



Applied Kinesiology versus Neural Kinesiology

A Medical Critique for the Clarification of Basic Concepts

by Dr. med. Hans Garten

Editor's preliminary comment: in the following article, the author, Dr. Garten, expresses his disagreement with statements of Dr. D. Klinghardt and L. Williams „on the targeted use of SANUM remedies“ (SANUM Post 30/1995). Dr. Garten is here primarily concerned with clarifying conceptual and procedural issues, and with this in mind, he here critically takes on the above mentioned article. This article is granted space in order to allow the free expression of differing opinions concerning the increasingly popular muscle test method.

SANUM preparations are valuable naturopathic remedies, which represent, in many cases, a very effective alternative even to surgical intervention (e.g. in cases of periodontitis or osteitis). These remedies offer an effective alternative to chemotherapy also in cases of systemic candidosis. They should be administered according to the diagnostic criteria of darkfield microscopy and bioenergetic testing. Out of a diversity of possible remedies, the optimal ones can then be filtered out in a kind of “final selection“ process. For this, however, clear diagnostic concepts are necessary.

In the article by Dr. D. Klinghardt and W. Williams, an attempt was made, under the category of “Neural Kinesiology“, to describe a further development of the kinesiological method. However, the scientific explanatory model presented in the article seems to this author to be fragmentary and not to correspond to the Applied

Kinesiology (AK) of George Goodheart. Therefore, it is questionable whether the method presented by Klinghardt & Williams meets the criteria for a reproducible test. It is the aim of the following exposition to substantiate this doubt.

Definition of AK and various muscle test reactions

Applied Kinesiology (AK) is primarily a diagnostic method which, by manual testing of individual muscles and the change in their reactions to many different kinds of diagnostic stimuli and therapeutic measures, enables conclusions to be arrived at concerning functional relationships between disturbances. Applied Kinesiology was developed by George Goodheart and is maintained by the International College of Applied Kinesiology (ICAK) internationally, as well as by ICAK-Germany (ICAK-D) in German-speaking countries. The medical and dental agency associated with ICAK-D is the *Internationale Ärztesellschaft für Applied Kinesiology (IÄAK)* [International Physician's Society for Applied Kinesiology].

Requirements for the patient-driven muscle test

Definition of the test procedure and mechanism of the manual muscle test in AK: the patient is asked to maximally flex the muscle (muscle complex) to be tested in a precisely predefined direction, while the investigator slowly exerts increasing force, sufficient to maintain constant the length of the muscle that the patient is contracting. This ensures that this part of

the test proceeds isometrically. When the patient's force no longer increases (maximum isometric contraction), the investigator increases his pressure a little bit, thus slightly lengthening the patient's muscle.

This slight increase in pressure beyond the maximum isometric contraction induces a transition from isometric contraction over to eccentric contraction. This leads to a slight lengthening (maximum 3° of joint movement), which in turn activates the muscle spindle's feedback mechanism. The muscle spindle is lengthened during the eccentric muscle contraction, and the Ia fiber conveys this impulse to the posterior horn. This spindle excitation then activates, via monosynaptic and polysynaptic connections, additional fibers of the contracting muscle.

The force that can be generated during eccentric contraction is greater than with isometric contraction. There, a muscle that is strong (either hyper- or normoreactive) can resist the investigator's additional force and maintain the test position. A muscle that cannot keep up with the increasing force exerted by eccentric contraction can be considered to be weak or hyporeactive.

Diagnostics in Applied Kinesiology

In order to explain how diagnoses are made in Applied Kinesiology and the significance that various changes can have in the muscle test reaction, we need to first define the various muscle test reaction to be differentiated.



Normoreactive muscle

During the defined muscle test procedure, the muscle (muscle complex) can resist the force exerted by the investigator and maintain the test position during the test. The muscle complex is designated as “normoreactive“ when the primary agonist in the test can be inhibited by one of the following measures, thus causing the joint to move:

1. Manual shortening of the spindle cells of the primary agonist in the test.
2. Stimulation of the sedation point of the meridian corresponding to the primary agonist.
3. Stroking the associated meridian in the opposite direction to its energy flow (“running the meridian“).
4. Applying one pole (north or south) of a magnet (at least 3000 Gauss strength) to the belly of the muscle.

Hyperreactive muscle

The muscle (muscle complex) can resist the force exerted by the investigator during the defined test procedure. However, the primary agonist cannot be inhibited by any of the measures defined above for the normoreactive muscle.

Hyporeactive muscle

The muscle (muscle complex) cannot resist the force exerted by the investigator during the defined test procedure. The test position cannot be maintained. The hyporeactive muscle can be differentiated from a functionally weak muscle by means of the following characteristic:

The inhibition of a hyporeactive muscle can be altered by means of

a sensory stimulus (Challenge) which the patient is exposed to, and become normo- or hyperreactive. This distinguishes a hyporeactive muscle from a weak muscle.

In addition to the above described purely neuromuscular mechanism of the muscle test, the Challenge involves alterations in the area of basic regulation as per Pischinger (4-7), which wind up having an effect on the muscle test reaction.

The Challenge Principle in AK diagnostics

By “Challenge“ is meant a diagnostic sensory stimulus that the patient is exposed to. These sensory stimuli include both mechanical (structural) as well as chemical and emotional stimuli. An oral test of a substance is a chemical stimulus; a test shove against a blocked vertebra is a mechanical Challenge; thinking about a psychically stressful situation is an emotional Challenge.

A positive Challenge is any diagnostic sensory stimulation which alters a muscle reaction compared to its reaction prior to the Challenge. The patient touching a disturbed body region is a variant of the Challenge, which may be designated as “Touch Challenge“. Using Goodheart’s terminology, one speaks of “Therapy Localization“.

In terms of the definition of Therapy Localization (TL), the following applies: when a patient touches a body region, and this induces a change in the muscle

reaction, then the touched location exhibits a deviation from the norm.

Significance of the reaction change caused by TL and Challenge

Every muscle test reaction that comes up normal signifies that the feedback circuit associated with the muscle (the viscerosomatic segment consisting of organ, vertebral plane, segmental blood circulation, segmental lymph supply, muscle, etc.) is in a normoreactive, nonregulatorily disturbed, burden- or stressfree state. Both hyperreactive and the hyporeactive muscles indicate that there is some stress or burden generally, or in the associated viscerosomatic segment specifically.

When using Applied Kinesiology, the reaction changes of a normoreactive muscle to a sensory provocation are nearly as often hyperreactive as hyporeactive (weakness). Both reaction changes can be interpreted as stress reactions of the muscle under test, somewhat analogous to Selye’s Generalized Adaptation Syndrome (9).

A critique of Klinghardt & Williams’ muscle test

Since Klinghardt & Williams refer exclusively to strong and weak muscles, and since reaction changes are described exclusively as strong and weak, these authors can hardly be testing the patients at maximum strength. This is not the way to arrive at usable test results. The following provisos apply for a reproducible muscle test:



1. Allowing the patient to initiate the test.
2. Allowing the patient sufficient time to build up to maximum strength.
3. Isometric contraction and, when maximum isometric strength is reached, minimal increase of the test force on the part of the investigator in order to test the patient's ability to maintain the test position.

The descriptions of the neurological mechanisms for therapy localization, as well as the description of "blocked regulation" and the described procedure for the testing of patients, seem to be a mixture of scientific explanatory models, esoteric conventions and evident contradictions. This will be substantiated in the following.

Various explanatory models for the neurology of the muscle test, as well as presumed mechanisms for the reaction change in the muscle test have been described by other authors. In particular, the mechanisms of the muscle spindles referred to by Klinghardt & Williams were described in 1994 by W.H. Schmitt (*Proceedings of the Winter Meeting of the ICAK-USAI 1994, ICAK-Canada Selected Research Papers 1994*). Additional explanatory models dealing with the phenomenon of therapy localization and Challenge were described in 1994 by H. Garten (*AK Review, "Mechanisms of Acupuncture Effects and a Different Concept of Test Phenomena in Applied Kinesiology"*).

If the positivity of the skin surface

over disturbed regions described by Klinghardt & Williams were in fact as measurable as claimed - for which they cite no references in the literature - then the explanatory model of the capacitor and its discharge by means of touching positively and negatively charged surfaces during therapy localization would be another interesting explanatory model for the phenomenon of the change in muscle reaction when the patient touches disturbed body regions.

Unfortunately, the authors maneuver themselves into a not very convincing position when they state, at the end of the article, that the physician had therapy-localized the wisdom-tooth region during the focal test with a gloved index finger. The question is: in this procedure, how is current supposed to have flowed between the investigator's hand and the wisdom tooth, despite the insulation of the latex glove? Since the description in the article is evidently standard practice on the part of the authors, it should be clear to the attentive reader that the authors of this article conduct tests in a purely imaginative (i.e. mental) sense, and use no reproducible Challenge. Reproducibility means that different investigators testing the same patients would come up with the same test results, and that these correlate with whatever objective findings are available (X-rays, laboratory test results).

The phenomenon of Therapy Localization, and of Challenge, is not explicable; at the most, there are explanatory models (1). Properly carried out, the test

methods of Applied Kinesiology are reproducible. They are taught by instructors of the International College of Applied Kinesiology. In order to confirm the investigatory findings, these test methods are always correlated with other clinical findings (e.g. OPT for dental foci, thermography, decoder dermogram, etc.).

Just as the authors, with gloved test fingers (see above), evidently make projections during focal testing rather than perform objective tests, so also do they use idiosyncratic conventions to decide whether a patient is "blocked" or "not blocked". The verdict is a pure product of the investigator's imagination, because Therapy Localization of the navel with overextended or non-overextended fingers yields identical results in neutral tests. The procedure is just as ambiguous as Klinghardt's description of "Finger Modes" (by way of clarification: when, for example, the therapist brings thumb and index fingertip together and supposedly gets a test reaction from that; this has just as much meaning as statement X, bringing together thumb and little fingertip as statement Y, and so forth). A muscle reaction change occurs only in the case of a focus in the navel region, as in a navel disturbance field. Any other interpretation is no more than an esoteric convention.

Diagnosis with Applied Kinesiology occurs, as described above, exclusively by means of Challenge, i.e. mechanical, chemical and psychic stimuli. It is not "asked" if

there is a vertebral blockage; instead, a mechanical test push is performed, which, if there is functional disturbance of the vertebra, leads to a muscle reaction change. It is not “asked“ if the patient is lactose intolerant; rather, the patient takes milk into his mouth, holds it for at least 30 seconds (in order to check also for delayed reactions), and then a muscle reaction change is tested for. A dental focus is therapy-localized using the patient’s own uninsulated finger. Often, in the case of dental foci, buccal, lingual and apical TLs are needed to locate them.

Actually, when it comes to dental foci, often the only preparations that are effective without surgical intervention are those by SANUM Kehlbeck (FORTAKEHL, NOTAKEHL, ARTHROKEHLAN), which should be tested in cases of periodontitis and osteitis. The procedure for the focal test in the dental region is summarized once more:

Focal test in the dental region

If the TL is positive, the following differential diagnostic needs to be made:

1. Structural disturbances: subluxation - neurological tooth, premature contact, impacted or mispositioned wisdom tooth.
2. Other disturbances: caries, osteitis, pulpitis (chronic, acute, gangrenous), granuloma, gumboil, periodontitis, gingivitis, amalgam toxicity, elevated stresses and flows.

Diagnostics: besides the classical diagnostics such as X-ray and vitality test, as well as Daunderer’s Dimaval test for amalgam toxicity, the AK-specific diagnostics are supplementary and in many cases indispensable, since only they - and not the mute X-ray picture and other negative findings - can point the way to go. In cases of positive AK findings and negative laboratory findings (radiological, chemical, etc.), some further focal diagnostic method should be used (e.g. thermography as per Roth

and/or decoder, among others) before surgical intervention (extraction, etc.) is resorted to.

Problems associated with systemic candidiasis

Chemotherapy treatment of systemic candidiasis is, unfortunately, not always successful, yet often accompanied by frequently recurring side-effects. Endobiosis therapy with SANUM preparations should be performed as a first choice, while monitoring candida antigen and antibody. ALBICANSAN, EXMYKEHL and PEFRAKEHL are isopathic agents which, after specific testing, are used with AK. In these cases, the therapy time will need to extend over several weeks.

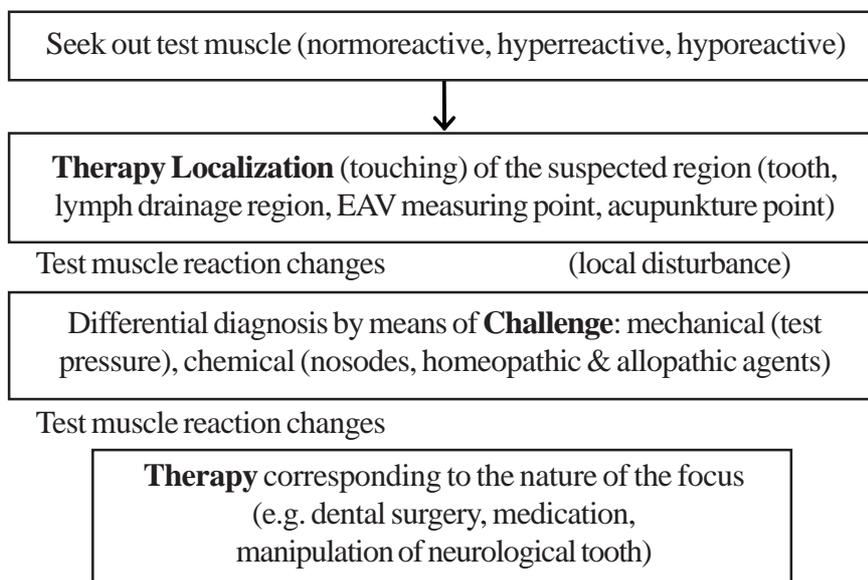
Summary

Applied Kinesiology, performed as described, is a reproducible bioenergetic test method which, in many cases, can disambiguate other stubbornly nebulous findings. There must always be a clear Challenge, and the investigator needs to guard against projections and misleading preconceptions.

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