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# An evolution and progression of using Applied Kinesiology for accessing negative reactions to foods

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Narrative: Using manual muscle testing for negative reactions to foods reaches back to the beginnings of Applied Kinesiology (AK). Refinements, methods, and improvements have occurred over the past four decades with the work of Goodheart, Schmitt, Lebowitz, Lang, and many others. I examine the work primarily of Drs. Walter Schmitt and report my own work and the progression of testing methods to eliminate false negatives, increase efficiency and efficacy.

Indexing terms: Chiropractic; Applied Kinesiology; muscle testing; food reaction; hypertonic reactions, biomagnetic testing.

## Introduction

Testing various foods for muscle inhibition has been a part of AK going back as far as 1969. (1) Goodheart observed that on specific patients stimulating either the gustatory or olfactory reflexes would cause inhibition of an indicator muscle. Testing for foods via AK became more common in 1982 with the advent of a test kit of powdered food put out by Dr Walter Schmitt in 1982 of 28 foods. According to Dr. John Schmitt (2) by 1982 patients that didn't respond to traditional AK were tested on these foods and elimination often brought symptom resolution along with stimulating the Chapmans reflex that negated the positive muscle test.

> *… Using AK to access negative food reactions is an invaluable tool. Just simply testing a food for inhibition of an indicator muscle probably brings a false negative reaction over 50% of the time …'*

## Discussion

### *Beginnings: 1969-1981*

Goodheart observed that on specific patients stimulating either the gustatory or olfactory with various foods, pollens and other noxious substances would cause inhibition of an indicator muscle. He found a correlation to hypochlorhydria (as shown with a bilateral *pectoralis major* weakness when tested simultaneously) as well as a deficiency in calcium. Walther shortly afterwards found a temporal bulge cranial fault also correlated with these reactions. (3) As research progressed, hypoadrenia was also found as a possible cause. (3) Hydrochloric acid and calcium were often supplemented as well as doing the necessary structural corrections.

### *Antronex/Histidine 1982-3*

In 1983 Dr Walter Schmitt wrote the first ICAK collected paper (4) on food testing. He would take an inhibited muscle and see if it strengthened (became temporarily facilitated) on insalivation of Antronex or weakened on insalivation of *histidine*. If either test were positive, the food kit above was then used to discern specific foods. This was a positive step in treating but at the same time many false negatives were occurring (patients negative to the screening procedure but positive on some of the foods in the kit) and each progression below minimised these more and brought us better results.

### *Kinin Mediated: 1986*

On a personal level by 1986 I (ML) was suffering from chronic fatigue and attended a Goodheart/Schmitt seminar in the Detroit area. Schmitt presented his new research on '*Kinin Mediated Allergies*' with an accompanying paper of the same name. (5) At the seminar I was asked to insalivate a sample of *cholecystokinin* (CCK). Inhibition (weakening) of an indicator muscle was a positive test and represented another indicator of food sensitivity that eluded the *histidine/ Antronex* screening. This was very useful especially with patients experiencing brain fog and fatigue. It was often negated by zinc supplementation as well as Chapmans reflex for the pancreas.

### *Other Patterns: 1987-89*

By 1987 Schmitt and Lebowitz started teaching together and delving deeply into fungal dysbiosis, food reactions etc. During that time Lebowitz wrote three papers for the *International College of Applied Kinesiology* (ICAK) that identified three new types of food findings. One (6) was a pattern of positive foods being negated by therapy localisation (TL) to the thymus gland and typically also negated by the mineral copper. I also observed another type negated by niacin (often found when *epinephrine* negated a weak indicator muscle – one step allergy screening paper). (7) On these patients a muscle facilitation response on an inhibited muscle was found on insalivation of *epinephrine*. Up to this point, most foods observed were causing universal muscle inhibition. In 1989 I observed that certain foods would only weaken a specific muscle but not cause universal weakness. (8, 9)

Even with these 5 methods it was observed that there were positive foods eluding these screening tests. Food test kits had expanded to approximately 100 foods. Set point technique (10) was added as a technique to desensitise the patient to the positive foods along with certain nutrients and correcting dysbiosis to help resolve the issues. As time went on other desensitisation techniques such as IRT, (11) master set points (12) and more were also utilised.

Simultaneously Lang was developing an AK technique utilising the same method of diagnosis but using a form of neurolinguistic programming to desensitise by gently pushing the eyes (100-200 gms, 4-8 oz pressure) in the direction that abolished the weakening response of the food as well as either inspiration or expiration (whichever negated the food reaction). (13) Using the gustatory reflex in the above techniques limited the number of items that could be tested each visit plus the actual insalivation could potentially alter the reactions of foods tested after a positive test.

### *Biomagnetic Testing: 1990-1*

Until 1991 only gustatory or olfactory challenge was generally accepted as a valid applied kinesiology method. (14)

In 1991 based on the research of William Philpott MD, (15) Lebowitz experimented with and introduced Biomagnetic testing to the ICAK which is still used today in many AK practices. Philpott had an instrument similar to an ohm meter and he observed that placing a food the patient was sensitive to under the south pole against the patient's body would cause the meter to

register while if they were not sensitive to the food, then no change would occur. Lebowitz changed this into an AK procedure. (16)

The procedure involved placing the suspect substance under the south pole of a strong 2x5 magnet up against the person's body and seeing if a strong indicator muscle weakened. The first patient Lebowitz observed this on was a disabled DC with a severe case of depression. Upon testing foods with oral insalivation all foods were negative but when placing the foods under the south pole against the patients head over 30 foods showed a positive reaction. Avoidance of those foods resolved the patient's severe depression, and he was able to return to work after a seven-year hiatus. Besides having less false negatives, other benefits of biomagnetic testing included time savings as well as ease (testing many substances on the tongue was cumbersome and limited in how many you could test in one visit). It was also not addressed how actual insalivation of the substance could alter physiology and subsequent items tested in that visit. As a result, testing 100 foods in one visit only took a few minutes and clinical results would be faster. This technique was shared with various physicians who were able to reproduce the results (17, 18) and over time the technique gained much popularity within applied kinesiology.

There were still some variables to consider, one sample of a food may test positive and another negative due to differences in growing conditions, pesticides, herbicides (organic or synthetic), hybridisation, and so on. It might also change if the food was fresh vs. dried vs. cooked. It was also observed that if a patient had been avoiding a food for an undetermined time period often a false negative would occur. It also appeared that testing the substance under the magnet over GV21 or GV27 in general showed the most positive responses and became the initial area to place the food in the Lebowitz protocol. This was realised after much trial and error with experimentation over various reflexes and organs.

### *Vial Testing: throughout the 1990s*

Lebowitz was testing various powdered food vials and seeing if the test results correlated well with homeopathics and various energetic vials of the same substance. For many years he was unable to find a strong correlation. Around the year 2000 he was able to find a company whose methods of making energetic vials was different and they correlated strongly with the actual substance. As a result, he and many others switch to energetic vial testing. This made for faster exam time without losing accuracy. This company no longer exists but there are other reputable companies though it is encouraged to cross test with actual foods to in a sense vet the company you are purchasing from for reliability.

### *Food Toxins: 2011*

Despite the advances above there were still many times where either

i) a patient knew they were reactive to a food and we would not get a positive muscle test or

ii) a patient would eliminate a certain food or foods and experience a resolution of symptoms despite the fact that the food when muscle tested had never exhibited a positive response.

Pondering this, Lebowitz decided to purchase a vial of *alpha solanine19,* a neurotoxin found in the nightshade family of foods. Using himself as a test subject, another physician found him to weaken on it despite not weakening on any nightshade food vials (tomatoes, potatoes). On eliminating nightshades from his diet his chronic hip that only had approximately 20° of external rotation now had 90° plus. Using that vial on patients he found 56% of his patients showed an inhibitory response but only 10-15% of individual nightshade foods. He then procured vials of *albumin*, *zein*, *caffeine*, *theobromine*, *paraxanthine*, *theophylline*, (20) *lactose*, *casein* and *alpha-gliadin* (21) and found similar findings and clinical improvement when removing the positive substances. Interestingly the *alpha-gliadin* vial was much more clinically relevant than a vial of *gluten*. This discovery helped many chronic patients who had plateaued to reach new levels of

wellness and is still a major part of what has been come to be known as the Lebowitz Protocol. (22)

Over time *oxalic acid* (23) vials as well as a *lectin* (24) vial and a *histamine* vial were added to food toxin screening. As mentioned earlier, some of these vials tested positive much more frequently when specific muscles were used. This was first observed a few years later. Most important was using the *peroneus* muscle for *oxalates* and the *psoas* for *histamine*. Many of the other food toxins were more sensitive to using a *pectoralis* (could be *sternal* and or *clavicular* division) as opposed to a regular indicator muscle. This is similar to findings of Schmitt and Lebowitz back in the late 1980's where they would put patients into either forward or backward 'C' curves to elicit more findings (25) in the sense that we needed to 'stress' the patient to bring out findings.

### *Hypertonic Reactions: 2011*

For some time (26) I was looking into whether a hypertonic muscle's reaction to a substance (food or nutrient) would cause an indicator muscle to have a hypertonic reaction (muscle would no longer weaken with approximating of its spindle cells). It was observed that some patients, especially younger ones, instead of showing inhibition of an indicator muscle, the muscle would become hypertonic as a positive food reaction. This was more common with foods containing caffeine and other stimulants but in some patients most of their reactions were hypertonic so we began testing for both inhibition and hypertonic reactions. (22) It was also observed that when testing foods that hypertonic reactions would turn into inhibition reactions if you continued to place the food under the magnet and leave it there for approximately 5-10 seconds.

### *Present day*

At this stage we find there are a number of ways a food may exhibit a positive reaction:

- weakening a facilitated indicator muscle
- causing a facilitated indicator muscle to exhibit hypertonicity
- an indicator muscle will only show a or b when the substance is placed under the magnet over an area of complaint or dysfunction
- placing the substance over an area you just 'normalised' via an adjustment, manual stimulation, acupuncture etc., will cause recidivism of the finding.

Testing may still bring some false negatives if the patient hasn't eaten the food for a while. Here a a false negative will often occur on testing. In very complex patients, vials may be negative while if the patient brings in the actual food it will test positive. As stated before, this could be due to sprays, harvesting and soil conditions, hybridisation, etc.

Some energetic vials did not use the real substance as a starting material which could affect the test.

Vials in a base with alcohol, sugar or charcoal could yield aberrant results if the patient is either sensitive to the substance or needs it. Charcoal can be therapeutic and a sugar base can give a false negative if the patient is hypoglycaemic at the time of testing, alcohol may give a false positive in patients with 'live stress' or inflammation.

Once the foods are discerned there are many ways to negate the positive tests and many fine AK physicians have developed techniques to help these but there are a few things to remember:

- you can't 'fix' what you can't find so using some of the enhanced techniques above can increase the number of findings
- food reactions are often secondary to dysbiosis, deficiencies, toxicities, genetics or inherited factors, emotional factors, etc. If this is the case, results will be either short lived or findings could change with different foods found on subsequent visits.

- as the world becomes more toxic in multiple ways and all types of stress increase, we are finding that elimination of the foods is needed more commonly and the patients, as a generalisation aren't as responsive to the desensitisation techniques as was common in the past.
- af a patient avoids a food for a period of time and then comes back in to see if it is time to reintroduce it, if they have been 100% avoiding it a false negative is common. You can have to patient reintroduce a portion of the food for 2 days in row before coming in. They might, if it is still an issue, have an observable recurrence of a symptom or you will find it on your retest. If many foods are involved this can be a little more complicated.

## Conclusion

Using AK to access negative food reactions is an invaluable tool. Just simply testing a food for inhibition of an indicator muscle probably brings a false negative reaction over 50% of the time. Enhanced techniques as stated above can greatly increase findings and results. A history of the evolution is presented for the physician to understand how we got to where we are today.

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