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DIAGNOSIS SHOCK: THE UNRECOGNIZED BURDEN OF ILLNESS

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Abstract

Diagnosis shock is the phobic reaction people experience the moment they first suspect or are told that they have a serious physical or emotional illness. Researchers have found that patients diagnosed with serious illness experience shock and trauma which can result in irrational reactions and behaviors and in some cases lead to serious psychological illness. This retrospective study of more than 100 patients was designed to help psychological and physical healthcare practitioners recognize, prevent, and treat diagnosis shock. This paper is the first report of diagnosis shock in patients with no clinical illness and the first report of the use of Energy Psychology techniques to successfully prevent or clear diagnosis shock from the unconscious mind and body.

This study summarizes findings from patients who came to the author's private practice for mind-body therapy using Healing from the Body Level Up™ (HBLU™) methodology. Patients came for help for a variety of life issues in the areas of relationship, career, performance, psychological problems such as depression, phobias, trauma, and anxiety as well as physical health problems. Regardless of the presenting issues, all patients were tested for diagnosis shock. All patients who were discovered to have diagnosis shock were asked to describe the emotions, beliefs, and reactions they consciously remembered at the moment of initial shock. They were then questioned using muscle testing to determine reactions at the unconscious and body levels. Treatment was given using Energy Psychology techniques for the negative emotions and limiting beliefs found in traumatic reactions associated with diagnosis shock. Each patient was followed for one month to one year after treatment.

This study found that, untreated, patient's phobic reactions to diagnosis shock could cause compliance problems including failure to follow through on instructions or participate in prescribed treatment plans for dealing with the disease that was diagnosed, behaviors possibly leading to adverse health outcomes. Diagnosis shock also adversely affected relationships of some patients with their healthcare providers, caregivers, and family members and diminished overall quality of life. This study also describes how diagnosis shock may interfere with doctor-patient relationships and cooperation, and can contribute to caregiver burnout. Based on these findings, healthcare practitioners are given treatment suggestions for preventing and, if necessary clearing, diagnosis shock from patients and their families.

Key words

Diagnosis shock, psychological shock of diagnosis, medical phobias and trauma, cancer fear, prevention, Healing from the Body Level Up™, HBLU™

Introduction

Diagnosis shock is the phobic reaction people experience the moment they first suspect or are told that they have a serious physical or emotional illness. Others have called it “psychological shock of diagnosis” which the author found clumsy and so renamed it diagnosis shock. More importantly, the term diagnosis shock was effective on muscle testing to reproducibly identify the pattern.

Researchers have found that patients diagnosed with serious illness experience shock and trauma, which can result in irrational reactions and behaviors and in some cases lead to psychological illness such as depression and anxiety (Chippindale and French, 2001; Connell, Boise, et al, 2004; Edwards and Clarke, 2003; Fukui and Ozawa, 2003; Gray, Fitch, et al, 1999; Greer, 2002; Harcourt, Rumsey, et al, 1999; Liefoghe, Michiels, et al, 1995; Maguire, 1994; McDaniel, Musselman, et al, 1995; Mekarski, 1999; Osowiecki and Compas, 1999; Rakovitch, Franssen, et al, 2003; Read, 2004; Rispolia, Pavonea, et al, 2005; Scuth, Karck, et al, 1994; Slijpera, Fretsb, et al, 2000; Slijper, van Teunenbroek, et al, 1998; White and Macleod, 2002; Williams, 2005).

Several of these researchers have also made excellent suggestions for minimizing the severity of diagnosis shock and for psychologically supporting patients and their families (Chippindale and French, 2001; Connell, Boise, et al, 2004; Fukui and Ozawa, 2003; Greer, 2002; Maguire, 1994; McDaniel, Musselman, et al, 1995; Rispolia and Pavonea, 2005; Schuth, Karck, et al, 1994; White and Macleod, 2002; Williams, 2005).

Traumatic reactions are conditioned responses of the fight/flight/freeze reflex that start when a person experiences a physical or emotional shock. At the time that the flight/fight/freeze reflex is activated, anything in the environment can get associated with that memory, which remains frozen in the body. Later on, these associations can trigger a ‘flashback’ to the memory of the original shock. Emotional trauma manifests as a phobic response, irrational and exaggerated. Physical trauma manifests as pain, stiffness, weakness, and restricted range of motion. Trauma of any kind can cause immune system reactions from immunosuppression to allergic reactions. Other diagnostic characteristics of trauma imprints include nightmares, and feelings of being ‘frozen’, stuck, blocked, unable to change, unable to breathe, and unable to access appropriate resources.

Once imprinted, traumatic reactions must be released from the body. This is why techniques that work only with the conscious or unconscious mind (such as talk therapy or hypnotherapy) are often ineffective or incomplete. Similarly, physical treatment modalities may be only partially successful in alleviating symptoms of physical injury trauma. Unless the shock imprint is also cleared from the body, the problem may last for years. A previous study (Swack, 1994) repeatedly demonstrated that clearing of trauma using HBLU™, an Energy Psychology methodology, often resulted in immediate and lasting elimination of both emotional and physical symptoms.

The purpose of this paper is to help healthcare practitioners recognize, prevent, and treat diagnosis shock. This paper is the first report of diagnosis shock in people with no clinical illness, and the first report of the use of Energy Psychology techniques to successfully prevent or clear diagnosis shock from the unconscious mind and body.

Methods

This study took place at the office of Healing from the Body Level Up, Inc. (formerly Judith A. Swack and Associates, Inc.) in Needham, MA. The people described in this study were all patients who came to the author’s private practice for mind-body therapy using Healing from the Body Level Up™ (HBLU™) methodology between 1993 and 2006 (over 400 patients). Patients sought help for a variety of life issues in the areas of relationship, career, athletic and artistic performance, and psychological problems such as depression, phobias, trauma, and anxiety. Patients also came for treatment for physical health problems such as cancer, heart disease, allergies, asthma, autoimmune diseases, Crohn’s disease, irritable bowel syndrome, interstitial cystitis, chronic fatigue

syndrome and fibromyalgia. Patients were male or female and ranged in age from less than 1 year of age to their late 70's. (Infants treated with HBLU typically suffered from birth, medical treatment, or adoption trauma.) Most patients were treated in the author's office or by phone. Most patients were citizens of the United States. A few patients were from Europe, Pakistan, South America, Thailand, and China.

All patients described in this study were tested, treated, and retested by the author. All data were collected in the form of case notes and muscle-tested answers to questions on a standardized intake form.

Each patient was taught to access information from the unconscious mind using the NLP technique of 'going inside and talking to the part that needs healing.' Patients were instructed to send questions down through their body or to direct their questions and attention to areas of the body where they were feeling discomfort and be receptive to unconscious mind responses which can take the following forms:

- Visual; a picture, a memory, a dream that you can see
- Auditory; a thought in words, a piece of music, a tone of voice
- Kinesthetic; a physical or emotional sensation felt in the body; a taste or smell

Patients often reported the answers as "what just popped up" in their mind.

Each patient was also taught to access information from the body level using the applied kinesiology technique of muscle testing in which the body answers 'true' or 'false' questions through differences in muscle strength. (For complete written muscle testing instructions go to www.HBLU.org/MuscleTesting.php. To see a live demonstration of muscle testing go to www.HBLU.org and click on "see the new video." For additional reading see Durlacher, 1994.)

All patients coming explicitly for help with medical problems were muscle tested for diagnosis shock in their first session and muscle tested to determine if that was the first pattern we needed to treat. All patients coming for help with non-medical issues were muscle tested in their first session for answers on the New Client Intake form which tests for many different patterns including diagnosis shock.

Patients found to have diagnosis shock were asked to describe the emotions, beliefs and reactions they consciously remembered at the moment of initial shock. They were then questioned using muscle testing to determine reactions at the unconscious and body levels. Treatment for the negative emotions and limiting beliefs found in traumatic reactions associated with diagnosis shock was done using Energy Psychology techniques including Natural Bio-Destressing, Tapas Acupressure Technique, and Unwinding Frontal Occipital Holding (Swack, 2001 www.HBLU.org; Fleming, 2001 www.TATlife.com; Eden, 1998 www.innersource.net) described below.

The author tracked treatment results for each patient in subsequent treatment sessions or by follow-up phone calls. Data was collected for one month to one year after treatment for diagnosis shock. Specific case examples are described as data to support the findings and as information to practitioners about what their patients experience but rarely share with them.

Results

Data from the clearing of the trauma of diagnosis shock was analyzed by muscle testing to confirm that all negative emotions, limiting beliefs and other emotional and physical symptoms of diagnosis shock had been cleared at the conscious, unconscious, body and soul levels. Patients were also asked to give subjective reports of how they felt about the treated issue when they thought back on the past memory and how they felt about the subject as they imagined the future. If there were

behavioral or physical symptoms associated with diagnosis shock, patients were asked to report on whether or not they observed any behavioral or physical changes after treatment.

Etiology of Diagnosis Shock.

Of the 400+ patients treated with HBLU, more than 100 were found to be positive by muscle testing for diagnosis shock. All patients in this study who came for HBLU treatment for medical or serious psychological problems and had been medically diagnosed with a serious physical or psychological illness had diagnosis shock. Patients specifically reported diagnosis shock from interactions with MD.s, nurses, nurse practitioners, physician's assistants, chiropractors, psychiatrists, social workers, counselors, mind/body therapists. Every one of them muscle tested positive that this was the highest priority pattern we needed to treat.

Many patients incurred diagnosis shock from descriptions of anticipated treatment procedures and side-effects (informed consent). Some patients expressed the concern that detailed description of possible treatment hazards might act as hypnotic suggestions to cause unwanted side-effects. A few patients, particularly patients about to undergo chemotherapy, radiation, and bone marrow transplantation, expressed the opinion that healthcare practitioners were torturing them and deriving sadistic pleasure from describing in detail possible treatment hazards.

Some patients experienced diagnosis shock when their healthcare practitioner suggested diagnostic tests for serious illness. Diagnosis shock was particularly severe when their healthcare practitioner added that he/she already thought they had an illness before the test results came back.

Some patients generated diagnosis shock through a process of self-diagnosis upon discovery of suspicious symptoms such as a breast lump, unexpected bleeding, or symptoms of mental illness. These included patients who came for treatment for diagnosis shock before medical testing was complete such as:

- a woman undergoing diagnostic biopsy for breast cancer who was subsequently found to have no disease
- two women with heart palpitations and irregular heart beat who feared they had heart disease (Test results showed that neither of these women had heart disease.)

Self-diagnosis shock was also found in a 36 year old woman who decided at age 6 that she was crazy because other children on the playground were laughing and running around while she just felt like isolating herself. As an adult she was diagnosed by a clinical psychologist to have Dissociative Disorder Not Otherwise Specified (DIDNOS) caused by physical and sexual abuse in childhood.

Surprisingly, some patients seeking help for non-medical issues were positive for diagnosis shock when muscle tested through the New Client Intake form. These included a 29 year old woman who wanted to get happily married. She had imprinted diagnosis shock at age 9 when she was prescribed glasses. She experienced a traumatic reaction in which she feared she would go blind and that wearing glasses would make her so ugly (compared to her other classmates none of whom wore glasses) that no man would ever want to marry her. In her late 20's she had laser eye surgery which corrected her vision, but she hadn't yet found a husband.

Initial Shock

At the moment of initial shock all patients reported asking themselves, consciously or unconsciously, "What could this ___ (news or symptom) possibly mean?" The unconscious mind instantly generated a worst-case scenario of loss of function or death so vivid, extreme, and frightening that it triggered a fight-or-flight reaction. Patients described this reaction as an intense

adrenaline rush of fear, a feeling of frozenness or numbness, and/or a sharp indrawn breath followed by an inability to breathe normally, think clearly, or hear anything that's said. Exclamations like "I don't believe it" or "It can't be true" were common. Patients instantly developed negative reactions to the setting and the people associated with that memory (negative conditioning). These exaggerated, irrational, emotional and physical, i.e. phobic, responses occurred so rapidly that some patients were not consciously aware of experiencing shock.

Coping strategies for dealing with diagnosis shock included:

- Panicking
- Repressing or denying the fear
- Attempting to talk themselves out of it: "I don't believe it." "That's ridiculous." "It's probably nothing." "That can't be real." "I'm not really worried." "I'll be all right, that's just my imagination."
- Attempting to dissipate the fear with magical thinking: "Someone or something will magically save me." "I believe in miracles." "A positive attitude will cure me."
- Distracting themselves by keeping busy or worrying about another person or topic
- Avoiding dealing with the issue
- Pretending the disease does not exist
- Looking for constant reassurance from others.

Even in cases where diagnosis shock occurred in the absence of any detectable serious illness, diagnosis shock remained imprinted in the unconscious mind and body. Because the unconsciously generated worst-case scenario felt real, patients reacted as if it was real. Thus, the degree to which each patient reacted did not correlate with the presence of an actual illness.

These coping strategies did not eliminate the fear or other symptoms of the traumatic reaction. As with the findings of Liefoghe and Michiels (1995) and Williams (2005) the author found that reactions to diagnosis shock could cause compliance problems, including failure to follow through on instructions or participate in prescribed treatment plans, behaviors potentially leading to adverse health outcomes.

While the author did not explore physical consequences of diagnosis shock in this study, there is substantial evidence from the field of psychoneuroimmunology that psychosocial stress adversely affects immune response through physiological mechanisms and can lead to adverse health outcomes (Swack, 2001). According to Kiecolt-Glaser (2002) and McGuire et al (2002) there is increasing evidence to suggest that treatment of medically-related stress significantly improves health outcomes and there is every likelihood that it will soon be found true for people suffering from diagnosis shock as well.

The structure of diagnosis shock is a loss trauma.

In agreement with others (White, Macleod, 2002; Williams, 2005), the author found that patients experienced diagnosis shock in the form of a loss trauma. (Swack, 1994, Table 1). Patients reported that at the initial moment of shock they suddenly felt that they had lost such things as their life, health, independence, livelihood/career, future, family, and the opportunity to share significant life events of loved ones. Their emotional reactions to these perceived losses included feelings of *shock, fear, anger, sadness, and hurt*.

Patients experienced *shame* about being sick (sometimes equated with sinful), feeling afraid (interpreted as being weak or cowardly), or needing to depend on others for physical/emotional support and care during and after treatment.

They experienced *guilt* about traumatizing or abandoning loved ones. Some patients compensated for the guilt by continuing to take care of others and carry on with business as usual instead of focusing on their own needs or allowing others to care for them when they needed it.

Patients also typically imprinted a series of irrational beliefs in attempts to rationalize how and why they became ill. They assigned *responsibility* or *blame* for this tragedy in the form of:

- "It's my fault because..." Some patients blamed their illness on risky behavior such as smoking. Some believed they were being punished for past failures or mistakes.
- "It's other people's fault because..." Patients blamed medical personnel and facilities or other family members for the problem. Complaints about medical personnel included, "the doctor didn't: warn me; tell me what to do to take care of myself; treat or test me; or interpret the results properly. The doctor (or lab) didn't give me my test results in a timely way or at all, etc." One patient with lung cancer blamed her husband for causing her to smoke by telling her not to do it.
- "It's God's fault because..." Patients reported feeling punished, cheated, or betrayed by God, fate, or luck. They asked, "Why me?" Patients reported feeling bitter, disappointed, and disconnected from God. Some even reported that they stopped praying.

Patients expressed worry about "Who will take care of me?" financially, emotionally, physically, and socially. They also felt that, "People will leave me; I can't trust them" and expressed fear that people would be repelled by their illness. Patients with this belief were commonly unable to share their feelings or show their 'real selves' to anyone for fear of alienating them. A variation of this was, "My body has betrayed me; I can't trust it."

Patients described feeling, "I am powerless or helpless/I have no control" over the disease, the treatment program, or their lives. Some patients were unable to take charge of the situation. As one patient put it, "I don't know what chemotherapy the doctor is using. My husband keeps track of all that. Furthermore, I dated the doctor in high school. I'm sure he's taking good care of me."

Patients reported feeling, "I am bad/unlovable/unwanted/undeserving-unworthy" or "I have no value." They felt that the attention they were getting was undeserved and unwarranted. Some patients turned down offers of assistance or felt that they must over-reciprocate for the love, friendship, and care they received.

Patients with diagnosis shock experienced a *feeling of emptiness*, a principle characteristic of loss trauma often described as a hollow sensation in heart or stomach, i.e. a sense of loss and that *something is missing*. This sensation can trigger addictive behavior in which people try to fill the empty space with food or alcohol. One patient said, "Since I'm going to die anyway, I may as well enjoy myself now," and subsequently developed a weight problem. The feeling of emptiness may also lead to depression. As another patient put it, "I'd rather die than live like this."

As in other loss traumas, patients with diagnosis shock reported *anticipatory phobias*, a pervasive underlying feeling of dread that the traumatic event will happen again. Patients reported anxiety about going to the doctor for fear of bad news. Even little symptoms or seemingly abnormal reactions triggered the fear that the illness had recurred. One patient with a prior heart attack panicked whenever he experienced shortness of breath. After repeated testing showed his heart to be normal, his cardiologist prescribed a tranquilizer that not only calmed him but also alleviated his shortness of breath (until the medication wore off). Some patients avoided attending support groups for fear that others in the group would die and depress or frighten them out of their optimistic healing attitude.

Some patients reported additional negative emotions (such as bitterness, hate, and disgust), limiting beliefs, and irrational thoughts. Some patients developed limiting identities such as, "I am a victim of this illness" or made limiting decisions such as, "I have to stay away from doctors." Some patients reported feeling that some part of them had died inside. In some cases, patients needed to forgive or make amends to themselves, God, and others to complete their healing process. Sometimes a root cause needed to be treated, such as an earlier trauma, underlying belief, or self-destructive behavior that had led to this problem.

Diagnosis shock can occur in the absence of clinical findings.

Case examples:

After a routine mammogram, patient A received a postcard requesting that she return for another mammogram. Hysterical, she refused to leave her house until she repeated her mammogram one month later. It was normal.

Patient B's gynecologist discovered a breast lump during an annual exam and recommended that she make an appointment with the receptionist for a mammogram. Patient B fainted in the waiting room, hitting her head on a table, and spent the rest of the day in the emergency room under observation for a head injury. Her mammogram was normal.

Clinical implications for physical health

Diagnosis shock can have adverse health effects caused by difficulty choosing treatment options, failure to follow through with prescribed treatment plans, or avoidance of treatment altogether.

Diagnosis shock in patients with confirmed physical or psychological illness can result in an inability to hear and understand medical explanations and treatment suggestions. People in a patient's support system can also experience traumatic reactions (Slijper and van Teunenbroek, 1998; Gray, Fitch, et al, 1999; Edwards and Clark, 2003; Connell, Boise, et al, 2004). While in this traumatized state themselves, patients are given treatment options and opinions and asked to make life and death treatment decisions while relying on their traumatized support systems for help.

Regardless of what they decide, there are often no guarantees. Patients may experience such intense feelings of doubt, confusion, and overwhelm that they develop secondary phobias about having these feelings. A common phobia is, "I'm afraid to feel doubt or confusion because it means that I made the wrong decision and it will kill me." This phobic reaction may lead people to avoid any treatment for fear of making a mistake. In contrast, they may second-guess, obsess, or over-treat themselves in an attempt to cover all the bases. If the treatment is unsuccessful, patients may blame themselves.

Case examples

Patient C was diagnosed with breast cancer nine years prior to HBLU treatment. Immediately after diagnosis she underwent a mastectomy. Although she was diagnosed as Stage IIA, she refused chemotherapy and tamoxifen. Patient C reported, "I was sure I could conquer cancer simply by eating better." As the cancer progressed she consulted many physicians and carefully studied their treatment suggestions, focusing only on how the treatment would harm her and its less than 50% probability of success. She never acknowledged how cancer itself, untreated, would kill her. Seven years later, she underwent radiation to a tumor "encroaching on her windpipe" to restore her ability to swallow. At the time of HBLU treatment, patient C had extensive tumors throughout her body. After clearing diagnosis shock, she consulted another oncologist who told her that she was now too weak to undergo any kind of treatment. She died two months later.

Patient D. is an MD. He was diagnosed with B-CLL (leukemia). He did not feel at all sick. He got several opinions about different types of chemotherapy, but declined any form of treatment for fear that the doctors were "being too aggressive" and trying to make him sick. A year later, his blood count had risen substantially, and the leukemia invaded his bone marrow. One week after clearing diagnosis shock he started chemotherapy. The treatment regimen required six rounds of chemotherapy at one month intervals. After the first treatment his blood count went to normal, and he considered discontinuing treatment. We treated diagnosis shock related to the treatment protocol, and he finished the series. One year later, he is free of cancer.

Diagnosis shock can have adverse health effects by interfering with doctor/patient relationship and cooperation, and may affect the caregiver as well.

Many people work well and respectfully with their doctors and health care providers. It is not uncommon, however, for shocked patients to blame their doctors for upsetting them. In addition, some recommended treatment options are extreme and shocking. Sometimes doctors aren't certain of the treatment plan or inform patients that there is nothing they can do. Suddenly, patients don't trust the doctors who they are depending on to save their lives. Sometimes doctors even become enemies in the patients' perceptions, and the patients simply refuse to return to those practitioners.

The fact is that there is no way to deliver this kind of bad news without shocking the patient. Unfortunately, health care practitioners don't know how to prevent or clear trauma from their patients when they deliver bad news. Patient's subsequent reactions to diagnosis shock can cause an energy drain on medical personnel when anxious patients become confused, irrationally angry, or so fearful that they require constant reassurance.

Case example

Patient E. was a naturopathic physician. Diagnosed with aggressive breast cancer, she underwent surgery and one round of chemotherapy and went into apparent remission. Patient E. contracted amoebic dysentery in the hospital and was too sick at the time to do a second round of chemotherapy. About a year later the cancer returned. She began researching alternative treatments but couldn't decide what to do. Upon inquiry about her oncologist's advice, Patient E. stated that she did not have an oncologist, and furthermore was unwilling to even visit the hospital oncology department. She said, "It would depress me too much to even enter the building because after treatment, my doctor told me that if the cancer did come back, it would kill me." After clearing diagnosis shock, Patient E chose treatment at an alternative medicine clinic. Her husband tried to help with her treatment by feeding her a raw food diet. She still refused any further consultation with an oncologist. When alternative treatment failed, she self-treated with over-the-counter angiogenesis inhibitors, including copper chelation agents. A year later Patient E. died of an intentionally self-administered overdose of prescription medication. At that time, she had tumors growing out of her body, and she could also feel them growing inside.

Clinical implications for quality of life

Diagnosis shock hurts relationships.

Patient F's husband developed brain cancer and could no longer work. He withdrew emotionally and mentally from their relationship. Patient F. got so angry with him for abandoning her that she fought with him almost daily and was arrested once for physically assaulting him. Although she knew this was wrong, she could not control herself. Following treatment for diagnosis shock, the fighting stopped.

Patient G. had a mild heart attack. After medical treatment, his doctor pronounced him fit enough to play baseball. His wife, however, stopped having sex with him for fear that any excitement or exertion might trigger another heart attack and kill him. We cleared Patient G's diagnosis shock. He then explained to his wife that after two years without sex, he felt like he wanted to die. That week they started having regular sex.

Patient H's wife had breast cancer. He worried so much about losing her that he became distracted at work, and developed a second loss trauma in the form of an anxiety that his work performance would slip to the point that he'd be fired. He angrily blamed his wife for both his emotional discomfort and his anticipated job loss. After treating Patient H. for both loss traumas, the blaming stopped.

Diagnosis shock diminishes overall quality of life

Patient I. was diagnosed with (and hospitalized several times for) bipolar disorder when she was in her 30's. Now over 50, she had never been married, lived in a condominium that she disliked, and dreamed of retiring from teaching to start her own business. Patient I. refused to take any medication for her problem and claimed to have spent hundreds of thousands of dollars looking for a psychological or spiritual cure. After treatment for diagnosis shock, she started medication. She is currently substitute teaching and in the process of building her business.

Clearing diagnosis shock

After diagnosis shock imprints, factual information to the contrary cannot erase it. Knowledge of the facts does not change a phobic reaction. A study comparing the psychological symptoms of women with ductal carcinoma in situ, (an easily treatable pre-cancerous condition) with the psychological symptoms of women with invasive cancer found their psychological symptoms to be identical (Rakovitch and Franssen, et al, 2003)!

Diagnosis shock must be cleared from the unconscious mind and body using suitable techniques. This study found the Neuro-Linguistic Programming (NLP) and Energy Psychology techniques to be highly effective (Swack, 1994). Patients often preferred an Energy Psychology technique called Natural Bio-Destressing (NBD) (Swack, 2001) originally derived from Thought Field Therapy (Callahan, 2000). NBD works by activating the calming reflex used by the nervous system to neutralize the fight-or-flight reflex, thus eliminating the phobic reaction (Swack, 2001). NBD involves using the fingertips to tap on selected areas of the face, torso, and hands, along with eye movements and left brain/right brain integration techniques to resolve unpleasant or traumatic memories. (Instructions for NBD and a protocol for clearing loss trauma are included in the Appendix and Figure I.)

Recommendations to health care providers

Patient J. sought treatment from a naturopath for Lichen Sclerosus, an incurable (by allopathic medicine) skin disease. He performed diagnostic testing with an electronic machine. During the testing process he frowned and asked her if she'd ever been to Africa (she had not). His machine was registering positive for an unusual parasite. At the look of alarm on the patient J's face, the naturopath told her not to be frightened because, with this machine, he could make a homeopathic remedy and treat for anything it could detect. She felt somewhat better, but reported to me that she still felt sufficiently frightened and angry that she did not want to return to that naturopath. Muscle testing revealed that she had experienced diagnosis shock when he told her he'd found a parasite, and that the degree of shock dropped by 30% when he told her he could make a remedy. Muscle testing also revealed that she still had 70% shock, and that if he had told her *before* he started testing that he could treat anything he found, she would not have experienced shock at all. She required treatment with an energy psychology technique to finish eliminating diagnosis shock, and she returned to the naturopath for further treatment.

Careful use of language can minimize diagnosis shock. The unconscious mind does not recognize the word 'no.' Therefore, the author specifically put only the positive helpful language. This is so that health care practitioners will consciously *and unconsciously* focus on the desired statements and not unconsciously imprint the undesired statements. Testing of different strategies and language patterns for minimizing diagnosis shock while discussing health issues resulted in the following communication guidelines for health care providers:

1. For a patient with no symptoms use the following language:

“Ms. Smith, I’d like you to get a blood test for _____ to make sure your _____ *is functioning normally.*”

“Ms. Smith, I’d like you to get a scan to confirm that the *therapy/treatment is working.*”

“Ms. Smith, you’re due for your *routine test* (mammogram, EKG, cholesterol, etc.)”

2. For a patient with symptoms, use the following language:

“Ms. Smith, I’d like you to do this test to *rule out the possibility of anything serious.*”

Refrain from giving the patient a definitive diagnosis until the results of the tests are back.

Instead, say: “*Let’s find out what this is* and then we’ll decide on a treatment plan.”

3. For a patient found to have a serious condition, if possible give the news in person, and be sensitive about the use of language (see (Maguire, 1994) and (Williams, 2005) for excellent suggestions). In agreement with others (Williams, 2005) this study found that proper environment and verbal technique alone can *minimize but not prevent* diagnosis shock. In this study we found that patients have been able to *prevent diagnosis shock* by using one of the following techniques while listening to the news.

Simple diagnosis shock prevention techniques

A. Frontal/Occipital Holding – The patient places one hand across her forehead and one hand across the back of her head and holds her head for at least the first few minutes of the discussion (Eden, 1998). If that is awkward, the patient may just place one hand across her forehead.

B. Tapas Acupressure Technique (TAT) – This technique provides a strong shock elimination effect (Fleming, 2001). The patient places the middle finger of one hand on his forehead between the eyes and holds the bridge of the nose with his thumb and ring finger. To improve the effect, he places the other hand across the back of his head.

C. Natural Bio-Destressing (NBD) – After discussion, the patient performs Natural Bio-Destressing (see Figure 1) to clear any diagnosis shock before leaving the office.

4. When explaining the risks of a particular treatment, use language such as,

“*In the past, a small percentage of other people* have experienced side effects like _____.”

If appropriate, add, “So we take the following measures _____ to *minimize that possibility.*”

Self-care for health care providers

Health care providers can experience psychological distress when working with patients and their families.

Patient K. was a rheumatologist treated with HBLU for *patient shock*. His SLE patient had just recovered from kidney failure. As he had recently learned of a new medication that could reduce the severity of this kind of episode, he shared the good news by telling his patient that for her next recurrence, she could use this new medication to minimize the effects. He was shocked when she became hysterical, screamed at him, called her husband into the office, and threatened to sue him. The rheumatologist had triggered his patient’s anticipatory phobia of having another episode, and she, in turn, triggered his patient shock.

Many healthcare practitioners experience burnout not only from heavy workloads, but also from the emotional stress of dealing with traumatized patients and their families. Many practitioners have reported that after a very stressful workday they sometimes wonder why they ever decided to become a helping professional. This has sometimes been called *compassion fatigue*. It is important

for the care-takers to take care of themselves so that they can maintain their energy and enthusiasm for this noble work. To that end, the author recommends that health care practitioners do a round of Natural Bio-Destressing immediately after working with a difficult case and before leaving work each day. This enables them to set a boundary and leave work at work. In fact, medical social workers at a major Boston Hospital who followed this advice reported feeling less stressed and burned out by their work (personal communication). The author also recommends that health care practitioners cultivate interests outside of work that are rewarding and pleasurable in order to create some balance in their lives.

Although healthcare practitioners are professionals in their work, they are also human beings and thus susceptible to experiencing shock when their patients die. Several MDs, nurses, and mental health therapists required HBLU therapy for loss trauma caused by death of their patients. One of these MDs quit her medical practice because of this. The author recommends that any healthcare practitioner who experiences a patient death be immediately treated for loss trauma (starting with step 2 of the appendix.)

Recommendations for patients

Since any allusion to the topic of illness may trigger a phobic reaction and make it difficult to have a rational discussion, the author starts work with patients *by clearing diagnosis shock*. Patients and their families are taught Natural Bio-Destressing. Patients are instructed to treat themselves with NBD every morning for what they dread will happen that day and every evening for anything that might have upset them during the day. The author recommends patients use NBD on the anticipatory fear of bad news before doctor's appointments, Frontal/Occipital Holding or TAT while talking with the doctor, and NBD after each doctor's visit to clear any upset.

Patients are instructed to use Natural Bio-Destressing before any kind of treatment to clear the body's fear of invasion and harm. While performing the technique, patients are instructed to convey messages to their bodies that this treatment is a healing intervention meant to make them well and to ask the body to fully receive the benefits of treatment. This includes asking the body to send the treatment where it is needed and to protect other parts of the body where treatment is not needed.

Finally, the author recommends that patients use Natural Bio-Destressing to clear feelings of doubt, uncertainty, and overwhelm.

Patients who followed these recommendations reported:

- Reduced fear
- Feelings of empowerment
- Smoother doctor/patient relationships
- Fewer side effects
- Quicker recovery times
- More peace of mind
- Better quality of life

Recommendations for the future

The author recommends that all healthcare practitioners be trained to recognize diagnosis shock and use these language and energy psychology techniques to prevent or treat it. Hospital medical social work departments could provide regular training in this area for all personnel, from MDs to receptionists, leading to a more pleasant medical experience for patients, their families, and the medical staff. Professional schools could make this training part of their curriculum. Future studies will be necessary to measure the effects of treatment for diagnosis shock on patient satisfaction, duration of hospitalization, amount of medical care needed, and the rate of caregiver burnout.

APPENDIX

Treating Diagnosis Shock

Whenever a person experiences a major loss (real or imagined), they feel a flood of negative emotions and develop a series of limiting beliefs shown in Table 1. (For a more in-depth explanation, see Maguire, 1994.) In order to remain calm, resourceful, and able to rationally deal with whatever needs to be done, follow these directions for clearing loss trauma:

Step 1. Return to the memory where you first suspected or found out that there might be something wrong with your health. Where were you at the time? Ask yourself:

- What made me suspect or think there was something wrong?
- Where did my unconscious mind go (i.e. worst-case scenario)?
- Where did I feel the shock in my body?
- What did I think/feel/imagine I lost in that moment?

Do Natural Bio-Destressing.

Step 2. Go through the items on the Loss Trauma outline one by one. Ask yourself:

- Did I feel this way or believe this?
- Where in my body do I feel this?

Do Natural Bio-Destressing.

After doing several rounds of Natural Bio-Destressing, you will feel calmer, more rational, and better equipped to cope with the situation if you actually have a serious condition that needs treatment.

Table 1. BASIC STRUCTURE OF LOSS TRAUMA

I. MAJOR NEGATIVE EMOTIONS

- A. *Initial Shock/Fear*
- B. *Anger/Rage*
- C. *Sadness/Sorrow*
- D. *Hurt/Pain*
- E. *Shame*
- F. *Guilt*

II. LIMITING (CORE) BELIEFS

- A. Responsibility (*blame*)
 - 1. It's my fault because _____.
 - 2. It's other people's fault because _____.
 - 3. Disconnection from God. It's God's fault because _____.
(How could this happen? There is no God.)
- B. Who will take care of me?
- C. People leave me. I can't trust them.
- D. I am powerless or helpless/I have no control.
- E. I am bad/unlovable/unwanted/undeserving-unworthy.

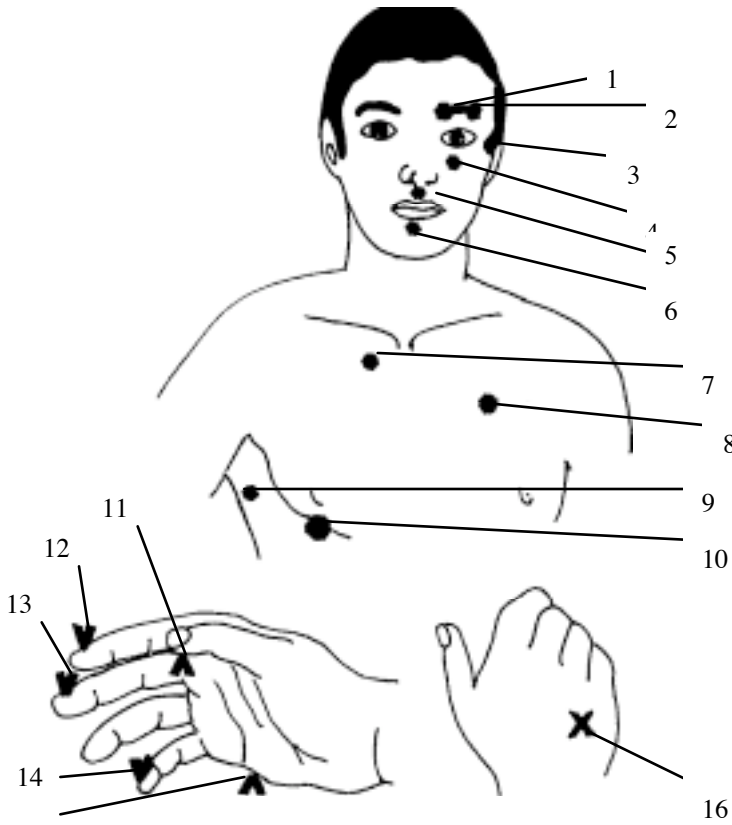
III. FEELING OF EMPTINESS (*also known as loss or grief*)

IV. ANTICIPATORY PHOBIAS

V. OTHER POSSIBLE EMOTIONS AND BELIEFS

- A. *Bitterness/hate*
- B. Any other negative emotions?
- C. Do you have any parts that feel "I'm already dead"?
- D. Other limiting beliefs
- E. Irrational thoughts
- F. Limiting Decisions
- G. Limiting Identities
- H. Do you need to do any amend-making or forgiveness?
- G. ROOT CAUSE: Was there an earlier trauma, grudge, or underlying belief that predisposed you or set you up to incur this trauma?

Figure 1: Natural Bio-Destressing



A. Concentrate on a specific feeling and notice its location in your body. On a scale of 1-10 rate how severe is the feeling.

B. Tap the Karate Chop Point, #15, while saying three times: “I totally and completely accept myself, even though I have this (problem, feeling of fear, guilt, anger, etc.)”

C. Stimulate nerve endings 1-15 by tapping with fingertips for a few seconds.* If you feel a lot of energy moving, or the scene is changing, stay on that point till the activity plateaus. If nothing happens on a specific point, move to the next one. Use your intuition about how long to stay on a point.

- 1. Bridge of nose by eyebrow
- 2. Outside edge of eyebrow
- 3. Side of eye
- 4. Under eye
- 5. Under nose
- 6. Under mouth
- 7. Under collar bone
- 8. Sore spot on chest (rub gently)

- 9. Under arm on rib (Ovary spot)
- 10. Bottom rib below nipple
- 11. Side of thumb
- 12. Side of index finger
- 13. Side of middle finger
- 14. Side of little finger
- 15. Karate chop spot

D. Do the 9-Gamut

Tap the Gamut Point, #16, on back of hand through the following steps:

1. Close eyes
2. Open eyes
3. Look down to one side
4. Look down to the other side
5. Roll eyes around in a circle in one direction
6. Roll eyes around in the other directions
7. Hum a tune
8. Count to 40 by 2's
9. Hum a tune

E. Repeat Step C

F. After every round, recheck how severe is the feeling. It should be gone altogether or very low on the scale. Think about what you learned and what feels or seems different about the situation to you now. If the level of that emotion still seems high, notice what *else* about the situation makes you feel--frightened, angry, sad, etc. Focus on that subject and repeat the process.

*At any point, feel free to add deep breathing, pacing back and forth, gently stamping your feet, or massaging or shaking the tension out of your body.

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