

Allergy Papers: Study of Initial Response and Reversion Rates of Subjects Treated with the Allergy Technique by Judith Swack, Ph.D.

Introduction

In October, 1987, Tim Halbom and Suzi Smith published an article in Anchor Point entitled “The Allergy Technique”.¹ It described in detail a neurolinguistic programming (NLP) technique derived from a procedure developed by Robert Dilts which was designed to eliminate allergic symptoms. (The technique is also described in two later books^{2,3}). The article described some case histories and claimed that most allergy reversals are immediate with 29 successes in 32 cases. As a research biochemist with extensive training in the field of human immunology⁴⁻⁹, I was intrigued with their results.

As a Master Practitioner of NLP I had acquired the skills necessary to reproduce the technique as described. Thus I performed a two year prospective study of allergy subjects designed to answer the following questions:

1. How many clients initially respond to the allergy technique by becoming asymptomatic, and
2. How long does the subject maintain this now normal immune response?

Section 2 – Methods

All test subjects, 8 women and 2 men, were unpaid volunteers who had at least one specific, testable allergy and who had not been trained in NLP. Allergies are defined as immune reactions characteristic of mast cell-mediated responses. These included upper respiratory symptoms such as sneezing, runny nose, wheezing, itchy mouth, lips, and eyes, and itchy or red skin rash. Some of the volunteers had experienced symptoms from childhood while others had developed allergies as adults.

All clients had been consistently symptomatic for a minimum of 5 years prior to treatment. Volunteers were treated with the Allergy Technique essentially as described¹ (and as detailed below in steps 1, 5-9) between May and June, 1989. They were asked to test their response immediately after treatment, periodically for two years, and then to report their subjective evaluation. Complete absence of symptoms was counted as a positive response to the treatment. Any remaining allergic symptoms were counted as a non-response to the treatment even if the client reported experiencing milder symptoms.

I later retreated some of the non-responders and those who had reverted with the following modified method:

1. Explain the function of the immune system.

The function of the immune system is to fight pathogens (disease-causing organisms) and cancer. It can distinguish harmful from non-harmful microbes and cells. The “allergic arm” of the immune system is actually designed to fight parasites. Thus, an allergic reaction is like a phobic response of the immune system because it mistakenly overreacts to something that is not a pathogen.

2. Explain that the immune system can be trained to make a mistake.

When a person experiences a traumatic or otherwise significant emotional event the biochemical stress can adversely affect the immune system by triggering or suppressing an immune response.

3. Ask the client “What is objectionable about the allergen?”

4. Clear the negative emotional charge from the allergy-associated reference experience.

People associate a specific allergy with a reference experience that is emotionally charged. The memory of the experience is stored as a trauma imprint, a compulsion structure, or a learned family pattern that with sufficient repetition creates a significant emotional response.

Responses to the question in step #3 such as “dogs die” and “cats jump on you” are indicative of a trauma imprint. The negative emotional charge and associated limiting beliefs can be cleared with a phobia cure, change personal history, or re-imprint.

Responses such as “dogs are dirty and have germs” and “dust is dirty and I hate dirt” are indicative of a compulsion structure which can be cleared with a compulsion blow-out.

“I have to be polite, follow the rules, behave in a certain way, etc. even though I’m suffering” are examples of learned family patterns that have associated negative emotional charge. Phobia cure, re-imprinting, and re-framing are appropriate interventions here.

Occasionally, the client will assert that there is nothing objectionable about the allergen. In this case it is important to find the root cause (original event) and clear the negative emotional charge by performing Time Line Therapy¹⁰. (Ask “when did you decide to become allergic to X?”)

During any intervention, assist the client to substitute other physical and mental resources to deal with life situations not requiring immune intervention. Then continue with The Allergy Technique as described below.

5. Calibrate the client.

Ask the client to imagine that the allergen is present and ask him/her to tell you where in the body he/she begins to experience the first symptoms. Then tell the client that the allergen is gone, so that he/she can return to a non-allergic state.

6. Anchor an appropriate immune response to a similar substance.

Remind the client that his/her immune system is mistakenly overreacting, but is really capable of responding in an appropriate manner to many similar substances. Ask the client to pick something to

which he/she knows he/she responds to normally that is just like the allergen. While holding the anchor have the client associate into the experience of the appropriate immune response.

7. While holding the anchor firmly, dissociate the client so that he/she sees himself/herself responding in an immunologically normal way to the resource substance.

Introduce the allergic substance and use hypnotic language to direct the client to have an appropriate immune response to this substance as well. Hold the resource anchor firmly during the entire intervention and instruct the client to see himself/herself at a distance (dissociated state) beyond a plexi-glass wall which would prevent any allergens from entering the room.

Have him/her interact with the substance to which he/she responds appropriately and notice that his/her immune system is functioning properly.

Introduce the allergen and use hypnotic language to suggest that his/her immune system can respond appropriately to the allergen in the same way that it responds to the similar substance. Ask “how are you doing over there with substance X?” If he/she still imagines an allergic response, ask the client “what else do you need over there in order to respond appropriately?” Anchor in those resources and check the response again.

8. When the client indicates that he/she now has a normal response to the allergen, have them re-associate while you hold the resource anchor the whole time.

“Bring the you over there with the appropriate response back through the plexi-glass and into your body here bringing with it its knowledge of an appropriate immune response”.

9. Test the results.

Ask the client to imagine that the former allergen is present in the room and to describe their response, now. If the imagined response is appropriate, instruct the client to test the substance appropriately in reality with curiosity and caution until they can fully gauge their new response.

Section 3 – Results

As shown in Table 1, 7 of 10 subjects initially responded to the Allergy Technique by becoming asymptomatic. Within 6-12 months 3 of 7 had reacquired symptoms. Thus, the overall success rate of this technique to induce change over time is 30%.

In my on-going work with clients, I discovered that an allergic response is linked to a compulsion or trauma structure, or a memory of an emotionally charged event arising from a learned family pattern. As in a phobic response, environmental cues that triggered the memory imprint caused a return of the allergic symptoms. I was able to re-treat several of the test subjects with the Modified Allergy Technique as described under Methods.

Of the retreated subjects, one who had initially responded and reverted in 5-6 months, has remained asymptomatic for 22 months (Table 2). Of two who did not respond initially, one became

asymptomatic after re-treatment with the modified technique. Another client with an allergy to dogs was initially treated with the Allergy Technique in December 1989 and did not respond. After re-treatment with the Modified Allergy technique, she has remained asymptomatic for 20 months.

Table 2
Responses of Subjects Treated with MidofiedAllergy Technique

Subject	Allergy Treated	Normal Immune Response (no allergi reaction)
7 S.O.1	latex glove powder inexpensive gold rings	yes yes
8 C.S..2	lilacs	yes
9 J.A.2	dogs	no

1This subject reverted after an initial positive response. After retreatment, this subject has maintained an appropriate immune response for 22 months.

2These subjects were initial non-responders

These data suggest that use of the Modified Allergy Technique as described here will allow for a better initial success rate, and will enhance the likelihood that the change will be maintained over time.

Section 4 – Discussion

In this two year prospective study of The Allergy Technique¹⁻³ I achieved an initial response rate of 70%. This rate is comparable to the “approximately 80%” rate described by Andreas and Andreas² and the 90% rate described by Hallbom and Smith¹ for cases in which the specific allergen has been identified. This study is the first two year follow-up study published to date, and of the 7 of 10 initial responders, only 4 of 10 maintained the asymptomatic state for over two years suggesting an overall response rate of 40%. Retreatment of non-responders and revertants with the modified technique has increased the initial success rate and the length of time that the change has been maintained. The belief system of anyone who works with people may affect their results. It is unlikely that practitioner bias has affected the initial response or reversion rate in this study because other practitioners have experienced similar initial response rates^{1,2}. Two other highly skilled NLP

practitioners using the published Allergy Technique reported revertants (Martin Lowenthal and Richard Clarke, personal communication).

In addition to the experimental subjects in this study, I have treated 25 other people. Clients with a single or a few (less than 4) specific allergies respond well to the Modified Allergy technique. Most of my paying clients, however, have multiple allergies (12-20 known triggers are not uncommon), and some are multi-allergic with asthma. These clients require several sessions and periodic follow-up to make sure that all the memory imprints, associated negative emotional charge, and limiting beliefs associated with the allergic trigger were cleared. Some of the common patterns that I have observed include:

1. A response to “what is objectionable about X” or “X gives me allergic symptoms” is usually not the root cause of the experience. The person did not already have the symptoms at the time when they decided to become allergic. In cases like this I use Time Line Therapy. I have seen two exceptions:

A. A client, who had symptomatically reverted after having been treated with the Allergy Technique, elaborated on what he objected to about the allergic reaction to cats. He described it as an illness that “snuck up on him”. Using the Modified Allergy Technique, we found that the associated memory involved an illness that “snuck up on him” when he ignored symptoms in the belief that he had to follow school rules. Re-framing and re-imprinting the knowledge that rules are often superseded in matters of health, and that each individual is responsible for decisions about his own health and well being. This allowed clearing of the cat allergy.

B. Another client, allergic to cigarette smoke, said that in the presence of people who smoked, she objected to not being able to breath or see while she sat there trying to be polite. After clearing the negative emotional charge on the symptoms and on belief #2B below, we cleared the cigarette smoke allergy.

2. Multi-allergic clients often have a limiting belief underlying their ability to generate allergies. Some common beliefs are:

A. The world is a dangerous or irritating or frightening or unfriendly place.

B. I can't escape because I have to be polite (no matter how much it hurts me). Other people or their feelings are more important than I am. This belief is particularly common in women and in more restrained cultures such as British.

C. It is not OK to say I do not like something or I do not want to do something (i.e. my feelings are not important, my opinion does not count).

I clear the overall limiting belief using Time Line Therapy and then track down individual episodes linked to specific allergies.

3. Sometimes clients use their immune systems to deal with life situations that do not require immune intervention.

A client who was allergic to the smells in a garden center told me that many of the items (such as insecticides) were dangerous. I suggested that her nose could tell her when there was something dangerous in the air, and that she could hold her breath and walk away. She did not need an asthma attack for protection.

I informed another client who had been extensively trimming his nose hairs and was allergic to dust that he had biochemical and physical means of disposing of dust. The hairs in his nose, the ciliated cells lining his lungs, and a reflex ability to sneeze out irritating particulate matter were sufficient to deal with dust. As part of the allergy intervention, he decided to stop trimming his nose hairs.

4. A client can invalidate and reverse a change if it violates his/her convincer strategy or if it triggers his/her unconvincer strategy.

I treated a severely asthmatic client by clearing the anger and fear associated with an early event after which his normal wheezing disappeared and he was able to breath easily. With 15 minutes left in the session he told me that nothing ever comes easily for him and regaled me with hard luck stories. Within a week, he had reacquired symptoms and refused to return for further treatment. (Jim Pike, in a personal communication, recommends saying to the client “So, I wonder if it would be OK with your unconscious mind to just allow this process to continue and progress uninterrupted or you could just choose to notice the ease and comfort with which you can breath in a way that would be totally ecological for you, now.”)

Another client who cleared an allergy to dust wondered if he was reverting after he sneezed a couple of times when he went into a dusty storage room. I explained to him that it is the body’s normal reflexive first line of defense to sneeze out irritating particulate matter, and this response does not require immune system participation. He realized that he was asymptomatic after leaving the storage room, and has been free of a dust allergy ever since.

5. Two multi-allergic clients with asthma who did not respond to the Modified Allergy Technique had an immune system part that did not know how to discriminate non-dangerous from dangerous. The ability to discriminate safe from dangerous existed in another part. We integrated the necessary skills for appropriate immune function by doing a visual squash of 2-3 parts. The clients subsequently responded to re-treatment with the Modified Allergy Technique. The inability of the immune system to distinguish dangerous from non-dangerous may be related to issues of incomplete sense of identity and boundaries.

6. Asthmatic clients are more complicated to treat because they have internal emotional triggers, external allergic substance triggers, and activity triggers (such as exercise). For example, four of four asthma clients whom I have treated since May, 1991, have been triggered by anger toward their mothers who they felt were not giving them enough or the right kind of

attention. Some of the emotional triggers are not associated with a specific event. Thus, I have used both Time Line Therapy and Applied Kinesiology to track down and clear specific emotions which trigger asthma attacks. Jim Pike reports similar experiences with asthmatic clients and recommends clearing all negative emotional charge and limiting decisions using Time Line Therapy (personal communication). (Long term follow-up on the asthma clients is in progress and will be reported at a later date.)

Section 5 – The Allergic Response

What is an allergic response? An allergic response occurs when a person's immune system makes a type of antibody called IgE which recognizes a specific allergen. The tail (Fc portion) of the IgE antibody binds to IgE receptors on the surface of mast cells many of which coat the mucosal linings of the respiratory system, skin, and gut. The head of the IgE (Fab portion) recognizes specific allergens. Allergens bind to several adjacent IgE molecules causing cross-linking of the IgE receptors (Figure 1). This triggers the mast cell to degranulate releasing a number of mediators including histamine, proteases, prostaglandins, and chemotactic factors which cause allergic symptoms¹¹⁻¹³. Several studies in humans suggest that allergic reactions can occur in the absence of allergen or physical irritant^{14,15}. These results suggest that neural stimuli such as sensory events (conditional stimuli) may become associated with allergens such that subsequent exposure to the conditional stimuli elicits an allergic response.

Animal studies support the idea that an allergy is a learned response. In a Pavlovian conditioning experiment, rats in the control group were exposed to an audiovisual cue (conditional stimulus) while rats in the experimental group were exposed to an audiovisual cue with an injection of an allergen (unconditional stimulus) which causes mast cell degranulation¹⁶. The control animals when re-exposed to the cue did not experience mast cell degranulation. The experimental animals re-exposed to the audiovisual cue alone experienced the same level of mast cell degranulation (conditioned response) as animals re-exposed to the audiovisual cue plus allergen. Conditional secretion of histamine was also reported for guinea pigs exposed to a specific odor with simultaneous injection of allergen¹⁷.

How does the central nervous system regulate an allergic response? Nerve cells communicate chemically at specialized junctions (synapses) using chemicals known as neurotransmitters. The presynaptic cell releases neurotransmitters which migrate across a synaptic cleft to bind to specific receptors on the postsynaptic cell causing it to transmit an electrical impulse. A cytokine is a chemical which is released by an immune cell and which binds to specific receptors on other immune cells causing them to respond in some way. Recently, however, neurotransmitter receptors have been found on cells of the immune system, and cytokine receptors have been found on cells of the central nervous system indicating direct communication between the nervous system and the immune system¹⁸.

Other mast cell surface receptors in addition to IgE receptors trigger or inhibit mast cell degranulation. Interestingly, some of these mast cell receptors are neurotransmitter receptors (Figure 1). In vivo and in vitro studies indicate that allergic reactions can be triggered by neuropeptides such as substance P¹⁹⁻²², adrenocorticotrophic hormone (ACTH)²³, and opiate peptides such as dynorphin and beta-endorphin²⁴⁻²⁶. Stress activates the release of ACTH and endogenous opioid systems²⁷ (of which beta endorphin and dynorphin are members), neuropeptides known to stimulate mast cell degranulation. As in the case of Pavlovian conditioning, it is possible that a significant emotional reaction acting as a conditional stimulus causes the release of stress neuropeptides which act as the unconditional stimulus resulting in a learned allergic (conditioned) response.

In contrast, other neuropeptides can inhibit mast cell degranulation even in the presence of IgE and allergen. In a study by Jankovic and Maric, rats were sensitized with an allergen²⁸. Some of the rats were concomitantly treated with 10 injections of the opioid peptides, met-enkephalin or leu-enkephalin. The rats were then given a sufficiently large dose of allergen to induce anaphylactic shock. The mortality rate of untreated rats was 70%, rats treated with 10 doses of leu-enkephalin for 5 consecutive days or 1 dose of met-enkephalin just 1/2 hour prior to challenge was 50%. Rats treated with 10 doses of met-enkephalin was 0%. Other neuropeptides can down regulate mast cell degranulation independently of IgE mediated pathways. For example, neurotensin inhibits mast cell degranulation triggered by substance P but not by IgE receptors, probably by interacting with the same receptor as substance P²⁰.

Consistent with the finding of neurotransmitter receptors on mast cells is the finding that mast cells are directly innervated by sensory and sympathetic peripheral nerves in virtually all tissues of the body^{29,30}. Not surprisingly, sensory neurons contain many neuropeptides including opioid peptides, substance P, and calcitonin gene related peptide (which inhibits mast cell degranulation)³⁰. The idea that allergic reactions can be directly mediated by the central nervous system is further supported by the work of Amir and van Ree who demonstrated that intracerebroventricular (i.c.v.) injection of gamma-endorphin significantly improved survival in anaphylactic shock in mice³¹. Furthermore, i.c.v. injection of beta-endorphin exacerbated anaphylactic shock, an effect which could be reversed by DT gamma-endorphin.

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