

Hypertension: An Integral Bodymind Healing Approach

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Hypertension affects approximately 50 million individuals in the United States (JNC-7, 2003) which is defined as systolic blood pressure (BP) of 140 mm Hg or greater, or diastolic BP of 90 mm Hg or greater. Thirty one percent (31.3%) of the adult population over 20 years old in the United States suffers from the effects of hypertension (CDC 6, 2006), and it is a significant risk factor for stroke, myocardial infarction, and congestive heart failure. These together account for more than 50 percent of deaths in the United States (Wollam et al., 1988, Rosen et al., 1993). The JNC-7 report concludes that “the relationship between BP and risk of cardiovascular events is continuous, consistent, and independent of other risk factors. The higher the BP the greater is the chance of heart attack, heart failure, stroke, and kidney disease (1997, p. 2).”

The problem with conventional treatments that use medication is that patients suffer from high costs and side effects. A survey by the British Medical Journal in June 2003 found that 97% of patients taking antihypertensive medications had suffered from significant side effects, and 17 percent continued to do so (Laragh, 2003). For example, with statins, questions remain regarding whether they really reduce calcified plaque (Hecht, 2003, Rogers, 2005), and whether they may actually increase heart disease due to their inhibiting the production of coenzyme Q10 (Ellis et al, 2003; Faloon, 2004; Mercola, 2005). There are increasing concerns regarding a wide array of the side effects of statins such as muscle damage, myopathy (Phillips, et al., 2002) cognitive loss, neuropathy, hepatic and sexual dysfunction (Golomb & Evans, 2008), neurodegenerative disorders and infectious diseases (Goldstein et al, 2009); and questions have been raised about their producing cancer in rodents (Newman et al., 1996; Ellison, 2005), and recently about their causing cancer in humans (Goldstein et al, 2009). (0). A long history of research points to hypotensive drugs negatively affecting carbohydrate and lipid metabolism (Polare et al., 1989; Medical Research Council Working Party, 1985) mood state, cognitive functioning, and sexual performance (Kostis, 1990). According to reports of a meeting of the American Society of Hypertension in May 2000, “More than 43 million Americans have high blood pressure (hypertension), but less than one third of them have achieved targeted levels of blood pressure. Even among the 23.4 million who take antihypertensive medications, only 42.9% of these patients actually get their blood pressure down to acceptable levels. (As reported by Mercola, 2000, Lam, 2000).”

Though there may be differences between various anti-hypertension drugs regarding adverse effects, dose-dependent issues, and compliance issues that relate to lack of lowering of BP, the “precautionary principle” (Raffensperger & Tickner, 1999) would advise our using the least invasive methods that will cause the least harm before moving up the hierarchy of more potentially dangerous treatment methods. Therefore, a growing body of research in the West has focused upon lifestyle modification as an alternative to anti-hypertensive drugs. According to the Joint National Committee report (JNC-V, 1993), lifestyle modification can

provide “multiple benefits at little cost and minimal risk” and may be used as a first step therapy for individuals within a high range of normal or who have Stage 1 hypertension. Lifestyle modifications can also be used for reducing the number and doses of anti-hypertensive medications required (Little et al, 1991). An update in this research in multicenter randomized trials shows that over 18 months, persons with prehypertension and stage 1 hypertension can improve control of blood pressure with lifestyle modifications, and that those lifestyle modifications are sustainable for that time period. (Elmer et al., 2006). It is now well known that hypertension is a disease with a psychosomatic component, and that mind-body interventions are an important part of the new paradigm of treating hypertension (Mann, 2000). From a neurobiological perspective, hypertension is oftentimes the result of prolonged stress and its lock of the fight, flight, or freeze response of the sympathetic nervous system (Cannon, 1914; Seyle, 1979; Sapolsky, 1998). One aspect of this adaptive sympathetic nervous system response is to narrow blood vessels to increase power. However, with prolonged stress from the vicissitudes of modern life, this natural stress response becomes maladaptive, and the glucocorticoids and other biochemicals, which are part of narrowing arteries, create many disorders and diseases (Sapolsky, 1994).

Qigong developed over thousands of years for survival purposes to transmute the stress response into a parasympathetic nervous system, neurophysiology of harmony. Qigong’s internal martial arts methods were used for self-defense purposes to reverse the stress/fear response when a person was in physical danger of being assaulted or killed, and its medical Qigong practices were developed to relax and heal the body (Cohen, 1997; Mayer, 2004). The purpose of this article is to present how Qigong and an integral (Walsh & Shapiro, 2006) psychotherapy, called *Bodymind Healing Psychotherapy* (Mayer, 2007, 2009) may add to mind-body approaches to hypertension. I, along with other clinicians, instead of using the term *mind-body*, use the term *bodymind* to describe this field (Dychwald, 1977; Aposhyan, 2004). This change of term addresses the need for modern psychology to resolve the mind-body split of Cartesian dualism (Damasio, 1994) in our overly mental culture where cognitive therapy is perhaps the best-known psychotherapy, and the most recognized treatment of choice for many conditions. The term *bodymind* expresses the core Eastern belief that the mind, body and spirit are one inseparable whole; placing the body in the forefront of the term goes along with research in the field that shows the importance of the body in psychotherapy (Gendlin, 1978; van der Kolk, 1994, 2002).

Qigong: An Energy Based Approach to Hypertension.

Qigong, one of the branches of Chinese medicine, is defined as a many thousand year-old method of cultivating the energy of life (called “chi” or “qi”) by using breath, movement, sound, touch, awareness, and imagery. Tai Chi is the most practiced and best-known system of Qigong. There is a growing body of research showing Qigong’s efficacy with a variety of health related conditions such as insomnia (Irwin, 2008), chronic pain (Wu, 1999), and attention deficit hyperactivity disorder (Hernandez- Reif, 2001).

There is growing scientific evidence that points to the importance of energy in healing (Oschman, 2000). Albert Szent Gyorgi (1960), the biochemist who won the Nobel Prize in physiology and medicine, and whose team (including Joseph Svirebely) discovered vitamin C says, “In every culture and in every medical tradition before ours, healing was accomplished

by moving energy.” There are many different terms for “energy” in different cultures: *Qi* in China, *Ki* in Japan, *Chiyyut* in Israel, *Wakantanka* in Native American tribes, *Num* in Aboriginal tribes, *Litima* among the Qisu tribe in Uganda (Meade, 2006). In Western psychology, psycho-energetic concepts are used such to describe the fundamental role of energy in psychotherapy, and its key to health and psychological functioning with concepts such as: libido, energy cathexis, energy catharsis, fixation (Freud, 1923, 1933) character armor (Reich, 1970), bioenergetics (Lowen, 1975), restoring flow (Aposhyan, 2004), modulating arousal levels (Schore, 2003), creating a felt energetic shift (Gendlin, 1978, 1980), and finding a new life stance (Mayer, 2007, 2009).

Traditional Western science feels more comfortable with easily measured energetic phenomenon such as the biological current from charged ions; and it easily accepts the healing effects of concrete electrical energy devices such as T.E.N.S. machines when they are applied successfully to healing the bones of our athletes. On the leading edge of acceptability in the Western study of energy medicine are terms like “bio-energy” (Rubik, 2002; Oschman, 2000); and the healing effects of the current of injury, direct current, and the perineural control system have been researched by Becker (1985) and others (Oschman, 2000). A wide array of research has examined the role of subtle energies and extremely low frequencies on health and healing and found positive effects (Oschman, 2000; Rubik, 2002; *Subtle Energies and Energy Medicine Journal*, 1997-2009). The energy in acupuncture meridians has for ages been associated with healing in China and evidence for the reality of such is beginning to be reported in respected Western journals (Hui, 2000, *Subtle Energies* 1997-2009). As cited earlier, there has been research on the role of Qigong’s effects on a wide variety of health related conditions such as insomnia, chronic pain, and attention deficit hyperactivity disorder, and a wide variety of other medical conditions (Sancier, 1996, 2004; Mayer, 2004, 2007, 2009).

Leading-edge scientists postulate that we are at the edge of a paradigmatic shift from Newtonian to Einsteinian medicine (Gerber, 1996, pp.42-45), a medicine that honors the role of subtle energies (Pert, 1997), and an era that is marked by a conceptual shift in the pyramid of science that integrates Newtonian and quantum realms into a new energetic medicine and psychology (Lipton, 2005, 2006). However, it is not the purpose of this article to review the validity of such claims and research, but rather to explore the clinical usefulness of integrating Qigong with a Western mind-body healing approach in the area of hypertension. Whether one wants to posit that the effects of Qigong are from energy, exercise, or other variables is not the purpose of this article; the research methodology issues regarding difficulties of this determination have been discussed elsewhere (Caspi et al., 2000; Wayne & Kaptchuk, 2008, Li et al, 2009). We are currently in a pre-paradigmatic phase (Kuhn, 1996) regarding which forms of energy-based treatments are beneficial for which patients and conditions at what times.

Qigong Research

In my earlier two peer-reviewed research articles (Mayer, 1999, 2003), I reviewed 33 studies representing approximately 5545 subjects who used Qigong to treat hypertension. Almost all

of the studies suggest that Qigong lowers BP to various degrees over various time periods.

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 twenty years. The basic design involved 204 patients with hypertension who were randomly assigned to Qigong practice and control groups. The ages of the subjects were not mentioned. Both groups were given antihypertensive drugs. The Qigong group of 104 patients reportedly practiced thirty minutes, twice per day, over twenty years. During the first two months, the BP of all patients dropped in response to the antihypertensive drug. Subsequently, and consistently over the period of twenty 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 percent in the Qigong practice group reduced the antihypertensive dosage, and for 30 percent in this group, the BP medication was eliminated. In contrast, 31 percent in the control group increased the antihypertensive dosage (Kuang et al., 1991). Kuang reports, in his twenty-year study, less 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 (cAMP and cGMP) in the Qigong compared to the control group (Kuang et al., 1991).

Most importantly, 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 thirty years, thirty minutes twice a day. The accumulated mortality rate was 25.41 percent in the Qigong group and 40.8 percent in the control group. The incidence of stroke was also significantly lower in the Qigong practice groups as compared to the control group, 20.5 percent and 40.7 percent respectively ($P < 0.01$). The death rate due to strokes was 15.6 percent and 32.5 percent respectively ($P < 0.01$) (Wang, 1993, as cited in Sancier, 1996; Sancier & Holman, 2004).

The weight of evidence of these studies, representing approximately 5,545 subjects, suggests that practicing Qigong has a positive effect on hypertension in the following areas: blood pressure; blood circulation; other cardiovascular measures; and other health-related measures, including strokes, deaths due to strokes, and overall mortality (Mayer, 1999, 2004). In another study it was found that two months of Qigong practice helped to significantly reduce hypertension compared to a control group using medication alone (Li, Pi, Zing, et al., 1994). Updated meta-analytic research (Lee, et. al., 2007) confirmed the findings of my review and reported that Qigong has positive results in some relevant outcome measures, such as lowering systolic blood pressure.

However, my review of the literature and Lee's (2007) meta-analysis both found that due to inadequate addressing of methodology issues it was difficult to determine just how effective Qigong is, and what other factors may contribute to the positive effects reported in the studies reviewed. In an update on the research on Qigong and hypertension, Guo's (2008) meta-analysis showed the following: (1) Qigong is better than no treatment controls in decreasing blood pressure, (2) Qigong combined with drugs has a better effect than drug treatment alone, and (3) Qigong helps not just in improving hypertension but also in adding to improving quality of life. For those interested in research methodology issues, refer to

Palmer's scholarly text on general problems with research in China (2007), my articles (Mayer 1999; 2003), and Guo's (2008) article. I said in my final abstract that whether Qigong alone can affect hypertension is not necessarily the most important question. I called for further research to assess and understand better the effect of adding Qigong into an integrated, multifaceted program that selectively incorporates diet, moderate aerobic exercise, relaxation training, and social and psychological dimensions.

Guo (2008) answered my call (Mayer, 1999, 2003) to include an exercise group as a control group in future research to rule it out as a confounding variable; and he could not find in the meta-analysis of studies he overviewed that Qigong was superior to control participants who did other active forms of exercise. However, the type of Qigong used in the comparisons was not specifically oriented to treat hypertension, and the Qigong practitioners may not have had enough time to learn to do the practice effectively (Lv et al., 1987; Cheung, 2005; Lee, 2007). An interesting study comparing Qigong to standard muscle relaxation therapy with hypertensive patients concluded that Qigong was more effective in improving well-being, sleep, and relaxation during the intervention as well as later on (Ritter & Aldridge, 2001).

My opinion is that a problem many researchers have in looking at Qigong as a treatment alone is similar to the problem of those who use a mental/psychological approach alone to healing hypertension. A more expansive, integral vision is needed. In my last two books (Mayer, 2007, 2009) and in the discussion that follows I address more deeply some of the psychological, clinical dimensions relevant to an integral approach to treat this major disease.

Qigong and the River of Life: A Quick Fix for Hypertension?

When I was working at the Health Medicine Institute (now called The Health Medicine Center), the medical director, Dr. Len Saputo, with whom I co-founded the clinic, asked me to do a session in a public forum with one of his patients suffering from hypertension. The Health Medicine Forum (HMF) is a leading-edge group of multidisciplinary health professionals trying to combine the best of modern traditional and age-old methods of healing. HMF is part of the movement to bring forth integrative medicine as the norm for twenty-first century healthcare (Saputo, 2009).

During the forum, in front of an audience of approximately 200 interested people, each doctor or health professional on the panel described how he or she would work with this patient. I always learn so much from hearing the dialogues between Ayurvedic doctors, acupuncturists, medical doctors, psychologists, and body workers. At this HMF event, Dr. Saputo asked me, and the aforementioned patient, who was a man in his late 60s, to take a risk and do something experiential in front of the assembled group. One of the chief medical researchers from a local hospital was there with a blood pressure monitor. He measured the systolic blood pressure rate of the patient at 168. I then did the *River of Life* hypnosis method (Mayer, 2003, 2007, 2009) with this patient in front of the group. Within about five minutes the patient's systolic blood pressure had gone down to 128 (Mayer, 1997). Many people in the audience were impressed, as was I – since by nature I'm a shy person, and I wondered what my blood pressure would be in front of such a large group if I were on the spot and had my level of tension measured.

There are many reasons why BP reduction on single occasions is not something about which we should be overly impressed. Let's look at some of these research methodology issues that are important to consider. First, we know that the relaxation response is capable of creating significant positive changes in blood pressure (Jacob et al., 1991; Linden & Chambers, 1994; Schneider et al., 1995). More important than any brief reduction in BP, by whatever means, we would want to know how long such reduction lasts, and whether the hypertensive person can call on this method at times when his or her BP rises. This would be one of the behavioral healthcare tests to determine whether a deeper, longer-lasting healing has taken place.

Case Illustration: The Hypertensive Executive — What Lies Beneath the Surface?

In accordance with the viewpoint of *Bodymind Healing Psychotherapy* (Mayer, 2007), the deeper psychodynamics, cognitions, and beliefs of a person need to be worked through before deep, long-lasting healing takes place. BMHP integrates traditional methods of psychotherapy (cognitive behavioral, psychodynamic, Gendlin's (1978) *Focusing*, symbolic process approaches such as the River of Life guided self-meditation practice, energy psychology methods (Mayer, 2009),¹ and Eastern meditation practices such as Qigong. BMHP has an "integrative approach" which when appropriate incorporates Qigong movements into psychotherapy and behavioral healthcare; and an "integral approach" (Walsh & Shapiro, 2006) which brings the essence of Qigong into psychotherapy without ever using a word about Qigong and without ever using a Qigong movement.²

I recall a patient who we'll call "Richard," a very wealthy married man and an executive in a local company. Richard's marriage was about to fall apart due to what his wife said was "his inconsiderateness," exemplified by his going out and buying expensive motorcycles without asking her first. An equally important factor in his upcoming divorce was that Richard only slept about four hours a night, and was described by his wife as a "workaholic" who didn't pay enough attention to his young children.

Richard was suffering from severe hypertension, and came to me after hearing about my articles and research on hypertension. Being very busy, he was interested in the quick fixes that he hoped would be part of this "Qigong/hypnosis thing." He was more than a little upset when, after our first session, I suggested that a combination of marital as well as individual therapy might be important to consider. He reluctantly agreed and later, after a few sessions of both individual and couples therapy, in one of our sessions I asked him to do our *River of Life* breathing method and "focus" (Gendlin, 1978) on what came up as he followed his exhalation down the river of breath through his body. As Richard "focused" on his body sense he became aware of a felt sense that he described as "high energy, yet disconnected." As he stayed with this inner sense a bit longer, he described the feeling as being like a disconnected live wire, after which a sense of anger arose in him. When I asked him to stay with the sense of anger and ask the feeling, "What is this all about?" another image arose. Somatic psychotherapists will recognize the following as an example of, "the issue is in the tissue."

Richard remembered a childhood scene from his dinner table when he came home with a “D” on his report card. He vividly recalled his father saying to him in a demeaning tone, “You’ll never amount to anything, you dummy.” All of his brothers joined in the shaming process. Laughing, mocking, and pointing at Richard, they said, “Don’t worry, you can always work on one of Uncle Jimmy’s garbage trucks and pick up the garbage from our mansions.” At that moment Richard made a promise to himself, “I’ll never rest until I make twice as much money as all of you combined.”

Indeed, Richard kept that promise and more than fulfilled this goal — but he had forgotten the promise he had made to himself. He didn’t realize how this unconscious motivation was driving him in his current life, and just how literally he was following through on this childhood promise when he said, “I’ll never rest.”

This insight began of Richard changing his behavior. He became aware of the advantages and disadvantages of this compulsion, which had both made him successful, and endangered his health and family. In the terms of the use of bodymind healing methods in psychotherapy, the resulting change could be called a felt energetic shift (Gendlin, 1980) or a change in life stance (Mayer, 2007, 2009) due to the patient’s “focusing” on the underlying felt meaning (Gendlin, 1978) of his hypertension. His wife marked this session as the beginning of Richard’s change in behavior, which saved their marriage and led to the opportunity to reduce and eventually eliminate his hypertension medication.

There are many interesting clinical points that can be learned from Richard’s story. His case illustrates how the “quick fixes” of relaxation modalities may not get to the deeper underlying psychodynamic issues that need to be addressed. Richard shows us the power of using an integrative psychotherapy; and, since one in twenty Americans suffers from hypertension, and 50 percent of Americans may die from its effects (Wollam, 1988), Richard’s case has bearing on the importance of a bodymind approach to solving a portion of this health crisis.

Chinese Medical Approach to Hypertension

Regarding a Chinese medical perspective on Qigong and hypertension, we need to be aware that Qigong practices are not so easily oriented towards Western notions of prescribing a single pill or movement. Western, nomothetic (general) categories may provide ease of scientific measurement, but they do not fit into holistic Chinese medical philosophy with its more ideographic (unique) ways of looking at various disorders. For example, the diagnostic category of Western hypertension as perceived in Chinese medicine may be due to a wide variety of energetic imbalances such as “an imbalance of the Yin and Yang functional aspects of Deficient Kidney Yin and Excess Liver Yang, and/ or an overabundance of phlegm and dampness within the body” (Johnson, 2000). In Chinese medicine, two different persons with the same Western diagnosis of “hypertension” may be treated differently depending upon specific diagnostic considerations that come from such general categories and tongue and pulse analysis. Ideographic factors related to the unique patient and the background of the particular Qigong healer/Chinese doctor are also part of the decision about what treatment, or combination of treatments, is chosen. Unique combinations of herbs, acupuncture, and a wide variety of Qigong movements are prescribed based upon what is suited to the individual

whole person.

Despite the caveat above, and the fact that most medical Qigong masters advise specific static Qigong practices, before and in the midst of, practicing medical Qigong movements (Ha, 1995, Ha & Olsen, 1996; Mayer, 2007, p. 101), I wish to suggest some general Qigong practices that may prove beneficial to those suffering from hypertension.

Breathing

One key element that may be a factor in hypertension is when a person's stomach goes in as he or she inhales. In Qigong language, this is called "reverse breathing." In a comprehensive clinical text on Qigong, Johnson (2000) states, "scientific studies confirm that 90 percent of hypertensive patients practice *Reverse Breathing* chronically." Though no reference citation is given for the research behind this claim, many others, including myself, have found that changing habitual reversed breathing is one factor to be considered in restoring parasympathetic relaxation to a person suffering from hypertension. One particular Qigong breathing method, called Microcosmic Orbit Breathing (Wilhelm, 1963), in my clinical experience seems to be particularly helpful in aiding the relaxation response (Benson, 1983), particularly in conjunction with a guided meditation of a river coming down the front of the body (*Ren channel*) (Mayer 2003). Further research is needed to see if other clinicians find similar results. One of the benefits of Qigong and Tai Chi in particular is that these traditions employ the synchronization of breathing and movement that creates a unique state-specific state (Tart, 1968), also called a state dependent (Rossi, 1986, 1988) state.

Standing Meditation Qigong

Most Qigong masters teach that the key to any form of Qigong is to first balance our energy state with a static Standing Meditation practice (Ha, 1995). Standing Meditation Qigong is a method to develop *fongsung*, or relaxed vitalization (Cohen, 1997; Mayer, 2004, 2007, 2009). My clinical experience shows that it is particularly beneficial for hypertensive patients. This may be due, in part, simply to its effect, like any form of meditation, on getting a person to slow down enough to do the practice. But the specifics of Standing Meditation, and imagining that we are "standing like a tree" rooted in the earth, can help to ground the energy of those hypertensive patients who have a high degree of pressure from the various vicissitudes of life that lead to pent up energy or resentment (excess Liver Yang). There is some research support for the beneficial elements of Standing Meditation to create balance in life and in the brain that are reported in academic exchange programs between China and the United States that warrant further replication and research (Yang, 1993; Li, 1995).³

From the time of early hunter-gatherer societies and particularly by shamans of the tribe, postural stances were used as a practical survival method, and to enter into a trance state for the purpose of healing (Goodman, 1990; Gore, 1995, p. 32). In early Buddhism, among the Ksatraya warrior class, static standing meditation postures were used for self healing, spiritual unfoldment, self defense, and changing one's psychological state (Tomio, 1994; Mayer, 2004, p. 15). In other cross-cultural traditions of postural initiation, such as

Qigong and Tai Chi, stances have been used to help center a person in the midst of the cross currents of life, and to help a practitioner to reverse fear and let go of tension (Mayer, 2000, 2004, p. 172). In modern trauma theory we would call this reversing the sympathetic nervous system fight, flight and freeze response by substituting for this an ability to relax and find a centered way to respond in the midst of danger. According to the internal martial arts traditions, those who were able to find such way of being were better able to respond to and survive attack. So, modern hypertension researchers may benefit from investigating the practices of such postural initiation traditions which advised specific natural breathing methods, bending the knees, slightly turning in the pelvis as if getting ready to sit down, keeping a little space in the armpits to loosen the ways the hands hang at the side, keeping the chin slightly tucked, and imagining hanging like a puppet from the heavens to give space to the spine to elongate, etc.⁴

In actuality, the way of being that is created by such stances was not just relaxing but was described in the Chinese internal martial arts as *fongsung*, i.e. relaxed vitalization. This state, cultivated by fine tuning of solo stances and two person exercises has much in common with the growing edge of research on arousal levels which show that the sympathetic and parasympathetic nervous systems can function in coupled and reciprocal ways (Schore, 1994). In a similar vein there was a longstanding debate in clinical hypnosis called the “activity-passivity paradox”(Gorton, 1957) where recent research shows that the nature of arousal or relaxation is dependent upon the type of suggestion made during hypnosis (Sturgis & Coe, 1990, p. 205). Adding to this research are studies that point to our brains optimal functioning in a state called “relaxed alert” which is in the upper range of alpha brain waves of 12-15 Hz (Aposhyan, 2004, p.168). This state is said to correlate with better neurological functioning and increased resiliency to strokes and head injuries (Robbins, 2000). Stephan Porges’ (1995) “state of engagement” with relatively high ventral vagal tone is an aspect of this relaxed alert state. Would Western trauma theory and clinicians not be able to learn something from a tradition of the internal martial arts such as Tai Chi where one’s life was dependent upon activating such states for survival, and from Qigong traditions which explored how shifts in intention (called *yi* in Chinese medicine) could generate healing effects while practicing Standing Meditation (Cai, 1986; Chuen, 1991, 1999)? Taoist scholar Ken Cohen (1997) calls Standing Meditation Qigong, “the million dollar secret of Qigong.”

When Standing Meditation Qigong is practiced to enhance *fongsong* it is integrated with various imagery techniques such as imagining standing like a tree (Chuen, 1991; Mayer, 2000, 2004), and such static practices are integrated with “dispersing stagnant chi exercises” (Johnson, 2000; Mayer, 2000, 2004).

Qigong Movements: Lowering the Qi with Heavenly Palms

As one common example of a Qigong movement used in the treatment of hypertension, Johnson (2004) suggests that patients be instructed to move their hands with palms downward along the front and side of the body in order to purge and guide the imbalanced Qi so that it descends down the liver and gall bladder channels, or down the torso to the hips. This is a similar movement to the Qigong practice called, *Lowering the Qi with Heavenly Palms* (Mayer, 1997). Specific acupressure points are also prescribed by Johnson (2004),

such as acupuncture point GB-30. And Deadman (1998) uses a variety of points such as Lu-7, LI-4, Lv-3, and K-1 (p. 652). As discussed in Chapter 10 with insomnia, BMHP uses the *River of Life* practice along with those other methods listed while the patient touches points such as these.

Just as Chinese doctors use acupuncture needles to treat different points for different people based upon their diagnosis of the tongue and pulses, so do I choose different points — either by borrowing the points used in the patient’s last acupuncture treatment, points suggested in consultation with an acupuncturist, or based my own assessment of the patient and his or her unique issues. When I suggest points, I hope that I make up for not being a Chinese doctor, and not having sophisticated pulse and tongue diagnosis methods in my tool kit, by helping patients evoke their life energy through various Bodymind Healing Qigong (BMHQ) methods (Mayer, 2004), while paying particular attention to the medical Qigong training dictum to anchor a patient first in stillness, return the patient to stillness during treatment, and find the stillness in movement and the movement in stillness (Ha, 1995, Ha and Olsen 1996). Some of these BMHQ movements include breathing methods that focus on the exhalation and sinking the Qi to the belly (*Tan Tien*), and visualizations such as imagining warm or cold water, depending upon the clinical condition, flowing in down the front central meridian (*Ren*) as in the *River of Life* practice. Sometimes I, and others (Johnson, 1990), use specific sounds to help patients relax and release pent up energy. In BMHQ, I use various non-forced sounds accompanying the exhalation, such as: “ssss” to release excess liver Qi; “ha” to let go in the heart; “whooh” or “chir-ee” to help the vitalizing functions of the kidneys; and “huh” for spleen stagnation. But I prefer a phenomenological approach (Mayer, 2007) to all of the above, trusting each patient’s own unconscious process to come up with sounds, images, visualizations, and movements that feel right to him or her. This is particularly well enhanced by Dr Eugene Gendlin’s (1978) “Focusing” process. Though there is a treasure house of knowledge in the specific series of points chosen by experienced Chinese doctors, the perspective outlined here is a way to pay our respects as Western clinicians to the essence of their tradition. Though limited in our understanding of their breadth of knowledge, Western bodymind health professionals can perhaps add an equally significant knowledge base to the multilayered bodymind methods needed for healing hypertension.

Case Illustration: Is Qigong Palatable to Fundamentalist Christians?

In conclusion, I’d like to mention, as a cautionary tale, a case that reminds us all about the problems that can occur when integrating practices from traditions that may not be familiar to many people in our culture. I tell this story in my trainings so that my students will not make the same error that I once did.

A doctor in our clinic referred a patient to me who was suffering from hypertension. After our first session, his SUDS level went down from an 8 to a 3, and “Paul” asked if there was anything he could do in-between sessions for homework. I suggested that he continue to practice the exercises we had done in the first session: *Microcosmic Orbit Breathing*, the *River of Life* visualization, and the *Lowering the Qi with Heavenly Palms* Qigong movement (Mayer 2004, pp. 81-88). I also mentioned that I had a booklet that illustrated these and other Qigong

movements that might be helpful. He took this booklet home with him.

In the next session he came in and told me that he was a Fundamentalist Christian and he wanted me to explain to him, “Why are these practices not the work of the Devil?” He went on to explain that he looked at my booklet and in it he saw the exercise called *Buddha Opens the Heart to the Heavens*. He told me that his beliefs were that, “Jesus is the only son of God. It is only through Jesus that a person can find his way to heaven, and that any others were destined to go to hell.”

After taking a breath, I complimented Paul on his coming back to this session, and I told him that I thought that this showed he was a true Christian by his wanting to discover the truth of things.⁵ I went on to explain to Paul that many people misunderstand the idea of the Buddha — that Buddha is not a God, as many believe Jesus is. The Buddha, I explained, is a state of mind that involves compassionate and enlightened awareness, and that any deity may be used in discovering this state of mind. I told him about Tibetan Buddhism where when you do certain practices (*Phowa, Tonglin*) of opening your heart to the compassion and light of the heavens, any deity, for example Jesus, can be imagined to be raining their light of love on you (Rinpoche, 1993, p. 218).

I asked whether he would like to try this, and after hearing an affirmative response, I instructed Paul to open his hands to the side and after they were raised over his head, to imagine Jesus in the sky; with a slow exhalation, I instructed him to lower his hands in synchronization with his out-breath and to imagine bringing the love of Jesus down through his body. He reported that his SUDS level went down significantly more when he imagined Jesus’ love coming down from the heavens.

Paul thanked me for our work together and said it really helped his hypertension. He then asked me for a referral to a therapist who specialized in a Christian approach to psychotherapy, which I gave him.

This case illustrates, among other things, how important it is to be aware of an individual’s cultural and religious beliefs when doing Qigong or any form of therapy.

Conclusion:

By combining Qigong and Western bodymind healing methods, with lifestyle factors, moderate exercise, and diet (Ornish et al., 1993), we may develop a rich, integral (Walsh & Shapiro, 2006) approach (Mayer, 2007, 2009) to further help those who suffer from hypertension. Further research is needed to explore just how much the integral approach suggested here of adding the *River of Life* self-hypnosis method, Qigong practices, and bodymind healing psychotherapy methods to contemporary standards of care (Rosen et al., 1993; Ornish et al., 1993; JNC-7, 2003; AHRQ, 2004;)⁶ will contribute a vital element to the healing equation.

References:

Aposhyan, S., (2004) *Bodymind psychotherapy: Principles, techniques and practical*

applications. New York: W. W. Norton & Co.

AHRQ, (2004). *Agency for healthcare research and quality*. Publication No 04-P018, Closing the quality gap: Hypertension care strategies fact sheet, U.S. Department of health & Human Services. (Retrieved October 8, 2009)
<http://www.ahrq.gov/QUAL/hypertengap.htm#findings>

Becker, R. (1985). *The body electric: Electromagnetism and the foundation of life*. New York: William Morrow.

Becker, R. (1990). *Cross currents: The promise of electro medicine*. San Diego, CA: Jeremy P. Tarcher.

Benson, H. (1975b). *The relaxation response*. New York: Avon Books.

Cai, S. F. (1986). *Wujishi breathing exercise*. Translated by M. Den. Revised by T. Shen. Hong Kong, China: Medicine & Health Publishing Co.

Cannon, W. (1914). "The interrelations of emotions as suggested by recent physiological researches, *American Journal of Psychology*, (25), 256.

Caspi, O., Millen, C, & Lee, S. (2000). Integrity and research: Introducing the concept of dual blindness. How blind are double-blind clinical trials in alternative medicine? *Journal of Alternative and Complementary Medicine*, Vol. 6, No 6, pp. 493-497.

Cheung, B. M. (2005). Randomized controlled trial of qigong in the treatment of mild essential hypertension. *Journal of Human Hypertension*, 19: 697-704.

Chuen, L. K. (1991). *The way of energy*. London: Gaia Books.

Chuen, L. K. (1999). *The way of healing: Chi Kung*. New York: Broadway Books.

Center for Disease Control, (2006) p. 312, Table 71, *U.S. Department of health and Human Services, National Center for Health Statistics*, United States, 2008, Hyattsville MD, [http://www.cdc.gov/nchs/data/08.pdf#071](http://www.cdc.gov/nchs/data/hus/08.pdf#071)

Cohen, K. (1997). *The way of Qigong*. New York: Ballentine Books.

Damasio, A. R. (1994). *Descartes error*. New York: Grosset/Putnam.

Deadman, P., Al-Khafami, M., & Baker, K. (1998). *A manual of acupuncture*. East Sussex, England: Journal of Chinese Medicine Publications.

Dychtwald, K. (1977). *Bodymind*. New York: Pantheon.

Ellison, S., (2005). Article Lipitor, Zocor, Pravachol: Cholesterol lowering drugs cause cancer? (Retrieved October 3, 2009)

http://www.communicationagents.com/sepp/2005/01/14/lipitor_zocor_pravachol_cholesterol_lowering_drugs_cause_cancer.htm. See his e-book at www.health-fx.net/eBook.pdf.

Elmer, P., Obarzanek, E., Vollmer, W. et al. (2006). Effects of comprehensive lifestyle modification on diet, weight, physical fitness, and blood pressure control: 18-month results of a randomized trial, *Annals of Internal Medicine*, April 4, Volume 144, Issue 7, pp. 485-495.

Ellis C.J., Scott R. (2003). Statins and coenzyme Q10. *Lancet*, Mar. 29;361(9363):1134-5.

Faloon, W. (2004) Cardiologists overlook lifesaving discovery, *Life Extension Magazine*, (Retrieved on-line October 9, 2009), http://www.doctorsorganicvitamins.com/info/lef/q10/cardiac_protection.pdf

Feinstein, D. (2008). Energy psychology: A review of the preliminary evidence. *Psychotherapy: Theory, Research, Practice, and Training*. 45(2), 199–213.

Feinstein, D. (2009). Facts, Paradigms, and Anomalies in the Acceptance of Energy Psychology: A Rejoinder to McCaslin's (2009) and Pignotti and Thyer's (2009) Comments on Feinstein (2008), *Psychotherapy: Theory, Research, Practice, Training*, June 2009, 46(2), 262-269.

Freud, S. (1923). *The ego and the id*. London: Hoggarthe Press.

Freud, S. (1933; 1990). *New introductory lectures on psychoanalysis*. New York: Norton.

Gallo, F. (2002). *Energy psychology in psychotherapy: A comprehensive source book*. New York: W. W. Norton.

Gendlin, E. (1978). *Focusing*. New York: Bantam Books.

Gendlin, E. (1980). Imagery is more powerful with focusing: Theory and practice. In J.E. Shorr, G.E. Sobel, P. Robin, J.A. Connella (Eds.), *Imagery. Its many dimensions and applications*, pp. 65-73. New York/London: Plenum Press. From http://www.focusing.org/gendlin/docs/gol_2148.html.

Gerber, R. (1996). *Vibrational medicine*. Santa Fe, NM: Bear & Co.

Goldstein, M, Mascitelli, L. Pezzetta, F. (2009) The double-edged sword of statin immunomodulation, *International Journal of Cardiology*, June 2009, Vol. 135, Issue 1, pp. 128-130.

Golomb BA, Evans MA. (2009). Statin adverse effects: A review of the literature and evidence for a mitochondrial mechanism. *Am J Cardiovascular Drugs*. 2008;8(6): 373-418

Goodman, F. D. (1990). *Where spirits ride the wind: Trance journeys and other ecstatic experiences*. Indianapolis: IN: University Press.

- Gore, B. (1995). *Ecstatic body postures*. Santa Fe, NM: Bear & Co.
- Gorton, B. (1957). The physiology of hypnosis. *Journal of the American Society of Psychosomatic Dentistry*, 4(3), 86–103.
- Guo, X., Zhou, B., Nishimura, T., Teramukai, M., & Fukushima, M. (2008). Clinical effect of Qigong practice on essential hypertension: A meta-analysis of randomized clinical trials, *Journal of Alternative and Complementary Medicine*, Vol. 14, No 1, pp. 27–37.
- Ha, F. (1995). *Stillness in movement: The practice of Tai Chi Chuan* (Video/DVD). San Francisco, CA: Vision Arts.
- Ha, F., & Olsen, E. (1996). *Yiquan and the nature of energy*. Berkeley, CA: Summerhouse Publications.
- Hecht H, & Harman, S. (2003). Relation of aggressiveness of lipid-lowering treatment to changes in calcified plaque burden by electron beam tomography. *Am J Cardiol.*, Aug 1, 92(3):334-6.
- Hernandez-Reif, M., Field, T., & Thimas, E. (2001, April). Attention deficit hyperactivity Disorder: Benefits from Tai Chi, *Journal of Bodywork and Movement Therapies*, Vol. 5 Issue 2, pp. 120–123.
- Hui, K., et al. (2000). Acupuncture modulates the limbic system and subcortical gray structures of the human brain. Evidence from MRI studies in normal subjects. *Human Brain Mapping*, 9(1), 13–25.
- Irwin, M., Olmstead, R., and Motivala, S. (2008). Improving sleep quality in older adults with moderate sleep complains: A randomized controlled trial of Tai Chi Chih. *Sleep*, Vol. 31, No 7.
- Jacob, R.G., Chesney, M. A., Williams, D. M., Ding, Y., & Shapiro, A. P. (1991). Relaxation therapy for hypertension. Design effects and treatment effects. *Annals of Behavioral Medicine*, 13, 9–17.
- JNC 7, (2003) Seventh report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure released in 1997, *U.S. Department of Health and Human Services*, NIH Publication No 03-5233, December 2003.
- Johnson, J. (2000). *Chinese medical Qigong therapy: A comprehensive clinical text*. Pacific Grove, CA: The International Institute of Medical Qigong.
- Kaplan, C., Heckbert, S., Thomas D., Koepsell, T. et al., (2000). Use of calcium channel blockers and risk of hospitalized gastrointestinal tract bleeding, *Arch Intern Med.*, 2000; 160: 1849-1855.
- Kostis, J., Rosen, R., Holzer, B., Randolph, C., Taska, L., & Miller, M. (1990). CNS side

effects of centrally active anti-hypertensive agents: A prospective placebo-controlled study of sleep, mood state, and cognitive and sexual function in hypertensive males. *Psychopharmacology*, 102, 163–170.

Kuang, A., Wang, C., Xu, D., & Qian, Y. (1991). Research on the anti-aging effect of Qigong. *Journal of Traditional Chinese Medicine*, 11(2), 153–158; and 11(3), 224–227.

Kuhn, T. (1996). *The structure of scientific revolutions*. Chicago, IL: University of Chicago Press.

Lam, M., (2000). http://www.drlam.com/articles/nutritional_medicine.asp, (Retrieved October 9, 2009) reports on Meeting of the American Society of Hypertension, May 2000.

Langsjoen P., Willis R., Folkers K., Treatment of essential hypertension with coenzyme Q10, *Mol. Aspects Med.* 1994; 15 Suppl: S265-72.

Larag, J. (2002.) Why has the treatment of Hypertension become such a deplorable fiasco? (Retrieved on October 2, 2009) http://www.stress.org/interview-Stress_Hypertension.htm

Lee, M. S., Hwa, J., Jeong, H., Kim, B. G., Ryu, H., Lee, H., Kim, J., Taeg, H., & Chung, H. (2002). Effects of Qi-training on heart rate variability *The American Journal of Chinese Medicine*, 30(4), 463–470.

Lee, M. S., et al. (2007). Qigong for hypertension: a systematic review of randomized clinical trials, *Journal Hypertension*, Aug; 25, (8):1525–32.

Li, C. (1995). Preliminary Exploration on the Scientific Proof of Being Sober-Minded, Sharp-Eyed and Energetic after Practicing Zhan Zhuang. Reported at the *Fourth International Conference on Qigong, Vancouver, 200-24*.

Li JY, Zhang YF, Smith, GS, Xue, CJ, Luo, YN, Chen, WH, Skinner, CJ, Finkelstein J. (2009). Quality of reporting of randomized clinical trials in Tai Chi interventions: A systematic review. *Evidence-based Complementary and Alternative Medicine. eCAM* advance access published on April 7, 2009, by Department of Epidemiology and Preventive Medicine, University of Maryland School of Medicine, Baltimore.

Little, P., Girling, G., Hasler, A., & Trafford, A. (1991). A controlled trial of low sodium, low fat, high fiber diet in treated hypertensive patients: Effect on anti-hypertensive drug requirement in clinical practice. *Journal of Human Hypertension*, 5, 175–181.

Linden, W., & Chambers, L. (1994). Clinical effectiveness of non-drug treatment for hypertension: A meta-analysis. *Annals of Behavioral Medicine*, 16, 35–45.

Lipton, B. (2005). *The biology of belief*. Santa Rosa, CA: Elite Books.

Lipton, B. (2006, May 4). *From keynote address at Association for Comprehensive Energy Psychology*

- Ly, Z. C., Yu, H. P., Liu, J. W., et al. (1987). Comparative analysis of Qigong, jogging and drug therapy on hypertension (In chinese). *Zhongguo Zhong Xi Yi Jie He Za Zhi*, 7 pp 462–464.
- Mann, S. J. (2000). The mind/body link in essential hypertension: A time for new paradigm, *Alternative Therapies in Health and Medicine*, Vol. 6, pp. 29–45.
- Mayer, M. (1982). The mythic journey process. *The Focusing Folio*, 2(2).
- Mayer, M. (1997). Combining behavioral healthcare and Qigong with one chronic hypertensive adult. *Mt. Diablo Hospital-Health Medicine Forum*. Unpublished study. (Video available from Health Medicine Forum, Walnut Creek, CA, www.alternativehealth.com).
- Mayer, M. (1999). Qigong and hypertension: A critique of research. *Journal of Alternative and Complementary Medicine*, 5(4), 371–382. (Peer-reviewed).
- Mayer, M. (2000). *Bodymind healing Qigong* (DVD). Orinda, CA: Bodymind Healing Center.
- Mayer, M. (2003). The river of life: A guided meditation for bodymind healing, CD produced by Deborah Wood Campbell.
- Mayer, M. (2003). Qigong clinical studies. In W. B. Jonas (Ed.), *Healing, intention, and energy medicine* (pp. 121–137). England: Churchill Livingstone. (Peer-reviewed).
- Mayer, M. (2004a). *Secrets to living younger longer: The self-healing path of Qigong, standing meditation and Tai Chi*. Orinda, CA: Bodymind Healing Publications.
- Mayer, M. (2004b). *Qigong: Ancient path to modern health* (DVD of keynote address to National Qigong Association). Orinda, CA: Bodymind Healing Publications.
- Mayer, M. (2007). *Bodymind healing psychotherapy: Ancient pathways to modern health*. Orinda, CA: Bodymind Healing Publications.
- Mayer, M. (2009). *Energy psychology: Self-healing practices for bodymind health*, North Atlantic/Random House.
- McCaslin, D. (2009). A review of efficacy claims in energy psychology. *Psychotherapy: Research, Practice, Training*, 49, 249-256.
- Meade, M. (2006). *The water of life: Initiation and the tempering of the soul*. Seattle, Washington: Greenfire Press, p. 210-211.
- Mercola.com, (2003).
<http://articles.mercola.com/sites/articles/archive/2003/12/03/hypertension-part-two.aspx>;

(retrieved October, 2, 2009).

Mercola.com (2005), article by Ron Rosedale M.D., cholesterol is not the cause of heart disease. Retrieved October 3, 2009,
<http://articles.mercola.com/sites/articles/archive/2005/05/28/cholesterol-heart.aspx>

Mercola.com, (2005b) <http://articles.mercola.com/sites/articles/archive/2000/05/28/blood-pressure-part-one.aspx> (Retrieved October 2, 2009).

Newman, Thomas B. et al. (1996). Carcinogenicity of lipid-lowering Drugs. *JAMA*. January 3, 1996, Vol. 275, No. 1.

Ornish, D., et al. (1993). Can lifestyle changes reverse coronary disease? *Lancet*, 336, 129–133.

Oschman, J. (2000). *Energy medicine: The scientific basis*. New York: Churchill Livingstone.

Pagels, E., (1981). *The Gnostic Gospels*, New York: Ballentine Books.

Palmer, D. (2007). *Qigong fever: Body, science and utopia in China*. New York: Columbia University Press.

Pert, C. B. (1997). *Molecules of emotion: The science behind mind-body medicine*. New York: Touchstone.

Phillips, P.S., Haas, R.H., Bannykh, S., Hathaway, S., Gray, N.L., Kimura, B.J., Vladutiu, G.D., England, J.D.; Scripps Mercy Clinical Research Center.(2002). Statin-associated myopathy with normal creatine kinase levels *Ann. Intern. Med.* Oct 1, 137(7): 581-5.

Pignotti, M., and Thyer, B. (2009). Some comments on “Energy Psychology: A Review of the Evidence”: Premature conclusions based on incomplete evidence? *Psychotherapy: Research, Practice, and Training*, 49, 257-261.

Pollare, T., Lithell, H., Selinus, I., & Berne, C. (1989). A comparison of the effects of hydrochlorothiazide and captopril on glucose and lipid metabolism in patients with hypertension. *British Medical Journal*, 321, 868–873.

Pollare, T., Lithell, H., Selinus, I., and Berne, C. (1989). Sensitivity to insulin during treatment with atenolol and metoprolol: A randomized, double blind study of effects on carbohydrate and lipoprotein metabolism in hypertensive patients, *British Medical Journal*, 298 (6681) April 29.

Porges, S. (1995). Orienting in a defensive world. Mammalian modifications of our evolutionary heritage: A polyvagal theory. *Psychophysiology*. (8), pp. 43-48.

Raffensperger, C. & Tickner, J. (1999) (eds.) *Protecting public health and the environment:*

- Implementing the precautionary principle*. Washington, DC: Island Press.
- Reich, W. (1970). *Character analysis*. New York: Farrar, Straus, & Giroux.
- Rinpoche, S. (1993). *The Tibetan book of living and dying*. San Francisco: Harper Collins.
- Ritter, C. & Aldridge, D. (2001). Qigong Yangsheng as a therapeutic approach for the treatment of essential hypertension in comparison with a western muscle relaxation therapy: A randomized controlled pilot (In German). *Chinesische Medizin*, 16: 48–63.
- Robbins, J. (2000). A sympathy in the brain: The evolution of the new brain wave biofeedback, New York: *Atlantic Monthly Press*, as reported in Aposhyan, op cit, 2004.
- Rogers, S. (2005). *The high blood pressure hoax*, Sarasota: Flo: Sand, Key Company.
- Rosedale, R. (2008). Cholesterol is NOT the Critical Cause of Heart Disease: By Ron Rosedale, MD, (Retrieved, October 9, 2009), <http://weeksmd.com/?p=485>.
- Rosen, R., Brondolo, E., and Kostis, J. (1993) Nonpharmacological treatment of essential hypertension: Research and clinical applications in ED: Gatchel, R. (1993). *Psychophysiological Disorders*, Washington, DC: American Psychological Association
- Rossi, E. (1986). *The psychobiology of mind-body healing: New concepts of therapeutic hypnosis*. New York: Norton.
- Rossi, E., & Cheek, D. (1988). *Mind-body therapy: Methods of ideodynamic healing in hypnosis*. New York: Norton.
- Rubik, B. (2002). The biofield hypothesis: It's biophysical basis and its role in medicine. *Journal of Alternative and Complementary Medicine*, 8, 703–717
- Sancier, K. (1996). Medical applications of Qigong. *Alternative Therapies*, 2(1), 40–46..
- Sancier, K. M., & Holman, D. (2004). Multifaceted health benefits of medical Qigong. *Journal of Alternative and Complementary Medicine*, 10(1), 163–166.
- Sapolsky, R. (1998). *Why zebras get ulcers: The updated guide to stress, stress-related diseases, and coping*. New York: W. H. Freeman and Company.
- Saputo, L. (2009) *A return to healing: Radical health care reform and the future of medicine*, San Rafael: Origin Press.
- Schneider, R. H., Alexander, C. N., et al. (2005). A randomized controlled trial of stress reduction in African Americans treated for hypertension for over one year. *American Journal of Hypertension*, 18, 8–98.
- Schore, A. (1994). *Affect regulation and the origin of the self*. Hilldale, NJ: Erlbaum.

Seyle, H. (1979). *The stress of my life*. New York: Van Nostrand.

Sturgis, L., & Coe, W. (1990). Psychological responsiveness during hypnosis. *International Journal of Clinical Hypnosis*, 38(3), 196–207.

Subtle Energies and Energy Medicine Journal, Arvada: Co.: ISSSEEM.
<http://www.issseem.org/storejournals.cfm>

Tart, C. (1968). *Altered states of consciousness*. New York: John Wiley & Sons.

Tomio, N. (1994). *The Bodhisattva warriors*. New York: Samuel Weiser.

Van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of post-traumatic stress. *Harvard Review of Psychiatry*, 1, 253–265.

Van der Kolk, B. A. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F. Shapiro (Ed.), *EMDR, Promises for a paradigm shift*, APA Press.

Wang, C., Xu, D., Qian, Y., Shi, W., Bao, Y., & Kuang, A. (1995). The beneficial effects of Qigong on the ventricular function and microcirculation of deficiency in heart energy hypertensive patients. *Chinese Journal of Internal Medicine*, 1, 21–23.

Wayne, P. M. & Kaptchuk, T. J. (2008). Challenges inherent to Tai Chi research: Part I—Tai chi as a complex multicomponent intervention, *Journal of Alternative and Complementary Medicine*, Vol. 14, No 1, pp. 95–102.

Wilhelm, R. (1931, 1963). *The secret of the golden flower*. New York: Harcourt, Brace, & Jovanovich.

Wollam, G., & Hall, W. (Eds.). (1988). *Hypertension management: Clinical practice and therapeutic dilemmas*. Chicago: Yearbook Publishers. Quoted by R. Rosen, E. Brondolo, & J. Kostis (1998). Non-pharmacological treatment of essential hypertension: Research and clinical applications. In Gatchel, R. & E. Blanchard (Eds.), *Psychophysiological disorders: Research and clinical applications* (pp. 63–100). Washington, DC: American Psychological Association.

Wu, W. H., Bandilla, E., Ciccone, D. S., Yang, J., Cheng, S., Carner, N., Wu, Y., & Shen, R. (1999, January). Effects of Qigong on late-stage complex regional pain syndrome. *Alternative Therapies*, 5(1). Peer reviewed.

Yang, S. (1993). *Second World Conference for Academic Exchange on Medical Qigong. Reported in the Qigong Database: the Qigong Institute of S.F.*

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Bio: Michael Mayer, Ph.D. is a licensed psychologist, hypnotherapist, and Qigong/Tai Chi teacher who specializes in giving his patients self-healing methods for health problems. Dr. Mayer presents his approach to bodymind healing at professional conferences, national/international workshops, universities, and hospitals; and he is a keynote speaker. He is a co-founder of, and a practitioner at, The Health Medicine Center, a multi-disciplinary medical clinic practicing integrative health-care. Dr. Mayer pioneered the integration of Qigong and psychotherapy, and was the first person in the United States to train doctoral psychology students in these methods. The World Institute for Self-Healing gave him an award for outstanding research and contribution to the advancement of mind-body medicine. He is the author of twenty publications on bodymind healing including five books, audiotapes on cancer and chronic disease, and articles on chronic pain and anxiety. His peer reviewed article on Qigong and hypertension appeared in *The Journal of Alternative and Complementary Medicine*, and is updated in the book *Healing, Intention and Energy Medicine*, by Dr Wayne Jonas, past director of the National Institute of Health, Office of Alternative Medicine. Dr. Mayer has served as a peer reviewer for *The Journal of Alternative and Complementary Medicine*, *Complementary Therapies in Medicine*, and *Annals of Internal Medicine*. His Bodymind Healing Qigong DVD is currently being used in training of trauma therapists by Dr. Bessel van der Kolk, Medical Director, The Trauma Center, Boston University School of Medicine. Dr. Mayer has certification programs which include Bodymind Healing Qigong for Qigong practitioners/teachers, and a Bodymind Health Practitioner's Certification Program for health professionals. His last book, *Bodymind Healing Psychotherapy* (2007), received endorsements from top leaders in mind-body medicine, and from the journal *PsyCritiques*. It has been released as a trade paperback called *Energy Psychology* by North Atlantic/Random House, 2009. Michael's guiding image of "two streams becoming one" guides him as he joins East/West, mind/body and ancient/modern in his work.

¹ Energy Psychotherapy is a current form of psychotherapy (Gallo, 2002; Feinstein, 2008), which is in the process of being evaluated regarding its efficacy (Feinstein, 2009; Pignotti & Thayer, 2009; McCaslin, 2009). *Bodymind Healing Psychotherapy* (Mayer, 2007) uses some energy psychology methods; however BMHP expands and deepens the field of energy psychology beyond the tapping techniques that many associate with energy psychology by BMHP's use of well established psychotherapeutic methods (cognitive/behavioral, psychodynamic, etc), Gendlin's *Focusing*, symbolic process traditions, depth psychotherapy, and Qigong (Mayer, 2009).

² In its "integrative approach" *Bodymind Healing Psychotherapy*, when appropriate, incorporates Qigong movements into psychotherapy and behavioral healthcare. As an "integral approach" (Walsh & Shapiro, 2006), BMHP brings the essence of Qigong into psychotherapy without ever using a word about Qigong and without ever using a Qigong movement. By integrating Qigong breathing methods such as Microcosmic Orbit Breathing

(Wilhelm, 1963; Mayer 2004, 2007, 2009), acu-point self-touch, imaginal/somatic approaches such as the River of Life method, symbolic process approaches such as the Mythic Journey Process (Mayer, 1982, 2007), and anchoring the bodily movements/postures expressed by patients at a moment of “felt energetic shift” (Gendlin, 1978), an integral paradigm for bodymind healing is accessible for clinicians and their patients to apply in brief or depth psychotherapy. I have proposed (Mayer 2007, 2009) that the movements/postures that oftentimes arise at the moment of “felt shift” (Gendlin, 1978) in psychotherapy resemble the movements/postures practiced by Tai Chi/Qigong practitioners; and that psychotherapists’ knowledge of such can help to further anchor and amplify the meanings of such somatic expressions to enhance therapeutic change.

³ Yang, S. (1993). *Second World Conference for Academic Exchange on Medical Qigong*. Reported in the Qigong Database: the Qigong Institute of S.F. This study analyzed the EEG patterns of young students, 17 to 20 years old, who had been practicing *Zhan Zhuang Qigong* (*Standing like a Tree*) for one year. Thirty-two persons in the Qigong group and thirty-five persons in the control group were involved in this experiment. During a one-year period of observation, the subjects of the Qigong group practiced Qigong for 40 minutes every day. The EEGs of the Qigong group were analyzed every half-year in meditation, and the EEGs were also recorded before learning Qigong. The students in the control group did not take part in the Qigong training and their EEGs were investigated at rest twice within an interval of one year. In the test, a computer on line simultaneously processed eight channels of EEGs for 20 minutes. After one year of Qigong training, total coherence between the left and right frontal regions increased from 0.84~0.07 to 0.87~0.06 ($p < 0.05$). Before Qigong training, the total coherence between the left and right occipital areas was 0.68~0.14. After a half year of training, it increased to 0.79~0.10, and after one year of training it was 0.76~0.10, ($p < 0.001$). The total coherence between the left and right temporal areas before Qigong training was 0.48~0.17; half year after Qigong training it was 0.55~0.13, compared with that before Qigong training ($p < 0.05$). One year after Qigong training it was 0.64~0.12, compared with those before Qigong training and half a year after Qigong training ($p < 0.001$). Qigong training had no significant influence on coherence between the left and right central regions and between adjacent anterior and posterior brain regions (F3-C3, F4-C4, C3-O1, C4-O2). The data from the two tests of the control group showed that the total coherence did not change significantly between the left and right corresponding brain regions and between the anterior and posterior adjacent brain regions. The author of the study (Yang, 1993) summarized, “The results showed that Qigong training had affected coherence of EEGs between the two frontal regions, between two occipital regions and between two temporal regions of the Qigong group in meditation. The most significant is that, with the increase of training period, the total coherence value between the left and right temporal areas went up. It seems that there is certain dosage effect relationship.”

Another study on *Zhan Zhuang* is by Li, C. (1995). Preliminary Exploration on the Scientific Proof of Being Sober-Minded, Sharp-Eyed and Energetic after Practicing *Zhan Zhuang*. Reported at the *Fourth International Conference on Qigong, Vancouver, 200-24*. This study reports improvement in uric acid level after practice. See Qigong Database from the Qigong Institute of San Francisco.

⁴ One reason for tucking in the pelvis in this method of postural initiation is to “fill in the hollow” in the lower back (*ming men*). It is believed in the Qigong tradition that this helps a person to withstand the forces of life that push on him or her, literally and figuratively. The *sifu* (respected teacher) pushes on the acolyte to test whether he or she can relax and not be pushed over; this is called *sili*, or testing the relaxation and groundedness of the person. The practitioner is called to find a state specific state that is both relaxed and energized; if the practitioner is tense or ungrounded, he or she is “a pushover.” Evaluating this stance regarding its ability to affect various health-related measures including hypertension would be useful. To see preliminary studies that need further research see endnote 3 above.

⁵ By my using the term "true Christian," and "the truth of things" I'm referring to the Christian "Gnostic" tradition one of the earliest forms of Christianity (as discussed in Elaine Pagel's book *The Gnostic Gospels*) that advocated the oneness of God in whatever form. As the Gnostic teacher Theodosius says, "Each person recognizes the Lord in this own way, not all alike. (Pagels, 1981, p. 20)."

⁶ The AHRQ, (2004). Agency for Healthcare Research and Quality of the U.S. Dept. of Health and Human Services reviewed more than 3,000 journal articles and conference papers for their hypertension study. They concluded, “Even small improvements in blood pressure control can have major public health impact. A 1990 systematic review of 14 randomized treatment trials for hypertensive patients showed that lowering diastolic blood pressure (DBP) by 5 to 6 points reduced stroke rates by 42%. Another recent study showed that lowering DBP by only 2 points could result in a 6% reduction in the risk of coronary heart disease, along with a 15% reduction in the risk of stroke and one type of heart attack.” However they also said, “Despite clear evidence showing that hypertension treatment reduces the incidence of stroke, heart attacks, and premature death, high blood pressure care in the United States often does not conform to evidence-based guidelines. The report calls for greater study into the adoption of best practices and the partnership between researchers, practitioners, and patients.”