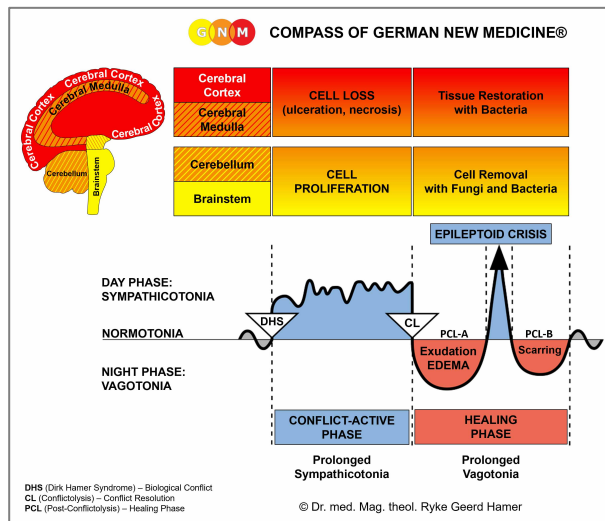


BIOLOGICAL SPECIAL PROGRAMS

EARS

written by Caroline Markolin, Ph.D.



Middle Ear and Eustachian Tubes

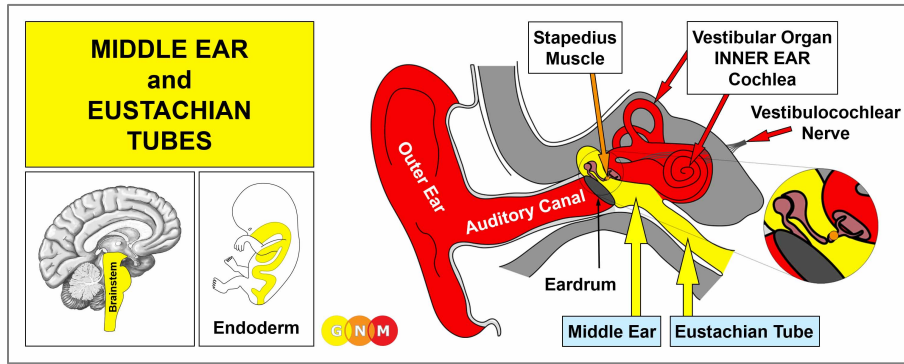
Stapedius Muscle

Inner Ear – Cochlea

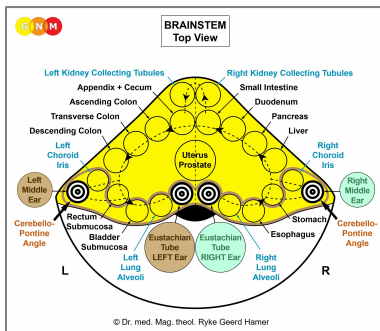
Inner Ear – Vestibular Organ

Outer Ear and Auditory Canal

Ear Cartilage



DEVELOPMENT AND FUNCTION OF THE MIDDLE EAR AND EUSTACHIAN TUBES: The ear consists of a peripheral and a central part separated by the eardrum or tympanic membrane. Sound waves captured from the external environment by the outer ear are first transformed by the tympanic membrane into mechanical vibrations, which are transmitted to the **ossicles** (malleus, incus, stapes) that carry the sound to the inner ear. From there, the acoustic waves pass along the vestibulocochlear nerve to the brain for interpretation. The Eustachian tubes connect the middle ear to the mouth and nasopharynx. They help to keep air pressure in the ears at the right level. In evolutionary terms, the middle ear and Eustachian tubes developed from the intestinal mucosa of the original gullet. Equal to the intestinal cells that absorb (absorptive quality) and digest (secretory quality) the “food morsel”, the biological function of the middle ear and Eustachian tubes is to “insalivate” and “digest” the “sound morsel”. The middle ear and Eustachian tubes consist of intestinal cylinder epithelium, originate from the endoderm and are therefore controlled from the brainstem.



BRAIN LEVEL: In the **brainstem**, the middle ear and Eustachian tubes have each two control centers, positioned in close vicinity to the brain relays of the organs of the alimentary canal.

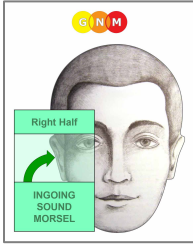
The right middle ear and right Eustachian tube are controlled from the right side of the brainstem; the left middle ear and left Eustachian tube are controlled from the left brainstem hemisphere. There is no cross-over correlation from the brain to the organ. The control centers of the middle ear are located laterally, at the margin of the brainstem and the cerebellum (known as the cerebellopontine angle). It is from this area from where the vestibulocochlear nerve emerges.

NOTE: The mouth and pharynx, tear glands, Eustachian tubes, thyroid gland, parathyroid glands, pituitary gland, pineal gland, and choroid plexus share the same brain relays.

BIOLOGICAL CONFLICT: The biological conflict linked to the middle ear and Eustachian tubes is a “**morsel conflict**”, specifically, a conflict related to a “**sound morsel**”.

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

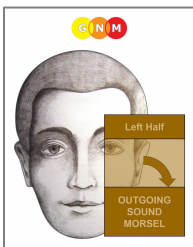
RIGHT MIDDLE EAR AND RIGHT EUSTACHIAN TUBE



Equivalent to the right half of the mouth and pharynx, the **middle ear and Eustachian tube of the right ear** correlate to an “**ingoing morsel**” and to “**not being able to catch a sound morsel**”.

The desired “sound” might concern the voice of a particular person. Newborns and infants suffer the conflict when they can’t “catch” the reassuring voice of the mother. A praise (at school, at home, at work), an acknowledgment, an approval, an offer, a compliment, a proposal, a promise, an apology, a confession, or the “I love you”-morsel one is “drooling” to hear could activate the conflict. In biological terms, the “sound morsel” is equal to nourishment. A hearing conflict can also be experienced when an important message (an announcement) or a sound (telephone ring, baby phone, siren or other acoustic warning signals) were overheard causing a predicament. The much desired “sound morsel” could also be the “sound of silence”.

LEFT MIDDLE EAR AND LEFT EUSTACHIAN TUBE



Equivalent to the left half of the mouth and pharynx, the **middle ear and Eustachian tube of the left ear** relate to an “**outgoing morsel**” and to “**not being able to eliminate a sound morsel**” (originally, the feces morsel).

Such an undesired “sound morsel” relates to any “acoustic dirt” one wants to “evacuate”, for example, an insult, verbal assaults, an accusation, complaints, scolding, criticism, distressing news, hearing something upsetting, the voice of a nagging boss, colleague, parent or spouse or, for a newborn, the voice of a stranger.

CONFLICT-ACTIVE PHASE: Starting with the DHS, during the conflict-active phase, cells in the middle ear or Eustachian tube proliferate proportionally to the intensity of the conflict. The **biological purpose of the cell increase** is to be better able to absorb (right ear) or expel (left ear) the “sound morsel”. Hence, during conflict activity the hearing ability is actually enhanced (in Nature, hearing the approach of a predator or other potential dangers is essential for survival). If the conflict persists, a flat (absorptive type) or compact growth (secretory type) develops in the ear. With prolonged conflict activity the cell buildup could completely fill the middle ear or occlude the Eustachian tube. The Eustachian tubes convey air from the back of the nose into the middle ear to equalize ear pressure. Once a Eustachian tube is blocked, the vacuum created in the ear pulls the eardrum inward making hearing difficult as the **retracted eardrum** can no longer vibrate. As a result, the **ear feels blocked**.

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 **ear discharge** and **earaches** due to the swelling with some degree of hearing loss. This is commonly called a **middle ear infection** (otitis media). When healing takes place in the Eustachian tube, the discharge flowing into the middle ear simulates a “middle ear infection”. **Candidiasis in the ear** occurs when fungi assist the healing process.

NOTE: The vestibulocochlear nerve runs through the brain relays of the middle ear. A middle ear infection is therefore accompanied by a **loss of sense of balance** (see also acoustic neuroma and vertigo related to the inner ear), which is not the case when the Eustachian tubes are 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 conventional medicine, this is usually diagnosed as an **ear polyp**.

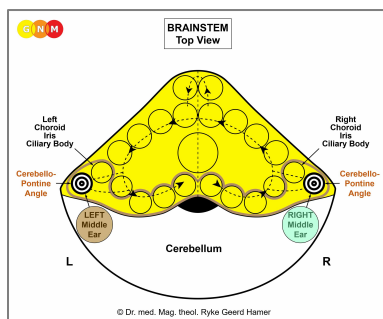
Chronic or recurring ear “infections” indicate that the hearing conflict has not been completely resolved (hanging healing). The constant tissue repair can lead to a **perforation of the eardrum** with pus continuously draining from the middle ear. Eventually, the **hearing ability becomes impaired** (compare with hearing loss related to the inner ear). Oftentimes, the distress of “not being able to catch a sound morsel” triggers further hearing conflicts worsening the condition. Hence, learning GNM *before* symptoms arise is **real preventive medicine**.

Hearing difficulties generate easily a self-devaluation conflict involving the small bones in the middle ear (**malleus, incus, stapes**). Over time, the continuing calcification of the ossicles causes **otosclerosis**, which contributes to the hearing loss.



A self-devaluation conflict can also affect the mastoid, the protruding bone located behind the ear, resulting in **mastoiditis**. A middle ear infection with temporary hearing problems is therefore frequently accompanied by an inflammation of the mastoid. The standard theory that the “infection spreads” from the middle ear (endoderm) to the mastoid bone (new mesoderm) has no scientific basis.

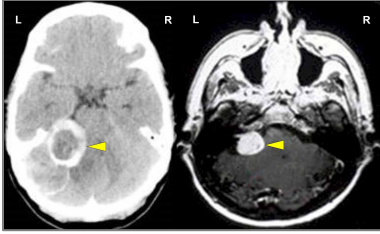
ACOUSTIC NEUROMA: According to conventional medicine, an acoustic neuroma is a “brain tumor” (glioma) on the acoustic nerve (compare with optic neuroma). The “tumor” is also termed “**vestibular schwannoma**” since the growth consists in addition to neuroglia of so-called “Schwann cells”, a certain type of glial cells. Because of the involvement of the vestibulocochlear nerve, a typical symptom of an acoustic neuroma is in addition to the loss of hearing a **loss of sense of balance** (see also vertigo related to the inner ear).



The auditory, or vestibulocochlear nerve leaves the brainstem at the cerebellopontine angle, the transitional area between the brainstem and the cerebellum, from where it ascends to supply the inner ear. It is precisely at this border from where the right and left middle ear are controlled and where acoustic neuromas are found.

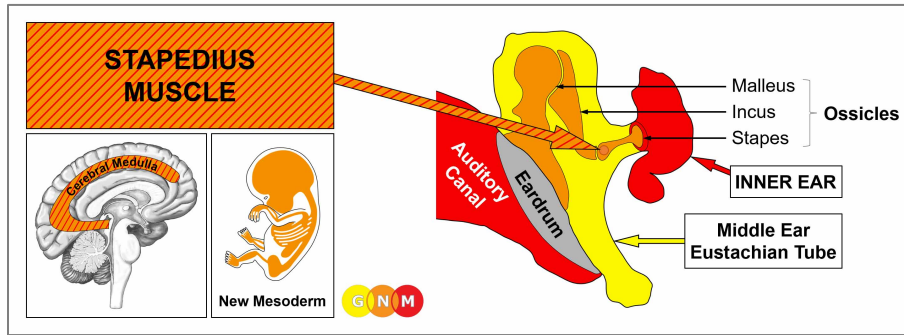
NOTE: When an edema in the brain relays of the choroid, iris, ciliary body or in the breast gland relays presses on the control center of the middle ear, this also causes balance problems (vertigo) since the vestibulocochlear nerve that regulates the sensation of balance and motion runs through the brain relays of the middle ear. A thorough brain scan analysis will reveal the exact cause of the symptom.

In GNM terms, an acoustic neuroma is neuroglia (brain connective tissue) that proliferates during the second part of the healing phase (**PCL-B**) in order to restore the area of the brain that had received the impact of the hearing conflict.



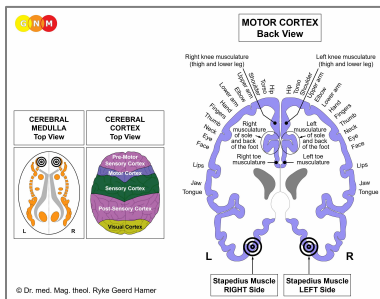
The CT on the left shows a glia-ring in the brain relay that controls the left middle ear (see GNM diagram above) indicating the beginning of **PCL-B**. The brain scan on the right shows an advanced healing process. In conventional medicine, the glia buildup is wrongly assumed to be a “brain tumor”.

NOTE: Neuroglia (visible as white on a CT scan) starts restoring the brain relay from the *periphery*! This is in clear contradiction to the established theory that a cancer, including a “brain cancer”, grows through continued cell augmentation leading to the formation of a tumor.



DEVELOPMENT AND FUNCTION OF THE STAPEDIUS MUSCLE: The middle ear contains three tiny bones or ossicles (malleus, incus, stapes) that carry the sound received from the auditory canal to the inner ear. The stapedius muscle, attached to the stapes, is fundamental in reducing sound transmission. Under normal circumstances, the stapedius is relaxed allowing sounds from the external environment to be perceived with clarity. However, when a sudden intense noise reaches the ear, the muscle contracts in order to dampen the sound to protect the inner ear from damage. The stapedius muscle consists of striated muscles, derives from the new mesoderm and is controlled from the cerebral medulla and the motor cortex.

NOTE: During sleep, the organism is in a natural state of rest (vagotonia), except for sensory sensitivities such as hearing, which are enhanced in order to become instantly aware of potential dangers. Hence, in vagotonia the stapedius muscle is relaxed in order to catch the smallest noise in the environment. This is one of the reasons why during pregnancy, starting at the fourth month, the child-bearing woman is in a prolonged state of vagotonia.



BRAIN LEVEL: The stapedius muscle 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 muscle is controlled from the **motor cortex** (part of the cerebral cortex). The stapedius muscle in the right ear is controlled from the left side of the cerebrum; the stapedius muscle in the left ear is controlled from the right cerebral hemisphere. Hence, there is a cross-over correlation from the brain to the organ (see GNM diagram showing the **motor homunculus**).

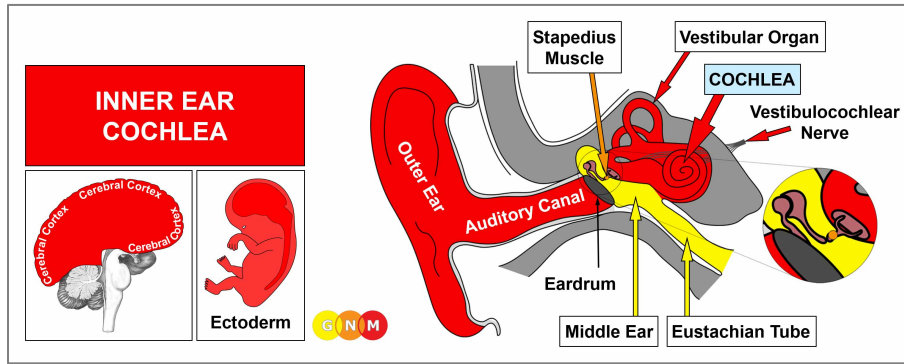
BIOLOGICAL CONFLICT: The biological conflict linked to the stapedius muscle is, according to its function, a **noise conflict** triggered by unbearable noises such as loud bangs, blasts, explosions, shots, blaring sirens, music with very high decibel levels, a sharp cry, a piercing scream, and the like.

CONFLICT-ACTIVE PHASE: **cell loss (necrosis) of stapedius muscle tissue** (controlled from the cerebral medulla) and, proportional to the degree of conflict activity, increasing **paralysis of the stapedius** (controlled from the motor cortex) causing **hyperacusis** with a decreased sound tolerance, while normal sounds are perceived as very loud (see also hyperacusis with facial paralysis).

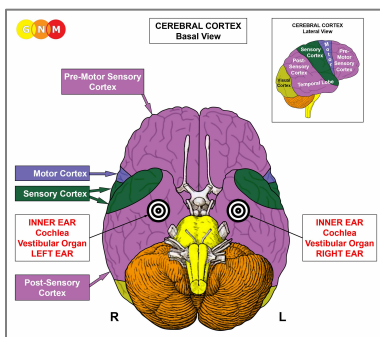
NOTE: The striated muscles belong to the group of organs that respond to the related conflict with functional loss (see also Biological Special Programs of the islet cells of the pancreas (alpha islet cells and beta islet cells), inner ear (cochlea and vestibular organ), olfactory nerves, retina and vitreous body of the eyes) or hyperfunction (periosteum and thalamus).

HEALING PHASE: During the healing phase, the stapedius muscle is reconstructed. The paralysis (hyperacusis) reaches into **PCL-A**. The Epileptoid Crisis manifests as **stapedial muscle spasms** (equivalent to a focal seizure) creating a painful fluttering sensation in the ear. In **PCL-B**, the function of the stapedius returns to normal.

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



DEVELOPMENT AND FUNCTION OF THE COCHLEA: The cochlea is a spiral-shaped cavity in the inner ear. It is the actual sensory organ of hearing. The cochlea receives the sound waves from the outer ear and auditory canal and converts them into electrical impulses that are transmitted to the brain via the auditory nerve for interpretation. The auditory nerve, or vestibulocochlear nerve, is divided into the vestibular branch, concerned with balance and motion, and a cochlear division responsible for hearing. The cochlea originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The cochlea is controlled from the **post-sensory cortex** (part of the cerebral cortex). The cochlea in the right ear is controlled from the left side of the cortex; the cochlea in the left ear is controlled from the right cortical hemisphere (temporo-basal). Hence, there is a cross-over correlation from the brain to the organ.

NOTE: The cochlea shares the control relays with the vestibular organ.

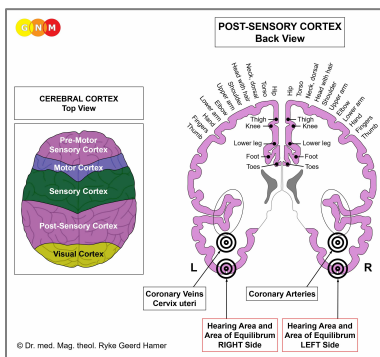
BIOLOGICAL CONFLICT: The biological conflict linked to the cochlea of the inner ear is a **hearing conflict** experienced as “**I don’t want to hear this!**”. Aggravating noises such as dog barking, a screaming child, construction noise (jackhammers, chainsaws, generators), traffic noise (loud trucks, sirens from ambulances, fire engines, or police cars), noisy neighbors, lawn mowers, grass trimmers, loud or annoying music, the nagging voice of a person, or something upsetting that has been said (“**I can’t believe what I just heard!**”) are examples of what might trigger the conflict. Often, hearing conflicts occur **on the phone**. Musicians and music lovers with very fine ears can suffer a hearing conflict during a poor musical performance. For someone who is noise-sensitive, the smallest noise can cause ear-related distress.

CONFLICT-ACTIVE PHASE: functional loss of the cochlear branch of the vestibulocochlear nerve resulting in the perception of sounds in one or both ears without an external source. This condition is called **tinnitus** (compare with hyperacusis caused by a noise conflict, linked to the stapedius muscle).

NOTE: The cochlea (inner ear) belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with hyperfunction (see periosteum and thalamus) or functional loss (see also Biological Special Programs of the vestibular organ (inner ear), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles).

The ringing, buzzing, humming, whistling, clicking, tinkling, hissing, roaring, and the like, is a frequency of the sound associated with the hearing conflict. The **biological purpose of the tinnitus** is to be a warning signal saying “last time you heard this, you were in danger. Watch out!”. This explains the variety of sounds heard by people with tinnitus. Depending on the magnitude of the conflict, the sounds or noises can be mild and only noticeable in a quiet room or become extremely loud causing difficulties hearing external sounds (compare with hearing loss in the healing phase). A person might also hear complete sounds or noises such as engine noise, the ringing of a telephone, a musical tune (“music tinnitus”), or a recurring sentence or word (“word tinnitus”). If the tinnitus is present all the time, this indicates that the conflict has not been resolved. Potentially, the tinnitus sound itself causes a hearing conflict, leading to a chronic condition (hanging conflict).

NOTE: Whether the cochlea of the right or left inner ear (or both) is affected is determined by a person’s handedness and whether the conflict is mother/child or partner-related.



The brain relays of the inner ear are located right underneath the control centers of the coronary arteries and coronary veins/cervix mucosa, which are assigned to a male territorial loss conflict and a female sexual conflict respectively. Hence, the hearing conflict (“I don’t want to hear this!”) involving the cochlea can also have a territorial or sexual aspect (the voice of a “predator” or rival in the territory, the voices of arguing people in the house; the voice of a sexual abuser, hearing the parents having sex, hearing that one’s sexual mate was unfaithful). The same applies to the vestibular organ. Whether the conflict is experienced in a male or female fashion is determined by a person’s gender, laterality, and hormone status.

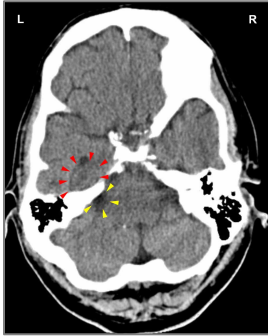
When both hearing conflicts are associated with sounds and noises, the person will develop a double “**sound tinnitus**” affecting **both ears**. If, however, one of the two conflicts or both were triggered by the voice(s) of person(s), this leads to **hearing voices**. In GNM we call this a **Hearing Constellation**. Conventional medicine considers hearing voices a mental disorder (“paranoid schizophrenia”). In the context of GNM, hearing voices is essentially a double tinnitus with the difference that instead of hearing one or more sounds, a person hears one or more voices. The voice(s) correspond to those that were heard when the original hearing conflict occurred. Traumatic hearing conflicts can result in severe auditory delusions.



Down Syndrome: Dr. Hamer made the ground-breaking discovery that Down Syndrome is not, as assumed, caused by a trisomy 21 (a third chromosome attached to the 21st gene pair) or mosaicism (some cells have a trisomy 21, others have the typical number of chromosomes) but by biological conflicts experienced by the fetus, precisely, by a **double hearing conflict** that occurred within the first three months of pregnancy (see GNM Article “Understanding Genetic Diseases” and how a four-year-old child overcame the condition through the application of German New Medicine).

NOTE: A Trisomy can be determined before conception since it is an occurrence that happens already in the egg or in the sperm. Yet, there are children who have a **Trisomy 21** **without the characteristic symptoms and features of Down Syndrome** (*Journal of Medical Genetics*, July 1997).

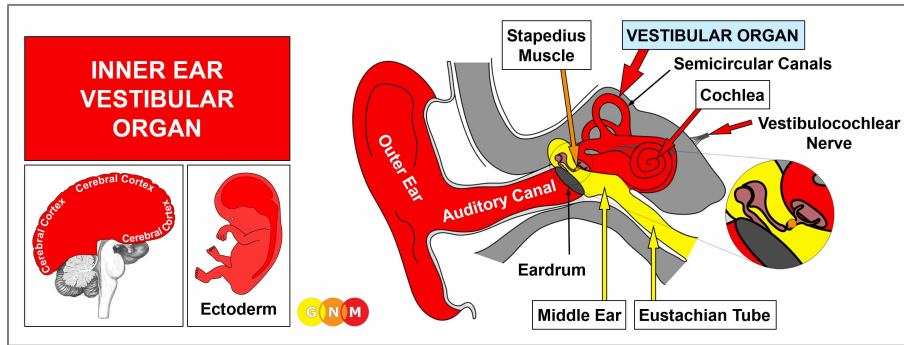
HEALING PHASE: During the healing phase ([PCL-A](#)) the volume of the tinnitus sound decreases. However, the swelling created by the edema (fluid accumulation) in the inner ear causes, for the time being, **hearing impairment** (a loss of the frequencies of the tinnitus sound) **or hearing loss** in the affected ear (compare with hearing impairment related to the middle ear). Once the edema has been expelled (during the Epileptoid Crisis) the hearing ability slowly returns to normal, provided there are no conflict relapses. Triggers that reactivate a hearing conflict could also be a smell (the odor of the “messenger”) or a visual track (the site of the acoustic source). With a hanging healing, the tissue in the inner ear eventually wears out leading in the long run to deafness. This is why it is important to identify and resolve the original conflict as soon as possible.



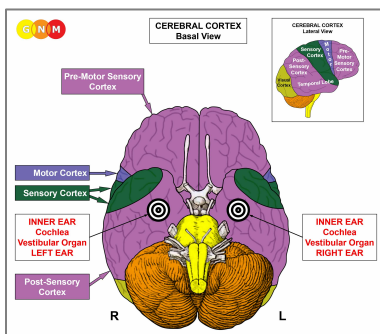
This CT scan shows an edematous ring (perifocal and intrafocal edema) in the “hearing relay” on the left side of the cerebral cortex (see red arrows – [view the GNM diagram](#)). Hence, the hearing impairment in the right ear (in [PCL-A](#)).

The yellow arrow points to an edema in the control center of the transverse colon (in the brainstem). The related “indigestible morsel conflict” most likely occurred together with the hearing conflict (for a right-handed person related to a partner).

Hearing difficulties often trigger self-devaluation conflicts because of “not being able to hear well”. This affects the small bones ([malleus](#), [incus](#), [stapes](#)) in the middle ear, which can result in a permanent hearing loss (see otosclerosis). Using a hearing-aid while the inner ear undergoes healing can, therefore, have a highly encouraging effect.



DEVELOPMENT AND FUNCTION OF THE VESTIBULAR ORGAN: The vestibular system is the region of the inner ear where the semicircular canals join with the cochlea. It is the part of the ear that regulates the sensation of balance and motion (the cochlear branch of the vestibulocochlear nerve is responsible for hearing). The vestibular organ originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The vestibular organ is controlled from the **post-sensory cortex** (part of the cerebral cortex). The vestibular organ in the right ear is controlled from the left side of the cortex; the vestibular organ in the left ear is controlled from the right cortical hemisphere (temporo-basal). Hence, there is a cross-over correlation from the brain to the organ.

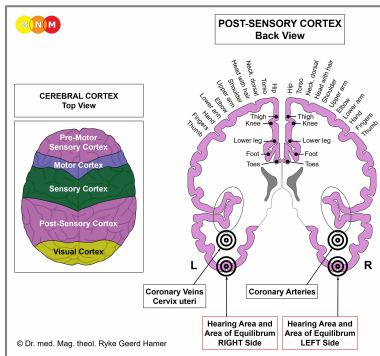
NOTE: The vestibular organ shares the control relays with the cochlea.

BIOLOGICAL CONFLICT: According to its function, the biological conflict linked to the vestibular organ is a **balance conflict**, more precisely, a **falling conflict**. Any fall (accidental fall in sports, at work, falling down the stairs, slipping on a wet or icy surface, a fall from a ladder, tripping over a cable) could trigger the conflict. Certain professions (builders, construction workers, roofers) but also infants and the elderly are more at risk. People with ALS or MS, who have difficulties balancing, often live in fear of falling; the same holds true for epileptics. The conflict also relates to seeing someone else fall or collapse (witnessing someone having a stroke or a heart attack) or hearing that a loved one fell or “dropped dead”. In a transposed sense, the conflict could be experienced as a “fall from grace” or as feeling “dumped”, let’s say, after a separation.

CONFLICT-ACTIVE PHASE: functional loss of the vestibular branch of the vestibulocochlear nerve resulting in a loss of balance, a condition called **vertigo** (see also acoustic neuroma and vertigo with a “middle ear infection”).

NOTE: The vestibular organ (inner ear) belongs to the group of organs that respond to the related conflict not with cell proliferation or cell loss but with hyperfunction (see periosteum and thalamus) or functional loss (see also Biological Special Programs of the cochlea (inner ear), olfactory nerves, retina and vitreous body of the eyes, islet cells of the pancreas (alpha islet cells and beta islet cells), skeletal muscles).

The **symptom** of vertigo is a **sensation of spinning, swaying or falling to one side** (vertigo “spins” should not be confused with light-headed dizziness). Whether the tendency is to fall to the right or left is determined by a person’s handedness and whether the conflict is mother/child or partner-related. Hence, if a right-handed person has a mother-related falling conflict, there is a tendency to fall or spin to the left, that is, towards the mother (with the Hamer Focus on the right side of the cortex); if the conflict is partner-related, the tendency is to fall or spin to the right, that is, towards the partner (with the Hamer Focus on the left side of the cortex). For left-handers, it is reversed. If the conflict concerns oneself, the falling or spinning always tends to the side which relates to the original conflict. For example, if the DHS was a fall to the left, the specific vertigo symptom is also a sensation of spinning or falling to the left.

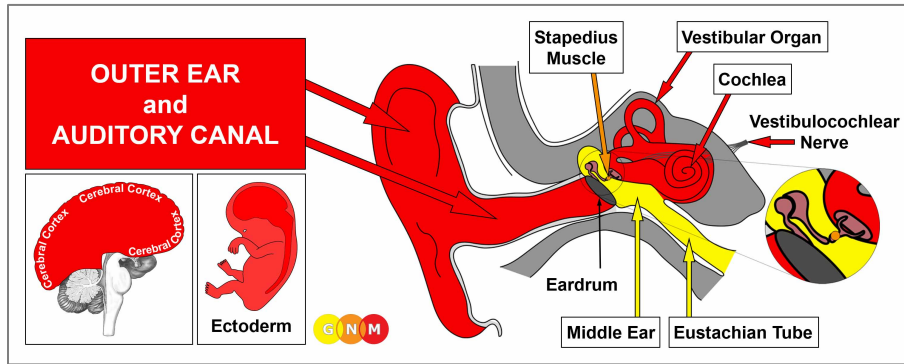


The brain relays of the inner ear are located right underneath the control centers of the coronary arteries and coronary veins/cervix mucosa, which are assigned to a male territorial loss conflict and a female sexual conflict respectively. Hence, the falling conflict involving the vestibular organ can also have a territorial or sexual aspect (feeling “dropped” by a partner). The same applies to the cochlea. Whether the conflict is experienced in a male or female fashion is determined by a person’s gender, laterality, and hormone status.

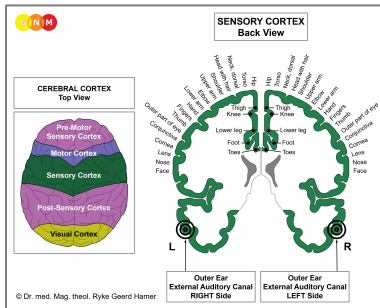
HEALING PHASE: During the healing phase the dizziness diminishes. The Epileptoid Crisis manifests as a sudden **vertigo fit**, potentially with severe nausea and vomiting. The extent of the Epi-Crisis is determined by the intensity and duration of the conflict-active phase. Recurring vertigo attacks are triggered by setting on a track that was established when the original falling conflict occurred. Alcohol, for example, could be such a track.

If the **falling conflicts** affect the vestibular organ of both ears this causes, in GNM terms, a **Vertigo Constellation**. The **symptoms** are a wide-based and unsteady stance and gait with reeling or lurching movements. The medical term for this condition is **ataxia or Friedreich’s ataxia**. The physical incoordination and clumsiness is not the result of muscle weakness but due to the unbalanced equilibrium caused by the “double vertigo”. Since infants and the elderly are more likely to suffer falling conflicts, ataxia develops more often in childhood and in later life.

Meniere’s disease, also known as **primary endolymphatic hydrops**, is, according to conventional medicine, “an inner ear disorder that affects balance and hearing”. Based on GNM, the condition is a conflict combination of a falling conflict (involving the vestibular organ) and a hearing conflict (involving the cochlea).

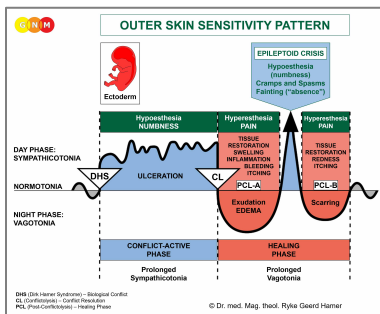


DEVELOPMENT AND FUNCTION OF THE OUTER EAR AND AUDITORY CANAL: The auditory canal extends from the outer ear to the eardrum (tympanic membrane). The outer ear, or auricle, is made up of cartilage covered with skin (corium skin and epidermis). The main function of the outer ear is to capture sound from the external environment and carry it through the auditory canal to the middle ear, where the acoustic wave is transformed into vibrations reaching the inner ear. The lining of the outer ear and of the ear canal consists of squamous epithelium, originates from the ectoderm and is therefore controlled from the cerebral cortex.



BRAIN LEVEL: The epithelial lining of the outer ear and auditory canal is controlled from the **sensory cortex** (part of the cerebral cortex). The outer ear and ear canal of the right ear is controlled from the left side of the cortex; the outer ear and ear canal of the left ear is controlled from the right cortical hemisphere. Hence, there is a cross-over correlation from the brain to the organ (see GNM diagram showing the **sensory homunculus**).

BIOLOGICAL CONFLICT: The biological conflict linked to the outer ear and auditory canal is a **“separation conflict”** associated with the ear. The conflict is experienced as a **loss of skin contact at the outer ear**, including the earlobe, or as **not wanting to be touched at the ear or in the ear** (licking or kissing the ear, unpleasant ear examination procedures, manipulation in the ear canal). Wanting to get rid of something in the ear, for example of water, could also trigger the conflict.



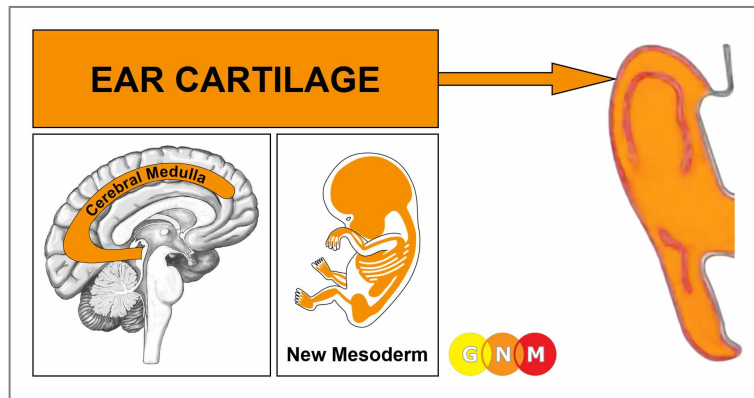
The Biological Special Program of the **outer ear and auditory canal** follows the **OUTER SKIN SENSITIVITY PATTERN** with hypoaesthesia during the conflict-active phase and the Epileptoid Crisis and hypersensitivity in the healing phase.

CONFLICT-ACTIVE PHASE: ulceration in the epithelial lining of the outer ear and/or the ear canal. The **biological purpose of the cell loss** is to widen the auditory passageway to improve the sound reception. With intense or prolonged conflict activity, the ulceration makes the **skin dry and flaky**; with acute conflict activity the skin on or in the ear feels numb (see Outer Skin Sensitivity Pattern above).

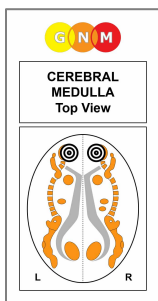
NOTE: The corium skin below the outer skin lining the ear canal contains sebaceous glands that produce ear wax. “Feeling soiled” in the ear (hearing “dirty” words) or an “attack conflict” (insulting words, for example, over the phone) lead to an **overproduction of ear wax** in the conflict-active phase.

HEALING PHASE: During the healing phase the ulcerated area is replenished with new cells. Typical healing symptoms are **itchy ears** and, if the healing process is more intense, a **skin rash** with **inflammation** and **redness**. The healing process in the ear canal might be accompanied by clear discharge, commonly called “**swimmer’s ear**”. A large swelling, termed a **cholesteatoma**, can cause a blockage in the auditory canal resulting in hearing difficulties until the healing process is complete.

NOTE: Whether the right or left ear 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 ear that is associated with the hearing or separation conflict.



DEVELOPMENT AND FUNCTION OF THE EAR CARTILAGE: The ear cartilage forms the shape of the ear and the outer third of the auditory canal. It consists of elastic connective tissue covered by a thin layer, called the perichondrium (unlike other connective tissue, cartilage does not contain blood vessels). The ear cartilage originates from the new mesoderm and is therefore controlled from the cerebral medulla.



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

BIOLOGICAL CONFLICT: The biological conflict linked to the ear cartilage is a **self-devaluation conflict** associated with the ear (compare with self-devaluation conflict related to the ossicles). Generally, the conflict is experienced as “my ears are worthless”, let’s say, because of having missed an important message. Being hard of hearing and therefore not being able to follow a conversation might also cause the conflict.

In line with evolutionary reasoning, **self-devaluation conflicts** are the primary conflict theme associated with **cerebral medulla-controlled organs** deriving from the new mesoderm.

CONFLICT-ACTIVE PHASE: **necrosis (cell loss)** of cartilage tissue, which goes unnoticed.

HEALING PHASE: During the first part of the healing phase (**PCL-A**) the tissue loss is replenished through **cell proliferation** with **swelling** due to the edema (fluid accumulation). If bacteria are available, they will assist the healing process. With an inflammation, the condition is called **perichondritis**.



Since the earlobe is not composed of cartilage, the inflammation is restricted to the auricle.

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

Source: www.learninggnm.com