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Retained Primitive Reflexes: Their relation to Pervasive Developmental Disorders, Autistic Spectrum Disorders, Attention Deficits, and Learning Difficulties

INTRODUCTION: The in-utero emergence and organization of a set of 'primitive' (i.e., brainstem level) reflexes allows infants to perform several automatic, survival-oriented functions during their first year of life. With normal development, these primitive reflexes are progressively integrated back into the brainstem and superseded by postural reflexes and volitional cortical functions. The Institute for Neuro-Physiological Psychology (INPP) in England and the Variably Maladjusted Primitives (VMP) group in Australia have studied primitive reflexes independently of each other over the past two decades. They have found that if primitive reflexes are 'retained' (i.e., not integrated) beyond the normal developmental period, then these 'Retained Primitive Reflexes' (RPRs) can adversely affect a child's maturation process, interfere with their cortical brain's ability to develop sensory processing skills, and/or delay development of bipedal posture, socialization, and learning.

METHODS: The Fear Paralysis Reflex (FPR), if retained beyond 2 months after birth, is associated with excess parasympathetic responses, including fear of new or novel situations, failure of social cueing, withdrawal, anxiety, and panic disorders. This reflex, which emerges first, is also usually evaluated and treated first. The patient is examined for and, if present, treated for vagal nerve entrapments and vagal perineural fascial adhesions in the cervical, thoracic, and abdominal regions, and at the jugular foramina using fascial release techniques. They are then evaluated for temporal bone fixations, which are corrected using intraoral chiropractic cranial adjusting. The Moro Reflex (MR), if retained beyond 6 months after birth, is associated with excess sympathetic responses including over-stimulation, hyper-vigilance, reactivity, and inattention. The patient is first evaluated in the 'fetal position' and treated for coronal or sagittal suture shearing. They are then evaluated in the 'startle position' (hands up, head/neck in full extension, mouth open, inhaling) and treated for shearing fixations in the lambdoidal and occipital-mastoid sutures. Following correction of the FPR or MR, related ocular patterns are balanced using habituation corrections to the eyes. Once FPR and MR are fully integrated, the other primitive reflexes (e.g., Palmar, Plantar, Tonic Labyrinthine, Tonic Neck, Rooting, and Spinal Galant) are corrected as found.

DISCUSSION: It is recommended that children who present with pervasive developmental disorders (PDD), autistic spectrum disorders (ASD), attention deficits (ADD/ADHD), and/or learning difficulties (LD) be evaluated for RPRs. Primitive reflexes are normal components of our phylogenetic and perinatal neurologic development. Both the FPR and MR are designed as early defensive mechanisms and MR is a standard component of the widely used APGAR Score of neonatal health. Ideally, the FPR is present to 2 months and MR is evident until 6 months postnatally. RPRs are evaluated and treated because, if they are not re-integrated into the brainstem at the proper time, it is posited that they can interfere with the normal development and function of cortically based postural reflexes, sensory integration, and cognitive activities. The FPR and MR can be gateways which inhibit integration of the other reflexes, ultimately leading to delayed development of critical skills related to bipedal posture, social behavior, and learning.

CONCLUSION: The goal of RPR therapy is to integrate primitive reflexes into the brainstem, allowing midbrain and cortical functions to develop and take precedence. There is supportive research that notes decreasing primitive reflex activity is associated with the onset of volitional motor activity in normal infants. Clinically it has been observed that integrating a RPR may positively affect a patient's neurologic development. RPRs can be a factor in patients presenting with PDD, ASD, ADD/ADHD, and/or LD. Additional study is called for to establish if chiropractic care for RPRs can demonstrate consistent positive outcomes and ultimately determine which subsets of patients would be best candidates for treatment. (*This is an abstract from a conference presentation only and does not represent a full work that has been peer-reviewed and accepted for publication*.)