The Temporomandibular Joint and Coccyx Relationship

Timothy D.Francis, D.C., F.I.A.C.A., D.I.B.A.K., M.S., D.H.M

7473 W.Lake Mead Blvd.,St.100
Las Vegas, NV 89128
(702)221-8870

Abstract

There is a relationship between the temporomandibularjoint (TMJ) and coccyx. This may be verified via Therapy Localization (TL). Correction of the coccyx subluxation will negate most TMJ dysfunctional patterns.

Introduction

The TMJ is the most important joint in the body according to Leaf and can be correlated to any joint dysfunction. The TMJ muscles (along with the upper trapezius and sternocleidomastoid) move the cranial bones via mastication, swallowing, and talking.

The coccyx is the final attachment point for the dura mater via the filum terminale and is the Lovett brother correlation for the sphenoid. The sphenoid is the center of cranial motion as it articulates with twelve other cranial bones.

The TMJ can be evaluated by testing a strong indicator muscle (IM) and having the subject move the mandible into a number of various positions with and without therapy localization (TL) to the TMJ. If a strong IM weakens, then TMJ dysfunction can be deduced and an appropriate treatment rendered (neurological tooth, fascial flush, and/or adjusting the spindle cell mechanism).

The coccyx may display TL only rarely in this author's experience and yet is a primary attachment for the dura and starting point for the governing vessel (GV) meridian as well as the attachment point for the pelvic diaphragm muscles. It moves with respiration (apex anterior on expiration and posterior on inspiration). Therefore, with such an obvious spinal importance why does it not TL more often?

TMJ imbalance is very common. If the TMJ displays this dysfunction via Applied Kinesiology (AK) protocols; then have the subject TL the coccyx. If the coccyx TL negates the IM weakness, challenge and correct the coccyx subluxation. Reexamine the TMJ and in a vast majority of instances the indicators for TMJ

dysfunction are negated. This TMJ-coccyx relationship confirms Goodheart's original hypothesis and causal relationship within the dura.

Discussion

Penfield and Rasmussen have stated that thirty-five to forty percent of all motor and sensory nerves of the body are related to the TMJ. The TMJ muscles move the cranial bones and have a dynamical relationship to sphenoid juxtaposition via attachment of the internal and external pterygoids as well as the anterior division of the temporalis. Normal cranial function is of paramount importance to overall body function and integration.

The coccyx is the final attachment of the dura via the filum terminale and is involved in the primary respiratory mechanism. The tip of the coccyx is the alarm point for the GV meridian and is the attachment for the coccygeus, ileococcygeus, and pubococcygeus muscles defining the pelvic floor. This makes the coccyx a pivotal key point for the spine and overall body function.

The TMJ should be observed for motion on opening and closing with the subject in the upright posture. Note any deviations of movement. Test a strong IM and have the subject bite down, open, lateralize, protrude, and retrude noting any change in the IM test. If there is a change in the IM in any mandibular position, TL the coccyx with both hands being careful not to let the hands touch each other. If this negates, the IM weakness, (which it does in a large majority of cases), challenge and correct the coccyx subluxation manually. Then recheck TMJ function utilizing the same protocol. The TMJ dysfunctional indicators should be negative. Then have the subject TL the TMJ and recheck all possible positions for weakening the strong IM (biting, opening, lateralization, protrusion, and retrusion). If the strong IM reweakens, cross TL (utilizing two hands-one to the TMJ and the other to the coccyx). Again, if this negates the AK indicators of TMJ dysfunction, rechallenge the coccyx and correct the subluxaton. Post correction of the coccyx usually corrects the TMJ malfunction. Reevaluate the entire pelvis. Often times, there is a sacral involvement of the apex posterior variety and/or a Category II that needs to be corrected. Have the subject walk, bend, chew, grind, and swallow. Re-evaluate the pelvis for a Category I and correct as indicated. The cervical spine should also be evaluated and correct any

subluxations/fixations/imbrications that are found. The TMJ at this point is usually negative for AK diagnostic evaluation.

Conclusion

The TMJ-coccyx relationship appears to be universal in all cases evaluated thus far by this author. This has a profound effect throughout the body which may be evaluated by various means especially via AK analysis.

The TMJ musculature appears to be a tension take up mechanism in response to a primary coccyx involvement. Correction of the coccyx seems to negate the TMJ indicators as well as to restore a more harmonious body status.

Resources

Goodheart, George J., You`ll Be Better, The Story of Applied Kinesiology, AK Printing, Geneva, Ohio.

Leaf, David, Applied Kinesiology Flowchart Manual, Privately Published, Plymouth, MA (1995).

Walther, David, *Applied Kinesiology: Synopsis 2nd edition*, Systems D.C., Pueblo, CO. (2000)