Classic and everyday children's illnesses in practice

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PREFACE

Dear colleagues,
dear friends of Bicom resonance therapy,

I came to bioresonance therapy 18 years ago and it soon took on a leading role in my practice and is, as many of you know, the main focus of therapy alongside holistic diagnosis.

A large proportion of my patients are children and it is these I should like to talk about today for we can offer a wide range of therapeutic help in the treatment of children and can also frequently achieve beneficial results in a very short space of time.

This applies, on the one hand, to acute disorders such as ENT infections and bronchitis as well as to the classic childhood diseases such as measles, mumps, scarlet fever, etc.

Yet chronic disorders such as infectious or allergically-induced asthma, neurodermatitis, food allergies, hay fever etc. also represent a rewarding challenge for us BicOm resonance therapists.

GENERAL

"Children are not small adults!" This statement is frequently encountered in conventional medicine and, whenever I hear it, I always stop short and give it some thought. Of course they are not "small adults" yet shouldn't we take them seriously as such and treat them accordingly?

We, of all people, with our many different programs can treat children as "small adults", naturally taking account of certain provisos which I shall examine later.

In my opinion, children are far more resilient than we adults believe. This is clearly demonstrated in our therapeutic measures where children eliminate better, react quicker and produce positive results more rapidly with holistic treatment.

The problem with treating children lies in the fact that we have not only seen an increase in multifactorial stresses in adult patients in recent years but also in children and adolescents whose disorders increasingly display a tendency to relapse. This leads to chronic processes which may manifest themselves in long-term disturbed development. You only have to think of the alarming rise in ADD and ADHD.

When enquiring about the patient's history, we can frequently tick off a checklist of the basic stresses with which children come to our practices: latent susceptibility to infection, lacking in vitality, tired, poor concentration, allergic stress, they suffer from digestive disorders, lack of appetite and frequently exhibit deficiencies.

When establishing a diagnosis, we generally find a combination of food allergies and latent intolerances, infestation with intestinal fungi, often already at the chronic stage, with attendant dysbiosis together with post-vaccinal complications and inherited toxic stress, energetic blocks, etc.

Let us look at the individual types of stress in more detail, taking into account fluid transitions and the underlying factors as hidden causes.

SPECIFIC DISEASES

Children frequently go through classic childhood diseases several times; I treated a child some considerable time ago who had been proven to have had scarlet fever twelve times.

Yet apart from these chronically progressing childhood diseases, which I shall discuss later, the acute classic childhood diseases can be dealt with very satisfactorily.

If the child with scarlet fever, measles, mumps etc. is able to come to the surgery, we use the numerous programs within the meridian- and indication-related follow-up programs alongside basic therapy which it is very important to test out.

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Within the basic therapies you will frequently find the "gentle" A-inverse programs Bicom 131 and 132 or else the H+Di-programs where the amplification of the H element is below 1.0, i. e. programs 100, 122, 123 and 124.

The current symptoms are generally prominent in the follow-up programs, e. g. lymph meridian 200 or 201, lymph activation 930, increasing powers of resistance 570, virus therapy 961 and 996.

In addition, the agents causing the particular disease should be taken from the CTT (combined test technique) childhood diseases test set and oscillated over using an Ai-program, testing specifically for amplification and therapy time.

In this way you reduce the pathogenicity of the causative agent, eliminate its products of metabolism and also activate the immune system thereby preventing a possible tendency to relapse as the pathogen's sounding board is no longer present in the body.

If medication with antibiotics is unavoidable, this antibiotic is treated with program 999 or 998 and oscillated over the BicOm chip to reduce side-effects.

The extent to which the intestinal flora should be supported and stabilised with symbionts, especially lactobacilli, should be weighed up at this stage too.

You basically follow this procedure with all other infections, whether otitis media, tonsillitis, inflammation of the paranasal sinuses, bronchitis, etc.

With these diseases you should always carefully identify the pathogenic organism via the bacteria and viruses CTT test set for the reasons I have just stated with the classic childhood diseases.

Where a child suffers a particularly severe bout of infection, there is basically always the danger of retoxic stress, i. e. the disease was not fully expressed and dealt with but is a sounding board on which pathogens remain, resulting in a tendency to relapse.

Both bacterially-induced and virally-induced childhood diseases display an increased tendency to relapse. Moreover, stresses from rotaviruses, herpes viruses and Coxsackie viruses are occurring with increasing frequency as an expression of sustained immunological stress.

Chronic stress from herpes and Coxsackie virus did not exist in children when I was training over 20 years ago. This is definitely one of the most significant and worrying signs of a latently over-worked immune system.

These diseases are generally treated with the so-called "anti-agents" such as antibiotics, antipyretics, antiphlogistics, antitussives and obviously cortisone.

In individual cases this might be totally justified but, in principle, it always holds the danger of retoxic stress from bacterial or viral catabolic products and thereby increases the tendency to relapse and manifestation of the initial stress. In addition to specific intoxication and possible regulatory inhibition through these preparations themselves.

A childhood disease which has not been fully expressed automatically flows into the mesenchyma with long-term disruption of cell metabolism and especially of the metabolism of the free radicals. The immune system is robbed of the possibility of finding an appropriate immune response which can only be built up through the course of an illness.

If the worst comes to the worst, recurrent infections turn into focal toxicoses. Examples of this are inflammations of the middle ear which may end in mastoiditis with permanent dispersion of streptococci.

Consequently I consider it essential not just to treat the acute symptoms and the current causative agent of an infection or of a childhood disease. In the case of the many chronic processes with which children present in our practices, a thorough search should be undertaken for the possible hidden causes of the particular disease.

MAIN STRESSES

I should like to examine two stresses in more detail since, as "conductor paths", they both set a chronic stress in motion and sustain it long-term. These are *inoculations* and *inherited toxic stresses.*

Inoculations

If we link diseases treated retoxically with the many inoculations which always represent a disease progressing subacutely, it is understandable that here too toxic deposition occurs in the mesenchyma, as defined by humoral pathology.

Inoculations always challenge the immune system and are generally to be welcomed, provided the immunological conditions are right. One example is the BCG inoculation with bovine tuberculosis in the first few days of life where the foundations for milk allergic reactions are frequently

laid, especially if an inherited toxic stress is also present through tuberculinum.

Inoculation may represent an excessive strain with compensatory reaction by the body whereby the post-vaccinal reaction is superimposed on immunological reactions already occurring in the body, the vaccination stimulus is simply too strong with the result that here too a retoxic process takes place as defined by humoral pathology.

As a rule, a baby will be inoculated against ten infectious diseases by the end of its second year and, with repeated vaccinations, makes contact with pathogens up to 25 times in an average six vaccination sessions.

In addition to destroyed or weakened germs (e. g. 9-11 thousand million destroyed germs in the case of whooping cough), the vaccines themselves contain adjuvants such as:

- formaldehyde
- aluminium hydroxide and/or
- sodium trimer phonate p-(ethyl mercury thio)-benzyl sulphonic acid.

The source of the pathogen cultures is also significant. Pathogens for manufacturing vaccines are cultured:

- from the blood of infected animals
- in the animal itself or on animal organs
- in so-called "cell lines" or "cell series", these being cancer cells
- through genetic engineering or
- on the membranes of incubated hens' eggs.

Consequently every vaccination holds the danger of a hyperintensive reaction and of an intoxication in the sense of provoking immunodeficiency.

I should like to define two terms more precisely as they lead to a better overall understanding of post-vaccinal complications:

1. Post-vaccinal encephalitis (PVE)

The Prague pathologist Prof. Lucksch coined this phrase in 1924 and described, in a number of scientific studies, brain damage following inoculations where the children were all over the age of three.

Austrian professors Kaiser and Zappert adopted Prof. Lucksch's designation in an investigation carried out on 240 children, 237 of whom were older than three at the time of vaccination.*2. (Bland) post-vaccinal encephalopathy*

The Dutch pathologist de Vries demonstrated that, up to the age of three, a child cannot react to damage caused by inoculation with an inflammatory defensive reaction of the brain! A baby's brain merely reacts to post-vaccinal damage with cerebral oedema and unformed blood constituents escaping from the blood vessels as an expression of disruption of the blood-brain-barrier.

Unlike encephalopathy, encephalitis is an easily identifiable clinical picture. Consequently post-vaccinal damage was identified in Austria, yet not in Germany and it is becoming apparent why there were seemingly fewer post-vaccinal reactions in Germany than in Austria.

Lucksch, Kaiser and Zappert were unable to make a distinction between the above terms as, in Austria and northern Bohemia, inoculations were carried out at a much later stage than was the case in Germany.

Post-vaccinal reactions /
post-vaccinal complications /
post-vaccinal damage

As defined by the German Federal Epidemics Law, post-vaccinal damage is health damage which extends beyond the usual extent of a post-vaccinal reaction and is generally permanent. This damage must become apparent within a certain period after inoculation and is known as "standardised incubation period". An incubation period of between three days and three weeks is given for PVE and post-vaccinal encephalopathy with acute symptoms of disorientation and even unconsciousness, fever extending beyond the tenth day after inoculation, convulsive attacks either generalised or accentuated on one side, limb palsy, occasionally isolated cranial nerve palsy, in rare cases meningism.

In addition, however, developments with fewer symptoms are described, known as bland post-vaccinal encephalopathy. The symptoms here are abnormal behaviour such as drowsiness, loss of interest, refusal to eat, vomiting, arrested development with loss of previously acquired faculties, progressive cerebral organic disorders.

In 1962 Professor Herrlich pointed out that post-vaccinal encephalopathy required a certain period of illness before anatomopathological changes developed in the central nervous system and yet these were barely identifiable externally. He named the main symptoms as hypersomnia with

disrupted day-night rhythm, apathy, unmotivated shrill crying, therapy-resistant convulsive attacks.

So it becomes apparent that, in the acute stage, encephalopathy is hard to identify, yet produces delayed damage to a large extent. Late sequelae are all the more severe, the younger the child is at the time of injury. Post-vaccinal damage is not generally immediately obvious. The possibility of damage is usually only considered weeks, months or even years later as there are virtually no characteristic medical features to indicate whether the child's symptoms are the result of vaccination or not. This generally applies to all vaccinations.

Basically there is only one definite hallmark of a post-vaccinal reaction, so-called "arrested development" following inoculation. If a child has developed normally and unimpaired up to a certain time and fairly soon after an inoculation remains at a certain stage or regresses and develops abnormal behaviour, then it can be assumed that the vaccination is the cause.

It is extremely difficult to identify this in infancy where points of development are fluid and where timing cannot be precisely determined; even if it has been admitted by official quarters that post-vaccinal damage may involve few symptoms.

Typical post-vaccinal reactions here are: agitation, tendency to take fright, irritability, uncertain movements and reactions, dazed state even apathy, eating disorders, disturbed sleep, fever, cutaneous reactions, headaches, twitching limbs, convulsive attacks, etc.

French and American studies (e. g. by Dr. Abeltier, Dr. Calmar and Prof. Delore) described changes in emotional state and character in the context of post-vaccinal damage with behavioural disorders such as lack of concentration, impaired learning faculties, aggressiveness, hyperactivity, reduced inhibitory threshold and much more.

Without doubt there is an enormous spread to the effect that most children tolerate vaccinations apparently without problems and others suffer severe brain damage with debility, paralysis or epilepsy.

Syndroms connected with post-vaccinal reactions

I shall now name some syndromes which are connected with post-vaccinal reactions with striking frequency in the literature:

1. Minimal Cerebral Dysfunction (MCD)

This is a collective term for changes in small children which are difficult to diagnose and which have been described with increasing frequency since the fifties. The frequency with which medical reports are received from countries where vaccination is carried out very early and on a particularly large proportion of children, such as the USA, France, the Netherlands and Germany, is striking.

The most frequent sign of a possible case of hard to identify minimal encephalopathy in children of average intelligence and normal functional capacity is severe distractibility with inability to focus attention and exaggerated coordinated movements. If the inducement is significantly increased, the child's emotional state is frail and their staying-power minimal, particularly as regards their memory and ability to learn as they are characterised by extreme restlessness.

The symptoms also extend to delays in speech development. In Germany the number of children who learn to talk very late and have difficulties forming proper sentences is estimated at between 18 and 34 %.

In the USA the number of children with learning difficulties increased by over 30 % between 1958 and 1980. This increase is debated in connection with three decades of whooping cough vaccination as the number of children with congenital alexia rose by leaps and bounds in a staggered manner.

2. Hyperkinetic syndrome (HKS) or Psycho-organic syndrome (POS)

This describes behavioural disorders which extend beyond those so far mentioned, characterised by hyperactive and uncontrolled behaviour, increased aggressiveness, reduced inhibitory threshold and significant loss of concentration. Instead of "fidgety Phil" here we have "problem children" who are treated with methods based on educational psychology and in extreme cases are prescribed psychopharmaceuticals with all the associated risks for their later emotional behaviour and physical activity. The number of children under 12 taking psychopharmaceuticals is around 1.4 million.

3. Autism

"Autistic syndrome", first described in 1943 by the American child psychiatrist Kanner, is characterized by disrupted intellectual and speech development, extreme isolation from their surroundings and an anxious, obsessive need to maintain the status quo in their material environment (fear of change).

The condition is suspected to be a consequence of post-vaccinal encephalopathy which was not identified, especially as the cause is known as "infantile cerebral organic damage" in conventional medicine.

It was noticeable, even in Kanner's day, that autism occurred predominantly in intellectual families with comprehensive medical provision.

There is so far no indication of autism in persons who have not been vaccinated.

4. Allergic diseases

Recent decades have witnessed an increase in this group of disorders which is expected to continue further.

In addition to food allergies, allergic asthma and neurodermatitis, hay fever is above all the disease perhaps most associated with infantile inoculation.

Interestingly, the first reports of hay fever came from England, only a few years after Edward Jenner incorporated foreign protein in the human body.

Sticker (1908) and Petov (1930) were able to prove beyond doubt firstly, that hay fever occurred far more frequently among the privileged classes of town dwellers than in the rural population where pollen was more prevalent. Secondly, they described initial manifestation following revaccination beginning in the person's early twenties, i. e. following the second vaccination against smallpox conducted in accordance with the German Reich's Vaccination Law.

While at that time only two vaccinations were given (at age 2 and 12), from the sixties onwards early multiple inoculations were carried out accompanied by the parallel geographical and sociological occurrence of epidemic hay fever in infants.

Pollen may perhaps be the external cause of this syndrome yet the organism's immunological sensitivity is the more fundamental process whereby, to appreciate Louis Pasteur's epidemiology, the underlying principle should be: *"Germs are nothing — it is the territory which is important".*

If today one child in four suffers from some form of allergy, the question must be asked as to whether the process of sensitising with forei I. protein represents not just immune training but possibly also leaves behind a confused "allergic" immune system.*Immunodeficiency*

The increase in children with lowered resistance from the recurrent infections described above, childhood diseases experienced retoxically, multiple bouts of a childhood disease, otitis or tonsillitis as toxic foci and the increase in bacterial and viral resistance.

4. Diabetes mellitus

So far twelve cases of infantile diabetes have been reported in the literature connected with prophylactic inoculation against smallpox.

Professor Herrlich was the first to point out this connection in the "Handbuch der Schutzimpfungen" [Handbook of prophylactic vaccinations]. Later it was the Prenzlau diabetologist Dr. Schneider (1973 and 1975) and also Prof. Stuck 1993 in *Peidiatrische Praxis* [Paediatric practice], volume 1 with the article: "Mumpsimpfung und Auftreten eines Diabetes mellitus Typ Ia" [Mumps inoculation and the occurrence of Diabetes mellitus type la], in which he described 19 cases connected with mumps vaccination.

5. Multiple sclerosis / facial paresis / Bechterew's disease

Articles 51 and 52 of the German Federal Epidemics Act make statutory provision for a condition to be recognised as "compensable post-vaccinal damage" and a hardship clause is included for disease where evidence of probability cannot be produced as medical science is undecided as to the cause of the diagnosed condition. This so-called "authorisation" was created by the legislator, aware that certain diseases may be provoked by external influences. We talk here of a "trigger mechanism".

Since viruses, acting as "trigger mechanisms", are capable of setting the start of these diseases in motion, it is just as possible that vaccines containing viruses or viral constituents can have the same effect.

MS and facial paresis are named in the Federal Epidemics Act and it is pointed out in "Anhaltspunkten fur arztliche Gutachtertatigkeit im sozialen Entschadigungsrecht und nach dem Schwerbehindertengesetz, Ausgabe 1983 [Grounds for expert medical involvement in social compensation law and under the Severely Disabled Act, Edition 1983]" in point 139 "Assessing causality" that Bechterew's disease also falls under Art. 52, Para. 2.

In 1973 the Bavarian Social Ministry recommended in a circular to benefit offices that MS should be recognised as a consequence of the oral polio vaccination in the course of authorisation if symptoms occur within six weeks of vaccination.

In Stickl and Weber's book "Schutzimpfungen" [Prophylactic vaccination], triggering MS episodes by prophylactic polio vaccination is rated equivalent to an ordinary infection.

8. Sudden infant death (SID) syndrome (cot death)

Virtually all infectious diseases have been declining regularly and almost uniformly for decades, yet the so far unexplained phenomenon of cot death has been increasing continuously, albeit with a slight regression in the last ten years. In 1965 the Leipzig pathologist P. F. Mahnke published his study: "Plotzlicher Tod im Kindesalter und vorausgegangene Schutzimpfungen" [Sudden death in childhood and previous prophylactic vaccinations]. The Paul Ehrlich Institute (PEI) published the following statement in numerous medical journals in October 1992: "The PEI is calling for cases to be reported. Death from unknown cause in babies and infants following prophylactic vaccination. The PEI is interested to learn whether deaths of babies and infants from unknown causes have been observed in Germany in the past 12 months, especially following prophylactic vaccination."

An abundance of detailed material, particularly related to the DPT vaccine, has been available in the USA since 1948 following a study in *Pediatrics* by Byers and Moll. Following a dramatic cluster of SID syndrome connected with decades of vaccination and reports to the FDA and CDC health authorities (the latter operates a system for monitoring disease following vaccination, the MSIFI), the whooping cough component was withdrawn for the time being resulting in a marked drop in SID syndrome.

Between 1978 and 1981, Japanese researchers Dr. Sato, Dr. Kimura and Dr. Fukumi developed a whooping cough vaccine whose toxicity could be reduced by 90 % with the result that SID syndrome scarcely occurs in Japan now the vaccine has been switched. Until then, American vaccines had been used exclusively in Japan.

I should particularly like to emphasise that I am in no way opposed to vaccination in principle, yet it is important to me to make you aware that you should not necessarily carry out every single vaccination and in particular should weigh up carefully how many multiple inoculations a child can cope with in one sitting.

In my experience and following numerous discussions with BICOm therapists and therapists from all fields of medicine, it is precisely these multiple inoculations which result in long-term irritation of the immune system.

Inherited toxic stresses

These sensitise the body from birth onwards to a slow and steady increase in the functional impairment of its organs and organ systems. Their toxic action is one of the foundations for the development of chronic disorders and its effect is life-long.

It is extremely important to identify inherited toxicosis early in the first few years of a child's life. Prompt therapy of an inherited basic stress not only leads to the current symptoms being completely cured but allows the child to pass through childhood, puberty and development hoping for long-term stable health.

Samuel Hahnemann recognised inherited toxic stresses, which he called "chronic miasms", diseases imprinted through heredity or transmission which prevent recovery from other illnesses.

He distinguished between the following three miasms:

1. *Psora* (scabies) as the primitive form of latent stresses found in virtually everyone.

   Hahnemann used this to describe all forms of: deficiency, inhibition, inferiority, disability, anxiety and cold. Hannemann's principal remedy for psora was sulphur. The nosode is psorinum.

2. *Sycosis* (gonococcinum)

   Hahnemann used this to describe all forms of hypertrophy, hyperplasia, hyperkinesis, proliferation and increased productivity. Hahnemann' s principal remedy for sycosis was thuja. The nosode is medorrhinum.

3. *Syphilis*

   Hahnemann used this to describe all types of destruction and degeneration, both somatical and psychological, and he spoke of "total stasis", "indifference even anarchy". The principal remedy was mercurius, the nosode is luesMum.

At the time of his psora theory, it was already known that miasms can be combined and his successors added the symptoms of pseudopsora (tuberculinum) as a mixed form of miasms.

Tuberculinum probably represents the most common inherited toxic stress. Its clinical picture is principally mesodermal and entodermal with general weakness of the skin, mucous membranes and connective tissue.

Gonococcinum stress is found mainly on the ectodermal germ layer of the skin, on the urogenital system and on the nervous system.

Luetic stress is mainly found ectodermally, especially on the nervous system and urogenital system.

Further inherited toxic stresses are found in the form of bacterial and viral stresses, toxic stresses and especially vaccine intoxication.

On the therapy of inheritated toxicoses

The timing for treating this inherited toxicosis is crucial. Since it is one of the basic stresses and factors triggering the pathological process, you must be fully aware that whenever you tackle this situation, the body will react.

You will possibly provoke a mesenchymal toxic episode which cannot be compensated if there is insufficient eliminating capacity.

Establishing the patient in an appropriate initial psychological condition minimises the risk of uncontrolled hypersensitive reactions.

- An allergic diathesis should be stabilised according to Dr. Hennecke's therapy concept.
- The intestinal wall lymphatic system must be prepared for toxin elimination, colonised physiologically with eubionts and free from mycoses and parasites.
- Measures to support the kidneys/bladder and liver/gallbladder are essential as well as a stable eliminating capacity on the part of the skin.
- Environmental toxins or heavy metals must be treated beforehand as treating inherited toxicosis can make these very acute.
- Susceptibility to infection, especially of a viral nature, should be stabilised.
- An essential condition is that focal stresses are stabilised.

In principle, however, the younger the patient, the sooner the inherited toxic stress can be tackled. When treating children this is a very rewarding part of therapy which frequently can be used at an early stage.

All the factors mentioned previously would be quite adequate to explain a multi-factorial process if it were not for a whole series of further forerunners of immunodeficiency and allergy triggers:

- heavy metals (mercury, lead, cadmium, chromium, zinc, copper, silver, arsenic, nickel)
- insecticides and herbicides, wood preservatives, formaldehyde and pentachlorophenol
- hydrocarbons, nitrogen oxides and dioxins
- radioactive radiation, ionising radiation and electromagnetic fields

The hazards associated with each of these substances have been researched and described in numerous studies.

Nobody denies the possible damage to the haematogenic system, to the nervous system or to the deposition and storage of these substances in the connective tissue and organs. Even one individual substance can cause irreparable damage such as mercury from amalgam fillings.

Amalgam particularly remains an on-going issue as was revealed by a Scandinavian study a few years ago which proved that the more amalgam the mother has in her teeth, the higher the level of Hg new born babies display in various tissues. This alone certainly also demonstrates for other environmental toxins that mothers today have a far higher intoxication rate than did our grandmothers.

An American study shows that the lead content of the blood of one in 10 children under the age of 6 is at the limit of toxicity. This study should definitely also be applied to European industrialised nations.

Heavy metals have half-lives of up to 30 years (cadmium). These substances and all other environmental toxins are found in our drinking water in increasing concentrations each year. The fact that the EU Commission in Brussels is currently discussing a threshold limit for dioxins in drinking water should make us think.

Dioxin is the worst environmental toxin of all and only very few know that it is a collective term for 210 individual substances. Dioxin, formaldehyde and lindane immissions have already been measured inside buildings in Germany which, if measured in the external air, would have led to smog warnings.

I have observed from the large number of tests I have carried out in recent years that I often find the complete range of stresses just mentioned when examining a child for the first time.

To an increasing extent, this multi-factorial process naturally also presupposes a psychological imbalance with increased aggressiveness as expression of compensation for stress.

How do we therapists escape from this dilemma of how to treat a child with so many different stresses?

Only a rigorous diagnostic system and a therapeutic program based upon this is capable of eliminating systemic stresses and reorganising the fine-tuning mechanism of biocybemetic control loops.

THE DIAGNOSTIC SYSTEM

I proceed here in such a way that, when taking the case history, I not only take note of the chronological development of the condition but also the family's medical history and especially the mother's disorders.

Then I consider the symptoms in the light of the meridians of the 5 element theory and possibly include the effects of sources of infection and dental status. At this point the development of the 8th odontoma is important, particularly in girls. Displaced or impacted wisdom teeth may be responsible for the appearance of allergic diathesis or adrenal insufficiency.

Right at the start I ask about the diathetic situation, drinking habits, care arrangements, psychosocial environment and sleep ergonomics.

In the actual testing I work with EAV and use the combined test technique (KTT*) test sets which very quickly identify both organ stresses and underlying pathogenic stresses. Obviously you can also use kinesiology, the biotensor or the RAC test.

I test the relevant key ampoules from the test sets in an ordered manner: allergens, bacteria, viruses and mycoses, vaccinations, metals and environmental stresses.

Testing enables the primary and secondary stresses to be organised according to the number of ampoules found and at how many meridian points the individual stresses were tested.

This also enables a systematic therapy plan to be established which should follow a particular course depending on the severity and priority of the stress (which obviously varies according to the subjective clinical picture).

K'TT = Kombinierte Testtechnik = combinded test technique

THE THERAPEUTIC SYSTEM

At first therapy sessions take place weekly. However, we switch to two or three weekly intervals if the situation develops positively.

As a first step it is usually necessary to conduct an allergy program after Dr. Hennecke. Parallel to this, possible known blocks (scar interference fields, geopathy, electrosensitivity, etc.) are considered and the lymphatic and mucosal situation is stimulated with regard to the eliminating and detoxifying organs. We stimulate immune performance and begin cleaning up the tested underlying stresses in a targeted manner as soon as possible.

It is important at this point that we work our way forward step by step through the course of the disease with regard to the causes.

Here I begin with damage which occurred or was acquired last, e. g. with cleansing intestinal mycosis or else with toxic damage from medication or a recent severe bout of infection.

I test specific stress ampoules on BICOm program 191 and, in the case of severe toxic or allergic stress, on program 193 as well. If I find this equalises a large number of meridians, I first treat with program 193 and then on 191 in the next therapy session.

The procedure is the same with all the other stresses, with viruses or bacteria, with intoxications, with childhood diseases, with post-vaccinal hyperintensive reactions and finally with inherited toxic stresses.

One condition of using stress ampoules is to test amplifications and therapy times accurately.

Each therapy session always begins with a basic program which has been precisely tested out and one or two follow-up programs taking account of the organs primarily affected (meridian programs) or taking account of the symptoms or energetic blocks (indication-related programs).

At each therapy session, whether introductory therapeutic measures or targeted measures to combat primary stresses, I always run a basic program, with the H+Di-programs having proved useful with children, e. g. 100, 121, 122, 123, 124 and 132. Basic programs with an H-amplification below 1.0 are generally needed, e. g. 122.

It has also proved beneficial separating Di from H, i. e. first I test a Di-program and straight afterwards an H-program runs, e. g. first program 103 or 104 and then program 105 or 135. Shorter therapy times are usually selected for this.

Inputs and output are used as needed as part of the individual therapy sessions, i. e. with an intestinal problem an input is laid on the abdomen in addition to a ball electrode in the hand. In the output I almost always use the BICOm 2000 mat while testing for DMI (dynamic multi-impulse packets) (build up or attenuation).

Following this, the follow-up programs mentioned previously are run, followed by therapeutic provocation with the pathogenic stress which is to be eliminated. If we take as an example antibiotics as the stress ampoule in the combined test technique formulation, then I proceed via 191 or 193 and test amplification and therapy time and put this in the input cup.

It is extremely helpful here to use the BICOm chip or Bicom drops and BicOm oil, particularly with the stabilising substances of the eliminating ampoules and the five element test set. Only with extremely serious toxic stresses do I possibly also give patients toxic information to take with them via the BicOm chip or BICOm drops or Bicom oil, e. g. to eliminate amalgam.

All three can possibly be used together and it is fascinating to see how many additional drug therapies can be saved in this way.

Whether preparing a targeted therapy system or in individual targeted therapy stages, certain programs have proved particularly useful and you can also find these in your operating and therapy instructions:

1. Vitalising therapy programs

Increasing powers of resistance	Program 570
Activating zest for life	Program 900
Lack of energy	Program 580
Immunodeficiency	Program 582
Improving vital capacity	Program 422

2. Metabolic programs

Improving oxygen intake	Program 802
Acid-base balance	Program 812
Metabolic therapy after Dr. Hennecke	Program 530
Cell stimulation	Program 839

3. Programs to counter blocks

Blocks from medication	Program 847 + 941
Tissue blocks	Program 951 +915
Blocks from scars	Program 910
Blocks from adhesions	Program 927
Geopathy / electromagnetic smog / radiation	Program 700 / 701 / 702
Impaired laterality	Program 535

4. Detoxification programs (in general: note eliminating organs!)

Detoxification of mucous membranes	Program 999
Liver detoxication	Program 430
Lymph activation	Program 930
Toxin elimination	Program 970

I generally use programs 999 and 977 for *treating allergens* and programs 191, 193, 978 and 979 for *eliminating toxic stresses*, individualising amplification and therapy time now and then.

The individual stages of therapy with the *&cam combined test technique* (KTT) are organised as follows:

1. Basic therapy

The patient is connected to the input and the output of the Bicom device. The input cup may possibly also contain additional substances secreted or excreted by the patient.

2. Meridian-related and/or indication-related follow-up programs

The patient is connected to the input and the output of the Bicom device. The input cup may possibly also contain additional substances secreted or excreted by the patient.

3. Pathogenic stress

The patient is only connected to the output of the Bicom device. The input cup contains the tested ampoule of the pathogenic stress, which is to be eliminated or relieved in that day's stage of therapy (e. g. Candida or Streptococcus). It is treated with an Ai-program. Always test amplification and time!

4. Stabilisation

The patient is only connected to the output of the Bicom device. The input cup contains the stabilising ampoules of the 5 element test set. They are placed in the input cup one after the other and treated with an A-program:

- first the primarily disturbed element is treated (if necessary).
- then the primarily disturbed meridian is treated.

Always test amplification and time!

CONCLUDING REMARK

Finally I hope this encourages you to proceed quite provocatively with children in particular, observing carefully tested BICOm resonance therapy. Thank you for your attention and I wish you every success with your continuing therapy.

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