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Article:

What follows is an article on Applied Kinesiology in Osteopathy, first publiched in Osteopathy Today, the monthly journal of the British Osteopathic Association.

This started so much debate, both enthusiastic and hostile, that we have decided to include both the original article and the letters that it generated, with Mr Lindley-Jones' responses. The reader can judge for themselves. Osteopaths, as you can see, don't always agree amongst themselves!

Applied Kinesiology: Osteopathic approach or alien mumbo jumbo?

With the profession gearing itself up to tackle the great CPD debate and ruminating over the knotty issue of whether or not specialists exist within osteopathy or whether this is a contradiction in terms, perhaps it is timely to raise the question of Applied Kinesiology and its role within osteopathy.

Applied Kinesiology, or AK as I shall refer to it, has attracted considerable interest within the profession over the last two decades. In its early osteopathic exposure it was, for many years, one of the most popular postgraduate courses regularly run at the BSO each year in the 1980's and has been taught round the country continuously ever since.

AK has absorbed some of the best minds of osteopathy due to its power to help read the wisdom of the body in clinically exciting and effective ways not only in the realm of biomechanics but also as an aid to unscramble complex biochemical and even some emotional issues and their influence on our health. And yet it remains curiously invisible when the profession comes to explore its different areas of competence, interests or specialism.

As someone who caught the AK bug as it entered the profession and who has been involved in learning and teaching it ever since, perhaps I might briefly publicly ruminate on the subject.

In all the discussions and questionnaires on Osteopathy and the various approaches used AK rarely features and yet many of us use this approach with almost every patient to help diagnose their complaints. Why should this invisibility exist?

Like the involuntary mechanism, the use of AK is not exclusive to Osteopaths, far from it. Because if its wide ranging search for answers to problems its discovery turned up it has drawn ideas from many of the healing arts. Depending on the medical subculture of the different countries it has taken root in, it has flourished, from its original development in America within the Chiropractic profession, out into Osteopathy, Dentistry and manual medicine and, rightly or wrongly like cranio-sacral therapy, sired a huge following in non professional groups through various types of Kinesiology shorn of their manipulative components.

The public are often more familiar with its lay off-shoots than its official professional body The International College of Applied Kinesiology, with its different regional chapters around the

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world. This has often created unfortunate confusion and misinformation largely to the detriment of AK.

Without wishing to go over ground I explored in depth many years ago what follows is an attempt to explore the role of AK within osteopathy, specialism or not and look briefly at how it sits within an osteopathic practice.

What is Applied Kinesiology?

Applied Kinesiology is a system, which evaluates our structural, mental/emotional and chemical functions. It employs muscle testing in combination with other standard methods of diagnosis. Diet, manipulation, orthomolecular supplementation, chinese meridian system, exercise and education are used therapeutically to help restore balance and maintain well-being.

Dr. George Goodheart is the man who discovered the importance of weak muscles and their clinical implications. He started these discoveries in 1964 and has researched, lectured and written about them ever since. He was the first to observe that in the absence of congenital or pathologic anomaly, postural distortion is often associated with muscles that fail to meet the demands of muscle tests designed to maximally isolate specific muscles.

Applied Kinesiology can be divided into two distinct parts.

1. **One is an aid to diagnosis.** Muscle testing is used to help diagnose what is functioning abnormally. This can be a problem with the nervous system, the lymphatic drainage, the vascular supply to a muscle or organ, a nutritional excess or deficiency, a problem with the cranial-sacral-TMJ mechanism, an imbalance in the meridian system or a host of other problems. Testing individual muscles in an accurate manner and determining what effects the relative strength of the muscle, when combined with knowledge of the basic mechanics and physiological functioning of the body, helps to more accurately diagnose what is going wrong.

2. **The second part of Applied Kinesiology involves the treatment phase.** Here, Dr. Goodheart, and others in the International College of Applied Kinesiology have adapted different treatment methods to the problems that have been diagnosed. From nutrition to osteopathic and chiropractic manipulation to cranial techniques to acupuncture-meridian therapies, to myofascial techniques to nervous system coordination procedures, to some of the latest theories in medicine involving control of the vascular and nervous system, may be employed to balance the malfunction found in the patient.

Applied Kinesiology borrows from many different disciplines and through the use of accurate, scientific muscle testing, in addition to the basic knowledge of the practitioner, helps direct the care to exactly what the patient's needs are, instead of what the practitioner habitually does.

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Separate discipline or diagnostic addition?

So the question remains how does all this fit into the Osteopathic picture and is AK a speciality within or outside of Osteopathy?

AK is less a discrete system with a totally different philosophical model, rather a wonderful additional cornucopia of diagnostic tools to unpack the complexity of problems that the more adventurous osteopath may wish to address in general practice. This potentially allows the practitioner to have greater confidence, both in the purely biomechanical sphere, through a more dynamic approach to dysfunction, but also to more confidently explore the naturopathic or functional medicine approaches to health care that some osteopaths aspire to. Of course this requires considerable ongoing study to support, but is enormously satisfying.

This dynamic approach has, for example, been well used in the AK driven Sunflower approach to helping children with learning difficulties such as dyslexia and dyspraxia, which is part of an ongoing university research project at present and which I have written about elsewhere.

How then does it all work in practice and how can AK so seamlessly fit into the diagnostic tool kit of an osteopath?

A case example

A typical example might serve to illustrate this.

A 22-year-old student presents with recurring pain and discomfort in her right buttock and referred pain down the lateral side of her leg.

Standard osteopathic practice pays particular attention to the palpation and treatment of the over contraction of muscles. Apart from very practical additional diagnostic approaches to unscrambling the spinal and pelvic imbalances, AK offers two other additional useful advantages.

Firstly one of Goodheart's earliest contentions was that, more often than not such muscle hypertonicity is often secondary to hypotonicity elsewhere. The osteopath using AK would have already analysed the state of all major relevant muscles in the body and found and corrected any deficits. But where the fun starts is in hunting for dynamic dysfunction, which only becomes apparent under an active examination.

After all statically observed bony and muscular imbalances have been attended to with the aid of AK to focus in on exactly what is going o,n the next stage of AK examination is undertaken.

Unpacking a cascade of dysfunction

This involving sequential tests of suspected muscular dysfunction so that a muscle such as piriformis which may appear to function normally tests weak subsequent to testing another muscle. This phenomenon is known as a reactive muscle pair.

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Inappropriate proprioceptive impulses from another previously contracted muscle, in this case, the left splenius capitis, causes temporary inhibition to the right piriformis (probably related to the contra-lateral piriformis due to the gait cycle). While it is reasonable to assume this is occurring most of the time in active living, it will only show up on the couch under dynamic examination. With piriformis intermittently being inhibited from above, one or other of its synergists involved in external rotation of the hip, in this case it was gluteus maximus, will, in time, become overstretched trying to do the work of two.

This can lead to a strain counter strain problem developing. Shortening this muscle and testing it then retesting it a second time can uncover this. Invariably it will hold its strength for a single test but become weak on subsequent tests.

Now we have uncovered three hidden dysfunctions but there may be more. If the external rotators of the hips here it was tensor fascia lata, are failing one or other of the internal rotators may, being unopposed, become incongruent with its overlying fascia which may cause it to be sending nociceptive impulses into the cord from the facial agglutination over the over shortened unopposed muscle leading to the body shutting down this muscle as well. This, if left long enough, can effect the patient's gait cycle and further cause hidden muscle inhibition, in this example, the quadriceps.

While it is somewhat long winded to describe, for the osteopath experienced in AK, it only takes a minute to test for and all of this hidden dysfunction can be revealed. For those not used to looking at the body in this way I can assure you, this type of hidden dysfunction is happening in a large number of your patients, and may account for some of the more difficult to resolve cases. We tend to examine our patients in a static way while they often experience their problems in dynamic situations. AK has evolved many attempts to overcome this.

AK examination is on its strongest ground when dealing with structure. Once the long road to effective muscle testing has been mastered, and surprisingly this science and art does take a while to perfect, AK can clearly be seen as a wonderful additional tool to unpack structural problems. However, somewhat more controversially, within clearly defined limits, it can aid in the unpicking of complex biochemical dysfunction as well, if used wisely and combined with other standard methods of diagnosis. Psychiatrist Dr. John Diamond and others have added to our knowledge of ways in which AK can also be used to understand psychological dysfunction as well.

What then, apart from having to learn the whole thing, are the advantages and disadvantages of using AK?

While many osteopaths have studied it some find it not to their taste and discontinue, why? One reason may be the increasingly complex cases to unscramble that start to present if you take on the AK challenge. Not every one wishes to take this on, nor do they wish to undertake the amount of extra study involved. Others find that the dynamic approach AK offers tends to subtly take them away from the intimate palpatory relationship with the patient and their living tissues. This is certainly a disadvantage that osteopaths, with our rich palpatory heritage, should and can guard against.

There are no perfect approaches, all have their merits and often it would appear to be more fate than choice that leads us to devote ourselves to certain course of life long study.

An area that AK bridges is that tired and illusory divide that still, even now, seems for some reason to exercise some in the profession. That revolves around contribution of Sutherland to osteopathy. The debate seems either at the dinosaur end of the

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spectrum to refute this rich seam entirely or on the other hand oddly to assume there is only one way of incorporating these insights clinically.

AK being of a magpie disposition thanks to Goodheart's extraordinary inquisitive genius has its own, all be it, rather less elegant way of incorporating this knowledge clinically, does that make those using it cranial osteopaths? I am not sure, but do I really care?

Specialism, to be or not to be?

Finally we are left with this unanswered question. Clearly, AK offers a pathway to advanced learning for the osteopath who is inclined in this direction. The steep learning curve and the initial complexity are not to everyone's taste. But all postgraduate training involves an element of this. The ICAK's pathway of learning is well marked out with a two-stage process.

The initial introductory AK course is a 100-hour hands-on course, normally run over eight weekends of an academic year, with home study and practice between. For the aficionados there is always the challenge of the more advance qualification, leading to Diplomate status, which qualifies one to teach AK. This requires about the same investment of time and effort as undertaking a M.Sc. Clearly this becomes a specialist field of knowledge, but whether or not it serves us at present to style ourselves as such is debatable. It is certainly a particular body of hard won skill and know how. However its very nature is to enable the user to be even more effective in general practice than before. It opens out avenues of clinical effectiveness rather than narrowing them down, so in one respect, it does not fulfil the model of specialist that implies a focus on discrete conditions or parts of the body.

The debate goes on, but AK is here to stay and both to add useful clinical insights to osteopathic practice and opens up rich dynamic veins of therapeutic endeavour for those inclined to make the years of investment required in any osteopathic journey. In the future as our discussions on CPD and the future of the profession evolve let us just remember and include it in our debate and recognise its contribution to the still unfolding story that is osteopathy.

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