

Identifying and Treating the Primary Problem in Patients

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Abstract

Using manual muscle testing (MMT) as part of the neurological exam is a powerful tool physicians have to assist the diagnosis of many ailments. Pinpointing health processes gone awry or being able to clearly define the etiology of a particular health problem is a difficult task. While this may be an understatement, unfortunately, this leaves many physicians treating symptoms and not the root cause.

Over time, and as an ailment progresses, patients tend to develop compensations of various degrees, both physically and chemically. These compensations are the body's way of dealing with the problem by adapting to change, so the person can essentially "live to fight another day." Unfortunately, these compensations merely act as a "smoke screen" for the physician and must be further investigated in order to determine what is contributing to or maintaining the problem at its origin.

Specific testing procedures must be employed, as described herein, by the physician to resolve compensations, to address/treat the health issue at its core/root and to prevent "painting over rust." As success of treatment is not just determined by whether or not a physician is able to identify indicators that arise during the treatment process but by whether or not one can discern the nature of a particular indicator, e.g. is it part of the overall health problem or is it simply an indication that the patient has mal-adapted to a specific offender over time.

Key Indexing Terms

Applied Kinesiology, Manual Muscle Testing (MMT), Acupuncture Meridian Therapy, Chapman's Reflex (CR), Spinal Subluxation, Injury Recall Technique (IRT)

Introduction

Applied kinesiology (AK) is a diagnostic system which employs manual muscle testing (MMT) with other standard methods of diagnosis. AK muscle testing is performed using specific muscle tests which provide a real-time sensory-motor (input-output) response. This combined with a thorough patient history, orthopedic and neurological testing, and often laboratory work, can render a thorough understanding of a person's health problems and guide treatment. AK is diagnostic; it is not a treatment procedure. A skilled AK physician will employ various treatment methods such as chiropractic manipulation, cranial techniques, myofascial release or trigger point therapy, acupressure, nutritional or dietary changes/counseling, exercise therapies, and emotional techniques, as well as other procedures to help the patient restore his or her health. The treatment is tailored to fit the individual patient based on the examination.

Patients compensate for problems by developing structural (musculoskeletal) and chemical (nutritional, hormonal, inflammatory) processes of varying degrees. Over time, most will compensate more for these compensations and essentially “add more layers to the ever growing onion.” Compensations are the body’s way of managing or coping with the problem by adapting to change—the body is more concerned with today and tomorrow than it is about survival and health next year. However, compensations muddy the water for the physician and must be dealt with to see what is truly at the core of the problem.

Often, physicians tend to treat symptoms based on the patient’s reports, leaving the true root problem untouched. It is important to remember certain training or diagnostic/examination procedures can lead physicians to believe they are treating the root problem. How do physicians really know if they are treating the patient’s problem and not just the multitude of adaptations or compensations the patient has developed? One would have to agree to some extent that it may be impossible to *always* know *all* the time; however, the more skilled and thorough the physician is in his or her examination, the more one reduces the chance of this occurring.

Physicians look at indicators when treating a patient to determine if their treatment protocol is successful, or not. The beauty of MMT is that the physician can quickly see if the treatment procedure employed is right for the patient, as the neurological response is immediate. This does not mean, however, that compensations are not also being addressed; one could simply be removing the indication that there is a problem, but not addressing it at all. For example, if the physician determines there is a spinal subluxation at a certain level of the spine, how does one know adjusting that subluxation is the root cause of the ailment (or part of the ailment), and not just the body’s indication that there is a problem? Clearly, there are other factors, which is why this example is referred to as a subluxation-complex, but what part of the complex should be treated? AK physicians pay specific attention to the muscle imbalances involved in such a process and often the reason for the subluxation is due to those muscular imbalances. Additionally, through the understanding that muscles have a viscerosomatic relationship, these imbalances are often due to a problem with a specific organ. Does the organ dysfunction create muscle imbalances and those muscle imbalances create the spinal subluxation, or does it start at the spinal subluxation? Do they treat the chicken or the egg (the spine or the organ or the muscle)? This is left for the physician to decide. Understanding whether they are treating a compensation and indication of a problem or actually the root problem is paramount.

Discussion

There are several factors which must be considered in order for the physician to be more certain they are addressing the primary cause, or causes, of the patient’s health issues. That is not to say that compensations are not to be addressed. Actually, compensations which the body has developed often need to be identified and treated accordingly so the physician may have a clearer picture of what is the true underlying condition.

The majority of compensations developed by a patient will be seen as injury patterns during the examination procedure and must be treated with injury recall technique (IRT).¹ The most certain way to tell if an injury pattern needs to be addressed is when the muscle does not strengthen with spindle cell activation. However, many times it may strengthen the weak (inhibited) muscle even

though there is injury affecting the dysfunction process somewhere in the body. Therefore, taking further steps described by this author in a previous paper will lead to the discovery of these injuries and subsequently to their correction.²

Cranial faults are also common components of the adaptation processes. They must be addressed either by manual correction, IRT correction, or via their relationship to their respective immune system viscera.³

A muscle tested through a standard Type I MMT (physician initiated), which is the primary way to test via AK methods, may be inhibited for several reasons, i.e. an organ dysfunction, a meridian imbalance or a nutritional/chemical component. Often, in the case of an organ dysfunction the organ's Chapman's Reflex (CR) will therapy localize (TL) indicating that the organ needs some form of treatment. The major question that arises when the muscle-organ (viscerosomatic) relationship is identified is how does the physician truly know if this is a primary issue, either entirely or at the current time of treatment, or just an adaptation process? This author submits that there are several ways to verify if the organ should be treated, because if the physician just assumes that a positive TL to the organ CR is enough to address the organ, he or she will often be misguided in their treatment and treat around the problem rather than the root cause of the issue.

One way to verify if the organ should be treated at the time is to use a Type III MMT (patient initiated submaximal MMT)⁴ and perform the opposite action to the organ's visceral referred pain area (VRP) than which was first seen. In other words, if there is a weak muscle and the physician rubs over the VRP of an organ (creating more parasympathetic activity) to verify if this is something that should be treated at the time then the opposite should hold true – the physician should use a different muscle (a strong indicator) and using a Type III MMT, the physician should create a sympathetic response over the organ's VRP, which is done by pinching that VRP. A weakening of this muscle during the Type III test would confirm the Type I finding.

**In essence: Type I MMT weakness > physician rubs over VRP = strong; then Type III MMT of a strong muscle should become weak when the physician pinches over the same VRP. If the Type III test does not support the Type I testing response then it is not time for the organ to be treated, and the physician should investigate why that is. Often there is an injury, cranial fault, TMJ or tooth problem, or an immune system issue that needs to be addressed first.

Another way to verify if it is time to treat the organ is to check the acupuncture meridian alarm point for the organ. The alarm point is very effective, particularly as a diagnostic tool. The alarm point for the organ, (there are twelve, so not all organs have an alarm point), should TL and either strengthen the muscle related to the organ dysfunction or weaken another indicator muscle.⁵

A third approach in the verification process is to check for any other parasympathetic or sympathetic activity which may be affecting the organ in question. This can be performed by having the patient gaze at a point in the distance or retract their jaw (either of which will simulate more sympathetic activity) or by asking the patient to gaze at the nose (cross-eyed) or protrude their jaw (either will simulate more parasympathetic activity). If either test changes the MMT response then that indicates that more sympathetic or parasympathetic activity is influencing that

muscle/organ in question from another viscerosomatic relationship. For example, if the patient has a weak latissimus dorsi and there is a positive TL to the pancreas CR, (the muscle strengthens), the physician may think that there is a need to address the pancreas. However, if the patient stares at the nose (without the TL to the CR) and this strengthens the latissimus dorsi, then this would indicate there is another organ in need of more parasympathetic activity, which is affecting the latissimus muscle and the pancreas. Therefore, the pancreas is not the primary organ and should not be addressed at that time in the treatment process. The physician should proceed by rubbing over the VRPs of other organs (parasympathetic effect) to see which one strengthens the latissimus and then continue based on that finding.

Cranial faults, temporomandibular joint (TMJ) dysfunction, tooth problems, and especially injuries, (actual injuries the patient has sustained as well as injuries that have occurred from compensations), can certainly be a primary problem, but are often secondary to another issue that needs to be corrected. As described in a previous paper by this author, TMJ problems are a common finding with dysglycemic patients, which comprises a vast majority of the population.⁶

Using the above procedures to verify if one should be treating a certain organ or other point at a certain time in the treatment process will also have a dramatic effect on the number of spinal subluxations which need to be corrected. As Walter H. Schmitt, D.C. describes, many subluxations or misalignments which appear to be in need of a correction are actually uncoupled, and that needs to be addressed before adjusting, or even adjusting at all.⁷ Using the weight bearing techniques to check for hidden injuries as previously described and the sympathetic and parasympathetic procedures, as well as determining any TMJ or tooth involvement and using pre-test imaging to screen for cranial faults³ will significantly decrease the amount of adjustments the patient needs. In this author's experience, it will often eliminate the need for them entirely.

Conclusion

A physician's success when treating a patient is largely determined by his or her skill in differentiating between what *is* a compensation and what *is not*. Essential to the physician's treatment process is being led by certain indicators as well as changes, signs, and symptoms which the patient experiences and presents with during the visit. Treating only an indication that there is a problem is ultimately a disservice to the patient as his/her improvement will eventually unwind resulting in the same problem or a variation thereof on subsequent visits. Basically, the physician will be pushing the health problem around and the patient will see little or no lasting results. Compensations do need to be addressed, but the physician must discern between what is a compensation and what is the actual problem. By following the procedures presented in this paper, physicians can have a better understanding when a procedure should be performed and when something requires further investigation, should the verification processes not support the findings present at that time.

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