With Dominance for All

Though it is little remembered, Abraham Maslow's early work dealt with the construct of dominance in humans, and how it influenced work, social matters, and especially sex. As one reads Maslow's early papers (anyone who would like copies for educational purposes please contact me) one is struck by the fact that the traits that Maslow attributes to dominant individuals (confidence, contact, ease, lack of self-consciousness or embarrassment, directness, feeling comfortable in one's own skin, freedom of action, assertiveness, poise, etc..) are in the Reich and Lowen tradition held as evidence of emotional health.

What Maslow implies, and what I whole-heartedly concur with, is that interactional dominance is an artifact of heterogeneous levels of emotional health meeting one another, rather than a social imperative. The emotionally less healthy (more armored or dissociated) person naturally defers to the more healthy (less armored) person. The coercive effort by the heavily armored to achieve influence is termed "domineering" by Maslow and distinguished from dominance. To be clear, emotional health and healing is not a zero-sum proposition as is implied by the term dominance. To gain emotional health one does not have to take it away from others.

So, dominance, in Maslovian terms, is really about grace and self-possession. While Maslow attributed this to some mysterious psychological property, readers of this blog know, it arises from the state of the body.

The present day "dating skills" community is also interested in dominance because of its connection to sexual attraction (as Maslow had well spelled out). That makes sense since dominance (as a social artifact) and attraction (as an experience) both arise from being in the presence of emotional (which implies physical) health.

The social psychologist Amy Cuddy has done some interesting work around body language and dominance. Basically, more collapsed postures represent submission, and more reaching or wider postures imply dominance. It seems that reaching out with the arms or assuming a spread out position is associated with confidence and a feeling of well-being. It is a fundamental tenet in the Reich and Lowen tradition that expansion is associated with joy and pleasure and contraction is associated with pain and fear. Expansion is seem easily in body language but is also probably present in joint spaces and rib excursion as well.
'Dominant' individuals are expanded most of the time. There is an interplay among people, wherein someone inclined to contraction may contract more if in proximity to someone who is expanded. Shame and 'basic fault' has a role here as well.

Real Change Destabilizes Relationships

Most couples who come to me for therapy are quite miserable but quite stable in the sense that they cannot separate. If one partner changes, the relationship is less miserable (for both) but also less stable. It is usually at that point that the couple stops coming. The same phenomenon is seen in individual clients. Of course relationships can and do stabilize on a better basis. But actually what is most desirable is less stability and more balance, just as it is with posture and movement. Stability is achieved (in furniture say) by having a wide base and low center of gravity. Humans have a narrow base (feet more narrow than shoulders) and a high center of gravity. That is why balance is so important, but it also why graceful quick agile movement is possible, leveraging rather than fighting gravity. But many of us have a fear of falling. The metaphor of a relationship being a dance is better understood in this way.

Another Value to Character Focus

David Shapiro has pointed out that 'historical' (psycho-dynamic) explanations of maladaptive behavior tend to be exculpatory, and so the client never really 'owns' the problem. He prefers 'contemporary' (cognitive) explanations which keep the client 'on-the hook' However, contemporary/cognitive explanations draw on the will for solutions, which will fail when the will inevitably tires and exhausts. Alexander Lowen's solution was 'character-focus' which provides a combined historical and contemporary explanation–historical in the sense of character formation, and contemporary in the sense of character functioning. The indicated solution, of course, since character resides in the body, is bodywork.

Transference Cure Revisited

In the realm of emotional suffering, there has always been an illusory type of improvement. If someone in the role of 'healer' is convincing enough, the recipient will tend to feel better, and even in limited ways function better, *if they remain in contact with the 'healer*, at least for a while. This is an extended or expanded placebo effect. The healer can be convincing because they are a charlatan or more often, simply convinced themselves.

In psychoanalysis this situation came to be called a *transference cure*. It was recognized that the effect inevitably decayed, but also the state of the relationship's transference affected it. The 'healer' always had to be an idealized healer. This becomes 'addicting.' This is how therapy cults start, but it also happens inadvertently to naive therapists, who may, and usually do, attribute the initial seeming improvement to their methods, and then continue to apply the method superstitiously

If a type of therapy has a manualized or set procedure, the risk of a transference cure is all the greater. There are currently some popular therapy approaches under various acronyms that seem to fit this profile. I sometimes get a request for a *set* 'bio-energetics' procedure. **Alexander Lowen never set one out perhaps understanding this very problem.** Reich does seemed to have effected quite a few transference cures in the sense that his personality was essential, and the relationships had some cult like aspects.

The Misuse of Reassurance and Release

Most clients arrive in therapy eager to talk about problems. This is informative briefly. for the therapist, but also a release of tension and anxiety for the client. The 'expected response' is reassurance from the therapist. I would say that the majority of masters-level therapy in the US is based on reassurance and problem talk. Some better-trained or more deeply understanding therapists do withhold reassurance so that the client must seek a different avenue of relief for anxiety.

However, it can be very difficult to move away from problem-talk format. Anxiety can be released temporarily by conversations about dangers and fear. However, this also just strengthens anxiety circuits in the limbic system and brainstem much like repetitive resistance training of the same muscle. Imbalance increases in the long run. It can be likened to an addictive process.

Now I am not advocating any type of 'positive thinking' model. Such an approach is dissociative at most and usually just an act of pretending.

The real core of change is developing new *motor-recruitment patterns*, which together with sensory development leads to new experience, perhaps even new *experience-recruitment* patterns. Where new experience comes about, new behavior patterns, if desireable, are practically self-installing.

Majid Ali, MD, who I cited in the last post, has a blog post of his own that makes a similar point: http://majidalimd.me/2014/05/27/four-important-videos-on-anxiety/

The Work of Majid Ali, MD

I am very interested in Dr Ali's work. He is outspoken about the both the limits and the contributions of allopathy. In his blog post below he gives his insights on what I have called sympathetic shift, and also endorses energy aspects of human functioning, but from the point of view of a practicing internal medicine MD. This is not just sprinkling a light vocabulary of 'holism' on standard approaches, he is very direct in working with the body in a Reich-and-Lowen-compatible way. http://majidalimd.me/2014/05/15/limbic-exercise

A Two-Way Street

I have noticed something changing slowly as over the years as I have pursued bodywork aggressively. People's responses to me are warmer and more attentive.

In the mainstream cognitive and behavioral tradition, a basic premise is that if we do something different, the responses of others will change. A story that epitomes this is by Albert Ellis of REBT fame. He relates a time as a young man feeling bad about not having a date. So he resolved simply to ask every young woman he met at the Brooklyn Botanical Gardens. He did get a date, but it seems unlikely peoples responses really changed–he was simply working the numbers. One cannot imagine that his real enjoyment increased.

I am a naturally reserved person and have always struggled with doing the 'out-going' thing. In fact, I have not yet taken it up. The different response I am getting is not because I am doing anything different but rather I am *being* something different. And by being different I certainly don't mean thinking something different!. My hunch is it involves vibration. The appearance of the face could also contribute. Now the combination of this warmer attention and stronger desire and energy is starting to lead to different responses from me, but not from trying or conscious planning. For things to change it is necessary not just to do something different but to experience something different, and to change experience the body has to change.

Working Transference in Therapy

I have Stephen M Johnson to thank for the idea. As far as the attitude toward change in therapy, clients seem to have three types:

- **Magic Transference** This is where the client expects the therapist to do something that will bring about the change. It is felt that just making it to the office should be sufficient. In this age of narcissism, this transference is not only common, but is also present with some very sophisticated individuals. Quick fixes are expected. Suggestions from the therapist may be complimented and discussed, but they are not implemented. There is very little holding the client once the novelty wears off.

- **Dependent Transference** This is where the client comes to the therapist expecting to relate as a young child to a parent. It is felt that just 'following' the therapist around should be enough. Support and sympathy is expected. Suggestions are followed weakly, without conviction. The client may stay for a long time without reference to change. In many therapy 'movements' dependent transference is seen in 'groupies' who are devoted to the movement without any conviction or even clarity about the groups fundamental positions.

- **Working Transference** This is ideal. it is felt and believed that application of practices and principles should be enough. Guidance is expected. A psycho-dynamic transference may be operating in the background but it doesn't dominate the client's approach to the work. The client is held to the therapy by experience of learning, change, and productive exchange.

A Great Diagram Contrasting Masculine and Feminine

Though this is a controversial area of discussion, the following diagram is well worth reviewing:

http://www.drglover.com/site/drglover/files/pdfs/masculine-feminine-aug-2012.pdf

A Second Great Divide

In my last post I discussed the persistent divide between disciplines that work with the body and those that work with the mind.

This got me thinking about another divides that make modern life easier to tolerate. Alexander Lowen frequently made reference to a strong difference between the Victorian period, in the tail end of which he was born, and the modern post-sexual revolution era in which his later therapy practice took place.

In Victorian times, behavior was strictly controlled while strong feeling was not only permitted but actually idealized. This at times led to hysteria in the Freudian sense in which feeling forced a different outlet than direct action. But in modern times, Lowen asserted, behavior is much freer but feeling is often removed from it. Coolness, and capacity to act advantageously is idealized. This leads to narcissism. In the present day, hysterical disorders are rare, but narcissistic disorders are commonplace. Perhaps civilization has, via families, a hard time permitting both high feeling and free behavior. But also there is great difficulty for individuals to tolerate both strong feeling and extensive freedom of choice. Achieving that capacity is the goal of Reich and Lowen therapy.

Bridging the Great Divide

I have been struck by how persistent is the *great divide* between *body workers* who try to change the human condition by disciplines such as Pilates, Yoga, Qi Gong, martial arts, deep tissue massage, Rolfing, Kit Lauglin's *Stretch Therapy*, or the people working *directly* with primitive reflex retention, and *mind workers* (psychotherapist) who try to change the human condition with ideas, validation, and inspiration. (Allopathic western medicine by the way treats the mind)

There is a minority of therapists advertising 'bodymind therapy' but largely the approach seems limited to working with the mind's conceptualization of the body rather than any actual kinesiological work.

For a time I have attributed this to a limitation of the practitioners (with, I admit it, a mild sense of culpability) Now I think this is too inhuman a view. A split between body and mind is driven by the need to keep from being overwhelmed. This is true for an individual, or a business, or a licensed discipline.

An individual may well undertake to bridge the divide–he or she could do well to employ both mind-and body workers. While specialization of this sort is in some fundamental way evidence of the problem, it seems to be the way excellence is packaged at our current time and place. My general recommendation is to anchor one's program in an excellent kinesiological discipline, ***and stay with it,*** knowing from Reich and Lowen principles that bumpiness is ahead in one's life. A non-judgmental sincere support group of some sort is the next lower hanging fruit, and this does not have to have any specialized knowledge. Last of all, a mind-worker may be of great assistance, but of course the choice needs to be carefully made. Some psychotherapy is inimical to the life of the body, but much of it is compatible with body work even if not synergistic. Really *character analysis*is the only mind work that is synergistic with body work

Michael Samsel

Turgor and Colloid–Any Connection With Fascia?

There is now on Youtube a very interesting video about the role of fascia in health The information certainly supports the Reich and Lowen tradition's emphasis on the muscular system as a main point of limitation in emotional human functioning. Neither Reich and Lowen considered the fascia much apart from muscles proper. Today fascial dysfunction is so evident that the distinction may have concrete benefits in pointing to remedial practices such as deep tissue massage techniques that separate muscles etc..
However, in the above linked documentary, there is also a fascinating look at the conductive properties of fascia. As reported, conductive 'spots' exist in the fascial layer that correspond to points along the energy meridians of traditional Asian medicine. A barrier to acceptance in Western medicine for the meridian model is that the meridians do not line up with nerves. Western concepts of physiology are very nerve-centric, perhaps because nerves are extensions of the brain, and Western concepts of physiology are very brain-centric.

Another non-neuronal energy system is turgor and colloid. Reich researched this, but Lowen did not address it other than in a 'diagnostic' sense, perhaps because it wasn't apparent how to work with turgor and colloid directly. The area truly has been orphaned with only the cosmetic industry taking interest but of course only in a specious framework of adding supplemental colloid from the skin inward rather than addressing the process from the core outward. A question occurs to me–do the fascia and turgor and colloid interact?

Missions and Tending

In my work with couples, I frequently encounter a difference in meeting responsibility. The masculine tends toward organizing responsibility in the format of 'missions,' discrete bursts of goal directed behavior, while the feminine tends to implement responsibility through 'tending,' a more continuous attention to maintaining good and desirable conditions.

Elements of Mission Focus

- **A Clear, Definable Objective**
- **A Definite Start Time** This can a trigger by circumstances, or based on when the 'team' is ready, or set arbitrarily.
- **A Stopping Rule** This can be achieving the objective, ascertaining the impossibility of achieving the objective, reaching a pre-determined time limit, exhaustion, or loss of interest
- **On/Off Nature**
- **A Team** Who is in the mission and who is not is clear. Efforts by people not in the mission to participate are considered intrusive
- **Set Responsibilities of Team Members** If one person is lucky and has nothing to do, there is not only no obligation to help others, but without an explicit request for help, trying to help is considered intrusive

Elements of Tending Focus

- **The Goal is Achieving A Feeling** The feeling can be felt by those sensitive to it, but is hard to define.
- **Continuous Duration** This may be at low intensity at times, but monitoring is always going on. There can be 'soft' start and stop times for activity based on thresholds in environmental or interpersonal conditions.
- **No Set Participants** Great efforts will be made to include everybody
- **No Set Roles.** It is a point of honor to help others and tasks are considered joint responsibilities. Efficiency is a secondary consideration, and specialization is generally considered abhorrent.

This small model by no means summarizes the differences between the masculine and the feminine, it is just an aspect. However, it is an aspect at the core of much domestic discord.

Both foci are biological, they are at base complementary. Some weaknesses of the mission focus is that 1) conditions slowly deteriorate because there are not clear triggers to action–the oft cited example is the infant with a diaper saturated with urine because there was no point at which the situation became critical, 2) the mission format can make some wasteful and pointless objectives seem worthwhile.

Some weakness of the tending focus are 1) it is a closed system and a type of psychological starvation happens when nothing is brought into the situation, and 2) novelty, adventure, and major renovations get framed as disruptive and messy.

In our economic life, most jobs now involve to tending to large systems. Only the highest status workers get to 'go on mission'. An exception to this is construction, where every job is a new mission. But most freedom of action is in the domestic arena where tending is again disproportionately called for. The result is that the masculine gets unjustly identified with uselessness and unresponsiveness. Situation comedies exagerate this. The solution is not more supression of the mission instinct. The solution is in more missions but ones in which the domestic situation is enriched and renewed.

The Darn Placebo Effect

Human suffering can be reduced considerably but temporarily by the initiation of any intervention that the sufferer believes in. This is the 'placebo' effect. This is why the tooth immediately hurts a lot less as soon as the dentist appointment is made and one hangs up the phone. I have mentioned before how the placebo effect interferes with the study of Reich and Lowen therapy. I now come to see how it also interferes with the delivery of it.

There are two problems with the placebo effect: 1) it decays over time, and 2) it cannot work synergistically with growth strategies to relieve suffering.

There are two seductions (or assets, depending on one's point of view) of the placebo effect: 1) It is immediate (unlike growth) and, 2) it is considerably stronger in effect *initially* than true growth effects.

The placebo effect is based on dissociation. Real growth is based on association (or re-association) In research, if another dissociative method (say a drug) is employed as the experimental condition, then the effects of that and the placebo may be additive. When the control group (which only has the placebo effect) is compared, the placebo effect subtracts out and demonstrates a treatment effect. Associative effects, however, are not additive to the placebo effect, in fact they may undermine it. Therefore, in testing something that leads to growth, when the experimental and the control group are compared, the shared placebo effect is like tall grass that hides what is happening on the surface, and no treatment effect is demonstrated. This is particularly true since studies tend to last less than 6 months, and the effects of growth in this arena usually take several years to manifest. This why effective 'alternative' treatments cannot be distinguished from ineffective alternative treatments by present day random-controlled trials—the subtle balancing and regulating effects (or their absence) are all hidden under the tall grass of the placebo effect.

In emotional well-being, the placebo effect is synonymous with what Alexander Lowen described as elation or illusion. As he often pointed out in his writings, the therapist's 'window of opportunity' for change is often to prevent the client from 'climbing back onto' the illusion (and the placebo effect,) after a collapse.

Placebo effects are in fact part of healthy human adaptation for causes of suffering that 1) will pass on their own, or 2) cannot be addressed immediately but which will be effectively addressed in the near future (such as the tooth example above.) Where the cause of suffering is persistent, placebo effects support an increasing dissociation that covers a slowly depleting work and pleasure function.

Placebo effects have to be renewed periodically, by finding some 'great new thing.' This leads to a very disorderly approach to health where the sufferer travels from one type of practitioner to another, never really committing to the practices. The immediate positive placebo effects are mistaken for the treatment effects, but as the novelty wears off, the practices seem to stop working, and something new becomes overwhelmingly attractive. This is placebo abuse. In my practice as a therapist, it greatly interferes with forming a working relationship because new clients compare the subtle differences I am pointing out to the strong if temporary morale-boosting available through starting 'something new.'

Deficit and Conflicts

Psychotherapy is about overcoming inabilities–and there are two main ways to approach these inabilities, as the result of deficits or as the result of conflicts. From the deficit point of view, the ability to proceed in life in a certain manner never developed, and encouragement is appropriate from the therapist. From a conflict point of view, desire or fear interferes with straightforward living, and judicious exposure and confrontation is appropriate from the therapist. Moreover, encouragement (and its cousin reassurance) could be detrimental because it parcels out the conflict between therapist and client instead of 'forcing' the client to handle both sides of it.

Deficits can be handled gently and non-confrontationally. In fact in this regard it is said it is better to "work with the client than with the client's defenses." Conflicts, on the other hand, do not succumb to half measures. Defenses must be aroused, named, stressed, and broken in

titanic struggles. **Therapists often divide into the two camps based on their individual eagerness or reluctance to challenge and confront.**

Freud of course is the man who gets credit for 'inventing' the conflict model. The psycho-dynamic tradition is named in part for an emphasis on conflict The humanist psychology tradition arose partly in response to the inherent asymmetry of the conflict model where the therapist does the confronting and the client does the adjusting (possibly recreating the original narcissistic injury). However, humanism took the deficit model a step further by implying that all deficits were really only deficits in *morale*, and so the therapist does not have to have greater understanding (just great empathy).

Wilhelm Reich and Alexander Lowen in some way married the two models by describing a process in which early conflict produced body and nervous system development that was deficient. The conflict existed in the past but the deficits exists now **(but importantly the deficits are not just ones of morale, but ones of neuro-muscular capacities**). Bodywork addresses the deficit model and character analysis addresses the conflict model.

However, within bodywork, the polarity recreates itself. Classic bio-energetic exercises are about confronting a conflict physically. They are 'stress' positions. Alexander Lowen prescribed bodywork on the basis of deficit but led it on the basis of conflict. But in my work, it has come to be my conviction that the idea of developmental stall is very relevant especially to 'early' characters, and that a less conflictual type of bodywork, neuro-muscular training, is beneficial. After all, a stressed system may *adapt* further, but it does not *grow,* either in strength or discrimination.

The extent to which character armor is given teleological explanations in the Lowenian analysis has been unsatisfying to me. That is, that the ultimate effect of character armor being the cause of that very armor's original development would make sense if a human will had interceded and managed the process, but it seems too glib in itself to explain a purely biological event. Likelier, character armor is the oft-repeated result of trial and error in adaptation among the biological and developmental forces occurring in a young human.

In Reich and Lowen therapy, (and all effective therapy) deficit work will itself lead to a particular conflict. Most early 'pre-oedipal' character structure have adapted secondarily to a regressed role. Assuming the adult role–both the burdens and the prerogatives is the implied goal of deficit work and so may be resisted.

Substituting the Extraordinary for the Ordinary

The drive to do extraordinary things is driven by three things: 1) genuine creativity, 2) narcissistic injury, and 3) a difficulty doing ordinary things.

Most recently I have been intrigued by the third reason. It seems that when activities of daily living, through sensory defensiveness or other reasons, lack satisfaction, that compensation is attempted through doing the extraordinary. Examples are being an astronaut or achieving samadhi, etc..

But when there is no satisfaction in the ordinary, there will be no satisfaction in the extraordinary.

Describing as Prescribing

There is a small trend in popular works on emotional health. A healthy state, like social adjustment or self-confidence, is described by the specific elements that indicate it. So far so good, sometimes this clarification has value. But then it is suggested or implied that reading the description is in itself a means to achieve this state–that is the description is presented as a prescription. The work of John Gottmann comes to mind–the excellence and accuracy of description is indisputable, and that must have considerable value, but it is not clear how to get from 'bad' to 'good.'

Generally a good thing is recognized when one sees it, but in the arena of good feelings there are usually barriers to achieving this by mere imitation.

Four Ways to Get Stuck

Stephen M Johnson is certainly a proponent of the Reich and Lowen tradition, but he does work more from the object relations end than the drive end. In his book *Symbiotic Character*, he takes Ronald Fairbairn's internal object relations and describes four adaptive styles to a negating force (internalized bad object). I think for clinicians, this description has great value, so using Johnson's/Fairbairn's work as a starting point I would like to expand on these styles below (including naming them descriptively rather than numerically):

Overcontrolled

Here the person identifies with the bad object against the self. The bad object is veiled in the guise of principles or scruples.

- Applies inhuman or impossible standards to themselves, somewhat more lenient standards to others. Identifies with succeeding in meeting these demands.
- Appraises self quite harshly, and others merely harshly.
- Keeps others involved by keeping the focus on should/good/right/best
- Self-observation over-active, and action is not natural or spontaneous.
- Exaggerates the rights of others. Considers violating social norms the same as violating the rights of others. Tries to follow social norms assiduously. In quite a quandary when social norms conflict because there is no option except to try to make things work.
- Internalizes responsibility, internalizes failure.
- Takes responsibility for all bad outcomes, even unforeseeable ones where he or she acted reasonably and responsibly.
- Assigns self tasks where the effort and cost obviously exceeds the benefit
- Behavioral and expressive repertoire constricted, but subjectively, this is viewed as discipline and not incapacity.

- Views self as deficient, although may have substituted his or her own reasons and superficially rejected parental criteria for criticism. Strong sense of guilt.
- May have superficially replaced family-of-origin repressions for a set of 'more enlightened' but equally limiting beliefs.
- Difficulty relaxing, must keep busy to control feeling (unless depressed)
- Uncomfortable in unstructured situations where there is no 'normal' or 'correct' behavior. (Fears punishment for inappropriate behavior of course but also does not trust self to be able to determine that)
- Resents less constricted people, but has trouble criticizing them plainly.
- Will inconvenience his- or herself greatly to prevent small inconveniences to others.
- Has trouble distinguishing between the wishes of others and the demands of others
- Will tend to punish self, calling it self discipline. May punish others, but this is completely unconscious

Excitable/Escaping

Here the 'self' 'sneaks' out on the bad object periodically, which blows off tension, but ultimately returns, like a runaway child, for punishment.

- Inconsistent in applying standards, to self and others, being harsh or lenient and having difficulty finding a balance.
- Usually fairly balanced (if not objective) in appraising self and others
- Keeps others involved by exciting/seductive/bad/dangerous behavior
- Self-observation inconsistent
- Blames self for keeping others from acting effectively in their own behalf
- Respects the rights of others
- Externalizes responsibility (usually), internalizes failure (usually)
- Tends to comply superficially with expectations, but episodically rebels or 'acts out'
- Does not try very hard not to get caught
- Violates social norms (sometimes flagrantly) but does not violate the rights of others

Protesting

Here the person, like in the over-controlled ego state, identifies with the bad object against the self, but will start to protest at times of stress. Sometimes psychotherapy will help the person move from over-controlled to protesting, but if that is all that happens, there is little real benefit as this is still a very repressed condition.

- Applies inhuman or impossible standards to his or herself, but protests the demands as if they come from others, and identifies with failure to meet the demands. In the course of this, applies such demands to others but doesn't enforce them.
- Appraises others quite harshly, appraises self merely harshly
- Keeps others involved by keeping the focus on what has been unfair/hard/out-of-reach (reproaches and laments)
- Self-observation over-active generally, dissociates from own hostile displays

- Exagerates the rights of others, except where he or she feels they cannot succeed in giving those rights, then flips and protests the other has no right to expect this etc…
- Considers violating social norms the same as violating the rights of others. When social norms conflict, blames somebody
- Internalizes responsibility, but externalizes failure
- Complains of powerlessness

Punishing/Abusive

This is the ego state that is described by "identification with the aggressor." The person 'becomes' the bad object, and projects the vulnerable (and hated) self out onto others.

- Applies inhuman or impossible standards to others, and enforces them sadistically. Holds self apart from and vigorously resists standards being applied to self.
- Appraises others quite harshly, although may be seductive. Appraises self quite highly (though may not believe it.)
- Keeps others involved by demands and accusations
- Self-observation under-active
- Violates the rights of others, justifying it as righting wrongs
- Disregards social norms, but may try to enforce them on others
- Externalizes responsibility, externalizes failure
- Often gravitates toward positions of power, police and military are obvious, and can be plainly abusive, but may also be in a position where others can be judged and limited such as teaching, criminal justice, and social work.

Common Features

- Joylessness and pleasurelessness
- Lack of real desire or purpose
- Tension in body
- Insecurity

Inspiration as Junk Food

As a therapist, I am chronically engaged in the study of what practices decrease human suffering. I am also engaged in the study of human growth, to the extent that growth can decrease suffering.

Everyone is aware that the most popular approaches to this undertaking are inspirational ones–Wayne Dyer, Eckhardt Tolle, Deepak Chopra, Tony Robbins, John Bradshaw to name a few. In these approaches, the recipient listens to a colorful speech or reads a book and feels his or her outlook on life has really changed. Now I am sure that these speakers help people and say many true and profound things. **But largely this is just a transference cure through identification with someone who acts out the image of 'having it really together.'** And the image of having it really together is put across with a flow of truisms.

Truisms are abstract summaries that don't include any actual practices. **Any topic discussed at a high enough level of abstraction sounds profound.** But there are no choices to make! Hearing truisms provides a sense of fitness without any steps being taken. The preference for live speaking or video in this area is not incidental. With every truism, the brain receives a blip of dopamine, and the mental state may be positive briefly. Almost never does this transfer to doing something differently. On the other hand, concrete practices, like breathing exercises, stretching, or even regular self-disclosure in a close relationship, if stayed with, bring about substantial if subtle changes in a life. **It's about changing the body, not the slogans.**

I have had therapy clients that were quite laudatory about the truisms in my web site (I admit I have quite a few!) but quite surprised that therapy was not about generating more truisms but about actual practices that had been summarized by those statements.

Durable Helplessness Not a Mental Mistake

There is an undisputable phenomenon in mice and humans (and all mammals in between.) The experience of being *helpless to protect oneself* can induce a durable (that is not necessarily permanent but possibly permanent) biological state in which attempts to help oneself diminish markedly, even in subsequent situations where the possibility of helping oneself is available and not even strongly hidden or hard to see.

This is called '***learned helplessness***' and it is a term and a construct that I have not questioned until recently. Now with mice of course, 'learned' implies conditioning, but with humans 'learned' implies a mental (or worse moral) mistake, since even if conditioning is an element, humans are 'expected' to recognize what is happening and either assent or contravene the conditioning by force of will.

A couple of definitions are in order. *Powerlessness* is the inability to control other people and events to further one's interests. Police and politicians have limited legal power, for instance, and the rich have some power to control conditions, but as humans, ***powerlessness is actually the normal state.*** It becomes an issue after narcissistic injury when the wounded party believes he or she should have this power, to make things right. Powerless is not the subject of this post but I define it here to better define helplessness, because in our deeply narcissistic and narcissistically-injured culture the two are confused.

Helplessness is the inability to protect one's integrity because one's native abilities are exceeded by the threat, and help cannot be recruited. A baby for instance is constantly on the verge of helplessness except for being able to recruit help from caregivers. If the caregiver is inadequate, the baby is actually helpless. Action-adventure movies often display implausible situations where the hero is rendered temporarily helpless by an evil genius–this is an primitive universal fear that fascinates us. However, in the movies, the hero is never daunted. That is inaccurate physiology.

The actuality of being helpless strongly induces the dorsal vagal freeze response. If this is not promptly reversed (in superheroes this is by implausibly skillful active defensive actions, but in normal humans needs to be done by say by trembling or crying), the freeze response becomes embedded in the person.

In chronic threat, there is no time to recover. Freeze becomes chronic physiologically which means submission becomes chronic interpersonally. Submission of course at times is the best response objectively, and so may be simulated. But physiological submission is involuntary, and renders the person truly helpless. Some would say that is its purpose–to create a circumstance in which predators have no worry and so relax–but I dislike teleological explanations. The question has been why is this state sustained well past the point when circumstance have changed?

An example is the actions of some recipients of intimate partner violence. Often it is noted that even after successful separation from the abusive partner, there is an ineffectiveness of self-protection, even if there is high-level performance in other areas of life. Learned helplessness disables the normal threat detection system of everyday life.

For this phenomenon I think the term durable helplessness is more accurate and less pejorative. Physiology as basic as the autonomic system is much more powerful than objective insight and this is true as well within the bodies of scientists. An avoidant attachment style may mean that little submission occurs short of gunpoint, but this does not rule out a strong chronic freeze response. Intellectualism is in part a by-product of the dissociative aspect of a dorsal vagal state.

Modern Medicine Dismisses Skill

Well at least health skills in patients. Health behaviors are requested from patients, but only unskilled ones! For instance, in asthma and obstructive pulmonary disease, no breathing skill is taught or even considered. In diabetes, eating (more than just avoiding something) might be considered a skill, but patients are told to eat anything and just keep adding insulin. And of course, in the voluminous area of inflammatory disease (which includes most 'auto-immune' disease) patients are steered away from any social, spiritual, or even breathing or kinesiological skill that would reduce physiological stress or inflammation. Drugs of course, are the epitome of 'unskilled' interventions–certainly unskilled for the recipient and perhaps largely unskilled for the prescriber.

It wasn't so drastically that way say 50, 40 or even 30 years ago. I don't think allopathy is intrinsically against patient skill. Why the change? Well Big Pharma has certainly been a factor. It funds most research and it certainly won't fund research on drug-less skills in living. Traditional health recommendations, like rest, relaxation, vacations, enjoying life, breathing slower, romance, meaningful hobbies, eating for true pleasure, etc are not based on double-blind studies and so it is now considered malpractice to recommend them. Physical therapy, formerly a storehouse of advice and training in posture and movement, is now treated as a crutch and wheelchair dispensary service.

Also skills are hard to make into independent variables for research because some participants might not really master the skill (and some of the 'controls' might already being practicing the skill) In this way, skills are never proven 'scientifically' and so no longer get recommended. Over the last few decades, health skills have been lost in the mainstream, and in medical education.

The Most Important Difference

The most important difference in growth is between almost nothing happening and actually nothing happening. Think of a child at 8 or 9 years of age. Nothing seems different than the day before but the child is growing rapidly and this is readily apparent over the months and years. Almost nothing happening is in fact the pace of even rapid change from the viewpoint of the ego.

When a therapy client reports to me rapid change or a breakthrough, it is almost surely a placebo effect or a demand characteristic. These are much larger and much quicker, but of course not cumulative or synergistic with growth. Real growth, where it is happening, is always concealed in the troughs of the placebo effect, which confounds the results of therapy no end (unless therapy is multi-year).

Of course, actually nothing happening is possible as well. How does one tell the difference? Well real growth is noticed by other people first. Other people do not feel our placebo effect. And unless they are the one 'demanding', they are unimpressed by demand characteristics. A slang term for this is JND, or 'just noticeable difference.' Often other people won't mention this, because they are unsure it is real. They also may have a hard-time putting their finger on exactly what is different.

Why Allopaths Do Not Trust Their Patients

In a previous post, I explained why I believe that most allopaths treat the mind not the body. I recently heard Dr Majid Ali reiterate that the mind is the only part of the human that lies. The body does not lie. Of course, this was also the creed of Wilhelm Reich and Alexander Lowen, but it is interesting to hear it from a physician who is practicing internal medicine, not psychotherapy. Of course when the term lie is used in this context, it is no deliberate malice that is referenced, but the general tendency to endorse an ego image and be alienated from physical reality as reflected in one's body.

I then realized the source of rampant distrust between allopaths and patients today: allopaths are treating the mind, which sometimes lies, even the mind of a good person. These doctors then have to be wary that they are treating liars, and so do not readily respond to patients assessment of the treatment. Yet these allopaths are unable to treat the body, as detailed in my previous post.

How Authority Trumps Evidence in Healthcare

I do not know if this is true in other practical applications of science, but in health care, authority picks and chooses the evidence it endorses. "Evidence-based medicine" exists partially of course, when the evidence points to what is consistent with mainstream values. Some areas simply aren't controversial. But quite more commonly than people think, evidence is undermined. In an area as hard to objectively study as humans, evidence may point in more than one direction. Below are some ways that authority steers the evidence

Meta-study Mortality. It is well understood and agreed that in any study once a participant is enrolled, that the result for that subject cannot be vacated casually even if the results don't seem right. In random-controlled trials the term for having less data points in the final results than were started is called mortality though it rarely means actual death. Meta-studies are undertakings where data from previous studies on a topic are added together and re-manipulated. The object ostensibly is to strengthen confidence levels in the data, by increasing the 'n', adjusting for methodological problems (not by changing what was done but by *statistical manipulation*), and creating a single uniform conclusion. Of course no study is exactly like another and so some studies must be excluded. This is exclusionary function of course works not as a subject by subject mortality (forbidden) but as a component study by component study mortality (allowed) It is easy to imagine how component studies that yield a result that is contrary to what authority thinks it 'should' be just have a tendency to seem methodologically flawed, because the determination of what methods were flawed is *subjective judgment*.

Declare Unwanted Results Incomprehensible. This when in fact, the results fit an out of fashion and parsimonious opposing theory. For an example see the ACCORD study. In that study, better blood glucose control achieved by intensive insulin administration increased the death rate. This fits the model of many prominent dissenting voices that diabetes is a disorder of insulin toxicity. However the mainstream researchers did not even mention that possibility but declared the results simply '*incomprehensible!*'

Refusal to Act in Accordance With the Data. This happens much more than people realize. Here is an example from the academic medical center where I work. It receives trauma patients from all over the region, and naturally drug and alcohol use is a known contributor to trauma. and especially repeat trauma. A study was done to measure the impact on subsequent drug and alcohol use by a brief chemical dependency intervention done for men and women who were patients for drug and alcohol related reasons. The study showed quite clearly that the intervention ***increased*** subsequent use. To those familiar with addiction this makes sense but it is not the point to made here. What happened? The intervention was made permanent and standard, because the people deciding what happened believed that is what should work, and they would be uncomfortable not doing it. That is authority totally contravened the evidence.

Nullifies Clinical Experience. Front line clinicians are expected to act uniformly according to authoritative dictates called 'standards of care' It is considered malpractice to tinker, even based on the results the clinician is seeing with his or here patient demographic. This is meant to improve care, and often does, but one can see how a bad idea that has become recommended would persist for longer this way than it would otherwise.

Makes Small Advantages Absolute Even if the data shows a tiny clinical effect, when it becomes a standard of care, it must be done. There is no way to judge if the costs outweigh the benefits in a particular situation. Statistical significance is not clinical significance. Often very small effects are deified this way. For instance a new drug does not have to be shown to do much, it only has to be shown to do 'something' faintly positive, and then it becomes malpractice not to use it.

Creating Smoke In real life situations, smoke usually means fire. But this can be manipulated. Hypotheses that authority feels 'ought to be true' are studied over and over

again (both because it is favored in professional circles and because it is what grants will pay for) Even if the evidence is inconclusive, it seems there must be something to it. The chemical imbalance theory of depression is along this line. Meanwhile studies that raise unwanted questions are not repeated and not cited, this has been called cul-de-sac epidemiology

Line and Dot Control Studies only produces dots of knowledge at best. Producing understanding requires 'connecting the dots' This is theorizing. Of course anyone can theorize. But orthodox theorizers in authority are considered to be merely obeying the dots they include. They also have the power to steer new investigation of course because money will fund studies along points of the lines that authority has drawn. Meanwhile politically-incorrect dots will be isolated (although less so in the age of the internet.) A lot of the work in my main website Reich and Lowen Therapy is about connecting the dots.
Michael Samsel

Purposelessness and Purposeless Violence

Everyone is mindful of recent mass killings. People seek to understand why. In such tragedies there are no personal grudges and no personal gain, and unlike serial killings, no sexual element. The perpetrators intended their own death. And these massacres are planned and executed in cold blood. Unimaginable!

Horrible as it is to write it, I believe the motivation is *to have a purpose,* even if just briefly. Alexander Lowen, in *Betrayal of the Body*, wrote of desperation and its increasing presence in our society. Desperate men and women have no feeling and also have no felt purpose, and perhaps this is why Charles R Kelley described Reich and Lowen work as *education in feeling and purpose*. Complete purposelessness leads to horrific personal suffering.
It is well known that many desperate people find energy and good feeling when they decide to kill themselves. This self-destructive plan provides a purpose and relieves suffering. It only does so if the plan is sincerely pursued–that is the nature of purpose. In the mass killings, the desperate person also finds a purpose. The drive to find relief of suffering is strong.

Why death? Why not a constructive purpose? Because these individuals have loss faith in life. They are alienated from the living. They taste death and seek to show death to the rest of us. The interest in limiting the availability of guns is natural and wise. However, there have been mass killings in China and elsewhere with knives. An even more pertinent concern would be with alienation, not just 'mental illness' (however that is defined) but alienation from life.

Holistic Lipservice

I was recently talking to someone who, in the last year, has been suffering from many urinary and pelvic symptoms and who had been been to *many* urologists and gynecologists without much help and with *no* clarity.

I mentioned the idea of *interstitial cystitis, e*specially because I knew of this persons history with depression and anxiety. None of the MDs had mentioned this possibility. I brought up the idea with the spoken caveat that allopaths rigorously resist the idea that emotions have anything to do with the body. A third person who was present at this conversation stated "I think its pretty well accepted by medicine that emotions do affect health"

The sufferer, who had had to put this to the test, had to agree with me, that of the practitioners she had seen, none of them ever proceeded as if emotions or stress were relevant. They were instead only looking for arcane micro-organisms etc. While it is easy for a health care provider to entertain the emotion/body connection as an isolated truism, the allopathic treatment procedure for any actual patient or symptom ignores emotion and stress. In fact not only is considering the mind-emotion-body connection not required in community treatment standards, it is considered to violate those standards!

Interstitial Cystitis is a *syndrome of disrupted homeostasis* (a term coined by Robert Scaer MD) That means that by definition, the symptoms alternate and wax and wane. Though such disorders are epidemic in our hurried, stressed, self-negated culture, allopathy is usually quite incensed by a patient who presents this way, and such a patient is usually spit out after months of diagnostics with the label 'somatization' officially and 'crank' unofficially. If there was ever an area for 'holistic understanding' this would be it! This perhaps highlights how lip service to holistic concepts is often superficial and irrelevant to how MD's actually practice.

It Matter Over Mind, If You Please

Frequently I am discussing a health issue within someone unfamilar with the Reich and Lowen tradition. As my emotion- and feeling- centered conceptual framework starts to show, the other person often quickly blurts out "Oh mind over matter" That is, when an interplay between body and mind is suggested, the common modern sensibility can often only think of the mind being in charge. The human ego has a hard time believing it is influenced by natural forces. Actually the lesson of the Reich and Lowen tradition actually is that it is usually matter over mind, as described below and in the main website under the heading of functionalism
Cartesian Dualism (The viewpoint of most scientists during working hours)

- Mind and body function completely independently
- The mind is superior to the body, because it can affect the body not directly, but through instrumental actions, to the limits of human thought and ingenuity

Mysticism (The viewpoint of most scientists in their personal lives and ambitions)

- Mind and body function independently except when the mind chooses differently
- The mind is superior to the body because the mind can affect the body and the mind can exist independently of any body

Functionalism

- Mind and body are a unity
- Humans overwhelmingly only experience them separately

- The mind and body affect each other directly, and although suffering can be somewhat greater in one than the other, the state of one cannot be *essentially* different from the state of the other (see the first bullet in this section)
- The body affects the mind much more strongly than the other way around, it is not symmetrical
- The body is superior to the mind because the body gives rise to mind, it is possible to have a body without a mind, but not a mind without a body.
- The mind can also affect the body through instrumental actions, but in a positive sense only if in accord with functional biological principles.

Cool Your Brain for Free

I happen to be attending a lot of 12-step meetings lately. I recommend these program to anyone who wants to grow as a human., whether there is behavior one wants to stop or not. The 'religious' aspect is often cited as an obstacle for some. I find that the permissive references to 'god' or a 'higher power' is just a call to humility. Benefiting from the Reich and Lowen tradition has always involved accepting one's place in a natural order that one doesn't control. The 12 steps center around humility and honesty, two body-based valuesthat give balance to the over reaches of the ego.

The basic in-meeting 12-step therapeutic technique is ***no-crosstalk-listening*.** This simply means that participants take turns talking while everyone listens without interrupting and with the understanding that they will not respond to the speaker. With time, in the listening role, one stops mentally formulating a response as well, and this is where the benefit kicks in. Without the need to defend one's point of view, the limbic areas of the brain and the autonomic system cool, while the cranial nerves (eyes, ears, throat) are activated. This is nothing other than a ventral-vagal shift. One could space out, and the benefit would not accrue during those moments, so interest plays some role, and the sincerity of the speaker plays some role in interest. Dissociation is defensive however, and with nothing to defend, dissociation recedes.

Honesty is encouraged as well, because the reception is the same whether one speaks honestly or dishonestly, sincerely or insincerely. This is more of a psychological benefit than the biological one described above.

Of course useful information is exchanged this way, but the benefit I am referencing is independent of insight or learning. Many indigenous cultures have a similar ritual.

Asperger's Freed From the Clutches of the APA!

I have, of late, been very interested in the construct of Asperger's Syndrome. Now from a Lowenian perspective, Asperger's traits have always been covered under the schizoid or creator character. As the reader may know, Lowenian characterology is a hard sell, because of the depth of the concept. By depth I don't mean abstruseness but rather comprehensiveness as far as all areas of human functioning. It seems that that a person's entire self-concept is

being questioned (it is in fact usually) and people are uncomfortable with that. However, Asperger's has found a place, albeit controversial, in mainstream discussion, despite being a deeper look at human functioning than is usually tolerated.

Perhaps this is because, in the construct of Asperger's Syndrome, little or no social criticism is implied. In fact, Asperger's is an outsider's point of view, the point of view of 97-98% of society that do not have the traits. Whereas Lowen described the inside point of view (in his case derived second-hand) in which the problems for the schizoid character were described, Asperger's is largely defined by the 'annoyances' presented to other people. It was for this reason that for a long-time I eschewed the construct entirely. However, I have come to believe that, from a secure enough base, Asperger insiders (aspies) could derive great value from this outsider's (neuro-typical) point-of-view. This is because of the immense observational detail that is available when aspies and neuro-typicals alike begin to share experiences in a context of curiosity. Here is my current article placing Asperger's traits in a body-mind context.

The construct of Asperger's never had an easy time fitting into the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA). It is now being deleted. I believe they are doing the right thing for the wrong reason.

Placing a 'diagnosis' in the DSM makes it 'legally' a disease. There has been an corporate and bureaucratic outcry that accommodating Asperger traits as a disability in work and school is starting to cost too much and that the potential cost is enormous. Hence great pressure to drop it from the DSM. Of course the APA cites over-diagnosis as a result of subjectivity in the criteria as the more seemly way to put it.

The DSM has always been a very adversarial undertaking, with healthy psychiatrists on one side of the codes and unhealthy and deviant patients on the other side. That is why most criteria therein are extreme. The DSM is certainly not a look at human functioning or even suffering, it is a nomenclature for individuals found disruptive by self-appointed social monitors.

But *recognition* is a different activity than diagnosis. Recognition brings benefit and understanding and doesn't require APA approval. Recognition of Asperger's has lately flourished but it has been hampered by running up against very narow DSM criteria. The criteria were kept narrow not for sound clinical reasons, but for arbitrary reasons of 'rationing.' the sick role. Now recognition of Asperger's can continue, with less confusion sown by the APA.

Incidentally, the rest of the world uses the ICD-10 for both 'psychiatric' and 'non-psychiatric' diagnosis. The US uses ICD-10 for everything except 'psychiatric' diagnosis. What does this say about American Psychiatry that it needs a unique definition of problems? Presumably, the ICD-10 is retaining Asperger's Syndrome and its criteria have always been broader.

Why is This Grave Danger so Compelling?

Autoerotic asphyxia is masturbating while depriving the brain of oxygen. It accounts for 250-1000 deaths a year in the United States. No one discusses doing this openly because the foolishness and grave danger is so apparent. So why does it persist?

Because humans crave full orgastic release. Lack of oxygen weakens the brain's inhibitory control over the muscles and makes way for powerful convulsive movements with orgasm. This is the orgastic potency that Wilhelm Reich talked about, achieved in an incredibly stupid and dangerous manner. One goal of Reich and Lowen therapy (admittedly a lengthy process) is to achieve the muscular freedom for this to happen without hypoxia.

What Do 'Socemes' Really Teach Us About Life

Soceme is a term I just coined (after the style of meme) It refers to any human tendency demonstrated in social psychology experiments. One example is the tendency for individuals in an anonymous group not to help in response to a general appeal, but to help if addressed directly. Another is the tendency of a subject to change an answer he or she knows is correct to conform with others in a group. There are many, many others.
Now I am a great fan of social psychology. This is because, unlike clinical psychology, social psychology discusses what usually actually happens instead of what 'should happen' The question is whether the real trajectory of a life can be altered this way. Socemes are not the type of thing that can be chained together or made into foundational traits. They are temporary sidesteps, relevant to marketers (who need to gain only a moment's attention) but not therapists. It is interesting to note that most 'pop' psychology, as in *Psychology Today* magazine discusses socemes and not fundamentals of emotional functioning.

Evidence is in, it is the Therapist That Matters

One thing that has disappointed me, and I think disappoints most therapists who are honest with themselves, is the gap between the aspirations of therapy and the *average* result.
The effectiveness of therapy (at least the effectiveness of what usually happens) has been studied very extensively, at least for most mainstream, conversational therapies. An excellent summary of these research results is done by Bruce Wampold in his book The Great Psychotherapy Debate. This book constitutes a meta-analysis of meta-analyses. The book demonstrates both the strengths of the 'scientific' method in understanding human change, and the weaknesses. Wampold emphasizes the former much more strongly than the latter.
The bomb for me came in the eighth chapter: **the greatest effect demonstrated by any factor in therapy is the difference between therapists within the same method. This is greater than even the average effect of therapy versus no therapy.**

This is in fact what clients are looking for, an individual that can 'make a difference.' A client need only find a single therapist afterall.

Wampold has his prejudices. He excludes from his meta-analyses any studies of body psychotherapy a priori– not from any empirical data but because of personal distaste (body-mind split?)(Chapter 9, pg 224). This is of course disappointing and irksome to me, because as readers will know, I have a strong conviction about the effectiveness of body psychotherapy. Alas, this type of therapy is not likely to be studied anyway, some of the reasons being listed in a previous post.

When it comes to distinguishing therapy methods, it seems that no difference has been shown. This is a difficult result to accept but the results are so overwhelmingly, as least in regards to typically rendered therapy, that it has to be accepted. This has given rise to the common factors theory. To oversimplify a bit, the common factors reduces the effect of therapy to 'being really nice' to clients.

Now I am inclined to believe that there are two tiers of therapeutic results. A first tier of on average milder results due to common factors, and a second tier, of much rarer but much more startling results due to real skill. I believe this is responsible for the ambivalent attitude toward therapy in our culture–it is both seen as generally ineffective but potentially life-changing. Now I must immediately point out that to back this explanatory model onto actual study results violates a basic statistical ethic. One cannot declare the outliers the real experiment and dismiss the neutral or small effects as not really the experiment! But how else can one study excellence?

But another factor is also demonstrated, the more the therapist believes in a method, the more effective they are! Wampold posits that this is because the strong placebo effect in this arena is enhanced by the sincerity of the therapist. Perhaps this is a factor, but I am not convinced.

Sometimes the question of therapeutic effectiveness has been summarized in the question [pardon the historical sexism] "Is it the man, or the method?" Well given Wampold's results about therapist variability, I believe both are necessary, neither is sufficient. Only a therapist that really understands a method can believe in it, and a method is only really employed if the therapist understands it. I believe that effective therapists are relatively rare and more or less equally distributed across methods. Some methods may be more effective than others but this is hard to demonstrate because results are diluted by the mass of therapy that is only supportive, and the mass of clients that are superficially engaged.

Two Sets of Books is not Crooked

David Shapiro is a therapist and writer who has partly followed the same fork in psychoanalysis toward character as did Wilhelm Reich, but he completely eschews the body, so his work reverts back to a highly cognitive *resistance analysis*.

He discusses a type of resistance he calls "two sets of books." This is when a client sometimes describes the environment unrealistically to the therapist's point of view (when defending how he or she feels) but sometimes describes it quite realistically (when facing concrete consequences.) He places a great deal of the responsibility for the client's suffering on this practice (which may be accurate, but seems to think of it as casually willful. Shapiro 'solution' is just to "stop it". He wants the client to start adhering only to the 'consensual set of books'

since it is proven he or she can. This is the foundation of all cognitive psychology, doing what one is capable of by will, inclinations be damned!

Surely with the 'unrealistic set of books' Shapiro is referring to the client's *felt* experience, which is a product of character interacting with the environment. With the realistic set of books, Shapiro is referring to the client's intellectual conclusions, heavily weighed with the expectations put upon him or her.

This split is the cause of suffering, but the solution is not completing the split by subjugating the feelings once and for all, but rather employing bodywork and expressive work to bring about harmony in mind, body, and environment!

One's internal experience is always compelling and it should be that way. When one's internal experience is not explainable by currently acceptable social constructions then it is natural to have two points of view. This is resilience of the organism. It is the limitations of this internal experience imposed by character that is the problem, not loyalty to feelings. Everyone in our culture must have two sets of books to some extent, but we do our best to hide it. When the split is very severe, it is harder to conceal. A therapist invites a client to reveal their splits, a body therapist by attention to the body and feelings, and a verbal therapist by asking the client to say "what's on their mind." It is cruel to make this a search and destroy mission.

Medical Calvinism and Oxygen

I have worked as a registered nurse for 26 years in a variety of settings. Supplemental oxygen is a cheap, well tolerated medical treatment available widely for six decades. (Only in extremely high concentration does it seem to have toxicity) One of my duties as a nurse, it has been modeled to me, is to wean (take away) oxygen as soon as possible. For a long-time I did not question this– it seemed self-evident that 'crutches' should only be used as little as possible.

I have come to wonder about this however, as I have started studying breathing. One of the main goals of the Reich and Lowen tradition is to increase oxygen available to the tissues. Now the healthy human body can breathe effectively enough to oxygenate for well-being without supplemental oxygen. However, once the entire respiration apparatus is out of kilter, as it is not only after a major illness, but in most of us most of the time, supplemental oxygen can have a role in rebalancing breathing because tissue hypoxia tends to perpetuate a state of physiological panic. For this see the work of Michael Grant White at breathing.com, or Majid Ali MD at majidali.com. Both discuss the use of oxygen apart from breathing emergencies.

Yet in general medicine, it is viewed as a moral hazard, if not a physiological one, if oxygen is used one second more than necessary. But oxygen use does not seem to cause up-regulation like opiates or tranquilizers (that is, there is no tolerance and no addiction) Despite this, it is considered good to limit it vigilantly. Well there may be some practical reasons, but the point I wish to make is that limiting oxygen is over-determined by pleasure anxiety. That is, oxygen gives people good feeling (if it gets to the tissues) and the concept of good feelings that are not 'earned' is threatening to many. Allopathic medicine is comfortable taking away bad feelings,

but distrusts anything that provides good feeling (the artificial good feeling of opiates is tolerated, because they are conceptualized as taking away pain.)

Just as with the blanket prohibition against saturated fat, or salt for non-salt-sensitive people, where there is only equivocal evidence, recommendations are based on a type of medical Calvinism which sees real pleasure and feeling as depraved and inimical to health.

Transference in Therapy, the Best Tool?

This discussion is not about the existence of transference or even the nature of transference in a therapeutic relationship. Rather, the question I wish to pose, is whether, as is sometimes charged, in the Reich and Lowen tradition, especially in Lowen's bioenergetic work, transference is not treated sensitively enough, and the relationship between the therapist and client is not explored adequately. These doubts have given rise to schools of 'Relational Somatic' therapy, meant to remedy this.

Transference has many definitions, but for Lowen it seemed to involve the client feeling and behaving toward the therapist in a way that is not fully realistic given who the therapist is and what the therapist has done. The client's perception and client's experience of the therapist arises out of the client's need to heal from an earlier relationship. F**rom this perspective, Lowen felt transference was more something to be kindly weathered in the therapy rather than something to get involved in**. In this, he split from mainstream psychodynamic therapy quite sharply.

It is not that Lowen considered transference trivial. Nor did he believe that transference was just a matter of distorted perception, or acting out symbolic roles (as family therapy does.) Rather, he described transference as an actual energetic attachment, made from the same energy that love is made from. An implication of this, is that low-energy clients (who are the majority) require a long-time to develop transference 'naturally.' Earlier distortions are 'run-of-the-mill' projections, which can be informative, but do not provide 'traction.' Reich, because of his strong personality, was able to perhaps to speed the development of transference. To the extent that bodywork increases flexibility and contact, it may 'speed' transference.

'Relational' work may be less effective early, when less energy flow is present. The most benefit may come from increasing grounding, vibration, and expression. Of course clients may be more 'involved' and actually 'work the program' more earnestly if transference is strong. But transference has many pitfalls, as is well described in the literature. This reality of course is not a license to deny transference of course. But if transference is a spontaneous, unpremeditated phenomenon to which all important relationships are subject, than therapists need not be under any special moral obligation.

There also is a phenomenon known as 'transference cure' or as Arthur Janov termed it, 'present symbolic fulfillment.' A client will tend to feel modestly better relatively quickly in therapy because of the effect of undertaken to do something about the suffering and the effect of having someone care about him or her. This can accentuated if much re-assurance is used or if the personality of the therapist is 'magnetic.' This easy cure, however, decays quickly, and

actually interferes with deeper work. The modest effect of most therapy that is recorded by investigators fairly soon after termination is likely mostly transference cure.

As a practical matter, the concept of transference often arises when special treatment is demanded or expected. That is, transference wounds are often declared when a therapist says or does something that is not inappropriate in itself, or makes some small human mistake that touches a painful sensitivity in the client. While this must be acknowledged and dealt with, it should not be so demonized that the therapist tip toes around and acts artificially. There is far too much of that in most therapy, and to my mind, that constitutes therapist fear of the transference more than the somewhat side-stepping Lowenian approach of redirecting attention back to bodywork or character analysis.

The biggest controversy is whether transference needs to 'be resolved' by relational behavior later in the therapy. Reich and Lowen seemed to believe that transference was an artifact of an armored state. If enough 'health' came into the client, both the therapist and other people in the client's life could be related to realistically. Transference would fall away. Because transference belonged to the earlier phase, it could be counter-productive to attempt to resolve the transference by discussing it.

However, counter arguments are very compelling. Others have pointed out that 1) the original split(s) in the person came about because a good-enough relationship was not available. If the client is to be regressed usefully back to the original split, a good-enough relationship needs to be available to 'catch' him or her. 2) re-organization requires something besides the 'self' to hang on to, it needs a 'self-object' in another person. That is why the person was not organized in the first place, the self-object candidates abdicated their role.

Is Narcissism The Proper Target in Therapy?

A Reich inspired therapist, Jack Willis, has left free on the web an enormously helpful book on Reich's therapy at reichiantherapy.net In reading this book, it is pretty clear that Willis has a lot of disdain for Alexander Lowen which is intriguing but not really explained. In any case he makes the statement that Lowen "to his shame" ignored narcissism, at least until the Lowen's book by the same name came out, and that that book has the role of playing catch-up.

Although I disagree with the shamefulness part, I agree that Lowen did not make narcissism at all central to his theories, and I think this is why: Narcissism is a psychological entity, and Lowen was concentrating on biological work. It is a bit of an over-simplification, but the idea in this tradition is, if one changes the biology, the psychology follows along nicely. The psychological part of the work is only intended to keep the ego from rejecting and fleeing from the biological change brought by the body work. Narcissism is a multi-character if not pan-character phenomenon, and Lowen concentrated on changing character, where he felt the essential resistance resided. He believed that narcissism, in all its forms, was an attempted solution to an emotional dysfunction that at root was biological

The psychoanalytic-based schools were working instead to change the ego into a more flexible, more open, more realistic entity, and of course they found narcissism squarely in the way. But

as intellectually deep as psychoanalysis and its descendents were and are, they are, in terms of the organism, working at a much more superficial level than Reich and Lowen therapy. The book Narcissism was not written to reconcile bioenergetics and psychoanalysis (as surely it does not!) but to end some confusion about whether Lowen and the psychoanalysts were talking about the same suffering people (they were.)

Can Anyone Spit in Their Own Soup?

I was recently contacted by someone who was inquiring if I had any work product along the lines of a questionnaire where 'lay people' could answer questions to identify their own character defenses. I replied that Alexander Lowen never trusted 'self-report' because the defenses a person is really using are going to be unconscious.

Of course many of us know of defenses conceptually, and can identify them in others. **But defenses must be unconscious, and this is why.** Defenses work by making and keeping knowledge and feeling unconscious. But the repressed material cannot be unknown if the 'hand' that is holding it down is known. This was the principle behind Alfred Adler's technique of '*spitting in the soup*'. In his day, when some schoolboys were quite hungry, they would spit in the soup of the boy sitting next to them. That boy would no longer want it, so he would give it up without a fight, because from the original owner's perspective the soup was no longer suitable for its purpose. Adler would describe the defense he thought the patient (client) was using, not as a interpretation, but as an educational moment. The patient presumably would give up the defense, because to use it at that point would become a conscious act, and so unsuitable for a defense.
Of course, people can recognize a defense at times. This seems to occur in two scenarios. One, with material at the 'border' of threateningness. For instance, a temporary stress brings on a bit of say projection, and when the stress is less, the projection is recognized. This triumph is not so much to the credit of insight, but to the credit of less stress, which always lowers defensiveness. Should stress rise again, the same defense may well be used again, despite being previously 'confessed'.

In fact defenses are used because they are necessary. Of course strong defenses limit experience and contact.

Two, a defense is recognized just as it is about to be given up. This can happen in the long term treatment of defensiveness because the person's and the body's capacity for feeling and honest expression has increased. But the 'catch-22' is that defenses must be lowered for this to happen. Hence the incredible complexity of psychotherapy.

Character of course is a complex where limitations are considered strengths by the holder. It might be possible to design questions that speak to aspirations and positive beliefs that would give a clue to character. How ever, these questions would then lack face validity, and so not be suitable as a self-learning tool. If there was face-validity, denial would distort answers.
This makes Lowen's typology completely different from say, Myers-Briggs typology, which is designed with self-report in mind. That is, Myers-Briggs is a measure of what learning modalities the person values and believes they use. Self-report of course may be inaccurate

and inconsistent in this case, but it is not *a priori* unsuited to the task, because it is not about defenses.

But this got me to thinking about bodywork. Lowenian character is defined by the state and functioning of the body. Psychological traits, though fascinating, are just confirmatory correlates. But the body, in our day and age, lacks 'face validity'. That is, the interpersonal and emotional struggle is reflected in the body (actually originates there) but is not recognized as such. That is why bodywork has the possibility of getting around defenses. The participant often has feeling or knowledge arise "out of nowhere" and the ego is not prepared to substitute another defense. (Although over time the ego can adapt, especially by learning to talk about bodywork and not actually do it!)
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Good Feeling Should Not Be a Secret

It has struck me as odd that while almost all cults use the same building blocks as cognitive therapy (cognitive reframes, schema changes, exhortations to think positively, commitment to change, etc) no one thereby alleges that these cognitive techniques are dangerous.

If on the other hand a cult uses any vegetative or body techniques that produce good feelings, it is likely alleged that this 'proves' the techniques are dangerous. What a double standard that just demonstrates widespread pleasure anxiety.

Now meditation is an experiential technique sometimes used by cults. The Reich and Lowen tradition has not emphasized meditation because of concerns it can become quietistic and possibly dissociative. Possibly the greater use of meditation in cults is an indication that it lends itself slightly more easily to misuse, but even here, it is not the inherent effect of meditation but the expert abuse of persons that installs the cult aspects.

Bwagwan Rajneesh gained some notoriety in Lowenian circles for employing bioenergetic exercises. Because of this, it has been 'whispered' that the exercises are dangerous if widely disseminated.

I disagree. Truly most people are starving for good feelings and searching desperately. Anyone who can give such a person a taste of true good feelings will get his or her attention strongly. **The problem is not the powerful or good feelings, but the fact that people have to go to esoteric sources to learn how to get good feelings from their own bodies!**

Making the Word Holistic Meaningful

Although the Reich and Lowen tradition never asked for it, in recent decades it has received the appellation "holistic." Now the word clearly is meant to have a positive connotation, but I believe, outside certain circles, the term 'holistic' is a detriment to credibility of any approach, suggesting mystical thinking. Maybe that is because the word has never been well-defined in this context, but rather has just been used loosely and impressionistically. As long as there is a need for a word like this to distinguish health promoting efforts from reductionistic efforts to block disease, I propose the following definition:

A health care undertaking is holistic if it stimulates, supports, or repairs the inherent self-regulation of the person

Many misuse the term holistic to describe the situation where a person without a medical license prescribes allopathic remedies that do not require a medical license to prescribe. Since on the allopathic side these remedies tend to be less effective it gives the impression that holistic is a synonym for marginal. Since they tend to come from individuals that clearly envy the power of physicians it gives the impression that holistic is simply a ill-guided end run around scope-of-practice laws

The truth is that mainstream medicine usually has no interest in measures that promote health, vitality and regulation, such as light, pleasure, posture and alignment, oxygen, breathing pattern, exercise, clarity, or conviction–*and neither do many so-called alternative providers*.

In the one area that mainstream medicine and holistic thinkers do share an interest, diet, mainstream medicine is only interested in the chemical composition and quantity of food, not in the experience of eating which includes pleasure, satisfaction, and nurturance.
Michael Samsel

Two Types of Warnings

There are two types of warning about an activity: 1) that the the activity *has* dangers, or 2) that the activity *is* dangerous. The difference usually lies not the magnitude of danger but rather in some moral judgment.

An example of the first type of warning is the common caution to drive carefully. Automobiles have the potential to kill people, and a certain number of people are killed every year. But the act of driving is considered so normative, that no one suggests that people should avoid automobiles.

An example of the second type of warning is the media translation of William J. Broad's new book on yoga. Although the examples of injuries he cites should be of keen interest to the yoga instructor community, they do not seem common enough to be cause of a general alarm raised to the public. Adult softball and boating for instance, get no such alarm. Yet yoga is now being headlined as something that ***is*** dangerous.

But Mr Broad is also 'warning' that yoga can raise one's libido and this is its true purpose! I think here is the real reason for the moral opprobrium, whether Mr Broad made it explicit or not. Yoga has the potential of raising one's life energy above what fits easily into our culture. Our society's collective pleasure anxiety is provoked.

The Reich and Lowen tradition has always faced the same double standard. Like yoga the energy it enhances has always been feared by some. This means that any less than perfect

result has been heralded as confirmation of a deep dangerousness. But the many popular activities that do not challenge quiescent life as a mass individual are not held to the standard of perfection.

Now of course attention to safety and improvement is always welcome, whether it is yoga or bioenergetics, or journalism. But there are real costs to doing nothing also, and very real costs to avoiding the body. As an antidote to Mr Broad's narrow view try the article below:

"How Yoga Will Not Wreck Your Body"

Insulin and Glucose Abuse

There is an absolute explosion of diabetes in our society over the last 30 years. It is not just explained by better detection in medical settings, it is an actual verifiable increase by testing non-clinical samples. Allopathic medicine is looking for a cause of this increase, though with its usual bias against anything natural or pleasureable.

Obesity is correlated to diabetes, although not perfectly. Diet is also correlated. Correlation is not causation of course. In correlation either of the correlated things could cause the other, *or, a third thing could be causing both*.

From a Reich and Lowen point of view, the likeliest cause is increased stimulation and the speeding of the pace of life. This causes a sympathetic shift and adrenal activity which raises blood sugar (glucose) rapidly. The sharp spike of glucose stimulates insulin production, which lowers blood sugar sharply, which itself is treated by the body as an emergency which the adrenals respond to emergently raising blood sugar in a burst. Overtime, insulin in the blood actually rises higher and higher, producing insulin resistance. (Though not all the functions of insulin decline at the same rate, for instance insulin's inhibition of fat burning.) The cyclicity and dysregulation of this is obvious. Eventually glucose cannot be controlled by the body and diabetes is first diagnosable by allopathic medicine, but this is actually late in the process.

Two things tend to happen along the way. One, sugar and insulin together tend to produce fat. Two, a craving develops for easily digested carbohydrate. That is, both obesity and a terrible diet appear in the person's life. All these things interact–which is cause and which is effect??

[Classically diabetes arose, usually at puberty, in a body starved for insulin. This circumstance, 'Type I', still occurs but is rare and completely dwarfed by the prevalence of the 'Type II' process discussed in this article.]

A higher blood level of glucose goes along with a doing and choosing frame of mind. Novelty stimulates both the adrenals and the hypothalamus (autonomic center) in the brain, which together raise blood sugar. **Brain cells themselves do not use insulin to take in glucose, so insulin resistance is of no concern of a brain alienated from the rest of the body!** But brain cells do care about low blood sugar because they are voracious and unable to use any other fuel. (Actually, *over time* the brain can adapt to using ketones as fuel,

which possibly can be re-regulating for some brain derangements. This is the principle behind the ketogenic diet for childhood epilepsy.)

The social psychologist Roy Baumeister has shown that willpower is enhanced by higher blood glucose levels. That is why, for alcoholics, abstinence is often supported by having candy always in reach. Now Dr Baumeister is a great fan of will power (and readers may know that I am not, just as Alexander Lowen was not). **In our will based lifestyle, there is a tendency to want to manipulate blood sugar to be on 'the high side' of normal.** This is done with caffeine, chocolate, sugar, stimulation, and willpower, resulting in allostasis and a positive feedback loop, as described above. Carbohydrates are definitely preferred to fats and proteins. (One has to wonder whether current, "Western Medicine" dietary recommendations that eschew, on little evidence, consumption of fat and protein, are subconsciously succumbing to the craving to raise blood sugar quickly)

Of course, once sugar and insulin abuse is established, modifying diet is a legitimate interest. **But there is a paradox in trying to use willpower to employ practices that lower average blood sugar levels, when the native effect of an increase in use of the will is an increase in blood sugar.**
Diabetics treated with insulin notoriously need more and more. While this is explainable in terms of insulin resistance (decrease in effect per unit), could it also be that the person 'fights' the lowering effect on blood sugar (by what they eat and by autonomic and neuro-endocrine shifts) because it challenges a way of being?

A Gut Feeling About Serotonin

There is a general understanding that well-being and serotonin are involved together. Just how they are involved is intricate and little understood. What understanding there is, is probably badly distorted by drug company marketing metaphors masquerading as physiological theories.

But hear this! **Ninety percent of all serotonin is made in the gut**. That is where the name comes from, one of the functions of serotonin is toning the serosa. The Reich and Lowen tradition has always emphasized 'having guts' as a foundation for satisfying person-hood. There is a connection between well-being and having guts. Serotonin is also involved in disgust, nausea, and vomiting. All anti-nausea medicines (anti-emetics) are serotonin blockers.

It is a classic Lowenian exercise to drink and then throw up a small amount of water in the morning. This helps with loosening of the throat, but also brings some good feeling at the end. (All bulimics have found this out, but bulimia is immensely more complicated than this). The good feeling comes partly from stimulation of the vagus nerve and afferent impulses into the brain, but possibly also partly because of serotonin production.

Alexander Lowen always deplored the practice of children being forced to eat what they did not want to. He felt it was designed to break their spirit. Perhaps this is how it works: When children are forced to eat what disgusts them, they must ignore their own disgust. Quite possibly, their bodies down-regulate serotonin production as an innate anti-emetic. This

lowered serotonin tendency, in the gut and perhaps also in the brain, translates in later life into a lessened self-hood, and a tendency toward depression.

The most disdainful, dominating, insult is "Eat shit." For humans, shit is the most disgusting substance to eat. To actually do so requires such an immense negation of disgust that it is almost unimaginable without a gun pointed at one's head. Folk wisdom seems to understand that being forced to eat what disgusts one, diminishes the capacity to stand up for oneself and be assertive.

The Tyranny of "Just Doing Something"

As I've written before, I work in an academic medical center. I am always impressed with the following contradiction: Although effort is made to follow the dictates of evidence, the evidential conclusion that there is *nothing effective to be done* is found abhorrent, and a tremendous amount of the ineffective is in fact done. These are not hopeless situations either, so the possibility of doing damage by doing something, 'logically' has to be weighed against just waiting and doing nothing. Some might identify this as just 'defensive medicine,' and there is something to that, but I think there is a more fundamental reason why this happens, in healthcare and in other situations.

In the above referenced medical center examples, the physicians ordering the ineffective treatment routinely and unhesitatingly describe it as such. However, one other thing is evident: **they always still feel better after doing it, at least momentarily.** Just deciding to do something provides relief.

In everyday life, the same bias exists I believe. The phenomenon is often less clear because in casual circumstances there is no 'evidence of ineffectiveness'. However, everyday observation will show that usually, when an 'expert' (police officer, bureaucrat, plumber, nurse, receptionist, etc..) indicates there is nothing to do but wait, there is great consternation at the other end. Often a token thing to do (like taking a phone number) is offered with some considerable soothing.

But more obviously we often hear others describe proudly their decisions to do something about something where it seems highly implausible that what they will do will help at all or is even truly related to the problem. yet the relief is evident.

Perhaps these are some reasons for this bias:

- Deciding to do something triggers the reward pathways in the brain, giving access immediately to some good feeling. This is independent of any results in the world that occur, so the quality or necessity of the decision is irrelevant.
- The pace of modern life, being rather more rapid than human rhythms generally, imbues life with a strong worry that one will be 'too late.'
- Sympathetic shift imparts a strong urge to do something
- The *illusion of control* is a psychological mechanism for keeping anxiety at bay. There are real costs here.
- Because resources and attention are finite, there is a real loss of opportunity to do other constructive things that bear on the situation indirectly (opportunity costs).

- Frenetic and hurried activity increases the very sympathetic shift that engenders it in the first place (a vicious circle or positive feedback loop)
- Quick decisions become addictive.
- Separating decisions and results in an emotional sense can promote sloppy decision making
- Clues that arise later indicating something constructive can be done my be missed because a false sense of completion
- Impatience becomes a social norm. Patience is seen as apathy or inadequacy

There is a saying "don't push the river, it runs by itself" It is acknowledgement that humans act in a natural context in which one's will has a role but that many uncontrollable but salutary forces are at work.

Stages of Happiness

Psychotherapy is conceived around the achievement of happiness, but overwhelmingly it is the study of suffering, which alas, is a compelling subject with tremendous gravitational pull.

Some social psychologists however, like Daniel Kahneman, have been able to keep focus on the goal of describing happiness, even if they have been not all that successful at it. This study is called hedonic psychology.

In this field, one thing seems to be clear. Actual happiness (not just the study of it) has two stages: 1) the sufficient presence of good feelings and perhaps feelings of security and 2) the subjective recognition and conscious enjoyment of this sufficiency.

It would seem that, however common or uncommon the first stage is, the co-existence of the second stage is less common. The absence of the second stage may represent only a small diminishment, but it can certainly wreak havoc on any study of happiness or psychotherapy effectiveness that relies on self-report. And of course, there are abundant attempts to 'force' or simulate the second stage when the first is not present.

Defining Factors

I have been reading about how research into the effectiveness of therapy is done. To compare one type of therapy with another it is necessary to make explicit the factors that define that approach. This is different from philosophical tenets–defining factors refers more to what one would see in a therapy session. Factors are broken down into 1) essential unique, 2) essential not unique, 3) acceptable not necessary, and 4) proscribed. The Lowenian tradition may have to split a bit from the Reichian tradition since this is not about foundational understandings but rather the brass tacks of a session, where, as many readers will know, there are real differences. Therefore, below I have tentatively listed the elements of *Bioenergetic Therapy* as I understand them. I would be glad to hear additions or disagreements.

Essential Unique

- Physical grounding
- Vibratory Enhancement
- Character Focus
- Education in the Pleasure Economy

Essential Not Unique

- Breathing Improvement
- Relating Present Functioning to the Effect of Early Experience
- Expressive Work
- Emphasis on Real Life Translation of Therapeutic Insight

Acceptable Not Necessary

- Interpersonal Skills
- General Coping Strategies for Depression and Anxiety
- Pleasureable Activities as 'Homework'

Proscribed

- Reassurance
- Life Guidance
- Direct Suggestion
- Goal Setting

Western Medicine Treats the Mind, Not the Body

Allopathic medicine seems to be driven by two mechanisms: 1) patient complaints, 2) producing the longest possible lifespan. **There is no governing idea or criteria of health (except maybe "not dead", which is discussed below.)**

In the first driver, allopathic medicine treats the patient's complaints of distress. Complaints may be a sign of un-health (or dis-ease), but they arise in the mind of the patient. What the patients mind thinks they should not experience, they complain about. Some complain much and early, some complain late or little. Many complain passive-aggressively. **Usually for the physician, the success is defined as eliminating complaints as rapidly as possible.**

In the second driver, by pursuing longevity apart from, and sometimes at the cost of health, allopathic medicine is working on behalf of the ego which wants to be immortal, not on behalf of the body that wants to be healthy and have pleasure.

Now western medicine does things ***to*** the body to be sure. In fact, it insists on doing things to the body and not the mind and emotions, because attacking and blocking biological processes are believed to be part of the scientific-ness of which it is so proud. No doubt many examples exist of bodies made healthy by allopathic interventions. This is largely a byproduct, however, not the governing principle of the intervention.

Patients are often told they are 'healthy' when the physician finds no fatal process to block, even though the patient is pale, weak, discouraged, tense, sleeping poorly, and without satisfaction. That is, lack of health is rampant, but Western Medicine has no way to address this. There is 'preventative' medicine, but this is focused on preventing a possibly life-threatening process from occurring. It too is focused on blocking.

At least according to literary depictions, a hundred years ago doctors, having fewer technological tools and medicines, practiced mostly by non-specifically increasing the vitality and health of patients. Starting such efforts only once serious illness was present, however, undermined the role of health focus within the life. Now, issues of health (separate from 'non-disease') are of little interest to mainstream medicine. An insidious effect of this is the ignoring of how blocking maneuvers may detract from health or take energy and focus away from opportunities to enhance health.

Wolpe was a Lowenian

Well perhaps the title to this post is an exaggeration, but there is a similarity in the basic approach. Generally "the behaviorists" are thought to be in an opposite camp from Wilhelm Reich and Alexander Lowen. If one makes a distinction between cognitivebehaviorists and behaviorists, however, the divide is not that wide. 'Straight' behaviorists are really working at the subcortical and autonomic aspects of self-regulation.

One case in point is the systemic desensitization work of Joseph Wolpe. This basically consists of developing the capacity and inclination to stay fairly parasympathetic in the face of a feared stimulus. He did this not with cognitive reframes, not even humanist understanding, but actual biologically active things, like food! Wolpe was correct that insight into fear was pointless as an end in itself, what was necessary was an increased freedom to act afforded by a less flooded state.

Two Types of Criticism

Alexander Lowen and Wilhelm Reich both left a mixed reputation when it comes to accepting criticism. Now it is not uncommon in everyday life to deal with people who have difficulty with criticism. But this tends to co-exist with very unrealistic points of view and unrigorous thinking. Just reading the writings of both men gives the impression that criticism would be welcome. There are in both cases reports that that was the case, but also in both cases anecdotal reports that it was not. What gives?

I believe the following may in part explain this split. There are two types of criticism of any well thought out position 1) criticism from someone who both truly understands the theory, and also understands how his or her objection has been anticipated by the originator of the position, and 2) criticism from someone who has not understood the theory, has no idea that their objection has already been considered in the theory, and is reacting to an impression.

It is understandable that the first type of criticism would be received warmly and the second received with impatience or exasperation, and this could provide a mixed picture. Likely there are also two complicating factors.

One, no criticism totally fits the first type. All criticism of innovative work has some element of type 2. If the innovator has become too sensitive to elements of type 2 criticism, all criticism can seem invalid.

Two, any theory of human functioning has to contain a personal plea to be accepted and understood. All criticism has to be experienced as a rejection on this level. This is probably a side-street of narcissism, where feeling unlovable for ourselves, we offer great works.

Dyscorporia

I am disinclined to invent a lot of jargon. However, when it comes to bodywork, there is a phenomenon that has not had a word to decribe it. That is the overall unfamiliarity with the body from the inside, including :

- not feeling the body unless it is externally impinged
- not being able to distinguish parts of the body from each other or only crudely able to do so
- not understanding instructions to move a certain way
- confusion of direction in movement
- unwanted movement, that is, difficulty isolating a movement
- apart from a small repertoire of habitual movements, not being able to have one's body do what one would like
- difficulty learning new movement, despite desire and expert coaching
Depersonalization seems too extreme to denote the above pattern. Clumsiness in the sense of dropping things and running into things may or may not coexist.

Difficulty reading is called dyslexia. Before reading was common, there was no need for this word. Before remedial bodywork was common (or needed) there was probably no need for a word for this situation. Therefore I nominate *dyscorporia*, unless someone knows a prior or better word.

Portlandia is a State of Character

Posted on January 5, 2012 by mjsamsel

The psychotherapist Theodore Rubin made the point that our culture (at least our more urban, liberal culture) tends to torture people with the simultaneous incompatible directives of equality and attainment. The result is a lot of exhausting, unsatisfying, indirect behavior. A slightly different formulation is that the dilemma arises first in individuals (most of us, actually) who, in accordance with character, seek both to be special, but also to make low interpersonal aggression into an asset. The result in a stiff competition with others to hurt others less, and impact others less, than anyone else. A farce is enacted, in which it is not really possible to act with feeling and conviction, despite the merits of the cause taken up. There is a great TV series satirizing the situation– Portlandia

The Mass Individual

Wilhelm Reich described the 'Mass Individual' that he felt was evolving a result of modern trends in culture. Overall, his tone is rather dismissing, which I think is unfortunate, because the core idea, a useful one, can easily be dismissed as political feuding. But we do not function

as a mass individuals because we are inferior (a common misunderstanding), but because our good intentions and natural drives are steered this way by familial and societal forces. The basic aspects of a mass existence are:

1. Looking outside oneself for standards, both moral and aesthetic
2. Channeling aggression into consumerism
3. Replacing the desire for liberty with the concept of a safe, well-regulated society

Are not the above points, in fact, what we are urged to do by our leaders–1) achieve according to recognized goals provided by academia, Hollywood, Wall Street, 2) start spending again to end the recession and rebuild the economy, and 3) accept the Patriot Act and other similar legislation?

Difficulty in Researching Reich and Lowen Benefits

From time to time people ask if there are any studies that verify the effectiveness of the Reich and Lowen tradition. If they have some training in research methods, they are probably meaning, are there random controlled trials (RCTs). While there is evidence of effectiveness, there is not any data from RCTs of which I am aware.

But I certainly do not think that that has any bearing on whether a human can choose Reich and Lowen therapy with conviction and benefit. Not all knowledge production comes from research; and not all research is in the form of RCTs. By far the most voluminous research in life is the cumulative trial-and-error life experiences of all people who are honest with themselves about their results. The Reich and Lowen tradition, like all traditions of help deserves scrutiny. On an individual level, it certainly does receive scrutiny; no one in my experience has ever actually persisted in bodywork for very long without an actual experience-born conviction that it is change-producing.

By way of contrast, I work in an academic medical center, and most things that are done to patients there either have not actually been 'researched' either (far more than people think) or are actually conducted in the face of research showing ineffectiveness. (I am not talking about absence of evidence in this last point, but actual evidence of absence.) That is, many things are done by authority, not evidence. Anyone who doubts that authority is very active in burying experimental evidence can read about the *consternation around the Accord Study on Diabetes*

I wish to point out also, that scientists, when they select particular tomatoes at the store, or choose a love partner, or vote for an issue or a candidate, like the rest of us, they do so with confidence that they know what is right, even though they have no 'objective' research. In their labs, however, they may pride themselves on harboring no conclusion that hasn't been 'proven.' If left at that, this is no more a double standard than a nuclear plant worker not wearing protective gear at home is a double standard. But if these scientists go on to misappropriate the self-imposed standards of their labs to consumer and life choices of other people, *this is a double standard.*

Wilhelm Reich thought of himself as an objective researcher, but he came to try to prove more basic biological or physical principles. He never thought to run the null hypothesis up against

psychotherapy. I would venture to guess that was because it seemed so self-evidently helpful. Later in his career, Alexander Lowen was asked by his followers to consider 'modern' style research to bring greater credibility to Bioenergetic Therapy practitioners. It seemed he felt this was a mis-application of effort and a misunderstanding of the nature of the undertaking. In that vein, the following list of reasons is an attempt to identify why a narrow view of scientific study has difficulties first with psychotherapy at all, and second and especially, has difficulties with therapies that have a higher potential gain but a lower percentage of actual acceptance and adherence.

Problems with Time: Growth takes place over time, but the experimental model usually cannot go over 6 months (longitudinal studies of course exist but they tend to track only independent variable and not whether the dependent variable or experimental condition has been maintained.)

The Placebo Effect as a Decoy: Any time a person that feels bad emotionally believes something or somebody is going to help them, they get quite a lift, at least for a time. This is actually dissociation. This is very useful to bridge a condition that will go away by itself fairly soon. This is called the placebo effect*, and in fact may be, de facto, the main effect of most psychotherapy. *With deeper, more persistent problems, the* limitation of the placebo effect is that it decays over time, and it cannot be built upon. *Reich and Lowen therapy, because it is the opposite of dissociation, if done right, actually weakens the placebo effect.* Reich and Lowen therapy however, can be built upon over years, by itself and by other deep therapies. Like the tortoise and the hare, placebo (reassurance) wins in the early going, but the tortoise (character and body change) wins in the long-run. But research studies are always in the short run.
*Sometimes in this arena the term placebo effect is applied to the result of *common factors* to all therapy such as a honest relationship with someone who is concerned, etc.., and while common factors can also be a confounding issue in evaluating specific strategies, 'placebo' as used above refers to the immediately available neurologically-mediated benefit of arranging and beginning treatment.

Problems with Self Report: Self-report can easily understate and overstate benefits. Of course if in the long-run the client him- or herself can not appreciate the benefit, what value is their in the undertaking. But most research evaluation is done in the short-run.
A person's mood and feelings of well-being go up and down anyway, but importantly, humans tend to color past and future with present mood. Also of course, there is the demand characteristic of having improved, which like the placebo effect, 'floats all boats,' including controls.

On the other hand, there is a type of magnification of problems that occurs when expectations or negative feelings increase as limitations on living are better perceived and more clearly felt by the client. This is why some critics accuse psychotherapy of putting problems in people's heads that weren't there before. This is partly true, the problems were there but in a different part of the body then the head.

Cyclicity: Human suffering is never uniform but cycles around the poles of collapse and compensation. People tend to come to therapy feeling very badly and tend to end it at a time when they are feeling better. This happens whether it is an remedial effect of the therapy, the

effect of time, or placebo effects. But if things are just cycling, collapse will come again, while if character and energy have changed, collapse may be of a lesser magnitude in the future, but most study time lines only encompass less than one cycle. Hans Eysenck famously mistook spontaneous remission to be equivalent to therapeutic effects because he was unable or unwilling to distinguish compensation from remediation.

Unacknowledged Dilution: Many providers say (and believe) they are practicing a therapy but are not. Alexander Lowen stated that he thought it took at least (as in necessary but not sufficient) 14 years to become a competent bioenergetic therapist, and 50 years for him to become an effective therapist. Neither statement was made ironically or sarcastically. Perhaps what should be studied is not the 'method' but the 'person'. It is my suspicion that 'the person' is the most limiting factor in the efficacy of therapy, but that all unusually efficacious therapists indeed have a method. Could it be that all therapists that have no more efficacy than *common factors* explain, actually have no method even if they believe they do?

Problems Detecting Excellence: Random controlled trials, or any trial, is intended to capture what usually happens, not what may happen. Commonly what happens less than five percent of the time is deemed not to have happened at all, but to those subjects, it really happened. Many people want to be as rich as Bill Gates or Warren Buffett, but in scientific terms, they don't exist! Outliers can represent bad data but they can also represent excellence

A Burdensome Experimental Condition: True application of Reich and Lowen therapy probably includes a great deal of frank self-examination and gut wrenching. Now life itself imposes a lot of gut-wrenching, so even in the short-run, the discomfort of Reich and Lowen therapy may arguably be no more than life itself. However, no investigator can insist on such an undertaking, and if he or she did, they could not enforce it. And of course it is not legitimate to retro-actively prune from the data any experimental subjects that did not really applly themselves. It seems, in fact, that it would only be possible to study relatively superficial therapy, and that existing studies are of rather superficial therapies or superficial applications of therapy.

No Agreement About What is Desirable: For instance, someone becoming a less-good employee when he or she realizes they don't like their job might be seen as an improvement (sign of life) by one person, a deterioration ('acting out') by another. (All right, there are depressive symptoms, the alleviation of which seem universally desirable.)
An unacknowledged 'rule' for most mainstream therapy is coaching 'good behavior. A type of work that judiciously encouraged masturbation, raising the voice, unapologetic anger, or ending unsatisfying relationships is not likely to be 'manualized' for a study!

Problems Appreciating Harmony: This is an aspect of 'defining the desireable' that is highly relevant to Reich and Lowen therapy. It is certainly possible to see grace when someone has it, but to operationally define it? This conundrum applies to most of the benefits of true human growth. The very insensitivity that is cultivated by scientists would tend to foil agreement by all parties on what has actually happened or changed. This of course is not a valid area for self-report, since everyone believes they are harmonious until and unless they become more harmonious.

No Dose Relationship: There probably is a minimum amount of therapy that constitutes a threshold at which effects can take place. While that amount may be longer than proponents

of the medical model may like, it should not be multi-year. Beyond that, effects from therapy, where they do happen, do not correlate well with the additional length of therapy. To cynics this is evidence of inefficacy. But change cannot be forced. Sometimes it is necessary to put oneself 'in harm's way of change' for quite a while before it strikes. This not necessarily evidence of fault, or any kind of evidence. Of course the possibility exists, in fact the situation must occur at times, that the client is not actually in harm's way but is doing something interminable. How that might be detected is of course a clinical question and maybe even a research question, but the answer will not necessary change the uncertain relationship between time and change.

Human Functioning is too Variable to be Disprovable: Karl Popper is famously known for pointing out that Freud's ideas were not falsifiable. This was not because they are bogus (a common misunderstanding of Popper's point) but because all outcomes (crudely considered,) are explained or explainable by the theory, so no outcome 'falsifies' it. For instance if a man undergoing a type of psychotherapy 'improves', seemingly the theory is supported, but if he does 'not improve', that can be attributed to resistance, a part of the theory, so the theory may be supported again, or at least is not 'falsified. This demonstrates not the illegitimacy of these type of theories but rather the limitation of Popper's tool in this arena. Now most people do have experience with someone who has simply 'explained away' in a facile manner all objections to a pet theory. How can useful, grounded, but un-falsifiable ideas of human functioning be distinguished from the crackpot? Here is where subjective appreciation of validity comes into play. If a very nuanced, not a crudely operationalized view of outcomes is taken, distinctions between say failure from resistance and failure from lack effect can be made, but not proven in the Popper sense.

Unpacking: People can only suffer so much at a time. When sad and difficult life events exceed that, there is shutdown, and losses accumulate in a sense, but they lie dormant and un-grieved. Most of us are well past this saturation point for suffering. Real progress in therapy tends to 'unpack' a life, in that, as something does get felt and grieved, something rises up more strongly that had not seemed 'so bad.' In a superficial sense, suffering seems the same because it remains at the saturation point. A difference exists, the life is slowly becoming 'truer' and more one's own, but this result is unappreciated by the mainstream.

On the other hand, the Reich and Lowen tradition is based on biological concepts and biological concepts should have a better chance of being demonstrated 'objectively' than psychological, or 'quality-of-life' concepts. Stephen Porges' measure of changes in respiratory sinus arrythmia come to mind. Also a discrete, limited, standardized sequence of bodywork, like David Bercelli's Trauma Release Exercises® has promise for research. Results in areas of research like balance or muscle tension should be less rejected. Also perhaps more discrete building blocks of growth, such as taking action, or working constructively with others, etc.. that might be altered by bodywork, can be studied in a social psychology format.
Michael Samsel

The Basic Oral Reenactment

There is a basic obstacle in psychotherapy and the healing professions that is so common that it may not be recognized as an element maintaining the suffering. The obstacle presents itself

when as an adult, the suffering person is encouraged to do something truly new, and he or she does not feel ready

All limitations of course have an actual present basis in adulthood, but characterologically, this one has roots in childhood, in the oral period from 6 months old to about 18 months. Issues of suffering are said to be 'oral' when they arise from a failure of nurture at this stage. Such a failure seems to happen from two slightly different situations: 1) the parents feel overwhelmed or discouraged or themselves cheated of nurturance, and the basic message is given: "hurry up and grow up so I won't be burdened with you any more!" 2) the parents feel that it is essential to make it in the world and so the message is given: "hurry up and learn and be the special person we need you to be." In both situations there is also the secondary directive " be happy and satisfied with what you got, it could be worse."
There are many consequences of this, but the one that is relevant to this discussion is the tendency of the child to attempt to be precocious by doing things before the neuro-muscular development is ready. The consequence is that things like toilet training, walking, grasping, etc are done by the wrong muscles and at a state of full contraction rather than just at the right tension. The experience and operating style for the child, and later the adult includes:

- A hurry to get things done quickly because the actual doing is not pleasureable or secure and the outcome always feels uncertain
- A physical fear of falling which also translates into a fear of failing
- A sense of being hurried to do things before one is ready (sometimes consciously denied)
- A lack of discrimination about how things are done, just getting something done seems paramount. Comments from others about how something is done seem unfair and cruel.
- A belief in a sense of effort and a disbelief in a sense of ease. If something is found effortful, may give up or may continue, but will not look for an easier way.
- Often learns the 'shell' of a movement, but not the 'guts.'
- A tendency to pretend one knows how to do things, and a difficulty asking how to do things, because it seems one should just know.
- Body sensation including emotion is not trusted as a guide
- A reluctance to try truly new things develops, often with a compensatory habit of taking on a lot of variations of things done well.
- A sense that the demands of life are unjust impositions.

The tragedy is that what would have been guidance and support at the right time became an imposition undermining security just by being hurried several months! The result is pleasurelessness and all its consequences as described by Alexander Lowen, especially as regards the oral or communicator character, but few of us are free of the above described traits.

The real catch however, seems to be this: even though as an adult there is an implied or explicit request for guidance and support from others (especially others seen as experts or authority figures), when it is offered by others it is not recognized as such by the suffering person, but rather rejected as an unfair imposition!

Now if the child had been able to protest the early situation as an imposition, that would be appropriate. As an adult, however, neuro-muscular development should be adequate, and new

physical and related interpersonal skills should ostensibly be formable. It is mis-development of the neuro-muscular system (clumsiness, poor balance, etc..) that makes the asked for changes (even in interpersonal behavior) seem impossible or unnatural or wrong. **The person is seemingly stuck in a state of prematurity**. That is why even accurate advice by others can be experienced as intrusive, rejecting, or re-traumatizing.
In typical psychodynamic or humanistic therapy, no performance demands are placed on the client for that very reason–to make clear that the therapeutic relationship is different. This is supposed to provide a platform for growth to occur spontaneously. Sometimes it does, more commonly it does not. Therapy as a *permanent* oasis from performance demands becomes an end to itself, rather than a means to an end. To the extent that the therapist can maintain this stance, the client becomes bored. To the extent that the therapist loses patience and pushes the client, the client feels misunderstood and pushed to do what is unfitting or premature. This latter case is the *Basic Oral Reenactment* that bedevils therapy.

T**he major contribution of Reich and Lowen was to see that what was also lacking is a neuromuscular and energetic platform for adult functioning**. They kindly and gently insisted on physical activities and character focus that brought the client in juxtaposition with his or her present incapacities. The irony is that, even though this was accurately intended to end the experience of prematurity, this often was another occasion that evoked it. Alexander Lowen felt his work was more educational than exploratory. He emphasized adult functioning and believed he was *pushing clients toward it*.
The opposition Lowen faced from within his own followers most of his later career seems to follow the same lines. Most therapists have had significant deprivation of nurturance. They looked to Dr Lowen as an expert for guidance about this. They brought their stories of not being ready. He pushed for adult functioning and sometimes became inpatient with the stories. A predictable loop developed. What is the solution? Well, according to his autobiography, Lowen came to view the solution as grounding and more grounding.
Michael Samsel

The Missing Psychopath

The psychopathic character is the only character concept that has much currency outside the Reich and Lowen tradition. Robert Hare Ph.D developed a well-validated tool for identifying this character based on biographical footprint (alas missing the physical and energetic aspects so well described by Alexander Lowen).
Hare and others have found that there is a considerable portion of political entities, corporations, non-profits, religious bodies, and even educational institutions headed by men and women that would rule in as psychopathic using his tool (and by Lowen's criteria also for that matter.) The result is harm dealt to outsiders in the short run, but also a self-destructiveness in the long-run.

But Hare also found something else: that there were many of these same types of institutions **that proceeded quite similarly even though no one in these groups could be considered a psychopath.** He concluded that collectively, in supporting the goals and images of the institution conscientiously and without reference to personal feeling, the people involved functioned in a way that put the goal ahead of the means and the image ahead of human feeling. Hare called this phenomenon "**the missing psychopath."**

As illuminating as the basic premise is, I find it stops short of a satisfying investigation. Attributing harm to the 'invisible hand' of psychopathy gives no clue how to address it. In fact the individuals involved must be doing things in this context that while not 'characteristic' gives some vent to 'secondary drives.' Below are some guesses at the making of the missing psychopath.

- It is hoped by various men and women in the organization that good performance will bring love and security. Thereafter, actions are judged not on their effects but on the likelihood of pleasing a parent figure.
- The survival of the organization becomes confused with personal survival, erroneously activating the 'self-defense doctrine,' in which harmful force is justifiable to prevent harm to oneself.
- Competition inside the organization intensifies the survival mentality.
- It is natural for people to seek broader affiliations. Organizations can encourage a tribal feeling, which can bring cohesiveness inside but which can also de-humanize outsiders.
- The views of outsiders are not considered according to their merit, but according to how much these views impede organizational goals. Outsiders trying to modify organizational behavior are seen as threats and enemies.
- The organization, being abstract, is easy to idealize. After all, it never mispronounces a word or has body odor.
- Successes or meritorious undertakings are attributed to the organization as a whole, while failures or shameful acts are blamed on individuals who are jettisoned. This scapegoating protects the image.
- The core aspect of anything idealized is that it can do no wrong, so critical and ethical thinking goes into abeyance.
- Marketing and branding efforts explicitly encourage an idealized image.
- A spotless and shiny campus or headquarters, and a professional dress code, seem to romanticize and sanitize what goes on there.
- The healthy playground feeling of competition is mis-generalized and mis-applied to the use of power to manipulate the legal, political, and market environments.
- The accountability cycle, if active at all, is much longer than 'natural.' Alert individuals have no power to stop a harmful practice because of the size of the organization. That requires a regulatory body which is cumbersome and takes years to respond. This means that things are apparently (if not actually) gotten away with, so it begins to seem that they are not in fact wrong.
- Most organizations project an image of being unique 'on the cutting edge' or representing 'the future now' so that 'making one's own rules' seems more plausible. Normal limits are not seen as applying.
- If an individual develops qualms, he or she may reason that "if I don't do it, someone else will." But having done something wrong once, one becomes desensitized.
- An organization has no reason for a 'story' except to explain a goal. As goals change, the story get re-spun or re-invented. This is a short step from the story becoming anything that 'gets the job done.'
- If an individual develops qualms, he knows he can and will be replaced by someone who presently at least, has no qualms.
- In a large group, it is easy to lose a sense of responsibility. Conformity is a natural tendency.

- If in fact other similar organizations are acting unscrupulously, then doing the same may seem to the individual to be "only fair." That is, it seems not like committing a wrong but actually righting a wrong.
- Good old repressed hostility can be vented but safely disowned.

Manic Depression in a Society

The connection between mania and depression in the individual has been understood for a long time. Alexander Lowen describes this in his book *Depression and the Body*. The mania is inevitably followed by a crash. This is a biological phenomenon. Bodies and persons have limits, and even if limits are stretched and abused by some pathological process, or by an over-reaching ego, nature asserts itself eventually.
I believe this process can occur in an entire society as well. Alexander Lowen in an interview in 1986 indicated he believed that our society (at least the United States) was at that time in a manic phase. When did the manic phase begin?

If mania is a form insanity in which limits are not recognized, then perhaps the de-regulation of the early 1980s was the start. The idea of economic growth without limits took hold. Probably the deregulation was not the cause but another sign of a culture that collectively did not want to admit limits.

Of course the economic reversals in 2008 seem an obvious date for the crash. **A psychological change seemed to occur overnight in which the desirability of getting more and more was no longer treated as a self-evident truth.**
Political leaders of all stripes in this country all have been trying to get citizens back on the mania track with stimuli of various sorts. It was determined that the banking system production of money should be able to continue higher and higher, and that the citizens' new-found reluctance to participate was 'the problem.' News coverage was and is selected to highlight isolated data that suggest expansion is starting again, in hopes of manipulating people's instincts to do what they think their neighbors are doing. But this trick isn't working. Stimuli don't work because, as a people we have been over-stimulated to much for too long.

The current 'depression' is the logical consequence of too much. Too much over-stimulation and overreaching, and plain too much. The crash may be, in fact, from a functional point of view, healthy. Slowing down will improve, health, family life, social activity, the care of children, and maintenance of what we already have, It will decrease stress, overwork, waste, pollution, and the tendency to treat ourselves and one another like commodities.
There is of course a mal-distribution problem
with some people still working overtime, and
many not working at all. This has been a problem all along of course. In France the work week is 35 hours a week. That amount seems to conform to a human rhythm in that if shorter people start to work a second job.

The Exciting Object Loop

Alexander Lowen worked at the drive end of things more so than the object relations end of things. However, he did emphasize the role of illusion in suffering. Perhaps the most common illusion is the illusion that real love has been found in an 'exciting object' Exciting object is a concept originating with Ronald Fairbairn and of course was primarily meant to describe 'an endopsychic structure' but it is much more useful to see how the dynamic plays out in actual relationships.

Subject

- The suffering person of interest, perhaps someone like you or me.
- Usually has little interest, or makes little progress, in forming close relationships with most people in their world
- From time to time, goes crazy when someone uncannily like one parent comes on to the scene.

Exciting Object

- Seems to have the same goals, tastes, desires as the subject (illusion of symbiosis)
- Seems to have infinite supplies of gratification
- Seems all accepting, and demands no accountability
- Seems to have no *real* faults (idealization)
- Cannot hold or sooth the subject; instead leaves or re-stimulates
- Provides no context in which to understand separation, allowing or encouraging the false belief that they will always be available
- Re-unification comes with a nullification of past history. It is as if everything starts anew, with past problems unacknowledged

Rejecting Object

- Every exciting object eventually becomes a rejecting object.
- Cannot soothe the subject, instead at stressful times blames the subject for his or her own distress
- No reliable means to be contacted between episodes (unavailability)
- If the subject expresses differences, the rejecting object punishes the subject (and vice-versa)
- Disappears rather than separates, often literally sneaks away
- Drops subject abruptly for other narcissistic supplies
- Leaves the subject feeling used

Holding Object

- A mature presence that contrasts with the exciting/rejecting object
- Reliable and predictable in contact
- Separation is an event handled honestly
- Has the capacity and willingness to soothe subject
- Is generally tolerant but has boundaries and defends them non-punitively
- Intimacy builds over the course of a shared history
- Differences are acknowledged and allowed to enrich relationship

The Loop

When the exciting object dynamic dominates human relations, as it does far more frequently than generally thought, a loop develops: 1) an exciting other arrives on the scene, and life

seems to have 'finally worked out', 2) soon this other seems to change and is disappointing, 3) the formerly exciting other is both rejecting and rejected, and 4) there is a reactive abstinence from the hope of love. Abstinence may last only hours, or it may last years. The cycle may repeat frequently or only a couple times a life-time. Staying in a loveless relationship is a way of maintaining abstinence.

This interpersonal process is an involuntary response, ultimately biological. High intelligence does not help moderate the effects very much once the loop starts (hence this is usually called 'going crazy' over someone, a term applied whenever an involuntary response defeats the will and intellect.)

Many people believe they have good object relations, but they are just in abstinence. In fact, people who have been alone for a long time are often strongly swept up once the 'right' person appears. A reluctance to get involved in relationships may understandably arise if one's only experience with love is this loop. It is possible also to become an excitement junky or 'love junky' and go immediate from one relationship of this nature to the next one. For a difference experience, a holding object must be available both internally and externally.

Taking the Pants Off

I was recently at the bi-annual IIBA (Lowenian) Conference in San Diego. I had the good fortune to attend an all-day workshop with a very experienced trainer Heiner Stekel, from Germany. Heiner has been teaching and performing bodywork for thirty years or more, sometimes assisting the late Dr Lowen.

Heiner related that he would typically ask a participant in such a workshop to take his or her pants off. This was not, of course, for any inappropriate reason but to demonstrate the reality of that person's support in the world. Sensing the chill toward baring the body in recent years and in the United States, Heiner asked the organizers if that would be okay. The answer was an unequivocal "no."

Now there probably is no bodywork that cannot be done just as well in loose fitting pants. Pants are not unduly constricting. But pants, like other clothes, can hide the physical reality of the person. Now I know a skilled clinician can deduce from movement and a clothed body and facial expression, etc… most everything that would be seen in a bathing suit for instance. Some information would still be unknowable but that that is not the main point I am about to make.

Even if I as a participant know what my legs look like, and the leader can accurately imagine what my legs look like, and I know that the leader knows the reality–still the pretense is possible and even likely that the image I try to project is in fact the reality. But if the my legs are bare, I know he knows and he knows I know he knows, and the other participants know, and we all know each other knows, and no pretense is possible!

It is understandable, that as a community Reich and Lowen therapists are sensitive to prevailing social and regulatory norms. However, it is possible also that the community is

quickly losing the understanding of when and why some social norms need to be set aside. There is a ***great*** and qualitative difference between violating a social norm and violating the rights of others.

The Sacred Cow of Muscle Tension

I have been reading an excellent book by Clair Davies on self-massage for 'trigger' points. This is based on the work of the late Janet Travell MD . Now the work of Dr Travell and Mr Davies is organized around the activity of myofascial pain relief, and it does an excellent job in that regard. That is where the name "trigger point" comes from.

But this concept is far more broadly applicable to bodyworkers as well. It has long been understood that tight muscles dampened vibration, suppressed emotion, limited vitality, and cramped expression. However, release is truly not easy. Diligent stretching, the obvious approach to releasing muscles, sometimes is incredibly slow or seems to hit 'a wall.' Bodyworkers have been intuitively massaging tight spots for a long time, with great success. However it seems that at times deep somewhat painful massage is required rather than a more general soothing massage. If the reason for this is not understood, this may be difficult to tolerate.

The reason that a deep, 'point-oriented' massage is necessary for release is that muscle tension is not homogenous. Rather small areas of muscles, 'trigger points', bunch up massively, stretching taut the rest of the muscle fiber. A muscle so distorted does not function well, has poor circulation and low oxygen availability, and is often left out of movement over time, shortening further, and distorting joint function and posture. Trigger points occur at the center of the muscle, where the nerve enters. Trigger point theory explains why muscle tension is self-perpetuating–merely pulling on the muscle fibers by trying to force the bodily movement keeps re-triggering the bunching up. Very tense tight muscles tend over time to involve neighbor muscles and connective (fascial) tissue.

Strangely, however, allopathic medicine has resisted the idea of muscle tension as the source of problems. Often very arcane joint or cartilege problems are proposed to explain pain or dysfunction a patient presents with. It seems that bone or cartilage changes have less *obvious* implication of emotional cause. This is because when cartilage or joint changes are demonstrable, it is attributed not to patients' own muscle tension, but rather to 'bad luck'! Why is this?
My hypothesis is this: muscle tension is present in almost everyone in our culture, and if it was recognized as a problem (as it surely is) then something would have to be done about it! Because muscle tension goes with will-based living, it is considered unavoidable or even desireable. Like stress, muscle (and fascial) tension is a sacred cow.
Now there is the diagnosis of fibromyalgia which is gaining some acceptance. I think it very likely that the cases being recognized are only the tip of the iceberg. Most people try to live in their egos and leave the body behind, or less commonly use the body like an object to attract others. We largely don't recognize our myofascial tightness until serious pain or dysfunction arises.

Fibromyalgia as a diagnosis was forced onto allopathic medicine by a very dysphoric and acerbic minority of people who insisted on their suffering being recognized. Thus, one particular adaptation to the suffering became confused with the problem itself. Fibromyalgia took on a stigma as a 'personality' problem. Chronic opiates were prescribed, for the pain of course, but also in a barely disguised way, as a mood soother. But chronic opiate use, besides the recognized side effects of tolerance and addiction, probably contributes to myofascial shortening. The resulting stigma has been huge.

Ordinal Abuse and Abuse of the Mean

I work in a large medical center, which is now expected to compare itself to other large medical centers in certain quality indicators. Now there could well be serious questions of the relevancy of these indicators, but setting that aside, this seems like an informative step.

But there is a very detrimental, dehumanizing second step. Raw scores, which tend to cluster closely together, are converted arbitrarily to ordinal rank. This is roughly how it works. Members of a group are given scores based on how often something desirable happens, and this score is often expressed as a percentage. Not uncommonly a distribution of these score might range from a high of 68 to a low of of 61. A conclusion from that might be that most every institution is *doing about as well as can be*. That is, the understanding that there are limits to human endeavors remains, even if one wishes to push closer to those limits.
But this is where the nefarious step comes. The institution with the 68 raw score is ranked 1st, and the institution with the 61 is ranked 100th (the last percentile). This gives the impression that those institutions ranked at the end are doing something quite unsavory, and have a whole lesser magnitude of quality than the top ranked.

In an athletic event, say a foot race, it is understood that entrants will be ranked by ordinals even if performance is barely different. But this is a *temporary competition*.When this type of thinking enters management of ongoing institutions it sets up *permanent competition* that induces desperation and even cheating. Ordinal ranking is disorienting from the natural order and perpetuates the illusion that there are no limits. It takes away the position of 'good enough' or even 'good' and replaces it with a permanent insecurity that is dehumanizing. Even if rank number one is achieved this year, what about next year? This technique manipulates an ego concept (rank) at the cost of true investigation and understanding about quality. Quality suffers.

Abuse of the Mean

Another misuse of statistics is to average performance (find the statistical mean) and publish the result as a criterion of okay-ness. This might be done with usage of a resource or with price. The mean becomes no longer the mean but actually the new de facto ceiling or floor. If participants distort their practices to comform to the new limit, another iteration may occur that makes the new higher or lower mean the new higher or lower limit. Neither diversity, quality, or personal relationships can survive many repetitions of this

The quibble is not with the setting of limits, but with the underlying belief that all human activity is interchangeable, and all relationships are reducible to a common output, which is really the belief that all humans are robots.

Pushing the Poles, or Feeding the Shadow

Posted on November 8, 2011 by mjsamsel

The shadow is a wonderful conceptual tool from the albeit somewhat dis-embodied Jungian tradition. Most human traits exist as polarities on a continuum. To be human means to possess the entire spectrum in some way, constructively or destructively or in between
Humans, though, often want to be superior or special, and so commonly, an unbalanced image of only one pole of the spectrum is pursued. An example could be a man or woman in the helping professions who wants to be selfless and eliminate self-interest. This is the subject of the excellent classic *Power in the Helping Professions* by Guggenbuhl-Craig

The harder one pole is pursued by will, the deeper into the unconscious the other pole is pushed. But the deeper into the unconscious something is pushed, the more active it becomes. This is called the shadow because the owner cannot see it, even if it dominates his or her results in life. We can usually see others' shadows plainly, as long as we do not share the shadow. This is not out of brilliance on our part, but is simply the way the process works. An implication is that members of *diverse* groups can be slightly self-correcting for each other.
In the above example, the would-be selfless person may become quite controlling without realizing it. If his or her relationship to self-interest was more straightforward, however, the person would generally be able to frequently but temporarily *set that aside* (as opposed to repressing it) and be capable of great acts of kindness.

Surprising stories emerge regularly about how someone publicly revered as 'good' is exposed as having a 'double-life' or behaving contrary to professed values. This happens with 'reform' politicians, clergy, coaches, and yes, even therapists. Some of these instances may be attributed to charlatanism, but mostly a deep split is evident, with one pole of a trait submerged and distorted and running amok. The mandated celibacy of Roman Catholic priests can be seen as pushing sexuality into the shadow, and horribly, the sex-abuse scandals thereby are understandable.

A common result of pushing the poles is cyclical behavior. That is, a particular area of 'good' behavior is pursued willfully without understanding all the underlying motivations. This can be sobriety, productiveness, diet, friendliness, patience with others, exercise, faithfulness, etc… These are good things surely. But when these things are pursued in this way, tension builds until there is a flip. Repressed distorted aspects of the self start to work outside the awareness of the person. Rapidly, however, the person starts to move toward fulfilling the 'bad' pole, and it is no long hidden, although it is not owned. The bad pole usually cannot be sustained long, and disgust or self-loathing arises. This state is then ended by renewed resolve to live out only the 'good pole.' This is a difficult pattern to recognize, even if quite regular, because the ego tends to extrapolate in a straight line and believe things are getting rapidly all better or rapidly all worse.

Another aspect of the shadow is a *white projection*. This is the projection of a concealing screen. Basically, we cannot see someone doing what we have pushed into our shadow. For instance, a man or woman that has a straight-forward relationship with anger can choose never to act against a child. Feeling and empathy over-determine this of course. Such a man or woman will consistently treat children well and *also will not likely miss clues that someone else is mistreating a child*. On the other hand, a man or woman that has both repressed anger

and identifies with children is of course frequently incapable of hurting children, but or she or he may miss clues that others are hurting a child. News stories are frequent in which this seems to have been the case with child protective workers.
Finally, a lesser but controversial point might be made about the rapidly increasing regulation of the psychotherapy profession. The barrier to entry has been raised and the idea of 'orthodox' practice has been strengthened. Clearly vulnerable people must be protected.

However, *many of the horror stories of therapy malpractice are attributable to individuals that actually had many more credentials than average.* A certain minimum of requirements to navigate may help keep out blatant charlatans, but if the shadow is responsible for most mistreatment by therapists, (and I think it is) then a sheer increase in hoops to jump may not help the problem at all, or may even confound it. It may lead to a more homogeneous community that is less able to self-correct.

What is Trust in Reich-and-Lowen Terms?

Posted on October 22, 2011 by mjsamsel

I have spent most of my working life in a large medical center with hundreds of patients and hundreds of other professionals. Patients are asked to do things that are not routine or established for them, and the professionals cannot establish much routine because they must adapt to the patient's apprehension and readiness.

In this absence of 'routines,' one thing seems salient: real trust is very rare. I'm not saying that compliance is rare, in fact, compliance is probably far to great. It should be possible to trust someone but say no to what they suggest.

Likewise it is possible to say "yes" to someone that is not trusted. This might be done because one calculates the risk to be low. "Yes" might also be said because one feels there are no other options, that is, one feels desperate. Or yes might be said because it is a social norm. In the absence of trust, however, there is always less than full-hearted participation.

There is a confusion in our culture between *trust* and *risk assessment*. People are often in a position where they feel they are risking a lot, but are unable to feel trust, and also unable to meaningfully assess the risk.
Trust is a feeling about another person. Like all true feelings, trust requires physical proximity, though voice over a phone can help. Trust can also be manipulated by others, but where there is good contact with feelings, this is limited.

Risk-assessment, on the other hand, is a cognitive product. Like all cognitive products, risk assessment can and often is distorted by unconscious feeling. Risk assessment is also vulnerable to false information. Risk assessment is especially vulnerable to the combination of unconscious feeling and a selective perception of information caused by that unconscious feeling or desire.

However, risk assessment can take into account the future, which trust cannot do. While seeking to guarantee the future with risk assessment can be unrealistic, avoiding some

surprises is possible. Risk assessment also is useful with strangers where there is no time to get to know them.

Americans are often frustrated by other cultures in which no business can be done until after some time is spent eating, drinking, meeting family, etc. The frustration arises because to the American, no further information pertinent to risk assessment is obtained, and so the time is seemingly "wasted." But to the other party, the time is well spent indeed because it provides a feeling of the level of trust.

Trust isn't only a tool in decision making, though it can be that. **The real role of trust, especially mutual trust, is as a state of communion with another that provides understanding and greater ease cooperating.** Even where trust matches risk assessment, trust is infinitely valuable in terms of good feeling, creativity, and collaboration. Trust as a feeling *about* others also produces feelings *in* those others. There is a motif in many stories, that someone, feeling the trust of another, has a hard time betraying or exploiting that person, despite great incentives and sometimes despite the fact that this was the original intent. Now of course, asymetrical trust like this has its limits. There are after all 'confidence' men whose method is to elicit trust just to exploit it. Con jobs, however, are performed with the aid of psychopathy, which is a bio-psychological process that denies feeling.
There is in fact, a truism that to be trusted, it is necessary to trust others. I think commonly this is interpreted to mean set an example. I believe, however, that this phenomenon has a functional, biological explanation–our feelings affect and engender feelings in others in a way that largely bypasses will and conscious decision making. That is, others don't decide on an intellectual basis to trust us because they follow our example. Rather they find themselves feeling trust.

In our culture, feelings are considered a legitimate basis for action only in trivial matters. However, in some spheres of life, action only matters if it is done in harmony with feeling, and trust is one of those feelings.

Transfusional versus Transformative Therapy

Posted on September 29, 2011 by mjsamsel

Many, perhaps most, clients come to psychotherapy at a low ebb. They do not have much energy, good feeling, anticipation of pleasure, warmth or optimism. What is normative in master's level therapy in the United States is a supportive approach-that is the therapist compliments the client, makes general suggestions, demonstrates empathy and provides encouragement.

The Freudian tradition, however, teaches that when this is done, nothing essential changes in the functioning of the client. Even if that truth is not believed in training, as it often isn't by well-meaning beginners, a conscientious therapist will in time rediscover it. Supportive therapy is like a blood transfusion–it is a transfusion of positive energy that can lead to improvement but does not address the underlying problem. The low ebb can re-occur, or probably more commonly, it never really goes away.

The bio-energetic therapy developed by Alexander Lowen, on the other hand, is clearly intended as transformative. So was (and of course is) psychoanalysis.

The difficult truth is that transformation, even modestly defined, is so much more difficult, for both the therapist to steer towards, and the client to work towards. The honest situation of therapy is that transformation occurs very rarely. It happens just often enough to maintain the mystique of psychotherapy in some quarters, but not often enough to really be trusted by the mainstream.

Transfusion, on the other hand is easier. It is, really, what well meaning people have always done for each other. It is reliable and fairly reliably reproducible. Where I practice, in the State of Washington, supportive therapy has become the community standard, both in what many practitioners expect from themselves and others, and in what the Department of Health considers professional.

It is also what most clients expect. Of course these clients often believe they are in fact seeking transformation. That is, they believe that if they can only finally get enough support, they will be transformed into happy. That is of course, the fantasy of the deprived/neglected/abandoned child that so many of us operate from.

Why not then provide both transfusional and transformative therapy (with the client's informed consent of course)? Well, passed-on wisdom of experience has taught that in many ways supportive therapy can impede transformational work. It seems to draw out the same old adaptive self of the client (and usually of the therapist–see also this discussion on rescue.) In the Reich and Lowen tradition, the therapist is warm and energetic, which hopefully 'rubs off' on the client. Bodywork is intended to show the client, however, that he or she can produce their own heat and energy.
Michael Samsel

The 'Assignability' of Anxiety

I was originally trained as a Family Therapist, using a systems point of view. Like Stephen M Johnson, I now agree that many useful ideas have come from systems therapy, but that compared to a Lowenian or neo-Reichian point of view, it is actually very superficial.

A large part of family therapy is based around a curious phenomenon: when several people live together or interact, they seem to pass around the anxiety. That is, one person can become the symptom bearer, having more than his or her fair share of suffering, while the others function better than their histories or 'skills' would predict. Symptoms can seem to actually leave a person quickly, without apparent substitution.

This concept, once accepted, has been shown to have such explanatory power for the dynamics of families that it is not seriously in dispute. That is, it really seems true. One might call it the *assignability of anxiety*.

But the next part is more questionable. The thinking in systems therapy seems to be, if anxiety and suffering can be assigned, why not assign it into a void or space? That is, manipulate experience such that subjects 'cannot keep' the problem but no one else close can take it on either. This is the premise behind many of the ingenious 'solution-focused' therapies.

I believe family therapy has shown by numerous examples that it is possible to appear to do this. Or said differently, it is possible to do this briefly.

But this doesn't change character. While a systems intervention may unstick a group from a specific problem, the same 'constellations' of suffering re-accumulate for individuals unless there is bodywork and focus on character. There is a role in Reich and Lowen therapy for the arranging of the environment to encourage 'out of character' experience, but it is to be managed by the client as he or she comes to understand the nature of their problems.
Michael Samsel