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*In This Issue:*

**PSYCHOTHERAPY AND PHYSICAL  
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## FOCUS ON THE PHYSICAL

### The Challenge for the Non-physician Psychotherapist

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A focus on the physical representations of emotional distress is critical to the success of psychotherapy, and to overall health. Non-physician therapists and many psychiatrists are often weak in this area, getting caught up in verbal content. Since my training was in social work rather than medicine, it has helped me to refer to the people on my caseload as patients, not clients. They are, in fact, living organisms ailing from emotional disorders that are lodged in their physiology. Many practitioners treat emotional illness and confusion as deficits in understanding, calling for cognitive assistance. Their course of treatment follows that assumption, but disappointment is often the result since life *experience* is *not* cognitive.

My own interest in psychotherapy came out of an admiration for psychoanalysis. I harbored a fantasy of exploring for hidden psychic patterns in the verbal productions of my patients. I dreamed of becoming an esteemed benefactor of health through well-formulated interpretations and elegant timing. The analytic model provided the tools to detect primitive archetypes behind the curtain of consciousness, so I anticipated a fascinating life of discovery, secretly holding the fantasy that the patients would forever love me as a brilliant sleuth.

Like most people, I was not comfortable with the stir of emotions deeply embedded in my own body. I must have been half-aware of the sense of emotional pressure there. To ward it off I used my head to become a first-class rationalizer. A decent intellect had drawn praise and had given me a competitive edge from early on, so it had become my subjective center of power and control. Naturally I believed I could help others by that same route.

My faith wavered when I found that a favorite graduate school professor had been twice analyzed, and even he knew he was hardly the picture of health. A new supervisor had done the same, twice, only to be disappointed. Other colleagues had tried for several years each and, while valuing the human support of the analyst, found it lacking in terms of a substantial effect on their personality. I, too, tried it for several years, terminating quite unfinished. And, by this time certain that the analytic

mode was not enough, I somehow could not stop those wise interpretations to my patients...only to see limited progress.

One experience that pulled me away from the cognitive perspective was a training requirement to take a guided personal tour of the gross anatomy lab at a nearby medical school. Until that day the body, to me, was a set of concepts and abstract functions from a biology class. Suddenly, here was a dismembered human leg...could someday be *my* leg. Not far away were eyeballs, testicles, a half-dissected skull and a new whole arrival bloating with formaldehyde as his life's blood slid into the floor drain. Thirty more corpses lay in plastic bags on a top shelf, waiting their turn. As a non-physician, I was startled into the physical reality of death and, by contrast, into the physical reality of life.

After that three-hour experience I could no longer work comfortably from abstractions about neurotic complexes and personality types. Playing on my mind was the actual physical impact of chronic emotional strain over a life span. Digestive troubles, tension-induced pain and malfunction, depression-induced resignation of the system, and all of the other familiar symptoms now produced vivid physical pictures in my mind. The old psychological models seemed removed from real flesh-and-blood life.

A second experience was an extensive course of body work as part of my training at the Radix Institute established by Dr. Charles Kelley, who made advances in methods originated by Wilhelm Reich. Experiences here helped me to sense directly how my own viscera and musculature captured, retained or released emotions. With trusted guidance and through proven physical techniques my own body eventually released long-suppressed sobs, mobilized repressed rage, and over time experienced a gradual muscular relaxation. This softening finally allowed open sadness, and happiness, and greater overall emotional responsiveness.

These experiences confirmed the truth: emotions reside in the body. Physical and perceptual distortions created by emotions reside in the body. Inhibitions to experiencing emotions, or to expressing them, reside in the body. Therefore, the path for cure resides in the body...not in the intellect, not in free association and not in the modification of social circumstances alone.

Because this is true we psychotherapists have to change our focus to the physiology. To accomplish this we need a major shift in our training. We

not only need competent help to get beyond our own intellectual defenses but also experiential preparation by way of body-oriented work with our own emotions. In addition we need education in the relationship between emotions and the physiology. Thus we can begin to prepare ourselves as healers, as persons who treat the body.

Any focus on emotions in the body requires spending time on a review of Reich's work which cannot be understood fully from reading alone. Since people often become afraid of the fundamental change that a pioneer portends, many have dismissed him prematurely without fully realizing the merits of his work. Witnessing many clinical incidents demonstrated in his model, and which also made sense in mine, I began to grasp the clinical power of his assumptions. You, the reader, may well have to witness the same.

Reich (1945) studied emotional processes in man based on his observations of features we share with primitive organisms. [See Darwin (1872).] Building on repeated observations of the physically ill, he identified a natural path of pulsating, life-giving motion through the body. This same physical pathway was also a channel for the natural and spontaneous expression of the various emotions. Reich saw that, during childhood development, fears of parental reactions and other restrictors began to produce physical patterns of restraint within the child. The child's participation in such restraint would include holding its breath and tensing particular muscle groups, including some internal organs. In this way painful or forbidden emotions could be physically "stopped" from expression, gaining the child a greater sense of subjective stability. A physical block could force the emotions into the background, and upon repeated use could force the awareness of those emotions completely out of consciousness. Over time these blocks would develop into chronic, unconscious patterns of tension with distinct features in set parts of the body. As these specific tensions blocked awareness of "selected" inner life, they tended as well to distort "selected" perceptions of external reality. Such chronic patterns of tension would then become part of a larger pressured physical mold, the basis of a character typology upon which Reich (1945), Lowen (1958), Kelley (1979) and others have elaborated. This pressured character mold, insofar as it chronically blocks a healthy flow within the body, contributes to physical symptoms and syndromes.

Reich (1945) referred to the patterns of physical tension as "armor" and determined how it is laid out in several segments of the body. He specified that since the physical habits of armoring originate in the body of the infant

and young child, it is the body which retains the "effects from the past" (p.423) in its structure.

Bar-Levav (1993) observed similarly what he called "tissue memory." He asked, "How can we ever know what happened before the patient had any memory and any consciousness?" and answered, "We cannot know it from what the patient says. But we can deduce it from what the patient is, and what he or she shows characterologically and characteristically" (p.5). Bar-Levav's view is that a sense of subjective fragility is the baby's basic emotional condition, causing tension to take root in the physical tissue of the developing infant's body. He elaborated how certain types of encounters with the earliest mothering person can inflame that sense of fragility, producing a primitive fear either of abandonment or of engulfment.

Claiming that nearly all character structure (including its physical component) is a result of layered adaptations to one of these two primary fears, Bar-Levav (1988) holds another key to the core of human functioning, physically and emotionally. His theory is one that steps beyond Freud and Reich, but more importantly, it opens yet another door to the preverbal core of the physical/emotional structures that we (and physicians) see. To elucidate his assumption that character adaptations to early fear are a main source of emotional and physical illness, Bar-Levav (1988) says:

The tendency to be sickly is another aspect of the physiologic basis of character. Some people typically respond to subjectively unbearable stress by developing physical symptoms, the direct bodily equivalents of emotions. (p.89)

Even though we idealize the brain in our culture, much more than 'peace of mind' must be found before relief is obtained. It is confusing and incorrect to regard body and mind as separate entities split from each other, since they react together, as parts of a whole usually do. (p.90)

While he did not focus on these specific primitive fears, Reich (1948) too spoke to the issue of a single source of physical and emotional trouble:

There is a general misconception that the organism is divided into two independent parts: one is the physico-chemical system, "soma" which is destroyed by cancer tumors and cachexia; and the other is

the "psyche" which produces hysterical phenomena, so-called conversion symptoms in the body, and which "wants" or "fears" this or that, but has nothing to do with cancer. This artificial splitting up of the organism is misleading. It is not true that a psychic apparatus "makes use of somatic phenomena"; nor is it true that the somatic apparatus obeys only chemical and physical laws but does neither "wish" nor "fear." In reality, the functions of expansion and contraction in the autonomic plasma system represent the unitary apparatus which makes the "soma" live or die. (p. 166)

The advent of technological medicine has delayed such pursuit of a unified emotional/physical source as many physical symptoms can now be approached from a more mechanical perspective, perhaps attractive to those doctors uncomfortable with involvement on an emotional level. Ferguson (1980) refers to this as a period of "unleavened" medical science. The emotional shortcomings of technological medicine, the remarkable results from emotion-oriented approaches to physical illness, and our new knowledge of more unified medical approaches from the Far East are encouraging us to again focus on a central disease process, and not just on symptoms.

Physical disease process is accompanied by emotional representations, just as emotional disorders have always had concomitant physical expressions. Some physicians testify that half of their patient visits are essentially emotional in nature. Sophisticated psychotherapists always see physical distortions produced by character adaptation. Therefore, while there has never been much question about a mind-body relationship, there is a compelling need to focus on the intrinsic involvement of emotions with the body.

This intrinsic involvement is active and never truly still. Even tension is, in fact, concentrated emotional/physical activity, a fact difficult for many to see. We typically prefer to see things as fixed. We like to give everything a definitive name, perhaps to gain a subjective sense of control over it. Ferguson (1980) quotes Dr. W. Ellerbroeck, a surgeon-turned-psychiatrist, who said: "We doctors seem to have a predilection for nouns in naming disease (epilepsy, measles, brain tumor), and because these things 'deserve' nouns as names, then obviously they are things to us. If you take one of these nouns--measles--and make it into a verb, then it becomes, 'Mrs. Jones, your boy appears to be measling,' which opens both your mind and hers to the concept of disease as process" (p. 257).

Fixed diagnostic categories and labels, both physical and emotional, frequently serve as an avoidance of truly "being with" our patients. This is a symptom of our discomfort with their internal primitive emotional processes. If we professionals can become internally secure enough to relate deeply, and without confusion, to our patients in their core state of commotion, we can then take steps closer to treating the central motivational process in them.

To summarize, physical and emotional health emanate from within a constantly pulsating, sensate and responsive container. Disturbances in the container, the body, are often created by emotional contractions. Chronic strain produced by these disturbances can finally break into a variety of physical symptoms. It only makes sense, then, that physicians should make an effort to see each patient as a living unit of activity, measling or cankering, depressing or fearing, and to look for the interplay of the patient's emotional process in disease activity. Likewise, it makes sense that psychotherapists "examine" each patient's body to better grasp and work with the interplay of the physical and the emotional, gradually abating the amount of physical distress over time.

How senseless it is to focus on verbal content alone! The sound of the human voice, enclosing a vibration (as a word) and propelling it with the respiratory apparatus into the air, gives a much better reflection of the physical/emotional *experience* of the speaker than the words themselves, which are secondarily selected by the intellect. The lungs and diaphragm work in tandem with muscular and organ tension to produce the propulsion behind the sounds. We, as "professional instruments" listening to and accurately "feeling" the music from inside the speaker, can obtain reliable clues about his or her actual subjective experience. A sensitive diagnostician can see, and to some extent feel, the outline of this process and very accurately identify with the patient. And the ability to accurately identify with the inner experience of the patient is one fundamental step toward cure.

Each time people enter my office for individual or group sessions, I am obliged to evaluate their physical presentation. Sensitivity to music helps me record the rhythm, volume, tone, size and percussiveness almost before anyone sits down. Posture, coloration and localized changes, typically around the eyes or mouth, are all part of the recording. Getting to know these people well over time permits greater sensitivity to subtle change in individual manner and presentation. *We hear what is being said in the context of what is being presented in the body.* These bodies speak

volumes and routinely communicate reactions before the words do and in a much different way. Once the diagnostic read is taken, the next step is to make meaningful interventions in ways that will not only make corrections in transference or projections, but will also produce benefit to the physiology.

Let me broadly describe one group and a case illustration from it:

Patti, 20, leads the way in. While short and quiet of foot, she travels in a straight line to her seat. Her eyes are hidden. Her history is one of withdrawal, and she will not likely speak early in the session. She is very sensitive but often holds her responses deeply inside. She always has.

Peter, a tall young professional in a dark suit, smiles officially and is sure to add a proper "hello." His speech is so fast that individual words are often hard to distinguish. And he smiles much too often. All of this is motivated by his chronic anxiety and his urgent wish for approval.

Todd, 32, is six-foot-three, athletic, and "jock-walks" his way in. His booming voice and manner defend against his sense of vulnerability. Underneath he has had frequent episodes of physical pain and massive anxiety. Over the years he has seen several therapists and has been prescribed numerous psychotropic medications.

Bob, a young man wearing glasses befitting an intellectual, has a soft manner and a mild whine in his voice. He wears wrinkled slacks as a badge of the liberal, is heady and watchful, and often not in touch with his emotions. This is evidence of not ever having felt safe enough with the mothering parent to have his feelings, and therefore his individuality, confirmed.

Belinda has angles, everywhere. She is thin, polite, almost perfectly kept, and almost never raises her voice. She has had a mild eating disorder. Again, the early mothering experience is disturbed in her case. While she can be more in touch with her emotions than Bob, she has a way of putting them cleanly out of sight. She occasionally flares up with colitis.

Nelly, middle-aged and absolutely appropriate, is wrapped with tension showing in a very deliberate walk and manner of speech. She is covered well by tasteful clothing and attitude. Serious headaches are just one of the resultant symptoms. For her too, being "just right" has not left much room for the real her.

Naomi is a fiftyish synthesis of old lady and little girl, crotchety and cute. She is semi-withdrawn, with very strained vocal cords. Her eyes can widen suddenly, or appear remote. She is very bright, but relates better to plants than to people.

These living beings will relate to me and to each other from within their individual physiologic frameworks. During nearly every verbal exchange it is my job to be aware of the eyes, posture, breathing, color or other relevant physical features. When the breathing becomes shallow, or the eyes appear remote, or the shoulders tense, or colors change, it is a signal that some emotional activity is at work. (*Emotion*: movement is an intrinsic part of the word.) The verbal content is not to be ignored, but it is usually not as important as the feeling behind the physiologic involvement. Each individual body actively engages in the process of expression, or in resistance to-expression. Even frozen withdrawal is a condensed physical involvement. At the high points of each person's unique type of physical involvement, a well-timed and well-dosed intervention is most important.

As an example, during one group session Naomi was talking with her characteristic mannerisms fully engaged, but almost no one was listening. She sat on the edge of her seat. Her voice strained and scratched more intensely than usual. The back of her neck was so tight that her chin tilted up and her head tilted back. In that position her glasses magnified her eyes which were focused so deeply within herself that she literally did not see other people. My co-therapist noticed and asked her if she was seeing anyone as she spoke. She paused momentarily, then acknowledged that she was not. She tried with spastic difficulty to go on with her story while attempting to see others. Her struggle for contact added to her agitation as her neck tightened even further and her breathing became severely distressed. She could not continue.

After a tense reflective moment she cried out that she must be frightened just to be with people while she was this open (emotionally). I had sat next to her, so I asked her permission to slightly move her neck and head as she spoke. [I typically have a "no touching" contract. And only with renewable permission where the patient truly has the freedom to refuse do I occasionally intervene in this way.] My aim was to loosen the fear-induced physical contractions in her neck and eyes, hoping to help her eventually become more present to literally see, and to be with others. This physical work, through moments of irregular visual and emotional contact, finally allowed deep direct expressions of fear coupled with tremor and crying along the way. Eventually, her whole physical being and manner softened.

as her primitive fear discharged in a safe, reality-based context. Finally the restraining tension in her eyes, neck and vocal cords yielded to allow some real contact with the others, even while she remained somewhat afraid.

Sometimes physical intervention is needed to promote presence of mind, meaningful contact and a beginning physical shift in respiratory and other tensions. But useful interventions do not always require direct physical touching. In fact physical touch can have complex meanings to the patient and, therefore, may be dangerous unless the therapist is very well trained (Bar-Levav, 1993). But useful interventions require at least a knowledge of the body and its emotion-related features, as well as a set of valid techniques (Kelley, 1979, Bar-Levav, 1988, Reich, 1945, Lowen, 1958). Over enough time most of the body's characteristic inhibitions and expressions will surface in the relationship with the therapist. These occasions present continuing opportunities for slight shifts on the physical level. Measuring such changes at the body level will eventually give us our criteria for success.

Chronic physical strain from emotion often leads to real physical illness which then requires the non-physician therapist to establish a relationship with a physician-ally. At this time neither specialty is able enough by itself to assume the entire responsibility for treating the patient's emotionally and physically interrelated system. Finding such an ally for a therapist is often difficult, as is finding a therapist-ally for the physician. Physicians, for valid reasons related to previously disappointing results from psychotherapy, may be reluctant to cooperate. And now that they have powerful new psychotropic medications at their disposal, they may see less reason to. As a result, we therapists have no choice but to become more expert in this area of the physical aspects of emotions and then to make ourselves fully known to potential medical allies. As pioneers on the frontier of emotions within the body, the ideal way to proceed is in such a relationship, when available.

Once allied, we need to work together against the "quick fix" delusion. Business-driven medicine presses for short-term treatment to contain costs. Aiming at symptom alleviation rather than system-cure, it will, over time, prove to be *cost-defective*. At the moment, though, short-sighted economics is king, more so than standards of health. And currently this system supports only a token involvement in psychotherapy. Since some of us now know how to proceed more effectively toward the emotional roots of many illnesses, we must substantiate our position to dispute the short-term trend.

Academic study alone will not bring us the expertise we need to take on this very difficult task. Each of us needs a qualified mentor to guide us through the new depths of this art. Unfortunately, at present there are only a few. Some of the more able have developed and tested new theories which are available for study: the theories of Bar-Levav, Kelley, Lowen and a few others even shape frameworks for practice. They differ somewhat from each other, but one can learn a great deal by studying their similarities and differences. The real learning key, however, is to gain personal experience with them or with one of their more able proteges. And beyond acquiring a valid theory, we need to be trained to become reliable emotional/physical instruments. We are at the same time the observer and the tool of influence on the emotional/physical being of the patient. Only after we work through the blocks in our own personality can we frame a relationship in which the patient can join us on the road toward health.

After all of the above is in place we should be able to see the significant emotional history of each patient, "bred" into the physical structure. The earliest life experiences, "written" nearest the core, profoundly color what developmentally follows, physically and emotionally. If subjective fright was a common condition in the earliest months and years, then later developmental experiences would be perceived with that fright and its resultant restraints already in place as a core experience, distorting the later experience. Therefore, reaching those earliest affective states is fundamental if we mean to influence the entire organism, emotionally and physically.

While there is much more to learn, we are in a position to significantly impact many of these difficulties if a secure therapeutic relationship is in place over a long enough period of time, and if we are competently equipped with knowledge of the body and appropriate interventions. Much more refinement is called for and, while it seems to be a huge job, we all ought to carefully think through the alternatives. The costs of not doing it this way to individuals, their families and our culture are too heavy and far-reaching to ignore.

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## Background Point of Theory

Illness, except when it results from normal aging, is often an expression of the continuing wish of individuals to be cared for by others, since such human closeness generally is reassuring. This, more so than genetic determinants, explains why some young and relatively fit bodies are much more susceptible to disease than others.

*Thinking in the Shadow of Feelings*, p. 73