

## WHAT YOU CAN EXPECT

### “THAT’S EXACTLY WHAT I DO!”

“If you’d like to come into the examination room with me and David, you can watch as I conduct a short test on him. This usually takes five or ten minutes and will reveal essentially what \$1,200 worth of neuropsychological or educational testing will tell you.” The father looked at his wife. They had, he told me already spent thousands of dollars, ever since David was diagnosed with dyslexia at age seven. They’d opt for the ten-minute exam. This preliminary “quick check” is something I conduct with every client who comes to see me.

## THE PROCEDURE WHERE BOOKS NEURAL THERAPY BEGINS

I ask David to take off his shoes and lie down on his back on my exam table. I first check whether his muscles are working properly as they would serve as my monitoring device. Few clients I see are familiar with muscle monitoring, but soon find it quite intriguing. Rather than digress and cover this methodology at this point, please note there is more information on this monitoring in chapter 6.

David’s muscles are working just fine, which allows me to move forward. I tap the top of David’s head gently several times and wink as I say, “Okay, I’m going to wake up your brain now.” David looks at me a bit quizzically but shows no resistance.

### *Test #1:*

I begin by asking David to put both of his thumbs into the roof of his mouth. I notice that he doesn’t have his thumbs back far enough, so I offer him the clue, “You know where the peanut butter gets stuck.” David adjusts his thumbs to the correct position. I proceed with the muscle monitoring and notice that there is a problem. “David, do you find that you can read, but you’re not the fastest reader in your class.” David lowers his eyes and nods silently. “And do you ever rub your eyes or feel sleepy after you’ve been reading just a few minutes?”

“That’s exactly what I do!” he replies.

I explain to David and to his parents that when I ask David to put his thumbs in his mouth, literally over part of the base of the eye socket, I’m doing a “quick check” for eye tracking. If the bones in the eye socket aren’t totally symmetrical, which I suspected they weren’t in David’s case, just from looking at his face, the muscles guiding the eyes during reading can’t possibly “team” together. That means one eye might be doing more of the work, almost dragging the other eye along; or the muscles on one side of the eye might be tighter than on the other side, making an uneven distribution of strength, allowing for weakness or instability of the eye muscles. That could be almost like weightlifting with the eyes, soon the eyes are tired, and then blinking or rubbing the eyes is pretty common.

### ***Test #2:***

I now ask David to keep his head perfectly still and follow my finger only with his eyes. I move my finger from right to left in front of his face.

People who read easily have eyes that move fluidly and rhythmically from one side to the other as they follow my finger. I notice that David's eyes, however, dart around. The jerky movements they make are sometimes fast and sometimes slow. One eye even moves up and around, like a lost cursor on the computer screen. His eyes move erratically and irregularly, like non-syncopated rhythms, at times almost stuttering or stammering with his eyes. I turn to David's parents ask them if they saw what I had noticed. They had.

"There is no way your son will be able to read properly with eyes that have to work so hard. When the eyes are not teaming, the brain has a lot of extra work to do, and what seems effortless for some people will be a huge effort for David's eyes. It's hardly surprising that David feels sleepy, even after short periods of reading," I explain.

"David, do you find yourself reading one line of text and then, without knowing it, skipping to the same word on the line below?"

"That's exactly what happens!" he exclaims. "I keep trying, but the same thing keeps happening so, pretty soon, I don't even know what I'm reading anymore. That's when I just give up and say I didn't want to read that anyhow."

His mother gives a knowing look. "That's when he throws the book to the other side of the room—or just lets it drop to the floor" she says.

The technical terms for this kind of eye movement is nystagmus or saccadic movements.

What it means for your child's eyes is that the rhythm and flow are disturbed, and reading becomes slow and laborious. Have you ever danced with someone really good and it's easy to follow them and you feel graceful just being with them? Well, that is just the opposite of how it feels inside your child's head. If anything, it's like music that sounds just awful and you just want the irritation to stop.

### ***Test #3:***

Now I move on and ask David to put his thumbs back into the roof of his mouth, just as he had done for the first test, but this time to push them out towards the molar teeth.

"Do you ever trip over your own words, David?" I ask. David nods his head. "And does it sometimes seem like your brain is working faster than your mouth?" Again, he agrees. "Do you mean to say one thing and something else comes out of your mouth? Or find that your words get twisted up in the sentence so that what you say isn't what you meant to say?" David looks surprised, as if wondering how I could possibly know that. "And did you ever stutter?"

David's mother answers this time, telling me that David had seen a speech therapist at the age of five and that problem had been dealt with.

I ask him to put his thumbs in this spot because it reveals some important information to me. Here I'm asking him to spread his upper palate, much like an orthodontic appliance might do. Did you know EVERY client with a learning problem has a problem with his TMJ (temporal mandible joint or jaw joint)? Now, you can have a TMJ problem without a learning problem, but if there is a learning issue, there will

ALWAYS be a TMJ problem! It's no wonder I see so many clients with braces already in their mouths. Their body is telling you there's a problem but, unless you are schooled in the relationship between the jaw joint and learning issues, you'd never know that. (Most orthodontists aren't schooled in this relationship either.)

#### ***Test #4:***

For the next step of the test, I ask David to put his index fingers in his ears, as if he were trying to block out all sounds. Once I have done my test, I motion for him to remove his fingers so I can continue with the questions.

- "Do you ever get distracted when there is noise going on around you?"
- "Do you lose your concentration when that happens and then have to start over with whatever you were doing?"
- "Are there times when you hear something another person says but you are not sure what you heard?"
- "And when that happens, do you ask the other person to repeat themselves; and by the time they do, you've figured out what they said the first time?"

In all cases, David agrees, adding, "That's exactly what happens."

David's father looks at me rather sheepishly. "And I thought he was just doing that on purpose to irritate me." Now he knew differently, which is why I like parents to come into the examination room. It is as much an education for them as it is for me and for their child.

*What does this test reveal?*

This test can clue me in to two different problems:

First, there is an auditory processing problem, which means he hears the word, but it comes in muffled, like when you're surfing radio channels, and you're close to receiving a station, but the sound is coming in rather garbled.

In this case, it isn't a hearing problem. It's a delay between when he hears the word and when he figures out what was actually said. The coping mechanism of asking the other person to repeat himself is a polite way of taking the necessary time to figure out what was said. To the teacher or the parent, however, it seems manipulative and the person who is asked to repeat himself over and over, thinks the questions are a way of being manipulative.

Second, there can be an auditory concentration problem, in which case the person involved loses his train of thought and has to start over with whatever they were doing. On timed tests and office deadlines, this can be a big problem—which can eventually spill over into text and performance anxiety.

#### ***Test #5***

For the fifth part of the test, I ask David to put his index and middle fingers of each hand on the side of each eye, around the temple area. With a positive test finding, I ask David: Do you find yourself yawning a lot? And can you blow out all the candles on your birthday cakes?

David's father asks me to stop the test for a moment, "I don't understand what blowing out candles has to do with my son's dyslexia. Can you explain why you asked David about that?"

“Have you ever noticed how some babies suck their thumbs long past their babyhood,” I ask. “Or have you noticed how old people like to sit in rocking chairs? If the brain isn’t getting enough cerebral spinal fluid (CSF), which is one of the ways the brain is nourished, then the body attempts to help out by engaging other body parts. Babies and small children sometimes suck their thumbs for emotional reasons. But many times, they are doing it in order to suck more CSF into their brains, like a vacuum pump sucks up water. Similarly, when people are older and less mobile they are more likely to want to sit in rocking chairs so they can rock and pump up more CSF into their brains.

“You see, there is a pump that starts at the sacrum,” I stop to show David’s father the bones below his waist in the back. “That pump should be moving this CSF up through the spinal cord and into the brain—all day, every day. But sometimes that pump isn’t working so well. That’s when the body, because it has all these wonderful back-up systems, figures out a way to artificially pump that fluid up through the spinal cord. That way, they have enough oxygen so they don’t have to yawn as much, and they have enough air to blow out the candles. Pretty clever, wouldn’t you say?”

Both of David’s parents, and their son, agree with me. I then continue with the test.

#### ***Test #6:***

For the sixth part of my test, I ask David to place two fingers on each temple to slide them along the bone—down on the left side and up on the right side of his eyes simultaneously. I detect a problem with my testing here and so I ask David: "Is reading hard for you? Do you find it harder to do word problems in math than just the number problems?"

I turn to David’s parents, telling them that this is another clue that certain parts of David’s brain are having a hard time doing their jobs.

#### ***Test #7:***

The next step is to ask David to reverse that previous task so that he moves his fingers up on the left side and down on the right side of his eyes simultaneously. This test was the first area where no problem was obvious. "Do you like drawing or perhaps play a musical instrument? Do you consider yourself pretty artistic or creative?"

Having already seen David’s childhood drawing, I thought I knew what to expect, but I ask the question regardless. David’s eyes look down and he mumbles, almost under his breath, “I don’t draw much. I just like to hang out with my friends.”

#### ***Test #8:***

With David’s permission, I move his left hand just above his left ear and his right hand on top of his left hand so it looks as if he is trying to protect his head from the driving rain. While this is the second test that didn’t apply to David, this one relates primarily to Attention Deficit with Hyperactivity Disorder (ADHD) tendencies, I explain to his parents that if this test were positive, I would have asked David, "Do you sometimes act before thinking? And if someone asks why you did that, you honestly couldn’t tell them because you didn’t think before you did it?"

“But David does do that sometimes,” his father tells me.

I reply, "Yes, I think every teenager is going to do that sometimes. But the point here is if this kind of behavior is a theme in David's life."

We discuss this briefly and come to the conclusion that ADHD is not the primary problem here.

"What other questions would you need to ask to check for ADHD?" David's mother asks me. "I'd like to know because a lot of people wonder if David isn't also ADHD."

I share a few questions such as:

- Do you get your homework completed on time?
- Do you remember to turn the paper in?
- Do you have a good sense of how much time it will take to complete a project?

David's mother confirms that although he frequently doesn't complete his homework, it isn't because he was distracted. "I watch him sitting at the kitchen table," she said, "and it's obvious to me that he just can't figure out the answers. If anything, he's more likely to put his head down. Probably, I realize now, just to give his brain a rest from having to work so hard on that eye tracking."

### ***Test #9:***

"Now," I say to David, "pretend you're parting your hair down the middle and put all the fingers of your left hand along that central parting," David does as he is told. Then I ask him, "Do you find it hard to remember what you just read or learned? And do you study for a test and when the time comes, it's like all that information just goes out of your head. You can't retrieve it, even though you knew the answer before the test?"

Do I detect a little glimmer of hope in David's eyes, as if he suddenly realizes there might be a logical reason why he does all of those things? "That's exactly what happens," he murmurs, adding, "You mean, there's a reason why I do these things and I'm not just stupid, like everyone says?"

My reaction is immediate and heartfelt, "Absolutely you are not stupid," I tell this young man, squeezing his arm gently in support. "Your brain has been doing a really good job for you and we're going to help your brain so that it won't have to work so hard."

David sighs in relief. I look over at his parents who still look puzzled. I explain to them that there is a bridge, called the corpus callosum, that connects the right and left hemisphere of the brain; and when we are under severe stress, it's as if that bridge collapses, preventing access to information on either side.

David's mother says, "Now that I think about it, there has been many a night when I personally sat at that kitchen table with David going through spelling words. And he knew them before he went to bed. But when he took the test the next day, it was as if he'd never seen the words before. But I know he studied, because I was there studying with him."

### ***Test #10:***

This last test is an oversimplified test of dominance and I illustrate it here to make a point. I ask David to do the following:

- I hand him a pen and notice which hand he uses to grab the pen. I note that he uses his right hand.
- I pretend to hand a phone to him saying he has a phone call and I notice which ear he brings it to. He brings it to his left ear.
- I ask him to imagine he's hitting a soccer ball and notice which foot he uses. He kicks the imaginary ball with his right foot.

Many times parents proudly tell me their child is ambidextrous. But upon further checking, I find that the child is neither right- nor left-handed and, really, he has no consistent dominant pattern. Also, many people have “mixed dominances,” which means they can be right-eyed, right-eared, left-handed and right-footed or other combinations.<sup>1</sup> When they are under stress, they may display a different pattern. The point here is that our bodies react differently under stress; the priorities change and learning becomes inconsistent or non-existent.

### ***Test over!***

“Okay, that’s it,” I tell David’s parents. Our teenager is instructed to get up off the table and put his shoes back on. His father had timed me and points out that the whole test took longer than I told him it would. I point out that was because of all of their questions and we all laugh.

Sitting back in my office, David and his parents wait to hear what I’ve discovered as a result of this series of tests.

“Even before doing the structural examination and a more in-depth neurological exam that I will do at our next visit, what’s obvious to me,” I begin, “is that David is a bright child who is not able to let the world know who he really is. Right now his brain and his body are working against him instead of befriending him. That constant invisible struggle is creating a lot of extra work in David’s brain.” I can see David shuffle in his seat and edge forward.

“I see why reading is an effort for David and it wouldn’t matter how much tutoring or therapy you paid for already. First, we have to correct the cause of the reading problem, the structural and neurological component. As long as those eyes and muscles are in the wrong place, there is no way he can read normally. And remembering what he reads and understanding it would be almost impossible for him. Do you appreciate why that is?”

“Reading is hard for David, not because he isn’t trying. On the contrary, his eyes, his muscles, and his brain are having to work extra hard to do something that other people who read normally find easy to do.”

I watch as David’s father reaches for his wife’s hand and squeezes it. “So what can you do for our son, Dr. Books?”

“With what I’ve seen in the last few minutes, and after twenty-five years of doing this work, I know one thing for sure. I can help David read better and faster. And when reading becomes easier, a lot of David’s other issues are going to clear up as well.”

“So, you’re telling us that David doesn’t have to be labeled as dyslexic for the rest of his life?” his mother asks as she leans forward.

“I can’t offer guarantees, but I can tell you that I have an 85 percent success rate. I’ve seen over and over that once these physical and neurological obstacles are balanced—such as getting David’s eyes to work properly and the two hemispheres of the brain

becoming synchronized—people get almost thirsty for reading and often develop an insatiable appetite for reading. The worst case scenario will be that David will be able to read and may choose to do other things with his life.”

As David and his parents get up to leave my office at the end of this preliminary session, I tell them what I tell every client who comes to see me: that I have the best job in the whole world because I get to watch people improve their lives and re-discover how magnificent they are.

### **WHAT A BOOKS NEURAL THERAPY™ SESSION LOOKS LIKE**

When you step into my office you’ll see teddy bears of all sizes and shapes. What you don’t see is the invisible detective hat I’m wearing. When children come from long distance for intensive week-long sessions, I often have the parents send me a short video of their child prior to their arrival so I can start the neurological observations in advance. In the office I often ask children to walk in front of me to the treatment room, so I can observe the way they walk.

- Does one arm swing more than the other?
- Does one foot splay out more than the other?
- Is the head centered onto the body (you won’t believe how many people literally “don’t have their heads on straight).”
- Is one hip higher than the other?
- Is one shoulder higher than the other?
- Is one ear higher than the other?

I have you stand behind me so you can see what I am noticing about your child from my vantage point. You’ll be surprised what you might not have noticed before, even though it will be obvious from this day forth. In fact, you’ll start noticing these very things in other children. And you can talk to their parents to see if their child has any of these things going on also.

David’s father, a sculptor, was astonished as he looked at the asymmetries in his son’s face, as if he really noticed them for the first time.

When your child sits down on the examination table:

- Does he look me straight in the eye?
- Do his eyes track together?
- When he opens his mouth, does his mouth form a perfectly shaped “O”?
- Is his head jutting forward, like a turtle?
- What is the texture of his skin? (“White-bread kids” have a certain pallor to their complexions. These are the kids who favor white foods such as bread, mashed potatoes, French fries, and macaroni and cheese.)
- How does he smell? That’s an odd question, but sometimes very important. (Sometimes little girls with a candida or yeast infection have a slightly “off”

smell—so bizarre when they are beautiful to look at—and this whiff of something spoiled is in the air around them.)

These observations become part of the structural and neurological exam. Behind every reading problem is something going on behind the eyes. The eyes aren't tracking, not because they don't want to, but because there is something just a little off with the bones and muscles around the eyes.

But first, let me briefly outline what I'm looking for structurally in addition to the eye tracking. The first thing I look for is whether the hips are even; then whether there is a curve in the spine. I look to see if there are any problems with the jaw, then I am interested in what's going on with the eyes. I address all of these issues with your child because they all have to do with integrating the survival system and the different parts of the brain.

In addition to laboratory testing and standardized neurological and orthopedic tests, I use a technique called "muscle monitoring" to give me a way to know what I need to address in each session and when the treatment is complete.

### **MUSCLE MONITORING**

Although there are very long and complicated scientific explanations of exactly how muscle monitoring works<sup>1</sup>, here's the simple explanation.

The body only knows how to tell the truth, and it communicates in its own language. Thankfully, there are ways of asking direct questions to which the body gives direct answers, just bypassing verbal language. Do you remember the old Indian adage, "He speaks with forked tongue," or the one that talks about someone "saying one thing out of one side of his mouth, but giving a different story out of the other side of his mouth"? Once reasoning and intellect are involved, answers can become distorted. In fact, oftentimes we don't get a truthful answer even when a person thinks that what he is saying is true. For example, I may ask little Johnny a question to which he replies, "No," but when I look over at his mother and she's nodding her head, contradicting that. Sometimes, too, patients don't always remember things, especially when there are head injuries involved, including the fact that they've even had a head injury!

Muscle monitoring is like checking an electrical outlet or circuit without a volt/ohm meter. When a tested muscle remains strong, there is no break in the continuity of the circuit. When a tested muscle goes weak, this indicates a break in the neurological circuit. In a way, muscle monitoring functions like a polygraph test. The kids call it a lie detector test.

When David was lying on the examination table I said I was going to ask him a series of questions. Rather than rely on the thinking part of his brain (the neocortex), I bypassed that sometimes unreliable response system by using one of his body's "indicator muscles" instead—typically one from an arm or a leg. What I tell the kids is that their arm or leg is going to be my printer, which will tell me the answer to the question I'm about to ask them. For the indicator muscle to be able to give me the answers I'm looking for, I have to ask binary questions, that is, ones requiring only two choices such as a yes/no, a true/false, or problem/no problem

response. The body responds to two choices only, so my questions need to be phrased with that in mind.

I must be careful to set my intention to “neutral” so that my thoughts or the clients don’t unintentionally influence the answer, and often ask the question silently. For example, I might check to find out more about Anne’s reading problems by putting my finger over one of her eyebrows while she keeps a finger from her left hand in an ear. I would ask Anne to extend her right arm. By placing our fingers on those places, I am alerting the body to a potential problem area and, in effect, asking the body if there is a problem in her vestibular-ocular system, i.e., “Does Anne currently have the potential to speed read?” If her arm is weak and drops down when I gently push on it, I’ll suspect she is a slow reader who has both to see the word and hear it at the same time, which means she cannot read fast.

We developed our orientation through the ears when we were on all fours (as crawling babies), and once we were able to stand up we instead used our eyes to orient ourselves. This sequence of orienting first and fully through the ears, and having all that circuitry wired in correctly before standing up, at which point we two-legged folks begin orienting by the eyes, is an extremely important building block for reading. If this vestibular system (ears) sequence didn’t finish properly, then the child will have to continue to use both ear and eye inputs as individual channels to be connected with each word, or else the word doesn’t make any sense. This one little glitch significantly slows down his ability to read.

When I’m using the indicator muscle, the muscle will either go weak (which means there is a problem) or stay strong (which means everything is coherent and no problem). In Anne’s case, if there is resistance as I gently push down on Anne’s arm—that is, the arm stays strong—then the developmental neurological problem has been corrected and my work is done.

The muscle monitoring part of my process is something that patients of all ages find fun, quick, and efficient, so much so that many of them ask me to teach them this method for their own personal use.

## **WHAT A BOOKS NEURAL THERAPY (BNT) SESSION LOOKS LIKE**

Now let me describe a typical session, which I’ve divided into two parts—the physical part and the emotional part. Actually, there are three parts to my work in all, the third one being the chemical part, which we address in another type of session. This categorization will help you see why this more complete and integrative approach addresses different parts of the whole problem.

### ***Physical Part***

In dyslexia, or any learning difference including ADHD, there are neurological issues under the surface that show up above the surface as a learning issue. Usually this begins as a developmental glitch that affects any development that happens “above or after” that. If you were building a house, you would first lay and set the basement. After all, there’s no sense putting down the first floor until the basement is complete. The same is true of the second floor. No sense putting it up until the

first floor is stable and complete. Our nervous system is similar to this. Unfortunately, nobody supervised from the outside how the inside of you was developing, which is how it can happen that the equivalent of an unstable basement or first floor can occur in your bones, muscles, and nervous system.

Remember before when I talked about the fact that I always dealt with the cause of a problem and not the effect? By physically addressing these neurological issues, they can actually change. Taking drugs to control something from the outside doesn't re-pattern the nervous system; it only covers up the issue. Likewise, sitting your child in front of a computer expecting the program to change the internal wiring of your child may help some kids. (My opinion on this is quite strong: if I were a child, I would much rather have face-to-face interaction that's tailored to my unique needs. I would like to feel that I mattered enough to warrant personal attention and not just placed in front of an impersonal computer doing an impersonal program.)

When I'm working with a child, and making contact with his body, he will often describe what I'm doing as massage, while adults may call it acupuncture. After I've made my assessment at each step of the Books Neural Therapy (BNT) protocol, I then apply direct contact to the area of the body/brain that is affected, either as light, sustained contact (no pressure, such as barely touching an eyelid), or maybe with slight circular rubbing or certain slow, sustained movement from right to left or vice versa.

Sometimes I use instruments. One is called the "adjustor" and it vibrates around an area to loosen the tight muscles and fascia. My younger patients call this the Woodpecker because it sounds like the old cartoon character, Woody the Woodpecker; most times they beg me to use Mr. Woodpecker!

The same begging is geared toward Mr. Happy, another massage-like instrument that looks like a fancy car polishing device. The kids named it that because it makes them smile and feel good. Many of them try to sing as I move Mr. Happy across their mid-back area, because the instrument vibrates so that their singing sounds like an old lady warbling in the church choir.

I use Mr. Woodpecker when desensitizing allergies. As mentioned in Chapter 5, when I'm addressing a particular allergen on a particular day, the child holds a vial with the allergic substance in it while I tap on various vertebra on the spine (the nerves from which go to various organs, like the liver and stomach, which are involved in allergies). The pressure is quite light, and the kids often laugh as if they are being tickled.

I bring out Mr. Happy, whose technical name is the Vibrastim, whenever there is extra tension on one side of the patient's body. My "listening hand" makes a steady contact on one area, such as a shoulder, while the instrument is placed on another area, such as the mid back. I know I'm finished with Mr. Happy when the muscles and tissue in the area of the body relax. When there has been an injury, the fascia (the gristle that attaches the muscle to the bone) is pulled tight like non-elastic scar tissue or SaranWrap, and needs to be allowed to go back to its pre-injury position in order for your body to be normal again. The first time I had this done to me, I felt such deep relaxation that I thought I'd just been in Hawaii on vacation for four days.

I mentioned that sometimes I will put my hand on a particular spot on the body and hold it there for awhile. It could be a spot on your feet, your knees, your shoulder, your torso, or your head. Sometimes I will rub the area in a small circular motion.

Let me illustrate how this works when addressing allergies. When the body senses an allergy, it goes into defense mode, as if the enemy were coming. So it suppresses the functions of certain organs, like the liver and the stomach, so no harm will come to them. The problem with that scenario is that it replays for the rest of your life. Even if you are getting shots, which merely stop the manifestation of the allergy (sneezing, etc), these shots don't ever clear up the allergy itself.

If you want to actually eliminate an allergy, it is necessary to apply the old basic biology approach of stimulus-response. You need to change the stimulus somehow if you don't want to keep getting the same response. So I have the patient hold the offending allergen while I, in effect, do this circular massage over body points on the knee or the foot, that send signals to the stomach or liver, for example. I know that sounds a bit strange that rubbing a spot on the foot could affect the messages going towards the liver. However, as I mentioned earlier, thousands of years ago, these points were recorded in medical books. The organ actually is getting new electrical input, which allows it to update its memory banks.

The way I imagine the problem, the liver gets temporarily confused. Unlike our neocortex, it doesn't question and rationalize the data, it just updates: "Oh, in relationship to corn, I no longer have to close down and defend." Now that organ is freed up and allowed to function normally even though the allergen is present. Again, this is the short version of the story here. The point is that it is possible to update and upgrade information via touch, without drugs or surgery, and make long-lasting, positive changes.

When I'm addressing the developmental sequences of your child's development —crawling, standing, walking, talking, and reading, I apply variations of light touch to various parts of the body, starting at the feet themselves and gradually progressing up the body. When I get to the head itself, I spend a lot of time very gently repositioning the bones and muscles around the eyes. Another important part deals with connecting the functions of the ear (balance, hearing, and gravity) with the eyes (taking in information visually, reading, and even speedreading)

As I said, thankfully, most children love this part of my work and refer to it as getting a massage.

### ***Emotional Work***

The emotional work around learning differences and dyslexia is huge. Here is where we move toward the middle of the three brains, the limbic or mammalian brain.

Can you recall a time when you studied for a test and it was important to you that you passed? Do you remember what was on that test? I'll bet what you remember now is not the material that you were studying, but the emotions around the test. Emotions play a big role in our learning. Those emotions can motivate us to

learn, whether from fear or joy, but the middle brain can also override what you remember from the third brain, the neocortex. Emotions can also make us forget what we know, at least temporarily. If you want to get a boxer or football player really confused on the field, shout something about his mother, and watch him lose his ability to think straight.

Emotions may creep into a session by surprise. Sometimes tears and feelings come out during sessions, and then I tap on places on the body as we neutralize those feelings and replace them with more positive choices. Let me give you some examples:

### ***Jared***

Jared came in at the age of fifteen with his mother, a school nurse who was well familiar with the part emotions can play in health and learning (how many tummy aches and headaches do you suppose she has dealt with in her position?). Jared's father, an accountant, passed away when Jared was seven. Jared's mom valiantly tried to get Jared to talk about his feelings about his deceased father, but Jared refused consistently. She sought counseling, but he refused to go. He had never really dealt with the whole issue.

One evening, after Jared's session, his mother called me to report that Jared "let loose" and was angry in the car the whole way home, yelling and screaming that his father left and how could he do that. She had waited for years for that moment. What had I done to help free up those pent-up feelings?

I was just doing my usual BNT protocol, nothing particular that should deal with the loss of his father. Furthermore, we hadn't been talking about his father or anything. What I had been working on with him that day was math. It turns out his wasn't the usual dyslexia, in that he actually had no trouble reading and writing. His diagnosis would more accurately be dyscalculia. And that day I was working on his eye tracking as he looked at numbers and performed various math calculations. His eyes worked fine for reading, but they didn't track well when he was doing math..

Remember that his father was an accountant, someone who makes his living by doing math every day? Until age seven, Jared had been doing grade-level math. After his father died, so did math apparently, until that session.

"The eyes are the windows to the soul," is the old saying, and the windows to Jared's soul and his memory of his dad were apparently "locked" or "frozen." When I could release the tension from the fascia (where the muscle attaches to the bones) around his eyes, he was somehow freed, and the stored emotions could flow freely, finally. Jared progressed rapidly after that. Years later, I spoke to his mother and she said he is doing great in all areas of his life.

That is one example how emotions can affect learning. Many is the time I have worked and worked and made good progress only to have the child go back into an emotionally-hostile/charged environment—maybe a divorce about to happen; maybe someone in the family has a serious disease; maybe there is just too much activity and no time to be seen or heard. It's hard to maintain all the progress when the emotions of others can unravel the progress the minute he walks in the door.

Often times Mom and Dad don't agree on various therapies for the child. Its

possible Dad has the same issues, and those issues were never addressed and handled when he was a kid and it is simply too painful to deal with.

### ***Harold***

Harold illustrates this point beautifully. His father heard about me from another doctor and would have flown his son to Texas where I was living. However, the twenty-one-year-old could not pass his driver's test. Dallas, for a big city, doesn't have much public transportation. I suggested instead, that his son take the bus from San Francisco to Solvang, California, where my parents lived and is like my second home. It was a small walk around the town, and I knew a place where he could stay for the week.

About the third day of my intensive five-day version of BNT, I asked him to write a letter to his father. Harold had never written a letter to his father—ever. He wrote three pages, and told me that once he started he almost couldn't stop.

Two years later, I was in California and interviewed both the son and the father.

The father admitted that he didn't really know his son; he had avoided him because he had the same issues and it was just too painful to watch. After the son's sessions with me, they were spending more time together, and bonding beautifully.

Incidentally, this son had tried to commit suicide several times, tired of being called stupid and thinking he could never learn. Within four days of our working together, he was doing simple math and reading voraciously. (His pre-arranged housing was with a former teacher who just couldn't not tutor him in basic math skills and penmanship.) Now, ten years later, the son is helping build houses in underdeveloped countries and befriending lots of children. In spite of his very severe learning disabilities, his heart got healed and he is such an asset to society.

Sometimes I don't deal with the emotions directly. Sometimes I do. When I first placed a book in Dennis' hand and asked him to read aloud to me, his face got all red and splotchy and the tears were trying to form in his eyes. When emotions are running strong like that, the emotion will win. It's hard to learn anything new while the emotion is so highly charged. In cases like Dennis's, I pull out counseling tools and sometimes use great tapping techniques such as Emotional Freedom Technique (EFT)<sup>3</sup> or Neuro Emotional Technique (NET) or Neuro Linguistic Programming (NLP). Sometimes we have to release the memories of an awful teacher who said mean things, or the grandparent who died and left them without a safe place to turn to. Again, emotion can run interference to any learning pattern.

The good news is, when your child is really motivated to learn, no matter how big the obstacle, he'll find a way to overcome it. If your child is feeling positive emotions about himself, there will be no stopping him. And if you truly believe in him and he senses that, he'll keep that fire strong inside him and persevere no matter what.

Let me quickly summarize what happens during typical Books Neural Therapy sessions:

- Your child is assessed and treated for neurological, emotional, and chemical factors that are contributing to the diagnosis of dyslexia. All parts of the brain

involved in movement and learning are addressed to build a strong foundation for good internal communication.

- Your child is treated each session in a sequential series of corrections by pre- and post-testing each portion of the protocol for the structural and neurological issues. Some emotional issues can be addressed in the office; some issues will be referred for appropriate types of counseling therapy.
- Your child's chemical needs are assessed in the beginning of care and again at periodic intervals for progress. In addition to neurotransmitter testing, heavy metal testing, allergy testing, and nutritional suggestions at these intervals, allergy desensitization and nutritional issues may be part of regular sessions.
- When your child's body finally recognizes what normal is, it wants to stay there.

Once the re-wiring and upgrading of all the foundational systems are in place, the good news is, the changes hold indefinitely. In 1996, after doing this work for ten years, I sent out questionnaires to former clients. More than 85 percent reported the changes were still holding after the initial two to three months of care.