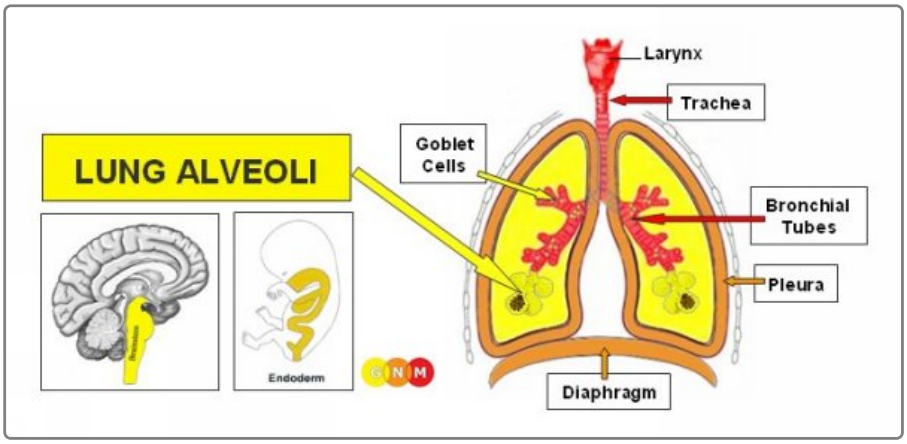
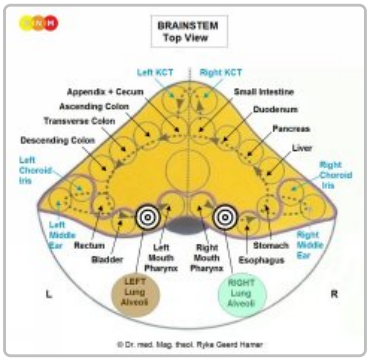
LUNGS Expand this ...

LUNGS



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

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



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

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

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

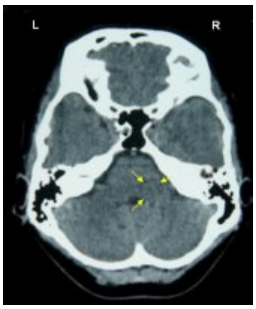
In line with evolutionary reasoning, **morsel conflicts** are the primary conflict theme associated with brainstem-controlled organs deriving from the endoderm.

A **death-fright** can be experienced in any life-threatening situation, for example, in the course of an accident or during a medical emergency. By far the most common death-fright conflict, however, is brought on by a **diagnosis shock**, particularly by a cancer diagnosis that hits a person like a death-sentence. Statements by a physician such as "the cancer is malignant", "inoperable", "aggressive", "invasive", "metastasizing" or remarks like "you have six months to live" and other verdicts of this kind can evoke an acute death panic. The same holds true for a negative prognosis and test results based on medical checkups (Pap tests, PSA tests, mammograms, colonoscopies, blood tests). We also

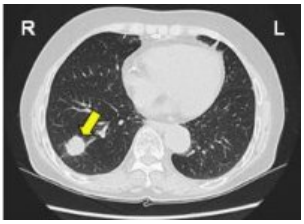
have to take into account potential **self-diagnosis shocks** triggered, for instance, when detecting a lump, let's say, in the breast, when there is blood in the stool, in the urine or in the vagina, or with other symptoms associated with having cancer ("a deadly disease"). Looking for information about a particular symptom on the internet with countless websites propagating the concept of "malignant diseases" can easily activate a death-fright conflict.

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

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



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



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

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

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

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

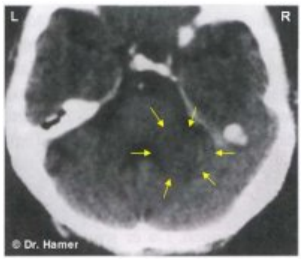
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria such as TB bacteria remove the cells that are no longer required. **Healing symptoms** are **coughing up milky or rusty-colored phlegm**. The **sputum might contain blood**. Because of the pus in the discharge, the symptoms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

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

Tubercular secretion, excreted through the sputum, **is rich in protein**. If the healing phase is long and intense, the protein deficiency could be fatal. Death, however, is not caused by the TB-"infection" but rather by the protein

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

Previously, the coughing up of blood (hemoptysis) was rightly diagnosed as **lung tuberculosis**. Today, the condition is called **lung cancer** (see also renaming of liver tuberculosis to liver cancer and kidney tuberculosis to "nephrotic syndrome"). It is the renaming of the disease why the numbers of lung cancer increased drastically, while tuberculosis "disappeared", notably in the Western World where the eradication of lung tuberculosis is attributed to the "success" of extensive antibiotics regiments. In the "developing world", tuberculosis is now considered a disease related to AIDS!



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

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

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

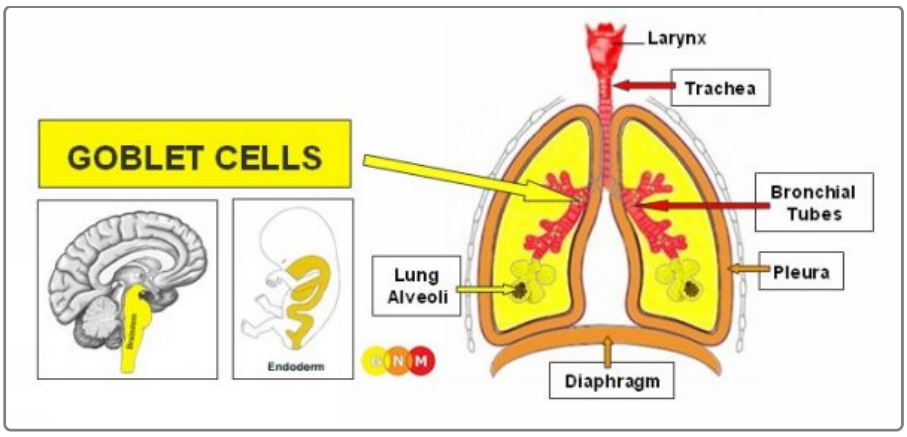
After the lung nodules have been removed, **caverns** remain at the site. The caverns are filled with air (compare with liver caverns, pancreas caverns, breast gland caverns). With a hanging healing, that is, when healing is continuously interrupted by conflict relapses triggered by death-fright tracks,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

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

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

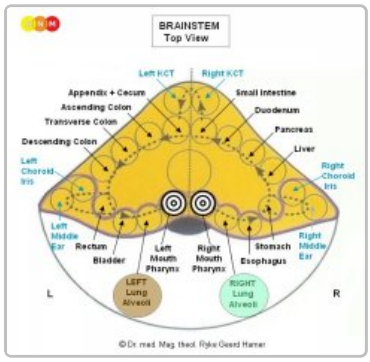
Pulmonary fibrosis is the result of recurring healing phases (compare with cystic fibrosis related to the goblet cells). In this case, the caverns are filled with fibrotic tissue. The condition is described as "scarring of the lungs". The buildup of scar tissue is also termed **pulmonary sarcoidosis**,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

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



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

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

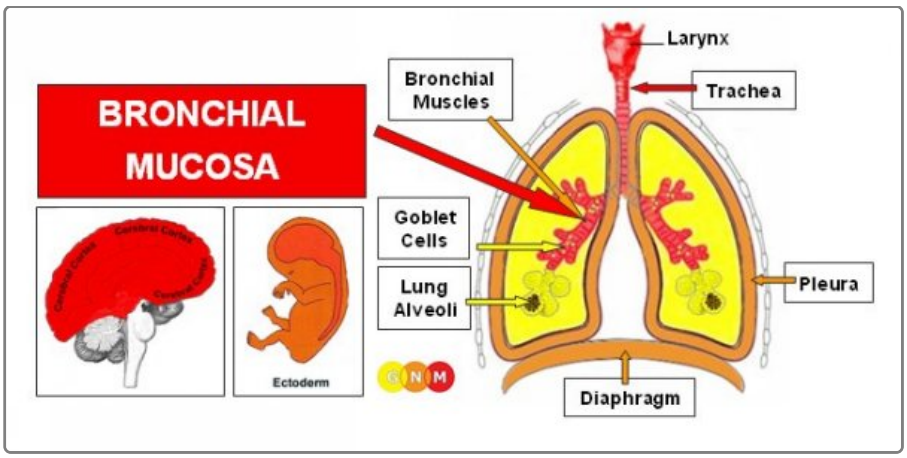


BRAIN LEVEL: In the **brainstem**, the goblet cells are controlled from the same two brain relays as the lung alveoli.

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

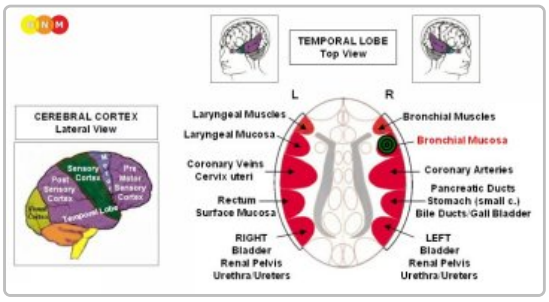
CONFLICT ACTIVE PHASE: In the same way as intestinal cells proliferate with a biological conflict associated with a "food morsel", during the conflict-active phase the goblet cells increase in number in response to the distress of not getting enough air. The **biological purpose of the cell proliferation**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

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



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

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

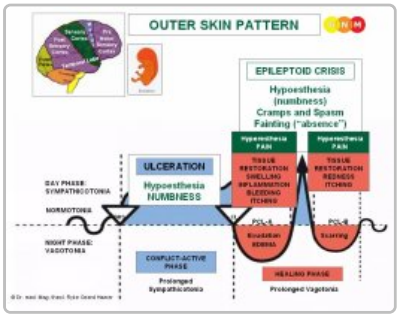


BRAIN LEVEL: The bronchial mucosa of both lungs is controlled from the right side of the **temporal lobe** (part of the **sensory cortex)**. The control center is positioned exactly across from the brain relay of the laryngeal mucosa.

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

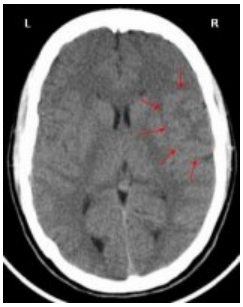
In line with evolutionary reasoning, **territorial conflicts**, **sexual conflicts**, and **separation conflicts** are the primary conflict themes associated with organs of ectodermal origin, controlled from the sensory, pre-motor sensory and post-sensory cortex.

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



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

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



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

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

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

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

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

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

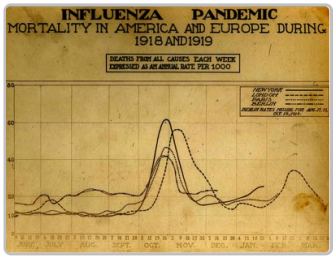
Pneumonia is bronchitis with the SYNDROME, that is, with water retention as a result of an active abandonment and existence conflict involving the kidney collecting tubules. In PCL-A, the retained water is exceedingly stored in the bronchial tubes (compare with lung edema). A lung puncture to drain the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

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

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

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

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



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

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

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

AIDS-Acquired Immune Deficiency Syndrome

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

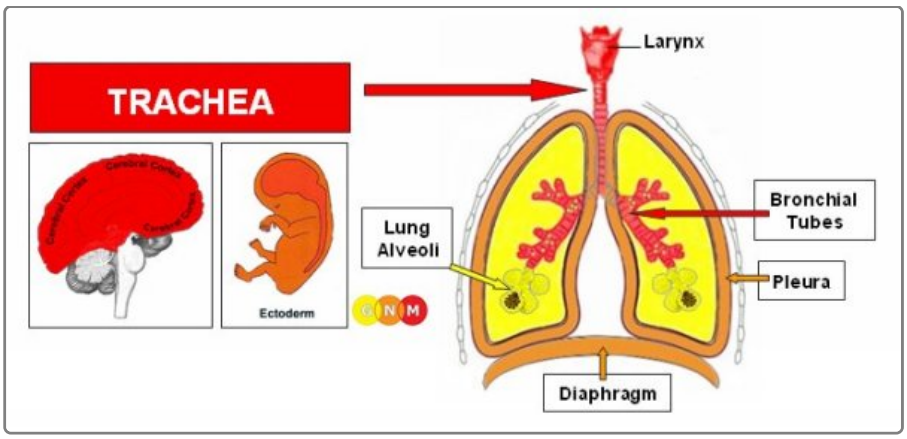
In 1983, the American researcher Robert Gallo claimed that he had discovered the "human immunodeficiency virus" (HIV) as the agent responsible for the cause of AIDS. In 1984, Gallo published four articles in *Science*, in which he stated that he had isolated the HIV virus. In December 2008, thirty-seven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

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

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

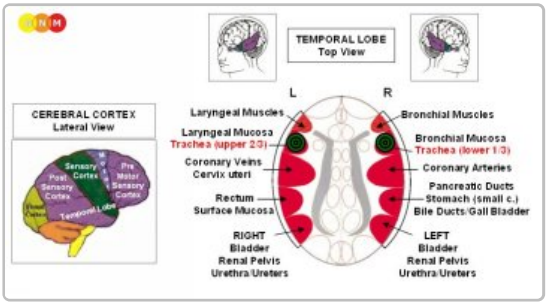
- death-fright conflict involving the lungs (lung cancer, lung tuberculosis, lung emphysema)
- scare-fright conflicts resulting in respiratory symptoms such as bronchitis or pneumonia
- frontal-fear conflicts (non-Hodgkin's lymphoma)
- abandonment and existence conflicts (kidney cancer)
- self-devaluation conflicts (anemia, leukemia, bone cancer, lymphoma)
- attack or "feeling soiled" conflicts (shingles), Kaposi sarcoma
- territorial anger conflicts (hepatitis)
- separation conflicts (skin rashes, herpes)
- bleeding conflicts triggered by blood tests leading to an enlarged spleen

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



Biological Conflict Conflict-Active Phase Healing Phase

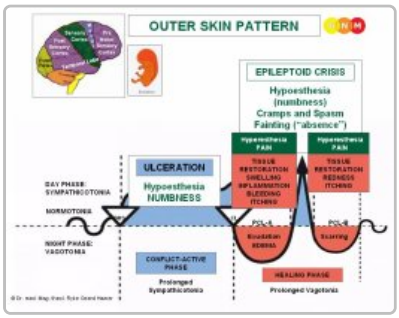
DEVELOPMENT AND FUNCTION OF THE TRACHEA: The trachea or "windpipe" is a hollow tube that connects the larynx to the two bronchi of the lungs. It has the vital function of providing air flow to and from the lungs for respiration. The trachea is composed of cartilage rings, smooth muscles, and connective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



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

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

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



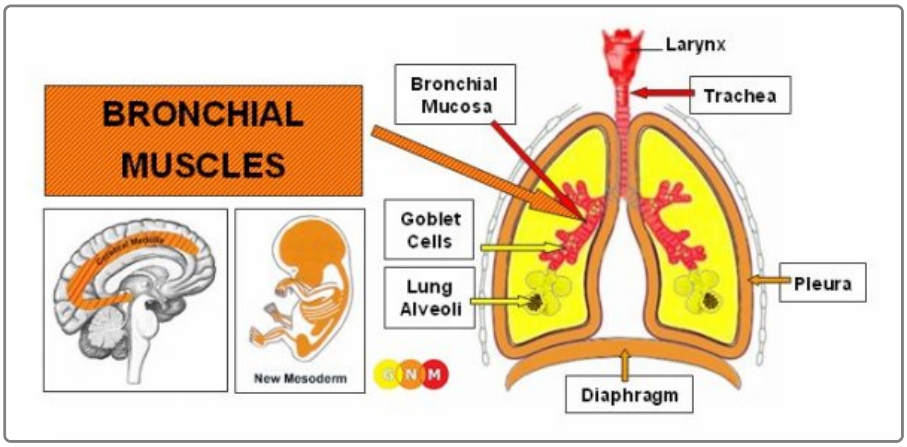
The Biological Special Program of the trachea follows the **OUTER SKIN PATTERN** with hyposensitivity during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

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

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

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

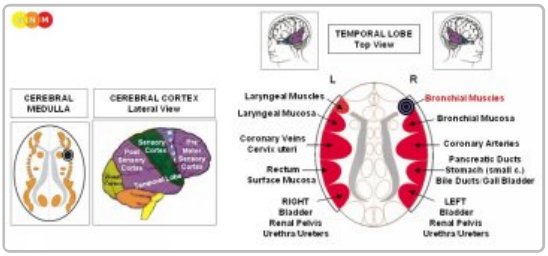
NOTE: All Epileptoid Crises that are controlled from the sensory, post-sensory, or pre-motor sensory cortex are accompanied by **troubled circulation**, **dizzy spells**, short **disturbances of consciousness** or a complete **loss of consciousness** (fainting or "absence"), depending on the intensity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



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

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

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



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

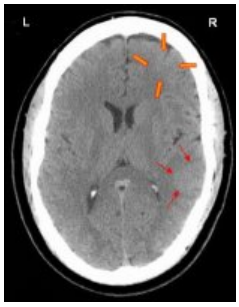
NOTE: Inhaling is controlled from the bronchial muscles relay (on the right side of the motor cortex) while **exhaling** is controlled from the laryngeal muscles relay (on the left side of the motor cortex). Normally these two breathing motions are in balance. This changes if a biological conflict involves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

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

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

NOTE: The striated muscles belong to the group of organs that respond to the related conflict 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.

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



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

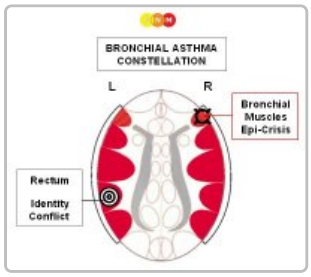
Recurring symptoms or an **"allergy cough"** are brought on by conflict relapses triggered by setting on a track that was established when the original conflict took place (see allergies).

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

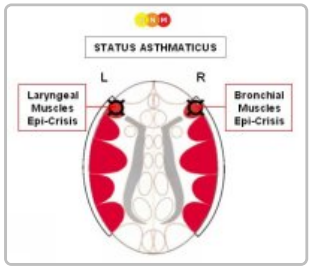
BRONCHIAL ASTHMA involves two Biological Special Programs (see also laryngeal asthma)

- conflict activity of a territorial fear conflict with the impact of the DHS on the right side of the temporal lobe in the brain relay of the bronchial muscles
- conflict activity of a scare-fright conflict, sexual conflict, identity conflict, or marking conflict, corresponding to the left side of the temporal lobe

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

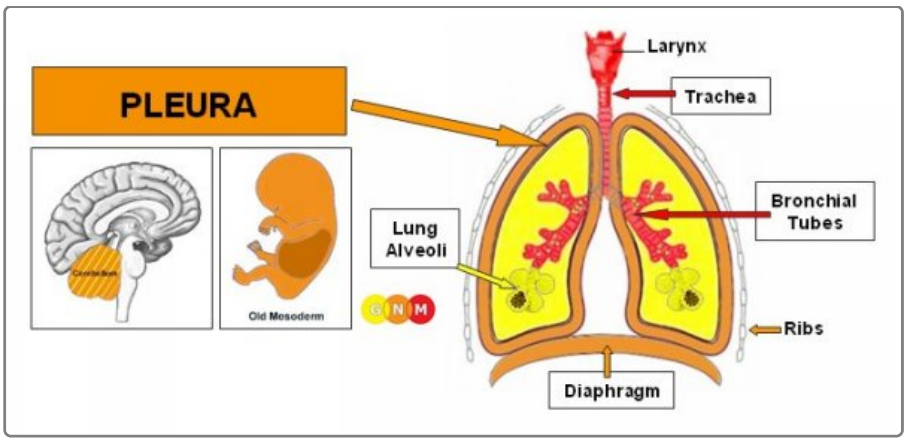


The actual **asthma attack** occurs during the **Epileptoid Crisis of the bronchial muscles** with convulsions moving towards the mouth, that is, outwards. The **symptoms** of bronchial asthma are therefore the typical **wheezing and prolonged expiration** of asthmatics (when the bronchial muscles are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



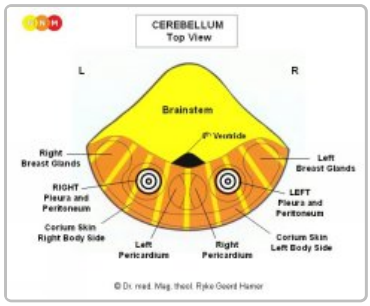
When both the bronchial and laryngeal muscles go through the Epileptoid Crisis at the same time, the asthma attack presents as prolonged exhaling with wheezing (bronchial asthma) and extended inhaling with gasping for breath (laryngeal asthma). This condition, called **"status asthmaticus"**, causes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

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



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

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



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

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

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

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

An attack against the chest or torso is experienced, for instance, through a blow, stab, or hit against the chest or ribs, for example, during a fight, accident, or in sports. "Sharp" words (accusations, criticism) directed at someone or "finger pointing" could also be registered as an attack (see also pericardium). However, surgery in the chest area (removal of a tumor, mastectomy) biopsies (breast cancer biopsy), thoracoscopies, exploratory lung punctures with an insertion of a needle into a lung, tubes placed in the chest to drain fluids, or the implantation of catheters or ports into a vein of the chest for long-term intravenous treatment, including chemo treatments, also trigger attack conflicts. A lung cancer diagnosis or comments by a physician like "your lungs are not working properly" can be perceived as an "attack" regarding the integrity of the organ. Attack conflicts also originate from inside the chest, for instance, with chest pain caused by coughing (pneumonia, bronchial asthma) or stabbing and piercing pain through the inhalation of fumes, gases, or volatile liquids.

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

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

No doubt, prolonged **exposure to asbestos** can cause a pleural mesothelioma. However, it is not a "carcinogen" that causes the cancer, as claimed by conventional medicine, but rather the inhalation of the sharp asbestos fibers (see micrograph image "*attacking*" the lungs. This explains why asbestos affects predominantly the pleura and to a much lesser degree other organs of the respiratory tract (if asbestos is associated with a death-fright

triggered by scary media reports, it affects the lungs; with a territorial fear related to the workplace, it affects the bronchia. In both cases the distress generates the development of a lung cancer.

Since there are no symptoms during the conflict-active phase, a pleural mesothelioma is usually only found through routine medical examinations, notably among asbestos workers who have to undergo regular lung check-ups.

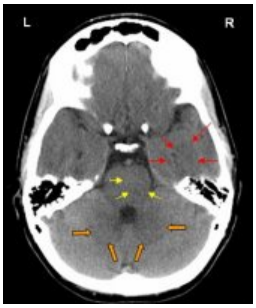
HEALING PHASE: Following the conflict resolution (CL), fungi or mycobacteria or other bacteria remove the cells that are no longer needed. **Healing symptoms** are **chest pain**, painful **coughing**, **breathing difficulties**, **fever**, and **night sweats**. If the required microbes are not available upon the resolution of the conflict, because they were destroyed through an overuse of antibiotics, the additional cells remain. Eventually, the growth becomes encapsulated with connective tissue. Now, the mesothelioma is regarded as "benign".

Pleurisy or pleuritis indicates that healing is accompanied by an inflammation – with fever, if the healing phase is intense. During the healing process (in PCL-A), the fluid in the pleura is naturally absorbed by the pleural membrane (**dry pleurisy**). Water retention, however, due to an active abandonment and existence conflict, increases the fluid accumulation (**wet pleurisy**) causing **acute breathing difficulties**; if bacteria assist healing, the fluid contains pus (**purulent pleurisy**). Wet pleurisy often develops during hospialization, after surgery in the breast or chest area, or following a lung cancer or pleural mesothelioma diagnosis.

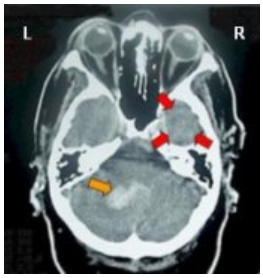
With the SYNDROME the retained water generates an **exudative pleural effusion** (excess fluid *around* the lungs as opposed to water *in* the lungs with pneumonia or a lung edema). Since the right and left pleura are separate from each other, the effusion occurs only on the affected side (compare with peritoneal effusion and pericardial effusion). A pleural effusion could cause serious complications, particularly when the fluid-filled pleural cavity compresses both lungs. In this case, a lung puncture to drain the lungs is unavoidable.

> **NOTE:** Fluid also enters the pleura when adjacent ribs or the sternum are in healing; in this case because of a self-devaluation conflict brought on, for example, by a lung cancer diagnosis, a breast cancer diagnosis, or a mastectomy. The large edema, usually caused by water retention due to the SYNDROME, "sweats" through the periosteum into the pleura creating what is called a **transudative pleural effusion** (which does not contain protein!).

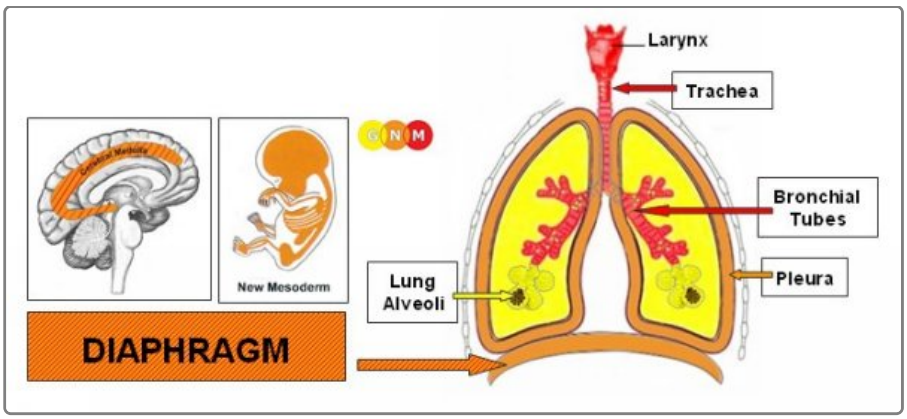
Pleural fluid is rich in protein. Hence, constant draining of the extra fluid leads to protein deficiency and rapid weight loss. Furthermore, the lung punctures trigger often new attack conflicts and conflict relapses with each procedure (hospital "track"), throwing the person into a vicious cycle. Puncturing the lungs also bears the risk of a lung collapse or pneumothorax (see also pneumothorax and lung emphysema).



This brain scan shows fluid accumulation (in PCL-A) in both pleura relays (orange arrows - view the GNM diagram) corresponding to a pleural effusion caused by an "attack against the chest"-conflict. In addition, we see a Hamer Focus (also in PCL-A) in the brain relay for the left inner ear (red arrows) related to a hearing conflict, presenting as hearing difficulties (compare with CT below). The yellow arrows point to the control center of the right kidney collecting tubules and an active existence conflict resulting in water retention (the SYNDROME). The retained water exacerbates the pleural effusion!

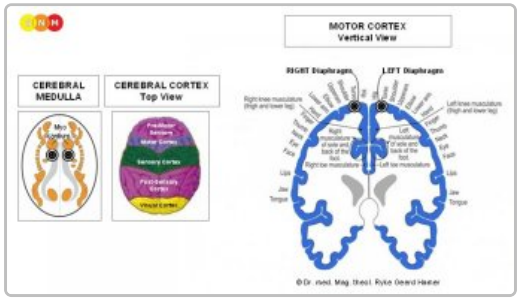


This CT scan shows the presence of neuroglia (in PCL-B) in the brain relay of the right pleura (orange arrow - view the GNM diagram), indicating that a pleural mesothelioma is healing at the time. In conventional medicine, the glia buildup is wrongly assumed to be a "brain tumor". There is also an active Hamer Focus in the control center of the inner ear (red arrows), confirming a tinnitus in the left ear (compare with CT above). The hearing conflict ("I don't want to hear this"!) was most likely triggered by the cancer diagnosis.



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

DEVELOPMENT AND FUNCTION OF THE DIAPHRAGM: The diaphragm separates the chest from the abdomen. It is the largest and most efficient muscle used in breathing. During inhaling, the diaphragm moves down, the lungs expand and air is drawn in; during exhaling, the diaphragm relaxes and air leaves the lungs (compare with bronchial muscles). In addition to breathing, the contraction of the diaphragm supports the heart muscle (myocardium) in sucking venous blood from the systemic circulation. For this, the left half of the diaphragm is of greater importance since the right half has less ability to move due to the liver positioned directly underneath. The diaphragm consists of striated muscles, originates from the new mesoderm and is controlled from the cerebral medulla and the motor cortex. For its involuntary supportive functions pertaining to breathing and circulation, the diaphragm also receives impulses from the brainstem.



BRAIN LEVEL: The diaphragm has two control centers in the cerebrum. The trophic function of the muscle, responsible for the nutrition of the tissue, is controlled from the **cerebral medulla**; the contraction of the muscles is controlled from the **motor cortex**. The right half of the diaphragm is controlled from the left side of the cerebrum; the left half is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The diaphragm is functionally closely tied to the myocardium. The control centers are therefore located right below the brain relays of the myocardium.

BIOLOGICAL CONFLICT: The biological conflict linked to the diaphragm is **not being able to breathe sufficiently or deeply enough**, for example, when getting out of breath during hard exercises such as jogging (sprinting) or when running too fast (catching a bus, escaping from danger). An unexpected shock ("it took my breath away"), fright or scare (see also scare-fright conflict) can cause this type of breathing conflict (see also trachea). Feeling **physically overwhelmed** ("I can't manage!", fitness training and workout stress) also affects the diaphragm (compare with emotional and mental overwhelmed conflict related to the myocardium). Coupled with the myocardium, the conflict is usually experienced as running out of breath because "This is too much!" (distress related to work, family, relationships).

CONFLICT-ACTIVE PHASE: cell loss (necrosis) of diaphragm muscle tissue (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the diaphragm muscle** (controlled from the motor cortex) causing **difficulties breathing** ranging from mild to severe. Lasting paralysis results in an elevated hemi-diaphragm.

> **NOTE:** The striated muscles belong to the group of organs that respond to the related conflict 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.

With lasting, intense conflict activity the ongoing tissue loss can lead to a rupture of the diaphragm (**diaphragmatic hernia**) with abdominal organs moving into the chest cavity. In case of a **hiatal hernia**, a small part of the stomach pushes through the diaphragm and into the chest (compare with inguinal hernia). The rupture could be brought on by coughing, heavy lifting, pulling or pushing, or pressing too hard, for example, during a bowel movement.

HEALING PHASE: In the healing phase, the diaphragm muscle is reconstructed. The partial paralysis reaches into PCL-A. The Epileptoid Crisis presents as **cramping or spasms of the diaphragm** accompanied by breathing difficulties. **Sleep apnea** with episodes of cessation of breathing is generated by the contractions of the diaphragm during the Epi-Crisis. Chronic sleep apnea points to conflict relapses (compare with sleep apnea related to the myocardium).

Stitches in the side, for example, when exercising shortly after eating, running too fast or talking during jogging, is a

manifestation of a small diaphragm-related Epileptoid Crisis. **Hiccups** (singultus) are diaphragmatic contractions or flutters, typically caused by eating or drinking too quickly without adequate breathing. In this case, the "conflict" is solely of a biological nature without an emotional component. However, persisting hiccups that last longer than 48 hours are caused by breathing conflict.

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

This CT scan shows the impact of a physical overwhelmed conflict in the area of the brain that controls the left diaphragm (view the GNM diagram). The sharp ring structure of the Hamer Focus indicates conflict activity.

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