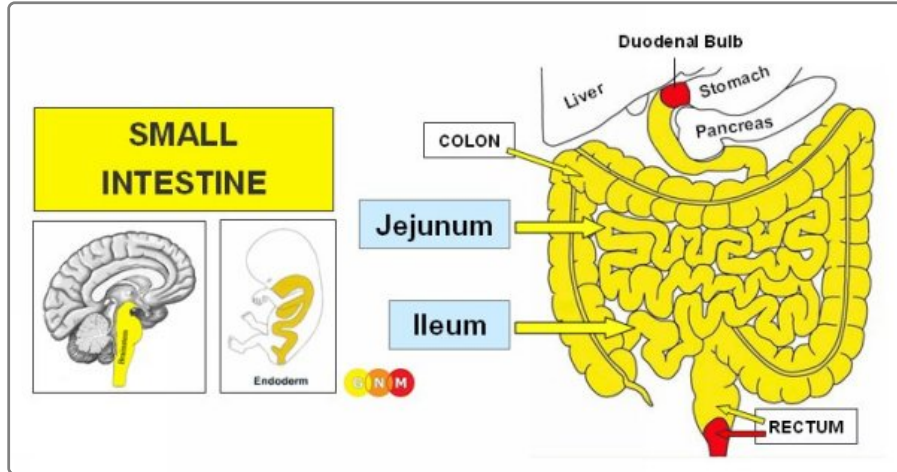
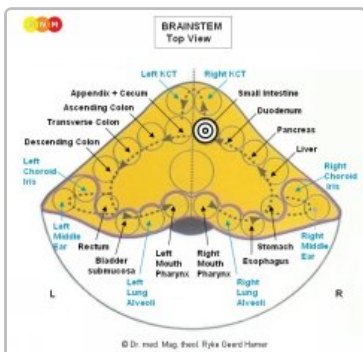


INTESTINES



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE SMALL INTESTINE: The small intestine is the portion of the gastrointestinal tract that connects the **stomach** with the **colon**. Following the **duodenum**, the **jejunum** is the upper part of the small intestine; the **ileum** is the final part that joins with the large intestine. The jejunum and ileum are the sections of the digestive tract where most of the absorption of nutrients (**resorptive quality**) takes place. The small intestine consists of **intestinal cylinder epithelium**, originates from the **endoderm** and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the small intestine (jejunum and ileum) is orderly positioned within the **ring form** of the brain relays that control the organs of the **alimentary canal**, precisely, between the **duodenum** and the **cecum** relays.

NOTE: The transition between the right and left brainstem hemisphere corresponds on the organ level to the ileo-cecal valve, positioned between the small intestine and the **cecum**, the first section of the **colon**.

BIOLOGICAL CONFLICT: According to its function, the **biological conflict** linked to the small intestine is “**not being able to absorb or digest a morsel**” (see also **stomach**, **duodenum**, **colon**, and **pancreas gland**). The conflict is experienced as **anger**, for instance, anger about a person (a family member, friend, neighbor, colleague, employee, supervisor, client, teacher, student, classmate, coach, doctor, authorities), about a situation (work-related anger, school-related anger, relationship-related anger), or about remarks (accusations, insults, criticism) or news that are “hard to take” or difficult to “digest”.

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

CONFLICT-ACTIVE PHASE: Starting with the **DHS**, during the **conflict-active phase** intestinal cells proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to be better able to absorb and digest the morsel. With prolonged conflict activity a flat growth (**resorptive type**) develops in the small intestine. At the distal end of the ileum, which has a thinner wall than the jejunum, the growth can also take a cauliflower-shaped form (**secretory type**). This could lead to a bowel obstruction or so-called **ileus**. In conventional medicine, the thickening of the intestinal wall might be diagnosed as a cancer (**jejunal cancer** or **ileal cancer**).

HEALING PHASE: Following the **conflict resolution (CL)**, **fungi** or **mycobacteria** such as TB bacteria remove the cells

that are no longer needed. **Healing symptoms** are **diarrhea** and **vomiting**, if the jejunum (upper part of the small intestine) is involved, and **night sweats**. **Abdominal cramps** (motor quality) occur particularly during the **Epileptoid Crisis** (see also **intestinal colic**). The participation of fungi during the healing process manifests as **intestinal candidiasis**. The extent of the symptoms is determined by the degree of the conflict-active phase.

NOTE: Eating disagreeable food also causes diarrhea. However, if bad food can be excluded as the source, diarrhea is a positive sign that the "indigestible morsel conflict" has been resolved and that the "morsel" is being eliminated - even without the assistance of microbes (sensory and excretory quality of the intestines).



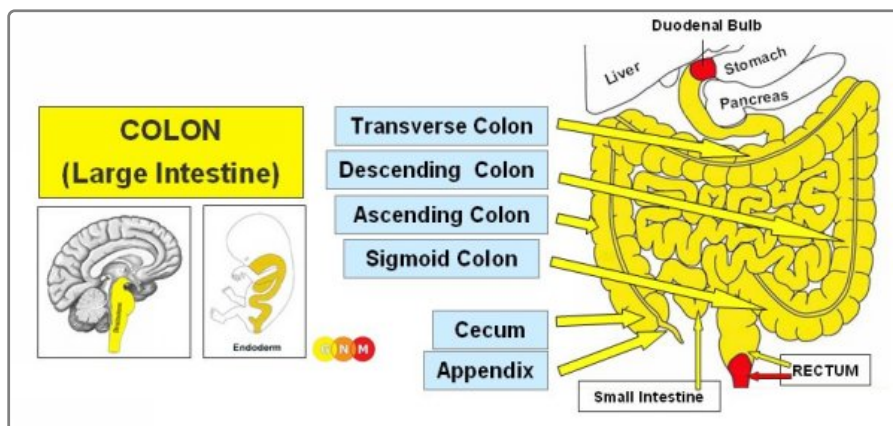
Drinking contaminated water can lead to severe diarrhea with acute, potentially life-threatening bleeding. This typically occurs in regions such as in Africa where people don't have access to clean water. Blaming an **Ebola virus** for the condition is a medical construct without any scientific basis ("... the world is exposed to horror scenarios about Ebola. These shocking media reports overlook the fact that the existence and pathogenic effects of all these allegedly contagious and even fatal viruses have never been proven.", *Virus Mania*, p. 25)

Note that in this "Ebola Virus Alert" picture, the face of the "Ebola victim" is marked with **smallpox**, which is entirely unrelated to Ebola. According to the **Center of Disease Control**, "Ebola symptoms" are: diarrhea, vomiting, abdominal pain, fever, and severe headaches.

Crohn's Disease is the healing phase of an "indigestible morsel conflict". **Ileocolitis**, affecting the final section of the small intestine, is the most common type of Crohn's. **Symptoms** are persistent **diarrhea with the elimination of mucus**, usually with **blood** (tarry stool), **abdominal pain**, and an **inflammation** of the bowel. A chronic condition indicates that **conflict relapses** prolong the healing process (**hanging healing**). Characteristic for **recurring Crohn's** are flairs-ups that occur every time the person sets on a **track** with condition-free periods in between.

Food allergies with recurring diarrhea reveal that an "indigestible anger" related to a particular food (milk, nuts, wheat, sea food, a certain fruit or vegetable) has not been completely resolved. **Multiple food allergies** indicate that several foods, including food elements (sugar, salt, lactose), are stored in the subconscious as **tracks** linked to the original **DHS**. Any food that is believed to be the probable source of the "allergy" constitutes a new "indigestible morsel" and is added to the list of **conflict tracks**. People who are always concerned about eating something "toxic" or "wrong" are therefore more prone to develop multiple food allergies. In case of **celiac disease** gluten, found in wheat and related grains, is associated with an "indigestible morsel conflict". The repetitive contact with the wheat ("allergen") leads eventually to an inflammation in the small intestine. A gluten-free diet, the standard recommended treatment, translates into staying away from the gluten-track without addressing the real cause.

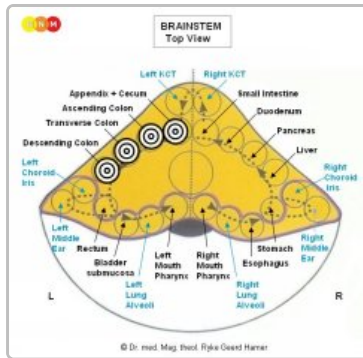
NOTE: In conventional medicine, certain foods are thought to be triggers for an anaphylactic shock. Anaphylaxis is said to be an **immune system** response to an allergen, including nuts, shellfish, or dairy products. From the GNM point of view, the symptoms are evoked by a **conflict relapse** ("allergy"), for example, of a **territorial fear** (breathing difficulties), a "morsel conflict" (swelling of the tongue), or a **separation conflict** (hives, fainting) by setting on a **conflict track**. It is quite possible that a strong conflict relapse leads to complications. A true anaphylactic shock with a quick drop of blood pressure, a loss of consciousness resulting potentially in death is caused by an over-exposure to chemicals such as drugs (morphine, aspirin, and others), X-ray dye, contrast substances, venoms, and other poisons.



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE COLON: Following the **small intestine**, the colon is the last portion of the gastro-intestinal tract. The colon is divided into several structural parts. The first section of the large intestine is the **cecum with the appendix**, a pouch-like blind-ended tube attached to the **ascending colon**. The **transverse colon**

extends from the right to the left side of the body, where it joins the **descending colon**. The **sigmoid colon** is the final section of the large intestine. Originally the entire intestinal canal served the absorption (**resorptive quality**) and digestion (**secretory quality**) of food. Today, the colon only secretes mucus and is the part of the intestinal tract where waste material from food is processed into feces and carried to the **rectum**, from where it is eliminated. The colon consists of **intestinal cylinder epithelium**, originates from the **endoderm** and is therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the colon has four control centers that are orderly positioned within the **ring form** of the brain relays that control the organs of the **alimentary canal**, precisely, between the **small intestine** and the **rectum** relays.

The control centers of the colon are located on the left side of the brainstem beginning with the brain relay of the cecum with the appendix, continuing counter-clockwise with the control centers of the ascending colon, transverse colon, and descending colon. On the organ level, the **small intestine** and the colon are separated by the ileo-cecal valve, marked on the brain level as the transition from the right to the left brainstem hemisphere.

BIOLOGICAL CONFLICT: The **biological conflict** linked to the colon (except the **sigmoid colon**) is an **"indigestible morsel conflict"** (see also **stomach**, **duodenum**, **small intestine**, and **pancreas gland**). For animals an indigestible morsel is a real piece of food; for humans it can also be a figurative "morsel", for example, a car, a house, or a valuable object. We might also perceive certain circumstances or an unpleasant event as a "morsel" and suffer the conflict when the situation is considered as "indigestible" or "non-absorbable", let's say, when an anticipated purchase, promotion, or promise cannot be "taken in". The distinctive aspect of the morsel conflict corresponding to the colon, including the appendix and the cecum, is that the **conflict is experienced as particularly "ugly"**, for instance, ugly fights over money or over a property, ugly divorces, ugly court cases, or ugly betrayals.

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

CONFLICT-ACTIVE PHASE: Starting with the **DHS**, during the **conflict-active phase** cells in the large intestine proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to facilitate the digestion of the morsel. Even though the colon has no longer a digestive function, in the event of a **biological conflict**, the large intestine still responds with cell augmentation because originally the entire intestinal canal served the digestion of food. With prolonged conflict activity (**hanging conflict**) a tumor or **colon cancer** develops as a result of the continuing cell augmentation. The tumor grows either on a flat plane (**resorptive type**) or takes a cauliflower-shaped form (**secretory type**). If the rate of cell division exceeds a certain limit, conventional medicine considers the cancer as **"malignant"**; below that limit the growth is regarded as **"benign"** or diagnosed as an **intestinal polyp** (see also healing phase). There are no symptoms during the conflict-active phase. However, a large tumor causes a narrowing of the colon (with "pencil stool"), which might lead to an obstruction of the bowel requiring **surgery**.

HEALING PHASE: Following the **conflict resolution (CL)**, **fungi or mycobacteria** such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **diarrhea (excretory quality)**, **blood in the stool** (tarry bowel movements), **abdominal cramps (motor quality)**, particularly during the **Epileptoid Crisis** (see **intestinal colic**), and **night sweats**. An **"intestinal yeast overgrowth"** indicates that fungi assist the restoration process. Depending on the degree of the conflict-active phase, the symptoms range from mild to severe.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of **antibiotics**, the additional cells remain. Eventually, the growth becomes encapsulated. In conventional medicine, this is most likely diagnosed as an **intestinal polyp** or a **"benign cancer"** (see also conflict-active phase).



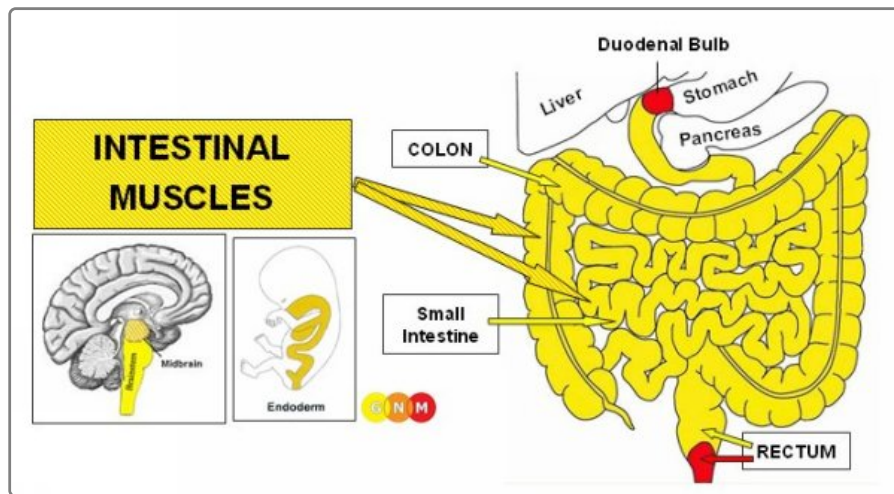
On this CT scan we see the impact of an **"indigestible morsel conflict"** in the colon relay on the left side of the brainstem (yellow arrows - view the GNM diagram). The **brain edema** (hypodense, showing as dark) indicates that the person is in **PCL-A**. There is an additional edema (fluid accumulation) in the **liver relay** (small yellow arrow), which reveals that a **starvation conflict** has also been resolved. A starvation conflict is often triggered by a colon cancer diagnoses associated with not getting food through the intestine, that is, to "starve". This is why **liver cancer** is the most frequent secondary cancer following colon cancer. It has nothing to do with a **"metastasizing cancer cells"**.

With the **SYNDROME** due to an active **abandonment and existence conflict** involving the **kidney collecting tubules** the **retained water** is exceedingly stored in the healing area. The enlarged swelling could obstruct the colon; in the appendix, an occlusion might already occur during the **conflict-active phase**. It is during the healing phase that the appendix becomes inflamed causing **appendicitis**. A rupture of the appendix happens when the **Epileptoid Crisis** is intense.

Colitis is an inflammation of the bowel with **abdominal pain**, **flatulence** and **diarrhea**, potentially with blood in the

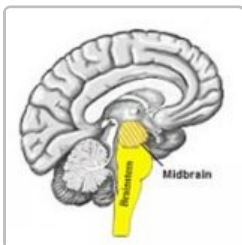
stool. Like **Crohn's Disease**, colitis ulcerosa develops after the **conflict resolution (CL)**. Persistent symptoms point to **conflict relapses** that interrupt and therefore prolong healing (**hanging healing**). What is known as **"Irritable Bowel Syndrome"** (IBS) is also a sign that an **"indigestible morsel conflict"** has been resolved. Compared with colitis, the symptoms are less intense.

Diverticulitis is the result of extended healing in the intestine. Because of the continuous cell removal process, the intestinal wall becomes thin leading to the formation of pouches (diverticula) on the outside of the colon. Diverticulitis is the condition when such a pouch becomes inflamed due to **conflict relapses**.



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

DEVELOPMENT AND FUNCTION OF THE INTESTINAL MUSCLES: The wall of the **small intestine** and the **colon** consists of **smooth muscles**. The longitudinal muscles regulate the muscle contraction while the transverse muscles regulate their relaxation. The alternating rhythm of contraction and relaxation causes the peristaltic motion (**motor quality**) that moves the "food morsel" along the intestinal canal (see also **heart muscle**/"blood morsel"; **pupil muscles**/"light morsel"). The smooth muscles of the intestine originate from the **endoderm** and are controlled from the **midbrain**.



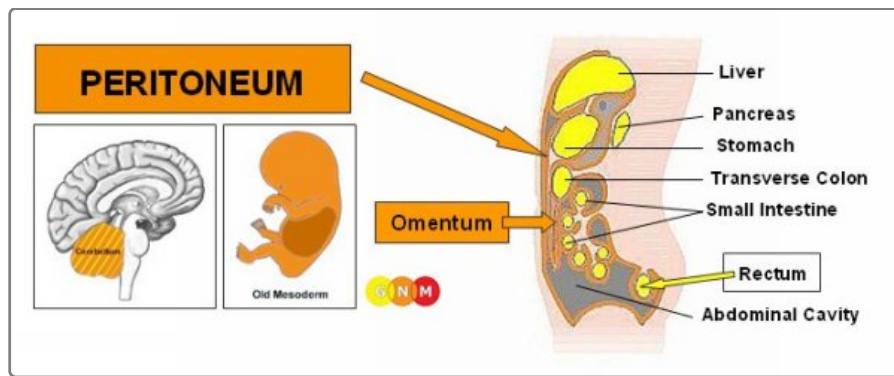
BRAIN LEVEL: The intestinal muscles are controlled from the **midbrain**, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The **biological conflict** linked to the intestinal muscles is **"not being able to pass an indigestible morsel"**. This relates to a "morsel" in real or figurative terms.

CONFLICT-ACTIVE PHASE: local tonic muscle contraction (hypertonus). The muscle spasms, or **local colic**, serve the **biological purpose** to push the morsel further with greater force. During this period the peristalsis in the other parts of the intestine slows down causing **constipation** and **abdominal bloating** due to the expansion of the intestinal muscles (see also **constipation** related to an **abandonment and existence conflict** involving the **kidney collecting tubules**). Very slow peristalsis in the small intestine is usually diagnosed as a "paralytic ileus" or bowel obstruction. **Dr. Hamer:** "This is incorrect, because there is no such thing as a "paralysis" of the smooth muscles, except caused by the toxicity of medication such as **morphine**". **NOTE:** Constipation can occur during any given conflict-active phase, since in **sympathicotonia** digestion slows down.

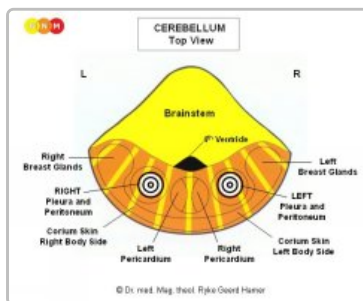
HEALING PHASE: clonic cramps (hyperperistalsis) of the entire intestine (intestinal colic) and increased **local tonic cramps** with **flatulence** during the **Epileptoid Crisis**. If abdominal cramps (**motor quality**) are followed by **diarrhea** (**sensory quality**) this indicates that the **Biological Special Programs** of the **intestinal mucosa** and of the smooth intestinal muscles run concurrently (digesting and passing the "indigestible morsel").

NOTE: When **striated muscles**, for example of the **skeletal muscles**, go through the **Epileptoid Crisis**, the tonic and clonic cramps occur together.



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE PERITONEUM: The peritoneum consists of a two-layered serous membrane. The parietal peritoneum lines the abdominal cavity whereas the visceral peritoneum (including the retroperitoneum) covers the individual organs such as the liver, spleen, pancreas, stomach, duodenum, small intestine, colon with the omentum, the upper part of the rectum, kidneys, bladder as well as the uterus, ovaries, and testicles (tunica vaginalis testis). The peritoneal cavity between the two peritoneal layers is filled with fluid that lubricates the peritoneal surfaces. In evolutionary terms, the peritoneum developed together with the pleura, the pericardium, and the corium skin. The peritoneum originates from the old mesoderm and is therefore controlled from the cerebellum.



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

NOTE: The peritoneum and pleura share the same brain relays, because originally the peritoneal and pleural membrane was one complex, which was later divided by the diaphragm that separates the chest and the abdominal cavity.

BIOLOGICAL CONFLICT: The biological conflict linked to the peritoneum is an attack conflict, specifically, an **attack against the abdomen** (see also attack conflicts related to the pleura, peritoneum, and corium skin).

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

An attack against the abdomen is experienced, for instance, through an attack by an animal or through a kick, punch, or stab into the stomach or belly during a fight; the same applies to attacks from behind against the kidneys. "Sharp" words or threats ("I'll kill you!") directed at someone can also be registered as an attack, affecting the retroperitoneal space if the verbal insult is perceived as a "stab in the back". However, surgery in the abdominal area (cesarean, hysterectomy, removal of a tumor, kidney or liver transplant), the fear of an operation (picturing "being cut open"), invasive wound pumps, peritoneal dialysis tubing (insertion of a catheter in the abdominal wall to filter the blood), or biopsies and punctures of the abdomen, including amniotic fluid tests where the uterus, the sac that surrounds the fetus, is punctured, also trigger the conflict. The diagnosis of a colon cancer, ovarian cancer, or liver cirrhosis can be perceived as an "attack" concerning the integrity of the organ. Attack conflicts also originate from inside, for instance, through acute abdominal pain (stomach ache, intestinal colic, menstrual pain) or pain during intercourse.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase peritoneal cells proliferate proportionally to the intensity of the conflict. The biological purpose of the cell increase is to create an internal reinforcement to protect the abdomen against further attacks. With prolonged conflict activity (hanging conflict) a bulb-shaped growth forms at the site; cell augmentation on a flat plane usually occurs when the attack conflict was more of a general nature. In conventional medicine, the thickening of the peritoneum is diagnosed as a (retro)peritoneal mesothelioma (see also omental mesothelioma, pleural mesothelioma, pericardial mesothelioma, and testicular mesothelioma). If the rate of cell division exceeds a certain limit, then the cancer is considered "malignant".

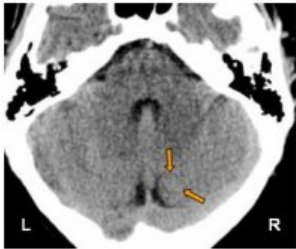
NOTE: Whether the mesothelioma occurs on the right or left side of the peritoneum is determined by a person's handedness and whether the conflict is mother/child or partner-related. A localized conflict affects the area that is associated with the "attack".

HEALING PHASE: Following the conflict resolution (CL), fungi, TB bacteria or other bacteria remove the cells that are no longer needed. Healing symptoms are abdominal pain and night sweats. With an inflammation the condition is called peritonitis. After the additional cells have been decomposed, caverns remain at the site. Over time, these caverns are filled with calcium showing on an X-ray as calcium deposits.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed

through an overuse of **antibiotics**, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. Now, conventional medicine regards the cancer as “**benign**”.

During the **healing phase** (in **PCL-A**) the fluid in the peritoneum is naturally absorbed by the peritoneal membrane (**dry peritonitis**). **Water retention**, however, due to the **SYNDROME** increases the accumulation of fluid (**wet peritonitis**) causing acute pain. If bacteria assist healing, the fluid contains pus (**purulent peritonitis**, tuberculous peritonitis). Since the peritoneum is not divided into a right and left part, the **exudative peritoneal effusion** (buildup of excessive fluid) develops in the entire peritoneum (compare with **pleural effusion** and **pericardial effusion**). Only the location of the **Hamer Focus** in the brain reveals on which side of the abdomen the attack was perceived and therefore from which brain hemisphere the **Biological Special Program** is directed and controlled.



This CT scan shows a **Hamer Focus** in the brain relay for the left half of the peritoneum (view the **GNM diagram**) corresponding to an **attack conflict**.

Concurrent **water retention** as a result of an active **abandonment and existence conflict** presents as an **abdominal ascites**. If a person is overweight the ascites might not be noticed.



With an intense **existence conflict**, often activated by a diagnosis shock, hospitalization, or after surgery in the abdominal area, an ascites can become quite large. Hence, **if someone has cancer** such as a **liver cancer**, **pancreas cancer**, **colon cancer**, **ovarian cancer**, **uterus cancer**, or a **peritoneal mesothelioma** an ascites always reveals a state of fear.

In people with **liver cirrhosis**, standard medicine attributes the fluid accumulation in the peritoneum to high blood pressure in the portal vein of the liver. From a **GNM** point of view, the ascites rather reveals recurring **territorial anger conflicts** affecting the **bile ducts** and ongoing **abandonment and existence conflicts**.

Peritoneal fluid is rich in protein. Thus, draining the excessive fluid could lead to serious complications since the body tries to replenish the protein shortage by withdrawing it from the organs, which causes rapid weight loss. **Dr. Hamer** therefore advises not to drain more than 1.5 liters at a time in order to prevent an acute protein deficiency. Moreover, puncturing the peritoneum triggers often new **attack conflicts** and **conflict relapses** with each procedure, throwing the person into a vicious cycle. **Dr. Hamer** recommends staying away from a puncture all together and to use instead a small balloon catheter that allows patients to regulate the drainage of the ascites themselves.

NOTE: Fluid also enters the peritoneum when **bones** such as **spinal vertebrae** adjacent to the abdomen are in healing; in this case because of a **self-devaluation conflict** brought on, for example, by a **colon cancer**, **liver cancer**, or **ovarian cancer** diagnosis, or a hysterectomy. The large edema, usually caused by **water retention** due to the **SYNDROME**, “sweats” through the **periosteum** into the peritoneum creating what is called a **transudative peritoneal effusion** (which does not contain protein!). The opening of a para-anal fistula (see **Douglas fistula**) also creates a direct outlet for an ascites.

The **GREAT OMENTUM (epiploon)** is a double peritoneal fold that hangs like an apron over the intestine giving the abdomen further protection. The lubricated surface of the membrane (**secretory quality**) provides the omentum with a special motility.

BIOLOGICAL CONFLICT: an **ugly belly conflict**, experienced as acute distress in relation to the abdomen. **Liver cirrhosis**, a **colon cancer** or **ovarian cancer** diagnosis could evoke the conflict.

“Cancer researchers have wondered why ovarian cancer cells are so attracted to the abdominal cavity, especially the omentum.”

Medical News Today, July 18, 2013

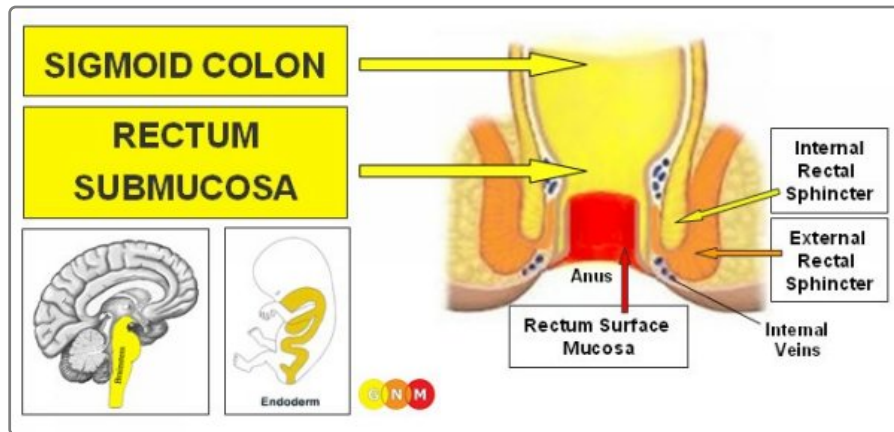
CONFLICT-ACTIVE PHASE: Starting with the **DHS**, during the **conflict-active phase** cells in the omentum proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to enhance the secretion of lubricating fluid to improve the motility of the omentum. This also allows to envelop inflammatory sites (**cold abscesses**) or to seal a **perforated appendix**, preventing intestinal content from leaking into the abdomen. With ongoing conflict activity (**hanging conflict**) a cauliflower-shaped growth (**secretory type**) forms as a result of the continuing cell augmentation. In conventional medicine, this is diagnosed as an **omental mesothelioma** (see also **peritoneal mesothelioma**, **pleural mesothelioma**, **pericardial mesothelioma**, and **testicular mesothelioma**). If the rate of

cell division exceeds a certain limit, then the cancer is considered "malignant".

HEALING PHASE: Following the **conflict resolution (CL)**, **fungi**, **TB bacteria** or other **bacteria** remove the cells that are no longer needed. Adhesions occur as a result of a prolonged healing process (**hanging healing**).

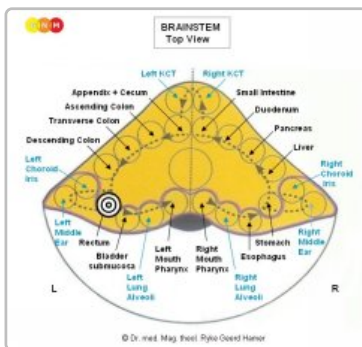
If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of **antibiotics**, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. In this case, the "cancer" is interpreted as "benign".

RECTUM



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE SIGMOID COLON AND RECTUM SUBMUCOSA: The sigmoid colon is the final portion of the **large intestine** joining the rectum. The rectum connects with the anus, the opening where waste matter in form of stool passes out of the body. To facilitate the expulsion of fecal matter, the **rectal sphincters** relax to allow feces to exit the intestinal canal. The sigmoid colon and rectal submucosa consist of **intestinal cylinder epithelium**, originate from the **endoderm** and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the control center of the sigmoid colon and rectum submucosa is orderly positioned within the **ring form** of the brain relays that control the organs of the **alimentary canal**, precisely, on left brainstem hemisphere following the control center of the descending **colon**.

BIOLOGICAL CONFLICT: The **biological conflict** linked to the sigmoid colon and rectum submucosa is a "**feces conflict**". The conflict is either about a real "feces"-**morsel** (human feces or animal poo) or is experienced in a figurative sense triggered, for example, by dirty business, malicious slander, mean accusations, in short, by a "shitty" incident (compare with feces conflict related to the **para-anal ducts** and the **sigmoid/colon muscles**).

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

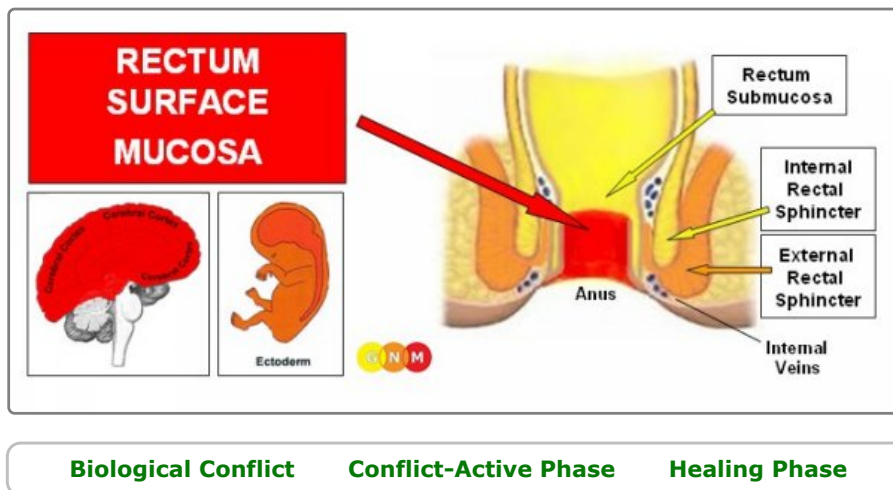
CONFLICT-ACTIVE PHASE: Starting with the **DHS**, during the **conflict-active phase** cells in the sigmoid colon and/or rectum proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to facilitate the digestion of the morsel. Even though the rectum has no longer a digestive function, in the event of a **biological conflict** the organ still responds with cell augmentation, because originally the entire intestinal canal served the digestion of food. With prolonged conflict activity (**hanging conflict**) a flat (**resorptive type**) or cauliflower-shaped growth (**secretory type**) develops in the sigmoid (immediately above the rectum) or in the rectum (underneath the **rectum surface mucosa**). In conventional medicine this is diagnosed as a **colorectal cancer** (compare with "**rectal cancer**" related to the **rectum surface mucosa**). If the rate of cell division exceeds a certain limit, the cancer is considered as "**malignant**"; below that limit the growth is regarded as "**benign**" or diagnosed as a **rectal polyp** (see also healing phase).

HEALING PHASE: Following the **conflict resolution (CL)**, **fungi** or **mycobacteria** such as TB bacteria remove the cells that are no longer needed. **Healing symptoms** are **rectal bleeding**, **tarry bowel movements**, and **night sweats**. **Rectal cramps or spasms** (**motor quality**) occur during the **Epileptoid Crisis** (see also rectal spasms related to the rectum surface mucosa, smooth rectal muscles, internal rectal sphincter, and striated rectal muscles and external rectal sphincter). Depending on the degree of the conflict-active phase, the symptoms range from mild to severe.

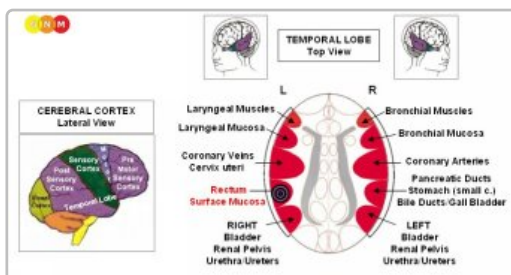
Like **colon cancers**, rectal cancers are usually only found in the healing phase when they start to bleed and cause discomfort. With **water retention** due to the **SYNDROME** the swelling enlarges and might cause a rectal obstruction (in PCL-A). After the **Epileptoid Crisis** the swelling recedes.

When TB bacteria remove a tumor in the rectum, an abscess might form in the course of the healing process. In conventional medicine such **rectal abscesses** with swelling and discharge of blood are often misdiagnosed as **hemorrhoids**.

If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of **antibiotics**, the additional cells in the rectum remain. Eventually, the growth becomes encapsulated. In conventional medicine, this is usually diagnosed as a "**benign cancer**", a **rectal polyp** (see also **conflict-active phase**), or as hemorrhoids.



DEVELOPMENT AND FUNCTION OF THE RECTUM SURFACE MUCOSA: The rectal surface mucosa covers about 12 cm of the endodermal **submucosa** in the lower section of the rectum. The surface mucosa consists of **squamous epithelium**, originates from the **ectoderm** and is therefore controlled from the cerebral cortex. The inner wall of the lower rectum is endowed with **striated muscles**.



BRAIN LEVEL: The epithelial lining of the rectum is controlled from the left side of the **temporal lobe** (part of the **post-sensory cortex**). The control center is positioned next to the **bladder relay** and exactly across from the brain relay of the **stomach (small curvature)**, **pylorus**, **duodenal bulb**, **bile ducts**, and **pancreatic ducts**.

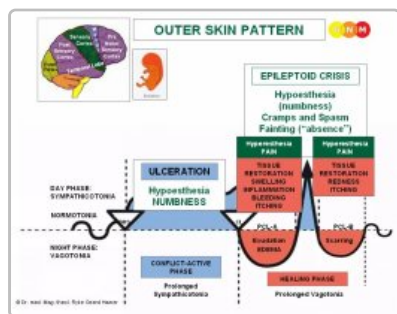
BIOLOGICAL CONFLICT: The **biological conflict** linked to the rectal surface mucosa is a female **identity conflict** or male **territorial anger conflict**, depending on a person's **gender**, **laterality**, and **hormone status**.

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

An **identity conflict** refers to the inability to establish one's position or place ("territory"), literally or figuratively. An unwanted move, change of school, or change of a workplace can activate the conflict. Feeling unsettled, not knowing where to belong, not finding one's place in a relationship, within the family, the group at work, or in the culture and society at large as well as discrimination against one's belief or sexual orientation are examples of what can evoke an identity conflict. The conflict is to a certain extent a **decision conflict** (not knowing what choice to make, not knowing where to go).

NOTE: Marking the place or territory with feces or urine is a typical behavior of mammals (see also **anal glands**). Hence, the rectum-related identity conflict is similar to a **marking conflict** involving the **renal pelvis**, **ureters**, **bladder** and **urethra**. In the brain, the control centers of the rectum and the bladder are located right

next to each other.



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

CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the rectum proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the rectum to allow faster defecation in order to be better able to establish one's place. **NOTE:** While conflict active, the person is **manic**.



This brain CT shows a **Hamer Focus** in the rectum relay (upper red arrows - view the **GNM diagram**) and the **bladder relay** (lower red arrows) related to an **identity conflict** and a **marking conflict**, respectively. The **sharp borders** of the Hamer Foci reveal that both conflicts are active. At this point there are no symptoms since both organs follow the outer skin pattern (hyposensitivity).

With prolonged conflict activity the continuing tissue loss in the rectum lining causes small tears or so-called **anal fissures**. An anal fissure can burst open, for example, with the passing of hard stool.

HEALING PHASE: During the first part of the **healing phase (PCL-A)** the tissue loss is replenished through **cell proliferation**. The **swelling**, caused by the edema, presents as **hemorrhoids** in the lower rectum (internal hemorrhoids) or around the anus (external hemorrhoids). With **water retention** due to an active **abandonment and existence conflict** (the **SYNDROME**) hemorrhoids become much larger. In conventional medicine, the "growth" might be diagnosed as a "**rectal cancer**" (compare with **rectal cancer** related to the **rectum submucosa**). Based on the **Five Biological Laws**, the new cells cannot be regarded as "cancer cells" since the cell increase is in reality a replenishing process.

Healing symptoms are **burning pain in the rectum, anal itching, rectal bleeding** (with hard bowel movements hemorrhoids crack and bleed), and **painful rectal muscle cramps or spasms** if the surrounding **striated muscles** of the inner rectum wall undergo the **Epileptoid Crisis** at the same time (see also rectal spasms related to the **rectum submucosa, smooth rectal muscles, internal rectal sphincter, or striated rectal muscles and external rectal sphincter**). Depending on the intensity of the conflict-active phase, the symptoms range from mild to severe. Typical for the healing phase is the feeling of incomplete emptying of the bowels following defecation, termed **rectal tenesmus** (compare with **bladder tenesmus**).

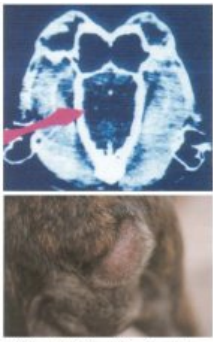
NOTE: All **Epileptoid Crises** that are controlled from the **sensory, post-sensory, or pre-motor sensory cortex** are accompanied by **troubled circulation, dizzy spells, short disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity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

Conventional medicine claims that hemorrhoids are "**varicose veins**" in the rectal area. In reality, the swelling occurs in the epithelial mucosa of the rectum. **Dr. Hamer's** brain scan studies demonstrate that every person who has hemorrhoids shows the **Hamer Focus** in the **cerebral cortex** in the control center of the **rectum surface mucosa** and not in the **cerebral medulla** from where the **blood vessels** are controlled (see also **esophageal varices**, erroneously linked to **liver cirrhosis**).

According to statistics, hemorrhoids are more common in women during pregnancy. They are said to be caused by the weight carrying the baby. From the **GNM perspective**, a pregnant woman only develops hemorrhoids, when she is in the healing phase of an **identity or decision conflict**. This is why not every pregnant woman has the condition.

NOTE: Hemorrhoids also occur after tearing in the rectal area during labor or because of straining during hard bowel movements. Regardless whether hemorrhoids are the result of an injury (without a **DHS**) or of a **rectum-related conflict**, the healing process is just the same.

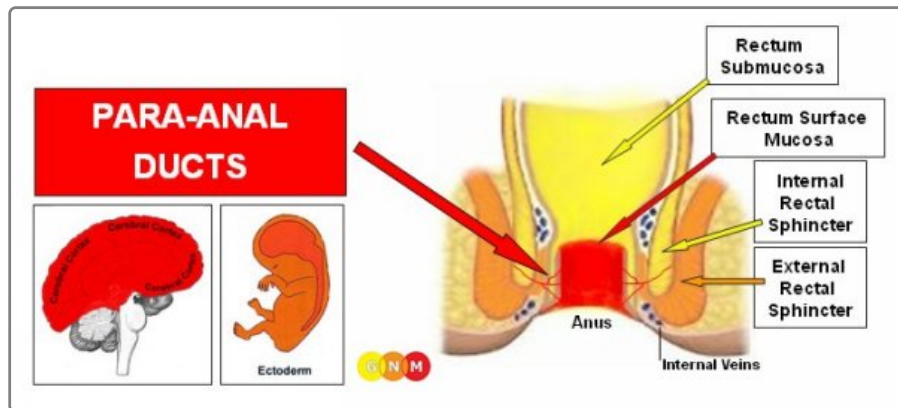
Surgical removal of hemorrhoids is only a temporary "solution" because, if the conflict has not been completely resolved new hemorrhoids start developing with the next **conflict relapse**, triggered by setting on a **track** that was established when the original **identity conflict** took place.



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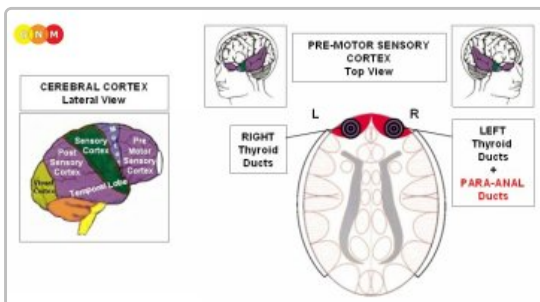
Animals get hemorrhoids too.

This CT scan was taken from a dog's skull. The red arrow points to the brain relay of the rectum lining on the left side of the cerebral cortex (view the GNM diagram) - striking evidence that humans share the Biological Special Programs with other species. The picture below shows the large hemorrhoids. The dog had suffered an identity conflict ("where do I belong?") during a move. The hemorrhoids appeared after he had settled in his new home.



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE PARA-ANAL DUCTS: The para-anal ducts carry fluid produced in the anal glands into the rectum to aid defecation. The glands themselves are located on either side of the anus between the internal and external rectal sphincter. In mammals, these glands are referred to as "scent glands" because they enable the animals to mark their territory (in addition to feces and urine) and to identify members within a species. The lining of the para-anal ducts consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.

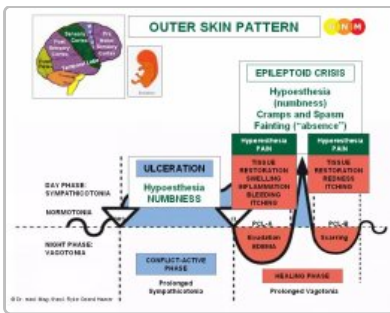


BRAIN LEVEL: The epithelial lining of the para-anal ducts is controlled from the right side of the frontal lobe (part of the pre-motor sensory cortex).

The control center of the para-anal ducts is positioned exactly across from the brain relay that controls the right thyroid ducts. Here is why: Originally, before the gullet broke open, the thyroid was an endocrine gland that released thyroxine into both sections of the intestine. The right thyroid ducts (controlled from the left side of the brain) excreted into the ingoing section (today's mouth and pharynx, esophagus, stomach and duodenum, small intestine) to aid the digestion of food; the left thyroid ducts (controlled from the right side of the brain) excreted into the outgoing section (today's rectum) to accelerate the disposal of feces. However, when the gullet ruptured, parts of the left thyroid ducts remained in the rectum. These residues are today's para-anal ducts. The close vicinity of the brain control centers of the para-anal ducts and the thyroid ducts represents the rupture of the gullet on the cerebral level.

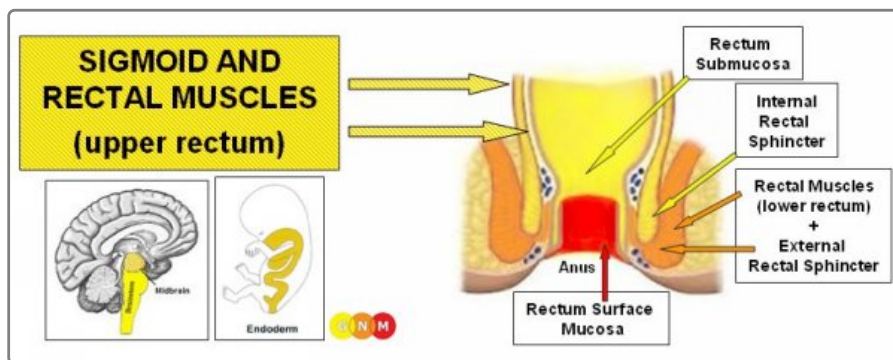
BIOLOGICAL CONFLICT: The biological conflict linked to the para-anal ducts is "not being able to eliminate feces fast enough". Such a "feces conflict" can be experienced in real terms (constipation) or in a transposed sense triggered, for example, by a "shitty" situation one experienceds unable to "evacuate" fast enough (compare with feces conflict related to the sigmoid/rectum submucosa and sigmoid/rectal muscles).

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

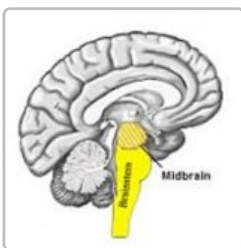


CONFLICT-ACTIVE PHASE: ulceration in the lining of the para-anal ducts proportional to the degree and duration of conflict activity. The **biological purpose of the cell loss** is to widen the lumen to facilitate faster defecation.

HEALING PHASE: During the first part of the healing phase (PCL-A) the tissue loss is replenished through **cell proliferation**. The **edema** (fluid accumulation) creates a **para-anal cyst**. **Healing symptoms** are **pain and itching**. If there are no **conflict relapses**, the cyst recedes during the healing phase. A **para-anal fistula** forms when a para-anal cyst breaks and empties outwards (see also **thyroid fistula**). This usually occurs when **large amounts of water are retained** in the cyst due to the **SYNDROME** or as a result of **conflict relapses** that prolong the healing process. Cysts that empty into the abdominal cavity are called **Douglas fistula**; in this case, the opening of the fistula creates a direct outlet for an **ascites**.



DEVELOPMENT AND FUNCTION OF THE SIGMOID AND RECTAL MUSCLES (UPPER RECTUM): Like the intestines {muscles}, the sigmoid colon and upper part of the rectum consists of **smooth muscles** originating from the **endoderm** and controlled from the **midbrain**.



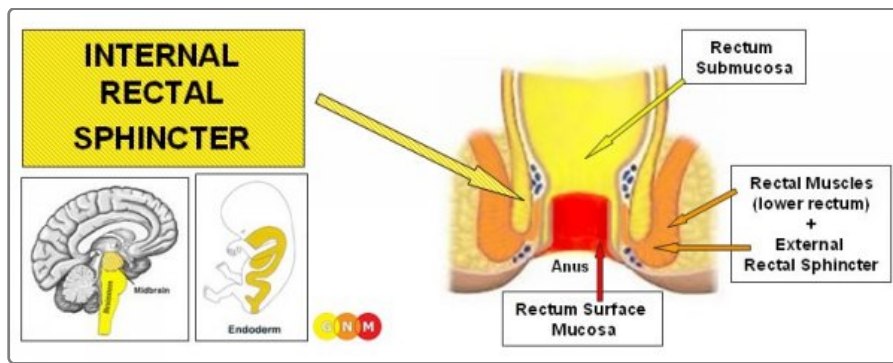
BRAIN LEVEL: The smooth muscles of the sigmoid colon and rectum (upper part) are controlled from the **midbrain**, located at the outermost part of the brainstem.

NOTE: The lower part of the rectum is endowed with **striated muscles**.

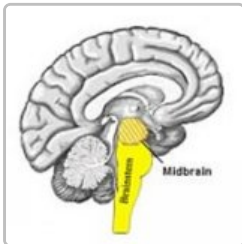
BIOLOGICAL CONFLICT: The smooth muscles of the sigmoid and upper part of the rectum are linked to a "**feces conflict**", experienced in real terms (**fecal incontinence**, persistent **constipation**) or in a transposed sense, as a "shitty" situation (see also feces conflict related to the **sigmoid colon and rectum submucosa** and the **para-anal ducts**).

CONFLICT-ACTIVE PHASE: increased muscle tension (hypertonus)

HEALING PHASE: muscle relaxation with **rectal spasms** during the **Epileptoid Crisis** (see also rectal spasms related to the **internal rectal sphincter**, **striated rectal muscles** and **external rectal sphincter**, **rectum submucosa**, **rectum surface mucosa**).



DEVELOPMENT AND FUNCTION OF THE INTERNAL RECTAL SPHINCTER: The internal and external rectal sphincters control the closing of the anus and the elimination of feces. The internal rectal sphincter is a muscular ring that surrounds the anal canal. It is formed by a thickening of the circular muscles of the rectum. The internal rectal sphincter consists of smooth muscle, originates from the endoderm, and is controlled from the midbrain.

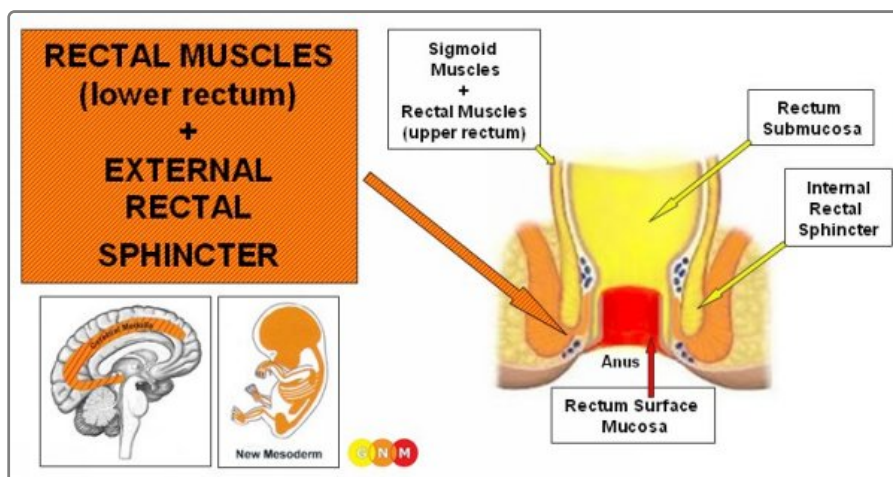


BRAIN LEVEL: The smooth muscles of the internal rectal sphincter are controlled from the midbrain, located at the outermost part of the brainstem.

BIOLOGICAL CONFLICT: The biological conflict linked to internal rectal sphincter is not being able to hold back feces, for example, because of fecal incontinence.

CONFLICT-ACTIVE PHASE: hypertonus of the internal rectal sphincter. The biological purpose of the increased muscle tension is to facilitate holding back the feces.

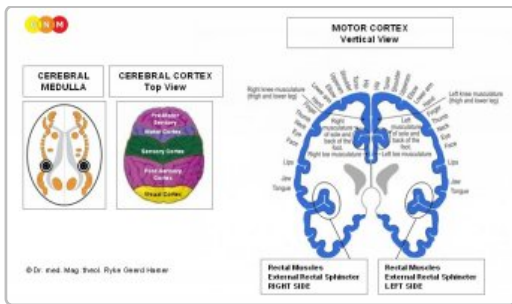
HEALING PHASE: The muscle tension goes back to normal. The Epileptoid Crisis presents as painful rectal spasms (see also rectal spasms related to the smooth rectal muscles, striated rectal muscles and external rectal sphincter, rectum submucosa, and rectum surface mucosa).



Biological Conflict Conflict-Active Phase Healing Phase

DEVELOPMENT AND FUNCTION OF THE RECTAL MUSCLES (LOWER RECTUM) AND EXTERNAL RECTAL SPHINCTER: The external rectal sphincter is a muscle that surrounds the anus immediately beneath the skin. Like the internal rectal sphincter, it regulates the closing and opening of the anus in order to hold and expel feces. The lower part of the rectal muscles and the external rectal sphincter consist of striated muscles, originate from the new mesoderm and are controlled from the cerebral medulla and the motor cortex.

BRAIN LEVEL: The striated rectal muscles and the external rectal sphincter have two control centers in the cerebrum. The trophic function of the muscles, responsible for the nutrition of the tissue, is controlled from the cerebral medulla; the contraction of the muscles is controlled from the motor cortex (part of the cerebral cortex). The right half of the rectal muscles and external rectal



sphincter are controlled from the left side of the cerebrum; the left halves are controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ. In comparison, the smooth muscles of the upper part of the rectum and of the internal rectal sphincter are controlled from the midbrain.

NOTE: The rectal muscles and external rectal sphincter, bladder muscle and external bladder sphincter, cervix muscles and cervical sphincter, and vaginal muscles share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the rectal muscles and external rectal sphincter is the same as with the rectum surface mucosa, namely, an identity conflict in the sense of an inability to establish one's position or place. Biologically, this translates into "not being able to sufficiently mark one's territory" (by defecation), similar to the marking conflict related to the bladder muscle and external bladder sphincter.

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of rectal muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing paralysis of the rectal muscles (controlled from the motor cortex). At the same time the rectal sphincter opens (no necrosis with sphincters!) which allows to better mark one's place.

NOTE: The striated muscles belong to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteal nerves and thalamus). In case of the striated muscles, the conflict-active phase manifests as muscle paralysis. From a biological point of view, the paralysis is an innate fake-death reflex in response to danger.

Persistent conflict activity causes fecal incontinence, an inability to control bowel movements (see also urinary incontinence). A sudden leakage of stool flow also occurs during the Epileptoid Crisis when the rectal sphincter opens.

NOTE: External sphincters (external bladder sphincter, external rectal sphincter, cervical sphincter) consist of striated muscles, while internal sphincters such as the internal bladder sphincter and internal rectal sphincter consist of smooth muscle. External sphincters have an inverse innervation, meaning that they close through contraction in vagotonia, i.e., in the healing phase, and open through relaxation in sympathicotonia, i.e., in the conflict-active phase and Epileptoid Crisis. Regarding the bladder and rectum, during an Epileptoid Crisis, for example throughout an epileptic seizure, both sphincters might open at the same time causing a complete emptying of the bladder together with an involuntary loss of stool.

HEALING PHASE: During the healing phase, the rectal muscles are reconstructed and the rectal sphincter closes. The Epileptoid Crisis manifests as painful rectal spasms (see also rectal spasms related to the internal rectal sphincter, smooth rectal muscles, rectum submucosa, and rectum surface mucosa).

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