ICM Institute For Complementary Medicine

ICM Journal

www.i-c-m.org.uk | Autumn 2006, Volume 1, issue 2

Moving Forward in Partnership

First of all, thank you to everyone who responded to the new, revamped edition of the Journal in the Summer. We were delighted to receive your feedback, together with suggestions for articles, which we will build on through the membership for the future.

As we come into the Autumn, we are pleased to advise members of another positive change at ICM. As some of you know, we have been in dialogue with the Nature Cure Clinic for the past eighteen months regarding potential areas of development and partnership. As a step towards this, we have jointly appointed a Project Manager who will be based at the ICM's premises from the end of October. The role of the Project Manager will be to work with the Trustees from both organisations in developing a new, Flagship Centre in London. The NCC administration will also move in with us during this planning period.

We are delighted to welcome our colleagues. The NCC was established in 1928 by Nina Hosali, a pioneer of natural medicine in her time, and has a long record of providing affordable natural health-care in London. We feel that, together, much can be achieved mutually with a new Centre for integral medicine, providing a range of services to the public and practitioners, and working to a sustainable model of social enterprise as well.

This is a major initiative, and we look forward to giving you more details – and introducing our new team members – in the next edition.

Meanwhile, we hope you enjoy this second edition of the new Journal. We are very pleased to include a paper from Dr. Tessa Adams, Visiting Fellow of Goldsmiths College UL, on therapeutic holding – a theme which practitioners of all disciplines may find valuable in relation to their own practice.

Psychotherapy standards and interface:

The interface between psychotherapy and other disciplines is of great interest to us at ICM. In relation to this we are reviewing the requirements and standards for registration within the BRCP Psychotherapy Division, taking account of proposed national standards. We expect to convene a BRCP working group to develop this further in consultation with some of our members. It is particularly important to us that the healing and spiritual elements of psychotherapy should have full and national recognition, with rigorously applied training standards.

I believe that the ICM/BRCP is well placed to take the debate on standards forward with colleagues, not only in the field of psychotherapy, but also in the context of natural and integral medicine.

We look forward to a busy autumn and to our future contact with you.

Beverly Martin, Chair to Trustees

CONTENTS:

News round-up 2

Feature – Psychological Holding *by Tessa Adams* 3

Special Report – CORH moves to Single Register *by Andree Sanford and Penny Horsburgh* 6

Special Report –The Hallmark of Best Practice – defining the status of a Senior Practitioner *by Beverly Martin* 7

Feature - Is Reflexology of help in the care of Cancer Patients *by Carol Ellis and Frances Fewell* 8

Feature - Eating Greens can be Seriously Deadly *by Anthony R Teal* 10

News round-up, Events 12

Something to say?

If you have a news story, up-coming event, point-of-view, or would just like to be in touch – do contact us on: **020 7237 5165** and ask for Frances, Clive or Adrian.

Medihoney better than antibiotics

Honey helps wounds heal better than many modern antibiotics, according to anecdotal evidence from Bonn University in Germany.

Doctors working on the cancer ward of Bonn University's Children's Clinic have used medihoney to treat wounds successfully for several years and are now embarking on a large-scale research study to assess its curative properties through objectively assessed data.

Medihoney is a special compilation of honeys, including one that forms small amounts of hydrogen peroxide, an effective antiseptic. The advantage of using hydrogen peroxide from honey, rather than that sold through pharmacies, is that the chemical is constantly being produced, so only small concentrations are needed to kill germs and skin cells remain undamaged.

Dermatological homeopathy trial goes to the dogs

Dogs with canine atopic dermatitis will be taking part in a clinical trial to assess the value of a range of homeopathic remedies, in an integrated CAM and conventional research project at Bristol University's School of Veterinary Science.

The trial involves homeopathic veterinary surgeon, Mr John Hoare, and Dr Robert Mathie, research development adviser at the British Homeopathic Association and Faculty of Homeopathy. The first phase of the trial will aim to measure the level of itching displayed by the dogs. If this phase proves homeopathy appears beneficial for some dogs, a further phase of the trial will take place, during which both itching and the level of the dogs' dermatitis will be assessed.

Brain's response to pain lowered by transcendental meditation

Twelve people who have practised transcendental meditation for thirty years demonstrated up to 50 percent less brain response to pain, compared to twelve non-meditators, according to a report published in NeuroReport in August.

Functional magnetic resonance imaging of the response to thermally induced pain applied outside the meditation period found that long-term practitioners of the transcendental meditation technique showed 40-50% fewer voxels responding to pain in the thalamus and total brain than in healthy matched controls. After the controls learned the technique and practised it for 5 months, their response decreased by 40-50% in the thalamus, prefrontal cortex, total brain, and marginally in the anterior cingulate cortex.

Until now, research into the effects of transcendental meditation has only indicated that meditators respond to stress more calmly than non-meditators. These latest findings suggest that this is not simply the result of a shift in approach to stress from meditators, but also a fundamental change in the way the brain actually functions.

Pomegranate juice slows progress of prostate cancer

A daily glass of pomegranate juice may slow the progress of prostate cancer, according to research published in the Clinical Cancer Research journal in July.

Prostate cancer cells produce a chemical called prostate-specific antigen (PSA). Pomegranate juice contains anti-oxidants and other chemicals which, the researchers from the University of California found, suppressed levels of PSA in fifty men who had rising levels of the chemical after surgery or radiation treatment for prostate cancer.

Previous research on prostate cancer cells in mice had suggested that pomegranate juice may have beneficial effects. This is the first time research has been carried out on humans.

The researchers measured how long it took for PSA levels to double in the patients monitored. The average doubling time is about 15 months, but in patients who drank eight ounces of pomegranate daily this increased to an average of 54 months.

Prostate cancer is often a slowly-progressing disease. The news that pomegranate juice may slow that progression even further suggests that – for older men – the juice may make it possible for them to outlive their risk of dying from their cancer.

Psychological Holding

By Tessa Adams

Tessa Adams is a Visiting Fellow of Goldsmiths College, Fellow of the Royal Society of Arts and the Director of Studies for the SOPH MA in Psychotherapy and Healing. She originally qualified as a fine artist, before training as a psychoanalytic psychotherapist with the Guild of Psychotherapists.

From his observations of babies and mothers in the middle part of the last century, psycho-analyst D.W.Winnicott came to understand a dynamic that he considered to be crucial to the development of autonomy and self-esteem. He recognised that while most mothers (or prime carers) were prepared to hold an infant in a physical sense, i.e. by cuddling or tending, many mothers failed to realise the nature of psychological holding that is needed to accompany the necessary physical engagement. Furthermore, Winnicott maintained that in the cases where this original quality of early infant maternal holding is absent the outcome for adulthood could be marked by the individuals' inability to 'hold' themselves. Winnicott's position clearly has implications for healing practitioners as well as for psychotherapists and counsellors, since it brings into focus how to hold psychologically with the emphasis on the individual's deficit in infancy. What is significant in Winnicott's analysis is the discrete nature of this original maternal encounter in that the holding is pre-verbal and relies on a symbiotic union. What this means is that, whether we work with the body, the spirit or the mind, the critical issue is not 'what the therapist does' (i.e. actions and interpretations) but *how* the environment of psychological holding is facilitated. This paper explores Winnicott's holding principle and indicates the means by which the subtleties of psychological holding can be embraced by the therapeutic process.

Holding, as we understand it in an institutional setting, can frequently imply a gentle, affirmative response to chaotic behaviours where the 'carer' is attempting to boundary the 'boundaryless' individual in such a way as to achieve a meaningful space for both of them. Holding in this sense could be seen to be the concretization of the symbolic holding which is proposed by Winnicott for psychodynamic therapy. With a view to exploring the nature of the relationship between the 'holder' and the 'held' I wish to discuss the parameters of this symbolic holding and not to place the emphasis on the concrete processes.

What does it mean to 'hold' in the psychological sense? When, in everyday life, we ask someone to hold something for us, we trust them. Trust them to do what? Not to drop, lose, break, damage or to keep the object. Holding something is keeping something safe for someone else – for a while. Holding is an impermanent state. We cannot hold something forever, for if we attempt to do so the concept can easily shift to the shadow 'holding on to'. Holding therefore is a necessarily a temporary state – a temporary trust that we give to someone to respond to for our sake.

Holding, therefore, is not an action, it is a process. To illustrate this further I will focus on a simple day-to-day request which embodies the collaboration of the holder and held:

'Please hold my cup of tea while I go through the door'.

If this was my request of you I would expect you to be concerned in several ways. If you drank some of the tea this would not be holding – it would be exploitation. If you spilt some of the tea it would not be holding – instead it would be dropping, disregarding, not taking care – and if I did get my tea back, you would have had to *let go*. This example embraces some of the key features embedded in Winnicott's concept of holding, which opens up the questions that surround 'being able to hold'.

Winnicott's theory

Winnicott's work on infancy illuminates the bond between the mother and child. He suggests that, in the early months, it is essential for the baby to experience reliable holding in the psychological sense. The birth rupture has shifted the mother's provision from unconscious to conscious and while it is obvious that the baby is dependent upon reliable physical attention, it is far less obvious that the baby also depends upon reliable psychological attention for his/her survival. Winnicott suggest that, unless the infant is held in the fullest sense, the development of ego-relatedness can suffer to the extent that the infant may have insufficient

confidence to venture creatively into the outside world.

In other words, the pre-natal state of sublime symbiotic union is necessarily transferred to the post-natal psychological union through the quality of the holding. A sufficient environment for the infant to develop autonomy and the capacity to separate confidently from the mother and to hold him or herself is thereby maintained. Where there is a rift in this early transformation and where the bond has not been sufficiently established, we can see the disruption in autonomy were venturing can become ritualised and the shadow – 'holding on to' (clinging) can become the response to change, as if holding, so essential for emotional development, is impaired. Psychodynamic work can be concerned with releasing such individuals from the constraints of 'holding on to'. In these incidences, it is the re-creation of a symbiotic union through the quality of the therapeutic alliance that can repair the poverty experienced. This allows the transformation to take place which suffered risk at the start of life.

Within Winnicott's concept of 'good-enough mothering' there are references to the essential features of a holding environment. Physical neglect of the tiny infant can hopefully be located by the health visitors and by weight checks at the clinic. However, checks on the holding environment are not easy to carry out and, unless physical neglect is apparent, tend to be made when the infant is demonstrating emotional disorder. Much of Winnicott's work embraced the diagnosis of tiny infants who were demonstrating emotional disorder and he would frequently work therapeutically with both the baby and the mother. Faced with pre-speech infancy in his consultations, Winnicott's resourcefulness led him to invent a game which became a useful tool for the diagnosis of both the quality of the mother's holding environment and the tiny infant's emotional response to adult care.

The Spatula Game

The mother, as we know, has the responsibility of identifying the infant's fluctuating needs for boundary and for space. The effective holding environment incorporates sufficient space for the development of the capacity for exploration – autonomy and sufficient boundary for the development of the capacity for consistency – stability. Winnicott's spatula game enabled him to evaluate this required sufficiency – that is, the game enabled him to identify the level of the tiny infant's anxiety in relation to his or her interaction with the outside world. In consultations Winnicott would place a spatula (just out of reach) between himself and the tiny infant. At the sight of this spoon-like shiny tongue-depressor the infant would salivate and hopefully make some gesture to secure the object in order to place it in his or her mouth.

There are three probable responses that a mother could make in this situation. Firstly she might notice that the infant is salivating and, for some benefit to herself, such as tidiness, would move the object firmly out of the infant's reach and proceed to distract the infant away from his/her desire. Secondly, she might notice the infant's deep attention to the spatula and, anticipating the infant's desire, would place the spatula in the infant's mouth. Thirdly, the mother might read the infant's desire and *interact* with this desire by pushing the spatula just near enough for the infant to reach out and secure the object. This results in a sense of achievement and exploration as the infant places the spatula in his/her mouth.

This third response illustrates, in Winnicott's words, 'the subtle co-operation which mothers can give, which supports yet does not dominate'.[1] It is just this 'subtle co-operative support' which is the basis of Winnicott's concept of holding. He suggests that it is only within the holding environment that the truly spontaneous gesture can be ventured. In this example we can see that in the first case there would be a sense of privation, while in the second case a 'too good' mother (too omnipotent) could dominate the infant to such an extent that exploration could be inhibited.

This concept was taken into Winnicott's therapeutic work with adults. He likened the overly interpreting therapist to the invasive mother (putting the spatula in the patient's mouth), where the potential of the patient's exploration would be inhibited by clever interpretations. Instead of creating the space for interaction in the therapeutic alliance, where the patient could venture, the patient would fear the therapist's omnipotence; thus the patient's defences would in turn be reinforced. In thinking of ourselves as 'good-enough holders' we can begin to see what we hope to achieve. If we are not good enough, we can become like the 'too-good mother' who holds on to, or holds too tight, or we can become like the neglectful mother who disregards and drops.

'Good enough' holding

How can 'good-enough' holding be achieved? Winnicott suggests that the mother's symbiotic union with the tiny infant depends upon her capacity to identify with her baby, therefore good enough holding could depend on our capacity to empathise. It is through empathy that we can interpret how to hold and when to let go, where holding can be spacious and flexible and letting go does not become dropping. Experience tells us that affirmative holding is not easy, we can be frequently asked to hold something that is very difficult, or we can be asked to hold something that we feel should be given to us.

In order to identify some of the difficulties of being able to hold, I will return to the 'tea' illustration. Dropping the cup indicates impatience. The holder becomes tired and wishes to be recognised and rewarded for their attention to the held. They let go, giving the responsibility precipitously back to the held. Drinking some of the tea indicates exploitation. The holder gives too much of themselves and through a process of collusion demands also to be held. Collusion impairs the holding environment resulting in the mutual dependency of the holder and held becoming ritualised. Spilling the tea indicates unreliability. Through erratic responses

the holder creates a sense of precariousness. Trust is insufficient and the held withdraws (takes the tea back) and fails to venture forward. The holder's finding of the cup to be too hot indicates unpreparedness: the task of holding is not analysed due to lack of evaluation and readiness. The holder gives into his/her sense of omnipotence (feeling they can take on anything) and holding cannot be sustained.

The holding environment

Having outlined some of the obvious difficulties in holding, I would now like to offer some suggestions which can contribute to a description of the holding environment. To do this I will look at the therapeutic alliance where holding plays such a significant part.

Clearly, I am writing with particular reference to psychotherapy, but holding is a potential valuable aspect of relationships between a far wider range of therapists and their clients. There is a relationship between a mother's capacity to identify with her infant, and our capacity to empathise with those whom we help. The mother has this by virtue of her own babyhood, while our empathy depends on our ability to translate and transpose our experience. This means that empathy does not develop or solely depend on 'having experienced', rather in empathising we have recourse to our ability to abstract, symbolise and transpose from experience. In the case of a miscarriage, for example, it would not be necessary for a therapist to have experience of this form of loss to be able to analyse the individual's distress. But it would be necessary for the therapist to be able to get in touch with the deep disappointment that could surround instances in their own life where creative ambition had been sabotaged and ruptured.

In attempting to define the conditions of holding I realised that while empathy is crucial it is not sufficient, for although we can easily imagine situations where we empathise but do not hold, it is difficult to conceive of a holding environment without empathy. What are the other factors? Winnicott gives us an indication in his phrase: 'the subtle co-operation which mothers can give, which supports yet does not dominate'. Psychotherapists and other therapists, teachers, counsellors and carers would probably see this phrase as embodying a large proportion of their work and some may feel that this should be the only basis of their work. Winnicott, while emphasising these qualities of holding, is equally concerned with the dangers of collusion – holding on. He illustrates this in his paper: *Hate in the counter-transference*, where he stresses how essential it is for negative feelings to be, not only identified, but occasionally expressed. He implies that a child who experiences a mother who appears to show only love despite its 'bad' behaviour, is faced with the illusion of carrying all the negative feelings of their relationship. This leads to fears that he/she is not loved at all. It is as if, in a relationship, one partner's continual insults and nastiness is repaid always with kindness. That person is made to feel wicked and not deserving of love. It is tempting for a mother to wish to appear only loving and thereby to hold-on to the symbiotic union. Similarly, as therapists, we may find it difficult to face the part of our work which does not feel co-operative. However, the dangers of collusion can remind us that holding is, as I have stated, a temporary state and will need to give way in part to include some dynamic work, for love to be fully experienced.

In our work (and here I am excluding work with actual tiny infants) we hope to identify when to hold and when to let go. To illustrate this use of Winnicott's concept of holding which I have suggested parallels the mother's symbiotic union with the early infant, I studied my own practices. Interestingly in my current case work while I can readily identify where I am letting go, I find it difficult to be sure of when I am holding in the fullest sense. On the other hand if I look at my past case work I can clearly locate phases of symbiotic union and find it difficult to see what brought about a change. Studying this further, I realised that when one is holding in the fullest sense it is our own presence which necessarily is absent. For holding is not dynamic interaction. The experience of the held is that there is a one-person environment where they are the only presence, the other's presence is merely implicit, a part of their own body – there is no 'other'. In other words, in the symbiotic union, symbolically, there is only one person in the consulting room – namely, the patient.

This explains why I cannot readily recognise when I am holding in the psychological sense. The reason being that my empathic presence does not even rely on my immediate understanding of the issues of distress. Instead, empathy relies on my ability to conceive my lack of literal presence, where symbolically I am part of the patient. This does not mean that I do not act or speak, but that I have to know and be *able to tolerate*, for this temporary time, that I am not – for the patient – identified as anything but part of them. Using my early illustration, in holding the tea, it is not the holder of the tea who is seen to be important, it is whether the tea is spilt or not that matters.

Holding is temporary and although the symbiotic union can be deeply rewarding for both the holder and the held, it has to change. We may wish to keep things as they are, not daring to let go, like the mother who fears weaning her child for her own needs. As the symbiotic union becomes more flexible in therapeutic work, dynamic interpretation, which could have ruptured the potential space in holding, becomes, at the right time, the essential feature to facilitate autonomy.

References:

1. Madeleine Davis and David Walbridge, Boundary and Space: An Introduction to the Work of W.D. Winnicott, Karnac Books, London 1981, p24

Further reading:

D.W. Winnicott, Playing and Reality, Pelican, London 1971.

CORH moves to Single Register

By Andree Sanford and Penny Horsburgh

Andree Sanford has practised homeopathy for 20 years. She has taught student homeopaths in two classical homeopathic colleges, is an advisor for the ICM, and a member of the Registration Group within CORH. Penny Horsburgh has been a practising homeopath since 1994. She originally qualified as a nurse and is also a teaching Rieki master and EFT practitioner. Both Andrée and Penny have been involved in the CORH council since its inception, representing homeopathic members of the BRCP.

Penny Horsburgh

CORH (Council of Organisations Registering Homeopaths) is the body charged through its constitution with putting into place a single register for all those who wish to be known as homeopaths. It s remit also involves the establishment of an infra-structure that is capable of supporting that single register with effective self regulation.

This work is gathering pace. The CORH council meets regularly and the four working groups: CPD (Continuing Professional Development), Ethics, Registration and Accreditation are poised to complete important areas of their work.

The aims of the council are the same as when it was formed in 1997. These aims are:

From The Constitution CORH…"is established, in the public interest, to represent the interests of those practitioners for whom homeopathy is their primary therapeutic practice and who wish to be identified as homeopaths". The current terms of reference are:

a. To establish a single voluntary, self-regulating register of professional homeopaths.
b. To establish a common code of ethics.
c. To establish criteria and procedures for the registration of homeopaths to a single UK register.
d. To establish an accreditation process to accredit courses of homeopathic education.
e. To define, promote and continually evaluate the elements and standards of best homeopathic practice.

It is anticipated that the single register will be open to applicants from summer 2007 and will go live from January 2008. The present CORH council will evolve to an elected body and will become the Board of the Council of Registered Homeopaths (CoRH). To begin with these elected members will come from the present registers and be elected by their members.

What will this mean to homeopaths registered with the BRCP (hom) and part of the ICM?

BRCP registered homeopaths will join the single register of homeopaths but still retain all the benefits of having the BRCP to maintain their insurance, personal safety to practise, access to continuing professional development and connection to the wider world of complementary therapies.

What is this going to cost?

At present it is likely that the fee for registering with CoRH.will be in the region of £50. The fee will be kept as low as possible and will ensure that each homeopath's name and the way they practise will be available to the general public through the register. It is envisioned that, in time, all UK homeopaths will be on this single register of homeopaths.

Voluntary self-regulation

The Prince's Foundation for Integrated Health (PFIH) has published a consultation document for all complementary therapists to record their views on a federal approach to the voluntary self-regulation of complementary healthcare.

CORH's experience in progressing its work to date would be helpful to the PFIH in its future work, whatever form that may take. Should the Foundation progress the work on a federal structure, depending on the results of the consultation, there will still be a place for continued positive dialogue and co-operation with uni-professional regulatory bodies.

These are exciting times for homeopaths as we work towards the single register. CoRH will be a self-regulating body. In time it may be that the way forward is to become a statutory body. But, whatever the future holds, we will be ready for the challenges ahead.

Information about CoRH and its work so far is available at www.corh.org.uk You may find it interesting to see CoRH's website and we would welcome your impressions of the work that has so far been completed.

Member Organisations of CORH are:

- Alliance of Registered Homeopaths (ARH)
- Association of Natural Medicine (ANM)
- British Register of Complementary Practitioners (BRCP Hom.Div.)
- Council for Homeopathic Colleges (CHC)
- Embody
- Fellowship of Homoeopaths (FelHom)
- Homeopathic Medical Association (HMA)
- International Register of Consultant Herbalists and Homoeopaths (IRCH)
- International Society for Homoeopathy (ISH[UK])
- National Association of Homeopathic Groups (NAHG)
- Scottish Association of Professional Homeopaths (SAPH)
- Society of Homeopaths (SoH)

The Hallmark of Best Practice – Defining the status of a Senior Practitioner

by Beverly Martin

Beverly Martin is Chair to Trustees at the ICM and Course Director for the MA in Psychotherapy & Healing, validated by Middlesex University as a 2-year, p/time course. She has a particular interest in training standards.

The establishment of a national Register of Homeopaths, as outlined in the adjacent article about CORH, is warmly welcomed by the ICM and the BRCP. In terms of national standards, we believe there is a need for further definition of training within the disciplines, and a recognised parity between the various training institutes. The work of CORH is a valuable initiative in this respect. Recognition of practitioners through single Registers will not only help to establish and endorse core training within a particular discipline, but should help to preserve essential and valuable differences between the various training organisations, as well as their aim of best practice.

At ICM/BRCP we are also interested in the endorsement and definition of a 'best practice' standard. We are considering that, in the near future, this standard could incorporate a definition of a Senior Practitioner and the award of a Fellowship of the ICM. We are considering both elements which would be based on the practitioner's achievement of:

- Graduation in a core training from one or more disciplines.
- A range of lock-on Modules related to best practice in whole-person/integral medicine and senior status.
- Recognised number of hours at senior level for theory, practice, supervision, and Continuing Professional Development.

Taken together, this additional standard could present an opportunity to discuss, develop and provide an agreed status in terms of a Senior Practitioner and/or Fellow of the ICM. It would also provide an additional element of career development for individual practitioners, and a recognised industry standard which could benefit all of us.

The value of further Practitioner status:

The definition of Senior status could also provide two further invaluable opportunities in the holistic field. Firstly, to establish more concretely the model of the whole person as a core agreement across the disciplines. Secondly, to build a bridge of language between complementary medicine and mainstream allopathic patient care. If we are to do this, then it would seem essential that, within the complementary medicine movement as a whole, we begin to define (a) the model of the person common to any discipline or intervention, and (b) how this relates to the spiritual dimension of theory and practice. To give some initial thoughts on each of these:

The model of the person: Mind

It could be suggested that the common core to most, if not all, disciplines in the holistic field relates to a healing of body, mind, spirit and feeling. Two of those are not too difficult to define: however, 'mind' and 'spirit' are much harder and far more controversial in their definition and effect on the person as a whole. *In terms of mind:* psychology has much to teach us about the way in which symptoms form which can in themselves affect the body. In the holistic approach, psyche and soma are not seen as separate entities but mirror one another. We learn from Freud – as far back as the late 19th century – that repressed energy within the psyche can cause physical symptoms, and that this repressed energy is then not sufficiently available within the system as a whole either for processes of homoeostatic repair, or personal development. A practitioner trained to understand this process, in a way which is compatible with their core training, will potentially work at deeper and more effective levels with their patients. We would include the value of creative dreamwork within this element together with self-help and educational approaches for patients where indicated.

The spiritual dimension

It is much harder to define what we mean by 'spiritual dimension' as this inevitably involves reference to aspects of our being which are not currently perceptible to empirical science. It is fair to say, however, that there is a general agreement within the holistic field that, by 'spirit', we do not mean necessarily a religious approach. Spirit is probably more genuinely defined in our movement as recognition of the subtle energy fields in and around the person, especially the etheric body where, arguably, symptoms may be discernible before manifesting in the physical. Many practitioners also include the chakra system, based on yoga philosophy, within this model. Spiritual healers will at times work to re-balance the chakras, or may work intuitively from the crown/heart/third eye centres, or may include non-verbal work on the inner level with images that come in a session. Some practitioners, especially naturopaths, may include adjustment to diet, vitamin and mineral therapy. More rarely, a practitioner may include all of these elements together with some form of radionics or kirlian photography as well.

Coming back to Freud, the central question in whole-person medicine may relate to the conundrum: "Where has the energy gone?" Freud's answer – and a century or more later, it may be ours too – was "the energy is attached to symptoms". If this is true, we can see how answering Freud's fundamental question may be limited today only by the practitioner's partial view of

the patient. If we are to take a genuinely holistic view, then our training in terms of the subtle energy fields needs serious thought and definition, informed by more than one tradition or element of training.

At present, much of the above is waiting in the wings for discussion, argument, definition and a national standard. It is also waiting most specifically for academic Research in the field. ICM and BRCP are fully committed to this process, and look forward to initiating them in consultation with our Membership. If we can achieve this, we will together be able to establish a new national standard for best practice which honours our individual areas of specialism in the context of a holistic model which has mutual recognition. We could suggest that, not only is this an essential step if we are to influence, and potentially change, some of the allopathic approaches to healthcare provision, but that it could also provide an invaluable opportunity for the spiritual dimension of the person, in terms of integral medicine and its wider implications, to be fully recognised.

Further Reading:

For a current exploration of the spiritual dimension from both the empirical and interpretative sciences see:

Ken Wilber, *Integral Spirituality: A Startling New Role for Religion in the Modern and Postmodern World*, Shambhala 2006

Marilyn Schlitz, Tina Amorok, IONS, and Marc S. Micozzi *Consciousness and Healing: Integral Approaches to Mind-body Medicine* Churchill Livingstone, 2005

Integral Medicine: A Noetic Reader, Editors: Marilyn Schlitz & Tina Hyman

Forward by Ken Wilber at http://wilber.shambhala.com/html/misc/integral-med-1.cfm

More information on the MA in Psychotherapy & Healing, of which Beverly Martin is Course Director, can be found at: www.marian2000.org.uk.

Is Reflexology of help in the care of Cancer Patients?

By Carol Ellis Bsc(Hons) and Frances Fewell Bsc (Hons), PG Cert

Carol Ellis is Pathway Leader and Lecturer in Complementary Medicine and Frances Fewell is Programme Leader, Allied Health and Counselling and Academic Lead, Complementary Medicine, both at Anglia Ruskin University.

An exploratory study into the effectiveness of reflexology treatments in the care of cancer patients was undertaken between April and August 2004 in a cancer treatment centre by BRCP-trained reflexologist Carol Ellis. The results are difficult to quantify, but revealed some interesting information about the appropriateness and benefits of reflexology in the context of serious illness. In particular, the research – limited and anecdotal though its findings are - suggested that, though usually contra-indicated with oncology patients, reflexology helped to relax the people in the survey and to relieve their anxiety before chemotherapy treatment.

Reflexology is the systematic application of special touch, or pressure to specific areas on the feet, known as reflex areas (Ingham, 1951, Hall, 1997, Dougans, 1996, Pitman, 1997). The consensus of opinion is that these reflex areas are found on the soles, top and sides of the feet and that they represent a microcosm of the body which, corresponds somatopically to specific organs, muscles, glands or structures in the body (Hall, 1997, Dougans, 1996, Pitman, 1997).

This view is based on the premise that the reflex areas are linked to their corresponding organs, via longitudinal energy zones (Norman, 1988, Lynn 1996, Soutar, 1998); and the application of pressure to reflex areas is supposed to stimulate the corresponding organs, muscles, glands or structures in the body, with the intention of clearing congestion and promoting homeostasis. (Dougans, 1996, Lynn, 1996, Hall, 1997, Pitman, 1997).

"Responses included feeling energised, a sense of calmness, feeling brighter and more positive, and a reduced perception of pain."

The concept of energy zones is not unique to reflexology. Acupuncture, shiatsu, acupressure, Tui Na, polarity therapy, therapeutic touch and energetic bodyworks are based on similar theories of innate energy that can be stimulated on the surface of the body to treat internal organs (Griffiths, 1996).

There are two standard reflexology treatments commonly used in the UK. (see box) For the purposes of the research study, both the Ingram and Morrell methods were used, alternately, with each patient.

But isn't reflexology contraindicated with cancer patients?

Some authors and practitioners consider reflexology so inherently safe there are virtually no contraindications. However, most training schools provide a list of situations in which reflexology is contraindicated. Cancer is normally on the list. However, our research suggests that oncology patients benefit from reflexology, provided that the kind of cancer, the date of diagnosis, treatment regime, client choice of care and also and most importantly the treatment rationale and application are all taken into account.

Research summary

In our clinical audit of reflexology, participants reported that after sessions they were able to manage their chemotherapy reactions more easily, with a reduction in anxiety and symptoms such as nausea and general tiredness. Many chose to book a reflexology session 24-48 hours before the next chemo session.

Research methods

The effectiveness of the reflexology was investigated using qualitative research. An open-ended questionnaire design was favoured over the interview technique to avoid interviewer bias/influence, to view treatments through clients' eyes by encouraging their subjective responses, and due to time-constraints

Research questions aimed at eliciting subjective responses from clients to questions such as: 'How they felt when they arrived', 'How they felt following the treatment', 'Which aspect of the treatment did they like/dislike', 'Which type of reflexology they preferred', and 'Why they preferred that type'.

The questions covered aspects of the reflexology likely to impact on participants' satisfaction with the treatment, their feelings and emotions before the treatment, any benefits experienced following the treatment, which aspect of treatment they liked/disliked, preference to treatment type, and the reason for their preference.

Allocation of clients to the study was administered by the centre manager Appointments were booked so that clients came clients came for six treatments on average one week apart. Questionnaires were kept anonymous to encourage client confidence in the privacy of the information.

Participants

Originally 24 participants (23 female, 1 male) were recruited . Fifteen of these had received reflexology before. Clients with all types and stages of cancer were eligible for the study, though those with a break, strain, cuts or recent surgery to the limb, or inability to read and write, were excluded. Two participants died during the study, and five did not return any questionnaires. This reduced the study size to seventeen participants (16 female, 1 male).

The clients were from a heterogeneous group with mixed age, gender, social, cultural, and ethnic backgrounds.

The length of time from diagnosis with cancer ranged from 3 weeks to 4 years, with a mean of 10.6 months. The primary cancer sites were varied. Fourteen clients had breast cancer and one each cancer of the vulva, ovary and colon respectively. Of those four had been diagnosed with secondary metastases: two in the liver, and one each in the brain and skin.

Research results

The most notable response was a sense of relaxation, experienced by both groups, regardless of which reflexology method was used. Other responses included feeling energised, a sense of calmness, feeling brighter and more positive, and a reduced perception of pain.

It is obviously difficult to be certain whether clients found their treatments relaxing and helpful because of the reflexology itself or because of the personal interaction between client and therapist.

However, when taken with the results of other studies (Hodgeson (2000) and Stephenson et al (2000)), it is clear that cancer patients do experience a sense of relaxation following reflexology, that feelings of stress and tension may be reduced, and outlook improved with participants reporting feeling brighter, more carefree and less anxious.

This study found that preference to treatment type was not conclusive, 10 (34%) preferred the Ingham (1951) method while 12 (41%) preferred Morrell (2002) reflex touch. There did not appear to be any correlation between the stages of illness or treatment schedule and preference for either modality. Some preferred the gentle, soothing, relaxing effect of Morrell (2002) reflex touch, while others preferred the firmer pressure of the Ingham (1951) method, which they reported 'feels its doing more', 'is more therapeutic', and 'more effective'.

Future moves

As a result of the study, we are looking into further research into the effectiveness of reflexology in relieving nausea among chemotherapy patients. We are also developing a new reflexology chart which will hopefully offer a new way of matching pressure points to organs that will serve the needs of oncology patients and other client groups.

To help establish reflexology as a therapy more research evidence is required into its clinical effectiveness, safety, mechanism and mode of action, cost effectiveness and contraindications. The evidence generated will not only inform conventional health care professionals, the NHS, and the general public, it will also provide the evidence on which to base practice (Mackereth and Tiran, 2002:62).

The Ingham (1951) method of reflexology uses corn starch/talc as a medium to smooth the surface and prevent friction. It incorporates a thumb technique, which resembles a caterpillar-like crawl movement, and deep, firm finger pressure applied directly to reflex points.

In contrast to Ingham, the Morrell (2002) reflex touch uses oil as a medium. The pressure is significantly lighter than the Ingham method. The pad of the thumb is gently pressed against the reflex areas, with the aim of energising the body into generating a bodily response rather than treating specific areas intensely.

Eating Greens can be Seriously Deadly

By Anthony R Teal (BSc MSc CSci CChem MRSC)

Anthony Teal recently retired as Deputy Director for Higher Education at a London College. He was previously Head of School and Principal Lecturer in Clinical Biochemistry.

"Greens" have never featured highly in most folks' ratings of culinary delights. Yet there is now convincing epidemiological evidence to show that *Cruciferous* vegetables (cabbages, kale, cauliflowers, broccoli, watercress, radishes, turnips, swedes and Brussels sprouts) are associated with a decreased risk of cancer. This association is particularly true for cancers that develop in the gut and respiratory tract, such as those occurring in the mouth, pharynx, lung, stomach, colon and rectum.

BioPathica Ltd

Homoeopathy
for All the Family

BioPathica Ltd
Sole UK Distributors for Heel Products
P.O.Box 217, ASHFORD, KENT TN23 6LZ
Phone: 01233 636678 | Fax: 01233 638380
Email: products@biopathica.co.uk
www.biopathica.com

These vegetables have been known to be a source of vitamins and minerals for some while. The traditional Dutch diet included a considerable amount of *sauerkraut* or fermented cabbage. As a consequence in the seventeenth century, their sailors rarely suffered with scurvy during long voyages of exploration as did those from other nations. In addition to vitamin C, broccoli, for example, provides an excellent supply of beta-carotene (thought to be protective against a variety of cancers)[1] together with significant amounts of niacin, calcium, thiamine, phosphorus and dietary fibre. Yet current interest in these brassicas centres on a self-defence mechanism that these plants have developed. They produce compounds called ***glucosinolates***, two of the most prevalent being ***sinigrin*** and ***gluconasturtin***. These lay dormant in the plant tissues until attacked by natural predators. Then an enzyme called myrosinase in the damaged cells catalyses the hydrolysis of the glucosinolates into chemicals called ***isothiocyanates*** and a variety of other products. These function to ward off insect attack.

Isothiocyanates and conjugates

When *Cruciferous* vegetables are used as a food source a similar chain of event occurs. During preparation such as chopping, cooking and chewing, cabbages and Brussels sprouts release these isothiocyanates. Intestinal bacteria also possess similar enzymes to myrosinase and so glucosinolates from cooked vegetables can yield the same products. They give the plants their slightly bitter taste and this is probably what motivated George Bush Senior to declare, "I'm President of the United States and I'm not going to eat any more broccoli". These isothiocyanates however have both anti-carcinogenic and anti-cancer activity. The anti-carcinogenic activity arises because the isothiocyanates are not inert but can diffuse into our cells and be further processed physiologically. This metabolism yields modified versions of the original molecules called conjugates. The conjugates and the parent isothiocyanates are the subject of intense scrutiny as they have the potential to be used in the chemical prevention of cancer.

In our liver and other tissues is a complex enzyme system called cytochrome P-450. This system is primarily responsible for converting many of the foreign chemicals that we are exposed to in our environment into reactive, and often toxic, substances. Isothiocyanates and their conjugates can inhibit and suppress various forms of cytochrome P-450 responsible for activating potential carcinogens.[2] They also directly increase the detoxification and clearance processes for these substances so the body can eliminate them more effectively.

Attacking tumour cells

However more recent studies[2] have shown that dietary isothiocyanates and their conjugates can also attack tumour cells directly, stopping them proliferating indefinitely and making them mortal (ie capable of dying, which some tumour cells are not). This involves the process of *apoptosis*, a major mechanism of cell demise. It is often referred to as programmed cell death as it represents a form of cellular suicide with affected cells fragmenting into particles that can be removed in a regulated way by phagocytosis. This is distinct from another uncontrollable form of cell death called *necrosis*, which is considered accidental and does not represent an active choice that the cell can make. If apoptosis becomes impaired and insufficient, unrestrained cell proliferation can result leading to tumour formation. In the case of cancer, defects in apoptosis not only contribute to the disease but thwart attempts to treat it by radiation or chemotherapy as resistant tumours can have a higher threshold for cell death.

Isothiocyanates and their conjugates can induce apoptosis in tumour cells. While the precise mechanism by which they bring this about is still being investigated, it appears that they may stimulate an unusual set of enzymes that exist within the cell. These are called *caspases* and once activated they are responsible for executing a death programme in a cascading sequence of stages that result in cell fragmentation and ultimate degradation. This is the way it is now believed that a consumption of cruciferous vegetables can contribute to a significant decrease in cancer incidence.

A recent study published in *Carcinogenesis*[3] by a group at the Institute for Food Research has shown that isothiocyanates from sinigrin in brassicas interrupts the division of colon cancer cells and induces apoptosis. Professor I Johnson, the team leader emphasised that while not being a miracle cancer cure, it does show that careful attention to diet is an important aspect in the anti-cancer armoury. He recommended that two to three helpings of brassicas a week are needed to achieve a benefit. The problem in realising this effect however is that different practices and varying conditions of food preparation and cooking can give a variable yield of isothiocyanates formation. Prof. Johnson suggested that the shorter the cooking time and the less water used to prepare the vegetables, the greater the preventive effect. However an alternative approach might be by prophylactic therapy with the isothiocyanates or their conjugates and certainly clinical trials of chemoprevention agents are reported to be in progress. Thus as it appears to be the bitter taste in broccoli that does you good, perhaps the former President might consider that the time has come to eat his words and re-instate purple-sprouting on the White House menu.

References

1 "Anti-oxidants and cancer", Borek, Carmia (1997) Science and Medicine (Nov/Dec) pp 52 - 61
2 Thomalley, P J (1997) The Biochemist (June) pp 19-23
3 Johnson, I T et al (2004) Carcinogenesis, 25 (8) pp 1409-1415

Sizzling Stir Fry (vegan)

Serves 4
Preparation time – 10 minutes
Cooking time – 8 minutes

Ingredients

15ml/1tbsp groundnut oil
1 red pepper (de-seeded & sliced)
2 garlic cloves crushed
3cm/1.5" root ginger (chopped)
1.5kg sliced vegetables
E.g. Peppers, spring onions, broccoli, carrots, baby corn
60ml/4tbsp soy sauce
Salt and pepper to taste

Method

1. **Heat oil in pan on medium heat, fry pepper, garlic, and ginger for 2 minutes.**
2. **Add sliced vegetables, soy sauce and seasoning and stir fry for approx. 6 minutes until vegetables are cooked but still firm and crunchy.**

Serve with rice.

Variations

1. Satay in a second – add chilli powder, a squeeze of lime and a large dollop of peanut butter.
2. Thai in no time - stir in some coconut milk, and a spoonful of your favourite Thai curry paste.
3. Add a spoonful of sugar, vinegar, orange juice and cornflour, if you like all things sweet and sour.
4. A splash of sesame oil and some cashew nuts will change this dish in an instant.
5. Use your noodles - add some straight to the wok!

Vegetarian Society

Copyright The Vegetarian Society

ISSN 1751-4711 (print)
ISSN 1751-472X (online)

Acupuncture is no pain in the neck

Acupuncture can relieve chronic neck pain, according to a recent review of the research literature of the subject.

Neck pain is common – one of the three most commonly reported complaints of the musculoskeletal system. A review, published earlier this year in *The Cochrane Database of Systematic Reviews*, examined ten trials (including 661 participants). Nine of the trials examined the effects of acupuncture for neck pain on individuals experiencing chronic pain that had lasted at least three months. The tenth trial included people who had pain for at least six weeks.

The review panel found that individuals with chronic neck pain who received acupuncture reported, on average, better pain relief immediately after treatment and in the short-term than those who received sham treatments. Individuals with chronic neck pain with symptoms radiating to the arms who received acupuncture reported, on average, better pain relief in the short-term than those who were on a waiting list.

However, the reviewers also stressed that the number of participants in each trial was relatively low and that more research involving greater numbers and looking at long-term effects are needed.

Diary of Events

Holistic Health 2006
When: 1st & 2nd October 2006
Where: Donington Park, East Midlands
What: Trade only. Holistic Health 2006 features the latest associated products and services on offer to therapists, practitioners and salon/treatment centre owners.
For more information: 01332 227698 for free tickets

Mind, Body and Soul Exhibition
When/where: 7th & 8th October 2006 in Brighton, 21st & 22nd October 2006 in Cambridge, 11th & 12th November 2006 in Olympia, London
What: The Mind Body Soul Exhibitions offer a vast array of therapies and products, from Aromatherapy to Yoga, with lectures, workshops and stage demonstrations.
For more information: 01787 224040

Yoga to Beat Fatigue
When: 9th - 13th October 2006
Where: Claridge House, Surrey
What: Four-day programme to beat fatigue using Yoga techniques taught by Fiona Agombar.
For more information: 01787 277326

Natural Living Show
When: 14th & 15th October 2006
Where: Cheltenham Pittville Pump
What: Therapists and treatments from around the world.
For more information: 01933 652445

CAMexpo – The Complementary & Natural Health Show
When: 15-16th October 2006
Where: ExCel, London
What: A premier event for the CAM community where around 4500 professional therapists and practitioners exhibit a wide range of therapies through demonstrations and seminars.
For more information: www.chexpo.com

Mind Body Spirit Northern Festival
When: 20-22nd October 2006
Where: G-mex, Manchester, M2
What: A wide range of products, therapies and treatments.
For more information: 020 7371 9191, www.mindbodyspirit.co.uk

Ilkley Complementary Medicine Festival
When: 28th & 29th October 2006
Where: Kings Hall, Winter Gardens, Ilkley
What: A wide range of remedies and therapies
For more information: 01943 872387, e-mail: michael@icmf.co.uk, www.ilkleyfestival.co.uk

Australasian College of Natural Therapies Seminar
When: 9 November 2006
Where: Australia House, The Strand, London
What: A free information seminar on courses available, including naturopathy, herbal medicine and aromatherapy.
For more information: 0207 632 0003, email: Kathleen.devereax@austrade.gov.au

Festival of Wellbeing
When: 4th & 5th November 2006
Where: Aylesbury Civic Centre
What: Information on complementary therapies, beauty treatments, stress management techniques and ways of improving your health.
For more information: 01844 353154

7th National Nutrition and Health Conference
When: 24-25 November 2006
Where: Olympia, London
What: Reviews and debates on topics such as pre- and pro-biotics, food labelling and a range of health issues
For more information: 0870 7663216, admin@nutritionandhealth.co.uk

Disclaimer:
Statements and opinions expressed in articles and communications herein are those of the author(s) and not necessarily those of the editor or publisher. The editor and publisher disclaim any responsibility or liability for such material and do not guarantee, warrant or endorse any product or service advertised in this website/publication, nor do they guarantee any claim made by the manufacturer of such product or service. Advice and information provided are for educational purposes only. Readers are advised to consult a qualified medical practitioner before following any treatment described.

Sophie McKenzie, Editor: s.mckenzie@i-c-m.org.uk
Ruth Soroko, Graphic Design: rutha@imap.cc
Editorial Assistant, Lena Gobine: admin@i-c-m.org.uk
Printed by: Matrix Print Consultants Ltd.
Autumn, tea cup, sea, pomegranate and acupuncture needles images courtesy of iStockphoto: www.istockphoto.com