Textbook on Evidence-Based Holistic Mind-Body Medicine

Holistic Practice of Traditional Hippocratic Medicine

SØREN VENTEGODT
JOAV MERRICK

Health and Human Development
Joav Merrick (*Series Editor*)

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HEALTH AND HUMAN DEVELOPMENT

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HOLISTIC PRACTICE OF TRADITIONAL HIPPOCRATIC MEDICINE

HEALTH AND HUMAN DEVELOPMENT

JOAV MERRICK - SERIES EDITOR

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HOLISTIC PRACTICE OF TRADITIONAL HIPPOCRATIC MEDICINE

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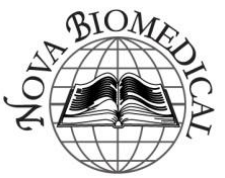
JOAV MERRICK



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Foreword

Daniel TL Shek, PhD, FHKPS, BBS, JP*

Chair Professor, Department of Applied Social Sciences,
Hong Kong Polytechnic University, Hunghom, PRC
Advisory Professor, East China Normal University, PRC
Honorary Professor, Kiang Wu Nursing College of Macau, Macau
Adjunct Professor, Division of Adolescent Medicine, Department of Pediatrics,
University of Kentucky College of Medicine, United States

Smuts (1) argued that there are seven levels of understanding when we attempt to look at living creatures. The first level is definite structures of synthesis with little internal activity, such as a chemical compound. The second level refers to functional structures in living bodies and the parts cooperating mutually for the maintenance of the whole, such as the plant. The third level is cooperative activity coordinated and regulated by a central, but mainly implicit and unconscious control (e.g. the animal). The fourth level is one at which centralizing control becomes conscious and culminates in personality (e.g. human beings). The fifth level involves central control interacting with its field forming composite holistic groups (e.g. society). The sixth level refers to super-individual associations of central control (e.g., the state and/or institutions). The final level refers to emergent ideal wholes or holistic ideals (e.g., truth, beauty, and goodness) that lay the foundation for a new cultural order. In conventional forms of medicine, focus has traditionally been placed mainly on the first three levels emphasizing deterministic mechanisms for human health, illness and behavior, such as genetic, biochemical and physiological mechanisms. The role of "human beings" as conscious beings with integrated personality is seldom taken seriously in medical assessment and analyses. One obvious limitation of conventional medicine is that drugs and related medical procedures cannot treat all forms of diseases and promote healthy behavior, particularly those diseases that are beyond reductionistic explanations. As such, there is an argument for a more holistic understanding of health and disease (i.e. holistic medicine). Despite the fact that the holistic medicine movement has existed for a few decades and there

*E-mail: daniel.shek@polyu.edu.hk

are more and more adherents of holistic medicine, several philosophical aspects of the concept of holistic medicine are still far from clear. The related questions include:

- What is quality of life, happiness, meaning in life?
- What is a human being?
- What is the biological connection between quality of life, disease and healing?
- What is the relationship between the brain and consciousness?
- How can we seize the meaning of life?
- What are the concepts involved in quality of life research?

The answers to the above questions are of paramount importance to health care professionals. In particular, without knowing the nature of human beings, treatment can be aimless and even misguided.

Against this background, I am very pleased to note that Søren Ventegodt and Joav Merrick took the courage to write a textbook on holistic medicine with reference to the science of and philosophy behind quality of life. There are many unique features of this book.

First, this book is written by two medical doctors trained in conventional medicine as well as in CAM. This feature can obviously enhance the relevance of this book to medical practitioners and allied health care professionals. Before we can apply techniques of holistic medicine, we have to build up concepts and theories about holistic medicine. Thus, this book can be regarded as a foundation upon which concepts and techniques of holistic medicine can be further constructed together with several theories on human existence.

Second, this book is integrative in nature. The authors integrate different theories and concepts on human nature and present their own conception as they attempt to examine the relationship between biological processes and psychological processes.

Third, this book highlights the importance of life meaning in human existence. In a world of moral confusion and value diversity, this emphasis is a very timely and appropriate reminder. This book gives a good introduction of the central concepts related to the study of quality of life and theories of human existence. The text is interesting food for thoughts for those who are interested in studying or conducting research in holistic medicine.

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Preface

Holistic medicine, or quality of life as medicine, as we often call it, is basically a strategy for improving the patient's quality of life, through mobilizing of inner resources. This can never harm and will almost always benefit the patient's wellbeing and often also help him or her to fight back the disease. The cure is very much the same for all patients: Help to know yourself better and to step into character and be more yourself, and more in tune with the universe. So it can be started right away, also without a specific diagnosis. Is modern, holistic medicine powerful? Oh yes, very much so. Holistic medicine is a truly powerful medicine, in spite of nobody really understanding the deepest structures of consciousness, the connection between mind and body, and the way holistic medicine works. But just because our scientific understanding still is limited we should not stop doing what we know works. In this book the authors cover the basic principles of healing and ethics of traditional Hippocratic medicine from a new and modern scientific approach.

Introduction

Søren Ventegodt and Joav Merrick

Clinical holistic medicine, also called scientific holistic medicine, has its roots in the medicine and tradition of Hippocrates, who around 300 BCE worked in the old Greece (1). Modern epidemiological research in quality of life, the emerging science of complementary and alternative medicine, the tradition of psychodynamic therapy, and the tradition of bodywork are merging into a new scientific way of treating patients.

On other continents similar medical systems were also developed. The medicine wheel of the native Americans, the African Sangoma culture, the Samic Shamans of northern Europe, the healers of the Australian Aboriginals, the ayurvedic doctors of India, the acupuncturists of China, and the herbal doctors of Tibet all seems to be based fundamentally on what could be called character medicine (2-8).

Recent advancements

Interestingly, two huge movements of the last century have put this old knowledge into use: psychoanalysis (9) and psychodynamic therapy (10,11) (most importantly STPP)(12,13) going through the mind on one hand, and bodywork (most importantly Reich, Lowen and Rosen) (14-16) and sexual therapy (especially the European tradition of the sexological examination and the Eastern tantric tradition (17)) going through the body on the other (see also section 11). A third, but much less common, path has been directly through the spiritual reconnection with the world (18,19).

Our international research collaboration became interested in existential healing from the data coming from epidemiological research at the University Hospital of Copenhagen (Rigshospitalet) starting in 1958-61 at the Research Unit for Prospective Paediatrics and the Copenhagen Perinatal Birth Cohort 1959-61 (20). In this research with more than 11,000 people in a series of huge surveys we found (quite surprisingly) that quality of life, mental and physical health, and ability of social, sexual and working ability seemed to be caused primarily by the consciousness and philosophy of life of the person in question, and only to a small extent by other factors (20).

This brought us to investigate the subject going to the roots of western medicine, or the Hippocratic character of medicine. This meant that we had to look at transcultural and integrative medicine, the emerging science of alternative medicine (scientific CAM theory) and to the forgotten traditions of psychosomatic, psychodynamic, and bodily oriented therapies. Around 1994 we received substantial funding for our research project trying to embrace this huge heritage of medical wisdom philosophically (21-28), theoretically (29-49), epidemiologically/statistically (50-71).

We have since 1997 with a great effort tried to take this knowledge into clinical practice (72-113) and with fine results. Clinical holistic medicine has in our Research Clinic for Holistic Medicine and Sexology in Copenhagen helped every second patient with physical, mental, existential or sexual health issues or diseases over one year (114-119). Finally we have been looking at what seems to be the common denominator for all existential healing work in all cultures at all times: the sense of coherence, most clearly expressed by Aaron Antonovsky (1923-1994), a sociologist from the Faculty of Health Sciences at the Ben Gurion University of the Negev in Israel (18,19,120-125). We have also been debating many difficult issues related to modern day medical science, especially in the British Medical Journal (126-139) and also a series of books on the "Principles of holistic medicine"(140-142).

What we have learned from this long journey through the grand medical heritage from the different cultures on this planet is that we need to work on body, mind and spirit at the same time (something that in fact the medicine man has always done with combined talking, touching, and praying)

We are more than happy to see our research project in scientific holistic medicine (clinical holistic medicine, CHM) developing. The most paradoxal aspect of this is that while we like to think we are taking medicine a step forward, we are actually just taking medicine back to its roots.

The most important thing is that research and development in this field is made in a dialectic process between qualitative and quantitative research.

Documentation of effect

There are basically two ways of documenting an effect of a holistic medical intervention, the quantitative and the qualitative approach. Much thought has been given to developing valid methodology and measuring tools, but the art of documentation has become a complex and expensive task. Due to lack of resources we have been forced to seek simple, but still valid ways of documenting effect of intervention (75). In this communication we will focus on the qualitative research method.

Fortunately the holistic approach makes it much simpler, because there are always three domains to investigate: health, quality of life (QOL) and ability. These three domains can be subdivided in as many detailed domains as one wish, but often three are sufficient for most purposes.

There are two qualitative aspects of documenting effect in medicine, often called subjective (that is from the perspective and experience of the patient) - and objective (that is from the perspective of the therapist or researcher). To document effect of an intervention

using both perspectives, the patient must be interviewed before and after the intervention. Semi structured interviews with interviewer rating of the state immediately before and after the intervention can be used to give the objective perspective on the effect of the intervention. Interviewing the patient after the intervention can give the patient's subjective experience of the effect.

Most importantly these perspectives often leads to two different results, but confronting the patient with the observed improvement, after the patient has given his own experience of the effect, can be very enlightening.

The consensus paradigm states that only to the degree that there is consensus between patient and therapist/observer, then the treatment has an effect. If the patient experience an effect that cannot be observed, something else is likely to have happened, i.e. an upgrade of other dimensions than the three defined above as outcome. Instead of QOL, health and ability the patient has gained self-esteem, confidence, admiration from others etc. As holistic medicine aims to improve life in these three domains, a pleasant experience with the therapy is not the same as an effect of a treatment.

If the patient does not experience an observed effect, this effect is most likely to be happening only in the observer’s mind. Very often a therapist is convinced that a cure or intervention gave a positive result, but the fact that the patient did not experience that is then often neglected. In holistic medicine the dimensions we want to improve are highly experiential, so if the patient did not experience any improvement, such an improvement is most likely not to have taken place.

Interestingly one single patient is enough to document effect with the consensus paradigm. If both the physician and his patient, after careful investigation before and after the treatment, find that the treatment has helped, this is most likely the case. The more precise the target group and the treatment are defined the more valuable the documentation. We recommend for securing the validity that the presented method is used with five highly comparable patients receiving five highly comparable treatments.

As always we recommend for the observer rating a five point symmetrical Likert scale with neutral middle point and equidistance (143). A clinically significant improvement must be half a step on this scale or more. The patient needs to express the gain as a "significant improvement". When both patient and observer find improvement of QOL, health, and ability significant (according to the above), we call the treatment "good".

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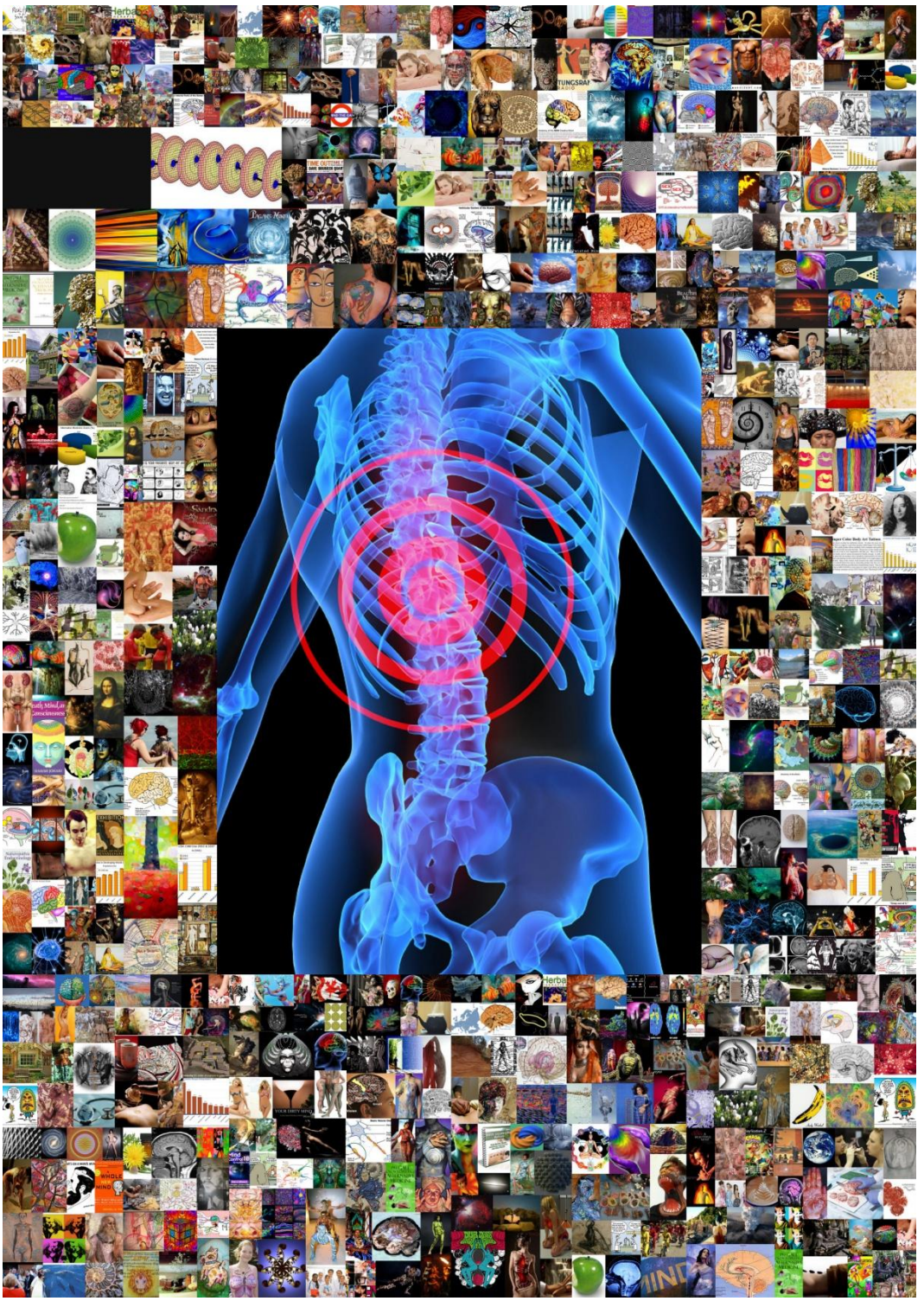
Section 1. Holistic medicine: Healing body and spirit



Chapter I

Introduction: Paediatrics and adolescent medicine

Children and teenagers are especially vulnerable and if they are not thriving they can also become ill. You can say that their illnesses are symptoms of quality of life problems. To care for kids is easy for the therapist who is also a parent; basically what you have to do is to be a stand-in for their own parents; you need to be the perfect parent. If you do not have children yourself this can be somewhat difficult to do. What is needed here is that you find an approach that you are feeling good about, i.e. be the kid's best friend. The problem here is that the child or teenager needs to feel safe and well guarded, so you might need to find some aspects of parenthood to practice with these young patients.

A different strategy that often works is to treat the parents. If the child is ill because of low quality of life their parents are likely to have big problems that burden the child. If you help the parents, so they find resources, personal energy and new happiness they are likely to be able to give the children and teenagers the support and care they need. This is often a much more constructive and easy way to success than treating the children. If the parents are in denial and refuse to assume responsibility you might need to treat the kids, but you can do that in such a way that the parents witnesses your treatment and learn from it. This is indirect treatment of the parents, and this is also often very successful.

In general you need to be sweet, imaginative, resourceful, courageous and bold to deal with children and adolescents; they know where you come from right away and they need to feel your complete dedication and to be there for them and help them. This is the most important aspect. Whether you are without experience in helping this group or not is of less importance. You need to start somewhere. Just do it, and give yourself up to the job. Then you cannot fail. And even if you fail you will learn, and your recovery will make it up to them… You are only human. Do not expect to be more than that. Do not worry. Just trust in yourself and life, come from your heart, and be happy in what you do. You will be fine also with this group of patients.

Children and teenagers are often treated by psychiatrists as their poor thriving and inadequate behaviour is becoming the centre of attention. But children and teenagers cannot

be seen as isolated individuals. When a child is dysfunctional it can be due to a dysfunctional family.

The holistic perspective is therefore more relevant here than anywhere else. The trend in society is to see the young person as an individual with individual problems of growth and development. This perspective is anti-holistic and the holistic psychiatrist is standing before a challenging task when a family is bringing a child or teenager for psychiatric treatment.

Children and young people somaticize and physical pain is very common during childhood and adolescence. Often psychosomatic pains are untreatable by the biomedical physician so patients with treatment-resistant physical pain often end up in psychiatric treatment as well. When the pain is connected to genitals and of unbearable intensity, as i the case with vulvodynia, the young patient also often is referred to psychiatric treatment. To help her the holistic psychiatrist must also be a sexologist and often also a gynaecologist. This is more specialties than can be expected from a physician, and the sad result is that the patient that could be cured from an integrated treatment stays chronically ill and untreated. In this case the physician must do his or her best in spite of not having all the formal competencies necessary for the treatment.

As with all medical care ethical aspects are very important in intervention and even so in holistic medicine (1),

Exercises

1. If you are scared of kids and feel they are difficult to relate to, find some kids to look after, preferably someone from your family who knows you a little already. Being a nanny 5-10 times will cure you from the worst fear and allow you to get started treating kids.
2. If it is hard for you to recall your own time as a teenager you should get a job, where you teach some teenagers. Get to know their habits and ways of thinking.

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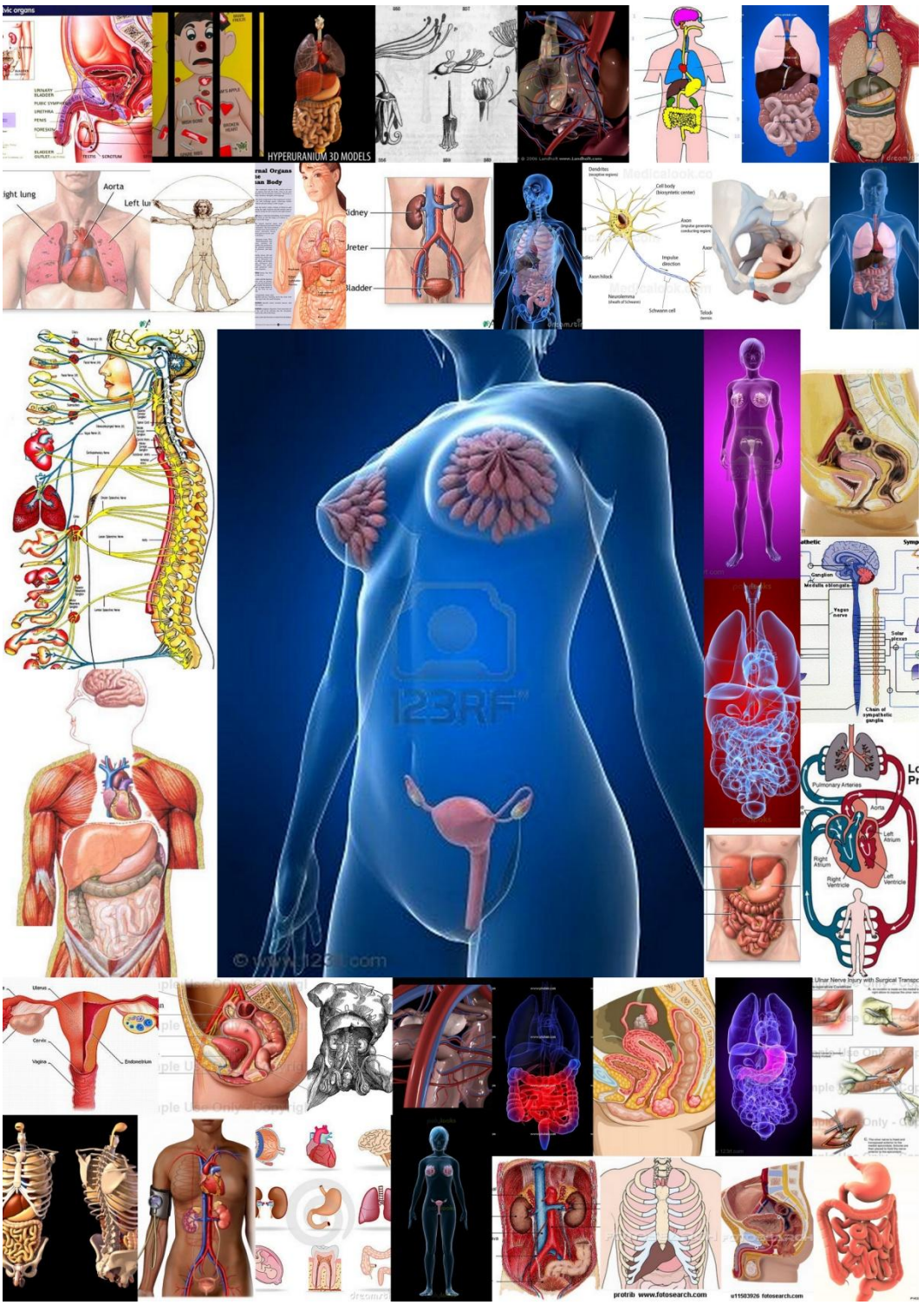

Chapter II

What is "quality of life as medicine" and how does holistic mind-body medicine cure the physical body?

It is fairly easy to understand physical disease as literally physical disorder in the body. The body consists of 10,000,000,000,000 human cells or so; these cells are descendants of single celled animal living in the ocean one billion years ago. During evolution they learned to form highly advances colonies with several hundreds of different cell types as we know it from the adult human body. But the cells are basically still single celled animals, and if you take a bit of a finger and put it into lukewarm salt sugar water it will grow and divide here. This is often called "to grow cells in a test tube". The cells are walking about at the bottom of the glass, dividing randomly, while lacking the biological information that normally (in the body) tells them what to do and when to do it. So the key to understanding physical health it to understand biological order.

The biological informational system is subject to intensive scientific investigation these years, and remains a complete mystery for science – a mystery in the same class as human consciousness. For how can a colony of cells feel like one single, awake organism, and even claim to be one single being - me? This research is completely fascinating. We are not able to give good scientific answers to the many questions that the mystery of biological information is raising. But we know this much: Feelings and emotions are happening in this collective of cells, on an intermediate level, between the cells and global consciousness. Therefore many researchers in holistic health believe that feelings have the power to disturb the biological order and make cells behave irrationally, i.e. divide in a non-orderly and chaotic manner which for example is the characteristic of cancer. If the order of blood vessels breaks down we see the plaques and stenosis that characterizes coronary vessel disorder, brain bleeding etc. If the cells of joints are disturbed we see all the malformation characterizing gout and arthritis. If the cells are diffusely disorganized in an area we see inflammation and pain, including autoimmune diseases like diabetes mellitus type I, and multiple sclerosis, lupus (LED) and hundred other diseases. So it is not difficult at all to understand how repressed negative emotions disturb the physical body on a cellular level. It might be very difficult to describe the exact mechanism in scientific terms, as we have no scientific language for life energy, sexual energy, etc.

Feel, understand, and let go. This simple formula will work wonders with most physical diseases, independent of type, and in our clinical experience almost every type of chronic pain

will respond immediately to the holistic intervention. When this is said we must admit that only half of chronic pain patients are cured with the kind of holistic medicine described in this book.

There exist more efficient interventions, like the shamanistic intervention done by many pre-modern cultures using huge dramas and often also hallucinogenic drugs. We call such interventions *one-session healings*. But this is another ambition that the physician of the Hippocratic tradition has. He is satisfied with small steps that in the end – after a year or so – will cure the patient. This is why clients in this type of medicine are called patients to start with – they have to be patient. The clients of pre-modern medicine men and shamans were not called patients. They were often called "the traveller" because one-session healing is a most dramatic tour down into your own personal underworld and back. A journey deeply into your soul and hidden core of existence, and back to normal reality. Many modern CAM (complementary and alternative medicine) systems also talk about "the journey" as the path towards learning, health, and happiness (1).

Holistic mind-body medicine (we call it often *clinical holistic medicine*, or *scientific holistic medicine*), has its roots in the classical European medicine, the medical tradition of Hippocrates. Modern epidemiological research in quality of life (QOL), the emerging science of complementary and alternative medicine (CAM), the tradition of psychodynamic psychotherapy (PP), the tradition of bodywork and body psychotherapy, and classical and modern sexology, are these decades merging into a new scientific, integrated way of treating patients (sometimes called *integrative medicine*).

This approach seems able to help every second patient with physical, mental, existential or sexual health problem in 20 sessions over one year, as we saw in section 1. This chapter discuss the development of holistic medicine into scientific holistic medicine with discussion of future research efforts.

Introduction

Hippocrates (460-377 BCE) and his students worked to help their patients to step into character, get direction in life, and use their human talents for the benefit of their surrounding world (1). For all we know today this approach was medicine that helped the patients to recover health, quality of life, and ability, and Hippocrates gained great fame. On other continents similar medical systems were developed. The medicine wheel of the native Americans, the African Sangoma culture, the Samic Shamans of northern Europe, the healers of the Australian Aboriginals, the ayurvedic doctors of India, the acupuncturists of China, and the herbal doctors of Tibet all seems to be fundamentally what we could call character medicine (2-8).

All the theories and the medical understanding from these pre-modern cultures are now being integrated in what is called integrative or transcultural medicine. Many of the old medical systems are reappearing in modern time as alternative, complementary and psychosocial medicine. This huge body of theory is now being offered as a European Union Master of Science degree at the University College in Graz, Austria (2-8).

What is happening today?

Interestingly, two huge movements of the last century have put this old knowledge into use: psychoanalysis (9) and psychodynamic therapy (10,11) (most importantly STPP) (12,13) going through the mind on one hand, and bodywork (most importantly Reich, Lowen and Rosen) (14-16) and sexual therapy (especially the European tradition of the sexological examination and the Eastern tantric tradition (17)) going through the body on the other (see also section 11). A third, but much less common, path has been directly through the spiritual reconnection with the world (18,19).

Over the past years more research has been conducted in the field of holistic medicine; the most impressive and successful being the team around Dean Ornish and David Spiegel in California trying to understand the mind-body connection and use it in medicine;. In Europe the Interuniversity College, Graz in Austria, has collected all existing knowledge on CAM (complementary and alternative medicine) from 40 academic institutions in Europe and created the Master's degree program EU-MSc-CAM (2-8). In Asia many universities are making a similar effort to collect all existing knowledge on non-drug medicine. So all over the world universities and research institutes are conducting research and developing non-drug medicine.

In this chapter we will tell you about the work of our own international research collaboration, which today counts more than 25 active researchers from all over the world, trying to integrate the many different active research programs.

This team, which gives you this textbook, became interested in existential healing based on the data from epidemiological research at the University Hospital of Copenhagen (Rigshospitalet) starting in 1958-61 at the Research Unit for Prospective Paediatrics and the Copenhagen Perinatal Birth Cohort 1959-61 examining the connection between global quality of life and health for more than 11,000 people in a series of huge surveys (20). We found (quite surprisingly) from this huge data base that quality of life, mental and physical health, and ability of social, sexual and working ability seemed to be caused primarily by the consciousness and philosophy of life of the person in question, and only to a small extent by other factors (20).

This scientific finding was not expected and we were forced to investigate the subject going to the roots of western medicine, or the Hippocratic character of medicine. This meant that we had to look at transcultural and integrative medicine, the emerging science of alternative medicine (scientific CAM theory) and to the very much forgotten traditions of psychosomatic, psychodynamic, and bodily oriented therapies. Around 1994 we received substantial funding for our research project trying to embrace this huge heritage of medical wisdom philosophically (21-28), theoretically (29-49), epidemiologically/statistically (50-71).

On the basis of this research we have tried to use this knowledge for clinical practice (72-113) and with fine results. Clinical holistic medicine has in our Research Clinic for Holistic Medicine and Sexology in Copenhagen helped every second patient with physical, mental, existential or sexual health issues or diseases over one year (114-119). Finally we have been looking at what seems to be the common denominator for all existential healing work in all cultures at all times: the sense of coherence, most clearly expressed by Aaron Antonovsky (1923-1994), a sociologist from the Faculty of Health Sciences at the Ben Gurion University of the Negev in Israel (18,19,120-125). We have also published our

thoughts and findings (126-143) in order to convey the messages that we have received from the research.

What we have learned from this long journey through the grand medical heritage from the different cultures on this planet is that we need to work on body, mind and spirit at the same time. This is what Hippocrates called "the Art" (1), not "the art of medicine" or "the art of right living", but simply "the art" – the way of the human heart, cultivating existence into sheer compassionate behaviour and joyful being, which has always been the ultimate goal of all the great healers in our history.

We are more than happy to see our research project in scientific holistic medicine (clinical holistic medicine, CHM) developing. The most important thing is that research and development in this field is made in a dialectic process between qualitative and quantitative research.

Qualitative and quantitative research

There are basically two ways of documenting an effect of a holistic medical intervention, the quantitative and the qualitative approach. Much effort has been given to developing valid methodology and measuring tools, but the art of documentation has become a complex and expensive task. Due to lack of resources we have been forced to seek simple, but still valid ways of documenting effect (75). In this communication we will focus on the qualitative research method.

Fortunately the holistic approach makes it much simpler, because there are always three domains to investigate: health, quality of life (QOL) and ability. These three domains can be subdivided in as many detailed domains as one wish, but often three are sufficient for most purposes. There are two qualitative aspects of documenting effect in medicine, often called subjective (that is from the perspective and experience of the patient) - and objective (that is from the perspective of the therapist or researcher). To document effect of an intervention using both perspectives, the patient must be interviewed before and after the intervention. Semi structured interviews with interviewer rating of the state immediately before and after the intervention can be used to give the objective perspective on the effect of the intervention. Interviewing the patient after the intervention can give the patient's subjective experience of the effect. Most importantly these perspectives often leads to two different results, but confronting the patient with the observed improvement, after the patient has given his own experience of the effect, can be very enlightening.

The consensus paradigm states that only to the degree that there is consensus between patient and therapist/observer, the treatment has an effect. If the patient experience an effect that cannot be observed, something else is likely to have happened, i.e. an upgrade of other dimensions than the three defined as outcome. Instead of QOL, health and ability the patient has gained self-esteem, confidence, admiration from others etc. As holistic medicine aims to improve life in these three domains, a pleasant experience with the therapy is not the same as en effect of a treatment. If the patient does not experience an observed effect, this effect is most likely to be happening only in the observer's mind. Very often a therapist is convinced that a cure or intervention gave a positive result, but the fact that the patient did not experience that is then often neglected. In holistic medicine the dimensions we want to

improve are highly experiential, so if the patient did not experience any improvement, such an improvement is most likely not to have happened.

Interestingly one single patient is enough to document effect with the consensus paradigm. If both the physician and his patient, after careful investigation before and after the treatment, find that the treatment has helped, this is most likely the case. The more precise the target group and the treatment are defined the more valuable the documentation. We recommend for securing the validity that the presented method is used with five highly comparable patients receiving five highly comparable treatments.

As always we recommend for the observer rating a five point symmetrical Likert scale with neutral middle point and equidistance (143). A clinically significant improvement must be half a step on this scale or more. The patient needs to express the gain as a "significant improvement". When both patient and observer find improvement of QOL, health, and ability significant (according to the above), we call the treatment "good".

Perspectives for future research and development

There are lots of possible advantages with the scientific holistic medicine that must be closely examined in future research:

- How can holistic medicine be make an affordable, efficient medicine for the future
- The possibility to prevent disease
- The possibility to cure cancer and coronary heart disease
- The possibility to seroconvert HIV-positive patients to HIV negative
- The possibility to relief pain and discomfort
- The possibility of rehabilitating working ability
- The possibility of improving peoples competency as parents
- The possibility of improving working efficiency though development of talent
- The possibility of helping people to be happy in spite of difficult circumstances and challenges
- The possibility of people developing consciousness and becoming more responsible for local and global environments

We hope that this work will be of value to all living beings.

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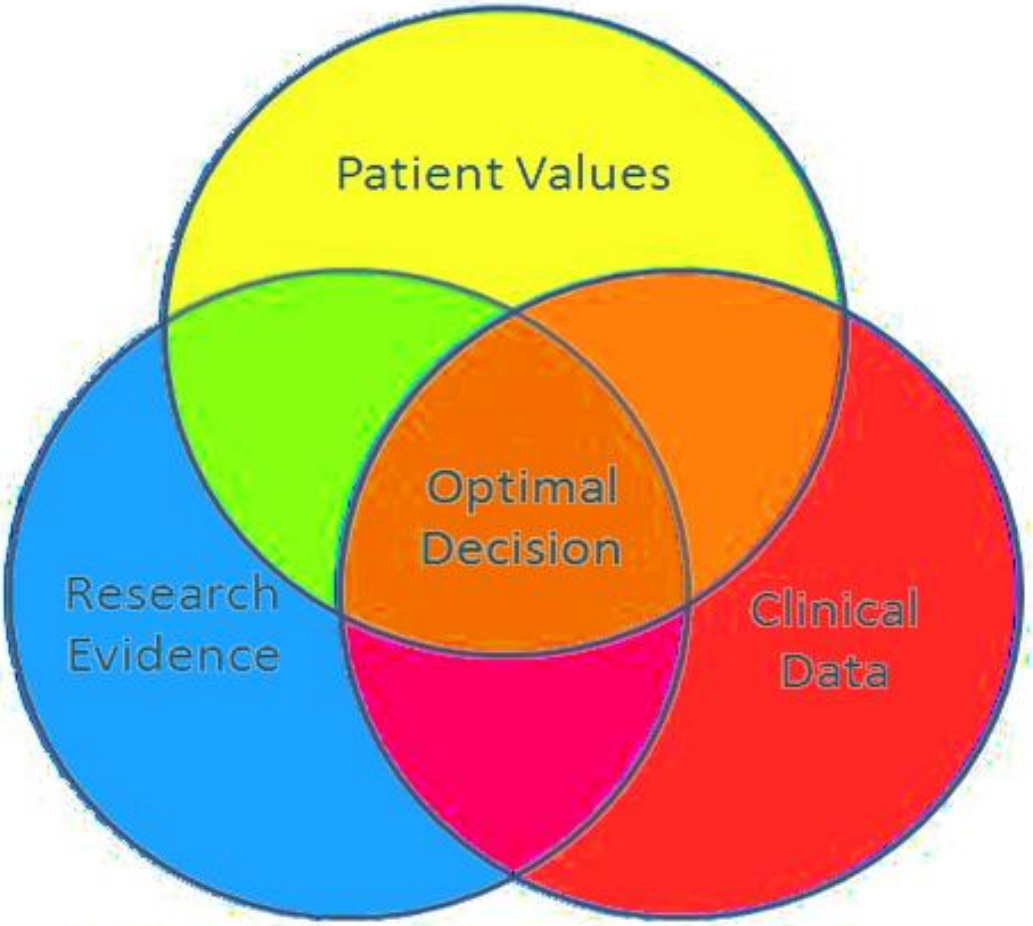

Evidence Based Medicine: when best evidence from research meets clinical information and patient values, optimal decisions are possible.

Chapter III

Definitions of non-drug medicine: Holistic, complementary and alternative medicine

To define non-drug medicine, often called *complementary and alternative medicine* (CAM) as it is complementary to *drug-medicine*, one must look at the definitions of biomedicine, holistic medicine, alternative medicine, integrative medicine, and scientific medicine.

Biomedicine involves using chemicals (medical drugs) for cure of the patient. Holistic medicine is using rehabilitation of the patient's wholeness (called holistic healing or salutogenesis) for cure. Alternative medicine is using whatever method found helpful (and not in use already by biomedical drugs), such as the medical systems of pre-modern cultures like acupuncture (China) or peyote (America). Integrative medicine is integrating the art and science of biomedicine and alternative medicine. Scientific medicine is built on scientific theory and documentations (evidence based medicine). Integrative, scientific medicine is only integrating the scientific medical systems.

So holistic medicine can be *scientific* (i.e., short-term psychodynamic therapy or non-scientific (i.e., aura-healing), it can be scientific and biomedical (treatment of post-traumatic stress) or scientific and alternative (holistic short-term psychodynamic therapy complemented with bodywork = "clinical holistic medicine"). Alternative medicine can be holistic or non-holistic, scientific or art. Most people seem to agree to define complementary and alternative medicine as "holistic health care."

Holistic health care is defined as the art and sciences of healing the whole person – body, mind and spirit – by integrating conventional and alternative therapies to prevent and treat disease in order to promote optimal health (from the constitution of International Society of Holistic Health).

In Europe, 40 universities and academic institutions has created a European Union Master degree in complementary, psychosocial and integrated health sciences. The fundamental educational program for this course can be seen as six issues of major importance for CAM:

- Fundamentals of salutogenesis, health promotion and individual promotion of health guided by resources
- Fundamentals of depth psychology and therapeutic relationship
  Working and writing scientifically in complementary medicine and integrated health
- Fundamentals of regulatory biology, paradigms and scientific backgrounds of regulatory methods
- Introduction of regulatory methods, systematics, description and current research
- Comparison and integration of complementary medical methods, humanity and medical science CAM often uses one or more of the five central, holistic principles of healing the whole person:

1. The principle of salutogenesis: the whole person must be healed (existential healing), not only a part of the person. This is done by recovering the sense of coherence, character and purpose of life of the person
2. The similarity principle: only by reminding the patient (or his body, mind or soul) of what made him ill, can the patient be cured. The reason for this is that the earlier wound/trauma(s) live in the subconscious (or body-mind)
3. The Hering law of cure (Constantine Hering, 1800-1880): that you will get well in the opposite order of the way you got ill
4. The principle of resources: only when you are getting the holding/care and support you did not get when you became ill, can you be healed from the old wound
5. The principle of using as little force as possible (Primum non nocere or first do no harm), because since Hippocrates (460-377 BCE, "Declare the past, diagnose the present, foretell the future; practice these acts.

Concerned with diseases, you should make a habit of two things, to help, or at least to do no harm" (1). It has been paramount in holistic medicine not to harm the patient or running a risk with the patient's life or health.

Complementary medicine is used more that biomedicine now in the United States and doubling every 10 years in most western countries making it most likely to be the medicine of this century. We recommend that complementary medicine become scientific and that governments support the development of theory and documentation of its effect.

What is holistic healing?

Holistic healing means healing of the whole human being, meaning body and sexuality, mind and feelings, spirit and heart. Other words for holistic healing are *existential healing* or s*alutogenesis* - rehabilitation of the *sense of coherence*. In lay terms "healing of the patient's life" is an often-used expression. The art of healing a whole life is called *existential therapy, holistic medicine, or consciousness-based medicine.*

Holistic healing was the intent of most premodern medical systems like Hippocrates' original medicine (1). The original way to induce holistic healing was the rehabilitation of the patient's character and knowledge of self – his or her mission in life, gifts, and true talents. Different medical systems have used different cosmologies to give the different conceptual

prisms through which the patient's character and personality were seen and understood, diagnosed and healed (see table 1).

Most *holistic healing* of today is done in alternative or complementary medicine still using these rather unclear and symbolic archaic concepts instead of scientific theory or documentation. A recent trend in medical science is *scientific holistic medicine* based on scientific theory of quality of life, sexuality and consciousness with scientific evidence of effect. Biomedicine is normally not holistic in its use of drugs that address the body's chemistry only and not the character, consciousness, and wholeness of the patient. It seems to be a worldwide trend that more and more patients acknowledge their need for *holistic healing* and as a result the biomedicine is losing terrain to the alternative, complementary and holistic medicine, when it comes to the number of consultations. In the United States there are now more holistic medical sessions than biomedical sessions and Europe is following.

Approaches to holistic medicine hold to the assumptions that the causes of the non-genetic, non-traumatic diseases - which mean practically all known diseases - are to be found in the depth of the patient's consciousness. As long as the deepest layer of existence has not been addressed the healing is only symptomatic, not holistic.

The central idea in *scientific holistic medicine* is that patient's *state of existence* can be more whole or more damaged, and this state determines the three fundamental existential dimensions of life: the quality of life, the physical and mental health, and the general ability of functioning – in working life, social life, family life and sexual life. The sign of holistic healing is thus the triple improvement of the patient's life in these three dimensions: the patients it turning *happy, sound, and able*. The sign of holistic damaging, the pathogenesis, is the reverse loss of quality of life, health and ability.

In *clinical holistic medicine* the holistic healing is based on scientific theories (e.g. the theory of Antonovsky-salutogenesis, the Life Mission Theory, the Theory of Human Character) and the holistic healing is induced by a combination of psychodynamic short time therapy, bodywork, and philosophy of life.

You can say that the real damage on human existence is happening in the patient's consciousness; and the imbalances and negativity in the consciousness is what creates the cascade of other problems in body, mind, sexuality or spirit. What seems to be most interesting about holistic medicine and holistic healing is that the life-time expense for medical attention with holistic medicine seem to be 1:100 or less of the price of biomedicine interventions, and often the effect with holistic healing is global – affecting all areas of the patients life – and lasting as the aetiology and primary cause of the disease has been dissolved.

The five central principles of holistic healing

1. The healing should be according to *the principle of salutogenesis*, addressing the existential core of the patient, and not a part of him or her, whether this is the body, the mind, the spirit/soul, or the gender and sexuality. Not even the health in symbolic significance is enough. When the patient heals holistically both past and future is healing, the whole personality heals and the person finds his true place in the

universe, to be the constructive and valuable, responsible and participating individual he was meant to be.

2. The healing should take the patient back to the time when and where the damage was done, using the *principle of similarity* going all the way back to Hippocrates. In the Hippocratic Corpus, the book titled *On the Place of Things which Regards to Man* (in Jones, 1923), we find the significant sentence: "Disease is born of like things, and by the attack of like things people are healed – vomiting ends though vomiting"; this is also the fundament of homeopathy. So many things can harm the patient's wholeness, and only by integrating this, meeting it again in life or in therapy the patient can truly heal.
3. *Hering's Law of Cure* states that in healing the patient will show all the symptoms that he showed on his route to the disease. When he heals the problems will surface coming from its hidden places in the core of the body, the vital organs and the head (upper body). A disease will therefore leave the organism in a specific pattern that can be seen and understood and accelerated by the physician or therapist.
4. *The principle of minimal use of force* is also known from Hippocrates – in Latin "Primum non nocere" – do no harm. Many patients prefer holistic healing methods to biomedical as the use of force is much less in psychotherapy, bodywork, philosophical exercises, than in using drugs and surgery.
5. The most important principle in holistic medicine actually initiating the holistic healing is *the principle of added resources*. It is the adding of resources in present time in the therapy that allows the patient to go back in time into the traumatic event that originally damaged his existence and only in doing that can the patient integrate the event and heal his existence. The reason for the necessity of going back and integrating the event is that what allow the trauma to be a trauma are the decisions the patient took in the moment of the trauma. It is this modification of the patient's consciousness and personal philosophy of life that is the real damage on the patient's existence and when the patient "let go" of the old negative and life-denying decisions, then the existential healing occurs.

Exercise

1. Define *manual sexological therapy* using the terms presented in this chapter (holistic or non-holistic? scientific or art? etc).

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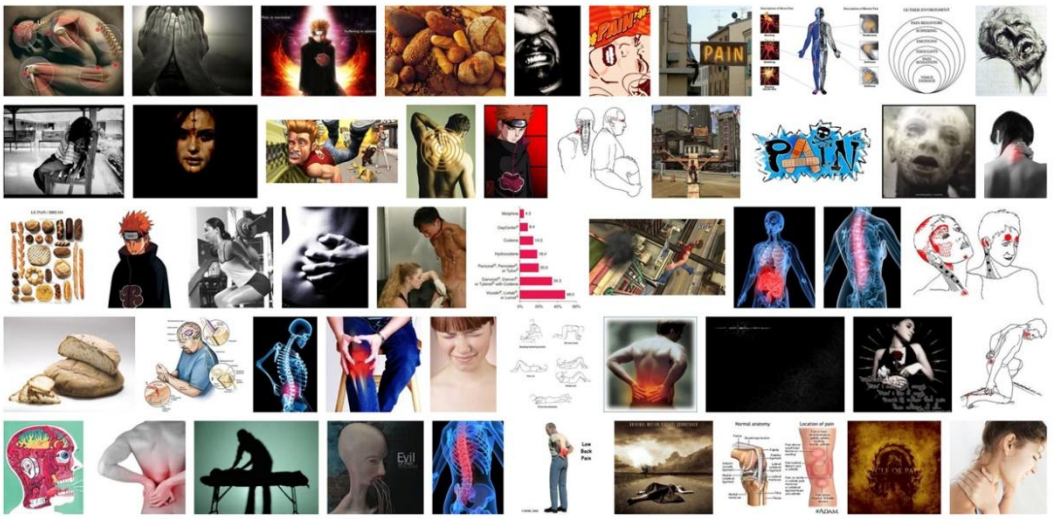

Chapter IV

Lifestyle, quality of life and health

What is most important for your health – life style including diet and exercise, or quality of life? Often we do not discriminate between how we live and how life is felt. But research shows that if you make this discrimination and look at the statistical association to health, quality of life – how life is felt – is many times more important than how you live – your life style. This chapter analyzes the connection and documents that what is important is consciousness, not the physical, practical world most people believe is important. If you look at a group of people who all have the same quality of life, you find almost no association between life-style and health at all! So if you are happy and feel good, you can eat fat meals, walk instead of running, you can even smoke and drink! After some years you might regret the smoking, though.

This chapter investigate the connection between lifestyle, quality of life and health status by way of a questionnaire based survey. The questionnaire was mailed to 2,460 persons aged between 18-88 years, randomly selected from the CPR (Danish Central Register) and 7,222 persons from the Copenhagen Perinatal Birth Cohort 1959-61. A total of 1,501 persons between the ages 18-88 years and 4,626 persons between the ages 31-33 years returned the questionnaire (response rates 61.0% and 64,1% respectively). Variables investigated in this study were: alcohol consumption, tobacco consumption, type of diet, amount of exercise taken, quality of life, self-assessed health status and number of medical complaints respondent suffered from. The results showed that health had a stronger correlation to quality of life ($r= 0.5$, $p<0.0001$) than it has to lifestyle ($r=0.2$, $p< 0.0001$). It is concluded that preventable diseases could be more effectively handled through a concentrated effort to improve quality of life rather than through an approach that focus solely on the factors that are traditionally seen to reflect an unhealthy life style.

Introduction

There is a general consensus that many of the diseases that plague the Western world (which are not the result of external factors such as starvation, micro-organisms, infection or genetic defects) are lifestyle related and as such, preventable through lifestyle changes. Thus increasing time and efforts are being spent on developing public health strategies to promote

"healthy" lifestyles. However, it is not a simple task to identify and dispel the negative and unhealthy parts of our modern lifestyle even with numerous behavioural factors that can be readily highlighted harmful, like the use of alcohol, use of tobacco, the lack of regular exercise and a high fat, low fibre diet. However there is more to Western culture and lifestyle than these factors and if we only focus on them we can risk overlooking others. We refer to other large parts of our life, for instance the way we think about and perceive life (our life attitudes, our perception of reality and our quality of life) and the degree of happiness we experience through the different dimensions of our existence. These factors or dimensions can now, to some degree, be isolated and examined (1,2). The medical sociologist Aaron Antonovsky (1923-1994) from Ben Gurion University in Beer-Sheva, who developed the salutogenic model of health and illness (3,4), discussed the dimension, "sense of coherence", that is closely related to the dimension of "life meaning" as perhaps the deepest and most important dimension of quality of life (2). Typically, the clinician or researcher, when attempting to reveal a connection between health and a certain factor, sides with only one of the possible dimensions stated above. A simple, one-dimensional hypothesis is then postulated, like for instance that cholesterol is harmful to circulation. Cholesterol levels are then measured, manipulated and ensuing changes to circulatory function monitored. The subsequent result may show a significant, though small connection which supports the initial hypothesis, which then in turn becomes the basis for implementing preventive measures, like a change of diet. The multi-factorial dimension is therefore often overlooked. The purpose of this chapter was to use the results of a cross-sectional survey examining close to 10,000 Danes to show and compare the connections between lifestyle and health, and the various dimensions of quality of life and health.

Study population

*Population 1 (CPR)*Using the Danish National Register (CPR-register) 2,460 Danes between the ages 18-88 years were chosen randomly and contacted with the same questionnaire (1). Of the 2,460 contacted we received 1,501 responses, corresponding to a response rate of 61.0%.

*Study population 2 (RH)*The Copenhagen Perinatal Birth Cohort 1959-61 (5-8) is a prospective longitudinal perinatal study that included all deliveries (over 20 weeks gestation, birth weight over 250g) that took place at the University Hospital (Rigshospitalet) in Copenhagen, Denmark during the period of September 21, 1959 to December 21, 1961. The cohort consisted of 9,006 pregnant women, who delivered 8,820 live born infants and 362 stillborn or late abortions over 250g. 170 women gave birth to twins, three to triplets and the remainder single births. The pregnant women were contacted and examined before delivery as early in pregnancy as possible. In order to evaluate and code the social, medical and obstetrical information uniformly, all examinations were performed by the same physician (5). He also saw all women after delivery and coded information made by the women herself during pregnancy and also information describing the events in the delivery room (7). The infants were examined by one of three paediatricians on the first and fifth day. The examination included physical and neurological examinations. Upon discharge the mothers received a questionnaire related to child development during the first year, which they brought to the hospital at the age of one year for a physical re-examination (a total of 8,425

children survived 28 days) (6-8). Follow-up physical examinations took place at age three and six years with developmental recording done by the mothers between examinations. At a later stage all school health records were retrieved and coded by one physician (9). More than 1,000 factors relating to pregnancy, birth and child development were collected on each child resulting in numerous scientific publications over the last forty years. In 1993 a new follow-up study was performed and 7,222 of the surviving children were identified (now aged between 31-33 years) and contacted with a non-anonymous questionnaire (1). A written reminder to non-responders was sent a month later resulting in 4,626 usable responses (f = 2,489, m = 2,131) corresponding to a response rate of 64.1%. The response rate for each individual question was typically a little lower. These 4,626 persons constituted population 1.

The questionnaire

The questionnaire used in the study, "questionnaire for the self-evaluation of quality of life", contained 317 questions with 205 placed in easy-to-answer multiple choice series. The questionnaire was divided into the following sections: social information, lifestyle, illness, sexuality, self-perception, life perception and eight series of questions measuring the quality of life (1). The development of the questionnaire and progression of the study was guided by the following methodological demands for quantitative questionnaire based quality of life research (1):

1. A clear definition of the quality of life
2. A philosophy of life based on the definition of point 1.
3. A theory that has this philosophy as its framework by a) deducing questions that were unambiguous, mutually exclusive and together fully exhaustive and by b) establishing the relative weight of each question.
4. A number of response options that might be given a quantitative interpretation on a fraction scale.
5. Technical checks in terms of reproducibility, sensitivity, wellscaledness etc.
6. The survey must be meaningful to researchers, respondents and those who use the results.
7. An appreciation of the aesthetic dimension.

The study followed these requirements with the theoretical basis for quality of life measurement bases upon the integrative quality of life theory (1). It organises eight individual theories of quality of life into a spectrum ranging from subjective (self-evaluated) to objective (externally evaluated) quality of life and spanning a core of theories that consider quality of life as deriving from human nature or human existence itself (existential theories). These eight theories or dimensions of life quality were operationalized into eight rating scales grouped into three dimensions:

I. *Subjective Dimensions* 1. Immediate, self-experienced well-being 2. Satisfaction with life 3. Happiness

II. *Existential Dimensions* 4. Needs fulfilment 5. Subjective experience of objective temporal domains ("family, work, leisure") 6.Subjective experience of objective spatial domains ("satisfaction with social relationships") 7. Expression of life's potentials
III. *Objective Dimension* 8. Objective factors (income, employment, education etc.) Eighty-five of the questions in the questionnaire were used to measure quality of life along these eight dimensions.

A Likert-scale with five response options was used symmetrically arranged around a neutral midpoint. As an example, well-being measured by the question "How are you feeling now?", and the response options given were "very good," "good," "neither good nor poor," "poor," "very poor." The central and precisely worded mid-point ("neither good nor poor"), the response options symmetrically aligned up and down the scale ("good," "poor") and the use of the same amplifier ("very") all combine to suggest that the five points on the scale may be considered equidistant.

If an underlying scale was selected ranging from 0% to 100%, from the worst imaginable to the best imaginable quality of life, the five response options may be reasonably positioned at 10%, 30%, 50%, 70% and 90%. In other words, if a respondent checks "good," his or her well-being is measured as 70%. In this manner, an approximated ratio scale was obtained, so that means could be computed and compared. A weighted mean for the eight quality of life dimensions was computed by way of means for the subjective and existential measures, respectively.

The resulting overall measure was global (covers all aspects of 157 life, not merely health-related aspects) and generic (not disease-related or intended for a specific category of patients).

Significance levels for the relationships between each variable and the measured quality of life were computed for the continuous variable using classical correlation and a modified regression [9], while in the case of the discrete variables, every group was tested individually against the rest of the sample HO: i = non-i (that is, the null hypothesis that the mean quality of life of a particular group (for example, smokers) was significantly different from the mean quality of life for the rest of the population (i.e. those that do not smoke)).

The questionnaire has been validated (1,2,10,11), and the measurement instruments (the rating scales) proved to be valid and sensitive to the same degree as commonly recognised international instruments.

A one month and a three month test-retest for reproducibility showed correlation coefficients for the eight instruments ranging from 0.6 to 0.9. A qualitative assessment of the validity of the questionnaire was performed, in which 80% of the respondents indicated that the questionnaire items expressed all dimensions relating to their quality of life, 17% were in doubt and 3% felt they did not, which was found acceptable.

The Questionnaire on health

The following questions on health were used in the questionnaire:

The Questionnaire on Health in SEQOL

The following questions on health were used in the questionnaire:

1. How do you rate your own physical health now?

	physical	mental
very good	1	1
good	2	2
neither good nor poor	3	3
poor	4	4
very poor	5	5

2. Do you have any of the following health problems now? (Please circle a number in each row)

	No	Yes, some-what	Yes, a lot
pain/discomfort in shoulder or neck?	1	2	3
pain/discomfort in back or buttocks?	1	2	3
pain/discomfort in arms, hands, legs, knees, hips, or joints?	1	2	3
headache?	1	2	3
a rapid heart beat?	1	2	3
nervousness, restlessness, or anxiety?	1	2	3
stress?	1	2	3
difficulty sleeping or insomnia?	1	2	3
melancholy, depression, or unhappiness?	1	2	3
tiredness?	1	2	3
stomach pain or stomachache?	1	2	3
indigestion, diarrhea, or constipation?	1	2	3
eczema, rash, or itching?	1	2	3
cold, head cold, or cough?	1	2	3
difficulty in breathing or breathlessness?	1	2	3
discomfort in the sexual organs (f)?	1	2	3

The Questionnaire on Lifestyle in SEQOL

The following questions were used in the questionnaire to assess lifestyle:

1. **Your eating habits? (Please circle the lines that relate most closely to you)**
   1 I eat what I like
   2 I think I have a healthy diet
   3 I think I have an unhealthy diet
   4 I have a low calorie diet because of my weight
   5 I eat ready-prepared dishes/fast food at least once a week
   6 I eat vegetarian food
   7 Information campaigns influence my eating habits

2. **How many hours of exhausting exercise do you get a week? (Possibly during work)**
   1 0 hours
   2 about 30 minutes
   3 about 1 hour
   4 about 2 hours
   5 about 4 hours or more

3. **How much alcohol did you drink in total last week (i.e., Monday, Tuesday, Wednesday, and Thursday)?**

   Ordinary beer (number of pints): ____
   Strong beer (number of pints) : ____
   Red or white wine (number of glasses): ____
   Dessert wine (number of glasses): ____
   Spirits (number of drinks): ____

4. **How much alcohol did you drink in total last weekend (i.e., Friday, Saturday, and Sunday inclusive)?**

   Ordinary beer (number of pints): ____
   Strong beer (number of pints) : ____
   Red or white wine (number of glasses): ____
   Dessert wine (number of glasses): ____
   Spirits (number of drinks): ____

5. **Was the past week typical of your normal level of alcohol consumption?**
   1 yes
   2 no, more than typical
   3 no, less than typical

6. **Do you smoke?**
   1 Yes, daily
   2 Yes, now and then
   3 No, I stopped less than a year ago
   4 No, I stopped more than a year ago
   5 No, I have never smoked

7. ***If yes*, how much do you smoke on average?**

   Number of cigarettes daily ____
   Number of cheroots daily ____
   Number of cigars daily ____
   Amount of smoking tobacco (grams) ____

Table 1. Pearson Correlation (r.p.) between Lifestyle Factors and Health

	Self-Evaluated Physical Health				Self-Evaluated Mental Health				Satisfaction with Health			
	CPR		RH		CPR		RH		CPR		RH	
	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)
Alcohol consumption	0.0496	0.0884	0.0124	0.4537	-0.0172	0.5671	-0.3730	0.0261	0.0389	0.1825	0.0158	0.3370
Smoking	-0.0604	0.0205	0.0799	0.0001	-0.0311	0.2461	0.0746	0.0001	-0.0524	0.0446	-0.0970	0.0001
Exercise	0.1209	0.0001	0.1495	0.0001	0.0589	0.0284	0.0926	0.0001	0.0898	0.0014	0.1225	0.0001
Diet* (Healthy/unhealthy)	-0.0046	0.8632	0.0459	0.0020	0.0153	0.0586	0.0343	0.0226	0.0108	0.6835	0.0279	0.0596
Health/unhealthy lifestyle	0.0886	0.0006	0.1433	0.0001	0.0641	0.0163	0.1241	0.0001	0.0778	0.0028	0.1309	0.0001

	Number of Complaints				Overall Health Status			
	CPR		RH		CPR		RH	
	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)
Alcohol consumption	0.0658	0.0230	0.0513	0.0019	0.0315	0.2981	0.0068	0.6934
Smoking	-0.1177	0.0001	-0.1815	0.0001	-0.0740	0.0061	-0.1189	0.0001
Exercise	0.0751	0.0040	0.1054	0.0001	0.1124	0.0001	0.1489	0.0001
Diet* (Healthy/unhealthy)	0.0315	0.2310	0.0405	0.0062	0.0290	0.2899	0.0557	0.0003
Health/unhealthy lifestyle	0.0823	0.0021	0.1503	0.0001	0.1073	0.0001	0.1684	0.0001

* Healthy diet was determined by the following factors: fat/low fat, fast-food/not fast-food, vegetarian/not vegetarian, and self evaluated as healthy / unhealthy by the respondent.
CPR = Sample randomly drawn from the Danish Central Persons Register.
RH= Sample taken from Rigshospitalet (The Copenhagen Perinatal Birth Cohort 1959-61 at University Hospital)

Table 2. Connection between Lifestyle and Health Expressed through weighted linear Regression (a.p.)

	Self-Evaluated Physical Health				Self-Evaluated Mental Health				Satisfaction with Health			
	CPR		RH		CPR		RH		CPR		RH	
	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)
Alcohol consumption	-2.7	±9.7	-11.1	±5.0	-2.9	±9.3	-12.1	±5.8	-8.7	±9.1	-7.4	±5.1
Smoking	-13.9	±10.3	-20.1	±10.5	-4.0	±10.6	-10.7	±11.5	-6.1	±9.7	-11.4	±10.5
Exercise	7.5	±3.5	10.0	±1.9	3.7	±3.6	6.8	±2.2	5.0	±3.4	8.4	±2.0
Diet** (Healthy/unhealthy)	6.1	±7.6	5.1	±5.1	7.4	±8.2	3.9	±5.7	4.0	±7.7	7.5	±5.1
Health/unhealthy lifestyle	13.8	±8.6	18.8	4.9	12.5	±8.8	18.0	±5.4	12.7	±8.1	15.7	±4.9

	Number of Complaints				Overall Health Status			
	CPR		RH		CPR		RH	
	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)
Alcohol Consumption	1.2	±5.6	6.2	±3.5	-5.4	±6.6	-8.9	±3.8
Smoking	-5.2	±6.3	-16.3	±6.9	-9.6	±7.3	-14.0	±7.5
Exercise	2.8	±2.1	5.0	±1.3	4.8	±2.4	7.2	±1.4
Diet** (Healthy/unhealthy)	1.6	±4.9	2.4	±3.4	4.0	±5.7	5.2	±3.7
Health/unhealthy Lifestyle	7.7	±5.0	11.9	±5.8	11.9	±5.8	15.3	±3.6

**a is the difference in health between the highest and lowest quality of life group as a percentage of the average health for all groups. $p = \pm 1.96 \times SE\{a\}$.
** Healthy diet was determined by the following factors: fat/low fat, fast-food/not fast-food, vegetarian/not vegetarian, and self evaluated as healthy / unhealthy by the respondent.
CPR = Sample randomly drawn from the Danish Central Persons Register.
RH= Sample taken from Rigshospitalet (The Copenhagen Perinatal Birth Cohort 1959-61 at University Hospital)

Table 3. Pearson Correlation (r.p.) between Health and Quality of Life

	Self-Evaluated Physical Health				Self-Evaluated Mental Health				Satisfaction with Health			
	CPR		RH		CPR		RH		CPR		RH	
	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)
Well-being	0.5020	0.0001	0.4687	0.0001	0.6595	0.0001	0.7052	0.0001	0.5230	0.0001	0.4699	0.0001
Life satisfaction	0.3812	0.0001	0.3667	0.0001	0.6217	0.0001	0.6531	0.0001	0.4369	0.0001	0.3971	0.0001
Happiness	0.2785	0.0001	0.3034	0.0001	0.5162	0.0001	0.5753	0.0001	0.3579	0.0001	0.3322	0.0001
Fulfillment of needs (approx. Maslow)	0.2457	0.0001	0.3185	0.0001	0.4888	0.0001	0.5155	0.0001	0.2838	0.0001	0.3117	0.0001
Temporal domains*	0.2886	0.0001	0.3454	0.0001	0.5263	0.0001	0.5451	0.0001	0.3206	0.0001	0.3647	0.0001
Spatial domains**	0.3023	0.0001	0.3530	0.0001	0.4560	0.0001	0.4643	0.0001	0.4048	0.0001	0.4378	0.0001
Expression of life's potential***	0.2274	0.0001	0.2400	0.0001	0.3264	0.0001	0.4062	0.0001	0.2337	0.0001	0.2457	0.0001
Objective factors	0.1745	0.0001	0.1910	0.0001	0.2142	0.0001	0.2907	0.0001	0.1714	0.0001	0.1892	0.0001
Overall QL	0.3749	0.0001	0.3722	0.0001	0.5232	0.0001	0.5903	0.0001	0.4175	0.0001	0.3899	0.0001

	Number of Complaints				Overall Health Status			
	CPR		RH		CPR		RH	
	(r)	(p)	(r)	(p)	(r)	(p)	(r)	(p)
Well-being	0.4513	0.0001	0.4710	0.0001	0.6815	0.0001	0.6830	0.0001
Life satisfaction	0.3876	0.0001	0.4182	0.0001	0.5800	0.0001	0.5855	0.0001
Happiness	0.2775	0.0001	0.3469	0.0001	0.4634	0.0001	0.4991	0.0001
Fulfillment of needs (approx. Maslow)	0.2749	0.0001	0.3240	0.0001	0.4191	0.0001	0.4736	0.0001
Temporal domains*	0.0307	0.0001	0.3485	0.0001	0.4722	0.0001	0.5162	0.0001
Spatial domains**	0.2848	0.0001	0.3158	0.0001	0.4694	0.0001	0.5065	0.0001
Expression of life's potential***	0.1927	0.0001	0.2106	0.0001	0.3170	0.0001	0.3479	0.0001
Objective factors	0.2197	0.0001	0.2480	0.0001	0.2275	0.0001	0.2843	0.0001
Overall QL	0.3621	0.0001	0.3988	0.0001	0.5235	0.0001	0.5588	0.0001

*Family, work, and leisure time.
**Self, others, world.
***Personal relations to all known persons, self, and surrounding world.
CPR = Sample randomly drawn from the Danish Central Persons Register.
RH= Sample taken from Rigshospitalet (The Copenhagen Perinatal Birth Cohort 1959-61 at University Hospital)

Table 4. The Connection between Quality of Life and Health Expressed through Weighted Linear Regression (a.p.)

	Self-Evaluated Physical Health				Self-Evaluated Mental Health				Satisfaction with Health			
	CPR		RH		CPR		RH		CPR		RH	
	(a)*	(p)	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)
Well-being	60.8	±10.3	57.4	±6.1	0.6595	±10.5	94.7	±5.4	58.0	±9.9	59.4	±6.1
Life satisfaction	37.2	±10.5	48.1	±5.5	80.3	±9.4	83.7	±4.9	51.2	±10.4	49.2	±5.4
Happiness	39.1	±14.4	44.5	±6.9	87.4	±12.8	95.9	±6.5	49.8	±13.6	45.9	±6.8
Fulfillment of needs (approx. Maslow)	24.3	±8.7	50.4	±14.9	64.1	±8.1	68.3	±15.6	28.6	±8.4	39.4	±14.8
Temporal domains	27.9	±11.1	60.6	±14.9	66.7	±10.5	87.2	±14.3	43.5	±10.6	71.9	±14.7
Spatial domains**	25.2	±16.4	42.1	±5.6	73.5	±15.8	64.9	±5.7	58.5	±15.3	56.9	±5.4
Expression of life's potential†	25.4	±9.6	25.3	±7.2	32.6	±10.2	42.8	±8.0	28.6	±9.2	25.5	±7.3
Objective factors	22.7	±16.6	36.7	±11.9	17.1	±19.0	51.2	±12.6	18.3	±16.3	37.1	±12.0
Overall QL	50.7	±7.6	46.7	±4.8	71.7	±7.9	78.0	±4.5	55.9	±7.6	47.8	±4.8

	Number of Complaints				Overall Health Status			
	CPR		RH		CPR		RH	
	(a)	(p)	(a)	(p)	(a)	(p)	(a)	(p)
Well-being	39.9	±6.3	48.9	±4.0	0.7	±6.2	62.7	±3.6
Life satisfaction	31.0	±6.0	42.1	±3.6	48.0	±6.3	53.6	±3.5
Happiness	38.6	±8.0	44.5	±4.5	53.4	±8.9	56.1	±4.6
Fulfillment of needs (approx. Maslow)	24.1	±5.3	45.3	±9.9	34.2	±5.7	53.5	±10.6
Temporal domains*	30.6	±6.8	36.7	±9.9	41.3	±7.1	62.4	±9.6
Spatial domains**	27.3	±9.9	28.0	±3.9	44.5	±10.3	47.0	±3.9
Expression of life's potential†	12.9	±5.6	11.8	±5.1	22.0	±6.7	22.5	±5.4
Objective factors	10.9	±9.7	21.6	±7.6	15.9	±11.1	35.6	±8.2
Overall QL	27.7	±4.8	36.4	±3.2	47.2	±5.0	50.3	±3.2

a is the difference in health between the highest and lowest quality of life group as a percentage of the average health for all groups. $p = \pm 1.96 \times SE\{a\}$.
*Family, work, and leisure time.
**Self, others, world.
†Personal relations to all known persons, self, and surrounding world.
CPR = Sample randomly drawn from the Danish Central Persons Register.
RH= Sample taken from Rigshospitalet (The Copenhagen Perinatal Birth Cohort 1959-61 at University Hospital)

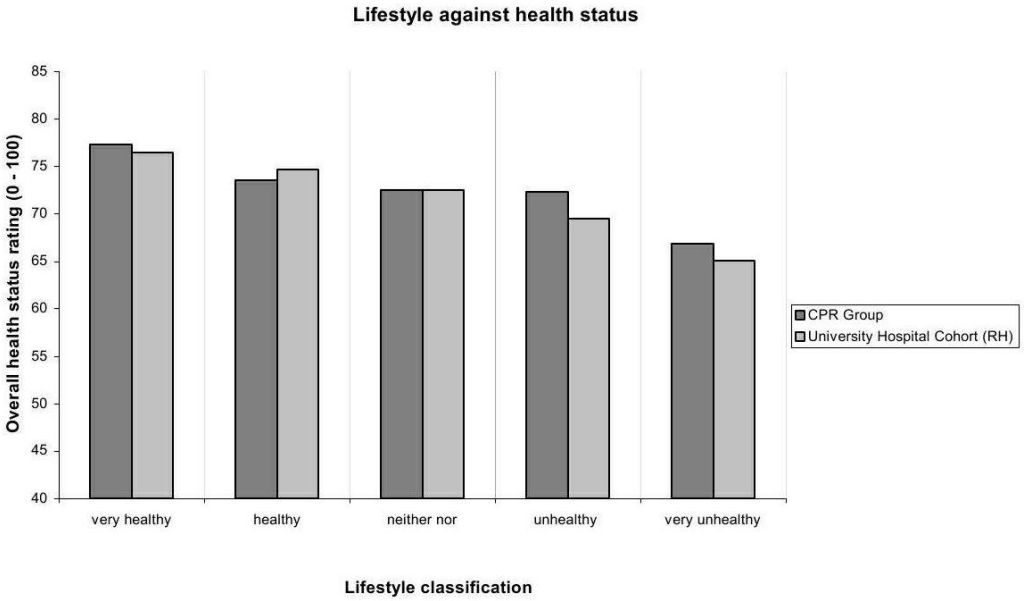

Figure 1. Lifestyle against health status. The statistical co-variation is about 10% in both studies. This is far weaker co-variation than is seen between quality of life and health (figure 2) suggesting that global QOL is the most important factor of the two preventing disease and improving public health.

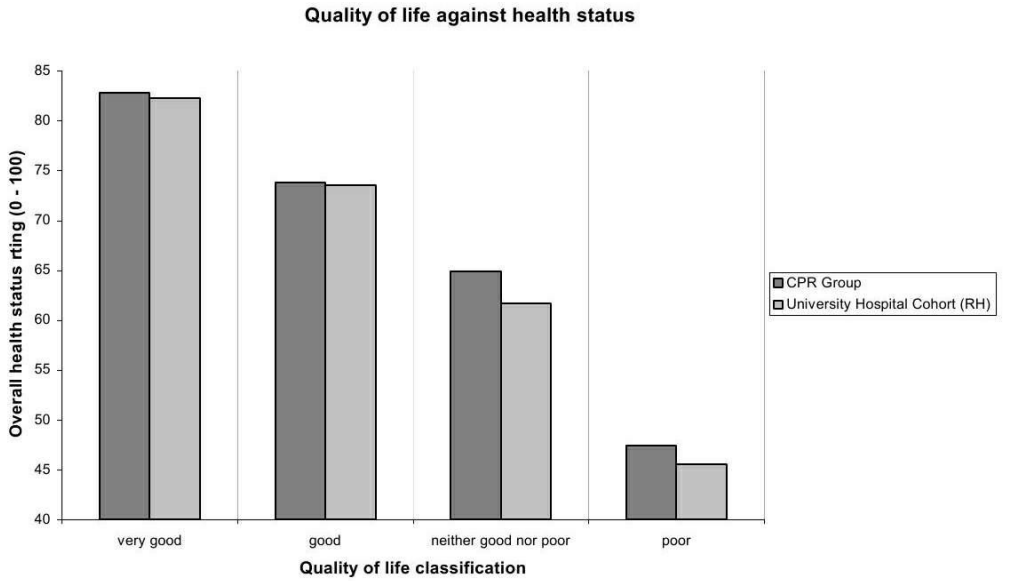

Figure 2. Global quality of life against health status. The statistical co-variation is about 40% in both studies. This is far stronger co-variation than is seen between lifestyle and health (figure 1) and between quality of life and lifestyle's (figure 3), suggesting that global QOL is the most important factor for preventing disease and improving health.

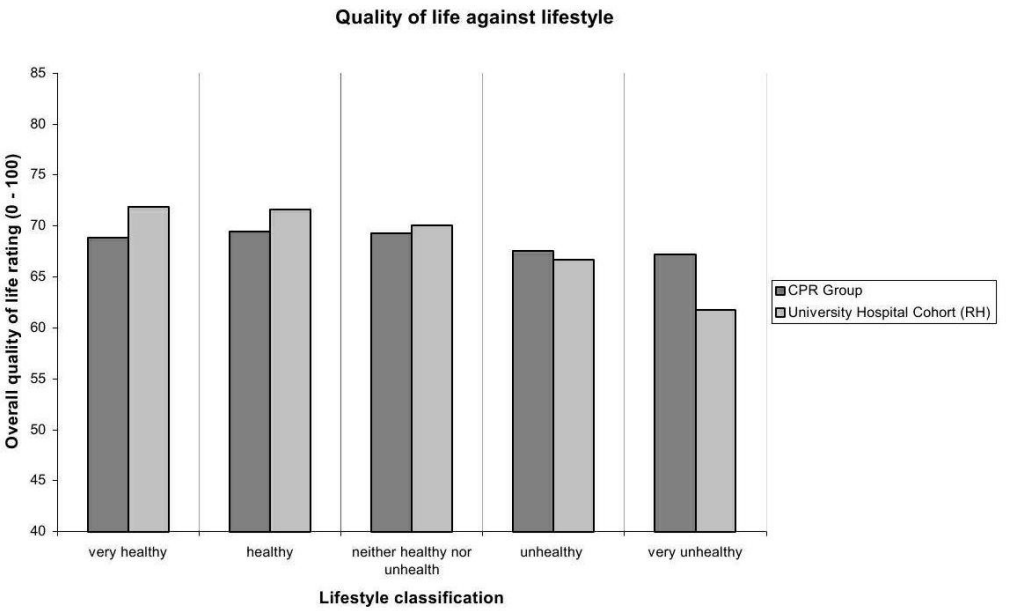

Figure 3. Global quality of life against lifestyle. The statistical co-variation is 5-10% in the two studies. This is a far weaker co-variation than is seen between quality of life and health (figure 2). Taken together with the week connection between lifestyle and health status (figure 1), the results suggests that lifestyle is only weakly connected to QOL and health. To improve QOL and health more than a change in lifestyle seems to be needed.

Quality of life against lifestyle. To illustrate the above findings it may be worth having a look at the connection between quality of life and lifestyle (see figure 1, 2 and 3). The important question is; what is the underlying factor responsible for determining the quality of life? Is it a simple and quite trivial connection to health status or is quality of life determined by numerous factors that people themselves have great influence over? Is it reasonable to suggest that a person through a deep insight and knowledge about life can live their life in such a way that they thrive and maintains their health, while those who lack knowledge about life live in such a way that quality of life is not experienced and they become more susceptible to illness. Of course this cannot be determined conclusively through a cross-sectional survey, and we continue the work prospectively. But the cross-sectional survey showed a strong connection between our quality of life and 167 of our personal relations - with partner, friends and work colleagues - and only a modest connection with objective factors like: annual income and level of education (12,13).

Discussion

The presented data seems to suggest that lifestyle factors have a much smaller connection with health than normally assumed in the medical world. On the other hand, quality of life, more specifically the self-experience of life, showed a very strong connection with health. Numerous clinical trials are found which demonstrate links between lifestyle factors and health status, but perhaps the connection is an indirect one. Perhaps lifestyle is just an

indicator of quality of life and it is quality of life that is the major determinant of health. When we control for quality of life we found, in general, no connection between a healthy/unhealthy lifestyle and self-evaluated health (13). It has been demonstrated in the literature that psychotherapy treatments, in which the patient focuses on emotions and personal relationships, have positive effects on quality of life and survival (14-16), and that radical changes in life behaviours and attitudes can be beneficial to recovery (14). There is also evidence to suggest that, in general populations, general well-being is positively related to life expectancy (17,18). In view of these studies and our own results, it may be reasonable to try and improve health by attempting to directly improve quality of life rather than just changing a particular aspect of someone's lifestyle, like diet or exercise, as it so often is advised by physicians. If a strong causal link between quality of life and health could be clearly demonstrated, it could maybe be more effective for public health strategist to look at motivating populations to identify and improve the aspects of their life they may be unhappy with, like their job or relationships. By developing our understanding of the link between quality of life and health, greater steps may be made towards health maintenance and improvement. Seemingly, we lack a structured science that can integrate the concepts of quality of life, experience and consciousness into medical theory and clinical practice. Nevertheless it can never be harmful to encourage people to focus on human relations: the good life is lived when we feel good about ourselves, other people and when we really enjoy the work we do.

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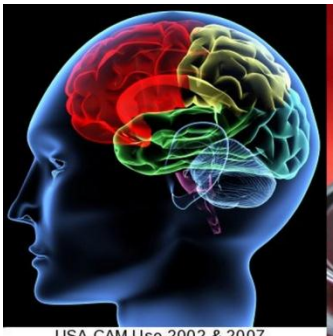

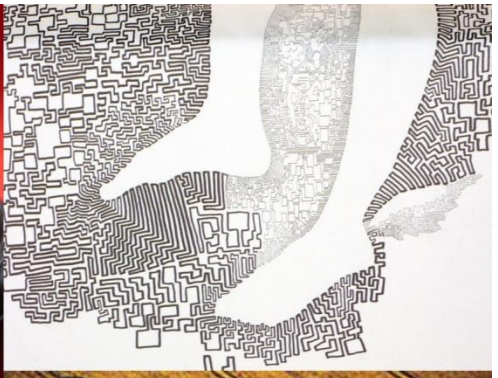

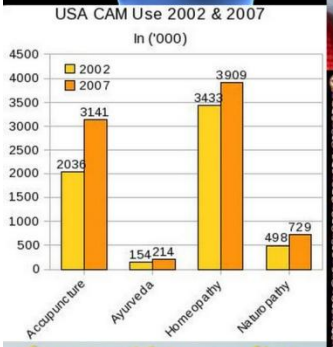

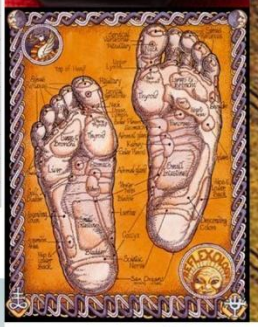

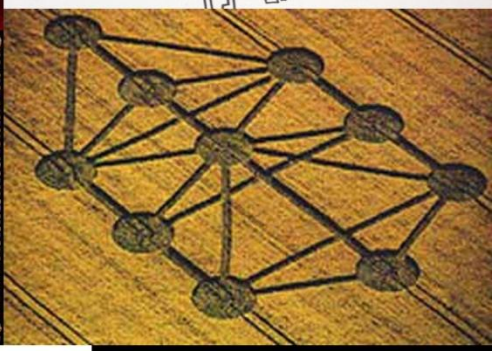

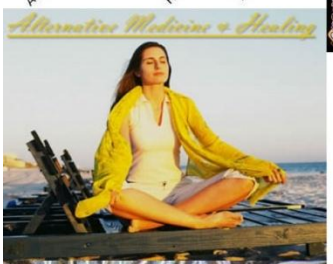

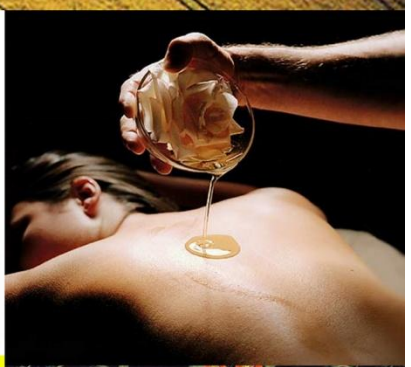

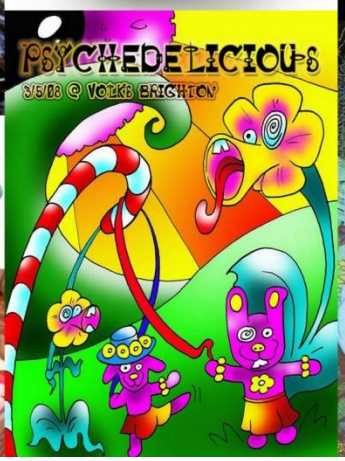

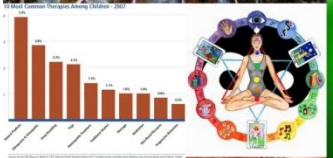

Chapter V

Chronic pain in the locomotor system

One patient in five is seeing his or her doctor because of chronic or recurrent pain. Pains can be anatomical or non-anatomical – connected to physical structures in the body or not connected to any specific tissue or organ or location. Non-anatomical pains are extremely common, but often not registered, as the idea of non-localised pains often is alien to both patient and doctor. As soon as a pain is seen and understood as non-anatomical, it is clear that is does not have an organic cause. It is psychosomatic in some way. Very often a non-anatomical pain is wandering and changing place in the body… which is very strange for people not familiar with the theoretical world of holistic medicine.

But also anatomical pain – pain closely related to a specific structure or organ – is often strangely variable. It comes and goes, like gout or arthritis only manifesting itself before bad weather is coming. If pain varies a lot, if it comes and goes, stays away for a week or a month and then re-appears, it is almost certain that the pain is not caused by a physical damage in the tissue or organs either. This might be highly frustrating for the physician who sees cartilage degenerations in the neck's spine, but cannot make the association to the pain.

So helping patients with pain is a science in the sense that you need to know what to look for. This is what we will teach you in this chapter. Most pains from the locomotor system arise due to involuntary, chronic tensions in the muscles or other tissues. When the patient is motivated, the pain is easily cured in most of the cases by using the tools of consciousness-based medicine, primarily therapeutic touch, conversation, and coaching the patient in a positive philosophy of life.

The pains are often caused by "blockages" in the "life-energy" (which we in scientific terms call "disturbances in the biological informational system") that may cause many problems other than just pain. Often it turns out that the blocked areas of the body develop actual physical damage over time: a slipped disk in the back, articular degeneration, or osteoarthritis when the cartilage is affected, can often be explained in this way. But when examined closely we often find that the blockage that causes the physical degeneration is also causing the pain - in a direct way, not through the tissue. The pain is related to what the old theosophists used to call "the emotional body".

Apparently, the exact areas where the blockage is situated cause cellular problems, disrupting cellular order. The holistic process theory of healing and the related quality of life theories state that return to the natural state of being is possible, whenever the person gets the

resources needed for existential healing. The resources needed are "holding" and "processing" – holding in the dimensions of awareness, respect, care, acknowledgment, and acceptance and processing of the traumatic content, allowing the patient to feel, understand, and let go of negative attitudes and beliefs.

When you have a patient with physical pain, do not be afraid to touch or to provoke an intensive pain in the area the patient complains about. If you can make the pain come just be pressing on the tissues, it is very likely that the pain is caused by tensions of the tissues! This means that you can cure or at least improve the patient in one single session.

The preconditions for holistic healing are trust and the intention for the healing to take place. Case stories of holistic treatment of patients with chronic back pain, low back pain, muscle problems, knee pain, and symptoms of rheumatoid arthritis are discussed with exercises relevant for patients with these conditions in the holistic clinic.

Introduction

Pain is the most common reason for consultation with a physician (1). Many of these pains are not cured by standard biomedical treatment (2), but become chronic with staggering negative health and economic consequences (3). Pain is an extremely complex and difficult subject as it involves a whole range of aspects of the human being from the most bodily-physical to the most mental and spiritual (2-5). Emotions seem to play an important role and pain is statistically connected to depression and anxiety (6). The problem is that the pain will not go away, no matter what, and experiments with alternative methods like psychotherapy (7), relaxation techniques (8) and "spiritual healing" (9-10) seem only to have very limited effect. When in severe or constant pain in the locomotor system, most patients go to see a physician and, in our experience, many patients can obtain partial or complete freedom from pain with consciousness-based holistic medicine. This is not the case when we are talking about terminal cancer or other terminal diseases, but even many of these patients can benefit from a holistic approach, as most patients have large hidden resources they can use. However, to obtain pain relief, the patient must be dedicated to develop into a more positive and happy individual who is less tense about him/herself and life. In our natural state, which holistic medicine helps us to recover, life is good and does not make the body hurt.

About 20% of the Danish population suffers from chronic pain and both children and adults are affected (11). Often the pain of the locomotor system is in the neck, upper or lower back, shoulders, elbows, knees, hands, or feet. Closer analysis shows that pain is often located in particularly sensitive areas in muscles, tendons, connective tissues, joints, and bones. These areas are often called trigger points and are located in the parts of the body where we find most local tensions or blockages.

There are many theories about why we have those tensions. The most common explanation is that tension is due to tenseness, meaning a tendency to develop a "tense" personality. Instead of relaxing and being our own good self, we strain ourselves in many ways, consciously or unconsciously. We become tense while trying to fit, cope, and adapt in a different way than we actually are deep down in our nature. The tensions go all the way down to the deepest level of our existence. As we find this level (our soul or whole being) causal to the pain, this is the level we primarily address in our holistic medicine.

Clinical holistic medicine

The life mission theory (12-17) states that every person has a purpose in life or huge talent. Happiness comes from living this purpose and succeeding in expressing the core talent in life. To do this, it is important to develop as a person into what is known as the natural condition, a condition where the person knows himself and uses all efforts to achieve what is most important for him. The holistic process theory of healing (18-21) and the related quality of life theories (22-24) states that the return to the natural state of being is possible, whenever the person gets the resources needed for existential healing.

The resources needed are "holding" in the dimensions of awareness, respect, care, acknowledgment, and acceptance with support and processing in the dimensions of feeling, understanding, and letting go of negative attitudes and beliefs. The preconditions for holistic healing are trust and the intention for the healing to take place. Existential healing is not a local healing of any tissue, but a healing of the wholeness of the person, making him much more resourceful, loving, and knowledgeable of himself, his needs, and his wishes. In letting go of negative attitudes and beliefs, the person returns to a more responsible existential position and an improved quality of life. The philosophical change of the person healing is often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life (25-32). The person who becomes happier and more resourceful often also becomes healthier, more talented, and more able to function (33-35).

Case stories from the holistic clinic

Blockages encompass old feelings and can be dissolved once the feelings are liberated. It is difficult to explain the pain from "tensions", because we cannot just feel joint capsules or bones where blockages are sometimes located. Since it is often possible to provoke pain by pressing swollen or tense body areas without any muscle function (for instance, connective tissue above the sternum or fatty tissue above the low back), there must be some other explanation. Blockages are not tensions in the traditional sense, although they may be the cause of chronic muscle tensions.

Female, aged 30 years, with pain in fingers: A 30-year-old woman presents with large swollen and tender finger joints. Signs of inflammation – sterile inflammation – and blood test results consistent with arthritis. The question is how the patient can strain her finger joints. By touch and massage ("manipulation") of the joints in her fingers, hands, arms, legs, feet and spinal column in holistic body therapy, an emotional tension was "released", as the patient becomes cross, angry and grumpy during the intense body therapy. Subsequently in gestalt therapy, the patient verbalised her feelings and finally understood who she is cross with and why. The arthritic symptoms – swelling and pain – vanished during the weeks that followed. Clinical experience indicates that physical pain can be released when the patient can accommodate emotional pain. In holistic medicine, the theory concerning chronic pain in the locomotor system is supported by clinical experience. When patients are touched on tense and tender areas of the body, they often come into contact with old, unresolved problems and painful feelings from their personal lives.

Male, aged 39 years, with low back pain: A 39-year-old man suffering from recurrent low back pain. Examination: his back is very tense and the facet joints in the low back have almost come apart in some places. Conversation revealed that he was suffering from anxiety. During gestalt therapy his anxiety was released, when he looked at his relationship with his authoritarian mother. Afterwards the back pain was resolved and did not return. When the patients remembered and fully understood what went wrong, the blockage and the pain disappeared. This experience forms the basis of the Rosen method[36] and holistic body therapy.

Blockages that are not released can cause tissue damage

Blockages may cause problems other than just pain. Often it turns out that the blocked areas develop actual physical damage over time such as a slipped disk in the back, articular degeneration, or osteoarthritis when the cartilage is affected. Apparently, the exact areas where the blockage is situated cause cellular problems, disrupting cellular order. This disruption is reversible. The renowned international medical textbook, *Harrison's Internal Medicine,* states that even degenerated cartilage, as it occurs in osteoarthritis, is sometimes seen on X-rays to have regenerated. That is the sort of healing effect that may occur once blockages around the joint are released. We have performed pilot studies in groups of pain patients with a regime combining life philosophy, psychotherapy, and body therapy. Some of the participants had severe physical disabilities and damage. The preliminary results of treating patients with different diagnoses indicate that, in general, working on the release of blockages in the body can be an effective way of abolishing chronic pain.

Female, aged 38 years, with chronic back pain: Conversation: She has had chronic back pain for over 12 years. On examination: Very tense in back muscles between iliac crest and column. She believes that the pain has a psychological explanation. She wants to work on herself to get rid of pain and arrive highly motivated. Subjective: She explains that her younger brother is mentally ill – anxiety, depression and attempted suicide – and starts crying. There have also been problems with the parents. "I am the one who has to cope with it all," she says when we talk about self-esteem, "but I'm not there." She can see that she is suppressing her feelings to make herself strong, and that this is how she avoids being present in life. She can feel that she does so by tensing the low back, exactly where it hurts.

EXERCISE for next time: "Find out where you are – where did you go?"

PLAN: When she is ready, she should have physiotherapy with massaging of back. Once one has seen how people suppress their lives to adjust to people around them, this pattern becomes easily recognizable in the patient. This woman has completely opted out of her own existence to be as sensible as she felt she needed to be in order to survive at the social level. The problem is that in the middle of all her control and sense, she is not at all present as a human being with feelings and presence. She is hiding; she has fled life. Unfortunately, the feelings of anxiety and discomfort are parked in her upper and lower back as tension, and that gives her great problems. Once she learns to apply herself better, her chronic back pain will go away. This typically takes six sessions over 3 months of exercise and assignments.

Male, aged 51 years, with chronic back pain: His back snapped following construction work. Pain and some throbbing down into the legs. Saw a chiropractor twice with no effect. On examination: no significant back pathology (in spite of X-rays), swollen and tender at sacroiliac joints and piriformis, which are massaged with some effect. The patient believes that this is old damage that cannot be helped. Very tense between shoulder blades, where the back has not yet "snapped". Manipulation not possible, because of muscle tension. He will come back for treatment of this region and further assessment in 14 days.

EXERCISE: Pelvic exercises and examine at home why he is so tense. The idea that the body is a machine that may break down irretrievably is widespread. If you understand the body the way we do, as a dynamic colony of cells controlled by the information flow, you would have to smile wryly at remarks of the type made by this patient: "Old damage that cannot be helped." When people "break their back", they believe that the back is almost torn apart, never to be put together again, like a trunk that has broken. In general, it is quite astonishing how little patients know about the anatomy of the back. Fortunately back problems can usually be resolved when the patient finds out why he or she is tense and tackles the underlying emotional issue. Once the patient has assumed responsibility for this, it is usually possible to manipulate the vertebrae back into place. Actually, vertebrae and joints, which can be quite distorted and shifted in relation to each other, will usually fall spontaneously into place once the muscles relax. Often a 10-minute talk on the couch before the manipulation will do the trick. It is peculiar how you tear and press and nothing happens, then you talk for a while and snap!…. it yields to the smallest pressure and the pain goes away.

Male, aged 61 years, with chronic back pain for 20 years: Immigrant presenting with back pain dating back 20 years. He has taken analgesics over the years. Now distinct tenderness (doorbell) corresponding to about L2. No other symptoms. Says chiropractor could not help. Remarkably rigid gait. Needs to exercise his back. Instructed in back exercises. Advised to swim once or twice a day. The effect will take a while to appear, perhaps months or years. But that is the only way out of the problem. Cultural differences and language barriers mean that we cannot apply a psychosomatic approach, but must try a combination of exercise and remarks to strengthen the patient's physical confidence. This is harder work, painful and sad.

Female, aged 24 years, with low back pain: Presents with low back pain corresponding to right sacroiliac joint [between Os sacrum and pelvis]. On examination: Articular tenderness consistent with /sprained left sacroiliac joint/. Very tense in scalenus muscles, neck, shoulders and particularly the center of the back, where large groups of muscle are organised as tethered and tense muscular masses causing /enlarged kyphotic curve/ that is compensated by /enlarged low-back lordosis/, which is presumably the cause of the low back pain. So the problem lies in the tensions. We talk about where they come from and the patient mentions her parents' divorce.

EXERCISE: Tilting and rotating the pelvis ("pelvic rotations" [good exercise in which the patient swings the abdomen around in a horizontal circle in a diameter of about one metre]).

Can return if the problem persists. Young people almost never process their parent's divorce. It is quite surprising how little it takes to start relevant processing. When the patient has some exercises that gently release the blockages from the body, combined with one that supports processing of the emotional trauma, a clear and motivated individual can rid himself of a chronic, low back condition fairly rapidly. Other times it may bother him for years.

Male, aged 61 years, with severe pain in thigh following intercourse: Left thigh very sore, daily attacks corresponding to posterior side of thigh, a piercing, throbbing, hammering pain, sometimes the whole day, sometimes up to a whole week after intercourse. Pain brought on by flexing of hips. Rectal exploration: no tumours, no tenderness, nothing abnormal. Free hernial orifices. Muscle tension corresponding to quadriceps femoris and psoas major muscles.

The familiar pain is induced by pressing on these muscles. /Muscle pain/ – does not want analgesics. He is instructed to try to breathe instead of tensing up and shutting off at attacks. Can come back if pain persists; then we shall have another talk about medication. When the familiar pain is induced by pressing on certain muscles, the patient knows that we are aware of his pain and why he is in pain. This means that the patient should be given a confrontational exercise where he can use his breathing (breathe in deeply and into the abdomen and then exhale) to be present when he is cramped and sore. That can often deal with the problem. The focused consciousness, where you become more familiar with yourself and your body, is a brilliant tool for the patient to use.

Male, aged 30 years, with knee pain: Presents with problems in left knee: hurts after he has been sitting for 10 min. On examination: oedema in legs and around the knee. Talk about job, using the body, etc.

We talk about him getting away from cyberspace (spending hours on the Internet) and finding a girlfriend – getting out into the world where his body is. His body would benefit from that. Guidance. Get a life! The body does not much like sitting in front of a computer screen day in, day out, completely denied by its owner.

Female, aged 55 years, with muscle problems: QOL conversation: Problems with muscles, tendons and joints for 12 years. Pain and reduced strength, particularly in the arms, the left being worse. Reduced mobility of shoulder. On examination: very small muscles that are chronically tense and resemble "steel strings" in shoulder girdle. Seems to be as frozen as an ice-lolly in the upper part of the chest. We talk about feelings, which in my opinion do not come alive in the patient. It is as if she is very warm, but has decided to be cold.

PLAN: The patient is adept at avoiding emotional pain, so we prescribe Rosen method 6 times every 14 days, which supports the patient in registering all those old, painful feelings that she has denied.

EXERCISE: Welcome all negative feelings. Be with them, inside them, allow them space. Come back in three months. Some patients are really hard to get through to. It is good for them to lie on a couch and feel, feel, feel, until one day they finally realize what it is all about. Then they can come back to our clinic and unable us to move on.

Discussion

The case stories show, in many different ways, how the physician assuming the holistic medical perspective addresses the physical pain. Not all patients welcome this perspective, as it inevitably ends with the patient going through often severe emotional difficulties, confronting negative attitudes and shadowy aspects of their own existence. A lot of trust in the physician is necessary before the holistic toolbox (37) can be used freely. To win the trust, the physician needs to care for his patient and express this care, which is difficult for many physicians with traditional biomedical training. When the trust is won, the patient must accept the holding and support and in this privileged state, the patient can heal. Therapeutic touch (38) is often helpful when trust is obtained. Often the problems are more of a social type than

of a somatic type (39). What might look easily treatable turns out to be very difficult, unless the social circumstance is handled successfully through coaching of the patient to help him create value and mobilize resources and talent in the social relationships. Sometimes, the physician must face severe problems connected with interpersonal chemistry; this is the case when he has something to learn from his patient because he is not sufficiently developed in the existential aspects relevant for the holistic treatment of this special patient (18). Most pain from the locomotor system arises because of involuntary, chronic tensions in the muscles or other tissues. When the patient is motivated, the pain is easily cured in most of the cases by using the tools of consciousness-based medicine, primarily therapeutic touch, conversation, and coaching the patient in a philosophy of life that supports life and a constructive behavior.

As previously discussed, the holistic process theory of healing (18-21) and the related quality of life theories (22-24) state that the return to the natural state of being is possible whenever the person gets the resources needed for existential healing. The resources needed are holding in the dimensions of awareness, respect, care, acknowledgment, and acceptance with support and processing in the dimensions of feeling, understanding, and letting go of negative attitudes and beliefs. The precondition for the holistic healing is deep trust and the intention of the healing to take place. The holistic cure for chronic pains and discomfort can be used on almost all patients independent of the site and affected tissue, but the efficiency of the cure has yet to be documented clinically in larger series of patients.

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Chapter VI

Chronic pain in the internal organs

Now you will understand that we believe that repressed feelings are the most common cause of many somatic disorders. Unfortunately it is quite impossible to say which feelings are repressed to which organs and tissues. You can of course make a simple map of body structure, function and related feelings, emotions and sensation, and get a clue from that. Sex organs are related to sexual feelings, locomotive structures to feelings connected to action etc. But we have not succeeded in making a consistent map, as we have seen all kinds of feelings and emotions connected to all different types of tissues and organs. So do not expect these connections to be easy, but instead expect that every patient is unique and that everybody has a special story with a special mission and special traumas connected to it.

Having said this, there are some tendencies to more sinister and difficult feelings ending up in inner organs. Like the locomotor system takes the simple ones, like antagonism, anger, hate, resentment, numbness, and hostility, while the inner organs accumulate feeling of anxiety, hopelessness, despair, helplessness, near-death, guild, shame etc. Again, it is not at all as clear as one would want it to be. But see if the first knee arthritis is not connected with resentment and sourness, and your first stomach ache not connected to anxiety… The tendency is often quite clear.

Holistic medicine is efficient in the treatment of chronic pain in the internal organs, including the genitals, especially when the pain has no known cause. It is quite surprising that while chronic pains can be one of the toughest challenges in the biomedical clinic, it is often possible to alleviate the pain in the holistic clinic in only a few sessions. These pains are regarded as caused by repressed emotions and explained as a psychosomatic reaction. Using holistic medicine, the patient can often be cured of the sufferings, when he or she assumes responsibility for the repressed feelings. The holistic process theory of healing states that the return to the natural (pain free) state of being is possible, whenever the person obtains the resources needed for the existential healing. This shift is explained by the related quality of life and life mission theories. The resources needed are “holding” or genuine care in the dimensions: awareness, respect, care, acknowledgment and acceptance with support and processing in the dimensions: feeling, understanding and letting go of negative attitudes and beliefs.

The preconditions for the holistic healing to take place are “love” and trust by obtaining full confidence of the patient, which seems to be the biggest challenge of holistic medicine,

especially when dealing with a patient in pain. For the sexologist the patient's chronic sexual or genital pain (dyspareuni, vulvodyni etc) is often a challenge, and often patients have their genital pains almost unchanged for many years in spite of visiting physicians, gynecologists and sexologists, But genital pain follows the same basic pattern of establishment (pathogenesis) and healing (salutogenesis) as all other chronic pain syndromes caused by psychosocial, "non-organic" ("non-anatomic") causes. Understanding the elementary dynamics regarding pain and healing empowers the sexologist to help the majority of patients with sexual and genital pain.

Introduction

About one in twenty Danes suffer from recurrent or chronic pain in their internal organs (1). If we use the example of chronic pelvic pain (2), it can result from a variety of abdominal and pelvic causes, including endometriosis, pelvic inflammatory disease, adhesions, urogenital causes and from bladder complaints, including overactive bladder, urinary tract infection and interstitial cystitis (IC).Often, there seems to be no medical explanation for the pain – apparently there is no ill health that can be detected within the internal organs (i.e. the stomach, intestines, gall bladder, pancreas, liver, bladder, kidneys or reproductive organs). In spite of numerous in-depth medical examinations nothing is revealed. Nevertheless, the pain such as for example primary vulvodynia (3) continues even for years resulting in severe disability for the patient.

To our knowledge and experience, even analgesics such as morphine, have little effect on chronic pain. Many patients have surgery on the suspicion that the problems may have a hidden, structural cause, which sometimes turns out to be the case, especially in acute pain. However, the operation may also result in adhesions and other sequelae, which might even aggravate the patient's pain. Sometimes the patients are repeatedly operated upon. This may even take place at the patient's instigation in the hope of sudden freedom from pain.

If pain is of a chronic nature it is our impression that exploratory surgery rarely produces significant findings and that it has little effect on the pain. Often, no physical reason can be detected for chronic pain in internal organs, leading us to assume that the pain is psychosomatic. Psychosomatic pain is often randomly distributed in the body and cannot be located within specific physical structures, tissues or organs. You believe that you have located it when pressing on a certain point, but the next moment it is gone again. It is as if the obstruction behind the pain is living its own life in the body. The pain is a warning sign of something that has been repressed and something in the life of the patient is not as it ought to be. This type of pain does not go away until the patient understands what he or she needs to "learn from the pain". The problems will persist until the patient takes up the challenge, begins investigating what is going on (or in popular terms the body is trying to tell you something), learns the lesson and take proper steps to amend it.

A part of the underlying, emotional pain, which the patient unwittingly tries to avoid by somatising the pain, lies in the acknowledgement that he or she has a personality imbalance – or call it personal flaws and weaknesses. Once patients reach this acknowledgement of their health status, they may soon achieve pain relief. When the patients understand the problem, they can also find a way to solve it. Then it is mostly just a question of time, before they can

move on. As simple as it might seem when expressed in this way, the process of supporting the patient and helping him or her go through the emotional pain and "take learning", is quite multidimensional. Let us take a brief look at some of the dimensions in the field of "quality of life as medicine".

Case stories

The treatment of pain in the internal organs begins with a comprehensive physical examination with the necessary tests to exclude somatic illness. According to the holistic process theory, the treatment involves a combination of body therapy, psychotherapy and life philosophy exercises, where the patients are first supported in achieving better understanding of their inner self by formulating a more positive attitude towards life and finally by living accordingly.

Female, aged 28 years with psychosomatic abdominal complaints. First visit: Diarrhoea for ten days with nausea; vomits every morning, complete loss of appetite, but drinks plenty. She was admitted to hospital by an emergency physician and referred for colonoscopy, numerous faecal cultures all turned out negative [faeces are stools; they are tested for amoebic abscesses, and parasites such as worms]. Current medication: Losec [omeprazole], Alopam [oxazepam], nausea-relieving suppositories of unknown brand. Something is wrong. I (SV) cannot immediately diagnose the source of the patient complaints. A second appointment for in-depth assessment is scheduled.

Second visit: Abdominal problems persist. I (SV) detect that the patient is anxious due to the death of her aunt at the age of 31 years by stomach cancer. In the aunts case her disease was wrongly diagnosed as gall-bladder stones. So far the patient has been to the emergency medical services, where she was given large numbers of pills, including Losec – which did not help. She is determined to be admitted to hospital immediately and regrets the fact that she did not accept the offer to remain in the hospital until her assessment was complete. My decision is to readmit the patient, since the thought of waiting for a distant appointment is greatly distressing the patient.

Third visit: when arriving at our third meeting she feels much better, now that the physical examinations in the hospital have shown her to be in good health. I postulate that her basic problem might be fear of dying, which leads to muscle tension, which causes abdominal and chest pain. We discuss her reasons for fear of dying, but the patient cannot concur. Further discussion into the matter unveils the amount of anxiety that disturbs the patient and she is advised to confront her fears instead of constantly avoiding it. At the end of the meeting the patient is diagnosed with anxiety neurosis. EXERCISE: She is than given an exercise to support her in confronting her anxiety and accommodating her feelings, when they overwhelm her.

The symptoms expressed by the patient looked like serious abdominal illness, but in fact diagnosed eventually as a simple somatisation of anxiety. As the patient will gather better control, she will understand the essence of her suffering and might be prepared to confront and process her anxiety. After such a process will take place the abdominal problems will disappear and replaced by the underlying problem of which they were symptomatic. Once the anxiety is integrated, she will have learnt something existential about life. This insight will strengthen her and will enable her to achieve a fuller life.

Female, aged 31 years with abdominal pain and pain during intercourse. The patient complains of continuous abdominal pain, which at times becomes severe. Pain is usually present during intercourse, especially during orgasm. The patient reveals that she suffered during previous relationship and suspects that the pain may be connected with her previous negative experience. Pelvic examination: normal. Smear taken. EXERCISE: The patient was instructed to write about her negative experiences during her previous relationships in as much detail as possible. When completing this task she was asked to read it aloud to a female friend or come for a second appointment to discuss her former experiences.

The patient showed many internal resources and needed little external help in order for her to solve her problems. The issue in this case was about getting the patient to change to a responsible and constructive perspective. Once the perspective is in place, the task is straightforward.

Female, aged 39 years with lower abdominal pain despite hysterectomy. Medical history: She had lower abdominal surgery with removal of uterus and ovaries. After surgery pain was reduced, but problems persisted. There are accompanying sleeping problems. She often stays at home sick and not attending work. Her family physician has prescribed Pantoloc [pantoprazole] for chronic gastritis. She is also taking antidepressants. “I have many skeletons in the cupboard that I can't or don't want to remember,” she says, sadly, thinking of her childhood. Physical examination: Presents with chronic pain in the flanks that can be provoked by pressing on psoas muscles. Quality-of-life conversation: I (SV) explain the correlation between pain and a full “internal waste bin” and we agree to try gestalt therapy to go over the patient's difficult past. We can prepare a development plan, if the patient benefits from gestalt therapy.

EXERCISE: Read books about topics resembling what you have experienced. PLAN: Trial gestalt session.

Patient history revealed that the patient had her uterus removed, which helped a little, but did not resolve the problem. At this stage it is more difficult to process the patient, due to the fact that the medical profession has burdened her with yet another trauma to process. Final developments of the patient will hopefully be gained during the gestalt therapy. Although the patient was found to have very little inner strengths and courage to clear up and thus eliminating the pain, we must not give up on her beforehand.

Discussion

According to the holistic medical theory (4,5) physical pains are often existential pains that the patient will not assume responsibility for. This perspective can be sometimes difficult to understand for a person, who has been educated within the biomedical paradigm, not acknowledging the depth of existence, the nature of the human wholeness and the causal nature of consciousness (6-14).

It is very important to rule out any serious and life-threatening diseases, when a patient presents with complains such as stomach pain, but when all medical enquiries and examinations have been exhausted without any results, treating the pain is often a simple procedure, using the holistic medical toolbox (3,15). In some cases, when the pain is in the region of the pelvis and a pelvic examination is to be carried out, we find it of value to use the holistic approach to the pelvic examination (16). This is extremely crucial in a case, where the

patient is scared and sensitive. If the complaints of the patient are related to social problems (17) these must be resolved. If the patient is a child, the parents might be involved in the process of healing (18).

It is quite surprising, that what can be considered one of the toughest challenges in the biomedical clinic can sometimes be one of the simplest problems to deal with in the holistic clinic. In our experience pains in the internal organs of an unknown origin are almost always caused by repressed emotions, giving the psychosomatic reaction. Using holistic medical toolbox, the patient is motivated towards personal development and can often be cured of the pains, when he or she assumes responsibility for the repressed feelings. The holistic process theory of healing and the related quality of life theories state that the return to the natural and pain-free state of being is possible, whenever the person gets the resources needed for the existential healing. We believe and our clinical experience has constantly verified that the resources needed are "holding" or genuine care in the dimensions: awareness, respect, care, acknowledgment and acceptance with emotional support and processing in the dimensions: emotion, understanding and abandoning negative attitudes and beliefs. The precondition for the holistic healing to take place is trust between the physician and the patient, which seems to be the biggest challenge of holistic medicine, especially when dealing with the patient in pain.

Exercises

1. Pain in the inner organs is often connected to pains in the locomotor system. Head ache is often caused by tense neck and jaw muscles and stomach pain felt in the intestines often by pain in the pelvic musculature. Explain the reason for this.
2. Referred pains are pains that are caused one place but experienced another. Give some examples. See if you can come up with a plausible explanation of the mechanism.

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Chapter VII

Chronic pain in children

In holistic medicine we understand the human as consisting of body, mind and spirit. These three parts contain a core talent: sexuality, consciousness and love. To function as a healthy person the child needs to develop the related functions: personal character and gender, verbal and intuitive intelligence, social and emotional capabilities. A child with arrested psychosexual development can deny its gender, have compromised development of language and social intelligence. When meeting the parents the reasons for the child's situation normally becomes obvious. The child is mirroring its parents, and the state of the child functions as the family's thermometer: If the child is ill, the whole family often also is. Sometimes chronic pains and also more severe health problems arising from the dysfunctional family patterns can be helped by addressing the problems courageously and openly. When the problems have been seen and expressed, the power of them is often reduced significantly, and a new development and healing can start.

Introduction

During the last decades research in holistic medicine and psychodynamic therapy has intensified (1-3). The reason seems to be an understanding that health and diseases is very much a product of psychosocial, quality of life and life-style factors. The approach in pediatrics has always been much more holistic than adult medicine and much of the focus on thriving, development and use of talents from the traditional holistic medicine - i.e. the holistic medicine going back to Hippocrates and the Greek physicians (4) has been traditionally preserved in this specialty.

Unfortunately the last decades of development has taken pediatrics much closer to biomedicine and the focus on the whole person and the family diminished, leaving many children with unsolvable problems from unattended psychosocial reasons (5-7).

The triad of poor physical health especially chronic pain, lack of motivation and other emotional disturbances, and arrested psychosexual development strongly indicates that the child-patients problem is of general and existential, "holistic" nature (8). Often an interview with the family will reveal a dysfunctional or broken family, and the emotional healing of the wound from lack of sufficient parenting must be the physician or therapist's primary focus.

If the child have recidivate physical pain then this is often the best place to start as everybody can agree that this is not right. Most often the parents will deny neglect or abuse of the child, whether this is psychologic and emotional, physical or sexual. The parents and other central family member's interaction with the child must be observed closely, and small and symbolic expressions of neglect and abuse must be addressed in the therapy, and the meaning and significance of concrete examples must be discussed in the family.

Holistic medicine is consciousness-based medicine (9), and the primary intention with the intervention is to make everybody present aware of what is going on and aware of the reasons why things are happening the way they are.

As a therapist it is often possible to give a good example of contact, communicational and emotional support for the parents and siblings etc. to learn from. Surprisingly often just this intervention can result in a complete change in the child's situation, and one single session where the parents gets a better idea of parenting and some sound principles can significantly change the health status of a child.

Body-mind-spirit

Holistic medicine sees man as consisting of body, mind and spirit. These three parts contain a core talent: sexuality, consciousness, and love. To function healthy the child needs to develop the related functions: personal character and gender, verbal and intuitive intelligence, and social and emotional capabilities. A child with arrested psychosexual development will often deny its sex or not present itself as a sweet and loving boy or girl; the development of language will be compromised and social intelligence will typically be poor (8).

When meeting the parents the reasons for the child's situation normally becomes obvious. The child is mirroring its parents, and the state of the child functions as the family's thermometer: If the child is ill, the whole family often also is. Interestingly most even severe health problems arising from even severely dysfunctional families can be helped by addressing the problems courageously and openly (9-11). As soon as the problems have been seen and expressed, the power of them are reduced, and a new development and healing starts.

In a general practice things are often neither good nor bad, but many things can be improved. During the years, when every visit to the doctor leads to a little improvement, some new important insights, and a few new exercises for use at home to improve the family relations, the whole family will grow and improve. The holistic physician can see himself as a gardener taking away some weed every time he passes the roses. As time goes by the roses will start to blossom again.

Chronic stomach pain and chronic knee pain can be supported with gentle massage to intensify the contact between patient and physician, and gentle exercises for home use can be given, as a way for the parents or siblings to give physical care and attention to the child (12-14). Everything that gets the sensation of allowing love to be expressed will help the child, for love is what every child in the end needs to be cured.

Conclusion

It is most important to understand that what children needs for growth, development and thriving is love, care, acceptance, awareness and respect for their individual psychologic world and personal character. The physician has a unique platform for demonstrating these parenting qualities. When it comes down to it these fine qualities are nothing but our common human nature, expressed into the work of the doctor. By his example he can and will have a major impact on the child and the parents, and even the hardest and most cold-hearted father or mother carries in his or her heart a genuine love for every child that can be awakened, acknowledged and expressed. When this is done poor thriving, arrested development and chronic pain and other health problems can be alleviated.

It might take some time to help, but if the physician believes in the inner healing power of man (15,16) and in the fine soul of every living being, and takes this trust into his clinical practice, just expressing this attitude can make a big difference to many patients and their families. Most often when it comes to sick kids, the key for healing and improvement is not blood tests, weighing and measuring and similar clinical procedures, but just being with the child and his family, helping them to understand their life and the dynamics of the family situation. The physician should not neglect his duties of physical examination, but always remember that for a child love and care means more that healthy food and exercise for health and quality of life.

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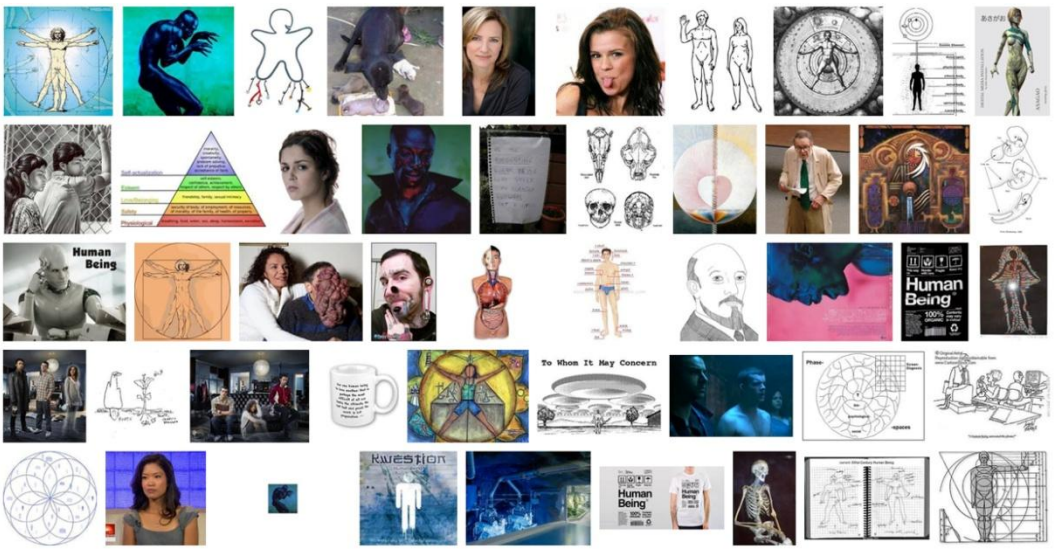

Chapter VIII

A theory for pain

Holistic theory, strongly inspired by integrative, transcultural medicine and psychodynamic theory (Sigmund Freud (1856-1939) and the tradition of psychoanalysis), perceive a person as a whole (a true self) composed of a body (with an Id), a mind (with an Ego) and a spirit (with a "Higher Self"). Therefore the will to exist is manifested though body, mind, spirit and heart, and holistic pain theory explains that pain basically arises, when the will to exist is compromised. Pain is thus existential and related to our wholeness as human beings, but this existential pain can be repressed to one of the three partial existential domains, either the spiritual, mental or the physical part (the spirit, mind or body). The reason for refereed pain to body and mind is mostly repression of unbearable pain. Most pains are according to the theory caused by non-organic, informational disturbances, which are caused by internalized and repressed early existential and emotional conflicts. When these old existential issues are solved, and the patient re-discovers herself and her purpose of life, and starts living her mission of life and using her great talents for the benefit of the world, most pain evaporates like "small pearls of water in the hot summer sun". In this paper we show how a simple holistic theory of pain leads to effective holistic pain management in the clinic, and sometimes even existential and physical healing of the patient.

Introduction

Pain is one of the most troublesome and mysterious phenomena and a frequent reason that brings the patient to consult their physician. Relief of pain is one of the most important functions of the physician. In this paper we suggest that pain is the experience of something going against our will to exist. As this will is originally manifested at a global, existential level, pain is fundamentally an existential experience. If existential pain cannot be overcome, it will be suppressed for the individual (most often the small child) to survive.

Pain can shift from our existence to a part of us, which is often felt like a great relief. From a holistic therapeutic point of view this is how we most often escape unbearable, existential pain. Physical pain is from spiritual, mental and existential perspectives only little burdensome to live with. Therefore many patients escape existential pain by trading it in for physical pain; other people accept their pain as spiritual or mental pain. Many patients escape

these kinds of pain sometimes by trading it for physical pain, and then, in periods of surplus and good times, trading it back to mental worries or religious sufferings.

Most unfortunately, physical pain is bound to its original existential connotation, which according to most theories for holistic medicine is present in the informational layer of the human being; this irrelevant information appears to be noise to the cells and tissues and is therefore a serious etiological burden for the body.

Physical pain therefore often shifts from being "non-anatomical" – i.e. not bound to any specific tissues but freely wandering round in the body - into being "anatomical" i.e. bound to specific tissues and body structures, which are now breaking down under the weight of the disturbing internalized existential pain.

The only way to heal the body and mind and make the pain go away is by supporting the patient in re-assuming existential responsibility and confronting the existential pain. What is needed is an inner search for the patient's true self and purpose of life, also called the "life mission". Only by owing, living and practicing this purpose of life, and using all human talents to do good in life can every bit of human pain be truly relieved. But as dead is inevitable, even this sacred blossoming of life is only a temporary joy.

If you search Medline (www.pubmed.gov) you will find hundreds of theories of pain, most of them fairly speculative (1-3). Most of these theories try to explain why pain is so hard to understand.

The problem of pain is that it often does not correlate to the patient's physical state – like the famous example of phantom pain. On the other hand, sometimes even the most severe destruction of the body, as seen in cancer, is almost non-symptomatic. Very often and very puzzling even the most severe pain has seemingly no biologic foundation.

Physical pain is connected with mental pain, like depression and mental pain is often connected with unsolved relational, spiritual and existential problems, like loving problems, sexual problem, religious problems, working problems etc.

Holistic theory, strongly inspired by integrative medicine and psychodynamic theory (Sigmund Freud (1856-1939) and the tradition of psychoanalysis (4)), sees a person as a wholeness (a true self) composed of body (with an Id), a mind (with an Ego) and a spirit (with a "higher self"). If you agree with this point of view, you also see the person's will to exist as manifested though these dimensions of existence.

Holistic pain theory claims that pain basically arises from the will to exist being compromised; pain is thus always existential (related to wholeness or heart), but this pain can be referred further to parts of the human being, either the spiritual, mental or physical part (the spirit, mind, or body). Pud et al (5) has tried to link pain to personality, but such research seems to document that pain is a condition for all human beings, in accordance with the life mission theory (6-12).

In this chapter we will see how a holistic theory of pain leads to holistic pain management. We have primarily done research in this field with adult patients. In children, especially if the pain is post-traumatic (i.e. post-surgical) we must for now recommend the methods described by Astuto et al (13), but a holistic approach for pain managing in children focusing on the child's consciousness and interaction with the whole family is under development.

A holistic theory for pain

Interestingly, existential pain seems to be a normal condition of living as children, when our parents, who use conscious powers, brains, and superior physicality, confront us. We lost the first battle of our life to our parents; and the existential pain from the confrontation was repressed for us to align with our parents and survive. This is basically the story of Freud, Jung, Adler, Lowen, Reich, Horney, Rosen, Grof and the other great psychodynamic thinkers of the last century (14-20). Researchers much less agree upon what happened with the repressed material; to answer this most important question seems to be one of the major research challenges of the present century.

The most simple answer seems to be that the internalized conflict material is kept by the informational system of the organism; it seems that it can be repressed to still deeper levels of existence; and in this "fall" from spirit to body though mind, there seems to be a fall in consciousness, from the clearly seen and aware, to the hardly known and dark.

Responsibility seems to be lost in the process of repression; and the closer the repressed material comes to the body; the more modest is the existential responsibility and spiritual ownership of the repressed material.

The internalized and repressed existential conflicts are thus haunting the human being like an internal ghost (21-27). The pain can move around in the body (28), suddenly appear in dreams, be activated by difficult life events and losses. It can according to holistic medical theory fixate in bodily tissues giving raise to even the most severe diseases like cancer and heart disease, immunological disturbances like autoimmune diseases etc.

It is most disturbing that pain thus can shift from body to mind and from mind to spirit and existence, and vice versa back again (29,30). And often all logic seems to be gone; a huge tumour burden from cancer can be connected with no pain at all; and a most severe pain can have no physiological reason at all.

Holistic pain management

A 65 year old woman with breast cancer and metastasis to the skin of her back. This patient was hospitalized at the University Hospital and she received solely palliative care with all hope of her fighting her cancer long gone. She received high doses of morphine, but her pain continued in full strength in spite of the drugs. In the search of a way to help the patient massage on the most painful area of her high back was offered. To the surprise of both patient and physician the pain of the skin disappeared almost completely after only five minutes of kind attention to the skin area.

This is a typical – but almost absurdly powerful reaction - to the human kindness offered patients in holistic therapy. "Holding", the combination of acknowledgment, awareness, respect, physical care and acceptance, is giving patients what they need in order to turn inwards toward their existence and re-find their sense of coherence, and the connection to self and existence that was lost, causing the existential pain, which was then somaticized.

The first thing to do to help patients getting rid of chronic pain, anatomical or non-anatomical, is therefore giving holding to the patient (31-34). The next thing is to take the patient back in time into the moment of repression of the existential conflicts most often with

father and mother. Interestingly, the processing step is often happening spontaneously, as in the example above, when the patient has the necessary confidence to relax and turn all attention inwards, as in the example above.

A well-spoken and intellectual patient can benefit tremendously from wording his purpose of life and working dedicatedly to putting it – and all the talents hidden in it - into a fruitful and valuable life-practice. Formulating a life-philosophy, writing a whole-life-biography, reading books on existential philosophy and holistic healing can also be of surprising help in managing chronic pain. Most interesting, what alleviates the pain, is also what cures the diseases: taking the informational disturbances out of the organism's informational system (35-37).

In clinical holistic medicine the strategy for managing pain is therefore not coping with the pain, but curing the patient. Cancer, heart disease or how hopeless it looks, is no excuse for not trying to cure the patient; even if this most often is doomed to fail, but much pain can be relieved this way (38-45).

Discussion

In principle, drugs and holistic care can be perfectly combined. As there is only very limited side effects (except from adaptation and dependency) of heroin and morphine, these classical drugs are the drugs of choice when NSAID and similar painkillers are not helpful.

But as pain is most often psychosomatic and caused by internalized existential conflicts, morphine will often not alleviate the pain, or only help for a short while. The problem of starting with drugs, which is so tempting as they are cheap and most easily disposed, is that they often sedates the patient making holistic healing procedures less efficient, or often not efficient at all. The administration of morphine or heroin can thus be a serious hindrance to healing the patient or to successful pain relief. Less efficient pain-killers are often also sedative, meaning that the patient using these drugs can be deprived of the possibility to heal without getting much pain-relief from the drugs to begin with. This is most unfortunate.

It is therefore recommended that the standard holistic healing procedures of holding and processing are used first, and only if pain cannot be sufficiently alleviated this way, drugs are also used (see list of advanced tools in (45).

Conclusion

There are many theories of pain. We suggest a simple one: that all pain basically is a manifestation of a compromised will to exist. Breaking a leg is painful for this reason; healing the leg also heals the pain, not because the pain comes from the damaged tissues, as most biologically oriented doctors would like to believe, but because the ability to use the leg is restored. There are C-fibres in the body and pain-provoking substances in the tissue, of cause, but why then, is there often almost no correlation between pain-level and disease level?

Most pains are seemingly caused by non-organic informational disturbances, and these seems to be caused by internalized and repressed existential conflicts; when these old existential issues are solved, and the patient re-discover himself and his sense of coherence,

purpose of life, and starts living his mission of life, the pain – being physical, mental, spiritual, or existential – most often evaporates like small pearls of water in the hot summer sun (46-51).

Exercises

There are two types of pains. One type has to do with the present; physical touch can often help. The other has to do with the past. In the last case consciousness simply keeps the pain into existence by believing in it. This is the most difficult type of chronic pain to treat because the treatment needs to address the patient's whole mind and way of thinking. How can you tell the difference in the clinic working with your patient?

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Chapter IX

Chronic infections and autoimmune diseases

The consciousness-based (holistic) medical toolbox might be useful in general practice and in cases of recurrent infections and chronic infection or inflammation. From our clinical experiences, there is hope for improvement from a number of diseases caused by disorders affecting the regulation of the immune system when the physician includes the holistic medical approach. Our scientific understanding of the connection between consciousness and cellular order is still limited. Consciousness-based holistic medicine removes (as explained by the holistic process theory of healing) the "blockages" in the tissues of the body and facilitates function and informational exchange of the cells of the body. Many blockages and repressed feelings in an area would imply "noise and disturbances" on the level of intercellular communications, which in turn means major difficulties for the cells of the immune system. For this they are totally dependent on the body information system, which the holistic treatment aims to recover. Processing the blockages increases the coherence of the cells and organism, thus increasing the intercellular flow of information in the area and thus strengthening the immune defence and healing the disease. The area of clinical holistic medicine is going through a rapid development and the toolbox of consciousness-based medicine is available for dealing with many diseases arising from disturbances in the regulation of the immune system. Holistic medicine has yet to be better explained scientifically and our proposed holistic cures have yet to be documented clinically. We invite the medical community to cooperate on this important challenge.

Introduction

Autoimmune diseases and chronic infections are mostly resistant to biomedical treatments and therapy mainly palliative. For many years, the spontaneous remission of autoimmune disease (like the spontaneous remissions of chronic infections) has been puzzling to physicians, with the spontaneous remission of type I diabetes being the most intensively studied (1-6). The observed dynamics strongly indicate that there are factors involved that we do not understand or control. The holistic approach might be relevant in general practice

when our biomedical tools prove inadequate, for instance, against recurrent infections in the throat, lungs, or abdomen in autoimmune diseases such as type 1 diabetes, sclerosis, and rheumatoid arthritis and in chronic infections such as hepatitis, mononucleosis, and possibly also in fighting the HIV infection. If not properly regulated, the immune system can cause a variety of diseases. It comprises billions of cells distributed throughout the body and to function well, it is highly dependent on intercellular communication. The immune system receives a lot of its information from the cells and tissues that it aims to protect. The cells in an area (for instance, connective tissue cells in an infected finger) tell the immune system about an impending danger that calls for immune defence. We know this from immunization studies where we often have to give a primer that is an irritant to tissues to raise an immune defence against the injected antigen (7,8). As our scientific understanding of consciousness is very limited, it is difficult to give a precise mechanical explanation as to how holistic medicine works. As an introduction, we understand that consciousness-based holistic medicine removes "blockages" (in a fairly complex, but understandable way, explained by the holistic process theory, see below) that disturb the tissues and cells of the body while processing the somatised feelings and gestalts placed in the tissue of the relevant organ(s) at the moment of shock and trauma; this approach seems appropriate for strengthening the immune defence. The explanation is that the wholeness of the person represses an unbearable feeling to a part of the body in order for this part to hold it until the person can take care of it emotionally. It is a sheer survival mechanism that works by allocating the tissue from its physiological purpose to the purpose of holding the gestalt. This disturbs the cells, as they cannot process the job at the present time, so they become less an integral part of the body than before. Thus, holistic healing is needed to make the patient whole again. After a short review of our work on holistic healing, we shall explain more about our understanding of the theoretically difficult psychobiological connection.

The control of the immune system

How is the immune system controlled? This question is quite central if we want to raise resistance to bacteria and viruses and to help the immune system to fight an infection, or if we need to weaken the destructive attacks of the immune system against the body's own cells, which is what happens in an autoimmune disease. In type 1 (juvenile) diabetes, the attack is aimed at the insulin-producing beta cells in the islets of Langerhans. In rheumatoid arthritis, the targets are the joint capsules. In sclerosis, the attack affects more-or-less well-defined areas of the brain and its nerves. Several theories exist on the regulation of the immune system. Biochemical theories point to chemical networks, while holistic theories centre on biological information, feelings, and consciousness. Accordingly, holistic medicine explains immune system disorders in the same way as it explains imbalances in other body tissues and organs: something prevents the immune cells from doing their job at their location. Something affects the cells of the immune system, keeping necessary information from them and preventing their prompt and efficient reaction to the intrusion of an enemy. Instead, their reaction is too weak or they attack healthy tissues that should certainly not have been destroyed.

The immune system has several lines of defence. The first is mechanical: the skin and mucous membranes prevent bacteria and other microorganisms from entering our sugar-containing body fluids in order to multiply. The next barrier is a nonspecific immune response where several cells, such as the macrophages, specialize in distinguishing between the body's own cells and structures (self) and foreign cells and structures that should be destroyed (nonself). The ability to distinguish between self and nonself is the backbone of the immune system, but there is little scientific knowledge about this ability. Interesting studies of the evolution of the immune system showed that this ability dates back to the very first living creatures on Earth. Since even the most primitive sponges, the first multicellular organisms were able to distinguish between self and nonself at the cellular level. If nonspecific immune cells fail to destroy an invading enemy, the specific immune system springs into action. It works by means of antibodies, especially against bacteria and killer cells, especially against viruses, which kill all virus-infected cells before they can pass on the virus. According to the holistic medicine theory, the way that the specific and nonspecific immune systems work depends on the number of blockages in the body. Many blockages and repressed feelings in an area would imply a lot of noise and disturbances in intercellular communications, which in turn means major difficulties for the cells of the immune system when they need to distinguish between self and nonself. For this they are totally dependent on the body's information system.

Fine tuning the immune system

If the patient is free from the disturbing blockages in the body, he or she will experience improved quality of life and become a more coherent person. The information systems of the body will again be able to deliver precise and correct information to the immune cells. In this way, the immune system is fine-tuned and better at eliminating foreign organisms, while letting the cells of the body live. At this moment, we do not know how effective holistic medicine is against, for instance HIV infection. Nor do we know how irreparable the damage caused by autoimmune diseases like type 1 diabetes and sclerosis. It is hoped that there are viable stem cells in the pancreas that can begin to produce insulin once the immune system stops destroying all the insulin-producing cells. As for sclerosis, the brain is known to have great potential, so if the immune system ceases to make plaque, or holes in the brain, even very poorly sclerotic patients should be able to recover dramatically once the autoimmune attacks cease.

Case presentations from the holistic research clinic

Clinical holistic health research work is an emerging field with small numbers of patients that we try to learn from, but judging from the clinical experiences, there is hope of improvement and recovery from a large number of diseases that have been caused by disorders affecting the regulation of the immune system.

Male, aged 47 years, with chronic sore throat and diabetes: First visit: Chronic sore throat for months, sensation of a "lump" in his throat. On examination: Strep A: negative. Oral cavity: No redness or coating, swelling around the larynx. /Chronic irritation of larynx/History of /NIDDM/. He is finding his work as an auditor difficult at the moment and would like to lose weight. This might enable him to go back to the tablets instead of injections of insulin. Weighs 118 kg. Wife says that he snores. His father has just died. We talk about only eating to satisfy his hunger.

EXERCISE: Avoid forcing your voice when you are speaking/working. Second visit: Throat complaints resolved since last visit due to the exercise. His throat complaint seems to be caused by his feeling that he cannot get his messages across. This makes him check his own expressions, so that tension builds up in his throat. He acknowledges this correlation and performs the exercise of trying to avoid the feeling of putting pressure on himself. That solves the matter and rids him of a month-long chronic throat condition.

Female, aged 38 years with chronic cough: Bronchial non-productive cough on and off for years. Taking strong Pectyl [combination drug with opioid] with inadequate effect. On examination: Auscultation of the lungs: normal. Severe tenderness on sternum, cervical muscles very tense, trigger points positive on upper and lower limbs. Obviously something is not quite right. The patient should find out herself what is wrong. Follow up. This patient was coughing and a strong cough mixture with opioid was not working. The trigger points in the chest region are very tender. Trigger points are the sites in the body where the physician can best reveal muscle pain and tenderness by touch and they coincide largely with the Chinese points of acupuncture. What is it about? The physician may have a strong suspicion, but that will not help the patient who must look into the matter herself. We hope that she will return and relate all her difficulties in liking herself and enjoying her life, however, it is undeniably simpler to take cough medicine with opioid than to think about blockages in the chest region. Unfortunately the easy solution did not help. That leaves the difficult one. Although holistic physicians often have a very precise idea of what is wrong, we cannot tell the patients; they must get in touch with their innermost feelings to understand what is happening in their lives. At that point, our words would only cause disturbance and blockage. So it is not that we are unwilling to help when we hold back and laconically write in the case record that "the patient should find out for herself what is wrong". In this respect, consciousness-based medicine, which is about developing the patient's consciousness and understanding, differs substantially from biomedicine, where the knowledge of the physician can be communicated verbally to the patient without any major difficulties.

Female, aged 46 years, with migrating physical irritation following daughter's suicide: First visit: Arrive four days after onset of tonsillitis. Last night, she was swelling like a toad and she presents with massive oedema on the face, chest and forearms. She is barely able to look out of her eyes and feels a burning sensation in the face. On examination: No fever. No redness or coating on the tonsils. Strep A test negative. No redness, but pronounced swelling and heat in the regions mentioned. /Hypersensitivity reaction following tonsillitis/ Prescribe antihistamine Zyrtec [cetirzine] 10 mg as required. Second visit: Problem 1: Good effect of Zyrtec on facial oedema, now fine. Problem 2: Three weeks of coughing with clear phlegm, "migrating irritation". Auscultation of the lungs: normal. Prescribe Pectyl [combination drug with opioid] cough mixture. Problem 3: Her daughter committed suicide three years ago and she has not recovered yet. Wants an appointment for conversation. The problems are closely interconnected. She has not processed her daughter's suicide properly. Painful feelings of guilt and sorrow are left in her system and cause disturbances that migrate within her system, as is the way with such blockages. When irritation is seen to migrate from place to place and from organ to organ, to us that is a sure sign of a psychosomatic complaint. Often, there is an on-going

emotional issue that can be resolved. Afterwards it will all fall into place and sometimes it is possible to resolve ten health issues in one trial when we get to the root of the problem. Third visit: We talk about the daughter's suicide, which took place right after her separation. She left three young children and the patient fails to understand this. We talk about having a broken heart, the greatest pain in life. The patient goes over the event, sobbing.

EXERCISE for next time, which the patient believes she can handle: Write down what happened, what did you feel. Write for 10 minutes a day and put the writing paper away in an envelope till next day.

Actually, it is more than just a trauma when your daughter commits suicide. It is a personal disaster, where no mother can avoid feeling guilty because you wonder if you have really been a good enough mother. All children end up feeling let down by their mother (and/or father), so there is plenty to tackle. If the mother goes through with the processing, which personal disasters like that require, she will surprisingly gain a new life from her daughter's death. Native Americans offer the words of wisdom that *the life she has given will return to her*. Note that the envelope will guard the hot topic until next day, so that it does not bother the patient in the meantime. After all, you cannot eat an elephant at one gulp, so where to put it between meals?

Male, aged 55, years with severe rheumatoid arthritis in knees: Tenderness in both knees. On examination: Left knee tenderness on medial side and in superior muscles. Joint line free, no accumulations, no drawer signs or other symptoms. Left knee: Patellar crepitation, no other pathological finding in spite of serious radiographic diagnosis of severe arthrosis. Clinically the patient's knee is fine today apart from the pain.

EXERCISE: Massage around the knees; raised awareness of knee movements, when walking, for instance 30-minute walks twice a week with a comfortable gait. The situation seems hopeless, but it is not. Even very severe rheumatoid arthritis may appear without severe pain, or there may be the most excruciating pain without any evidence of arthritis or articular damage. We believe that pain and blockage are closely related and once the blockage is lifted, the pain will disappear. Since the blockage also caused articular and cartilage degeneration, the knee will be free from pain (including the way we see it) and begin to heal. Sometimes, cartilage becomes as good as new on the X-rays, so we do not regard an X-ray as a final verdict, but as a report on the current condition. Unless there is evidence to the contrary, we expect our arthritic patients to become well again. Why would they not, if the body is nothing but a colony of cells controlled by information flows that we can optimize, fine tune, and adjust?

Female, aged 35 years, with type 1 diabetes: The patient wants to be cured of her type 1 diabetes that has lasted 19 years. The project is uncertain, but perhaps the pancreatic stem cells can propagate to form new insulin-producing beta cells once the autoimmune response cease as a result of the processing of gestalts in the pancreas. BP 130/75. Occasional eye problems, but not today. Some white spots in one eye. The picture varies a little. Other problems: 1. Professionally a perfectionist. 2. "I am happy – I choose to be," the patient says. On a scale from 1 to 10, how happy? 10! I have the best friends and the best family in the world. She no longer has a boyfriend. "I can handle the sexual drive" she says. She sounds very convincing, when stating that she can suppress it. She is very much afraid of becoming unhappy, when the facade cracks. 3. Worries too much about certain people and certain things – very worried about her family and her three brothers. Mother died of cancer two years ago. She cries when talking about her. "I will not accept that life hurts. I cannot do without them. I totally rely on them." 4. She cannot

bear to fall out with someone. “Afraid of conflicts?” I suggest. But no, conflicts are fine; they should merely be turned into positive experiences.

EXERCISE: “Mentally I am not very strong,” she says – write two A4 pages about that for next time. Describe your mental frailty. I am rational – not emotional. Why should it not be possible to make the stem cells mature into insulin-producing cells so that they can cure diabetes? In theory, this should be possible when the imbalances behind the diabetes have been removed with the patient’s mind set on healing. This project looked very optimistic, but the patient lost some of her enthusiasm when she realized that it will take years of hard work on the odd chance of achieving a doubtful result.

Sclerosis

The following case history concerns a patient with sclerosis. Sclerosis is an autoimmune disease where the patient’s own immune defence attacks areas in the brain. Sclerosis generally causes disability and it is one of the diseases that we cannot do much about with established biomedicine. Here, I (SV) am trying to help a young man to improve his quality and meaning of life by mobilization of his inner resources based on the life mission theory[2].*Male, aged 32 years, with sclerosis* quality-of-life (QOL) conversation: A period of fatigue and attacks, paraclinical findings with changes on the MRI scan and slightly elevated IgG index plus evoked potentials showing effects corresponding to visual evoked potential on the right eye, which leads us to the conclusion that here we have a demyelisation disorder. /Multiple sclerosis/ Several months ago, the patient tried to commit suicide and now wishes to have a conversation. Second QOL conversation: Conversation about sclerosis (MS). I explain the disease: autoimmunity. During the last four months, the patient has also suffered from a buzzing in right ear. The patient went to an ear specialist, who thinks that the hearing loss is due to MS. He also has problems with right eye on exertion. On examination: Muscles soft, weak, body emaciated; he has lost 12 kg over the last couple of months. Something seems wrong with his will to live. He has always felt that he would not grow very old.

EXERCISE: I recommend that he writes his autobiography, looking for problematic situations, especially where he opts out of life. What happened? What did he decide? Can return in six weeks for another conversation.

Writing an autobiography is a highly effective tool in order to make people realize what is wrong with them. The exercise should be given at the right time, otherwise it will not work and it cannot be applied again later. Timing is everything according to the purpose of life theory because the patient must have resources and motivation for the assignments given. Otherwise, the patient becomes overwhelmed and simply does not return, or at least not with a will to cooperate. Here, the exercise solved the ear problems. Third QOL conversation: Ear problems now gone. He brings a 23-page story of his life. Good work and he is encouraged to continue, focusing on emotional events that he should describe in detail. It is important that he regards this work as strictly confidential. The patient should do an EXERCISE accounting for his life energy (what provides and what requires energy) and his enjoyment of life (what provides and what requires), and for next time he should look at how to optimise his life energy and enjoyment of life. Fourth QOL conversation: The patient is feeling well, no major ear or eye conditions or any other sclerotic symptoms. He has migraine again, which he has not experienced since he developed sclerosis. I suggest that this could be a step forward, since he is again able to feel something in his head. He has not been able to feel anything during the episode of sclerosis. He has done his homework – good lists. I (SV) particularly noticed: what provides life energy: “When I feel well and have done something that I am proud of.”

The patient has also discovered the statement "What's the point." This is an interesting statement, which to him means something like: "My life is a waste of time." Talk about the meaning of life.

EXERCISE: Write 1000 times: "What's the point?" and see what feelings it provokes in you. A return to previous stages of the disease and the recurrence of minor complaints that preceded the current major ones are things that we would usually regard as healthy signs — signs that things are moving in the right direction and that the patient is slowly, but steadily, working his way backwards and down through his personal "rubbish heap" towards the gold representing the purpose of life.

Fifth QOL conversation: The patient has done his homework and written 300 to 400 times the statement: "What is it all about … that we are born and die," the patient says. When his mother died when he was nine, he repressed all his feelings and made the decision that life was close to meaningless – expressed by the statement "What's the point." He let go of this statement. No feelings emerge except meaninglessness, so I suspect that he still restrain his feelings. The way I see it the patient is making good progress. He should continue working on it by himself. We find that this patient's course of treatment is one of those that bring us real satisfaction. His recovery was fast and the development project surpassed our expectations. The patient was cooperative, committed, and diligent; he accepted even very hard exercises, which means good and rapid progress. Already after five sessions, he can work independently with things. The symptoms went and we expect that he will do well in spite of a very serious diagnosis. How he actually will do, will become apparent over the next 10 years. The way we see it, autoimmune diseases are caused by blockages that disrupt the ability of the immune system to distinguish between self (the body's own tissues) and nonself (foreign cells and elements). When blockages are processed, the immune defence re-establishes the ability to distinguish between self and nonself, and the autoimmune attacks will cease. Let it be said that there are many layers in this patient's consciousness that have not been processed, so normally new episodes of sclerosis could emerge, which would then require new therapeutic sessions. Only when the patient's life is coherent on the emotional level will he stay healthy without the risk of a relapse.

Conclusion

Our scientific understanding of the connection between consciousness and cellular order is very limited and it is difficult to give a precise mechanical explanation for the healing mechanisms of holistic medicine on a biological level. Consciousness-based holistic medicine removes "blockages" that disturb the tissues and cells of the body. Holistic medical theory attempts to explain how the disturbances of the information to the cells influence and weaken both the specific and nonspecific immune systems. Many blockages and repressed feelings in an area would imply disturbances in intercellular communications, which in turn means major difficulties for the cells of the immune system when they need to distinguish between self and nonself. The field of clinical holistic medicine is going through a rapid development and the toolbox of consciousness-based medicine now seems adequate for dealing with many diseases arising from disturbances in the regulation of the immune system. The proposed holistic cures have yet to be documented clinically. We invite all members of the international medical community to participate in the important project of developing consciousness-based medicine. For the purpose of developing an evidence-based holistic medicine, we have developed an affordable documentation method especially useful for documenting the effect

of alternative complementary and holistic medicine and we hope that this affordable and simple method will be taken widely into use. As our final remark, we strongly suggest that research in holistic medicine, with its promising new cures for a long series of diseases, receives more financial support from governments and foundations, to further accelerate the development of a new medicine that is not dependent on expensive drugs and can be of use for poor people and even in the poor regions of the world.

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Chapter X

Asthma, allergy, and eczema

This chapter shows how consciousness-based holistic medicine can be used in the case of asthma, allergy, and eczema. We have many fine drugs to relieve patients from the worst of these symptoms, where many children and adults suffer health problems related to hyper-reactivity of the immune system. Many symptoms remain throughout life because the drugs do not cure the allergy and allergy today is the sixth leading cause of chronic illness. The etiology of the immune disturbances is mostly unknown from a biomedical perspective. Consciousness-based holistic medicine could therefore be used to treat these diseases if the patient is willing to confront hidden existential pain, is motivated to work hard, and is dedicated to improve quality of life, quality of working life, and personal relationships. Improving quality of life is not always an easy job for the patient, but it can be done with coaching from the physician. An increased physical health is often observed after only a few sessions with a physician skilled in using holistic medical tools and able to coach the patient successfully through a few weeks of dedicated homework. Children with allergy and asthma can also be helped if their parents are able to do work on personal development, to improve the general quality of life in the family and their relationship with the child.

Introduction

Asthma, allergy, and eczema are believed to have a psychosomatic dimension (1-3), which can be understood due to the fact that many children and adolescents who have asthma, allergy, or eczema grow out of it. This is very fortunate because many modern-day children suffer from allergies (4). Each year, more than 50 million Americans suffer from allergic diseases and allergies are the sixth leading cause of chronic disease in the U.S., costing the healthcare system $18 billion annually (4). Estimates of allergy prevalence in the US were 9–16%, with the prevalence of allergic rhinitis increased substantially over the past 15 years (4). Approximately 16.7 million office visits to healthcare providers each year are attributed to allergic rhinitis[4]. Since many children, adolescents, and adults are afflicted with allergies, it is worth looking at “what growing out of it” means and how this process of spontaneous healing can be supported.

Asthma, allergy, and eczema are diseases that are associated with some minor disturbances in the immune system. In allergy, the body attacks foreign antigens (substances that are alien to the body) even if they are not in any way harmful to the body. So when the immune system defends itself against pollen that penetrates down into the lungs, this may result in allergic asthma; in the nose, it can cause hay fever (allergic rhinitis) and on the skin, allergic eczema. Very often, there is nothing clearly allergic in eczema, even though we know that it is generally associated with allergy. When the skin is weak, this is not due to chance, from a holistic point of view, but to the work of the cells in the skin that usually make the skin thick, strong, and healthy, disturbed due to blockages contained in it.

When we grow out of our disease, it is because during development we are confronted with many of the things that disturb our inner balance and in the process the blockages are lifted. When we sometimes do not grow out of diseases, it is because we have managed to avoid confronting our earlier emotional difficulties. The holistic physician will support the patient in confronting the problems beneath the surface that are the cause of the disease from a holistic perspective.

Case reports

The following case stories are all about adults, but we believe that children can be helped in a similar way. Allergy has been on the increase and it afflicts millions of people in the Western world (4), but we have seen that it can be treated with consciousness-based medicine if the patient is willing to look at her/himself and life honestly. It is quite remarkable and enlightening to experience how a physical ailment can be slowly transformed into the mental and emotional ailments underlying it. The patient in the case below did really well and was rewarded almost immediately by ridding herself of the allergy.

Female, aged 29 years, with allergy: First visit: Auscultation of the lungs: Among other things, highly stressed. She has been coughing for eight days, severe headaches a few days ago, her eyes are very sore with allergy, also has problems with her former partner, who does not see their joint child regularly. We talk a little about the patient's apparent terror of illness and doctors. She can come for conversation on allergy etc., if she wishes to do so.

Second visit: Conversation: The patient talks about the imbalances in her life that she would like to correct: "I never feel that I am" – the being/doing imbalance; "more brain than heart" feeling/thinking imbalance and give/take imbalance: "I always have to give, so my new boyfriend will have to give to me" – she is critical, demanding, controlling instead of loving and accepting. She has family and work, but no leisure time. EXERCISE: She will look at that for next time.

Third visit: The allergy is getting better. She comes with four written pages, which she reads out, but does not want to hand over, as she feels vulnerable. That is fine, she has done her homework. We talk about her vulnerability. She feels abandoned, alone, demeaned, naked and small. She therefore sets aside her emotions; she associates those with weakness and vulnerability, which she does not like. We talk about her superficiality, and as an EXERCISE for next time she is to draw up a list of her qualities as a beautiful, good and true individual and a list of the losses in her life, where she gave up being that kind of an individual. The project is rehabilitation of her emotions. She is pleased with the way things have gone.

Fourth visit: Conversation. We talk about the patient having gone to extremes in being active (high tempo, action), controlling, "masculine", remote and superficial. She describes her relations with men as "non-serious" and her relationships as "empty" - but life itself has lots of content. We talk about the possibility of the activity being a defence against a deeper pain, which she is running away from. EXERCISE: Sit and be, feel your emotions, let go of body and thoughts. 5 – 10 – 15 – 20 min everyday, preferably increasing slowly, for example weekly.

The personal problems will take her years to solve and she will probably not avoid having a prolonged course of gestalt therapy, or something similar, if she wants to entirely rid herself of the feeling of being "abandoned, alone, demeaned, naked and small". We again see that as soon as the patient starts on her exercises, works purposefully, and under precise guidance on herself at home and in her everyday life, things move quickly and effectively. Note also the severe pain suffered by the patient in the process. These pains come about when the patients look at themselves and acknowledge how things really are. Many patients are not at all willing to feel small, alone, humiliated, abandoned, the feeling of being naked, because being looked through one's suffering is quite simply terrible — embarrassing and shameful — for many people. There is therefore good reason to carry on living with the allergy you received.

Female, aged 44 years, with burning sensation in joints: Physiotherapy helps. The therapist writes that development of the patient's overview and understanding of the situation is going well. There is "burning" in the body and joints. On examination:

Tender and tense muscles in legs, thighs and back. We talk about the sadness of life. Ought to be moving on, but where to? EXERCISE 1: By next time, the patient must learn to accept her emotions of sadness, she should ideally sit on a bench for five to ten minutes and be as sad, as she can when the sadness comes over her. Divorced ten years ago with small children and that was difficult. The eldest two have left home, only a boy of ten is left. EXERCISE 2: Make a good plan for your new life. What do you wish for yourself? How can you obtain it? Prescribe continued physiotherapy.

In this case, we also looked for a form of allergy: spontaneous "burning" or rather a feeling of inflammation in the body, which is due to the tissues that hold on to the repressed emotions being able to react with inflammation. Inflammation is a way of the cells to shout "help, there is something wrong here!" The signal is often mediated by histamine, which several types of cell can secrete (e.g., mast cells). An antihistaminergic drug (e.g., Zyrtec [cetirizine]) can therefore subdue the symptom. We naturally prefer a causal cure.

Female, aged 38 years, Will she do something herself?

1. Complain of urticaria. No visible patches. 2. Low-back pain. On examination: muscle tension between the shoulder blades, tender trigger points corresponding to the low back (sacro-iliac joints), tender over left knee, thinks herself that she has food allergies and arthritis. There is nothing to suggest this. I tell the patient this. I am in doubt as to whether the patient wishes to do something herself for her own health. This patient tells me that she has arthritis and food allergy. Bent Weeke, specialist in allergy at Copenhagen University Hospital, carried out a study, where he gave around 150 patients what they could not tolerate as "astronaut food", that is to say in a tube[29]. They did not know what was in it. Without being aware that they were actually receiving the very substance they could not tolerate, they all, apart from two, were able to tolerate the food to which they were "allergic". This study showed that food allergy in 98.5% of the cases is not allergy or hypersensitivity in the traditional biological sense, but something else,

> which relates to the mind. When a patient tells me that she has a food allergy, we therefore know immediately that there is a less than 2% probability that this is correct. She did not have arthritis or urticaria (nettle rash) either.

So there is a clear somatisation of a psychological or existential problem here. Her problem can be solved, but she first has to acknowledge her "real disease", that is to say the problems, which she somaticized. She was not motivated for that. So what can be done? We cannot medicate her for diseases she does not have and we cannot just ignore her when she comes looking for help. In reality, she is stunningly indifferent towards our professional advice, she already knows what is wrong with her, so just treat that, if you please! Incredible! Even the greatest capabilities are insufficient to deal with this. We have to ask her to please find another physician with greater expertise.

> *Female, aged 58 years, with obsessive-compulsive neurosis, allergy unlikely*: Quality-of-life conversation: The patient has a history of autoimmune myxoedema treated with Eltroxin [levothyroxin]. She is well controlled according to test results reported by her own physician. Had a heavy fall nine years ago while skiing with subsequent back problems. A few months afterwards she fell backwards off a step-ladder, eight years ago myelography, subsequent complications in the form of persistent headache, for months afterwards hearing problems and impaired vision, which the patient still has, in addition the patient had allergy with stinging pain in the digestive system, "food allergy", established by specialist in allergy, apparently does not tolerate chemical things, moulds and sprays, curry, chilli, oregano, pills in general. In recent years constant pain in joints and muscles, spontaneous fracture in the knee last year – one month in cast. The patient has always been hypermobile. Has previously gone from doctor to doctor without success, has also tried alternative medicine, like attending a nutrition clinic for three to four years and has been given a dietary supplement without any beneficial effect. The patient is at present claiming compensation from an insurance company. The assessment is a patient in a poor condition physically, mentally and also in need of extensive holistic rehabilitation. The patient insists that a number of perspectives and matters are of importance and totally true. It seems that the problem is a move of her life energy out of her body and into her head. /suspected obsessive-compulsive neurosis/. PLAN: She should have gestalt therapy, where a treatment plan is to be drawn up. EXERCISE 1: Fill about four pages of A4 paper with afflictions by next time – list all the problems in life: social, physical, sexual, financial, spiritual etc. EXERCISE 2: Also draw up a detailed list of your wishes.

We feel that this patient experienced discomfort with all the things mentioned and we did not believe that the correct diagnosis is "allergy". We believe that she has a serious mental disorder and conclude with a tentative diagnosis of "obsessive-compulsive neurosis". Genuine food allergy, as mentioned above, is extremely rare.

Discussion

To explain the etiology of the disturbances in the regulations of the immune system, we need to understand the connection between consciousness and the cellular order of the body. As consciousness is almost a complete mystery for biochemical science, we have to wait a while to get the full explanation, which obviously must be presented, if we are to integrate

biomedicine and consciousness-based medicine. But having two or even three different paradigms — the manual, the biomedical, and the holistic — with a similar number of toolboxes and approaches, works really well for us. The depth of existence and nature is really overwhelming, but this should not prevent us from doing well as medical doctors. Sometimes we prescribe a drug to a businessman not motivated for spending many hours contemplating the meaning of his life; sometimes we give an exercise like "write your biography" to patients in a period without a job, allowing them to use the precious time of their life on themselves, improving not only their health, but also their general quality of life, ability to function, and expression of their talents, thus preparing them for a fine comeback to professional life. To be dynamic, flexible, and receptive as physicians seems to be of utmost value to our patients.

Asthma, allergy, and eczema can often be cured with consciousness-based holistic medicine. A high percentage of our children and almost as many adults suffer from such health problems related to the immune system (4). We have drugs that can relieve the patient from the worst of these symptoms, but the problems often remain throughout life, as a chronic disease. The etiology of the immunological disturbances, i.e., the hyper-reactivity-related diseases, which have been the focus of this chapter, are mostly unknown from a biomedical perspective. Turning to consciousness-based holistic medicine seems quite simple to cure these diseases if the patient is willing to confront hidden existential pain, is motivated to work hard, and is dedicated to improve the quality of life, quality of working life, and personal relationships. This is not a small task, but can be done over time and the improvement of the symptoms are often noticed after only a few sessions with a physician skilled in using holistic medical tools and able to coach the patient successfully through a few weeks of dedicated homework. Children can also be helped, if their parents are willing to do work on personal development, to improve the general quality of life in the family and their relationship with the child. We often see that the child's quality of life and health status from the perspective of holistic medicine often is a thermometer for the thriving of the whole family.

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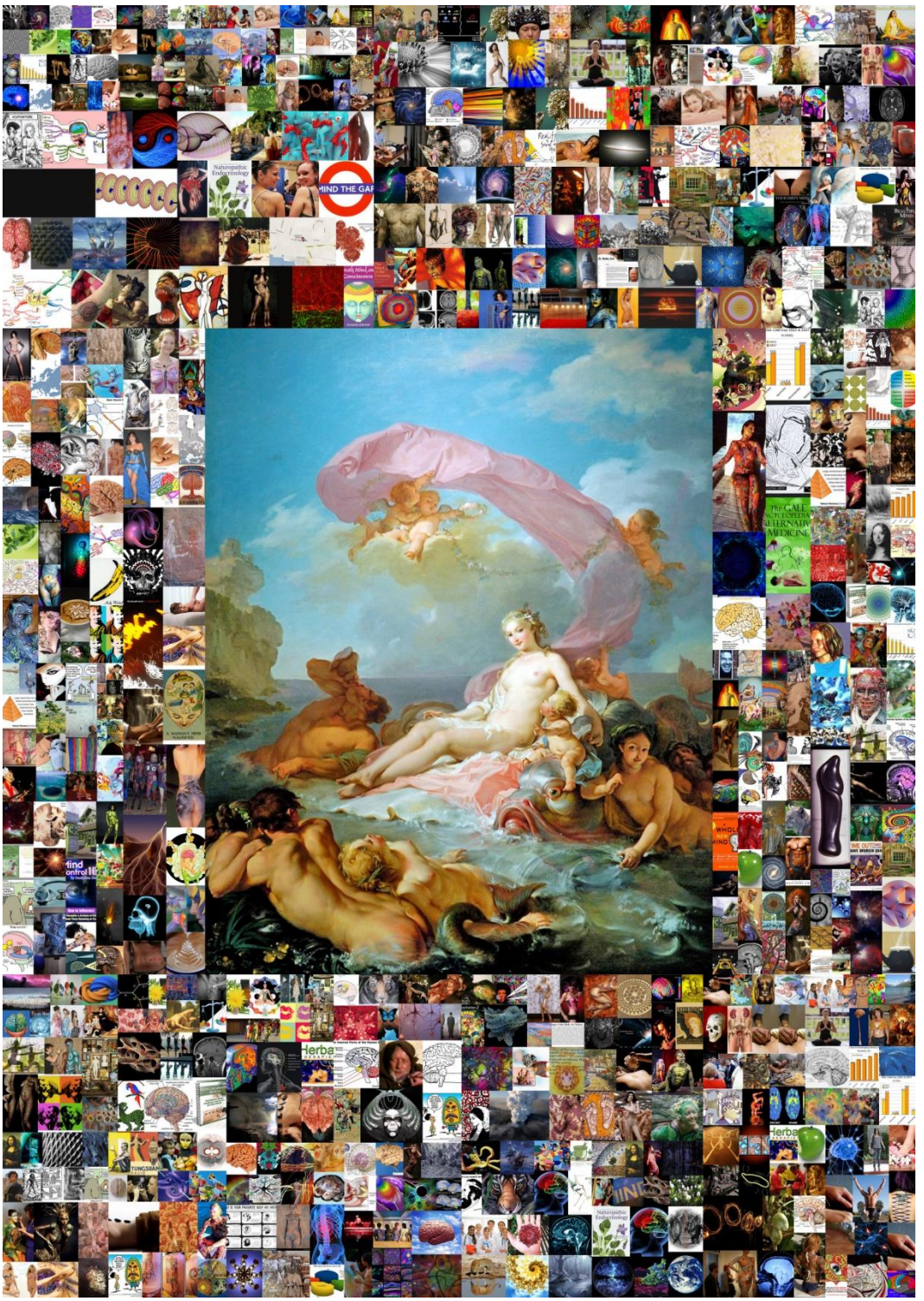

Chapter XI

Whiplash, fibromyalgia and chronic fatigue

Holistic treatment of the highly complex, "new diseases" are often possible with the tools of consciousness-based medicine. The treatment is more complicated and the cure usually takes longer than for less-complex diseases. The problem with these patients is that they have less easily accessible resources than most patients, as they suffer from a combined socio-psycho-physical problem with depression, poor social standing, low confidence, and low self-esteem. Often, they have also already tried most of the specialist and alternative treatments on the market. To cure them, the most important thing is to coach them to improve their social life by changing their behaviour to be of more value to others. Holding and processing must be especially careful and the contract with the patients must be extremely explicit in order to work on their personal development for 6–12 months. The new diseases can be cured with consciousness-based medicine if the patients are motivated and keep their appointments and agreements. Low responsibility, low personal energy, little joy of life, and limited insight into self and existence are some of the features of the new diseases that make them difficult to cure. The important thing is to keep a pace the patient can follow and give the patient a row of small successes and as few failures as possible. The new diseases are a challenge, a unique chance to improve communication, holding, and processing skills.

Introduction

In recent years, a number of "new diseases" have emerged. These are suspected of being lifestyle diseases that are particularly characteristic of our western culture. The best known are whiplash, fibromyalgia, and chronic fatigue syndrome. These diseases appear to be non-existent in many indigenous cultures, such as those in Africa, and the cause of these diseases is a mystery. The "new diseases" are characteristically vague, which makes them technically difficult to diagnose. In addition, they seem to be related to some intense, peculiar, and inscrutable personality disorders that can make the patient look like one major apology for existing or even a social outcast who is just looking for a good alibi to avoid all social and

human commitments. Accordingly, many physicians do not recognize the new diseases as being real diseases and understand them as mere social problems or personality disorders.

From a holistic perspective, illness can be any conglomerate of poor posture, emotional pain, and physical blockages, so we see no difficulty in acknowledging the new diseases as a form of illness. The holistic medicine explanation allows the new diseases to be treated and the treatment is often surprisingly effective. Before we discuss the three illnesses and their suggested holistic cures, we will give a short review of our previous work in the field of consciousness-based medicine — or "quality of life as medicine" — as we often call our style of holistic medicine. With the new diseases many new and alternative treatments have come into use; unfortunately we have recently found therapies like gestalt therapy, Marion Rosen therapy, and Cranio Sacral therapy to be of little value to chronic WAD patients (1). In this chapter we present the method of holistic existential therapy, which efficiency still needs to be documented.

Whiplash: Status over a typical "new disease"

For some years, there has been an intense debate on the nature of chronic whiplash-associated disorders (WAD) (1). The Quebec Task Force Classification defined five groups for the acute phase of WAD (2) with most of the whiplash patients healing spontaneously, but some continuing into a chronic phase, reported by different researchers from 0% to above 30% (2-5). In the acute phase, immediately after the physical impact and the whip-like movement of the spine, everybody seems to agree that there might be some physical damage to the muscles, bones, joints, tendons, fascia, and the connective tissue, even in the case of no obvious fracture or other gross damage.

The issue of discussion is why these often small and dispersed damages are followed by symptoms that last for years. One theory is that high quality of life is associated with less worry about the physical pain, resulting in better healing (6). One study demonstrated a number of minor damages, like small cracks in the bones (7), but most MRI (magnetic resonance imaging) studies have not shown any sign of significant damage (8) in the initial phase, except for one study that found minor whiplash-associated damages to the disc in a small percentage of the patients (9). The chronic phase has been difficult to understand. One group worked with the theory that the facet joints were causing the pain and found that about half of the patients had a positive effect from local anaesthesia (10,11). Other groups found small diversities from normal in rotation pattern (12) or eye movements (13,14), but it was very difficult to establish a single, well-defined organic damage to blame for the diversity of WAD symptoms found. Our group of patients (1) had the typical cocktail of symptoms: pains; difficulties in moving the head, neck, and back; vertigo; low personal energy; lack of concentration; lack of motivation; sleeping disturbances; lack of sexual interest and energy; and a general feeling of being sick. It is believed that psychological factors are of major importance in WAD. One study showed that the most important predictor for pain and discomfort at a later stage was the patient's insurance situation, because if the patient was going to fight for insurance money, it was very likely that he or she would have WAD symptoms at a later stage (15).

In countries with less insurance, the average healing time was much shorter (2,16-18). There has been critique of the conclusions because the number of participants was small (19) and because of difficulties in comparing the technical circumstances of the incidents (20). Another indicator of the importance of psychological factors in WAD was the fact that the threshold for sensing pain is dramatically increased with growing mental involvement (3,21]. We all know the extreme situations, like when you were relaxing at the beach and an ant bite felt like a lion bite or, on the other extreme, the soldier at war continuing to fight in spite of being wounded. The memory of an old wound, now healed, can even cause pain (22,23). The whole area of psychosomatics is well described in medical science, as are many psychoimmunological factors. A post stress syndrome is found to be a prognostic factor (24). From the present knowledge, we are forced to conclude that the etiology of WAD is still not well understood and an important contribution from psychological and existential factors must be expected. In the acute phase, there are several methods in use from immobilization (25), "live as usual" programs (26), mobilizations (27), to exercise (28), but it is not clear if any of these has any preventative effect for the later development of a chronic phase of WAD. The best advice in the acute phase at the moment seems to be to live as usual, as exercise is better than the cervical collar (29) still used for 85% of the patients in, for example, Germany (30). For the chronic phase of WAD there is no cure available.

Fibromyalgia

This syndrome of unknown etiology is characterized by chronic extensive pain, increased tenderness to palpation, and additional symptoms such as disturbed sleep, stiffness, fatigue, and psychological distress (31,32). In spite of a reasonable amount of research, little progress has been made in the treatment during the last decade and very few trials have actually assessed improvement in functional status (33), as the relief of the chronic pain has been the major ambition of most interventions. The complexity of the syndrome causes many researchers to recommend a multidisciplinary treatment program (31), but unfortunately, there is no evidence that a multimodal mind-body intervention program is better than education and support (34). Many different approaches have been tried, often with modest effect on only about a third of the patients, like exercise (35), ultrasound (34), pool exercise therapy (36), and biofeedback (37). Biomedicine has shown very little effect; amitriptyline and low-power laser therapy gave clinically significant results, but only about 30% of the patients responded (38-42). Serotonin reuptake inhibitors, NSAIDs, and corticosteroids have not been effective (40).

A psychological approach has shown similarly poor results, but making the patients aware of their basic psychological problems might be helpful to some patients (37), whereas integrated group therapy might be helpful to others (41). Patients with fibromyalgia have painful tensions and blockages throughout their bodies. Conventional medicine works with a number of hypotheses for the disease, of which the autoimmune hypothesis (the hypothesis of myositis) is probably the most interesting. Psychologically, these patients often insist on the strategy of attributing all complaints, including emotional ones, to physical causes. One possible explanation of this tendency is that their emotional pain can be much worse to experience and relate to than their physical pain.

From a holistic medical perspective, a patient with fibromyalgia does not become well until he, or more often *she*, is willing to feel the emotional pain, relate to it, and act on it. If the patient is willing to assume responsibility for the pain, treatment is possible and through a persistent and targeted effort, the patient can regain mobility and normal capacity for work in a matter of years. These patients can become free from pain, but this necessitates a comprehensive healing process where they work on the total pain load that they have accumulated during their personal lives. In short, it appears that these patients can become well again under professional holistic guidance if they are willing to fight for it. As with many holistic therapies, there is insufficient scientific evidence of the effect of this therapy. The Quality of Life Research Centre is currently carrying out a number of projects to gain evidence and is trying to obtain funding for systematic studies of the effect of holistic medicine on the numerous diseases where it apparently has an effect.

Male, aged 45 years, with fibromyalgia: First visit: 1. Presents with tightness in the chest and diffuse symptoms of low well-being. He has been coughing for 21 days and running a temperature nine days ago. Stopped smoking four years ago. Apparently he has a history of fibromyalgia and collapse of vertebrae and a tendency towards depression. Previously treated twice with antidepressants. In addition, he takes antidepressants, anxiolytics and receives physiotherapy. On examination: Normal mood. Auscultation of the lungs: everywhere vesicular respiration with no abnormal sounds, slightly "asthmatic" respiration, peak flow 360, 370, 390 (normal range 410–540). Cardiac auscultation: Irregular pulse, suspected arrhythmia? BP: 120/90. Apparently no fever. Trigger-point test and medical history point to /fibromyalgia/. The acute deterioration is probably due to /suspected influenza/. 2. The patient worries that his depression may return; we shall help him with that. Can return for conversation. 3. He has been out of the labour market for 16 years. Now his children are grown up and he wants to get back and train for work. Second visit: Conversation: He is showing good progress. He is "pumping iron" at the physiotherapy clinic, but not finding it easy. He talks about his insectophobia, and I give him the EXERCISE to sit for 5–10 minutes and feel his fear, instead of running about screaming as he is doing at present. He can do this with other feelings that suddenly overwhelm and upset him. The important thing is for him to be in control, and to learn in a constructive manner to accommodate his feelings. I prepare him for working on his depression in the same way, should it appear again. On examination: rather apathetic. Will postpone training for work until we have found a way to do it. Third visit: His entire body is sore from mowing the grass two days ago. Massaging of tender muscles. We talk about the physiotherapy: he is still progressing and likes doing it, but feels guilty at spending all that money. He also swims, which costs money too. He does not like to spend too much. I ask whether his wife is finding that a problem, which is far from the case. Then I ask him what he believes his wife would prefer: that he becomes well, or that he saves the money. He becomes cross with me: "Don't make me feel guilty. I've felt guilty all my life." We talk about his feeling of guilt and how he can move beyond it. It is important that he allows himself the treatment he needs. He makes another appointment. As mentioned, patients with fibromyalgia can be rather sad people with a mixture of serious, sometimes disabling, physical, mental, and social problems that are characteristic of the disease, combined with a rare ability to do nothing about them. Difficulties accumulate because of the patient's failure to assume responsibility for his or her own life and lack of self-discipline. The aim of the regime is to treat the apathy or defeatist attitude hidden in the mentality of these patients and this can prove difficult if the patient is unwilling to look below the surface, assume responsibility, and work with him- or herself. Once the patient has decided to become well and is willing to pay the price in the form of working intensively, fibromyalgia becomes "simple to treat".

However, the treatment can be a protracted affair, taking 6 months, 12 months, or even a decade with the focus on personal development following the holistic regime.

Female, aged 51 years, with fibromyalgia, severe overweight, depression, and social phobia quality-of-life (QOL) conversation: 1. Fibromyalgia: The patient suffers greatly from pain in her legs, thighs and arms and wants to be free from pain. 2. Severe overweight; today she weighs 138 kg (dressed). Normal weight 65 kg; since 1985 when she gave birth her weight has gone up. 3. Depression, for which she takes Cipramil [citalopram] 60 mg daily plus a sedative 20 mg in the evening – she has had death wish – and she also had a history of social phobia. We talk about how life hurts, and how we can only obtain physical freedom from pain by being willing to feel the pain emotionally. We have a long and deep conversation about this, and the patient cries a little, while reflecting on this. She does not want to go on living, she says, but in reality this is not about a death wish, but merely a resignation with regard to living. She is constantly gaining weight and no longer weighs herself. We have a good talk about life philosophy and agree that the patient should have 6–10 sessions of Rosen therapy, after which she can return to me (SV). We believe that all four major problems have the same underlying cause, which gives us hope that we can deal with all four diseases in one go, if the patient acknowledges the unavoidable pain of life and balances it with enjoyment of life. We talk about enjoyment of life lying at the very bottom beneath all the blockages, and the patient seems to understand this. Second QOL conversation: We talk about "how to eat an elephant" – the patient's insurmountable problems which keep growing – which you do one bite at a time. The elephant is the patient's neurosis, which feeds on her life energy and grows, because she keeps feeding it. That is how she loses energy. We talk about how big the elephant is at present and how small she is, and the patient says that it is 4 metres, while she herself is only half a metre. Six-month objective: The patient should become at least as big as the elephant so that it can no longer be in charge of her life. We agree that she should end up being slightly bigger than the elephant, and she should know how to catch and eat an elephant by then so that her positive development will continue after she finishes in our clinic. If she succeeds, she will get her life back and have set a course to continue improving it. Basic work includes perception, conduct of life and the reestablishment of the patient's self-respect. She promises to do her exercises and follow the treatment for six months. I (SV) promise that we will give her all the help and support she needs during this period. The patient understands that she herself has to do the work involved in recovering; she is responsible for getting back on her feet – we provide help for self-help. She (her white side) allies herself with us to deal with the problems that she would be powerless to confront on her own. Agreed: The patient is to work with herself two hours daily. EXERCISE: Life story – write down all emotional events; what happened, how did you feel, what did you think, did you make any decisions. Start from the present. Third QOL conversation: Since last session the patient has begun to work out. Her fibromyalgia pain is no better, but is less significant and controls her less. She has begun to lose weight and today weighs 135 kg. She has done all her homework well. Her objective, which we correct below, and personal history are full of disappointments. We talk about confidence: it appears as though the pattern has been broken. So if she could let go of her basic lack of confidence in herself, other people and life itself, she would see life in its proper perspective. She makes the following statement: "They don't want what's good" – other people cannot be trusted. "You cannot trust anyone", "Everything looks hopeless", "I am hopeless", "I am stupid", "I am disappointed". The patient lacks self-respect. On the shopping list: new backbone. Weekly weighing here in clinic. EXERCISE: Write your life story including above statements. A topic for each day: write down all events, afterwards you can let go of the statement. She wants to talk more before Rosen treatment[1]. Another appointment is made. Fourth QOL conversation: She is showing progress in spite of everything. Talks about the Rosen sessions. She can talk with the Rosen practitioner to put her mind at ease. Weight today:

134.0 kg. Dietary advice: Eat vegetables, fruit in moderation and lean meat. Vegetables: eat as much as you like of cucumber, tomatoes, lettuce, asparagus, celery, fennel and cabbage. Avoid: fatty foods (ice-cream), potatoes, rice and bread, sweets and chocolate. The patient is getting more exercise – gym work, swimming – try a centre, which has hot-water baths. Takes a 30–60-min walk every evening. Sauna against pain. Concerning social phobia – talks only to an elderly man on her stairway who calls her and her children. EXERCISE: Always trying to avoid contact. Now do the opposite: make yourself available, go and sit in the park and talk to people who come up to you. PLAN: Rosen method six times a week, then clinic again, perhaps followed by gestalt. Fifth QOL conversation: She had been to Rosen therapy three times, which has gone really well. She says: "it is strange to be understood; I'm not used to that". Now she has reached a point where it does not feel so good, but makes her want to run away. "It's as if I'd rather be invisible." We talk about that – when her feelings are strong, she is scared of being condemned. We talk about offender, victim, helper/deserter and self-torturer. Remembers hitting her doll. Acknowledges that she is a teeny bit evil. She understands that - "it's scarily human," she says. She is aware that she is protecting herself by becoming invisible, but then is not herself, which is very bad for her. She is pleased with the result so far. Ninth QOL conversation: Weight today: 114 kg. She has lost 22 kg of the 25 kg she had set as her target. "Wow, am I good," she says grudgingly, laughing. Social phobia – she can talk to people now, but still has periods when she keeps to herself. Right now she has come out of her isolation. Fibromyalgia – a great deal of pain in thighs and legs, arms and back. Her suppression of herself and all pleasure is what causes the muscle pain. Depression – her psychiatrist has prescribed 60 mg citalopram daily. Currently no symptoms, but when the medication is tapered she has thoughts of not wanting to live. Once she is able to enjoy things more she should gradually reduce dosage to 30 mg together with psychiatrist and then stop taking medication. All in all she is showing good progress. After 9 months, this patient has almost reached her target: to become bigger and more powerful than her neurosis, symbolized as an internal elephant at the beginning of therapy. Now it is only slightly bigger than her and her favourable development is continuing. It appears as though she is getting there.

Chronic fatigue syndrome

Generally, biomedicine has not been of much help to patients with chronic fatigue syndrome (CFS). Intravenous immunoglobulin was used 20 years ago, but it was not very effective, as only 31% (over placebo) of the patients were somewhat helped (43). Hydrocortisone and fludrocortisone (44), melatonin or phytotherapy (45), acyclovir (46), tricyclic antidepressants, and other pharmacological treatments have generally not been effective (47). Cognitive therapy (CT) has been a little helpful, guided support groups less efficient, but the best treatment so far seems to be CT even though only 27% of the patients reported improvements in one study (48). Cognitive behaviour therapy is definitely not a cure, as only every third of the patients benefit clinically in the most favourable studies (49-51). A review concluded that "there is no satisfactory evidence for the effectiveness of CT in patients with the milder forms of CFS found in primary care or in patients who are so disabled that they are unable to attend out-patients" (52).

For teenagers 11–18 years of age, family therapy seemed helpful (53). It is obvious that CFS is a very difficult syndrome to treat with an uncertain etiology, but several theories exist from immunological (45) to existential. One important concept in holistic medicine is

"somatisation" (literally meaning "making bodily"). Somatisation comes from our freedom to choose our own content of our consciousness and, thus, our freedom to repress unwanted feelings, thoughts, perceptions, and other existential material. In this repression, our mental, existential, and emotional problems take on a physical manifestation. Often, we find it easier to bear our problems as a physical ailment rather than as an emotional or existential problem, as we see with many patients in the holistic clinic. It is, therefore, logical to regard CFS as a somatised depression. Depression is the result of handling a major collection of repressed emotional pain systematically by taking the life-limiting decision (or generalized justification) that one is worth nothing, that one has very little self-confidence, and can cope with very little. By systematically invalidating our own self-esteem and self-confidence, we become dull, slow, sad, and emotionally dead — in other words, depressed. Depression is painful in itself, so we can flee from that too, which we do by banishing the depression to the body. In this way, virtually all feelings and all life energy have been banished to an area beyond our consciousness and the result is a total loss of personal energy: CFS. Below, two case stories are presented to illustrate the condition.

Male, aged 25 years, with lethargy QOL conversation: The patient is suffering from serious problems with pain and tension in shoulders, "oxygen deficit"-like lethargy and physical weakness (including an urge to sleeping). On examination: a palpable muscle knot of 1.5 x 1.5 cm corresponding to C3-C4 (right side). Other problems: General scepticism about people's ulterior motives – seems not to read their intentions. Some shyness is easily compensated by "performance". Sex life marked by control. A general lack of energy and joy; for example, he finds climbing upstairs to the 3rd floor very strenuous. Suggested causes: Control-survival pattern [when our survival is threatened we seek to control reality; it is very difficult to break out again of this pattern, which distorts our focus towards the head and it can persist throughout life], probably at an early stage – embryonically? Mother had murine typhus in late pregnancy – born prematurely? EXERCISE: Write five A4 pages about the listed problems. Find out if they have a common cause. Look at the suppression of your feelings, especially when you are withholding your goodness and friendliness. Second QOL conversation: He has done his homework: Very intellectual description of something very simple: that he is suffering from anxiety. Anxiety with the following symptoms: 1) his neck is tense, so he cannot sense his feelings; 2) he is shy = social phobia; 3) he is scared of being condemned by others, looked down upon, weighed and found wanting; 4) needs to control feelings and thoughts; 5) needs to keep others at a distance = scepticism, mutual distrust; 6) needs to perform and come out top compensation for fear of social exclusion? On the couch he works on being present in the emotional space, which is much less developed than the physical and mental space. He suffers from anxiety and explains that his mother was never there for him on the emotional level, so /emotional neglect/ from age 3–4 years. Psychosomatic stomach ache as a child. EXERCISE: "Sense your feelings, allowing them space. Sit down for 10 min every day and sense your feelings - egg-timer. Each time that a feeling is provoked in your life you should acknowledge it, allowing it space. Rosen therapy? Lethargy of this type is not chronic fatigue, but a milder condition. However, this case history is a fine example of how fatigue and lethargy may be due to internal conflicts that can be processed without any major difficulties, if the patient is willing to go along with it.

Female, aged 40 years, with chronic fatigue syndrome:/Essential hypersomnia/ diagnosed in hospital after preclusion of narcolepsy. She has taken antidepressants for a year, stopped two months ago. Things are coming to a head, she says. She has a 12-year

old daughter and has had a boyfriend for seven years. Before him she had another boyfriend for one year, and finally she lived for six years with her child's father, whom she met when she was about 21 years. Depressed during her teens; it was as if she had fallen into a deep, black hole that she could not escape from. She did not know who she was. She wanted to die, but then her mother could not wake up and see her, as the patient longed for her to do. She made herself ill, for instance by walking barefoot through the snow or deliberately falling from a tree so as not to have to go to school. She fantasised about the bus crashing so that she would go to hospital. Sexual abuse by stepfather, who had been in the house since she was two years old. Remembers an episode from when she was about nine, when her stepfather carried her into bed and touched her between the legs. It was a lovely sexual tickle, but she knew she should pretend being asleep. He also tickled her while she was having a bath, but then she laughed and thought that this was how it should be. When she was 16 years old, he watched her secretly in the bath, and one night when she had fallen asleep he undressed her. She dared not refuse him. Talent: To be beautiful. Life purpose: – I am beautiful? I would say /suspected chronic fatigue syndrome/. EXERCISE: Write your life story for 30–60 min daily – what happened? How did you feel? What happened? What decision did you make, if any?) For each situation with a strong emotional content – divorces, assaults, etc. Start from the present. EXERCISE: Accommodate your boyfriend during his mood changes. (Power game? Exercise about this later.) PLAN: To come to the clinic every two weeks; Rosen therapy every two weeks.

Whiplash: When the bridge to the body is barred

In our culture, a sprain of the cervical joints may follow a very protracted and sometimes even chronic or life-long course. We now know that a rear-end vehicle collision can cause a number of microscopic injuries to soft tissues and supporting structures in the neck, but it is very strange indeed why neck ligaments and supportive tissues fail to heal properly in some people and why the natural protective immobilization of cervical muscles, serving the purpose of allowing damaged tissues to heal, is never completely healed. There is no apparent reason why those joints should differ from any other joints in the body. Typically, clinical examination of a whiplash patient reveals excessive cervical muscle tension, but no significant damage to ligaments and joints.

A holistic explanation of whiplash injuries comprises two important factors that affect the protective immobilization rendering it permanent following the accident. First, the neck is an especially sensitive region because it is the vulnerable link between head and body and has an important symbolic and emotional meaning. Often, when we shut off our emotions, we experience neck tensions. Second, the muscle tensions storing old, traumatic feelings can shift about in the body. Often during therapy, we experience that one body region has been freed of blockages only to find that another region is equally tense and locked a week later. Tensions migrate from back to neck, from neck to low back, from low back to knees, from knees to feet, effortlessly moving about from one joint to another and from one muscle group to another.

When these two circumstances are combined, we obtain a simple psychological explanation of the whiplash syndrome: In order to shut out the painful feelings from his or her personal history, the patient is subconsciously moving old muscle tensions up into the tense

muscles in the shoulder and neck. The resulting, very severe, blockage in the neck can have many sequelae such as dizziness, impaired concentration, and depression. That explains why whiplash sometimes causes disabilities that are very difficult to overcome.

It is important to understand that the patient often already has emotional problems, which provide reasons for the relocation of muscle tension. Therefore, a patient with chronic whiplash injuries will need a comprehensive regime to sort out his or her personal history with its painful impact on the tensions locking the neck.

In an extremely well-motivated patient, this can sometimes be achieved in one session of consciousness-oriented body therapy, where the patient is made aware of all the problematic aspects. At other times, a long period of therapy is required, perhaps up to 6 months. At any rate, it is treatable if the patient is willing to do the work involved.

Male, aged 34 years, with whiplash: QOL conversation: The patient has suffered from whiplash injury since 1996, accompanied by severe back pain. Migraine since his teens. Has tried NLP, cranio-sacral therapy, healing, a clairvoyant, a chiropractor, etc., but with no lasting effect. Guidance: Basic conflicts of life cause these complaints. PLAN: Rosen method six sessions + gestalt six sessions + reading one book per month – talk to the manager of the QOL Bookstore for advice on literature on personal development, and philosophy of life training. Write autobiography: What happened? How did you feel? Write about all the events in your life when you harboured strong feelings. In the case above, the treatment went by the book. If the patient does his exercises diligently, he will become better in all likelihood. Below, follow another whiplash story where we describe the patient's visit instead of presenting the case record. This man in his forties came to our clinic because his wife had read an article about our work in the chapter. She thought it was high time he saw someone to get a grip on the condition that had bothered him for the last 5 years and now constituted a threat to the things he valued most in his life — his managerial position heading a department of 25 people, his relationship with his wife after 12 years of marriage, his health and mobility. He was thick-set, muscular, and strong, but there was something strained and tense about him. He obviously had a sensitive and humane side, but overall gave the impression of being a violent person, one who sought to solve all problems, great and small, with the "hammer he had in his hand". Three years ago, he went out for a run that turned into a tough experience. He and his partner really exerted themselves, but it was the beginning of a new season and they were not really fit for the effort they made. At home, after the run, he had a terrible headache and went to bed. However, instead of disappearing, his headache increased over the next days, turning into an unbearable pounding in his head, while his neck became increasingly rigid. He had a tingling sensation in the facial skeleton and went to see his physician. Ordinary painkillers provided no relief and he became increasingly tormented. He was admitted to hospital and examined using the finest and most expensive scanners, the state of the art in medical science. However, neurologically, the patient was completely intact with no pathological findings. Nothing could explain his headache. At the centre of his spinal cord, one of the CT scans showed a small stripe that was not supposed to be there. It was suspected that a small vesicle might be pressing on his spinal cord, causing his symptoms. Although now, 1 year after the accident, he was developing a tendency to tingling sensations in his hands, but only when he clenched them or held them in awkward positions. And the vesicle could not explain the headache, the tingling in his brain, or the strange sensations in his face. According to the great medical textbook, that sort of tingling would usually start in one side and not in both sides, as it had in his case. After all those careful assessments, nobody could explain what was wrong with the patient. We asked him to undress and examined him quite thoroughly. There was nothing of note on the vertebral column, but around the cranial base and

superior cervical region, his muscles were very tense. There was a wooden feeling and around his body we found muscles that were extremely hard and dead to the touch. They showed no reaction at all to being touched and were completely tense. Suddenly the "fog lifts": He has whiplash! Whiplash is a disorder where tension, when induced, can lodge around the neck causing headache and the very symptoms that this patient was suffering from and the lesion need not even be extensive. To relieve the patient of these complaints, we needed to relieve him of the massive tensions in his body. "I believe that you have got whiplash," I (SV) tell him. "I do not believe that you have a degenerative nervous disorder. Nothing points to that in our opinion. The whiplash injury was caused by all that muscle tension. They tense up to hold on to the pain. I believe that all the tensions we found inside you before are due to the way you try to solve all problems 'with a hammer'. Instead of having an honest and respectful dialogue with your family and your staff, you try to *hammer* your way through." "Yes, that is true," the man says. "They say that when I enter a room everybody shuts up, because they know that either they do as I say, or I give them what for." "Couldn't you consider using a little less power and becoming a slightly more loving person?" I ask him. "Yes, I could consider that. I have thought about it myself," he says. "To me, there are two phases in recovering. First, you need to find a way of life so that you do not hurt people. Because that is the pain hidden inside you in all those tense muscles. Then, in order not to become even worse, you will have to find a more loving and respectful way of life, so that you do not hurt other people. You need to open up for your feelings. Neck tension serves to 'sever' the head from the body, separating sense and sensibility, so that you can continue your powerful leadership style without feeling how hurtful it is to others. Once you have learnt to behave in a loving and respectful manner and not to hurt people, you will be able to let go of your neck tensions and allow yourself to feel again. Then comes the time when you have to make amends and put everything right again." "I hope you do not see me as a wicked person?" he asks. "No, and I do not believe you want to do anything wicked. You just happen to hurt other people. This makes you wicked for all practical purposes and not as good as you might be. What I see is two phases, where first you have to learn a loving and respectful dialogue with the people around you and then clear up all the misery that you have caused." Surprisingly, the man looks at me as if he understands what I am saying. "I had better go home and practice," he says. Perhaps he will be in therapy for years because he cannot let go of his abuse of power towards other people. Perhaps he really understood the essence of it and has decided not to exert his authority over the many people for whom he is responsible. In our opinion, his fate will be decided by his philosophy of life from now on. Faced with the prospect of much-too-early retirement and disaster brewing at home, where his wife is finding him more or less intolerable, he seems to have become highly motivated for understanding and trying to improve. A cosmic setup has been at work. All we need to do is to indicate a way out of the problems and, thus, the road to a new life.

Female, aged 48 years, with chronic whiplash: Car accident 18 months ago with whiplash injury. Since then, the patient can only turn her head through 15 degrees either way and she suffers from headache and impaired concentration. Still working, but it causes her major problems. Time line therapy for the trauma. During her therapy the patient remembers that the other party died, and she feels immense guilt. After thoroughly going over the episode three times she can talk about the trauma. After the session the patient can move her head freely, she laughs and cries and is very happy. This introduces an important topic of psychosomatics: feelings of guilt. Apparently, the hardest pain in our lives comes from the pain we inflict on others. Killing somebody by accident releases a highly problematic, emotional reaction that is easily repressed, but may have serious consequences for the future well-being of that person. In this case,

much of the energy behind the patient's whiplash seemed to stem from that feeling of guilt.

Discussion

Holistic treatment of the highly complex, "new diseases" are often possible with the tools of consciousness-based medicine (54). The treatment is more complicated and the cure usually takes longer than for less-complex diseases. The problem with these patients is that they have less easily accessible resources than most patients, as they suffer from a combined socio-psycho-physical problem. Often, in our clinical experience, they are depressed and in poor social standing with low confidence and low self-esteem and they have become resigned by not believing that they will get better because they have often already tried most of the specialist and alternative treatments on the market. To cure them, the most important thing is to coach them to improve their social life by changing their behaviour to be of more value to others. Many patients give up when challenged by the physician to improve their quality of life and patients with no initiative or will to get well again are almost impossible to cure, even for the best physician. Holding or care and processing must be especially careful and the contract with the patients must be extremely explicit in order for them to work on their personal development for an hour a day, for 6 or 12 months. Often, they need to read books, write their biography, and many more demanding exercises. If a patient stops doing the prescribed exercises, this must have immediate consequences and the patient must understand that this is not acceptable because if the treatment fails, this is as much a failure for the physician as it is for the patient. This honest and direct approach is often necessary to prevent the patient from taking the easy way out with many of the existential problems that surface during the holistic treatment.

The new diseases can be cured with consciousness-based medicine if the patients are motivated and keep their appointments and all the agreements made. Low responsibility, low personal energy, little joy of life, and limited insight into self and existence are some of the features of the new diseases that make them difficult to cure, also when it comes to holistic medicine. Actually, the patients cannot be cured in the normal sense of the word. They can only cure themselves with coaching by the physician. They must take the initiative and work hard to be well again, they must be their own physician in a way. Due to the fact that they only assume very limited responsibilities or are often "rather emotionally dead", the problem and the trick of treating them is to make a contract the patients are willing and able to keep. Often, treatment of such patients can take years. The important thing is to keep a pace the patient can follow and give the patient a row of small successes and as few failures as possible. The new diseases are a fantastic challenge for the physician, a unique chance to improve his communication, "holding", and processing skills. Only if the physician refuses to give up on these patients will they have a chance. On the other hand, it is very important that the physician is direct and strong in order not to be a part of the low-responsibility games these patients unconsciously play.

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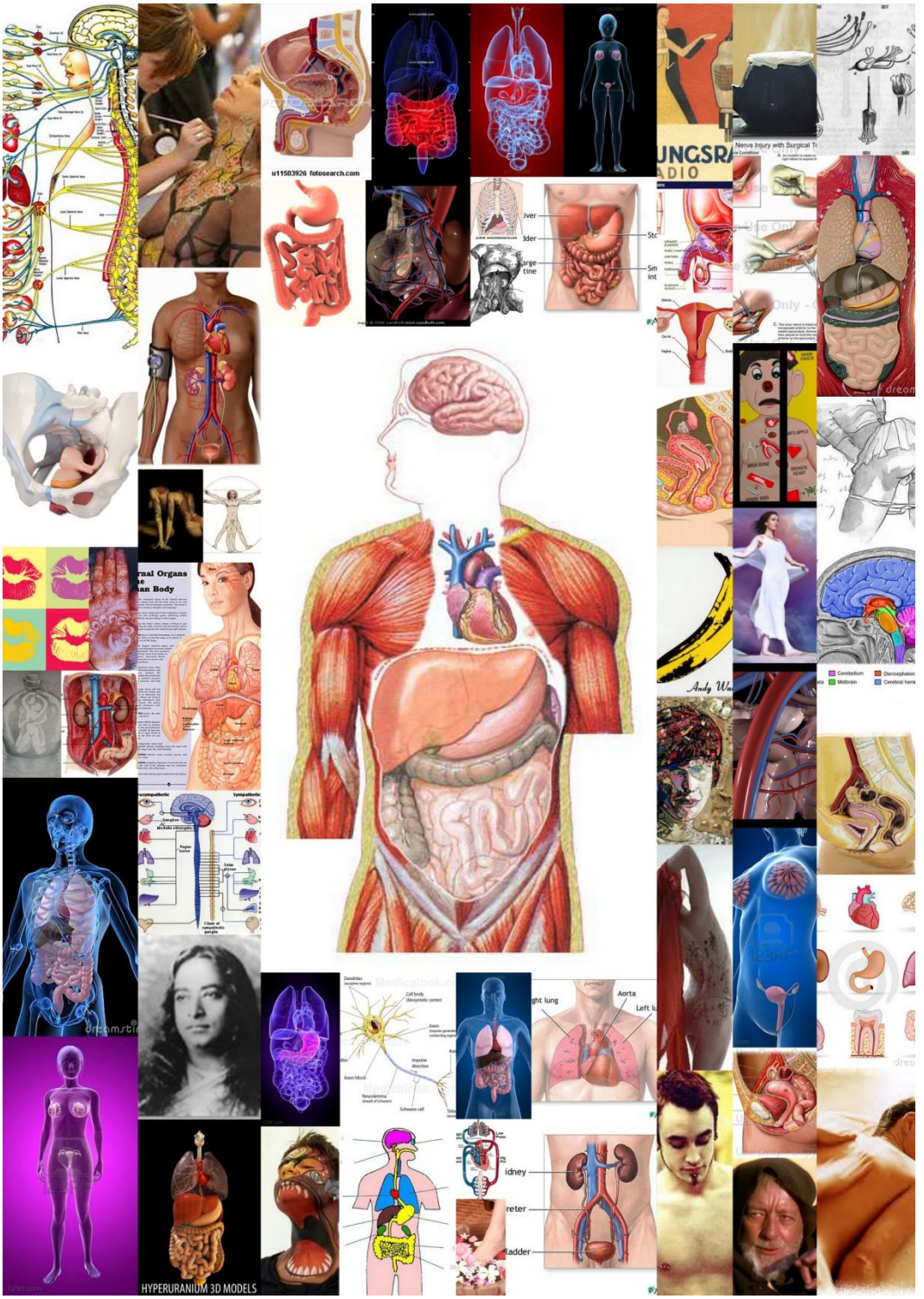


Chapter XII

Alcoholism

Alcoholism can be understood as self-treatment for existential pain. A five-day treatment was designed to relief this psychological pain and existential anxiety and thereby diminishing the need for self-treatment with alcohol. The basic principle behind the treatment was holistic, restoring the quality of life (QOL) and relationship with self, which according to the life mission theory happens when life-denying views are corrected and inner emotional conflicts are solved. The methods in this treatment were a course with teachings in philosophy of life, psychotherapy, and body therapy.

The synergy attained was considerable and the outcome demonstrated that in the course of one week, people have time to revise essential, life-denying views, to integrate important, unfinished life-events involving negative feelings. This was demonstrated by an improved QOL and a decrease in their dependency and need for alcohol-abuse. In the week before, after the five-day course and again after one and three month, the 16 participants completed the SEQOL (Self Evaluation of Quality of life Questionnaire) questionnaire on quality-of-life and health. This was a pilot study based on a pre-experimental design, without a control group and without clinical control. Common for the group was a low quality of life, numerous health problems and alcohol dependency in spite of treatment with Antabus (disulfiram). The study showed an increase in QOL from 57.6% before the course to 69.4% three month after the course, or an improvement in quality of life of 11.8%. There was a 24.0% improvement in self-perceived mental health, and satisfaction with health in general was improved by 11.1%. The total sum of health symptoms in the group was reduced from 59% of maximum to 33%. It is concluded that for this small, but motivated group with alcohol problems it was possible to improve quality of life and health in only five-days with a holistic treatment that combined philosophy of life, psychotherapy and body therapy, but the results are not final. Further research is needed.

Introduction

Alcoholism is a public health issue costing every modern society billions of dollars in direct and indirect expenses (1,2). The aetiology of alcoholism is not well understood. Some research has found a genetic connection, while others have suggested that alcoholism is

basically self-treatment for anxiety and psychological pain (3,4). This is in accordance with the known tranquillising effect of alcohol. The most famous medical cure for alcoholism is treatment with disulfiram (Antabus) and recently two more drugs, acamprosate and naltrexone, has been introduced to treat severe alcohol dependence and reduce alcohol intake (5). The need for drinking seems not to be removed by this treatment, but can be helped by a psychosocial intervention, the most famous of these being the Minnesota 12- Step approach (6,7). The Minnesota model is based on admitting the alcohol dependency to peers in basic trust. It starts with a 5-week in-patient course, helping people to realise their poor situation and their need for personal improvement. The Minnesota Model demonstrates that psychosocial treatment can be very effective, but many alcoholics are hesitating to participate, as they feel uneasy with the religious concept and as it is also fairly expensive (in Denmark about 8,000 USD for the first five weeks) and many alcoholics are not helped by this intervention in the long term. Since 1990, the Quality of Life Research Centre in Copenhagen has studied the connection between quality of life and a large number of factors, one among them the abuse of alcohol (8,9). In our work with quality of life we have focused on measuring global and generic quality of life, using SEQOL (Self Evaluation of Quality of life Questionnaire), a self-administered, theory-based questionnaire (10) and through the Copenhagen Perinatal Birth Cohort 1959-61 looked at long term aspects of quality of life (QOL) compared with events in pregnancy and early childhood (11,12). We believe there is a connection between quality of life and health in the way that the connection is hypothesised to be causal from quality of life to health (13), meaning that health improves when quality of life improves. We also believe that this hypothesis (that quality of life and self-perceived health are susceptible dimensions that can be improved considerably in a short time) must be scientifically tested through intervention studies. The factors that were subject to influence were brought together in a concept for the intensive five day quality of life and health course (5D-QOL intervention). The purpose of the experiment was to test qualitatively and quantitatively the hypothesis that quality of life and subsequently subjective health can be improved effectively by a combination of philosophy of life, psychotherapy, and body therapy, supporting the salutogenetic process (14,15).

The philosophy behind the pilot study

According to the life mission theory, (13) global quality of life is improved when the patient lets go of negative beliefs. Negative beliefs according to the theory are based on emotional pain, which are “deposited” in body and mind, giving poor QOL, poor mental and physical health with a low ability of functioning. The philosophy behind this study is for practical reasons somewhat simplified. The human being is here described as existing in three different inner worlds, which are parallel to each other: a mental world, an emotional world, and a physical world. The reason for compartmentalizing human existence into these three worlds (the mind, feelings, and the body) is that they seem to live their own lives inside us to such a degree that they develop independently of each other. Training and teaching (for example in philosophy) can improve our understanding of life. When processing our personal history, therapy can help us towards a healthier emotional life. When we work with our body we become more present in it, less shameful for example about our sexuality, and we can come to

feel that 'the energies flow'. Such subjective experiences seem to be highly important for the cure for alcoholism. But most important is the experience of healing ones existence, of finally being oneself: the person you were meant to be (13). It seems that combining work with the body, the feelings and the mind can give the patient this unique and important experience, which often gives the patients a permanent betterment. This seems to explain the observed large synergy of these three methods. It is important to stress that the effect could also follow from other factors, like a lucky presentation for the subject in the study, rendering them highly motivated for personal development. Our approach differs from the normal approach in that we attempt to solve the inner conflicts that we believe is the real cause of alcoholism. In the AA-program the participant must accept that the urge for alcohol is a permanent feature of the personality, and that the person after successfully completed treatment is a "dry alcoholic". We hope by our holistic approach to help the patient to abandon alcohol and become a whole, happy and free person. The five day treatment consisted of the following three elements and their axiomatic fundamentals: Philosophy of life: find your constructive philosophy of life (use psychotherapy and body therapy)

Our study

The study was an intervention study without a control group. It was not an experiment, but a study based on a pre-experimental design. The group of 232 participants in the course was all alcoholics on disulfiram or Antabus with many years history of alcohol abuse. Common for the group was poor quality of life and many health problems. The end points or dependant variables of the study were quality of life, and self-perceived mental health, and satisfaction with one's health and the number and intensity of the health problems. 18 long-term alcoholics from the town of Elsinore (the city of Hamlet) in the north of Copenhagen, who were treated and followed by the alcohol clinic in Frederiksborg County, enrolled in the course and 16 completed the course. The primary contact was through a lecture on personal development given at the clinic on "How to improve your quality of life". The participants volunteered for the experiment after they had been introduced to the concept and the underlying philosophy of life, whose main message was that all people possess large hidden resources to be used for improving global quality of life and health. The participants were measured the week before and after the five-day intervention course and again after one and three month (response rate 17/18, 14/18, 14/18 and 12/18 respectively). The self-administered 'Questionnaire on Quality of Life and Health for alcoholics' was used. It contains the SEQOL questionnaire for self-evaluation of quality of life and health) (8-10). The first mentioned questionnaire was developed for the Danish 'Quality of Life' Population Survey at the University Hospital of Copenhagen (8,10). The questionnaire contained 317 questions. A qualitative form containing open questions and textual responses was also used and the forms were completed in the usual surroundings of the participants. The group was split into two smaller groups that received therapy simultaneously. Mornings and afternoons were devoted to lectures on philosophy of life to sum up the events of the day and put it into perspective. Evenings were for individual sessions in psychotherapy and body therapy for those especially in need of this. No strangers, observers or friends were allowed into the therapy rooms, while the philosophy room was videotaped for documentation. All participants were bound to

secrecy regarding the experiences of others. The course took place at the education centre "LO Skolen" in Elsinore, Denmark. The following concept for measuring global, generic quality of life was used (8):A clear definition of the quality of life (QOL) A philosophy of life on which the definition of QOL was based on a theory that makes this philosophy operational by deducing questions that are unambiguous, mutually exclusive and comprehensive as a whole and establishing the relative weights of each question. A number of response options that can be quantitatively interpreted on a fraction scale. Technical quality in terms of reproducibility, sensitivity and wellscaledness (appropriate scale characteristics) must be meaningful to researchers, respondents and those who use the results (including criterion validity).

Our findings

Results (see table 1, table 2, and figure 1) are from the four measurements of quality of life, health and dependency of alcohol (sum of symptoms) of the 18 participants with the SEQOL questionnaire (8-10). Immediate subjective well-being was measured with only one question on a five point symmetric Likert scale, as was satisfaction with life and happiness. Satisfaction of needs was measured with five questions about satisfaction of needs according to a modified theory of needs based on Maslow's hierarchy of needs. All five questions were rated on five point Likert scales. The composite global QOL- measure "Family, work, and leisure time" were rating global quality of life at home, at work, and in the leisure time using three questions and three five point Likert scales. The "Quality of relationships" was given an average of the rating of all close relationships on five point Likert scales. Total QOL was calculated as usual in SEQOL that was according to the integrated quality-of-life theory (IQOL theory), except for the objective factors not included in this study (8).

Table 1. Measurings of global QOL and self-assessed health with the SEQOL questionnaire, before and after the 5 day QOL intervention

	T1	T2	T3	T4	T4-T1	*p* Value
Immediate subjective well being	56.7	70.0	75.3	78.3	21.6	< 0.05
Satisfaction with life	60.0	68.6	70.0	75.0	25.0	< 0.05
Happiness	56.7	64.3	64.7	68.3	11.6	ns
Satisfaction of needs	63.2	68.6	67.1	75.0	11.8	< 0.05
Family, work, and leisure time	65.6	71.4	73.3	72.4	6.8	ns
Quality of relationships	60.0	65.4	69.1	68.5	8.5	< 0.05
Total QOL	**57.6**	**64.6**	**66.4**	**69.4**	**11.8**	**< 0.05**
Self-assessed physical health	76.7	71.4	77.1	78.3	1.6	ns
Self-assessed psychological health	50.0	65.0	71.4	74.0	24.0	< 0.05
Satisfaction with health	62.2	65.7	71.3	73.3	11.1	< 0.05
Sum of health problems	5.9	5.4	3.7	3.3	2.6	< 0.05
Total self-assessed health	**63.9**	**67.9**	**72.0**	**76.7**	**12.8**	**< 0.05**

T1: the week before the QOL-course. T2: the week after. T3: one month after. T4: three month after. N is the number of participants answering the questionnaire. N=18 at T1, N=14 at T2, N=15 at T3, and N = 12 at T4. The level of significance for the QOL measures is estimated using table 9.1 in [8] Total QOL is calculated as usual in SEQOL that is according to the Integrated quality-of-life theory (IQOL theory), except that objective factors is not included in this study [see 8]. NS: Non-significant.

Table 2. Health problems, which was relieved by the five day QOL intervention, measured by the SEQOL questionnaire. The health problems was self-assessed on a three point scale, where 1 means no symptoms at all, 2 means that the respondent has the health problem to a small extent, and 3 means that the respondent suffers severely from the health problem

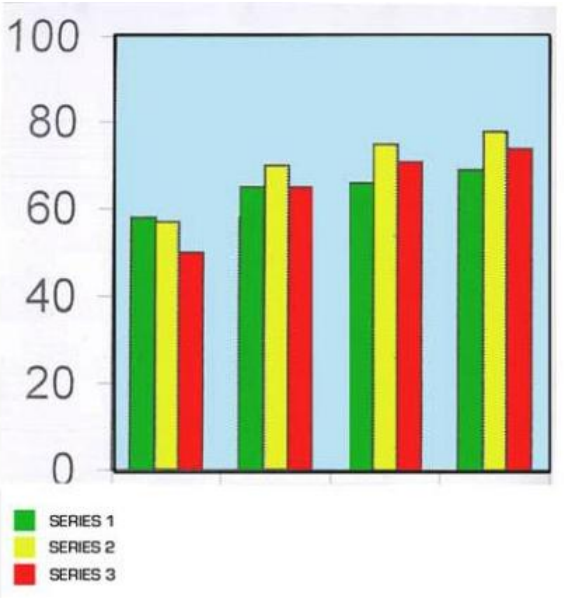
	Measured Before Intervention	Measured After Intervention	*p* Value	N
Pain or discomfort in back or buttocks	1.93	1.67	0.04	15
Headache	1.67	1.40	0.04	15
A rapid heart beat	1.33	1.06	0.04	15
Difficulty sleeping (insomnia)	1.80	1.27	0.001	15
Impairment of memory	1.80	1.27	0.01	15
Melancholy, depression, or unhappiness	1.53	1.00	0.006	15
Indigestion, diarrhoea, or constipation	1.47	1.00	0.01	15
Pain (% of maximum, all measured pains)	37.8%	26.7%	0.005	15
Sum of health problems	5.9	3.3	0.001	14

Health problems not found to be significantly relieved in 235 this study was: Stress; uneasiness, nervousness, restlessness or anxiety; eczema, rash, or itching; cold, head cold or cough; difficulty in breathing or breathlessness. When all pains tested by the questionnaire were summed up to one measure of global, chronic pain, it appears that the pain-level of the participants is relieved by the 5 day QOL intervention, similar to our earlier finding that the QOL intervention is efficient in relieving chronic pain [16]. In this study we find a 29.4% reduction in pain. 44.1% of all health problems disappeared from T1 to T4 as measured by SEQOL. Level of significance is calculated using the TTEST procedure in SAS.

Self-assessed physical health, self-assessed psychological health, and satisfaction with health were all measured with one question using a five point Likert Scale. "Sum of health problems", was a measure of the total amount of health problems and self-assessed on a three point Likert scale, where 1 means no symptoms at all, 2 means that the respondent had the health problem to a small extent, and 3 means that the respondent suffered severely from the health problem. "Total self-assessed health" was calculated as a weighted average of the four health measures as described by Ventegodt (8). The psychometric property of the used five point Likert scale in global QOL instruments was documented in other papers (10,16).

Quality of life

At the first measurement, the quality of life of the participants was clearly below average. The subjective dimensions immediate subjective wellbeing, satisfaction with life and happiness rated 56.7%, 60.0% and 56.7% respectively as compared to normally about 70.0% for these dimensions. This group was really low in QOL. Compared to this, quality of life at the second measurement was considerably higher and a little below the normal level. Immediate subjective well-being, satisfaction with life and happiness rated now 70.0%, 68.6% and 64.3% respectively. The improvement was immediate and surprisingly large.



See table 1 for the data. T1: the week before the QOL-course. T2: the week after. T3: one month after. T4: three month after.

Figure 1. Immediate subjective total QOL (gray), well-being (white) and psychological health (black) before, and one week, one month and three month after the 5-Day QOL intervention as measured by the SEQOL questionnaire. It is interesting that the participants seemed to continue to improve their QOL and health in months after the intervention. We believe that this is because they were using the tools and concepts for personal development they were trained to use during the 5 day QOL course.

We now expected the values to slowly return to normal, but we found at the third and fourth measuring that QOL was still increased. The third QOL measuring showed that immediate subjective well-being, satisfaction with life and happiness rated 75.3%, 70.0% and 64.7% respectively. The fourth QOL measuring showed that immediate subjective well-being, satisfaction with life and happiness continued upwards to almost incredible values of 78.3%, 75.0% and 68.3% respectively. It must be admitted that we lost five of the participants during this period so that response rate felt down to 66.6%, but this is still fair even if it can explain some of the difference. But in the end of the study the participants could not be discriminated from the normal population by their global QOL ratings.

Health

Data on health problems were collected by means of a questionnaire on health problems included in SEQOL with some questions originally developed by the Danish Institute for Clinical Epidemiology (DICE). Before the QOL course the first measurement showed a considerable difference between the 18 participants and the general population with regard to health. The self-assessed physical and mental health rated 76.7% and 50.0% respectively, the first being normal, the second far below population average of 71.0%, but equal to that of mental health patients. Satisfaction with health rated 62.2% compared to an average of the general population of 72.0%. Another important health dimension was the number and

intensity of symptoms from all the organs systems of the organism. We had included a screening of this, which we called the sum of symptoms. The group rates 59.0% of maximum before the QOL intervention. This was a very negative result and far below the average of the general population. The calculated 'total health' based on these data was assessed to 63.9% compared to the general level of 71.0% in the normal population, a difference of 9.8% and 7.1%, respectively.

The most important observation here seems to be the self-assessed mental health, in accordance with the hypothesis that psychological pain and discomfort was the real, but hidden reason for the dependency of alcohol. Immediately after the five day QOL course, the second measurement showed a considerable improvement in self-assessed mental health (while the physical health went down). The self-assessed physical and mental health now rated 71.4% and 65.0% respectively, both now being within the normal range. Satisfaction with health rated 65.7% coming close to the general population of 72.0%. Sum of symptoms now rated to 54.0% of maximum, before the QOL intervention, still rather bad and below the average. The calculated 'total health' was now assessed to 67.9%, also close to normal. As was the case with the QOL, health also continued to improve in the month after the course. One month after the five day QOL course, the third measurement again showed a considerable improvement in self assessed mental health now rating 71.4%. The physical health had now risen to 77.1% respectively. Satisfaction with health rated 71.3% identical to the rating of the general population of 72.0%. Sum of symptoms rated 37.0% of maximum in the third measurement, a remarkable improvement. The calculated 'total health' was now assessed to 72.0%, which was normal. The fourth measuring showed that self-assessed mental health rated 74.0%. The physical health rated 78.3% respectively. Satisfaction with health rated 73.3%. Sum of symptoms rated 33.0% of maximum, a surprising development. The calculated 'total health' was now assessed to 76.7%. We had some scepticism about the results and therefore make a conservative calculation of our results. Even if we took an average of the two first measurings as basis and compared this value with the two later 238 measurings, the improvement was both statistically significant and remarkably large (see table 1). A very interesting observation was that the holistic cure seemed to alleviate symptoms from all organs systems, like upper and lower back pain, depression and unhappiness, indigestion, palpitations, impairment of memory, insomnia and headaches (see table 2). Pain in general was reduced by 29.4% in accordance with earlier findings that the 5-day QOL cure is efficient in relieving chronic pain (17).

Discussion

We were genuinely surprised that quality of life (QOL) and health, especially self-assessed mental health, seemed to continue improving in months after the five day QOL-course. We believe this is primary a consequence of the philosophy of life that stresses personal development. The size of the changes in quality of life, health and alcohol dependency were generally unexpectedly large. Considering that only a five-day course of intervention took place, the difference of 10-20% in the above-mentioned dimensions from before till after the course must be seen as great and distinctive. We were quite happy with the therapeutic results after the course, but had a conservative expectancy to the outcome during time as it is

normally believed that life cannot be changed in a few days, but that the QOL only temporary can be improved. The fact that the gains of the participants were still increasing three months later is promising, but still it is not likely that they become permanent without reinforcement, although it seemed fair to expect that the measured QOL- and health dimensions will not return to their previous low level.

Good attitudes are known to decay over time and must be reinforced constantly, something that is part of human nature. The new understanding of life and understanding of the basic principles of personal development, which the course provided to the participants, were thought to be more permanent. It must be considered a possibility that we collected patients that were highly motivated for personal development, so that the participants were different from the average alcoholic. The area from which we recruited the participants (the North part of Sealand) is known to have a higher socioeconomic level than the rest of Denmark and it is possible that the participants were higher motivated and more resourceful than the average Danish alcoholic. The scientific method suffered from the lack of a control group, because it is easy to suspect that just being removed from your every-day routine and placed together with others in a beautiful conference centre next to the sea for five days and nights will make a great momentary difference to your quality of life. The group was well-known as chronically, mental ill from sulfiram or Antabus-resistant alcohol dependency and we believe that the treatment group was typical for the heavy segment of the Danish alcoholics, but they might be more motivated than average to help themselves, because of the way they were initially recruited (by a lecture recommending intensive, personal development). At the beginning of the course the participants were socially poor functioning and none of the participants were able to work. We made a two day follow up for the group after six month and were informed that three of the participants had got a job six months after intervention, and that nine of the 16 participants, who did complete the course were feeling a lot better than before the course. Most of the participants continued drinking, but they noted that the drinking patterns had changed from weeks of uncontrolled abuse to just a few days tour with much more control. This pilot study looks promising, but no final conclusions can be made, since it is important to repeat such a study under clinically controlled conditions with a larger number of participants and a longer follow up.

Conclusion

Our pilot study showed apparently that a five day QOL course combining training in philosophy of life, psychotherapy and body therapy can give an alcohol abusive person a large, fast and efficient improvement in quality of life, health and reduce alcohol dependency. This is in support of the hypothesis that people drink, because of psychological and existential pain and discomfort. It is not known whether these changes will be permanent or if these promising results can be reproduced in a controlled clinical trial with more participants. Further research in this regard with control groups should be conducted. We hope to be able to follow the Cochrane standard in future "QOL as medicine" studies. We also hope that the international medical community will find this new approach interesting and join us for future cooperation. We hope and encourage that the powerful medical institutions of this world, like

university hospitals, private foundations, sponsors, and governments will support this promising line of holistic medicine and psychosomatic research.

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Chapter XIII

Psychoactive drugs and quality of life

In this chapter we describe a representative sample of the Danish population, where we investigated the connection between the use of psychoactive drugs and quality of life (QOL) by way of a questionnaire based survey. The questionnaire was mailed to 2,460 persons aged between 18-88 years, randomly selected from the CPR (Danish Central Personal Register) and 7,222 persons from the Copenhagen Perinatal Birth Cohort 1959-61. A total of 1,501 persons between the ages 18-88 years and 4,626 persons between the ages 31-33 years returned the questionnaire (response rates 61.0% and 64,1% respectively).

Variables investigated in this study were ten different psychotropic drugs and quality of life. Our survey showed that over half the Danish population had used illegal psychotropic drugs. The most commonly used was cannabis (marijuana) though experience of this drug appeared not to co-vary with QOL to any significant extent. Cocaine, amphetamine and psilocybin had been used by 1.2- 3.3% of the population and this varied with QOL to a clear albeit small extent. LSD has been used by 1.2% of the population and the users had a QOL score 10% lower than people, who had never used psychotropic drugs. The group with the lowest quality of life was found to be persons who had used heroin, morphine, methadone and a mixture of alcohol and tranquillisers (10-20%) below the group with the highest quality of life.

Introduction

It is generally assumed that the use of euphoric or conscious altering drugs is detrimental to the quality of life (QOL). However, there are very few studies documented in the literature that have investigated this assumption. For non-clinical populations we could not find research performed and studies with an element of quality of life measurement were restricted to opiate users receiving treatment from various agencies (1-7). Due to the scarcity of such studies it was difficult to gain an overall picture of the connection between drug use and quality of life. Furthermore, the quality of life measures and methods that have been used vary considerably, so conclusions are difficult to draw. Non-opiate, non-agency samples though more representative of national patterns of illicit drug use have been relatively neglected and knowledge on this group limited. A better knowledge of the use and misuse of

illicit drugs and the effect they have on quality of life was therefore desirable. It is important that the practitioner is aware of the relationship between psychotropic drugs and quality of life, so that he or she may offer suitable help to alleviate the problems presented. We therefore used the results of a cross-sectional survey examining close to 10,000 Danes to investigate the prevalence of drug use in the Danish population and compare with their quality of life.

The question-measures on the use of psychotropic drugs were multiple-choice, where the respondent could mark an earlier or present use of the following drugs: 1. Hashish/cannabis/marijuana; 2. LSD; 3. Psilocybin (mushrooms); 4. Mescaline (cactus); 5. Amphetamine, speed; 6. Cocaine; 7. Crack; 8. Ecstasy; 9. Methadone; 10. Heroin, morphine; 11. Tranquillisers with alcohol.

For the discrete variable (e.g. use of a given drug) the average quality of life of the group that had used the drug was compared with the average quality of life of population or cohort as a whole. Even though in this isolated case, it would have been more suitable to compare with those that did not have the problem, the above comparison was chosen to allow comparisons with correlations of other variables examined in this study. The variation over the measured interval was given both as an absolute number and a percentage of the population's or the cohort's average quality of life. This number can be compared from variable to variable, so that the size of the correlation between quality of life and a specific variable (e.g. an experience of cannabis) can be compared with the size of the correlation between quality of life and other variables (e.g. an experience of cocaine). These varying degrees of correlations between quality of life and different measured variables were divided into five classifications, which qualitatively compensated for the possibility that the measured variable, directly or indirectly, formed part of one or more of the eight quality of life measures. The observed deviation in the size of these correlations translated into the following categories: "very small" (responses corresponding to a correlation of 0% - 5%), "small" (5% - 10%), "intermediate" (10% - 20%), "large" (20 - 40%), "very large" (over 40%). Please note that the number of crack and ecstasy users at the time of the survey were too small to give significant measures for these groups.

What we found

Hallucinogens became extremely popular in Denmark during the youth revolution of the 1960s, and the use of cannabis among the young believed (despite legislation making these drugs illegal) to be almost as common as tobacco and alcohol. Hallucinogens are characterised by their wide-ranging psychological effects. They vary in strength from the mild, such as cannabis to the strong, like psilocybin or LSD.

Cannabis/hashish/marijuana

Cannabis use in Denmark, like alcohol, tends to be recreational. The dose price ratio for this illegal drug is often considerably lower than the dose price ratio for alcohol. 55.7% of the 31-33 year olds (RH sample) and 24.9% of the population sample (CPR) had used cannabis (see

table 1 and 2). Among the 31-33 year olds those that had used cannabis had a QOL score 4.0% below the cohort's mean QOL score, while for the population sample, those that had used cannabis had a QOL score 2.8% below the general population mean QOL score, this is a small but significant correlation (see table 3 and 4).

Tables 3 and 4 shows the correlation is consistent through the eight quality of life measures.

Table 1. Quality of Life at Ages 31 to 33 Years vs. Experience of a Given Drug

	%	1		2		3		4		5		6		7		8		Overall QL (Weighted)	Test (p–value)
No Drugs	42.9	73.2	1979	71.0	1978	67.7	1979	69.8	1818	76.3	1952	69.1	1909	63.1	1966	74.9	1936	71.7	** 0.0001
Cannabis	55.7	71.1	2570	68.2	2571	65.1	2567	67.2	2349	73.9	2534	65.6	2502	60.1	2563	71.9	2516	68.9	** 0.0001
LSD	3.0	67.6	141	62.5	141	62.1	141	65.4	123	73.0	133	60.9	136	54.6	139	63.1	134	63.5	** 0.0001
Psilosybin	5.1	69.2	234	66.2	234	63.2	234	65.9	205	73.8	225	62.0	225	56.7	232	65.5	225	65.4	** 0.0001
Amphetamine	14.3	69.0	662	65.3	662	62.9	662	65.1	596	72.7	644	62.8	640	57.4	656	67.0	642	65.8	** 0.0001
Cocaine	6.0	68.8	279	66.3	279	64.1	279	66.9	245	74.1	269	63.4	267	57.4	277	67.3	267	66.4	** 0.0001
Crack	0.1	50.0	5	50.0	5	38.0	5	48.1	4	48.1	4	55.0	4	51.0	4	60.7	4	—	—
Ecstasy	0.3	68.6	15	62.0	15	59.3	15	63.4	14	70.4	14	59.4	14	55.9	14	64.6	14	—	—
Methadone	1.4	62.2	64	59.7	64	59.1	64	64.8	53	71.8	56	60.7	58	53.6	62	56.8	61	59.9	** 0.0001
Heroine, morphine	2.8	63.5	130	61.2	130	58.9	130	64.4	106	72.5	121	61.1	121	55.4	128	61.9	119	62.2	** 0.0001
Tranquillizers and alcohol	4.7	62.4	218	59.6	218	58.4	218	61.3	187	68.7	207	59.4	210	54.0	215	60.5	202	60.5	** 0.0001
Overall average; Total number		70.7	6277	68.0	6277	65.1	6274	67.5	5682	74.3	6141	65.7	6068	60.0	6238	71.0	6102	68.6	

*The columns show: the percentage who tried the drug mentioned; the average QOL Score (on a 0–100 scale), the number of respondents in each group; the overall QOL score and resulting p value.

Columns: 1 – Immediate, self–experienced well–being; 2 – Life satisfaction; 3 – Happiness; 4 – Fulfillment of needs; 5 – Experience of objective, temporal domains (family, work, leisure); 6 – Experience of objective, spatial domains (self, others, world); 7 – Expression of life's potentials; 8 – Objective factors

Table 2. Quality of Life the CPR Group vs. Experience of a Given Drug

	%	1		2		3		4		5		6		7		8		Overall QL (Weighted)	Test (p–value)
No Drugs	74.5	72	1083	70	1079	66	1081	70	958	77	1020	70	976	46	1070	70	982	68.3	** 0.0001
Cannabis	24.9	71	367	68	367	65	367	67	338	74	359	66	352	44	367	68	352	66.5	** 0.0001
LSD	1.2	65	17	62	17	58	17	58	15	71	16	64	16	41	17	66	17	61.9	** 0.0001
Psilosybin	1.2	74	18	63	18	63	18	67	16	73	18	64	17	42	18	69	18	65.9	** 0.0001
Amphetamine	3.3	74	49	70	49	65	49	68	48	75	49	66	45	44	48	71	46	68.1	** 0.0001
Cocaine	1.2	66	17	61	17	57	17	58	16	70	17	60	16	38	17	57	17	58.3	** 0.0001
Methadone	0.4	63	6	60	6	57	6	54	5	71	6	55	6	33	6	54	6	55.7	** 0.0001
Heroine, morphine	0.5	73	6	67	6	50	6	57	6	67	5	62	5	42	6	65	6	61.7	** 0.0001
Tranquillizers and alcohol	0.5	67	7	61	7	53	7	58	7	72	6	61	6	38	7	49	6	55.6	** 0.0001
Overall average; Total number		72.1	1570	69.2	1566	65.3	1568	68.9	1409	75.8	1496	68.9	1439	44.9	1556	69.0	1450	67.5	

*The columns show: the percentage who tried the drug mentioned; the average QOL Score (on a 0–100 scale), the number of respondents in each group; the overall QOL score and resulting p value.

Columns: 1 – Immediate, self–experienced well–being; 2 – Life satisfaction; 3 – Happiness; 4 – Fulfillment of needs; 5 – Experience of objective, temporal domains (family, work, leisure); 6 – Experience of objective, spatial domains (self, others, world); 7 – Expression of life's potentials; 8 – Objective factors

Table 3. Quality of Life at Ages 31 to 33 Years vs. Experience of a Given Drug

	%	1	2	3	4	5	6	7	8	Overall QL (Weighted)	Test (p–value)
No Drugs	42.9	1.8	2.3	2.3	2.2	1.9	3.0	2.8	2.4	2.8	** 0.0001
Cannabis	55.7	–1.2	–1.6	–1.6	–1.6	–1.4	–2.3	–2.1	–1.7	–2.1	** 0.0001
LSD	3.0	–6.0	—9.9	–6.2	–4.3	–2.6	–9.2	–11.0	–13.8	–11.0	** 0.0001
Psilosybin	5.1	–3.7	–4.5	–4.5	–3.6	–1.4	–7.6	–7.7	–10.4	–7.7	** 0.0001
Amphetamine	14.3	–4.0	–5.8	–5.0	–4.8	–2.9	–6.4	–6.5	–8.3	–6.5	** 0.0001
Cocaine	6.0	–4.3	–4.3	–3.2	–2.1	–1.1	–5.5	–6.5	–8.0	–6.5	** 0.0001
Crack	0.1	–30.5	–27.9	–42.6	–29.6	–26.6	–24.0	–26.9	–17.0	–26.9	—
Ecstasy	0.3	–4.5	–10.6	–10.3	–7.2	–5.9	–11.4	–9.0	–11.6	–9.0	—
Methadone	1.4	–13.5	–13.9	–10.7	–5.2	–4.2	–9.6	–12.8	–22.3	–12.8	** 0.0001
Heroine, morphine	2.8	–11.6	–11.7	–10.9	–5.7	–3.2	–9.0	–9.8	–15.4	–9.8	** 0.0001
Tranquilizers and alcohol	4.7	4.7	–14.0	–11.7	–10.3	–8.2	–11.4	–12.0	–17.3	–12.0	** 0.0001
Overall average; Total number	42.9	1.8	2.3	2.3	2.2	1.9	3.0	2.8	2.4	2.8	

The columns show: the percentage who tried the drug mentioned, the deviation from average QOL score in the measures 1-8; the deviation from the overall QOL score; the resulting p-value.

Table 4. Quality of Life the CPR Group vs. Experience of a Given Drug

	%	1	2	3	4	5	6	7	8	Overall QL (Weighted)	Test (p–value)
No Drugs	75	0.5	0.9	0.7	1.0	1.0	1.6	1.4	0.6	0.9	** 0.0001
Cannabis	25	–0.8	–2.1	–0.8	–2.8	–2.4	–4.1	–2.9	–1.3	–1.91	** 0.0001
LSD	1	–9.4	–11.1	–11.1	–15.9	–6.2	–8.3	–9.9	–5.2	–8.6	** 0.0001
Psilocybin	1	3.3	–8.8	–3.3	–3.3	–4.5	–6.9	–7.4	0.1	–2.8	** 0.0001
Amphetamine	3	2.8	0.8	–1.2	–1.7	–0.9	–5.2	–1.7	3.1	0.5	** 0.0001
Cocaine	1	–7.7	–12.8	–12.9	–15.9	–7.4	–13.2	–15.5	–18.1	–14.1	** 0.0001
Methadone	0.4	–12.1	–13.6	–13.5	–22.1	–6.4	–20.6	–26.2	–22.4	–18.1	** 0.0001
Heroine, morphine	0.5	1.8	–4.0	–23.6	–18.3	–11.4	–10.5	–7.1	–6.2	–8.9	** 0.,0001
Tranquilizers and alcohol	0.5	–6.8	–11.6	–19.3	–17.1	–5.0	–11.5	–14.8	–29.3	–18.0	** 0.0001
Overall average; Total number	42.9	1.8	2.3	2.3	2.2	1.9	3.0	2.8	2.4		

The columns show: the percentage who tried the drug mentioned, the deviation from average QOL score in the measures 1-8; the deviation from the overall QOL score; the resulting p-value.

LSD (Lysergic acid diethylamide)

Since its emergence in the 1960s as a cult drug, LSD has typically been used by the experimental youth of Denmark as a chemical short-cut to transcendental experience and introspection or as an escape from the established values and behaviour patterns of society. 3.0% of the 31-33 year olds and 1.2% of the population sample had used LSD (see table 1 and

2). The 31-33 year olds who had used LSD had a QOL score 11.6% below the cohort average, while for the population sample it was 9.5.% below population average, which again is a small, but a significant correlation. Tables 3 and 4 demonstrate that the connection was uniform through all eight quality of life measures with a tendency to be bigger in the objective measure for the 31 - 33 year olds.

Mescaline

Mescaline is found in a variety of hallucinogenic cacti, such as peyote and Don Pedro and was traditionally used by Native Americans for medicinal and ceremonial purposes. In Denmark it is an illegal synthetic drug and used in much the same way as LSD, though it is said to give a "softer" and more "bodily" experience. 1.2% of the 31-33 year olds had used mescaline and 0.2% of the population sample (see table 1 and 2). The group of 31-33 year olds that had used mescaline have a QOL score 11.6% below the cohort's average score.

Psilocybin

It is now common knowledge that a number of wild Danish mushrooms contain the hallucinogenic agent psilocybin. Psilocybin mushrooms, traditionally used by Native Americans, are used in Denmark for much the same purpose as LSD. This research together with others (8) suggested that psilocybin was the most frequently used hallucinogenic in Denmark. One explanation for this may be the common perception that the psilocybin trip is less dangerous for the psychological balance. 5.1% of the 31-33 year-olds had used psilocybin and 1.2% of the population sample (see table 1 and 2). The 31-33 year-olds who had used psilocybin had a QOL score 8.9% below the cohort mean, while the population group for those who have taken psilocybin was 3.7% below the mean QOL score, which we classify as a small, but significant connection. Tables 3 and 4 show that the connection is uniform through all quality of life measures with a tendency to be a little larger in the objective measure for the 31-33 year olds.

Stimulants

While hallucinogenic drugs alter experience, the stimulants work only to amplify feelings and/or mental activity. Ecstasy is placed on the borders between these two, while the normal course of intoxication is said to be a temporary amplification of feelings and hallucinations can be experienced.

Amphetamines

Amphetamines have a profoundly stimulating and arousing effect on the central nervous system. In Denmark it is typically used by the young, who wants extra energy and an

enhanced state of mood at social occasions. Amphetamines are significantly cheaper than cocaine on the street, but the effect is said to be almost the same except that the amphetamine trip lasts about 10 times as long. 14,3% of the 31-33 year olds and 3.3% of the population sample had used amphetamine. Of the 31-33 year olds, who had used amphetamine, 8.4% had a QOL score below the cohort mean QOL and for the population group 0.7% had a QOL score below the mean, which is a small, but important and significant connection. Tables 3 and 4 shows that the connection is consistent through all eight QOL measures. The results do not strongly support the hypothesis that amphetamine is detrimental to quality of life. Physicians and social welfare agencies should though be aware of the use of amphetamine by the young to boost a low self-confidence in a social connection. Low self-confidence is statistically linked to low quality of life (9,10) and therefore can be an explanation of the correlation.

Cocaine

Cocaine has been used as a stimulant by the Indians of Central America. Like amphetamine it gives an enhanced sense of mental and physical energy and elevates the mood, but is - probably because of the high price - a lot less prevalent. Of the 31-33 year olds 6% had used cocaine, while only 1.2% of the population sample (see table 1 and 2). Of the 31-33 year olds, who have used cocaine, 7.6% had a QOL score below the average for the cohort, while for the population sample, those who had used cocaine, had a QOL score 15% below the average. This is a small to intermediate, significant connection.

In tables 3 and 4 it is shown that the connection is uniform through all eight measures, though there is a tendency for the connection to be bigger in the objective measure. The results supported, to a degree, the hypothesis that cocaine was detrimental to quality of life, although it is not known if the low QOL leads to the use of cocaine. Cocaine, as with amphetamine, is used mainly by the young to boost self-confidence in social situations. Low self-confidence is directly correlated to a lower quality of life (9,10) and this could be a possible explanation of the connection found with quality of life. This may mean that drugs such as cocaine are in themselves not dangerous, but their use functions as indicator of a weaker, vulnerable and marginalized group.

The relatively low objective quality of life we find within the group that has tried cocaine (18.7% and 10.4% respectively below the groups that had not used drugs) is thought to support this hypothesis.

Euphorics

Euphorics are drugs that are said to produce mental calmness, sedation and a euphoric detachment. An effective adaptation in the brain gives these drugs the capacity to create a strong physical dependence. The drugs are typically from the opiates and among regular users heroin is the drug of choice, because of sudden high - "rush" - it gives when injected.

Heroin/Morphine

Heroin is widely prevalent in Denmark and very strict prohibition has not had any effect in limiting its prevalence (11,12). Indeed, prohibition may have increased the commercial attractiveness of the drug to the criminal underworld. In Denmark, young people typically use heroin and other opiates in order to cope with existential discomfort.

A parallel study in which we examined 50 heroin users showed that this group, in relation to the population in general, were more likely to have had a far worse background in terms of major traumatic events in childhood, like neglect, abuse and sexual abuse (unpublished data). Of the 31-33 years old 2.8% had used heroin/morphine and 0.4% of the population sample (see table 1 and 2). Those of the 31-33 year olds, that have used heroin/morphine, had a QOL score 13.5% below the cohort average and for the population sample, those who had used heroin/morphine had a QOL score 9.8% below the population average, which is classified as an intermediate connection. Tables 3 and 4 shows the connection is uniform through the eight QOL measures. Presumably only a proportion of the 130 aged 31-33 years that experimented with heroin/morphine developed dependence and heavy users are unlikely to answer a questionnaire. On the basis of the present research, it is difficult to make any conclusions with respect to the hypothesis that a few experiences with these drugs are detrimental to quality of life.

Methadone

In Denmark methadone is distributed to registered drug addicts. Its prevalence on the black market is mainly due to heroin addicts selling these prescribed rations to buy heroin instead. 1.4% of the 31 -33 year olds had used methadone and 0.4% of the population sample (see table 1 and 2). The 31-33 year olds were 16.6% below the mean QOL (see Table 3). Methadone users lie markedly low in objective quality of life, expressed in terms of social status and the wealth a person has attained: financial, physical and social.

Polyuse

Polyuse is illustrated in this study by use of an example, namely the combination of alcohol with diazepam/valium (a widely prevalent benzodiazepine). There is a powerful synergy between these two drugs, when taken together give a very strong intoxication. 4.7% of the 31-33 year olds had used this mixture (see table 1) and the group had a QOL score 15.9% below the average (see table 3). This corresponds closely with methadone misuse and we also saw a large overlap between these two groups. Multiple misuses are the cheapest form of chemical escape. It gives a powerful intoxication rather than a general feeling of euphoria and is thus an effective way of dealing with severe existential discomfort. From the data it seemed mixed drug use was just as damaging to QOL as heroin or morphine. However, it seems unlikely that the mixture of diazepam and alcohol, in itself, should be especially detrimental to quality of life. It is more probable that a low quality of life makes polyuse seem attractive. It is

unlikely that legislation against the problem of multiple uses could be made, since this would entail removing either alcohol or benzodiazepine from the Danish population.

Discussion

The use of conscious altering drugs is widespread in Denmark. We found a small to intermediate correlation with quality of life (QOL). The connection was often a little bigger objectively than subjectively. Mixed use of socially acceptable drugs thought to be relatively harmless like alcohol and diazepam (Valium) showed just as large a connection to quality of life and a similar prevalence as the so-called "hard" drugs, like heroin, cocaine and LSD. Most of the hallucinogenic drugs had a relatively weak connection to quality of life with cannabis having a very modest correlation. The stimulants showed the same modest connection. The depressants showed an intermediate and significant connection with quality of life. It should be considered whether the statistical connection is caused by adverse effects of the substance or through attempts to treat personal problems such as psychosis, low self-confidence or existential discomfort. It was found that approximately half of the Danish population have used illicit drugs. It seems that both mixing legal drugs to derive a similar effect as illegal drugs are widespread. By far the majority of these people have taken the drugs independently of illness, which presumably means that the use of drugs will not be discovered by the general practitioner in the normal course of a consultation. Those that have used psychotropic drugs have, in general, a QOL score that is about 5% under the population average.

There is a need for a discussion by physicians and social welfare workers and agencies as to determine what the practical consequences of this ought to be. However, in situations where a patient describes general feelings of discomfort it may be beneficial for the physician to approach the subject of drug use. It is important to admit that such a small difference in QOL could be more important that it seems, as there presumably is a strong statistical connection between QOL and functional ability in general. In a competitive society a loss of e few per cent of a person’s functional ability can actually be important when it comes to job application etc. Of course one cannot claim that the use of psychotropic drugs is the cause of a low QOL. Quality of life is a very complex entity that involves all aspects of life like attitudes, behavioural habits, relationships, understanding of life and self, and self-expression. It is developed throughout life from the earliest childhood. It is therefore much more likely that a low quality of life encourages drugs use. It seems highly relevant to think of the use of psychotropic drugs in terms of self-medication. After diagnosis of a drug problem, as with other problems, it is tempting to take a direct approach and suggest reduced dosage regimens, detoxification with monitoring of blood and urine. The presented modest, albeit clear connection between use of drugs and quality of life suggests that working with quality of life and human relations in general may be a fruitful exercise. A better relationship to self, partner, family, work place or friends could probably, in most cases, lead to direct solutions of many of the problems underlying misuse. From the point of view of society and public health, serious consideration ought to be given to the prohibition of drugs. Evidently it does not have a considerable effect on the availability of drugs in the market place, and in many cases forces young people into a world of criminality and prostitution. In our society

resources might be spent more wisely on supporting the low QOL fractile of the population to a better QOL, instead of criminalizing a use of the psychotropic drugs that in many cases looks more like justified self-medication for pour QOL than as a criminal activity chosen by a healthy and sound person by free will.

Conclusion

Experience of hallucinogenic and other psychotropic drugs is prevalent in the population and more the rule than the exception in the younger population. Only the use of euphoric drugs showed a significant connection of intermediate size with quality of life. Since it is not clear whether the use of the drug itself leads to a poor quality of life or whether it is a poor quality of life, which leads to self-medication with drugs, it is suggested that the physician in general practice and the social welfare worker and agencies consider, together with detoxification and therapy, also more general attempts to provide the patient/client with resources that may help them improve their quality of life.

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Chapter XIV

Coronary heart disease

Dean Ornish at the Preventive Medicine Research Institute in Sausalito, California, has created an intensive holistic treatment for coronary heart patients with improved diet (low fat, whole foods, plant-based), exercise, stress management and social support that have proven to be efficient. In this chapter we analyse the rationale behind his cure in relation to contemporary holistic medical theory. In spite of a complex treatment program the principles seem to be simple and in accordance with holistic medical theories, like the Antonovsky concept of rehabilitating the sense of coherence and the life mission theory for holistic medicine. We believe there is a need for the allocation of resources for further research into the aspects of holistic health and its methods, where positive and significant results have been proven and re-produced at several other sites.

Introduction

Holistic medicine can be an efficient tool in cases, where the goal of intervention is in the improvement of global quality of life (QOL), health and ability of the patient (1-11). In the past decade, holistic medicine with a focus on improving the quality of life of the patient has shown remarkable results in several studies published in the most recognised medical journals (12,13), even with cancer and coronary heart disease. The field has been difficult to approach from a theoretical perspective, as the depth of consciousness and experience still is out of the reach of established medical science. In spite of this, several theories of the connection between QOL seems to be very meaningful and also to some extend documented, like the work of Aaron Antonovsky (1923-1994) on sense of coherence (14-17), the work of Abraham Maslow (1908-1970) on needs (18) and Viktor Frankl (1905-1997) on meaning (19). Our own theory of the purpose of life (the Life Mission Theory) has tried to crystallise the essence on the basis of the work done by these pioneers (20-26). Everybody will eventually die and most from coronary vessel failure. It is extremely interesting to look at the research by Dean Ornish, MD (founder, president, and director of the non-profit Preventive Medicine Research Institute in Sausalito, California. He is Clinical Professor of Medicine at the University of California, San Francisco and received his medical training from the Baylor College of Medicine, Harvard Medical School and the Massachusetts General Hospital), who for the past

25 years has directed clinical research demonstrating that comprehensive lifestyle changes may begin to reverse even severe coronary heart disease, without drugs or surgery and it seems that he is able to heal at least a fraction of these patients (13,27-29). In this chapter we intent to analyse his cure for coronary heart disease to see if we can find it related to and substantiated by contemporary holistic medical theory, in the same way as we have analysed the work of Ryke Geerd Hamer, MD on cancer (30).

Preventive medicine research institute, Sausalito, California

Statistically, one Dane in two will die from a cardiovascular disease. Most "heart conditions" are due to a constriction in the coronary arteries from atherosclerosis. Keeping heart and blood vessels healthy are therefore very important to our life expectancy and well-being. Within the last decade, holistic medicine has achieved a break-through in the understanding and treatment of heart conditions. With this new angle on body and soul it is possible to make even very advanced heart disease disappear, when the patients work on themselves. Many scientific measurements have shown that the constricted coronary arteries are able to physically expand again. The pioneer within this field and a great source of inspiration is Dean Ornish.

Ornish et al (31) already in 1983 published a study to evaluate the short term effects of intervention (stress management training and dietary changes) in patients with ischemic heart disease (IHD), who received the intervention and 23 controls. After 24 days the experimental group had a 44% mean increase in duration of exercise, a 55% mean increase in total work performed, a 20.5% mean decrease in plasma cholesterol and a 91.0% mean reduction in angina episodes. It was a break-through for holistic medicine in 1990, when Ornish et al (13) demonstrated that patients through change of life can make their constricted coronary arteries expand again. This was a one- year follow-up study of 28 patients (with 20 controls), who changed their lifestyle radically. They began to eat low far vegetarian diet, they stopped smoking and they worked in a purposeful manner to lift the 261 stress through stress management training (meditation) and moderate exercise. Artery lesions analysed by quantitative coronary angiography showed regression in stenosis diameter and overall 82% of the experimental group had an average change towards regression, even in severe coronary atherosclerosis after one year without use of lipid reducing drugs. His key tools are love, intimacy and a new life philosophy in our interpretation of his intervention. The treatment regime affects many aspects of life. As far as we can see, the regime was designed to give the patient a feeling of being more whole and healthy. It addressed the patient's perceptions and consciousness. To us, this points to the real cause of cardiovascular disease – and of any number of other disorders and ailments – our self-created, non-optimal perception of ourselves, our lives and our bodies.

In 1998 these pilot studies were further expanded with 194 in the experimental and 139 in the control group (32) and it was found that the experimental group (with the training and changes listed above) was able to avoid revascularization for at least three years by making comprehensive lifestyle changes at substantial low cost without increase in cardiac morbidity or mortality. At this five year follow-up (33) 48 patients with moderate to severe coronary

disease were randomised to an intensive lifestyle change group or to the usual care group and 35 completed the five year follow-up quantitative coronary angiography at two tertiary care university medical centres. More regression of coronary atherosclerosis occurred after five years than after one year in the experimental group, while the control group showed coronary atherosclerosis progression and more than twice as many cardiac events. A study in 2003 with 440 patients (35) (mean age 58 years, 21% women) with coronary artery disease at baseline and at three and twelve month follow-up showed significant improvements due to the intervention program for both genders and in both the medical and psychosocial sphere. The improvement in women was similar to than in the men, which is important because women in general have higher morbidity and mortality after a heart attack, angioplasty or bypass surgery.

A scientific explanation

Atherosclerosis is not a phenomenon that can be understood in a purely mechanical manner the way we understand lime scale in a coffee maker. Blood vessels are damaged, because the cells do not work the way they should, but "scamp" and build delicate and sickly vessels. According to holistic medicine the cells are "scamping", because their work is disturbed. The disturbing factor seems to be our repressed feelings acting as blockages. They are identifiable in the patient's body as muscle tensions and tender "trigger points", sites in the body that become especially tender, when we restrain our feelings. These trigger points are also popular "points of attack" in the treatment for the holistic body therapist by acupressure or other techniques.

Our favourite approach is direct interaction with the patient's consciousness, where gestalts are identified and integrated. We believe that acupressure and body therapy are needed less, when the patient is cooperative and willing to work on himself. Conversation is the most effective tool we know. Holistic medicine works by helping the patient to feel his blockages and old life pain in his body. Then the patient is helped to understand the correlation between body and soul in order to formulate difficult feelings. Finally the patient will acknowledge his inappropriate decisions in life, which have restrained the problems in the body up to the present.

As soon as we acknowledge the perceptions and viewpoints we harbour against life, we can let go of them and change our perspective to a happy and trusting philosophy of life, where we openly and honestly feel life as it is and accept it as a gift. Patients with a heart condition need a program focusing on improving the quality of life with a combination of life philosophical tuition, training and supervision.

Dean Ornish use the expression "opening the heart" – physically, emotionally and spiritually and the clever backbone of his course of treatment (and one that we use in our research clinic in Copenhagen) is an individual program that combines holistic medical treatment with a personal development program for the patient to carry out on his or her own. The patient, who has experienced heart problems before is offered "secondary prevention" in the form of a personal development program that should counteract any future heart conditions.

Case stories

Male, aged 43 years with heart problems. For a month he has had transient attacks during which he felt poorly with pain in right arm and right side of the head. He believes that his heart is not beating quite the way it should. He also has some existential aspects that need looking at. On examination: Auscultation of the heart, lungs and blood pressure: normal. Trigger points in chest, arms and legs consistent with chronic stress that can damage the heart. Prescribe exercise ECG and another appointment in three weeks. EXERCISE: Find out what you can improve in your life. The electrocardiogram did not show much unless the patient was physically challenged, when it is called an exercise ECG. In our experience, the short exercise in how to improve life can solve stress-related heart conditions like the one in hand rapidly and effectively. Actually we do not know whether it is the heart or the muscles causing the symptoms. In this case the doctor could not provoke pain by pressing on the muscles. This leads us to suspect that it may in fact be the heart causing the symptoms. Very mild cardiac disturbances are unlikely to be captured on an ECG. As an exception we bring below a case record that is not our own, but was written by a Rosen 263 practitioner at our instigation. It is instructive and shows important aspects of how to heal your heart.

*Male, aged 56 years with heart problems***.** This patient is in his mid-50s, a family man and manager of a private firm. He seems a happy and extrovert man with a good grip on things. However, his body was heavy and his muscles were very hard. Shortly before he started at the Copenhagen clinic, he had been in hospital with a blood clot in his heart and prescribed medication for hypertension. Most of the times on the couch he fell into a deep sleep that was frequently interrupted by some very violent jerks throughout the body, which he called his electric shocks. Several times during the period, when he came to see me he was admitted with extreme cardiac pain and angina. And eventually he was given medication for these symptoms and put down for bypass surgery. During some of his private sessions he became aware of some of the things that had greatly influenced his life, including an alcoholic father, who was violent towards his mother and the fact that when he was very young he had had electroconvulsive therapy for severe depression. After he had realised this, the jerks that used to wake up both him and his wife ceased or diminished. It also became apparent to me that he was taking strong antidepressants and had done so for years. He now chose to reduce dosage so that he was far below the daily dose and he was doing well without the excessive medication. Throughout the therapy he had some major problems with his staff, which he felt had taken a dislike to him. The patient mobilised all his strength to give notice and start again from scratch in another firm, where he is working today. At some point he was again admitted with extreme pain and angina that the hospital considered to be life-threatening, so he was transferred to a cardiology ward for surgery at the earliest opportunity. However, when the cardiologists examined him thoroughly they could not find any disorder or defect in the heart or surrounding blood vessels, so they discharged him again. During my last private session with the patient he was truly happy about life and full of vigour to devote himself to his family and friends. His jerks and cardiac problems had vanished completely, and he was enjoying his new job. The Rosen method and other body therapies that make the patient note the feelings located in the body are effective tools in holistic medicine. Sometimes the patient can verbalise his feelings and let go. For many middle-aged men, their "Achilles' heel" is allowing themselves to feel. Often, it is extremely unpleasant for a grown-up man in a managerial position to register the old feelings from his childhood of being small, 264 frightened and helpless with a feeling that it is an insult to his ego that he is still harbouring such emotions. To release them is good for the heart.

Discussion

Ornish et al (13,28,29,31-33) have shown that when patients with heart conditions caused by severe atherosclerosis change their lives and start to meditate, the constricted blood vessels can expand again. In the controls, the blood vessels continued to constrict and soon these patients needed bypass surgery to graft new vessels in their hearts. Often the new vessels after surgery will also narrow and block in time. A new lifestyle seems to be the only lasting solution to this problem. So far the most troubling problem seemed to be that the success of Ornish et al to induce these healings has not been repeated by other medical teams. It is well known that the charisma of a therapist can be so enormous that this therapist can make almost all cures work, even when treating the patient with poisonous drugs like arsenic, which was often used as medicine only a century ago. Dean Ornish is known to be a man of such charisma and maybe it is him more that his treatments that actually cure the patients. In order to test this it was urgently needed that multi-centre studies be made using Ornish program for "opening the hearth", which in fact has been done in 2003 (34). This study examined both medical and psychosocial aspects of 440 patients (with mean age 58 years and 21% women) with coronary artery disease at baseline and a three and 12 month follow-up. All were part of a multi-centre Lifestyle Demonstration Project, where the participants improved diet (low fat, whole foods, plant based), exercised, learned stress management and received social support. Partners were also asked to participate in order to maximize the effect on the family unit. Both genders had significant improvements in their diet, exercise and stress management practices. These improvements were maintained over the 12 months course of the study. Both women and men also showed significant medical (e.g., plasma lipids, blood pressure, body weight, exercise capacity) and psychosocial (e.g., quality of life) improvements.

This multi-centre study showed that a multi-component lifestyle change program could be successfully implemented and repeated at various sites. It seems that the results of the clinical work of Dean Ornish as a whole on patients with coronary heart disease is fairly well explained by contemporary holistic medical theory. When a person heals emotionally and these emotions are connected to blockages in the heart region of the body, all tissues might be affected in this region and the coronary vessels being the weakest link is breaking down first. When the person integrate the feelings giving informational disturbance to the tissues the tissues will heal, and thus the coronary vessels can open again as the cells aging receive correct information on structure and functioning from the information system of the body (35). For his work we believe that Dean Ornish should get the Nobel prize in medicine.

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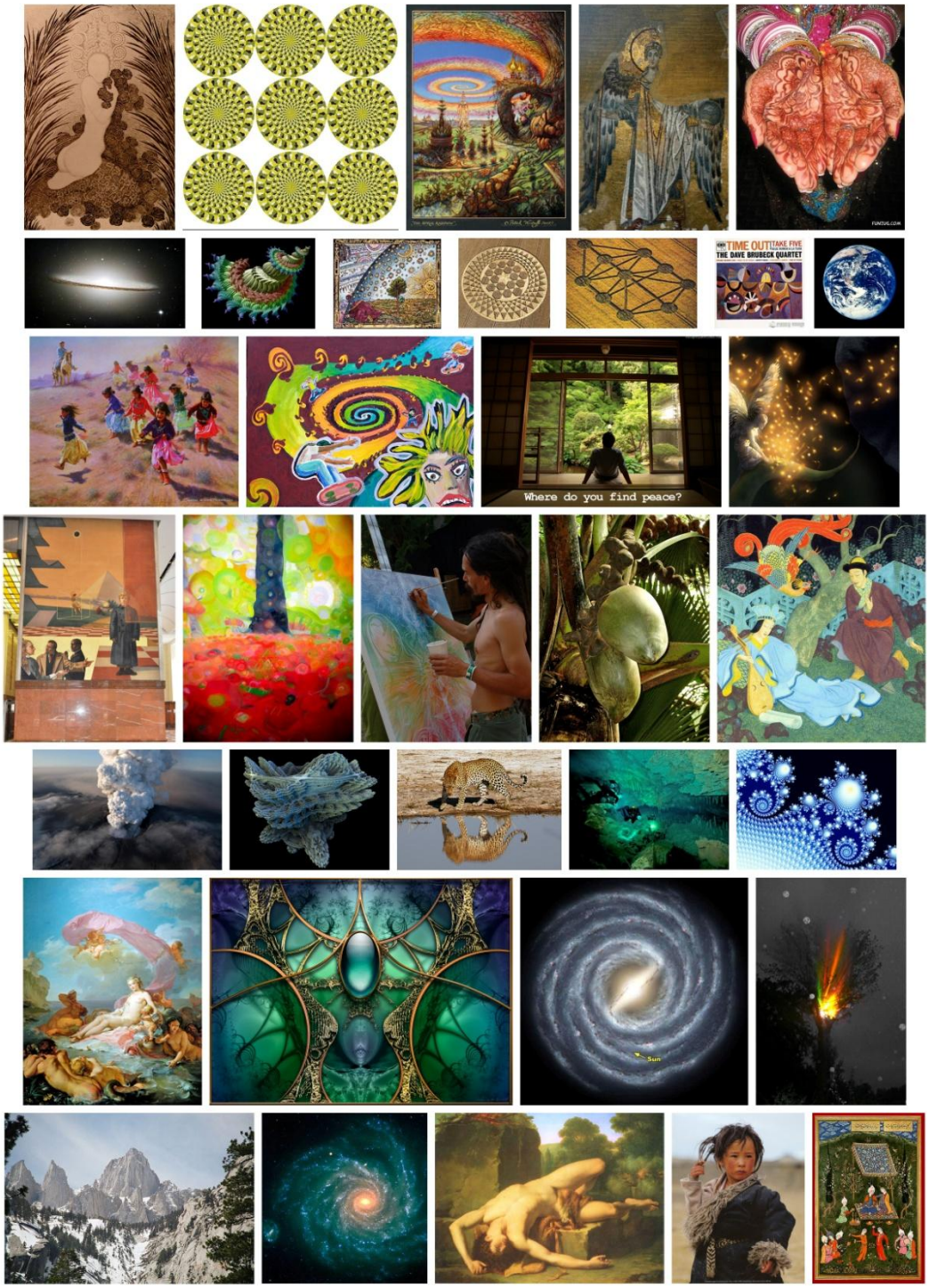


Chapter XV

Spontaneous remission of cancer. Is it possible to induce?

The recovery of human character and purpose of life with consciousness-based medicine seems to be able to induce spontaneous remissions in several diseases. On two different occasions we have observed breast tumours reduced to less than half their original diameters (clinically judged) during a holistic session, when working with the patients in accordance with the holistic process theory of healing, the life mission theory and the theory of human character. One tumour was histologically diagnosed as malign breast cancer previous to the session, while the other was under examination. As both patients had the affected regions of the breast surgically removed immediately after the session, we are unable to determine, if they were actually healed by the holistic treatment. We find it extremely interesting that the size of a tumour can be dramatically reduced within a few hours of holistic treatment, when the patient is highly motivated for personal development. The reduction of tumour size is in accordance with the holistic view that many types of cancer are caused by emotional and existential disturbances.

From a holistic perspective cancer can be understood as a simple disturbance of the cells, arising from the tissue holding on to a trauma with strong emotional content. This is called "a blockage", where the function of the cells is changed from their original function in the tissue to a function of holding emotions. The reduction of the tumour in the two cases happened, when old painful emotions were identified in the tissues, in and around the tumour, and processed into understanding. When the patients finally did let go of negative beliefs and attitudes that had kept the feeling(s) repressed to that part of the body, the tumour first softened and then disappeared, presumably by apoptosis. We believe that the consciousness-based/holistic medical toolbox has a serious additional offer to cancer patients, and we will therefore strongly encourage the scientific society to explore these new possibilities. Our holistic medical research meets both ethical dilemmas and practical difficulties, as it obviously is important for the research in induced spontaneous remissions that surgery and chemotherapy is not used before it is absolutely necessary.

Introduction

Cancer is one of the most common diseases and in modern society the second cause of death after heart disease in the adult population. Cancer can be seen as the breakdown of the cellular order and the chaotic growth of its cells. When the hidden principle that keeps all the cells in their surprising order in the body breaks down or becomes disturbed, cancer is the disease that we might expect. The dynamics of cancer is highly complex and dependent on the original tissue from which it originates And we see a wide variety of cellular behaviour. Each type of cell has specific predilections for other tissues of the body to colonialize. The pattern of growth and the rate of damage caused by the cancer will vary with the cell types. Because of this variation many researchers find that cancer is not one disease, but hundreds of different diseases.

What we know about cancer is that it often develops over years, which dysplasia (abnormal tissue development) is often an early stage and that carcinoma in situ (at site) is often found, before the cancer spreads (metastasis). We also know that the order of the cell as a whole, the tissue and the organelles of the cells are often lost at the same time, making cancer a disease characterised by a multi-level structural breakdown. Quite surprisingly cellular order is not just lost, sometimes it is also gained and the order of the body can reappear spontaneously. This is the famous picture of spontaneous remission of cancer. The concept of spontaneous remission is rather well documented in the literature, and the Danish researcher Ulrik Dige has shown that two out of three patients going through such a spontaneous remission experiences a spiritual awakening, before the remission happened (1). Let us here define spontaneous remission of cancer, as a remission that is not caused by a biomedical treatment normally considered powerful enough to cure it. When a patient is cured with holistic medicine we call it "induced spontaneous remission", which sounds like a paradox, but we find the meaning exact enough to use the phrase. In general it seems that recovery of life purpose and human character is the factor most permanently connected to spontaneous remissions of cancer. It is therefore not too surprising that working on the recovery of the purpose of life and the human character (2), the essence of our holistic and consciousness-oriented medicine, can lead to spontaneous remissions of cancer. It seems in general that the cancer cells are disappearing by apoptosis (cell death by injury or cell suicide), so a holistic cure for cancer is most likely to be successful if apoptosis can be induced. It might be a surprise for many researches, which follow the typical biochemical way of thinking, that induction of apoptosis seems quite possible and quite natural from a holistic medical perspective, as we believe that we are dealing with the same formative forces – the overall information system of the body (3-10) - in the body that induced apoptosis in embryonic life. If we radically can increase the coherence of the organism (11-15) and remove the disturbances that gives the cell problems with their communication, the level of information in the tissue can be radically improved due to holistic healing (16) and the apoptosis thus induced, as apoptosis presumably happens as a function of the cells realising that it is not a natural and sound part of the body any more. To understand this line of thinking, let's review some of our work with holistic medicine and existential healing.

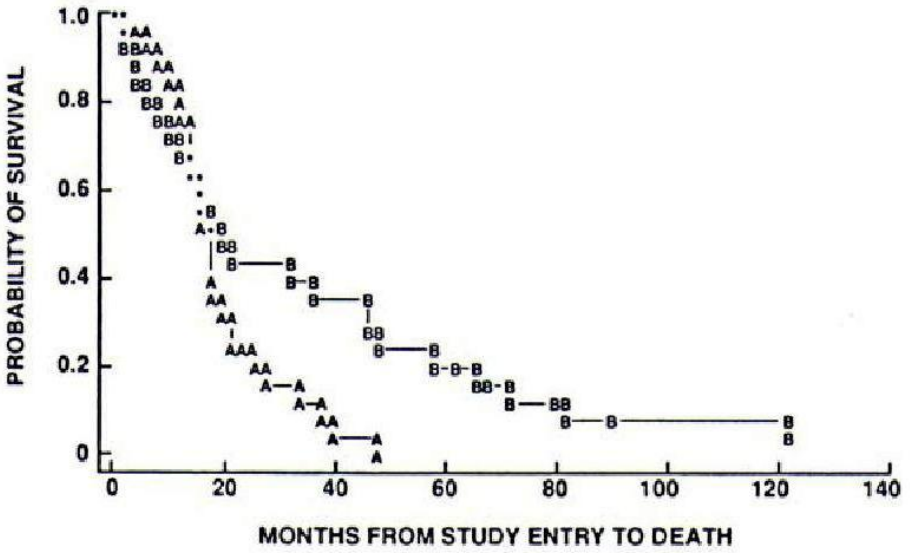
Spontaneous remission of cancer

Cancer is a general term for more than 100 different diseases, which all have in common that cells divide uncontrollably and form nodules that often spread and invade the surrounding tissue, such as nerves and blood vessels, which can result in a fatal outcome. In Denmark, one in three die from cancer, so cancer is one of the diseases to which we are all genetically predisposed. The question is what cancer really is and whether there are ways to prevent or treat cancer. Biomedical treatment is only curative in a very small group of the 100 different types of cancer although life is often prolonged. But perhaps improved quality of life can increase the 274 individual's resistance to cancer, so that cancer may be prevented and treated by means of holistic medicine that effectively leads to improved quality of life? There are several indications to that effect, although there is insufficient evidence in this field. Professor David Spiegel of the Psychosocial Treatment Laboratory at Stanford University in California is one of the great pioneers, who researched the correlation between quality of life and cancer. Spiegel and his co-workers have demonstrated that women with breast cancer, who work on themselves to improve their quality of life, survive twice as long as a control group (17). Some of the patients who worked with themselves in his group and met once a week for a year, have survived for ten years, while all the patients in the control group had died after only four years

The purpose of the study was to help women diagnosed with terminal cancer to improve the remaining part of their life. After 12 months Spiegel and his co-workers demonstrated a significant improvement in the patients measured by various psychological tests: reduced pain, milder depression, less anxiety, etc. "Actually, we started looking at the ten-year survival pretty much by chance and we were very surprised by the result," he told one of the authors (SV) on a visit at Stanford. He showed us how he worked with these patients and it was a great experience. The women shared their difficult lives with each other and their condition steadily improved as they talked about and discussed the major issues that concerned them. What can I do to improve my life? What do I need? How can I achieve that? The women in the group searched and found internal and external resources for their struggle to improve life.

Spiegel has created a forum, where it is acceptable to talk about the meaning of life. It was a peculiar feeling that such quiet, profound acknowledgement of the true values in life was far more valuable to health than the major emotional catharsis characteristic of many therapy courses. The way we see it, Spiegel has found a way to improve the quality of life of these women. Apparently, patients with breast cancer can do more for their own health and well-being by improving their quality of life than we, as physicians, can do for them with all our medical and surgical skills. International studies, such as the one by Spiegel, indicate that improved quality of life is the best treatment available today, once the cancer has spread throughout the body. As the patients who improve their quality of life most effectively may also be assumed to be the ones to survive their cancer, there is the exciting prospect that improved quality of life would probably also be effective in preventing and perhaps even curing cancer. The common definition of spontaneous remission is "a complete or partial, temporary or permanent disappearance of all or at least some relevant parameters of a soundly diagnosed malignant disease without any medical treatment or with treatment that is considered inadequate to produce the resulting regression (18). A search for "spontaneous

remission of cancer" on Medline (we used www.pubmed.gov) on October 01, 2005 resulted in 5,545 references and it seems that spontaneous regression happens with almost all kinds of cancer (19), although it is reported far more often with some kinds of cancers (20-25).



Kaplan-Meier survival plot.

A = control (n = 36), B = treatment (n = 50), and * = overlapping control and treatment probabilities of survival. Some points represent more than 1 case.

Figure 1. A group of women with metastatic breast cancer worked to improve their quality of life for 90 minutes a week for a year, and on average they survived twice as long as the controls, who did not work systematically to improve their lives (17).

A few years ago the discussion was about the question, if spontaneous remission of metastasised cancer really happened (26), as it might have been a question of misdiagnosis (27). Today the discussion is about the possible mechanisms and how it can be induced (28) – the ideal, optimal solution to a fast killing disease. The mechanism of spontaneous remission is not clear, but apoptosis seems to be a part of it (29). There are many speculations as to the cause of apoptosis, some believe in immunological factors (29,30), like natural killing activity (31) or antibodies (32), while others speculate on the positive effect of fever (33), thyroid hormone stimulation (34) and surgery (35,36). The incidence is also highly controversial, from 1900 to 1960 only 176 cases were reported and some authors believe in an incidence of 1:100.000 (37), while others report a number 50 times higher for some types of cancers (38).

The researcher Ulrik Dige from Denmark (1) found over 40 cases, most not reported in the literature, indicating a ratio of 1:10.000 or even higher, and a massive scientific under-reporting of the spontaneous remissions. He found that about 2/3 of the patients has undergone some kind of spiritual awakening, before the remission took place, indicating that the patient himself had an important role in the process of healing. Improving the quality of

life seems to have much to do with survival and remission of breast cancer (39), but the psychological and existential elements in the process of spontaneous remission remains controversial (40,41). The common definition seems to refer to the biomedical intervention only, as most of the spontaneous remissions at least according to the findings of Dige (1) seem to be induced by the patients themselves, alone or in cooperation with others. This is why we in this chapter use the concept of "induction of spontaneous remission of cancer", which of cause literally is a contradiction, but we believe that this is most correct in the light of the traditional meaning of the terms in use.

Critique of the biochemical theory on cancer

According to the most accepted biomedical theory on cancer, the genes of the cells mutate (change spontaneously), so that over time the chromosomes in the cells become worn, damaged and the oncogenes comes into play. An oncogene is a gene that when mutated or expressed at abnormal high levels contributes to converting a normal cell into a cancer cell. This leads to sick cells, which no longer fulfil their functions in the body and divide without control. We know these colonies as the cancerous tumour, which – as they grow – may impinge on blood vessels, nerves or other vital structures to threaten our bodily functions and in fact our entire existence. We believe in natural science and appreciate the contribution by medical science to the collection of a vast and complex knowledge of all the different molecular and chromosomal changes of the cells of the different cancer types. Yet the whole body of knowledge is built on the simple axiomatic understanding that the body is chemical machinery, which can only be understood from the chemical level. We have given an extensive critique of this perspective and the biomedical paradigm elsewhere (3-10,42-48). We believe that there exist some rare cancer forms that is caused by the genes or chromosomes, but in accordance with the lack of finding such genes related to most cancer forms, we believe that cancer is caused from our consciousness, when we repress emotions and place them in the tissues of the body (16). We therefore also believe a cure of cancer to come from fundamental shifts in our consciousness and state of being. If we are old and our days are numbered, cancer is no tragedy, because death is an inevitable fact of life. But often, cancer strikes – as a consequence of our poor living, in our view - long before our time should be up. What should be done depends naturally on the individual understanding and perception of cancer as a disease. If the cancerous nodule is discovered at an early stage, in many cases it can be removed completely by surgery and/or chemotherapy. This is in many cases a fairly effective solution, which most patients choose. But often the cancer reoccurs after even the most successful treatment, perhaps at an entirely different site in the body. The cancerous nodules may be a symptom of a fundamental disturbance in the body rather than an actual, local disease.

A holistic theory on cancer

According to the holistic theory on cancer, the cells as such are not sick – although they may appear to be very sick under the microscope – but rather the entire organism is unbalanced. In

order for the cells to do their job and stop dividing uncontrollably, they must receive information on what to do. According to this theory, cancer results from a disturbance in the information system, which prevents the body from providing the requisite flow of information to the cells, because of the phenomenon we refer to as a "blockage" at the particular location. Scientific understanding of such blockages and information disturbances is still poor. In the healthy body – in our natural, living condition – all cells communicate. Cells are tiny living animals that have lived for some 3,800 million years, reproducing by division and creating perfect replicas of themselves. One thousand million years ago, these cells learned how to create the marvellously complex cell colonies, which constitute man today. We consist of 200 different kinds of cells, all having the same progenitor: the fertilised egg. All cells communicate with each other and therefore know exactly what to do in their specific location. However, sometimes things go wrong. In some areas of the body biological order collapses and the cells start acting more and more autonomously and less and less socially – often gradually over many years. Ultimately, they act almost like free-living amoebae in the primeval sea from which we evolved. The observation that cancer does not occur at random, but rather in areas of the body, where the individual has had emotional problems earlier in life – the reproductive organs, intestine, neck, etc. – is not new. However, many forms of cancer cannot be explained by this observation, as they occur throughout the body, for example in the immune system in the form of lymphatic cancer.

Blockages make the body ill

According to the holistic view cancer occurs at sites, where there is insufficient information to the cells. The work of the cells is disturbed by "blockages" in the form of painful feelings which have been repressed from the conscious to the subconscious mind through less constructive decisions in the life of the individual. As described elsewhere, one can choose to shift one's life perspective, when life hurts and in that way avoid the pain. Often we choose a life perspective that reduces our own share of the responsibility for unpleasant events. Naturally, we cannot escape responsibility in the absolute sense, but we can disclaim it subjectively. We do so by making the decisions referred to as life's "small lies", self-delusion or negative attitudes to life. What they are called is really not that important as long as we understand that they are about negative decisions contrary to life, which we make in the course of our lives to get out of difficulties and avoid the pain. Science has yet to find out why such negative decisions weaken our bodies and make us ill. The oldest explanation of this phenomenon is that, by means of our negative decisions that suppress aspects of ourselves, we split our existence into parts. The decisions are lodged in the body in such a way that our contact with this part is impaired which in turn leads to this part of the body becoming ill.

For example, if we decide that we do not care for sex, we split off our reproductive and sexual "energy", and this often gives problems in our reproductive organs and quite often in other organs in the pelvis as well when the repressed material is placed here. If we do not care for other people, we split off our ability to love (our "heart energy"), which may cause us to develop a heart condition if the repressed material is placed in the hearth. The body is a complex whole, sustained by information flowing in all directions, and such split-offs are

bound to have some adverse consequences for our health. In a complex manner, our negative decisions added together untie and break down the inner coherence of the body. Thus, the risk of cancer or another serious illness increases as we tell ourselves more and more lies and our biological coherence deteriorates. Understanding the exact mechanical correlation is usually far more important to the physician than to the patient. What most patients need to understand is that improved quality of life is the road to recovery; in this way the body can restore the information flow to all its parts. Therefore, the primary goal of conversational therapy – "the quality-of-life conversation" – in cancer patients is to readjust the life perspective of the patient. Apoptosis is extremely important to the spontaneous healing process that the holistic physician hopes to stimulate. Apoptosis is the mechanism used by medical science to explain how even patients with advanced cancer may recover miraculously, if they radically improve their quality of life. Apoptosis means that the cells self-destruct by splitting into two or three pieces, which are subsequently "devoured" by the adjacent 279 cells. This occurs once the cells discover that they are in a location in the body, where they are not supposed to be. Apoptosis is currently the object of intense research worldwide.

Case story

The following case history from the Holistic Research Clinic in Copenhagen concerns a woman with non-metastatic breast cancer treated according to the "feel – acknowledge – let go" concept. Her case is interesting, because apoptosis was apparently induced – spontaneous remission of her tumour by spontaneous cell death.

> A small, somewhat dishevelled 42-year-old female enters the clinic. She sits down, panting, gives me a confused look and says: "It has just been confirmed that I have breast cancer. I am to have an operation, then radiotherapy 30 times and perhaps chemotherapy as well." One in nine women develops breast cancer, so these patients are not rare. But this particular patient was somewhat rare, because she came to me and was not willing to make do with conventional treatment. "And what do you want me to do?" I asked her, full of sympathy for her tough situation. "I would like acupuncture or something like that, I want to do something myself to fight the disease and prevent it from recurring." Indeed, the disease recurs in about 40 per cent of patients who undergo surgery for breast cancer, although the cancer was apparently removed completely the first time. "That is a good idea," I (SV) said. "What do you expect acupuncture can do for you?" "I don't know really, perhaps I should try something else. What would you suggest?" "I suggest we work a little on your view of life and make you focus on all the good things in life, and less on your disease," I told her. She agreed to work for an hour or so – this service is called the "quality-of-life conversation" and "healing through a shift in perspective", if the process is successful and the patient succeeds in replacing her negative and bleak life perspective with a more positive one. I sensed that she is sceptical and I asked her about it. It turned out that she just finished a long-term relationship and was therefore somewhat sceptical about men in general, but after a brief talk she agreed to do some work on the couch. Here, she admitted that she really was very bitter and angry and we talked about all the harm men had done to her. Humbly I asked her to forgive all the harm inflicted on her by my gender throughout her life. That is one of my most cunning tricks, which I learned from a gestalt therapist. I shamelessly scoop up responsibility for myself, leaving only a small amount of responsibility, which the patient has to take herself. The patient, whose emotional response has been arid up to now, suddenly becomes so moved

by my prayer of forgiveness that tears start to flow. "I am moved," she said. She allowed me to feel the tumour, which was clearly palpable as a 2 x 2 x 2 cm movable tumour in the lower part of her right breast. While holding the tumour, I used the same method as when locating chronic muscle tension, for example in the neck in a whiplash patient. I asked her over and over: "What feeling lies here?" She could not answer that, so I made her say: "I hate you, Daddy. I am angry with you. I give up." I was "fishing" and tried to make her feel the negative and hostile emotions in herself, which I sensed hidden in the area around the lump. "I have a feeling of desolation," the patient then said. I worked for a while to make her reach beyond her emotional surface and into the deeper layer, where hopelessness and powerlessness reside, and then to continue down into the deepest layer filled with life and a belief that life will carry her. Then the patient need not take on the unbearable task of carrying her own life. We talked about surrendering to God, about the parable of the lilies of the field and the birds of the air that teaches us to believe that life is truly good and will carry us. Now and then I sensed deflation, as though the tension and alien character left the lump and it subsided and "melted" away beneath my fingers. Speechless, I once watched a video where the healer Martin Brofman turned such a tumour (the size of a hen's egg) into something that resembled gravel and pebbles in a mere 20 minutes. Indeed, I had read Bruno Klopfer's account from the middle of the last century where this had occurred as a case report with no scientific documentation. I had also read and heard of spontaneous remissions and of inexplicable cell death in cancerous tumours, but experiencing the tumour melting beneath my fingers was truly great. But even greater when the patient had the same experience, so I could not help but asking the patient to feel for herself whether there is a difference: "Feel the lump yourself. Is it the same, or is there a difference?" I asked her as neutrally as possible. "It feels as though it has become a little smaller," the patient said. "How big do you think it is?" "Now it feels like it is 1.5 cm, it was bigger before." The next time I asked her, it has become even smaller. We believe that this patient was actually ready to take responsibility and cure herself of breast cancer, but then again she had decided to have the operation. I did not contradict her and hope that they will take the trouble to carry out microscopic examination of the lump again before their final decision on radiotherapy. I can picture the pathologist writing: No confirmed malignant cells. I talked to her on the phone a few days later. She had slept a lot, felt rather dazed since our last conversation and she did not want to continue in my clinic. Now she just wanted to get the operation over with, as the surgeon told her that the lump was "enclosed" and could be removed in one piece, which sounded good. Nevertheless, she seemed to have grasped the essential point, that life should carry her, instead of her dragging along with life. If she seizes the opportunity and learns the lesson of what happened to her, the breast cancer will probably not recur.

Spontaneous remission of tumour through work with life purpose

We (SV) have experienced another 2.5 cm x 2.5 cm breast tumour in a 35- year-old female disappearing almost instantaneously, when she broke through and rediscovered her life purpose. The tumour, which had grown rapidly, was to be removed surgically a short time after. She participated in one of our summer course "Life philosophy that heals" and worked purposefully on herself during the course. She was a beautiful young woman, who had had problems with love her entire life. When she found her purpose in life, she could see how she had denied herself all the love and kindness that she possessed. We (SV) worked with her for some sessions over a couple of hours, with the other participants forming a circle around us,

watching us. During the session, I supported her breast with the lump to help her confront the difficult feelings buried in the tissue. It was a very loving session and a moving scenario as she ascertained with great surprise that the tumour grew smaller and softer in the course of the session and we were all close to tears, when at the end of the last session she found almost in a state of shock that not only had the tumour gone soft, it had become as small as a "sunflower seed" and was very difficult to locate. The tumour worked and changed beneath my hands during the session. It became less hard as she took responsibility for her pain and explored her fundamental, past feeling of being helpless and unloved. During the sessions, she searched for her fundamental denials of her life purpose and she found what she was searching for. A number of negative decisions that she had made during her life and could now let go of. She healed, and the tumour vanished almost completely. The remainder of the tumour was surgically removed the following week. This story about remission of the tumour following acknowledgement of the life purpose illustrates the purpose of life theory of holistic medicine. Another participant at the course was asked to describe her experience.

> *JM, participant in "Life Philosophy that Heals"[28], Course 2, 2002, wrote:* One of the participants at the course was a woman, NN, with an extremely good-looking and loving appearance. From the time when I first saw her, I thought she had a delicate, angelic appearance, and she was definitely a person that I considered to be very "sweet". Actually, I sensed that on the one hand NN was extremely delightful, loving and warm, but on the other dismissive, calculating and cool. About halfway into the course, NN told us that when she returned from the course she was going home to have a lump in her right breast removed. She told us that the tumour was very hard and about the size of a hazelnut. She continued to say that she is very nervous about the operation and scared. She said that she joined the course, because she did not believe in what the conventional health care system has to offer. Also, she wanted to find out, whether SV could help her. Then SV asked NN, if she wanted him to work with her. She did and SV asked all of us whether we felt it was all right for him/us to spend some of the afternoon working with NN. SV suggested that he/we spend about 3 or 4 periods of 45 minutes on NN's lump. Everybody agreed that it was the most important thing right now and naturally he/we should work with NN, since she felt like doing it now. Then we placed some quilts in the middle of the floor and NN lied down on them, while SV held her head in his lap. The rest of us sat down on the floor around them, but not too close. SV asked NN if he could feel her breast and if she would show him where the lump was. NN agreed to that and she located the tumour, which according to SV was 2.5 x 2.5 x 2.5 cm. SV spoke very softly and tenderly to NN and an atmosphere of tenderness, care and love spread around them. Before long NN looked like a little girl cared for by her father. SV felt and held the lump. Then he started massaging it, while asking NN what feelings were located in her breast and what feelings were in the lump. NN starts to cry, as I remember it, like a little girl. NN said that she was always required to be 'big'. She talked about the time when her mother died, NN was about 13 or 14 years old and how her father was very incoherent afterwards and how NN became the one who kept herself and her father together. She said that she had not mourned or cried about the loss of her mother, since there simply was no room for that and how she had run the house for her father and thereby assumed her mother's role. She became her father's wife. NN cried in the process, and SV massaged her, while meta-communicating with her, assuring her that it was fine for him/us to spend time on working with her lump. That nobody felt that she was taking time away from us, neither causing any inconvenience or trouble. The reason that SV made a point of emphasising this was that NN seemed to find it difficult to relax. It seemed as though NN felt that it was not worth spending any time on her and her lump.

As though she cannot believe and accept that, we all felt that she should have that kind of attention and love. SV asked her about that, and she explained how she always found it difficult to accept attention and care. NN said that, in fact, 283 she was never able to accept it, except when she was ill. The result was that now and then she would be ill, during which time she would then receive and be able to accept love. That was NN's pattern: illness means love. While massaging and working with NN, SV asked her to feel the lump now and then. The more NN acknowledged her situation, the softer the lump seemed to become and when NN realised that ill means love, the lump also began to diminish. In the evening, following 4 x 45 minutes of work on NN's tumour, he asked her to locate it and give an estimate of its size. To begin with NN actually had difficulty locating it, she was clearly much moved, and she was crying tears of joy, whereupon she told us that now she thought it was the size of a sunflower seed. She had signs of relief, both in her voice and in her eyes. She had managed to give herself up to the process, whereupon her tumour had become softer and then smaller. She had received attention, respect, love and could now go home with a tumour the size of a sunflower seed. All in all, it was an extremely beautiful, quiet and very moving experience and I am very grateful for having had the opportunity to witness it. From the point of view of holistic medicine, what happens is that, as discussed in the previous chapter, the malignant cells self-destruct (apoptosis), when the blockage is removed. The information relationships in the tissues are restored and the cells suddenly discover that they are growing in a place in the body, where they are not supposed to be.

Discussion

Every physician must treat his patient according to his knowledge and his consciousness with the intention to help the patients as much as possible, and if possible, cure them. The first and most important medical law ever since Hippocrates (460-377 BCE) is "First, do no harm". Harming a patient include not keeping up one`s knowledge of best practice, for instance not knowing diagnostic practices and the documented cures of a disease. But even when you know how to diagnose and which cures and treatments are available, things are often complicated when it comes to cancer. For often, the cures are not too good and the drugs have very high Number Needed to Treat (NNT) of often 5, 10 and even 20 or more and the surgical procedures are often not efficient in preventing the disease from coming back, which often happens with terrifying incidences (up to 30% of patients with a positive family history for breast cancer operated themselves for a breast cancer will have tumour recurrence (49) and when there are metastasis to lymph nodes, the 10 year survival rate is only 56 % (50). This means that the offer too many cancer patients are not really good. We know that spontaneous remission of cancer is seen with almost all kinds of cancer and we know that it often happens after a spiritual break through. The spiritual breakthrough is almost always about being more alive, knowing oneself and the purpose of life better, stepping fully into personal character, realising talents and how to use them. Al this is what holistic medicine aims at supporting the patient to achieve. This means that we have a chance of inducing this "spontaneous" remission, making the patient not only well, but also much happier, wise and with a life. Improving the quality of life is the "name of the game" and we believe quality of life to be the best medicine there is. The chance of inducing the remission must be only 5% (as it was in the famous study by Spiegel (17), but it might be that our new understanding of recovery of character and purpose of life makes the fraction much higher. How can we find out how

powerful our holistic medical tools are, when it comes to cancer? Only by trying to heal the patients and whenever we see a radical reduction of a tumour by believing it and daring to wait and see what happens: will it come back or will it disappear completely? The experiment is highly risky, as we risk that a patient who could have survived with immediate surgery get metastasis and dies, as a consequence of the experiment. But then again, if the patient gets the surgery, what is the change for a recurrence after this treatment? And what if the chance for a recurrence of the tumour disappeared completely, because this patient learned from the disease and reorganised her life, including all values, philosophy of life, lifestyle etc? What the patients has gained in the latter case is often described as something of tremendous value, subjectively valuable even enough to justify getting the disease in the first place. If the patient is an adult s/he must take every opportunity into consideration and make up his or her own mind, about what is the optimal and appropriate treatment or combination of treatments. In the end, the decision must be made by the patient. But as we know how difficult a situation it is to be seriously sick and how often the patient just follows the recommendation of the physician out of fear, we as physicians cannot escape our responsibility that easy. We need to be clear about our own position in order to be able to guide the patients. Sometimes the patient has several physicians and if they work within different medical paradigms [56] they are likely to give the patients different advice and even to judge and condemn the treatment given by the physician from the different paradigms. The problem becomes even more complicated, if there is a documented biomedical treatment, say with a 10 year survival rate of 50%, and another treatment, say consciousness-based, which is undocumented as most of these treatments unfortunately are due to the sad contemporary lack of research funding. So the research is practically only carried out with single patients, like the two cases reported in this chapter. So how can this research best be done? And what are the ethical dilemmas involved? Obviously, the patient will benefit tremendously from her different physicians giving her the freedom to choose her own treatment and not to push her, but just inform her honestly and objectively. The research would benefit tremendously from that to. 285 In many cases the combination of the biomedical and the holistic treatment is very simple and without any problems at all. If the cancer has metastasised to the lung or liver there is no effective cure and the oncologist will fully accept that the patient tries any kind of alternative treatment. If the patient has already decided not to get the biomedical treatment of chemotherapy or surgery and come to the holistic physician the situation is in principle simple, but in this case the holistic physician is at risk of being accused of giving an alternative that cheats the patient to feel that there is a real choice, when only the biomedical treatment is documented. In this case it would be fair to look at the circumstances before judging: is the alternative therapist a physician who knows the disease of the patient, and the biomedical treatments, and their effect? Is he doing research, systematising his efforts, explaining in a scientific way what he is doing? If the patient is on a waiting list for treatment, or if the tumour is small and the risk of metastasis is known to be limited, this is also an important aspect to consider in favour of allowing the patient to try alternative treatments, while there is time. From our perspective there is so much theory and so many useful techniques in holistic medicine/consciousness-based medicine that this should be taken seriously by biomedical physicians also, so that what might be a very important scientific development is not hindered, because of sheer conservatism in the medical community. As our consciousness-based medicine has not been clinically tested yet we fully understand scepticism. But as we believe that recovery of the human character and the purpose of life

have a chance of being developed into a cure or supplementary cure for the segment of patients motivated to work with themselves, we believe it should be tested. Also because such a cure for cancer might be suspected to be highly effective in preventing cancer in the long run and at the same time dramatically improve the quality of life, general health and ability of the patient, we feel obliged to test it in the clinic. We are obliged to get full consent of the patients, after having informed them that they participate in an experiment and that there is a high risk of having no effect at all on the disease. We believe that we are ethically obliged to take our great medical science further and develop new treatments, where the old ones have failed or are insufficient as it is often the case with the biomedical treatments of cancer. We believe in the new medicine as we have already seen so much good happen to our patients using it with a variety of diseases. We are at the beginning of using it and we do not know very much about its effects or side effects and we will undoubtedly make some mistakes, while experimenting. In spite of our very best efforts not to do harm, some patients might even die because of choosing our offer instead of the traditional biomedical treatment, which we would regret bitterly. But we believe that we in the end will provide the world with a complementary, efficient tool for curing at least a part of the most motivated fragment of the cancer patients. As we see it, this cure will have very few and very limited negative side effects with a lot of positive impact on the quality of life, general health and ability of the 286 patients. This is our hope and belief, but we beg forgiveness, if we in the future come to make the patients suffer because of it.

Conclusion

The recovery of human character and purpose of life with consciousness based medicine seems efficient in inducing spontaneous remissions of many different diseases (41-44,46,47,51-57). At two different occasions we have ourselves observed breast tumours reduced to less than half their original diameters (clinically judged) during a holistic session, while working with the patients in accordance with the holistic process theory of healing, the life mission theory, and the theory of human character. One of the tumours was histologically diagnosed as malignant breast cancer previous to the session, the other was under examination. As both patients had the affected regions of the breast surgically removed immediately after the session, we do not know if they were actually healed by the holistic treatment. We find it extremely interesting that the size of the tumour can be dramatically reduced within a few hours of holistic treatment, when the patient was highly motivated for personal development. The reduction of tumour size is in accordance with the holistic view of many types of cancer as caused by emotional and existential disturbances; from a holistic perspective cancer can be understood as a simple disturbance of the cells, arising from the tissue holding on to a trauma with strong emotional content, in what we call “a blockage”, allocating the function of the cells from their original function in the tissue to a function of holding emotions. The reduction of the tumour happened when old painful emotions were identified in the tissues, in and around the tumour, and processed into understanding; when the patients finally did let go of their negative beliefs and attitudes that kept the feeling(s) repressed to that part of the body, where the tumour first softened and then disappeared, presumably by apoptosis.

We believe that the consciousness-based/holistic medical toolbox has a serious offer to cancer patients, and we will therefore strongly encourage the scientific society to explore these new possibilities. Our holistic medical research meets both ethical dilemmas and practical difficulties, as it obviously is important for the research in induced spontaneous remissions that surgery and chemotherapy is not used before it is absolutely necessary; on the other hand is it important for the patient's survival that they receive any well-documented treatment as soon as possible. An additional aspect is that if the patient can cure her own cancer, she is much less likely to get cancer again, and much better prepared to deal with other diseases and challenges in life. Knowing that one can fight even cancer gives a strong belief in life and in our own power to improve the quality of life. The high incidents of secondary cancers, the physical and emotional wounds on many cancer patients under biomedical treatment seem to justify a focus on prevention. To support the patient in learning from the disease the mastery of coherence of body and life, using the crisis of cancer to recover the human character and the purpose of life seems turning a personal potential disaster into the greatest gift of all. When it comes down to it, life is not just about surviving. What is more important is to live life fully, to learn from the great challenges of life, and to obtain the optimal quality of life while being here.

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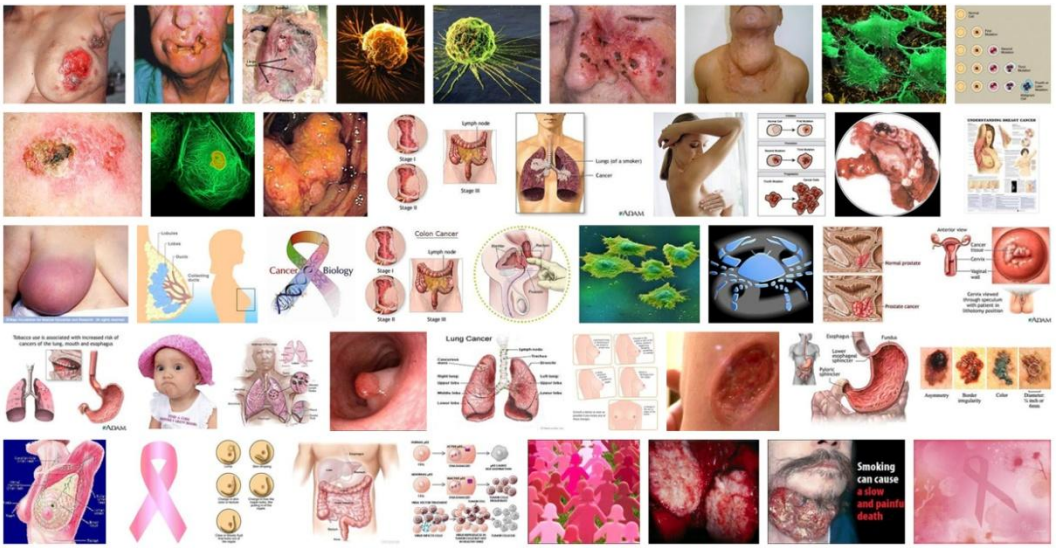

Chapter XVI

Metastatic cancer

We believe that the consciousness-based/holistic medical toolbox has a serious additional offer to cancer patients and as a consequence designed a treatment for the patient with metastasised cancer. From a holistic perspective cancer can be understood as a simple disturbance of the cells, arising from the tissue holding on to a trauma with strong emotional content. This is called "a blockage", where the function of the cells is allocated from their original function in the tissue to a function of holding emotions. We hope to be able not only to improve the quality of life, but also to improve survival and in some cases even induce spontaneous remission of the metastasised cancer.

In this chapter we describe how the work with the patient with metastasised cancer can be done in the holistic clinical practice in 14 days on an individual basis, helping the patient to recover her human character, purpose of life, coherence, and will to live, thus improving quality of life and possibly also survival time. The holistic therapeutic work included 1) teaching existential theory, 2) working with life perspective and philosophy of life, 3) helping the patient to acknowledge the state of the disease and the feelings connected to it and finally 4) getting the patient into the holistic state of healing: a) feeling old repressed emotions, b) understanding why she got sick from a holistic point of view and finally c) letting go of the negative beliefs and decisions, that made her sick according to the holistic theory of non-genetic diseases. The theory of the human character, the quality of life theories, the holistic theory of cancer, the holistic process theory of healing, the theory of (Antonovsky) coherence, and the life mission theory are the most important theories for the patient to find hope and mobilise the will to fight the cancer and survive. The patient went through the following phases: 1) Finding the purpose of life and hidden resources; 2) Confronting denial; 3) Taking responsibility for being very ill; 4) Severe existential crises with no wish to live while still fighting; 5) Integration of many repressed feelings and negative decisions thus rehabilitating character; 6) Confronting lack of intimacy and trust in others and this way rehabilitating the ability to love; 7) Rehabilitating the will to live, breaking through and falling in love with life; 8) Assuming responsibility for the social relations; and sometimes 9) Quality of life is improved radically with indications of spontaneous remission of the liver tumours.

Introduction

Working with the patient with metastasised cancer and a very poor prognosis is one of the most challenging and difficult tasks any physician can encounter. When the biomedical treatment has come to an end, the patient informed that the situation is hopeless, further treatment is not likely to help and survival from the cancer is not possible, some patients prefer to turn to the physician with a holistic approach. In this situation, the holistic physician can do much for the patient on the emotional level by improving the quality of life (QOL) of the patient and thus help the patient to fight the cancer more vigorously and maybe even survive longer. It is a difficult situation with many pitfalls and it is extremely important not to make the situation worse for the patient by inducing depression, feelings of guilt or by using the few resources the patient has on exercises that are not likely to help. It is also extremely important not to promise something that cannot be kept, or to give false hopes or illusions of survival. In this chapter we will describe how we have been working with a patient with metastasised breast cancer, trying to avoid most of these pitfalls and succeeding in helping the patient to improve her quality of life. The purpose of our intervention in the holistic clinic is strongly inspired by the work of David Spiegel et al (1), who helped women diagnosed with terminal cancer to improve their QOL in the remaining part of their life. After 12 months Spiegel and his co-workers demonstrated a significant improvement in the patients measured by various psychological tests: reduced pain, milder depression and less anxiety, so we believe that QOL can be improved for this group. David Spiegel also showed one of the authors (SV) how he worked with these patients and how he supported the women in finding their internal and external resources for their struggle to improve the quality of life.

Improving coherence, quality of life and survival

What we know about cancer is that it often develops over years; that dysplasia (change to the cells) is often an early stage; and that carcinoma in situ (in the local place) often found before the cancer metastasises. We also know that the order of the cell as a whole, the tissue and the organelles of the cells are often lost at the same time, making cancer a disease characterised by a multi-level structural breakdown. Cellular order is not just lost, sometimes it is also gained and the order of the body can reappear spontaneously, which is called spontaneous remission of cancer (2,3). In our opinion it seems that recovery of life purpose and human character are the factors most permanently connected to spontaneous remissions of cancer and it is therefore not surprising that working on recovery of the purpose of life and the human character (2) can lead to spontaneous remissions of cancer, which is the essence of our holistic, consciousness-oriented medicine. It seems in general that the cancer cells are disappearing by apoptosis (for every cell, there is a time to live and to die and there are two ways in which cells die: killed by injurious agents or they are induced to commit suicide. Programmed cell death is also called apoptosis), so a holistic cure for cancer is most likely to be successful if apoptosis can be induced (2). It might be a surprise for many researchers, who follow the typical biochemical way of thinking, that induction of apoptosis seems quite

possible and quite natural from a holistic medical perspective, as we believe that we are dealing with the same formative forces – the overall information system of the body (5-12) - in the body that induced apoptosis in embryonic life. If we can increase the coherence of the organism (13,14) and remove the disturbances that gives the cell problems with their communication, the level of information in the tissues can be radically improved due to holistic healing (15) and the apoptosis thus induced, as apoptosis presumably happens as a function of the cells realising that it is not a natural and sound part of the body any more. To understand this line of thinking, let's review some of our work with holistic medicine and existential healing. Many patients go to a holistic doctor in the hope of surviving the cancer, hoping that the cure will induce spontaneous remissions of cancer (16). It seems that spontaneous regression happens with almost all kinds of cancer (17), although it is reported far more often with some kinds of cancers (18-23). A few years ago there was a discussion if spontaneous remission of metastasised cancer really happened (24), as it might be a question of misdiagnosis (25). Now the discussion is about the possible mechanisms and how it can be induced (26) – the ideal, optimal solution to a fast killing disease. The mechanism of spontaneous remission is not clear, but apoptosis seems to be a part of it (27). There are many speculations as to what causes this apoptosis; some believe in immunological factors (28,29), like natural killing activity (30) or antibodies (31), while other speculate in a positive effect of fever (32), thyroid hormone stimulation (33) and surgery (34,35). The incidence is also highly controversial. From 1900 to 1960 only 176 cases was reported, but some authors believe in numbers like 1:100,000 (36), while other believe in a number 50 times higher for some types of cancers (37), but the psychological and existential elements in the process of spontaneous remission remains controversial (38,39). The common definition seems to refer to the biomedical intervention only, as most of the spontaneous remissions seem to be induced by the patients themselves, alone or in cooperation with others. This is why we do not exclude the possibility of "induction of spontaneous remission of cancer", even with the most terminal of patients, which literally is a contradiction (40). At the same time we always stress that the likelihood is small and that it is the patients him/herself, who has to do the job of improving the quality of life and coherence in order to survive.

What can be achieved with a patient with metastasised cancer?

The first and most important thing is to cooperate with the patient, helping the patient to achieve what is possible in every single case. This is extremely difficult, because the resources of the patient are often small, but if the will to live is strong, then there might be extraordinary resources in the patient. Therefore the assessment of the patient's resources and direction is the first thing to do and everything is dependent on this judgment. The second thing is to understand the patient's individual process of learning and transformation and especially what the patient is willing to give up in this process. Because the basic rule, if you want a fundamental renewal of your life, is the price of your new life for your old life. So if you will not let go of your old way, values, perspectives and habits not much can be done for you. This willingness is in part related to the level of personal resources and in part related to the will to survive.

A general thing to learn from your cancer is that you can come closer to life. You can change, you can move into life, you can conquer the meaning of life, understanding its purpose and stepping into character more fully, being yourself more. This strange process of "becoming yourself" is what holistic medicine is all about, because you are this wholeness and healing is to become your true, whole self. So dependent of the resources, the will to live and the willingness to "let go of the ego and surrender" and take learning and thus transform into a more true and whole person, there is very little or very much that a holistic physician can do for his patient. The case in this chapter is about a patient with intermediate resources and a modest will to live, but with an impressive willingness to take learning and to transform. The fast rehabilitation of the character and purpose of life made is possible to improve her quality of life in 14 days. We believe this patient was motivated for personal growth, but in no way exceptional. Her young age of 29 years and seven year old daughter was in the favour of the holistic treatment, helping us to mobilize her will to live.

Working with a patient with metastasized cancer

We worked with the patient in a team consisting of two male physicians and a female physiotherapist with an intervention period of two weeks of two hours sessions each time and therapy daily except for Sunday. We followed the four standard steps of the holistic treatment (40): "Loving" the patient, winning the trust of the patient, getting permission to give the patient holding and taking the patient into the holistic process of healing: feel, understand and finally let go of your negative beliefs, attitudes and decisions The shadow side of the patient gave us fierce resistance, but we managed to establish and keep the alliance with her conscious self (her "white side"), helping her to identify the self-destructive patterns in her own (sub) consciousness. Little by little she noticed the many negative beliefs, which has been accumulating in her personal "philosophy of life" throughout her life. Letting go of them, she healed deeps wounds in her existence and improved her quality of life radically – from a self-evaluated QOL of "bad" to "very good" (from 4 to 1 on a Likert scale from 5 to 1, 5 being the worse). QOL measured by the QOL5 questionnaire rose from 3.8 to 2.3, which is very satisfying. The patient went through the following phases in the course of the treatment: Finding her purpose of life and initiating the process by mobilising hidden resources Confronting her complete denial Sudden realisation of being very ill and taking responsibility Severe existential crises with no wish to live, while still fighting coming back to life Integration of many difficult feelings and negative decisions and rehabilitating her character Confronting the fundamental lack of intimacy and trust in others, rehabilitating her ability to love and be loved Rehabilitation her will to live, and BREAKTHROUGH feeling in love with life Returning home and assuming responsibility for her social relations. Liver tumours at follow-up smaller.

Case story

Female, 29 years old with breast cancer with numerous metastases to the liver. Session (April 20, 2004): SV (leading physician) and MES (assisting physician) and ES (physiotherapist). The patient has been treated at the Norwegian Radium Hospital, Montebello, Oslo. Breast cancer detected April 29, 2003 with metastasis to the liver (ductal carcinoma, stage III). Received antihormone treatment, Zoladex injections 3,6 mg pr. month, and Femar 2,5 mg per day. Also chemo therapy, radiation therapy (25 times) with right breast and all lymph nodes related to it surgically removed. Growing liver metastases, three large and many small. We informed the patient that she enters a clinical research study with the purpose of improving her QOL, her survival and if possible, inducing "spontaneous remission" of her cancer (2). She is informed that we have made a search at Medline (www.pubmed.gov) today and found that the mean statistics for survival in her case is about 4.23 months and spontaneous remission is extremely rare (this reference seems to be the one that most precisely describes the patient's situation; it says: factors that significantly predicted a poor prognosis on univariate analysis included symptomatic liver disease, deranged liver function tests, the presence of ascites, histological grade 3 disease at primary presentation, advanced age, oestrogen receptor (ER) negative tumours, carcinoembryonic antigen of over 1000 ng/ml and multiple versus single liver metastases; the patient has oestrogen receptor (ER) positive tumours, but multiple liver metastasis so we believe 4.23 month to be a fair prognosis based on this paper). We offer her an experimental treatment in a hopeless situation and we cannot promise her anything. She fully understood. Goal of treatment: Improvement of QOL measured by the QOL5 and QOL1 questionnaires (self-evaluated global QOL), improved survival, induction of spontaneous remission (induction of apoptosis, spontaneous cell death) of the cancer by rehabilitating her purpose of life, human character and will to live. Theory is given on: love, trust, holding and processing together with the holistic process theory, the theory of evil and theory of character. Session (April 20, 2004): Process on recovery of purpose of life and character (4). The patient co-operates smoothly and we succeeded to find her purpose of life and character: Purpose of life: I am honest (may have to be upgraded). Spiritual character: Truth (with law and will) (4). Mental character: Integrity[5] Physical character: Light/Humor (air) with clown, irony, neurotic, nerd, cynical (?), charm and firmness (5). It made good sense to everybody, including the patient. This was a very fortunate opening of the therapy.

EXERCISE: Act as the one you are!! EXERCISE (recapitulation) – with MES: Write your biography; start in the present, write about all incidents with strong emotional content - sexually, love, socially, family, work - elated to all people you have known in your life. Make a complete list of all the people you have known. What happened? What did you feel? What happened, what did you feel? What did you decide? Goal: to make a timeline from conception until present time. (With MES)

EXERCISE – with ES: Find out what prevents you from feeling trust and intimacy, and what feelings exist in the various organs and parts of your body. Plan: Improved QOL and health in 14 days, 4 sessions with MS, 4 session with ES, and 4 sessions with SV + MS + ES (a total of 24 hours of therapy in two weeks). We arranged for the patient to live in a private apartment free for 14 days. This agreement was written as a "contract of treatment" signed by the patient and physician in charge.

EXERCISE: Reading material on "Consciousness-based medicine"(2,40). Session (April 21, 2004, MES): The patient has started writing the list of names; it is now three pages long and she is not done. She has not written anything else. First, a brief talk about the experience of being here, the different mind-set, etc. She thinks it all makes sense, that it is "logical". Social information: The patient's mother converted to Jehovah's Witnesses as an adult, the patient's father did not want to. Today, she has good contact

with her father, whom she visits several times per week. She feels fully accepted and loved by him. She works in the customer service of a transportation company. She has a 7-year old daughter. The father takes care of the daughter half the time and it works out well. Afterwards, lying on the examination couch, she is told to try to think of a recent incident involving strong emotions. She mentions a phone conversation with her boyfriend the day before. He did not have time to talk; he was with his friends, which made the patient feel rejected. She feels sad and cries a little. She lacks his support every time she really needs it. The patient thinks for a long time before another incident dawns on her, which releases emotions: a brief message exchange with her mother around 300 Easter time. "Mother has controlled me since I was little, I feel she only accepts me when she is in the mood – otherwise she does not." She does not really feel capable of making large decisions without her mother's approval. The patient is used to frequent sarcastic remarks from her mother, but she claims to have had a pretty good relationship with her mother last summer (impression: good when the patient acts appropriately). After this, she cannot remember any incidents involving strong emotions. She says she was kicked out of Jehovah's Witnesses 6 years ago. The course of events: she was going out with NN (also a Jehovah's Witness) and had premarital sex; she became a problem in the community. She had lots of feelings of guilt and ended up marrying him to clear her case, but changed to another community shortly after. Following was an incident of kissing another man at a party. Feelings of guilt drove her to confess, and she was kicked out of the community. Her husband, Ronny was kicked out as well, when they discovered that he was snuffing tobacco and lost his driver's license after driving while intoxicated. This resulted in a very bad relationship with her mother. The patient joined the community again after her cancer diagnosis. The mother then took her back in. Brief talk afterwards: The patient still does not grasp the gravity of the situation, the time factor. I spell it out to her, and she reacts. (Impression: She is hard to get going. So far she has come in contact with feelings). Conference with SV: The patient must stick to working with her exercises. SV emphasizes this to the patient. I call the patient later that day to stress the importance of the exercises. Phone conversation at 4 pm: She says things are progressing slightly. She has a long list of names now and has started writing, but she doesn't think she experiences any feelings when writing about people and incidents involving negative feelings. Session (April 22, 2004, SV with MES): The patient has worked on her biography, but she has absolutely no feelings associated with it. We get an image of the patient's "inner garbage bin" in the shape of a can that is just about to explode due to the rotten content, like the canned fermenting fish some Swedish people eat ("surstrømming"). We talk about the lid being glued to the can and that the patient will die, when the can explodes. We agree to use today's session to loosen the lid so the patient can get in touch with her feelings. On the examination couch SV press her ribs on the side first, then the side of her breastbone to solar plexus and then her heart. The patient is instructed to replace the physical pain, which is close to being unbearable with an emotional and existential pain, which is worse. The patient succeeds much better than expected. She starts out being angry and then says: "I don't like myself." She cries hard and the following sentences come out: "I hate you - I hate me - I detest myself - I disgust myself" - and finally, when I press a finger "into" the patient's brain: I am so unhappy". We talk about self-worth, which according to the patient is at point -50 on a scale from –100 to +100. I think it is at -80. We talk about all the feelings she has of damaging herself, of being a failure, of feeling powerless and hopeless with self-hatred and anger. Many feelings emerge and the patient understands why she has become ill with cancer and what it takes to heal. She needs to acknowledge and integrate all these feelings, and when writing her biography, she needs to find the story behind all these feelings.

EXERCISE: Use a roll of paper towels to let go of emerging negative sentences/essences. MES helps. Session (April 22, 2004, MS): We work with "I do not like myself". Things are moving slowly and the patient must be pushed to get started.

After 5 attempts there is finally a reaction and she cries for a long time. I try several times afterwards to work with the sentence "I detest myself", but it does not work. It does not "catch on" with her. I ask her to think about other words or sentences that may be a better fit. She quickly replies: "I am a bad person. I am evil. I am bad". She tries to let go of the first one. She immediately starts crying and does not have the energy to work on any more exercises. We have a brief conversation about the progress of her writing exercise. Impression: her motivation is falling and she has put the lid back on. I tell her this; she sees it and promises to work hard. According to the patient's wish, I remove 1 stitch and drainage from her wisdom tooth in her left lower jaw. The patient has informed SV today that she is on hormone treatment (Femar) instituted by the clinic in Oslo. Session (April 23, 2004, ES): On the examination couch, I work with the diaphragm, intercostally in the chest and back between ribs 9 and 12 and on quadratus lumborum. The pain is nearly unbearable, but she shifts between laughing and twitching in pain and "flails her arms". It is hard for her to enter the pure, physical pain and move to the emotional pain. "It hurts so much", the patient says. While I work on the psoas muscle, she starts thinking about the midwife, who completely wore her out when she delivered her daughter and she feels anger. At this time, I take her hand to support her and it really makes her sad (she cries). She acknowledges the fact that she did not receive or accept much support in her life. It seems to me as if support and care brings her in touch with her feelings more quickly than all the physical pain in the world, which is easier for her to ignore. She thinks about her daughter; feels sad again and cries: "I am a bad mother". She remains lying on the couch, while I physically support her and hold her. The sentence "if this does not work, I can just die" emerges and I reflect it back to her and tell her 302 that it sounds as if she wishes to die. She becomes utterly sad and finds the sentence "I may as well die". The patient acknowledges that it is hard to allow herself to enjoy having me near her physically, and that I care for her. "It is not wise to think that having someone near you is good, because everybody disappears anyway," she says, feels sad and cries. We talk about the fact that she has been let down many times. We agree that she will continue to work on her biography and include all the times she has felt abandoned and let down, and to also work on these sentences: "It hurts so much" - "I am a bad mother" - "I may as well die" - "It isn't wise to think that having someone near you is good, because everybody disappears anyway". She feels pretty exhausted after the session and acknowledges that this is a painful emotional process. She can feel that she is entering the emotional pain, which she is actually afraid she will not survive. She understands the connection between acting dead emotionally and her illness, and that the emotional pain she feels right now makes her more alive. Session (April 24, 2004, ES): She has been on the verge of crying all day, also on the bus on her way here. She read SV's book and says that it is not until now she believes that she can get well. She feels happy and sad at the same time. We work on the examination couch with iliacus/psoas, the diaphragm/solar plexus and above her pubic bone. Intense, almost unbearable physical pain. Negative sentences to let go of: I'm held down There is no room for me I am dizzy When I become ill, my mother loves me more I am willing to do anything to get my mother's love It is just physical pain I am in despair I do not get it (the feelings) out I am quite hopeless I experience that I can do almost anything I want with her body and release the strongest pain without her reacting with anything but laughing and sweetness; "it hurts". I reflect back her indifference to her body, and her indifference in general. It is as if her body does not really concern her. No will to survive and live. These sentences then emerge: My body is not delicate, I am clumsy, My body is ridiculous, I resign, I give up, I do not fix it, I do not make anything work, Nothing works, I do not give a damn, It does not work. We talk about her being in touch with her resignation and resistance, and that it's hard for her to get in touch with her body and her feelings. I give her the exercise to let go of the sentences as many times as she can at night. Session (April 25, 2004, MES): The patient felt down after body therapy yesterday. She did not think she could enter the feelings

again. This was in hard contrast to the hope and the joy of life she experienced after having read material on "Philosophy of life that heals", before she arrived in Copenhagen. Regarding the home exercises of "letting go": she finds it difficult and does not completely understand what good it does to let go of the feelings she has. Perhaps it is a linguistic issue. We discuss her work with "emptying the inner garbage bin", piece-by-piece. The patient feels that she is "in her head" too much, that she intellectualises. She has written 30 pages in her biography that are not chronological. She thinks she has got some clarity of some of her patterns and indicates that rejection is a recurring factor. She has learnt the technique of capturing the essence of the stories, which has sped up her work a lot. More memories keep emerging. Also names. I read a few of the incidents from her biography aloud, and we talk about the associated feelings. But she does not reach them. I then mention some incidents for her to tell me about in detail; she gets in touch with her feelings and cries a little. She finds it difficult to tell me these incidents several times, and I feel that we do not "get to the bottom" anywhere. The patient sees that she already very early on learned to put a lid on her feelings. Several people have described her as being "cold" and "strong" in highly emotional situations (including during her stay at the hospital, while being treated for cancer). She remembers an incident when she was 10 or 12 years old, where she cried in front of her mother and father (because their dog had been "put down" due to her mother's allergies and the patient had not been told). They huffed at her for not having discovered it sooner (apparently, it had happened a week earlier). She understands how she was not met with respect and love. Another incident emerges and she remembers her mother clearly indicating how much better the patient's friend was at writing than her. The patient "was never good enough" (in her mother's eyes) at school. Her father was more supportive. She tells me that she in certain situations pretends not to understand how she is offended; she acts stupid. "Are you stupid?" "No. I am smarter than they are", she says. The patient has described several incidents where she yells at and is tough on her daughter. She tells me that she finds the daughter to be "frustrating and irritating" when she cries and she often makes her daughter stop by being authoritative. She sees the parallel to how her own mother raised her. She feels sad. I compliment her for her good work on the biography and stress the importance of her having to work more intensely. Keep doing the let-go-exercises. Session (April 26, 2004, SV with MES and ES): We discuss the patient's trust in the treatment which is crucial SV offer her to get her money back (the half which is not yet used), if she already now knows that she does not have trust in the work we do. She has to choose and so she chooses to stay and work seriously, cooperate and form an alliance between her own "white side" and the white sides of MES, ES and SV. On the examination couch, we work with shame. MES takes care of the patient's safety, so she will not be in any more pain than she can endure. ES gives holding and SV process her through the rough pains of the past: "I am a pig who emerge nasty, ugly and disgusting" - "I am ashamed of my body and my sexuality; mostly my vagina and my clitoris", the patient says after an everlasting battle against her shame, which completely prevents her from saying anything for 20 min. "My labia are not filled with shame", she says; "I has been preoccupied with my clitoris and vagina since she was a child".

EXERCISE: Place yourself in embarrassing positions at home and delve deeply into your shame; find out what it means and where it comes from. Write a journal of all the embarrassing and shameful incidents in your life.

EXERCISE: Use a paper towel roll and let this go: "I am a pig - I am nasty - I am ugly - I am disgusting". Session (April 27, 2004, ES supported by SV): In this session we use the sexological techniques called acceptance though touch. We work on the examination couch with her shame. We work with her stomach and thighs and we talk about her having to take off her panties to get deeper into her feeling of shame. She does not feel like doing this at all, but she understands that it is necessary for her to process the shame that will emerge in her and she takes off her panties underneath the sheet. The

sentence "I am far away" emerges, and she lets it go. She places her right hand over her genitals and ES places her hand on top of the patient's hand. There seems to be much shame associated to the support from the hand of 305 ES. She fights against her shame by spreading her legs very slowly, until the soles of her feet touch and her knees drop to the side. There is much tension and pain in the adductor muscle group and in her hips. Slowly and gradually she removes her hand, so that ES's hand lies on top of and touches her labia, clitoris and the opening of her vagina. This makes her feel great shame and self-condemnation. Her sentences come out with the words: He must not see me, It is nasty, I am nasty, It is disgusting/I am disgusting, It is not right to do, You do not do such a thing, I become tired, My legs hurt, I cannot, I am dirty, I am gross, I probably smell, I am nasty and I like it, I grieve for myself, I am a nasty person, yikes… I want to throw up, I have given up on myself, I am crazy, I am stupid. During the process, the patient remembers an incident as a little girl where she is standing naked in the bathroom with her mother, when her father enters. She feels fear and hides naked behind the door: "He must not see me". She also remembers how her mother gave her clear instructions on how to wash herself thoroughly down below. Her exercise is to let all these sentences go using the paper towel roll. She has great pains in her hips, buttocks and loin. She gets a massage and care, which helps. But she feels "like a 90-year old woman" in her body when she goes home. Later on the phone with SV, she is told what the positive sides of her character are. She has to explore this herself as well. Session (April 29, 2004, SV): The patient shows no will to live today; she is completely negative, obstinate and contrary. She does not want to be here, does not feel like it. We talk about what is going on with her and reveal a death wish and an old feeling of wanting to take revenge on her parents, because she cannot have it her way. "Nothing happens", the patient says. And I make her repeat it, until she remembers that her parents always fought, when she was about 9 years old. "Everybody is stupid", she says, and "it is just nonsense". "I do not think your tumours are growing anymore," I say when asking about her illness. I have to disappoint her and tell her that as long as she does not want to live and continues to be so negative and against life, she should, in my opinion, not hope for recovery. She needs to find her will to live. That is a good project for the day. Say "I want to live" a 1,000 times", I tell the patient. But this is extremely difficult for her. I can barely get her to do it. She puts her head between her legs and covers her face with her hands; she is in great pain. "I feel like sitting in a corner and doing like this," the patient says and crosses her arms very tightly in front of her chest and face. She is only 2-3 years old now and it is impossible for her to live with all the people who are unfair and untrue around her. She fights, grieves, defeats herself, cries and says: "I want to live" in a more and more convincing way. "I want to liveeekI want to liveI feel so stupidI want to live..."

EXERCISE: Go to the sea and yell, "I want to live" many times, until every fibre, cell and organ in your body wants to live.

EXERCISE: She needs to let go of these sentences: "Nothing happens - Everybody is stupid – It is just nonsense - I do not feel like it - There, you see? (Revenge) - I do not want to - I do not get it?" I get her permission to make her journal public anonymously, in writing as well as verbally. Session (April, 29, 2004, ES): The patient has been to the sea and tried to yell, "I want to live", but she did not quite manage to set herself free. She is very tired and has given up on herself. It disturbed her that so many people were there to see her and hear her yell "I want to live", and it deeply upset her that she could let that stop her from doing what she needs to do. My thought is that it resembles her experiences with her parents, but she cannot fully agree. We work on the examination couch with processing her negativity and lack of will to live. She needs to take a chance and use her will to choose life over death. I instruct her to go back to being a formless mass of energy, where she lets go of everything, all feelings, all thoughts, all form, and all ambitions… And when she reaches that point, I instruct her to remain in the energy, to feel its force and let it fill every cell of her body. Feel the energy and the force and tell

yourself inside: "I want to live" and when you are ready and able to say it from all parts of you, from all your cells, you say it out loud as many times as you can. In the middle of the process, SV pops in and asks how we are doing and we are both even more moody and negative, but tell him that we are doing fine. We continue the process with an even stronger negativity. After about 20 minutes, she stops. "I am far away", the patient says. She feels sad and in despair, because she cannot say "I want to live". "I cannot fix it," she then says and cries even more. It is my experience that she meets her negativity and processes it. We talk about the fact that the pain she feels is an old pain from a time early in her life, when she did not survive unless she changed herself. However, she is now an adult and receives the necessary support to change her decision, and she can use her will to choose life. She cries again and the sentence: "I do not want to die" emerges. She feels very sad and in deep despair. She repeats the sentence many times. "Then what do you want?" I ask. After a little while, the patient says, "I want to live", and she repeats it 10-20 times. It sounds as if she means it. She cries and laughs. I cry and laugh with her. Afterwards she is both tired and happy, "like after a good orgasm or long lovemaking. I feel like I have just fallen in love," the patient says. We discuss that she has to choose life over and over again, every time she encounters the choice. She has to be true to herself.

EXERCISE: Make a positive flower, where the core is called "I want to live", and every petal describes what makes living joyful to you the opposite of negativity. Session (April 30, 2004, SV with ES and MES): We talk about feelings and anger. She has to be emotionally honest in every situation. She has to pay attention to what she feels and what she can do.

EXERCISE: to practice expressing her feelings in every situation with other people. We talk about what is ahead of her and I tell her how people normally feel and emotionally move up and down during a personal growth process. When they integrate old feelings they get new resources, which make them able to get in touch with larger problems. When they integrate the new feelings, they again get new resources to get in touch with even larger problems. Often this continues for years. Plan: We are almost done for now. With ES: She can work with ES on expressing her anger; she can work with MES to get an overview of the past 14 days of progress she has just been through. With MES, who will make sure to get the patient's own notes on record and to make an approximately 5 pages long resume with an introduction that briefly summarizes the patient's progress. Continue doing your EXERCISES about acting who you are. I see myself in a different way - it's good to be me. This is primarily thanks to ES' session with the patient, where she learned to accept herself. The patient is informed that it is now up to her to stay on track and create a good life; she must put everything she has learned into practice. We formally review the result of the treatment with QOL5[96, for the calculations below see also this reference]: QOL5 at the beginning of the treatment: Q1-Q6: 3,4,6,3,4,4; QOL= (3.5+4+4)/3= 3.8 (4 is bad). QOL5 at the termination of treatment today: Q1-Q6: 3,1,6,3,1,1; QOL = (2+4+1)/3=2.3 (2 is good). Self-evaluated QOL: Before: 4 (bad), after: 1 (very good). Difference: 1.5 scale steps of improvement on measured quality of life, 3 scale steps of improvement on self-evaluated quality of life. Overall a good result up until now. After she comes home, SV would like to be informed weekly via email about how she is doing. We discuss that she may possibly join the quality of life summer course and we will see what she needs by then. We must also communicate about how we can support her daughter. Session (May 4, 2004, ES): "Where are you?" I ask the patient when we are about to start, 10 minutes late, because she has been talking on her cell phone. "I am at home", the patient says. I confront the patient and tell her frankly that I am angry with her for wasting my time, which I have scheduled to help her and I am angry, because of her indifferent and arrogant attitude. I reflect that back to her and confront her with my anger. She responds in a patronizing and grumpy way and tells me to "get over it". The patient describes that her body becomes timid - otherwise she would have walked away from this situation. "I feel like I am 7

years old and cannot talk back" ("I am not allowed" - "It's not permitted" - "You don't do such a thing"). On the examination couch we work with her time line and the feeling of not being able to express her anger: I hold her stomach, chest and neck. 6-7 years old: She is picked on badly by her friend's sister. She becomes angry and paralysed. Finally, she is chased off. 29 years old, she is treated for cellular toxicity: She is very tired and asks her father to take care of her daughter. But he will not, because he has to go get potatoes. She feels powerless and angry. She cannot say anything, because that will make him cross and sulky. 12 years old: Erika, the family dog has died, but she only finds out several days after the parents have secretly taken the dog away to be "put down". She is sad and angry, runs out and bikes off far away. She feels rejected: Her reaction was unnecessary. She gets in touch with chaos when we follow her time line. It is hard for her to think of more incidents, although she knows there are many. I apologize to her for having hurt her by getting angry with her and I respect the vulnerable state this causes her to enter. We follow the time line again and search for incidents when her anger got dramatic consequences. I hold the front and back of her neck, chest and stomach. She does not remember any incidents, but she feels afraid. She is afraid to be abandoned. She is sad and feels pain/pressure in her chest and stomach. Sentences emerge: "When I am angry, you leave me" and "Everybody disappears when I am angry" - she LETS GO of this under much resistance. She feels sad and cries. We talk about her having to let go of this sentence many times, so she can lose her resistance to being angry. Contain her anger of being rejected, as opposed to repressing it. Contain her 309 anger instead of enclosing it with her body. Dare to be rejected, but not reject herself. Choose to live. We look at her human character and purpose of life in order to review what it means to act out your character and discuss how to form an alliance with the good and positive in your character in choosing to live. This is the last treatment she gets. Note (October 4th , 2004 and DAY 150 (SV)): Concluding remark. She is doing well. I have received several sets of ultrasound pictures from the University Clinic in Oslo showing in successive ultrasound examinations that her lever metastasis are disappearing (compare her diary below). Now there are only a few tumours left in her liver. She has attended our 5-day summer course on quality of life and she is still working on improving her quality of life further. It seems thus that her development is positive and stable.

Diary of the patient

DAY 1: First session with Søren (SV), where he introduces me to Elin (ES) and Mads (MES), who will apparently also work with me. We talk a little, and then he rearranges the chairs, so that Elin (ES) comes to sit right next to me, really close. I get hot, and don't like it! Søren asks what happens and I ask him if this is necessary – she crosses my barriers, I don't want her so close! I move away a little and he asks me if I know what I am doing? Am I aware, that I am rejecting the trust she tries to show me? I get embarrassed, put out...he is right! What is wrong with me? So I move my chair back, and stay there for the rest of the session. I am told to write my autobiography, from this day backwards, to my birth. Oops! And me that cannot remember my childhood!? We find my life mission: I am honest. It doesn't take them many minutes to describe the exact person that I am…scary.

DAY 2: Session with Mads: I was lying on a bench like at a psychologist, talking about emotional episodes. Cried some. Must start with my biography now. Søren (SV) and Mads (MES) are pushing me hard. Mads (MES) is concerned that I haven't realised the severity of my situation, how little time I have left. I go home to get started. First the name list….oh my god, 300 names so far, and there are still many that I have forgotten.

Spend two hours on the biography, not easy. Feelings and tears coming out, and then it is over. Cannot remember any more episodes, feel completely cold. Worries me.

DAY 3: Session with Søren and Mads: I say I am worried about the writing, no more feelings. Søren explains that he will help me with this today. Asks me to undress to my underwear…I resist. Undress? On the bench I lie with a sheet over me. Søren asks me if there is anywhere he may not touch me. He wants to touch me EVERYWHERE????? Well, I must trust him, so ok. Mads 310 is also to touch me. Ok. Søren finds places on my chest where he applies pressure, says that this is where I "hide" feelings…..it hurts like hell! He tells me to transfer the pain into emotions and let them out….transfer??? He says I must feel, not think! At the same time he talks to me about the negative stuff I may have hidden here. He asks Mads to hold my hand for support. THEN the emotions appear! I cry a lot. Søren helps me to verbalise them, asks me who I hate….I hate ME!!! I cry, I feel the pressure from his hands and it is very painful. He moves his hands to over my heart. Terribly painful, even worse than before! I feel very unhappy now. Cannot stop crying. He moves his hands to my belly, where the self-value emotions apparently lie. Does not hurt physically, I cry less, but tears keep rolling down my cheeks… He asks me what score I would give myself, in value, on a scale from –100 to +100, where 0 is neutral. I say –50. Søren says –80, I cry and cry….I realise that I simply don't like myself! I see that Søren(SV) has helped me remove the lid on my "internal garbage bin". I had it glued on with superglue. Søren gives me an exercise: to say the negative sentences out loud, while I hold something in my hand and squeeze it as hard as I can, thereby transferring the sentences to it, and at the same time touch my forehead in the middle just above the eyebrows, to make contact to my spiritual side. Say it out loud to myself so I feel the emotion, and then let it go. I am to do this every morning and evening, repeat the negative sentences…"I hate myself, I puke at myself, I despise myself, I don't like myself, I am a bad person", etc. etc. After a while I suppose more sentences will come…the point is to *feel* the emotion, then squeeze it into something else, and then let go of it. Søren goes and Mads keeps working with me on this. He is not merciful…. I cry…and finally can no more. I get dressed, we small talk a little and borrow their computer to check my email. Mads comes back with an earnest expression…he worries that I am not fully serious about this. That I have already put the lid back on. I can feel that it is true. It is NO problem to put it back on… Had tea with Søren in the evening…. I appear to be a "difficult" patient. He says I am very ignorant and distant to the world. That I am very neurotic and controlled by feelings that I deny. I don't realise that I am very ill and will die…SOON if I don't let go of my old patterns. He said he was surprised at how hard he had to work on me today…that I am very cold. DAY 4: Søren says I must pay the fee now, partly symbolic, so I don't consider these days a "testing period" for effect. If I pay now, I get more hungry to get value for money…I get the idea… Session with Elin: We talk a little, she asks me to lie on the bench. She uses much the same technique as Søren…It really hurts. She applies pressure and squeezes my back, for a long time. Then she says it feels like I manage to leave my body. I think she is right, for I can only feel physical pain. After a while she takes my hand….THAT'S when my feelings burst out, and I cry. I admit that if this doesn't work, I might as well die! I am deeply unhappy, a poor mother, a bad human being…. Get these expressions onto my list of sentences to let go of. I am very tired….. and sad. And very fearful that I will fail to let go of these feelings. New talk with Søren in the evening: Today he talks about my friends and relatives that will fight the new "me" when I get back home. That I must find new friends that share my view of philosophy of life and I see what he means. A good friend from home had called me, cried and was angry, didn't understand why I am going through with this, wanted me to demand a second round of chemotherapy instead. I felt no support from him. Søren says it is important I stay away from him for a while. Only share what is happening with those who can support and

believe in what I am doing. Take use of the friends that give energy, not the others. And me thinking that hell was over once I got back home….

DAY 5: Started reading Søren's book on "Philosophy of life that heals" and had an enlightening experience. He actually knows what he is talking about. I see my body as a bunch of cells…that are just like single individuals. Strange. Feel like I am high….happy and sad at the same time….I am going to get well!!! Session with Elin: I am initially happy and chatting stupidly, feeling certain things will go the right way…but no. Elin squeezes my belly and pelvis. Hurts a lot, but no emotions. Can't "disconnect" my head. Get disappointed….am I really this cold? Elin says I am one of the coarsest, most ignorant patients she has had. That everything impacts my body, but not *me*. Scary. Find many new sentences to work with tonight….got to get going! I leave, sad and disappointed with myself. DAY 6: Tea with Søren: He is mad at me. Feels that I am hiding behind a facade of being stupid, while really being quite intuitive and intelligent….who me??? I think he is right. It is easiest not to make so much of myself, not be in the way. But Søren says that life is not about being in other's way, the point is not that others like you, but that I can do something of value to others. Why is it so enormously important for me to be liked?? I think about my job, that I do nothing meaningful to others there.. Søren says I must stop trying to understand everything with my head, that it is impossible….and I know that this is a great part of my problem. I DON'T UNDERSTAND!!!! Søren says that even if I think things are not progressing, they are. I just don't realise it. Session with Mads: Things go much easier today. He reads up some of the situations from my past, we talk about them. He asks me to tell the story of my cancer, the treatment, etc. I realise how distant I have been to it all. How much I have abused my body. I feel a deep sorrow and cry. That I have been so stupid… I also realise that I haven't had much support in my life. No wonder I have learnt to repress my feelings! It is tragic to see my patterns, and understand how "destroyed" I am.

DAY 7: Session with Søren, Elin and Mads: Søren starts by apologizing for being a little hard on me, that he has fought a lot with my doubts, etc. He sees that he doesn't love me enough. I think: "of course he can't do that, I don't let him in…" I cry. He says, he has considered giving me half of the money back, and send me home. I must answer if I want this. I DON'T! He says ok, but then I must decide to believe in that he can help me. I do that, realising that my defences have been producing my doubts. On the bench, Elin and Mads give support. Søren talks and finds points to press on. Asks me to say: "I am a pig" (a dirty person). It is VERY hard for me to say it; I just lie there, laughing. After a while I understand what he is aiming at…I cry and cry. He talks of shame, guilt, sexuality and food. Speaks a lot of shame over my sexuality and wants me to name the body parts that I am ashamed of….very hard to say it out loud. Finally he says we can take another approach if I like….ok. He asks me to spread my legs a little…WHAT?? Spread my legs?? Is he going to touch me there??? No thanks! I must say it instead. He helps me find the words, I say them….phew! That was hard! This was an important lesson for me. I get a good hug from Søren before I go, and feel much more confident in him now…good! I am given as an exercise: To find sexual positions that I am ashamed of…eh? I feel there is no such position for me, but Søren figures that I haven't tried hard enough…hmmm.

DAY 8: Feel very tired. Last evening was tiresome, everybody called me. Had no peace…realised I have to tell everybody that I need peace, that I will contact them if I need to talk. They don't understand what I am doing anyway. Session with Elin and Søren: Today they will work on my shame of my sexuality, and Elin suggests that I take off my underpants and that they will touch me. I feel my tummy tighten, I get embarrassed and worried. Start to cry. I don't want to, one can't do that! I finally take them off. Søren asks me to put my hand on my pelvis. I do it, and Elin puts her hand on top of mine. Then he asks me to spread my legs. My legs lock themselves… spread my legs??? Tears roll and roll down my cheeks and I fight a huge fight with myself.

Suddenly Søren asks me where I am…I have fled! To the universe, somewhere, far away! I let go of the sentence: "I am far away", and try to focus. Søren has another patient, must go, and leave me with Elin. She asks me to spread my legs, very slowly, stop along the way, and sense the emotions that come to me. It is a big fight, lots of bad feelings and shame. And I realise that I flee within a moment, can hardly feel I am doing it. It happens a lot, I have to work hard to be present. It hurts, but is at the same time strange to experience. Terrifying to see that I have repressed so much shit. Elin asks me if I am ready to remove my hand. What? I remove it slowly, and finally her hand is on my pelvis. I am ashamed to realise that I enjoy it… Yuk! She asks me which emotions come up, and at one point I feel sick. I am disgusting and sick and shake my head and body (and I do it again now as I am writing...). Elin asks me how old I think I am. I don't know, cannot see that these are feelings I had as a child. Afterwards she touches me even more closely, I find it disgusting. What if I am smelly? Now she gets it on her fingers, I get sick again. It is really a very tiresome session; I have a headache at the end of it. Elin gives me some massage for my sore back and thigh, they just hurt more and more. She thinks the pain is also due to the process I am in. I get a sheet of paper with 18 sentences to let go of at home…phew! I ask Elin about the purpose, the effect of this process. She explains that it is to acknowledge what burden the cells are carrying. Finally an answer that I understand!! I have to let go in order to help my cells! Of course! Leave with a deep sensation of sorrow. Work hard on letting go in the evening. My body feels heavy and sad. Very tired, headache. I almost feel sick while doing it, my head is shaking. Crazy. Look forward to becoming a "new" person, the real me, for this is gruesome to go through. I realise what Søren meant by having to "die" to become the "real me". If I survive this, I will survive ANYTHING!!!!

DAY 9: Session with Mads: We work on the shame-part. He read out from my notes on shameful experiences. Not so much feelings today, but on having to tell the same story several times I realise that more and more details come to me. Strange. We find out that the shameful sexual episodes I have written about actually weren't shameful…so where does the shame come from?? I cannot remember any sexual assault during childhood, but when Mads asks me if I have been raped as a grown-up, I jolt. But have no memory of this either, so I don't understand that reaction. The brain is funny…. I go home and feel completely at loss. Cannot remember a single episode, everything goes very slow. Try to let go of some sentences, but I feel nothing. I give up, have a shower.

DAY 10: Session with Søren: He says we must get my will going! He asks if I think my cancer has stopped growing. I say I think so, he says it probably hasn't! Because I lack the will to live! He asks me to say out loud: "I want to live!" I have great difficulty in saying it…start to cry and want to hide myself. He asks me to go out to the ocean and scream out loud that I want to live…hmmm…ok. I find a suitable place on the beach and manage to say it quite loud, but worry that someone will hear me. I know it is stupid, but cannot overcome that fear, feel very silly. Work on it for an hour; feel that I am going home without having accomplished what I was supposed to. Disappointed and tired. Session with Elin (ES): I am frustrated. Why was I so worried that people would hear me, who do I connect these people with? I don't know. I lie on the bench, Elin wants me to sense all my emotions, and let go of them, feel that I am only mass and energy….and feel that I want to live with every cell in my body, and then say it out loud. Søren knocks on the door, interrupting us, and I try again…but cannot. Get very desperate, Elin says I must use my will…Tears roll and I want to escape… Elin explains that this was how it was for me when I was a child, with no support, but that I now have the support I need. I start to cry a lot, and Elin cries with me. Finally it comes to me: "*I don't want to die*!!!" Elin asks me what I want, and I say: "**I want to live!!!**" I cry and cry and repeat that I want to live. Suddenly, I start to laugh, and we both laugh a lot. Feels good, I feel like in love, high on life, call it what you like, but I am very happy! Tired, but very happy! I am given an exercise: To draw my positive flower. I walk off feeling that I have lots of

energy, merely floating down the street. Imagine, *I want to live*!!! Great! I think about all that I want to do in the future. I want to live!!!!!!!

DAY 11: Session with Søren, Elin and Mads: Still high on life, I am bubbling! Søren says that he had planned to send me back in time to my foetal age, but is reluctant, since I am so delightedly happy…We finally agree to get me on the bench, and he will try to bring out my anger…he says anger sets itself in the liver! Oops! Makes sense! I know that I can explode if I get really mad. Elin and Mads support me. Søren pushes and squeezes so hard I think my ribs will break, but I cannot get angry, it just hurts really badly! He tries to make me call him names, to growl and scream, but I can't. Just laugh and feel really stupid. But I see my problem. I have always repressed my anger, because one just doesn't get mad at people, and the few times when I have, it has taken off completely…it scares me a lot to think about having to tell people off when I get angry… Now Elin switches with me, gets on the bench, and growls and screams "I hate you" to Søren. But it does not help to make me yell at him…sigh! I get dressed, and we talk a little. I sign the papers on allowing them to use my case in an article. And then it hits me, are we finished??? Is this all? Help!!! I walk home and feel that everything is chaos! How will I survive at home? If I start telling people off, I will be all alone, etc. I feel fear of going home. FEAR!

DAY 12: Session with Mads: My body feels strange, bad, I am sweating even though I haven't been running, yuk! This session doesn't make sense to me, so we make a new appointment for tomorrow. Back home, in bed, I am suddenly hit by the fear that I used to have for demons during my childhood. I fall asleep and dream that something or somebody tries to tear off my sleeping quilt, and wants to hurt me, scare me. I get terrified and breathe heavily, like paralysed…it is all very lifelike…painful…I am very afraid!

DAY 13: Wake up, very tired. Feel alone and afraid. I burst into tears and cry for a long time. Cry myself back into sleep. When I wake up again things feel lighter and Elin joins me for a trip to Tivoli. We have a good time and talk a lot. Sleep well this night.

DAY 14: The biggest fear is over, I know I can succeed! Good mood today. Talk with Mads; we go through the whole therapy period. I realise that I have changed, and how important it is to me not to fall back into old patterns when I get back home. It will be a big fight, for I understand how I have been hiding instead of living! Locking up all emotions, not feeling, not sensing! Session with Elin: I arrive 15 minutes late. Elin tells me off for being late and I feel my chest tightening. She says I am "pissing on" the time she has reserved for me. I get very ashamed and apologize. But she doesn't give up and I feel I get angry. This will have to do! At the same time I suspect that she is trying to "trigger" my emotions and I must say she succeeds. I get moody and think "get over it", and Elin finds me condescending…I recognise the pattern; this is what I have always done! But I can't just answer back? One doesn't do that! We discuss it, and I realise that I have learnt this pattern early. One must be polite and never step on someone's feelings…but what about *my* feelings??? Hmm… I get on the bench, and Elin asks me to visualise myself from today and backwards, to my birth. Not think, just close my eyes and see what happens. The earliest episode with anger….I remember being told off by a girl after I had told her little sister off. She scolds med completely, and I get paralysed, cannot say a word, just feel my anger growing. In the end she chases me, and I just walk away. I guess I was about 7 years old. Elin asks me to close my eyes again, and I remember a time when I was very tired, needed support to look after my daughter for a while. I asked dad for help, but he wouldn't help me, he was about to go with someone else to pick up potatoes…. I got furious. Potatoes???!!!! But I didn't say anything, because then dad would become moody (I feel my tummy tightening now…)! I also remembered when my parents had my dog put down without telling me, and how angry I got when they just laughed at my sorrow…and I just took off on my bike… Close my eyes again, I am now to find an episode where I got angry, and it had dramatic

consequences for me. I remember nothing, everything is just chaos! My belly is singeing, think it is the lunch I had, only it is a strange burning sensation. Elin says it is probably the fear I am feeling. Of course! Elin then asks me how I feel about the sentence: "When I get angry, you leave me". I start to cry. She asks me then to let go of it, and I feel great resistance. But finally succeed. We are done, and I am worn out. Feel the fear of going home in my belly. I think I had never gone home if it wasn't for my daughter… I sit, trying to write about what happened today with Elin, but cannot. It hurts too much. I understand how I am "saving" myself by not letting my anger out. A friend calls me, and I get annoyed with her, but do not express it. Why??? I feel stupid and finally call her back to tell her off, realising that this was an excellent opportunity to practice….Phew! It went well.

DAY 15: Mads calls me, says he needs the rest of my diary before I go back home today. My belly tightens again! I guess I had hoped it could wait a few days…? I am a big girl. Imagine that this should be so hard! I see how I am trying to hide from myself, cheat on myself. Ok, I'd better get going…

DAY 41 (e-mail): Today I had an ultrasound test of my liver and remember that the case record said there were many small tumours here? They are GONE!!!!!!!! I am so happy There is one big and one much smaller now; I will get the proper test result in a month! I like you so much. Have a nice weekend

DAY 121 (e-mail): Good news – another tumour has gone!!! I was at ultrasound today and now they could only find two tumours… formally this 316 is only a temporary answer (until I meet with the physician), but they said it looks good and positive! I am so happy….. and grateful for your help, dear Søren and Elin! Big hugs and lots of love.

DAY 1050 She dies, after 3 and a half years, with about 2 of the years being happy.

Discussion

Improving the quality of life can be done in a few days or weeks by the recovery of character (4), purpose of life and will to live. It is not known if the effect of this treatment on QOL is permanent and we see that emotions will be unstable for month or even years afterwards. Our patient has both biomedical and holistic physicians and this can give her problems, because the two paradigms understand life, healing and the cancer disease very differently. The physicians are therefore likely to give her different and conflicting advice. If she follows one advise the other might judge and condemn this treatment. In this situation biomedicine did not have much more to offer, so there were no big ethical issues (2). In many cases like the present the combination of biomedical and holistic treatment is very simple and without any problems at all; when the breast cancer had metastasised to the lung or liver, there is no effective known cure and the biomedical physician will usually not hesitate to accept that the patients try any kind of alternative treatment. It is important to say that our consciousness-based medicine has not been clinically tested at this moment. We believe that all physicians are ethically obliged to take medical science a step further and develop new treatments, where the old ones have failed or are insufficient. We believe that the new medicine can help cancer patients subjectively; as we have already seen much good happen for the patients using it with a variety of diseases. We are in the beginning of using this method and we do not know very much about its biological effects or side effects and we will undoubtedly make some mistakes while experimenting in spite of our very best efforts. As we see it the holistic treatment of

patients with metastasised cancer has very few and very limited negative side effects, but instead a positive impact on the quality of life, general health and ability of the patient.

The recovery of human character (4), purpose of life, coherence and will to live (5-12), with consciousness-based medicine seems highly efficient in improving the QOL of patients with metastasised cancer and presumably also their survival in some cases. We find it important that the holistic treatment, which for the patient highly motivated for personal development can be done with a limited number of hours of holistic therapy during a few days or weeks, is developed to a general offer to patients with metastasised cancer. From a holistic perspective cancer can be understood as a simple disturbance of the cells, arising from the tissue holding on to a trauma with strong emotional content, in what we call "a blockage", allocating the function of the cells from their original function in the tissue to a function of holding emotions; improving QOL and helping the patient to process and integrate these traumas might even help the patients to survive longer. We believe that the consciousness-based/holistic medical toolbox has a serious offer to patients with metastasised cancer, and we will therefore strongly encourage the scientific society to explore these new possibilities. Our holistic medical research meets both ethical dilemmas and practical difficulties, but it seems evident from case studies that if the patient is motivated for personal development, QOL can easily be improved by helping the patient recover her character, purpose of life and will to live. To support the patient in learning from her disease the mastery of coherence of body and life, and using the crisis of cancer to recover the human character and the purpose of life seems turning a personal potential disaster into the greatest gift of all. When it comes down to it, life is not just about surviving; what is more important is to life fully, to learn from the great challenges of life, and to obtain the optimal quality of life while being here.

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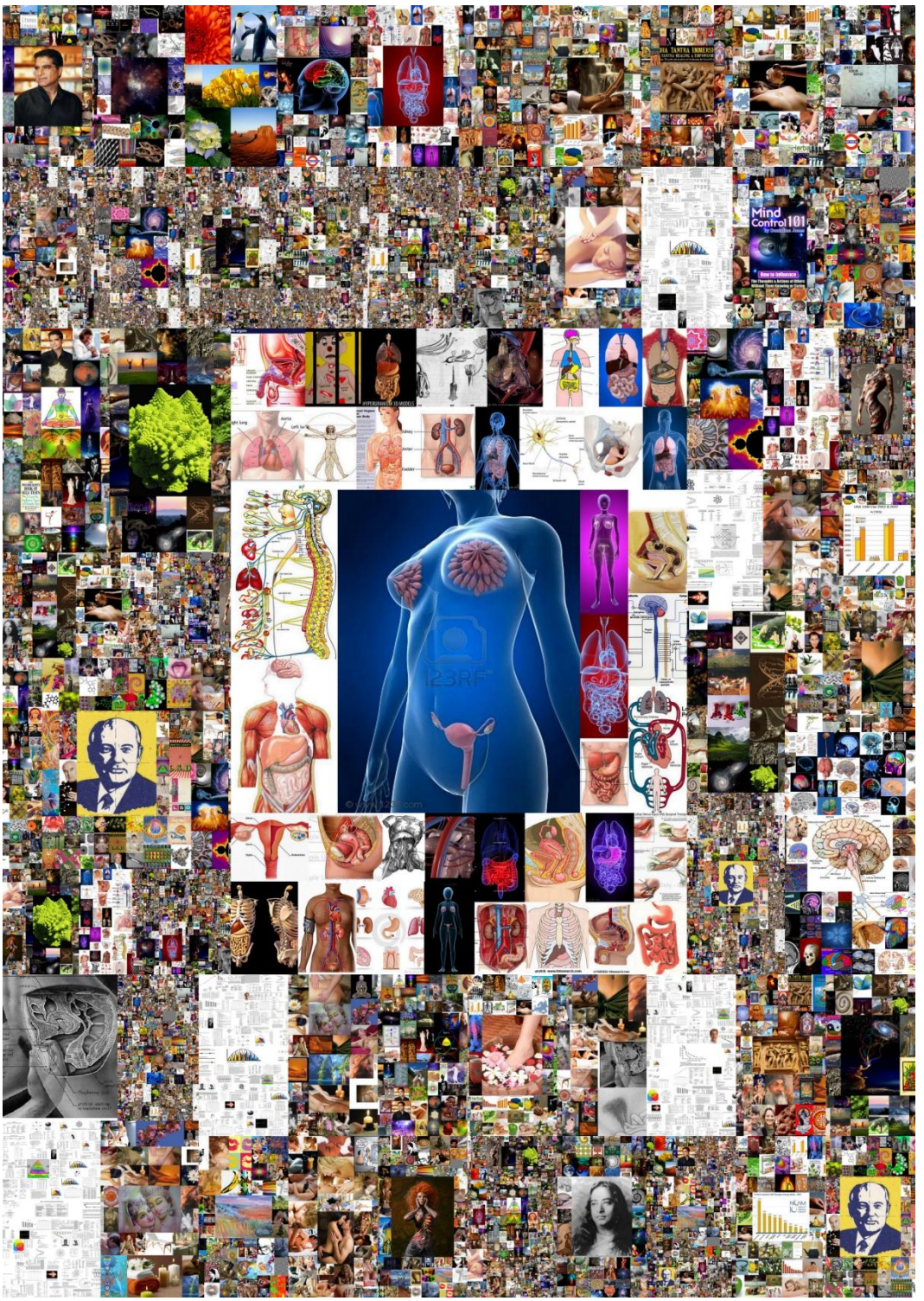

Chapter XVII

HIV and quality of life

In this chapter we describe a study to examine the association between the immunological impact of HIV (measured by CD4 count) and global self-assessed quality of life (QOL) (measured with QOL1) for people suffering from HIV, to see if the connection was large and statistically strong enough to support our hypothesis of a strong QOL-immunological connection through the non-specific, non-receptor mediated immune system, and thus to give a rationale for a holistic cure for HIV. This cross sectional population study in Uganda included 20 HIV infected persons with no symptoms of AIDS and a CD4 count above 200 mill/litre. The main outcome measures were CD4 count, global QOL measured with the validated questionnaire QOL1, translated to Luganda and translated back to English. We found a large, clinically significant correlation between the number of T-helper cells (CD4) and global self-assessed quality of life (QOL1) ($r = 0,57$, $p=0,021$), when controlled for age, gender and years of infection. The results have together with other studies and holistic medicine theory given rationale for a holistic cure for HIV. We suggest, based on our findings and theoretical considerations, that HIV-patients who improve their global quality of life, also will improve their CD4 counts. Using the technique of holistic medicine based on the life mission theory and the holistic process theory of healing, we hypothesize that the improvement of QOL can have sufficient biological effect on the CD4, that could avoid or postpone the development of AIDS. A holistic HIV/AIDS cure improving the QOL draws on hidden resources in the person and is thus affordable for everybody. Improving global QOL also means a higher consciousness and a more ethical attitude, making it more difficult for the HIV-infected person to pass on the infection.

Introduction

It is well known, but poorly understood why HIV infected patients have very different survival rates and some sex-workers for example are immune to HIV virus (1-3). A HIV positive person very rarely converts to HIV negative and we only know of one case, a patient in France who was "healed" by Martin Brofmann (4,5). The Norwegian professor Gunnar Tellnes (6) witnessed a minor positive change seemingly caused by alternative treatment: "I know a patient who was having alternative treatment and his HIV count has gone down since

he started on that treatment". CD4 counts, showing the concentration of T-helper cells in the blood, is a good indicator for the stage and seriousness of the HIV virus infection. Several studies have shown associations between different dimensions of quality of life and the CD4 counts for HIV infected persons: Health-related quality of life (HRQOL) (7,8), general health disability (9,10), social functioning, pain symptoms (10), functional performance (9) and HIV Overview of Problems Evaluation System (HOPES) have all shown associations with CD4 counts for people with HIV/AIDS. Other studies have proven HRQOL (11,12) and psychological aspects (9) to have no association with CD4 counts. These findings could be explained by the fact that the quality of life (QOL) concept covers many different aspects of life, measured by different questionnaires (13,14), but we use the most simple and general questionnaire called QOL1 (15). The proximity between consciousness and health is not new. It has shown to be beneficial for people to engage in attempts of personal growth, for example in groups where they can meet and talk about their life and problems. This has shown to postpone the time of death for the women with metastasised breast cancer (16) and to postpone the time for the next thromboses for people with coronary restrictions and partial thrombosis (17).

Our organism is equipped with several lines of immunological resistance. Some of these lines are apparently not based on receptor mediated immune response, and they constitute the non-specific immune system highly dependent on the "soft" non-receptor-mediated, biological information (18-20) and the macrophages and similar cells receive their information about what to engulf and present directly from this information source. According to our knowledge of the immune system's evolution, the non-specific immune system is not only the first to appear in the multicellular organisms; many data support our hypothesis, essential for the proposed cure, that it is also still the foundation of the highly developed immune system of the present-day organisms (18,19). In our opinion, a well-functioning non-specific immune system is derived from great inner coherence of the body (21-32), which in turn is related to a high order of the intercellular communication locally and globally, which is experienced as a high quality of life. Such a harmonic, coherent state can be obtained by consciousness-based, holistic medicine, helping the patient to heal existentially and develop internal and external coherence (20-24,30-33). Maybe this is the main reason why some African prostitutes do not contract HIV despite massive exposure to HIV virus or in other words due to a well-functioning and extremely effective basic, nonspecific immune system. Several theories exist on the regulation of the immune system. Biochemical theories point to chemical networks and Jerne-network, while holistic theories centre on biological information on the level of the whole organism. It is in this last perspective, where we suggest that increasing the QOL and thus the coherence of the person and the organism, will increase the immunological self-nonself discrimination, and thus the whole immune system's performance.

Our pilot study in Uganda

To test our hypothesis of a connection between quality of life and immunity to HIV one of our collaborators went to Uganda, where a decreasing part of the population (about 7% over 15 years) are infected with HIV (34), in order to collect data. To make it simple, the short,

validated, global quality of life QOL1 and QOL5 (15) questionnaires were chosen, The questionnaires were translated to Luganda and back with iterative corrections until the translation from Luganda to English was correct, using three different translators. The person responsible for the blood tests at a TASO (the AIDS Support Organisation) centre provided the blood-tests data and we collected the QOL-data of the patients with their consent for participation in the study, when they were tested. The survey included 22 HIV infected persons between 25 and 52 years of age, known to have been infected for 0-8 years; two persons with a CD4 count below 200 Mill/litre was excluded from the study as they were suspected to have AIDS, which can compromise the QOL in itself.. Only one received ARV (anti-retro viral drugs). No one had any visible signs of AIDS or any infectious disease when examined. The persons were randomly chosen as they came by, without any other kind of selection.

Results from our study (35)

The association between CD4 counts and QOL1 was large and both clinically and statistically significant (see figure 1, table 1); no significant association was found between CD4 and age (p=-0.055, r=0.823) but age was correlated to QOL1. The SPSS version of Pearson´s Correlation and linear regression were used to describe the associations and partial correlation was used to control for age, gender and years of infection.

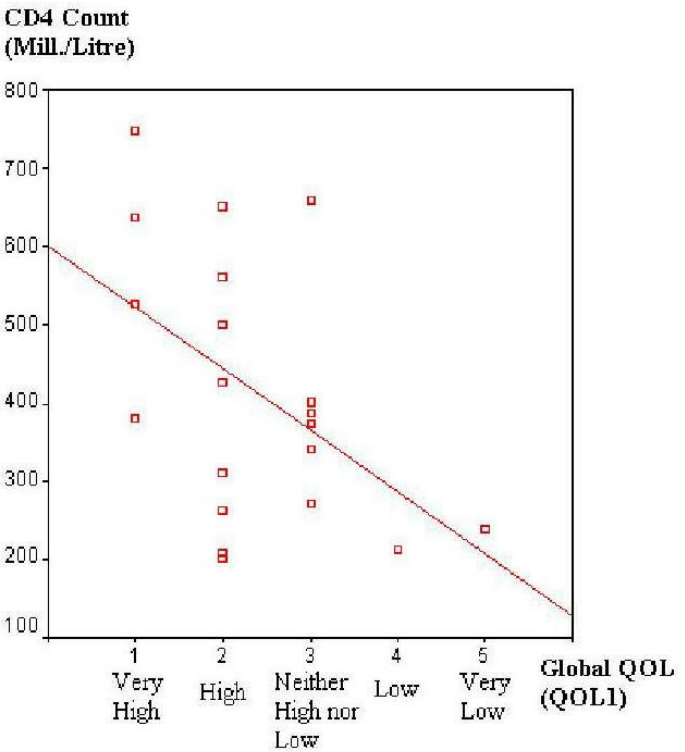

Figure 1. Association between CD4 count and global quality of life (QOL1).

We found in the survey of these 20 HIV infected persons a correlation between the number of T-helper cells (CD4) and global self-assessed quality of life measured with QOL1 controlled for age, gender and years of infection (r= -0.569, p = 0.021, when controlling for the all three), but no significant data was collected with the more complex QOL5 questionnaire (with resemblance to the HOPES 342 questionnaire) [33]. This was presumably due to the small sample (N=20) as we found the correlation between QOL1 and QOL5 to be r=0.70, p=0.001. Even when we controlled for self-evaluated physical health, a factor known always to correlate strongly to quality of life, we still observed the tendency (r=0.37, p=0.12). Often the CD4/CD8 count was calculated also (N=14), the correlation between with QOL1 was here insignificant, presumably due to the small numbers. Quite surprisingly, it seemed that the more globally the QOL was measured, the stronger the statistical connection to the CD4 count. Figure 1 is generated from using the shortest of all QOL questionnaires, the validated QOL1 [15], which measure the self-evaluated QOL with only one question: How would you assess the quality of your life now? Answer: I: very high, II: high, III: neither high nor low, IV: low, V: very low. Using this simple, generic and global questionnaire, we have found what seems to be one of the strongest psychobiological connections ever seen, between global QOL and CD4.

Discussion

The life mission theory states that everybody has a purpose of life or a talent. Happiness comes from living this purpose and succeeding in expressing the core talent in your life. To do this, it is important to develop as a person into what is known as the natural condition, a condition where the person knows himself and uses all his efforts on achieving what is most important for him. The holistic process theory of healing and the related quality of life theories (30-32) states that the return to the natural state of being is possible whenever the person gets the resources needed for the existential healing.

The resources needed are according to the theory in the dimensions: awareness, respect, care, acknowledgment and acceptance with and support and processing in the dimensions: feeling, understanding and letting go of negative attitudes and believes. The precondition for the holistic healing to take place is trust, together with the intention of the healing to take place. Existential healing is not a local healing of any tissue, but a healing of the wholeness of the person, making him much more resourceful, loving, and knowledgeable of himself and his own needs and wishes. In letting go of negative attitudes and beliefs the person returns to a more responsible existential position and an improved quality of life. The philosophical change of the person healing is often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life (22-29). The person, who becomes happier and more resourceful is often also becoming more healthy, more talented and able of functioning (36-38). Holistic therapy is thought to increase coherence and thus to reduce noise and disturbances in the intercellular communications. This in turn improves the immunological self non-self discrimination, which we believe is the main reason for the QOL-CD4 connection. The information system(s) of the body will thus deliver more precise and correct information to the non-specific immunological cell-lines (the macrophages, Kupfer cells, and others).

Table 1. Connection between global quality of life and number of CD4 cells (T- helper cells) shown by partial correlation and linear regression analysis (SPSS)

	Pearson Correlation, Partial Correlation (QOL1)	Pearson Correlation, Partial Correlation (QOL5)
CD4	r = –0.486 (p = 0.030)	r = –0.114 (p = 0.631)
CD8	r = 0.306 (p = 0.287)	r = 0.380 (p = 0.180)
CD4/CD8	r = –0.344 (p = 0.228)	r = –0.178 (p = 0.542)
CD4 controlled for age and gender	r = –0.565 (p = 0.018)	r = –0.300 (p = 0.242)
CD4 controlled for number of years infection (known years)	r = –0.505 (p = 0.028)	r = –0.137 (p = 0.577)
CD4 controlled for self-assessed physical health	r = –0.373 (p = 0.118)	r = 0.376 (p = 0.113)
CD4 controlled for age, gender, and number of known years of infection	**r = –0.569 (p = 0.021)**	**r = –0.367 (p = 0.163)**

Coefficients[a]

Model		Unstandardized Coefficients B	Unstandardized Coefficients Std. Error	Standardized Coefficients Beta	t	Sig.
1	(Constant)	680,379	254,065		2,678	,018
	sex	-115,595	83,534	-,338	-1,384	,188
	age	2,953	5,803	,135	,509	,619
	Number of years infected	19,022	19,590	,214	,971	,348
	Q6	-105,977	40,901	-,622	-2,591	,021

a. Dependent Variable: CD4

When QOL is improved the immune system should, at least in theory, be fine-tuned to better eliminating the virus infected T-helper (CD4) cells, while letting the body's uninfected Th-cells live. This is in accordance with a study showing that QOL actually can predict survival, even if it is not completely clear what causes the high QOL of some patients in this study (39).

Nobody knows yet how effective this holistic cure is against HIV and AIDS as it still needs to be clinically tested. We have loosely predicted the amount of therapy necessary for healing the HIV infection, from our experience with other patients, healing from very serious illnesses in our clinic (see table 2) (33). If our assumptions of the meaning of biological coherence for the regulation of the human immune system are correct, the highly sensitive information system of the body might even be able to detect the passive, incorporated DNA fragments incorporated by the HIV retro virus making it possible to eliminate the HIV virus completely from the body by apoptosis of the CD4 cells. Presumably such radical eradication of viruses would require much greater inner coherence than is required to sero-convert and many years of existential therapy. A study of only 20 persons, from Uganda which is very different from our western setting might be too small a study for reliable hypothesis, but together with similar result from other studies we believe that the QOLCD4 connection is to be trusted. Finding a large, significant connection in such a small group means that we have a tendency of large clinical significance.

Table 2. A holistic cure for HIV: improving the global quality of life might improve the CD4 (T-helper cell) blood count

Stage	HIV Status	Holistic Therapy	Immunological Status and Degree of Personal Development
1	HIV↑+/AIDS	None	Many inner conflicts that prevent inner coherence and disturb the nonspecific line of the immune system.
2	HIV+	6–12 months	Few inner conflicts, signifying HIV+ without reduced immunity (AIDS). This individual has processed the first 100 gestalts during intensive holistic therapy.
3	HIV↓+?	12–24 months	Few antibodies, which shows that the nonspecific immune system catches most cells expressing the HIV virus. This individual is aware of his purpose of life and happy about his life and personal character.
4	HIV–, but still infected	24–36 months	Great inner cohesion allows the nonspecific immune system to catch most cells before they express the HIV virus. This individual knows his purpose of life and lives accordingly a life with high quality.
5	HIV–, not infected, resistant to recontagion	6 years?	Apoptosis of cells with DNA with HIV virus incorporated as a function of a perfectly fine-tuned biological information system. This individual consistently acts out his purpose of life and is living his social dreams — he has accomplished his social utopia.

The participants were representative for Uganda's population, as such a large part of the population is infected. Another very important fact was that we looked at a group of people not receiving ARV, disturbing the picture in many other studies. The disturbance of the medicine is both on the biological and the measurement level, because of the use of health related questionnaires often including the symptoms expected to be alleviated, instead of the more neutral generic and global questionnaires used in our study.

The presented data suggested that global quality of life has a strong connection with the progression of the HIV virus infection. Since this connection also has been proven in several other studies, there is fair reason to believe that people, who radically improve their quality of life, as seems to be possible over a short period of time (36-39) will enhance their immunological status and improve their CD4 count.

An important argument against the proposed cure is that sufficiently improvement in QOL to be of major importance for the HIV patients is seldom seen in QOL intervention studies. This makes the possibility for complete sero-conversion to HIV negative unlikely unless the patient is highly motivated for personal change.

Even if a sero-conversion made the patients unable to pass the HIV virus on, this situation might not be stable. Such an HIV-negative patient is not cured of the HIV infection, as the retrovirus remains incorporated in the DNA of the T-helper cells throughout life. The most important aspect of a psycho-somatic HIV/AIDS cure is that it is affordable for the poor people of the world, who cannot afford the antiviral drugs.

Another very important aspect is that improving global QOL always means a higher consciousness and a more ethical attitude (23,29), making it a bigger and more visible problem for the HIV-infected person to pass the infection on. The development of the consciousness of the infected people might in the end be what it takes to puts an end to our global HIV epidemics, the most serious public health problems in the world today.

Conclusion

We found in a small survey of 20 HIV infected persons from Uganda a statistically significant connection between the number of T-helper cells (CD4) and global self-assessed quality of life (QOL). We suggest, based on this finding and theoretical considerations, that HIV-patients who improve their global quality of life, can improve their CD4 values and thus avoid or postpone the development of AIDS. The rationale for the cure is found in holistic medical theory, the recently published life mission theory and the holistic process theory of healing, according to which general health can be improved when the patient improve their quality of life. The proposed cure is essentially about helping the patients to improve their QOL and thus their internal coherence. This is on the cellular level equivalent to improving the intercellular communication, which supports the immune system and thus improve the patient's immunological status. We hypothesize that this can be done to such an extent that the patient gradually improve their CD4 count.

As a result of our experience with holistic therapy based on the life mission theory and the holistic process theory of healing, we have defined a scheme for the connection between HIV status and the improvement of QOL by personal development raising the internal coherence. A holistic HIV/AIDS cure improving the QOL draws on the hidden resources of the person and thus affordable for everybody. Improving global QOL also means a higher consciousness and a more ethical attitude, making it more difficult for the HIV-infected person to pass the infection on. The development of the consciousness of the infected people might in the end be what it takes to puts an end to our global HIV epidemic.

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Chapter XVIII

Reflections: What are the true potentials of holistic medicine?

Quality of life (QOL) and health are not the same. QOL is the state of being or existence of the person, while health is the state of body, mind and spirit. QOL is the state of your totality, your wholeness. QOL is influenced to some degree by our health, but much more by a few core dimensions of life related to love, consciousness, gender and sexuality. So if someone for example gets cancer and becomes very sick and this person wants to improve the ability to love, understand and enjoy, then the QOL can also be improved, in spite of being very ill. Doing this intervention the person might then even improve the health also. Actually, it seems that if you grasp the secrets of life, if you connect to your inner wisdom, you might even be able to cure yourself. Spontaneous healing is connected to the recovery of existential coherence. The gain of coherence can be a slow arduous process, or it can be a much more speedy transformation of your whole character and existence, if you dare to challenge your own philosophy of life and develop what we could call "deep cosmology" or an understanding of life that is rich in concepts on the subjective life. To explore our inner realms and dare to confront, and make friends with the deepest structures in brain-mind, body-mind, and soul - this is really what it takes. But we have so many difficult emotions connected to body and mind; so little self-esteem, so little confidence, and so little love for ourselves that these inhibitions will often limit us being able to really improve QOL, when a serious disease has arrived.

We must therefore make holistic medicine efficient and speedy, which is really what our efforts are all about. It is interesting that “love” is only a four letter word, but we spend all our lives chasing after it. Prevention is so much better than cure and personal development is really a possibility to achieve by using the concepts of holistic medicine. Development of talent and personal value seems to be the most efficient of all tools for improving QOL, health and general ability of functioning. Talent is coming from realising potential within ourselves. We all have one primary talent and only after finding and using this, can we really blossom as people. When we are creating value to other people and ourselves we are realising our self. We are living the life we were meant to be from the very beginning. It is our hope that every physician and therapist will have the development of talent as their primary focus, whenever they are involved with the art of helping. "Give a man a fish and you have made his

day; teach the man how to fish and you have made every day of his life" is an old Chinese saying. Teaching the patient how to fish is really what holistic medicine is about.

Potential of holistic medicine

In this book we have seen that even heart disease, cancer and HIV seem to be well within reach of holistic medicine. This is highly surprising and a positive direction, since biomedicine has been able to do very little about these diseases, which are the major causes of death on the planet today. Most people in the west will get one of these diseases and in most cases only helped modestly by biomedicine. Scientific holistic medicine seems to have a real huge potential. The cure that is most intensely documented is the Dean Ornish heart program, which has been published in the Lancet. But little has happened in the world with regard to the implementation of Ornish methods.

The conservatism against this new strange medicine and curing with love, not the power of drugs has confused and even worried many people close to the power of the medical systems. It is too strange, too unexpected, and too difficult to believe in. In a way, holistic medicine is way too good to be true! The other difficult issue is the resistance of what has been called the medico-industrial complex: the pharmaceutical industry and the physicians working together, sharing the money the patients pay for the drugs. This is quite serious that many pharmaceutical companies are making their own “quality of life research” only to convince physicians and politicians that they indeed think about the quality of life of the patient, while they in reality do nothing than market drugs and protect their business. Yet another problem is the difficulty most physicians these days have with intimacy and honesty with their patients. To be really supportive the physician must be able to care for the patient and win his trust. Love and trust are seldom the focus of the modern bio-medically oriented physician or clinic. So everything is set up for using drugs, even when loving care and attention often could do much more good for the patient.

The true potential of scientific holistic medicine is that every physician can be able to support and heal most of his patients, if they want to do some serious work to improve quality of life themselves. The patients that really improve their QOL and health, also often improve their abilities and their concern for family, society, environment, and the global ecosystem of Planet Earth. If a million physicians in year 2040 use holistic medicine to help one billion people, 10% of the world’s population could be helped to be more conscious and caring for the world. This would make a huge difference for mankind in the future and the destiny of the planet, which right now seems to be in severe trouble. One more interesting potential of holistic medicine is finance. It seems that it is much cheaper and more efficient than biomedicine, so the societies that switch to this kind of medicine could be much richer than others. If the employees that use holistic medicine also work better and more talented this could also be in favour of countries choosing to use this new medicine. This could give Asia a huge competitive advantage, as much medicine is holistic there already. So holistic medicine might be a very important factor in the future global economy.

The ideas of life, good, death, evil and love are not new thinking, in fact on the last day of his life Moses (Moshe Rabainu) at the age of 120 years gathered together the whole Jewish people and initiated them for the last time into the covenant of God (Hashem), before they

entered the Holy Land (Erez Israel). He wanted them to choose life (Devarim/Deuteronomy 30, 15- 20): "See, I have placed before you today the life and the good, and the death and the evil, that which I command you today, to love Hashem, your God, to walk in his ways, to observe his commandments, his degrees and his ordinances, then you will live and you will multiply, and Hashem, your God, will bless you in the land to which you come, to possess it.

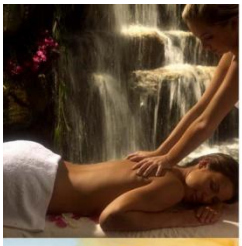
Holistic future

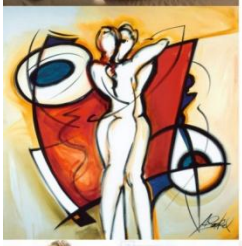
What is needed now more than ever is money for research in scientific holistic medicine: can we really cure cancer? Can we cure AIDS? Can we cure coronary heart disease? Who can be helped? What does it take? One of the most important things right now is the establishment of holistic pilot research hospital, where the many cures that now are developed can be tested. We believe that with support for research from neutral sources, holistic medicine would in one decade be a common product available for most physicians.

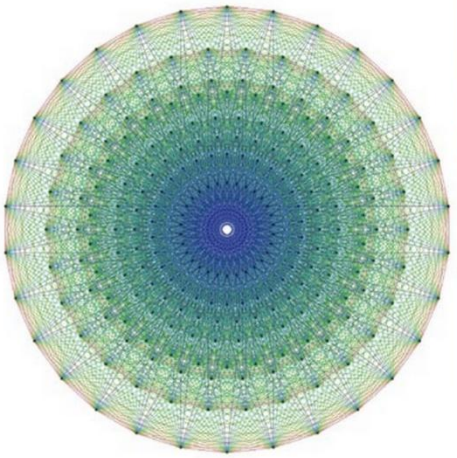
We would like to see the establishment of large research holistic health service center, which could function as a center for development and testing of the new holistic medicine and test the strengths of the psychosomatic treatment concept related to a series of concrete target groups: People suffering from back problems, chronic pains, depression, anxiety, fibromyalgia, allergies, asthma, whiplash, symptoms of burnout, alcoholism, gambling addiction, and later on also serious diseases such as cancer or cardiovascular disease. Scientific explanations for treatment methods and results will be precisely documented.

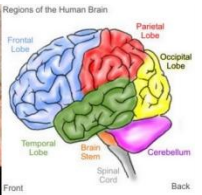
The primary purpose of establishing this health center is the improvement of research based on the philosophy on quality of life and health described in this book and the earlier published book on the "Philosophy behind quality of life". Improvement of quality of life, health and quality of working life – locally, nationally and globally. Prevention and treatment of diseases, loss of physical, mental and social ability to function as well as physiological aging via improvement of quality of life.

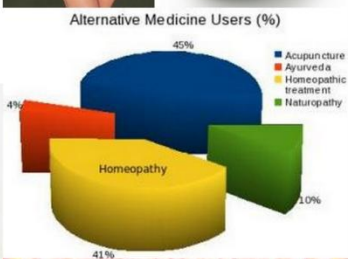
Research, development and information regarding quality of life, health and quality of working life seen from a holistic perspective. The mean to reach the above goals is holistic medical treatment, which support people's personal development and consists of kindness, thoughtfulness, inspiration, training in life philosophy, attention, respect, care, emotionally liberating psychotherapy, and body therapy dissolving blockages. The strength of such a health center is to help and support chronic patients and patients who wish to take responsibility for their own life and work with their personal development in order to become healthy, happy and well-functioning people.

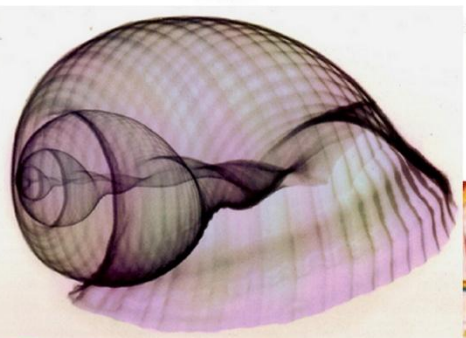


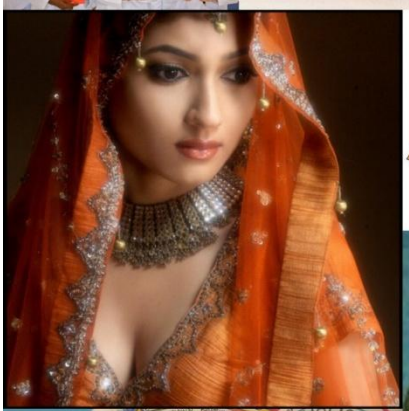


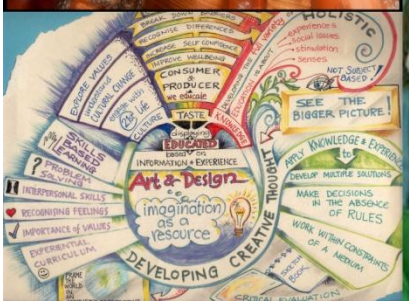


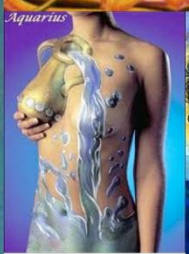












Chapter XIX

Use and limitations of the biomedical paradigm

The bio-medical paradigm is so convincing from a biochemical point of view, and highly efficient in many cases of acute medical problems and emergencies, but unfortunately most chronically ill patients cannot be treated to get much better only with drugs, they need to do something about their lives themselves.

It is highly important for the modern physician to understand the strength and weakness of the modern biomedical paradigm, to understand when and when not to administer drugs to their patients. Often a symptom can be eliminated for a while with drugs, but this is not always good as the patient might need the learning from studying the imbalances in life causing the disturbances and symptoms.

Sometimes the treatment with a drug can falsely teach the patient that quality of life is the responsibility of the physician and not the patient. This learned attitude can give the patient problems later or make them less active in helping themselves (responsibility transfer in the wrong direction). This chapter gives a number of examples, where medical drugs really are the treatment of choice in general practice, and some more doubtful examples of using of the biomedical paradigm. We also argue that sometimes life can be extended in spite of the subjective fact for the elderly patient that life has come to its end, but such a prolongation might not be ethical.

Introduction

In the past more than 50 years we have seen the emergence of a new medical science based on molecular biology, often called biomedicine. It is a highly developed, biochemical science with pharmaceuticals – chemical drugs based on specially designed molecules, often with a specific effect on cellular receptor molecules. Chemically and technologically, this is science at its most advanced stage. On the other hand many diseases end up being chronic, meaning that they persist in spite of the pharmaceutical treatment.

Chronic disease and disability represent a huge burden of ill health and a large – and growing - cost to modern society (1). The problem of chronic disease has led to the very

provocative conclusion that “drugs don’t work” (2,3). It is well known that most drugs need five patients or more treated to demonstrate an effect, meaning that most of the patients are not helped by most of the drugs, a fact that even the medical industry seems to admit now. This leaves us with extremely interesting questions: who will get well again and who will not? Or put it in another way: What kind of diseases shall we expect to be cured by pharmaceuticals drugs and which diseases would it be wise to treat with other medical strategies, i.e. alternative or holistic therapy on body, mind and feelings?

The strengths and weaknesses of the biomedical paradigm

This chapter provides some success stories of biomedical treatment, to demonstrate sufficient examples of successful biomedicine to crystallize the biomedical paradigm in its most useful form. The physician is intervening at the cellular level, often with highly designed and very biologically potent drugs. It is thus possible to regulate aspects of cell-functioning, like acid-forming cells can be stopped producing gastric acid (e.g. with Losec), or the communication between cells can be overridden so that the ovaries no longer produce eggs (contraceptive pills), or bacteria can be fought (with drugs like penicillin that inhibit bacterial growth) without any significant impact or damage to the cells of the body in the person treated. Biomedicine is known as "bio", because it applies biochemistry and molecular biology, thereby interfering with the chemistry of life itself.

When you stop and think about it, you will realize that this is really amazing. In principle, biomedicine is highly effective, when it can do this. When you look at it more closely and from a theoretical viewpoint, however, it is less impressive because many of the effects, side-effects and adverse reactions of a pharmaceutical product in a clinical test cannot be explained or predicted on the basis of biomedical theory. The truth is that we do not understand the information systems of the body at the molecular level well enough to do so. Whenever we treat our patients with designed molecules that interfere with the body’s intercellular communication, we are not in complete control of the effects and adverse reactions of the drug, in spite of even numerous clinical trials in animals and humans. Since we do not have complete knowledge of the underlying causes of a disease – the large biomedical textbooks state with regard to almost any disease that its cause is not understood – and since we do not have complete control of the effects of the drugs prescribed, whether in the short or the long term, we need to keep an eye on how any specific drug will act in a given patient.

Biomedicine has been developed and tested in order to counteract a specific, well-defined pathology. The physician prescribes it for that indication, e.g., depression, allergy or hypertension. Before it is launched on the market, it has been tested as mentioned above for effects, side-effects and adverse reactions in long series of studies, first in animals and then in humans. It is not possible to know exactly what will happen in the patient, until it has been tried. If the medicine works the way it should without any visible damage it will be marketed.

Biomedicine is really good at treating lots of diseases. But there is a limit to what you can achieve by biochemical means, and we should be highly alert to that limit in our medical

practice. We should be particularly alert, because the problems that many of our patients are facing can often be solved without pills, which after all cannot solve all their problems.

Below are some examples of what we call "perfect biomedicine". These are biomedical cures that we still use in our own medical practice, even when we master a series of holistic treatment techniques, because we acknowledge these cures to be of excellent and unique value to our patients. It consists of antibiotics and other drugs that we safely apply. Sometimes we face problems that we as physicians cannot solve with biomedicine, and must therefore look more closely at the limitations of biomedicine. Both ways of looking gives important information that guides us in our choice of treatment in the clinic.

Let us emphasize, if you should doubt it, that we have absolute faith in science. When a new pharmaceutical has been investigated in randomised studies, which is in principle a thoroughly sound scientific basis, by objective and unbiased researchers and according to standard protocols, we will usually not hesitate to acknowledge the documented effect. However, often times many details in the studies performed are open to criticism, especially the danger of scientific bias, when a pharmaceutical company needs to document the efficacy of its own drug. According to recent investigations, such bias appears to be a real threat to the scientific integrity of a study (4) making many patients take pills that actually does not work well on their condition.

When a drug in a clinical study is tested actively for a given symptom we would generally believe in its effect. But the situation is more complicated: this does not mean, however, that it would be a sensible move in general practice to remove that symptom with this drug, just because it is possible. The symptom suppressed will perhaps just be replaced by a symptom or problem that is deeper, more dangerous and more difficult to trace. And perhaps the patient has a lesson to learn from the condition, which is why it would be highly problematic to eliminate it, depriving the patient of vital learning.

The modern biomedical physician applies about 100 different medicinal products in his practice. For a pharmacology examination, an excellent test would be to let the student choose the 15 drugs that would suffice in a biomedical practice in the great majority of cases, including antibiotics, analgesics, diuretics, hydrocortisone, anticoagulants, etc. All these drugs have their clinical merits, including from the perspective of holistic medicine. Below, we shall look at some uses of biomedicine with which we fully agree. But first we need to present our holistic perspective so the reader understands, why we so willingly admit the drugs to be of limited use: we have an alternative to drugs when it comes to many chronic diseases.

Pneumonia and penicillin

Penicillin is the classical drug and the basis of the biomedical paradigm. We find it a great drug, largely non-toxic, inexpensive, produced from moulds that have attacked our food, since the beginning of time and thus presumably have been known to the body for thousands of years. Penicillin is highly active against a range of micro-organisms that often affect humans.

Once this is said, penicillin is not really very active in cavities such as the frontal sinus or middle ear, which are almost never reached by the blood distributing the drug in the body.

Several studies have shown that penicillin only shortens the course of the disease by a few days on average in the case of inflammation in a cavity. People are happy to be given penicillin. Now they are on medication, things are happening, and all will be well, since everybody knows penicillin and how effective it is. The following cases of pneumonia are trivial from a medical point of view, but it shows how the daily life of a modern family physician practising biomedicine is an oft-repeated theme with minor variations.

Female, aged 24 years with pneumonia
She has suffered from chest constriction for two days. Auscultation of the lungs: rhonchi and "dense" sounds. Diagnosis: /Pneumonia/ Prescribe penicillin.

Female, aged 86 years with pneumonia
Breathing difficulties for 14 days. Feels very ill, is freezing and sweating. Examination: fever, auscultation of the lungs: rhonchi, crackles /Pneumonia/ cannot tolerate penicillin. Prescribe Erythromycin.

The high efficiency of antibiotics gives us another problem, a difficult ethical problem. Perhaps in the case of the old patient she should be allowed to die from her pneumonia? Before modern antibiotics, pneumonia provided a quick and gentle death – ”an old woman's best friend”, as Aldous Huxley (1894-1963) said. Today we keep people alive as long as possible often with little consideration for their quality of life, until they develop dementia or a painful cancer, which most people eventually do when they are old enough. Death can be a protracted affair, painful, lonely and terrible. It can also be quick and merciful. We believe that old people should be afforded a merciful death when their time is up. And there is really no need for the physician to decide when that is. As doctors, we could do the decent thing and ask the old person whether he or she wants help to live on. Many old people are quite clear in their mind and know when their time is up (5).

Other infections

Female, aged 27 years with vaginal discharge
Negative urine stick. Pelvic examination: Cervical motion tenderness of the uterus, otherwise normal. Wet smear: 80% clue cells /Trichomoniasis/ Prescribe Elysol [metronidazole] 500 mg bid for five days. Since she often forgets to take contraceptive pills we talked about switching to an Implanon implant. She will think about it.

Metronidazole preparations are excellent against the bacteria that usually cause this form of lower abdominal infection (Trichomonas vaginalis).

Female, aged 88 years with impetigo
Presents with small pustules and an even rash on the back and with large red erythematous elements on the left arm without sores or blistering. /Impetigo/ Prescribe culture, locally mupirocin (Bactroban) and Azithromycin orally for five days. Should return if the problem persists.

Impetigo is a very common superficial skin infection caused by streptococci, staphylococci or a combination of both. They can cause impetigo, erysipelas, cellulitis, lymphangitis, furuncles and abscess. Impetigo can be common in children, but also in adults, where advanced age can low resistance as in the case above.

Male, aged 56 years with Lyme disease following a tick bite

Bitten by a tick below the right clavicle. Large erythema 25 x 25 cm, growing every day. /Erythema migrans/suspected Lyme disease/Prescribe penicillin.

Here we have some probability of saving the man from neuroborreliosis, a borrelian infection in the brain. This is a very unpleasant disease, if left untreated often ending in brain damage or death.

Antibiotics are probably the group of drugs that have gained biomedicine most respect among the general population. It is indeed a great thing to have drugs formulated as eye drops or vagitories to get rid of that terrible itching. All in a few days.

Vitamin and mineral supplements

Another great example of the biomedical paradigm is the highly effective treatment of a vitamin deficiency with oral vitamin pills. Now that we are talking about placebo, it is logical to move on to the vitamin and mineral supplements so often used, probably the clearest example of placebo available today. In our opinion, vitamin and mineral supplements do very little to promote health, objectively speaking. Most scientific studies conclude that minerals and vitamins like vitamin C, widely believed to be beneficial for the general health, make no difference to a person's health (6,70), except in the very few people suffering from a deficiency condition, while other studies show only what seems to be a modest, beneficial effect (8). So why do people still take these pills?

The health problems affecting the population are rarely due to vitamin or mineral deficiencies, which is why they cannot be cured by these dietary supplements. Nor will the body benefit from getting any more vitamins or minerals than it needs.

Many people take vitamin C when they have a cold. To our knowledge, no scientific study has come up with evidence of the sense in that. Even very large daily supplements of many grams of vitamin C have no guaranteed effect. We can only conclude that lemon tea and grapefruits, rather like rum toddies, are great placebo remedies for the common cold. And if you are now thinking: “but I can feel the effect”, then we will not deny this in any way, but merely ask: “why do you feel that way?” Is it not because a person you trust greatly, perhaps your mother, once told you that it was good?

The very limited insight in biochemistry most people have means that there is an incredible market for this kind of remedies. People believe in advertising telling them that they will feel fine once they have taken a vitamin pill, and of course they will, because it saves their conscience. Each year, people buy completely useless vitamin pills and mineral supplements for billions of EUROs and dollars.

Female, aged 52 years with iron deficiency

Blood tests showed iron deficiency and slightly elevated blood sedimentation rate. No other signs of infection. Still chest pain. We try prescribing Modifenac [diclofenac], Multitabs [vitamins and minerals], Ferro Duretter [ferrous salt] bid + physiotherapy. Check iron with new blood test in three months.

The classic: Prescribing iron against iron deficiency. Here the cause of iron deficiency was not discovered. Occult bleeding? Our general advice on vitamins and minerals is: unless you suffer from a diagnosed state of deficiency, it is not wise to waste money, time and energy on vitamin and mineral supplements. If you want to pamper yourself, you can do better and gain more nourishment by putting your money and efforts into cooking.

Immune system disorders

In the following we present some case studies that describe one of the most frequent causes of visits to the physician: immunological disorders.

Boy, aged four years with asthma

Four-year preventive surveillance examination. Good development, happy, speech well developed, extrovert, sweet and interested. Weight and height catching up, but he is still asthmatic. Recently the parents apparently increased medication to Spirocort [budesonide] 2 x 200 bid.

Many children suffer from asthma, and asthma drugs are very effective. However, we feel that a symptomatic therapy of this kind is not quite satisfactory, when instead we might address the root of the problem. To us, this is a question of understanding the child's life and his basic requirements for well-being in his family. We see the child as the thermometer of the family, and when the child is sick there is often cause for improvement in the family. Basically, based on the strong covariance of asthma attacks with stress and other psychological factors (9), we see asthma as a psychosomatic disorder with medication as symptomatic therapy. Nevertheless it works really well and with good effect.

Girl, aged eight years with eczema

This girl has eczema on her forearm with well-defined, delimited scaly patches, 2 x 2 cm, mostly on left side. Possibly /fungal infection/Prescribe Brentacort [hydrocortisone, miconazole].

A fungal eczema – we prescribed Brentacort ointment with hydrocortisone and a fungicide.

Male, aged 37 years with neurodermatitis

He has been suffering from intense itching and a rash around the penis for six months. He scratches it every day with long nails. Wife claims to have same problem. We need to see her, too, as they may be passing it on to each other. The patient has been informed of this. Examination: Intense rash resembling neurodermatitis 6 x 7 cm on the anterior and lateral

parts of the penis. Standard check for STDs. No pustules, margins not affected, skin much thickened and eczematous. Scabies suspected, but no visible burrows in the epidermis. Two years ago, elbow region and groin also affected. Most probably a case of /Tinea cruris [jock itch; ringworm]/ /suspected neurodermatitis/. We try prescribing Brentacort [hydrocortisone, miconazole] ointment. If no marked effect within two weeks, the patient should return to the clinic.

Neurodermatitis is very interesting. It means that the patient will scratch, where it itches. When he scratches, it itches more, and so he will scratch even more. In the end damage to the skin is complete. It appears thick, uneven, bleeding with deep hollows and old scabs; it can be a terrible sight. It is truly incredible how much damage people with a propensity to scratching can do to themselves. We recall a psychiatric patient, who inflicted a hole in his arm right down to the muscle. The cure is simple: Stop scratching! We break the vicious circle with hydrocortisone, which effectively calms the itching.

Male, aged 61 years with pulmonary oedema?

Breathing difficulties, believes he has water in the lungs. Auscultation of the lungs: normal. Somewhat gasping respiration that is difficult to interpret. No fever. We try increasing Furix [furosemide] 40 mg bid. He should call out-of-hours service or emergency room, if there is no improvement and he deteriorates over the weekend.

Idiopathic pulmonary oedema – which is self-originated without any external cause – is caused by irritation of pulmonary tissues that makes the vessels become permeable and leak, with plasma pouring into the alveoles. Diuretic drugs are highly effective and have saved many patients in that situation.

Girl, aged two years – Atopic dermatitis – infantile eczema

Atopical dermatitis. Prescribe hydrocortisone ointment. Mother should treat her for 14 days and wait and see. Should return if the problem persists.

Hydrocortisone ointment is certain to help. It is good and effective, and the fear of adverse reactions in topical use is highly exaggerated. In our opinion it is quite harmless.

Male, aged 62 years with rheumatoid arthritis?

Complaints of pain in right ankle. Tender, red, swollen and slightly warm corresponding to both ankles, probably mild rheumatoid arthritis. Some points are very tender, especially laterally below the malleolus. We try prescribing Ibuprofen [ibuprofen] with follow-up for further testing.

Ibuprofen and the other NSAIDs are very satisfactory to use. They take it all: fever, inflammation, pain, swellings, redness, heat. And they are tolerated by most patients, they are cheap and you can take them throughout your life. (But why does the patient contract rheumatoid arthritis?)

Female, aged 32 years with urticaria

She had urticaria this morning, which has abated substantially by 2 p.m. Prescribe Zyrtec [cetirizine] 10 mg as required. We talked a little about feelings and the correlation between body and mind – about feelings controlling the body most of the time.

The antihistaminergic drugs are highly effective against urticaria and similar inflammatory complaints.

Female, aged 43 years with hay fever

Diprospan [betamethasone] 2 ml IM in the right gluteus maximus muscle. We talk a little about what she can do to minimise her hay fever symptoms.

Our "little talk" will make many biomedical physicians smile, because what indeed can you do yourself about hay fever? But the intensity of hay fever may fluctuate considerably. And if the patient can see, when and why she is not bothered by the allergy at all she might do something to turn these blissful periods into a permanent state.

Well, hydrocortisone is truly effective, and the season is not that long, so serious adverse reactions rarely occur even at high doses. Personally, we would prefer holistic therapy to Diprospan.

Constipation, diabetes and hypertension

Below is a wide range of problems that can be solved with biomedicine.

Female, aged 42 years with possible gastritis

In connection with working on shifts, which will come to an end on the 19th this month, the patient vomits at each meal and has pain immediately after the meal and before vomiting corresponding to solar plexus. She is also experiencing problems with her boss. No blood in faeces /suspected gastritis / Prescribe Losec [omeprazole]. If the problems continue she should be referred for gastroscopy.

Losec belongs to a group of agents that can inhibit gastric acid secretion almost completely. In many cases the symptoms disappear as if by magic. Only not in this patient, whom we had to refer to gastroscopy. Losec is a convincing drug; it is rather expensive, but it is genuinely effective and for most patients almost without side effects.. It is impressive. (But why do people develop gastritis?).

Female, aged 62 years with hypertension

BP 150/80, has taken Cozaar [losartan] 50 mg x 1, since half a tablet was too little; the headache returned. Now well-controlled.

Hypertension is a dangerous condition, which increases the risk of a stroke. So if not for the adverse reactions of the drug – some rather diffuse and quite common adverse reactions such as fatigue or loss of energy – this therapy would be just fine.

Since lowering the blood pressure is important, and since the drugs at our disposal today are not extremely effective, we need to combine two or three at a time. Often there are serious adverse reactions such as impotence, when beta-blockers also have to be used.

> *Male, aged 43 years with hypertension*
> Complains of large pull in left calf. If there is suspicion of deep vein thrombosis, the right cure will be immobilisation and ultrasound, but as the condition appears to be almost back to normal today with no real deep tenderness, mobilisation is prescribed; the patient walks well on his leg following massaging of calf. Second BP check. Headache. At home: BP measured at 145/95-105; Here, BP = 150/105. He should continue with Norvasc [amlodipine]. Check-up in three months.

This patient will presumably take this medication for half his life. We believe that it is possible to get rid of the elevated blood pressure through personal development, where the patient ”grows” out of the problem, so to speak. It is a good alternative for those, who are interested in personal development. However, because of his view of life we cannot reach this patient with holistic therapy. So we will not bother him with it.

> *Male, aged 85 years with type 2 diabetes*
> Diabetes check. Blood glucose 8.9; BP 130/90, well-controlled.
> Adult-onset diabetes, now known as type 2 diabetes mellitus (NIDDM), is one of the diseases that we can manage well, and the same applies to type 1 diabetes. That is something to be proud of. Today, people with diabetes have a life, and the complications – the breakdown of nerves, vascular system, eyes - are very limited compared with before biomedicine. This is a great result. (Imagine, though, if young people could completely avoid developing diabetes and having to inject insulin throughout their lives?).

Contraception and abnormal uterine bleeding

If there is one thing that the biomedical physician is good at, it is preventing unwanted pregnancies. Once the functions of the reproductive organs are understood, it is easy to understand the effect of forms of contraceptives such as condoms, the femidom, intra-uterine devices, diaphragms or contraceptive foams. Abnormal uterine bleeding is often easy to correct with hormones. A well-known and serious adverse effect of “the pill” is that chemical contraception often makes the women loose much of her sexual desire, female polarity and orgasmic potency.

Depression and psychotic mental illness

As we have seen in section one patient with depression and schizophrenia are only helped little by the psychopharmacological drugs and severe adverse effects are very common.

Discussion

Biomedicine is often highly effective when facing acute, somatic problems. It is easy to administer and the effort or time for the physician often very limited. Contraceptives are of huge value, although they often deprive the women of the sexual desire. Morphine is a sublime help in many cases of terminal disease, but can shorten life.

Unfortunately the target of biomedicine is mostly the symptoms and not the real cause of the disease. When the immunological resistance is temporarily weakened and an infection is threatening the life of the patient, an antibiotic can save him by killing the micro-organism causing the infection, but even here the cause of the disease is not really the bacteria itself, but the weakened immune response. Most often, the disease is not cured by the biomedical intervention, and masking the symptom does not help the patient in the long run. He will get sick again, if the immune resistance is not recovered.

For the last five decades physicians have been very optimistic about what could be obtained with a developed biomedicine – from cures to cancer to dramatic prolongation of youth and long vitality. What we generally have seen – with some important exceptions naturally - is more and more specialized drugs, more and more expensive drugs and more and more potent drugs curing a still minor fragment of the patients treated. The big pharmaceutical companies have been admitting that "the drugs don't work" (2,3) and huge companies like NovoNordisk are now claiming that prevention of disease, and not curing them, seems to be the future for the industry (10).

To understand the seriousness of the problem, let us quote the BMJ editor Richard Smith (2): "Now business has outdone parody, and Allen Rogers, worldwide vice president of genetics at Glaxo SmithKline, is reported on the front page of the Independent as saying: "Our drugs don't work on most patients." This is of course not news to physicians. Anybody familiar with the notion of "number needed to treat" (NNT) knows that it is usually necessary to treat many patients in order for one to benefit. NNTs under 5 are unusual, whereas NNTs over 20 are common."

This it important so let us give it a second though, from the emotional perspective of the physician: What will a sincere and ambitious physician feel, when he gives a drug to a patient with a NNT of 2 or less? What can he tell his patients, if he is to be honest? With an NTT of 2 he can say: "There is a fair change that you get well again, and he will feel severely frustrated that this is the help he can give his patient, because he wants to make much more than 50% of his patients well. With a number on NNT of 3, he must say: Most likely this drug will not help you, but let give it a try, and he will feel terrible. With a NTT of 5 he must admit: it is highly unlikely that this drug will help you, but there still is a chance, so let us go for that, and he must feel despair. With a NTT of 20, which is common, he must say: "I will give you this drug because it helps sometimes, but do not rely on it in any way; this drug cannot even justify a hope". And the ambitious and caring physician will feel like hopeless and helpless. Because if you only help 5% of your patients, 95% will leave your clinic without improvement, but instead waste money on the drugs, have severe side effects. But most important, often with a resignation that is as life-threatening as the disease itself.

Medicine is evolving, and the hope we had for biomedicine is turning into frustration, scepticism and for many physicians despair. This despair can be found in the frustration, that physicians cannot really rely on the drugs, that was supposed to heal. The drugs will

undoubtedly play an important role also for the future medicine, but simple manual medicine like therapeutic touch (11) and the emerging new toolbox of consciousness-based, holistic medicine must also be taken into use by the physicians to have a probate set of medical tool for the new century (12,13).

What is important now is that the physician really relies on his own senses. If he experience that the drugs work, he should use them. As the pharmaceutical companies do almost nothing, for understandable financial reasons, to narrow the indications so that only the patients likely to benefit will get a drug, this must be the task of the physician. And it is not that difficult. It takes some experimentation on the part of the physician, some alternative medical tools to shift among in order to provide alternatives to the drugs in your practice. This is the purpose in our series of papers on clinical holistic medicine.

So we are not unhappy that biomedicine turned out to be of restricted value to the patients. Actually, an extended bio-psycho-social medical toolbox (see section eleven) including also the consciousness-based, holistic medicine will have many advantages, not only for the patient on an individual level, but also for society at large, making its citizens grow into being more conscious, more ethical, more talented and more socially minded.

Conclusion

The drugs do work. But only in special situations, and only as a basic rule, where there are background resources to back up the local healing. The drugs have specific activities, which can be used when this specific action is needed.

But very often the symptoms are caused by psychosocial imbalances, which should be corrected. These imbalances can be attributed to many aspects, like poor living conditions, so the symptoms have to create or generate a learning process for the patient, so curing the disease that reveals the imbalance in life often prevents the patient from using his opportunity for the learning process. Sometimes a life can be saved with drugs remedying an acute crisis. But many times this crisis is only a symptom of a chronically poor mental and physical health or even a terminal state of life, and saving the patient which might seem to be a good thing to do today, can be seen as a cruel thing tomorrow.

In general, drugs are highly efficient in an acute phase of a physical disease, but almost inert in the long run and of little help in the treatment of mental disorders. To improve health and cure chronic disease the whole life and its quality must be improved. This takes more than drugs; this takes a responsible and determined effort on the part of the patient. This is why, in most cases, a holistic approach to the patient is needed, if the physician is to bring permanent improvements in quality for life and health to the patient.

The bio-medical paradigm is very convincing from a biochemical point of view, and highly efficient in many cases of acute, somatic medical problems and emergencies. Unfortunately most chronic patients cannot be treated to get much better with drugs, they need to do something about their lives themselves.

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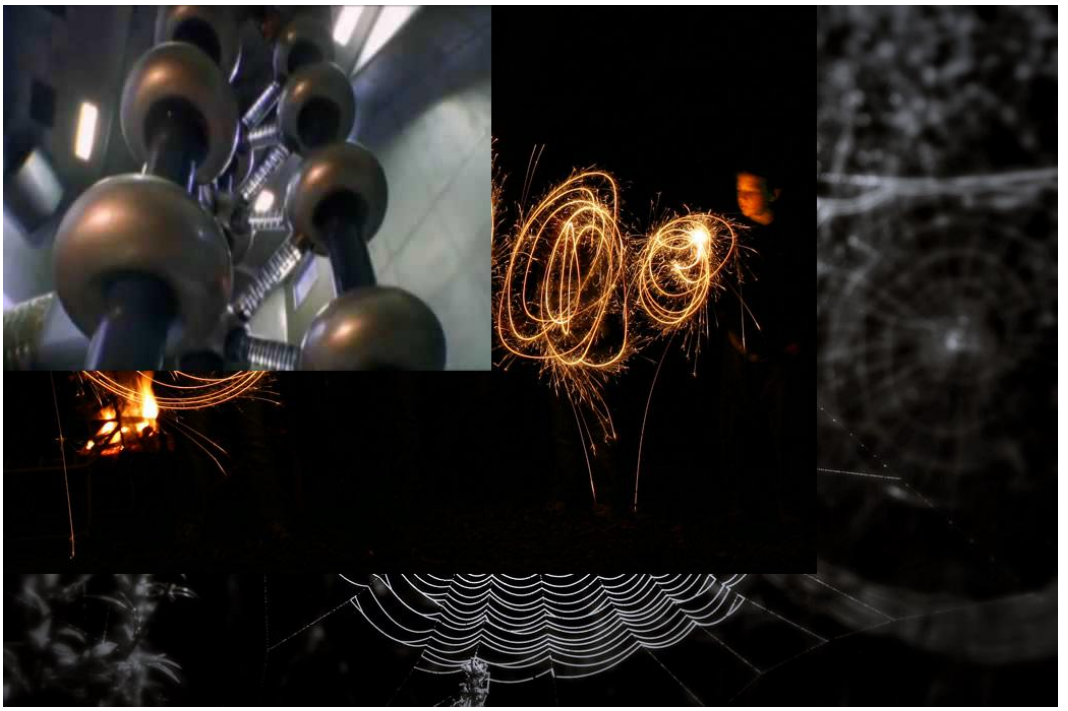
Section 2. Acknowledgments



Chapter XX

About the authors

Søren Ventegodt, MD, MMedSci, EU-MSc-CAM is the director of the Nordic School of Holistic Medicine and the Quality of Life Research Center in Copenhagen, Denmark and an editor of several scientific journals in alternative and holistic medicine. He is responsible for a Research Clinic for Holistic Medicine and Sexology in Copenhagen and used as a popular speaker throughout Scandinavia. He has published numerous scientific or popular articles and a number of books on holistic medicine, quality of life, and quality of working life. Recently he has written textbooks on holistic psychiatry and holistic sexology. His most important scientific contributions are the comprehensive SEQOL questionnaire, the very short QOL5 questionnaire, the integrated QOL theory, the holistic process theory, the life mission theory, and the on-going Danish Quality of Life Research Survey, 1991-94 in connection with follow-up studies of the Copenhagen Perinatal Birth Cohort 1959-61 initiated at the University Hospital of Copenhagen by the late professor of pediatrics, Bengt Zachau-Christiansen, MD, PhD. 2006-2008 he was director and lecturer, Inter-University College, International Campus, Denmark in collaboration with Inter-University Consortium for Integrative Health Promotion, Inter-University College Graz, Austria and the Austrian Ministry of Education, Science and Culture. He is the author of 15 books and about 200 scientific papers on quality of life and holistic medicine. E-Mail: ventegodt@livskvalitet.org. Website: www.livskvalitet.org

Joav Merrick, MD, MMedSci, DMSc, is professor of pediatrics, child health and human development affiliated with Kentucky Children's Hospital, University of Kentucky, Lexington, United States and the Division of Pediatrics, Hadassah Hebrew University Medical Center, Mt Scopus Campus, Jerusalem, Israel, the medical director of the Health Services, Division for Intellectual and Developmental Disabilities, Ministry of Social Affairs and Social Services, Jerusalem, the founder and director of the National Institute of Child Health and Human Development in Israel. Numerous publications in the field of pediatrics, child health and human development, rehabilitation, intellectual disability, disability, health, welfare, abuse, advocacy, quality of life and prevention. Received the Peter Sabroe Child Award for outstanding work on behalf of Danish Children in 1985 and the International LEGO-Prize ("The Children's Nobel Prize") for an extraordinary contribution towards improvement in child welfare and well-being in 1987. E-mail: jmerrick@zahav.net.il; Home-page: http://jmerrick50.googlepages.com/home

Chapter XXI

International review board

This book is written by Søren Ventegodt and Joav Merrick and the result of more than ten years of work together, but also an international collaboration with a group of very special people that we have published many papers with. This book project (a total of six books on mind-body medicine) has been a tremendous effort and we have been guided, helped and supported by a group of international collaborators and colleagues. These busy academics and clinicians have given of their time and expertise to advise us, so we wish to acknowledge their incredible support and friendship in this endeavour.

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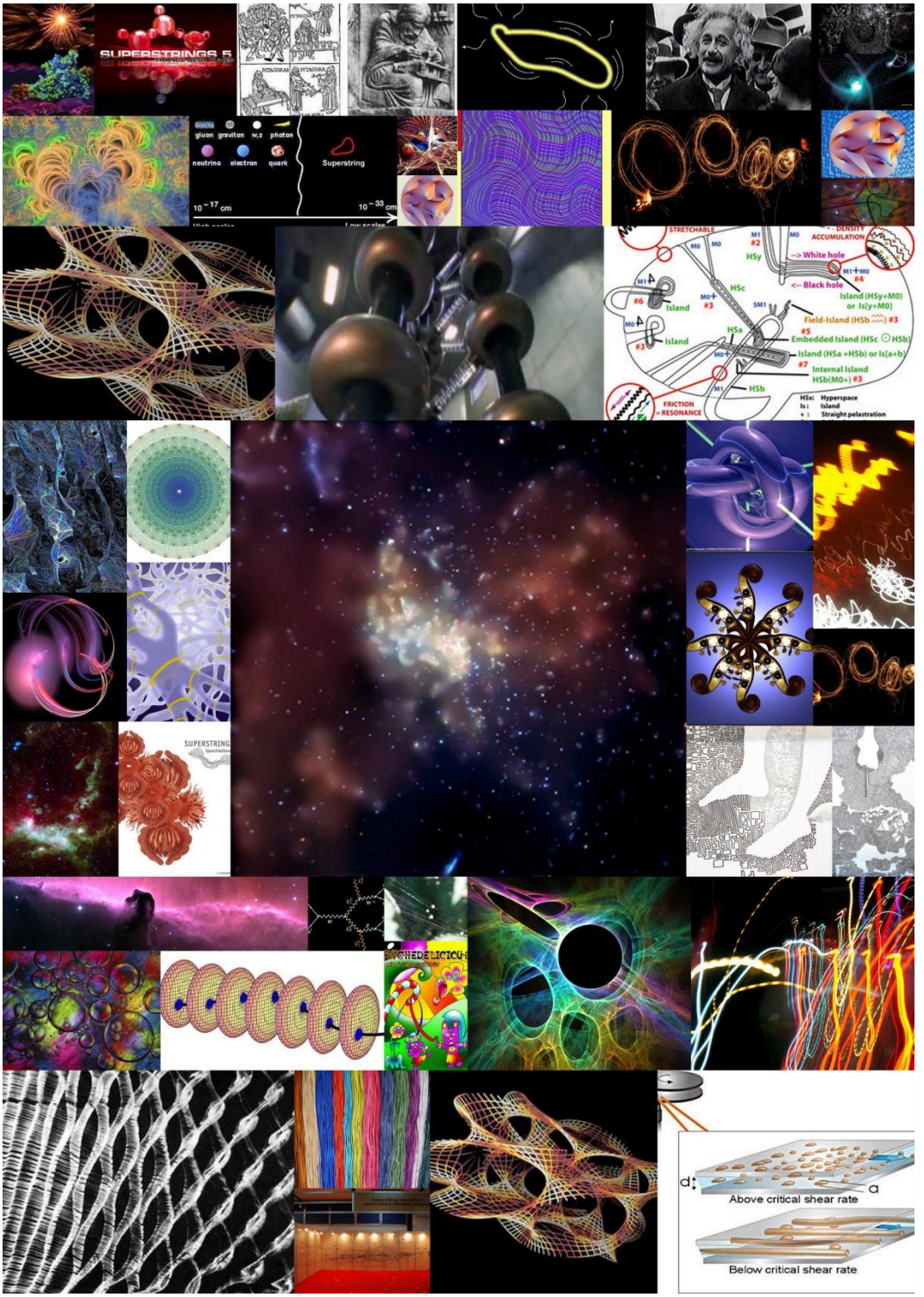

Chapter XXII

About the Quality of Life Research Center in Copenhagen, Denmark

The Quality of Life Research Center in Copenhagen was established in 1989, when the physician Søren Ventegodt succeeded in getting collaboration started with the Department of Social Medicine at the University of Copenhagen in response to the project "Quality of life and causes of disease". An interdisciplinary "Working group for the quality of life in Copenhagen" was established and when funds were raised in 1991 the University Hospital of Copenhagen (Rigshospitalet) opened its doors for the project.

The main task was a comprehensive follow-up of 9,006 pregnancies and the children delivered during 1959-61. This Copenhagen Perinatal Birth Cohort was established by the a gynaecologist and a pediatrician, the late Aage Villumsen, MD, PhD and the late Bengt Zachau-Christiansen, MD, PhD, who had made intensive studies during pregnancy, early childhood and young adulthood. The cohort was during 1980-1989 directed by the pediatrician Joav Merrick, MD, DMSc, who established the Prospective Pediatric Research Unit at the University Hospital of Copenhagen and managed to update the cohort for further follow-up register research, until he moved to Israel. The focus was to study quality of life related to socio-economic status and health in order to compare with the data collected during pregnancy, delivery and early childhood.

The project continued to grow and later in 1993, the work was organized into a statistics group, a software group that developed the computer programs for use in the data entry and a group responsible for analysis of the data.

Quality of Life Research Center at the university medical center

The Quality of Life Center at the University Hospital generated grants, publicity with research and discussions among the professionals leading to the claim that quality of life was significant for health and disease. It is obvious that a single person cannot do much about his/her own disease, if it is caused by chemical defects in the body or outside chemical-physical influences. However, if a substantial part of diseases are caused by a low quality of

life, we can all prevent a lot of disease and operate as our own physicians, if we make a personal effort and work to improve our quality of life. A series of investigations showed that this was indeed possible. This view of the role of personal responsibility for illness and health would naturally lead to a radical re-consideration of the role of the physician and also influence our society.

Independent Quality of Life Research Center

In 1994, The Quality of Life Research Center became an independent institution located in the center of the old Copenhagen. Today, the number of full-time employees has grown. The Research Center is still expanding and several companies and numerous institutions make use of the resources, such as lectures, courses, consulting or contract research. The companies, which have used the competence of the research center and its tools on quality of life and quality of working life, include IBM, Lego, several banks, and a number of counties, municipalities, several ministries, The National Defense Center for Leadership and many other management training institutions, along with more than 300 public and private companies. It started in Denmark, but has expanded to involve the whole Scandinavian area.

The centre's research on the quality of life have been through several phases from measurement of quality of life, from theory to practice over several projects on the quality of life in Denmark, which have been published and received extended public coverage and public impact in Denmark and Scandinavia. The data is now also an important part of Veenhoven's Database on Happiness at Rotterdam University in the Netherlands.

New research

Since The Quality-of-Life Research Center became independent a number of new research projects were launched. One was a project that aimed to prevent illness and social problems among the elderly in one of the municipalities by inspiring the elderly to improve their quality of life themselves. Another project about quality of life after apoplectic attacks at one of the major hospitals in Copenhagen and the Danish Agency for Industry granted funds for a project about the quality of work life.

Quality of life of 10,000 Danes

There is a general consensus that many of the diseases that plague the Western world (which are not the result of external factors such as starvation, micro-organisms, infection or genetic defects) are lifestyle related and as such, preventable through lifestyle changes. Thus increasing time and effort is spent on developing public health strategies to promote "healthy" lifestyles. However, it is not a simple task to identify and dispel the negative and unhealthy parts of our modern lifestyle even with numerous behavioural factors that can be readily

highlighted harmful, like the use of alcohol, use of tobacco, the lack of regular exercise and a high fat, low fibre diet.

However there is more to Western culture and lifestyle than these factors and if we only focus on them we can risk overlooking others. We refer to other large parts of our life, for instance the way we think about and perceive life (our life attitudes, our perception of reality and our quality of life) and the degree of happiness we experience through the different dimensions of our existence. These factors or dimensions can now, to some degree, be isolated and examined. The medical sociologist Aaron Antonovsky (1923-1994) from the Faculty of Health Sciences at Ben Gurion University in Beer-Sheva, who developed the salutogenic model of health and illness, discussed the dimension, "sense of coherence", that is closely related to the dimension of "life meaning", as perhaps the deepest and most important dimension of quality of life. Typically, the clinician or researcher, when attempting to reveal a connection between health and a certain factor, sides with only one of the possible dimensions stated above. A simple, one-dimensional hypothesis is then postulated, like for instance that cholesterol is harmful to circulation. Cholesterol levels are then measured, manipulated and ensuing changes to circulatory function monitored. The subsequent result may show a significant, though small connection, which supports the initial hypothesis and in turn becomes the basis for implementing preventive measures, like a change of diet. The multi-factorial dimension is therefore often overlooked.

In order to investigate this multifactorial dimension a cross-sectional survey examining close to 10,000 Danes was undertaken in order to investigate the connection between lifestyle, quality of life and health status by way of a questionnaire based survey. The questionnaire was mailed in February 1993 to 2,460 persons aged between 18-88, randomly selected from the CPR (Danish Central Register) and 7,222 persons from the Copenhagen Perinatal Birth Cohort 1959-61.

A total of 1,501 persons between the ages 18-88 years and 4,626 persons between the ages 31-33 years returned the questionnaire (response rates 61.0% and 64,1% respectively). The results showed that health had a stronger correlation to quality of life ($r= 0.5$, $p<0.0001$), than it had to lifestyle ($r=0.2$, $p< 0.0001$).

It was concluded that preventable diseases could be more effectively handled through a concentrated effort to improve quality of life rather than through an approach that focus solely on the factors that are traditionally seen to reflect an unhealthy life style.

Collaborations across borders

The project has been developed during several phases. The first phase, 1980-1990, was about mapping the medical systems of the pre-modern cultures of the world, understanding their philosophies and practices and merging this knowledge with western biomedicine. A huge task seemingly successfully accomplished in the Quality of Life (QOL) theories, and the QOL philosophy, and the most recent theories of existence, explaining the human nature, and especially the hidden resources of man, their nature, their location in human existence and the way to approach them through human consciousness.

Søren Ventegodt visited several countries around the globe in the late 1980s and analysed about 10 pre-modern medical systems and a dozen of shamans, shangomas and spiritual

leaders noticing most surprisingly similarities, allowing him together with about 20 colleagues at the QOL Study Group at the University of Copenhagen, to model the connection between QOL and health. This model was later further developed and represented in the integrative QOL theories and a number of publications. Based on this philosophical breakthrough the Quality of Life Research Center was established at the University hospital. Here a brood cooperation took place with many interested physicians and nurses from the hospital.

A QOL conference in 1993 with more than 100 scientific participants discussed the connection between QOL and the development of disease and its prevention. Four physicians collaborated on the QOL population survey 1993. For the next 10 years the difficult task of integrating bio-medicine and the traditional medicine went on and Søren Ventegodt again visited several centers and scientists at the Universities of New York, Berkeley, Stanford and other institutions. He also met people like David Spiegel, Dean Ornish, Louise Hay, Dalai Lama and many other leading persons in the field of holistic medicine and spirituality.

Around the year 2000 an international scientific network started to take form with an intense collaboration with the National Institute of Child Health and Human Development (NICHD) in Israel, which has now developed the concept of "Holistic Medicine". We believe that the trained physician today has three medical toolboxes: the manual medicine (traditional), the bio-medicine (with drugs and pharmacology) and the consciousness-based medicine (scientific, holistic medicine). What is extremely interesting is that most diseases can be alleviated with all three sets of medical tools, but only the bio-medical toolset is highly expensive. The physician, using his hands and his consciousness to improve the health of the patient by mobilising hidden resources in the patient can use his skills in any cultural setting, rich or poor.

Contact Person

Director Søren Ventegodt, MD, MMedSci, MSc
Quality of Life Research Center
Frederiksberg Allé 13A, 2tv
DK-1820 Copenhagen V
Denmark
E-mail: ventegodt@livskvalitet.org
Website: www.livskvalitet.org

Chapter XXIII

About the National Institute of Child Health and Human Development in Israel

The National Institute of Child Health and Human Development (NICHD) in Israel were established in 1998 as a virtual institute under the auspices of the Medical Director, Ministry of Social Affairs and Social Services in order to function as the research arm for the Office of the Medical Director. In 1998 the National Council for Child Health and Pediatrics, Ministry of Health and in 1999 the Director General and Deputy Director General of the Ministry of Health endorsed the establishment of the NICHD. In 2011 the NICHD became affiliated with the Division of Pediatrics, Hadassah Hebrew University Medical Center, Mt Scopus Campus in Jerusalem.

Mission

The mission of a National Institute for Child Health and Human Development in Israel is to provide an academic focal point for the scholarly interdisciplinary study of child life, health, public health, welfare, disability, rehabilitation, intellectual disability and related aspects of human development. This mission includes research, teaching, clinical work, information and public service activities in the field of child health and human development.

Service and academic activities

Over the years many activities became focused in the south of Israel due to collaboration with various professionals at the Faculty of Health Sciences (FOHS) at the Ben Gurion University of the Negev (BGU). Since 2000 an affiliation with the Zusman Child Development Center at the Pediatric Division of Soroka University Medical Center has resulted in collaboration around the establishment of the Down Syndrome Clinic at that center. In 2002 a full course on “Disability” was established at the Recanati School for Allied Professions in the

Community, FOHS, BGU and in 2005 collaboration was started with the Primary Care Unit of the faculty and disability became part of the master of public health course on "Children and society". In the academic year 2005-2006 a one semester course on "Aging with disability" was started as part of the Master of Science program in gerontology in our collaboration with the Center for Multidisciplinary Research in Aging. In 2010 collaborations with the Division of Pediatrics, Hadassah Medical Center, Hebrew University, Jerusalem, Israel.

Research activities

The affiliated staff has over the years published work from projects and research activities in this national and international collaboration. In the year 2000 the International Journal of Adolescent Medicine and Health and in 2005 the International Journal on Disability and Human development of De Gruyter Publishing House (Berlin and New York), in the year 2003 the TSW-Child Health and Human Development and in 2006 the TSW-Holistic Health and Medicine of the Scientific World Journal (New York and Kirkkonummi, Finland), all peer-reviewed international journals were affiliated with the National Institute of Child Health and Human Development. From 2008 also the International Journal of Child Health and Human Development (Nova Science, New York), the International Journal of Child and Adolescent Health (Nova Science) and the Journal of Pain Management (Nova Science) affiliated and from 2009 the International Public Health Journal (Nova Science) and Journal of Alternative Medicine Research (Nova Science).

National collaborations

Nationally the NICHD works in collaboration with the Faculty of Health Sciences, Ben Gurion University of the Negev; Department of Physical Therapy, Sackler School of Medicine, Tel Aviv University; Autism Center, Assaf HaRofeh Medical Center; National Rett and PKU Centers at Chaim Sheba Medical Center, Tel HaShomer; Department of Physiotherapy, Haifa University; Department of Education, Bar Ilan University, Ramat Gan, Faculty of Social Sciences and Health Sciences; College of Judea and Samaria in Ariel and in 2011 affiliation with Center for Pediatric Chronic Diseases and Center for Down Syndrome, Department of Pediatrics, Hadassah-Hebrew University Medical Center, Mount Scopus Campus, Jerusalem.

International collaborations

Internationally with the Department of Disability and Human Development, College of Applied Health Sciences, University of Illinois at Chicago; Strong Center for Developmental Disabilities, Golisano Children's Hospital at Strong, University of Rochester School of Medicine and Dentistry, New York; Centre on Intellectual Disabilities, University of Albany,

New York; Centre for Chronic Disease Prevention and Control, Health Canada, Ottawa; Chandler Medical Center and Children's Hospital, Kentucky Children's Hospital, Section of Adolescent Medicine, University of Kentucky, Lexington; Chronic Disease Prevention and Control Research Center, Baylor College of Medicine, Houston, Texas; Division of Neuroscience, Department of Psychiatry, Columbia University, New York; Institute for the Study of Disadvantage and Disability, Atlanta; Center for Autism and Related Disorders, Department Psychiatry, Children's Hospital Boston, Boston; Department of Paediatrics, Child Health and Adolescent Medicine, Children's Hospital at Westmead, Westmead, Australia; International Centre for the Study of Occupational and Mental Health, Düsseldorf, Germany; Centre for Advanced Studies in Nursing, Department of General Practice and Primary Care, University of Aberdeen, Aberdeen, United Kingdom; Quality of Life Research Center, Copenhagen, Denmark; Nordic School of Public Health, Gottenburg, Sweden, Scandinavian Institute of Quality of Working Life, Oslo, Norway; Centre for Quality of Life of the Hong Kong Institute of Asia-Pacific Studies and School of Social Work, Chinese University, Hong Kong.

Targets

Our focus is on research, international collaborations, clinical work, teaching and policy in health, disability and human development and to establish the NICHD as a permanent institute at one of the residential care centers for persons with intellectual disability in Israel in order to conduct model research and together with the four university schools of public health/medicine in Israel establish a national master and doctoral program in disability and human development at the institute to secure the next generation of professionals working in this often non-prestigious/low-status field of work.

Contact

Joav Merrick, MD, DMSc
Professor of Pediatrics, Child Health and Human Development
Medical Director, Health Services, Division for Intellectual and Developmental Disabilities, Ministry of Social Affairs and Social Services, POB 1260, IL-91012 Jerusalem, Israel.
E-mail: jmerrick@zahav.net.il

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