand dystonia** the finger or fingers – usually of one hand (handedness!) – curl into the palm or extend outward. The condition occurs most common among surgeons, dentists, and musicians, since people whose profession or hobbies require fine motor skills are more likely to experience a motor conflict associated with the finger(s) and hand(s) (compare with Dupuytren's contracture, a hand deformity related to the connective tissue). In sports such as tennis, baseball, or golf, the wrist spasms are commonly called **yips**. In **cervical dystonia**, also referred to as **muscular torticollis** or "wry neck", the muscles around the neck contract intermittently, forcing the head to tip to one side with the chin thrust upwards. The underlying cause is a neck-related motor conflict. Generalized dystonia affecting most or all of the body presents as twisting of the limbs, specifically of the foot and leg or hand and arm, or of the torso (called **Oppenheim's disease**). It is wrongly believed to be a "genetic disorder". In people with Parkinson's dystonia often arises from the effect of using the medication Levodopa (L-dopa).

Tetanus

Tetanus is characterized by **muscle stiffness and body spasms**. Tetanus is thought to be caused by nerve toxins, produced by the bacterium *Clostridium tetani* that presumably enters the central nervous system through a wound. According to the medical literature, a "local tetanus", in which patients have muscle contraction in the area of the injury, might be followed by a "generalized tetanus". In GNM terms, the seizure-like muscle cramping takes place during the Epileptoid Crisis of a motor conflict that occurred during the fall which led to the injury. If anything, bacteria *assist* healing. Tetanus vaccinations might prevent "tetanus" but not the symptoms!

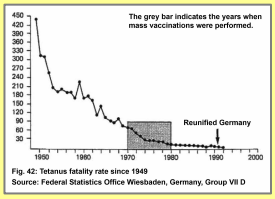


Fig. 42: Tetanus fatality rate since 1949
Source: Federal Statistics Office Wiesbaden, Germany, Group VII D

This diagram shows the tetanus death rates in Germany between 1949 and 1995. The grey bar indicates the years when mass vaccinations were performed (1970-1980). Source: Federal Statistics Office Wiesbaden, Germany

The statistics demonstrate that the vaccination program started in 1970, well after the peak of the tetanus epidemic (see also polio vaccination program and measles vaccination program).

STROKE with motor paralysis

According to conventional medicine, the main causes of a stroke are:

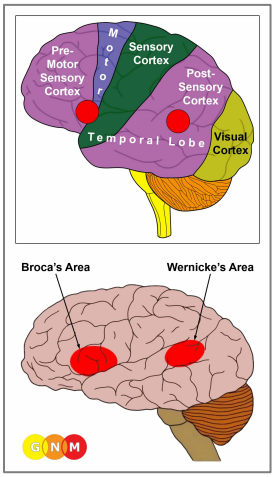
- high blood pressure. This theory is purely hypothetical because there are people who suffer a stroke although the blood pressure is normal, and the other way around, there are people who have elevated blood pressure and never have a stroke (see hypertension related to the kidney parenchyma and the myocardium).

- a blocked brain artery (ischemic stroke). This theory is based on the assumption that a thrombus, an embolus, or cholesterol plaques originating in the heart or in a vein obstruct a blood vessel in the brain leading to a loss of brain function. Even though it has been firmly established that in the event of an occlusion of a cerebral artery auxiliary vessels or collaterals act as a natural bypass to maintain the blood and oxygen supply to the brain, the blockage-theory still persists.

- bleeding in the brain (hemorrhagic stroke)

In GNM, we differentiate between a **sympathicotonic stroke** (“white stroke”) and a **vagotonic stroke** (“red stroke”).

The **white stroke** occurs at the moment of the DHS. The impact of the motor conflict in the motor cortex generates sudden muscle weakness in one or more limbs, typically on one side of the body. Which side is affected is determined by a person’s handedness and whether the conflict is mother/child or partner-related. At this point, the weakness of the muscle(s) might be diagnosed as MS or ALS. However, an intense conflict leads quickly to muscle paralysis, possibly with paralysis of the facial muscles, including the tongue, affecting speech and swallowing (see Bell’s palsy). Now, the condition is called a “stroke”. Difficulties formulating words, termed **Broca’s aphasia**, involves the motor center for speech, known as the Broca’s area, located on the left side of the cerebral cortex in the brain relay that controls the laryngeal and vocal cord muscles. Hence, in people with Broca’s aphasia, the paralysis is always on the right side of the body. Numbness (sensory paralysis) in the face, arm and/or leg points to an additional separation conflict.



NOTE: Wernicke’s aphasia is a condition that affects a person’s ability to speak coherently (saying the wrong words, using made-up words that have no meaning, formulating sentences that don’t make sense). In severe cases, the person has problems understanding what others are saying and to read and write properly (someone with Broca’s aphasia also has troubles formulating words but what is being said is intelligible).

The Wernicke’s area, responsible for the processing of words, is located in the post-sensory cortex in close vicinity to the left temporal lobe. The corresponding conflict is a separation conflict (the Broca’s area is located in the left motor cortex in the brain relay of the laryngeal/vocal cord muscles and linked to a scare-fright conflict or territorial fear conflict; the difficulties formulating words results from being “speechless with fear”). The struggle of finding the right word presented with Wernicke’s aphasia is a manifestation of the short-term memory loss that is typical for separation conflicts. In this case, the shock over the separation (DHS) is experienced as being stunned to a point that one is unable to articulate one’s thoughts. Taking into account a person’s biological handedness, for right-handers the separation conflict is associated with a partner; for left-handers, the conflict is mother/child-related. The degree of the speech impairment is determined by the intensity of the conflict. A stroke associated with Wernicke’s aphasia is, in GNM terms, a sympathicotonic stroke (“white stroke”).

YouTube This video shows Grammys Reporter Serene Branson with an onset of aphasia during an on-air report.

With a white stroke the muscle weakness or paralysis lasts throughout the conflict-active phase (cold hands, little appetite) and reaches into PCL-A. The Epileptoid Crisis, which is the period when the brain edema in the motor cortex is expelled, triggers uncontrolled jerking and contractions of the affected muscle(s) or an epileptic seizure. This is why it is sometimes difficult to tell strokes and seizures apart.

The **red stroke** takes place when a brain edema in close vicinity to the motor cortex presses onto the motor cortex, for example, an edema in the brain relay of the bronchi, larynx, or the myocardium. The “stroke” is initiated at the onset of the Epileptoid Crisis and lasts throughout the crisis from a few minutes (“transient ischemic attack”) to a few hours, depending on how long it takes to expel the edema. Impaired vision following a stroke occurs when a brain edema injures the optic nerve that runs through the cerebrum. After the Epileptoid Crisis, in PCL-B, the paralysis recedes and the motor ability slowly returns to normal. However, if the brain edema cannot be completely expelled, the paralysis (partly) remains since the synapses between the neurons don’t connect properly. This usually happens because of water retention due to an active abandonment or existence conflict (the SYNDROME) where water is also stored in the area of the brain that is healing at the time. Permanent paralysis can also be the result of repetitive scarification processes in the motor cortex due to continuous conflict relapses.

Source: www.learninggnm.com