

IV. Energetic Testing Explained

Introduction

“Any sufficiently advanced technology is indistinguishable from magic.”

—Arthur C. Clarkeⁱⁱ

The term “energetic testing” is an umbrella-like term to describe various techniques that interpret the body’s various signals—muscle strength, arm and leg lengths, acupressure points and energy fields—in order to arrive at a more precise diagnosis and effective treatment. These methods have the benefit of directly testing a patient’s body in present time, as opposed to attempting to interpret often days, weeks, or months-old radiographs and laboratory tests. “In vivo”⁹³ energetic testing can greatly augment these static tests, as well as the standard diagnostic office procedures (a thorough history and exam), thereby helping the doctor or practitioner arrive at a more specific and personalized treatment.

For example, through effective energetic testing measurements, it can be determined exactly which nutritional supplements a patient needs—in what particular form and which brand, how many per day, what time of day (breakfast, lunch, dinner or between meals) and for how long. In other cases, energetic testing can help in determining important dental referrals—when it’s appropriate to remove mercury amalgam fillings, whether to replace a suspected toxic crown and when to suggest the need for cavitation surgery.

⁹³ As opposed to *in vitro* at means “within a glass or observable in a test tube,” *in vivo* means “within the living body.”

ANCIENT SYSTEMS

India's Ayurvedic medicine—over 5,000 years old, and Chinese Medicine—over 2,000 years old, can be considered to be the first recorded systems of energetic testing. Through various methods of evaluating the patient's body—pulse and tongue diagnosis, reading the eyes, lips, face, and so forth—Ayurvedic and Chinese doctors could better determine the primary cause of the patient's symptoms. These assessments would then indicate the most appropriate treatments—a change of diet, herbal medicines, breathing exercises, essential oils, massage, acupuncture and others. The Chinese, Indian Hindus, as well as the Egyptians, Persians, Medes, Etruscans, Greeks and Romans, also used the ancient science and art of dowsing to aid in their diagnosis of the ill.ⁱⁱⁱ ⁹⁴ Further, there have been countless other civilizations and indigenous tribes existing in various parts of the ancient world—including other parts of Asia and Europe, Africa, and South America—that had their own unique (but often not recorded or written) systems of divining treatments for disease.

TWENTIETH CENTURY

However, as the centuries passed, the steady rise of industrialization and scientific materialism greatly contributed to the loss of much of these traditional forms of physical examination, as medicine became more tailored to a strictly pathological model. In fact currently, the vast majority of orthopedic, neurological and physiological tests students learn in (holistic and allopathic) medical schools, when positive, are primarily indicators of serious disease *already present*—with few sensitive enough to reveal the more subtle signs indicative of future disease and dysfunction. Thus, not only does modern allopathic medicine fail individuals with the prescription of toxic medications, but it also often gives patients a false sense of security through a “clean bill of health” derived from a physical exam unable to detect anything other than present-time gross pathology. This trend is well illustrated by a warning—largely unheeded over the next century—from a physician in an article entitled, “The Sin of Treating Symptoms,” published in a 1918 edition of *The Journal of the American Medical Association*:

“The clinician must not allow the laboratory or the specialist to make his diagnosis; if so, his days of usefulness are gone. These factors are *only aids*. One cannot always delay until the pathognomonic symptom⁹⁵ appears... We

⁹⁴ Although dowsing is still not accepted as a science in America, in France, Germany, and other parts of the world it has considerable more respect. The practice of dowsing for water has been most widely propagated, as well as the most convincing to skeptics. For example, in the early twentieth century, Henry Gross, probably the most celebrated American dowser, while sitting at his kitchen table in Maine, accurately pinpointed on a map of Bermuda (where no source of water had been yet found) the exact spots where to drill to locate underground water. (Tompkins, P. and Bird, C. *The Secret Life of Plants*, p. 310) For further information on the ancient art of dowsing read Lloyd Youngblood's excellent article, “Dowsing: Ancient Art,” at www.neholistic.com/articles/0008.htm.

⁹⁵ *Pathognomonic* refers to when a sign or symptom is *so* characteristic of a disease that a diagnosis can be confidently made from this single aspect.

should, however, remember the plea to view the *whole patient* as a diagnostic problem.”^{iv} (Italic emphasis by author)

Fortunately, during the second half of the twentieth century, along with a revival in popularity and respect for systems of medicine from ancient cultures, there has also been a birth of new and extremely innovative energetic testing methods. These recently developed systems that are described in this section, with their very precise and unique testing methods, can greatly supplement the deficiencies found in modern orthodox physical examinations. And through the resulting more personalized diagnoses and more specific treatments, these newer methods can greatly help prevent the future onset of serious disease.

This new renaissance of energetic testing systems that began evolving in the middle of the twentieth century continues to this day. These systems primarily originated through the innovation and intuition of holistic medical doctors in Germany and France, and chiropractic physicians in the U.S.

ELECTROACUPUNCTURE

In 1955, the German physician Reinhold Voll originated *electroacupuncture*, a diagnostic method that combined the ancient principles of Chinese acupuncture with modern electronics.^v Voll's electroacupuncture method known as EAV (Electroacupuncture According to Voll), utilized what he termed a *Dermatron* instrument, consisting of four main components attached together in an electrical circuit: a diagnostic probe, an ohmmeter, an ampule container and a cylindrical electrode. To operate, the patient holds the cylindrical electrode while the EAV practitioner tests his/her acupuncture points (beginning and end points on the distal fingers and toes) and observes the reading of the ohmmeter (or current detector).

For example, a patient suffering from acute abdominal pain and diarrhea might have his large intestine meridian point test positive with an increased conductivity reading on the ohmmeter or current detector (over 50 using a 1 to 100 range). The EAV practitioner can then place different diagnostic ampules in the ampule container (or honeycomb) to see which ones balance the ohmmeter (to a reading of 50). For example, if the patient recently returned from a trip to Mexico or India, a homeopathic salmonella ampule may balance the ohmmeter if he has acute food poisoning. This patient's most appropriate treatment can then be ascertained through testing likely remedies in the ampule container such as *Arsenicum album 30C* or *Podyphyllum peltatum 30C*.

A few years later another German physician, Helmut Schimmel, developed a similar instrument to Voll's *Dermatron* which he called the *VEGA* tester. In contrast to Voll's technique, however, Schimmel primarily utilized only one acupressure point on the foot or hand and measured this point over and over again while challenging different diagnostic and therapeutic ampules in the ampule container. Eventually, many other electroacupuncture instruments were generated throughout the world, including the U.S., England, Hungary and Russia.^{vi}

The primary benefit of these electronic instruments—similar to all quality energetic test-

ing tools—is that they can often detect underlying pathophysiological processes that escape the more gross standard diagnostic examination and laboratory tests.

However, electroacupuncture instruments have been criticized for two major reasons:

1. The ohmmeter or current detector can be influenced by the amount of pressure the examiner applies to the diagnostic probe (or point detector). Therefore, it is imperative that electroacupuncture practitioners become skilled at applying the same amount of consistent pressure at all times on each point in order to arrive at the most objective and unbiased readings.
2. Electroacupuncture instruments induce low voltage into patients' acupressure points, as well as to the examiner who is also part of the electrical circuit of energy, throughout testing. This causes two problems:

- A. Distortion in acupressure point readings: According to Dr. Van Benschoten, an oriental medicine doctor in Southern California, *any* voltage introduced into the body over 180 millivolts causes neurological disturbance (nerves fire at around 60 millivolts), and disruption of the even-more-subtle acupuncture meridian energy flow of chi (qi).^{vii} For example, Voll's Dermatron instrument imparts 900 millivolts and Schimmel's Vegetest imparts 1500 millivolts into the patient's body. Therefore, although the patient is in no danger of being shocked by these voltages, Benschoten found that they were high enough to disrupt acupuncture meridian energy flow.

Through this electrically-induced distortion, Benschoten asserted that many of the locations of Voll's newly discovered acupuncture meridians, as well as the classic Chinese meridians for which Voll had discerned new locations, were actually in error. For example, without electrical interference, Benschoten found that the lung meridian corresponded to the same location where the ancient Chinese had determined it to be, and not on the other side of the thumb where Voll had later measured it.^{viii}

However, despite these voltage stresses and distortions, many electroacupuncture practitioners do good work. The reason for this, according to Benschoten's "working hypothesis," is that examiners override the electromagnetic disturbance patterns of the instruments by "unconsciously varying the pressure" on the diagnostic probe in order to arrive at diagnostic conclusions consistent with their intuition and their years of

clinical experience in treating patients.^{ix 96}

- B. Electromagnetic Stress Induced in the Patient and Examiner: These low electrical currents also cause mild to moderate stress in sensitive patients, as well as the examining doctor or practitioner—especially during lengthier visits. Dr. Schimmel recognized this problem, especially in the form of examiner fatigue, and tried to reduce this stress by placing magnets on the diagnostic probe or having the examiner wear a magnetic belt. However, over time these and other methods have proven quite limited in mitigating the electromagnetic stress to the nervous system, the subtle flow of acupuncture meridian chi (qi) and the energy fields of the body. And thus far, no new electroacupuncture-type devices that conform to Benschoten’s recommendations (180 millivolts of DC current or less) have been developed.

For more information on electroacupuncture, go to www.vegatest.de and click on “English” for the VegaTest, or www.biomeridian.com for information on Voll’s Dermatron instrument.

KINESIOLOGY

In 1964, a Michigan chiropractor named George Goodheart originated the technique of Applied Kinesiology (AK). This unique method of energetic testing uses the body’s muscle tone as a feedback system to assess dysfunction in patients and to determine the most appropriate treatment. For example, in the presence of a major toxin, a previously strong muscle can test quite weak. The kinesiologist can then determine the needed treatment by challenging specific remedies to see which one causes the weakened muscle to strengthen (known as a “2-point”).

Many readers may be vaguely familiar with muscle testing from observing someone demonstrating how refined sugar or other toxic foods adversely affect the body through the weakening of a previously strong muscle. Although these types of demonstrations can be quite dramatic and instructive, in actuality, kinesiology is an art and a science best utilized by trained and experienced practitioners and physicians. For example, to become a diplomate in AK a doctor must have practiced AK a minimum of three years, attended at least 300 hours of instruction given by a certified AK teacher, submitted two original papers, and passed both a written and a practical exam.⁹⁷

Goodheart and his colleagues introduced a whole host of original contributions in

⁹⁶ Thus, what electroacupuncture practitioners are often criticized for—varying the pressure on the probe, is also the primary methodology intuitive practitioners often use unconsciously to arrive at diagnoses less affected by electromagnetic distortion.

⁹⁷ For more information on becoming an AK diplomate contact ICAK at (913) 384-5336 or email them at ICAK@DCI-KansasCity.com.

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AK, including the diagnostic correlation of specific muscles to specific organs and tissues, the concept of a therapy localization (TL) and the phenomenon of a “two-point” (e.g., weak muscle going to strength with a positive challenge). Further, a multitude of new and innovative treatments have been developed in AK, including numerous specific treatments for each muscle group such as the use of neurovascular and neurolymphatic reflexes, acupuncture points, nutritional supplementation for the correlating organ, and related cranial and spinal adjustments. Due to the clinical success of these and other techniques experienced by more and more physicians, the International College of Applied Kinesiology, or ICAK, was formed in 1973 to oversee the growing field of AK and to administer examinations for doctors wishing to become diplomats in the technique.

AK has been a collaborative effort since its inception. Through the innovative contributions of Walter Schmitt, DC, David Walther, DC, David Leaf, DC, Phillip Maffetone, DC, Michael Lebowitz, DC, Sheldon Deal, DC, John Bandy, DC, Robert Blaich, DC, and many more, the field of Applied Kinesiology has grown in sophistication and numbers. Through the efforts of these leading instructors—especially over the past two decades—AK doctors are currently taught not only the principles and skills involved in accurate muscle testing, but also learn the neurological, physiological, immunological and biochemical concepts and pathways underlying the particular dysfunction or disease they are diagnosing and treating.

The uniqueness and effectiveness of AK has also inspired the development of other schools of kinesiology. In 1974, John Thie, DC, an AK diplomate who was on the original AK board of directors, founded the Touch for Health Foundation (TFH), which has taught thousands of practitioners as well as the lay public all over the world the basic principles of muscle testing. Later, a psychiatrist, John Diamond, MD, introduced another offshoot of AK—Behavioral Kinesiology (BK), which utilized muscle testing principles to help treat mental and emotional disturbances in patients. Another AK practitioner and clinical psychologist, Roger Callahan, PhD, has developed a system to address psychological issues, which is presently called Thought Field Therapy (TFT). And later in 1998, Scott Walker, DC, another long-term AK physician, introduced Neuro-Emotional Technique (NET), which had its own unique methodology and techniques to help assess and treat the emotional aspects of disease and dysfunction.

In 1978, another brilliant protégé of Goodheart’s, Alan Beardall, DC, introduced his own form of advanced muscle testing he called Clinical Kinesiology, or CK. Through extensive clinical research on hundreds of patients, Beardall expanded Goodheart’s original fifty-four muscle relationships into over 250.^x Additionally, Beardall introduced the use of specific finger positions known as hand modes to further augment the specificity of diagnosis in muscle testing. After Beardall’s untimely death in a car accident in 1987, several of his students continued to teach as well as develop new concepts and hand modes in CK including Gary Klepper, DC, Richard Holding, DO, Solihin Thom, DO, Rene Espy, DC, Nancy McBride, DC, Robert Shane and the author.

Appendix

In 1993, Dietrich Klinghardt, PhD, MD, and the author, co-developed Neural Kinesiology (NK), an offshoot of AK and CK that emphasized the primacy of the autonomic nervous system in muscle responsiveness. Klinghardt and Williams utilized many European principles in NK, including blocked regulation (disturbed homeostasis) and the specific diagnosis and treatment through neural therapy (with and without needles) of dominant foci and toxic ganglia. Additionally, the essential importance of appropriate detoxification of heavy metals and petroleum chemicals, as well as primary food allergies, was greatly emphasized in NK. Dr. Klinghardt continues to teach this style of muscle testing today through his Autonomic Response Testing method, or ART.

The primary criticism leveled at kinesiologists is that muscle testing can be too subjective. This is indeed a valid criticism because with muscle testing the doctor's or practitioner's body *is* the primary unit of instrumentation. Although this obviates electromagnetic stress coming from a machine, it is imperative that the doctor or practitioner be as clear as possible. Skillful kinesiologists are quite aware of this and detoxify their heavy metals, use petroleum-free personal care and cleaning products, have their dominant foci treated, and so forth, in order to conduct more authentic testing and have less biased results.⁹⁸ Further, like all knowledgeable and experienced energetic testers, kinesiologists recognize that their diagnostic findings must be correlated with other information, including a thorough history, physical exam, x-rays and laboratory tests.⁹⁹

⁹⁸ This concept of the doctor needing to heal him/herself was further described in the previous "Final Notes" section.

⁹⁹ This is an opportune time to revisit what was discussed in the Introduction to Chapter III—that based on each individual's unique biochemical make-up, laboratory tests are not the pillars of accuracy and objectivity in which they are often viewed. For example, through his innovative study of blood, urine and other laboratory tests, the world-renowned biochemist Roger Williams concluded that these supposedly objective tests are not at all free from error or misinterpretation. In Dr. Williams' landmark book, *Biochemical Individuality*—a must for all health practitioners, he cites the *wide* variations in individual's biochemistry that can result in erroneous conclusions by doctors who are used to interpreting laboratory tests through the lens of "average ranges" laid down by orthodox medicine. For example, Williams cites "incontrovertible" and "substantial intra-individual variation" in glucose values, alkaline phosphatase, amino acids and other factors in blood and urine tests in *healthy* individuals (pp. 57, 60–61, and 78). Additionally, he and his colleagues not only found "extremely variable" shapes, sizes, and locations of organs such as the thyroid gland (from 8 to 50 grams, some connected by an isthmus and others are not, and some thyroids are located at the base of tongue), but also a "wide variation in thyroid activity" (from 2.5 to 11.5 micrograms of protein-bound iodine in the blood, and a 10-fold variation in TSH) in *normal* individuals (pp. 90–93). Williams further noted that when these values were originally tabulated, a number of errors were made including the use of small samples (50, 20, 10, 5 or even less subjects tested), the throwing out of a substantial percentage of "abnormal" variations among healthy subjects, not repeating some tests, and failure to take into mind diurnal, lunar or seasonal variations (pp. 61–64). In his book originally published in 1956, Williams apologizes for the paucity of tests on this controversial subject. However, this lack of valid research on the variations of laboratory norms is *still* grossly inadequate as dramatically evidenced today by the current popularity of the highly profitable statin drugs that are based on the high cholesterol scare propagated by pharmaceutical companies. In fact, in contrast to the ever-lowering bar pharmaceutical companies and medical allopaths have assigned "healthy" cholesterol levels to be (currently 180), a review of the scientific literature reveals that cholesterol levels ranging up to 400 and higher have *not* been correlated to atherosclerosis or cardiovascular disease, and in fact, with *increased* longevity. (For more information on cholesterol and statin drugs see the next section, "How Scientific is Allopathic Medicine?" Further, the two articles, "The Benefits of High Cholesterol" and "The Dangers of Statin Drugs," in the Spring 2004 *Wise Traditions* journal, Volume 5, #1, have a wealth of well-documented information on this subject. Call (202) 333-HEAL or email WestonAPrice@msn.com.)

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For more information on Applied Kinesiology, contact ICAK at (913) 384-5336 or go to www.icakusa.com. For information on Clinical Kinesiology, contact Dr. Christopher Beardall at (503) 982-6925 or beardall@hotmail.com, or Robert Shane at shanebob@msn.com. For information on Touch for Health seminars contact the foundation at (888) 785-0110 or go to thie@touch4health.com. For information on Dr. Klinghardt's ART seminars, call (425) 637-9339 or go to www.neuralththerapy.com.

AURICULOMEDICINE

While electroacupuncture and kinesiology were being developed in Germany and America, Paul Nogier, MD, was simultaneously researching his own form of energetic testing in France. In 1966, this brilliant thinker who had earlier originated auriculotherapy in 1951, discovered that the radial pulse could be used to measure the state of health, or lack of it, through the body's electromagnetic field. He named this method *Auriculomedicine* since he noticed changes in the radial (wrist) pulse or "vascular signal"—an intrinsic aspect of the technique—while stimulating the ear.^{xi 100}

In Auriculomedicine, the examiner challenges the patient's electromagnetic field (EMF) by waving a special three-phase filter (red, blue and green Wratten color gels) beside the patient's ear where the body's EMF is most apparent, while simultaneously monitoring the radial pulse (or *Vascular Autonomic Signal*, or VAS). A toxic challenge causes the EMF—which normally closely surrounds the body in an energetic protective manner (as measured by esoteric healers as well as through Kirlian photography)—to move out several feet. However, when an appropriate remedy is then challenged, the EMF will return to a healthy and protective position in close proximity to the body's surface (less than approximately three to four millimeters away.)

During Dr. Nogier's life as well as after his death (1908-1996), Auriculomedicine continued to be expanded and further refined. The most important contributors to this method include Raphaël Nogier, MD and Rene Bourdiol, MD in France; Frank Bahr, MD in Germany; and Mikhael Adams, ND in Canada. For more information on Auriculomedicine in North America contact Dr. Adams at (905) 878-9994, Dr. Bryan Frank at www.auriculartherapy.com, Dr. Nader Soliman at www.alternativemedicine-seminars.com, or the Auriculotherapy Certification Institute (ACI) at www.auriculotherapy.com. In Europe, contact Dr. Frank Bahr at www.akupunktur-arzt.de/dr.bahr or Dr. Beate Strittmatter at www.akupunktur-arzt.de/dr.strittmatter.

¹⁰⁰ *Auriculomedicine* is a diagnostic testing method while *auriculotherapy* is a treatment method. Nogier, himself, underlined the fact that these two techniques are "totally different" and should not be confused with each other because of the similar-sounding names. (Nogier, P. *From Auriculotherapy to Auriculomedicine*, p. 67)

ARM AND LEG LENGTH MEASUREMENTS

For over a century, chiropractic physicians have utilized the measurement of the legs—for example, a patient presenting with a short right or left leg¹⁰¹—as an indicator of the presence of spinal subluxations (misalignments). Many specialized methods have been developed to assess this very apparent signal of an osseous misalignment, most notably DNFT and SOT.¹⁰² In the 1970s, Dr. Alan Beardall included the arm length measurement—for example, a patient presenting with a short right or left arm—as another indicator of dysfunction in the body.

Later, in the early 1990's, an Austrian osteopathic physician and renowned cranio-path, Raphael van Assche, originated a variation of the arm length test he termed the Armlength Reflex (AR) test, also referred to as the Reflex Arm Length (RAL) test. Dr. van Assche, a student of Beardall's, was further inspired by the osteopathic research of Gordon Zink, DO, who taught that the difference in muscle tone on the right and left sides of the body is regulated through the corpus callosum (the structure that separates the two hemispheres in the brain) and is compensated primarily by various fascial (soft tissue) patterns in the region of the chest. Through his clinical research, van Assche discovered that the AR test could measure this abnormal fascial disturbance initiated and regulated through the central nervous system (brain and spinal cord). Further, by monitoring the change in arm length to various challenges—similar to a weak muscle going strong in kinesiology—the AR examiner can determine more accurate diagnoses as well as more specific treatments. The AR test has the benefit of being easier to learn and also slightly more sensitive than kinesiology testing. Further, since no electrical apparatus are needed it is electromagnetic stress-free.

In 1998, the author introduced the Arm Measurement-Field Measurement (AM-FM) technique. This method was inspired by van Assche's AR test and the assessment of the body's electromagnetic field (EMF) originated by Nogier. However, in the AM-FM method, the "FM" or EMF is determined through a therapy localization of the ulnar bone, as a microrepresentation of the body's energy field. Further, the "AM" aspect of the test recognizes that there *is* a difference in a right versus a left short arm response, based on the six-channel adaptation patterns used in Chinese Medicine.¹⁰³ The AM-FM technique also includes the use of Dr. Beardall's (and others') hand modes for further

¹⁰¹ Ninety-eight percent of the time the patient's leg length is not permanently short (except in the case of previous multiple leg fractures, surgical implants, congenital defects, and so forth), but simply temporarily appearing as short on one side as the result of a compensatory pelvic torque. This pelvic compensation is typically secondary to all the concepts described in this book—a major focus, toxic metals and chemicals, dysbiosis, food allergy, and so forth.

¹⁰² DNFT, or Directional Non-Force Technique, was originated and taught by Richard Van Rumpft, D.C. SOT, or Sacro Occipital Technic, was originated and taught by Major Bertrand DeJarnette, D.C.

¹⁰³ Short arm and leg length patterns (e.g., a short right leg and a short left arm) were originally correlated to specific six-channel adaptation patterns by Dr. Alan Beardall. In the AM-FM method, these patterns are used to determine the underlying adaptation—that is, why the pelvis (short leg) and shoulder girdle (short arm) had to compensate and malalign (twist or torque). It has been found over the years through extensive clinical research that *any* dysfunction in the body—a congested liver, a tonsil focus or a toxic celiac ganglion—can cause the (less vital to survival) structure to adapt which then initiates a compensatory uneven arm and leg length pattern.

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specificity in diagnosis and emphasizes several “sine qua non” therapies described in *Radical Medicine*, including auriculotherapy and neural therapy in the treatment of chronic foci, their disturbed fields and toxic ganglia; the appropriate removal and detoxification of amalgam fillings and petroleum chemicals; constitutional homeopathy according to the Sankaran System; and the use of Belgium drainage remedies.

For more information on the AR test, go to www.wso.at or contact Dr. van Assche at raphael.van.assche@wso.at. For more information on the AM-FM method, go to www.iamfm.org, or contact the author at (415) 460-1968 or email her at info@iamfm.org.

CONCLUSION

Energetic testing is just that—the testing of the energetic influence of a suspected diagnostic or therapeutic challenge, and the subsequent reading (positive or negative response) of the body’s various signals (acupoints, muscle tone, pulse, electromagnetic field, and arm and leg lengths) to that challenge. Experienced physicians and practitioners are aware that no human endeavor is perfect, and therefore realize that although energetic testing methods are not absolutely foolproof, they are an extremely valuable tool to help assess actual or potential disease and determine appropriate treatment. Knowledgeable practitioners also incorporate in their decision making process the data from laboratory tests and x-rays, the information from a thorough history and exam, and their years of clinical experience.

Since most of these methods just recently emerged during the mid-twentieth century, the renaissance period of the development of energetic testing is still in full bloom, and there is much work and further research to do. Further, although physicians and practitioners in different schools may argue about specific methodology and various techniques, they all agree about the primary principle underlying energetic testing: That “in vivo” communication with the body’s innate wisdom through the accurate interpretation of its signals can greatly augment more precise and specific diagnoses, as well as the most appropriate and effective treatments.