

SOC and Interpretation of Values

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Base Considerations

There are some core points to be understood so that the rest of this note is put in context.

1. The SOC is undeniably valuable in helping to identify and work with client's lifestyle changes.
2. The SOC does influence certain aspects in the programme.
3. The influence on test scores was not present until approximately 5 years ago: in early programmes in my possession it did not have an effect on the test matrix. This meant that the oft touted reference points of scores above 85 had some validity. The change I believe was prompted by the fact that QX users did not pay attention to lifestyle issues and when clients did not make progress based upon solely QXCI treatment asked QX Ltd why. One underlying factor was that the SOC in many cases was not accounted for nor the lifestyle issues addressed. This in my belief led to a change so that SOC values scaled the scores and the number of significant (red and purple) items so that the practitioner would take note.
4. Dr Nelson some months ago said that the option of whether you use the SOC in the programme is up to the practitioner: however lifestyle issues must be part of the client assessment.
5. It is possible to use any SOC value and still work with the results. Essentially scores in sub-screens (vitamins, minerals etc.) all derive in some way from the main matrix screens (more detail below). Thus essentially making a note of the number of and score banding in reds and purples gives you a reference point when assessing whether an item is significant in the total context of the client presentation.
6. Notwithstanding this you can also view individual screens (minerals, vitamins etc.) within their own context. Look for the extremes of the hyper-reactive and the hypo-reactive. Reflect on what visually the organ chart, risk profile chart etc. tell you about imbalances in identifying aspects that lie outside the middle band i.e. the deep valleys and the high mountains. If you were a nutritionist with no other knowledge and just used the nutrition screens then this approach would be effective: possibly not as effective as placing the optimum support for the client where it should be. This means that minerals and vitamins may not feature at all in the red and purple significant bands in the main text matrix (or their mirror image at the low end of the matrix).

Personally I have no difficulty in discriminating which aspects are relevant to the client and which may be of secondary support importance. For example if nutrition does not feature highly in a client but my view of their vitality and presentation is that certain minerals, whilst not essential would be supportive, then I will suggest this possibility. Personally I cannot explain when I do and don't use SOC values in the programme. I always have as part of the questionnaire the client brings to each consultation, a listing corresponding to the SOC table. I will also use the SOC table to illustrate the change in reducing obstruction to the health recovery process that increasing/decreasing certain items will effect.

Reference Test Scores

Person Type	SOC	Test Score	No Reds	
<i>Theoretical</i>	1	all 50	0	Perfect health
<i>Ideal</i>	1	40-80	0	Perfect Health
<i>Well</i>	1	to 110-120	2-4	
<i>Unwell</i>	1	to 120-130	6-20	

The effect of the SOC on scaling of test scores.

Person Type	SOC	Test Score	No Reds	
<i>Theoretical</i>	1	all 50	0	Perfect health
<i>Ideal</i>	1	40-80		Perfect Health
<i>Well Child</i>	10	to 110-120	2-4	
<i>Unwell Child</i>	10	to 120-130	6-20	
<i>Healthy Adult</i>	30	to 110-130	4-6	

SOC Influence on Test Scores

Person Type	SOC	Test Score	No Reds
Well Child	10	to 110-120	2-4
Unwell Child	10	to 120-130	6-20
Healthy Adult	30	to 110-130	4-6
Adult SOC	100	to 140-160	10-25
	200	to 180-200	20-40
	400	to 300-400	30-60

Varhope Score

When using a blood flow detector that uses IRed to examine the circulation, the client must not smoke for 20 minutes before the test. Smoking (amongst other things) affects the peripheral circulation. The calibration basis needs to be appropriate.

In measuring the resistance of the client the QX method is the amount of time it takes for a signal from one input score to be detected at another distal one. If there was a piece of internal wire running between the points there would be a short circuit and a very rapid transit time. If there was a wired up jaw then there would again be a degree of short circuiting. If there are mercury fillings in the mouth and given the electrolyte nature of fluid in the mouth there will be a degree of short circuits. Thus a judgment has been made in terms of adjusting the resistance to account for the number of mercury fillings. It is a value judgment and there is no way to scientifically definitively do this: it is just impracticable to test 6,000 clients 10 times before and after mercury filling removal.

Similarly other aspects will affect voltage and amperage (smoking, caffeine etc.) again a judgment call has been taken and an adjustment made.

Whilst absolute values are important it is also the progressive change in Varhope values that are relevant. So consider both aspects and in particular the change as your client undergoes successive treatments.

Origination of Individual Screens

There are a variety of methods used for derivation of the individual screens. A primary factor in this is whether multiple variations of the same item (e.g. different forms of magnesium) exist in the test matrix. For some items there is a singular correspondence. The following may help:

1. *Minerals*: there are multiple forms in the main text matrix and my perception is an average is calculated. Thus if an item appears to be an issue or there is an item that you wish to evaluate you search in the main matrix to find it and do an individual reaction. Personally I find the individual reaction in the main matrix considerably more useful and consistent than in the subscreens. QX have been requested to make this facility identical throughout but there appear to be technical difficulties in implementing this.
2. *Vitamins*: the average values are a re-test of the whole group. In my opinion they are not representatively useful and the values in the B vitamins etc. should be individually assessed. Some of these directly transpose from reactivity scores in the main matrix. Others, where there are multiple forms of the same item, appear to be calculated values.
3. *Amino Acids*: as above.
4. *Oriental herbs, aroma*: these are directly transposed from the main matrix reactivity scores.
5. *Allergy items*: these are transposed directly as reactivity scores from the main matrix. However please do note that the banding is applied within the allergy items and is totally different from the main matrix colour banding. Please also note if you work extensively with allergies that foods or food extracts should be used in the individual reaction. Allersodes are at a desensitising potency and thus the allergic reactance is not always a reliable indicator of the allergic component of the reactivity.
6. *Allergy panel: group items*. These reactive scores correspond to some general NV and DR homeopathics in the main test matrix.

7. *Hormones* in nutrition and homeopathy: these appear to correspond to reactivities in the main test screen.
8. *Sarcodes*: the majority of these derive from the main test screen reactivity scores.

For a variety of the reasons above whilst personally I find the sub-screens useful they are not for me definitive and my main exploration and validation is undertaken in the full test matrix.

Final Note on Reference Values

I see many times on the discussion groups that everything over 85 is an issue. This is not so black and white.

Please reflect on the reference test scores in the first table.

Essentially:

1. If there is a real life SOC of 1 then the absolutely totally (impossible) person in perfect health would have every test score of 50 and no reds. The person would also be dead because they are homeostatic not homeokinetic.
2. The less theoretical real ideal perfect health person would have an SOC of 1 and a score band range of 40-80. This would reflect ideal health and homeokinesis.

There are known instances of for example monks presenting with almost this score range and no reds. This I believe is statistically possible but may also reflect the degree of artificial intelligence within the programme.

The 40-80 range thus provides the perspective for someone who has a brilliant lifestyle. You could then take everything below 40 and everything above 80 as being a hypo or hyper-reactive issue.

In terms of other clients with SOC values then the red and purple bands should be employed. The programme software only enables banding to be displayed for the top scores and not the hypo-reactive significant items at the bottom. You can however adopt one or two measures to get a handle on this. Probably the significance of doing this will be more important if:

1. The client indicates hypo-reactivity.
2. There is not a preponderance of empties at the bottom of the score list. (The empty signatures are probably equivalent to distilled water for which there should be a nil reaction. If the client is reacting properly then they will have a nil reaction to this and all the 100 or so empties should line up at the bottom of the matrix).

The methods to band the bottom are:

1. Look at the difference between the bottom and top reds and purples and apply the same difference calculation to the bottom of the matrix.

2. Count up how many reds and purples there are and apply the same methods.