



White House Commission on Complementary and Alternative Medicine Policy

Fact Sheet Complementary and Alternative Medicine

Complementary and Alternative Medicine (CAM) practices and products covers a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions.

People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a "complementary" or an integrative approach.

Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.

CAM's Growing Popularity in the United States

A published survey shows that the number of Americans using an alternative therapy rose from about 33 percent in 1990 to more than 42 percent in 1997.¹ People in this study reported using the following therapies most often: herbal medicine, massage, megavitamins, self-help groups, folk remedies, energy healing, and homeopathy.

In addition, Americans spent more than \$27 billion on these therapies in 1997, exceeding out-of-pocket spending for all U.S. hospitalizations.

A survey published in 1994 reveals that more than 60 percent of doctors from a wide range of specialties recommended alternative therapies to their patients at least once. In addition, 47 percent of the doctors in this study reported using alternative therapies themselves.²

Indeed, 75 out of 117 U.S. medical schools offered elective courses in CAM or included CAM topics in required courses, according to an article published in 1998.³

Another survey found that people used CAM not only because they were dissatisfied with conventional medicine, but because these health care alternatives mirrored their own values, beliefs, and philosophical orientations toward health and life.⁴

Health care professionals and the public need policies to help coordinate and stimulate rigorous research of CAM practices and products, as well as the access and delivery of such services, education and training of practitioners and the provision of evidence-based information to the public.

¹ Eisenberg, D.M., Davis, R.B., Ettner, S.L., Appel, S., Wilkey, S., Van Rompay, M., Kessler, R.C. "Trends in Alternative Medicine Use in the United States, 1990-1997. Results of a Follow-Up National Survey." *JAMA*. November 11, 1998. 280(18):1569-75.

² Borkan, J., Neher, J.O., Anson, O., Smoker, B. "Referrals for Alternative Therapies." *Journal of Family Practice*. 1994. 39(6):545-50

³ Wetzel, M.S., Eisenberg, D.M., Kaptchuk, T.J. "Courses Involving Complementary and Alternative Medicine at U.S. Medical Schools." *JAMA*. September 2, 1998. 280(9):784-7.

⁴ Astin, J.A. "Why Patients Use Alternative Medicine. Results of a National Study." *JAMA*. May 20, 1998. 279(19):1548-53.



White House Commission on Complementary and Alternative Medicine Policy

Fact Sheet White House Commission on Complementary and Alternative Medicine Policy

The White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) was established by Executive Order 13147 on March 7, 2000, to develop a set of legislative and administrative policy recommendations that will maximize the benefits of complementary and alternative medicine (CAM) practices and products for the general public. The Commission has been charged to submit a report to the President and Congress by March 2002.

The President's executive order outlined four broad topic areas for consideration by the Commission:

- (1) coordinated research to increase knowledge about CAM practices and products;
- (2) the provision to health care professionals of reliable and useful information about CAM that can be made readily accessible and understandable to the general public;
- (3) guidance for appropriate access to and delivery of CAM; and
- (4) the education and training of health care practitioners in CAM.

On July 13-14, 2000, 14 Commissioners were appointed by the President, representing a diverse range of expertise in medical, scientific and CAM fields. The 14 commissioners include the Chair, James S. Gordon, M.D., and George M. Bernier, Jr., M.D.; Thomas M. Chappell; Effie Poy Yew Chow, Ph.D.; George Thomas DeVries, III; William R. Fair, M.D.; Joseph J. Fins, M.D.; Wayne B. Jonas, M.D.; Charlotte Rose Kerr, R.S.M.; Dean Ornish, M.D.; Conchita M. Paz, M.D.; Buford L. Rolin; and Julia Scott. Eventually, the Commission will comprise a total of 20 members.

In response to its mandate, the Commission will focus on one or more of the four major topic areas during each of its full group meetings. A planning meeting was held on July 13-14th; the next meeting, focusing on Coordinated CAM Research, is scheduled for October 5-6th. All meetings are open to the public and will be held in Washington, D.C.

To maximize the opportunity to receive public input, the Commission will hold a series of Town Hall Meetings throughout the country over the next several months. The first two already are scheduled: September 8th in San Francisco, California, and October 30-31st in Seattle, Washington. Additionally, the public will be invited to present comments during Commission meetings held in Washington, D.C. throughout the coming year. Written comments may be sent electronically, by fax or mail to the addresses below.

Contacting WHCCAMP:

Stephen C. Groft, Pharm.D.
Executive Director
OR

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Executive Secretary

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White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
September 8, 2000, San Francisco, CA

ROSTER & ORDER OF SPEAKERS

1. **MARILYN SCHLITZ, PHD**
Institute for Noetic Sciences & CA Pacific Medical Center
San Francisco, CA
2. **BEVERLY RUBIK, PHD BIOPHYSICS**
Institute for Frontier Science
Oakland, CA
3. **CATHERINE DOWER, JD**
UCSF Center for Health Professions
San Francisco, CA
4. **MAY LOO, MD**
Stanford Medical Center
San Jose, CA
5. **DEBORAH KESTEN, MPH**
CA Pacific Medical Center
San Francisco, CA
6. **CORINNE GIANONIO, PHD**
Kaiser Permanente
Gold River, CA
7. **SAVELY SAVVA**
Monterey Institute for the Study of Alternative Healing
Carmel, CA

8. ADAM BURKE, PHD, MPH, LAC
San Francisco State University/IHHS
San Francisco, CA
9. DANA ULLMAN, MPH
Homeopathic Education Services
Berkeley, CA
10. CRAIG LITTLE, DC
American Chiropractic Association
Arlington, VA
11. MILLIE TSENG, BSN
Santa Clara County Employee Wellness
San Jose, CA
12. LIXIN HUANG
American College of Traditional Chinese Medicine
San Francisco, CA
13. BRUCE SHELTON, MD, MDH, DIHOM
AZ Board of Homeopathic Medical Examiners
Phoenix, AZ
14. KENNETH SANCIER
Qigong Institute
Menlo Park, CA
15. PEG JORDAN, RN, PHD (candidate)
Integrative Health Circles
Oakland, CA
16. MICHAEL MAYER, PHD
The Bodymind Healing Center
Berkeley, CA
17. LYNN MURPHY
Feingold Association of the US
San Jose, CA
18. KAREN SCOTT
Progress in Medicine
San Jose, CA

19. **STEPHEN BENT, MD**
OSHER Center for Integrative Medicine, University of CA
San Francisco, CA
20. **BRADLEY JACOBS, MD, MPH**
UCSF OSHER Center for Integrative Medicine, University of CA
San Francisco, CA
21. **SITA ANANTH, MPH**
Health Forum/American Hospital Association
San Francisco, CA
22. **JAN DEDERICK, BA, DC, CSI**
East Bay Shen Center
El Cerrito, CA
23. **BRIAN FENNEN, LAC, OBT, QME**
Council of Acupuncturists & Oriental Medicine
Calistoga, CA
24. **CAROL CERESA, MHSL, RD**
California Dietetic Association
San Rafael, CA
25. **ANNE KOLKER, MS (Nutritional Science)**
SFVA
San Francisco, CA
26. **ANDREA GAREN, BS (Dietetics)**
California Dietetic Association
San Rafael, CA

12:00 p.m. – 12:45 p.m. ❖ OPEN SESSION ❖

12:45 p.m. – 1:45 p.m. ❖ LUNCH BREAK ❖

1:45 p.m. ❖ AFTERNOON SESSION ❖

27. **VENY ZAMORA**
Administration on Aging
San Francisco, CA
28. **CYNTHIA COPPLE, BS, CMP**
Lotus Holistic Health
Capitola, CA
29. **ALEX FENG, PHD, OMD, LAC**
UCC AOM
Berkeley, CA
30. **RICHARD PAVEK**
Shen Therapy Institute
Sausalito, CA
31. **NICOLA HENRIQUES**
Institute of Classical Homeopathy
St Helena, CA
32. **ADRIAN LOWE, GRANDMASTER**
Lamas Qigong Association
Worksop Nottinghamshire, UK
33. **GEORGE WEDEMEYER**
National Council of Field Labor
San Francisco, CA
34. **MICHAEL TRAUB, ND**
American Association of Naturopathic Physicians
Kailua Kona, HI
35. **JAY AZAROW, MD**
Stanford University School of Medicine
Stanford, CA
36. **ANTONIO MARTINEZ, JD**
American Specialty Health, Inc.
Washington, DC
37. **DEANE HILLSMAN, MD**
Union of American Physicians & Dentists
Sacramento, CA

38. SALLY LAMONT, ND, L.Ac.
CA Association of Naturopathic Physicians
San Rafael, CA
39. EVELYN LEE, EDD, LSCW
Richmond Area Multi-services
San Francisco, CA
40. JENNIFER BOLEN, BA
JURIMED
Novato, CA
41. RICHARD HANSEN, DMD
Advanced Health Research Institute
Fullerton, CA
42. RICKI POLLYCOBE, MD
CA Pacific Medical Center
San Francisco, CA
43. ROY UPTON
American Herbal Pharmacopoeia
Santa Cruz, CA
44. JAMES UNDERDOWN, BA
Center for Inquiry - West
Los Angeles, CA
45. MARC HALPERN, DC
California College of Ayurveda
Grass Valley, CA
46. CARLA WILSON, L.Ac.
Quan Yin Healing Arts Center
San Francisco, CA
47. HOWARD MOFFET, MPH
American College of Traditional Chinese Medicine
San Francisco, CA
48. PERFECTO MUNOZ, MA, PHD
Health Plan of San Joaquin
Stockton, CA

49. LEN SAPUTO, MD
Health Medicine Forum
Walnut Creek, CA
50. BURTON GOLDBERG
Alternative Medicine.com
51. KAREN EHRLICH, CPM, LM
CA Association of Midwives
Santa Cruz, CA

5:00 p.m. – 6:00 p.m. ❖ OPEN SESSION ❖

6:00 p.m. ❖ CLOSING ❖

• ANNOUNCEMENT •



White House Commission on Complementary and Alternative Medicine Policy Town Hall Meeting September 8, 2000 in San Francisco, CA

The White House Commission on Complementary and Alternative Medicine Policy is sponsoring a town meeting on complementary and alternative medicine (CAM) practices and products. Members of the community are invited to present comments and suggestions to the Commission about the coordination of CAM research, information dissemination, access to and delivery of CAM practices and products, and training and education of CAM practitioners and other health care providers.

NOTE: The event is free and space is limited on a first come, first serve basis. **Registration to speak must be received by September 1st, 2000.**

COMMISSIONERS:

James Gordon, Chair of the White House Commission on Complementary and Alternative Medicine Policy, and Director of the Center for Mind-Body Medicine in Washington, D.C.

Effie Poy Yew Chow, Qigong Grandmaster, founder of the East West Academy of Healing Arts in San Francisco in 1973 and, more recently, The EWHA Qigong Institute, the American Qigong Association, and the World Qigong Federation.

Wayne Jonas, former director of the Office of Alternative Medicine at the National Institutes of Health; he also served as Director of the World Health Organization Collaborating Center for Traditional Medicine.

Dean Ornish, founder, president, and director of the non-profit Preventive Medicine Research Institute and founder of the Osher Center for Integrative Medicine; he was the first to prove that heart disease is reversible by changing diet and lifestyle.

WHEN AND WHERE:

Friday, September 8, 8:30 a.m. – 6:00 p.m. at the
Holiday Inn Golden Gateway, Emerald Ballroom
1500 Van Ness Boulevard
San Francisco, CA (415-441-4000)

HOW TO REGISTER: (DEADLINE IS SEPTEMBER 1st!)

Call 1-800-953-3298 or register on-line at <https://safe2.sba.com/whccamp/index.cfm>. To contact the Commission, e-mail us at whccamp@nih.gov or call 301-435-7592.



White House Commission on Complementary and Alternative Medicine Policy

An Open Letter of Welcome

We are pleased to welcome you to the first Town Hall Meeting of the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP). The Commission, established by Executive Order on March 7, 2000, has been charged to submit a report to the President and Congress by March 2002, providing policy recommendations to help guide the nation's use of complementary and alternative medicine (CAM) practices and interventions.

We are glad you are here today. Your participation in this important process is critical.

The President's Executive Order outlined four broad topic areas for consideration by the Commission: (1) coordinated research to increase knowledge about CAM practices and products; (2) the provision to health care professionals of reliable and useful information about CAM that can be made readily accessible and understandable to the general public; (3) guidance for appropriate access to and delivery of CAM; and (4) the education and training of health care practitioners in CAM. A copy of Executive Order 13147 is included in this information packet.

To maximize the opportunity to receive public input, the Commission will hold a series of Town Hall Meetings throughout the country over the next several months. A proposed schedule is included in this information packet. Although the sites and dates of the Town Hall Meetings may change, there will be ample opportunity for interested individuals throughout the country to provide their input. Additionally, the public will be invited to present comments during Commission meetings held in Washington, D.C. throughout the coming year. The next Commission meeting is scheduled for October 5-6th.

Because of the diversity and scope of issues related to CAM practices and products, we have developed a list of questions to help guide and focus discussion. We encourage you to review these questions and use them when you prepare your oral or written statements. A copy of these questions are included in your packet as part of the "Federal Register Notice" for this meeting.

Registration has now begun for the next Commission Town Hall Meeting in Seattle, Washington on October 30-31. An announcement of the meeting is included in this information packet, and may be copied and distributed freely. To attend the Town Hall Meeting in Seattle, please register no later than October 23. You may call 1-800-953-3298 or use our on-line registration web-page, <https://safe2.sba.com/whccamp/index.cfm>, to register to attend. If you have general questions, or need to contact us, please call Ms. Michele Chang, at 301-435-7592, or send us an e-mail at WHCCAMP@od.nih.gov.

We invite you to inform others about our work and hope that you will encourage your colleagues and constituents to participate in this critical process, particularly by attending our Town Hall Meetings.

James S. Gordon, M.D.
Chair

Stephen C. Graft, Pharm.D.
Executive Director

THE WHITE HOUSE
Office of the Press Secretary

For Immediate Release

March 8, 2000

EXECUTIVE ORDER 13147

WHITE HOUSE COMMISSION ON COMPLEMENTARY
AND ALTERNATIVE MEDICINE POLICY

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App.), and in order to establish the White House Commission on Complementary and Alternative Medicine Policy, it is hereby ordered as follows:

Section 1. Establishment. There is established in the Department of Health and Human Services (Department) the White House Commission on Complementary and Alternative Medicine Policy (Commission). The Commission shall be composed of not more than 15 members appointed by the President from knowledgeable representatives in health care practice and complementary and alternative medicine. The President shall designate a Chair from among the members of the Commission. The Secretary of Health and Human Services (Secretary) shall appoint an Executive Director for the Commission.

Sec. 2. Functions. The Commission shall provide a report, through the Secretary, to the President on legislative and administrative recommendations for assuring that public policy maximizes the benefits to Americans of complementary and alternative medicine. The recommendations shall address the following:

- (a) the education and training of health care practitioners in complementary and alternative medicine;
- (b) coordinated research to increase knowledge about complementary and alternative medicine practices and products;
- (c) the provision to health care professionals of reliable and useful information about complementary and alternative medicine that can be made readily accessible and understandable to the general public; and
- (d) guidance for appropriate access to and delivery of complementary and alternative medicine.

Sec. 3. Administration. (a) To the extent permitted by law, the heads of executive departments and agencies shall provide the Commission, upon request, with such information and assistance as it may require for the purpose of carrying out its functions.

(b) Each member of the Commission shall receive compensation at a rate equal to the daily equivalent of the annual rate specified for Level IV of the Executive Schedule (5 U.S.C. 5315) for each day during which the member is engaged in the performance of the duties of the Commission. While away from their homes or regular places of business in the performance of the duties of the Commission, members shall be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701-5707).

(c) The Department shall provide the Commission with funding and with administrative services, facilities, staff, and other support services necessary for the performance of the Commission's functions.

(d) In accordance with guidelines issued by the Administrator of General Services, the Secretary shall perform the functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App.), with respect to the Commission, except that of reporting to the Congress.

(e) The Commission shall terminate 2 years from the date of this order unless extended by the President prior to such date.

WILLIAM J. CLINTON

THE WHITE HOUSE,
March 7, 2000.

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White House Commission on Complementary and Alternative Medicine Policy

Town Hall Meeting
September 8, 2000 8:30 a.m. – 6:00 p.m.
Holiday Inn Golden Gateway, Emerald Ballroom, San Francisco, CA

AGENDA

7:30 a.m. – 8:30 a.m.

Registration

8:30 a.m.

Introductions

Dr. Stephen Groft, Executive Director

Welcoming Remarks

Dr. James Gordon, Commission Chair

Harriet Ishimoto, Office of Congresswoman Nancy Pelosi

Catherine Dodd, Director, USDHHS Region IX

Steven Ottenstein, USDHHS White House Liaison

Commissioners:

Dr. Effie Poy Yew Chow

Dr. Wayne Jonas

Dr. Dean Ornish

9:00 a.m.

Morning Session (pre-registered speakers)

12:00 p.m.

Open Session (on-site registrants*)

12:45 p.m.

Lunch Break and Afternoon Registration

1:45 p.m.

Afternoon Session (pre-registered speakers)

5:00 p.m.

Open Session (on-site registrants*)

6:00 p.m.

Closing Remarks

Dr. James Gordon, Commission Chair

**Participants may register for a 5-minute slot prior to the scheduled Open Sessions. Speakers will be accepted in the order received, time permitting and at the discretion of the Chair.*



Qigong Institute

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Kenneth M. Sancier, Ph.D.

President, Qigong Institute
Professor Research, American College Traditional Chinese Medicine
Editor, Journal International Society Life Information Sciences
Council Member, World Academic Society Medical Qigong
Senior Scientist (retired), SRI International

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August 29, 2000

Stephen C. Groft
6701 Rockledge Drive, Room 1010, MSC-7707
Bethesda, MD 20817-7707
E-mail; WHCCAMP@nih.gov

Dear Dr. Groft:

I am honored to be invited to address the Town Hall Meeting, September 8th, 2000, in San Francisco sponsored by the White House Commission on Complementary and Alternative Medicine Policy. In preparation for that meeting I attached to this Email comments on some of the areas of concern expressed in the Federal Register (August 22, 2000). Several members of the Qigong Institute contributed to the remarks.

Please contact me if you need further clarification.

Cordially,

(electronic signature)

Kenneth M. Sancier, Ph.D.
Chairman, Board Directors
Qigong Institute

RESPONSE TO THE QUESTIONNAIRE BY THE WHITE HOUSE COMMISSION ON CAM

I have divided the following discussion into two main sections. The first is an Issues Concerning Qigong Research that will be the basis of my oral presentation. I have chosen Qigong because it is a powerful CAM and also the area of my expertise. The second section is our responses to the Questionnaire by the White House Commission on CAM.

ISSUES CONCERNING QIGONG RESEARCH

What is Qigong?

Qigong is a body-mind-spirit practice including exercises such as breathing, movement, intention, massage, stretching, posture and chanting. Qigong can be regarded as an Energy Medicine for adjusting the balance of energy within the body. Self-practice is the most practical form of Qigong for most people. When a person is seriously ill, a Qigong master, who is highly skilled, can accelerate healing by emitted Qi, the vital energy, to the patient. However, there are not enough Qigong masters to treat many people, hence the importance of self-practice.

Qigong, taught by qualified, competent teacher, enables the individual to implement and maintain a low-cost health maintenance system that often includes the elimination of symptoms of illnesses, which are costly to treat. Specific chronic conditions that can be treated with Qigong include lower back pain, repetitive stress injuries, asthma, hypertension, cardiovascular disease and emotional disorders such as depression. Research has shown that Qigong can increase the immune function of the body and hence its ability to fight disease. Its effectiveness in stress-reduction and increased energy can make people feel and perform better. A competent Qigong therapist can administer medical therapy that is effective in controlling or eliminating pain and inflammation of minor traumas, e.g. sprain, whiplash, dental pain and swelling. In combination with conventional medical treatment, Qigong therapy increases post-operative recovery with a reduction in time in the hospital, clinic and sick-at-home days. The net result is more comfortable patients and substantial economic savings.

Qigong is an approach to health and healing that is complementary to conventional medicine and the two approaches can work side by side. CAM programs, such as Qigong, can provide guidelines for developing nations to help deal with their health issues and reduce medical costs.

Research on Medical Applications of Qigong

Qigong has been traced back 5000 years, and it is estimated that there are 4000 different forms. Other related energy medicine forms include Tai Chi, Reiki, and Yoga. Among all energy medicine forms, Qigong is probably the most extensively researched and scientific studies have focused primarily on medical applications.

Research has shown that medical applications of Qigong encompass almost all aspects of health maintenance and healing. Research on medical Qigong began in China starting about 1980, and since that time researchers in China have produced almost all the research. To my knowledge, we measure the effects of Qi on living subjects and not Qi itself. Even so, there is convincing evidence of the existence of emitted Qi.

Research outside of China has been proceeding at a slow pace. Scientists in Japan are the most active in studying the effects of body energy systems, including Qigong. They publish their research in the Journal of the International Society of Life Information Science (ISLIS), and are funded by the Japanese government. ISLIS received a grant of about one million dollars for the first 5 years, and this year (2000) the grant was renewed with an increase by a factor of about 2.5. Perhaps more than 40 researchers are active in Japan.

In the United States, only a few investigators are active in Qigong and energy medicine research. Dr. Kevin Chen, Dr. Glen Rein, Dr. Y. Omura and myself have complete research, often with little or no funding. Dr. Amy Ai is presently researching the effects of Qigong during cardiovascular surgery under a NIH contract. Lack of financial support and recognition of the value of such research hamper progress in research and publication.

In Germany, Dr. Reuther reported significant improvement by Qigong treatment of asthmatic patients over a year. She reported that drug dosage could be decreased 20-fold and that monetary benefits included substantial decreases in emergency care, loss of work time, and drug costs.

An account of most research to date is described in the Computerized Qigong Database¹, which contains 1660 citations with abstracts in English. About eighty percent of the citations relate to research in China and come from proceedings of international conferences; the remainder comes from the scientific literature. In general, Chinese research is not published except at conferences because China does not have suitable journals. The English abstracts, which provide the only collected record of research in China, have several limitations: they are brief (however, some are several pages with tables of data and statistical analysis), they tend to be poorly translated, and most of the research does not meet strict scientific protocol. In spite of these limitations, the vast amount of research provides a guide to what approaches and applications hold promise for CAM and what further research should be done to validate the earlier studies.

Obstacles to research

Medical professionals need to become involved in Qigong research. But in almost all countries, medical professionals are reluctant to become so involved for various reasons: lack of training and knowledge of CAM modalities and fear of losing credibility among peers. To counter this reluctance, we must develop creditable research studies for guidance of medical professionals.

¹ Computerized Qigong Database is provided on a CD for Macintosh or Windows and is sold by the Qigong Institute.

Researchers of Qigong are often employed by organizations with well-equipped laboratories, however, these facilities are usually not available for Qigong research for the same of the reasons that medical professions are reluctant to participate. As a result, research has be "pirated" wherever possible, and researchers often fund their own research. By contrast, in Japan it is common for scientists to bring their special instruments to a given laboratory for cooperative research. The scientists also have funds to visit China to conduct experiments with exceptionally gifted masters.

As for most CAM projects, a difficult hurdle in Qigong research is funding. Another is a rigid mind-set that requires that CAM research conform to the strict placebo, double-blind protocol. This hurdle is especially difficult for body-mind-spirit approaches such as Qigong. To reduce this barrier, I suggest that pilot studies be made available for promising CAM research to demonstrate feasibility without the strict placebo, double-blind protocol. If the pilot study is successful, a larger more controlled study should be implemented.

RESPONSE TO THE QUESTIONNAIRE BY THE WHITE HOUSE COMMISSION ON CAM

I. Coordinated Research and Development to Increase Knowledge of CAM Practices and Interventions

(A) What can be done to expand the current research environment so that practices and interventions that lie outside conventional science are adequately and appropriately addressed?

Opportunities to develop knowledge of CAM practices can be found by addressing some of societies problems and needs. Typical among these are:

1. Western medical facilities such as hospitals, clinics, and medical schools to study how CAM can augment conventional medical care.
2. Oriental medical facilities such as traditional Chinese medicine colleges and clinics often want to develop associations with conventional medical facilities.
3. Industrial companies and manufacturing plants are beginning to search for ways to reduce stress and increase productivity by CAM techniques.
4. Insurance companies including workman compensation can reduce liability costs by incorporating some CAM techniques.
5. Schools at all levels can use mind/body/spirit techniques to reduce stress, increase learning abilities, and ameliorate disruptive behavior. A Qigong master in Spain is working with hundreds of school children. He reports that Qigong is effective in helping kids develop more harmonious relationships with peers, parents and siblings, calming anxiety and hyperactivity, and improving academic and athletic performance.
6. Prisons, juvenile detention homes, and drug rehabilitation centers can use CAM techniques to help rehabilitate inmates. Some researchers are interested in pursuing the use of Qigong in detention centers. Developing suitable controls for such groups can be a daunting task.

(B) What types of incentives are needed to stimulate the research of CAM practices by the public and private sectors?

1. Demonstration of economic benefits is probably the most significant factor. For example, Dr. Reuther of Germany demonstrated that Qigong treatment of asthmatics could significantly decrease medical costs by decreasing emergency care, sick time from work, and drug costs.
2. Managers, such as school administrators, clinic directors, and prison wardens must be approached and shown by research that CAM approaches work.
3. To achieve the above and develop scientific data, pilot studies in different work environments should be encouraged. Pilot studies would be cheaper to fund than a strict placebo, double-blind type protocol and proposals for such studies would be easier to write. If the outcome of the research is favorable, an expanded research study with stricter scientific protocol should be required, where possible.

II. Guidance for Access to, Delivery of, and Reimbursement for CAM Practices and Interventions

(A) Do you have ready access to CAM practices and interventions?

Yes, but it is difficult to know how to find good practitioners. It would be helpful to have large clinics that are equipped with proper acute care capability and at the same time cater to a public population that wants more "Natural Healthcare." Public money should be going into funding Natural Healthcare facilities. These should include inpatient and outpatient capability, as well as hospice care.

(B) How can access to safe and effective CAM practices and interventions be improved?

We need to look to the examples of integrated medicine as practiced in China and Japan. Only trained herbalists must prescribe Oriental herbs, which incidentally, are not pharmaceuticals. We must think about herbs in yet a new way. Regulatory agencies must treat them for what they truly are, and understand clearly the beneficial application of an herb before stumbling about making uninformed decisions.

(B) What types of CAM practices and interventions should be reimbursable through federal programs or other health care coverage systems?

Acupuncture
Breath therapy
Chiropractic
Herbology
Hypnotherapy
Movement therapy

Qigong

Therapeutic massage

Anything that requires one to develop skills for improved health!

III. Training, Education, Certification, Licensure, and Accountability of Health Care Practitioners in Complementary and Alternative Medicine

(A) How can uniform standards of education, training, licensure and certification be applied to all CAM practitioners?

Uniform standard cannot be applied to ALL CAM practitioners! We must force ourselves to think in a new way about such things.

(B) What training and education should be required of all health care providers to assure access to safe and effective CAM practices and interventions?

There are currently numerous excellent schools and training centers for CAM. Some of these provide the best education in their field that can be found in the Western world and have proven their excellence. One such institution is the American College of Traditional Chinese Medicine here in San Francisco. These Institutions house a great faculty that is tremendous reservoir of information, skill, experience and knowledge. Our government should be supporting the work of medical practitioners who have immigrated to this country in dedication to furthering medicine. They are here, they are ours and we should support and further their work, and harness its full contribution to our society.

We must remember not to become victims of our modern, western minds. We need to fully and enthusiastically allow for new ways of thinking to emerge and blossom. This kind of approach can bring us into a real renaissance in medicine.

(C) What sources of funds exist for the education and training of CAM practitioners?

Very little, if any.

(D) Are performance standards or practice guidelines needed to ensure the public will have access to the full range of safe and effective CAM practices and interventions?

No, not always. We must be careful in regulating forms of medicine we do not understand. For example, some Qigong practitioners work with people through the dying process. This is both physiological and spiritual guidance in one. It is assistance into natural death. This kind of guidance can neither be measured nor regulated.

IV. Delivery of Reliable and Useful Information on Complementary and Alternative Medicine to Health Care Professionals and the Public

(A) How can useful, reliable, and updated information about CAM practices and interventions be made more accessible? How would you like to receive such information?

Information should be disseminated through local Natural Health Centers staffed with practitioners from all the healing arts. Of course, such information should be available on the World Wide Web.

(B) As a consumer, what kinds of information about CAM practices and interventions are most needed and important to you?

How can CAM practices help me with?

1. Things Western Medicine cannot help me with, or do so unsatisfactorily.
2. Things that I thought I just had to live with but can actually be resolved with CAM treatment
3. Things we normally regard as normal, but from the CAM point of view are actually the early expression of illness.

(C) As a health care provider, what kinds of information about CAM practices and interventions are most needed and important to you?

1. How do I know which CAM therapies to recommend to help improve the health of my patients?
2. What methods tend to work with what syndrome?
3. Who are the skilled practitioners in our area?
4. What are side effects?

BIOGRAPHICAL SKETCH

NAME: KENNETH M. SANCIER **POSITION:** CHAIRMAN, BOARD DIRECTORS, QIGONG INSTITUTE

EDUCATION/TRAINING

INSTITUTION AND LOCATION	DEGREE	YEAR(S)	FIELD OF STUDY
Polytechnic Institute of Brooklyn Brooklyn, N.Y.	B.S.	1938-1942	Chemistry
Johns Hopkins University Baltimore, MD	MS	1946-1947	Chemistry
Johns Hopkins University Baltimore, MD	Ph.D.	1947-1949	Chemistry

Research and Professional Experience:

1942-1946: Gas research chemist, Linde Air Products Company, Buffalo, NY.

1947-1949: Instructor in chemistry, Johns Hopkins University, Baltimore, MD;

1948: Instructor, in chemistry, Connecticut College, Storrs, CT.

1949-1954: Researcher at Brookhaven National Laboratory, Brookhaven, NY

1954: Research on electronic properties of solutes in solutions at low temperature

1954-1986: Senior Material Scientist (retired):SRI International, Menlo Park, California

Basic and applied research on process for pure silicon, life sciences projects, magnetic properties of materials, solar energy conversion, pigment for paints, dry bleaches, electron spin resonance spectroscopy, heterogeneous catalysis, instrumentation, and semiconductor surface reactions.

1988-date: Consultant, Scientific Qigong

1988-96: Qigong Institute, East West Academy of Healing Arts, Vice President & Director of Research

1996-date: Qigong Institute, President & Director of Research. Designed and tested experimental equipment for research on body energy as affected by internal and external qi; published 6 scientific articles on qigong; developed the computerized Qigong Database, organized 65 lectures on qigong

1997-date: Director, California Information Center, International Society of Life Information Science (ISLIS)

1997-date: Editor, Journal International Society of Life Information Science (JISLIS)
Council, World Academic Society Medical Qigong

1997-date: Advisory Board, Journal of Alternative Therapies

1998-date: Senior Research Professor, American College of Traditional Chinese Medicine, San Francisco, Calif. Carrying out research involving students; organized a series of lectures on Medical Qigong

2000: Chairman, Board Directors, Qigong Institute.

Professional Associations

World Academic Society of Medical Qigong, Council member

Shanghai Qigong Institute, Advisor

Journal International Society of Life Information Science, Editor

Alternative Therapies, Advisor

National Qigong Association American Chemical Association, Honorary Member
American Association for the Advancement of Science

Academic Honors

National Science Foundation Visiting Scientist to the University of Tokyo (1966 - 1967);
Fellowship from the Standard Oil of Indiana (1948 - 1949)
Phi Beta Kappa
Phi Lamda Upsilon
Sigma Xi.

Publications relevant to Qigong and this proposal:

- Sancier, K.M. and Chow, E.P.Y., 1989, Healing with qigong and quantilative effects of qigong measured by a muscle test.: J. Am. Coll Trad Chinese Med, 7, p. 13-19.
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REVIEW ARTICLE

Qigong and Hypertension: A Critique of Research

MICHAEL MAYER, Ph.D.

ABSTRACT

Research studies have pointed to various health-related positive effects of qigong; however, problems in much of the current qigong research methodology have limited interpretation of the potential benefits of qigong. Examples of research on qigong and hypertension are used to bring to light some of these methodological issues. In a review of 30 representative studies, various areas of concern are addressed, including: the sources of studies, lack of random assignment, selection biases, treatment effects, placebo response issues, expectancy biases, blinded outcome assessment, adherence to treatment, reliability of blood pressure measurements, regression to the mean, publication biases, and lack of consistency of measurement. One of the longest term studies, conducted by Kuang et al. (1991) and updated by Wang et al. (1993) is examined in greater detail to illustrate these issues. This study took place over 20 years and reported significant differences between a group practicing qigong and a control group in a variety of measures including a reduction of total mortality rate. The weight of evidence suggests that practicing qigong may have a positive effect on hypertension. Whether qigong alone can affect hypertension is not necessarily the most important question. Further research will be required to better assess and understand the effect of adding qigong into an integrated, multifaceted program that selectively incorporates diet, moderate aerobic exercise, relaxation training, and social and psychological dimensions.

INTRODUCTION

We are in the midst of a revolution in healthcare where age-old healing methods from other cultures are now being integrated into the Western healthcare system (Eisenberg et al., 1998; Ornish, 1990; Zinn, 1990). Among the treatment methods being researched is qigong, a practice that has existed for several thousand years and that invokes awareness, intention, breath, posture, movement, touch, and sound to cultivate qi, understood as the vital energy of life.

The purpose of this article is to first briefly review selected research on hypertension and the practice of qigong to evaluate qigong's potential efficacy as a treatment for hypertension. Second, methodological issues are discussed to guide future researchers in the field.

Hypertension affects 20% or more of the adult population in Western societies and is a significant risk factor for stroke, myocardial infarction, and congestive heart failure. Together these account for more than 50% of deaths in the United States (Wollam et al., 1988). It is estimated that about 50 million Americans have

elevated blood pressure (BP), which is defined as systolic BP of 140 mm Hg or greater, or diastolic BP of 90 mm Hg or greater (Joint National Committee on Detection, Evaluation, and Treatment of High BP, 1993).

The disadvantages of conventional treatments that use medication include high costs and negative side effects on mood state, cognitive functioning, and sexual performance (Pollare et al., 1989; Medical Research Council Working Party, 1985; Kostis et al., 1990). Therefore, a growing body of research in the West has focused on lifestyle modification as an alternative to hypotensive drugs. According to the Joint National Committee report (1993), lifestyle modification can provide "multiple benefits at little cost and minimal risk" and may be used as a first-step therapy for hypertension or as a means of reducing the number and doses of hypotensive medications required (Little et al., 1991).

REVIEW OF LITERATURE ON QIGONG AND HYPERTENSION

To survey the field, the Qigong Institute of San Francisco's computer database was searched. Seventy studies on hypertension were reviewed that came mostly from conference proceedings (Sancier, 1997). Other reviewed sources include various journal articles (Shih et al., 1998; Kuang et al., 1991; Wang et al., 1995; Sukuki et al., 1993), books (Cai, 1986; Chia, 1990; Chuen, 1991; McGee and Chow, 1994; Cohen, 1997), write-ups from qigong institutes (Xu and Wang, 1993), journals (Kuang et al., 1991; Wang et al., 1995) and reports from peer-reviewed scientific journals (Sancier, 1996a, 1996b). Thirty representative studies were selected for review. All of these sources (except Zhang et al., 1993) report that in hypertensive patients, the practice of qigong positively affects BP, other blood flow measures, cardiovascular outcome measures, and other aspects of health.

BLOOD PRESSURE

Many studies suggest that qigong lowers BP (Bornoroni et al., 1993; Huang, 1990; Jing, 1988;

Kuang et al., 1989, 1991; Li et al., 1988; Pan et al., 1990; Qu, 1990; Shih et al., 1998; Tainjin et al., 1988; Wang et al., 1994, 1995; Wu and Liu, 1993; Xu and Wang, 1994; Young et al., 1998; Yuan et al., 1996). The most in-depth of these studies is the Kuang study (Kuang et al., 1991, updated by Wang et al., 1994), which took place over 20 years. The basic design involved 204 patients with hypertension, randomly assigned to qigong practice and control groups. Age of subjects was not mentioned. Both groups were given antihypertensive drugs. The qigong group of 104 patients reportedly practiced 30 minutes twice per day, over 20 years.

During the first 2 months, the BP of all patients dropped in response to the hypotensive drug. Subsequently, and consistently over the period of 20 years, the BP of the group practicing qigong stabilized while that of the control group increased ($p < 0.01$). Due to the stabilized BP, 48% in the qigong practice group reduced the hypotensive dosage, and for 30% in this group, the BP medication was eliminated. In contrast, 31% in the control group increased the hypotensive dosage (Kuang et al., 1991).

Other studies report that patients suffering from various degrees of hypertension can withdraw from their medication, and that BP reduced over various time periods: after one session (Li et al., 1988; Tianjin Research Institute of Traditional Chinese Medicine, 1988), 14 days (Wu et al., 1993), 2 months (Jing, 1988; Tianjin Research Institute of Traditional Chinese Medicine, 1988; Shih et al., 1998; Yuan et al., 1996), and 1 year (Huang, 1990). Jing et al. (1988) reports that for patients with a long history of hypertension and no satisfactory results with medication, BP stabilized within 2 months and 3 years after starting to practice qigong.

OTHER BLOOD MEASURES

In studies that were not specifically described as randomly assigned control group studies, significant differences were reported between qigong and control groups on eight blood flow measures (Chu et al., 1988), in ten indices of microcirculation ($p < 0.05$ – 0.01) by (Wang et al., 1995). At three major laboratories

in China, Wang et al. (1990) used a photoelectric earlobe sphygmograph that measures blood volume, and reported a 30% increase in the group practicing qigong versus ordinary state ($p < 0.01$). Chai and Wang (1990) used a laser microcirculation blood flow meter to measure blood flow, and found an increase in experimental versus control group ($p < .001$). Qu et al. (1998) found blood flow resistance and vascular tension reduced in the group practicing qigong versus the control group ($p < 0.001$) even after 1½ hours of rest.

In randomly assigned controlled group studies, Kuang et al. (1991) reports, in his 20-year study, fewer cardiovascular lesions ($p < 0.05$), decreased blood viscosity, improved platelet aggregation, decreased triglycerides and increased high-density lipoprotein cholesterol (HDL-C, "good cholesterol") in the groups practicing qigong. Beneficial changes were reported in total peripheral vascular resistance, plasma cholesterol and in two messenger cyclic nucleotides (cyclic adenosine monophosphate [cAMP] and cyclic guanosine monophosphate [cGMP] in the qigong compared to the control group (Kuang et al., 1991). Xian (1990) reports that after 6 months of practice, the blood of the group practicing qigong, compared to the control group showed less tendency to form abnormal blood clots and contained significantly higher levels of high-density lipoprotein cholesterol (HDL-C).

OTHER CARDIOVASCULAR OUTCOME MEASURES

A wide variety of other cardiovascular measures are reportedly improved by practicing qigong. Less congestive heart failure and acute myocardial infarction was reported ($p < 0.001$) by Xing (1993), but existence of control groups was not mentioned. A shorter comparative study (Kuang et al., 1991) was done on a randomly divided subgroup of 98 cases of hypertension accompanied by coronary heart disease. There was a comparable control group based on age, gender and course of disease. Significant improvement was reported in the group practicing qigong compared to the control group in retinopathy ($p < 0.05$) and fewer cardiovascular lesions were found ($p < 0.05$).

In the latest update of the research of Kuang by Wang et al. (1995), significant differences were reported in subjects who reportedly practiced qigong for 30 years, 30 minutes twice a day. The accumulated mortality rate was 25.41% in the qigong group and 40.8% in the control group. The incidence of strokes was also significantly different in the qigong practice groups as compared to the control group, 20.5% and 40.7%, respectively. The death rate due to strokes was 15.6% and 32.5%, respectively ($p < 0.01$) (Wang et al., 1993, from Sancier, 1996).

Wang et al. (1995; Wang in Sancier, 1996a:41) reported that after 1 year, many significant changes took place in a subset of 8 elderly hypertensive patients with heart energy deficiency (a Chinese medical diagnosis), which often presents as a weakened function of the left ventricle and a disturbance of microcirculation. Researchers evaluated the results of qigong exercises on patients through measurements done by ultrasonic cardiography and indices of microcirculation. Subjects were divided into three groups: hypertensive patients with heart energy deficiency, without heart energy deficiency, and with normal BP. Left ventricular function (LVF) improved in the group practicing qigong compared to the normal BP group ($p < 0.05-0.01$), and other cardiac measures increased including ten indices of abnormal clinical blood conditions, for example blood flow and petechiae (fragile capillaries creating red dots on the skin) ($p < 0.05$). This study exemplifies problems related to regression to the mean, discussed in a later section.

OTHER SYMPTOMS REDUCED

Reports suggest qigong practice affects other chronic diseases and physical complaints associated with hypertensive states. Aching, distention, dizziness, and insomnia were reduced in a hypertensive group practicing qigong compared to a control group (Jing, 1988). In a group of chronic renal failure patients, swelling disappeared and fatigue was reduced (Suzuki, 1993), attributed to qigong exercises. In the Kuang et al. (1991) study, a subgrouping of 16 male patients with hypertension associated

with diabetes reportedly had, after 6 months of practice, significant reduction ($p < 0.01$) in symptoms of polydipsia (excessive thirst), polyphagia (overeating), polyuria (excessive urination), fatigue, weakness, blurred vision and hyperesthesia (skin sensitivity); and when 40 patients from the qigong group were examined by ultrasound, they were found to have better left ventricular function (Wang et al., 1995; Cohen 1997:58).

RESEARCH CRITIQUE: METHODOLOGICAL ISSUES AND PROBLEMS

Inadequate design makes the scientific validity of these studies difficult to determine. However, faulty methodology does not mean that the phenomenon under study is not worthy of further research. The methodological inadequacies of each individual study above will not be analyzed, but rather, the focus of the next section is general themes, for illustrative purposes. The Kuang study (Kuang et al., 1991) has been selected as an example because it is one of the longest qigong studies and the methodology has been clearly described.

SOURCE OF STUDIES

The bulk of the studies reviewed have been collected from the San Francisco Computerized Database, and for the most part, come from proceedings from various qigong conferences. Some relevant data is missing, particularly from secondary reports. It cannot be determined how much of the missing descriptions were not part of the original research, were not presented at the conference, or were lost in translation. Many of the journal articles, reports from various qigong institutes, and books reviewed are difficult to assess methodologically, because these reports generally have not appeared in peer-reviewed journals that adhere to accepted scientific standards of reporting.

RANDOM ASSIGNMENT

Of the many studies surveyed, only five authors (Huang, 1990; Kuang et al., 1991; Li et al.,

1990; Wang et al., 1994; Yuan et al., 1996) explicitly state that they used randomly assigned control groups. Without such random assignment, outcome measures are open to other interpretations, including habituation, seasonal effects, placebo response, and changes in instrumentation.

Even in the randomly assigned control group studies, there can be other potential explanations for the reported results, such as, not including all subjects who were assigned in follow-up measures, isolating causes of reported treatment effects, patients' biases that arise because of expectancy of treatment effect, and lack of blinded outcome assessment.

SELECTION BIASES

Even in studies where there was a randomly assigned control group, methodology of the selection process may be problematic. In the Kuang study (Kuang et al., 1991), for example, although it is reported that patients with hypertension were randomly divided into a qigong and control group, specific relevant factors of the recruitment process were not mentioned. For example, we do not know how many people refused to participate, nor do we know when or how the random assignment was made. This makes it difficult to determine whether the two groups were similar at baseline.

These questions may affect the ability to generalize to the larger population and the external validity of the study. This problem may reflect a "population selection bias." If some people selected for the qigong group refused to enter into the 30-minute twice a day practice and were eliminated from the study, this could be because they were too sick, busy, or tense. This could bias the results by eliminating the most unhealthy people from the treated group, and falsely increase the qigong practice groups' health outcomes. Likewise, if some of the subjects initially selected for the control group wanted to practice qigong and were eliminated, this could eliminate the healthier controls.

TREATMENT EFFECTS

What are the results of the various studies actually measuring? In virtually all of the stud-

ies reviewed, including the Kuang et al. (1991) study, we do not know whether the improved health of the qigong practice group was a function of qigong exercises, or some epiphenomenon associated with qigong practice, such as general physical exercise. In most of the studies (eg, Huang, 1990; Kuang, 1991) there is not sufficient information to determine whether measurements took place shortly after qigong practice, and therefore whether improvements in BP or other blood flow measurements were lasting effects of qigong or a temporary result of movement and exercise.

Physical exercise is a possible source of explanation in the sphygmograph blood volume study by Wang et al. (1990), which showed a 30% increase in qigong versus ordinary state ($p < 0.01$), and Chai et al.'s (1990) finding of a significant increase in blood flow in experimental versus control group ($p < 0.001$). Other studies state that BP reductions and other blood flow measures were maintained between 2 months and 3 years (Jing, 1988), and 1 and 3 years (Li and Zhang, 1988) of practice. However, reports do not specifically mention how long after qigong practice measures were taken. In the Shih et al. (1998), study it is stated that BP measures were taken after the study; but it was not stated how long after and whether qigong was practiced before measures were taken. A study that did take this variable into account was that conducted by Qu et al. (1998) who found that blood flow resistance and vascular tension was reduced in qigong versus control ($p < 0.001$) groups, even after 1½ hours of rest.

In future research, it would be useful to add a control group who exercise but do not practice qigong. If this exercise group had fewer beneficial health results, a useful step would be made in ruling out exercise as a confounding variable. Also, it should be more clearly stated how long after qigong practice measures are taken to determine how long-lasting are the results.

Two studies are of interest in this regard. First it was recently reported in the *Journal of the American Medical Association* that Taiji, the most popular form of qigong, helped to reduce falls among the elderly more than seven other different forms of physical exercise measured at eight different medical facilities (Province et al., 1995). Second, Johns Hopkins University re-

searchers who were exploring whether exercise lowers BP needed a control group that did not exercise. They picked Taiji because they thought it was so slow that it would not affect BP (Young et al., unpublished observation). To their surprise, by the end of the 12-week study, the BP of both groups dropped nearly the same amount. This latter study is important in factoring out certain expectancy biases inherent in studies done by Taiji advocates.

Finally, in terms of other alternative explanations for results, even in controlled studies, the validity of qigong could be better determined by giving both groups a questionnaire addressing diet, exercise regimens, possible differences in setting between the qigong and the control group, occupation, adherence to treatment (taking medication and practicing qigong), or other significant variables. The authors in the Kuang study (Kuang et al., 1991) did not report measuring differences with regards to such possible confounding variables between the two groups at the beginning, middle, or end of treatment. Because there was reportedly a random division into experimental and control groups at the beginning of the study, this might mean that such variables were controlled; however a questionnaire could help determine the extent to which differences in health were related to qigong.

PLACEBO RESPONSE: EXPECTANCY BIASES AND DOUBLE BLIND ISSUES

In behavioral research with humans, unlike animal or drug research, it is difficult to have a double-blind study, because the subjects usually know the group to which they belong, and the therapist knows which group is receiving treatment. With qigong research, qigong practitioners are aware that they are practicing a specific healing technique, and the qigong teacher/therapist knows that the qigong students are being treated. Thus, results of many of the studies cited could be based on placebo response rather than on qigong *per se*.

A placebo response is a type of expectancy bias based on the belief of the patient, the belief of the therapist and the interaction between the two. A well-designed study attempts to tease out how much expectancy biases or the

treatment effects, cause reported differences between the treatment and control groups. For example, if the qigong students had a teacher who showed them positive regard, or if students had a sense of mission and purpose to prove the efficacy of qigong as compared to a control group, these rather than qigong itself could have caused the reported differences. The Kuang study (Kuang et al., 1991) and others in the review of the literature (eg, Chai et al., 1990; Huang, 1990, 1993; Jing, 1988; Qu et al., 1998) did not address this in the discussion section, nor did they attempt to control for these potential sources of bias.

BLINDED OUTCOME ASSESSMENT

It was not reported in the Kuang study (Kuang et al., 1991) nor in other studies reviewed whether the data collectors were blinded to group assignment. This source of potential bias could be a source of conscious or unconscious skewing of measurements. In subsequent research, it should be reported whether the data collectors were blinded to group assignment.

The one study in our review that did address this issue was a master's degree thesis from Columbia University's Program in Physical Therapy (Shih, 1998). To the credit of this study, the investigators taking measurements were blind to group affiliation, and baseline measurements were taken on each subject prior to treatment establishing a greater chance of validity of BP measurements. This study involved subjects who practiced qigong twice a week during an 8-week period. Subjects reportedly showed significant decreases in systolic and diastolic BP, mean arterial pressure, and respiratory rate. In this study a quality of life questionnaire and a subjective self-report questionnaire indicated improvements in many areas such as relief of chronic back pain, migraine headaches, and insomnia, better ability to cope with life stresses, decreased anxiety, and increased peace and contentment. However, because the control group was taken from drop-outs of the study, the positive results could be explained by differences between groups in such variables as personality characteristics or

health rather than qigong. Also, it cannot be determined whether the treatment group's positive results are due to other variables such as exercise in general, group support, or general expectancy biases.

ADHERENCE AND THE DOSE RESPONSE EFFECT

The dose-response effect, ie, that a greater dose of the experimental variable increases positive outcome, is important to consider in therapeutic studies. If we knew that people who practiced qigong for longer periods of time, or were more skilled, had increased health, this could increase our confidence in the effects of qigong.

In the Kuang et al. (1991) study, how many in the qigong group actually practiced 30 minutes per day twice a day? The original research by Kuang did not specifically report how long the qigong practitioners practiced per day; however, Wang et al. (1993; reported in Sancier, 1996a:41) reported that the qigong group practiced 30 minutes twice a day. Still, from this report we cannot be certain specifically how many subjects practiced this long. Among the people in the qigong group who died, did they practice more or less, or were they more skilled than those who lived longer? Were members of the qigong group eliminated from the analysis if they did not practice? How was adherence to the practice regimen assured? Because qigong in China is practiced by many millions of people, and is as common as aerobics in our culture, how did the researcher insure that the control group did not practice any qigong over a 20-year period?

An important part of an analysis of a clinical trial is called "the intention to treat principle," which means that to maximize validity, every patient assigned to a group must be analyzed, including those who dropped out at the beginning or during the course of the study. To the authors credit, and adding to the study's validity, they did address the issue of drop-outs during treatment. It was reported that 204 of the 218 cases (93.58%) were included in the study over the 20-year time line, and were continuously monitored and analyzed. The inclu-

sion of this impressive percentage in the analysis lessens the potential of this selection bias.

Most of the studies reviewed do not mention how many subjects actually adhered to the practice regimen; and therefore it cannot be determined whether there was a dose response effect. If we knew this then it would be more likely that the qigong practice contributed to the treatment effects, rather than expectancy effects from being involved in a qigong group.

Chai et al. (1990) did report a direct relationship between blood flow and the subjects' length and level of qigong training ($p < 0.001$), which is a dose-sensitive relationship, but these researchers did not randomly assign a control group. Likewise Shih et al. (1998) reported a dose response effect, but due to the earlier cited problems with the selection of control group from drop-outs, alternative explanations could be posited for reported treatment effects.

PROBLEMS WITH RELIABILITY OF BLOOD PRESSURE MEASUREMENTS

There are general difficulties in establishing reliable BP measurements in terms of establishing a stable baseline for any researcher. A subject's BP may fluctuate for a variety of reasons at different times, making analysis difficult. Many studies in our review do not adequately address this problem, although some studies have given attention to establishing stable baseline BP measures, and monitoring BP continuously over the course of the study (eg, Shih, 1998). However, even in this study, it was not reported whether such measures were taken at times other than directly after the qigong meditation period. Such measures would help to determine whether meditative exercise itself is a confounding variable (ie, whether qigong versus control groups temporarily reduces BP after exercise) or if qigong produces longer lasting effects.

REGRESSION TO THE MEAN

Studies that select subjects by extremely high or low levels of any variable have the methodological problem of follow-up measures hav-

ing a general tendency to move toward the center. In the earlier cited Wang study (Wang et al., 1995; Wang, in Sancier, 1996a:41), 80 aged hypertensive patients were divided into three groups: hypertensive patients with heart energy deficiency (HED), without heart energy deficiency, and with normal BP, and were given treatment targeted to increase heart energy efficiency. LVF, other cardiac measures and ten indices of abnormal clinical blood conditions improved ($p < 0.05$) in the qigong group with heart energy deficiency versus both control groups. However, the nonrandom division into groups of greater and lesser heart deficiency at the outset allows for regression to the mean to explain the positive results.

Regression to the mean could be a confounding variable in Xu et al's 1993 use of a pretest and posttest design in reports regarding patients with degeneration of the heart, brain, and kidney functions, and senility, and their improvements in these functions.

PUBLICATION BIAS

Any field of research is subject to publication biases. Studies that support a given treatment are published, while those that do not lend support tend not to be published. Most qigong studies report positive results. However, Zhang et al, 1993, in a study that addresses qigong practice problems, reports that a qigong group that thought they could open their "third eye" "emit qi", and develop natural gifts had worse systolic and diastolic BP and heart rates after treatment. The article warns that patients with hypertension must be careful when practicing qigong to concentrate their minds on the lower abdomen ("tan tien").

LACK OF CONSISTENCY OF MEASUREMENT: MANY STYLES OF QIGONG

Further research needs to be conducted on the varied qigong traditions to determine which particular type or sequence of qigong movements may be most beneficial to a given patient at a given time. In any sample of the

many qigong traditions (Cohen, 1997) each may focus upon various combinations or types of qigong: healing internal organs, stretching muscles, dispersing stagnant chi, tapping, breathing, making sounds, using pulsing movements, using qigong animal-like movements, self-massaging, and spiritual awareness exercises. Qigong also uses nonmovement techniques such as standing meditation to activate qi (Cai, 1986; Chuen, 1991; Diepersloot, 1995; Ha, 1996; Mayer, 1997c).

We should be aware that qigong practices are not so easily oriented toward Western notions of prescribing a single pill or movement. Such an approach provides ease of scientific measurement, but does not fit into holistic Chinese medical philosophy that includes unique combinations of herbs, acupuncture and a wide variety of qigong movements suited to the individual whole person.

GENERAL DISCUSSION

Although many of the studies of qigong practice and hypertension are flawed, controlling for the methodological biases listed above represents high expectations in any behavioral or clinical research. The methodological problems addressed above may account for some unknown portion of improved health outcome measures, but we should be circumspect before fully discounting positive effects reported in mortality rates, incidence of strokes and retinopathy (Kuang et al., 1991), and other positive outcome measurements in patients who have suffered from long term hypertension (eg, Jing, 1988; Wu, 1993), or chronic renal failure (Suzuki, 1993).

In general, Western hypertension research (COTA, 1978; Cohen, 1997:345), as well as Chinese qigong studies, suffer from problematic research design. In an overview of hypertension studies, Rosen states, "methodological problems, such as small sample sizes and lack of experimenter-blind assessment, have limited the generalizability of results from most studies" (Rosen et al., in Gatchel, 1998; Kaufmann et al., 1988; TOHP Collaborative Research Group, 1992).

Taken as a whole, many studies on hypertension do not address the criteria we outlined

above for reasons as varied as difficulties inherent in behavioral research itself, lack of adequate training in research methodology, general issues cited above in BP measurements, lack of funding, and the orientation of the clinician to heal rather than measure.

The treatment effects of qigong on hypertension are worthy of note and are potentially profound in their implications. qigong fits well into the guidelines stated by a National Institutes of Health Panel (NIHTAP, 1996) that concluded that "integrating behavioral and relaxation therapies with conventional medical treatment is imperative for successfully managing these conditions." The panel did not endorse a single technique, but stated that a variety of them worked in "lowering one's breathing rate, heart rate and BP" as long as they included two features: "a repetitive focus of a word, sound, prayer, phrase or muscular activity, and neither fighting nor focusing on intruding thoughts."

EASTERN AND INTEGRATIVE METHODS

Many Eastern methods of stress reduction have been used successfully with hypertension. Transcendental meditation (TM) has been shown in well-designed randomly assigned studies to positively affect the BP of hypertensives (Schneider et al., 1995, Alexander et al., 1996). Other TM studies that demonstrate significant changes in BP were even measured at times other than during the meditation period (Benson et al., 1973). Positive results have been claimed in combining vipassana meditation and stress reduction techniques at the University of Massachusetts Medical Center (Zinn, 1990). When yoga was integrated into an intensive multifaceted lifestyle change program with a low fat, low cholesterol vegetarian diet, daily meditation, moderate aerobic exercise and group support, hypertension and coronary disease were reduced (Ornish, 1990; Ornish et al., 1990).

Like yoga (Ornish et al., 1990) and other Eastern relaxation methods that have reported beneficial results in treating hypertension, qigong is a tradition that combines relaxation, breath-

ing and a mindful relationship to body awareness. Further research could compare yoga, qigong, exercise, and other relaxation and/or meditative traditions. Each different Eastern meditation modality may have its own advantages and disadvantages for different patients. For example, yoga may be the most appropriate exercise for patients who cannot stand, while qigong may be more beneficial for type A, sedentary office workers who would benefit from movement. For those who would most benefit from mantra yoga, TM may prove appropriate, while those who are overly intellectual and stressed may benefit from the bodily orientation of qigong.

Qigong has the advantage for elderly hypertensives of being low impact, and therefore potentially less dangerous compared to traditional aerobic exercise (Province, 1995). In general, a variety of factors could be considered in a given patient's choice of exercise at a given time, such as physical limitations, availability, suitability of a given instructor, life circumstances, or basic beliefs.

Finally, whether qigong alone can affect hypertension is not necessarily the most important question to be answered. Multifaceted programs (Joint National Committee on Detection, Evaluation and Treatment of High BP, 1993; Kostis et al., 1992; Little, 1991; Ornish et al., 1990; Rosen et al., 1989) that integrate diet, aerobic exercise, relaxation techniques, social, hypnotherapeutic, and psychological dimensions may be most effective in treating hypertension. For example, the Heartsavers Lifestyle Program (Rosen et al., 1989) treated middle aged and elderly patients with hypertension and found the greatest improvements in middle aged and elderly patients with hypertension who followed a multifaceted program as compared with a medication and placebo control group. Quality of life also improved based on the patients' reports of increased energy levels and improved sexual performance compared with both drug and placebo (Rosen et al., in Gatchel, 1998:91).

Western psychotherapeutic and hypnotherapeutic methods have been used successfully with hypertensive patients (Benson, 1983a, 1983b; Crasilneck et al., 1985; Yanoviski, 1962). The energetic dimension has long been advo-

cated as a significant part of body-mind healing in the West (Reich, 1949; Lowen, 1958). It may be a useful next step to add qigong methods to this tradition. Further research has been suggested (Mayer, 1994, 1996, 1997a, 1997b, and 1997c, 1998) with hypertensive patients to explore and validate the integration of psychological methods such as hypnosis, self-soothing, visualization, psychodynamic interventions, and cognitive restructuring and focusing on the felt meaning of one's hypertension (Gendlin, 1978) with qigong techniques such as microcosmic orbit breathing (Wilhelm, 1962) and other Taoist qigong breathing methods, touching of acupressure points (Gach, 1990), and belly massage from chi nei tsang (Chia, 1990).

As a practice that integrates relaxation, meditation, and exercise, qigong could play a potential role in multifaceted interventions. Doctors (Maisel, 1963) and medical hospitals such as California Pacific Medical Center in San Francisco and Columbia Presbyterian Hospital in New York, are increasingly using qigong for their cardiology patients (Motz, 1997).

CONCLUSION

Qigong appears to help in the treatment of hypertension, but due to inadequate addressing of methodology issues it is difficult to determine just how effective qigong is, and what other factors may contribute to its positive effects.

We hope that Western researchers join hands with those in China who are investigating qigong, because the world may benefit from further studies to establish whether or not qigong may provide a beneficial adjunct to other treatments.

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QIGONG AND BEHAVIORAL MEDICINE:

An Integrated Approach to **CHRONIC PAIN**

BY MICHAEL MAYER, PH.D.

"It is probably true that, in general, the most fertile developments in the history of human thought are born at the intersection of two currents of ideas. These currents may originate in the midst of totally different cultural conditions, in diverse epochs and places. But from the time that they effectively meet and maintain a relationship sufficient for a real interaction to take place, one can hope for new and interesting developments to occur."

—Werner Heisenberg

AS A NURSE AT A LOCAL HOSPITAL, Terry had the best hospital care money could buy when she suffered a terrible car accident. Her car was damaged so badly that the jaws of life had to be used to free her crushed foot from the accordionized automobile. Six months later, Terry needed to use a crutch and had been in excruciating pain anytime she reduced her pain medication. The Doctor that had given her pain medication told her she would probably need to be on it for the rest of her life. By the time she came to me she was beginning to be addicted to the pain medication.

PAIN AND ECONOMICS

Surveys indicate that 11% to 12% of the adult population in the United States report difficulties related to chronic pain.¹ According to *The Pain and Absenteeism Report*, employee benefit managers believe that 20% of their employees suffer from various types of pain conditions.² It's hard to fathom that estimates for the direct and indirect costs of pain related syndromes in the United States each year range between 90 to 100 billion dollars, and that 20 million tons of aspirin are consumed annually.³

A wide variety of well documented research studies, and the recent National Institute of Health's report in the *Journal of the American Medical Association* has shown that solid evidence exists for the ability of various techniques of behavioral medicine including relaxation, hypnosis and meditation to alleviate chronic pain.⁴ However, fueled by drug company advertising, and our cultures' propensity for instant gratification, mass marketing has programmed us to go on a quest for "God in a pill" the moment we have a problem with pain.

Certainly, many people who are suffering

from extreme pain have much for which to be thankful with medical diagnosis and pharmacology.⁵ The decision when to be diagnosed by a western Doctor, when to use Western pharmacology's pain reducing drugs, and when to use our own diagnostic intuition and pursue alternative or complimentary methods is a complex question that needs to be decided by each individual. As is true for life in general, "instant cures" do not come without costs.⁶

Pain is a call from our body to learn to read its language. The awareness of our primordial self is tested with each ache. Is our body saying that we have a serious problem that is there to teach us to let go of our self-healing arrogance and rely on the advice of a medical professional who can help us deal with an early warning sign of cancer or liver disease; or, on the other hand, are we giving away our power to the medical propaganda machine that benefits from convincing us that every ache is a call to go to the temple of Western medicine for relief?

At those times when our own inner temple has the resources to heal us, it is empowering to activate these inner healing abilities, and avoid the side effects of modern drugs. If these methods fail, then we may choose to move up the hierarchy of responses.⁷

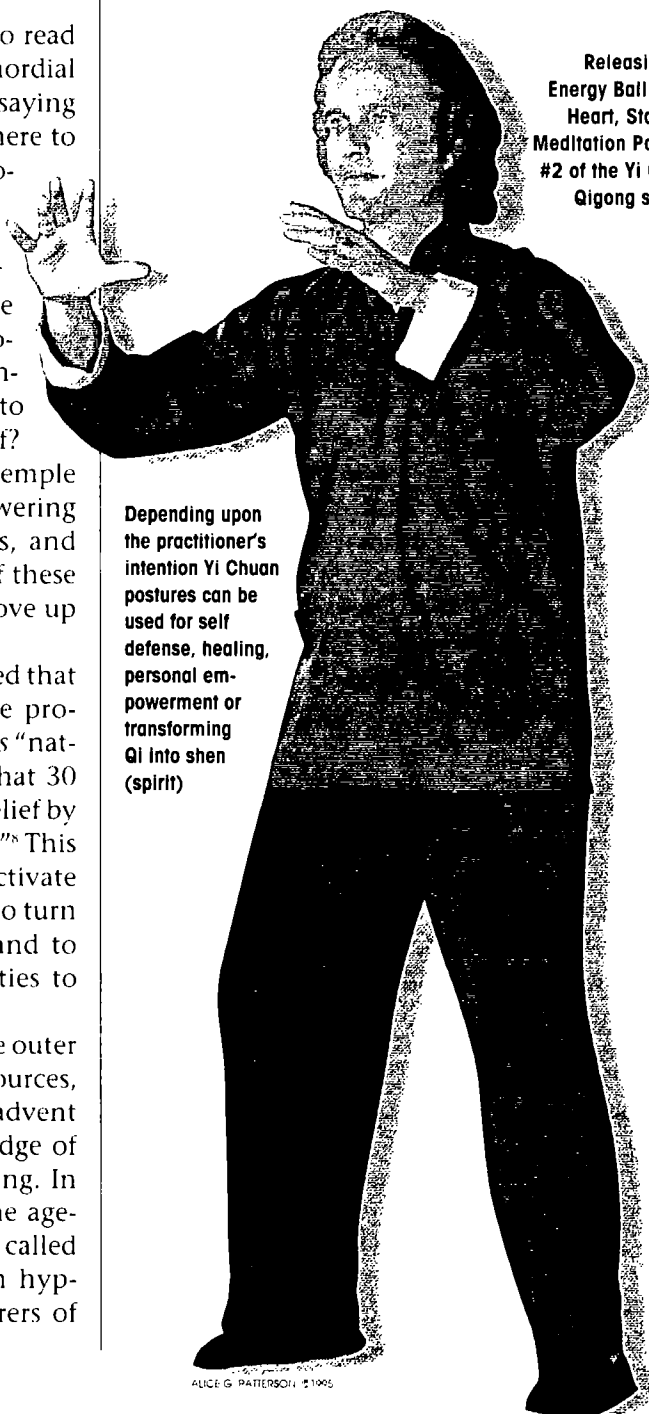
Modern neuroscience has demonstrated that many chemicals of the outer world are produced in our brains, such as the *endorphins* "natural morphine." An interesting fact is that 30 to 60% of patients will experience pain relief by being given a placebo, i.e. a "dummy pill."⁸ This shows that the mind has the ability to activate inner pain medication if we could learn to turn the key. The question becomes how, and to what extent, can we increase our abilities to unlock our natural powers.

In a culture like ours, so oriented to the outer world, we oftentimes forget our inner resources, and the old traditions, long before the advent of Western medicine, that held knowledge of how to use these abilities to effect healing. In this article we shall focus upon how one age-old tradition, of relaxation and healing, called *qigong*, can be integrated with modern hypnotherapeutic techniques to help sufferers of chronic pain.

QIGONG AND HYPNOSIS: PARTNERS IN PAIN RELIEF

The many systems of *qigong* are ancient methods of cultivating the body's vital energy, called *ch'i* (also spelled *qi*). They use breath, movement, posture, awareness, and touch; and are one part of the multi-faceted system of Chinese medicine. Many scholars believe that *qigong* began at the time of the Yellow Emperor,

Releasing the
Energy Ball of the
Heart, Standing
Meditation Position
#2 of the Yi Chuan
Qigong system



Depending upon
the practitioner's
intention Yi Chuan
postures can be
used for self
defense, healing,
personal em-
powerment or
transforming
Qi into shen
(spirit)

ALICE G. PATTERSON © 1995

2690-2590 BC., when the theoretical foundation for Chinese medicine was laid." It has been estimated that in Beijing alone 1.3 million people practice just one form of qigong every day, and that in China as a whole, eighty million people practice qigong everyday.¹⁰

Western culture was first introduced to the pain reducing effects of Chinese qigong in 1971 when the *New York Times* columnist James Reston had an emergency appendectomy, had acupuncture needles applied, and felt no pain. Since that time a wave of interest has gradually grown in investigating the wider dimensions of qigong. The PBS special with Bill Moyers and Dr. David Eisenberg introduced the Western TV audience to the use of *ch'i* in medical treatment in Chinese hospitals. A number of well-respected authors have written on the applications of qigong in medical settings including Michael Lerner in his *Choices in Healing*,¹¹ and Dr. David Eisenberg's *Encounters with Ch'i: Exploring Chinese Medicine*.¹² There have been six international conferences reporting research results. At these conferences¹³ numerous studies from China reported qigong's effect on a wide variety of diseases with positive results including kidney disease,¹⁴ chronic hepatitis,¹⁵ cancer,¹⁶ and paralysis due to stroke.¹⁷ The International Society for the Study of Subtle Energies and Energy Medicine (ISSSEEM) has compiled hundreds of studies and papers on the uses of energy in healing.¹⁸

Just how qigong creates a healing response is still a matter of speculation. Research is still in the process of trying to determine the extent to which the energy spoken of in many ancient healing traditions exists, or whether the healing response to qigong is a function of, or a combination of energy, hypnosis, biochemical reaction, endorphin response, etc.¹⁹ This subject is beyond the scope of this article which is oriented to explore the clinical usefulness of qigong as a complimentary tool for pain relief.

METHODOLOGY: MICROCOSMIC ORBIT BREATHING AND PAIN RELIEF

When Terry, came into my office, I asked her to give me a current rating of her pain on a

IT HAS BEEN ESTIMATED THAT, IN BEIJING ALONE, 1.3 MILLION PEOPLE PRACTICE JUST ONE FORM OF QIGONG EVERY DAY, AND THAT IN CHINA AS A WHOLE, EIGHTY MILLION PEOPLE PRACTICE QIGONG EVERYDAY.

S.U.D.S. scale (subjective units of distress)—10 being the greatest it had ever been, and 0 being pain free. She said it was an 8 now because she had reduced her medication to "see what this hypnosis stuff could do" for her. After taking a case history, I introduced Terry to an approach that integrates qigong and hypnosis.

First, I taught Terry how to activate her *ch'i* by noticing her in-breath coming up the *microcosmic orbit*. *Microcosmic orbit breathing* is the method referred to in *The Secret of the Golden Flower*.²⁰ It was claimed that this breathing technique, when done properly, could help a person activate a healing state that leads to increased youthfulness and vibrancy. It consists of the following steps:

1. Begin by focusing on the breath coming up the back of the spine from a point at the bottom of the spine at the perineum, (between the anus and the genitals), and imagine it coming over the top of the head. The tongue touches the palate right behind the teeth connecting two of the major meridian lines in the body. The one up the back, the governing vessel, is called the *Tu Mei*; the one going down the front of the spine, the conception vessel, is called the *Jen Mei*.
2. On the out breath focus on the breath coming down the front of the body until it reaches the *Tan T'ien*, a point approximately three fingers width beneath the belly button. Feel the pause after the out breath.
3. The movement of the *ch'i* continues downward to the perineum, (also called the *hui yin* point) a point between the anus and genitals. Here our in-breath arises for a new cycle up the *Tu Mei*.

The length of the breath associated with the development of *ch'i* is called "long breath." To practice, we imagine that our out-breath is like a tire that has a slow leak in it, and someone is sitting on the tire. This can be differentiated from "short breath" that is like a blow out in a tire. Long breath builds *ch'i*, and leads to a grounded yet light feeling.

MACROCOSMIC ORBIT BREATHING

After Terry moved into a state of relaxation with microcosmic breathing, I introduced *macrocosmic orbit breathing*,²¹ an extension of the above method whereby the person enlarges the circle, imagining it coming up from the ground over the head on the in-breath, and then down the front of the body on the out-breath.

The use of imagery adds to the healing effects of qigong.²² I had Terry imagine a waterfall coming up over the top of her head on the in-breath, on the out-breath she visualized water coming down the front of her body and out her right injured leg.

Terry told me that another health practitioner told her to imagine putting healing energy into the pain in her right leg; but that just made it more swollen. This illustrates the Taoist notion that when there is an excess of yang we want to decrease the energy there, not increase it, as may happen when we concentrate too much on a point that is already suffering from excess. I told her to experiment with focusing, not on the spot that was hurting, but on the river above and below that spot. Since she described the pain as having a warm, stuck quality to it, the following image was constellated to use along with her macrocosmic orbit breathing:

Where you feel the energy blocked, you might imagine it as stuck leaves in a river, or anything else that you picture the block to be, and, without forcing it, notice how many breaths it takes for the cool waters to flow through the dammed up place.

In the modern use of hypnosis, visualization is a tool often used with chronic pain patients.²³ The Taoist parallel and addition to this idea is to use the thousand year-old understanding of the meridian lines, and vital points of the body, to activate the vital energy of the body (ch'i) to aid this process. Terry visualized the bubbling well point (Kidney 1) at the bottom of her foot²⁴ with water being drawn into the body from there, then spiraling up the leg and up the back of the body over the top of the head, to the *baihue* point. Then she visualized it coming over the top of the head, down the front of the body, and exiting from the foot through the

bubbling well point. The Taoists, and practitioners of Chinese medicine, believe that this point is one key place where energy can be drawn into the body, as well as being a point where the waters of life can wash out toxins from the body.

In the first session Terry went to a #2 S.U.D.S. level. She was amazed because this was the most pain free she had been without medication since her accident six months before. In subsequent sessions, Terry learned these and other methods of practice with her pain. In our second meeting she was able for the first time to experience a zero S.U.D.S. level. With the consent of her Doctor, she started to use medication on a less frequent basis. In the third and subsequent meetings, we focused our efforts on achieving this state outside of session.

YIN-YANG BALANCING METHOD

One other method I taught Terry to ease her pain is the *yin yang balancing method*. I derived it from a hypnotherapeutic technique called "pain transferal" which involves a person imagining the transferal of their pain to another part of the body.²⁵ By adding to this the idea of *yin* and *yang* in Taoist theory, we have the benefit of adding a many thousand year-old understanding of the pathways of energy in the body, thereby allowing the person to transfer the energy by coming into alignment with a ready made stream. Whether we want to believe that this stream is "real," when we visualize it, and imagine that it is real, our mind activates our healing powers.²⁶

In the *yin yang balancing method*, a person imagines more energy flowing through the *yin* (cold, weakened, etc.) part of the body and less energy going through the *yang* (hot, strong, acutely injured) part of the body. Terry learned to imagine and experience her breath turning into warm water flowing through her uninjured left leg, and cooling gentle waters flowing through her injured leg.

Terry learned to play with the sensations, and to control and trick her body. For example, in one session, she imagined "a hula hoop"²⁷ extending through the points on both ankles. At first the hula hoop was blocked where her injury was; but gradually, as she imagined the

compassionate light of the sun melting the ice block there, the water flowed throughout the hoop evenly. While she was playing with her mind/body connection she forgot which leg was the one in the accident.

FINDING THE BALL OF CH'I WITH OUR HANDS: FOR PAIN RELIEF AND HEALING

The use of various postures is another Taoist contribution to alleviating pain, and perhaps also developing the ability to heal a particular damaged or diseased region of the body. One posture involves using outstretched arms to enhance the healing ability and cultivate the *ch'i* in our hands.²⁸

Directing a subject to experience the force that attracts outstretched hands together is well known in hypnotherapy. In the *Stanford Hypnotic Clinical Scale* a subject's ability to enter into trance is assessed is by putting his or her hands in a position facing each other, and imagining a force attracting them toward each other.²⁹

Another hypnotherapist who uses the outstretched hands to create trance is Ernest Rossi. He uses it for the purpose of ideomotor signaling, to measure the subjects responsiveness to the inner work occurring.³⁰ For example, "If your creative (healing) unconscious is ready to begin therapeutic work, you will experience those hands moving together all by themselves to signal yes; but, if there is another issue that you

need to explore first, you will feel those hands being pushed apart."

In *qigong* practice, a similar posture is held, though the methodology is more intricate (having developed over thousands of years) and the intention is more broad. The hypnotherapist focuses on using the outstretched hands to create a "trance" and to facilitate the reorganization of the psyche. For the practitioner of *qigong*, the energy in the outstretched hands is developed for the purpose of self-defense, personal empowerment, and healing acute and chronic disease. As well, a long Taoist lineage promotes meditation in these the postures to find keys to open the energy gates to the spiritual healing energy of the body and the cosmos.³¹ Cultivating the energy in between the hands is viewed as a way to effect the universe of energy that the practitioner holds, qualitatively and quantitatively.

For example, the *Yi Chuan* *qigong* tradition³² is oriented to experiencing a ball of *ch'i* which then can be used for whatever purpose the practitioner focuses upon.³³ *Yi* translates as intention, and *Chuan* literally translates as fist. But the esoteric meaning of holding the five fingers into a fist is to grasp, or bring into a whole, the healing energies of the five elements: fire, earth, metal, water and wood. Depending upon the practitioner's intention the *yi chuan* postures can be used for self defense, healing, personal empowerment or transforming *ch'i* into *shen* (spirit). The

outstretched hands in the position used in the Stanford scale and by Rossi is similar to position number six of eight postures used in the *Yi Chuan*.

In this tradition, a period of sitting or standing in stillness is advised as a first step before raising the two hands into a fixed posture.³⁴ These meditation positions are very specific, and oriented to developing to a maximum the body's energy.

A few of the elements to be aware of while practicing sitting or standing are: In sitting, place yourself on the edge of the chair, the spine is straight, chin slightly tucked, hands on the knees face down, feet straight forward and



Dr. Michael Mayer (center) checks standing meditation postures of doctoral Psychology students and a medical doctor who are learning how to use *Qigong* for healing at the California Institute of Integral Studies Psy. D. Program.

under the knees. For standing meditation, the hands are by the side, the feet straight forward, knees slightly bent, chin slightly tucked, and the pelvis is slightly tucked so that the *ming men* center behind in the lower back is filled out.³⁵

The spine is naturally stretched by these methods so that the *ch'i* is sunk and the spirit is raised. The practitioner may be instructed to either practice microcosmic orbit breathing for a few minutes, focus on the natural breath or focus the intention on the *tan tien*.³⁶ Then the teacher may tell the student to allow the hands to rise, as if in water, until they are in front of the heart. Palms are facing each other as if they are around a helium balloon, the elbows are slightly away from the body and are not locked. The practitioner continues the breathing techniques mentioned above with the hands in this position, and then is instructed to see if he or she can experience a stickiness as the hands are gently pulled apart, away from the ball of energy. Likewise, the person is instructed to try to compact the ball of energy and see if they can experience its substance.

In more advanced practice, a student of the tradition learns to direct the *ch'i* of the *meridians* (lines of energy through the body) with his or her intention. One method used is to practice the focus of intention on one hand and note any sensations or energy that follow the movement of awareness. Small circular hand movements are sometimes used to enhance this direction of healing energy into the *laogong* points³⁷ in the center of the palms or finger tips. For example, in the Tai Chi Ruler qigong tradition³⁸ (*Tai Chi Chih*), wooden balls are held between the palms and circular movements are practiced to open the *laogong* points. The practitioner is also instructed in how to cultivate *ch'i* by moving the hands in small circles without the ball there.

It would be heuristic to further explore how the combination of hypnotherapeutic visualization techniques and qigong postures enhance "trance" and healing. In my private practice, for example, I may ask a client to imagine the following:

The ball that you feel in your hands can be filled with whatever you desire, and its energy can be

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*directed to wherever you choose. First, you might imagine that the love in your heart enters into the balloon. Then, just as you earlier felt energy enter into one hand through the direction of intention there, so can you feel it's energy spread throughout the body wherever you want to direct it. By letting go on your out-breath, and imagining the compassion of your heart melting any ice blocks in the rivers of your *ch'i*, you can gradually let go of tension in your body, and direct that liberated healing energy to wherever it is needed.*

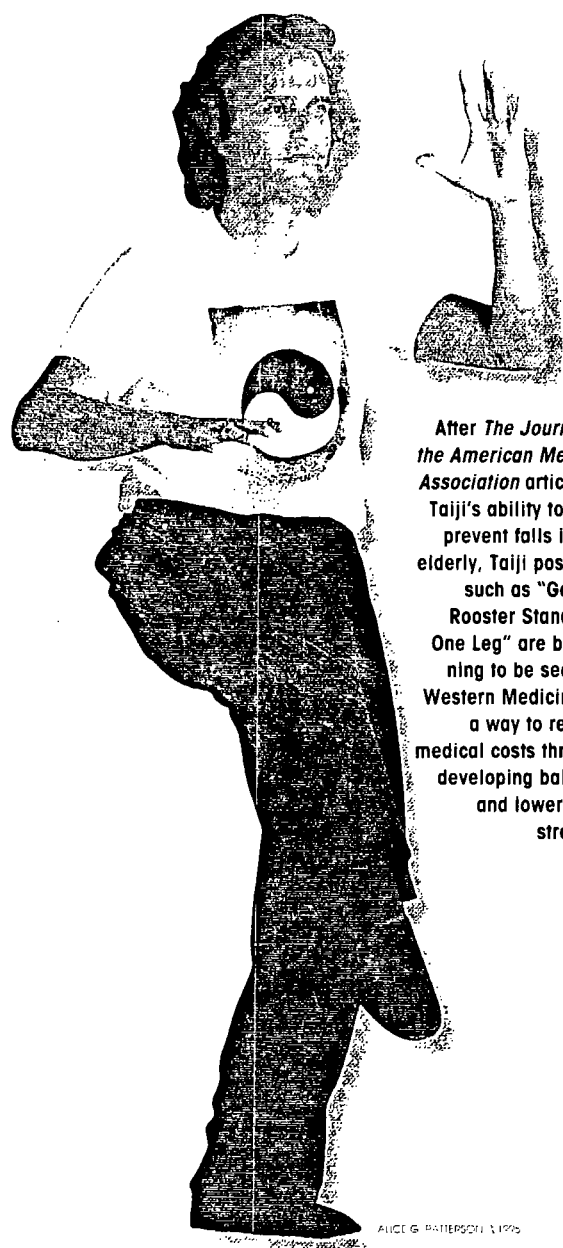
ACUPRESSURE POINTS AND PAIN

In various qigong traditions, including acupressure, touch is used to focus the *ch'i* developed in fixed postures. Touch adds a further step to the *yin yang balancing method*. By teaching psychotherapy clients to touch their own acupressure points, rather than a practitioner touching them, various ethical and clinical problems are avoided.³⁹

Terry learned to hold her hands apart to activate the experience of the ball of *ch'i* in her hands. When the inside of her ankle hurt, she learned to touch and direct healing energy to points on the outside of the ankle, more strongly as she either very lightly made contact with the inside point that hurt, or didn't touch the inside point at all.

When Terry touched a point in the little hollow anterior to the outside ankle bone (Gall Bladder 40), known to be beneficial to ankle pain, she reported a release of the pain to zero S.U.D.S. level within ten out-breaths, accompanied by a perception of green light filling the room. (Terry had never had an experience of seeing light like this before.) If the outside of the ankle hurt, we would have similarly had her experiment with touching a point next to the inside of the ankle bone (such as Kidney 4). Also, Terry learned to press acupressure points more strongly on the ankle opposite to the one which was hurt and to touch points on her hurt ankle more softly, or not at all. This helped her to learn to balance the energy in both legs. In the very first session that she tried this, she had the experience of creating that balance.

Terry began to see her homework as spiritual practice to learn to work with her pain and let it teach her. She opened her heart to send love to the hula hoop of her pain. She also reported the experience of the hula hoop dissolving, and a feeling like the water in it changed to gas, as the boundaries between herself and the world dissolved into a pleasant feeling of lightness and heaviness combined. If an old Taoist was listening to modern Terry he or she might describe the boundless feeling she experienced as *wu chi*, described in ancient texts as the void, emptiness or healing reservoir from which *ch'i* derives.⁴⁰



After *The Journal of the American Medical Association* article on Taiji's ability to help prevent falls in the elderly, Taiji postures such as "Golden Rooster Stands on One Leg" are beginning to be seen by Western Medicine as a way to reduce medical costs through developing balance and lower limb strength

After 5 sessions Terry felt like she no longer needed to see me because she was able to achieve a zero S.U.D.S. pain level anytime she did the above practices. In addition, she noted improvement in her ability to walk, though from a scientific standpoint we can not know whether this improvement in ability to walk was a function of time and would have occurred without treatment.⁴¹

An important final note of caution: Not all people will find relief from these methods as quickly as did Terry. From the perspective of *qigong*, pain relief is one step on the path to spiritual growth, and letting go of trying to get rid of pain. "Trying" constricts the river of *chi*, "letting go" to our process allows the river to expand and find its natural course. There may be moments when we hit into the rocks in the downward currents of the river of our pain, and breathe in and out of it to find our center as we ride the rapids of physical and emotional agony. At other moments our breath leads us to merge with *wu chi*; and we are held in the warm embrace of the ocean of energy that is the mother to all life.

With any technique we need to be careful that we don't produce a personal attribution of shame when "cure" doesn't come as quickly as we might like. Hence the distinction between *cure*—the absence of symptoms, and *healing*—an attitude that whatever life presents us with is an opportunity for psychospiritual growth in the meeting of suffering. Many patients who have had more severe long-lasting pain than did Terry, report being thankful that they have *qigong* as a partner that gives them breathing room, and to find the heart of being with pain.

DEALING WITH VARIOUS TYPES OF PAIN: THE MEDICINE WHEEL OF POSSIBILITIES

Each type of pain leads us on a journey to different methods from the wide variety of healing traditions. As the native Americans would say each place on "the Medicine Wheel" has its value.⁴² Sometimes the pain due to a subluxated vertebrae may be helped by a chiropractic adjustment, at times when our own *qigong* practice is not able to remove a given energy block an acupuncture treatment may help. When a person is too debilitated to do standing or even sitting meditation, yoga postures lying down may be

the best posture in which to breathe and work with our pain. Sometimes prayer helps.⁴³

Pain leads us on a journey to rediscover the natural healing elements of the world around us. The most basic elements of the *yin* and *yang* of life, such as hot and cold, may become the medicine we need. Using ice packs during the early phases of an acute injury, and warm compresses during the later stages, or in chronic blockages exploring the back and forth of warm and cold packs may do the trick. An herbalist may have information for us that will help us remember that the world of nature is our ally.⁴⁴ Homeopathic remedies are based on the notion that like cures like, and use the minutest amounts of a substance to create a response in our immune system, for example using a diluted amount of nettles to heal pain. Homeopathic treatment opens our mind to wonder about the healing potentials of the things around us that we take for granted; including our own minds.

Western Doctors and medications may help us to appreciate being part of evolving civilization, for the pain killing drugs used by modern pharmacology, at times derive from the eons of embodied biological intelligence that has developed in the natural world. For example, a new pain relieving drug, SNX-111, is a synthetic copy of a natural neurotoxin isolated from the venom of seagoing snails.⁴⁵

Qigong energetic practices can be viewed as the center of the Medicine Wheel approach to pain; they can be combined with any other approach, including pharmacological. For example, in a research study in China, 127 patients with advanced cancer were divided into two groups, a *qigong* practicing group and a control group, which did not practice *qigong*. Both groups took drugs. The *qigong* group improved significantly compared to the control group in the following measures: strength, appetite, diarrhea free, weight gain and in their immune systems' phagocyte rate. The *qigong* practices helped to ameliorate the effects of the drugs.⁴⁶

Each different type of pain initiates us into the lessons of its own particular pathway. At times, finding ways to distance from the pain is helpful. We use our breath to find a calm place inside where we know we have pain, but are not that pain. We may thereby learn to cultivate concentration and equanimity in the midst of our suf-

fering. At other times, we may choose to go into the pain. Buddhist *mindful meditation* can be very helpful at such times to be with the sensation of pain instead of distancing from it.⁴⁷ We explore its various qualities including temperature and tightness; metaphors arise of pin pricks, knife stabbing or demons grabbing our stomachs as we become yogis, or internal marital artists, exploring and handling the elements of pain. Something about us shifts in the being with it; maybe we find compassion for our pain instead of fighting against it.

"FOCUSING" ON THE MEANING OF OUR PAIN

Every pain contains a message that has its own unique meaning, and its own voice. If we listen to it, we are led to appropriate action. Sometimes our stomach pain says that a certain food is disagreeable to us. Other times a psychological meaning needs to be faced. Being able to read the inner book of our feelings is the missing ingredient in "symptom relief" schools of thought on pain relief.

Western psychotherapy has many tools to discover the meaning of pain.⁴⁸ Gendlin's *Focusing*⁴⁹, for example, is a six step process for finding the felt meaning of any psychological issue, including our pain. First we learn how to *clear a space* from our pain through a variety of distancing techniques that enable us to find the right distance from our pain, not too far away and not too close. I often have patients use *qigong* breathing techniques to clear a space. For example, we can use the macrocosmic orbit to breath out pain or tension, and imagine the pain coalescing into an image of ourselves. From this distance we may be able to get a better handle on its meaning. Secondly, we *find a felt sense* of the issue, by tuning into that unclear sense in the body where the felt meaning feels like its "on the tip of our tongue." Third, we *find a handle word or image* that opens the door to the description of that sense. Fourth, we *resonate* the emerging thoughts or images back with the body sense to see if we're hitting the center of the target. Fifth, we, or our focusing guide, *ask questions* of the felt sense such as "What's the worst thing about this issue?" While practicing these five steps, oftentimes the felt meaning of the issue emerges and a *felt shift* occurs. Sixth, we *receive* the information we get from our body/mind with appreciation, and

explore where the information leads us in terms of life changes.

For example, one man in his early 40s who focused on the thoughts that arose while breathing into, and out from, his chronic lower back pain, remembered repeated beatings with a wire coat hanger by his mother when he was a child. He was able to begin a process of working through his feelings about this, and releasing the held emotions that had been stored there for years. A continuously smiling teacher, who focused on her recurring headaches, realized that they often occurred when her husband didn't help with the housework and meal preparation.

By being conscious of her pain she was able to work through a long standing message from her matrilineal lineage that "women are supposed to grin and bear it." As she learned to be comfortable expressing her feelings, including anger, her headaches disappeared.

Generally speaking, in cases of internally generated pain such as headaches, muscular aches and energy blockages, stress begins at the level of mind, signaling us that inner emotional reprogramming needs to take place. Before realignment takes place, the off-centered pattern manifests on the level of *ch'i*, then is translated into the musculature and finally to the spine. By using psychotherapy in conjunction with *qigong* practices, we can work on realigning ourselves, and finding our center in the midst of the cross-currents of our emotional terrain. The *yi chuan* standing meditation *qigong* practices discussed earlier can be particularly helpful in this regard for experiencing, and realigning, structural deficits that derive from our genetic and characterological makeup.

CONCLUSION

In 1996 the *Journal of the American Medical Association* reported on The National Institute of Health panel which reviewed numerous well designed studies of pain relief. The panel concluded that chronic pain could be significantly reduced with a wide variety of behavioral and relaxation methods.⁵⁰

In the present article we have explored how

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qigong can be an addition to the relaxation and hypnotherapeutic methods that have been used to alleviate the suffering of chronic pain. As a

practitioner, I have appreciated seeing the positive effects of these age-old Chinese methods in my private psychotherapy practice on Western patients with a wide variety of acute and chronic pain related syndromes including cancer, multiple sclerosis and back and neck problems.⁵¹ As well, I feel grateful for having the opportunity to stand at a place and time

where the streams of Western behavioral medicine and ancient *qigong* practices can merge together to benefit people in the healing the body and mind in general.⁵²

In the past, western culture has looked at the practices of indigenous cultures as something less than Western medicine and psychology. We have treated these age-old practices with an attitude similar to the way the missionaries treated the practices of Native Americans.

In the midst of the current health care crisis of dollars and values we may do well to investigate and incorporate the teachings of ancient lineages into our current medical and psychological methodologies—honoring our ancestors and colleagues who learned to heal from traveling pre-technological pathways. By not including ancient sacred wisdom traditions into our approach to the psyche we commit a crime analogous to our cultures running over the Native Americans. We get to occupy the land; but we lose the sacred knowledge of how to be with its treasures.



Dr. Michael Mayer has dedicated the past twenty years to teaching and writing about the integration of ancient and modern methods of healing the body/mind. During this time, he has been a practitioner and teacher of various approaches to oriental healing including taiji ch'uan, *qigong* and acupressure. He enjoys presenting his integrated approach to healing at national and international conferences and workshops, at various universities including The California Institute of Integral Studies, and at various hospitals including Alta Bates. Dr. Mayer is author of *The Mystery of Personal Identity* (ACS 1985), *Trials of the Heart: Healing the Wounds of Intimacy*

(Celestial Arts, 1994) and is currently working on a book on *Healing with Qigong and Psychotherapy*. He is a licensed psychologist, hypnotherapist, and a teacher of qigong. He can be contacted at The Psychotherapy and Healing Center, of which he is the director, at 2029 Durant Ave., Berkeley, CA 94704; Phone 510-849-2878, Fax 510-254-5647, Email: mm@slip.net

FOOTNOTES

1. Sternbach, R., *Survey of Pain in the United States: The Nuprin Pain Report*, The Clinical Journal of Pain, 1, 49-53, 1986.
2. Employees think that more than two-thirds of all full-time employees, the equivalent of more than 80 million people, suffer from pain related conditions. Managers think 20% of employees suffer from pain. *The Pain and Absenteeism Report: A Study of Full Time Employees and Employee Benefit Managers*, Ortho McNeil Pharmaceutical and Louis Harris and Associates Inc., June, 1996. For a copy of this report fax 212-885-0570.
3. The cost of \$90 billion includes compensation claims, time off work, medication, disability allowance and direct treatment. See Taylor, S., *Health Psychology*, 2nd ed. New York: McGraw Hill, 1991 Quoted by Groth-Maarnat, G. Professional Psychologist in General Health Care Settings: *A Review of the Financial Efficacy of Direct Treatment Interventions*, Professional Psychology: Research and Practice, Vol. 27, No 2, p.166, 1996. The statistic of \$100 Billion for pain remedies include temporary pain relief from colds, headaches, chronic pain etc. Taylor, S., *Health Psychology*, 2nd ed. New York: McGraw Hill, 1991 Quoted by Groth-Maarnat, G. Professional Psychologist in General Health Care Settings: *A Review of the Financial Efficacy of Direct Treatment Interventions*, Professional Psychology: Research and Practice, Vol. 27, No 2, 161-174, 1996.
4. For a review of the literature on various relaxation and behavioral techniques for relieving chronic pain see the report from the NIH (National Institute of Health) Technology Assessment Panel on *Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia*, Journal of the American Medical Association, July 24, 1996 Vol. 276, No 4. The NIH panel reviewed numerous well designed studies of pain relief which used a variety of behavioral medicine approaches including: relaxation methods such as progressive relaxation (tightening and loosening various muscles of the body), meditation, hypnosis, autogenic training, biofeedback, and cognitive behavioral therapy. The report found strong evidence for the reduction of pain using relaxation techniques and hypnosis and moderate evidence for the usefulness of CBT and BF. The data of meta-analysis consistently showed positive effect of these behavioral and relaxation programs; evidence was insufficient to show that one technique was more effective than another in reducing chronic pain. "For any given individual patient... one approach may...be more appropriate than another."
5. One source for a wide review and discussion of the medical literature on pain and pain medication is the Roxane Pain Institute, check at www. Roxane. com. In terms of medical devices there are a wide variety. such as electrical transcutaneous electrical nerve stimulation (t.e.n.s units), i.e. electrically stimulation devices that give relief to many who suffer sports related, and other kinds of pain. Some of the modern drugs that are used for pain relief are coumarin, which has collagen reducing effects, cortico-steroids, percodan, dilaudin, elavil and heparin. The most recent advertised "panacea" for severe pain are the long-acting opiates, such as morphine— now given in graduated doses to provide steady relief, but no euphoria. The idea behind this pharmacological advance is that this will lessen addiction to these drugs; and there is some evidence to prove this is the case. Addiction is composed of two factors, tolerance—the compulsive craving for increasing amounts of a drug over time, and dependence—the withdrawal symptoms that come from stopping a drug abruptly without tapering off. The evidence is still inconclusive; but research at this time seems to show that when

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taken properly, long acting opiates do not produce tolerance in most people; however, they can produce dependency. See Jetter, A. *The End of Pain*, Hippocrates, Sept. 1996, p. 45.

6. Side effects of various drugs need to be carefully weighed in the decision as to whether and when to use various medications. Speak to your Physician about this and check yourself such books as the Physicians Desk Reference, PDR; *Worst Pills, Best Pills II*, Public Citizens Health research Group, 1993; Breggin, P., *Toxic Psychiatry*, St. Martin's Press, 1991, etc.
7. As one example of the presentation of considerations about taking medication see Jetter, A. *The End of Pain*, op. cit. On the "critical of opiates" side of the debate is John Loeser, a neurosurgeon from the University of Washington School of Medicine in Seattle. On the pro-opiate side is Dr. James Campbell who runs the pain clinic at John Hopkins Hospital. Also Dr. Russell Portnoy, a neurologist at New York's Sloan Kettering Hospital reports that his cancer patients on opiates did not develop tolerance—a compulsive craving for increased amounts of the drug.

Another area of caution involves contradictory scientific reports on the relationship between opiates and cognitive deficits. Hippocrates op cit. p 48. Dr. Loeser says that the opiates dull patient's thinking in some cases, whereas a study at John Hopkins on 20 patients found no evidence of mental clouding after six months of use. Other studies support Loeser's view. Other areas of consideration that need to be taken into account when taking these drugs are the early side effects of sleepiness, nausea during the initial phase of taking it; and constipation often can be longer lasting. A potentially fatal risk factor involves the person who takes too much at once and doesn't listen to the advice of their Physician who usually advises carefully ratcheting up the dosage over a few weeks. Going against the advice of a Doctor here can potentially have dire consequences—respiratory failure and death. Those who use morphine pumps to provide graduated doses often get infections at the point of insertion. On the other hand, many people in severe pain get the benefit of relief, since long acting opiates mimic the body's pain fighting endorphins. They blanket the spine's pain receptors, preventing the message from arriving.

8. Chopra, D., *Quantum Healing*, Bantam Books, 1989, p 62-3.
9. Other historical researchers date qigong to 168 BC, where, in the King Ma tomb, forty four standing and seated Qigong postures were depicted in a chart with associated commentaries and prescriptions for various diseases. Cohen K., *Qigong: Cultivating the Vital Breath*, ISSSEEM, Vol. 1, No 2, Fall 1990, p.9. Some speak of its origins in the *Yi Ching*, or book of changes. One source describing the history of qigong is Ming, Y.J., *Chi Kung: Health and Martial Arts*, YMAA Pub., 1985, Chapter 1.
10. The Beijing estimate is from Eisenberg, D., *Encounters with Qi*, W.W. Norton 1995. p.207. The estimate of 80 million qigong practitioners in China comes from *Life Magazine*, *The Healing Revolution*, September, 1996.
11. Lerner, M., MIT Press, Cambridge: Mass, 1994 p 389
12. Eisenberg, D., *Encounters with Qi*, W.W. Norton, 1995.
13. A qigong data base of 1000 abstracts of the papers presented from these proceedings, including articles from 160 scientific journals, has been prepared by the Qigong Institute of San Francisco, 450 Sutter St. #2104 S.F., 94108. At the "First World Conference for Academic Exchange of Medical Qigong" which was held in Beijing in October 1988 many scientific papers were presented giving data to support claims of the effectiveness of Qigong in healing. Of 137 papers presented only three were from the United States, one from Canada almost all of the others were from China. The research described in the abstracts does not always meet strict scientific standards; but taken as a whole the favorable results suggest that there should be more rigorously done follow up studies to determine how qigong can improve western health care.
14. Lu, Guangjun, 2nd World Conference for Academic Exchange of Medical Qigong, Record 8010, Database from Qigong Institute of S.F.
15. Shen, Fudao, Hubei College, Wuhan China, Second World Conference, 1993 See record 8090 Qigong Institute Data base.

16. Wang, Shouzhang., Henan Tumor Hospital, Zhengzhou, China and Annual Conference, Since 1985, cancer patients have used long-term qigong exercises side by side with giving them routine treatments such as chemotherapy, radiotherapy and surgery. Results seem to show that this combination of qigong-chemotherapy in the management of cancer has the advantage of raising the curative rate, extending the tumor-free survival time of the patients, lessening of nausea, increased strength, improvement of appetite, and bettering the quality of their survival. See McGee, C. and Chow, *Miracle Healing from China*, Medi-Press, 1994 Coer d'Alene: ID 1994, p.173.
17. See McGee, C. and Chow, E. *Miracle Healing from China: Qigong*, Medipress, 1994., pp. 203-210.
18. For copies of their materials and conference proceedings contact ISSSEEM, 356 Goldco Circle, Golden, Co., 80403.
19. Many psychophysiological measures may be effected by practicing qigong. There may be psychophysiological correlaries to the relaxation response including change in brain wave patterns, neurochemical release, etc. Research from Japan indicates qigong's ability to effect the immune system and endorphin levels. In this study, a sitting control group experienced a 35% decrease in endorphins after 1 hour sitting, whereas the qigong group showed an increase in endorphins after practicing qigong. Higuchi, Y., *Endocrine and Immune Response during Qigong Meditation*, Journal of International Society of Life Information Science, (ISLIS) Vol. 14, No. 2, Sept., 1996. Many questions remain as to whether studies on *ch'i* have proved the existence of *ch'i* or whether some epiphenomenon is being measured. Voll measured the electrical conductance of the skin above individual acupuncture points of qigong practitioners, and significant differences were found. It should be kept in mind that this doesn't necessarily measure *ch'i*, it measures "it's" effects. See Sancier, K., *The effect of qigong on therapeutic balancing measured by electroacupuncture according to Voll*, Acupuncture and Electro-Therapy Res. Int. Journal 1995, 19: 119-127. See reports of Feng Li Da's ability to increase or decrease bacteria cell growth with qigong, in McGee, C. and Chow, E. *Qigong: Miracle Healing In China*, Medipress, 1994. Likewise, this study points to the effects of a qigong masters hands over a medium, and doesn't necessarily show whether *ch'i* exists. In the past, Western scientists viewed the actuality of energy existing in the meridians of the human body with skepticism, but recent research is exploring the ancient notion that meridian lines of energy in the body in fact exist. On the side of *ch'i* being objectively real see Kaptchuk, T. *The Web that has no Weaver*, Congdon & Weed: NY., 1983. Thermally sensitive film shows qigong masters' emission of energy down lines similar to classical acupuncture meridians in Lerner, M., *Choices in Healing*, MIT Press, Cambridge, Mass., 1994 p. 389. Credit should be given to the early research of Becker, R., *The Body Electric*, William Morrow, N.Y. 1985 pp. 234-7, has shown the healing effects of electrical energy in a Western context. Also see Serizawa, K., et al., University of Tokyo School of Medicine; "Individual Pattern Changes in the Distribution of Skin Temperature and Electrical Resistance," 1964 and "The Distribution of Skin Temperature and Point Meridian Phenomena, 1976 quoted by Teeguarden I. in *The Joy of Feeling*, Japan Pub., 1987. In general, see the vast literature on acupuncture. A hypothesis for this stage of our knowledge is that qigong practice induces effects in many areas of the human anatomy simultaneously: energetic, brain wave functioning, biochemical measures such as endorphin levels etc.
20. Among the numerous sources for descriptions of microcosmic orbit breathing are: Huang, Wen-Shan, *Fundamentals of Tai Chi Chuan*, South Sky Book Company, Hong Kong, 1974; Chia, Mantak, *Iron Shirt Chi Kung*, Healing Tao Books, Huntington, N.Y., 1986. Wilhelm, R. & Jung, C., *The Secret of the Golden Flower*, Harcourt, Brace & Jonovich, 1931; and Cleary, T., *The Secret of the Golden Flower*, Harper, S.F., 1991.
21. The macrocosmic orbit travels from the bubbling well points on the bottom of the feet (K 1) up the legs and back and then like the microcosmic orbit over the top of the head down

Research from Japan indicates qigong's ability to effect the immune system and endorphin levels. In this study, a sitting control group experienced a 35% decrease in endorphins after 1 hour sitting, whereas the qigong group showed an increase in endorphins after practicing qigong.

through the pallet where the tongue touches the roof of the mouth behind the teeth and then down the front of the body to the feet (K 1).

22. Two sources for the use of imagery in healing: Achterberg, J. *Imagery in Healing: Shamanism and Modern Medicine*, New Science, 1985; and Rossi, E. *Mind-Body Therapy: Methods of Ideodynamic Healing in Hypnosis*, W.W. Norton, 1988.
23. Hilgard and Hilgard, *Hypnosis in the Relief of Pain*, William Kaufman Inc., Los Angeles, 1983, see also earlier footnote on NIH report on pain.
24. Check with an acupuncture chart to see the exact location of K 1 which is slightly forward of the bottom center of the foot.
25. See Hilgard and Hilgard, *Hypnosis in the Relief of Pain*, William Kaufman Inc., p. 65, 1983.
26. There is a voluminous research that demonstrates that by imagining something to be real in the body, oftentimes physiological changes take place. See for example Achterberg, J., *Imagery and Healing*, New Science, 1985, Chopra D. *Quantum Healing*, Bantam, 1990 and Rossi, E. op.cit.
27. A hula hoop, for those who do not know, is a modern toy made of plastic, formed in the shape of a hoop that is usually placed around the waist, and kept in motion by gyrating movements in the pelvic area.
28. In China there are a wide variety of reports that qigong masters can emit energy from the hands and effect cell cultures, increasing or decreasing bacteria, and even killing cancer cells. See Sancier, K., *Medical Application of Qigong and Emitted Qi on Humans, Animals, Cell Cultures and Plants: Review of Selected Scientific Research*, American Journal of Acupuncture, Vol. 19, No. 4, 1991. Also see *Qigong, Miracle Healing in China*, p 164-165, op. cit, for reports of Feng Li Da's controlled study whereby killing and inactivation of 31 % of cancer cells occurred in the experimental group with emitted chi. All cancer cells survived in the control group. Reported at the First Medical Conference for Medical Exchange of Medical Qigong, 1988. The line is difficult to draw between whether studies on qi emission prove emission of qi, or is a function of hypnosis, some psychokenetic phenomenon, biochemical release of endorphins and other neurotransmitters, etc. Research in this emerging field needs to be subjected to further research and analysis. In private correspondence Dr. Sancier reports that low frequency sound in the 3-12 hertz range has been measured from the laogong points. There are those that have developed "Qi Machines" that attempt to replicate the vibratory rate of qi, such as Richard Lee, China Healthways 1-800-743-5608. Further research needs to be done as to how these machines measure up to the real thing, and what their positive and negative side effects may be.
29. See Hilgard and Hilgard, *Hypnosis in the Relief of Pain*, William Kaufman Inc. 1983 pp. 241-250. The scale was standardized by Arlene Morgan and Josephine Hilgard.
30. Rossi, E and Cheek, D., *Mind-Body Therapy-Methods of Ideodynamic Healing in Hypnosis*, W.W. Norton, N.Y., 1988, p. 39.
31. For example, one energy gate in the center of the palms is called the *Laogong* point or Pericardium 8. They can be found by making the fingers curl inward into a fist, where the fingers press into the inner palm between the extension of the bones of the two inner middle fingers. These points are also useful on a cold day to generate heat in the hands. Massage practitioners and healers that use qigong report using these points for emitting *ch'i* to heal others. See later footnote # 35 for more information on these points.
32. Dr. Mayer has practiced *Yi Chuan qigong* (Yi means intention in Chinese), also called *zhan zhuang* (standing like a tree), for twenty years. He taught it at JFK University and at the California Institute of Integral Studies Doctoral Program, and was introduced to it by Masters Fong Ha and Han Xingyuan, the latter having studied with its originator Wang Xiangzhai. One person whom Dr. Mayer taught it to, Taoist Scholar, Ken Cohen describes this method as the million dollar secret of qigong in his *Way of Chi Gung* Tapes from Sounds True Catalogue, Boulder, Co. One written source for learning how to work with the ball of magnetic force between the hands in the *zhan zhuang*

tradition is Chuen, L., *The Way of Energy*, Gaia Books, 1991, p. 127. Also see Diepersloot, J., *Warriors of Stillness*, Walnut Creek: Center for Healing and the Arts, 1995. Paul Dong in his book, *Chi Gong: The Ancient Chinese Way to Health*, Marlowe & Co. New York, 1990, p.127 reports that the zhan zhuang standing meditation practice began 2,000 years ago with Taoist philosopher Wang Chong-Yang.

33. As well it is used to embark upon the path toward developing the much talked about "empty force," *kung jing*, whereby the practitioner discharges a fellow practitioner without touching them. See Ha, F., "Is Empty Force Real?" *Tai Chi Magazine*, Los Angeles, Vol. 15, No 4, August 1991, also see Dong, P., *Chi Gong...*, Marlowe and Co., N.Y., 1990 and his later book specifically on *kong jing*.
34. The qigong meditation posture in stillness is called *wu chi*, translated as the void, stillness or reservoir from which *ch'i* emerges.
35. For more specific instructions See Ha, F., *Yiquan and the Nature of Energy*, Summerhouse Publications, Berkeley, Ca., 1996 or Diepersloot, J. op.cit. But the best way to learn these methods to assure proper posture and training is to study it with a teacher of the *Yiquan*.. For example, when standing we can imagine four points in a straight line, to activate our center line, the points being: the point between the two feet, the *huiyin* point between the anus and genitals, the center point between the *tan tien* and *ming men* right below the navel and the *baihue* point at the top of the head. Without postural corrections from a teacher limitations or pitfalls in practice can arise.
36. Taoists believed that this energy center, two or three finger widths beneath the navel, was a key point for meditation, being at the center of the body.
37. Some evidence supports the idea that *chi* is emitted from the *laogong* points, also called Pericardium 8, can be found in Mcgee, C., and Chow, E., *Qigong: Miracle Healing from China*, Medi-press, 1994, pp. 37-38. Measures include raman spectra, ultraviolet spectra, infrasonic emission at low frequencies in the one to twelve hertz range, microwave emissions, magnetic field generation and electrostatic field generation. Reports in this book say that qigong master Yan Xin could effect the decay rate of a radio-active compound. The studies reported in this book often were not footnoted, or subjected to Western Scientific methodology, and need to be further documented and replicated. Scientists with whom this author has dialogued in private correspondence have many doubts about some of the data, in particular on raman spectra and the effects on radio-active compounds. These reports on infrasonic emissions from the hands seems more likely to have validity. (See qigong data base from the Qigong Institute of San Francisco, op.cit.) Another clinician and researcher, Dr. Leonard Laskow in a controlled study reports measuring the ability of magnetic field emission from his hands being able to inhibit tumor cells 18% while practicing microcosmic orbit breathing. see Laskow, L., *Healing with Love*, Harper and Row, 1992, p 306.
38. Dunn, T., *Tai Chi Chih*. Interarts Productions, Beverly Hills, CA. Tai chi ruler can also be practiced without the technological devices of the ruler or balls by doing circular movements with the hands held apart like a ball.
39. Kilburg, R., *Psychologists and Physical Interventions: Ethics, Standard, and Legal Implications*, *Psychotherapy*, Vol. 25, No.4, Winter 1988, pp. 487-491. Goodman, M., *To Touch or Not to Touch*, *Psychotherapy*, Vol. 25, No. 4, Winter 1988, pp. 492-500.
40. Jou, T. *The Tao of Tai Chi Chuan*, Charles, Tuttle; Vermont, 1980 pp.77- 78. He discusses the classic notion of how Tai Chi, the yin and yang of creation derives from *wu chi*, or nothingness. One of the feelings associated with *wu chi* and *chi* is of heaviness and lightness at the same time. For more about the *wu chi qigong* tradition that the author has studied with Masters Cai Songfang and Fong Ha see Diepersloot, J., *Warriors of Stillness*, Center for Healing and the Arts, Walnut Creek, CA., 1995.
41. It would be interesting to have further controlled studies to determine if the methods above enhance healing compared to non-treated controls.

There is well documented evidence of the use of mindfulness meditation in reducing pain at the Stress Reduction Clinic at the University of Massachusetts Medical Center. In one study there, meditators showed a 36% improvement in pain...

42. Storm, H., *Seven Arrows*, Harper and Row, 1972.
43. For research on prayer's role in healing see Dossey, L., *Healing Words*.
44. One source of natural herbal remedies is Heinerman's Encyclopedia of Fruits, Vegetables and Herbs, Parker Publishing Company, West Nyack, N.Y.
45. Hall, C., *Snail Venom May Zap Pain*, S.F. Chronicle, October 10, 1996, p. B1, B4. Final proof that SNX-111 is effective is a long way off., and questions remain regarding side effects and dosage. However it appears to be promising in patients unable to tolerate conventional pain treatments including morphine. The drug blocks the calcium channel which is the neurochemical pathway through which pain signals travel through the spinal cord to the brain.
46. Sun Quizhi, Zhao, Li., *Clinical observation of qigong as a therapeutic aid for advanced cancer patients*, Proceeding, Second World Conference for Academic Exchange of Medical Qigong, Beijing, China, 1993. See Sancier, K. *Medical Applications of Qigong, Alternative Therapies*, Jan 1996, Vol. 2, No 1, p. 43.
47. There is well documented evidence of the use of mindfulness meditation in reducing pain at the Stress Reduction Clinic at the University of Massachusetts Medical Center. In one study there, meditators showed a 36% improvement in pain on the McGill-Melzack Pain Rating Index (PRI) while nonmeditators had no improvement, meditators showed a 87% improvement in mood, while the nonmeditators showed only a 22% improvement, meditators showed a 77% improvement in psychological distress, nonmeditators had an 11% improvement. Zinn, p 291, also reports that several laboratory experiments with acute pain have shown that "tuning into sensations is a more effective way of reducing the level of pain experienced when the pain is intense and prolonged than is distracting yourself." Zinn, J.K., *Full Catastrophe Living: Using the Wisdom of your Body and Mind to Face Stress, Pain and Illness*, Bantam 1990, pp. 288-318.
48. For example, psychoanalysis uses free association, phenomenological methods let a person explore their own unique experience, hypnotherapeutic traditions have contributed much and there are also contributions from cognitive -behavioral psychology in the management of pain using such techniques as relaxation, distraction and imagery. References for these go beyond the scope of this article.
49. Gendlin, E., *Focusing*, Bantam Books, 1978. Dr. Mayer was Eugene Gendlin's Focusing Training coordinator for 10 years.
50. The data of meta-analysis consistently showed the positive effects of these behavioral and relaxation programs; and that evidence was insufficient to show that one technique was more effective than another in reducing chronic pain. "For any given individual patient... one approach may...be more appropriate than another." The assessment panel specifically excluded the study of "religious and spiritual approaches which are among the most commonly used health-related actions by the US population." See earlier footnote on the NIH (National Institute of Health) Technology Assessment Panel on *Integration of Behavioral and Relaxation Approaches into the Treatment of Chronic Pain and Insomnia*, *Journal of the American Medical Association*, July 24, 1996 Vol. 276, No 4.
51. These results need to be subjected to a scientific research design, replicated by others, controlled for halo effects and positive transference in the self-reports of patients, etc.
52. At the California Institute of Integral Studies Doctoral Psychology program, and in his upcoming book, the author discusses his experience in the wider uses of qigong in psychotherapy and behavioral medicine. For a sense of the range of medical applications of qigong for healing, see Sancier, K., *Medical Applications of Qigong*, *Alternative Therapies*, Jan. 1996, Vol 2., No.1.

Testimony to the White House Commission on Complimentary and Alternative Medicine
Policy. September 9, 2000

San Francisco, CA

Lynn Murphy, Executive Director, Feingold Association of the U.S.

Thank you.

Introduction.

The Feingold Association is a non-profit consumer network of parents of children who are sensitive to food additives. We personally assist about 3,000 families a year and see a 60-75% success rate. They are the lucky ones, they have stumbled upon (usually without the help of a doctor) part or all of the answer to their child's chronic attention, behavior or health problems. But there are still many more. Consider just one condition, Attention Deficit Hyperactivity Disorder (ADHD), affects one out of 20 children. Over the past 25 years, we have assisted over half a million families nationwide to improve their quality of life simply by eating real food. It may sound strange, but we show them how to find real food in fast food restaurants and supermarkets and how to re-discover cooking. Most families who give it a good try report everything from "it takes the edge off my child's anger" to "completely normal, delightful child".

There are about 2 million other families of children with ADHD who are searching for answers to their children's problems. These are children who are at risk for school failure, child abuse, delinquency, adult criminal behavior and depression. Simply eating real food would not help every symptom in every person but one thing is for sure:

Why shouldn't they be told of this before they are put on powerful psycho-active drugs?

One reason is the physicians may be afraid to recommend something that is "a departure from the mainstream". One such physician, who you will hear about from the next speaker, had a licensing action against him for "departing from the mainstream". One of

the charges was recommending an elimination diet to rule out food and food additives as a trigger of behavioral symptoms. The irony is that there were many more studies showing a link between food coloring and hyperactivity than there were about the safety of psycho-active drugs. It did not impress the judge, however. The way it works in California is it doesn't matter if the patient gets better, and it doesn't even matter whether there are studies, is it "What is the mainstream of doctors doing."

What the mainstream is doing about Attention Deficit Hyperactivity Disorder is recommending a series of drugs and giving an approving nod to psychotherapy. Period. This does not foster progress in understanding the biological basis for ADHD, it does not serve families well and our nation's children are being drugged--many unnecessarily, *and there are severe side effects.* Hillary Clinton's task force is interested in just the safety-of-drugs issue.

Request #1. Could you please call her up and let her know that there is an issue that should be asked first--are these drugs really needed in the first place. I tried and she never returned my call.

The Feingold Association has also asked the assistance of the National Institutes of Health. Almost 2 years ago, a special panel developed a consensus statement about ADHD which included: "the studies were intriguing and worthy of more research."

Request #2. Could you please help us understand, how many studies are enough?

The Feingold Association is not the only organization to recognize the importance of the diet/behavior connection already existing in the literature.

The Center for Science in the Public Interest recently reviewed the studies for the past 25 years. Their recommendations include :

1. Government, private agencies and health practitioners concerned about children with ADHD and other behavioral problems should acknowledge the potential for diet to affect

behavior. They should advise parents to consider modifying their child's diet as a first means of treatment. Groups such as the U.S. Food and Drug Administration, International Food Information Council, and the National Institute of Mental Health should stop misinforming the public. How they are doing this is detailed in this report.

Request #3 Is there anything you can do to help correct this misinformation?

The CSPI report also recommends:

2. Research needs to be conducted to determine which (and to what extent) foods and food additives affect behavior, develop methods for identifying children most sensitive to foods, and investigate the underlying biological bases for sensitivity to dietary constituents. After all, understanding the underlying causes for these sensitivities may teach science something about the body, the brain and this syndrome called ADHD. The CSPI report has other recommendations, reviews the history of the research on of ADHD and diet. It details elements that should be considered in future studies.

A physician who
was working on
this was
disciplined
by the Medical
Board of Cal.

A side issue is relevant to all research which threatens the safety of a product. Just like the tobacco industry played around with facts about the safety of their products, there may be an equivalent in the food coloring industry. What 12,000 average people consume in food coloring in a day was studied and arbitrarily reduced. This is one way of insuring that few if any people will react to a chemical. Test just a trace of it. I've given you all the first page of the report that appeared in the journal Food Technology. Also there is a page showing the part that an industry group had in establishing these figures.

In summary, please check out the research yourself, and if there is anything you can do to get the powers that be to stop lying about the studies showing a ^{very REAL} connection between

food coloring and behavior, we would be very grateful--so would about 2 million kids and their families.

Thank you.

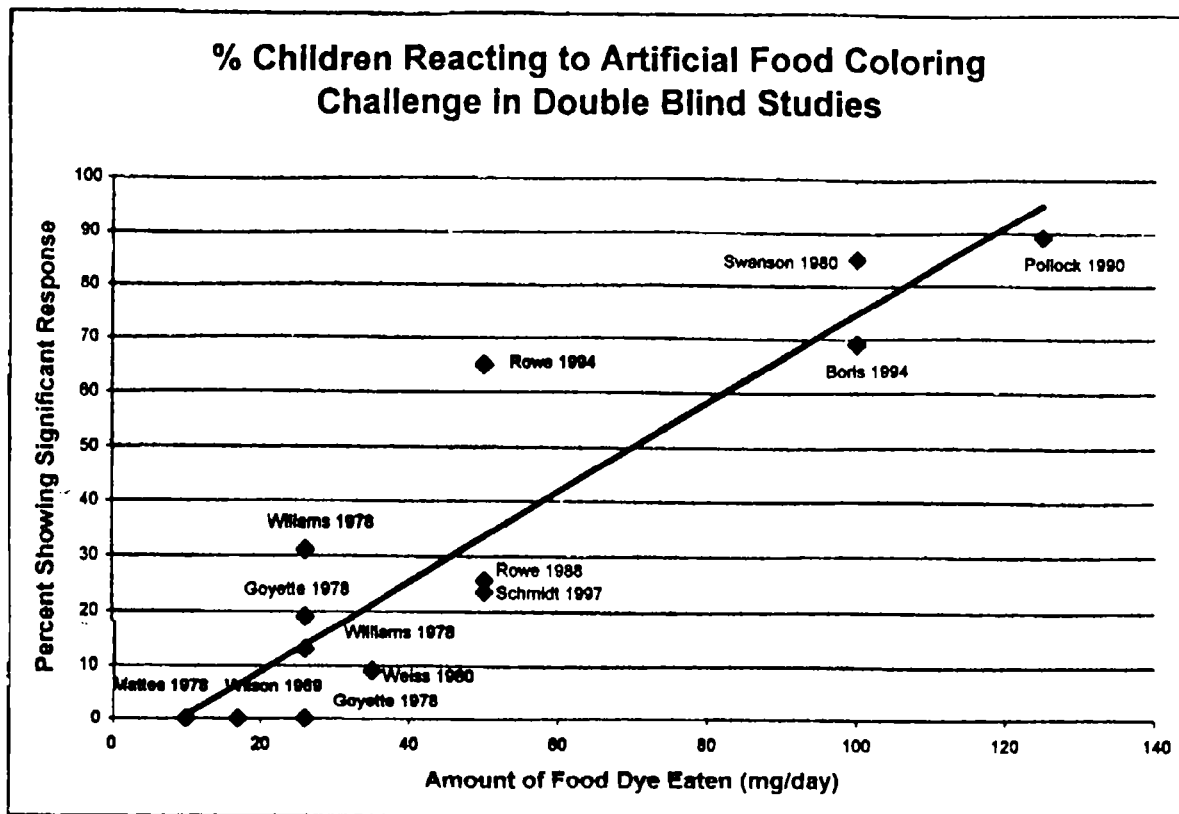


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A dietary connection to better behavior, learning and health
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→ 1977 National Academy of Science Survey of

Certified FD&C Colorants Consumed *per person per day* **327.6 mg**

→ **Nutrition Foundation** recommendation for amount of

artificial food coloring to be used in studies *per person per day* . . . **27 mg**

→ Amounts of artificial food coloring used in most

early studies on "Feingold"-type diets *per person per day* **10 mg – 35 mg**

? Who was the Nutrition Foundation?

It was a food industry organization, including:

- Hoffmann-LaRoche, Inc. – *makes pharmaceuticals/drugs*
- Fritzsche-D & O, Inc. – *makes artificial flavors*
- Stange Company – *makes artificial colors & flavors*
- Florasynth, Inc. – *makes artificial flavorings*
- Griffith Laboratories – *makes nitrites*
- H. Kohnstamm & Co., Inc. – *makes artificial colors & flavors*
- ICI Americas inc. – *makes dyes, pesticides, petrochemicals*
- Ajinomoto Company, Inc. – *makes MSG*
- Monell Chemical Senses Center – *develops artificial flavorings*
- The Coca Cola Company
- Dow Chemical Company

For complete list, see www.feingold.org/nut.html

NATIONAL ACADEMY OF SCIENCES

1977 Survey of the Amount of Certified FD&C Colorants Consumed

Colorant	Average Daily Intake (mg)
FD&C Red No. 3	24.0
FD&C Blue No. 2	7.8
FD&C Yellow No. 5	43.0
FD&C Green No. 3	4.3
FD&C Blue No. 1	16.0
FD&C Red No. 40	100.0
Orange B	7.8
FD&C Yellow No. 6	37.0
FD&C Red No. 3 Lake	15.0
FD&C Blue No. 2 Lake	3.1
FD&C Yellow No. 5 Lake	22.0
FD&C Blue No. 1 Lake	6.6
FD&C Red No. 40 [Lake]	27.0
FD&C Yellow No. 6 Lake	14.0
TOTAL	327.6

- Sample size = 12,000 persons over 2 years old surveyed for 14 days. Apparently, each person's intake of each coloring was averaged over this period of time.
- 99% of the population sampled was estimated to have intakes equal to or below the value shown.
- No bell curve or distribution information is available. Therefore, how MUCH lower is not known. Some of these colors have since been banned. Judging by how much brighter many breakfast cereals are today, the 99th percentile of those still allowed may be much higher now.
- In studies of the Feingold diet, most researchers used approximately the amount of artificial food color recommended by the NUTRITION FOUNDATION
 - **Why** did the Nutrition Foundation recommend such a low amount? Look at the other side of this flyer to see who they are.
 - **Why** did the researchers go along with this peculiar recommendation? Many of them were funded by the Nutrition Foundation. Perhaps it became the status quo?
 - **Why** did the researchers give the same amount of food color to small and large children, when they would never do that with a drug? It is no surprise that smaller children were often the ones to respond to these small doses.

27 mg
per person
per day

Clinton Presidential Records Digital Records Marker

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Diet, ADHD & Behavior

A QUARTER-CENTURY REVIEW



Center for Science in the Public Interest



For the past 16 years, my sister and I have been patients of Dr. Robert Sinaiko. He was an allergist and immunologist in the San Francisco Bay Area until October of last year. His story exemplifies how our access to Alternative and Progressive physicians and treatments has been denied.

Dr. Sinaiko is an exceptional physician who was working to improve the lives of people suffering from complex and poorly understood problems such as Chronic Fatigue, Multiple Chemical Sensitivity, Attention Deficit Hyperactivity Disorder (a.k.a. ADHD) and Autism. In an effort to bring to his patients the latest advances in medicine, Dr. Sinaiko was using a treatment called EPD, Enzyme Potentiated Desensitization. EPD consists of low-dose antigens mixed with an enzyme.

EPD has been used in Europe for decades and a number of studies have been published on EPD proving its effectiveness. It is currently in this country under an IRB (Institutional Review Board) through the Great Lakes Association of Clinical Medicine.

Dr. Sinaiko was also working on ways to improve the care of his patients using the best knowledge of several fields of specialty; he was particularly involved in developing more knowledge of the sulfation system function and its relation to diet therapy in Autism and ADHD. His research included developing a non-invasive test that would pre-determine which ADHD and Autistic children would respond to diet and anti-fungal therapies. Usually, these children are simply given drugs, namely, Ritalin. Additionally, Dr. Sinaiko taught a medical ethics class at UCSF.

In a zealous attempt to stamp out alternative medicine, the Medical Board of California has forced this physician out of practice with a "kangaroo trial" that had nothing to do with justice. Despite the fact that no patients have been harmed, and that his use of new diagnostic and therapeutic measures has improved the quality of life for his patients with chronic illnesses.

Experts who testified on the Doctor's behalf -- including a former Assistant Secretary for Health at the Department of Health and Human Services and the City Physician for the City of Oakland -- were deemed "of questionable credibility" by the Board. On the other hand, the Board's expert witnesses consisted of two psychiatrists, a neonatal specialist, and, as the sole representative of the allergy/ immunology field, an allergist who practices in the same vicinity as Doctor Sinaiko, competes for patients with Dr. Sinaiko, and has had patients leave his practice to go to Dr. Sinaiko.

Further, the Medical Board refused to allow into evidence science and research studies that validated the progressive care Dr. Sinaiko was providing his patients. They instead followed their own "experts' opinions" -- with no supporting evidence or research.

The Medical Board has stated that the aforementioned illnesses do not exist and has chosen not to look at evidence to the contrary. It becomes clear that diagnosing Chronic Fatigue or Multiple Chemical Sensitivity, treating an ADHD child for allergies, or bringing the latest advances in science to patients is dangerous to a medical practitioner's license in the

State of California. The California Medical Board has arrogated to itself the right to decide scientific controversy ... and remove the license or severely punish anyone who dares disagree.

Dr. Sinaiko now works at Sharper Image. The Medical Board of California put him on a "probation" so restrictive and horrendous that he is not allowed to care for any of his patients. His office has been closed and countless patients are unable to find medical care for their difficult-to-treat illnesses. **Their access to progressive medical care has been denied.** My sister and I have been forced to seek medical treatment two states away. Many patients are in fragile condition and more than a few patients say that they are in danger of dying without the care they need. **Their access to alternative care has been denied.**

The Principles of Medical Ethics adopted by the American Medical Association in 1980 states that " **A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public,**"

The World Medical Association's International Code of Medical Ethics under Duties of Physicians to the Sick -- "**A physician shall owe his patients complete loyalty and all the resources of his science.**"

And their **Declaration of Tokyo** states that "4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to **alleviate the distress of his or her fellow men, and no motive, whether personal, collective, or political shall prevent against this higher purpose.**"

I believe that all human beings have the inherent right to choose how to best care for their health. That the Medical Board of California would use public funds in an administrative office to carry out a private agenda against Alternative and Progressive physicians is an outrage. They have put many people at risk and I believe have violated basic medical ethics with their actions.

Additionally, we have just learned that the FDA is "investigating" Enzyme Potentiated Desensitization. They have restricted use of the informational website, and disallowed new patients to the IRB. Despite the very successful treatment of thousands of patients with EPD, **and the science behind EPD**, we are very afraid that the treatment we depend so much on is on the verge of being banned in this country by the FDA.

We are in desperate need of Federal intervention-- such as The Access to Medical Treatment Act or The Thomas Navarro FDA Patient Rights Act. We need protection against private agendas being played out publicly.

It is my hope that the White House Commission on Complementary and Alternative Medicine will be a positive step forward in restoring freedom of Medical Choice to Americans, and preventing the persecution and injustices done to forward-thinking physicians using leading-edge medicine.

Karen Scott
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Additional Information:

Additional information about Dr. Sinaiko's case can be found at: www.treatmentchoice.com

Enzyme Potentiated Desensitization (EPD)

Following its serendipitous discovery more than thirty years ago, EPD was ushered through a series of painstaking animal and human trials under the leadership of Dr. Len McEwen, at St. Mary's Hospital Laboratory in London, England. Among the physicians who have advocated and adopted the use of EPD are some of the outstanding allergists in England and Europe, including Jonathan Brostoff, the author of a number of widely used medical textbooks, including *Food Allergy and Intolerance*, and *Clinical Immunology*, and Josef Egger, a pediatric neurologist who has co-authored an outstanding series of articles in *The Lancet*, a leading British medical journal, proving with his elegantly controlled studies the importance of food allergy in the causation of migraine and certain learning disorders and seizure disorders in children. In 1992, Drs. Egger and McEwen co-authored a landmark article in *The Lancet*, proving the effectiveness of EPD in hyperactivity of childhood. Dr. Egger has published a double-blind, placebo-controlled study demonstrating the effectiveness of EPD in the treatment of migraine. A number of studies published in European medical journals over the past several years have demonstrated the effectiveness of EPD for nasal allergy. Professor Luisa Businco, of Rome, Italy, has published the very positive results of her placebo-controlled trial of EPD in childhood asthma, and a recent editorial by Jack L. Pulec, M.D., in the October, 1996 issue of *Ear Nose and Throat Journal*, advocates EPD as "a major breakthrough" in allergy treatment.

Excerpts from the California Medical Association's Amicus Brief on Dr. Sinaiko's Reconsideration Hearing

"The opinion in the Sinaiko case is disturbing insofar as it: ...

- 6 reflects that the Medical Board should choose to make a priority of spending \$99,000 worth of its staff and DAG time and labor prosecuting a case where there is no patient harm, not a single patient testified or complained, and where two conflicting but arguably legitimate segments of the medical community are simply at odds as to the methods of diagnosis and treatment at issue in this case. "

"The testimony of more than ten expert witnesses for Dr. Sinaiko, each highly qualified with an 'impressive Curriculum Vitae,' were simply dismissed with a cryptic comment by the ALJ that they were: '...of questionable credibility ...'"

"There were no patient injuries, no patient complaints, and much of the medicine alleged to be inappropriate by the Medical Board apparently has at least a significant, if not a majority following, among the medical profession. "

"CONCLUSION

The Medical Board's decision in this case does not inspire confidence. The decision fails to show how the Medical Board proved by clear and convincing evidence that Dr. Sinaiko was guilty of the charges alleged. The fact that there was no harm to patients, and no patients complained against Dr. Sinaiko, raises a question as to exactly why the Medical Board went after Dr. Sinaiko with such a vengeance, a vengeance reflected amply in its cost recovery bill. ... **If the Medical Board just wants to "get the doctor" at any cost, this decision shows how it's done. "**

The complete California Medical Association Amicus Brief can be found at <http://www.treatmentchoice.com/cma.html>.