Textbook on Evidence-Based Holistic Mind-Body Medicine

Basic Principles of Healing in Traditional Hippocratic Medicine

Søren Ventegodt
Joav Merrick

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HEALTH AND HUMAN DEVELOPMENT

TEXTBOOK ON EVIDENCE-BASED HOLISTIC MIND-BODY MEDICINE

BASIC PRINCIPLES OF HEALING IN TRADITIONAL HIPPOCRATIC MEDICINE

HEALTH AND HUMAN DEVELOPMENT

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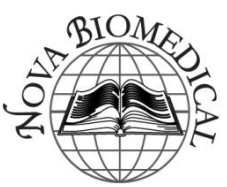

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Contents

Foreword

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"Only the joyful can see clearly."

Integrative medicine affirms the importance of the clinician-patient relationship, focuses on the whole person (body, emotions, mind, spirit, and social relationships), is informed by the evidence, and uses all appropriate therapeutic approaches, health professionals and disciplines to achieve optimal health and healing. This definition was adopted by the Consortium of Academic Health Centers for Integrative Medicine in May, 2004. It affirms the fact that integrative medicine is good medicine, aspiring to the same high ideals as conventional care. Complementary and alternative medical (CAM) therapies are subsets of the therapeutic options available within this context.

The increasing numbers of people who use CAM therapies supports the theory that conventional medicine is failing to meet citizens' goals for health, and that a more comprehensive, patient-centered approach that focuses on health outcomes rather than disease management is desirable. A functional system of care requires a shared vision; coordinated, sustainable strategies to move toward that vision; consequences for adherence to and deviations from strategically driven actions; data collection to monitor the process and outcomes; feedback; and timely, rational revisions to strategies, behaviors, monitoring systems, and consequences.

Health care does not occur in a vacuum, but within a larger socio-political and environmental context. The authors provide a straightforward explanation of the role of politics and the pharmaceutical/insurance industry influences on health care, including its research agenda, research publications, and care guidelines, and media coverage of research and guidelines as well as direct-to-consumer advertising. Similarly, corporations selling

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unhealthy products such as tobacco, alcohol, and processed foods as well as reliance on automobile transport rather than walking or biking advertise heavily, influencing individual and community decisions, which in turn influence health. The tension between individual responsibility to maintain healthy habits in a healthy habitat and corporate influence over governmental policies that set the stage for poor decisions has not been fully embraced by health systems. The call to empower citizens rather than concentrate decision making power in the hands of corporate-influenced government officials will be most useful if the citizens are truly free and informed, rather than constantly subject to mind-bending marketing.

Although use of CAM is increasing, only a minority of patients talk with their conventional physicians about their use of CAM. The most commonly used CAM therapies depends on several factors including the definitions of CAM (is prayer included or not) and cultural/geographic/ethnic/demographic factors. Generally vitamins, minerals, fish oil, herbs, and other dietary supplements are most popular, but few patients tell their doctor they are praying for their health or that they take supplements, remedies, or teas. In the early 1990's, it was thought that the reason for non-disclosure was fear of rejection, condemnation, or derision, but subsequent research revealed that the reasons most patients did not disclose their use of CAM therapies were that a) they were not considered relevant in a biomedical context, b) the doctor did not seem interested, and c) the doctor would not be knowledgeable in this area. These facts have led to repeated calls to increase professional education about CAM so that clinicians routinely ask patients about all the therapies being used for health purposes and can provide evidence-based counseling about integrating CAM and conventional care.

Cost is an important factor influencing professional and patient choices. The authors make an innovative argument here comparing the cost-effectiveness of various CAM therapies to conventional care, concluding that CAM is far more cost-effective. Whether this analysis bears up when repeated by researchers with diverse backgrounds remains to be seen, but the basic premise of using a level playing field to compare the costs and effectiveness of diverse strategies in achieving patient-centered outcomes is sound.

This raises the question of what are the targets, the outcomes of interest. For most of biomedicine, the target is a disease or symptom. The therapy eliminates the pathogen, the cancer, or addresses the traumatic injury, and the patient feels better. That is, addressing pathogenesis leads to better health. For many CAM therapies, the target is the person's overall well-being and vitality. When the patient feels better, s/he has fewer symptoms and is less susceptible to injury and disease. That is, supporting salutogenesis leads to better health. Embracing both models, integrative care rises above the "us vs. them" mentality of CAM vs. conventional medicine.

The authors of this new text take a unique approach to medicine, including considerations of character, life mission, and sense of coherence, and sexual health. They humbly provide evidence from one of their own trials which had a negative result, drawing lessons from the experience. The numerous case examples help illustrate their approach in more detail. The writing is informal, and reading the text feels more like having a conversation with a passionate advocate than reading a dry medical text. Although I do not agree with every point in this book, I feel strongly diverse opinions, grounded in compassion are essential for advancing health care. May each reader extend and receive many blessings on the path ahead.

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 well-being 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 admittedly 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

All cultures through time have had medicine. Physical and mental disorders has tormented man for as long as we have recordings, and all cultures have used much effort on developing medical systems that could solve the problems and heal the people. These systems were based on strong intuition, thousands of years of expierience and lots of human intelligence. It would be a fault to assume that our ancestors were unintelligent. They were highly inventive and they were well rooting in experience. Most cultures used hallucinogenic drugs to do qualitative research in body and mind, and the language used was often symbolic and about the nature and structure of the energy of life. Sexuality was often a central part of this. The efforts of the medicine man were to help the patient get self-insight and help him or her to balance all aspects life. The flows of life energy was carefully analyzed and if blocked or disturbed brought back into its normal and healthy flow. On the mental side, the patient's philosophy of life was treated with interventions that helped let go of evilness and negative beliefs. The pre-modern cultures often also used the dark of medicine to harm and get revenge. Woo doo has been known to be highly efficient if you is a part of the culture and believe firmly in it.

As you might have guessed, magic medicine and shamanism never developed into what we understand as a science: A system of clear and logic principles that can be used systematically and in a reproducible way so that every practitioner can agree on the intervention needed in a given situation. Shamanistic medicine has in spite of its well documented medical effects (1) remained shamanism.

But one premodern medical system was different. About 400 BC on the island of Cos a hospital was raised by a doctor whose name is still held in high respect: Hippocrates of Cos. Hippocrates was a real doctor and Plato wrote on his fame. Hippocrates not only had a hospital, he also had a medical school. And contrary to other pre-modern cultures, Hippocrates did not believe in drugs. He had medical herbs, but only for external use. He believed plants and minerals to be too toxic to be used for internal use. Instead he intervened directly on the patient's consciousness using therapeutic touch and talk. And nothing else really. Hippocrates was a strong believer in reason. He isolated the healing principles and together with his students he wrote about 70 books on medicine, which was translated into many other languages of that time, including Arabic. Two thousand years later scholars have

been able to reconstruct almost all these books, which are now collected into the famous Corpus Hippocraticum (2). We therefore have excellent sources on the Hippocratic medicine.

What we know from reading this collection is that Hippocrates and his students addressed all parts of man at the same time: body, mind, spirit, and heart. Disease was thought to be caused by lack of self-insight, and healing was about assisting the patient to regain self-awareness. The goal was the patient should be well again and the primary tool was helping the patient to know him/herself well enough to step into character and life his/her purpose of life. The focus on stepping into character gave birth to the other classical name of this kind of medicine: Character medicine. Central in the human character, and integrating all the energies from body, mind and spirit, was sexuality. To step into character meant to be the man or woman the Gods meant you to be. You could not choose your character, it was God-given, and you had to obey. Disobedience to the Gods was the direct road to Hell and all kind of personal troubles and diseases.

Reestablishing the sense of coherence (3,4), helping the patient back into his or her true role in the universe, was the cure that eventually would lead the patient to recovery and healing. It is interesting that modern medical science have confirmed the "salutogenic" healing power of developing sense of coherence (5,6).

If you are familiar with biomedicine and the function of drugs, based on biochemical knowledge, you might find the text above strangely abstract and unappealing. It is difficult to understand the Greek medicine as it is consciousness-based, and consciousness itself is really hard to comprehend. The Greek doctors managed to overcome these problems and formulated the principles of healing intervention on human consciousness. Their understanding of anatomy and physiology was modest, and many ideas were not correct, as we know today. But their healing principles have worked wonders ever since, and for more than two thousand years the Hippocratic medicine was the medicine of Europe. Of course we also had shamanism, witches and druids, wise men and women knowing the use of medical herbs, monks at the monasteries cultivating them etc. But these people did not win the trust of the European people, while the Hippocratic doctors did.

Still today 10% of all medical treatments are done with homoeopathy alone, a system directly based on one of the Hippocratic healing principle, the principle of similarity: What made you sick will also make you well again. This might sound really strange if you think in terms of molecules and poisons; but if you think about consciousness this principle is the basis of all psychotherapy. If you were beaten up or raped, the only thing that can help you back is to confront what happened and take learning. You need in your mind to go back to the painful event, confront it and integrate it. This is the principle of similarity. We all know that it works. We just need someone to help us going there because of our mental and emotional defenses. If you understand just this simple principle, and know how to use it, you can be a therapist. It is not hard to do.

The Hippocratic doctors were holistic physicians. They address all aspects of their human patient at the same time. They had several principles for doing that, not just one. A good understanding of man and the flawless ability of applying all these healing principles smoothly and at the same time when working with the patient, is what makes a good holistic physician. In principle this is not difficult; in practice it takes many years of practice even for a talented student to come to master.

The importance of self-insight in the process of healing, and as part of this the understanding of the life force - call it prana, qi, or sexual energy as you like - as a central,

integrative energy that must flow freely for body and mind, spirit and human character at large to be powerful, present and healthy, might be the most difficult part to understand for the modern physician. The student of holistic medicine often needs to develop as a person to become a great doctor. Only if you dare to be your true Self - if you truly know and understand yourself in all deepths - can you understand and help other people in an ego-less and efficient way. This is much to ask from a doctor. And being yourself is not a mental thing. It is you stepping into character in your life, you taking the medicine yourself. As all great healers and shamans have done through the ages.

The Hippocratic doctors worked on all types of patients. No disease was too serious or difficult for a good try. At the same time the results of the cure was not up the them but up to the will of the Gods alone. The Hippocratic doctor had surrendered himself to the universe and was a perfekt part of it, and everything could be healed with love if this was how it was meant to be.

The Corpus Hippocraticum contains all the major diagnosis we know today, under different names of course: Infections, cancer, heart condition, pains, depression, schizophrenia, sexual dysfunctions, infertility etc. If there is a drug that will cure the disease right away, like penicillin for syphilis and neuroboreliosis, we do not recommend holistic medicine for such a disease. The drug is most definitely the right solution here. So the modern doctor should definitely work integratively and know the drugs and what they are good for, and use every medical tool to help and cure his patient. But if the problem cannot be solved with a drug, as are the cases for a large number acute and a majority of the chronic physical and mental disorders, holistic medicine might very well be the solution. And as all drugs have significant, adverse effects, while holistic medicine has none, holistic medicine will often be the informed patient's first choice, if a disease is not acutely life-threatening.

Holistic medicine, or quality of life as medicine, as we often call it, is basically a strategy for improving the patients quality of life, through mobilizing of inner resources. This can never harm and will almost always benefit the patients 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. We would like to start out this book with a tribute to the holistic physician Dean Ornish, who during a decade has documented that holistic medicine might be the most efficient cure we have for coronary heart disease; now he has also succesfully started to treat some sorts of cancer. 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 admitedly still is limited we should not stop doing what we know works.

After reading this book (and hopefully the total six books in this mind-body series) we hope that you will agree that we understand quite a lot, though. It is not a deep mystery that people who are happy often also is healthy and that increasing happiness will also increase health (5,6). It is quite reasonable. Please hang on and allow us to explain how and why everything works in scientific holistic medicine. We are honored that you have chosen our book. We have worked hard on it to make it the best textbook on consciousness-based medicine and non-drug CAM there is today. We hope you find that we have succeeded. May it serve all living beings.

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Section 1: General introduction

Being a student of holistic medicine

Before we start, there are a few things we would like to tell you, if you are a student. The first and most important thing is: Do not believe in anything you are told. Do not believe in books, in words. Do not even believe in what you see for yourself, for your eyes are colored by your mind, your expectations and previous beliefs. Do not believe in interpretations and theory. Believe in what you, deep within yourself, sense is true—in your gut feeling, in your intuition. Find yourself and be your true Self if you want to be a good doctor. This is the most important. And then: believe in yourself not in us.

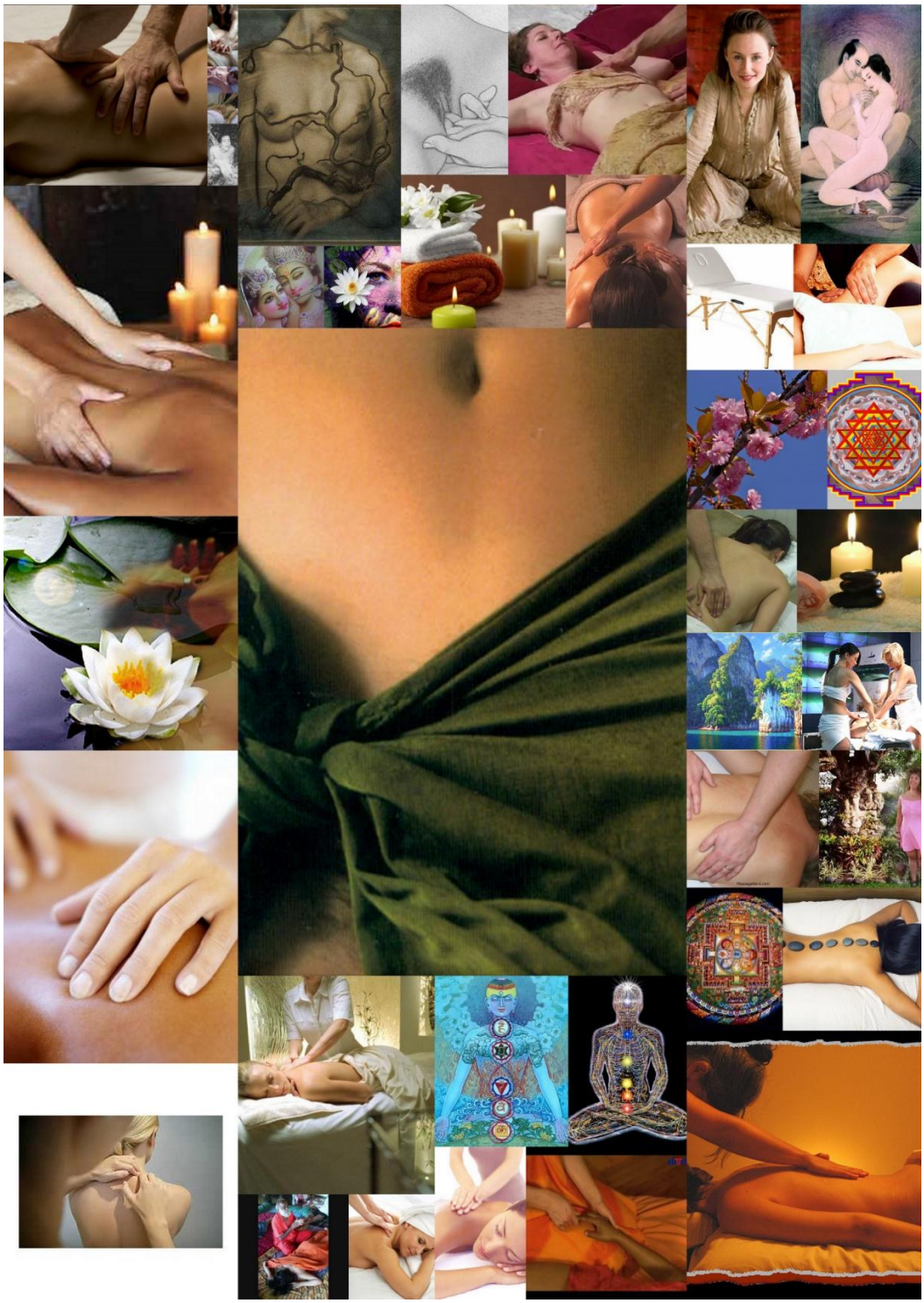
We are academic, "smart" people, but we are also caught in our minds. We have read so much that we have lost our simplicity. We have almost lost contact with the roots, with the Earth that you are still standing on, in spite of our continuous efforts not to. If you are young and have not lost contact, start with the new, fresh, vibrant life.

Do not go where we have gone—to complex theories—if you can avoid it. Go to simplicity, to calmness and being. Believe in your good heart. Do good without a thought for the consequences. Open your eyes and senses, your intuition, and see what really works. Use your good brain, intelligent feelings and your common sense to contemplate reality.

People are sick, unhappy, caught in all kinds of negative and difficult life conditions. Why is that? It could be society not giving them a chance, it could be their parents giving them a bad upbringing, or it could be themselves not understanding how to create a good life. What do you think? Is there a deeper meaning to human suffering that should be understood and acknowledged? Now, instead of just thinking, take a careful look and contemplate somebody who is ill and whom you know well. Is there a hidden order, maybe even a spiritual reason, for the manifestation of the disease in this person's life? See what we mean? Nothing is really as you could expect.

The world is a mystery. Live in it. Celebrate it. Remember to love and enjoy. Only the joyful can see clearly.

Be full of joy. Be a happy, honest, loving and caring person, in private and as a doctor. Only that way can you win life, time and the world.



Chapter I

Quality of life as medicine

Quality of life as medicine is a classical strategy of improving health by improving life in general. It has been used by physicians in Europe since Hippocrates and by medicine men, shamans, Sangomas, druids and healers in all known pre-modern cultures. The physician can intervene on the philosophy of life of his patient, his state of consciousness, state of existence, or on the quality of life, subjective mental and physical health, and subjective ability of social, sexual, work-related and study-related functioning.

Any interventions that will improve one or more of these factors are likely to also improve objective health and survival. The physician using quality of life as medicine is basically intervening on the patient's consciousness and lifestyle, encouraging the patient's exploration of self, leading to increased self-awareness and self-insight.

A better understanding of one's own talents and physical, mental, spiritual and sexual character and of the existential core, which some cultures call "the divine Self," leads to a more relaxed, loving and generous attitude and to a better use of character and talents in all relationships. The improved appreciation of inner life and the outer world and the more natural presence in it leads to an increased creation of value to self and others, an improved quality of life, and in that way to a better physical, mental, social, sexual and spiritual health. The interventions that help the patients address one or more of the following dimensions:

- Philosophy of life: a) Conception of life, b) conceptions of self, c) conception of surrounding world.
- State of consciousness: Positive doing, positive being and existential healing (salutogenesis).
- State of being: Subjective mental health, subjective physical health, quality of life, and subjective ability of functioning (social, sexual, work-related, study-related, etc.)

Introduction

"Health comes from happiness; happiness comes from stepping into character, knowing oneself and all one's talents, and using these talents to create value for other people and

oneself"—this is the essence of what was already said by the Greek physician Hippocrates in 400 BCE in the teaching of the Corpus Hippocraticum (1).

Well-being—whatever you call it, happiness, satisfaction, or meaning of life—has for a very long time been the sign of the good human life (1). Today, we often call this dimension *quality of life (QOL)*, especially in medical science. We call it quality of life to let the world know that we acknowledge that it is a complex term (2). It is happiness, but sometimes even the most difficult and unhappy times carry meaning and value for us, because we learn more about life when difficulties force us to stop and reflect. This understanding of our true Self, other human beings and the world at large gained from overcoming our challenges will often lead to future happiness (3,4).

A philosophical difficulty with the concept quality of life is that we see ourselves as human beings in space and time, as travellers on the journey of our souls. True quality of life comes from finding inner peace, from finding a place within our self that never journeys or changes. According to the existential philosophers, even personal crises, disease and great loss can contribute to our personal development of wisdom or even better to a more intimate contact with the life of which we consist (3-6). This is often in religious literature called "realizing the Self."

Evolution is still going on, and we are all part of the creation of the future human being; therefore, our personal struggles can even be seen as part of the bigger struggle of man to evolve to a species that can inhabit this planet in harmony with all the other species that inhabit it. Spiritual and religious people, believing in concepts like karma and divine order, would believe that the universe contains other more subtle energies than just matter, taking also elements from the development of our consciousness into the grand equation of the development of the universe (7).

In this immensely complex universe, of which contemporary science only covers a small corner, we strive for order. We strive to organize our knowledge for the benefit of mankind, to facilitate growth and healing of the unhappy and the ill. A holistic medical science must, therefore, include as many as possible of all the layers, structures and aspects of the world, without losing simplicity, efficacy and direction (8-12).

We cannot be naïve and deny the complexity of the world or of human life. On the other hand, we cannot afford to be mysticists, if we are to make a medical science that in a simple, rational and efficient way can guide our daily actions. So we need to simplify the world in our description to make it a science, but we also need to keep our model in accordance with truth, knowing that we always will lose some depth and truths in the process of simplification. The sad fact is that the truth you can intuit is often lost just in putting things into words; the true master stays free of mind.

The cascade of life and the logic of traditional non-drug medicine

Seen through time, life is like a cascade. A fertilized egg becomes a conscious human being that interprets, makes choices and acts in a complex world. The actions lead to experiences, which lead to re-interpretation of the world, new choices, new actions and so forth. Sometimes we get sick, and sometimes we get better again fast. Other times, we lose our

health on a continuous basis through time, until we die. Other times again, we are close to dying from cancer or a heart condition, but on our way down, we learn something of extreme importance that allows us to turn the sad development and regain health and happiness. Sometimes we get a bad start, with parents that are sick or dysfunctional. In spite of that, we break the evil patterns of the family and lead great lives. Sometimes we come from the most privileged of families, with incredible wealth and unlimited possibilities of doing good, but for some inner reasons we do not appreciate what we have, and end up losing it all, in abuse of alcohol, sex and drugs.

Life is highly dynamic, and it seems that we are creating our own lives, futures and destinies through our philosophy of life, state of consciousness, strategy of self-realization and the way we use our characters and talents to be fit and able and create value in this world (13). Can the way we create or destroy our own health, happiness and ability be understood in scientific terms? Can we make the dynamic of life a science? Yes, we believe we can.

During the last four or five decades, about 1,000,000 scientific papers have explored different aspects of the dynamic of human life, and quality of life is a central concept in close to 125,000 papers in biomedicine alone, if you search for "quality of life" in Medline/PubMed on the day of writing this introduction; the number will be even greater when this book will be published. So we know a great deal about these dynamics now. Many research centres all over the world have started to use this knowledge to cure even the most severe diseases like poor quality of life (14-16), chronic pain, metastatic breast cancer (17) and coronary heart disease (18,19). Recent reviews have shown that holistic non-drug medicine is safe and efficient as medicine (20-27), which might be the main reason for the including of mind-body medicine in the curriculum of most United States medical schools (28).

The therapeutic value of medical systems based on the idea of quality of life as medicine should not surprise us too much as all medical systems in the pre-modern cultures have been using such strategies of medicine for as long as man has existed (29-35).

The modern European medicine started in Greece and was highly developed about 400 BCE, when Hippocrates and his students as mentioned above wrote about 70 books on the science of medicine. This well-preserved source of medicine, called the Corpus Hippocraticum, was at its time translated to many European languages and became the basis for European medicine for the next two millennia (1). The essence of the Greek character medicine was that the patient was ill because he or she did not know him- or herself well enough to acknowledge his or her own talents and step into character to contribute and create value in all relationships. The key to health was surprisingly simple: The physician helped the patient to gain self-insight and coached the patient to better use his or her talents on all levels of existence—physical, mental or spiritual—in all relations, to family, friends and the world at large. Sexuality was ascribed a lot of importance, and a normal cure for female conditions of all kinds of diseases, from physical to mental illnesses, was rehabilitation of female sexuality and normal sexual function. It is clear from the writings that the concept of character included the patient's sex-character as man or woman. In today's holistic cures, i.e., the cure for coronary heart disease developed by Dean Ornish (18,19), the rehabilitation of patient's ability to close emotional contact and intimacy is still a cornerstone, indicating that even the most modern of today's "quality of life as medicine" cures are paying tribute to the character medicine of Hippocrates (460-377 BCE) (1).

Key concepts for quality of life as medicine

Table 1 lists the key concepts that most often have been the focus of research in human life. The table uses the somewhat artificial compartmentalization of the human existence into an inner part (life), an outer part, (the world), and a middle part (self).

Table 1. The dimensions of quality of life as medicine (Map of life). Life can be seen as a cascade in time and space that is determined by a series of factors that determines the next level that again determines the next level, etc. At each level there is inner, outer and intermediate factors called "life," "self" and "surrounding world." The subject is further complicated by interactions on all levels at all times. The physician can thus interact with a patient's philosophy of life, state of consciousness, ability of live, or his objective health and survival

Life (Inner or divine Self)	Self (I)	Surrounding world
EARLY FACTORS		
Biological inheritance including DNA.	Social inheritance, life-mission, choices, experiential learning, mental learning, experience, personal development, self-actualisation, spirituality and	Parents state of being, qualify of relating, and behaviour.
Character, talent, will to live, life-energy, evolution of man		Childhood living conditions, quality of schools and institutions, life events, offered possibilities, environment, impact from society.
For religious people: Will of God, karma, inherent Buddha nature,, etc.		Impacts from the collective process of evolution.
PHILOSOPHY OF LIFE		
Perception of life (including cosmology)	Perception of self (including self-insight and self-awareness)	World view (including choice of behaviour)
STATE OF CONSCIOUSNESS		
Salutogenesis (existential healing)	Sense of Coherence (SOC)	Self-actualisation (stepping into character, using all physical, mental and spiritual talent to create value in the world)
ABILITY TO LIVE		
Subjective physical, mental, spiritual and sexual health	Quality of life (well-being, satisfaction, happiness, meaning of life)	Ability of functioning (social, sexual, work-related, study-related,, etc.)
OBJECTIVE DISEASE		
Break down of biological order, physical disorder	Loss of life energy, mental disorder	Loss of relations, social disorder
DEATH		
Loss of life	Loss of self	Loss of the world

There is a strong mirroring of the inner world into the outer world, and vice versa, making such a description of man somewhat rigid; the Asian "spiritual" cultures have always believed that the outer life is a materialization of the inner life (the person's consciousness) (7). The material Western cultures have often stressed the positive or negative impact of the surrounding world on the person more.

The cultures of the East have always stressed the causal importance of the content of a person's consciousness, like divine potentials, the potential Buddha hood, and the karma, i.e., inherited impurities to be processed during one's lifetime. The modern Western cultures are stressing materialistic factors like the impact on DNA and genes on health and happiness. Most pre-modern cultures seem to agree with the Eastern traditions on the importance of consciousness in the creation of a person's life and destiny (29-35). In this book, we look for a balanced view that can be accepted by people of all cultures and all over the world. We believe that the work of Aaron Antonovsky (1923-1994) (36,37) might be especially valuable as a basis for such an endeavour.

1. Early factors

Most researchers in the dynamics of life use the timeline to organize the events of life and usually start with the conception (13). Materialistic researchers insist that at this point in time, there is only the information in the zygote that is carried by the DNA and the biological structures of the cell and its cytoplasm. Spiritualistic researchers suggest that this first cell already has a consciousness and makes conscious choices. It has been difficult for science to establish the truth regarding these matters, as our science of consciousness still is insufficient for the final documentation of early consciousness. Evolutionary theory has not been able to establish the evolutionary value of consciousness, but many appealing theories have been presented that could potentially expand our understanding of the role of consciousness in evolution and individual ontogenesis. The dimensions biological inheritance, social inheritance and contribution of own interpretations and choices are seen in the model we use as the backbone for this book (see Table 1).

2. Philosophy of life

As soon as the individual is established with his or her own consciousness, whether this happens at the minute of conception, in the middle of embryonic life when the brain and nerve system gets active, or early in childhood, when the brain is mature, the individual starts interpreting the world and making choices that guide behaviour.

To understand what is going on, the individual needs to discriminate between self and other, between me and you, internal life and external life. This need gives birth to the perception of internal life, world and self. These three fundamental dimensions of interpretation of reality become fixed and stable in time and make the person's philosophy of life. This collection of ideas, conclusions and descriptions of reality are used for perception, interpretation and choosing. The philosophy of life can be seen as the axioms of the consciousness; the invisible structures holding the content of consciousness, very much the same way as a mathematical universe is determined by its axioms. As soon as the axioms are

in place, the mathematical universe can have its content. In a similar way, the content of the human consciousness is sourced by the philosophy of life.

3. The six central states of consciousness

We know our consciousness from its content; we know that we can be in different states of consciousness, and many scientists have explored altered states of consciousness, with the aim of understanding the nature of human consciousness. In Eastern philosophy, the deepest state of consciousness is experienced when you realize your true Self, and this is empty of any content or phenomenon; it is only a potential, but out of this emptiness comes the whole world (called Maya because of its dreamed or illusory nature).

Unfortunately, we do not yet have a satisfactory theory of consciousness or a science of consciousness. The deeper structures of consciousness have been subtle, illusive and hard to identify; many scientists that have pursued this endeavour have ended up using religious terms. To give a model of human consciousness is not the aim of this book; we will acknowledge the complexity and focus on the states of consciousness relevant for our subject, which is quality of life as medicine. In Table 1, three states of consciousness are listed: the salutogenetic state (37,38), the state of sense of coherence and the dynamic state of self-realization using talents and character to create value for self and others.

The state of salutogenesis means the state of existential healing; it is a kind of existential crises, where you heal damage to your existence that has been caused by emotionally painful life events and destructive decisions earlier in life.

The state of sense of coherence is a state of being, where you acknowledge that you are coherent with everything else in the world; that you are an integrated part of the world and inseparable from it. The classical experience is sat-sit-ananda (to use a Hindu term), meaning being-knowing-happiness. In many religions and pre-modern cultures, this state of being is seen as "home," the natural, true state of being.

The state of self-realization has been seen by sages, philosophers and some scientists (like Buddha, Frankl, Gourdjeff, and Maslow to mention a few) as the highest obtainable state of action in the human being (5-7). In this state of consciousness, you find total inner peace, and from this peace, you step into character and use all your talents on all levels of existence in a natural way to create value for self and others. You can play music, you can be a skilful carpenter, you can dance, talk, think, write poems… it does not matter what you do, as long as you fulfil your existential determination.

To help the patient achieve this state of consciousness seems to have been crucial in non-drug medicine at all times. The physician often used a threefold strategy of helping the patient to heal, helping the patient to be and helping the patient to do. When the patient healed, being and doing was improved; with improved doing and being, more resources were available for the process of healing.

If you want health and happiness, you need to shift among three positive states of consciousness: positive doing, positive being and positive reorganization of you internal realm: existential healing or salutogenesis. Positive being is also called neutral being, and this is often said to be the most important aspect of these three for true happiness; positive doing simple comes naturally and effortlessly out of this state of being.

If you live in states of negative doing, negative being and negative crisis, where you continuously stretch your own existence to survive and fit to the environment while compromising your contact to your true self, you will eventually go down in unhappiness and ill health.

Thus, good consciousness-based medicine will build you up by leading you into states good being, of good doing, and the crisis of healing; while a hard, exhausting life will take you down by leading you into the destructive states of negative doing, negative being and degenerative crises.

Many philosophers talk about a simple awakening to truth, a revelation of one's true and eternal perfect nature, and then there is nothing to build up really; all there is to do is to tear down what is false and untrue, and then you will reappear as the divine Self.

4. State of existence

The good life or human existence has three key dimensions: quality of life, health and ability. A poor health is often what brings the patient to the physician, but almost as often, unhappiness or problems of sexual or social functioning or problems at work or study bring the patient to consult the physician. You can say that the skilful physician knows how to bring health, quality of life and ability to the patient by helping the patient to realise who he or she really is. To do this is the core of good medicine.

The same way as philosophy of life is the hidden basis of the states and contents of consciousness, the states and content of consciousness is the hidden basis of the state of existence: the person's subjective physical and mental health, quality of life, and general ability of functioning.

5. Disease

If a patient is ill, the patient will often also be unhappy and poorly functioning. Vice versa, it is also correct that a poorly functioning person often will be unhappy, and an unhappy patient often will be ill. We know of countless examples of this from medical science. If you are depressed, you are likely to have chronic pains; if you are unhappy, you are much more likely to develop cancer or a bad heart. If you have a crisis in your marriage and repress your sexuality, you will become unhappy, emotionally instable and often also depressed. We all know from personal experience that our allergy, flu or common cold comes in periods of bad thriving. It is not a new idea. It is an old truth, old as medicine itself.

Mental and physical disorders have for millennia been cured by interventions that improved quality of life and related dimensions. Often the strategy for improving health, happiness and ability has been to improve the patient's state of consciousness. This has been the basic tool of shamanistic healers. But many physicians and healers have gone deeper and have worked directly with the patient's philosophy of life.

The fundamental beliefs about self, life and the world have often been found to be very negative by the classical physicians, and debugging the patient's negative beliefs have been their art of medicine. If we go to Hippocrates and his students, most of the interventions seem to address the exploration of the Self, the philosophy of life, the patient's state of

consciousness, while other interventions addressed the concrete thinking and the subjective feeling of health, happiness and ability.

It seems that most of the modern strategies of non-drug medicine also address all layers of human existence, both philosophy of life, state of consciousness, and the dimensions we call ability to live, or the "art of living"—subjective health, quality of life and ability in general.

6. Death

The final outcome of life, with or without disease, is death. Spiritual cultures, like the Japanese Zen tradition, describe the good death as the chosen death; often, the Zen master invites his students to a special ceremony, under which he reads a Zen poem written for the occasion. After reading the poem, the Zen master simply sits down to die.

In materialistic cultures, death is often seen as something bad or negative, something that should be avoided at any cost, something that only comes from disease and disaster.

We know from many studies now that the strongest predictor of survival is a good self-assessed health and good quality of life (38-41). We know that people with little meaning in life often die, like, for example, we often see disease and sudden death occurring more often after we have retired from work. We thus know that feeling good, healthy and being actively participating in reality are important for survival. Preventive medicine is, therefore, about helping people to the experience of good health, high quality of life and a valuable presence in their world. Good and efficient non-drug medicine is about helping people to a positive philosophy of life and happy, healthy, healing states of being. Good medicine is about helping the patient to know him- or herself, to self-realization where all talents, physical, mental and spiritual are taken into use.

The good physician helps the patient gain self-awareness and self-insight by the examination of both body, mind, spirit and whole life together with the patient in order for the patient to explore negative philosophy of life, destructive states of consciousness, compromised quality of life and abilities, a poor physical, mental and sexual health.

The classical tools for doing this are talk and touch. Everything can in principle be used as medicine, as long as it has a positive impact on the patient's philosophy of life, state of consciousness and ability to live. A positive impact on any level will have a positive impact on subjective health, objective health and survival.

Conclusion

Classical medicine has for millennia, independent of the culture you investigate, been about helping the patient back into happiness, good health and a constructive role in society by helping the patient to increased self-awareness, self-insight and self-realization. The fruit of realizing your self is a profound and constant happiness—a feeling of being welcome and an integral part of the world; the fruit of realizing your own talents and character is the experience of being of value to one self and other people—being of value in all relationships, private or professional.

From the experience of this happy and constructive state of being comes all good things, a positive understanding of life, a positive state of consciousness, a positive state of existence and finally good physical and mental health, high quality of life, and excellent ability of functioning in all areas of life.

Whether we call this classical medicine, alternative medicine, quality of life as medicine, consciousness-based medicine, character medicine, placebo medicine, holistic medicine or any other equivalent label, it is basically about helping the patient to know him- or herself and to live in accordance with this knowledge.

Life is simple for the wise and complex for the fool. It is difficult for the person who does not understand it and easy for the person who understands this much: that the good life comes from sharing, giving and contributing.

You could say that the good life is about staying as your true, loving Self. This might be the simplest way to express the wisdom of Hippocrates and his students, of the Native American shamans, of the African Sangomas, the Australian Aboriginal medicine man, the Celtic druids or the Same healers. This is also the simple message of all sages at all times, and it is the core of all religions. The good healer is one with the universe, and from this place he loves his patient and this love brings back the patient's ability to love life, self and other living beings. In principle, it is really that simple. Being one with everything is love. That is what love is all about.

How powerful is quality of life as medicine then? If we go to religion, we will hear that everything can be healed, if your faith is strong enough. If we go to the most sceptical of the sceptics, you will learn that placebo has no healing power at all—at least in the form it is used in the pharmaceutical randomised clinical tests (42). In other chapters of this book, we will try to give a balanced answer to this question, based on four or five decades of established science in the dynamics of life.

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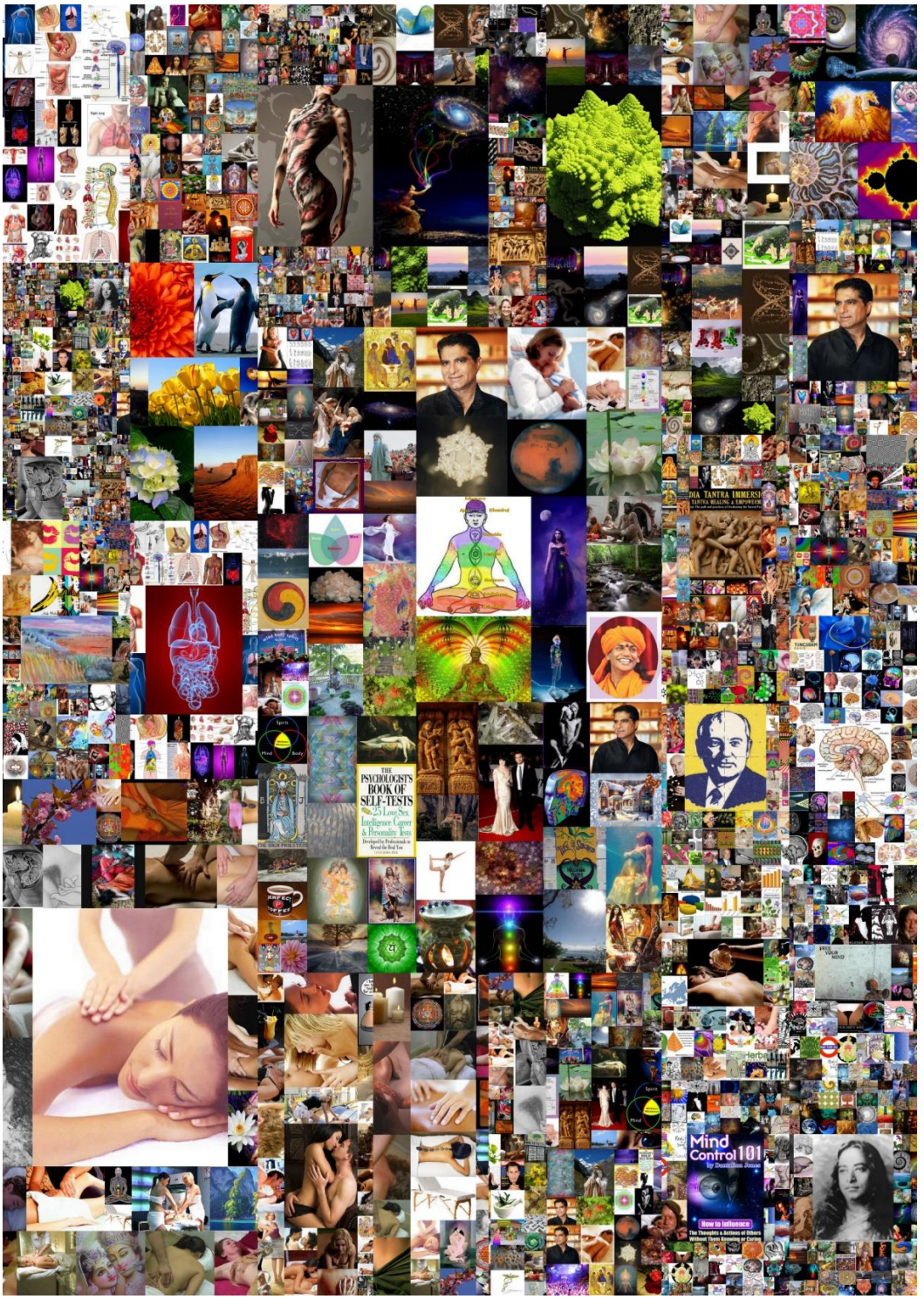

Chapter II

The ten class categorical system for all types of medicine, based on four levels of human existence: Molecules, body, mind and spirit (the European CAM system and the NCCAM system)

Medicine today is a mess. There are all kinds of medicine, chemical medicine and informational medicine, new and old, scientific and artistic, effective medicine and snake oil. There are plant medicine, touch medicine, talk medicine, spiritual medicine, shamanism and healing. There are doctors in white coats; there are energy healers in rainbow dresses; there are tidily dressed psychoanalytic therapists with and without long beards. There are non-sexual body-workers, physiotherapists, chiropractors, reflexologists, and there are tantra masseuses, substitute partners, and prostitutes and everything in between. Medicine is really a mess. And calling something medicine and other things not might be very difficult if you look at the efficacy. The shamans might be extremely successful healers, while modern therapists and doctors might be rather unsuccessful. We believe in science, but science might not be the most efficient way to healing. The Philippine healers with all their dramatic acts might be very good healers in spite of the fact that the tumor they take away from your body is actually chicken liver.

The most powerful player in the world on the CAM-science is the National Center for Complementary and Alternative Medicine (NCCAM) of the United States National Institutes of Health (NIH), doing research with a budget of about one billion USD. NCCAM has come up with a classification of CAM in five major categories:

1) Whole medical systems such as homeopathy, naturopathy, traditional Chinese medicine, and ayurveda.
2) Mind-body medicine such as meditation, prayer, mental healing, art therapy, music therapy, and dance therapy.
3) Biologically based practices such as dietary supplements, herbal supplements, and other scientifically unproven therapies such as shark cartilage.

4) Manipulative and body-based practices such as spinal manipulation (both chiropractic and osteopathic) and massage.
5) Energy therapies such as qi gong, Reiki, therapeutic touch, and electromagnetic therapy.

But NCCAM has been criticized for not being clear in their concepts and systematic of CAM (just look at what the Wikipedia says about NCCAM, but take what Wikipedia says on CAM with "a grain of salt" since there has been a very strong influence from the pharmaceutical industry).

While we in general are strong supporters of NCCAM, the critiques might have a point when it comes to the fundamental concepts used in their CAM research. It seems a matter of fact that in spite of the massive financial support, NCCAM is only making slow and small progress in understanding the mechanisms of healing and finding out which type of CAM is the most efficient and harmless.

For 20 years, a group of European researchers has developed a European systematic of CAM based on the basic structure of the human being—the four levels of chemicals, body (cells, tissues, organs) mind (brain) and spirit/consciousness. We find this classification much clearer than NCCAMs and will use this systematic in this book. The ten classes of medicine are according to the European system:

1) Chemical medicine (biomedicine with bioactive molecules)
2) Chemical CAM (flower medicine, herbal medicine, diets, minerals, vitamins,, etc.)
3) Body-medicine (massage, reflexology, physical therapy/physiotherapy,, etc.)
4) Mind-medicine (psychotherapy—psychodynamic, cognitive, gestalt,, etc.-psychoanalysis, meditation)
5) Spirit-medicine (philosophical interventions, energy medicine, prayers, spiritual healing (i.e., Reichi), shamanism, spiritual CAM (i.e., crystal healing),, etc.)
6) Mind-body medicine (acupuncture, acupressure, chiropractics, homeopathy, manual sexology, body-psychotherapy, Reichian bodywork, Rosen therapy, ergo therapy,, etc.)
7) Body-spirit medicine (prayer involving physical activity,, etc.)
8) Holistic body-mind-spirit medicine, including existential therapy (clinical holistic medicine, holistic body-psychotherapy, holistic bodywork, the sexological examination, holistic mind-body medicine, holistic sexology).
9) Chemical-body-mind-spirit medicine (shamanism with peyote, Ayahuasca or magic mushrooms; Grof's LSD-psychotherapy,, etc.)
10) Social and environmental medicine (coaching,, etc.)

While not everybody agrees that the fundamental structure of a human being is well described in the four levels—molecules, body, mind and spirit—the European classification system seems to allow for the identification of the fundamental healing principles used in all types of CAM. The system thus gives us an idea of expected effect size, clinical conditions that can be treated, and possible side effects of the ten different types of medicine it describes.

The system also allows for a cost-benefit and cost-efficacy analysis and for rational supervision of CAM treatment. It also helps practitioners to be clear about what they do and

thus to perform according to ethical standards. With this said, medical ethics is a complicated field of medicine, as we shall see in Section Four.

Introduction

A central problem with a classification system is that the categories are not mutually exclusive. This means that a medical system might be found in several of the five classes of the National Center for Complementary and Alternative Medicine (NCCAM). If you take the traditional European Hippocratic medicine—often called character medicine or "clinical holistic medicine" (CHM)—it is placed in class 1, because it is a medical system offering cures for every single patient: The cure helps the patient explore self, step into character, improve quality of life and thus heal diseases (1). It is mind-body medicine because it combines therapeutic talk (releasing repressed traumas, emotions and gestalts and improving philosophy of life) and therapeutic touch (often healing massage that helps the patient back into body and sexuality). It could be argued that it is a biology-based practice as it addresses the biological information in the organism. It is definitely also body based. And as biological information is what is experienced as "energy" ("life energy," "sexual energy," "spiritual energy,", etc.) by the patient, it is most definitely also "energy therapy."

On the other hand, "energy therapy" is a concept reserved for a special definition of psychic energy; biologically based CAM practice often means interventions with diets and herbs, and even the concept "mind-body medicine" has come to mean something different from "medicine working through the patients mind and body." So the lack of conceptual clarity has made the somewhat "ad hoc" systematic of NCCAM less useful than it should be to classify, analyze and understand CAM.

We believe that much of the critique NCCAM has received (2) is caused by the lack of a clear scientific systematic, making it difficult to move forward and create the science of CAM needed for CAM to be an integrated part of evidence-based medicine. In this chapter, we try to solve this problem by suggesting a much simpler and clearer systematic of medicine, including both biomedicine, drug-cam, and non-drug CAM like Hippocratic character medicine (CHM).

There are hundreds of types of CAM—so what do we do?

Today there are hundreds of different types of CAM, including massage and therapeutic touch, psychotherapy and psychodrama, art therapy and spiritual medicine, and different types of holistic mind-body medicine integrating several of these aspects. When the "Committee on the Use of Complementary and Alternative Medicine by the American Public" wrote the compressive report on" Complementary and Alternative Medicine (CAM) in the United States" (3) they used several pages to list all the different systems of alternative medicine. The Committee used description by the practitioners of the different methods and the results were somewhat peculiar. Therapeutic touch happened without the therapist touching the patient, and mind body medicine was classified as a specific type of therapy. Mind-body medicine methods like "Zero balancing, hands-on body-mind system to align

body energy with body's physical structure" and the "Rosen method" on mind bodywork and movement, which combines emotional psychotherapy with physical awareness (4) were not listed as mind-body medicine. Major alternative mind-body medicine systems practiced also in USA like BodyTalk, Reichian massage and Boysen's Body Psychotherapy, Hippocratic Character Medicine (full engagement) and holistic sexology (i.e., the Betty Dodson method) (5) were not mentioned in the report at all. When the European Masters of Science degree in CAM was established a few years ago, all information on CAM was collected from 40 academic institutions and the problem was the same: How can we categorize all the different CAM systems and the healing principles that work in them? (6).

The big problem for the group was how to define CAM (3). What should be included and what should be omitted? Coaching is not included, but should clearly be and look at this inclusion in the report: "Didjeridoo." A form of sound therapy with an aboriginal wind instrument that has been used for healing for 40,000 years, where circular breathing supported by the sound frequency reaches deep into the subconscious.

We find this very interesting. Of course the instruments used for meditation are also therapeutic. But what about the Indian flute, played by Krishna? What about the Tibetan bells, drums and gongs? What about the grand piano played by so many great classical musicians obviously touching the listeners feelings and causing relief, happiness and healing to some and what about jazz?

And what about spas and massaging machines? What about the services of prostitutes? What about good restaurants, are they not healing with their great meals and relaxing atmosphere? What about public swimming halls and gyms? Qi Qong and Tai Chi is on the list, but Taekwondo and Aikido is not. How can that be?

The herbs and spices, the diet, the lifestyle, the attitude, the relationship, the philosophy… everything will influence the patient health. Even harmonic living environments, nature, beautiful houses etc must be seen as therapy. And what about pets, cats, dogs and horses? What about holidays and nice tropical beaches—they can be highly therapeutic. And love relationships. Sex. Drugs. Mind-expanding drugs were the core method of many pre-modern shamanistic healing systems, and we find shamanism on the list:

> Shamanism. Traditional native healing systems practiced throughout the world. Archaic magico-religious phenomenon in which the shaman may use fire, wind, or magical flight as part of a healing ceremony.

But the mind-expanding drugs, like Ayahuasca, Peyote and San Pedro Cactus, Psilocybin mushrooms ("Magic mushrooms"), the African plant Ibogain, the mushroom Amanita Muscaria traditionally used in Northern Europe are not mentioned here. Why is that? For political reasons presumably. "Fire" and "wind" is fine, while Peyote being an LSD-like drug is a little too much.

Girls who are raped are often seen to have improved more than a control group after completing therapy, a phenomenon called paradoxical, post-traumatic growth (7). So even rape can be therapeutic. Even surviving mortal danger, even war, can heal. "Anything that don't kill you will make is stronger" is an often used saying in Northern Europe. In reality everything can be healing, everything can have a positive impact on your life, your health and your spirits. Everything that is difficult, painful and challenging can develop you and give

you a lesson for life. Even work! So everything can be CAM. Just everything. And this is really a mess.

The seven-class cam system

So we need to find some principles to create order in this chaos. And using the three levels of human nature—body, mind, spirit—seems to be the simplest. We have developed such a system (see Table 1) to evaluate the efficacy, the harm of different types of CAM (8), to establish the different healing principles in them (9) and the major errors you can make in non-drug medicine (10).

The system has chemical medicine (biomedicine and chemical CAM) as class 1, body-medicine as class 2, mind medicine as class 3, spirit medicine as class 4, mind-body medicine as class 5, holistic mind-body-spirit medicine as class 6 and shamanistic medicine using mind-expanding drugs (chemical-body-mind-spirit medicine) as class 7 (see Table 1).

We did not include a class for body-spirit medicine, or for mind-spirit medicine, as all kinds of spiritual medicine seems to have a bodily practice. In Tibetan prayer, for example, you need to kneel 100,000 times. But to be academically correct, we need to include herbal and diet treatments as "chemical CAM," and we need to make a category for social and work-related health interventions like coaching or stress management. Sexology could have its own class, but as sexology is practiced as body-medicine, mind-medicine, mind-body-medicine and mind-body-spirit medicine and always will be a part of the therapy, at least to some extent as we are sexual beings, this would be irrational. We, therefore, keep sexology integrated in this system.

Table 1. Classification of medicine according to the use of the healing principles of CAM into seven principal classes (different styles of sexology is included in many of if not all the classes)

1. Chemical medicine (biomedicine, herbal medicine with bioactive molecules)
2. Body-medicine (massage, reflexology, physical therapy, physiotherapy, spa, sauna, etc.)
3. Mind-medicine (psychotherapy—psychodynamic, cognitive, gestalt, etc., psychoanalysis, meditation, no-touch sexology, couching, healing music)
4. Spirit-medicine (philosophical interventions, energy medicine, prayers, spiritual healing (i.e., Reichi), shamanism, spiritual CAM (i.e., crystal healing), etc.)
5. Mind-body medicine (acupuncture, acupressure, chiropractics, homeopathy, manual sexology, body-psychotherapy, Reichian bodywork, Rosen therapy, ergo therapy,, etc.)
6. Holistic (body-mind-spirit/existential) medicine (holistic medicine, clinical medicine, clinical holistic medicine, holistic body-psychotherapy, holistic bodywork, the sexological examination, holistic mind-body medicine, biodynamic body-psychotherapy, tantric bodywork and massage, holistic sexology, Native American rituals).
7. Chemical-body-mind-spirit medicine (Shamanism with peyote, Ayahuasca, magic mushrooms, Ibogain, etc.; LSD and NMDA psychotherapy,, etc.)

The ten-class cam system

The value of this seven-class categorization system is that there are healing principles related to chemistry, body-body interactions, mind-mind interactions, sprit-spirit interactions and the combination of these four. It seems that it is these healing principles that determine the efficacy and safety of the specific type of CAM (see Table 2) (8). From this work, we have thus been able to identify the methods, which are most likely to be efficient and safe for the patients.

Table 3 presents our new and expanded classification of medicine (including biomedicine, chemical medicine, energy medicine, spiritual medicine, etc.). We include chemical biomedicine to make it complete.

Class 3 has been subdivided because there are some side effects of high-energy body manipulation, like broken bones, which are not happening with low-energy body work like gentle massage. According to NCCAM, this is without significant side effects, as we shall see later.

Table 3. Classification of medicine (Including CAM and biomedicine) into ten principal classes

1. Chemical medicine (biomedicine with bioactive molecules)
2. Chemical CAM (flower medicine, herbal medicine, diets, minerals, vitamins,, etc.)
3. Body-medicine
    a. Low-energy: massage, reflexology, physical therapy, physiotherapy, spa, sauna, etc.
    b. High energy: chiropractics,, etc.
4. Mind-medicine (psychotherapy—psychodynamic, cognitive, gestalt,, etc., psycho-analysis, meditation, no-touch sexology, couching, healing music)
5. Spirit-medicine (philosophical interventions, energy medicine, prayers, spiritual healing (i.e., Reichi), shamanism, spiritual CAM (i.e., crystal healing),, etc.)
6. Mind-body medicine (acupuncture, acupressure, homeopathy, manual sexology, body-psychotherapy, Reichian bodywork, Rosen therapy, ergo therapy,, etc.)
7. Body-spirit medicine (prayer involving physical activity, etc.)
8. Holistic body-mind-spirit medicine—including existential therapy (holistic medicine, clinical medicine, clinical holistic medicine, holistic body-psychotherapy, holistic bodywork, the sexological examination, holistic mind-body medicine, biodynamic body-psychotherapy, tantric bodywork and massage, holistic sexology, BodyTalk, Native American rituals).
9. Chemical-body-mind-spirit medicine (shamanism with peyote, Ayahuasca, magic mushrooms, Grof's LSD-psychotherapy, etc.)
10. Social and environmental medicine (coaching, work-related personal development programs, stress management, leadership training, gardening, aesthetic architecture, Feng Shui,, etc.)

Systematising all cam-systems into the ten classes

The next thing we need to do is to fit all classes of CAM into the ten-class system and see how it fits. We have done that in Table 4.

Table 4. The 226 alternative medical systems (drug-CAM and non-drug CAM including holistic medicine, shamanism and sexology) which have been researched and organized into ten classes (see Table 3)

1. Chemical medicine

1. Biomedicine with bioactive molecules

2. Chemical CAM

1. Apitherapy (Bee Venom).
2. Aromatherapy.
3. Body Electronics.
4. Cell Therapy (not done in U.S.).
5. Chelation Therapy.
6. Detoxification Therapy.
7. Diets.
8. Enzyme Therapy.
9. Essences Therapy Fasting (Cleansing).
10. Flower medicine.
11. Herbal medicine.
12. Hydrogen Peroxide Therapy.
13. Juice Therapy.
14. Macrobiotics.
15. Minerals.
16. Naturopathy.
17. Nutritional Therapy.
18. Ozone-Oxygen Therapy (Bio-oxidative Therapy).
19. Panchakarma Therapy.
20. Prolotherapy.
21. Urani Medicine
22. Urine Therapy.
23. Vitamin Therapy.

3. Body-medicine

1. Acceptance through touch (sexology).
2. Applied Biomechanics.
3. Applied Kinesiology.
4. Balneotherapy.
5. Biofeedback.
6. Bowen Therapy.
7. Cheirology (Palmistry).
8. Chiropractic.
9. Guided masturbation (sexology).
10. Colon Hydrotherapy.
11. Contact Reflex Analysis (CRA).
12. Cupping (Moxibustion).
13. Ear Candling.
14. Electrotherapy Gerson Therapy.
15. Healing power of intimacy
16. Herbal Medicine.
17. Holistic gynechology
18. Hydrotherapy.

Table 4. (Continued)

19. Hyperbaric Oxygen Therapy.
20. Hyperthermia.
21. Luminous.
22. Manual pelvic physical therapy (infertility).
23. Massage therapies (several hundred types).
24. NAET (Nambudripad's Allergy Elimination Therapy)
25. Manual therapy.
26. Naprapathy.
27. Nasal Irrigation.
28. Neuromuscular Therapy (Trigger Point Myotherapy)
29. Pet Therapy
30. Physical therapy.
31. Physiotherapy.
32. Pilates.
33. P6 acupressure (pregnancy, birth).
34. Polarity.
35. Qigong.
36. Reflexology (feet).
37. Relaxation Therapy.
38. Rolfing (Somatic Ontology/Structural Integration).
39. Sauna.
40. Spa.
41. Sports.
42. Tai Chi.
43. Visceral Manipulation.

4. Mind-medicine

1. Aversion Therapy.
2. Cognitive therapy
3. Couching.
4. Craniosacral Therapy.
5. Dream Therapy.
6. Eye Movement Desensitization and Reprocessing.
7. Gestalt therapy
8. Guided Imagery.
9. Healing music.
10. Hypnotherapy Neuro-Linguistic Programming (NLP).
11. Meditation.
12. No-touch sexology.
13. Psychoanalysis.
14. Psychodynamic psychotherapy.
15. Psychotherapy
16. Rapid Eye Technology.
17. Visualization

5. Spirit-medicine

1. Art Therapy.
2. Autogenic Therapy.
3. Bach Flower Remedies
4. Chromatotherapy.
5. Color Therapy.

6. Crystal healing
7. Emotional Freedom Technique (Tapping) (also called Thought Field Therapy).
8. Energy Field Medicine.
9. Energy medicine.
10. Feldenkrais Method.
11. Journey work (the soul's journey).
12. "Healing Touch" without physical touch.
13. Humor Therapy.
14. Iridology.
15. Kirlian Photography.
16. "Light Therapy."
17. "Molecular therapy."
18. Music Therapy.
19. Naturopathic Medicine.
20. Orthomolecular Medicine.
21. Past Life Therapy.
22. Philosophical interventions.
23. Positive psychology.
24. Pranic Healing.
25. Prayers.
26. Radiance Technique (TRT).
27. Reiki.
28. Satsangs with spiritual masters (i.e., Satya Sai Baba)
29. Scientology (OT-training).
30. Spiritual CAM (Interuniversity College, Graz).
31. Spiritual healing.
32. Spiritual Healing.
33. TAO (health philosophy).
34. Transcendental Meditation™.
35. Transpersonal Psychology.

6. Mind-body medicine

1. Accessing the unconscious through touch (basic Rosen method).
2. Acupressure.
3. Acupuncture.
4. Alexander technique.
5. Betty Dodson method (sexology).
6. Bioenergetics (Lowen)
7. Body-psychotherapy (Boyesen).
8. Chiropractics.
9. Clinical medicine (the examination is the treatment).
10. Crisis intervention.
11. Ergo therapy (occupational therapy).
12. Gestalt therapy.
13. Hellerwork.
14. Holistic pelvic examination.
15. Homeopathy.
16. Jaffe-Mellor technique (JMT).
17. Jin Shin
18. Jyutsu
19. Kegel exercises.
20. Manual sexology.
21. Medical intuitive.

Table 4. (Continued)

22. Physical therapy for the pelvic floor Reichian bodywork.
23. Rosen therapy (basic Marion Rosen)
24. Ryke Geerd Hamer's System for holistic treatment of metastatic cancer (German New Medicine, GNM).
25. Shiatsu.
26. Short-term psychodynamic psychotherapy complemented with bodywork.
27. Trager method.
28. Transformational.
29. Transsage.
30. Watsu.
31. Wave work.
32. Zero balancing.

7. Body-spirit medicine

1. Aboriginal medicine men.
2. Anthroposophy.
3. Druids (Traditional Keltic Healers).
4. Dynamic meditations (Osho).
5. Prayer involving physical activity.
6. Samic healers.
7. Sangomas (African Traditional Healers).
8. Shamanism (without drugs).
9. Tantra (sexual-spiritual practice).
10. Witchcraft medicine.

8. **Holistic body-mind-spirit medicine—including existential therapy**

1. Bengt Stern's Meet yourself Course.
2. Biodynamic body-psychotherapy.
3. Body-based self-development courses.
4. BodyTalk (Veltheim).
5. Boysen's Body Psychotherapy.
6. Breathwork (holistic, holotropic, bioenergetic, sexological, etc.).
7. Chakra experiencing.
8. Clinical holistic medicine (CHM).
9. Clinical medicine.
10. David Spiegel's Holistic cancer medicine (QOL improvement, Stanford University).
11. Dean Ornish's cure for coronary heart disease.
12. Depth psychology.
13. Guided imagery.
14. Hippocratic Character Medicine (i.e., Full Engagement).
15. Holistic body-psychotherapy.
16. Holistic bodywork.
17. Holistic medicine.
18. Holistic mind-body medicine.
19. Holistic sexology.
20. Holotropic breastwork (Grof).
21. Homeopathy.
22. Huna.
23. Induction of spontaneous remission of cancer by recovery of the human character and the purpose of life.
24. Intensive body-psychotherapy combined with mindfulness meditation at Mullingstorp in

Sweden (Bengt Stern).
25. Logo Therapy (Frankl).
26. Mindful short-term psychodynamic psychotherapy complemented with bodywork (CHM).
27. Mindfulness meditation.
28. Native American rituals.
29. Psychic massage (Osho).
30. Psychodrama (gestalt therapy) using controlled violence and sexual abuse (Simili similibus currentur, Bengt Stern).
31. Quality of life as medicine (Ventegodt).
32. Reichian massage.
33. Rosen Method (advanced).
34. Rubenfeld Synergy.
35. Salutogenic therapy (Antonovsky).
36. *Sexological examination, the.*
37. Shamanism (without drugs).
38. Spiritual crisis intervention.
39. Tantric bodywork and massage.
40. Therapeutic relationship formation between self-awareness and casework (Interuniversity College, Graz).
41. Tuina.
42. Vaginal acupressure.
43. Yoga.

9. Chemical-body-mind-spirit medicine

1. Ayurvedic Medicine.
2. CAM regulatory methods.
3. Grof's LSD-psychotherapy.
4. Lifestyle changes for coronary heath diseases (Spectrum—Dean Ornish).
5. MDMA psychotherapy.
6. Shamanism with peyote, Ayahuasca, magic mushrooms, etc.
7. Traditional Chinese Medicine (Oriental Medicine).

10. Social and environmental medicine

1. Aesthetic architecture.
2. Arena Method (Aina Søbakk, Norway).
3. Behavioral therapy.
4. Clubbing.
5. Coaching.
6. Education, academic training.
7. Feng Shui.
8. Gardening. Therapy gardens.
9. Holistic rehabilitation.
10. Leadership training.
11. Psychosocial medicine.
12. Stress management.
13. Work (development of skills, talents, self-confidence, self-worth, etc.).
14. Work-related personal development programs.

To be honest, this is not perfect. Many systems can be practiced in many different ways, allowing for the system to appear in several different classes. But we have thought about this and realized that if this is the case, the system is really more systems under one common

label. The system might have a problem defining itself and understanding what healing is about, and we understand of course that many CAM practitioners can disagree with our position.

Discussion

We believe that we have developed a useful system for CAM, but we invite NCCAM and all other CAM researchers to help us improve it further and to fit the different CAM systems into the correct categories. What we have done here is not the final answer to a CAM systematic but a new beginning, organizing CAM according to human nature and fundamental structure not to ad-hoc labels coming from cultural and historic influences.

Conclusion

We have suggested a ten-class classification system for medicine—including both CAM and biomedicine—based on the fundamental structure of a human being, with molecules, body, mind and spirit. There are many advantages of such a general and broad classification.

First of all, the systematic of the activities and thus the identification of the healing principles in use (8-10). This gives a fair idea of expected effect size, clinical conditions that can be treated, and possible side effects (8,9).

The system allows for a cost-benefit analysis (11); if you want the cost-benefit expressed in QALY, you can use data on QOL collected with a short questionnaire like QOL10 (12). Then, if you are to supervise the CAM treatment, you will also know which formal errors the therapists using the different systems can make (10). When you know what is going on and, therefore, also where the borders are for the expected activities, it will help practitioners to treat according to ethical standards (13).

Finally we have found this systematic to make research in CAM clear and efficient (14,15). As non-drug CAM is more than consciousness-based medicine using the placebo effect as an instrument for cure, RCTs with placebo control cannot be used (16) for research in non-drug CAM. We suggest a simple design where patients are measured before and after treatment and again after one year (15). We have used this design to document the effect of clinical holistic mind body medicine (CHM) and found it to be efficient (17).

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Chapter III

Cost-benefit analysis of ten types of evidence-based medicine: Which type of medicine is best? Cheapest? Most efficient? Safest? Which brings most happiness? Which brings most health?

In this chapter, we will make a comparative analysis of cost-benefit and cost-effectiveness of all types of evidence-based medicine for all clinical conditions. We will look at the "therapeutic value"—which is the ratio benefit to harm—and the price per cured patient in EUROs. We will also look at the cost of happiness, measured in quality-of-life years (QALYs), and at the cost of health, measured in health-adjusted life years (HALY). Finally, we will look at the number of harmed patients per patient helped or cured.

Our aim is ambitions: We will compare cost-benefit and cost-effectiveness of all types of evidence-based medicine, both pharmaceuticals and non-drug CAM—and for all clinical conditions.

Our method is simple: We will calculate the "therapeutic value" (TV)—the ratio benefit to harm ($TV=NNH_{total}/NNT$) from existing data, using the best and most reliable sources: The Cochrane reviews. We will look at the cost per cured patient though time—because patients most often live for many years and the long-term effect is much more interesting and relevant than the short-term benefit the pharmaceutical industry always focus on (we look at years 1-50).

The cost is presented as EURO per cured patient, but the EURO, the USD and the GBP are about the same size so if you simply think dollars or pounds, then you will get the right impression. The results are not that certain, actually you can multiply or divide by 2 or 3, and you will still be okay. What we give you here are rough estimates, but still very informative, we believe.

Medicine has a price: EURO per QALY, EURO per HALY, and number of harmed patients per cured patient.

The costs of one year of treatment of any kind are set to 2,000€ in this chapter, which is obviously not correct—this is one reason for the uncertainty. Prayer is cheaper (you get it for a

cup of coffee), and cancer-chemotherapy much more expensive (you can swop a year of therapy with your brand new car).

What we find in these analyses is very clear: The most effective CAM-types are mind-body medicine, holistic medicine and shamanism. These types are for most clinical conditions (but there are many exceptions, like syphilis, gonorrhea, and malaria) around 1,000 times as cost effective and 100,000 times less harmful compared to pharmaceuticals.

The 50-year estimated cost for one patient cured was for most clinical conditions treated with drugs about 1,000,000€. Treatment with physical therapy cost over 50 years was around 100,000€; psychotherapy 100,000€; mind-body medicine 50,000€; holistic mind-body medicine 20,000€; and one-session shamanistic healing with hallucinogenic drugs 2,000€. Native medicine is often ridiculously cheap and surprisingly efficient—which is why the pre-modern cultures used it. Today, there is so much politics and economy in medicine that money, not effect and safety, has come to determine which medicine we use—as you will learn in this chapter.

The reason why we focus on holistic mind body medicine in this book will be clear from the cost-benefit analysis. There are, as we learned in the last chapter, several hundred different types of non-drug medicines. When we narrow it to holistic mind-body medicine, there are still many more types of therapy than we can write about in this book. We have chosen to focus on what we believe are the most efficient and safe types of holistic medicine; but we are certain that we have excluded many important and good methods, which deserve to be described and explained in much more detail. We hope to be able to include this in the next edition of this book.

CAM is more efficient than drugs for most clinical condition; and the types that combine harmless techniques, like talk and touch, have no significant side effects and adverse events. Whereas treatment with drugs might be necessary i.e., for acute infections (antibiotics) or as hormone substitutes (thyroidal hormones, growth hormone, insulin,, etc.), it is important to remember that chemicals always have adverse effects and events.

To be useful, medicine must have significant therapeutic value (good ratio of benefits to harm: TV $\geq$1) and documented long-term effects and safety. The use of holistic medicine instead of drugs for a long row of diseases would in general improve health and quality of life, improve happiness and wealth in societies and reduce harm to patients and the cost of healthcare to a small fraction of what it is today.

We have observed that there is a war going on regarding medicine because of all the money that can be made. Strict laws should be introduced immediately in all countries to stop the pharmaceutical industry from promoting drugs without therapeutic value and from repressing CAM researchers and CAM practitioners. The most successful CAM people are often discredited by rumors or even made-up stories of malpractice and harm to patients. As talk and touch therapy in general are not harmful in any way, such stories are almost always lies created to dominate and destroy the CAM therapist. In Europe, many of the pioneers of healing have been sent to jail, even in modern times. Wilhelm Reich and Ryke Geerd Hamer are famous examples. When you see the numbers in the tables in this chapter, you will first think that we lie to you and manipulate data.

When you think again, you will wonder if this can be true. If you think deeper, you will understand what is happening: money and politics run the world, not common sense, not love, not rationality, and not human compassion. Your contribution is needed to make it a better world. Practicing CAM is one way to contribute.

Introduction

We have suggested that the five major categories of CAM used by NCCAM are revised into a ten-class system for evidence-based medicine in general (1), as we agree with the point of view often presented that CAM and biomedicine must be one integrated medical system of evidence-based medicine (2) (see Table 1).

Table 1. Classification of medicine (including CAM and biomedicine) into ten principal classes, Class 1 and 2 are chemical medicines; 3-10 are informational medicines

1.	Chemical medicine (biomedicine with bioactive molecules)
2.	Chemical CAM (flower medicine, herbal medicine, diets, minerals, vitamins,, etc.)
3.	Body-medicine (Low-energy types: massage, reflexology, physical therapy, physiotherapy, spa, sauna etc; High-energy times: chiropractics,, etc.)
4.	Mind-medicine (psychotherapy—psychodynamic, cognitive, gestalt,, etc., psychoanalysis, meditation, no-touch sexology, couching, healing music)
5.	Spirit-medicine (philosophical interventions, energy medicine, prayers, spiritual healing (i.e., Reichi), shamanism, spiritual CAM (i.e., crystal healing),, etc.)
6.	Mind-body medicine (acupuncture, acupressure, homeopathy, manual sexology, body-psychotherapy, Reichian bodywork, Rosen therapy, ergo therapy, etc.)
7.	Body-spirit medicine (prayer involving physical activity like in Tibetan Buddhist-style meditation, pilgrimage,, etc.)
8.	Holistic body-mind-spirit medicine—including existential therapy (holistic medicine, clinical medicine, clinical holistic medicine, holistic body-psychotherapy, holistic bodywork, the sexological examination, holistic mind-body medicine, biodynamic body-psychotherapy, tantric bodywork and massage, holistic sexology, Native American rituals).
9.	Chemical-body-mind-spirit medicine (shamanism with peyote, Ayuhuasca, magic mushrooms, Grof's LSD-psychotherapy,, etc.)
10.	Social and environmental medicine (coaching, work-related personal development programs, stress management, leadership training, gardening, aesthetic architecture, Feng Shui,, etc.)

In this chapter, we want to examine the cost-benefit and cost-efficiency of the ten different types of evidence-based medicine. We want to look at the ration benefit to harm (often called therapeutic value), the cost of the production of quality of life (QALY) and self-rated health (HALY) and the cost of health in patient damage.

Health measures

Today, there are three major population health measures permitting morbidity and mortality to be simultaneously evaluated: QALYs (quality of life-adjusted life years), HALYs (health-adjusted life years) and DALYs (disability- adjusted life years). In this chapter, we will only estimate QALYs and HALYs.

The method is estimating the general numbers from meta-analyses, preferably Cochrane reviews and when possible, meta-analyses covering one or more of the different types of evidence-based medicine.

We will include estimates from the leading medical journals of typical numbers of NNTs and NNHs. To make such a high-level analysis, where we look at all types of medicine for all clinical conditions, we will need to simplify matters.

The prize of pharmaceutical drugs will be calculated from the Danish cost of drugs to more than two million chronic patients in Denmark using biomedicine; this number might be high compared to the number in developing countries where medicine often is sold cheaper. The price of CAM treatments are also coming from Danish circumstances, where a year of therapy often is about 20 sessions, costing around 2,000€; in developing countries the prize is often a tenth of that.

The calculation of QALY and HALY is using the knowledge on normal loss of quality of life and self-rated health when people get ill in Denmark; as we have a lot of social security to some extent compensating for loss of quality of life and health, the prize per QALY and HALY might be lower in less developed countries.

As our results are calculated based on estimate, numbers we must admit have an uncertainty of +/- 100%; we believe our results to be correct within a factor three. As the differences between the different types of medicine are often a factor 10 or 100, this large uncertainty is still acceptable.

As the biggest problem in medical research today is bias from economical interests, we have avoided sources that might be strongly biased, like RCTs from pharmaceutical industry, overoptimistic estimates in reviews from CAM-journals not represented in MedLine/www.PubMed.gov, etc.

Actually, the process of limiting bias has been our biggest problem, forcing us to leave out most of the sources often used in this type of analyses, like statistics made by public organs headed by people close to the pharmaceutical industry. Such statistics seems mostly to be extremely biased in favor of biomedicine.

There are many fundamental problems in biomedicine we could have addressed to make this study more thorough; there are problems from the practical use of drugs with low compliance, wrong diagnosis, errors in prescriptions and overmedication; there are problems with the RCTs at its very roots making the NNT and NNH numbers from industrial testing difficult to trust, and this chapter is, after all, based on numbers coming from the pharmaceutical industries use of the RCT in testing its products. So we know that we are only scratching the surface of the problems in this chapter.

We have wanted things to be so simple that complexity of things could not allow us to bias this chapter or ourselves. What happens in any complex procedure is that you unconsciously will take things in the direction you want or expect, and only by making things so simple that there are no steps to twist or manipulate can you truly avoid bias. We believe that the simplicity of our calculations and estimates has led us to trustworthy, fairly unbiased results.

Our main source of information is the Cochrane library. In former chapters, where we have analyzed aspects of one of the ten types of medicine, we have had several hundred references. In this chapter, we are using the whole Cochrane library as reference. To make the reference list of acceptable length, we are only listing complementary material used in the study in the reference list.

What did we find?

Based on the Cochrane library, we have evaluated the benefit and harm from pharmaceutical drugs and the different CAM systems. We have looked at the likelihood to benefit using Number Needed to Treat (NNT), the likelihood to be harmed by the different adverse effects/side effects by using Number Needed to treat to Harm (NNH), and the total likelihood to get one side effect/adverse reaction or adverse event (NNH_{total}), and from this, we have calculated the ratio "benefit to harm" called the Therapeutic Value of the treatment (TV= NNH_{total}/NNT) (3,4,5), for the ten different types of medicine, see Table 2.

While it took a long time, thanks to the many Cochrane reviews, it has been easy to find NNT and NNH numbers for most pharmaceutical drugs; it has been more difficult to establish NNT and NNH numbers for the many different types of holistic and alternative medicine (CAM) and the relative harm of non-drug medicine had to be estimated from the number of reported cases in the literature (6). Recently, more than hundred Cochrane reviews have been made on a large number of CAM-types for a large number of clinical conditions, and NCCAM, the U.S. Research Center for CAM, has published a number of reports on five major categories of CAM, allowing us for a far better estimate of NNHs and NNTs (7,8) (see Table 2). As an example, NCCAM has evaluated the number of patients treated every year in the U.S. with massage therapy (therapeutic touch) and the number of patients experiencing significant side effects from such treatments; NCCAM found that 20,000,000 adults and 700,000 children are treated every year with very few patients harmed (9), allowing us to estimate NNH>1,000,000 for massage and similar types of therapeutic touch. Of the 145 Cochrane reviews of CAM analyzed by "Committee on the use of complementary and alternative medicine by the American public" (8), 38.4% of the reviews showed a positive or possibly positive (12.4%) effect. These Cochrane reviews documented typical NNTs of 2-30, depending on CAM type, and typical NNHs of 1000-1,000,000. Typical NNTs and NNHs for the ten types of evidence-based medicine are presented in Table 2 (3,5).

Two things are especially interesting for the patient: 1) How efficient is the medicine? This is best known from Number Needed to Treat (NNT) telling how likely it is that the patient will benefit from the treatment. 2) How harmful is the medicine? The absolute harm is important but even more important is the ratio benefit to harm. Many patients will feel that a treatment is of therapeutic value if its advantages (statistically) dominate its disadvantages. The ratio benefit to harm is simplest expressed by the ratio TV=NNH_{total}/NNT, where NNT_{total} is the total likelihood of getting a side/adverse effect or adverse event. Typical values of HHN_{total} and TV can also be found in Table 2.

In general, chemical medicine, whether biomedical drugs or CAM (herbs, aromatic oils, diet changes etc.), has high NNH_{total}s and low TVs. The effect of chemical CAM seems to be less than pharmaceutical drugs, but it is a lot safer.

If you manipulate the biological informational system of the patient (for the scientific concept of biological information, see 12) instead of body chemistry, you seem to avoid side/adverse effects and adverse events. Some types of CAM have a low efficacy, but still the TV is high, because of the relative safety. Some types of CAM are both efficient and safe. Holistic mind-body medicine seems to be as safe as other kinds of CAM but more efficient and there has the highest TV.

Table 2. Typical numbers for effect and harm, and the ration of *benefit to harm* for ten classes of evidence-based medicine (NNTs, NNHs, NNH_{total}s and TVs) (estimated from Cochrane reviews of RCTs and from clinical studies with chronic patients (3,4,5,6,8,9,10), see text)

CAM class	Short-term effect (0-6 months)	Long-term effect (6-24 months)	Side effects/ adverse events	Total risk of harm	Therapeutic Value $TV=NNH_{total}/NNT$
	NNT	NNT	NNH	NNH_{total}	TV (6-24 months)
Class 1-Biomedicine (pharmaceuticals)	20 (5-50)	50 (5-100)	1-5	1-3	1-0.01
Class 2-CAM (Chemical CAM)	≥20	≥50	25 (allergy)	25	0.5
Class 3a-CAM (Physical therapy, low-energy i.e., massage, therapeutic touch)	2-4	6	>1.000.000	>1.000.000	167.000
Class 3b-CAM (Physical therapy, high-energy i.e., chiropractic treatment)	2-4	6	1000 (fractures)	1000	167
Class 4-CAM (Psychotherapy)*	3	6	>1.000.000	>1.000.000	167.000
Class 5-CAM (Spiritual therapy)	>10	>20	>1.000.000	>1.000.000	50.000
Class 6-CAM (Mind-Body medicine)	2	4	>1.000.000	>1.000.000	250.000
Class 7-CAM (Body-Spirit medicine)	Not known	Not known	>1.000.000	>1.000.000	Not known
Class 8-CAM (Holistic mind-body medicine)	2	1-2**	>1.000.000	>1.000.000	500.000-1.000.000
Class 9-CAM (Shamanism w. drugs, etc.)***	1	1	>1000	>1000	>1000
Class 10-CAM (Social medicine)	1	10	>1.000.000	>1.000.000	100.000

* Some types of psychotherapy have short-term NNTs of 2-3 (STPP) and long-term NNTs of 1-2 (LTPP) for mental, somatic and sexual health problems (see 3,10). **The effect of clinical holistic medicine and similar medical systems seem to continue to increase though time (11). NNT: Number Needed to Treat. NNH: Number Needed to Harm, NNH_{total}: Total likelihood of getting one side effect/adverse effect or adverse event. TV: Therapeutic Value, which here means ratio of benefit to harm. For a treatment to be of true value to patients, is must be efficient, with a low NNT number and a high TV-number. ***Adverse effects, mostly brief reactive psychoses, are only seen with mentally ill patients (6).

Interestingly, there are adverse effects of the drugs traditionally used in shamanism (6), giving shamanistic medicine the lowest TV of all CAM treatments; but if you look at the cost during a 50-year lifespan, Shamanism ends up looking the best of all known treatments (see Table 6). As we do not want to return to Shamanism, we would like to give our tribute to the pre-modern medicine. Indigenous people often know much about medicine.

The cost of different drugs and different CAM treatment varies a great deal. Within every class of evidence-based medicine, there are expensive and cheap alternatives. We have found it fair to set both a pharmaceutical and a CAM treatment to 2,000€ per year, knowing that praying is cheaper and cancer-chemotherapy is more expensive. If you know the NNT-number and the cost of one patient treated, you can find the cost for one patient cured (or at least treated successfully) by multiplying these numbers (Cost of one patient cured = NNT x

yearly treatment cost) (Table 3). The next year, the cured patients will not cost anything, but the patient not cured will still cost the yearly treatment cost. In this way can we estimate the 10- and 50-year cost of one patient cured (Table 3). If the NNT is very high, very few patients are getting cured and most become chronic patients. This is the case for pharmaceutical drugs, so here the calculation is simple: The cost as times goes by is calculated as *yearly cost X time*. If all or most patients are cured in one or a few years, the calculation is similarly simple: The total treatment cost is the one-year treatment cost. When patients get better little by little, as in psychotherapy, a more complicated estimate must be made, accounting for the current recovery of patients. Our estimates of all ten classes are found in Table 3. Due to lack of data, we could not make estimates for Classes 5 and 7.

If there are many adverse effects and events, these cost sick-days, hospitalization, etc. We know that drugs are always poisonous to some extent and that it is estimated that there are now 100,000 deaths a year in U.S. hospitals directly caused by pharmaceutical drugs (13). This is a huge cost, but we have only included the direct cost to the drugs in our estimate. The true cost is likely to be several times larger.

A popular effect measure is QALY, or Quality Adjusted Life Years. The idea is simple: Survival has in itself no value; if you survive but suffer to en extreme extent, it might be better if the doctor had not saved you in the first place. To secure that the patient gets value for money, the cost per QALY must be calculated. As QOL of life in general is 20% lower for ill people than for healthy (14), we can make a simple estimate of cost/QALY, presented in Table 4.

Table 3. Accumulated cost (number of patient with side effects/adverse effects and adverse events) for one patient cured through time (year one, ten and fifty) for ten classes of evidence-based medicine

Continuous treatment (only stopped if the patients gets cured)	Cost per patient-year	Accumulated cost (€)		
	per treated patient	per cured patient		
	First year	First year	Year 10	Year 50
Medicine with drugs (chemical medicine) Class 1 – Chemical medicine[1]	2,000	≥100,000	≥200,000	≥ 1,000,000
Class 2- CAM (Chemical CAM)	2,000	>100,000	> 200,000	> 1,000,000
Non-drug CAM (informational medicine)				
Class 3-CAM (Physical therapy)	2,000	12,000	60,000	100,000
Class 4-CAM (Psychotherapy)	2,000	12,000	60,000	100,000
Class 5-CAM (Spiritual therapy)	Not known	Not known	Not known	Not known
Class 6-CAM (Mind-Body medicine)	2,000	8,000	30,000	50,000
Class 7–Body-Spirit medicine	Not known	Not known	Not known	Not known
Class 8-CAM (Holistic mind-body medicine)	2,000	5,000	10,000	20,000
Class 9-CAM (Shamanism w. drugs)	500	600	800	2,000
Class 10-CAM (Social/environm. medicine)	5.000	50.000	350.000	500.000

[1](cost of biomedical examination, hospitalization, and treatment of adverse effects and events not included) (estimated round numbers, see text).

Table 4. Accumulated cost of one QALY (Quality of life-adjusted Life Year) through time (year one, ten and fifty) for ten classes of evidence-based medicine

Continuous treatment (only stopped if the patients gets cured)	QOL improvement from treatment (%) if successful	Prize of one QALY calculated from NNT and accumulated cost (Table 3)		
	Global QOL	per cured patient	per cured patient	per cured patient
		First year	Year 10	Year 50
Medicine with drugs (chemical medicine) Class 1 – Chemical medicine[1]	20%	500,000	≥1,000,000	≥ 5,000,000
Class 2- CAM (Chemical CAM)	20%	>500,000	> 1,000,000	> 5,000,000
Non-drug CAM (informational medicine)				
Class 3-CAM (Physical therapy)	20%	60,000	300,000	60,000
Class 4-CAM (Psychotherapy)	20%	60,000	300,000	60,000
Class 5-CAM (Spiritual therapy)	20%	Not known	Not known	Not known
Class 6-CAM (Mind-Body medicine)	20%	40,000	180,000	40,000
Class 7–CAM Body-Spirit medicine	20%	Not known	Not known	Not known
Class 8-CAM (Holistic mind-body medicine)	20%	25,000	50,000	10,000
Class 9-CAM (Shamanism w. drugs)	20%	3000	4000	800
Class 10-CAM (Social/environm. medicine)	20%	250.000	1,750.000	2,500.000

[1](cost of biomedical examination, hospitalization, and treatment of adverse effects and events not included) (estimated round numbers, see text).

The principles of the estimate are simple: If a patient is cured right away and stays healthy and would have become a chronic patient without treatment, the cost for one cured patient is multiplied with the time the patient's health is improved. As very few patients are cured with biomedicine, the cost of one QALY becomes astronomic as the treatment continues for life without results—which is normally the case in Denmark where we have socialized biomedicine, free or very cheap for all chronic patients. On the other hand, a QALY-unit, with an efficient CAM cure, with normally has the extra plus that patients not only stays healthy but also improves health through time (as they have learned the basic principles for human development) as times go by be relatively cheaper. For every past year, the quality of life and health is already paid, as shown in Table 4. Interestingly one-session shamanistic healing is far the cheapest kind of medicine, presumably explaining its great popularity in almost all pre-modern cultures. In one-session healing, you are normally taken unto a daylong journey of guided self-exploration where you come to understand how you make yourself ill by the way you life and look at things. It's thus a life-style and philosophy of life intervention. From a theoretical point of view, it might actually work.

Instead of QALYs, WHO often recommends the use of HALYs (and DALYs), which is exactly the same, only with health (most often self-rated health) instead of quality of life. We know that the strongest measure of health is self-rated health (15-18), and we also know that sick people experience their health very much the same way as they experience their quality of life (14), allowing us again to use a difference of 20% between healthy and ill people.

Table 5. Accumulated cost of one HALY (Quality of life-adjusted Life Year) through time (year one, ten and fifty) for ten classes of evidence-based medicine

Continuous treatment (only stopped if the patients gets cured)	Health improvement Prize of one HALY calculated from NNT from treatment (%) and accumulated cost (Table 3) if successful			
	Self-rated health	per cured patient per cured patient per cured patient		
		First year	Year 10	Year 50
Medicine with drugs Class 1 – Chemical medicine[1]	20%	500,000	≥1,000,000	≥ 5,000,000
Class 2- CAM (Chemical CAM)	20%	>500,000	> 1,000,000	> 5,000,000
Non-drug CAM				
Class 3-CAM (Physical therapy)	20%	60,000	300,000	60,000
Class 4-CAM (Psychotherapy)	20%	60,000	300,000	60,000
Class 5-CAM (Spiritual therapy)	20%	Not known	Not known	Not known
Class 6-CAM (Mind-Body medicine)	20%	40,000	180,000	40,000
Class 7–CAM Body-Spirit medicine	20%	Not known	Not known	Not known
Class 8-CAM (Holistic mind-body medicine)	20%	25,000	50,000	10,000
Class 9-CAM (Shamanism w. drugs)	20%	3000	4000	800
Class 10-CAM (Social/environm. medicine)	20%	250.000	1,750.000	2,500.000

[1](cost of biomedical examination, hospitalization, and treatment of adverse effects and events not included) (estimated round numbers, see text).

Table 6. Accumulated harm through time (year one, ten and fifty) for ten classes of evidence-based medicine—prize for one patient cured

Continuous treatment (only stopped if the patient gets cured)	Number of patients harmed Accumulated harm (number of patients harmed For one patient cured per patient cured)			
	Self-rated health	per cured patient per cured patient per cured pt.		
	NNH_{total}	First year	Year 10	Year 50
Medicine with drugs Class 1 – Chemical medicine	3	17	25	50
Class 2- CAM (Chemical CAM)	25	2	4	5
Non-drug CAM				
Class 3a-CAM (Physical therapy, Low E)	1,000,000	0.000,01	0.000,1	0.001
Class 3b-CAM (Physical therapy, High E.)	1,000	0,002	0,01	0,1
Class 4-CAM (Psychotherapy)	1,000,000	0.000,01	0.000,1	0.001
Class 5-CAM (Spiritual therapy)	1,000,000	Not known	Not known	Not known
Class 6-CAM (Mind-Body medicine)	1,000,000	0.000,01	0.000,1	0.001
Class 7–CAM Body-Spirit medicine	1,000,000	Not known	Not known	Not known
Class 8-CAM (Holistic mind-body medicine)	1,000,000	0.000,01	0.000,1	0.001
Class 9-CAM (Shamanism w. drugs)	1,000	0.001	0.001	0.001
Class 10-CAM (Social/environm. medicine)	1,000,000	0.000,01	0.000,1	0.001

This gives us Table 5, showing that mind-body medicine gives lots of health for the money, while chemical medicine and social medicine does not.

The harm caused by the ten different types of evidence-based medicine as times goes by has been estimated in Table 6. Patients using biomedicine for years without being cured, as is normally the case, are accumulating the harmful adverse effects and events caused by the pharmaceutical drugs. Non-drug CAM does not cause significant harm. The hallucinogenic drugs have some rare but significant adverse effects but as shamanistic medicine is often very efficient with result that lasts for life due to increase self-awareness and self-insight, the harm inflicted over a lifespan becomes similar to the level of harm inflicted by the other CAM systems, indicating that we might be more open to the potential benefits of pre-modern medicine and drug-induced one-session healing, like Grof's LSD therapy (19).

Discussion

For a society, the most important thing is to choose a medicine that is affordable, which in general benefits the patients, without harming them. Table 6 shows the sad consequences of the large NNH and NNH_{total} numbers of the chemical medicine in the long run. As one of three patients are harmed every year with pharmaceutical drugs, and treatment often continues for life when the patient is not cured, the consequence is that almost every patient is harmed in the end, and 50 patients are harmed for every single, chronic patient helped or cured. In Denmark over two million chronic patients out of a population of five million uses drugs for about six billion Euros pr. Year (or 2-3,000 EURO per chronically ill patient, confirming the price of drugs used in Table 3). It is clear for us that the same money spent on the most efficient types of non-drug CAM (group 3,4,6,8) would do immensely more for the population's health.

As this is not new, one wonders why chemical medicine is so much used and why mind-body medicine is not part of the official health system. One likely explanation is the close connection among pharmaceutical industry, the physicians and the public health system—often called the "medico-industrial complex." This system is often seen to actively work against CAM, repressing CAM researchers and effectively by all means keeping CAM out of the political scene (20). Drugs obviously turn patients into chronic patients instead of curing them. Half the population of the Western world today is chronically ill, seemingly because of strong political and financial interests in biomedicine, leading to massive oppression of CAM in favor of drugs. The shift from drugs to CAM would improve health radically in the society and reduce the cost of healthcare to a small fraction. Strict laws should be introduced immediately in all countries to stop the pharmaceutical industry and its collaborates from promoting drugs without evidence of therapeutic value (the ratio benefits: harm larger being no less than 1) and long-term effect and patient safety and from repressing CAM.

Conclusion

Strong economical and political interest seem to control medicine in Denmark and many other countries, making the pharmaceutical drugs often used, in spite of better and safer

alternative for almost all clinical conditions (see 3,10 for comprehensive lists of clinical conditions that can be helped or cured with mind-body medicine).

People who still doubt the reality of the low cost, high efficacy and safety of CAM presented in this chapter are encouraged to study Dean Ornish's cure for coronary heart disease. It was this well-documented CAM cure for a serious disease that made us believe in the potentials of CAM (21,22).

We have seen that the ten different types of evidence-based medicine have very different profiles when it comes to efficacy, cost pr. cured patient, cost per QALY, cost per HALY, and cost in harm on patients. In general chemical medicine, biomedicine as well as CAM is expensive and harmful in the long run, while CAM i.e., massage therapy and psychotherapy, is safe.

The best types of CAM, like mind-body medicine, holistic mind-body medicine (i.e., the classical Hippocratic medicine, often called clinical holistic medicine/CHM) are 50.000 times less harmful and 100 times more efficient in producing health and happiness (quality of life). The cost of one cured chronic patient is about 1,000,000€ with pharmaceutical drugs and 100,000€ or less with the efficient types of CAM.

Surprisingly we found pre-modern medicine—shamanism—to win the race in the end. While the drugs used often have some rare adverse effects, the efficacy of traditional one-session healing might make shamanistic medicine the cheapest, safest and most effective in the end. While we do not advocate the back-propagation to pre-modern times, we find it very interesting that such a medicine exists, inspiring us all to continue our quest for a still better medicine.

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Chapter IV

Review and meta-analysis of positive effects, side effects and adverse events of holistic mind-body medicine

In the last chapter, we analyzed the different types of medicine and found that holistic mind-body medicine, or scientific holistic medicine for short (often called clinical holistic medicine), seems to be far the most efficient medicine there is, compared both to other types of CAM and to chemical medicine (both chemical CAM and pharmaceutical drugs).

Why is safe and efficient medicine so important? Well, about 50% of the general population has a chronic disease not cured by biomedicine, in the modern, Western countries. These people contribute only little and might in the future become a severe burden for the global eco-system, thus being a central part of what is threatening our collective survival. All these chronically ill patients could use holistic medicine, and according to the statistics many could be cured, become more conscious, responsible and aware of self and others.

In this chapter, we make a meta-analysis of the most efficient and sage type of non-drug medicine: clinical holistic medicine (CHM). We look at chronic patients treated and analyse the outcomes in the three most important dimensions:

1) Global quality of life (general happiness, life satisfaction, fulfilment of needs, I-strength, quality of relations)
2) Self-rated physical/mental health and objective health
3) Ability of functioning—social, sexual, work-related, study related

The method is a search in Medline and PsycINFO and specific journals and academic books included. We reviewed 113 papers and twelve clinical studies (20,000 participants) for this meta-analysis. Positive effects: Quality of life (NNT=2), physical health problems (NNT=2-3), physical pain (NNT=2), low self-rated physical health (NNT=2), mental health problems (NNT=2-3), low self-rated metal health (NNT=2), low self-esteem (NNT=2), poor working/studying ability (NNT=2), sexual dysfunctions (NNT=1), anorgasmia (NNT=1), incontinence (NNT=2) infertility (NNT=3). Suicide was prevented (NNT=1). Side effects and

adverse events: re-traumatisation (NNH >20,000); brief reactive psychosis (if mentally ill) NNH=10,000; brief reactive psychosis (if not mentally ill) (NNH >10,000); brief reactive psychosis, all patients (NNH = 20,000); depression (NNH>20,000); depersonalisation and derealisation (NNH>20,000); iatrogenic disturbances NNH>20,000; minor bone fractures (ribs, hand) NNH=5,000; serious bone fractures (spine, scull, pelvis) NNH >20,000; suicides during or less than three month after therapy (NNH >20,000); suicide attempts (NNH>20,000). Therapeutic value TV=NNH/NNT=10,000.

We found that CHM is an efficient CAM treatment for most clinical conditions. Every second patient with physical and mental disorders, sexual dysfunctions and existential problems was helped. CHM had no significant side effects or adverse events.

Introduction

While pharmaceutical medicine seems to be with some problems (1), CAM seems to blossom worldwide. The RCT-test used to document pharmaceutical medicine has some flaws (2), and evidence supporting non-drug medicine is now appearing—evidence that documents that non-drug medicine can be used for many clinical conditions in an efficient and safe way for the patients.

The classical Hippocratic character medicine has been characterised as *holistic medicine*, because all aspects of body, mind and spirit are in focus (3). It is called *character medicine*, because health is believed to come from using your physical, mental and spiritual talents—or inherent character. It has been called *clinical medicine*, because the thorough examination of the patient together with the patient creates the self-awareness and self-insight, which is also the solution to the patient's problems on all existential levels—thus the cure.

In the middle of last century, most physicians considered the traditional holistic medicine to be inferior to biomedical treatments with drugs. During the last three decades, this attitude has shifted and many physicians and therapists are now practicing different forms of holistic mind-body medicine, and more and more patients are seeking this kind of alternative medicine (CAM) (4,5). At the same time, holistic medicine has shifted from being a medical art to being evidence-based medicine (EBM), defined as "integration of best research evidence with clinical expertise and patient values" (6).

Mind-body medicine has for the last decade been a part of most curricula at U.S. medical schools (7,8), and recently a European Master Program in CAM at the Interuniversity College in Graz, Austria, has been established with holistic mind-body medicine as a central position in the curriculum (9). In the U.S., mind-body medicine is officially listed as one of the five major types of CAM (4,5).

The aim of this chapter is to evaluate the efficacy and safety of the scientific version of the classical Hippocratic medicine, which we call *holistic mind-body medicine*, or *holistic, clinical medicine* (CHM).

Our search

We performed a meta-analysis of all studies of clinical holistic medicine where chronic patients were treated and where the outcome was one of the following:

1) Global quality of life or survival
2) Self-rated physical or mental health, quality of life or ability of functioning
3) Patients felt cured for a specific disease of dysfunction

NNT and NNH were estimated in review and if possible calculated in meta-analysis. MEDLINE and PsycINFO and the specific journals of CAM (*J Compl Integr Medicine, J Altern Med Res, Evid Based Complement Alternat Med, Complementary Health Practice Review, Transcultural Psychiatry*) were searched with academic books on mind-body medicine included.

To secure high methodological quality for studies, we included in the meta-analysis only studies that could be given 14 or more points on the "checklist for measuring study quality" (10). Clinical trials on chronic patients serving as their own control with dichotomized data were included. Positive effects were documented by high-quality outcomes documenting that the patients significantly improved or cured, like global quality of life, survival, self-assessed physical and mental health, sense of coherence, self-assessed ability of functioning and self-reported cure from severe physical or mental disease. Negative effects were documented by screening all treated patients for important side effects and adverse effects. We only included studies with dichotomised data, and to make this meta-analysis, we, therefore, had to exclude many of the most successful studies of mind-body medicine. We excluded the effects that are not seen as side effects in holistic clinical medicine, i.e., hypomania and developmental crises (11-14).

We prioritised the outcomes according to the tradition in evidence-based physical therapy (15,16) and only included excellent and good outcomes (see Table 1).

Table 1. Hierarchy of Outcomes—most valuable to least valuable as documentation for cure (based on 15,16)

	Excellent
1.	Self-assessed global QOL
2.	Survival
3.	QALY (survival time x global OQL)
	Good
4.	Self-assessed sense of coherence
5.	Self-assessed physical and mental health
6.	Self-assessed ability of functioning (social, sexual, working/studying)
7.	Self-reported cure from experienced severe, chronic physical or mental disease.
	Fair
8.	Objectively measured physical and mental health
9.	Objectively measured ability of functioning (social, sexual, working/studying)
	Poor
10.	Objectively measured local aspects of health (i.e., coughing, motility, etc.)
11.	Health-related QOL
12.	Patient satisfaction

The outcomes that best documented a curative treatment effect were the subjective factor "self-rated global quality of life" and the objective factor "survival." Good but not excellent documentation was according to Bø et al.'s (16) self-rated improvement of physical and mental health and the ability of social, sexual and working/studying functioning. Fair outcomes were objective data on global aspects of health and functioning. Poor outcomes were objective measures of minor aspects of health, hybrid measures as "health-related quality of life" without clear meaning, and patient satisfaction that might not be related to improvement of health at all but to aspects like hospital food, indoor decoration, dressing and professional behaviour of staff (see Table 1).

What we found

The general search for mind-body medicine resulted in about 100 papers (case reports, case series, reviews and meta-analyses), which documented that many diseases and health problems could be treated (4,5,10-11,16-119) (see Table 2). Based on these papers, a Number Needed to Treat (NNT) could be estimated for most clinical conditions (see Table 2). In general, one in two patients was cured from physical and mental disorders, sexual dysfunctions, and existential problems within one year (NNT=2). Almost all these studies reported no significant side effects but unfortunately without specifying which side effects had been included in the study.

Table 2. Clinical conditions that has been proven treatable with holistic mind-body medicine (CHM) (Number Needed to Treat (NNT) is best estimate from the provided data)

Physical diseases
Asthma, eczema, allergy (NNT=2) (21,62,101)
Cancer—quality of life/reduced pain/increased survival (NNT=2/3/7) (70,77,103,106,119)
Chronic infections and autoimmune diseases (NNT=2) (91)
Chronic pain (musculoskeletal and inner organs) (NNT=2) (21,62,92,100)
Coronary heart disease (NNT=2) (55-57)
Cystitis (NNT not estimated) (48-59,114)
HIV—improving quality of life (NNT not estimated) and possibly also survival (83)
Incontinence (NNT=2) (16,59)
Infertility (NNT=3) (1002,115)
Labour, problems related to (NNT=2) (73)
Multiple diseases (NNT not estimated) (91)
Nausea (NNT not estimated) (17)
Neurologic dysfunction (Brain Damage, Narcolepsy, Dementia, Intelligence Deficit) (NNT not estimated) (86)
Pregnancy, problems related to (NNT=2) (74)
Rheumatologic disease (NNT=3) (29,62)
Self-rated physical health (NNT=2) (20,24,25-28,30,36,46,68,69,107,112)
Tinnitus (NNT not estimated) (98)
Urgency-frequency syndrome (NNT=2) (115)
Vomiting (NNT not estimated) (17)

Mental disorders
Adolescent medicine (NNT=1) (105)
Alcoholism, ludomania, other types of dependency (NNT=3) (58,90,99)
Anxiety (NNT=2) (58,78,79,113)
Borderline and other disorders of personality (NNT=3) (58,78,79,94)
Children and adolescence with autism or behavioural disturbances including ADHD (NNT=2) (58)
Depression and hypothymia (mood and emotional disorders) (NNT=3) (58,71,78,79)
Eating disorders (NNT=2) (58,80)
Low self-esteem and self-confidence (NNT=2) (58,71,111)
Post traumatic stress and other sequelae of violent or sexual trauma like rape and incest (NNT=2) (58)
Schizophrenia and schizotypia (NNT=3) (58,67,85)
Self-rated mental health (NNT=2) (24-28,30,36,46,68,69,71,108,112)
Suicide prevention (NNT=1) (14,18,71,95)

Sexual and gynaecological problems
Adolescent gynaecological problems (NNT=2) (16,41)
All major sexual dysfunctions and sexual pain/vulvodynia (NNT=1) (1619,22,23,37,38,40,41,41-45,49-52,54,60-66,72,81,82,88,96,109,115,115, 117)
Couples therapy (NNT=3) (41,61,104)
Self-rated sexual function (NNT=2) (35,39,53)

Existential and working/studying problems
Low sense of coherence (NNT=2) (39,47,71,87)
Low working/studying ability (NNT=2) (47,71,84,87,118)
Poor quality of life and existential problems (NNT=2) (18,47,71,87)
Self-rated quality of life (NNT=2) (32-34,39,75,110)
Self-rated social ability (NNT=2) (30,31,39,75,97)
Self-rated working ability (NNT=2) (39,75,76)
Stress, life crises, burn out syndromes—general rehabilitation (NNT=2) (47,53,71)

Table 3. Side effects and adverse events of holistic mind-body medicine (CHM) modified after (14). N: number of patients in study. SE/AE% (Side effects/Adverse events): fraction of patient with side effects or adverse events in percent. (* These patients were mentally ill before treatment)

	Denmark (72,81,107-111)		Sweden (32-34)		Norway (119)		UK (18)		Germany (18)		All patients		
	N	SE/AE (%)	N	SE/AE (%)	N	SE/AE (%)	N	SE/AE (%)	N	SE/AE (%)	N	SE/AE (%)	NNH
Re-traumatisation	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Brief reactive psychosis, mentally ill*	500;	0.00%	2000;	0.05%	750;	0.00%	3000;	0.00%	3750;	0.00%	10,000;	0.010%	=10,000
Brief reactive psychosis, not mentally ill	500;	0.00%	2000;	0.00%	750;	0.00%	3000;	0.00%	3750;	0.00%	10,000;	0.010%	>10,000
Brief reactive psychosis, all patients	1000;	0.00%	4000;	0.05%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.010%	=20,000
Depression	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Depersonalisation and derealisation	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Implanted philosophy	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Iatrogenic disturbances	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Negative effects of hospitalisation	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Minor bone fractures (ribs, hand)	1000;	0.00%	4000;	0.10%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.020%	=5,000
Serious bone fractures (spine, scull)	1000;	0.00%	4000;	0.10%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.022%	>20,000
Suicides during or less than three month after therapy	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000
Suicide attempts during or less than three month after therapy	1000;	0.00%	4000;	0.00%	1,500;	0.00%	6000;	0.00%	7500;	0.00%	20,000;	0.00%	>20,000

Table 3 shows the meta-analysis of papers that did report on the specific type of side effects and adverse events. We found 12 studies including the treatment of 20,000 chronic patients in United Kingdom, Germany, Norway, Sweden and Denmark, where specified side effects were mentioned. Rare, minor and temporary side effects were bone fractures, presumably in the elderly population and brief reactive psychosis for mentally ill patients. The latter, often called a developmental crisis, is in most holistic medicine systems believed to be an integral part of the treatment and a necessity for healing and, therefore, not a side effect or adverse event nor a complication. Table 3 shows that no significant side effects were found from holistic mind-body medicine. In about 80 cases, an intended suicide (with decision) was seemingly prevented (NNT=1).

Discussion

Regarding the positive results, we also need data from the treatment of patients with a variety of concrete diseases like cancer or coronary heart disease. Unfortunately, we have not found the data presented of a dichotomize type easily included in this type of review. This does not mean that it cannot be done; the next natural step is to get the raw data from the researchers and make the same analysis on these data. There are few studies of high quality but sufficient to make a robust conclusion on the efficacy and safety of holistic mind-body medicine (holistic clinical medicine).

When it comes to the clinical value for patients, the important thing is the ratio between benefit and harm (we call this the Therapeutic Value, TV). TV is excellent for holistic mind-body medicine; we calculate $TV_{CHM}=NNH_{total}/NNT=20{,}000/2=10{,}000$. ($NNH_{total}$ expresses the total likelihood for getting a side effect/adverse effect). A similar number can be calculated for pharmaceutical drugs, which often has a NNT=20 (5-50, see 120) and a NNH_{total}=1-5: $TV_{DRUGS}=3/20=0{,}15$ (0.02-1). We find it important to notice that the ratio TV_{CHM}/TV_{DRUGS}= 100,000 (10,000-500,000), meaning that if there is both a non-drug treatment and a pharmaceutical treatment for your clinical condition, the patient is likely to benefit significantly more from the non-drug treatment, making this "the cure of choice."

Non-pharmaceutical CAM treatment with holistic mind-body medicine of the subtype clinical holistic medicine (in Denmark and Norway often called "clinical holistic medicine," in Sweden "mindful mind body medicine," and in UK and Germany often called "holistic body psychotherapy") has been tested on patients with many types of physical and mental illnesses, sexual dysfunctions, low quality of life and other clinical conditions, and in general found to be efficient. For physical disorders, we found NNT=2-3, for mental disorders NNT=2-3, for sexual dysfunctions NNT=1, and for existential problems we found NNT=2. Clinical holistic medicine has no significant side effects or adverse events (NNH>20,000) and prevents suicide (NNT=1). The ratio benefit to harm is excellent for most clinical conditions treated with clinical holistic medicine (TV_{CHM}=10,000).

We, therefore, recommend clinical holistic medicine to be a medical treatment of first choice for chronic conditions and second a biomedical pharmaceutical treatment, if holistic medicine fails to cure.

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Chapter V

Two different medical systems

In Chapter 1, we gave you our holistic map of the world—all the fundamental concepts that we use when we analyse patients, think about treatments, make theories about health and disease. If you use this approach and map, you will think and behave like a holistic doctor. If this map was all you had, you would simply give your patients loving care, attention, support, and help them to explore themselves, dig into their hidden resources, find new understanding and fight their way into a new and better life. But life is not that simple. You are likely to have heard about chemistry, physics or biology, and you may know thousands of concepts from the science of the material world. You might already have a completely different map of reality in your head. If you have, chances are that you have to de-learn a great deal of knowledge before you can act successfully as holistic practitioner. It is not so that you need not to know chemistry and biology, cytology and histology, anatomy and physiology to be a great doctor. You need to know all that. But you need to have a focus on what is important. And *what is important is everything directly related to consciousness*. You need to know all kinds of little details, but only if you can comprehend the big picture can you really help.

In the world today, we have two scientific medical traditions, two schools or treatment systems: traditional holistic and alternative medicine on one hand, and commercial, industrial biomedicine on the other. These two systems exist in two very different universes. This makes it very difficult to compare the therapeutic value of each system. To do so, you need to look at a well-defined group of diseases and see how successful each system is in treating the patients. But then again, the two systems have chosen totally different ways of measurement of outcome. Biomedicine will almost always look at improvement of some specific symptom, while holistic medicine will look at some global quality of life self-rated health or quality of life. The drug industry will provide data from large randomized studies, while papers on holistic medicine will give you data, where the patients (in small numbers) serve as their own control. Each system argues why their way is better. In this chapter, we will try to compare the two systems using the psychiatric diseases as an example.

Warning

Commercial medicine—one of the largest industries of the world today—has had much power to re-define reality, inventing even whole new medical theories, diagnostic systems

and diagnostic tools, helping the pharmaceutical industry to market its product. Please do not be naïve about it. Just take it into consideration when you contemplate what is true and right in medicine. Is this theory right (who makes money from it?)? Is this diagnosis relevant (what is the consequence of giving it?)? Is this medical tool helpful (will the patient's quality of life improve?)? Many things are simply not invented to help the patients but serve commercial interests. This is kind of hard to comprehend, but you need to include politics and money, when you think of medicine.

In Europe, you can be a master of science in complementary, integrative and psychosocial medicine (EU-MSc in CAM at the Interuniversity College, Graz in Austria) or you can be a master of science in biomedicine (MD/MMedSci). These two different curriculums have almost nothing in common (we know since we (SV) have both degrees), the first being about consciousness and the latter about biochemistry. But we would say that both systems are *scientific*.

The two traditions are based on two very different *philosophical positions*: subjectivistic and objectivistic. The philosopher Martin Buber (1878-1965) taught us that you can say I-Thou or I-It, holding the other person as a subject or an object (1). These two fundamentally different attitudes seem to characterize the difference in worldview and patient approach in the two schools, one coming from psychoanalysis and the old, holistic tradition of Hippocratic medicine, the other from the modern natural sciences.

Holistic medicine has during the last three decades developed its philosophical positions and is today an independent, medical system seemingly capable of curing mentally ill patients at the cost of a few thousand Euros with no side effects and with lasting value for the patient (2). The problem is that very few studies have tested the effect of holistic medicine on mentally ill patients. Another problem is that the effect of holistic medicine must be documented in a way that respects this school's philosophical integrity, allowing for subjective assessment of patient benefit and using the patient as his/her own control, as placebo control cannot be used in placebo-only treatment.

As the existing data are strongly in favour of using holistic medicine, which seems to be safer, more efficient, and cheaper, it is recommended that holistic medicine also be used as treatment for mental illness. But more research and funding is still needed to develop and document scientific holistic medicine.

Introduction

It is most interesting that the last century left us with two completely different, scientific traditions for treating the physically and the mentally ill: a subjectivistic and an objectivistic. These two traditions correspond exactly to the two different ways man can relate to his world, with the famous philosophical position of the existential philosopher Buber (1): as a "thou" or as an "it." Buber published his famous book *I and Thou* in 1923, and it had quite an extreme impact on the development of the way therapists understood their own works at that time. They understood that man has only two fundamental relations in the world, either I-Thou or I-It.

Either you come from a subjectivistic position, said Buber, or from an objectivistic position; either you come from sheer love or from bruited force. There is no in between, no

middle way, no way to mix the two. We must choose our approach and take the consequences. The person before you may be a divine being, with an autonomy equal to your own, to see, understand, and interpret the world; a centre in the universe like yourself, and you have no power over this other person at all; (s)he is a unique presence, a source of existence like yourself, and you can only surrender and serve, if you want to relate at all.

On the other hand, there is the person who regards another person as an object, which can be analyzed and manipulated, trimmed, supported, or broken down; you are in power, and the other person is at your command and for your use. Buber found this position to be instrumental and exploitive and not loving and supporting at all.

One of the most celebrated researchers of the objective, medical tradition is Archie Cochrane (1909-1988). The stimulus inciting the interest of Cochrane in scientific medicine is claimed to be his own ill health and the inability of psychoanalysis to cure his problem of sexual dysfunction (3).

The treatment undertaken by Cochrane failed possibly because his condition was organic, and thus evidence-based medicine was founded on Cochrane's critical evaluation of his own psychoanalytic psychotherapy. The objectivistic tradition of medical science thus founded now believes that objective physical and chemical etiologies exist for all disease not only organic problems but also mental problems. In psychiatry, the objectivistic approach has led to extremely complicated and detailed systems for psychiatric diagnostics related to brain-chemistry and pharmaceutical treatments thereof.

In holistic medicine, the tradition of psychodynamic therapy going back to Freud (4) and Jung (5) has been developed into a variety of ways to support patients' body, mind, spirit, and whole existence. Most popular is existentially oriented conversational therapy (see (6)), emotionally realizing bodywork (7-9), and spiritual exercises that develop the patients' consciousness and autonomy (basically taking the patients back to what Huxley called the "perennial philosophy" (10)). The holistic medical tradition believes that subjective choices and shift in consciousness are the aetiology of most diseases, both somatic and mental.

Holistic approach to psychiatry

In medicine, these are two philosophically equally valid positions, the subjectivistic and the objectivistic, which means that we as doctors either come from an objectivistic science that tries to understand our patient by using tools for scientific analysis, diagnostics, and treatment, or from a subjectivistic science that focuses on meeting the other person soul to soul, on "loving the other" in an unselfish way, in letting yourself as a doctor be "the tool" in your impeccable service of the other. What you to do here is to bring the patient's subjective being into focus and surrender your own self to that meeting.

The objectivistic position is the position of the biomedical psychiatrist, for example, the doctor has the full power to change the situation of the mentally ill patient, because of his medical and scientific knowledge and competence that allows him to see and understand the mental disease as nothing more than an objective disturbance that can be treated and cured with biomedical science and its understanding of the brain and its consciousness.

The subjectivistic position is the position of the holistic doctor insisting on meeting the mentally ill patient in a nonjudging way, believing in his/her inner self-healing powers and

innate knowledge and wisdom, and, therefore, taking the position that what is happening inside the other person is a product of this person's autonomously assumed choices and philosophical positions. As the person is obviously in trouble, the doctor surrenders his own ego and will to the situation, and coming from unselfish unconditional love, he gives what he can of attention, care, respect, acknowledgment, and acceptance to the other, in all aspects of this person's manifestations, i.e., physical, mental, spiritual, and existential.

In practice, nothing is as black and white as the two philosophical positions, but when you look for it, you can easily find these two positions as fundamental reasons for the materialization of two completely different traditions in medical science.

Evidence-based medicine

During the last decades, medical science crystallized its contemporary insistence on evidence-based medicine with a focus on the effect of a medical treatment that must be scientifically documented. Interestingly, both the subjectivistic and the objectivistic traditions accepted the necessity of documenting results, but naturally in the ways determined by the different nature of their approaches.

The objectivistic medical tradition has designed a genius method to exclude subjectivity, objective examinations, and pharmaceutical treatment under placebo control. Deep psychopharmacological analysis of the brain and its transmitter systems has made it possible for the doctor to interact directly with the brain's chemistry, allowing him/her to balance the brain and thereby take the person back to normal, which then can be documented by objective measurement of the symptoms of neural malfunctioning before and after, controlling for the placebo effect by giving a similar group of patients only a placebo pill. A large number of meta-analysis now exists that documents the effect of a large number of drugs on certain psychiatric symptoms in psychiatry.

The subjectivistic medical tradition has designed a similar brilliant method to exclude the objectivity: subjective meetings with the patient; focus on self-insight, personal development, and emotional and philosophical work; results controlled by psychometric rating of the patient's subjective evaluations of health, quality of life, and ability to function, controlled by measuring the patient's subjective state of being before and after treatment (compare Chapter 56). As the intervention in holistic medicine is primarily on the patient's state of consciousness and philosophy of the world, the treatment can be understood as a treatment with placebo only, rendering the objectivistic method of placebo control completely useless and even fatal; by admitting full value to the psychometric evaluation of the patient's own subjective state of being before and after treatment (and again after one year to be sure of a lasting effect), the effect of therapy can be easily measured.

The most extreme and radical schools of subjectivistic therapists claim that even measuring subjectivity is objectivistic and that evaluation of the value of treatment should be done only qualitatively, not quantitatively. As these schools might have a philosophical point, the problem is that the effect of the treatment here is going to be so "invisible" that it becomes too easy to cheat oneself as a therapist and make believe that the patient has actually been helped, even when this is not the case; this problem, called the hermeneutic problem, is well known from the philosophy of science (11).

Searching Medline

If you are a student, you must learn to search Medline/PubMed (http://www.ncbi.nlm.nih.gov/sites/entrez). Here, you can find almost all relevant information within a blink of an eye. Unfortunately, much of the research on holistic medicine and CAM is not listed here, so you need to go to Google Scholar or a similar system to search.

Warning

A fast evaluation of the quality of a scientific paper is guided by two factors: where was it published, and who made it? If it is a paper on a pharmaceutical product made by the company producing the drug and printed in a minor journal, you can be almost certain that the study is of poor quality, somewhat manipulated to serve its purpose; on the other hand, if it is a paper published by independent researchers in a major journal, then it should be fine. The Cochrane collaborations papers are often fine, but sometimes they are made by "industrial agents"—people working close to the pharmaceutical industry, making the paper to benefit the industry—so please be careful.

A search on PubMed in 2007, for "Cochrane and mental illness" gave 955 hits, "Cochrane and schizophrenia" gave 264 hits, while there were 403 hits for "Cochrane and depression." Many of these studies are meta-analyses of pharmaceutical studies. One recent example is Adams et al. (12), who tested chlorpromazine, the drug of choice through decades, versus placebo for schizophrenia:

> MAIN RESULTS: …We found chlorpromazine reduces relapse over the short- (n=74, 2 RCTs, RR 0.29 CI 0.1 to 0.8) and medium-term (n=809, 4 RCTs, RR 0.49 CI 0.4 to 0.6), but data are heterogeneous. Longer-term homogeneous data also favoured chlorpromazine (n=512, 3 RCTs, RR 0.57 CI 0.5 to 0.7, NNT 4 CI 3 to 5). We found chlorpromazine provided a global improvement in a person's symptoms and functioning (n=1121, 13 RCTs, RR 'no change/not improved' 0.80 CI 0.8 to 0.9, NNT 6 CI 5 to 8).
>
> Fewer people allocated to chlorpromazine left trials early (n=1780, 26 RCTs, RR 0.65 CI 0.5 to 0.8, NNT 15 CI 11 to 24) compared with placebo. There are many adverse effects.
>
> Chlorpromazine is clearly sedating (n=1404, 19 RCTs, RR 2.63 CI 2.1 to 3.3, NNH 5 CI 4 to 8); it increases a person's chances of experiencing acute movement disorders (n=942, 5 RCTs, RR 3.5 CI 1.5 to 8.0, NNH 32 CI 11 to 154), Parkinsonism (n=1265, 12 RCTs, RR 2.01 CI 1.5 to 2.7, NNH 14 CI 9 to 28). Chlorpromazine clearly causes a lowering of blood pressure with accompanying dizziness (n=1394, 16 RCTs, RR 2.37 CI 1.7 to 3.2, NNH 11 CI 7 to 21) and considerable weight gain (n=165, 5 RCTs, RR 4.92 CI 2.3 to 10.4, NNH 2 CI 2 to 3).

(RCT means Randomised Clinical Trial (to be discussed in detail in a later chapter), NNT is Number [of patients] Needed to Treat [for one to reach the treatment goal], and NNT is the Number [of patients] Needed to treat to Harm [one patient].)

This is fine science in the objectivistic tradition; most unfortunately, the results are not really good: NNT is 4 to 6, meaning that between four and six patients must be treated for one to benefit significantly. Another issue is that the patients were not cured; the test is only for

"improvement." And the side effects were dramatic: weight gain in one of two, sedation to one in five,, etc. The drug harmed many more patients than it helped. If one reads the paper, one will notice that the only dimension relevant for the patients' mental health, called "mental state," was not improved at all, by any antipsychotic drugs. Similar results exist for major depression; most of the meta-analysis shows NNT in the same range, although the side effects are somewhat milder; unfortunately, few studies exist of treatment of major depression versus placebo and still fewer vs. active placebo.

The psychodynamic tradition is somewhat in between the biomedical and the holistic school. A meta-analysis conducted (14,15), for example, showed that short-term psychodynamic psychotherapy (STPP) was as effective as the psychiatric standard treatment for many mental disorders. Unfortunately, STPP has not been clearly stating its "holistic" position, often using psychiatric diagnoses, etc. Buber's "I and Thou" position is not found here much. To base treatments on clear philosophy, we must continue the spectrum all the way to scientific holistic medicine, especially the recently developed "clinical holistic medicine" (CHM), which has done much to state its philosophical position in the treatment of a number of diseases and illnesses (16–60).

In holistic medicine, the psychodynamic type psychotherapy is combined with therapeutic bodywork, and our team has worked with a subtype of holistic medicine that we call clinical holistic medicine (CHM), which uses the five known principles of healing (see Section 2).

Going to holistic medicine, a search on PubMed for "holistic medicine and meta-analysis" in 2007, gave zero hits, not surprisingly. "Holistic medicine and Cochrane" gave five hits, among these a paper on the holistic strategy for testing treatment effect called the "square curve paradigm" (61), also from our group, but no test results. Searching for "square curve paradigm" on www.pubmed.gov, we found two studies using this strategy for documenting effect (62,63), but only the first study is actually testing the development of the patient's subjective experience of mental health or illness after holistic medical treatment. The details from the results of the treatment of mental and other patients with CHM, which combines STPP, bodywork, and spiritual exercises, as holistic medicine often does, are found in several articles (64-68).

The treatment group in Ventegodt et al. (67) was 54 chronically ill patients, where the patients were their own control in the study; it is a diverse group of patients only having in common that they all consider themselves to be severely mentally ill before treatment. The results were surprisingly good: 31 of 54 patients, or 57.4 (CI 43.2–70.8), were subjectively cured by the treatment consisting of 20 sessions of CHM. But as the holistic approach did not allow for specific psychiatric "objective" diagnoses, we do not know exactly how this group of patients would be diagnosed if they had gone to standard psychiatry assessment. But we do know that 40% of the patients had already been to a psychiatrist and that the chronically ill mental patient entering the clinic after abandoning psychiatry on average rated 3.7 on a five-point Likert scale on self-evaluated mental health (from the validated questionnaire QOL5 (69)).

The group did not receive any drugs and only regression in the pace that their system could tolerate, and those who did in accordance with this did not report any side effects from the treatment (NNTH with CHM is estimated to 500, NNTB = 2 CI 1.4–2.3). The square curve paradigm analysis in Ventegodt et al. (62) documented that these results seemed to be lasting.

The scarcity of published data from studies in peer-reviewed PubMed listed medical journals makes this study somewhat unique. Here, we have a group of patients who reported that they felt mentally ill before treatment, and this feeling disappeared for good in half the patients after 20 sessions of CHM with no side effects. But how can we be sure that the patients in this group are really mentally ill, in the psychiatric sense of this word? Well, we cannot.

We know that 40% were treated by a psychiatrist, psychologist, or general practitioner (GP) for a mental illness, and we know that this group was helped as much as the patients that entered the clinic directly, because of their personal conviction that they needed holistic therapy. But that is all.

A subjectivistic researcher would argue that what really is important is not the psychiatrist's judgment, but the patient's experience of being mentally ill or well. For it is mental pain that brings them to the doctor, and if the treatment cures this pain, without damaging other aspects of the patient, well, then we believe the patient has been helped.

Interestingly, the cost of the treatment is also mentioned: 1,600 Euros. Standard psychiatric treatment normally costs ten, 100, or even 1,000 times this. How can we compare the value to the patients of the treatments of these two very different medical schools, both obviously coming from fine scientific medical traditions, the biomedical and the psychoanalytic? And how do we make a fair cost/benefit analysis?

If we take the data from the papers—with all that uncertainty that is, because one school can refer to huge meta-analyses and the other school only to single studies with few patients from the CHM group—we can observe that:

- Holistic medicine helps one in two; psychiatry helps one in five.
- Holistic medicine cures the patient subjectively, while psychiatry takes some of the objective symptoms away but without curing the patient.
- Holistic medicine has no side effect, where psychiatric treatment harms more patients than it helps.
- Holistic medicine has lasting effect, while psychiatry struggles with relapse.
- Holistic medicine costs a few thousand Euros, while psychiatry often costs hundreds of thousands of Euros.

In later chapters, we shall analyse this in much more detail.

Discussion

We are not at all accustomed to thinking seriously over philosophical matters, but very much is dependent on it. As medical doctors, we are not at all used to taking a philosophical stand, and we normally do not like philosophy matters, as we are practical people, who want to get things going.

Deep philosophical issues should better be left to the philosophers. However, the development of two parallel medical schools that each build on different philosophical traditions, the subjectivistic and the objectivistic, challenges this attitude, for obviously our philosophical attitude matters in the treatment of our patients.

Maybe one reason why psychiatry has so little effect on helping patients is because patients are reduced to objects, while the soul, integrity and autonomy of the patient are neglected in the treatment of the patient's body, brain, and behavioural symptoms.

Unfortunately, the methodology from objectivistic medical science is now also used to evaluate subjectivistic medical science. Cochrane tests of the value of complementary and alternative medicine (CAM) are conducted. In the following example (70), the value of therapeutic touch (TT) was tested in anxiety disorder, therapeutic touch being common in the holistic treatment of patients (18,28): "Inclusion criteria included all published and unpublished randomized and quasi-randomized controlled trials comparing therapeutic touch with sham (mimic) TT, pharmacological therapy, psychological treatment, other treatment or no treatment/waiting list."

The problem here is that holistic therapy does not work in either of the conditions that are listed in the list of inclusion criteria, and the insistence of placebo control, sham touch, or randomization to pharmacological therapy or psychological treatment is with absolute certainty excluding the patients that really believe in CAM, because they would never accept to be a part of a study where they could be randomized to pharmacological or psychological treatment.

The only way to document therapeutic success here would be to measure the patients before and after treatment, and after a sufficiently long time, to see if their subjective assessments of their own mental health really improved.

So what is happening now is that objectivistic science is evaluating subjectivistic medicine on objectivistic permission, and this is obviously not giving holistic medicine a fair deal or trial. To test holistic medicine, the square curve paradigm or a similar method has to be used, using the patient's own subjective evaluations of health and quality of life as endpoints, and avoiding placebo controls and other objectivistic tools that destroy the possibility of a fair scientific testing of medical interventions based on developing the patient's consciousness.

The belief of biomedicine and psychiatry is that a placebo control is necessary to take away all disturbing subjectivity from the study. From a subjectivistic perspective, there is already a huge surrender on a philosophical and existential level, when you choose psychiatric treatment, and without testing for subjective factors like patient confidence in the doctor and in this kind of medicine, the placebo effect is still 100% working on the patient and not controlled in the study. In general, the two schools have little understanding for each other's position and find their own arguments completely valid, but only when a clear philosophical analysis is made can an openness and understanding for the other school take place.

Conclusion

When two equally acceptable medical systems or schools exist, as is the case with psychiatric and holistic treatment of mentally ill patients, the only rational way to choose between one or the other system is to look at the results of the treatments. But here, we face a big problem because the two schools use their own philosophic value systems as a premise for the scientific evaluation.

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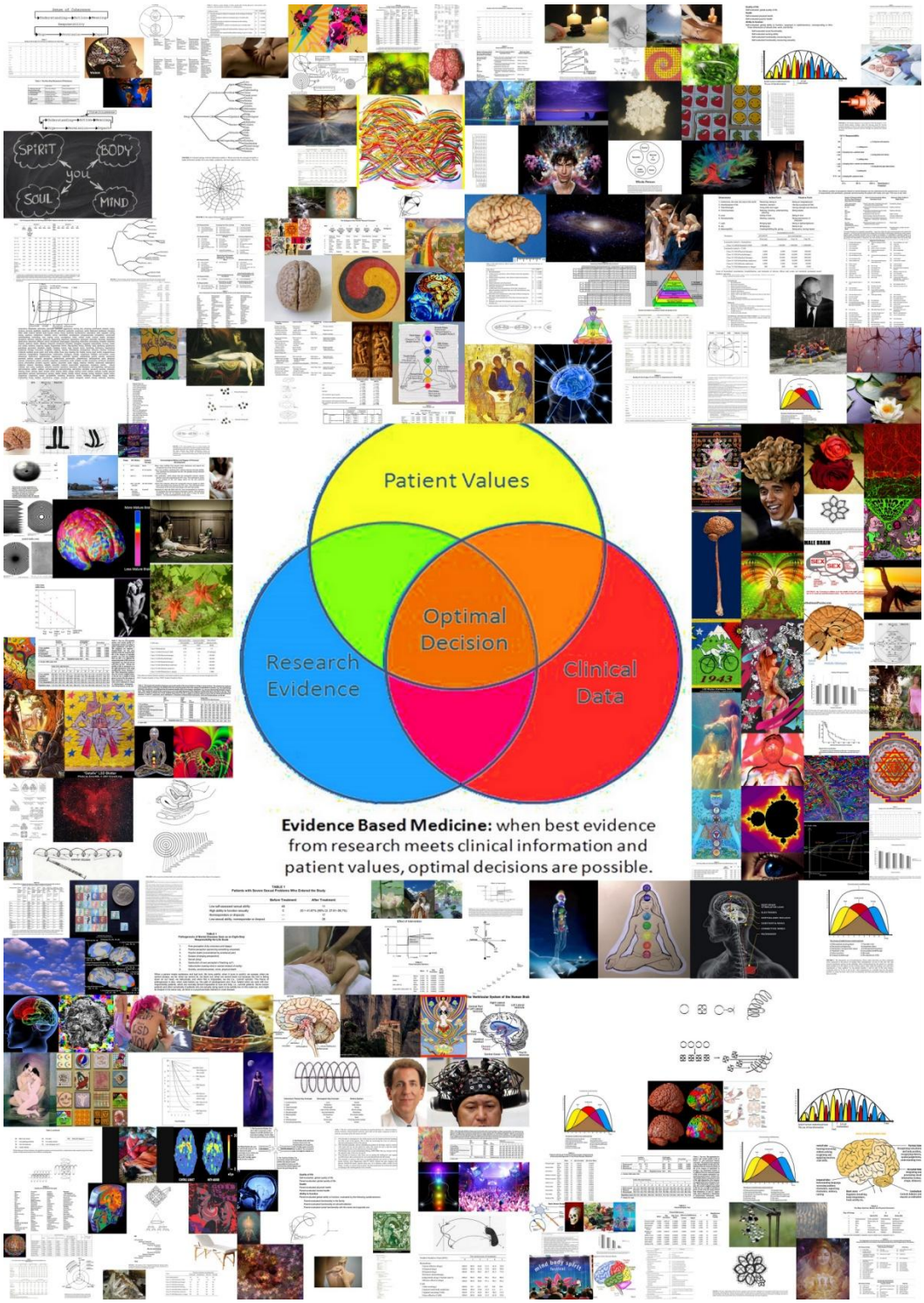

Chapter VI

The need for evidence-based non-drug medicine

The last chapter was a mess. We have to admit that. We are not proud of it, but we needed to show you "state of the art"—how things are right now when it comes to scientific documentation of treatment effect. If you managed to read the chapter at all, you might very well sit with the bad feeling that we are not really to be trusted. We are making our conclusions on far too modest a material, and it is coloured by our own interest and prejudices. We are certain that you are right. This needs to be done better. As it is now, neither biomedicine nor holistic medicine are well documented. We simply need a solid and bulletproof strategy for documenting treatment effects.

Let us also admit that we are not proud of the way this book is written. It is "meandering and fitful" not structured in a predictable way, going smoothly from a to z. We know that as a student, you would have liked that. But we are not trying to make things difficult for you. Things simply are complicated, and we have decided to share the full complexity of the matter with you. Why is that? Partly because you need your good brain well trained in analyzing complexity to deal with patients and partly because research in medicine—which is where we come from—simply is full of complexity and mysteries. You might like it—if you do, we are most happy—but you might also hate it. If you do, we truly want to apologize that we cannot make holistic medicine tidy and simple. Well, it is simple to us now, but whenever we try to put a pen on the paper, everything grows complex in no time. We guess this is just how reality is. So the faster you get used to dealing with complexity, the faster will you arrive to simplicity behind the appearances.

During the last two or three decades, a new approach of documenting effects of a medical treatment has evolved: *Evidence-based medicine*. Hopefully, this way will soon be standard in all kinds of medicine. When you read this chapter, you will understand that evidence is not just evidence. It must be classified and scrutinised. This is so annoying in a way: Why does it have to be this hard to document effect? Because of the danger of bias is to cheat, twist and manipulate to promote specific interests. Bias is a huge danger to medicine. When a company documents its own drugs, there will inevitably be bias making the drugs safer and more efficient. When we document holistic medicine are we—in spite of all efforts to make it objective—likely to induce bias in favour of this kind of medicine, in which we believe so

much? So we need a common standard that can minimize bias so that the results can be trusted and used safely by our patients.

Evidence-based medicine (EBM) has been defined as "the integration of best research evidence with clinical expertise and patient values" (1,2). EBM is based on *three equally important key factors*: 1) The best available scientific evidence, 2) The physician's experience and intuition and 3) The patient's preferences and values.

EBM uses a hierarchy of evidence and critical appraisal of the sources, which makes it possible to balance high quality of evidence with documented efficacy. A treatment that is more safe and efficient but less well documented might very well be the treatment of choice. Ethics—not putting the patient at risk of harm with a treatment if this can be avoided at all—is an important part of EBM.

As most pharmaceutical drugs, as we shall see in other chapters of this book, have a Number Needed to Treat about 20 (NNT=20) (5-50) and are much more harmful than non-drug medicines, most EBM-treatments are likely to be non-drug treatments in the future.

There are six steps to practice EBM:

1) The patients and the physician must work together to define the problem.
2) The patients and the physician must explore the patient's values and preferences.
3) The information about the possible alternative medical interventions must be discussed and critically appraised.
4) The best, relevant evidence must be applied to the patient as a treatment or cure.
5) The patient and the physician must together evaluate how useful the intervention was.
6) If the intervention did not help sufficiently, the process must start over again.

In this chapter, we explain how non-drug EBM is practiced. The term "Non-drug medicine" covers all kinds of medical interventions that do not use drugs internally—psychotherapy, bodywork, acupuncture, aromatherapy, body psychotherapy, BodyTalk and other types of mind-body medicine. Normally herbal medicine i.e., herbal teas that are not using herbs with strongly working chemicals, are also included in this term as are most other types of CAM like homeopathy, healing or prayers. In the next chapter, we will have a closer and critical look at the general efficacy of CAM inspired by the EBM approach.

Introduction

Since around year 2000, the medical world seems to have agreed that the process of decision in medicine should be based on the following *three equally important key factors* (see Figure 1) (1,2):

1) The best available scientific evidence.
2) The physician's experience and intuition.
3) The patient's preferences and values.

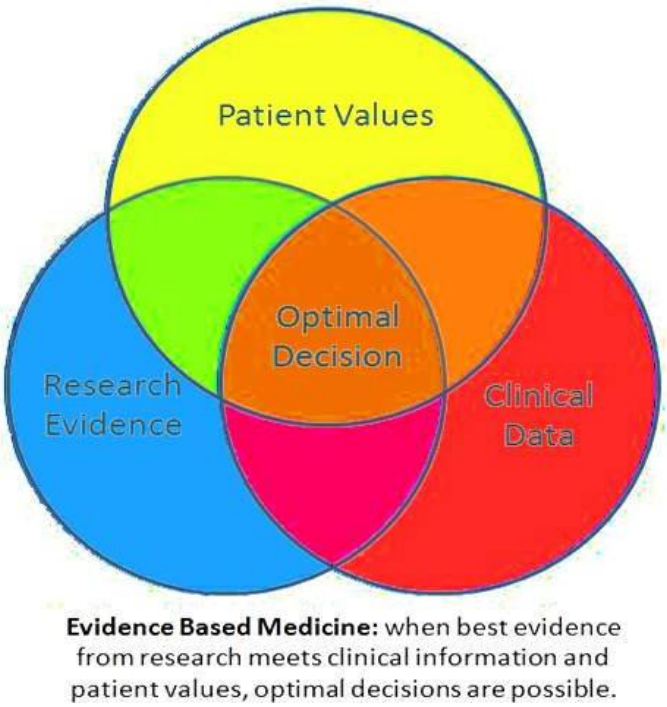

Figure 1. Evidence-based medicine.

The international medical community seems to agree to call this *Evidence-based medicine* (EBM), in spite of other names like *Patient-centred medicine* or *Experience-based medicine* would be as appropriate labels of EMB (comp. Figure 1). It has been seen as a new paradigm replacing a more authoritarian opinion-based, rule-based paradigm (3), where treatment followed simple rules established by medical authorities but unfortunately not build on scientific evidence. In the last two decades, a number of important books and papers on EBM have appeared, often in the JAMA and the BMJ (1-41), and BMJ has concluded that EBM is among the 15 most important contributions to medicine in the last two centuries.

The paradigm of EBM teaches us that a medicine guided by simple and authoritarian rules is of little value in a world, where the body of medical evidence is growing every day. Where educated and well-informed patients more and more are taking part in the decision process around the treatment of their own clinical conditions, and where the experience, intuition and individual contribution of the physician is more and more appreciated.

The steps to practice EBM follow from its three key factors (1-4):

- The patients and the physician must work together to define the problem.
- The patients and the physician must explore the patient's values and preferences.
- The information about the possible alternative medical interventions must be discussed and critically appraised.
- The best, relevant evidence must be applied to the patient as a treatment or cure.
- The patient and the physician must together evaluate how useful the intervention was.
- If the intervention did not help sufficiently, the process most start over again.

Most diseases and other clinical conditions can be treated in a number of ways; often there are several pharmaceutical drugs as well as a number of non-drug medical interventions that can be applied. The patient often sees the drugs as a fast and easy alternative; the non-drug cures often take some personal development—including personal involvement, responsibility for own future health, and a somewhat burdening process of emotional and mental confrontations. So the patient's preferences are often to take a drug. But as it is well known, drugs normally have a high Number Needed to Treat; according to an estimate made by the BMJ, most drugs have a NNT number around 20 ("NNTs under 5 are unusual, whereas NNTs over 20 are common," meaning NNT=5-50) (42). So only one patient in 20—if you are lucky five and if you are unlucky 50 patients—will be significantly helped by the drugs.

This means that most patients treated with drugs eventually will arrive to step six without having been helped; even if another drug is used and this is repeated several times, the likelihood speaks for the patient not being sufficiently helped. In this situation, most of the patients will shift values and preferences towards the non-drug treatment.

This shift will force the physician to investigate the many possible non-drug cures. The more specific the problem is formulated, the more difficult it will be to find evidence for a cure. But the shift to a general problem, like a bad self-rated health (physical or mental or both), like a poor quality of life or a low level of functioning regarding work, study, sex or social relations, will make it much easier to find relevant literature with evidence.

The shift in values towards non-drug treatments will, therefore, invite a shift in the way examinations and diagnoses are made. In the biomedical clinic blood test and biochemical tests, histological test, scans and microscopic examinations are necessary for the establishment of the exact diagnosis. In non-drug medicine, the focus will shift from objective towards subjective, from concrete to abstract, from local to general.

As many patients are not sufficiently helped with pharmacological medicine, the majority of patients will end up having non-drug medical treatments, if EBM is done by the book. If the physician and the patient fail to acknowledge the failure not only of a specific drug, but of drugs in general to help and cure most patients, which is more likely to happen if the physician is unaware of the possibilities of non-drug medicine and unfamiliar to how it is practiced, the process of repeating use of useless drugs can continue for years.

To evaluate the outcome of an intervention, the simplest way to do it is distributing a small questionnaire like the QOL10 (see appendix A) (43,44) to the patient before and after the intervention. This questionnaire measures the self-rated health, quality of life and abilities in the major domains of life. If the patient has not improved—and normalized—on this measure, the intervention is simply not curing the patient. If there is an improvement, but not a total cure, the intervention is likely to work to some extent but possibly not sufficiently. The patient and the physician must discuss if a new treatment should be initiated at this stage.

EBM: A definition

A commonly quoted definition of EBM comes from Sackett et al. (1996): "Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients"(1). A punchier description comes from

Sackett et al.'s little blue book on how to practice and teach EBM: "Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values"(2).

Evidence is defined by its ability to establish or support conclusions. EBM equates evidence with scientific evidence and views factors such as clinical expertise as important in moving from evidence to action (4). Scientific evidence includes clinical evidence, theoretic evidence, practical evidence, expert evidence, judicial evidence and ethics-based evidence, and all these must be included in the decision process (5).

The essential components are: 1) the evidence, 2) clinical experience and 3) the patient. In short, EBM is a philosophy about how to decide what appropriate treatment for a patient is. It requires that the physician understands the process of healing and knows what treatments have been shown to work and then integrates this knowledge with his/her own expertise and the patient's circumstances and values in order to recommend a course of action most likely to benefit the patient.

How are treatments shown to work? This is a matter of numbers—the treatment must have been tried on others, and the results thereof carefully observed. While intellectually satisfying (and of course useful in other ways, such as developing further hypotheses) to know the theories behind why a treatment might work; the bottom-line is that if it works, it works; and if it doesn't, it doesn't.

While EBM focuses on the individual patient, the term "evidence-based healthcare" is sometimes used to describe the application of evidence-based approaches at the population level. Researchers describe opinion-based decision-making where little attention is given to evidence derived from research (1,4,8,31). However, as the pressure on resources available for healthcare increases, decisions will have to be made explicitly and openly, thereby leading to a transition from opinion-based decision-making to evidence-based decision-making.

The hierarchy of evidence

Evidence is information from research—the "truth" as demonstrated objectively through scientific studies. There exists a hierarchy of evidence, and higher levels of evidence are held to have a greater likelihood of reflecting the "truth" than lower levels. Scientific studies are taken to be of a higher level of evidence than expert opinion, because we can see the results for ourselves, follow the process of reasoning, and examine each step of the research methodology.

Experimental studies are by some felt to provide evidence of a higher level than observational studies, because properly conducted experiments are believed to be able to control for biases and confounding factors more effectively than observational studies (4). Other researchers believe observational studies to be at least as valuable as experimental studies, as they are dealing with real patients in a real, functioning world (33-35).

Various factors influence the likelihood that what we see from a study is the "truth." The number of the subjects in a study is one—the larger the study size, the less likely that any results observed are the result of statistical fluctuation. Unless, of course, all the studies are using the same flawed RCT-test (45).

Having a control in a study is another factor—the control being the same, as far as possible, as a study subject, except for the item of interest under study (e.g., a risk factor or an

intervention). One of the most powerful factors is that of randomization of study subjects into either a control arm or an interventional arm of a clinical trial. Unfortunately, this procedure has only validity if the randomization is blind. In studies with drugs, the toxicity often breaks the blinding and in studies of non-drug medicine, blind or double-blind trials are not possible at all (46). In EBM, these factors are taken into consideration and called "the process of critical appraisal."

The systematic review and meta-analysis can help in establishing evidence. Recently, Cochrane meta-analyses have shown that anti-depressant (46) and antipsychotic drugs (47) are of less value and more harmful than single RCT-studies have made us believe.

Critically appraising all relevant studies and statistically combining the results, where appropriate, can be a useful method to make sense of information from different studies. Sackett et al. revised in 2000, the "Hierarchy of quality of evidence" (see Figure 2) (2). *Systematic Reviews* is on the top, and below this, we find the c*ritically appraised topics*, similar to the chapters of this book. Further below, we find *critically appraised individual articles*. These are the three levels of filtered information.

Below this, we have all the raw, unfiltered and often severely biased information. And below this again, we have the *expert opinions* which are not considered to be science; this is hardly evidence, but in very rare cases, it can be the best there is (i.e., when it comes to rare kinds of treatment or rare diseases). In a hierarchy of evidence, the physician will start with applying the highest level of evidence that is in accordance with the patient's values and preferences.

If a patient who is against surgery has a coronary artery stenosis, and surgery giving her a stent is the treatment in accordance with the highest quality of evidence, a non-surgical cure must still be tried.

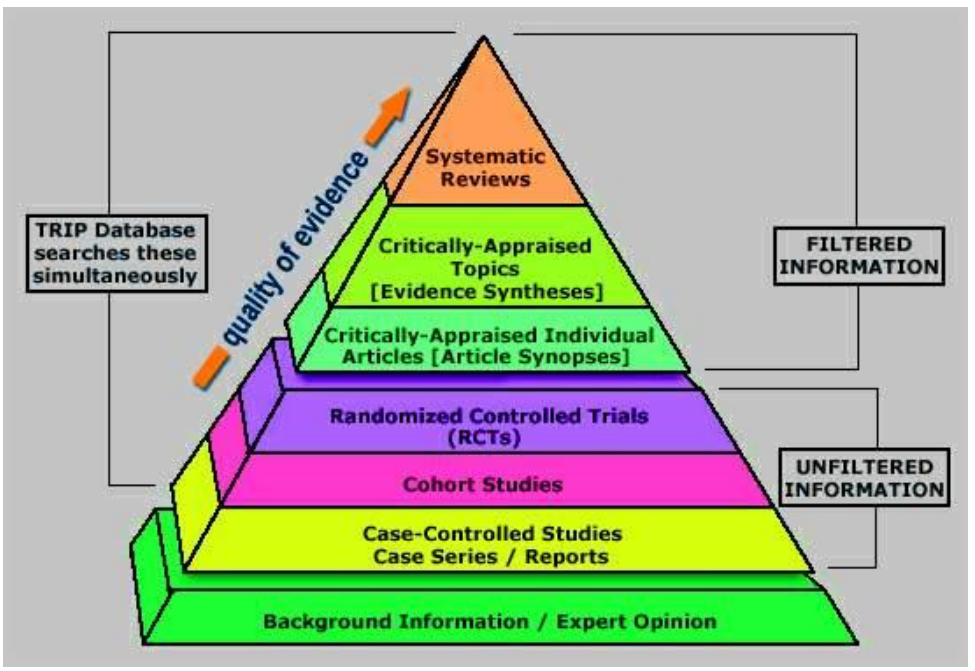

Figure 2. Hierarchy of quality of evidence.

Even if there are only expert opinions on what to do in this situation, this information is now the highest available, applicable information, so this is according to EBM the best possible treatment. According to the old rule-oriented paradigm, the patient was offered surgery, and if the patient refused, no alternative treatment was offered. Luckily for this patient, the EBM-practitioner will find that there are RCTs of non-drug treatments done with patients with coronary heart disease (49,50). If the physician masters non-drug medicine, he can offer this treatment or else he can refer her to the physician who has this competency.

Balancing quality of evidence with documented efficacy

Modern medicine is a game of money, and whenever there is a possibility to make money, there is money for science to explore and use these possibilities. A drug that is inefficient (with a high NNT number like 100, meaning that it only significantly helps one patient in a hundred) can still be very well documented; a cure that is highly efficient can, on the other hand, be poorly documented if nobody has been interested in documenting it, because money cannot be made from it.

When the quality of evidence is lower and the documented effect of the intervention is better, a critical appraisal is needed for the patient and the physician to decide which alternative is best for the patient. This act of balancing all factors included in the dimensions of EBM is often quite difficult even for the most talented physician.

How to practice non-drug ebm and how to use this book

Very few systematic reviews have been made in non-drug medicine, so c*ritically appraised topics* are normally the best quality evidence available. In most chapters of this book, you find most clinical conditions presented as c*ritically appraised topics.* The idea is that you, with this book in your hand, are able to offer many patients a non-drug medical intervention based on solid scientific evidence.

Of course, you will not be an expert just from reading. You must practice, and you must do this under supervision, until you are familiar with the logic, the principles and the practice of non-drug medicine. But with this said, the steps are simple:

Step 1—Define the problem: The patients and the physician must work together to define the problem.

Before getting an answer to a question, one will need to know what the question is. Framing the right question that fits your patient's circumstances means that the answer one comes up with is likely to help your patient. In biomedicine, you will often focus on concrete aspects of body or mind, which will take a good understanding of biochemistry and pharmacology. In non-drug medicine, you will look at the patient's whole existence, body, mind, spirit, heart, feelings and sexuality. This takes a good, general understanding of the human being. You will try to understand the patient's problem in general and existential

terms as possible, because the more general you can work, the more aspects of the patient's life will heal and be helped.

Step 2—The patients and the physician must explore the patient's values and preferences.

Often, the patient has been ill for a while, and many different interventions have already been tried and have failed. The patient is in the process of re-evaluating values and preferences, and this important process must be thoroughly understood and facilitated by the physician. Only when the patient has clear and well-defined preferences will it be possible to make the often crucial and fatal decisions that must be made.

Step 3—The information about the possible alternative medical interventions must be discussed and critically appraised.

To look for the evidence, it helps to know where one is likely to find it. This depends a great deal on the nature of the planned treatment.

For evidence of a biomedical treatment, the nature of primary research evidence is that it is reported in sources such as medical journal articles rather than textbooks. Advances in information technology mean that we do not have to hand-search individual journals to seek out relevant articles, as the searching can instead be done on electronic databases. One such database is MEDLINE, available freely on the Internet through "www.PubMed.gov." This bibliographical database lists articles published in Index Medicus journals and is an invaluable resource when you search the literature. Other databases exist and should also be searched, depending on how thorough the search needs to be. A subsequent article in this series will look more closely at information sources and strategies for searching.

For evidence of a non-drug treatment, much primary research evidence is reported in the above-mentioned sources. But for most clinical conditions, there is no evidence in the large biomedical databases. You need to go to textbooks, which often are hundreds of years old, like the *Hahnemann's Organon* (51) or the I (52). Recently, the European Master Program on complementary, integrative and psychosocial medicine (53-59) collected all the existing knowledge from 40 European research institutions and integrated this in their curriculum. But most physicians find these comprehensive sources full of unknown concepts and ideas that are, therefore, hard to read. We have made about 50 papers with c*ritically appraised topics* if you want to use holistic medicine (60). This book you are reading has a similar number of chapters that introduces you to non-drug medicine for all clinical conditions in general. From the chapters of this book, you will be able to find relevant reviews about the more specific methods you and your patients could be interested in, and these reviews will lead to you the specific papers you might want to read and present for your patients.

Step 4—The best, relevant evidence must be applied to the patient as a treatment or cure.

Once you have found studies that appear to address your question, the next step is to decide if they are relevant and in accordance with your patients values and preferences, if the studies have been properly conducted, and if the conclusions are valid. This would involve careful reading and analysis of the articles with respect to how the study was carried out (the methodology), what the results were, and whether the conclusions arrived at were reasonable. Critical appraisal is a skill that needs to be learned and developed. The reader would also find useful the series of articles on "How to read a paper" in the *British Medical Journal*, which are freely available on the Internet at http://bmj.bmjjournals.com/collections/read.shtml; and the "Users Guide" articles in the *Journal of the American Medical Association*, which is freely available from the website of the Canadian Centre for Health Evidence at http://www.cche.net/usersguides/main.asp.

Having found the relevant evidence, it is time to apply it to the patient. This step is no less important than the others, and it is a distinct and separate step. The evidence contributes to but is not the only factor that decides what appropriate treatment for the patient is. This is where you have to apply your own clinical experience and knowledge of the particular circumstances of the patient and respect the values and wishes of the patient.

Step 5—The patient and the physician must together evaluate how useful the intervention was.

Having applied the first five steps, the next step is a feedback loop in which the effectiveness and efficiency of the process is determined. In other words—how much did the process help the patient, and if not much, what could be done to improve it the next time? We strongly recommend the use of a small questionnaire evaluating the self-rated mental and physical health, quality of life, and ability of functioning on a number of relevant domains: Social, sexual, work, study, etc.

Step 6—If the intervention did not help sufficiently, the process must start over again.

Ethics

The NNTs of non-drug medicine is often 1, 2 or 3, making non-drug medicine much more efficient than drugs; and there are almost no side effects of non-drug medicine, whereas drugs always have a substantial risk of harming the patient. The Hippocrates Ethics Primum Non Nocere is well respected by non-drug medicine but not always by drugs. Therefore, the ethical first choice will often be the non-drug medical intervention (12).

Discussion: A limitation of the evidence

Having seen the five-step approach, it should be apparent that the practice of evidence-based medicine is not an easy thing. The relative youth of EBM contributes to one of its more difficult limitations: the methodologies of EBM are still developing and playing catch-up with its high ideals. For example, methods for evaluating treatments are different from evaluating diagnostic tests, which are again different from evaluating risk factors. Only if we use integrative, global, high-level questionnaires like the QOL10 (Appendix A) can we integrate diagnostic and evaluative tools and evaluate benefits and harms in one movement (44).

The steps in critical appraisal of randomised controlled trials are advanced and well recognized—i.e., the strategy for making Cochrane reviews. Similar strategies exist for critique of the RCT-test (45). But the same is not true for other study designs, where the physician needs to be awake and actively analyzing what is going on.

It follows logically from the EBM procedure and the general high NNT-numbers and low NNT-numbers for drugs (many patients being harmed while only a few are helped) (61-63), that most EBM treatments in the future are likely to be treatments with *non-drug medicine*, which have the opposite profile of the drugs: Always a high NNH (> 10.000 meaning safe!) (61-63) and sometimes a low NNT (1-3 meaning highly efficient!)—the art being to identify the non-drug treatments that actually works, because this is a jungle!

The immense financial interests in the pharmaceutical drugs have given us lots of high-level information on the effects of drugs; we also know for sure that these cures are extremely inefficient as only a few percent of the patients are helped by drugs with an NNT=20—which according to BMJ, one of the most esteemed medical journals in the world, is normal (42).

Compared to this, the non-drug medical interventions are much more poorly documented; but on the other hand, the effect for the most efficient types seems to be about ten times larger or so than the average pharmaceutical drug (NNT=1 or 2 for the most efficient) (1-3).

Many modern and busy patients prefer drugs compared to a non-drug intervention, as this is quick and easy; but as times goes by and the drugs don't cure them or help them much, many patients are re-defining their values and want a non-drug cure.

It has been difficult to find the evidence to use in this situation as the solution of specific clinical conditions with non-drug medicine is often not well-researched as nobody has sufficient financial interests in such interventions to cover the expenses (it costs millions of EUROs to make a randomised clinical trial (an RCT).

One of our true motivations for writing this book was our wish to make the c*ritically appraised topics* available for every physician who wants to offer an efficient non-drug medical treatment to his or her patient. In many countries, you are at risk of being called a "quack" (which can ruin your clinical practice on a day when it hits the media) if you offer a non-drug treatment without having such documentation (the dangers of practicing non-drug medicine for you as a physician will be discussed in a chapter in the last section on politics and economy; knowing these dangers is a smart way to avoid them).

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Chapter VII

Is alternative medicine (CAM) efficient? An RCT with alternative therapy for whiplash associated disorder (WAD)

We have learned in the former chapter that the rather complex strategy of EBM is necessary to be fairly certain that a treatment is working. The last chapter was a nice jump out of the chaos presented in Chapter Two. In Chapter Three, everything gets into order. But in practice, this is still very complicated, as we shall see in this chapter.

Let us start by telling you the story. In 2000, we got a lot of funding for CAM research. We established a Research Clinic for Holistic Medicine and Sexology in central Copenhagen and hired the best CAM practitioners we could find—all famous people who at the point in time were active leaders of their own therapeutic schools, where they trained other therapists. They were all full of self-confidence and of confidence in the therapeutic method they used.

They worked in our clinic for a couple of years, on a broad variety of patients. After we were quite certain that they actually helped a majority of their patients, we set up a randomized clinical trial (RCT) together with the University of Odense. We should treat half the patients, while the other half, chosen randomly, should be the control group. Every patient suffered from a severe chronic condition called whiplash associated disorder (WAD)—whiplash for short. It was common sequelae to car accidents, where you are hit from behind i.e., sitting in your car waiting for the green light.

The first thing we did was analyze the condition, until we felt that we understood what was going on with the patients. Already this was quite difficult as most of these patients waited for their insurance to be paid and if they got better they would get less money. This was only the first issue in a long number of psycho-social complications that made it difficult for us to understand the reality of things.

The next step was to put together a team of CAM practitioners to deal with this condition. The third thing was to select a questionnaire, which could detect even small improvements in the relevant dimensions: Quality of life, health and ability. A number of objective measures (doctor's observations) were also included. All patients were then measured before and after the intervention.

The intervention went well, and many patients thanked us cordially. We were completely certain that the results would be great. But we were immensely surprised when Odense University Hospital, who analyzed the data from the study, informed us that there was no improvement to measure in any dimension—subjective or objective! This was the Armageddon of our CAM-research. We had to accept that these brilliant therapists failed miserably in helping these patients when it came to the objective measures.

We would like to be quite specific in this chapter, so you can see for yourself what we did… and reflect upon our failure. As you might guess, this study was a real eye-opener to us. We had to realize that not all CAM interventions are helpful for the patients. This was what brought us into holistic medicine of the mind-body type that we practice today—and which is the subject of this book. But now, see if you can find out what we did wrong—why our intervention did not show a huge difference in the participants' health!

The chronic state of whiplash-associated disorder (WAD) might be understood as a somatisation of existential pain. Intervention aimed to improve quality of life (QOL) seemed to be a solution for such situations. The basic idea behind the intervention was holistic, restoring quality of life and relationship with self, in order to diminish tension in the locomotion system, especially the neck. A psychosomatic theory for WAD is proposed. Our treatment was a short two-day course with teachings in philosophy of life, followed by six to ten individual sessions in gestalt psychotherapy and body therapy (Rosen therapy and Cranio Sacral therapy), followed by a one-day course approximately two months later, closing the intervention. Two independent institutions did the intervention and the assessments.

In a randomized, clinically controlled setting, 87 chronic WAD patients were included with a median duration of 37 months from their whiplash accidents. One patient never started. Forty-three had the above intervention (female/male = 36/7, ages 22–49, median 37 years), and another 43 were assigned to a non-treated control group (female/male = 35/8, ages 18–48, median 38). Six had disability pension, and 27 had pending medicolegal issues in each group. Effect variables were pain in neck, arm, and/or head; measures of quality of life and daily activities; as well as general physical or mental health. Wilcoxon test for between-groups comparisons with intention-to-treat analyses was conducted; the square curve paradigm testing for immediate improvements of health and quality of life was also used.

The groups were comparable at baseline. From the intervention group, 11 dropped out during the intervention (four of those later joined the follow-up investigation), 22 of the remaining 32 graduated the course, and 35 of the 43 controls did as well. Approximately three months later, we found no clinically relevant or significant increase in any effect measure. The above version of a quality of life intervention based on alternative therapy had no effect on patients with chronic WAD.

Introduction

For some years, there has been an intense debate on the nature of whiplash-associated disorders (WAD). The Quebec Task Force Classification has defined five groups for the acute phase of the disease (1). Most whiplash patients heal spontaneously, but some continue into a chronic phase, reported by different researchers from 2–34% (1-3). In many Western countries, 5–20% of the patients still have symptoms six months after their injuries. Part of

the reason for the above variation is the difference in definition, but the fact is that some of the patients will have permanent invalidism and never be able to work again or lead a normal life. This fraction of WAD patients was our target group for intervention.

The biological damage

In the acute phase, immediately after the physical impact and the whip-like movement of the spine, there is agreement that there might be some physical damage to the muscles, bones, joints, tendons, fascia, and/or 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 do not heal. One theory is that patients with a high quality of life (QOL) worry less about their physical pain, resulting in better healing (5). One study has demonstrated a number of minor damages, like small cracks in the bones (6), but most MRI studies have not shown any sign of significant damage (7) in the initial phase, except for one study that found minor damages to the disc (8).

The chronic phase has been difficult to understand. One group has worked with the theory that the facet joints are causing the pain and found that about half of the patients have a positive effect from local anaesthesia (9,10). Other groups have found small diversities from normal in rotation pattern (11) or eye movements (12,13), but it has been very difficult to establish a single well-defined organic damage to blame for the diversity of WAD symptoms found. Our group of patients 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 or energy; and a general feeling of being sick.

Psychological and existential (deep psychological) dimensions

It is believed that psychological factors are of major importance in WAD. One study indicated that the most important predictor for pain and discomfort at a later stage was the patient's insurance situation, because if the patient were going to fight for insurance money, it was very likely that he or she would have WAD symptoms at a later stage (14). In countries with less insurance, the average healing time is much shorter (15-17). There has been critique of the conclusions, because the number of participants was small (18) and because of difficulties in comparing the technical circumstances of the incidents (19). Other indicators of the importance of psychological factors in WAD are the fact that the threshold for sensing pain is dramatically increased with growing mental involvement (4,20). We all know the extreme situations, such as when you are relaxing at the beach and an ant bite feels like a lion bite or, on the other extreme, when a soldier at war continues to fight in spite of being wounded. Even the *memory* of an old wound, now healed, can cause pain (21,22). 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 (23).

From the present knowledge, we are forced to conclude that the aetiology of WAD is still not well understood and an important contribution from psychological and existential factors must be expected.

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 sensation of pain (24,25). In our work with quality of life, we have focused on measuring global and generic quality of life using SEQOL and QOL5, two self-administered, theory-based questionnaires (26,27) and through the Copenhagen Perinatal Birth Cohort 1959–61 follow-up, we looked at long-term aspects of quality of life compared with events in pregnancy and early childhood (25,28)

We believe there is a connection between quality of life and health in the way that the connection is hypothesized to be causal from quality of life to health (29), or in other words, 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.

Treatments for WAD

In the acute phase, there are several methods in use from immobilization (30), "live as usual" programs (31), mobilizations (32) and exercise (33), but 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. For the chronic phase of WAD, there is no cure yet.

Philosophy behind our pilot study

According to the life mission theory (29), global quality of life is improved when the patient lets go of negative beliefs. According to the theory, negative beliefs are anchored in emotional pain, which is "deposited" in body and mind, giving poor quality of life, poor mental and physical health, and a low ability to function. For practical reasons, the philosophy behind this study was somewhat simplified. The human being is described here 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) was that these different worlds seemed to live their own lives inside us to such a degree that they are normally taken as free to 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 WAD, but most important is the experience of healing our existence, of finally being oneself or the person one was meant to be (29). It seems that combining work with the body, the feelings, and the mind can give the patient this unique and important experience, which often seems to give the patients

improvement, but we still need to demonstrate that it can be done under controlled circumstances.

A psychosomatic theory for WAD

According to the life mission theory, a psychosomatic theory for WAD would be that our existential pain can take form as blockages in the body. A common form of blockage is the chronic tension of muscles.

A person with severe existential pain suppressed in the body can suddenly get sick if these blockages relocate to a sensitive part of the body, such as the neck. After a whiplash lesion, the natural process of healing includes the fixation of all the muscles in the area to protect the tissue while healing. The chronic tension of the muscles in the neck region "invites" the relocation of the blockages to the neck region, where they are much more harmful than their original place, i.e., in the long muscles of the back. Psychologically, there is a great advantage in holding the neck tension as emotional numbness. A person that keeps a lot of tension in the neck is much less emotional than a relaxed person.

The neurotic benefit of the tension in the neck area makes it hard to let go and so, therefore, the WAD. It is very difficult for the patient to reverse the WAD, because this demands that the person take responsibility for his or her own emotions. The cure is to make the person conscious of his or her present emotional state and allow the person to process the hidden existential pain.

Our work with the patients and their strong reactions to our attempts to mirror them in their emotional present states (numbness and hidden pain) confirmed this presumption to us. The purpose of the experiment was to test qualitatively and quantitatively the hypothesis that quality of life and subsequent subjective health could be improved effectively by a combination of philosophy of life, psychotherapy, and body therapy, supporting the salutogenetic process (29,34-36).

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) (24). In the present pilot study (37) described in this chapter, the focus was on using the best from alternative therapy in a theoretically optimal combination of alternative therapy: the combination of gestalt therapy, Rosen Body Work, and Cranio Sacral therapy, especially adapted to the needs of every patient.

The effect of the alternative treatment was optimized by teaching the patient the philosophy of life and health needed for maximal cooperation with the treatments. The concept in the present study was "two days of philosophical training, followed by six to ten individual sessions of alternative therapy, and a one-day follow-up."

The purpose of the experiment was to test qualitatively and quantitatively the hypothesis that quality of life and subsequent subjective health could be improved effectively by a combination of philosophy of life, psychotherapy, and body therapy, supporting the salutogenetic process (34,35). Unfortunately, the patients were not sufficiently informed about the alternative treatment, bringing their existential problems up to the surface of consciousness, which can be emotionally painful, so many patients resisted the alternative treatment.

Our study

This study (37) had a prospective, randomized, controlled design, where an intervention group was compared to a non-treated control group. The patients were recruited through their family physicians or from newspaper advertisements. The treatment was a simple intervention with alternative medicine and philosophy of life according to the protocol.

Criteria of inclusion were that the person was hit sitting in a car from behind by another car in an angle of between +45 and –45 degrees. Time since accident had to be from six months to ten years. Average pain level had to be at least 5 on a visual box scale from 0 to 10 and age 18– 70 years. Criteria of exclusion:

- Signs of fracture or dislocation (Quebec Task Force category 4).
- Mental disease, such as depression and other severe psychiatric disease.
- Disease making interpretations of symptoms difficult.
- Significant problems with neck prior to whiplash.
- Abuse of alcohol or medicine.

Baseline examination was an objective examination with palpation of eight preselected muscles, cervical range of motion by CROM instrument, SPNT-test (Smooth Pursuit Neck Torsion test) (12,13) and a questionnaire (symptoms, time for inset of symptoms, development of symptoms since the inset, intensity of pain, body area hit by pain, paraesthesia, symptoms that are not painful (vertigo, disturbance of vision, tiredness, irritability, anxiety, memory-difficulties, difficulties sleeping, and hypersensitivity to noise), technicalities about the accident, social data and Global quality of life (SEQOL)). The following concept for measuring global, generic quality of life was used (26):

- A clear definition of the quality of life.
- A philosophy of life on which the definition of quality of life was based.
- 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 "well scaledness" (appropriate scale characteristics).
- The survey must be meaningful to researchers, respondents, and those who use the results (including criterion validity).
- An appreciation of the aesthetic dimension. Immediate subjective well-being was measured with only one question on a five-point symmetric Likert scale, as were satisfaction with life and happiness. Satisfaction of needs was measured with five questions 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 quality-of-life measure "family, work, and leisure time" rated 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.

The three days of training in philosophy of life had the purpose of giving the patients a positive perspective and basic understanding of life (5,24,29,36). 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) (24,38,39). In our study, the focus was on using the best from alternative therapy in a theoretically optimal combination of alternative therapy: the combination of gestalt therapy, Rosen Body Work, and Cranio Sacral therapy, especially adapted to the needs of every patient. The effect of the alternative treatment was optimized by teaching the patient the philosophy of life and health needed for maximal cooperation with the treatments. The concept in the present study was "two days of philosophical training, followed by six to ten individual sessions of alternative therapy, and a one-day follow-up."

At three months after the last session, the participants received a questionnaire where outcome measures were pain level, daily functioning, and ability to work/have work, as well as an overall measure of quality of life.

The patients were placed in the two groups using a PC program (40). The analyses were made as nonparametric comparisons of two independent groups (the Mann-Whitney and X_2 test). There is no known cure for the WAD patients included. The quality-of-life intervention is believed not to have negative side effects and the Danish Scientific Ethical Committee (IRB) approved the project.

The square curve paradigm (see Chapter 12) is a simple way to test the efficiency (clinical significance) of a cure that improves the quality of life health within a month (41). As we believed that an efficient cure for WAD would have measurable results within this time frame, we hoped to be able to document the efficiency of the alternative treatment, but we failed to see this improvement. The name of the paradigm comes from the "square curve" made of a base line, a sudden vertical jump during a successful intervention, and a new baseline (a constant level of quality of life, health, and/or ability) on a significantly higher level.

What did we find what this intervention?

Unfortunately, the study was not fulfilled as planned. The treatment schedule became somewhat irregular, and the motivation was generally poor, in part due to a public criticism of the concept while the project took place. The project leader declined from fulfilling the study due to this. The plan was to include 120 patients, but only 87 patients were randomized, with 44 in the intervention group and 43 in the control group. The average time since accident was 37 months. The intervention took place at the Back Research Center at the local hospital. One patient dropped out before the start, 32 completed the intervention, while another 11 dropped out during the treatment. The main reason for this drop out was that the participants found the intervention and the therapists too provoking. Of the 32 persons who completed the intervention, 22 filled out the questionnaires at three-month follow-up. Four of the patients who dropped out, and 35 of the controls also completed the questionnaires (see Figure 1).

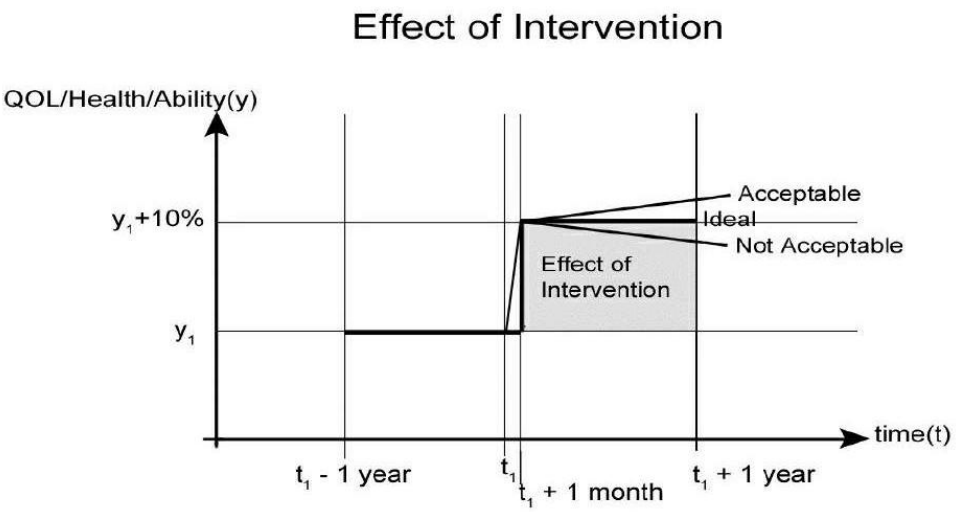

Figure 1. The patient flow through the study.

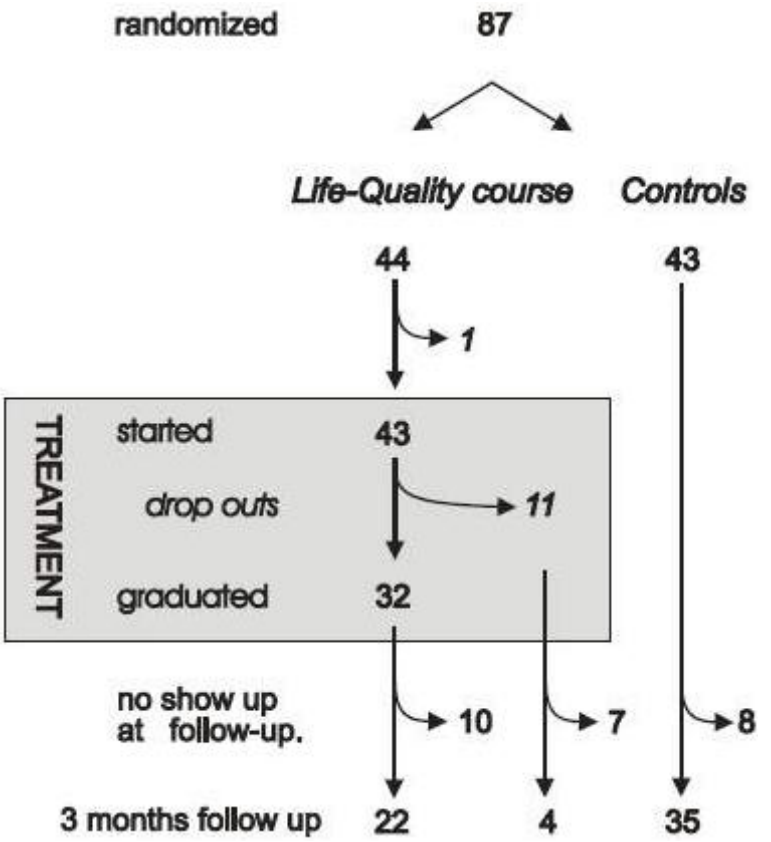

Figure 2. The patient flow through the study.

Table 1. Intervention Group vs. Control Group (Initial Values before Intervention)

		N =	Median/Ratio	Range	IQR	p (Intervention = Control Group ?)
Gender	All in intervention group	43	F:36 M:7			0.78
	graduating	32	F:27 M:5			0.74
	Control group	43	F:35 M:8			
Age	All in intervention group	43	37	22–49	33–43	0.79
	graduating	32	38	23–49	33–44	0.72
	Control group	43	38	18–48	31–44	
Sick leave/WL	All in intervention group	40	Y:10 N:30			0.85
	graduating	31	Y:6 N:25			0.46
	Control group	41	Y:11 N:30			
Pension/WL	All in intervention group	43	Y:6 N:37			1.0
	graduating	32	Y: 5 N:27			0.84
	Control group	43	Y:6 N:37			
Medicolegal issues	All in intervention group	43	Y:27 N:16			1.0
	graduating	32	Y:20 N:12			0.98
	Control group	43	Y:27 N: 16			
Neck pain	All in intervention group	43	7	2–10	5–8	0.14
	graduating	32	7	2–10	5–8	0.24
	Control group	43	6	0–10	4–8	
Arm pain	graduating	43	4	0–10	1–5	0.75
	graduating	32	3	0–10	1–5	0.69
	Control group	41	3	0–10	0.5–5.5	
Headache	All in intervention group	43	7	1–10	5–8	0.32
	graduating	32	7	1–10	5–8	0.30
	Control group	43	6	0–10	4–8	
Global QOL	All in intervention group	43	3	1–5	2–3	0.14
	graduating	32	2.5	1–5	2–3	0.42
	Control group	43	2	1–5	2–3	
Health, physical	All in intervention group	43	3	1–5	2–4	0.53
	graduating	32	3	1–5	2–4	0.88
	Control group	43	3	1–5	2–4	
Health, mental	All in intervention group	42	2	1–5	2–3	0.61
	graduating	31	2	1–5	2–3	0.77
	Control group	43	2	1–5	2–3	
Revalidation	All in intervention group	40	Y:2 N:38			0.69
	graduating	31	Y:1 N:30			0.47
	Control group	42	Y:3 N:39			

N = number of participants, F = female, M = male, Y = yes, N = no, IQR = interquartile range, p = level of significance. Differences between the numbers in Fig. 2 and that of the Table reflect missing values.

In Table 1, results from the intervention and control group are shown at the time before the intervention, while Table 2 shows the data three months after the terminated intervention on the two measurements of quality of life, health, and the above-mentioned WAD-related dimensions.

We found no significant difference between the intervention group and the control (p = 0.28) on global quality of life or any of the health dimensions.

Table 2. Intervention Group vs. Control Group (three months after Intervention)

		N =	Median	Range/Ratio	IQR	p (Intervention = Control Group ?)
Neck pain	All in intervention group	26	6	1–8	4–7	0.86
	graduating	22	6	1–8	4–7	0.56
	Control group	34	6	1–9	5–8	
Arm pain	All in intervention group	26	4	0–9	1–6	0.94
	graduating	22	4	0–9	1–6	0.68
	Control group	34	4	0–9	4–9	
Headache	All in intervention group	26	5.5	1–9	4–7	0.79
	graduating	22	5	1–9	3–6	0.69
	Control group	34	5	1–10	4–7	
Sick leave/WL	All in intervention group	26	Y:8 N:18			0.19
	graduating	22	Y:6 N:16			0.30
	Control group	29	Y:4 N:25			
Sick leave/not WL	All in intervention group	28	Y:1 N:27			0.10
	graduating	21	Y:0 N:21			
	Control group	29	Y:1 N:28			
Global QOL	All in intervention group	26	3	2–4	2–3	0.28
	graduating	22	3	2–4	2–3	0.24
	Control group	35	3	1–5	3–3	
ADL, sum	All in intervention group	26	16.5	1–25	13–20	0.57
	graduating	20	15.5	1–25	13–20	
	Control group	33	15	0–27	9–21	
Sleep	All in intervention group	25	2	1–4	2–3	0.43
	graduating	22	2	1–4	2–3.3	0.58
	Control group	30	2	1–4	1–3	
Vertigo	All in intervention group	23	2	1–4	2–3	0.73
	graduating	20	2	1–4	2–3	0.99
	Control group	29	2	1–3	1.5–3	
Health, physical	All in intervention group	26	3	1–5	2–4	0.40
	graduating	22	3	1–4	2–3.3	0.24
	Control group	34	3	1–5	2–4	
Health, mental	All in intervention group	26	2	1–5	1.8–3	0.18
	graduating	22	2	1–5	1–3	0.16
	Control group	33	2	1–5	2–3.5	
Pension/WL	All in intervention group	26	Y:4 N:22			0.91
	graduating	22	Y:3 N:19			0.95
	Control group	25	Y:5 N:20			
Revalidation	All in intervention group	11	Y:3 N:8			0.94
	graduating	9	Y:2 N:7			0.72
	Control group	21	Y:6 N:15			

N = number of participants, F = female, M = male, Y = yes, N = no, IQR = interquartile range, p = level of significance. Differences between the numbers in Fig. 2 and that of the Table reflect missing values.

Discussion

Scarcity of resources, a general belief in holistic therapy, and trust in the alternative therapists, made us change the original successful five-day intervention to "two days of philosophy of life, six to ten individual sessions of alternative therapy, and one day of follow-up," which may be one reason for the lack of demonstrated effect.

We succeeded in recruiting some of the most recognized spine therapists in Denmark, several of them having 20 years of experience and running their own therapeutic training institutes. The justification for this modification was the belief that individual sessions of Rosen therapy, Cranio-Sacral therapy, and gestalt therapy supporting the different steps of the holistic healing would have a strong beneficial effect on the WAD patients. We have learned from this study that our assumption was false with this patient group. As the motivation of the patient to help himself is believed to be a key factor in alternative medicine, another study with alternative medicine must use the dimension of motivation as inclusion criteria.

Patients were informed that the project was going to offer them a new experimental treatment for WAD; the emphasis was not sufficiently laid on the dimension of personal development. When the subjects arrived for the two-day course, they were not motivated for personal development, as they did not expect that as the central core of the project. At a time during the two days, it was obvious that one third of the patients had made an alliance to resist the fairly emotional painful holistic process that was the essence of the possible rehabilitation. These patients refused to cooperate with the therapists and caused a lot of disturbances. The emotional pain, according to the theory that was the hidden aetiology behind the WAD, was easily seen and surfaced readily, but many of the patients could not take responsibility for it and blamed the therapist for their pain.

In the therapeutic team, we had to conclude that we failed to get the patients into a holistic process of healing (42,43). In other pilot studies (see chapters 13 and 14), we managed to include highly motivated patients. It was the impression of the treatment staff that in this study, it turned out quite opposite, since we recruited patients without much motivation for personal development. To make it work better, it is of crucial importance that the patients know exactly what they are signing up for, which therapist and methods they will meet, what is expected from them, and which concepts, ideas, and philosophy they will find in the project.

It is very important to mention, amidst the obvious failure, that we saw half the patients becoming better for short periods of time. Three of the patients were completely free from any symptoms for hours and days, and several of them declared at the end of the study that they felt their quality of life had improved and the impact of the WAD had diminished radically.

However, due to the overall equality in effect, the treatment must have worked in the opposite direction for some other patients. At the end of the intervention, we talked with the patients about their subjective experiences of their health and quality of life. Fifteen patients said their WAD symptoms were the same as before, two said they felt worse than before, and five said the symptoms had diminished. Five patients said that their quality of life was the same, three felt worse than before, and 15 said they felt better in some way or another than before entering the study.

One patient openly expressed the frustration over “falling down again” from a period of eight hours completely free of any WAD symptoms after years of constant suffering. What we learned was that the complex psychobiological scene inside the WAD patient was obviously highly dynamic, and in this way, WAD looked like a psychosomatic disease. The opinion of the treatment staff was that the observed dynamics may be explained like this: A very important understanding in holistic medicine is that problems can be moved from the physical body to the emotional sphere, but if they are not confronted and processed here, they will return to the physical body, and the symptoms will reappear. The patient can only

become healthier and feel better if he understands the problem well enough to find and let go of the negative decision that ties his life to the "ground." It is the essence of the life mission theory, the basis of the philosophy behind this study. This could be an explanation for the lack of an observed effect that the patients may not have achieved this understanding.

Conclusion

A combination of a weekend course with quality-of-life (QOL) philosophy and six to ten sessions of alternative therapy (Rosen Body Work, gestalt therapy and Cranio Sacral therapy) with a treatment series fitted for every patient's personal needs could not improve the quality of life and health status for WAD patients in the actual setting. So we must conclude that: "*As regretful it is for man to fail, so fruitful it is for him to learn from his failure.*"

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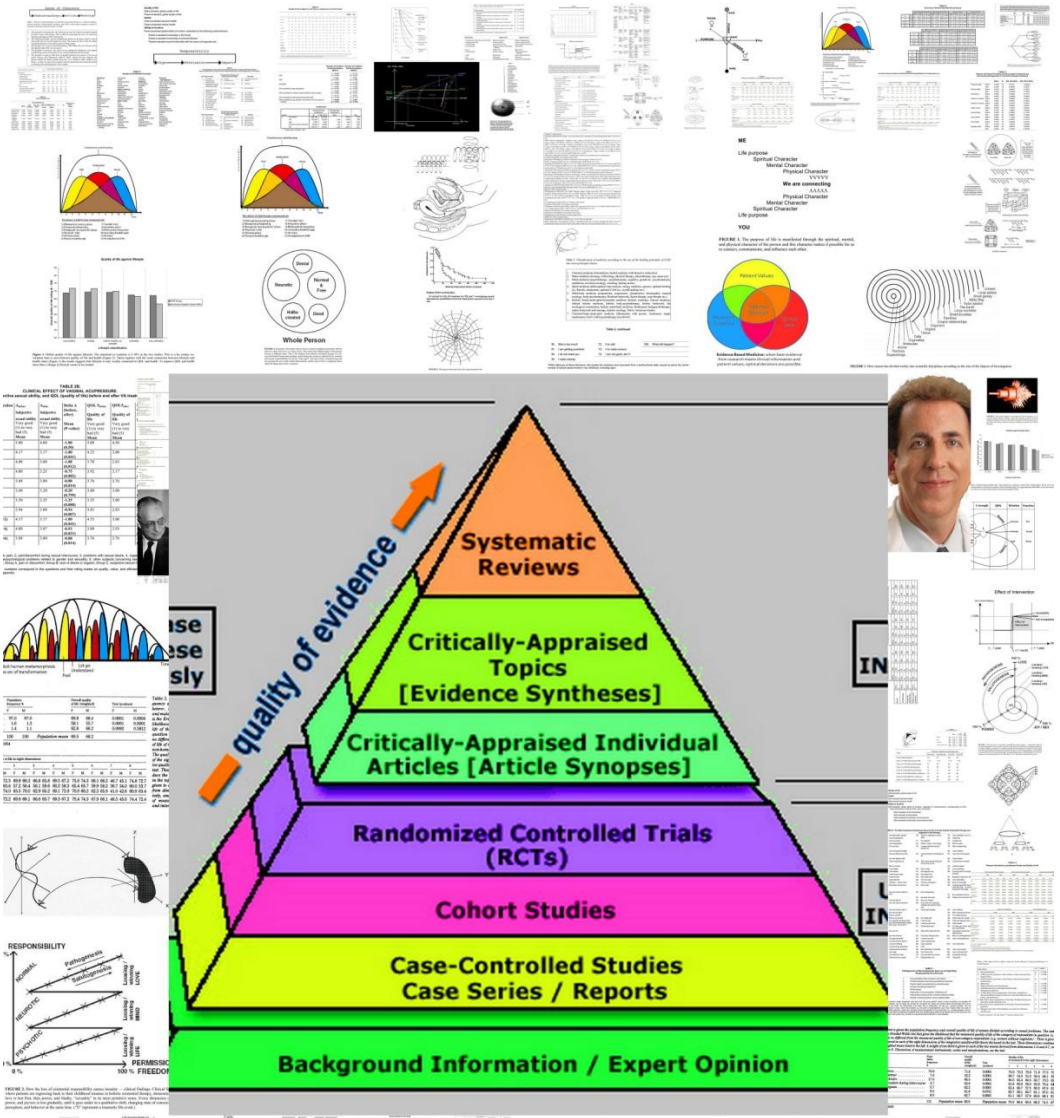

Chapter VIII

Scientific problems in holistic medicine: The "new medicine" of Ryke Geerd Hamer

In the last chapter we saw that whiplash was not cured by CAM in a project where we included the best of therapists. Still to this day we are not sure what went wrong. Either whiplash is without therapeutic reach, or these methods did not work at all in general, or the therapists could not perform under the controlled circumstances that were demanded for a clinical trial. We concluded that these forms of CAM in general are not efficient and that a stable treatment effect is something quite difficult to obtain. So what types of CAM are efficient and what can CAM cure? Are most types of CAM really holistic, addressing all aspects of the patient—body, mind, spirit, heart, character, sexuality? We are not sure that any of the CAM treatments the therapists offered reached into the spiritual domain, and sexuality was not touched in any depth. So the treatment we gave was hardly holistic in that sense.

The problem is of course that CAM is a million different things. Just stating that "this is method A" has proven to be of little worth when it comes to treatment effect; actually most research has pointed to the practitioner as the efficient component of therapy, more than therapy itself. This is highly problematic, but we believe it to be true: A great therapist will make any method work, and a poor therapist will not succeed with even the smartest and the most elaborate of methods. This is why leading holistic therapists like for example Michael de Vibe, the chairman of International Society of Holistic Health, stated that *"The physician IS the medicine."*

We have heard about Dean Ornish's project to cure severe coronary artery stenosis—coronary heart disorder—and even cancer, and we have noticed his remarkable success in these endeavours. But there are so many more charismatic practitioners working with severe diseases. Most of them are highly controversial. Ornish's reputation is saved by his publications in Lancet and other premier league scientific journals. But the more practically oriented practitioners are not publishing in Lancet; they are not even making quantitative research on the treatment effect of their cures. One of these controversial physicians, who seemingly managed to cure patients even with metastatic cancer—one of the biggest challenges in medicine—is the German physician Ryke Geerd Hamer.

This chapter is about him and his work. The reason to focus on Hamer is not that he was an extraordinarily good doctor. According to the statics, we know of only one in seven of his patients survived. But surviving metastatic cancer—and inducing spontaneous healings systematically and one after another—is still miraculous. This is by far better than the results that normally come from biomedicine regarding this group of patients.

What makes us focus on Hamer is his insisting on discovering the fundamental *principles of healing*. The idea that these principles can be found is very interesting and important. Hamer seemingly did not know of Hippocrates—the ancient master of medicine who 2,400 years ago succeeded in finding the secret key to healing (the five principles we shall discuss in section two)—and Hamer denied his whole life that his medicine was even "holistic" or "complementary." He would not hear of that. For him, what he had invented—discovered by pure accident, he claimed—was the *new medicine* (NGM), the medicine that would solve all the problems of the world and make all use of pharmaceutical drugs unnecessary in the future.

The aim of this chapter is to examine if the "medical laws" found by the German physician Ryke Geerd Hamer are substantiated by classical or contemporary holistic medical theory. Hamer developed a psychosomatic theory after a personal emotional trauma, which he believed resulted in his subsequent development of a testicular cancer. This led him to believe that emotional traumas are important in development of cancer. He got spontaneously well again after working with this trauma, making him believe that cancer is a reversible disease—and that all diseases are reversible. These principles are his two first "laws."

From our analysis, it is clear that the two most fundamental principles of Hamer's work, the psychosomatic "iron law of cancer" (Hamer's first "law") and the principle of pathogenesis being reversed into salutogenesis (Hamer's second "law"), are similar or identical to well-established principles of holistic medicine, going all the way back to Hippocrates. Had Hamer only been a reader of Hippocrates, we think his life would have been a lot easier. He is believed to be the inventor, and in idiosyncratic ways he tried for a whole life to convince the world that he had got it—that he had found the magic, precious key to healing, which we are certain that he had.

Hamer's understanding of symbols in medicine, on virus and bacteria and on the evolutionary process itself (Hamer's third, fourth and fifth "law"), differs a great deal from both traditional and contemporary holistic medical theory, and we did not find them substantiated. Hamer's understanding of cancer metastasis was built on these failing principles and, therefore, not substantiated either.

Altogether, it seems that Hamer's thinking was basically sound as the most fundamental principles of his work were built on an understanding very similar to holistic medical thinkers of today. We found his postulate that metastatic cancer patients can be healed or their health improved by using his system of holistic medicine likely to be true, at least for some motivated patients. Having Dean Ornish's results with cancer in mind, this seems fair to accept. The results of Hamer must however be tested scientifically before being accepted. His presentation to the world of his system and work has been idiosyncratic and highly provocative, which alienated him from the whole medical community. We have worked with a similar method in our own research clinic based on the healing principles of Hippocrates and have seen several cases of induced spontaneous remission, making us believe that Hamer was actually doing what he claimed to do—not with 100% of his patients as he also claimed but with 14%, which is still good.

Introduction

The aim of this chapter is to review from a theoretical perspective the Hamer system of holistic cancer medicine (1-4), which he called the "New German Medicine" (NGM), with the purpose to guide both the physician and the patient in the very difficult area of holistic treatment of cancer. We all want the best for our patients, and we believe the solution to recommend is a wise combination of conventional and holistic therapies—in medicine in general and also in the treatment of cancer. We were not aware of the work by Ryke Geerd Hamer until recently, when his work was discussed at a conference where we presented our own holistic cancer healing project (5,6). This chapter is a critical review of the publications of Hamer (1-4) after reading his material and conducting an internet and Medline search. Our aim was to examine if the medical principles found by Hamer, what he called his "medical laws," are substantiated by contemporary holistic medical theory.

Ryke Geerd Hamer

Ryke Geerd Hamer, MD was born in 1935, and grew up in Frisia, Germany. He started medical and theological studies in Tubingen, and at age 20, passed the preliminary examination in medicine and completed his theological examinations at 22 years of age. At 24 years, Hamer passed his medical state examination in Marburg, and after his residency two years later, he was granted a professional license as a doctor of medicine. Then followed a number of years at the University Clinics of Tubingen and Heidelberg and in 1972, his specialization in internal medicine (1). Due to the controversy about his work with patients, he has not been allowed to practice medicine since 1986. The reasons for revoking his license, according to his own biography, were due to his lack of ability to cooperate with the German biomedical physicians (1).

Hamer did spend many years in prison for "practicing medicine without a licence." He was sentenced to prison in 1993, and again in 1997, for "unlawful practice of medicine" in Germany. He simply continued to treat his patients, in spite of all hindrances set up for him by colleges and the medical authorities. He believed in what he did and believed in going to jail for it. Thousands of patients remained loyal to him, thanking him for saving their lives, and new hopelessly ill patients continued to come to him.

Followers of Hamer in Austria and France have been investigated for murder after cancer patients have terminated their prescribed chemotherapy to follow the treatment scheme of Hamer. Holistic treatment of cancer has been increasingly popular and one of the most popular, but also one of the most controversial systems in Europe has been the Hamer system of holistic cancer treatment.

Hamer received his experience from working with cancer patients (1), and several self-help groups are building on his ideas in Germany, Austria, Italy and Norway today. Hopelessly sick patients from all over the world study his system to find hope for themselves, while texts, audiotapes and books by him and about him (1-4) have been widely distributed and translated into numerous languages.

Hamer worked together with his wife, Sigrid, also a physician, in private practice, and together they had two girls and two boys. He worked on several projects and created several

inventions, like the non-traumatic Hamer-scalpel for plastic surgery, which cuts twenty times more sharply than a razor, a special bone saw for plastic surgery, a massage table that automatically adjusts to the contours of the body and a device for transcutaneous serum diagnosis.

In august 1978, his son, Dirk Hamer, was accidentally shot. Dirk's battle before death lasted for almost four months, while his father watched him day and night. It became clear to Hamer three years later that this sad life event had created an internal shock, which he believed resulted in the development of a testicular carcinoma. He worked on understanding his own disease and during this process, he experienced a spontaneous remission. This gave him the understanding that the things he corrected within himself during this process of accelerated personal growth were actually what cured his own cancer. He later named this type of cancer-inducing conflict the "Dirk Hamer Syndrome": a biological conflict or shock that catches one unexpectedly and remains in the body for years, leaving it vulnerable to development of disease (1).

In 1981, Hamer thought that these connections applied to cancer and submitted his discovery to the University in Tubingen, as a post-doctoral thesis for qualification as a university lecturer. The main objective of the thesis was to provide his results to the University in order to test his hypothesis on patients. In May 1982, the University rejected the work on the interconnections between the psyche and cancer. Over the next few years, Hamer tried repeatedly to open a hospital or a clinic as a refuge for his patients so that they could benefit from his knowledge. This was made impossible by court actions against him. In 1986, the District of Koblenz initiated an action to stop Hamer from practicing medicine on the basis that he "failed to deny the iron rule of cancer and failed to convert to the tenets of official medicine." The court also ordered that the University of Tubingen should continue his post-doctoral thesis proceedings. Nothing happened until January 3, 1994, when the judgment to validate Hamer's thesis was executed, but after 13 years, it was unlikely that the University would test his ideas and on the 22nd April, the University announced that "a verification within the framework of the post-doctoral thesis was not planned."

In 2003, branches of the "New Medicine" opened in Oslo and Bergen, where they through the writings of Hamer claim that international Jewry knows the cure for cancer and other lethal diseases, but refuses to disclose it in order to exterminate the non-Jews of the world. Hamer has drawn heavily on the racist writings of British New Age conspiracist David Icke, but in this review, we will concentrate on his claims for a cure of cancer. The activities of the New Medicine were condemned by the Norwegian Research Council in March 2003, but Hamer is presently living in Norway.

A critical review of the work of Hamer

As it seems that Hamer has found something of importance for many patients, we found it of importance to understand how his problems with the academic society and "medical establishment" came about, since it seems as if he were successful in many cases, loved and appreciated by many of his patients. Unfortunately, a Medline search (www.pubmed.gov) showed that we completely lack clinical trials testing his method. From a scientific point of view, Hamer's life and work is interesting and important for the development of scientific

holistic medicine. Most of the problems of Hamer's work (seen from the written texts on his work only) has seemingly arisen from the way Hamer has structured his understanding into an idiosyncratic system of holistic healing with five fundamental "medical laws," intending to address the healing of the patient as a whole person, while healing spirit, mind and body at the same time. Some of these "medical laws" are in agreement with the theories acknowledged by modern holistic medicine, like the theory of coherence by Aaron Antonovsky (1923-1994) explaining that health comes from re-establishing coherence (7-12). This is related to the work and ideas of Abraham Harold Maslow (1908-1970) and Viktor Emil Frankl (1905-1997) and the most progressive resilience literature, as well as our own work, theory of the purpose of life and the life mission theory, explaining the cause of much suffering and disease from resignation of the purpose of life (13-21). The simple explanation is that we repress our deep wishes and needs—our self—to adapt to our early environment and our parents; when we do so too radically, we accumulate vulnerability, which becomes an important co-factor in a later development of diseases like cancer.

Other of the medical principles Hamer identified and called "medical laws" unfortunately lack the content and structure that is normally expected from medical science, as they do not acknowledge and incorporate the established knowledge of immunology, toxicology, and other medical fields. While reading his book, it appears that Hamer was a truly holistic physician: "The most important of everything is that the patient… has obtained new understanding, deep trust in the physician and a real insight in what is going on" (1). Hamer has in his work used the well-known efficiency and healing power of first winning the trust of his patients and then letting the patient do the work of healing himself. From our perspective, built on many such meaningful statements, his widespread reputation and popularity among patients, Hamer was a clinical physician.

From our review of some of his writings, it seems that he was not so great on theory. The lack of an academically acceptable explanation for his work is really very sad. Had Hamer only known more of Hippocrates, the holistic medical history of Hinduism, Buddhism and Islam, he would have been much better off referring to these traditions instead of insisting on finding out everything for himself and making his own new system. On the other hand, we need the wheel of medicine to be reinvented again and again to keep it fresh and useful for the patients of our time and in the actual cultural setting. Hamer has done this with great effort and with the intent to benefit his patients. Many of his patients have apparently rejected the help they could have gotten from conventional physicians, like chemotherapy and radiation therapy, and turned to Hamer, but that made him open for criticism by other physicians, who saw him as responsible for harming these patients. What is stated by Hamer in his book (1) might very well be understood as a warning to the patients towards his biomedical colleagues, and thus he might actually be responsible for inspiring some patients to choose not to accept a documented cure, and thus, if not cured by Hamer, they died in spite of the existence of a cure.

We believe that an adult patient must be respected for his autonomy and integrity, but at the same time, a physician must do whatever he can to convince the patient to accept the most rational treatment. When it comes to metastatic cancer, the problem is that there often is little to do, which has a documented clinical significant effect, the NNT (numbers needed to treat) to obtain an effect going up to between 10 to 20 (6,13). Patient autonomy must, therefore, from a medical ethical perspective be stressed more, and the paternalistic position of the physician stressed less.

Still, if we as physicians can understand the Hamer system and give advice to the patients about this system, we will be able to form a good dialogue with the autonomous and often desperate cancer patient.

We have no intention of testing the Hamer system clinically but only to analyse it from a theoretical point of view. We wanted to compare the Hamer system with contemporary theoretical holistic medicine to see what in his system must be acknowledged as true and valuable insight into the mechanism of holistic health and healing and what must be seen as not true (from our present state of knowledge).

A deeper theoretical understanding of holistic medicine in the future might show that this analysis is unjust to Hamer's system. To make it simple, we have chosen to build this chapter on a small book based on interviews with Hamer called *Cancer—the riddle that do not exist* (1) instead of on the very comprehensive and complex presentations (2-4) of his work. We believe that an analysis of the five principles or "medical laws" presented as the fundamentals of his holistic system of healing is sufficient for establishing the theoretical value of the Hamer system. In this chapter, we use our own wordings of Hamer's last four "medical laws," not to confuse the subject with the many idiosyncratic concepts of Hamer.

The Hamer "iron law of cancer"

Law Number 1

Hamer claimed that all cancer forms arise from an emotional and "biological" shock (1), causing the patient to retract from the world with a destructive resignation regarding his fundamental wishes. He stressed that this shock must go so deep that it influences the whole biology of the patient's organism, and it must go deeper into existence than just the mind.

Interestingly, this law is consistent with both Antonovsky's work on coherence (7-12) and on our own life mission theory (14-21), which explains development of non-genetic and non-traumatic disease in general and in the same way. Unfortunately, Hamer insists that there are no genetic causes of cancer and that no drug can cause cancer either (1). In his radical insistence on an all-psychological approach, Hamer intimidates a generation of physicians doing research in genetics and the toxicological dangers of smoking. Nevertheless, his "Iron Law of Cancer" stating the psychosomatic element seems to be basically in accordance with the works of Antonovsky, Frankl, and our own work in holistic medicine. From a theoretical perspective, we, therefore, conclude that Hamer's first law of cancer seems substantiated. Interestingly, the process of healing according to Hamer includes a period called the "epileptoform crises" (analogous to an epileptic attack with muscle spasms), where the patient spontaneously regresses to the trauma to integrate this crisis (22). Only after this incident of healing the patient will improve (1). It is most noteworthy that Hamer observed that the crisis must be sufficiently strong for the patient to heal (1). What Hamer described here is exactly the same process of healing as described in most work with holistic healing of the patient's whole existence, improving health, quality of life and ability in general, as explained by the Antonovsky's concept of salutogenesis and the holistic process theory of healing (22,23).

The fundamental understanding of the psychosomatic cause of cancer and the ability to win the patient's trust and take them into the process of holistic healing of life and existence might very well explain why Hamer's clinical work has been successful for his patients. Claiming that traumas can produce cancer, we can also with our present knowledge comprehend, but also understand, why he was not well understood and received 20 years ago. As a hypothesis for further research, we would like to see this simple and somewhat provocative statement of Hamer expressed in a little more complex and deeper-rooted way to embrace a better understanding of human consciousness (24-31). Only after decades of theoretical work and only after we recently have been able to induce similar healing processes with cancer patients in our own research clinic have we been able to accept and understand the controversial first law of Hamer.

Law number 2: Every disease has a pathogenetic and salutogenetic phase

Unfortunately, Hamer did not know the work of Aaron Antonovsky (7-12), who at the same time did his clinical work and constructed his theory of salutogenesis. Antonovsky simply explained what Hamer observed, making the process of healing the reverse process of the process of pathogenesis (getting sick). His understanding of pain seems also to be in accordance with the contemporary understanding of pain, physically, emotionally and existentially, as a necessary part of the process of healing (1). Most importantly, Hamer stressed the importance of solving existential problems in real life not only in the psyche (1). Understanding the process of healing and being able to take the patient into the process is really what makes a good holistic physician. From the success of Hamer with his patients, it seems he was able to do this.

Law number 3: Cancer development follows a simple system of symbolic transformation from psyche to brain and the organs of the body

Many holistic physicians and some of the very popular health prophets of our time, like Louise Hay (32), have claimed the existence of such simple systems, which can be used to read the mental and spiritual cause of a physical disease.

Unfortunately, we have not yet seen such a system. Quite on the contrary, it seems from our research that repressed emotional problems can be moved around in the body and resettle wherever it is most convenient for the organism. The chronic state of whiplash associated disorder is an example of this (33).

So law number 3, which Hamer gives fylogenetic and ontogenetic arguments for, seems from our present state of knowledge to be less accurate. Still, there might be a considerable symbolic element in the disease making the patients able to "listen to the body," but not as schematic as Hamer believed, although we must admit that there could actually be such a symbolic psychosomatic system working in our organism, only with a more complex and not yet discovered set of rules. This is also an important hypothesis for further research.

Law number 4: Bacteria and virus are controlled by the body and help the body in the process of healing

This law seems in complete contradiction with our present knowledge of immunology, so it is not likely to be true. The reason for this understanding seems to be the benefit for the patient of going deeply into the salutogenic crisis, which often is taking so many resources from the patient that (s)he will get an opportunistic infection.

Law number 5: All diseases are rational and for the benefit of the patients

Hamer argued thus from an evolutionary and possibly teleological perspective. We have not found contemporary knowledge to support this law.

Discussion

Ryke Geerd Hamer wanted his peers to acknowledge his discoveries as hard science. He, therefore, used the CT-scanner to make images of the brain and found that circular patterns (well known as artefacts from the CT-scanner) carry vital information on the process of disease and healing. After studying the patterns for years, he claimed that visual pattern, which he then called the "Hamer Herd" or "Hamer focus" (the German word "herd" means "hearth," the central place of fire in the house), was always present in the CT scan of a cancer patient's brain in the pathogenic phase, revealing the path to healing for this patient. The Hamer focus looks like concentric circles around the part of the brain that in Hamer's interpretation represented the sick organ.

There is a slight possibility that the Hamer focus is actually a great new scientific discovery. It is, though, much more likely to be an artifact to which Hamer, in lack of other hard evidence of his theory (which he desperately needed to get his position back in the medical society), gave too much importance. Unfortunately, we do not have the resources necessary to test this part of Hamer's work. The concentric circles in the Hamer focus, shown on the front page of his book (1), look like an artefact and very little like a biological phenomena, which in humans are almost never seen as concentric circles. If the centre of the phenomena actually is placed in the brain according to the system Hamer described, this must be given further analysis.

The way we recommend holistic medicine to be practiced (34-51) and understood (14-23,52-54), the use of CT scans and other high-tech tools are not necessary, as the direct communication and emotional contact with the patient gives all the necessary information for the anamnesis and treatment. One of Hamer's mistakes, in our opinion, might have been to connect what seems to be an important re-discovery of the Hippocratic tradition of holistic treatment used on cancer patients, with the CT-scan picture, which made it very easy for his peers to ridicule his "spiritistic readings" of the CT-images. The most problematic consequence of this attachment to his third law and the CT scans was his belief that cancers were not able to metastasise (1). He believed that metastases were new cancers developed by the new shocks patients received when they encountered biomedicine. This conviction made

him highly unpopular with many biomedically oriented oncologists (cancer physicians), because it made many of his believers avoid the conventional physicians. Our own position is the opposite, and we believe that the modern holistic medicine should acknowledge the well-documented and sad fact that cancers do metastasise, often with the death of the patient as a consequence.

It seems to us that Hamer was too little rooted in the science of biology to make sufficient theories of the highly dynamic picture of cancer he experienced in his clinical practice. On the other hand, biology definitely needs an upgrade to embrace this dynamic (27,28), as already stressed by big thinkers like Nobel laureate (in 1933) Erwin Schrödinger (1887-1961) (55).

Our review of the work of Hamer came to the same conclusion as the Swiss Study Group for Complementary and Alternative Methods in Cancer (SCAC) (56), who found no evidence that most of his assertions were correct, no case of a cure has been published, and an investigation by Der Spiegel through the German authorities identified 50 cancer patients that had been in the care of Hamer only seven of whom survived (56). Still, we find that when treated only with psychosocial intervention, a success rate of 14% with this group of mortally ill metastatic cancer patients is remarkable and encouraging for further research.

It is pretty clear, though, from our analysis, that the two most fundamental principles of Hamer's work, the principle of psychosomatically caused vulnerability ("The Iron Law of Cancer," Hamer's first "law") and the principle of salutogenesis as the reverse of pathogenesis (Hamer's "second law"), are today well-established principles of holistic medicine, worded nicely by the Jewish thinker Aaron Antonovsky but in reality going all the way back to the father of medicine Hippocrates (57). Hamer's understanding of symbols in medicine, on virus and bacteria and on the evolutionary process itself differs a great deal from traditional science, and we cannot in contemporary holistic medical theory find support for his last three principles or "medical laws." As Hamer's understanding of cancer metastasis was built on these failing principles, we suggest that this aspect of Hamer's thinking, which has been a major reason for controversy, is also not substantiated: Cancer metastasis is not likely to be new cancer induced by the shock the modern biomedical physician gives his patient.

Altogether, it seems that Hamer is in accordance with contemporary holistic medical theory, as the most fundamental principles of his work are built on an understanding very similar to holistic medical thinkers of today and of the past going all the way back to Hippocrates; regarding the most fundamental postulate that cancer patients can be healed by his system of holistic medicine, this could actually be the case for some of the motivated patients. This must however be tested scientifically before being accepted. If proven, we must recommend a rehabilitation of the name and work of Ryke Geerd Hamer. Clinical testing of a cure for cancer based on Hamer's system must be considered worth the effort; it must be done with (physicians trained by) students of Hamer, if at all possible.

At the Research Clinic for Holistic Medicine and Sexology in Copenhagen, we do clinical research to understand how to use the Hamer's first two seemingly well-established "Laws of Cancer": that we are often damaged by emotionally painful life events, making us vulnerable also to the development of cancer and that we can heal by reversing the pathogenetic process into a salutogenic process and regaining biological order (5,6,22,23,33,51,58).

It is of utmost importance that we test and document the effect of such experimental treatments, and we have, therefore, developed a simple, easy-to-use, and low-cost strategy for

documenting holistic healing (59). We have invited the scientific medical community to cooperate in this important new field of evidence-based holistic medicine growing from an emerging scientific understanding of the connections among health, quality of life, and consciousness (31). Some possible mechanisms explaining how Hamer's cancer cure works are discussed in Section 8.

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Exercises

Many colleagues have talked against Hamer's work and called it impossible, meaningless and even worse. Hamer even had to go to prison. Why has Hamer's cancer cure been so controversial?

What is the major cause of cancer in your belief? Do you think cancer is one disease with a lot of subtypes or many different types of diseases?

Do you believe that Hamer could cure some patients with metastatic cancer? If you do, how is that possible? Which mechanisms do you think work here?

Chapter IX

Evidence-based holistic medicine and CAM: How efficient is it? How safe is it? What can be cured?

Needless to say, we are working with holistic medicine because we are convinced that it is safe, cheap, efficient and full of other positive effects than just curing your disease. Holistic medicine is addressing the whole being and is beneficial on all levels of existence, from quality of life to physical and mental health to ability in general—physical and mental ability, social ability, working and studying ability.

It is good for your relations and for your children. Basically, it is about being the wonderful, talented, loving being you were meant to be. When you become happy and use yourself in good ways in the world, health will inevitably follow.

Right now, this is our belief. If you come from biomedicine and are used to treating patients with drugs, you know that medicine is far from being a perfect thing; most patients that we see in the clinic are often chronic patients, they have been to doctors before, and they have often tried many types of drugs without being cured or helped. So we fully understand your scepticism.

You are likely to look upon us as naive people, as saved, fanatic believers in some strange new religion called holistic medicine.

This chapter is about this. Can we document the effect of holistic medicine—in such a way that even the most sceptical of sceptics will start to believe that there could be a little bit of truth in what we are saying?

Then again, when we tell you that this kind of holistic mind-body medicine that we believe in has been practiced for millennia throughout all of Europe, you will be even more sceptical: If it is so good, why on Earth did physicians stop using it? There are very good reasons for that—political and economic reasons. Some of the political reasons have to do with the development of the modern city culture, where sexuality had to be much more regulated because people started to live so closely together, always being in large groups in school, at work, etc.

The classical holistic medicine is emphasizing sexuality, which makes it somewhat difficult to practice in a culture that represses sexuality to a large extent. Another thing with

the industrial revolution is that culture got materialistic, so the core of holistic medicine, being humanistic values like love, care and spiritualism, was abandoned by the culture.

But the real killer for traditional medicine was the development of natural science, especially biochemistry, and based on that—the pharmaceutical industry. The pharmaceutical industry is today one of the leading industries worldwide, and the largest companies have yearly turnovers that can be compared to small nations. Early in its development, the pharmaceutical industry understood that it needed to work together and stay close to academia and to the national health authorities to make the most of it. Soon, in most Western countries, a large medico-industrial complex ("Big Pharma") was developed, including all major pharmaceutical companies, all major universities and all national health organizations. Politically the new, chemical medicine was a hit, as everybody believes strongly in science—meaning natural science! The doctors, who believed even more in science than normal people, liked the new power of the drugs to kill infections and remove patient's pains in the blink of an eye… Being insecure in human relations like all other human beings, they often felt a true empowerment from the new drugs.

Pharmaceutical companies and academic researchers soon promised the moon to everybody: "In a short while, we will be able to cure depression, schizophrenia, cancer, coronary heart disease, etc." Everybody believed this around 1980, and the media—private companies also driven by money of course—sided up with the pharmaceutical industry. The story of the *brave new medicine* was a good one, and the readers loved stories about scientific miracles.

But now, 30 years after, it is pretty clear that the pharmaceutical industry did not keep its promises. Well, it made drugs for everything, but almost no patient is cured from a severe physical or mental disease, and most patients get some adverse effects. So we have ended up with a biomedicine that is helping in some cases and also harming others, a biomedicine that is kept in place not by its great results, because its results are very modest at best, but of an extremely strong pharmaceutical lobby and a trillion dollar business that is marketing its products in such a way that everybody believes that this is the solution, while it most definitely is not. The marketing is smart—namely through the physicians. Patients believe in their doctors, and their doctors believe in the industrial products, and the doctors are often employed by the state, making national authorities tell everybody that drugs are the solution.

This is how capitalism works. We do not say that there is another political system that works, we are not communists, but the dark side of capitalism is that money speaks very loudly, it speaks its own interest, and you need to understand that we live in a world run by money and politics.

So this is our understanding of why excellent medicine, which for thousands of years had been successful, today is regarded as old-fashioned and obsolete. We hope that you, after reading this chapter, will be open to re-evaluate your position on these matters, if you have grown up with biomedicine, which you probably have if you live in Europe and in some parts of the USA.

Non-drug medicine has during the last decades become increasingly popular with patients and some physicians worldwide as it is realised that CAM (complementary and alternative medicine) is efficient for physical and mental diseases, sexual dysfunctions and existential problems without the side effects of pharmaceutical medicine. We have identified five classical healing principles allowing us to define seven classes of CAM (six types of non-drug

and shamanistic healing using hallucinogenic drugs); for each class, we have estimated the efficacy of the treatments.

Based on clinical studies, where the patients act as their own control (used because of lack of relevant RCTs), we have estimated, using the concepts NNT (Number [of patients] Needed to Treat [for one patient to obtain the treatment goal]) and NNH (Number [of patients] Needed to treat to harm [one patient with a specific side/adverse effect]):

- Class 1-CAM (Chemical CAM) NNT≥10, NNH=25
- Class 2-CAM (Physical therapy but not high-energy manipulations): NNT=2-4, NNH>64,000
- Class 3-CAM (Psychotherapy): NNT=3, NNH>64,000
- Class 4-CAM (Spiritual therapy) NNT=10, NNH>64,000
- Class 5-CAM (Mind-Body medicine): NNT=2, NNH>64,000
- Class 6-CAM (Holistic medicine addressing mind, body and spirit): NNT=2, NNH>64,000
- Class 7-CAM (Shamanism with hallucinogenic drugs) NNT=1, NNH≥1000.

We can compare this to the general data on biomedicine: NNT=5-100, NNH=1-4 (meaning 1-20% of patients helped and 25-100% of patients harmed from adverse effects. Antibiotics like penicillin can be more efficient and less harmful; anti-cancer chemotherapy, antidepressive drugs and antipsychotic drugs can be less effective and more harmful, see below).

Efficient non-drug cures exist for subjectively poor physical health (NNT=2), coronary heart disease, (NNT=2-3); cancer (QOL NNT=2, survival NNT=7); chronic pain (NNT=2-3), subjectively poor mental health (NNT=2-3), schizophrenia (NNT=3-5), major depression (NNT=2-3), anxiety (NNT=3), social phobia (NNT=3), subjectively poor sexual functioning (NNT=2); male erectile dysfunction (NNT=2), female orgasmic dysfunction (NNT=1); female lack of desire (NNT=2), female dyspareunia (NNT=2); vaginismus (NNT=2), vulvodynia (NNT=2); infertility (NNT=6); subjectively poor quality of life (NNT=2); sense of coherence (NNT=2-3); suicidal prevention (NNT=1)L; low self-esteem (NNT=2); poor working ability (NNT=2).

Holistic medicine and CAM seems highly cost efficient. We would like to see more use of non-drug medicine and advocate for a shift to non-drug medicine as a primary type of medicine provided. We like the concept Therapeutic Value (TV), which is how many patients are helped compared to how many patients are harmed.

We estimate TV of holistic medicine to be 64.000/2=32,000, while TV of an average biomedical drug is 2/20= 0.1. We often make the joke that the therapeutic value (TV) of non-drug medicine is about 1,000,000 times better than TV for drug medicine. It is not a million times better; of course, the ratio is only 320,000:1, and there are many cases i.e., with acute tropical infections, where drugs are a million times better than holistic medicine. But then you need to think about the fact that most diseases are chronic diseases and that holistic medicine also gives you all the other benefits you get from personal development, which you will not get from using drugs. In most cases of chronic disease, we find that non-drug medicine is actually a million times better than drugs.

Introduction

There has been an increasing awareness of lack of efficiency and high incidence of side effects and adverse events in pharmacological medicine, which has created a renewed interest in the classical non-pharmacological medicine. The Western tradition of scientific medicine started in Greece 400 BCE, where the physician Hippocrates and his students had a hospital on the island of Cos. The original writings are preserved as the Corpus Hippocraticum (1). The medicine of Hippocrates was holistic as it intervened on all aspects of man—body, mind and spirit—at the same time. For over 2000 years, this medicine was practiced all over Europe almost completely without the use of drugs. Its fundamental idea was to induce salutogenesis (2,3)—i.e., healing of the patient's whole life and existence—by helping the patient to increased self-insight and self-awareness. This was done through the concept of *talents* and *character*. When the patient understood him- or herself and was able to use all talents—bodily, mental and spiritual—to create value to self and others, he or she recovered the *sense of coherence* (SOC) and improved *quality of life* (QOL), physical and mental health, and ability in most aspects of life (4).

This route of "quality of life as medicine" or personal development for health is the fundamental principle of holistic medicine and CAM today (5).

Non-drug medicine

As natural science, especially chemistry, developed a long list of pharmaceutical drugs that became available to the physician in the 20th century, many medical schools accepted biomedicine as the dominant type of medicine, while other kinds of medicine were defined as "alternative" or "complementary" to the drugs. Table 1 gives a classification of non-drug medicine, which is a revision based on the five healing principles of an earlier classification (see below) (6).

A conceptual hierarchy can be made with seven or so levels of CAM (see Table 1). The "concretisation path" that leads to the classical Hippocratic Character Medicine and related methods is shown in Table 1. CAM is everything, most CAM systems are non-drug medicines; most types of non-drug medicine uses talk and touch therapy, making it mind-body medicine; a fair fraction of these abstain from rough handling of the body, and a part of these includes spirit and sexuality, making it *holistic*. Most holistic medicine works through the patient's self-insight and personal development, giving us *holistic, clinical medicine*. Level 7 in Table 1 lists a number of concrete methods and schools under this general concept. In section two we shall describe the healing principles in more detail, allowing you to understand why Hippocratic medicine ended up as it did.

Clinical medicine can be defined as the exploration of the patient's inner life in the intent of developing the patient's *self-insight (self-awareness as medicine)* (4). High-energy manipulations (i.e., in chiropractic) are associated with side effects and, therefore, normally not used in holistic medicine (7). We have found it practical to keep it simple and suggest that the classification of CAM in Table 2 is generally used.

Table 1. The seven levels of integrative medicine

Level 1: CAM
Level 2: Non-drug medicine
Level 3: Mind Body Medicine
Level 4: Mind Body Medicine without high energy manipulation
Level 5: Holistic Mind Body Medicine
Level 6: Holistic Mind Body Clinical Medicine = Holistic Clinical Medicine
Level 7: Hippocratic Character Medicine, Clinical Holistic Medicine, Holistic Manual Sexology,
Vaginal Acupressure, Osho's Psychic Massage, Grof's Holotropic Breath Work, Boyesen's Holistic (Biodynamic) Body Psychotherapy, Stern's Holistic (Mindful) Mind-Body Medicine, Ornish's Holistic Heart Cure, Levenson's Holistic Cure for Cancer, etc.

Table 2. Classification of CAM into seven principal classes according to area of intervention (cells, body, mind and/or spirit)

Chemical medicine (working on the cellular level).
A. Chemical biomedicine (pharmaceutical medicine using highly bioactive often toxic drugs)
B. Chemical alternative medicine (alternative diets, herbal medicine with mildly bioactive often nontoxic drugs: low fat diet, herbal tea, flower medicine, aromatherapy, color therapy, crystal healing, "orthomolecular medicine," "vibrational medicine," "quantum medicine," etc.)
Body-medicine (i.e., Swedish massage, Thai-style massage, no-talk acupuncture /acupressure, reflexology, physical therapy, physiotherapy, spa, sauna, dance therapy)
Mind-medicine (i.e., psychotherapy (psychodynamic, cognitive, gestalt, primal, etc.), psychoanalysis, meditation, integral psychology, positive psychology, no-touch sexology, couching, healing music, psychodrama, dream work, art therapy)
Spirit-medicine (philosophical interventions, energy medicine, prayers, spiritual healing (i.e., "Reiki healing," "aura healing," "DNA-activation," theosophical "astral journeys")
Mind-body medicine (acupuncture/acupressure with talk, chiropractics, homeopathy, manual sexology, body-psychotherapy, Reichian bodywork, Neo-Reichian bodywork, Alexander technique, Rosen therapy, ergo therapy, etc.)
Holistic (body-mind-spirit/existential) medicine (holistic medicine, clinical medicine, clinical holistic medicine, holistic body-psychotherapy, holistic bodywork, the sexological examination, holistic mind-body medicine, biodynamic body psychotherapy, tantric bodywork and massage, holistic sexology, Native American drug-free rituals).
Chemical-body-mind-spirit medicine (Shamanism with peyote, Ayahuasca, magic Psilocybin mushrooms, etc.), Grof's LSD-psychotherapy, MDMA psychotherapy, etc.).

Healing principles

The most impressing aspect of non-drug medicine is that it offers healing—or you could say a true cure—for many diseases, as it addresses the causes of the diseases. This stands in contrast to many biomedical interventions, where the drugs only modify the symptoms of disease. The healing principles will be discussed in section two. The Interuniversity College, Graz in Austria has collected all existing knowledge on CAM (complementary and alternative medicine) from 40 academic institutions in Europe and made the Master's degree program EU-MSc-CAM (8-15). The body of knowledge has crystallised five central principles of healing, which are used in CAM (see Table 3). All five principles were seemingly used by the Hippocratic physicians 400 BC.

Table 3. The five central principles of healing in non-drug therapy (i.e., clinical medicine, holistic medicine, clinical holistic medicine, and CAM) from the curriculum of the EU-master in CAM

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* (2,3), 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's 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." As to diseases, make a habit of two things—"to help, or at least to do no harm" has been paramount not to harm the patient or running a risk with the patient's life or health (1).

Quality of data

In CAM, we cannot control for placebo, as CAM uses the placebo effect as part of the cure. We, therefore, use studies where chronic patients acted as their own control. The studies are often giving non-dichotomised data making it necessary to estimate a NNT (number need to treat). These estimates are based on the size of the total effect and the statistical data presented. Often the estimate is not accurate; a NNT=3 could be 2 or 4. In this chapter, when we make a general evaluation of the efficacy of CAM, this is of limited importance to the big picture. We will accept that sceptical readers add 1 to all the presented NNTs. We have given the estimated NNTs and NNHs (number needed to harm) that we believe are correct. We need more research to estimate the NNTs accurately. We find the NNHs to be quite accurate. The

NNTs and NNHs of general biomedicine come from the highly estimated medical journal *BMJ* (16), who got them from the pharmaceutical industry. We believe most NNTs and NNHs from the pharmaceutical industry are biased to some extent (see section 10).

Efficacy of cam-therapy according to class

As a rule of thumb, the therapy is more efficient and NNT, therefore, smaller when more aspects of the patient (body, mind and spirit, relations, character, sexuality) are influenced by the therapy (14,15). The trend is, therefore, to combine therapies from different areas into a more holistic therapy (i.e., physical therapy and psychotherapy into mind-body medicine, and mind-body medicine with spiritual intervention i.e., mindfulness, into clinical holistic medicine). The primary focus of successful intervention seems to be body and mind (Class 2,3,5) The intervention might be enhanced by spirituality i.e., a positive, holistic philosophy of life (Class 6).

The most effective healing with the most lasting results seems peculiarly to happen in shamanistic healing rituals with hallucinogenic drugs (Class 7), but we assume that for cultural reasons this is of little interest to contemporary physicians. In general, the most efficient CAM methods we have today helps one in two of the patients (NNT=2) (17-26). At the same time, most researchers seem to agree that these methods have no side effects or adverse events (7,27-30).

If one looks at the long-term results, the spiritual and philosophical dimension of the intervention seem to be important; a lasting result seems to need a change in consciousness and attitude. This is why it is generally suspected that the real active component in CAM treatment that gives improvement of health, quality of life and ability (salutogenesis) (1-3) is the development of the patients' consciousness. Examples of treatments from the seven classes:

Class 1: Flower medicine (31) and diets (32) has a NNT=10-∞
Class 2: Physiotherapy (26) has a NNT=2-4 for a number of diseases
Class 3: Psychodynamic psychotherapy for example with schizophrenia (22,33) with NNT=3
Class 4: Prayer (see 34). Effect size unknown
Class 5: Body psychotherapy (35,36) has NNT=2
Class 6: Clinical holistic medicine (37-44) has NNT=2, Sexology has NNT=1-2
Class 7: LSD-psychotherapy (45-52) has NNT=1

The Hippocratic character medicine was holistic, and it seems that many types of problems could be treated. Interestingly there was only one cure: To help the patient to gain self-insight and step into character. Table 5 shows the efficacy of different CAM cures for different diseases, dysfunctions, etc. In non-pharmaceutical CAM, we cannot meaningfully randomize to placebo, as all interventions presumably are on the patient’s consciousness and, therefore, in essence placebo cures.

Table 4. NNT and NNH numbers of the seven CAM classes estimated from clinical studies (with chronic patients, see text) (21-44,53-67). The effect of clinical holistic medicine and similar medical systems seem to continue to increase though time (53). (NNT: Number Needed to Treat. NNH: Number Needed to Harm)

	Short-term effect	Long-term effect	Side effects and
	(0-6 month)	(6-24 month)	adverse events
Class 0-Biomedicine	NNT=5-50 (16)	NNT=10-100	NNH=1-4
Class 1-CAM (Chemical CAM)	NNT≥10	NNT≥20	NNH=25 (allergy)
Class 2-CAM (Physical therapy)	NT=2-4	NNT=6	NNH>64,000
Class 3-CAM (Psychotherapy)	NNT=3	NNT=6	NNH>64,000
Class 4-CAM (Spiritual therapy)	NNT=10	NNT=20	NNH>64,000
Class 5-CAM (Mind-Body medicine)	NNT=2	NNT=4	NNH>64,000
Class 6-CAM (Holistic medicine)	NNT=2	NNT=1-2	NNH>64,000
Class 7-CAM (Shamanism w. drugs)	NNT=1	NNT=1	NNH≥1000

Table 5. Estimated NNT-numbers of the CAM treatments of physical, mental, existential and sexual health issues and working disability (mostly based on clinical studies using chronic patients as their own control, see text)

CAM for physical health	
Subjectively poor physical health	NNT=3 (17,18,39)
Coronary heart disease	NNT=2-4 (65,66)
Cancer (QOL/survival)	NNT=2/7 (67,68,69)
Chronic pain	NNT=2-3 (20,39)
CAM for mental health	
Subjectively poor mental health	NNT=2-3 (17-20)
Schizophrenia	NNT=3-5 (22,33,)
Major depression	NNT=2-3 (58-60)
Anorexia Nervosa	NNT=3 (58-60)
Anxiety	NNT=3 (58-60)
Social phobia	NNT=3 (58-60)
CAM for sexual dysfunctions	
Subjectively poor sexual functioning	NNT=2 (41,61,62,63)
Male erectile dysfunction	NNT=2 (62)
Female orgasmic dysfunction	NNT=1 (63)
Female lack of desire	NNT=2 (61,62)
Female dyspareunia	NNT=2 (26,44,62)
Vaginismus	NNT=2 (26,62)
Vulvodynia	NNT=2 (26,44,62)
Infertility (close ovarian tubes)	NNT=6 (57)
CAM for psychological and existential problems	
Subjectively poor quality of life	NNT=2 (35,36,42)
Sense of coherence	NNT=2-3 (35,36)
Suicidal prevention (with decisions)	NNT=1 (29)
Low self-esteem	NNT=2 (43)
CAM for low working ability	
Subjectively poor working ability	NNT=2 (38)

If you give strychnine to rats and randomise to control with strychnine all the rats will die, but you can conclude that the drug is not poisonous. If you randomize massage to psychotherapy, you do the same in principle. Therefore, you need to study patients with chronic conditions you know will not disappear by themselves and use the patients as their own control. In acute disease, you must randomise, because you need to know the efficacy of a treatment in a situation where most patients heal spontaneously.

Side effects and adverse events

Drugs are known to have many and serious adverse effects and events, while CAM is known to have very few (19,20,27,34). Table 5 presents data from 18,500 patients treated with the most intensive holistic medicine (7,28,29,37-44,63). A review of the literature estimated in accordance with this NNH=65,000 for all non-drug therapies in general (7).

Table 6. Side effects and adverse events caused by physical therapy, psychotherapy, mind-body medicine, and holistic therapy (body-mind-spirit intervention) (based on 18,500 patients) (modified after (7))

Method	Side effect	Number needed to harm (NNH)
Psychotherapy		
1.	Re-traumatisation	NNH>18,500
2.	Brief reactive psychosis	NNH>18,500
3.	Depression (and hypomania)	NNH>18,500
4.	Depersonalisation and derealisation	NNH>18,500
5.	Implanted memories and implanted philosophy	NNH>18,500
6.	Iatrogenic disturbances	NNH>18,500
7.	Negative effects of hospitalisation	NNH>18,500
8.	Suicide and suicide attempts	NNH>18,500
Bodywork		
1. Brief reactive psychosis		NNH>18,500*
2. High-energy manipulations of the body in chiropractics can cause damage to the spines of vulnerable patients.		NNH>18,500
Damage to the body if the therapists are unaware of illnesses or for example fractures.		NNH> 4,500
4. Suicide and suicide attempts		NNH>18,500
Holistic medicine (psychotherapy and bodywork) i.e., manual sexology like *the sexological examination*, clinical holistic medicine (CHM), and Grof's holotropic breath work		
1.	Brief reactive psychosis	NNH>18,500
2.	Implanted memories and implanted philosophy	NNH>18,500
3.	(Developmental crises)	NNH>18,500
4.	Suicide and suicide attempts	NNH>18,500

* Found to be NNH=1000 (estimated) if patients have been mentally ill before (29).

Discussion

The standard of documentation used for the pharmaceutical industry—the RCT—is not applicable in CAM. In CAM—all types of non-drug medicine including traditional holistic medicine—chronic patients must serve as their own control. In this chapter, we have looked at these studies, and we found that CAM has no side effects or adverse events and the intervention able to help patients with many sorts of physical and mental diseases, sexual dysfunctions, existential and psychological problems. Also, low working ability was efficiently solved with CAM.

We have observed that only CAM involving an intervention on body and/or mind was highly efficient, and the combination into mind-body medicine seems to be the best solution, if you go for high efficacy. The addition of a holistic philosophical framework might increase efficacy further. The most efficient treatment seems to be shamanistic ceremonies with hallucinogen drugs, like Peyote cactus or Ayahuasca, but we believe these rituals to be irrelevant to modern medical practice, although still of academic interest.

The quality and efficacy of the provided CAM varied with the number of healing principles used—or put in another way, with the number of formal errors being made in the therapy (70). To ensure a high quality of service, we suggest combining efficient training and supervision of therapists with the use of a system for quality assurance (71). The same type of CAM can be extremely efficient or totally inefficient depending on the therapist's ability to bond, give holding and processing to the patient (70). The activity of the five healing principles is highly dependent on the practitioner and little dependent on the therapeutic system. In reality, you can have the best of systems with no effect of all if the practitioner does not understand engaging of the healing principles. This is why we say: "The doctor is the tool."

Researchers have suggested that the placebo effect, the health-improving change in the patient's consciousness, which is the principal core effect of CAM, is non-existent (72). It is important to remember that the studies used for this analysis all have intended to document effect of a treatment in contrast to a placebo treatment; the placebo cure was, therefore, intentionally designed to have the smallest possible positive impact on the patients' consciousness, and it is most unfortunate that the researchers forgot to adjust for this fact in their analyses, making their conclusions incorrect; Kaptchuk et al. (73) found the most important factor in the highly beneficial placebo effect in medicine was *a supportive patient-practitioner relationship*. They concluded that "the patient-practitioner relationship is the most robust component." And we know that this dimension is intentionally eliminated in almost all industrial studies giving a strong bias in favour of the drugs. We know today that just using an active, poisonous drug boosts the placebo effect enough to destroy the effects of a drug i.e., antidepressants (74).

For many diseases and health problems, non-pharmaceutical medicine can be the cure of choice. We have observed that its antibiotic and antiparasitic potentials have not been explored. We would also expect holistic medicine to be efficient in the treatment of HIV (as it is in cancer and coronary heart disease), but this remains to be clinically tested (75).

CAM is cost-efficient (19,20,76), as we shall see in section ten. The biggest challenge of CAM today is how it can be turned into a comprehensive science. Most fortunately, the European Master's program has already done an important job here, crystallising the

fundamental principles of healing in CAM and accordingly the errors that can be made in CAM.

CAM has become a science, and we recommend all medical schools include non-pharmaceutical medicine, especially the classical Hippocratic type, in the medical curriculum. (We will be more than happy to assist any academic institution that needs our help in this process.) We must also recommend that all nations with nationalised medicine shift to CAM as a primary type of medicine provided, with biomedicine only given to the patients that cannot be helped with CAM.

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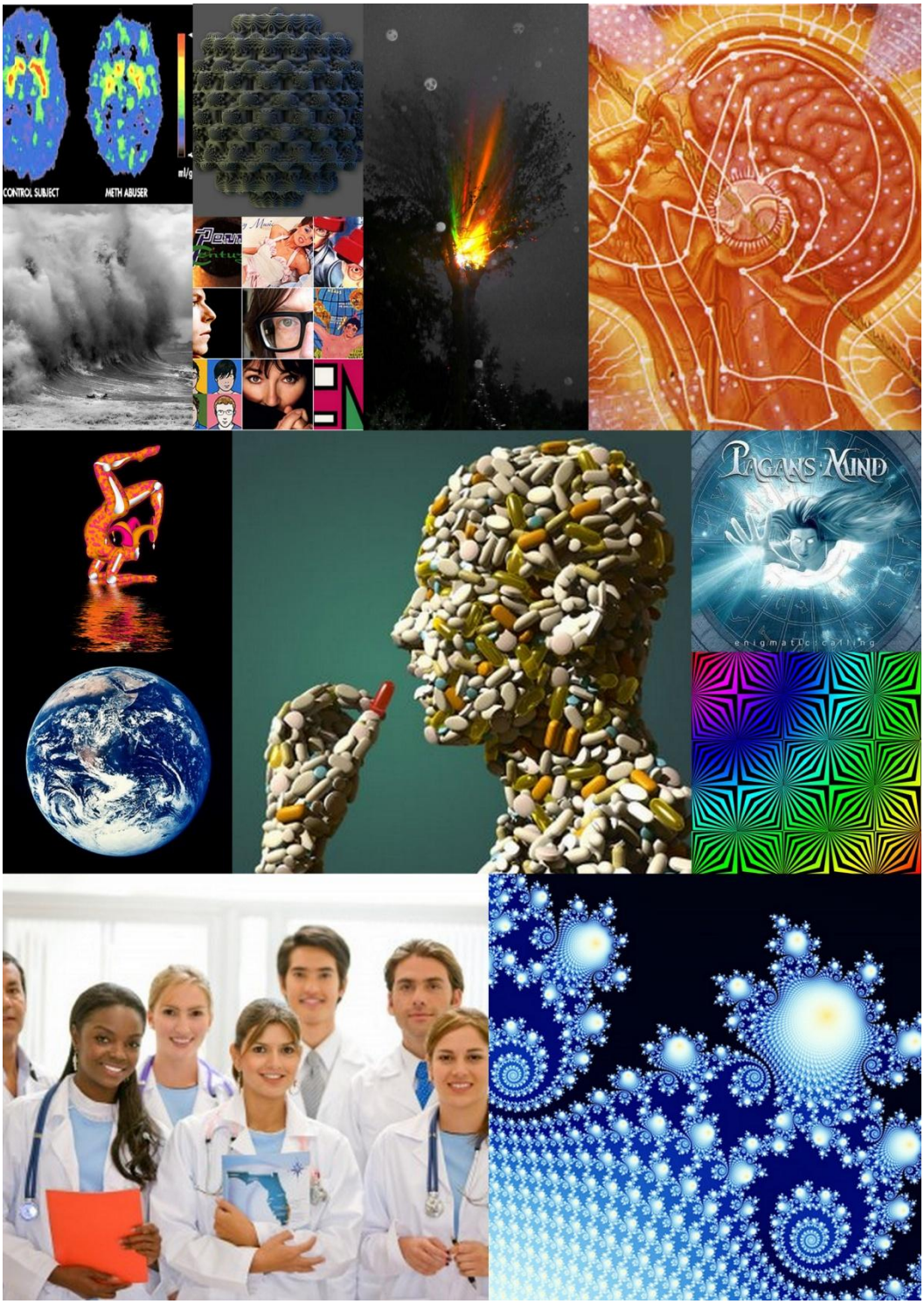
Exercises

Do you really believe us when we state that holistic medicine is a million times better than biomedicine? In what way have we manipulated to make this statement look true?

Do you think NNT and NNH is a fair measure of efficacy and harm? Maybe it would be better to measure improvement on average of all patients in the study, to see if the group benefit as a whole? Should less improvement than reaching the treatment goal also be counted as an effect? Would making the calculation of benefit and harm in another way make the drugs look more beneficial and less harmful?



Chapter X

The Danish experiment with free medicine: What can we learn from socialized medicine? How is the world's best health care model?

We would like to think that medicine is free of all cultural and traditional bonds. It must be possible to make a science of medicine that only looks at man. Culture is so complex, with history and values and thousands of interactions. Physical and mental health could be defined independently of all that. A healthy body, a healthy brain, like perfect objects just hanging there in space and time, that exist independently in the universe. We human being are beings of consciousness, and consciousness is non-local. It is not limited to the body or to the mind; it is omnipresent, everywhere, connected with everything. Therefore, you cannot make a science of the brain, where the brain just functions independently in the lab as a flask filled with hot, sweet water… You can grow a foetus in a flask but not a man. You can have a small colony of cells in a lab bottle but not a human body. We need to be connected to the world to function and survive. In the same way, you cannot make a medical science without including relations, family, work, society and culture. Medicine is bio-psycho-social, as is man. To understand the connection between medicine and society, it might be worthwhile to study a grand-scale experiment that somehow failed our expectations: Socialized medicine in Denmark.

Socialized medicine has, in spite of the best of intentions, severely failed to keep the population healthy. Half the population in Denmark and other countries that utilize socialized medicine is chronically ill despite the abundance of pharmaceutical drugs. The reason for this failure seems to be that socialized medicine concentrates power, enabling industrial lobbyism and empowering the pharmaceutical industry. Socialized medicine, therefore, turns medicine into industrial biomedicine and doctors into "pushers of pharmaceutical drugs." Non-drug alternatives, such as massage, acupressure, and body psychotherapy, which may induce salutogenesis and help cure some patients, are made less likely for physicians to understand and provide or offer to their patients.

A solution to the current crisis of medicine is to empower citizens to choose freely how they will use health insurance money. We may need a public health insurance program but only together with strong laws that ensure that citizens are completely free to use health

insurance money according to the person's own philosophy of life and understanding of health. Commercials for pharmaceuticals must be strongly regulated and must only inform consumers based on evidence. An independent institute for evidence-based medicine is needed to compare all existing treatments to ensure that the effect of drug and non-drug treatments is documented in the same way so it is possible to compare the effect of both. Global quality of life must always be the endpoint, and chronic patients must be used as their own control to ensure real progress in the management of illness and promotion of health.

Introduction

Many people in the United States (U.S.) seem to be aware that the U.S. health care system is not functioning well (1). Countless critiques have reached the press, and a systematic investigation of the negative effects of this health system has made researchers conclude that those in poverty are not being sufficiently helped, and almost a million U.S. citizens are killed every year, with many more harmed due to hundreds of millions of unnecessary, unscientific, or incorrectly used health interventions (2,3). As noted by Null et al. (2): "It's a failed system in need of immediate attention." As noted by *Times* reporter Park: "Despite advances in medicine, Americans are less healthy than we used to be, and the next generation may be even worse off" (1).

Often. the suggested solution has been to have socialized medicine become the basis of the U.S. health care system. Society seems infatuated with the idea of every citizen having free access to all medical treatments when necessary. This idea is as beautiful as the whole idea of communism originally presented by Karl Marx: One must give to society that entirely one is able to and receive in return only what one needs. In Denmark, there has been socialized medicine for many years. Most Danes are happy with their public health care system, as they find it to be it fair, decent, and even believe it to be evidence based. Patients at public hospitals in Denmark are treated equally regardless of being a poor worker or a famous movie star. Of course, the richest people will often go to a private hospital or clinic, even in Denmark. The doctors working in the private hospitals often also work at the public hospital as the physicians in charge. So we like to think that the standard of the public system is not much worse that in the private hospitals.

So for many people, this model of socialized medicine appears to work well. However, with closer observation, it is not that simple, for the outcome of the socialized public health care system, when measured in terms of overall public health, is not significantly better that the outcome of the private system in the U.S. Actually it might be worse, as 20% of everybody in Denmark has a serious, chronic, mental illness, and 30% has a serious, chronic physical disease (4). Research has noted that 25% of the Danish population suffered from chronic pain (5), and about half the adult population is unable to study or work normally. The tax burden for an average citizen working in the private sector has, therefore, risen to about 70% of the last earned money for over one million Danes, because of the need to pay for the 50% of citizens not working and the 20% of all citizens working in the public sector—mostly the social and health sectors. In Denmark, the debate centres on what went so terribly wrong with the public health service, a system that turned half the population into chronically ill patients.

United States and European health care systems

In the United States, 14% of the Gross National Product was spent on health care, reaching $1.6 trillion in 2003; this fraction is the same in Denmark (5,6). In the U.S. and Denmark, about half of the population uses pharmaceutical drugs (6). The number of surgical operations per citizen is about the same in both countries. The number of consultations per capita with biomedical doctors is about the same, and the number of prescriptions per capita is also about the same. Also, the number of errors made by doctors is about the same. One can only conclude that society is looking into really serious health problems in the future. Such a comparison of these two systems, the liberal U.S. health care system and the socialized European model health care system, reveals that the problem is not really with the structure or organization of the health system; it is a much more profound problem that concerns the very nature of the medicine that is used.

However, what is essentially wrong with medicine of the early 21st century? The fundamental problem is the way it is researched and developed by the pharmaceutical industry, and the way their drugs are promoted and controlled as the best available treatments by this same industry that seeks high profits from its medications (7). This problem has been addressed many times. For example, Jonathan Quick, director of Essential Drugs and Medicines Policy for the World Health Organization (WHO), wrote in a recent WHO Bulletin: "If clinical trials become a commercial venture in which self-interest overrules public interest and desire overrules science, then the social contract which allows research on human subjects in return for medical advances is broken" (8). A 2002 report by the network ABC News concluded that one measurable tie between pharmaceutical companies and doctors amounts to over $2 billion a year spent for over 314,000 events that U.S. doctors attend (9). Data on financial involvement showed that in 1981, the drug industry "gave" $292 million to colleges and universities for research; this increased to $2.1 billion in 1991 (9).

Also, an editor of the *New England Journal of Medicine*, Marcia Angell, wrote an editorial titled "Is academic medicine for sale? " (10). Angell called for stronger restrictions on pharmaceutical stock ownership and other financial incentives for researchers. She said that growing conflicts of interest are tainting science. She warned that "When the boundaries between industry and academic medicine become as blurred as they are now, the business goals of industry influence the mission of medical schools in multiple ways." She did not discount the benefits of research, but wrote that a Faustian bargain now existed between medical schools and the pharmaceutical industry.

The problem is that medicine has basically turned into business and politics, and objective science has been lost as a result. Even when well-respected scientists have shown that pharmaceutical products are damaging, the pharmaceutical industries use their considerable lobbying power to maintain product presence in the market. Massive misinformation and strong pro-drug campaigns have led consumers to believe products that are inefficient and even harmful are really useful and needed for improved health. It can be problematic for researchers to show that a product is not evidence based and, therefore, not likely to be helpful; for example, it was noted that after Tom Jefferson revealed concerns with the efficacy of the influenza vaccine in several papers in the *Lancet*, he received death threats (11).

Another example is seen with that of the German statistician Ulrich Abel, who analyzed data from thousands of cancer studies and concluded that chemotherapy for almost all types of cancers (the epitheloid cancers) only shortened life and destroyed the quality of life (12). Chemotherapy was not taken off the market as a result of his report; on the contrary, Abel's personal character was seriously questioned, and soon after this report, his computer mainframe broke down and the backup was also lost, with the result that all his data was destroyed. After that, the industry stopped testing chemotherapy against no treatment as controls, but only against the old drugs that Abel has proved to be harmful.

Unfortunately, this is not at all a unique story. In Sweden, a trial at the Swedish High Court forced an anti-ADHD drug company to reveal its research protocols after accusations about the research being paid secretly by the industry. The day after the trial proceedings, all the papers about the protocols burned, and the product stayed on the market and continues to be given to one out of three school boys in Southern Sweden (13).

A Cochrane meta-analysis showed in 2004, that antidepressant drugs are not better than active placebo (14); the consequence of this study is that these drugs not only have adverse effects but have no proven beneficial effect except for placebo. Thus, one can ask why they are still on the market and over 10% of the population were prescribed these drugs in 2008, in both the U.S. and Denmark (4). Another recent Cochrane meta-analysis of antipsychotic drugs showed that these drugs did not improve the patient's mental state; only the patient's hallucinatory behaviour was improved, most likely, because the patients were pacified and sedated by the drugs (i.e., made passive, obedient and cooperative, not better mentally) (15). Despite such evidence, however, about 5% of the population in the United States and Denmark is prescribed these drugs.

When reviewing the meta-analysis of the research, the conclusion was that "the drugs do not work" (16), or that they help one in 5-20 (The Number Needed to Treat, or NNT). In Denmark, the NNT have in recent years disappeared from all product information, both the one given to patients and to the physicians. This can only serve one interest: the interest of the pharmaceutical industry. At the same time, all complementary and alternative medicine (CAM) products (medicines and nutritional supplements) that have not been evidence-based have been banned and removed from the market. This amounts to the majority of CAM products, because there is little research on its effectiveness. No government agency or private research sponsor will pay to document the effects of these alternative options for management of illnesses.

Many practitioners of holistic medicine are now being prosecuted by the national health authorities in Europe for giving non-evidence-based medicine to their patients. It is correct that many of the holistic treatments are not well documented because of lack of interest in funding such research, such as looking at effects of massage therapy for chronic pain. In the Unites States, CAM remains popular with the general public. The amount of money spent on CAM was larger than the amount spent on biomedicine in 1990; however, in Denmark, only 10% of the health budget is used on CAM.

In socialized medicine, we have a very large, actually nationwide, highly authoritarian system. The physician's fundamental need for freedom to choose the most appropriate treatment method to help the patient is in many cases repressed as a consequence of this. A few powerful doctors came to define the treatment standard for all diseases in the whole country.

Much special knowledge is lost this way, and clinics and hospitals historically accumulated knowledge and competence are often forgotten because of the authorities' insistence on the "Nation's need to modernize health care"—even when the old methods did the job excellently, and the new methods are not yet sufficiently tested.

Socialized medicine gives, on the other hand, a health system that is strongly conservative when it comes to letting go of obsolete and in efficient drugs, when immensely strong, commercial interests support these. It sadly seems that a socialized medicine is much easier manipulated by the pharmaceutical industry, the lobbying made easy by the very small number of super-influential and powerful people you need to get to change attitudes and to impact the decisions of what physician's treatments are available everywhere in the whole country.

The top of a single huge pyramid gives very few people to go to for the lobbyists, and everybody knows who they are. In such a model, small players like researchers, therapists and intellectuals get little to say compared to powerful players backed up by big money and brutal economic force; the consequence is, as we have seen, that pharmaceutical agents become the dominant and almost the only model of treatment for the public.

Experience with more than 40 years of socialized medicine in Denmark has shown that the health of its citizens has not improved. Health does not come from pills but from healthy, positive attitudes, awareness with self-insight, sense of coherence (17,18), quality of life, good relations, and constructive behaviour in accordance with this. You cannot place the responsibility for health on society; it must be placed on empowered citizens. Only by empowering citizens to make the choice of what kind of medical treatment they want (i.e., drugs, massage, biomedicine, psychotherapy or CAM others) can true health emerge and not just profits for the pharmaceutical industry.

The dominance of the industry is well known from their cooperation with the large health insurance companies in the United States. The pharmaceutical industry contracts with powerful health insurance companies in the United States and regulates what drugs and pharmaceutical products physicians can prescribe for their patients. In our view, this is not in the best interests for the health of patients, though it is good for the profits of both the pharmaceutical industries and the large insurance companies.

The issue of limiting the management options for physicians is not improved with the socialized medicine model. In this system, the government is extremely sensitive to political pressure from lobbyism, and this determines what medications and other management options are available to physicians, instead of direct control by large insurance companies. This becomes even worse for the practicing physician, for if s/he does not obey the dictums of the government, resulting in loss of medical licensure and other punishments (i.e., fines, prison). This is already in place for physicians in the U.S., who face fines and prison if convicted of not obeying government rules on billing for patient services.

Discussion

In view of these comments, the question remains what model would curtail or end unhealthy pharmaceutical industry manipulation? We conclude that socialized medicine needs to be eliminated in its present form, as noted, for example, in Denmark. Health companies should

be prevented from dictating treatment options for physicians. The key is to make each citizen responsible for his or her own public health insurance account.

A mandate should be established where every citizen who can afford to have a public health insurance account is required to have one. Also, one's government should supply a public health insurance account to those citizens who cannot afford one.

When a citizen becomes ill, one or two independent doctors should diagnose the condition, while standard charges and reimbursements should be set for various treatments. The patient should be empowered to use these monies any way s/he chooses. For example, do we know for sure that a vacation trip is less healthy or less efficient than use of drugs for a patient with depression? Do we know if CAM and massage is better for chronic pain disorder than pain medications and surgery? Let the patient decide, let the patient make choices in his or her treatment, and allow the money for treatment to follow the patient's understanding of health and life. Incorrect and non-documented information advertisements should be banned. It should be illegal for the media to manipulate and misinform the citizens. Studies on CAM and holistic medicine should use chronic patients as their control group and encourage these studies to be acknowledged as accepted, scientific documentation. One should request the use of active placebos, and allow public access to all research data. One should request that the global quality of life (e.g., QOL1 or QOL5) (19) is always a control parameter, as this simple measure adds positive and negative effects to any treatment. The public should understand that the pharmaceutical industry has become too powerful, systematically giving us only the data and results that are in their commercial interests.

Most importantly, drugs should be banned that are shown to be ineffective. This is only possible to do on a national level, due to the political force of wealthy drug companies. If any government would try to ban chemotherapy, in spite of the use of chemotherapy never being based on evidence (as demonstrated by Abel) (12), the pharmaceutical industry is likely to fill the media with stories about people now dying because of lack of chemotherapy, and large fractions of the population will believe these anecdotal stories.

Regulation of the media is critical. By making it expensive for the media to tell fabricated horror stories about doctors and therapists killing their patients, it will regulate the pervasiveness of this message. Media that abuse their power in this way must be severely punished or banned altogether. The industry that pays for the media to tell these stories or that fabricates these stories must be held responsible for the false information they are purveying. Society needs laws to protect medicine, and we need a number of truly independent institutes that analyze cures and treatments for evidence-based outcomes. It is necessary to fight the dark and inhumane side of money, materialism and ruthless profiteering.

The solution to this dilemma in the U.S. of more money being spent on health care with a reduced healthy state of its citizens is to go beyond socialism and capitalism and consider them as obsolete poles in the development of a workable health care system. This is important in the search to create a truly intelligent and responsible culture in which a society can support its citizens to stay healthy. Society needs a sustainable world and also a sustainable culture. Either we solve this problem of medicine and health in our cultures, or we will collectively become too sick to take care of our irreplaceable ecosystem and our precious planet. The shift to a better and more awake world will not come by itself. We all need to work for this together.

Conclusion

Socialized medicine has failed miserably in its intention to keep the population healthy. Public medicine concentrates power and makes lobbyism easy; it empowers the pharmaceutical industry and weakens holistic as well as non-industrial medicine. It turns medicine into industrial biomedicine, and we have seen in Denmark how it has made half the population chronically ill. Socialized medicine has become a system that pushes drugs for treatment of illnesses in spite of lack of proof for their benefits and in spite of the adverse or unspecific negative effects of these drugs. A recent review of the literature showed that non-drug treatments might help half of the chronically ill patients get back to health in only one year (20). Good non-drug treatments that probably could help also the severely ill (e.g., patients with coronary heart disease (21)) are repressed and made illegal, and physicians can even lose their licenses if they don't comply and prescribe drugs.

The solution to the current crisis of the health care system is to empower the citizens. Everybody must be able to choose freely how to use his or her money for health care services. As people never expect to get ill, we cannot expect them to make their own savings, so it is wise to have a kind of public health insurance, so people have financial resources if they become ill. However, then we also need strong laws that ensure that the citizen can use the health insurance money according to his/her own individual philosophy of life and understanding of illness and health.

Commercials for drugs must always quote evidence, and independent institutes for evidence-based medicine must control the quality of documentation and compare all existing treatments for each disorder and health problem to ensure that the positive and negative effects of all treatments—both drug-treatments and non-drug treatments—are documented in the same way. Global quality of life and self-rated health must always be endpoints in documentation so adverse effects are included in the global effect measures to avoid the strong bias from what has been called "narrowness of worldview"—that you only include the factors you are interested in observing—that so many of the industrial studies of today suffer severely from in order to boost profits.

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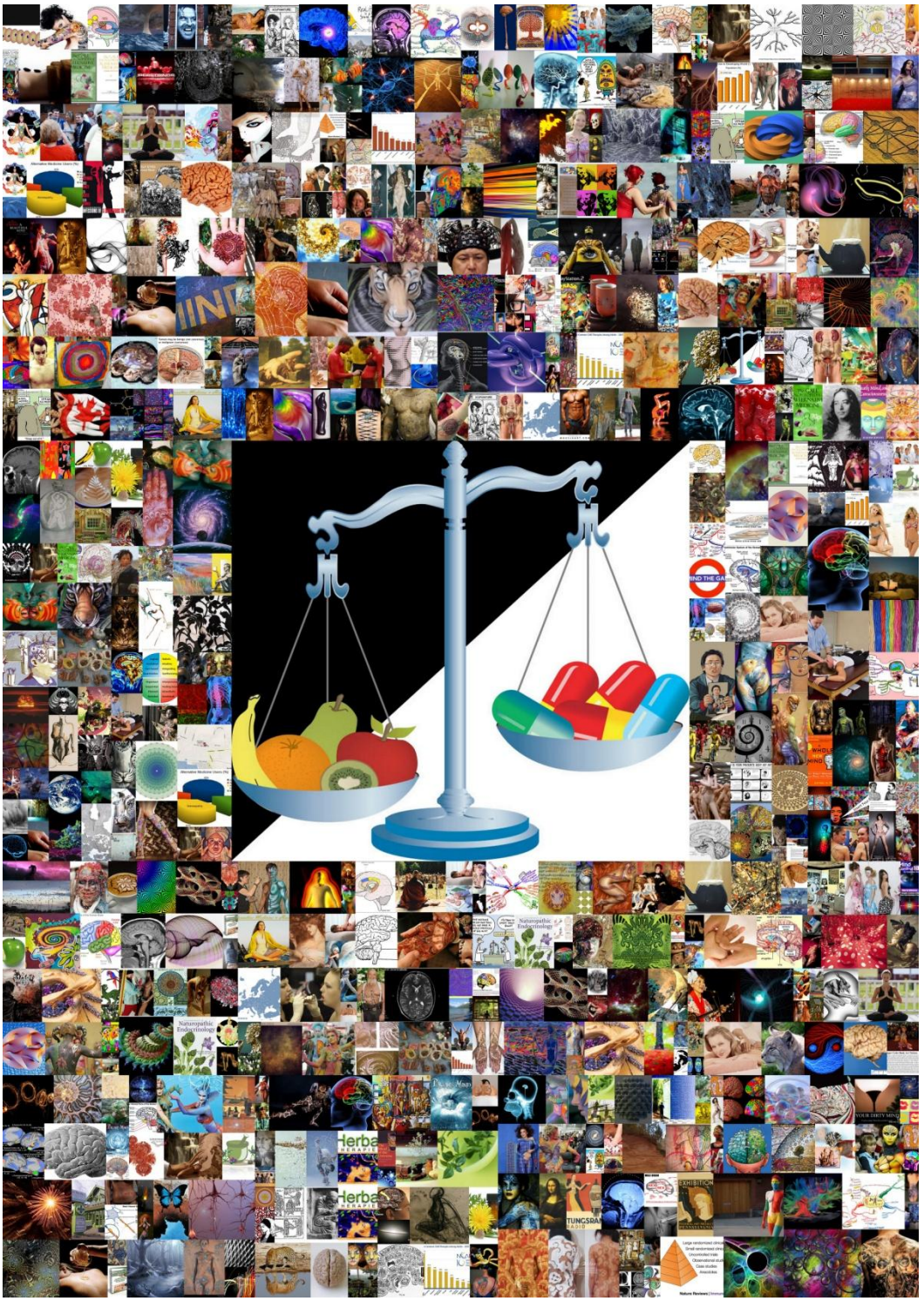
Exercises

1. In ancient China, the physician was paid by the patient when the patient was healthy. If the patient was sick, the physician had failed and should receive no money. Discuss the pros and cons of such a payment system.
2. Could a system with socialized holistic medicine work? Is it important that the citizen pays the physician him/herself, for the patient to remain responsible for own health?
3. Can medicine in principle be provided by the nation if it is about personal development?



Chapter XI

Effectiveness of traditional pharmaceutical biomedicine versus complementary and alternative medicine in a physician's general practice

When you make a scientific study on treatment effect, you normally work on a highly selected sample of already diagnosed patients. Patients you can give a simple diagnosis are rare. Most patients are complex beings with several interlinked health issues and a long history of health problems. If you see the patients coming to a general practitioner (GP), you will see that most of these patients are chronically ill people, who regularly visit the doctor, almost as a part of their lifestyle. They have often resigned in life, and accepted being chronically ill, unhappy and often also more or less socially isolated; a fair part are also unemployed. If they have a partner, they have severe sexual problems; if married, they have an old story of marital problems, infidelity, etc. So these are the patients we are trying to help with medicine. Reality is complex and a little more social-realistic than we like. Life is sour for a large fraction of chronic patients. And this sourness is the true cause of the disease they present. This is what we need to help them to get rid of if they are to get any better.

In this chapter, we want to show the reality concerning today's medicine. We are going to show you, from another angle, how hopeless it is to use pharmaceutical drugs to keep a nation happy and healthy. If you are tired of us giving you all these analyses, you might just jump on to section two. But some sceptical doctors believing firmly in biomedicine might need another "beating," before they let go of their well-established beliefs in only pharmaceutical drugs. So here comes our experiences from Denmark—a medical experiment on a national scale.

Holistic, complementary and alternative medicine (CAM) is non-drug medicine, where no pharmaceuticals are prescribed. CAM uses the placebo effect i.e., the patient's own consciousness and self-insight to heal: the examination is the cure. The only tools necessary are talking and therapeutic touch. A CAM treatment does not need a firm diagnosis, the treatment can start right away, and the treatment can be applied on all patients. Mind-body medicine, the most efficient type of CAM, cures according to a number of recent studies

about 50% of the patients in one year for physical, mental, psychological, existential and sexual health problems, and work-related problems can also be solved (NNT=2). CAM harms only one in 64,000 (NNH_{total}=64,000). In pharmaceutical medicine (biomedical drugs), the patients need to be ill, their illness needs to be diagnosed correctly and secondly to be curable with drugs and thirdly, patients need to be compliant with the treatment plan. Only one patient in 625 (True NNT= 625 (196-24,242)) and one chronic patient in 20,000 (True NNT=20,000 (333-200,000)) are being helped or cured in a biomedical general practice. In Denmark, every second patient receives a drug; as drugs harm one in three patients (total of side effects for most drugs: NNH_{total}=3), one patient in six visiting the GP is harmed. CAM is, compared to biomedicine, about 300 times as efficient and 10,000 times less harmful. We, therefore, recommend a shift towards non-drug medicine as the primary health service. All general practitioners must be trained in non-drug medicine.

Introduction

The last two decades has seen more research in holistic medicine (CAM) than the two preceding centuries. For the first time, we are, therefore, able to say something substantial about the efficacy and harm of non-drug CAM compared to treatment with biomedical drugs in general practice.

According to Hippocrates, the father of classical holistic "clinical medicine," *examination is the cure* (1). Together with the patient, the physician or therapist was responsible for examining and exploring the patient's mind, body, spirit, whole existence, and outer reality to help the patient get self-insight regarding his or her problems and "step into character" (2). The realization of one's own resources and talents helps the patient to return to a constructive, happy, and healthy state of being, where the patient creates value in all relationships by active, conscious use of all physical, mental, and spiritual talents. Basically, the idea of "clinical medicine" is to use *improvement of quality of life as medicine*, or more profoundly the rehabilitation of the patient's *sense of coherence* (3,4). In psychoanalytic language, this form of medicine is about integrating the repressed content of a patient's subconscious onto the patient's consciousness. In modern coaching language, this approach is about "personal development."

This kind of medicine is also known as "holistic medicine," "character medicine," "non-drug complementary and alternative medicine (CAM)," or "mind-body medicine." Only two tools are used for therapy: talking and therapeutic touch (5). Because the examination of the patient together with the patient is what brings the cure, practically every single patient can immediately be treated, which is extremely efficient in general practice (6-8). No diagnosis is needed. While many contemporary physicians find this approach less scientific, recent reviews have found that holistic mind body medicine is surprisingly effective (NNT=2(1-3)) (5-12). Most importantly, this number comes from *intention to treat analyses*, meaning that all patients entering the clinic with a problem are counted in the study. Holistic, clinical medicine has (13) been shown to be almost completely without side effects (NNH=64,000 (5-14). Comparatively, biomedicine has been estimated to help between one in five and one in fifty of patients, often one in twenty (NNT=20(5-50)) (15). Unlike holistic medicine,

pharmaceuticals have numerous side effects. When the likelihood of getting one side effect is counted, drugs often harm one in three patients (NNH_{total}=3(1-10) (16).

The real difference between biomedical drugs and holistic CAM lies in its practicality. As physicians, we all know that before giving a drug, we must be sure that the diagnosis is correct. Once we have correctly identified the diagnosis and determined the appropriate prescription, we need the patient to comply with the treatment, which is to take the drugs as prescribed.

Most patients cannot be treated without a long and complicated examination, involving dozens of biological tests (i.e., blood and tissue samples, expert evaluation of test results, etc.). In this chapter, we want to analyze the clinical significance of this complicated practice of biomedicine and compare it to non-drug CAM.

Estimating the true NNT for biomedicine from an intention to treat analysis of a biomedical general practice

About half the patients that come to a general practitioner (GP) in Denmark suffer from sexual, psychological, existential, or work-related problems that are not seen as physical or mental (psychiatric) health problems. Table 1 lists the major problems that brought new patients to our holistic medical clinic in 2004-2005 (17-22). From our experience in other general practices in Denmark, this seems to be the general pattern; at least every second patient shows up with a problem that is not related to a physical or mental health problem. For all of the patients who are not physically or mentally sick, there is little meaning in treating them with biomedicine and pharmaceuticals.

Of the remaining half of patients presenting with a real health problem, about two-thirds of them (or 33% of the total number of patients) presented with a chronic pain condition; only about one in six of these patients had an organic (biologic) reason for the pain (e.g., an infection), while most of these patients had pain with no known cause (e.g., low back pain from muscular tension, stomach pain from anxiety, primary vulvodynia, and tension head ache). These pain conditions are most likely to be psychosomatic (23-25), and they are not successfully treated with drugs.

Table 1. Patients' major problems (% of all major problems) (17-22)

	N	Relative %
Physical health issues	31	11.4%
Mental health issues	54	19.9%
Sexual problems	48	17.7%
Existential problems (related to general quality of life)	55	20.3%
Minor psychological problems (self-esteem problems)	43	15.9%
Working or studying problems	40	14.8%
Total	271	100.0%

About 25% of the whole Danish population has a chronic pain condition in spite of free socialized biomedicine (26). A substantial fraction of minor non-pain health issues that made patients visit the physician (e.g., constipations) also had obvious psychosocial causes; we estimate the number to be 50%. Of the remaining 25% of patients with physical health conditions, half of them presented wounds, influenza, and other small minor issues that normally would heal spontaneously. Treating these patients with pharmaceuticals would subject them to a risk of adverse effects with no therapeutic benefit.

Of the remaining 12.5% of the patients who could potentially benefit from biomedicine, about half of the patients were old and had a severe health issue that was known to be incurable with biomedicine, (e.g., metastatic cancer, coronary heart disease and dementia). The therapies used were palliative in nature not able to cure. Thus, biomedicine is normally of little help with this group of patients (16). Younger patients with diseases like arthritis often felt helped but remained chronic patients. We need to recall that most drugs do not cure but only improve some specific symptoms, while they also have adverse effects. Since the primary goal of medicine is recovery of health, these chronic patients should not be counted when we make a comparative study of the curing efficacy of CAM and biomedicine.

The remaining 6% of patients who had a curable health issue and actually needed treatment must have a correct diagnosis to be treated appropriately. It is well known (e.g., from autopsy (27-29)) that about 33% of all biomedical somatic diagnoses are wrong (see also 30-35); we also know that in psychiatry, the variation of the diagnosis from one psychiatrist to the other is about the same size. A precondition for a drug to work is that it is given on the right indication (30). False positive and false negative tests contribute to this, about 5% being false negative and 5% being false positive in most biological tests, reducing the possibility of a right diagnosis further by 10% (36).

Of the about 4% of patients who are diagnosed correctly, about 10% are given the wrong drug or the wrong dose (37). Of the remaining 3.6% of patients, about one in two do not comply with the treatment regime (38-43), reducing the number of patients who can be helped by biomedicine further to 1.8% of the total number of patients (see Table 2 for the exact estimate). Now we need to look at the number needed to treat (NNT), and with a mean NNT of 20, we know that only 1.8%:20=0.09% of patients are likely to be cured by biomedicine.

Based on this intention to treat analysis, we have the True NNT = 1000 for biomedicine (outcome: “Cured”), while True NNT remained two for non-drug CAM (outcome: “Cured"). The same number for the outcome “improved, not cured” is about 500 for biomedicine and one for the most efficient types of non-drug CAM (5)! The observant and ethical physician who makes this analysis for each patient will only give drugs to the 2% that really needs them; but this is not how drugs are used in Denmark in general. Estimated from numbers of patients visiting the physician each year and the prescription of drugs in Denmark, it seems that at least every second patient gets drugs from his or her doctor (drugs like contraceptives not given as treatment excluded). When we have a NNH=3 we know that one in six, or 17% of all the visiting patients, are harmed by the pharmaceutical drugs.

When we analyze the True NNT and True NNH on an intention to treat basis for biomedicine and holistic non-drug CAM, we find for biomedicine: True NNT=1,000, and True NNH=6, while for non-drug CAM we find: True NNT=2 and True NNH=64,000.

Table 2 shows how this analysis varies according to the different sources. The most optimistic estimates give a True NNT for biomedical general practice of 100 (1% of patients

cured or improved), while the most pessimistic estimate is 500,000 (0.002% of patients cured or improved). A moderate estimate gives True NNT=1,000, or one patient out of 1,000 cured or improved.

The "dilution" of biomedical efficacy is well illustrated this way, using the moderate numbers established in Table 2: First about 50% of the patients coming to the GP is not physically or mentally ill but suffering from social, financial, sexual, psychological, spiritual or existential problems.

Half of the ill patients are suffering from psychosomatic or developmental problems (i.e., psychosomatic, non-organic pain). Of the 25% of patients left, half of these are ill with a disease incurable by biomedicine, leaving 12.5% to be cured with drugs. Of these 12.5%, a substantial fraction is wrongly diagnosed, presumably about 50%. Of the correctly diagnosed remaining 6.3% of patients, about 50% does not have compliance. Of the about 3,1% that are compliant, only one in 20 (NNT=20 (5-50)) are cured or improved, meaning that only 0.16% are cured, or about one in thousand.

Table 2. Analysis of True NNT for *all patients* (outcome: "Cured") in general practice with the variation that comes from the different sources. "Minimum estimate" is the most optimistic and "Maximum estimate" the most pessimistic estimates from the different sources, calculated relative to the relevant group. Taken all together, this sums up to a factor 100, clearly indicating our lack of precise knowledge in this area

All patients coming to the GP	Absolute Fraction(%) of visiting patients	Relative. Fraction (%) Maximum estimate	Relative. Fraction (%) Fair estimate	Relative. Fraction (%) Minimum estimate
Patients not physically or mentally ill but suffering from social, financial, sexual, psychological, spiritual or existential problems.	50.0%	67%	50%	33%
Patients ill from psychosomatic or developmental problems (i.e., psychosomatic pain)(non organic).	25%	75%	50%	25%
Patients ill but disease incurable by biomedicine.	12.5%	90%	50%	50%
Patients ill, curable but wrongly diagnosed 6.25%.	6.25%	67%	50%	33%
Patients ill and curable, correctly diagnosed, in need of cure but without compliance.	3.13%	90%	50%	40%
Ill patients, curable, in need of cure, correctly diagnosed and compliant.	3.13%	0.001%	3.13%	10.1%
Patients cured or improved by biomedicine (NNT=20 (5-50)).	0.16%	$2x10^{-4}$%	0.16%	0.51%
True NNT (Outcome: "Cured" or "improved").	625	24.242	625	196

Table 3. Analysis of True NNT for *chronic patients* (outcome: "Cured") in general practice for chronic mentally or physically ill patients. "Minimum estimate" is the most optimistic and "Maximum estimate" the most pessimistic estimates from the different sources, calculated relative to the relevant group

Chronic patients coming to GP	Absolute Fraction(%) of visiting patients	(Relative. fraction)% Maximum estimate	(Relative. fraction)% Fair estimate	(Relative. fraction)% Minimum estimate
Patients chronically ill but disease curable by biomedicine.	10%	5%	10%	25%
Ill patients, curable, correctly diagnosed.	1%	5%	10%	50%
Patients ill and curable, correctly diagnosed, in need of cure but without compliance.	0.1%	5%	10%	50%
Ill patients, curable, in need of cure, correctly diagnosed and compliant.	0.1%	0.001%	0.1%	6.2%
Chronic patients helped or cured by biomedicine. (NNT=20 (10-50))	0.005%	$5.0x10^{-5}$%	0.005%	0.3%
True NNT (Outcome: "Improved" or "Cured").	20.000	200.000	20.000	333

Table 3 presents the same analysis for chronically physically and mentally ill patients. Of these patients, a substantial fraction has been incurable by biomedicine, as all patients have been treated with at least one and often ten different pharmaceutical drugs. The likelihood of the next drug being efficient is, therefore, small. It is very likely that 90% of these patients never will be helped by a drug. Of the patients that are curable, a large majority, presumably 90%, have been wrongly diagnosed, and as these diagnoses often follow the patient, the diagnosis is not likely to be correct in the future. This leaves us with 1% of patients being curable and correctly diagnosed. Sadly, most chronic patients are severely dis-encouraged; they often start doubting in the doctor and losing hope, and their compliance is bad, falling down to presumed 10%. Finally, the NNT for this group is presumably much lower than for the normal patients (NNT=50?), but as we don't have numbers, we use the NNT=20 here also in our calculation. We find that only 0.005% or one in 20,000 (True NNT=20.000) of the chronic patients are helped or cured by biomedicine—which is why they are chronic and most often stay that way for their whole lives.

Discussion

We are making an important analysis in an area where there is little knowledge. We are using estimates and data of limited quality, but in spite of this, we have been able to complete the analysis and obtain a result that we find to be trustworthy. It might be that a more accurate

analysis shows a different result, but we find it most likely in that case to be a much smaller number of patients that are helped by biomedicine.

There are some kinds of CAM that are ineffective (5), so we recommend that mind-body medicine, which seems to be the most efficient kind of CAM, be used as reference in such studies. If you use ineffective CAM, you can always show that biomedicine is effective. This is precisely what has happened in the test of biomedicine versus placebo, where the placebo effect intentionally has been reduced to zero in industrial trials (44), with elimination the most important element of placebo: the close relationship between the physician and his patient (45). Non-drug CAM is nothing but placebo used effectively, and it cures one in two patients, even for coronary heart disease (46,47). So we need to respect this traditional kind of medicine.

We have defined the therapeutic value TV as NNH_{total}/NNT; estimated from this, we have TV= 3/1000=0.003. Compared to this, the therapeutic value of holistic clinical medicine (non-drug CAM) is thus around TV= 64.000/2=32,000, or 10 mill as high.

The calculation of Therapeutic Value (TV) clearly shows the difference in value between the two different types of medical interventions, biomedicine versus non-pharmaceutical CAM. In the last chapter, we claimed that non-drug medicine was 1,000,000 times as good as drug medicine. In this chapter, we raise the bar to 10,000,000.

If we just look at the positive effect, we found that while clinical medicine helps one in two patients, biomedicine in general practice helps only one in 625 (True NNT= 625 (196-24,242)) patients. If the patients were chronically physically or mentally ill, these numbers fell down to 20,000 (True NNT=20,000 (333-200,000)). As at least every second patient was treated with a pharmaceutical drug (NNH=3), we know that one in six of these patients had an adverse effect, meaning that about 100 patients are harmed for one patient to be helped or cured (Therapeutic Value TV=NNH/NNT=0.01).

In general practice, CAM helps or cures one in two and is thus about 300 times more effective than biomedicine. When we look at the negative effect of drugs, we find that True NNH_{total} for biomedicine is about six, and for CAM about 64,000 (13). Biomedicine is thus 10,000 times more harmful than non-drug CAM. One in six of the patients going to a biomedical general practitioner in Denmark is harmed, while one in 64,000 going to a holistic general practitioner in Denmark is harmed.

When we compare this to the patients helped, we see that biomedicine in reality helps almost nobody, while it harms a large fraction of its patients, whereas non-drug CAM helps half the patients and harms practically nobody. This is why we recommend that non-drug CAM is the practice of choice for all patients, and only when CAM cannot cure the patients, should pharmaceuticals be tried.

If we presume that the price of biomedicine and CAM is about the same, we can tell that non-drug CAM gives about 300 times as much health for the money, without harming the patients, which also is costly (consistent with more detailed analyses (9,10,48)).

We also easily understand why half the Danish population remains chronically ill in spite of free, socialized biomedicine: The drugs simply don't cure them. Biomedicine cannot keep a nation healthy. We, therefore, recommend that all nations shift their primary health care to holistic, clinical medicine, where talk and therapeutic touch are the primary medical tools. All general practitioners should be trained in holistic clinical medicine, the original type of medicine, highly successful ever since the days of Hippocrates 400 BCE. Drugs should only be used when non-drug interventions fail to help.

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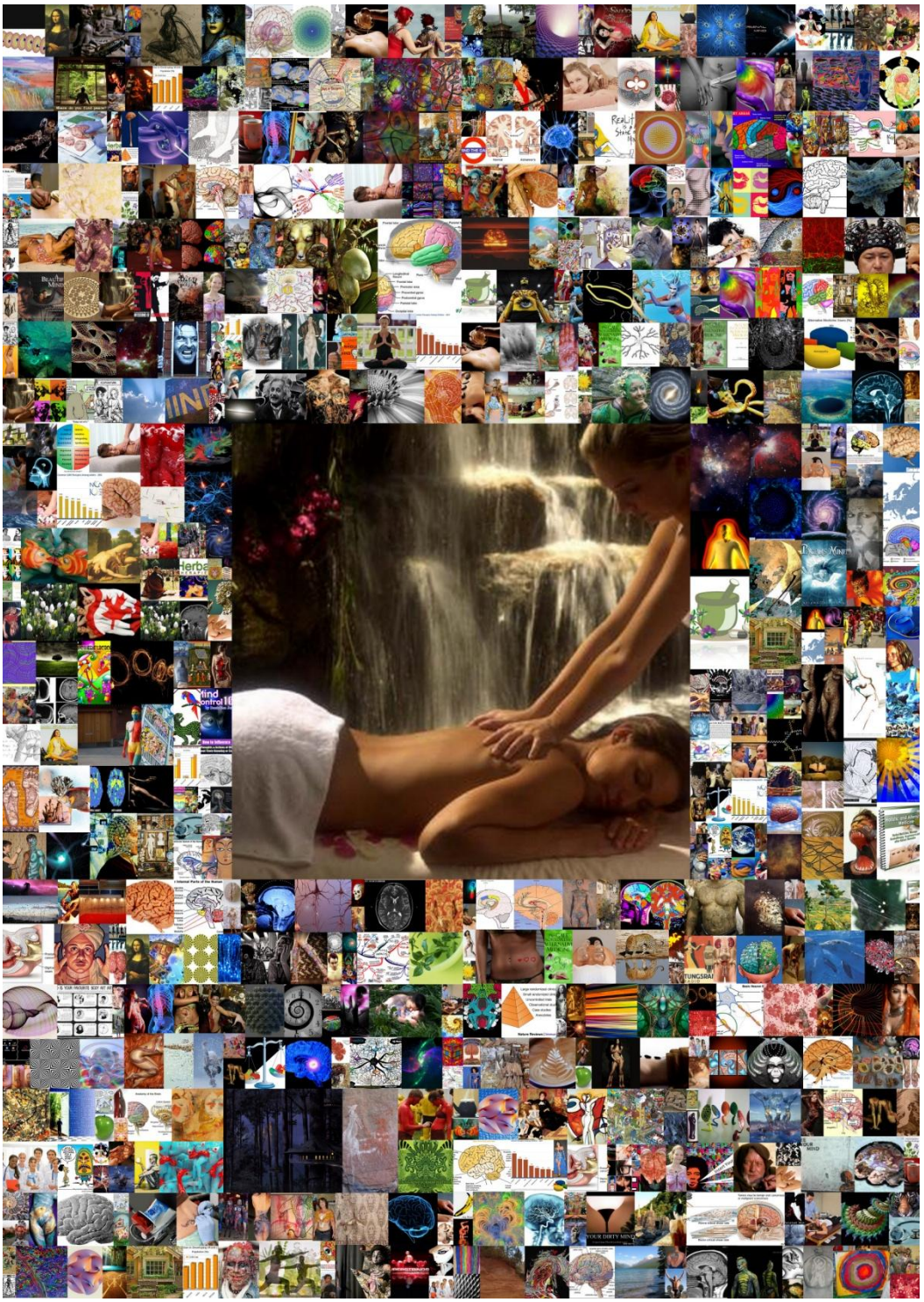
Exercises

1. In this chapter, we found the Therapeutic Value of non-drug medicine to be 10,000,000 than of drug medicine. What can be criticized regarding the way we have calculated this result?
2. Therapeutic Value is not an established concept in biomedicine, as most drug companies to not want to compare harm and benefits of the drugs in this way. Find all the arguments that you would use if you had a pharmaceutical company and would like to market a drug.
3. Discuss the truth in the sentence "A therapeutic benefit is often worth more than a dozen adverse effects."



Chapter XII

Factors influencing the therapeutic decision-making

We have in the former chapters talked about the complexity of health problems, which follows from the fact that human life itself and the reality that modern human lives are really complex. So complexity is in general what we have to deal with, if we want to help troubled people.

Biomedicine always tried to make things simple. The ideal situation is that we can give the patient a diagnosis like syphilis or meningitis, which is caused by certain microorganisms that can be killed with penicillin or a similar antibiotic. Here, the intervention is simple and rational: give the drug, kill the germ, and cure the patient.

Holistic medicine is never simple. There is almost always a whole spectrum of problems, and a classical strategy is to work with a whole spectrum of aspects in order to improve life. Then again, this can be turned into a rather mechanical and simple strategy—check diet, lifestyle, attitudes, philosophy of life, social family situation, etc., and change whatever needs to be changed. This is the famous "spectre strategy" that has made Dean Ornish successful.

Human interaction is always extremely complex, if you analyse in all details what is really happening. The trickiest thing about being human is that we are beings of emotions and even sexuality. To be a holistic health practitioner, you need to accept complexity and learn to swim in the ocean of chaos. Surprisingly, we have intelligence faculties that makes this possible, but faculties that we often do not learn to use during school and academic training.

This chapter is about letting go and starting to be this joyful dolphin having fun in the sea of unpredictability and change. For us, a great practitioner is able to deal with all kinds of human problems and is able to use all existent tools in his or her practice. Knowing a lot of tools, like different styles of talking and therapeutic touch, will give you a lot of possibilities. The difficult part is to find the right tool you will use. The tools will be described in the later sections of this book.

Here and now, we want to make you understand why you will want to learn to use so many different tools so that you always have something to do, in every single situation you will meet in the clinic. The most difficult choice is when to use the sexological tools, as almost all chronically ill patients also will have sexual problems.

We consider the classical holistic medicine, psychiatry and sexology to be a part of the Hippocrates holistic medicine. Most of the sexological procedures used in manual sexology,

like the sexological examination, were in some form described in the classical textbooks of Hippocratic medicine. Both modern sexology and modern holistic psychiatry acknowledge these ancient roots and share the same close relationship to the contemporary scientific holistic medicine. Actually 2,400 years ago, psychiatry and sexology were not two disciplines but only one; the mental disorders of the female was under one category called "hysteria" from Greek Hystera, uterus. Hysteria was caused by energetic malfunction of the female genitals. This is hard to understand for modern biomedical psychiatrists that do not operate with this energy, but it is very similar to Indian and Chinese medicine, where the existence of psychic energy is an inherent part of the philosophical system describing the disorders.

Holistic medicine is different from many types of alternative and complementary medicine (CAM), as it focus on the *whole person*, body, mind, spirit and heart together with the person's *character, life mission and sense of coherence* (SOC) with the surrounding world.

Modern, scientific holistic medicine is built on holistic medical theory, on therapeutic and ethical principles. The rationale is that the therapist can take the patient into a state of salutogenesis, or existential healing, using his skills and knowledge. The formal distinction between holistic medicine, psychiatry and sexology is a very recent development; in the original holistic medicine, the whole existence was cured independent of symptomatology. Mental, physical and sexual problems were all treated almost alike.

However much we want to make therapy a science, it remains partly an art, and the more developed the therapist becomes, the more of his/her decisions will be based on intuition, feeling and even inspiration that is more based on love and human concern and other spiritual motivations than on mental reason and rationality in a simple sense of the word.

The provocative and paradoxal medieval Western concept of the "truth telling clown," or the Eastern concepts of "*crazy wisdom*" and "*holy madness*" seems highly relevant here.

The problem is how we can ethically justify this kind of highly "irrational" therapeutic behaviour in the rational setting of a medical institution. We argue here that holistic therapy has a very high success rate and is doing no harm to the patient, and we encourage therapists, psychiatrists, psychologist and other academically trained "helpers" to constantly measure their own success-rate.

This chapter discusses many of the important factors that influence clinical holistic decision-making. The holistic theories of mental disorders still have deep roots in sexuality; many psychoanalysts from Freud to Reich and Searles have believed that sexuality, or Eros, is the most healing power that exists and also the most difficult for the mind to comprehend. To deal with the seemingly irrational elements of therapy, such spiritual and erotic elements have been named the "crazy-wise" tool of therapy.

Introduction

Four hundred thousand Danes used CAM (complementary and alternative medicine) in 1990, which is holistic and alternative medicine (defined as non-biomedical complementary, alternative, integrative or psychosocial interventions for medical purposes). This increased to 800,000 by year 2000 (1), and is expected to be 1,600,000 as we write this book. If the development continues, as it has done in the United States already, there will be more CAM

consultations than biomedical consultations in Denmark by year 2020. One of the fastest growing areas of CAM in the whole Western world is sexology, presumably reflecting both a liberalisation of society and an increasing rate of severe sexual problems in the population.

In spite of all this activity, the effect of CAM in general is still not clear at all. This is primarily because the term now refers to hundreds of treatment systems focusing on some aspects of "the whole patient" and not primarily on symptoms or diseases, as is normal practice in today's mainstream biomedicine (pharmacological medicine).

What works in holistic medicine is healing of the patient's existence, called "salutogenesis" by Aaron Antonovsky (1923–1994) (2-9). This is most often done by creating a deep shift in the consciousness of the patient towards a more positive and constructive attitude towards self, including body and mind, other people, and the world at large. The reason for the medical efficiency of such a shift towards positive attitudes and behaviours seems to be that consciousness is the primary determinant of global quality of life (QOL), health and ability in general (10-14). Because of the appreciation in the causal power of consciousness, many physicians and therapists are now focusing on this important shift in the patient's consciousness as their primary goal in treatment when they want to improve QOL, health, and ability of the patient. This focus has caused the emerging field of scientific holistic medicine, i.e., "clinical holistic medicine" (15-55).

We have been able to document that such an approach can help every second patient in the patient's own experience—with physical illness and chronic pain, mental illness, low self-esteem, sexual dysfunction, low quality of life, and low working ability (56-62). Interestingly, we tested the holistic therapy on patients that could not be helped by their doctors with the standard treatment (drugs), and many of the patients had had their chronic conditions for many years. This indicates quite a powerful effect of scientific holistic medicine. The clinical decision-making was guided by many sound and rational theories and principles, but the different treatments took so many different routes that we literally invented a new cure for every new patient, leaving us with a need of deep reflection on what really is happening in the therapy. What are the "unpredictable" factors that are so radically influencing the therapist's decisions, when not the rational principles of healing and therapy themselves? From where comes the surprising creativity in the session that in the end seemingly sets the patient free?

The therapeutic principles

Since Hippocrates, holistic healing has been guided by medical principles (63). The better the holistic therapist knows and understands these principles, and the more fluent he is in using them, the more efficient will the therapy be and the more lasting the results. Holistic therapy uses primarily four core principles of treatment (56) (a fifth principle been the ethical principle "First do no harm"):

Induce healing of the whole existence of the patient (salutogenesis) and not only his/her body or mind (2-9). The healing often included goals like recovering purpose and meaning of life (64-72) by improving existential coherence (71) and ability to love, understand, and function sexually (67).

Adding as many resources to the patient as possible as the primary reason for originally repressing the emotionally charged material was lack of resources — love, understanding,

empathy, respect, care, acceptance, and acknowledgment — to mention a few of the many needs of the little child (17,49,68). The principle was also to use the minimal intervention necessary by first using conversational therapy, then additional philosophical exercises if needed, then adding bodywork or, if needed, adding role play, group therapy, and finally when necessary in a few cases, referring to a psychiatrist for psychopharmacologic intervention (49). If the patient was in somatic or psychiatric treatment already at the beginning of the therapy, this treatment was continued with support from the holistic therapist.

Using the similarity principle (see 56 for references) that seems to be a fundamental principle for all holistic healing (63). The similarity principle is based on the belief that what made the person sick originally will make the patient well again, when given in the right, therapeutic dose. This principle often leads to dramatic events in the therapy and to efficient and fast healing but seems to send the patient into a number of developmental crises that must be handled professionally (50-52).

Using Hering's Law of Cure (see 56 for references) to support the patient in going once again through all the disturbances and diseases, in reverse order, that brought the patient to where he or she is now. Other important axioms of Hering's Law of Cure are that the disease goes from more to less important organs, goes from the inside out, and goes from upside down. The scientific rationale for the last three axioms are less clear than for the first: The patient must go back through his/her timeline in order to integrate all the states and experiences he/she has met on his/her way to disease. Going back in time is normally done though spontaneous regression in holistic existential therapy.

These four principles seem to be a lot to keep in mind when you are practicing therapy, but you will soon learn that they are all aspects of the same fundamental principle, the abstract law of integration—everything too emotionally intense in your patient's life must be felt again, recalled and understood, and finally "melted" into the patient's own, natural understanding of life and being. This is the same as the patient returning to being him- or herself. So in this respect, everything gets simpler as you get more experienced as therapist. Get your patient back into contact with the world through body and mind, heal the patient's psychoform and the somatoform dissociation, restore the patient's sense of coherence, and you are home free. But in practice, therapy develops paradoxically more and more complex and more and more simple at the same time—more and more complex for the therapist's mind, and more and more simple for the therapist.

What is a decision?

One rational way of understanding the development of a treatment of a patient is as a series of rational choices, each one serving the purpose of using tools for healing the patient's life. This is a nice idea, and highly popular with academic thinkers. Unfortunately, most choices in therapy are not based on ratio and reason but on emotions, feelings, sensations and intuitions. This is because we are dealing with emotions. Therapy is about integrating difficult emotions. But still there is a consciousness and a will guiding these choices.

Philosophically, in the grand tradition of existentialistic thinkers, every person has free will and from that, free choice (73,74). Choice is a consequence of the presentation in our

human consciousness of more than one alternative for future action. The more conscious we are, the more alternatives will be acknowledged by our self, the wiser the choice, and, thus, the bigger the power and influence of the choice on our future destiny.

In the existentialistic philosophy of Søren Kirkegaard (1813-1855), we are divine beings empowered to create our own destiny, good or bad. The empowerment comes from man containing in his innermost existential core the possibility to connect to the universe, and from this connection in each situation draw the wisdom to make the good choice. When we lose this connection to the universe, we lose our existential orientation, and we fall into darkness and random choices, leaving responsibility for our life and relationship behind.

Sigmund Freud (1856-1939), Carl Gustav Jung (1875-1961) and their students elaborated on this further, defining the subconscious and the repression of emotions and sexuality, giving the science of psychodynamic therapy (75,76). Antonovsky gave, in the 1980s, his theory of "sense of coherence" (2,3), which stated that the healthy person has a sense of coherence—inwards towards life and inner self making him alive, and outwards towards the world, making him real. Being alive and real is what a sound person is, and loss of health is loss of the sense of coherence making the person emotionally dead, mentally delusional, and spiritually aloof.

Recent developments in research on therapy have identified that this sense of coherence has two main vehicles, the mind and the body. The sense of coherence can be lost in part when one of our two channels to the world shuts down, either as somatoform or psychoform dissociation.

Or both these vital channels can be closed leaving the patient without any real contact to the outer world, in a severely ill state, often suffering from both mental, existential, physical, sexual problems and illnesses.

Rehabilitation of the connectedness to life and to the world, i.e., rehabilitation of the sense of coherence, is also the rehabilitation of the patient's life, power, wisdom, and freedom of choice. This total healing of the patient's existence, the existential salutogenesis, is the primary intention in scientific holistic therapy; this fundamental shift from not being into being seems to be the central theme of the works of Kierkegaard on "hjælpekunst" (Danish: the art of helping) and the focus of the old holistic medical tradition going all the way back to Hippocrates, who calls his noble medical art of helping and healing for "the art" (63).

In practice, the therapist will make many choices in each treatment, but as the fundamental problems of revitalisation and existential rehabilitation in holistic therapy are pretty much the same with each patient, the choices seem to repeat themselves. The uninspired, experienced therapist will tend to take therapy into a boring and non-productive state of mechanical repetition, which is a dead end for therapy. When routine and dullness takes over, the love dies; the investment of the therapist's libidinous energy in the relationship with the patient is closed down; and what is left is the remote and formal relationship. The experienced, but inspired, therapist will move in the complete opposite direction, into a state of being where there are almost no choices left but just a stream of consciousness and dancing libidinous energy, in which the whole therapeutic setting and therapeutic process is embedded.

The therapist as the tool

To be in flow (77), to be conscious (78) and to be happy (in the state of sat-shit-ananda: present, knowing and happy) seems to be the holistic therapeutic ideal of a human being; this can be further developed into non-knowing (cp. Zen: "state of no mind"), just being dancing with the patient's consciousness in a state where all decisions are not made, and the action never becomes a problem. This is the intuitive state of the experienced holistic therapist, coming from love and being completely in service of his patient.

Holistic therapy and the process of existential healing is unwrapping the personal history of the patient, sending him back to heal all wounds on body, mind and soul, rehabilitating the "natural philosophy" of the patient and understanding the life that best serves his character and purpose of life.

Unfortunately, every therapeutic action is intensively impacting the philosophy of life of the patient, actually implanting philosophy in the patient; this philosophy must be de-learned for the natural philosophy of the patient to emerge.

The holistic therapeutic principles include the most important principle of similarity; the patient will have to transfer his past into the present and transfer the emotional charges of his childhood traumas on the therapist. Without this actualisation of the past, the therapy cannot work, as was already noticed by Freud.

As we are transferring from both our bodily (emotional, sexual), and mental (philosophical, energetic) and spiritual (consciousness, love) realms, holistic therapy is often extremely complex and much too complex to monitor by the therapist brain-mind. The body-mind (instinctive domains) and spirit-mind (intuitive domains) must be strongly involved for the therapist to be effective and successful as a healer.

The most important thing in holistic therapy is the state and quality of the tool (oneself as therapist), and personal development to a state where unconditional love to all human beings is natural, a sine qua non; unfortunately, most therapists reach this level late in life, if the therapist's own therapy is not intensified and buddhahood (enlightenment) actively pursued.

Only in the state of unconditional love can the therapist be pure or unselfish and coming from his heart in order to give service. Only love allows the therapist to use all aspects of himself without hesitation to help the patient to heal his existence. Only another person's true love can set a tormented soul free, and that is what holistic healing is all about. And when you love, most choices are easy, because your personal interests are suspended, and all that matters is what best can help your patient.

When the patient feels your love as a therapist, he or she will let go of the neurotic control that for survival reasons has replaced responsible conscious being, and the existence will heal and re-emerge.

The philosophy of life of the therapist

Holistic, existentially oriented, therapy is basically about re-interpreting life and, through a more containing philosophy of life, being able to integrate past events. The expansion of the patient's philosophy of life is done by consciously or unconsciously implanting a more accepting and loving philosophy of life in the patient.

This is done through the body language of the therapist, the way the clinic is decorated, the quality of therapist's awareness, the concepts used, the attitude in the meeting, the nature of the therapeutic contract, the methods and technologies used, and, of course, primarily by the inspiration coming from meeting on a regular basis with a (hopefully) more sound and higher developed person than the patient him- or herself. Even if the relation is equal, holistic therapy can only work if the therapist is empowered by the patient, by the patient's illusion of the therapist being in some aspects wiser and superior—because most traumas and philosophical misunderstandings come from the patient's childhood, and the therapist must substitute the parent(s) to make the healing happen.

The therapist's own philosophy of life, therefore, becomes of crucial importance, and the more evolved and deep-sighted the therapist's philosophy is, the more efficiently he can plant the containing philosophy. Truthfulness and honesty about the philosophical implantation will ease the process of de-learning the philosophy in the final stage of therapy. When the therapist is honest, the patient will suffer, and this suffering is the patient's meeting with reality that in the end will restore sense of coherence with the outer world. The loving acknowledgment will support the patient in rehabilitating the sense of coherence inwards towards life and the deeper existential and spiritual layers (the "soul"). It is, therefore, helpful for the therapy that the therapist has values such as honesty, openness, directness and compassion as a part of his actively worded philosophy.

Understanding the therapeutic process

The processes of healing the existence are quite predictable and in an abstract sense always the same (see Figure 1). The movement is from the body (holding the repressed material) to the mind (denying responsibility by negative philosophy of life) to the spirit (the original cause of the problems by the historic unwise choices of the original, spiritually awake being). In the process of healing, there are obligatory developmental crises, which the patient must go through to rehabilitate ability of love, to understand and to be in a sexual body. The better the therapist understands the process and the nature of the crisis, the better the patient's resistance and problems can be handled in the therapy.

Many patients in intensive therapy experience the healing as a series of phenomena or breakthroughs and existential crises with characteristic content. The most intense crises are metaphorically called the "psychotic," the "visionary," and the "suicidal" crises. They include feelings of going insane, not knowing the world or oneself, and wanting to die. Knowing what is coming next in the course of therapy is of great help to the patient, making it much easier to confront and integrate the often extremely intense, painful emotions and states of being arising from integrating the early childhood traumas.

The 12 steps (see Figure 1) are some possible steps in the process of healing and human transformation, understood though an ancient and powerful metaphor as the steps of "human metamorphosis" (52).

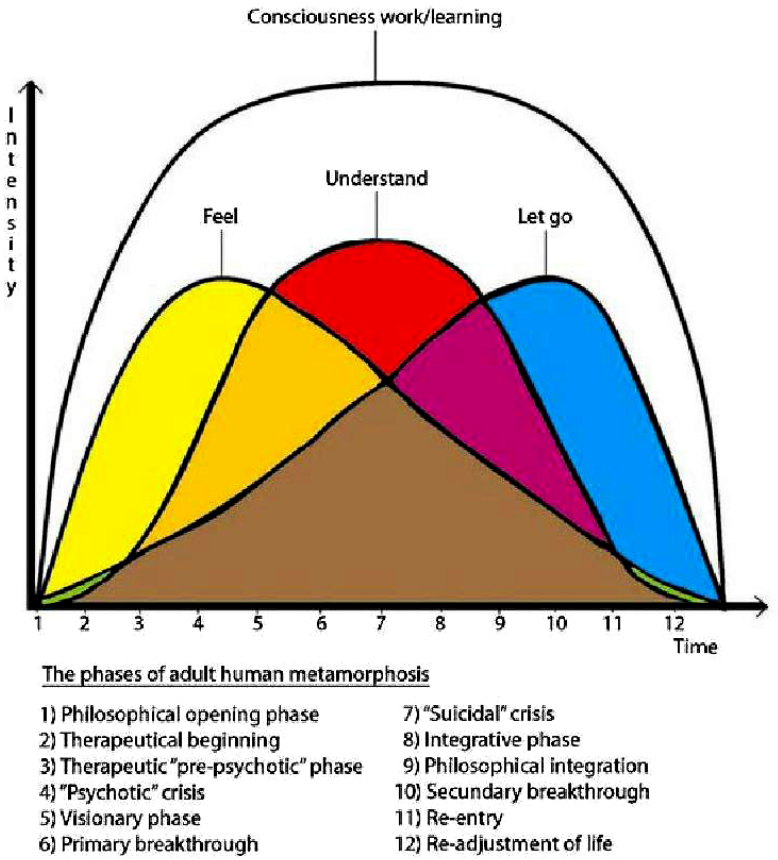


Figure 1. The process of holistic healing seen as three phases of feeling (yellow), understanding (red), and letting go (blue) of negative beliefs, attitudes, and decisions. As an end result, the process was improving the patient's philosophy of life and thus allowed the patient to rebalance existence and to assume responsibility for life. During the process, the patient's will re-established quality of life, health, and existential coherence, along with the ability to love, understand, and enjoy the whole spectrum of feelings and emotions, including sexuality.

Understanding health and disease

The human being consists of body, mind and spirit, and many of the energies are going though all aspects of the human being, like sexuality, meaning, and sense of coherence. The highly complex construction of the human being through billions of years of evolution and the limited ability to represent complexity in the brain-mind, the brain after all just being a small part of the human being, makes understanding health and disease one of the most central problems and most crucial issues in holistic therapy.

The modern holistic therapist must know a wide range of sciences from physics, biochemistry and biology, to medicine (anatomy, physiology, pathology), psychology, philosophy, and sociology. At the same time, the therapist must be trained in art and literature, and he must also be deeply involved in the project of self-exploration to develop a deep and thorough understanding of all aspects of self—from sexuality to spirituality.

The training and education of a holistic physician thus never ends. And many therapists get exhorted in the process of assimilating all existent scientific knowledge and end up feeling insecure and insufficient. The temptation of closing one's view down to a specific therapeutic system with specific tools is big, but holistic medicine can newer work if the doctor himself is not the tool. The person cannot be substituted with procedures or machinery. Many therapists end up not working holistically but just practicing some procedure and techniques mechanically, without the therapy healing existence and giving lasting effects.

Hermeneutic problems

The most fundamental problem of working professionally with induction of shifts in consciousness are the hermeneutic problems: that what we believe will be our reality. The reason for this is that our reality is a materialisation of our consciousness (79). Therefore, we will always find confirmation for our beliefs in reality, in spite of our beliefs being in deep conflict with life itself and with the larger world. This problem makes it a necessity for the holistic therapist to be involved in a spiritual practice to develop consciousness.

Awareness of planting philosophy of life in the patient is a condition for de-learning the philosophy in the end of the therapy. Not doing this leads to all the problems with dependence between therapist and patient, extended therapeutic courses with no progress lasting up to many years, and the famous problems of implanted memories, known from the trials where the family sues the therapist for implanting incest-memories—such "fake memories and ideas" are just the events of the patient's personal history, interpreted though the "glasses" of the implanted philosophy, lasting after therapy because of lack of philosophical de-learning.

Supervision

The quality of the holistic therapist's choices is, because of hermeneutic problems, completely dependent on second opinions; Balint group work and supervision is mandatory. The therapist must work in his own therapy with the existential problems that continue to be revealed, because of a mirroring effect from the patients into the therapist—the famous process of counter-transference.

We have identified (71) nine key dimensions of existence, which exist in a passive and an active form, corresponding to the dimensions related to being and doing of life (see Table 1).

Interestingly, as a person develops, the nine areas merge completely; every part of existence becomes conscious, filled with love, meaningful, joyful, enlightened, purposeful, urge-driven, ecstatic and coherent, as all parts of existence expands into the neighbouring areas. This expansion of all existential areas is the project of personal development, such as sex expands into the consciousness and love expands into sexuality, we have the classical art of sexual tantra (see "the path of tantra" (reference 71, Figure 4), which is integrating sex and consciousness). One by one all, the splits and participations that torment modern man heal in this process of existential integration. Existential healing is, therefore, the primary goal of personal development (2,3).

Table 1. Nine key dimensions of existence, which exist in a passive and an active form, corresponding to the fundamental dimensions of being and doing of life

	Active form	Passive form
1. Coherence, the web, the nest of the world	Receiving, taking in	Being an integrated part
2. Intent/purpose of life	Intention, decision	Having a purpose (of life)
3. Talent/strength	Using skills and urges	Having strength and structure
4. Consciousness	Noticing, knowing, understanding, planning	Being awake
5. Love	Acting in love	Being in love
6. Sex/physicality	Meeting, enjoying	Being man/woman of character
7. Light	Bringing light	Being in light/enlightened
8. Joy	Bringing joy	Being in joy
9. Meaning/QOL	Creating/fulfilling life, giving	Being alive, having impact

State of mind

The more relaxed, in flow, free, and happy, the therapist is, and the less he controls his rational and irrational impulses of talking and acting, the more flawless and efficient is the holistic therapy. Modern short-term therapy, where huge problems are intended to be solved in only 10 or 20 sessions, demands the therapist to be extremely active, in strong contrast to the old-style psychoanalytical therapist, who did almost nothing but listen to the patient while he did his free associations.

Body work is becoming more and more common, and spiritual and philosophical exercises has become modern all over the Western world as a part of holistic therapy. This puts new demands on the therapist to be ethically aware and conscious about sexual transferences and abuse, emotional energies or symbiotic dependencies.

The therapeutic tools

The ideal therapist uses only the loving and caring contact with the patient to induce holistic healing, the process Antonovsky called "salutogenesis." But as we are not as loving as we potentially could be, our love is often not powerful enough to make the healing happen, and then we can go to using tools as a compensation for this lack of healing power. Unfortunately, tools are a meager substitute, and results obtained with tools are often temporary and not long lasting.

But as everything is a learning process, the acceptance of one's limitations is an important prerequisite for growing, and daring to use tools to materialise one's firm intent of helping the patient to heal is the road to learning how to practice medicine, as it inevitably reveals our own impurities and shadow sides—if we dare to look, and we have someone to assist us by pointing at what we least of everything want to see in ourselves.

The "staircase" of therapeutic tools of increasing power

As demonstrated throughout our many papers on clinical holistic medicine (15-55), almost everything can be used as a tool, since only imagination sets the limit. To induce the state of consciousness that we call "being in the process of healing" (17), the physician (according to Yalom (80)) needs to invent a new cure for every patient. This ability to be imaginative, creative, and use whatever is necessary to induce the healing is the hallmark of the excellent therapist. Good intent, balanced action, and good results are definitely needed in holistic medicine. Giving up on your patient and not doing anything at all might be a bigger sin, in many cases, than doing your best as a holistic physician. Still you need to use a tool only after careful consideration, respecting the golden rule never to use a tool more powerful and dangerous than necessary (compare that both in surgery and with chemotherapy, the patient is risking death as a result of the treatment).

Almost everything in the world can be used as a tool, but as the physician lines up his tools, some tools are used naturally before others, and some might be painfully out of reach, because of lack of expertise or due to the laws of your country. The ranking of tools after intensity, danger, and needed expertise of the physician gives a "staircase" of advanced tools of holistic medicine; its function is to help the holistic physician to "step up" in the use of the techniques one level at a time, if needed.

Let us admit that therapy often is a little "messy" with the combination of a number of tools and techniques. To think of therapy as the clear-cut process of "walking the staircase" is too simple. Often, many of the steps are used in subtle and symbolic ways by the skilled therapist, i.e., hidden in jokes and ironic remarks. So this staircase is meant for education, training, and treatment strategy and not to limit the flexibility and spontaneity of the therapy.

The concept of "stepping up" in the therapy by using more and more "dramatic" methods to get access to repressed emotions and events has led to the common notion of a "therapeutic staircase" with still stronger, more efficient, and more potentially dangerous traumatic methods of therapy (see Figure 1). We have identified ten steps of this staircase:

1. Is about establishing the relationship
2. Is about establishing intimacy, trust, and confidentiality
3. Is about giving support
4. Is about taking the patient into the process of physical, emotional, and mental healing
5. Is about social healing of being in the family
6. Is about spiritual healing—returning to the abstract wholeness of the soul
7. Is about healing the informational layer of the body (from old times called the ethereal layer)
8. Is about healing the three fundamental dimensions of existence: love, power, and sexuality in a direct way
9. Is mind-expanding and consciousness-transformative techniques, and
10. Techniques transgressing the borders of the patient and, therefore, often traumatizing, like using force and going against the will of the patient.

When the holistic physician or therapist masters one step, he can go on to training and using the techniques of the next step of the staircase. As step 10 is often traumatizing for the patient even with the best of physicians, it is generally advised that the holistic physician or

therapist does not go there. When mastered by the physician, steps 5–8 (9) can be used, when steps 1–4 do not help the patient sufficiently. The tools must be used one level at a time, and each step implies an increasing risk for traumatizing the patient. Levels 8 and 9 often take many years of practice to master.

When everything else has been tried, but the healing has not occurred and the physician still senses that there is more to be done, the holistic physician can — if he has the necessary qualifications such as training in medical ethics and in the different treatment techniques, combined with a sufficient level of personal development and sufficient courage — use the advanced tools of holistic medicine. The advanced holistic physician's expanded toolbox contains powerful tools that can be organized into a staircase of the intensity of the therapeutic experience that they provoke and the level of expertise they take to master (see Figure 1 and Table 1). The more intense a therapeutic technique, the more emotional energy will normally be contained in the session and the higher the risk for the therapist to lose control or lose the patient to the dark side, which can make the therapeutic session very traumatic and damaging. These induced problems can almost always be healed, if the patient stays in the therapy, so the real risk is losing the patient because he or she completely drops out of the therapy.

Libidinous investment in abstinence as effective, crazy-wise, therapeutic behavior

Interestingly, the destiny of the therapist's experience with therapy is his choice of closing down or opening up for his libidinous energy towards his clients; the most dangerous of these energetic openings are of course the acceptance of the transference and counter transference of Oedipal love, because the temptations of not keeping the borders are biggest here. Harold F Searles stated in his brilliant paper "Oedipal love in the counter transference"(81) the thesis that it is the therapist's libidinous investment in sexual abstinence that helps mentally ill patients to recover; he is believed to have cured 40% of his schizophrenic patients by using the combination of a good heart and a brilliant administration of sexual energy to cure his patients. Using the therapist's own sexuality in combination with a strict sexual ethic as the therapeutic tool is an example of a crazy-wise therapeutic behaviour that most people would abandon, if it were not for the fact that he cured so many patients and harmed no one. Most interestingly, if you are a firm believer in Freud's theory of libido as the only creative power of man, you will not find a libidinous investment in a patient "crazy-wise" or plain crazy, you would find it rational and well based on theory. From a crazy-wise perspective, the Freudian concept of libido is a crazy-wise theory in itself.

Intention and spiritual matters

The nature of the human wholeness is difficult to grasp as it is abstract; the essence of man—the essence of the soul—seems to be love in a particular colour, the gift of the person, or the mission of the person's life (64-72). When the patient recovers his remembrance of what he

really is, the great talents of his personality are also revealed. Life is from this perspective about being of value to the world by using one's talents to enrich the surrounding world and thus contributes in all relations.

The theory of existential coherence explains many of the same facets of existence covered by the "four quadrant theory" of Ken Wilber (82). He also started with "The great nest of being," what we call the coherent matrix of energy and information or the web of the world. Wilber's four quadrants are intentions, behaviour, culture and social relations, but love is rejected as a central concept in Wilber's model, making this model less useful for deep holistic, existential therapy, where love, trust, and holding are prerequisites for taking the patient into the state of consciousness we call "being in the process of existential healing" (17). Responsibility for the person's own world is also difficult to rehabilitate using the Wilber model, whereas this is the consequence of walking the path of responsibility, noticing and reacting to your own impacts.

Research and development

Both human, culture, and society develops, and medicine must follow, if it is to be contemporary and helpful to modern man. But research is always about stepping over the borders of today and yesterday, and sometimes the decisions taken in a field of little experience will come out wrong or insufficient.

In this field, making the wrong decisions is allowed, for you cannot make any decision on incomplete foundation of knowledge without the attitude that it is fine to make mistakes when you only learn from them and do whatever you can to adjust your treatment for the benefit of the patient. Research will naturally be done with the group of patients that cannot be helped with the standard method, and it is justified by their need for help. Often, the case is that if the holistic therapist cannot help them, nobody can, as the biomedical doctor is sought first in most cases.

Both positive and negative results must be shared with the international community for the patients not to have suffered for nothing. The decision of doing something completely new with the intent of helping the patient on an experimental basis is the most difficult decision to make in the holistic clinic. Surprisingly, if the therapist remembers the principles of healing and makes sure that the experimental treatment complies with these few basic rules, most new interventions will in our experience help the patient, also when all hope is lost. We have seen this with cancer patients, where chemotherapy has failed to help, and we have tried something untraditional to induce holistic healing; in most examples, this has seemingly actually helped the patients to survive the life expectance given them by their biomedical doctor.

Learning process

The attitude that "I as a physician" myself have a little of all diseases, imbalances, impurities, and disturbances is extremely helpful to accept the often dramatic impact on oneself from holistic therapy on the patient. The openness to learn takes the humility of a therapist, who

knows that he or she is not at all either perfect or completely sound. But to look deeply into your own wounds from being raised, for example, in a dysfunctional family with incestuous bindings are really challenging. And when it comes down to it, perfect parents are really rare. So we are all quite neurotic and damaged and in need of healing our existence ourselves.

Helping other people, knowing this about ourselves, takes the challenge of being a therapist to a new level. Surprisingly, the fact that therapy is provoking and inspiring our own personal growth is what makes being a holistic therapist so satisfying and extraordinary. Only the painstaking process of personal growth will lead us to realise that there really are no limits for what we can do for yourself and your patients.

Humility, love and acceptance

Coming from the heart is the solution to the problem of how to help. Because we are all caught in our mental description of the world, we will inevitably start our medical practice as less holistic and more "methodological" and instrumental. But as we little by little realise that the drugs are not really helping much, and that other therapeutic tools and techniques are only excuses for intimacy, closeness and loving contact with the patient, we will day for day stand more bravely forward and finally admit that we are beings of love and that our natural tendency is to care and to give without getting anything but our own happiness in return. And in this realisation, we will grow into powerful holistic healers at the same time as we will feel more and more humble and powerless.

The paradox of love is that only when we let go and accept that we really cannot do anything for another person, for the person must decide for himself, and create his own life—autonomously—for himself, can we help. This is the paradox and the miracle of holistic medicine. Being a successful therapist in this field is very much a question of surrendering to reality, being one with the "Great Spirit," being purely of service, or how you want to put it.

Metamorphosis

The belief of most holistic healers is that the blueprint of body, mind, and spirit is always intact and that contacting this informational source within can lead to complete healing in spite of every seemingly misery and hopelessness of the situation. This is really a kind of religious belief, where life is in our imagination empowered with almost magic powers. Because of the logic of hermeneutics, this belief will often materialise so the therapist that believes in true miracles will see them every day, and the therapist that does not will never see them. When the sceptical therapist enters the optimistic therapist's clinic, he will find nothing but doubtful successes and certain failures, and when the trusting and positive therapist comes to the sceptical physician's clinic, he will find miracle after miracle happening even there.

Patients who believe will go to therapists that believe and here go though adult human metamorphosis (83-92) and be transformed into wonderful, able and happy people—even their bodies will be transformed. And patients that do not believe will go to the therapist and get their bodies and minds damaged and destroyed. The religious healer will attract religious

patients. And the sceptical healer will attract sceptical patients. Every person will get what he materialises. The therapist's role is to serve and to materialise what he believes in. The holistic therapist will often believe in healing the whole existence. And all choices will be made in that belief.

Different worlds

The fact that the biomedical and holistic therapist are living in very different worlds with very different cosmologies and very different experiences is often becoming a problem for the patient, who has to chose between two fundamentally different worlds and different treatments.

The sceptic mind is often much more powerful than the trusting soul, making biomedicine win many legal and political battles. But all over the world, people are more positive in their attitudes and philosophies, and holistic medicine is growing fast with more consultations now in the USA than biomedical consultations. The battles are becoming intensified all over the world, and it seems that we in the next 20 years or so will have a complete commercial shift into holistic medicine; this shift is already predicted and being prepared for by many of today's large pharmaceutical companies. At the same time, we see increasing lobbyist activities from physicians and industry trying to suppress holistic medicine—the war against homeopathy in Germany being an example.

The war is happening in the way that the holistic medicine is tested on the premises of biomedicine. With homeopathy, it is most unlikely that it is the homeopathic drugs in themselves that have any effect; the healing happens as the patient becomes more conscious of his human character and thus more accepting and integrating in attitude and philosophy of life. But instead of looking of these shifts in consciousness and acknowledging all the good things, there is happening for the patients who believe, sceptical research is des-empowering the homeopathic tradition, obviously with the intention of substituting it with biomedicine ("rational medicine," "evidence-based medicine").

There is really nothing evidence based about the way the war is going on; only materialisation of beliefs, as both patients and researchers are caught in the hermeneutic illusory web of interpretation of the world. We need a truly integrative medicine now, with space for more than one cosmology, i.e., a poly-cosmological entrance. Because biomedicine is not wrong; from one perspective, the world is really chemistry and physics only. And the spiritual medicine is not wrong either. From another perspective, everything is really a materialisation of consciousness. It is time to embrace a poly-paradigmatic medical science.

Ethics

The purpose of medical ethics is to ensure that the patient is not exploited or harmed in any way. To monitor the effect of the therapy and to be sure that it really helps and that it does not harm the patient is the primary ethical concern in holistic medicine. As the sense of coherence is the primary goal, and as this has been difficult to measure directly (4-9), the effect of holistic therapy on quality of life, health and ability has proven easy and efficient as an effect

measure (it takes only five minutes to fill in the QOL5 questionnaire (93) for self-assessed QOL, subjective health (physical and mental) and the quality of human relationships); ability of functioning (love, work, social, sexual) is also relevant to measure.

To measure the patients before and after treatment seems to be mandatory, and we have done that for years in our clinic, being able to document sufficient results of the interventions on more than half the patients (56-61).

Bodywork is a hallmark of holistic therapies, and bodywork introduces a lot of ethical problems known already by Hippocrates and his students (63). The ethical problems of modern bodywork might be best illuminated by using the extreme example of holistic sexological bodywork, originating both from the Hippocratic tradition and from the Asian/Indian holistic medical tradition (54,55). The procedure of Hippocratic pelvic massage, in Denmark known and practiced by hundreds of therapists as "acupressure through the vagina," is such a technique that seemingly is extremely efficient to help patients with primary vulvodynia and chronic pelvic pain but must be performed according to ethical standards. The holistic sexological procedures are derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts) and close intimacy without any sexual involvement.

In psychology, psychiatry and existential psychotherapy (80), touch is often allowed, but a sufficient distance between therapist and client must always be kept, all clothes kept on, and it is even recommended that the first name is not taken into use to keep the relationship as formal and correct as possible. The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement. In the original Hippocratic medicine (63), as well as in modern holistic existential therapy, such a safety zone was not possible, because of the simultaneous work with all dimensions of existence from therapeutic touch (22) of the physical body, feelings and mind to sexuality and spirituality. The fundamental rule has since Hippocrates been that the physician must control his behaviour and not abuse his patient. The patients in holistic existential therapy and holistic sexology are often chronically ill, and their situations often pretty hopeless, as many of them have been dysfunctional and incurable for many years or they are suffering from conditions for which there are no efficient biomedical cures.

The primary purpose of the holistic existential therapy is to improve quality of life, secondary to improving health and ability. The severe conditions of the patients and the chronicity is what ethically justify the much more direct, intimate and intense method of holistic existential therapy, which integrates many different therapeutic elements and works on many levels of the patient's existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology. The general ethical rule is that everything that does not harm and in the end will help the patient is allowed ("first do no harm"). An important aspect of the therapy is that the physician must be creative and in practice invent a new treatment for every patient, as Yalom has suggested (80). To perform the sexological technique of acupressure through the vagina, the holistic sexologist must be able to control not only his/her behaviour, but also his sexual excitement to avoid any danger of the therapeutic session turning into sexual activity. Most physicians can do the classic pelvic examination after their standard university training, but the vaginal acupressure we are discussing here in this chapter can only be obtained through long training and supervision in order to reach a level where such a procedure can be performed.

Side effects of the treatment can be soreness of the genitals and periods of bad mood, as old painful repressed materials are slowly integrated. We have seen acute psychosis as a sexually abused woman confronted her most painful experiences, but she recovered in a few days without the use of drugs, and this episode was an integral part of her healing. In fact, it was her therapeutic breakthrough. As it is possible that the patient can feel abused from transferences, it is extremely important to address this openly to prevent this situation. We recommend that the patient is contacted or followed for one to five years to prevent and handle any potential long-term negative effects of the treatment. In spite of these problems, we have found the treatment with holistic existential therapy combined with the tool of vaginal acupressure to be very valuable for the patients (54,55).

Discussion

There are many factors influencing the therapist's choice of action in the therapeutic session. We have presented it as if the therapist had the power of deciding what is going on. The reason that every treatment of a patient takes its own route might very well be that every patient because of his or her basic resistance is struggling very hard not to get well, not to get cured, not to get into the state of salutogenesis. The reason for this is clear from a psychodynamic perspective: The defences are created for survival of difficult situations in the past, and the patent will unconsciously feel like dying if these situations reappear in consciousness.

So therapy is a dance, or a fight, or a play; a complex pattern is created like always when the forces are almost of same size and opposite each other, and creating a chaotic, highly dynamic middle zone of whorls and constant changes.

Our list of factors influencing therapy might be completely useless, if it is so simple that the patient subconsciously is doing whatever possible for destroying the therapy, and the therapist just is following along as well as possible. Because then the "individual cure for every patient" is nothing, but the patient's escape route before he or she is finally caught, and the destructive, neurotic or psychotic survival patterns busted for good.

The argument that the large creativity observed in clinical holistic therapy is coming from the therapist's emotional and spiritual intelligence might just be the therapist's narcissistic positive interpretation of what it is like to be almost completely out of control in the session. Maybe it is not a deeper and wiser layer of the therapist taking over, but just the patient unconsciously fighting for his or her survival and, therefore, naturally investing more energy and efforts and, therefore, being smarter than us.

Many of the tools of the advanced holistic medical toolbox are inducing dramatic feelings in the patient, and it is an art to know when to use and when to avoid using a specific tool. The truth is that in spite of all the rational principles, only the emotional intelligence can provide us with the wisdom of when to use a tool, because of the extreme complexity of the human consciousness. The central thing is, therefore, that the therapist at all times is aware of his intentions, and certain that he is in good intent towards his patients and acting in accordance with all professional and ethical principles. It might be almost impossible to control this from outside; because of this measuring the results of therapy and being sure of really helping his patients might in the end be the most ethical the therapist can do.

Conclusion

Clinical holistic medicine is curing every second patient—in the patient's own experience—from physical illness and chronic pain, mental illness, low self-esteem, low quality of life, sexual dysfunction and low working ability (57-62). But the therapy is not following any nice and reproducible pattern, in spite of four rather clear therapeutic principles and a well-defined toolbox (49). On the contrary, every treatment has its own course, often unpredictable, meandering and fitful, and we say that we need to invent a new treatment for every patient. We are, in this chapter, identifying many of the factors that seem to come into play guiding the therapist's decision-making in the session. We are suggesting that crazy-wise aspects of the therapist are responsible for the creativity that in the end will take the patient into existential healing (salutogenesis).

"Holy madness" (94) is a well-known concept from Eastern spiritual teaching (as a Google search will show) and seems to be a very appropriate expression for what is going on in the therapy, inside the therapist when he is fully engaged. Most interestingly, "holy madness" is also a very accurate description of the state of consciousness called "holistic healing" (17). And maybe all the chaos and creativity is not really delivered by the therapist, but much more by the patient him- or herself; as therapists, we like to flatter ourselves with the idea of being in control, creating the cure, and helping the patient. Making the patient be responsible and healing is the art.

We suggest that the therapist that allows himself to be existentially absorbed and engaged beyond the mind in the therapeutic process, and who is able to use all aspects of himself, body, mind and spirit included in the service of the patient, is much more successful in inducing existential healing in the patient than the classic, rational, distant, mind-oriented, physician who uses only reductionistic and scientific principles and tools for therapy.

Spiritual commitment and love is what we firmly believe heal the patients; only by letting go of the mind's firm grip on reality can love find its natural and full expression in the therapy. Sexuality and libidinous interest is a natural part of this, and the investment of libidinous energy without acting out sexually has been suggested as the key to entering the universe of "crazy-wise healing."

Only by allowing the energy to dance within ourselves and make the therapeutic decisions that we instinctively know are right to free our patient and by allowing ourselves to speak and act completely without censorship can we be as natural and powerful as we need to be to overcome the resistance—the dark side of ourselves and the patient in combination—and induce Antonovsky salutogenesis (2,3), a healing of the patient's whole existence that will be followed by recovery of illness, improving of the patient's abilities, and recovery of the patient's global quality of life.

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Exercise

1. Researchers in human intelligence often discriminate between as many as seven different types of human intelligence. What is your understanding of human intelligence? How many types of intelligence do you acknowledge? What are their functions?
2. How do you make a difficult decision i.e., a choice of partner? Are you primarily a rational being or more driven by feelings and emotions?
3. What role do you think sexuality has in health?
4. Do you consider yourself primarily motivated by sexuality as Freud suggested? Are these drives conscious or unconscious? Can we allow ourselves to act instinctively, if we are unconsciously driven by sexual desires?
5. Will that make "crazy-wise" behaviour into a bad excuse for behaving in a sexual way towards patients? Can we afford to let go of control?
6. Explain the meaning of the word "justification."

Chapter XIII

Getting started—start practicing non-drug medicine today

Hippocrates (1) did not, according to the sources, discriminate between a physician and a good man and between medicine and the art of helping. He did not talk about the art of medicine or the art of good living. He simply talked about "the art." His teaching was, as we understand it, an abstract teaching about being a good person and doing whatever possible to help, "in every house he entered."

Being a holistic practitioner does not take a lot of expertise; before anything else, it takes heart. If you care for the person you are with, you will wish for this person's happiness, and if there is anything you can do to help, you would do it. Unfortunately, most often, the only person that really can help that person is the person him- or herself. Therefore the art of helping is really the art of supporting the troubled in helping him- or herself.

How is this done? "Meeting yourself" is an often used expression in holistic medicine. You need to confront yourself, feel the feelings, contemplate and understand, and finally let go of negative pictures, beliefs or events you are carrying with you. Fill, understand, let go. This is the formula of healing. So you need to be present with the person who needs help, and you need to give your support so that the person can meet him- or herself and confront all difficult emotions or thoughts. This is done quite simply by sitting next to this person, giving your undivided attention, and maybe a supportive touch, like a hand on a shoulder, or holding hands. You need to show that you are available and that you mean to be there and help. Being a caring person is where it starts, and caring is about … caring. You find this place, where you care deeply within yourself, and you simply practice your love and concern. Now you have started. That was not that hard, was it?

You need to be there and to listen. Asking questions might be a little overwhelming, so often silence and no questions are better for a start. Being there, holding the hand, and saying nothing, signifying your presence in your touch, your firm grip of the other person's hand or shoulder. That is enough. Now the magic is working. You have started to help. You are in business.

To talk and to touch are really the only tools there are, connecting your body to the patient's body and your mind to the patient's mind. If you are mindful, a closer contact will arise, a contact soul to soul through your body and your patient's body, and through your mind and your patient's mind. Meeting soul to soul, being together, breaking loneliness,

isolation, hopelessness, despair, is already a miracle. You have helped the person to understand that he or she is not alone in the world. There is a connection to the universe. A sense of coherence, of being at home in the universe arises from this simple meeting. Do not think it is small. It might be the first time in the patient's life that he or she experiences unconditional love. Because this is what it really is about: loving with no conditions. Loving the other person exactly as this person is. Accepting everything, just acknowledging the person's being, nature, soul and talents. Showing the patient respect. Caring and showing it. Being aware, basically.

So start today, find your intention of being of service to all, find your love to all living beings, and start from there. If you do, you will already be a holistic physician, and you will see your patients getting better, sometimes miraculously fast. Understand that it is not you as a person that helps. Love is really an impersonal power, a gift that everybody has. So do not get the idea that you are fantastic. Life is fantastic. Life is a true miracle. You have just discovered this in yourself.

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Exercises

1. Think about the nature of love, maybe you would like to read a book on unconditional love like *The art of loving* by Erik From or Martin Buber's classical book *I and Thou*.
2. Find love within yourself. Celebrate life with the people you love. Express your love. Be a loving person. Let love take you. Surrender to love. Be a being of love.
3. Touch people more. Give them hugs. Hold their hands. Let your small children sit with you and be with you. Close the distance. Close the physical gab between you and others. Change attitude. Be positive about touch.
4. Talk and listen. Share intimate details about yourself with your friends and express appreciation when people share with you, also when you have an emotional issue with what they might share and reveal.

Tip

Self-inquiry can be made in many ways but basically it is about observing one's thoughts, feelings, and body, and realising what you are and what you are not. You are not any phenomena that you can observe. You are the witness. You are not your thoughts; you are not your mind. You are something immensely bigger. You are the consciousness itself. You are the space of awareness watching the world.

Section 2: Tools for mind-body medicine

If you have read section one of this book, you will already know the basic ideas and concepts of holistic medicine. You will know that it is about healing, that this healing happens when the patients gain more self-insight and self-awareness and that this process of meeting and confronting oneself in all aspects, physical, emotional, spiritual and sexual area is facilitated by presence, loving care, and awareness of respectful, accepting and acknowledging quality.

You will know that it is about the good intent.

It is about the gift of unconditional love.

It is about talking and touching with the intent of healing.

And you will know that all aspects of life are improved in the process of healing, not only health. Most importantly: It's not about method. It's about *you* being the tool of healing. That's simple if you are present yourself. And in a way, this is all there is to it.

But then again: When you think about cancer and coronary heart disease, about severe depression, schizophrenia and chronic pain, you will soon realize that there must be more to it. It cannot be just about love. That's too simple. Right?

Yes and no. Love is it. But you have to be conscious. Only if you are conscious can you help. If you love without consciousness it is most likely that you will not have any significant impact. You need to be conscious. Consciousness is about knowing yourself. How will you wake up? What is needed? What is the door into consciousness? How can you develop and raise consciousness? What's the path?

Most people are caught in the ego, so the first thing to do is to get out of the ego and into life. How is this done? The classical answer in holistic medicine is that it happens through awareness of the body, its organs, and its energy. Basically, it is about realizing one's life energy. When you look deeply into what is happening around the body, you will see a strong identification with the body called "identity." You are this man or woman, boy or girl, you are Tom or Anna, your are engineer or plumber. This is who you believe yourself to be. But when you take a deeper look, you will find that you are not the body really, you are the one who identifies with the body—you are the consciousness itself.

A developed consciousness comes from a development of one's life energy. This energy starts according to most pre-modern cultures—and also according to Hippocrates and his students—as a raw, sexual energy, which is then cultivated and developed until it takes the form of conscious mind and awakened spirit. You could say that you develop this energy until it is so beautiful that it can be recognised by the spirit, and then a great merging happens,

in which your true Self is awakening. Many cultures believe that the more immature consciousness can awaken as the divine Self.

For modern man it is often somewhat difficult to let sexuality play a central role in healing. If only we could wake up with some nice prayer or some exotic mantra from a guru. We cannot say that prayers and mantras do not help some people; we are sure they do. When you can go straight to the Self, this is the best. But for many people, this is not an option. These people might benefit from knowing that one of the classical tools for developing consciousness in holistic medicine is about owing and accepting one's sexuality.

This is not so much about sex at you might think; it is not like having sex or engaging in some pornographic activity. No, it is just about acknowledging the sexual energies as one's basic bodily life energy, and working with and transforming this energy inside oneself. The sexual energies are really carrying the person's "genital character"—with a bold Reichian expression. Being one with these energies, being one with life energy, is a way to understanding the nature of the basic identity as a human being.

If you study the classical texts on psychoanalysis written by geniuses like Freud or Searles, you will notice that almost every single page is about sex in some aspect. Not about having sex, not about the physiology of intercourse, but about accepting the body and wakening its sexual energies, learning to know them as one's personal power, and becoming aware of their subtle nature and effects.

All psychodynamic psychotherapy is, when it comes down to it, about obtaining mastery of one's bodily or sexual energies. All artistic blossoming, all social success, can be seen as collecting and celebrating sexual energy. Self-realisation itself is to take one more step and realise that you are not really the body and its energies but only the consciousness witnessing them; you are not the identity, you are not Tom or Anna, but you are the awareness observing the body and all phenomena of the world through this body.

If you are a doctor trained in biomedicine, you will have your head full of biochemistry, and you are likely to be alienated towards sex. And the idea of being the consciousness will look pretty farfetched!

You have been trained to analyse the patient mentally, to have a table between you and the patient, never to touch except for a formal handshake and the physical examination necessary for giving the diagnosis. You will have learned to keep a "professional distance" and to put a thorough lid on any sensation that could be interpreted as sexual or even loving. You have been de-sexualized. Your sexuality has been squeezed out of you in all aspects related to work. Strong feelings for patients are not even allowed.

If you are a medical student, chances are that you will already have been professionally deformed by your medical training. You have become more professional and less human. More arrogant and less equal. More focused on brute force and less focused on love. More focused on matter and molecules and less focused on spiritual issues. So if you are a doctor or a student trained in biomedicine, you need to un-condition yourself. You need to heal from all the conditionings, from the professional deformation of your training and come back to being a natural and innocent human being, coming from the existential core that is your true Self, or at least from body, mind and spirit—from sexuality, consciousness and love.

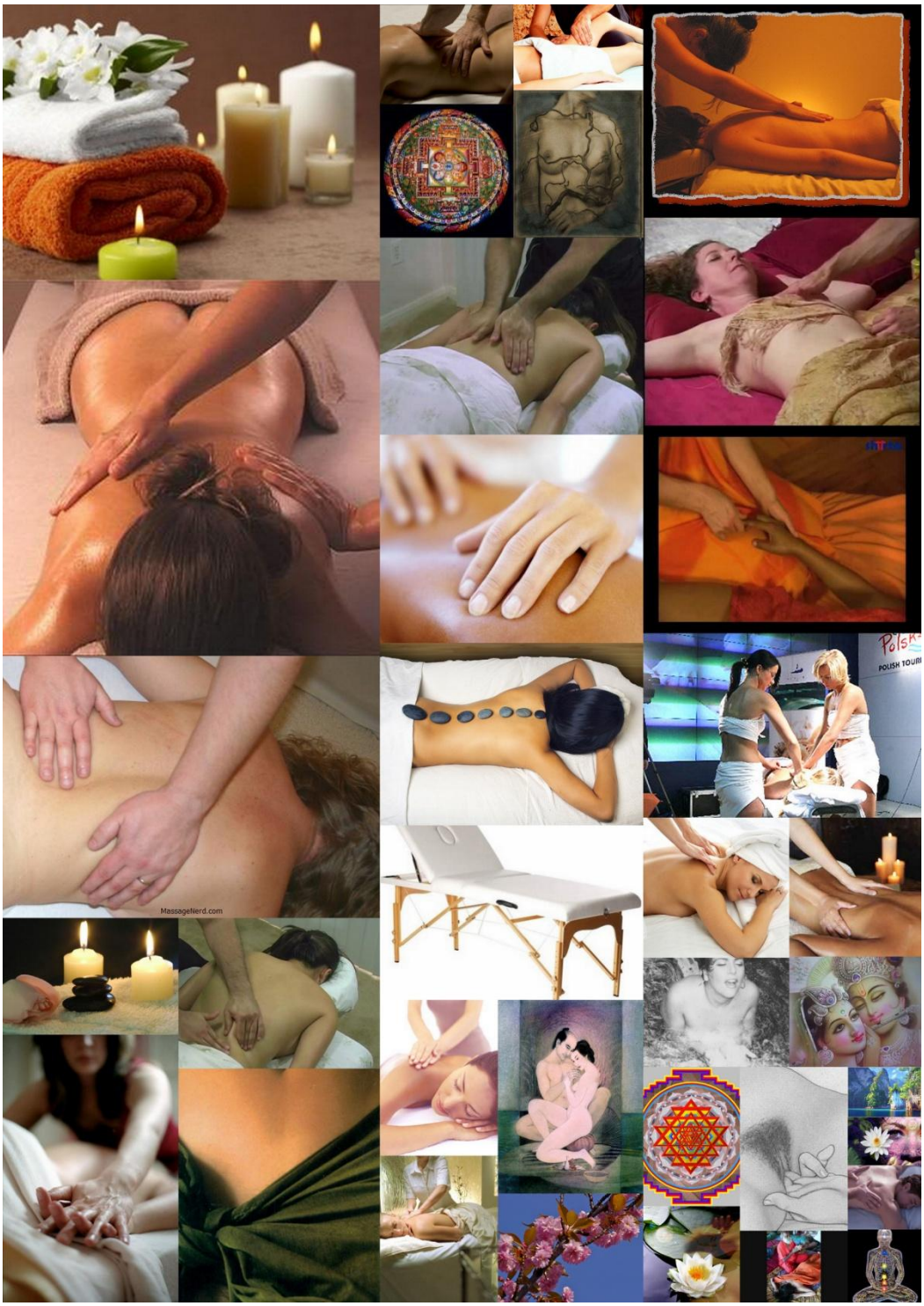
Body, mind and spirit meet in the heart, and only when you meet other people heart to heart can you heal. When you heal, you heal yourself and you heal them. This is the true magic. Healing is always also healing yourself, learning what you need to learn, discovering what you need to find out. To be a great holistic practitioner, you need to develop yourself.

Only when you are in a process of personal development, continually moving closer to life and to the world, will you be able to help and inspire the people that need your help.

Please forgive us for demanding that you change and grow. We have made this book to inspire you to be a great physician, an outstanding healer. We know that you are born to heal; that you are born with this gift of love and acceptance needed for other people to grow. We all are. If you dare follow us on this journey, we believe there is a very significant chance that you will succeed. We need you to let go of all seriousness and stiffness. We need you to be soft, warm, and a life. Present here and now. In your body, all its organs, all your energy. We need you to be mindful. We need you bold and alive.

Come, we invite you on a magic journey. Let your hair down and enjoy.

Or even better: Come, we invite you to wake up. Remember your true Self and be happy!



Chapter XIV

Introduction to talk-touch therapy: Every contact should be therapeutic

We need to heal because we are wounded. Maybe emotionally wounded by our parents early in life. The most difficult feelings from our childhood traumas are repressed. When we explore them, we will learn that the most difficult is related to our body, to its function, to its pleasures and pains. The most painful feelings and emotions are very often related to sexuality: Guilt. Shame. Disgust. Hatred. Hopelessness. Helplessness. Feelings of dead and dying.

Shame seems to be one of the most difficult feelings of all, and that means that shame has often been repressed. Repressed shame often results in low self-esteem, low genital self-esteem and sexual dysfunction, often with genital pain. When it comes to gender and sexuality, shame and guilt are undoubtedly the most destructive feelings. Open shame can be destructive, but even more destructive is the repressed shame that lives its secret life in the tissues and inner space of the body—especially in the pelvic and genital area.

The sign of repressed shame is the appearance of an unappealing bodily "energy." If the genital tissue holds on to shame, the patient will feel her genitals somewhat "dark," "dirty" or even "disgusting," and the physician can often relate to this experience from the quality of the tissue—from completely healthy to somewhat disturbed and out of balance. The energetic colour of the genitals will almost always colour the "feel" of the whole person. Reich noticed this and talked about genital health and genital character. Most doctors do not want to go there. We are so shameful about our own sexuality that we cannot manage the feelings provoked in us by disturbed sexuality of others.

Introduction: the body is sexual

The most common feeling connected to sexuality is without any doubt *shame*. Repressed shame is one of the primary causes of sexual dysfunction. We sometimes call this syndrome of intense shame, repressed, and general sexual dysfunction "repressed shame syndrome." Repressed shame results in low self-esteem, low genital self-esteem and sexual dysfunction, often with pain. When it comes to gender and sexuality, shame is undoubtedly the most destructive feeling. If the genital tissue holds on to shame, the patient will feel her genitals

somewhat "dark," "dirty" or even "disgusting," and the physician can often relate to this experience from the quality of the tissue—from completely healthy to somewhat disturbed and out of balance. A low genital self-esteem is often connected with general sexual dysfunction like lack of desire, anorgasmia, or pain, either during intercourse or chronic, often in the form of primary vulvodynia (1,2).

Interestingly the "repressed shame syndrome" in our clinical experience can be cured by simply giving acceptance to the patient's body, sexuality and genitals. Every contact with such a patient can and should be curative, as there are plenty of possibilities to give acceptance to the patient both through conversation and physically. Orally, the acceptance can be the assurance that the genitals look completely normal and sound, and physically, the acceptance can be given in the way the genitals are touched during the pelvic exam (3). Not giving the acceptance needed by the patient can lead to very negative experiences of the pelvic examination, which seems to be directly traumatic to young woman in some cases (4).

In the Research Clinic for Holistic Medicine and Sexology in Denmark, we have made the simple experiment of giving such accepting psychological and physical contact to 20 woman with severe sexual dysfunction. We noticed that 56% of the woman experienced an immediate and radical improvement (5). We used the explorative phase of the pelvic examination as the occasion to give the acceptance that the woman needed. We experienced that when the issue of repressed shame was addressed in the session, it seemed to be integrated right away. Just confronting the shame and understanding its irrationality is often enough to make it disappear. We noticed that the repressed shame resulted in what is now often called psychoform and somatoform dissociation, meaning that the patient has difficulties in connection through mind and body to another person, including the partner. By integrating the shame, we can help the patient close this gap in contact, immediately improving self-esteem, genital self-esteem, and sexual function.

Interestingly, sexual problems like lack of desire, anorgasmia, chronic pelvic pain and primary vulvodynia are also often cured when the repressed shame is integrated, giving substance to the hypothesis that primary vulvodynia and the related pelvic-pain disorders are originally caused by repressed shame disturbing the tissue that is holding on to it. A tendency to chronic recidivant infection and reduced immune resistance in the genital area might also be related to repressed shame.

Every contact with a physician can result in a major impact on the patient's understanding of life and disease—a fundamental philosophical impact that is very curative if positive. Every contact must be used to improve the patient's understanding of responsibility for health and quality of life. Every close contact to the patient physically or mentally must be used to close the gap of somatoform and psychoform dissociation. Every contact with the patient about gender or sexual issues must intent the processing of repressed shame and other emotions that are capable of giving the patient severe sexual problems. Only by using every opportunity can we improve the general state of sexual functioning, an area where about one in two or three have significant sexual problems (6).

We sincerely apologize for giving you such an abrupt introduction to the practical work in the last chapter. Intimacy and sexuality are, as you most certainly will realize as soon as you start working with patients, issues of great importance to the practice of holistic healing. We wanted to introduce you right away to the important dimension of sexuality to get your own therapy started if you have problems in this area. Because you cannot be a good holistic therapist if you have these problems.

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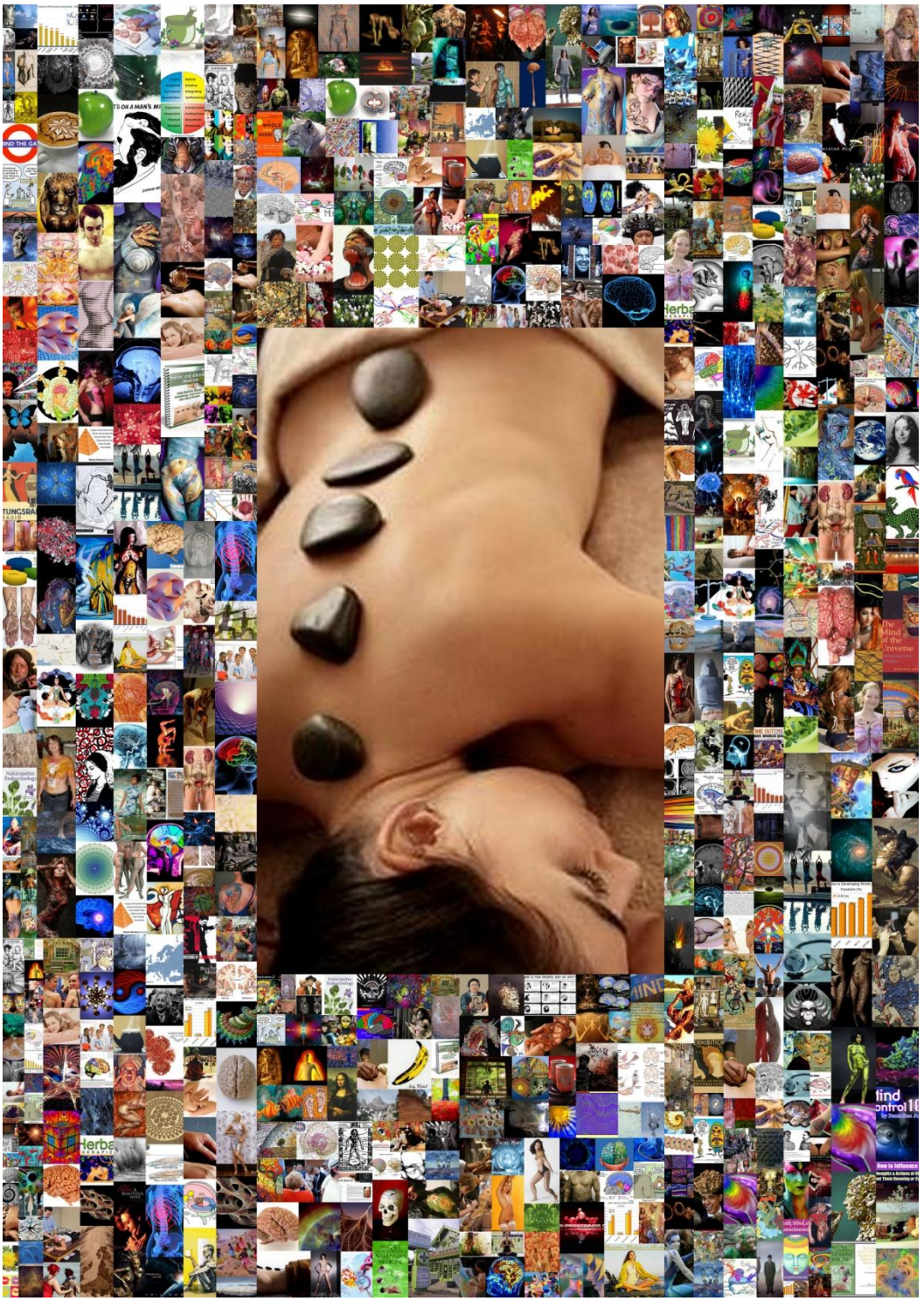
Exercise

1. Before you start healing others, you need to heal yourself. If you are suffering from low bodily or genital self-esteem, you need to look into this and get your acceptance up and your sexuality straightened out. You might need to get some therapy. Maybe today is a good day to start. We recommend holistic therapy, where healing touch is combined with existential talk.



Chapter XV

Tools for holistic medicine

Healing does not really need tools. It only needs you to be present. The more you can stay as your Self the more you can help others. The more you can rest in yourself, the more naturally you can interact with others. The more you can just be, the more you come from love, and the more miracles will happen around you.

If you are less perfect than coming from pure love and presence, you will come from mind and knowledge and then some tools are needed. What is a tool? Well, everything can be a tool in the holistic clinic. Pleasing, ignoring, or scolding the patient, paying compliments, touching softly, and touching hard. Giving pain and giving pleasure, be it the safe and predictable, or the surprising and unexpected. Literally, everything can be a tool; the solid rocks we are building on are not concrete behaviours but abstract principles.

So what is *a tool*? Basically it is something we define to make order in chaos. We want to make what we do look sane, scientific, systematic, and trustworthy. Therefore we define a set of "tools" that can be used in the clinic. Holistic medicine has, as you will learn in this section, an enormous toolbox. We can present them to the patient as "the tools," and the patient will attribute significance to these behaviours and schemes. But even the concept of "tools" is really nonsense, if you think about it. There is but one tool in the holistic clinic, and this tool is YOU. So everything you do is a tool. You talk, so talking is a tool. You touch, so that is a tool. You think and set perspective, so that is a tool. The more you learn about yourself the more "tools" you will have.

In this book, we like to present everything in an orderly fashion giving you as a student the impression that holistic medicine is a science. In a way it is, of course. There are systems and theories, diagnoses, healing principles, tools, goals, instruments for documenting treatment effects, and strategies for analysing the data.

But if you take a deeper look, all this is illusory. We use our values to define our goals. Who says these values are sound and true? How can we tell? If we help a patient out of his physical or mental pain, is that a good thing? What if the price is the patient's personal development and learning (as we only take radical learning when we are in pain and trouble)? Or what if this pain was his way to purify his soul and karma? What if what we do changes the patient's belief and makes him less autonomous and more dependent on us? Is freedom a value? Is spiritual depth a value? Well, we think so but these things are not a part of our

formal tools for documenting treatment effect (neither in holistic medicine nor in biomedicine). So this is really a mess.

We would like to present the whole area to you as if it were fine and in good order. Unfortunately it is not. Reality is quite chaotic, and we have made order in this chaos, but maybe not in an optimal way. You need to think! Further research and development is needed in holistic medicine. On the other hand, we are proud of the state of affairs in holistic medicine. It works wonders, and we have made it so simple, so easy to understand and use, that you just can start practicing. Enjoy! Have fun! But think!

Biomedicine focuses on the biochemistry of the body, while consciousness-based medicine—holistic medicine—focuses on the individual's experiences and conscious whole (Greek: *holos*, whole). Biomedicine perceives diseases as mechanical errors at the micro level, while consciousness-based medicine perceives diseases as disturbances in attitudes, perceptions and experiences at the macro level—in the organism as a whole.

Thus, consciousness-based medicine is based on the whole individual, while biomedicine is based on its smallest parts, the molecules. These two completely different points of departure make the two forms of medicine very different; they represent two different mind-sets, two different frames of reference or medical paradigms. This chapter will explain the basic tools of clinical holistic medicine based on the life mission theory and holistic process theory with examples of holistic healing from the holistic medical clinic.

Introduction

This chapter will explain the three basic tools of consciousness-based medicine, where *feelings* are at the core of holistic medicine. Holistic medicine is dealing with man as a whole, and this wholeness, global level of existence or "soul" is integrating all the being, having and doing of the individual. We believe this top level of the biological organism to be the seat of consciousness, which is the reason why we focus on consciousness in our holistic medicine. The first step for the patient is, therefore, to reach inside the body to reveal the feelings and impressions hidden there. They are often rooted in the personal history (unfinished issues or the so-called gestalts). The next step is to verbalize the feelings, to understand and finally let go of the life-limiting perspective in order to find a new perspective, which is more nourishing and supporting for life. We will see how this is done in a case story. Based on this example, we will analyze the main differences between biomedicine and consciousness-based medicine. As can be seen from different chapters in this book, there are still a number of important aspects of being a person and working on one's health, which is difficult to fit into the holistic theories, so the job of developing the new medicine is far from finished. We hope for the medical community to engage in the exiting challenge of making consciousness-based medicine work in the medical clinic, hopefully for the benefit of many chronic patients, not sufficiently helped neither by biomedicine nor alternative treatment as we know it today.

It is important to stress that the word holistic has been used in many different meanings, so there are many different kinds of "holistic medicine." Often, spirituality has been stressed in holistic medicine, but the meaning of this word has not always been clear. In our version of holistic medicine, spirituality is *the abstract.* The life mission theory (1-6) states that essence of man is his life purpose, and this is the abstract core of the being. The ideal contact between

two persons is the contact we call “love,” so important in our clinical work, where our wholeness (“soul") openly and in full acknowledgment meets the other person’s wholeness (“soul”). This is a meeting “soul to soul,” where we connect as deeply as humanly possible. In a way, we merge our consciousness with the consciousness of the other, with the intention to serve this other person, while realizing our own purpose of life, which is always about creating value for the other (2). The life mission theory (1-6), the holistic process theory of healing (7-10) and the related quality of life theories (11-13), the philosophical change, difficulties in life (14-21) becoming more healthy, talented and more able to function (22-24] are described in Chapter 4.

Two simple clinical examples

Female, aged 35 years—Feel!

The patient presents with neck pain and tensions in the thoracic and intercostal muscles [the muscles between the ribs]. We talk about the presence of a feeling, which the patient does not want to acknowledge.

EXERCISE: Sit down for tern minutes every day with your eyes closed and sense your feelings. Make room for all negative and positive feelings.

Another physician might refer this woman to a physiotherapist and prescribe analgesics, if the neck pain is severe. Contrary to this, we recommend that she take the time to listen to her emotional life. Unprocessed feelings—anger, anxiety or frustration—often manifest themselves as tensions in the body. If that is the case for this woman, we may be able together to solve her troubling and probably recurring problems without any physical or chemical intervention.

That is how consciousness-oriented medicine differs from biomedicine. The biomedical physician typically resorts to medication and physical manipulation, while consciousness-based medicine will often begin by turning the patient’s attention to the underlying emotional problems. Our feelings are a great source of knowledge of the unique causes of our diseases and health.

In modern society, we often fail to recognise the importance of feelings. We rely on reason and suppress many of the painful reactions to our less than perfect reality, which are basically natural and require some space. But suppressed feelings tie into knots, and frequently we will not get rid of a symptom until we open ourselves to the repressed emotional pain.

Female, aged 20 years—abortion trauma

Quality-of-life conversation. The patient presents with fatigue and persistent low spirits. ”I feel bad about my body and myself”—low self-esteem—e.g., the statement “I am worthless.” Had an abortion six months ago, which still troubles her. Cries on the couch, I hold her hand and she talks about the abortion. Conclusion: She has no close, intimate friends whom she trusts. A consequence of low self-esteem, which makes her certain that once she is seen, she will be rejected. Early problem when the patient felt rejected.

EXERCISE: List of problems—describe your social, psychological, physical, educational and sexual problems

EXERCISE: Write a description of the course of the abortion from beginning to end, and bring it back for follow-up conversation.

PLAN: Feel, acknowledge, let go—for the next six months. Another appointment in two weeks.

It is estimated that there are at least 26 million legally terminated pregnancies each year throughout the world, at least 20 million illegally terminated with the result of at least 78,000 maternal deaths (25). Every abortion is an emotional trauma that often is not processed and torments the woman for years. This is a great shame, since the problem can be solved by relatively simple means. In this specific case, the problem was low self-esteem, a feeling with which so many young people struggle today. When we take a look together behind the facade and view her self-esteem as the essential problem, she also will be able to see that her entire existence reflects her low self-esteem. The abortion is like an emotional plug in her, and once it is removed, it releases a number of emotional problems that concerns her relationship with the significant individuals in her life.

As homework, the physician asks her to describe the abortion and make a list of all the problems in her life. These two exercises deal with the past and the present and, if successful, she will feel as if she has been relieved of a great burden. Once she has confronted the painful feelings, she will get a much clearer view of her position in life, and she will be able to let go of many negative attitudes towards herself and others. In our view, these three steps are required to sort things out and heal: First, one has to *feel* the old emotional pain again, then clearly *acknowledge* the nature of the problem and where life took the wrong track, and finally *let go* of the negative attitudes to life that accumulate in all of us, when life is hard on us or we fail at something we want.

Holistic process theory (9)

We formulated these three steps—feel, acknowledge and let go—following studies of therapeutic approaches of alternative therapists. What do alternative therapists do for their patients and clients? Well, either they touch the patients and help them feel the emotions and "energies" that are restrained in their bodies, for example, by means of massage, zone therapy, Rosen sessions, kinesiology, acupuncture, craniosacral therapy, bioenergy, primal therapy or holotropic breathwork. Or they help their patients verbalise their feelings and sensations and support them in acknowledging the structure of their lives, for example, through Gestalt therapy and other psychotherapy, cognitive therapy, transaction analysis or existential group therapy sessions. They can also work with the patients' thinking and consciousness and help them towards new perspectives and life philosophies, for example, through Body Mirror System Healing, psychosynthesis, NLP, philosophical counselling, existential therapy, thought field therapy and on life philosophy courses such as our own summer courses "Life philosophy that heals" in Denmark.

With these measures and techniques, alternative therapists can help the patients let go of physical tension, emotional tension or tension in their minds. We call the combination of these three essential steps: "feel, acknowledge, let go," the holistic process theory. "Holistic," because it draws on the whole formed by the body, emotional life and mind. And "process" because it describes the process, where the pain load that a person has repressed earlier in life (from the spiritual to the physical level through life) once more becomes conscious and integrated. Thus, through the holistic healing process, one becomes aware of the causes of one's diseases and disorders, and at the same time as the misfortunes of the past are sorted out, one's quality of life, health and functional capacity improve.

Let us provide an example from the clinic: A woman suffers from urinary tract infections that keep recurring, and she is treated over and over again—we see that in the clinic occasionally. What could be the cause, seen from a holistic angle, and how should it be treated holistically? As children we need love; without love, we become anxious and insecure. If the anxiety becomes unbearable, we can escape from it by a ”decision” that we are not worth loving. The pain may, in this perspective, be wrapped up and placed, for instance, in the skeletal muscles between the ribs or in the smooth muscles in the pelvis. Indeed, therapy often reveals that as adults, we carry the anxiety from our childhood hidden in the organs of the pelvis—in the intestine, bladder, sexual organs or skeletal muscles. If the anxiety is hidden away in the pelvis, it may weaken our bladder region and cause repeated or chronic infection of the urinary tract. To get rid of such chronic infection, the patient has to “become present in the pelvis” and feel the anxiety again. The gestalt—“the frozen now” with the original emotional pain—must be caught, verbalised and made conscious. Finally, the patient must let go of his or her old perception of being unlovable. Not only will the cystitis go away as a result of this process; the patient will also attain higher self-esteem and thereby become easier to love. The patient has learned from his or her disease, the disease has been cured, and the patient has re-emerged in an improved version. The holistic process theory thus implies that the patient must work with body, feeling and mind at the same time.

A practical solution is to let the patient draw on a team of therapists, some specialised in work on the body, others in words and feelings, and yet others in the mind and life philosophy. At the Quality of Life Research Center and Clinic in Copenhagen, the patient will typically see a body therapist, a psychotherapist and a physician trained in the holistic-oriented approach, who also is in charge of referrals and the overall therapy. In our experience with this kind of work, a course of treatment to improve quality of life typically lasts about six months—consisting of 10 to 15 individual sessions at two-week intervals. The treatment should be supplemented by reading relevant literature, perhaps a course in life philosophy and possibly participation in a “growth and development group” directed by a psychotherapist. In this group, patients join and support each other in the development process. Regardless of their practical focus, the holistic treatment regime shares the approach of working with the patient rather than with the disease. The focus is on improving the quality of life. That is the reason why we often say “quality of life as medicine,” when we explain the concept of consciousness-based medicine.

Theory of cognitive dissonance

Let us take a closer look at what will happen when a person establishes the traumas, which the holistic process theory seeks to eliminate. Let us draw on the classic socio-psychological theory of cognitive dissonance (26). According to this theory, a person has a number of cognitions at any time, i.e., beliefs, attitudes and perceptions. These cognitions may be more or less inconsistent. When there is a conflict between them, which Leon Festinger (1919-1990) from Stanford University called cognitive dissonance, this is perceived as discomfort. Festinger viewed people as thinking individuals who need to have balance in their thoughts as well as their actions. This idea of balance is key to his theory of cognitive dissonance. Much research is still being conducted today in social psychology to answer some of the questions

that cognitive dissonance has raised. Let us look at an example. A small child begins by having the attitude "I am worth loving." But if the child feels constantly punished by its father, the child will acquire the experience "I see that I am not loved." Such dissonance is unpleasant and, according to Festinger, the child will attempt (118) to change it to create consonance (harmony) between the cognitions. If the child cannot make the father stop the punishment so that the child achieves the cognition "I experience being loved," it is forced to change the cognition that it controls, i.e., the attitude "I am lovable." Consequently, the child will gradually change it into "I am unlovable." Now there is cognitive consonance between the child's two cognitions: "I experience being punished" and "That is because I am unlovable." Festinger used his theory to explain why and how we change our own and others' attitudes and values (cognitions). It provides an excellent framework for our observations at the clinic of both traumatised children and adult patients reliving a traumatic childhood. However, we will demonstrate further below that patients often harbour numerous, mutually conflicting perspectives. Not until the traumatic material becomes conscious can the patient heal and become himself again. This healing can only take place once the gestalt—the painful "frozen now"—has moved from *the body*, where it is apparently stored and kept, and into the *emotional* dimension, where the old painful feelings should be contained and confronted, and further into *the mind* as a clear acknowledgement that can make us re-assess our old choices of existential survival. If we come to grief so early in life and make such self-destructive decisions as is often the case—I am unlovable, I am no good, I am hopeless, there is something wrong with me—we take vast amounts of vital energy from our living and bind this life force in unfinished gestalts. If we are to get well again and regain our vital energy, we have to melt the ice cubes of the past and in this way restore the exchange of information in the body.

We must make the separate "parts" of ourselves, our denied sides, merge into our whole again. That is how we heal and regain our health and life force. "The frozen now" is the essential element that binds our vital energy, and that is conventionally called a "gestalt" (we sometimes use the phrase holo-gestalt, when body, feeling and mind are involved at the same time). The gestalt begins as a pain that is unbearable, the next step is a life lie that relieves us from responsibility for the pain, and the third step is the parking of the entire gestalt in the part of the body that is able to contain it (typically a group of muscles or another organ structure).

Tools

> "Please—tame me!" he said.
>
> "I want to, very much," the little prince replied. "What must I do, to tame you?" asked the little prince.
>
> "You must be very patient," replied the fox. "First you will sit down at a little distance from me—like that—in the grass. I shall look at you out of the corner of my eye, and you will say nothing. But you will sit a little closer to me, every day..." (Saint-Exupéry: The Little Prince) (27]

According to Irvin D Yalom, Emeritus Professor of Psychiatry at Stanford University School of Medicine (28), the good therapist must invent a unique treatment for each patient,

and the only thing that can really make a difference is attention, as Jiddu Krishnamurti (1895-1986) (29) pointed out throughout his life. Nevertheless, there appears to be some more concrete tools, which the therapist can acquire and learn to master in the interest of the patient. When we meet a patient, the first thing we notice is typically how much closeness the patient allows between us. Some patients are good at closeness and intimacy; they have come far in their personal development and are very open and honest, both to themselves and to us. They trust in us and our good intentions as physicians and immediately accept our *attention, respect, care, acknowledgement and acceptance*, which we consider the five fundamental therapeutic tools that any holistic doctor has to master to provide optimal holding, and on which every treatment should be based. The trusting patient often makes rapid progress, if the therapist succeeds in combining these fundamental qualities in a smooth and unbiased manner, in the exact proportions needed by the patient, guided by the therapist's kindness towards—or perhaps even love of—the patient. Other patients show little trust; they are emotionally distant and characterised by being equally unable to give and take. Attention hurts them, so we need to be very careful when we show them our attention and treat them. We experience these patients as severely damaged. In such cases, the first therapeutic goal is to restore their trust by supporting them to feel, acknowledge and let go of the trust-damaging traumas. The most important tools to achieve this goal are *touch, conversation and sharing of life perspective.* Touch comes at all levels of intensity, from the handshake to the embrace. Conversation comes in all degrees of intimacy, from the entirely impersonal to the most intimate conversation. Sharing of life perspective ranges from sharing of trivial, shallow views to generous sharing of our greatest moments and most significant experiences. People who cannot show trust can be very difficult to like and very difficult to help. The most damaged patients will not establish eye contact when they first visit the clinic; they are unable to see the world from any other viewpoint than the one in which they are stuck. We are not allowed to respect them, because they cannot meet us at the line between us but are either below or above that line. Nor are we allowed to touch them, for they cannot bear close contact with others. These patients may be normal in the psychiatric sense, but from an emotional view, they are terrible, and from an existential view they are very ill. They have withdrawn from life completely and are stuck in a negative, mental position of defence.

One patient is an example, a 50-year-old man, whom we (SV) perceived as totally impossible. All that I was allowed to do was to share his perspective, namely that he wanted to die. I could not talk him out of it in any way. I ended up giving him the only thing that I could, namely my meeting him concerning his death. Intuitively, I felt that meeting him there was the only right thing to do, so we discussed suicide methods to find the exact method that would best suit him. Then, gradually I felt how his basic attitude changed: since I no longer tried to pull him from the grave, but accepted his independence and will to die and cooperated with him on his departure, part of him awoke. Ever so slowly, he started struggling to live rather than struggling to die. At the end of the session, he declared that he no longer wanted to die. We had but a single tool, one single straw to which the physician could cling as therapist, namely to join him unreservedly and without resistance where he was, in *his* mental perspective. The attitude and in a way generosity of the physician at this point apparently set him free. Half an hour later, he was laughing at himself and his futile suicidal thoughts, and the crisis had passed. The physician used his last and perhaps most important tool, namely to look at the situation from the patient's point of view, supported by the *intention* to help him.

Ideally, the holistic therapist is able to support the patient in all the processes concerned with feeling, acknowledging and letting go. The goal of the therapy is to help the patient return to his or her natural state, where the patient surrenders to life and find peace in life. The *care* of the physician helps the patient to be present in order to feel what is hidden away in the body. The *respect* of the physician enables the patient to establish his own well-defined space, which in turn enables the patient to understand himself and his life. The *attention* of the physician enables the patient to see himself and his life from many perspectives and to choose the very best and most affirmative views. Care, respect and attention will not help the patient until he can accept them, and that is a question of trust. Trust enables the patient to accept the most nourishing support (called "holding""), which makes the deep and spiritual processes take their course. Holding requires that the patient lets himself "be held," i.e., surrenders and lets the therapist take full control of the situation. That is the control held naturally by the parents before the fundamental breach of trust occurred.

Usually, the patient would not let the parents or anyone else take control ever again. Healing takes place through surrender, where the patient once more lets go of all the ways he or she holds back: physical tension, emotional dissociation and all the mental reservations. When the patient lets go, life returns. Healing will only be possible when the patient can accept being held, almost like a trusting infant. These resources—being met with respect and love, being seen, touched—are the very resources that were missing in the original traumatic situation in life. In the successful cases, the ability to be close is recreated slowly, but steadily. It is quite remarkable that one is able to provide parenthood with a delay of 30, 50 or 70 years, and in that way make up for a terrible, traumatic loss of love and closeness in the past of the patient that has damaged the patient right up to the present.

In therapy, the road to sufficient trust and profound healing is often long. Some of our patients have already been in therapy for many years before seeing us without having found help in relation to their fundamental problems. The first three months are sometimes spent unlearning bad habits and misapprehensions that the patient has picked up during therapy or in other contexts. Just how long that road is seems to be a question of the therapist's professional skill, emotional generosity and intention. The therapist may be infinitely wise, but to no avail if he is unable to give. The ability to give must be sincere and loving. To be a good holistic therapist, one must make sure that one's own feelings are available for the encounter with the patient and that one is aware of one's own intentions. One must be able to withstand being reflected by the patient. One must master the classic concepts, such as transference and projection. As a person, the therapist should be attentive, respectful and caring. Then we can begin practising the three tools mentioned above that create trust and closeness. Let us take a closer look at them.

1. Touch

A caressing touch is the essence of care, and as such one of the most natural and vital things for us as children. Most of us do not receive the care we need as children and are still deeply hurt. Therefore, when the therapist touches his patient, there is a risk that he may open some of the most painful wounds and expose the patient to more than he or she can handle. If we are not attentive and respectful, and attain the patient's complete acceptance, it may easily

seem like an assault. On the other hand, there is no other way of healing the old wounds than to go back and relive the pain.

Therefore, there is no alternative to touching the patient. The simplest and most natural thing is thus the hardest for us as therapists in the clinic. It is in the touching of our patients that we prove our worth as holistic physicians. When supporting the patient to feel what lies hidden in the body—as being taught by Marion Rosen who developed the Rosen method (30)—the holistic therapist should place his hands on the patient and support the tense, blocked and perhaps diseased area of the body. The purpose of the touch is to meet the patient soul to soul through the two bodies. In order for the touch to establish contact with repressed matter, the therapist's genuine intention with the touch should be to encounter the patient's self, not just the patient's body. Therefore, the therapist has to recognise qualities in himself such as curiosity towards the other person, pleasure in the contact or wanting to touch, all qualities which are considered unwanted and unwelcome in general medical practice.

Marion Rosen said (30): "When you touch the client, the client also touches you." That is true, which for a while can cause some difficulties, because it means that a therapeutic touch performed correctly in the holistic context leads to uncompromising and quite provocative closeness. When the patient, slowly and step by step, becomes present in a sick and blocked area, the repressed feelings and problems, which are often placed there in early childhood, will slowly rise to the surface of consciousness. The patient becomes present and meets the therapist and the gestalt that was hidden in the tissue resurfaces with all its negative feelings. Mostly, this process is gradual and quiet, but sometimes it is explosive. And then the trick is not to comfort the patient. We begin the physical touch of the patient in a fairly neutral place, on the hands or knees; on the couch, we proceed to touch the head, chest and abdomen, corresponding to the third eye, the heart/solar plexus and the Hara centre. When we touch a patient on the forehead and a handbreadth below the navel, this double touch can lead to deep contact, which triggers the holistic healing process. Two dormant intelligences, intuition in the body and the analytical intelligence in the mind, can be activated in this way, and applying these talents may really speed up the patient's process.

Touch combined with conversation can change the patient's well-being radically over a short time. It is always surprising for the patient when an opening appears and feelings return. Not always pleasant, of course, as the patient finds the feelings exactly the way they were left: often in unbearable pain. The patient may suddenly begin to laugh and then to cry bitterly on the couch—in a way that the patient has not cried for half his life. The "feel therapy" is the port of entry. Without it, there is no hope of therapeutic progress in the context of consciousness-based medicine.

2. Conversation

The holistic conversation has the same purpose as holistic touch: soul-to-soul contact, this time through our two minds. Conversation has it all: body, feelings and thought. A voice contains so much body, so much feeling with so much to tell about the person it belongs to. And the choice of words tells its own story, the tone of voice and finally the sentences and the intention behind them that carry them forth. It is tempting to believe that conversation embraces all of it. What else is needed when we meet but to speak together sincerely, openly, honestly and intimately? In the same way that touch becomes extremely difficult due to old

neglect, the conversation that is supposed to be so natural becomes so difficult because of all the abuse, verbal assaults and mental defeats that we have suffered in our lives. Conversation is, therefore, also a door to awareness, but many feelings and events are so painful or so well repressed that they are actually unreachable through conversation and memory.

As with touch, important questions relate to conversation. What happens when two people are good at talking to each other, and what is it about conversation that really redeems and develops the patient? How to help a person towards consciousness and clarification? In our experience, the conversation does not take on real value until the patient begins to express himself. It seems that every person contains a very large, inner truth, and only when it is verbalised can the person live and apply that truth. The conversation should support the patient to find his own unique and original expression, which is verbal, emotional and spiritual all at once. We really mean something; we are not vacillating or indifferent. Deep down, we represent something. Finding this content in life, verbalising what we feel and think so that our mind become clear—that is where conversation supports the patient. In a way, each fruitful conversation is like a vortex, pulling the meaning and content towards its centre and down towards the depth of the soul. And not until the basin is emptied and the vortex has become completely still and is completely centred in its own centre is the process over. The person has become aware, emotionally focused and conscious. The patient has "opened up his heart" as the feelings returned, and mind and body reach each other once again. The opening of the heart and the recuperation of feelings reopen the door to the depth of existence, the wholeness of man—or the soul.

3. Setting perspectives

Generally, we may not notice that our attention changes its nature in relation to what we do and the place within us from which we work, but this is a very important point in the holistic clinic. Touch, for instance, works best when the physician is centred in the abdomen and pelvis, in the Hara centre, which is our centre of being and physical desire. Conversation is most constructive and natural with the centre in the heart and solar plexus, since the heart creates connection and the solar plexus creates clarity and definition. When we become centred in the centre of the mind, traditionally called the third eye, we gain access to the quality we call acuity. It is a frightening quality that relates to making conscious choices.

What we can choose in a state of acuity is our philosophical position, our perspective. It appears that over time most people move away from a perspective close to life, often towards a very strange perspective distant from life. When we, as holistic physicians, are to help our patients, perhaps our strongest tool is the awareness of life perspective and the invitation to a shift in perspective. Once we have gained the patient's trust, we can make a journey together, exploring a number of alternative life perspectives and their consequences for our lives. It often comes as a shock to discover the decisive influence of our personal life perspective on our quality of life and well-being.

If we succeed in helping the patient return to his or her natural life perspective, which is in full harmony with the inner life, this patient will often get well. As the patient lets go of all mental difficulties and firm views, he or she will return to the natural life perspective that expressed the patient's inner truth. At last the patient can experience the correlation between the inner and outer life, which was disturbed temporarily by the old traumas. The inner

conflicts and contrasts dissolve, and the patient can experience happiness, perhaps for the first time. When we succeed in helping the patient become focused in his or her own mind, we say that the patient has become conscious. From that moment on, the patient is in control of his or her own destiny. Choosing a life perspective that is in harmony with one's inner life means *taking responsibility for life*.

Let us look at an example of this. The patient in the following case presented with a terribly disfiguring scar in the lower part of the face. She wanted to die, because she looked so ugly that nobody could love her, not even her own parents. The physician (SV) first made her choose to live by setting a dramatic perspective, where she is made aware of the choice between life and death, and she chooses life. Subsequently, he applied touch, with her permission, first resting his hands on her old disfiguring scar and then massaging the scarred tissue. She starts crying hysterically, as she spontaneously goes back to the time when she suffered burns. The re-experience is so intense that her lips turn blue again, and she gasps desperately for air as if the flames prevent her from breathing here and now.

> Female, aged 20 years—healing scars on face after severe burns First session. She had a large scar on her face after suffering burns at the age of three. On the couch, therapy centres on spontaneous regression to the episode with massaging of the scar, which healed nicely in terms of energy. She cried and relived a lot of suffering, which was processed. Before this, we talked about choosing a life of suffering or a peaceful death. She disclaimed responsibility based on karma theory [it is not her fault that things are the way they are, it is because of her bad karma, i.e., the consequences of harmful actions in previous lives that pursue her], which we discussed. Another appointment in two weeks.
>
> EXERCISE: Write a complete list of all your problems in life. Write half a page on each problem.

The physician touched her, and she felt. The healing process was underway. The patient must then be supported in acknowledging, and she has to verbalise the difficult feelings that emerged. The physician then joined her in her feelings. It was important that the physician accommodate the patient with all her feelings, allowed her to express herself and her feelings in the situation, even if she was very childish, very aggrieved and very hurt. All these feelings have nothing to do with the physician, they are things of the past, which the patient really needed to talk about and express. This took place during the second session with the patient. Second session. She has done her homework—about ten pages about her problems—she will type it out and improve it for next appointment. Her father abused her sexually when she was 16 years old. "Perhaps before that, too?" the patient asked. Has a boyfriend, but right now neither of them knows whether they should keep seeing each other. She is very dependent on the security and closeness that she gets with him. She feels very sorry for herself. Her wicked mother has ruined her life. EXERCISE: Write an essay on your self-pity. Also write a little about your conceitedness.

Next time: We continue to work on the scar. Have a portrait taken that clearly shows your scars. In helping the patient to acquire a more down-to-earth and constructive life philosophy, we have to join her in her perception of reality. Again, we can meet soul to soul, this time through the mind, and together examine whether the patient's present life perspective is the view of life that she basically has and wants to have. Massive self-expression concerning life perception, perhaps in the form of a written biography, promotes this process considerably. The therapist must be able to accommodate even the most sinister view of life and existence

to help the patient acquire a more down-to-earth life perspective. In this session, preparations are made for the major shift in perspective, which the patient needs in order to regain her enjoyment of life.

Third session. She has done her homework—about ten A4 pages, partly about self-pity. The patient's name used to be P, but she went to a numerologist and then changed her name to the present one. That way, she felt that she got away from her old life. It felt good. "Have barely seen my parent for a couple of years—they sort of destroyed me," she says. She cries and refuses to take responsibility for her past. EXERCISE: Write from the present and go back through all the major events that have evoked feelings in you: what happened, what did you feel, what happened, what did you feel,, etc.—and what did you decide in each situation. May take up to 100 pages. One hour a day. Another appointment in two weeks. To help the patient experience a real breakthrough to herself, she now has to begin sorting out everything that keeps her from being herself.

It is a vast job, but it can be done. Now our job is to motivate her to make a persistent and substantial effort, perhaps for a year or so, until she finally and inevitably breaks through to her real self. A patient who chooses the soul's perspective often experiences a more profound meaning of life, joy in being alive and fundamental peace and being. It feels like coming home, like knowing oneself again, like being back in control. Like this statement from one of our patients: "I haven't felt like this before. I have always been insecure. People have always led me by the nose. Now it is completely different, and now *I* am back in charge. And I am happy."

This experience of things falling into place in life triggers an inner revolution, which frees the self-healing powers of the body and mind. Personal development is a life-long process, but the road to health need not be as long. And in the long term, we also develop good quality of life and good functional capacity—at work, socially or sexually. Therefore, we believe, holistic medicine is a key to the good life in a broad sense and also a key to help people become useful to and coherent with those around them and society. Holistic medicine is thus also a sustainable project of public utility, which optimises the value of the individual in relation to its fellow human beings, society and the ecosystem. It should be emphasised that the starting point of consciousness-based medicine also includes the individual's physical and mental appearance, first and foremost the body, which can be regarded as a direct manifestation of the patient's consciousness. In our view, the body and feelings contain just as much consciousness as the head and mind. That is because our consciousness cannot be narrowed down to the mind and, therefore, does not reside in the head but indeed in the whole that embraces all our parts. It is an interesting fact that what patients need to heal spontaneously is the combination of attention, respect and care. And it is an interesting fact that this very combination cannot be given without profound and genuine love of the other person.

What may appear to be technique and scientific knowledge in the eyes of the young therapist, gradually—as experience and wisdom grow—increasingly resembles genuine love and kindness towards one another. Consciousness-based medicine thus moves towards what we call social utopia. We consider the holistic process the first step towards consciousness-based medicine.

Discussion

Biomedicine focus on the biochemistry of the body, while consciousness-based medicine (holistic medicine) focuses on the individual's experience and conscious whole (Greek: *holos*, whole). Biomedicine perceives diseases as mechanical errors at the micro level, while consciousness-based medicine perceives diseases as disturbances in attitudes, perceptions and experiences at the macro level—in the organism as a whole. Thus, consciousness-based medicine is based on the whole individual, while biomedicine is based on its smallest parts, the molecules. These two completely different points of departure make the two forms of medicine very different, they represent two different mindsets, two different frames of reference or medical paradigms.

Biomedicine, consciousness-based medicine or holistic medicine

The physician helps you. The physician supports you in helping yourself. The physician is responsible for how you are doing. You are responsible for how you are doing. The physician treats you with medicine and surgery. You develop by feeling, understanding and letting go of negative perceptions based on body and compliance, based on consciousness and learning. Disease controls the individual. Health and quality of life are created through personal development.

Peace and quiet to recover. Inspiration to rediscover hidden resources. Focus on lifestyle and physical factors. Focus on life philosophy, wholeness or "soul," responsibility, love, respect and care. Your genes determine how beautiful, good and true you are. Your degree of inner consonance determines how beautiful, good and true you are. The greatest and most conspicuous difference between biomedicine and consciousness-based medicine concerns the perception of resources. According to biomedicine, you need support in the form of chemical substances, when you are ill or weak, while according to consciousness-based medicine, you need to mobilise your hidden resources. This does not imply that a holistic physician will not prescribe penicillin to treat pneumonia, or that the biomedical oriented physician will not talk to his patient. But it does imply a totally different perception of the resources required to help the patient get better and function better.

Another highly striking difference between biomedicine and consciousness-based medicine is the relationship with quality of life. To biomedicine, good quality of life is a result of health, meaning that the patient's quality of life will improve when the doctor treats the body or mind with medicine. To the holistic physician, improvement of the quality of life is the very key to mobilising the hidden resources. To the biomedical physician, increased quality of life is a result of improved health, while to the consciousness-oriented physician, improved health is a result of increased quality of life. According to consciousness-based medicine, the patient acquires quality of life when he or she takes responsibility for his or her life.

According to biomedicine, the patient acquires quality of life when the doctor takes responsibility for the patient. Hence, the perception of the patient's responsibility for his or her own life and illness is another important difference between biomedicine and consciousness-based medicine. Therefore, biomedicine may be defined simply as medicine

based on a biochemical perception of man: we are chemical machines. Similarly, consciousness-based medicine is founded on the consciousness of man: we are conscious beings, who choose our own lives and thereby to a great extent create our own lives. The biomedical perception of reality is that everything consists of atoms and that experiences and consciousness are kind of by-products of the chemical processes in the brain. The brain chemistry makes all decisions; consciousness actually lags far behind, but merely imagines that it matters.

Consciousness-based medicine considers consciousness to be just as real as—but not more real than—substance. Consciousness is a real phenomenon, an element, if you will, in the same way as atoms. And our consciousness has great influence. Through all of our minor and major, conscious choices, consciousness is the primary cause of our present lives. In this chapter, we have compared biomedicine and consciousness-based holistic medicine. It is very important to stress that we imagine the excellent physician to use both toolboxes and more (31) in his treatment of his patients; we actually want the physician to be *multi-paradigmatic* (32). Often both biomedicine and holistic medicine must be taken into use to cure a patient; mostly the acute problems can be solved using biomedicine, while chronic health problems need a holistic approach (33-37).

Using holistic medicine and therapeutic touch, being very intimate with and very close to the soul of the patient, emotions and body, is only possible with an ethical consciousness on the part of the physician (31,37). We strongly believe that the results of a holistic physician never will be better than his ethical standard.

There are many great theories and philosophies in favour of a holistic approach to human health, like the works of Maslow (38), Antonovsky (39,40), Frankl (41) and Jung (42), but what is a thousand times more important for medicine than the opinions and perspectives of wise old men is your own understanding in the daily clinical practice of what it takes for you as the physician to cure your patient and make him or her well again.

Conclusion

There is only one tool in holistic medicine, and that tool is you. When you come from love and beingness, you will have a dramatic impact on people around you; you will inspire to self-exploration and deep contemplation, and self-insight will rise in people around you.

If you are less realized, you come from mind and then you need a toolbox. The better you are to use the tools and the more advances this toolbox is, the more patients you can help, and the better can you help. But don't ever forget that these tools are illusory, and that in the end there is only you as the tool, and only your love and care to help the patient.

One of the great advantages of consciousness-based medicine is that, in an abstract sense, the physician should always do the same thing, regardless of what is wrong with the patient, namely support the patient in becoming more conscious, more whole and more himself. Biomedicine often requires advanced technological assessment programmes and completely accurate diagnoses prior to implementing a successful treatment. In the field of consciousness-based medicine, it is far more important—as Hippocrates (460-377 BCE) already taught us—which person has a disease, than which 129 diseases a person suffers

from. The holistic medicine is basically, as it was in the days of Hippocrates, about the recovery of the human character, serving the realization of our purpose of life.

Therapeutic talk and therapeutic touch are arts, spiritual arts really. The day you truly master them you don't need them any longer.

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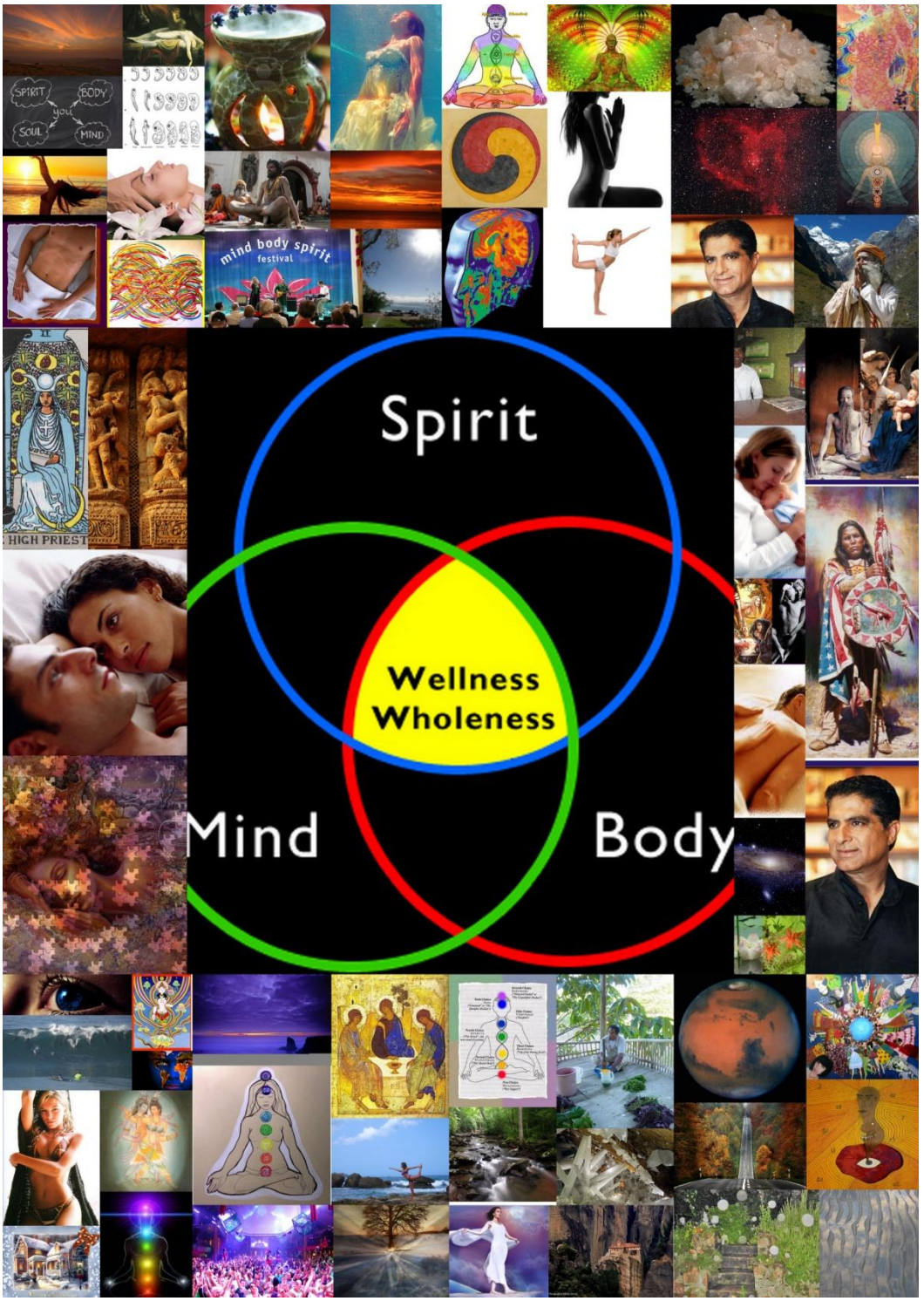
Exercise

1. What is a tool? Use a hammer or a similar tool to define what a tool is. Are tools relevant to interventions that address the consciousness? Are there structures like nails and bolts that can be hammered and screwed in consciousness? What are the structures and how do we intervene on them?
2. What is touch? Analyse the process of touch in detail and see if you can split the process of touching up in sub-processes. Use a simple example as holding hands to see if you can understand what is really going on. You might be surprised to see that most of the process is happening before the physical touch begins. "It's all in the mind"—is it?
3. Can you say more through your presence than through words? Can what you do to help be completely non-verbal and even non-active?



Chapter XVI

Clinical medicine and psychodynamic psychotherapy: Evaluation of the patient before intervention

Let us admit that we have a problem. There is almost no data in holistic medicine. It is mostly about philosophy, different perspectives on human nature and existence. In holistic medicine, the doctor is the tool, so what we have to say is really about you. And it is far better that you explore and find out for yourself than if you are told about you by us. There is a lot to be said about man and human nature in general, and, therefore, is this book filled with pages. But as you read along, you will find that most of our writings repeat themselves almost infinitely. There is very little new, if any. What might be new is the perspective itself: That we are loving beings who can help each other. But we know that already. What is difficult in reality is to stick to this perspective when things get hot—as they always do. So our chapters are a little like a Catholic mess: You know what is coming, you know the tune, the fragrance, the meaning, the message. You have heard it all before, and you are never really surprised. You came because you needed to be reminded about what is good in life, when life is getting tough.

By now you know where we are coming from; you know when you see the headline what is in the chapter. We simply repeat ourselves in more and more detail, until we feel certain that you have got it… but if you are clever, you got it already. In this chapter, we will once again explain to you that holistic medicine is about helping the patient to self-insight.

Clinical medicine has been defined as "the study and practice of medicine by direct examination of the patient." This approach to medicine is appropriate whenever the patient's problem or disease is caused by repressed material contained in the patient's unconscious. According to psychoanalysis, body-psychotherapy and clinical holistic medicine, most mental and physical illnesses are caused by informational disturbances in the body's tissues likely to be a direct consequence of repressed emotions, feeling and thoughts from traumas earlier in life. This is the most logical explanation why the rehabilitation of the sense of coherence seems to induce healing of both physical and mental diseases.

If it is unconscious material that causes the patient's disorders, the patient will not be helped by a precise anamnesis and an accurate diagnosis; the only thing that can cure is the unconscious material being integrating in the patient's consciousness. If a chronic patient

with a long history in biomedicine has not been helped, in spite of many biomedical doctors using their best efforts on this, the likely cause of the patient's illness or disease is in the unconscious. In this case, there is no reason to spend much time on anamnesis and diagnosis of the patient; the right thing to do is to start the exploration of the patient's inner, unconscious life together with the patient right away. This strategy leads to the most cost-efficient use of time and often to the healing of the patients experienced health-problems in only 20 sessions. Many disorders can be treated effectively and without adverse effects/side effects with clinical medicine (NNT=1-3 and NNH>1000), which should be compared to NNT=5-20 and NNH=1-4 for most drugs.

Introduction

The concept of "clinical medicine" has two meanings; the one is the well-known science of practical medicine, and another is much more traditional, well expressed by "BioMedExperts.Com" (1): "Clinical medicine: The study and practice of medicine by direct examination of the patient."

Before physicians had drugs—from around 1900 and all the way back to the old Greek physicians in the line of Hippocrates (2)—medical treatment was about examination the patient and shedding light, consciousness and understanding on the human problems. In this process of common exploration of the patient, where the patient little by little understood what was wrong and what needed to be corrected in life, the patient was healed (or died). The disease process could be of one of two types, disease caused by external causes (epidemics were well known even in Hippocrates time (2)) and by internal causes. The internal causes were seen as caused by either divine influence or of lack of self-knowledge at that time. Devine influence was harder to deal with, but the exploration into self and the unconscious seem to be an integrated part of the practice that later was labelled "character medicine."

Character medicine was about balancing the four symbolic elements of water, fire, earth and air in the person's character. The Greek medical system was holistic and could best be translated into something like "energy healing" or "consciousness-based medicine." The tools for the combined examination-treatment was talking and touching; therapeutic touch in the form of massage and acupressure seems to have been the normal treatment of a long series of problems.

Freud and psychoanalysis

The concept of "the unconscious" was developed first by Sigmund Freud (1856-1939) and the psychoanalysts of the 20th century. The unconscious was always feelings/emotions and thoughts linked to personal history and especially painful and overwhelming moments called traumas or "gestalts." Freud, Reich, Jung, Lowen Rosen, Anand (3-9) and other psychoanalysts and body-psychotherapists focused on sexual traumas as events that seemed to hold on to the most intense feelings that needed to be integrated by the patient in order to heal physical and mental illnesses. The successful healing of a long number of mental illnesses including schizophrenia (10) led to the conviction that all mental illness were caused

by unconscious material—traumas with repressed sexuality. Wilhelm Reich (1897-1957), another therapist like the many from the contemporary schools of body-psychotherapy, believed that even cancer and coronary heart disease were caused by repressed emotions and sexuality, and still today we have physicians like Dean Ornish who cure heart patients by learning his patients' intimacy, and thus "opening their hearts physically, emotionally, and spiritually" (11,12). In New York, psychoanalysts seemingly have good results with treating cancer patient in much the same way (13,14), and in Germany, complementary therapists are going the same way with their patients (15). The understanding of holistic healing has recently been more clear after the work and development of "salutogenesis" by Aaron Antonovsky (1923-1994) (16,17).

Exploring the unconscious with the patient

To cure a patient from a problem caused by traumatic content in the patient's subconscious is in principle easy: Just explore the unconscious together with the patient, help him or her to confront the difficult emotions and feelings, and integrate all that happened in the consciousness. This is the strategy of psychoanalysis, where free associations have been the major tool. This has also been the strategy in Reichian bodywork and body-psychotherapy. It was also, as mentioned above, the core of the therapy of the old, holistic physicians working with conversation and touch therapy to develop the patient's self-insight and character.

Interestingly, the process of healing in "clinical medicine"—exploring the patient together with the patient in the intent to cure—are almost opposite the process of today's biomedicine, where anamnesis, testing and examination leads to diagnosis, and first after that the establishment of the right drug, surgery or other (mechanical or chemical) intervention for treatment. In biomedicine, the accuracy of the anamnesis and diagnosis is essential to competent treatment. In clinical medicine, the anamnesis and diagnosis are only of importance if the physician is in doubt of the cause of the disease. If the cause is external—bacteria as in syphilis for example—it has little meaning to work on the patient's unconscious, but as soon as the cause is established as internal, based in the patient's subconscious, there is no more need for anamnesis and diagnosis. All energy must now be focused on the process of healing, by shedding light into the patient's unconscious.

If the patient is a chronic patient, who already has been to a number of well-trained biomedical physicians, there is no reason to suspect that the reason is external, because that would have been discovered already. In this situation, the treatment should start right away by taking the patient unto the journey of exploring the patient's inner life.

The efficacy of clinical medicine

Clinical medicine has been documented effective in physiotherapy (18-23), psychodynamic psychotherapy (24-26), sexology (27-30), and CAM, i.e., clinical holistic medicine (31-38). Number Needed to Treat has normally been about NNT=2, and Number Needed to treat to Harm has been shown to be NNH>1000 or more (39,40). Heart diseases and cancer have been rather successfully treated (NNT=3-7), and even some cases of schizophrenia seem to

respond well (NNT=3) (10). In comparison to this, most drugs have a NNT=5-20 (41) and a NNH =2-4 (compare i.e., the statistics for the antipsychotic drugs (42)).

In spite of the success for therapists using clinical medicine to help their patients with physical, mental, existential, sexual health problems and dysfunctions, there has been little interest in research and development of this kind of medicine by universities and government institutions. The pharmaceutical industry has no natural interest in this kind of medicine, and the large industrial lobby might be one of the reasons for the almost complete lack of interest in this field until recently. With the non-drug medical tools of psychotherapy, sexology and CAM, many of the health problems that torment today's citizen could be alleviated.

A practical solution for research and quality assurance

Instead of using much time on anamnesis and diagnosing, we recommend the patient should fill out a short questionnaire like QOL5 (43) or QOL 10 (44) (see section 10) to measure:

1. Self-rated physical health
2. Self-rated mental health
3. Self-rated sexual functioning
4. Self-rated self-esteem
5. Self-rated I-strength
6. Self-rated relation to partner
7. Self-rated relation to friends
8. Self-rated social ability
9. Self-rated working/studying ability
10. Self-rated quality of life

To establish that one or more of these dimensions are low is sufficient to justify the immediate onset of the treatment with an appropriate clinical medical tool (45), a sexological tool (46) or a psychoanalytical tool (47,48) for healing mental disorders or personality disturbances.

If the therapist measures the patient before and after the treatment and again after one year—i.e., following the square curve paradigm—it is easy to see if a patient was helped and make the statistics over the efficacy of the clinical work in relation to the different health problems (compare how we did it for Research Clinic for Holistic Medicine and Sexology (32-39)). The one-year follow up is important to document that the results are stable through time (38).

Conclusion

In general, clinical holistic medicine helps chronic patients cure physical, mental, existential and sexual illnesses and dysfunctions that primarily are caused by repressed thoughts and

emotions in the patient's unconscious. Often, the patient has tried to be helped by biomedical drugs without success. If a patient has a chronic condition that has not been cured with biomedicine, there is no reason to spend time once again making a thorough anamnesis and to give an accurate diagnoses; a rough categorization into the categories of feeling physically ill, mentally ill, sexually dysfunction, etc., by a short questionnaire is sufficient for documenting the patient's progress.

In general, the anamnesis and diagnosis has little therapeutic value in clinical holistic medicine, as all patients in principle are treated the same way, to rehabilitate their existence, improve their sense of coherence, and improve health, quality of life, and ability in general—the sexual, social, working, studying ability, etc. We recommend that all patients fill out a short questionnaire on self-assessed physical and mental health, quality of life, and ability, like the QOL5 (43) or QOL 10 (44) (see Section 10).

The patient's and the physician's and time, money and other resources should be used wisely and focused on healing that happens when the physician and the patient together explore the patient's inner life to re-integrate repressed feelings. Using too much time on taking the patient's life story and on giving the patient specific, biomedical diagnoses that are only useful when you are treating with drugs is wasting time and money in clinical holistic medicine and holistic sexology and might, therefore, be considered a principal error.

Never forget that what in the end helps the patient is his or her improved self-understanding.

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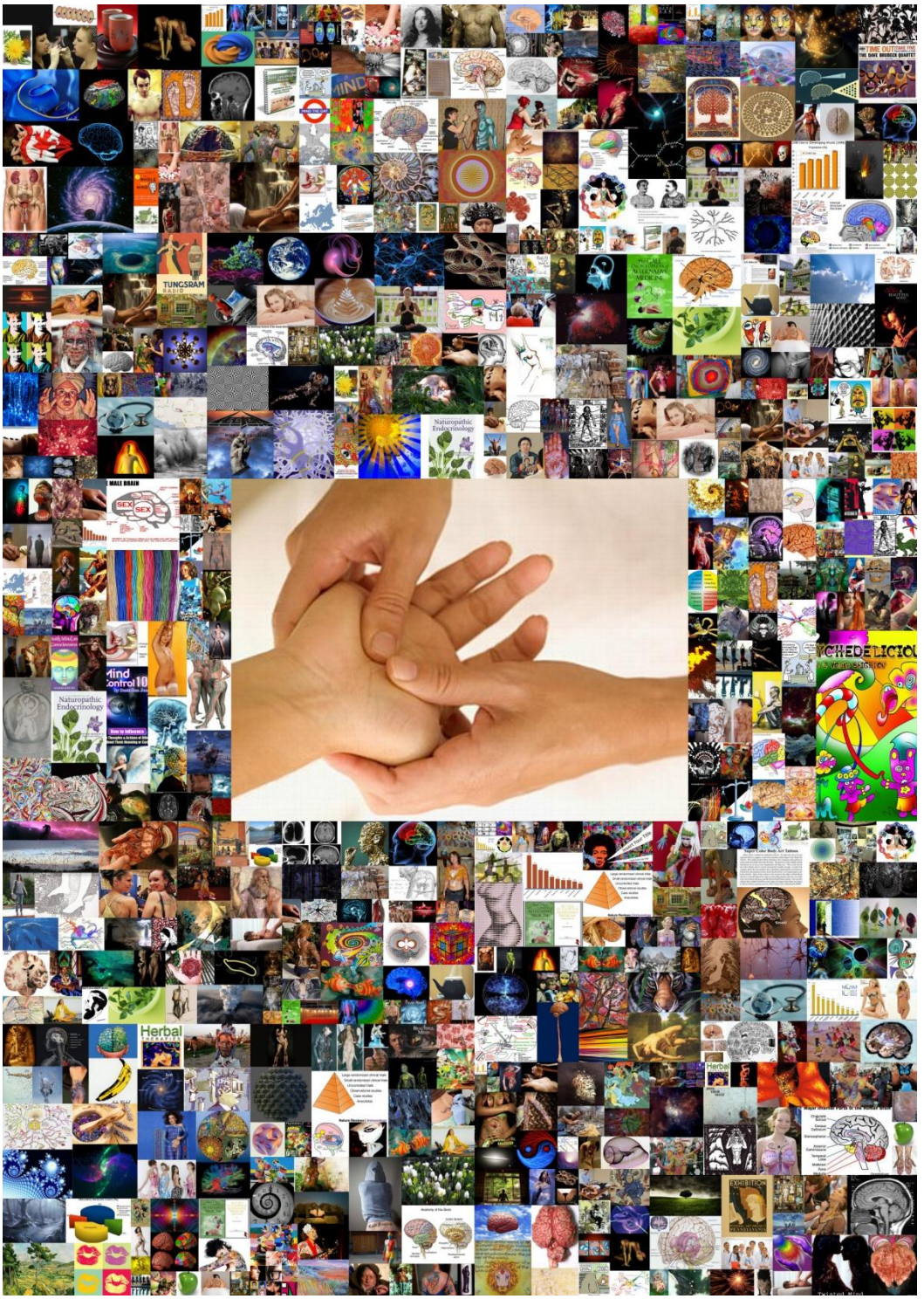

Chapter XVII

Therapeutic touch as a classic art of healing

If you have a very strong presence, you don't have to touch to heal. The physical contact is only necessary when you need to get a healing going that will not happen without your touch. This is the first and most important thing we have to tell you about physical touch in the holistic clinic.

With this said, it is time for us to explain to you about therapeutic touch. Sadly, there is not much to say. You need to learn by experience. Only by touching and being touched, by touching as many people you can and being touched by so many, in so many ways possible, can you learn about touching. Only by meditating on touch, contemplating touch, experimenting with touch, playing with touch, can you learn to touch. When you start, you will soon realise that touching is DIFFICULT. It is an art to relax and let go, to give acceptance and the feeling that everything that happens is just fine. It is an art, really. And you must LOVE to touch to be good at it. To love it, you need to have a positive attitude toward the body and everything that goes with it. This is the most difficult thing, of course. The body has lots of secret spaces, fluids and secrets; it has strong odours and other often-provoking qualities. Just to look at a body can impact you severely. You can feel disgust, pity, sadness, or positive feelings like sympathy, love, care and even sexual arousal. So touching the body is very intimate, very private, very close to another person, much too close for most physicians who have been accustomed to the safe distance of a desk and a prescription of drugs. So you need to find you own personal way to deal with this.

Touching was the primary tool in classical holistic medicine, but now it is often a forgotten part of medicine. The manual medicine or therapeutic touch (TT) is much more powerful than many modern, biomedically oriented physicians think. Pain and discomfort can be alleviated just by touching the sick area and in this way help the patient to be in better contact with the tissue and organs of their body. Lack of presence in the body seems to be connected with many symptoms that can be readily reversed simply by sensitive touch. When touch is combined with therapeutic work on mind and feelings, holistic healing seems to be facilitated, and many problems can be solved in a direct and easy way in the clinic without drugs. This chapter will give examples of the strength of manual medicine or therapeutic touch in its most simple form and points to the power of physical contact between physician and his patient in the context of the theory and practice of holistic healing. Intimacy seems

highly beneficial for the process of healing, but it is very important to distinguish clearly between intimacy and sexuality for the physician and his patent to be able to give and receive touch without fear and without emotionally holding back.

Introduction

The emergency room is the place in the hospital where physicians can be rewarded with immediate gratification as they treat and repair people who come with acute damage to their arms, legs, stomach, back, eyes or ears. It is quite amazing how far you can get towards improvement and relief of problems just with a handful of simple steps and a comprehensive understanding of the human body. In brief, it is possible to divide injuries into visible or external injuries that can be taken at face value and internal, less visible injuries that require the assessment of a skilled physician and sometimes also x-ray, ultrasound, CT scanning and blood tests. A truly experienced physician should be able to see at a glance whether a patient is acutely or chronically ill, whether the patient is in imminent danger, as might be the case following a stroke or a heart attack or a perforated appendix. Here, the principle is the good intention to help, combined with often very simple steps and procedures. Some words of comfort, assuring the patient that it will grow together again, heal nicely and become as good as new, a bandage, perhaps a splint or plaster and perhaps a painkiller or two. While there are new tools such as CT scanning, which help in making a better diagnosis and replace the guesswork and clinical assessments of former times, most treatment options are the classical ones. The modern physician does not seem to believe in the healing power of the therapeutic touch (TT). But the simple manual procedures are not all that the skilled and holistically oriented physician can do with his hands. Since ancient times, all the way back through history to Hippocrates (460-377 BCE), the physician has used his hands to cure (1,2). Many of these treatments are today not used and looked upon as inefficient or meaningless.

The holistic process of healing

New understanding of the holistic process of healing seems to cast new light on these old procedures, which could give them a renaissance in the medical clinic. We have used the life mission theory (3-8), the holistic process theory of healing (9-12) and the related quality of life theories (13-15) in our work and understanding of healing. The philosophical change of the healing of a person is often a change towards preferring difficult problems and challenges instead of avoiding difficulties in life (16-23). The person who becomes happier and more resourceful is often also becoming more healthy and more talented and able to function (24-26). In this chapter, we will acknowledge the fine art of simple, local and, therefore, mostly non-holistic manual medicine or therapeutic touch with a number of examples of complete healing with simple mechanical means. This is the kind of procedure by the physician that most people acknowledge and appreciate. We believe that manual medicine or therapeutic touch combined with work on mind and feelings can give healing to the patient on a more global and profound level in accordance with the holistic process theory of healing and the related theories.

Physical injuries

The body is frail. The flesh is easily injured. Many structures such as the skin, muscles, cornea, ear drum and mucous membranes are vulnerable. If we regard the body as a mechanical structure or machine, there is every reason to worry. It is practically designed to break by normal use. Obviously, life can only take such liberties with the design, because the body has such tremendous healing potentials. If something breaks, it will knit together again. This means that a great deal of the treatment is explaining to the patient that there is no cause for worry, because the good body will take care of itself if you leave it to heal in peace. Sometimes, though, we can do much to help promote the healing process. Below are three short case reports (as taken from the notes of the family physician) to describe classical medical treatment of physical injuries:

Male, aged 36 years with an eye injury

The patient was cutting stone with an angle grinder without wearing glasses and received a glowing metal chip 1 mm x 0.3 mm in the left cornea at 7 o'clock, outside the central vision. Chip removed with a needlepoint without any visible epithelial damage following anaesthesia. Treatment: eye pad and eye drops. He was instructed to return in three days if pain persisted. The cornea of the eye consists of an external mucous membrane, the epithelium, under which is a crystalline layer of protein fibres that turn opaque, when exposed to heat, because of coagulation (as with egg white). However, the greatest damage to organs is often caused by the body seeking to heal them. If the foreign object is removed, the patient can avoid a lengthy and painful inflammatory healing process, which in the worst case may cause permanent damage to the cornea. The art is to remove the foreign object without causing damage. When that is not possible, the physician must avoid causing more damage than the natural healing process would do. In this case, the chip that was burnt into the cornea of a 36-year-old worker was removed without any significant damage. The patient was more frightened than hurt.

Male, aged 45 years with a burst eardrum

The patient burst an eardrum, when blowing his nose yesterday. Examination: Small cut 1/4 of the eardrum diameter, neatly closed with coagulum. Should return to consultation in three weeks, if hearing is not back to normal. It is the most exalted job of the physician to convince the patient that the body is strong enough and will heal without any problems. Naturally, the latter is not always true, but we believe that the lack of confidence may delay the healing of damaged tissue if it leads to a withdrawal of attention from the area. The bad habits that may spring from the patient's lack of confidence in the body following a trauma can also lead to more damage. If you do not trust your foot to carry you after an injury, protracted incorrect use of and putting of overload on the foot may lead to new injuries.

Male, aged 45 years with scar tissue

Keloid formation—hard scar tissue 40 x 3 x 3 mm above right heel—corresponding to wound caused earlier by the hoof of a horse. Gentle massage. Prognosis: will pass in the course of six months. The patient can continue to do his own massage. Wounds may heal with considerable keloid formation. We believe that recovery will be quicker if we massage the tension and shock out of the wound, but there is no scientific evidence of this. Under any circumstances, the patient will become familiar with the scar during the massage and will often feel the problem diminishing, whether the keloid disappears or not.

Pain in the locomotor system

Pain in the locomotor system constitutes the greatest complaint by people in the Western hemisphere, although it is actually quite easy to relieve. Nevertheless, many adults and children do not get the help they need from their family physician or general practitioner (GP).

In any schoolyard, you can find children sitting on benches with growing pains, unless they are limping about playing. Many cases of stomachaches in children are caused by tension in the abdominal muscles because of fear and insecurity. Often, it is easy to remedy these problems, if the GP and the parents are willing to consider what lies behind them.

Male child, aged 13 years with knee pain and growing pain

Pain in left lower leg three cm below the knee and laterally. Examination: there is no pathology around knee or leg. Only finding is a very tender area 3 x 3 cm about a hands breadth below the knee, which is massaged until free from pain, when walking no longer hurts. Instruction in self-treatment. A young boy comes limping into the surgery. His knee hurts, and he can barely walk. Ten minutes later, the painful area has been identified and massaged until free from pain. And miraculously, the boy has a normal gait again without any complaints. Contact, touch, reassurance, confrontation of the pain—and when the patient becomes present in the knee again, the symptoms are gone. We wonder whether it is mostly in the boy's consciousness that the status of the knee is upgraded from bad to healthy? Pain that vanishes on touch can be instructed and explained to the mother in order to touch her child, be attentive and the pain will often disappear. We work with holistic medicine, and because we approach the cause of the problem we are able to help the boy.

Female, aged 36 years with knee pain after fall

She fell on her knee three months ago with no swelling or discoloration at the time. Her knee is still hurting. She believes that there is a bone fragment or similar. Pain localized in subcutis just below a scar on the knee that becomes visible with the leg extended. Knee is massaged almost until free from pain. The patient is encouraged to let partner massage ten minutes each day for two weeks. Should return if the problem persists. Children are not alone in finding it difficult to repossess their bodies after a trauma. Often people really, truly hurt, day in and day out, until someone asks: "Is *this* where you hurt?" pressing the fingers right into the pain and making the patient catch his breath and then breathe it all out, letting go of whatever he is unconsciously guarding, the painful site. *Letting go* is a simple cure, as old as the art of healing but truly difficult for people of the world today, who keep hanging on to it all.

Female, aged 28 years with sprained ankle

Industrial injury yesterday—stumbled and twisted her ankle. Slight swelling around left ankle laterally, claims having difficulties making her toes "work." Examination: No indirect tenderness, direct tenderness corresponding to strokes from lateral epicondyle to forefoot. No loss of sensitivity. Protective immobilization of sprain. Instruction: Able to work. Prescribe mobilization until pain threshold, analgesics if required. Estimated time before healing two to three weeks. Some of the joys of being a physician come from knowing the natural course of healing. Once you pass this knowledge on to the patient, who then accepts the situation, the problem is often solved. Pain or discomfort for three weeks is quite acceptable once you know that this is how it is supposed to be. So a brief talk to make the patient aware of this is very valuable.

Male, aged 21 years with back problems after football

This patient has had back pain for two months, since he fell on a hard surface, landing straight on his back while playing football. Examination: Spine: normal tension corresponding to neck and shoulders, upper and lower back. It is possible to induce the familiar pain by pressing on the tense muscles, but not by pressing the spinous processes. No doorbell syndrome, no subluxations. Recommended exercises: Press-ups; bending forward as in touching the toes. Break the vicious circle by relaxing and exhaling when it hurts instead of getting tense. Should return if the problem persists. Many people see the back as a weak structure. It is not, but quite the contrary. When people get "back trouble," it is mostly mild sprains or minor muscular problems that will normally resolve easily with training and exercises. Every now and then a patient does not willingly accept the thesis that the back is strong. When some people refuse to drop the idea that "their back is weak," until they have had psychotherapy, it is because of the important symbolic meaning of the spine. A patient who subconsciously feels "spineless" cannot have a strong back. There is a lot of rough play on the sports fields, and young men may suffer some serious tissue damage when playing football or doing other sports. Fortunately, the body has great healing potentials, so all they really need to worry about is the head (brain) and knees (cruciate ligaments). The knee seems to be the football player's weakest link. Remaining aware of the knee during the game is the best form of prevention, and it can be developed through different exercises in enhanced presence in the body.

Female, aged 24 years with back pain

Back pain. T2-T12 very tense and tender, almost arched, manipulated into place with 10-20 loud snaps following a brief talk about why the patient is tense: she is moving and is finding it very problematic. Afterwards, she feels much better. Back pain is another widespread complaint often encountered in medical practice. Often people do not realize or simply ignore the correlation between major acute problems in life and stresses in the back. As soon as they become aware of the correlation, they virtually hit jackpot. The back pain is almost gone in a minute, and the problems resume their full emotional scope. It seems possible to temporarily "park" acute emotional problems as stresses in the back. Obviously this does not solve the problems but rather makes them worse.

Male, aged 74 years with "frozen shoulder"

After helping out during a removal, the patient had pain in the left arm, and he found it difficult to lie on the arm or carry things. There is a slight tingling down into the fingers. He has trouble getting dressed. Examination: Distinct tenderness corresponding to lateral end of left supraspinatus muscle and tenderness in the shoulder. No lowered sensitivity, but reduced strength in brachial muscles, probably because of protective reaction. Diagnosis: Tendinitis in left supraspinatus muscle without rupture. Intervention: Referral to physiotherapy and prescription for analgesics and to avoid lifting heavy objects with arm for two to three months but remember to use it. Protective immobilization can be deceptive. There is nothing wrong except pain or tenderness, but the whole arm may have lost almost all its strength. A few carefully chosen remarks to the effect that all is well will often, as in this case, restore a lot of the strength. And in our opinion, the arm should be used with care and not spared completely. It should be exercised and used to the pain threshold.

Infections

The human body would be eaten by viruses, bacteria, fungi and other parasites within just 24 hours, if not for an effective immune defence. At the microbial level, we fight bravely for our survival.

Once the bacteria get the upper hand for a while, the alarm is sounded in the immune system. Only then do we become aware of their existence. Infections are some of the most frequent disorders in general practice. Infections come about when the immune system is weak, which is often the case when a person is not thriving.

Male, aged 41 years with a chronic throat infection

Severe throat complaints with pain and recurrent tonsillitis. Examination: Oral cavity: Larynx swollen and tender, no coating. Strep A negative; distinct pain corresponding to hyoid bone, which is unlikely to be related to the inflammation; three large lymph nodes bilaterally along the sternoclaidomastoideus muscle. Diagnosis: chronic throat infection. We talk about potential causes of this problem, and it turns out that the patient sings and has to force his voice. It began with a throat infection. Pain probably due to tension in the throat because of incorrect use. He needs to work with his voice and learn to relax. We shall wait and see. A chronic inflammation of the throat is interesting in that it often appears to be completely or almost sterile. It is not caused by bacteria but rather by an internal disturbance in the body itself that the patient can suppress with training, exercises and working with his or her consciousness while seeking the cause of the disease.

Oedema and allergy

Several other conditions can be relieved by some simple steps and/or patience. Let us look at some of them in the next case records.

Female, aged 20 years with ankle oedema (swelling)

Oedema in lower limb; stands a lot. Auscultation of the heart: normal. Diagnosis: suspected idiopathic [not caused by another disease] ankle oedema. Prescribe exercises to activate skeletal calf muscle pump. Should come back for follow-up to talk about body use when standing at work. A young woman should not suffer swollen legs. There is some imbalance that she ought to get rid of. But how deep can you go when talking to a young woman living a fast life? So we provide a "quick fix" and tell her that she can come back for more. She does not, offhand, feel the need to. She is given ankle-flexing exercises, but not diuretic drugs.

Female, aged 51 years with an itching eye

Allergic conjunctivitis [a sterile inflammation of the conjunctivae, the mucous membranes covering the eye] in right eye, intensified by her scratching. We try prescribing eye compress and eye drops... Another classic: When it itches, you scratch, making the itching worse, and then you scratch even more. Where does it end? In this case, the patient had to have her eye covered. That broke the circle, and the eye was allowed to heal.

Male, aged 35 years with pain in the scrotum

Presented with very tender right side of scrotum a week ago, now no complaints except for worry. He was informed that the finding is quite normal, and so is varicocele [swelling of the scrotum]. Should return in the event of acute problems. Embarrassing parts of the body, the parts most often the objects of teasing when we are little, are hard to relate to and often problematic.

Psychological and social problems

Often, a patient consults a physician about problems that are not physical. Our mentality and our environment are intricately connected, so here we are really put to the test. To help a patient with psychological problems, he or she will often need to work on perception of life and human nature. Many times, it does not take a lot to achieve great results. The key to the matter is to put the patient on the right track, and the rest will follow. In the case of children, sometimes the parents are behind the problem and in need of help. Also here physical touch and holding seems mandatory for success. Often, this is not even mentioned in the case record as it is taken for granted. Sometimes the holding is solely emotionally but of the same intense quality as physical holding. This is "holding without holding," a beautiful art that can solve many problems.

Girl, aged five weeks with crying

Five-week examination. She develops normally and well. Parents believe she has colic. She is very hot, because her parents dress her too warmly for the weather, 25-30ºC. She stops crying when they take some of her clothes off and begins again when they put her clothes back on. Guidance. Parents who cannot make their child stop crying will often say that it has "abdominal colic," spontaneous stomach ache of unknown cause. In our experience, it is always possible to make the child stop crying, if you can satisfy its needs (perhaps except for children with severe brain damage). This child was undressed in the summer heat and immediately stopped crying. After the examination, the parents dressed their child again, who immediately started crying. It is sometimes a mystery how parents can be so unobservant. It gives a feeling that really skilled specialists are needed in childcare. Modern physicians do not believe that "colic" can explain why children cry, but in the old days, this was considered a reasonable explanation. We have a patient, who was left to cry in the stairway for three months on end. Obviously, it is not acceptable to neglect and maltreat infants in this manner.

Girl, aged three years with a fussy mother

The girl is thriving and looking well, but mother thinks she has a sore throat. Examination: Tonsils swollen, but not read or coated. General health not affected. Diagnosis: Viral infection. Wait and see for eight days. The "fussy mother" torments people around her. It is difficult to inspire a mother with confidence that her girl is strong and able to cope if she fundamentally lacks faith in life. We simply ask the girl, who says that she is fine. If she is not the least affected, she has the last word on the matter.

Female, aged 25 years and a single mother

1. Ear pain that turns out to stem from a major blockage/muscle tension in the neck, which is massaged.

2. Crying. She has many problems with her son, hard to be a lone parent. Cannot manage the son, who is far too active and domineering. She wants to do really well for him. We talk about her defining her own limits instead of setting limits for her son, which could be the cause for the tension in the neck. Instructed not to hit the child. Invited to come back to talk problems over. Things often tie together—and often the whole situation crystallizes as soon as the patient receives help in analyzing it. Here, the mother is having trouble controlling herself, which is taken out on the child, whom she feels she cannot manage. She is tense and hurts, which makes her torment her child even more. With enhanced consciousness and acknowledgement, things slowly fall into place.

Female, aged 61 years with severe overweight and cervical problems

Weight 115 kg. Presents with problems with her neck, which locks in an anteflexed position [bending forward]. Has seen a chiropractor, who said there is no physical obstacle to her lifting her head. Examination: Lumbar lordotic curve much enlarged and compensated by a greatly enlarged kyphotic curve. No signs of spinal disorders. She is instructed to lose weight and strengthen back muscles by eating less, taking long walks, swimming two to three times a week, preferably doing back tension and extension exercises and exercise by "Reaching down to the toes from front and side." The holistic physician is a nightmare to any severely overweight back patient. After all, it is really your own responsibility how much you weigh and what state your back is in. We encourage them to look at themselves from the outside, assume responsibility and do something about their situations. Either we get through to them—or they look for another doctor with a more "understanding" attitude. In our opinion, the latter option would be likely to lead to a long career as a patient in the health care system.

Female, aged 38 years with overweight

Slimness plan. 131 kg. Presents fully motivated and has made the following plan: 1) Swimming twice a week. 2) Cycling to town and to bingo. 3) Eating low-fat food, mostly crisp bread with low-fat cheese. We talk about how diet should include many vegetables and little meat. She intends to live off her fat deposits and wants to lose 31 kg over the next 31 weeks to weigh 100 kg. This means lowering her daily calorie intake to two-thirds of current level. We talk about how to mentally overcome the sensation of hunger. Check-up every month. A patient who has made her own plan for slimness should mean business. For some reason, it is almost as difficult to stop overeating as it is to quit smoking. We believe in addressing the dependency directly, but this is often very tough on the patient. Beneath a pattern of eating disorders, the patient often has some serious existential problems.

Sexual problems and pain during intercourse

Discomfort during intercourse is more likely to have a psychological than a physiological explanation. A large amount of superfluous testing is done because people are not in sufficient contact with their private parts (27).

Female, aged 35 years with lack of resources

For the past four weeks, this patient has suffered from pain, dizziness, headache and fatigue with perhaps a slightly elevated temperature. Pain during intercourse. Two young children, full-time job, marital problems. Examination: A patient who is tired with few places to refuel. Pelvic examination: tenderness in upper left side of the vagina. Sterilized, faithful to her husband. Inspection: vulva, vagina, vaginal orifice all natural except from some yellowish discharge (microscopy): an imbalance due to absence of lactobacilli [lactic acid bacteria], otherwise normal, no clue cells [cells covered by tiny bacteria only visible under a microscope]. Exploration: No adnexal tenderness or cervical motion tenderness corresponding to the uterus, otherwise as stated above. Auscultation of the lungs and heart: normal. No focus found. Diagnosis: limited resources. Prescribe lactic acid bacteria vagitories. When the energy of life is low, the patient often develops symptoms from all organ systems—from headache to abdominal complaints. This patient feels that her body is "slipping," but she does not recognize the pattern behind it, namely that she lives all wrong and that is what her symptoms are about. It is easy to see from the outside. Although we owe it to the patient to examine her thoroughly, the conclusion is almost given beforehand Two young children and a full-time

work is a lot, marital problems factored into the bargain are clearly too much. She should stay home from work for a week and reconsider her life. Her body tells her that she has reached the limit. But will she understand? And is she ready to do something about it? The classic art of healing is still a great part of the work of a general practitioner, and in daily practice we often call it "manual medicine." It is based on a solid understanding of the human body, the mind and the correlation between them causing the symptoms that are bothering the patient. This understanding will help the physician to work on the relevant attitudes and behaviour of the patients, so that the patient becomes present in the body and uses the body in a better manner. The body is relieved of some of the pressure, and the self-healing forces are set free. As illustrated by the above cases, it often takes surprisingly little, and the effect may well be substantial and lasting. In manual medicine, we work with the body as it is. This imposes some limits on how far we can go—limits that can be expanded considerably by the experienced physician.

Discussion

There are many ways of touching, like therapeutic massage (MT), healing touch (HT), Reiki or therapeutic touch (TT), which can be classified as energy or metaphysical therapies, one of the five domains created by the National Institutes of Health (NIH) Office of Complementary and Alternative Medicine (CAM) (28). A Medline (PubMed) search under the heading of TT showed that many studies are published in nursing journals with evidence that TT has the ability to cause relaxation, also laboratory evidence for physiological change towards relaxation and improved immune function, but also on improvement of symptoms in cancer (29). For example a randomized, prospective, two-period, crossover intervention study (29), where the authors tested the effects of therapeutic massage (MT) and healing touch (HT), in comparison to presence alone or standard care, in inducing relaxation and reducing symptoms in 230 subjects. MT and HT lowered blood pressure, respiratory rate and heart rate. MT lowered anxiety, and HT lowered fatigue, and both lowered total mood disturbance. Pain ratings were lower after MT and HT, with a four-week treatment with non-steroidal and anti-inflammatory drug useless during MT. There were no effects on nausea. Presence reduced respiratory rate and heart rate but did not differ from standard care on any measure of pain, nausea, mood states, anxiety, or fatigue. This treatment was an addition to receiving cancer chemotherapy. We see problems mainly connected to three areas: pain and damage, love and intimacy, gender and sexuality with ethical and legal problems included.

Pain and damage

Often, when we work with physical pain in the clinic, like knee pain, we must actually enhance the pain to make the patient confront it and integrate this area of the body with the connected shock and feelings. It is extremely important to discriminate between pain that feels like something is wrong or being destructed, *destructive pain*, as when some bone is broken inside, and you create a pressure on the wounded periost, and the therapeutic pain, called *paradoxal pain*, as when sore shoulders is massaged, which hurt in a good, comforting way. Intense paradoxal pain is often needed to heal strong physical locomotor pain (30), and

it is very important that the patient fully understand the integrative process. If not, you can be accused of causing a worse condition than before, and you now become the cause of the condition in the mind of the patient. This is a self-defence on the part of the patient, not wanting to assume responsibility for his/her own pain and not wanting to go into this area of the body and the connected often strong and negative feelings from a personal past. So the physician's whole attitude towards pain is of extreme importance for the success of the therapeutic touch. The physician must be loving and holding on one side, and firm (in a way, merciless), direct and determined and totally without pity for the patient on the other. To accomplish this, where you can hold and move the patient at the same time, is the fine art of medicine. You are to be trusted by the patient, while you inflict pain often rising to almost the same intensity as the original trauma, if just for a short moment, for the patient to confront, integrate and heal. There is, in contrast to the normal idea of the body's inner space as hidden, no place of the body that cannot be reach by the hands of a proficient physician, except from the areas completely covered with bone (the brain, deep nasal cavity, spine cavity, bone marrow). "Manipulation" is taking touch into physical movement. This is highly effective but needs so much sensitivity for the patient's body and feelings that it is best to avoid it in many situations, not to do harm, especially when it comes to the neck. Chiropractic high-energy manipulations of the back and neck and other joints can be very efficient in "opening" old blockages; doing this in the high neck takes a specialist or very experienced physician, because of the danger of causing whiplash-like damage. The danger is not really as much that you can make a physical damage, because the force of your hands are only a small percentage of the force inflicted in a car accident, but again the patient can believe that you made further damage on his neck. Manipulation of children also takes an expert.

Love and intimacy

The following case record from an advanced holistic session (31) shows the intimacy needed for healing of the deeper layers of the patient's existence (love, power and sexuality) (6).

> Female, aged 30 years but emotionally and sexually "dead"
>
> Eleventh conversation and sexological procedure: acceptance through touch. She is so beautiful, fine and sensitive with a pure innocent consciousness. And at the same time, she is to a great extent completely dead. We have agreed that today I (SV) will play the role of the good father she has never had. She lies on the couch crying, and I hold her and kiss her neck and tell her that she is the apple of my eye. We talk about what enneagram subtype she is: social, sexual or survival, and it is in her judgment as though all her problems are concerned with gender and sex. I am in agreement with this. We therefore agree to work on her acceptance of her own gender and her own sexuality through accepting touch: Supportive acceptance through contact. She first holds herself on the outside of the vulva (on the outside of her briefs), with my hand supporting around hers. Afterwards, I hold right on, while she holds her hand on top of mine. If she holds harder, I hold harder; if she holds more softly, I hold more softly; if she lets go, I let go, too. In that way she controls the session, according to her need for support. Conversation: In the meantime, we talk about how her boyfriend only wants to do it right for her sexually, while she only wants to do it right for him. She is reading a book about women's orgasms—mostly for his sake! And when they are together, from his side, it is only about her desire. It has completely gone off the rails in my opinion, but because

she feels completely devoid of value, she cannot allow herself to feel any joy or desire at all. It is a Gordian knot. Here she hits the "wall," and sees far more clearly than before how ill she is and what has to be done to cure her. She sobs inconsolably, lies on her side and asks me to hold her. Please remark the physical and emotional closeness in the sentence: "She lies on the couch crying, and I hold her and kiss her neck and tell her that she is the apple of my eye." Touch has a completely different function here, giving the patient the holding she needs. To kiss a patient is a dangerous thing to do, as it is very important that the patient is totally clear of the physician's intentions. If misunderstood, the patient could interpret the closeness as the beginning of a sexual relationship. On the other hand, it is very important that the physician does touch, when he understands that this is what is needed. The medical session so important to the patient's future health is definitely not to be disturbed, slowed down or even interrupted by negative thoughts, judgment and lack of physical and emotional generosity. It is completely fine to take a crying patient on your lap and hold your arms around her when she psychologically is four years old and desperately needs that care she never had, to heal her old wounds on her soul. But let always the patient know what is going on and why, by being verbally explicit about it.

Gender and sexuality

Touch is a very dramatic and mutual thing for our physical and emotional being; when I touch you, you touch me (32). As many people only know touch in connection with sexual behaviour, a sexual reaction to a completely innocent touch is not rare in the clinic. If sexually aroused, the female can react as "if she has sexual organs all over her body," making physical contact with her very electric and sexual, and this reaction can come very sudden and highly unexpected and not always convenient. If the physician retracts from her in this situation, which would be the immediate reaction of most normal people, she will experience that her body, gender and sexuality is not acceptable, which destroys intimacy and trust negatively for the patient and the professional relationship. Being there, staying in contact, takes a great deal of spaciousness on the part of the physician. This spaciousness should be a part of our medical training, but is often not, making so many pelvic examinations and other procedures emotionally painful and awkward for both physician and patient. Penetration of the female vagina is normally considered to be sex, so this takes a specific medical reason and an extended contract with the patient (27,31). Different countries have very different juridical practices, so be aware of the laws that regulate the behaviour of the physician in your country. The subject of ethics has been of utmost importance for the physician, since Hippocrates and whenever the physician touch the patient the ethics of the action must be considered. The problem of touch is mostly much more of an ethical problem than it is a legal problem: Why do you touch the patient, what is the intention? If the intention is for the physician to enjoy his patient—what we do most of the time with people in private—we consider this unethical, even if this is just holding hands. The physician should have the healing of the patient as his sole focus, and if the intention of the physician is wholehearted and rooted in deep medical expertise to heal the patient (and in this intention touch any part of the body including the genital), this is ethical. Interestingly, the physician's ethics seems to be proportional with his results with his patients. Only the clearest of intentions can bring us outstanding results (22).

Conclusion

Touching for healing or therapeutic touch (TT) is an almost forgotten art of medicine, and many areas of the human body cannot be touched even by the physician without a specific reason of examination or biomedical treatment. But simply touching sensitively—the essence of manual medicine—is a much more powerful tool than many modern and biomedically oriented physicians assume. Many pains and discomforts can be alleviated just by touching the sick area and can help the patient to be in better contact with the troubled tissue and organs of the body.

Lack of presence in the body seems to be connected with many symptoms that can be readily reversed simply by sensitive touch in the intention of healing. When touch is combined with therapeutic work on mind and feelings, holistic healing seems to be facilitated and many problems can be solved in a direct, easy and effective way in the clinic, without the use of drugs.

Manual medicine even in its most simple form is a powerful and often underestimated medical tool. The great power of physical contact between physician and his patient, which is even stronger in the context of the theory, practice and intent of holistic healing, is often not taken sufficiently into use in the medical clinic today, where everything is supposed to be cured with a drug. Much suffering and money could be saved, if the physicians of our time were able to discriminate more clearly between intimacy and sexuality and thus dared to be more intimate and physical with their patients.

If the physician truly masters the art of touch, he can even give the quality of holding without touching.

If the physician has a very strong presence, there is no need to touch because this presence is already touching the patient deeply.

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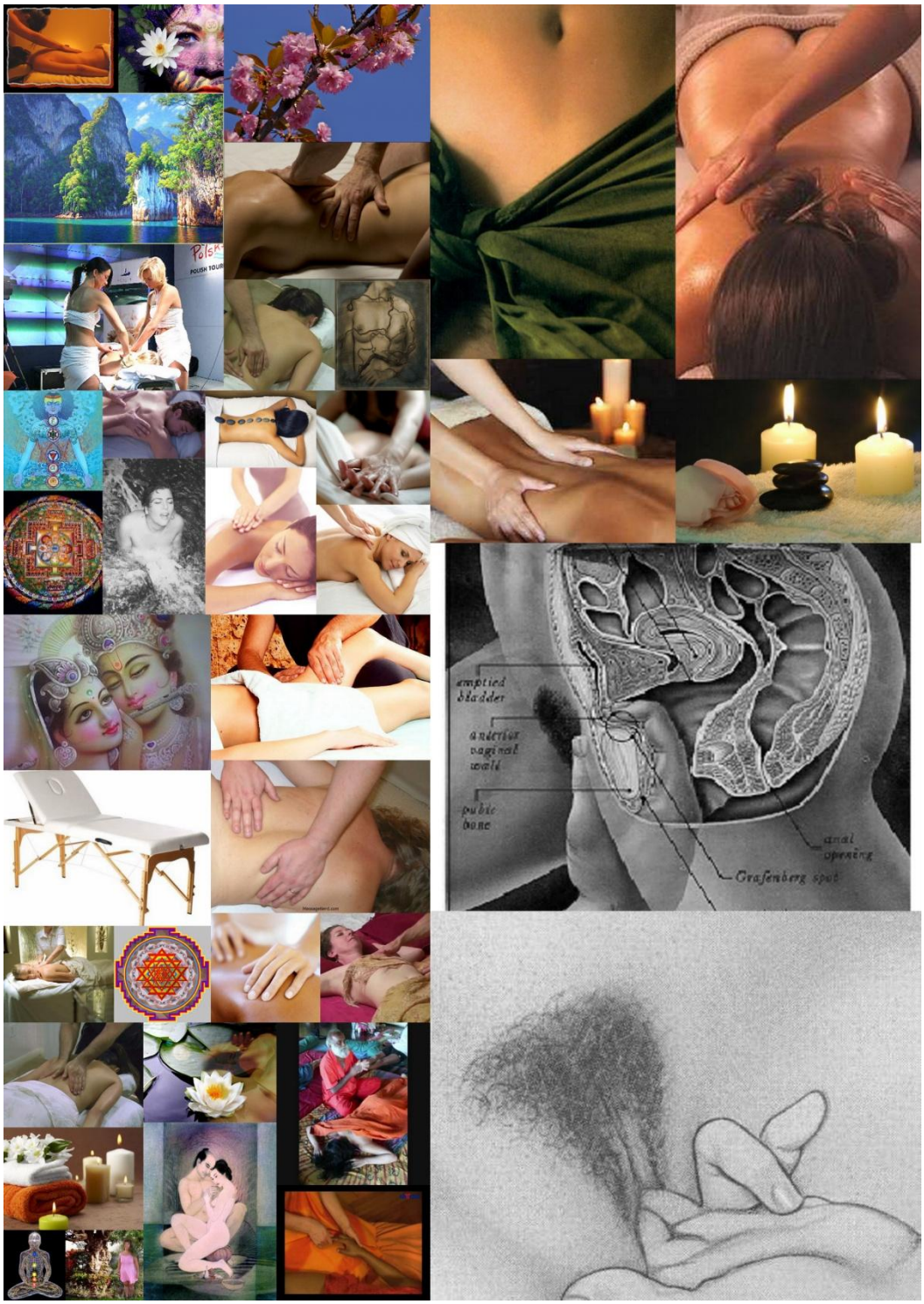
Exercises

1. Find a male and a female partner and give each other massage. Explore your own reactions to touching and being touched and share all your feelings, thoughts and reactions.
2. Repeat massaging each other during some weeks or months until you no longer have a strong emotional reaction to touching and being touched. Remember to share all feelings and reactions all the way.
3. Watch carefully to notice the change within yourself towards other people as you go along. Many people experience being more loving and caring. What is your experience?



Chapter XVIII

Advanced tools for holistic medicine and sexology

When you are fully trained as a holistic medicine practitioner, you should immediately know what to do with any patient showing up in your clinic. There are so many things that you could do, but where to start? You will soon find out that a patient rarely has only one problem; normally there will be three, five or more serious issues that should be handled. Some problems are easier for the patient to present, like a physical pain, while mental problems, existential crises or sexual dysfunctions often are difficult and take a lot of confidence and trust. We always screen our patients with a small questionnaire on QOL and all relevant major areas of life (The QOL10, see section 10) to find out where the biggest problems are and after discussion with the patient, we make a treatment plan. This procedure makes everything look highly structured and organised and even rational for the patients. And in a way it is. But at a closer look, things are much more chaotic and things are really going their own way in the treatment. The patient will, at each consultation, present the material that needs to be confronted and integrated, and the real problem for the therapist is how much heat he should turn on. Heat comes from a series of more and more intense situations—or "tools"—you can put the patient into. You can be more and more intimate, come still closer to the problematic areas in the patient's unconscious. As you do this, the patient's resistance will grow, and therapy will get more and more intense. How much intensity a patient can take at a given point in time during the therapy is really a matter of intuition and common sense. But then again, if you can present a staircase of still more intense and radical techniques, the patient will understand where you come from and cooperate with you, even when it is emotionally hard—which holistic existential therapy often is. In this chapter, we will give you such a staircase with well-ordered tools of still higher intensity. We recommend that you train by using the lowest steps of the staircase first and gradually include the more difficult and intensive steps. Step 10, the most radical and intense, should be avoided if possible at all, as it might traumatise your patient. And we are sure you remember the Hippocratic ethics: First, do no harm. You do not want to harm your patients. With holistic medicine, you can actually practice without harming anybody; that is the most charming side of "quality of life as medicine."

According to holistic medical theory, the patient will heal when old painful moments, the traumatic events of life often called "gestalts," are integrated in the present. The advanced

holistic physician's and sexologist's expanded toolbox has many different tools to induce this healing, some which are more dangerous and potentially traumatic than others.

The more intense the therapeutic technique, the more emotional energy will be released and contained in the session, but the higher is also the risk for the therapist to lose control of the session and lose the patient to his or her own dark side. To avoid harming the patient must be the highest priority in holistic existential therapy, making sufficient education and training an issue of highest importance.

The concept of "stepping up" the therapy using more and more "dramatic" methods to get access to repressed emotions and events has lead us to a "therapeutic staircase" with ten steps: 1) establishing the relation, 2) establishing intimacy, trust and confidentiality, 3) giving support and holding, 4) taking the patient into the process of physical, emotional and mental healing, 5) social healing of being in the family, 6) spiritual healing—returning to the abstract wholeness of the soul, 7) healing the informational layer of the body, 8) healing the three fundamental dimensions of existence: love, power and sexuality in a direct way, using among other classical techniques "controlled violence" and "acupressure through the vagina," 9) mind-expanding and consciousness-transformative techniques like psychotropic drugs used by most medicine men and shamans of the pre-modern cultures, but only rarely by contemporary therapists and 10) techniques transgressing the patient's borders, and, therefore, often traumatizing, like the use of force against the will of the patient.

We believe that the systematic use of the staircase will greatly improve the power and efficiency of the holistic medicine and sexology for the patient, and we invite a broad cooperation in scientifically testing the efficiency of the advanced holistic medical and sexological toolbox on the many chronic patients in need for cure.

Introduction

In principle, holistic healing of a person is a simple thing: an old and frozen "now" or "gestalt" containing repressed and painful emotions from past life events need to merge with the present, and when this process of integration of denied parts of existence is successfully done, the healing is completed (1-4). In practice, the merging is often simple.

One of the strongest reasons is that the patient really does not want to suffer again (because he has to deal with old "hidden" pain). So the most fundamental principle in clinical holistic medicine is working with the patient's resistance towards feeling, remembering and confronting the content of the subconscious (5). In principle, the holistic physician or therapist can do this work in two opposite directions and either go with the resistance or go against it.

In therapeutic practice, this is always "a dance," one step in the one direction and one step in the other (compare with Chapter 17 on the often problematic decision-making in the holistic medical and sexologic clinic). When you go with the resistance, you comfort your patient and win sympathy, when you go against it, you raise the patient's consciousness, awareness and presence. When you go with your patient's true self, you go against the resistance and when you go with the resistance, you go against the patient's true self.

Unfortunately, because of the patient's repression of the true self, going with the deepest emotional layer of the patient is often going against the more superficial layer of the patient's

existence, and paradoxically, this is often experienced by the patient as going against him or her—hence the dance.

As the therapy progress successfully, earlier experiences for the patient's personal history– the still old repressed painful gestalt—are appearing in the therapeutic sessions. As therapy goes back to earlier in life, more and more abstract existential problems are confronted, and the philosophy of life of the patients are gradually turning more positive and responsible (4), while the negative attitudes serve the purpose of justification of displacement of responsibility from self to the outer world.

As the patient often spontaneously moves back in time during the therapy, integrating more and more of the repressed material, the "energy" of the gestalts is normally raising. The reason for this paradoxical situation is that the patient will confront still stronger emotional pains as the therapy goes deeper due to the level of arousal and the intensity of emotions, which is generally higher if the traumas were from childhood.

When the patient is back in early childhood, the emotional intensity is normally quite extreme (compare to Janov's "Primal Scream") compared to the emotional intensity of adults and as the regression progresses further into the re-experience of the life in the womb (6). These well-repressed traumas are often so intense that it takes several persons to support the patient to give enough holding for him or her to fully confront the extremely intense both pleasant and unpleasant subconscious material (7).

The dark side of therapy

To get a patient who is in need of care and attention to work in therapy is often quite easy. Physicians often work as therapists after only a few weeks of training, as we know it from young physicians entering psychiatry. Working with biography and personal history, perception of self and reality, and similar issues are also often quite easy with a motivated patient.

As the therapy goes deeper, the patient will reveal a higher and higher degree of resistance, and the competence of the physician or therapist must rise accordingly to match the needs. When the therapy takes the patient into the deepest layers of the consciousness, the experiences often get quite disturbing for the patient. The emotional pain will often be overwhelming, and the therapist will then meet the dark side, the shadow, of the patient and in this meeting, the therapist will often also meet his own shadow. In some cases, this shadow can materialize as directly evil towards the physician and others (8).

This can be shocking for the therapist, when the patient suddenly turns with evil intentions towards the therapist who is only trying to help the patient from the best of intentions. When the therapist uses strong therapeutic techniques to confront the shadow side of the patient, the patient cannot escape, and all the negative aspects can then arrange themselves around an abstract centre of evil, which in many ways are similar to the good essence of the person, which is his purpose of life, or life mission (9).

Confronting the patient in his negative, evil intended side can take form as the classical ritual of "exorcism" (8), where the patient is completely obsessed with "the devil," or the patient can enter into a psychotic state of mind lasting for minutes, hours or days (10,11). If the therapist is not experienced or confident with the holistic treatment of insanity, the

therapist can be overwhelmed as the resistance of the patient "wins the game," and then the holistic therapy can be turned into traditional psychiatry with the danger of creating further trauma and without healing of the patient's existence, which was the purpose of the therapy.

If the therapist is caught unprepared in the process of meeting the shadow side, which we call negative transference (often happening after a period of positive transference, where the patient has been into strong admiration or even secretly in love with the therapist), and works into the dangerous trap of counter-transference and suddenly is the weaker part, instead of staying strong, balanced and in control of the session, the therapist can also be deeply hurt emotionally.

If the therapist goes completely out of control and into emotionally driven, highly irrational behaviour (it can happen when the therapist is strongly hit by what is happening), very unfortunate things can happen. Sometimes, the patient will fight to leave the room, while the physician will physically hold him or her back. Afterwards, the patient might complain that the therapeutic contract was violated or even accuse the physician of violent or sexual abuse. Such an experience can be so embarrassing that it can tempt even a trained therapist to drop his whole career as a therapist.

So "the dance" of therapy, as it grows in intensity, can turn into a fight and a true nightmare, where the therapist loses all control and the patient's dark side takes over the session. What normally happens in this situation is from a depth-psychological perspective that powerful gestalts of the therapist himself—his own inner conflicts—materialize during the therapy. The better the therapist knows himself, the farther the therapist has come in his own therapy, the farther into the depth of the ocean of consciousness the therapist himself has penetrated, the farther he/she can also take the patient.

But everybody has their repressed emotions, and every therapist must learn in order for severe errors, mistakes and failures not to happen. Constant supervision and personal therapy is a must, and lifelong supervision strongly recommended. Over time, the therapist will normally step by step be more confident and competent and able to use still stronger tools from the advanced holistic medical toolbox.

The holistic therapist or sexologists should, therefore, not expect to be able to use the most difficult tools for the first several years, since it takes a lot of time and experience to learn to lead the session at that speed and intensity; the maturity of the therapist must also be taken into consideration here.

When regular therapy is not enough

The holistic physician and sexologist normally work with love, trust, holding (awareness, respect, care, acceptance and acknowledgment), therapeutic touch, conversational therapy and exercises intended to upgrade the philosophy of life of the patient, combined with the standard medical or sexological assessment and examination (12,13) (see also Chapter 109).

Except for a modest risk of verbal abuse and physical intimidation, these techniques must be considered safe for the patient, if they are done correctly and according to a previous therapeutic contract. But these rather risk-free techniques are not always enough to make the patient heal. And failure is not really an option, as failure normally means the patient's gradual or sudden loss of health, ability, and quality of life.

In the many cases where a mental or physical disease is not disappearing in spite of more superficial therapy, it is sometimes necessary to use techniques that help the patient to match the high levels of neural arousal and emotional intensity of the early traumas. Some patients with a more reflectory nature will need a deeper process, and some diseases like cancer often need a deeper process than a less severe disease like arthritis.

To fully rehabilitate the three most fundamental dimensions of existence, which according to our thinking are love, power and sexuality (14-16), the therapist will need to guide the patient into the deepest corners of the soul, mind and spirit or life itself. This journey goes into the famous underworld and inferno of Dante (Dante Alighieri,1265-1321) (17), which will take the patient through the most intense emotional and spiritual pains.

Life is suffering, as Gautama Buddha (563-483 BCE) taught, and deep existential therapy often reveals this fundamental truth. Only when we let go of what we cling to, Buddha also said, will the suffering disappear. Letting go of what we cling to in our mind and life is essentially what existential holistic therapy is about.

In the situation where the patient is not healing, because deeper existential layers need to be integrated the physician is obliged to take the art of healing a step further. A "radical new cure" must now be invented for the patient, and the means must be judged against the risks. The physician must deeply consider the old Hippocratic saying: "First do no harm."

It is true that no physician can be expected to cure all patients, but still it is the duty of the physician—as long as the patient himself insists on fighting for his life—to do his best and continue to do so until the day the battle is either definitely won or definitely lost. The physician must judge in every case if it is possible at all to cure the patient and if this is really within his reach as physician.

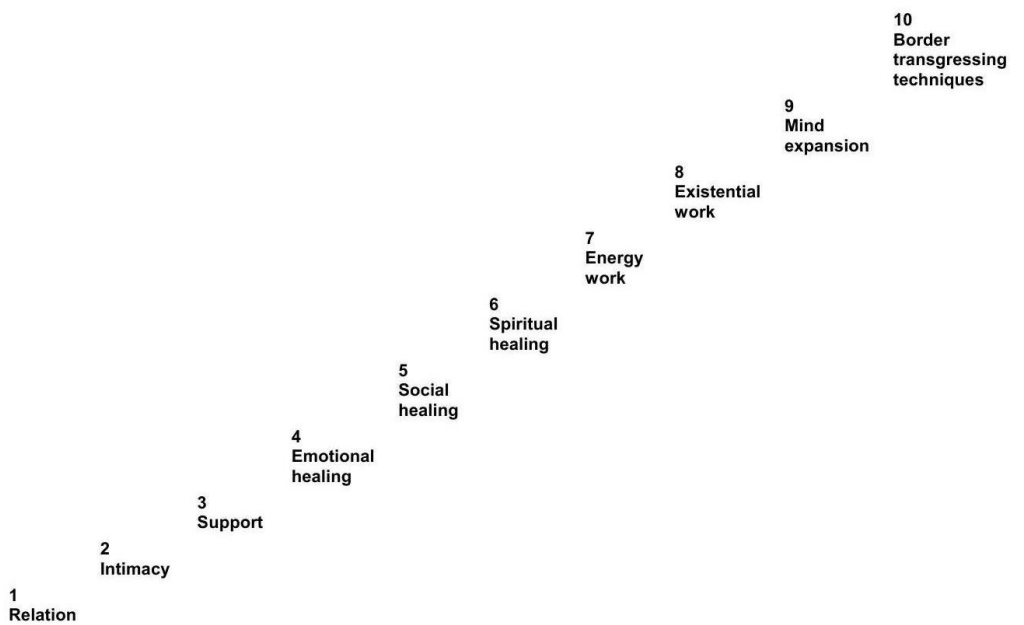


Figure 1. The staircase of advanced tools for holistic medicine. First talk, then touch the body if necessary, then use more advanced techniques but only if necessary. The master of holistic medicine can heal most patients by talking.

As the outcome of any treatment is really unknown beforehand, because it is strongly dependent on the patient himself, the physician must also estimate a likelihood that the intended cure will help in order not to waste time and resources on a hopeless case.

When everything else has been tried but the healing has not occurred and the physician still senses that there is more to be done, the holistic physician can—if he has the necessary qualifications, such as training in medical ethics and in the different treatment techniques, combined with a sufficient level of personal development and sufficient courage—use the advanced tools of holistic medicine.

The advanced holistic physician's expanded toolbox contains powerful tools, which can be organized into a staircase of the intensity of the therapeutic experience that they provoke and the level of expertise they take to master (see Figure 1 and Table 1).

The more intense a therapeutic technique, the more emotional energy will normally be contained in the session and the higher the risk for the therapist to lose control or lose the patient to the dark side, which can make the therapeutic session very traumatic and damaging. These induced problems can almost always be healed, if the patient stays in the therapy, so the real risk is losing the patient, because he or she completely drops out of the therapy.

Table 1. The staircase of increasingly intense and potentially traumatic and dangerous holistic medical therapeutic tools: 1) love, 2) trust, 3) holding, 4) healing, 5) group therapy, 6) life purpose-character-coherence, 7) "energy" work, 8) cathartic work, 9) mind-expanding/ego-transformative techniques, 10) extreme (often traumatising) techniques (see text)

1 **Relation**	2 **Intimacy**	3 **Support**	4 **Emotional healing**	5 **Social healing**
Love and acknowledgment; Talking about patient's biography	Winning the patient's trust; Music and art therapy; Dance and movements; Massage	Giving holding: awareness, respect, care, acceptance, and acknowledgemnt; Coaching; Time-line therapy	Taking the patient into the process of healing by touching, talking, and setting perspective; Intentional work (sweat lodge ritual)	Active work with projections; Mirroring good and evil in the patient; Working visibly with and against the patient's resistance; Group therapy, psychodrama, body dynamics; Sharing circle (native social rituals)
6 **Spritual healing**	**7** **Energy work**	**8** **Existential work**	**9** **Mind expansion**	**10** **Border transgressing**
Rehabilitation of life purpose, character, and coherence; Acceptance through touch; Soul-body-body-soul; Deep coherence between patient and therapist	Rising energy circles; Holistic breath work; Painful provocative body work; Sexual polarity work	"Controlled violence"; Acupressure through the vagina and anus; Direct sexual stimulation; "Controlled sexual abuse"; "Exorcism"; "Controlled fail" of the patient"	Psychotropic drugs; Substitute partners; Death-rebirth rituals; Mitote ritual; Ritual life burial; Killing and revival; Sundance ritual; Shamanism (i.e., materialization)	Sedating drugs, antipsychotic drugs; NCE; Use of force against patient's will; Institutionalization; Surgery in general; Mutilating rituals like hanging in the chest muscles (Native American procedures); [Direct sexual involvement]

As demonstrated throughout our many papers on clinical holistic medicine (10-13,18-49), almost everything can be used as a tool, since only the imagination sets the limit. To induce the state of consciousness we call "being in the process of healing" (4), the physician according to Yalom (50,51) needs to invent a new cure for every patient. This ability to be imaginative, creative and use whatever is necessary to induce the healing is the hallmark of the excellent therapist. Good intent, balanced action, and good results are definitely needed in holistic medicine. Giving up on your patient and not doing anything at all might in many cases be a bigger sin than doing your best as a holistic physician and still losing your patient.

Still, you need to use any tool only after careful consideration, respecting the golden rule never to use a tool more powerful and dangerous than necessary (compare that both in surgery and with chemotherapy the patient is risking death as a result of the treatment). Almost everything in the world can be used as a tool, but as the physician lines up his tools, some tools are natural to use before others, and some might be painfully out of reach because of lack of expertise or due to the laws of your country. The ranking of tools after intensity, danger, and needed expertise of the physician gives a "staircase" of advanced tools of holistic medicine; its function is to help the holistic physician to "step up" in the use of the techniques one level at a time.

Let us admit that holistic medical and sexological therapy often is a little "messy" with the combination of a number of classical and modern tools and techniques (see Chapter 17). To think of therapy as the clear-cut process of "walking the staircase" is too simple. Often, many of the steps are used in subtle and symbolic ways of the skilful therapist, i.e., hidden in jokes and ironic remarks. So this staircase is meant for education, training and treatment strategy not to limit the flexibility and spontaneity of the therapy.

The concept of "stepping up" in the therapy using more and more "dramatic" methods to get access to repressed emotions and events has lead to the common notion of a "therapeutic staircase" with still stronger, more efficient and more dangerous potentially traumatic methods of therapy (see Figure 1).

We have identified ten steps of this staircase: 1) is about establishing the relation, 2) is about establishing intimacy, trust and confidentiality, 3) is about giving support, 4) is about taking the patient into the process of physical, emotional and mental healing, 5) is about social healing of being in the family, 6) is about spiritual healing—returning to the abstract wholeness of the soul, 7) is about healing the informational layer of the body (from old times called the ethereal layer), 8) is about healing the three fundamental dimensions of existence: love, power and sexuality in a direct way, 9) is mind-expanding and consciousness-transformative techniques, and 10) are techniques transgressing the borders of the patient and, therefore, often traumatizing, like using force and going against the will of the patient.

When the holistic physician, sexologist or therapist masters one step, he can go on to training and using the techniques of the next step of the staircase. As step 10 is often traumatizing for the patient even with the best of physicians, it is generally advised that the holistic physician or therapist does not go there.

When well mastered by the physician, steps 5-8 (9) can be used, when steps 1-4 do not help the patient sufficiently. The tools must be used one level at the time, and each step implies an increasing risk for traumatizing the patient. Levels 8 and 9 often take many years of practice to master.

Level 1: relationship/love

Loving (caring for) your patient is the first step of helping, since only with love can you be at service in an unselfish, ego-less way, and love is the strongest resource in the art of helping another fellow human being. If love is not there, it cannot be forced or willed; maybe there is kindness and care, maybe an interest in the other person, which can be turned into a relationship.

Just establishing a relationship is a powerful thing to do, and in the acknowledgment of the other person's personal history, you will be able to help many wounds to be healed. It is important to say that love in our understanding originates from the urge to use your personal talents and give what you need to give to the world. Love is about living your personal mission.

Level 2: Intimacy/trust

When there is love, the patient's trust can be won, often little by little during time. With trust comes intimacy—physical, emotional and mental closeness. Then many things are possible, like massage, dance, art therapy, etc. Just learning how to trust and be intimate is a giant step forward for most patients, and their quality of life and self-esteem can be radically improved by the techniques of this level.

Level 3: Support and holding

When the patient trusts you, you can get permission to give holding; the five dimensions of this crucial existential support are 1) awareness to the mind, 2) respect for the patient's emotional space, 3) care for the body, 4) acceptance of gender and sexuality, and 5) acknowledgement of the soul and personal character. In giving these five qualities in a rich blend, you can help almost everybody to feel good and right.

Level 4: Physical, emotional and mental healing

When the holding is there, the patient can get the support in the actual moment, which empowers him/her to go back to the old, emotionally painful and confront the repressed content of the traumas.

Getting help now to process the old trauma is the secret of healing. To take the patient into the state of mind, which we call "being in the process of healing," is what holistic medicine basically is about (4). To get the patient into this state is really a question of intention; both the physician and the patient must be intent on the healing, and "the bubble" the patient is isolated in must be open from inside and from outside at the same time, as the shamanistic tradition claims (52).

Level 5: Social healing—healing the being in the family

This level is about healing the relation with the group and the family, where using a group for this kind of healing is a must. The Native Americans had their sharing circle and the talking stick; today we have the holistic existential group therapeutic process (7). In the group, everybody can watch everybody, and one great advantage of this kind of work compared to individual therapy is that the process of working with or against the resistance becomes obvious to every member of the group.

This makes it possible to help the member to watch his own projective mechanism of the consciousness, helping him or her to assume responsibility for the unconscious attitudes, the "colour of the glasses of the spectacles" so to speak. This makes it possible for the therapist to effectively mirror the patients in the group, effectively helping the patients to realize their own idiosyncrasies, blind spots and neurotic survival patterns.

Level 6: Spiritual healing—healing the abstract wholeness of the patient

On this level, the therapist must use his ability to sense the purpose of life (6,9) and the physical, mental and spiritual character of the patient (7). The purpose of life, or the life mission, is the core talent of this person, and happiness is about using this talent to be of value to the world. Other supporting talents surround the core talent, and when claiming them, yet another series of tertiary talents comes into use.

Being gifted and contributing to the persons dear to him or her and to society at large rehabilitates the existential coherence, the deep feeling of connectedness and belonging, which we long for deepest in our hearts. Rehabilitating the spiritual side of the patient is really allowing the patient to dig deeply into the hidden resources for healing him or her.

Unfortunately, the ability to use the abstract sense necessary to master this level takes a lot of practice and time, often years. It develops as you obtain coherence with the outer world yourself, as a product of your own successful personal development. As you find this coherence, you will notice that you can connect soul to soul with you patient through your body and the body of the patient. When you take this skill into the sexual area and give acceptance to the body, the organs, the gender and the sexuality of the patient, you master the technique called "acceptance through touch" (13); the touching may simply just be placing your hand on the patient's body.

Level 7: Healing the informational system of the body (ethereal healing)

Consciousness meets the body in a peculiar way, creating what is often experienced as "circles of energy," the different qualities of the body and mind being sensed as circulating sexual, emotional, mental and spiritual energy [see (16) for an overview of the qualities]. Raising these subjective circles of "energy" is called "working with the energy," and it really is difficult to describe what is going on in this work, as it is about supporting the patient in exploring all the hidden qualities of body, mind and spirit.

Often, breathing is involved in this work, with holotropic breath work (53) as a fine example of this kind of energy work. It often helps the patient to integrate very early gestalts, and spontaneous regression into the womb is normal in this kind of work. Some patients recall earlier incarnations, especially if the physician is open for this.

Working with the energies of the body often leads to recollection of extremely painful memories from early life. Also, intense sexual energies are often awakened, and training the patient to be a male/female pole in the universe is a part of the successful balancing of the patient's energy.

This level of biological information is poorly understood by contemporary science, and for the last two centuries occult research has been carried out referring to this layer of the human being as the "ethereal body" (54).

Level 8: Direct existential healing of love, power, and sexuality

According to the theory of talent, there are three fundamental dimensions of existence: love, power and sexuality. These dimensions can be confronted en bloc, which gives overwhelming and extremely intense experiences in the therapy. When all the evil sums up to the essence of the shadow, the person manifests his evil alter-ego, and it really looks like he is obsessed by Satan; hence the name "exorcism" for this tool (see Chapter 4).

When a person has been violently violated throughout his childhood, anger can be so repressed that only hitting him again can release it. This can be used as the therapeutic technique originally developed by the famous founder of gestalt therapy, Perls (3), and we call this method for "controlled violence."

Actually, every time the therapist goes against the resistance, there is an element of controlled violence toward the patient's emotions, which often reacts hurt and offended. Every time the therapist goes against the patient's true self, there is an element of controlled violence against the patient's soul. But violation of emotions and the soul is often not seen and is widely accepted. Violating the body physically by beating it (with open hand not to cause any harm though) is seen as many people as unacceptably violent. From a theoretical analysis, there is really no difference; it is all controlled violence.

Another set of very strong and efficient techniques at this level are the technique's relation to sexuality. The therapist can work against the resistance and with the patient by directly stimulating the patient sexually, which is a seldom-used technique. More often, the therapist will use a formalized technique like the classical Hippocratic method of acupressure though the vagina to raise the energies in the pelvic area (55) or to confront repressed material connected to sexual abuse or neglect by the stimulating the relevant tender-points in the genitals and deep pelvis reached through the anus and the vagina.

The last technique has an aspect related to controlled violence, and this kind of work is called "controlled sexual abuse," as the patient in this kind of healing often will find the old painful emotions from the trauma in the present moment, not in the past (see Chapter 21). This seems to be a general rule of all high-energy traumas: the higher the energy and the more intense the emotional pain, the higher the likelihood for the trauma to manifest itself in present time during life or in therapy.

This means that you as a therapist should not always expect a child-rape trauma to be presented to the patient as a child-rape trauma but sometimes as an—initial—experience of

the patient of being abused in present time in the clinic by the physician because of the transferences. The only way that the therapist can survive this legally is to address the problem directly and to make a therapeutic contract of "controlled sexual abuse," for the trauma to re-appear in the session under controlled conditions and not allowing the patient to get away with the transference of the old, extremely painful material (47-49).

This kind of work takes a high level of expertise and years of practice to master. It must always be done with supervision to be completely sure that the physician or sexologist is not involving his own shadow in this kind of work. If the physician subconsciously is engaging in counter-transference here, it can be very traumatic for the patient.

The most painful and difficult of the tools on this level is the "controlled failure of the patient." There is hardly a patient who has not extremely severe wounds on their soul from early childhood, as it really is impossible to be a perfect parent, since just 30 minutes of mental distraction or physical absence in some cases can be experienced as a complete loss of both parents by a sensitive and vulnerable child.

Some patients are worse off, as they as children had experienced systematic failure from their parents. Often, they had the role as parents for their own parents from early childhood and to compensate for this, they developed a tendency to cling and adhere in order to finally obtain the love and contact they needed. In theory, this failure should be easy to alleviate, but as love is what is most important for us as human beings, systematically not getting the love we need and fight for throughout our childhood is often resulting in a traumatic series of emotionally painful wounds. When the therapist in the treatment intends to give his love, the resistance of the patient will be so intense that no love can be received.

So going with the resistance is the only way to proceed, and sometimes this means ignoring and abandoning the patient while he or she is in the therapeutic session. This really is a paradox: the patient is paying for therapy and nothing is happening, no, less than anything! Only the philosophically highly developed patient will understand what is going on, and even this mental understanding will not help. This is as terrible as it gets, since this is sheer hell raised once again, but it is not really happening in present time in the therapy, as a normal sound person will not enter into a deep process of holistic healing and feeling emotionally completely destroyed just from being ignored by another person. But these patients will. As the therapist can easily feel the transference, he must now avoid getting into counter-transference and avoid starting to feel evil himself.

The technologies on this level are highly efficient, yet they are just drills derived from the inner logic of the therapeutic process of holistic healing. In the hand of an untrained and poorly developed therapist, these are the cruel tools of torture and abuse that finally gives him the dark power over another person that his own evil shadow side has longed for a whole life. It is really easy to be tricked into the dark side using the tools of level 8, so never start using level 8 tools without intense supervision and coaching by an experienced holistic physician mastering this level himself.

Level 9: Mind-expanding and consciousness-transformative techniques

If level 8 was difficult, then level 9 is an art that really cannot be mastered without perfect mastery of the tools of level 8. One of the techniques of this level is being a substitute partner. To give yourself to this process of pairing up with a sexually dysfunctional person with the

only purpose of healing their sexuality takes a rare kind of devotion. When it is done professionally and according to a contract—which normally implies only seeing each other for 14 days or so—it really works wonders for the patients (56,57).

Some of the techniques in this group are so difficult that in the pre-modern societies, it took a shaman or high priest, one of the highest developed persons in the tribe, who had devoted his whole life to this kind of practice and service. This is very much still the case. You can only develop the mastery of the skills of level 9 by being completely devoted to this kind of work for decades—unless you have a very special gift for it, as a few students have. Gifted or not, you need to be a trained by a master in these techniques for years before you can do them on your own.

Some of the tools that demand this kind of mastery are the healing rituals, mostly carried out by Native Americans and other pre-modern cultures as extremely intense rituals, taking you all the way down to the core of your existence. One ritual takes you through a subjective experience of death and rebirth, while others makes your worst nightmare come true in the form of a life burial to (almost) die from suffocation alone in darkness (used for integrating some of the most terrible foetal experiences, compare Stanislav Grof's BPM2) (6) and thereafter miraculously coming back to life as your true self that you felt you had lost forever.

To master such rituals takes the most loving and empathic of therapist, who minutely can read the state of mind and observe all changes of the patient's consciousness accurately enough throughout every moment of the whole ritual to meet the needs for the healing of the patient. It takes a therapist who is completely familiar with the whole range of experiences of ego-death and personal transformation. This competence is only slowly developed though supervised training and personal experience throughout years.

Other tools of the ninth level that take similar mastery are the use of psychotropic drugs in therapy. In many ways, this is a lost art, but it has been extremely widely used, as most pre-modern cultures have used them for millenniums. The word for medicine is the same as the word for the peyote cactus in many native North American tribes (58-60). Other tribes have used the fungi of the species Psilopsybe (containing psilocybin) and the cactus called San Pedro (Trichocereus pachanoi), which like peyote contains mescaline as its major active substance. The drink made of liana called Ayuhuasca (Banisteriopsis caapi) among others has been used in the South America, while other cultures like the old Egyptians used an LSD like alkaloid derived from the Ergot of Rye, a plant disease caused by the fungus Claviceps purpurea (61).

All these drugs contain psychotropic (mind-expanding, active placebo) drugs or the hallucinogens but with a different profile from the recreational drugs in popular use among young people all over the world today (62), like ecstasy, cocaine, and amphetamine, which has a strong CNS-stimulating effect in addition to a more modest, mind-expanding quality.

The purpose of the use of the mescaline-cacti among Native Americans is to bring the patient to a state of consciousness where he can realize how he makes himself ill by not living in accordance with the deep self (58) or in our interpretation with the true human character and the purpose of life (63). This makes the fairly mysterious native medicine, often completely incomprehensible due to the use of massive symbolism, very difficult to understand.

We are proud to say that the consciousness-based medicine we have developed these years normally do not use any kinds of drugs, as this has not been necessary because of highly

efficient therapeutic techniques and strategies, many inherited from the classical Hippocratic tradition that does not use pharmaceutical drugs at all.

Level 10: Techniques that transgresses the patient's personal borders (often traumatizing)

It is obvious from Figure 1 that many of the level 10 tools are in frequent use in modern day medicine. When the use of moderate power does not work, more powerful tools are frequently used; this includes techniques like brute force against the patient's will, sedating drugs, institutionalization, and in some countries even imprisonment and severe invalidations of basic human rights, even though most researchers agree that they are often severely traumatizing the patient. The reasons why they are in use are of course the failure to help the patients with less radical means or the failure of confidence in the lower steps, making the physician skip the level, jumping directly to level 10. Most of the steps of the staircase are not taken into use by many modern physicians in the Western world; sadly in many highly developed countries, often only level 1 techniques are tried before going to level 10.

It seems that the art of holistic healing using the first nine steps are sadly lost in many countries, and instead of practicing love and healing the patient, "brute force" seems in use. We hope that re-introducing the therapeutic staircase will inspire many physicians and therapists to use less powerful and less traumatizing means of the lower steps to heal their patients in the future.

One other potent tool, which is often used by modern day therapists, sometimes motivated by love, sometimes motivated by abusive intentions, is direct sexual involvement with the patient. While such endeavour has been talked strongly against ever since Hippocrates, it seems that there has been a constant decay of some therapist's ethics throughout the last century. One female patient around 25 years old with a personality disturbance could tell us about at least four different therapists who had abused her sexually. The reason for not having sex with a patient is that this behaviour completely disturbs the relationship with the therapist, turning it upside down, giving the power to the patient and making therapy impossible. As the patient often loves and admires the therapist, this can also be seen as abuse of the power of the therapist, and too often the female is left behind as the therapist moves on to abusing yet another patient and thereby failing the patient and the profession. Because of the negative view of such a relationship from the society, it is recommended to keep such an engagement within the frames of the tool of substitute partner. Direct sexual engagement with a patient is a good example of a level 10 tool often having a traumatizing effect. The level 10 tools are in general so traumatizing in spite of all good intentions that they cannot be recommended in the holistic medical clinic.

Using the staircase for training the holistic physician or sexologist

The training of the holistic therapist is difficult, since the only way to learn is to practice and to do it. Learning by doing means that the student in the beginning will make every possible

mistake and error, and the coach must be very involved and close to correct the errors and mistakes before they have any serious consequence. In practice, it is often very easy for a skilled therapist to correct the errors; if the student loses control of the session, the senior therapist will take over and redirect the student very much the way a new driver learns to drive a car.

Interestingly, in therapy, the situation with the patient is as a rule better after a failure and a recovery than before the failure. This situation is a result of the mutual learning of the patient and the physician or student. Not being willing to learn from mistakes, and, therefore, hiding them from oneself or others, is the most dangerous behaviour a trainee or physician can have.

Unfortunately, many university hospitals have little mercy with physicians and students making mistakes, which creates an environment of fear and of hiding. The most important thing in good training is the rule that mistakes are allowed but only once. In biomedicine, a mistake with drugs and surgery is often fatal, so this kind of freedom is more difficult to give students, while in the holistic clinic, the most difficult of tools are hardly ever fatal.

Complete familiarity and mastery of one level of techniques leads naturally to the next, and after many years of training and practice, all the levels can be used. Using the level 10 tools is something even the most skilled holistic therapist only will do hesitatingly. It is of utmost importance to know how to use these tools and to use them wisely to avoid dramatization. If force is necessary or if the use of strong sedatives and antipsychotic drugs are necessary (i.e., because the patient is trying to kill somebody or trying to commit suicide), the physician must know exactly how to react concerning force or drugs used.

If the physician or sexologist has fallen in love with a patient, bringing therapy to an end, he or she must know how to deal with this extremely difficult situation by finding a supervisor for support, avoiding sexual contact before the roles are sufficiently re-defined and the relationship balanced, so that this can be considered safe for the patient.

Not knowing how to use these tools can be very dangerous for both the patient and the physician. Let us underline that we most strongly do recommend that a sexual relationship between a physician and his patient are to be avoided at all times, also after the treatment is formally terminated. In some countries, it is not at all acceptable to have a relationship with a former patient at any stage.

Discussion

One of the most important principles in medicine since Hippocrates has been "first do no harm." The medical ethics is, therefore, of primary concern when using advanced and emotionally intense tools of holistic medicine with the potential to afflict further traumas instead of helping.

Often in the clinical practice, even a severe mistake can fortunately be corrected, as traumas induced by therapy can be healed in the same way as every other trauma. On the other hand, it will take a therapeutic session of similar intensity as the damaging session to heal the wound, and sometimes this is not possible as the patient is not willing to give it another try if the first session was very painful and scary. In daily practice, this means that every procedure must be justified in two ways: 1) No procedure should be carried out when

one with less risk and less intensity of the impact/emotionally, physically and otherwise can do the job, 2) What is likely to be won for the patient by using this procedure should be much more that will likely be lost. The patient must always be informed of the risk involved in the treatment and must give his or her consent after this information.

The basic principle for holistic healing (4) is to reverse the pathogenetic process by taking the patient into a holistic process of healing, which has been called salutogenesis by the great Jewish thinker Aaron Antonovsky (1923-1994) (1,2) from the Ben Gurion University of the Negev. In the holistic clinic, this is done by giving the patient the love, support and holding (awareness, care, respect, acceptance and acknowledgement), which was so intensely lacking in the original traumatic events and caused the loss of inner balance, the disturbances and the inner conflicts and which was the cause of the disease for which the patient now needs healing. The trauma was caused by the repression of unbearable negative emotions, and the healing must be the reverse process of the pathogenetic process according to Antonovsky. This can only happen when the patient confronts and integrates these painful emotions.

The characteristics of the state of consciousness in which patients heal (which we normally call "being in the process of healing") are the same emotions and neural arousal as the original trauma. Because of the extreme intensity of emotions connection to certain traumas, especially from violent and sexual abuse, and especially if this happens in early childhood, it is often difficult to get these patents into the state of healing. Often, lengthy therapy is needed, and patience is a must with these patients, but sometimes the therapy comes to a seemingly dead end and only more drastic and intense methods will yield the result of taking the patient into the old traumas again.

In general, what gives the holistic physician the ability of using a tool of a certain level is the complete mastery of the tools of the former steps of the staircase. Many fine books have been written on most of the techniques, and level 7 and level 9 have been intensively researched, while research done with the tools at level 8 has been modest. The reason for that seems obvious: both sex and violence is taboo in our culture, while being among the best selling commercial products (i.e., in movies and pornography), medical science in its attempt to be clean and pure has avoided working seriously with these issues.

The problem by excluding level 8 tools is that without mastering this level, the next level, 9, becomes very difficult to handle for the therapist. Only a few contemporary therapists have used psychotropic drugs successfully, like the LSD-therapy pioneer Stanislav Groff, while most often drugs has been seen as a fast route to enlightenment, the most prominent example being the drug guru Timothy Leary.

More reflective people like the brilliant philosopher Aldous Huxley and Hoffmann understood perfectly well the potential of the drugs but could not really tell how to use the drugs in therapy. The Native Americans have undoubtedly done this for years using many different drugs derived from plants and mushrooms.

The rationale for the techniques found on the therapeutic staircase [originally introduced to us by Gormsen (68)] is the most simple of all: healing happens when the present moment or now of the patient and the old repressed and emotionally painful now are taken together and integrated. Healing is thus the opposite of cutting your existence into parts as you do when you repress a trauma.

You heal when you in present time get what you could not get and needed in the past traumatic old now. So the art of holistic existential healing is really keeping the patient in the

present moment giving him or her everything needed and at the same time taking him or her back in time into the old painful now, confronting what happened when the fundamental needs were not met. If the trauma was less intense, just talking about personal history might do the job (biography work).

With more intense feelings, trust and physical contact are often needed; massage is a fine example of this level 2. With more severe trauma, as neglect in early childhood, re-parenting is necessary, giving the patient the care needed but not received in childhood (level 3).

Level 4 takes care of deeps wounds in the existence, so this is the first level of holistic existential healing. It involves a mysterious dimension of intent, and all higher level of healing work is dependent on this. Often, the trauma happened in a group setting, taking us to the logic of level 5: working with the patient in a group, re-creating the sound family, healing trauma from dysfunctional families.

Level 6 is rehabilitating the character and purpose of life (the soul); these deeper layers of existence are often wounded already in the womb and without the art of deep coherence between physician and patient, allowing for an energetic imitating the connection of the foetus and his/her mother, these wounds cannot be healed.

Level 7 takes care of the body and of deep and early wounds in sexuality and gender. Level 8 integrates trauma with severe sexual and violent abuse. Direct sexual stimulation can be necessary to awaken a deeply repressed sexuality, although we strongly recommend that a patient is not stimulated into orgasm to avoid the risk of the relationship turning into a sexual relationship.

Level 9 awakens the deepest layers of consciousness; the psychotropic drugs destabilize the old patterns of perception making a breakthrough possible, where the patient leaves a mental survival perspective (being in the head) to experience life fully. This project has been described as "no mind" by the Zen Buddhists.

The holistic physician only uses level 10 in exceptional cases: when nothing else has worked or when time or other serious conditions do not allow for trying many different things, i.e., with terminal and suicidal patients. Direct sexual involvement with the patient will often harm the patient and cannot be recommended.

The concept of controlled violence is somewhat disturbing, and it is very important that the beating is done only with open hand and extremely carefully, symbolically. The ethical problems using the holistic medical tools in general and especially the level 8, 9 and 10 techniques has been researched intensively by our team the last several years.

The tool of controlled violence is highly efficient to provoke anger in patients who are so damaged by violent abuse that they no longer are able to feel and express anger, but it is difficult to avoid strong transferences of the therapist being the violator instead of the original violator from the patient’s past, making controlled violence a very dangerous tool to use for the therapist, if the patient chooses to complain.

Most often, the patients in need of this tool will be severely repressed, and they often live in chronic fear or complete emotional numbness, socially isolated from the world. The danger of this treatment is obviously not to get them sufficiently into healing to be whole and well functioning but sufficiently into their old material to be projecting the anger towards the therapist, in worst case complaining or even suing you for malpractice.

Another unwanted side effect are, in rare cases, temporary psychotic episodes normally followed by recovery within hours; happily, such episodes do not seem correlated to any negative effects of the treatment. Having a legal system in most countries not accustomed to

the level 8, 9 and 10 techniques makes the use of these tools somewhat difficult; we must recommend that you always comply rigidly with the laws of your country to avoid compromising yourself or holistic medicine and sexology in general. In spite of the dramatic qualities of the therapeutic tools, we know from large reviews of the literature that side effects of holistic medicine and sexology are very rare (NNH=64,000) (69).

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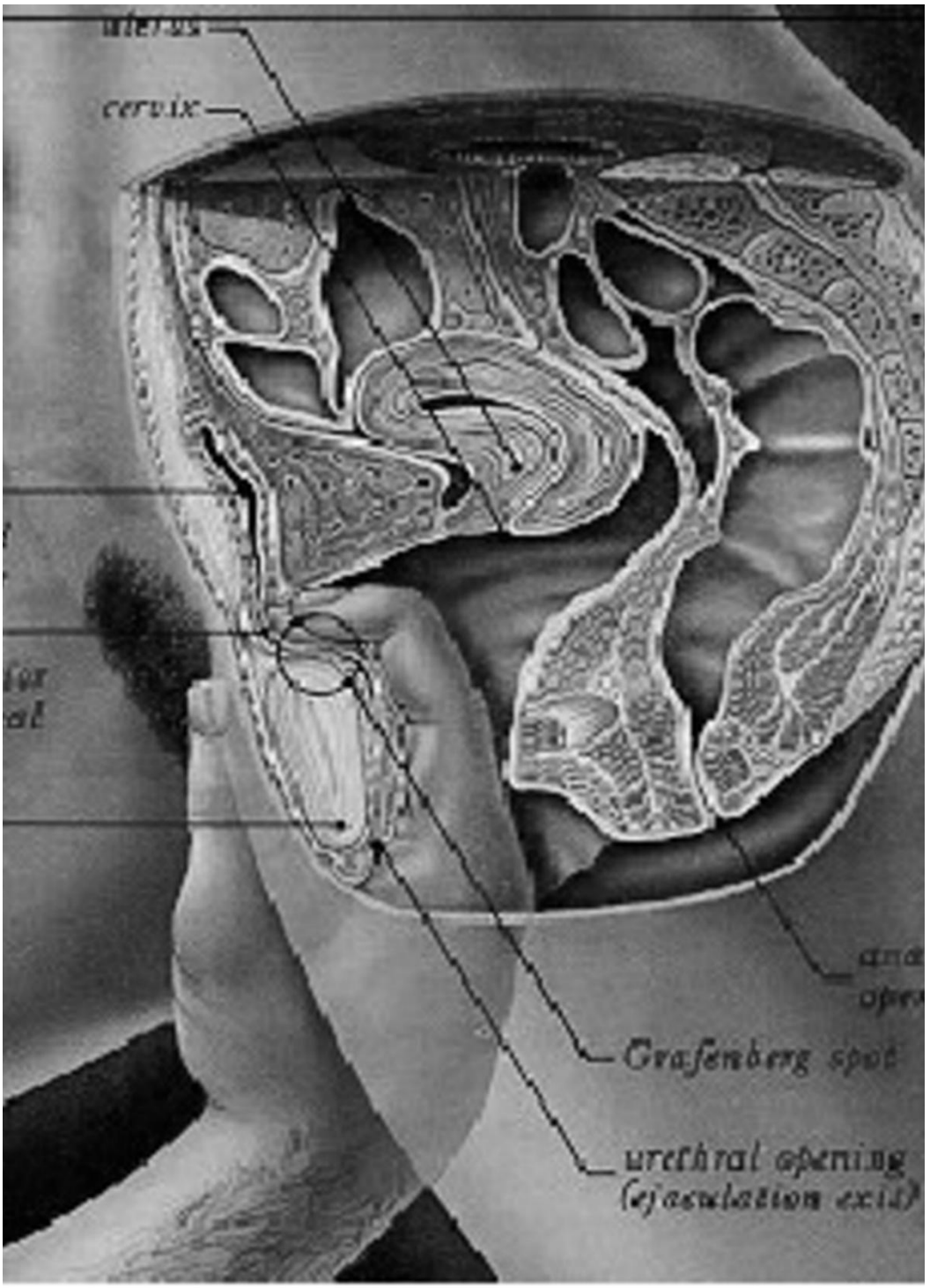
Exercises

1. How far will you go to help a patient heal? Will you risk looking crazy to your surrounding world? Will it be acceptable for you to cause your patient pain and discomfort? Where is your own limit for personal involvement in a patient?
2. Many of the tools of holistic medicine have a dramatic or theatrical quality to them. To heal, the patient needs to enter a "healing crisis," and such crises are often very dramatic, both for the patient self and for the therapists. Would it be okay for you to put your patient in crisis?

3. We are sexual beings, and the more close to and intimate with the patients you get, the more likely is it that sexuality in some form will appear in the therapy. What do you think of that?



Chapter XIX

Five tools for manual sexological examination

Sexology was, before 1900, an integrated part of holistic medical practice, but with urbanisation came an understanding of sexuality, forcing doctors to leaving many of the sexological procedures used by the classical physicians. At the same time, sexology developed into a practice in its own right, and as more and more people got sexual problems, the sexologists had a blooming business. Today, at least one in four women is reporting severe sexual dysfunction, making the sexologist needed even more than before. Unfortunately, the sexual taboo that seems to grow in strength and intensity has made it difficult for the holistic physician to use all the tools that have been used by the classical doctors. In this chapter, we will present these tools. We do not recommend that you use a larger tool than you can master and that your society and local health authority will accept; having said this, we must also point out that if you heal a patient's sexuality, you will be surprised to see general improvement in quality of life, physical and mental health, social, studying and working ability, etc. Solving sexual problems is really a general key to improved health and happiness. Therefore, you need to be able to use at least some of the lesser sexological tools. And don't be scared. It's not difficult when you first get started. And you will soon see that it is great fun and a mighty help to your patients.

The two major tools in sexology are, not very surprisingly, also about talking and touching. Manuel sexology is about therapeutic touch in the sexual area. We are sure you sense the danger… so we guess we have your full attention.

Manual sexology is clinical, holistic medicine focused on sexual healing. Sexual healing occurs when the patient understands and assumes responsibility for the disturbances in her psychosexual development. The tools can be categorized as small and large tools of manual sexology, with comparison to the pelvic examination. Before starting to work with manual sexology, the therapist must be well trained in the general use of therapeutic touch (see Chapter 13) and must have a thorough understanding of the dynamics of erotic transference and counter-transference (see section 7).

This chapter reviews five classical tools for examination and the simultaneous treatment of the patient (i.e., clinical medicine):

- "Acceptance through touch" is therapeutic touch in sexology, where the therapist give acceptance to the patient on a sexual and bodily level that she needs but did not get from her parents.
- Vaginal acupressure (Hippocratic pelvic massage) is massage of the organs of the pelvis through the vagina, which helps the patient to get present in the lower parts of her body and integrate repressed negative feelings and emotions often related to sexual traumas. Hippocrates and his students used this method 2,300 years ago for the treatment of hysteria.
- The pelvic examination is itself highly therapeutic but only if the sexologist, physician or gynaecologist addresses the emotions it provokes.
- The holistic pelvic examination is the pelvic examination done in an empathic and therapeutic way.
- The sexological examination, often called the "educational, gynaecological, sexological examination" is a yet more complicated and time consuming and also more therapeutic procedure that involves the exploration of the patient's sexual energies, character, sexual problems, sexual history and also use the large therapeutic tool of direct sexual stimulation of the patient's clitoris and vagina. This tool can often bring a chronic, an-orgasmic patient all the way back to orgasmic potency in short-term therapy. It has been used for sexological research but has so strong curative qualities that it potentially could help many patients who are not sufficiently helped with the smaller sexological tools.

The ethical and legal aspects of the manual sexological tools are discussed shortly and will be discussed in length in section 4.

Introduction

The pains and discomforts and problems related to the organs of the female pelvis like the female sexual pain disorders, vulvar vestibulitis syndrome, dyspareunia and vaginismus have been variously classified through time as sexual disorders, pain disorders, psychosomatic disorders or urogenital disorders (1) (see also section 5 on healing of pain). The ambition to create a precise diagnostic system for these pains, discomforts and dysfunctions has largely failed (2,3), and the complexity of the matter remains basically a mystery for both the clinician and the researcher.

The fundamental lack of scientific understanding of the female problems has lead to a severe lack of sufficient treatment. About one third of the women in the Western work have, in spite of seeing their doctor on a regular basis, recurrent complaints or chronic conditions related to the organs of the pelvis, especially the genitals, bladder and muscular system, which are obviously not cured or even helped much by the standard biomedical examination and treatment (4).

The problems of the female patient have been important issues from the beginning of medicine; the famous physician Hippocrates and his students used pelvic massage and similar treatments for a vast number of such female illnesses and health conditions, which were

already at that time related to problems with the sexual energies of the womb and the general psychosexual development of the mature female character and sexuality (5).

Since the development of modern sexological science around 1950, such manual sexological procedures as pelvic massage (often called "vaginal acupressure" and "physical therapy for the pelvic floor") have again been acknowledged by physicians and sexologists as efficient medical tools for a number of sexual problems, pelvic and genital pains, and other dysfunctional conditions in the pelvic area (6-13).

Since Freud and Jung, repressed libido and sexuality has been seen as a primary cause of many mental and physical problems (14,15); quite surprisingly, these researchers seemed to be in accordance with the Hippocratic tradition in their understanding of sexuality and its fundamental importance for human health.

In contrast to this holistic medical tradition, we have the biomedical science that does not see sexuality but biochemistry and genes as a leading cause to the patient's mental and somatic health problems; this understanding has lead to a large number of pharmaceuticals, which most unfortunately does not seem able to help most of the female patients with problems related to sexuality and the energies in the pelvic area.

While Freud's psychoanalysis used only talking (14), manual sexology much inspired by Reich (6) often used bodywork, focused on the genitalia, to free the repressed sexuality and painful emotions that have caused the problems. Reich therapy was in its direct, genital approach close to the classic Hippocratic physicians, also using genital massage as one of the standard tools for most female conditions, including the female mental disorders (called "hysteria").

Many pains and discomforts of the pelvic organs are not well understood today. It is a fair guess that repressed emotions related to sex (including the oral and anal aspects described by Freud) also cause many of the most common problems like the urinary tract infections (UTIs) and the genital tract pseudo-infections that mimics the UTIs but has no bacteria (or insufficient bacteria to explain the symptoms). Fifty percent of women have these symptoms at some occasion, and it has been estimated that half of the genital tract infections (GTI) are actually sterile inflammations caused by something else other than bacteria (16). Most likely the inflammation is simply caused as a somatisation of the sexual blockages caused by difficult repressed sexually related emotions.

The general practitioner or gynaecologist will, therefore, be well advised to always look for a psychosomatic, sexual cause for recurrent or chronic pelvic or uro-genital pain or discomfort. The most efficient way to look for this is by using the combined exploration and treatment known as the classical "sexological examination" (6-13). Most unfortunately, this examination is highly complicated and takes 30-90 minutes even for a trained physician.

To make sexology more ethical, rational and also more customized to the needs of each individual patient, and to make it possible in the future to treat the many female patients with such conditions also in a general practice with more limited time for such procedures than the sexological clinic, we have during the last ten years developed smaller and faster tools than the thorough, traditional sexological examination.

During this period of research at the Research Clinic for Holistic Medicine and Sexology in Copenhagen, we have found that about 40% of the female patients with problems in the pelvic area could be cured just with the smallest of these tools, acceptance through touch (17), and about 60% can be cured with vaginal acupressure (also called Hippocratic Pelvic Massage), where the patient's resistance is addressed and analyzed (18,19).

Most interestingly, we found that the pelvic examination had a large therapeutic potential in itself, if it is used wisely, and its healing potential is exploited (20), but the strong traditional taboos of this procedure make this somewhat difficult. A therapeutic element can, after the patient's consent, be added to this procedure, which we have found to be a great help for patients who need a more empathic style of pelvic examination, i.e., because of sexual traumas.

Finally, the large, full-scaled sexological examination can be used to help the patients that cannot be helped by these smaller tools; this procedure includes the provocative tool of direct sexual stimulation of the female patient (6-13); the use of this dramatic tool is justified by a curative rate of about 90% of the patients with chronic conditions like anorgasmia (21).

The ethical principle of using the smallest tool that helps the patient must always be remembered. It is also important to discriminate the different tools accurately to get the consent from the patient to exact the planed procedure. A smaller procedure makes it easier for the patient to participate, making sexological therapy possible even for the patients that have been severely traumatized sexually, i.e., by rape or incest.

It should be mentioned that a substantial fraction of the patients—we estimate one in three—who realize that their problem is related to a disturbed, psychosexual development can be helped without any manual sexological treatment but just with a combination conversational of therapy and customized exercises (22-24). This is easier, if the patient already has a sexual partner to do exercises with, the lack of which is often an important part of the problem. The use of non-sexological bodywork in clinical holistic medicine and sexology will often speed the treatment up also of sexological problems and reduce the number of sessions it takes to help the patient, and it might also increase the fraction of patients being cured to about 40% (25). Research has shown that psychotherapy in general is less efficient to cure sexual dysfunction than sexological therapy (26).

Five tools for manual sexology

The five tools for manual sexology are listed in Table 1. Before a manual sexological tool is used, it is wise to get written consent and also not to be alone with the patient during therapy. It is important to measure the state of sexual dysfunction or pain with a simple questionnaire like the QOL10 (27) or a visual analogue scale to document the effect of the treatment and also to know when to step up and use a larger tool because the one in actual use is not working.

Table 1. The five tools for manual sexology. These tools should only be used when conversational therapy, anatomical education, sexual biography, etc., have failed to solve the problem, and then the smallest tool that can cure the patient should be used (28)

1.	Acceptance though touch
2.	Vaginal acupressure
3.	Pelvic Examination
4.	Holistic Pelvic Examination
5.	Sexological examination

1. Acceptance though touch

This procedure of accepting therapeutic touch (6-13,17,30,31) is the most basic tool of sexology, as it just gives acceptance to the patient's body. In principle, the accepting touch can be applied everywhere; just holding the patient's hands with great acceptance is highly therapeutic. To make this tool more efficient, it can—after consent made before the session starts to avoid the possibility that the patient feels overwhelmed, or even exploited or abused—be used directly on vulva; it is wise to start by putting the patient's own hand on her vulva and the sexologist's hand on top of hers; it is also wise to start by doing it with the clothing on and having a nurse in the room also. If this does not help the patient, the patient is asked to undress, and the vulva can be treated in a quiet, calming manner. In this process, the therapist takes the role of a caring parent and gives as much as possible his unconditional love and acceptance to the patient, her body and her sexuality.

Just the experience of finally getting the acceptance that she never got from her parents can make small miracles happen; if the patient suffers from a sexual aversion disorder or low sexual self-esteem, this procedure will often be experienced as a very strong intervention, in spite of its minimal size as a therapeutic tool, and the effect can be surprisingly large.

To understand the therapeutic value of acceptance though touch, one should remember that the patient did not get the acceptance of her body, gender, genitals and sexuality she needed in childhood and repressed her sexuality and sexual feelings; the traumatic repression happened in childhood every time she was overwhelmed by negative emotions that she could not contain. These sexual traumas are often not connected to physical abuse, but they can be. Almost all international studies made during the last decades have documented that about 15% of females have been sexually abused in their childhood (see 30). Therefore, such traumas are not uncommon at all and must be expected with the female sexological patients, as the traumatized patients are much more likely to have problems in the pelvic area.

The reason for the strong therapeutic effect of such a simple tool as acceptance through touch is that it gives resources to the processing and integration of sexual traumas, also when these are not caused by abuse, but simply by sexual neglect, which often is equally traumatic as abuse (31). The surprisingly simple tool of "acceptance though touch" thus often opens up for a constructive and therapeutic dialog about the patient's sexual history. A sexual trauma that comes from the dramatic events of incest or rape are often more deeply repressed and take time and often also larger tools to cure, like the sexological examination (see below).

2. Vaginal acupressure

This intervention is actually the classical Hippocratic vaginal massage; it is simply done as the explorative phase of the normal pelvic examination with a focus on the feelings and negative emotions associated to the different places, anatomical structures, tissues and organs in the pelvis, including the muscles and the outer and inner genital structures. The penetration of vagina symbolizes the intercourse (14), and the patient's subconscious will often react to the digital penetration similarly to the reaction to penile penetration. Therefore, just penetrating the vagina with one or two fingers already puts the female patient in a position where all the difficult and painful emotions connected to sex can be exposed and processed.

A few dysfunctional patients react with sexual arousal on this procedure, but most react with resistance. About half of all sexual problems and genital pains can be cured just by addressing and processing the repressed emotions and feelings behind this resistance, as already discovered by Reich (6). Sometimes, the procedure needs to be repeated, while layer after layer of repressed material are integrated (32-34). Again, a nurse should be in the room also.

3. The pelvic examination

It is well known that female patients with sexual traumas often react negatively to this procedure (35); many of these patients complain that they feel the pelvic exam as humiliating and traumatic in itself. If that is the case, a smaller tool must be used, until the resistance towards the pelvic examination is reduced to a manageable level. The negative emotional reaction is coming from the strong similarity between the pelvic examination and many sexually charged and traumatizing elements, like being controlled, being looked at, being penetrated in a vulnerable position, being penetrated with a large, hard, physical object (the vaginal specula), being tortured (pain from the procedure, both from penetration and different sorts of tests taken). The deep exploration of the uterus including the visual inspection of the portio vaginalis cervicis uteri is often extremely provocative, as "nothing is left uncovered."

This is, in essence, a complete exposure of the patient, and it demands a high level of trust with a complete emotional and behavioural surrender of the patient to the physician or gynaecologist making the examination. Using the therapeutic value of the pelvic examination is not difficult at all; all it takes is an honest talk with the patient about what the different aspects of the examination procedure symbolizes and what this does to her emotionally. The problem here is that the patient often has been to gynaecologists, and she has felt negative about the procedure. She will be surprised to meet a therapist that acknowledges the emotional aspects of the procedure and cares to explore the emotional roots of her reactions to the procedure. As the emotional response to the standard pelvic examination often is a rather large and actually somewhat hard to integrate emotionally for most patients with sexual problems, it is wise to start with a smaller tool, if the intent is exploring and curing issues related to sexuality. Again, a nurse should also be in the room during examination.

4. Holistic pelvic examination

Instead of using a smaller tool like acceptance through touch or vaginal acupressure, the pelvic examination can be done in a slow and emphatic way, where the patient gets the time she needs to become accustomed to every step of it. If this is done with patients with sexual traumas, it can be extraordinary therapeutic, but the session can take one or even several hours, and this is often not possible in a busy clinic with limited professional resources. We have found that this procedure can change the patient's biology at a very profound level (20). Basically, what makes this intervention "holistic" is the "love and care" for the patient that allows her to take part in everything that is happening in the consultation.

The pelvic examination can, according to our experience, when used in this therapeutic way, help patients with sexual desire problems, sexual arousal problems, lubrication

problems, lack of sexual pleasure, negative feelings about sexual interaction, genital arousal disorder, lower genital arousal associated with intercourse, pain due to psychosocial factors, deficient pelvic muscle control, etc. A nurse should be present during the examination.

5. Sexological examination

There are various kinds of sexological examinations, but the following is often used and was created in 1965, by Hartman, Fithian and Morgan (8,10,12) and inspired by Reich, Hoch and Kegel (6,7,11,12). The sexological examination was designed to evaluate and assess the various components of human sexuality (e.g., perception, feeling, arousal, and response patterns) present or absent in varying degrees in research and therapy populations. The examination was a supplementary to the examination given by a gynaecologist or other medical specialist. The objectives of the examination include (8,10,12,13):

1. Providing a learning experience in physiological psychology for a husband and wife, committed partners, or singles.
2. Dealing with the self-concept of women who want to know, "Am I normal?" "Is my clitoris/labia too big or too small?"
3. Teaching women specific vaginal exercises.
4. Giving the therapist a clear picture of the response patterns of the subject through verbal reports of sensations to stimulation in each area of the vagina.
5. Identifying, where present, causes of dyspareunia and pain in the female. Some pain or discomfort may be psychological.
6. Giving genitalia their correct anatomical names.
7. Making the individual more at ease with her sexuality and sexual functioning.
8. Enhancing communications between couples about genitalia and functioning.
9. Overcoming the reluctance by some individuals to have non-intercourse genital contact, such as touching the penis or putting a finger in the vagina.
10. Helping the patient to intimately explore own (and partner's) genitals.
11. Teaching the use of other techniques to be used later during treatment, in privacy, where they may be carried on to fruition. This, for example, might include the squeeze technique.
12. Explaining other sexual options where, in private, the partner may stimulate the spouse to climax without the use of the penis.
13. Observing psychological conditions and responses to be treated during the therapy.
14. Acquainting the female with her own body to dispel some of the feeling that the genital area is a special place forbidden for all but physicians to see.
15. Checking the clitoris to see that it is free of adhesions. Women typically say their physician has never examined it.
16. Searching for areas where nerve endings come together in a systematic way, suggesting that this may develop positive feelings.
17. Assisting women in determining areas of perception, feeling, and awareness in their vagina. Pointing out areas in the vagina that tend to be more sensitive and responsive for many women (i.e., 12 o'clock, 4 o'clock, and 8 o'clock positions).

18. Determining a woman's response and arousal patterns. Indicating to her whether or not she lubricates well and vasocongests when she does.
19. Locating areas digitally that may be producing pain, discomfort, or problems with sexual arousal or intercourse—such as separation of muscle in the vaginal wall; long labia minora; scarring, which may be tender or fibrous—and to pinpoint the source of "pain" when present.
20. Identifying, where present, reasons for vaginismus, which are not only physiological but psychological.
21. Teaching a male partner how to caress the female's vagina.

The most radical aspect of the sexological examination and what makes it different from the other manual sexological procedures is that it involved the technique of direct sexual stimulation. Direct sexual stimulation of a client toward a high level of arousal is not, and never has been, a part of the sexological examination conducted at our Centre. Still, some women do become aroused, and occasionally a sex flush will be observed in the process practice of the vaginal caresses according to Hartman and Fithian (13).

The sexological examination is also examining the clitoris: "More important than the stimulation of the clitoris in the female sexological examination is the determination of whether or not clitoral adhesions are present. This is a condition where the prepuce is stuck or adhered to the glans clitoris. For pre-orgasmic women, the inability of the clitoris to withdraw as part of sexual arousal may prevent particular women from full response. Even though some women are orgasmic with clitoral adhesions, freeing them usually results in easier, quicker orgasms and less discomfort due to calcified, trapped smegma" (13).

The sexological examination is explicitly sexual, and it addresses all relevant issues of sexual nature, and the female patient's sexual responses are tested in the clinic directly by letting the patient feel sexual desire, arousal and pleasure and report on it. The sexological examination can be taken all the way to instant sexual healing of the female an-orgasmic patient, who cannot by herself get an orgasm. This technique has been used for 30 years by sexologists like Betty Dodson in the USA and Denmark and is still considered highly controversial in spite of its extreme efficiency, allowing therapists like Dodson to cure about 90% of the female patients with chronic anorgasmia, in only 15 hours of intensive therapy (21).

Ethical and legal considerations

The major concern that professionals have about the sexological examination is that untrained or unethical therapists might use it unwisely (6-13). Manual sexology must, therefore, be performed according to the highest ethical standards. The holistic sexological procedures are derived from holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts), and close intimacy without any sexual involvement.

The general ethical rule is that everything that does not harm and in the end will help the patient is allowed ("first do no harm") (27), but we understand that the more radical, manual

sexual procedures are not accepted in many countries due to the sexual taboo. But a physician is allowed to touch his patient, and every time there is a touch, acceptance can be given. So every physician and therapist in every culture of the planet can use the smallest of the manual sexological tools. The physician or therapist is well advised to adjust his practice to the laws of the country.

To perform the sexological techniques, the sexologist must be able to control not only his/her behaviour, but also his sexual excitement to avoid any danger of the therapeutic session turning into sexual activity. The necessary level of mastery of this art can only be obtained through training, supervision, and the presence of a third person. We recommend the ethical rules of the International Society for Holistic Health to all practitioners of sexology, bodywork, and clinical medicine (27) (see Section 4).

We will ask the reader of this chapter who is left with the feeling that manual sexology is unethical and potentially abusive because it allows the physician or therapist to touch the patients genitals, which potentially could be done for the therapist's own pleasure and not for the benefit of the patient, to take into the consideration that the patients that seek sexological assistance are doing this consciously, with full consent, and often because they are chronically ill and severely tormented by their sexological health issue. Many of these patients are not able to find a sexual partner, and their situations in life seem often pretty hopeless; many of them have been dysfunctional and incurable for many years (we found a mean of 8.9 years in our study of vaginal acupressure) (19), often with chronic pains, and they are depressingly aware that they are suffering from a condition for which there is no efficient biomedical cure, because they often have tried every possible treatment, sometimes even including genital surgery for the pains!

Many of the patients are also unaware of body memory or repressed memory due to earlier traumatic stress (30), and some patients only open their mind up for their earlier sexual abuse through the sexological examination, because the touch becomes the trigger that reconnects body with soul and recovers the patient's sense of coherence (36,37). Therefore, manual sexology has a unique healing potential in a time where sexual abuse and repressed sexual traumas are frequent. We are aware that manual sexology is still not legal in some countries, and therapists need to be aware of the local laws.

Discussion

The primary purpose of sexological therapy is to improve the global quality of life and secondarily to improve health and ability, which often happens when sexuality is improved (5,6,14,15). The severe conditions of the patients and the chronicity and the high efficiency of the sexological procedures, are what ethically justify the much more direct, intimate, and intense methods of manual sexology.

The sexological intervention is ideally a holistic procedure also addressing the patient's mind and spirit, not only the body; it integrates many different therapeutic elements also from psychoanalysis and short-term psychodynamic psychotherapy (22-24); it works on many levels of the patient's existence and personality at the same time, including spiritual aspects like the character and the meaning and purpose of life (the life mission) (38). We find it,

therefore, correct to call these above-mentioned procedures for "holistic sexology" or "holistic existential therapy," and include them in the concept of clinical holistic medicine.

Sexual problems are not only very distressing for the patient; they are also an integrative part of a psychological developmental disturbance that affects the personality of the patient at its roots. Reich wrote about the "genitally mature character," or the "genital character" for short (6), and we have often seen that healing a patient's sexual problems leads to the subsequent healing of the patient's mental and existential problems also, indicating that a major reason that many mentally and existentially troubled patients never recover might be the constant repression of their sexuality and libido, as already suggested by Freud and Jung (14,15).

Sexuality is still one of the strongest taboos we have in our Western culture, and only if all physicians and health professionals work in concerted action will we be able to do something about this within a few generations. It might be the missing link to a more healthy population at large.

Psychotherapy must be considered as an alternative to sexological therapy, but there seems to be a general acceptance of the fact that many sexual dysfunctional states are not cured by psychotherapy alone (24) and that sexological procedures are necessary for patients that are non-responders to psychotherapy. Clinical holistic medicine that includes philosophy of life and body work are often efficient with sexual problems and seem to be able to cure 40% of these patients only by use of therapeutic touch including acceptance through touch (25).

In psychology, psychiatry, and existential psychotherapy (39,40), touch is often not allowed, and this might be the reason for these treatment methods not being very efficient with sexual dysfunctions.

Physicians and therapists who have general concerns about pelvic floor physiotherapy should know that over 50 randomized clinical trials have shown vaginal physiotherapy to be rational and efficient for incontinence, pelvic and genital pain syndromes,, etc., without any significant side effects (41), but when it comes to sexual dysfunctions, the physiotherapists recommend the sexological examination to improve efficacy.

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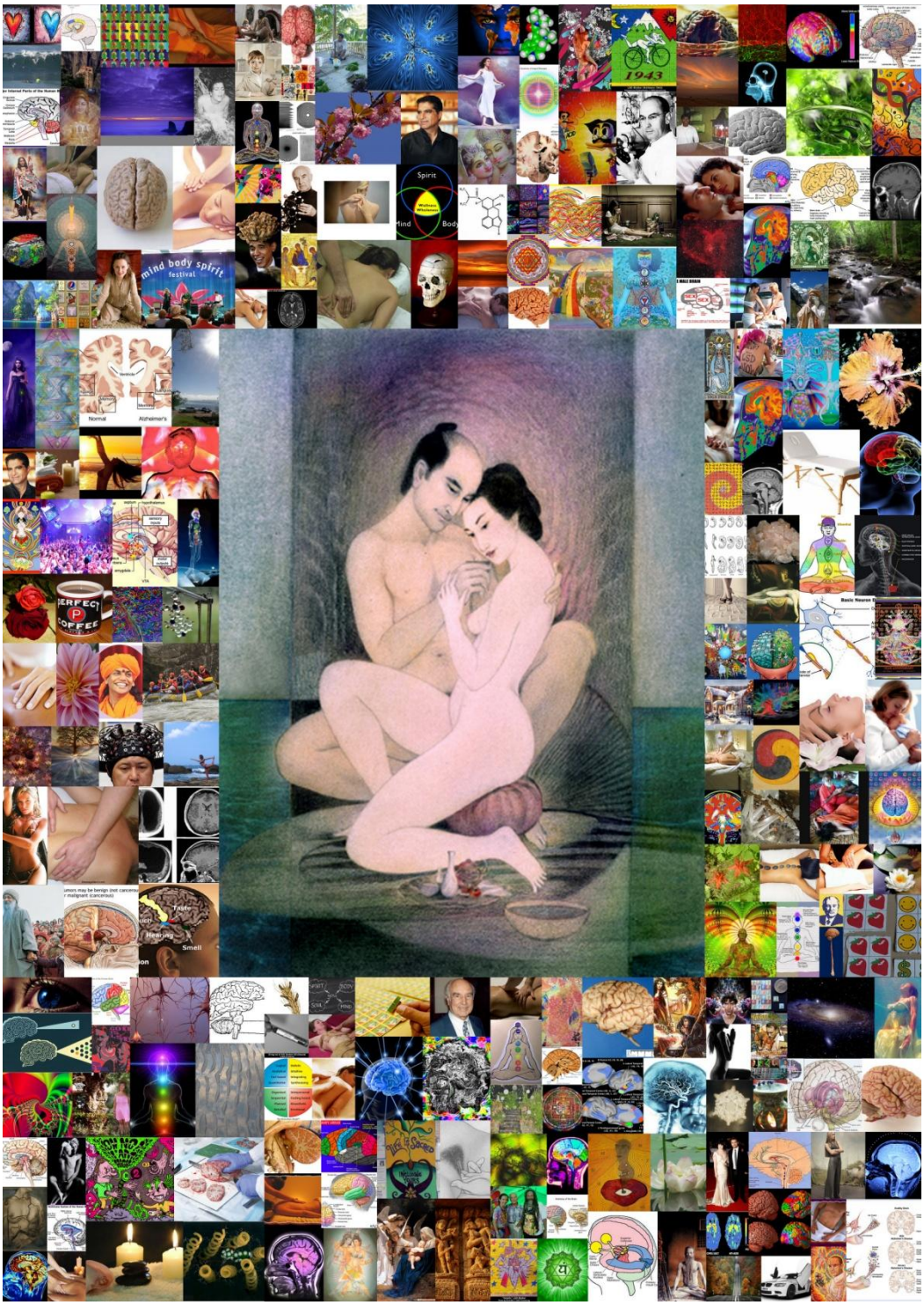
Exercises

1. The manual sexological techniques are most easy to learn as a student, if you practice them with your intimate partner. You will discover the strange fact that these procedures are not sex nor are they very sexual. They come from loving care and deep concern for the other person's life and well-being, and only when you find this spot in yourself and come from that will you be successful as sexologist.
2. If you work as a GP or gynecologist, notice the emotional reaction there always is toward the pelvic exam. Take time to talk to the female patients about their reactions, and you will soon learn how to practice vaginal acupressure. Physical contact and talk therapy in combination is what it takes to cure many types of sexual dysfunctions. When the feelings are processed, the traumas are healed and the patient returns spontaneously to normal function.



Chapter XX

How to avoid suppressing the patients' sexuality: Problems related to manual sexology and the pelvic examination

Is gentle touch always good and therapeutic? Well, it depends on the intention behind the touch. If the intention is not to heal, touch might not be healing. If you have other intentions than healing when you touch, your touch might not be healing. If you live together with a partner and have the intention of mutual sexual enjoyment, such an interaction could in principle be healing, but most often it is not. Men and women with sexual problems often continue to have them, in spite of many intercourses, hours of petting and physical contact. So, much physical contact is obviously not healing. Normal sex seems in general not to be healing.

Many women speak about difficulties after examination by their doctor. Here, the intent is examination, taking samples and reaching diagnoses. This is not a healing intent either. And such contact is not healing. If it is harmful is hard to tell; the females often report it as unpleasant or even very unpleasant. But unpleasant feelings are not harmful in themselves. Harm is only done when feelings are *repressed*.

Is the traditional pelvic exam such a situation where feelings are repressed? Is the pelvic exam in general traumatic and harmful? And if it is, how should we approach the patient, how should we examine and touch in this situation?

In this chapter, we are looking at some of the difficult aspects of bodywork. Knowing what causes the problems should prevent you from causing them. We must admit that this chapter is not based on quantitative data, so we do not know if the worries we present are substantiated. We think they are, at least to some extent, but we do not know. We have included this chapter because we think that it is better to be safe than sorry. Better to carefully avoid potential risk that just acting unaware and blindly.

It is so easy to see the errors of the past and so difficult to see the errors of today when we are doing what we used to do and take it for granted that it is fine. As is often said: "First do no harm." We have been wondering why so many young people have severe problems in their love and sex lives, not being able to avoid sexually transmitted diseases, and why so many people have sexual problems.

Introduction

In "Lessons from medicine's shameful past" (1), the editor focused on the medical profession's repression of homosexuality only a few decades ago (2,3), using the aggressive and destructive methods so strongly criticized by Illich (4). It is so easy to see the errors of the past and so impossible to see the errors of today. But we believe that it is more important for our patients to reflect on our methods of today than to judge the past. We have been wondering why so many young people have severe problems in their love and sex lives, not being able to avoid sexually transmitted diseases and why so many people have sexual problems. About one in ten young adult women suffers from vulvodynia, a shameful "new" disease that only half the patients bring to their physicians (5). Around every third woman seems to have sexual problems of some kind (6), and as every woman has a physician, it seems that we are generally not very good at helping. But it may be even worse. Why is it that the standard gynaecological procedures we use as physicians in the every-day clinical practise, like the pelvic examination, are seemingly repressing the sexuality of the woman? Let us take a critical look.

Is the pelvic examination a harmful and sexually suppressive procedure?

The pelvic examination is a common examination performed in general practice or by the gynaecologist. Whenever a woman complains of pain or discomfort in the abdomen or pelvic area, the general practitioner/gynaecologist is in principle obliged to carry out a pelvic examination in order to rule out STDs, ectopic pregnancy, acute inflammation of the lower abdomen or something else that can seriously affect the patient. The patient is examined in the traditionally gynaecological position with her legs in stirrups, after which the physician can inspect, examine, explore and take samples.

When we speak to women about their experiences in this situation, a surprisingly large number of women—at least one in three, and more than half of teenagers—report that they have felt humiliated and devaluated by the procedure that is normally followed. They often find it insulting to be put in positions where their reproductive organs are exposed, without being in any way able to look after themselves. They often feel incapable of protecting themselves against an examination that may be insensitive, rushed and not leave space for them as human beings, the sole intention being to perform a physical procedure as efficiently as possible.

It is worrisome that the numerous physicians and gynaecologists around the world subject women to examinations that may be a stressful and perhaps even traumatic experience. Part of the problem is obviously due to shortage of time, but another important part of the problem appears to be due to misunderstood respect for the woman's sexual boundaries, which means that the physician feels more secure in reducing the female patient to a pure object of examination. It is considerably easier to examine a set of organs than to relate to a living person, with feelings of shame and desire and a sexuality that can threaten to end the career of the physician, if he so much as relates to it.

Mere suspicion that the physician may assault the woman who is placed in what is a very vulnerable position can cause the physician to entrench himself behind this clinical facade in a way that is in itself dehumanising. Instead of being present, the physician almost tries to avoid being there and becomes an excuse for himself. Paradoxically, this gives rise to another type of violation—being rummaged around in the woman's most delicate parts, as though one was something rather like a car engine. Pushed to its extreme, it is as though the medical profession has decided once and for all that it is difficult to show human respect and care in the situation where the patient's reproductive organs are exposed. Instead, it is necessary to make do with showing the craftsman's respect that a skilled clockmaker displays with a sophisticated timepiece. We have ourselves faced ethical problems in putting women or young girls who have previously been subjected to sexual assault through the general examination procedure, because this procedure can bring back memories of assault. Nor is it possible to solve a problem of that kind by simply passing the buck on to the gynaecologist, who although he has more experience generally has far less knowledge of the patient. One of the emotionally most difficult aspects of the pelvic examination is the physical touch itself, which the gynaecologist tries to make less dangerous by using rubber gloves and instruments. Due to a strict professionalism with often a brusque silence (because the physician is afraid of saying the wrong thing), the women can sometimes be reminded of up-tightness, bad sexual experiences with insensitive lovers, or even insulting sexual touches, rough partners, attempted rape or, in the worst case, assault in childhood.

Where sexually harmless situations are concerned, the physician generally does not have any objection to calming the patient through touch, for example, by putting his hand on the arm of a woman who is upset. This often causes difficulties in the gynaecological context, because if the situation is misunderstood by the woman, the entire medical career of the physician can be finished in an afternoon.

It is important that both the patient and the physician realise that instead of avoiding any human touch in connection with a pelvic examination, the physical touch can and must also be an entirely natural constituent element here too. As in any other emotionally difficult situation, supporting physical touch may help the woman to feel acceptance and support, and in that way promote her sense of security in the situation and not least her confidence in the physician and the treatment.

Many male medical students at first have serious problems with the pelvic examination (as an example one student became impotent for months, after spending a period of time in a gynaecology department). We also often encounter patients who clearly hated the pelvic examination because it reminded them of unpleasant things from their past. There we must consider whether it might not be possible to turn the unavoidable touching of the woman around, so that it becomes not an evil that has to be minimised, but a therapeutic resource that can be drawn on or, in other words, instead of masking the touch, using it to express respect for and care of the woman in the examination situation.

The holistic pelvic examination

When there is an actual sexual trauma, the situation is even more complex. The purpose is the healing of the patient, to re-establish the natural relationship with the body, sexuality and

reproductive organs also in patients with acknowledged or suspected sexual violations. For integration of presumed traumas following incest and sexual assaults, it is recommended to carry out a slow pelvic examination, based on the holistic principles of holding and processing. On top of the normal examination in such cases, all the legal aspects according to the law in the specific country must also be followed.

Due to the fact that we had a patient with a need for a considerate procedure of this type, we arranged for a very thorough, careful and well-planned procedure, which specifically tried to avoid turning the patient into an object and instead to treat the woman as a woman. The idea was to make the pelvic examination slow—very slow, in fact, so slow that the physician could be sure that the patient was entirely there at all stages of the examination, indeed in everything that was done with her. We also went through the procedure with the nurse, who approved it.

We found, to our surprise, that the pelvic examination was in fact healing and therapeutic for the patient when it was performed in this slow and attentive way. We have discovered that it was not unpleasant (as a male physician) to be present in the examination situation. The new and more relaxed attitude and new acceptance of this unavoidable physical touching of the woman's reproductive organs led to a surprising change in the patient's experience of the examination.

With this new approach, women started to say that it was nowhere near as bad as it used to be. In contrast to what might have been imagined, the empathic and physically present form of examination also becomes less sexually provocative for the physician than the normal, rapid gynaecological procedure. Since that time, we have allowed ourselves an extra amount of time when we have had female patients with sexual problems, who perhaps have been subjected to sexual assault—the truth of which, however, it is never possible to know for sure—but who have been very vulnerable, sensitive and perhaps even full of shame and self-condemnatory in relation to their sex, reproductive organs and sexuality.

If sexual assault is suspected, we use the slow procedure with preparation of the patient, where she is thoroughly informed about it beforehand, so that we can be sure of her complete acceptance and assistance throughout the procedure.

The purpose is re-establishment of the natural relationship with the body, sexuality and reproductive organs in the patient, who has problems due to acknowledged or suspected sexual violations.

Sexual violations are often forcibly repressed. It appears that the tissues that are touched during the violation often bear the trauma. It is characteristic of these patients that their love lives are often problematic and do not provide the necessary support to heal the old wounds in the soul, and therapy is, therefore, indicated.

When this is concerned with the reproductive organs, it poses particular difficulties, as the therapy can easily be experienced as a repetition of the original violation, not least due to the risk of projection and transference.

There is, therefore, a need for a procedure that is familiar and safe for the patient, but it involves therapeutic touching of sexual organs over and beyond what is standard medical practice. We establish the following procedure, with which the patient is familiarised and accepts, before the treatment is initiated. The procedure is carried out with a nurse and ample time allocated (three hours). The procedure includes:

- Conversation about the present condition—relationship to body, sexuality and reproductive organs, including investigation of problems in sex life such as pain and painful memories are recapitulated.
- Conversation about the concept of boundaries, so that the patient understands fully where her own sexual boundaries are in order that the examination is not experienced as an assault.
- Conversation about how the assault can be projected into the present. How do the patient and therapist act, if the patient finds the therapy a violation? It is important to say so immediately if something feels unpleasant or wrong.
- The establishment of the therapeutic room as a safe place.
- Stopping exercise—touching of the body and reproductive organs on the outside of the clothes, where the patient says stop, and the hands are removed at once.
- Contact: Physical touching of the body—from the head down to the stomach, pelvis and lower abdomen—slowly and in suitable steps, so that the patient is present and secure throughout.
- Visualisation of extended pelvic examination, where the therapist runs through the steps of the examination thoroughly so the patient can imagine them before they are due to happen.
- Touching on the outside of the clothes with repetition of the "Stop" procedure if necessary.
- Pelvic examination paying special attention to traumatised (damaged/scarred /blocked) areas.
- Feel, acknowledge and let go of the traumatised areas. If there are areas that appear blocked or "the patient not present," has pains or other discomfort, we then give special attention with regard to their integration. This is not fundamentally different, for example, from the treatment of growing pains in children by touching the areas that are sore, for example, around the knee. If the sick areas are attended, they are also usually healed.
- Post-processing of emotions and traumas. The work with blocked places in the body often releases painful gestalts from childhood and adolescence, which must be talked through, in the same way that the patient's painful feelings must be supported and accommodated by both physician and patient.
- Healing is only possible when negative decisions are found and dropped. The patient has to come back to the present, let go of negative sentences or ideas and planned for further positive progress.
- These points above are printed out, signed and approved by the patient as a formal contract.

So we do not just need attention, respect and care—and acknowledgement of our soul—we also need something bodily, physical and down-to-earth, namely acceptance of our gender. When it is possible as a physician to meet the patient with respect and within boundaries to recognise her as a woman, then we can help her and give her our full acceptance. Many problems related to sexuality then appear to decrease, as they are probably due to self-condemnation and lack of sexual self-acceptance.

Slow pelvic examination with a therapeutic element

It is important to notice that we introduced a slow pelvic examination with a therapeutic element, relevant for a wide range of psychosomatic disturbances related to gender and sexuality, from infertility to gynaecological and sexual psychosomatic problems and the long-term consequences of child sexual abuse. On one hand, this opens up a clinical practice with many beneficial and healing qualities for the patient, because it allows a much closer and more intimate relationship between the patient and the physician that has been the traditional practice; but on the other hand, this procedure has several disadvantages.

In many cultures, this cannot be practiced due to cultural or religious reasons and the sexual taboo being so strong that the female will experience the process as overwhelming or even insulting. In the United States, it might be practically impossible to follow our recommendations in many cases because of the time consumption, economics and reimbursement issues of this culture and the heavy "malpractice culture" in that country.

The most difficult problem of this procedure seems to be that is makes it very difficult to be sure that the procedure and all the involved steps are always necessary and rational. This procedure and the cultural issues involved means that it has a high potential for malpractice, but this can be minimized dramatically by the following steps: 1) Before the procedure is done, the patient must read about it with at least one case study like the one in this chapter to fully understand the emotional and existential implications of the procedure, so she has time to contemplate and make her decision of whether to accept the physicians offer or not; 2) The procedure is also orally presented by the physician to the patient before she signs the contract; 3) The physician must be in supervision to discuss the problems, if any, about borders, intimacy, emotional and sexual issues. Close supervision and full inter-collegial openness is the best prevention of malpractice, as malpractice often occurs with physicians without a network and without openness about what is going on in their clinics.

The ethical aspects

Touch is a very dramatic and mutual thing for our physical and emotional being: when I touch you, you touch me (7). As many people only know touch in connection with sexual behaviour, a sexual reaction to a completely innocent touch is not rare in the clinic. If sexually aroused, the female can react as "if she has sexual organs all over her body," making physical contact with her very electric and sexual, and this reaction can come very suddenly and highly unexpectedly and not always conveniently. If the physician retracts from her in this situation, which would be the immediate reaction of most normal people, she will experience that her body, gender and sexuality is not acceptable, which destroys intimacy and trust negatively for the patient and the professional relationship. Being there, staying in contact, takes a great deal of "spaciousness" on the part of the physician. This spaciousness should be a part of our medical training, but is often not, making so many pelvic examinations and other procedures emotionally painful and awkward for both physician and patient.

The subject of ethics has been of utmost importance for the physician since Hippocrates, and whenever the physician touches the patient, the ethics of the action must be considered. The problem of touch is mostly much more of an ethical problem than it is a legal problem: Why do you touch the patient, what is the intention? If the intention is for the physician to enjoy his patient—which we do most of the time with people in private—we consider this unethical, even if this is just holding hands. The physician should have the healing of the patient as his sole focus, and if the intention of the physician is wholehearted and rooted in deep medical expertise to heal the patient (and in this intention touch any part of the body including the genital), this is ethical. Interestingly, the physician's ethics seems to be proportional with his results with his patients. Only the clearest of intentions can bring us outstanding results (8).

But simply touching sensitively—the essence of manual medicine—is a much more powerful tool than many modern and biomedically oriented physicians assume. Many pains and discomforts can be alleviated just by touching the sick area and helping the patient to be in better contact with the troubled tissue and organs of the body. Lack of presence in the body seems to be connected with many symptoms that can be readily reversed simple by sensitive touch in the intention of healing. When touch is combined with therapeutic work on mind and feelings, holistic healing seems to be facilitated, and many problems can be solved in a direct, easy and effective way in the clinic, without the use of drugs.

Manual medicine even in its most simple form is a powerful and often underestimated medical tool. The great power of physical contact between physician and his patient, which is even stronger in the context of the theory, practice and intent of holistic healing, is often not taken sufficiently into use in the medical clinic today, where everything is supposed to be cured with a drug. Much suffering and money could be saved, if the physician of our time were able to discriminate more clearly between intimacy and sexuality and thus dared to be more intimate and physical with their patients. If the physician masters the art of touch, he can even give the quality of holding without touching.

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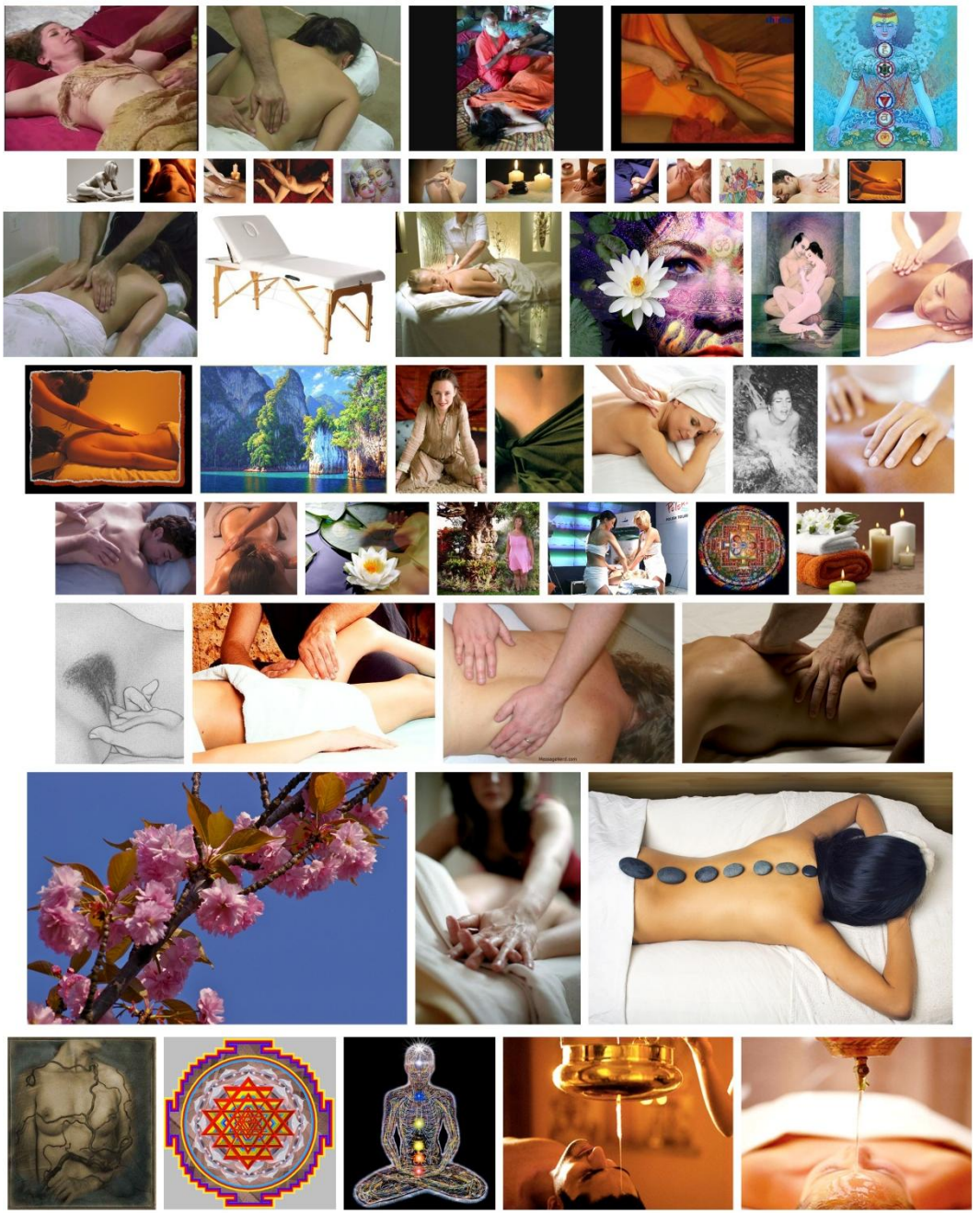
Exercise

1. Talk to young women about their experiences of the pelvic exam. Is there a problem, and if there is, what is the problem and how can it be alleviated?



Chapter XXI

Existential therapy and acceptance through touch

In this chapter, we will give you the key to sexual healing. Quite surprisingly, it is a procedure that can be used independent of genital contact. You can touch your patient's hand, arm, shoulder, foot or any other part of the body and give it: Accepting touch. It is very likely that you will not get it at first. It takes a lot of practice to master this simple technique. It really is the simplest thing in the world, and yet it might be the most difficult of all the things we do in the holistic medical clinic. Acceptance is magic, an extraordinary thing. It is a strong blessing. It is really you saying that my body is compatible with your body, and my sexuality finds your sexuality fine. This is pretty deep when you think about it. Therefore, it is also very difficult to master. Only by trying again and again can you as a student come to master it. In trying, you will heal yourself from the problems you might have in the sexual area. For when you touch another person, this person will also touch you. And touch and contact in the intent of healing will, in the end, heal.

Sexual problems are found in four major forms: lack of libido and desire, lack of arousal and potency, pain and discomfort during intercourse, and lack of orgasm. It is possible to work with a holistic approach to sexology in the clinic in order to find and repair the negative beliefs in the mind, the repressions of gender and sexuality in the body, and lack of love and purpose of life in the spirit, which according to holistic philosophy of life and understanding of man are the root causes of to the problems related to desire, arousal, orgasmic potency and sexual pain.

It is important not to focus only on the gender and genitals in understanding the patient's sexual problems. It is of equal importance not to neglect the body, its parts or the feelings and emotions connected to it. Shame, guilt, helplessness, fear, disgust, anger, hatred and other strong feelings are almost always an important part of a sexual problem, and these feelings are often "held" by the tissue of the pelvis and sexual organs.

The patient with sexual problems can be helped both by healing existence in general and by discharging the old, painful emotions from the tissues. The later process of local healing is often facilitated by the simple technique of therapeutic touch: accepting contact soul to soul via physical touch.

This is a very simple technique, where the self-acceptance and bodily and genital self-esteem of the patient is to be developed and encouraged. One way of doing this is by asking

the female patient to put her own hand on her stomach and upper part of mons pubis (over the top of uterus and ovaries), or over the vulva (clitoris, vagina, urethra, lower part of the uterus), after which the holistic physician puts his hand supportively on top of hers.

When done with care and after obtaining the necessary trust and consent of the patient, this aspect of holding often releases the old negative emotions of shame, hopelessness, disgust, despair, etc., bound to the touched areas. Afterwards, in following sessions, these emotional and existential problems are the subject for conversational therapy, further holistic processing and healing.

Primary vulvodynia is one of the diseases that seemingly can be cured after only a few successful sessions of working with acceptance through touch. The technique can be used as an isolated procedure or as a part of the pelvic examination. When touching the genitals with the intention of sexual healing, a written therapeutic contract with the patient is highly recommended, and a strict ethical code is necessary to avoid malpractice.

As about one woman in two or three in the Western world suffers from severe sexual problems, many of which according to the statistics (NNT=1-2; see section 3 and Chapters 26-28) can be efficiently alleviated by the simple holistic techniques of "holding and processing," it is very important that the holistic physician is trained to work in the sexual sphere in order to be able to support his patients fully.

Introduction

Sexology is the medical specialty concerned with sexual dysfunctions. The major breakthrough in this field was made by pioneers like Reich, Masters and Johnson in the middle of the last century with the mapping of the human sexual functions and dysfunctions (1,2). When a sexual problem cannot be solved together with the physician in his practice, the patient is often referred to a sexologist, still using the techniques developed by these pioneers. As so many people have minor sexual problems, it is not possible to refer everyone. Most problems should, therefore, be treated in general practice, and minor problems can most likely be solved just by conversation. There remains a residual quantity that apparently cannot be "talked away" (see Chapter 11) (2), and for these we recommend the methods of this section of the book.

It appears as though some children have developed a sexuality that is greatly impaired and destroyed by the lack of sexual acceptance, condemnation or merely failure in physical contact, because a child needs accepting touch (2,3), which, of course, must not lead to sexual abuse of the child. Intimacy is not sexuality, as every parent will know. Accepting the child's sexuality is not the same as encouraging sexual activity but just acknowledging it as a sexual pole, either male or female (3-5).

The sexual problems resistant to conversational therapy are typically problems with acceptance of one's own sex and sexuality, which as originally suggested by Masters and Johnson can be a result of not having received the loving acceptance and touch needed in childhood (2,6). If one is a girl, there is a need for her father to think she is lovely, delightful and "good enough to eat" (6). It is obviously important that borders are not violated, but it is just as important that the father does not withdraw from physical contact, as he may, for example, if he is afraid of his own sexual feelings or if he has repressed his own sexuality, so

that he does not feel any physical interest in his daughter at all. The same applies to mother and son. Most parents show their acceptance or lack of acceptance through closeness and physical contact—ranging from warm, nourishing care to mental and physical violence. Regardless how good one is at talking, the conversation does not (at least according to our clinical experience) reach as deep as touch.

In Denmark today, the common understanding is that repressing a child's sexual activity can be traumatising, while in other cultures and especially in the past, child sexual activity was not allowed, and such behaviours were seen as abnormal. At the times of Sigmund Freud, children were sent to the physician for masturbatory tendencies, but as times goes by and the subject has been studied scientifically, child sexuality has been more and more accepted as a normal and even necessary aspect of normal child development (7).

As adults, repressed childhood sexuality can be observed in physical behaviour, where the person does not act with a sexual character. Either the person is acting sexless, or the person concerned is virtually behaving like a person of the opposite sex—far too masculine or too feminine.

That poses many problems to many people who experience not having sufficient sexual attraction, not being sexually delightful, being sexually inadequate—e.g., lacking physical or orgasmic potency—and not having the desire for sex. Sexual problems seem in general to be related to physical and mental health problems, existential problems and poor quality of life (8).

Repression of sex and sexuality appears to happen through a decision that sex is wrong and shameful or that one is not as delightful, as feminine or masculine as one ought to be. Early in life, denial of one's sex can be done very effectively by deciding that one is of the opposite sex, in order maybe to meet the wisher of the parents, as we shall see in an example below. Based on our clinical observations, this results in some strangely unmanageable sexual problems, which are difficult to understand.

Existential healing or healing of the wholeness of the person on the deepest level of his or her existence is needed for the "abstract" sexual problems not related to a concrete physical problem. Before we continue, let us take a look at holistic medicine and the concept of existential healing.

The scientific basis for modern, holistic medicine and sexology

In this book, we will introduce to you the major theoretical frameworks we have formulated to give us self-satisfactory explanation of what is going on during the process of healing the many different health issues that patients presents to us.

We will discuss the life mission theory (9,10-13), based on the philosophy that everybody has a purpose of life or talents. 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 or a condition where the person knows himself and uses all his efforts to achieve what is most important for him. The theory of talent (12) states that we have three major talents in life, called purpose, consciousness, and gender. In relation to this chapter, these dimensions may simply be: love, power, and sex. Gender and sexuality is a

fundamental dimension of human existence, which must be in a sound, natural and undenied state for the person to live and function naturally and in full power.

We will also discuss the holistic process theory of healing (14,15) and the related theories for salutogenesis (16,17), meaning of life (18), and quality of life (19-21), which state that a return to the natural state of being is possible whenever the person gets the resources needed for the existential healing. The resources needed are holding 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 beliefs. The preconditions for the holistic healing to take place are trust together with the intention of the healing taking place.

Existential healing is not, as mentioned above several times, a local healing of any tissue but a healing of the wholeness of the person, making him much more resourceful, loving and aware of himself, his own needs and wishes. In letting go of negative attitudes and beliefs, the person returns to a more responsible existential position with an improved quality of life. The philosophical change taking place when the person is 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 healthier, more talented and better able to function (30-32).

Sexual problems are found in four major forms: lack of libido, lack of arousal and potency, pain and discomfort during intercourse and lack of orgasm (2). It is possible to work with a holistic approach towards sexology in the clinic in order to find and repair the negative beliefs, repressions of love and lack of purpose of life, which seemingly are the core to problems like arousal, potency and pain, with repression of gender and sexuality (33,34).

The theory of talent (12) thus seems to be relevant for understanding human sexuality. It is highly important not to focus on the gender and genitals in understanding the patient's sexual problems, because many problems related to sex can be solved on the level of the whole person (2,33,34). But as important as it is not to focus there, it is also essential not to neglect the body and the feelings connected to it. Shame, guilt, helplessness, fear and other strong feelings are almost always an important part of a sexual problem (2).

Acceptance through touch

Acceptance is one quality of "holding" that is more related to the healing of human existence in the sexual dimension than others. Acceptance has to do with the biological fact that we were not rejected from the womb, even when we were not syngenic with our mothers, a marvelous biological fact still scientifically unexplained. Acceptance in early life has to do with close physical contact and touch, where the child needs touch almost more than anything. Sometimes, our needs for touch and acceptance of our body, energies and functions were not fulfilled in early life, which can give us severe problems accepting ourselves as adults (2-5). One of the areas of existence most vulnerable to lack of acceptance seems from our clinical experiences to be our sexuality.

As physicians, we have discovered in our practice that some of the problems related to gender and sexuality can be tackled by a simple technique: accepting contact via touch. It is

possible to extract this simple but essential aspect of the holistic pelvic examination (34), where it is a central feature and use it outside the primary medical pelvic examination.

The following case is an example where the patient did not reveal her actual problem from the beginning, although she had been circling around her sexual problems with shame and embarrassment from the first conversation. Once we got a hold on the actual problem, progress was quick. We applied a very simple sexological technique, where self-acceptance was to be promoted by asking the patient to put her hand on her own reproductive organs with the physician having his hand supportively around hers.

The position of the physician's hand mirrors exactly the position of the patient's hand, so that the vulva is only touched directly by the patient and indirectly by the physician. The applied pressure is adjusted to the situation to optimise the therapeutic effect as described by Marion Rosen (35). The indication for using this procedure in the holistic medical clinic must always be the physician's understanding of the patient's need for physical acceptance. An attending nurse will give "holding" to the patient.

The procedure needs to be performed according to ethical standards. The holistic sexological procedure is derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts), and close intimacy without any sexual involvement.

In psychology, psychiatry and existential psychotherapy (36,37), touch is often allowed, but a sufficient distance between therapist and client is always kept, all clothes kept on, and it is even recommended that the first name is not taken into use to keep the relationship as formal and correct as possible (38). The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement.

In the original Hippocratic medicine (39), as well as in modern holistic existential therapy, such a safety zone is not possible because of the simultaneous work with all dimensions of existence from therapeutic touch (40) of the physical body, feelings and mind to sexuality and spirituality. The fundamental rule has since Hippocrates been that the physician must control his behaviour in order not to abuse his patient.

The patients in holistic existential therapy and holistic sexology are often chronically sick, and their situations are often pretty hopeless, as many of them have been dysfunctional and incurable for many years, or they are suffering from conditions for which there are no efficient biomedical cures or therapies. The primary purpose of the holistic existential therapy is, therefore, to improve quality of life and secondly to improve health and ability.

The severe conditions of the patients and their chronicity is what ethically justify the much more direct, intimate and intense method of holistic existential therapy, which integrates many different therapeutic elements and works on many levels of the patient's existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology.

The general ethical rule is that everything that does not harm and in the end helps the patient is allowed. An important aspect of the therapy is that the physician must be creative in practice because no patients are alike, and he must invent a new treatment for every patient, as Yalom has suggested (36,37).

To perform the sexological technique of acceptance through touch in the genital areas of the body, the holistic sexologist must be able to control not only his/her behaviour, but also his sexual excitement to avoid any danger of the therapeutic session turning into sexual

activity; the necessary level of mastery of this art can only be obtained through training and supervision. After the case stories, we will come back to this important issue of ethics.

Case story

Female, aged 33 years with vaginismus

The patient arrived by her own choosing to the clinic, presenting her vaginismus still not sufficiently cured after 16 years of consultations with both physicians and alternative therapists. As nothing else seemed to work, we found it acceptable to offer her the experimental sexological treatment of "acceptance through touch," to which she consented. The six first consultations were used to prepare her for the treatment.

Seventh conversation: The patient related that immediately when intercourse begins, she experiences pain. When she was 17 years old, she tried "a thousand times" to have intercourse with her boyfriend but was unable to do so. The physician diagnosed vaginismus, which she still suffers from, although today she is able to have intercourse, most of the time with only modest discomfort. EXERCISE for the patient: Do not accept him until you really have desire. Caress in all other ways first. On the couch, we worked on serious chronic tensions in the part of the adductor brevis muscle [one of the femur adductors], which inserts on the pubic bone. Along the way, she related that when she was 14 years old, she would lie in bed masturbating for two and a half hours at a time; she was sure that she was the only one from school who did it. Her very strong desire was then suppressed so that she did not even feel desire during petting, until her boyfriend made her go and see the physician when she was 17 years old. We talked about such strong enjoyment being a great talent, which must be administered consciously. It is a great gift but induces great resentment if it is not controlled (= condemnation as cheap, a "tart," etc.). We worked on her shame, guilt and self-condemnation, which were very marked, and slowly the muscles loosened. [The authors would like to point out that encouragement of sexual activity at such ages is not allowed under laws in the United States. The age of consent is 18 years in Arizona, California, Delaware, Florida, Idaho, Maine, Massachusetts, N. Dakota, Oregon, Tennessee, Utah, Virginia, and Wisconsin and 17 years in Colorado, Illinois, Louisiana, Missouri, Nebraska, New Mexico, New York and Texas. In Denmark, sexual debut at the age of 13 years is not uncommon, and it is legal if the partners are both under 15 years (but not legal if one partner is 15 years or above); in spite of this, a teenager can get contraceptives from his/her physician, and the physician will treat his/her sexual problems in very much the same way as an adult. In many countries, the practice is different, so please adjust your practice to the law and culture of your country].

Eighth conversation and sexological procedure: *acceptance through touch.* It is going really well for her—everyone notices that she is well. Had her period last Saturday—regularly now for the third time in a row 29/5 with normal amount of menstrual bleeding instead of blood "pouring out." Was "dumped" just after the last session by her boyfriend, which was not much fun. She is advised to let go of the boyfriend. On the couch, we worked on acceptance of her sex—her hand right down against the vulva, mine (SV) supportively on top. We discussed that perhaps her purpose in life was to bring joy and happiness—and that made her completely desperate and unhappy. If she could choose a talent, it would be to be leader of large gatherings. "It's so unfair that I did not become a man," she says. She related that her mother and father thought she was a boy, and she was to have been called Peter. There was a terribly great charge at this point of the conversation, which was then released.

We can here see a very great effect of this extremely simple technique. The sudden, completely spontaneous recognition that she was to have been a boy, with the serious consequences this has had for her in the form of unconscious self-condemnation and suppression of her own sex. The technique is traditional in the Hippocratic holistic medical tradition but unusual in modern biomedicine, because there is direct focus on her own acceptance of her physical sex.

Because of the sexual taboo, she has apparently never received this acceptance previously. We often see, as is also the case here, that menstrual periods become far more regular and there is far less bleeding when the woman has her relationship with her genitals and her sexuality normalised. Menstrual pain can also disappear. These findings are in concordance with the old tantric tradition of sexual yoga (5).

The next case is about a female who had seen the physician (SV) many times and slowly gained her confidence. This enabled him to come close to her and give acceptance of her female side. It is the same treatment as above but taken a step further. Note that although this holistic treatment with a focus on contact is rather unusual from a traditional medical perspective, the professional border is well defined and sharp. Instead of avoiding touch, the physician uses it as a therapeutic resource and a way of helping the patient. As usual, we use the principle of minimal intervention.

Case story

Female, aged 30 years saying "sex is not me"

Tenth quality-of-life (QOL) conversation: Has been very sore in the lower abdomen, corresponding to the ovaries, she herself thinks. The discharge is normal and white. She still finds it difficult to accept physical contact, touch and care from her boyfriend. She feels nauseous if he kisses her when she is not in the mood for it. On the couch, we work on the problems in the lower abdomen in the form of muscle tension on the inside of the pelvis, probably the psoas muscle [the "loin" running from the inside of the vertebral column to the femur], mostly on the right side. Her pelvic area appeared to be more cohesive and less blocked, but there were still severe tensions corresponding to the spina iliaca anterior superior [the anterior, superior tips of the pelvis].

Eleventh conversation and sexological procedure: *acceptance through touch.* I (SV) tell her that she looks so beautiful, fine and sensitive and like a pure innocent consciousness, but at the same time, she looks to a great extent completely dead. She reacts positively to this acknowledgment and to the statement of my subjective impression of her problem. We have agreed that today, I will play the role of the good father she has never had. She lies on the couch crying, and I hold her and kiss her neck and tell her that she is the apple of my eye. [The technique of re-parenting can only be done when the holistic physician allows him/herself to behave as if the patient was his/her little child; it is of course extremely important that this is done with full consent and after making an explicit therapeutic written contract of re-parenting. The kiss in the neck with no sexual intention given completely relaxed and another therapist or nurse present cannot be taken as a sexual act and will not be experienced as such by a patient in such therapeutic setting. Please notice that working with this degree of intimacy requires an experienced holistic, existential therapist with another person present, and despite of all these precautions, this is still unacceptable in many countries]. We talk about what type she is: social, sexual or survival and it is in her judgment

> as though all her problems are concerned with gender and sex. I agree with this. We, therefore, agree to work on her acceptance of her own gender and her own sexuality through accepting touch: Supportive acceptance through contact. She first holds herself on the outside of the vulva (on the outside of her briefs), with my hand supporting around hers. Afterwards, I place my hand on her vulva (outside her briefs), while she holds her hand on top of mine. The reason for this step was for this patient to confront and process the shame bound to her genitals. The physician's hand did not move during the procedure; it was resting for as long as she needed to confront the repressed feelings, which was called forth by this procedure, allowing her to enter the first phase of the holistic process of healing (14). If she holds harder, I hold harder; if she holds more softly, I hold more softly; if she lets go, I let go, too.

In that way, she controls the session, according to her need for support. [The patient response to the therapy was spontaneous regression to a very early age, judged from the way she spoke, moved, and from her non-abstract pattern of thinking combined with the characteristic expression in her face indicating the regression, where she seemingly needed more contact and support than could be done by the indirect touch of the vulva normally used. Touching the patient's vulva when she is in deep regressive therapy does not call on any sexual reaction but is reacted to in the same way as a baby reacts to touch. Of course, this further step requires a holistic physician being able to discriminate carefully between intimacy and sexuality to be able to hold and respect the sexual borders of the patient]. Conversation: In the meantime, we talk about how her boyfriend only wants to do it right for her sexually, while she only wants to do it right for him. She is reading a book about women's orgasms—mostly for his sake. And when they are together, from his side, it is only about her desire. The relationship has completely gone off the rails in my opinion, but because she feels completely devoid of value, she cannot allow herself to feel any joy or desire at all. It is a Gordian knot. Here she hits the "wall," and sees far more clearly than before how ill she is and what has to be done to cure her. She sobs inconsolably, lies on her side and asks me to hold her.

> Twelfth conversation and sexological procedure repeated. Since last time: things have gone very well, success at work by working for her own sake, organised a family birthday, etc. … She has been really like a teenager. We talk about her still being developed psychosexually like a big child. Sexually, she made her breakthrough with her boyfriend last Friday and has since felt blissful. First vaginal orgasm together with him and first orgasm during intercourse. The feeling spread first to the whole vagina, then to the whole pelvis, then up into the abdomen and down into the thighs. On the couch, sexological procedure as last time is repeated. All in all, the patient is making fine progress and today looks like a really delightful woman. Confrontation in front of the mirror reveals that she hates the appearance of her own labia—shame and guilt. We must continue working on that.

Vulvodynia and acceptance through touch

Vulvodynia is a condition of unexplained chronic vulvar-vestibular pain with the etiology being extremely illusive (41). It is important to underline that vulvodynia can be primary vulvar discomfort, or secondary to a wide range of dermatological diseases, vulvar infections, inflammation, vulvar cancer and vulvar dysplasia (42), so it is of extreme importance to

examine the patient for such an often hidden etiology, before giving the patient the diagnosis "primary vulvodynia."

A study including 4,915 American woman aged 18 to 64 years showed that 16% of the women had experienced vulvodynia that lasted for at least three months, and 7% had it at the time of the survey (43). As it is known to be much more prevalent with the young adult woman (44) with a prevalence of 7%, it makes vulvodynia one of the most common hidden problems for young women. Only half consult a physician, and the condition is very often misdiagnosed (45); but even with the correct diagnosis, a variety of treatments are used, like muscle relaxing training, surgery, electric stimulation, biofeedback therapy, (46), tricylic antidepressants (46,47), topical nitro-glycerine (48), steroids (49) or spinal cord stimulation (50). Only about half the women got more than half of the pain relieved (43) and that at the very best clinics, making the problem a vast unsolved problem for 5-10% of young women. Often, the chronic pains end in surgical procedures, giving some of the patients an immediate relief in their vulvar discomfort (51), but also giving many of the girls' severe side effects like scaring and mutilating of the vulva. CO2-laser treatment is sometimes used but seems often to give scaring and severe mucosal atrophy (52). One sad fact is that while most women with or without treatment will feel less troubled by vulvodynia over time, most of the women will not experience what deserves to be called "a cure" (43).

Interestingly, work with the pelvic floor muscle using electromyography-assisted rehabilitation seems effective in many cases of vulvodynia (53), illustrating the complex, presumably highly psychosomatic, dynamic of the sensations of the vulva and the whole pelvic region. Vulvodynia seems also to be correlated to QOL (quality of life) (54,55); shame seems to be highly correlated to vulvodynia (56), and shame and self-condemnation are exactly what the holistic procedure of acceptance through touch are intended to heal. Acceptance through touch, used alone or as a part of the holistic pelvic examination [34], seems to be an alternative strategy to alleviate the problem.

Case story

> Female, aged 24 years with primary vulvodynia
>
> Holistic gynaecology. Known with/primary vulvodynia/and sharp pain, when touching the vulva and introitus, as well as pains when inserting a finger into the vagina. Has always felt very uncomfortable when touched, especially if the man uses a rubbing movement from the vagina towards the clitoris. Cannot touch herself with her fingers without being in pain and feeling uncomfortable. She thus never masturbates using her hand but uses a teddy bear or another soft object. We discuss that she is generally very inhibited sexually, and she would like to do something about that./Sexual abuse?/

Slow gynaecological procedure following therapy contract (34). Vulva, vagina in natural condition. Last menstruation took seven days, no PMS. Due to the pain, no instruments in vagina. Exploration for tenderness, which gradually wears off through the session. We work with the painful areas, which send the patient into a deep feeling of humiliation, an unbearable feeling of shame and helplessness, a feeling of being held down and not being able to escape. As she works through the feelings, the pains in vulva-vagina disappear, and at the end, the patient can touch herself without further problems and feel good about caressing

herself. A two-hour session well completed. EXCERCISE: masturbate using your hand; give yourself room to experience everything difficult associated with it. Write down what pops up, and let us talk about it next time.

The problems of this patient did not come back. She described that it felt as if her vulva was "completely reorganised" during the session, and after the session, she noted that it now felt as an integrated part of her body for the first time in her life. She reported in the next session that she had no problems doing the exercise and that she was convinced that her vulvodynia was cured.

Discussion with ethical considerations

The holistic process of healing starts with the physician "caring for his patients." This care or maybe, in other words, professional love invites the trust of the patient. Treatment or "holding" that should result in a process of healing can only take place when the patient fully trusts his or her physician. Holistic healing is not so much a technique but rather a gift of caring in an unselfish support of the patients. Touching the genitals of a patient with the intention of giving acceptance cannot be successfully accomplished without the combination of care and a high ethical standard. To say this very clearly, only the physician who has a heart and care can touch the patient for the sake of healing the patient. Without such loving care, confidence and skilful holding (12,33,34), the procedure will not work.

In holistic sexological work with patients, where the physician tries to be present as a human being, the physician often has qualms and concerns. We have been extremely cautious and conscientious, but we have been painfully aware that the sexologist in the Kegel tradition is "being on thin ice," when breaking one of the toughest taboos of the (medical) world, namely sex. It is severely frowned upon for biomedical practitioners to touch the female private parts, if it is not in connection with a standard pelvic, biomedical examination.

In the traditional sexological clinic (going all the way back to Hippocrates), there is place for what we as sexologists intuitively feel to be especially important for the patient's sexual healing, namely the natural accepting touch. A holistic physician or sexologist may hold his patient in the same way that a father or mother supports his or her child through care or touch and have physical contact with precisely the area that is affected by problems. This is also the case where the most sensitive and difficult areas of the body are concerned.

It gives pause for thought that there are a large number of alternative therapists who sell these sexological services, for example in the form of vaginal acupressure, the sexological examination, and even direct sexual stimulation (see Chapters 8 and 9), which is increasingly commonly practised and accepted in, for example, Denmark.

Vaginal acupressors have made a living by massaging acupressure points in the vaginas of women who typically suffer from diminished libido (57). This should put our fine senses as therapists and sexologists into perspective. The traditional sexological methods like vaginal acupressure and the sexological examination make sense, since they are thorough and persistently repeated confrontations of all the points in the lower abdomen that normally carry the sexual blockages.

People who offer the most controversial and radical of these sexological services (like the Dodson method described in Section 7) typically have roots in Indian yoga (Tantra) (5) and not in Western medical science.

It is clear that we as sexologists are battling against our absolute professional fear of confronting sexual problems in society in general and in the entire health service in particular. We may conclude that when blocked or traumatised areas of the body generally react positively to touch and the laying-on of hands, it is not so surprising that sexual areas do so too.

As long as it is ensured that the patient is in full control and is not violated—and that the therapist does not have sex with the patient in any form (in other words does not seduce her or manipulate her into a sexual relationship, what sexologists very strikingly call "professional incest" and otherwise refrain from any sexual behaviour in relation to the patient)—such a treatment can never be unethical in our opinion. It is an important thing for a physician or sexologist to be able to support his patients fully, including within all aspects of the sexual sphere.

The subjects of sexual healing and of ethics have been of utmost importance to the physician since Hippocrates (460-377 BCE), and whenever the physician touches the patient, the ethics of the action must be considered. The problem of touch is more of an ethical than a legal problem: Why do you touch the patient; what is the intention? If the intention is for the physician to enjoy his patient—what we do most of the time with people in private—we consider this unethical, even if this is just holding hands (see Chapters 36 and 37).

As often pointed out in the writings of Hippocrates (39), the physician should have the healing of the patient as his sole focus, and if the intentions of the physicians are wholehearted and rooted in deep medical expertise to heal the patient, his life and existence (and in this intention touch any part of the body including the genitals), this is ethical. This kind of expertise is the expertise of the experienced holistic physician, who can take his/her patient into the state of consciousness we know as the process of salutogenesis (16,17) or holistic existential healing (14,15). We believe, as did Hippocrates, that the physician's ethics seem to be proportional with his results with his patients (39). Only the clearest of intentions can bring us outstanding results.

Let us conclude by saying that as far as men are concerned, our experience from the clinic is that sexual problems are often more mental and psychological. It is our experience that the deep, existential conversation on its own is sufficient to solve most of the problems, which do not have a physical cause (somatic/organic etiology).

When this is said, it is likely that a small fraction of men only will be helped by an understanding partner, making good reason for the famous and somewhat controversial use of substitute partners in the sexological clinic (2,58). We believe that the technique of acceptance through gentle and respectful touching (including, when necessary, the direct touch of the genitals possible when combining the technique of therapeutic touch with the pelvic examination) (34), followed by the existential conversation and further processing is sufficient to induce the holistic healing of most patients in the sexual realm.

The next logical step in sexological research is to take the above-mentioned holistic methods into controlled clinical testing in the hope that a great number of diseases can be cured with the sexological tools (see Chapter 33). In such research, we believe that the patients should be used as their own control (we have found the "square curve paradigm" to be a useful research design) (59).

Conclusion

Sexual problems are found in four major forms: lack of libido and desire, lack of arousal and potency, pain and discomfort during intercourse, and lack of orgasm (anorgasmia, orgasmic dysfunction, lack of multiple orgasms in women). It is possible to work with a holistic approach to sexology in the clinic in order to find and repair the negative beliefs, repressions of love and lack of direction in and purpose of life, which according to holistic philosophy are causing the problems with desire, sexual excitement and potency, sexual and genital pain, and repression of character, gender and sexuality. The tradition of psychoanalysis, positive psychology (60-62) and modern theories like the life mission theory (theory of talent) (12) seem relevant for a thorough understanding of human sexuality.

Shame, guilt, helplessness, fear, disgust, anger, hatred and other strong feelings are almost always an important part of a sexual problem. These feelings are often directly connected to the tissue of the sexual organs and related areas of the body. In order to initiate the process of healing the patient in the existential aspects related to gender and sexuality, we have discovered that some patients are helped by a simple technique of accepting contact via touch.

This is a very simple sexological technique, in which the patient's self-acceptance is to be developed by asking the patient to put her hand on her stomach (over uterus) or vulva (over clitoris and vagina), after which the physician puts his hand supportively around hers.

This often releases the emotions bound to the areas, making them a subject for conversational therapy and holistic processing. This can also be an integrated part of a pelvic examination, if the procedure for this is followed (34). This method is a classical method for sexual healing used by European physicians since Hippocrates, and it has been described in many of the classical medical sources and textbooks of medicine (63). The way this process was rediscovered by our group was actually the intentional use of acceptance during the gynaecological standard procedure, with the somewhat surprising observation of a result of sexual healing, as described in (34).

The ethical aspects in holistic sexology is of extreme importance (34,40). As long as the physician loves and cares for his patient, gets the trust of the patient, gives holding flawlessly and as long as it is ensured that the patient is in full control and is not in any way violated, such a treatment can never be unethical. The physician must also follow the ethical rules of the country where the practice is performed, and many countries have restrictions to such a holistic practice.

It is important to understand that this contact is not and shall not be a sexual contact, and the most important qualification of the physician trained in the body works of holistic medicine is his/her ability to control his own intention and level of sexual excitement to ensure that this contact never turns into a sexual contact.

Many young women suffer from sexual pain and discomfort, and 10% of all young women are found to have vulvodynia, a painful state with no biomedical cure. Such conditions can often be cured by discharging the shame from the sexual organs with existential holistic therapy and acceptance through touch. As one patient in two or three has a serious problem related to sex and gender (8), which is likely to be related also to the person’s level of psychosocial development (12), it is important for the holistic physician and

sexologist to be able to support his patients fully, including all aspects of the sexual sphere, for the patient to develop and heal both gender and existence.

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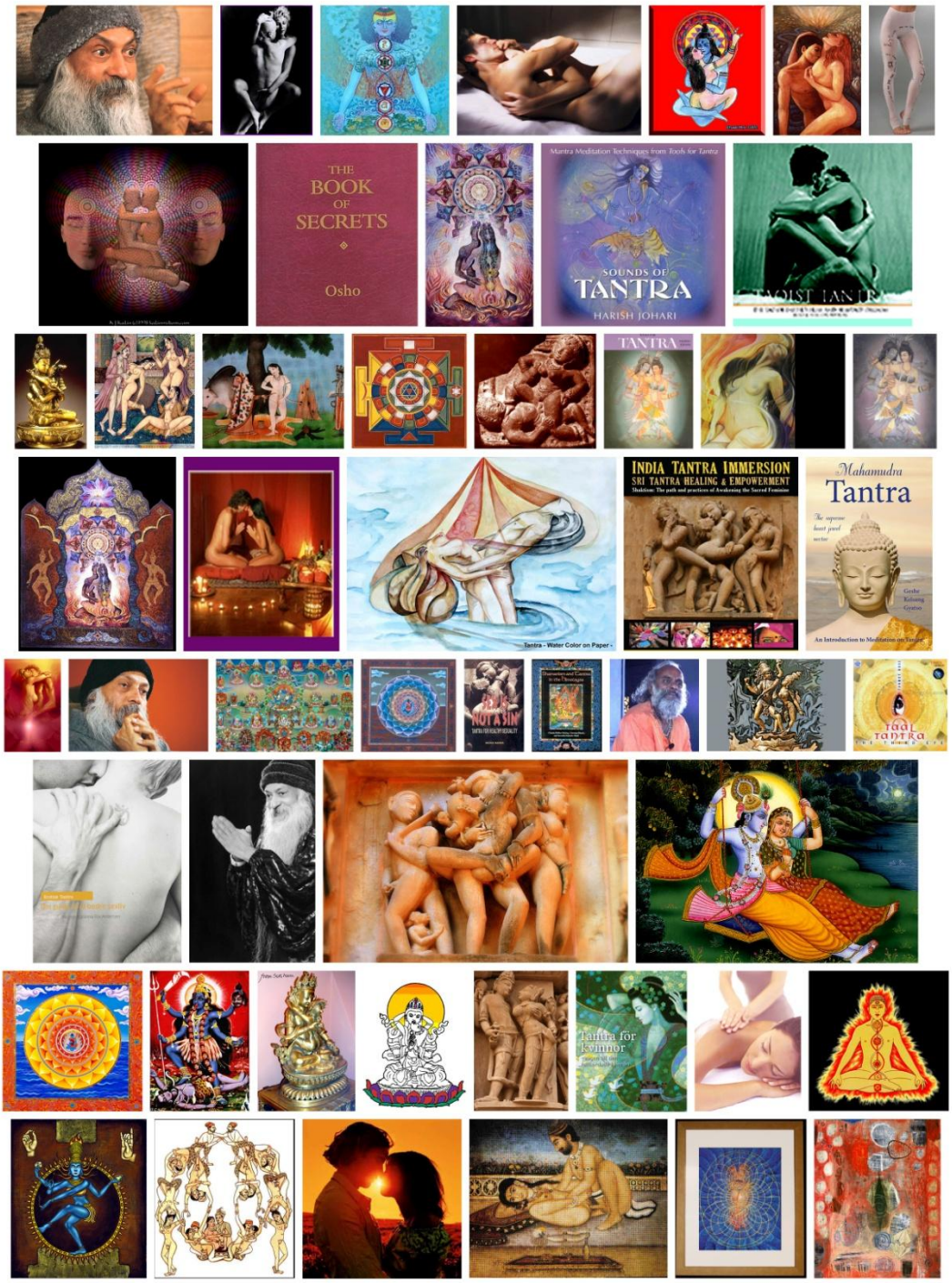
Exercise

1. Touch your intimate partner or best friends—or find another student to practice with—in different ways, expressing the different possible intentions you can master: Awareness, care, respect, acknowledgment, and acceptance. See if you can feel and understand the difference. You are working on a very subtle level; holistic therapists often express it in the way that they are working with the different energies that are available. After some training, you can express care, curiosity, acceptance, etc., in your touch. We find it is quite miraculous that just changing intention will change the quality of contact and the results of the procedure. See if you can come to this realisation.



Chapter XXII

Holistic pelvic examination

To be a holistic therapist means that you are able to help you patients in all areas of life. Many things will be difficult to handle, and even more aspects of life will be impossible to do something about. There can be severe lifestyle issues that are too difficult to approach like the patient living in an abusive relationship with strong dependence or a metastatic cancer where chemotherapy has failed to improve tumour status. The art of helping is to know what can be changed by the patient and what is out of reach. Interestingly, areas such as destructive attitudes towards life, negative experience of the body and problems with sexuality are often within reach of therapy. The pelvic area is, needless to say, often disturbed, because of all kinds of psychosexual problems and developmental disturbances. So this area is among the areas most often complained about by the female patient. Many alternative and complementary therapists are afraid to approach the female pelvis and genitals and refer the patient to a gynaecologist. But most often, the patient has already been to gynaecologist without being helped, so a new reference often helps very little. In this case, the therapist can choose to try to help, even if it is clear from the often-long story of chronic symptoms that this is not going to be easy. But often just a holistic approach to the problems is helpful. Often, even big problems can be solved if the patient is engaged in self-exploration, supported by the therapist.

All treatment in a holistic health clinic should start with talking. Only when conversation therapy is unable to solve the patient's problem should the therapy be taken to the next level, where the patient's body is directly addressed. The standard tool for examination in the pelvic area is the pelvic examination. In the physician's clinic, this is often done fast and efficient with the purpose to examine for STDs, dysplasia or for example cancers.

The patients with problems related to pelvic organs that enter holistic or sexological therapy have often been through a series of standard pelvic examinations. The patient will usually only come to the holistic therapist after the gynaecologist has made sure that the pain, discomfort and other problems related to the pelvic area *are without an organic cause*. It is, therefore, likely that the problems the patient is facing are *psychosomatic*. The intention of the holistic pelvic examination in this situation is very different from the standard medical pelvic examination, because in the holistic pelvic examination, the therapist supports the patient's own exploration of the pelvis and its organs. The understanding with the practitioner that needs to be shared with the patient right away is that non-organic problems most often are of

psychological and emotional (psychosomatic) origin and that only increased self-awareness and self-insight will help.

In clinical holistic practice, it is, therefore, recommended to spend ample time with the gynaecological or pelvic examination, especially in cases of women with suspected old emotional traumas following early childhood cases of incest or sexual abuse. If you work with such patients, you will soon realise that a large fraction of these patients has been abused in some way or another.

The holistic principles of holding and processing should be followed with the purpose of healing of the patient, re-establishing the natural relationship with the body, sexuality and reproductive organs. Sexual violations are often forcibly repressed. It appears that the tissues that were touched during the violation often bear the trauma. It is characteristic of these patients that their love lives are often problematic and do not provide the necessary support to heal the old wounds in the soul, and therapy is, therefore, indicated. When this is concerned with the reproductive organs, it poses particular difficulties, as the therapy can easily be experienced as a repetition of the original violation, not least due to the risk of projection and transference. There is, therefore, a need for a procedure that is familiar to and safe for the patient for all work that involves therapeutic touching of sexual organs over and beyond what is standard medical practice.

This chapter presents one case story of earlier child sexual abuse and one case of temporary infertility. We have established a procedure of slow or extended pelvic examination, where time is spent to make the patient familiar with the examination and accept the whole procedure before the treatment is initiated.

The procedure is carried out with a nurse, and one to three hours are set aside, depending on the patient's needs. It includes conversation on the present condition and symptoms, concept of boundaries, about how earlier assaults can be projected into the present, establishment of the therapeutic room as a safe place, exercises on when to say stop, therapeutic touch, visualisation of the pelvic examination step by step beforehand, touching on the outside of the clothes with repetition of the "stop" procedure if necessary, pelvic examination paying special attention to traumatised (damaged/scarred/blocked) areas with feel, acknowledgement and letting go of the traumatised areas, post-processing of emotions and traumas with finally healing.

The patient cannot be healed until negative decisions are found and dropped with a tour back to the present, to let go of negative sentences and ideas and planning for further positive progress.

Introduction

The pelvic examination is a common examination performed in general practice. Whenever a woman complains of pain in the abdomen, the general practitioner is in principle obliged to carry out a pelvic examination in order to rule out ectopic pregnancy, acute inflammation of the lower abdomen or something else that can seriously affect the patient. The patient is examined in the traditional gynaecological position with her legs in stirrups, after which the physician can inspect, examine, explore and take samples.

When we speak to women about their experiences in this situation, a surprisingly large number of women report that they have felt humiliated and devaluated by the procedure that is normally followed. They often find it insulting to be put in positions in which their reproductive organs are exposed, without being in any way able to look after themselves. They often feel incapable of protecting themselves against an examination that may be insensitive, rushed and not leave space for them as human beings, the sole intention being to perform a physical procedure as efficiently as possible.

When there is an actual sexual trauma, the situation is even more complex. The purpose is the healing of the patient, to re-establish the natural relationship with the body, sexuality and reproductive organs also in patients with acknowledged or suspected sexual violations. For integration of presumed traumas following incest and sexual assaults, it is recommended to carry out a slow pelvic examination, based on the holistic principles of holding and processing. On top of the normal examination in such cases, all the legal aspects according to the law in the specific country must also be followed.

The pelvic examination

It is worrisome that numerous physicians and gynaecologists around the world subject women to examinations, which in themselves may be stressful and perhaps even traumatic experiences. Part of the problem is obviously due to shortage of time, but another important part of the problem appears to be due to misunderstood respect for the woman's sexual boundaries, which means that the physician feels more secure in reducing the female patient to a pure object of examination.

The holistic pelvic examination

Due to the fact that we had a patient with a need for a considerate procedure of this type, we arranged for a very thorough, careful and well-planned procedure, which specifically tried to avoid turning the patient into an object and instead to treat the woman as a woman. The idea was to make the pelvic examination slow—very slow—in fact, so slow that the physician could be sure that the patient was entirely there at all stages of the examination, indeed in everything what was done with her.

If sexual assault is suspected, we use the slow procedure with preparation of the patient, where she is thoroughly informed about it beforehand, so that we can be sure of her complete acceptance and assistance throughout the procedure. In the medical literature, it is normally recommended that a nurse or other person should always be present when the physician performs gynaecological or sexological procedures.

A case story

Female, aged 28 years with pain in lower abdomen, sexual problems and suspicion of incest is seen for the first quality-of-life (QOL) conversation. On the couch, we work (through

conversation) on her 12 years of problems with her failure and loss of confidence. She still has pain in the right side of the lower abdomen, and a pelvic examination should be performed, but in view of the delicate mental state of the patient, it is deferred.

Second QOL (quality-of-life) conversation: Talked about boundaries—being below the line in relationship with her father, above it, having completely disappeared and taking up the whole space = taking responsibility for everything. Exercise for next conversation: Find and describe situations where there are good examples of this.

Third QOL conversation: She had problems in her anus, which tore, and she felt a large cavity in her abdomen together with constant problems in the lowest part of the large bowel. She suspects, with horror, sexual assaults in the anus but cannot remember anything. "It would fit in well with what I feel," she said. She related that her first intercourse broke her hymen. There was no way of knowing what traumas lied within her, and they will not emerge until she has had enough confidence to accept the holding. She has had desire for her boyfriend three times, but the last time she had to stop, as the desire did not last.

Fourth QOL conversation: We talked about her anxiety about coming here, about going into therapy, about meeting me (SV) as a man, about the anxiety, which she suffers from frequently. We talked about philosophy of life. We talked about access to feelings, sex and love by noting what is hidden in the body. Exercise for next conversation: Feel all the emotions you have. Stop and feel them. Write down what you feel on a piece of paper.

Fifth QOL conversation: Things have gone well, she said. "What did you think about on the way to see me?" "It's a bit like school—as though I have to perform well," she said. "I find the situation with you today very stiff," I answered her. We talked about this. She has felt alone and avoided trust and closeness. She has done her homework: she would like to have desire for her boyfriend but does not, just hopes he will not come and take her. We talk about this. While she is on the couch, we work through the conversation to get into her feelings. It becomes very sensitive, and it appeared as though she was about to be suffocated in the gestalt and feelings that came to the surface. She cried and said "It does not matter to me" and "I do not care."

Sixth QOL conversation: On the couch, we work on being present in the body; she lies on her back with her legs spread out and feels hard pressure across her chest and lower abdomen; I support her on the thigh and across the top of the head. She cried silently therapeutic tears and afterwards she was better. No exercise for next time; it is going the way it should without.

Seventh QOL conversation: Wanted to get to the couch straight away and does so. We talked about taming her like the little prince—she understands that well. We work on tensions in the low back, lower abdomen, pelvis and thighs. The sartorius muscle [which runs across the thigh] in particular is extremely tense and is very sore when she spreads her legs. We talk about her being chronically tense to close her lap and hide her sex. She was also very sore in the left knee "because I hide myself [i.e., her reproductive organs] by pushing my pelvis backwards." Exercise: Stop and feel, when you feel something. Allow space for your emotions. They are your life energy, regardless of how difficult they are.

Eighth QOL conversation: … She cries a lot and does not think anything is happening at all. She has come to a standstill. On the couch, we work on her abdomen; she is still sore, corresponding to the large bowel on the left side. Pelvic examination still indicated but not urgent, since it is difficult to obtain permission to approach the regions without her having the sensation of being assaulted, and this must be respected. We talked about the paradox: the more she goes into the gestalt, where she has emotionally "died," the more she feels she is not getting anywhere, but that is a good sign therapeutically. Exercise for next week: accept that you have come to a standstill. Spend time being at this standstill. Do not force yourself to do anything. Just be at a standstill.

Ninth QOL conversation: Has been very, very far away and sad. On the couch, we continued to work on joining her two halves above and below the navel. It is as though she runs away from feeling everything below the navel. Being together with her boyfriend has returned the trauma with focus in the area of her lower abdomen, and she felt suffocated. She needs to do the same exercise as homework, since she had not done it for this time. Pelvic examination still indicated. We agree that next time there will be a long session with our nurse, where we will perform an extended pelvic examination with respect to identifying traumas in the tissue. We establish a safe place or point. The whole procedure is visualised. Everything takes place very slowly and after practising the stopping procedure. We are to talk about projections of the assault into the present. A plan is drawn up, with which the patient associates herself fully before we start. Three hours are set aside.

Tenth QOL conversation and session with the nurse: We run through the case report together, and it adds up to suspicion of sexual assault. Following acceptance by the patient, we implement a slow pelvic examination for integration of presumed traumas following incest and sexual assaults. The purpose is re-establishment of the natural relationship with the body, sexuality and reproductive organs in the patient, who has problems due to acknowledged or suspected sexual violations.

Sexual violations are often forcibly repressed. It appears that the tissues that are touched during the violation often bear the trauma. It is characteristic of these patients that their love lives are often problematic and do not provide the necessary support to heal the old wounds in the soul, and therapy is, therefore, indicated. When this is concerned with the reproductive organs, it poses particular difficulties, as the therapy can easily be experienced as a repetition of the original violation, not least due to the risk of projection and transference. There is, therefore, a need for a procedure that is familiar and safe for the patient, but it involves therapeutic touching of sexual organs over and beyond what is standard medical practice. We establish the following procedure, with which the patient is familiarised and accepts, before the treatment is initiated. The procedure is carried out with a nurse, and ample time allocated (one to three hours). The procedure includes:

- Conversation about the present condition—relationship to body, sexuality and reproductive organs, including investigation of problems in sex life such as pain and painful memories are recapitulated.
- Conversation about the concept of boundaries, so that the patient understands fully where her own sexual boundaries are in order that the examination is not experienced as an assault.
- Conversation about how the assault can be projected into the present. How do the patient and therapist act, if the patient finds the therapy a violation? It is important to say so immediately, if something feels unpleasant or wrong.
- The establishment of the therapeutic room as a safe place.
- Stopping exercise—touching of the body and reproductive organs on the outside of the clothes, where the patient says stop, and the hands are removed at once.
- Contact: Physical touching of the body—from the head down to the stomach, pelvis and lower abdomen, slowly and in suitable steps, so that the patient is present and secure throughout.

- Visualisation of extended pelvic examination, where the therapist runs through the steps of the examination thoroughly, so the patient can imagine them before they are due to happen.
- Touching on the outside of the clothes with repetition of the "Stop" procedure if necessary.
- Pelvic examination paying special attention to traumatised (damaged/scarred /blocked) areas.
- Feel, acknowledge and let go of the traumatised areas. If there are areas that appear blocked or "the patient not present," has pains or other discomfort, we then give special attention with regard to their integration. This is not fundamentally different, for example, from the treatment of growing pains in children by touching the areas that are sore, for example, around the knee. If the sick areas are attended, they are also usually healed.
- Post-processing of emotions and traumas. The work with blocked places in the body often release painful gestalts from childhood and adolescence, which must be talked through, in the same way that the patient's painful feelings must be supported and accommodated by both physician and patient.

Healing is only possible when negative decisions are found and dropped. The patient has to come back to the present, let go of negative sentences or ideas and plan for further positive progress. These points above are printed out, signed and approved by the patient as a formal contract.

This procedure was carried out with success in this patient. The gynaecological and rectal examination was normal except for a lesion of blockage type (3x1 cm in size) with brownish, folded skin between labium minor and labium major on the left side (which was processed with partial success) and tenderness in the vagina 5 cm up on both sides, but nothing abnormal discovered. There were problems with the "stop and start" safety procedure, which we have to repeat 20 times in four series before she could say yes and no. She was happy and at ease after the procedure, but a little disappointed at not having broken down/having achieved a breakthrough.

> Eleventh QOL conversation: She has felt lighter and freer since last time. She has not menstruated, but pregnancy test is negative. She must test again in three weeks, if menstruation does not arrive. She feels pressure over her lower back, as though it is on the way, but it does not come. This is a normal body reaction, and she to be calm, but remember that the most common reason for a period not to occur is pregnancy in her age. She has started to say stop in relation to her boyfriend sexually when she does not feel desire. She relates that he respects this, but then she herself has great desire. She needs to say no sometimes during intercourse, and we discuss how they must practise this together.

This conversation was a very moving experience for the three people present (the patient, the physician and nurse). The patient was shaking with nervousness when she arrived but quickly adapted as she got on very well with our nurse. It was clear that the patient found it very difficult to say no or stop to others. In our preparatory training procedure, she had to say stop about 100 times before she could continue the session. For us as physicians, it is hard to

comprehend how someone can become an adult without such a fundamental skill, because she will constantly be in conflict in relation to men or sex since she is not able to set boundaries.

So, although the patient felt disappointed after the extended pelvic examination that she had not "broken through," in fact, she had. This treatment became a turning point in her life and in the therapy. After that session, she began to let go of what she was clinging onto and what limited her. So, in fact, that session was a very important and moving session. The patient did not like the look of her external reproductive organs, because of the dark and blocked area between the labia on one side. Nothing was noted if one did not look for blockages, but the area was clearly in the patient's negative focus. It was found to be very important for her sexual self-esteem to have the problems confronted here. The important aspect is that after the procedure in which the physician finds such an area of embarrassment, he is forced to touch the very place of which the patient is most ashamed. It is there that she is confronted with her own self-condemnation, which can then be processed and integrated. The nurse had a very important role as the supporter as she held the patient in her hands, while the physician carefully gave contact. It is also important to note that the patient's concern about pelvic examination afterwards has largely disappeared.

So we do not just need attention, respect and care—and acknowledgement of our soul—we also need something bodily, physical and down-to-earth, namely acceptance of our sex. When it is possible as a physician to meet the patient with respect and within boundaries to recognise her as a woman, then we can help her and give her our full acceptance. Many problems related to sexuality then appear to decrease, as they are probably due to self-condemnation and lack of sexual self-acceptance.

Involuntary childlessness, infertility and personal development

Sometimes, when a relationship is not working, the result can be unwanted childlessness or infertility. It frequently happens that couples previously unable to conceive have a child when one or both partners start on self-development. The physician can initiate this process of healing by a holistic approach, as shown in the following case story.

A case story

> Female, aged 30 years with involuntary childlessness and the first QOL conversation. Involuntary childlessness or infertility for several years. Investigated by her gynaecologist, who found everything to be normal. Social history taking revealed that her mother had disappeared when the patient was four years old. She had developed sleeping problems, which began when she found her mother again two years ago, and she afterwards died of heart disease one year ago. Evaluation after the conversation: The patient does not appear to be a giving person, was a neglected child with a "closed heart," who is only able to receive, which is even a problem. We discuss responsibility for one's own life, know yourself, your needs and make sure that you have them fulfilled, and then you will be able to have a good life. Plan for next conversation with two exercises: Make a complete list of all the problems in your life (working life, social life, family, sex life and friends). Make a list of everything you want for

yourself, of your deep, genuine needs and what would make you completely happy. What do you long for? Come back in 14 days.

Second QOL conversation: The patient broke down after the last time she came to see me and has had a hard time since. We talk about what feelings surfaced. She felt immense grief with a feeling that the world simply came to a standstill. During the weekend, she became completely hysterical, unable to understand why her friends could be able to chat about trivial matters when an acquaintance had just died. She became the unreasonable little child sitting in the car again. She was told during the conversation that "You must not anticipate becoming pregnant for the first three years" to which she was shocked but later accepted and bought a cat instead. Concerning the exercise, she came with four pages of problems and one page of wishes. Most important was her statement that "I am not satisfied with myself and not happy either," followed by "I have not had a child yet by the age of 30 years" and "I do not know what I want, I do not know my wishes." Her most important wish was to have a child, followed by becoming happy and able to be something for other people. Her needs were "to get to know myself—to find out what I want to do." Exercise for next time: Come with a deeper and truer version of the same lists—so that you can fold out and go further in your growth and development, because now you seem to have come to a complete stop. New appointment scheduled in two months.

Third QOL conversation: Has finally become pregnant—just like that. She feels fine now. We talk about relaxing in relation to the pregnancy—taking things as they come, since everything looks fine now. She should do everything she is good at in terms of work, travelling and experiencing the world with her own family. Has re-discovered some decisive confidence in life and found her surplus. Exercise for next meeting: Read some books (suggestions given), which will give her "food for thoughts" and ideas to think about. Come back in two months.

This patient is going through a painful process, in which she is letting go of her compulsory need to become pregnant here and now. From a biomedical point of view, it is completely unreasonable to torment the patient and burden her with all the strenuous exercises. From a holistic perspective, this is necessary for her awareness, growth and drive in life. Maybe there is a very often a good reason for temporary infertility, as not all women are ready to become mothers and give constant care for the next 12-18 years, which children need them to do. Nature is wise, and very often it is better to rely on the deep wisdom of the body, than mechanically to force a solution. If the woman is not ready to have a child, it is hardly good for the child to be born now either.

It appears as though people who wrestle with their existential problems find it more difficult to have children than people who do not. It is as though body and soul know well that now is not the time to have children. The unfortunate aspect is that these same people in their daily lives do not have access to this deep wisdom.

Discussion

It is important to notice that we introduced a slow pelvic examination with a therapeutic element, relevant for a wide range of psychosomatic disturbances related to gender and sexuality from infertility to gynaecological and sexual psychosomatic problems and the long-term consequences of child sexual abuse. On one hand, this opens up for a clinical practice with many beneficial and healing qualities for the patient, because it allows a much closer and

more intimate relationship between the patient and the physician that has been the traditional practice; but on the other hand, this procedure has several disadvantages.

In many cultures, this cannot be practiced due to cultural or religious reasons and the sexual taboo being so strong that the female will experience the process as overwhelming or even insulting. In the United States, it might be practically impossible to follow our recommendation in many cases, because of the time consumption, economics and reimbursement issues of this culture and the heavy "malpractice culture" in that country.

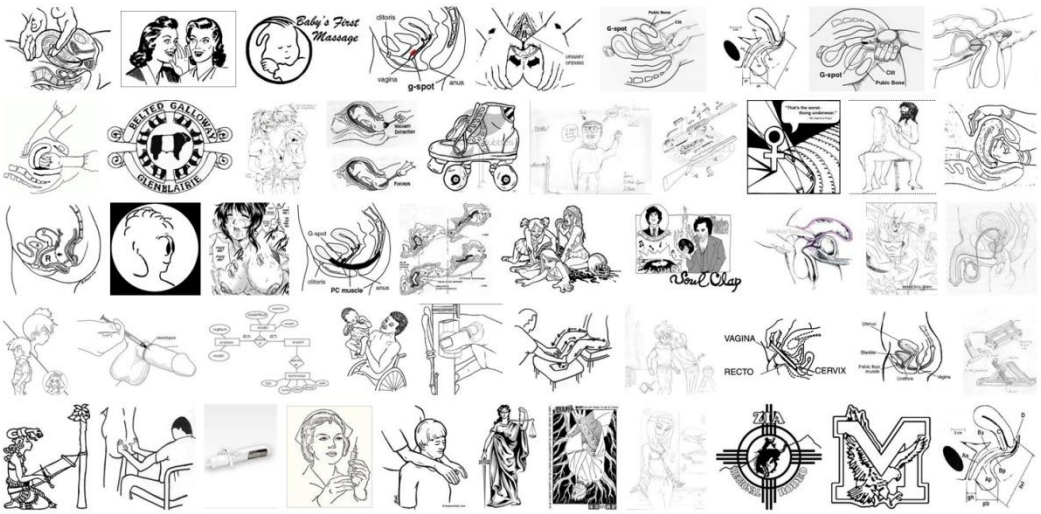
The most difficult problem of this procedure seems to be that it makes it very difficult to be sure that the procedure and all the involved steps are always necessary and rational. This procedure and the cultural issues involved means that it has a high potential for malpractice, but this can be minimized dramatically by the following steps: 1) Before the procedure is done, the patient must read about it with at least one case study like the one in this chapter to fully understand the emotional and existential implications of the procedure, so she has time to contemplate and make her decision of whether to accept the physician's offer or not; 2) The procedure is also orally presented by the physician to the patient before she signs the contract; 3) The physician must be in supervision to discuss the problems, if any, about borders, intimacy, emotional and sexual issues. Close supervision and full inter-collegial openness is the best prevention of malpractice, as malpractice often occurs with physicians without a network and without openness about what is going on in their clinic.

Conclusion

The holistic pelvic examination is designed for solving gynaecological and sexual problems of psycho-somatic origin. It is a recommended alternative to the standard procedure whenever there is a well-documented non-organic cause or a suspicion of a history of sexual assault or sexual abuse, even when that abuse took place many years ago. It is often more time consuming and can involve strong emotions on the part of the patient, as earlier unresolved traumas are contacted during the examination.

In the holistic pelvic examination, this is not a problem, but quite opposite the release of suppressed emotions might be healing to the patient, if the physician knows how "to hold" (meaning to care for) the patient and how to process the problems and emotions in order for the patient to heal.

A holistic approach in general can help the woman not to feel humiliated or devalued by the pelvic examination procedure but instead respected, acknowledged and accepted as the woman she really is. Sometimes this is all it takes to solve even more severe medical problems like involuntary childlessness, as shown in the presented case.



Chapter XXIII

Acupressure through the vagina (Hippocratic pelvic massage)

Sometimes acceptance though touch is too little and a holistic pelvic exam too much. In this case, there is an intermediate-size tool, which we call "vaginal acupressure." It is basically genital accepting touch combined with talk therapy. The method is the classical Hippocratic method of sexual healing; the method was also used to cure all kinds of female mental problems and illnesses, as the Greek physician firmly believed that mental problems were caused by disturbed psychosexual development, which could be corrected—healed—by this simple procedure, combined with talk therapy.

Many gynaecological and sexological problems (like dyspareunia, urine incontinence, chronic pelvic pains, vulvodynia and lack of desire, excitement, and orgasm) are resistant to standard biomedical treatment, but classical sexological procedures like the sexological examination, which includes vaginal massage, seems to be efficient (see Chapters 8 and 9).

In our work at the Research Clinic for Holistic Medicine and Sexology in Copenhagen, we have found that many problems can be helped by vaginal acupressure, or Hippocratic pelvic massage, which is a smaller technique than the pelvis exam and the classical sexogical examination, which is a long and detailed procedure.

Technically, vaginal physical therapy is a very simple procedure, as it corresponds to the explorative phase of the standard pelvic examination, supplemented with the patient's report on the feelings it provokes and the processing and integration of these feelings. Sometimes it can be very difficult to control the emotions released by the technique, i.e., regression to earlier traumas from childhood sexual abuse, but still the technique is much less radical and confrontational than the traditional sexological examination itself.

The vaginal acupressure seems to be the first part of the sexological examination, and if this smaller procedure can solve the patient's problem, there is no reason to use the bigger tool of sexological examination, with direct sexual stimulation of the patient (see Section 5).

This chapter discusses the theory behind vaginal acupressure and ethical aspects with presentation of a case story. This procedure helped the patient to become present in her pelvis and to integrate old traumas with painful emotions. Holistic gynaecology and sexology can help the patient to identify and let go of negative feelings, beliefs and attitudes related to sex, gender, sexual organs, body and soul at large. Shame, guilt, helplessness, fear, disgust, anxiety, anger, hatred and other strong feelings are almost always an important part of a

sexual or functional problems as these feelings are "held" by the tissue of the pelvis and sexual organs.

Acupressure through the vagina/pelvic massage must be done with great care by an experienced physician or sexologist, with a third person present, after consent and obtaining the necessary trust of the patient. It must be followed by conversational therapy and further holistic existential processing.

Introduction

Sexology is the medical specialty concerned with sexual dysfunctions with the major breakthrough in this field made by Reich, Masters and Johnson in the middle of the last century, mapping the human sexual functions and dysfunctions (1,2). William Howell Masters (1915-2001) was a gynaecologist and Virginia Eshelman Johnson (1925-) was a psychology researcher. They teamed up in 1957, to study human sexuality. Before them, in the late 1940s and early 1950s, Wilhelm Reich (1897-1957) had mapped the sequences of the *human sexual response cycle* in four phases ("the curve of orgasm" with the *excitement phase*, the *plateau phase*, the *orgasm phase* (to be repeated in women) and finally the *relaxation phase*), and Alfred C Kinsey (1894-1956) had published two surveys of modern sexual behaviour, "Sexual behaviour in the human male" and "Sexual behaviour in the human female," which founded the groundwork for Masters' and Johnson's work.

Instead of asking people about their sexual activities, as Kinsey had done, Masters and Johnson observed sexual activity directly in the laboratory. They developed tools and techniques for accurately measuring the physical responses of 700 men and women during masturbation and intercourse. They published their findings in the book *Human sexual response*, in 1966 (1). This book was well received by the general public, even though it was intended for the medical community, since the mechanics of sex had so far been a mystery. Masters and Johnson based their findings on these observations in the laboratory and were the first to accurately identify and describe the anatomy and physiology of the Reichian human sexual response cycle. This opened up for more effective treatments of all the sexual dysfunctions. Dissatisfaction with sexual activity was presented as a natural and healthy human trait.

Masters and Johnson afterwards published *Human sexual inadequacy* (2), which discussed common problems, such as impotency and premature ejaculation, and how to treat them. Of almost a thousand treated patients, about 85% were cured for their severe sexual dysfunction (NNT=1). No side effects where reported from intensive, sexological therapy (NNH>1,000). This work was the key in the development of sexual therapy, and together they opened a clinic in St. Louis for the treatment of sexual problems.

Holistic sexology

The most profound theory for sexuality seems to be the theory of the anima and animus—the inner man or woman—of Carl Gustav Jung (1875-1961) (3,4). Holistic sexology aims to take the established knowledge on sexology into an existential perspective, including the sphere of

existential dimensions and problems (5,6), in the treatment of sexual and gynaecological problems (7). Existential dimensions are needed in this work, because the sexual and gynaecological problems are symptoms of unsolved existential problems where the patient's inner potentials for healing own life, body and existence are not mobilised. The reason that standard treatments do not work on some patients is not obvious. Often, there are hidden and severe traumas from violent or sexual abuse in the past, and these negative emotions are held by the pelvic tissues and organs. Studies from different Western countries indicated an incidence of about 15% of girls being assaulted sexually in childhood (8-10), and many of these girls are likely to demonstrate severe pelvic problems in their youth. Sexual and gynaecological problems resistant to standard therapy are typically problems with acceptance of own sex and sexuality, which do not have to originate from abuse. As originally suggested by Masters and Johnson, they can be a result of not having received the loving acceptance and touch needed in childhood (2,11). It is obviously important that borders are not violated, but it is just as important that the father give the contact and acceptance the child needs, as part of her infantile and undeveloped sexuality (7).

The Hippocratic (Hippocrates, 460-377 BCE) physician was aware of these diseases, and his treatment included different physical procedures focused on the female pelvis, like smoking the vagina and massaging the pelvis (12). The reason why these treatments were later condemned is debated, some authors finding it a form of sexual abuse of the woman by the medical profession with insufficient ethics (13). Maybe there has been a regrettable crisis in the ethical standard of the average physician upon entering the modern day commercial medicine, where power and money often seem more important for the physician than care for the patient. In holistic medicine, the physician and his patient are almost always very close, and ethics are a subject of utmost importance (see the discussion). When it comes to the practice of pelvic massage, we might be at the essence of medical ethics, and the ability to perform this procedure might have been the very reason why Hippocrates invented his strict medical ethics in the first place.

The technique of acupressure though the vagina has been tested and developed at the Research Clinic for Holistic Medicine in Copenhagen and discussed with members of the International Society of Holistic Health on several occasions at international meetings. The comments and critique have been integrated in the present chapter.

Many chronic patients need holistic existential healing or healing of the wholeness of the person on the deepest level of their existence in order to become better. Before we continue, let us, therefore, take a look at holistic medicine and the concepts of existential healing.

The scientific basis for modern holistic medicine and sexology

From the days of Hippocrates, the development of human character and purpose of life has been the key to healing. We have put this classical knowledge in a modern formula: The life mission theory (5,11,14,15,16) is based on the philosophy that everybody has a purpose of life or talents. 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 or a condition where the person knows himself and uses all his efforts to

achieve what is most important for him. The theory of talent (5) states that we have three major talents in life, called purpose, consciousness and gender. In relation to this chapter, these dimensions may simply be: love, power and sex. Gender and sexuality is a fundamental dimension of human existence, which must be in a sound, natural and un-denied state for the person to live and function naturally and in full power.

The holistic process theory of healing (18,19) and the related theories for salutogenesis (20,21), meaning of life (22) and quality of life (23-25) found 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 holding 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 trust together with the intention of the healing taking 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 aware of himself, his own needs and wishes. In letting go of negative attitudes and beliefs, the person returns to a more responsible existential position with an improved quality of life. The philosophical change taking place when the person is healing is often a change towards preferring difficult problems and challenges instead of avoiding difficulties in life (26-33). The person who becomes happier and more resourceful is often also becoming more healthy, more talented and able to function (34-36).

Sexual problems are found in four major forms: lack of libido and desire, lack of arousal and potency, pain and discomfort during intercourse, and lack of orgasm (anorgasmia, low orgasmic potency) (2). It is possible to work with a holistic approach to sexology in the clinic in order to find and repair the negative beliefs, repressions of love and lack of purpose of life, which seemingly are the core to problems like arousal, potency and pain with repression of gender and sexuality (2,6,7,37,38). The theory of talent (5,6) thus seems to be relevant for understanding human sexuality. It is highly important not to focus on the gender and genitals in understanding the patient's sexual problems, because many problems related to sex can be solved on the level of the whole person (2,6,7,37,38). But as important as it is not to focus there, it is also essential not to neglect the body and the feelings connected to it. Shame, guilt, helplessness, fear and other strong feelings are almost always an important part of a sexual problem (2,7).

Acupressure through the vagina

The method that we call acupressure though the vagina has also been called holistic physical therapy for the pelvic floor, Hippocratic pelvic massage, the holistic pelvic examination, tantric massage, and vaginal therapy. It is basically the first introductory phase of the traditional sexological examination. The name acupressure comes from the Asian tradition of tantric massage and acupressure. The most basic acupuncture point in the classical acupuncture system are the first points on the sexual meridian (Conception Vessel 1, 2 and 3), which all are placed in the vulva or close to the vulva. The idea of acupressure is to press on the tense spots to release the accumulated tension ("energy") here.

Thousands of women have problems related to their pelvis and its organs, dominated by sufferings of the sexual organs, problems of the urinary tract, the locomotor system, and the intestines (39). Another large group of patients have "non-anatomic" pelvic pains and discomforts of presumably psychosomatic nature, which often are very difficult to treat with biomedicine, but which seem to react better to psychosomatic treatments (40,41). The classical sexological tool, the sexological examination, is time consuming, difficult and in many cultures of today also too radical to be used by the physicians or physiotherapists (see Chapter 109); only the classically trained sexologist will use it.

We, therefore, urgently need new, less radical but still efficient treatment tools for this broad range of female problems, from urine incontinence, bleeding and hormonal disturbances, unwanted childlessness, sexual problems like pain during intercourse, primary vulvodynia, or low ability to feel desire, sexual pleasure, sexual excitement and/or to reach sexual climax (orgasm), to an-inflammatory perineal and anal pains and discomforts like idiopathic aches (primary pruritus).

These problems are, from a holistic medical and sexological perspective, often caused by unsolved emotional and sexual problems, which have been repressed into the pelvis and its organs. The emotional problems are related to negative beliefs about self, gender, body, organs and sexuality.

We have tested the hypothesis that sexual and existential healing (salutogenesis) can be done with the much smaller tool of vaginal acupressure instead of using the sexological examination. Judging from clinical experience from the Research Clinic for Holistic Medicine and Sexology in Copenhagen treating 20 patients with a majority of the ten different problems mentioned above with holistic sexology (acceptance through touch and when necessary vaginal acupressure but not the sexological examination), we believe that the model can be of help, but we are aware that the sample is small. Such problems can often be solved through healing the old wounds on body and soul in holistic existential, gynaecological and sexological therapy.

The healing process has, as in all other holistic therapy, three obligatory steps, which we sum with the words: feel, understand, and let go (see Chapter 2) (18,19,42). First, the emotions have to be felt again: we call this phase "putting feelings onto the body." Then, the patient have to find words, verbalize the emotions and understand where the problems are coming from: we call this "putting words on the feelings." Last but not the least, the person's healing has to let go of the negative attitudes and decisions that were made when the trauma happened: we call this "putting consciousness in the words." In the clinical work, we use the therapeutic staircase, which give us the best assurance that we do not use a more invasive and potentially dangerous technique than necessary (43). Acupressure through the vagina always builds on earlier sessions of acceptance through touch, which again comes after sessions of emotional healing, trust, holding and to begin with always "love and care" for the patient.

This knowledge of healing life—improving health, quality of life and ability in one integrated movement—is well known and described in a number of books from the cradle of medical sciences on the island of Cos around 300 BCE, known as Corpus Hippocraticum. Hippocrates (460-377 BCE) was held to be the best physician of his time and father of the first scientific system of holistic healing described in numerous books. It is interesting that massaging the pelvis through its openings was an acknowledged method in ancient Greece (12) and in use throughout Europe for centuries (13). This necessitated the very stringent medical ethics that was founded by Hippocrates, probably as mentioned above with the

purpose that he himself and his many pupils could give this kind of treatments. Massage of the pelvic structures of a woman through the vagina and anus could among other things heal disturbances in the woman's energy system, known as a disease called "hysteria," from the Greek word for uterus, hysteria. The treatment was in use in most of the Western world until the industrial revolution, where it was condemned as pornographic and hence no longer an acceptable medical treatment.

Today, after the sexual revolution in the sixties and seventies, we have a more relaxed attitude to body and sexuality, and some therapists work again through the vagina and anus with this kind of therapy, either by using their hand to cure sexual and other problems (44) or by using a vibrant penis substitute (a "dildo") to cure incontinence (45) or orgasmic problems (46). The Danish physiotherapist Birgitte Bonde reports that one to six sessions with the vibrator can help many incontinent women who are not sufficiently helped by the standard program of training the pelvic floor (45). The rationale for the use of the vibrator is that the woman cannot get in contact with their own pelvis, as they "cannot find their pelvic floor," presumably because they have completely eradicated some of the pelvic structures from their inner description of their own body.

There are several different forms of pelvic massage/vaginal acupressure (see Table 1) used for different purposes with as many philosophies about its mechanisms. Most therapists intend to raise the energies in the meridians after the Chinese system [44], hence the name "vaginal acupressure" for the technique often used for healing chronic pains in the pelvis or genitals and treating the highly inconvenient pattern of frequent re-infection of the urinary system. Other therapists intentionally liberate the sexual energies with sexual stimulation according to the old Indian Tantric tradition, in order to teach the woman to contain and handle her sexual energies [47]. We find it here important to note that the physician under no circumstances should attempt to stimulate the woman to an orgasm in order to avoid a sexual situation. Others work with confrontational therapy to heal traumas of incest and rape by integrating the bio-energetic system of Lowen [48], Reich's sexual therapy [49] and the gestalt therapeutic tradition [50] to be able to release all negative emotions and other problems caused by the prior sexual violation—or neglect. In our clinic in Copenhagen, we have also found it useful to help women heal what we call the "sex – love split," making them have two partners, one for sex and one for love and being unhappy with not being able to have love and sex with the same person.

All the above-mentioned practices have in common that they seek to help the patient notice the tensions and blockages in the pelvic region and the parallel attitudes fragmentising the patient's life. When the patient confronts and integrates the repressed painful feelings that created them, they develop a new more positive understanding of life, love, feelings and sexuality. It is clear that elements of acupressure through the vagina must be adjusted to the needs of the patient. A patient with chronic bladder infection and a patient with chronic pain in the pelvis or the sexual organs (primary vulvodynia) should be treated differently. It is important to always go for the lesser level of treatment that can solve the problem and the least provocative or painful of methods must be tried before more "embarrassing" methods are taken into use. We recommend that simple antibiotics are used to alleviate some of the problems, and only problems that cannot be efficiently treated with such drugs should be handled with the emotionally challenging procedure of acupressure through the vagina, except in the cases where the patient for personal, political, religious or other reasons does not want to take the drugs.

Table 1. Different forms of pelvic massage/acupressure through the vagina organised according to the emotional core problems. The therapy must always be followed by thorough conversational therapy for full integration and performance must be according to ethical standard (see text). Interestingly, classical Western medicine, Chinese medicine, and Indian medicine seem to have used related techniques

Dominant Emotional Problem	Style of Work	Corresponding Chakra	Primary Inspiration
Anxiety, insecurity, Physical pain related to kidney and urinary tract and intestines	Acupressure through the vagina, pelvic massage Meridian work	Root Root, All	Chinese medicine Hippocratic med.
Incontinence, shame	Use of vibrator	Root, Hara	Modern sexology
Sexual and hormonal. Problems Pains during intercourse Problems with lust, joy, excitement, and orgasm, shame Low self esteem, Polarity problems Sexual energy work	Pelvic and anal massage/ acupressure through the vagina and anus Use of vibrator Raising energy circles	Hara, Root Hara, Root Hara, All	Hippocratic medicine, Indian tantric tradition, Chinese medicine Modern sexology Jung's theory of anima and animus
Relational problems Problems with men after incest, rape and other violations, hate, anger, shame, guilt	Pelvic and anal massage, acupressure through the vagina and anus Controlled sexual abuse[43]	Solar plexus Solar plexus, All Solar plexus	Hippocratic med. Chinese medicine Gestalt therapy
Problems with integrating Love and sexuality "Sex love split", Adultery Prostitution, Sexual domination/submission	Pelvic and anal massage, acupressure through the vagina Direct sexual stimulation[43] Use of role-plays	Heart, Root, Hara Hara, Heart, 3 eye Heart, All	Hippocratic medicine Chinese medicine Indian tantric tradition Gestalt therapy

If the physician believes several methods to be equally efficient, he should always tell the patient about the alternative treatments and respect the patient's choice. Holistic existential therapy will be more work for the physician and in the end less money paid by the patient, as health problems are often solved permanently with holistic existential therapy.

If a sexual problem can be solved with just giving acceptance to the body, there is no reason to approach the sexual organs. If just giving acceptance to the outside of the vulva is enough to solve the problem, there is no rationale for penetrating the vagina (7). Often, the feelings of guilt and shame that are the cause of the problems can be solved by the smaller process we call "acceptance through touch" (see Chapter 29), and in this case it would be unethical to start with acupressure though the vagina.

If conversational therapy can do the job, touching the vulva will be unethical. In every case, the physician must treat according to his or her best judgment. Medicine will always be an art, and only the trained physician knows which tool to use with a patient, as both intuition and experience is necessary for the decision.

The procedure of vaginal acupressure

Vaginal acupressure is technically the simplest procedure, as it corresponds to the explorative phase of the classic pelvic examination, except that the purpose of the digital penetration is treatment and not examination. Vaginal acupressure is performed by placing the woman on the physician's table in a relaxed position with free passage to the vagina (see Figure 1). The physician penetrates the vagina with one or two fingers and presses systematically on the sore and tense areas in the pelvis. Most organs are accessible to the trained therapist. The position of the physician's hand must be so that only the structures that need to be touched are contacted (it is important that the clitoris is not touched unintentionally). The applied pressured is adjusted to the situation to optimise the therapeutic effect, as described by Marion Rosen (51). The indication for using this procedure in the holistic medical clinic must always be the physician's understanding of the need of the patient for contact with the structures inside the pelvis. An attending nurse or another person must be present and give "holding" and support to the patient.

It is important to understand that the procedure of acupressure through the vagina is the same exploration part of the standard pelvic examination by a gynaecologist, but in this case, done so slowly that the woman can feel the emotions held by the different tissues contacted by the finger of the physician (38). It can be used in combination with the pelvic examination and as the woman always will contact some feelings while being examined in her vagina, the situation is really that every pelvic examination contains an element of acupressure through the vagina. Often the awakening of unpleasant feelings is very emotionally painful for the woman and if not taken care of by the physician/gynaecologist, it will make the standard pelvic examination difficult for the woman, as many women actually experience. Just ignoring the fact that the woman is a living human being reacting emotionally to the pelvic examination is not going to help the woman not to feel.

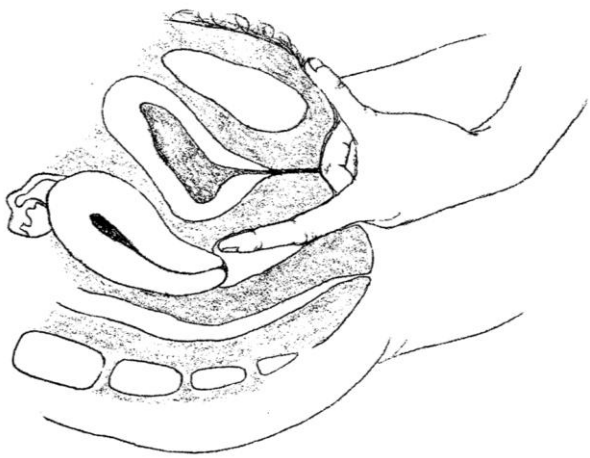


Figure 1. Sexual healing though the vagina by pressing on the tissues and helping the patient to identify and process the repressed feelings and old traumas held by the pelvic organs (47). The vagina is penetrated with one or two fingers and all the structures of the pelvis are systematically worked through. The patient is invited to open up to the feelings hidden in the tissues, and these feelings are then processed in holistic existential therapy.

Ethical aspects

The procedure of acupressure through the vagina must be performed according to ethical standards. The holistic sexological procedures are derived from the holistic existential therapy, which involves re-parenting, massage and bodywork, conversational therapy, philosophical training, healing of existence during spontaneous regression to painful life events (gestalts) and close intimacy without any sexual involvement.

In psychology, psychiatry and existential psychotherapy (52,53), touch is often allowed, but a sufficient distance between therapist and client must always be kept, all clothes kept on, and it is even recommended that the first name is not taken into use to keep the relationship as formal and correct as possible (54). The reason for this distance is to create a safety zone that removes the danger of psychotherapy leading to sexual involvement. In the original Hippocratic medicine (12), as well as in modern holistic existential therapy, such a safety zone is not possible because of the simultaneous work with all dimensions of existence, from therapeutic touch (55) of the physical body, feelings and mind, to sexuality and spirituality. The fundamental rule has, since Hippocrates, been that the physician must control his behaviour, not to abuse his patient. The patients in holistic existential therapy and holistic sexology are often chronically ill, and their situations often pretty hopeless, as many of them have been dysfunctional and incurable for many years or they are suffering from conditions for which there are no efficient biomedical cures.

The primary purpose of the holistic existential therapy is to improve quality of life, secondary to improve health and ability. The severe conditions of the patients and the chronicity is what ethically justify the much more direct, intimate and intense method of holistic existential therapy, which integrates many different therapeutic elements and works on many levels of the patient's existence and personality at the same time. Holistic sexology is holistic existential therapy taken into the domain of sexology. The general ethical rule is that everything that does not harm and in the end will help the patient is allowed ("first do no harm"). An important aspect of the therapy is that the physician must be creative and in practice invent a new treatment for every patient, as Irvin D. Yalom has suggested (52,53). To perform the sexological technique of vaginal acupressure, the holistic sexologist must be able to control not only his/her behaviour, but also his sexual excitement to avoid any danger of the therapeutic session turning into sexual activity. Most physicians can do the classic pelvic examination after their standard university training, but the vaginal acupressure we are discussing here in this chapter can only be obtained through long training and supervision in order to reach a level of quality where an effective, healing procedure can be performed.

Side effects of the treatment can be soreness of the genitals and periods of bad mood, as old painful repressed material are slowly integrated. We have observed a patient going into a two-hour-long acute psychotic-like state after therapy as this sexually abused woman confronted her most painful experiences (rape in childhood): she recovered fully in a few days without the use of drugs, and this episode was an integral part of her healing. In fact, it was her therapeutic breakthrough. As it is possible that the patient can feel abused from transferences, it is extremely important to address this openly to prevent this situation. We recommend that the patient is contacted or followed for one to five years to prevent and handle any potential long-term negative effects of the treatment. In spite of these problems,

we have found the treatment with holistic existential therapy combined with the tool of vaginal acupressure to be very valuable for the patients.

The following case story from the Research Clinic for Holistic Medicine in Copenhagen and also the case of Anna (see Chapters 23-25) (56) made us re-invent the method of vaginal acupressure. This cancer patient did not heal in the therapy, although levels 1-7 of the therapeutic staircase (43) had been taking into use for several months, so instead of giving up on her, we re-invented the level 8 technique of acupressure through the vagina. The patient was part of our cancer project, where we try to induce spontaneous remissions in metastatic cancer (57). She had opted not to receive surgery, chemotherapy or radiation therapy, as she was dissatisfied with the less that 30% chance of surviving her cancer with biomedicine (this was the option given to her at the Department of Oncology at the University Medical Centre, where she was diagnosed and offered treatment).

Case story

Female, 39 years, multiple sexual traumas in childhood and now metastatic breast cancer (excerpt from our chart)

20th session at our clinic: The cancer is not healing judged from the size of the tumours. Her tumours in the right breast and in the armpit are still growing. The patient is remarkably difficult to get into the emotional process of healing, presumably because the repressed emotional pains from the childhood sexual traumas are too strong. We agree to try to send her back into the gang rape traumas from her youth by using tools of the next treatment level. After written consent, we decided to use acupressure through the vagina. We combined the level 5 and level 8 of the therapeutic staircase by having several nurses present to optimise holding. Immediately after the penetration of the vagina, she regressed into being in one of the rape situation, and she suffered unbearable emotional pain, which she this time succeeded in confronting. For the first time, she was able to confront what happened on an emotional level. Conversational therapy.

After the above session, there were several sessions of integrative conversational therapy. For the first time, she was able to enter the holistic process of healing in the sessions. The uncontrolled growth of her tumour stopped after the session above. It thus seemed that there was a connection between the emotional pain from the rape trauma with the growth of her cancer (which is in accordance with the holistic theory for cancer) (57,58). Acupressure through the vagina did in this case what less intense holistic medical tools could not do for her. The acupressure sent her into the old emotional pain, helped her to integrate it and thus heal her existence and maybe also her cancer. If she survives the cancer, it looks like this session was the turning point.

Discussion

In all work with clinical holistic medicine, ethics is of utmost importance and when the physician penetrates (with his finger) the vagina of a patient with the intention of healing, we are at the most critical of situations. Hippocrates said: “First do no harm,” and acupressure

through the vagina is potentially extremely harmful, and we judge it to be one of the most difficult of the holistic medical tools to master. Three aspects of the physician's behaviour must be taken under careful consideration before the therapy begins: What is the intention of this treatment? Can the result be achieved in other ways? Does the physician have the required skills to perform the therapy? Is there a (written) consent from the patient? Have all steps of the procedures been discussed thoroughly so that the patient knows exactly what to expect? Have there been taken care of prevention of later interpretation of the treatment as a violation of the patient? Does the physician have the proper insurance for this kind of work?

During the therapy, it is of utmost importance that the physician and the patient remain in contact at all times; the physician must look the patient in the eyes in a relaxed way to ensure the patient that everything is going as it should. The nurse must give holding to the patient. Balance and contact is the key word for smooth and trouble-free therapy. If the patient gets into emotional pains, this must be taken care of right away; if the patient unintentionally gets sexually exited, the physician must be trained to contain that without getting into sexual excitement him- or herself. The physician must be trained to be able to control his own sexuality to such a degree that the healing of the patient is the sole focus of the physician's intention, and acupressure through the vagina must always be done under proper supervision.

The effect of the therapy must always be measured. A small quality of life and health questionnaire like QOL1 and QOL5 (59-61) administrated to the patient before, after, and years after the therapy is a must in this kind of therapy, so that the physician can be sure that he actually helps the patient, also long term. It is easy to believe that the patient has been helped immediately after the completion of the therapy, but what is important is that the patient also finds that the therapy has been helpful years after it has ended. After each session, it must be thoroughly discussed with the patient what happened, and the patient-physician relation must be cleared whenever there is a retraction or an emotional issue in the relationship.

It should always be remembered that holistic existential therapy and healing is not really a technique, but rather a gift of care or in essence love in an unselfish support of the patients. Touching the genitals of a patient with the intention of (sexual) healing cannot be successfully accomplished without the combination of love, or intense care, and a high ethical standard. To say this very clearly, only the physician who has a heart and care can touch the patient for the sake of healing the patient. Without love, confidence and skilful holding (5,38,39) the procedure will not work.

In holistic sexology, working with patients, the physician must always be present as a human being. Often, the physician doing this kind of work will have qualms, concerns and must be extremely cautious and conscientious when breaking one of the toughest taboos in the medical world, namely sex. It is severely frowned upon to touch the female private parts, if it is not in connection with a pelvic examination. There was no real place for what we intuitively felt to be infinitely important, namely supporting the women while confronting the emotions contained in their most private part of the body, the pelvis and its organs.

It gives pause for thought that there are alternative therapists who sell not only the service "vaginal acupressure," which is increasingly commonly practised and accepted in for example Denmark, but also methods even more radical than the sexological examination, i.e., the Dodson method. Vaginal CAM acupressors have made a living from massaging the acupressure points in the vaginas of women who typically suffer from sexual dysfunction (44) and urine incontinence (45). These treatments seem to be popular. They are, according to

observation, research efficient (see section 3: NNT=1-2) and have surprisingly few reported side effects (NNH>1000); but for ethical reasons, we believe that such procedures are best done by educated, trained and supervised health professionals, preferably physicians and sexologists.

It is clear that we as physicians are battling against our absolute terror of sex in society in general and in the entire health service in particular. We may conclude that when blocked or traumatised areas generally react positively to touch and the laying-on of hands, it is not so surprising that sexual areas do so too. As long as it is ensured that the patient is in full control, not violated and that the therapist does not have sex with the patient in any form (in other words, does not seduce her or manipulate her into a sexual relationship, which we see as "professional incest" and a criminal act that is not acceptable), we believe that such a treatment cannot be unethical. It is an important thing for a physician to be able to support his patients fully, including in the sexual sphere.

The subjects of sexology and of ethics have been of utmost importance to the physicians since Hippocrates (460-377 BCE), and whenever a physician touches a patient, the ethics of the action must be considered. As often pointed out in the Hippocratic writings (12), the physician should have the healing of the patient as his sole focus. If the intention of the physicians is wholehearted and rooted in deep medical expertise in order to heal the patient, his life and existence (and in this intention touch any part of the body including the genitals), then we believe the treatment is ethical. This kind of expertise is the expertise of the experienced holistic physician or sexologist, who can take his/her patient into the state of consciousness we know as the process of salutogenesis (20,21), or holistic existential healing (18,19). We believe, as did Hippocrates, that the ethics of the physician or sexologist seem to be proportional with his results with his patients (12). Only the clearest of intentions can bring us outstanding results.

We believe that the technique of acupressure through the vagina, followed by the existential conversation and further processing is sufficient to induce the holistic healing of patient's in the pelvic area and the sexual realm. It is rarely necessary to use the full procedure of the radical sexological examination. The next logical step in our own research is to take the smaller sexological tools we have described into controlled clinical testing to document the efficacy of them on a variety of female, clinical conditions. We believe the square curve paradigm to be useful here (59-61).

Let us end this discussion with a serious warning. Many (23%) incest victims have felt that their therapist abused them sexually during the therapy (62) and they have often developed this feeling long after the therapy has ended. This is presumably due to the mental reorientation necessary for re-repression of the painful emotions emerging during therapy, which in the end of therapy is not sufficiently integrated.

It is extremely important to contact your patients sufficiently long after the closure of the therapy to be sure that the patient is not building this kind of idea, which will be harmful both to the patient and to the physician or sexologist.

As it often is incest victims reporting this experience, it is extremely important that you process all incest traumas to the end, before closing the therapy. It is important to make the patient agree to be in therapy for sufficiently long time for this thorough integration to happen. We recommend that the therapy last for about two years, and we recommend the physician to follow up five years after the closure of therapy to prevent "implanted memories after therapy" and sudden accusations of sexual abuse based on these.

Conclusion

Pelvic massage or acupressure through the vagina is mind-body medicine, or a sexological bodywork technique. It seems to have been used by physicians ever since Hippocrates. The larger tool called the sexological examination that includes direct sexual stimulation has recently been condemned by some physicians as pornographic, but such methods still seem to be very much needed to cure chronic patients suffering from a wide range of problems resistant to standard treatment and related to the structures of the pelvis: urine incontinence, tensions and chronic pains, and a wide range of sexual problems and dysfunctions.

The rationale behind vaginal acupressure is that this procedure of moderate size and intensity can help the patient to confront old painful emotions held by the local tissue, identify and let go of negative beliefs and decisions from the traumatic life events, and do this more elegantly than the larger tool of sexological examination.

The vaginal acupressure (VA) procedure is a more patient and less radical way to free the patient and their pelvis from the repressed feelings, love and purpose of life. When the patient feels her repressed emotions, understand their message and lets go of the negative beliefs, which have repressed her, she will heal her whole existence, including the body, its organs, energy and sexuality at large.

The ethical aspects in holistic sexology are of extreme importance. As long as the physician loves and cares for his patient, gets the trust of the patient, gives holding flawlessly and as long as it is ensured that the patient is in full control and not in any way violated, such a treatment can never be unethical. The physician must certainly follow the ethical rules of the country where the practice is performed, and many countries have legal restrictions to such a holistic practice. It is important to understand that this contact is not and shall not be a sexual contact. The most important qualification of the physician trained in the bodyworks of holistic medicine is his/her ability to control his own intention and level of sexual excitement to ensure that this contact never turns into a sexual contact. The ethical problems of the vaginal acupressure are similar to the ethical problems of the traditional pelvic examination.

As one patient in two or three has a serious problem related to sex and gender, it is important for the holistic physician or sexologist to be able to support his patients fully, including in all aspects of the sexual sphere. Acupressure through the vagina seems to be a valuable and sufficient tool for helping many women, but further research is needed to document its clinical value in a wide range of clinical conditions.

In every pelvic examination, there will be an element of acupressure through the vagina, and the physician always needs to be aware of the repressed feelings that are released by this procedure. If the physician ignores the emotional pains re-experienced by the woman during the pelvic exam, this procedure will become more and more difficult, and the woman will soon hate this examination, which unfortunately is a constant part of every modern woman's life. We, therefore, recommend that every physician be well acquainted with the method of acupressure through the vagina. If the method of vaginal acupressure does not cure the female patient, it is recommended to use the traditional sexological examination, but be aware that local legal restrictions may make the use of this much more radical sexological procedure impossible.

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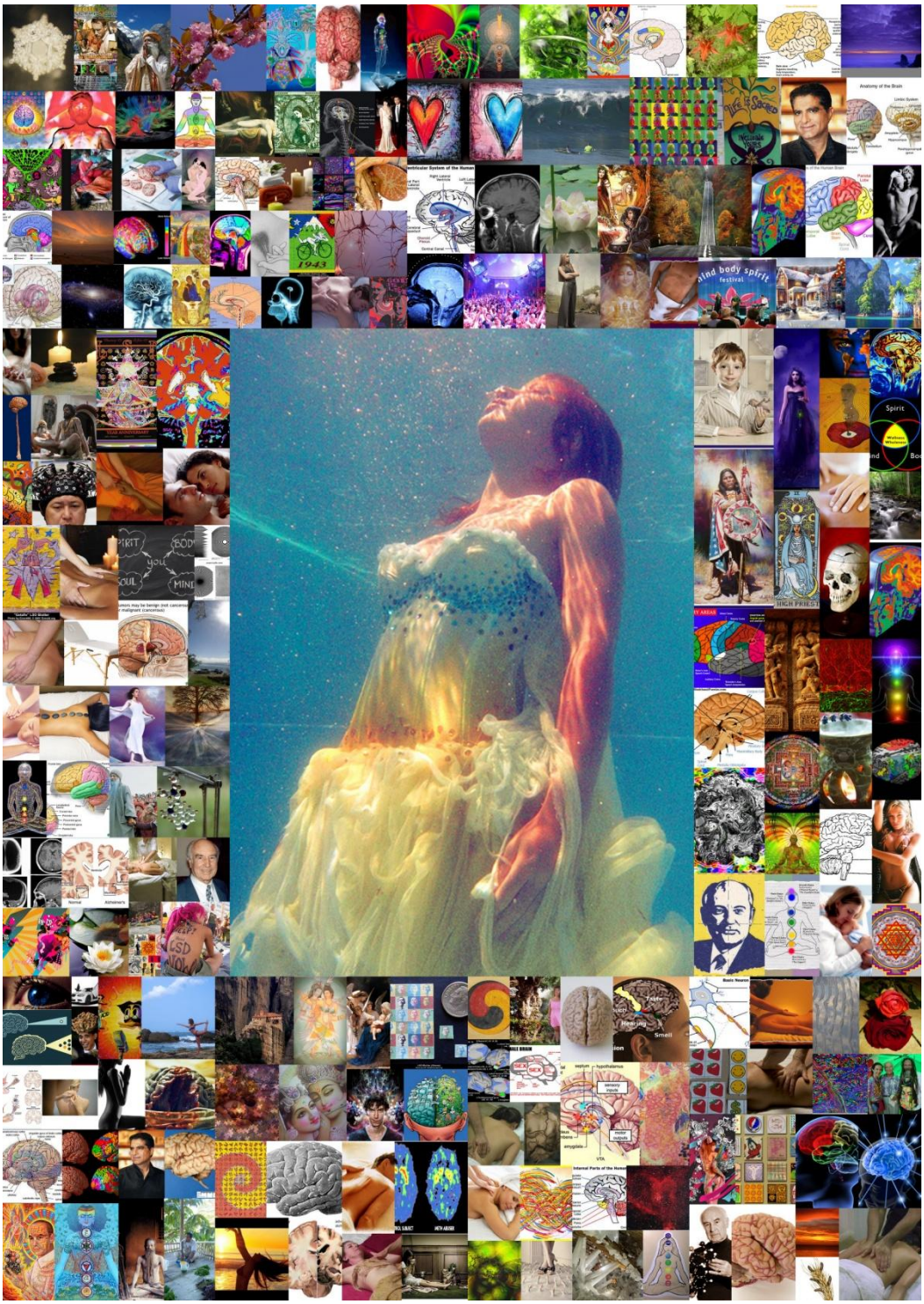

Chapter XXIV

How to recover memory without "implanting" memories

You have undoubtedly heard about the complex problems in court cases where a woman accuses a close relative of sexual abuse in childhood based on "recovered memory" of the abuse. The defence often claims that it has never been scientifically proven that memories can be repressed and later recovered, so the memory might be false and an "implant." No doubt it is very difficult to use human memory as proof, as it is often wrong. And no doubt such cases are extremely painful for all involved parties. With this said, we have no doubt that memories do get repressed and sometimes recovered in therapy. If there is a strong visual memory and the patient shows all the relevant feelings, it is most likely that the event really happened. In therapy, it does not matter if the story is TRUE or not. What matters is that this is the patient's story and that the emotional charge connected to it is burdening the patient, often to a degree of mental illness and also severe sexual dysfunction. So it is mandatory for the patients to get these traumas healed. As the biomedical physician, psychiatrist or gynaecologist rarely are healers, the healing work is up to you as a holistic practitioner. You need to know how to discriminate between implanted and real (recovered) memories. You need to understand the nature of repression and emotional charge. You need to understand how the human unconsciousness works. You need to be certain that you are not implanting any memories in the patient. This chapter will give you an introduction to this complex and difficult area of therapy.

Every therapeutic strategy and system teaches us the philosophy of the treatment system to the patient, but often this teaching is subliminal and the philosophical impact must be seen as "implanted philosophy," which gives distorted interpretations of past events called "implanted memories." The weaker the patient, the greater chance for mental implants. The mentally ill patients are known to be among the most vulnerable and fragile of patients, making this problem more pronounced with these patients than with any other category of patients.

Based on the understanding of the connection between "implanted memory" and "implanted philosophy," we have developed a strategy for avoiding implanting memories arising from one of the seven most common causes of implanted memories in psychodynamic and holistic therapy: 1) Satisfying own expectancies, 2) pleasing the therapist, 3)

transferences and counter transferences, 4) as source of mental and emotional order, 5) as emotional defence, 6) as symbol and 7) from implanted philosophy.

Traditionally, mental disorders are understood by holistic medicine and psychiatry as arrested psychosexual development. Freud taught us that child sexuality is "polymorphously perverted," meaning that all kinds of sexuality is present at least potentially with the little child; and in dreams, consciousness often goes back to the earlier stages of development, potentially causing all kinds of sexual dreams and fantasies, which can come up in therapy and look like real memories.

The therapist working with psychodynamic psychotherapy, clinical holistic medicine, psychiatry, and emotionally oriented bodywork, should be aware of the danger of implanting philosophy and memories. Implanted memories and implanted philosophy must be carefully handled and de-learned before ending the therapy. In conclusion, modern sexology and contemporary holistic medicine ("clinical holistic medicine") have developed a strategy for avoiding implanting memories.

Even the best of therapists can sometimes not prevent the patient from developing an "implanted memory" to some extent, as this is a natural part of the therapy, as will be discussed in Chapter 20. If the patient has a strong female Oedipus complex, it might even be necessary to use the avoidable "implanted memory" as a tool for healing; how this is done is discussed in Chapter 20.

The rule is to avoid implanting memories in the patient, if at all possible. In reality, it is the patient him- or herself that implants these memories, which are interpretations of the past and not memories in the classical (visual) sense, but these dynamics are only to a certain degree under the control of the therapist.

Introduction

During the last decade, there has been an intense and ongoing debate in the medical scientific community about therapy and implanted memories (1,2). It has generally been concluded that memory is not perfect and often more like an idea or an impression than actually like a movie that you can play again and see what really happened. Memory in this sense is known to be highly sensitive to emotions and expectations, as is well known from forensic psychology. Another problem is that the human being constantly has fantasies and reveries (3,4), and when we remember such a fantasy, this is an actual remembrance but of an unreal event. If this happens with a patient, this can cause large confusion in therapy. In general, the mind is not very reliable, and the interpretation of the world in present time and in the past seems to be easily affected by intentions and needs, both bodily and mental.

Because of this vagueness of most people's memories, it is now generally believed that it is actually possible to implant "memories" during therapy. The normal solution in therapy is to be sure that you do not make any judgments about what actually happened, until the patient finds out for herself what happened. It is important to actively avoid influencing the process of interpretation (i.e., give suggestions that can be taken as indications of how a feeling or gestalt should be interpreted by the patient). The central dogma of not interpreting the material of the patient is at the root of classical psychoanalysis and gives a relaxed and often

not-so-intense kind of therapy that often includes several hundreds of hours of therapy during several years.

When it comes to intensive psychodynamic short-term psychotherapy (often defined as less that 40 sessions) and existential psychotherapy, the therapist becomes more dependent on his own theory for the individual patient (5,6). Unfortunately, the patient will often know this theory, or sense it as the therapist cannot help revealing its central idea in the way he approaches the patient and the subjects he addresses in the therapy. In the beginning of the therapy, the only way the patient can cooperate is letting go of the control and playing along. In doing this, there is a lot of learning that is actually implanting philosophy. When the patient's personal past is seen in the light of this new or corrected philosophy, the whole past will look different, which is actually also the core idea of therapy. So every therapist is in fact implanting memories in the broadest sense of this concept.

When the therapist expects sexual abuse to be the caboose of a complex of symptoms, the patient will look for and often find events that can be interpreted in this way in order to comply. Here, we have the implanted memories of incest or abuse. The problematic thing about such memories is that if they are taken as real, the patient needs to "clear" the relationships with the relevant people (often the parents or other family members), and often this is done in a non-forgiving and destructive way, harming the patient and sometimes also her surroundings.

The loss of self-esteem in connection with such a recovery of incest memories is always a difficult problem but can be solved in existential therapy. If the events are implanted memories, incongruence is introduced, making it very difficult for the patient to move forward and heal herself and her relationships to the people of her world. (Please notice that we use "she" as the sexually abused patient is normally a woman, but the patient could as well be a man; we use "he" about the therapist who is sometimes a man but could as well be a woman).

This becomes even more problematic when intensive psychodynamic short-term psychotherapy are combined with bodywork and holistic gynaecological/sexological therapy (7-18), where the intensity of the confronted repressed emotions in the therapy often is getting high. The reason for using the combination of techniques is that the patient needs a lot of support on many different levels to be able to confront i.e., a childhood rape scenario without experiencing unbearable existential pain in the session.

We have worked with the problem of how to avoid implanted memories for years in the research project "Quality of life and etiology of diseases" and believe that we have come to a practical solution of the problem, allowing us to make the most intensive therapy without damaging the patients (i.e., by implanting memories).

A follow-up of 109 patients from our Research Clinic for Holistic Medicine in Copenhagen after clinical holistic medical treatment (receiving the mindful combination of psychodynamic short-time therapy and bodywork) has documented that the patients were not harmed but often helped by this therapy (19-24).

A pilot study of 20 women that had continuous sexual problems on average for almost nine years (in spite of seeing physicians and alternative therapists over that period) showed that most of the patients were helped in this therapy, and no patient was harmed (reporting significant side-effects or ending at a lower score in quality of life, health and ability that before starting the therapy) (17).

We have solved the problem on a theoretical level, and when we took this solution into practice, we found that it worked well with reliable results. We used contemporary models from the research fields of quality of life, human development, and holistic medicine to understand what happened in therapy to make implanted memories possible. We found a simple solution to the complex problem of implanted memories, which is recovering the memory and sense of truth in general in the patient.

Seven causes of implanted memories

The seven most common causes of implanted memories are:

- Satisfying own expectancies: If the patient expects that she had been abused sexually i.e., because a sister was, she can implant more or less vague memories of incest herself.
- Pleasing the therapist: The patient wants to be in accordance with the therapist and is, therefore, accepting his view or what she believes or imagines is his view. This is enhanced if the therapist shares his interpretations and gives the patient leads (i.e., questions that are not neutral but biased in some direction), and even more if the therapist is making judgments on what happen instead of bearing not knowing what happened until the patient finds out for herself.
- Transferences and counter transferences: If the patient develops sexual feelings towards the therapist and if these are ignored by the therapist, or if the patient senses that the therapist will not accept them, this can enhance sexual fantasies, which eventually can take the form as an implanted memory; old sexual fantasies can also be boosted by this unconscious wish in the patient, and even real events can be distorted and reinterpreted, now filled with the sexual feelings that the patient cannot allow to emerge in the personal relationship to the therapist.
- As source of mental and emotional order: A third source of implanted memories has nothing to do with the therapy in itself. The patient needs to get a kind of order in the chaos of emotions and symptoms, and having a simple explanation can be a relief instead of living with chaos and mystery.
- As emotional defence: Sometimes the recovered but false memory is hiding another event that is much more painful. This could be that her father left her and her mother when she was a child. This may be much more difficult to integrate than sexual abuse. If the patient is desperately angry with her father and cannot confront the event causing the anger, an implanted event can be a solution. It could also be neglect that is the problem; it seems that neglecting the bodily presence and sexual character of a girl can be as destructive to her self-esteem and psychosexual development as actual physical or sexual abuse.
- As symbol: Often, the parents have been abusing the child in subtle and psychological ways, (i.e., not respecting the child's sexual borders or having used the child as a sexual partner, which is most often seen when a parent lives alone with a child of the opposite sex). This does not mean that there was a sexual act of objective, physical, incest like coitus, but what we could call the "symbolic incest" or

"energetic incest" is often extremely painful and very harmful to a child on an emotional level. "Energetic" incest happens typically when her father being the only parent raises a girl (or when a mother raises her son alone), and the two of them "pair up" as man and woman making wholeness emotionally and energetically comparable to the wholeness of a sexual couple but without the sexual acting out. A lot of sexual energies are accumulated and circulated here, and the girl is often, as Freud pointed out, having secret sexual dreams about her father with lots of shame and guilt. An implanted memory that carries all the shame and energy of a real incestuous trauma, but where intense therapy does not reveal any recorded "movie" of the event(s), might very well come from "energetic incest."

- Implanted philosophy: When a patient learns that problems often are caused by traumas, she often starts speculating which traumas could have caused which problems. Sexual problems often then lead to dreams about sexual dominance /abuse/perversions, and dreams can be interpreted as memories. Freud taught us that the child's sexuality is "polymorphously" perverted, meaning that all kinds of sexuality are present at least potentially with the little child. In dreams, according to Freud, consciousness often goes back to the earlier stages of development, potentially leading to all kinds of sexual dreams and fantasies.

The mind can interpret the same event in many different ways, and one version of a "memory" cannot immediately be trusted over others. Many therapists, therefore, turn to the physical body for the truth about the past of the patient, assuming that the body cannot lie, because it carries the traumas as tensions that can be released when the emotional and cognitive content of the gestalt is reintegrated in the consciousness of the patient. But as the body is seen through the patient's delusive mind, just turning from the mind to the body does not solve the problem of validating that a particular event actually happened as the patient recalls it.

Three phases of existential holistic therapy

During the last decade of research in clinical holistic medicine at the Research Clinic for Holistic Medicine in Copenhagen, we have found that the therapy in general has three phases (25-28):

- Feeling the repressed emotions of the past
- Understanding the objective elements of the traumatic event
- Modifying/changing negative beliefs about the traumatic event ("letting go")

We have analysed the therapeutic work of about 500 patients with a number of different diseases and health issues (29-45) and learned that, in general, therapy has the following course. In the first sessions, the emotional discharge dominates; as intensity in therapy grows, the element of understanding the traumatic event becomes dominant, and in the end when the intensity leaves the therapeutic process, a deeper understanding arises from the bottom of the patient's soul (wholeness).

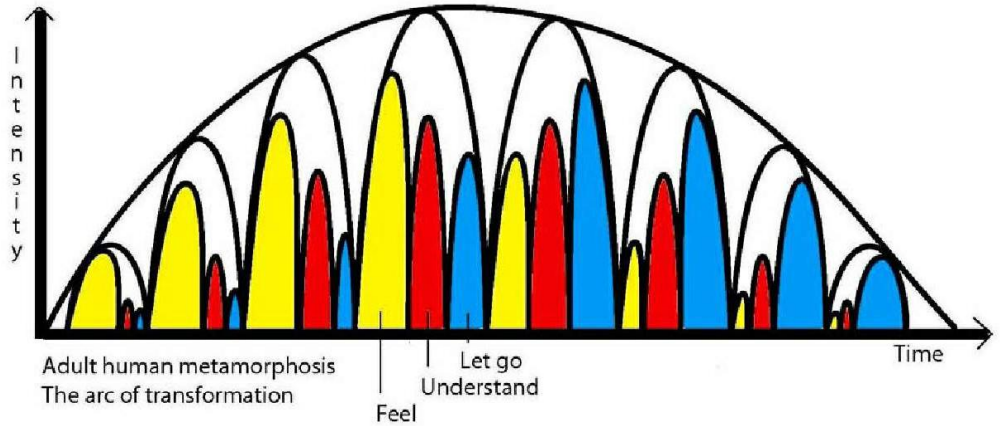

Figure 1. The arch of therapeutically transformation in clinical holistic medicine. There are three core elements of the therapeutic process: to feel (yellow), to understand (red), and to let go (blue) of negative, life-denying beliefs and attitudes. In the first sessions, the emotional discharge dominates; as intensity in therapy grows, the element of understanding becomes more dominant, and in the end when the "heat" leaves therapy, cool understanding raises from the bottom of the patient's soul (wholeness) (15).

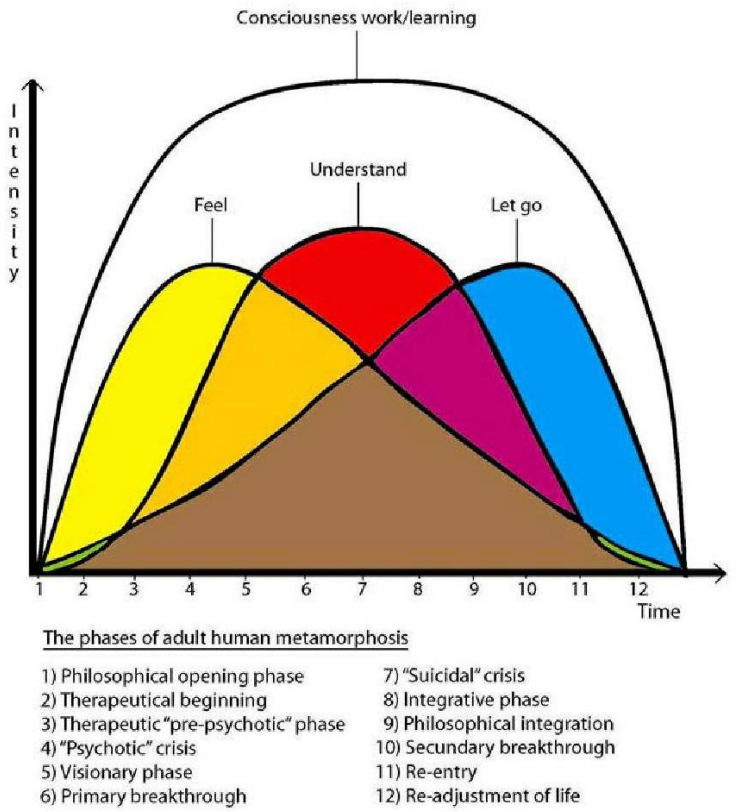

Figure 2. The experimentally found major phases and crisis in intensive dynamic short-time therapy when complemented with bodywork (15).

We have also learned that the therapeutic process can be understood as a metamorphosis (see Figure 1)—the patient enters the therapy like a butterfly's larvae in need of transformation; she lets go of her old identity and melts down (entering the "pupae"). In this state, she develops a new understanding from recalling what she was originally meant to be; and finally she enters the world again as a renewed and transformed person (free to fly like the butterfly), much more beautiful, good and true. We know this process as the autogenetic process (46,47), where the patient regains physical and mental health, quality of life, and the ability to function in all areas of life. During this process, the patient will experience a number of crises that are not dangerous to the patient assuming that the patient is cared for intensively and properly (see Figure 2).

A model for the wholeness of man

Humans have classically been described as consisting of three separate entities, all of which in psychoanalytical therapy are seen as carrying each a very different representation of self: the body carrying the Id, the mind carrying the Ego, and the wholeness carrying the True Self (higher self, soul, comparable to Freud's "Super Ego"). The wholeness of man consist of these three parts, and this point to a simple reason why neither the body nor the mind can be trusted much: they are only parts of our being, and as such they are not able to contain the totality. Only through our wholeness can we truly "see" the world and our personal history.

This understanding is very important as it gives us a key to understanding why patients cannot remember much in the beginning of the therapy, when they are starting to confront their own emotions. We also understand the reason for the intensive involvement of the mind in the second phase of the therapy, which does not provide clear understanding and recalling (memory) to the patient. It is only in the third phase of therapy, when the patient lets go of all negative and defensive beliefs and attitudes and returns to her natural philosophy of life will everything become clear, and (s)he will find herself remembering and understanding everything as the "true" reality.

Interestingly, the majority of patients may see themselves as part and parcel of a severely harmed body and not a free and enjoyable spirit (the wholeness, the free and true "soul"). In therapy, the patient needs first to recover the energy of the body (physical character and sexuality—a process, which has been used as medicine since Hippocrates), then they need to recover the mind (the mental character), and finally they will recover the spiritual dimensions of love, individual talents, higher intelligence (the spiritual character and purpose of life/life mission), and real happiness coming from being able to contribute to the world.

In the therapy, we often teach this in a popular way to the patients, talking about "the four doors of existential therapy":

- getting into sexuality
- getting into consciousness
- getting into love
- getting into life

Most (Danish) patients realize the needs of re-conquering these dimensions of life, and, therefore, understand and accept this path to the healing of existence (salutogenesis) (46-48) immediately. Interestingly, as this process proceeds, first ability to feel, then ability to understand, and finally ability to judge what is true and what is not comes into focus. This originates from the patients reconnecting to the universe and obtaining the Antonovsky's existential experience of the sense of coherence (46,47,49).

Case story

A 24 year-old psychology student, very intelligent, with a "head-centred," mental approach to the world and with a strongly repressed sexuality presents in clinical holistic therapy desiring to solve her existential and sexual problems. She strongly expected her father to have abused her sexually and remembers many such events. As therapy progresses and the emotional charge is relieved, she gradually changes her mind about the occurrence of abuse. After the fifth session, she starts to doubt that she has been physically abused, and in the end, she realises the sexual abuse to be energetic (symbolic). Before the therapy, she rated herself as functioning poorly sexually, with lack of sexual interest and orgasm, but after the integration of the energetic incest, she was able to enter a relationship and a satisfying sex life. She managed to keep this relationship vital for years.

Intensive psychodynamic short-term psychotherapy with role-playing (re-parenting) and bodywork (body dynamics, vaginal acupressure) was used with this patient using the advanced therapeutic toolbox (12). In the beginning of the therapy, emotions were not intense with this patient, but only slowly did she open up. When she finally did, the session was almost exploding in intensity. The breakthrough session happened at point 6 in Figure 2, right when the most intense feelings were turned into understanding. At this point in time, the realistic memories of the abuse were still hidden from the soul, and the mind can interpret such events in many different ways. The repressed sexuality of this patient seemed to distort the patient's memory up to and including sexual sadism. Most interesting was the therapeutic catharsis and the effect of allowing the patient to go fully into exploring her past history of sexual abuse, making her finally doubt that it really happened: "I can't understand that this should really have happened." In the session, the patient was sent back into the early events using the principle of similarity. The issue related to using similarity is that you cannot, as a therapist, avoid "implanting the memory" that the patient and you as a physician agree upon treating. But in this phase, the trauma cannot be remembered, because the emotional charge is efficiently clocking the admittance to the time line. So we are really making a drama, only led by the emotional charge of the patient's repressed traumas. But only by supporting the patient in confronting these emotions can she get closer to a real memory of what happened to her. This is a most difficult technique that only can be done when there is a very close and intimate relationship between the patient and the physician. At the same time, this intimacy invites implanted memories of the "transferences and counter transferences" kind (see above point 3 in causes of implanted memory). The situation looks impossible, but fortunately the processing of the trauma and the subsequent emotional discharge is, in the end, the key to solving the problem. The only thing the therapist cannot do is to back out and abandon the patient.

A most interesting thing to observe in this example is the high degree of certainty she had about past traumatic events at the beginning of the session. When the memories start to clear up, after she confronted the unbearable emotions of the gestalts, she became more and more doubtful that what she has remembered was "real." After reflecting deeply over the content of the session for some months, she concluded that the abuse had not actually happened on a physical level although it did happen energetically. Thus, it was a symbolic representation of energetic abuse (the 6th reason of implanted memories, see above).

Discussion

The use of the similarity principle with patients that believe they have been sexually abused sometimes reveals that what they seem to remember and recover in the therapy did not actually happen. This is an amazing process of recovering severe sexually traumatic memories, and through careful evaluation, the patient realizes that something completely different and much more complex actually happened.

We are complicated beings with needs and consciousness of many layers. As we develop, we need to be physically touched and emotionally supported, met at our borders and loved unconditionally. Unfortunately, most parents are not really able to meet the demands of their children, and many children ends up more or less traumatized—a sad fact known ever since Freud.

The only way to cure somatic, mental, existential, and sexual problems arising from early childhood trauma is to discharge the emotional components by confronting the content of the traumas. The emotional charge also makes the trauma impossible to remember; the only route for inducing healing of the patient's existence (salutogenesis) (46-48) is to support a "blind" confrontation of the repressed emotional content of the patient's subconsciousness. The similarity principle seems most useful (49-55), as this principle allows the therapist to take the patient directly down to confronting the old traumas causing the problems.

The problem with this kind of therapy has been the fear of planting memories by the therapy itself. Our experience with holistic existential therapy is that sometimes such false memories are in fact implanted, but as therapy progresses, these implanted memories are seen as not true. This is happening when the patient acquires a soul-perspective and becomes able to look at the whole life—the whole timeline from conception to now—as one single event, that is understandable in the light of the purpose of life that then is denied and repressed (see the life mission theory (56-62)).

The only real problem with this form of therapy is if the patient drops out of the therapy, before the temporarily false memories are reinterpreted and integrated. It is the obligation of the therapist to continue the therapy until the patient is cured and free of her problem. Therefore, it is important that the patient stays in therapy no matter how unpleasant emotionally it is to confront the old traumas.

We have analysed the problem of implanted memories and found that such implantations indeed do happen in therapy for a number of reasons. When extreme memories of sexual abuse occur in patients with a strongly repressed sexuality and a very active mind, the therapist should consider if the memories are actually implanted. This does not mean that he should disrupt the therapy, but he should most carefully be sure not to interpret for the patient.

This allows the patient to modify the memories about what has really happened in her childhood. If the emotional charge of the early traumas—often feelings of guilt and shame—is systematically relieved, the patient will in the end obtain the position of being able to review her whole time line and understand the real events (no matter how traumatic) leading to the emotional charge that has given the patient so many challenges.

Only when the patient can look from her wholeness can the truth be perceived and the past truthfully remembered. The therapist must be extremely certain that the therapy reaches this conclusion. Fictive memories temporarily implanted are not a problem if this happens but will be if the therapy for some reason is disrupted.

Using the similarity principle (49-55) during intensive, mindful psychodynamic short-term psychotherapy complemented with bodywork seems to be the most direct way to induce holistic healing—salutogenesis—in patients with a complex of somatic, mental, existential and sexual problems. The therapy will often be very intense, and the content of the therapy might be extremely explicitly sexual. If the therapist can contain the patient and all her emotions, the existential healing can be completed with no serious hindrances.

Freud taught us that mental illness comes from arrested psychosexual development and that the child sexuality is "polymorphously" perverted, meaning that all kinds of sexuality are present at least potentially with the little child; and in dreams, consciousness often goes back to the earlier stages of development, potentially causing all kinds of sexual dreams and fantasies, which can come up in therapy and look like real memories.

The therapist working with holistic medicine and psychiatry, sexology, psychodynamic psychotherapy, mind-body medicine, body psychotherapy and other kinds of emotionally oriented psychotherapy and bodywork should be aware of the danger of implanting philosophy and memory. Implanted memories and implanted philosophy must be carefully handled and de-learned before ending the therapy. In conclusion, modern sexology and scientific, holistic medicine and psychiatry (clinical holistic medicine) has developed a strategy for avoiding implanting memories.

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Chapter XXV

The use of Hippocrates' healing principle of similarity in classical sexology and traditional, holistic medicine

In this chapter, we shall, for the first time in this book, look deeper into the principles of healing. The discovery Hippocrates made and put on formula, which should have so dramatic importance for European medicine ever since, was that the process of healing was guided by two oppositely working principles. Of course, the physician should care for the patient and give all kinds of support to body, mind and spirit, but offering resources (the principle of resources) was not enough to induce healing. An opposite directed force, the healing stimulus, was needed. This stimulus sends the patient back in time and allowed the problem to surface in the session and in the patient's consciousness. This stimulus had to be provocative; it had to send the patient into the harm and pain inflicted during the traumas. It had a sting. It needed to look a little like the thing that caused the problem to begin with. Hippocrates said: *Like cures like*, or as it was known for two millennia in Europe: *Simili Similibus currentur.* So the bad that had hid the patient needed to be represented in the therapy, of course in a loving, caring, respectful and supportive environment. The evil was represented. Loving the patient, and showing this love while administering the correct, small dose of the evil, harmful stimulus, for the patient to process what originally harmed him or her was the art of medicine. This is the famous *principle of similarity*. Hippocrates also noted that it was the whole existence that should be healed, the patient's character. The global approach to healing is known as the *principle of salutogenesis*. He observed that when a patient heals, the history of how the patient got sick repeats itself but backwards. This is the also famous *Hering's law of cure*. Finally, Hippocrates observed that as little force as necessary should be used, as it was more important than anything that the patient was not harmed by the doctor and the process of healing; this is the ethical principle of using as little force as possible or *primum non nocere.*

When you think about it, this is quite complex. You need to be good and bad at the same time, but at all times you most hold the intention of healing. So you need, at certain times during the process of healing, to be bad to the patient to do good. This is really difficult for most normal Western people to understand, for good is good and bad is bad. In personal development and holistic healing, it is really not so. Nothing is really good, and nothing is

really bad. Something is appropriate, and something is not. You may have heard the saying: "What will not kill you will make you stronger." "God challenges the one he loves" is an old, similar saying. And yet another: "If you want to know a person's character, you must give him difficult times." The concept of being a "spiritual warrior" was often used by pre-modern cultures i.e., the Native American shamans. Only a spiritual warrior could be a shaman, and only by inspiring the patient to accept the spiritual challenge could this patient be healed. In the pre-modern world, means of personal development, used in transitional rites, often nearly killed the student. Hippocrates insisted that only harmless measures were used. But harmless measures could still be experienced quite dramatically—even violently—by the patient. A cure always has a drama, because to be in healing means to be in crises—in *the healing crisis*. The healing crisis is very similar to the crisis that harmed the patient to begin with. To call it a healing crisis is just another way of expressing the principle of similarity.

We do not expect you to like what you learn in this chapter. It is so much non-Western in its content. It is so difficult from all modern pedagogies. It does not look like biomedicine at all. It has a completely different feel to it. It is *paradoxal* more than anything. And we are not good with paradoxes because they are strange to the mind. The mind doesn't like paradoxes, it cannot really cope with them. So you need to hold the paradox with your existence not with your mind. You need to come from existence, not from your head, to be a good holistic physician. This is what makes holistic medicine so outlandish and so difficult to learn and to master.

In this section, we have focused quite a lot on sexuality. The reason is that sexuality is so close to existence that it makes it easier to understand healing if you start with looking at sexuality. Let's take an example. A young woman is raped. She represses the feelings, because they are so intense and difficult that she cannot deal with them at all in the situation. Now she has a trauma. What is needed for her to be healed? She needs to integrate the trauma. How is this done? In therapy, she is confronted with what happened again and again, until she remembers and understands it all, and until she finally forgives the perpetrator. Only when she forgives and lets go of the negative learning will she be free.

How is she reminded of the rape in the therapy, then? The simplest way is to talk about it. She knows she was raped, and there is a lot she does remember. Talking about that makes her remember more and still more, until she has recalled everything. This is simple. But it does not always work! Sometimes, her psychic defences are so strong that she manages to keep the most traumatic elements repressed. Maybe she was scared to death by something he said—like that he would kill her mother if she ever told anyone... Maybe he blocked her breathing. Maybe he hit her. The key to healing is now using the body, for the body always remembers. If she is placed in the physical position of the rape, the whole incident often comes back. If her perpetrator held a hand over her mouth, just a soft hand here will make her remember this. And so forth. Small doses of what happened will bring all elements of the trauma back. And the moment she recalls and integrates everything, the trauma's power over the person is broken. And the patient is free as if it had never happened except for the learning and experience making her so much stronger than she was before. This is called paradoxal posttraumatic growth. It is often found statistically with groups of rape victims: If they get the therapy and healing they need, and get to the point of forgiveness, they are often stronger than they were before. So the therapist needs to make her confront and re-experience the trauma and every little detail in it. This is rough.

Existential therapy is tough. The evil is very present in the therapy, and only by understanding everything and going beyond can a person heal from severe traumas. The bad news is that the younger you are, the more intense and destructive are the traumas. Therefore, everybody has a bag full of severe traumas. So therapy will be hard for anyone who really wants to go to the bottom of her existence and clean out all the dirt that manifests itself as disease—cancer, coronary heart disease, depression, sexual dysfunction, etc.—all kinds of unhappiness and failure in life. So now you are starting to get the perspective of holistic medicine. You can also understand that it takes love and care of enormous intensity to support the patient who is travelling though the underworld to heal. The patient will literally re-experience being failed, abused, neglected, ridiculed, etc., once again. And you will be the one holding the light so the patient can see what really happened and why it happened, because there is a hidden order in life, which will appear little by little. There is a hidden meaning, an inner logic in life that guides everything that is happening. This inner order is the subject of Section 3.

Hippocrates induced healing (salutogenesis) with the "principle of similarity"—like cures like. The similarity principle has been used as the major therapeutic principle in the modern holistic medicine. One radical style of holistic mind-body medicine has been developed by the late Swedish physician Bengt Stern. This type of therapy that makes use of dramatic, sexological elements has recently been found highly efficient in improving quality of life and normalizing sense of coherence (estimated NNT=2) without any side effects or adverse events (NNH>4,000).

Stern's therapy mimics the most difficult events in life during role-play. His unique therapeutic program, "Meet yourself," takes the participant through the most difficult aspects of life, including birth, death, and neurotic and evil human interactions, also of violent and sexual nature. More than 4,000 patients have now been trough the "Fascist exercise" without getting side effects or adverse events (NNH>4,000). This exercise includes the methods of controlled sexual and psychological abuse (level 8 in tools of clinical holistic medicine, see Chapter 15).

Since Freud, it has been known that to rehabilitate a patient's health, the healing of the patient's sexuality is particularly important. In his therapy, Stern has done what Freud could not do for moral reasons a hundred years ago: Making the full, painful drama of early life happen again for patients to heal not only their physical, mental disorders and sexual dysfunctions, but their whole lives and existence.

The therapeutic program of Bengt Stern is evaluated in this chapter and found to be ethical and in accordance with the healing principles and traditions of holistic medicine, in spite of its use of explicit sexual elements that outside the therapeutic sessions often are believed to be harmful. The use of such elements in the therapy has ever since Hippocrates been the essence of using similarity for healing. All the five healing principles of holistic medicine are used in this therapy.

We find it is worth thinking about that Bengt Stern's "Meet yourself" course, in spite of all its drama and intensive crises it provokes, has been found to be highly effective, non-pharmaceutical medicine and completely without side effects or negative events like suicide attempts. Actually, it was found even to prevent suicide when people already had decided to end their own lives before attending the course.

Introduction

The principle of "the same cures the same" was made famous by Christian Friedrich Samuel Hahnemann (1755-1843), who wanted to find more elegant solutions to the rather painful, traditional Hippocratic cure of exposing patients to the same violation that originally made them ill (1). Hippocrates and his students did practically not use drugs for medicine (2). Instead, they rehabilitated the patient's character by supporting self-exploration—a strategy called "clinical medicine" (3). What needed exploration were all the episodes and events from the patient's life that were painful and problematic—traumatic and repressed—in modern psychodynamic language.

Hahnemann's intent was impeccable. If a woman had been raped, we all know how painful it is for her to go back to relive the trauma in therapy to integrate the unbearable feelings of the violation. If a person had been abused or neglected as a vulnerable, little child, we all know how troublesome therapy is when taking the patient back to this painful event. If this could be solved in a more elegant way, this would be extremely valuable.

Homeopathy has been very successful, and today about 10% of all treatments in the world done by a physician are done with homeopathy. Most unfortunately, homeopathy has not been very effective, at least according to much recent research. Therefore, therapy has not been able to move away from the strategy of directly confronting patients with the content of their traumas. This can be done in many therapeutic ways.

Some types of therapy only work through the mind, others only though the body, while other systems combine conversation and touch therapy, and still others intervene holistically on all aspects of man at the same time. The latter is called holistic medicine. It exists today as many non-scientific systems i.e., the shamanistic healing ceremonies known from almost all pre-modern cultures. It is also developed into medical science as in clinical holistic medicine.

There are different styles of clinical holistic medicine: Holistic body psychotherapy (England, Germany) (4-8), holistic mind body medicine (Sweden) (9-13) and the Nordic School of Clinical Holistic Medicine (Denmark) (14-16). The most intensive of these are undoubtedly the Swedish system, which works very directly on healing physical and sexual abuse and violation by use of the similarity principles.

How unpleasant this therapy might be felt by the participants, it is known to be absolutely safe, without any significant side effects or adverse events (8,9,13,17). The physical intensity of this therapy is well reflected in the fact that one participant in 1,000 broke a rib (13).

Bengt Stern's therapy

Bengt Stern, MD (1938-2002) was a physician who believed strongly in non-drug medicine. He built his holistic therapy on the most efficient and intense non-drug techniques he could find or invent himself (9). He used the Reichian therapeutic principle of working against the resistance.

Stern's therapy was about "raising the patient's consciousness." According to his book *Feeling bad is a good start* (9), his therapy combines a number of highly provocative and intense techniques: Body-psycho-therapy, psychodrama, gestalt therapy, transactional analysis, and Janov's primal therapy. Holotropic breath work of the Stanislav Grof type is

also used to make his therapy among the most intensive non-drug therapies in use today. The techniques he included are efficient, because

> they activate painful emotional memories. In processing these memories, one understands the effect these experiences have had on one's adult life. Sometimes you re-experience very clearly, and in detail, painful emotional memories from early childhood.

Stern wrote about his body psychotherapy:

> Body-psychotherapy is not psychotherapy in its usual sense, but rather a technique to contact pre-intellectual emotional memories, so called cell memories. Body-psychotherapy is the conscious activation of these cell memories in your body. In its practical application body-psychotherapy consists of hundreds of different breath exercises, body movements, massage techniques,, etc. The pioneer of body-psychotherapy was Wilhelm Reich (1897-1957). Other prominent figures within this science are Alexander Lowen, John C Pierrakos, Charles Kelley and David Boadella.

Bengt Stern was interested in all major aspects of life, especially the three aspects he found most difficult and traumatizing: birth, human interaction and death. To help the participants in his therapeutic course "Meet yourself," he made everyone go through three most intense exercises, which he labelled the "birth excise," the "fascist exercise," and the "death exercise" (9). In all three exercises, he used psychodrama, role-play, and imagination to mimic the emotional reactions in every little detail of a painful and difficult birth, sexual and non-sexual abuse, violation and repression in human interactions, and the transformative crises of the psychological death process—often called "metamorphosis" (18-21).

The text below is Bengt Stern's own description of his most central and famous "fascist exercise" from his book (9). Around 1985, when his book appeared in the first edition, a great number of people had already participated in it, and most fortunately, this exercise proved to have no side effects of adverse events associated with it, as Bengt Stern stated in his book:

> The "Fascist exercise" in the "Meet Yourself Process"
>
> An essential exercise, a kind of psychodrama, is part of the first step. This exercise has the nickname "the "fascist" exercise." The aim is for the participants to become aware of their fascistic shadow. That is the part which people unconsciously allow to leak out on their daily life. When participants become aware of their fascistic tendencies, these tendencies lose their destructive energy. So these tendencies will, to a great extent, start disappearing.
>
> Just as with other intense exercise in the Meet Yourself Process, this exercise is explained in detail beforehand. No participant is told they must participate in this exercise. Rather, every participant will have to express a wish to take part. Some of them might be advised by the course-leader not to participate in this particular exercise.
>
> In the exercise, participants, working in couples, suppress each other within a given framework. They are, of course, not allowed to hurt each other physically, but within the given framework they are encouraged to participate totally. In the role of oppressor they are to use all their creativity to offend their partner. In the role as victim they use all their creativity to enter the role of being totally invaded. This exercise lasts for about thirty minutes before the partners change roles.
>
> Participants react in a variety of ways. Many participants totally enter both roles. Some are quite capable of handling the role of the oppressed but have difficulties being the

oppressor, or vice versa. Occasionally, participants are psychologically paralyzed, mostly in the role as the oppressor, but sometimes even in the role of oppressed.

If participants do become paralyzed they will receive an individual emotional release session with one of the course-leaders. It is then evident that the psychological paralysis is their way of avoiding contact with the memory of the mental, and often physical, violence to which they were subjected by one of their parents early in life.

In such a session the participant has an opportunity to express his pain and rage, because of the violence. The opportunity to complete this exercise through such a session is a great relief for the participant.

After this exercise, the couples share their experience with each other—i.e., how they are now able to identify their oppressive role and their victim role in their everyday life.

This is followed by an exercise of emotional expression in which the participants liberate them-selves from all the pre-intellectual pain that has been activated during the exercise.

About two thousand people have been through the "fascist" exercise. They consider this exercise one of the most essential of the course. Although it is demanding, nobody regrets having participated in it. Those who wholly participate in this exercise stand a great chance of avoiding being suppressive or of allowing suppression in the future.

Case reports

After the documentation of the efficacy of Bengt Stern's therapy, it has been taken into use in all the Nordic countries. In Denmark, the "Fascist exercise" is used especially for the training of therapists that work with traumas from violent and sexual abuse, i.e., incest. One training centre that uses it is the Nordic School of Holistic Medicine in Copenhagen. The following are descriptions of how two participants experienced this exercise:

I felt such an immense relief. Lying there on the floor, I realized that this was what had been repressed and what caused my vulvodynia. It was like a huge matrix of negative emotions, thoughts and beliefs that came from adapting to my sexually rather dysfunctional parents when I was very small.

Training session, female holistic body psycho-therapist, 28 years old. For many years, I had vulvodynia with strong daily genital pains and not being able to have intercourse. I had the condition for 15 years, and I had been to a large number of experts, physicians, gynaecologists, sexologists and complementary therapists and used a lot of money on these treatments but with almost no results. I had finally given up. As part of my training as therapist, I finally encountered the gestalts that had caused my gynaecological problems. This happened in the "Fascist exercise." In this exercise, it was not difficult for me being the oppressor. I was together with a man around 40 years, and I humiliated him totally, but this did very little to me. I just felt like he deserved it. When it was my turn to be the "slave," this was something totally different. I felt from the beginning the most intense anxiety. Just meeting him and seeing him standing there in front of me, sensing his scary, dominating, male, aggressive energy was quite impossible for me to cope with. So the exercise hardly started before I broke down and regressed into an ocean of the old emotions of shame and being abused. The idea that I had to obey him in spite of his intention to abuse me was totally intolerable for me. Without him doing or saying much I felt so abused, so violated. I just had

to obey. It was like being buried in an avalanche of shame and humiliation. What really got to me was the idea of not being able to have my own opinion. It was like my will was broken at its very root.

He started calling me names and humiliating me. He did not touch me, but that didn't matter. If he had raped me, this could not have been much worse. I felt like dying. At the same time, I was completely aware that this was an exercise and that I just stood and confronted a normal, rather good looking, intelligent and empathic man, who actually had been kind to me just an hour ago. In the normal world, I liked him. But in this exercise, he was the devil himself. I was not in present time. I was with my parents a long time ago when I was a little child.

The next thing I was asked to do was to dress naked and lie on the floor in front of him. I did it, but I felt like dying every second. He told me I was the most ugly girl he had ever seen and that I had a clammy body. He yielded at me and told me in the meanest way that I was just a pussy. He then ordered me to show him my vulva. This did it for me; it was like an old cinema movie that suddenly broke. I just disappeared. I found myself in the position typically held by embryos and felt like vomiting. I felt really sick. After this, I was done. And I was through. I felt such an immense relief. Lying there on the floor, I realized that this was what had been repressed and what caused my vulvodynia. It was like a huge matrix of negative emotions, thoughts and beliefs that came from adapting to my sexually rather dysfunctional parents when I was very small. I felt it like hell at that time. I was not physically abused, but energetically I had been violated again and again. The feelings could not have been worse. They were really unbearable. No wonder I did not have access to them in my normal therapy. The degree of resistance I had made for myself made it necessary for me to get through to myself only in the course of the "Fascist exercise."

The exercise released the most intense bodily emotions, and already the next day I felt much better. Since then my vulvodynia has been gone. Sometimes I still have pain during intercourse, but my daily genital pains have disappeared. I feel much more proud of my body (and my genitals), and my self-esteem has improved radically. I was scared of getting men's attention, but this has also changed. Today, I can perform for a crowd with a relaxed attitude. When men say something humiliating to me, as they sometimes do, I don't care much. It is like it doesn't get to me anymore. When somebody tells me that I look bad, I simply cannot believe it. My whole experience of myself as woman has improved immensely thanks to this exercise. What from the outside looked like I was being tortured was experienced from the inside the most healing event.

Training session, male holistic body psycho-therapist, 42 years old.

The most intense exercise for me was the "fascist exercise," where you work with a partner; normally, the couples consist of a man and a woman. The idea is that a person of the opposite gender has repressed everybody earlier in life and because of this there has been a sexual element in the repression. Often, there has been more than that—a direct violation, physical, mental or sexual. In this exercise, the participants are allowed to work with all these painful aspects of unequal human interaction. The instructor told us that he would not guide our experience—we could go where we needed to go in this exercise—but for him, it had been about sexuality, from beginning to end. In this way, everybody who needed to work on their sexuality—and I think we all did—got acceptance to go into this most difficult and painful space of sexual trauma to heal whatever wound we would have here.

In the exercise, the person who feel most violated started by "getting even" by violating the partner. All energy from old traumas are used, the preparation takes everybody deeply into the feeling of being hurt and wanting go get revenge by repressing the person that hurt you—by proxy, using the partner in the exercise.

The beauty of the exercise is that it really is cooperation, where you mutually allow yourself and your partner to go into the sexually wounded space and express all you anger, grief, fear, etc. In the role of the oppressor, you do to the other what originally, traumatically, was done to yourself. In real life, you are never allowed to go into this "evil" space; the strong sexual taboo of our culture also makes this absolutely impossible. But in this exercise, you go there together with your partner, who also wants to heal and even more importantly, also wants to help you heal by giving you the opportunity to express the most dark and dirty sides of your own shadow and to re-experience being violated and abused. In the exercise, this happens in a useful way that helped me to integrate my past and to learn that I today am a strong adult that in reality cannot be so deeply hurt any more. What harmed us happened to us when we were vulnerable kids, which could not withstand the hard pressure of our parents. Today, we are not vulnerable kids any more.

First one is "fascist" and the other is a "slave" for 30 minutes, and after that the partners shift roles. So all the humiliations you just got from the other are given back right away. What a wise and wonderfully balanced design of this exercise!

There are some rules in the exercise: You must promise confidentiality; you are not allowed to touch the other person; you are not allowed to put bodily fluids (spit, sweat etc.) on the other person, and you must stay in the exercise for the 60 minutes it takes, if you accept to participate. You are supposed to cooperate and help the other person repress and humiliate you by revealing your sore spots and suggesting things that could be done to you that you would feel awful. As people come for healing, everybody engaged is surprisingly willingly in this. When you are a "slave" you are supposed to obey your "master." But you are allowed not to, if what you are asked is too difficult.

Now the idea of the exercise is that the "fascist" uses his or her imagination to abuse and exploit the "slave." This can be done by asking the "slave" to undress, take humiliating positions and say horrible things about him- or herself… The "fascist" may scold the "slave," ridicule, etc. The art is to find out how to "break down" the partner, as this break is exactly the historical break the partner needs to confront and heal. So the whole exercise is nothing but support to go back into the core trauma of life, regarding the body, sexuality, self-worth, etc. You are allowed to break down and just lie on the floor, crying or whatever you are doing, feeling the old painful emotions again. You are not allowed to leave the room during the exercise. During the whole exercise, there is a physician present to ensure that no person is getting "repressed" more that necessary for the healing to happen. The therapists will also moderate the participant's behaviour—tell the "fascist" to go slower, or faster, and the "slave" to let go of fear and engage more fully in the exercise.

I was given a partner by the therapists, a woman about 30 years old and judged from her behaviour in the exercise with a personal history of sexual traumatisation. I was worried that she would be harmed by this exercise, so I talked to the therapists about my great concern for her future well-being, but they all ensured me that the exercise was harmless, if done correctly. I had heard that this kind of therapy could cause re-traumatisation—giving a new similar trauma on top of the old one—but the therapists ensured me that this never had happened in this kind of therapy {which is in accordance with (8,9,13,17)}.

Finally we engaged in the exercises, and the things she got me to do gave me a feeling of shame so badly that I felt I should die. I was exactly like a little boy that was ridiculed and humiliated by his mother, who hated men and sex. I had no recalling of my mother doing this to me, but as the exercise went on, I felt more and more that I had been harmed by my mother's energy and her sex-negative attitude that had colored my relation to my own body and sexuality. It was a deeply healing experience, in spite of it being ugly.

When it was my turn, I asked her to undress and show herself to me. She had extreme resistance and finally she broke down and cried as a little child. The most difficult thing was

that I liked it! I had never seen myself as a sexual sadist, but I realized that I contained so much hatred and anger toward the woman (= my mother). I was very surprised at all the repressed sexuality this exercise released for both of us. It was a small miracle, and Bengt Stern was right. Confronting this was not yet another trauma on top of the other. The principle of similarity took us straight back to some of the most difficult and most efficiently repressed feelings and events in our lives. The exercise did not turn me into a sexual sadist, but it made me own my sexual aggression, which had been repressed since early childhood. I felt that I finally became a man. It was wonderful. My partner revealed she had a similar experience, and that she finally dared to be sexual again.

The double action of tempting and humiliating me took me into the most difficult feelings of male repression by dominant women, like being castrated—the "vagina dentata" from Freud's writings.

I was obviously one of the participants that became paralyzed from the exercise and was therefore offered a special session (as described above), which I accepted. This was a session with three female therapists at one time. The three women intended to help me free my life energy and sexuality further. They did this by tempting me with their bodies, moving sexually around me, inviting my interest in them, flirting and revealing parts of breasts, stomach and other intimate parts of their bodies, and whenever I revealed the slightest interest they scolded and humiliated me for being a pig, a horny, dirty man, totally worthless and good for nothing, a pervert and a real lowlife scumbag. The double action of tempting and humiliating me took me into the most difficult feelings of male repression by dominant women, like being castrated—the "vagina dentata" from Freud's writings. It was really amazing what it did to me to confront the most evil aspects of the feminine—it was like dancing with the good Kali from Indian mythology. The energy was totally wild and animalistic. Little by little, I came to peace with the shadow of the female.

Not so long time after this exercise, I was able to take a big step forward in my own relationship and surrender to my own woman. I finally was able to choose her as my partner for life. The exercise had helped me confront the most dark side of my "own inner woman" and finally taught me to let go of my fear and bond devotedly to my own women. I also felt like being a much better therapist after this. I found new trust in the female, and I dared to help women who had been raped or sexually violated in their childhood in a much more open and intimate way. I got better results and much better feedback from the female victims of sexual abuse and incest that I had in therapy. I realized that sexual torture, the most harmful kind of torture there is, is damaging because it repeats the child's reality, where the victim must adapt him- or herself to the reality of the offenders—similarly to the child's need to adapt to its parents reality for survival. As adult human beings, we do not need to adapt in this way, hence we are not vulnerable.

Elements of Bengt Stern's holistic philosophy

One very important aspect of Stern's therapy is forgiveness (9):

In forgiveness, man moves beyond his intellect and explores his greatest vulnerability. He encounters the pain of his unprocessed emotional memories. Only by stopping and encountering this pain may it be released and allowed to disappear. Clearly, forgiveness is not a superficial, intellectual process, but an energy release at one's very depth.

Another aspect is that sexuality is the basic energy in life. Our culture strongly represses, which leads to prostitution, pornography, child abuse and incest. On the latter subject, Bengt wrote:

> Incest: The reason behind incest is suppressed sexuality. A culture, which is dominated by feelings of guilt, because of sexuality and/or intercourse before marriage, encourages early marriages. Before marriage neither the woman nor the man is allowed to have intercourse. As their marriage continues the two partners might find that they are not compatible, although they now have children and refrain from having sex with each other. In the vacuum that then arises, a father who suffers from perverted sexuality may approach his daughter and a mother who suffers from perverted sexuality may approach her son. Both parents are always responsible for the incestuous act by not taking responsibility for having a mature and satisfying sexual life with other or with new partners.

Stern was a strong believer in self-insight as the primary outcome of psychotherapy:

> The role of psychotherapy: Profound self-insight is knowing oneself beyond the intellect and contacting one's wholeness. Self-insight then increases and brings about the understanding and practicing of an existential view of humanity and the world. Through profound self-insight people can find the existential answer as to why they are feeling bad. Once that is understood the leap toward well-being is not far away. However, profound self-insight is not limited to treating mental problems. Even many physical problems, often irrespective to the degree of difficulty they cause, improve dramatically when man understands the reasons behind the problems. Above all, when people come to know themselves, their quality of life increases in every respect.

Discussion

The principle of similarity has been used to an extreme degree in Bengt Stern's holistic mind-body medicine, which is why it has been so effective in inducing *salutogenesis* i.e., existential healing (22,23). Recent analysis of the effects of Bengt Stern's therapy has proven it highly efficient with people who have the most severe mental and existential problems including suicidal patients (8,9,13,17).

Not only the principle of similarity is taken into use in this therapy; all five healing principles of holistic medicine are used (8), and this is done impeccably, without any of the medical errors it is easy to make in this kind of therapy (24). This is making the therapy highly effective with NNT-2 for improving of quality of life and sense of coherence estimated from the non-dichotomous data in (2-4).

There might potentially be an ethical problem in making the participants engage in repressing, abusing and violating each other, but it is important to understand that all participants as described by Stern above were fully informed about the purpose of the exercise, how it would be practiced and what the expected benefits were for the participants, based on experience with more than 4,000 participants who had been through the therapy during the 24 years since it was invented by Bengt Stern (13).

All participants are free not to participate in an exercise if they do not feel up to it or do not see how this exercise could help them. Therefore, everything is happening with consent after full information. The purpose of it is clear, and everybody who is participating is doing this to help him- or herself and the partner in the exercises.

Having a physician present to exclude patients that are not likely to benefit from the therapy is an extra precaution that we do not believe is necessary anymore based on the complete lack of side effects and negative events with the fascist exercise. We know of no cases where the physician prohibited a patient from participating.

We have evaluated the therapy according the Ethical Rules for International Society for Holistic Health and found all the exercises in Bengt Stern's "Meet Yourself" course to be in accordance with the ethical standards of holistic medicine (25). Controlled sexual and violent abuse and repression are well-known tools of holistic medicine (categorized as "level 8 tools" in (26)). They have been used since Hippocrates and cause no side effects or adverse events if used correctly (1,3,9,13,17). They are especially useful in the training of therapists that work with healing traumas of incest, violent, sexual or mental abuse, repression and violation.

The principle of similarity, which has been known since Hippocrates, has been cultivated into its purest form in Bengt Stern's therapy. Because of the courage of Bengt Stern to mimic the most difficult events in life in role-plays in his therapy, he has created a unique therapeutic program that in one single process takes the participant though all the most difficult aspects of life, including birth, death, and neurotic and evil human interactions, also of violent and sexual nature. People who would judge this kind of therapy as bad and unethical are the people who haven't understood the basic rules of holistic non-drug therapy.

Bengt Stern's "Meet yourself" course is a candidate to be among the most effective types of holistic mind-body medicine in use today, thanks to his thorough understanding of the principle of similarity and consequently his inclusion of controlled sexual and violent abuse into the therapeutic program. Since Freud, it has been known that to rehabilitate a patient's health, the healing of the patient's sexuality is particularly important.

Stern did what Freud could not for moral reasons do hundred years ago: Making the full, painful drama of early life happen again for the patients with physical and mental disorders and sexual dysfunctions, who need to confront the most intense and difficult of traumas to heal life and existence. The program is evaluated and found to be ethical and in accordance with the traditions of holistic medicine.

Stern's "Meet yourself" course is effective non-pharmaceutical medicine with radical, sexological elements that do not cause any harm, neither side effects nor adverse events (estimated NNT=2 for the outcome "quality of life improved" and NNH>4000 for significant side effects).

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Chapter XXVI

The medical record

In holistic medicine, one of the most important tools is the medical record. If you are a medical student, you will most likely hate it; in biomedicine, it mostly serves as a documentation of all actions and errors. Most physicians make the medical record very short and formal for defensive reasons. In holistic medicine, the medical record is a brilliant possibility to repeat for the patient what you have said and what you have discussed for the reflective process to continue at home. It is also your chance to give the whole thing a second thought. We encourage you to make very detailed records and to share all records with your patient. This way, the patient will know what happens in your head, and it will create trust and confidence.

The modern physician is often multi-paradigmatic as he serves many different types of people in many different existential circumstances. The physician basically often has three very different sets of technologies or "toolboxes" at his disposal, derived from three different medical paradigms: *physical therapy, biomedicine and holistic or consciousness-oriented medicine.*

The excellent physician uses the most efficient way to help every patient, giving him or her exactly what is needed under the circumstances. The excellent physician will choose the right paradigm(s) for the person, the illness or the situation, and use the case record to keep track of all the subjective and objective factors and events involved in the process of healing through time.

The case or medical record/chart has the following purposes: *A. Reflection:* To keep track of facts, to provide an overview, to encourage causal analysis, to support research and learning and to reveal mistakes easily. *B. Communication:* To communicate with the patient with a printout of the case record to the patient to create trust and help the patient to remember all assignments and exercises. *C. Evidence and safety:* To provide evidence and safety for the patient or to be used in case of legal questions. *D. Self-discipline:* To encourage discipline, as a good case record is basically honest, sober, brief and sticks to the point. It forces the physician to make an effort to be more diligent and careful than a busy day usually invites. *E. Research:* To be able to look back and use the material to evaluate treatment or procedures from a scientific point of view.

The intention of the case or medical record is ethical: to be sure that you as a physician give the best possible treatment to your patient. It helps you as a physician to reflect deeply, communicate efficiently, provide evidence and safety, and back your self-discipline, never to

be carried away by the high speed of modern day clinical work to give less that the optimal treatment. The patient's life, now and in the future, is in the palm of your hand, and to assume this huge responsibility; the physician has got to be anxious and careful about the quality of the medical record. Much too often, the essence of the session is nowhere to be found in the case record, so most of the generated value is lost between consultations.

Introduction

All medical work is based on the intention of doing good, either improving the health, the quality of life or the ability of functioning—or a combination. Independently of the good intention from the physician, the medical work is always bound to some medical theory or a frame of interpretation. Hence, the different paradigms (1)—giving a number of different perceptions, hypothesis, diagnoses, actions and reactions (comp. How we construct our consciousness in general and our reality) (2,3). The process of healing is—as life itself—often fairly complicated. The course of the disease, the healing process, personal development, learning and coping in connection with a disease is often highly individual. The modern physician is often multi-paradigmatic as he serves many different types of people in many different existential circumstances. He basically has the three very different sets of technologies or "toolboxes" at his disposal, derived from three different medical paradigms:

Classical manual medicine, where the hands—used with the best and most humane intentions—constitute the main tools. It dates back to Hippocrates (460-377 BCE) and Greek antiquity (4,5).

Biomedicine, which came into widespread use around 1950, born paradigmatically along by the discovery of penicillin, where biomedicine focus on body chemistry and physiology (6).

Holistic medicine or consciousness-oriented medicine, which is a new and increasingly popular trend with many family physicians in the Western world. It draws on a variety of healing processes, philosophies and systems, taken in the original or modified forms from the pre-modern cultures. The most important thinkers influencing holistic medicine in northern Europe today are great physicians and philosophers like Jung (7,8), Maslow (9), Antonovsky (10,11), Frankl (12), Fromm (13), Goldman (14,15), Sartre (16), Kierkegaard (17) and Allardt (18). The holistic approach focus on the person as a whole, and this wholeness or soul or total existence is thought to be able to heal from its very totality—becoming "whole again," if the wholeness is lost partly or completely (18-28).

Depending on the perspective, or paradigm, very different things might happen to the patient when treated by the physician, and the signs and symptoms of development or progress of health and disease are interpreted very differently. If you go to a homeopathic physician, which for example is fairly common in Germany, it is seen as a good sign if the treatment makes you feel worse for a while (29-32), but if you consult a biomedical physician, then medicine is expected to make you feel better almost at once. If you consult a holistic physician working according to the holistic process theory and the life mission theory (7,27,28), you would normally expect a very different path and even when occasionally confronting painful old traumas becoming more happy and resourceful. The reason for this is that the earliest existential wounds normally are the toughest to overcome, but the more

resources you have, the more severe wounds on your soul, you will manage to confront and heal (see Figure 1).

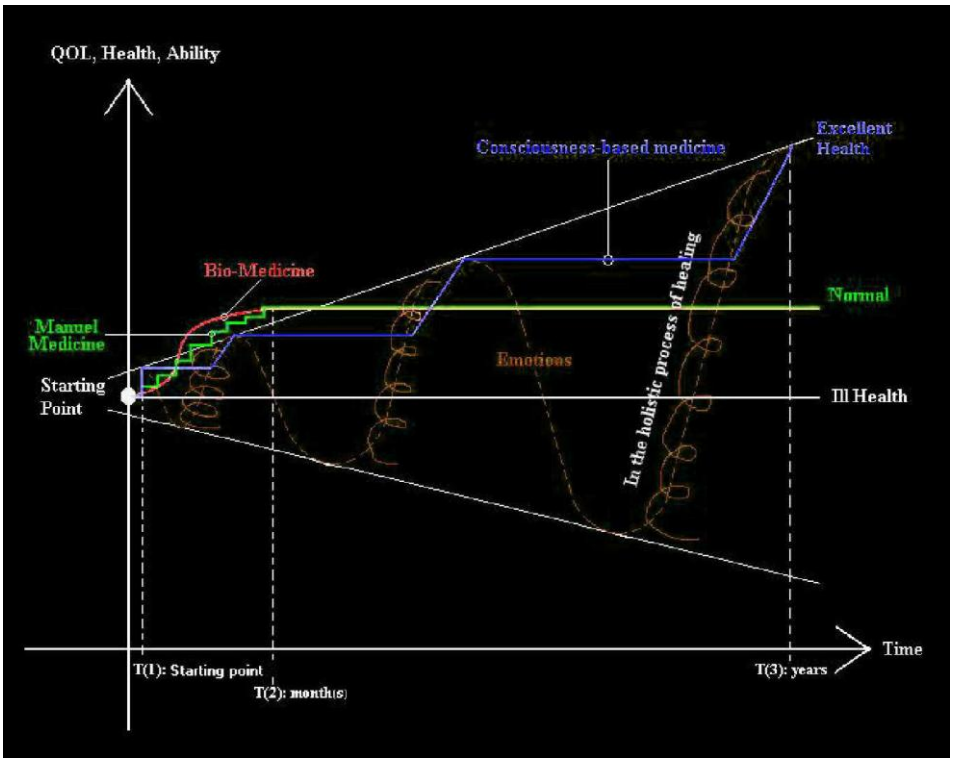

Figure 1. The common course of the healing process, within the three discussed paradigms. Where the manual medicine often gives an immediate improvement of health, the biomedicine takes awhile, and the holistic medicine has phases of holistic healing (often hours, marked coiled), phases of recreation (weeks to months) and prolonged phases of learning and personal growth (typically years). The manual medicine takes care of the body here and now. The biomedicine takes care of biochemical and physiological disturbances, often of long duration, if the disease is not cured but becomes chronic. The holistic medicine engages the patient in a process of existential healing and personal growth, often for life.

For lack of a better term, we have called the extended medical science, integrating these three different paradigms and their three strands of tools and methods, the "new medicine" (or the old medicine in a new bottle). Clinical holistic medicine is base on the following ideas: The life mission theory [19-24], the holistic process theory of healing [27,28] and the related quality of life (QOL) theories [33-35], the philosophical change of the person healing often a change towards preferring difficult problems and challenges, instead of avoiding difficulties in life [36-44] will make the person healthier, more talented and more able to function [45-47].

In the search for the best way to make a new medical clinical practice and to serve the new type of patients we now see in our Western society (the critical and knowledgeable patient or the patient focused on personal or spiritual development), we have worked with three different approaches to the new medicine:

Approach a. Quality of life as medicine. Focusing on human feelings and emotions, we have combined biomedicine with a number of complementary therapies, like Rosen body work, classical Chinese acupuncture and gestalt psychotherapy. We have called this holistic approach "quality of life as medicine" (45-47). The combined treatment has the intention of inducing existential healing (27,28) and encompasses three phases, popularly described as: "Feel, understand, and let go": *Feel* the blockages in body and mind, behind your health problems and symptoms, *understand* the life-denying conclusions you reached then that created them, and *let go* of these decisions once you are ready to assume responsibility and be your true, responsible self again. The team of physicians and alternative therapist complementing each other's work under medical supervision could be the most efficient way to induce existential healing, in spite of the differences in professional language, culture and paradigm.

Approach b. Meaning of life as medicine. Focusing on the purpose of life, meaning of life, life mission, and talent (19-24). Focusing on the hidden potentials, on the beauty and magnificence of the soul and on the power of our existential choices gives many patients faith and a fast healing progress. When the existential theories, the QOL philosophy and theories, and the QOL concepts are explained to the patients and internalised, patients gradually find themselves and return to a natural state of being, comparable in some aspects to the state in which they were born with a certain purpose of life and certain great talents to be used. The life mission theory simply states that denying your meaning in life leads you to illness, unhappiness and poor performance, while recovering your purpose of life depends on finding and working for your purpose of life.

Approach c. Love as medicine. Based on the concept of genuine human relationships and the power of unconditional love and acceptance, we have worked with the spiritual gift of love and the healing power of this in what we have designated an experimental, social utopia (47,48). When patients belong to a small community with true companionship, contact and emotional surplus, their way to recovery seems to be much shorter. The problem with social utopia is that it is very difficult to create and even more difficult to control. One of the preconditions seems to be that the participants do not have sex with each other, as this disturbs the possibility of intimacy in the group setting. Although consciousness-based medicine supports individuals in their personal development, therapy and the patient-physician relationship can never replace a vibrant reality lived with those most important to them. It is the conquest of a good personal world to live in that can bring wholeness and healing. Quite simply, an individual can only realize the meaning and purpose of life in a social context. This purpose is what we are meant to be and with this gift we will be able to give to others. This can only happen most fully in intimate relationships, full of trust and love. A huge body of evidence has been collected on the connection between health and survival, love and intimacy (49). Many medical doctors seem to be unable to work with therapists not scientifically trained, and many therapists do not like to be directed by a physician, which makes an approach very difficult. Problems of this kind in the treatment team do not help the patients, as we have painfully experienced in our own clinical practice.

> What will make a physician good is his good intentions, his deep knowledge and developed skills. What makes a physician brilliant is his or her ability to stay as the Self. As a paradox the true Self has no intentions.

As human beings, we are limited to loving only a few percentages of our fellow men. This is an issue that often naturally grows to a larger fraction, as we grow older, wiser, more spacious and containing, as we understand that love might be a leading concept in medicine, maybe even the strongest of the three concepts for inducing existential healing. Since such an approach for many seems unnatural, we are for all practical purposes left with the second approach in order for the modern physician to use the "new medicine." Interestingly, the three approaches above express to what degree the physician is willing to come close with the patient. This mirrors the intention of the physician towards his patient. In a) the physician has the intent of helping the patient to heal, in b) he has the intent of personally giving a gift to the patient from the bottom of his heart and in c) the physician has the intention to let the patient be a part of his life, in true appreciation of the magnificence of this unique soul in front of him. We believe that most physicians of our time who search their souls will find that the intentions of b) are an appropriate ambition for their work. The physician who truly can give the holding [9,10] and processing in order to come close to his patients' needs will always be loved and respected by his patients.

WHAT MAKES A PHYSICIAN EXCELLENT? What will make a physician great are his good intentions, his deep knowledge and developed skills. But true excellence comes from an ability to stay as the Self, as the physician is really the tool himself. In order to assist his patient to a successful treatment and help his patient, the physician is only excellent when the good intentions result in the patient being adequately helped. The patient is helped when one of the following two conditions is fulfilled: 1) The patient gets what he wants: quality of life in some aspect or globally, health in some aspect or globally, or ability of functioning in some aspect or globally—or a combination of these, 2) The physician gets what he wants: the broken leg healed or the disease treated or prevented. So the situation is fairly complex, and much is depending on the physician choosing the right medical paradigm or toolbox. It is not easy to tell what a good medical treatment is unless: 1) you understand the paradigm chosen and look at the patient from inside it, 2) You keep track of all the subjective, objective factors and events involved in the process of healing through time, 3) You have a valid way of testing the end result of the treatment. All this is more or less complicated depending on the paradigm, with the subjective paradigm the easiest to demonstrate (26). This makes it surprisingly easy to make research and quality improvement in the holistic medical clinic, introducing existential healing according to the holistic process theory, and surprisingly difficult to document effect of the biomedical treatments because of the objective approach. This later approach needs a difficult set-up with control groups in the Cochrane design in order to be valid.

An example of the three medical paradigms at work: low back pain

A patient comes to the physician with low back pain. If the physician uses manual medicine, he will examine the patient carefully to exclude the need for surgery; he works with his hands on the patient, helping the patient to be more relaxed, less tense and less in pain. Most fine body workers or chiropractors can remove a normal low back pain within an hour. When the cause in the body is understood and removed, the job is done. If the pain returns, so must the

patient. If he gets a bad discus (a slipped disc) and a severe problem later with compression of the spinal nerves, it is not related to this treatment. If the physician is working according to biomedicine, he will examine the patient carefully to exclude the need for surgery, and if the problem is not serious he will mobilise the patient and use the painkillers necessary for this. He will talk about prevention, avoiding heavy lifting or poor working postures. If the cause of the pain is understood, this is fine, but mostly the low back pain has no objective cause, and this is no obstacle for giving the treatment. When the patient is well again after the mobilisation—it normally takes a couple of days—the job is done. If the physician is working with conscious-based medicine, he will examine the patient carefully to exclude the need for surgery. He will look for the cause of the illness in the patient's consciousness—difficult feelings repressed and placed in the longissimus thoraces muscles and other muscles. He will talk to the patient, give holding and processing, and inspire him to a more honest and joyful living. When the cause in the consciousness is understood and removed, and the pain is gone, the job is done. It is not that any of these medical paradigms are better or worse than the other. The excellent physician mastering what we call the "new medicine" uses the most efficient way to help every patient, giving him or her exactly what is needed under the circumstances.

What is the purpose of the case record?

The physician is normally unable to make the quantitative research necessary to document the effect of his treatments, although he can use the square curve paradigm (see Chapter 12) or similar for quality improvement (26). The best way of documenting the cure, noticing the paradigm in use, keeping track of all the subjective and objective events and to see the final results, is using the case record or chart. The case record has several general purposes (48), which include:

A. Reflection. To keep track of facts. It documents the physician's actions and considerations so that no patient is subjected to casual or careless treatment. Important issues are not forgotten. There is continuity of care. To provide an overview. The physician gains an important overview when writing down key information about patient and care. To encourage causal analysis. Very often, a physician may not realise that individual symptoms could be related. One symptom may lead to another, or, as is often the case, they may have a common underlying cause that the physician should be wise to look for while reflecting on the patient's situation when reading through the case record. To support research and learning. Detailed case records constitute unique tools of learning. When a physician writes down what is done and what is not done in each situation, it is possible to see afterwards what works and what does not work. In spite of all the learning in the world, each physician must draw his own conclusions and proceed by trial and error, and in this process the physician carries out a compulsory, qualitative research project with the case record at the centre. To discover mistakes easily: any mistakes made can often be discovered before the patient comes to any harm if important therapeutic details are written down, such as the dosage of a drug, and the case record is read at the next visit.

B. Communication. To communicate with the patient: often, we give the patient a printout of the case record so that he or she can remember any assignments or exercises and can reflect at home on the potential causes of the disease and what the patient will have to do to get well.
C. Evidence and safety. To provide evidence and safety for the patient: the case record protects the patient against errors in another important manner: under Danish law, a patient is entitled to a copy of his case record and to use it to consult another doctor who may then continue treatment and point out any irregularities. To be used in the physician's defence: the physician may need to document what he has done, for instance, if a patient lodges a complaint.
D. Self-discipline and ethics. To encourage discipline and ethics: a good case record is basically honest, sober, brief and to the point. Writing three lines following each session forces the physician to make an effort to be more diligent and careful than a busy day at the surgery usually invites.
E. Research and evaluation. As mentioned above, as a tool in research and evaluation. So the intention with the case record is actually ethical: to be sure that you as a physician give the best possible treatment to your patient. It helps you as a physician to reflect deeply, communicate efficiently, provide evidence and safety, and support your self-discipline, never to be carried away by the high speed of modern day clinical work to give less that the optimal treatment. The patient’s life, now and in the future, lies in the palm of your hand, and to assume this huge responsibility, the physician must be anxious and careful about the quality of the case record. Much too often, the essence of the session is not to be found in the case record.

Some case examples from family practice

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

Male, aged 36 years with eye injury. The patient was cutting stone with an angle grinder without wearing goggles and got what seems to be a glowing metal chip 1 mm x 0.3 mm in the left cornea at 7 o'clock seen from my position, outside the central vision. Chip removed with a needlepoint without any visible epithelial damage following anaesthesia. Eye pad. He was instructed to return in three days, if pain persisted. Prescribe Fusithalmic [fusidic acid] eye drops.

Female, aged 38 years with overweight. Slimming plan. 131 kg. Presents fully motivated and has made the following plan: 1) Swimming Tuesday + Thursday. 2) Cycling to town and to bingo. 3) Eating low-fat food, mostly crisp bread with low-fat cheese. We talk about how diet should include many vegetables and little meat. She intends to live off her fat deposits and wants to lose 31 kg over the next 31 weeks to weigh 100 kg. This means lowering her daily calorie intake to two-thirds of current level. We talk about how to mentally overcome the sensation of hunger. Check-up every month.

The record or chart of the family physician is usually short and not like the usual chart in a hospital university department, where many students, physicians and consultants have to be involved. The chart of the family physician is usually for his own utilization in order to keep

track of his patients and the treatment he has given. The three cases mentioned above are examples from a regular daily clinic of a busy family physician at work. Pneumonia is seen fairly often, especially in the winter period and straightforward to treat and the entry in the chart, therefore, very short and concise. Eye trauma is very important to treat at once and also important with follow-up in order to think about referral to a specialist. Obesity is many times a "mission impossible," because of the lack of motivation from the patient, and here follow-up and self-esteem very important aspects of the treatment.

> Female, aged 56 years with growing old much too soon. 1. Has slept on her side, pain corresponding to outside of left arm for three weeks. Loss of strength assessed as being of "protection—fixation type." No sensory deficit, no affliction of feet or lower legs/to be followed up/. 2. Oedema (swelling) around the ankles. Prescribe Furix [furosemide] (a diuretic). 3. Patient requests a blood sample for gout, but I see no signs of this disorder in her, so there is no immediate indication for it. "If she doesn't get it, her husband will tear the whole clinic apart." She is informed in detail of the risk of prescribing too much medicine, if blood tests are not clinically justified and show false-positive results. 4. Productive morning cough for many months. Auscultation of the lungs: nothing abnormal discovered. No fever. May have slight bronchitis. 5. We talk about her everyday life, which is difficult; she becomes increasingly insecure. We talk about anxiety and menopause. 6. Headache almost daily. BP 130/90. This patient has grown old 20 years too soon. She desperately wants to be examined, "since there must be a disease," which the other physicians have overlooked and for which she can be treated. But upon examination, there is no disease. A good physician usually knows intuitively whether or not people are seriously ill. To the best of our knowledge, this patient is not ill. We do not want to examine her for something, which we are certain she does not have—with the risk that the blood samples show a slight imbalance (one in twenty blood samples show a false-positive result). All the biomedicine in the world cannot save her. She has to save herself. Otherwise it will not happen. So was this a good consultation? It depends very much on the consequences. Did the dialog inspire her to take more responsibility for her own life and health? As this is not likely, the answer seems to be in the negative, the consultation was less than excellent.
>
> Male, aged 13 years with psychosomatic abdominal pain. Increasingly frequent, very severe abdominal pain for the past year, forcing the patient to unbutton his trousers and lie down until it passes.
>
> Examination: No blood in faeces, no vomiting or loss of appetite. Abdominal muscles very tender, especially at umbilical level on the right side. Otherwise, soft, non-tender and without palpable masses. The abdominal pain can be provoked by manual stretching of the abdominal muscles. Socially: The patient's parents have just separated.
>
> The patient says: "School is no good, they don't teach you anything," "mum tells me off a lot," "she is stupid," when she does that. He feels that it is a burden being the big brother of three sisters and responsible for them all. He cannot keep up at school and needs extra reading lessons; he is due to have some lessons after the holidays. The father feels that he is unable to get the school's attention—it is like talking to a brick wall. And that reflects on the boy as well, Diagnosis:/Psychosomatic abdominal pain.

We agree that the father should discuss the situation with the mother and return with a plan, which we will go over together during a conversation. Sometimes, parents need to understand that their mutual conflicts can affect their children, who can display their anxieties with psychosomatic symptoms. That is hard to acknowledge, because the last thing we want

is to be bad parents, but a divorce need not always affect the child's health, although that is very often the case.

We have also seen several examples of women who become very abusive because they felt bad, while many men in a similar situation can become withdrawn and desert or neglect their children. Probably the hardest thing for the child is the need to be loyal to both the father and the mother, and this can easily lead to a conflict that cannot be resolved. There is a deep psychological explanation for this need for two-sided loyalty, namely that each individual contains the two genders, represented by our parents. The quality of our future love life depends on how lovingly these two aspects of ourselves meet. Here in this case, we see a different approach, the psycho-social approach characteristic of the consciousness-oriented medicine. The case record is good, because the psycho-social paradigm, the consequent actions, and the basic idea of the treatment is clear from the journal. The next case shows the rhythm of the new medicine, integrating the three paradigms by alternating between them. Please note the nature of the exercises meant to raise the consciousness of the patient and help her assume responsibility:

> Female, aged 28 years, who cannot function with boyfriend.
>
> First quality-of-life conversation. The patient suffers from lack of a boyfriend and a chronic feeling of being rejected—I would say that the feeling is: "He does not like me." Has been married, has two children, boy aged eight and girl aged five years. The boyfriend before the husband broke her heart when, for the second time, he found someone else. She is "emotional," as though made for love, care and sex, but she is blocked in this and is now unable to love. Her father regarded her as stupid and delightful. Her mother, whom the patient calls manipulative, found her irritating. The patient acted as a psychological mother for her own mother and as a partner for her father. Examination: Tensions in the back and particularly in the abdomen, around the pelvis and the insides of the thighs. Cries when these tensions are contacted. There is a "pit in her abdomen."
>
> EXERCISE 1: Let go of negative decisions: "I'm no good" and "I'm irritating."
>
> EXERCISE 2: Patient is overweight –10-20 kg– and eats in the evening in order not to feel. So: sit for 10 minutes daily in your emotional space and feel your emotion of being let down and rejected, insulted, fed up and so on.
>
> EXERCISE 3: Find more negative decisions in their precise formulation and let go of them.
>
> PLAN: Rosen sessions (manual therapy) every 14 days, appointment with me in between if needed.
>
> Second quality-of-life conversation. Her mother was always irritated with her. Since the patient was three years old, she has always been contrary, defiant and stubborn. Did not want to show me her notes today. "I'm no good" is the basic problem; the patient says, and: "I'm not worth loving."
>
> EXERCISE 1. Describe all your advantages in wielding power.
>
> EXERCISE 2. Make lists of all your power games in relation to love, sex and friendship, as well as work and motherhood.
>
> Third quality-of-life conversation. The patient hands over a list of power games in relation to children and husband. It is clear that the patient wanted to rule and to control both her son and her ex-husband when they were together. During the conversation, the understanding is crystallised in the sentence "I determine..." in the sense of....everything! Since she was three or four, the patient has been "a sweet, warm-hearted and fair tyrant" in relation to those around her.
>
> EXERCISE 1: Let go of the sentence "I am the one who rules."

EXERCISE 2: Accommodate your anger and other emotions, and be a pressure cooker for next time.

This kind of "I am the one who rules" decision, which guides the patient in her sub-consciousness, is a very serious and destructive decision, which has been made at a time of extreme distress during childhood. When the patient finds it and let go of it, all her energy and the whole quality of her personality will change radically. It is incomprehensible and quite alarming that our old decisions have such power over us that they destroy our lives together throughout our lives. We create our lives through our decisions. It is, therefore, vitally important to be clear about what decisions are at work here and now.

Sixth quality-of-life conversation. Condition: feeling of being rejected has disappeared. The feeling of being irritating has disappeared. Power games have disappeared; the patient spends time with her children in a far more caring and loving way. Very few conflicts with the children. "Yesterday they sprayed water all over the bathroom, and I didn't even lose my temper. Previously, I was not allowed to console my son or come close to him, now I can do that." Finished.

This problem afflicts one in two modern people: we cannot make our lives together work. Attempts are often made to solve problems in relationships by power. That is not nice. Resignation or break-ups and divorces are normally the result: submit or disappear! But before love finally dies out, the energy left in the love is often channelled into long and painful power struggles. The power games are generally based on earlier patterns of survival from childhood. When patients let go of their decisions about having to be in control and determine everything, they can then enter into a warm and rewarding relationship of love. Power games are highly destructive for love; fortunately, most patients are willing to let go of the dark power games when their attention is drawn to them.

Discussion

In our wealthy society, every second individual suffers from chronic illness—a disease that is not cured in spite of modern medical treatment. One in five suffers from chronic pain (50,51), one in eight has a weight problem, one in ten an alcohol problem. Back pain, osteoarthritis and rheumatoid arthritis, migraine, asthma, allergy, depression, hypertension, recurrent infections, personality disorders ... the list of chronic disorders in the modern Western society is long.

This makes it clear that prevailing biomedicine, which seeks to treat almost everything with pharmacotherapy, is far from adequate. Biomedical treatment is the right choice for many *acute* disorders and problems, but it is obviously not enough in chronic illness—or it would not have become chronic. Nor is biomedical treatment very useful against existential crises, burnout, social phobia, decreased libido, anxiety, age related decline, dementia or the other complaints that afflict so many people today.

What is wrong with biomedicine? As long as you only suffer from a variety of ailments and symptoms like mild pain, a slight allergy, mild depression or sleeping problems, the pills may well provide relief. Everybody can take pills, and in many cases, they help us with what afflicts us, which is basically fine. The difficulties with biomedicine begin at a later stage. Once we become really ill, which most people do in due course, the pills of biomedicine no longer suffice. So, once you become seriously ill, you will often become *chronically* ill. And

what good is the physician and all his fine molecular medicine, the specially designed molecules of the pharmaceutical industry that cost billions to research, if the medicine cannot make us well again when we really need it? That is certainly one of the greatest problems of biomedicine. One explanation of the shortcomings of biomedicine could be that many of our health-related problems are merely symptoms of the poor quality of life and inadequate conduct of life that half of us experience: an unsatisfactory relationship without true love, a meaningless working life, no fulfilling leisure-time activities and a family life without any real togetherness. This is the sort of life that will make us ill in due course. At some point, we will need to assume more responsibility for our own lives if we want to stay healthy. Here, the physician may help to support and inspire the patient, increasing the patient's awareness of his or her options, hidden resources and potentials. To this end, the physician needs an extended form of medical science that supplements our valuable knowledge of biochemistry with an insight in psychosomatics and consciousness.

The mastery of several medical paradigms empowers the physician to help almost every patient that trusts in him. We recommend that every physician includes the physical therapy, biomedicine, and the holistic, consciousness-based medicine in his toolbox.

Holistic means focusing on the patient's totality, soul and consciousness—including his or her perception of life and the world and, in particular, his or her often considerable hidden resources. The actual guidance of the patients to make them assume responsibility for their own lives and mobilise their self-healing potential is one of the most important tasks of consciousness-based medicine and of the modern day physician. Our consciousness carrying our purpose of life, our talents and our love may be the most characteristic feature of our personality as a whole, and enhanced awareness of our existence is the key to better existential choices, personal responsibility and thereby a better life.

Encouraging their patients to assume more responsibility for their own health, quality of life and expression of skills and talents does not mean that there will be less to do for physicians. More than ever, we need skilled physicians of good will and intention, who know their jobs: how to help people get well. As a well-educated and highly specialised expert in human healthcare, life and well-being, the physician has an important part to play in the society. In the future society with many more conscious and enlightened people knowing everything there is to know from the internet, the medical doctor must be the carrier of wisdom, not only knowledge, if the physician intents to stay a valuable expert deserving the respect of his patients. The wise physician mastering the new medicine can help patients focusing on their efforts in defining their lives and providing a meaningful content.

Personal development and existential healing seem to be important concepts for restoring the health, happiness and ability to function of the people of our time. How the physician work with all the many aspects from the physical level to the spiritual is best illustrated through the case record, where the stories about illness and recovery that they tell can be used as teaching examples.

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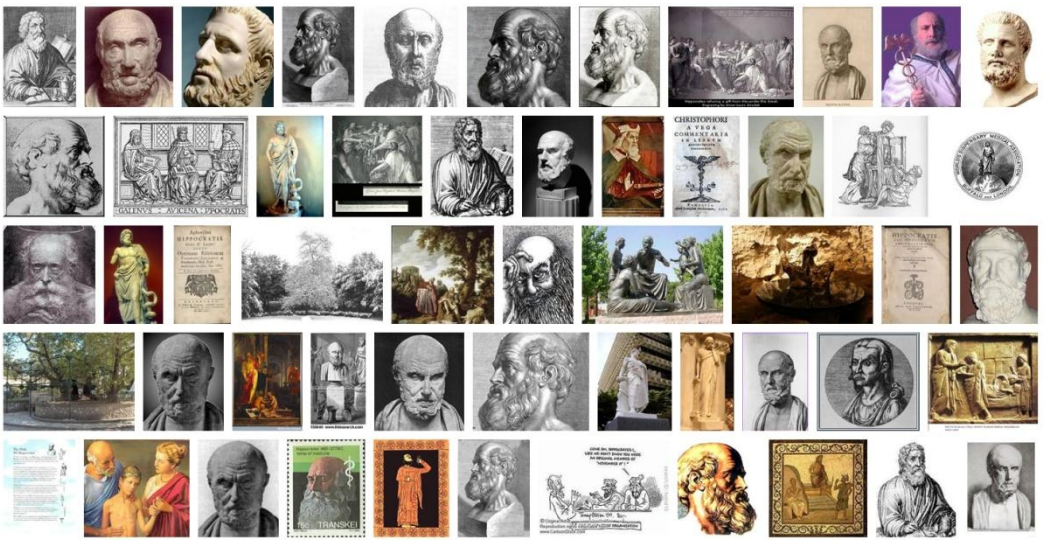
Exercise

1. Talk to a dear friend about life and reveal some secrets to each other. After the session, write five lines on the essence of your talk. Be sure that you get what is relevant from a developmental perspective down on the paper.



Chapter XXVII

The ten core dimensions in holistic medicine: Diagnosis in holistic medicine

A diagnosis is a statement of something that is wrong and needs to be corrected by the cure. In holistic medicine, the most important dimension is *quality of life* (QOL), how your life is experienced at large. The global assessment of quality of life is easiest done with a questionnaire, where the patient's QOL is rated by him- or herself. Most of times, the physician will agree with the patient in the rating, but sometimes the patient will estimate his or her own QOL as much lower or higher than the therapist. In this situation, we recommend the measuring to be repeated after a month of therapy, when the patient is starting to understand the perspective set by the holistic therapy. Often, the patient and the physician will agree on the patient's rating at this time.

Physical and mental health are almost as important as QOL, and again the self-rated physical and mental health are two extremely important dimensions of health; actually self-rated health has been proven to be the best predictor of future health and survival of all the different health parameters known to man. Self-rated physical and mental health is easily measured with a self-administered questionnaire. The quality of relations and the ability of functioning—social, sexual, stud related, work related—are of equal importance as QOL and health, and again ability of functioning are easily measured with a small questionnaire.

If you measure the status of QOL, health and ability, you can reach the patient diagnosis based on this; and the goal of the treatment is given in the same moment. If a patient has a low QOL a reasonable goal is a high QOL, etc. We have identified ten core dimensions that can be used for diagnosis and goal setting in the holistic medical clinic.

Introduction

Life is complex, and human life is even more so. Holistic derives from the Greek word *όλος*, *holos*, meaning whole or complete. Looking at the whole organism minimizes loss of meaning when the chaos of the detail is examined. Holistic medicine aims to restore health to all levels of the human being, including body, mind, spirit and the environmental system in

which the patient lives. We aim to understand the patients in their systems and avoid imposing an alien system that detracts from being able to understand the fully functioning person.

Quality of life (QOL) is a broad-based concept that gives a framework to holistic care. This has the drawback of potentially being over inclusive and does not easily allow for quantitative data analysis. As physicians and therapists, we want to know the state of body and mind—we want to know about the physical and mental health of the patient. We also want to know how well the person relates to herself and others, how well he or she functions socially, in the work environment and the quality of their sexual relationships. We seek to understand the I-Strength of the person and how well they have been able to integrate mind, body, spirit and how this relates to the social system that she functions and lives in. This approach of a detailed history allows the therapist to create a broader understanding of the patient in the psychosocial and community context.

A model of the whole human being and ten fundamental diagnoses

Box 1 lists the ten diagnoses that often form the basis of holistic care. Figure 1 shows a symbolic drawing of a human being with these ten dimensions in focus. In the middle, we have the central dimension of quality of life (QOL) (1), which is an umbrella-term for all related concepts like happiness (ad modum Aristotle), satisfaction (2), fulfillment of needs (3), meaning of life (4) and sense of coherence (5,6). As we shall see, just improving QOL will improve all the other dimensions of life; this is why we talk about "QOL as medicine." If an individual is physically diseased and for some reason able to achieve a positive outcome in one dimension of her life, then it is probable that her overall health will improve. It might seem strange for a physician trained in biological medical sciences that quality of life is associated with health, but many others find this intuitively plausible, and there is an evolving evidence base to support this perspective on health and well-being.

We also refer to Table 1: Entering the person reveals the body and mind like two separate entities with their representations of self. The abstract level of the human being is often called the spiritual level, and the representation of self here is called the soul. The scientific concept of soul is somewhat different from the religious in that the soul is seen as a part of the human triumvirate—BODY – MIND - SOUL, all integrated in the *I*, symbolized with the heart on the drawing in Figure 1. The Body-Mind-Soul axis corresponds to the three ancient Greek concepts of the animal, the human and the divine, living in all of us. Those who are interested can study the Dionysus ritual where the participants first penetrate the animus—human sacrifice; finally being lifted to the demi-gods, the Titans.

The physical, mental and spiritual components of health are the foundations of a holistic approach; spiritual aspects of health and well-being are often overlooked—spiritual dimensions in healthcare and the healing arts are difficult to quantify and thus defy the logic of a reductionist evidence-based medical bioscience. Furthermore, confusion with religious dogma and fundamentalism with perceived proximity to the esoteric fringe have largely removed spiritual aspects of health in mainstream modern medical practice.

Box 1. The ten fundamental dimensions of holistic medicine (D1-10). The five important life areas are labels A1-5. For practical reasons, we have omitted the diagnosis: "Spiritual health: How is the patient's spiritual health?" see text

A1: Quality of life:
D1. How is the quality of your life?
A2: Health (physical, mental, spiritual):
D2. Physical health: How is the patient's physical health?
D3. Mental health: How is the patient's mental health?
A3: I-Strength:
D4. How is the patient's I-strength (ability to love)?
A4: Relations:
D5. How do the patient's relation with him/herself?
D6. How are the patient's relationships with friends?
D7. How is your relationship with your partner?
A5: Functioning:
D8. How do you consider your sexual functioning at the moment?
D9. How do you consider your social functioning at the moment?
D10. How is your working ability at the moment?

The cohesive integration of these components into a functioning whole (i.e., an Operative—I) is often called the I-Strength and is found between the dimension of QOL and Health on the figure. The external environment is represented to the right of the figure with relations and function.

The quality of a person's relations are strongly dependent on the person's relations with self (the I-Soul relation, theoretically influenced by the Mind-Soul, the Body-Soul, the Mind-I and the Body-I relations). The most important external relations are believed to be with partner and friends; relations to children and colleagues are also important, but statistically they are found to be of much less significance to a person's QOL (7-10). If you love yourself and have good friends and a loving partner, you might have problems with your children and your colleagues, but these problems will not affect your QOL much; if you have problems with your friends and partner, your relationships with children and colleagues will not be able to compensate for this, and you will be unhappy.

The relations are on the border to the objective, but most researchers will still say they are primarily subjective dimensions. On the right side of the figure lies the objective level of functioning. We have found social functioning, functioning at work and sexual functioning to be three important dimensions of functioning that are strongly related to QOL.

Box 1 lists the ten dimensions of life that appear to the most significant when considering quality of life, and, therefore, also the ten most important holistic dimensions to consider in the clinic. The ten dimensions are easily rated in the clinic by use of a small QOL-questionnaire i.e., the QOL10 (11) made for this purpose. It is anticipated that patients will easily grasp the ten domains of quality of life; and assessment of these domains will reveal where the focus of a healing intervention should focus. The QOL10 use a five-point symmetrical Likert scale, which we have found to be most efficient for collecting psychometric data (1).

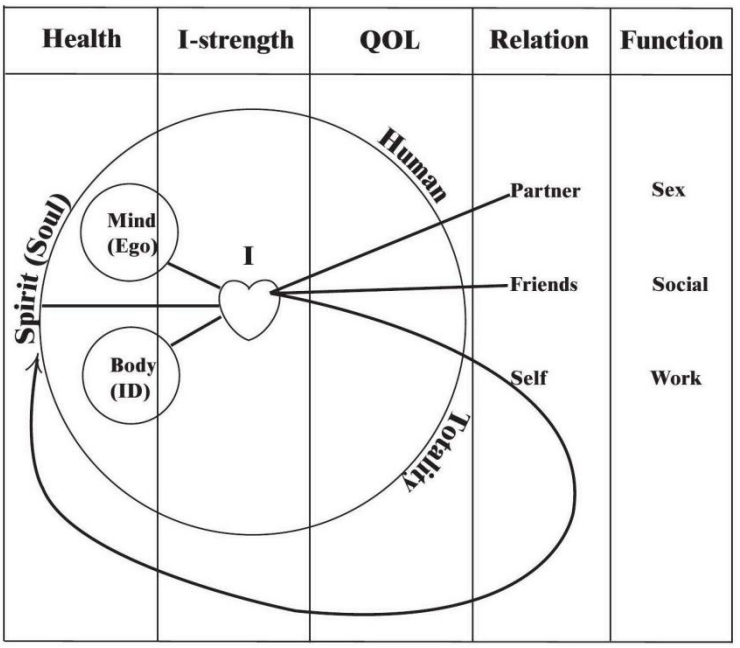


Figure 1. The ten most important dimensions of human life. The great circle symbolizes the wholeness of the human being, and the state of this wholeness is what we call quality of life. Inside, we find body and mind, outside relations and objective functioning. Sexuality is really the all-penetrating life energy (not on the drawing).

The power of simple diagnoses

Modern medicine suffers from the impact of a faulty medical diagnoses. A diagnosis of diabetes is often achieved by a series of blood tests, which can be used to confirm the diagnosis, but this process does not describe the complex emotional and psychological consequences of such a devastating disorder. A psychosocial and spiritual assessment with the questions from Table 1 relies on information that is already well known to the patient, but being able to share such personal information in a clinical setting is limited; however we hope that such a questionnaire might also serve to elucidate relevant personal information. One of us (SV) has experienced that the process of developing a therapeutic relationship with patients on such a level has been a powerful experience for both patient and therapist; he has experience of being able to use the energy transference of this process to engage patients with improving their quality of life. SV brings the patient to the centre of a healing team, and through the process of sharing often works with patients to empower themselves to create their own solutions to improving their lives.

A "whole life assessment," accesses information about problems; problems summon a solution—this is the practice of holistic medicine. This is not complicated, or difficult, but relies on old-fashioned concepts of creating a therapeutic relationship, understanding that transference and counter-transference exist in all human relationships and that the energy released in such well-intentioned healing relationships can greatly empower patients to begin to change their own lives.

Table 1. Ten questions for rating the patient and giving the Ten essential diagnoses (11)

Q 1. How do you consider your physical health at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 2 How do you consider your mental health at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 3 How do you feel about yourself at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 4 How are your relationships with your friends at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 5 How is your relationship with your partner at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad --6 I do not have a partner
Q 6 How do you consider your ability to love at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 7 How do you consider your sexual functioning at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 8 How do you consider your social functioning at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 9 How is your working ability at the moment?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad
Q 10 How would you assess your quality of your life now?
1 very good -- 2 good -- 3 neither good nor bad -- 4 bad --5 very bad

This process relies on the trust and commitment of the doctor/therapist and patient. Part of this process is being able to be a humble practitioner knowing that we are all human, and thus being able to meet our patient on this level of humility can be helpful to the healing process. A holistic approach to care can take place in any healing setting—the use of pharmaceutical agents or surgical procedures should not allow the doctor-patient relationship to be reduced to a series of clinical interactions that fail to take account of the human being in all of us. We need to remind ourselves that the healer is there to serve the patient, and understanding the powerful and subtle processes that take place in any healing interaction can greatly add value to any modern biomedical intervention. This is the true benefit of a holistic approach—that it is universal, crosses cultural boundaries, and can be part of any therapeutic intervention—a solid and honest therapeutic contract.

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Chapter XXVIII

Five dimensions of mental health and a model for holistic diagnoses and holistic treatment of mild, borderline and psychotic personality disorders

Let us start this chapter by asking a basic question: What is a mental disease? Well, it is about the mind not working as it should in some way. But what is causing that? While biomedicine will answer this question at least partly by referring to brain chemistry, holistic medicine takes a global approach and states that as the mind's primary function is survival, mental illnesses comes from survival adaptations in childhood. The patient managed to grow up in spite of a difficult childhood, so the survival strategy worked. But now the problem is that the reality for a grown up is very different than the reality of a small child. So all the adaptations that allowed for surviving the childhood circumstances are not a problem in adult life. We could call the adapted mind, with which the patient has identified himself, for the personality. Holistic philosophy frankly states that what is wrong is the personality. The personality is NOT the person; it's a collection of mental survival patterns. As soon as the patient realises this and lets go of identification, the personality loses its destructive power and the patient get well again.

Mental disorder comes from conditioning. Only by breaking the patterns of conditioning can a mentally ill person be truly healed. And this can only happen when he wakes up as himself from the deepest level of existence. From this perspective, even the person is an illusion.

Diagnostic systems exist on many levels of detail. In the last chapter, we saw a high-level analysis of a human being in ten major dimensions. Such a system is good for most purposes, and it is wise to measure all patients to document the progress of the clinics patients in general.

But for some purposes, a more detailed analysis is beneficial. Sometimes it will even be of value to make a very detailed analysis of the patient's physical, mental and spiritual character and purpose of life (essence, life mission), as we shall see later.

The treatment of the mentally ill patient often benefits from an analysis of the patient's level of sexual development, the patient's state of sexual energy, the patient's affective/emotional state, the patient's level of mental development, the patient's spiritual state and finally the patient's "state of heart" or I-Strength. All these things, and more, are part of the disturbed personality causing the trouble.

The reason why these five dimensions are especially important to monitor is that these dimensions often can be addressed and improved in holistic therapy, causing fast and major progress in the patient. Just helping the patients to grow and develop sexually often creates a major improvement.

When all these dimensions are improved, the mentally ill patients are often cured. In biomedicine, a cure of mental disorder is rare (estimated NNT=20-100); compared to this, it is surprisingly common in holistic medicine that the mentally ill patients are cured by a skilful therapist (estimated NNT=2-3).

Harold Searles cured, according to the statistics, one in three schizophrenic patients in this way, as mentioned earlier. It is extremely rare that biomedicine cures a schizophrenic patient if it ever happens. (If you have come to believe otherwise—in spite of clear statistics showing no improvement in mental state/mental health for schizophrenic patients in antipsychotic drugs, as we have thoroughly documented elsewhere in this book—please reflect on the commercial interests in the field…)

Today's categorical system of diagnosing personality disorders in ICD-10 and DSM-IV should in ICD-11 and DSM-V be substituted with a simpler, more comprehensive, five-dimensional model. The proposed model gives a tremendous simplification of today's diagnostic universe and empowers the psychiatrist and therapist with tools that facilitate an integrated holistic practice of understanding, diagnosing and healing the mental disorders in general. The five dimensions are based on the classical Hippocratic description of man: 1) body and sexuality, 2) consciousness and psyche, 3) feelings and emotions, 4) spirituality and ability to love and 5) an integrative function of the "I" often called "the heart."

We present seven easy-to-use rating scales of 1) Therapist's global impression of the patient (as normal, low self-esteem, low self-confidence, nymphomaniac, dependant, nervous/evasive, compulsive, labile, narcissistic, hysteric/histrionic, dyssocial/antisocial, paranoid, schizoid, autistic, dysphoric, hypomanic, depressive, manic, bipolar, schizo-affective, schizophrenic); 2) Level of sexual development (genital, immature oral/anal/clitoral, infantile autoerotic); 3) State of sexual energy (free or blocked); 4) Patient's affective/emotional state (vital, flat, blocked); 5) Level of mental development (mature, immature, instable, deluded, deluded-instable, disintegrated); 6) Spiritual state (whole, flat or split); and 7) "I-Strength" also called "state of heart" or "degree of development of integrative ability" (fair, intermediate, weak).

The seven rating scales make diagnosis and planning of the psychodynamic or holistic therapy easy and opens up for a constructive dialog about the goal of therapy with the patient. The five-dimensional diagnostic system has been clinically tested and seems to humanize psychiatry and improve treatment efficiency and compliance.

Introduction

There seems to be a general agreement that the categorical system of diagnosing the personality disorder used both in ICD-10 (1) and DSM-IV (2) is highly impractical and presumably even outdated (3,4). We need a much simpler and more logical system that integrates our understanding and knowledge of the mental disorders and empowers us as therapists to treat and cure the patients suffering from personality disorders. Especially problematic are the complex relations between personality disorders and genuine mental illnesses. From all we know, the mental diseases present themselves in a perfect continuum, which is only artificially made into categorical diagnoses, and this transformation of continuous phenomenons into categories is a severe hindrance to exploration, diagnostics and healing work. Especially the dialog with the patients has become much more difficult than it need to be, as patients most often show severe resistance against the diagnosis. The resistance often comes from an experience of stigmatization, as nobody likes to accept to be in a specific category of personality disorders. On the other hand, every patient will agree that his or her feelings, mind, sexuality, etc., are somewhat less that perfectly developed, and the degree can be satisfactorily negotiated during treatment. This dialog is extremely important in therapy, making the diagnosis of ICD-10 and DSM-IV highly contra productive and difficult to use in the clinic.

The personality disorders are traditionally placed between the completely mentally healthy state and the most psychotic mentally ill schizophrenic state. Historically, the personally disorders are collectively characterized by causing unproductive conflicts in the person's inner and outer life. When only the patient himself is tormented by the mental disorder, we often use the work "neurosis," i.e., "anxiety neurosis" but almost always anxiety will give the patient an evasive trait—paradoxically creating lots of conflicts around the patient as the entire patient's fears one by one materialize—turning the neurosis into a personality disorder. The concept of "neurosis" is, therefore, well substituted with the concept of personality disorders. All mental illnesses are rooted in psychological defence and, therefore, also based in personality disorders. The distinction between personality disorders and mental illnesses are, therefore, also totally artificial. Theoretically, there is no reason not to integrate the mental illnesses and the personality disorders, as we have done in our suggested five-dimensional model of personality disorders (see Table 1).

In the psychodynamic literature, there seems to be an agreement that the outer conflicts are a materialization of the person's inner conflicts, which are understood as internalized early external conflicts, often going all the way back to the earliest childhood and even the womb. The reason for the internalization is adaptation to the environment and parents to increase the holding and love, thereby optimizing the basic conditions for personal development and survival.

Traditionally, the personality disorders have been categorized as mild, borderline and psychotic, and we have developed a five-dimensional model that we suggest should enter the ICD-11 and DSM-V classification. We have tested the model in clinical practice and found that it allows successful healing work with both patients with personality disorders and with mental illnesses (5,6).

Holistic medicine and biomedicine in the treatment of personality disorders

Historically, the treatment of personality disorders like hysteria goes all the way back to Hippocrates and the Greek doctors who used massage of the uterus combined with conversational therapy to heal the sexual disturbances believed to be the primary cause of personality disturbances (7-9). Holistic medicine that combined conversational therapy with bodywork was the European medicine for more than 2,000 years, and Freud started himself as a holistic doctor giving massage to the hysterical patient's legs (10). Freud left bodywork and initiated the tradition of psychodynamic psychotherapy, but he struggled with the problem that contemporary culture was extremely negative towards physical touch and bodily intimacy, and he gained great fame from developing a style of therapy that left bodywork behind to focus on the talking; in spite of this, the psychosexual developmental problems of the patient were still seen as the primary course of personality disorders.

During the 20th century, psychiatry came up with neurobiological hypothesis for personality disorders, and the more severe mental problems were less treated with conversational therapy and more and more often treated with psychopharmacological drugs, often combined with ECT (electroconvulsive therapy).

It is difficult to compare the results from the three different ways to treat personality disorders, but it seems that Philippe Pinel (1745-1826) could cure 70% of his patients—presumably a mixture of schizophrenics and borderline patients—with his version of holistic medicine, the "traitement moral" that had a strong focus also on philosophical and somatic aspects of the patient around 1800 (11). Psychodynamic psychotherapy with conversational therapy alone could cure around 33% of the patients with personality disorders and schizophrenia from 1900 to 1970 (12-14), while psychopharmacological treatments only have helped a few percent of the patients with personality disorders since 1970 (1), and cured even less.

The reason for the use of psychopharmacological drugs in the treatment of the personality disorders (in spite of Cochrane's or other studies documenting clinically significant effect here) is simple: Firstly, the belief that mental disorders are caused by chemical disturbances in the brain makes this natural, and secondly an extremely large number of patients can be treated with a minimal of the physician's time. The sad fact is that the urbanization, modernization and the shift to a strong focus on natural science and biochemistry in medicine seems to take the healing power out of medicine.

To increase the rate of patients being cured, it seems that we are forced to take medicine back to its holistic roots; only if we work with therapy, and preferably the classical combination of bodywork and conversational therapy, can we really come back to the excellent results of the former era's holistic doctors. We have tested this idea in clinical practice and found that 57.4% of mentally ill patients seen at the Copenhagen Clinic can actually be cured (self-rated outcome in mental health) just in one year and with 20 hours of treatment (6) using the system of clinical holistic medicine (CHM) that our international research team has developed during the last two decades (15-28). CHM is easy to use and highly efficient, as we have documented this approach in a number of uncontrolled studies addressing a long serious of physical, mental, sexual and existential problems (6,29-32), and

the treatment plan comes quite naturally if the physician uses the five-dimensional, diagnostic system.

After a decade of treatment experiments and research into the process of holistic healing, we have come up with a theoretical framework that we have used to explain and map all major personality disorders (see Table 1) together with the mental diseases (33). We have learned that we are indeed capable of understanding and also curing many of the patients with these disorders and illnesses using the simple tools of clinical holistic medicine (28). Of course, one can disagree with the holistic description of man as consisting of body, mind, spirit and heart and with the idea of the sexual energy as the fundamental life energy of man. Without this perspective, the presented theory of personality disorders and the holistic cures will be of little value. On the other hand, one can argue that the fine results of the methods derived from this understanding can be taken as an empirical confirmation of the holistic theory of man.

The definition of personality

In holistic medicine, the personality is different from the being (34). The entity, or real person, is behind every appearance always intact and can be revitalized just by letting go of all the patient's many layers of existential learning and adaptation that we call personality. The personality is in this sense *neurotic and created for survival and adaptation* and very different from the person's character (35) and life mission (33,35-40) that are the person's real talents given already at conception intended for *living and growing*. So in this sense, a completely healthy person does not have a personality but is striving for self-realization to be able to create value in the world. A mentally healthy person can create conflicts, but these conflicts will always be about maximizing value and taking down hindrances for what is considered good by the individual. On the other hand, personality disorders will always lead to neurotic conflicts that will consume a lot of time and energy and only lead to modest results, if any. More often, the conflicts will be destructive to the individual in spite of the experience of the conflicts being necessary and for the good of all. A person with severe personality disturbances will always blame the surrounding world for the problems and conflicts, while a mentally healthy person will assume full responsibility for all conflicts.

Conflicts can be made actively and passively; the psychodynamic concept of "passive aggression" is often very well used in relation to personality disorders. Autism can be seen as the pure crystallization of passive aggression towards the parents; it can also be seen as a product of arrested psychosexual development around the foetal or infantile state called "infantile autoerotism" by Freud (41).

Holistic theory of personality disorders

Man is seen holistically as body, mind, spirit and heart with sexuality as a penetrating ubiquitous energy, which circulates in the whole energetic system of the person and connects all parts of it.

Table 1. The personality disorders (according to ICD-10 and DSM-v) and the mental illness can be seen as a simple product of the combination of psychosexual, emotional, mental, spiritual and integrative problems that often can be successfully addressed in holistic therapy (CHM). Most interestingly this analysis does not justify the traditional distinguishing between personality disorders and mental illnesses, and all mental disorders are seemingly curable in therapy (11-14, 42-44)

	ICD-10	DSM-IV	I-Strength (integrative ability, "heart")	Sexual development	Affective (emotional) state	Mental state	Spiritual state
Normal, healthy person	-	-	Strong	Genital, free	Vital	Mature	Whole
	Low self-esteem *	Low self-esteem *	Fair	Genital, free	Flat or blocked	Mature	Whole
	Low self-confidence *	Low self-confidence *	Fair	Genital, free	Vital	Immature	Whole
	Nympho-mania *	Nympho-mania *	Fair	Sexualised, often genital	Vital	Mature	Whole
Mild (neurotic)	Dependant	Dependent	Fair	Often immature, free	Vital	Often immature	Whole
	Nervous/ Evasive	Evasive	Fair	Often immature, free	Vital	Often immature	Whole
	Compulsive	Compul-sive	Fair	Often immature, often blocked	Often flat	Often immature	Whole
	Dysphoric *		Fair	Often immature, blocked	Flat	Often immature	Whole
	Hypomanic*		Fair	Often immature, free	Vital	Often immature	Whole
Borderline	Emotionally labile	Instable	Moderate or weak	Immature, free	Vital	Often immature	Whole
	-	Narcissistic	Moderate or weak	Infantile autoerotism, free	Vital	Often immature	Whole
	Histrionic (Hysteric)	Histrionic (Hysteric)	Often weak	Sexualised, often genital	Vital	Often immature, instable	Whole
	Dyssocial	Antisocial	Weak	Immature, sexualised or blocked	Often flat	Often immature	Flat
	Depressive **		Moderate	Immature, Blocked	Flat	Often immature	Flat
	Manic**		Moderate	Immature, often sexualised	Vital or flat	Often immature	Flat
Psychotic	Paranoid	Paranoid	Weak	Immature, blocked	Often flat or blocked	Immature, deluded	Flat

	ICD-10	DSM-IV	I-Strength	Sexual	Affective	Mental	Spiritual

			(integrative ability, "heart")	development	(emotional) state	state	state
	Schizoid	Schizoid	Weak	Immature or infantile autoerotism, blocked	Blocked	Immature	Split
	(Autistic*)	Schizotypi-cal	Weak	Infantile autoerotism, blocked	Blocked	Immature, deluded	Split
	Bipolar**		Weak	Immature, instable, blocked or sexualised	Vital or flat	Immature, deluded, instable	Split
	Schizo-affective **		Weak	Immature, blocked or sexualised	Vital or flat	Immature, Deluded	Split
Schizo-phrenia *	Schizo-phrenia**		Weak	Infantile Autoerotism, blocked	Blocked	Immature, deluded, dis-integrated	Split

*) Not considered a personality disorder in ICD-10 and DSM-IV.
**) Mental illnesses according to ICD-10 and DSM-IV.

The mild personality disorders (the dependent, the nervous, the narcissistic and the labile) are characterized by an open heart and whole and functionally intact spirit, often a normal emotional life, but a somewhat immature mind and sexuality. The borderline, or intermediate, personality disorders (the compulsive, the hysteric (histrionic), the anti-social (psychopathic), the depressive, the manic, and the schizotypical) are characterized by a blocked heart making connections to people very difficult; often a "flat" spirit, flat or labile emotions, a somewhat immature mind, and often a blocked sexuality.

The psychotic personality disorders (the autistic, the bipolar, the paranoid, and the schizoid) are characterized by a blocked heart making connections to people very difficult; a split spirit, flat, a immature and deluded mind with often a completely blocked, little developed sexuality. The schizophrenic patient is at the extreme end of the spectrum with infantile auto-erotism and no objects-related sexuality, split spirit, often highly underdeveloped, strongly deluded mind, and most often complete, emotional flatness.

In principle, body and sexuality must be rehabilitated first, then emotions and mind, and finally spirit and heart. In practice, the course of therapy is always strongly dependent on the patient and the holistic therapist need to invent a new cure for every new patient. Table 1 shows the system of personality disorders and the underlying sexual, mental, spiritual and integrative (I/heart) problems that must be addressed in therapy to cure the patient.

Five dimensions of mental health

1. Sexuality

Sexuality has been known to play a central role in personality disorders all the way back to Hippocrates and the Greek physicians, and this perspective has been kept in today's

psychoanalysis, psychodynamic psychotherapy and holistic medicine from Hippocrates to Freud, Jung, Reich, Searles and many other grand therapists (13,34,41,45,46). Sexuality lies at the core of human existence, and the level of psychosexual development and the free or blocked flow of sexual energy is easily observed in clinical practice from the level of libido, sexual aggression, will to live and level of life energy. The development goes from object-less, infantile autoerotism through immature sexuality to the mature, genital sexuality needed for mutually satisfying, sexual intercourse. Freud described the immature sexuality as oral or anal. It has in the literature of erotic tantra been suggested that immature female sexuality can be seen as "clitoral" opposed to mature, vaginal sexuality (47). Sexuality (the sexual energy) can be free, blocked or sexualized. Sexualized energy is neurotically boosted; compare this with the classical diagnosis of "nymphomania," which is neurotically boosted sexuality in an otherwise normal patient (nymphomania is, therefore, included in Table 1 as a normal condition and not a disorder).

Many hysteric patients are strongly sexualized and have an obvious nymphomaniac trait. Promiscuous behaviour is sometimes the behavioural derivate of sexualisation also in normal people, but this is not a mental disorder as we see it. This problem and many other related sexual problems like vulvodynia belong to the field of sexology in spite of obvious presence of personality disorders in these patients.

Eating disorders are often more strongly related to sexual than to mental problems and should, therefore, also be treated under the specialty of sexology. In the future, psychiatry and sexology might also be integrated into a more holistic model; as physical health is also strongly related to mental and sexual problems, we must always remember that body and mind cannot truly be separated in medicine. A few minutes talk about sexuality will reveal the patient's level of psychosexual developmental status; often just the way the patient dresses and contacts you will let you know.

2. Affect/emotions

The emotional state of a human being goes from vital and healthy to flat and further to completely blocked. A person can contain a whole palette or rainbow of emotions, every moment being like a colourful painting; or emotional life can be flat and simplistic, one single emotion at a time, and no symphony of tones, no profoundness and mystery; or emotional life can be completely blocked. The palette can be dominated by dark colours in depression, or light colours in mania, and the whole palette can be changing unpredictably as in cyclothymia and emotional lability. The emotional status of the patient is easily experienced in personal contact.

3. Mind

The mind can be immature or maturely developed; it can contain complex concepts and fine language for describing the world or intelligent and creative processes to model the surrounding world and meet the multiple challenges from inside and outside. It can be a sharp, precise, stable, and useful tool, a reliable source of information and true resource for problem solving. When mind is immature, its description of the world can be instable,

deluded, an unreliable source of information, or even a severe burden insisting compulsively on the patient doing or thinking specific thoughts or actions, and in the psychotic patient deluded thoughts and ideas can lead to highly destructive acts. In the most undeveloped and disturbed form, the conception is confused and disintegrated. An hour of conversation will allow the therapist to estimate the level of development of patient's mind.

4. Spirit

In this important, but abstract, dimension of man lies our ability to love and give unconditionally. If wholeness or the concept of soul is denied in the patient's personal philosophy, the ability to love unconditionally is often destroyed. The spiritual dimension also holds our mission of life, i.e., our core talents that we need for being of true value in our social relationships. The spiritual dimension can be whole and vital, flat and reduced, or split in two or more parts, giving the most severe personality disorders. The split spirit is a well-known defence mechanism. Splitting is our normal reaction to traumas early in life, when the mind is still too immature to cope. In holistic therapy, we often find these traumas under deep regression to the womb, where they can be healed (25-27,34,48,49).

The clinical assessment of this is quite difficult. A split spirit should not be mistaken for the phenomenon of multiple personalities that we all, sound as sick, contain as a condition for normal mental functioning; normally our multitude of "personalities" are not visible due to a high level of integration. But split spirit often materializes though the phenomenon of inner conflicts between the inner personalities, and the extreme example of this has given the name to the illness schizophrenia, meaning "split spirit" in Greek. Another manifestation of the split defence is ambivalence, which in marriage can be seen as a strong tendency to adultery, in work seen as a strong tendency to change work places, in friendship seen as a high rhythm of meeting and sacking friends.

Diagnosing the patient's spirit is the most difficult part of the diagnosing process. To master diagnoses and holistic therapy with patients with split-spirit problems, the therapist needs to go through deep and regressive therapy himself, allowing for deep self-exploration into the spiritual domain. But even the inexperienced student will soon learn to identify ambivalence and strong inner conflicts in the patient coming from the obvious split defence.

5. Heart

The experience of an integrated "I" is a function of a complex integrative function developed though childhood and adolescence (34,41). We often call this function the "human heart." The heart integrates body, mind and spirit, or more accurately the patient's Id, Ego and Self (soul). The function of the heart makes it possible for us to meet another person as a subject (Though) and not an object ("it") (50). If a person becomes emotionally wounded, the heart can be temporarily "broken" or more permanently blocked (a "closed heart"), and relating becomes difficult. This influences the whole experience and appearance of the person. Psychiatry has often understood the concept of I-Strength as a mental quality, while holistic medicine traditionally has seen is as an existential quality. Holistic medicine is aligned with the more common understanding of the heath; people who "have a heart" or "an open heart"

are able to meet the world and other people in an open-minded, assertive, empathic, accepting, involved, respectful, interested and loving way. The status of the heart is thus easily observed in clinical practice.

Diagnosis in the five-dimensional system

The power of the five-dimensional system lies in its practicality in daily work. To use the system, we always start with an interview about the patient's status in the five dimensions; the therapist's global impression grows organically out of this dynamic interaction. After rating this general global impression and also the five dimensions, the diagnosis is easily found using Table 1. It is strongly recommended also to use a patient-rated questionnaire like QOL1, QOL 5 or QOL10 (51) and compare the two ratings to secure a reasonable concordance between the two sets of ratings. If the ratings differ much, the reason for the discrepancy must be thoroughly analyzed (52). In general, holistic therapy will not run smoothly without a fundamental agreement between the therapist and the patient about what the patient's problem is and what the solution and goal of the therapy is.

Schizophrenia is recognized as the lower extreme of all five dimensions combined. In a non-categorical system as the one presented, there are no qualitative characteristics that make it possible to identify the "schizophrenic patient" per se (like hearing voices). Schizophrenia is a state characterized by extreme lack of personal development of body, mind, spirit, sexuality and heart. Because of this perspective, schizophrenia can be treated as well as the other mental diseases.

Therapist-rated questionnaire for diagnosing the personality disorders and mental illnesses (The holistic five-dimensional system suggested for ICD-11 and DSM-V)

Q1: Therapist's global impression:
Normal (no significant personality disorder or mental illness)
Normal, low self-esteem
Normal, low self-confidence
Normal, nymphomaniac
Dependant
Nervous/evasive (including anxiety)
Compulsive
Dysphoric
Hypomanic
Labile
Narcissistic
Hysteric (Histrionic)
Dyssocial/Antisocial
Depressive
Manic
Paranoid
Schizoid
Autistic
Bipolar
Schizo-affective

Schizophrenic
Other, mild personality disorder
Other, borderline personality disorder
Other, psychotic personality disorder
Other, psychotic mental illness
Q2: How I-strong is the patient (heart open/closed)?
Strong ("open heart")
Fair
Moderate ("broken heart")
Weak ("closed heart")
Q3: How developed is the patient's sexuality?
Genital (mature)
Autoerotism (immature clitoral/oral/anal)
Infantile autoerotism (no object)
Q4: How blocked or sexualized is patient's sexual energy?
Free
Sexualized
Blocked
Q5: How vital are the patient's emotions?
Vital
Flat
Blocked
Q6: How developed is the patient's mind?
Mature
Immature
Immature, instable
Deluded
Deluded, instable
Deluded, disintegrated
Q7: How whole is the patient's spirit?
Whole
Flat (remote)
Split

Principles of holistic therapy

The key to helping the patient to heal his or her life and existence (salutogenesis) (53,54)) lies in truly meeting and understanding the patient (55). The traditional psychodynamic style of therapy is patient conversations allowing the patient to explore and understand himself, and this method is highly efficient (34,42-44,48,49), and with most mental disorders more efficient than psychiatric treatments as usual (42-44). The holistic style of therapy is much more intensive with physical holding and direct processing of old traumas in spontaneous regression.

Psychodynamic psychotherapy works much with transferences, reflection on the therapist-patent relation being the primary tool. Holistic medicine uses both conversation and bodywork to allow the patients to work more directly with the healing of early traumas. Interestingly, Freud did this in the beginning of his career (10), but presumably for political

reasons living in a sex-and-body-negative culture he later abandoned bodywork. We have argued that the price Freud paid for psychoanalysis to be accepted in contemporary society was the effect of therapy, where holistic medicine seems to do in only 20 sessions (56) what often takes 1,000 hours of classical psychoanalysis (13).

Holistic therapy is basically re-parenting, where the therapist gives the patient the love, support and holding the parents were unable to give with the intent of healing the old traumas and integrating all the different feelings often related to body and sexuality. This allows the arrested psychosexual development to continue into the mature state. Sexuality almost always plays a central role in personality disorder (see Table 1). The intimate love and care from the holistic therapist and assistants allows the patient to return to early childhood or even into the womb foetal state and reconnect to the emotional and sexual energies often left behind. Regression to the early stages of life is often experienced as extremely sexual in regressive therapy, and the successful revitalization of the sexuality seems to be a condition for complete healing of a personality disorder.

The mind and the patient's philosophy of life and ability to think and analyze must also be rehabilitated. This is often done though reading and philosophical exercises, careful writing of patient's biography and artwork (25-27). The spiritual dimension of the patient's life is most simply seen as ability to love and use core talents to be of value to self and others (33-40).

When the patient regains ability to unconditional love, most of the personality disorder is often cured. This happens in the traditional Hippocratic holistic medicine, when the patient recovers his true physical, mental and spiritual character. This kind of medicine has, therefore, also been called for "character medicine" (45,57).

What we call "the heart" is as mentioned above really the abstract, integrative function of the human consciousness that allows us to connect to other people as a wholeness presenting body, mind and spirit at the same time, in a delicate balance. It is quite clear that a profound understanding of one's self and also holistic theory and philosophy are preconditions for efficient treatment of patients with mental illnesses. Love and generosity are always the primary tools in therapy. Often, the therapist's ability to love and care is challenged by the cold-hearted, mentally undeveloped and sexually unappealing patients presenting the personality disorders.

It is important to contain all these often-repelling characteristics of the mentally disturbed patient and to see all these unappealing aspects of the person as sides of the disease to be worked upon and healed in the end. A list of the many tools that can be used in holistic therapy can be found in (28).

Discussion

Psychodynamic psychotherapy has a long tradition (41-44), and in our experience it is not difficult to use this intervention form to cure or heal the personality disorder in therapy. A therapist that understands the basic principle of healing can cure mental illnesses (49). A skilled therapist like Searles cured 33% of even the most severely ill schizophrenic patients, even after years of hospitalization with 900 hours of psychoanalysis (13); in our study, we found that 57% of the mentally ill patients experienced to be cured with clinical holistic

medicine (6). In our experience, it is important to work with a broad variety of patients, also including the most ill patients, for the therapist to fully understand the basic constitution of the personality and the problems connected to it. Only in the most severely ill patients does the whole structure of man become transparent and visible. When you can cure schizophrenia, everything else becomes easy.

Working with the patient's sexuality is normally the biggest problem for the modern physician, because of the strong sexual taboo of society. We must stress that this is an absolutely necessary step in helping most patients with severe personality disorders and not only a thing that should be cared about when rehabilitating the patient with explicit sexual traumas. It is also important to remember that one girl in seven is still being sexually abused, and these girls very often become the adult patients that seek therapy for personality disorders and mental problems.

The therapist needs to be without prejudice and be generous, caring and containing on order to help patients re-integrate their ability to feel sexual interest, desire and arousal. Often, the patents need to verbalize many sexual issues that normal people would never care to verbalize, i.e., their experience of the bodily reactions or orgasm. Most therapists feel quite awkward and embarrassed in the beginning working explicitly with patent sexuality, but it is really worth getting past this point, because it gives the patient motivation and energy to raise the mind. The use of therapeutic touch is paradoxically reducing the need of verbalizing and is also dramatically reducing the intensity of sexual transferences, but they will never completely disappear, making supervision and Balint Group work mandatory for holistic therapists. Written consent is mandatory, and the medical record must contain detailed records of all procedures and emotionally charged wordings.

If patient-physician "chemistry" is bad with little love and affection, it is wise to allow the patient to change therapists. If the relation is healing up, this is a sign of the patient's sexuality healing; in this case, it is wise not to abruptly end therapy, as it can set the patient seriously back. Of course, the therapist is responsible for keeping the sexual boundaries and respecting the ethical rules of holistic therapy. We recommend the rules of the International Society for Holistic Health (see www.internationalsocietyforholistichealth.org).

To obtain fast results in the therapy, it is paradoxically important to allow the patient to develop slowly out of a psychotic state or a psychotic crisis. Therefore, we recommend as a general rule that anti-psychotic and sedative drugs are not used in holistic psychiatry. It is much better to process the patient in his or her psychosis than to bring them fast and violently down to normal consciousness with drugs. It is difficult in the beginning to meet psychotic people and work with them in therapy; surprisingly, bodywork and therapeutic touch are often much more efficient in this phase than psychotherapy and words. In general, all shifts of mind and understanding must happen slowly and gradually. The patients must be allowed to grow very much as grass, trees or flower grow in the garden. "The grass grows by itself" is an old saying that is relevant here.

Conclusion

ICD-10 and DSM-IV are, in our opinion, not well suited for diagnosing the personality disorders or the mental illnesses in general for that sake. We suggest the categorical diagnosis

substituted with a five-dimensional holistic system that allows for a simple analysis and thus a clear understanding of the different personality disorders (including the mental disorders of the affective and schizophrenic spectres). Our analysis links the personality disorder close to the traditional mental illnesses, and the system allows for a simple and efficient treatment plan: healing the mentally ill patient along the five axes, independent of what mental illness the patients would have in the ICD-10 or DSM-IV systems. This basically means that all mentally ill patients can be treated with holistic non-pharmaceutical medicine. It also means that the classical mental diagnoses are not needed in holistic psychiatry. It might very well be that they are actually therapeutically counterproductive as they make patients think badly about themselves. Therapy should in general avoid inducing negative philosophy.

The relational and psychosexual developmental problems seem to be at the core of every personality disorder, and only by healing the patient's sexuality, mind and spirit can health in the end be healed. The strength of this integrative dimension is what determines the functional capability of the patient and thus the severity of the personality disorder.

We recommend that the dimensions of emotion and sexuality are addressed first in the therapy, as the more profound problems of mind, spirit and heart crystallize well during the process of emotional and sexual healing (23,47). Only when the patient's sexuality, mind, and spirit are all healed can the integrative function known as the patients "I-strength" or "heart" be recovered. The "I-strength" is still in our model the central characteristic and determines the severity of the personality disorder, but we add a focus on the development of sexuality, mind, and spirit that has been somewhat neglected by modern biomedical psychiatry.

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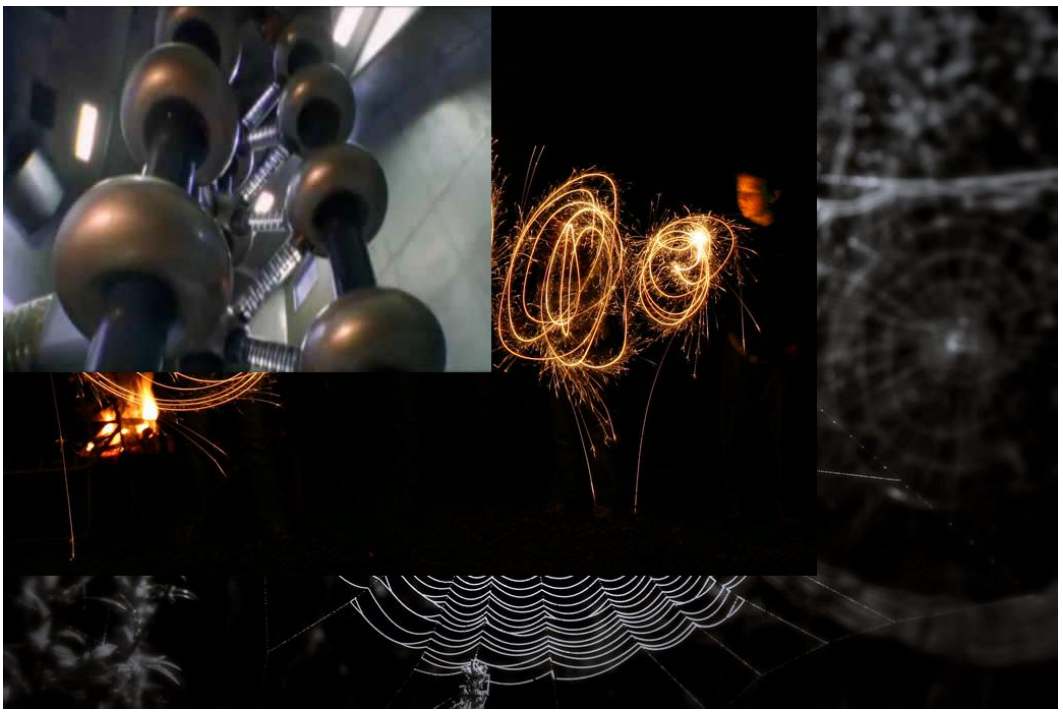
Exercises

1. Find another student, and rate each other and yourself in the five dimensions. Find your position in Table 1. What will you do to improve and develop as a person? How can you help you student friend to heal?
2. If you trust in each other, you can agree of meeting ten times within three months to help each other grow and heal. Use the tools for holistic medicine to help each other. Remember that you can only help a person you love.

3. If you get problems in the process of healing your friend, find a professional therapist to supervise you. Don't give up. Your first patient will always be the most difficult.
4. Watch your thinking until you can see how the thoughts come and go. Realise that they come from conditioning, that they are often not true, and that you have a choice to believe in them or not. Mental illness is when you believe in thoughts that are not true.

Section 3. Acknowledgments



Chapter XXIX

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 ongoing 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. From 2006 to 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.

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Chapter XXX

International review board

This book is written by Søren Ventegodt and Joav Merrick and is the result of more than ten years of work together but also an international collaboration with a group of very special people with whom we have published many papers. 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 endeavor.

Andersen, Niels Jørgen
Andreasen, Tove
Anyanwu, Ebere C (deceased)
Bassaine, Laila
Brom, Bernard
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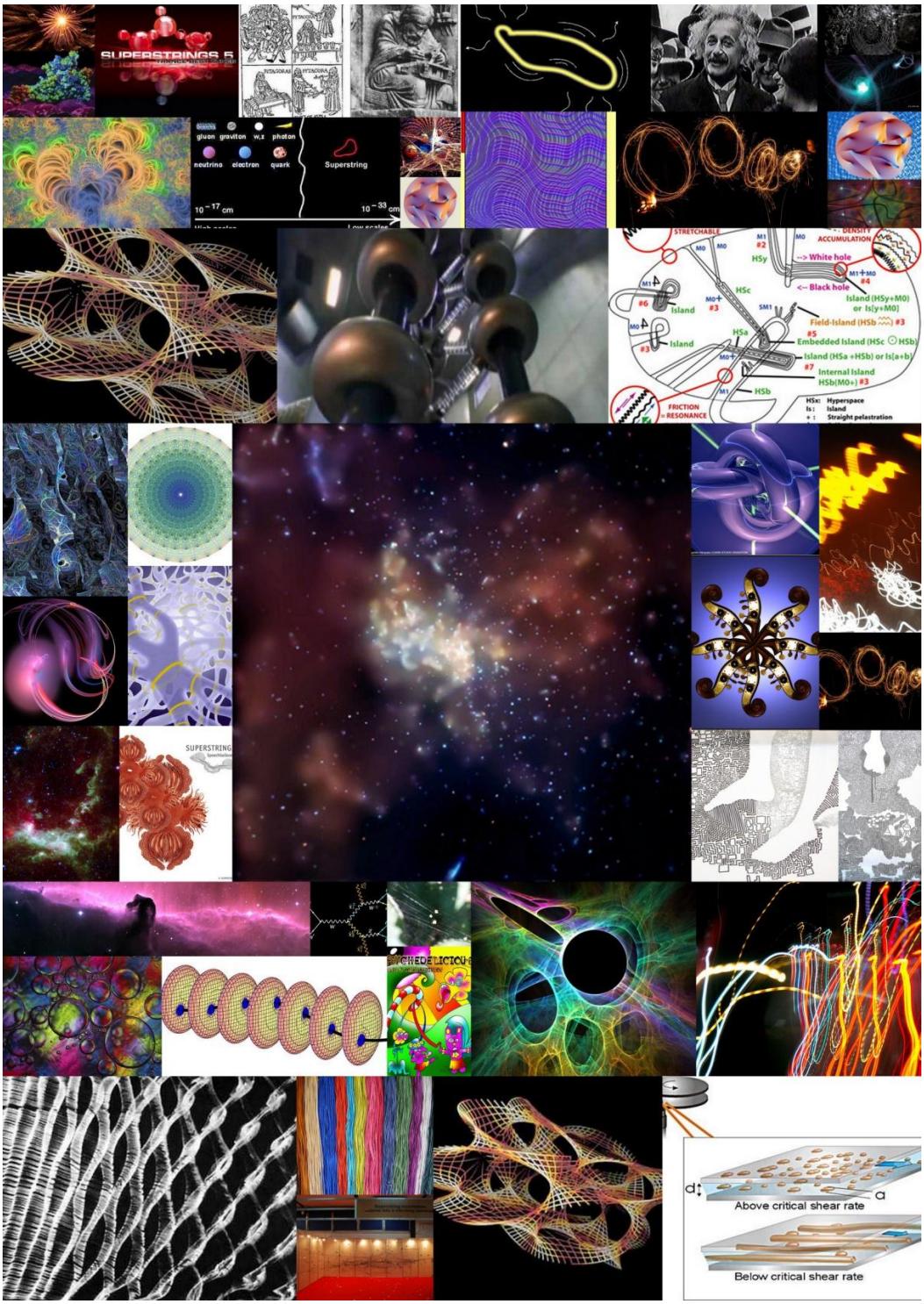

Chapter XXXI

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 a 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 gynecologist 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, 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 center's research on the quality of life has 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 was a 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, microorganisms, 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 as 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 connections among 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 n approach that focuses solely on the factors that are traditionally seen to reflect an unhealthy lifestyle.

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 ten 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 broad 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 ten years, the difficult task of integrating biomedicine 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 biomedicine (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 biomedical 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.

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Chapter XXXII

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

The National Institute of Child Health and Human Development (NICHD) in Israel was established in 1998, as a virtual institute under the auspicies 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, there were 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 disabilities 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.

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Section 4. Index

Index

B

C

D

E

F

G

H

I

J

K

L

M

N

O

P

Q

R

S

T

U

V

W

Y

Z