THE FIVE BIOLOGICAL LAWS OF THE NEW MEDICINE

"The differentiation between the psyche, the brain, and the body is purely academic. In reality they are one." (Ryke Geerd Hamer)

FIRST BIOLOGICAL LAW ("The Iron Rule of Cancer")

1st Criterion: Every "disease" - hereinafter called **Significant Biological Special Program (SBS)** - originates from a **DHS** (Dirk Hamer Syndrome), which is an unexpected, highly acute, and isolating conflict shock that occurs simultaneously in the psyche, the brain, and on the corresponding organ.

2nd Criterion: The content of the conflict determines which organ will be affected and from which area of the brain the SBS will be controlled.

3rd Criterion: Every SBS runs synchronously on the level of the **psyche**, the **brain**, and the **organ**.

NOTE: The abbreviation SBS derives from the German "**S**innvolles **B**iologisches **S**onderprogramm" (meaningful biological special program). As an integral component of the GNM terminology, the acronym SBS is protected by copyright.

In GNM terms, a **DHS** is an emotionally distressing event that we could not anticipate and for which we were not prepared. From a biological point of view "unexpected" implies that, unprepared for, the situation could be detrimental for the one who was caught off-guard. In order to support the organism during the unforeseen crisis, a **Significant Biological Special Program** on stand-by for exactly that conflict is instantly activated. The significance of this meaningful biological program of Nature is to improve the function of the organ, so that the individual is in a better position to manage and eventually resolve the conflict. Since the DHS occurs at once in the psyche, in the brain, and on the corresponding organ, we speak in GNM of **biological conflicts** rather than of psychological conflicts.

NOTE: Biological conflicts are always linked to the function of the correlating organ. The organs of the alimentary canal relate therefore to "morsel conflicts" (not being able to catch, swallow, digest, or eliminate a morsel), theuterus and prostate to procreation conflicts, or the skin to separation conflicts.

Sorrow
over the loss of a mate

Animals suffer biological conflicts in real terms, for instance, when they are attacked by an opponent, when they lose their nest or territory, or when they are separated from a mate or an offspring. It is this biological conflict experience that connects us with all life.

Since human beings are capable of symbolic thought, we are able to experience biological conflicts also in a figurative sense. For us, an attack conflict can be brought on by an offending remark, a territorial loss conflict with an unwanted move, a starvation conflict through the loss of income, a sexual conflict when our partner is "mating" with someone else, a self-devaluation conflict because of abuse, or a death-fright conflict through the shock of a cancer diagnosis.

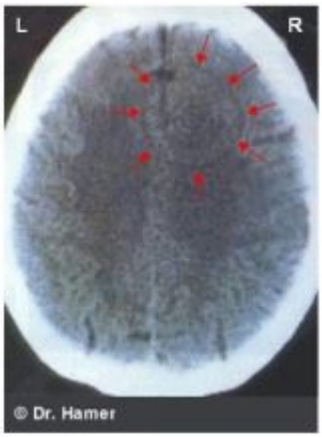
In GNM, the **PSYCHE** is regarded as an integral part of the human biology. It is the 'organ', so to speak, that inherently recognizes dangers. At the very instance of a DHS the psyche associates with the event a specific *biological* conflict theme such as "anger in the territory", "worries in the nest", "abandonment by the pack", "separation from a mate", "loss of an offspring", and so forth. This association happens in a

split second and entirely on a subliminal level. Thus, it is the subconscious reading and **subjective assessment of the conflict situation** that determines which Biological Special Program will be activated. Yet, how exactly the subconscious mind perceived the particular conflict is only revealed when the physical symptoms arise. Whether a person gets a sore throat, comes down with a cold, has diarrhea, develops a skin condition or a certain cancer is therefore dependent on how the conflict was experienced when the DHS occurred. **NOTE:**We can also suffer a conflict with or on behalf of someone else.

It goes without saying that our past experiences, our social and cultural conditioning, our values, our beliefs, our knowledge, our expectations, our vulnerabilities, our fears, and other factors contribute greatly to the perception of a conflict situation. Psychological aspects can undoubtedly create a predisposition for a biological conflict. However, independent of a DHS they are not able to activate a Biological Special Program, because, like other species, we humans respond to unexpected distress *biologically* rather than intellectually or on a solely psychological level.

When the DHS occurs, the conflict is registered on all three levels at once.

BRAIN LEVEL: At the moment of the DHS, the conflict shock impacts in a specific, predetermined area in the brain. On a brain CT (brain computer tomogram) the impact is visible as a set of sharp concentric rings or as a semicircle, depending on the location. In GNM, such a ring configuration is called a **Hamer Focus or HH** (from German: **H**amerscher **H**erd). The term was originally coined by Dr. Hamer's opponents, who mockingly named these structures "dubious Hamer Foci".

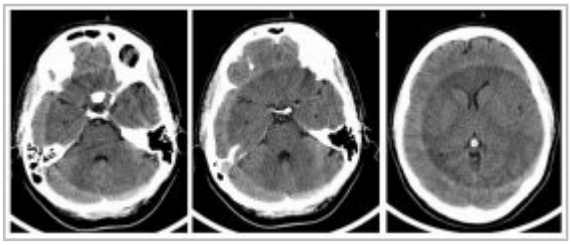


The **location of the Hamer Focus** is determined by the nature of the conflict.

The **size of the Hamer Focus** is determined by the intensity of the conflict.

On this CT scan the Hamer Focus (HH) shows in the area of the brain that controls the left arm. It tells the story of a left-handed woman who had suffered a motor conflict when she unexpectedly lost a beloved friend (she was not able to hold him with her left "partner-arm"). The sharp ring configuration indicates that she is in the conflict-active phase.

Before Dr. Hamer discovered these ring structures in the brain, radiologists disregarded them as artifacts created by a glitch in the machine. But in 1989, Siemens, a manufacturer of computer tomography equipment, certified that these target rings cannot be artifacts, because even when the tomography is repeated and taken from different angles, the same configuration always appears in the same location. Moreover, during the course of a SBS the Hamer Focus changes from a sharp ring configuration (conflict-active phase) to an edematous ring structure (in PCL-A) to a HH with neuroglia (in PCL-B). Hence, if several Biological Special Programs run concurrently, more than one Hamer Focus is visible on a brain scan, and this often in different phases.



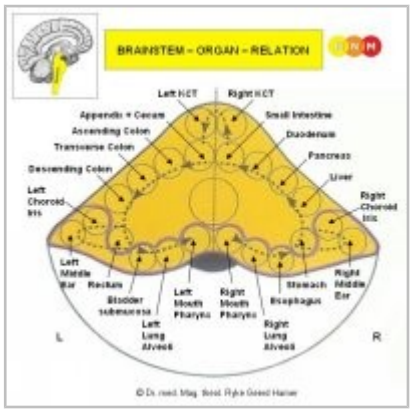
This series of CT images show real ring artifacts. The rings appear in a uniform phantom at each angular position. This usually happens when a detector is out of calibration.

In the practice of GNM a brain CT is the ultimate diagnostic tool. A thorough brain scan analysis allows drawing reliable conclusions as to the nature of the DHS, the intensity of the conflict, which organ is

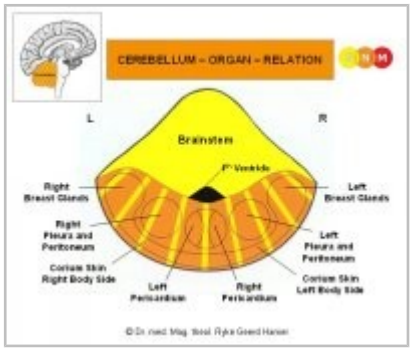
affected, whether the SBS is in theconflict-active phase or in the healing phase, and what healing symptoms have to be expected once the conflict has been resolved. The Hamer Foci (we could also call them "conflict markers") are the exact proof that the psyche communicates with all organs of the body via the brain as the control station from where the Significant Biological Special Programs are coordinated.

NOTE: In GNM, a brain scan analysis is based on a CT taken without contrast substance. The images are viewed from the perspective of the client (right side of the CT = right side of the brain).

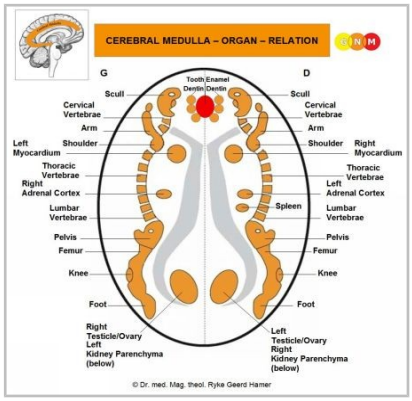
The Psyche – Brain – Organ Relation



In the **brainstem**, the control centers of the organs of the intestinal canal and its descendants are arranged in a ring-form order, starting on the right hemisphere with the brain relays of the mouth and pharynx, lung alveoli, esophagus, stomach, liver parenchyma, pancreas gland, duodenum, small intestine, continuing counter-clockwise with the brain relays of the appendix, cecum, colon, rectum and bladder on the left side of the brainstem.

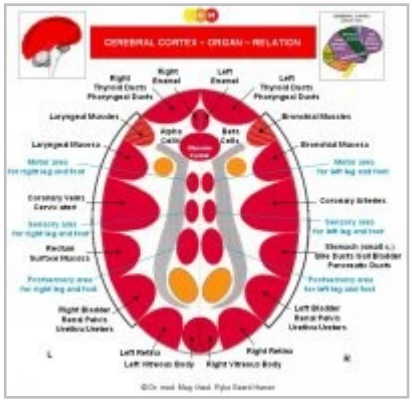


The **cerebellum**, next to the brainstem, controls the "skins" (corium skin, pleura,peritoneum, pericardium) that protect the body and the vital organs as well as thebreast glands.



In the **cerebral medulla**, the brain relays of the skull, arms, shoulders, vertebrae (spine), pelvis, hip, knees, and feet are orderly arranged from head to toe.

The **cerebral cortex** is divided into a

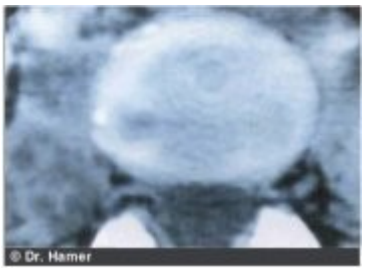


- **pre-motor sensory cortex** (frontal: thyroid ducts, pharyngeal ducts)
- **motor cortex** (striated muscles; laryngeal muscles, bronchial muscles)
- **sensory cortex** (skin, larynx, bronchia)
- **post-sensory cortex** (periosteum, coronary arteries, coronary veins, cervix, rectum surface mucosa, stomach (small curvature), bile ducts, pancreatic ducts, renal pelvis, ureters, bladder and urethra)
- **visual cortex** (retina, vitreous body)

NOTE: The glucose center (see GNM diagram) is controlled from the diencephalon.

Head Brain and "Organ Brain"

This meaningful interplay between the psyche, the brain, and the body has been in place for millions of years. Originally, these biological survival programs were directed from the "organ brain" (plants still possess such an organ brain). With the growing complexity of life forms, however, a "head brain" (the master controller) developed from where eachBiological Special Program is coordinated. The transfer from the "organ brain" to the "head brain" explains why, in line with evolutionary reasoning, the control centers in the brain are arranged in the same order as the organs in the body. The cells of the human body are quasi the "primeval brain" with the cell nuclei as the micro-computers controlled from the head brain as the supervising home station. The head brain and the cell-"brains" are neurally connected. They therefore vibrate at the same frequency.



This remarkable organ CT, showing a Hamer Focus in the area of the 4th lumbar spine (active self-devaluation conflict), makes the communication between the brain and an organ strikingly visible.

ORGAN LEVEL: With the impact of the conflict in the correlating brain relay, the DHS is instantly communicated to the corresponding organ and the Biological Special Program is set into motion.

BIOLOGICAL HANDEDNESS

In the practical application of GNM it is of utmost importance to ascertain a person's biological handedness, because the handedness determines whether the **conflict impacts on the right or left side of the brain** and whether a **symptom**(skin rash, muscle weakness, rheumatic pain, breast cancer) **occurs on the right or left side of the body**, taking into account the cross-over correlation from the brain to the organ (the brain-organ relation is always unequivocal).

NOTE: The biological handedness is established at the moment of the first cell division after conception. This is why with identical twins one is biologically right-handed and one is left-handed. Many left-handed people were retrained in early childhood in order to fit into the right-handed world. The real ratio of right-handers and left-handers is approximately 60:40.

In addition, the **right and left side of the body are assigned to mother/child and partner-related conflicts** (seenest-worry conflicts, separation conflicts, hearing conflicts, attack conflicts, self-devaluation conflicts). A partner includes a person's spouse, siblings, relatives, colleagues, business partners, neighbors, school mates, friends, or foes. For a man his child is associated with his mother/child-side when he is raising the child or when his father feelings are very strong, otherwise the child is considered a partner. For a child, his/her father is the first "partner". By the same token, the mother can be perceived as a partner when the child grew up with the grandparents or when the mother-child relationship has deteriorated. If an adult cares for a sick father like for a child, the father is most likely associated with the mother/child side. A pet can be perceived as a child or as a friend (partner). A conflict evoked by a partner, for example a separation conflict, is mother-related if the subconscious mind makes a connection with the mother ("This also happened to my mother"). What ultimately counts is with whom the conflict is associated at the moment of the DHS (compare withlocalized conflicts).

An easy way to establish the biological handedness is the **clapping test** - clapping the hands like applauding in the theatre . The hand that is on top is the leading hand and tells whether a person is right-handed or left-handed. Also, right-handers start walking with the right foot, left-handers with the left foot. Left-handers are usually ambidextrous.

Right hand on top: right-handed

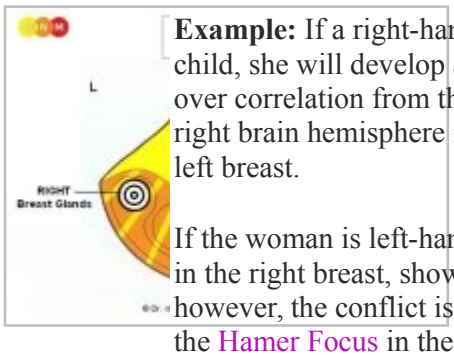
Left hand on top: left-handed

Just as every human is right-handed or left-handed,
each animal is right-pawed (right-hooved) or left-pawed (left-hooved).
As seen in the above picture, one dog gives the right paw, the other the left paw.
Watch with what leg your pet makes the first step!

The principle of laterality: A **right-handed person** responds to a conflict with his/her mother or child with the left side of the body and to a conflict with a partner with the right side. With left-handed people it is reversed. Hence, a **left-handed person** associates a conflict with his/her mother or child with the right side of the body and a conflict with a partner with the left side. This rule applies to all organs controlled from the cerebellum, cerebral medulla, and cerebral cortex (except for the temporal lobe, glucose center, and brain relays of the thyroid ducts and pharyngeal ducts – see principle of gender, laterality, and hormone status below). **NOTE:** With organs controlled from the brainstem a person's handedness is irrelevant.

A right-handed woman holds her child on her left arm, a left-handed woman on her right arm so that the dominant hand is free to operate. This innate behaviour became the biological blueprint for the mother/child side.

NOTE: The organism of the infant and of the mother vibrates in the same frequency. The mother/child and child/mother conflict is therefore associated with the same breast and registered in the same brain relay.

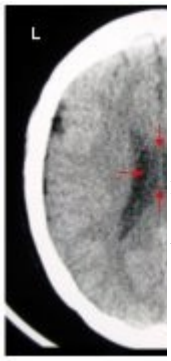


Example: If a right-handed woman suffers a "nest-worry conflict" over the health of her child, she will develop a glandular breast cancer in her left breast. Since there is a cross-over correlation from the brain to the organ, the Hamer Focus shows on a brain scan on the right brain hemisphere in the area of the cerebellum that controls the glandular tissue of the left breast.

If the woman is left-handed, the "nest-worry conflict" over her child manifests as a cancer in the right breast, showing the impact on a brain CT on the left brain hemisphere. If, however, the conflict is over her partner, she develops breast cancer in her left breast with the Hamer Focus in the breast relay on the right side of the cerebellum.

The biological right and left-handedness proves that physical symptoms arising from a DHS originate from a *biological*conflict. Standard medical theories claiming that "diseases" are caused by a "weak immune system", a wrong diet, faultygenes, pathogenic microbes, geopathic stress, or by beliefs ("Beliefs can make you sick" - Bruce Lipton) are not able to explain why a specific condition such as dermatitis, joint pain, muscle paralysis, or certain cancers develop on the right or left side of the body (or on both). From a strictly psychological point of view, this makes no sense either.

A **central or para-central conflict** refers to a DHS that affects the mother/child and partner-side simultaneously. This could happen, for example, when a grown-up child or the mother is also perceived as a partner (80%). In this particular case, the center of the Hamer Focus is located on the partner-related brain hemisphere (para-central). A (para)central conflict also occurs when the conflict relates to the mother/child and partner at the same time, for example, a separation conflict associated with both parents. If the conflict is linked to a paired organ such as the breasts, the nest-worry conflictimpacts in both breast gland relays, involving the right and left breast.

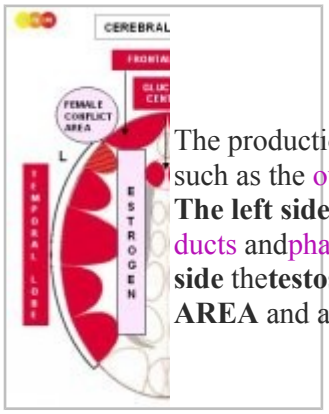


This brain CT shows the impact of a central separation conflict with a Hamer Focus (HH) reaching equally over both brain hemispheres; the center of the HH is on the midline of the sensory cortex (view the GNM diagram). The symptom on the organ level is a skin rash on both legs.

A **localized conflict** affects the area of the body that was associated with the conflict. For example, a hit on the right shoulder (attack conflict) affects the relevant area of the corium skin, independent of the mother/child and partner-side. A**generalized conflict** relates to a DHS that affects a person as a whole. Subsequently, the symptoms occur on both sides of the body. Generalized conflicts (separation conflicts, self-devaluation conflicts) occur predominantly in children and the elderly.

THE PRINCIPLE OF GENDER, LATERALITY, AND HORMONE STATUS

With organs and tissues controlled from the **temporal lobe** (bronchial muscles, bronchial mucosa, laryngeal muscles,laryngeal mucosa, coronary arteries, coronary veins, cervix uteri, small curvature of the stomach, bile ducts, pancreatic ducts, rectum, renal pelvis, ureters, bladder, and urethra), the **frontal lobe** (thyroid ducts, pharyngeal ducts), and theglucose center (alpha islet cells and beta islet cells of the pancreas), we have to take into account a person's gender,handedness, and hormone status. Whether the conflict is mother/child or partner-related is of no consequence.



The production of sexual hormones, including estrogen and testosterone, occurs in organs such as the ovaries and testicles**. The hormone levels are also controlled from the brain. The left side** of the temporal lobe, frontal lobe (brain relays of thyroid ducts andpharyngeal ducts), and glucose center controls the **estrogen status**, the **right side** the**testosterone status**. In GNM we speak therefore of a **FEMALE CONFLICT AREA** and a**MALE CONFLICT AREA**, respectively.

NOTE: If the conflict involves the **left temporal lobe**, the person is **manic** (dynamic, energetic driven, over excited, active) throughout the conflict-active phase; if the conflict involves the **right temporal lobe**, the person is **depressed** (listless, sad, melancholic, passive) while conflict active.

A **change of the hormone status** alters a person's biological identity and consequently the way in which conflicts are perceived. For example: When a woman is postmenopausal, her testosterone level is relatively higher than her estrogen level; she experiences therefore conflicts just like a male. **In females, the estrogen level decreases** during pregnancy and nursing, after menopause, with an ovarian necrosis, when one or both ovaries have been removed, and due to estrogen-lowering medication or contraceptives (progesterone in birth control pills suppress the production of estrogen).**In males, the testosterone level decreases** in elderly men, with a testicular necrosis, when one or both testicles have been removed, and due to testosterone-lowering medication. After radiation or chemo treatments the production of sexual hormones drops altogether.

NOTE: Even though after menopause a woman is, in biological terms, a „male", she can still suffer a nest-worry conflict (see glandular breast cancer) because a mother always feels like a mother, including towards other family members, regardless at what age.

With the impact of a DHS in the female conflict area, the estrogen level decreases proportionally to the degree of conflict activity. Conversely, with an impact in the male conflict area, the testosterone level goes down. In GNM we call this a**conflict-related hormonal imbalance**.

THE SCALE RULE

- **Gender and laterality determine whether a conflict impacts on the right or left side of the brain.**

- **The hormone status determines whether a conflict is experienced in a male or female fashion**.

In the practical application of GNM, the knowledge of the Scale Rule allows to establish with certainty

the type of conflict that causes the symptoms on the corresponding organ.

Let's take as an example the scenarios of a male territorial fear conflict and a female scare-fright conflict related to thebronchia and the larynx (controlled from the temporal lobe).

Right-handed and left-handed females with a normal hormone status

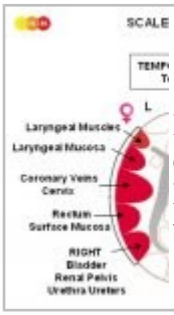
If a RH-female with a normal hormone status experiences a scare-fright conflict, the conflict impacts on the left brain hemisphere in the larynx relay (female conflict area). For a LH-female the scare-fright conflict impacts in thebronchia relay.

NOTE: With left-handers the conflict is transferred to the opposite brain relay on the other brain hemisphere. After the resolution of the conflict, right-handers and left-handers respond therefore to the same conflict with a different organ manifestation (bronchitis or laryngitis). Since the right temporal lobe controls organs with a potentially serious healing phase, the principle of transferring conflicts to the other side of the brain serves the purpose to enhance the survival of the group in the event that disaster hits the territory and the pack.

Right-handed and left-handed females with a low estrogen status

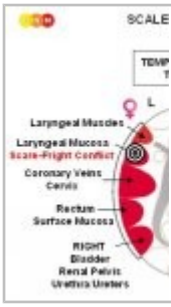
A woman with a low estrogen level is no longer able to suffer female conflicts in biological terms. Hence, if a RH-female with a low estrogen status suffers a male territorial fear conflict, the conflict impacts on the right brain hemisphere in the male conflict area, precisely, in the bronchia relay. For a LH-female the conflict is transferred to the other brain hemisphere and is registered in the larynx relay.

Right-handed and left-handed males with a normal hormone status



If a RH-male with a normal hormone status experiences a territorial fear conflict, the conflict impacts on the right brain hemisphere in the bronchia relay (male conflict area). For a LH-male the conflict is transferred to the other brain hemisphere and impacts in the larynx relay.

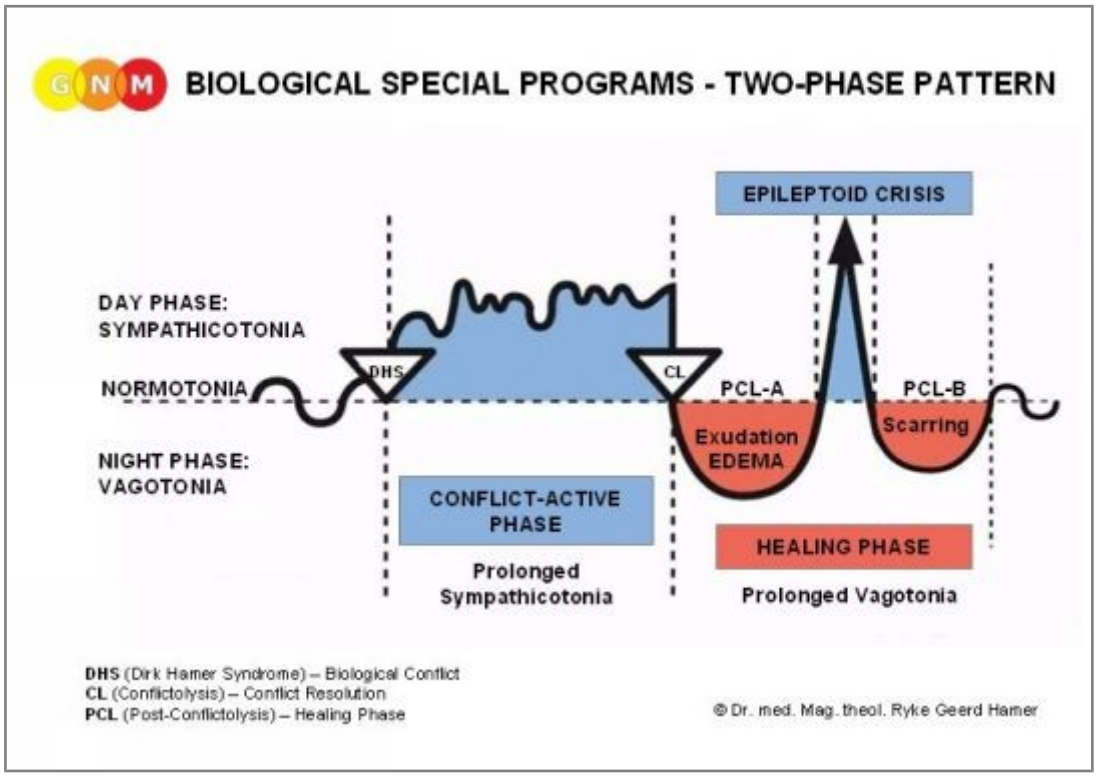
Right-handed an left-handed males with low testosterone status



A man with a low testosterone level is no longer able to suffer territorial conflicts in biological terms. Hence, if a RH-male with a low testosterone level suffers a female scare-fright conflict, the conflict impacts on the left brain hemisphere in the female conflict area, precisely, in the larynx relay. For a LH-male the conflict is transferred to the other brain hemisphere and is registered in the bronchia relay.

THE SECOND BIOLOGICAL LAW

Every SBS-Significant Biological Special Program runs in two phases provided there is a resolution of the conflict.



Normotonia, sympathicotonia, and **vagotonia** are terms that relate to the autonomic nervous system which controls vegetative functions such as sweating, respiration, digestion, excretion, constriction of blood vessels, and the heartbeat.

Normotonia indicates a balanced day-night-rhythm where sympathicotonia alternates with vagotonia. During the day, the organism is in a normal sympathicotonic state of stress ("fight or take flight"), during sleep in a normal vagotonic state of rest ("rest and digest"). The sympathicotonic phase lasts roughly from 4 am in the morning to 8 pm at night.

The Second Biological Law shows that every Biological Special Program proceeds in this two-phase pattern. In GNM, the change of the vegetative rhythm is an important diagnostic criterion for establishing whether a person is in the conflict-active phase or in the healing phase.

THE CONFLICT-ACTIVE PHASE (CA-Phase)

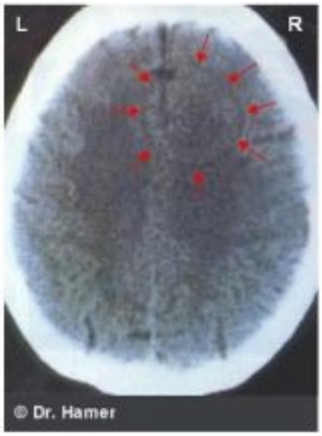
When the DHS occurs, the normal day-night-rhythm is instantly interrupted and the **autonomic nervous**

systemswitches into **lasting sympathicotonia** and a prolonged state of stress with **nervous restlessness**, a **fast heartbeat, elevated blood pressure**, **slow digestion**, **frequent urination**, and **little appetite**. Since the blood vessels are constricted during stress, typical signs of conflict activity are **cold hands**, cold sweats, and the shivers. We therefore call the conflict-active phase also the **COLD phase**.

The **PSYCHE** is in a **compulsive thinking** mode. The constant dwelling over the conflict causes sleep disturbances (waking up shortly after falling asleep, usually around 3 o'clock in the morning). The extra waking hours and the total focus on the conflict serve to find a resolution to the conflict as soon as possible.

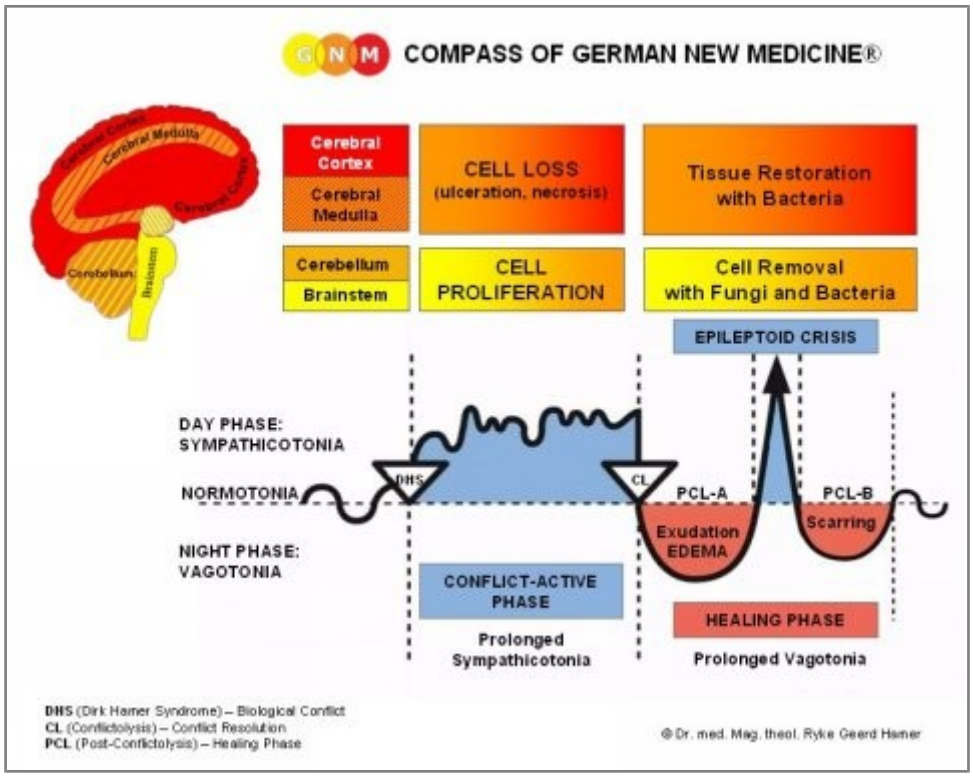
The psyche, the brain, and the corresponding organ are three levels of ONE unified organism that always work in synchronicity.

BRAIN LEVEL: The Biological Special Program is directed from the brain relay that corresponds to the specific conflict as well as to the correlating organ.



In the conflict-active phase, the sharp ring-configuration of the Hamer Focus remains unchanged.

ORGAN LEVEL: In unison with the psyche and the autonomic nervous system, the conflict-related organ responds with physical changes that serve the **biological purpose to *improve* the function of the organ** so that the individual is in a better position to cope with the conflict.



If more tissue is required to facilitate a conflict resolution, the corresponding organ generates cell proliferation during the conflict-active phase. This process applies to all organs and tissues that are controlled from the brainstem and the cerebellum such as the lungs, liver, pancreas, colon, thyroid, or breast glands. In embryological terms, these organs derive from the endoderm or from the old mesoderm (see Third Biological Law).

NOTE: Undernourishment, injuries, and poisoning can lead to a dysfunction of an organ, but do not cause cancer.

With long-lasting conflict activity the continuous cell augmentation forms a tumor or cancer. Since the additional cells (the "cancer cells") proliferate proportionally to the degree of conflict activity, they have the ability to multiply very quickly (they also differ genetically from the original cells). Conventional medicine considers the fast cell mitosis erroneously as "abnormal" and as "cells growing out of control". If the rate of cell division exceeds a certain limit, the tumor is interpreted as "**malignant"** (based on an academic consensus!). Dr. Hamer's discoveries turn this paradigm completely on its head by demonstrating that "diseases" such as cancer are not, as assumed, malfunctions of an organism but instead Significant Biological Special Programs of Nature designed to support an individual during unexpected distress. His research provides the scientific evidence that **cancer cells are in reality specialized cells** that actively participate in the function of an organ in order to assist the organism in the event of a biological emergency situation. In lung cancer, for example, the extra cells improve the capacity of the lungs in response to a death-fright conflict, in colon cancer they increase the production of digestive juices to be better able to manage an indigestible morsel conflict, in breast cancer the additional milk-producing cells allow a female to provide more milk for a sick offspring in the event of a nest-worry conflict. In light of the Five Biological Laws and the new understanding of "diseases", the distinction between "malignant" and "benign" becomes entirely meaningless.

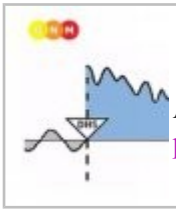
Dr. Hamer: "In GNM there is no 'benign' or 'malignant'; just like there is no benign or malignant in biology."

If less tissue is required to facilitate a conflict resolution, the organ or tissue responds with cell loss. This process applies to all organs and tissues that are controlled from the cerebral medulla and

the cerebral cortex such as thebones and joints, ovaries, testicles, coronary arteries, coronary veins, cervix, bronchia, larynx, and the skin. In embryological terms, these organs derive from the new mesoderm or from the ectoderm (see Third Biological Law).

NOTE: The skeletal muscles, islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochleaand vestibular organ), retina and vitreous body of the eyes, and the olfactory nerves belong to the group of organs that respond to the related conflict with functional loss or hyperfunction (periosteal nerves and thalamus).

HANGING CONFLICT



A "**hanging conflict"** refers to the situation where a person remains in the conflict-active phase because the conflict cannot or has not yet been resolved.

Many of us are living with "hanging conflicts" with little or no symptoms since symptoms in the conflict-active phase are rare. Lasting intense conflict activity, however, drains the body of energy, which could lead to death. Yet, a person can never die of cancer! Those, who don't make it through the conflict-active phase die as a result of energy loss, weight loss (see protein depletion), sleep deprivation and, above all, because of the fear of the "disease", particularly the fear of cancer. With a negative prognosis ("You have six months to live!"), "metastasis"-scares ("The cancer is spreading!"), and highly toxic chemo treatments added to the emotional and mental distress, cancer patients have little chance to survive. Worn out and exhausted, they waste away and eventually die of cachexia.

"**The majority of cancer patients die because of chemotherapy**, which does not cure breast, colon or lung cancer. This has been documented for over a decade and nevertheless doctors still utilize chemotherapy to fight these tumors."

Allen Levin, MD, The Healing of Cancer, 1990

In **GNM**, we take the following **approach: If an intense conflict cannot be resolved at the time, the objective is to downgrade the conflict** by **finding partial resolutions**. Downgrading a conflict slows down the cell proliferation on the corresponding organ and reduces therefore the size of a tumor that develops during the conflict-active phase. We can live with a hanging conflict and *with* cancer into old age (for reassurance surgery is an option).

ATTENTION: Under certain circumstances, it is imperative NOT to resolve a conflict in order to prevent a difficulthealing crisis. A sufficient knowledge of GNM is essential for assessing the situation.

CONFLICTOLYSIS (CL)

The **resolution of the conflict** is the turning point of the Biological Special Program.

Conflicts always originate from real life circumstances, brought on, for instance, by problems with a spouse (separation conflicts), the death of a loved one (loss conflicts), troubles at work or in school (territorial conflicts, self-devaluation conflicts), financial difficulties (starvation conflict, morsel conflicts), worries about a family member (nest-worry conflicts), or concerns about oneself (existence conflicts, death-fright conflicts). Trying to find a **practical solution** is therefore the best as it is most lasting. The loss of a workplace, for example, could be dealt with by picking up an old hobby; constant "territorial anger" with a neighbor might require a move. Sometimes, conflicts resolve themselves, for

instance, when life-circumstances change or when other matters gain more priority. On a spiritual level, conflicts we are facing are an invitation to reconsidering our attitude, letting go of anger, viewing the situation from a different angle, trying to see the larger picture, understanding the position of the people involved, and to practicing forgiveness and loving kindness as the true source of healing. From a higher viewpoint, making GNM part of our daily life contributes greatly to our personal growth and development. It is not without reason that the Spanish call the New Medicine *la medicina sagrada*or *The Sacred Medicine*.

Dr. Hamer: "We have to resolve our conflicts twice. First in real terms, then spiritually."

Learning GNM not only allows us to become aware of our individual conflicts as the cause of an ailment, it also puts us into the fortunate position to welcome – free from fear - the healing symptoms.

THE HEALING PHASE (PCL= post-conflictolysis)

With the resolution of the conflict, the **autonomic nervous system** switches into **lasting vagotonia** and a prolonged state of rest with **fatigue** but **good appetite**. Resting and the desire to eat provide the organism with the necessary energy for healing. If the healing phase is intense, the tiredness could be so overwhelming that one can hardly get out of bed. The need for sleep is particularly strong during the day (in conventional medicine, persistent tiredness is diagnosed as "chronic fatigue syndrome"). Accompanying symptoms are a **slow pulse** and **low blood pressure**. During vagotonia the blood vessels expand causing **warm hands** and a warm skin. We therefore call the healing phase also the **WARM phase**.

The **PSYCHE** is in a state of relief.

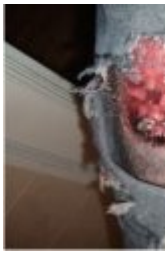
FIRST PART OF THE HEALING PHASE (PCL-A)

ORGAN LEVEL: During the healing phase the affected organ is restored to its normal function.

Tumors that developed in the conflict-active phase such as a lung tumor, colon tumor, liver tumor, prostate tumor, or atumor in the breast glands immediately stop growing and the extra cells that are no longer required **are broken down**with the help of microbes (Fourth Biological Law). This applies to all organs controlled from the brainstem and thecerebellum.

Conversely, **cellular depletion**, for example, in the cervix, ovaries, testicles, bronchia, milk ducts, or bile ducts is**refilled and replenished with new cells** (in conventional medicine, the new cells are wrongly regarded as "cancer cells"). This applies to all organs and tissues controlled from the cerebral medulla and the cerebral cortex.

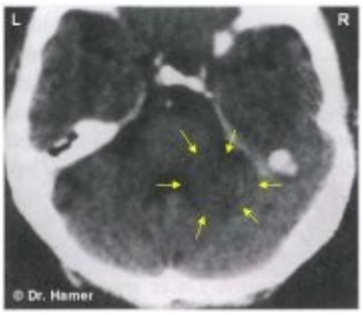
In **PCL-A (exudation phase)** an **edema** forms at the site to protect the area that is healing at the time. With water retention as a result of an active abandonment and existence conflict (see the SYNDROME) the retained water is exceedingly stored in the healing area, which enlarges the swelling. Other signs of healing are **fever** and **inflammation**because of the increased blood flow into the healing tissue, **discharge** to expel the by-products of the cell removal process, **itching** when epithelial tissues such as the skin are affected, and **night sweats** when fungi and TB bacteria are involved. The swelling and the inflammation can cause considerable **pain**. The severity of the healing symptoms is determined by the intensity of the preceding conflict-active phase. **NOTE:** Complications don't arise from high fever but due to a large brain edema.



Many of these symptoms (pus, inflammation, swelling, pain) occur when any wound is healing. The healing of cancer is exactly the same.

Dr. Hamer: "If the patient has been made aware of all the facts, he will no longer need to get frightened by his symptoms. He can now fully accept these as the healing symptoms they are - all of which had until now caused fear and panic. In the greatest number of cases, the whole episode will pass without any serious consequences."

BRAIN LEVEL: Parallel to the healing of the psyche and the organ, the corresponding area in the brain also undergoes a restoration process. Like on the organ level, during the **first part of the healing phase** (PCL-A) water and serous fluid are drawn to the affected brain relay, creating a **brain edema** to protect the brain tissue during that period. The extent of the edema is determined by the intensity of the preceding conflict and the size of the Hamer Focus created at the moment of the DHS.



In PCL-A, the sharp target rings (see conflict-active phase) submerge in the edema, presenting on a CT scan as dark (hypodense) - compare with PCL-B. Water retention due to the SYNDROME increases the size of the edema considerably. In conventional medicine, a growing brain edema might be erroneously diagnosed as a "brain tumor".

This CT shows a brain edema in the control center of the lung alveoli, which reveals that adeath-fright conflict has been resolved. Most death-frights are triggered by a cancer diagnosis shock.

It is the swelling of the brain edema that causes cerebral healing symptoms such as **dizziness** and **headaches**. Headaches that occur during PCL-A are dull pressure headaches. Sharp, stabbing headaches, on the other hand, happen after the Epileptoid Crisis (in PCL-B). Once the brain edema has been expelled the mechanical pulling on the meninges is felt as sharp pain. **Migraine headaches** start in the healing phase and are most intense during the Epileptoid Crisis(rightfully, migraines were once called "small epilepsy"). They involve predominantly the premotor-sensory cortex. Conflicts linked to migraines are, for example, powerless conflicts, frontal-fear conflicts, scare-fright conflicts, territorial fear conflicts, stink conflicts, resistance conflicts, or bite conflicts. Typically, the conflict-active phase was short but intense. Recurring migraine attacks are caused by conflict relapses ("Sunday migraines" are triggered by a "Sundaytrack").

NOTE: In order to bring down the edema, it is helpful to put an icepack on the head or taking cold showers (stabbing headaches don't respond to icepacks since there is no longer an edema in the brain). When lying in bed, it is recommended to position the head elevated to release the brain pressure. The fluid intake should be kept to a minimum in order not to increase the swelling. Absolutely to be avoided are direct sunlight on the head, sauna visits, and hot baths.

In general, the brain edema is nothing to worry about. However, a big swelling, usually caused by water retention (theSYNDROME) might create such strong pressure that a person falls into a coma and dies. The same risk exists with multiple brain edemas. **Sudden infant death** occurs due to large swellings in the brain.

THE EPILEPTOID CRISIS is initiated at the height of the healing phase and takes place simultaneously on all three levels. At the start of the crisis the entire organism is pulled out of the vagotonic state and the individual is for the time being in a conflict-active state of stress. The

reactivation of the conflict generates **restlessness, nausea, elevated blood pressure, a raised pulse, cold sweats, and the shivers**. The biological purpose of the sympathicotonic surge is to expel the edema that developed both on the organ and in the correlating brain relay (in PCL-A); the expelling of the brain edema is particularly vital as it relieves the brain pressure. The Epi-Crisis is **followed by a urinary phase**, in which the body eliminates all the excess fluid. If the edema cannot be completely expelled because of the SYNDROME (water retention) or due to conflict relapses, the residual edema remains until the Biological Special Program is complete.

The exact type of Epileptoid Crisis is determined by the nature of the conflict, which organ is affected, and which part of the brain is involved. When a brain edema is in the motor cortex, the crisis manifests as **rhythmic convulsions** (seeepileptic seizure), **muscle cramps** or **spasms**; in the sensory or post-sensory cortex it generates **dizzy spells**, **short disturbances of consciousness** or, with an intense conflict, a complete **loss of consciousness ("absence") due to the drop of blood sugar**. Some Epi-Crises could be dangerous, especially when the conflict-active phase was long and intense. This applies, for instance, to heart attacks or strokes. The Epileptoid Crisis is a significant biological counter-regulation. Dr. Hamer therefore strongly advises not to take antispasmodic or sedative medication during this period in order not to interrupt this highly critical event. Sedatives administered at that point could cause a person to fall into a coma.

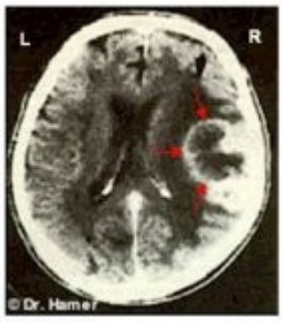
ATTENTION: Conflict relapses around the time of the Epileptoid Crisis exacerbate the symptoms! This is why it is of greatest importance not to address the conflict during the resolution phase, since this "puts the finger on the wound", to use Dr. Hamer's words. The "clearing of conflicts" while a person is already in healing - as it is practiced by certain "alternative therapies" – bears the risk of serious complications for a client. The same holds true for psychological therapies. Dr. Hamer: "The physician has to understand the psyche; the psychologist needs to understand medicine."

The Epileptoid Crisis usually occurs during periods of rest (weekends, holidays, vacation), in the early morning hours or during sleep when the organism is in deep vagotonia. The extent of the Epileptoid Crisis is determined by the degree of the conflict-active phase. Hence, most of the time the healing crisis is completely harmless and only evident, for instance, as coughing fits, diarrhea attacks, nose bleeds, or as "the cold days" (chills) and nervousness.

SECOND PART OF THE HEALING PHASE (PCL-B)

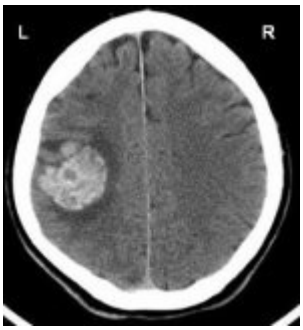
Passing the Epileptoid Crisis is like turning a corner. Now, the organism enters the second part of the healing phase, or**PCL-B (scarification phase)**. Scarring occurs predominantly through the production of collagen manufactured by specialist cells, called fibroblasts, located in the connective tissue around the healing area. By the end of the Biological Special Program the original function of the organ is restored and the day-night-rhythm returns to normotonia.

BRAIN LEVEL: After the brain edema has been pressed out, **glial cells** proliferate at the site to finish the healing process on the cerebral level. **Neuroglia** ("glia" comes from the Latin word for "glue") is brain connective tissue that insulates and supports neurons. Only 10% of the brain consists of nerve cells; 90% is made up of glial cells, which indicates their importance. A major distinction between the two types of brain cells is that neurons do not divide by mitosis, while glial cells have the ability to multiply. Similar to the role of connective tissue in wound healing, the function of neuroglia is to repair brain damage, for example after a brain injury or brain surgery. Glial cells also help to restore the area in the brain that received the impact of a DHS. Intense conflict activity as well as the brain edema (in PCL-A) stretch the synapses (junction between nerve cells) putting stress on the insulation around neurons. During the healing phase, glial cells mend the neural sheath by forming an additional insulating layer. This repair work is crucial to ensure a normal function of the organ that is controlled from that particular brain relay.

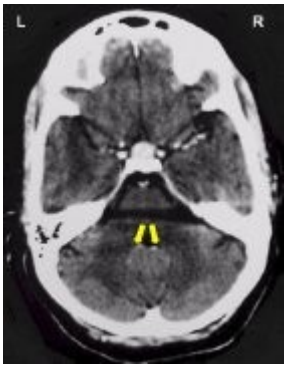


On a brain CT the proliferation of glial cells shows as white (hyperdense) - compare with PCL-A. In this image we see a glia-ring in the control center of the coronary arteries, indicating that the related territorial loss conflict has been resolved. The CT was taken shortly after the person had the expected heart attack (Epileptoid Crisis).

NOTE: Neuroglia starts restoring the brain relay from the *periphery*! This is in clear contradiction to the established theory that a cancer, including a "brain cancer", grows through continued cell augmentation leading to the formation of a tumor.



This brain scan illustrates a more advanced healing phase with an accumulation of neuroglia in the area of the brain that controls the cervix, related to a sexual conflict (simultaneously, a cervical cancer is undergoing a healing process on the organ level). Because of the high cellular density, conventional medicine classifies the glia buildup as a "high grade glioma" with a poor prognosis.



After healing has been complete, the scar tissue in the affected brain relay appears on a CT scan as a washout pattern, showing here in the part of the brain that controls the pituitary gland.

In conventional medicine, the natural buildup of neuroglia is wrongly believed to be a "**brain tumor"**, termed "glioma", "glioblastoma", or "astrocytoma" (referring to the star-shaped form of glial cells). The classification of brain tumors (grade 1 to 4) is based on the density of glial cells; grade 4 is considered the "most aggressive" with the propensity to "spread throughout the brain". If more than one "tumor" is found in the brain, the diagnosis reads: "multiple brain metastases" (which usually triggers instantly a new DHS!).

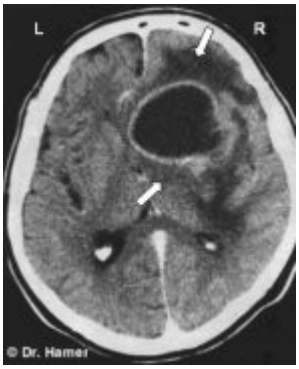
Dr. Hamer demonstrated already in the early 1980s that so-called brain tumors are not cancers but instead an indication that a natural healing process is taking place in the brain parallel to the healing on the corresponding organ (symptoms on the related organ might not be noticed, particularly, if there is no water retention which would increase the swelling, causing pain). In GNM terms, a brain edema and a "brain tumor" is a Hamer Focus in different phases of a Biological Special Program.

NOTE: According to the orthodox metastasis theory, "**metastatic brain tumors**" arise from cancer cells (breast cancer, prostate cancer, colon cancer, lung cancer, etc.) that supposedly travel via the bloodstream to the brain. Strangely, this firm medical dogma entirely disregards the blood-brain barrier that is formed by the very same glia cells that presumably create a "brain cancer". It is a well known fact that the blood-brain barrier restricts the passage of "harmful substances" from the circulating blood into the brain. One would expect that this includes cancer cells! Current medical theory is that metastasizing cells are *of the same kind* as those in the original tumor. Based on this claim, cancer cells originating in the breast, colon, prostate, and so forth, should therefore be found in the brain. There is no evidence of that! Another point

that remains open to question is: why do brain tumors never “metastasize” TO the body?

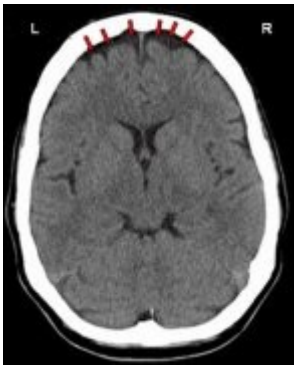
The **surgical removal of a tumor** does not stop the healing process. This is why “brain tumors” come back, unless the mutilating surgery went far into the healthy tissue. After the excision, the surgical cavity forms a cyst that becomes over-inflated by the surrounding edema. Measures such as inserting a shunt into the brain to drain the extra fluid put additional stress on the brain.

A **brain cyst** also forms when the healing phase is repeatedly interrupted by conflict relapses. With the constant alteration between conflict activity and healing, the brain edema alternatively contracts and expands. Due to the "accordion effect" the brain tissue becomes rigid and inflexible. At one point, the tissue ruptures resulting in the formation of a fluid-filled cyst. The tearing might cause **brain bleeding** (erroneously believed to be caused by a stroke). Chemo treatments have the same effect. With each chemo regimen the healing process comes abruptly to a stop and the brain edema gets smaller; after the treatments healing continues and the edema starts to grow again. Radiation treatmentsalso compromise healing. Brain tissue that has been irradiated loses the elasticity required when new brain edemas form in the course of future healing phases.



A brain cyst is a kind of hollow sphere structure filled with fluid (compare with brain edema). On a brain scan, the cyst appears therefore as dark. The glia-ring (white) lining the cyst provides a supportive layer. Because of the presence of glia, a brain cyst might be misdiagnosed as a “brain tumor”.

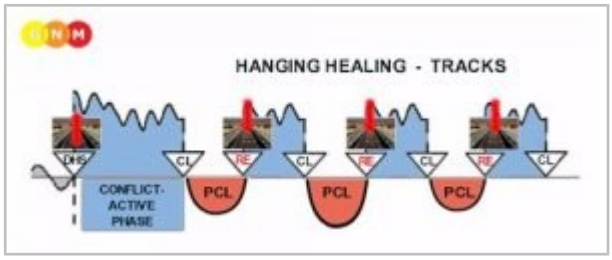
This CT presents a brain cyst in the area of the brain that controls the left shoulder, linked to apartner-related relationship self-devaluation conflict since the person is left-handed. Frequentconflict relapses led to the rupture of the brain tissue with bleeding and the formation of a cyst. With water retention due to the SYNDROME, fluid sweats through the cyst (see white arrows). Dr. Hamer: “The medical picture looks much worse than it actually is.” After the fluid is absorbed, the cyst becomes hard and encapsulates.



What is termed “**brain atrophy”** is caused by repetitive scarring due to continuous conflict relapses. Over time, the affected brain relay shrinks and the empty space is filled withcerebrospinal fluid, visible on a brain scan as dark (see red arrows)

This brain CT shows the accumulation of cerebrospinal fluid in the cerebral cortex, precisely, in the area that controls the thyroid ducts and pharyngeal ducts linked to a powerless conflict and a frontal fear conflict.

HANGING HEALING



A “**hanging healing**” refers to the situation where the healing phase cannot be completed because of continuous conflict relapses (RE).

When we experience a DHS, our mind is in a state of acute awareness. Highly alert, our subconscious picks up all components considered as relevant in association with the conflict situation. In GNM, we call the imprints that remain in the aftermath of a DHS **conflict tracks**. Tracks are, for example, the location

where the conflict took place, a person or pet that was involved, the taste of a particular food, specific sounds or noises, the weather condition, a certain scent (perfume, flowers), certain words, a voice, a gesture, and so forth. Tracks can be highly emotional. In fact, feelings such as fear or distress itself can become a track. Other tracks stored in the biological memory are more subtle, for instance, a food ingredient or certain pollen. The **biological purpose of the tracks** is to function as a warning signal in order to avoid experiencing the conflict a second time. In the wild, these alarm signals are vital for survival.

The Biological Special Program runs on tracks established at the moment of the DHS.

If we are in the healing phase and all of sudden encounter a track, either through direct contact or by association, the original conflict is instantly reactivated. Each **conflict relapse** interrupts and therefore prolongs the healing process – on the organ and in the brain – leading to a **chronic condition**. Persistent skin conditions (dermatitis, psoriasis), arthritis,Crohn's disease, Parkinson's, "chronic fatigue syndrome" (prolonged vagotonia), or constant low blood pressure are examples of a hanging healing. Like with a healing wound that is torn open again and again, with conflict relapses the affected organ heals only very slowly. This is why we should try to resolve a conflict as soon as possible. **NOTE:** A newDHS and extreme stress also interrupts healing. This includes states of fear and panic.

Tracks also have to be taken into consideration when we are dealing with **recurring conditions** such as recurring colds,skin rashes, diarrhea, hemorrhoids, "infections", or recurring cancers. Returning symptoms are always a sign that certain tracks associated with a particular conflict are still of importance, although the healing phase has been complete. At that point, setting on a track activates a quick replay of the Biological Special Program with the conflict-related *healing symptoms*, including symptoms of the Epileptoid Crisis (coughing fits, asthma attack, migraine attack) following right away. Based on GNM, so-called "**allergies"** are therefore always manifestations of tracks. **NOTE:** Dreams can trigger conflict relapses as well.

In light of the significance of tracks, so-called "allergens" (pet dander, pollen, foods) are important warning signals. Contrary to the standard theory, antibodies do not, as assumed, fight the allergen (based on the construct of an "immune system") but put the organism on the alert by reactivating the conflict. For this reason white blood cells start to produce "antibodies" (really a misnomer) as soon as the DHS occurs. Their sole purpose is to set off an alarm (the organ related symptoms) in the event of an encounter with a conflict track. This is why an allergy test is "positive" if the applied antigen, for example a certain food, happens to be a track.

GNM is able to explain why one and the same allergen, for instance a milk-track, causes different symptoms in different people. It is the actual allergy symptom (runny nose, red and itchy eyes, coughing, diarrhea, or a skin rash) that reveals the nature of the original conflict. Hence, we are not allergic to specific foods, cleaning agents, cosmetics, metals (jewellery made of gold or silver), mold, or dust mites but rather to what we associate with it! We can therefore also be "allergic" to a certain person, a specific location, or a particular piece of music.

In the practical application of GNM identifying the track(s) is of utmost importance, because only then will an allergy stop reoccurring. Recognizing that the conflict has been resolved and bringing into awareness that the tracks are no longer a "danger" provides the ultimate chance to complete the healing of chronic conditions. **NOTE:** Talking about the DHS can reopen the conflict wound. The true GNM therapist will therefore proceed with caution and care.

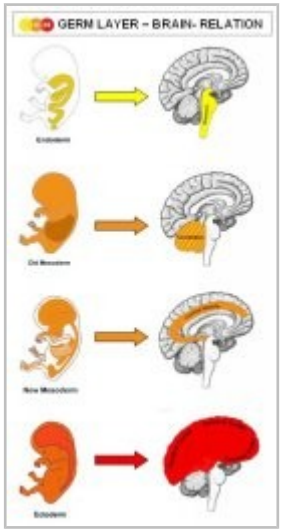
THE THIRD BIOLOGICAL LAW

Dr. Hamer: "The medical textbooks of the future will no longer assign diseases to special disciplines but will instead categorize them according to their embryonic germ layer relation. The NEW MEDICINE offers a reliable scientific system that allows a classification of diseases in line with embryological

aspects."

Dr. Hamer's medical research is firmly anchored in the science of embryology. Taking into account the development of the fetus (ontogenesis) he discovered that the correlation between the psyche, the brain, and the organs is closely connected to the three embryonic germ layers (endoderm, mesoderm, ectoderm) from which all organs of the human body originate. The Third Biological Law shows that the location of the Hamer Focus in the brain as well as the cell proliferation or cell loss following a DHS are not accidental but part of a meaningful biological system inherent in every living organism. The Biological Special Programs of Nature are encoded in every human cell and thus inscribed in the DNA, the carrier of genetic information (see GNM Article "Understanding Genetic Diseases").

Through analyzing and comparing thousands of brain scans Dr. Hamer found that organs originating from the same embryonic germ layer are controlled from the same part of the brain.



All organs that derive from the **endoderm** are controlled from the **brainstem**. Primitive life forms such as bacteria have only endodermal functions.

All organs that derive from the **old mesoderm** are controlled from the **cerebellum**.

All organs that derive from the **new mesoderm** are controlled from the **cerebral medulla**.

All organs that derive from the **ectoderm** are controlled from the **cerebral cortex**.

Some organs, notably the colon, originate only from one embryonic germ layer. Others such as the kidneys are made up of tissues that derive from all three germ layers. Over time, the tissues merged for functional purposes and formed one organ or organ system (reproductive system, digestive system, renal system, respiratory system, circulatory system). This explains why parts of one organ have their control centers in different areas of the brain. In the body, organs of the same germ layer origin, for instance the larynx, cervix, coronary veins, rectum, and bladder are not always grouped together. In the brain, however, their control centers are positioned side by side, in perfect order.

Each of the three embryonic germ layers corresponds to very specific biological conflicts that date back to the time when the life-threatening crisis (existence conflict, starvation conflict, water conflict, territorial loss conflict) first occurred. Hence, certain conflict themes belong to a particular evolutionary period.

The **endoderm** is the oldest germ layer. Organs that derive from the **endoderm** such as the lungs, the organs of the alimentary canal, the uterus and prostate correlate therefore to the oldest biological conflicts **related to breathing** (death-fright conflict), **food** (morsel conflicts), and **reproduction** (procreation conflict). The Biological Special Programs are controlled from the brainstem, the oldest part of the brain.

Endodermal tissues consist of intestinal cylinder epithelium. In the event of a biological conflict, the related organ generates during the conflict-active phase cell proliferation in order to facilitate a conflict resolution. In the healing phase, the additional cells that are no longer required are removed with the help of fungi and tubercular bacteria(Fourth Biological Law).

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The **mesoderm** is divided into an older and younger group.

Organs that derive from the **old mesoderm** such as the corium skin beneath the epidermis as well as the pleura,peritoneum, and pericardium covering the vital organs are primarily responsible for protection. The main conflict theme relates therefore to "**attack conflicts"**. The Biological Special Programs are controlled from the cerebellum.

In the event of a biological conflict, the related organ generates during the conflict-active phase cell proliferation in order to facilitate a conflict resolution. In the healing phase, the additional cells that are no longer required are removed with the help of fungi and bacteria (Fourth Biological Law).

Organs that derive from the **new mesoderm** give stability to the body (striated muscles, bones, tendons, ligaments, connective tissue) and allow mobility. The lymphatic system and the blood vessels (except the heart vessels) also originate from the new mesoderm. The main conflict theme related to new mesodermal tissues are**self-devaluation conflicts**. The Biological Special Programs are controlled from the cerebral medulla.

In the event of a biological conflict the related organ generates during the conflict-active phase cell loss (necrosis). In the healing phase, the tissue loss is restored with the help of bacteria (Fourth Biological Law).

NOTE: All new-mesodermal tissues ("surplus group") show the **biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict of the same kind.

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The **ectoderm** covers the endodermal submucosa of most organs and lines the ducts within an organ, for example, the bile ducts, pancreatic ducts, and milk ducts. It also lines the cervix of the uterus, the bronchial tubes, the heart vessels, and forms the epidermal layer of the outer skin.

Organs that derive from the **ectoderm** correlate to more advanced conflicts, primarily to conflicts concerned with social contacts (**separation conflicts**, **sexual conflicts**, **territorial conflicts**). The Biological Special Programsare controlled from the cerebral cortex.

Ectodermal tissues consist of squamous epithelium. In the event of a biological conflict, the related organ generates during the conflict-active phase cell loss (ulceration) in order to facilitate a conflict resolution. In the healing phase, the tissue loss is restored with the help of bacteria (Fourth Biological Law).

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THE FOURTH BIOLOGICAL LAW

For the first 2.5 billion years, microbes were the only organisms inhabiting the earth. Gradually, they populated other life forms, including plants, animals, and humans. It is estimated that the number of microbial cells residing in the human body (known as the "human microbiome") outnumbers the body cells ten to one. Owing to their symbiotic relationship with the human organism and their vital role in maintaining the body tissues, microbes have become indispensable for our survival.

NOTE: The placenta that connects the developing fetus to the uterus is not sterile, as previously thought, but harbors a rich collection of bacteria. Mycobacteria such as TB bacteria are introduced to the newborn through the breast milk.

The theory that certain "diseases" are caused by "pathogenic microbes" is one of the most persistent doctrines of modern medicine. This general conception is largely attributable to the fact that microbes are present at the site of a "diseased" organ. And since the activity of microbes is accompanied by swelling, fever, inflammation, pus, discharge and pain, microbes are believed to be the cause of "**infectious diseases**". Similar to the idea that an "abnormal" growth of cancer cells leads to the development of a "malignant" tumor, it is wrongly assumed that microbes growing beyond their normal ranges (see immune system theory) results in virulent "infections".

"If I could live my life over again, I would devote it to proving that germs seek their natural habitat - diseased tissue - rather than being the cause of the diseased tissue."

Rudolph Virchow

Microbes don't cause diseases but play instead a vital role during the healing phase.

The Fourth Biological Law shows that so-called "infectious diseases" occur exclusively in the second phase of a Biological Special Program, where the organism uses the microbes to optimize healing. During their activities microbes require a warm environment, hence, the development of an inflammation and fever. Microbes also need an acidic milieu, which is suitably provided through the vagotonic state that is dominant in every healing phase. The onset of an "infection" is therefore not, as presumed, brought on by an imbalanced pH level (a "wrong diet") but rather by the transition from theconflict-active phase into the healing phase.

NOTE: Microbes are endemic. They live in harmony with all organisms of the ecological milieu in which they have developed over millions of years. Contact with microbes that are foreign to the human body, for example through traveling abroad, does not cause per se a "disease". However, if, let's say, a European happens to resolve a particular conflict in the tropics and comes in contact with local microbes, the related organ will use them for the healing process. Since the body is not accustomed to these **exotic microorganisms**, the healing symptoms can be quite severe.

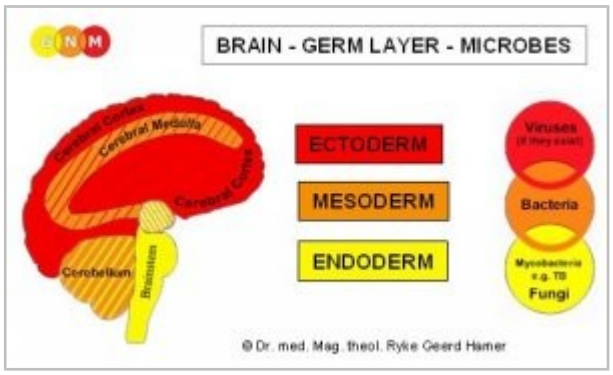
White blood cells such as leucocytes and lymphocytes support the microbial work. Governed by images of a biological warfare raging within the human organism, conventional medicine interprets a rise in white blood cells ("killer cells") as an "immune response" aimed at "attacking" and "fighting the infection". In light of the Fourth Biological Law, the academic construct of an "**immune system"**, envisioned as a "defense system" against microbes (and cancer cells), becomes entirely meaningless; in fact, the term "infection" itself becomes obsolete. The invention of "auto-immune diseases", in which the immune system apparently attacks the body's own tissue, shows how a scientific culture can become blinded by its own beliefs.

Diseases are not contagious!

Based on the two-phase pattern of every SBS (Second Biological Law), "infections" cannot be transmitted to another person since the symptoms (discharge, inflammation, fever) are already *healing* symptoms. Moreover, a DHS that activates a Biological Special Program is a highly individual conflict experience. If two or more people happen to have the same symptoms, for example a cold, diarrhea, or a stomach flu , this means that all of them are in the healing phase of the same type of conflict (stink conflict, indigestible morsel conflict, territorial anger conflict) that took place, let's say, in school, at home, or at work. The idea that everyone had a "weak immune system" just at that time is rather far-fetched. The same holds true for **epidemics** which are the result of conflicts affecting large populations (attack conflicts, territorial fear conflicts, death-fright conflicts). This was the case, for instance, with the Great Plague, the Spanish Flu, and the lung tuberculosis epidemic after World War I. Nowadays, such collective conflict shocks are easily evoked through frightening media reports (threats of an economic collapse, threats of a global war, threats of terrorist attacks, threats of a "deadly virus"). The ensuing pneumonia outbreak (termed SARS, the swine flu, and so forth) is a self-fulfilling prophecy.

NOTE: Cultural, political, social, or economic aspects are decisive factors as to why people in certain regions are more (or less) vulnerable to experience specific types of conflicts. For instance, the incidence and prevalence rates of diabetes (linked to resistance conflicts) are much higher among indigenous peoples compared to the general population. The fact that western women have greater rates of breast cancer (linked to separation conflicts) than Chinese women has nothing to do with their different diet, as suggested, but with the significantly higher rate of divorces of women living in North America and Europe.

The Ontogenetic System of Microbes



This GNM diagram shows the classification of microbes in relation to the three embryonic germ layers and the areas of the brain, from where the microbial activity is controlled.

Controlled from the brain, microbes work in a well-planned manner. In normotonia and in the conflict-active phasemicrobes are dormant, but as soon as the conflict is resolved they start the work assigned to them.

FUNGI and MYCOBACTERIA are the oldest microbes. They therefore work exclusively on organs and tissues that originate from the endoderm (controlled from the brainstem) and the old mesoderm (controlled from thecerebellum).

Initiated by the DHS, fungi and mycobacteria multiply at the same rate as the cell proliferation on the related organ, so when the conflict is resolved they will be in sufficient amount available to **remove the cells that are no longer required**.

NOTE: Bacteria such as **TB bacteria** are already detectible in the blood during the conflict-active phase, that is, *before* the "infection". From blood analysis observations, Dr. Günther Enderlein (1872-1968) postulated that microbes mutate into "pathogens" because of a high acidity level of the blood. Based on Enderlein's theory, known as pleomorphism, acidosis is thought to be a breeding ground for diseases. In reality, the low**pH level** provides the ideal milieu in which an organ heals. It is worth mentioning that in the early 1990s, Dr. Alan Cantwell, M.D., detected a "pleomorphic cancer microbe" that he considered closely related to the*mycobacterium tuberculosis*!

In their function as natural micro-surgeons, fungi and mycobacteria remove tumors in the colon, lungs, kidney, liver, or in the breast (see Fungus Theory). This clearly shows that cancers are reversible! Typically, microbes decompose a tumor starting from the center, hence, the clinical term "centrally necrotizing carcinoma" (in comparison, glial cells repair a brain relay starting from the periphery). Fungi and mycobacteria are acid-resistant allowing them to survive in the acidic environment of the gastro-intestinal tract and in the lungs (carbon dioxide, or carbonic acid, is a respiratory acid excreted as gas by the lungs).

NOTE: "Tumor cells" differ in size and shape as well as genetically from the original cells. They also have the ability to divide faster than "normal cells". From these differences, conventional medicine created the dogma of "malignant cancer cells". Yet, it is precisely this distinctive feature that enables

mycobacteria and fungi to recognize which cells need to be eliminated and which have to stay. They never "invade" neighboring tissue, let alone "spread" to other organs (see "Metastasis Theory" article). This is why lung tuberculosis is confined to the lung alveoli (endoderm) and never "infects" the bronchia (ectoderm). Dr. Hamer explains the genetic difference between cancer cells and normal cells with the fact that cancer cells have a specialized, temporary function.

Candidiasis, for example in the mouth or intestines, occurs when the fungus *candida albicans* is involved. The degree of microbial activity in the healing phase is determined by the intensity of the conflict-active phase.

Pus and **discharge** produced during the decomposing process are excreted through the stool (colon), the urine (kidneys), or the sputum (lungs). Throughout the repair phase the capillaries break easily, thus, the discharge might be mixed with blood.

A symptom that ALWAYS occurs when fungi and TB bacteria are active is **night sweats** (the metabolic waste is eliminated through the sweat glands and the skin). If the healing phase is intense, the sweating could be excessive. Night sweats are usually accompanied by light fever.

ATTENTION: Fungal and tubercular discharge contains large amounts of protein. **It is therefore vital to replenish the protein deficiency** through protein-rich foods, protein-drinks, amino acid supplements, and the like. A restriction to raw food diets, alkalizing diets, juice diets, or even fasting, which is often recommended when someone has cancer, might put a person into a critical situation. One of the reasons why many cancer patients don't survive chemo treatments is, in addition to its extreme toxicity, a loss of appetite leading to acute protein depletion. When a protein shortage occurs, the body tries to restore the loss by withdrawing protein from the organs and from fat tissue resulting in rapid weight loss and wasting away (cachexia).

As far as **protein-intake** is concerned, protein-rich food should be consumed before 3 pm, because after 3 pm the organism has a hard time breaking down proteins. Athletes, people who exercise a lot, and all those who burn a great deal of proteins, need to be especially aware of the correlation between protein deficiency and the role of fungi and TB bacteria during the healing of certain cancers.

After the cell (tumor) removal process has been completed, **caverns** remain at the site, which are eventually filled with calcium. A prolonged decomposing process (hanging healing), however, results in a decreased or insufficient function of the organ, as seen in hypothyroidism.

NOTE: Fungi and mycobacteria have to be present *before* a conflict occurs. If TB bacteria are introduced later, for example by coming in contact with the saliva of a person who carries them, they will be on stand-by for future healing phases. Drinking raw milk for a couple of weeks is also a good way to introduce the body to tubercular bacteria.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of **antibiotics**, the growth encapsulates and stays in place without further cell division. In conventional medicine this is usually diagnosed as a "benign cancer" or as a polyp. **NOTE:** Today, the overuse ofantibiotics is one reason why more cancers are found during (routine) examinations.

Dr. Hamer: "Regarding the diagnosis of cancers, about 40% of routine examinations reveal old encapsulated tumors, which should be left untouched. If the diagnosis has caused any conflicts, such as a death-fright conflict or aself-devaluation conflict, these conflicts need to be addressed. In any case, there is never a reason to panic or to be scared of 'metastasizing cancer cells'."

BACTERIA that are not TB bacteria work primarily on organs and tissues that originate from the new

mesoderm(controlled from the cerebral medulla).

During the healing process, **bacteria help to replenish the tissue loss that took place in the conflict-active phase**. Most bacteria are specialized. Staphylococcus bacteria, for example, support the reconstruction of bone tissue; streptococcus bacteria help to rebuild tissue necroses in the ovaries.
In PCL-A, bacteria form **abscesses**. Bacteria also participate in the healing of wounds caused by injuries.

NOTE: When the medical team sterilizes the hands and the medical tools, the microbes that would otherwise be used during healing are not transmitted to the patient. Hence, no "infection". This explains, for example, the reduction of childbed fever, observed by Ignaz Semmelweis in the late nineteen-hundreds. Lately, the MRSA-Methicillin-resistant Staphylococcus aureus (methicillin is a penicillin-related antibiotic) has been made responsible for the "spread" of infections in hospitals via contaminated hands of hospital staff. The truth is that hospitals, where most patients are in a healing phase, offer staphylococcus bacteria a rich field of activity.
What distinguishes bacteria is their **overlapping function**. When fungi and TB bacteria are absent from old mesoderm such as the breast glands or the corium skin, other bacteria step in to remove the additional cells that are no longer needed.

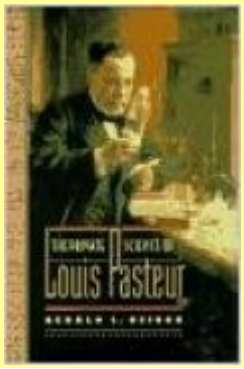
In ectodermal organs bacteria help to restore the cell loss. Streptococcus bacteria, for instance, assist healing in the throat (see strep throat), pneumococcus bacteria restore the bronchial mucosa, gonococcus bacteria work in the uro-genital area, and the helicobacter pylori repairs the stomach and pylorus lining. This, however, only happens when the ulceration in the conflict-active phase reaches far into the tissue. Otherwise, the healing process takes place without microbes.

With an intense healing phase, the bacterial work is accompanied by high fever.

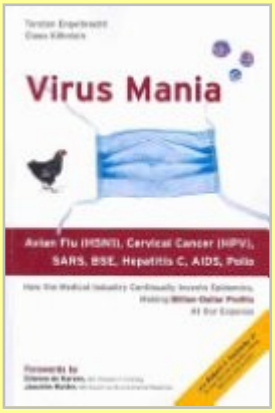
If bacteria are not available healing still occurs, although not to the biological optimum.

In line with evolutionary reasoning, **VIRUSES** should - theoretically - assist the reconstructions of organs and tissues deriving from the ectoderm (controlled from the cerebral cortex).

Concerning viruses, in GNM we prefer to speak of **hypothetical viruses** because the existence of viruses that cause so-called "viral infections" has never been scientifically substantiated. None of the alleged viruses (HIV et al) has ever been isolated from a host cell nor has their DNA been properly identified, which are the basic criteria for the proof of the existence of a virus (details presented in the "Virus Mania" GNM DVD). Since viruses that supposedly cause AIDS, SARS, pneumonia, the avian flu, bird flu, swine flu, hepatitis, herpes, measles, polio,cervical cancer, and the like cannot be found in the human body, orthodox medicine uses a rather unscientific method, namely to conclude from the rise of antibodies (produced by the alleged "immune system") the presence of the virus and hence an "infectious disease". This method is called "indirect evidence".



In 1996, Gerald Geison (Princeton University) published his book "The private science of Luis Pasteur". Based on Pasteur's lab notes, Professor Geison exposed **Pasteur's germ theory** as being **based on fraudulent data**. In spite of the evidence that Pasteur had committed scientific fraud, Pasteur's theory is still governing today's medicine and medical science. Considering that there is no scientific evidence for the claim that viruses cause diseases, including cancer, this implies that world-wide vaccination programs imposed on an entire population, particularly on children and the elderly, are based on a scientific hoax.



Virus Mania by Torsten Engelbrecht and Claus Köhnlein (2007)

"The existence of these so-called 'killer viruses' must first be proven. And this is where the trouble begins. Consequential, scientifically-sound evidence has never been provided, even though it's as easy as taking a sample of a patient blood and isolating one of these viruses in a purified form with its complete genetic material (genome) and virus shell directly from it, and then imaging it with an electron microscope. But these critical initial steps have never been done with H5N1 (avian flu), the so-called hepatitis C virus, HIV, and numerous other particles that are officially called viruses and depicted as attack-crazy beasts." (43)

In their publication *Virus Mania* the authors demonstrate that the **alleged viruses are in reality micro-particles produced by the body cells themselves**. These particles have been identified as ribosomes, which are protein factories of the cells (viruses are defined by the absence of ribosomes!). This is in full accordance with Dr. Hamer's view. Dr. Hamer is of the opinion that what is interpreted as "viruses" are actually **protein globulins** ("antibodies") that emerge with the DHS (see antigens and tracks). During the healing phase, **where they are measurable, antibodies** (produced by white blood cells) assist the restoration of ectodermal tissue such as the skin, nasal membrane, bronchia, or the cervix. Proteins that are produced by endodermal organs (prostate, liver, pancreas) orold-mesodermal organs (breast glands) on the other hand, are already detectible in the blood during the conflict-active phase. These constitute the real **tumor markers** (see PSA).

Based on the Fourth Biological Law and in view of the lack of scientific evidence of diseases-causing microbes, **vaccinations** are entirely unjustified. Vaccinations are not only unnecessary but also unsafe because of neurotoxins, including formaldehyde, aluminium phosphate, or thimerosol (a mercury-based preservative) contained in vaccines. It goes without saying that a distressing vaccination experience can also trigger a DHS (scare-fright conflict, territorial fear conflict, fear-disgust conflict, feeling-stuck conflict) leading to asthma,diabetes, or muscle paralysis (see also meningitis).

It has been argued that the increase of antibodies following "immunization" is an "immune response" to the "virus" against which the person is vaccinated (the protein in vaccines is wrongly claimed to be an extract from "infected" cells). This is obviously a false and misleading conclusion. Since antibodies play an important role in wound healing, the rise of antibodies is rather an indication that the body is trying to heal the cell damage caused by the harmful toxins than a "reaction" of an "immune system" that no one has ever seen.

Vaccines: A Peek beneath the Hood by Roman Bystrianyk and Suzanne Humphries, MD

"Analysis of the data shows that the often-repeated mantra that vaccines were key in the decline of infectious disease deaths is a fallacy. Deaths had decreased by massive amounts before vaccinations…"

The Chiropractic Story of Masha and Dasha

"The new mother was told that her twin babies had died after birth. However the truth was far different: they were sent to an institute near Moscow to be studied. This was to be the fate of Masha and Dasha, one of the most unusual sets of Siamese or conjoinedtwins ever born.

Because their circulatory systems are interconnected, the twins share each other's blood. Therefore, a bacterium or virus that enters one twin's bloodstream will soon be seen in the blood of her sister. Yet surprisingly, **illness affects them differently**. Dasha is short-sighted, prone to colds and right-handed. Masha smokes occasionally, has a healthier constitution, higher blood pressure than her sister, good eyesight and isleft-handed.

The twins differing health patterns present a mystery. Why did one become ill with a childhood disease, likemeasles for example, while the other did not? The measles "bug" was in both of their bodies, in their collective bloodstream; so why didn't both get the measles? Evidently there is more to "getting the measles" than having the measles "bug". This phenomenon was seen over and over again with the girls (flu, colds, and other childhood diseases were all experienced separately). **If germs alone had the power to cause infectious diseases, why would one of the twins be disease-free while the other was ill?** …"

THE FIFTH BIOLOGICAL LAW

THE QUINTESSENCE

Every so-called disease is part of a Significant Biological Special Program of Nature created to assists an organism (humans and animals alike) during unexpected distress.

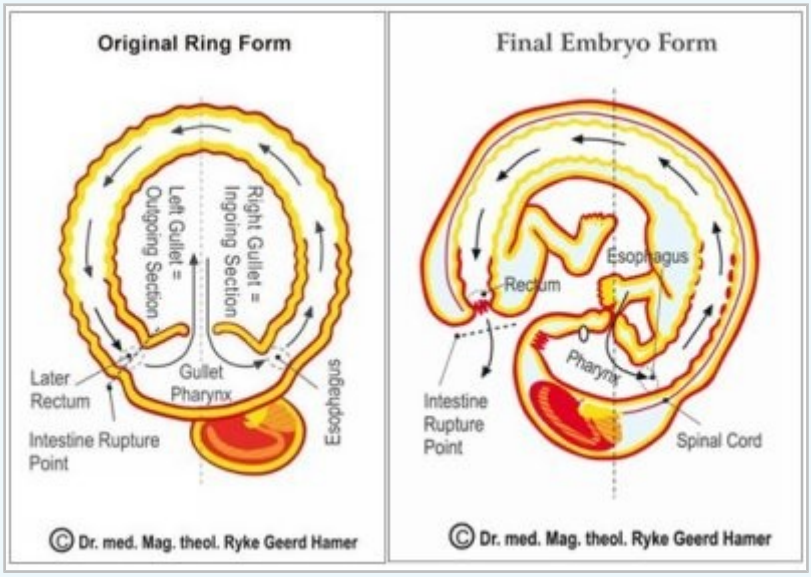
Dr. Hamer: "All so-called diseases have a special biological meaning. While we used to regard Mother Nature as fallible and had the audacity to believe that She constantly made mistakes and caused breakdowns (malignant, senseless, degenerative cancerous growths, etc.) we can now see, as the scales fall from our eyes, that it was our ignorance and pride that were and are the only foolishness in our cosmos. Blinded, we brought upon ourselves this senseless, soulless and brutal medicine. Full of wonder, we can now understand for the first time that Nature is orderly and that every occurrence in Nature is meaningful, even in the framework of the whole. **Nothing in Nature is meaningless, malignant or diseased**."

EMBRYOLOGY

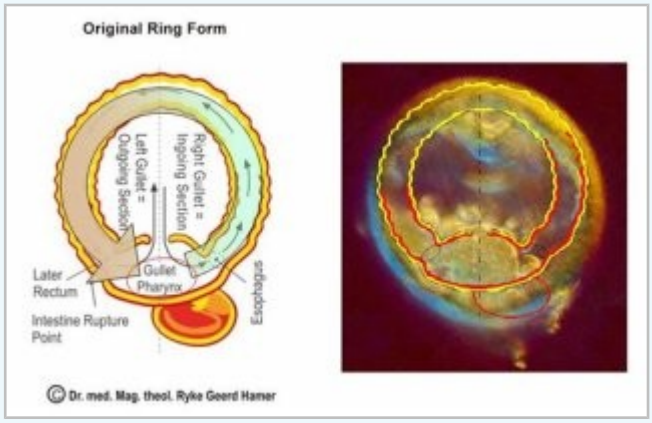
"The science of embryology and our knowledge of the evolution of man is the foundation of medicine. They are the two sources that reveal to us the nature of cancer and of all so-called diseases."

Dr. med. Ryke Geerd Hamer

DEVELOPMENT FROM THE ORIGINAL RING FORM TO THE FINAL EMBRYO FORM

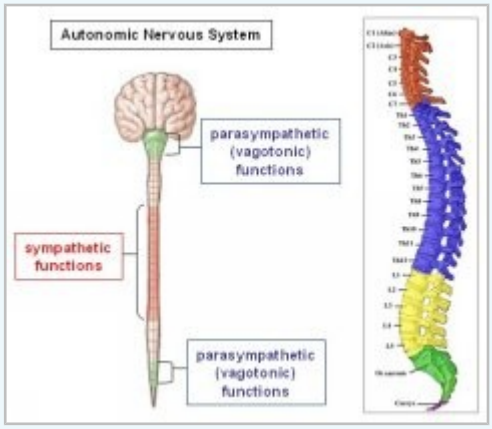


Human life begins as a single cell holding all instructions for its growth and development. Starting with the first cell division, the embryo grows into a cluster of cells called a **blastocyst**. Two weeks after conception, the blastocyst divides into **three embryonic germ layers**: an inner **endoderm**, an outer **ectoderm**, and a **mesoderm** forming in between. Over the course of gestation the embryonic germ layers develop all organs and tissues of the body. Throughout this period the growing fetus passes through all the evolutionary stages from a single-celled organism to a complete human being. **NOTE:** The three germ layers give rise to the same tissue types in all organisms, including animals and plants.



We know from the science of biology that the first life forms were **ring-formed organisms** consisting solely of **intestine**. At this early development stage both the intake of food and elimination were shared by one opening, the so-called **GULLET** (see GNM diagram). The ingoing section of the gullet served the intake and digestion of food, the outgoing section regulated the disposal of feces.

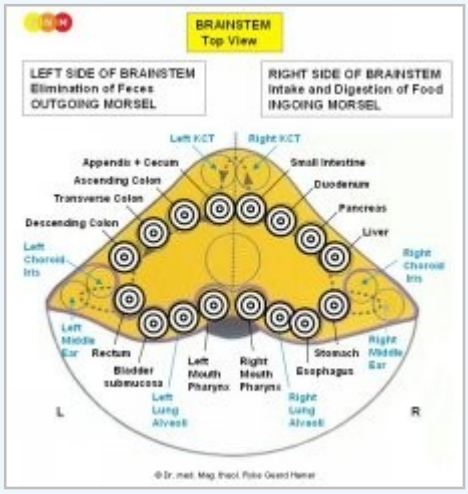
The image on the right shows a five days old human embryo. The ring form is still maintained.



The nerve contribution of the autonomic nervous system before birth also points to the primordial **ring form**. While the sympathetic nerves are arranged in the middle of the **spinal cord**, the parasympathetic (vagotonic) nerves are located on the periphery, namely at the base of the brain and in the sacral region, close to the pharynx and the rectum. This strongly suggests that the parasympathetic divisions were once connected.

We have to envision the development of the spinal cord and the spine progressively from the cervical (C), thoracic (T) and lumbar spine (L) to the sacrum; first, in a round configuration

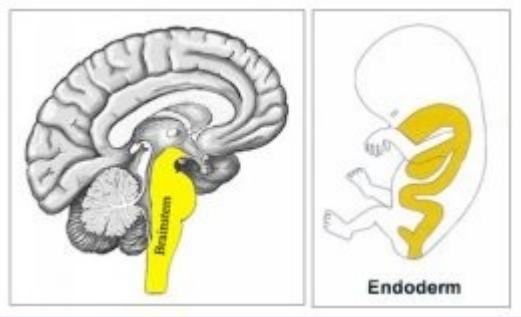
equal to the ring form of the intestine. We can speak of an upper and lower section of the spine only after the gullet had broken open. The sympathetic trunks, which are two long chains of nerves on each side of the vertebrae, allow nerve fibers to travel to spinal nerves that are superior or inferior to the one in which they originate.



In the **BRAINSTEM**, the oldest part of the brain, the control centers of the organs of the intestinal canal are also arranged in a **ring-form order**, starting on the right hemisphere with the brain relays of the mouth and pharynx (incl. thyroid gland,parathyroid glands), esophagus, stomach, liver parenchyma, pancreas gland,duodenum, small intestine, continuing counter-clockwise with the brain relays of theappendix, cecum, colon, rectum and bladder on the left side of the brainstem. The transition from the right to the left brainstem hemisphere corresponds on the organ level to the ileo-cecal valve, positioned between the small intestine and the cecum, the first section of the large intestine.

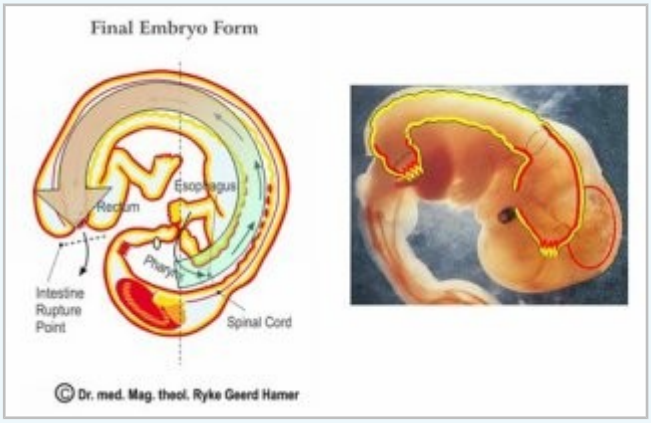
The lung alveoli, middle ear and Eustachian tubes, tear glands, choroid, iris and ciliary body of the eyes, kidney collecting tubules, adrenal medulla, prostate, uterus and fallopian tubes, Bartholin's glands, smegma producing glands as well as thepituitary gland, pineal gland, and choroid plexus originate from the intestinal mucosa. They are therefore controlled from the brainstem.

Equal to the intestinal cells that absorb (resorptive quality) and digest (secretory quality) the "food morsel", the lung alveoli "absorb" and "digest" the "air morsel", the middle ear and Eustachian tubes the "sound morsel", the tear glandsand uvea the "visual morsel", and the kidney collecting tubules the "water morsel".



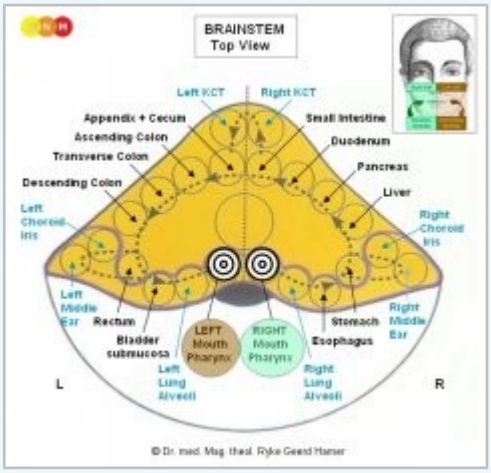
All organs that are controlled from the **BRAINSTEM** derive from the**ENDODERM**, the first and oldest embryonic germ layer. Because of their origin from the intestinal mucosa, they consist of **INTESTINAL CYLINDER EPITHELIUM**.

In the event of a biological conflict, the related organ generates during theconflict-active phase cell proliferation. In the healing phase, the additional cells are removed with the help of fungi and tubercular bacteria.



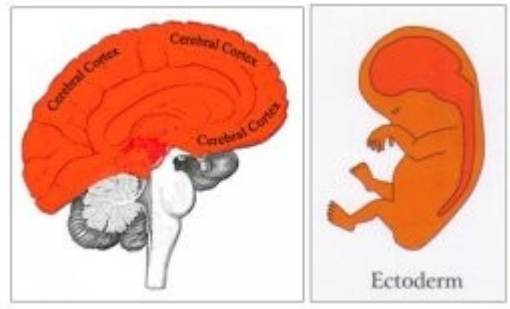
Over the course of evolution the GULLET BROKE OPEN. The new opening of the outgoing section developed into today's rectum, the remaining gullet became in its entirety the mouth and pharynx (see GNM diagram).

The image on the right shows the further development of the fetus to the final embryo form, outlining the embryonic germ layers.



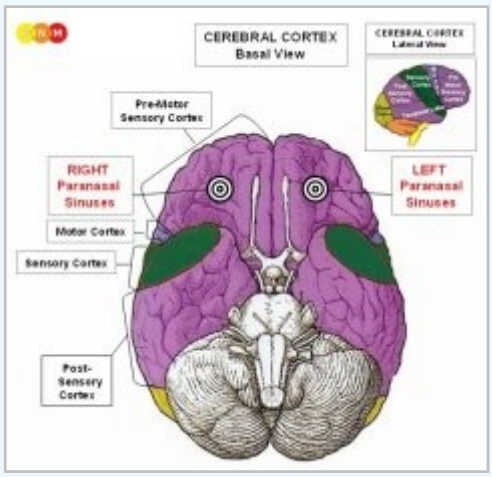
The intestinal rupture occurred close to the left half of the gullet. This explains why the control center of the **mouth and pharynx** is divided into **two brain relays** located opposite each other at the midline of the brainstem hemispheres.

The **right half of the mouth and pharynx** is controlled from the **right side of the brainstem** that still regulates ingestion ("ingoing morsel"), while the **left half of the mouth and pharynx** is controlled from the **left side of the brainstem**, which, however, no longer regulates excretion (this is now managed by the rectum) but instead the vomiting reflex (a remainder of the gullet's previous fecal disposal function). The preservation of the original innervation of the left half of the gullet also serves the biological purpose to be able to expel a morsel (excretory quality) that might cause harm to the organism.



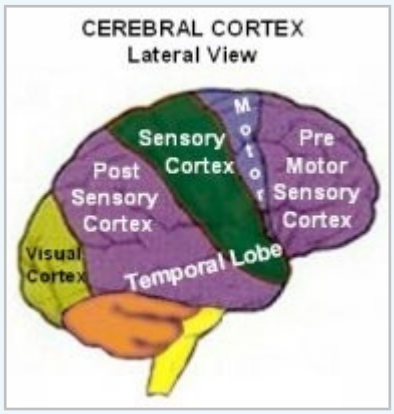
The **rupture of the gullet** happened at a point in time when so-called**SQUAMOUS EPITHELIUM** that originated from a new embryonic germ layer, namely from the **ECTODERM**, had already migrated from the gullet both into the ingoing and outgoing section of the intestine. During gestation the ectoderm develops on the seventeenth day after fertilization. All organs and tissues that derive from the ectoderm are **controlled from the CEREBRAL CORTEX**.**NOTE:** The alpha islet cells and beta islet cells of the pancreas, the olfactory nerves, and the thalamus are controlled from the diencephalon (part of the cerebrum).

In the event of a biological conflict, the corresponding organ generates during theconflict-active phase cell loss (ulceration). In the healing phase, the cell loss is restored with the help of bacteria. **NOTE:** The inner ear (cochlea and vestibular organ), retina and vitreous body respond to the related conflict with functional loss or hyperfunction (periosteal nerves).



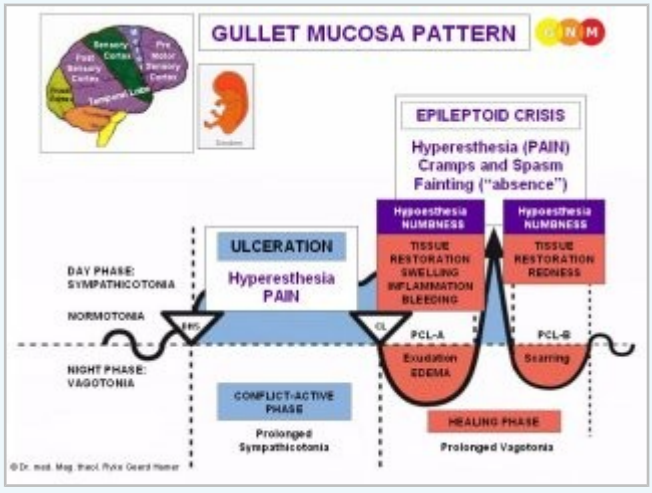
The **starting point of the ectodermal cell migration** was the squamous epithelium covering the periosteum of the **paranasal sinuses**. The sensitive nerves of the epithelial sinus mucosa provided a heightened sense of smell facilitating survival (scent of danger) as well as procreation (scent of a mate).
The control centers of the paranasal sinuses are located at the base of the cranium. They form the junction between the premotor-sensory and post-sensory cortex.

The **squamous epithelial cell migration into the INGOING SECTION OF THE GULLET** explains why ectodermal tissue is found in today's …



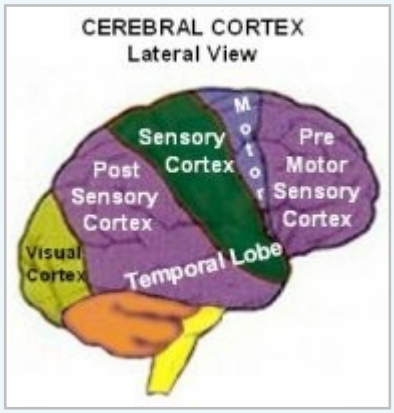
… mouth and pharynx, salivary gland ducts, paranasal sinuses, tooth enamel, tear ducts,thyroid ducts, and pharyngeal ducts. All these tissues are **controlled from the PRE-MOTOR SENSORY CORTEX**.

… esophagus (upper two-thirds), stomach (small curvature), pylorus, duodenal bulb, bile ducts, gall bladder, pancreatic ducts, coronary arteries, coronary veins, ascending aorta, internal carotid arteries, inner sections of the subclavian arteries, carotid sinus, glans penis and glans clitoris. All these tissues are **controlled from the POST-SENSORY CORTEX**.

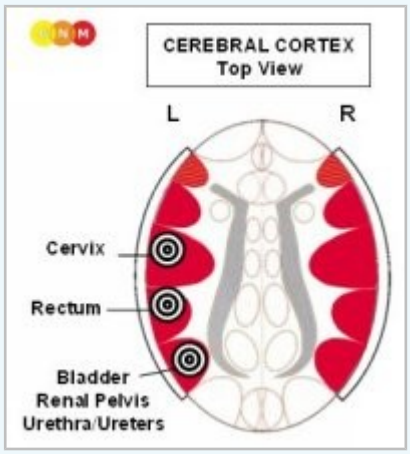


Concerning their sensitivity, both organ groups follow the **GULLET MUCOSA PATTERN** (so named because of its connection to the gullet) with **hypersensitivity during the conflict-active phase and the Epileptoid Crisis** and **hyposensitivity during the healing phase**.

The **squamous epithelial cell migration into the OUTGOING SECTION OF THE GULLET** explains why ectodermal tissue is found in today's …

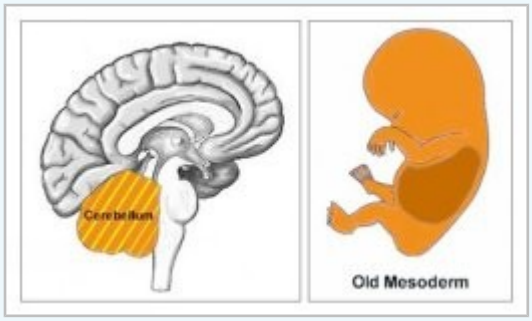


… renal pelvis, ureters, bladder, urethra, rectum, para-anal ducts, and cervix uteri. All these tissues are **controlled from the POST-SENSORY CORTEX**.



NOTE: After the gullet had broken open, the sensitive nerves as well as the motor innervation of the entire urino-rectal system had to be rewired through the spinal cord (this is why these organs paralyze with paraplegia) and were connected to the **OUTER SKIN PATTERN**. In the brain, the organs are orderly arranged side by side on the left side of the cerebral cortex.

The **MESODERM**, which developed after life had moved on land, is divided into an older and younger group.



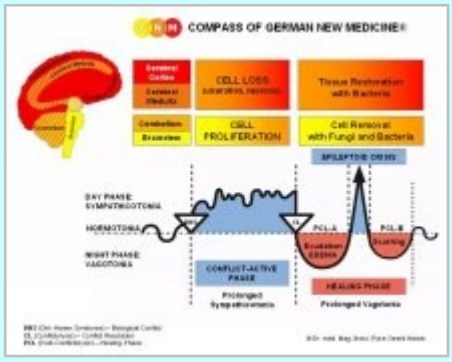
The **OLD MESODERM** develops the corium skin (incl. sebaceous glands andsweat glands), pleura, peritoneum, great omentum, pericardium, breast glands,tunica vaginalis testis, and eyelid glands. All organs and tissues that derive from the old mesoderm are **controlled from the CEREBELLUM**, which had formed next to the brainstem.

In the event of a biological conflict, the related organ generates during theconflict-active phase cell proliferation. In the healing phase, the additional cells are removed with the help of fungi and bacteria.

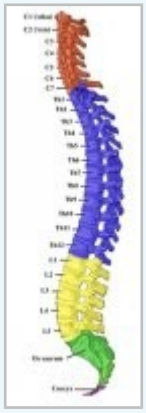
The **NEW MESODERM** develops the bones (incl. bone marrow and blood cells),tooth dentin, periodontium, periosteum, striated muscles, cartilage, tendons,ligaments, fat tissue, connective tissue (incl. neuroglia and myelin),endocardium and heart valves, blood vessels (incl. descending aorta, external carotid artery, outer sections of the subclavian arteries, abdominal aorta, cerebral arteries), meninges, lymph vessels with lymph nodes, spleen, ovaries,testicles, corpora cavernosa (penis), kidney parenchyma, adrenal cortex, and parts of the vitreous body. All organs and tissues that derive from the new mesoderm are **controlled from the**

CEREBRAL MEDULLA, which had formed underneath the cerebral cortex.

In the event of a biological conflict the related organ generates during theconflict-active phase cell loss (necrosis). In the healing phase, the cell loss is restored with the help of bacteria.



The ability of the primordial cell to divide through mitosis, creating diploid cells which contain two sets of chromosomes, became the blueprint for Old Brain (brainstem and cerebellum) controlled organs that generate cell proliferation during the conflict-active phase. The so-called reduction division (meiosis) where the number of chromosomes is reduced from diploid to haploid became the plan for cerebrum (cerebral medulla and cerebral cortex) controlled organs that generate cell loss during conflict activity. The Biological Special Programs are inscribed in the genetic make-up of each cell of the human organism.



NOTE: The bones of the skeletal system are supplied by the spinal nerves. The innervation of the bones comes from the second to fourth cervical nerves (C 2 – C 4). The corium skin is supplied by the second to fifth cervical nerves (C 2 – C 5), almost parallel to the bone innervation. The epidermis is supplied by the fifth to seventh cervical nerves (C 5 – C 7). The reason for the different innervation of the bones and the epidermis is that the bones, originating from the new mesoderm, developed much earlier than the outer ectodermal layer of the skin.

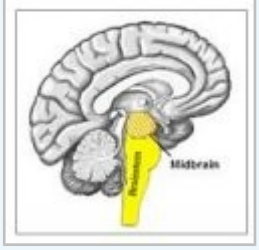
At first, the periosteum that envelops the bones of the skeletal system was covered with squamous epithelium. After themuscles, ligaments, tendons and two skin layers (corium skin and outer skin) had given new support to the bones, the squamous epithelial layer degenerated (in the fetal development this process occurs during the first two weeks of gestation). What remained was a sensitive network of periosteal nerves (controlled from the post-sensory cortex).

NOTE: The previous, old squamous epithelium (compare with young squamous epithelium of the epidermis) still lines today's paranasal sinuses, periodontium, glans clitoris and glans penis. The periosteal membrane of the glans penis is a remainder of the periosteum that covered the previous penis bone.

THE DEVELOPMENT OF MUSCLE TISSUE

SMOOTH MUSCLES: The smooth muscles of the human body originate from the intestinal muscles of the original gullet.

The **smooth muscles** of the intestines, sigmoid colon and rectum (upper part), internal rectal sphincter, renal pelvis, ureters, bladder, urethra, internal bladder sphincter, esophagus, bronchia,larynx, uterus, myocardium (atria), blood vessels (incl. coronary arteries, coronary veins, aorta, carotid arteries, subclavian arteries), lymph vessels, pupils, and ciliary muscles originate from the**ENDODERM**.

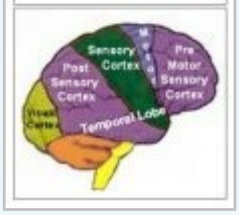


Smooth muscles are involuntary non-striated muscles. Their ability to contract allows moving the "food morsel" (intestinal muscles), the "blood morsel" (atria, blood vessels), the "air morsel" (laryngeal muscles, bronchial muscles), the "urine morsel" (renal pelvis, ureters, bladder, urethra, internal bladder sphincter), the "semen morsel" (prostatic ducts), and the "light morsel" (pupil muscles) through specific organs by peristaltic motion.

The smooth muscles are controlled from the **MIDBRAIN**, located at the outermost part of the brainstem. **NOTE:** The male and female germ cells are also controlled from the midbrain.

In the event of a biological conflict, the related muscles generate during the conflict-active phasecell proliferation with an increase of muscle mass and increased local muscle tension (hypertonus). In the healing phase, the muscles relax. The Epileptoid Crisis presents as muscle spasms. In theuterus, the additional muscle cells remain after healing has been complete.

STRIATED MUSCLES: The striated muscles developed at a time when more efficient muscle functions were required.



The **striated muscles** of the skeletal musculature, myocardium (ventricles), coronary arteries,coronary veins, aorta, carotid arteries, and subclavian arteries, blood vessels, tongue, jaw, ear,bronchia, larynx, diaphragm, esophagus, stomach (small curvature), pylorus, duodenal bulb,pancreatic ducts, bile ducts, gall bladder, cervix, cervical sphincter, vagina, rectum, external rectal sphincter, renal pelvis, ureters, urethra, bladder, external bladder sphincter, eyelid muscles, ciliary muscles, and extraocular muscles derive from the **NEW MESODERM**.

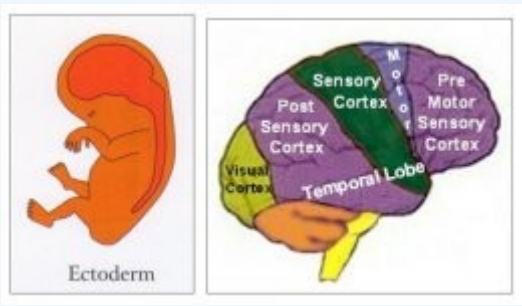
The trophic function of the striated muscles is controlled from the **CEREBRAL MEDULLA**.

The ability to move the muscles is controlled from the **MOTOR CORTEX**.

In the event of a biological conflict, the related muscles generate during the conflict-active phasecell loss and muscle paralysis. In the healing phase, the muscles are reconstructed. The Epileptoid Crisis manifests as muscle cramps, rhythmic convulsions, spasms, or muscle twitching. **NOTE:**From an evolutionary point of view, it is the tonic-clonic contractions during childbirth that became the blueprint for the Epileptoid Crisis of the striated muscles.

NOTE: The striated muscles, islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), retina and vitreous body of the eyes, and theolfactory nerves belong to the group of organs that respond to the related conflict with functional loss or hyperfunction (periosteal nerves and thalamus).

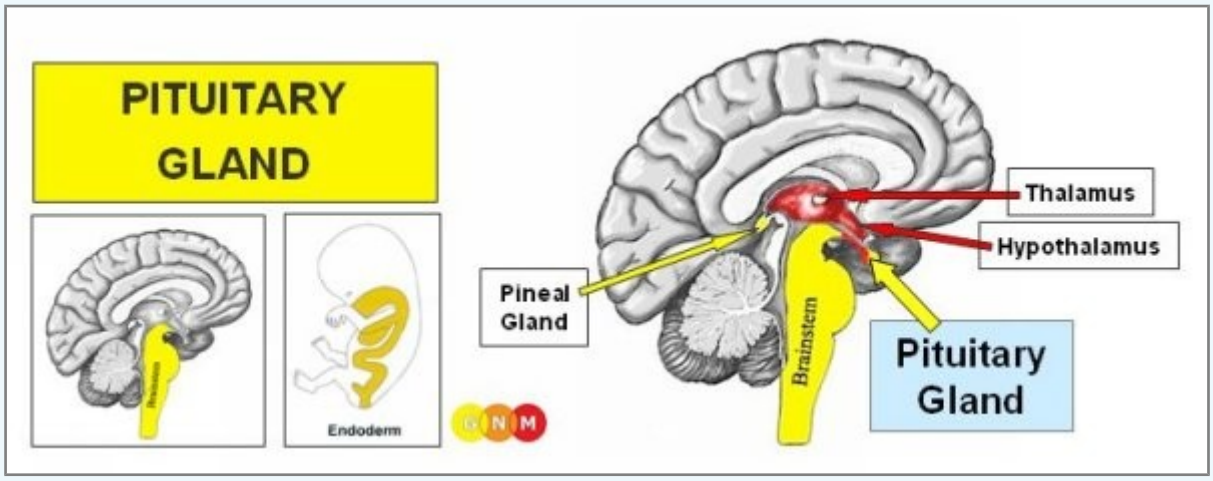
Lastly, the **ECTODERM** developed the **OUTER SKIN** that covered the entire corium skin (under skin). From the outer skin ectodermal **squamous epithelium** migrated through the nipples into the milk ducts, into the ear canal, nasal cavities and respiratory tract. It also covered the outer part of the eyes. This is why squamous epithelium is found in today's …



The retina and the vitreous body of the eyes derive from the **ECTODERM**. They are controlled from the **VISUAL CORTEX** located in the occipital lobe in the back of the brain. The visual cortex and its corresponding organs developed before the sensory and motor cortex.

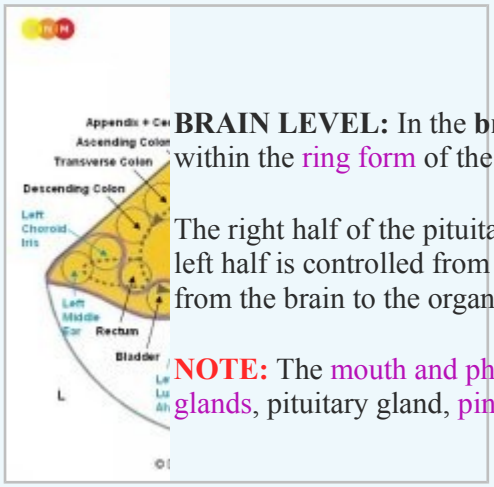
In the event of a biological conflict, the related tissue generates during theconflict-active phase functional loss. In the healing phase, the function is restored.

BRAIN



STH Producing Cells **Prolactin Producing Cells** **LH and FSH Producing Cells**

DEVELOPMENT AND FUNCTION OF THE PITUITARY GLAND: The pituitary gland, or hypophysis, is an endocrine gland (see also pineal gland, or epiphysis) situated at the base of the brain in the sella turcica, a saddle-shaped depression in the sphenoid sinus. It is a protrusion off the bottom of the hypothalamus. The pituitary gland secrets hormones (secretory quality) responsible for physical growth (growth hormone STH-Somatotropin Hormone), reproduction (LH-Luteinizing Hormone promotes ovulation; FSH-Follicle Stimulating Hormone plays a role in pubertal development), metabolism (TSH-thyroid stimulating hormone), cortisol levels (ACTH-adrenocorticotropic hormone) and some aspects of pregnancy, childbirth (oxycotin induces the contraction of the uterus muscles during labor) and lactation (prolactin stimulates the breast glands to produce milk). The anterior lobe of the pituitary gland consists of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem. The posterior lobe is of ectodermal origin (to date, the related biological conflict is unknown).



BRAIN LEVEL: In the **brainstem**, the pituitary gland has two control centers, positioned within the ring form of the brain relays that control the organs of thealimentary canal.

The right half of the pituitary gland is controlled from the right side of the brainstem; the left half is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

STH-PRODUCING CELLS

BIOLOGICAL CONFLICT: The biological conflict linked to the **STH-Somatotropin Hormone producing cells** of the pituitary gland is a **morsel conflict**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

RIGHT HALF of the pituitary gland: Equivalent to the right half of the mouth and pharynx, the **right half of the pituitary gland** correlates to an "**ingoing morsel"** and to "**not being able to grab a morsel because the individual is too small"**. Example: a young child is competing with an adult or a bigger child, let's say, in sports such as soccer.

LEFT HALF of the pituitary gland: Equivalent to the left half of the mouth and pharynx, the **left half of the pituitary gland** correlates to an "**outgoing morsel"** and to "**not being able to get rid of a morsel because the individual is too small"** (originally, the feces morsel). Example: a child or adolescent has to take over a parent's role.

In general, the conflict is brought on by **feeling "too little"** (provoked, for instance, by comments of a parent, teacher, or coach). The distress of being "too small" can also occur in adults.

CONFLICT-ACTIVE PHASE: During the conflict-active phase, the STH producing cells in the pituitary gland proliferate proportionally to the intensity of the conflict. The **biological purpose of the additional cells** is to increase the production of growth hormones to put the individual into a better position to grab (right half) or get rid of a morsel (left half). With prolonged conflict activity a compact tumor (secretory type) forms as a result of the continuous cell augmentation. In conventional medicine, a tumor in the pituitary gland is called a **pituitary adenoma** (generally considered as "benign").

In children and adolescents, the **overproduction of growth hormones** leads to real, potentially excessive physical growth (**gigantism**). If the conflict happens in adulthood the increased hormone production causes enlarged hands, feet, and facial feature (**acromegaly**). When the left pituitary gland is affected, the lips also enlarge (the gullet openingbecomes larger so that the morsel can be better expelled).

Maurice Tillet (1903 – 1954), a French professional wrestler, developed acromegaly in his twenties.

At the age of 13, Maurice still had a normal stature.

HEALING PHASE: In the healing phase, fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. The healing process is accompanied by night sweats.

NOTE: Circumventing the blood-brain barrier system, the pituitary gland receives its blood supply directly from the internal carotid artery. This allows mycobacteria to assist healing (see also pineal gland and choroid plexus).

If healing cannot be complete (hanging healing) because of recurring conflict relapses, more and more pituitary gland tissue is lost leading to a decrease or complete cessation of STH-Somatotropin Hormone production. During the growing period of a child, this results in a short stature (**dwarfism**). The delayed growth might already occur during pregnancyprompted, for example, by a doctor's comment such as "the fetus is too small" (see intra-uterine conflicts). In this case, the condition is termed "**intra-uterine growth retardation"** (IUGR).

PROLACTIN PRODUCING CELLS

BIOLOGICAL CONFLICT: The biological conflict linked to the **prolactin producing cells** of the pituitary gland is a**feeding conflict** as in "**not being able to nourish the child or the family"**, let's say, because of financial difficulties (e.g., unemployed or self-employed single mothers). The conflict can affect either of the two halves of the gland.

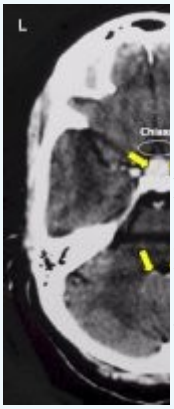
CONFLICT-ACTIVE PHASE: During the conflict-active phase, the prolactin producing cells in the pituitary gland proliferate proportionally to the intensity of the conflict. The **biological purpose of the additional cells** is to increase the secretion of prolactin to be better able to nurse the child or the family. With lasting conflict activity the additional cells form a compact growth (secretory type). In conventional medicine, the tumor is termed a "**secretory pituitary adenoma"** or **prolactinoma**. The **overproduction of prolactin** causes an increased milk production, if a woman is breastfeeding at the time of conflict activity. However, even if a woman is not nursing, the increase of prolactin still results in a secretion of milk, noticeable as a milky nipple discharge or spontaneous flow of milk from the breasts. Lactation also occurs in males who suffered a feeding conflict (see also breast cancer in men). In both sexes the condition is called **galactorrhea**.

HEALING PHASE: With a prolonged healing phase more and more glandular tissue gets lost as a result of the continuous cell removal process. In nursing females, this causes a reduced or complete stop of milk production. If this happens during pregnancy, a woman has little or no breast milk after the birth of her child.

NOTE: In mammals, the milk flow is stimulated by eating the placenta of their young after birth. Studies at the University of South Florida have shown that new mothers who ate their own placenta had a significantly improved lactation. A biological conflict related to the placenta triggered, for example, by a doctor's comment such as "the placenta does not produce any amniotic fluid", might possibly also affect milk production (this has not been confirmed by Dr. Hamer's research).

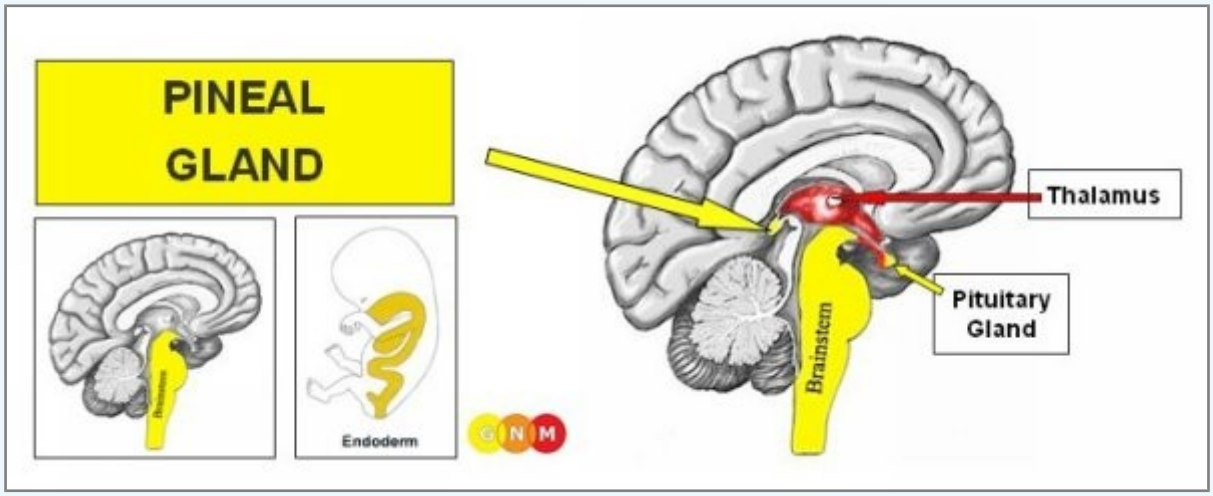
LH and FSH PRODUCING CELLS

BIOLOGICAL CONFLICT: The biological conflict linked to the **LH-Luteinizing Hormone** and **FSH-**follicle stimulating hormone producing cells of the pituitary gland is "**being too immature"**, literally or figuratively, with an overproduction of LH and FSH in the conflict-active phase. The conflict occurs before puberty. In children, continuous conflict activity leads to a **premature development** (precocious puberty). A long-lasting healing phase causes a decrease of LH and FSH production resulting in **delayed puberty** (no breast and ovary development in girls by the age of 13 or growth of testes in boys by the age of 14).



This brain CT shows calcification (upper arrows) in the pituitary gland (compare with calcification in the pineal gland and choroid plexus). The scarring in the brain relays that control the pituitary gland (lower arrows - view the GNM diagram) confirms that the healing phase has been complete.

NOTE: The pituitary gland is located close to the optic chiasm. Hence, a large pituitary gland tumor (usually because of water retention due to the SYNDROME) might compress the optic nerve causing temporary vision impairment; damage to the optic nerve can result in blindness.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PINEAL GLAND: The pineal gland (epiphysis) is a small endocrine gland located deep in the center of the brain behind the third ventricle, precisely, in the groove where the two halves of thethalamus join (compare with pituitary gland, or hypophysis). The pineal gland is comprised of pineal cells (pinealocytes) that register the incidence of light (resorptive quality) and produce melatonin (secretory quality). Melatonin (not to be confused with the pigment melanin) plays an important role in regulating the night-day cycle in synchronization with the sleep-wake cycle (circadian rhythm). The pineal gland consists of intestinal cylinder epithelium, originates from theendoderm and is therefore controlled from the brainstem.

NOTE: In evolutionary terms, the melatonin producing pinealocytes derive from intestinal cells, hence, theirresorptive and secretory function. Initially, the pineal cells also had a photosensory function serving to receive light similar to retinal cells. Some embryologists therefore suggest that the pineal gland was once an eye (the "third eye" looking upwards). Based on the knowledge of GNM, the pineal gland is biologically related to thechoroid, the oldest tissue of the eye capable of capturing light. Both the choroid and pineal cells are of endodermal origin (the retina covering the choroid developed later and originates

from the ectoderm). During the embryonic development, the pineal gland begins to form during the seventh week of gestation. The pineal evagination ("pineal eye bubble") has a striking resemblance to the choroid constituting the primordial "eye cup".

BRAIN LEVEL: In the **brainstem**, the pineal gland has two control centers positioned within the ring form of the brain relays that control the organs of thealimentary canal.

The right half of the pineal gland is controlled from the right side of the brainstem; the left half is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

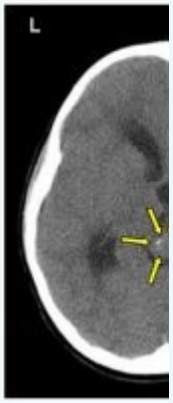
NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict associated with the pineal gland is linked to **sudden long darkness**(compare with light-related conflict linked to the pupil muscles). The right half of the pineal gland correlates to "not being able to capture light", whereas the left half of the pineal gland corresponds to "not being able to get rid of darkness". The conflict is brought on, for instance, by distress experienced in dark places (basement, underground mines or caves, tunnels) or, figuratively, through being kept "in the dark".

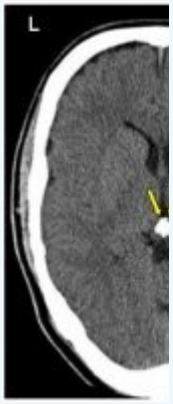
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the pineal gland proliferate proportionally to the intensity of the conflict. The **biological purpose of the additional cells** is to increase the production of melatonin in order to increase the reception of light. With prolonged conflict activity a compact (secretory type) or flat growing tumor (resorptive type) forms as a result of the continuous cell augmentation. In conventional medicine, a tumor in the pineal gland is called a **pinealon**. A large growth might constrict the oculomotor nerve (thirdcranial nerve) that supplies the majority of the extraocular muscles controlling eye movements. Damage to the nerve leads to an inability to move the affected eye normally (see strabismus). If the tumor compresses the third ventricle , this causes a hydrocephalus.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. The healing process is accompanied by night sweats. During the decomposing process the tumor might bleed. The bleeding occurs when the outer wall of the tumor breaks (compare with brain bleeding due to the rupture of a brain cyst).

NOTE: Circumventing the blood-brain barrier system, the pineal gland receives its blood supply directly from the cerebral arteries. This allows mycobacteria to assist healing (see also pituitary gland and choroid plexus).

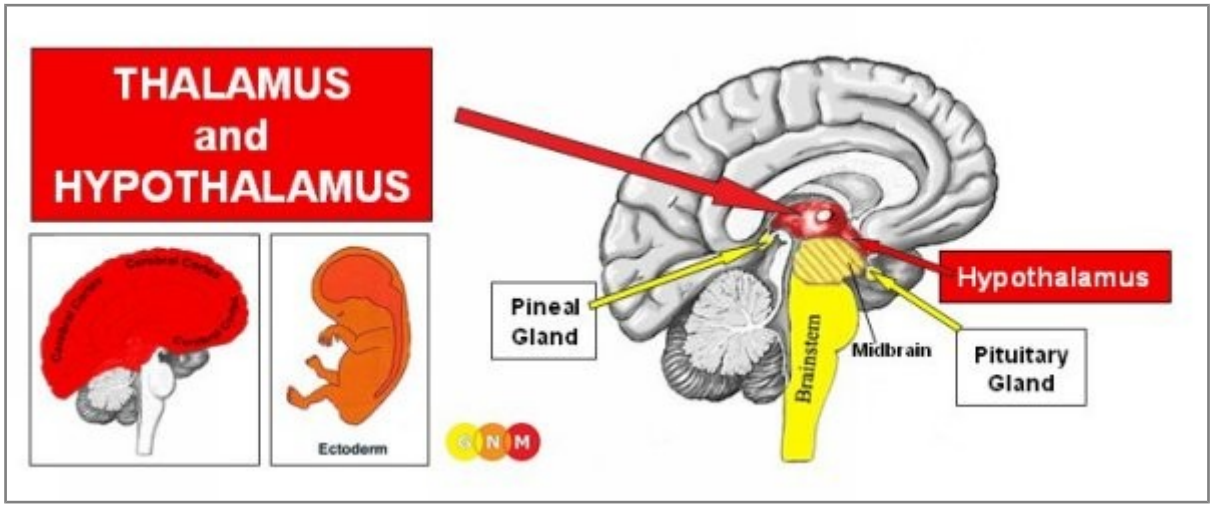


This brain scan was taken after a pinealon was removed with the help of TB bacteria. The caverns that are created after the tumor has been decomposed are filled with calcium. Here already visible as white specks. Tiny calcified structures in the pineal gland, indicating a short healing phase, are known as corpora arenacea, or **brain sand**.



This brain CT shows the completion of the calcification process (compare with calcification in the pituitary gland and choroid plexus).

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the tumor cannot be broken down and therefore remains. Eventually the growth becomes encapsulated. A **pineal cyst** is an encapsulated pinealon containing fluid due to water retention.

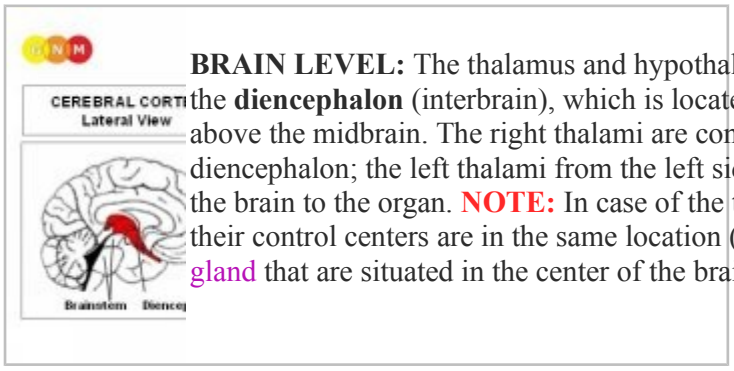


Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE THALAMUS AND HYPOTHALAMUS: The thalamus and hypothalamus are situated deep in the brain between the cerebral cortex and the midbrain. They form the larger part of the diencephalon (interbrain). The two halves of the thalamus are located symmetrically on each side of the third ventricle. The hypothalamus is located below the thalamus. The hypothalamus is the coordinating center of the autonomic nervous system and the endocrine system, affecting sleep rhythm, metabolic functions, intake of food and water (hunger, thirst), body temperature,

and the release of hormones from the pituitary gland. The thalamus and hypothalamus originate from the ectoderm and are controlled from the diencephalon.

NOTE: Like the pineal gland, the thalamus receives its blood supply directly from the cerebral artery and is therefore not isolated from the body by the blood-brain barrier.



BRAIN LEVEL: The thalamus and hypothalamus are controlled from the **diencephalon** (interbrain), which is located in the central part of the cerebrum just above the midbrain. The right thalami are controlled from the right side of the diencephalon; the left thalami from the left side. There is no cross-over correlation from the brain to the organ. **NOTE:** In case of the thalamus and hypothalamus, the organs and their control centers are in the same location (compare with pituitary glandand pineal gland that are situated in the center of the brain but are controlled from the brainstem).

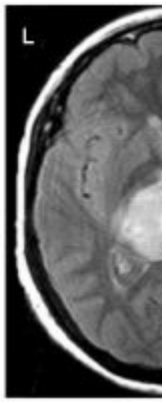
BIOLOGICAL CONFLICT: complete self-abandonment; complete resignation ("I wish I were dead")

CONFLICT-ACTIVE PHASE: change of hormonal parameters and activation of the autonomic nervous system(sympathicotonia) in order to be able to manage the stress. **Symptoms**: **wakefulness and extreme restlessness**.

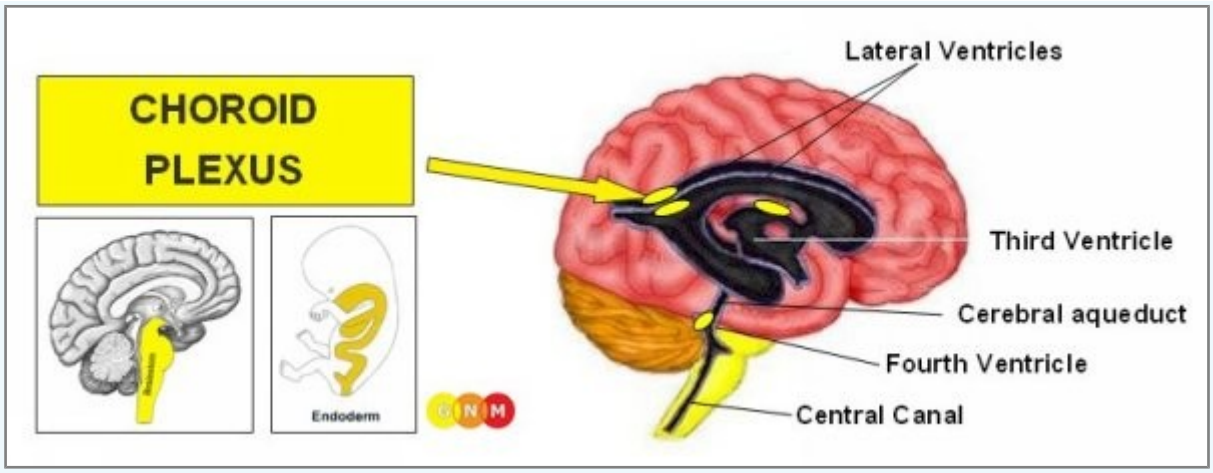
NOTE: The thalamus and hypothalamus belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with hyperfunction (see also periosteum) or functional loss (see Biological Special Programs of the inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles).

HEALING PHASE: In the course of the healing phase the hormonal parameters normalize and the nervous system switches into vagotonia.

With the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict, there is a risk that a large brain edema (PCL-A) compresses the third ventricle (see hydrocephalus); even more so, when both halves of the thalamus undergo the healing process at the same time.



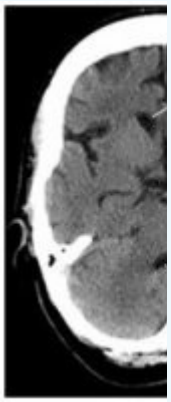
This MRI taken with contrast substance shows a healing process in the area of the brain that controls the left thalamus (view the GNM diagram). In conventional medicine, the "mass" is erroneously diagnosed as a "brain tumor" ("thalamic glioma").



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CHOROID PLEXUS: The choroid plexus is a dense network of small blood vessels in the ventricular system of the brain. There are four choroid plexuses in the brain, one in each of the ventricles.

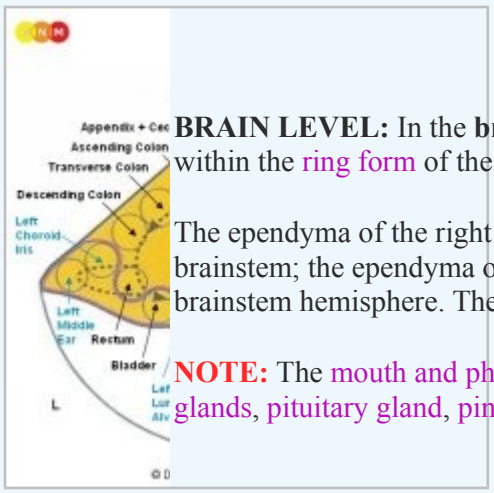
The **ventricular system** is made up of four cavities joined by narrow passages to allow the circulation of cerebrospinal fluid. The highest ventricles are the two lateral ventricles deep within the cerebral hemispheres. Each lateral ventricle is structured in a C-shape, reaching from the temporal lobe to the premotor-sensory cortex. The third ventricle below them is located in the diencephalon (interbrain) between the right and left thalamus. The fourth ventricle between the brainstem and the cerebellum connects with the subarachnoid space (see meninges) and the central canal of the spinal cord. The cerebral aqueduct joins the third and fourth ventricle. The ventricles and cerebrospinal fluid protect the brain and spinal cord from injury.


This image highlights the four ventricles as they show on a brain CT.

The choroid plexus consists mainly of ependymal cells. The main function of the ependymal cells is the **production of cerebrospinal fluid** (secretory quality) through the filtration of arterial blood. Cerebrospinal fluid (CSF) drains from the lateral ventricles into the third ventricle further via the cerebral aqueduct into the fourth ventricle. From there the fluid escapes through lateral openings of the fourth ventricle into the subarachnoid space. The ependymal cells of the choroid plexus form a thin layer (ependyma) that covers the inner wall of the ventricles and surrounds the core of the plexus. The ependyma acts as an important filter, known as the **blood-cerebrospinal fluid barrier** (BCSFB). The blood-cerebrospinal fluid barrier is in addition to the **blood-brain barrier** (BBB) a dynamic interface to maintain a stable environment for brain cells (neurons). The two barriers restrict the passage of large molecules, including microbes andcancer cells, into the brain while allowing the entry of water, lipid-soluble substances (oxygen, carbon dioxide), and molecules such as amino acids and glucose. Sugar is nutrition for the brain. Cerebrospinal fluid, also known as cerebrospinal “liquor” (sweet substance), is therefore rich in glucose (the brain consumes 25% of the body’s energy using about 150g of glucose

daily).

The ependymal cells of the choroid plexus originate from the endoderm and are therefore controlled from the brainstem. Neuroglial cells that provide support to the ependymal cells are of new mesodermal origin.



BRAIN LEVEL: In the **brainstem**, the choroid plexus has two control centers positioned within the ring form of the brain relays that control the organs of thealimentary canal.

The ependyma of the right lateral choroid plexus is controlled from the right side of the brainstem; the ependyma of the left lateral choroid plexus is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

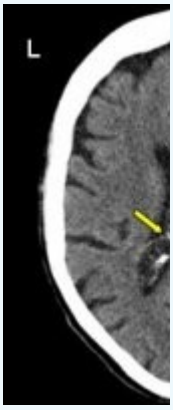
BIOLOGICAL CONFLICT: According to its function as the "waterworks of the brain", the biological conflict linked to the choroid plexus is "**the brain is not moist enough"** or "**the brain is dry"** experienced, figuratively, when one has difficulties thinking (the thoughts don't flow smoothly) or memorizing. A distressing mental "black out", short-term memory loss (see separation conflict), or learning difficulties could cause such a conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase ependymal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the production of cerebrospinal fluid. With prolonged conflict activity a compact tumor (secretory type) forms as a result of the continuing cell augmentation. In conventional medicine this is called an **ependymoma**. Contrary to a glioma, an ependymoma is a real brain tumor (see also pinealon and a pituitary adenoma). Which one of the four choroid plexuses is affected by the conflict is random.

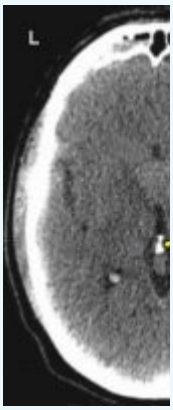
NOTE: Based on the wrong assumption that ependymal cells are "specialist glial cells", conventional medicine claims that an ependymoma is a type of glioma, also termed chordoid glioma. In reality, ependymal cells are descendants of the intestinal mucosa and therefore of endodermal origin, while neuroglia (brain connective tissue) originates from the new mesoderm.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. With the participation of TB bacteria the condition is called **ependyoma tuberculosis**, typically accompanied by night sweats. During the decomposing process the tumor might bleed into the affected ventricle. The bleeding occurs when the outer wall of the tumor breaks (compare with brain bleeding due to the rupture of a brain cyst).

NOTE: Circumventing the blood-brain barrier system the choroid plexus receives its blood supply directly from cerebral arteries. This allows mycobacteria to assist the healing process (see also pineal gland and pituitary gland).



After an ependyoma has been decomposed, caverns remain at the site that are eventually filled with calcium, showing as calcium deposits on a brain scan (here in the lateral ventricles).

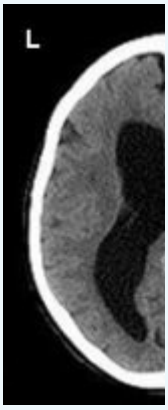


This brain CT demonstrates a complete calcification process in the third ventricle (compare with calcification in the pituitary gland and pineal gland).

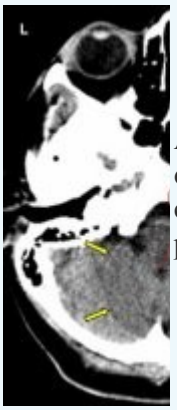
HYDROCEPHALUS

A hydrocephalus is a condition in which excess cerebrospinal fluid (CSF) accumulates in the cavities of the brain. This occurs when a tumor or a big brain edema compresses one of the ventricles or the cerebral aqueduct. A brain edema in the control center of the kidney parenchyma could lead to a compression of the cerebral aqueduct. Swelling in the brain relays of the lung alveoli (related to a death-fright conflict) can compress the fourth ventricle resulting in the dilation of the entire ventricular system. A healing process involving the thalamus or the myocardium might block the third ventricle from both sides. Brain edemas usually enlarge due to water retention (the SYNDROME) and an active abandonment and existence conflict. The accumulation of CSF and the pressure caused by the fluid buildup increases the size of the ventricles creating an **internal hydrocephalus**. With an **external hydrocephalus** the fluid accumulation occurs in thesubarachnoid space; if it involves the frontal lobe it is characterized by a prominent forehead developing in infancy.

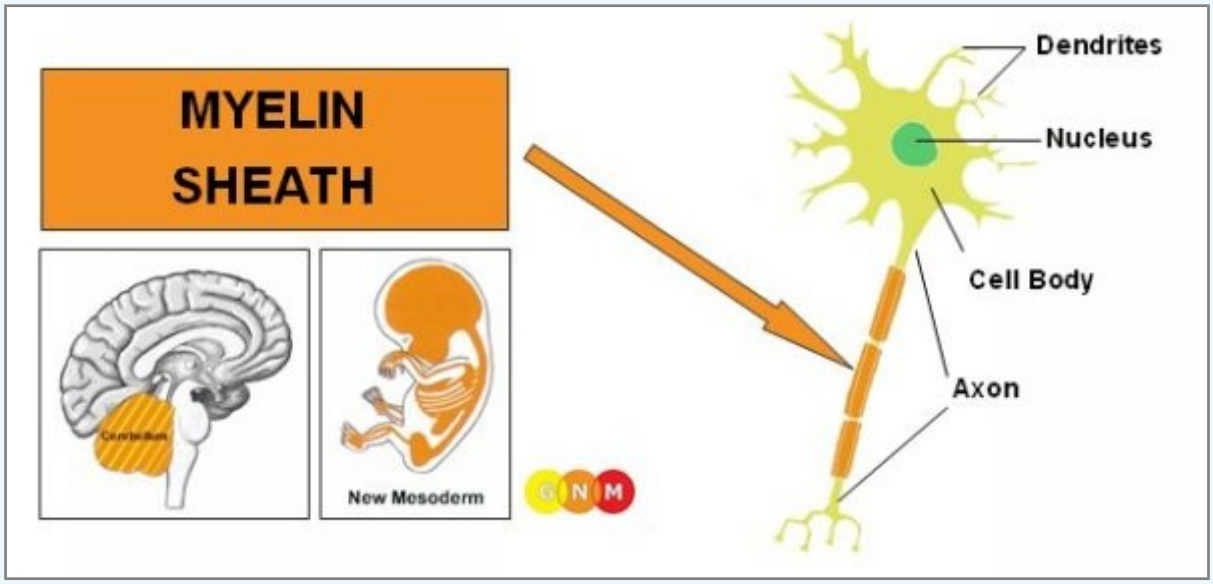
The enlargement of the head happens when the skull bones are not fully fused, which is the case in fetuses and infants up to the age of two. Unborn children experience existence conflicts and death-fright conflicts because of extreme distress in the womb (see intra-uterine conflicts); newborns suffer abandonment conflicts when they are separated from the mother at birth. In adults, the skull cannot expand to accommodate the buildup of cerebrospinal fluids. Subsequent symptoms are headaches, nausea, and drowsiness. Strong, elevated intracranial pressure may result in an elongation of the cerebellar tonsils, the rounded lobes underneath the cerebellar hemispheres; a life-threatening condition occurs when the pressure pushes the tonsils out of the skull (the decent of the cerebellar tonsils is termed “tonsillar herniation”). Lasting increased pressure on the optic nerve cuts off the oxygen supply to the optic nerve, causing it to swell. Swelling of the optic nerve at the point where the nerve joins the eye is called a **papilledema** (compare with excavation papillae due to permanent elevated intraocular pressure). Damage to the optic nerve from papilledema can result in visual field loss. With hydrocephalus, a weakening of the nerves that control eye movement creates eye misalignment (see strabismus). Symptoms such as weakness of the legs, epileptic seizures, or speech problems, however, are not brought on by a hydrocephalus, as claimed, but relate to specific Biological Special Program.



This brain CT shows an expansion of the lateral ventricles (internal hydrocephalus) caused by an accumulation of cerebrospinal fluid.



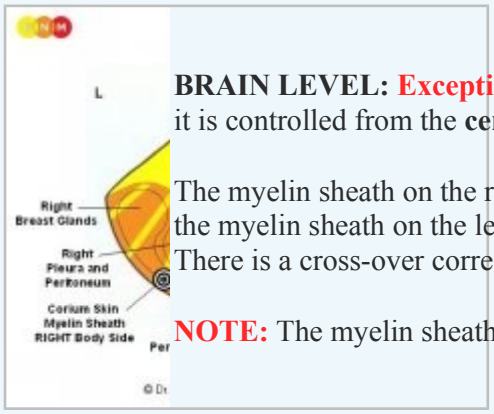
A compression of the fourth ventricle can be the result of an **acute fear of life conflict**leading to a hydrocephalus after the conflict has been resolved. In this example, the corresponding Hamer Focus reaches over the entire brainstem. Excessive noise during pregnancy, for example, could trigger the panic in the unborn (see intra-uterine conflicts).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MYELIN SHEATH: The myelin sheath forms an insulating layer around nerves, including nerves in the brain and spinal cord. Each nerve cell or **neuron** consists of a cell body with a **nucleus**(which contains DNA) and **dendrites** (nerve endings) projecting out from the cell body to receive signals from other neurons. The **axon** is an extension that differs from the dendrites insofar as it carries impulses away from neurons, sometimes over a considerable distance. Longer axons are covered with a myelin sheath. The function of the myelin sheath is to speed the electrical transmission along the nerve cells. The myelin sheath enveloping motor neurons aids in the conduction of nerve impulses to the muscles; sensory neurons communicate sensory stimuli such as touch. Myelinated neurons are therefore typically found in the peripheral nerves.

Myelin originates from Schwann cells, which are specialized glial cells. Glial cells (also called neuroglia) provide support and protection for neurons in the brain and spinal cord (central nervous system). Schwann cells, on the other hand, are found in the peripheral nervous system (outside of the brain) where they form the myelin sheath around nerve cells. In humans, myelination begins in the 14 week of the fetal development. Like glia, myelin consists for the most part of connective tissue. The myelin sheath derives therefore also from the new mesoderm.



BRAIN LEVEL: Exception: Even though the myelin sheath is of new mesodermal origin, it is controlled from the **cerebellum** rather than from the cerebral medulla.

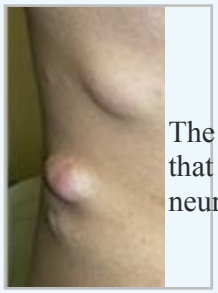
The myelin sheath on the right side of the body is controlled from the left side of the brain; the myelin sheath on the left side of the body is controlled from the right brain hemisphere. There is a cross-over correlation from the brain to the body.

NOTE: The myelin sheath is controlled from the same brain relay as the corium skin.

BIOLOGICAL CONFLICT: The biological conflict linked to the myelin sheath is a **touch** conflict of not wanting to be touched because the touch is experienced as painful, unpleasant or unwanted (compare with separation conflict related to the outer skin). The fear of being touched (physical abuse, sexual abuse) can already evoke the conflict. The myelin sheath also responds to a **pain conflict** triggered by acute pain due to an injury, fall, or hit. Severe pain, for example,bone pain can also activate the Biological Special Program.

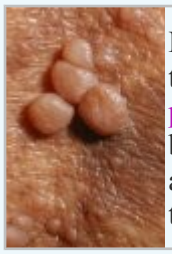
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase the myelin sheath thickens through cell proliferation forming a **neurofibroma** beneath or on the skin (like a melanoma, the neurofibroma is an archaic form of defense). The size of the nodule(s) is determined by the intensity of the conflict. The **biological purpose of the cell increase** is to block the peripheral sensory stimuli from being transmitted to the brain. The extra tissue absorbs the unwanted touch or pain. **Symptom**: a **loss or decreased sensitivity to touch at the affected area** (see also hyposensitivity involving the epidermis or the periosteum).

NOTE: Even though myelin and neuroglia are related tissues they behave differently. A neurofibroma (also referred to as a "peripheral glioma") grows during the conflict-active phase (like all tissues that are controlled from the cerebellum) whereas the proliferation of neuroglia (see "brain tumor") occurs in the healing phase (inPCL-B).



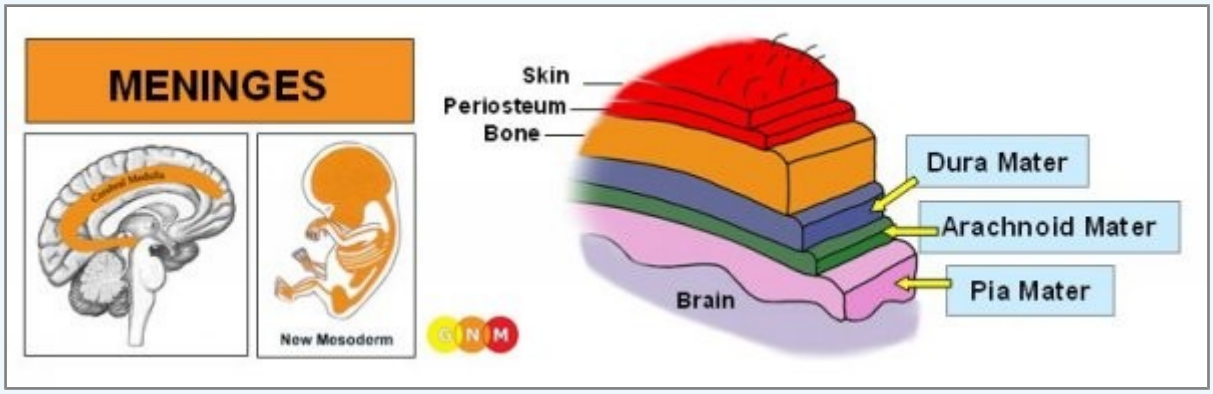
The appearance of a neurofibroma under the skin (subcutaneous neurofibroma) is similar to that of alipoma involving the fat tissue. When situated immediately beneath the skin, neurofibromas are readily movable.

NOTE: Whether the right or left side of the body is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the part of the body that is associated with the touch conflict.



Multiple neurofibromas beneath or on the skin (cutaneous neurofibroma) are termed**neurofibromatosis type 1** (NF1) or **Recklinghausen's disease**. Café-au-lait pigmentations (coffee-colored patches on the skin) classified as symptoms of NF1 are, based on GNM, related to the epidermis rather than to the nerve sheath. The fact that café-au-lait spots are observed in the majority of people with NF1 is an indication that the two Biological Programs (separation conflictand touch conflict) often run concurrently.

HEALING PHASE: Following the principle of organs deriving from the new mesoderm ("surplus group"), the neurofibroma(s) stay in place. With the completion of the healing phase the sensitivity returns to normal.



DEVELOPMENT AND FUNCTION OF THE MENINGES: The meninges are the three thin membranes that envelop the brain and the spinal cord. The primary function of the meninges is to protect the central nervous system. The meninges consist of the **pia mater** (inner meninges), which follows closely the contours and folds (gyri and sulci) of the brain, the**arachnoid mater**, and the **dura mater** (outer meninges). The space between the pia mater and arachnoid mater (**subarachnoid space**) is filled with cerebrospinal fluid (see choroid plexus). The outer surface of the skull bones is covered by the periosteum and the skin (corium skin and epidermis). The pia mater ("soft mother") is a delicate membrane endowed with many blood vessels that nourish the brain. The dura mater ("tough mother") is composed of dense fibrous tissue with a periosteal layer close to the inner surface of the skull. The dura mater, arachnoid mater, and pia mater originate from the new mesoderm and are controlled from the cerebral medulla. The periosteal nerves covering the periosteum of the dura mater are controlled from the pre-motor sensory cortex; the control center is located close to the brain relays of the pharyngeal ducts and thyroid ducts at the front of the cortex.

Meningitis

Conventional medicine argues that inflammations of the meninges are the result of "infections" with viruses, bacteria, orfungi that allegedly migrate via the bloodstream to the brain and spinal cord. Any such claim is highly questionable because the blood-brain barrier that separates the circulating blood from the cerebrospinal fluid allows only water, lipid-soluble substances, and molecules (glucose and amino acids) into the brain. This strictly *excludes* the entry of microbes that are supposedly transmitted to humans by "infected" ticks leading to meningoencephalitis, an inflammation of the meninges and the brain (see also Lyme disease-associated meningitis). Moreover, the cerebrospinal fluid that occupies the subarachnoid space isolates the meninges well from the circulatory system. This means that under no circumstances are bacteria able to reach the meninges via the bloodstream. The assertion that bacterial meningitis is "highly contagious" is therefore unfounded.

NOTE: Within the brain, the pituitary gland, pineal gland, and choroid plexus receive the blood supply directly from the cerebral arteries. This allows TB bacteria to assist healing.

The only way bacteria find their way into the central nervous system is when the spinal cord gets punctured. During the puncture a hollow needle is inserted into the subarachnoid space to collect cerebrospinal fluid. In today's medicine, a lumbar puncture, colloquially called a spinal tap, is a common diagnostic procedure to confirm or exclude meningitis.

Based on GNM, meningitis occurs

- when a brain edema (PCL-A) presses onto the pia mater (inner meninges). This applies to any edema that develops in the cerebral cortex , for example, in the brain relay of the thyroid ducts, pharyngeal ducts,bronchial mucosa, laryngeal mucosa, in the visual cortex (retina, vitreous body) or at the transitional area between the brainstem and the cerebellum (cerebello-pontine angle that controls the middle ear).

- when an edema that develops in the skull bones (in the healing phase of an intellectual self-devaluation conflict) presses onto the dura mater (outer meninges). Meningitis does, of course, not occur when the edema is located on the surface of the skull bone.

In PCL-B, after the brain edema has been expelled, glial cells proliferate at the site to complete the healing process. In conventional medicine, this is often diagnosed as a **meningioma**, believed to be a "brain tumor" arising from meningothelial cells in the meninges.

Depending on the location of the edema **signs and symptoms of meningitis** range from flu-like symptoms andpneumonia to neck stiffness, muscle paralysis, epileptic seizures or skin rashes. The **severe headaches** are caused by the swelling of the brain edema as well as by the inflammation (compare with headaches in the course of any Biological Special Program and migraine headaches). The inflammation is typically accompanied by **high fever**. With sudden water retention due to an active abandonment or existence conflict (the SYNDROME) the brain edema increases quickly in size and the meningitis symptoms occur within a few days.

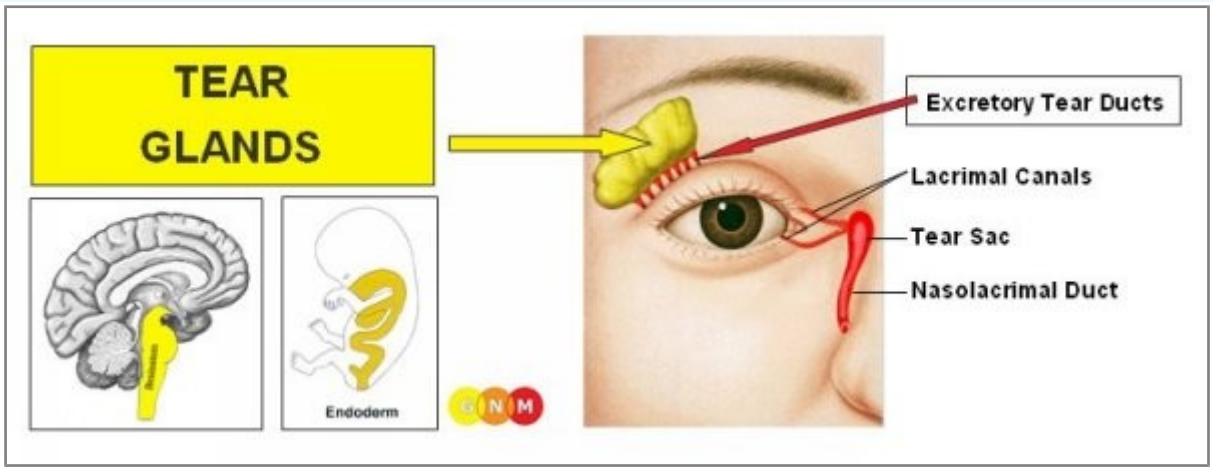
Meningitis most commonly affects children under five years of age, particularly babies under the age of one. Brain damage associated with meningitis is unlikely caused by a brain edema (wrongly assumed to be a swelling of the meninges) but rather by vaccines containing neurotoxins such as formaldehyde, aluminium phosphate, or thimerosol that bypass the blood-brain barrier resulting in potentially serious neurological disorders, without a DHS!

http://www.nvic.org/CMSTemplates/NVIC/pdf/49-Doses-PosterB.pdf

If several healing phases happen to occur at the same time, the swellings in the brain can lead to an inflammation of the brain, termed **encephalitis**. Like meningitis, this has nothing to do with an "infection". Encephalitis might also develop after a brain injury or brain surgery. A swelling in the area of

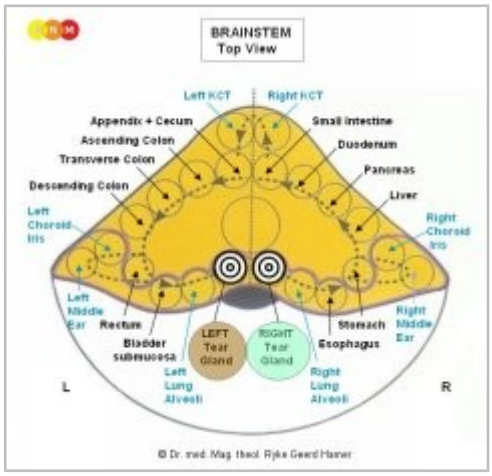
the spine (see osteosarcoma) can put pressure on the meninges of the spinal cord leading to **myelitis**. A large swelling might cause serious complications.

EYES



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE TEAR GLANDS: The tear glands are located in the temporal orbit (eye socket) on the outer portion of the upper eyelids. They produce the watery layer of the tear film that keeps the outer part of the eye and the conjunctiva moist. The tear fluid reaches the eye through the excretory tear ducts. Excess tears drain through the lacrimal canals, tear sac, and nasolacrimal duct into the nasal cavity. In evolutionary terms, the tear glands developed from the intestinal mucosa of the original gullet. Like the intestinal cells that digest the "food morsel", the biological function of the tear glands is to "digest" (secretory quality) the "visual morsel". The tear glands consist ofintestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the tear glands have two control centers that are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal.

The right tear gland is controlled from the right side of the brainstem; the left tear gland is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal

gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the tear glands is a "**morsel conflict"**, specifically, a conflict related to a "**visual morsel"** (see also choroid, iris, and ciliary body).

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

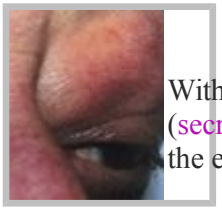
RIGHT TEAR GLAND

Equivalent to the right half of the mouth and pharynx, the **right tear gland** correlates to an"**ingoing morsel"** and to "**not being able to catch a visual morsel" because the morsel was ignored by someone else**. For example: A child has set eyes on a toy and expects to get it but the parents ignore it, hence, it could not grab the "visual morsel"; a child wants to see his friends or wants to watch TV but the parents don't allow it; a woman draws her husband's attention to a ring in a window of a jewellery shop and anticipates getting the ring, but he disregards the "visual morsel" she desires.

LEFT TEAR GLAND

Equivalent to the left half of the mouth and pharynx, the **left tear gland** relates to an"**outgoing morsel"** and to "**not being able to eliminate a visual morsel" because the morsel was ignored by someone else**. For example: A painter wants to sell his paintings but no one takes notice of them; a real estate agent is unable to sell a property, a salesman is left with his products; a person wants to get rid of "morsels" at a garage sale but no one shows up; due to a cancellation a lecturer is unable to share his presentation; a child shows its mother a drawing but she pays no attention.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the tear gland proliferate causing an **enlargement of the lacrimal gland**. The **biological purpose of the cell increase** is to enhance the production of tear fluid so that the "visual morsel" can be better absorbed (right tear gland) or expelled (left tear gland). Thus, the affected **eye is teary and watering** (see also nasolarcimal ducts and conjunctiva).

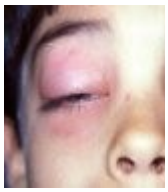


With continuing, intense conflict activity (hanging conflict) a cauliflower-shaped growth (secretory type) forms in the tear gland. A large swelling ("**lacrimal gland tumor"**) bulges the eyelid outwards, as shown in this picture.

NOTE: Baggy eyes are related to the kidney collecting tubules and an activeabandonment and existence conflict. The skin beneath the eyes is very thin; this is why the water retention is more noticeable in that area.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **swelling of the tear gland** caused by the edema (fluid accumulation) and **purulent eye discharge**. In PCL-B, the sticky pus dries up showing as yellowish **eye crust** around the eye(s). In conventional medicine, agglutinated and crusty eyelids are associated with "allergies" (see conjunctivitis).

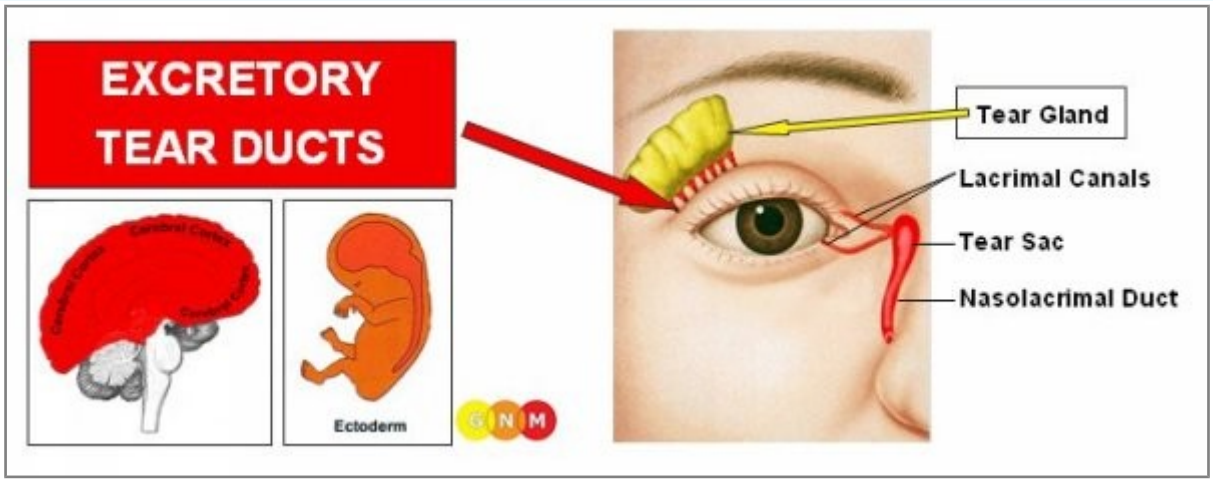
The healing phase might be accompanied by an inflammation (**dacryoadenitis**) with redness and painful swelling of the lacrimal gland. With the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict, the swelling increases even more. The condition occurs quite often in children.



RIGHT eye: not being able to catch a visual morsel

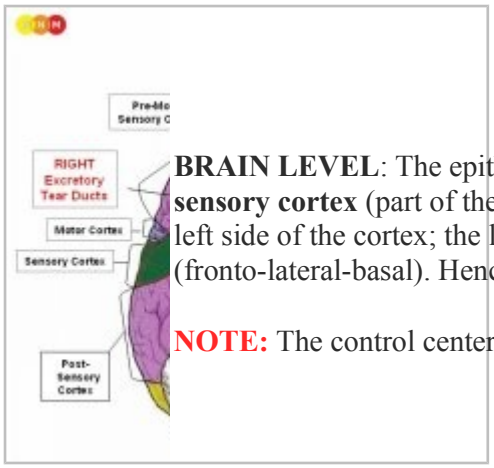
LEFT eye: not being able to eliminate a visual morsel

With a hanging healing due to constant conflict relapses more and more tear gland tissue is lost resulting in a decreased tear flow or a complete cessation of tear fluid production. The drying-up of the lacrimal flow (**xerophthalmia**) is termed**Sjogren's** or **Sicca syndrome** (see also dry eyes related to the excretory tear ducts, eyelid gland ducts, conjunctiva, and Sjogren's associated with a dry mouth).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

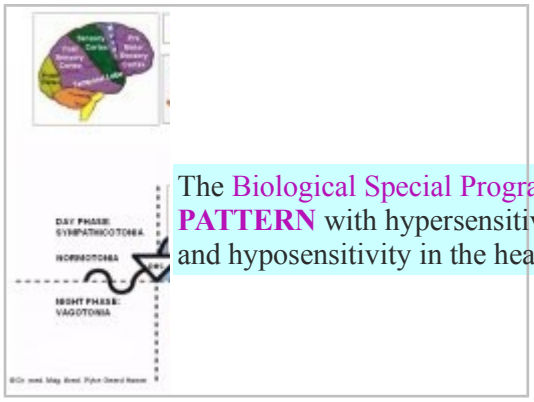
DEVELOPMENT AND FUNCTION OF THE TEAR DUCTS: The excretory tear ducts release the tear fluid produced by the tear glands into the top part of the conjunctiva and to the outer surface of the eyes. The lacrimal canals, which are two curved tubes located at the inner border of each eyelid, drain excess tears into the tear sac and through the nasolacrimal duct into the nasal cavity. The lining of the tear ducts consist of squamous epithelium, originates from theectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the tear ducts is controlled from the**premotor-sensory cortex** (part of the cerebral cortex). The right tear ducts are controlled from the left side of the cortex; the left tear ducts are controlled from the right cortical hemisphere (fronto-lateral-basal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The control centers are located closely to the brain relays of the eyelid gland ducts.

BIOLOGICAL CONFLICT: Similar to a separation conflict, the biological conflict linked to the tear ducts is "**wanting to be seen"** (not being noticed or overlooked, feeling visually ignored, not allowed to be seen) or "**not wanting to be seen"** (wanting to be invisible; a fear of getting caught, let's say, in a criminal act, a sexual act, or when cheating).



The Biological Special Program of the tear ducts follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

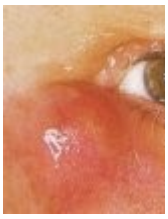
CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the tear ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts in order to increase the tear flow. The "shiny eyes" makes the one who has been overlooked more eye-catching (in Nature, this is vital to attract a mate).**Symptoms** are **teary eyes** and potentially painful pulling in the affected tear duct. With an acute conflict the tearing could be excessive (see also watery eyes related to the tear glands and the conjunctiva).

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. Depending on the intensity of the conflict-active phase, the swelling could lead to an **obstruction of the tear ducts** causing **dry eyes**. A chronic condition because of continual conflict relapses is called **Sjogren's** or **Sicca syndrome** (see also dry eyes related to thetear glands, eyelid gland ducts, conjunctiva), and Sjogren's associated with a dry mouth). However, in this case, Sjogren's is not preceded by a swelling of the tear glands. An occlusion of the excretory tear ducts leads to an enlargement of the entire tear gland. The swelling is therefore frequently misdiagnosed as a lacrimal gland tumor.

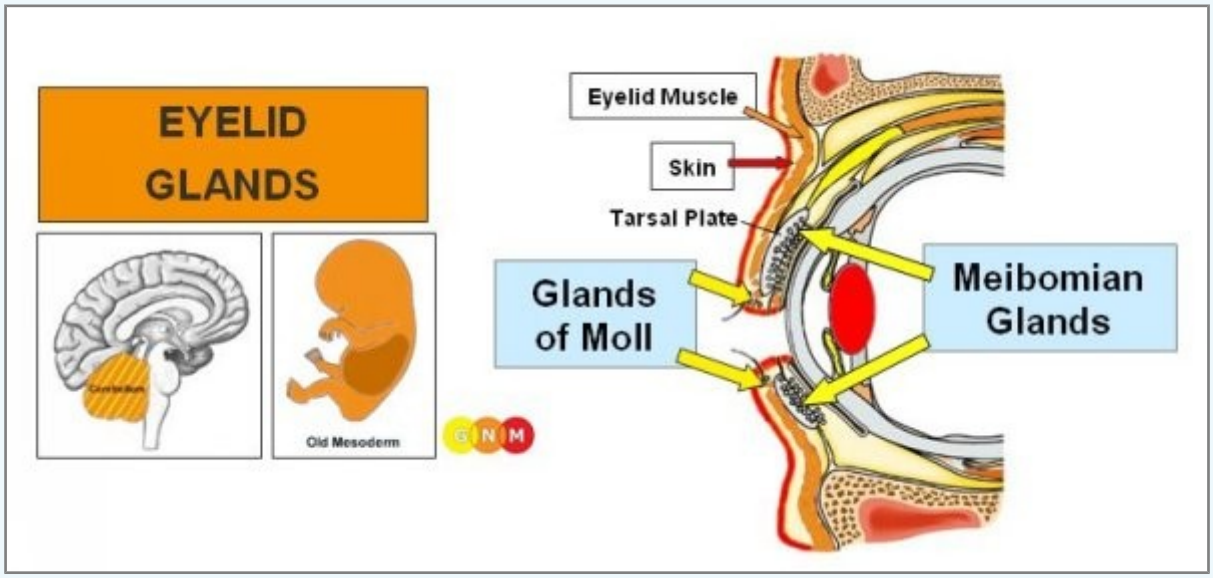
NOTE: Whether the tear ducts of the right or left eye are affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

Blocked tear ducts are quite common in infants. In infants and newborns the condition reveals the distress of "wanting to be seen" (not getting enough attention) or "not wanting to be seen" (too many visitors stopping by to see the new baby).

If the nasolacrimal ducts are blocked, tears cannot empty into the nasal cavity. The back-up of tears results in **watery and teary eyes**. An obstruction of the nasolacrimal duct with swelling and redness in the area between the eye and the nose, including the lacrimal sac, is called **dacryocystitis** ("tear sac infection").

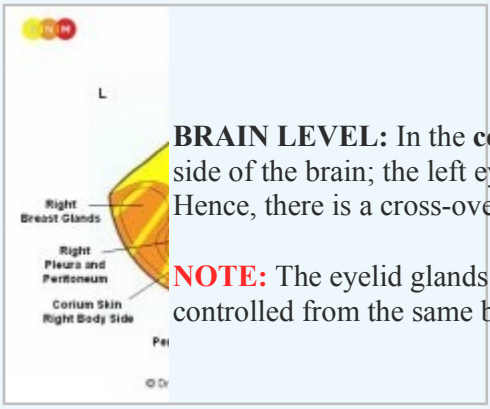


This picture shows a child with a large swelling of the left nasolacrimal duct. If the child is right-handed, this indicates that the conflict (wanting to be seen or not wanting to be seen) was associated with the mother but has now been resolved. With concurrent water retention (theSYNDROME) due to an active abandonment conflict the swelling increases considerably.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE EYE LID GLANDS: The eyelids are movable folds of skin that cover and protect the eyes. The eyelashes attached to the upper and lower eyelids form a second protective shield against dust and other elements that could injure the eye. The outermost layers of the eyelid consist of epidermal tissue (outer skin) andfat tissue. Two eyelid muscles allow the opening and closing of the eyelids. The inside of the lids are lined with theconjunctiva. The main function of the eyelids is to keep the front surface of the eyeball and cornea moist. The**meibomian glands**, or tarsal glands, are a special type of oil-producing sebaceous glands located at the rim of the upper and lower eyelids inside the tarsal plate. Close to the base of the eyelashes are also sweat glands, called the**glands of Moll** (both the sebaceous glands and sweat glands are embedded in the corium skin). The excretory ducts of the eyelid glands carry the oily sebum into the tear film to lubricate the eye during blinking. The eyelid glands originate from the old mesoderm and are therefore controlled from the cerebellum.



BRAIN LEVEL: In the **cerebellum**, the right eyelid glands are controlled from the left side of the brain; the left eyelid glands are controlled from the right brain hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The eyelid glands are embedded in the corium skin of the eye. They are therefore controlled from the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the eyelid glands is an attack conflict, specifically, an **attack against the eye** (see also corium skin).

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

Dust, sand, or other particles (or a bug) hitting the eye can be registered as an attack conflict. In a figurative sense, the "attack" could be triggered by an insulting look (the "evil eye") or a look of approach. The conflict also relates to **feeling disfigured, soiled or "dirty" concerning the eyelids**. A "yucky" touch or kiss on the eye(s) might activate the conflict. Buying into the theory that touching the eyes after contact with a person who has a cold causes an "eyeinfection" only creates a predisposition for the conflict.

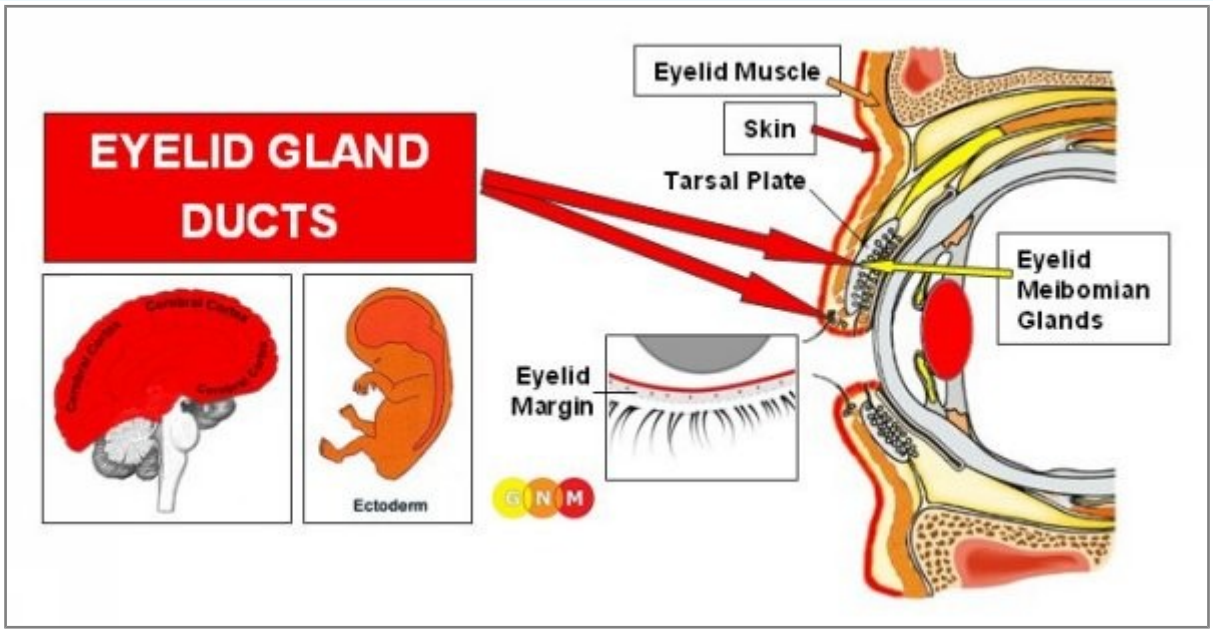
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the eyelid glands proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to provide an external reinforcement in order to protect the eyelid against further "attacks". If the conflict persists, a bulb-shaped growth forms at the site, possibly diagnosed as an **eyelid tumor** (compare with a melanoma of the eyelid involving the corium skin).

HEALING PHASE: Following the conflict resolution (CL), fungi or bacteria remove the cells that are no longer needed. During the healing process, the affected area swells up causing what is referred to as a **stye** (hordeola). The painful sore is **red and filled with pus**.

NOTE: Whether the right or left eyelid is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the eye that was associated with the "attack".

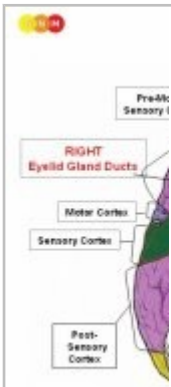
External styes involve the glands of Moll. They develop on the upper or lower lid margin at the base of the eyelashes.**Internal styes** relate to the meibomian glands and occur on the inside of the eyelid. If the meibomian glands become blocked and inflamed this results in a so-called **chalazion** (see right picture above), presenting as a granuloma that typically forms inside the upper eyelid. A chalazion is usually an indication of a hanging healing due to frequent conflict relapses. Feeling disfigured because of the appearance of the style prolongs the healing phase.

If the required microbes are not available at the time, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE EYELID GLAND DUCTS: The excretory ducts of the eyelid glands are located along the margin of the eyelid. They carry the oily substance (sebum) produced in the meibomian glands into the tear film to keep the eyes moist and prevent tears from evaporating too quickly. The eyelid gland ducts consist ofsquamous epithelium, originate from the ectoderm and are therefore controlled from the cerebral cortex.

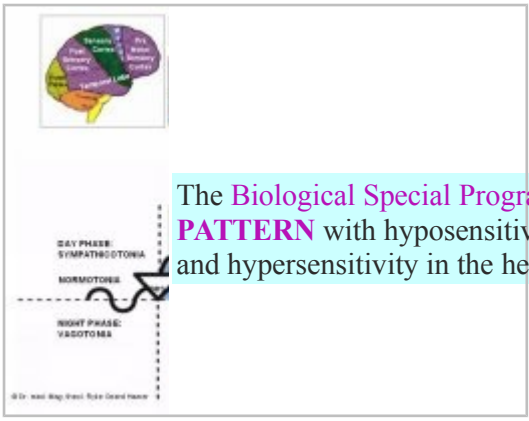


BRAIN LEVEL: The epithelial lining of the eyelid gland ducts is controlled from the **pre-motor sensory cortex** (part of the cerebral cortex). The right eyelid ducts are controlled from the left side of the cortex; the left eyelid ducts are controlled from the right cortical hemisphere (fronto-lateral-basal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The control centers are located closely to the brain relays of the excretory tear ducts.

BIOLOGICAL CONFLICT: The biological conflict linked to the eyelid gland ducts is a **visual separation conflict**experienced as **having lost sight of someone**, for example, of a loved one who has moved away, has left or has died (see also outer skin of eyelid, conjunctiva, cornea and lens). The conflict also relates to **not being allowed** or **not wanting to see someone** (a specific person or certain people). **NOTE:** A visual separation conflict only refers to people and animals such as a pet but not to objects (ring, car, favorite toy) or a home. This would instead involve the tear glands or the uvea of the eye.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

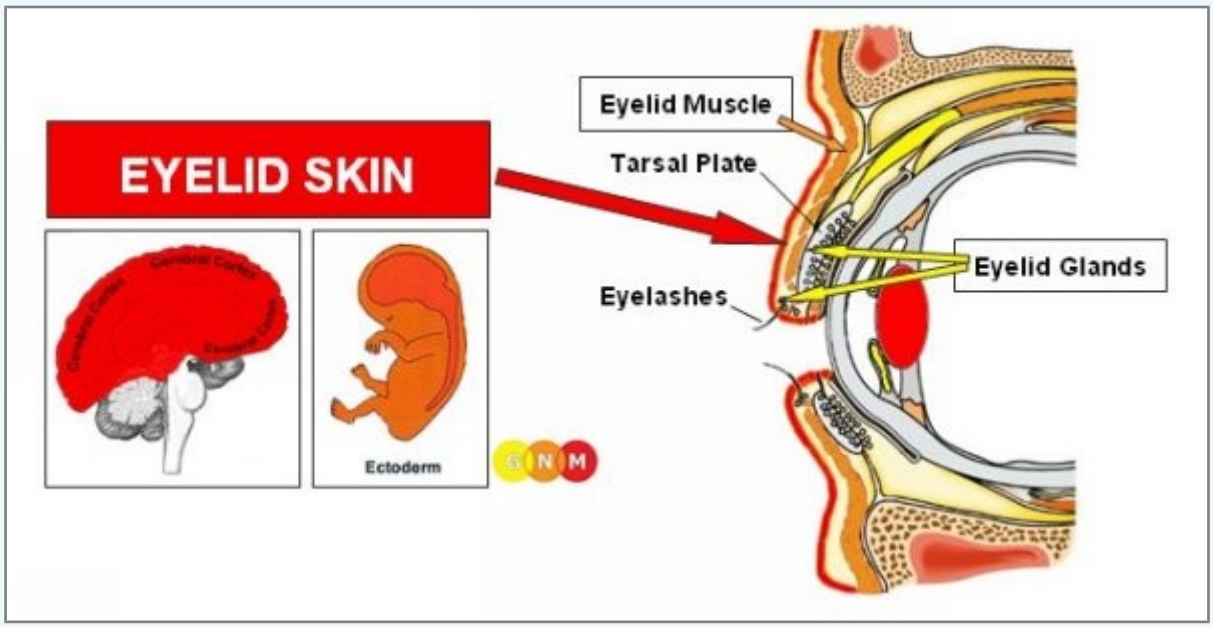


The Biological Special Program of the eyelid gland ducts follows the**OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the eyelid gland ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts to increase the flow of lipids to keep the eye lubricated. In Nature, the clearer vision allows to quickly recognize a new mate that "strikes the eye".

NOTE: Whether the ulceration occurs in the right or left eyelid gland ducts is determined by a person'shandedness and whether the conflict is mother/child or partner-related.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. The swelling might occlude the ducts (called "obstructive meibomian gland disease"). The blockage leads to a thinning of the lipid tear film layer and increased evaporation of tears causing **dry eyes**. If the symptom becomes chronic because of conflict relapses, then the condition is termed **Sjogren's** or **Sicca syndrome** (see also dry eyes related to the tear glands, excretory tear ducts,conjunctiva, and Sjogren's associated with a dry mouth).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE EYELID SKIN (EPIDERMIS): The eyelid skin consists of two layers: thecorium skin containing oil-producing sebaceous glands and the outer skin (epidermis). The inside of the eyelid is lined with the conjunctiva. The outer eyelid skin, which is relatively thin, is supported by the tarsal plate to which the eyelid muscles are attached. The outer skin of

the eyelid consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

BRAIN LEVEL: The eyelid skin (epidermis) is controlled from the **sensory cortex** (part of the cerebral cortex). The right eyelid skin is controlled from the left side of the sensory cortex; the left eyelid skin is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the eyelid skin is a **visual separation conflict**, specifically,**having lost sight of a person while one had the eyes closed**. For example, a loved one left or died unexpectedly while one was asleep; a mother lost sight of her infant while she was dozing off (compare with visual separation conflict related to the eyelid gland ducts, conjunctiva, cornea and lens). The skin of the eyelid also relates to a separation conflict(loss of physical contact) of **wanting to be touched on the eyelid** (caressed or kissed) or **not wanting to be touched** there (see outer skin). **NOTE:** A visual separation conflict only refers to people and animals such as a pet but not to objects (ring, car, favorite toy) or a home. This would instead involve the tear glands or the uvea of the eye.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

NOTE: Whether the right or left eyelid is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

The Biological Special Program of the eyelid skin follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

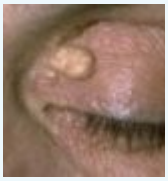
CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the eyelid skin proportional to the degree of conflict activity. The ulcerative process makes the **eyelid skin dry and flaky**. The Biological Special Program of the outer skinis always accompanied by a **short-term memory loss**, which serves the purpose to forget temporarily the one who is absent, here, specifically, the one who is out of sight.

HEALING PHASE: During the healing phase (in PCL-A the ulcerated area is replenished with new

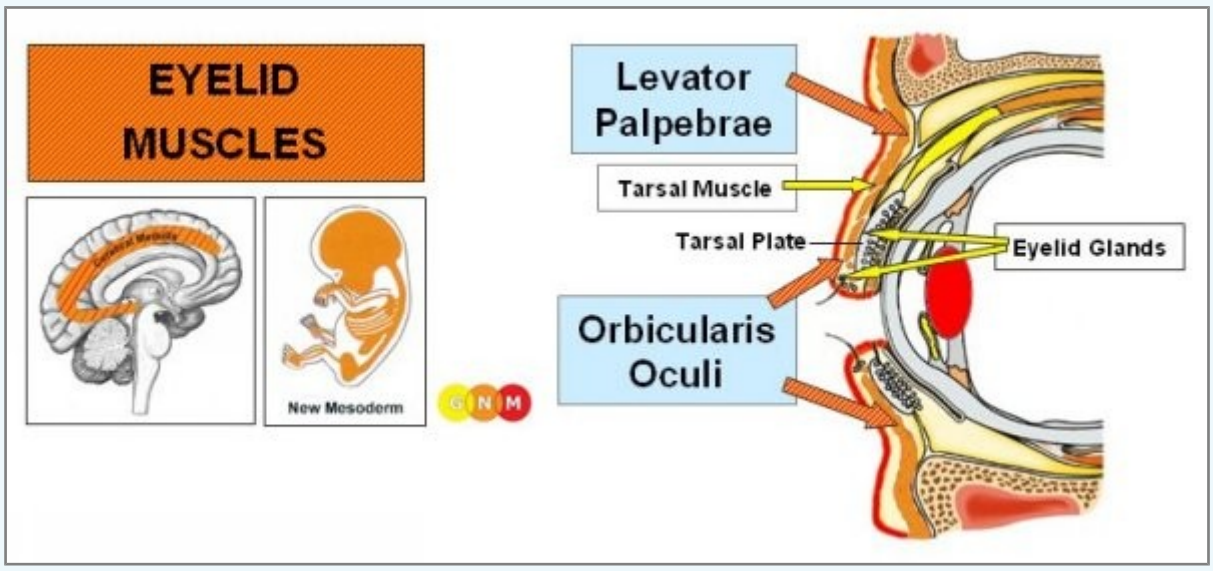
cells. With an inflammation the condition is called **blepharitis**. The symptoms, including swelling, redness, a burning sensation and itching, range from mild to severe, depending on the intensity of the conflict-active phase.

This picture shows blepharitis on the left eye, indicating the healing of a visual separation conflictassociated with a partner, if the person is left-handed. For a right-hander the conflict relates to his/her mother or child.

The healing process might also present as a **rash on the eyelid (eyelid dermatitis)**.

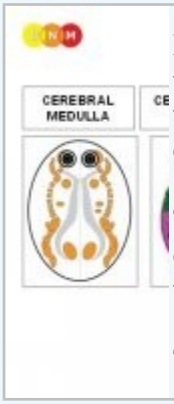


A fat nodule on the eyelid, called a **xanthelasma**, is linked to a self-devaluation conflictassociated with the eye (see fat tissue).



Levator Palpebrae Muscle **Orbicularis Oculi Muscle**

DEVELOPMENT AND FUNCTION OF THE EYELID MUSCLES: The eyelids contain three main muscles that control the movement of the eyelid. The two muscles involved in opening the upper eyelid are the **levator palpebrae muscle** (for voluntary opening) and the **tarsal muscle** (for involuntary opening). The **orbicularis oculi muscle** in the upper and lower eyelid controls the closing of the eye. As the eye elevates the levator muscle contracts and raises the eyelid; when the levator relaxes, the eyelid closes passively. Active eyelid closure to protect the eyes from injury and from excessive light (see pupil muscles) is achieved by the contraction of the orbicularis oculi. The eyelid muscles also control the blink reflexes. Blinking provides moisture to the eyes and the cornea by using tears (produced in the tear glands) and oily substances (secreted by the eyelid glands) to keep it from drying out. The eyelid muscles are attached to the tarsal plate that gives the lids shape and strength. Underneath and within the tarsal plate lie the meibomian glands. The levator palpebrae and orbicularis oculi consist of striated muscles, originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The levator palpebrae and orbicularis oculi have two control centers in the cerebrum. The trophic function of the muscles, responsible for the nutrition of the tissue, is controlled from the **cerebral medulla**; the ability to move the eyelids is controlled from the **motor cortex** (part of the cerebral cortex).

The eyelid muscles of the right eyelid are controlled from the left side of the cerebrum; the eyelid muscles of the left eyelid are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

The smooth tarsal muscle is controlled from the midbrain.

LEVATOR PALPEBRAE MUSCLE

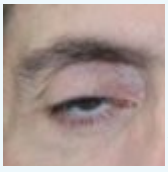
BIOLOGICAL CONFLICT: The biological conflict linked to the levator papebrae muscle is **not being able to keep the eye(s) open** (because of extreme fatigue, working night shifts) or **not having kept the eye(s) open** (having been wide awake) **at the right time** (having missed a red traffic light or an important visual message, e.g., on a blackboard or screen; having overlooked something of importance such as the small print of a contract). Certain professions, for example, policemen, detectives, pilots, professional drivers, people attending monitors and other devices used for observation are more susceptible to suffer this type of conflict. The levator muscle also relates to **not being allowed to keep the eye(s) open** (being prohibited to see or watch something) or **not wanting to keep the eye(s) open**(wanting to avoid seeing something distressing).

NOTE: Whether the levator muscle of the right or left eyelid is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of the levator palpebrae (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the levator muscle** (controlled from the motor cortex).

NOTE: The striated muscles belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but 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, retinaand vitreous body of the eyes) or hyperfunction (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

Because of the weakness or paralysis of the levator muscle, responsible for raising the eyelid, the **upper eyelid sags**and fails to fully open. Depending on the intensity of the conflict, the droop may be barely noticeable or the eyelid can descend over the entire pupil. Yet, the eyelid doesn't close to cover the eye completely since the tarsal muscle prevents a complete closing. In medical terms, a drooping eyelid is called **blepharoptosis** (or **ptosis**). The inability to fully close the eyelid is termed **lagophthalmos**.



If the right upper eyelid droops, as seen in this image, the conflict is partner-related provided the person is right-handed.

HEALING PHASE: During the healing phase the levator muscle is reconstructed; the paralysis reaches into PCL-A. TheEpileptoid Crisis manifests as eyelid muscle spasms (**blepharospasm)**. Depending on the

degree of the conflict-active phase, the rapid movement of the eyelid ranges from minor **eyelid fluttering** to strong **eyelid twitching or eyelid tics** (compare with facial tics). In PCL-B the function of the eyelid muscle returns to normal.

Excessive eye blinking also involves the levator muscle. The explicit **conflict linked to the blink reflex** is **feeling sussed out or figured out**, for example, when someone was caught cheating, lying, or playing tricks. The rapid blinking occurs during the Epileptoid Crisis and is typically triggered when setting on a track, for example, when the person is telling a lie.

ORBICULARIS OCULI MUSCLE

BIOLOGICAL CONFLICT: The biological conflict linked to the orbicularis oculi muscle is **not being able to close the eyes** (in order to avoid seeing something unpleasant or undesirable; wanting to turn a "blind eye" to something) or **not having closed the eyes at the right time** (accidents caused by exposure to fire or explosives or by unsafe work with a welding device). The orbicularis oculi also relates to **not being allowed to close the eyes** (not being permitted to sleep or not getting enough sleep, for example, mothers with newborns, students working on last-minute term papers, shift workers, long-distance truck drivers) or **not wanting to close the eyes** (kids refusing to nap).

NOTE: Whether the orbicularis muscle of right or left eyelid is affected is determined by a person's handednessand whether the conflict is mother/child or partner-related.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of the orbicularis oculi of the upper or lower eyelid (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the orbicularis oculi muscle** (controlled from the motor cortex).

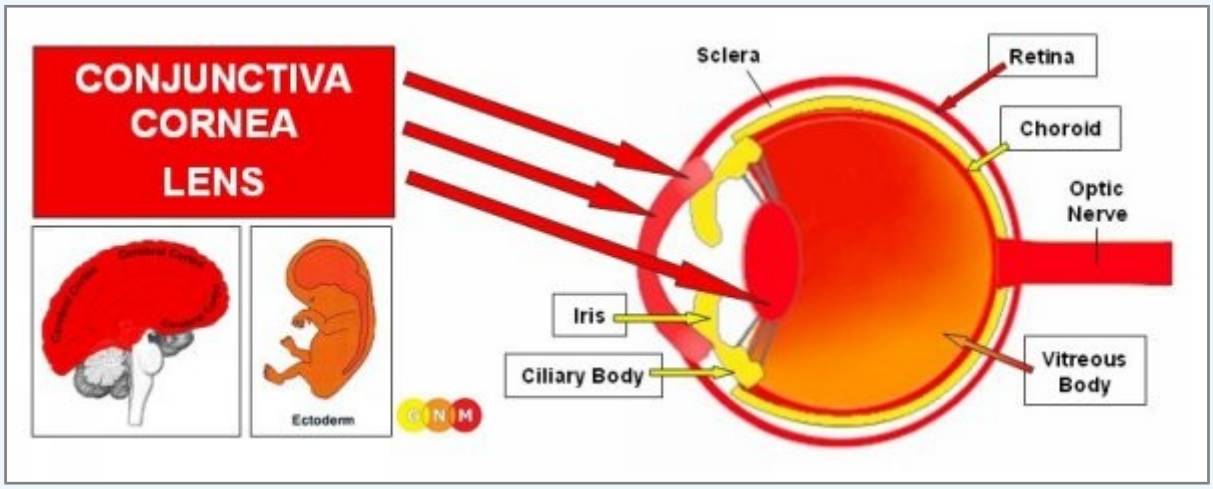
NOTE: The striated muscles belong to the group of organs that respond to the related conflict with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

Because of the weakness or paralysis of the orbicularis oculi muscle, responsible for closing the eyelid, the upper and lower **eyelid cannot be closed properly** (see also facial paralysis with the inability to close the eye on the paralyzed side. The orbicularis oculi and the facial muscles are both supplied by the facial nerve).

If the **lower eyelid** is affected, the **decreased tension** of the orbicularis oculi causes the lower lid to sag outwards, away from the eye. This condition is known as an **ectropion** (see picture). If the upper eyelid is affected, the upper eyelid droops (compare with ptosis related to the biological conflict of the levator palpebrae muscle.

HEALING PHASE: During the healing phase the orbicularis oculi muscle is reconstructed; the paralysis reaches intoPCL-A. The Epileptoid Crisis manifests as eye muscle spasms (**blepharospasm)** of the upper or lower eyelid. Depending on the degree of the conflict-active phase, the rapid movement of the eyelid ranges from minor **eyelid fluttering** to strong **eyelid twitching or eyelid tics** (see also facial tics).
In PCL-B the function of the eyelid muscle returns to normal.

With a hanging healing due to continual conflict relapses the prolonged **increased tension** of the orbicularis oculi of the **lower eye lid** causes the eyelid to fold inwards. This condition, called an**entropion**, is quite uncomfortable since the eyelashes constantly rub against the eye leading to redness and irritation of the eye.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

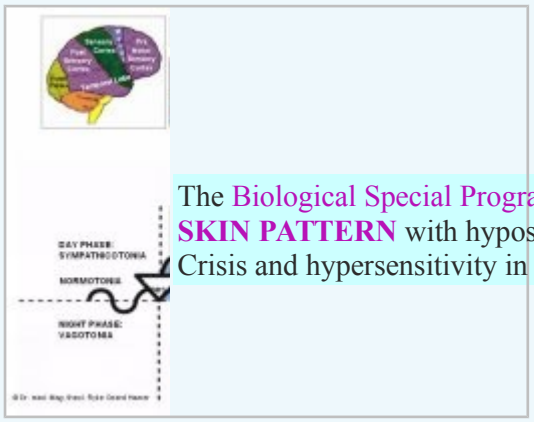
DEVELOPMENT AND FUNCTION OF THE CONJUNCTIVA, CORNEA, AND LENS: The **conjunctiva** is a clear mucous membrane that lines the sclera (the white of the eye) and the inside of the eyelid. The main function of the conjunctiva is to produce tears to keep the front surface of the eyeball moist. The larger volume of tear fluid, however, is secreted by the tear glands. The **cornea** is a transparent structure that covers the iris and the pupil. The cornea controls the entry of light into the eyes. When light strikes the cornea it refracts the incoming light onto the lens that refocuses the light onto the retina. The crystalline **lens** is located behind the iris and held in place by the ciliary muscles that allow to alter the shape of the lens in order to get sharp images of objects at various distances. Both the cornea and the lens are responsible for the eye's focusing power and for fine-tuning the vision process. The conjunctiva, cornea, and lens consist of squamous epithelium, originate from the ectoderm and are therefore controlled from the cerebral cortex.

BRAIN LEVEL: The conjunctiva, cornea, and lens are controlled from the **sensory cortex** (part of the cerebral cortex). The conjunctiva, cornea, and lens of the right eye are controlled from the left side of the sensory cortex; the conjunctiva, cornea, and lens of the left eye are controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the conjunctiva, cornea, and lens is a **visual separation conflict** of **having lost sight of someone**, for example, of a loved one who has moved away, left, or has died (see also eyelid gland ducts and outer skin of eyelid). This includes having lost sight of a pet. The conflict also relates to **not being allowed to see someone** (a grandchild, a lover, a friend, a school mate, a relative in the hospital) or **not wanting to see someone** ("get out of my sight!").

The fear of not being able or not being permitted to see a certain person might already trigger the conflict. The degree of the conflict determines which one of the three tissues will be affected by the DHS. The conjunctiva is associated with a moderate visual separation conflict, the cornea with a more severe conflict; the lens is affected when the conflict is experienced as very intense. **NOTE:** A visual separation conflict only refers to people and animals such as a pet but not to objects (ring, car, favorite toy) or a home. This would instead involve the tear glands or the uvea of the eye.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

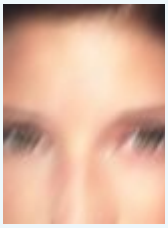


The Biological Special Program of the conjunctiva, cornea, and lens follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the conjunctiva, cornea, or lens. In the lens, the **loss of crystalline cells**improves the reception of light and therefore the visual acuity with the **biological purpose** that the person fading from one's sight will be longer visible. The enhanced distant vision also increases the chance of detecting a lost "pack member" in the far distance. The Biological Special Programs of the conjunctiva, cornea, and lens are accompanied by a**short-term memory loss**, which serves the purpose to forget temporarily the one who is out of sight (see separation conflict related to the skin).

NOTE: Whether the conjunctiva, cornea, or lens of the right or left eye is affected is determined by a person'shandedness and whether the conflict is mother/child or partner-related.

In the **conjunctiva**, the **ulceration makes the eye(s) dry** (see also dry eyes related to the tear glands , excretory tear ducts, and eyelid gland ducts).



In the **cornea**, the prolonged ulceration leads to a so-called **keratoconus** in which the normally round cornea becomes thin and begins to bulge into a cone-like shape. The asymmetrical, unequal shape of the cornea causes **astigmatism** with **distorted and double vision** (see also healing phase). Typical is a constant blur for both near and distant vision. Because of the cornea's function to refract light, people with astigmatism are **light sensitive**.

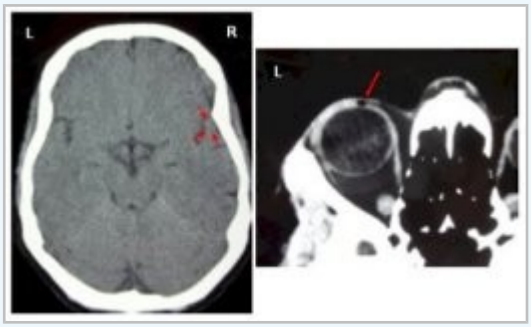
If the cornea's angle of curvature becomes to steep, this causes **nearsightedness** or **myopia** (see also smooth ciliary muscles and retina). **Farsightedness** or **hyperopia** occurs when the cornea has too flat of an angle (see also striated ciliary muscles and retina).

HEALING PHASE: During the healing phase the cell loss is restored and replenished.

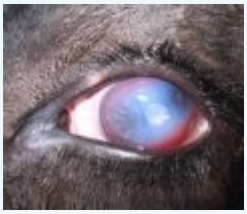
Concerning the **lens**, the healing process manifests as **clouding of the lens** with a **fuzzy or hazy vision** (there are no symptoms in the conflict-active phase). If the healing phase cannot be complete because of continuous conflict relapses, the clouding remains (see picture). A permanent opacity of the lens is called a "**grey cataract"** (compare with "green cataract" related to thevitreous body).

According to conventional medicine, cataracts are considered a normal part of the aging process even though not every person develops a cataract at an older age. From a GNM point of view, it is rather the increasing incidences of visual separation conflicts – from a parent, a spouse, a long-time companion or friend – why cataracts are much more common in older people.

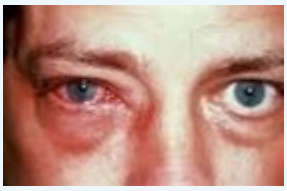
In the **cornea**, the healing symptom presents as **clouding of the cornea**. With an inflammation the condition is called**keratitis**. The symptoms include pain, redness and blurry vision. With constant conflict relapses the **astigmatism** (seeconflict-active phase) becomes permanent due to recurrent scarring processes in the cornea.



In the left image we see a Hamer Focus (in PCL-A) on the right side of the sensory cortex in the area that controls the cornea of the left eye (view the GNM diagram). A look at the orbit section (right image) confirms that a healing process in the cornea (red arrow) is under way.

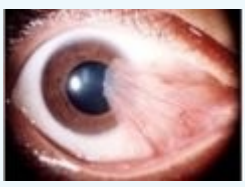


This picture shows a dog with keratitis in the left eye. If the dog is left-pawed, this indicates that the visual separation conflict is linked to a "partner" such as his master or another dog or animal friend.

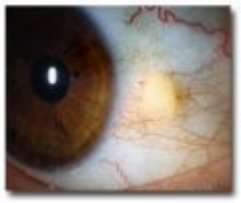


Conjunctivitis (pink eye) with red, burning, itchy, and watery eyes occurs when the**conjunctiva** is in healing (see also watery eyes related to the tear glands or nasolacrimal ducts). The inflammation often involves the inside of the eyelids (compare with blepharitisrelated to the eyelid skin). The symptoms range from mild to severe, depending on the intensity of the conflict-active phase. For a right-handed person, the right eye is affected if thevisual separation conflict is associated with a partner; if the person is left-handed the conflict ismother/child-related.

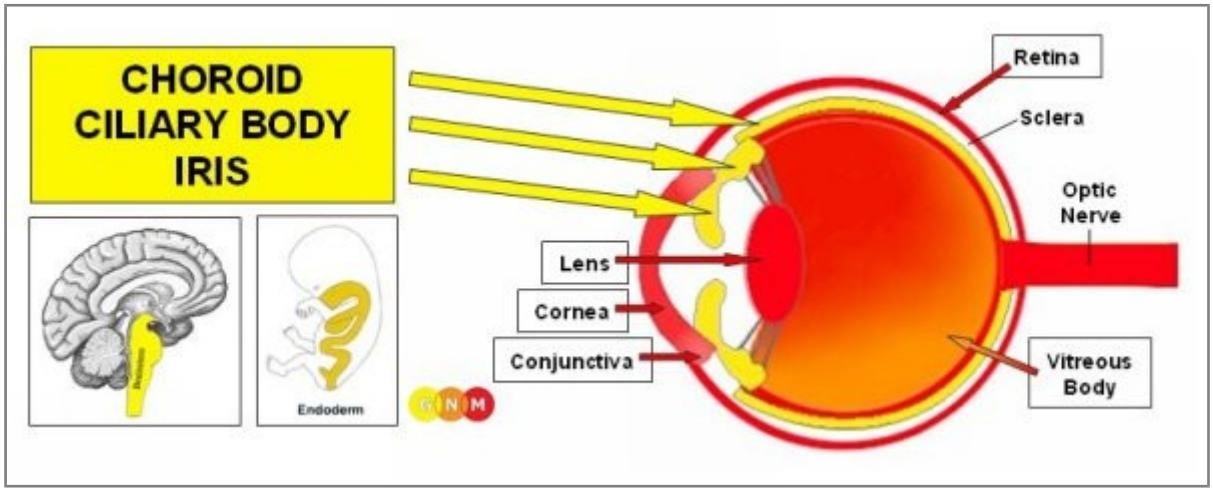
Conjunctivitis is commonly associated with "allergies" and assumed to be caused by the exposure to pollen. With concurrent cold symptoms such as a runny nose, the "allergy" is called "**hay fever"**. In GNM terms, the combination of the symptoms is a sign that the healing phase of a visual separation conflict and of "scent or stink conflict" related to thenasal mucosa happen simultaneously. Agglutinated and crusty eyelids reveal that an additional "visual morsel conflict" involving the tear glands has also been resolved.



A so-called **pterygium** is the result of a prolonged healing process (hanging healing) with a buildup of scar tissue that grows from the conjunctiva towards the center of the eye onto the cornea.

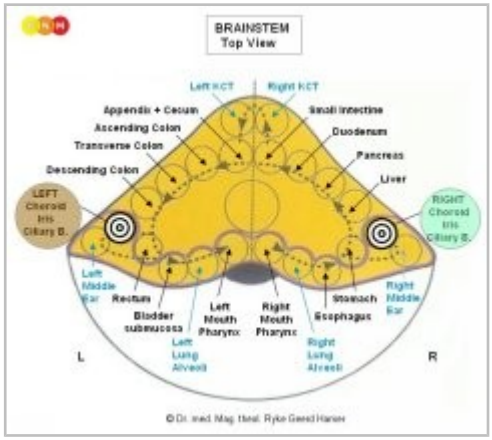


A **pinguecula** (“eye bump”) is a yellowish or white patch growing on the conjunctiva, also a result of a hanging healing due to continuous conflict relapses. Unlike a pterygium, the growth does not reach into the cornea.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CHOROID, IRIS, AND CILIARY BODY: The choroid, iris, and ciliary body are collectively called the uvea. The **choroid** lines the inner surface of the eyeball and supplies the overlying retina with nutrition. The **iris** in the front of the eye is part of the choroid. The iris helps to regulate the amount of light that enters the eye (see also cornea) and is therefore functionally closely tied to the pupils. The **ciliary body** connects the choroid with the iris. The ciliary body produces a watery fluid to keep the eye moist and secretes a gel-like substance which fills the vitreous body. It also contains the ciliary muscles that control the shape of the lens to allow clear vision. The uvea contains considerable amounts of melanin pigments to protect the eye from excess light (see also corium skin). In the iris, the quantity of melanin determines the color of the iris ranging from brown to blue. In evolutionary terms, the choroid, iris, and ciliary body constitute the primordial eye cup that developed from the intestinal mucosa of the originalgullet (see also pupil muscles and ciliary muscles). Like the intestinal cells and digest the “food morsel”, the biological function of the uvea is to “absorb” (resorptive quality) and to “digest” (secretory quality) the “visual morsel”. The choroid, iris, and ciliary body consist of intestinal cylinder epithelium, derive from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the choroid, iris, and ciliary body have two control centers that are positioned in close vicinity to the brain relays that control the organs of the alimentary canal.

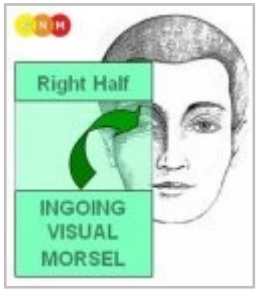
The choroid, iris, and ciliary body of the right eye are controlled from the right side of the brainstem; the choroid, iris, and ciliary body of the left eye are controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The optic nerve emerged from the brain relays that innervated the primordial eyecup (today’s choroid).

BIOLOGICAL CONFLICT: The biological conflict linked to the choroid, iris, and ciliary body is a "**morsel conflict"**, specifically, a conflict related to a "**visual morsel"** (see also tear glands).

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

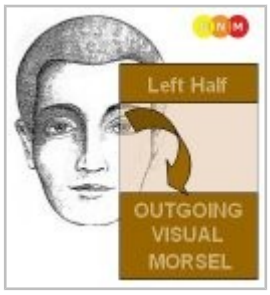
UVEA OF THE RIGHT EYE



Equivalent to the right half of the mouth and pharynx, the **choroid, iris, and ciliary body of the right eye** correlate to an "**ingoing morsel"** and to "**not being able to catch a visual morsel"**.

In biological terms, the ingoing "visual morsel" is equal to nourishment (see also sound morsel related to the middle ear and Eustachian tubes). Figuratively speaking, the conflict experience is "I want to devour what I desire with my eyes". What one is "drooling" to see can relate to anyone or anything one is not or no longer able to see or not allowed to see, for example, a beloved person or a home one had lost. It might also be about something one had anticipated to see (a certain person, paper money, a toy, a TV program, a vacation resort) and could unexpectedly not visually "grab" or "catch sight of". The fear of becoming blind ("not being able to catch a visual morsel") triggered, for example, by a MS diagnosis, a diabetes diagnosis (see diabetic retinopathy), or the negative prognosis of a macular degeneration could also prompt the conflict.

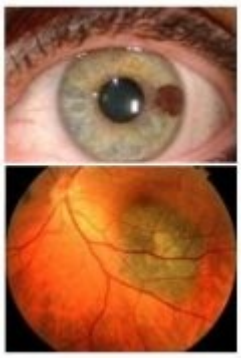
UVEA OF THE LEFT EYE



Equivalent to the left half of the mouth and pharynx, the **choroid, iris, and ciliary body of the left eye** correspond to an "**outgoing morsel"** and to "**not being able to eliminate a visual morsel"** (originally, the feces morsel).

Such an undesired "visual morsel" relates to any "eye sore" one wants to get rid of ("I can't bear the look at it") or images one wants to erase from one's memory. Eye-witnessing an accident or crime, seeing a spouse or partner with someone else, or watching something disturbing on TV can activate the conflict. Children suffer the distress when "catching" their parents or witnessing family abuse. The unwanted "visual morsel" could also be a person one does no longer want to see (a relative, parent, ex-spouse, "friend", colleague, teacher, visitor).

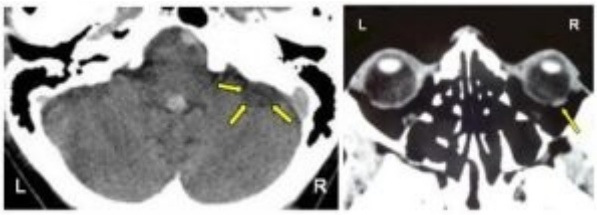
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the choroid, iris, and ciliary body proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to be better able to absorb (right eye) or expel (left eye) the "visual morsel". Which one of the tissues is affected is random.



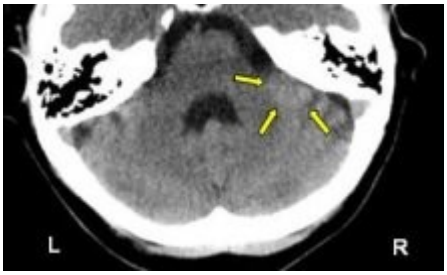
With prolonged conflict activity a flat (resorptive type) or compact (secretory type) growth develops from the pigmented cells of the uvea. In conventional medicine, this is called a **ciliary body melanoma**, **iris melanoma** (upper picture) **choroid melanoma** (lower picture). Histologically, the term "melanoma" is actually incorrect since the uvea does not have a corium skin; the term "adenoma" would be more applicable. The same pertains to what is called"**retinitis pigmentosa**" which is, according to Dr. Hamer's findings, a condition of the choroid (choroid adenoma) rather than of the retina.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required.

In the **choroid**, the tubercular lesions are visible as white spots behind the retina which; they disappear with the completion of the healing phase. A continuous decomposing process, however, creates **caverns in the choroid** that are eventually filled with calcium deposits. The loss of pigmentation causes **light sensitivity**.

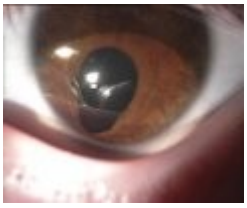


On the left image we see a brain edema (in PCL-A) on the right side of the brainstem in the area that controls the choroid of the right eye (view the GNM diagram). On a brain scan the fluid accumulation presents as dark (hypodense). The orbit section (right image) shows the presence of TB bacteria (yellow arrow).



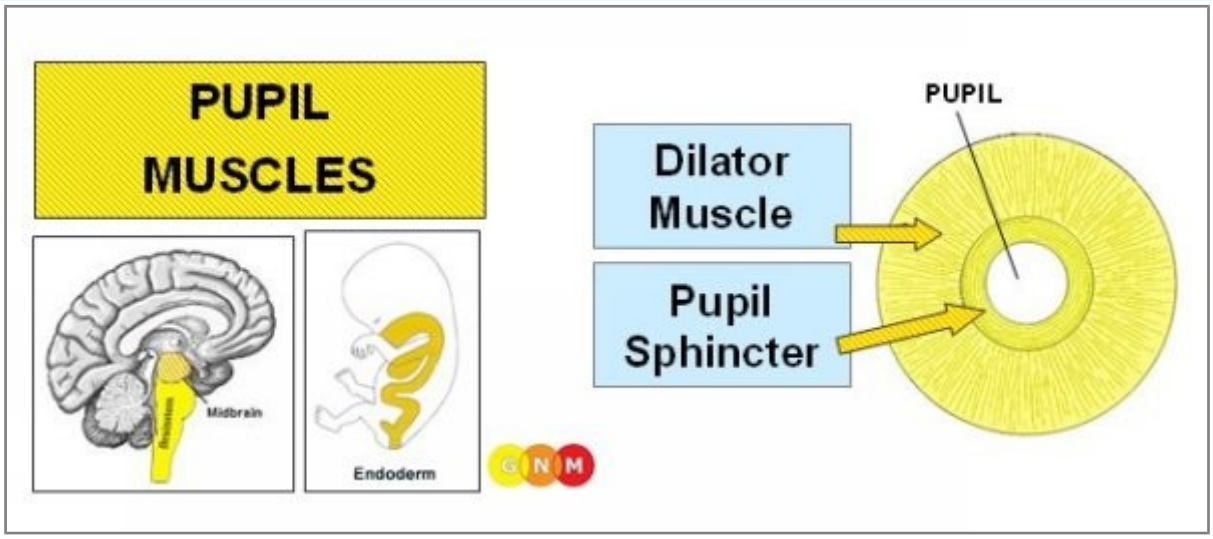
During the second part of the healing phase (in PCL-B) glial cells proliferate at the site to restore the brain relay where the visual morsel conflict was registered. On a brain CT the glia accumulation shows as white (hyperdense). In conventional medicine, the glia buildup is wrongly believed to be a "brain tumor".

NOTE: The optic nerve is a paired nerve that transmits visual information from the retina to the visual cortex at the back of the brain. It is one of the two cranial nerves (the other being the olfactory nerve innervating theolfactory bulb) that are a protrusion of the cerebrum. The optic nerves are largely composed of glial cells. An enlargement of the optic nerve is therefore referred to as an "optic nerve glioma", or optic neuroma, which can arise anywhere along the pathway of the optic nerve. In GNM terms, an **optic neuroma** that develops in the brainstem (in PCL-B) originates from a "visual morsel" conflict involving the choroid (compare with acoustic neuroma related to a "sound morsel" and the acoustic nerve).



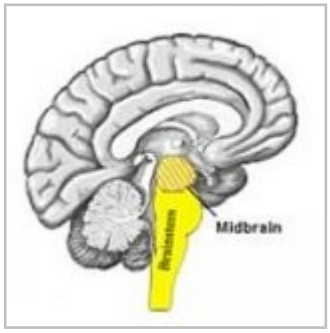
In the **iris**, lasting tuberculosis leads eventually to a loss of iris tissue (**coloboma**) with the result that the pupil becomes larger at that area.

Iritis is a painful inflammation of the iris. The condition can occur together with **choroiditis**, an inflammation of the choroid. **Uveitis** involves the entire uvea.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PUPIL MUSCLES: The pupil is the black round hole in the center of the iris. Its blackness is due to the lack of reflection of light from within the eye. The pupils consist of two muscles that regulate the amount of light that enters the eye. The **dilator muscle** widens the pupils allowing more light to pass through the eyes; the **pupil sphincter** narrows the pupils so that less light reaches the retina. In bright light the sphincter muscle contracts while the dilator muscle relaxes, making the aperture smaller. In dim light the sphincter muscle relaxes while the dilator muscle contracts, opening up the aperture. The dilator muscle is supplied by sympathetic nerves, which is why the pupils become large during stress (sympathicotonia) or sexual arousal. The pupil sphincter is supplied by parasympathetic nerves making the pupils small during relaxation (vagotonia). In evolutionary terms, the pupil muscles belong to the primordial eye cup that developed from intestinal cells (see also ciliary muscles and ciliary body). Like theintestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the pupil muscles contract and expand in response to the "light morsel". The dilator muscle and pupil sphincter are composed of smooth muscle, derive therefore from the endoderm and are controlled from the midbrain.



BRAIN LEVEL: The pupil muscles are controlled from the **midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: According to their function, the pupil muscles are linked to a **light-related morsel conflict**– literally or figuratively.

The **dilator muscle** of the **right pupil** corresponds to the conflict of "**not enough light to catch a**

morsel". This can relate to any important information (on a board or screen), warnings ("watch your step!"), signs (a road sign) or a person that was overlooked because of insufficient light. The **left pupil** correlates to "**not enough light to eliminate a morsel"**, for example, if one is not able to avert a dangerous situation (an accident, an attack) because it was too dark (compare with the distress of sudden long darkness associated with the pineal gland). In a figurative sense, the conflict can be provoked if one is unexpectedly not in the "lime light" or not presented in the "proper light".

The **pupil sphincter** of the **right pupil** corresponds to the conflict of "**too much light to catch a morsel"** (a visual morsel that is of importance), let's say, because one was blinded by the sun or by bright light such as head lights, spotlights, a search light, a (police) flash light, or a welding device. The **left pupil** correlates to "**too much light to eliminate a morsel"**, for example, if one is not able to prevent a dangerous situation because it was too bright. In a figurative sense, the conflict could be triggered when the "spotlight" is turned on someone, bringing something unpleasant or embarrassing "to light".

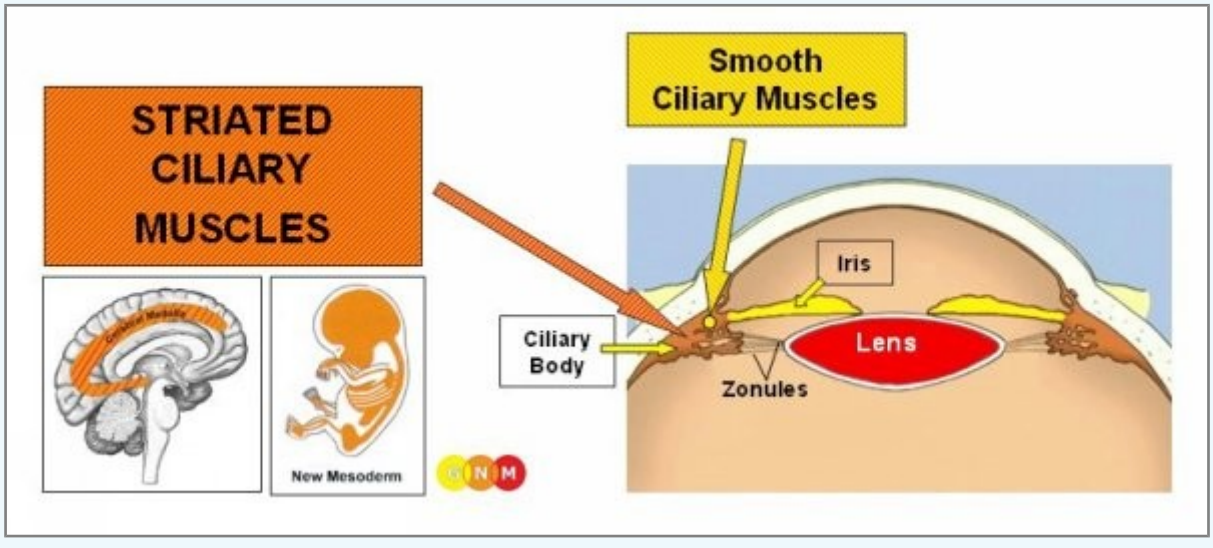
CONFLICT-ACTIVE PHASE:

The distress of „too much light" causes a sustained **hypertonus of the pupil sphincter**. The**biological purpose of the increased muscle tension** is to make the pupil smaller so that less light enters the eye. A prolonged or excessive **constriction of the pupil** is called **myosis**.

The distress of „not enough light" causes a sustained **hypertonus of the dilator muscle**. The**biological purpose of the increased muscle tension** is to widen the pupil so that more light can pass through the eye. A prolonged or excessive **dilation of the pupil** is called **mydriasis**, which causes **light sensitivity**.

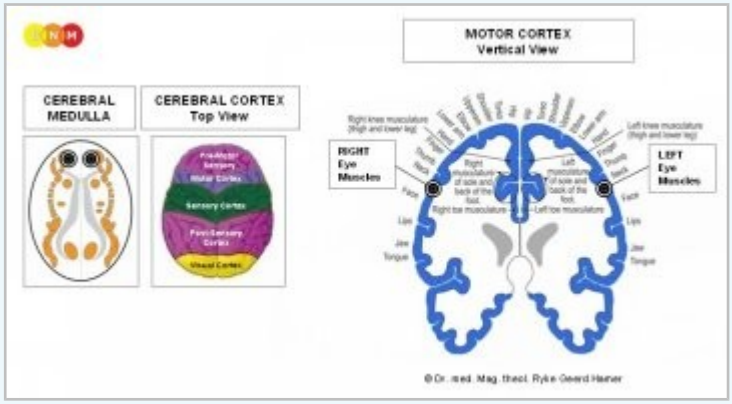
An enlargement of the right pupil, as seen in this picture, reveals that the person is conflict active with "not enough light to catch a morsel".

HEALING PHASE: During the healing phase the muscle tension goes back to normal. The Epileptoid Crisis presents as**pupil spasms** (compare with fluttering of the lens and nystagmus related to the extraocular muscles).



Smooth Ciliary Muscles **Striated Ciliary Muscles**

DEVELOPMENT AND FUNCTION OF THE CILIARY MUSCLES: The ciliary body contains a set of ciliary muscles that regulate the changing of the lens shape (accommodation) to produce a clear vision at varying distances. Ligaments called zonules connect the ciliary body with the lens to hold it in place. The contraction of the ciliary muscles relaxes the zonules causing the lens to become rounder, which increases its power to focus on nearby objects. When the ciliary muscles relax, the zonules pull the edges of the lens making it flatter to see objects in a far distance. The ciliary muscles are composed of smooth muscle (involuntary) and striated muscles (voluntary) allowing a sharp focus through squinting. In evolutionary terms, the smooth ciliary muscles belong to the primordial eye cup (see ciliary body and pupil muscles); they therefore originate from the endoderm and are controlled from the midbrain. The striated ciliary muscles derive from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The striated ciliary muscles have two control centers in the cerebrum. The trophic function of the muscles, responsible for the nutrition of the tissue, is controlled from the**cerebral medulla**; the ability to contract and relax the ciliary muscles is controlled from the **motor cortex** (part of the cerebral cortex). The striated ciliary muscle of the right eye is controlled from the left side of the cerebrum; the ciliary muscle of the left eye is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ. The smooth ciliary muscles are controlled from the **midbrain**, located at the outermost part of the brainstem.

NOTE: The striated ciliary muscles and extraocular muscles share the same brain relays.

SMOOTH CILIARY MUSCLES

BIOLOGICAL CONFLICT: The biological conflict linked to the smooth ciliary muscles is "**not being able to see what is close"** (difficulties reading small print, for example, in a newspaper, on a blackboard, computer screen, or phone screen) , "**not being allowed to see what is close"**, or "**not wanting to see what is close"** (not wanting to see what takes place right in front of one's eyes, e.g. family violence; wanting to play outside rather than doing homework).

CONFLICT-ACTIVE PHASE: sustained **hypertonus** (contraction) **of the smooth ciliary muscles** causing a relaxed tension on the zonules and subsequently a curved lens, which serves the **biological purpose** to be better able to see what is close. Ongoing conflict activity results in **nearsightedness** or **myopia** (see also cornea and retina). **NOTE:**Working with fine tools (needle work) or "staring at the screen all day" strains the focusing power of the ciliary muscles leading over time to nearsightedness – without a DHS.

HEALING PHASE: During the healing phase the muscle tension goes back to normal. The Epileptoid Crisis manifests as**fluttering of the lens** to which the ciliary muscles or rather the zonules are attached (compare with pupil spasms andnystagmus related to the extraocular muscles).

STRIATED CILIARY MUSCLES

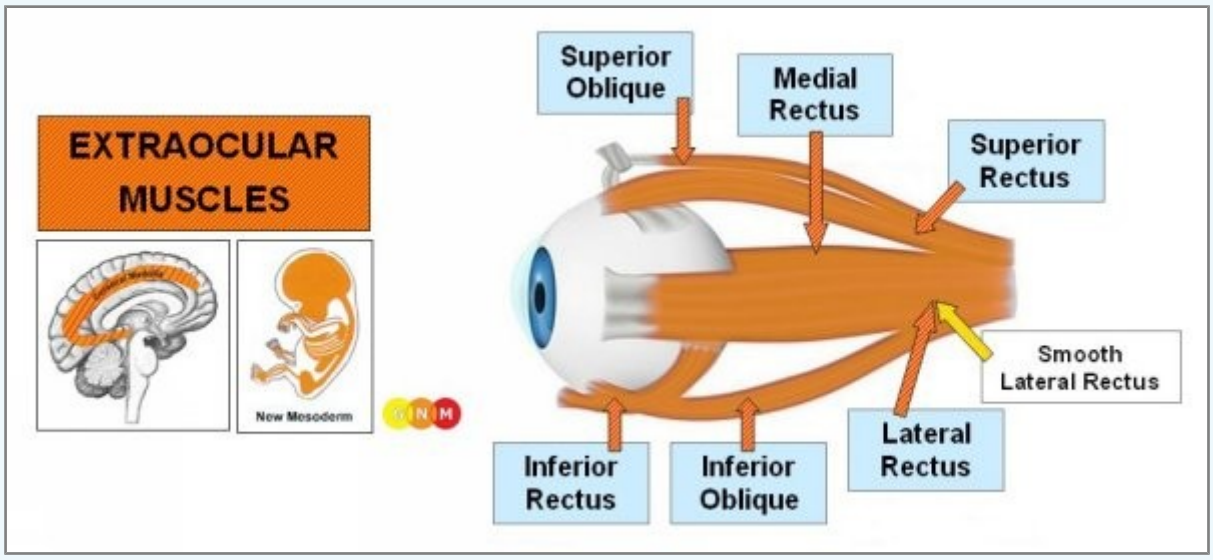
BIOLOGICAL CONFLICT: The biological conflict linked to the striated ciliary muscles is "**not being able to see what is in the distance"** (a person or object is too far away to be recognized or identified; difficulties reading a sign because it is too far away) or "**not being allowed to see what is far away"** (not being permitted to visit someone or to go on a journey) but also "**not wanting to see what is in the distance"** (a person who is leaving).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis** (weakness) of the striated ciliary muscles (controlled from the motor cortex). This causes the zonules to tighten making the lens flat, which serves the **biological purpose** to be better able to see what is far way. Prolonged conflict activity results in **farsightedness** or **hyperopia** (see also lens and retina).

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

HEALING PHASE: During the healing phase the necrosis is reconstructed and the muscle tension goes back to normal. Since the ciliary muscle is attached to the lens through the zonules, the Epileptoid Crisis manifests as a **fluttering of the lens** (compare with pupil spasms and nystagmus related to the extraocular muscles).

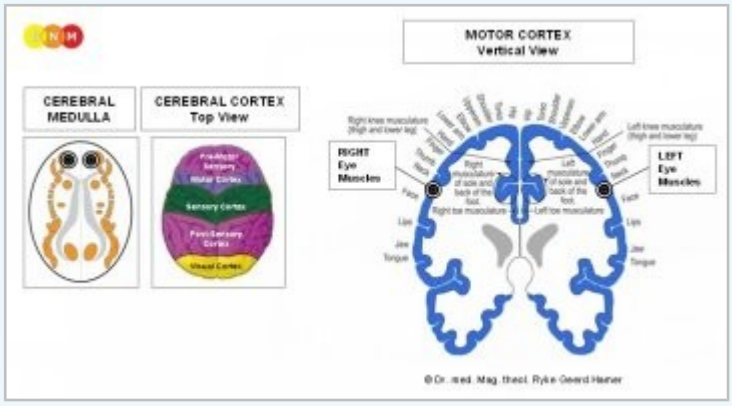
At the end of the healing phase the ciliary muscle will be stronger than before. This principle, namely that an organ works more efficiently after healing has been complete, applies without exception to all cerebral medulla controlled organs.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE EXTRAOCULAR MUSCLES: The extraocular muscles are six small muscles that surround the eye and control its movement. Four rectus ("straight") muscles regulate the movement of the eyeball from left to right and up and down: the **superior**

rectus moves the eye upward, the **inferior rectus** moves the eye downward, the **medial rectus** moves the eye inward (towards the nose), and the **lateral rectus** moves the eye outward (away from the nose). The two oblique muscles are primarily responsible for rotating the eyes: the **superior oblique** rotates the eye inward and downward, the **inferior oblique** rotates the eye outward and upward. The extraocular muscles are mainly made of striated muscles originating from the new mesoderm. They are controlled from the cerebral medulla and the motor cortex (compare with smooth lateral rectus muscle).



BRAIN LEVEL: The extraocular muscles have two control centers in the cerebrum. The trophic function of the muscles, responsible for the nutrition of the tissue, is controlled from the**cerebral medulla**; the ability to move the eye is controlled from the **motor cortex** (part of the cerebral cortex).

The right eye muscles are controlled from the left side of the cerebrum; the left eye muscles are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The extraocular muscles and striated ciliary muscleshare the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the extraocular muscles is "**not wanting to look into a certain direction"** because of something distressing "there". Newborns, for example, suffer the conflict when they are blinded by bright fluorescent light in the delivery room. The extraocular muscles also correspond to "**not being allowed to look *there***" (a student is caught cheating while he was trying to copy the exam from his neighbour) and "**not being able to look *there***" (an infant is unable to look towards the mother).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the affected eye muscle** (controlled from the motor cortex).

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

The paralysis or weakness of the eye muscle causes **strabismus**, the inability to attain binocular vision (see also strabismus caused by the damage of the oculomotor nerve due to a pineal gland tumor). Depending on the exact nature of the conflict, one or both eyes deviate inward, outward, upward or downward.

NOTE: Whether the eye muscle of the right or left eye (or both) is affected is determined by a person'shandedness and whether the conflict is mother/child or partner-related. A localized conflict affects the eye muscle that is associated with the specific conflict situation.

Strabismus esotropia (cross-eyed): one or both eyes deviate inward.

Both eyes turn inward and downward because the eye muscles that pull the eyes outwards (lateral rectus) and upwards (superior rectus) are paralyzed.

The right eye turns inward because the eye muscle that pulls the eye outward (lateral rectus) is paralyzed. If the person is left-handed then the conflict ("didn't want or was not aloud to look to the right") is associated with the mother or situation-related.

Strabismus exotropia (wall-eyed): one or both eyes deviate outward.

The right eye turns outward because the eye muscle that pulls the eye inward (medial rectus) is paralyzed. If the person is right-handed then the conflict ("didn't want or was not aloud to look to the left") is associated with a partner or situation-related.

Strabismus hypertropia: one or both eyes deviate upward.

The right eye turns upward because the eye muscle that pulls the eye downward (inferior rectus) is paralyzed. If the person is left-handed then the conflict ("didn't want or was not aloud to look downward") is associated with the mother or situation-related.

Strabismus hypotropia: one or both eyes deviate downward.

The right eye turns downward because the eye muscle that pulls the eye upward (superior rectus) is paralyzed. If the person is right-handed then the conflict ("didn't want or was not aloud to look upward") is associated with a partner or situation-related.

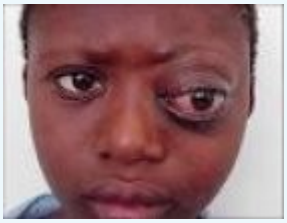
Cyclophoria is a type of strabismus in which the axis of one or both eyes rotates inward or outward due to the paralysis of the oblique muscles.

If the right eye is affected and the person is right-handed, then the conflict ("didn't want or was not aloud to look downward and to the right") is associated with a partner or situation-related.

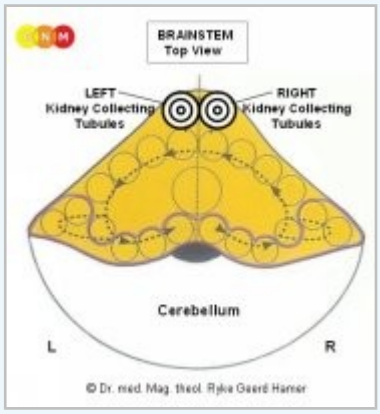
HEALING PHASE: During the healing phase the necrosis is reconstructed. The paralysis reaches into PCL-A. TheEpileptoid Crisis presents as involuntary eye movement, called **nystagmus**. Depending on the exact nature of the conflict, the eyeball flutters up and down or side to side (compare with fluttering of the lens and pupil spasms). Recurring flutters are triggered by setting on a track that was established when the "don't want to look there"-conflict took place. Uncontrollable eye movement could also occur together with a generalized seizure (grand mal) involving the entire motor cortex. After the Epileptoid Crisis, during PCL-B, the function of the eye muscle returns to normal.

At the end of the healing phase the eye muscle will be stronger than before. This principle, namely that an organ works more efficiently after healing has been complete, applies without exception to all cerebral medulla controlled organs.

Bulging eyes (proptosis, exophtalmos) is caused by an enlargement of structures within the eye socket pushing the globe of the eyes out of the orbit – like a telescope. Continuous swelling of the tear gland, for example, can lead to an anterior displacement of the eye. Also, a buildup of connective tissue; in this case, the underlying conflict is a self-devaluation conflict. The condition, also known as **Graves' disease or Basedow disease**, is generally associated withhyperthyroidism. From a GNM viewpoint, an overactive thyroid and a protrusion of the eyeball only occur together when the thyroid conflict is coupled with a self-devaluation conflict related to the eyes ("My eyes failed to be fast enough to catch or eliminate a morsel").



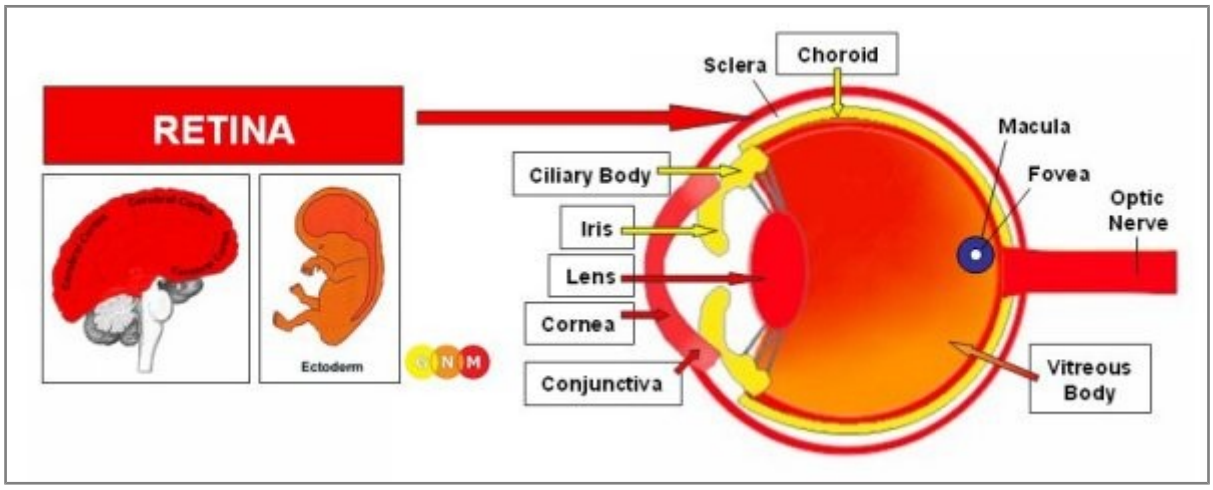
The theory of a correlation between Graves' disease and hyperthyroidism cannot explain why the eyeball protrusion affects only one eye. Based on the principle of laterality, a displacement of the left eye (as seen in this picture) reveals that the self-devaluation conflict is associated with the mother, if the boy is right-handed.



The **smooth lateral rectus** is supplied by the abducens nerve (sixth cranial nerve) that originates in the pons of the brainstem, precisely, in the control centers of the kidney collecting tubules.

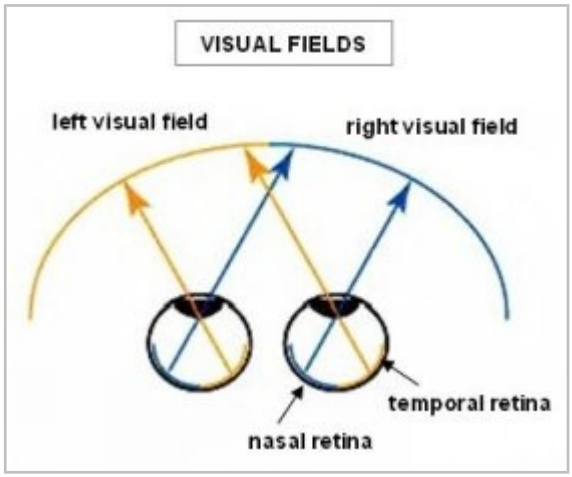
In the event of an abandonment and existence conflict the lateral rectus pulls the eye(s) outward. When the conflict impacts in the right kidney tubules relay, the right eye deviates towards the right; when the left kidney tubules are affected, the left eye deviates towards the left. With two active abandonment or existence conflicts involving both kidney tubules both eyes deviate sideways. This is commonly called a "**lazy eye"**, or **amblyopia**. It should not come as a surprise that the condition often occurs in children. If the smooth part of the lateral rectus is affected, the person is able to pull the eye voluntarily into the correct position since the eye muscle is not paralysed. In this case, the person is conflict active with an abandonment and existence conflict rather than with a visual "stuck"-conflict related to thestriated lateral rectus with paralysis in the conflict-active phase (see strabismus exotropia).

These two pictures of the French existentialist Jean-Paul Sartre show that at one time the right eye deviates outwards and another time the left eye, pointing to alternating existence conflicts.

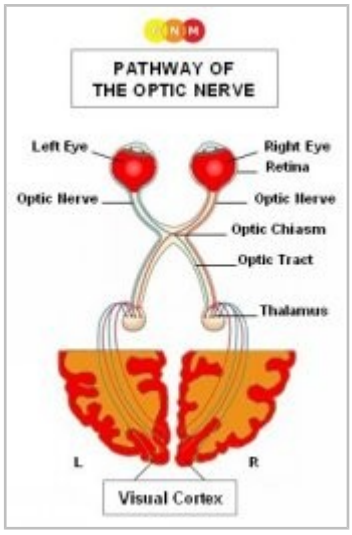


Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE RETINA: The retina is a light-sensitive layer of nerves that lines the back of the eye. It covers the underlying choroid and is in close contact with the vitreous body. The retina contains neurons such as photoreceptors (rods and cones) that receive light and colors from the lens and convert them into impulses that are sent via the optic nerve to the visual cortex at the back of the brain. The **macula**, located near the central portion of the retina, is responsible for central vision. Within the central macula lies the fovea, which is a small pit that permits the highest visual acuity. The retina originates from the ectoderm and is controlled from the visual cortex.

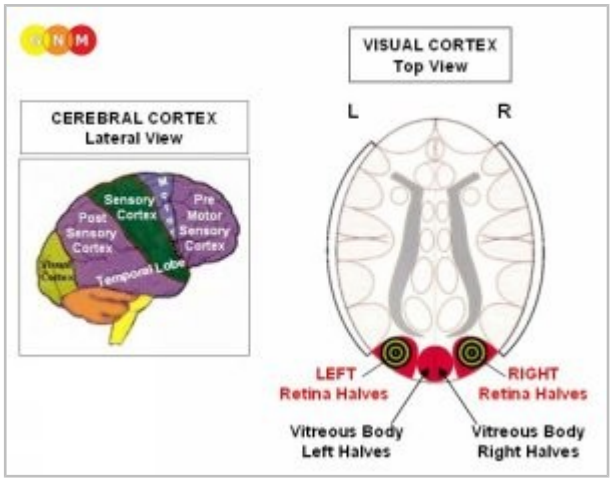


The **visual fields** of each eye are divided into a right and left field, called the temporal fields (close to the temporal bone) and nasal fields (close to the nose). Equally, the retina of each eye is divided into two halves: the temporal retina and the nasal retina. The right halves of the retina of both eyes (orange arrows) receive images predominantly from the left visual field (90% from the left, 10% from the right) whereas the left halves of the retina (blue arrows) receive images mainly from the right visual field (90% from the right, 10% from the left). Taking into account the refraction of light by the cornea and the lens, the image projected onto the retina is actually reversed. Therefore, what is in the temporal field of vision of either eye is perceived by the nasal retina and what is in the nasal field of vision is perceived by the temporal retina (see also vitreous body). **NOTE:** When the eyes were still positioned on the side, the visual fields did not overlap. The joint visual fields of both eyes developed, after the eyes had moved to the front.



Pathway of the Optic Nerve: Visual perception, generated by photoreceptors in the retina, leaves the eyes by way of the optic nerve. The right and left branches of the optic nerve join behind the eyes, just in front of the pituitary gland, to form a cross-shaped structure called the **optic chiasma**. Within the optic chiasm, the nerve fibers from the nasal half of each retina cross over, but those from the temporal half do not since they are already positioned to see the reverse side of an image. After the optic chiasm, the nerves continue their path along the optic tracts. Most of the nerve fibers enter the thalamus. From there the nerves lead to the visual cortex at the back of the brain. The nerves of the right retina halves that receive images from the left visual field go to the right side of the visual cortex; the nerves of the left retina halves that receive images from the right visual field go to the left hemisphere. The crossing of the optic nerves at the chiasm is the requirement that the images projected onto the retina reach both sides of the visual cortex. There, the images seen by each eye are processed into a single picture, representing the image as it was originally perceived.

NOTE: The optic nerve emerged from the brain relays that innervated the primordial eyecup (today's choroid).



BRAIN LEVEL: The retina is controlled from the **visual cortex**. The right half of the retina of each eye is controlled from the right side of the visual cortex; the left half of the retina of each eye is controlled from the left brain hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The control centers of the retina are next to the brain relays of the vitreous body.

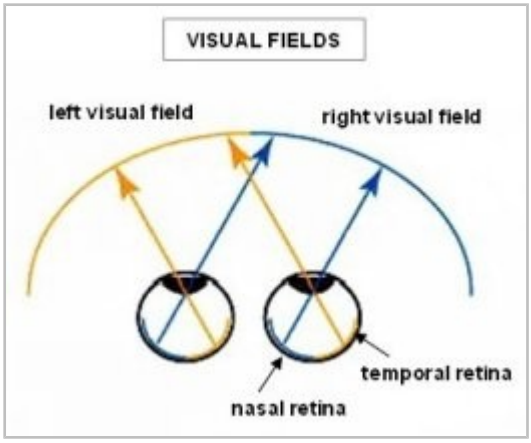
BIOLOGICAL CONFLICT: The biological conflict linked to the retina relates to a **fear that cannot be shaken off**
(compare with vitreous body). This refers to *any* fear, for example, to the fear of losing a loved one or a home, the fear of punishment, abuse, unemployment (debts, poverty), persecution (religious, ethnic, political), the fear of cancer (including medical tests and follow-up examinations), and so forth.

CONFLICT-ACTIVE PHASE: functional loss of retinal photoreceptor cells with the **biological purpose** to make that what evokes the fear temporarily invisible (when children are scared they cover their eyes). The loss of rod cells, responsible for vision at low light levels, results in **nyctalopia** or "night blindness" with difficulties seeing in dim light or in the dark.

NOTE: The retina belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the vitreous body, the inner ear (cochleaand vestibular organ), olfactory nerves, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles) or hyperfunction (see (periosteal nerves and thalamus).

Intense conflict activity causes a **diminished vision in a defined area of the visual field (scotoma)** due to the breakdown of retinal cells (compare with scintillating scotoma). However, with a moderate conflict the reduced vision might not be noticed since the other retina halves compensate the vision loss.

NOTE Whether the right or left retina halves are affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.



Concerning the retina, the principle of laterality is reversed.

The right halves of the retina (orange arrows) look predominantly to the left to receive images from the left visual field. Hence, for right-handed people the right retina halves relate to the mother and child(ren), for left-handers to a partner.

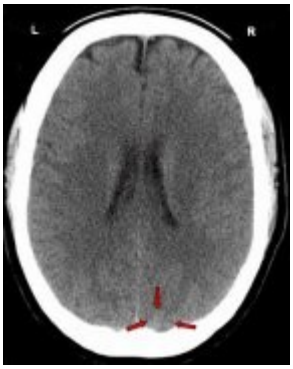
The left halves of the retina (blue arrows) look to the right to receive images from the right visual field. Hence, for right-handed people the left retina halves relate to a partner, for left-handers to the mother and child(ren).

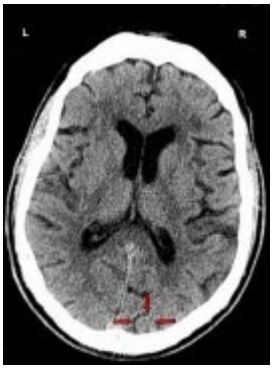
HEALING PHASE: During the healing phase the function of the photoreceptor cells is restored. In PCL-A an edema forms between the choroid and the affected area of the retina. During the Epileptoid Crisis the edema is expelled, which is noticeable as **flashes of light** (photopsia). The flashes could be short bursts or happen continually until the retina is repaired.

A "**scintillating scotoma"** presents as visual sparks, flickering lights, shimmering zig-zag lines, or colourful patterns in the visual field. Recurring episodes are triggered by setting on a track that was established when the original fear-conflicttook place; their duration is determined by the intensity of the Epileptoid Crisis.

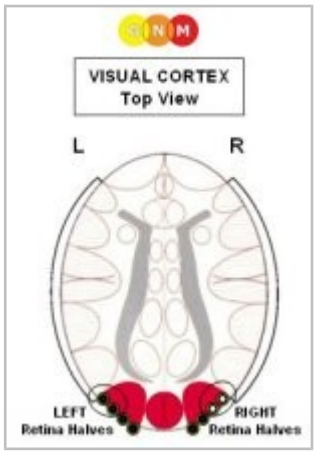
The visual auras often precede a migraine headache. However, not every person with migraine headache experiences them and oftentimes the auras appear without the pain of migraines. Hence, we have to consider a combination of two different Epi-Crises events.

Recurring conflict relapses lead to the buildup of scar tissue and a hardening (callosity) in the retina. If the hardening occurs laterally (on the side), the eyeball elongates causing **nearsightedness** or **myopia** (see also smooth ciliary muscle and cornea), whereas hardening in the back (dorsal) compresses the eyeball causing **farsightedness or hyperopia** (see also lens and striated ciliary muscle) in both eyes. At this point the condition is irreversible.





Both CT scans show a Hamer Focus (on different layers) in the right retina relay for the right retina halves of both eyes. The image on the left presents the conflict-active phase (sharp ring configuration); the image on the right the healing phase (edematous ring). For a right-handed person the fear-conflict relates to his/her mother or children; for a left-handed person to a partner (see handedness above).



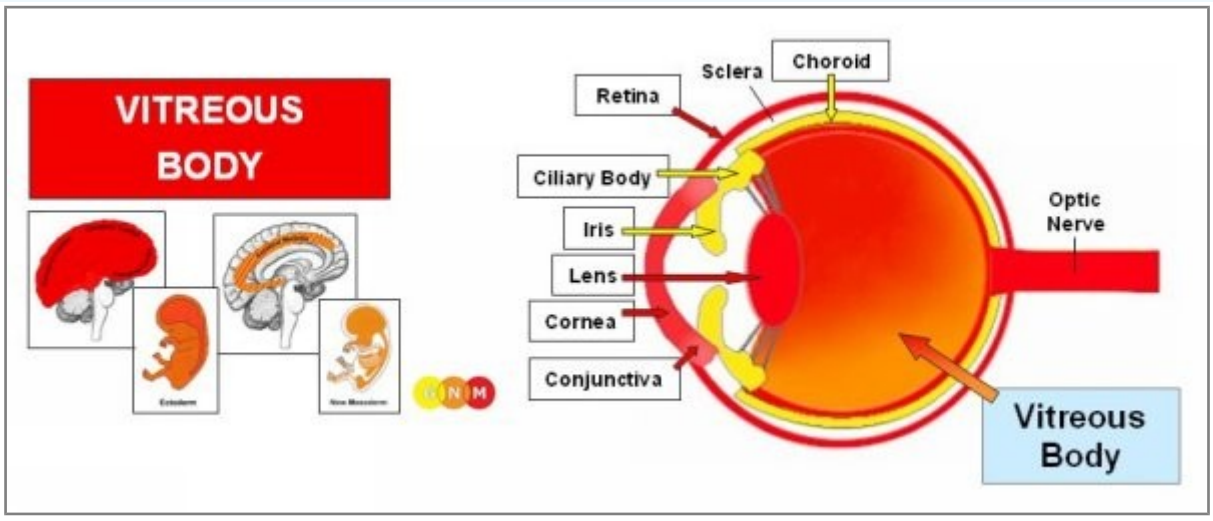
NOTE: The right retina halves look 90% to the left and 10% to the right (the left retina halves look 90% to the right and 10% to the left) - see visual fields. If the impact of theretina-related conflict occurs in the outer portions of the right retina relay (see GNM diagram) only the right eye is affected (the same applies to the vitreous body).

A large edema between the choroid and retinal layer (usually because of water retention due to the SYNDROME) pulls the retina from its normal position. This is generally called a **retinal detachment** (strictly speaking, a misnomer since the retina does not "detach"). With no conflict relapses the condition reverses on its own. However, if the fear-conflictpersists healing cannot be complete and the vision becomes drastically reduced. The panic of becoming blind often adds new fears creating a progressive condition. **CAUTION:** Stooping or physical exertion, for example when lifting something heavy, can cause a rupture of the retina!

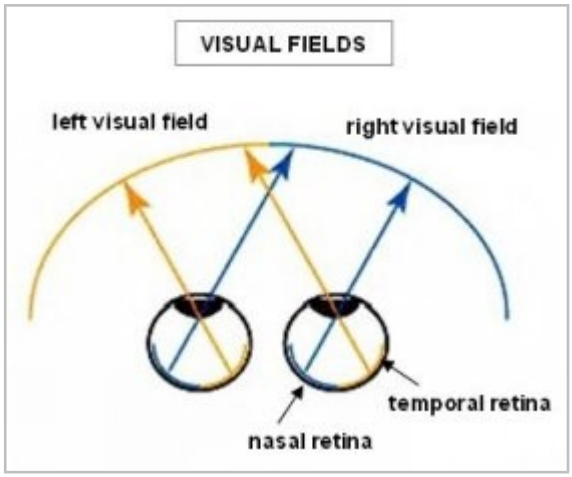
What is termed "**diabetic retinopathy"** is based on the assumption that an elevated blood sugar level damages the retina. Yet, not every diabetic develops the condition! From the GNM point of view, it is the additional resistance conflict(a resistance to the fear-provoking situation) why the two Biological Special Programs often run simultaneously (see also "diabetic peripheral neuropathy" related to the periosteum).

A **loss of central vision** develops when the healing process involves the macula, a small and highly sensitive part of the retina responsible for detailed central vision (compare with loss of peripheral vision related to the vitreous body). If healing cannot be complete because of continuous conflict relapses, the condition can lead to blindness.

A "**dry macular degeneration"** occurs, in GNM terms, in the conflict-active phase; a "**wet macular degeneration"**, indicating the presence of an edema(fluid accumulation), during the healing phase.

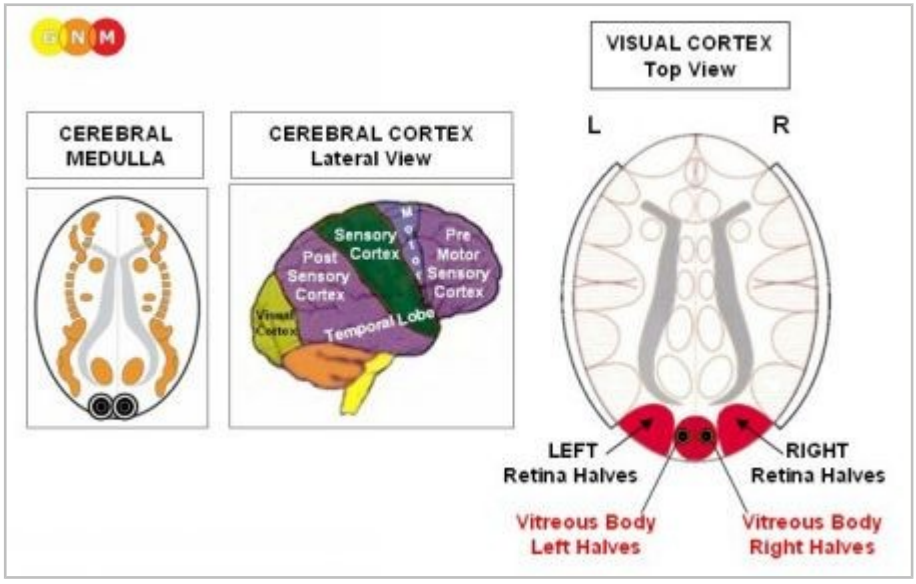


DEVELOPMENT AND FUNCTION OF THE VITREOUS BODY: The vitreous body occupies the space between the lensand the retina at the back of the eye. Fluid produced in the ciliary body fills the vitreous with a gel-like substance made up of about 99% water. The gel, composed mainly of collagen, is transparent so that light rays are able to pass through it to reach the retina. The intraocular pressure maintains the shape of the eye and prevents the walls of the eyeball from collapsing. The sclera, a sheath of connective tissue, supports the eyeball from the outside. The vitreous body consists ofmesodermal parts, controlled from the cerebral medulla, and ectodermal parts, controlled from the visual cortex.



Like the retina the vitreous body is divided into two halves, a temporal vitreous (close to the temporal bone) and a nasal vitreous (close to the nose). This confirms that the vitreous body and the retina are functionally closely connected.

Analogous with the information transfer of the right and left retina halves, the images perceived from the right and left visual field go from the right and left halves of the vitreous body over the optic chiasm to the visual cortex (see pathway of the optic nerve).



BRAIN LEVEL: The control centers of the vitreous body are in the **visual cortex** (ectodermal parts) and in the **cerebral medulla** (mesodermal part). The right half of the vitreous of each eye is controlled from the right side of the cerebrum; the left halves of the vitreous of each eye are controlled from the left cerebral hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The control centers of the vitreous body are next to the brain relays of the retina.

BIOLOGICAL CONFLICT: The biological conflict linked to the vitreous body is a **fear of a "predator"** who is "sneaking up from behind" (compare with fear-provoking conflicts related to the retina). Thus, the conflict is always a fear of a person, for example, the fear of an abuser, a stalker, a character assassin, a threatening ex-spouse, a relative who is after one's inheritance, a supervisor, a

teacher, a parent, a doctor, a lawyer, or an authority (government, tax office, bailiff, police, judge) that is "breathing down one's neck". A fear of dogs could also evoke the conflict.

NOTE: Whether the right or left halves of the vitreous body are affected is determined by a person's handednessand whether the conflict is mother/child or partner-related. As with the retina, the principle of laterality is reversed. Hence, for a right-handed person the right halves of the vitreous relate to his/her mother and child(ren), the left halves of the vitreous body to a partner; for left-handed people it is the other way around.

CONFLICT-ACTIVE PHASE: necrosis (controlled from the cerebral medulla) and **functional loss** of the vitreous body (controlled from the visual cortex), causing an interference of the transmission of light to the retina and therefore a**clouding of the vitreous**. This is called a "**green cataract"** (compare with "grey cataract" and a clouding of the lens). Considering that due to the refraction of light by the cornea and the lens the images projected onto the retina are reversed (what is perceived in the temporal field of vision is registered on the nasal vitreous), the clouding of the vitreous **affects predominantly the nasal halves and therefore the peripheral vision** (see visual fields**). The biological purpose of the clouding** is to blur the sight of the "predator" (horse-blinkers phenomenon) to be able to focus fully on the escape route.

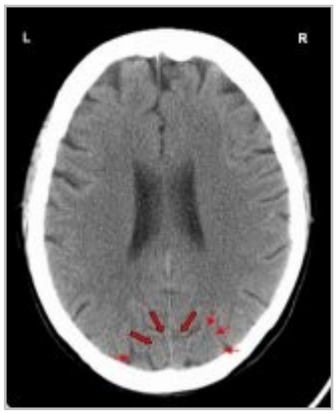
Prolonged conflict activity leads eventually to a progressive **loss of peripheral vision** (compare with loss of central vision related to the macula).

NOTE: The vitreous body belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the retina, the inner ear (cochlea and vestibular organ), olfactory nerves, islet cells of the pancreas (alpha islet cells and beta islet cells),skeletal muscles) or hyperfunction (see periosteal nerves and thalamus).

HEALING PHASE: During the healing phase the clouding of the vitreous recedes. In PCL-A an edema (fluid accumulation) develops at the site. Frequently, the edema reaches into the opening where the optic nerve leaves the eye. During the Epileptoid Crisis the edema is pressed out. However, in order to keep the eyeball firm and prevent it from collapsing, the **vitreous fluid production and intraocular pressure increase during PCL-B**. This is what is called a**glaucoma**. The "glaucoma attack" occurs shortly *after* the Epi-Crisis as a result of the sudden rise of eye pressure in the vitreous. With a hanging healing due to continuous conflict relapses the condition becomes chronic. Dr. Hamer advises that laser treatment should not be performed since the vitreous body will become irreversibly damaged. Permanent elevated intraocular pressure might lead to a depression of the optic disc, termed **excavation papillae** (compare with papilledema caused by increased intracranial pressure; see hydrocephalus).

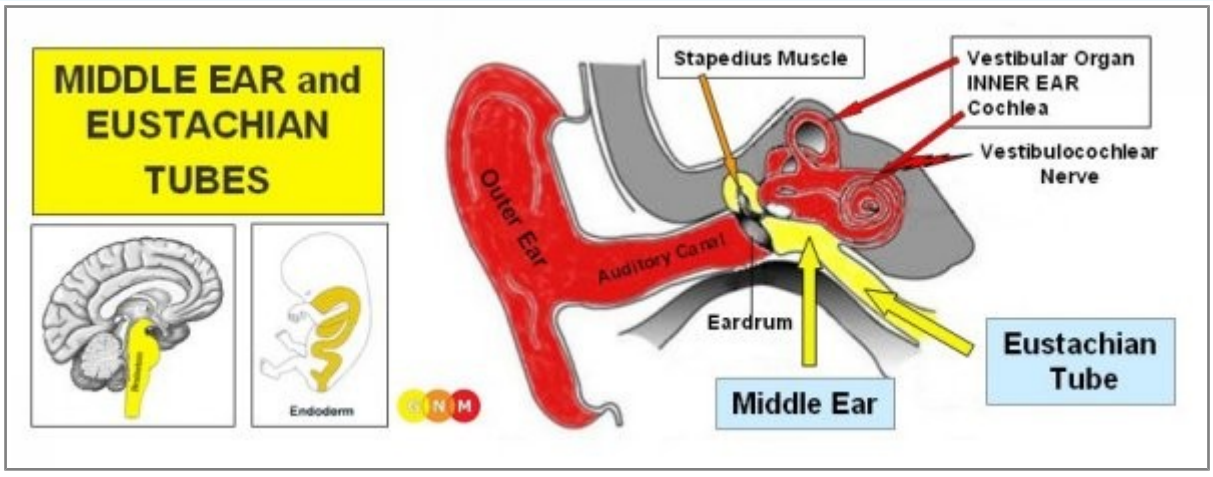
NOTE: Fluid from the vitreous body also flows into the anterior eye chamber (between the cornea and the lens) where it is absorbed into the blood. This is why elevated eye pressure never occurs in the frontal eye chamber but only in the vitreous chamber that has no blood vessels.

The scarring process (in PCL-B) is noticeable as **eye floaters** (mouches volantes) that appear as spots, threads, black or grey specks, strings or cobwebs that drift about with the movement of the eyes. Floaters are visible because of the shadows they cast on the retina. After the healing process has been complete, the floaters disappear.



This CT scan shows a central conflict (related to a person's mother/child and partner) in the area of the visual cortex that controls the vitreous body (view the GNM diagram). The small arrows point to the control centers of the retina (view the GNM diagram) with a Hamer Focus in both relays. The partly edematous rings (PCL-A) indicates that the person has stillrelapses of fear conflicts. The combination of the Biological Special Programs of the retina and vitreous body occurs, for example, if a child lives in fear of being punished (retina) by its parents (vitreous body).

EARS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MIDDLE EAR AND EUSTACHIAN TUBES: The ear consists of a peripheral and a central part separated by the eardrum or tympanic membrane. Sound waves captured from the external environment by the outer ear are first transformed by the tympanic membrane into mechanical vibrations, which are transmitted to the ossicles (malleus, incus, stapes) that carry the sound to the inner ear. From there, the acoustic waves pass along the vestibulocochlear nerve to the brain for interpretation. The Eustachian tubes connect the middle ear to themouth and nasopharynx. They help to keep air pressure in the ears at the right level. In evolutionary terms, the middle ear and Eustachian tubes developed from the intestinal mucosa of the original gullet. Equal to the intestinal cells that absorb (resorptive quality) and digest (secretory quality) the "food morsel", the biological function of the middle ear and Eustachian tubes is to "insalivate" and "digest" the "sound morsel". The middle ear and Eustachian tubes consist ofintestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.

BRAIN LEVEL: In the **brainstem**, the middle ear and Eustachian tubes have each two control centers, positioned in close vicinity to the brain relays of the organs of the alimentary canal.

The right middle ear and right Eustachian tube are controlled from the right side of the brainstem; the left middle ear and left Eustachian tube are controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ. The control centers of the middle ear are located laterally, at the margin of the brainstem and the cerebellum (known as the cerebello-pontine angle). It is from this area from where the vestibulocochlear nerveemerges.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the middle ear and Eustachian tubes is a "**morsel conflict"**, specifically, a conflict related to a "**sound morsel"**.

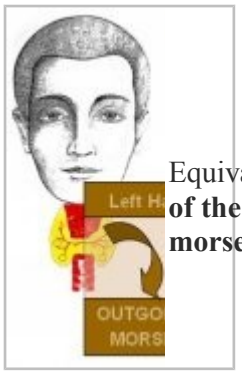
In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

RIGHT MIDDLE EAR AND RIGHT EUSTACHIAN TUBES

Equivalent to the right half of the mouth and pharynx, the **middle ear and Eustachian tube of the right ear** correlate to an "**ingoing morsel"** and to "**not being able to catch a sound morsel"**.

The desired "sound" might concern the voice of a particular person. Newborns and infants suffer the conflict when they can't "catch" the reassuring voice of the mother. A praise (at school, at home, at work), an acknowledgement, an approval, an offer, a compliment, a proposal, a promise, an apology, a confession, or the "I love you"-morsel one is "drooling" to hear could activate the conflict. In biological terms, the "sound morsel" is equal to nourishment (see alsovisual morsel related to the tear glands). A hearing conflict can also be experienced when an important message (an announcement) or a sound (telephone ring, baby phone, siren or other acoustic warning signals) were overheard causing a predicament. The much desired "sound morsel" could also be the "sound of silence".

LEFT MIDDLE EAR AND LEFT EUSTACHIAN TUBES



Equivalent to the left half of the mouth and pharynx, the **middle ear and Eustachian tube of the left ear** relate to an "**outgoing morsel"** and to "**not being able to eliminate a sound morsel"** (originally, the feces morsel).

Such an undesired "sound morsel" relates to any "acoustic dirt" one wants to "evacuate", for example, an insult, verbal assaults, an accusation, complaints, scolding, criticism, distressing news, hearing something upsetting, the voice of a nagging boss, colleague, parent or spouse or, for a newborn, the voice of a stranger.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the middle ear or Eustachian tubes proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase**is to be better able to absorb (right ear) or expel (left ear) the "sound morsel". Hence, during conflict activity the hearing ability is actually enhanced (in Nature, hearing the approach of a predator or other potential dangers is essential for survival). If the conflict persists, a flat (resorptive type) or compact growth (secretory type) develops in the ear. With prolonged conflict activity the cell buildup could completely fill the middle ear or occlude the Eustachian tube. The Eustachian tubes convey air from the back of the nose into the middle ear to equalize ear pressure. Once a Eustachian tube is blocked, the vacuum created in the ear pulls the eardrum inward making hearing difficult as the **retracted eardrum** can no longer vibrate. As a result the **ear feels blocked**.

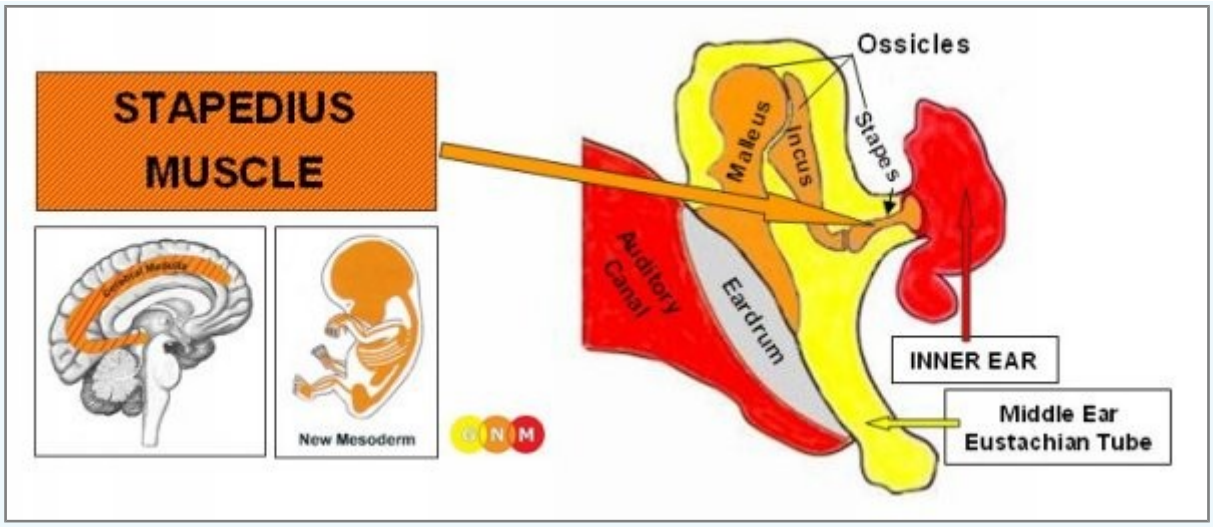
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **ear discharge** and **earaches** due to the swelling with some degree of hearing loss. This is commonly called a **middle ear infection** (otis media). When healing takes place in the Eustachian tubes, the discharge flowing into the middle ear simulates a "middle ear infection". **Candidiasis in the ear**occurs when fungi assist the healing process.

NOTE: The vestibulocochlear nerve runs through the brain relays of the middle ear. A middle ear infection is therefore accompanied by a **loss of sense of balance** (see also acoustic neuroma and vertigo related to theinner ear), which is not the case when the Eustachian tubes are healing.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine this is usually diagnosed as an **ear polyp.**

Chronic or recurring ear "infections" indicate that the hearing conflict has not been completely resolved (hanging healing). The constant tissue repair can lead to a **perforation of the eardrum** with pus continuously draining from the middle ear. Eventually, the **hearing ability becomes impaired** (compare with hearing loss related to the inner ear). Oftentimes, the distress of "not being able to catch a sound morsel" triggers further hearing conflicts worsening the condition. Hence, learning GNM *before* symptoms arise is real preventive medicine.

Hearing difficulties generate easily a self-devaluation conflict involving the small bones in the middle ear (malleus, incus, stapes). Over time, the continuing calcification of the ossicles causes **otosclerosis**, which contributes to the hearing loss.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE STAPEDIUS MUSCLE: The middle ear contains three tiny bones or ossicles (malleus, incus, stapes) that carry the sound received from the auditory canal to the inner ear. The stapedius muscle, attached to the stapes, is fundamental in reducing sound transmission. Under normal circumstances the stapedius is relaxed allowing sounds from the external environment to be perceived with clarity. However, when a sudden intense noise reaches the ear, the muscle contracts in order to dampen the sound to protect the inner ear from damage. The stapedius muscle consists of striated muscles, derives from the new mesoderm and is controlled from the cerebral medulla and the motor cortex.

NOTE: During sleep, the organism is in a natural state of rest (vagotonia), except for sensory sensitivities such as hearing, which are enhanced in order to become instantly aware of potential dangers. Hence, in vagotonia the stapedius muscle is relaxed in order to catch the smallest noise in the environment. This is one of the reasons why during pregnancy, starting at the fourth month, the child-bearing woman is in a prolonged state of vagotonia.

BRAIN LEVEL: The stapedius muscle has 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 muscle is controlled from the**motor cortex** (part of the cerebral cortex). The stapedius muscle in the right ear is controlled from the left side of the cerebrum; the stapedius muscle in the left ear is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

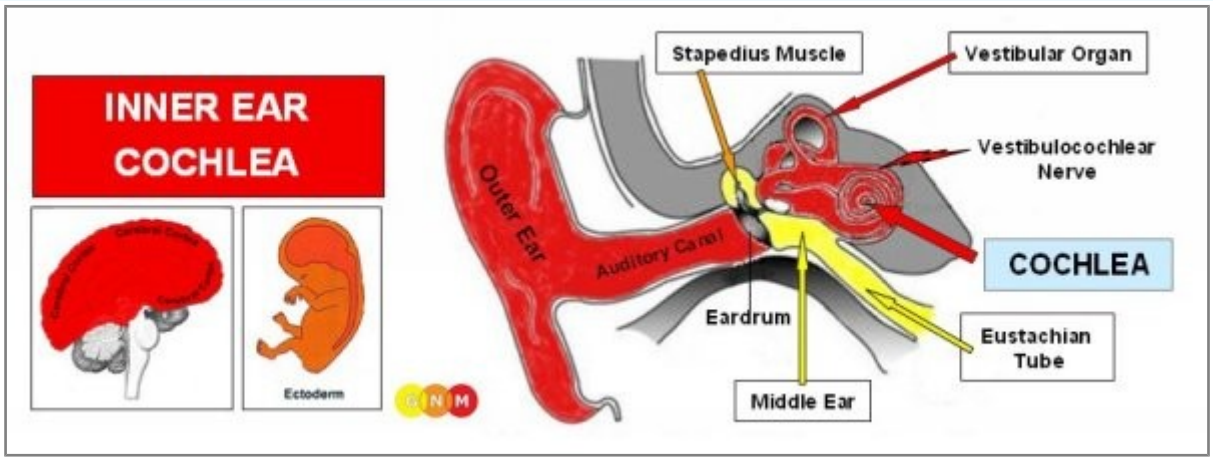
BIOLOGICAL CONFLICT: The biological conflict linked to the stapedius muscle is, according to its function, a **noise conflict** triggered by unbearable noises such as loud bangs, blasts, explosions, shots, blaring sirens, music with very high decibel levels, a sharp cry, a piercing scream, and the like.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of stapedius muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the stapedius** (controlled from the motor cortex) causing **hyperacusis** with a decreased sound tolerance, while normal sounds are perceived as very loud (see also hyperacusis with facial paralysis).

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

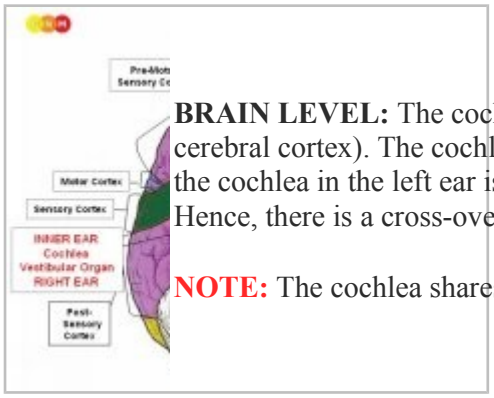
HEALING PHASE: During the healing phase, the stapedius muscle is reconstructed. The paralysis (hyperacusis) reaches into PCL-A. The Epileptoid Crisis manifests as **stapedial muscle spasms** (equivalent to a focal seizure) creating a painful fluttering sensation in the ear. In PCL-B, the function of the stapedius returns to normal.

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



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE COCHLEA: The cochlea is a spiral-shaped cavity in the inner ear. It is the actual sensory organ of hearing. The cochlea receives the sound waves from the outer ear and auditory canal and converts them into electrical impulses that are transmitted to the brain via the auditory nerve for interpretation. The auditory nerve, or vestibulocochlear nerve, is divided into the vestibular branch, concerned with balance and motion, and a cochlear division responsible for hearing. The cochlea originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The cochlea is controlled from the **post-sensory cortex** (part of the cerebral cortex). The cochlea in the right ear is controlled from the left side of the cortex; the cochlea in the left ear is controlled from the right cortical hemisphere (temporo-basal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The cochlea shares the control relays with the vestibular organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the cochlea of the inner ear is "**I don't**

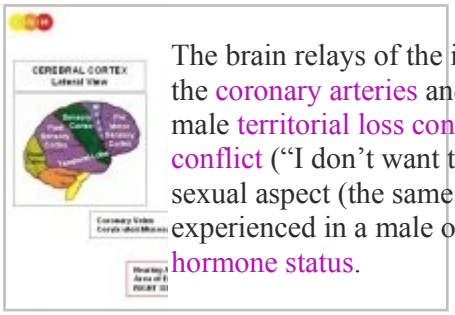
want to hear this!"(see also outer ear and auditory canal). Aggravating noises such as dog barking, a screaming child, construction noise (jackhammers, chain saws, generators), traffic noise (loud trucks, sirens from ambulances, fire engines, or police cars), noisy neighbors, lawn mowers, grass trimmers, annoying music, the nagging voice of a person, or something upsetting that has been said ("**I can't believe what I just heard!"**) are examples of what might trigger the conflict. Often, hearing conflicts occur on the phone. For someone who is noise-sensitive the smallest noise can cause ear-related distress.

CONFLICT-ACTIVE PHASE: **functional loss** of the cochlear branch of the vestibulocochlear nerve resulting in the perception of sounds in one or both ears without an external source. This condition is called **tinnitus**.

NOTE: The cochlea (inner ear) belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the vestibular organ(inner ear), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells andbeta islet cells), skeletal muscles) or hyperfunction (see periosteum and thalamus).

The ringing, buzzing, humming, whistling, clicking, tinkling, hissing, roaring, and the like, is a frequency of the sound associated with the hearing conflict. The **biological purpose of the tinnitus** is to be a warning signal saying "last time you heard this, you were in danger. Watch out!". This explains the variety of sounds heard by people with tinnitus. Depending on the magnitude of the conflict, the sounds or noises can be mild and only noticeable in a quiet room or become extremely loud causing difficulties hearing external sounds (compare with hearing loss in the healing phase). A person might also hear complete sounds or noises such as engine noise, the ringing of a telephone, a musical tune ("music tinnitus"), or a recurring sentence or word ("word tinnitus"). If the tinnitus is present all the time, this indicates that the conflict has not been resolved.

NOTE: Whether the cochlea of the right or left inner ear (or both) is affected is determined by a person'shandedness and whether the conflict is mother/child or partner-related.



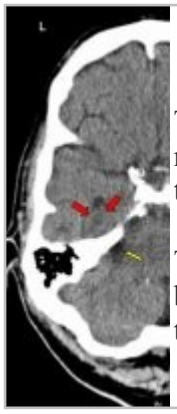
The brain relays of the inner ear are located right underneath the control centers of the coronary arteries and coronary veins/cervix mucosa, which are assigned to a male territorial loss conflict and a female sexual conflict respectively. Hence, the hearing conflict ("I don't want to hear this!") involving the cochlea can also have a territorial or sexual aspect (the same applies to the vestibular organ). Whether the conflict is experienced in a male or female fashion is determined by a person's gender, laterality, and hormone status.

When both hearing conflicts are associated with sounds and noises, the person will develop a double "**sound tinnitus"**affecting **both ears**. If, however, one of the two conflicts or both was triggered by the voice(s) of person(s), this leads to**hearing voices**. In GNM we call this a Hearing Constellation. Conventional medicine considers hearing voices a mental disorder ("paranoid schizophrenia"). In the context of GNM, hearing voices is essentially a double tinnitus with the difference that instead of hearing one or more sounds, a person hears one or more voices. The voice(s) correspond to those that were heard when the original hearing conflict occurred. Traumatic hearing conflicts can result in severe auditory delusions.

Down Syndrome: Dr. Hamer made the ground-breaking discovery that Down Syndrome is not, as assumed, caused by a Trisomy 21 (a third chromosome attached to the 21st gene pair) but by biological conflicts experienced by the fetus, precisely, by a **double hearing conflict** that occurred within the first three months of pregnancy (see GNM Article "Understanding Genetic Diseases" and how a four-year old child overcame the condition through the application of German New Medicine).

NOTE: A Trisomy can be determined before conception since it is an occurrence that happens already in the egg or in the sperm. Yet, there are children who have a Trisomy 21 without the symptoms and characteristic features of Down Syndrome.

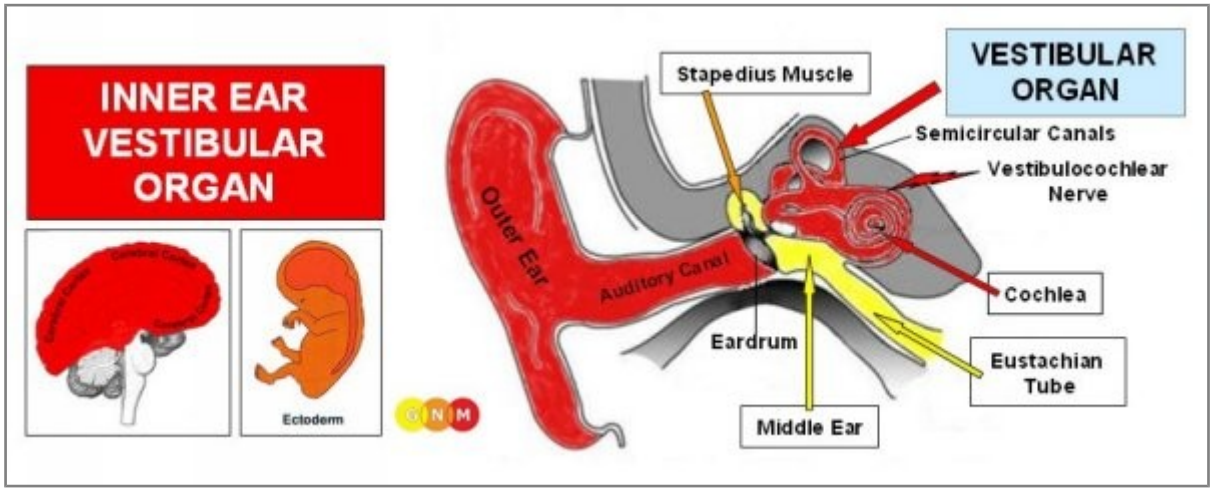
HEALING PHASE: During the healing phase (PCL-A) the volume of the tinnitus sound decreases. However, the swelling created by the edema (fluid accumulation) in the inner ear causes, for the time being, **hearing impairment** (a loss of the frequencies of the tinnitus sound) **or hearing loss** in the affected ear (compare with hearing impairment related to the middle ear). Once the edema has been expelled (during the Epileptoid Crisis) the hearing ability slowly returns to normal, provided there are no conflict relapses. Triggers that reactivate a hearing conflict could also be a smell (the odor of the "messenger") or a visual track (the site of the acoustic source). With a hanging healing the tissue in the inner ear eventually wears out leading in the long run to deafness. This is why it is important to identify and resolve the original conflict as soon as possible.



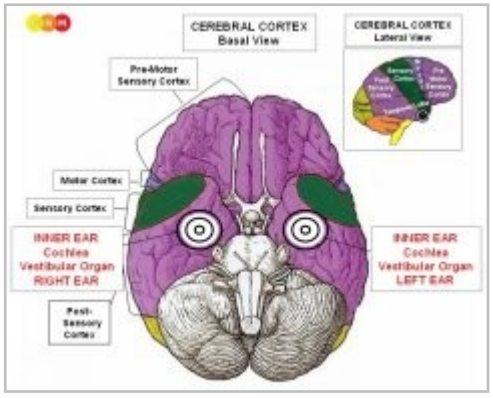
This CT scan shows an edematous ring (perifocal and intrafocal edema) in the "hearing relay" on the left side of the cerebral cortex (red arrows - view the GNM Diagram). Hence, the hearing impairment in the right ear (in PCL-A).

The yellow arrow points to an edema in the control center of the transverse colon (in the brainstem). The related "indigestible morsel conflict" most likely occurred together with thehearing conflict (for a right-handed person related to a partner).

Hearing difficulties often trigger self-devaluation conflicts because of "not being able to hear well". This affects the small bones (malleus, incus, stapes in the middle ear, which can result in permanent hearing loss (see otosclerosis). Using a hearing-aid while the inner ear undergoes healing can therefore have a highly encouraging effect.



DEVELOPMENT AND FUNCTION OF THE VESTIBULAR ORGAN: The vestibular system is the region of the inner ear where the semicircular canals join with the cochlea. It is the part of the ear that regulates the sensation of balance and motion (the cochlear branch of the vestibulocochlear nerve is responsible for hearing). The vestibular organ originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The vestibular organ is controlled from the **post-sensory cortex** (part of the cerebral cortex). The vestibular organ in the right ear is controlled from the left side of the cortex; the vestibular organ in the left ear is controlled from the right cortical hemisphere (temporo-basal). Hence, there is a cross-over correlation from the brain to the organ.

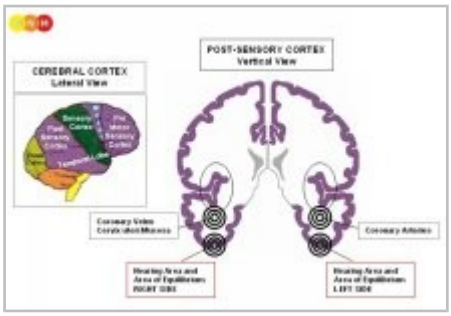
NOTE: The vestibular organ shares the control relays with the cochlea.

BIOLOGICAL CONFLICT: According to its function, the biological conflict linked to the vestibular organ is a **balance conflict**, more precisely, a **falling conflict**. Any fall (accidental fall in sports, at work, falling down the stairs, slipping on a wet or icy surface, a fall from a ladder, tripping over a cable) could trigger the conflict. Certain professions (builders, construction workers, roofers) but also infants and the elderly are more at risk. People with ALS or MS who have difficulties balancing often live in fear of falling; the same holds true for epileptics. The conflict also relates to seeing someone else fall or collapse (witnessing someone having a stroke or a heart attack) or hearing that a loved one fell or "dropped dead". In a transposed sense, the conflict could be experienced as a "fall from grace" or as feeling "dumped", let's say, after a separation.

CONFLICT-ACTIVE PHASE: functional loss of the vestibular branch of the vestibulocochlear nerve resulting in a loss of balance, a condition called **vertigo** (see also acoustic neuroma and vertigo with a "middle ear infection").

NOTE: The vestibular organ (inner ear) belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the cochlea(inner ear), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells andbeta islet cells), skeletal muscles) or hyperfunction (see (periosteum and thalamus).

The **symptom** of vertigo is a **sensation of spinning, swaying or falling to one side** (vertigo "spins" should not be confused with light-headed dizziness). Whether the tendency is to fall to the right or left is determined by a person'shandedness and whether the conflict is mother/child or partner-related. Hence, if a right-handed person has a mother-related falling conflict, there is a tendency to fall or spin to the left, that is, towards the mother (with the Hamer Focus on the right side of the cortex); if the conflict is partner-related, the tendency is to fall or spin to the right, that is, towards the partner (with the Hamer Focus on the left side of the cortex). For left-handers it is reversed. If the conflict concers oneself, the falling or spinning always tends to the side which relates to the original conflict. For example, if the DHS was a fall to the left, the specific vertigo symptom is also a sensation of spinning or falling to the left.

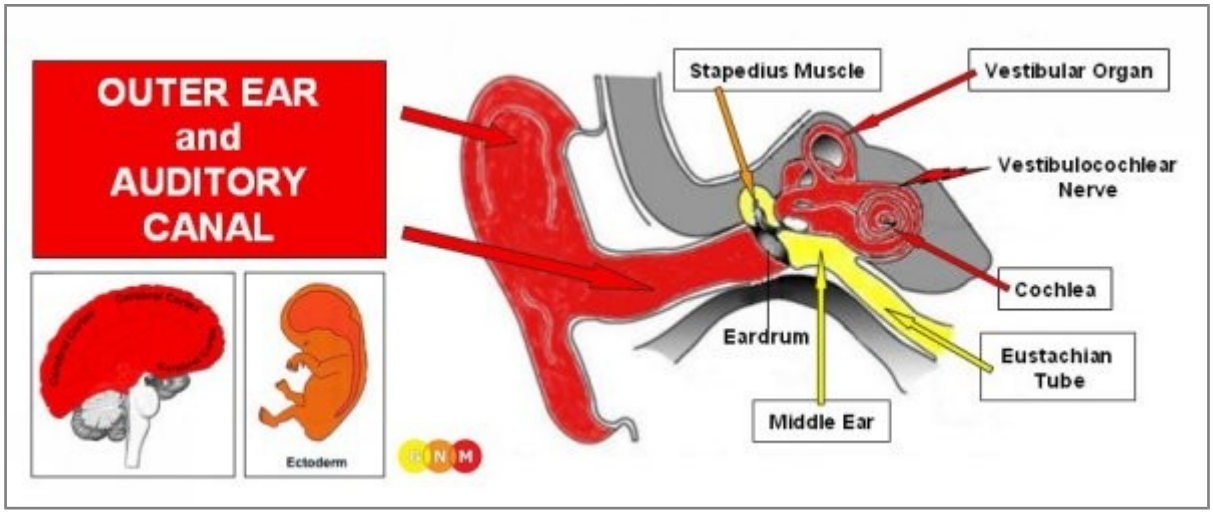


The brain relays of the inner ear are located right underneath the control centers of the coronary arteries and coronary veins/cervix mucosa, which are assigned to a male territorial loss conflict and a female sexual conflictrespectively. Hence, the falling conflict involving the vestibular organ can also have a territorial or sexual aspect (the same applies to the cochlea). Whether the conflict is experienced in a male or female fashion is determined by a person's gender, laterality, and hormone status.

HEALING PHASE: During the healing phase the dizziness diminishes. The Epileptoid Crisis manifests as a sudden**vertigo fit**, potentially with severe nausea and vomiting. The extent of the Epi-Crisis is determined by the intensity and duration of the conflict-active phase. Recurring vertigo attacks are triggered by setting on a track that was established when the original falling conflict occurred. Alcohol, for example, could be such a track.

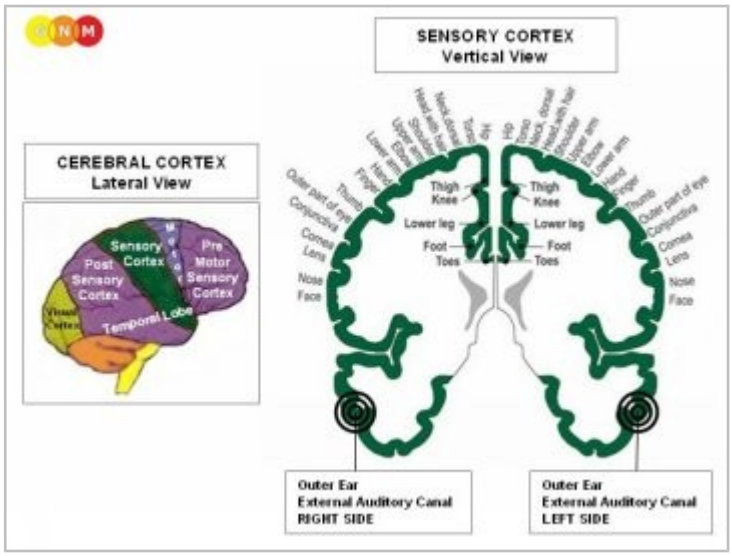
If the **falling conflicts** affect the vestibular organ of both ears this causes, in GNM-terms, a Vertigo Constellation. The**symptoms** are a wide-based and unsteady stance and gait with reeling or lurching movements. The medical term for this condition is **ataxia or Friedreich's ataxia**. The physical incoordination and clumsiness is not the result of muscle weakness but due to the unbalanced equilibrium caused by the "double vertigo". Since infants anIn GNM terms, a "constellation" means that a person is conflict-active with two or more conflicts involving the right and left side of the brain.d the elderly are more likely to suffer falling conflicts, ataxia develops more often in childhood and in later life.

Meniere's disease is, according to conventional medicine, "an inner ear disorder that affects balance and hearing". Based on GNM, the condition is a conflict combination of a falling conflict (involving the vestibular organ) and a hearing conflict (involving the cochlea).



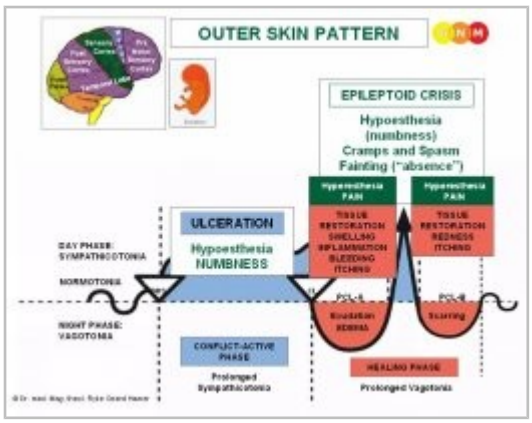
Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE OUTER EAR AND AUDITORY CANAL: The auditory canal extends from the outer ear to the eardrum (tympanic membrane). The outer ear, or auricle, is made up of cartilage covered with skin (corium skin and epidermis). The main function of the outer ear is to capture sound from the external environment and carry it through the auditory canal to the middle ear, where the acoustic wave is transformed into vibrations reaching theinner ear. The lining of the outer ear and of the ear canal consists of squamous epithelium, originates from the ectodermand is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the outer ear and auditory canal is controlled from the **sensory cortex** (part of the cerebral cortex). The outer ear and ear canal of the right ear is controlled from the left side of the cortex; the outer ear and ear canal of the left ear is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the outer ear and auditory canal is a "separation conflict" associated with the ear. The conflict is experienced as a **loss of skin contact at the outer ear**, including the ear lobe, or as **not wanting to be touched at the ear or in the ear** (licking or kissing the ear, unpleasant ear examination procedures, manipulation in the ear canal). Figuratively, the "separation" correlates to **not wanting to hear something** (compare with hearing conflict linked to the inner ear) as well as **not hearing what one expected**, for example, a desired praise, proposal, apology, and the like (see also right middle ear). Wanting to get rid of something in the ear, for example of water, could also trigger the conflict.



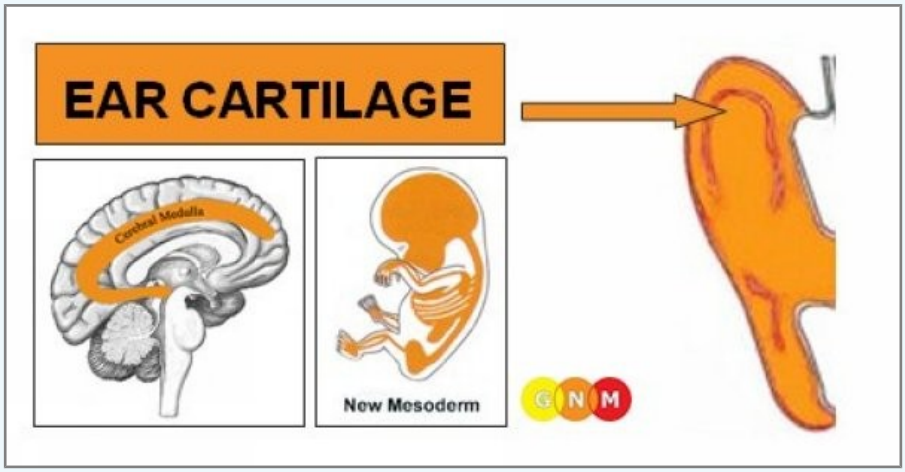
The Biological Special Program of the mucosa of the outer ear and auditory canal follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the outer ear and/or the ear canal. The **biological purpose of the cell loss** is to widen the auditory passage way to improve the sound reception. With intense or prolonged conflict activity, the ulceration makes the **skin dry and flaky**; with acute conflict activity the skin on or in the ear feels numb (see Outer Skin Pattern above).

NOTE: The corium skin below the outer skin lining the ear canal contains sebaceous glands that produce ear wax."Feeling soiled" in the ear (hearing "dirty" words) or an "attack conflict" (insulting words, for example, over the phone) lead to an **overproduction of ear wax** in the conflict-active phase.

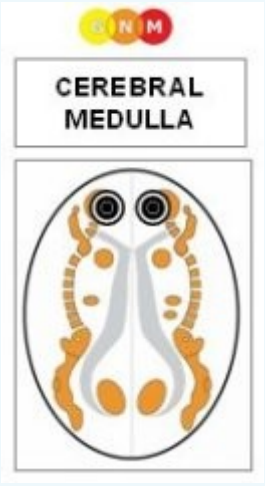
HEALING PHASE: During the healing phase the ulcerated area is replenished with new cells. Typical healing symptoms are **itchy ears** and, if the healing process is more intense, a **skin rash** with **inflammation** and **redness**. The healing process in the ear canal might be accompanied by clear discharge, commonly called "**swimmer's ear"**. A large swelling, termed a **cholesteatoma**, can cause a blockage in the auditory canal resulting in hearing difficulties until the healing process is complete.

NOTE: Whether the right or left ear is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area of the ear that is associated with thehearing or separation conflict.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE EAR CARTILAGE: The ear cartilage forms the shape of the ear and the outer third of the auditory canal. It consists of elastic connective tissue covered by a thin layer, called the perichondrium (unlike other connective tissue, cartilage does not contain blood vessels). The ear cartilage originates from the new mesoderm and is therefore controlled from the cerebral medulla.

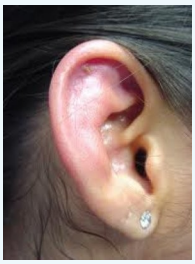


BRAIN LEVEL: In the **cerebral medulla**, the ear cartilage of the right ear is controlled from the left side of the brain; the ear cartilage of the left ear is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the ear cartilage is a **self-devaluation conflict** associated with the ear (compare with self-devaluation conflict related to the ossicles). Generally, the conflict is experienced as "my ears are worthless", let's say, because of having missed an important message. Being hard of hearing and therefore not being able to follow a conversation might also cause the conflict.

CONFLICT-ACTIVE PHASE: necrosis (cell loss) of cartilage tissue, which goes unnoticed.

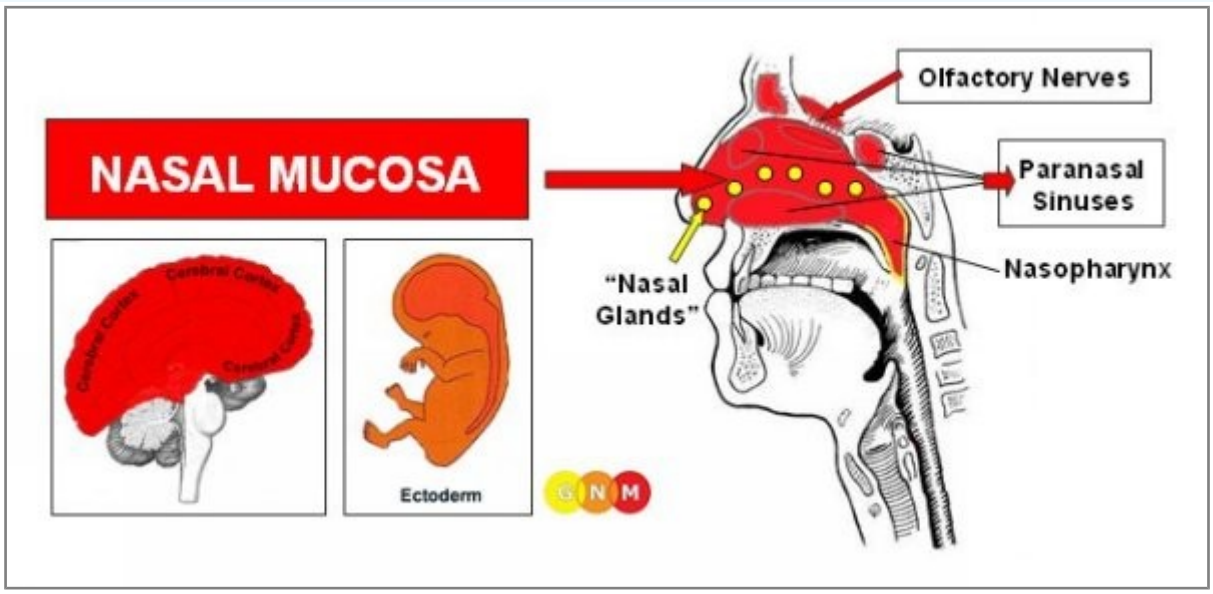
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation). If bacteria are available, they will assist the healing process. With an inflammation, the condition is called **perichondritis**.



Since the ear lobe is not composed of cartilage, the inflammation is restricted to the auricle.

NOTE: Whether the right or left ear is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the ear that is associated with the self-devaluation conflict.

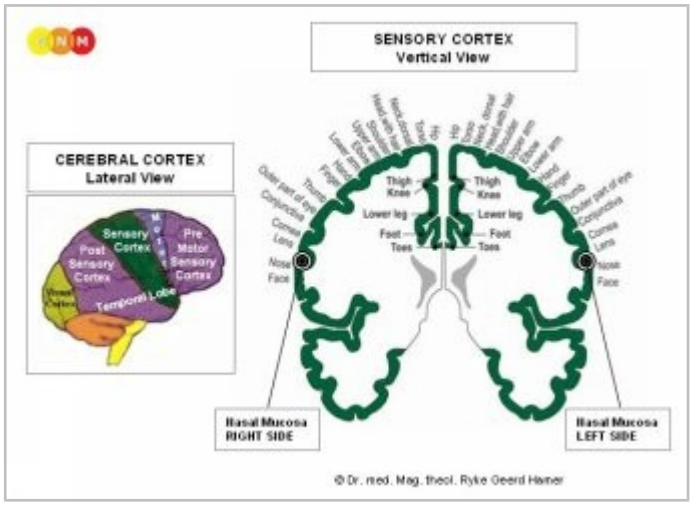
NOSE & SINUSES



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE NASAL MUCOSA: The nasal cavity is divided into a right and left passageway that connect with the paranasal sinuses through small orifices. In the back they join with the nasopharynxand the mouth. Of the five senses (sight, smell, taste, touch, hearing) the olfactory sense is the oldest. In humans, it is the most powerful sense at birth. The sense of smell is to a large extent linked with the sense of taste. The mucosa covering the inside of the nose cleans and moistens the air before entering the lungs. The nasal mucosa consists ofsquamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

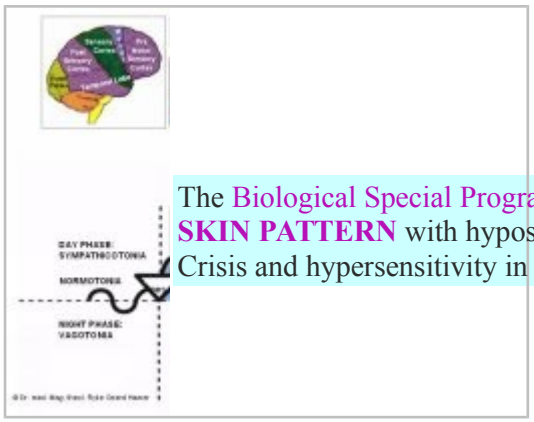
NOTE: The nasal cavities are no longer endowed with an endodermal submucosa. However, the epithelial nasal mucosa still contains residues of endodermal cells ("nasal glands") that produce nasal mucus (see also paranasal sinuses).



BRAIN LEVEL: The nasal mucosa is controlled from the **sensory cortex** (part of the cerebral cortex). The mucosa of the right nasal cavity is controlled from the left side of the sensory cortex; the mucosa of the left nasal cavity is controlled from the right cortical hemisphere (deep basal). Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the nasal mucosa is according to its function a **scent conflict**(see also paranasal sinuses). For animals, the conflict might be provoked by the scent of an approaching predator or the smell of poisonous fumes. For humans, the conflict translates into "smelling" trouble or a potential threat, for instance, "smelling" a competitor or an opponent at work, in school, at home, or in a relationship. The nasal mucosa corresponds also to a **stink conflict**. A stink conflict is experienced in real terms through an offending odor or unpleasant smell, but also if the particular smell is associated with danger. The exposure to cigarette smoke can therefore trigger the conflict for someone who believes that second hand smoke causes lung cancer. In a transposed sense, a stink conflict relates to any situation that is perceived as "This stinks!" or "I am fed up with this!". This might also concern an annoying person (a "pest"). It is a type of "separation conflict".

NOTE: Whether the right or left nasal cavity is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A general "stink conflict" affects both sides.



The Biological Special Program of the mucosa of nasal mucosa follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration of the nasal mucosa proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the nasal passages in order to enhance the sense of smell (in nature, smelling a predator or other potential dangers is essential for survival). **Symptom:** a **dry nose** due to the loss of nasal mucus producing cells.

HEALING PHASE: During the first part of the healing phase (PCL-A) the ulcerated area is replenished through **cell proliferation**. **Healing symptoms** are a **stuffed up nose** caused by the **swelling** of the nasal membrane, a reduced sense of taste and smell (compare with anosmia related to the olfactory nerves), **nasal discharge** to eliminate the remnants of the repair process, **headaches** because of the brain edema in the corresponding brain relay, **elevated temperature or fever**, and **fatigue** since the autonomic nervous system is in the "warm phase" and in a prolonged state of rest (vagotonia). The **shivers** occur in the conflict-active "cold phase" as well as throughout the Epileptoid Crisis.**Sneezing** and **nose bleeds** are

also a sign of the Epi-Crisis. In short, the healing phase of the nasal mucosa presents as the typical **common cold**. The degree of the symptoms is determined by the intensity of the conflict-active phase.

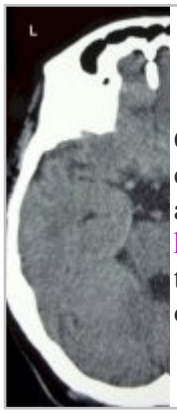
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

When the cold is accompanied or preceded by a sore throat, this indicates that the scent or stink conflict happened together with a conflict of not wanting to "swallow" a situation or accept what "stinks". Coughing, related to the bronchiaor larynx, reveals an additional territorial fear or scare-fright conflict. Typical for this conflict combination are unexpected distress at work, at school, or at home. As soon as the conflicts are resolved, the healing symptoms start all at once or in quick succession.

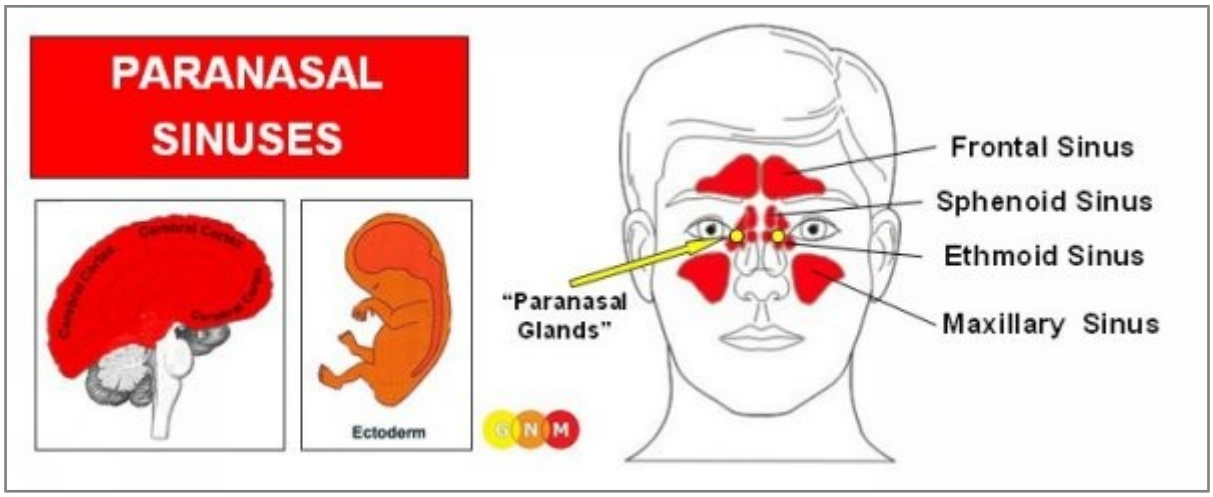
If a number of people have a cold at the same time, we can conclude that everyone who is affected had perceived a certain conflict situation the same way (troubles in day care or kindergarten, poor marks for all students, an unfair teacher, arguments involving several family members, problems at the work place) and is now in healing. In the northern hemisphere such collective "This stinks!"-conflicts are usually brought on at the beginning of the winter season – but only for those who "hate winter" . In spring, the same symptoms are referred to as the "**seasonal flu"**.

Conventional medicine claims that the cold or flu (see also influenza) are caused by viruses. However, to this day, the evidence of the existence of these alleged viruses has never been provided (details presented in the "Virus Mania" GNM DVD). Moreover, **the symptoms of the cold and flu are *healing* symptoms, which highly questions the persistent claim that they are "contagious"**.

Recurring or chronic cold symptoms occur when the scent or stink conflict is reactivated by setting on a conflict track such as a certain smell (food, perfume, flower, grass, cigarette smoke) or taste (milk, nuts, a spice), pet dander, pollen, mold, wind, rain, and so forth. In conventional medicine, this is usually interpreted as an "allergy". People with**pollen allergies** might in reality be "allergic" to the cold symptoms ("This stinks!") or to the "threat" of the "allergy season" resulting in common-cold symptoms (termed "**allergic rhinitis"**) each year. If the nasal congestion is accompanied by watery eyes (see conjunctivitis) then the "allergy" is called "**hay fever"**. In GNM terms, the combination of the symptoms indicates that the healing phases of a scent or stink conflict and a visual separation conflict("I don't want to see this"!) run concurrently.



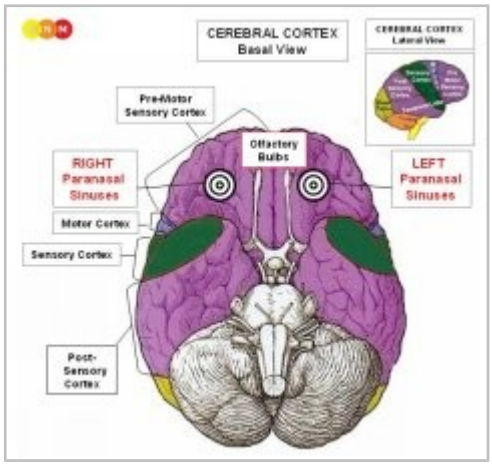
On this CT scan we see the impact of a stink conflict in the area of the sensory cortex that controls the nasal mucosa of the left half of the nasal cavity (view the GNM diagram). For aright-handed person the conflict is associated with his/her mother or child; for a left-handerwith a partner. The uneven, partly edematous ring of the Hamer Focus reveals that the person has already resolved the conflict and is now in the healing phase with symptoms of a cold.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PARANASAL SINUSES: The paranasal sinuses are symmetrically arranged hollow, air-filled cavities lined by a mucous membrane. They are located behind the eyebrows (**frontal sinuses**), behind the nasal cavities (**sphenoid sinuses**), between the eyes and nose (**ethmoid sinuses**), and behind the cheek bones (**maxillary sinuses**). Their function is to moisten and warm the inhaled air and produce mucus that cleans the nasal passages. The paranasal sinuses mucosa consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex. Like the nasal cavities, the paranasal sinuses contain residues of endodermal cells("paranasal glands") that produce nasal mucus.

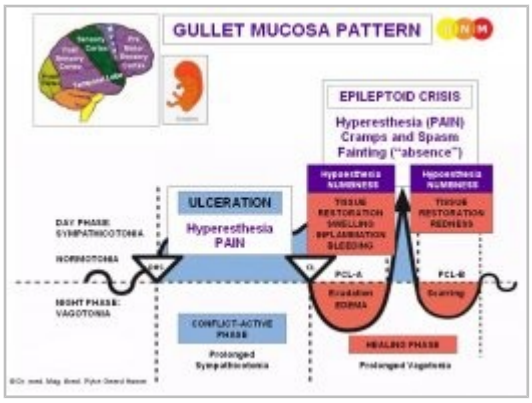
NOTE: The paranasal sinuses are the site from where the ectoderm (outer embryonic germ layer) emerged.



BRAIN LEVEL: The paranasal sinuses mucosa is controlled from the **pre-motor sensory cortex** (part of the cerebral cortex). The mucosa of the right sinuses is controlled from the left side of the cortex; the mucosa of the left sinuses is controlled from the right cortical hemisphere (fronto-basal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The nasal mucosa is controlled from the sensory cortex.

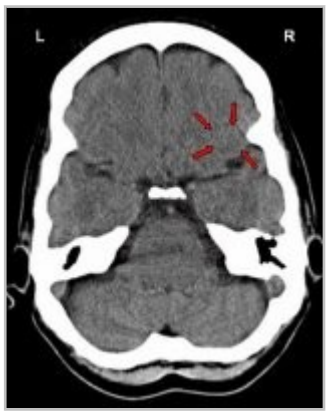
BIOLOGICAL CONFLICT: The biological conflict linked to the paranasal sinuses is the same as the conflict related to the nasal mucosa, namely a **scent conflict or stink conflict**.



The Biological Special Program of the paranasal sinuses mucosa follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the mucosa of the paranasal sinuses proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to enhance the sense of smell. **Symptom:** mild to severe**pain**.

NOTE: Whether the mucosa of the right or left sinuses is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A general "stink conflict" involves both sides. Which one of the paranasal sinuses is affected by the DHS is random.

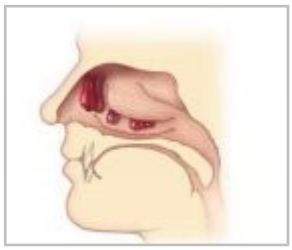


This CT scan shows an active Hamer Focus with a sharp ring configuration on the right side of the premotor-sensory cortex for the left paranasal sinuses (view the GNM diagram), linked to a scent or stink conflict related to a partner if the person is left-handed; for a right-handed person the conflict is associated with his/her mother or child.

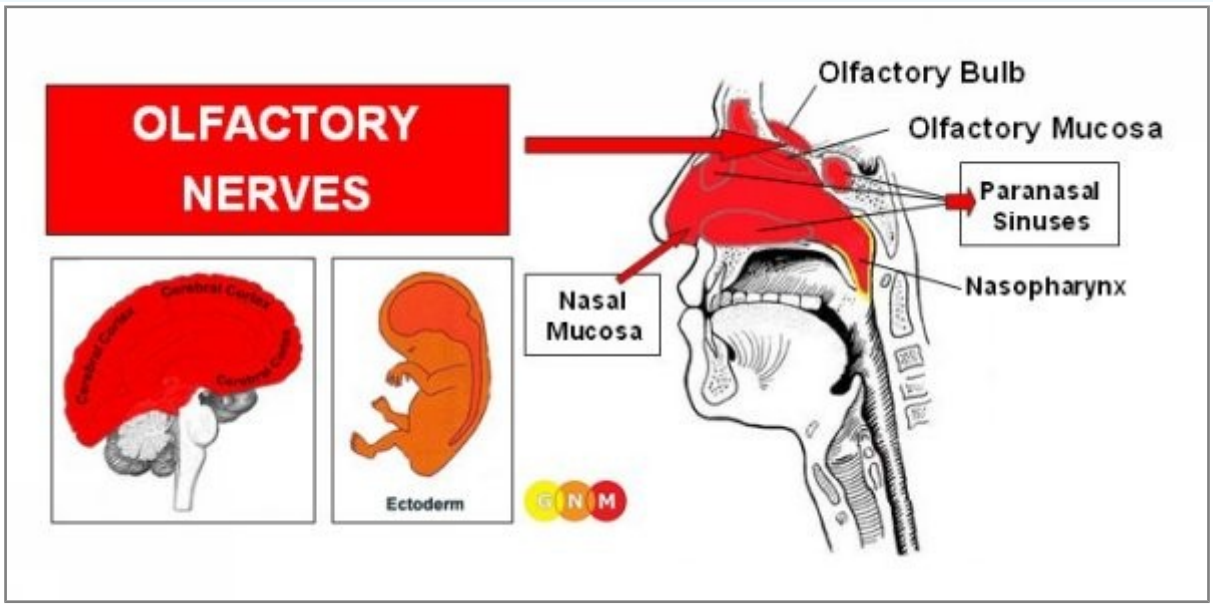
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. **Healing symptoms** are **swelling** of the sinus membrane due to the edema (fluid accumulation), **nasal congestion**, **throbbing headaches** (sinus headaches) and **facial pain**. The pain could last throughout the entire healing phase (in PCL-A and PCL-B) the pain is not of a sensory nature but rather pressure pain). Concurrent water retention because of the SYNDROME enlarges the swelling and increases the pain.

An inflammation of the sinuses is called **sinusitis**. Recurring sinusitis indicates conflict relapses triggered by setting on atrack that was established when the original stink conflict took place. The claim that sinusitis is caused by a "viral infection" is purely hypothetical.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

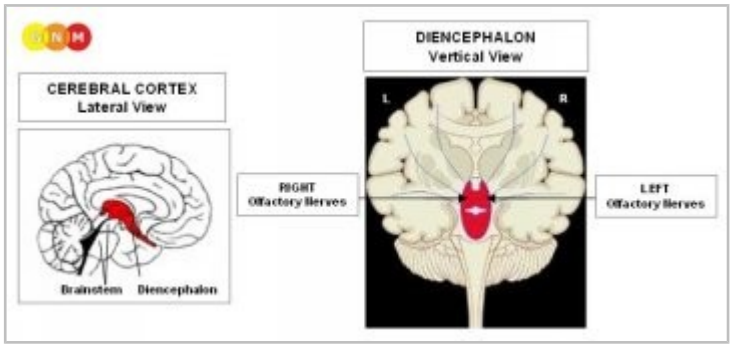


Polyps in the paranasal sinuses are growths in the squamous epithelial sinus mucosa. They typically develop in the ethmoid and maxillary sinuses from where they grow into the nasal cavity (compare with nose polyps in the submucosa of the nasopharynx). With a hanging healing, that is, when the healing phase is continually interrupted by conflict relapses, the polyps can completely close the nasal passages.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE OLFACTORY NERVES: The olfactory nerves play a significant role in the sense of smell. They are composed of a collection of sensory nerve fibres (fila olfactoria) that extend down from theolfactory bulb located at the frontal base of the cerebral cortex. Endowed with special receptor cells the olfactory nerves carry the olfactory signal from the mucosa at the roof of the nasal cavity to the olfactory bulbs. From there the information is transmitted to the brain where the smell is perceived on a conscious level. The olfactory nerves originate from the ectoderm and are controlled from the diencephalon.



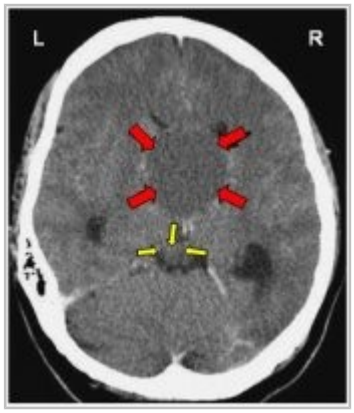
BRAIN LEVEL: The olfactory nerves are controlled from the**diencephalon** (interbrain), which is located in the central part of the cerebrum just above the brainstem. The olfactory nerves in the left nasal cavity are controlled from the right side of the diencephalon; the nerves in the right nasal cavity are controlled from the left side. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the olfactory nerves is "**not being able to smell something or someone"** (in Nature this occurs when a female cannot smell a lost offspring) or, the opposite, "**not wanting to smell something or someone"**, for example, an overpowering stench or the odor of a rival.

CONFLICT-ACTIVE PHASE: functional loss of the olfactory nerves with the **biological purpose** to block the olfactory memory (equal to the short-term memory loss during conflict activity of a separation conflict) or the perception of the unwanted odor. The result is a reduced ability to smell the odor associated with the conflict (**hyposmia**; compare with hyperosmia) or a complete loss of smell (**anosmia**).

NOTE: The olfactory nerves belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the inner ear (cochlea andvestibular organ), retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles), or hyperfunction (see (periosteal nerves and thalamus).

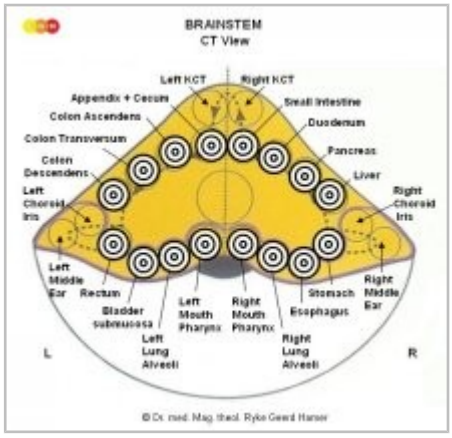
HEALING PHASE: During the healing phase, the sense of smell is restored, shortly interrupted with a temporary loss of smell during the Epileptoid Crisis.



This CT scan presents a Hamer Focus in PCL-A with fluid accumulation (brain edema) in the control center of the olfactory nerves (red arrows - view the GNM diagram), indicating that the related conflict has been resolved. With water retention due to an active abandonment and existence conflict involving the kidney collecting tubules (yellow arrow) the brain edema increases significantly.

HYPEROSMIA

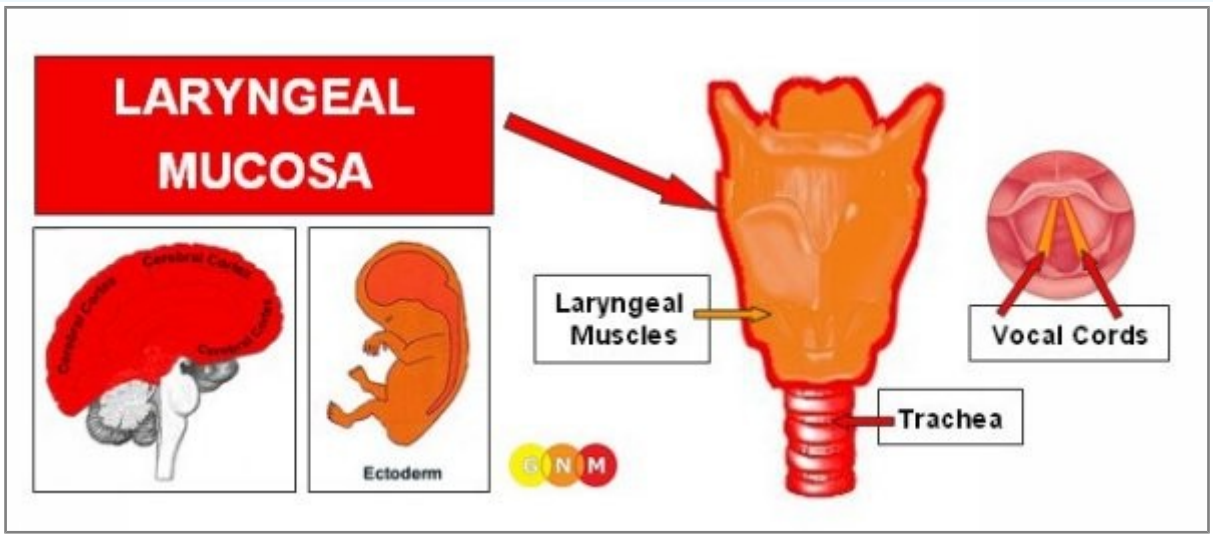
Olfactory hypersensitivity (hyperosmia), an increased sensitivity to smell, relates biologically to the sensitivity of the original gullet.



BRAIN LEVEL: In the **brainstem**, the brain relays of the olfactory nerve (first cranial nerve) are evenly distributed over the control centers of the gastro-intestinal tract.

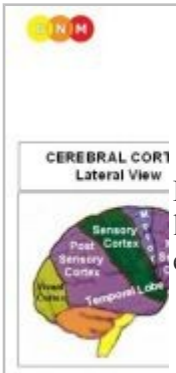
The **biological conflict** linked to the primordial intestinal sensitivity is "**not being able to *sufficiently* smell or identify a (food) morsel"**. The oversensitivity to smells occurs in the conflict-active phase. The **biological purpose** is to be better able to identify the "morsel" (in Nature this is vital for survival). During the healing phase the sense of smell returns to normal.

LARYNX



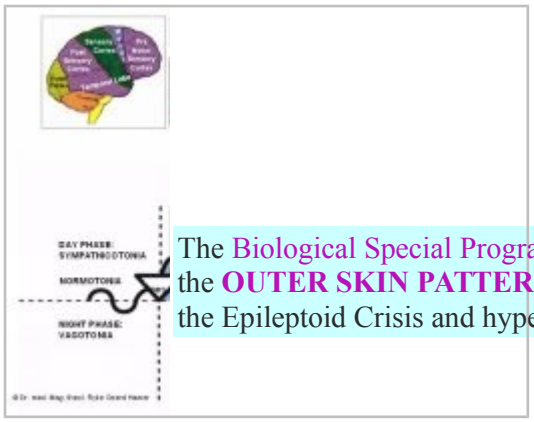
Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE LARYNGEAL MUCOSA: The larynx is a tube-shaped organ that connects the pharynx with the trachea. The larynx is part of the respiratory tract and involved in talking and swallowing. The vocal cords, located within the larynx, participate in the production of sound (this is why the larynx is colloquially called the "voice box"). The mucosa of the larynx and vocal cords consists of squamous epithelium, originates from the ectodermand is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The mucosa of the larynx and of the vocal cords is controlled from the left side of the **temporal lobe** (part of the **sensory cortex**). The control center is positioned exactly across from the brain relay of the bronchial mucosa.

BIOLOGICAL CONFLICT: The biological conflict linked to the mucosa of the larynx and vocal cords is a female **scare-fright conflict** or a male territorial fear conflict, depending on a person's gender, laterality, and hormone status. A scare-fright conflict is the female response to unforeseen danger while a territorial fear conflict is the male response to a territorial threat. The conflict can be triggered by any frightening experience.



The Biological Special Program of the mucosa of the larynx and vocal cords follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the laryngeal mucosa proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the larynx to allow more air-intake to be better able to cope with the fright. **NOTE:** While conflict active, the person is in manic.

This brain CT shows the impact of a scare-fright conflict in the area of the cerebral cortex that controls the laryngeal mucosa (view the GNM diagram). The sharp ring structure of theHamer Focus reveals that the person is conflict active.

HEALING PHASE: During the first part of the healing phase (PCL-A)the tissue loss is replenished through **cell proliferation**. In conventional medicine, the cell increase is diagnosed as a **larynx cancer or "throat cancer"**. Based on the knowledge of GNM, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **pain** due to the swelling caused by the edema (fluid accumulation), **difficulties swallowing**,**coughing**, and a **hoarse voice** or even a complete loss of voice since the vocal cords are affected as well. Depending on the intensity of the conflict, the symptoms range from mild to severe. With an inflammation the condition is called**laryngitis**, typically accompanied by **fever**.

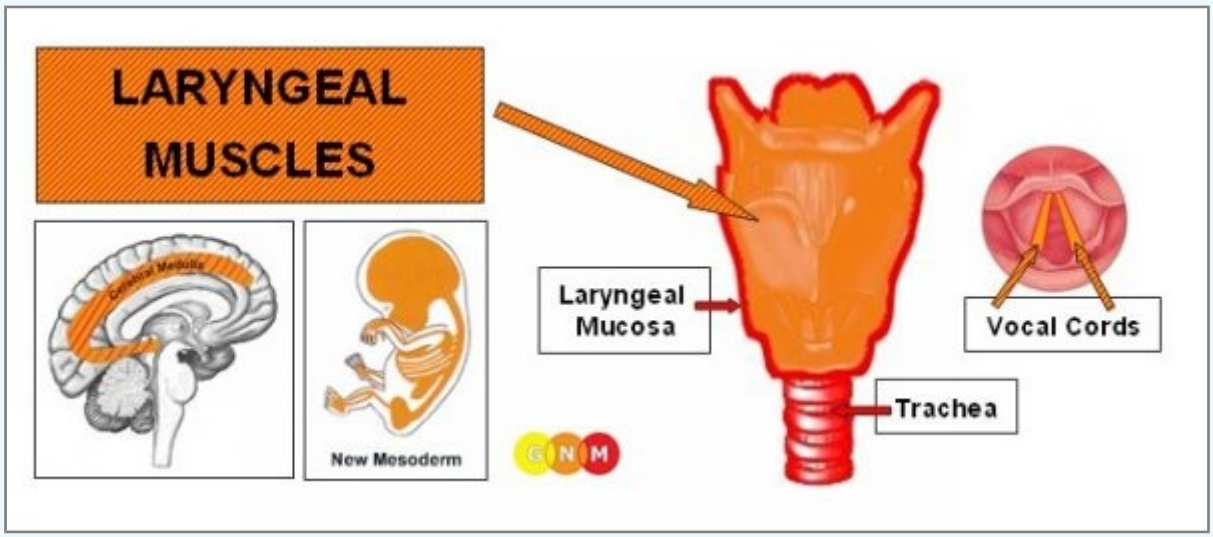
After the Epileptoid Crisis, the swelling subsides and in PCL-B the organ slowly returns to its normal function.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

What is termed "**diphtheria"** is, in GNM terms, a healing process in the larynx with the SYNDROME. The concurrentwater retention enlarges the swelling and increases the pain; breathing also becomes more difficult.

Vocal cord polyps are hardened squamous epithelial warts that develop as a result of repetitive healing

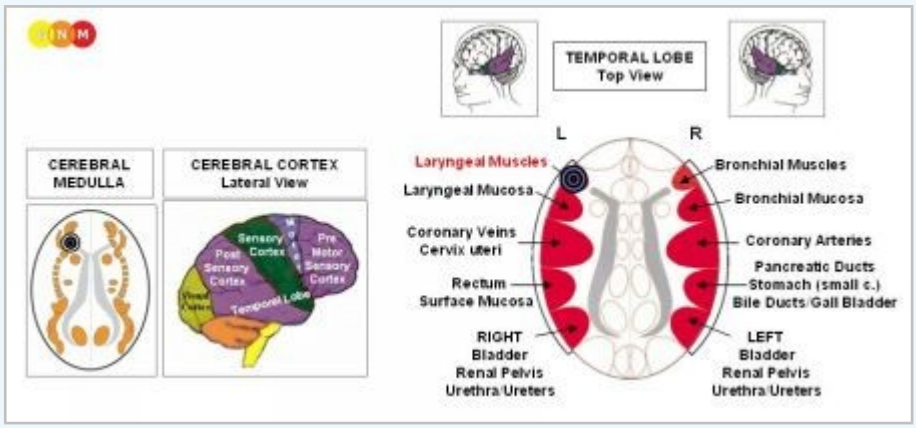
due to conflict relapses. So-called “Singer’s Nodes” are vocal cord nodules caused by injury to the vocal cords because of voice abuse (singing, yelling). In this case, the nodules form as a consequence of the recurring tissue repair - without a DHS.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE LARYNGEAL MUSCLES: The larynx consists of an epithelial mucosa and a layer of smooth and striated muscles. The main function of the laryngeal muscles is to regulate the expansion and contraction of the glottis, the vocal apparatus of the larynx with the two vocal cords. The laryngeal muscles keep the glottis open during respiration and more closed during vocalization. The striated part of the laryngeal muscles originates from the new mesoderm and is controlled from the cerebral medulla and the motor cortex.

NOTE: The **smooth laryngeal muscles** are of endodermal origin and controlled from the midbrain. Like theintestinal muscles that move the “food morsel” along the intestinal canal through peristaltic motion, the smooth laryngeal muscles facilitate the intake of the “air morsel” (inhaling). The elimination of the “air morsel" (exhaling) is supported by the smooth bronchial muscles.



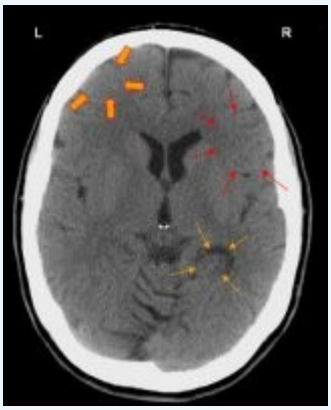
BRAIN LEVEL: The laryngeal muscles have two control centers in the cerebrum. The trophic function of the muscle, responsible for the nutrition of the tissue, is controlled from the **cerebral medulla**; the contraction of the muscles is controlled from the left side of the **motor cortex** (in the **temporal lobe**). The control center is positioned next to the brain relay of the laryngeal mucosa and exactly across from the brain relay of the bronchial muscles.

NOTE: Inhaling is controlled from the bronchial muscles relay (on the right side of the motor cortex) while **exhaling** is controlled from the laryngeal muscles relay (on the left side of the motor cortex). Normally these two breathing motions are in balance. This changes if a biological conflict involves one of the two brain relays or both.

BIOLOGICAL CONFLICT: The biological conflict linked to the laryngeal muscles is the same as for the larynx mucosa,namely, a female **scare-fright conflict** or a male territorial fear conflict, depending on a person's gender, laterality, and hormone status. The distinguishing aspect of the conflict related to the muscle tissue is the additional distress of "not being able to escape", "not being able to (re)act", feeling "rooted to the ground" (petrified), or "feeling stuck" (seeskeletal muscles).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of laryngeal muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the laryngeal muscles** (controlled from the motor cortex). The paralysis causes **breathing difficulties**, explicitly, **difficulties exhaling - inhaling is extended**because of the reduced function of the laryngeal muscles that control exhaling. If the vocal cords are affected, this causes a **voice changes** (voice break) or, with an intense conflict, a vocal cord paralysis with an inability to produce sound. **NOTE:** While conflict active, the person is manic.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.



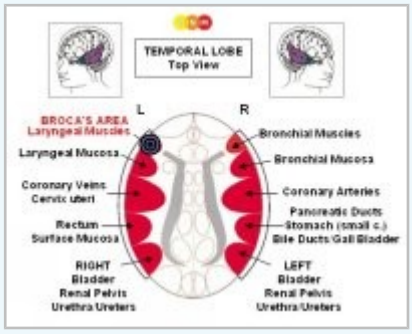
This brain CT shows conflict activity in the laryngeal muscle relay (left side of the cerebral cortex - orange arrows - view the GNM diagram) as well as in the brain relay of the bronchial mucosa (right side of the cerebral cortex – red arrows). The sharp borders of the Hamer Focireveal that both conflicts, namely a scare-fright conflict and a territorial fear conflict are still active (see laryngeal asthma below). A water or fluid conflict (currently in PCL-A) related to the right kidney parenchyma (lower orange arrows) has already been resolved.

HEALING PHASE: During the healing phase the laryngeal muscles are reconstructed. The paralysis reaches into PCL-A.The Epileptoid Crisis presents as **coughing fits** with **spasm and convulsions of the larynx**, equivalent to a focal seizure. The cough that comes from the larynx sounds like "barking" (the expression "kennel cough" points to a scare-fright conflict suffered by animals in the kennel). In PCL-B the function of the laryngeal muscles returns to normal.

What is termed "**spastic laryngitis"** indicates that the laryngeal muscles as well as the larynx mucosa are in healing.**Whooping cough (pertussis)** is also such a combined process (see also whooping cough related to the bronchial muscles).

Recurring symptoms or an "**allergy cough"** are brought on by conflict relapses triggered by setting on a track that was established when the original conflict took place (see allergies).

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



The **Broca's area or speech center** is embedded in the brain relay of the laryngeal muscles (on the left cortical hemisphere). The specific biological conflict linked to the Broca's center is an inability to speak or **speechless conflict**, experienced as an acute fright and being "speechless with fear". This causes during the conflict-active phase **speech impairment**, precisely, difficulties forming words. The condition reaches into PCL-A. but normalizes after the Epileptoid Crisis (see also stroke and speech impairment).

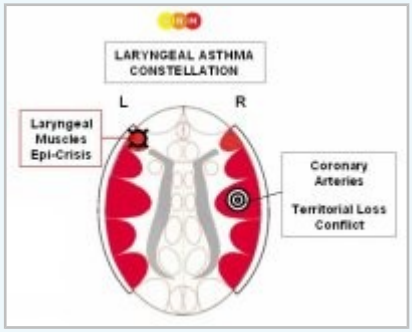
Simultaneous conflict activity of a territorial fear conflict, territorial loss conflict,territorial anger conflict, or territorial marking conflict, controlled from the right temporal lobe, causes **stuttering** (Stuttering Constellation).

LARYNGEAL ASTHMA involves two Biological Special Programs (see also bronchial asthma)

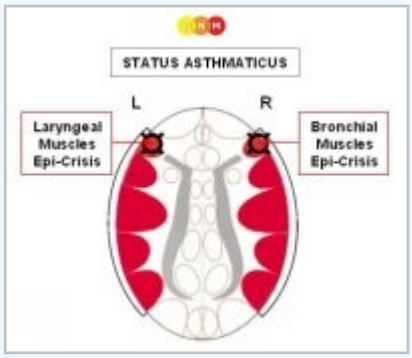
- conflict activity of a scare-fright conflict with the impact of the DHS on the left side of the temporal lobe in the brain relay of the laryngeal muscles

- conflict activity of a territorial fear conflict, territorial loss conflict, territorial anger conflict, or territorial marking conflict corresponding to the right side of the temporal lobe

In this case, the person is in a Laryngeal Asthma Constellation, also throughout the Epileptoid Crisis which is a temporary reactivation of the conflict-active phase.



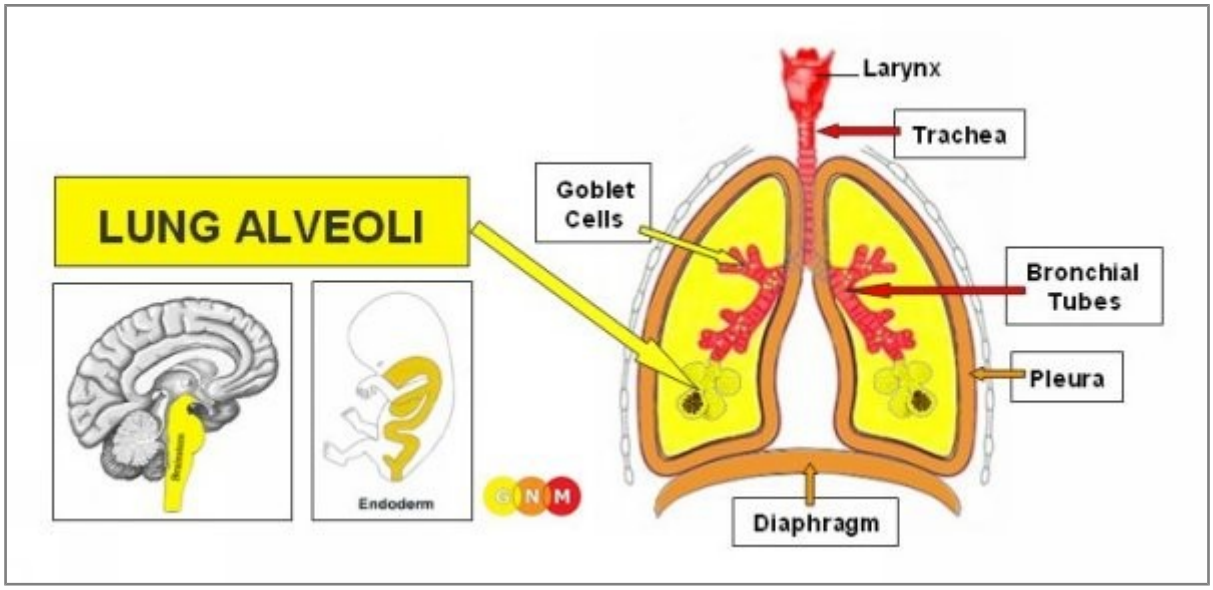
The actual **asthma attack** occurs during the **Epileptoid Crisis of the laryngeal muscles** with convulsions moving inwards.
The **symptoms** of laryngeal asthma are therefore the typical **gasping for breath and prolonged inhaling** (when thelaryngeal muscles are affected, inhaling is extended because of the partial functional loss of the laryngeal muscles that control exhaling). With concurrent water retentiondue to the SYNDROME the asthma attack could be severe. Caution with cortisone!



When both the laryngeal and bronchial muscles go through the Epileptoid Crisis at the same time, the asthma attack presents as prolonged inhaling with gasping for breath (laryngeal asthma) and extended exhaling with wheezing (bronchial asthma). This condition, called "**status asthmaticus"**, causes acute breathing difficulties!

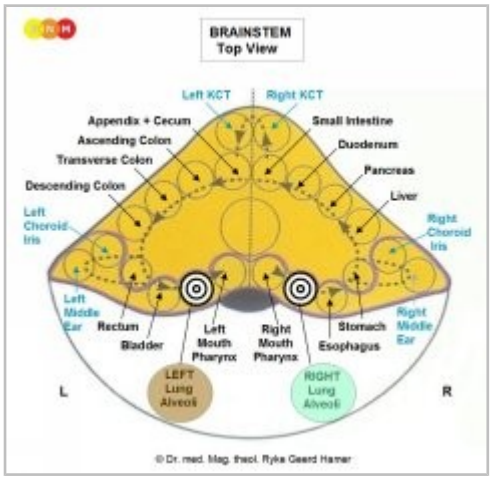
Chronic laryngeal asthma attacks indicate that the related scare-fright conflict has not been completely resolved. In conventional medicine, recurring asthma attacks are usually associated with an "allergy".

LUNGS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE LUNG ALVEOLI: The lungs are located on either side of the thorax and are separated from each other by the heart. They are enclosed by the ribcage and the diaphragm, the chief muscle of respiration. The pleura protects and cushions the lungs. The function of the lungs is to deliver oxygen into the body through inhaling and to remove carbon dioxide through exhaling. After entering the nose or mouth, air travels down thetrachea. The trachea divides into two bronchi that continue to split into smaller and smaller branches, called bronchioles. The bronchioles end in tiny air sacs, or lung alveoli. The alveolar cells (pneumocytes) lining the lung alveoli regulate the gas exchange between the alveoli and the blood. In evolutionary terms, the pneumocytes developed from intestinal tissue. Equal to the intestinal cells that absorb the "food morsel", the biological function of the alveolar cells is to "absorb" (resorptive quality) the "air morsel". The alveolar cells consist of intestinal cylinder epithelium, originate from the endoderm, and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the lung alveoli have two control centers, positioned within the ring form of the brain relays that control the organs ofalimentary canal.

The lung alveoli of the right lung, originally responsible for the intake of oxygen, are controlled from the right side of the brainstem (see right half of the mouth and pharynx corresponding to the intake of food). The lung alveoli of the left lung, originally responsible for the output of carbon dioxide, are controlled from the left brainstem hemisphere (see left half of the mouth and pharynx corresponding to elimination). Today, both lungs share the same function (see also development of the kidneys).

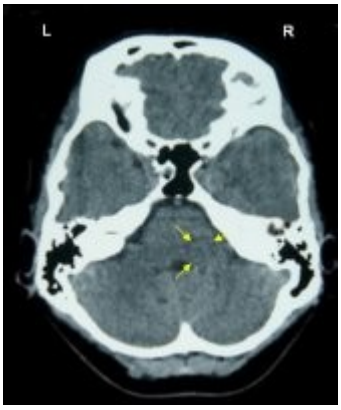
BIOLOGICAL CONFLICT: The biological conflict linked to the lung alveoli is a **death-fright conflict** because, in biological terms, the death panic is equated with not being able to breathe. The control center on the right side of the brainstem relates to "**not being able to catch the air morsel"**, that is, not being able to inhale. The control center on the left side of the brainstem relates to "**not being able to eliminate the air morsel"**, that is, not being able to exhale, for example, due to hyperventilation.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

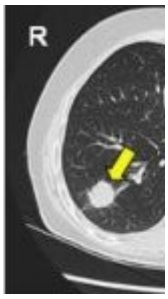
A **death-fright** can be experienced in any life-threatening situation, for example, in the course of an accident or during a medical emergency. By far the most common death-fright conflict, however, is brought on by a **diagnosis shock**, particularly by a cancer diagnosis that hits a person like a death-sentence. Statements by a physician such as "the cancer is malignant", "inoperable", "aggressive", "invasive", "metastasizing" or remarks like "you have six months to live" and other verdicts of this kind can evoke an acute death panic. The same holds true for a negative prognosis and test results based on medical checkups (Pap tests, PSA tests, mammograms, colonoscopies, blood tests). We also have to take into account potential **self-diagnosis shocks** triggered, for instance, when detecting a lump, let's say, in thebreast, when there is blood in the stool, in the urine or in the vagina, or with other symptoms associated with having cancer ("a deadly disease"). Looking for information about a particular symptom on the internet with countless websites propagating the concept of "malignant diseases" can easily activate a death-fright conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase lung alveoli cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to improve the function of the lungs by supplying the organism with more oxygen so that the individual is in a better position to escape from the life-threatening situation. With prolonged conflict activity (hanging conflict) flat-growing lung nodules (resorptive type), referred to as a **lung cancer**, develop as a result of the continuing cell augmentation (compare with "lung cancer" related to the bronchia). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant".

NOTE: A death-fright can be experienced for one's own life or for the life of others (a family member, beloved friend, or a pet). **Multiple lung nodules** reveal that the death-fright conflict relates to oneself. A **single lung nodule** forms if one suffered the conflict with or for another person (or animal); two nodules develop for two people (for example, with a death-fright for both parents), three nodules for three people, and so forth. The same principle applies to liver nodules.



On this brain CT we see the impact of a death-fright conflict in the area of the brainstem that controls the lung alveoli of the right lung (view the GNM diagram). The sharp border of the Hamer Focus reveals that the person is still conflict active.



This image shows a single lung nodule in the right lung. On an organ CT, the compact (hyperdense) lung nodule, indicating the conflict-active phase of a death-fright conflict, appears as white.

Since there are no noticeable symptoms during the conflict-active phase, lung nodules are at this point only detected through routine medical checkups or follow-up examinations. Because of today's increased pressure for "preventive" screening and more sophisticated diagnostic tools, particularly with the invention of MRIs and mammograms, a lot more cancers are found. Consequently, many more people suffer death frights. This explains why lung cancer is still the most frequent cancer in spite of a significant decrease of the number of cigarette smokers and why even heavy smokers don't necessarily develop lung cancer - or *any* cancer (see carcinogens theory).

Animals, like our pets, rarely get lung cancer, not because they don't smoke but because they are oblivious to a diagnosis. Nancy Zimmermann, director of medical support at Banfield, the Pet Hospital, one of the world's largest veterinary practices: "It's important to note that there's no absolute direct link between smoking and cancer in pets." (*National and Oregon Health and Wellness Information and Medical News*, January 19th, 2009)

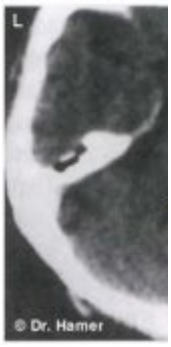
Lung X-rays are usually performed after the diagnosis of a first cancer such as a breast cancer, colon cancer, prostate cancer, and others. The time-lapse between the diagnosis and further tests is therefore crucial, because it is during this period that the lung nodules develop. Repeated follow-up exams keep the death-fright active (hanging conflict). According to Dr. Hamer, lung nodules are already visible on an X-ray after a couple of weeks following the DHS. Conventional medicine interprets the nodules as a "metastasizing cancer". In reality, the lung cancer was caused by the death-fright over the devastating diagnosis of the first cancer resulting in a new, that is, a **secondary cancer**.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **coughing up milky or rusty-colored phlegm**. The **sputum might contain blood**. Because of the pus in the discharge, the symptoms might be diagnosed as **purulent pneumonia** or a "lung infection" (compare with pneumonia related to the bronchial mucosa). Another typical healing symptom is **night sweats**. If fungi assist healing, this causes **lung candidiasis** or a so-called "**pulmonary fungal infection**".

CAUTION: During the healing process the lung tissue is very soft. A jerky or vigorous move could rupture the lungs resulting in acute bleeding (pulmonary hemorrhaging).

Tubercular secretion, excreted through the sputum, **is rich in protein**. If the healing phase is long and intense, the protein deficiency could be fatal. Death, however, is not caused by the TB-"infection" but rather by the protein depletion (for that reason, tuberculosis was formerly called "consumption"). This is exactly what happened during the **lung tuberculosis epidemic of 1918/19** (see fatality statistics), after millions of people had resolved the death-fright conflicts suffered during four years of war. The end of the war initiated a mass-healing, so-to-speak, resulting in two pandemics (see also Spanish Flu). Due to the extreme poverty caused by the world economic crises that followed First World War, those afflicted with tuberculosis did not get the protein-rich food needed for healing. Only those who could afford adequate nutrition were able to survive. The poor had no chance. Historical reports about tuberculosis epidemics claim that tuberculosis disappeared after the social and sanitary conditions had improved. In reality, it was the ensuing adequate nutrition that improved the situation. The total eradication of tuberculosis took only place where the TB bacteria were destroyed through large-scale administrations of **anti-TB antibiotics**, introduced in 1944. In the late 19th century, before the appearance of antibiotics, tuberculosis sanatoria provided those who were able to afford it with good nutritiontogether with enforced rest – a perfect setup for assisting the healing process.

Previously, the coughing up of blood (hemoptysis) was rightly diagnosed as **lung tuberculosis**. Today, the condition is called **lung cancer** (see also renaming of liver tuberculosis to liver cancer and kidney tuberculosis to "nephrotic syndrome"). It is the renaming of the disease why the numbers of lung cancer increased drastically, while tuberculosis "disappeared", notably in the Western World where the eradication of lung tuberculosis is attributed to the "success" of extensive antibiotics regiments and vaccinations (the BCG-Bacillus Calmette-Guérin vaccine was first introduced in 1921; however, it only became widely used after the Second World War). In the "developing world", tuberculosis is now considered a disease related to AIDS!



The "swollen", edematous rings of the Hamer Focus in the right lung alveoli relay (view the GNM diagram) tell that the person has resolved the death-fright conflict and is now in PCL-A.

NOTE: With water retention due to the SYNDROME there is a risk that an enlargedbrain edema compresses the fourth ventricle causing a hydrocephalus.

With water retention due to an active existence conflict involving the kidney collecting tubules, the accumulation of**fluid in the lungs** (in PCL-A) creates a **lung edema**, or **alveolar edema** (compare with cardiac pulmonary edemarelated to the myocardium and lung edema related to the mitral valve). The fluid in the lungs causes severe breathing difficulties and potentially respiratory failure (compare with water around the lungs related to the pleura). Such an acute situation typically occurs because of fear ("my life is at stake!") or during hospitalization (see Kidney Collecting Tubule Syndrome).

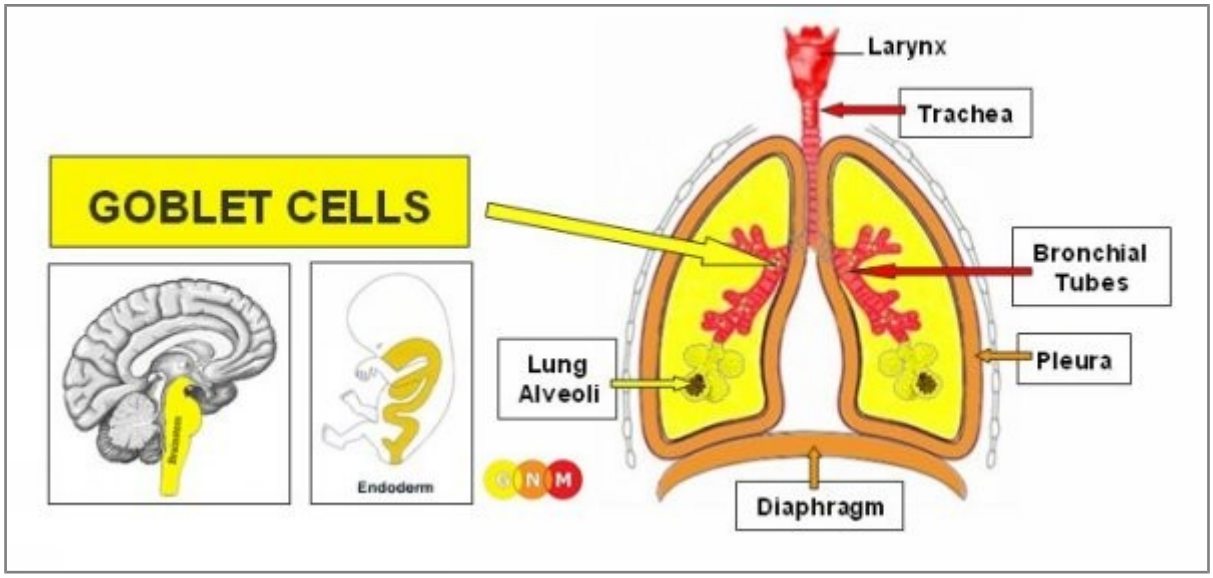
After the lung nodules have been removed, **caverns** remain at the site. The caverns are filled with air (compare withliver caverns, pancreas caverns, breast gland caverns). With a hanging healing, that is, when healing is continuously interrupted by conflict relapses triggered by death-fright tracks, the caverns increase in size; even more so with theSYNDROME when the retained water over-inflates the caverns.

The “holes in the lungs” present the clinical picture of a **lung emphysema** with a chronic shortness of breath.

During an accident, a fall, or a vigorous move, for example, in sports, a lung cavern can rupture, leading to a **pneumothorax** with air entering the pleural space causing a collapse of the lungs. A pneumothorax could also occur through a lung puncture (see pleural effusion).

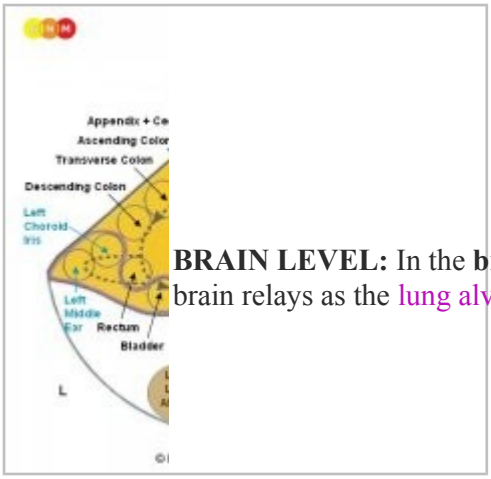
Pulmonary fibrosis is the result of recurring healing phases (compare with cystic fibrosis related to the goblet cells). In this case, the caverns are filled with fibrotic tissue. The condition is described as "scarring of the lungs". The buildup of scar tissue is also termed **pulmonary sarcoidosis**, or **Morbus Boeck**.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the lung nodules cannot be broken down and therefore remain. Eventually they become encapsulated. Hence, today’s excessive use of antibiotics contributes significantly to the increasing number of lung cancers that are detected during medical exams. Such encapsulated lung nodules that originated in a long-gone death-fright, might be accidentally discovered years or even decades later.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE GOBLET CELLS: The goblet cells are single-celled glands found scattered in the bronchial mucosa and the trachea. In the bronchi, the goblet cells secrete mucus that moistens the respiratory passages and cleanses the air entering the lungs. In embryology, the goblet cells are considered residues of intestinal cells. They therefore consist of intestinal cylinder epithelium, originate from the endoderm and are controlled from the brainstem.

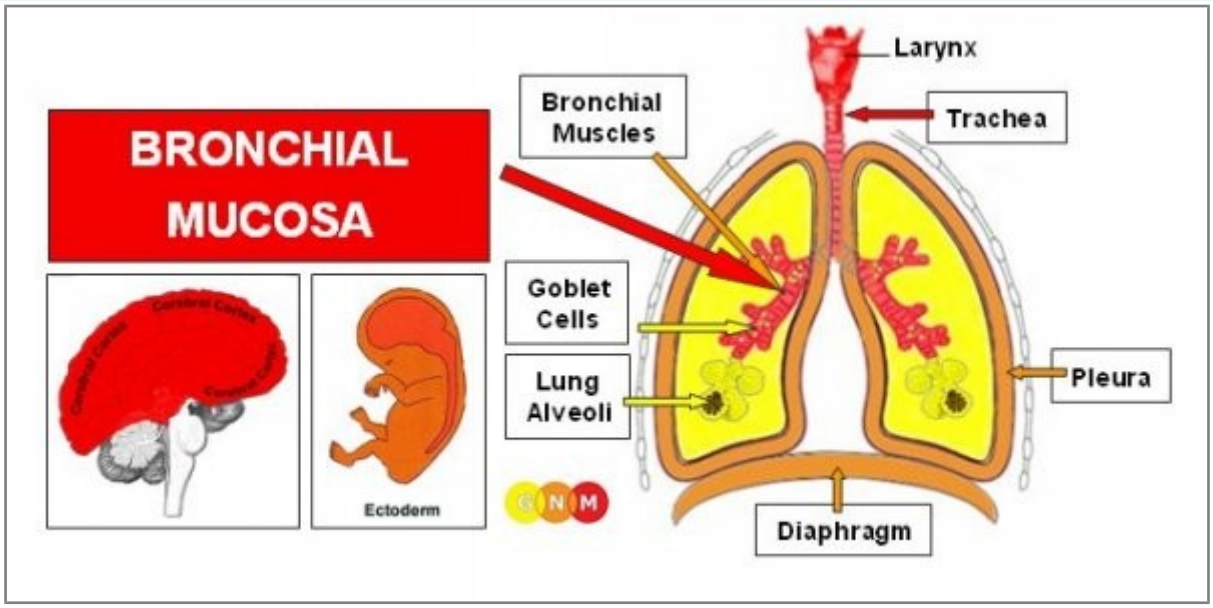


BRAIN LEVEL: In the **brainstem**, the goblet cells are controlled from the same two brain relays as the lung alveoli.

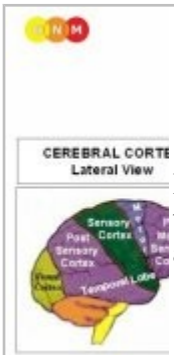
BIOLOGICAL CONFLICT: The biological conflict linked to the goblet cells is a **fear of suffocating, a panic of not getting enough air**. The conflict could be experienced, for example, during an accident (drowning, smoke poisoning, strangulation) or a medical emergency such as an asthma attack. Newborns suffer the panic of suffocating when the umbilical cord is wrapped around the neck or is cut too early, because the lungs of the newborn need a certain amount of time to get used to independent breathing. Infants have the conflict, when they are put in a position where they are unable to breathe.

CONFLICT ACTIVE PHASE: In the same way as intestinal cells proliferate with a biological conflict associated with a "food morsel", during the conflict-active phase the goblet cells increase in number in response to the distress of not getting enough air. The **biological purpose of the cell proliferation** is to enhance the secretion of mucus in order to better insalivate the "air morsel". In conventional medicine, the additional cells are diagnosed as a **intra-bronchial goblet cell carcinoma**.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **coughing up of purulent, yellow phlegm**, and **night sweats**. With an intense healing phase, the accumulation of thick, viscious mucus in the bronchi could cause a complete clogging of the airways resulting in **mucoviscidosis** or **cystic fibrosis** with severe breathing difficulties (compare withpulmonary fibrosis related to the lung alveoli). If the healing process is prolonged (hanging healing) because of continualconflict relapses, the recurring decomposing process leads eventually to a loss of goblet cells resulting in a reduction or cessation of mucus production.



DEVELOPMENT AND FUNCTION OF THE BRONCHIAL MUCOSA: The bronchial tubes branch from the trachea into two main bronchi from where they subdivide inside each lung into numerous small ducts, called bronchioles. The main function of the bronchi and bronchioles is to carry air into the lung alveoli where oxygen and carbon dioxide are exchanged during respiration. The bronchial mucosa consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

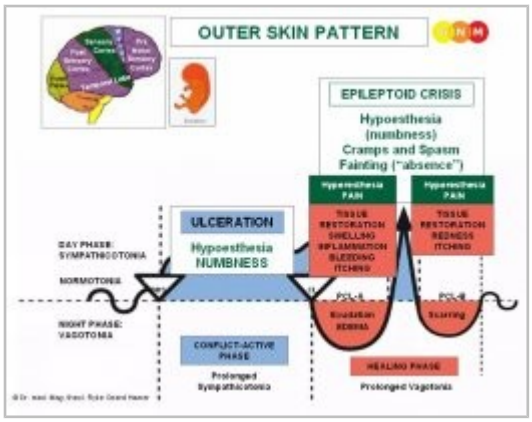


BRAIN LEVEL: The bronchial mucosa of both lungs is controlled from the right side of the **temporal lobe** (part of the **sensory cortex)**. The control center is positioned exactly across from the brain relay of the laryngeal mucosa.

BIOLOGICAL CONFLICT: The biological conflict linked to the bronchial mucosa is a **male territorial fear conflict** or female scare-fright conflict, depending on a person's gender, laterality, and hormone status. The male territorial fear conflict is the equivalent to the female nest-worry conflict. In fact, originally, Dr. Hamer termed the bronchia-related DHSa "territorial-worry conflict".

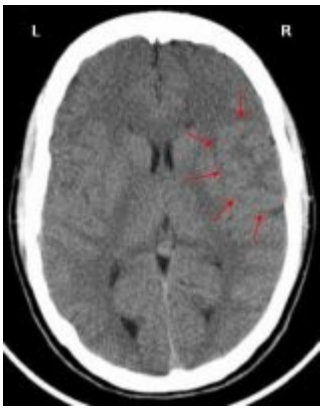
In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial fear conflict** refers to a **threat to the "territory"**, a **fear within the "territory"** (at home, at work, in school, at the playground, in kindergarten or day care, in a seniors home, in the hospital, or in the village, city, and country where one lives), and to a **fear regarding one's own safety** as well as the safety of the "pack". Physical abuse, family violence, mobbing, bullying, an accident, fire or flooding, an acute medical condition, a frightening diagnosis or prognosis, scary medical procedures, or hospitalization are a few examples of what can trigger the conflict. Children suffer the conflict when they are punished, abused, or yelled at, when they are terrified of a person or a situation, when they watch spooky films or videos showing monsters or vampires, or when they have nightmares. An adult's panic can also create a territorial fear in a child! Unborn children experience the conflict in the womb when the mother is in danger or at birth during a difficult delivery. The conflict could also concern a member of the "territory" (a fear of losing a partner who secures a home or when a loved one is seriously ill, hospitalized, or diagnosed with cancer - associated with a "fatal disease"). A territorial fear can be shared by people of large regions, for example, during a natural disaster, during wartimes, or through scares of terrorist attacks or pandemic fear-mongering (AIDS, SARS, Swine Flu, and the like) by the media.



The Biological Special Program of the bronchial mucosa follows the**OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

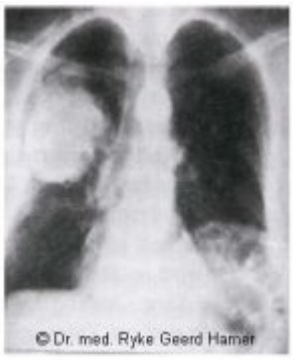
CONFLICT-ACTIVE PHASE: ulceration in the bronchial mucosa proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the respiratory passageways so that more air can reach the lungs. The enhanced function of the lungs serves to facilitate a conflict resolution. There are no symptoms in the conflict-active phase. **NOTE:** While conflict active, the person is in a depressed mood.



This brain CT shows the impact of a territorial fear conflict in the area of the cerebral cortex that controls the bronchial mucosa (view the GNM diagram). The sharp border of the Hamer Focus reveals conflict activity.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. **Healing symptoms** are **pain** due to the swelling caused by the edema (fluid accumulation), **tickles in the lungs** (itching or pruritus is characteristic for any healing involving squamous epithelial tissue such as the skin**) and coughing**. Coughing facilitates bringing up phlegm containing remnants of the repair process. Depending on the intensity of the conflict, the symptoms range from mild to severe. After the Epileptoid Crisis, in PCL-B, the swelling recedes and the function of the bronchia returns to normal.

In conventional medicine, the cell proliferation that takes place in PCL-A is diagnosed as a "**lung cancer"** or **bronchial cancer** (compare with lung cancer related to the lung alveoli). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.



The swelling in a bronchial tube can block the air passages resulting in a bronchial **atelectasis**. On a lung X-ray, the bronchus, void of air due to the obstruction, appears as white (see picture). After the Epileptoid Crisis, the bronchial tube reopens accompanied by heavy coughs and sputum production. However, with a hanging healing, when the repair process is continually interrupted by conflict relapses, the scar-buildup eventually hardens with the result that the atelectasis remains. The bronchial constriction causes permanent breathing difficulties, even after the healing phase has been complete.

According to Dr. Hamer, an atelectasis is often misdiagnosed as a bronchial tumor.

Bronchitis occurs when healing is accompanied by an **inflammation**, typically with **fever**, **headaches** because of the swelling in the corresponding brain relay, and **fatigue** since the autonomic nervous system is in a state of prolonged rest**(**vagotonia**)**. In conventional medicine, recurring bronchitis is generally associated with "allergies" (see also bronchial asthma).

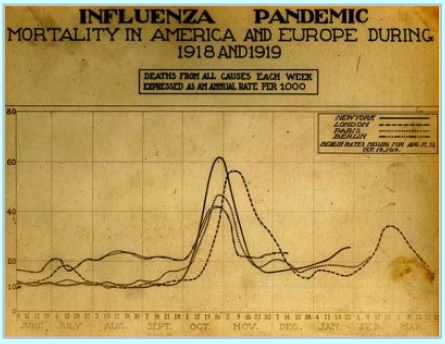
Pneumonia is bronchitis with the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict involving the kidney collecting tubules. In PCL-A, the retained water is exceedingly stored in the bronchial tubes (compare with lung edema). A lung puncture to drain the fluid can be life-saving. Yet, for someone notfamiliar with GNM, the procedure might trigger an "attack against the chest"-conflict with an acute pleural effusion(accumulationof water around the lungs) after each puncture. On the brain level, the excess water could lead to serious complications, particularly during the Epileptoid Crisis, which is the critical point ("pneumonic lysis") when the brain edema is expelled. The brain pressure caused by the sympathicotonic surge could be so strong that the person falls into a coma and dies. However, if the conflict-active phase lasted less than 4-5 months, the Epi-Crisis is, according to Dr. Hamer, not life-threatening.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

So-called **Legionnaires' disease** is a type of pneumonia. The name originates from an outbreak of pneumonia among people who had attended a convention of the American Legion in Philadelphia in 1976. What was possibly the territorial fear conflict experienced by so many participants of the meeting?

"**Bacterial pneumonia"** indicates that the repair and scarring process (PCL-B) is assisted by bacteria. This is usually the case, when the ulceration that takes place in the conflict-active phase reaches deep into the bronchial tissue.

Conventional medicine claims that "**viral pneumonia"** is caused by viruses, notably by influenza viruses that purportedly caused the **Spanish Flu pandemic** after the First World War or, in our days, SARS, the Bird Flu, the Swine Flu, and the like. However, none of the influenza viruses have ever been scientifically verified (details are presented in the "Virus Mania" GNM DVD). Threats of a global "influenza pandemic", however, can trigger territorial fear and existence conflicts among the population resulting in a fast increase of **influenza** cases.



These statistics of the Spanish Flu pandemic show that the outbreak started at the beginning of October 1918 reaching its height 3-4 weeks later. According to historical records, Germany asked the Allies for ceasefire on October 4th, 1918 (the official date of the end of the First World War is November 11, 1918).

With the prospect of peace, millions of people worldwide went into healing of territorial fear conflicts they had suffered during four years of war (see also lung tuberculosis epidemic of 1918/19).

Pneumonia is also the most common lung condition associated with HIV and **AIDS**. As we now come to understand, there is no causal relation at all to the alleged HI-Virus but rather to a "territorial fear" or scare-fright conflict associated with the "disease".

AIDS-Acquired Immune Deficiency Syndrome

"Up to today there is no single scientifically convincing evidence for the existence of HIV. Not even one such retrovirus has been insolated and purified by the methods of classical virology." (Dr. Heinz Ludwig Sanger, Emeritus Professor for Molecular Biology and Virology, Max-Planck-Institute for Biochemistry, Munich)

In 1983, the American researcher Robert Gallo claimed that he had discovered the "human immunodeficiency virus" (HIV) as the agent responsible for the cause of AIDS. In 1984, Gallo published four articles in *Science*, in which he stated that he had isolated the HIV virus. In December 2008, thirty-seven legal, medical and research professionals sent a letter to the journal, asking it to officially retract the original four papers that made the case for HIV as the cause of AIDS. According to the authors, widespread evidence had emerged that Gallo's studies were not only poorly carried out, but that their results were falsified. The letter from the 37 experts includes a letter from Gallo himself, admitting to another researcher that HIV could not be isolated from human samples alone. In addition, a letter from an electron microscopy expert revealed that there was no HIV virus contained in Gallo's 1984 samples.

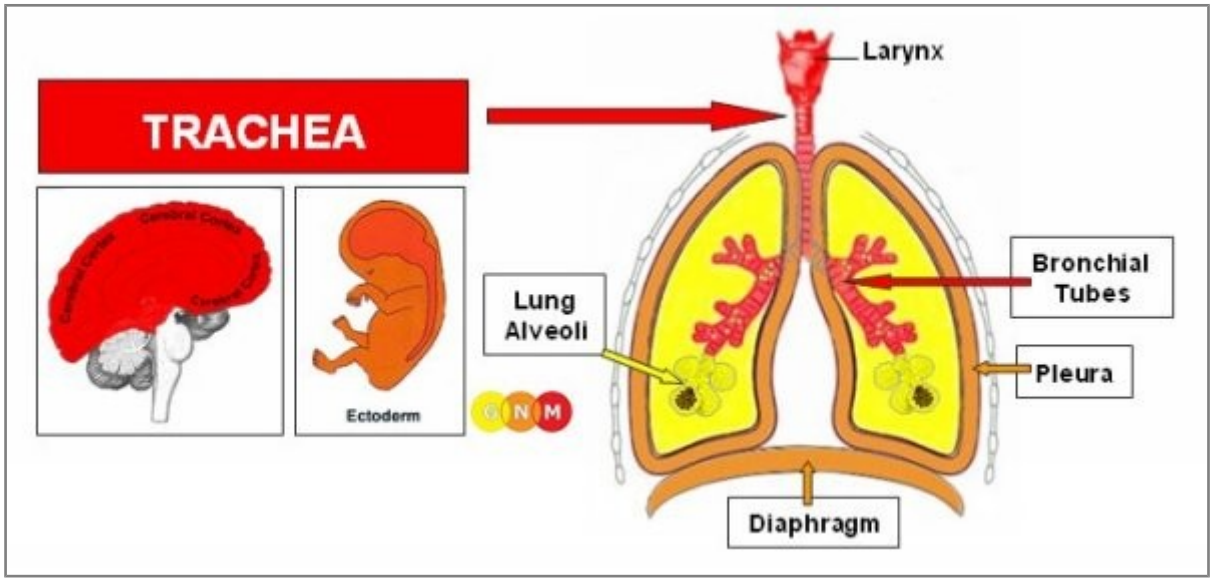
Dr. Hamer: "The 'AIDS' symptoms are the result of the invention of AIDS."

Based on the understanding of the Five Biological Laws, most of the "AIDS" symptoms are caused by the diagnosis shock and of biological conflicts triggered by the fear of the disease. Here are a few examples:

- death-fright conflict involving the lungs (lung cancer, lung tuberculosis, lung emphysema)
- scare-fright conflicts resulting in respiratory symptoms such as bronchitis or pneumonia
- frontal-fear conflicts (non-Hodgkin's lymphoma)
- abandonment and existence conflicts (kidney cancer)
- self-devaluation conflicts (anemia, leukemia, bone cancer, lymphoma)

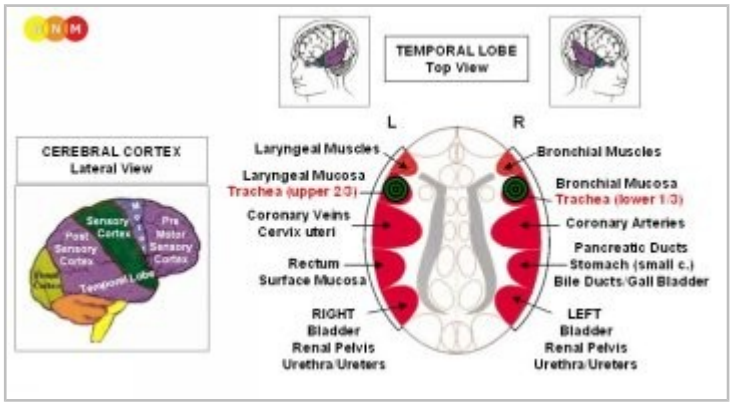
- attack or “feeling soiled” conflicts (shingles), Kaposi sarcoma
- territorial anger conflicts (hepatitis)
- separation conflicts (skin rashes, herpes)
- bleeding conflicts triggered by blood tests leading to an enlarged spleen

NOTE: Usually, a rise in antibodies is considered a sign of a “strong immune system”. But not when it comes to AIDS. In HIV tests, the presence of antibodies is considered an indication that the person is “seropositive”, in other words, “infected” with the “Human Immuno *Deficiency* Virus”!



Biological Conflict **Conflict-Active Phase** **Healing Phase**

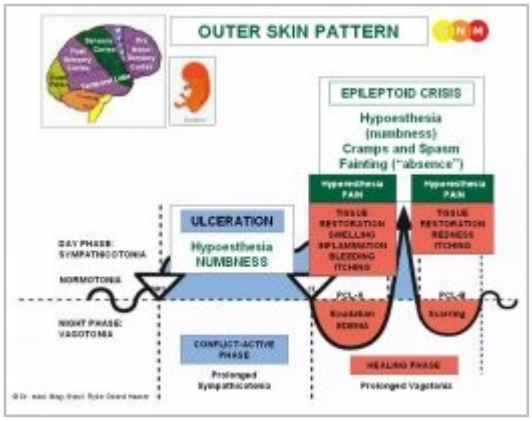
DEVELOPMENT AND FUNCTION OF THE TRACHEA: The trachea or “windpipe” is a hollow tube that connects thelarynx to the two bronchi of the lungs. It has the vital function of providing air flow to and from the lungs for respiration. The trachea is composed of cartilage rings, smooth muscles, and connective tissue. The tracheal mucosa lining the inner wall of the trachea consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The trachea is controlled from the **sensory cortex** (part of the cerebral cortex). The brain relay of the upper two-thirds of the trachea is located on the left side of the cortex, precisely, underneath the control center of thelaryngeal mucosa; the brain relay for the lower third is located in the right cortical hemisphere, underneath the control center of the bronchial mucosa.

NOTE: The control centers of the trachea are located outside of the temporal lobe, hence, the principle of gender, laterality, and hormone status does not apply.

BIOLOGICAL CONFLICT: The biological conflict linked to the trachea is **not getting enough air** (compare with conflict related to the diaphragm), for example, when a thyroid cyst presses onto the trachea.



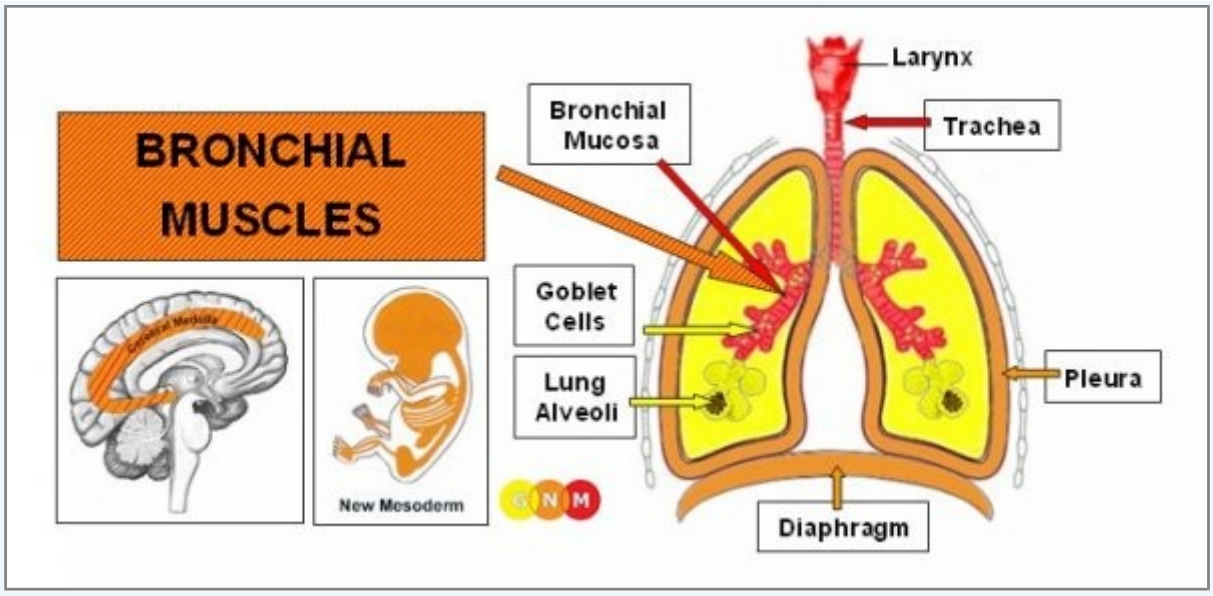
The Biological Special Program of the trachea follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration of the tracheal lining proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the trachea to get more air.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. If the lower section of the trachea is affected, this causes **pain** behind the sternum due to the swelling and **breathing difficulties**. With water retention (the SYNDROME) the swelling could lead to a severe airway obstruction. With an inflammation, the condition is called **tracheitis**, typically accompanied by **fever**. In conventional medicine, the cell increase might be diagnosed as a **tracheal cancer**. According to GNM, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process. However, a large swelling might obstruct the trachea requiring surgery to open the trachea and improve breathing.

After the Epileptoid Crisis, the edema subsides and in PCL-B the organ slowly returns to its normal function.

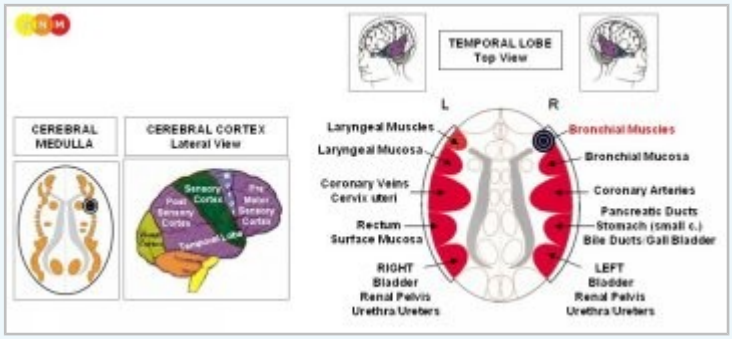
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BRONCHIAL MUSCLES: The wall of the bronchi and bronchioles consists of an epithelial mucosa and a layer of smooth and striated muscles. The function of the bronchial muscles is to alter the lumen of the bronchial tubes to increase the airflow during breathing (compare with diaphragm). The striated part of the bronchial muscles originates from the new mesoderm and is controlled from the cerebral medulla and the motor cortex.

NOTE: The **smooth bronchial muscles** are of endodermal origin and controlled from the midbrain. Like theintestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth bronchial muscles facilitate the flow and elimination of the "air morsel" (exhaling). The intake of the "air morsel" (inhaling) is supported by the smooth laryngeal muscles.



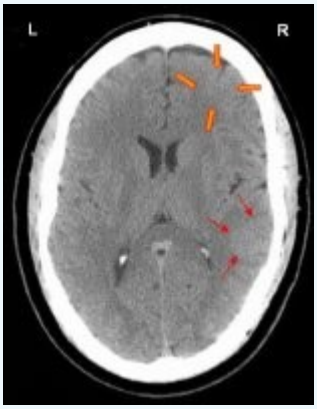
BRAIN LEVEL: The bronchial muscles have two control centers in the cerebrum. The trophic function of the muscle, responsible for the nutrition of the tissue, is controlled from the**cerebral medulla**; the contraction of the muscles is controlled from the right side of the **motor cortex** (in the**temporal lobe**). The control center is positioned next to the brain relay of the bronchial mucosa and exactly across from the brain relay of the laryngeal muscles.

NOTE: Inhaling is controlled from the bronchial muscles relay (on the right side of the motor cortex) while **exhaling** is controlled from the laryngeal muscles relay (on the left side of the motor cortex). Normally these two breathing motions are in balance. This changes if a biological conflict involves one of the two brain relays or both.

BIOLOGICAL CONFLICT: The biological conflict linked to the bronchial muscles is the same as for the bronchial mucosa, namely, a male territorial fear conflict or a female scare-fright conflict, depending on a person's gender, laterality, and hormone status. The distinguishing aspect of the conflict related to the muscle tissue is the additional distress of "not being able to escape", "not being able to (re)act", feeling "rooted to the ground" (petrified), or "feeling stuck" (see skeletal muscles).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of bronchial muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the bronchial muscles** (controlled from the motor cortex). The paralysis causes **breathing difficulties**, explicitly, **difficulties inhaling - exhaling is extended**because of the reduced function of the bronchial muscles that control inhaling. **NOTE:** While conflict active, the person is in a depressed mood.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.



This brain CT shows the impact of a territorial fear conflict in the bronchial muscles relay (orange arows - view the GNM diagram) and of a territorial anger conflict in the stomach relay(red arrows). The sharp borders of the Hamer Foci indicate that both conflicts are active.

HEALING PHASE: During the healing phase the bronchial muscles are reconstructed. The paralysis reaches into PCL-A. The Epileptoid Crisis presents as **coughing fits** with **bronchial spasm and convulsions**, equivalent to a focal seizure(codeine-containing medication suppresses the coughing; like morphine, codeine is an opium derivative). The cough is dry, if the Biological Special Program involves only to the bronchial muscles. However, often the conflict affects both the bronchial muscles and the bronchial mucosa, which has the advantage that the combined Epileptoid Crisis facilitate a faster expelling of mucus from the bronchia. This condition is referred to as "**spastic bronchitis"**. **Whooping cough (pertussis)** is also such a combined healing process (see also whooping cough related to the laryngeal muscles). InPCL-B, the function of the bronchial muscles returns to normal.

Recurring symptoms or an "**allergy cough"** are brought on by conflict relapses triggered by setting on a track that was established when the original conflict took place (see allergies).

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

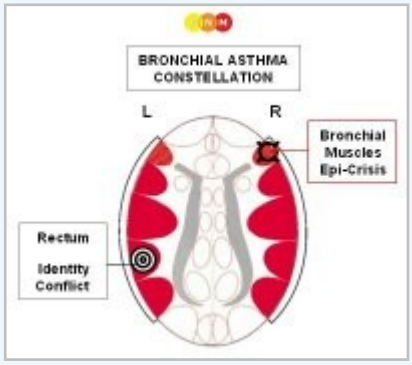
BRONCHIAL ASTHMA involves two Biological Special Programs (see also laryngeal asthma)

- conflict activity of a territorial fear conflict with the impact of the DHS on the right side of the

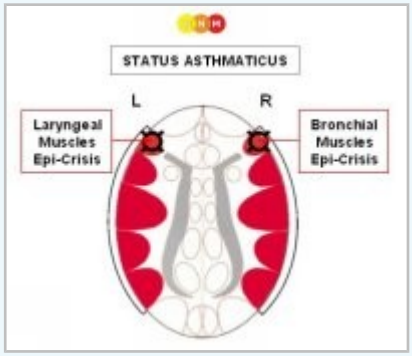
temporal lobe in the brain relay of the bronchial muscles

- conflict activity of a scare-fright conflict, sexual conflict, identity conflict, or marking conflict, corresponding to the left side of the temporal lobe

In this case, the person is in a Bronchial Asthma Constellation, also throughout the Epileptoid Crisis which is a temporary reactivation of the conflict-active phase.

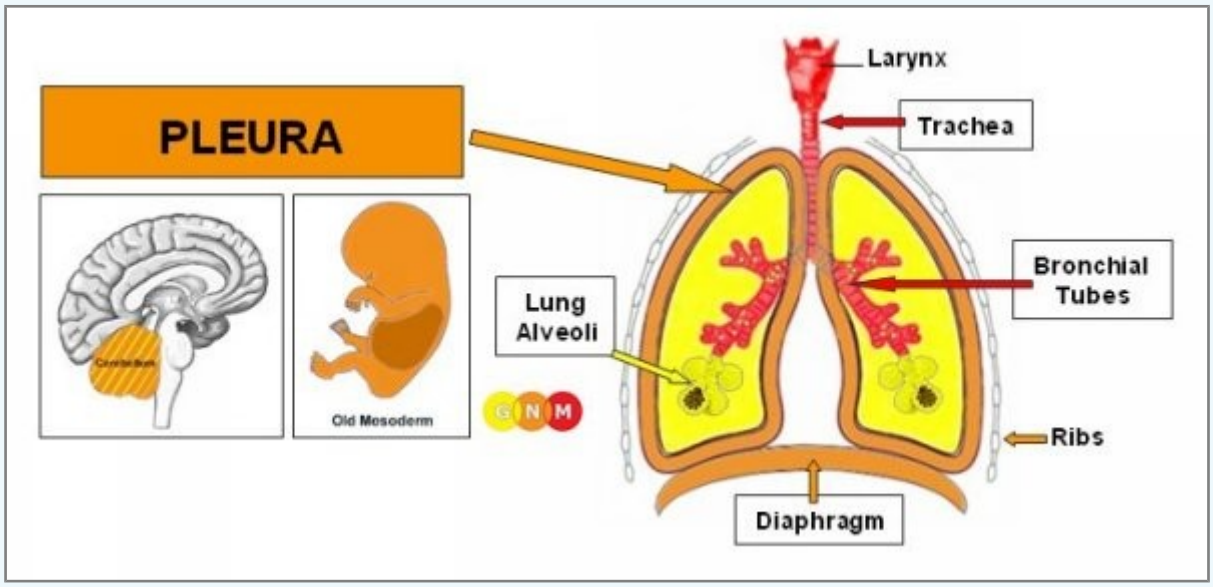


The actual **asthma attack** occurs during the **Epileptoid Crisis of the bronchial muscles** with convulsions moving towards the mouth, that is, outwards. The**symptoms** of bronchial asthma are therefore the typical **wheezing and prolonged expiration** of asthmatics (when the bronchial muscles are affected, exhaling is extended because of the partial functional loss of the muscles that control inhaling). With concurrent water retention due to the SYNDROME the asthma attack could be severe. Caution with cortisone!

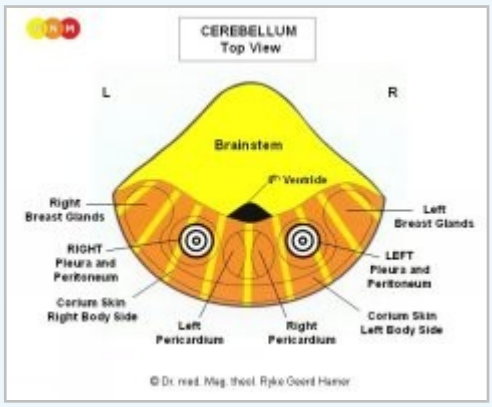


When both the bronchial and laryngeal muscles go through the Epileptoid Crisis at the same time, the asthma attack presents as prolonged exhaling with wheezing (bronchial asthma) and extended inhaling with gasping for breath (laryngeal asthma). This condition, called "**status asthmaticus"**, causes acute breathing difficulties!

Chronic bronchial asthma attacks indicate that the related territorial fear conflict has not been completely resolved. In conventional medicine, recurring asthma attacks are usually associated with an "allergy".



DEVELOPMENT AND FUNCTION OF THE PLEURA: The pleura is a two-layered membrane that lines the lungs (visceral pleura) and the walls of the thoracic cavity (parietal pleura), including the ribs and the diaphragm. The thin space between the two pleural layers, known as the pleural cavity, is filled with serous fluid that protects the underlying tissues and allows the lungs to move easily during respiration. In evolutionary terms, the pleura developed together with the peritoneum, the pericardium, and the corium skin. The pleura originates from the old mesoderm and is therefore controlled from the cerebellum.



BRAIN LEVEL: In the **cerebellum**, the right pleura is controlled from the left side of the brain; the left pleura is controlled from the right brain hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The pleura and peritoneum share the same brain relays, because originally the pleural and peritoneal membrane was one complex, which was later divided by the diaphragm that separates the chest and the abdominal cavity.

BIOLOGICAL CONFLICT: The biological conflict linked to the pleura is an attack conflict, specifically, an **attack against the chest** (see also attack conflicts related to the peritoneum, pericardium, and corium skin).

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

An attack against the chest or torso is experienced, for instance, through a blow, stab, or hit against the chest or ribs, for example, during a fight, accident, or in sports. “Sharp” words (accusations, criticism) directed at someone or “finger pointing” could also be registered as an attack (see also pericardium). However, surgery in the chest area (removal of a tumor, mastectomy) biopsies (breast cancer biopsy), thoracoscopies, exploratory lung punctures with an insertion of a needle into a lung, tubes placed in the chest to drain fluids, or the implantation of catheters or ports into a vein of the chest for long-term intravenous treatment, including chemo treatments, also trigger attack conflicts. A lung cancerdiagnosis or comments by a physician like “your lungs are not working properly” can be perceived as an “attack” regarding the integrity of the organ. Attack conflicts also originate from inside the chest, for instance, with chest pain caused by coughing (pneumonia, bronchial asthma) or stabbing and piercing pain through the inhalation of fumes, gases, or volatile liquids.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase pleural cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to create an internal reinforcement to protect the chest against further attacks. With prolonged conflict activity a bulb-shaped growth forms at the site; cell augmentation on a flat plane usually occurs when the attack conflict was more of a general nature. In conventional medicine, the thickening of the pleura is diagnosed as a **pleural mesothelioma** (see also peritoneal mesothelioma, omental mesothelioma, pericardial mesothelioma, and testicular mesothelioma). If the rate of cell division exceeds a certain limit, then the cancer is considered “malignant”.

NOTE: Whether the right or left half of the pleura is affected is determined by a person’s handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area of the pleura that is associated with the attack.

No doubt, prolonged **exposure to asbestos** can cause a pleural mesothelioma. However, it is not a "carcinogen" that causes the cancer, as claimed by conventional medicine, but rather the inhalation of the sharp asbestos fibers (see micrograph image "*attacking*" the lungs. This explains why asbestos affects predominantly the pleura and to a much lesser degree other organs of the respiratory tract (if asbestos is associated with a death-fright triggered by scary media reports, it affects the lungs; with a territorial fear related to the workplace, it affects the bronchia. In both cases the distress generates the development of a lung cancer.

Since there are no symptoms during the conflict-active phase, a pleural mesothelioma is usually only found through routine medical examinations, notably among asbestos workers who have to undergo regular lung check-ups.

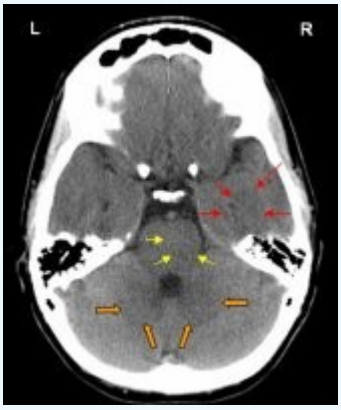
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria or other bacteria remove the cells that are no longer needed. **Healing symptoms** are **chest pain**, painful **coughing**, **breathing difficulties**, **fever**, and**night sweats**. If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. Now, the mesothelioma is regarded as "benign".

Pleurisy or pleuritis indicates that healing is accompanied by an inflammation – with fever, if the healing phase is intense. During the healing process (in PCL-A), the fluid in the pleura is naturally absorbed by the pleural membrane (**dry pleurisy**). Water retention, however, due to an active abandonment and existence conflict, increases the fluid accumulation (**wet pleurisy**) causing **acute breathing difficulties**; if bacteria assist healing, the fluid contains pus (**purulent pleurisy**). Wet pleurisy often develops during hospialization, after surgery in the breast or chest area, or following a lung cancer or pleural mesothelioma diagnosis.

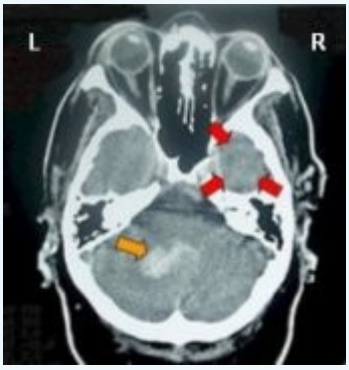
With the SYNDROME the retained water generates an **exudative pleural effusion** (excess fluid *around* the lungs as opposed to water *in* the lungs with pneumonia or a lung edema). Since the right and left pleura are separate from each other, the effusion occurs only on the affected side (compare with peritoneal effusion and pericardial effusion). A pleural effusion could cause serious complications, particularly when the fluid-filled pleural cavity compresses both lungs. In this case, a lung puncture to drain the lungs is unavoidable.

NOTE: Fluid also enters the pleura when adjacent ribs or the sternum are in healing; in this case because of aself-devaluation conflict brought on, for example, by a lung cancer diagnosis, a breast cancer diagnosis, or a mastectomy. The large edema, usually caused by water retention due to the SYNDROME, "sweats" through theperiosteum into the pleura creating what is called a **transudative pleural effusion** (which does not contain protein!).

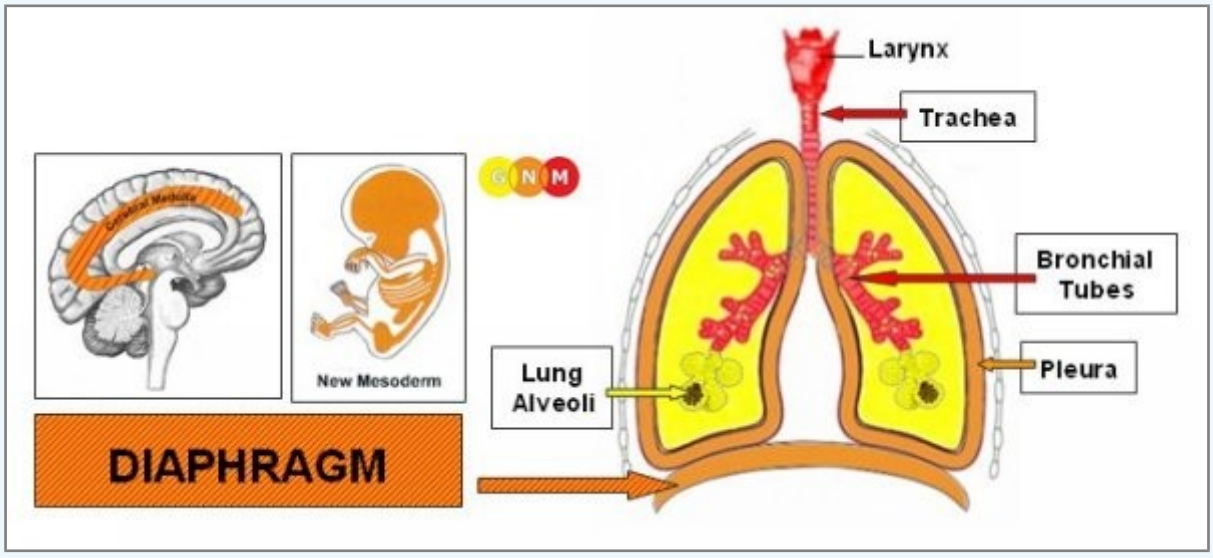
Pleural fluid is rich in protein. Hence, constant draining of the extra fluid leads to protein deficiency and rapid weight loss. Furthermore, the lung punctures trigger often new attack conflicts and conflict relapses with each procedure (hospital "track"), throwing the person into a vicious cycle. Puncturing the lungs also bears the risk of a lung collapse or pneumothorax (see also pneumothorax and lung emphysema).



This brain scan shows fluid accumulation (in PCL-A) in both pleura relays (orange arrows -view the GNM diagram) corresponding to a pleural effusion caused by an "attack against the chest"-conflict. In addition, we see a Hamer Focus (also in PCL-A) in the brain relay for the left inner ear (red arrows) related to a hearing conflict, presenting as hearing difficulties (compare with CT below). The yellow arrows point to the control center of the right kidney collecting tubules and an active existence conflict resulting in water retention (theSYNDROME). The retained water exacerbates the pleural effusion!

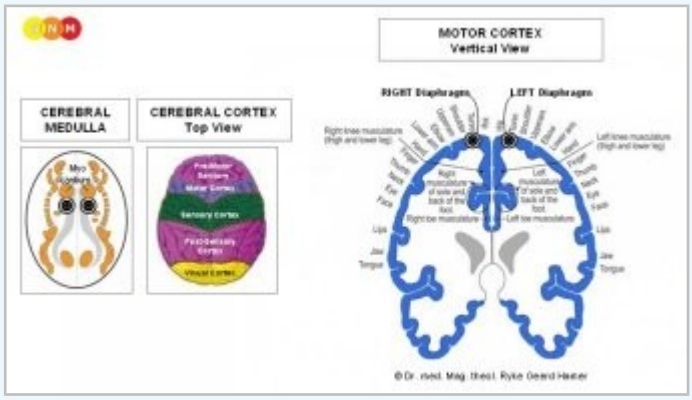


This CT scan shows the presence of neuroglia (in PCL-B) in the brain relay of the right pleura (orange arrow - view the GNM diagram), indicating that a pleural mesothelioma is healing at the time. In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor". There is also an active Hamer Focus in the control center of the inner ear(red arrows), confirming a tinnitus in the left ear (compare with CT above). The hearing conflict ("I don't want to hear this"!) was most likely triggered by the cancer diagnosis.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE DIAPHRAGM: The diaphragm separates the chest from the abdomen. It is the largest and most efficient muscle used in breathing. During inhaling, the diaphragm moves down, the lungs expand and air is drawn in; during exhaling, the diaphragm relaxes and air leaves the lungs (compare with bronchial muscles). In addition to breathing, the contraction of the diaphragm supports the heart muscle (myocardium) in sucking venous blood from the systemic circulation. For this, the left half of the diaphragm is of greater importance since the right half has less ability to move due to the liver positioned directly underneath. The diaphragm consists of striated muscles, originates from the new mesoderm and is controlled from the cerebral medulla and the motor cortex. For its involuntary supportive functions pertaining to breathing and circulation, the diaphragm also receives impulses from the brainstem.



BRAIN LEVEL: The diaphragm has 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**. The right half of the diaphragm is controlled from the left side of the cerebrum; the left half is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The diaphragm is functionally closely tied to the myocardium. The control centers are therefore located right below the brain relays of the myocardium.

BIOLOGICAL CONFLICT: The biological conflict linked to the diaphragm is **not being able to breathe sufficiently or deeply enough**, for example, when getting out of breath during hard exercises such as jogging (sprinting) or when running too fast (catching a bus, escaping from danger). An unexpected shock ("it took my breath away"), fright or scare (see also scare-fright conflict) can cause this type of breathing conflict (see also trachea). Feeling **physically overwhelmed** ("I can't manage!", fitness training and workout stress) also affects the diaphragm (compare with emotional and mental overwhelmed conflict related to the myocardium). Coupled with the myocardium, the conflict is usually experienced as running out of breath because "This is too much!" (distress related to work, family, relationships).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of diaphragm muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the diaphragm muscle** (controlled from the motor cortex) causing **difficulties breathing** ranging from mild to severe. Lasting paralysis results in an elevated hemi-diaphragm.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

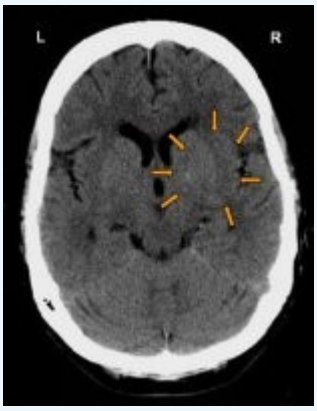
With lasting, intense conflict activity the ongoing tissue loss can lead to a rupture of the diaphragm (**diaphragmatic hernia**) with abdominal organs moving into the chest cavity. In case of a **hiatal hernia**, a small part of the stomach pushes through the diaphragm and into the chest (compare with inguinal hernia). The rupture could be brought on by coughing, heavy lifting, pulling or pushing, or pressing too hard, for example, during a bowel movement.

HEALING PHASE: In the healing phase, the diaphragm muscle is reconstructed. The partial paralysis reaches into PCL-A. The Epileptoid Crisis presents as **cramping or spasms of the diaphragm** accompanied by breathing difficulties.**Sleep apnea** with episodes of cessation of breathing is generated by the contractions of the diaphragm during the Epi-Crisis. Chronic sleep apnea points to conflict relapses (compare with sleep apnea related to the myocardium).

Stitches in the side, for example, when exercising shortly after eating, running too fast or talking during jogging, is a manifestation of a small diaphragm-related Epileptoid Crisis. **Hiccups** (singultus) are diaphragmatic contractions or flutters, typically caused by eating or drinking too quickly without adequate breathing. In this case, the "conflict" is solely of a biological nature without an emotional component.

However, persisting hiccups that last longer than 48 hours are caused by breathing conflict.

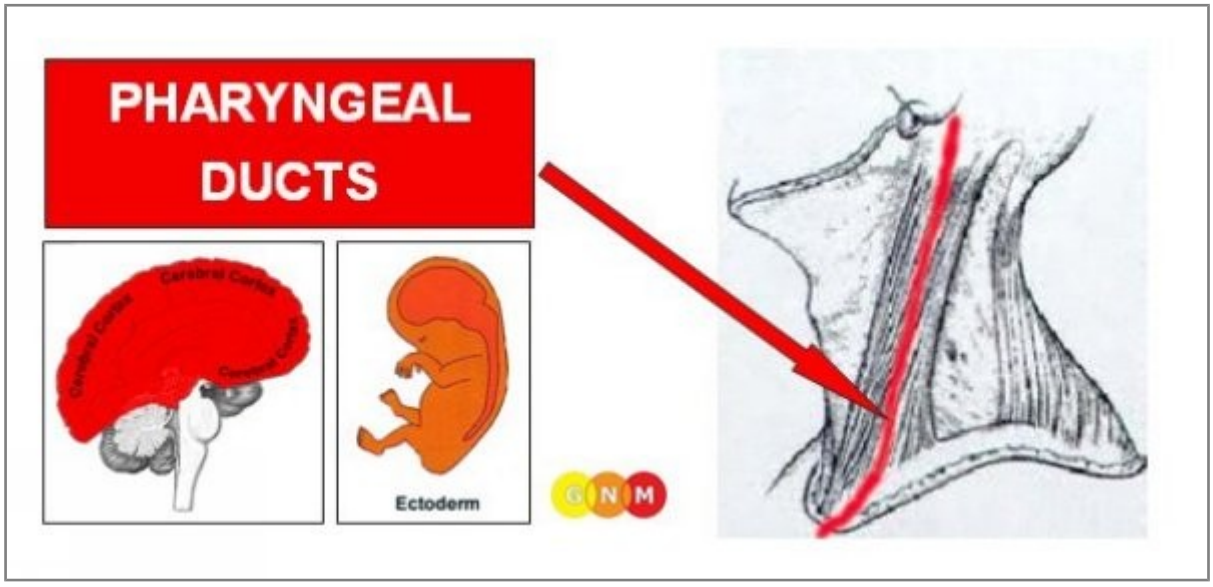
NOTE: All organs that derive from the new mesoderm ("surplus group"), including the diaphragm, show the**biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict of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



This CT scan shows the impact of a physical overwhelmed conflict in the area of the brain that controls the left diaphragm (view the GNM diagram).
The sharp ring structure of the Hamer Focus indicates conflict activity.

NOTE: Whether the right or left diaphragm is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

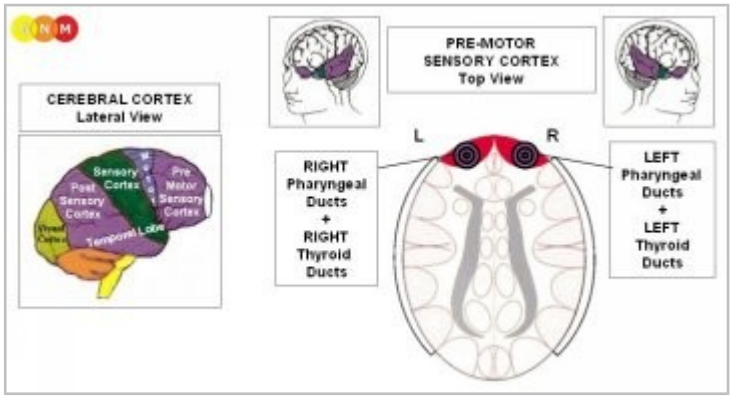
PHARYNGEAL DUCTS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PHARYNGEAL DUCTS: The pharyngeal ducts reach from the front and back of the ears into both sides of the neck further into the mediastinum, which is the middle section of the chest cavity containing the lungs, the heart, the esophagus, and the trachea. The lining of the pharyngeal ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

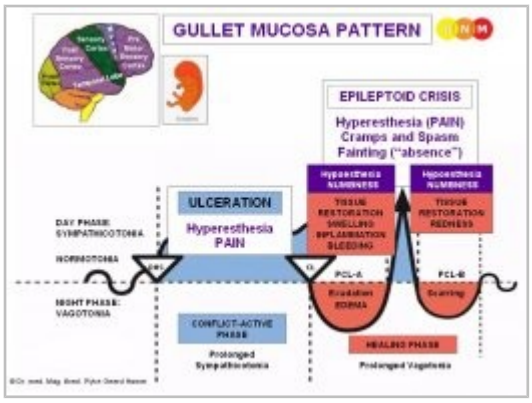
NOTE: The pharyngeal ducts developed at a time when life existed only in the ocean. In fish and amphibians they are equivalent to the gills, the respiratory organs that extract oxygen from water. The pharyngeal ducts are descendants of the pharyngeal arches (see also coronary arteries, coronary veins, aorta, carotid arteries, and subclavian arteries that derive from the pharyngeal arch arteries. In the embryo, the pharyngeal arches, or branchial arches (Greek branchial = gill), give rise to structures of the head and neck (see also thyroid ducts). In humans, the pharyngeal ducts develop during the fourth week of gestation.



BRAIN LEVEL: The epithelial lining of the pharyngeal ducts is controlled from the **pre-motor sensory cortex**, or **frontal lobe**(part of the cerebral cortex). The left pharyngeal ducts are controlled from the right side of the cerebral cortex; the right pharyngeal ducts are controlled from the left cortical hemisphere (frontal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The pharyngeal ducts and thyroid ducts share the same brain relays.
The DHS affects either one of the tissues or both, depending on the intensity of the conflict.

BIOLOGICAL CONFLICT: The biological conflict linked to the pharyngeal ducts is a male **frontal-fear conflict** or female powerless conflict, depending on a person's gender, laterality, and hormone status. A frontal-fear conflict is a big fear of **heading into a dangerous situation** or of **danger that is moving directly towards one**. The conflict can be experienced in real terms, for example, during a head-on accident or a frontal attack by a person or an animal. In a transposed sense, the approaching danger could be a threat, shocking news perceived as a "blow in the face", or an upsetting confrontation. The conflict is often triggered by follow-up examinations or the announcement of a medical procedure such as surgery. One of the most common frontal-fear conflicts is being faced with a cancer diagnosis. This is why in GNM we call the conflict related to the pharyngeal ducts also a "**cancer fear conflict**".



The Biological Special Program of the pharyngeal ducts follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

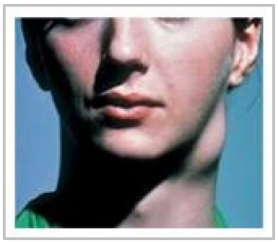
CONFLICT-ACTIVE PHASE: ulceration in the lining of the pharyngeal ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts to allow more oxygen intake, even though in humans the pharyngeal ducts have no longer a respiratory function. **Symptoms**: mild to severe **pain** in the neck area.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished

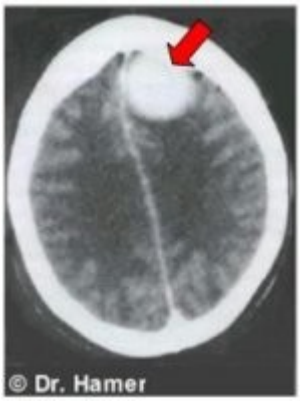
through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area.

The swelling in the pharyngeal ducts might be diagnosed as **mononucleosis** or **Pfeiffer's disease** (compare withmononucleosis related to the lymph nodes). Whether the swelling occurs in the pharyngeal ducts or in the lymph nodes can be easily established with the help of a brain CT that shows the impact of the related conflict in the corresponding brain relay. In addition, if the lymph nodes are affected the lymphocyte count is elevated, which is not the case with a healing process in the pharyngeal ducts.

A hanging healing due to continuous conflict relapses leads to the back-up of fluid in the pharyngeal ducts resulting in the development of a **cyst located laterally on the right or left side of the neck or collar bone area** (compare withthyroid cysts located towards the middle) or **in the mediastinum** where it is called a **retrosternal struma**. After theEpileptoid Crisis the cyst recedes parallel to the completion of the healing process. However, if the healing phase cannot be complete, the cyst hardens and stays.



A cyst in the pharyngeal ducts (shown in this picture on the left side of the neck) is often diagnosed as a **non-Hodgkin's lymphoma**, based on the wrong assumption that the "tumor" develops in the cervical lymph node (see Hodgkin's lymphoma). The pharyngeal ducts are known in embryology. In the medical practice they are completely ignored.



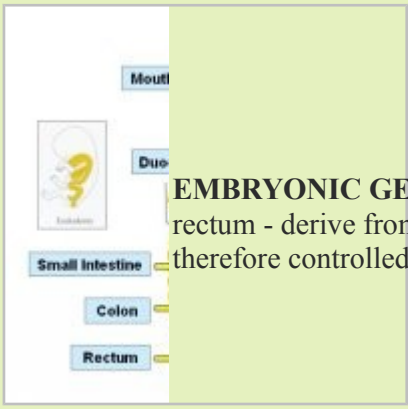
This brain CT shows an accumulation of neuroglia in the control center of the left pharyngeal ducts (view the GNM diagram), indicating that the person has already passed the Epilepoid Crisis and is now in PCL-B of the healing phase (both on the brain and on the organ level). In conventional medicine, the glia buildup is erroneously believed to be a "brain tumor".

Found in the mediastinum, a cyst in the pharyngeal ducts is diagnosed as a "**small cell bronchial carcinoma**" **or**"**small cell lung cancer**", even though neither the lungs nor the bronchia are involved (see also mediastinal osteosarcoma). In the mediastinum, a large cyst might compress vital vessels or cause breathing difficulties due to the pressure on the trachea with acute shortness of breath and choking fits during the Epileptoid Crisis, when the fluid in the cyst is expelled. With the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict (diagnosis shock, hospitalization) the situation could become critical.

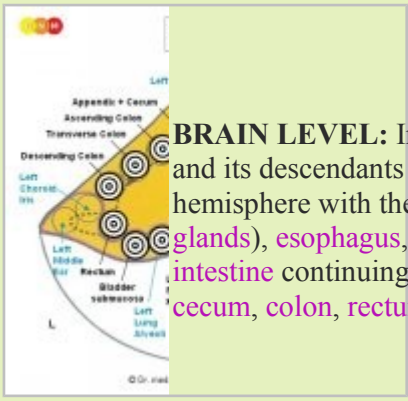
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

MOUTH & PHARYNX

THE SIX QUALITIES OF THE ORGANS OF THE ALIMENTARY CANAL



EMBRYONIC GERM LAYER: The organs of the alimentary canal - from the mouth to the rectum - derive from the oldest embryonic germ layer, which is the **endoderm**, and are therefore controlled from the **brainstem**, the oldest part of the brain.



BRAIN LEVEL: In the **brainstem**, the control centers of the organs of the digestive system and its descendants are positioned in a **ring-form order**, starting on the right brain hemisphere with the brain relays of the mouth and pharynx (incl. thyroid gland,parathyroid glands), esophagus, stomach, liver parenchyma, pancreas gland,duodenum, small intestine continuing counter-clockwise with the control centers of theappendix, cecum, colon, rectum, and the bladder on the left side of the brainstem.

BIOLOGICAL CONFLICTS: According to their function, the conflicts linked to the organs of the alimentary canal are**MORSEL CONFLICTS** of "**not being able to catch/eliminate a morsel"** (mouth and pharynx), "**not being fast enough no catch/eliminate a morsel"** (thyroid gland), "**not being able to swallow a morsel"** (esophagus), and"**not being able to absorb and digest a morsel"** (pancreas, stomach, duodenum, small intestine, colon). For animals a morsel concerns a real piece of food whereas for humans a morsel can also be of a figurative nature.

Sensory quality: relates to analyzing a food morsel according to its chemical make-up, that is, whether the morsel is useful (nutritious) or harmful (poisonous) for the organism. If a disagreeable morsel is in the mouth or pharynx, the instinctive reaction is to spit the morsel out; if an "indigestible morsel" is in the stomach, the vomiting reflex is activated in order to eliminate the morsel; if it has already reached the small intestine, this causes diarrhea.

Motor quality: relates to the peristalsis, the wave-like muscle contraction that moves food along the gastro-intestinal tract. In order to be able to pass a morsel, the peristalsis increases locally while slowing down in the remaining intestine.

Secretory quality: relates to the secretion of digestive juices. In the event of a biological conflict, cells in the corresponding organ proliferate in order to aid the digestion of the morsel. The cell buildup typically

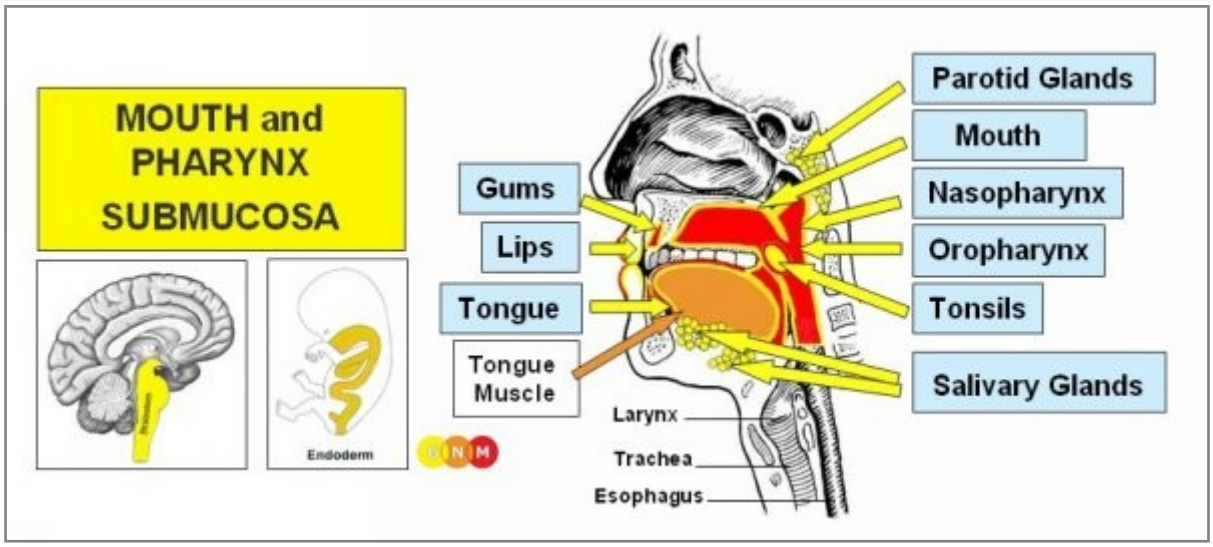
takes a cauliflower-shaped form.

Resorptive quality: relates to the absorption of nutrients. In the event of a biological conflict, cells in the corresponding organ proliferate in order to be able to absorb the morsel. The cell buildup typically develops on a flat plane.

NOTE: The lung alveoli, middle ear and Eustachian tubes, tear glands, choroid, iris and ciliary body of the eyes, kidney collecting tubules, adrenal medulla, bladder trigone, prostate, uterus and fallopian tubes,Bartholin's glands, smegma producing glands as well as the pituitary gland, pineal gland, and choroid plexusoriginate from the intestinal mucosa. These organs have therefore also a secretory and resorptive quality.

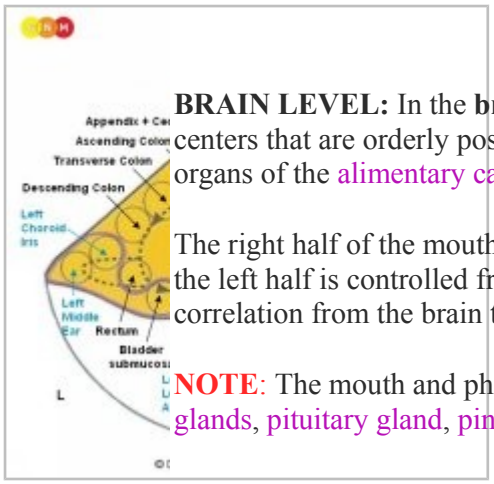
Excretory quality: relates to the excretion of toxic waste. Toxic substances that cannot be excreted through thekidneys are excreted into the intestine. **NOTE:** With diarrhea caused by disagreeable food, the sensory, motor, and excretory qualities go together without a cell increase.

Hormonal quality: relates to the hormone production of the accessory organs of the alimentary canal (thyroid gland, pancreas, liver) to aid digestion.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MOUTH AND PHARYNX SUBMUCOSA: The mouth is the opening of thealimentary canal and the place where the digestion (secretory quality) and absorption (resorptive quality) of food starts. The tongue is an accessory digestive organ that aids in chewing and swallowing. Through chewing food is broken into small pieces. Saliva produced in the salivary glands moistens the food bolus to make swallowing easier. The salivary glands are located in several parts of the mouth. The largest salivary glands are the parotid glands in front of the ears, the sublingual gland underneath the tongue, and the submandibular gland beneath the lower jaw. The pharynx connects the mouth and nasal cavities with the trachea and the larynx. The nasopharynx, located in the back of the nose, extends to the upper surface of the palate which forms the roof of the mouth; the oropharynx is at the very back of the mouth. On both sides of the pharynx lie the tonsils. Branching off the pharynx is the esophagus that carries food from the mouth to the stomach. The submucosa of the mouth and pharynx (including the lips, gums, palate, tongue, salivary glands, tonsils, and throat) consists of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the organs of the mouth and pharynx have two control centers that are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal.

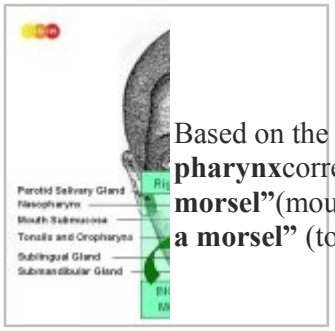
The right half of the mouth and pharynx is controlled from the right side of the brainstem; the left half is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the submucosa of the mouth and pharynx, including the lips, gums, palate, tongue, salivary glands, tonsils, and throat is a "**morsel conflict"**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

RIGHT HALF OF THE MOUTH AND PHARYNX

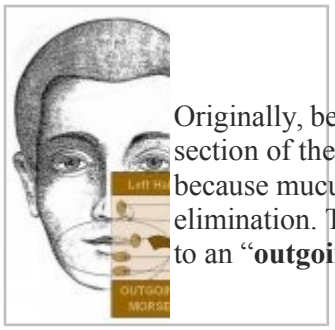


Based on the original function of the gullet, the **right half of the mouth and pharynx**correlates to an "**ingoing (food) morsel"** and to "**not being able to catch a morsel"**(mouth, lips, gums, palate, tongue, salivary glands) or "**not being able to swallow a morsel"** (tonsils, pharynx, throat).

Newborns and infants experience the conflict in real terms when they can't get the "milk morsel", let's say, because the mother is not able to nurse or is not feeding her baby in time. Seniors in nursing homes and hospital patients suffer the conflict when they are unable to eat because of pain; also cancer patients who are not able to eat as a result of chemo treatments. Having to refrain from eating one's favorite food (e.g., being put on a strict diet) can also cause a morsel conflict.

A figurative morsel one is not able to "catch" refers to something that one had expected or was looking forward to "grab" and "swallow" and is unexpectedly not able or not allowed to (see also biological conflict linked to the esophagus). Such a desired "morsel" could be a deal, a contract, a business, a job, a position, a promotion, a "money morsel" in form of a loan, a profit, a gift, or an inheritance (house, apartment); for children it could be a "toy morsel" or a "good grade morsel". The conflict might also concern a person one cannot "catch" or "get a hold of" or a relationship one is not able or not allowed to "consume".

LEFT HALF OF THE MOUTH AND PHARYNX



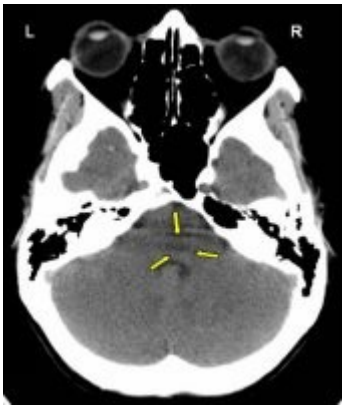
Originally, before the rupture of the gullet, the biological conflict related to the outgoing section of the intestine was "not being able to sufficiently insalivate the fecal morsel", because mucus produced in the gullet also served the lubrication of feces to facilitate elimination. Today, the conflict linked to the **left half of the mouth and pharynx**correlates to an "**outgoing (food) morsel"** and to "**not being able to expel a morsel (spit it out)"**.

This refers, for example, to food or medication one wants to "puke out". An undesirable morsel might be associated with a commitment or promise one wants to revoke or an agreement one wants to call off. A newly hired employee, a new tenant or room mate, a new sibling, or an annoying visitor could be perceived as a "morsel" one wants to get rid of. In sports, it could relate to not being able to pass the ball (soccer) or puck (hockey). An "outgoing morsel" can also be a word or words one is not allowed or unable to "spit out", for instance, an apology, a confession, a plea, or a complaint. Unwanted or forced oral sex might evoke the conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the submucosa of the mouth or pharynx proliferate proportionally to the intensity of the conflict.
The **biological purpose of the additional cells** is to better insalivate a morsel in order to absorb (right half) or expel (left half) it faster. Salivation is stimulated by the autonomic nervous system. This is why the secretion of saliva increases with the smell of "mouth-watering" food. In the English language, "salivating" and "drooling" are synonyms for "craving" for something or someone desirable.

With prolonged conflict activity a flat growth (resorptive type) develops in the submucosa of the mouth. In the palate, salivary glands, tonsils, pharynx, and throat it can also take a cauliflower-shaped form (secretory type). A large growth is usually diagnosed as an **oral cancer** (compare with "oral cancer" related to the mouth surface mucosa) or as a "glandular tumor" if it involves the salivary glands.

Smoking and alcohol abuse are said to be risk factors for cancers in the mouth, including **tongue cancer**. Yet, not everybody who smokes or drinks develops oral cancer. If, however, the "cigarette morsel" or the "alcohol morsel" causes distress, for example, due to abstinence, withdrawal, or a fear of getting mouth or tongue cancer, the Biological Special Program will be set into motion.

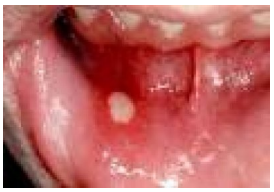


On a CT scan, the conflict-active phase of a "morsel conflict" presents as a Hamer Focuswith a sharp ring configuration. Here, on the right brainstem hemisphere in the brain relay of the submucosa of the right side of mouth (view the GNM diagram). At this point, the conflict of "not being able to catch a morsel" is still active.

Adenoids in the nasopharynx form as a result of a hanging conflict, that is, when the conflict cannot be resolved in time (compare with polyps in the paranasal sinuses). If the tonsils are affected, this causes **tonsillar hypertrophy**, or enlarged tonsils. Since the tonsils and the nasopharynx share the same biological conflict, **nose polyps** and **enlarged tonsils** often occur together.

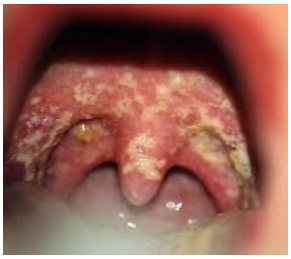
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed.

In the mouth, the healing phase presents as **canker sores (aphthous ulcers)** on the inside of the lips or cheeks, on the palate or tongue, or in all areas of the mouth, depending on the perception of the conflict situation (compare withaphthous ulcers related to the mouth surface mucosa). Canker sores appear as round or oval white spots with an inflamed border. They can be quite **painful**. On the gums, the pus-filled pocket is called a "dental abscess" or gum abscess. The tuberculous discharge causes bad breath.

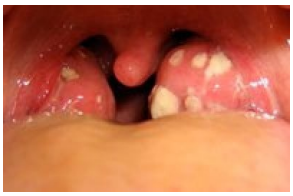


A canker sore on the right side of the mouth (here on the inside of the lower lip) indicates that the conflict of "not being able to catch a morsel" is resolved and that healing is underway.

If the required microbes are not available upon the resolution of the conflict, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine this is usually diagnosed as a **mouth polyp** or "malignant cancer". A **gum polyp** might reach into the neck of a tooth.



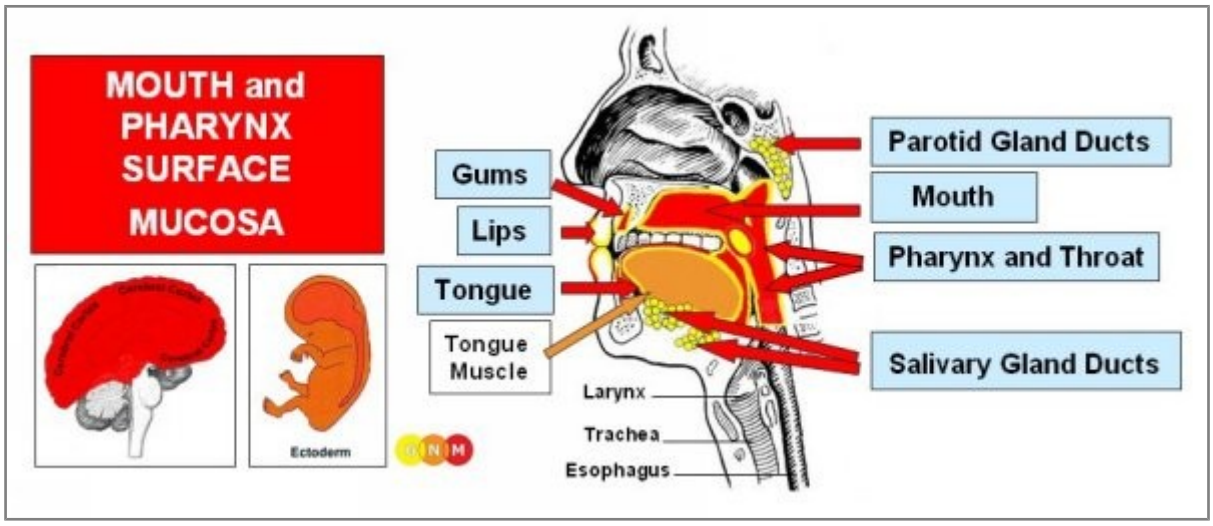
Oral candidiasis or **thrush**, presenting as creamy pus, occurs when fungi assist the healing process. Babies typically develop thrush when they suffer the distress of not getting the "milk morsel".



Tonsillitis, an inflammation of the tonsils, is a sign that the related morsel conflict has been resolved (the left tonsil corresponds to "not being able to eliminate a morsel"). Pain is caused by the swelling of the tonsils and the stretching of the overlying sensitive mouth surface mucosa. If the outer layer opens, pus produced during the healing process (**purulent tonsillitis**) is released into the mouth causing smelly breath. Here we also find **tonsil abscesses**. When fungi are involved, this causes so-called **tonsillar mycosis** or **candidiasis of the tonsils** (compare with "strep throat" with the involvement of streptococcus bacteria).

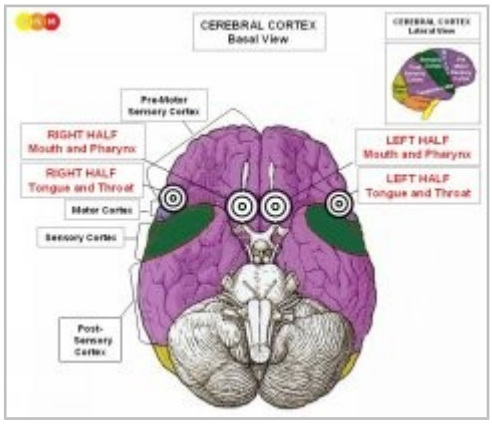
In the nasopharynx, adenoids that developed during the conflict-active phase are removed with the help of fungi or TB bacteria, provided they are available. A **nose abscess** with painful swelling containing pus also develops in the healing phase.

In the salivary glands, a prolonged healing process (hanging healing) leads to a complete loss of the saliva producing acinar cells resulting in a permanent **dry mouth** or what is called **Sjogren's** or **Sicca syndrome** (see also dry mouth related to the salivary gland ducts and Sjogren's associated with dry eyes). An inflammation in the salivary glands, for example, in the parotid glands causes **parotitis**, also known as **mumps** (see also parotitis related to the salivary gland ducts).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MOUTH AND PHARYNX SURFACE MUCOSA: The submucosa of the mouth and pharynx is covered with a cell layer composed of squamous epithelium, which derives from the ectoderm and is therefore controlled from the cerebral cortex. **NOTE:** The tonsils do not have an ectodermal surface mucosa.

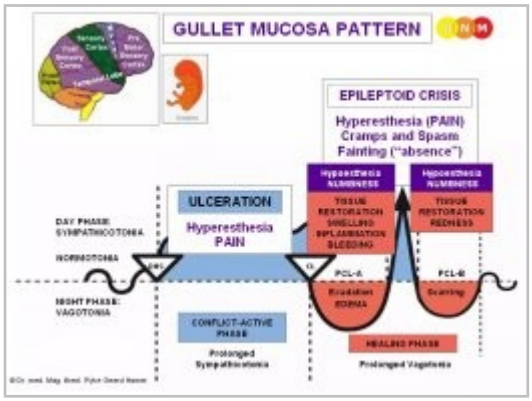


BRAIN LEVEL: The epithelial lining of the mouth and pharynx, including the surface mucosa of the throat, is controlled from the **pre-motor sensory cortex**(part of the cerebral cortex). The right half of the mouth and pharynx is controlled from the left side of the cortex; the left half is controlled from the right cortical hemisphere (medio-fronto-basal). Hence, there is a cross-over correlation from the brain to the organ. The brain relays of the tongue and throat are located laterally.

MOUTH SURFACE MUCOSA

BIOLOGICAL CONFLICT OF THE MOUTH SURFACE MUCOSA: The biological conflict linked to the mouth surface mucosa (including the lips, gums, palate, and tongue) is an **oral conflict** of either "**not being able to take something into the mouth"** or, the opposite, of "**not being able to get rid of something that is in the mouth or on the tongue"**. In both cases this concerns food one desires but is unable or not allowed to "take in" (being on a restricted diet, e.g., diabetics) or food one wants to "spit out". Regarding the latter, this differs distinctively from the conflict of "not being able to eliminate a morsel" linked to the left half of the mouth submucosa. While the deep endodermal layer of the mouth correlates biologically to the actual morsel (real or figurative) one wants to expel, the upper ectodermal layer is rather about contact with the "morsel", namely, wanting to separate from what is in the mouth (see separation conflictrelated to the skin). Conversely, the conflict of not being able to get something desirable into the mouth can be triggered by having to refrain from cigarette smoking or alcohol. A lip-related conflict translates into the loss of physical contact or the fear of losing contact associated with the lips, for example, if one is no longer able or allowed to kiss a person or a pet. Equally, it also applies to not wanting to be kissed or having tongue or lip contact. This includes contact with objects such as a drinking glass, a straw, eating utensils, dental tools, and the like. In a figurative sense the oral conflict translates into not being allowed or able to say something that is "on the tip of the tongue".

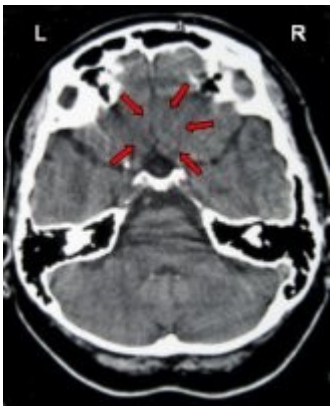
In line with evolutionary reasoning, **territorial conflicts, sexual conflicts, and separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the mouth surface mucosa, including the lips, gums, palate, and tongue follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

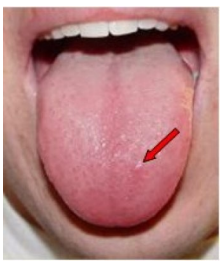
CONFLICT-ACTIVE PHASE: ulceration in the epithelial mouth mucosa proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the oral cavity in order to facilitate the intake of or the separation from the "morsel". With an intense conflict **aphthous ulcers** develop at the site (compare with canker sores related to the mouth submucosa). If the oral conflict is associated with the tongue, this causes **tongue burning**.

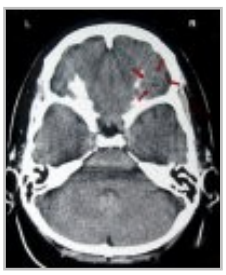
NOTE: Whether the right or left half of the mouth is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area of the mouth that is associated with the "oral distress".



This brain CT shows conflict activity of an oral conflict with aphthous ulcers on both sides of the mouth. The Hamer Focus reaches over both brain hemispheres. In GNM, we call this a "central conflict", meaning that the conflict was associated with the person's mother/child and partner at the same time. An adolescent caught smoking by his/her parents would be a classic conflict scenario.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. **Healing symptoms** are **swelling**, **water-filled blisters**, **redness** (see "raspberry tongue" with scarlet fever), and possibly bleeding. On the lips such blisters are commonly called "cold sores" or "herpes" (see also herpesrelated to the skin).

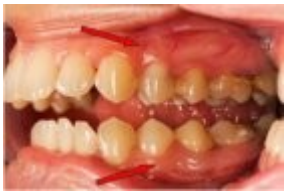




For a right-handed person, a blister on the left half of the tongue reveals amother/child-related oral conflict (the story: a right-handed teenage girl was caught tongue-kissing by her mother).

The CT scan presents the Hamer Focus in the area of the brain from where the left half of the tongue (view the GNM diagram) is controlled.

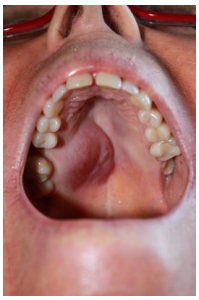
Gingivitis is restricted to the gum tissue. An inflammation of the gums might also arise during the healing ofperiodontosis. In this case, the condition is called **periodontitis**. In today's dentistry it is wrongly assumed that gum diseases are caused by dental plaque.



Here we see gingivitis exclusively on the left side of the mouth (see red arrows). For a left-handed person this indicates that the conflict was associated with a partner.

A **gum abscess** originates in the mouth submucosa. Here we see a gum abscess on the right side of the mouth related to "not being able to catch a morsel". The pus-filled abscess develops in thehealing phase.

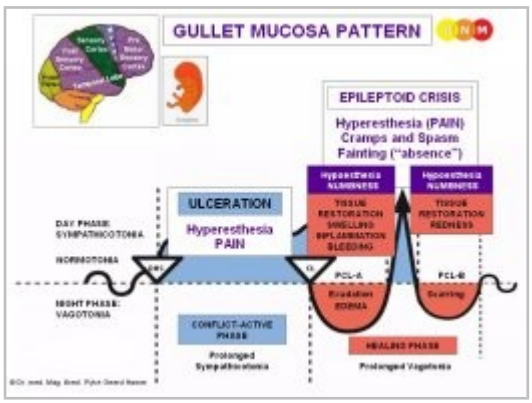
An intense healing phase with a large swelling in the mouth area might be diagnosed as an "**oral cancer"** (compare withoral cancer related to the mouth submucosa). Based on the knowledge of GNM, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.



This picture shows acute swelling on the right side of the hard palate. It is a positive sign that the related oral conflict has been resolved. Water retention due to the SYNDROME increases the swelling significantly.

PALATE AND TONGUE

BIOLOGICAL CONFLICT OF THE BACK OF THE PALATE AND POSTERIOR THIRD OF THE TONGUE: Thebiological conflict linked to the soft palate is "**wanting to get rid of something that is on the palate"** (dental tools). The back of the tongue relates to "**not being able or not wanting to taste something"** (certain foods or liquids).



The Biological Special Program of the back of the palate and tongue follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration of the epithelial lining of the palate and/or tongue (posterior

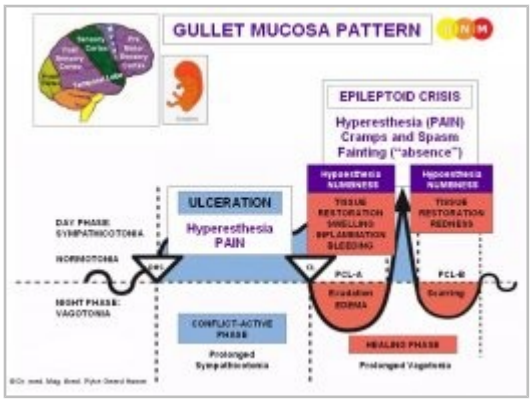
parts) proportional to the degree and duration of conflict activity. **Symptoms**: **painful ulcers in the back of the palate or tongue** with a**hypersensitivity to taste** (in Nature, the sensory perception of a spoiled "food morsel" or poison is essential for survival).

NOTE: Whether the right or left half of the palate or tongue is affected, is determined by a person's handednessand whether the conflict is mother/child or partner-related. A situation-related conflict affects both sides.

HEALING PHASE: The ulceration in the palate and/or tongue is refilled and replenished. The affected area is swollen and might bleed. During PCL-A and PCL-B there is a **hyposensitivity to taste** (compare with loss of sense of taste withfacial paralysis).

PHARYNX AND THROAT

BIOLOGICAL CONFLICT OF THE PHARYNX AND THROAT SURFACE MUCOSA: Like the conflict linked to the upper two-thirds of the esophagus to which the pharynx and throat connect, the biological conflict corresponding to the pharynx and throat surface mucosa is "**not wanting to swallow a morsel**". Figuratively, this refers to any incident or situation one refuses to accept or which is perceived as hard to "swallow".



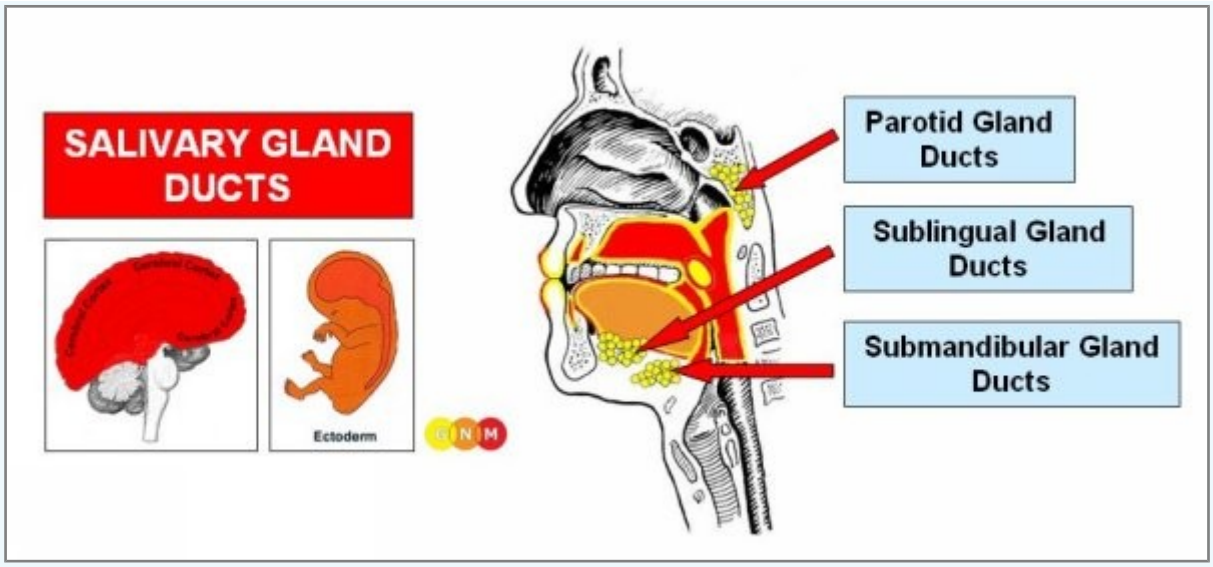
The Biological Special Program of the pharynx and throat follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration of the epithelial lining of the pharynx and throat proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the lumen of the pharynx and throat in order to be better able to eliminate the undesirable "morsel". The ulceration causes a **sore throat**, explicitly, a **scratchy throat**.

NOTE: Whether the right or left half of the pharynx and throat is affected, is determined by a person'shandedness andwhether the conflict is mother/child or partner-related. A situation-related conflict affects both sides.

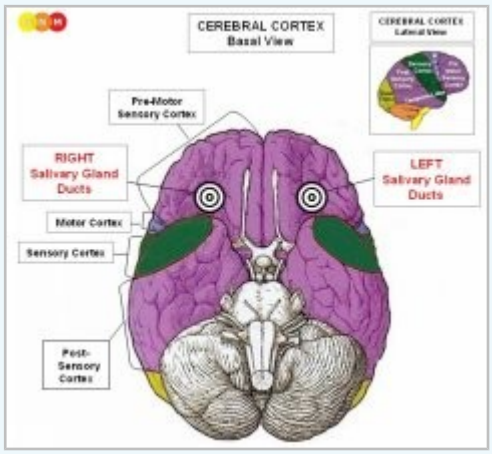
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. **Healing symptoms** are **swelling** due to the edema (fluid accumulation), **difficulties swallowing (a thick and tight throat)** with pain (in PCL-A and PCL-B the pain is not of a sensory nature but rather pressure pain). Concurrent water retention due to the SYNDROME enlarges the swelling and therefore increases the pain. With an inflammation, the condition is called **pharyngitis**, typically accompanied by fever.

What is commonly called a **strep throat** indicates that the healing process is assisted by streptococcus bacteria. This is generally the case when the ulceration that takes place in the conflict-active phase reaches deep into the epithelial tissue.



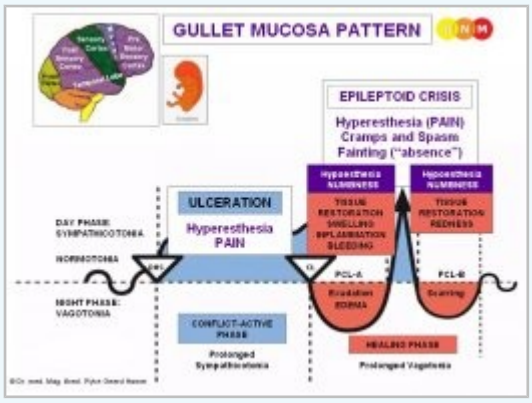
Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE SALIVARY GLAND DUCTS: Saliva, produced in the salivary glands(sublingual gland, submandibular gland, parotid gland) reaches the oral cavity through the salivary ducts. The moisturizing function of saliva allows to insalivate the "food morsel" so that it can pass easily from the mouth into theesophagus. The lining of the salivary gland ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the salivary gland ducts is controlled from the **pre-motor sensory cortex** (part of the cerebral cortex). The right salivary gland ducts are controlled from the left side of the cortex; the left salivary gland ducts are controlled from the right cortical hemisphere (fronto-lateral-basal). Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: Based on the role of saliva in the insalivation of food, the biological conflict linked to the salivary gland ducts is "**not being able to eat"** or "**not being allowed to eat"**. Children experience the conflict when they don't get a desired "food morsel" (chocolate, ice cream, candy), but also adults, particularly women, when they don't allow themselves to eat in order to lose weight. People on strict diets, including diabetics, are more susceptible to suffer the conflict.



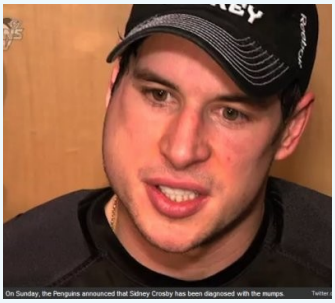
The Biological Special Program of the salivary gland ducts follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the salivary gland duct(s) proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts so that more saliva can be delivered to the mouth to facilitate the insalivation of food. **Symptom**: **pain** ranging from mild to severe.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. With concurrent water retention(the SYNDROME) the increased swelling might obstruct the salivary gland ducts causing **parotitis**, or **mumps**. Mumps is not only a "children's disease" but also affects adolescents and adults. The theory that men who "contract mumps" after puberty have the risk of developing orchitis, an inflammation of the testicles, has no scientific basis. Besides, the existence of a "mumps virus" has never been substantiated.

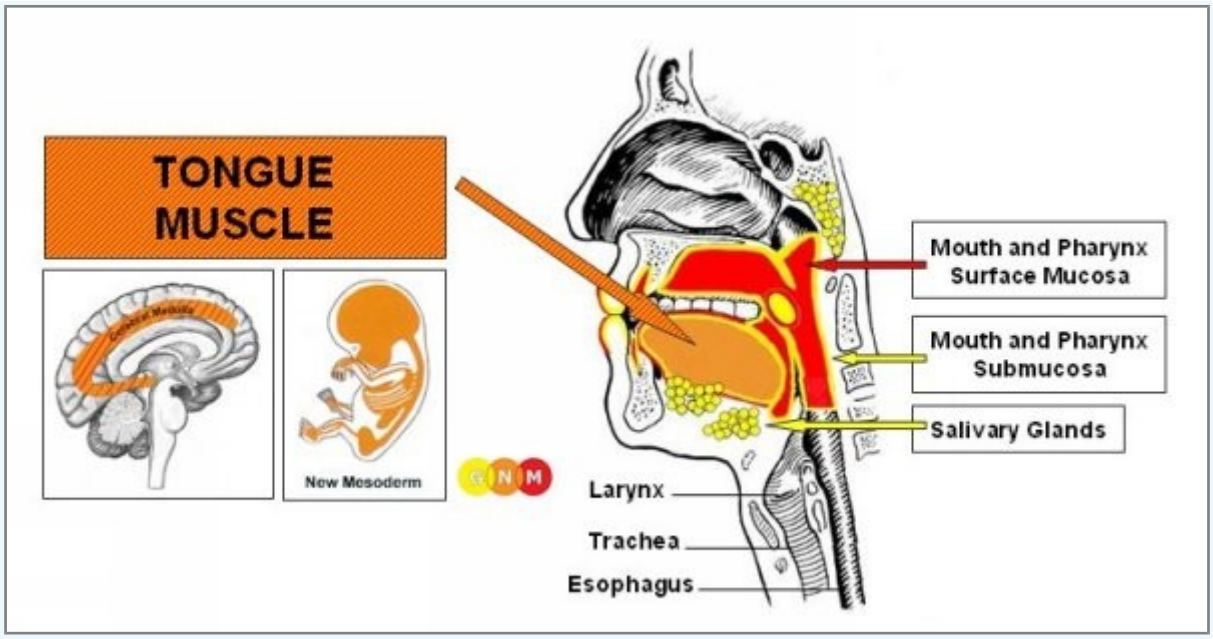
NOTE: Whether the right or left salivary gland ducts are affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

MUMPS develops in the healing phase of "not being able or not being allowed or being unwilling to eat" with swelling in the parotid gland ducts or of "not being able to catch a morsel" (right side) or "not being able to eliminate a morsel" (left side) involving the parotid gland.



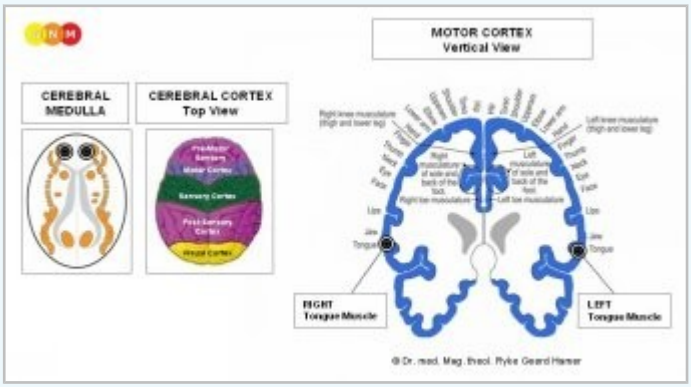
This picture shows hockey star Sidney Crosby of the Pittsburgh Penguins with mumps (parotitis) on his right side. The distress of not being able to catch the "puck morsel" (e.g., not being in the lineup for playing a game) is a possible conflict scenario.

Prolonged healing because of continuous conflict relapses results in a permanent blockage of the saliva flow causing a**dry mouth**. This condition is called **Sjogren's** or **Sicca syndrome** (see also dry mouth related to the mouth submucosa and Sjogren's related to dry eyes). Conventional medicine argues that Sjögren's is linked to a low estrogen level since it affects predominantly women after menopause. However, not every postmenopausal woman has Sjögren's! From the GNM perspective, the increasing rate of the "dry mouth syndrome" is not at all related to a woman's hormone level but rather to today's diet-mania and more women experiencing the distress of "not being allowed to eat". The theory that Sjögren's is an autoimmune disease, suggesting that the body's immune system "mistakenly" attacks it own body cells, is in light of the Five Biological Laws pointless.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE TONGUE MUSCLE: The tongue is a muscular organ covered by anendodermal submucosa and an ectodermal surface mucosa. The tongue coats food with saliva, aids in chewing and pushing food into the pharynx from where it goes through the esophagus into the gastro-intestinal tract. Next to chewing and swallowing, the tongue muscle also assists in speech and the formation of words. The tongue consists of striated muscles, originates from the new mesoderm and is therefore controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The tongue muscle has 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 ability to move the tongue is controlled from the **motor cortex** (part of the cerebral cortex). The right half of the tongue is controlled from the left side of the cerebrum; the left half is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the tongue muscle is "**not being able to pull the tongue away"** (contact with hot liquids or hot food) or "**not being able to move the tongue"**. A difficult dental procedure or intubation could cause such tongue-related distress; also, sexual abuse (oral sex, forced tongue kissing). Taking into account the function of the tongue in articulation and talking, not being able to speak or not being allowed to speak (to get a word off the tongue) can also trigger the conflict. The masticatory muscle relates to the conflict of "**not being able to chew"** (e.g. with braces or dentures).

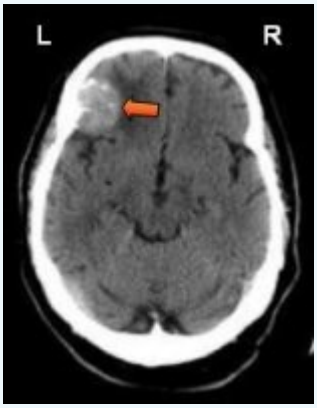
CONFLICT-ACTIVE PHASE: cell loss (necrosis) of tongue muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the tongue muscle** (controlled from the motor cortex) **affecting speech and swallowing** (see also stroke and tongue paralysis). Whether the right or left side of the tongue is affected is determined by a

person's handedness and whether the conflict is mother/child or partner-related.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

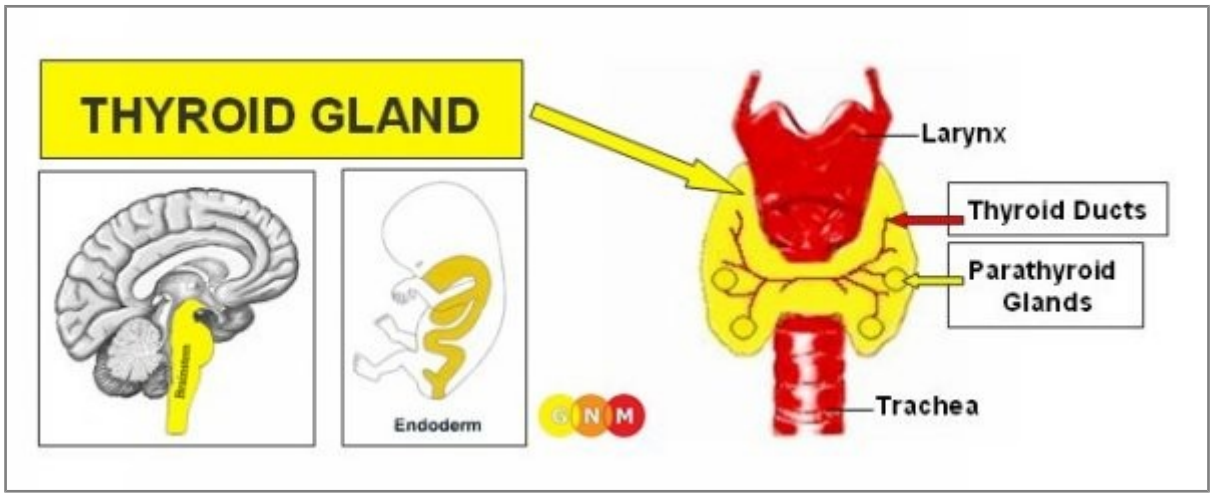
HEALING PHASE: During the healing phase the tongue muscle is reconstructed. The paralysis reaches into PCL-A. After the Epileptoid Crisis, during PCL-B, the function of the tongue muscle returns to normal.

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



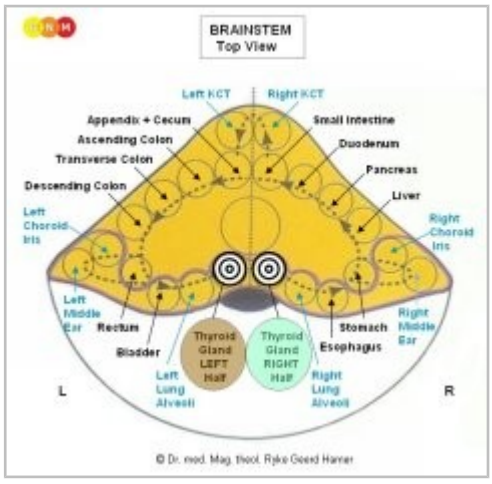
This brain CT presents a Hamer Focus in the scarification phase (PCL-B). The accumulation ofneuroglia (visible as white) in the area of the motor cortex controlling the muscle of the right half of the tongue (view the GNM diagram) indicates that the tongue-related conflict has been resolved. In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor".

THYROID



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE THYROID GLAND: The thyroid gland is situated at the front of the lower neck below the larynx with a right and left lobe on each side of the trachea. Originally, the thyroid gland was located in the oropharynx from where it descended to its final position, taking a path through the tongue and the neck. This connection is known as the thyroglossal duct . The primary function of the thyroid is the production of thyroxine (secretory quality), a hormone that regulates the rate in which nutrients are converted into energy. Initially, the thyroid was an exocrine gland excreting hormones into the ingoing and outgoing section of the intestine to facilitate the ingestion of food and the elimination of feces. After the gullet had broke open, the thyroid became an endocrine gland releasing thyroxine directly into the bloodstream. The thyroid gland consists of intestinal cylinder epithelium, originates from theendoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the thyroid gland has two control centers that are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal.

The right half of the thyroid gland is controlled from the right side of the brainstem; the left half is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland,parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

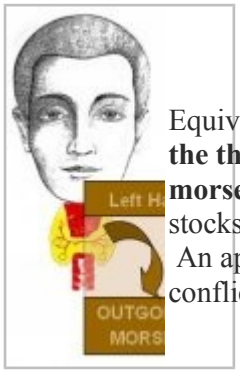
BIOLOGICAL CONFLICT: Consistent with its role in digestion, the biological conflict linked to the thyroid gland is a"**morsel conflict"**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

RIGHT HALF OF THE THYROID GLAND

Equivalent to the right half of the mouth and pharynx, the conflict linked to the **right lobe of the thyroid** relates to an "**ingoing morsel**" and to "**not being fast enough to catch a morsel"**. Such a "morsel" concerns, for example, a job, a position, a promotion, a contract, a business, or a purchase one strongly desires but is too slow to "grab". The expected "morsel" could also relate to a person one is too slow to "catch" or "get a hold of".

LEFT HALF OF THE THYROID GLAND

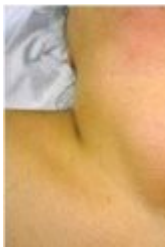


Equivalent to the left half of the mouth and pharynx, the conflict linked to the **left lobe of the thyroid** relates to an "**outgoing morsel"** and to "**not being fast enough to eliminate a morsel"** (originally, the feces morsel). This could be a term paper, any kind of goods, foul stocks or a person (tenant, employee, business partner) one was too slow to "get rid of". An apology or a proposal that was expressed too late can also evoke this type of "morsel" conflict.

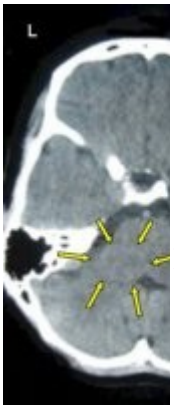
People who are driven to "get things done", who have professions and activities that involve competition (business managers, sales agents, vendors, athletes and sports competitors), who are under deadline pressure (journalists, manufacturers) or constant pressure to "keep up" (working two jobs, working mothers) are more susceptible to experience the conflict. Children and adolescents suffer thyroid-conflicts when they are pushed by a parent, teacher, or coach ("You are too slow!").

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase thyroid gland cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to improve the production of thyroxine so that the individual becomes faster to catch the desired morsel (right half of the thyroid) or to get rid of an undesired morsel (left half of the thyroid). This causes an **overactive thyroid** or **hyperthyroidism**. Because of the body's enhanced metabolism, persons with an overactive thyroid are often overexcited, nervous, irritable, and have trouble sleeping.

With persistent conflict activity the growth (secretory type) created by the continuing cell augmentation forms a **hard struma**, or **goiter** (compare with euthyroid struma related to the thyroid ducts). The enlargement of the thyroid could cause breathing difficulties due to the pressure on the trachea. A large swelling with profuse cell proliferation might be diagnosed as a **thyroid cancer**.



It is a wide-spread belief that hyperthyroidism is caused by iodine deficiency. This theory, however, cannot explain why, for example, a goiter develops in the right or left thyroid lobe (see picture), or in both.



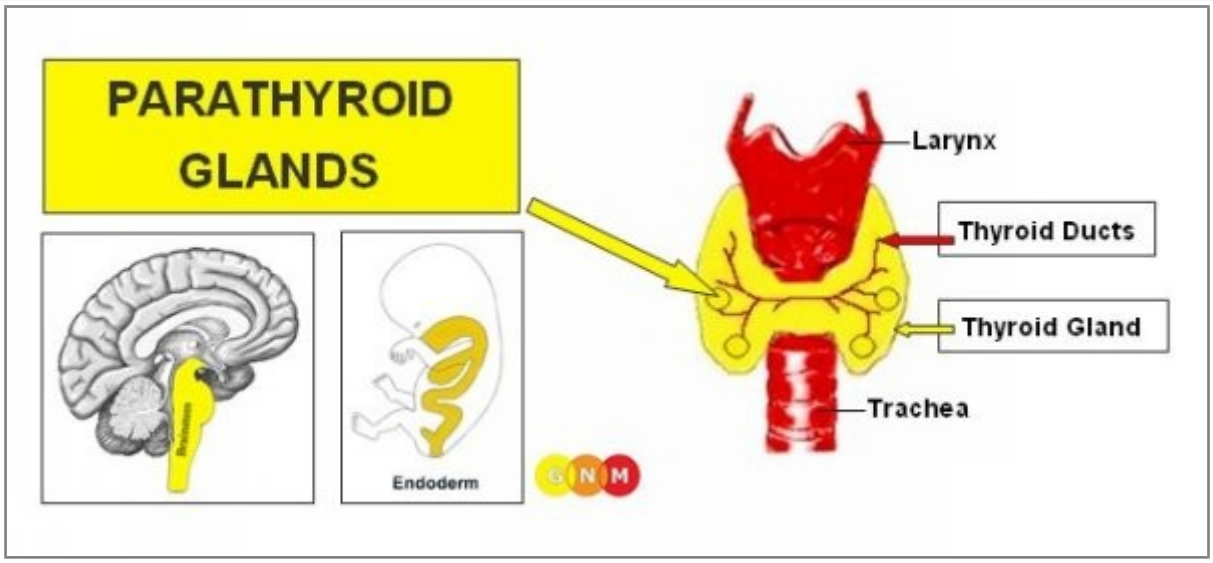
This CT scan highlights the area in the brainstem from where the left thyroid gland is controlled (view the GNM diagram). The sharp ring configuration of the Hamer Focusindicates conflict activity, hence, an overactive thyroid.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **pain** due to the swelling, **difficulties breathing and swallowing**, and **night sweats**. If the healing process is accompanied by an inflammation, this causes **thyroiditis**.

With the completion of the healing phase the thyroxine level returns to normal. However, with a hanging healing, that is, when healing is continually interrupted by conflict relapses, the prolonged decomposing process results in a loss of thyroid gland tissue causing a chronic **underactive thyroid**, or **hypothyroidism**, also termed **Hashimoto's disease**.**Symptoms** are **fatigue and low energy**, since the insufficient production of thyroxine slows down the body's metabolism. In this case, supplementing thyroxine is advisable.

NOTE: Hypothyroidism is always preceded by hyperthyroidism!

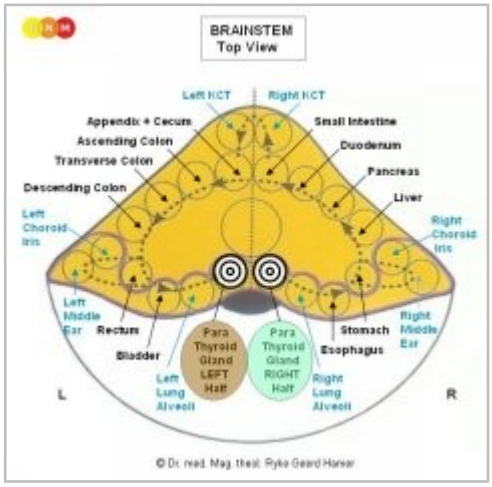
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells in the thyroid gland cannot be broken down. Consequently, the growth or goiter stays **maintaining the overproduction of thyroxine** with **lasting hyperthyroidism**, even though the conflict has been resolved (see also parathyroid glands, pancreas gland, adrenal gland, prostate gland). To normalize the thyroxine production, surgery might have to be considered.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PARATHYROID GLANDS: The parathyroid glands are two pairs of small glands located on the back side of the thyroid gland. Their main function is to

secrete a hormone (PTH-parathyroid hormone) that helps maintain the proper level of calcium (secretory quality), a mineral essential for muscle contraction. Like the thyroid gland, the parathyroid glands were originally exocrine glands that excreted into the intestine. Today, they are endocrine glands that release their hormones directly into the bloodstream. The parathyroid glands consist ofintestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the parathyroid glands have two control centers that are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal.

The right parathyroid gland is controlled from the right side of the brainstem; the left parathyroid gland is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland, parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: According to the function of the parathyroid glands, the corresponding biological conflict is a"**morsel conflict"**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

RIGHT PARATHYROID GLANDS: Equivalent to the right half of the mouth and pharynx, the conflict linked to the right parathyroid glands relates to an "**ingoing morsel"** and to "**not being able to catch a morsel" because of a low calcium level limiting the muscle contraction required to ingest a food morsel.**

LEFT PARATHYROID GLANDS: Equivalent to the left half of the mouth and pharynx, the conflict linked to the left parathyroid glands relate to an "**outgoing morsel"** and to "**not being able to eliminate a morsel" because of a low calcium level limiting the muscle contraction required to eliminate a morsel.**

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the parathyroid glands proliferate causing an **overproduction of PTH** or **hyperparathyroidism** with the **biological purpose** to supply the organism with more calcium to improve the muscular contraction so that the morsel can be better absorbed (right glands) or eliminated (left glands). Consequently, the calcium level in the blood increases causing **hypercalcemia**(compare with hypercalcemia related to the bones). In conventional medicine, a large growth in the parathyroid glands might be diagnosed as a **parathyroid cancer**.

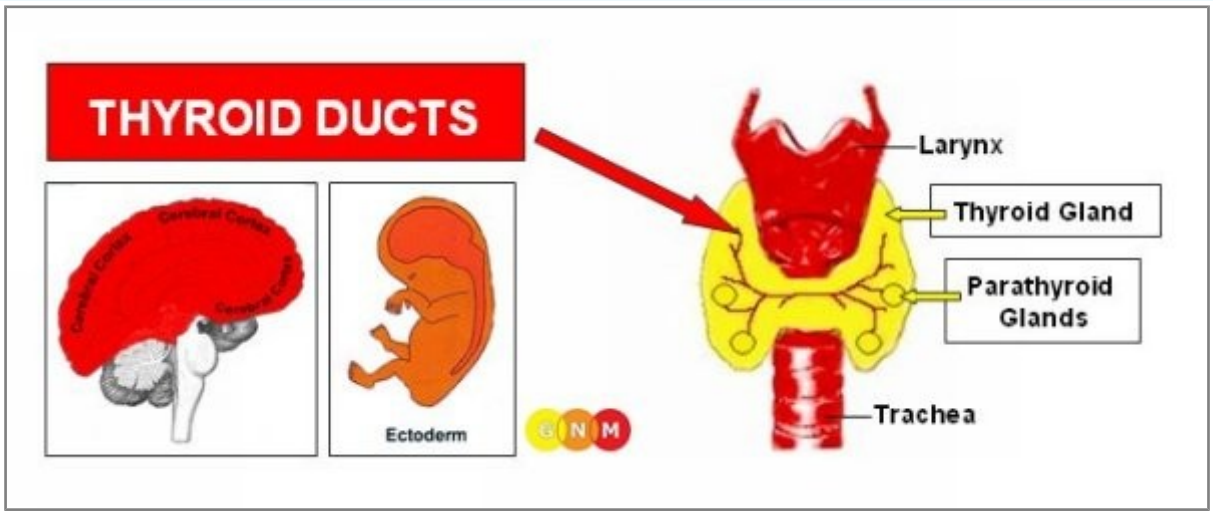
NOTE: The PTH-parathyroid hormone draws the required calcium from the bones. However, this does not causeosteoporosis, since PTH ensures at the same time that excess calcium is not excreted through urination but carried back to the organism.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. This process is accompanied by night sweats. With the completion of the healing phase the PTH level returns to normal. However, with a hanging healing, when healing is continually interrupted by conflict relapses, the prolonged bacterial activity leads to a loss of parathyroid gland tissue causing chronic **hypoparathyroidism** with constant low calcium levels. In this

case supplementation is advisable.

NOTE: **Hypoparathyroidism is always preceded by hyperparathyroidism!**

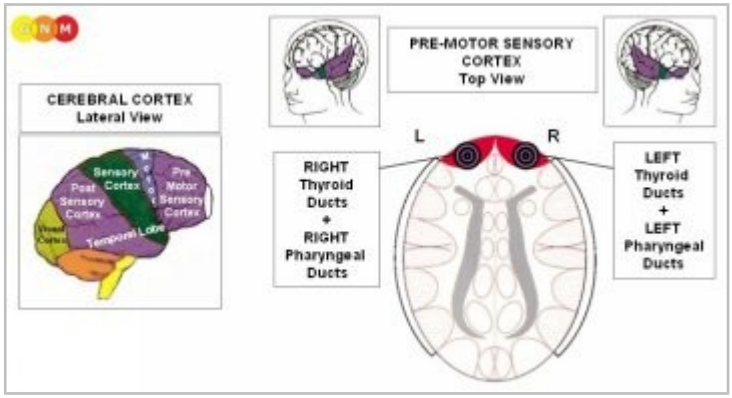
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells cannot be broken down causing **lasting hyperparathyroidism**(see also thyroid gland, pancreas gland, adrenal gland, prostate gland). To normalize the thyroxine production, surgery might have to be considered.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE THYROID DUCTS: The thyroid ducts branch throughout the thyroid gland in a tree-like structure. The original function of the thyroid ducts was to carry hormones produced in the thyroid into the ingoing and outgoing section of the intestine to aid the metabolism of food and the disposal of feces. After the rupture of the gullet, the thyroid ducts closed and the thyroid became an endocrine gland. Today, the thyroid ducts deliver thyroxine directly into the bloodstream. The lining of the thyroid ducts consists of squamous epithelium, originates from theectoderm and is therefore controlled from the cerebral cortex.

NOTE: The thyroid ducts are descendants of the pharyngeal arches (see also coronary arteries, coronary veins,aorta, carotid arteries, and subclavian arteries that derive from the pharyngeal arch arteries. In the embryo, the pharyngeal arches, or branchial arches (Greek branchial = gill), give rise to structures of the head and neck (see also pharyngeal ducts).

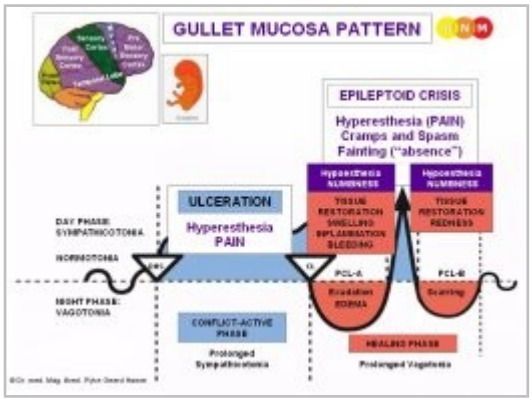


BRAIN LEVEL: The epithelial lining of the thyroid ducts is controlled from the **pre-motor sensory cortex** (part of the cerebral cortex). The left thyroid ducts are controlled from the right side of the cerebral cortex; the right thyroid ducts are controlled from the left cortical hemisphere (frontal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The thyroid ducts and pharyngeal ducts share the same brain relays.
The DHS affects either one of the tissues or both, depending on the intensity of the

conflict.

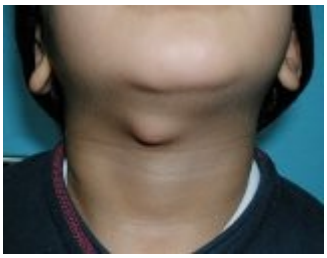
BIOLOGICAL CONFLICT: The biological conflict linked to the thyroid ducts is a female **powerless conflict** or malefrontal-fear conflict, depending on a person's gender, laterality, and hormone status. A powerless conflict is experienced as feeling helpless ("there is nothing I can do about this", "my hands are tied") or of not being in control of a situation. Generally speaking, the conflict relates to any kind of imposition, external control or decision made over one's head.



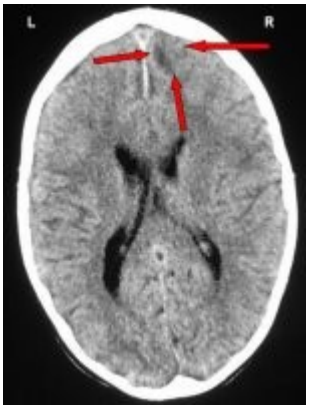
The Biological Special Program of the thyroid ducts follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the lining of the thyroid ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts to supply the organism with more thyroxine; this provides the individual with more energy to resolve the conflict. **Symptoms**: mild to severe **pain**, depending on the intensity of the conflict. Since the lumen of the thyroid ducts enlarges, the thyroxine level rises slightly during the conflict-active phase. This, however, must not be confused with hyperthyroidism because the thyroxine production in the thyroid gland is unaffected.

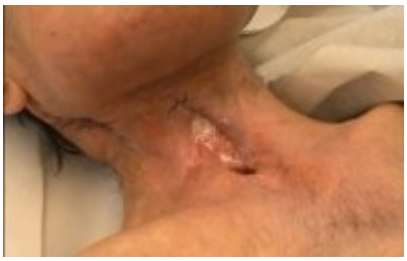
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. Since the thyroid ducts have no external opening, a cyst forms as a result of the back-up of fluid in the duct. Such a thyroid cyst is called a **euthyroid struma**, or **goiter** (compare with goiter related to the thyroid gland). Since there are no thyroxine-producing cells involved, the thyroxine level stays within the normal range. **Thyroid cysts are located towards the middle (median)** on the right or left side of the neck (compare with cysts in the pharyngeal ducts located laterally). If there are no conflict relapses, the swelling recedes in the course of the healing process. However, with a hanging healingthe cyst stays until healing is complete.



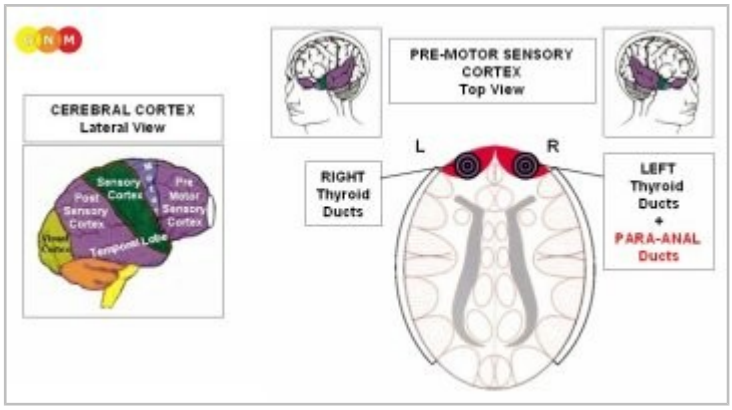
Thyroglossal cysts develop in the thyroglossal duct that connects the thyroid gland with the base of the tongue.



This brain CT presents a Hamer Focus on the right side of the cerebral cortex, precisely, in the area from where the left thyroid ducts and thyroglossal duct are controlled (view the GNM diagram). The small fluid accumulation, showing as dark, indicates the beginning of PCL-A.

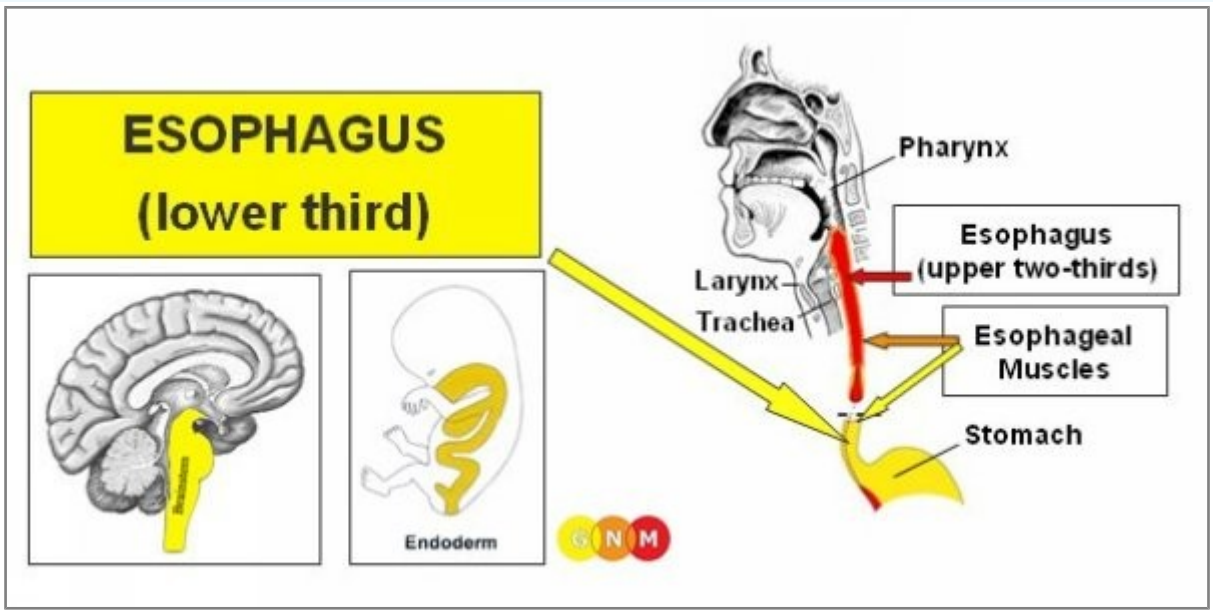


A **thyroid fistula** is an external opening of a thyroid duct caused by the rupture of athyroid cyst (euthyroid struma) with fluids emptying outwards. A thyroid cyst can break, for example, when large amounts of water are retained in the cyst due to theSYNDROME or as a result of continuous conflict relapses that prolong the healing process. Yet, a fistula is only created when the right thyroid ducts are affected since they are located closer to the skin. This explains why a **thyroid fistula always forms on the right side of the neck**.



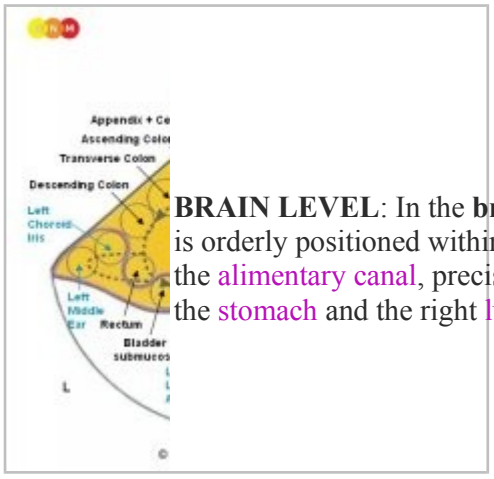
In the brain, the right thyroid ducts, where the fistula occurs, are controlled from the left cortical hemisphere exactly opposite the brain relay of the left thyroid ducts and the para-anal ducts. Here is why: Originally, before the gullet broke open, the thyroid was an exocrine gland that released thyroxine into both sections of theintestine. The right thyroid ducts (controlled from the left side of the brain) excreted into the ingoing section (today's mouth and pharynx, esophagus, stomach and duodenum, small intestine) to aid the digestion of food; the left thyroid ducts (controlled from the right side of the brain) excreted into the outgoing section (today's rectum) to accelerate the disposal of feces. However, when the gullet ruptured, parts of the left thyroid ducts remained in the rectum. These residues are today's para-anal ducts (seepara-anal fistula). The close vicinity of the brain control centers of the thyroid ducts and para-anal ducts represents the rupture of the gullet on the cerebral level.

ESOPHAGUS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE ESOPHAGUS (LOWER THIRD): The esophagus is located behind thetrachea and the larynx. Originally, the entire alimentary canal – from the mouth to the rectum - served the absorption (resorptive quality) and digestion (secretory quality) of food. Today, the main function of the esophagus is to carry food, liquids, and saliva from the mouth to the stomach. The act of swallowing is facilitated by the peristaltic movement (motor quality) of the smooth muscles in the esophagus (the upper two-thirds of the esophagus are mainly made up ofstriated muscles). The deep esophagus mucosa consists of intestinal cylinder epithelium, originates from the endodermand is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the lower third of the esophagus is orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, on the right brainstem hemisphere between the relays of the stomach and the right lung alveoli.

BIOLOGICAL CONFLICT: The biological conflict linked to the lower esophagus is "**not being able to swallow a morsel"**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

This type of morsel conflict relates to a "morsel" one had expected (a job, a promotion, a position, a deal, a purchase, an inheritance, a gift, an apology, a proposal) but unexpectedly does not receive the desired "morsel". A promise that has not been kept, something of personal value that has been taken away, projects or plans one is unable to carry out are other examples of what could evoke the conflict. A "morsel" one is unable to "swallow" could also concern a new relationship or a specific person such as a tenant, an employee, or a friend one had to give up.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase esophageal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to be better able to absorb and digest the desired morsel. Even though the esophagus has no longer a digestive function, in the event of a biological conflict the organ still responds with cell augmentation, because originally the entire alimentary canal served the absorption and digestion of food. With prolonged conflict activity (hanging conflict) a cauliflower-shaped growth (secretory type), referred to as an **esophageal cancer**, develops in the lower esophagus (compare with "esophageal cancer" related to the upper two-thirds). The tumor might also grow on a flat plane (resorptive type). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as an **esophageal polyp** (see also healing phase).

It is assumed that an esophageal cancer is linked to gastric reflux. No question, the backflow of stomach acid might irritate the esophagus but this does not cause a "cancer". In GNM terms, cell proliferation in the esophagus only occurs in response to the correlating biological conflict, namely to "not being able to swallow a morsel". Gastric reflux, on the other hand, originates in the stomach and is related to a territorial anger conflict.

Esophageal spasms occur during the Epileptoid Crisis (see also esophageal spasms related to the upper two-thirds of the esophagus).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **pain behind the sternum** due to the **swelling**, and **night sweats**. A large swelling could constrict the esophagus with difficulties swallowing solid foods. With an acute narrowing, a feeding tube may have to be used until the tumor has been decomposed, provided the necessary microbes are available when healing sets in. **Esophageal candidiasis** indicates that fungi assist healing.

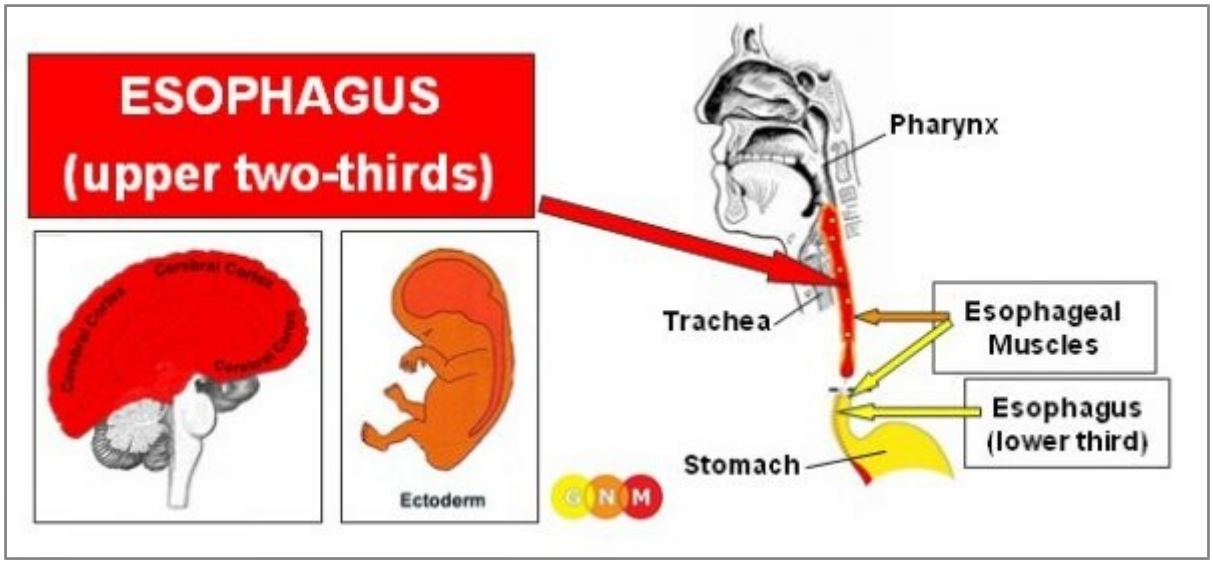
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine, this is usually diagnosed as an **esophageal polyp** or as a "benign cancer" (see also conflict-active phase).

With the SYNDROME, that is, with water retention brought on by an active abandonment and existence conflicts, the retained water is exceedingly stored in the healing area, which increases the swelling. If the swelling becomes very large, this could lead to a serious situation, because the pressure that occurs during an intense Epileptoid Crisis might break blood vessels causing **severe bleeding into the intestine** (tar stool) and **vomiting blood**.

Dr. Hamer: "The therapy is at times difficult. However, the patient can cope with the complications much better when he knows that they are only temporarily and that the bleeding can be managed with regular blood transfusions until the healing process has been complete."

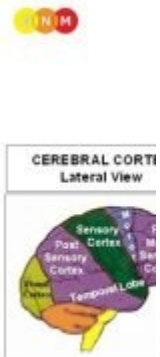
Esophageal "varices": According to conventional medicine, esophageal varices are swollen veins in the lining of the lower esophagus. They are associated with liver cirrhosis and high blood pressure in the portal vein. Based on GNM, the swellings are in reality pouches in the esophagus lining (similar

to diverticula in the intestines resulting from recurring repair processes). Moreover, the veins (new mesoderm) and the lower esophagus lining (endoderm) are different tissue types that derive from different embryonic germ layers and are therefore controlled from different areas in the brain. Hence, every person who has esophageal varices shows – without exception – the Hamer Focus in the brainstem, precisely, in the control center of the lower third of the esophagus (view the GNM Diagram), and not in the cerebral medulla from where the blood vessels are controlled (see also the theory suggesting that hemorrhoids are swollen veins in the rectum).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

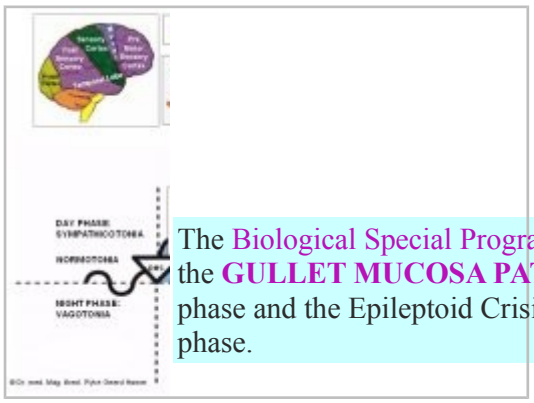
DEVELOPMENT AND FUNCTION OF THE ESOPHAGUS (UPPER TWO-THIRDS): Originally, the inner wall of the entire esophagus consisted solely of intestinal cells (cylinder epithelium). At a later evolutionary stage, the endodermal lining of the upper portion of the esophagus was replaced with a new cell layer composed of squamous epithelium. However, clusters of endodermal cells remained also in the upper part. The epithelial lining of the upper two-thirds of the esophagus originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the upper esophagus is controlled from the **post-sensory cortex** (part of the cerebral cortex). The left half of the esophagus is controlled from the right side of the cortex (in the vicinity of the stomach relay); the right half of the esophagus is controlled from the left cortical hemisphere. There is a cross-over correlation from the brain to the organ.

NOTE: The control centers of the esophagus are located outside of the temporal lobe, hence, the principle of gender, laterality, and hormone status does not apply.

BIOLOGICAL CONFLICT: While the lower third of the esophagus is linked to "*not being able* to swallow a morsel", thebiological conflict associated with the upper two-thirds is the opposite, namely, "**not *wanting* to swallow a morsel"**(see also pharynx and throat). It is a type of "separation conflict". This refers to any incident or situation one refuses to accept or words (accusations, insults, reproaches, criticism) that are difficult to "take" or hard to "swallow". The unwanted morsel can also concern real food or medication.



The Biological Special Program of the upper two-thirds of the esophagus follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

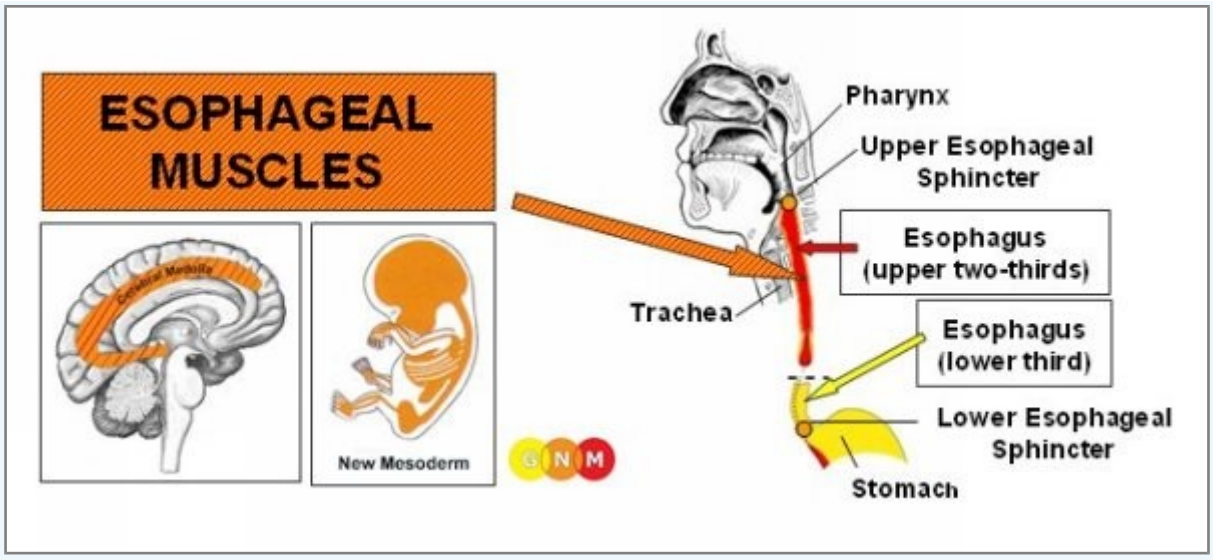
CONFLICT-ACTIVE PHASE: ulceration of the lining of the upper esophagus proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the diameter of the esophagus to be better able to eliminate the undesirable "morsel". Since the esophageal squamous epithelium is rather thick, it can take some time before deep ulcers are detected through an esophagoscopy. **Symptoms:** mild to severe **pain**. The typically burning pain is often misinterpreted as heart burn or "gastroesophageal reflux".

NOTE: Whether the right or left half of the upper esophagus is affected is determined by a person's handednessandwhether the conflict is mother/child or partner-related.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. In conventional medicine, this might be diagnosed as an "**esophageal cancer"** (compare withesophageal cancer related to the lower third of the esophagus). According to the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

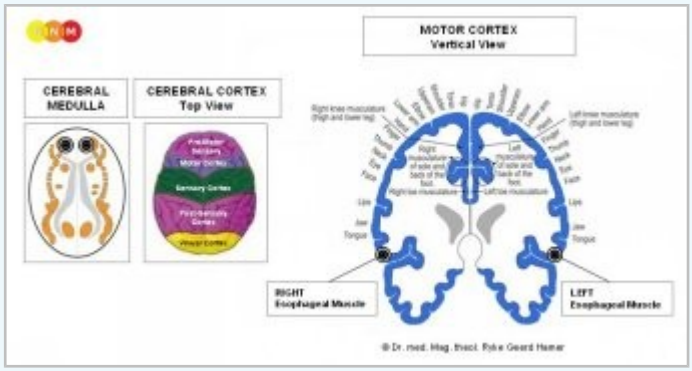
Healing symptoms are **difficulties swallowing** because of the swelling and **pain**, which could last throughout the entire healing phase (in PCL-A and PCL-B the pain is not of a sensory nature but rather pressure pain). Concurrent water retention due to the SYNDROME enlarges the swelling. With an inflammation, the condition is called **esophagitis**. TheEpileptoid Crisis manifests as **acute burning pain**.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE ESOPHAGEAL MUSCLES: The esophagus is a muscular tube composed ofsmooth muscle in the lower part and striated muscles in the upper two-thirds. The tension of the muscles stabilizes the esophagus and allows swallowing and the transition of food. The esophagus is surrounded by two muscular rings, known as the esophageal sphincters. The opening of the upper esophageal sphincter is triggered by the swallowing reflex. The lower esophageal sphincter, also known as the cardiac sphincter, surrounds the lower part of the esophagus. At the level of the cardia, the opening connecting the esophagus with the upper part of the stomach, the esophagus rotates on its axis and thereby forms an elastic, twisting occlusion which contributes to the function of the sphincter, namely to open in order to allow food pass into the stomach and to close to keep it there. **NOTE:** The esophageal sphincters are functional but not anatomical sphincters like the bladder sphincter, rectal sphincter, or cervical sphincter. The smooth esophageal muscles derive from the endoderm and are controlled from the midbrain. The striated esophageal muscles originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The striated esophageal 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 right esophageal muscles are controlled from the left side of the cerebrum; the left esophageal muscles are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the upper esophageal muscles is "**not being able to regurgitate a morsel"**, literally or figuratively (insult, accusation, diagnosis) because the morsel is considered too big.

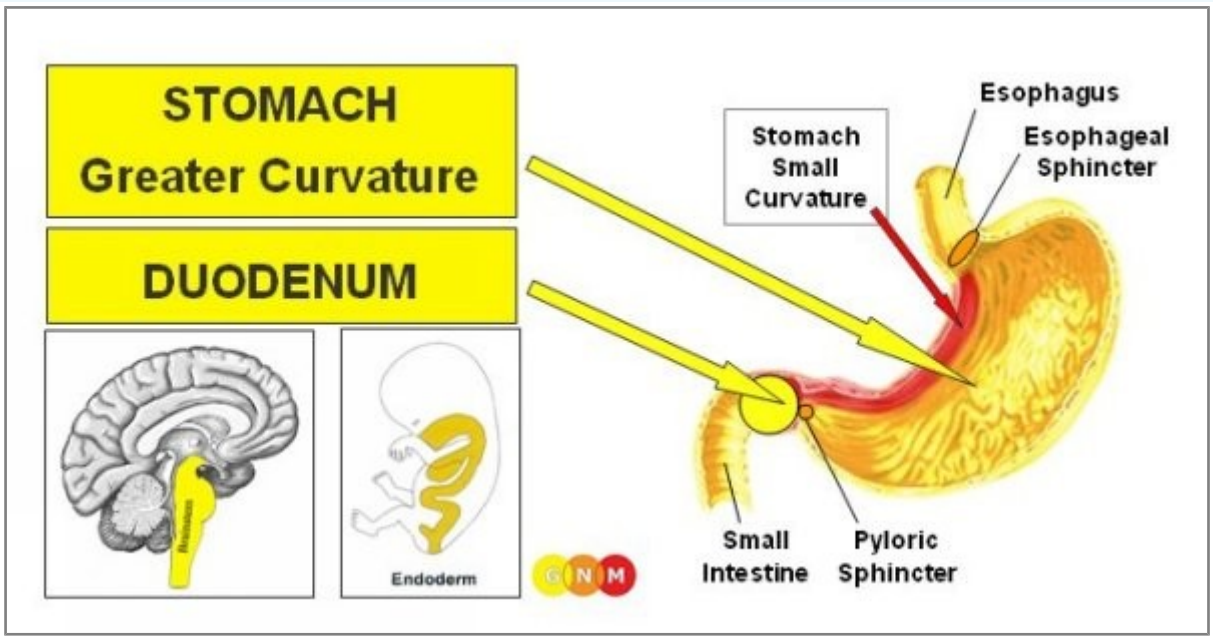
CONFLICT-ACTIVE PHASE: cell loss (necrosis) of esophageal muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the esophageal muscles** (controlled from the motor cortex) causing **difficulties swallowing foods and liquids**.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

HEALING PHASE: During the healing phase, the esophageal muscles are reconstructed. The paralysis, reaches intoPCL-A. The Epileptoid Crisis presents as **esophageal spasms** (see also esophageal spasms in the lower third of the esophagus). Depending on the degree of the conflict-active phase, the contractions range from mild to severe. DuringPCL-B, the function of the esophagus muscles returns to normal. Recurring esophageal spasms indicate a hanging healingdue to conflict relapses.

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

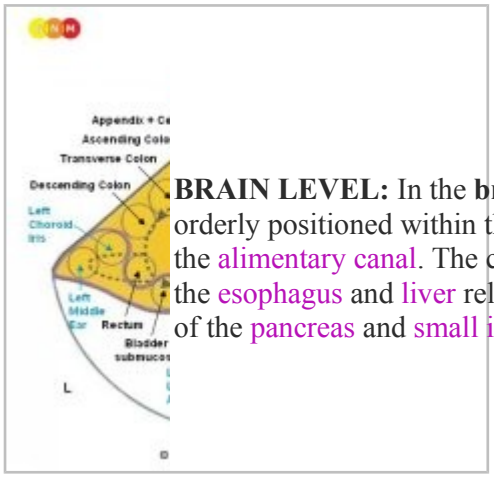
STOMACH & DUODENUM



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE STOMACH AND THE DUODENUM: The **stomach**, located in the upper part of the abdomen, connects the esophagus with the intestinal tract; the top of the stomach lies against thediaphragm. The stomach contains glands that secrete gastric acids and digestive enzymes (secretory quality) to aid the digestion of food. The **duodenum**, the first section of the small

intestine, absorbs the nutrients (resorptive quality) from the food passing through it. For the breakdown of foods, the duodenum receives bile from the liver and through thepylorus pancreatic juices produced in the pancreas. The lower esophageal sphincter at the top of the stomach prevents the backflow of stomach content. The stomach (except the small curvature) and the duodenum (except the duodenal bulb) consist of intestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control centers of the stomach and duodenum are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal. The control center of the stomach is located between the esophagus and liver relays; the control center of the duodenum between the brain relays of the pancreas and small intestine.

BIOLOGICAL CONFLICT: The biological conflict linked to the stomach and duodenum is an "**indigestible morsel conflict"** (see also pancreas gland, small intestine, and colon). For animals an indigestible morsel is about a real piece of food, whereas for humans the conflict relates also to any situation or circumstances one is, figuratively speaking, unable to digest or "can't stomach", as the English expression goes.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

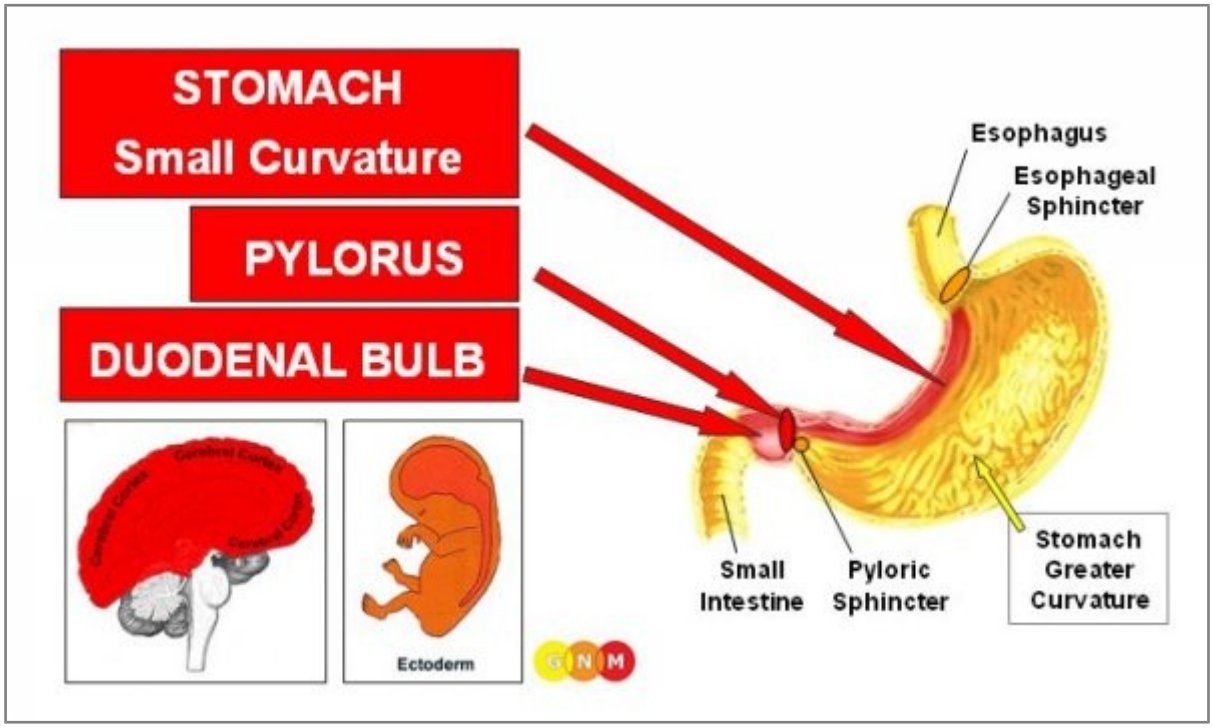
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the stomach or duodenum proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the production of gastric juices and other digestive fluids so that the morsel can be better digested and absorbed; the improved function of the organs serves to facilitate a conflict resolution. With prolonged conflict activity (hanging conflict)a flat growth (resorptive type), referred to as a **stomach/duodenal cancer**, develops in the stomach or duodenum as a result of the continuing cell augmentation (compare with "stomach cancer" and "duodenal cancer" related to the small curvature of the stomach and the duodenal bulb). In the stomach the growth might also take a cauliflower-shaped form (secretory type). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as a **polyp** (see also healing phase).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. Because of the environment in which they work, fungi and tubercular bacteria are stomach acid-resistant. **Healing symptoms** are **nausea**, **indigestion**, **abdominal pain**, and **night sweats**. Depending on the degree of the conflict-active phase, the symptoms range from mild to severe. **Vomiting** typically occurs during theEpileptoid Crisis; in acute cases the vomit contains blood.

NOTE: Eating disagreeable food also causes an **upset stomach and vomiting**. However, if bad food can be excluded as the source, vomiting is a positive sign that the "indigestible morsel conflict" has been resolved and that the morsel is being expelled, even without the assistance of microbes (sensory and excretory quality of the intestines).

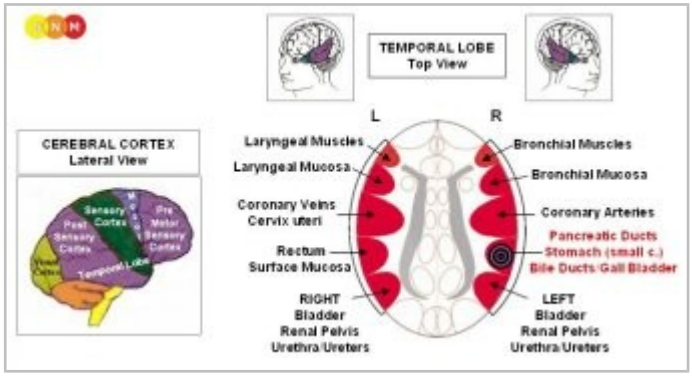
When fungi participate in the healing process this causes **stomach- or duodenal candidiasis**, which becomes chronic when a person is in a hanging healing because of continuous conflict relapses.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells in the stomach or duodenum remain without further cell division. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine, this might be diagnosed as "benign cancer" or as a **stomach polyp or duodenal polyp** (see also conflict-active phase).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE STOMACH (SMALL CURVATURE), PYLORUS, AND DUODENAL BULB: The small curvature of the stomach extends between the esophageal sphincter and the pylorus on the medial surface of the stomach (the lateral surface is called the greater curvature). The pylorus is a short, funnel-shaped tube that connects the stomach with the duodenum. The pyloric sphincter allows food to pass into the small intestine. The duodenal bulb is located at the upper portion of the duodenum. The small curvature of the stomach, the pylorus, and the duodenal bulb consist of squamous epithelium, originate from the ectoderm and are therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial mucosa of the stomach (small curvature), the pylorus, and the duodenal bulb are controlled from the right side of the **temporal lobe** (part of the **post-sensory cortex**). The control center is positioned exactly across from the brain relay of the rectum lining.

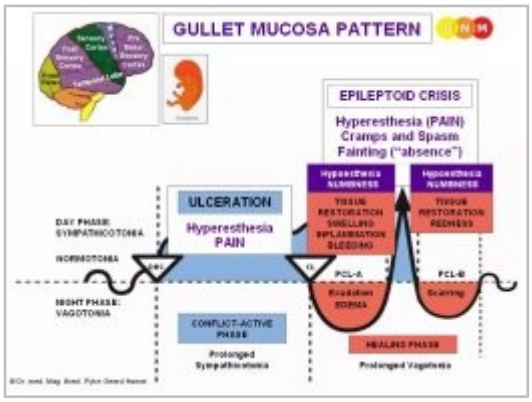
NOTE: The stomach (small curvature), pylorus, duodenal bulb,bile ducts, gall bladder, and pancreatic ducts share the same brain relay

and therefore the same biological conflict. Which one of these organs will be affected by the DHS is random. A severe conflict can affect all organs at once.

BIOLOGICAL CONFLICT: The biological conflict linked to the stomach (small curvature), pylorus, and duodenal bulb is a male **territorial anger conflict** or a female identity conflict, depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

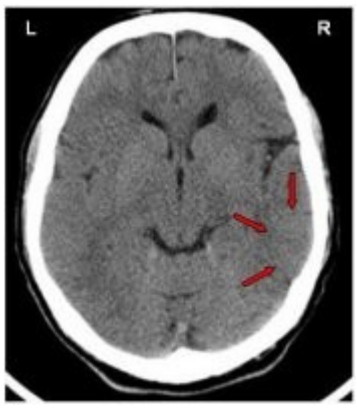
A **territorial anger** relates to anger in the environment and places which one considers as his or her domain - literary or figuratively. Typical territorial anger conflicts are disputes at home, feuds at the workplace, anger in school, in kindergarten, at the playground, in a seniors or nursing home, or in the hospital; also in the extended "territory" such as in the village, town, or country where one lives. Battles over a land or property, annoying noise in the house or neighborhood, a fight over a parking place or over a toy, are other examples of what can provoke a territorial anger conflict.



The Biological Special Program of the stomach and duodenum follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the lining of the stomach, pylorus, and/or the duodenal bulb proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the passageway of the digestive tract so that the nutrients can be utilized more efficiently. This, in turn, provides the individual with more energy to resolve the conflict. **Symptoms**: **indigestion** and mild to severe **pain**, depending on the intensity of theterritorial anger conflict. Food enhances the pain because of the increased secretion of stomach acid produced in thestomach. **NOTE:** While conflict active, the person is in a depressed mood.

Painful ulcers develop when a territorial anger conflict persists for a longer period of time (hanging conflict). **Stomach (peptic) ulcers**, **pyloric ulcers**, and **duodenal ulcers** often occur together. If the ulceration reaches deep into the tissue, the epithelial layer becomes thin and might rupture. A perforation of the stomach is a life-threatening situation!



This brain CT shows the impact of a territorial anger conflict in the cerebral cortex, precisely, in the area that controls the small curvature of the stomach (view the GNM diagram). The sharp border of the Hamer Focus reveals that the person is conflict active.

According to conventional medicine, stomach ulcers are supposedly caused by gastric acid. This assertion, however, is inaccurate because gastric acid is produced and stored in the bulk of the stomach which never develops ulcers. Ulcers develop exclusively in the *lining* of the stomach or the pylorus, namely, in the conflict-active phase. The theory that stomach ulcers are related to the bacterium *helicobacter pylori*, a claim for which Barry Marshall and Robin Warren received the Nobel Price in Physiology and Medicine in 2005, is therefore also inconclusive, because microbes are only active in the healing phase (Fourth Biological Law). Hence, the *helicobacter pylori* does not, as assumed, *cause* stomach ulcers but helps to restore(!) the stomach and pylorus lining after a territorial anger conflict has been resolved.

Gastric reflux or heartburn (nowadays called "gastroesophageal reflux diseases" or GERD) is organically linked to thelower esophageal sphincter located at the top of the stomach and responsible for preventing the backflow of stomach contents. During conflict activity of a territorial anger as well as throughout the Epileptoid Crisis the sphincter opens prompting the reflux of stomach acid. The backflow of gastric acid might irritate the esophagus but can never cause an esophageal cancer, as claimed by conventional medicine.

Stomach cells secrete the so-called intrinsic factor that helps the body to absorb vitamin B12 in the small intestine. Vitamin B12 is needed for the production of red blood cells. The loss of stomach cells during conflict activity of aterritorial anger conflict can therefore cause **pernicious anemia** (compare with anemia related to the Biological Special Program of the bones).

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. In conventional medicine, this might be diagnosed as a "**stomach cancer"** or "**duodenal cancer"**(compare with stomach/duodenal cancer related to the bulk of the stomach and the duodenum). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process. **Healing symptoms** are **swelling** due to the edema (fluid accumulation) and **stomach pain**, which could last throughout the entire healing phase (in PCL-A and PCL-B the pain is not of a sensory nature but pressure pain). With an inflammation, the condition is called **gastritis**.

An inflammation of the gastrointestinal tract (**gastroenteritis**) with vomiting and diarrhea is colloquially called a"**stomach flu"**. Conventional medicine claims that the "infection" is caused by a variety of viruses, including the infamous "Norwalk Virus" …

"Norwalk virus is a common cause of vomiting each winter and has often been referred to as "stomach flu" or "Winter Vomiting Disease". Norwalk virus infections have been linked to outbreaks of vomiting in institutions such as child-care centers and long term care facilities as well as on cruise ships, camps, schools and households." (Source:http://www.simcoemuskokahealth.org/Topics/InfectiousDiseases/DiseaseInformation/FactSheetsMN/Norwalk.aspx).

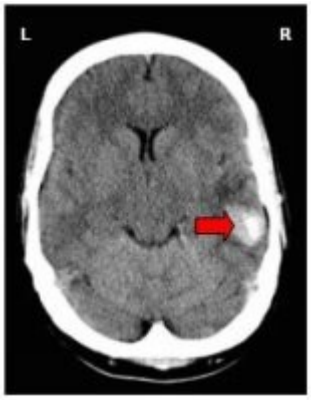
From the GNM perspective, **stomach flu outbreaks** are, contrary to the common belief, not at all related to viruses (which have never been scientifically verified*) but rather to "*indigestible morsel-conflicts"

and territorial anger conflictsexperienced simultaneously by a group of people (city residents, villagers, family members, colleagues, school mates, room mates, friends) who share the same anger-environment (at home, at work, in day care, in kindergarten, in school, in nursing homes, etc.). Territorial anger conflicts can involve large numbers of people. Unexpected, upsetting political decisions, for example, can trigger regional conflict shocks followed by a "stomach flu" outbreak in the affected population, after the conflict has been resolved. **Stomach flu epidemics** therefore typically occur after natural disasters such as floods or earthquakes, that is, during the resolution phase.

NOTE: Eating disagreeable food also causes an **upset stomach and vomiting** (sensory and excretory quality). However, if bad food can be excluded, vomiting is a positive sign that the territorial anger conflict has been resolved.

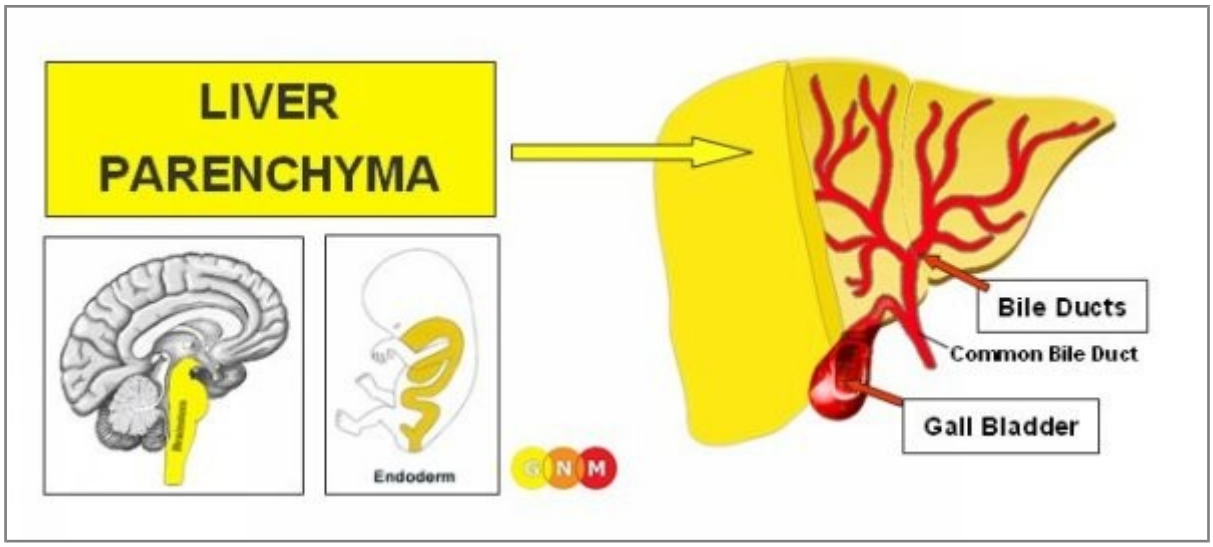
The Epileptoid Crisis manifests as **acute sharp pain** and **cramps or spasm** (**stomach colic**) if the surroundingstriated muscles of the stomach or pylorus undergo the Epileptoid Crisis at the same time (except for the small curvature of the stomach and the pylorus, the stomach wall consists of smooth muscle). **Bleeding** (with black tar stool) requires immediate medical attention! **Vomiting** also occurs during the Epileptoid Crisis.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete**loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).



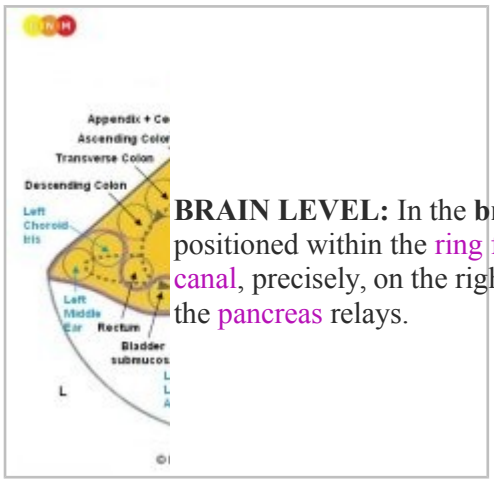
This CT scan shows an accumulation of neuroglia in the area of the brain that controls the small curvature of the stomach (view the GNM diagram), indicating that the related territorial anger conflict is resolved and that the person is currently in PCL-B (both on the brain and organ level). In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor".

LIVER & GALLBLADDER



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE LIVER PARENCHYMA: The liver parenchyma forms the bulk of the liver. It consists for the most part of so-called hepatocytes, which are the prime functional cells of the liver. Their main activities are the production of bile (secretory quality), a substance that helps to remove toxins from the body. Bile made in the liver travels via the common bile ducts to the small intestine where it aids the absorption of fats (resorptive quality). During times, when bile is not needed in the intestines, it is stored in the gall bladder until required. In addition to secreting bile, the liver also produces cholesterol. The liver parenchyma is composed of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the liver parenchyma is orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, on the right brainstem hemisphere between thestomach and the pancreas relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the liver parenchyma is a **starvation conflict**.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

A person can suffer a starvation conflict in real terms due to a lack of food. Hence, being put on a strict diet, not being allowed to eat one's favorite food, a colon cancer diagnoses associated with not getting food through the intestine, wearing a colostomy bag, a loss of appetite and excessive vomiting during chemo treatments, or unintentional weight loss might trigger the conflict. However, a "threat of starvation" could also be brought on when one is – unexpectedly – in a situation of not being able to make ends meet, let's say, because of the loss of a workplace, pay cuts, the loss of a business, bankruptcy, the

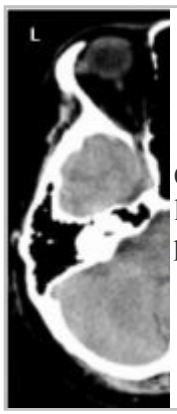
loss of clients, an unexpected rent increase, an economically devastating divorce, the confiscation of property, the loss of savings, financial debts, or losing a family member who provided financial support. In short, the conflict translates into the distress of running out of resources to feed oneself and those one feels responsible for.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase liver cells (hepatocytes) proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to improve the function of the liver so that the smallest food particles can be used to its optimum. With prolonged conflict activity (hanging conflict) liver nodules, referred to as a **liver cancer** ("hepatocellular carcinoma"), develop as a result of the continuing cell augmentation (compare with "liver cancer" related to the bile ducts). Usually, the nodules are flat-growing (resorptive type); infrequently, they take a cauliflower-like shape (secretory type). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant". "Benign" liver nodules are termed **Focal Nodular Hyperplasia** (FNH).

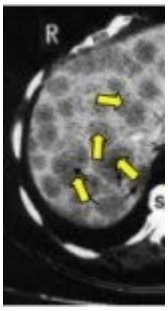
NOTE: Multiple liver nodules indicate that the starvation conflict relates to oneself. A **single liver nodule**forms if one suffered the "threat of starvation" with or for another person (a family member, a beloved friend, a pet); two nodules develop for two people, three nodules for three people, and so forth. The same principle applies to lung nodules.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **pain** due to the **swelling of the liver** and **night sweats**. The liver blood parameters are in the normal range. A **liver abscess** is a liver nodule filled with pus. What is commonly called a "**fatty liver**" refers, in GNM terms, to fat deposits in the healing liver.

Liver tuberculosis, indicating the activity of TB bacteria, is much more frequent in regions where there is famine, such as in Africa (see also kidney tuberculosis linked to an existence conflict and lung tuberculosis related to a death-fright conflict). The correlation between tuberculosis and poverty has long been noticed by medical historians. In the Western world, where tuberculosis is supposed to be eradicated, liver tuberculosis is now called **liver cancer** (see also renaming of lung tuberculosis to lung cancer and kidney tuberculosis to "nephrotic syndrome"). The disease names have changed, the symptoms didn't!



On this brain CT we see two brain edemas in the area of the brainstem that controls the liver parenchyma (view the GNM diagram), revealing that the person is in the healing phase (PCL-A) of two independent starvation conflicts.

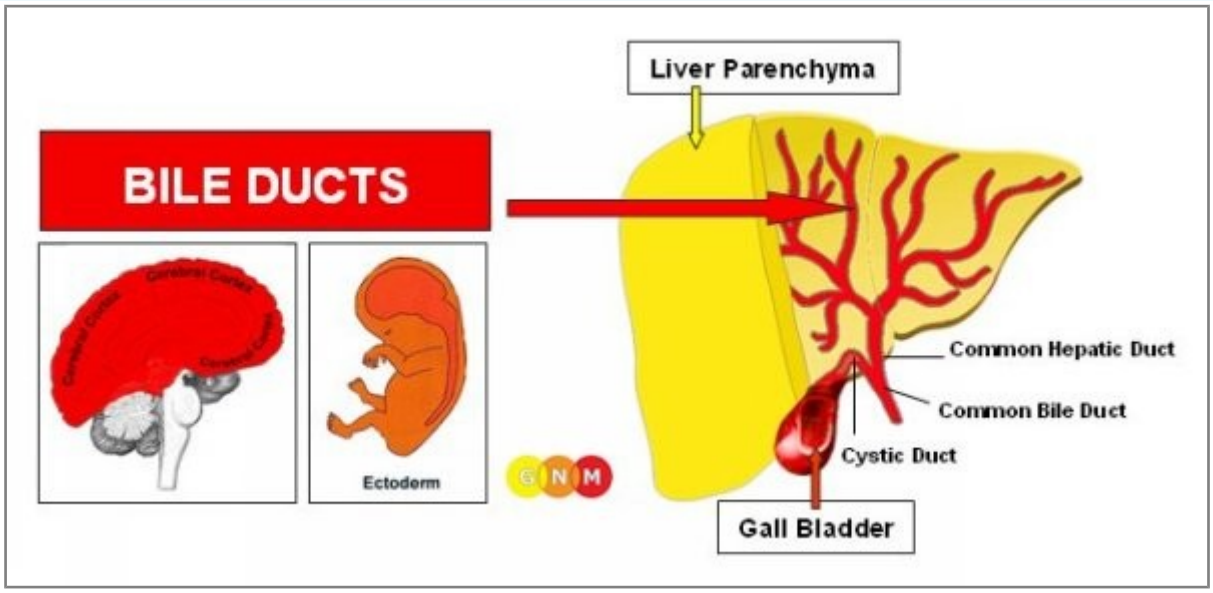


On an organ CT, the liver nodules appear as round dark spots.

The liver is the only organ that is capable of regenerating itself by making new liver tissue (Prometheus phenomenon). However, when healing is prolonged (hanging healing) and continually interrupted by conflict relapses, the ongoing decomposing process leaves **caverns in the liver** (see also pancreas caverns, lung caverns, breast gland caverns).**Liver cysts** (also called "**polycystic liver disease"**) develop when the caverns are filled with water due to an activeabandonment and existence conflict (the SYNDROME).

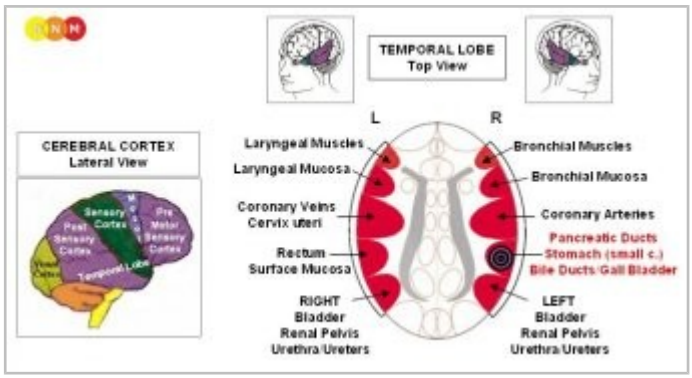
Water retained in the healing liver leads to an **enlarged liver or hepatomegaly** (see also hepatomegaly related to thebile ducts), often with an ascites caused by the excess water in the peritoneum. A large swelling close to the common hepatic duct bears the risk of a mechanical obstruction of the bile duct with symptoms characteristic for jaundice. Acute complications arise when the swelling compresses the portal vein. In this case surgery is a must.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the liver nodules cannot be broken down and therefore remain. Eventually they become encapsulated with connective tissue. Such "tumors" are often accidentally discovered during a routine checkup or follow-up examination. Hence, today's excessive use of antibiotics contributes significantly to the increasing number of cancers that are detected during medical exams.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BILE DUCTS: The bile ducts branch through the liver in a tree-like structure. The common hepatic duct joins the cystic duct coming from the gall bladder to form the common bile duct. The common bile duct meets the pancreatic duct before it opens into the intestine. Bile, produced in the liver and stored in the gall bladder, flows into the duodenum (the first section of the small intestine) where it is required for the digestion of food, particularly of fats. Bile also helps the body get rid of waste material that is filtered out of the bloodstream by the liver. The lining of the bile ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



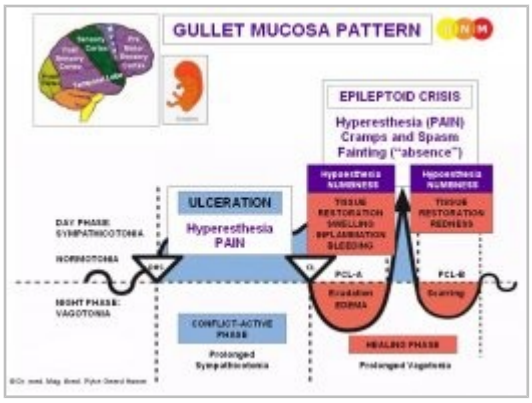
BRAIN LEVEL: The epithelial lining of the bile ducts is controlled from the right side of the **temporal lobe** (part of the **post-sensory cortex**). The control center is positioned exactly across from the brain relay for the rectum lining.

NOTE: The bile ducts, gall bladder, stomach (small curvature), pylorus, duodenal bulb, and pancreatic ducts share the same brain relay and therefore the same biological conflict. Which one of these organs will be affected by the DHS is random. A severe conflict can affect all organs at once.

BIOLOGICAL CONFLICT: The biological conflict linked to the bile ducts is a male **territorial anger conflict** or a female identity conflict, depending on a person's gender, laterality, and hormone status.

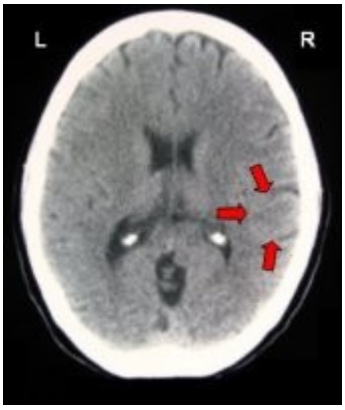
In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial anger** relates to anger in the environment and places which one considers as his or her domain - literary or figuratively. Typical territorial anger conflicts are disputes at home, feuds at the workplace, anger in school, in kindergarten, at the playground, in a seniors or nursing home, or in the hospital; also in the extended "territory" such as in the village, town, or country where one lives. Battles over a land or property, annoying noise in the house or neighborhood, a fight over a parking place or over a toy, are other examples of what can provoke a territorial anger conflict.



The Biological Special Program of the bile ducts follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the lining of the bile ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts to enhance the flow of bile to the intestine for better digestion. This in turn improves the metabolism providing the individual with more energy to resolve the conflict. Depending on the intensity of the territorial anger conflict, the ulceration affects one or several ducts. The **symptom**: mild to severe **pain**. **NOTE:** While conflict active, the person is in a depressed mood.



This brain CT shows the impact of a territorial anger conflict in the bile ducts relay (view the GNM Diagram). The mostly sharp border of the Hamer Focus indicates that the person is still conflict active; the edematous parts (dark) point to short healing phases that are interrupted by conflict relapses.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. In conventional medicine, this is usually diagnosed as a "**liver cancer"** (compare with liver cancerrelated to the liver parenchyma). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **swelling** due to the edema (fluid accumulation) and **abdominal pain**, which could last throughout the entire healing phase (in PCL-A and PCL-B the pain is not of a sensory nature but pressure pain). Concurrent water retention because of the SYNDROME enlarges the swelling and increases the pain.

A large swelling in the common bile duct or in several ducts blocks the bile flow resulting in **jaundice**. Jaundice shows asyellow skin and a yellow sclera; also, the urine becomes brown and the stool light yellow due to the lack of bilirubin. Jaundice is quite common in newborns. Conventional medicine presumes that this is linked to a baby's still developing liver not being yet able to remove adequate bilirubin from the blood. However, if this were correct, why is then not every baby born with jaundice? From the GNM perspective, jaundice in newborns is rather caused by a territorial anger that occurred already in the womb (see intrauterine conflicts). A fetus can also suffer a territorial anger conflict with or in behalf of the mother. Distress in the delivery room, a difficult delivery, or the way the newborn is handled at birth can evoke a territorial anger with jaundice in the healing phase, when the baby feels safe.

Hepatitis occurs when healing is accompanied by an **inflammation**. "Acute hepatitis" indicates that the bile duct-related conflict is reactivated through setting on tracks established when the original territorial anger took place. "Chronic hepatitis" reveals a hanging healing due to continual conflict relapses that delay the completion of the healing phase.**Icteric hepatitis** with the typical symptoms of jaundice develops when a bile duct occlusion involves several ducts or the common hepatic duct.

Conventional medicine claims that hepatitis is caused by hepatitis viruses (A, B, C, D, E). However, as demonstrated in the publication Virus Mania by Torsten Engelbrecht and Claus Köhnlein, "certainly nobody has yet managed to detect a corresponding virus structure in the blood serum of so-called hepatitis C patients. As with HIV, the virus purification necessary for a clear identification has not taken place." (p. 155). In short, none of the alleged hepatitis viruses – or *any*virus - has ever been scientifically verified (details are presented in the "Virus Mania" GNM DVD). This seriously questions the justification of vaccinating newborns and of imposing "immunization" on travelers who, naturally, develop hepatitis after having resolved the territorial anger conflict - away from the "anger"-environment.

With hepatitis, the **level of Gamma-GT**, a significant liver enzyme parameter, **rises** in PCL-A with a sharp drop during the **Epileptoid Crisis**. The Epileptoid Crisis presents as **acute sharp pain** and **cramps or spasm** (**liver colic**) if the surrounding striated muscles of the bile ducts undergo the Epileptoid Crisis at the same time. In PCL-B, the bile ducts open and the function of the organ returns to normal.

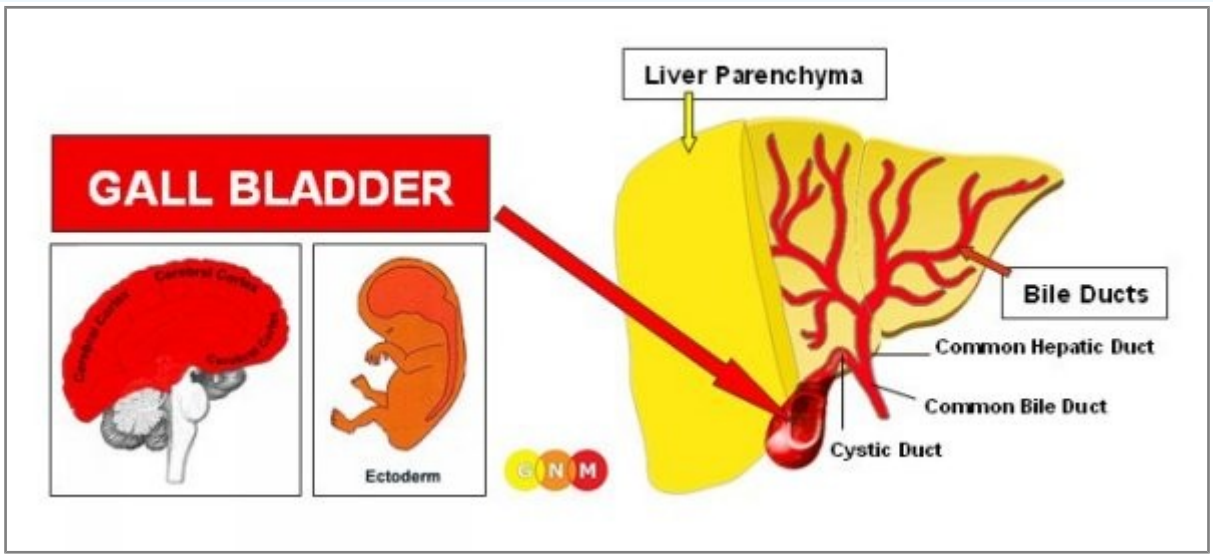
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory

cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

Hepatitis with the SYNDROME, that is, with water retention due to an active abandonment and existence conflictinvolving the kidney collecting tubules causes an **enlargement of the liver (hepatomegaly)** with acute pain (see alsohepatomegaly related to the liver parenchyma). Excessive water retention could create a critical situation, since the additional water is also stored in the brain edema that develops parallel to the edema on the healing organ. Because of the strong brain pressure a person might fall into a coma (hepatic coma) and die.

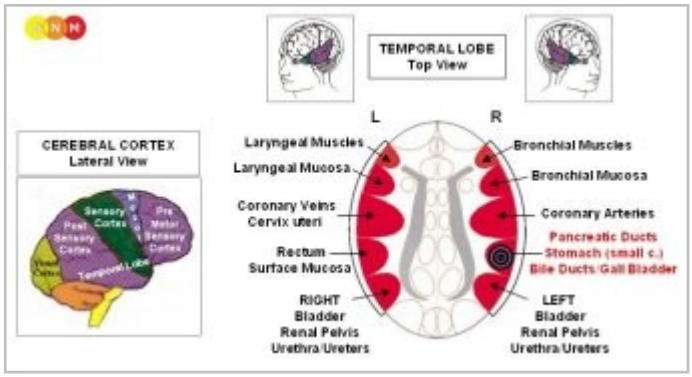
Liver cirrhosis is the consequence of constant relapses of territorial anger conflicts. As a result of the recurring repair processes in the bile ducts, the squamous epithelial lining is gradually replaced by scar tissue (in PCL-B). Over time, this severely compromises the function of the liver. Hence, without addressing the underlying conflict, the condition might be fatal. About 50% of patients with liver cirrhosis also develop an ascites (water belly). According to conventional medicine, the fluid in the abdomen is caused by high blood pressure in the portal vein of the liver (the same theory is applied to esophageal varices). If this theory were valid, why does "cirrhotic ascites" then not occur in 100% of the cases? Based on the knowledge of GNM, the water retained in the abdominal cavity demonstrates that the person is experiencing territorial anger and abandonment and existence conflicts at the same time. An existence conflict could also be caused by the diagnosis shock, since liver cirrhosis has generally a poor prognosis.

Liver cirrhosis has nothing to do with alcohol consumption (just as there is no correlation between smoking and the development of lung cancer). There are people who have liver cirrhosis who don't drink and there are alcoholics who never develop liver cirrhosis. But territorial anger conflicts and drinking often go together! Dr. Hamer: "The majority of alcoholics belong to the lower classes of society. There, they are much more vulnerable to suffer conflicts than "good" citizens. Liver cancer does not come from alcohol, but alcohol and cancer come from sorrow and misery."



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE GALL BLADDER: The gall bladder connects to the hepatic system with the cystic duct that leads directly into the common bile duct. During periods when bile, made in the liver, is not flowing into the intestine it is diverted into the gall bladder, where it is stored until needed for digestion. The lining of the gall bladder consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



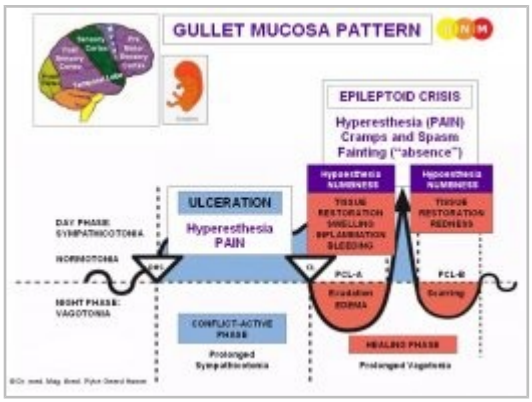
BRAIN LEVEL: The epithelial lining of the gall bladder is controlled from the right side of the **temporal lobe** (part of the **post-sensory cortex**). The control center is positioned exactly across from the brain relay of the rectum lining.

NOTE: The gall bladder, bile ducts, stomach (small curvature), pylorus, duodenal bulb, and pancreatic ducts share the same brain relay and therefore the same biological conflict. Which one of these organs will be affected by the DHS is random. A severe conflict can affect all organs at once.

BIOLOGICAL CONFLICT: The biological conflict linked to the gall bladder is a male **territorial anger conflict** or a female identity conflict, depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial anger** relates to anger in the environment and places which one considers as his or her domain – literary or figuratively. Typical territorial anger conflicts are disputes at home, feuds at the workplace, anger in school, in kindergarten, at the playground, in a seniors or nursing home, or in the hospital; also in the extended "territory" such as in the village, town, or country where one lives. Battles over a land or property, annoying noise in the house or neighborhood, a fight over a parking place or over a toy, are other examples of what can provoke a territorial anger conflict.



The Biological Special Program of the gall bladder follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

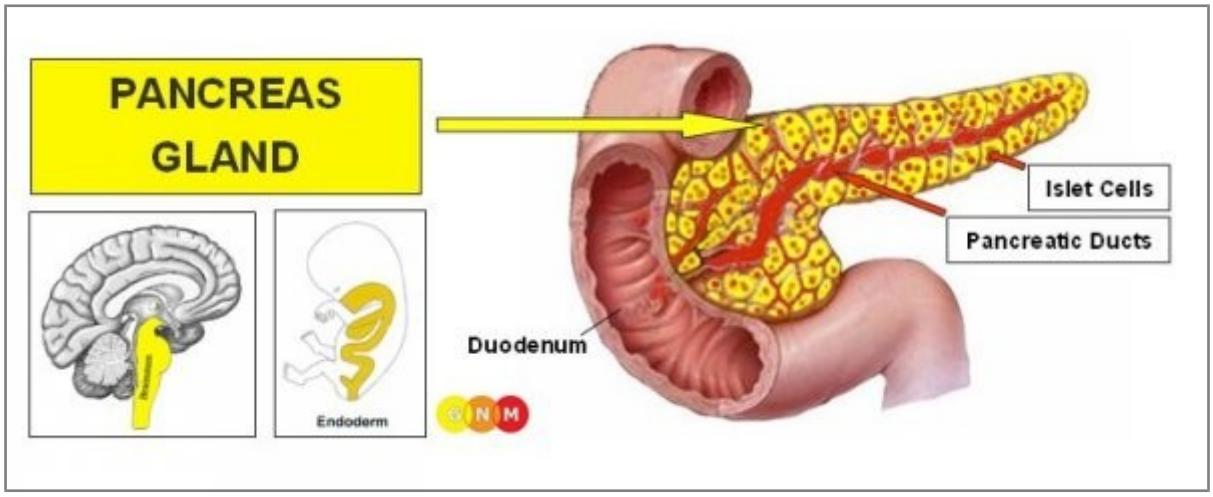
CONFLICT-ACTIVE PHASE: ulceration in the lining of the gall bladder proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to increase the flow of bile to the intestine, which provides the individual with more energy to resolve the conflict. The ulceration could also involve the cystic duct. The **symptom**: mild to severe pain, denpending on the intensity of the territorial anger conflict. **NOTE:** While conflict active, the person isdepressed.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. Healing symptoms are **swelling** due to the edema (fluid accumulation) and **abdominal pain** (in PCL-Aand PCL-B the pain is not of a sensory nature but pressure pain). Concurrent water retention due to the SYNDROMEenlarges the swelling and increases the pain. With an inflammation the condition is called **cholecystitis**.

The Epileptoid Crisis manifests as acute **pain** and **cramps or spasm** (**gall colic**) if the surrounding striated muscles of the gallbladder undergo the Epileptoid Crisis at the same time. The Epi-Crisis could last up to thirty hours. With a hanging healing, that is, when the healing phase is continually interrupted by conflict relapses, the buildup of bile eventually leads to the formation of **gallstones**. At one point during the Epileptoid Crisis, they are pushed through the cystic duct and the common bile duct into the small intestine, which is very painful. In PCL-B the gall bladder slowly returns to its normal function.

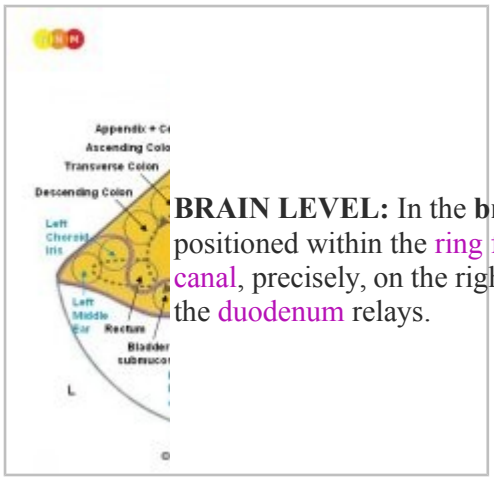
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

PANCREAS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PANCREAS GLAND: The pancreas is a tube-shaped organ located in the back of the abdomen behind the stomach. The head of the pancreas lies within the curvature of the duodenum. The pancreas gland produces hormones (hormonal quality), including insulin and glucagon, and secretes pancreatic juices (secretory quality) that are released into the small intestine to assist the digestion of food. The pancreas gland consists of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



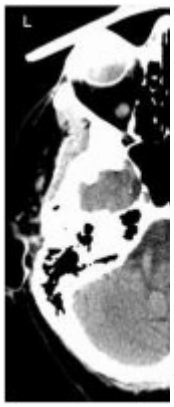
BRAIN LEVEL: In the **brainstem**, the control center of the pancreas gland is orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, on the right brainstem hemisphere between the liver and the duodenum relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the pancreas gland is linked to an "**indigestible morsel conflict"** (see also stomach, duodenum, small intestine and colon). The conflict is typically brought on by arguments with family members, for instance, over an "inheritance morsel", a "property morsel", or a "money morsel" and by insults or accusations that are hard to digest.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the pancreas gland proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the secretion of pancreatic juices so that the morsel can be better digested. With prolonged conflict activity (hanging conflict) a cauliflower-shaped growth (secretory type), referred to as a **pancreas cancer**, develops as a result of the continuing cell augmentation (compare with "pancreas cancer" related to the pancreatic ducts). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as a **polyp** (see also healing phase).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **indigestion**, **abdominal pain** because of the swelling in the pancreas, and **night sweats**. The extent of the symptoms is determined by the degree and duration of the conflict-active phase. Water retention due to the SYNDROME increases the swelling considerably. With an inflammation the condition is called **pancreatitis** (compare with pancreatitis related to the pancreatic ducts).



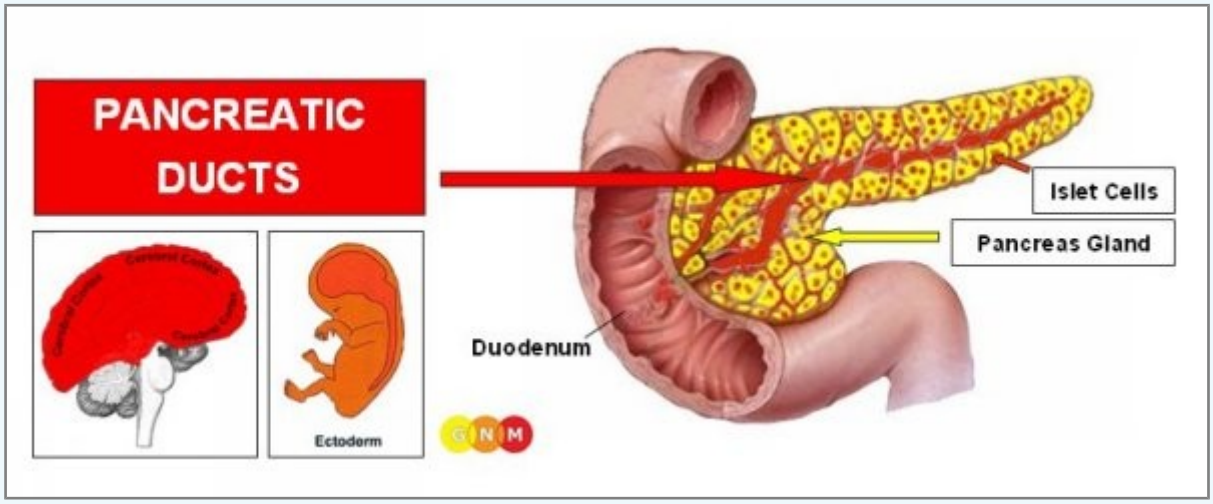
During the first part of the healing phase (in PCL-A) a brain edema develops in the area of the brain that controls the pancreas gland (view the GNM Diagram). On a brain scan the edema (fluid accumulation) appears as dark (yellow arrow). The white arrow points to a glia buildup (PCL-B) in the brain relay of the kidney collecting tubules, linked to an abandonment and existence conflict.

The corresponding story: A 43-year old woman developed pancreas cancer after her father had told her that she is not his real daughter. The brain scan reveals that she experienced the conflict situation as an "indigestible morsel conflict" (affecting the pancreas) as well as an abandonment conflict (affecting the kidney collecting tubules). Both conflicts have been resolved; hence, healing also occurs on the related organs.

A prolonged decomposing process (hanging healing) due to continual conflict relapses leaves **caverns in the pancreas**(see also lung caverns, liver caverns, breast gland caverns). The loss of pancreas tissue results in an **inability to produce pancreatic fluids** and thus to digest food properly, causing

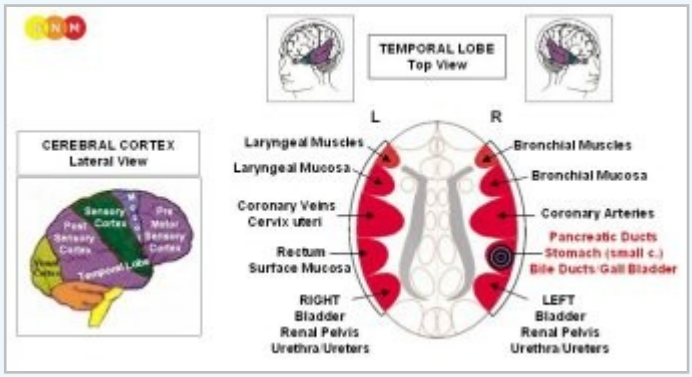
persistent **flatulence and diarrhea**. However, the deficiency can be supplemented with digestive enzymes (lipase, protease, amylase) and enzyme-rich food.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain without further cell division. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine this is usually diagnosed as a **pancreas polyp** or as a "benign cancer" (see also conflict-active phase). In case of the pancreas gland, the cells that could not be removed keep producing digestive juices resulting in a permanent **overproduction of pancreatic fluid** (see also thyroid gland,parathyroid glands, adrenal gland, prostate gland).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PANCREATIC DUCTS: The main pancreatic duct connects the pancreas with the small intestine. Its main function is to carry the pancreatic juices produced in the pancreas gland into theduodenum, the first section of the small intestine. The lining of the pancreatic ducts, including its many small branches, consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



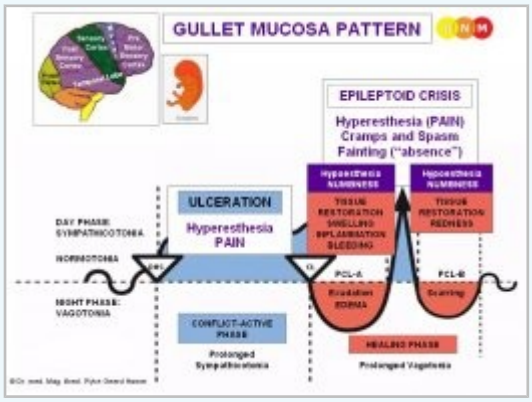
BRAIN LEVEL: The epithelial lining of the pancreatic ducts is controlled from the right side of the **temporal lobe** (part of the**post-sensory cortex**). The control center is positioned exactly across from the brain relay of the rectum lining.

NOTE: The pancreatic ducts, bile ducts, gall bladder, stomach (small curvature), pylorus, and duodenal bulb share the same brain relay and therefore the same biological conflict; which one of these organs will be affected by the DHS is random. A severe conflict can affect all organs at once.

BIOLOGICAL CONFLICT: The biological conflict linked to the pancreatic ducts is a male **territorial anger conflict** or a female identity conflict, depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial anger** relates to anger in the environment and places which one considers as his or her domain - literary or figuratively. Typical territorial anger conflicts are disputes at home, feuds at the workplace, anger in school, in kindergarten, at the playground, in a seniors or nursing home, or in the hospital; also in the extended "territory" such as in the village, town, or country where one lives. Battles over a land or property, annoying noise in the house or neighborhood, a fight over a parking place or over a toy, are other examples of what can provoke a territorial anger conflict.



The Biological Special Program of the pancreatic ducts follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

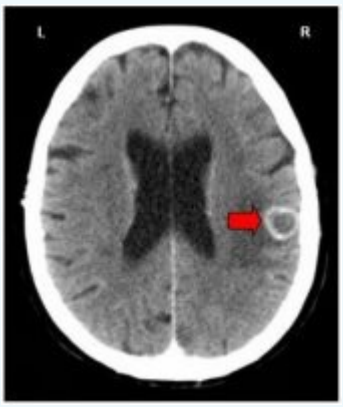
CONFLICT-ACTIVE PHASE: ulceration in the lining of the pancreatic ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts in order to increase the flow of pancreatic fluids. The improved metabolism provides the individual with more energy to resolve the conflict. Depending on the intensity of the territorial anger conflict, the ulceration affects the main duct and/or its small branches. **Symptom**: mild to severe **pain**. **NOTE:** While conflict active, the person is in a depressed mood.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. In conventional medicine, this is usually diagnosed as a "**pancreas cancer"** (compare with pancreas cancer related to the pancreas gland). According to Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **swelling** due to the edema (fluid accumulation), **indigestion**, a **fatty stool**, and **abdominal pain**, which could last throughout the entire healing phase (in PCL-A and PCL-B the pain is not of a sensory nature but pressure pain). The **pancreatic enzymes** (amylase) in the blood serum **are elevated**. The extent of the symptoms is determined by the intensity and duration of the conflict-active phase. **Pancreatitis** occurs when healing is accompanied by an inflammation (compare with pancreatitis related to the pancreas gland). With water retention due to theSYNDROME the enlarged swelling might occlude the ducts(s) leading potentially to serious complications.

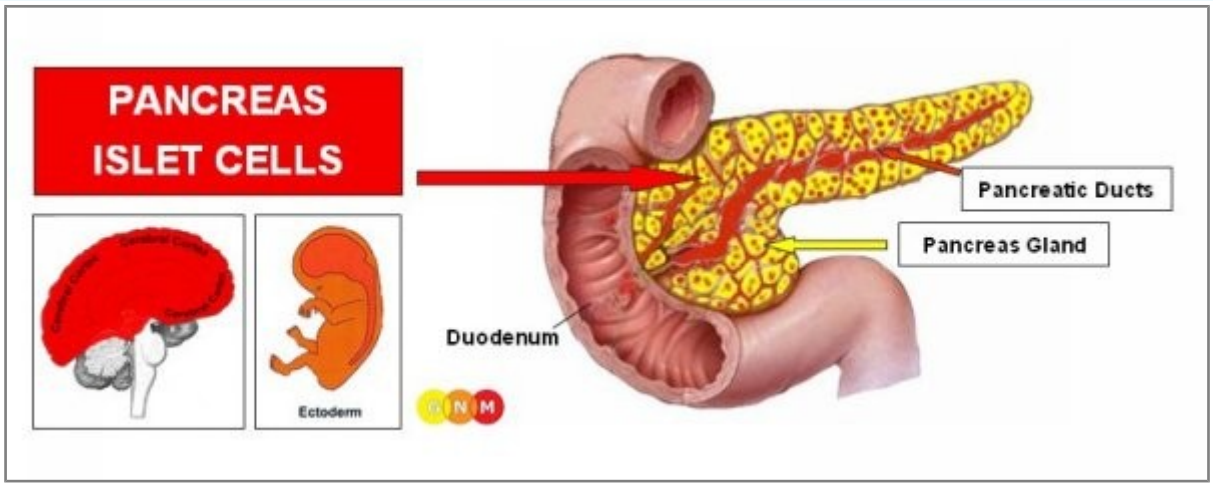
The Epileptoid Crisis manifests as **acute sharp pain** and **cramps or spasms (pancreatic colic)** if the surroundingstriated muscles undergo the Epileptoid Crisis at the same time. In PCL-B, the pancreatic ducts open and the function of the organ slowly returns to normal.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).



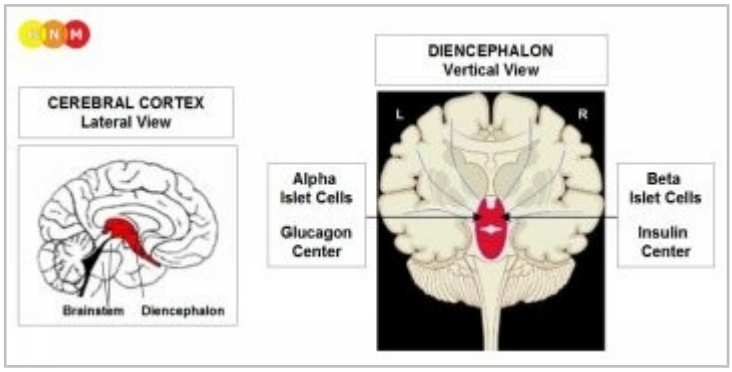
This brain CT presents a Hamer Focus in PCL-B with a glia-ring in the brain relay of the pancreatic ducts (view the GNM diagram), indicating that a territorial anger conflict has been resolved. The CT was taken shortly after the Epileptoid Crisis.

NOTE: Neuroglia (visible as white on a brain scan) starts restoring the brain relay from the*periphery*! This is in clear contradiction to the established theory that a cancer, including a "brain cancer", grows through continued cell augmentation leading to the formation of a tumor.



Alpha Islet Cells **Beta Islet Cells**

DEVELOPMENT AND FUNCTION OF THE ISLET CELLS: Embedded in the pancreas gland are cell clusters called the islets of Langerhans that play a significant role in the regulation of blood sugar (glucose). The **alpha islet cells** secrete glucagon, a hormone that stimulates the liver to convert glycogen to glucose causing an increase of blood sugar. Insulin, produced by the **beta islet cells**, helps to convert blood sugar into energy by delivering glucose into the body cells. Insulin therefore decreases the blood sugar level. The alpha and beta islet cells originate from the ectoderm and are controlled from the diencephalon.



BRAIN LEVEL: The islet cells of the pancreas are controlled from the **diencephalon** (interbrain), which is located in the central part of the cerebrum just above the midbrain. The **alpha**islet cells are controlled from the left side of the diencephalon (glucagon center); the **beta** islet cells are controlled from the right side (insulin center). The two brain control centers are positioned exactly opposite each other.

ALPHA ISLET CELLS

BIOLOGICAL CONFLICT: The biological conflict linked to the alpha islet cells is a female **fear-disgust conflict** or a male resistance conflict, depending on a person's gender, laterality, and hormone

status.

A **fear-disgust conflict** is a fright coupled with disgust regarding a situation or a person. The conflict can be brought on, for example, by revolting sexual experiences (sexual abuse, unwanted sexual practices, violent sex) or distress involving blood, feces, urine, or vomit. Being frightened of a drunk family member could provoke a fear-disgust conflict with the smell of alcohol as a potential track. Children suffer the conflict, when they have to eat "disgusting" food.

CONFLICT-ACTIVE PHASE: During the conflict-active phase the function of the alpha islet cells is reduced. The decrease of glucagon production causes **hypoglycemia**.

NOTE: The alpha and beta islet cells belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the inner ear (cochleaand vestibular organ), olfactory nerves, retina and vitreous body of the eyes, skeletal muscles) or hyperfunction (see periosteal nerves and thalamus).

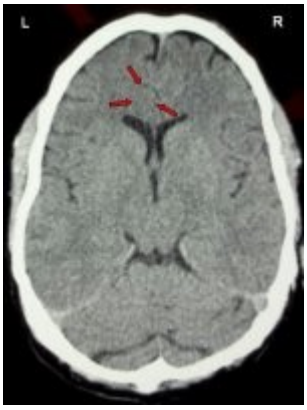
Symptoms of hypoglycemia are **nausea**, **dizziness**, **fainting** (which explains why some people pass out when they see blood), **trembling** and a **fluttering heart beat** due to the glucose deficiency in the muscles, including the heart muscle. Typical for a low blood sugar is a **craving for sugar and sweets**, which serves the purpose to balance the blood sugar level. The steady over-eating leads to **weight gain and obesity** (compare with obesity related to water retention). Because of the regular intake of sugar-rich foods, hypoglycemia usually goes unnoticed.

HEALING PHASE: During the first part of the healing phase, in **PCL-A**, the glucose level slowly rises to a normal level. However, for the period of the Epileptoid Crisis, when the conflict-active symptoms are reactivated, the blood sugar drops temporarily. Acute hypoglycemia (hypoglycemic shock) is a medical emergency! In **PCL-B**, the blood sugar level increases above the normal range showing the symptoms of **diabetes** (compare with beta islet cells-related diabetes in the conflict-active phase; see also diabetes insipidus related to the kidneys). At the end of the healing phase, the blood sugar level is back to normal.

With continuous conflict relapses (hanging healing) diabetes becomes chronic. In this case, insulin is still produced but is not utilized for carrying glucose to the body cells (compare with beta islet cells-related diabetes with no insulin production). This is called **insulin resistance** and categorized as **type 2 diabetes**, also referred to as **adult-onset diabetes** (compare with type 1 diabetes or juvenile diabetes).

NOTE: Whether diabetes occurs in the healing phase involving the alpha islet cells or in the conflict-active phaserelated to the beta islet cells is determined by a person's gender, laterality, and hormone status rather than a person's age. Hence, from the GNM perspective, the differentiation between "juvenile" and "adult-onset" diabetes is meaningless.

It has been observed that most people with "type 2 diabetes" are overweight. Being overweight or obese is therefore assumed to be a risk factor for developing diabetes. Based on the GNM knowledge, namely that hypoglycemia and diabetes are two conditions of the same Biological Special Program, we learn to understand that so-called "**type 2 diabetes**" (in PCL-B) is not caused but rather ***preceded*** **by hypoglycemia** with craving and consequent weight gain during the conflict-active phase.



On this CT scan we see the impact of a fear-disgust conflict in the area of the brain that controls the alpha islet cells of the pancreas (view the GNM Diagram). The partly dark border of the Hamer Focus indicates the presence of fluid, which typically occurs at the beginning of the healing phase or after a conflict relapse.

BETA ISLET CELLS

BIOLOGICAL CONFLICT: The biological conflict linked to the beta islet cells is a male **resistance conflict** or a femalefear-disgust conflict, depending on a person's gender, laterality, and hormone status.

A **resistance conflict** is a strong opposition against a person (parent, stepparent, sibling, relative, spouse, teacher, colleague, supervisor, doctor), against a situation (at work, at home, in school, in a relationship), against an institution (school, church, hospital, government, political regime), or against decisions made over one's head. Children suffer the conflict at an early age, when they resist day care, kindergarten, or school, or when they strongly oppose what they are told to do.

CONFLICT-ACTIVE PHASE: During the conflict-active phase the function of the beta islet cells is reduced, causing**hyperglycemia** (high blood sugar) or **diabetes** (compare with alpha islet cells-related diabetes; see also diabetes insipidus related to the kidneys). The **biological purpose of storing glucose in the blood** is to prepare the individual for the conflict resolution by providing the organism, particularly the muscles, with sufficient amount of blood sugar in order to be able to fight with full force. The degree of hyperglycemia (how much "fuel" will be available) is determined by the extent of the conflict. For additional support, the liver also secretes glucose, a process called gluconeogenesis. Biologically speaking, the active fight, the response of standing up and to breast, is the distinctive male response to a resistance conflict, whereas the female reaction to a fear-disgust conflict is backing off (fainting).

NOTE: The alpha and beta islet cells belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the inner ear (cochleaand vestibular organ), olfactory nerves, retina and vitreous body of the eyes, skeletal muscles) or hyperfunction (see periosteal nerves and thalamus).

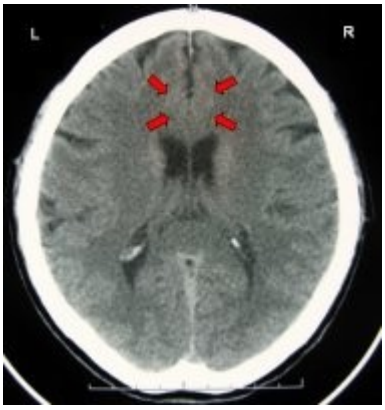
Typical for diabetes is **extreme thirst**, which serves the purpose to dilute the high blood sugar level (just as the craving for sweets serves to balance the low glucose level in case of hypoglycemia).

With lasting conflict activity diabetes becomes chronic. This is called **insulin-dependent diabetes** and categorized as**type 1 diabetes**, also referred to as **juvenile diabetes** since it apparently occurs predominantly in children and adolescents (compare with type 2 diabetes or adult-onset diabetes). In this case, insulin therapies and dietary measures are vital until the conflict has been resolved.

NOTE: Whether diabetes occurs in the healing phase involving the alpha islet cells or in the conflict-active phase related to the beta islet cells is determined by a person's gender, laterality, and hormone status rather than a person's age. Hence, from the GNM perspective, the differentiation between "juvenile" and "adult-onset" diabetes is meaningless.

It is a wide-spread belief that high blood sugar causes damage to the arteries and "indirectly" to the nerves

leading to a loss of sensation, especially in the extremities. However, not every diabetic develops the condition! Neither can this theory explain why an elevated glucose level would, for example, affect the feet (or just one foot or toe) in one person and the arm(s) in another. Based on GNM, what is called "**diabetic peripheral neuropathy"** is a combination of twoBiological Special Programs running simultaneously: one involves the beta islet cells of the pancreas linked to a "resistance conflict" causing diabetes, the other involves the periosteum related, in case of the legs, to "wanting to kick somebody away" (usually the person one resists) with the development of leg ulcers or gangrene, depending on the intensity and duration of the conflict (see also "diabetic retinopathy").

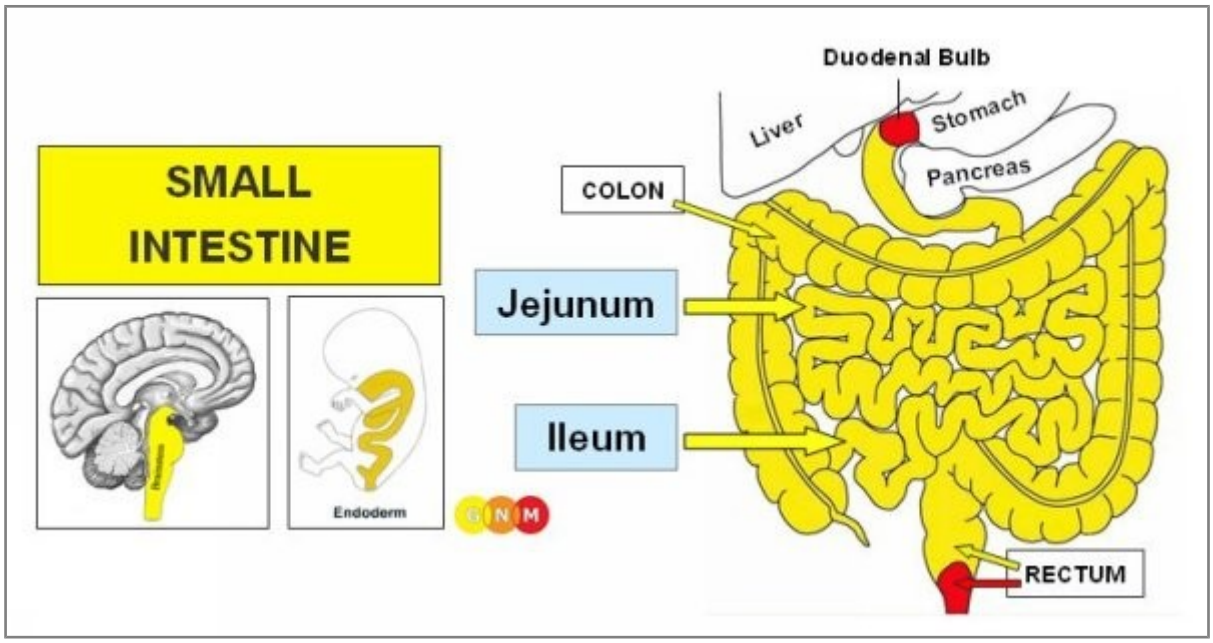


This CT scan shows a central conflict with a Hamer Focus reaching over both brain hemispheres of the glucose center (view the GNM diagram). Such a situation occurs, when a person experiences the conflict in a male (resistance) and female (fear-disgust) fashion, for example, during the period when a woman is going through menopause. In this case there are no symptoms since hypoglycemia and diabetes balance the blood sugar level.

HEALING PHASE: During the first part of the healing phase, in **PCL-A**, the glucose level decreases to a normal level. However, for the period of the Epileptoid Crisis, when the conflict-active symptoms are reactivated, the blood sugar rises temporarily. Acute hyperglycemia (hyperglycemic shock) can induce a "diabetic coma"! In **PCL-B**, the blood sugar level decreases below the normal range showing the symptoms of **hypoglycemia** (compare with alpha islet cells-relatedhypoglycemia in the conflict-active phase). At the end of the healing phase, the blood sugar level is back to normal. However, with a hanging healing due to continuous conflict relapses, hypoglycemia becomes chronic (and so does the craving for sweets).

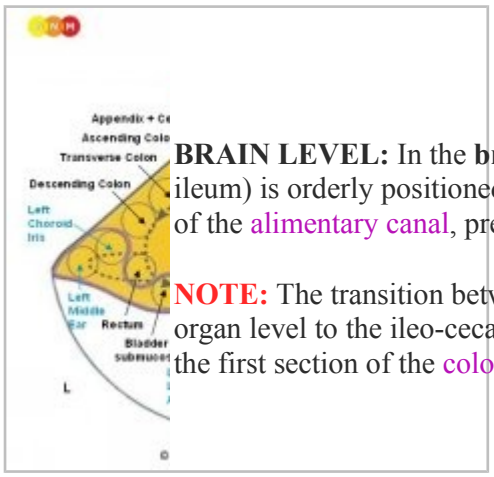
CAUTION: Because of a potentially serious Epileptoid Crisis, an intended resolution of a conflict related to Alpha and Beta Islet Cells should only be approached under the supervision of a health care professional!

INTESTINES



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE SMALL INTESTINE: The small intestine is the portion of the gastro-intestinal tract that connects the stomach with the colon. Following the duodenum, the **jejunum** is the upper part of the small intestine; the **ileum** is the final part that joins with the large intestine. The jejenum and ileum are the sections of the digestive tract where most of the absorption of nutrients (resorptive quality) takes place. The small intestine consists of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the small intestine (jejunum and ileum) is orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, between the duodenumand the cecum relays.

NOTE: The transition between the right and left brainstem hemisphere corresponds on the organ level to the ileo-cecal valve, positioned between the small intestine and the cecum, the first section of the colon.

BIOLOGICAL CONFLICT: According to its function, the biological conflict linked to the small intestine is "**not being able to absorb or digest a morsel"** (see also stomach, duodenum, colon, and pancreas gland). The conflict is experienced as **anger**, for instance, anger about a person (a family member, friend, neighbor, colleague, employee, supervisor, client, teacher, student, classmate, coach, doctor, authorities), about a situation (work-related anger, school-related anger, relationship-related anger), or about remarks (accusations, insults, criticism) or news that are "hard to take" or difficult to "digest".

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase intestinal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to be better able to absorb and digest the morsel. With prolonged conflict activity a flat growth (resorptive type) develops in the small intestine. At the distal end of the ileum, which has a thinner wall than the jejunum, the growth can also take a cauliflower-shaped form (secretory type). This could lead to a bowel obstruction or so-called **ileus**. In conventional medicine, the thickening of the intestinal wall might be diagnosed as a cancer (**jejunal cancer** or **ileal cancer**).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **diarrhea** and **vomiting**, if the jejunum (upper part of the small intestine) is involved, and **night sweats**. **Abdominal cramps** (motor quality) occur particularly during the Epileptoid Crisis (see also intestinal colic). The participation of fungi during the healing process manifests as **intestinal candidiasis**. The extent of the symptoms is determined by the degree of the conflict-active phase.

NOTE: Eating disagreeable food also causes diarrhea. However, if bad food can be excluded as the source, diarrhea is a positive sign that the "indigestible morsel conflict" has been resolved and that the "morsel" is being eliminated - even without the assistance of microbes (sensory and excretory quality of the intestines).

Drinking contaminated water can lead to severe diarrhea with acute, potentially life-threatening bleeding. This typically occurs in regions such as in Africa where people don't have access to clean water. Blaming an **Ebola** virus for the condition is a medical construct without any scientific basis ("… the world is exposed to horror scenarios about Ebola. These shocking media reports overlook the fact that the existence and pathogenic effects of all these allegedly contagious and even fatal viruses have never been proven.", *Virus Mania,* p. 25)

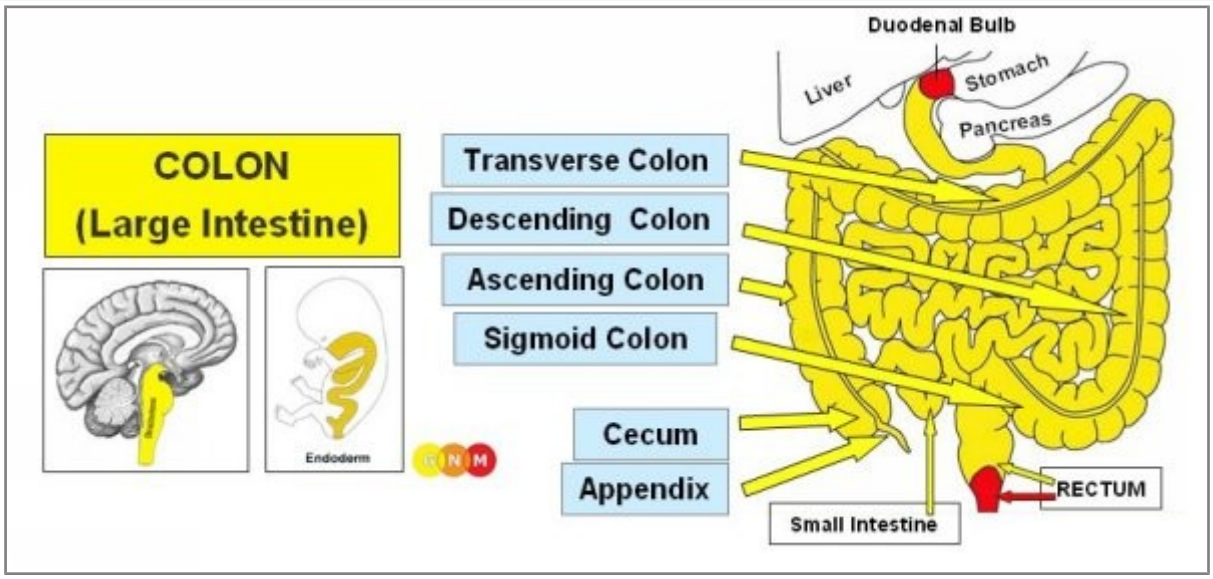
Note that in this "Ebola Virus Alert" picture, the face of the "Ebola victim" is marked withsmallpox, which is entirely unrelated to Ebola. According to the Center of Disease Control, "Ebola symptoms" are: diarrhea, vomiting, abdominal pain, fever, and severe headaches.

Crohn's Disease is the healing phase of an "indigestible morsel conflict". **Ileocolitis**, affecting the final section of the small intestine, is the most common type of Crohn's. **Symptoms** are persistent **diarrhea with the elimination of mucus**, usually with **blood** (tarry stool), **abdominal pain**, and an **inflammation** of the bowel. A chronic condition indicates that conflict relapses prolong the healing process (hanging healing). Characteristic for **recurring Crohn's** are flair-ups that occur every time the person sets on a track with condition-free periods in between.

Food allergies with recurring diarrhea reveal that an "indigestible anger" related to a particular food (milk, nuts, wheat, sea food, a certain fruit or vegetable) has not been completely resolved. **Multiple food allergies** indicate that several foods, including food elements (sugar, salt, lactose), are stored in the subconscious as tracks linked to the original DHS. Any food that is believed to be the probable source of the "allergy" constitutes a new "indigestible morsel" and is added to the list of conflict tracks. People who are always concerned about eating something "toxic" or "wrong" are therefore more prone to develop multiple food allergies. In case of **celiac disease** gluten, found in wheat and related grains, is associated with an "indigestible morsel conflict". The repetitive contact with the wheat ("allergen") leads eventually to an inflammation in the small intestine. A gluten-free diet, the standard recommended treatment, translates into staying away from the gluten-track without addressing the real cause.

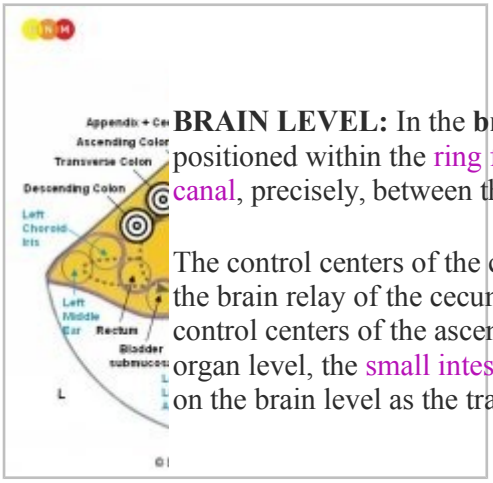
NOTE: In conventional medicine, certain foods are thought to be triggers for an anaphylactic shock. Anaphylaxis is said to be an immune system response to an allergen, including nuts, shellfish, or dairy products. From the GNM point of view, the symptoms are evoked by a conflict relapse ("allergy"), for example, of a territorial fear(breathing difficulties), a "morsel conflict" (swelling of the tongue), or

a separation conflict (hives, fainting) by setting on a conflict track. It is quite possible that a strong conflict relapse leads to complications. A true anaphylactic shock with a quick drop of blood pressure, a loss of consciousness resulting potentially in death is caused by an over-exposure to chemicals such as drugs (morphine, aspirin, and others), X-ray dye, contrast substances, venoms, and other poisons.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE COLON: Following the small intestine, the colon is the last portion of the gastro-intestinal tract. The colon is devided into several structural parts. The first section of the large intestine is the**cecum with the appendix**, a pouch-like blind-ended tube attached to the **ascending colon**. The **transverse colon**extends from the right to the left side of the body, where it joins the **descending colon**. The sigmoid colon is the final section of the large intestine. Originally the entire intestinal canal served the absorption (resorptive quality) and digestion (secretory quality) of food. Today, the colon only secrets mucus and is the part of the intestinal tract where waste material from food is processed into feces and carried to the rectum, from where it is eliminated. The colon consists ofintestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the colon has four control centers that are orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, between the small intestine and the rectumrelays.

The control centers of the colon are located on the left side of the brainstem beginning with the brain relay of the cecum with the appendix, continuing counter-clockwise with the control centers of the ascending colon, transverse colon, and descending colon. On the organ level, the small intestine and the colon are separated by the ileo-cecal valve, marked on the brain level as the transition from the right to the left brainstem hemisphere.

BIOLOGICAL CONFLICT: The biological conflict linked to the colon (except the sigmoid colon) is an "**indigestible morsel conflict"** (see also stomach, duodenum, small intestine, and pancreas gland). For animals an indigestible morsel is a real piece of food; for humans it can also be a figurative "morsel", for example, a car, a house, or a valuable object. We might also perceive certain circumstances or an

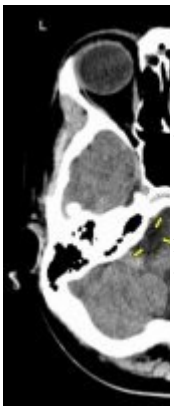
unpleasant event as a "morsel" and suffer the conflict when the situation is considered as "indigestible" or "non-absorbable", let's say, when an anticipated purchase, promotion, or promise cannot be "taken in". The distinctive aspect of the morsel conflict corresponding to the colon, including the appendix and the cecum, is that the **conflict is experienced as particularly "ugly"**, for instance, ugly fights over money or over a property, ugly divorces, ugly court cases, or ugly betrayals.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the large intestine proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to facilitate the digestion of the morsel. Even though the colon has no longer a digestive function, in the event of a biological conflict, the large intestine still responds with cell augmentation because originally the entire intestinal canal served the digestion of food. With prolonged conflict activity (hanging conflict) a tumor or **colon cancer** develops as a result of the continuing cell augmentation. The tumor grows either on a flat plane (resorptive type) or takes a cauliflower-shaped form (secretory type). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as an **intestinal polyp** (see also healing phase). There are no symptoms during the conflict-active phase. However, a large tumor causes a narrowing of the colon (with "pencil stool"), which might lead to an obstruction of the bowel requiring surgery.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **diarrhea** (excretory quality), **blood in the stool** (tarry bowel movements), **abdominal cramps** (motor quality), particularly during the Epileptoid Crisis (see intestinal colic), and**night sweats**. An "**intestinal yeast overgrowth"** indicates that fungi assist the restoration process. Depending on the degree of the conflict-active phase, the symptoms range from mild to severe.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated. In conventional medicine, this is most likely diagnosed as an **intestinal polyp** or a "benign cancer" (see also conflict-active phase).



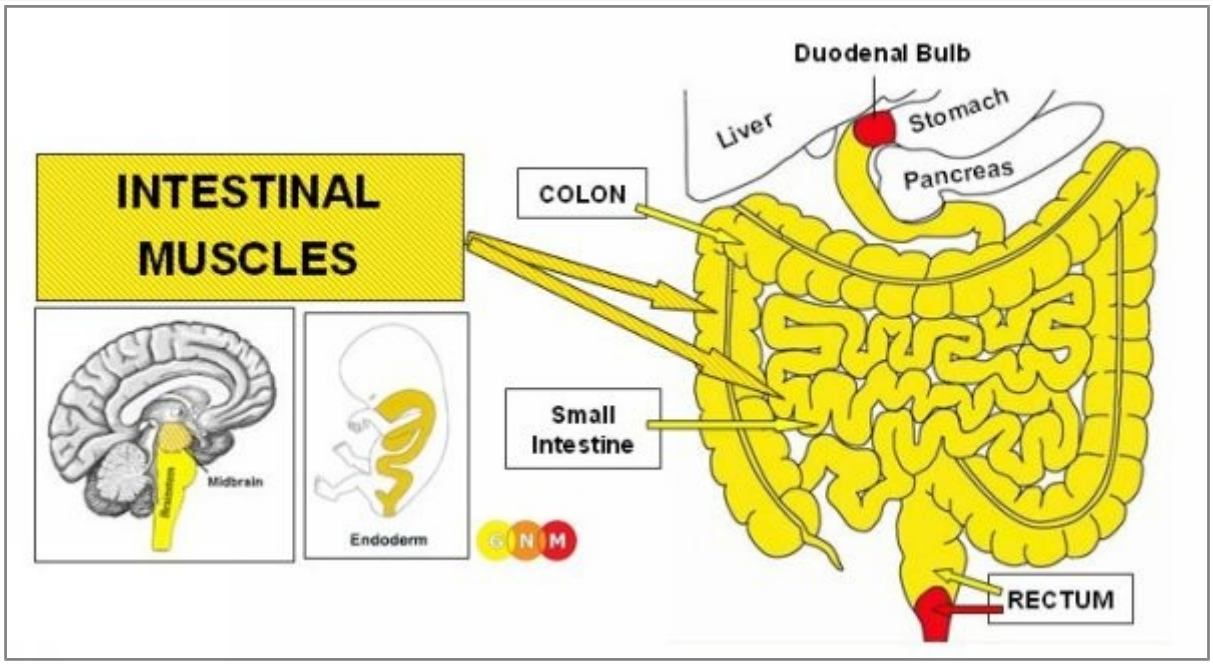
On this CT scan we see the impact of an "indigestible morsel conflict" in the colon relay on the left side of the brainstem (yellow arrows - view the GNM diagram). The brain edema(hypodense, showing as dark) indicates that the person is in PCL-A. There is an additional edema (fluid accumulation) in the liver relay (small yellow arrow), which reveals that astarvation conflict has also been resolved. A starvation conflict is often triggered by a colon cancer diagnoses associated with not getting food through the intestine, that is, to "starve". This is why liver cancer is the most frequent secondary cancer following colon cancer. It has nothing to do with a "metastasizing cancer cells".

With the SYNDROME due to an active abandonment and existence conflict involving the kidney collecting tubules theretained water is exceedingly stored in the healing area. The enlarged swelling could obstruct the colon; in the appendix, an occlusion might already occur during the conflict-active phase. It is during the healing phase that the appendix becomes inflamed causing **appendicitis**. A rupture of the appendix happens when the Epileptoid Crisis is intense.

Colitis is an inflammation of the bowel with **abdominal pain**, **flatulence** and **diarrhea**, potentially with blood in the stool. Like Crohn's Disease, colitis ulcerosa develops after the conflict resolution (CL).

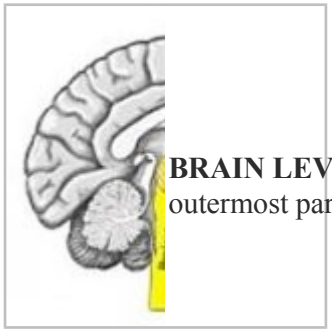
Persistent symptoms point toconflict relapses that interrupt and therefore prolong healing (hanging healing). What is known as "**Irritable Bowel Syndrome"** (IBS) is also a sign that an "indigestible morsel conflict" has been resolved. Compared with colitis, the symptoms are less intense.

Diverticulitis is the result of extended healing in the intestine. Because of the continuous cell removal process, the intestinal wall becomes thin leading to the formation of pouches (diverticula) on the outside of the colon. Diverticulitis is the condition when such a pouch becomes inflamed due to conflict relapses.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE INTESTINAL MUSCLES: The wall of the small intestine and the colonconsists of smooth muscles. The longitudinal muscles regulate the muscle contraction while the transverse muscles regulate their relaxation. The alternating rhythm of contraction and relaxation causes the peristaltic motion (motor quality) that moves the "food morsel" along the intestinal canal (see also heart muscle/"blood morsel"; pupil muscles/ "light morsel"). The smooth muscles of the intestine originate from the endoderm and are controlled from the midbrain.



BRAIN LEVEL: The intestinal muscles are controlled from the **midbrain**, located at the outermost part of the brainstem.

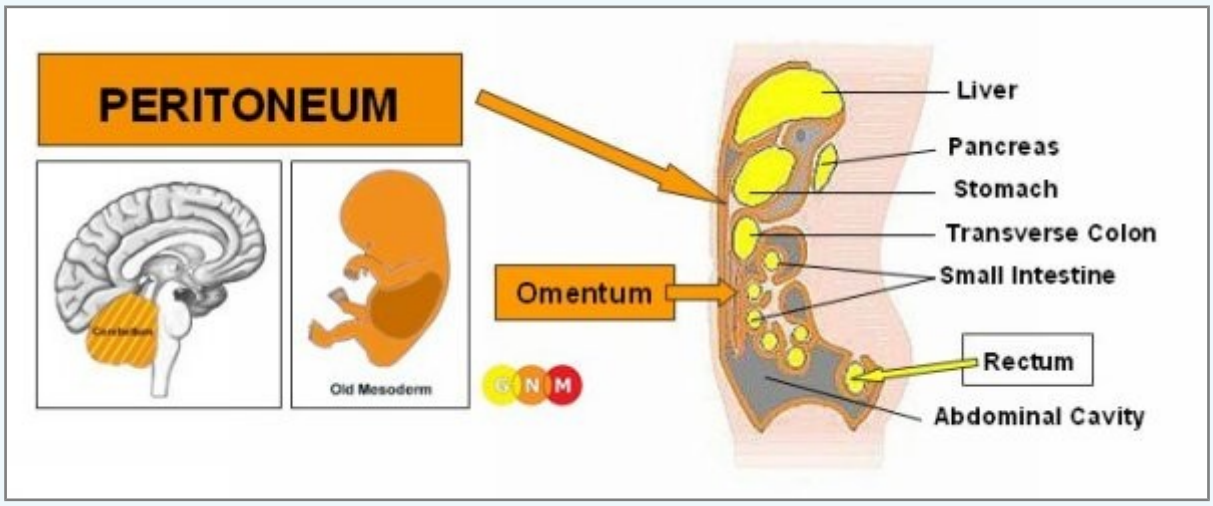
BIOLOGICAL CONFLICT: The biological conflict linked to the intestinal muscles is "**not being able to pass an indigestible morsel"**. This relates to a "morsel" in real or figurative terms.

CONFLICT-ACTIVE PHASE: local tonic muscle contraction (hypertonus). The muscle spasms, or **local colic**, serve the **biological purpose** to push the morsel further with greater force. During this period the peristalsis in the other parts of the intestine slows down causing **constipation** and **abdominal**

bloating due to the expansion of the intestinal muscles. Very slow peristalsis in the small intestine is usually diagnosed as a "paralytic ileus" or bowel obstruction. **Dr. Hamer**: "This is incorrect, because there is no such thing as a "paralysis" of the smooth muscles, except caused by the toxicity of medication such as morphine". **NOTE:** Constipation can occur during any given conflict-active phase, since insympathicotonia digestion slows down; also with too little fluid intake.

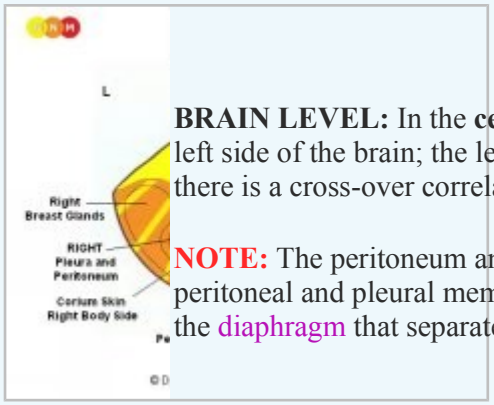
HEALING PHASE: clonic cramps (hyperperistalsis) of the entire intestine (intestinal colic) and increased **local tonic cramps** with **flatulence** during the Epileptoid Crisis. If abdominal cramps (motor quality) are followed by diarrhea(sensory quality) this indicates that the Biological Special Programs of the intestinal mucosa and of the smooth intestinal muscles run concurrently (digesting and passing the "indigestible morsel").

NOTE: When striated muscles, for example of the skeletal muscles, go through the Epileptoid Crisis, the tonic and clonic cramps occur together.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PERITONEUM: The peritoneum consists of a two-layered serous membrane. The parietal peritoneum lines the abdominal cavity whereas the visceral peritoneum (including theretroperitoneum) covers the individual organs such as the liver, spleen, pancreas, stomach, duodenum, small intestine,colon with the omentum, the upper part of the rectum, kidneys, bladder as well as the uterus, ovaries, and testicles (tunica vaginalis testis). The peritoneal cavity between the two peritoneal layers is filled with fluid that lubricates the peritoneal surfaces. In evolutionary terms, the peritoneum developed together with the pleura, the pericardium, and thecorium skin. The peritoneum originates from the old mesoderm and is therefore controlled from the cerebellum.



BRAIN LEVEL: In the **cerebellum**, the right half of the peritoneum is controlled from the left side of the brain; the left half is controlled from the right brain hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The peritoneum and pleura share the same brain relays, because originally the peritoneal and pleural membrane was one complex, which was later divided by the diaphragm that separates the chest and the abdominal cavity.

BIOLOGICAL CONFLICT: The biological conflict linked to the peritoneum is an attack conflict, specifically, an **attack against the abdomen** (see also attack conflicts related to the pleura, peritoneum, and corium skin).

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

An attack against the abdomen is experienced, for instance, through an attack by an animal or through a kick, punch, or stab into the stomach or belly during a fight; the same applies to attacks from behind against the kidneys. "Sharp" words or threats ("I'll kill you!") directed at someone can also be registered as an attack, affecting the retroperitoneal space if the verbal insult is perceived as a "stab in the back". However, surgery in the abdominal area (cesarean, hysterectomy, removal of a tumor, kidney or liver transplant), the fear of an operation (picturing "being cut open"), invasive wound pumps, peritoneal dialysis tubing (insertion of a catheter in the abdominal wall to filter the blood), or biopsies and punctures of the abdomen, including amniotic fluid tests where the uterus, the sac that surrounds the fetus, is punctured, also trigger the conflict. The diagnosis of a colon cancer, ovarian cancer, or liver cirrhosis can be perceived as an "attack" concerning the integrity of the organ. Attack conflicts also originate from inside, for instance, through acute abdominal pain (stomach ache, intestinal colic, menstrual pain) or pain during intercourse.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase peritoneal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to create an internal reinforcement to protect the abdomen against further attacks. With prolonged conflict activity (hanging conflict) a bulb-shaped growth forms at the site; cell augmentation on a flat plane usually occurs when the attack conflict was more of a general nature. In conventional medicine, the thickening of the peritoneum is diagnosed as a **(retro)peritoneal mesothelioma** (see also omental mesothelioma, pleural mesothelioma, pericardial mesothelioma, and testicular mesothelioma). If the rate of cell division exceeds a certain limit, then the cancer is considered "malignant".

NOTE: Whether the mesothelioma occurs on the right or left side of the peritoneum is determined by a person'shandedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area that is associated with the "attack".

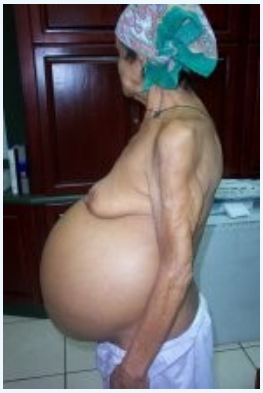
HEALING PHASE: Following the conflict resolution (CL), fungi, TB bacteria or other bacteria remove the cells that are no longer needed. **Healing symptoms** are **abdominal pain** and **night sweats**. With an inflammation the condition is called **peritonitis**. After the additional cells have been decomposed, caverns remain at the site. Over time, these caverns are filled with calcium showing on an X-ray as calcium deposits.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. Now, conventional medicine regards the cancer as "benign".

During the healing phase (in PCL-A) the fluid in the peritoneum is naturally absorbed by the peritoneal membrane (**dry peritonitis**). Water retention, however, due to the SYNDROME increases the accumulation of fluid (**wet peritonitis**) causing acute pain. If bacteria assist healing, the fluid contains pus (**purulent peritonitis**, tuberculous peritonitis). Since the peritoneum is not divided into a right and left part, the **exudative peritoneal effusion** (buildup of excessive fluid) develops in the entire peritoneum (compare with pleural effusion and pericardial effusion). Only the location of the Hamer Focus in the brain reveals on which side of the abdomen the attack was perceived and therefore from which brain hemisphere the Biological Special Program is directed and controlled.

This CT scan shows a Hamer Focus in the brain relay for the left half of the peritoneum (view the GNM diagram) corresponding to an attack conflict.

Concurrent water retention as a result of an active abandonment and existence conflict presents as an **abdominal ascites**. If a person is overweight the ascites might not be noticed.



With an intense existence conflict, often activated by a diagnosis shock, hospitalization, or after surgery in the abdominal area, an ascites can become quite large. Hence, **if someone has cancer** such as a liver cancer, pancreas cancer, colon cancer, ovarian cancer, uterus cancer, or aperitoneal mesothelioma **an ascites always reveals a state of fear**.

In people with liver cirrhosis, standard medicine attributes the fluid accumulation in the peritoneum to high blood pressure in the portal vein of the liver. From a GNM point of view, the ascites rather reveals recurring territorial anger conflicts affecting the bile ducts and ongoing abandonment and existence conflicts.

Peritoneal fluid is rich in protein. Thus, draining the excessive fluid could lead to serious complications since the body tries to replenish the protein shortage by withdrawing it from the organs, which causes rapid weight loss. Dr. Hamertherefore advises not to drain more than 1.5 liters at a time in order to prevent an acute protein deficiency. Moreover, puncturing the peritoneum triggers often new attack conflicts and conflict relapses with each procedure, throwing the person into a vicious cycle. Dr. Hamer recommends staying away from a puncture all together and to use instead a small balloon catheter that allows patients to regulate the drainage of the ascites themselves.

NOTE: Fluid also enters the peritoneum when bones such as spinal vertebrae adjacent to the abdomen are in healing; in this case because of a self-devaluation conflict brought on, for example, by a colon cancer, liver cancer, or ovarian cancer diagnosis, or a hysterectomy. The large edema, usually caused by water retention due to the SYNDROME, "sweats" through the periosteum into the peritoneum creating what is called a **transudative peritoneal effusion** (which does not contain protein!). The opening of a para-anal fistula (see Douglas fistula)also creates a direct outlet for an ascites.

The **GREAT OMENTUM (epiploon)** is a double peritoneal fold that hangs like an apron over the intestine giving the abdomen further protection. The lubricated surface of the membrane (secretory quality) provides the omentum with a special motility.

BIOLOGICAL CONFLICT: an **ugly belly conflict**, experienced as acute distress in relation to the abdomen. Liver cirrhosis, a colon cancer or ovarian cancer diagnosis could evoke the conflict.

"Cancer researchers have wondered why ovarian cancer cells are so attracted to the abdominal cavity,

especially the omentum."

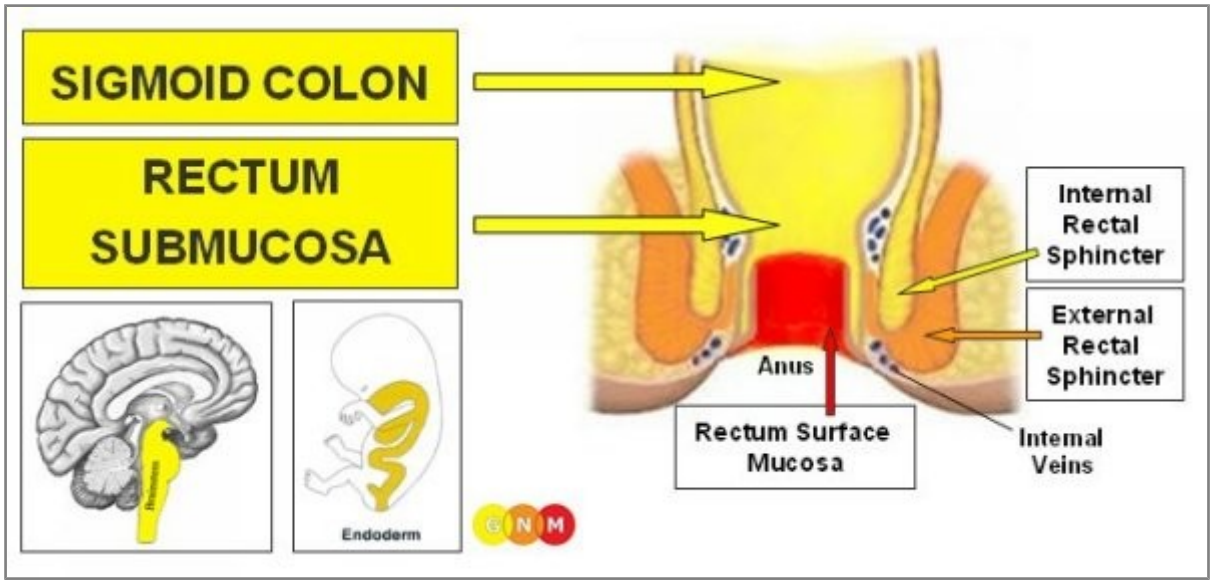
Medical News Today, July 18, 2013

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the omentum proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the secretion of lubricating fluid to improve the motility of the omentum. This also allows to envelop inflammatory sites (**cold abscesses**) or to seal a perforated appendix, preventing intestinal content from leaking into the abdomen. With ongoing conflict activity (hanging conflict) a cauliflower-shaped growth (secretory type) forms as a result of the continuing cell augmentation. In conventional medicine, this is diagnosed as an **omental mesothelioma** (see also peritoneal mesothelioma, pleural mesothelioma, pericardial mesothelioma, and testicular mesothelioma). If the rate of cell division exceeds a certain limit, then the cancer is considered "malignant".

HEALING PHASE: Following the conflict resolution (CL), fungi, TB bacteria or other bacteria remove the cells that are no longer needed. Adhesions occur as a result of a prolonged healing process (hanging healing).

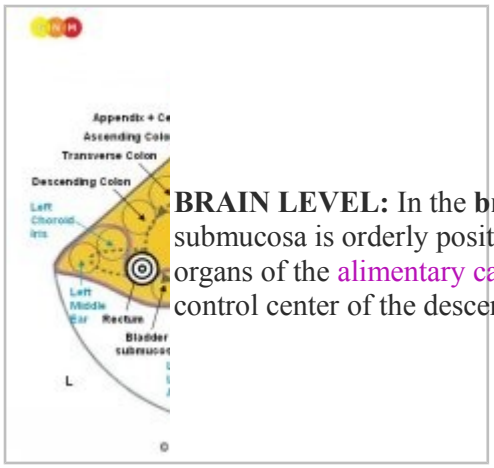
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In this case, the "cancer" is interpreted as "benign".

RECTUM



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE SIGMOID COLON AND RECTUM SUBMUCOSA: The sigmoid colon is the final portion of the large intestine joining the rectum. The rectum connects with the anus, the opening where waste matter in form of stool passes out of the body. To facilitate the expulsion of fecal matter, the rectal sphincters relax to allow feces to exit the intestinal canal. The sigmoid colon and rectal submucosa consist of intestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the sigmoid colon and rectum submucosa is orderly positioned within the ring form of the brain relays that control the organs of the alimentary canal, precisely, on left brainstem hemisphere following the control center of the descending colon.

BIOLOGICAL CONFLICT: The biological conflict linked to the sigmoid colon and rectum submucosa is a "**feces conflict"**. The conflict is either about a real "feces"-**morsel** (human feces or animal poo) or is experienced in a figurative sense triggered, for example, by dirty business, malicious slander, mean accusations, in short, by a "shitty" incident (compare with feces conflict related to the para-anal ducts and the sigmoid/colon muscles.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

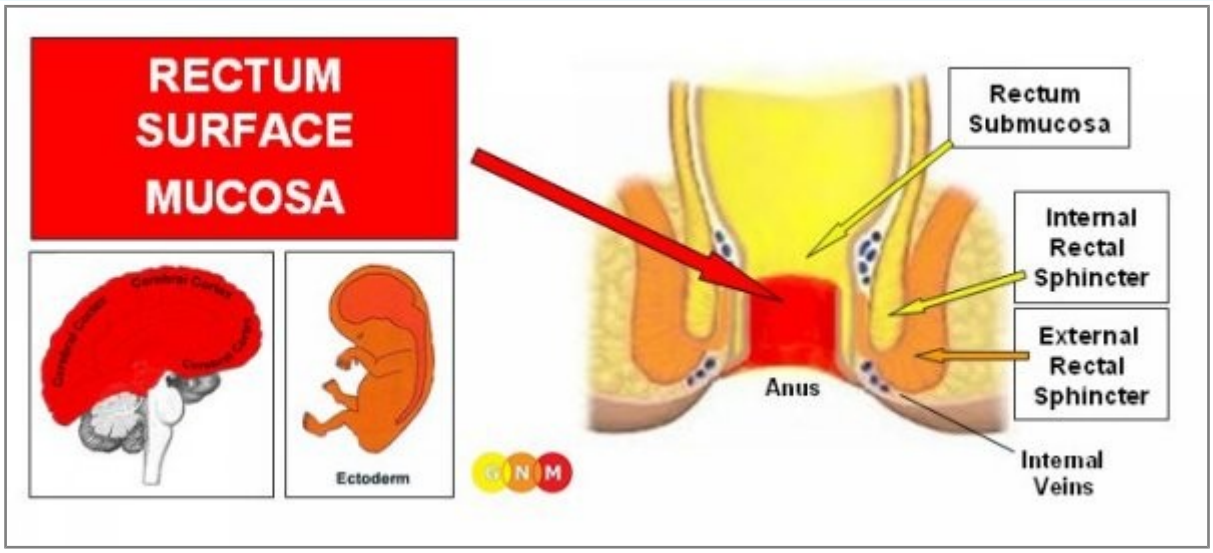
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the sigmoid colon and/or rectum proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to facilitate the digestion of the morsel. Even though the rectum has no longer a digestive function, in the event of abiological conflict the organ still responds with cell augmentation, because originally the entire intestinal canal served the digestion of food. With prolonged conflict activity (hanging conflict) a flat (resorptive type) or cauliflower-shaped growth (secretory type) develops in the sigmoid (immediately above the rectum) or in the rectum (underneath the rectum surface mucosa). In conventional medicine this is diagnosed as a **colorectal cancer** (compare with "rectal cancer" related to the rectum surface mucosa). If the rate of cell division exceeds a certain limit, the cancer is considered as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as a **rectal polyp** (see also healing phase).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **rectal bleeding**, **tarry bowel movements**, and **night sweats**.**Rectal cramps or spasms** (motor quality) occur during the Epileptoid Crisis (see also rectal spasms related to therectum surface mucosa, smooth rectal muscles, internal rectal sphincter, and striated rectal muscles and external rectal sphincter). Depending on the degree of the conflict-active phase, the symptoms range from mild to severe.

Like colon cancers, rectal cancers are usually only found in the healing phase when they start to bleed and cause discomfort. With water retention due to the SYNDROME the swelling enlarges and might cause a rectal obstruction (inPCL-A). After the Epileptoid Crisis the swelling recedes.

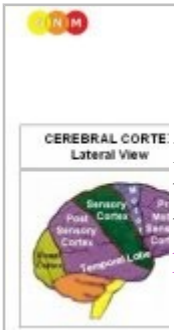
When TB bacteria remove a tumor in the rectum, an abscess might form in the course of the healing process. In conventional medicine such **rectal abscesses** with swelling and discharge of blood are often misdiagnosed ashemorrhoids.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells in the rectum remain. Eventually, the growth becomes encapsulated. In conventional medicine, this is usually diagnosed as a "benign cancer", a **rectal polyp** (see also conflict-active phase), or as hemorrhoids.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE RECTUM SURFACE MUCOSA: The rectal surface mucosa covers about 12 cm of the endodermal submucosa in the lower section of the rectum. The surface mucosa consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex. The inner wall of the lower rectum is endowed with striated muscles.



BRAIN LEVEL: The epithelial lining of the rectum is controlled from the left side of the **temporal lobe** (part of the **post-sensory cortex**). The control center is positioned next to thebladder relay and exactly across from the brain relay of thestomach (small curvature), pylorus, duodenal bulb, bile ducts, andpancreatic ducts.

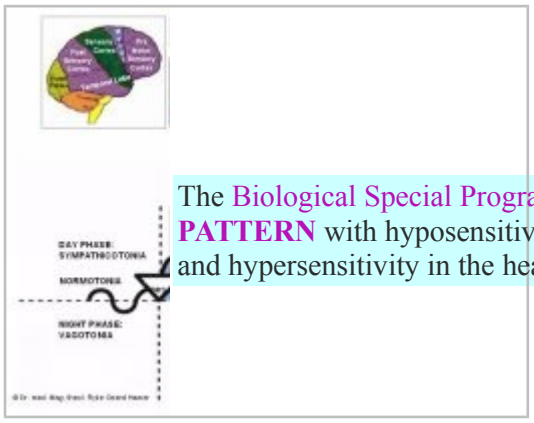
BIOLOGICAL CONFLICT: The biological conflict linked to the rectal surface mucosa is a female **identity conflict** or male territorial anger conflict, depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

An **identity conflict** refers to the inability to establish one's position or place ("territory"), literally or figuratively. An unwanted move, change of school, or change of a workplace can activate the conflict. Feeling unsettled, not knowing where to belong, not finding one's place in a relationship, within the family, the group at work, or in the culture and society at large as well as discrimination against one's belief or sexual orientation are examples of what can evoke an identity conflict. The conflict is to a certain extent a **decision conflict** (not knowing what choice to make, not knowing where to go).

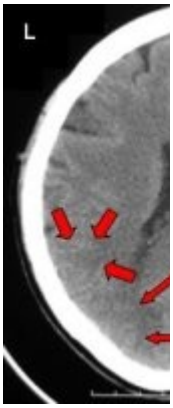
NOTE: Marking the place or territory with feces or urine is a typical behavior of mammals (see also anal glands). Hence, the rectum-related identity conflict is similar to a marking conflict involving the renal

pelvis, ureters,bladder and urethra. In the brain, the control centers of the rectum and the bladder are located right next to each other.



The Biological Special Program of the rectum surface mucosa follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the rectum proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the rectum to allow faster defecation in order to be better able to establish one's place. **NOTE:** While conflict active, the person is manic.



This brain CT shows a Hamer Focus in the rectum relay (upper red arrows - view the GNM diagram) and the bladder relay (lower red arrows) related to an identity conflictand a marking conflict, respectively. The sharp borders of the Hamer Foci reveal that both conflicts are active. At this point there are no symptoms since both organs follow the outer skin pattern (hyposensitvity).

With prolonged conflict activity the continuing tissue loss in the rectum lining causes small tears or so-called **anal fissures**. An anal fissure can burst open, for example, with the passing of hard stool.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. The **swelling**, caused by the edema, presents as **hemorrhoids** in the lower rectum (internal hemorrhoids) or around the anus (external hemorrhoids). With water retention due to an active abandonment and existence conflict (the SYNDROME) hemorrhoids become much larger. In conventional medicine, the "growth" might be diagnosed as a "**rectal cancer"** (compare with rectal cancer related to the rectum submucosa). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **burning pain in the rectum**, **anal itching**, **rectal bleeding** (with hard bowel movements hemorrhoids crack and bleed), and **painful rectal muscle cramps or spasms** if the surrounding striated muscles of the inner rectum wall undergo the Epileptoid Crisis at the same time (see also rectal spasms related to the rectum submucosa, smooth rectal muscles, internal rectal sphincter, or striated rectal muscles and external rectal sphincter). Depending on the intensity of the conflict-active phase, the symptoms range from mild to severe. Typical for the healing phase is the feeling of incomplete emptying of the bowels following defecation, termed **rectal tenesmus** (compare withbladder tenesmus).

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a

complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

Conventional medicine claims that hemorrhoids are "varicose veins" in the rectal area. In reality, the swelling occurs in the epithelial mucosa of the rectum. Dr. Hamer's brain scan studies demonstrate that every person who has hemorrhoids shows the Hamer Focus in the cerebral cortex in the control center of the rectum surface mucosa and not in the cerebral medulla from where the blood vessels are controlled (see also esophageal varices, erroneously linked to liver cirrhosis).

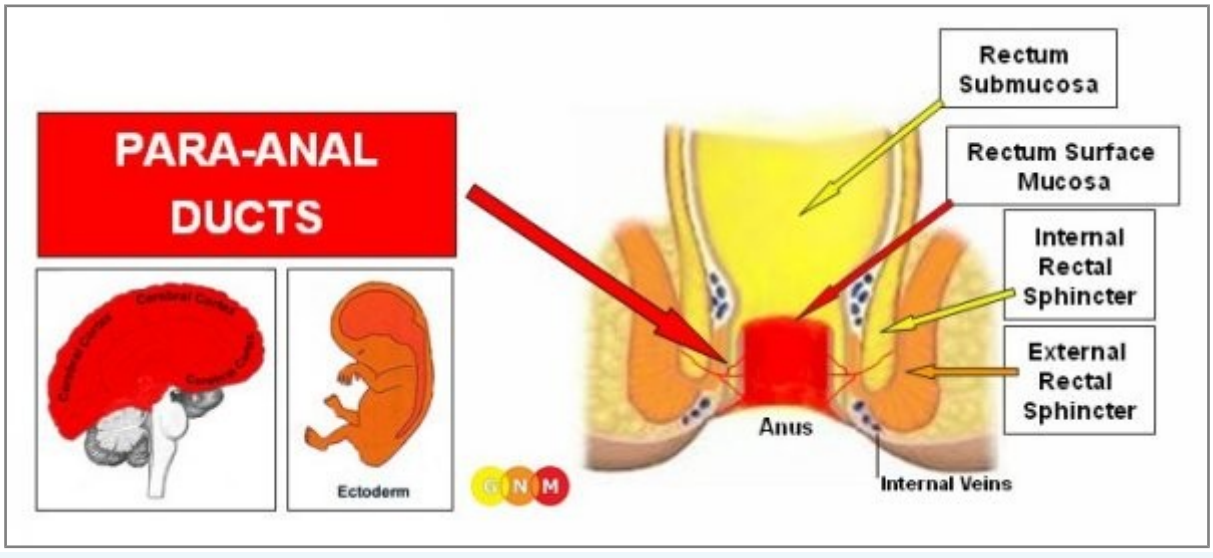
According to statistics, hemorrhoids are more common in women during pregnancy. They are said to be caused by the weight carrying the baby. From the GNM perspective, a pregnant woman only develops hemorrhoids, when she is in the healing phase of an identity or decision conflict. This is why not every pregnant woman has the condition.

NOTE: Hemorrhoids also occur after tearing in the rectal area during labor or because of straining during hard bowel movements. Regardless whether hemorrhoids are the result of an injury (without a DHS) or of a rectum-related conflict, the healing process is just the same.

Surgical removal of hemorrhoids is only a temporary "solution" because, if the conflict has not been completely resolved new hemorrhoids start developing with the next conflict relapse, triggered by setting on a track that was established when the original identity conflict took place.

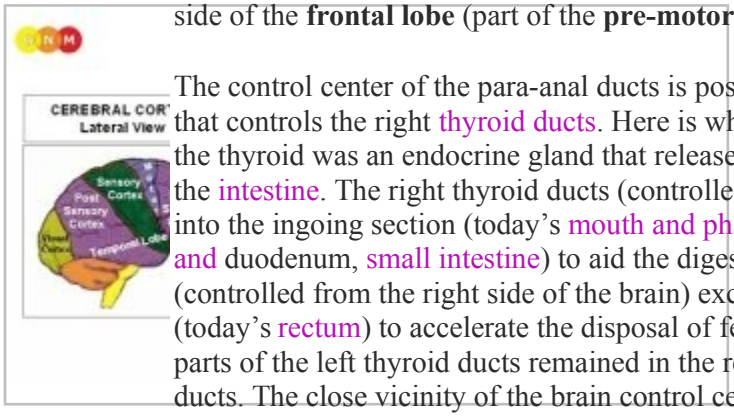
Animals get hemorrhoids too.

This CT scan was taken from a dog's skull. The red arrow points to the brain relay of the rectum lining on the left side of the cerebral cortex (view the GNM diagram) - striking evidence that humans share the Biological Special Programs with other species. The picture below shows the large hemorrhoids. The dog had suffered an identity conflict ("where do I belong?") during a move. The hemorrhoids appeared after he had settled in his new home.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

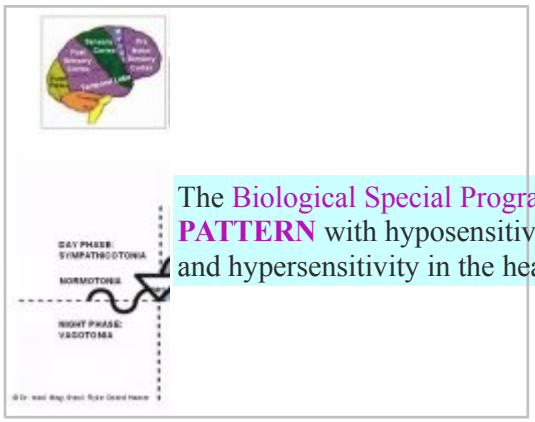
DEVELOPMENT AND FUNCTION OF THE PARA-ANAL DUCTS: The para-anal ducts carry fluid produced in the anal glands into the rectum to aid defecation. The glands themselves are located on either side of the anus between theinternal and external rectal sphincter. In mammals, these glands are referred to as "scent glands" because they enable the animals to mark their territory (in addition to feces and urine) and to identify members within a species. The lining of the para-anal ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the para-anal ducts is controlled from the right side of the **frontal lobe** (part of the **pre-motor sensory cortex**).

The control center of the para-anal ducts is positioned exactly across from the brain relay that controls the right thyroid ducts. Here is why: Originally, before the gullet broke open, the thyroid was an endocrine gland that released thyroxine into both sections of the intestine. The right thyroid ducts (controlled from the left side of the brain) excreted into the ingoing section (today's mouth and pharynx, esophagus, stomach and duodenum, small intestine) to aid the digestion of food; the left thyroid ducts (controlled from the right side of the brain) excreted into the outgoing section (today's rectum) to accelerate the disposal of feces. However, when the gullet ruptured, parts of the left thyroid ducts remained in the rectum. These residues are today's para-anal ducts. The close vicinity of the brain control centers of the para-anal ducts and the thyroid ducts represents the rupture of the gullet on the cerebral level.

BIOLOGICAL CONFLICT: The biological conflict linked to the para-anal ducts is "**not being able to eliminate feces fast enough"**. Such a "**feces conflict"** can be experienced in real terms (constipation) or in a transposed sense triggered, for example, by a "shitty" situation one experienceds unable to "evacuate" fast enough (compare with feces conflict related to the sigmoid/rectum submucosa and sigmoid/rectal muscles).

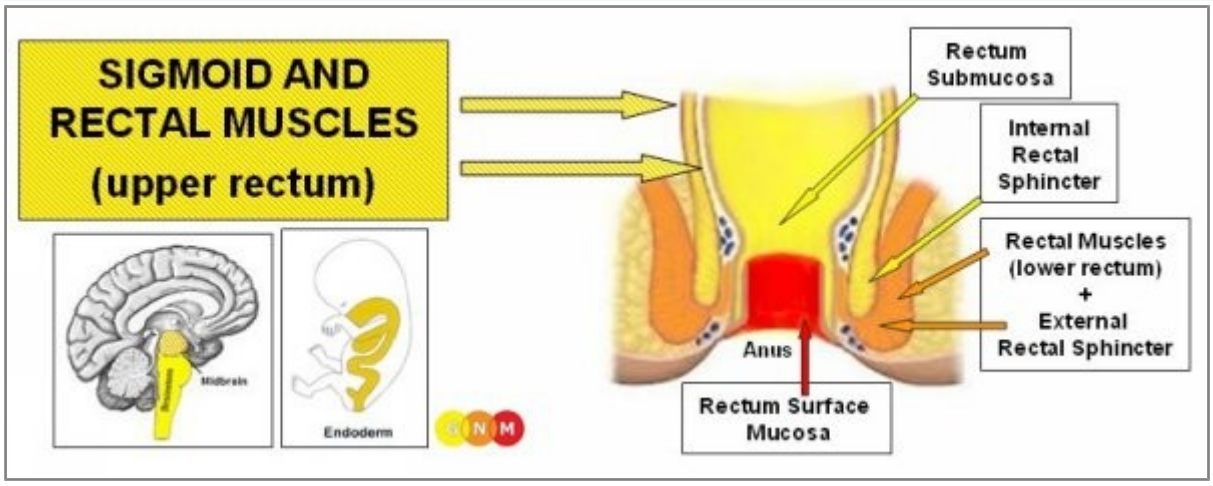


The Biological Special Program of the para-anal ducts follows the**OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

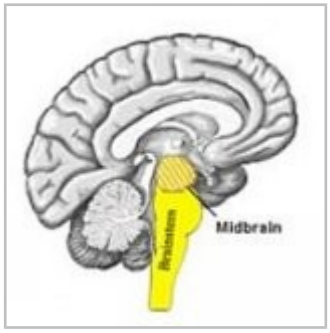
CONFLICT-ACTIVE PHASE: ulceration in the lining of the para-anal ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the lumen to facilitate faster defecation.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. The edema (fluid accumulation) creates a **para-anal cyst**. **Healing symptoms** are **pain and itching**. If there are no conflict relapses, the cyst recedes during the healing phase. A **para-anal fistula** forms when a para-anal cyst breaks and empties outwards (see also thyroid fistula). This usually occurs when large amounts of water are retained in the cyst due to the SYNDROME or as a result of conflict relapses that prolong the healing process. Cysts that empty into

the abdominal cavity are called **Douglas fistula**; in this case, the opening of the fistula creates a direct outlet for an ascites.



DEVELOPMENT AND FUNCTION OF THE SIGMOID AND RECTAL MUSCLES (UPPER RECTUM): Like the intestines{muscles}, the sigmoid colon and upper part of the rectum consists of smooth muscles originating from the endodermand controlled from the midbrain.



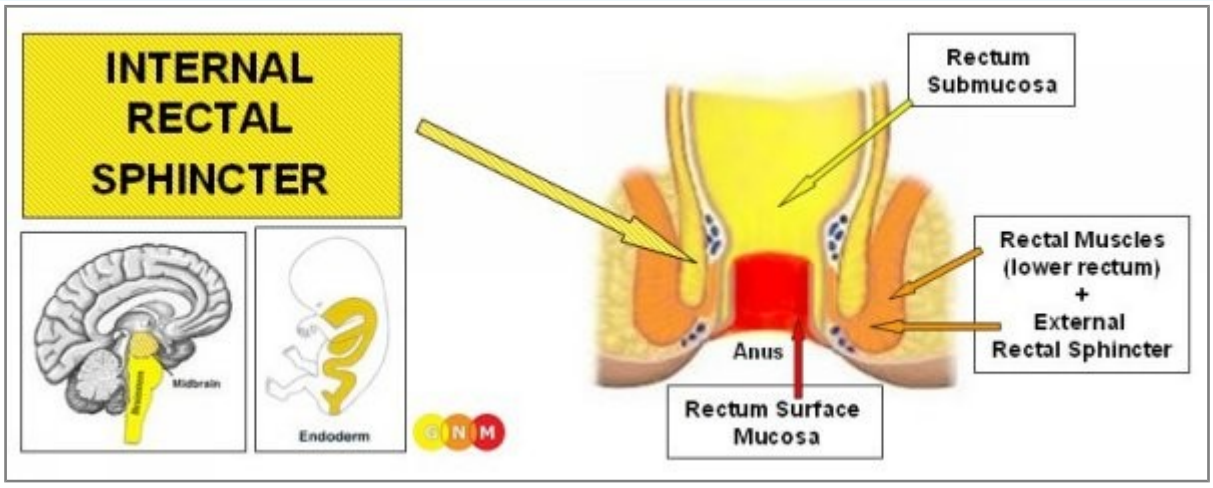
BRAIN LEVEL: The smooth muscles of the sigmoid colon and rectum (upper part) are controlled from the **midbrain**, located at the outermost part of the brainstem.

NOTE: The lower part of the rectum is endowed with striated muscles.

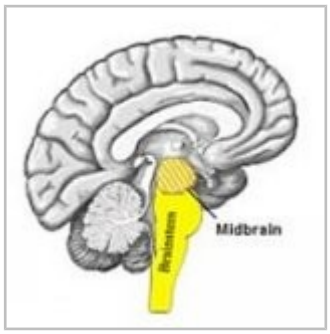
BIOLOGICAL CONFLICT: The smooth muscles of the sigmoid and upper part of the rectum are linked to a "**feces conflict"**, experienced in real terms (fecal incontinence, persistent constipation) or in a transposed sense, as a "shitty" situation (see also feces conflict related to the sigmoid colon and rectum submucosa and the para-anal ducts).

CONFLICT-ACTIVE PHASE: increased muscle tension (hypertonus)

HEALING PHASE: muscle relaxation with **rectal spasms** during the Epileptoid Crisis (see also rectal spasms related to the internal rectal sphincter, striated rectal muscles and external rectal sphincter, rectum submucosa, rectum surface mucosa).



DEVELOPMENT AND FUNCTION OF THE INTERNAL RECTAL SPHINCTER: The internal and external rectal sphincters control the closing of the anus and the elimination of feces. The internal rectal sphincter is a muscular ring that surrounds the anal canal. It is formed by a thickening of the circular muscles of the rectum. The internal rectal sphincter consists of smooth muscle, originates from the endoderm, and is controlled from the midbrain.

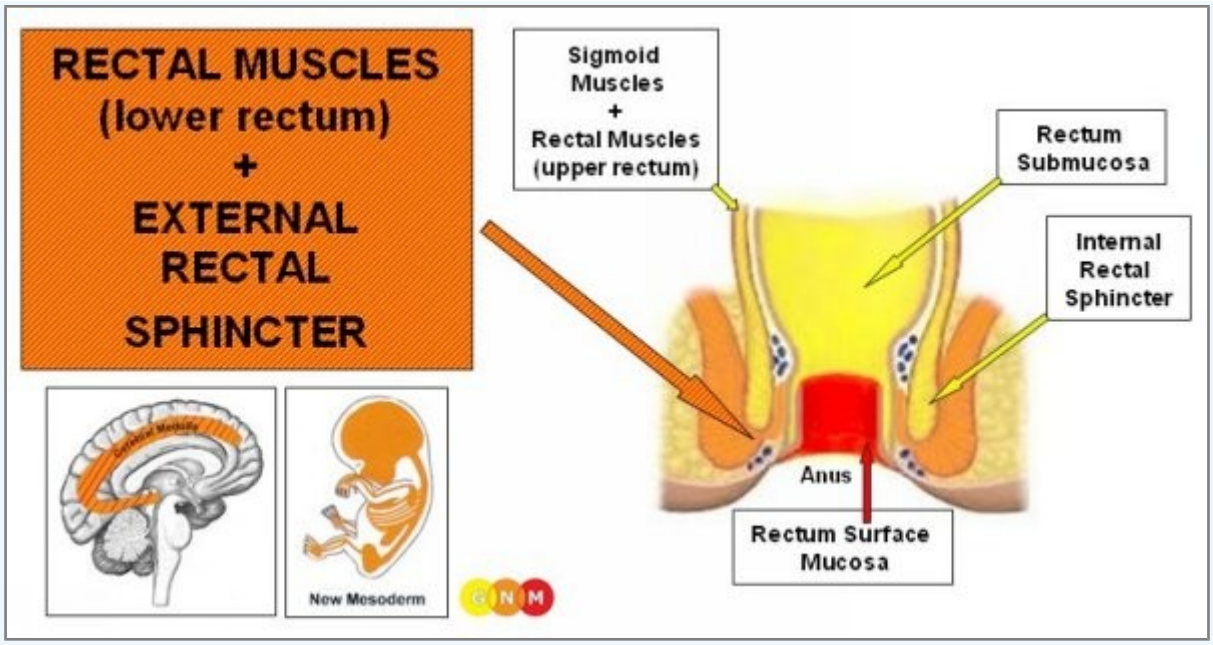


BRAIN LEVEL: The smooth muscles of the internal rectal sphincter are controlled from the**midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to internal rectal sphincter is **not being able to hold back feces**, for example, because of fecal incontinence.

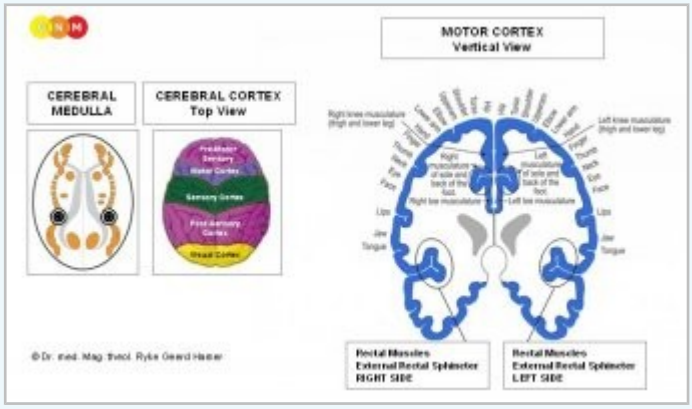
CONFLICT-ACTIVE PHASE: hypertonus of the internal rectal sphincter. The **biological purpose of the increased muscle tension** is to facilitate holding back the feces.

HEALING PHASE: The muscle tension goes back to normal. The Epileptoid Crisis presents as painful **rectal spasms**(see also rectal spasms related to the smooth rectal muscles, striated rectal muscles and external rectal sphincter,rectum submucosa, and rectum surface mucosa).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE RECTAL MUSCLES (LOWER RECTUM) AND EXTERNAL RECTAL SPHINCTER: The external rectal sphincter is a muscle that surrounds the anus immediately beneath the skin. Like theinternal rectal sphincter, it regulates the closing and opening of the anus in order to hold and expel feces. The lower part of the rectal muscles and the external rectal sphincter consist of striated muscles, originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The striated rectal muscles and the external rectal sphincter have two control centers in the cerebrum. The trophic function of the muscles, 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 right half of the rectal muscles and external rectal sphincter are controlled from the left side of the cerebrum; the left halves are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ. In comparison, the smooth muscles of the upper part of the rectumand of the internal rectal sphincter are controlled from the midbrain.

NOTE: The rectal muscles and external rectal sphincter, bladder muscle and external bladder sphincter, cervix muscles and cervical sphincter, and vaginal muscles share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the rectal muscles and external rectal sphincter is the same as with the rectum surface mucosa, namely, an identity conflict in the sense of an

inability to establish one's position or place. Biologically, this translates into "**not being able to *sufficiently* mark one's territory"** (by defecation), similar to the marking conflict related to the bladder muscle and external bladder sphincter.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of rectal muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the rectal muscles** (controlled from the motor cortex). At the same time the rectal sphincter opens (no necrosis with sphincters!) which allows to better mark one's place.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

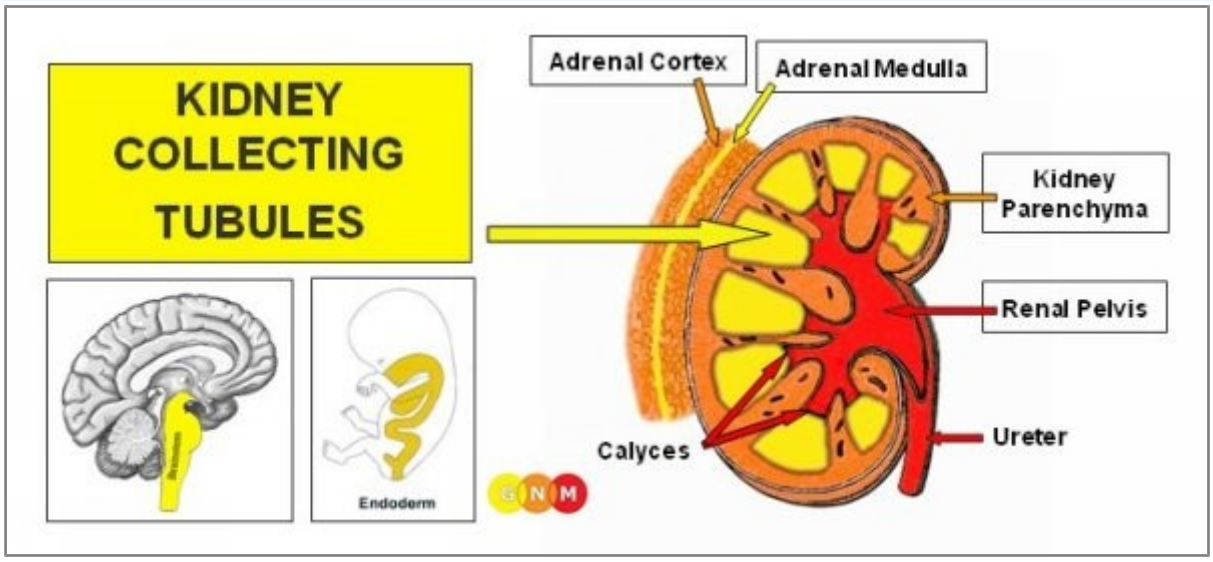
Persistent conflict activity causes **fecal incontinence**, an inability to control bowel movements (see also urinary incontinence). A sudden leakage of stool flow also occurs during the Epileptoid Crisis when the rectal sphincter opens.

NOTE: External sphincters (external bladder sphincter, external rectal sphincter, cervical sphincter) consist ofstriated muscles, while internal sphincters such as the internal bladder sphincter and internal rectal sphinctersconsist of smooth muscle. External sphincters have an inverse innervation, meaning that they close through contraction in vagotonia, i.e., in the healing phase, and open through relaxation in sympathicotonia, i.e., in the conflict-active phase and Epileptoid Crisis. Regarding the bladder and rectum, during an Epileptoid Crisis, for example throughout an epileptic seizure, both sphincters might open at the same time causing a complete emptying of the bladder together with an involuntary loss of stool.

HEALING PHASE: During the healing phase, the rectal muscles are reconstructed and the rectal sphincter closes. TheEpileptoid Crisis manifests as painful **rectal spasms** (see also rectal spasms related to the internal rectal sphincter,smooth rectal muscles, rectum submucosa, and rectum surface mucosa).

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

KIDNEYS



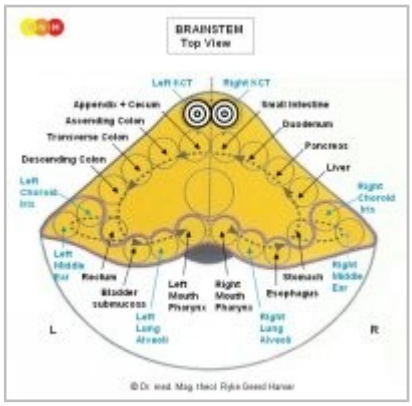
Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE KIDNEY COLLECTING TUBULES: The kidneys are positioned on each side of the lower spine at the back of the abdomen (retro-peritoneal). The function of the kidney collecting tubules is to collect urine produced in the kidney parenchyma and funnel it through several cup-shaped calyces to the renal pelvis. From there, the urine passes further into the ureters, bladder and urethra for excretion. Urine consists for the most part of water (about 95%). The rest is made up of electrolytes (mainly sodium, potassium, chloride and calcium) and uric substances such as uric acid, urea and creatinine. The kidneys filter daily approximately 180 liter of blood. However, 99% of the filtrate is reabsorbed by the kidney tubules and returned to the bloodstream, leaving a urine output between 1.5 and 2 liters.

NOTE: The salt content of bodily fluids, notably of the tears, blood, and amniotic fluid is exactly the same as the isotonic salt concentration in seawater, namely 0.9%. This clearly suggests that organic life originated in the ocean.

In evolutionary terms, the kidney collecting tubules are the oldest tissue of the kidneys. Like the intestinal cells that digest the "food morsel", the biological function of the kidney tubules is to "absorb/retain" (resorptive quality) and "digest" (secretory quality) the "water morsel". The kidney collecting tubules consist of intestinal cylinder epithelium, originate from the endoderm and are controlled from the brainstem.

NOTE: Originally, the kidneys were one single organ that later divided into two kidneys.



BRAIN LEVEL: In the **brainstem**, the kidney collecting tubules have two control centers that are positioned in close vicinity to the brain relays of the organs of thealimentary canal.

The kidney collecting tubules of the right kidney, originally responsible for the urea cycle (conversion of ammonia into urea), are controlled from the right side of the brainstem. The kidney collecting tubules of the left kidney, originally responsible for processing water, are controlled from the left brainstem hemisphere. Today, both kidneys share the same function (see also development of the lungs).

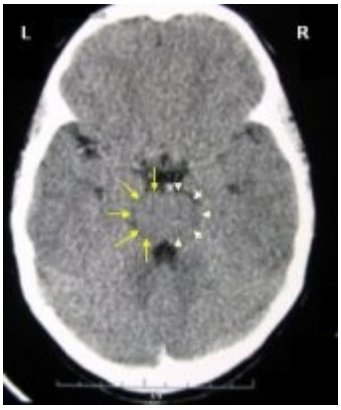
BIOLOGICAL CONFLICT: The biological conflict linked to the kidney collecting tubules originates at a time when life existed only in the ocean and being thrust out of the water environment created a life-threatening situation. This kind of distress also concerns human life because water is the primordial home of all living organisms. We humans experience the conflict of "**feeling like a fish out of water"** when we are unexpectedly "swept out" of our familiar surroundings or when we lose our "pack". In GNM, we refer to the conflict of the kidney collecting tubules as to an **abandonment conflict**, **existence conflict**, or **refugee conflict**.

Abandonment conflicts are brought on by feeling ousted, excluded, unwanted, rejected, not understood, ignored, left out, isolated and alone. Children experience the conflict when they are put into daycare, when they feel unloved or excluded from the group (at home, on the playground, in kindergarten, in school), when their parents don't spend enough time with them, when a new sibling is born who gets more attention, when a grandparent dies, or when a family member leaves. It is the loss of safety and the loss of an emotional shelter which makes them feel utterly alone. The same can be said about the elderly who end up in nursing facilities, away from their home and their family. Newborns are equally vulnerable. Thus, being taken away from the mother at birth for one or the other reason can cause a severe abandonment conflict. Pets also suffer terribly when they are left behind.

An **existence conflict** is a fear for one's life - equal to the fish out of water in danger of dying. This fear is often triggered by a cancer diagnosis or negative prognosis associated with "**my life is at stake"** (compare with death-fright conflict related to the lungs). Waiting in an emergency room, being in an ambulance, and **hospitalization** (undergoingchemo treatments, surgery, not feeling cared for, a lack of support by doctors, nurses, or relatives) also evoke existence and abandonment conflicts. The fear of having to go to the hospital might already activate the conflict. An existence conflict also relates to one's livelihood. The feeling behind the conflict is "**I have lost everything"**. This could be the loss of a workplace, financial losses, the loss of a home, or the loss of a person who provided security, economically or emotionally.

A **refugee conflict** is experienced as being "thrown into the desert", as feeling uprooted or "in exile", for example, due to an unexpected transfer or move (change of neighborhood, change of school) or being forced to flee from one's home or homeland. Traveling away from a familiar home or a loved one can provoke the conflict. Air travelers are particularly prone to suffer refugee conflicts. By the same token, feeling uncomfortable on an airplane (a fear of flying) might trigger an existence conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the kidney tubules proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to close the excretion filter in order to withhold water so that the organism has a better chance to survive. This innate water retention program is vital because without water all metabolic processes stop functioning. **NOTE:** Whether the conflicts affect the right or left kidney is random.



On a brain scan the kidney tubules relays (view the GNM diagram) are visible on several layers.

In this image, the Hamer Focus on the left brainstem hemisphere shows the impact of the conflict on a slightly higher level than the one on the right side. The sharp ring structuresindicate that the conflicts are active, affecting both kidneys on the organ level. In GNM we call this a Kidney Collecting Tubule Constellation, which manifests mentally as disorientation and confusion, as seen, for example, in Alzheimer's disease – linked toabandonment and existence conflicts!

Symptoms of the conflict-active phase:

- **water retention**
- **elevated uric acid levels**
- **elevated urea and creatinine levels**
- **decreased urine output**

The degree of **WATER RETENTION** is determined by the intensity of the conflict. Typical signs of water retention are baggy eyes, swollen hands, swollen feet and ankles (see also peripheral edema) and **weight gain** (1 liter of retained water weighs about 1 kilo or 2.2 pounds). With a persisting abandonment and existence conflict a person can gain a lot of weight (100 kg and more) in spite of regular exercises, a normal diet or even fasting. The retained water is predominantly stored in the fat tissue, mainly in the abdominal area (see ascites). In this case, obesity is not caused by excess body fat but by excess accumulation of water as a result of lasting conflict activity (compare with obesity due to hypoglycaemia).

… feeling "like a fish out of water".

German New Medicine offers an entirely new understanding of the increasing number of overweight people, including children, in the Western world by taking into account social changes (the dissolution of traditional family structures, growing divorce rates, infants in daycare, the elderly in homes) and alarming economic developments (increasing unemployment, poor prospects for the youth, mounting debt). Whether we consider nowadays the water retention (weight gain) useful or not is irrelevant. What matters is that this Biological Special Program has proved itself biologically meaningful over millions of years.

Daycare Linked to Being Overweight

"Young children who attend daycare on a regular basis are 50% more likely to be overweight compared to those who stayed at home with their parents, according to a study by researchers at the University of Montreal and the CHU Sainte-Justine Hospital Research Centre."

Science Daily, Nov 16, 2012

NOTE: During the conflict-active phase it is recommended to reduce the **fluid intake** unless there is sufficient daily urine output (compare with fluid intake in the healing phase and with the SYNDROME). Too little fluid intake, however, increases the water retention (and weight gain) because even without a conflict the organism still retains fluids to maintain the body's water balance. This also happens with insufficient protein in the diet.

In the conflict-active phase, the organism not only withholds water but also uric substances such as uric acid, urea and creatinine. Hence, these levels rise proportionally to the degree of conflict activity and the number of kidney tubules that are affected (compare with elevated uric acid, urea and creatinine levels related to the kidney parenchyma). The standard theory that **ELEVATED URIC ACID LEVELS** are linked to a diet high in proteins (see gout) is inconclusive since vegetarians also happen to have high levels of uric acid.

Urea and creatinine are waste products of the protein metabolism and are normally excreted with the urine. However, in the critical event of an existence conflict the organism recycles the retained substances into protein to provide the organism with nutrition. Why? Because, in biological terms, the conflict of being thrust out of the water environment means next to the danger of drying out also a threat of starvation, particularly of dying from protein deficiency. For this emergency situation Nature created yet another survival program, which is to convert toxins such as urea and creatinine into food to help the organism to overcome the crisis. **ELEVATED UREA AND CREATININE LEVELS** are therefore not diseases ("**uremia"**) or malfunctions ("**kidney insufficiency**"), as claimed by conventional medicine, but serve a biological purpose. The retention of urea and creatinine is in addition to storing water an innate response in case water and protein are not available for a longer period of time.

The retention of water and urine results in a **DECREASED URINE OUTPUT**. Thus, during the conflict-active phase the**urine is concentrated and dark yellow**. Since water is also absorbed from the intestines, the stool is dry and hard. When more kidney tubules are involved, the urine excretion can decrease drastically causing **oliguria** (urine output between 150 – 400 ml daily) or **anuria** (less than 50 ml per day).

NOTE: According to Dr. Hamer, with a daily urine elimination of 150 – 200 ml (oliguria, almost anuria) the organism still eliminates uric substances in sufficient amounts. A creatinine level above 12 mg/dL indicates that the kidney tubules of both kidneys are affected. In this case dialysis is a necessity.

With prolonged conflict activity a flat (resorptive type) or cauliflower-shaped growth (secretory type) develops in the kidney collecting tubules. In conventional medicine this is diagnosed as a **kidney cancer** or "**renal cell carcinoma"**(compare with "kidney cancer" related to the kidney parenchyma). If the rate of cell division exceeds a certain limit, the cancer is considered as "malignant".

CONFLICT RESOLUTION: With the resolution of the conflict (CL) **the retained water is immediately released**through the unaffected calyces . Depending on the degree of water retention the elimination of urine could be profuse. Standard medicine views this copious urination (**polyuria**) as "abnormal" and "pathological". With the knowledge of GNM, we welcome this **URINARY PHASE** with great relief (see also urinary phase shortly after every Epileptoid Crisis).

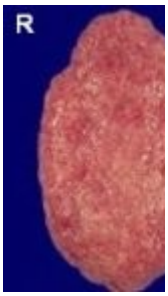
HEALING PHASE: Following the conflict resolution, fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are a **cloudy urine** since the discharge produced during the decomposing process is excreted via the urinary tract (the discharge might contain

blood), **pain** due to the swelling, and **night sweats**. With an inflammation the condition is called "**nephritis"** (compare with glomerulo nephritis related to thekidney parenchyma). **Renal candidiasis** reveals that fungi assist healing.

If TB bacteria are present this causes a "**bacterial kidney infection"** (compare with "kidney infection" related to therenal pelvis), or **kidney tuberculosis**. After the tuberculosis, particularly when the healing phase lasted for a long period of time, the affected calyces appear on an X-ray plump rather than with sharp contours. It is from this roentgenological appearance that doctors make the diagnosis "**nephrotic syndrome"** (see also renaming of lung tuberculosis to lung cancer and liver tuberculosis to liver cancer).

Tubercular secretion is rich in protein. Hence, when the additional cells are broken down, the elimination of protein through the urine is higher than normal. This is clinically termed **proteinuria** or **albuminuria** (in conventional medicine, protein in the urine during pregnancy is considered a "pregnancy disorder", called pre-eclampsia). In the blood, however, the protein concentration is low (**hypoproteinemia**) because in the event of a protein deficiency, the organism takes proteins from the blood in order to balance the protein loss. If protein-rich nutrition or supplementation is not sufficient to correct a protein shortage, administering albumin infusions temporarily is crucial. At the end of the healing phase, the protein levels as well as the urea and creatinine values are back to normal.

NOTE: Concerning **fluid intake**, during the healing phase drinking adequate amounts of water is important in order to support the elimination of the remnants of the cell-breakdown (compare with fluid intake in the conflict-active phase and with the SYNDROME).



With chronic tuberculosis (hanging healing) more and more kidney tissue is irretrievably lost. The result: a **cirrhotic kidney** (see left kidney in this picture) and the inability to eliminate sufficient amounts of urine (compare with cirrhotic kidneyrelated to the kidney parenchyma with insufficient urine production). If healing cannot be completed in time, this ultimately leads to "**tubulous kidney insufficiency"**(compare with "glomerulous kidney insufficiency" and eventually to **kidney failure**. When both kidneys fail dialysis is inevitable.

NOTE: Uremia does *not* cause kidney failure!

GNM offers an explanation as to why **acute kidney failure** is the most frequent complication in hospitalized patients, particularly in **intensive care units** (see existence conflict).

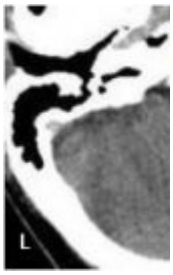
"The mortality associated with acute renal failure (ARF) in the intensive care unit (ICU) has remained greater than 50% during the past three decades, despite improvements in renal replacement technology." (Journal of the American Society of Nephrology, 2011)

Kidney failure as a result of abandonment conflicts is one of the leading causes of death in pets.

In the event of a new kidney tubule-related conflict, a cirrhotic kidney is no longer able to retain water. As a consequence, large volumes of diluted urine are eliminated. This condition is called **diabetes insipidus**. The theory that diabetes insipidus is linked to a "hormonal defect" is pure assumption.

When the affected kidney is surgically removed, a new or re-activated abandonment or existence conflict affects the other kidney because the water retention program has highest priority. This initiates the development of a new kidney tumor, interpreted by conventional medicine to be a "metastatic cancer".

NOTE: A transplanted kidney is not controlled from the brain. Its function is maintained artificially.



On this brain CT we see both kidney collecting tubules relays involved (view the GNM diagram) after the impact of two independent abandonment or existence conflicts. The edema (fluid accumulation) on the left side (hypodense, showing as dark) indicates Healing Phase-A, also in the left kidney; the presence of neurogliaon the right side (hyperdense, showing as white) reveals that the right kidney tubules are already in PCL-B. In conventional medicine, the glia buildup is wrongly interpreted as a "brain tumor".

The blue arrows point to an edema in the control center of the choroid on the right side of the brainstem. This tells that the person is in the healing phase (PCL-A) of a visual morsel conflict (not being able to see a beloved person) that occurred together with the abandonment conflict.

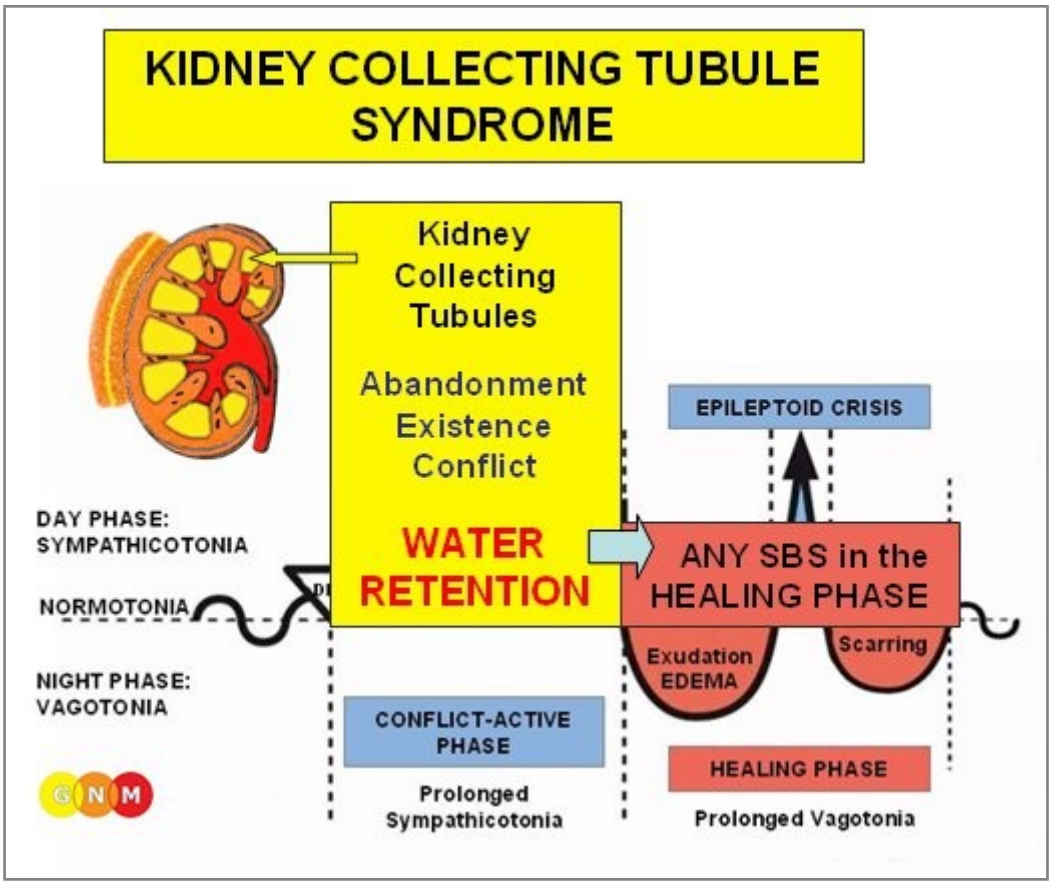
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated. In the kidney this could cause an occlusion of the opening to the renal pelvis. In this case, surgery might have to be considered.

KIDNEY STONES (Calcium Oxalate Stones)

With constant conflict relapses the accumulating salt and mineral residues in the renal pelvis eventually form kidney stones, which are released during the Epileptoid Crisis with spasms (**kidney colic**) and acute pain, particularly if a stone obstructs the urinary tract (see also kidney colic related to the renal pelvis).

Kidney stones in the tubules are dark or white calcium oxalate stones (compare with green or yellowish uric acid stones in the renal pelvis.

THE KIDNEY COLLECTING TUBULE SYNDROME

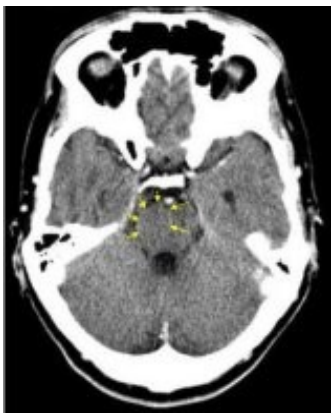


The **Kidney Collecting Tubule Syndrome**, in short: **the SYNDROME**, involves:

a) water retention because of an active abandonment or existence conflict

b) ANY Biological Special Program in the healing phase

When the organism withholds water, the excess fluid is also stored in the healing organ and in the correlating brain relay. Hence, the size of the edema that develops in **PCL-A** (exudative phase) is not only determined by the duration and intensity of the preceding conflict-active phase but also by the degree of water retention due to an active abandonment or existence conflict. Whether water retention is responsible for large swellings in the healing phase can easily be established by evaluating the urea and creatinine levels and by measuring the urine output. In the practical application of GNM, a brain CT analysis is an invaluable diagnostic tool for assessing the situation.



This CT scan shows a Hamer Focus in the brain relay that controls the kidney collecting tubules of the left kidney (view the GNM diagram). The sharp ring configuration indicates conflict activity, hence, water retention.

NOTE: With the SYNDROME, the autonomic nervous system is in sympathicotonia and vagotonia at

the same time. Thus, extra sleep (fatigue) and a good appetite that are vital for healing are disrupted by the conflict-active state of stress with little appetite and difficulties sleeping. The result: nervous exhaustion, weight loss, and energy loss.

The SYNDROME can create serious complications both on the organ and the brain level, specifically during the Epileptoid Crisis.

Consequences of the SYNDROME on the ORGAN LEVEL:

- **increased pain** due to the enlarged swelling, leading to the use of stronger pain medication such as morphine.

- **harmless swellings might turn into a complicated case** causing obstructions, for example, in the colon or in the bile ducts, requiring surgery and hospitalization. This often triggers further existence conflicts with the result of even more fluid accumulation in the affected organ.

- **healing tumors**, for example, in the lungs, bronchia, liver, pancreas, colon, thyroid, breast (glands or milk ducts),cervix, uterus, ovaries, prostate, or testicles **increase in size**. This is when conventional medicine speaks of "fast-growing" or "aggressive" cancers.

- **growths that had encapsulated** because of a lack of fungi or TB bacteria **appear bigger** and might be detected during a routine medical checkup or follow-up examination (mammography, colonoscopy, etc.).

- **caverns** that remained as a result of a prolonged healing process (hanging healing), for example in the breast glands, **increase with water retention**, presenting now as cysts.

- **cysts** such as liver cysts, thyroid cysts, ovarian cysts, testicular cysts, or kidney cysts **become larger and might even burst**. The fluid released into the neighboring area can lead to acute complications.

- **an effusion**, for example, in the pleura, peritoneum, or pericardium **can cause a serious medical condition** due to the additional water stored in the already fluid-filled membrane. When retained water accumulates in the lungsthis causes a lung edema, which is often fatal.

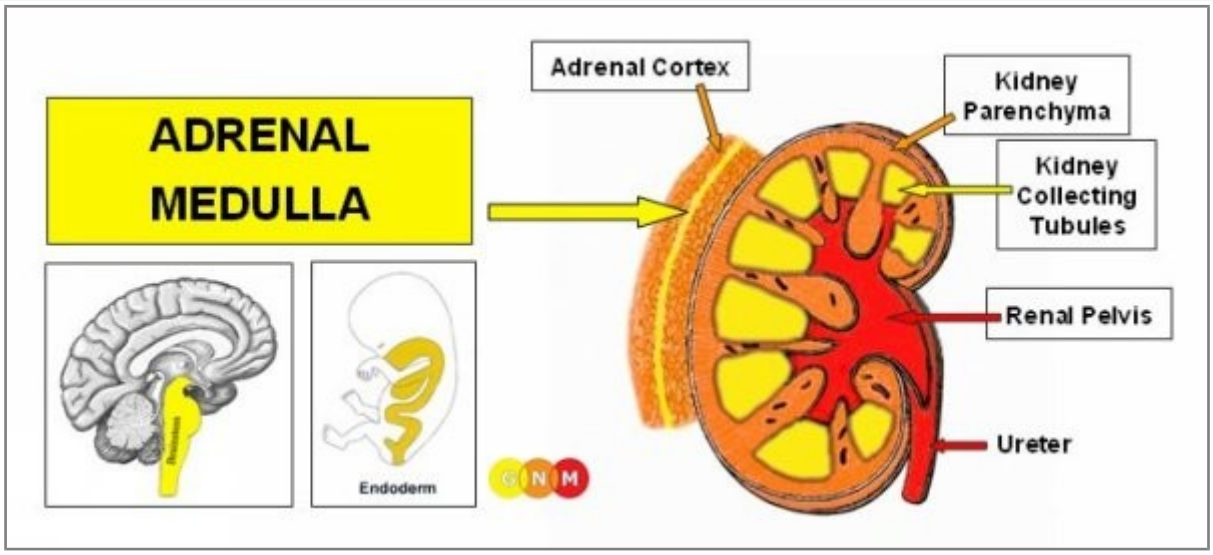
- **skin conditions** (involving the under skin or the epidermis) **show more dramatic**

- **inflammations become more severe**

- **arthritic conditions are more painful** due to the increased swelling

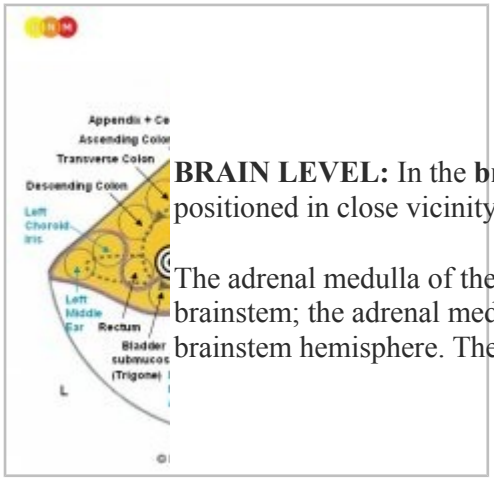
- **with water retention arthritis becomes gout**

- **bronchitis becomes pneumonia**



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE ADRENAL MEDULLA: The adrenals are paired hormonal glands seated on top of the kidneys. The adrenal medulla, at the core of the gland and surrounded by the adrenal cortex, consists of so-called chromaffin cells, named for their characteristic brown staining with chromic acid salts. The adrenal medulla produces hormones (secretory quality), predominantly stress hormones such as dopamine, noradrenalin, and adrenalin (also known as catecholamines). The adrenal medulla consists of intestinal cylinder epithelium, originates from theendoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the adrenal medulla has two control centers, positioned in close vicinity to the brain relays of the organs of the alimentary canal.

The adrenal medulla of the right adrenal gland is controlled from the right side of the brainstem; the adrenal medulla of the left adrenal gland is controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: unbearable intense stress

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase adrenal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the production of stress hormones in order to improve the performance during acute stress. Hence, the **dopamine**, **noradrenalin and adrenalin levels rise**. **Symptoms** are onsets of **rapid heart beats**, **elevated blood pressure**, **excessive sweating**, and **anxiety** due to the intense state of stress. **NOTE:** These parameters increase to a certain extent in theconflict-active phase of any Biological Special Program.

With lasting conflict activity a compact, cauliflower-shaped growth (secretory quality), referred to as an **adrenal cancer**(**pheochromocytoma**), develops in the adrenal gland (compare with "adrenal cancer"

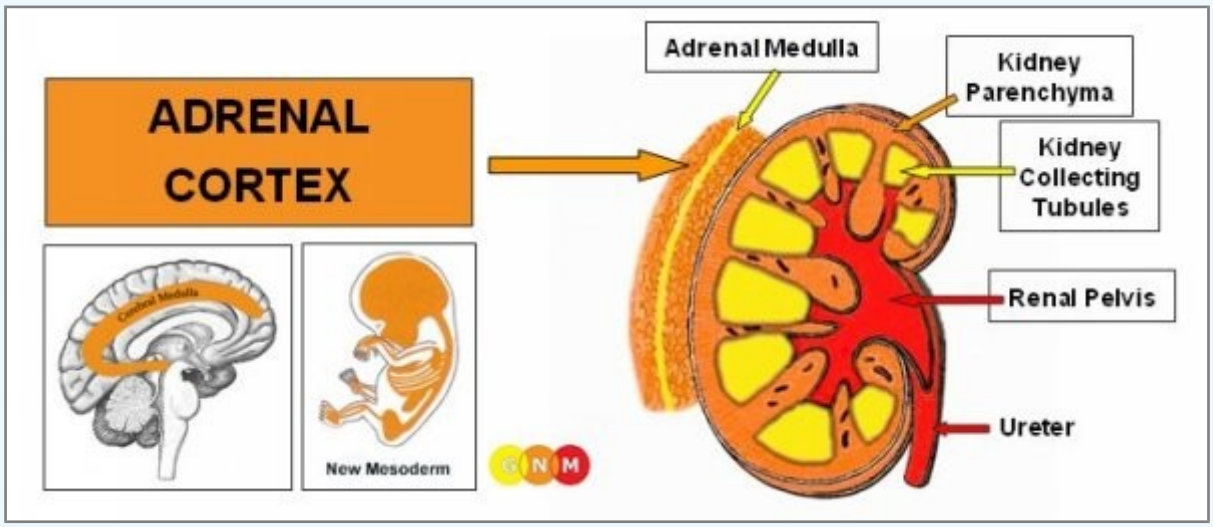
related to the adrenal cortex). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant".

NOTE: Whether the conflict affects the adrenal medulla of the right or left adrenals is random.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **pain**, caused by the **swelling**, and **night sweats**. With the completion of the healing phase the hormone levels are back to normal.

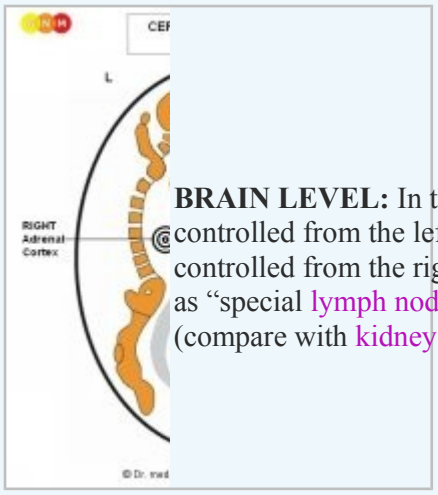
A prolonged healing process due to continuous conflict relapses leads to chronic **tuberculosis in the adrenal medulla**. Because of the brown coloration of the chromaffin cells the condition presents on an organ CT as dark; this might be mistaken as bleeding in the adrenal glands (adrenal apoplexy).

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated resulting in a**permanent overproduction of stress hormones** (see also thyroid gland, parathyroid glands, pancreas gland,prostate gland).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE ADRENAL CORTEX: The adrenal cortex forms the outer layer of the adrenal gland. Like the adrenal medulla, the adrenal cortex produces hormones, mainly stress hormones such as cortisol and aldosterone as well as androgens. The adrenocorticotropic hormone (ACTH) regulates the levels of cortisol released from the adrenals. In evolutionary terms, the adrenal cortex developed from lymphatic tissue, originates therefore from thenew mesoderm and is controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the adrenal cortex of the right adrenal gland is controlled from the left side of the brain; the adrenal cortex of the left adrenal gland is controlled from the right cerebral hemisphere, precisely where the adrenals have their place as "special lymph node". There is a cross-over correlation from the brain to the organ (compare with kidney parenchyma).

BIOLOGICAL CONFLICT: The biological conflict linked to the adrenal cortex is being "**thrown off course**", **having gone into the wrong direction, having made the wrong decision or the wrong choice**.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) in the adrenal cortex proportional to the degree and duration of conflict activity. The **biological purpose of the tissue loss** is to decrease the production of stress hormones in order to force the individual to slow down on the wrong path. The subsequent **symptom**: **feeling stressed-tired** because of the low cortisol and aldosterone levels. This differs from any other conflict-active phase with an increase of energy due to the release of cortisol (fright and flight response). The condition of an insufficient production of steroid hormones is termed**hypoadrenalism** or **Addison's disease**.

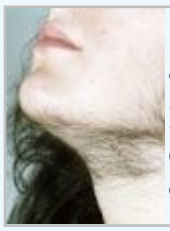
NOTE: Whether the adrenal cortex of the right or left kidney is affected is determined by a person's handednessand whether the conflict is mother/child or partner-related.

HEALING PHASE: During the healing phase an **ADRENAL CYST** develops at the site of the necrosis. In PCL-A adrenal cells multiply inside the cyst to refill the tissue loss that occurred in the conflict-active phase. Found at this point, the cyst is diagnosed as an "**adrenal cancer"** (compare with adrenal cancer related to the adrenal medulla). Based on theFive Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

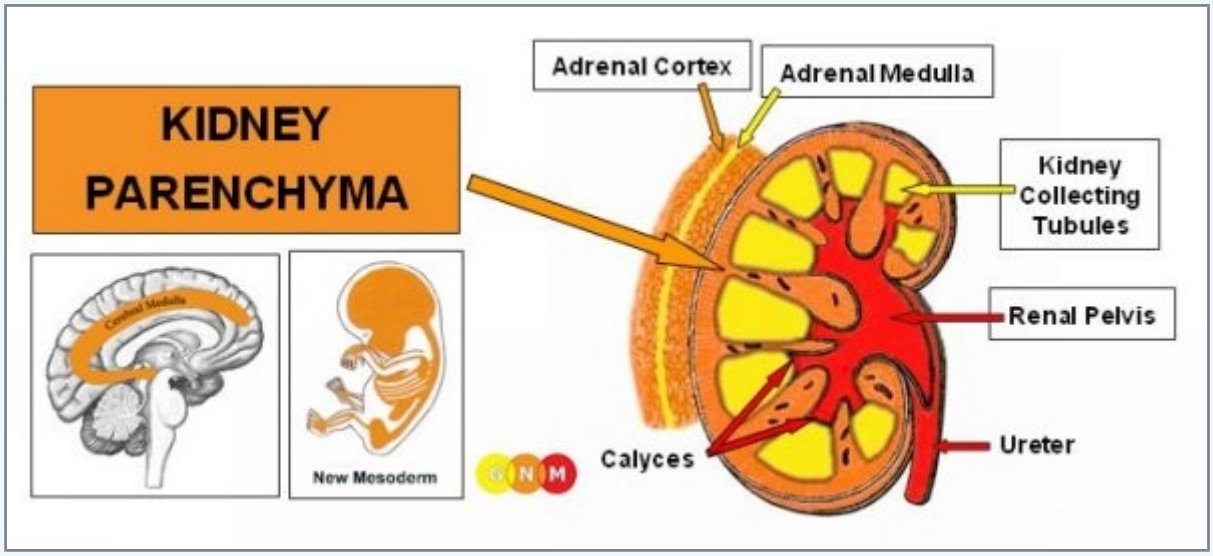
Within nine months, provided there are no conflict relapses, the cyst hardens and becomes an integral part of the hormone-producing function of the adrenals (see also kidney cyst, ovarian cyst, and testicular cyst). The increased production of stress hormones serves the **biological purpose to assist the organism in staying on the right track**.

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

If the conflict-active phase was intense, such an adrenal cyst can become quite large, resulting in an excess production of adrenal hormones (**hyperadrenalism**), termed **Conn's syndrome** (with an overproduction of aldosterone), or**Cushing's syndrome** (with an overproduction of cortisol). The symptoms of Cushing's are a round-shaped face (or "moon face") and weight gain, particularly on the trunk, neck, and upper back. The puffy face and the weight gain are caused by water retention, if the person is at the same time conflict active with an abandonment or existence conflict(the SYNDROME). The water retention also increases due to the overproduction of cortisol (a stress hormone). **NOTE:**The symptoms of Cushing's are "side effects" of corticosteroids. Hence, so-called "Iatrogenic Cushing's Syndrome" is quite common because of the widespread use of these drugs.



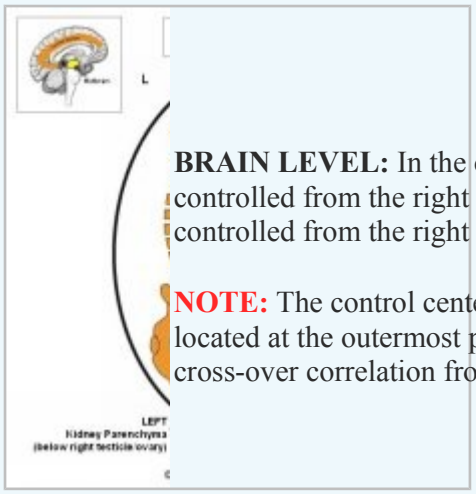
The adrenals also produce androgens, a hormone that is responsible for hair growth in locations such as the face and the chest. Women with Cushing's have therefore typically extra facial and body hair. A large adrenal cyst can cause excessive hair growth as a result of the increased production of androgens. This condition is called **hirsutism**.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE KIDNEY PARENCHYMA: The kidney parenchyma forms the bulk of the kidney. Composed of millions of nephrons, its main function is to filter blood and produce urine. Each nephron consist of a glomerulus, which is a capillary network surrounded by a membrane called the Bowman's capsule. It is the blood pressure within the small blood vessels and the Bowman's capsule that regulates urine formation (after life had moved on land, the production of urine was no longer regulated through the intestine but instead through the blood circulation and the kidneys). As blood passes through the glomeruli, water and metabolic wastes are filtered through the capillary walls. However, most of the filtrate is reabsorbed by the kidney collecting tubules and returned to the blood, leaving about 1.5 to 2 liters of urine for elimination. The rate at which the kidneys filter blood is called the glomerular filtration rate (GFR). The kidney parenchyma originates from the new mesoderm and is therefore controlled from the cerebral medulla.

NOTE: Originally, the kidneys were one single organ that later divided into two kidneys. If the kidneys don't fully separate during fetal development this presents a so-called "**horseshoe kidney**", with the two kidneys still fused in a U-shape at the lower base.



BRAIN LEVEL: In the **cerebral medulla**, the kidney parenchyma of the right kidney is controlled from the right side of the brain; the kidney parenchyma of the left kidney is controlled from the right cerebral hemisphere.

NOTE: The control centers are located in the transitional area between the midbrain, located at the outermost part of the brainstem, and the cerebral medulla. Hence, there is no cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The kidney collecting tubules, which developed at a time when life existed only in the ocean, relate to the biological conflict of water *deprivation* (fish out of water). In contrast, the kidney parenchyma is associated with *too much* water, because with living on land water itself had become a danger through flooding and drowning. The conflict linked to the kidney parenchyma is therefore a **water or fluid conflict**.

A water conflict can be experienced with any accident in or on the water. However, a burst water pipe, water leaks, aflooded home, or sewage-related problems also trigger water conflicts. A constant reminder of unrepaired water damagemight keep a water conflict active. Heavy rain, thunderstorms, hails, snow storms, or ice storms cause weather-related water conflicts. If rain, including the forecast of rain, becomes a track, this results in recurring or even permanentconflict-active symptoms.

… flooding can affect the population of large regions.

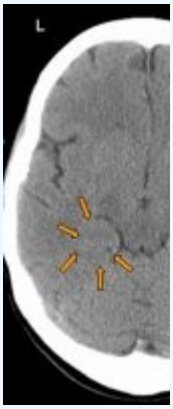
Fluid conflicts refer to distress involving liquids, for example, harmful chemical substances, infusions or injections (medical drugs, cytostatics, street drugs, vaccines), oil (oil disasters), gasoline (running out of gas, rising gas prices), alcohol (including alcohol withdrawal), chemicals in liquid food or cleaning products associated with "allergies" or believed to be carcinogens. The conflict also relates to bodily fluids such as urine (incontinence), sperm (sexual abuse, unwanted sexual practices), amniotic fluid (water breaking during pregnancy), or fluid discharge (vaginal discharge). For someone not familar with GNM, water retention (see kidney collecting tubules) can activate a water conflict. **NOTE:** Blood correlates biologically to a bleeding conflict involving the spleen.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) in one or, with multiple conflicts, in several places of the kidney(s). During conflict activity the arterial blood pressure goes up causing **hypertension**.
The **biological purpose of the elevated blood pressure** is to compensate for the loss of glomerular tissue, which allows the kidney to perform its function despite the reduced number of urine-producing cells (compare with hypertension related to the rightmyocardium; see also adrenal medulla).

The level of blood pressure is determined by the extent of the tissue loss. Hence, with an intense conflict the blood pressure can increase considerably (see also hypertension during the Epileptoid Crisis).

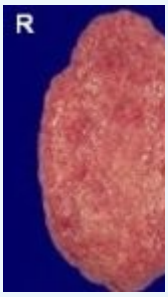
However, **hypertension is never a reason to panic** because elevated blood pressure does neither cause a heart attack nor a stroke, as claimed by conventional medicine, but is rather a biological backup program to sustain the function of the organ. Blood pressure lowering medications (ACE inhibitors) only interfere with this natural response. An overuse of anti-hypertensive drugs is therefore very hard on the kidneys and may even cause kidney failure.

Since the levels of uric substances depend on the Glomerular Filtration Rate (GFR), the **uric acid, urea and creatinine values increase** during the conflict-active phase (compare with elevated uric acid, urea and creatinine levels related to the kidney collecting tubules).



This brain scan shows a Hamer Focus in the cerebral medulla, precisely, in the area that controls the left kidney parenchyma (view the GNM diagram). The mainly sharp border of the ring structure indicates that the person is conflict active with short healing phases in between (edematous part).

NOTE: Whether a water or fluid conflict affects the right or left kidney parenchyma is random.



A progressing loss of parenchymal kidney cells causes a **cirrhotic kidney** (see left kidney in this image) with the inability to produce sufficient amounts of urine (compare with cirrhotic kidney related to the kidney collecting tubules with insufficient urine elimination). Without a conflict resolution this leads eventually to a so-called"**glomerulous kidney insufficiency"** (compare with "tubulous kidney insufficiency") and **kidney failure**. When both kidneys are affected, dialysis is inevitable.

If the affected kidney is surgically removed the blood pressure goes back to normal. However, in the event of a new or reactivated water conflict, the DHS will impact in the brain relay of the other kidney causing the blood pressure to rise again.

HEALING PHASE: Following the conflict resolution (CL), the tissue loss is replenished with new cells, ideally assisted bybacteria. **Healing symptoms** are **pain** due to the swelling of the kidney and potentially **blood in the urine** (see alsorenal pelvis and ureters, bladder trigone, bladder mucosa, and prostate). During the healing phase, the blood pressure as well as the uric substances levels goes back to normal. Yet, with every conflict relapse the blood pressure increases temporarily causing "**unstable hypertension**" ("chronic hypertension" indicates prolonged conflict activity). The blood pressure also rises briefly and potentially significantly for the period of the Epileptoid Crisis.

If healing involves the glomeruli, then the condition is called **glomerulo nephritis** (compare with nephritis related to thekidney collecting tubules). With recurring healing phases, scar tissue forms in the filtering unit of the kidney (in PCL-B). This is termed **focal segmental glomerulosclerosis** (FSGS).

A special characteristic concerning the healing of the kidney parenchyma is the formation of a **KIDNEY CYST**. Provided there are no conflict relapses that interrupt healing, this process takes nine months to complete (see also adrenal cyst,ovarian cyst, and testicular cyst). The development of the cyst occurs in several steps.

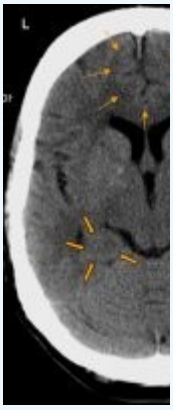
Initially, during **PCL-A** a fluid-filled capsule or cyst forms at the site of the necrosis. The cyst bulges either outward or grows inward. Its size is determined by the intensity and duration of the preceding conflict-active phase. With concurrentwater retention (the SYNDROME) as a result of an

active abandonment or existence conflict, the cyst in the kidney parenchyma can become quite large since the retained water is exceedingly stored in the healing area. Large cyst(s) can cause considerable pain. What is termed "**polycystic kidney disease"** (PKD) points to multiple water or fluid conflictsresulting in many cysts (the theory that the condition is a "genetic disorder" is purely hypothetical).

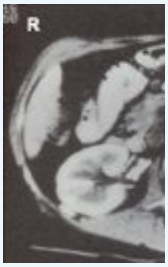
In order to restore the cell loss that occurred during the conflict-active phase, the remaining kidney cells multiply inside the cyst. During this phase the cyst attaches itself to neighboring tissue for blood supply. Adhering to adjacent tissues also stabilizes the cyst. Detected at this stage, the "growth" is diagnosed, in conventional medicine terms, as an"**invasive or infiltrating" kidney cancer** and interpreted as a "metastasis" (compare with kidney cancer related to the kidney collecting tubules). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

After the Epileptoid Crisis, in **PCL-B,** the cyst has lost most of its fluid. At this point the "cancer" is diagnosed as a**Wilms' tumor or nephroblastoma**. **NO PANIC!** Because within nine months (with no conflict relapses), the cyst that had started out as a liquid-filled capsule becomes hard, releases itself from neighboring tissue and, endowed with blood vessels, becomes an integral part of the kidney **partaking – like a third kidney - in all functions of the organ**.

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



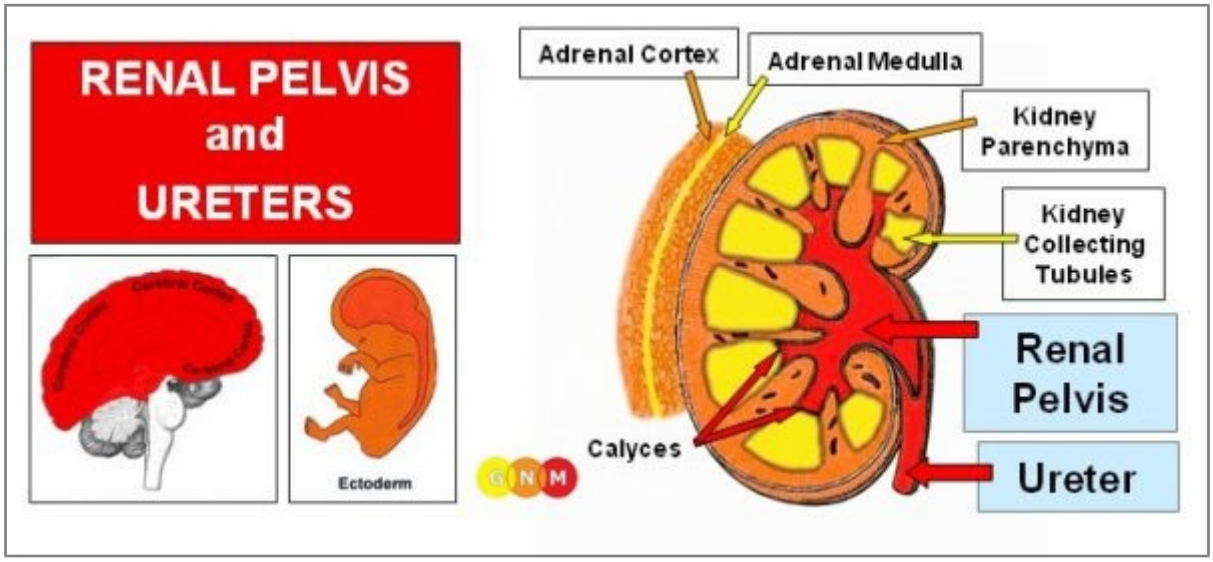
On this brain CT we see a Hamer Focus in the area of the brain that controls the left kidney parenchyma (lower orange arrows - view the GNM diagram) corresponding to a kidney cyst on the left kidney. Hence, the water or fluid conflict has been resolved. The upper arrows point to a Hamer Focus in the brain relay of the tooth dentin related to a bite conflict, currently in the resolution phase.



With water retention due to the SYNDROME a kidney cyst can become very large, as shown on this organ CT.

If the pressure in a liquid or semi-liquid cyst becomes too strong, the cyst might burst. A blow against the kidney, exploratory puncture, or premature surgery can cause the rupture. When the cyst breaks, the fluid finds its way into theretro-peritoneum and into the abdominal area with the released kidney cells attaching to the abdominal wall or an abdominal organ such as the stomach, duodenum, colon, liver, or pancreas. In this case the completion of the cyst development occurs outside the kidney. Found in these areas such cysts are often misdiagnosed as "pockets of lymph nodes or as "liposarcomas" believed to arise from fat cells or from soft tissue ("leiomyosarcomas"). In conventional medicine the growth is considered "malignant".

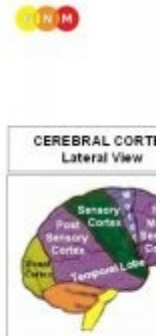
According to Dr. Hamer, the removal of a kidney cyst should only be performed when the cyst is fully matured (indurated). Surgery on a semi-liquid cyst disseminates the parynchemal cells into the surrounding area with unnecessary complications (see ovarian cysts and endometriosis). With concurrent water retention brought on by anexistence conflict, usually evoked by the diagnosis of the kidney cancer or the fear of hospitalization, the cyst hardens only partially. Resolving the kidney tubules-related conflict must therefore have priority.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE RENAL PELVIS AND URETERS: The renal pelvis and ureters represent the upper urinary tract. The renal pelvis receives urine from the kidney collecting tubules through their cup-shaped calyces. From there, urine flows into the ureters and further to the bladder and urethra (lower urinary tract) for elimination. The inner wall of the renal pelvis and ureters is endowed with smooth and striated muscles. Like the intestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth muscle of the renal pelvis and ureters facilitate the flow of the "urine morsel". The lining of the renal pelvis, including the renal calyces, and ureters consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

NOTE: Originally the kidneys were one single organ, which later divided into two kidneys. This is why the renal pelvis and ureters have two brain control centers, one on each brain hemisphere.



BRAIN LEVEL: The epithelial lining of the renal pelvis and the ureters is controlled from the **temporal lobe** (part of the **post-sensory cortex**). The renal pelvis of the left kidney and the left ureter are controlled from the right side of the temporal lobe; the renal pelvis of the right kidney and the right ureter are controlled from the left cortical hemisphere (next to the control center of therectum lining). Hence, there is a cross-over correlation from the brain to the organ.

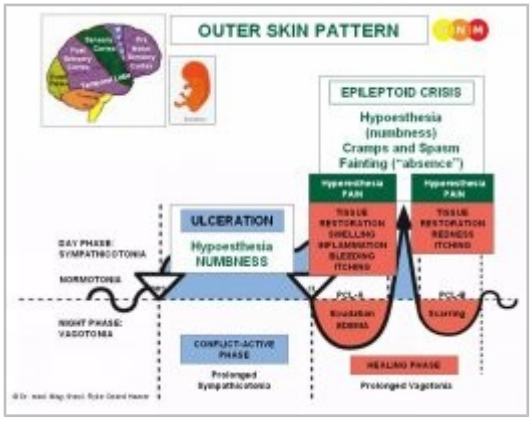
NOTE: The renal pelvis and ureters as well as the bladder and urethra share the same control centers. Whether the conflict affects the renal pelvis, ureter(s), bladder or urethra is random. The prostatic ducts are also controlled from the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the renal pelvis and the ureters is a male **territorial marking conflict** or a female **marking conflict** (see also bladder and urethra) depending

on a person's gender, laterality, and hormone status. A male territorial marking conflict refers to an unexpected invasion of the outer boundaries (male mammals mark the outer boundary of the territory with urine by hiking up their legs) whereas a female marking conflict relates to a breach of the inner boundaries (female mammals mark the inner boundary of their place by squatting). The female marking conflict is similar to an identity conflict, involving the rectum surface mucosa. This is why the brain relay of the renal pelvis, ureters, bladder and urethra is located next to the rectum relay (on the left side of the temporal lobe).

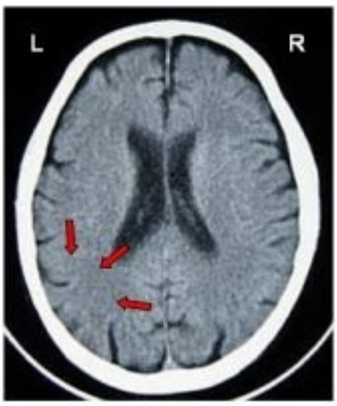
In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial marking conflict** refers to an intrusion into one's place (home, property), including the extended territory (neighborhood, village, city, country). Work-related marking conflicts are provoked, for example, through fights over a position or when a competitor moves into the professional terrain. Relationship-related marking conflicts concern members of the domain (spouse, children, parents, relatives, room mates, class mates, friends, visitors, neighbors, colleagues, teachers, supervisors) who are "crossing the line" or meddling in one's business. Feeling controlled by a spouse, partner, or parent can evoke a marking conflict. An invasion of one's private sphere also includes disrespect for one's belongings. A man can suffer a territorial marking conflict, when another male is interested in his female or when his wife or girlfriend sleeps with someone else. Unwanted sex or sexual abuse can be perceived as an invasion of one's intimate space. An assault against one's beliefs, racist remarks, or harassment of any kind could prompt a marking conflict. Children experience the conflict in school, kindergarten, daycare, or on the playground, also, when a new sibling is born, when they have to share the room with a family member, or when they fight over a toy. Pets suffer marking conflicts when other animals (or humans) occupy their territory or when they are relocated.



The Biological Special Program of the renal pelvis and ureters follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the lining of the renal pelvis, renal calyces and/or ureter(s) proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to enlarge the volume of the renal pelvis and to widen the ureter(s) to improve the urine flow in order to be better able to mark the territory. **NOTE:** If the conflict impacts on the left side of the temporal lobe, the person is manic; if the conflict impacts on the right side of the temporal lobe, the person is in a depressed mood while conflict active (see principle of gender, laterality, and hormone status).



This image (MRI) shows the impact of a marking conflict in the area of the cerebral cortex that controls the renal pelvis and ureters as well as the bladder and urethra (view the GNM diagram). The sharp border of the Hamer Focus indicates that the conflict is still active. What part of the urinary system is affected will only be revealed when healing sets in. In any event, with the knowledge of GNM the person will be prepared for the healing symptoms.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. **Healing symptoms** are**burning pain during urination** (when the ureters are affected) and potentially **blood in the urine** (see also kidney parenchyma, bladder trigone, bladder mucosa, and prostate). Depending on the intensity of the conflict, the symptoms range from mild to severe. An inflammation in the renal pelvis is called **pyeltis**. The Epileptoid Crisis manifests as **acute pain** with **cramps or spasm** (**ureteric colic**, **kidney colic**) if the surrounding striated muscles of the renal pelvis and/or ureters undergo the Epileptoid Crisis at the same time (see also kidney colic related to the kidney collecting tubules).

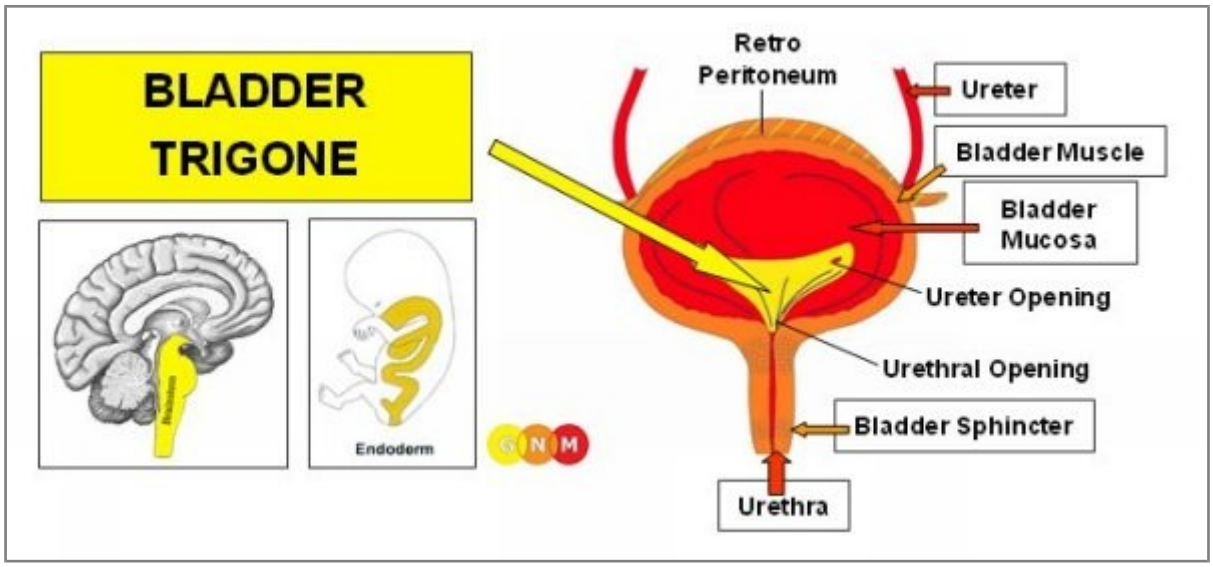
NOTE: All Epileptoid Crisis that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

A "**bacterial infection" in the renal pelvis or ureters** indicates that the repair and scarring process (PCL-B) is assisted by bacteria. This is usually the case when the ulceration that occurred in the conflict-active phase reaches deep into the renal or ureteral tissue (see also "kidney infection" related to the kidney collecting tubules). Recurring "infections" point to conflict relapses triggered by setting on tracks that were established when the original marking conflict took place.

An occlusion of the renal calyces caused by a prolonged healing phase, leads to the formation of **kidney stones**. At one point, typically during the Epileptoid Crisis, the stones are pushed through the neck of the calyx into the renal pelvis and further to the bladder. This process causes acute pain, mainly because of the spasms and cramps (kidney colic) in the inner wall of the renal pelvis.

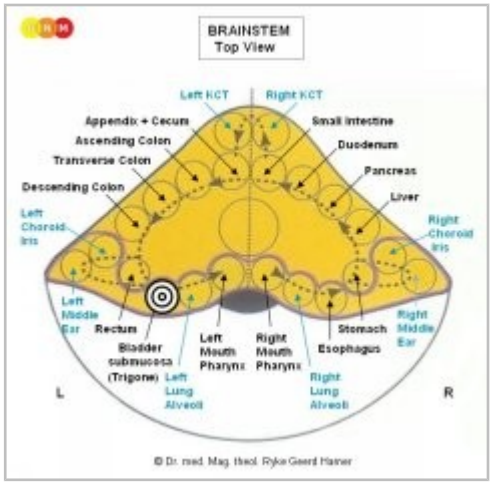
Kidney stones in the renal pelvis are green or yellowish **uric acid stones** (compare with white or dark calcium oxalate stones in the kidney collecting tubules). Urates, as a result of territorial marking conflicts, are very common in dogs and cats.

BLADDER



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BLADDER TRIGONE: The bladder trigone is the triangular area between the openings of the ureters and the urethra. When the bladder muscle contracts, the trigone funnels urine that is temporarily stored in the bladder into the urethra. Equal to the intestinal cells that digest and absorb food, the biological function of the bladder trigone is to "digest" (secretory quality) proteins and "absorb" (resorptive quality) urine (similar to thekidney collecting tubules). The bladder trigone consists of intestinal cylinder epithelium, originates from the endodermand is therefore controlled from the brainstem.



BRAIN LEVEL: The bladder trigone is controlled from the left side of the**brainstem**, next to the control center of the rectum submucosa.

NOTE: The bladder trigone (bladder submucosa), Bartholin's glands, and smegma producing glands share the same brain relay.

BIOLOGICAL CONFLICT: The biological conflict linked to the bladder trigone is a "**dirty" morsel conflict** (dirty business, dirty tricks, dirty sex, etc.) similar to a "shit conflict" related to the sigmoid colon and rectum submucosa.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

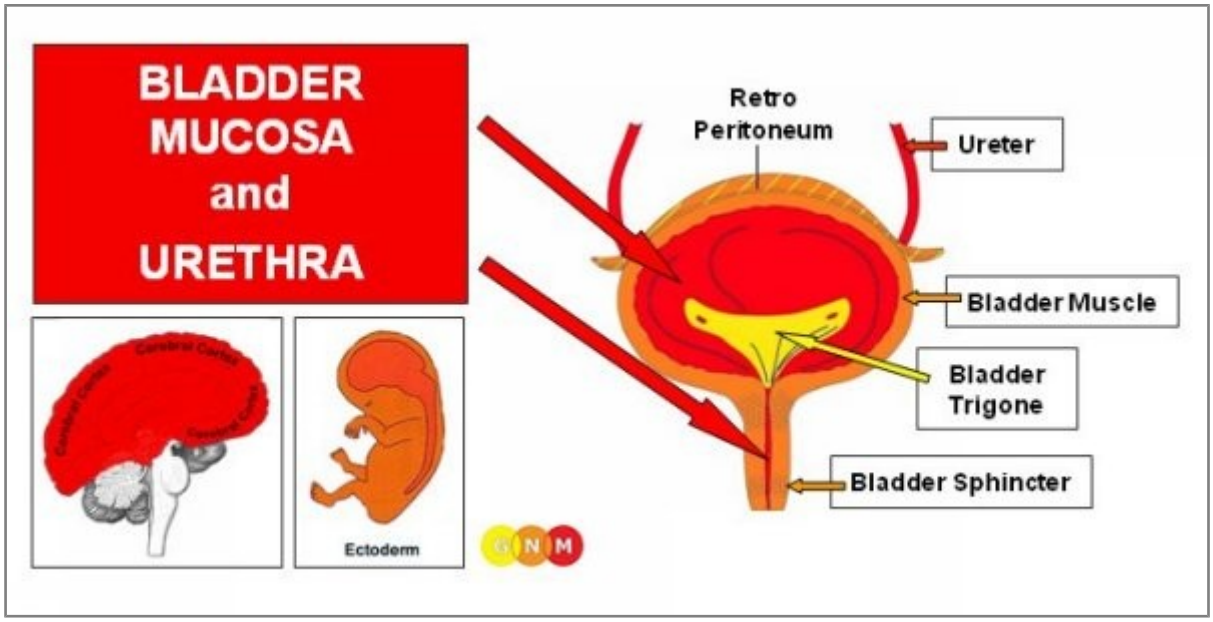
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the bladder trigone proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to improve the ability to "digest" or "absorb" the "dirty morsel". With prolonged conflict activity a flat (resorptive type) or cauliflower-shaped growth (secretory type) forms in the trigone. In conventional medicine, this is diagnosed as a **bladder cancer**(compare with "bladder cancer" related to

the bladder mucosa). If the rate of cell division exceeds a certain limit, then the cancer is considered "malignant"; below that limit the growth is regarded as "benign" or diagnosed as a **bladder polyp** (see also healing phase).

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. This causes **purulent cystitis** or a "**bacterial bladder infection"** (see also "infections" related to the bladder mucosa and bladder muscle). **Healing symptoms** are **pain** due to the swelling, a **cloudy urine**, potentially **blood in the urine** (see also kidney parenchyma, renal pelvis and ureters, bladder mucosa, and prostate), and **night sweats**. Depending on the degree of the conflict-active phase, the symptoms range from mild to severe.

When fungi participate in the healing process, this causes "**candida cystitis"**, which becomes chronic when a person is in a hanging healing due to conflict relapses. Contrary to the claims of conventional medicine, the fungal "infection" in theendodermal(!) bladder trigone cannot "spread" to other areas in the urinary tract such as to the ureters, bladder or urethra (originating from the ectoderm) because fungi don't cross the germ layer threshold!

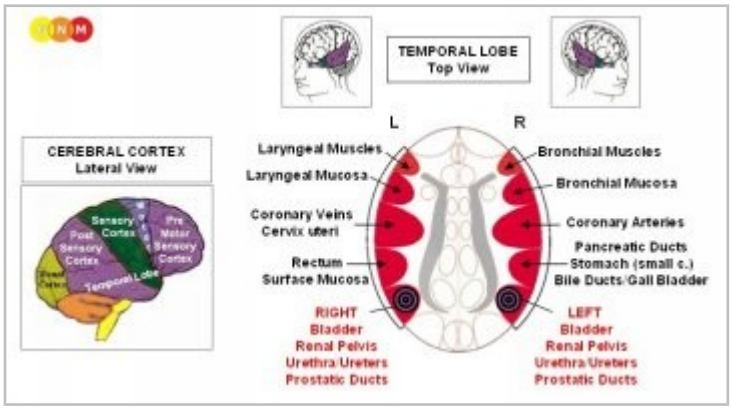
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. This is usually diagnosed as a **bladder polyp** or as a "benign cancer" (see also conflict-active phase).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BLADDER MUCOSA AND URETHRA: The bladder and urethra make up the lower urinary tract. In females, the bladder lies just behind the uterus; the urethra is positioned near the front wall of thevagina. In males, the urethra extends to the end of the penis and carries urine as well as semen during ejaculation; at the neck of the bladder the urethra is surrounded by the prostate. The bladder is a hollow muscular organ where urine received from the renal pelvis and ureters is temporarily stored. Urine exits the bladder through the urethra. The inner wall of the urethra is endowed with smooth and striated muscles. Like the intestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth muscle of the urethra facilitate the flow and elimination of the "urine morsel". The lining of the bladder and urethra consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

NOTE: Originally, the urinary system consisted of two bladders. Over time, the two bladders grew together forming one single organ (conversely, the kidneys were at first one organ, which later divided into two kidneys). This is why the bladder and urethra have two brain control centers, one on each brain hemisphere.

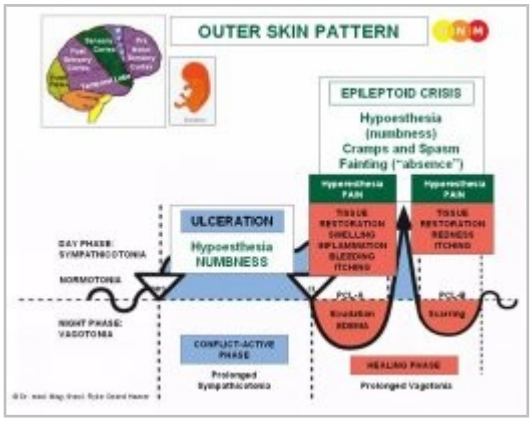


BRAIN LEVEL: The epithelial lining of the bladder and the urethra is controlled from the **temporal lobe** (part of the **post-sensory cortex**). The left half of the bladder and the left half of the urethra are controlled from the right side of the temporal lobe; the right half of the bladder and right half of the urethra are controlled from the left cortical hemisphere (next to the control center of the rectum lining). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The bladder and urethra as well as the renal pelvis and ureters share the same control centers. Whether the conflict affects the renal pelvis, ureter(s), bladder or urethra is random. The prostatic ducts are also controlled from the same brain relays.

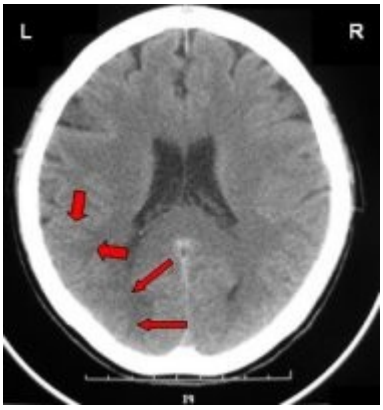
BIOLOGICAL CONFLICT: The biological conflict linked to the bladder mucosa and urethra is a male **territorial marking conflict** or a female **marking conflict** (see renal pelvis and ureters), depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the bladder mucosa and urethra follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the bladder mucosa and/or in the lining of the urethra proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to enlarge the volume of the bladder and to widen the urethra to improve the urine flow in order to be better able to mark the territory. **NOTE:** If the conflict impacts on the left side of the temporal lobe, the person is manic; if the conflict impacts on the right side of the temporal lobe, the person is in a depressed mood while conflict active (see principle of gender, laterality, and hormone status).



This CT scan shows two Hamer Foci in the left temporal lobe; one in the brain relay for the bladder mucosa (lower red arrows - view the GNM diagram), the other in the rectum relay (upper red arrows). The sharp borders reveal that the person is conflict active with amarking conflict (not being able to establish one's boundaries) and an identity conflict("where do I belong?").

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. In conventional medicine, this might be diagnosed as a "**bladder cancer" or urothelial carcinoma**, also called **transitional cell carcinoma**(compare with bladder cancer related to the bladder trigone). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **frequent urges to void with burning pain during urination and elimination of only small amounts of urine**; there is potentially **blood in the urine** (see also kidney parenchyma, renal pelvis and ureters, bladder trigone, and prostate). Typical is also the **feeling of constantly needing to urinate and of incomplete emptying of the bladder** following urination, a condition termed **bladder tenesmus** (compare with rectal tenesmus). With water retention due to the SYNDROME the enlarged swelling might block the urine flow in the urethra. This is an acute medical situation! In this case, Dr. Hamer recommends a temporary bladder catheter (see also urinary tract obstruction in males caused by an enlarged prostate or a prostate tumor).

The Epileptoid Crisis manifests as **acute pain** with **cramps or spasm** if the surrounding striated muscles of the inner wall of the urethra undergoes the Epileptoid Crisis at the same time.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

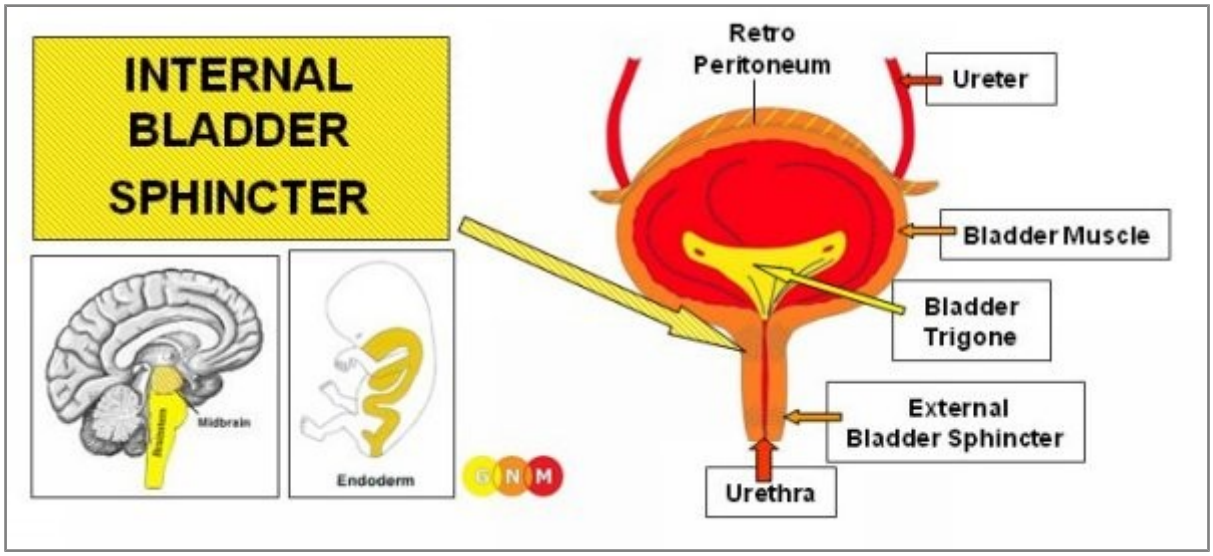
A **urinary tract infection in the urethra or a bladder infection (cystitis)** indicates that the repair and scarring process (PCL-B) is assisted by bacteria (see also UTI related to the ureters and "bladder infections" related to thebladder trigone and bladder muscle). This is usually the case when the ulceration that occurred in the conflict-active phase reaches deep into the urethral and bladder tissue. Recurring "bladder infections" point to conflict relapses triggered by setting on a track that was established when the original marking conflict took place.

Urethral gonorrhea is an inflammation of the mucous membrane of the urethra or of the prostatic ducts with**discharge** due to the activity of bacteria (*neisseria gonorrhoeae*) during the healing process. Contrary to standard beliefs, gonorrhea cannot be sexually transmitted since the symptoms are already healing symptoms, explicitly, of a(territorial) marking conflict regarding the sexual space (see also sexual separation conflict and genital herpes). If the symptoms are less severe, the condition might be diagnosed as urethritis or cystitis. What is euphemistically termed "honeymoon cystitis" is caused by frequent and prolonged sexual intercourse.

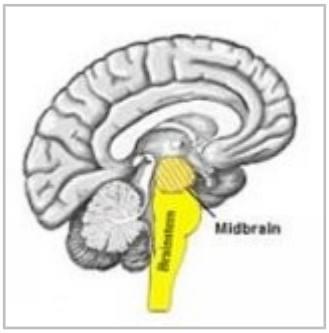
NOTE: In men, the urethra is also used for ejaculation. Hence, the Biological Special Program of the urethra corresponds also to an "**ejaculation conflict"** as in "not being able, not being allowed, or not

wanting to ejaculate" (for example, premature ejaculation).

Bladder warts (papilloma) are the result of a prolonged healing in the urinary bladder. Erroneously these harmless residues are interpreted as cancers. Bladder warts are quite common in cats and dogs (territorial marking conflict!).



DEVELOPMENT AND FUNCTION OF THE INTERNAL BLADDER SPHINCTER: The internal bladder sphincter is a ring-shaped muscle located at the lower neck of the bladder. Its muscular mechanism involuntarily regulates the flow of urine from the bladder into the urethra. The external bladder sphincter at the lower end of the urethra provides a second means to control urine elimination. The internal bladder sphincter consists of smooth muscle, originates from theendoderm and is controlled from the midbrain.

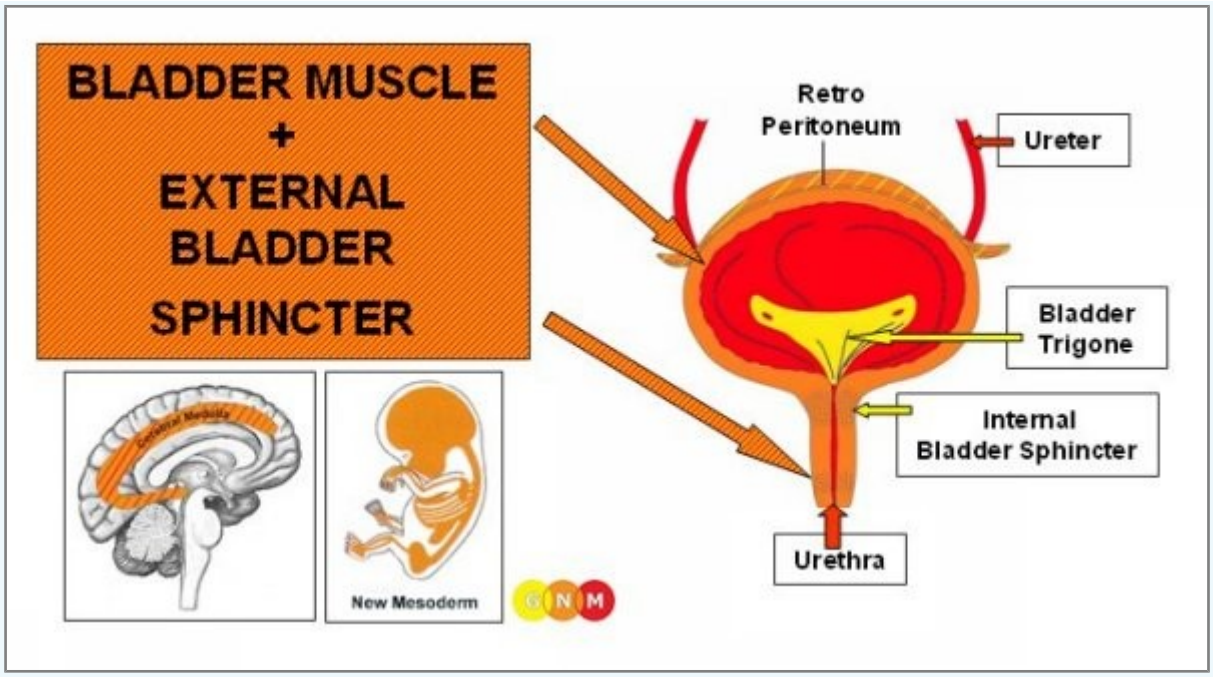


BRAIN LEVEL: The smooth muscle of the internal bladder sphincter is controlled from the**midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to internal bladder sphincter is **not being able to hold back urine**, for example, because of incontinence. Urinary incontinence is one of the most frequent conflicts following aprostate operation.

CONFLICT-ACTIVE PHASE: hypertonus of the internal bladder sphincter. The **biological purpose of the increased muscle tension** is to facilitate holding urine in the bladder.

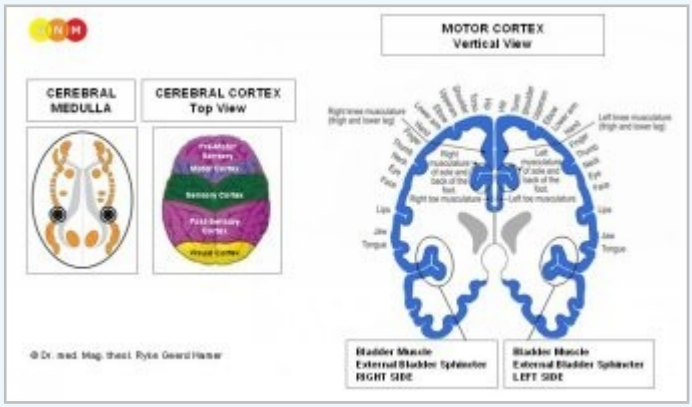
HEALING PHASE: The muscle tension goes back to normal. The Epileptoid Crisis presents as painful **bladder spasms**(see also spasms in the ureters, bladder muscle, bladder mucosa and urethra).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BLADDER MUSCLE AND EXTERNAL BLADDER SPHINCTER: The bladder is a hollow organ for storing urine. The bladder wall consists of muscles which contract during urination forcing urine out of the bladder into the urethra; at the same time, the two sphincters open to allow urine to be expelled. The external bladder sphincter surrounds the lower end of the urethra and is, in addition to the internal bladder sphincter, a second muscular mechanism that regulates the elimination of urine. The striated bladder muscle and external bladder sphincter derive from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.

NOTE: Originally, the bladder consisted only of smooth muscles that developed from intestinal muscles of thegullet. The striated muscles of the bladder developed at a later time together with the external bladder sphincter; both are voluntary muscles that can be consciously controlled.



BRAIN LEVEL: The striated bladder muscle and external bladder sphincter 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 muscle is controlled from the **motor cortex** (part of the cerebral cortex). The right half of the bladder muscle and external bladder sphincter are controlled from the left side of the cerebrum; the left halves are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ. In comparison, the smooth muscles of the internal bladder sphincterare controlled from the midbrain.

NOTE: The bladder muscle and external bladder sphincter, rectum muscles and external rectal sphincter, cervix muscles and cervical

sphincter, and vaginal muscles share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the bladder muscle and external bladder sphincter is "**not being able to sufficiently mark one's place"** (see also external rectal sphincter). The conflict typically occurs when aterritorial marking conflict cannot be resolved for a long period of time. The bladder muscles also relate to a self-devaluation conflict, usually brought on by urinary incontinence.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of bladder muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the bladder muscle** (controlled from the motor cortex). At the same time the external bladder sphincter opens (no necrosis with sphincters!), which increases the urine flow in order to be better able to mark the territory.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

Urinary incontinence, an involuntary outflow of urine, is a sign that a persistent marking conflict is still unresolved. Depending on the intensity of the conflict, the condition ranges from mild leaking (when coughing, sneezing, laughing) to uncontrollable wetting (see also fecal incontinence). A sudden urine outflow also occurs during the Epileptoid Crisis when the bladder sphincter opens. Incontinence often generates self-devaluation conflicts involving adjacent tissues such as the pubic bone or pelvic floor muscles. Hence, weak pelvic floor muscles don't *cause* incontinence but are rather the result of continuing bladder-related self-devaluation conflicts; the same holds true to recurring "bladder infections".

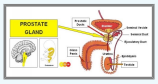
NOTE: External sphincters (external bladder sphincter, external rectal sphincter, cervical sphincter) consist ofstriated muscles, while internal sphincters such as the internal bladder sphincter and internal rectal sphinctercconsist of smooth muscle. External sphincters have an inverse innervation, meaning that they close through contraction in vagotonia, i.e., in the healing phase, and open through relaxation in sympathicotonia, i.e., in the conflict-active phase and Epileptoid Crisis. Regarding the bladder and rectum, during an Epileptoid Crisis, for example throughout an epileptic seizure, both sphincters might open at the same time causing a complete emptying of the bladder together with an involuntary loss of stool.

Bedwetting (noctural enuresis) is the unintentional voiding of urine during sleep. The involuntary urination takes place during the Epileptoid Crisis which typically occurs at night, that is, in vagotonia. With the brief sympathicotonic stress, the bladder sphincter opens causing the urine excretion. Persistent or chronic bedwetting indicates that the person, often children, has continual conflict relapses followed by the "nighttime accident". **NOTE:** A complete emptying of the bladder can happen in the course of any intense Epileptoid Crisis.

HEALING PHASE: During the healing phase the bladder muscle is reconstructed and the bladder sphincter closes. Ifbacteria assist healing, this causes a "**bacterial bladder infection**" (see also bladder trigone and bladder mucosa) with painful **bladder spasms** during the Epileptoid Crisis (see also spasms related to ureters, internal bladder sphincter,bladder and urethra).

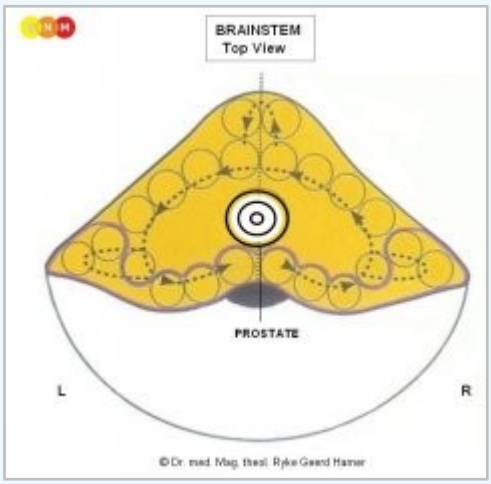
NOTE: All organs that derive from the new mesoderm ("surplus group"), including the bladder muscle, show the**biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict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

MALE SEXUAL ORGANS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PROSTATE GLAND: The prostate is located in the male pelvis just below the bladder. Anatomically, the prostate gland is in the same position as the female uterus. The urethra, which carries both urine and semen, passes through the center of the prostate from where it extends to the head of the penis. The main function of the prostate gland is to secrete seminal fluid (secretory quality). During sexual arousal, a considerable portion of semen is also produced in the seminal vesicle, a sac-like pouch that opens into the ejaculatory duct that joins with the prostatic urethra. Seminal fluid provides sperm cells with energy and aids in their motility. One of the components of prostatic secretion is the so-called PSA-Prostate Specific Antigen (see also "female prostate" or Skene's gland). Prostatic fluid contains the fragrance that gives semen its typical musky scent. In Nature, the odor of the seminal scent-marksignals the female sexual potency and male strength. The prostate gland consists of intestinal cylinder epithelium, originates from the endoderm and is therefore controlled from the brainstem.



BRAIN LEVEL: The prostate gland is controlled from the center of the **brainstem**.

NOTE: The prostate gland and the uterus share the same brain relay.

BIOLOGICAL CONFLICT: Consistent with its vital role in reproduction, the biological conflict linked to the prostate gland concerns procreation (equal to the uterus in females). A man can suffer a **procreation conflict** when he is unable to father children, for instance, due to erectile dysfunction or infertility, including his partner's inability to conceive (female infertility). A vasectomy (surgical sterilization) might invoke a procreation conflict on a subtle psycho-biological level. Males also experience the conflict when their descendants don't reproduce, let's say, because of

a homosexual orientation, staying childless by choice, miscarriages, or abortions. The male prostate also correlates to a **mating conflict**. In the human world, "not being able to mate" or "not being allowed to mate" translates into sexual rejection and feeling sexually unwanted (compare with female mating conflict related to the cervix). Mating conflicts are activated through the loss of a sexual mate or through sexual rivalry (the "fight over a female"). A man's fear that his sexual mate is attracted to another man could already trigger the conflict, especially when the competitor is younger or has more "potential". In addition, the prostate corresponds to a **gender conflict** experienced as an "ugly conflict with a female". Being dominated, controlled, or humiliated by a woman (an imperious wife or mother) or degraded by a female authority (supervisor, judge, lawyer, doctor, police officer, and the like) can go straight to a man's prostate. A spiteful divorce, custody battles, emotional or financial abuse are other possible conflict scenarios. In a broader sense, the prostate-related conflict concerns maleness itself, in the sense of being disregarded as a man, as a lover, as a husband, or as the provider of the family.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase prostate cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the additional cells** is to increase the amount of semen in order to enhance the chance of impregnating a female once a sexual mate becomes available. With prolonged conflict activity (hanging conflict) a growth (secretory type), referred to as a **prostate cancer**, develops as a result of the continuing cell augmentation (compare with "prostate cancer" related to the prostatic ducts). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant".

Hormone therapies, the standard treatment for prostate cancer, are aimed at "slowing the growth of the cancer" by suppressing the production of male hormones such as testosterone (based on the assumption that androgens stimulate prostate cancer cells to grow). Side effects of the drugs are erection problems, breast tenderness, and hot flashes. The reason why the "therapy" seems to work is that the hormonal manipulation changes a man's biological identity. As a result, the originally male conflict (procreation conflict, mating conflict, gender conflict) becomes irrelevant and the prostate tumor shrinks.

During conflict activity the **PSA level rises** at the same rate as the cell proliferation in the prostate gland.

NOTE: Strictly speaking, the term "**PSA-Prostate Specific Antigen"** is a misnomer because so-called PSA is also produced in the liver, lungs, or salivary glands. This explains why men whose prostate has been removed might still show an elevated PSA level. Even female organs such as the breast and the Skene's gland produce "PSA".

Conventional medicine uses PSA as a tumor marker, whereby a serum PSA level higher than 4 ng/ml is regarded as "abnormal". Based on this consensus, prostate cancer became quickly the leading cancer in men, just as breast cancerbecame the most common cancer in women with the introduction of mammography.

Questioning PSA Screening

Founded on latest research, the *American Society of Clinical Oncology* and the *American College of Physicians* concluded that "it is uncertain whether the benefits associated with PSA testing for prostate

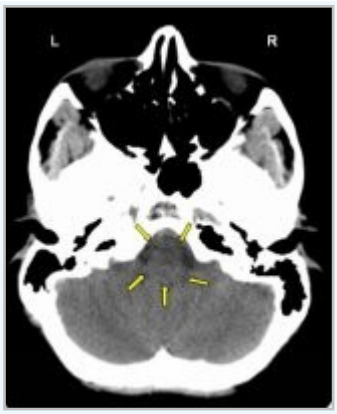
cancer screening are worth the harms associated with screening and subsequent unnecessary treatment." (Journal of Clinical Oncology, August 2012)

Oftentimes, a positive PSA test and a subsequent prostate cancer diagnosis lead to radiation treatments or **surgery**. After a radical prostatectomy (removal of the prostate) most men are left with urinary incontinence and erectile dysfunction, which in turn causes self-devaluation conflicts affecting the bones closest to the prostate. Bone cancer of thepubic bone or lower spine is therefore next to lung cancer (death-fright conflict) the most frequent secondary cancer in men. It has nothing to do with "migrating cancer cells" ("metastasis").

If the prostate tumor is found in the lateral lobes of the prostate, it is usually diagnosed as a "cancer". What is termed**benign prostate hyperplasia** (BHP) is an augmentation of prostate cells in the central portion of the prostate causing a general **enlargement of the prostate gland** (the same diagnostic standard is applied to endometrial hyperplasiarelated to the uterus). Typically the cell proliferation occurs on a flat plane (compare with prostate hyperplasia related to the prostatic ducts). If the swelling presses on the urethra, the **urine flow is delayed and slow** with only small amounts of urine being expelled (see also healing phase). According to Dr. Hamer, a prostate enlargement occurs when aprostate-related conflict becomes more of an overall "issue", for example, if a man feels that he is no longer attracting females as he used to. Also, when a man ages, his testosterone level decreases; so does his sex drive, which can easily cause a mating conflict. These are all factors that explain why "benign prostate hyperplasia" is attributed primarily to older men and why PSA levels tend to increase with age. However, the changes are *always* linked to a biological conflict. This is why not all men have elevated PSA levels when they get older.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. The **discharge** produced during the cell (tumor) breakdown is excreted through the urethra. Thus, the **urine is cloudy**, potentially mixed with blood (as to blood in the urine, see also healing phase related to the bladder trigone, bladder mucosa, renal pelvis and ureters, and kidney parenchyma). Blood might be in the ejaculate as well. The healing process is accompanied by **night sweats**. With an inflammation, the condition is called **prostatitis**. **Candidiasis**involving the male genital organs originates in the prostate, the smegma producing glands, or in the corium skin covering the penis and the scrotum.

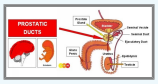
If the swelling is in a location that it presses onto the prostatic urethra, this causes a **delayed and slow urination** (see also conflict-active phase). A large swelling might compress the urethra completely with urine flowing back into the kidneys. Should an obstruction of the urethra arise, Dr. Hamer recommends the use of a catheter until the healing process has been completed and the normal urine flow restored (see also urinary tract obstruction related to the urethra).



This brain CT belongs to a man who is in the healing phase of a prostate cancer. The fluid accumulation (PCL-A) in the prostate relay (view the GNM diagram) occurs parallel to the swelling (edema) on the healing organ.

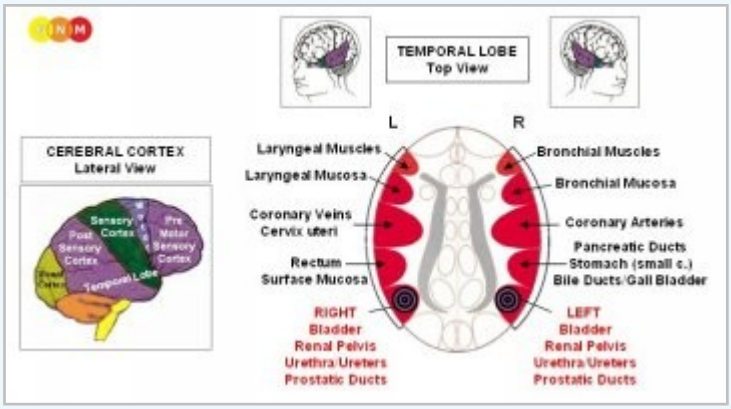
After the completion of the healing phase the prostate gland regains its normal size and the **PSA level returns to normal**. However, with recurring conflict relapses the PSA level fluctuates up and down in synchronicity with the degree of the reactivated conflict.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. The tumor that cannot be broken down eventually encapsulates. As a result the delayed urination becomes permanent. **The PSA level continues to be elevated!** If the tumor blocks the urethra, surgery is inevitable.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PROSTATIC DUCTS: The prostatic ducts lie within the prostate gland. They carry the fluid produced in the prostate into the prostatic portion of the urethra, where the secretion blends with the seminal fluid from the seminal vesicle. During ejaculation, semen empties into the urethra and is expelled through the urethral opening at the tip of the penis. The wall of the prostate and of the prostatic ducts is endowed with smooth muscle. Equal to the intestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth muscles of the prostatic ducts facilitate the flow and elimination of the "semen morsel". The lining of the prostatic ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



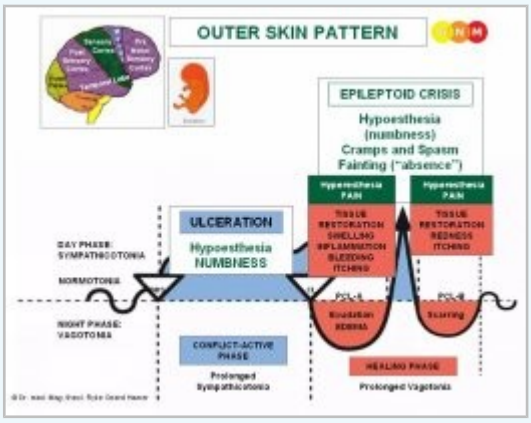
BRAIN LEVEL: The epithelial lining of the prostatic ducts is controlled from the **temporal lobe** (part of the **post-sensory cortex**). The prostatic ducts located next to the right half of the prostatic urethra are controlled from the left side of the cortex; the left prostate ducts are controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The prostatic ducts, renal pelvis,

ureters, bladder, and urethra share the same brain relays and therefore the same biological conflict.

BIOLOGICAL CONFLICT: The biological conflict linked to the prostatic ducts is the same as for the urethra, namely a**territorial marking conflict**. In this case, the marking conflict has a distinctive "prostate quality". A man can suffer the conflict when, for example, his ex-wife doesn't allow him to see his children or when his space is invaded by a sexual rival or by a domineering female.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



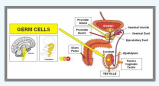
The Biological Special Program of the prostatic ducts follows the**OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration (cell loss) in the lining of the prostatic ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the ducts to improve the flow of prostatic secretion to be better able to mark the (sexual) territory.

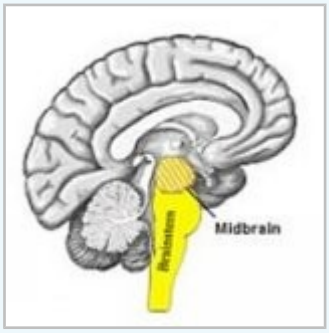
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with swelling due to the edema (fluid accumulation). Water retention brought on by an active abandonment and existence conflict (the SYNDROME) increases the swelling causing an **enlarged prostate**. Conflict relapses delay the completion of the healing process. **NOTE:** Contrary to a prostate enlargement related to the prostate gland, the PSA levelstays within the normal range.

If the preceding conflict-active phase was intense and lasted over a long period of time, the profuse cell proliferation that occurs during PCL-A is diagnosed as an **intraductal prostate cancer** (compare with prostate cancer **related to the**prostate gland). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Gonorrhea (see urethral gonorrhea) can also originate in the prostatic ducts. If the symptoms (inflammation, discharge) are less severe, the condition is usually diagnosed as prostatits.



DEVELOPMENT AND FUNCTION OF THE MALE GERM CELLS: In the human reproductive organs, germ cells are the cellular units that give rise to gametes (sperms and eggs). The primordial germ cells appear first in the yolk sac of the embryo from where they migrate through the developing intestine to the new gonads (testicles or ovaries). In thetesticles, the germ cells form so-called spermatogonia (secretory quality), which are precursor cells of sperms. Beginning with puberty, spermatogonia start to develop into mature sperm cells. This process, called spermatogenesis, takes place in the seminiferous (sperm-producing) tubules of each testicle and continues to old age (oogenesis, the creation of egg cells in the female ovaries, lasts only until menopause). Germ cells derive from the endoderm and are controlled from the midbrain.



BRAIN LEVEL: The male (and female) germ cells are controlled from the **midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to the germ cells is a **profound loss conflict**, often the loss of a child (compare with loss conflict related to the testicles).

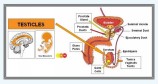
CONFLICT-ACTIVE PHASE: During the conflict-active phase a **testicular teratoma** (secretory type), or **germ cell tumor**, develops in the testicles (see also ovarian teratoma in females). The significance of a teratoma relates to the primeval ability of parthenogenesis, the reproduction without fertilization. The **biological purpose of the additional germ cells** is to facilitate faster reproduction in the emergency of the loss of an offspring. In conventional medicine, a "malignant teratoma" is classified as a **testicular cancer** (compare with "testicular cancer" related to the testicles).

NOTE: The cell proliferation that takes place with the growth of a teratoma is the same as it occurs in thedevelopment of the fetus. During the first three months of pregnancy, the cell increase follows the principle of old brain-controlled organs with cell proliferation in sympathicotonia (conflict-active phase). Starting at the fourth month of gestation, the cell proliferation follows the pattern of cerebrum-controlled organs with cell proliferation invagotonia (healing phase).

HEALING PHASE: With the conflict resolution (CL) the teratoma stops growing only slowly since embryonic tissue develops in spurts ("fetal growth spurt"). During the healing phase, fungi or mycobacteria such as TB bacteria may decompose the teratoma, provided they are available. The swelling filled with pus presents as a **testicular abscess**. The healing process is accompanied by night sweats. If the teratoma remains, the growth encapsulates. Remarkably, an encapsulated teratoma, termed a **dermoid cyst**, might contain structures such as hair, teeth, or bones. Teratoma or dermoids are also found in the spinal area, that is, in close vicinity to where the testicles originate during the fetal development.

„The discovery of the New Medicine began with the death of my sonDirk. On August 18, 1978, Dirk was shot near the Adriatic Island of Cavallo by the Italian Crown prince Emanuel of Savoy. Three and a half months later, on December 7, 1978, Dirk succumbed to his injuries and died in my arms at the University Clinic in Heidelberg…

… now I am aware that on that day, I had suffered a profound loss conflict with the development of a testicular cancer. The biopsy revealed a testicular teratoma. At the time I underwent surgery. Today, with the understanding of the Iron Rule of Cancer, I would certainly never do so…" (Ryke Geerd Hamer)



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE TESTICLES: In the male fetus, the development of the testicles starts in the abdominal cavity at the height of the upper lumbar region, approximately in the same area as the female ovaries. Around the seventh month of gestation, the testes descend into the scrotum. Like the peritoneum that covers the abdominal organs, a peritoneal layer (tunica vaginalis testis) envelops the testicles for protection. The testicles contain germ cellsand interstitial cells (Leydig cells) that are responsible for the production of testosterone as well as small quantities of estrogen. Testosterone is required to transform germ cells into mature sperms with a head and a short tail. The tail allows the sperms to propel into the epididymis at the surface of the testicle, where they are stored up to one month. When a male is sexually aroused, sperms enter the seminal duct. Mixed with the seminal fluids from the prostate glandand the seminal vesicles, semen empties into the urethra and is expelled during ejaculation. The testicles originate from the new mesoderm and are therefore controlled from the cerebral medulla.

BRAIN LEVEL: The testicles are controlled from the **cerebral medulla**, at the area where it adjoins the midbrain. The right testicle is controlled from the left side of the brain; the left testicle is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The testicles and the ovaries share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the testicles is a **loss conflict** concerning the loss of a loved one (the loss conflict related to the male germ cells is more of a primeval nature). The fear of losing a beloved person can already trigger the conflict. The same holds true for the loss of a pet. Constant self-blame after a break-up or death of someone close can keep the conflict active. A loss conflict can also be evoked through an argument, betrayal, or unfaithfulness of a partner or friend. **NOTE:** The loss conflict related to the testicles only concerns a person or a pet and NOT the loss of a home or of a business (see territorial loss conflict).

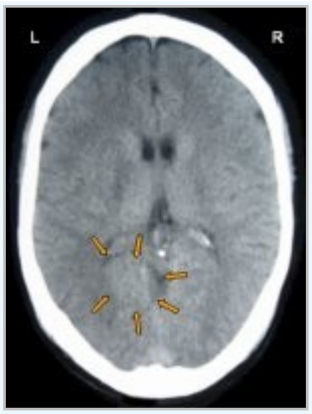
CONFLICT-ACTIVE PHASE: necrosis (cell loss) in the testicle, noticeable as light pulling in the scrotum. Because of the reduction of testosterone-producing cells the **testosterone level decreases** resulting in a **reduced sperm production**(see also low testosterone due to a conflict-related hormonal imbalance). Lasting conflict activity can therefore cause**infertility**, at least until the conflict is resolved.

NOTE: Whether the right or left testicle is affected is determined by a man's handedness and whether the conflict is mother/child or partner-related.

HEALING PHASE: Starting with the conflict resolution (CL) the tissue loss is replenished with new cells. **Healing symptoms** are **pain** and **swelling** in the testicle. An inflammation or "infection" of a testicle (a sign that bacteria assist healing) is called **orchitis**. Conventional medicine claims that adult men who had "contracted mumps" in their teenage years are at risk of developing an inflammation of the testicles and will become infertile as a result of it. Yet, the theory does not explain why the alleged "mumps virus" would "attack" just the testicles; why the right testis or the left or both? However, the distress of not being able to father children, based on the "mumps causes infertility" myth, can certainly trigger a loss conflict.

A special characteristic regarding the healing of the testicles is the development of a **TESTICULAR CYST**. Provided there are no conflict relapses that interrupt healing, the process takes nine months to complete (see also ovarian cyst, kidney cyst, and adrenal cyst). The cyst formation occurs in several steps.

During **PCL-A** a fluid-filled capsule or cyst forms at the site of the necrosis. In order to restore the cell loss that occurred during the conflict-active phase, testicular cells proliferate inside the cyst. At this early stage, the cyst attaches itself to neighboring tissue for blood supply. Found during this period, the "growth" is usually diagnosed as a **testicular cancer**(compare with testicular cancer related to the germ cells). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.



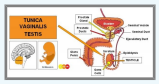
This brain CT shows an indistinct, partly edematous Hamer Focus in the area of the brain that controls the right testicle (view the GNM diagram), corresponding to a testicular cyst on the organ level. For a right-handed male the loss conflict relates to a partner; for a left-hander to his mother or child.

After the Epileptoid Crisis the cyst has lost most of its fluid. In **PCL-B** the **cyst** becomes hard, releases itself from the neighboring tissue and, endowed with blood vessels, **integrates itself completely into the hormone producing function of the testicles**. And this is precisely the **biological purpose**. The increased testosterone production provided by the cyst makes the male more masculine and more fertile, which puts him into an ideal position to attract a female, make up for the loss of a mate or a child, and produce new offspring.

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

If the pressure in a liquid or semi-liquid cyst is too strong, the **cyst might burst**. A blow against the testicles, exploratory puncture, or premature surgery can cause the rupture. When the cyst breaks, the fluid is released into the testicular sack resulting in the formation of new cysts! Hence, according to Dr. Hamer, the **surgical removal** of a testicular cyst should only be performed when the cyst is fully matured (indurated).

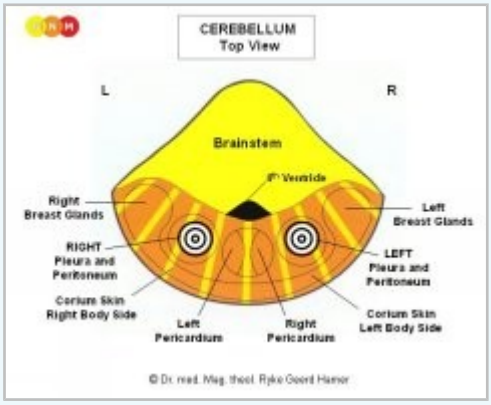
In men with testicular cancer a lymphoma or a bone cancer is frequently found in the upper lumbar spine. They are wrongly assumed to be the result of "metastasizing" cells that have traveled there from the testicles. In reality, the enlarged lymph nodes relate to a self-devaluation conflict brought on by feeling "devalued" as a man, triggered by the cancer diagnosis. The lymphoma develops in the area of the lumbar spine (L 2) where the testicles were originally located. If the self-devaluation conflict is experienced as more severe, it affects the lumbar vertebra.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE TUNICA VAGINALIS TESTIS: Starting at the seventh month of gestation, the testicles move from the abdominal cavity through the inguinal canal into the scrotum drawing a portion of peritoneal tissue (abdominal lining) with it as they descend. The inguinal canal closes shortly after birth. The peritoneal layer covering the testicles is known as the tunica vaginalis testis. Its fluid filled membrane aids the support and protection of the organ. As part of the peritoneum, the tunica vaginalis testis originates from the old mesoderm and

is therefore controlled from the cerebellum.



BRAIN LEVEL: In the **cerebellum**, the tunica vaginalis of the right testicle is controlled from the left side of the cerebellum; the tunica vaginalis of the left testicle is controlled from the right cerebellar hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

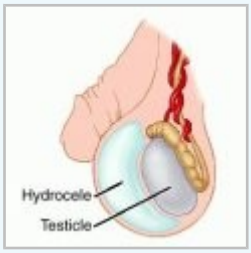
BIOLOGICAL CONFLICT: The biological conflict linked to tunica vaginalis testis is an **attack against the testicles**. Such an attack conflict might occur in the course of an accident, for example, in sports (hockey, soccer) or with an unexpected kick in the testicles. Verbal threats ("I am going to punch you in the balls!") could have the same effect. A testicular cancer diagnosis or surgery on the testicles, perceived as an "attack" concerning the integrity of the organ, can also trigger the conflict.

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the tunica vaginalis proliferate. The **biological purpose of the cell proliferation** is to thicken the peritoneal layer in order to protect the testicle from further attacks. With prolonged conflict activity the additional cells form a lump, considered by conventional medicine as a malignant **testicular mesothelioma** (see also peritoneal mesothelioma, omental mesothelioma, pleural mesothelioma, and pericardial mesothelioma).

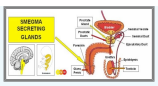
NOTE: Whether the right or left testicle is affected is determined by a man's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the "attacked" testicle.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **pain** because of the swelling and **night sweats**.



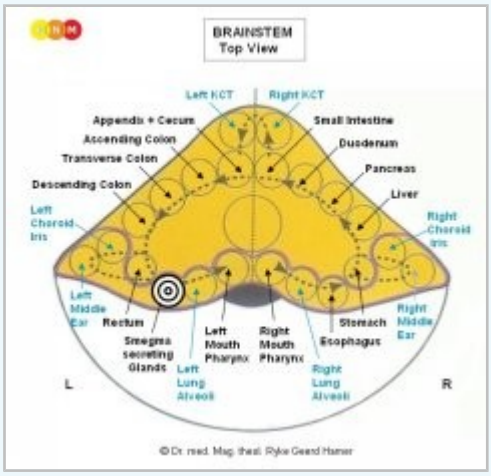
With water retention due to the SYNDROME additional fluid is stored in the membrane of the tunica causing a so-called **hydrocele** ("water in the testicles"). However, an injury to the testicles also causes a hydrocele.

NOTE: If the inguinal canal does not completely close after birth, fluid accumulated in the peritoneum of the abdominal cavity (see ascites) leaks into the scrotum, resulting in a hydrocele. Also, an inguinal canal that does not close properly leaves a weakened area in the groin. Pressure in the abdomen from straining or heavy lifting can cause an **inguinal hernia** – without a DHS (compare with hiatel hernia related to the diaphragm).



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE SMEGMA SECRETING GLANDS: The smegma secreting glands are embedded in the mucus membrane of the inner foreskin that covers the glans penis. The glands secrete a whitish substance (secretory quality) to keep the penis head lubricant during sexual activity (compare with Bartholin's glandsthat lubricate the vaginal opening). The smegma secreting glands originate from the endoderm and are controlled from the brainstem.



BRAIN LEVEL: The smegma producing glands are controlled from the left side of the **brainstem**, next to the control center of the rectum submucosa.

NOTE: The smegma secreting glands, Bartholin's glands, and bladder submucosa (bladder trigone) share the same brain relay.

BIOLOGICAL CONFLICT: The biological conflict linked to the smegma producing glands is "**not being able to penetrate a tight or dry vagina"**.

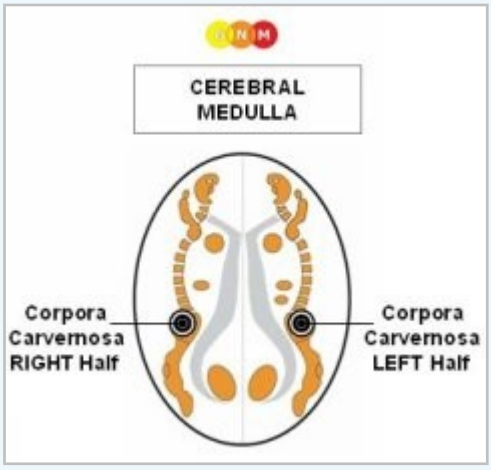
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase smegma producing cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to improve the smegma production to allow easier penetration.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **pain** due to the swelling and **oozing from the foreskin**. If fungi assist healing, this causes "**penile candidiasis"**. The candidiasis symptoms are already *healing* symptoms, hence, the condition cannot be contagious (see venereal diseases)!

Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE CORPORA CAVERNOSA: The penis consists of a root, a shaft and theglans. The corpora cavernosa are two cylinder-shaped chambers that stretch from the pubic bone along the penis shaft to the head of the penis, where they join. They are made of expandable erectile tissue composed mainly of connective tissue. Their core contains a specialized arrangement of blood vessels that fill with blood to achieve an erection. The corpus

spongiosum surrounding the penile urethra is for the most part made of smooth muscle. During ejaculation, the muscles contract in a rhythmic movement to allow the expulsion of the ejaculate. The cavernous body is enveloped by a dense fibrous sheath, known as the tunica albuginea. The corpora cavernosa originates from the new mesoderm and is therefore controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the right half of the corpora cavernosa is controlled from the left side of the cerebral medulla; the left half is controlled from the right cerebral hemisphere (in the pelvis relay - see bones). Hence, there is a cross-over correlation from the brain to the organ.

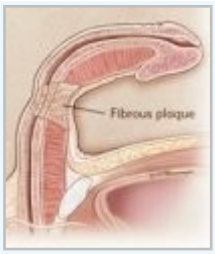
BIOLOGICAL CONFLICT: The biological conflict linked to the corpora cavernosa is a **self-devaluation conflict related to the penis** brought on, for example, by erection problems after a prostate surgery or due to the adverse effects of testosterone suppressing drugs or antidepressants. Condescending remarks regarding a man's sexual performance or the size of his penis, not meeting a partner's sexual expectations, premature ejaculation, and offensive rejections of intercourse or oral sex are other examples of what can make a male feel "worthless there".

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

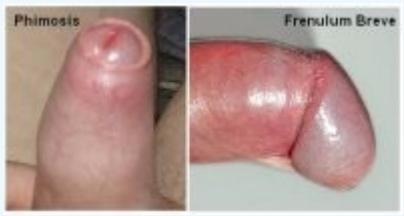
CONFLICT-ACTIVE PHASE: necrosis (cell loss) in the erectile tissue of the penis shaft leading temporarily to an inability to achieve or maintain an erection. For a man unfamiliar with GNM, this typically prompts further penis self-devaluations leading to chronic **erectile dysfunction** (see also erectile dysfunction related to the penile arteries). The physical impotence does not affect a male's sex drive, since the testosterone level is in the normal range.

NOTE: The penile erection is controlled from the parasympathetic nervous system, ejaculation from thesympathetic nervous system. Hence, the male sex drive is activated in vagotonia. This is why a man cannot have an erection under stress or with intense conflict activity of any biological conflict. The same applies to females (see also vaginal lubrication).

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is restored with new cells and the erectile function returns to normal. However, when the healing process is prolonged due to constant conflict relapses, the excess scar tissue affects eventually the flexibility of the penis.



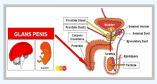
The accumulation of fibrous plaque and hard lumps in the tunica albuginea, the sheath surrounding the corpora cavernosa, causes a permanent bend of the penis. This condition is termed **Peyronie's disease**. If a baby boy is born with a curvature of the penis, this reveals that he (perhaps preferred by his mother or parents to be a "she") had suffered a penis self-devaluation in the womb.



Phimosis, the inability to fully retract the **foreskin** over the glans, and **frenulum breve**, a shortening of the **frenulum** restricting the movement of the foreskin, relate, in GNM terms, to self-devaluation conflicts experienced as "I am worthless *there*!"

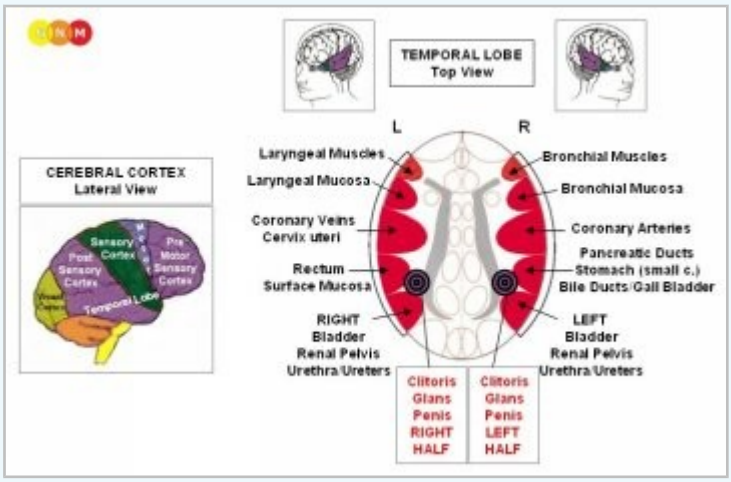
The connective tissue of the foreskin and of the frenulum derives from the new mesoderm and is controlled from the same area in the cerebral medulla as the corpora cavernosa.

Genital warts relate to a sexual separation conflict involving the epidermis of the penis.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE GLANS PENIS: The glans penis forms the bulbous-shaped head of the penis shaft. The foreskin covering the glans is a retractable double layer of epidermal tissue enfolding the glans. The foreskin is continuous with the penis skin. The inner foreskin contains smegma secreting glands. The frenulum on the underside of the penis is a small elastic band that allows pulling the foreskin over the glans to protect the urethral opening at the tip of the penis. The glans penis consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex. **NOTE:** The glans penis is covered by an epidermal skin layer but not endowed with a corium skin(under skin).



BRAIN LEVEL: The glans penis is controlled from the **post-sensory cortex** (part of the cerebral cortex). The epidermiscovering the glans is controlled from the sensory cortex (see brain relays of external genitals).

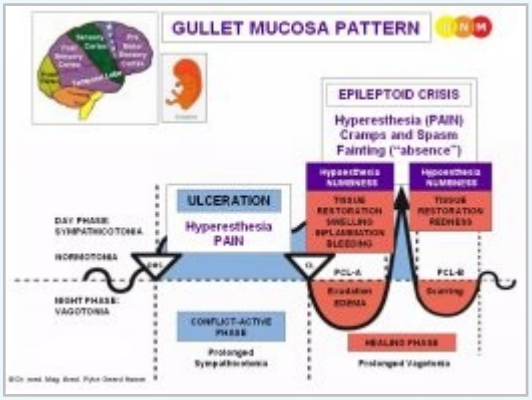
The right half of the glans penis is controlled from the left side of the post-sensory cortex (between the rectum and left bladderrelays); the left half is controlled from the right cortical hemisphere (between the stomach and right bladder relays). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The glans penis and glans clitoris share the same brain relays. Their

control centers are located outside of the temporal lobe, hence, the principle of gender, laterality, and hormone statusdoes not apply.

BIOLOGICAL CONFLICT: The biological conflict linked to the glans penis is a **severe separation conflict associated with the penis**, experienced, for example, with the loss of a sexual mate or harsh sexual rejection (see also sexual separation conflict related to the epidermis of the penis and scrotum). The conflict also refers to not wanting to be touched at the penis (sexual abuse, sexual molestation, rough handling, unpleasant oral sex, a fear of contracting avenereal disease) or not being allowed to be touched, including touching oneself (a DHS triggered when caught masturbating). The surgical procedure of male circumcision can also prompt a **penis conflict**.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the glans penis follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

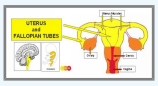
NOTE: With the exception of the glans penis and clitoris, the external genitals follow the Outer Skin Pattern since they are controlled from thesensory cortex.

CONFLICT-ACTIVE PHASE: ulceration (cell loss) in the epithelial lining of the glans. During conflict activity the penis head is overly sensitive to touch (**hypersensitivity**).

HEALING PHASE: During the healing phase the ulceration is replenished with new cells. The healing process manifests as **hyposensitivity** (numbness) of the glans with decreased or, if the conflict was intense, a complete loss of sensitivity. The hypersensitivity is briefly reactivated during the Epileptoid Crisis. With the completion of the Biological Special Program the penile sensitivity returns to normal.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare with hypoglycemiarelated to the islet cells of the pancreas).

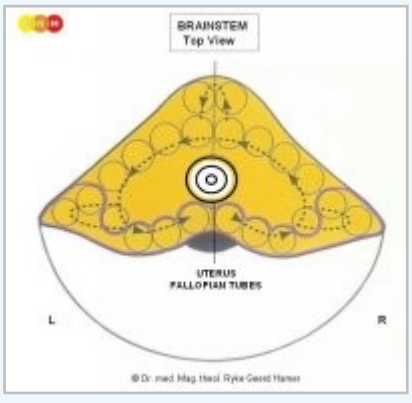
FEMALE SEXUAL ORGANS



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE UTERUS AND FALLOPIAN TUBES: The uterus (corpus uteri) is located in the female pelvis behind the urinary bladder. Anatomically, the uterus is in the same position as the male prostate. The uterus is held in place by uterine muscles, known as the myometrium. The outer layer of the uterus (perimetrium) consists of a peritoneal membrane that gives additional support to the organ. Throughout the menstrual cycle, the endometrium (inner lining of the uterus) grows a tissue layer rich of blood vessels to provide an optimum environment for an embryo. If the fertilization of the egg does not occur the endometrial lining is shed and expulsed during menstruation. The uterus opens into the vagina through the cervix, or "neck of the uterus" (cervix uteri). Two fallopian tubes connect the uterus with the ovaries. The tubes produce a secretion (secretory quality) that aids to carry sperm and the fertilizedovum to the uterus, where the blastocyst adheres to the endometrium. Next to nourishing the developing fetus, the uterus secrets prostaglandin (secretory quality), a hormone-like substance that stimulates uterine contraction at the beginning of labor. The uterus and fallopian tubes consist of intestinal cylinder epithelium, originate from the endodermand are controlled from the brainstem.

NOTE: At first, the female reproductive system had two uteri that eventually grew together forming one single organ. Two uteri also form initially in the human embryo fusing into a single uterus during the development of the female fetus. The same process takes place with the originally two bladders.



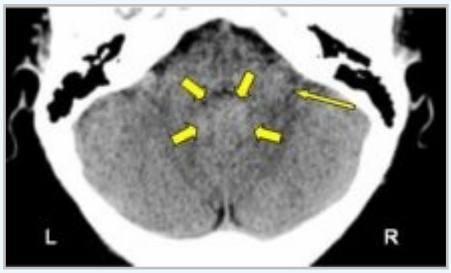
BRAIN LEVEL: The uterus and fallopian tubes are controlled from the center of the**brainstem**.

NOTE: The uterus, fallopian tubes, and the prostate share the same brain relay.

BIOLOGICAL CONFLICT: The biological conflict linked to the uterus and fallopian tubes is a **procreation conflict**(equal to the prostate-related conflict in males) or an "**implantation conflict"** (compare with mating conflict related to the cervix). Hence, a miscarriage, an abortion, not getting pregnant (see also uterus muscles) as well as the loss of a child or grandchild (compare with loss conflict related to the ovaries) can trigger the conflict. In addition, the uterus and fallopian tubes

correspond to a **gender conflict** experienced as an "ugly conflict with a male". Feeling humiliated by a man (physical, sexual, or emotional abuse), verbal insults, disrespectful treatment by a partner, spouse, male relative or friend, offensive behaviour of a colleague, or harassment by a former boy friend, ex-spouse (after an "ugly" divorce), or a male authority (supervisor, doctor, judge, policeman, etc.) are possible conflict scenarios. A distressing gynaecological exam could also provoke the conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the uterus proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to thicken the uterus mucosa to aid the implantation of the fertilized egg. With prolonged conflict activity (hanging conflict) a cauliflower-shaped growth (secretory type), referred to as a **uterus cancer (endometrial cancer)**, forms as a result of the continuing cell augmentation. If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as "malignant"; below that limit the growth is regarded as "benign" or diagnosed as an **uterine polyp** (see alsohealing phase). A growth that develops on a flat plane is termed **endometrial hyperplasia** (the same diagnostic standard is applied to prostate cancer and prostate hyperplasia). There are no symptoms during the conflict-active phase. In the fallopian tubes, however, a compact growth (secretory type) might temporarily obstruct the affected tube causing**pain, especially during ovulation** (also in the healing phase).



On this brain CT we see a Hamer Focus in the uterus relay (view the GNM diagram) corresponding to a uterus cancer. The Hamer Focus in the control center of the liver(on the right brainstem hemisphere) shows the impact of a starvation conflict, which occurred most likely together with the conflict related to the uterus.

HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer needed. The healing process is accompanied by night sweats. When fungi assist healing, this causes**uterine candidiasis** (compare with vaginal candidiasis related to the Bartholin's glands). The discharge produced during the cell (tumor) breakdown is excreted through the vagina. The discharge is white (cheese-like), has a distinct foul-smelling odor, and might contain blood. **NOTE:** The "**vaginal discharge"** originates in the uterus or fallopian tubes and not, as assumed, in the vagina since the vaginal canal is not endowed with an endodermal submucosa and subsequently not populated by fungi or bacteria.

Endometritis (not to be confused with endometriosis) is an inflammation in the uterus with painful swelling. With concurrent water retention (the SYNDROME) as a result of an active abandonment and existence conflict the swelling increases and so does the pain. In the fallopian tubes, the swelling could temporarily block the affected tube (see alsoconflict-active phase). Since the fallopian tubes are permeable, the discharge produced during the decomposing process might leak into the abdominal cavity. A tubal inflammation is called **salpingitis** or **adnexitis** (the same medical term is used for an inflammation of the ovaries). Whether the conflict affects the right or left fallopian tube is random.

With an intense healing phase the outer wall of the uterus tumor might break resulting in acute **bleeding or hemorrhaging**, particularly during menstruation when the tumor removal concurs with the shedding of the decidua (endometrial lining). Hence, **heavy menstrual bleeding (menorrhagia)** might point to relapses (tracks) of a uterus-related conflict (see also heavy periods related to the uterus muscles, ovaries, and cervix mucosa). Light bleeding accompanies healing when the preceding conflict activity was less intense or if a woman is already postmenopausal or is not menstruating at the time when healing takes place.

If the **required microbes are not available upon the resolution of the conflict**, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In conventional medicine this is usually diagnosed as a "benign cancer" or a **uterine polyp** (see alsoconflict-active phase).

Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE UTERUS MUSCLES: The middle layer of the uterus, known as the myometrium, makes up most of the uterus volume. The myometrium is for the most part composed of smooth muscle. The main function of the uterus muscles is to hold the fetus and to aid its delivery during childbirth. The hormone oxycotin, produced in the pituitary gland, induces the contraction of uterus muscles during labor. The uterus muscles derive from the endoderm and are controlled from the midbrain.

NOTE: Like every Biological Special Program of Nature, a **pregnancy** progresses in two phases. Throughout the first three months of pregnancy the muscle tension increases (sympathicotonia) to secure the newly implanted embryo. However, in order to prevent a premature birth, the uterus muscles relax for the duration of the remaining six months of gestation (vagotonia). Unexpected distress (conflict activity) experienced by the unbornor by the mother can therefore cause a miscarriage. Starting at the onset of labor, the uterus muscles contract (prolonged tonic cramps) with simultaneous rhythmic, clonic, peristaltic motions (equal to an intestinal colic) to facilitate delivery (see also cervix muscles, cervical sphincter and vaginal muscles). From an evolutionary point of view, the tonic-clonic labor contractions became the blueprint for the Epileptoid Crisis of the striated muscles.

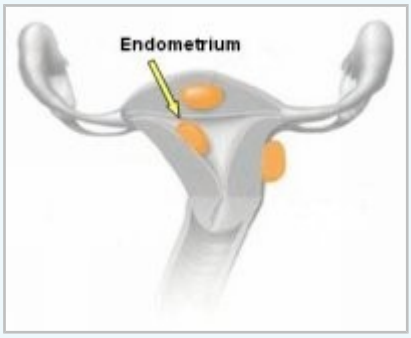
BRAIN LEVEL: The uterus muscles are controlled from the **midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to the uterus muscles is "**not being able to hold the fetus"**(complications during pregnancies, miscarriages, abortions; see also cervix muscles) or **not getting**

pregnant (compare with procreation conflict related to the uterus). Hence, not being able to have children because of an early menopause, the removal of both ovaries, infertility, a mate's infertility or erectile dysfunction, difficulties conceiving, or an unfulfilled desire to have (more) children are typical conflict situations. Having the "tubes tied" (tubal ligation), the use of an IUD to prevent pregnancy, or taking contraceptives might invoke the conflict on a subtle psycho-biological level. A woman can experience the conflict also with or in behalf of a female member of the group (her daughter or granddaughter, a close female relative or friend).

CONFLICT-ACTIVE PHASE: cell proliferation with the formation of **uterine fibroids (fibromyomas or leiomyomas)**. The **biological purpose of the additional muscle tissue** is to increase the tension (hypertonus) and to strengthen the uterus muscles in order to be better able to hold the fetus or to facilitate delivery. The size of the fibroid(s) is determined by the degree and duration of conflict activity.

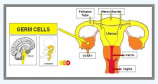
HEALING PHASE: The muscle tension normalizes. However, to secure procreation the **fibroids remain past the completion of the healing phase**.



Fibroids located close to the endometrium of the uterus can cause acute **bleeding**, particularly during the Epileptoid Crisis, and **heavy menstrual periods** since the fibroids are covered by the endometrial lining that is shed during menstruation (see also heavy periods related to the uterus mucosa, ovaries, and cervix mucosa).

With the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict involving the kidney collecting tubules, the retained water increases the size of fibroid(s). A large growth in the uterus musculature might be diagnosed as a **myometrial sarcoma**.

Uterine prolapse: The uterus is also held in place by ligaments. A lasting self-devaluation conflict ("I am not good enough *there*!") weakens the structures causing the uterus to descend into the vaginal canal.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF FEMALE GERM CELLS: In the human reproductive organs, germ cells are the cellular units that give rise to gametes (eggs and sperms). The primordial germ cells appear first in the yolk sac of the embryo from where they migrate through the developing intestine to the new gonads (testicles or ovaries). In theovaries, the germ cells form so-called oogonia (secretory quality) that are precursor cells of oocytes from which an egg or ovum develops. This process, called oogenesis, takes place during the development of the fetus. Thus at birth, the female infant is born with the entire number of eggs (in males, spermatogenesis, the production of sperms, continues throughout life).

Starting with puberty, each month during ovulation a mature egg is released into the fallopian tube for fertilization (ovulation is stimulated by the LH-Luteinizing Hormone produced in the pituitary gland). After the discharge of the ovum, the **corpus luteum** ("yellow body"), a hormone-producing cell cluster in the ovaries, secretes progesterone that helps to prepare the uterus and uterus muscles for pregnancy and to maintain gestation. It also plays a role in the development of the breast glands in preparation for nursing (this is why progesterone in birth control pills leads to breast growth). The corpus luteum as well as the germ cells derive from the endoderm and are controlled from the midbrain.

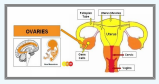
BRAIN LEVEL: The female (and male) germ cells are controlled from the **midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to the germ cells is a **profound loss conflict**, often the loss of a child (compare with loss conflict related to the ovaries).

CONFLICT-ACTIVE PHASE: During the conflict-active phase an **ovarian teratoma** (secretory type), or **germ cell tumor**, develops from the corpus luteum (see also testicular teratoma in males). The significance of a teratoma relates to the primeval ability of parthenogenesis, the reproduction without fertilization. The **biological purpose of the additional germ cells** is to facilitate faster reproduction in the emergency of the loss of an offspring. In conventional medicine, a "malignant teratoma" is classified as an **ovarian cancer** (compare with "ovarian cancer" related to theovaries).

NOTE: The cell proliferation that takes place with the growth of a teratoma is the same as it occurs in thedevelopment of the fetus. During the first three months of pregnancy, the cell increase follows the principle of old brain-controlled organs with cell proliferation in sympathicotonia (conflict-active phase). Starting at the fourth month of gestation, the cell proliferation follows the pattern of cerebrum-controlled organs with cell proliferation invagotonia (healing phase).

HEALING PHASE: With the conflict resolution (CL) the teratoma stops growing only slowly since embryonic tissue develops in spurts ("fetal growth spurt"). During the healing phase, fungi or mycobacteria such as TB bacteria may decompose the teratoma, provided they are available. The swelling filled with pus presents as an **ovarian abscess**. The healing process is accompanied by night sweats. If the teratoma remains, the growth encapsulates. Remarkably, an encapsulated teratoma, termed a **dermoid cyst**, might contain structures such as hair, teeth, or bones.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE OVARIES: The ovaries are located at the right and left side of the uterus to which they attach through cord-like ligaments. During a woman's monthly cycle, an egg, formed from primordial germ cells, grows into a tiny sac, called a follicle. At the time of ovulation, the follicle breaks open allowing the ovum to be released and travel from an ovary through the fallopian tube to meet a sperm for fertilization. After about six days, the fertilized egg or blastocyst implants in the uterine cavity. The **corpus luteum**, a progesterone-producing cell cluster in the ovaries, facilitates pregnancy. The ovarian tissue contains interstitial cells resembling those of the testicles. The interstitial cells are responsible for the production of estrogen and small quantities of testosterone. Estrogen plays a significant role in a woman's sex drive and "readiness to mate". The ovaries originate from the new mesoderm and are therefore controlled from the cerebral medulla.

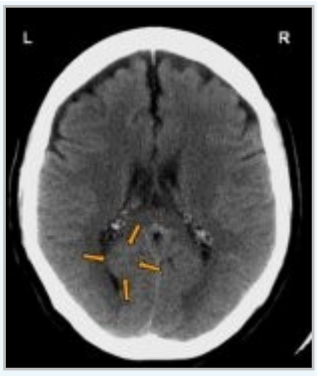
BRAIN LEVEL: The ovaries are controlled from the **cerebral medulla**, at the area where it adjoins the midbrain. The right ovary is controlled from the left side of the brain; the left ovary is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The ovaries and the testicles share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the ovaries is a **loss conflict** concerning the loss of a loved one (the loss conflict related to the female germ cells is more of a primeval nature). The fear of losing a beloved person can already trigger the conflict. The same holds true for the loss of a pet. Constant self-blame following a break-up or the death of someone close can keep the conflict active. Women also suffer loss conflicts after miscarriages or coerced abortions (compare with implantation conflict related to the uterus). A loss conflict can be activated through an argument, betrayal, or unfaithfulness of a partner or friend. **NOTE:** The loss conflict related to the ovaries only concerns a person or a pet and NOT the loss of a home or of a business (see separation conflict related to the milk ducts).

CONFLICT-ACTIVE PHASE: necrosis (cell loss) in the ovary. Because of the reduction of estrogen-producing cells the**estrogen level decreases** (see also low estrogen due to a conflict-related hormonal imbalance). Depending on the intensity of the conflict, prolonged conflict activity results in **irregular periods**, a **delayed menarche** (first menstruation), **amenorrhea** (absence of menstruation), or **infertility** until the conflict is resolved (see also cervix). The "loss" of the unconceived child can lead to lasting infertility.

NOTE: Whether the right or left ovary is affected is determined by a woman's handedness and whether the conflict is mother/child or partner-related.



On this brain scan we see an active Hamer Focus (sharp target ring) in the area of the brain that controls the right ovary (view the GNM diagram) - compare with brain CT below. For aright-handed female the related loss conflict is associated with a partner, for a left-handedfemale with her mother or child.

HEALING PHASE: Following the conflict resolution (CL), the tissue loss is replenished with new cells, ideally assisted bybacteria such as streprococcus bacteria. **Healing symptoms** are **pain** caused by the swelling. An inflammation or "infection" of the ovaries is called **adnexitis** (the same medical term in used for an inflammation of the fallopian tubes).

A special characteristic regarding the healing of the ovaries is the development of an **OVARIAN CYST**. Provided there are no conflict relapses that interrupt healing, the process takes - like a pregnancy - nine months to complete (see alsotesticular cyst, kidney cyst, and adrenal cyst). The cyst formation occurs in several steps.

During **PCL-A** a fluid-filled capsule or cyst forms at the site of the necrosis. With water retention (the SYNDROME) brought on by an active abandonment and existence conflict an ovarian cyst can become quite large since the retained water is exceedingly stored in the healing area. Large cyst(s) cause considerable **pain and heavy menstrual bleeding**(see also uterus mucosa, uterus muscles, and cervix mucosa). What is termed "**polycystic ovaries**" (PCO) points to multiple loss conflicts resulting in "many" cysts.

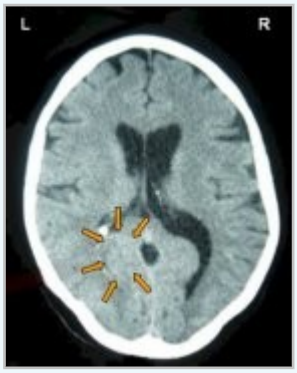
In order to restore the cell loss that occurred during the conflict-active phase, ovarian cells start to proliferate inside the cyst. At this early stage, the cyst attaches itself to neighboring tissue for blood supply; adhering to adjacent tissues also stabilizes the cyst. Detected during this period, the "growth" is diagnosed, in conventional medicine terms, as an"**invasive or infiltrating" ovarian cancer** (compare with ovarian cancer related to the germ cells) and wrongly assumed to "metastasize" to nearby organs. Based on the Five Biological Laws, the new ovarian cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

NOTE: Conventional medicine uses a "cancer antigen" called CA 125 as a tumor marker for ovarian cancer. Like the PSA test, the CA 125 screening test is unreliable and inconclusive. "The problem is that while CA 125 is produced by epithelial ovarian cancer cells, it is also made by normal cells. Some people have naturally high levels of CA 125. In many cases, inflammation or irritation of tissues in the abdomen, or conditions including uterine fibroids can cause CA 125 levels to rise. Endometriosis, liver ailments including hepatitis and cirrhosis, and pelvic inflammatory disease can also affect CA 125 levels. On the other hand, 10 to 20 percent of ovarian cancer patients have normal levels of CA 125 when their tumors are diagnosed. One study found that among patients with stage 1 ovarian cancer, fewer than half had abnormal levels of CA 125." (Special Report: Tumor Marker CA 125)

After the Epileptoid Crisis the cyst has lost most of its fluid. In **PCL-B** the **cyst** becomes hard, separates from the neighboring tissue and, endowed with blood vessels, **integrates itself completely into the hormone-producing**

function of the ovaries. And this is precisely the **biological purpose**. The boost of estrogen provided by the cyst makes the female who has lost an offspring or a mate more attractive, increasing at the same time her readiness to mate, which puts her into an ideal position to make up for the loss and become pregnant again.

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



This brain CT shows swelling (edema) in the brain relay of the right ovary (view the GNM diagram), pushing into the left lateral ventricle. The CT confirms the presence of an ovarian cyst on the organ level (compare with CT scan above).

If the pressure in a liquid or semi-liquid cyst becomes too strong, the **cyst might burst**. Water retention due to theSYNDROME, a blow against the abdomen, a fall or accident, exploratory puncture, or premature surgery can cause the rupture. When the cyst breaks, the fluid passes into the abdominal cavity with the released ovarian cells attaching to the abdominal wall (peritoneum) or an abdominal organ such as the bladder or rectum. In this case the cyst development takes place outside the ovary. This is what is erroneously termed **endometriosis**. According to conventional medicine, endometriosis is a "growth of endometrial tissue outside of the uterus". However, Dr. Hamer's brain scan analyses demonstrate that every woman with endometriosis shows the Hamer Focus not in the brainstem from where the endometrium (inner lining of the uterus) is controlled but rather in the cerebral medulla, namely in the area of the brain that controls the ovaries (see CT scan above). This also explains why endometriosis increases a woman's estrogen level, a fact that so far could not have been explained.

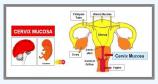
Dr. Hamer strongly advises that an ovarian cyst should only be removed when the cyst is fully matured (indurated).**Surgery** on a semi-liquid cyst disseminates the ovarian cells into the abdominal area causing unnecessary complications. In conventional medicine, the "spreading tumor cells" are usually interpreted as "metastasis". Moreover, the announcement of the surgery and the actual operation might trigger an "attack conflict" resulting in the development of aperitoneal mesothelioma, a tumor on the abdominal wall at the site of the surgery. The fear of cancer and hospitalization can provoke an existence conflicts, leading to the development of an ascites (water retention in the abdomen), which is often seen in women after a diagnosis with ovarian cancer.

NOTE: The removal of the ovaries, habitually performed with a hysterectomy (ablation of the uterus), drastically changes a woman's hormone status and subsequently her biological identity (see gender, laterality, and hormone status).

Are Hysterectomies too common?

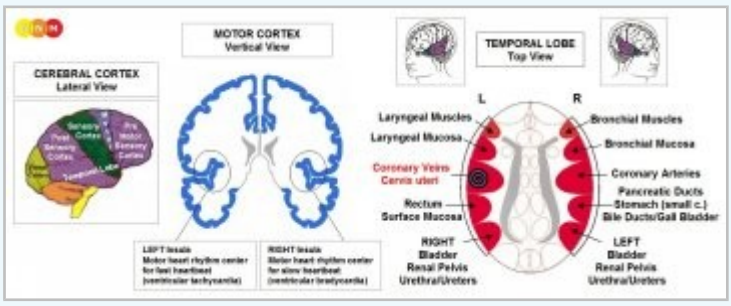
More than **600,000 American women this year** will undergo a hysterectomy, or removal of the uterus. That rate is among the highest in the industrialized world, By age 60, one in three women in den U.S. will have had the surgery, and in more cases than not, they will also have had their **ovaries and fallopian tubes removed during the procedure**. Doctors have long turned to hysterectomy as a treatment for conditions that range from heavy periods to ovarian cancer, but **its widespread use concerns some critics who say it's tantamout to female castration**.

TIME MAGAZIN, July 17, 2007



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CERVIX MUCOSA: The cervix uteri or "neck of the uterus" is the lower portion of the uterus that leads into the cervical canal. The orifice of the cervix opens into the top end of the vaginaallowing sperm and menstrual fluid to move through. The cervix is surrounded by a cylinder-shaped muscular structure, the orifice by a sphincter muscle. The inner lining of the cervix is a mucous membrane that secrets fluids, mainly water, to keep the cervical canal moist. The cervix mucosa consists of squamous epithelium, originates from the ectoderm andis therefore controlled from the cerebral cortex.



BRAIN LEVEL: The cervix mucosa is controlled from the **left insula** (part of the **temporal lobe**). The insula is located deep in the cerebral cortex, exactly at the point where the four cerebral cortices meet (pre-motor sensory cortex, motor cortex, sensory cortex, post-sensory cortex).

NOTE: The cervix mucosa and the coronary veins share the same brain relay and therefore the same biological conflict. Hence, in females, the Biological Special Programs run simultaneously.

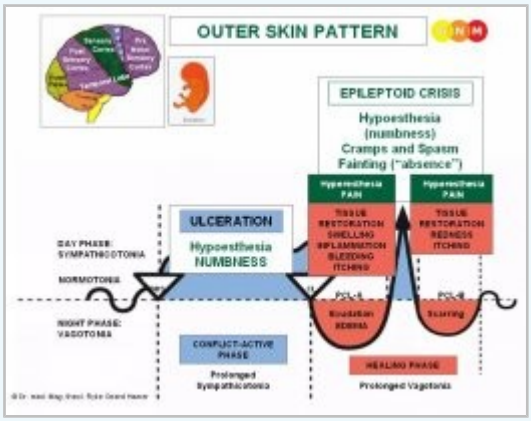
BIOLOGICAL CONFLICT: The biological conflict linked to the cervix mucosa is a **sexual conflict** or **mating conflict**(meaning, in biological terms, that reproduction is at stake). In comparison, the conflict associated with the uterus is foremost about "implantation"; in males, the mating conflict corresponds to the prostate.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A sexual conflict refers to any **distress concerning sexuality**. This includes painful (first-time) sex, sexual abuse, sexual harassment, unwanted sexual practices, sexual rejection, feeling sexually unwanted, a lack of sexual activity because of an

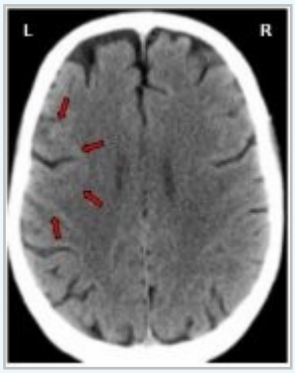
unexpected separation or loss of a mate. Offensive pornography, finding out that the partner or spouse is sleeping with someone else, or interruptions during sexual intercourse can trigger the conflict. As a result of early sexualization girls experience nowadays the conflict at a very young age. Tubal ligation ("tied tubes"), the use of an IUD, or taking contraceptives to prevent a pregnancy might invoke a sexual conflict on a subtle psycho-biological level.

NOTE: If a woman has a low estrogen status, for example after menopause, she is no longer able to experience a mating conflict in biological terms. She will therefore respond to sexual distress more likely with the uterus. This explains, why according to epidemiological studies, 90% of women with uterus cancer are over 50 years of age.



The Biological Special Program of the cervix mucosa follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration of the cervix mucosa proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the cervix, so when mating takes place more sperm can reach the uterus which enhances the chance of conception. The conflict affects at the same time the coronary veins. The ulceration of the coronary veins intima causes **moderate angina pectoris**. **NOTE:** During conflict activity, the female is manic.



This CT scan shows a Hamer Focus in the area of the brain that controls the cervix (view the GNM diagram). The sharp border indicates that the woman is active with a sexual conflict.

With the impact of the conflict on the left side of the temporal lobe (female conflict area) the**estrogen level decreases**. In GNM, we speak in this case of a conflict-related hormonal imbalance. Depending on the intensity of the conflict, lasting conflict activity results in**irregular periods, a delayed menarche** (first menstruation), **amenorrhea** (absence of menstruation), or **infertility** until the conflict is resolved (see also ovaries).

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. In conventional medicine, a profuse cell proliferation is diagnosed as a **cervical cancer**. Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **pain** and **bleeding from the cervix**, ranging from mild to severe. A prolonged, intense healing process (hanging healing) causes long **and**

heavy menstrual periods (see also uterus mucosa, uterus muscles, andovaries). Throughout the Epileptoid Crisis, the muscles in the inner wall of the cervical canal contract with **painful cramps**. Other symptoms of the Epi-Crisis are a **rapid heart beat** (tachycardia) since the coronary veins undergo the healing crisis at the same time.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare with hypoglycemiarelated to the islet cells of the pancreas).

In PCL-B, the swelling in the cervix slowly subsides; so does the bleeding and the pain. **Cervical warts**, also called**genital warts** or **condyloma**, are the result of continuous conflict relapses (see also vaginal warts).

The **PAP TEST** is a cancer screening test that checks for changes in the cervical tissue. Hence, the test can be positive ("pre-cancerous") in the conflict-active phase (ulceration in the cervical mucosa) as well as in the healing phase (restoration of the squamous epithelial layer of the cervix through cell proliferation). None of these changes are "abnormal" but occur naturally during the two phases of the Biological Special Program. Like the PSA test, a Pap test is just a marker indicating the degree of conflict activity or healing.

The medical industry claims that cervical cancer is caused by the so-called **Human Papilloma Virus** (HPV), allegedly transmitted through sexual contact (see venereal diseases). In 2006, the FDA approved the vaccine *Gardasil* to supposedly "protect" teen girls against "cervical cancer". The vaccine is also imposed on boys at the ages of 9 to 12 to "prevent the spread of the HPV infection".

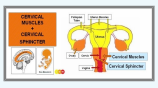
"The cervical cancer risk in the U.S. is already extremely low, and vaccinations are unlikely to have any effect upon the rate of cervical cancer in the United States. In fact, 70% of all HPV infections resolve themselves without treatment in a year, and the number rises to well over 90% in two years." (Dr. Diane Harper)

Dr. Diane Harper was a leading expert responsible for the Phase II and Phase III safety and effectiveness studies which secured the approval of the human papilloma virus (HPV) vaccines, Gardasil™ and Cervarix™. She is now the latest in a long string of experts who are pressing the red alert button on the devastating consequences and irrelevancy of these vaccines. Dr. Harper made her surprising confession at the 4th International Conference on Vaccination which took place in Reston, Virginia, in 2015.

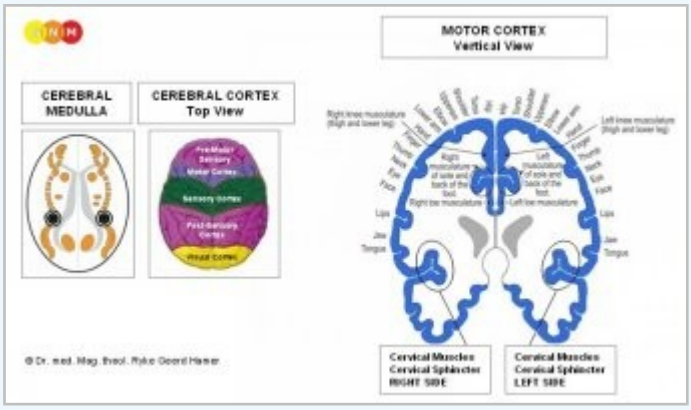
Source: The Daily Sheeple, Aug 20, 2015

"As with HIV, hepatitis, Sars, Polio, H5N1, H1N1–
a HPV has never been isolated and scientifically proven."

T. Engelbrecht and C. Koehnlein, Virus Mania, 2007



DEVELOPMENT AND FUNCTION OF THE CERVICAL MUSCLES AND CERVICAL SPHINCTER: The cervix is surrounded by a body of muscles with a sphincter muscle at the opening into the vagina. During labor, the cervical muscles contract and the sphincter opens to aid the delivery of the child (see also uterus muscles and vaginal muscles). The same occurs during the female orgasm where the cervical sphincter relaxes so that the penis can penetrate easily into the cervix with the cervical muscles holding the penis tight. The cervical muscles and the cervical sphincter are composed of striated muscles, originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The cervical muscles and cervical sphincter 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 right half of the cervical muscles and cervical sphincter are controlled from the left side of the cerebrum; the left halves are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The cervical muscles and cervical sphincter, vaginal muscles,bladder muscle and external bladder sphincter, rectum muscles and external rectal sphincter share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the cervical muscles and cervical sphincter is "**not being able to sufficiently hold the fetus"** (difficult pregnancy, fear of miscarriage, abortions; see also uterus muscles) or "**not being able to hold the penis tight enough during intercourse**" (compare with vaginal muscles). The conflict is similar to a self-devaluation conflict.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of cervical muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis or weakness of the cervical muscles** (controlled from the motor cortex). At the same time, the cervical sphincter opens (no necrosis with sphincters!).

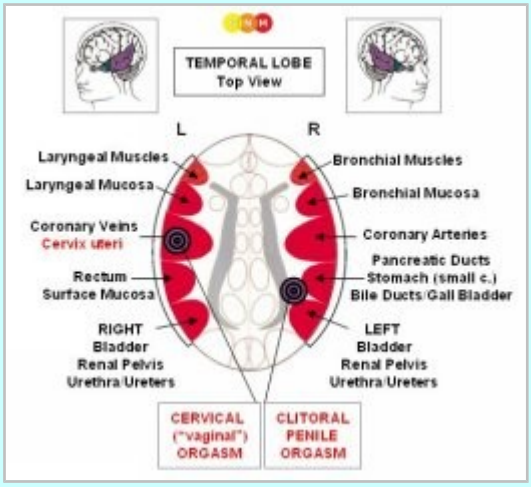
NOTE: The striated muscles belong to the group of organs that respond to the related conflict with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

rectal sphinctercconsist of smooth muscle. External sphincters have an inverse innervation, meaning that they close through contraction in vagotonia, i.e., in the healing phase, and open through relaxation in sympathicotonia, i.e., in the conflict-active phase and Epileptoid Crisis. Regarding the cervical sphincter, sudden distress suffered by a pregnantwoman or by the unborn opens the sphincter inducing a premature birth or miscarriage.

HEALING PHASE: During the healing phase, the cervical muscles are reconstructed and the cervical sphincter closes. The Epileptoid Crisis presents as **cervical spasm**.

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

THE FEMALE ORGASM

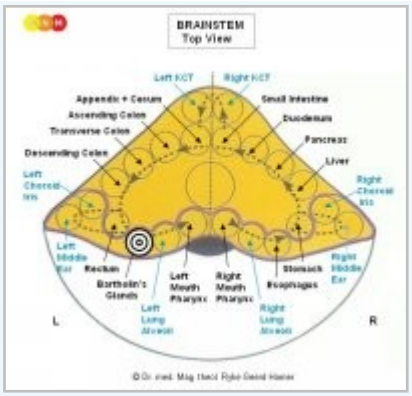


During the female orgasm, the cervical sphincter opens while the cervical muscles contract (equal to the rhythmic muscle contraction that occurs in the Epileptoid Crisis of the skeletal muscles). When the male ejaculates, the "sucking" movement of the cervix helps to draw the semen into the uterus. The**cervical** (rather than vaginal) **orgasm** is initiated from the "female conflict area" on the left side of the cerebral cortex, precisely, from the brain relay that controls the cervix mucosa(see GNM diagram). At the height of the orgasm, the entire left temporal lobe becomes involved, including the larynx (gasping) and the rectum. The **clitoral orgasm** as well as the penile orgasm is controlled from the right side of the post-sensory cortex (see clitoris); the rectal orgasm is controlled from the left side.

Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BARTHOLIN'S GLANDS: The Bartholin's glands are located on each side of the opening to the vagina. Equal to the smegma producing glands that lubricate the penis head, the function of the Bartholin's glands is to secrete mucus (secretory quality) to lubricate the vaginal entrance in preparation for sexual intercourse. The Bartholin's glands consist of intestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.

NOTE: The **Skene's gland**, situated on the upper wall of the vagina, is the equivalent to the male prostate gland. The secretions produced by the Skene's gland contain prostatic fluid, including PSA! As with the prostate, the ducts of the gland open into the urethra. During sexual arousal, the fluid is expelled through the urethral opening, explaining "female ejaculation". In 2002, the *Federative International Committee on Anatomical Terminology*officially renamed the Skene's gland to "female prostate".



BRAIN LEVEL: The Bartholin's glands are controlled from the left side of the**brainstem**. The control center is located next to the control center of the rectum submucosa.

NOTE: The Bartholin's glands, smegma producing glands, and bladder submucosa (bladder trigone) share the same brain relay.

BIOLOGICAL CONFLICT: The biological conflict linked to the Bartholin's glands is "**not being able to produce sufficient vaginal mucus"**. Insufficient foreplay and painful sex when the vagina is not lubricated enough typically activates the conflict.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase cells in the Bartholin's glands proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to augment the secretion of vaginal mucus to facilitate easier penetration.

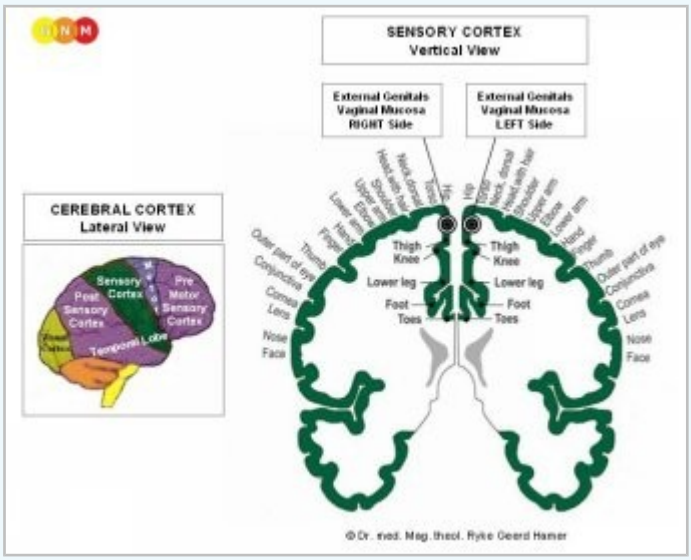
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. If the healing process is intense, the accumulation of pus forms an abscess (**Bartholin's abscess**) or a fluid-filled cyst (**Bartholin's cyst**) that empty spontaneously during the Epileptoid Crisis. With concurrentwater retention due to the SYNDROME the abscess or cyst might occlude the duct exiting the gland.

When fungi assist healing, this causes **candidiasis** (see also candidiasis related to the uterus mucosa and fallopian tubes). The fungal discharge produced during the cell removal is excreted through the vaginal opening. **NOTE:** The"**vaginal discharge"** originates in the Bartholin's glands and not, as assumed, in the vagina since the vaginal canal is not endowed with an endodermal submucosa and subsequently not populated by fungi or TB bacteria. Frequent conflict relapses lead to a loss of glandular tissue resulting in permanent **vaginal dryness** (see also vaginal mucosa). Like other so-called venereal diseases candidiasis is not contagious! If the male partner happens to have the condition as well, this reveals that he experienced – at the same time - the conflict of "not being able to penetrate a tight or dry vagina" with subsequent penile candidiasis in the healing phase.

NOTE: Antibiotics also cause vaginal dryness. They destroy the normal vaginal flora that is largely inhabited by lactobacillus acidophilus bacteria. The "fungal infection" is brought on by the side-effects of the medication ("not being able to produce sufficient vaginal mucus"). The candidiasis symptoms (discharge, itching) occur in the*healing* phase or after the antibiotic treatment is over. Further treatments create a vicious cycle.

Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE VAGINAL MUCOSA: The vagina is the passageway that leads from thecervix to the exterior of the body. The outside wall of the vagina is composed of muscles. The interior surface is a layer ofconnective tissue allowing for greater elasticity during sexual intercourse and childbirth. The mucous membrane of the inner lining maintains a steady level of moisture in the vaginal canal. The vagina itself has no glands. However, blood plasma seeping through the permeable vaginal walls keeps the vagina moist at all times. When a woman becomes sexually aroused, the increased blood flow to the area causes more fluid to seep through. The Bartholin's glands produce mucus at the opening of the vagina to facilitate the penetration of the penis. The vaginal mucosa consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex. **NOTE:** The vagina does not have an endodermal submucosa.

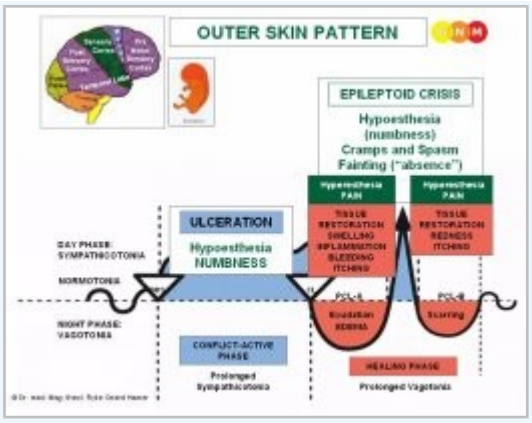


BRAIN LEVEL: The vaginal mucosa is controlled from the**sensory cortex** (part of the cerebral cortex). The right half of the vagina is controlled from the left side of the sensory cortex; the left half is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The vaginal mucosa and epidermis of the external genitals (male and female) share the same brain relays (see GNM diagram).

BIOLOGICAL CONFLICT: The biological conflict linked to the vaginal mucosa is a **sexual separation conflict associated with the vagina**. Similar to a sexual conflict related to the cervix mucosa, a woman can suffer the conflict through the unexpected loss of a sexual mate, sexual rejection, her partner's impotence, or when she finds out that her man is sleeping with someone else. The suspicion that her partner has sexual contact with another female can already trigger the conflict. Conversely, a sexual separation conflict refers to *not* wanting to have sex, for example, because of a lack of emotional intimacy, painful intercourse, insufficient foreplay, or unwanted sexual practices. The fear of contracting a venereal disease can also provoke the conflict.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the vaginal mucosa follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration (cell loss) in the vaginal mucosa with a decrease or, with intense conflict activity, a complete loss of sensitivity. The **vaginal hyposensitivity** (numbness) serves the **biological purpose** of not being able to "feel" anything in order to be better able to cope with the sexual separation (see short-term memory losswith a separation conflict).

Ongoing ulceration in the vagina leads to **vaginal dryness** (see also Bartholin's glands). For women who are sexually active, the pain during intercourse causes usually new sexual separation conflicts together with the distress of "not being able to produce sufficient vaginal mucus". As a result, the vaginal dryness becomes chronic.

NOTE: Vaginal lubrication is controlled from the parasympathetic nervous system. This is why the vagina does not become moist when a woman is under stress or with intense conflict activity (sympathicotonia) of any biological conflict (see also penile erection).

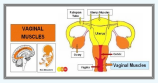
HEALING PHASE: During the first part of the healing phase (PCL-A) the ulceration is replenished through **cell proliferation**. **Healing symptoms** are **vaginal dermatitis** with **vaginal itching** (pruritus) and **pain**(hypersensitivity). With an inflammation the condition is called **vaginitis**. Unlike the discharge produced by fungal activity (candidiasis) in the uterus or Bartholin's glands, the **vaginal discharge** is clear, potentially with some light bleeding.

After the Epileptoid Crisis, in PCL-B, the condition normalizes, provided there are no conflict relapses.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare with hypoglycemiarelated to the islet cells of the pancreas).

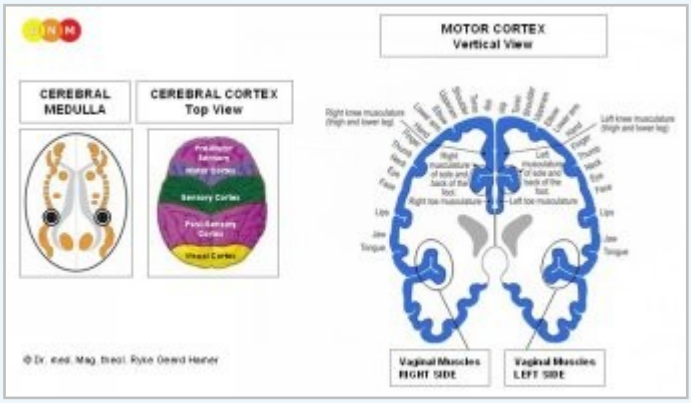
Vaginal herpes are blisters and sores in the vagina (see also herpes on the external genital organs). According to conventional medicine, genital herpes is a "sexually transmitted disease" caused by a "herpes virus", a theory that has never been scientifically proven. Like other venereal diseases genital herpes cannot be sexually transmitted since the symptoms are already healing symptoms.

Vaginal warts, also called **genital warts** or **condyloma**, are the result of continuous conflict relapses (see also cervical warts).



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE VAGINAL MUSCLES: The vaginal muscles surround the entire vaginal canal. Their function is to hold the penis during sexual intercourse and to expand and contract throughout labor to facilitate delivery (see also cervix muscles, cervical sphincter and uterus muscles). The vaginal muscles are striated muscles, derive therefore from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.



BRAIN LEVEL: The vaginal 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 and expansion of the muscles is controlled from the**motor cortex** (part of the cerebral cortex). The right half of the vaginal musculature is controlled from the left side of the cerebrum; the left half is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The vaginal muscles, cervix muscles, cervical sphincter,bladder muscle and external bladder sphincter, rectum muscles and external rectal sphincter share the same brain relays.

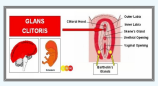
BIOLOGICAL CONFLICT: The biological conflict linked to the vaginal muscles is "**not being able to hold the penis"**or **not being able to prevent vaginal penetration** (forced sex, unwanted sex, a fear of sexual intercourse because of discomfort or pain).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of vaginal muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **weakness of the vaginal muscles** (controlled from the motor cortex), which is usually not noticed.

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 (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

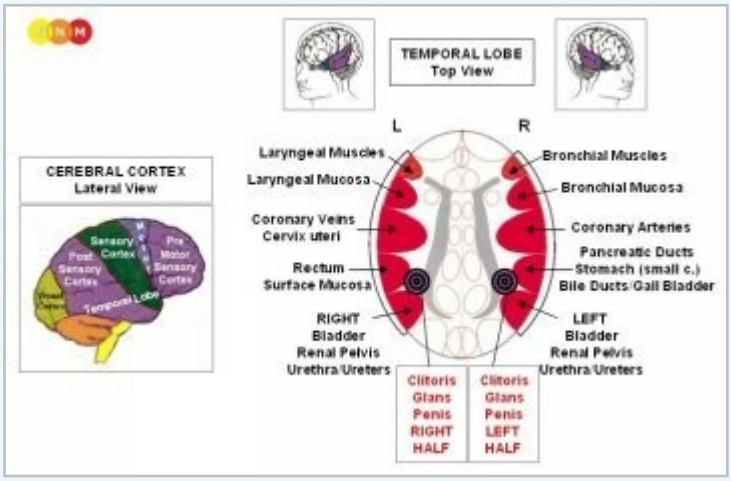
HEALING PHASE: In the healing phase the vaginal muscles are reconstructed. However, during the Epileptoid Crisis themuscles contract causing **tonic-clonic vaginal cramps**, a condition known as **vaginismus**. The distress associated with painful intercourse can become a track resulting in symptom relapses.

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



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE GLANS CLITORIS: The clitoris is situated within the front junction of the inner labia, above the opening of the urethra. The clitoris is made up of the glans, the clitoral shaft, and the clitoral hood (equivalent to the glans penis, penis shaft, and foreskin in males). The clitoral glans consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex. **NOTE:** The clitoral glans is covered by an epidermal skin layer but not endowed with a corium skin (under skin).



BRAIN LEVEL: The clitoral glans is controlled from the **post-sensory cortex** (part of the cerebral cortex). The epidermiscovering the clitoris is controlled from the sensory cortex (seebrain relays of external genitals and vaginal mucosa).

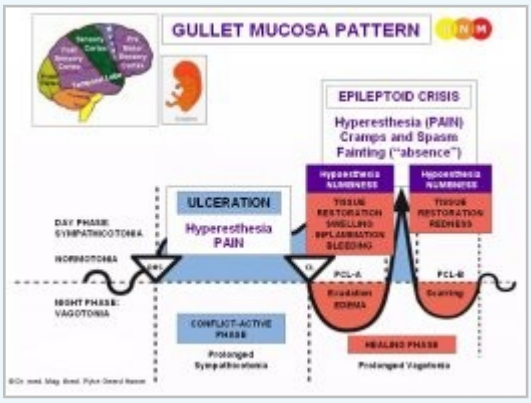
The right half of the clitoral glans is controlled from the left side of the post-sensory cortex (between the rectum and leftbladderrelays); the left half is controlled from the right cortical hemisphere (between the stomach and right bladder relays). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The glans clitoris and glans penis share the same brain relays. Their control centers are located outside of the temporal lobe, hence, the principle of gender, laterality, and hormone statusdoes not apply.

BIOLOGICAL CONFLICT: The biological conflict linked to the clitoris is a **severe separation conflict associated with the clitoris**, for example, through the loss of a sexual mate or sexual rejection (see also sexual separation conflictrelated to the vagina and to the epidermis of the external genitals). The conflict also refers to not wanting to be touched at the clitoris (sexual abuse, sexual molestation, resistance to oral sex, unpleasant clitoral stimulation) or not being allowed to be touched at the clitoris, including touching oneself (a DHS triggered when caught masturbating).

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-

motor sensory and post-sensory cortex.



The Biological Special Program of the glans clitoris follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

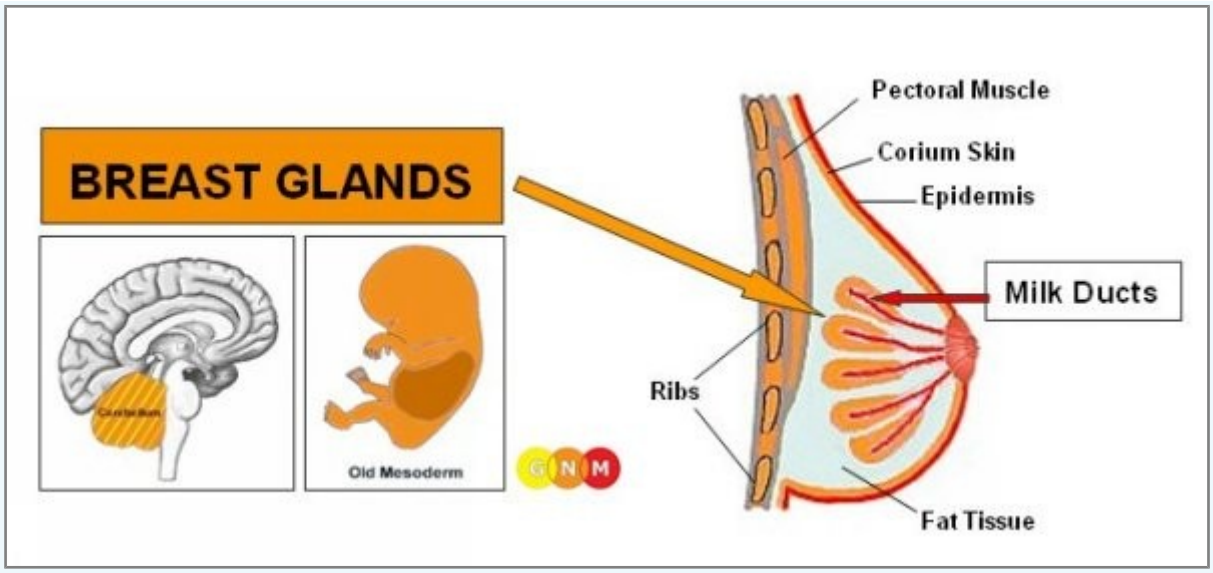
NOTE: With the exception of the glans penis and clitoris, the external genitals follow the Outer Skin Pattern since they are controlled from thesensory cortex.

CONFLICT-ACTIVE PHASE: ulceration (cell loss). During conflict activity the **clitoris is overly sensitive to touch**(hypersensitivity).

HEALING PHASE: During the healing phase the ulceration is replenished with new cells. The healing process manifests as **clitoral hyposensitivity** (numbness) with decreased or, if the conflict was intense, a complete loss of sensitivity. The hypersensitivity is briefly reactivated during the Epileptoid Crisis. With the completion of the Biological Special Programthe clitoral sensitivity returns to normal.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare with hypoglycemiarelated to the islet cells of the pancreas).

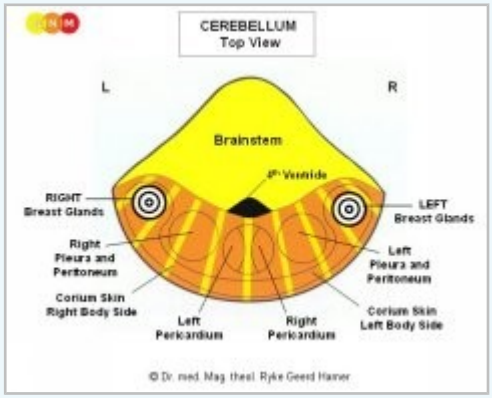
FEMALE BREAST



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE BREAST GLANDS: Anatomically, the breasts cover the chest (pectoral) muscles in front of the ribs and the sternum. Fat tissue, connective tissue, and ligaments (Cooper's ligaments) provide support to the breasts and give them their shape. The female breasts are mammary glands that contain in each breast 15-20 lobes comprised of many small lobules. The function of the breast glands is to produce milk to feed young offspring. During pregnancy hormones such as prolactin change the glandular tissue in preparation for lactation. When a woman breastfeeds her baby, the milk travels through a network of milk ducts to the nipple at the tip of the breast. The nipple is bordered by a dark area of skin, called the areola. In evolutionary terms, the breast glands developed from sweat glands of the a corium skin. The nipple is an evagination of the corium skin; this is why both the nipples and the areola are highly pigmented. Like the corium skin, the breast glands originate from the old mesoderm and are therefore controlled from the cerebellum.

NOTE: With the rise of mammals, milk lines developed on the right and left side of the midline, reaching from the thorax to the groin area. Normally, human females have two mammary glands, one on either side of the sternum, but breast tissue and nipples may form anywhere along the embryonic milk lines.



BRAIN LEVEL: In the **cerebellum**, the breast glands in the right breast are controlled from the left side of the brain; the breast glands of the left breast are controlled from the right brain hemisphere (lateral). Hence, there is a cross-over correlation from the brain to the organ.

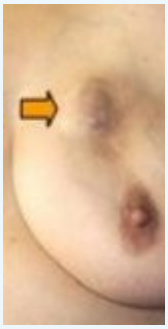
NOTE: The right and left milk line are controlled from the same brain relays as the a corium skin.

BIOLOGICAL CONFLICT: In biological terms, the female breast is synonymous for caring and nurturing. The conflict linked to the breast glands is therefore a **nest-worry conflict** concerning the well-being of a loved one (including a pet) or worries about the "nest" itself (distress regarding a woman's home or workplace). The breast glands also correspond to an **argument conflict**. Typically, the argument (with a partner, one of the children, a parent, a friend) has a "worry"-aspect.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase breast gland cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the function of the breast glands in order to have more milk available when a nest-member is in need (female mammals also nurse the adult males in the event of an emergency). Even if a woman is not breastfeeding at the time or is no longer of childbearing age, her breasts still respond to a worry conflict in this biologically meaningful manner.

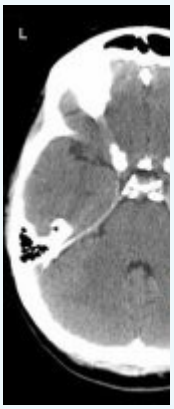
NOTE: Whether the right or left breast (or both) is affected is determined by a woman's handedness and whether the conflict is mother/child or partner-related. If the conflict is about the nest itself, it involves the mother/child-breast (left breast for right-handed females, right breast for left-handed females).

With prolonged conflict activity (hanging conflict) a compact nodule develops in the breast (it can also form along themammary line). Throughout this period, the nursing mother has more milk in the conflict-related breast. In conventional medicine, the growth is called a **glandular (lobular) breast cancer** or a **mamma carcinoma** (compare with "breast cancer" related to the milk ducts); if the rate of cell division exceeds a certain limit, then the cancer is considered "malignant".



This image shows the nodule of a glandular breast cancer in the left breast, caused by a nest-worry-conflict concerning her mother or child if the woman is right-handed. The size of the nodule is determined by the duration and intensity of the conflict.

Dr. Hamer: "A woman associates the bond with her children and her partner predominantly with her breast. This is why diseases of the breast are the most common medical conditions in women".

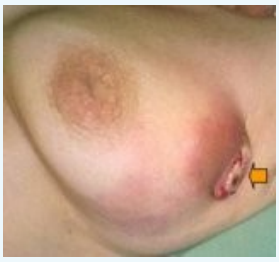


On this brain CT we see the impact of a nest-worry-conflict on the right side of the cerebellum(view the GNM diagram). It is the brain relay from where a glandular breast cancer in the left breast is controlled. The sharp border of the Hamer Focus indicates conflict activity.

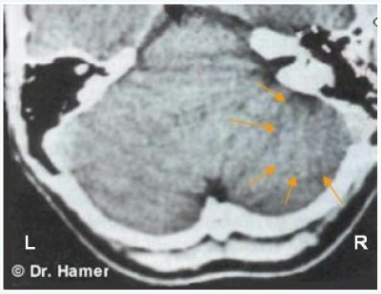
Breast cancer in men: Men also have mammary glands, but the breasts remain undeveloped because of their higher testosterone level (in females, estrogen promotes the development of the breasts). However, if a man has a low testosterone level due to an active loss conflict (see testicles) or a conflict-related hormonal imbalance, he can suffer anest-worry-conflict just like a woman. Men usually don't pay attention to breast nodules, neither do they (have to) go for mammograms, which is why the number of breast cancers found in men is very low. **NOTE:** Male lactation occurs with a conflict related to the pituitary gland that secrets prolactin, the hormone that stimulates the breast glands to produce milk.

HEALING PHASE: Following the conflict resolution (CL), the cells that are no longer needed are broken down with the help of fungi, TB bacteria or other bacteria. During this process an **abscess** forms in the breast. **Healing symptoms** are**swelling** due to the edema (fluid accumulation) in the healing breast (in PCL-A) and **night sweats**. With theSYNDROME, that is, with water retention as a result of an active abandonment and existence conflict, the swelling becomes much larger. The repair of the breast tissue is noticeable as **sharp pain**, which is characteristic for the healing of all old-mesodermal

tissues (see shingles). The extent of the symptoms is determined by the degree and duration of the conflict-active phase. Depending on the size of the tumor, the healing process can take several months.



When the pressure of a tumor breaks the overlying epidermis, the bloody and **foul-smelling discharge** finds its way through the external opening to the outside of the breast (left breast in this picture).



On a brain scan, the healing phase (PCL-A) of a glandular breast cancer in the left breast presents as "swollen", edematous rings (brain edema) in the breast gland relay located on the right side of the cerebellum(view the GNM diagram).

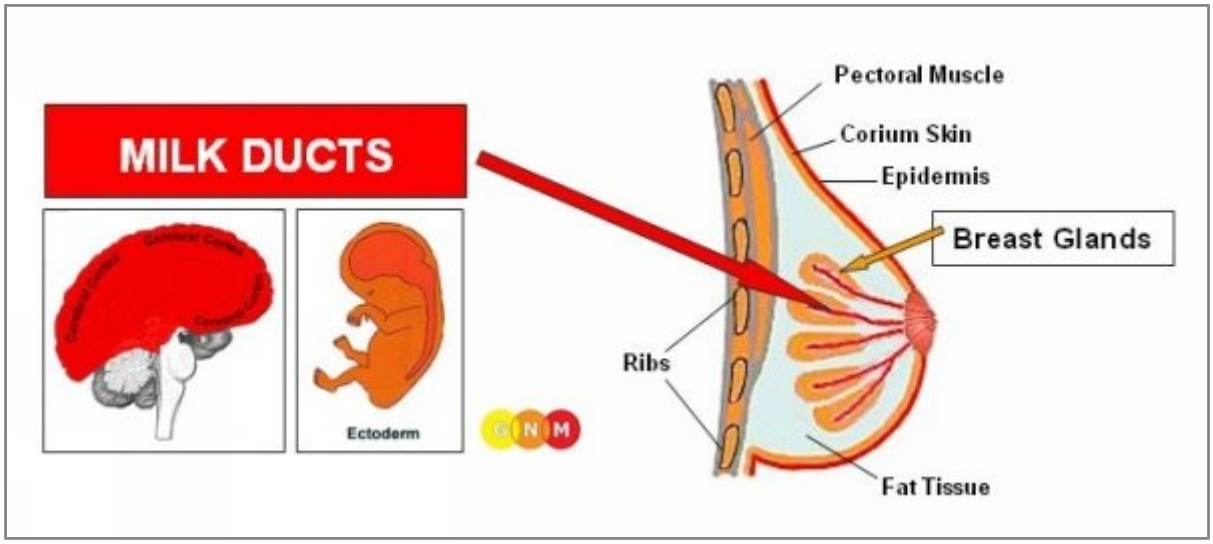
Complications with glandular breast cancer arise when the corium skin of the affected breast undergoes a healing phase at the same time (see skin tuberculosis). This happens either with an "attack conflict" triggered, for example, by a breast biopsy or when a woman suffers a "disfigurement conflict" evoked by the appearance of her breast. With a hanging healing the breast oozes constantly (watch the protein loss!) contributing, additionally, to "feeling soiled"-conflicts. In this case, surgery might have to be considered.

The by-products of the cell removal process are eliminated through the lymphatic system. The lymph fluid travels predominantly to the axillary lymph node located in the armpit of the healing breast. Hence, in the healing phase the lymph node swells up.

Women who have breast cancer often suffer a self-devaluation conflict leading to the development of a lymphoma in the axillary node. In conventional medicine, the new "tumor" is interpreted as a "metastasizing cancer", based on the wrong assumption that the lymph vessels are pathways for "spreading cancer cells". If the self-devaluation conflict is more severe, usually following a mastectomy, this affects the sternum or ribs underneath the amputated breast (see bone cancer). The mastectomy could also trigger an "attack conflict" with the development of a melanoma in the area of the surgical scar. Potential complications occur when the fluid from the edema enters the pleura causing a transudative pleural effusion. The self-devaluation conflict ("my breast looks ugly") could also involve the fat tissue with a localized swelling (see lipoma) in the breast during the healing phase. It is not uncommon that such a growth is misdiagnosed as a breast cancer, or "metastasis".

After the tumor has been decomposed by bacteria, a **cavern** remains at the site (see also lung caverns, liver caverns,pancreas caverns) that is eventually filled with calcium. On a mammogram the calcium deposits show as**macrocalcification** (compare with microcalcification in the milk ducts). Concurrent water retention due to theSYNDROME inflates the cavern creating a **breast cyst** (compare with breast cysts in the milk ducts). So-called**fibrocystic breasts** are the result of recurring healing and scarification processes (PCL-B) in the breast.

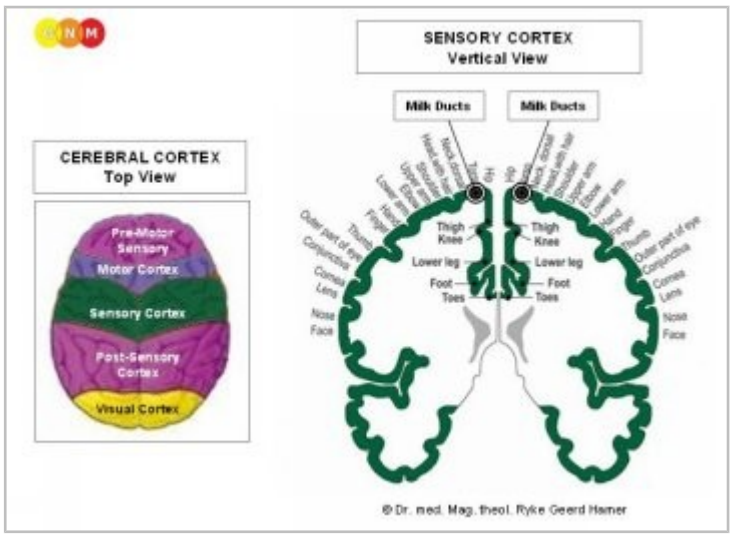
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the tumor becomes encapsulated with connective tissue. Such an encapsulated nodule might be found years later during a mammogram, often with dire consequences.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MILK DUCTS: The milk ducts are a structured network of ducts that attach to the lobules of the breast glands. They merge into the main mammary ducts at the nipple. The nipples are small projections of the skin endowed with special nerves making them sensitive to stimuli such as touch. In lactating females, the milk ducts carry milk to nurse the infant. The inner lining of the milk ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

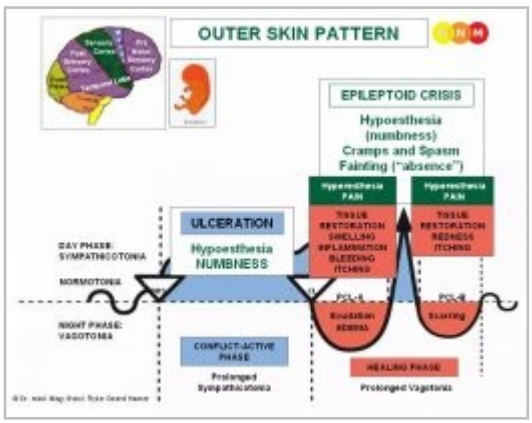
NOTE: Once the breast glands developed, squamous epithelial cells migrated from the outer skin through the nipples into the milk ducts.



BRAIN LEVEL: The epithelial lining of the milk ducts is controlled from the **sensory cortex** (part of the cerebral cortex). The milk ducts in the right breast are controlled from the left side of the cortex; the milk ducts in the left breast are controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the milk ducts is a **separation conflict** experienced as if a loved one was „torn from my breast“ (compare with loss conflict related to the ovaries). Women suffer separation conflicts through an unexpected divorce, a break-up with a partner, her child, a parent, or a friend or when a beloved person (or pet) dies. The fear of a separation can already activate the conflict. Similarly, the milk ducts correlate to the distress of **wanting to separate**, let’s say, from a spouse or from a parent because of a betrayal, constant fighting, or abuse. The separation from a home (a woman’s “nest”) also corresponds to the milk ducts (compare with nest-worry-conflict linked to the breast glands). The loss of the “nest” is the equivalent to the male territorial loss conflict.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the milk ducts follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the lining of the milk ducts proportional to the degree and duration of conflict activity. The ulceration occurs in the branches exiting the lobules of the breast glands or in the main ducts close to the nipple. A severe separation conflict could affect all milk ducts in the conflict-related breast. The **biological purpose of the cell loss** is to widen the ducts so that the milk that is no longer required (due to the separation) can drain off easier; the larger lumen of the ducts prevents a congestion of milk in the breast. The ulceration usually goes unnoticed because of the hyposensitivity in the milk ducts during the conflict-active phase (Outer Skin Pattern). The **loss of sensitivity**might reach into the **nipple**.

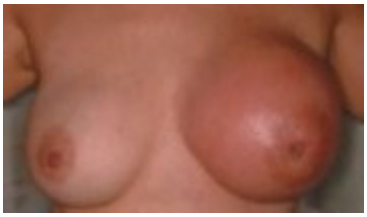
NOTE: Whether the right or left breast is affected is determined by a woman's handedness and whether the conflict is mother/child or partner-related. If the conflict is about the nest itself, it involves the mother/child-breast, i.e., the left breast for a right-handed female, the right breast for the left-handed female.

With persistent conflict activity the continuous ulceration contracts the milk ducts resulting in **cirrhous knots** and painful pulling in the breast. The contraction is visible as a local retraction at the breast and an **inverted nipple**. The affected breast becomes considerably smaller (recurring scarification because of a hanging healing in PCL-B also makes the breast smaller). On a mammogram a cirrhous knot might appear in the shape of a compact nodule and subsequently diagnosed as a cancer ("**cirrhotic carcinoma**"), even though there is no "cancer cell" mitosis!

The conflict-active phase is accompanied by a **short-term memory loss** that reaches into PCL-A. This is characteristic for all separation conflicts (see Biological Special Program related to the skin).

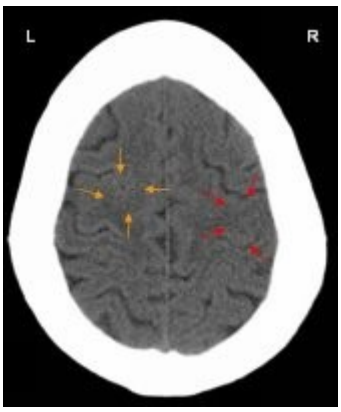
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. The **breast is swollen, red, hot, and itchy**. When the separation is also associated with the skin, a rashdevelops on the breast as well (see Paget's disease). In the healing phase the sensitivity returns, markedly withhyperesthesia, a heightened sensitivity to touch, specifically at the nipple. The swelling makes the nipple appear inverted (compare with inverted nipple in the conflict-active phase).

In conventional medicine, the cell proliferation in the milk ducts is diagnosed as an **intraductal breast cancer**, with an inflammation as an **inflammatory breast cancer** (compare with breast cancer related to the breast glands). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.



This picture presents the healing phase of an intraductal breast cancer in the left breast.

The theory that breast cancer is linked to "abnormal genes" cannot explain why the "tumor" develops in the right or left breast, why it affects the milk-ducts or the breast glands, or why the "cancer" occurs at a certain time in a woman's life.



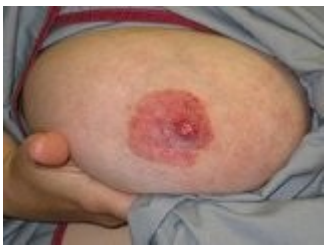
The red arrows on this CT scan point to the area of the brain (in the sensory cortex) from where the healing of an intraductal breast cancer in the left breast (view the GNM diagram)is controlled. The uneven, partly edematous ring of the Hamer Focus confirms that the woman (she is left-handed) has resolved a separation conflict related to her partner.

However, she is still conflict active with an overwhelmed-conflict associated with her child, involving the left myocardium. The Hamer Focus shows as a sharp ring configuration in the corresponding brain relay in the motor cortex (orange arrows). The two conflicts occurred most likely together.

With the SYNDROME due to an active abandonment and existence conflict the retained water is exceedingly stored in the healing breast, which increases the swelling. A large swelling might **occlude the milk ducts**. In this case, the discharge produced during the repair process becomes clogged in the breast, particularly behind the nipple. Biologically, this complication is not planned because if a female is nursing, the baby would normally suck the breast dry (adult mammals suck the udder of the female when the milk is congested). In non-lactating women, however, the secretion has no outlet, which increases the swelling and the pain. Dr. Hamer therefore recommends to drain the fluid twice a day with a milk pump or have it sucked out by her partner, a friend, or her midwife since this is less painful (the discharge has a slightly sweet taste like milk). If a scirrhotic breast is not drained during the healing phase, the breast becomes small and hard.

A **leaking breast** is an indication that the milk duct is not entirely blocked. The secretion emptying through the nipple is a clear or bloody fluid (compare with smelly discharge when a glandular breast tumor is healing and milky dischargerelated to the prolactin-producing pituitary gland). With concurrent water retention, the swelling in a milk duct is usually diagnosed as a **breast cyst** (compare with breast cyst in the breast glands).

Mastitis (periductal mastitis) occurs when the ducts under the nipple become inflamed. Mothers who are separated from their baby, for example after delivery, develop mastitis as soon as they are able to nurse their infant uninterrupted.**Lactation mastitis** or an **inflammation of the nipple** (**thelitis**) is either linked to a separation conflict or, in breast-feeding women, when the nursling is sucking too strong. A wart in the milk duct (**intraductal papilloma**) is the result of recurring and prolonged healing.



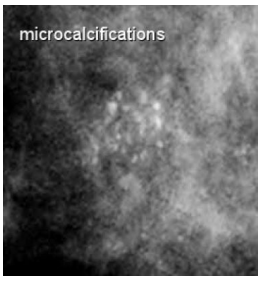
If the healing process involves the nipple, including the areola, this is diagnosed as **Paget's disease**. In conventional medicine, it is considered a breast cancer!

An eczema on the areola (see epidermis) indicates that the separation conflict from a child or partner was associated with that particular part of the breast, for example, when breastfeeding is discontinued (hospitalization of the nursling or the mother) or through a loss of physical contact related to that area. Hence, "Paget's disease" and an intraductal breast cancer can easily occur together.

The Epileptoid Crisis manifests as acute pain. The pain is not of a sensory nature but a strong pulling pain. Pain also occurs in PCL-B; in this case due to the scarification process.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

After the Epileptoid Crisis, the swelling of the breast goes down.



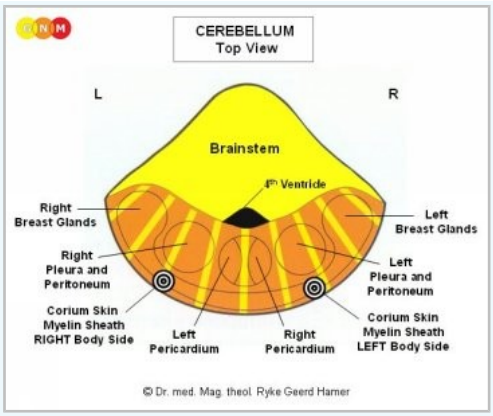
On a mammogram, the **completion of the healing process** shoes as specks of calcium, or**microcalcifications** (compare with macrocalcification in the breast glands) caused by the temporary backup of the milky discharge. In today's medicine, however, microcalcifications in the breast are considered an early sign of breast cancer!

SKIN

Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CORIUM SKIN: The skin consists of two main layers, namely, the epidermis(outer skin) and the corium skin (dermis or under skin). The function of the relatively thick dermis is to protect the organism against injury and attacks. The corium skin is composed largely of melanocytes, which are the cells that make the pigment melanin that gives color to the skin and hair (melanin is also produced in the iris and ciliary body of theeyes). Melanin acts as an effective absorber of light to shield the skin from UV radiation. Embedded in the dermis aresebaceous glands and sweat glands. In evolutionary terms, the corium skin developed together with the pleura, theperitoneum, and the pericardium. The corium skin, including the sebaceous glands and sweat glands, originates from theold mesoderm and is therefore controlled from the cerebellum.

NOTE: The clitoris and glans penis are covered by an epidermal skin layer but not endowed with a corium skin. With the rise of mammals, the breast glands developed from the sweat glands in the corium skin.



BRAIN LEVEL: In the **cerebellum**, the corium skin (including the sebaceous glands and sweat glands) of the right half of the body is controlled from the left side of the brain; the corium skin of the left half of the body is controlled from the right brain hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The myelin sheath is controlled from the same brain relay as the corium skin.

BIOLOGICAL CONFLICT: According to its protective function, the biological conflict linked to the corium skin is an**attack conflict** (see also attack conflicts related to the pleura, peritoneum, and pericardium).

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

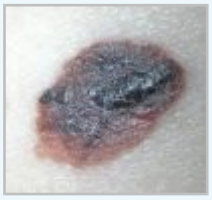
An **attack conflict** is experienced, for instance, through an attack by a person or by an animal or through a hit against the body or the head (in sports, in a fight or in an accident). However, medical procedures such as surgery (the image of being cut with a scalpel), a needle biopsy, injections, vaccinations as well as stabbing or piercing pain could also be registered as an "attack". Verbal attacks, for example, being yelled at, scolded, assaulted or threatened with sharp and aggressive words typically "hit" the face, the forehead (an insult against one's intelligence), or the back ("stab in the back"). Sexist remarks, sexual accusations, or an attack against one's sexual orientation usually strike "below the waist". Hearing offensive words affects the corium skin of the ear. Being criticized in a hostile manner, discrimination, defamation, or an insult against one's integrity could have an impact on the whole body (generalized conflict). A skin condition such as acne or surgical scars in the face or on the body (after a mastectomy) can evoke a **disfigurement conflict** which also corresponds biologically to the corium skin.

In addition, the conflict linked to the corium skin relates to **feeling unclean** (smelly sweat, stinky feet, malodorous discharge, incontinence) or **feeling soiled**, for example, when coming in contact with something considered as repellent such as dirt, feces, urine, vomit, saliva, (menstrual) blood, sweat, or sperm. "Dirty" words thrown at one's face or gossiping behind one's back might provoke the conflict, because the psyche, in GNM terms, cannot differentiate between real dirt and figurative dirt. A "feeling soiled"-conflict could be triggered through physical contact with a person who is regarded as "repulsive", for instance, a drunk person, a smelly person, or a person who has a "contagious disease" (venereal disease), provided that one believes that "infectious diseases" are transmittable. The fear of an "infection" and of contracting a disease can affect an entire population (see epidemics such as the Great Plague).

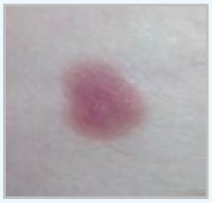
CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase melanocytes in the corium skin proliferate at the "attacked" or "soiled" site forming a compact growth or **melanoma**. In conventional medicine the growth is considered a **skin cancer** (see also basal cell cancer and squamous cell skin cancer). From an evolutionary viewpoint, however, a melanoma is an archaic form of

defense that serves the **biological purpose** to provide a protective layer or "thicker skin" against further attacks (see also pleural mesothelioma, peritoneal mesothelioma,pericardial mesothelioma).

NOTE: Excessive UV radiation from the sun can certainly damage the skin but **does not cause skin cancer**, as claimed. It is rather the *fear* of skin cancer that results in the development of a melanoma. Sun lotions don't protect the skin from "cancer" but reduce the *fear* of getting skin cancer! Besides, melanomas and other types of skin cancer appear on areas of the body that have not been exposed to the sun. Neither does the UV-theory explain why a skin cancer occurs on a very specific location (on the cheek, on the breast, on the back), why on the right or left side of the body, and why at a certain time in a person's life.



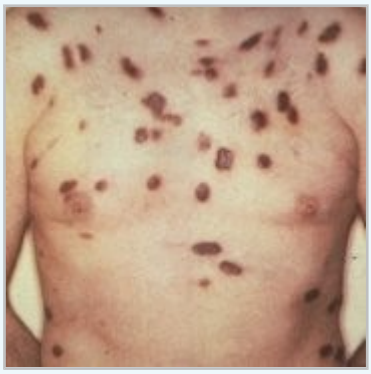
If the melanoma is pigmented it appears as **black, brown or blue**. A **melanotic melanoma**always involves a mole. Moles are remnants of the dark-pigmented skin that once covered the entire body as a protection against excessive sun exposure, which is still seen in dark-skinned people living at lower latitudes such as in tropical Africa. Light skin pigmentation as found in the European population evolved much later.



A non-pigmented or **amelanotic melanoma** appears as pink since it does not contain pigments (see shingles).

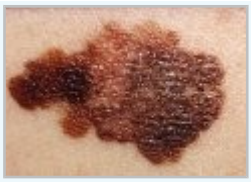
NOTE: Whether the right or left side of the body is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area of the skin that is associated with the attack or with "feeling soiled".

The appearance of a melanoma can provoke a disfigurement conflict with the result that in a short period of time other melanomas occur in the same area. A surgical removal of the growth might trigger an attack conflict leading to the development of new melanomas – a vicious cycle for someone who is not familiar with GNM.



What is termed **Kaposi sarcoma** (KS) are "tumors" that show as purple or brown blotches. They present the typical picture of **melanomas**. Yet, in conventional medicine, the growths are nowadays considered an AIDS-defining illness (see also shingles): "AIDS-related Kaposi sarcoma arises in people who are infected with HIV. It was in part the unusual and sudden appearance of this form of KS in so many young men at the start of the AIDS epidemic that led doctors to realize that a new disease had emerged." (Is Homosexuality a Health Risk?). Based on the knowledge of GNM, the rise of "the new disease" was caused by the *fear* associated with HIV and AIDS ("feeling soiled" or "infected" by a person who is "HIV positive" or feeling attacked because of one's sexual orientation) rather than by a virus that has never been proven to exist.

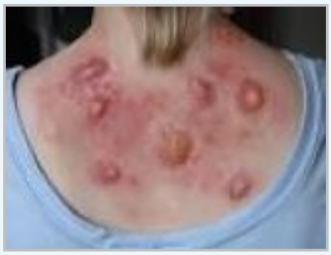
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria or other bacteria remove the cells that are no longer needed. The involvement of TB bacteria causes **skin tuberculosis**.



During the decomposing process the **melanoma changes its texture** (the growth becomes soft and spongy), **its shape** (it becomes larger and asymmetric with uneven edges), and it **might bleed**. When the overlying epidermis opens, the smelly discharge produced by the TB bacteria breaks through the skin (see also healing phase of glandular breast cancer).

If the required microbes are not available at the time, the growth remains. However, with constant conflict relapses the melanoma continues to grow.

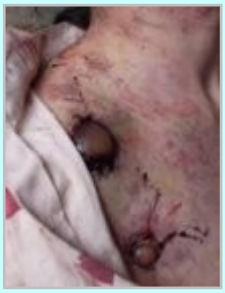
A **carbuncle** or **furuncle**, also known as **boil or skin abscess**, is a nodule filled with pus produced by the bacterial activity in the corium skin. **Carbunculosis** or **furunculosis** occurs with an inflammation. A furuncle or carbuncle could also originate in the connective tissue; in this case the related conflict is a self-devaluation conflict. A **pilonidal cyst** is a boil that develops on the tailbone near the cleft of the buttocks as the area where the attack conflict was registered. Interestingly, the condition was widespread in the United States Army during the Second World War. It was termed "jeep riders' disease", because a large number of soldiers who were being hospitalized for it rode in Jeeps. The prolonged rides in the bumpy vehicles must have triggered an "attack" conflict.



This picture shows several boils spread over both sides of the upper back. Malicious badmouthing behind one's back would be a conflict scenario of an attack conflict perceived at this particular area of the body.

THE GREAT PLAGUE (1348-1351)

The **Great Plague** is estimated to have killed 30-60% of Europe's total population. It is said that the disease was brought to Europe through trade ships carrying infected rats. Curiously, the rats did not get the plague!

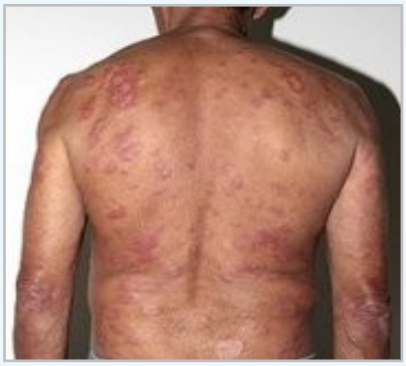


Symptoms of the **Bubonic Plague**: **dark, purple swellings** with the characteristic foul-smelling discharge indicating a skin tuberculosis, linked to a "feeling soiled"-conflict and the panic of contracting an "infectious disease" (the plague).

Symptoms of the **Pneumonic Plague**: **cough with bloody sputum and hemorraghing of the lungs** indicating a lung tuberculosis, linked to a death-fright conflict (fear of the "deadly plague"). **NOTE:** 95% of the people died of the pneumonic plague!

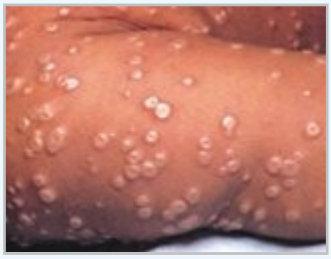
In 1894, the Swiss physician Alexandre Yersin, a student of Louis Pasteur, examined plague victims in Hong Kong. Under the microscope he found masses of bacteria. He asserted that these bacteria had caused the Great Plague and named the bacterium ***Yersinia pestis***. One of Yersin's students claimed that he had found the Yersinia pestis bacillus in the stomach of rat fleas. He argued that the flea bite had injected the people with the bacteria…

In March 2014, after the excavation of a mass grave in London with plague victims of the 14th century, researchers analyzed the teeth of some of the skeletons. The teeth contained indeed the DNA from the bacterium Yersinia pestis (termed "Yersenia pseudotuberculosis"!). However, the DNA analysis revealed that "**the Black Death was not bubonic plague, as has been thought, but pneumonic plague**."(Health and Medicine, March 31, 2014). This confirms that the Great Plague was in reality an epidemic ofdeath-fright conflicts (triggered by the "deadly disease") that had seized the European population.



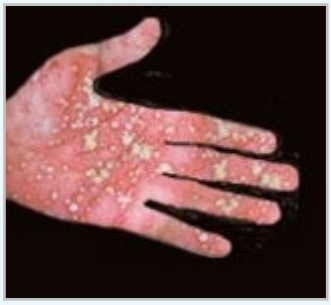
In **leprosy** (linked to attack conflicts) the growths develop on a flat plane rather than forming compact boils. However, like open pest boils the tubercular discharge (skin tuberculosis) produced by the *mycobacteria leprae* has a foul-smelling odor. The continuous repair processes (hanging healing) in the dermis lead eventually to disfiguring skin sores, usually due to the condition itself (feeling soiled and disfigured).

Smallpox is allegedly caused by the so-called *variola major virus*. It is speculated that the virus evolved from a rodent virus between 68,000 and 16,000 years ago. Starting in 1967, the World Health Organization ordered a global vaccination program against smallpox; the "disease" was supposedly eradicated in 1979.



Smallpox presents as sharply raised pustules.

In the 1600s European "settlers" first brought smallpox to North America. In 1633-1634 the disease (in reality "attack conflicts") wiped out entire Native American tribes. **NOTE:** Death of smallpox usually occurred from pneumonia, generated by territorial fear and existence conflicts!



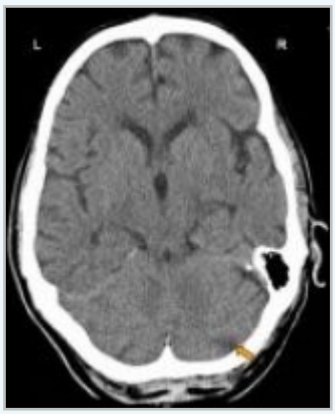
This image shows the clinical picture of **pustular eczema**. The pus-filled papules on the skin appear on an inflamed surface (see dermatitis). In this case, the Biological Special Programsof the corium skin (attack or "feeling soiled"-conflict) and of the epidermis (separation conflict) run concurrently.

At the turn of the 20th century, the Irish playwright George Bernard Shaw, who was a member of the Health Committee of the London Borough Council, stated: "I learned how the credit of vaccination is kept up statistically by diagnosing all the revaccinated cases of smallpox as pustular eczema, or what not – anything except smallpox." (Source: Doctors Change Names of Diseases when Vaccines do not work). The same tactic was employed by renaming polio to Guillain-Barré syndrome.

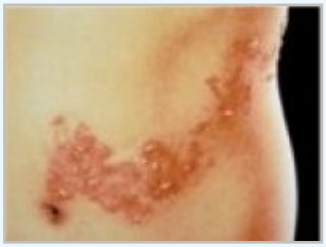
Shingles are small, non-pigmented (amelanotic) growths that develop along one or several segments of the skin. During the healing phase the skin lesions become **swollen and red** due to the inflammation and the **blisters are filled with pus** produced by the bacteria. After the Epileptoid Crisis, in PCL-B, the blisters dry up, form scabs, and gradually fade away. The scarification process is accompanied by acute **sharp, stinging pain**. This is characteristic for the healing of allold-mesodermal tissues (see also glandular breast cancer). Recurrent bouts of shingles are triggered by conflict relapsesthrough setting on a track that was established when the original attack or "feeling soiled"-conflict took place.

Conventional medicine claims that shingles are caused by a reactivation of a

previous infection with the "varicella-zoster virus" (a type of "herpes virus") that supposedly causes chickenpox (by the same token it is said that people who had chickenpox have a "life long immunity" against a new "infection" with the "zoster virus"). It has been suggested that the virus migrates along the sensory peripheral nerves, replicates at the area of the skin supplied by that nerve, which then results in the development of shingles. The virus theory, however, can not explain why the "virus" would affect a very specific skin segment (face, shoulder, thorax, torso, genital area) and why the condition occurs on the right or left side of the body or on both. The immune system theory does not provide any answers either. Besides the fact that the existence of the alleged virus is highly questionable, Dr. Hamer's research demonstrates that every person with shingles shows on the brain scan the Hamer Focus in the cerebellum, precisely, in the area of the brain that controls the corium skin (see brain scan below); hence, the activity of bacteria(!) in the healing phase. The skin rash that occurs with chickenpox, on the other hand, involves the epidermis and is controlled from the cerebral cortex.



On this brain scan, the orange arrow points to a small edema on the right side of the cerebellum (view the GNM diagram). It is an indication that an attack or "feeling soiled"-conflict has been resolved. In the healing phase, shingles developed on the left side of the body.



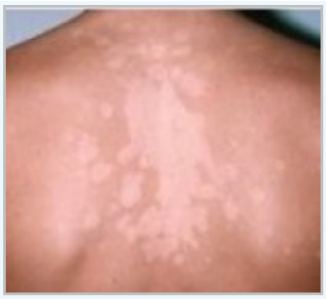
Shingles on the left torso reveals that the conflict (feeling attacked or soiled "below the waist") was associated with a partner, if the person is left-handed. For a right-handedperson the conflict would be mother/child-related.

NOTE: The shingle rash can involve simultaneously the corium skin (feeling soiled) and theepidermis (e.g., wanting to separate from a repulsive person; see herpes).

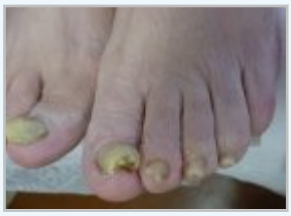
Like Kaposi sarcoma, in conventional medicine shingles is construed as a "disease" related to AIDS: "In the days before the HIV/AIDS pandemic, shingles used to be seen only in older people or in those who had weakened immune systems. Nowadays shingles is very common with HIV infections and AIDS." (click to read the article)

Candidiasis of the skin (subcutaneous candidiasis) occurs when fungi assist healing. In the **genital area**, this might be provoked by "unclean" sex, "dirty" sexual practices, or feeling "soiled" through sexual insults (compare with vaginal candidiasis and penile candidiasis). In sick or elderly people requiring nursing care "dirty diapers" typically cause candidiasis in the genital and anal region.

A fungal infection of the skin is commonly known as "**ringworm**". The medical term is tinea. It has nothing to do with a worm.



Tinea versicolor is a skin condition that presents as hyperpigmentation (in the conflict-active phase) or hypopigmentation (in the healing phase). The white patches are the result of lasting fungal activity, or hanging healing, leading to the depigmentation of the corium skin (compare with white skin patches in vitiligo related to the epidermis).

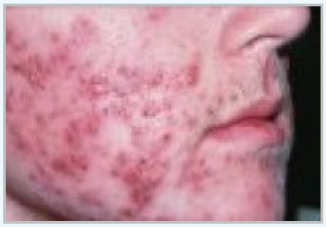


A **nail fungus** (tinea unguinum or onychomycosis) develops in the corium skin underneath the nail plate of the toe or finger nails through coming in contact with something considered as "disgusting" (see also Athlete's Foot).

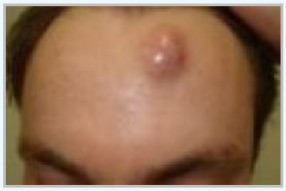
SEBACEOUS GLANDS

The **sebaceous glands** are exocrine glands that secrete an oily substance (sebum) to lubricate the skin. They are most abundant in the face and scalp. The distress over getting bald (a typical male concern) or over a hairdo (a typical female concern) could therefore be the underlying cause for having a greasy scalp.

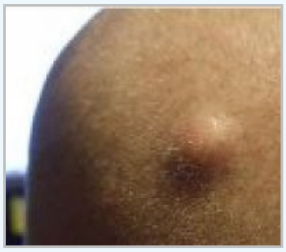
Acne is, in GNM terms, linked to an attack or "feeling soiled"-conflict.
The **inflammation** with **swelling, redness, and pustules filled with pus** is already the **healing phase**, assisted by bacteria (*propionibacterium acnes*). During the**conflict-active phase**, the **skin appears bumpy**. Depending on the intensity of the conflict, the condition ranges from small pimples to a severe skin condition. The theory that acne is related to hormonal changes is inconclusive, because not every teenager has acne and adults have it too.



Acne most commonly appears on the face, particularly in puberty since adolescents are much more vulnerable concerning their looks. Feeling unattractive or not good looking can therefore easily lead to acne. Also, the teenage years are the time where there are more confrontations (verbal attacks) with adults (parents, teachers, authorities). Usually, it is the appearance of acne itself (feeling "soiled" in the face) that delays the completion of the healing process.



A **sebaceous cyst** is a lump beneath the surface of the skin filled with yellowish sebum (see also stye and chalazion related to the sebaceous glands in the eyelids; compare with fat nodules, or xanthomas). A sebaceous cyst on the forehead reveals an attack conflict related to an intellectual performance ("You fool!"). For a right-hander, a cyst on the left side points to a conflict associated with a partner.



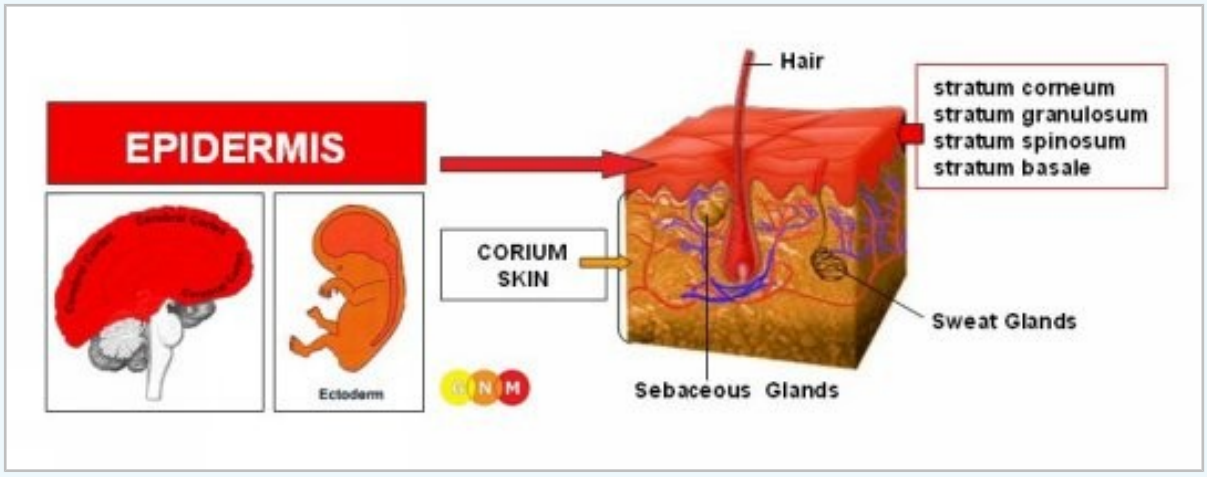
Trichilemmal cysts, also known as **wen**, originate in a hair follicle in the dermis. They are therefore often found on the scalp, which has a high hair follicle concentration. The cheese-like odor of the cysts is a sign that mycobacteria are at work.

SWEAT GLANDS

The **sweat glands** in the corium skin produce a watery, salty film that regulates the body temperature and prevents the organism from drying out. Moreover, the sweat glands are responsible for the elimination of metabolic waste (see alsonight sweats). Sweating is regulated by the sympathetic nervous system, which is why perspiration increases with stress, nervousness, or excitement and during conflict activity (cold sweats).
In the **conflict active phase** of an attack or "feeling soiled"-conflict the sweat gland cells proliferate causing **excessive sweating (hyperhidrosis)**. Depending on the individual conflict situation, the sweating can either be generalized or confined to a specific area of the body such as the armpits, groin, palms of the hand, soles of the feet, or the scalp (localized conflict). In the course of the healing phase, the additional sweat gland cells are removed by fungi or bacteriaaccompanied by a **strong odor**.

Tinea pedis is a "fungal infection" involving the sweat glands in the feet (compare with nail fungus). The "feeling soiled"-conflict typically occurs when the feet come in contact with something "dirty", for example, through walking on filthy floors (public showers, locker rooms, washrooms), wading in dirty water, or stepping on animal poop. Sweaty boots, sweaty shoes, or sweaty socks considered as "yucky" also trigger the conflict. During the **healing phase**, the fungi produce a cheese-like substance that creates the distinctive smell of "**Athlete's foot**" (the term became popular since the condition is common among athletes). The smelly feet usually lead to new "feeling soiled"-conflicts with the consequence that the fungal activity continues. Shoes associated with the smelly feet or dirty public facilities can become a track leading to a chronic condition. The reason why remedies such as "walking barefoot on morning dew grass" work is that the feet are no longer associated with being "soiled" but instead with being fresh and clean, which clears the tracks allowing the completion of the healing phase.

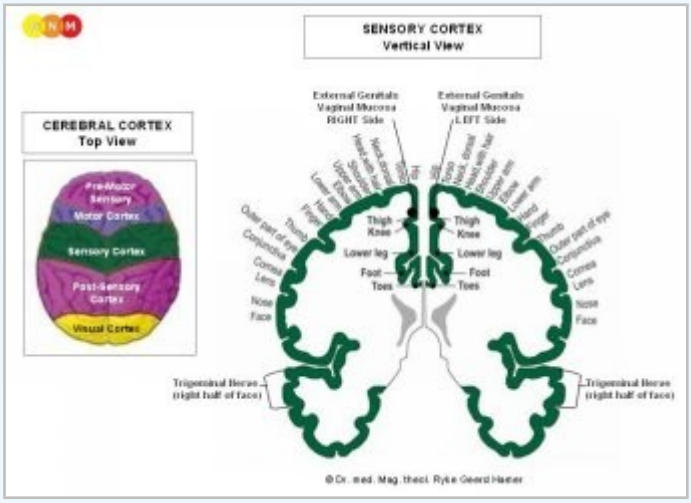
NOTE: Whether the attack or "feeling soiled"-conflict affects the sebaceous glands or the sweat glands is random. However, the attack conflict related to the corium skin is always experienced as more severe.



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE EPIDERMIS: The epidermis (outer skin)

covers the underlying corium skin(dermis or under skin). The epidermis is predominantly responsible for sensory perception such as temperature, pressure, and touch. Most cells in the epidermis are keratinocytes (keratin-producing cells) that originate in the deepest layer of the epidermis, called the **stratum basale**. This layer also contains pigment-producing melanocytes (the majority of melanocytes are, however, in the corium skin). From the basal layer keratinocytes migrate through the **stratum spinosum** and **stratum granulosum** up to the **stratum corneum**. Once they reach the surface of the skin, they are gradually shed and replaced by newer cells pushed up from below. Keratin is also the main structural component of hair and nails. The epidermis consists of keratinized squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epidermis is controlled from the **sensory cortex** (part of the cerebral cortex). The skin of the right side of the body is controlled from the left side of the sensory cortex; the skin of the left side of the body is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

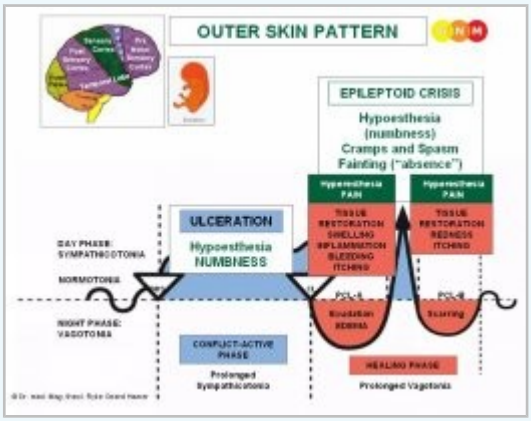
BIOLOGICAL CONFLICT: The biological conflict linked to the epidermis is a **separation conflict** experienced as a loss of physical contact (see also separation conflict related to the periosteum).

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

Newborns suffer the conflict when they are separated from the mother at birth (put in an incubator, given up for adoption). A separation conflict can already occur intrauterine, for example, because of ultrasound procedures. The ultrasound noise drowns out the heartbeat of the mother, which can be highly traumatic for the fetus; each ultrasound test triggers a conflict relapses for the unborn (see Down syndrome). Children experience separation conflicts when they are scolded, punished or abused, when a new sibling is born who gets more attention, when the parents split up, when they are not allowed to see their friends, when they have to separate from a favorite doll, teddy bear, stuffed animal or pet they like to cuddle; also, when the mother goes back to work, when they are put into daycare, kindergarten or to relatives, or when they are left with a sitter or nanny. Similarly, the elderly feel separated from the "pack" when they have to move into a nursing home or after the death of a life-long spouse or companion. The fear of losing touch or contact with someone (the threat of a divorce, a difficult long-distance or weekend relationship, the fear that a loved one might leave, move away, or die) or feeling rejected by a person, let's say, because of a disagreement can evoke the conflict. Pets suffer separation conflicts, for example, when their master leaves or

dies or when they are put in a kennel. By the same token, the conflict refers to **wanting to separate** from a person in the sense of wanting but not being able to push someone away (literally or figuratively), for example, a terrorizing boss or teacher, an annoying colleague or schoolmate, or an abusive parent or spouse (compare with touch-conflict of not wanting to be touched related to themyelin sheath).

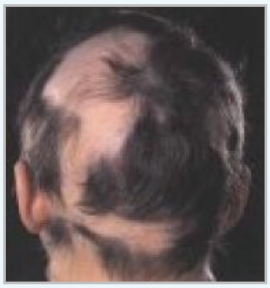
A separation conflict also pertains to **wanting to separate from something close to the skin** (face mask, oxygen mask, a helmet, hat, clothing, shoes, tight stockings, wet linen, wet diapers). The same applies to a **separation from something that one is no longer allowed or able to touch** (a musical instrument, keyboard, tennis racket, golf club, steering wheel) **or feel on the skin** (an engagement ring, a favorite pillow). **NOTE:** A separation from a home is not a separation conflict in biological terms, since it does not relate to the skin but concerns the "territory" (see territorial loss conflict).



The Biological Special Program of the epidermis follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: During the conflict-active phase the epidermis ulcerates at the area(s) associated with the separation. The ulcerations are microscopic and usually go unnoticed. With continuing conflict activity, however, the **skin becomes dry, rough, flaky, pale, and cold** from poor blood circulation. Eventually, the skin begins to crack causing**fissures** that may bleed. If an intense conflict persists for a long period of time, the skin opens at the ulcerated area (seeleg ulcers). **Ichthyosis**, a skin condition characterized by fine scaling similar to fish-scales, is also an indication of long and intense conflict activity.

On the **scalp** the flaky skin shows as **dandruff**. Deep ulceration of the epidermal skin causes **hair loss (alopecia)**; also in pets.



In this example, the bald spots are exclusively on the left side of the scalp. This reveals that the loss of physical contact (say, missing to be stroked on the head) is related to a partner if the man is left-handed or to his mother if he is right-handed.

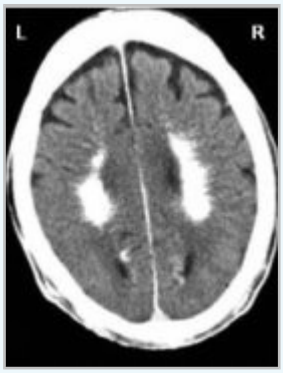
With the resolution of the conflict, the hair starts growing back.

Because of the loss of epidermal cells the **sensitivity of the skin decreases** (compare with hyposensitivity related to the periosteum). If the separation conflict is severe the **skin can become completely numb** (sensory

paralysis). Sudden sensory numbness, for example of an arm or leg, is often confused with a stroke. A brief reactivation of the**sensory paralysis** arises during the Epileptoid Crisis.

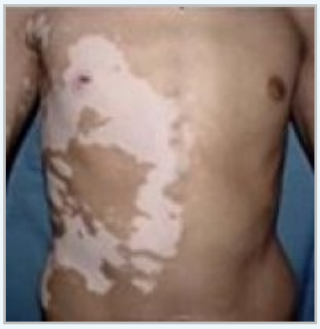
A typical symptom of the conflict-active phase is a **short-term memory loss**, which serves the purpose to temporarily "forget" the one who was "torn from the skin" by blocking out the memory (in the animal world, a mother cat does no longer recognize her offspring when they are separated from her too early). The short-term memory loss reaches into the first part of the healing phase (PCL-A). In children, the poor memory shows as learning difficulties and focusing problems labelled, nowadays, as **Attention Deficit Disorder (ADD)**. In adults, long-lasting separation conflicts can lead to**dementia**.

NOTE: Short-term memory loss occurs during any Biological Special Program (in the conflict-active phase andPCL-A) involving the sensory, post-sensory, or premotor-sensory cortex because, in biological terms, the squamous epithelium of the entire organism is associated with a "separation conflict" (see, for example, biological conflict related to the milk ducts, mouth surface mucosa, nasal mucosa, or esophagus).



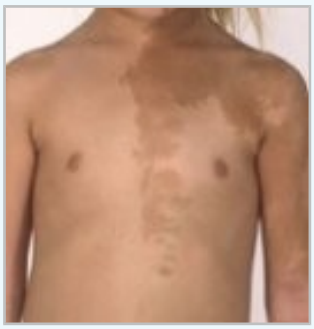
This brain scan shows large calcium deposits in the sensory cortex (view the GNM diagram). The calcification results from constant relapses of separation conflicts.

VITILIGO develops when the ulceration reaches into the basal layer of the skin that consists of melanin-producing cells. The depigmentation creates the **white patches** typical for vitiligo (compare with tinia versicolor involving the corium skin; see also Scarlet Fever). The separation conflict related to the deepest layer of the epidermis is – subjectively - perceived as particularly cruel or "brutal" (loss of a loved one, physical abuse). The white macules appear at the site(s) associated with the separation. Hair that grows on areas affected with vitiligo turns white. **Albinism**, characterized by white skin and white hair, is caused by a generalized, "brutal" separation conflict suffered by the unborn child. Due to the complete loss of the pigmented skin layer a repigmentation is no longer possible, even if the conflict is resolved.



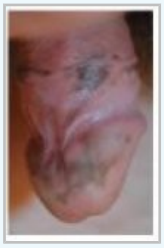
Vitiligo on the right side of the trunk reveals a "brutal" separation from a partner (for a right-handed man).

During the first part of the healing phase (in PCL-A) the affected area of the skin becomes pinkish and red, followed by a slow (!) repigmentation process in PCL-B. However, recurring conflict relapses during this phase lead to hyper-pigmentation presenting as brown spots, known as café-au-lait spots.



Here, the **café-au-lait spots** are on the left side of the upper body, exactly respecting the midline. Hence, the separation conflict is associated with the mother (for a right-handedperson) or with a partner (for a left-hander).

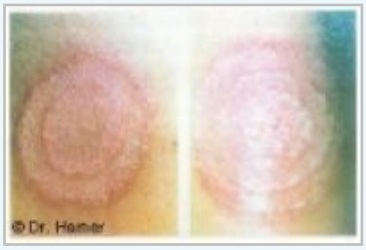
In conventional medicine, six or more café-au-lait spots are diagnosed as Von Recklinghausen disease. According to Dr. Hamer's research, "Von Recklinghausen's" relates biologically to themyelin sheath and is linked to a touch conflict (see neurofibroma).



This picture shows café-au-lait spots (light brown) on the glans penis caused by a severe separation conflict (e.g., not wanting to have sexual contact). The melanomas (dark brown) on the penis shaftcorrelate to "feeling soiled" (the development of melanomas is confined to the penis shaft since the penis head is not endowed with a corium skin).

HEALING PHASE: During the first part of the healing phase (PCL-A) the ulcerated area of the skin is replenished through**cell proliferation**. The **skin swells up**, becomes **red, inflamed, irritated, itchy**, and **sensitive to touch**(hypersensitivity). The small fluid-filled edemas appear as **blisters**. After the Epileptoid Crisis, in PCL-B, the blisters dry up and the skin normalizes, provided there are no conflict relapses.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare with hypoglycemiarelated to the islet cells of the pancreas).



Under a microscope the ulceration that occurs in the conflict-active phase (left picture) and the small edemas developing in the healing phase (right picture) show as a ring-configuration, strikingly similar to a Hamer Focus (click to view the image) in the correlating brain relay.

The healing of the skin manifests as a **SKIN RASH**, termed **dermatitis**, **eczema**, **hives (urticaria)**, **measles, rubella, chickenpox**, **rosacea**, **lupus**, **psoriasis**, **herpes**, et cetera. Based on GNM, it is all the same, namely the healing phase of a separation conflict.

SKIN RASH LOCATION

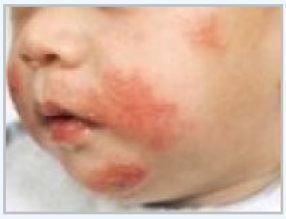
An unwanted separation (not being able or allowed to embrace or hold a beloved

person or a pet) typically presents as a skin rash on the ***inside* of the arms, hands, fingers, or legs**, while wanting to separate from a person affects predominantly the ***outside* of the arms, hands, elbows, legs, knees, shinbones**, or **ankles** used, figuratively, to push or kick someone away. Depending on the exact conflict situation, focal skin rashes also appear on the **head** (scalp),**face** (see also outer skin of the eyelid), **lips** (cold sores, **chest**, **belly**, **external genitals**, or on the **back**. A**widespread skin rash (exanthema)** reveals a generalized separation conflict suffered by a person as a whole. A body rash can also be caused by poisoning, for example, from medication - without a DHS.

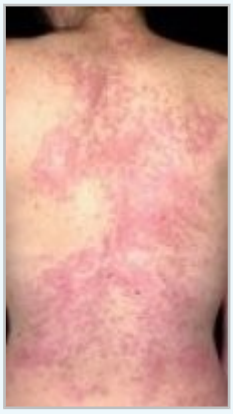
NOTE: Whether the right or left side of the body (or both sides) is affected is determined by a person'shandedness and whether the conflict is mother/child or partner-related. A localized separation conflict affects the area of the skin that is associated with the separation.

Chronic or recurring rashes occur due to conflict relapses triggered by setting on a track that was established when the separation conflict first took place. If the rash is on the hands or fingers it is called a "**contact eczema**" or "**allergic contact dermatitis"** (see "allergies"). Tracks that prompt the outbreak of such eczemas are, for instance, a specific fruit or vegetable, a piece of jewellery (ring or necklace), a certain body care product or perfume, or animal hair (a pet).

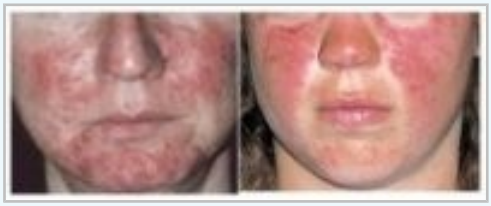
NOTE: Topical corticosteriods (see cortisone) used in inflammatory skin conditions interrupt the healing phase. This is why the rash reoccurs shortly after the application is discontinued.



Babies develop **dermatitis** around the mouth and on the cheeks when the mother stops breastfeeding too abruptly. The separation conflict is brought on by the loss of contact with the mother's breast. If the first taste of commercial milk is established as a track, this causes a so-called "milk allergy".



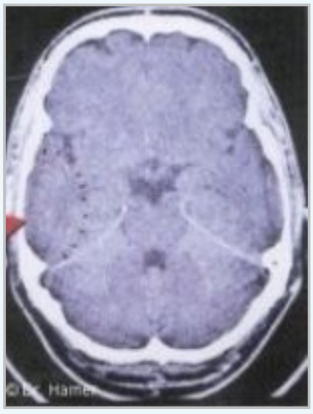
Hives, also known as **urticaria**, is also believed to be a type of "skin allergy". The picture shows a hives outbreak on the back provoked, for example, by a "get off my back"-track.



Both **rosacea** (left picture) and **lupus erythematosus** (right picture) are skin rashes that appear on the nose, chin, and cheeks. The conflict is experienced as a separation "from the face" either through a loss of contact or through wanting to separate ("get out of my face!"). The pus-filled pimples (here with rosacea) involve the corium skin and are linked to a disfigurement conflict, usually caused by the skin condition itself.

Since the face is supplied by the trigeminal nerve, healing of the facial skin is often accompanied by **nerve pain**, called**trigeminal neuralgia** (see also trigeminal neuralgia related to the periosteum and to the facial bones).

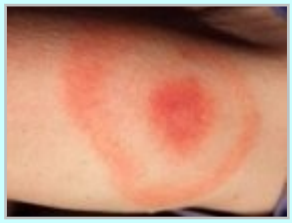
NOTE: The trigeminus nerve has sensory and motor branches. The motor branch of the nerve is involved withfacial paralysis.



This CT scan highlights a Hamer Focus in the brain relay that controls the right trigeminal nerve. In this case, the person (a left-handed male) suffered a separation conflict from hismother. The trigeminal neuralgia occurs therefore on the right side of the face.

LYME DISEASE

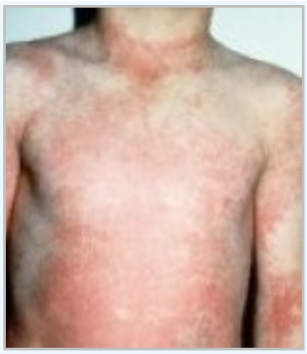
Lyme disease is said to be transmitted to humans by the bite of ticks infected with the bacterium*borrelia burgdorferi*. According to the theory, if left untreated the "infection" spreads to other parts of the body.



The typical symptoms of **borreliosis** include fever, body aches, fatigue, headaches, and a **circular outwardly expanding rash**, called erythema migrans (EM), at the site of the bite. Based on GNM, the characteristic reddening is not the result of an "infection" but rather the healing of the injury caused by the tick bite (the release of histamine enlarges the pores in the blood vessel wall to increase the blood flow at the affected area). The same response occurs, for example, after a bee sting.

Symptoms that develop *after* the tick bite are brought on by conflicts triggered by the Lyme disease diagnosis (a "feeling-soiled" conflict with a fungal infection known as "ringworm", a motor conflict of not being able to escape with muscle paralysis) and the fear of the "serious consequences of Lyme disease" (see meningitis). Water retention due to the SYNDROME (active existence conflict caused by the panic) exacerbates the symptoms. **NOTE:** There are people who are diagnosed with "Lyme disease" without ever being bitten by a tick.

In **measles**, **rubella** (also known as German measles), and **chickenpox** the skin rash covers most of the body. Generalized separation conflicts, which affect the entire body, are typically experienced by infants and young children who are much more vulnerable regarding separations from the "pack" (at home, at school). How the "childhood disease" presents itself depends on which epidermal layer is involved (chickenpox goes deeper than measles and rubella) and on the intensity of the preceding conflict-active phase (rubella causes milder symptoms than measles). With theSYNDROME, that is, with water retention as a result of an active abandonment conflict, the blisters of the skin rash appear more dramatic. An intense healing phase is accompanied by high fever.



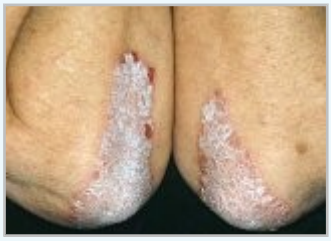
Scarlet Fever occurs when the separation conflict affects the underside of the epidermis (showing as white patches - see vitiligo) and the upper side of the epidermis with the development of a skin rash after the conflict has been resolved. A red and swollen tongue("raspberry tongue") indicates an additional "oral conflict" (possibly food-related); a "strep throat" points to a conflict of "not wanting to swallow a morsel" (food or, figuratively, a situation that is "hard to swallow"). The theory that the skin rash in scarlet fever is a "streptococcus infection" is, from a GNM point of view, irrelevant.

Based on the understanding of the Fourth Biological Law, these "**childhood diseases"** are not "contagious viral infections", as claimed, but the *healing phase* of separation conflicts experienced by more children at the same time (the existence of viruses that supposedly cause measles, rubella, or chickenpox has never been scientifically substantiated). Such collective separation conflicts can be school-related (a separation associated with a schoolmate or teacher) or home-related affecting all siblings. Not being allowed or not wanting to have contact with someone who has the "infection" results in a "spreading" of separation conflicts rather than of the condition itself. Measles outbreaks in school or among a larger population are often linked to the fear of coming in contact with an "infected" person.

This diagram shows the measles death rates in Germany between 1961 and 1995. Source: German Federal Office of Health Wiesbaden.

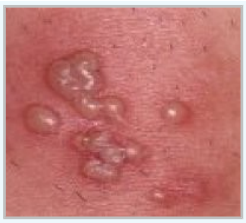
The measles vaccination program ("Impfeinführung") started in 1976, well after the peak of the measles epidemic (see also polio vaccination program and tetanus vaccination program).

Psoriasis involves two separation conflicts; one is in the conflict-active phase causing a flaky skin, the other is in thehealing phase showing as an inflammation. The two phases overlap at the same area(s), presenting as silvery scales on a thick, red surface. The location reveals which part of the body was associated with the conflict. What is termed"**psoriatic arthritis"** is, in GNM terms, a combination of separation conflicts and self-devaluation conflicts (see joints) that occurred simultaneously.

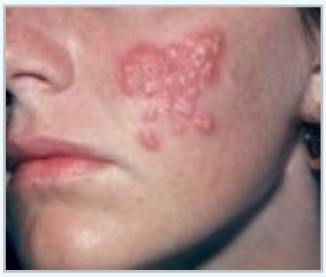


This picture shows psoriasis on both elbows indicating two localized separation conflicts of wanting to push someone away in defense (or wanting to get some "elbow room") related, let's say, to a terrorizing colleague at work and simultaneously to an annoying family member at home. The exact appearance of the condition is determined by which one of the two conflicts is active or healing at the time.

Psoriasis affects the two upper layers of the epidermis , namely the granular layer where squamous epithelial cells are converted into keratin and the stratum corneum where the buildup of keratin forms white plaques on the surface of the skin.

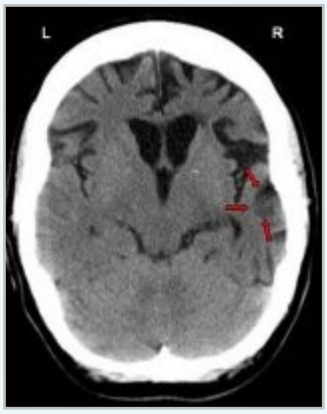


Herpes (here, a close-up image) presents as small, fluid-filled blisters similar to dermatitis orchickenpox. They develop at the area of the skin that correlates to the separation conflict, for example, on the lips (missing to be kissed or not wanting to be kissed, oral sex-related distress, lip contact with a dirty glass or an "infected" straw, cigarette "withdrawal"). On the lips such blisters are commonly called "**cold sores"**. The sun can be a trigger or track for recurring "solar herpes" on the lips.



Herpes on the left cheek reveals that the separation conflict was associated with a partner, if the person is left-handed. For a right-hander it indicates a mother or child-related conflict.

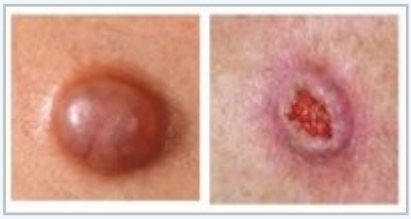
A localized conflict translates into being touched at this particular area of the skin at the moment when the DHS occurred.



This brain CT shows fluid accumulation (in PCL-A) in the right sensory cortex from where the epidermis of the left side of the face is controlled (view the GNM diagram). Hence, the development of a skin condition in this particular area.

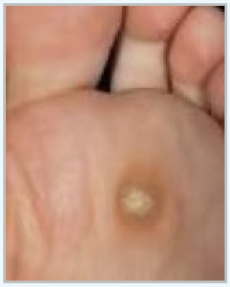
Genital herpes on the external genitals (vulva, labia, penis, scrotum) or in the vagina are linked to a **sexual separation conflict** (loss of a sexual mate, sexual rejection, unwanted sex, sexual abuse). The fear or suspicion that a sexual mate might sleep with someone else can already trigger the conflict. The healing phase could also manifest asdermatitis on the genitals or as genital warts. Skin lesions on the genitals (male and female) might be diagnosed as **soft chancre (ulcus molle)** or **chancroid**. In conventional medicine, it is considered the "first sign" of **syphilis**.

Venereal diseases are generally assumed to be bacterial or viral infections that "spread through sexual contact". Yet, to this day, the existence of disease-causing viruses (herpes simplex virus, herpes zoster virus, HIV, HPV, and the like) has never been scientifically proven! Apart from that, based on the knowledge of the Five Biological Laws, venereal diseases such as gonorrhea, chancroid, syphilis, genital herpes as well as candidiasis (see penile candidiasis or vaginal candidiasis) and cancers involving the sexual organs (see cervical cancer) cannot be sexually transmitted since the symptoms are already *healing* symptoms. Hence, a sexual partner can only get, for example, herpes if he/she suffered a separation conflict at the same time, let's say, because of imposed sexual abstinence based on the belief that the condition is contagious. The fear of having contracted a "sexually transmitted disease" could also activate a separation conflict. The distress experienced through unwanted sexual practices or forced prostitution explains why the incidence of "venereal diseases" is more common among particular groups and populations.

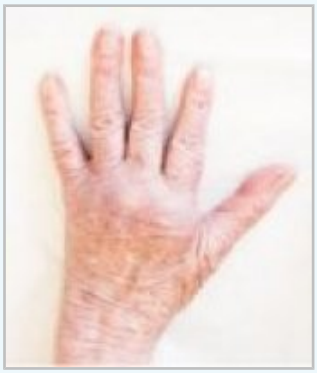


A **basalioma** or **basal cell carcinoma** (left picture) arises from the basal layer of the epidermis that consists mainly of pigment-producing melanophores. Hence, the brownish color of the growth. A **squamous cell carcinoma** (right picture) originates in the upper layer of the epidermis. Both occur during the healing phase of a separation conflict. In conventional medicine, they are erroneously thought to be "skin cancers" caused by prolonged exposure to sunlight (see also melanoma).

Warts are the result of excessive healing due to continuous conflict relapses. They develop alone or in groups at the area of the skin that was associated with the separation; they appear raised or flat depending on the intensity of the recurring conflict. **Skin tags**, which are small flaps of tissue that hang off the skin by a connecting stalk, are similar to warts.**Genital warts** (condyloma) on the external sexual organs, in the vagina, in the cervix, or on the penis reveal persistent sexual separation conflicts.

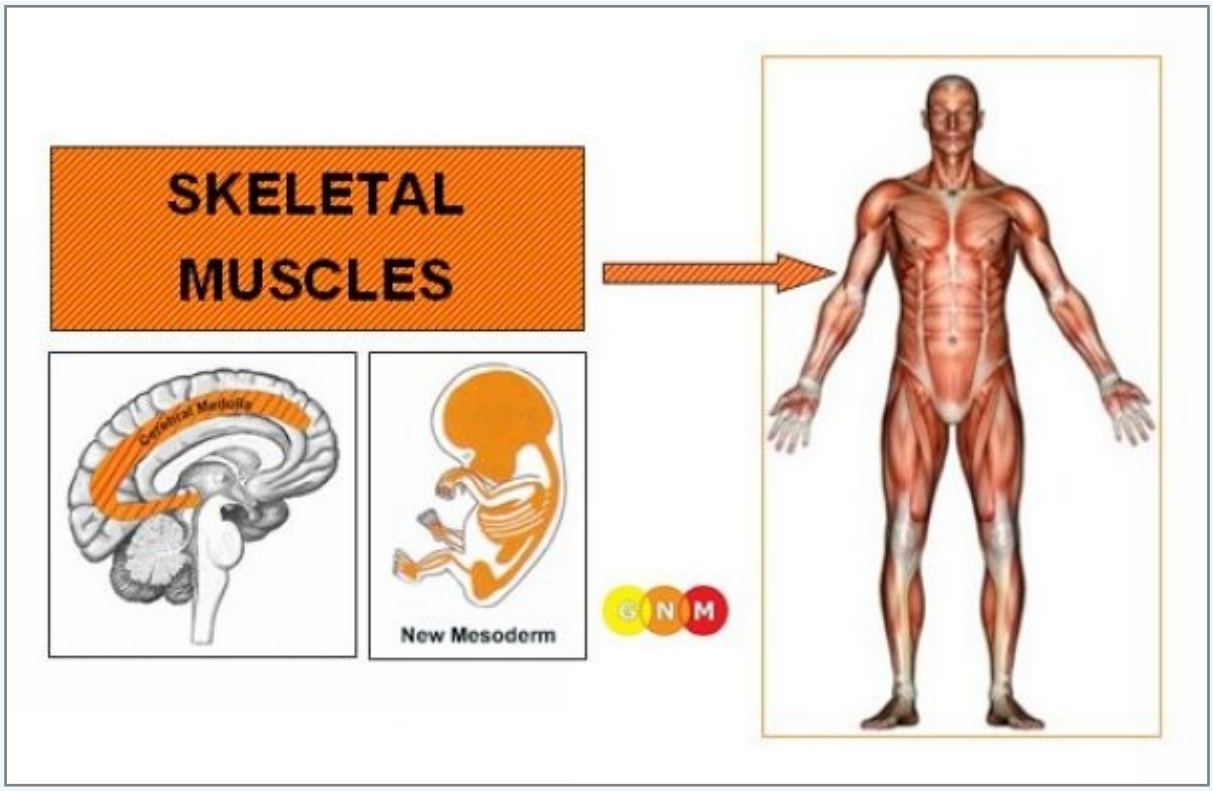


Plantar warts originate in the deep basal layer of the epidermis. They typically occur on the sole (Latin: planta) or toes of the feet. Wanting to "separate" from the ground one is standing on or, the opposite, namely not wanting to leave a place (workplace, sports facility, home, village, town, country) is the underlying conflict experience. Cats and dogs develop warts as well, for example, because of an unwanted move. Shoes such as work boots or hiking shoes one wants to get off, also lead to plantar warts, particularly at pressure points. The same applies to a **clavus**, commonly called a "corn". The claim that plantar warts, unlike corns, are caused by the "contagious human papilloma virus (HPV)" has no scientific basis.



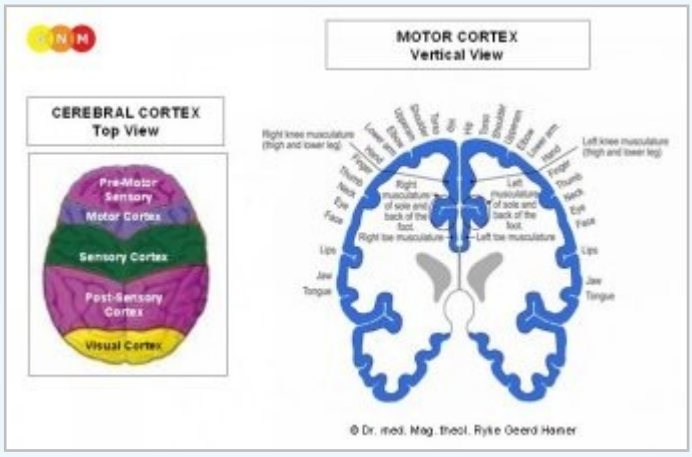
A lasting, intense healing phase (hanging healing) leads over time to a hardening of the skin or**scleroderma**, locally or throughout the body (generalized). Scleroderma can also involve theconnective tissue layer underneath the skin. Often, the two Biological Special Programs(separation conflict and self-devaluation conflict) run concurrently.

SKELETAL MUSCLES

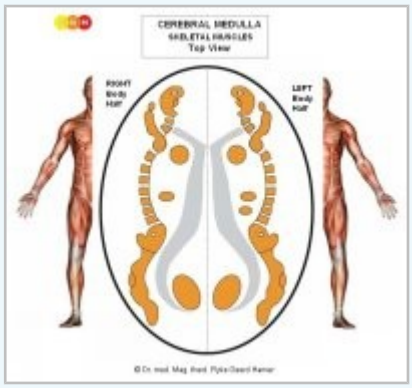


Biological Conflict **Conflict-Active Phase** **Healing Phase**

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 throughtendons 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.



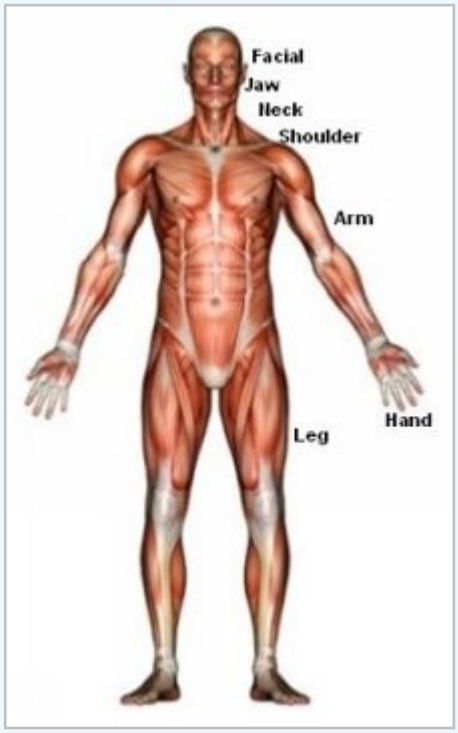
In the cerebral medulla, the bones, skeletal muscles, lymph vessels with lymph nodes,blood vessels, connective tissue, and fat tissue share the same brain relays and therefore the same biological conflict, namely a self-devaluation conflict. The control centers are orderly positioned from head to toe.

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), 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 avaccination, 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 (wheel chair image).

Motor conflicts can also be experienced **with or in 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").

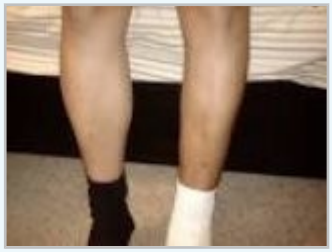
A fetus might endure the conflict of "not being able to escape" when the mother is in danger or because of threatening noises in the immediate environment (jackhammers, chain saws, lawn mowers, grass trimmers), loud kitchen equipment such as blenders held close to the womb, or screaming and yelling (fights between parents). 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.

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 (see conflicts triggered through the practice of animal testing).

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). 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 (periosteal nerves and thalamus).

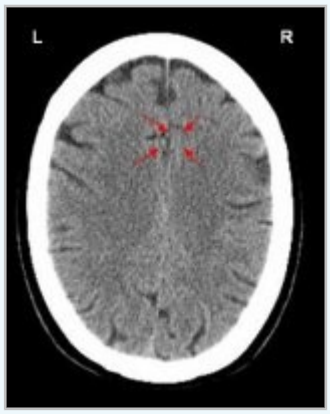
Prolonged conflict activity leads to **muscle atrophy** (muscle wasting) *without* paralysis if the conflict is experienced solely as a self-devaluation conflict. The pelvic floor muscles become weak because of a difficult pregnancy, sexual humiliation, chronic constipation, or urinary incontinence making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

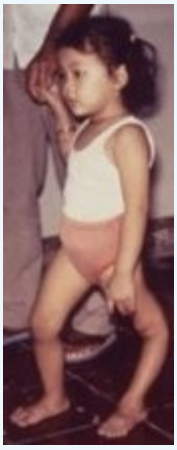
With a motor conflict muscle atrophy and muscle paralysis occur together, particularly when the distress of not being able to move an arm or leg (or both) causes a self-devaluation conflict.

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), **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").

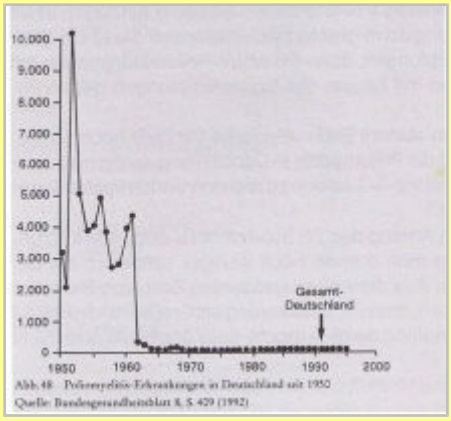


This brain CT shows the impact of a motor conflict. The center of the Hamer Focus is on the right brain hemisphere (para-central), precisely, in the area of the motor cortex that controls the left leg (view the GNM diagram). The partly edematous ring (dark) indicates that the healing phase is interrupted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



This diagram shows the incidence rates of poliomyelitis in Germany between 1950 and 1992. Source: German Federal Office of Health, 1992.

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

Detailed incidence rates of poliomyelitis in Germany and the USA can also be found on this website.

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

"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." (Vaccination, Greg Beattie)

Source: Doctors Change Names of Diseases when Vaccines do not work

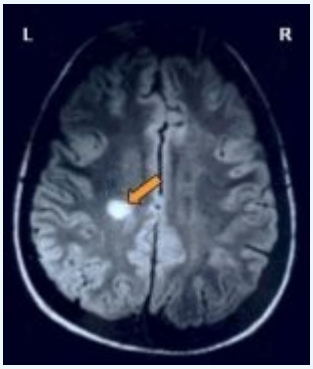
Multiple Sclerosis (MS)

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.

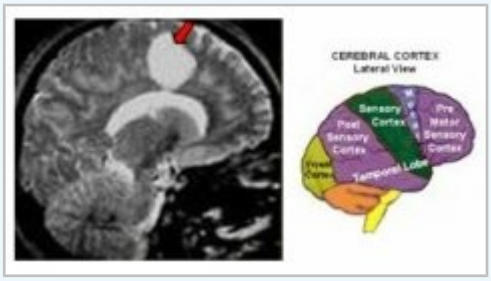
Dr. Hamer: "The big danger is that the patient suffers a **motor conflict due to the diagnosis shock**, since he has been told that he will most likely be in a wheelchair for the rest of his life."

Without the knowledge of GNM, a MS diagnosis causes great panic. The same holds true when a person is diagnosed withALS. 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 themuscle atrophy also advances leading to clumsiness, difficulties walking, and frequent falls (see also "falling conflict" andvertigo). 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 diseases" makes a person whose parent has the condition more vulnerable to suffer a motor conflic (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 thetongue, 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). The motor branch of the trigeminus nerve (fifth cranial nerve), which provides motor control to the jaw muscles, affects motor functions such as biting and chewing.

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).

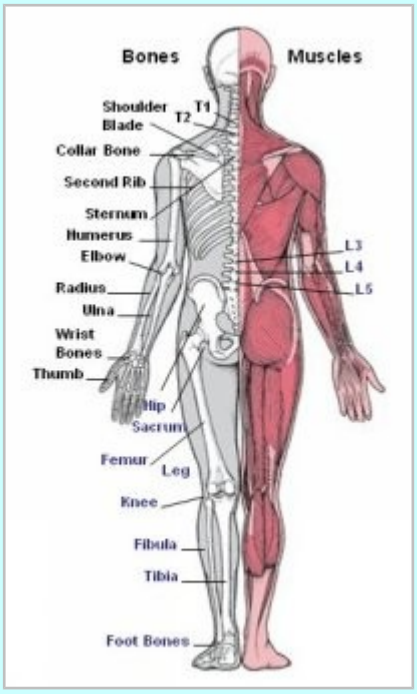
Muscle hypertrophy, an enlargement of the muscle, is the result of a continuous healing process (hanging healing).

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 complete, the organ or tissue is stronger than before, which allows to be 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'shandedness and whether the conflict is mother/child or partner-related. **Fibromyalgia** is the medical term for widespread muscle pain. In GNM terms, fibromyalgia indicates 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 infectionwith the "Epstein Barr virus" that has also been made responsible for mononucleosis presenting as swollen lymph nodesin 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, collar bone, shoulder blade, upper part of the sternum as well as the second rib and second and third thoracic vertebrae (T 1 and T2) are a functional unit.

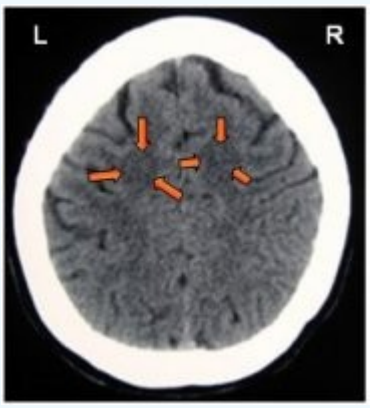
LEG SEGMENT: The musculoskeletal segment of the leg, including the foot bones (ankle, heel bone, toe bones), fibula and tibia, knee, femur and femoral neck, hip and sacrum as well as the third, fourth, and fifth lumbar vertebrae (L 3, 4, 5) are a functional unit.

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 medullareaches 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 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

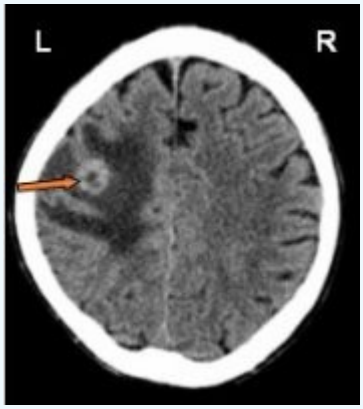
An intense Epileptoid Crisis manifests as an **epileptic seizure** with tonic-clonic convulsions and rapid muscle contractions. A localized or **focal seizure** with spasms or jerking of a single muscle or muscle groups is confined to the conflict-related muscles, for example in the leg(s) or arm(s). In a **grand mal seizure** the convulsions involve the muscles of the whole body, sometimes accompanied by 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.

NOTE: Epileptic seizures (preceded by partial paralysis) 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 with rabies typically present a dropped jaw due to the paralysis of the jaw muscles ("not being able to bite" the opponent).

A person who has a grand mal seizure might lose consciousness and fall to the ground (see also "falling conflict" causingvertigo). In this case the motor conflict is coupled with a separation conflict that typically generates an "absence" (fainting) during the Epileptoid Crisis. This would explain why "absence seizures" are more common in children than adults. In a **petit mal seizure** the zoning out only lasts a few seconds. "**Ecstatic seizures"** that produce altered states of consciousness, out-of-body experiences, or euphoric religious feelings relate, in GNM terms, to a schizophrenic constellation involving the brain relays of the bronchia and larynx in the temporal lobe. Interestingly enough, in neurological research an "ecstatic seizure" is referred to as a "temporal lobe epilepsy"!

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.



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 (presenting as white on the scan) indicates that the person is already in PCL-B. The edema located in the cerebral medulla (showing as 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.

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 byscare-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 theEpileptoid 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!

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: German Federal Office of Health Wiesbaden

The statistics demonstrate that the vaccination program started in 1970, well after the peak of the tetanus epidemic (see alsopolio 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 plaque 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 arteryauxiliary 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”).

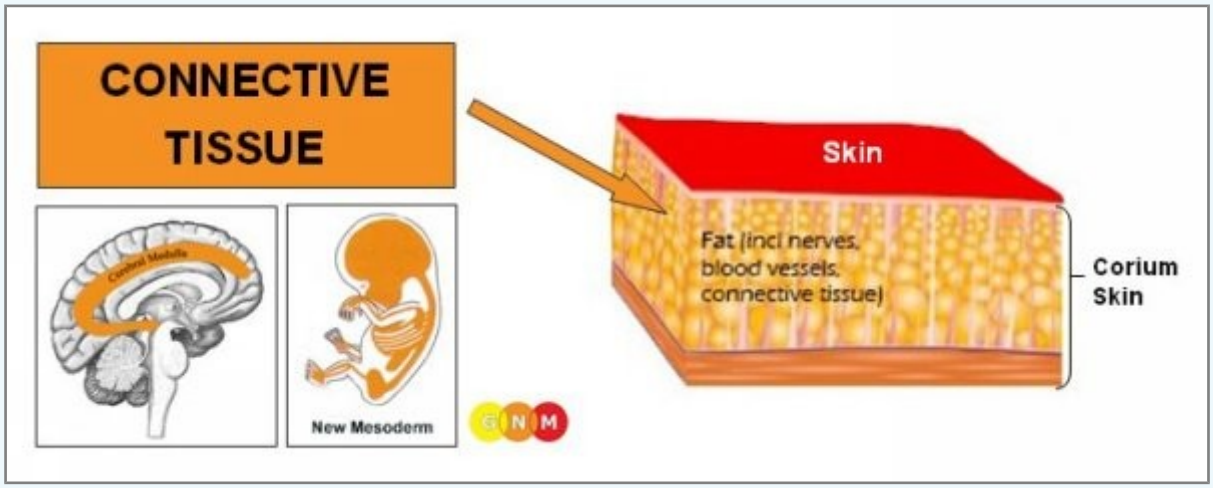
The **white stroke** occurs at the moment of the DHS. The impact of the motor conflict in the motor cortex generates sudden muscle weakness in one or more limbs, typically on one side of the body. Which side is affected is determined by a person’s handedness and whether the conflict is mother/child or 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 thelaryngeal 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.

The muscle weakness or paralysis lasts throughout the conflict-active phase (cold hands, little appetite) and reaches intoPCL-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 bronchia, 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

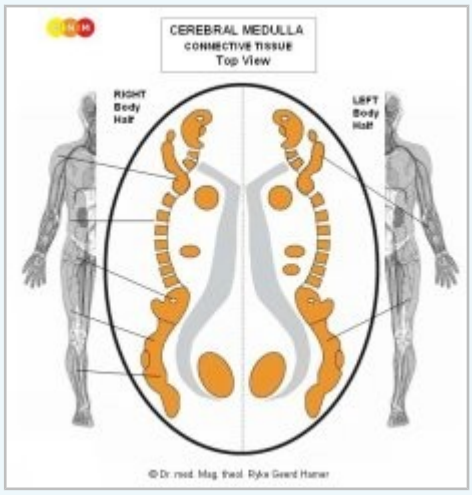
cerebrum. After the Epileptoid Crisis, in PCL-B, the paralysis recedes and the motor ability slowly returns to normal. However, if the brain edema cannot be completely expelled, the paralysis (partly) remains since the synapses between the neurons don't connect properly. This usually happens because of water retentiondue to an active abandonment and 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.

CONNECTIVE TISSUE



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CONNECTIVE TISSUE: As the name implies, connective tissue joins other tissues of the body together. It connects muscles to bones and gives strength to tendons and ligaments; it consists for the most part of elastic fibers. A layer of loose connective tissue containing fat cells lies directly underneath the skin(subcutaneous). Next to providing structural support, connective tissue aids in tissue repair by forming fibrous scar tissue (during PCL-B). Neuroglia is a specialized form of connective tissue that assists healing processes in the brain. Connective tissue derives from the new mesoderm and is therefore controlled from the cerebral medulla. **NOTE:** Like the connective tissue, neuroglia is also of new mesodermal origin.



BRAIN LEVEL: In the **cerebral medulla**, the connective tissue of the right side of the body is controlled from the left side of the brain; the connective tissue of the left side is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The bones, skeletal muscles, lymph vessels with 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.

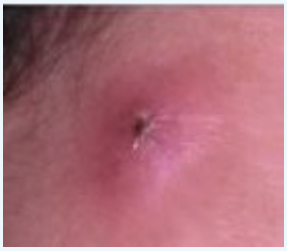
BIOLOGICAL CONFLICT: The biological conflict linked to the connective tissue is a **light self-devaluation conflict** or**loss of self-worth**. The specific self-devaluation conflicts are the same as for the bones and joints.

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

NOTE: Whether the conflict affects the connective tissue of the right or left side of the body is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the connective tissue that is closest to the site associated with the self-devaluation conflict.

CONFLICT-ACTIVE PHASE: connective tissue necrosis (cell loss)

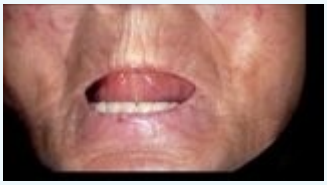
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation). With profuse cell growth the swelling might be diagnosed as a **connective tissue sarcoma**, considered in conventional medicine as a "malignant" cancer (see alsomuscle sarcoma). However, if the rate of cell division is be below a certain limit, then the growth is regarded as a "benign" tumor or **fibroma** (compare with neurofibroma related to the myelin sheath).



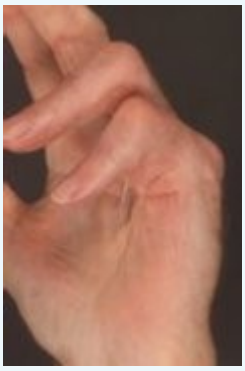
A **carbuncle** or **furuncle**, also known as **boil**, develops at the area of the body where the self-devaluation conflict was experienced, for example, on the forehead because of an intellectual self-devaluation conflict.

The abscess originates in the connective tissue layer underneath the skin. Often, a boil starts in a hair follicle, which reaches deep into the subcutaneous tissue. If bacteria such asstaphylococcus bacteria assist healing, the painful growth becomes filled with pus, typically accompanied by an inflammation, termed **carbunculosis**, **furunculosis** or **folliculitis**. A carbuncle or furuncle could also originate in the corium skin; in this case, the related conflict is an attack or "feeling soiled" conflict.

Keloids are an overgrowth of scar tissue at the site of a wound, for example, after burns. However, keloids also form as a consequence of long-lasting healing phases due to continuousconflict relapses, particularly during the scarification phase (PCL-B). The recurring repair leads to the thick, raised appearance characteristic of keloidal scars.



Scleroderma ("hard skin") is a condition in which the skin becomes thick and hard and loses its elasticity. It is the result of prolonged healing in the connective tissue layer underneath the skin. Scleroderma around the lips reveals that the self-devaluation conflict was associated with the mouth area similar to an oral conflict (see also scleroderma related to theepidermis).



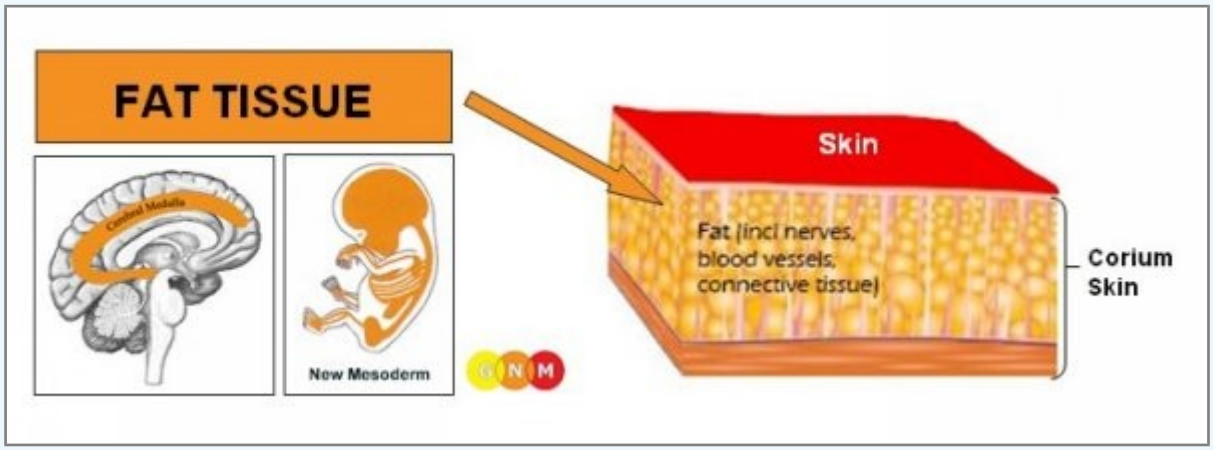
A thickening and tightening of the connective tissue of the palm and fingers is termed**Dupuytren's contracture** (the condition does not involve the tendons, as generally assumed). Symptoms include painful bumps (nodules) that develop into tough bands of tissue, causing the fingers to curl (compare with focal hand dystonia where the finger(s) curl into the palm due to sustained muscle contractions). A recurrence after surgery is an indication that the conflict has not been resolved.

A self-devaluation conflict related to alcohol problems (associated with the hand holding the drink) is a possible conflict scenario…

... or a self-devaluation conflict related to driving (associated with shifting gears).

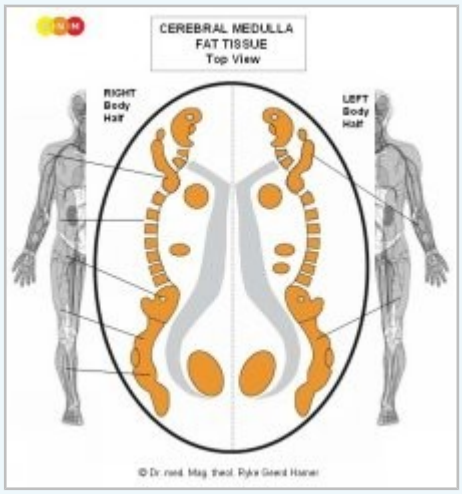
NOTE: All organs that derive from the new mesoderm ("surplus group"), including the connective tissue, show the **biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict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

FAT TISSUE



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE FAT TISSUE: The fat tissue forms a thick layer underneath the skin(subcutaneous fat) and around internal organs (visceral fat). It has an insulating as well as a supportive function. In addition to adipose cells, fat contains components of loose connective tissue such as elastic fibers. Fat tissue originates from the new mesoderm and is therefore controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the fat tissue of the right side of the body is controlled from the left side of the brain; the fat tissue of the left side is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The bones, skeletal muscles, lymph vessels with 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 CONFLICT: The biological conflict linked to the fat tissue is a **light self-devaluation conflict** or **loss of self-worth**. The specific self-devaluation conflicts are the same as for the bones and joints.

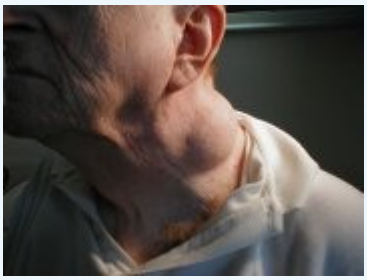
In line with evolutionary reasoning, **self-devaluation conflicts** are the primary conflict theme associated with cerebral medulla-controlled organs deriving from the new mesoderm.

NOTE: Whether the conflict affects the fat tissue of the right or left side of the body (or both sides) is

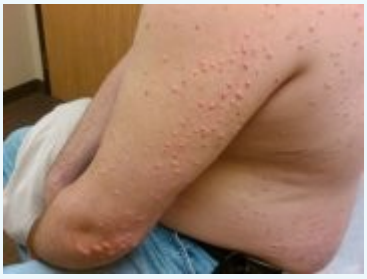
determined by a person's handedness and whether the conflict is mother/child or partner-related.
A localized conflict affects the fat tissue that is closest to the site associated with the self-devaluation conflict.

CONFLICT-ACTIVE PHASE: fat tissue necrosis (cell loss)

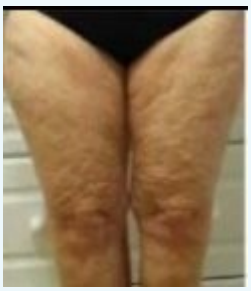
HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. Depending on the intensity and duration of the conflict-active phase, the growth(s) vary in size.



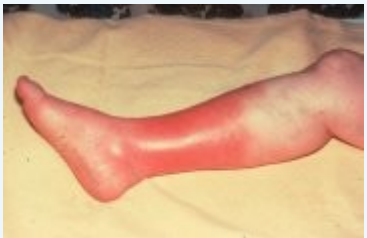
A localized swelling presents as a **lipoma** (in its appearance a lipoma looks similar to aneurofibroma). A lipoma on the left side of the neck corresponds to an intellectual self-devaluation conflictrelated to a partner, if the person is left-handed (compare withHodgkin's lymphoma and non-Hodgkin's lymphoma).



Small fat nodules are called **xanthomas**. The affected area reveals with what part of the body the self-devaluation conflict was associated.



Cellulite, also known as adiposis edematosa, shows as fat pockets just below the skin, giving it a dimpled, lumpy appearance (this differs from loose and wrinkly skin as a result of the natural aging process). Cellulite affects mainly women, often at an early age, and predominantly "problem areas" such as the thighs and buttocks considered as "too fat" (a perception that is culturally conditioned; in Nature there is no "too fat" or "too thin"). The "unattractive" look usually creates additional self-devaluation conflicts, which worsens the condition.

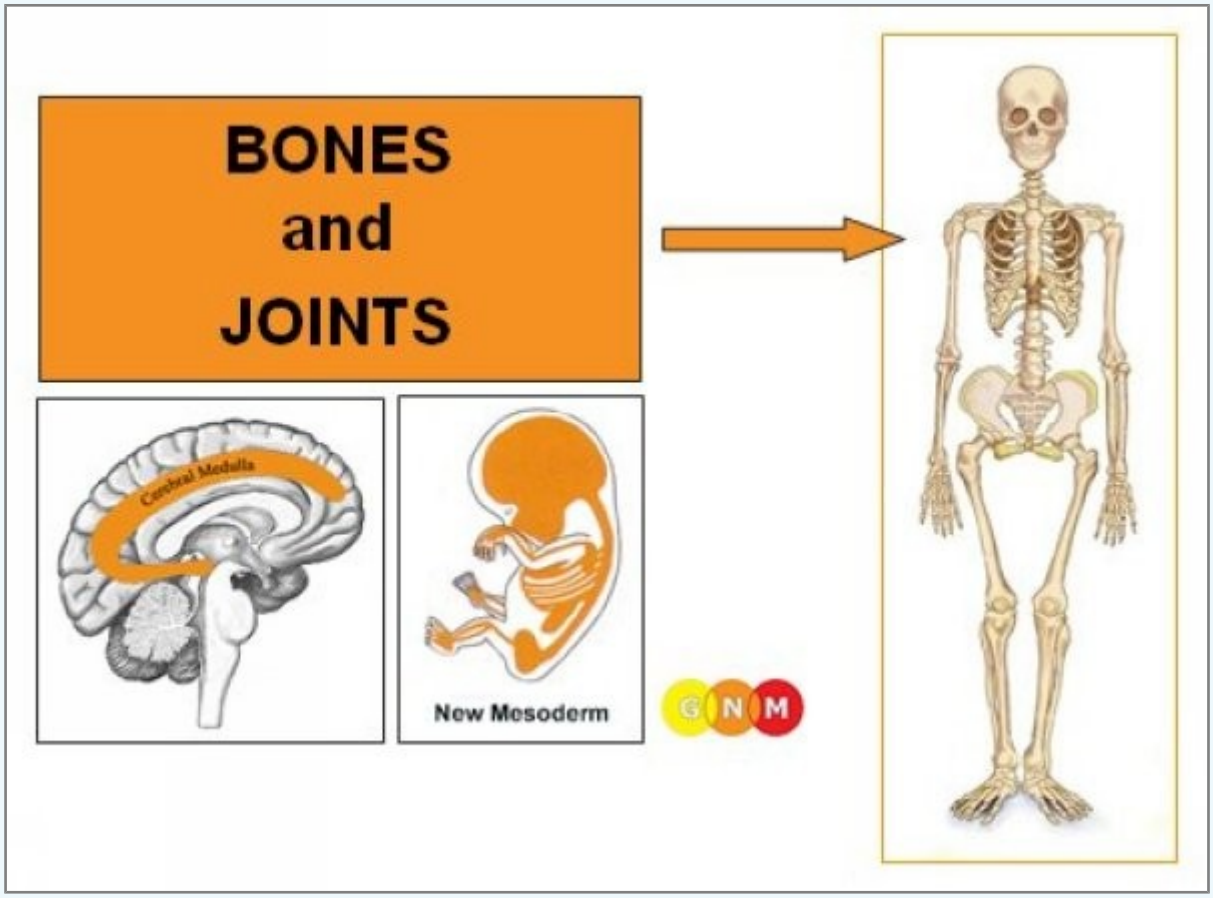


In **cellulitis** (not to be confused with cellulite), the affected area is swollen and inflamed, particulary when bacteria assist the healing process.

A self-devaluation conflict associated with the leg could be triggered by not being able to keep up (literally or figuratively). If the condition occurs on the right leg (see picture), this points to a mother or child-related conflict, if the person is left-handed.

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

BONES & JOINTS



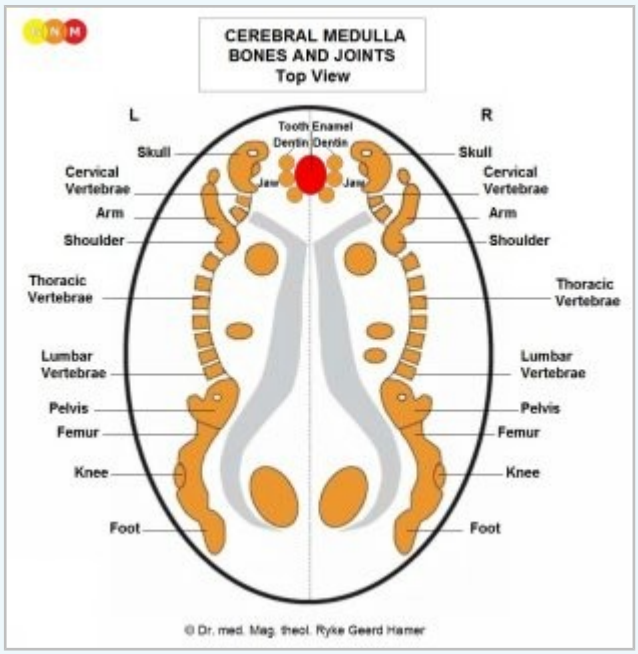
Biological Conflict **Conflict-Active Phase** **Healing Phase**

Anemia and Leukemia

DEVELOPMENT AND FUNCTION OF THE BONES AND JOINTS: The skeletal system includes all bones and joints of the human body. **Ligaments, tendons, cartilage**, and connective tissue connect and stabilize the bones. Together with the skeletal muscles, the bones and joints allow controlled physical movements. They also provide protection for many of the body's internal organs. The ribs, for example, protect the pleural cavity containing the heart and lungs. The bone tissue stores several minerals, specifically calcium and phosphorus that keep the bones strong. The red bone marrowinside of bones produces most of the blood cells, including erythrocytes (red blood cells), leukocytes (white blood cells), and thrombocytes (platelets). Most bones of the limbs contain mainly yellow bone marrow composed for the most part of fat. However, if the body suffers large amounts of blood loss, yellow marrow is converted into red bone marrow to ensure blood cell production. Osteocytes ("mature bone cells") and osteoblasts ("immature bone cells") are the major cellular components of bone. Osteoblasts are bone-building cells that also form callus required for bone repair (see also dentin-producing odontoblasts). The outer surface of the bones is covered by the periosteum, except the joints and sites attached to ligaments and tendons, which are capped with cartilage. The firm cartilage surface reduces friction during joint movement (compare with elastic ear cartilage). The cartilage is covered by the perichondrium, the equivalent to theperiosteum lining the bones.

NOTE: The embryonic skeleton is mainly made up of cartilage which is gradually replaced by bone. This process, called ossification, does not complete until after birth. Some parts of the body remain as cartilage, for example, the tip of the nose and the external ear.

The bones as well as the cartilage, tendons and ligaments originate from the new mesoderm and are therfore controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the bones and joints (incl. cartilage, tendons, and ligaments) of the right side of the body are controlled from the left side of the brain; the bones and joints of the left side of the body are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The bones, skeletal muscles, lymph vessels with 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 CONFLICT: The biological conflict linked to the bones and joints is a **severe self-devaluation conflict or loss of self-worth**. The cartilage, tendons, and ligaments correlate to a light self-devaluation conflict.

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

A **generalized self-devaluation conflict** concerns the whole person. The conflict is experienced, for example, through humiliation (accusations, scoldings, derogatory remarks), abuse (physical, sexual, verbal), failure (at work, in school, in sports, in a relationship, as a parent or partner), a poor performance (intellectual, artistic, athletic), or feelings of shame and guilt. The loss of a status, the loss of a workplace, retirement, illness or injuries ("I am out of commission"), aging ("I am not as good as I used to", "I am getting old and useless") or the loss of a person, who made one feel appreciated and needed, are other conflict scenarios. The way we perceive ourselves or speak to ourselves ("I am a failure", "I will never succeed") create mental predispositions for generalized self-devaluation conflicts. Children and the elderly are more vulnerable to suffer the conflict.

A **localized self-devaluation conflict** (see localization) relates to a specific part of the body. A poor artistic or athletic performance, for example, corresponds to the hands or legs. A self-devaluation conflict brought on by a cancer diagnosis (colon cancer, prostate cancer, breast cancer), a negative prognosis ("You won't be able to walk again!"), the removal of an organ (mastectomy), or continuous localized pain correlates to the nearest bone or joint. In comparison, a moderate self-devaluation conflict would involve the closest lymph node or muscle.

NOTE: Whether the conflict affects a bone or joint on the right or left side of the body (or both sides) is determined by a person's handedness and whether the conflict is mother/child or partner-related.
A localized conflict affects the bone or joint that is associated with the self-devaluation conflict.

LOCALIZATION: Each part of the skeletal system has its specific conflict content.

Skull and Cervical Spine: intellectual self-devaluation conflict. The conflict could be triggered by failing an intellectual task (in school, at work), by having made a mistake, or by condescending remarks of teachers, coaches, employers, colleagues, a parent or a partner, making a person feel "slow" or "stupid". People who have an occupation that is intellectually demanding (scholars, academics, writers, and others), whose self-worth is built on their intellectual achievements, or are academically overambitious are more susceptible to experience the conflict. Self-talks ("I am an idiot!", "I am not smart enough!") can generate a self-inflicted loss of self-worth. The fear of failing might already activate the conflict. Unexpected **injustice** ("This is not fair!") also affects the skull and cervical spine.

Facial Bones: self-devaluation concerning ones look or reputation

Orbital Eye Socket: self-devaluation related to the eyes, for example, after surgery ("You look like a monster!")

Jaw bones: not being able to bite, literally or figuratively

Ossicles and **mastoid** in the ear: self-devaluation associated with the ears (hearing impairment)

Shoulders, Humerus (upper arm) and Collar Bones: relationship self-devaluation conflict (having failed as a partner, parent, colleague, friend, or team mate) often in association with guilt and blaming oneself. A poor performance, let's say, in sports (baseball, handball, golf, hockey) also affects the shoulder, as the "joint of action".

Elbows: self-devaluation involving the elbow, for example, in sports (tennis, squash), playing a musical instrument (violin, cello), or work-related activities. Also, not being able to embrace or hold a person or a pet, associated with the elbow(s).

Wrist, Hands and Fingers: **dexterity conflict** caused by failing a manual task or by a poor manual performance. People whose self-confidence relies predominantly on their manual achievements, whose occupation requires fine motor skills (surgeons, dental hygienist, jewelers) and finger dexterity (typing, needle work, playing a musical instrument such as the guitar or the piano) are more likely to suffer this type of self-devaluation conflict.

Ribs and Sternum: self-devaluation conflict prompted, for example, by a breast cancer diagnosis, a mastectomy, or a heart condition (see heart valves)

Thoracic and Lumbar Spine: central self-devaluation conflict that shatters the core of one's self (humiliating and degrading treatment). The lower back is also associated with feeling **unsupported** ("not backed up") by a family member, partner, friend, teacher, colleague, or employer. A cancer diagnosis related to the area of the thorax (lung cancer) or the lumbar spine (prostate cancer, kidney cancer, colon cancer) or constant pain (abdominal pain, menstrual pain) affect the closest vertebrae.

Pelvis and Pubic Bone: sexual self-devaluation conflict. Sexual abuse, erectile dysfunction, not "performing" as expected, finding out that the partner is having an affair, sexual rejection, feeling devalued below the waist, not getting pregnant, miscarriages, a hysterectomy, a prostate cancer diagnosis, prostate surgery, or urinary incontinence could provoke the conflict.

Coccyx (tailbone) and Sacrum: self-devaluation associated with the buttock; "a tergo" sex perceived as humiliating, pain during intercourse, local symptoms (hemorrhoids, chronic diarrhea, vaginal dryness)

Ischial Bone: inability to posses something (we figuratively "sit on" what belongs to us in order to secure it), being unable to sit something out, not being able or allowed to sit on one's place (desk, car,

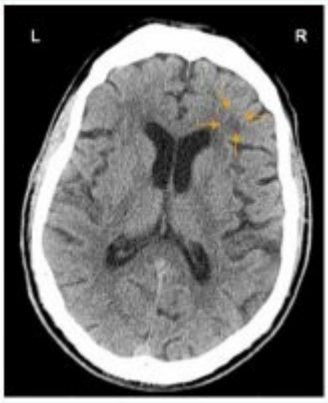
bike, motorcycle, horse)

Hip and Femoral Neck: not being able to endure a situation because of unexpected or continuous demands ("This is too much to carry!", "I can't manage!" , "I can't get through this!"). The **femur** is linked to a **physical performance conflict**.

Knees and Lower Legs: physical performance conflict, for example, difficulties walking or climbing stairs, not being able to keep up, a poor performance in sports (having lost a game, being put on the reserve bench, humiliating remarks by an instructor, not performing up to our standards or the expectations of a coach, parent, or spouse), feeling less mobile during pregnancy or because of having gained weight

Feet, Ankles, Heels and Toes: **not being able to walk, run, jump, dance,** or **balance**; also, not being able to kick someone away in defence. The underside of the heel is linked to not being able to "crush" a person or a situation.

CONFLICT-ACTIVE PHASE: During the conflict-active phase the affected **bone decalcifies** creating gaps and little holes in the bone. The location of the **osteolysis** ("bone breakdown") is determined by the exact type of self-devaluation conflict; the degree by the intensity of the conflict. The decalcification of the bone increases the serum calcium levels (compare with hypercalcemia related to the parathyroid glands); the loss of bone marrow that occurs together with the bone osteolysis alters the blood parameters (see Anemia and Leukemia).



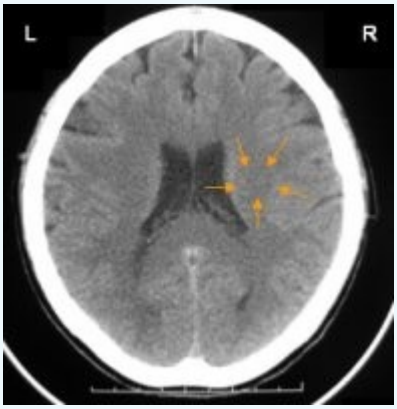
This brain CT shows a Hamer Focus in the area of the cerebral medulla that controls the left shoulder (view the GNM diagram). The sharp border of the ring structure indicates conflict activity with a relationship self-devaluation conflict associated with a partner, since the person is left-handed.

NOTE: A Hamer Focus in this brain relay corresponds to the left shoulder joint, thesurrounding cartilage, tendons, ligaments, connective tissue, fat tissue, or the closest lymph node (axillary node) since these tissues share the same control center. In this particular case, the osteolysis in the left shoulder was confirmed by an X-ray.

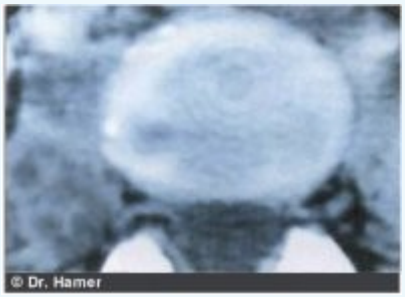
A decrease in bone mass is commonly called **osteoporosis** ("brittle bone"). Conventional medicine claims that osteoporosis is linked to a decline of estrogen production in women after menopause. The theory of a correlation between bone loss and estrogen deficiency is purely hypothetical, because there are postmenopausal women who don't have osteoporosis and there are women who have osteoporosis before they enter menopause. Men get osteoporosis as well and so do children, but men and children are not under pressure to undergo regular bone density tests. They are not (yet) considered to fall into a "risk group". Osteoporosis in men is also played down as it doesn't fit the definition of a woman's disease caused by a lack of estrogen.

From a GNM point of view, osteoporosis is a lasting generalized self-devaluation conflict affecting most of the skeletal system. The steady bone decalcification caused by continuous, often subtle self-devaluations could be compared with dripping water, in line with the saying "constant dripping wears the stone". Based on the psyche-brain-organ relation, osteoporosis in postmenopausal women has nothing to do with a reduced estrogen production or a calcium-low diet but rather with a woman's attitude towards aging and the changes that come with menopause (feeling less attractive, feeling no longer needed, a low libido). In societies where women age naturally and without the Western "anti-aging" hype, older women don't get osteoporosis. It goes without saying that the osteoporosis diagnosis and the fear of a "crippling disease" contributes to additional self-devaluation conflicts leading to a chronic condition. This is why we have to learn GNM early!

If someone has already a cancer, the loss of bone tissue is usually diagnosed as an "osteolytic bone cancer" or
"bone metastasis", even though there is no tumor growth (compare with bone cancer in the healing phase). In the majority of cases the self-devaluation conflict is triggered by the diagnosis of the first cancer, a negative prognosis ("the cancer is incurable"), or the debilitating side effects of cancer treatments (surgery, radiation and chemotherapy). This is why bone cancer is next to lung cancer the most frequent secondary cancer. Typically, the "bone cancer" develops close to the site of the primary cancer ("now I am useless there!"), thus, in the sternum and/or ribs with breast cancer or in the lower back with prostate cancer.



On this CT scan we see the impact of a self-devaluation conflict in the brain relay for thelumbar spine (view the GNM diagram). The sharp border of the Hamer Focus reveals that the person is in the conflict-active phase.



This remarkable organ CT showing a Hamer Focus in the area of the fourth lumbar spine (active self-devaluation conflict) makes the communication between the brain and the corresponding organ (here the spine) strikingly visible.

If the **tendons or ligaments** are affected by a self-devaluation conflict, the cell loss presents as **soft tissue necrosis**with an increased risk of injury since the weak tissue ruptures easily. This happens with an **Achilles tendon tear**, which originates in a heel-related self-devaluation conflict. Prolonged loss of cartilage, for example in the knee or hip, is called**arthrosis**, also known as **osteoarthritis** (not to be confused with arthritis that occurs when a joint is healing).

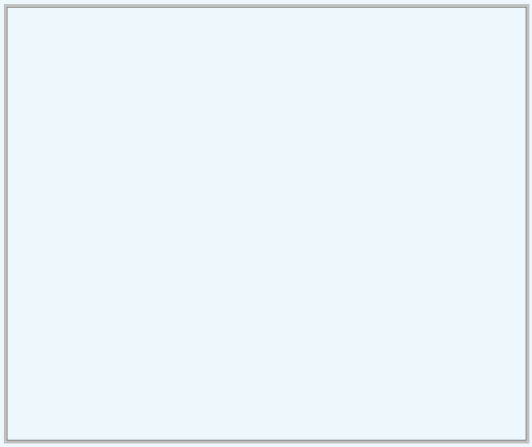
HEALING PHASE: In the healing phase, the **bone is reconstructed with callus** produced by bone-buildingosteoblasts (see also tooth repair with odontoblasts). The soft, new bone substance eventually hardens into a hard callus. In standard medical practice, however, the soft callus is often mistaken for pus and subsequently removed with the effect that the holes in the bone (osteolysis) remain.

If available, bacteria assist the reconstruction of the bone. **Staphylococcus bacteria** are specialized in restoring bone tissue. This is why surgeons who operate on fractures commonly find a "staph infection" in the area not realizing that these bacteria are vital for bone healing (see Methicillin-resistant Staphylococcus aureus in hospitals). If the helpful bacteria are not present at the time because they were eradicated through antibiotics, healing still occurs but not to the biological optimum.

NOTE: Tubercular secretion originating in the corium skin (following an "attack conflict", including a hit or fall) can leak into the healing bone. This is erroneously called **bone tuberculosis**.

Conflict-related bone fracture: If a fracture was accompanied by a self-devaluation conflict (typical for

athletes) this generates bone osteolyses at the fractured site (termed **Sudeck's atrophy**). The same might happen after orthopedic surgery associated with a self-devaluation (not being able to do physical work or sports). As a result of the decalcification the fracture cannot heal properly. According to Dr. Hamer, it is of utmost importance not to perform an exploratory puncture in order to prevent the development of an osteosarcoma.



When a bone heals, the swelling expands the periosteal layer covering the bone. The stretching of the periosteum causes considerable **bone pain** since the periosteum is endowed with highly sensitive nerves. The pain is similar to the **rheumatic pain** that involves the upper layer of the periosteum and occurs in the conflict-active phase of a severe separation conflict. Commonly, the condition is referred to as **rheumatoid arthritis** (compare with acute joint rheumatism). Water retention exacerbates the pain.

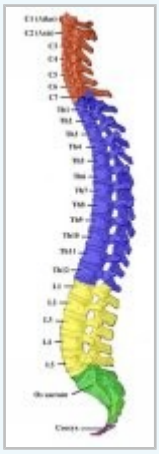
In GNM we call the combination of the two Biological Special Programs the "**Bone Syndrome**".

What is more, when the periosteum lifts from the bone due to the swelling, the bone loses its support and breaks easily. Unless the bone osteolysis is severe, during the conflict-active phase there is no real risk of fracture since the periosteum still covers the bone tightly. **Bone pain** is a necessary part of healing, because it forces the person to rest in order to prevent a spontaneous fracture, for example, of the femoral neck. If the spine is involved, Dr. Hamer strongly advises that the patient stay in bed in order not to put stress on the spine and possibly break a vertebra resulting in paraplegia. The pain associated with a healing bone can take several months, even longer with conflict relapses. The better a person is prepared for the pain the easier it will be to endure the *temporary* discomfort. Recognizing that the pain is a sign of healing can prevent new self-devaluation conflicts triggered by the pain itself.

NOTE: A lack of movement or one-sided activities putting constant strain on a specific part of the body generates musculoskeletal pain *without* a biological conflict. However, even though the problems are unrelated to a DHS, the pain can prompt a self-devaluation conflict ("my back is finished") resulting in a chronic condition. The same holds true for injuries and physical traumas.

A **herniated disc**, commonly called a "slipped disc" or **disc protrusion**, develops when the swelling tears the outer ring (anulus fibrosus) of an intervertebral disc with parts of the gel-like central portion (nucleus pulpous) bulging into the vertebral canal. The pressure on the spinal nerve causes acute pain, for example in the lower back (**lumbago**). Withwater retention due to the SYNDROME the pain is even more severe since the retained water increases the swelling.Muscle spasms in the surrounding area are caused by "not being able to move" due to the pain in the lower back. **NOTE:**When the periosteum stretches during the healing of a vertebra this might look, roentgenologically, like a protrusion of the disc.

If the cervical spine (intellectual self-devaluation conflict) is affected, the pain radiates from the neck down to the shoulders, arms and fingers. **Sciatica** occurs when the swelling of a lumbar disc (central self-devaluation conflict) presses onto the sciatic nerve. Recurring sciatica is brought on by conflict relapses. Constant pressure on a spinal nerve (hanging healing) can lead to serious nerve damage resulting in a loss of sensation in the lower extremities (compare with sensory paralysis related to the periosteum). In this case, preventive surgery must be considered.



Swelling in the region of the plexus sacralis, formed by the fourth and fifth lumbar nerves (L 4 and L5) and the first, second, and third sacral nerves causes pulling on the *back* side of the leg.

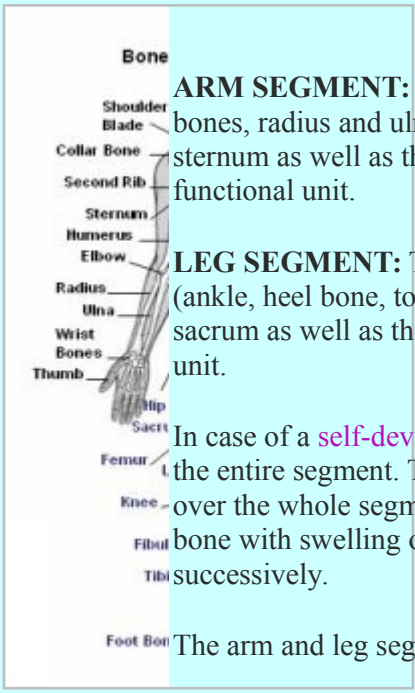
Swelling in the region of the lumbar plexus, formed by the first four lumbar nerves (L 1 – L 4) and the last thoracic nerve (T 12) causes pulling on the *front* side of the leg and in the groin.

NOTE: A localized self-devaluation conflict involving the testicles (testicular cancer diagnosis, removal of a testicle) affects the second lumbar nerve (L 2), because before the testicles moved into the testicular sac they were located just in front of the second lumbar vertebra.

A so-called **sequestered disc** is a fragment of the disc's nucleus that is no longer attached to the disc. This happens when the healing disc ruptures, for example, through lifting something heavy.

With a hanging healing, that is, when the healing process is constantly interrupted by conflict relapses, the recurring recalcification eventually leads to a deformation of the spine. presenting as **scoliosis** (lateral or sideways curvature),**lordosis** (exaggerated forward curvature of the lower spine), or **kyphosis** (backward rounding of the upper spine, commonly called hunchback). Juvenile kyphosis is termed **Scheuermann's disease**. Even though the distortion of the spine is not reversible, with the understanding and knowledge of GNM it can be stopped from further progression.

Spondylosis involves the vertebral discs, for example, the lumbar spine as a result of continual conflict relapses of a central self-devaluation conflict. If it affects the neck area (linked to an intellectual self-devaluation conflict) this results in **cervical spondylosis** (compare with a stiff neck and torticollis related to the neck muscles). **Spondylitis** occurs when the healing process is accompanied by an inflammation.



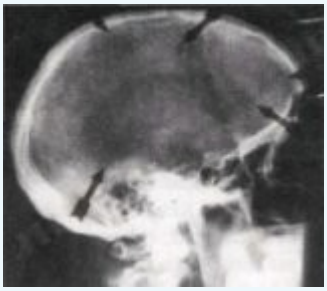
ARM SEGMENT: The musculoskeletal segment of the arm, including the thumb, wrist bones, radius and ulna, elbow, humerus, collar bone, shoulder blade, upper part of the sternum as well as the second rib and second and third thoracic vertebrae (T 1 and T2) are a functional unit.

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 (L 3, 4, 5) 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 medullareaches 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).

When the skull bone (intellectual self-devaluation conflict) is healing, a big swelling might press onto the dura mater(outer meninges) resulting in meningitis. With the SYNDROME, that is, with water retention as a result of an activeabandonment and existence conflict, the swelling can become quite large. The condition causes severe headaches, particularly during PCL-A. Evidently, meningitis does not occur when the swelling (edema) is located on the outer surface of the skull.



This X-ray shows bone osteolyses (visible as dark) in several areas of the skull, indicating conflict activity with an intellectual self-devaluation conflict or "This is not fair!"-conflict. In early childhood the condition is called **rickets** (weak bones). Rickets can also affect the arm,legs, spine, or the entire skeletal system (generalized self-devaluation conflict). The theory that rickets is caused by a vitamin D deficiency is pure assumption.

Pain of the facial bones, linked to a self-devaluation conflict associated with the face (for example, concerning one's look or reputation), presents as **trigeminal neuralgia** since the face is innervated by the trigeminal nerve (see also trigeminal neuralgia related to the periosteum and to the facial skin).

A **heel spur**, a small bony growth on the underside or back side of the heel develops after the related self-devaluation conflict has been resolved. The pain subsides with the completion of the healing phase, provided there are no conflict relapses. The bone spur, however, remains. If the self-devaluation conflict affects the joint at the base of the big toe(MTP-metatarsophalangeal joint), the growth on the foot creates a deformity of the great toe, called a **hallux valgus or bunion**. Pain in the heel or at the bottom of the foot could also be the result of a self-devaluation conflict involving the plantar fascia, the ligament that connects the heel bone to the toes. The inflammation, known as **plantar fasciitis**, occurs during the healing phase.

When a long bone such as a bone in the arms or legs recalcifies, a hole is left in a certain area to allow the fluid of the edema to drain off. In the **leg** the fluid creates a temporary **peripheral edema** (see also peripheral edema related to the leg veins or the myocardium).

Arthritis is the healing of a joint (hip, knee, shoulder, elbow, finger) accompanied by an inflammation. What is wrongly termed **acute joint rheumatism** (see rheumatism related to the periosteum) is the condition when the fluid in theedema, usually in big joints such as the knee or shoulder, pushes through the cartilage into the joint causing a transudative effusion (see also transudative effusion with fluid entering the pleura or the pericardium from adjacent ribs or the sternum). This is usually the case with water retention due to the SYNDROME. Conflict relapses also increase the swelling! As a result, the joint becomes red, hot, and very swollen. If such a swollen joint is punctured for exploratory purposes, this can create a large osteosarcoma. Swelling outside of the periosteum also occurs when the fluid of the bone edema leaks through the membrane of the periosteum. If this happens in the groin or in the area of the top of the femur, the swelling is often misdiagnosed as a thrombosis.

Chronic arthritis is a sign that the healing process cannot be complete because of constant conflict relapses. With arthritis a person is quickly in a vicious cycle since the arthritic pain (pain track) and the restriction of movements often causes additional self-devaluation conflict at the same location. Sooner or later, this "freezes" a joint, for example, theshoulder. **Polyarthritis** affecting "many" joints reveals that the person had suffered the self-devaluation conflict as a whole (generalized self-devaluation conflict).

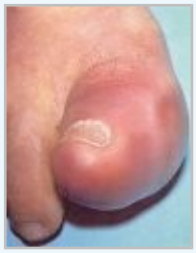
The continuous alteration between decalcification (conflict-active phase) and recalcification (healing phase) eventually deforms the finger joints. Continuous conflict relapses worsen the deformation because of the buildup of more and more bone tissue (hardended callus) at the site.

So-called **Carpel Tunnel Syndrome** occurs when the swelling of bones, ligaments, or tendons narrows

the carpal tunnel, the passageway between the wrist and the hands, causing the median nerve, which reaches from the forearm into the palm of the hand, to become compressed. Hence, the typical symptoms of tingling, numbness, and sharp, piercing nerve pain running from the wrist up to the entire arm. Based on GNM, the condition is not, as suggested, the result of "wear and tear" (typists and dental hygienists are the professional groups with the highest incidents of CTS) but rather of a self-devaluation conflict associated with the hand(s).

Wrist tendonitis develops after a dexterity conflict has been resolved. **Achilles tendonitis** reveals that the self-devaluation conflict was associated with the foot. Tendonitis affecting the elbow relates typically to sports activity such as tennis (having played a bad game), hence, the term "**tennis elbow"** (**epicondylitis**). **Bursitis** is an inflammation of the bursae, the cushions between a bone and the surrounding soft tissue. It usually occurs close to joints such the elbow,knee, hip or shoulder, depending on the specific self-devaluation conflict.

With water retention due to the SYNDROME involving the kidney collecting tubules arthritis becomes **gout**. The elevated uric acid level gives rise to the belief that a vegetarian or low-purine diet would alleviate the pain. From the GNM point of view, it is rather the underlying abandonment and existence conflict that has to be addressed! Gout in the joint at the base of the big toe is commonly associated with excess alcohol consumption; although, not every heavy drinker has gout! If, however, the intoxicated condition triggers a conflict of "not being able to walk or not being able to balance", the development of gout is preprogrammed; whether it affects the right or left toe is determined by a person's handednessand to whom the self-devaluation conflict relates – to the mother, the partner, the children?

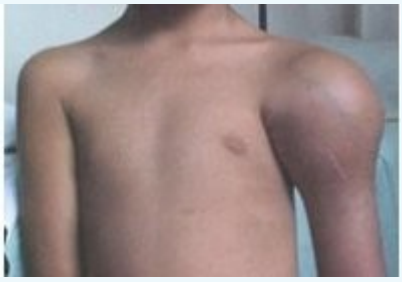


An inflammation of the gout nodules causes acute pain, particularly during the "gout attack" that occurs during the Epileptoid Crisis.

BONE CANCER AND OSTEOSARCOMA

Under normal circumstances, when a bone or joint heals callus also accumulates outside the bone, to be precise, underneath the protecting shield of the periosteum. The callus-buildup (showing on an X-ray as white) forms a temporary, natural cuff around the bone to stabilize the affected bone section while healing runs its course. Yet, in conventional medicine the callus "growth" is considered a **bone cancer** (compare with "bone cancer" in the conflict-active phase). A "tumor" in the femur, pelvis, humerus, or ribs is generally classified as **Ewing's sarcoma**.

ATTENTION: If the periosteum seam ruptures because of an injury (accident, fall, bone fracture) or an **exploratory puncture** (biopsy), the callus finds its way through the open periosteum into the surrounding tissue creating a large**osteosarcoma** (compare with muscle sarcoma and connective tissue sarcoma). In conventional medicine an osteosarcoma is considered a "malignant" type of bone cancer with a poor prognosis. Without a puncture, the surrounding tissue would just have swollen somewhat since only the fluid would flow out of the edema but not the callus. The process would have been similar to acute joint rheumatism that has a remission after a certain amount of time. With the understanding of GNM exploratory excisions become entirely unnecessary. Our experience shows that a brain CT scan provides much more reliable information about histological formations than any biopsy.



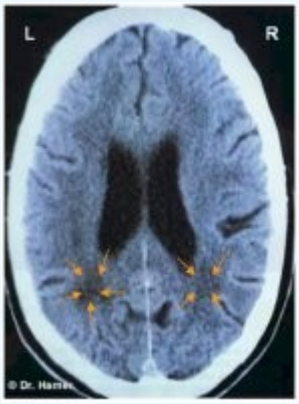
Osteosarcoma in the left shoulder

In addition to creating an artificial osteosarcoma, the outflow of callus into the neighboring tissue leads to a decalcification and eventually dissolution of the affected bone. In case of an osteosarcoma around the knee, this usually results in an amputation of the leg.

NOTE: As long as the healing phase persists, after an **amputation** the bone pain continues as a **phantom limb pain** just as if the bone were still in place (see leg segment). This implies that the amputee has also leukemiauntil healing on the emotional and cerebral level is complete. Phantom pains also occur with every conflict relapse! The same applies to rheumatic phantom pain with prolonged conflict activity of a severe separation conflict related to the periosteum.

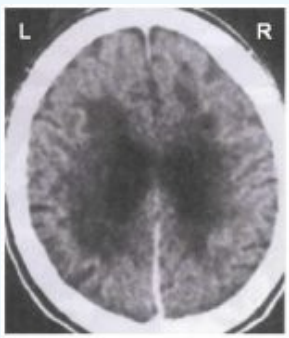
With a puncture of the ribcage the callus might escape into the breast. The self-devaluation related to the ribs is usually caused by a breast cancer diagnosis. If hardened callus is found in the breast (as a consequence of the rib puncture!) it is usually diagnosed as a "metastatic breast cancer", although the growth (in reality an artificial osteosarcoma) is not even adhered to breast tissue. A mastectomy followed by chemo treatments are the standard "therapies". For women unfamiliar with GNM, further self-devaluation conflicts are just a matter of time.

A **mediastinal osteosarcoma** develops when callus leaks out of a thoracic vertebra into the mediastinum. This is particularly dangerous since the hardened callus can compress the heart (compare with pericardial tamponade), the trachea, the lungs, or veins that supply the mediastinum with blood. Callus found close to the bronchia is often diagnosed as a "small cell bronchial carcinoma". In reality, the "small cells" are callus! Dr. Hamer advises to surgically remove the callus from the mediastinum to prevent complications



Parallel to the healing bone or joint (localized self-devaluation conflict) a brain edema develops in the cerebral medulla (in PCL-A) showing on a brain CT as dark (hypodense).

In this example, the edemas are located on the right and left side of the cerebral medulla(view the GNM diagram). They reveal that the person associated the conflict of "not being able to endure a situation" with his/her partner and children, manifesting as pain in both hips.



Overall **cerebral swelling** of the cerebral medulla, as seen in this image on a higher CT section, typically happens with a generalized self-devaluation conflict. The swelling causes severe headaches.

NOTE: A large edema might compress the lateral ventricles (see hydrocephalus). In extreme cases, a big swelling can lead to a brain coma. This usually only occurs with acute water retention (the SYNDROME) as a result of an active abandonment and existence conflict(hospitalization).

Intravenous infusions contribute to the water retention!

The Epileptoid Crisis is the period when the brain edema as well as the edema around the healing bone or joint is expelled. This reduces both the swelling and the pain. The Epi-Crisis presents as the "cold days" with chills, cold perspiration, and feeling uneasy.

At the end of the healing phase, the bone is completely restored.

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

ANEMIA AND LEUKEMIA

Blood is made up of blood cells, blood plasma, and blood serum. It circulates through the heart, arteries and veins, which jointly comprise the circulatory system. The main function of the blood is to transport oxygen, carbon dioxide, nutrients, metabolic wastes, hormones, and other elements to and from the body's cells. **Red blood cells (erythrocytes)** are filled with hemoglobin, an oxygen binding iron-containing pigment responsible for delivering oxygen into all parts of the body. **Platelets (thrombocytes)** are involved in blood clotting mechanisms at the site of wounds.**Plasma and serum** are the liquid parts of the blood; plasma contains blood clotting factors as well. **White blood cells (leukocytes)** are believed to be part of the body's immune system, envisioned by conventional medicine as a defense system against "disease-causing" agents. In reality, white blood cells (including phagocytes and lymphocytes) play an important role during the healing phase by removing the by-products of the microbial repair work. Hence, they are part of an innate *support* system designed to assist the healing process.

The production of blood cells (hematopoiesis) takes place in the **bone marrow** inside the bones. Bone marrow contains blood-forming stem cells that give rise to all blood cells. Like the bones from where they originate, the blood cells derive from the new mesoderm. Technically, blood is a highly specialized vascular tissue, hence, its mesodermal affinity also to the blood vessels.

NOTE: According to the standard view, during the fetal development, the liver and the spleen are the sites of the formation of blood cells, which would be later replaced by the bone marrow. Based on this theory, it is assumed that the liver and spleen takes over the blood production in the event that the bone marrow is not able to produce blood. Dr. Hamer: "To me this seems incorrect in some respects. As far as blood production is concerned, the first part of pregnancy shows the production of "fetal erythrocytes", which originate from theendoderm (the first and oldest embryonic germ layer). However, these are not identical with the mesodermal erythrocytes that develop later during gestation. It is highly unlikely that the liver would resume the original fetal function from the first weeks of the embryonic phase. If that were the case, we would see completely different kind of erys, namely "fetal erythrocytes." - Dr. med. Ryke Geerd Hamer, *Vermächtnis einer Neuen Medizin*(Legacy of a New Medicine), Vol 1, p. 477.

CONFLICT-ACTIVE PHASE: The bone tissue loss (osteolysis) that takes place during the conflict-active phase of aself-devaluation conflict also involves the bone marrow, resulting in **anemia** (low red blood cell count), **leucopenia**(low white blood cell count), and **thrombocytopenia** (low platelet count). During conflict activity, the hemoglobin (Hb) and hematocrit (Hct) values are also low (the hematocrit is the quotient of the erythrocyte volume over the total blood serum). The loss of bone marrow (**panmyelophthisis**) has an effect on the whole blood cell production system, even if the DHS affects only a particular site (localized self-devaluation conflict). The reason for this is most likely that in newborns all bones still have an active marrow (adult bone marrow is found only in the flat bones).

Because of the decreased number of platelets there is a **tendency to bruise and bleed more easily** (see alsothrombocytopenia related to the spleen). Internal bleeding, for example, bleeding stomach

ulcers, intestinal bleeding, oruterine bleeding that occur in the healing phase of the corresponding conflict could lead to serious complications with a concurrent self-devaluation conflict, which is oftentimes triggered by the diagnosis (colon cancer, uterus cancer).**CAUTION:** Without a sufficient knowledge of GNM, rushing into "clearing" conflicts as it is practiced by some alternative modalities could have grave consequences.

HEALING PHASE: In the healing phase, the restoration of the bone marrow occurs parallel to the reconstruction of the bone. The resumption of the blood cell production (hematopoiesis) proceeds in four phases:

PHASE 1: still anemia, leucopenia, and thrombocytopenia

For the first three weeks, the blood values are still low. At this point, however, the low blood cell count is deceiving because the expansion of the blood vessels during vagotonia enlarges the vessels up to five times of its normal size (insympathicotonia the blood vessels are constricted). The extra volume is filled with blood serum. As a result, the blood cell count per cubic millimeter (erythrocytes, leucocytes, thrombocytes) *appears* low although, in reality, the absolute number of red and white blood cells has not changed. The same can be said for the hemoglobin and hematocrit level as well as for the platelet count. In addition to the fatigue characteristic for *any* healing phase, anemia causes extreme tiredness (in the conflict-active phase, the sympathicotonic state of stress still counteracts the fatigue to some extent).

In conventional medicine terms, this stage is called "**a-leukemic leukemia**", meaning that leucoblasts are not (yet) found in the peripheral blood ("a-leukemic") but are already found in large numbers in the bone marrow (detected through puncture of the bone marrow!)

PHASE 2: still anemia and thrombocytopenia but rise of leucoblasts

After three to six weeks into the healing phase, the bone marrow starts to produce large amount of leucoblasts. Leucoblasts are specialized leucocytes. Their main function is to support the repair of the bone that is currently under way. It should be noted that the count of normal leucocytes, which assist the bacterial work in the healing phase, are not affected by the increase in the number of blasts. Once the leucoblasts have done their job, they are reabsorbed by the organism and replaced by new ones until the production of normal cells is back in full swing. Those leucoblasts that cannot be broken down in the liver are left in the peripheral blood where they are found through a blood test. Since leucoblasts differ from leucocytes, conventional medicine considers them as "immature" and as "cancerous" (cancer of the blood), even though they don't show cell division (mitosis) which is the required criterion of cancer cells.

It is the high count of leucoblasts that is diagnosed as **LEUKEMIA**. Because of the extreme fatigue due to the ongoing anemia, it is in this phase that most of the leukemia cases are detected. Based on the knowledge of GNM, the overproduction of leucoblasts is a positive sign that the self-devaluation conflict has been resolved and the bone, including the bone marrow, is now healing. Hence, the higher the leucoblast count the better! In Phase 2, the production of erythrocytes (red blood cells) has also started but their number is only noticeable later in the process. Because of the low thrombocytes count (thrombopenia) there is still a risk of easy bleeding!

NOTE: Radioactive exposure as a consequence of nuclear bombing (Hiroshima, Nagasaki) or the release of radioactive material through nuclear accidents (Chernobyl, 1986) damages the bone marrow with the development of leukemia during the repair phase (without a brain edema, unless the tragedy prompts a self-devaluation conflict). Medical radiation as well as chemo treatments also destroys the bone marrow! This is most detrimental if a bone is healing since, in addition to the restoration of the bone, the bone marrow has to overcome the damage caused by the radiation "therapy" and the chemical poisoning.

The extent of the leukemic stage is determined by the duration and intensity of the conflict-active phase. "Chronic leukemia", referred to as "slow growing leukemia", implies, in GNM terms, that the healing phase is continuously interrupted by conflict relapses. "Acute leukemia", referred to as "fast growing

leukemia", indicates an intense first-time leukemic healing process, usually caused by a highly dramatic self-devaluation conflict.

In conventional medicine, the different types of leukemia are classified according to the blood stem cells that are involved, hence, the use of terms such as "monocytic leukemia", "T-cell leukemia", "thrombocyte leukemia", "erythroleukemia", "lymphoblastic leukemia", "myelogenous leukemia", "plasmacytoma", and so forth.

A **plasmacytoma** or **multiple myeloma** is a growth of plasma cells (white blood cells) that originates in the bone marrow. The bone marrow necrosis (panmyelophthisis) takes place in the conflict-active phase. With an inflammation and the participation of bacteria (if available), the condition is called **osteomyelitis**. The fluid emitted from the edema in the bone marrow stretches the periosteum causing considerable pain. Plasmacytomas typically develop in flat bones such as the hip bone, sternum, spinal vertebrae, skull, or ribs. This confirms that the condition is linked to a self-devaluation conflict.

NOTE: A **bone marrow transplant** is a procedure where the bone marrow of a leukemia or lymphoma patient is replaced with "healthy" bone marrow stem cells from a donor. Before the treatment, high-dose chemotherapy,radiation, or both are given to eliminate *all* bone marrow. Subsequently, the harvested stem cells are injected into the circulation on the assumption that they will travel to the bone marrow where they settle and begin producing "normal leukocytes". Radioactive marking of the donor's marrow, however, has shown that within a few weeks there is no foreign marrow left in the recipient's body. It has all been annihilated as result of a natural reaction to the foreign cells. If the bone marrow does start the blood cell production, it is only due to the fact that the dose of radiation and chemo treatments has not destroyed the entire bone marrow, allowing the remaining stem cells to eventually produce new blood cells.

"**Lymphoblastic leukemia**", which is closely associated with the lymphatic system, is usually caused by a self-devaluation conflict of a lesser degree. Lymphatic leukemia occurs more common in children as a result of a generalized self-devaluation conflict.

NOTE: **Lymphocytes** are white blood cells that derive from stem cells in the bone marrow. They are not, as assumed, produced *in* the lymph nodes but migrate from the bone marrow via the lymph fluid to the lymph nodes, where they play an important role in removing the remnants of the microbial repair work in any givenhealing phase (contrary to the immune system theory). Since the lymphocytes make up lymphoid tissue, the lymphocyte count is elevated in case of a lymphoma (Hodgkin's disease). With lymphatic leukemia, however, only the count of lymphoblast increases - *without* the swelling of a lymph node, unless the two Biological Special Programs run simultaneously.

The various types of leukemia can occur simultaneously or change from one type to another, particularly with additionalself-devaluation conflicts that are often triggered by the leukemia diagnosis itself. From a GNM perspective, all types of leukemia are good news, since it confirms that the self-devaluation conflict has been resolved and healing is now under way. Essentially, every condition that occurs in the healing phase of a bone or joint, whether it is arthritis, lumbago(pain in the lower back), or a tennis elbow is accompanied by a small leukemia. Dr. Hamer: "If conventional doctors were to diagnose more accurately, they would have to decimate the entire sports world with chemotherapy!"

PHASE 3: rise of erythroblasts and thromboblasts

At the end of the leukemic phase, shortly after the Epileptoid Crisis, the production of red blood cells also starts to pick up. However, a large number of the new blood cells (called erythroblasts or normoblasts) are still rejects and functionally unusable as oxygen carriers. At that point, at least for a short period of time, the production of erythroblasts and leucoblasts occurs together. Hematologists view this combination as a double threat, named "**erythroleukemia"**.

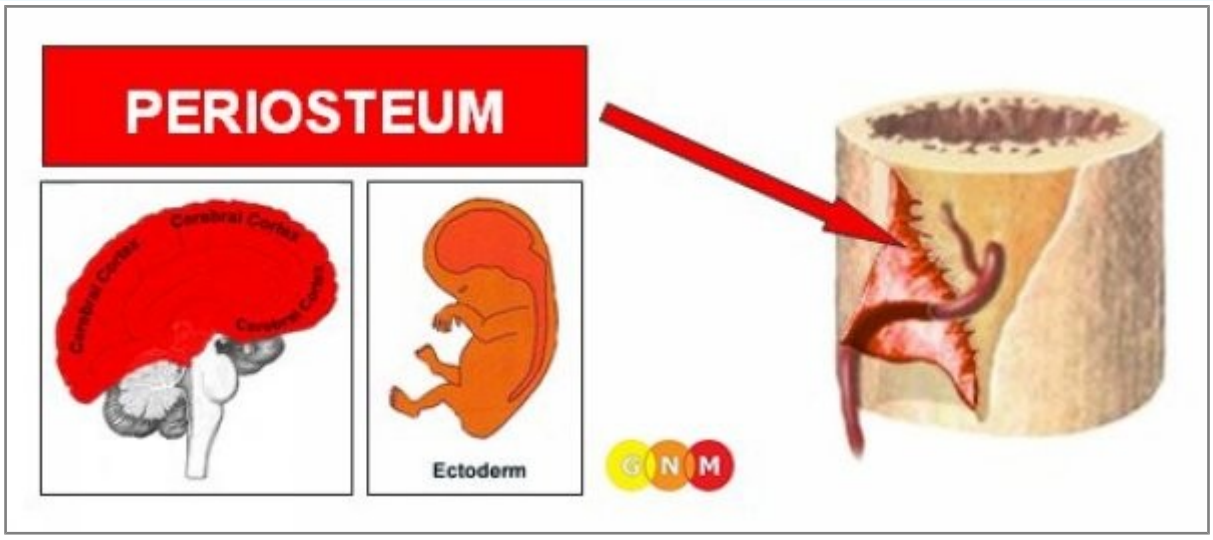
In Phase 3 the platelet production begins as well. Like the erythroblasts, the first new platelets (called thromboblasts) are still functionally deficient and have no blood clotting ability. However, in conventional medicine the elevated count of thromboblasts is considered a "blood disorder", termed "**thrombocyte leukemia"** (compare with thrombocytosis, an increased level of thrombocytes, related to the spleen).

PHASE 4: production of normal leucocytes, erythrocytes, and thrombocytes

During the last part of the healing phase the blood values return to normal, notably both in the peripheral blood as well as in the bone marrow. This is particularly important for thrombocytes and their blood clotting ability.

NOTE: Iron is an essential element for blood production. With the rapid production of erythrocytes, the body requires far more iron than usual. This leads easily to **iron deficiency**. In this case, the lack of iron is unrelated to blood loss due to heavy bleeding (gastrointestinal bleeding, heavy and long menstrual periods). An elevated iron level, called **hemochromatosis**, occurs when the production of red blood cells is suppressed (see conflict-active phase) and the iron available from food can therefore be used for blood production. Over time, the extra iron is stored in various organs, particularly in the liver.

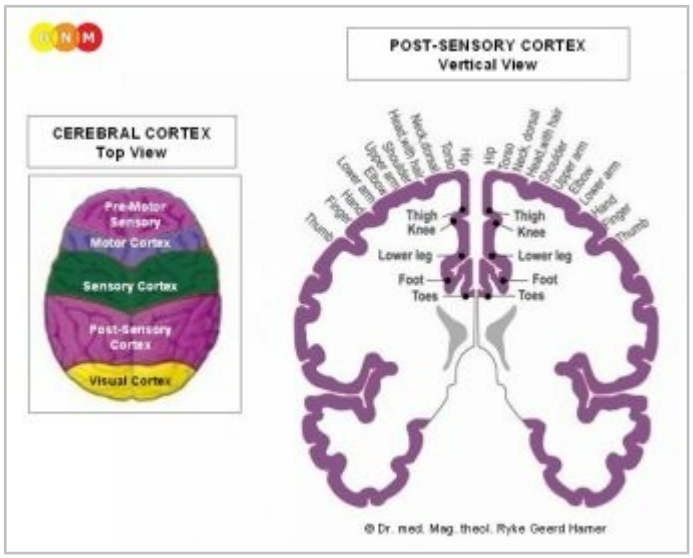
PERIOSTEUM



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PERIOSTEUM: The periosteum covers the outer surface of all bones, except the joints, which are capped with cartilage, and sites that attach to muscles, ligaments and tendons. It consists for the most part of connective tissue (see also periodontium of the teeth). At first, the periosteum was lined with squamous epithelium. After the muscles, ligaments, tendons and two skin layers (corium skin and epidermis) had given new support to the bones, the epithelial layer degenerated (in the fetal development this process occurs during the first two weeks of gestation). What remained was a sensitive network of nerves. The **neural network of the periosteum** has two layers: a lower layer, which registers the pain caused by the swelling of a healing

bone, and an upper layer that generates rheumatic pain. The periosteal nerves originate from the ectoderm and are therefore controlled from the cerebral cortex. The innervation of the entire periosteum originates in the spinal marrow of the cervical spine.



BRAIN LEVEL: The periosteal nerves are controlled from the **post-sensory cortex** (part of the cerebral cortex). The periosteal nerves of the right side of the body are controlled from the left side of the cortex; the periosteal nerves of the left side of the body are controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

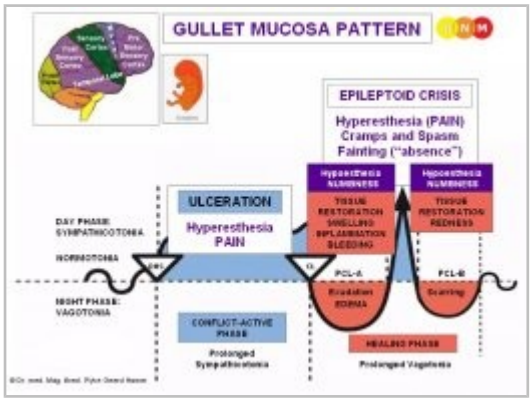
NOTE: The periosteal nerves of the dura mater (see meninges) are controlled from the pre-motor sensory cortex.

BIOLOGICAL CONFLICT: The biological conflict linked to the periosteum is a **severe separation conflict**.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

In comparison to the separation conflict related to the skin, the conflict linked to the periosteal nerves is experienced as more dramatic, even as brutal or cruel. Depending on the exact conflict situation, the separation might be associated with the arms (not being able to hold a beloved person of a pet), hands (a loved one slipped away), legs and ankles (wanting to push someone away), or feet (a separation from the familiar ground through an unexpected move or the loss of a home). The periosteal nerves lining the eye socket correlate to a visual separation conflict (having lost sight of someone). Like with the epidermis, the conflict also corresponds to wanting to separate from a person.

NOTE: The separation conflict related to the periosteal nerves only refers to a separation from a person or from an animal such as a pet but not to objects (jewlery, car, house) or a separation, let's say, from a home (seeterritorial loss conflict).



The Biological Special Program of the periosteum follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

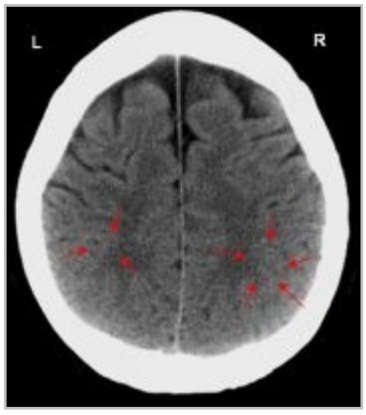
CONFLICT-ACTIVE PHASE: hypersensitivity of the affected part of the body. Conflict activity with

a separation conflict is always accompanied by a **short-term memory loss**, which serves the purpose to forget temporarily the one who has left by blocking out the memory (see also Biological Special Program related to the skin).

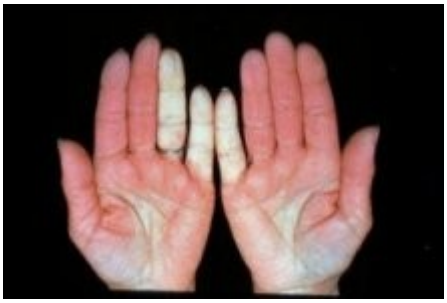
NOTE: The periosteal nerves belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with hyperfunction (see also thalamus) or functional loss (see Biological Special Programs of the inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles).

The **symptoms** include a sensation of **tingling and sharp, stinging pain** ("pins and needles"). The neuralgic pain is commonly referred to as **rheumatism** (compare with rheumatoid arthritis and acute joint rheumatism). There might also be a soreness to touch. Severe or long lasting pain can trigger a self-devaluation conflict involving the underlyingbone causing rheumatic pain in the healing phase. In GNM, we call the combination of the two Biological Programs the "Bone Syndrome". Pain reaching into the muscle tissue generates **soft tissue rheumatism** (compare withfibromyalgia). Also, the **affected part of the body feels cold** ("cold" muscle pain points to conflict activity related to the periosteum whereas "hot" muscle pain is a sign that the muscle itself is healing). This is why warming the area is soothing and alleviates the pain.

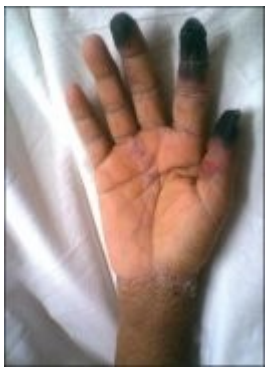
NOTE: Whether the right or left side of the body is affected (or both) is determined by a person's handedness andwhether the conflict is mother/child or partner-related. A localized conflict involves the part that is associated with the separation conflict.



This CT scan shows the impact of a severe separation conflict in the post-sensory cortex, precisely, in the area that controls the right and left hand and fingers (view the GNM diagram). The Hamer Focus on the right side is noticeably larger than the one on the left. The sharp borders reveal conflict activity, hence, the stinging, rheumatic pain in both hands (more in the right hand than in the left).

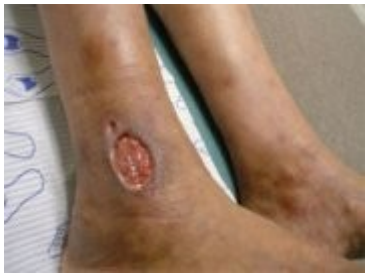


The periosteum and the arteries are both innervated from the sympathetic trunks. Hence, during conflict activity (sympathicotonia) of a separation conflict involving the periosteum the capillaries become narrow causing a restricted blood circulation. With an intense conflict the affected area(s) turn white due to the reduced blood flow (similar to frostbites). This condition is termed **Raynaud's disease** (compare withperipheral artery disease).



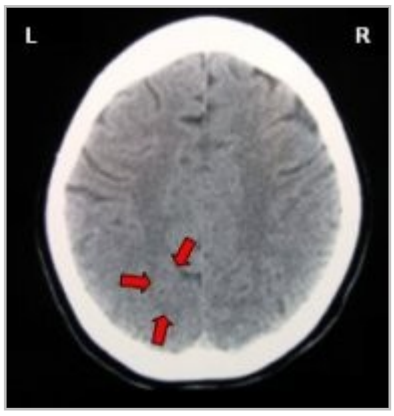
If the conflict persists over a long period of time, the tissue eventually dies resulting in**gangrene**.

NOTE: The amputation of the affected limb does not necessarily remove the pain. A **rheumatic phantom pain** will occur as long as the person is conflict active (see also phantom limb pain involving the bones).



Foot and leg ulcers develop when the Biological Special Programs of the periosteum and of the epidermis run concurrently (both are linked to a separation conflict). During theconflict-active phase the ulcerated area of the skin opens, creating a hole. Often, this occurs in the area of the lower leg or ankle (wanting to push someone away in defence). A person's handedness determines whether the conflict is mother/child or partner-related.

The periostal nerves are part of the peripheral nervous system. In conventional medicine, the nerve pain as well as thenumbness are referred to as "**peripheral neuropathy"**. It is a wide-spread belief that high blood sugar causes damage to the arteries and "indirectly" to the nerves resulting in pain or a loss of sensation, especially in the extremities. Yet, not every diabetic develops the condition! Neither can this assertion explain why an elevated glucose level would, for example, affect the feet (or just one foot or toe) in one person and the arm(s) in another. Based on the knowledge of GNM, what is called "**diabetic peripheral neuropathy"** is a combination of two Biological Special Programs running simultaneously: one involves the beta islet cells of the pancreas linked to a "resistance conflict" causing diabetes, the other involves the periosteum related, in case of the legs, to "wanting to kick somebody away" (usually the person one resists) with the development of leg ulcers or gangrene, depending on the intensity and duration of the conflict (see also "diabetic retinopathy").



This CT scan presents a Hamer Focus in the area of the brain that controls the periosteal nerves of the right leg (view the GNM diagram). The sharp border of the ring structure indicates that the separation conflict is still active, presenting as neuralgic pain in the right leg.

Trigeminal neuralgia occurs when the separation conflict was associated with the face, either literally (loss of "cheek"-contact) or figuratively (a "slap in the face"). The sharp, electric-like pain along the trigeminal nerve (fifth cranial nerve) innervating the face is brief but strong and might reoccur many times over the course of the day. The condition is usually confined to one side (see also trigeminal neuralgia related to the facial bones and to the facial skin).

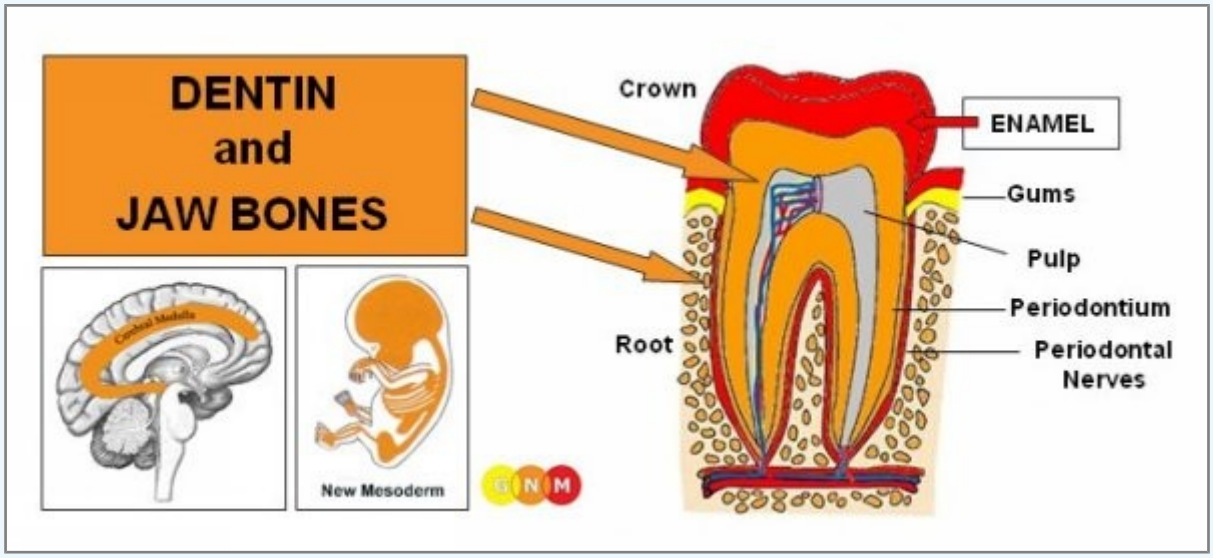
NOTE: The trigeminus nerve has sensory and motor branches. The motor branch of the nerve is affected withfacial paralysis.

HEALING PHASE: hyposensitivity. Because of the **loss of sensitivity** the affected part of body (hands, arms, legs, feet) feels **numb** (compare with hyposensitivity related to the epidermis and a loss of sensation, for example in the lower extremities, due to a compression of a spinal nerve).

The short term memory loss reaches into PCL-A. For the period of the Epileptoid Crisis, the rheumatic pain returns; typically during the night hours. During PCL-B, the sensitivity slowly normalizes, provided there are no conflict relapsescausing pain flare-ups.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

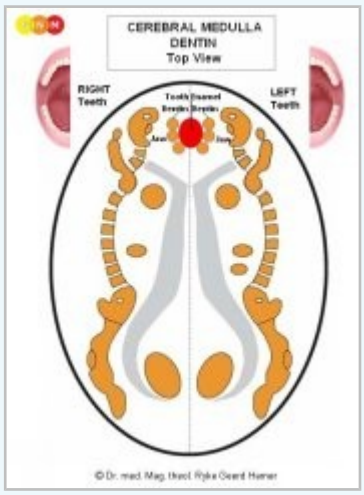
TEETH & JAW



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE DENTIN AND THE JAW BONES: A human adult has 32 teeth, 16 in the upper jaw and 16 in the lower jaw. Each tooth consists of a crown (above the gum line) covered by enamel and a root (below the gum line). The tooth is for the most part made of dentin. Its calcified structure is denser than that of bones, which allows withstanding the stress of biting and grinding. The roots of the teeth reach into the upper or lower jaw bones. The root canals extend from the tip of the root into the pulp chamber, located in the center of the tooth. The pulp contains blood vessels that nourish the tooth and nerves that provide sensitivity to heat, cold, pain, and pressure. The pulp cells, called odontoblasts, are capable of producing dentin (similar to bone-building osteoblasts). The pulp is quasi the "bone marrow" of the tooth. The periodontium (also termed odontoperiosteum) surrounding the dentin provides support to the teeth (equivalent to the periosteum covering the bones). The gums (see mouth submucosa and mouth surface mucosa) or gingiva lies over the jaw bones and hugs the tooth

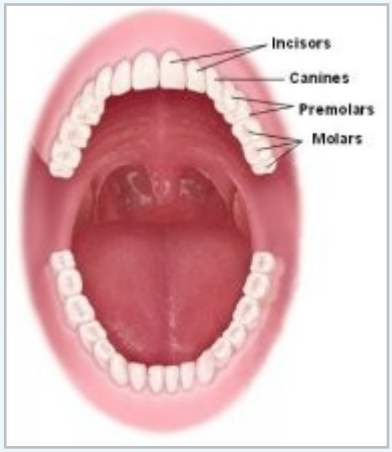
tightly at the neck. The jaw is a pair of bones that forms the framework of the mouth. It consists of the maxilla (fixed upper jaw bone), the mandible (movable lower jaw bone), and the temporomandibular joint (TMJ). The function of the jaw is its use for biting and chewing (see also jaw muscles). The dentin and jaw bones originate from the new mesoderm and are therefore controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the dentin of the right teeth and the right jaw bones are controlled from the left side of the brain; the dentin of the left teeth and the left jaw bones are controlled from the right cerebral hemisphere (paramedial). Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the dentin is **not being able to bite**, either literally (being unable or having difficulties manipulating food) or figuratively, in the sense of **not being able to "bite" or "snap" an opponent**, **because the individual is in a weaker position** (compare with bite conflict related to the enamel and thejaw muscles). For example, physically weaker (a child vis-à-vis a bigger child or an adult, a woman vis-à-vis a man, a small dog vis-à-vis a big dog), in a weaker position at the workplace (an employee vis-à-vis the boss or a colleague in a higher position), in school (a student vis-à-vis a teacher, a teacher vis-à-vis the principle), within the family (a child vis-à-vis a parent or an older sibling; a new spouse or partner vis-à-vis a stepchild), or in a weaker position vis-à-vis an authority (government official, policeman, doctor, judge, bank manager). Discrimination, political oppression, abuse (physical, sexual, verbal), punishments, restrictions, provocations, or being scolded create situations that could trigger a bite conflict. The conflict is experienced as not being able to fight back or fight someone off in defense ("showing one's teeth"). Verbal fights and constant arguing with a family member are classic bite conflicts. The bite conflict related to the dental bone is a type of self-devaluation conflict (see bones and joints). Unattractive teeth, because of poor dental hygiene, can therefore also cause a dentin-related conflict. The bite conflict associated with the jaw bones is perceived as more intense.

Location: Which teeth are affected by the bite conflict is determined by the individual perception of the conflict situation in correspondence to the specific function of the teeth.



The **incisors** (front teeth) are used for biting and cutting food. The related bite conflict: not being allowed to bite, snap, or show one's teeth.

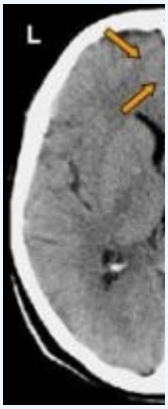
The **canines** (at the corner) are used for gripping and tearing food. The related bite conflict: not being allowed to snatch a person.

The **molars** (at the back) are used for crushing and chewing food. The related bite conflict: not being allowed to crunch or grind an opponent ("chewing him up and spitting him out").

NOTE: Whether the jaw or teeth on the right or left side (or on both sides) are affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.

CONFLICT-ACTIVE PHASE: loss of dentin causing holes (**cavities**) in the tooth. Since dentin cavities are painless (contrary to cavities in the enamel) they are usually only detected through an X-ray. If, however, a cavity progresses to the pulp, the exposure of the pulp causes a painful sensitivity to hot, cold, sweet, or sour foods and drinks. Excessive dentine loss due to lasting conflict activity destroys the internal structures of the tooth with the result that the tooth breaks. Without blood supply to the pulp the tooth starts to rot from the inside.

NOTE: Tooth decay, whether it occurs in the dentin or in the enamel, is unrelated to sugar in foods or liquids. Not every child or adult with a "sweet tooth" develops cavities! Conversely, cavities are also found in people who hardly eat any sweets. Tooth decay is also unrelated to dental care. Persons who are consistent with their dental hygiene also have cavities, and the other way around.



Here we see the impact of a bite conflict in the control center of the dentin (view the GNM diagram). The Hamer Focus reaches over both brain hemispheres (central conflict). This reveals that the person associated the conflict with his/her mother/child and partner, for example, with both parents (father and mother), causing cavities in the right and left teeth (compare with impact of a central conflict in the enamel relay).

If the jaw is affected, the **jaw bone decalcifies** (osteolysis). With prolonged conflict activity, the neck of the tooth gets visibly longer, the gums recede and the tooth becomes loose and unstable. Consequently, the gums tear easily causing**gum bleeding** (gum diseases such as a tooth abscess or gingivitis relate to the mouth submucosa and mouth surface mucosa). The degeneration of the periodontal structure is called **periodontosis**. There is a risk that the tooth falls out.

HEALING PHASE: In the healing phase, the cavities in the tooth are refilled with dentin callus produced by odontoblasts in the pulp (similar to the reconstruction of bones with callus produced by bone-building osteoblasts). The soft callus eventually hardens.

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

In the jaw, the soft bone callus makes the tooth or teeth shift easily. Dental braces designed to align and straighten the teeth work therefore best during that period.

If a tooth cavity has an external opening (see tooth fistula) the callus finds its way into the mouth. Combined with food remnants and saliva, the sticky substance adheres to the surface of the teeth contributing to the formation of **tartar**, a form of hardened **dental plaque**. Contrary to the common belief, dental plaque does not cause cavities. Plaque is also believed to cause tooth decay and gingivitis, an inflammation of the gums. These theories, however, cannot explain whycavities or gingivitis occur on

the right or left side of the mouth, why cavities develop in a very specific tooth, why they affect the front teeth or molars, or why the "caries" occurs in the dentin or in the tooth enamel. German New Medicine offers insights into the cause of "tooth diseases" that will fundamentally change dental medicine as we know it.

During the replenishing process the periodontium covering the tooth stretches due to the swelling. This can cause severe**toothache** since the squamous epithelial layer covering the periodontium is endowed with highly sensitive nerves (compare with dental pain involving the enamel). If the cavity formed inside the tooth rather than towards the border, the swelling might press on the pulp. In this case, the pain could be excruciating. Prolonged pressure on the pulp (hanging healing) might damage the tooth's nerves (the pulp can also become damaged through repeated dental work on a tooth or large fillings). At that point, the standard treatment is a root canal or an extraction of the tooth.

The **root canal** procedure entails removing the entire contents of the pulp and filling the cavity with a plastic material called gutta-percha. There is more to it than that: The filling also contains formaldehyde and arsenic!

"There is no justification, whatsoever, for the use of arsenic in modern dental practice."

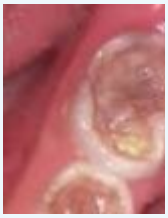
National Center of Biotechnology

The same must be said about the use of dental fillings containing mercury,
a neurotoxin that can cause serious neurological problems.

What is left after a root canal is a dead and toxic tooth! The theory that a root-canaled tooth bears the risk of developing cancer or of having a heart attack, as originally proposed by Dr. Weston A. Price (in 1922), is, based on the Five Biological Laws, highly doubtful. From a GNM point of view, a root canal should be avoided at all costs. In exceptional cases, the affected tooth might have to be extracted and replaced.

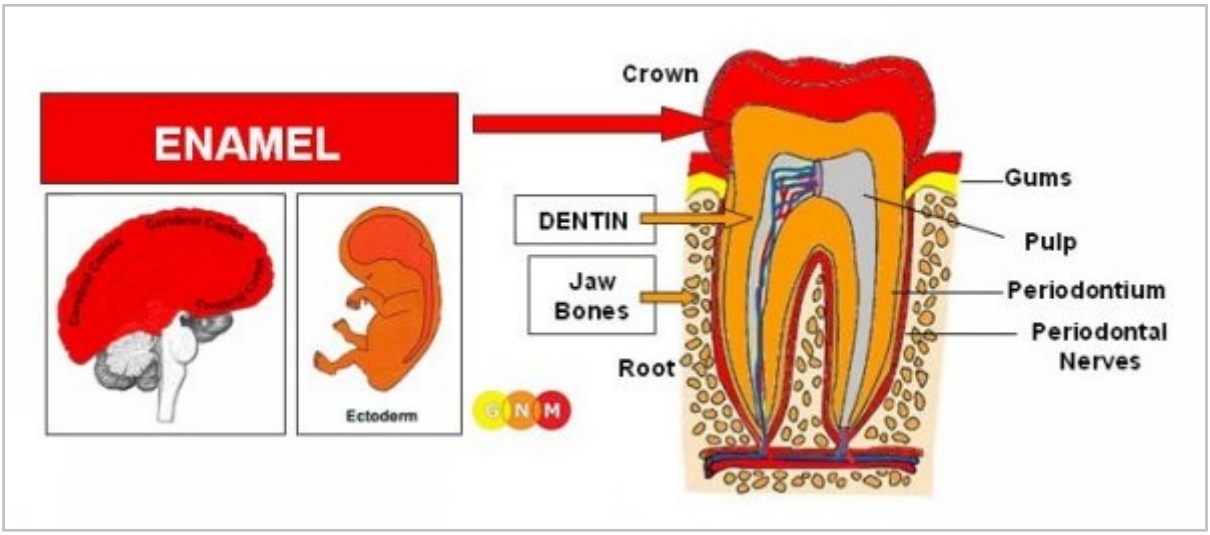
"A tooth's nerve is not vitally important to a tooth's health and function. Its only function is sensory to provide the sensation of heat or cold. The presence or absence of a nerve will not affect the day-to-day functioning of the tooth." (Dental Health and Root Canals)

Bacteria, provided they are available, assist the reconstruction of the tooth. The microbial activity causes an **abscessed tooth** with an accumulation of callus and pus inside the tooth (compare with gum abscess). The pain of the tooth abscess is due to the buildup of pressure inside the tooth. If, however, the cavity has created an external opening, called a **tooth fistula**, the pus will leak out and drain the abscess on its own.



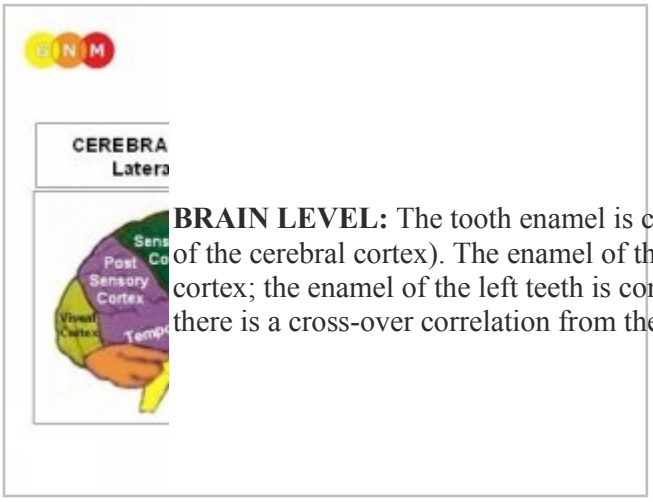
The **swelling** around the tooth (see picture) results from to the edema (fluid accumulation) in the healing area. With water retention because of the SYNDROME the swelling becomes considerably larger, noticeable as facial swelling.

In the jaw, the recalcification that occurs during the healing phase is also accompanied by swelling and pain, caused by the stretching of the periosteal layer covering the jaw bones. A large swelling is usually diagnosed as **jaw cancer** (seebone cancer). Pain in the temporomandibular joint is referred to as **TMJ syndrome**.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

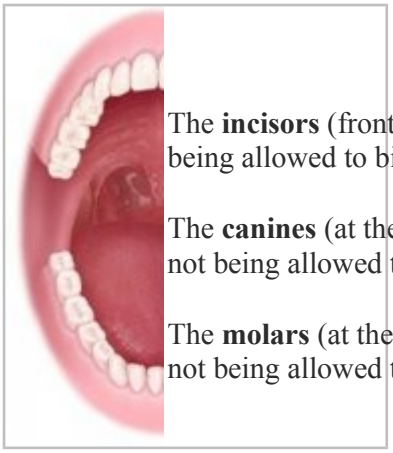
DEVELOPMENT AND FUNCTION OF THE TOOTH ENAMEL: The enamel covers the crown of the tooth above thegums. It is composed of large amounts of minerals (more than contained in dentin) accounting for its strength to protect the teeth from daily use such as chewing, biting, and grinding. Like the neural network of the periosteum, the enamel has two layers: an inner layer close to the dentin, and an outer, visible layer. The lining of the periodontium (odontoperiosteum) on top of the dental bone consists of squamous epithelium. The outer layer of the enamel is hardened squamous epithelium. The enamel originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The tooth enamel is controlled from the **pre-motor sensory cortex** (part of the cerebral cortex). The enamel of the right teeth is controlled from the left side of the cortex; the enamel of the left teeth is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: While the tooth dentin relates to "not being able to bite", the biological conflict linked to the tooth enamel is **not being allowed to bite** either literally (a big dog is not allowed to bite a small dog because his master is holding him back; not being allowed to "bite into" one's favorite food – compare with oral conflict) or figuratively, in the sense that **the individual is prevented from "biting" or "snapping"**. More precisely, the person could "bite" because he/she is stronger or in a higher position or rank but because of rules (rules of etiquette or political correctness) or for ethical reasons is not permitted to "snap". The bite conflict associated with the enamel also corresponds to "not being allowed or not being able to hold on to something" (similar to a mother cat holding her kitten by gripping its neck with her teeth). It is a type of separation conflict (see periosteum).

Location: Which teeth are affected by the bite conflict is determined by the individual perception of the conflict situation in correspondence to the specific function of the teeth.

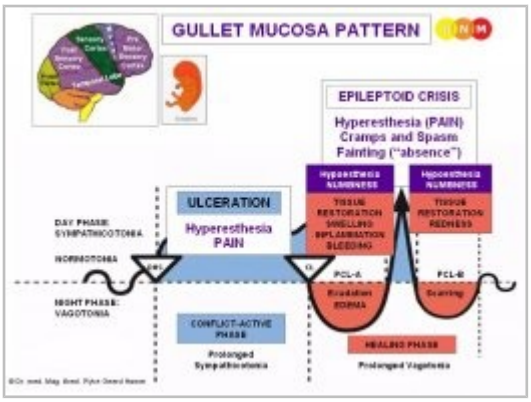


The **incisors** (front teeth) are used for biting and cutting food. The related bite conflict: not being allowed to bite, snap, or show one's teeth.

The **canines** (at the corner) are used for gripping and tearing food. The related bite conflict: not being allowed to snatch a person.

The **molars** (at the back) are used for crushing and chewing food. The related bite conflict: not being allowed to crunch or grind an opponent ("chewing him up and spitting him out").

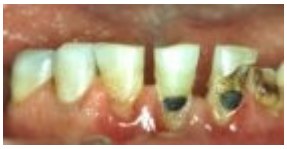
NOTE: Whether the teeth on the right or left side (or on both sides) are affected is determined by a person's handedness and whether the conflict is mother/child or partner-related.



The Biological Special Program of the tooth enamel follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

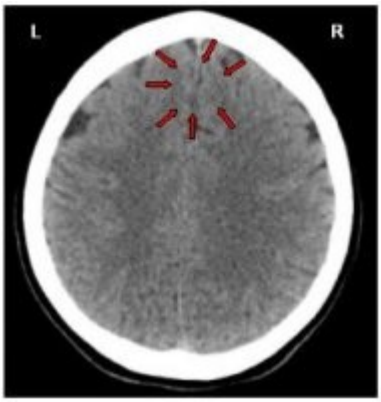
CONFLICT-ACTIVE PHASE: ulceration of the enamel causing **cavities** in the affected tooth or teeth (compare with cavities in the dentin). The **biological purpose** of the enamel loss is to make the tooth blunt in order to be unable to bite (since it is not allowed). The **pain** ("**tooth rheumatism"**) is similar to the rheumatic pain involving the periosteal nerves. Like the neural network covering the periosteum, the periodontium (odontoperiosteum) lying on top of the dental bone is supplied by highly sensitive nerves (compare with toothache in the healing phase of the dentin caused by the stretching of the periodontium). When the enamel is lost, there is also a heat and cold sensitivity.

With prolonged conflict activity the **decayed tooth** shows black spots or becomes entirely black, depending on the intensity and duration of the conflict. Tooth decay, whether it occurs in the dentin or in the enamel, is unrelated to sugar in foods or liquids.



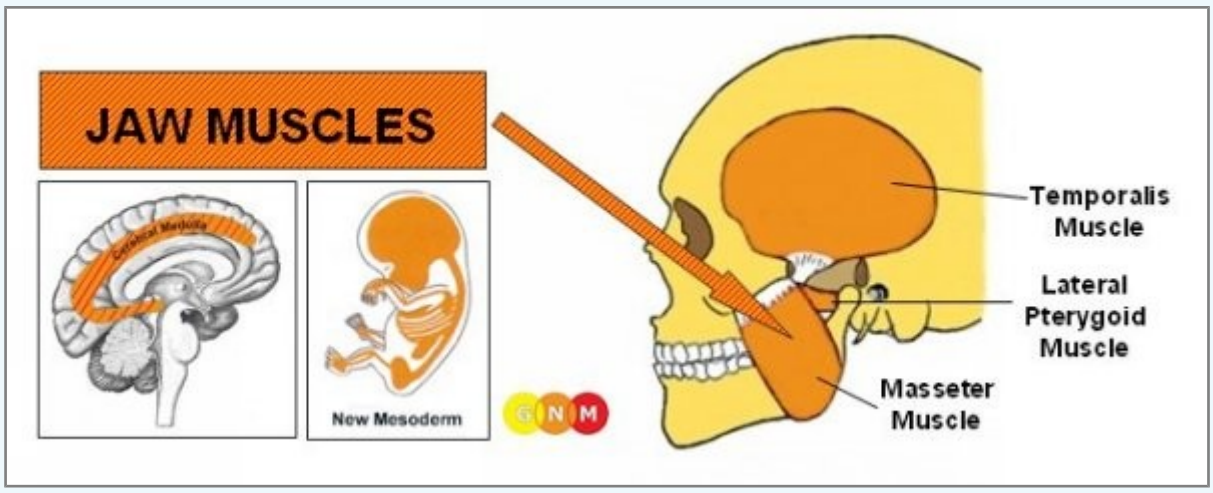
Note in this picture that the decay of the enamel only involves the incisors of the left teeth. If the person is left-handed, this reveals that the bite conflict was associated with a partner.

This picture shows advanced enamel cavities restricted to the right and left incisors. This indicates that the bite conflict is related to the person's mother/child and partner.



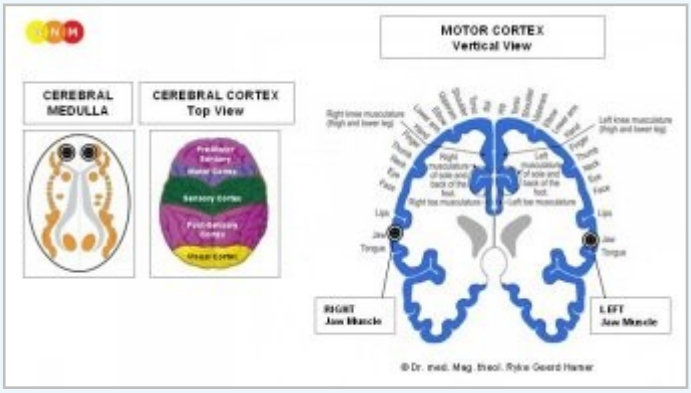
Accordingly, the Hamer Focus showing on a CT scan in the enamel relay (view the GNM diagram) reaches over both brain hemispheres (central conflict) – compare with impact of a central conflict in the dentin relay.

HEALING PHASE: During the healing phase the enamel tissue is replenished (contrary to the standard view). The restoration process is, however very slow, even without conflict relapses. After the repair, the affected area of the tooth or teeth will remain darker.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE JAW MUSCLES: The jaw muscles, or muscles of mastication, are a group of muscles associated with the movements of the jaw (temporomandibular joint), explicitly, with the ability to open and close the mouth, bite, and chew food. The masseter muscle is the primary chewing muscle. It covers the sides of the jaw just behind the cheeks. It is also the main muscle that allows clenching the jaw and grinding the teeth. The jaw muscles consist of striated muscles, originate from the new mesoderm, and are controlled from the cerebral medulla and the motor cortex.



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

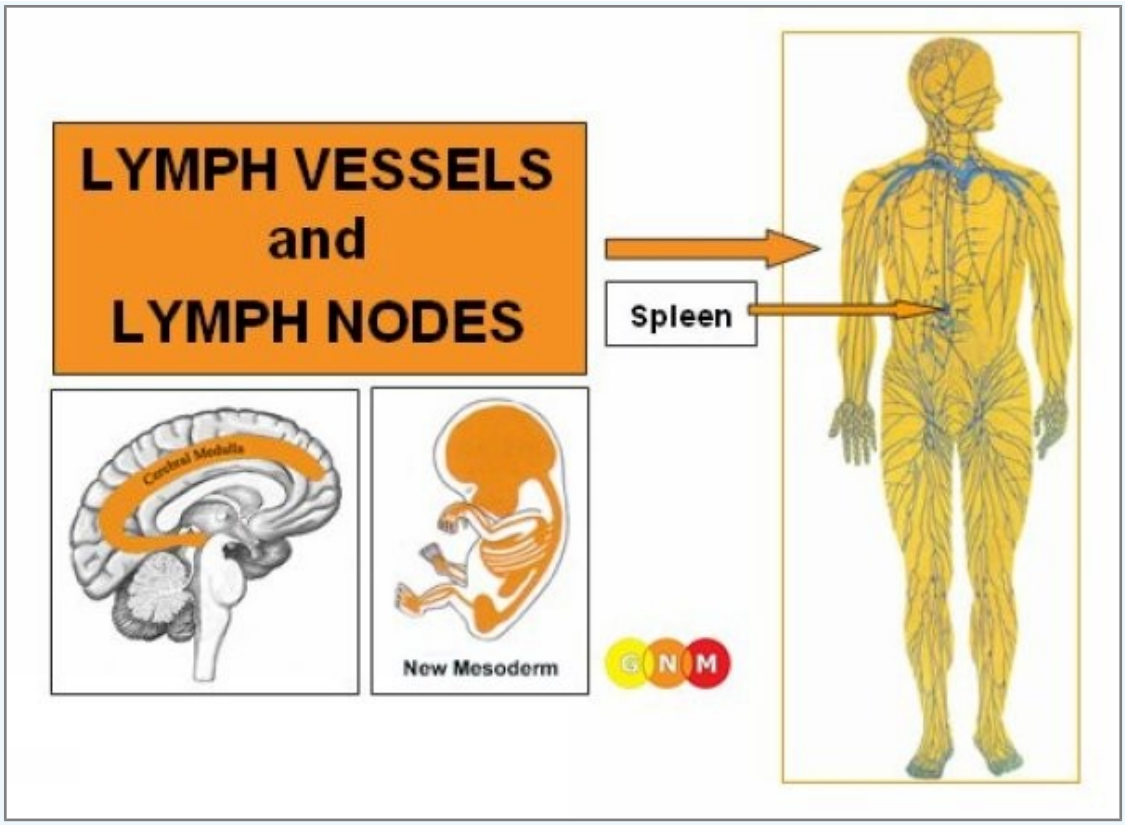
BIOLOGICAL CONFLICT: The biological conflict linked to the jaw muscles is a **bite conflict** of not being able or not being allowed to "bite, snap, chew or grind an opponent", for example, a competitor, colleague, class mate, teacher, family member, relative, or neighbor (see also bite conflict related to the dentin and enamel). The conflict can also be experienced in real terms as in "not being able to open the mouth widely enough or 'properly'" (for instance, during a dental procedure) or "not wanting to open the mouth". It is a type of localized motor conflict.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of jaw muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the jaw muscle** (controlled from the motor cortex) **affecting the ability to move the jaw**. Difficulties opening or closing the mouth, called **lockjaw**, are also associated with the temporomandibular joint (TMJ).

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 (periosteal nerves and thalamus).

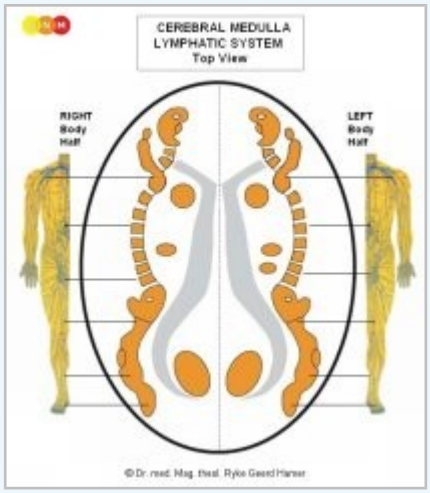
HEALING PHASE: In the healing phase, the jaw muscle is reconstructed; the paralysis reaches into PCL-A. TheEpileptoid Crisis presents as **spasms of the jaw muscles**. **Bruxism**, excessive grinding of the teeth and/or clenching of the jaw, typically occurs during sleep. After the Epi-Crisis, in PCL-B, the function of the jaw muscles returns to normal.

LYMPHATIC SYSTEM



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE LYMPH VESSELS AND LYMPH NODES: The lymphatic system consists of lymph vessels, lymph nodes, and lymphatic organs such as the spleen. Working in conjunction with the circulatory system, the lymph vessels branch like the blood vessels into all tissues of the body. As blood passes through the capillaries, some of the liquid cellular and metabolic waste escapes through the capillary walls and fills the space between the tissue cells. The intercellular fluid is then picked up by the lymph capillaries. Equal to the peristaltic motion of theintestinal muscles that move food along the intestinal canal, the smooth muscle of the lymph vessel wall move the lymphatic fluid to the lymph nodes located throughout the body. The lymph nodes filter the cellular waste from the lymph. After passing through the lymphatic ducts, the lymph is returned to the bloodstream and excreted through thekidneys. The lymph vessels originate from the new mesoderm and are therefore controlled from the cerebral medulla.



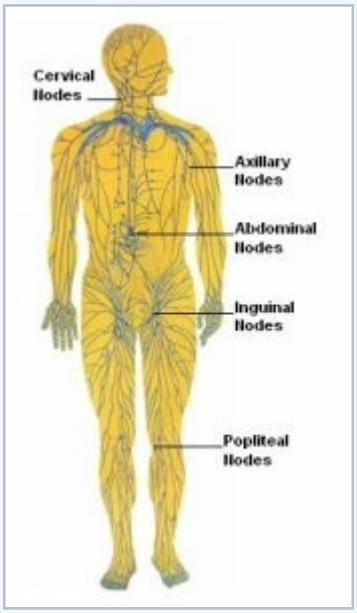
BRAIN LEVEL: In the **cerebral medulla**, the lymph vessels and lymph nodes of the right side of the body are controlled from the left side of the brain; the lymph vessels and lymph nodes of the left side are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

The smooth muscle of the lymph vessels are controlled from the midbrain.

NOTE: 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 CONFLICT: The biological conflict linked to the lymph vessels and lymph nodes is a **moderate self-devaluation conflict** or **loss of self-worth**. 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.



Cervical nodes located in the **neck**: intellectual self-devaluation conflict

Axillary nodes located in the **armpits**: relationship self-devaluation conflict

Abdominal nodes located in the lower abdomen: self-devaluation conflicts associated with the abdominal area, brought on, for example, by a cancer diagnosis (stomach cancer,colon cancer, liver cancer, pancreas cancer)

Inguinal nodes located in the **groin** at the bend of the hip: "unable to endure a situaton" or a physical performance conflict

Popliteal Nodes located near the **knees**: physical performance conflict

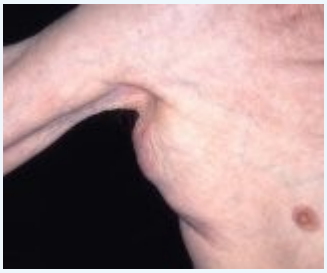
NOTE: Whether the conflict affects a lymph vessel or lymph node on the right or left side of the body (or on both sides) is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the lymph tissue that is closest to the site associated with the self-devaluation conflict.

CONFLICT-ACTIVE PHASE: necrosis (cell loss) in the conflict-related lymph vessel or lymph node.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. With water retention as a result of an active abandonment and existence conflict involving the kidney collecting tubules the swelling increases significantly. Bacteria, provided they are available, assist the healing process. The by-products of the microbial repair work are cleared away by lymphocytes and other white blood cells (contrary to the immune system theory claiming that lymphocytes "fight infections"). Healing might be accompanied by an inflammation.

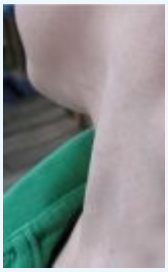
If a lymph node is affected, conventional medicine considers the cell increase a cancer, termed **Hodgkin's lymphoma**(compare with non-Hodgkin's lymphoma related to the pharyngeal ducts). Based on the Five Biological Laws, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process. "Hodgkin's" is often found in the vicinity of a tumor that has been surgically removed. The "new growth" is then incorrectly interpreted as a "metastasis". In reality, the development of a lymphoma follows the resolution of the self-devaluation conflict initiated by the removal of the "cancer", for example, of a colon cancer or breast cancer.

NOTE: Lymphoid tissue is made up of lymphocytes. In case of a lymphoma, the lymphocyte count is therefore elevated (compare with lymphatic leukemia where the count of lymphoblast increases - without lymph node swelling).



A lymphoma in the armpit reveals that a relationship self-devaluation conflict has been resolved. For a right-handed person the swelling occurs on the right side, if the conflict is associated with a partner.

Women develop a **lymphoma** in the axillary nodes when, for instance, a nest-worry conflict is coupled with guilt ("I failed as a mother", "I failed as a partner"). A breast cancer diagnosis and the image of an amputated breast can provoke a self-devaluation conflict involving the axillary gland close to the affected breast. This is why lymphoma is one of the most frequent cancers following breast cancer. It has nothing to do with a "metastasizing" process, as argued.



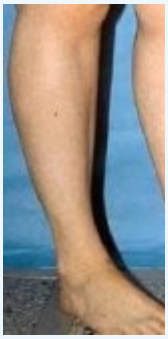
An enlarged lymph node in the neck area indicates the healing phase of an intellectual self-devaluation conflict (compare with non-Hodgkin's lymphoma and lipoma). For a right-handedperson the swelling occurs on the left side, if the conflict is mother or child-related.

A swollen lymph node in the neck might also be diagnosed as **mononucleosis** or **Pfeiffer's disease** (compare withmononucleosis linked to the pharyngeal ducts). A sore throat accompanying the condition, points to an additional conflict of "not wanting to swallow a morsel" (see strep throat). In conventional medicine, "mono" is believed to be an "infection" caused by the "Epstein Barr virus" transmitted through saliva (hence, the name "kissing disease"). There is no scientific evidence for such a claim.

After the Epileptoid Crisis, in PCL-B, the swelling subsides, provided there are no conflict relapses.

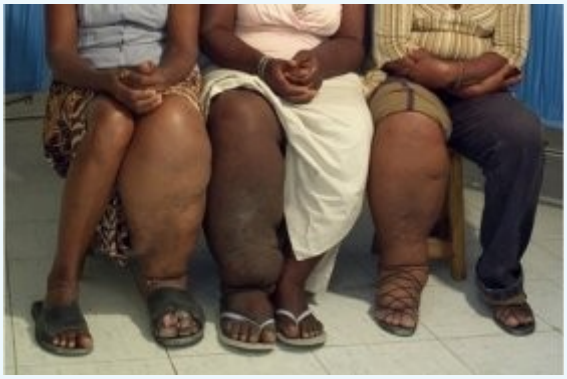
NOTE: Considering the function of the lymphatic system as a drainage system, the lymph nodes also swell – without cell proliferation – during a healing process that produces large amounts of metabolic waste and intercellular fluid. This includes healing from injuries or operations such as a mastectomy. The lymph fluid from a healing breast cancer passes to the axillary nodes. The lymph nodes in the groin (inguinal nodes) swell when there is healing in the genital area or in the legs. With tonsillitis, pharyngitis, or an abscessed tooth, the lymph nodes in the neck become swollen and tender to touch. In conventional medicine, a "swollen gland" is considered "benign" and a sign of an "infection", whereas the swelling of a lymph node caused by cell mitosis is interpreted as a "malignant" cancer. The lymphatic system is also wrongly believed to be a passageway for "metastasizing cancer cells" (see GNM Article "Questioning Metastasis").

A **lymphedema** develops when a lymph vessel undergoes healing, for example, in one of the arms, legs, or knees. The accumulation of fluids (lymph and water) in the intercellular tissue causes the lymph fluid to back up leading to the large swelling. If lymph fluid leaks into a blood vessel, this is often misdiagnosed as a "thrombosis" (compare with **peripheral edema** related to the leg veins, leg bones, or the myocardium).



With water retention due to the SYNDROME the swelling increases considerably, as seen in this picture. A lymphedema in the left leg is associated with a partner, if the person is left-handed.

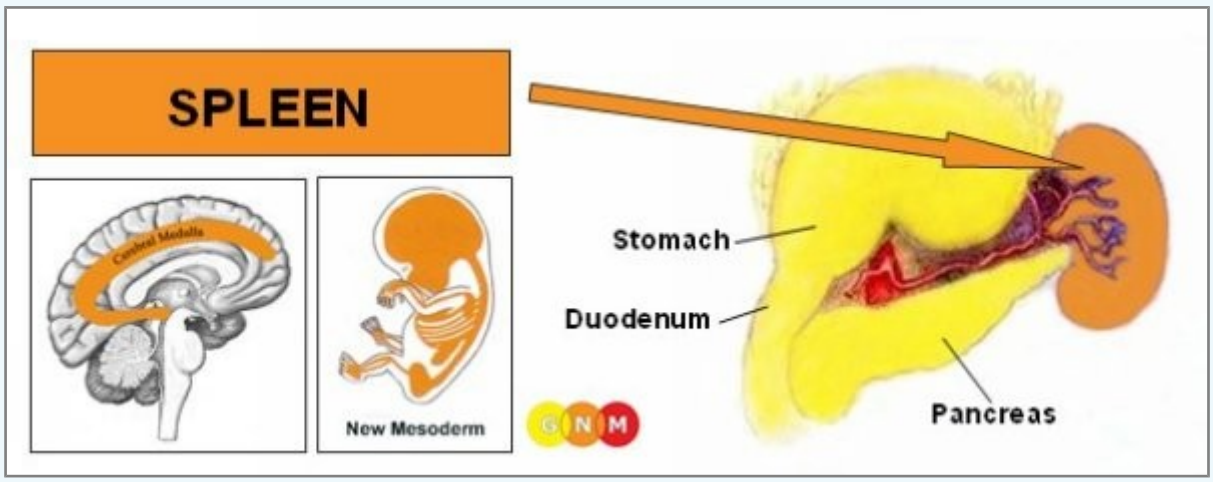
An extreme form of lymphedema is termed **elephantiasis** (lymphatic filariasis). Elephantiasis is said to be caused by a parasitic worm "picked up from mosquitoes and passed on through biting a new victim".



This picture shows three women from Haiti with lymphatic swelling, noticeably only on one leg – linked to a physical performance conflict of "not being able to run" (fast enough). In Haiti, 80% of the population has the condition. In Port-au-Prince the "disease" was unknown until the earthquake in 2010!

A right-handed person makes the first step with the right leg, a left-handerwith the left leg. Hence, the woman sitting on the right side must be left-handed and the other two right-handed.

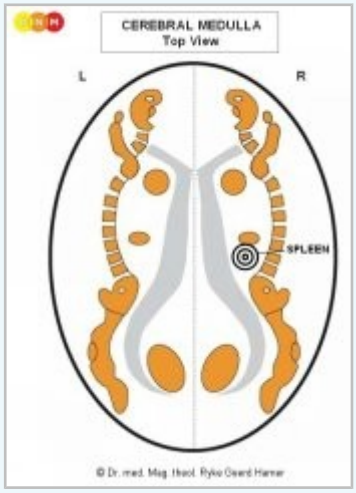
NOTE: All organs that derive from the new mesoderm ("surplus group"), including the lymph vessels and lymph nodes, show the **biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict of the same kind.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE SPLEEN: The spleen is located on the left side of the upper abdomen behind the stomach just below the diaphragm. The spleen is a specialized lymph node and therefore an important part of thelymphatic system. Its main function is to filter blood and to store platelets (thrombocytes). Platelets are blood cells (produced in the bone marrow) that have a blood clotting ability and are therefore vital for wound repair. When a blood vessel wall is damaged through a cut or injury, the platelets stick together and seal the breaks to stop the bleeding by forming blood clots, a

process called coagulation. The spleen originates from the new mesoderm and is therefore controlled from the cerebral medulla.

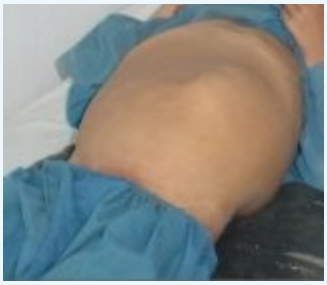


BRAIN LEVEL: In the **cerebral medulla**, the spleen is controlled from the right brain hemisphere. The brain relay is located exactly in the area where the spleen has its place as a lymphatic node. There is a cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the spleen is a **bleeding or injury conflict** (a type of self-devaluation conflict since bleeding can quickly lead to death). In real terms, the conflict is triggered by bleeding due to an injury, hemorrhaging, or heavy periods but also when there is blood in the stool, in the urine or in the vaginal discharge, which often causes great panic. A "blood cancer" (leukemia) diagnosis, a positive HIV test (the fear of being HIV positive), being on dialysis, blood transfusions, or distressing blood test results could also evoke a bleeding conflict. Taking blood-thinning medication can keep a bleeding conflict active because of the danger of severe bleeding.

CONFLICT-ACTIVE PHASE: During the conflict-active phase the spleen necrotizes creating little holes in the spleen. The necrosis can occur on the outside or on the inside of the spleen. Starting with the DHS (in Nature equal to bleeding), the platelets that are not required (for wound repair) leave the peripheral blood stream and move to the spleen, where the necrotized area provides an ideal reservoir for storing the platelets until the bleeding conflict is resolved. Hence, during conflict activity the **platelet count is low**. If the conflict is intense, the thrombocyte count drops to values showing **thrombocytopenia** (compare with thrombocytopenia related to the bone marrow). The low amount of platelets in the blood serves the purpose to prevent the formation of a blood clot or thrombus in the blood vessels. Because of the decreased number of thrombocytes there is a **tendency to bruise and bleed more easily** (also during an active self-devaluation conflict involving the bones). This can lead to additional bleeding conflicts. Diabetics who bruise easily have most likely a "blood(!) sugar" conflict.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. This causes an **enlargement of the spleen** or **splenomegaly**. The spleen might also become inflamed (**splenitis**), particularly when bacteria assist healing. **Splenic cysts** develop with concurrent water retention but only when the necrosis was located on the outside of the spleen.



With water retention (the SYNDROME) the spleen can enlarge considerably in size. Theexistence conflict is usually triggered by fear, for instance, when a person is hospitalized.

A spleen enlargement is typically seen in people with leukemia or with AIDS who have to undergo blood

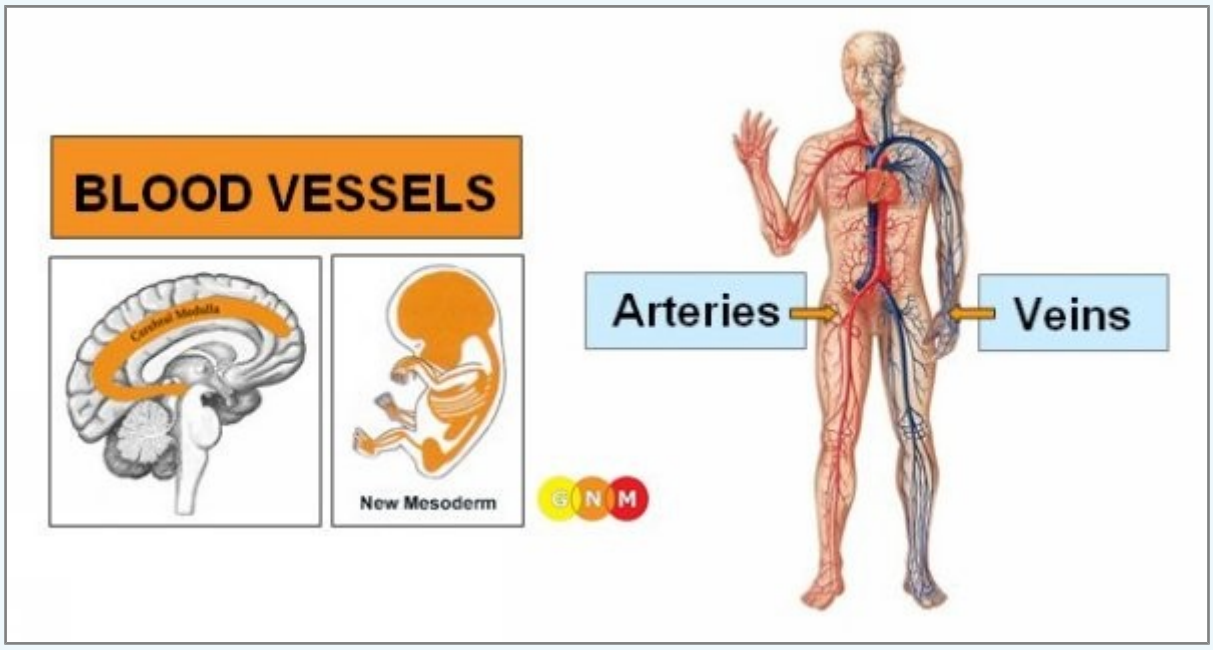
tests or blood transfusions on a regular basis. For someone unfamiliar with GNM, these procedures often become tracks that continuously reactive the blood conflict and prolong healing. If the spleen is surgically removed (splenectomy), a neighboring lymph node will take on the function of the former spleen. According to Dr. Hamer, surgery should be considered if the bleeding conflict is severe and of long duration.

In the healing phase, the platelets return to the peripheral blood stream and their number increases - temporarily - above the normal range (**thrombocytosis** or **thrombocythemia**). There is no danger of blood clotting or so-called "thrombosis" as long as the person is mobile. In conventional medicine, the elevated platelet count might be diagnosed as thrombocyte leukemia.

At the end of the healing phase, the thrombocytes values are back to normal. However, the spleen remains enlarged.

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

BLOOD VESSELS

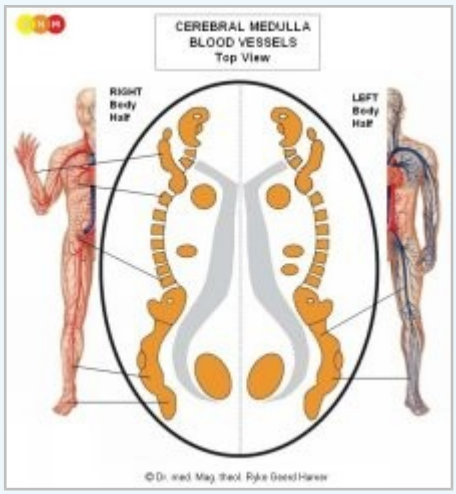


Arteries **Veins**

DEVELOPMENT AND FUNCTION OF THE BLOOD VESSELS: The blood vessels make up the body's cardiovascular system. The systemic circulation carries oxygenated blood from the left ventricle through the **arteries** to the various tissues of the organism. In the capillaries, the smallest of blood vessels, oxygen and other nutrients are exchanged for cellular waste and carbon dioxide.
The **veins** take de-oxygenated blood back to the heart and deliver it through the right heart chambers and

the pulmonary arteries to the lungs. The pulmonary circulation returns oxygenated blood from the lungs to the left atrium, which empties into the left ventricle, completing the cycle of blood circulation. The blood vessel wall is endowed with connective tissue, smooth muscle, and striated muscles. Equal to the intestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth muscles of the arteries and veins facilitate the flow of the "blood morsel". The inner lining of the arteries and veins, the so-called intima, originates from the new mesoderm and is therefore controlled from the cerebral medulla.

NOTE: The intima of the cerebral arteries, descending aorta, external carotid arteries, outer sections of the sybclavian arteries, and abdominal aorta is of new mesodermal origin (controlled from the cerebral medulla) whereas the intima of the coronary arteries, coronary veins, ascending aorta, internal carotid arteries, inner sections of the subclavian arteries derives from the ectoderm (controlled from the cerebral cortex).



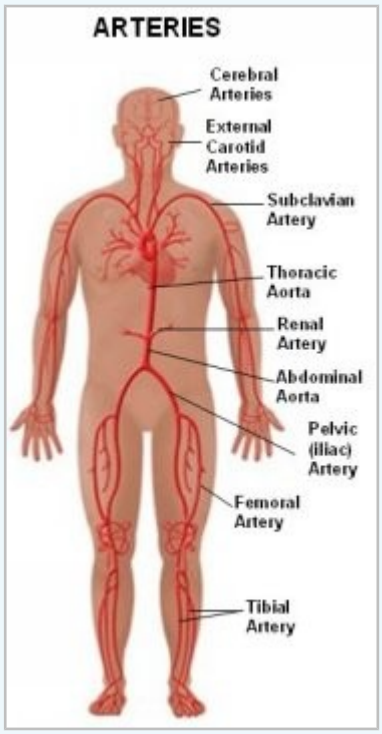
BRAIN LEVEL: In the **cerebral medulla**, the arteries and veins of the right side of the body are controlled from the left side of the brain; the arteries and veins of the left side of the body are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The bones, skeletal muscles, lymph vessels with 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.

ARTERIES

BIOLOGICAL CONFLICT: The biological conflict linked to the arteries is a **light self-devaluation conflict** experienced in the area of a particular artery. 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.



A person who has a hard time walking (after an accident, illness, surgery) can suffer a**self-devaluation conflict** (physical performance conflict) affecting the arteries of the legs (**femoral arteries**) or the feet (**tibial artery**). The **abdominal aorta** is linked to a self-devaluation conflict associated with the abdominal area (abdominal pain, constipation, Crohn's, colon cancer diagnosis, surgery) and the fear that something is wrong "there". The same applies to the **thoracic aorta** that runs through the chest and other arteries such as the **renal artery** or **pelvic artery** which supply the kidneys and pelvic area. The **outer sections of the subclavian arteries** carrying blood to the shoulder and arms relate to a relationship self-devaluation conflict (having failed as a partner or as a parent). The **external carotid arteries** that deliver blood to the face and the scalp as well as the **cerebral arteries** are linked to an intellectual self-devaluation conflict. The cerebral arteries respond also to the distress of "the brain doesn't get enough oxygen"; a parent can suffer this conflict for and with a newborn.

NOTE: Whether the conflicts affects an artery on the right or left side of the body is determined by a person'shandedness and whether the conflict is mother/child or partner-related. A localized conflict affects the artery that is closest to the site associated with the self-devaluation conflict.

CONFLICT-ACTIVE PHASE: localized necrosis (cell loss) of the artery proportional to the degree and duration of conflict activity. While the intima necrotizes, the smooth muscles of the artery become thicker in order to prevent a perforation of the arterial wall. However, if an intense conflict persists for a long period of time, the blood vessel wall becomes weak causing a localized bulge or **aneurysm**, for instance, in one of the **external carotid arteries** (compare with carotid artery aneurysm related to the internal carotid artery). A **cerebral aneurysm** in other brain arteries than the carotid arteries is extremely rare. The most common location of arterial aneurysms is the abdominal aorta, specifically the segment of the abdominal aorta below the kidneys. An **abdominal aortic aneurysm** located below the kidneys is called an **infrarenal aortic aneurysm**. Small aneurysms may go completely unnoticed. However, as the aneurysm becomes larger there is a greater risk of rupture. Normally, the smooth muscle fibers embedded in the striated muscles of the arterial wall stabilize the blood vessel. Hence, an aneurysm rupture only occurs because of a vigorous move, lifting something heavy, or pressing too hard during a bowel movement. Hemorrhaging into the abdomen is a medical emergency. When a cerebral aneurysm bursts, this causes bleeding in the brain (compare with bleeding due to aruptured brain cyst). A brain hemorrhage, however, is not related to a stroke, as claimed by conventional medicine.

HEALING PHASE: During the first part of the healing phase (PCL-A) the necrotized area in the affected artery is replenished through **cell proliferation** with localized **swelling**. Bacteria, if available, assist the healing process, potentially accompanied by an inflammation (**arteritis**).

The blood vessel is repaired with the help of calcium and cholesterol. With continuous conflict relapses plaques accumulate at the site leading to **arteriosclerosis**. Arteriosclerosis in the penile arteries, linked to a sexual self-devaluation conflict, restricts the rush of blood into the penis necessary to get and maintain an erection (see also erectile dysfunction related to the corpora cavernosa). In the major arteries (coronary arteries, ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries) the arteriosclerotic plaques certainly compromises the blood flow but do not cause a heart attack or a stroke, as claimed.

In the legs, the swelling and buildup of plaques narrow the lumen of the artery leading to **pain and**

difficulties walking. Medically this is referred to as **peripheral artery disease** or "**intermittent claudication"**. If the striated muscles of the leg arteries are involved due to a motor conflict of "not being able to walk", **leg cramps** occur throughout theEpileptoid Crisis. For a person unfamiliar with GNM, the condition usually triggers new self-devaluation conflicts ("My legs are useless"!) resulting in a chronic condition.

VEINS

BIOLOGICAL CONFLICT: Like the arteries, the veins are also linked to a **self-devaluation conflict**. The specific self-devaluation conflicts are the same as for the bones and joints.

The **leg veins** relate in particular to a **ball-and-chain conflict**, experienced as a limitation of the freedom to move. A pregnancy, having to care for someone, a "clingy" person, feeling shackled to a place, a job, a project, or a relationship can provoke the conflict. People with professions that require standing or sitting a lot (cashiers, taxi drivers) are more likely to suffer the conflict, unless they truly enjoy their work.

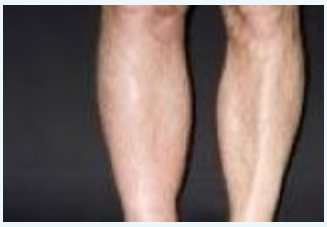
NOTE: Whether the conflict affects the veins of the right or left leg, is determined by a person's handedness and whether the conflict is mother/child or partner-related.

CONFLICT-ACTIVE PHASE: localized necrosis (cell loss) proportional to the degree and duration of conflict activity. While the intima necrotizes, the smooth muscles of the vein becomes thicker in order to prevent a perforation.

HEALING PHASE: During the first part of the healing phase (PCL-A) the necrotized area in the affected vein is replenished through **cell proliferation**. With an inflammation (**phlebitis**) the area around the vein is red, warm, and tender. Bacteria assist the healing process, provided they are available.

NOTE: Staphylococcus bacteria are also involved during the healing of a vein that was injured through an intravenous injection or the use of a venous catheter. In fact, any invasive devices harming a tissue will activate bacteria to assist wound repair.

The accumulation of fluid in the healing area creates a **peripheral edema**, for example, in the ankles, feet and legs (see also peripheral edema related to the myocardium or to the leg bones; compare with lymphedema).



Concurrent water retention due to the SYNDROME increases the swelling considerably, as shown in this picture. For a right-handed man the swelling of the right leg indicates that theball-and-chain conflict or the self-devaluation conflict was associated with a partner.

In conventional medicine, pain and swelling in the leg is often misdiagnosed as "**deep vein thrombosis"** or"**thrombophlebitis"**, based on the wrong assumption that the swelling and inflammation of the vein is caused by a thrombus.

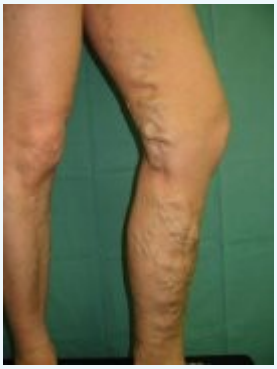
NOTE: A **thrombus** is a blood clot that forms when blood is not moving and subsequently coagulates. Such a thrombus can develop in the lower extremities after an operation, an induced coma, a prolonged stay in bed, or following an injury. Any sort of prolonged inactivity increases blood clotting in the deep veins of the leg. Pain is caused by the stagnant blood. At some point, small pieces of these clots may

break away, travel through the venous system and lodge in the lungs. A clot in the lungs can lead to a lung embolism without a DHS (seecoronary veins). However, if a person is mobile, the working of the calf muscles and the contractions of the muscles in the blood vessel wall facilitate the flow of blood through the venous system, reducing the risk of blood clot formation. Small clots are broken down in the blood stream and absorbed by the body, a process called fibrinolysis. At any rate, a blood clot can never cause a heart attack or stroke, as argued, since in the event of an obstruction auxiliary vessels supply the heart and the brain with blood (see carotid arteries).

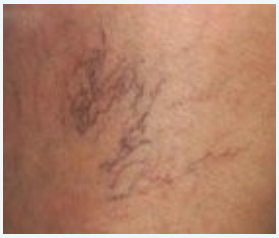
Example of a Medical Narrative

"In cardiovascular disease, abnormal clotting can result in a heart attack or stroke. Blood vessels injured by smoking, cholesterol, or high blood pressure develop cholesterol-rich build-ups (plaques) that line the blood vessel; these plaques can rupture and cause the platelets to form a clot. Even though no bleeding is occurring, platelets sense the plaque rupture and are confused, thinking that an injury has taken place that will cause bleeding. Instead of sealing the vessel to prevent bleeding as would occur with a cut, a clot forms in an intact blood vessel, causing a blockage of blood flow." (American Heart Association)

Varicose veins are a hanging healing in the leg veins caused by continuous conflict relapses. The leg valves that prevent blood from flowing backwards are also affected. With recurrent repair processes the valves become scarred (PCL-B) and porous with the result that the veins thicken.



This picture shows a man with varicose veins on his left leg. If he is right-handed this reveals aball-and-chain conflict related to his mother or children; if he is left-handed the conflict would be associated with a partner.



So-called **spider veins** are small varicose veins, caused by a ball-and-chain conflict (on the legs) or a self-devaluation conflict ("I am not pretty there") associated with the area of the body where they appear, for example, on the face, the chest, or on the abdomen (during pregnancy).

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

HEART

THE HEART IS NOT A PUMP

Contrary to the official theory, findings from embryology and other sources have shown that the heart is not a mechanical pump pushing blood through the blood vessels but that the blood is instead propelled by its own biological force boosted by the heart. In Nature, fluids move in a spiral manner. It has therefore been suggested that the structure of the cardiovascular system is taking full advantage of this natural tendency of fluids to spiral.

The rotary motion of the heart and blood was detected and measured by several researchers:

As early as 1908, **James B. Pettigrew**, Professor of Medicine at St. Andrews University (Scotland), performed dissections of the heart and discovered that the heart muscle has seven muscle layers. Pettigrew postulated that one group of muscles contracts during systole while the other stores energy that is utilized in diastole. In his view, the motion of the heart muscle is like that of a torsional (twisting) pendulum. (*Design in Nature*, 1908).

In the 1920s, scientist and philosopher **Rudolf Steiner** taught his medical students that the spiral flow in the blood vessels of the embryo was propelled by its own biological momentum initiated in the tubes that eventually become the heart. The heart is only aiding this process. In *Psychoanalysis and Spiritual Psychology*Steiner states: “The pressure is not the cause of the blood flow but the result of it”.

In 1932, Harvard University scientist **J. Bremer** filmed the blood flow in embryos before the formation of theheart valves. He observed that the spiralling blood is boosted by the pulsating heart without creating turbulence in the blood. He described two streams in the heart tubes that spiral with different forward velocities around their own longitudinal axes and around each other (*Presence and influence of spiral streams in the heart of the chick embryo*, American Journal of Anatomy, 49: 409-440). Bremer’s findings were confirmed in 1981 by the surgical studies of A. Arbulu and I. Asfaw: “Not only is the blood flow well maintained in the embryo before the formation of the valves; there are reports of adults in whom both infected tricuspid and pulmonary valves were surgically removed and not replaced by prosthetic valves, without significant problems”.

The Austrian researcher **Viktor Schauberger** (1885-1958), celebrated for his extraordinary discoveries of the energy effects of water, stated on many occasions that the heart was not a pump but that the function of the heart was rather that of a regulator of the blood flow. He saw the peristaltic and pulsatory action of theblood vessels as the elements responsible for the blood’s circulation. According to Professor **Kurt Bergel** (ca. 1925-30) of Berlin University, this function was carried out by the millions of highly active capillaries permeating the body. Bergel had detected this pulsation by observing the small blood vessels that formed around the yolk-sac of a bird’s egg. Upon opening the egg, he noticed that blood vessels surrounding the yolk-sac pulsated before they cooled off, although the heart had not yet been formed.

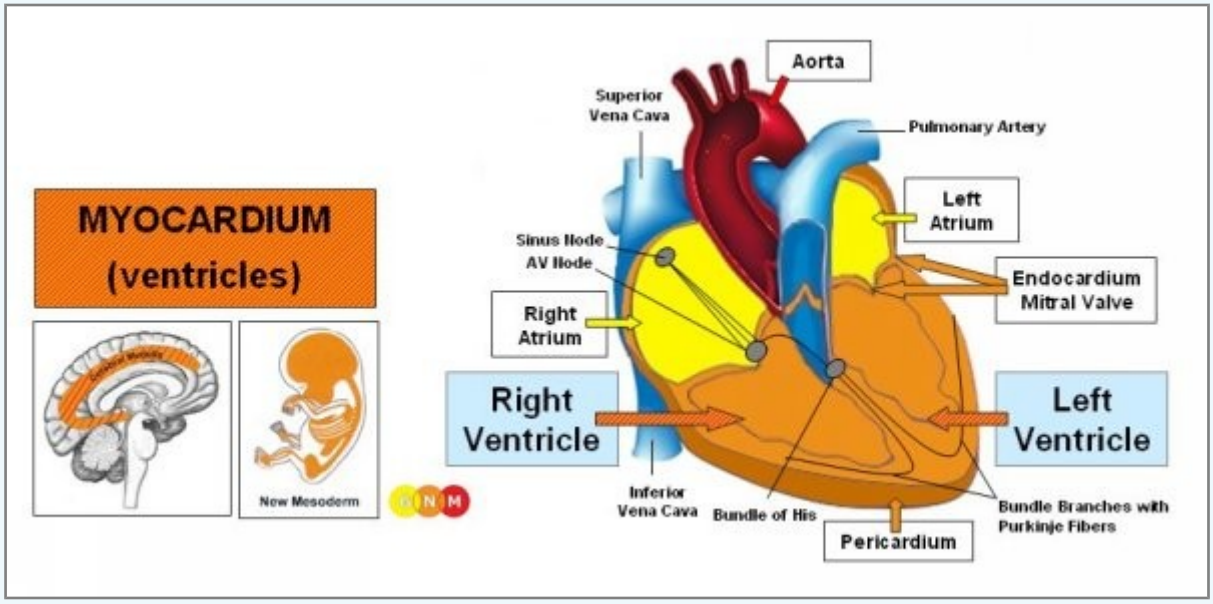
Ralph Marinelli of Temple University in Philadelphia wrote: “When the heart begins to function, it enhances the blood's momentum with spiralling impulses. The arteries serve a subsidiary mimical heart function by providing spiralling boosts to the circulating blood. In so doing the arteries dilate to receive the incoming blood and contract to deliver an impulse to increase the blood's momentum.” (*The Heart is not a Pump*, 1995)

The spiral theme is apparent in the function and form of the heart and blood vessel: “The spiral

shape on the inner surface of the blood vessels, the temperature differential between core and extremities, and the electromagnetic charge differential between arterial (oxygen-rich) and venous (CO2-rich) blood also seem to support circulatory action" (Viktor Schauberger). "The musculature of the heart and arteries all the way down to the pre-capillaries is spirally oriented, and both the heart and arteries move spirally to augment the momenta of the blood" (Stonebridge and Brophy, 1991). "The heart moves the way it does because of its bundles of striated muscle fibers, which are oriented spirally in the same direction and work together to effect motion … in 3D, healthy hearts do their own version of twist. Rather than a simple pumping action, they circulate blood as if they were wringing a towel." (Harvard School of Engineering and Applied Sciences, February 24, 2014)

Modern analysis of the heart has shown that the amount of pressure actually required to force the blood through the entire length of the body's blood vessels would have to be able to lift a one hundred pound weight one mile high. Given that the human body contains at least 60,000 miles (96,500 km) of blood vessels, it is inconceivable that the heart would be capable of producing sufficient power needed to circulate the blood (Ernst O. Attinger, *Hydrodynamics of Blood Flow*, Univ. Virginia Med. Center, Charlottesville, VA).

Sources: "The Heart is not a Pump. A Refutation of the Pressure Propulsion Premise of Heart Function" by R. Marinelli et al. (Frontier Perspectives, The Journal of the Center for Frontier Sciences at Temple University in Philadelphia, Pa, 1995) and "Living Energies, Viktor Schauberger's Brilliant Work with Natural Energy Explained" by Callum Coats, 1995.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MYOCARDIUM (VENTRICLES): The heart is located in the thoracic cavity in between the lungs. The base of the heart is closely attached to the diaphragm; the pericardium envelops the heart and holds it in place. The coronary arteries and coronary veins supply the heart muscle with blood.

The heart consists of four chambers, the right and left atrium (upper chambers) and the right and left ventricle (lower chambers). The two sides of the heart are separated by the septum. The myocardium is the muscular tissue that makes up the majority of the cardiac wall. It forms the thick middle layer between the outer epicardium, which is part of the pericardium, and the inner endocardium that lines the heart cavities and the heart valves. The contractions of the myocardium create the force that initiates the flow of blood through the blood vessels. The two ventricles carry the blood out of the heart. From the right ventricle oxygen-depleted blood travels through the pulmonary artery to the lungs (pulmonary circulation) while the left ventricle delivers oxygen-rich blood through the aorta to all other organs (systemic

circulation). The two atria receive the blood returning to the heart. The right atrium receives deoxygenated blood from the superior and inferior vena cava, the left atrium receives oxygenated blood from the lungs through the pulmonary veins. Continuing the blood flow cycle, the atria empty the blood into the right and left ventricles. Heart valves positioned within the chambers of the heart open and close allowing the blood to flow in one direction.

NOTE: Throughout the "fish-period", the heart consisted of two tubes with one tube carrying oxygen-rich blood from the gills to organs, the other tube carrying oxygen depleted blood back to the gills (see pharyngeal ducts). During the evolutionary period when life moved onto land, the lungs developed which allowed oxygen being taken from the air instead of from water. This was the time, when gill breathing was replaced with lung breathing. In order to make room for the newly developing lungs the **heart tubes twisted** about 180 degrees. As a result, the original right tube became the left heart chamber with the left atrium and left ventricle and the original left tube became the right heart chamber with the right atrium and the right ventricle. The septum separated the heart into two distinct units. The coronary vessels laid on the outer surface of the heart developed from the pharyngeal arch arteries (see also aorta, carotid arteries, and subclavian arteries).

In the human embryo the two heart tubes develop during the first 21 days. Starting on the 22nd day, the heart tubes begin to merge. The twist of the embryonic heart occurs between the 22nd and 24th day. The blood flow is well maintained before the formation of the heart valves (see J. Bremer).

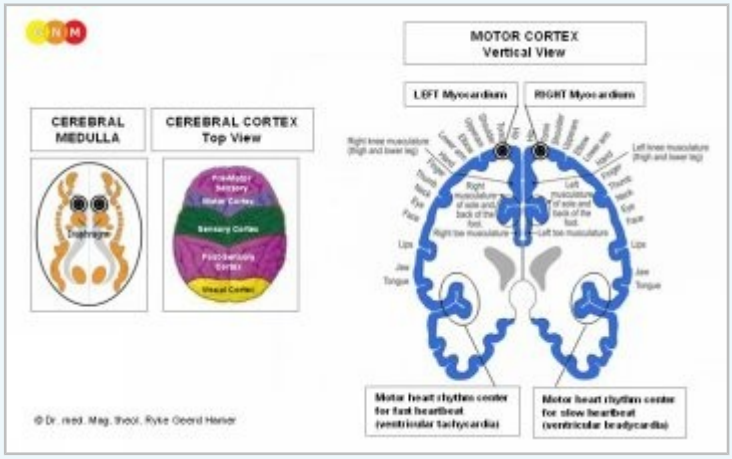
This picture shows the two heart tubes of a human embryo before the twist.

In this video Alexander Tsirias shares a powerful visualization of the human development from conception to birth.

The AV node (atrioventricular node), situated on the border between the right atrium and right ventricle, picks up the electrical signals for the heartbeat from the sinus node (in the right atrium) and sends them to the bundle of His that carries the cardiac impulse through the bundle branches to the Purkinje fibers. The Purkinje fibers are composed of specialized muscle cells that are able to transmit the electrical discharge more quickly to the ventricles than the other parts of the heart's conduction system.

NOTE: Originally, the entire heart consisted solely of smooth muscle. Over time, the smooth muscles of the ventricles were for the most part (about 90-95%) replaced by more efficient striated muscles. Hence, today, the Bundle of His conducts the atrial excitation only to the smooth ventricular muscles.

The striated muscles of the ventricles originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex. The smooth muscle are controlled from the midbrain.



BRAIN LEVEL: The myocardium (incl. the AV node, bundle branches, Purkinje fibers) has 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 ventricles and the ventricular conducting system are controlled from the **motor cortex** (part of the cerebral cortex). The right myocardium is controlled from the right side of the cerebrum; the left myocardium is controlled from the left cerebral hemisphere. Because of the 180 degree twist of the heart tubes there is **NO cross-over correlation from the brain to the organ**. The motor heart rhythm centers control the slow heart beat (ventricular bradycardia) and the fast heartbeat (ventricular tachycardia).

NOTE: The heart muscle is functionally closely tied to thediaphragm. The control centers of the myocardium are therefore located right above the brain relays of the diaphragm.

BIOLOGICAL CONFLICT: The biological conflict linked to the myocardium is an **overwhelmed conflict** brought on by negative stress overload (compare with physically overwhelmed-conflict related to the diaphragm).

NOTE: The **conflict is always with reference to a person or people** (e.g., an overwhelming workload is associated with a demanding boss or with an unsupportive co-worker rather than with the work itself). Whether the right or left myocardium (or both) is affected is determined by a person's handedness and whether the conflict is mother/child or partner-related. Due to the twist of the heart tubes, the principle of laterality **is reversed**. Hence, a right-handed person responds to a mother/child-related overwhelmed-conflict with the right myocardium; if the conflict is associated with a partner with the left myocardium. A left-handed person responds to a mother/child-related overwhelmed-conflict with the left myocardium; if the conflict is associated with a partner with the right myocardium.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of heart muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the heart muscle** (controlled from the motor cortex).

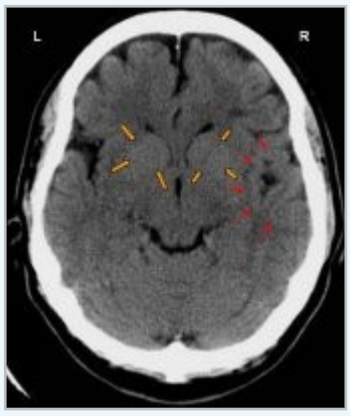
NOTE: The striated muscles belong to the group of organs that respond to the related conflict with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

The necrosis takes place on the outside of the myocardium, in the middle, in the inside, or "transmural" (affecting all layers). The loss of cardiac muscle tissue slows the conduction of the heart's electrical impulses since the signal of theAV node has to circumvent the necrotized area. This causes **irregular heartbeats** (compare with bradycardial arrhythmia and tachycardial arrhythmia). The condition is called

a “**bundle branch block”** (compare with AV block). If the conflict persists, the thin myocardial wall might rupture with blood flowing into the pericardium (see transudative pericardial effusion). A myocardial perforation could also occur during the Epileptoid Crisis. The rupture causes a **cardiac arrest**.

NOTE: According to conventional medicine, the necrosis of the heart muscle is caused by a lack of blood supply due to a coronary occlusion. Based on the GNM knowledge and the latest findings in cardiology, this assumption has proven to be wrong (see healing phase of the coronary arteries).

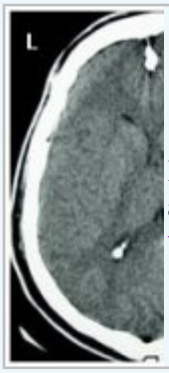
With lasting conflict activity the heart muscle becomes weaker resulting in **physical weakness** (difficulty climbing stairs or walking short distances) because of the reduced ability of the heart to carry sufficient amount of blood into the body’s circulatory system. This is medically termed a **myocardial or cardiac insufficiency** (colloquially called a “heart failure”). If the left myocardium is affected, the decreased heart muscle contraction slows the blood flow in front of the left heart. With an intense conflict, the back-up of fluid collected in the lungs leads to acute **shortness of breath** due to the raise of pressure in the lungs and to a **lung edema**, also called cardiac pulmonary edema (compare with alveolar edema related to the lung alveoli; see also lung edema with mitral valve insufficiency). If the right myocardium is affected, the congestion of blood occurs in front of the right heart. The subsequent accumulation of interstitial fluid in the capillaries creates a **peripheral edema** with swelling, particularly in the ankles, feet and legs (see also peripheral edema related to the leg veins or leg bones). In the conflict-active phase involving the right myocardium the **blood pressure is elevated** (see also hypertension during the right myocardial heart attack).



This brain CT belongs to a right-handed man who suffered an overwhelmed-conflict when his wife left him with their children. The brain scan shows the impact in both myocardium relays in the cerebral medulla (orange arrows - view the GNM diagram), associated with hismother/child and partner side. The scan also shows a Hamer Focus in the brain relay of thecoronary arteries (red arrows), which reveals that he experienced at the same time aterritorial loss conflict. The uneven, edematous ring indicates that the territorial loss conflict has already been resolved. However, the partly sharp border tells that he has still conflict relapses.

HEALING PHASE: During the first part of the healing phase (PCL-A) the necrosis of the heart muscle is replenished through **cell proliferation**. In conventional medicine the “tumor” could be diagnosed as a **myocardial sarcoma**. With an inflammation the condition is called **myocarditis**. The paralysis of the heart muscle and the related symptoms (shortness of breath, physical weakness, elevated blood pressure) reaches into PCL-A. Recurring healing phases due to continual conflict relapses cause an **enlarged heart (cardiomegaly)**. Constant physical exertion, for example in sports, can also result in a large heart *without* an overwhelmed-conflict.

NOTE: All organs that derive from the new mesoderm (“surplus group”), including the myocardium, show the**biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict of the same kind.



In PCL-A, an edema develops in the corresponding brain relay. This CT scan shows such a**brain edema** in the area of the cerebral medulla that controls the right myocardium (view the GNM diagram).

During the **EPILEPTOID CRISIS** the brain edema is expelled through a sympathicotonic surge. This is the period when the **myocardial heart attack** occurs. Like the heart attack related to the coronary arteries, the myocardial infarction is initiated in the brain! Controlled from the motor cortex, the myocardial attack manifests as **contractions of the heart muscle with painful cramps** ("heart epilepsy"). An intense Epileptoid Crisis can trigger a generalized epileptic seizurewith convulsions involving the whole body, leading potentially to a wrong diagnosis.

The rapid contractions of the myocardium causes **tachycardia**, a fast heartbeat, also referred to as **heart palpitations**or **ventricular fibrillation** (compare with atrial fibrillation related to the smooth heart muscle and ventricular tachycardia related to the coronary veins). The fast heartbeat serves the purpose to ensure the transportation of blood to and away from the heart. The strong heartbeats are typically felt in the neck area. If the contractions are severe, the heart muscle might tear leading to a cardiac tamponade with blood leaking into the pericardium (see also myocardial perforation in the conflict-active phase). This is usually the case if the heart muscle has already been worn out and scarred due to many conflict relapses. With water retention (the SYNDROME) a rupture is more likely to happen. Under normal circumstances, however, the smooth part of the ventricular muscles (about 5-10%) is able to prevent a rupture.

The myocardium is functionally closely tied to the diaphragm, the chief muscle of respiration (in the brain, the brain relays of the diaphragm are located right underneath the control centers of the myocardium). Hence, the myocardial heart attack is always accompanied by **diaphragm cramps** and **breathing difficulties**, notably with a right myocardial heart attack since the wall of the right heart is firmly attached to the diaphragm muscle.

Typically, the Epileptoid Crisis is brought on during periods of rest (in vagotonia), often during sleep. The healing crisis occurs as a single event or appears in sequences (see night time coughing fits). In case of the myocardium, this presents as **sleep apnea** with episodes of cessation of breathing (lasting from a couple of seconds up to two minutes) generated by the contraction of the diaphragm. In GNM terms, sleep apnea is essentially a series of "mini myocardial attacks" with short diaphragm cramps. Chronic sleep apnea indicates conflict relapses triggered by tracks that were established when the original overwhelmed-conflict took place. Dreams can also evoke conflict relapses! Sleep apnea is more likely when the left myocardium is involved, because the right diaphragm can't expand as much since the liver is positioned directly underneath it. **NOTE:** Sleep apnea also occurs with a physical overwhelmed conflict involving only the diaphragm.

Conventional medicine knows only one type of heart attack. According to the standard theory, an "acute myocardial infarction" ("anterior myocardial infarction" or "posterior myocardial infarction") is caused by cholesterol plaques or athrombus in the (anterior or posterior) coronary arteries that presumably block the blood and oxygen supply to the heart muscle, resulting in a heart attack. In spite of the evidence that the majority of people who suffered a myocardial heart attack had no coronary artery occlusion and normal cholesterol levels, the coronary artery obstruction hypothesis still prevails. Based on the science of GNM, the myocardium and coronary arteries originate from different embryonic germ layers, are controlled from different areas of the brain, are linked to different biological conflicts, and cause therefore different types of heart attacks, with very specific – predictable - symptoms.

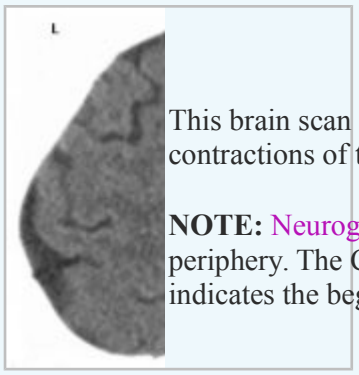
"Concerning heart attacks, we have failed to recognize the significant role of the brain, just as we've overlooked the important role of the brain in cancer."

Dr. med. Ryke Geerd Hamer

A characteristic symptom of the myocardial heart attack is an **acute change of blood pressure** due to the distinctive pathways of the two circulatory systems. The right myocardium initiates the flow of blood to the lungs (pulmonary circulation) while the left myocardium moves blood via the aorta to the rest of the body (circulatory system). Since the distance of blood travelling from the heart trough the entire body is much longer than from the heart to the lungs, the left ventricle requires more initial force ("pressure") than the left heart muscle. This also explains why the left myocardium is larger.

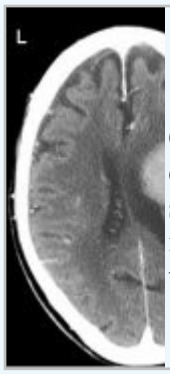
Right myocardial heart attack: If the heart attack involves the right myocardium, the blood pressure in the left heart chamber increases quickly leading to **hypertension**. The blood pressure is already elevated in the conflict-active phaseand in PCL-A due to the paralysis of the right heart muscle. During the Epileptoid Crisis the blood pressure rises significantly higher in order to compensate the uncoordinated contractions of the right ventricle. Hence, **elevated blood pressure does not cause a heart attack**, as claimed, but is instead a vital, compensatory symptom during the right myocardial attack (see also kidney parenchyma with hypertension in the conflict-active phase to sustain the function of the kidneys). In contrast, with a heart attack linked to the coronary arteries the blood pressure remains in the normal range. **NOTE:** Sustained elevated blood pressure can distort the muscles of the myocardium where the heart valves are attached.

Left myocardial heart attack: When the left myocardium undergoes the Epileptoid Crisis, the blood pressure in the right heart chamber decreases leading to **hypotension** (see also hypotension related to the Carotid Sinus). The low blood pressure causes a poor circulation (paleness, light-headedness) and, in acute cases, a complete collapse of the systemic circulation with a loss of consciousness (compare with "absence" during a heart attack involving the coronary arteries). In order to maintain the cardiac function, the pulse rate accelerates. Because of the drop of blood pressure the left myocardial heart attack is considerably more dangerous than the right myocardial attack. The decreased blood pressure reduces, on the other hand, the risk of a myocardial rupture when the heart muscle cramps ("heart epilepsy"). This is why perforations during left myocardial heart attacks are rare. The attempt to raise the blood pressure through medication can result in a rupture of the heart muscle and death.

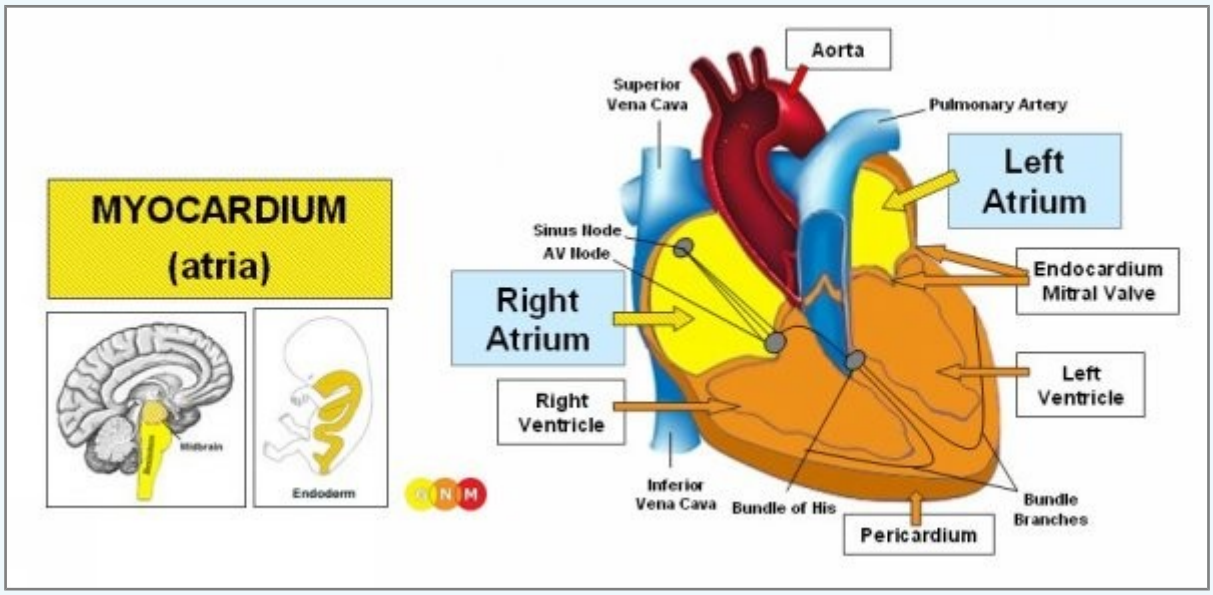


This brain scan shows a glia-ring in the area of the motor cortex that controls the contractions of the right myocardium (view the GNM diagram).

NOTE: Neuroglia (brain connective tissue) restores the brain relay starting from the periphery. The CT, taken shortly after the myocardial heart attack (Epileptoid Crisis), indicates the beginning of PCL-B.



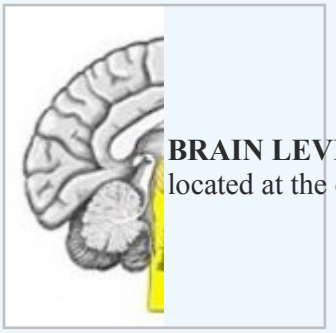
On this brain CT we see the presence of neuroglia in the area of the cerebral medulla that controls the trophic function of the right myocardium (view the GNM diagram). The second part of the healing phase (PCL-B) following the myocardial heart attack is already in a more advanced phase. In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor".



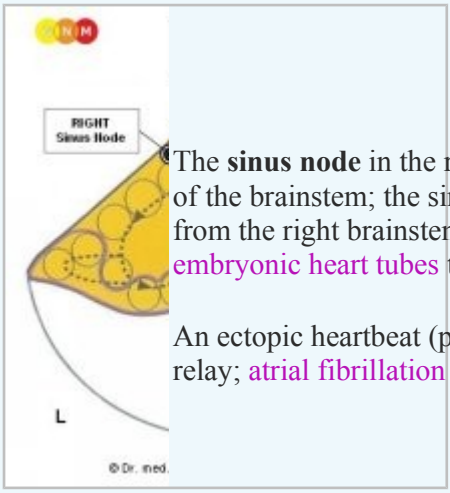
Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE MYOCARDIUM (ATRIA): The right and left atrium constitute the two upper heart chambers. The right atrium receives oxygen-depleted blood from the superior and inferior vena cava; the left atrium receives oxygen-rich blood from the lungs through the pulmonary veins. The atria empty the blood into the right and left ventricles that carry the blood through the pulmonary artery (pulmonary circulation) to the lungs and through theaorta to all other organs (systemic circulation).

The atrial wall consists of smooth muscle (in comparison, the ventricles are mainly composed of striated muscles). Like the intestinal muscles that move the "food morsel" along the intestinal canal through peristaltic motion, the smooth heart muscle continually contracts in order to move the "blood morsel" to the ventricles. The rhythmic contraction of the atria is stimulated by the **sinus node** (sinoatrial node or SA node) located in the upper portion of the right atrium. The sinus node generates an electrical impulse that initiates the heartbeat and sets the rhythm of the pulse (around 50 to 90 time per minute at rest). From there, the electrical signal reaches the AV node and the bundle of His which carry the cardiac impulse through the bundle branches to the ventricles. The heart rate is also determined by the autonomic nervous system: The sympathetic nerves accelerate the heart rate, for example, during excitement and stress as well as during conflict activity and the Epileptoid Crisis (in sympathicotonia); the parasympathetic nerves slow the pulse during rest and sleep (in vagotonia). The two nerves meet at the sinus node where they influence the frequency of the heartbeat. The smooth muscles of the atria originate from the endoderm and are controlled from the midbrain.



BRAIN LEVEL: The smooth muscles of the atria are controlled from the **midbrain**, located at the outermost part of the brainstem.



The **sinus node** in the right atrium (previous left heart tube) is controlled from the left side of the brainstem; the sinus node in the left atrium (previous right heart tube) is controlled from the right brainstem hemisphere. **NOTE:** Because of the 180 degree twist of the embryonic heart tubes there is a cross-over correlation from the brain to the organ.

An ectopic heartbeat (premature atrial contraction) arises in the right sinus node relay; atrial fibrillation arises in left sinus node relay.

NOTE: Originally, the heart had two sinus nodes located in the right and left atrium. The right sinus node (controlled from the right side of the brainstem) was linked to the "intake and transport" of the "blood morsel" (equivalent to the "intake and transport" of the "food morsel" in the intestine); the left sinus node (controlled from the left side of the brainstem) related to the "elimination" of the "blood morsel". With the twist of the heart tubes the innervation from the brain to the sinus nodes switched as well. The left sinus node, controlled from the right side of the brainstem, became responsible for the ejection of blood (into today's aorta), the right sinus node, controlled from the left side of the brainstem, for the suction of blood (from today's vena cava) into the right atrium. Over time, however, the left sinus node atrophied. This is why the right sinus node, situated in the right atrium, is now the single conductor serving the function of both atria.

BIOLOGICAL CONFLICT: The biological conflict linked to the atria of the myocardium is "**not being able to move the blood (morsel)"**. The conflict linked to the atrial myocardium relates to the biological distress that the heart is unable to manage the blood flow and to supply the organism with sufficient amount of blood.

In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated withbrainstem-controlled organs deriving from the endoderm.

The conflict is usually brought on by a diagnosis such as "your blood flow is poor", "your arteries are clogged", "yourcarotid artery is blocked", or the scare of a heart attack or stroke, including self-inflicted fears (a "family history of heart diseases"). Taking "blood-thinners" can keep the conflict active!

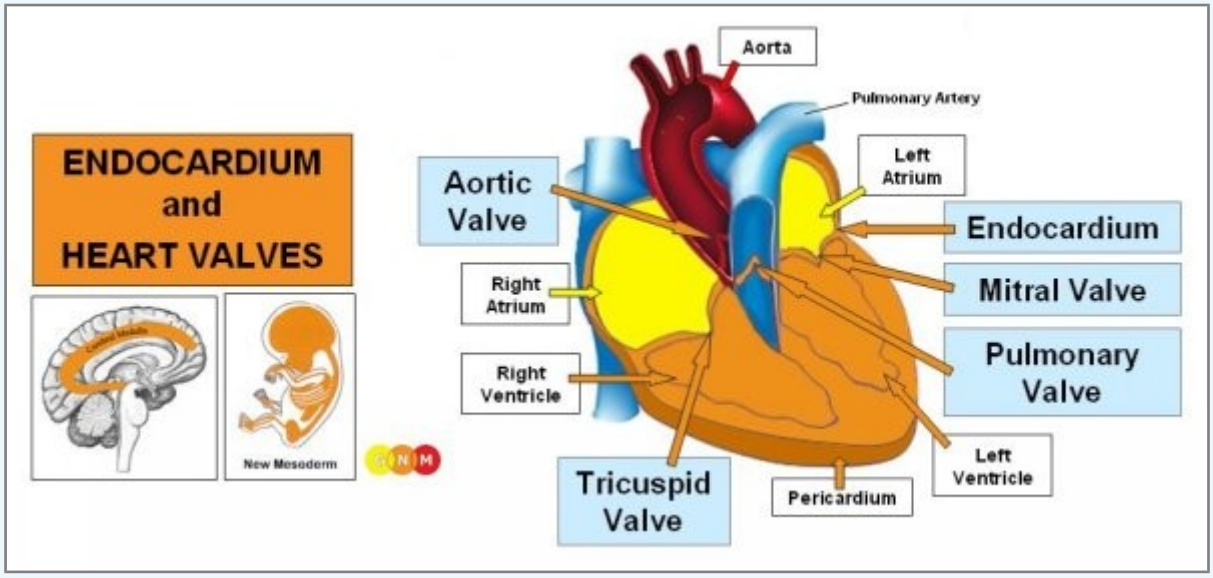
CONFLICT-ACTIVE PHASE: hypertonus of the atrial muscles. The **biological purpose of the increased muscle tension** is to improve the blood circulation.

HEALING PHASE: During the healing phase the muscle tension goes back to normal. The Epileptoid Crisis manifests as augmented peristalsis of the heart muscle causing **atrial fibrillation** with **tachycardia**, an accelerated heartbeat (compare with ventricular fibrillation related to the ventricles and tachycardia during a lung embolism involving thecoronary veins). Recurring episodes

occur with every conflict relapse. With the completion of the healing phase the heart rate goes back to normal.

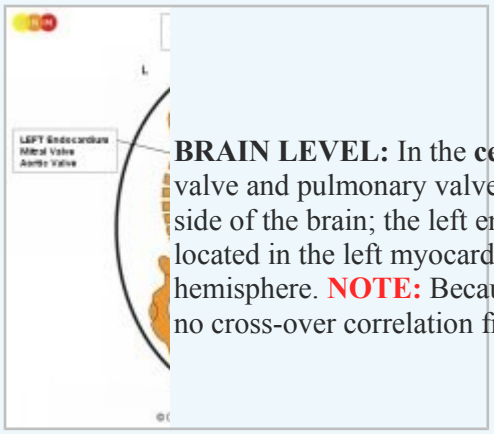
NOTE: Compared to the ventricular muscles, the Epileptoid Crisis of the smooth atrial heart muscles does not present as a heart attack but rather as a "heart colic" similar to an "intestinal colic" (see smooth intestinal muscles).

An artificial pacemaker designed to stabilize the heart rate by taking over the job of sending out electrical impulses is, according to Dr. Hamer, only useful when the pacemaker activates both the sinus node and AV node since the two electrical relay stations work together. If, however, the irregular heartbeat originates in the bradycardial or tachycardial heart rhythm center (see coronary arteries and coronary veins), then it is sufficient to stimulate only the AV node.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE ENDOCARDIUM AND HEART VALVES: The endocardium is the innermost layer of the myocardium, lining the heart cavities. The myocardium contains four valves that direct the blood flow in one direction. The heart valves are vital to the efficiency of the circulatory systems. The **tricuspid valve**, located between the right atrium and the right ventricle, opens to empty oxygen-depleted blood into the right ventricle. When the right ventricle contracts, the **pulmonary valve** opens to deliver the blood into the pulmonary artery that carries the blood to the lungs where it picks up oxygen (pulmonary circulation). Oxygenated blood returning to the heart enters the left atrium where it is stored until the left atrium contracts. At this point, the **mitral valve** opens allowing the blood to enter the left ventricle. With the contraction of the left ventricle, the **aortic valve** opens to deliver the blood into the aortafrom where it is distributed to the body's blood vessels (systemic circulation). The endocardium and the heart valves are made of connective tissue, originate from the new mesoderm and are therefore controlled from the cerebral medulla.



BRAIN LEVEL: In the **cerebral medulla**, the right endocardium as well as the tricuspid valve and pulmonary valve, located in the right myocardium, are controlled from the right side of the brain; the left endocardium as well as the mitral valve and the aortic valve, located in the left myocardium, are controlled from the left cerebral hemisphere. **NOTE:** Because of the 180 degree twist of the embryonic heart tubes there is no cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the endocardium and the heart valves is a **self-devaluation conflict associated with the heart** (see connective tissue). Persistent angina pectoris, heart arrhythmia, a previous heart attack or the fear of getting a heart attack (because it "runs in the family"), the diagnosis of a "cardiac insufficiency", or a doctor's verdict such as "your heart is weak" or "your heart is not working well" are examples of what can trigger the conflict.

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

CONFLICT-ACTIVE PHASE: necrosis (cell loss) of the endocardium and/or heart valve(s)

HEALING PHASE: Following the conflict resolution (CL), the tissue loss is refilled and replenished with new cells. If the healing of the endocardium or heart valves is accompanied by an inflammation, this causes **endocarditis**. Bacteria such as staphylococcus bacteria assist the healing process, provided they are available. Theories that bacteria from aninfected tooth or from the throat ("strep throat") would travel to the heart where they supposedly attach to the heart valves, are totally unfounded. In conventional medicine, the symptoms of endocarditis are classified under "rheumatic fever", even though it is entirely unrelated to rheumatism.

NOTE: All organs that derive from the new mesoderm ("surplus group"), including the rendocardium and heart valves, show the **biological purpose at the end of the healing phase**. After the healing process has been complete, the organ or tissue is stronger than before, which allows to be better prepared for a conflict of the same kind.

With a hanging healing, that is, when the healing phase is continually interrupted by conflict relapses, the recurring**scarification** (in PCL-B) eventually impairs the valve(s). **Symptoms** of valve insufficiencies are **heart murmurs**.

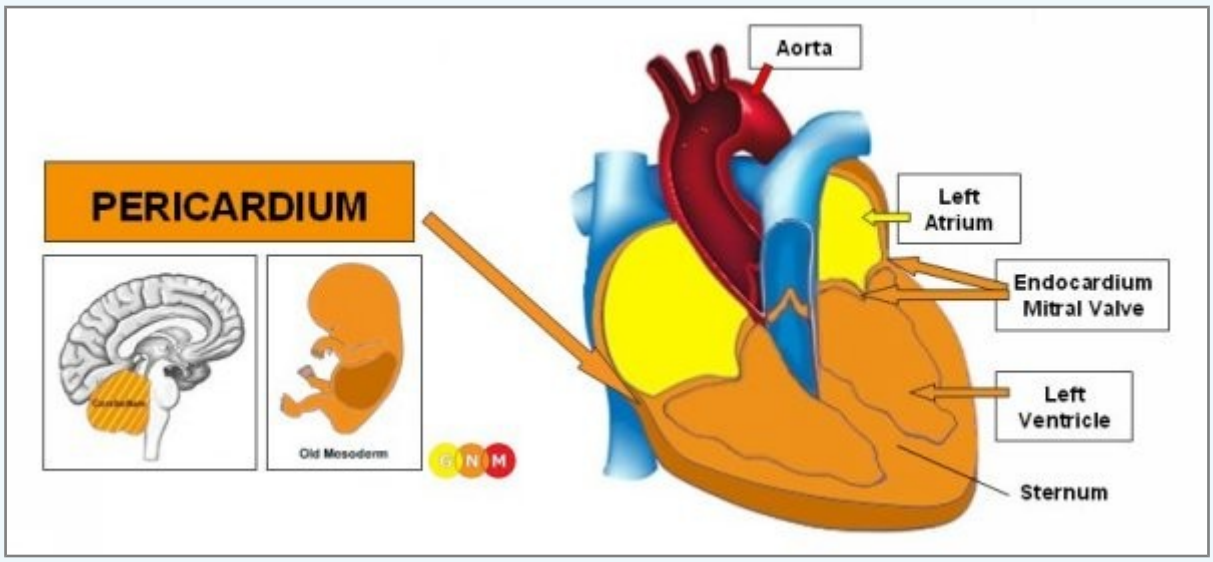
A **mitral insufficiency** involves the heart valve situated between the left atrium and the left ventricle. When the mitral valve is affected, the valve does no longer close completely and blood leaks backwards through the valve into the pulmonary veins when the heart muscle contracts (such a leakage can also be the result of a progressive necrosis due to a prolonged conflict-active phase). At that point, the condition is irreversible (compare with the distortion of heart valves caused by a pericardial effusion with a restoration of the valve's function after the healing phase has been complete).

If the scarification thickens the opening of the mitral valve, the orifice becomes narrow and the valve does no longer open fully. This is known as **mitral stenosis**. A narrowing of the mitral opening compromises the free blood flow from the left atrium to the left ventricle, which **increases the diastolic blood pressure** (while the systolic blood pressure decreases). The same applies to a **tricuspid valve stenosis**. At an advanced stage of a mitral valve impairment, surgical procedures might be required in order to prevent a **lung edema** caused by the congestion of fluids in the lungs (see also lung edema related to

the myocardium and alveolar edema related to the lung alveoli).

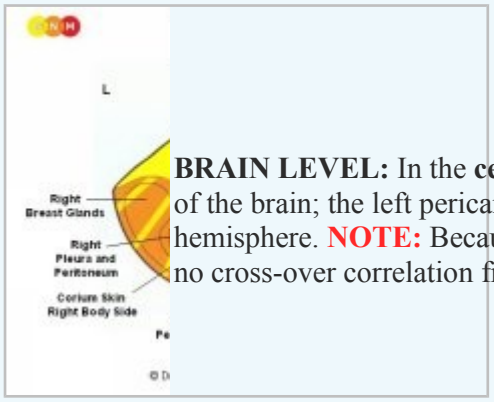
An **aortic insufficiency** develops when the aortic valve between the left ventricle and the aorta does no longer close properly due to the scarification. An **aortic stenosis** occurs when the aortic valve narrows, preventing the valve from opening fully. The obstruction of blood flow impedes the blood flow from the heart into the aorta and to the rest of the body. In this case, the **diastolic blood pressure decreases** (while the systolic blood pressure increases). The same applies to a **pulmonary valve stenosis**. **Symptoms: dizziness, fatigue and weakness**.

For a person unfamiliar with GNM, the diagnosis of a "heart valve defect" can cause additional self-devaluation conflictsassociated with the heart, creating a progressive condition.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE PERICARDIUM: The pericardium is a two-layered membrane that envelops and protects the heart. The inner layer (visceral pericardium) is in contact with the heart (epicardium); the outer layer (parietal peritoneum) is attached to the sternum and fused to the diaphragm at the base of the heart. Laterally, the pericardium adheres to the pleura. The visceral pericardium is covered by a cell layer called the mesothelium. The mesothelial cells secrete small amount of serous fluid that fill the space of the pericardial cavity to minimize the friction between the pericardial membranes. In evolutionary terms, the pericardium developed together with the pleura, theperitoneum, and the corium skin. The pericardium originates from the old mesoderm and is therefore controlled from the cerebellum.



BRAIN LEVEL: In the **cerebellum**, the right pericardium is controlled from the right side of the brain; the left pericardium is controlled from the left brain hemisphere. **NOTE:** Because of the 180 degree twist of the embryonic heart tubes there is no cross-over correlation from the brain to the organ.

BIOLOGICAL CONFLICT: The biological conflict linked to the pericardium is an attack conflict,

specifically, an **attack against the heart** (see also attack conflicts related to the pleura, peritoneum, and corium skin).

In line with evolutionary reasoning, **attack conflicts** are the primary conflict theme associated withcerebellum-controlled organs deriving from the old mesoderm.

An attack against the heart is experienced, for instance, through a stab or blow against the heart or through a push or hit in the upper body during a fight or accident (see also pleura). In a transposed sense, "sharp" words (verbal insults) could be perceived as being "cut to the heart". Heart surgery such as a bypass operation or a valve replacement might be registered as an assault against the integrity of the organ. In fact, the announcement of a heart surgery and the mental image of being "cut open" can already trigger the conflict. A diagnosis of a "heart disease" or comments of a physician like "your heart is not working properly", "your ECG results are abnormal", or "your blood pressure is too high, associated with a risk of a heart attack, could easily evoke a fear for one's heart (it might also trigger a self-devaluation conflictaffecting the heart valves). The conflict can also be experienced with or in behalf of someone else, let's say, when a loved one suffered a heart attack. Attack conflicts related to the heart also originate inside the chest, for example, with chest pain caused by angina pectoris or during a heart attack.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase pericardial cells proliferate proportionally to the degree and duration of conflict activity. The **biological purpose of the cell increase** is to create an internal reinforcement to protect the heart against further attacks. With prolonged conflict activity a flat or compact growth develops at the site. In conventional medicine, the thickening of the pericardium is diagnosed as a **pericardial mesothelioma** (see also pleural mesothelioma, peritoneal mesothelioma, omental mesothelioma, and testicular mesothelioma). Since there are no symptoms during the conflict-active phase, the growth is usually only detected during a routine check-up or follow-up examination.

NOTE: Whether the the right or left side of the pericardium is affected is determined by a person's handednessand whether the conflict is mother/child or partner-related. A localized conflict affects the area that is associated with the "attack". Due to the twist of the heart tubes the principle of laterality is reversed. Hence, a right-handedperson responds to a conflict related to a partner (triggered, for example, by witnessing the heart attack of a spouse) with the left pericardium. A left-handed person would respond with the right side.

HEALING PHASE: Following the conflict resolution (CL), fungi, TB bacteria or other bacteria remove the cells that are no longer needed. **Healing symptoms** are **pain behind the sternum** caused by the swelling, and **night sweats**. If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated.

Pericarditis occurs when healing is accompanied by an inflammation. During the healing phase, the fluid in the pericardium is naturally absorbed by the pericardial membrane (**dry pericarditis**). Concurrent water retention due to theSYNDROME, however, increases the fluid accumulation (**wet pericarditis**). Wet pericarditis often develops duringhospitalization following a heart surgery.

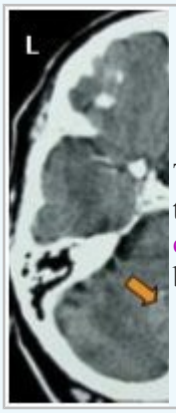
Excessive water retention brought on, for example, by an existence conflict (the distress of a heart attack) generates an**exudative pericardial effusion**, a buildup of fluid around the heart. In some people, the pericardium is separated at the midline; the effusion occurs therefore only on the affected side (see also pleural effusion). If the pericardium is not divided, the effusion develops in the entire pericardium (circular pericardial effusion). Only the location of the Hamer Focus in the brain reveals on which side the attack conflict was perceived and therefore from which brain hemisphere theBiological Special Program is directed and controlled.

An acute pericardial effusion could become critical because too much water in the pericardium

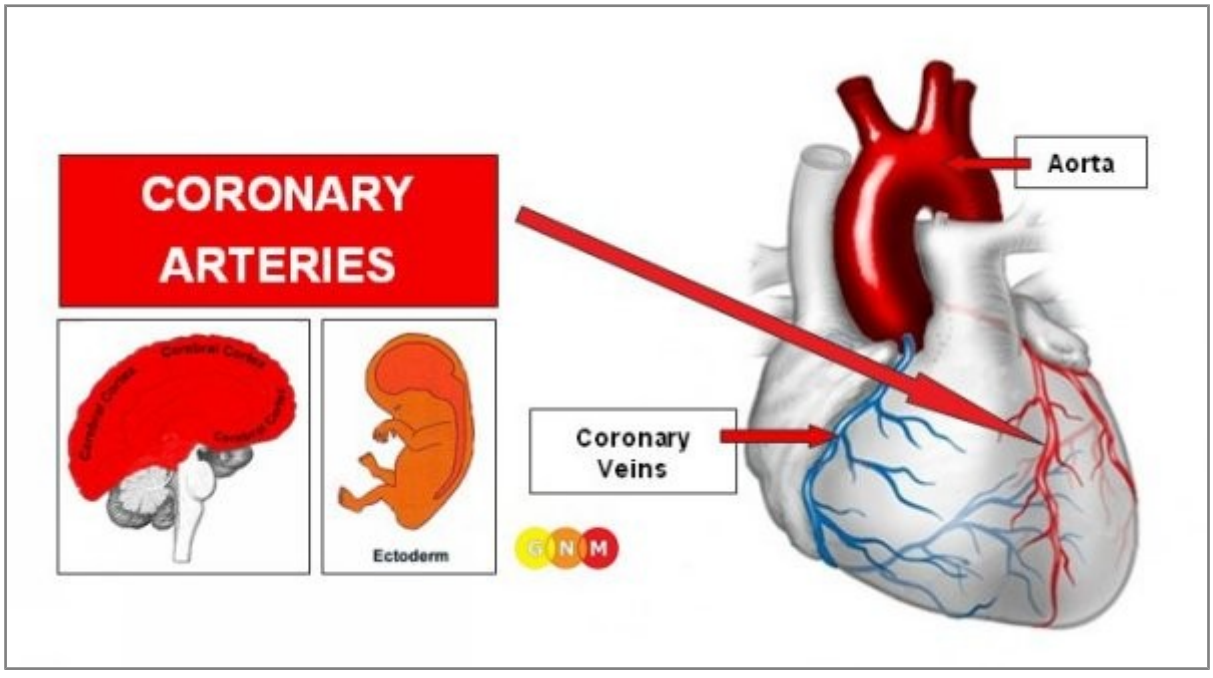
compresses the heart. Medically, this is termed a **cardiac tamponade**. The tamponade limits the heart's normal range of motion leading to severe **breathing difficulties, pressure in the chest**, and potentially to a **cardiac arrest**. This explains why a cardiac tamponade is the most feared complication after a heart attack or following heart surgery.

NOTE: Fluid also enters the pericardium when adjacent ribs or the sternum are in healing; in this case because of a self-devaluation conflict provoked, for instance, by a lung cancer or breast cancer diagnosis. The edema "sweats" through the periosteum into the pericardium creating what is called a **transudative pericardial effusion**. A transudative pericardial effusion can also occur when the heart muscle ruptures with blood leaking into the pericardium.

The pericardial effusion might distort the heart valve(s). However, after healing has been complete the valves regain their normal function (compare with mitral insufficiency where the condition is irreversible).



This CT scan shows scarification (PCL-B) in the area of the cerebellum that controls theright and left pericardium (view the GNM diagram), which indicates that the attack conflictwas associated with the entire heart. However, the Biological Special Program has been complete.

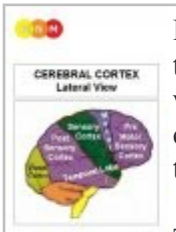


Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CORONARY ARTERIES: The coronary arteries and coronary veins run along the outer surface of the heart in a crown-like ("coronary") shape. Two coronary arteries branch off from the aortanear the top of the heart. Their main function is to deliver oxygen-rich blood to the heart muscle. Contrary to other blood vessels, the inner lining of the coronary

arteries, the so-called intima, consists of highly sensitive squamous epithelial cells that originate from the ectoderm and are therefore controlled from the cerebral cortex. The arterial wall is composed of smooth muscle and striated muscles.

NOTE: The coronary arteries are descendants of the pharyngeal arches which consist of pharyngeal arch arteriesthat give rise to several major arteries (see also coronary veins, ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries).



BRAIN LEVEL: The coronary artery intima is controlled from the **right insula** (part of the **temporal lobe**). The insula is located deep in the cerebral cortex, exactly at the point where the four cerebral cortices meet (pre-motor sensory cortex, motor cortex, sensory cortex, post-sensory cortex). The trophic relays of the diaphragm and of the myocardium housing the AV-node border on the insula from within.

The control center of the coronary arteries is positioned across from the brain relay of the coronary veins.

The **INSULA** is the most important control center in the cerebrum. It is the area of the brain that controls the lining of the large blood vessels (coronary arteries, coronary veins, aorta, carotid arteries, and subclavian arteries) that deliver blood to and from the heart. Controlled from the motor cortex, the right and left insula also regulate the slow (bradycardial) and fast (tachycardial) heartbeat. The **bradycardial heart rhythm center** is located in the **right insula**; the tachycardial heart rhythm center is located in the left insula. The heart rhythm (slow and fast) constitutes together with the diaphragmatic breathing a superordinate center.

NOTE: The coronary arteries, ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries share the same control center and therefore the same biological conflict; which one of these arteries will be affected by the DHS is random. The carotid sinus is also controlled from the same brain relay but is linked to a different biological conflict.

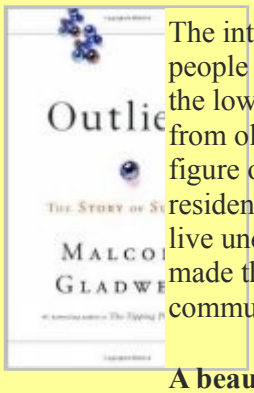
BIOLOGICAL CONFLICT: The biological conflict linked to the coronary arteries is a male **territorial loss conflict** or a female sexual conflict, depending on a person's gender, laterality, and hormone status.

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A **territorial loss conflict** is experienced through the **loss of the private domain** (a home because of an unexpected move or a divorce, the confiscation of a property, fire, flooding) or a threat to the safety of the place where one lives. Assets of the "territory" that are of personal value such as a car, jewellery, a private collection, stocks, investments, a license, an immigrant status, or a club membership also fall into this category. The **loss of the professional domain**could occur through the loss of a business, bankruptcy, the loss of a workplace because of lay-offs, a merger, a transfer, or an early retirement due to illness or cut-backs. Not being able to continue pursuing a **hobby** (playing a musical instrument, painting, writing, gardening, a sports activity) can be perceived as a territorial loss. The conflict also refers to the **loss of the intellectual domain**, for instance, to the loss of one's skills as a result of an accident, or, literally, to the loss of the intellectual property (research results, confidential data, patents, trade secrets). The **loss of a member of the territory** (parent, spouse, partner, child, a pet, friend, colleague, client, customer) because of an argument or a separation can prompt the conflict. Men suffer territorial loss conflicts when they lose a sexual mate. The male territorial loss conflict is the equivalent to the female sexual conflict (the brain relays of the corresponding organs, namely of the coronary arteries and the cervix, are positioned exactly across from each other in the cerebral cortex).

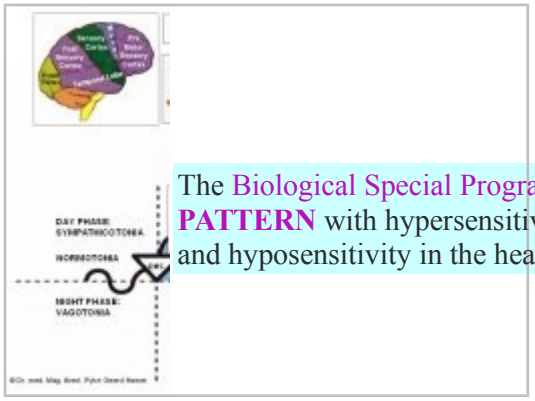
NOTE: If a man is at an age where he can no longer have a territorial loss conflict due to a low testosterone status, a mating conflict (loss of a sexual mate, sexual rejection, sexual frustration) affects more likely theprostate rather than the coronary arteries. This explains why prostate-related symptoms (elevated PSA, prostate hyperplasia) are more common in older men.

The Roseto Mystery
described in Malcolm Gladwell's novel *Outliers*



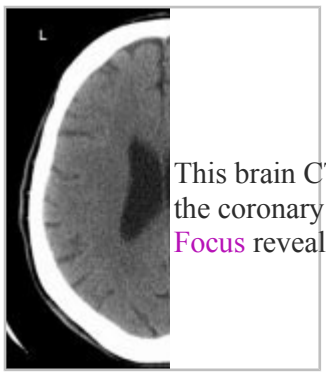
The introduction to *Outliers* tells a story about the town of Roseto, Pennsylvania, where the people originally migrated from Roseto, Italy. The people of Roseto amazed doctors with the low occurence of heart disease in their community. People here were more prone to die from old age than anything else. The doctors performed all kinds of tests, but couldn't figure out why this was. They then looked to the social structure of Roseto. Many of the residents would stop to chat with neighbors. Sometimes three generations of a family would live under one roof. It seems as though it was the sense of community and togetherness that made them live happy, long lives. "No one was used to thinking about health in terms of community."

A beautiful example of GNM in Practice



The Biological Special Program of the coronary arteries follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the inner lining of the coronary arteries. The **biological purpose of the cell loss** is to widen the lumen of the coronary vessel so that more blood can flow to the heart. The enhanced energy puts the individual in a better position to get the territory back or establish a new one. The ulceration of the sensitive intima causes **angina pectoris** (and not, as assumed, a myocardial insufficiency). Depending on the degree of conflict activity, the **chest pain** ranges from mild to severe. **NOTE:** While conflict active, the person is in a depressed mood.



This brain CT shows the impact of a territorial loss conflict in the brain relay of the coronary arteries (view the GNM diagram). The sharp border of the Hamer Focus reveals that the person is conflict active.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation). The swelling might

temporarily occlude the affected artery, particularly with concurrent water retention (the SYNDROME). However, a narrowing (stenosis) of the coronary vessel can never lead to a heart attack because, should the situation of an occlusion arise, **auxiliary vessels or so-called collaterals act as a natural bypass to supply the heart with blood** (the collaterals are like a dry river bed, so to speak, that are filled with blood within 2-3 days after a coronary blockage. In embryological terms, the collateralblood vessels originate from the new mesoderm). This clearly refutes the standard theory claiming that a heart attack is caused by a coronary artery obstruction. It also questions the need of bypass operations or angioplasty.

"A study by Rentrop *et al* in the April 1988 issue of *The American Journal of Cardiology* has produced results completely at odds with the coronary artery blockage theory. In an accompanying editorial, Dr. Stephen Epstein of the National Heart, Lung and Blood Institute summarizes Rentrop and colleagues' "extremely important observations." They found that in an advanced state of the narrowing of the coronary arteries, the supply of blood to the heart muscles is fully assured via collaterals that enlarge naturally in response to the blockage. Interestingly, they observed that the more the coronaries narrow, the less danger there is of a heart infarction… Therefore, heart bypass would be redundant to a large degree." (World Research Foundation, 2007)

"Bypass operations don't prolong life or prevent future heart attacks. Nor does angioplasty, in which narrowed vessels are expanded and then, typically, propped open with metal tubes called stents" (Bloomberg Business, 2005)

The lining of the coronary artery is restored predominantly with the help of cholesterol. Hence, during the healing phase, the **cholesterol level rises**. With a hanging healing, that is, when the healing process is continually interrupted byconflict relapses, the buildup of cholesterol plaques leads to **arteriosclerosis**, a "hardening" of the artery (see alsoarteriosclerosis related to the aorta, carotid arteries, and subclavian arteries and other blood vessels).

Cholesterol is mainly produced in the liver. In fact, 80% of the total cholesterol is synthesized within the body; only 20% come from dietary sources. The liver uses fats from foods as raw material to manufacture cholesterol. The so-called LDL-cholesterol, labelled as the "bad cholesterol", is particularly useful as it is very sticky and therefore ideal for repairing the blood vessel wall. Cholesterol lowering medication such as statin drugs suppress the liver's cholesterol production. This is why statin drugs have a negative effect on the liver. Statin drugs also damage muscle tissue, including the heart muscle, which is detrimental for the overall function of the heart.

"Making a link between elevated cholesterol and the onset of a heart attack is a fundamental error in scientific reasoning."

Dr. med. Ryke Geerd Hamer

"Cholesterol is important for cardiovascular health. Cholesterol is a necessary ingredient in any sort of cellular repair."

Dr. Ron Rosedale, M.D., *The Cholesterol Myth*

NOTE: During the healing phase of the coronary arteries, the **blood pressure is in the normal range** (see hypertension related to the right myocardium and the kidney parenchyma). This explains why, according to medical records, many heart attack patients did not have elevated blood pressure prior to the attack.

The **EPILEPTOID CRISIS** is the moment when the heart attack occurs. Like the heart attack related to the myocardium, **the heart infarction is initiated in the brain**, precisely, when the brain edema that developed in PCL-Ais expelled through a sympathicotonic surge triggered by a brief, pre-programmed

reactivation of the conflict. From a biological point of view, the heart attack is crucial, since the heart can only resume its normal function after the brain edema has been pressed out.

NOTE: The Epileptoid Crises happens three to six weeks after the conflict resolution. If an intense conflict activity lasted for more than nine months, the heart attack is most likely fatal (see also lung embolism related to thecoronary veins). However, if the conflict-active phase was shorter than four month, then the symptoms are mild and might not even be noticed. This observation only applies to the coronary vessels!

With water retention as a result of an active abandonment and existence conflict (hospitalization!) the heart attack is more dramatic, since the retained water enlarges the brain edema significantly.

The heart attack linked to the coronary arteries presents as **acute angina pectoris with strong pain behind the sternum**. The pain might radiate into the left shoulder and left arm. Accompanying symptoms are **cold sweats** and**nausea**. Since the striated muscles of the coronary artery wall undergo the Epileptoid Crisis at the same time, **heart vessel spasms occur together with the angina pain**. These muscle cramps are entirely unrelated to themyocardium, which is controlled from a different part of the brain and linked to an overwhelmed-conflict. During the contractions of the coronary artery muscles, cholesterol plaques from the intima might become loose and get carried into the blood stream, where they are washed out in the normal course of blood flow (compare with lung embolism).

NOTE: All Epileptoid Crisis that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

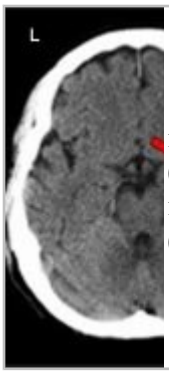
The real danger of the heart attack is the involvement of the bradycardial heart rhythm center. Normally, the heart beats in a regular, balanced rhythm. This, however, changes for the duration of the Epileptoid Crisis when the brain edema in the coronary artery relay is expelled. The pressure created by the momentary sympathicotonic surge slows the pulse, causing **bradycardia** (compare with tachycardia related to the coronary veins; see also bradycardia related to thecarotid sinus). Recurring episodes of bradycardial arrhythmia are triggered by conflict relapses. If the Epi-Crisis is very intense, the person becomes unconscious; an extremely slow heart rate is fatal.

Dr. Hamer: "We viewed the loss of consciousness that occurs during the Epileptoid Crisis as particularly dramatic. With 3-4 heartbeats per minute and even very flat breathing a person can stay alive for a long period of time, basically until the often long lasting absence and the slowdown of the pulse is over. The ECG provides in such cases the evidence."

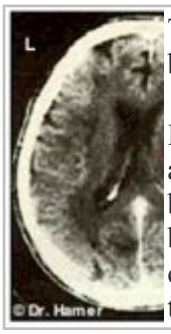
In conventional medicine, bradycardia is thought to be caused by a blockage of the electrical conduction system at the AV node and therefore referred to as an atrioventricular block or **AV block** (compare with "bundle branch block"). Dr. Hamer's research, however, shows that the function of the AV node is only to transfer the electrical impulses from the sinus node to the ventricles, while the synchronization of the heartbeats is coordinated and controlled from the bradycardial and tachycardial heart rhythm centers located in the insula of the cerebral cortex (see brain relays of the coronary arteries and coronary veins).

This CT scan shows a brain edema (fluid accumulation) in the control center of the coronary arteries (view the GNM diagram). The edema developed after the territorial loss conflict was resolved (in PCL-A). Water retention due to the SYNDROME enlarges the edema considerably.

NOTE: A large brain edema in this part of the cerebrum might press onto the motor cortex, specifically during the Epileptoid Crisis when the actual heart attack occurs. The

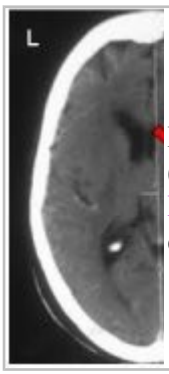


involvement of the motor cortex results in a temporary paralysis on the left side of the body (see red stroke). In conventional medicine, the dark (hypodense) area on the brain scan is interpreted as a "brain infarction", believed to be caused by a blockage of a cerebral artery (see collateralsensuring the cerebral blood flow).



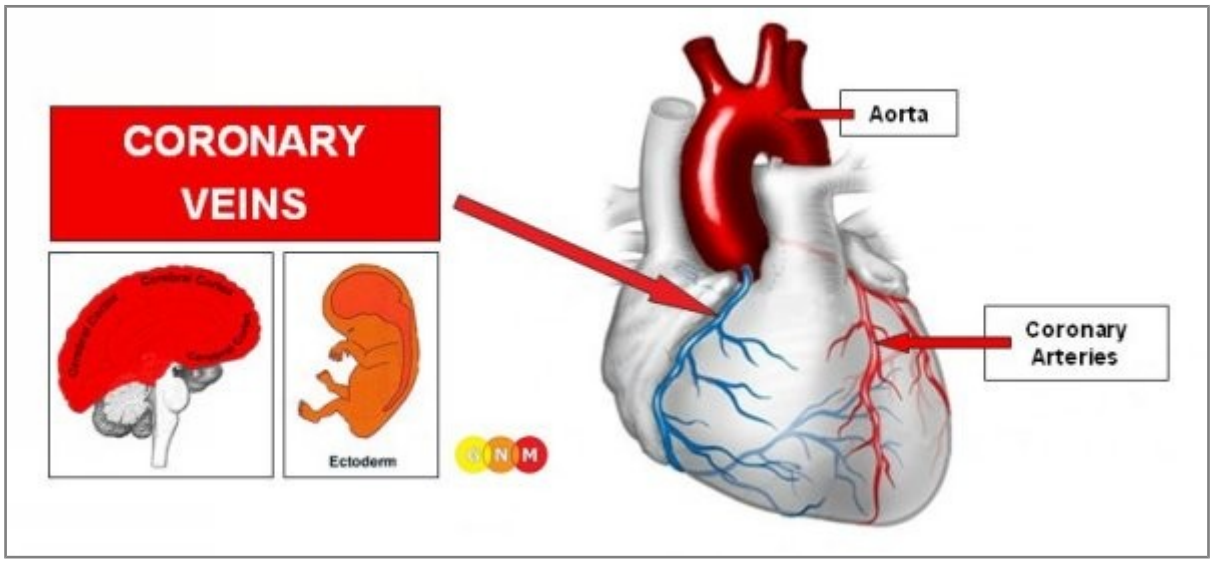
The glia-ring in the coronary arteries-relay (view the GNM diagram) indicates the beginning ofPCL-B. The brain scan was taken shortly after the expected heart attack.

In conventional medicine, the presence of glia is diagnosed as a "brain tumor", precisely, as a high grade glioma (glioblastoma) "white on the outside and necrosis in the middle". The brain CT, however, demonstrates that neuroglia (brain connective tissue) starts restoring the brain relay from the *periphery*! This is in clear contradiction to the established theory that a cancer, including a "brain cancer", grows through continued cell augmentation leading to the formation of a tumor.



Based on the established "brain tumor" theory, conventional medicine classifies the white (hyperdense) area as a "grade 4 glioma" with a poor prognosis. According to Dr. Hamer'sresearch, the buildup of neuroglia is a positive sign that the healing process in the coronary arteries (view the GNM diagram) is almost complete.

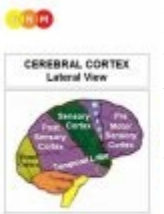
VERIFICATION: On **September 6, 1984**, Dr. E. Mannheimer, MD (Cardiology Clinic, Vienna), Prof. Pokieser and Prof. Dr. Imhof (radiologists at the University of Vienna, Austria) tested Dr. Hamer's findings of the correlation between heart attacks, territorial loss conflictand alterations in the brain, visible as a so-called Hamer Focus (HH). The results confirmed that all heart attacks had occurred after the territorial conflict had been resolved.



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE CORONARY VEINS: The coronary arteries and coronary veins run along the inner surface of the heart. The coronary veins receive oxygen-depleted blood from the heart muscle and empty it into the right atrium from where it passes to the right ventricle and further into the lung artery and the lungs, where the blood picks up fresh oxygen (pulmonary circulation). The pulmonary artery is unique insofar as it is the only artery in the human body that carries de-oxygenated blood. Contrary to other blood vessels, the inner lining of the coronary veins, the so-called intima, consists of highly sensitive squamous epithelial cells that originate from the ectoderm and are therefore controlled from the cerebral cortex. The wall of the coronary veins is composed of smooth muscle and striated muscles.

NOTE: The coronary veins are descendants of the pharyngeal arches which consist of pharyngeal arch arteriesthat give rise to several major arteries (see also coronary arteries, ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries).



BRAIN LEVEL: The coronary vein intima is controlled from the**left insula** (part of the **temporal lobe**). The insula is located deep in the cerebral cortex, exactly at the point where the four cerebral cortices meet (pre-motor sensory cortex, motor cortex, sensory cortex, post-sensory cortex). The trophic relays of thediaphragm and the myocardium housing the AV-node border on the insula from within.

The control center of the coronary veins is positioned across from the brain relay of the coronary arteries.

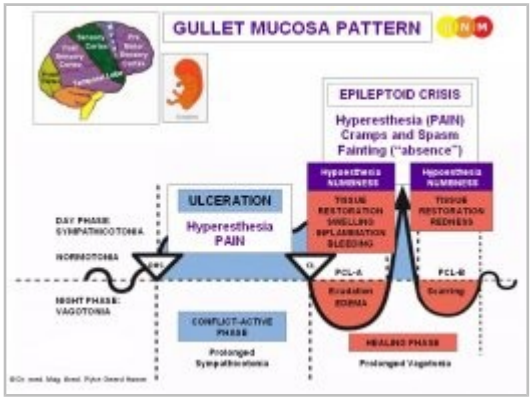
The **INSULA** is the most important control center in the cerebrum. It is the area of the brain that controls the lining of the large blood vessels (coronary arteries, coronary veins, aorta, carotid arteries, and subclavian arteries) that deliver blood to and from the heart. Controlled from the motor cortex, the right and left insula also regulate the slow (bradycardial) and fast (tachycardial) heartbeat. The **tachycardial heart rhythm center** is located in the **left insula**; the bradycardial heart rhythm center in the right insula. The heart rhythm (slow and fast) constitutes together with the diaphragmatic breathing a superordinate center.

NOTE: The coronary veins and the cervix uteri share the same brain relay and therefore the same biological conflict. Hence, **in females the Biological Special Programs run simultaneously**.

BIOLOGICAL CONFLICT: The biological conflict linked to the coronary veins is a female **sexual conflict** or a maleterritorial loss conflict, depending on a person's gender, laterality, and hormone status. In women, a sexual conflict also affects the cervix mucosa.

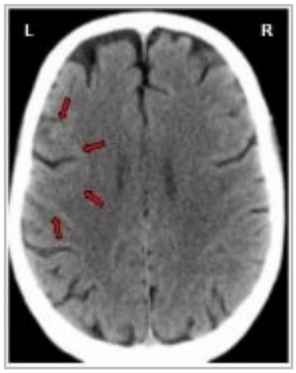
In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

A sexual conflict refers to any **distress concerning sexuality**. This includes painful (first-time) sex, sexual abuse, sexual harassment, unwanted sexual practices, sexual rejection, feeling sexually unwanted, a lack of sexual activity because of an unexpected separation or loss of a mate. Offensive pornography, finding out that the partner or spouse is sleeping with someone else, or interruptions during sexual intercourse can also trigger the conflict.



The Biological Special Program of the coronary veins follows the**GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the inner lining of the coronary veins proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the lumen of the blood vessel to improve the blood flow. The ulceration of the sensitive intima causes **moderate angina pectoris**. In females, the cervical lining also ulcerates, which, however, goes unnoticed. **NOTE:** While conflict active, the person is manic.



This CT scan shows the impact of a sexual conflict in the area of the brain that controls thecoronary veins (view the GNM diagram). The sharp border of the Hamer Focus indicates conflict activity. In females, this also affects the cervix.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. Like the restoration of the coronary arteries, the repair of the coronary veins is mainly accomplished with the help of cholesterol.

The **EPILEPTOID CRISIS** presents as a temporary reactivation of **angina pectoris** with **cramp-like chest pain** since the striated muscles of the coronary veins are also involved. During the muscle contractions, small pieces of cholesterol plaque are pulled off from the blood vessel wall and are pushed into the lung circulation, where they block the lung artery causing a **lung embolism** with **shortness of breath**. Depending on the intensity and duration of the conflict-active phase, the symptoms range from mild to severe.

NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

Conventional medicine claims that a lung embolism is caused by a blood clot that supposedly arises in the lower extremities and travels through the entire venous system, including the heart, all the way to the lungs. In reality, the "pulmonary emboli" are healing scabs originating in the coronary veins. Blood-thinning medication taken at that point to "reduce blood clotting" might contribute to acute bleeding from the cervix that undergoes the Epileptoid Crisis at the same time.

NOTE: A **thrombus** (blood clot) forms inside a blood vessel when blood is stagnant, because blood is viscous and thickens when it is not flowing. This happens, for example, when a person is inactive or immobile for a long period of time (following an operation, an induced coma, hospitalization, after an injury or prolonged stay in bed) - see also leg vein thrombosis. The main risk of general anesthetics is death from blood cloths! Thus, a thrombus in the lungs can prompt a lung embolism without a preceding DHS. Whether the lung embolism is related to anEpileptoid Crisis or to a thrombus can be easily established with the help of a CT scan (see below). Also, with a lung embolism that occurs during the healing crisis, the condition involves angina pain and tachycardia, which is not the case if the lung embolism is caused by a thrombus. At any rate, a blood clot can never lead to a heart attack or stroke, as claimed, since in the event of an obstruction auxiliary vessels supply the heart and the brain with blood (see also carotid arteries). In addition, pathological studies have confirmed that there is no relationship between the occurrence of a blood clot in the arteries and a heart attack, which refutes the thrombus-infarction theory all together. Furthermore, clinical observations have shown that in the treatment of angina pectoris anticoagulants (blood-thinners) given to prevent a heart attack are totally inefficient.

Why Thick Blood Protects From a Heart Attack

Researchers at the University Hospital Heidelberg (Germany) "examined mice with elevated blood fat levels and a genetic defect that leads to an increase in blood clotting. The mice developed larger plaques than those without the genetic defect, but the **plaques** were more stable. In addition, **no vascular obstruction was observed, as the vascular wall expanded to adapt to the new situation**. The negative effect of larger plaques on circulation was compensated by the positive effect of stability and a greater vessel diameter. However, the long-term use of anticoagulants (in this case, low molecular weight heparin) reversed these advantages. The size of the plaques was reduced, but stability was lost, increasing the risk of complications.

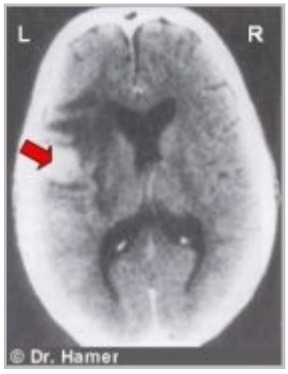
"Our findings were made on mice, but they confirm the results of clinical studies on humans," says Dr. Isermann. "In addition, in vitro studies show that human cells react similarly to mouse cells." The team assumes that the results can be transferred to humans and recommends weighing the advantages and disadvantages of anticoagulants carefully before administering them to a patient.

Science News 2009/08

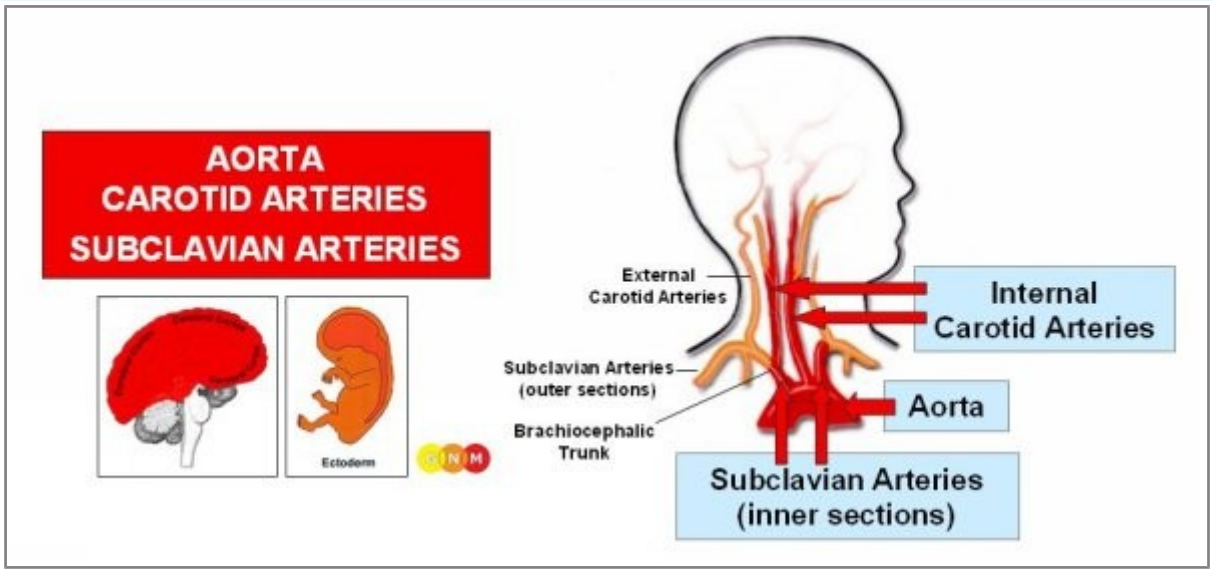
The real danger of the lung embolism is the involvement of the tachycardial heart rhythm center. Normally, the heart beats in a regular, balanced rhythm. This, however, changes for the duration of the Epileptoid Crisis when the brain edema in the coronary vein relay is expelled. The pressure created by the momentary sympathicotonic surge accelerates the pulse, causing **tachycardia** (compare with bradycardia, a slow heartbeat, related to the coronary arteries; see alsoventricular tachycardia and atrial tachycardia). Recurring episodes of tachycardial arrhythmia combined with rapid breathing (tachypnea) or gasping for breath are triggered by conflict relapses. Permanent tachycardial arrhythmia, however, can cause death since the incessant fluttering heartbeats eventually stop the blood

flow (hemodynamic stasis).

NOTE: The Epileptoid Crises occurs three to six weeks after the conflict resolution. If an intense conflict activity lasted for more than nine months, the lung embolism is most likely fatal (see also heart attack related to the coronary arteries). However, if the conflict-active phase was shorter than four month, then the symptoms are mild and might not even be noticed. This observation only applies to the coronary vessels!



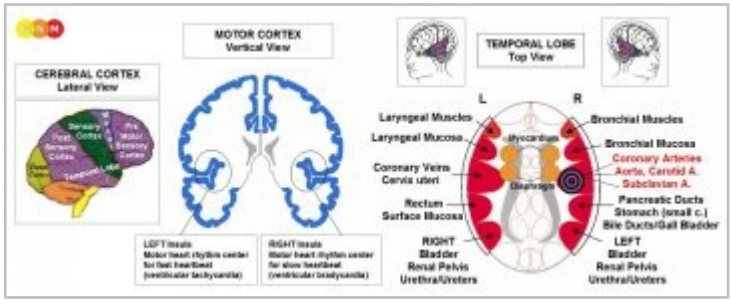
The accumulation of neuroglia in the brain relay of the coronary veins (view the GNM diagram), indicates that the person has already passed the Epileptoid Crisis (lung embolism) and is now in the second part of the healing phase (in PCL-B). In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor".



Biological Conflict **Conflict-Active Phase** **Healing Phase**

DEVELOPMENT AND FUNCTION OF THE AORTA, CAROTID ARTERIES, AND SUBCLAVIAN ARTERIES: The aorta is the main artery of the body. The aorta arises at the pericardium directly after the aortic valve where it takes the blood from the left ventricle and distributes it to the rest of the body (systemic circulation). Anatomically, the aorta is a tube that extends from the heart upward (ascending aorta), curves over the heart (aortic arch) and continues downward through the chest (descending aorta). There it subdivides into the thoracic aorta and abdominal aorta. The **carotid arteries** run along both sides of the head and neck. The internal carotid arteries carry blood from the heart to the brain; the external carotid arteries deliver blood to the face and the scalp. The cerebral arteries arise from the internal carotid artery. The **subclavian arteries** are paired arteries below the collar bone that supply the arms with blood. The left subclavian artery arises from the aortic arch; the right subclavian artery branches off the brachiocephalic trunk that merges with the right carotid artery. Contrary to other blood vessels, the inner lining of the ascending aorta, the internal carotid arteries, and the inner sections of the subclavian arteries consists of squamous epithelium, originate from theectoderm and are therefore controlled from the cerebral cortex. The arterial wall is composed of smooth muscle andstriated muscles.

NOTE: The descending aorta, the external carotid arteries, the outer sections of the subclavian arteries, and the cerebral arteries originate from the new mesoderm and are controlled from the cerebral medulla (see blood vessels). Eventually, the mesodermal and ectodermal sections joined. The ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries are descendants of the pharyngeal arches which consist ofpharyngeal arch arteries that give rise to several major arteries (see also coronary arteries and coronary veins).

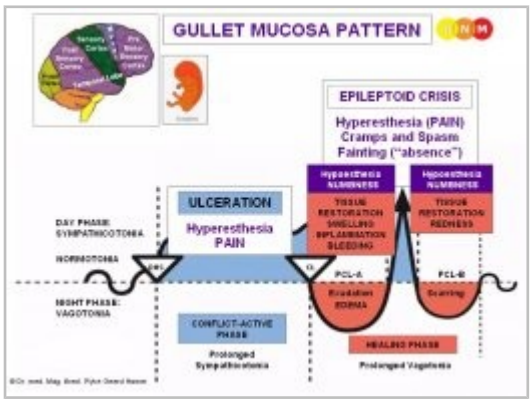


BRAIN LEVEL: The squamous epithelial lining of the ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries is controlled from the **right insula** (part of the**temporal lobe**). The insula is located deep in the cerebral cortex, exactly at the point where the four cerebral cortices meet (pre-motor sensory cortex, motor cortex, sensory cortex, post-sensory cortex). Their control center is positioned across from the brain relay of the coronary veins.

NOTE: The ascending aorta, inner carotid arteries, inner sections of the subclavian arteries, and the coronary arteries share the same control center and therefore the same biological conflict; which one of these arteries will be affected by the DHS is random. The carotid sinus is also controlled from the same brain relay but is linked to a different biological conflict. The descending aorta, external carotid artery, and outer sections of the subclavian arteries are linked to a self-devaluation conflict.

BIOLOGICAL CONFLICT: a male **territorial loss conflict** or a female sexual conflict, depending on a person's gender, laterality, and hormone status (see coronary arteries).

In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts**are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.



The Biological Special Program of the aorta, carotid arteries, and subclavian arteries follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the affected artery proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the lumen of the arterial vessel to improve the blood flow.**Symptoms**: **pain** ranging from mild to severe. **NOTE:** While conflict active, the person is in a depressed mood.

If the conflict persists, the blood vessel wall becomes weak causing a localized bulge at the ulcerated area. This is called a **carotid artery aneurysm** or **subclavian artery aneurysm** (compare with abdominal

aortic aneurysm and aneurysms related to the external carotid artery, the outer sections of the subclavian arteries, or cerebral aneurysm). Small aneurysms may go completely unnoticed. However, as the aneurysm increases in size there is a greater risk of rupture with bleeding into the surrounding tissue and potentially serious complications. Normally, the smooth muscle fibers embedded in the striated muscles of the arterial wall stabilize the blood vessel to prevent a rupture. An aneurysm rupture therefore only occurs because of a vigorous move or heavy lifting.

HEALING PHASE: During the first part of the healing phase (PCL-A), the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation) in the healing area. The blood vessel wall is repaired mainly with calcium and cholesterol. With a hanging healing, that is, when the healing process is continually interrupted by conflict relapses, the buildup of cholesterol deposits eventually leads to **arteriosclerosis**, a "hardening" of the artery (see also arteriosclerosis related to the coronary arteries and other blood vessels). A large swelling, usually because of concurrent water retention due to the SYNDROME, and the accumulation of arteriosclerotic plaques can lead to a narrowing of the artery with dizziness and fainting, if the carotid artery is affected (**carotid artery stenosis**).

"Observations that a small proportion of stroke patients have severe carotid stenosis and that many elderly people have severe carotid stenosis but no symptoms suggest that the degree of stenosis is not the sole variable in predicting stroke risk."

American Journal of Neuroradiology, January 1999

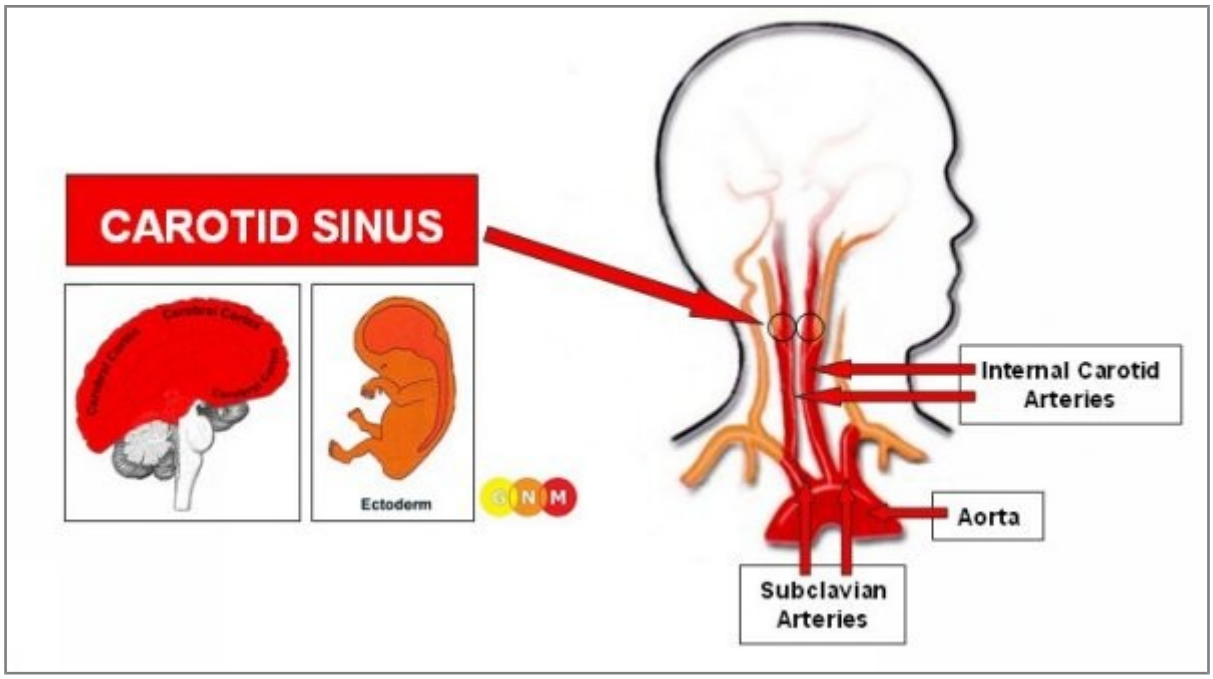
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity of the conflict. Another distinctive symptom is a **drop of blood sugar** caused by the excessive use of glucose by the brain cells (compare withhypoglycemia related to the islet cells of the pancreas).

During the muscle contractions that take place in the arterial wall throughout the Epileptoid Crisis, small pieces of cholesterol plaque (erroneously believed to be a "thrombus") might break off and travel to the brain. However, a blockage of the carotid artery does not cause a stroke, as claimed by conventional medicine. As is the case with anocclusion of the coronary arteries, should the situation of an obstruction arise, auxiliary vessels or so-called collaterals act as a natural bypass to supply the brain with blood and oxygen.

Cerebral Collateral Circulation in Carotid Artery Disease

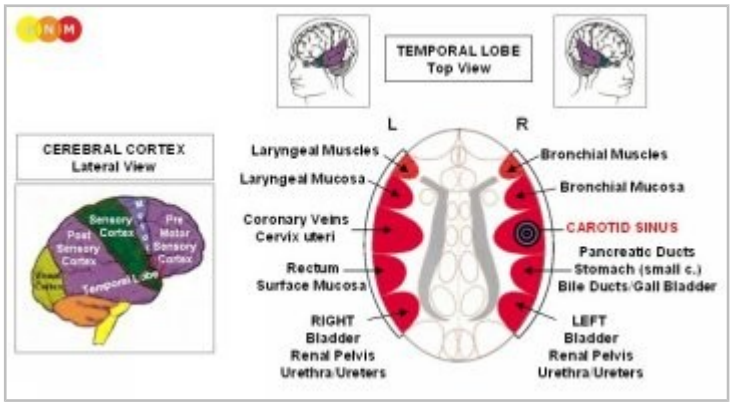
"In case that one of the major cerebral arteries is compromised by occlusive disease, the cerebral collateral circulation plays an important role in preserving cerebral perfusion through enhanced recruitment of blood flow."

Current Cardiology Review, November 2009



Biological Conflict **Conflict-Active Phase** **Healing Phase**

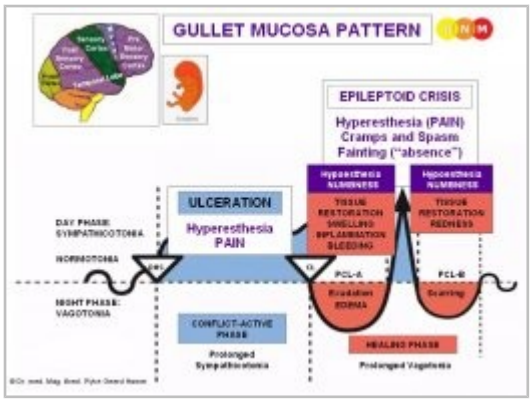
DEVELOPMENT AND FUNCTION OF THE CAROTID SINUS: The carotid sinus is a bulbous area, located bilaterally (on both sides of the neck) close to the point where the carotid arteries bifurcate. The carotid sinus contains pressure receptors that control the body's blood pressure by mediating changes in the heart rate. The lining of the carotid sinus consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The carotid sinus is controlled from the **right insula** (part of the **temporal lobe**). The insula is located deep in the cerebral cortex, exactly at the point where the four cerebral cortices meet (pre-motor sensory cortex, motor cortex, sensory cortex, post-sensory cortex). Their control center is positioned across from the brain relay of the coronary veins.

NOTE: The carotid sinus shares the control center with the brain relays of the coronary arteries, the ascending aorta, internal carotid arteries, and inner sections of the subclavian arteries.

BIOLOGICAL CONFLICT: the **blood pressure is too high**



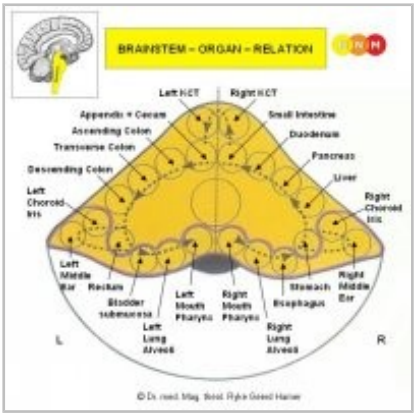
The Biological Special Program of the carotid sinus follows the **GULLET MUCOSA PATTERN** with hypersensitivity during the conflict-active phase and the Epileptoid Crisis and hyposensitivity in the healing phase.

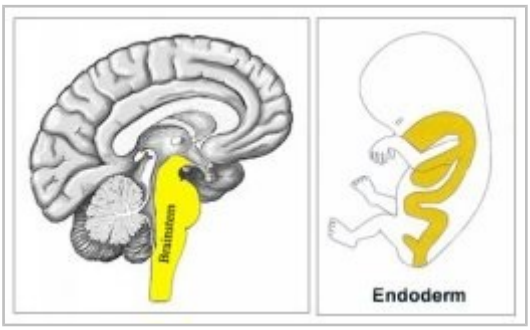
CONFLICT-ACTIVE PHASE: ulceration in the carotid sinus proportional to the degree and duration of conflict activity. The **biological purpose of cell loss** is to lower the blood pressure. Continuous, intense conflict activity causes **carotid sinus hypersensitivity** with marked **bradycardia** (compare with slow heartbeat during the coronary artery-related heart attack) and a **drop of blood pressure** (compare with drop of blood pressure during the left myocardial heart attack).

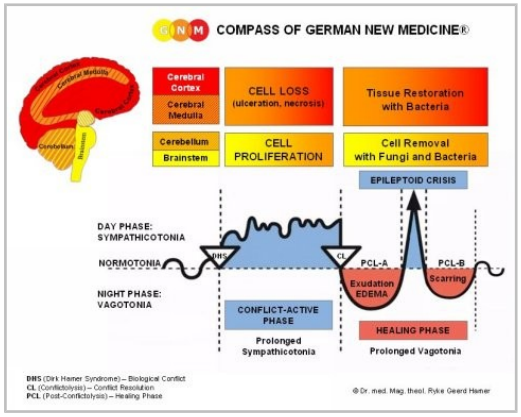
HEALING PHASE: During the first part of the healing phase (PCL-A) the ulcerated area is replenished through **cell proliferation**. The carotid bulb is repaired predominantly with cholesterol. With a hanging healing the accumulation of cholesterol plaque, called a **carotid bifurcation atheroma**, narrows the lumen of the carotid artery (compare withcarotid artery stenosis causing dizziness and lightheadedness but NOT a stroke (see cerebral collateral circulation in carotid artery disease).

Biological Special Programs - Overview

ORGANS CONTROLLED FROM THE BRAINSTEM





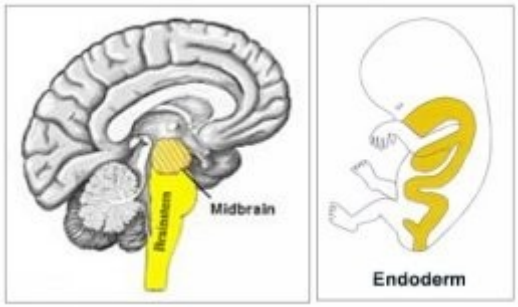


ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Mouth and pharynx submucosa	morsel conflict	oral cancer, tongue cancer, nose polyp, nose abscess, tonsillar hypertophy, tonsillitis, canker sores, thrush, mumps, Sjogren's

	right side: not being able to catch a morsel left side: not being able to eliminate a morsel conflict related to a visual morsel	syndrome
Tear glands	right side: not being able to catch a morsel left side: not being able to eliminate a morsel conflict related to a visual morsel	lacrimal gland tumor, dacryoadenitis
Choroid Iris Ciliary body	right side: not being able to catch a morsel left side: not being able to eliminate a morsel conflict related to a sound morsel	choroid melanoma, iris melanoma, ciliary body melanoma, optic neuroma, coloboma, choroiditis, uveitis
Middle Ear Eustachian tubes	right side: not being able to catch a morsel left side: not being able to eliminate a morsel	middle ear infection, ear polyp, retracted eardrum, acoustic neuroma
Lung alveoli	death-fright conflict	lung cancer, lung tuberculosis, lung edema, lung emphysema, pulmonary sarcoidosis
Goblet cells	fear of suffocation	mucoviscidosis, cystic fibrosis
Thyroid gland	morsel conflict right side: not being able to catch a morsel left side: not being able to eliminate a morsel morsel conflict	hyperthyroidism, hard struma, thyroid cancer, hypothyroidism
Parathyroid glands	right side: not being able to catch a morsel left side: not being able to eliminate a morsel	hypertparathyroidism, hypercalcemia, parathyroid cancer, hypoparathyroidism
Esophagus (lower third)	not being able to swallow a morsel	esophageal cancer, esophageal varices
Stomach Duodenum	indigestible morsel conflict	upset stomach, stomach cancer, duodenal cancer
Liver parenchyma	starvation conflict	liver cancer, liver abscess, liver tuberculosis, liver cyst, hepatomegaly
Pancreas gland	indigestible morsel conflict	pancreas cancer, pancreatitis

Small intestine	not being able to digest/absorb a morsel	jejunal cancer, ileal cancer, ileus, intestinal candidiasis, Crohn's disease
Colon	indigestible morsel conflict	colon cancer, intestinal polyp, intestinal candidiasis, appendicitis, Irritable Bowel Syndrome, colitis, diverticulitis
Sigmoid colon Rectum submucosa	feces conflict	colorectal cancer, rectal polyp, rectal abscess
Kidney collecting tubules	abandonment conflict, existence conflict, refugee conflict	water retention, uremia, kidney cancer, kidney tuberculosis, nephritis, nephrotic syndrome, cirrhotic kidney, kidney stones
Adrenal medulla	unbearable intense stress	adrenal cancer
Prostate gland	procreation conflict, mating conflict, gender conflict	prostate cancer, prostate hyperplasia, prostatitis
Smegma secreting gland	not being able to penetrate a tight vagina	penile candidiasis
Uterus Fallopian tubes	procreation conflict, implantation conflict, gender conflict	uterus cancer, uterine polyp, endometrial hyperplasia, endometritis, uterine candidiasis
Bartholin's gland	not producing sufficient vaginal mucus	Bartholin's cyst, Bartholin's abscess, vaginal dryness
Female germ cells Male germ cells	profound loss conflict	ovarian teratoma, testicular teratoma, dermoid cyst
Pituitary gland	morsel conflict right side: not being able to catch a morsel left side: not being able to eliminate a morsel	gigantism, acromegaly, intrauterine growth retardation, dwarfism, prolactinoma, galactorrhea, premature development, delayed puberty
Pineal gland	sudden long darkness	pinealon
Choroid plexus	the brain is too dry	ependymoma, hydrocephalus

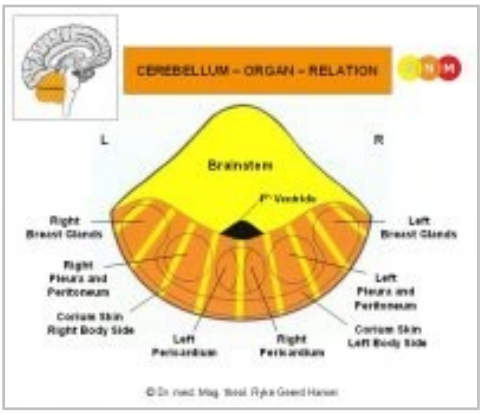
ORGANS CONTROLLED FROM THE MIDBRAIN

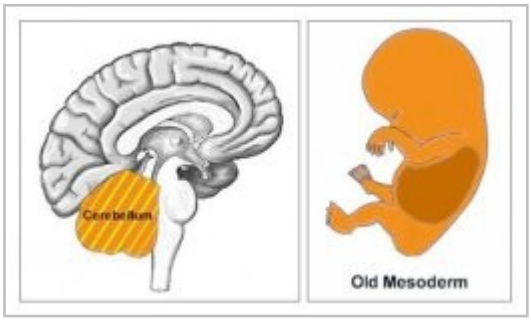


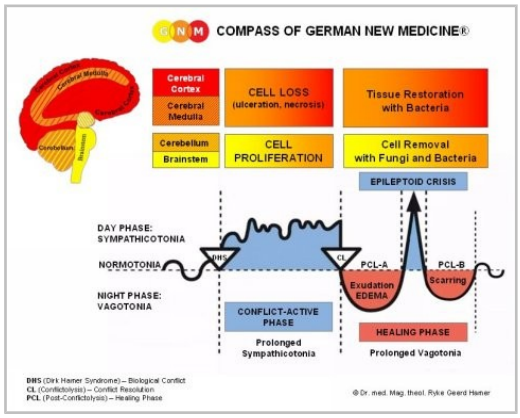
ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Intestinal muscles	not being able to pass an indigestible morsel	intestinal colic
Rectal muscles (smooth)	feces conflict	rectal spasms
Internal rectal sphincter	not being able to hold back feces	rectal spasms
Internal bladder sphincter	not being able to hold back urine	bladder spasms
Uterus muscles	not being able to hold the fetus	uterine fibroids

Myocardium (atria)	not being able to move the blood morsel	atrial fibrillation
Ciliary muscles (smooth)	not being able to see what is close	nearsightedness
Pupil muscles	light-related morsel conflict	myosis, mydriasis

ORGANS CONTROLLED FROM THE CEREBELLUM

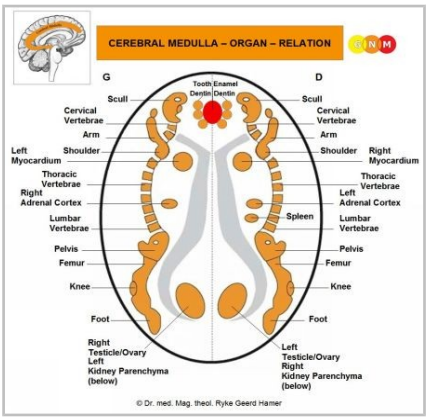


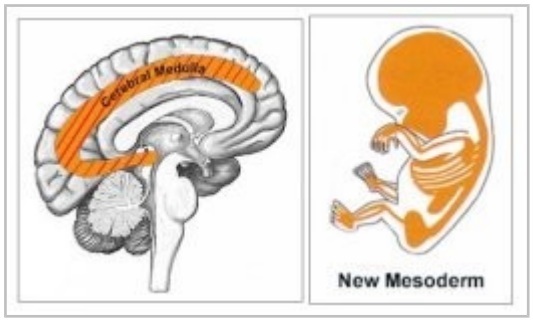


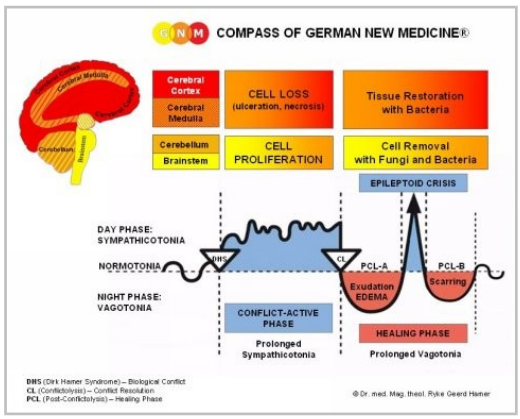


ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Corium skin	attack conflict, disfigurement conflict, feeling soiled	melanoma, skin tuberculosis, Kaposi sarcoma, leprosy, carbuncle, furuncle, pilonidal cyst, smallpox, shingles, acne, nail fungus, Athlete's foot
Breast glands	nest-worry conflict, argument conflict	glandular breast cancer
Pericardium	attack against the heart	pericardial mesothelioma, pericarditis, pericardial effusion, cardiac tamponade
Pleura	attack against the chest	pleural mesothelioma, pleurisy, pleural effusion
Peritoneum	attack against the abdomen	peritoneal mesothelioma, peritonitis, peritoneal effusion, ascites
Great omentum	ugly belly conflict	omental mesothelioma
Tunica vaginalis testis	attack against the testicles	testicular mesothelioma, hydrocele
Eyelid glands	eye-related disfigurement conflict	stye, chazalion, eyelid tumor
Myelin sheath	touch conflict	neurofibroma, Recklingshausen's disease

ORGANS CONTROLLED FROM THE CEREBRAL MEDULLA

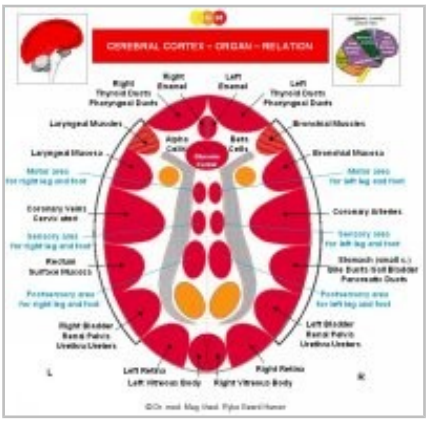


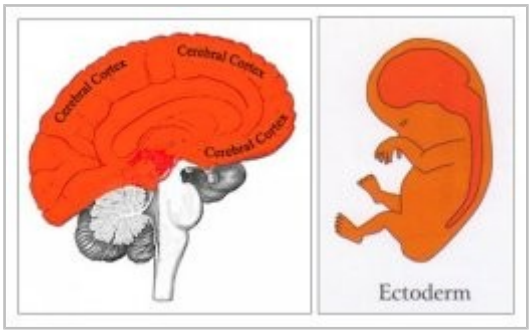


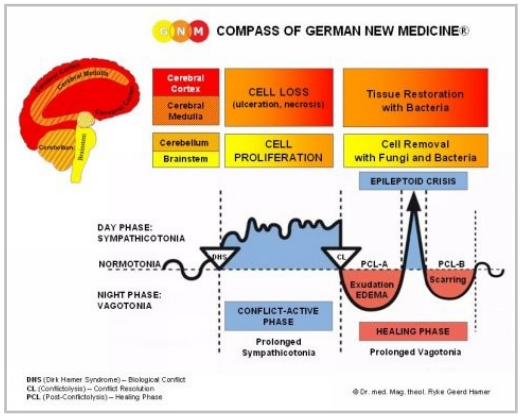


ORGANS	BIOLOGICAL CONFLICT	CONDITIONS **conflict-active or healing phase**
Bones and joints	self-devaluation conflict	osteolysis, osteoporosis, arthritis, carpal tunnel syndrome, herniated disk, lumbago, sciatia, cervical spondylosis, scoliosis, kyphosis, lordosis, heel spur, bunion, gout, bone cancer, osteosarcoma, anemia, leukemia, plasmacytoma, hemochromatosis
Tendons	self-devaluation conflict	tendonitis
Cartilage	self-devaluation conflict	arthrosis, perichondritis
Dentin Jaw bone	bite conflict	cavities, periodontosis, tooth abscess, jaw cancer
Muscles	self-devaluation conflict	muscle atrophy, muscle necrosis
Lymphatic system	self-devaluation conflict	lymphoma, lymphedema, mononucleosis, Pfeiffer's disease
Spleen	bleeding conflict	splenomegaly, splenitis, splenic cyst
Connective tissue	self-devaluation conflict	fibroma, boil, keloids, scleroderma, Dupuytren's contracture
Fat tissue	self-devaluation conflict	lipoma, xanthoma, cellulite, cellulitis
Blood vessels	self-devaluation conflict ball-and-chain conflict	arteritis, arteriosclerosis, abdominal aneurysm, cerebral aneurysm, phlebitis, varicose veins
Ovaries	loss conflict	ovarian cyst, endometriosis, ovarian cancer
Testicles	loss conflict	testicular cyst, testicular cancer
Corpora cavernosa	self-devaluation conflict	erectile dysfunction, Peyronie's disease, phimosis, frenulum breve
Myocardium (ventricles)	overwhelmed conflict	cardiac insufficiency, myocarditis, myocardial sarcoma, ventricular fibrillation, myocardial heart attack, sleep apnea
Heart valves Endocardium	self-devaluation conflict	mitral insufficiency, mitral stenosis, aortic insufficiency, aortic stenosis, pulmonary valve stenosis, endocarditis
Diaphragm	not being able to breathe sufficiently, physical overwhelmed conflict	diaphragmatic hernia, hiatel hernia

ORGANS CONTROLLED FROM THE CEREBRAL CORTEX



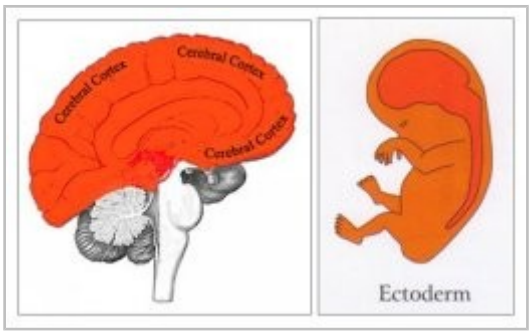




ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Mouth and pharynx surface mucosa	oral conflict	aphtous ulcers, oral cancer, gingivitis, gum abscess
Throat	not wanting to swallow a morsel	sore throat, strep throat
Salivary gland ducts	not being able or allowed to eat	parotitis, Sjogren's syndrome
Nasal mucosa	scent conflict, stink conflict	common cold, nose bleeds, hay fever
Paranasal sinuses	scent conflict, stink conflict	sinusitis
Trachea	not getting enough air	tracheitis, tracheal cancer
Esophagus (upper 2/3)	not wanting to swallow a morsel	esophageal cancer
Tear ducts	wanting to be seen, not wanting to be seen	dry eyes, Sjogren's syndrome, dacryocystitis
Eyelid gland ducts	visual separation conflict	dry eyes, Sjogren's syndrome
Conjunctiva Lens Cornea	visual separation conflict	conjunctivitis, pterygium, pinguecula, grey cataract, keratitis, astigmatism, farsightedness, nearsightedness
Enamel	bite conflict	cavities
Epidermis	separation conflict	alopecia, vitiligo, albinism, dermatitis, eczema, hives, measles, rubella, chickenpox, scarlet fever, rosacea, lupus, herpes, psoriasis, warts, basalioma, scleroderma
Milk ducts	separation conflict	scirrhous knots, intraductal breast cancer, breast cyst, mastitis, Paget's disease
Cervix mucosa	sexual conflict	cervical cancer
Vaginal mucosa	sexual separation conflict	vaginal dryness, vaginal herpes, vaginal warts
Clitoris	separation conflict	clitoral hypersensitivity, clitoral hyposensitivity
Prostatic ducts	territorial marking conflict	intraductal prostate cancer
Glans penis	separation conflict	penile hypersensitivity, penile hyposensitivity
Pharyngeal ducts	frontal-fear conflict or powerless conflict	non-Hodgkin's lymphoma, small cell bronchial carcinoma, mononucleosis, Pfeiffer's disease
Thyroid ducts	powerless conflict or frontal-fear conflict	euthyroid struma, thyroid cyst, thyroglossal cysts, thyroid fistula
Larynx mucosa	scare-fright conflict or territorial fear conflict	laryngitis, larynx cancer, vocal cord polyps

Bronchial mucosa	territorial fear conflict or scare-fright conflict	bronchitis, pneumonia, influenza, atelectasis, bronchial cancer
Coronary arteries	territorial loss conflict or sexual conflict	angina pectoris, arteriosclerosis, heart attack
Coronary veins	sexual conflict or territorial loss conflict	angina pectoris, lung embolism
Aorta Carotid arteries Subclavian arteries	territorial loss conflict or sexual conflict	carotid artery aneurysm, carotid artery stenosis, subclavian artery aneurysm
Carotid sinus	blood pressure is too high	carotid bifurcation atheroma
Stomach (small curvature) Pylorus Duodenal bulb	territorial anger conflict or identity conflict	stomach ulcers, pyloric ulcers, duodenal ulcers, gastric reflux, gastritis
Bile ducts Gallbladder	territorial anger conflict or identity conflict	jaundice, hepatitis, hepatomegaly, liver cirrhosis, liver cancer, cholecystitis, gall stones
Pancreatis ducts	territorial anger conflict or identity conflict	pancreatitis, pancreas cancer
Renal pelvis Ureters	territorial marking conflict	kidney infection, pyelitis, kidney stones
Bladder Urethra	territorial marking conflict	urinary tract infection, cystitis, urethral gonorrhea, bladder warts, urothelial carcinoma
Rectum surface mucosa	identity conflict or territorial anger conflict	hemorrhoids
Para-anal ducts	not being able to eliminate feces fast enough	para-anal cyst, para-anal fistula, Douglas fistula

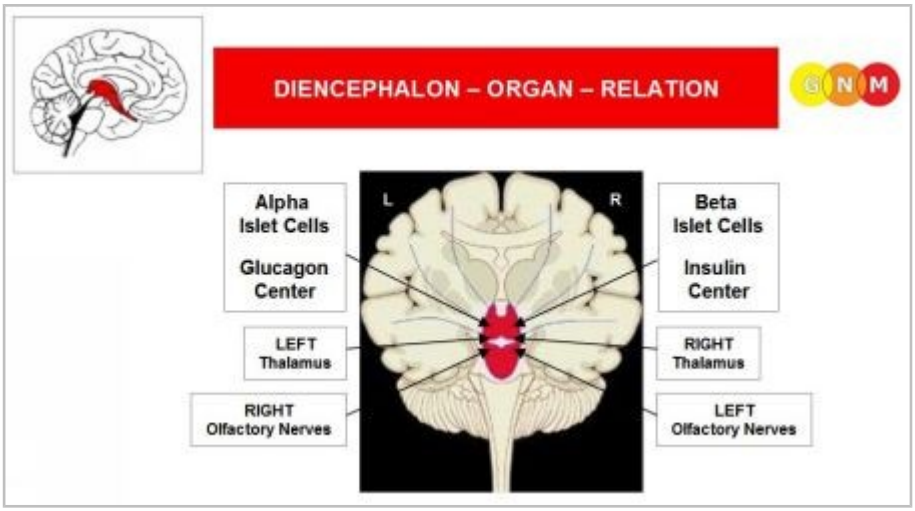
ORGANS CONTROLLED FROM THE CEREBRAL CORTEX with functional changes or functional loss

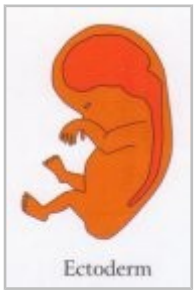


ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Skeletal muscles	motor conflict of not being able to move, feeling stuck	paralysis, Bell's palsy, polio, ALS, multiple sclerosis, Guillain-Barré syndrome, epileptic seizure, focal dystonia, Parkinson's, tetanus, stroke
Stapedius muscle	noise conflict	hyperacusis, stapedial muscle spasms
Esophageal muscles	not being able to regurgitate a morsel	esophageal spasms
Tongue	not being able to pull the tongue away	tongue muscle paralysis

Jaw muscle	bite conflict	lockjaw, bruxism
Eyelid muscles	not being able to keep the eyes open not being able to close the eyes	blepharoptosis, lagophtalmos, ectropion, entropion
Ciliary muscles (striated)	not being able to see what is in the distance	farsightedness
Extraocular muscles	not wanting and not being allowed to look into a certain direction	strabismus, nystagmus, lazy eye
Bronchial muscles	territorial fear conflict or scare-fright conflict	whooping, cough, spastic bronchitis, bronchial asthma
Laryngeal muscles	scare-fright conflict or territorial fear conflict	whooping cough, spastic laryngitis, laryngeal asthma
Cervical muscles	not being able to hold the fetus	cervical spasms
Vaginal muscles	not being able to hold the penis	vaginismus
Rectal muscles (striated)	not being able to sufficiently mark the territory	fecal incontinence, rectal spasms
Bladder muscle	not being able to sufficiently mark one's place	urinary incontinence, bladder spasms, bedwetting
Periosteum	severe separation conflict	rheumatism, trigeminal neuralgia, numbness, foot ulcers, leg ulcers, Raynaud's disease, gangrene
Cochlea	hearing conflict	tinnitus, hearing impairment
Vestibular organ	balance conflict, falling conflict	vertigo, ataxia, Menier's disease
Retina	fear that cannot be shaken off	nearsightedness, farsightedness, scotoma, retinal detachment, macular degeneration
Vitreous body	fear of the predator	green cataract, glaucoma

ORGANS CONTROLLED FROM THE DIENCEPHALON
with functional changes or functional loss





ORGANS	BIOLOGICAL CONFLICT	CONDITIONS conflict-active or healing phase
Olfactory nerves	not being able to smell someone or something	hyposmia, anosmia, hyperosmia