# Individuality

When we assess patients we seek out their individual characteristics, their distinctive, idiosyncratic, inborn and acquired features, since it is these which offer evidence, clues, hints at what might be causing the individual's complaints. We look for observable anomalies (short leg, small hemi-pelvis, etc.) but of course many variations are unseen. Anatomists have made us aware that anatomical and structural features such as nerves, blood vessels and even organs are not infrequently variable in their location, dimensions and orientation. Examples include individuals with duplex ureters, which sometimes merge before they reach the bladder and sometimes do not. In the field of manual therapy we have the example of the relationship between the piriformis muscle and the sciatic nerve which it overlays in about 80% of people, but is penetrated by (totally or partially) in the remainder, with potentially painful results (Travell & Simons 1992)

We naturally also evaluate body type (endomorph, ectomorph, mesomorph, or some other categorization model); physiological tendencies (hypermobility for example); and then we might assess for the individual features relative to posture and gait – comparing what we note with hypothetical norms; and then we try to unveil individual patterns of adaptation, and consequent joint and soft tissue restrictions and compensations (restricted, blocked, short, weak, etc.) and localized dysfunctions (trigger points, fibrosis for example)...and out of all this information a picture is built, in which these findings are laid against a background of the patient's history...and out of this a rational plan of therapeutic or rehabilitation action hopefully emerges.

In the wider world of health care the study of individuality has reached complex proportions, and some of the issues raised, and the methods used, may be seen to potentially impact on the bodywork, movement arena, offering even finer grids through which our patient's history and characteristics might usefully be sieved.

Over 30 years ago Williams (1976) identified biochemical individuality when he demonstrated that, in groups of students at the University of Texas, there were variations in individual requirements (to maintain optimum health) of as much as 700% for most nutrients, for example vitamin C.

Around the same time, looking at what came to be termed 'metabolic individuality', Kelley (1974) and Bieler (1978) separately observed that there appeared to be a dominance of one or the other aspect of the endocrine system in most people (thyroid, pituitary, adrenal, etc.) and constructed protocols for health enhancement (and in Kelley's case, the treatment of cancer) based on these observations.There were close approximations between the Kelley and Bieler classifications, for example, what Kelley called 'sympathetic-vegetarian' was very similar to Bieler's 'pituitary type', while Kelley's 'parasympathetic-carnivore' equated closely with Bieler's 'adrenal type'.

In recent years, D'Adamo (2001) has constructed a framework which helps to clarify the confusion arising from such diversity, by first linking a host of variables to blood type, and then to secretor status. This makes a great deal of sense, and seems to be backed by solid scientific observation of the way in which the body works. It may also explain why the Bieler and Kelley classifications exist, and clearly offers additional validation for William's work. Wolcott and Fahey (2000) have also gone far beyond Kelley's original work and have attempted to blend autonomic type, blood type, oxidative type, endocrine type, electrolyte balance, prostaglandin balance, acid/alkaline type, constitutional type and catabolic/anabolic balance.

Do we all have different biochemical needs because we are different metabolically, or are we different metabolically because of our inborn variables. And most critically, if genetics is the determining factor, is this a fixed

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state of affairs, or conceivably modifiable?

Bland (Martin 2001) suggests that gene expression is 'not hard wired', and might be capable of being influenced by environmental factors (including diet). And now Ames et al. (2002) have shown this to be so. Ames lists more than 50 genetic diseases successfully treated with high doses of vitamins and other nutrients, most of them rare inborn metabolic diseases due to defective enzymes.

So where does this leave bodyworkers? Possibly in need of updating our understanding of this broader view of individuality, and how it may be possible to influence gene-expression via alteration of biochemistry, through diet for example. There seem to be great potentials for influencing the biomechanical status of our patients, via their biochemistry.

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