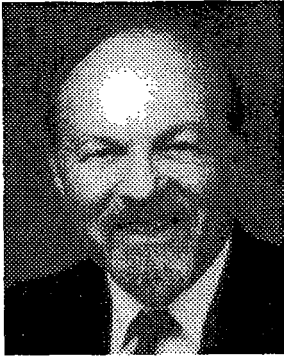


## On Diaphragms and Deer, or Yardsticks of Success and Failure in Psychotherapy



Life is truly an ongoing miracle, much more so as I age. Thankfully, I'm not only in good health but increasingly also understand more fully life's intricacies and the complex work that we do. So far I'm getting better, not declining. Here are a few important new observations about psychotherapy whose exact nature became clearer only of late.

Some people fill their time with hobbies, others with work, but Elaine always busied herself with doctors. Her calendar was heavily populated with at least one, and sometimes with several, doctor appointments on just about any day, and she would make the rounds between her internist, cardiologist, dermatologist, neurologist, rheumatologist, gynecologist, podiatrist and surgeon. Almost every system of her body was checked, and double- and triple-checked, and she would complain of aches and discomfort as if she were old and worn out, though she was only in her 40s. Always worried about her health, she was nonetheless functioning well as wife, mother and friend.

In general the doctors could find no anatomical or physiologic basis for her many persistent complaints, and they eventually tired of her and of her repeated demands for relief, or else she would tire of them. But she had a good and long relationship with Dr. S., her internist, who was steady, sympathetic and wise, recognizing that at least subjectively her pains were real. Patiently he always continued to assume that perhaps some well-hidden pathologic process was at the root of all this trouble. Even so, he would softly suggest from time to time that it was probably a good idea to also consult a psychiatrist-friend of his, adding somewhat apologetically that she had nothing to lose by following his suggestion.

Elaine always expressed "surprise" and became indignant on such occasions. "I don't understand you, Dr. S.," she would proclaim, "you know that I am always busy with doctors, and now you push me to see one more? At least my psyche is okay! At least one of my systems isn't in trouble! In fact I'm sick and tired of doctors. They haven't done me any good. You are not trying to just be rid of me," she paused and carefully looked him over, "or are you?"

And so it went, year after year. He knew a young, "promising" and reasonably bright doctor, he told her, and it really made sense to at least check him out. Finally she did, perhaps five years after he first started mentioning my name.

Elaine was likeable, talkative and obviously quite insecure emotionally. It was clear from the start that she was a natural product of very poor early mothering, and that she fully expected to always get her way—the result of insufficiently firm and consistent fathering. But she was charming, and all this did not interfere very much with her being happily married to an easy-going, compliant and well-off husband. Socially always busy and physically always in motion, she lacked inner peace. But she did not know how to describe the almost complete absence of serenity in her body, and the doctors whom she consulted didn't recognize the problem for what it was.

This preverbal hunger to be touched, welcomed and warmed, and to be physically and emotionally reassured by a steady presence of a calm human being was satisfied neither by adult sex nor by the desperate attempts to reach out to doctors. So Elaine compulsively also reached out to other people. Every single day she would mail three, four, or even more birthday and anniversary cards to her many acquaintances, and with the help of her meticulously kept records, she never forgot anyone. She was a busy lady indeed. But the unrecognized fear of abandonment dominated her living and filled her with much ever-present anxiety in spite of these many superficial involvements.

It was not surprising, however, that she quickly settled down, probably for the first time in her entire life, once she got really involved in our relationship (which was based on two individual and two group sessions every week). She was soon able to take a deep breath without rushing to make another contact with someone, and reported before long that her high blood pressure became almost normal, even without medications. Practically all her other symptoms also disappeared, and with them her daily visits to physicians. She even neglected her appointments with Dr. S., and it was necessary for me to insist, on the pain of being unwilling to continue seeing her, that she have a yearly physical check-up. Both in reality and transferentially she was very grateful. I had proven to be a steady and reliable anchor and thus also became the "good mother" that she had always yearned for, and had never found before.

A success story? It surely appeared to have the makings of one.

And then came her two-week trip to Italy. Early in the first session after her return she told me with much excitement and joy that she had "forgotten" to inform me during the 2½ years of her therapy that among her many previous complaints she had also been severely allergic to wine. Her husband was a successful businessman, and being well-off they would often go to fine restaurants. On several occasions over the years she had to be rushed to an emergency room in the middle of a meal because of severe, asthma-like breathing difficulties. Time and again they would eventually discover that the chef had used a little bit of wine in one of his sauces, which was enough to precipitate an attack. Herb, her husband, was understandably shocked, therefore, when she casually asked him to order a bottle of wine one fine, romantic evening in Florence. He warned her: she might not find competent medical help in Italy, and not as quickly as

back in the U.S. She was making no sense, he said, and was acting irrationally. But Elaine refused to yield and, with him, whenever she insisted, she prevailed.

So, she was now telling me with delight that indeed nothing bad happened, and that they enjoyed a good bottle of wine every evening thereafter. The change was "obviously" the result of our therapy, she insisted, though I refused to accept any credit for having done her any good on this score. "I did not even know of the existence of this symptom," I said, but she refused to accept any explanation. "I *know* that my body has been changing and that physically I'm not the same as I used to be years ago. Somehow I knew that it was safe for me to enjoy wine, and that drinking it would not harm me. I thank you very, very much."

In spite of her gratitude and high praise I considered it a bad omen. Magical thinking which does not yield to reason can easily turn into condemnation.

Elaine's mother died suddenly soon thereafter, before we had time to work through her transference confusion. The mother died on a Friday morning, a day before the beginning of a weekend marathon in my practice which Elaine was scheduled to attend. This 28-hour session would start, as usual, on Saturday morning and last till Sunday at noon, with a break for a few hours of sleep. Even then, long before I had conducted some 250 such marathons, I knew that it probably would be very helpful for Elaine to attend at least part of the marathon, if no reality reasons existed to prevent her from doing so. Here was a place where she would be free from having to do anything for others, a place and time to mourn, or not to mourn, for her mother without guilt, shame or societal pressures, an ideal setting to be true to herself. The funeral was not scheduled until well after the end of the marathon, and I strongly advised her not to give up this opportunity unless pressing family obligations or the need to make practical arrangements interfered.

I thought of the marathon as a uniquely well-timed gift for Elaine, and pressed her at least to consider the idea seriously. But she was so hurt, insulted in fact, by my apparent "insensitivity" and lack of understanding or empathy that not only did she not show up for the session but she also left therapy suddenly, angrily and in deep disappointment. I now know what I did not know then—that our real-relationship, though solid, was too tenuous to withstand the powerful storms of transference disappointment.

Elaine was markedly improved by then, free of the preoccupation with her symptoms and without her chronic wine allergy. So, is hers a success story or one of failure in psychotherapy? What counts for more: the freedom from somatization or her psychotic-like confusion about my intentions?

By the time she left, Elaine had only entered the middle phase of therapy and the changes, though real, were not yet solidly fixed. For all I know, her previous "knowledge" that no one was reliable or truly dependable was confirmed in her eyes by my well-meaning intervention. At that point I may also have transference-ally become a bad, non-caring and insensitive mother for her. Did she regress later? Did her symptoms return, or perhaps even worsen? Since she disappeared

and several attempts to contact her always ended without success, I never found out. From time to time I think of her sadly even now, with concern, wondering how her life continued after she left. Her miracle-like cure from the wine allergy notwithstanding, to me Elaine's story is not one of success.

To really achieve a successful result in psychotherapy, I've since learned, it is necessary to undo the autonomic, physiologic responses of the body, especially to irrational fear and hurt. That fear and hurt are in us and a part of each of us since all humans are born a year or two before much conscious understanding exists. Before we emerge from normal autism we cannot but misinterpret many of life's early experiences which are in fact safe, and our small bodies frequently rattle in that period as if our very existence had been endangered. Since no conscious memory exists yet, early pre-memories of such experiences are registered in the fibers of our musculature, and *they* must be changed if chronic despair and depression are truly to be lifted. Elaine did not reach this phase and did not go through such changes. She was much better, but obviously not well. Internal storms of fear, hurt, anger or disappointment would still damage, and perhaps destroy, other relationships.

Ruthie, on the other hand, has valiantly struggled against these demons for many, many years, but she is somehow still unable to achieve the final victory in this difficult war to liberate herself. She understands and sees more of what she was blind to before, her physical appearance and social relationships have markedly improved, and this previously very troubled woman now also earns a living. But she still lacks sufficient serenity in her body. Without effective therapy she would probably have been long dead, either from her chain-smoking and general carelessness with her welfare, the natural consequences of deep hopelessness, or from suicide. Perhaps she would have existed at the extreme margin of society, a homeless person with middle-class credentials. Instead, at age 44, although still somewhat isolated, suspicious and single, she nonetheless is often friendly, and increasingly even experiences moments of joy.

But where is the end point, both of us sadly wonder. Our relationship is essentially clear of transference distortions now, but she still dares not let go of me, her anchor, when, on occasion, the yet undrained pools of deep hurt and her sense of having been basically wronged threaten to drown her. Her own yardstick for assessing reality is not yet dependable enough. After 12 years, is this a failure, or a story of impending success in psychotherapy?

I have been examining and continue to check my motives for not insisting that she leave. I've always tried to live and to practice by adhering strictly to ethical standards, but still, I'm earning my living from my patients and must therefore keep watching for a possible conflict of interest. Although I'm genuinely and deeply touched every time Ruthie and others take another step towards individuation, I'm constantly alert to the fact that her welfare requires that she make an independent life for herself, away from the support that she's getting here. I'm acutely aware of the passage of time. I know that there are endless ways to improve a manuscript but that at some point it has to be published,

which renders it finished. When will Ruthie be done? She's alive and in many ways well, but is our so far interminable work together a sign of failure?

The proper ending of psychotherapy should obviously *not* be a function of the patient's wishes and preferences. This statement may at first strike some readers as authoritarian, anti-democratic and arbitrary, something to be quickly dismissed. But don't we all agree that we humans have a hidden inner life, the one which Freud called the Unconscious? We now know that many of his other formulations about the causes of anxiety and the genesis of emotional illness were wrong, but he was obviously right in stating that we all help ourselves survive by repressing and by suppressing that which is too conflictual, or too painful, for us to deal with openly. Surely, no psychotherapy would ever be needed if the storms of emotional conflict within the psyche were not hidden from the patient's view. Consequently, patients often want to end their treatment long before they are ready, or well.

### THE NEED TO ASSUME A LEGITIMATE AUTHORITATIVE STANCE

Generally, what people want is just to get relief from their despair, hopelessness and pain. They want to be happy and comfortable. Psychologically sophisticated patients in acute distress and pain also tend to "forget" that feeling better is not the same as being well. We psychotherapists are really in the very same position vis-a-vis our patients that all other healers are: we have, and must use, our special expertise and knowledge to guide our interventions and judgments. The patient's preferences are often dangerously wrong. It is not only foolhardy but also irresponsible to ask the patient (who may be panicky or too confused to understand much) what he or she wants us to do.

In democracies people are free to make autonomous decisions about their lives, and as adults we are indeed expected to chart our own course. But in many areas we still need experts to tell us which options are available to us, and which are likely to fit us best. *Caveat emptor* often gives rise to anxiety even when we merely are about to spend large amounts of money; much more anxiety (and less clarity) exists when a person in acute distress seeks the help of a healer. Embarrassment and fear often cause people to minimize, or even to obscure, their troubles, but knowledgeable experts are expected to see beyond it and to objectively determine what course of treatment is called for. As in Elaine's case, it is our responsibility to strongly recommend interventions that may be different from, or even contrary to, what a patient may seek, wish or request. To do otherwise may sometimes even border on professional malpractice. Ultimately, the patient is the one who decides, but we ought to try very hard to win her or him over to our expert point of view, even risking our own commercial interests in the process.

Psychotherapists who for whatever reason cannot or will not assert themselves in such an authoritative manner are reminded that the current decline in the use of psychotherapy, and the preference for medications, are a direct result of doctors

going along with what their patients ask for. They expect a quick fix. Prompted by ignorance, greed, the pressure of drug company representatives and the universal wish for easy solutions to difficult problems, physicians prescribe and patients eagerly take their Prozac (or whatever) with the naive expectation that this can solve life-long difficulties. But we psychotherapists surely know that to merely treat the symptom is often to overlook the patient's real needs.

People are commonly unaware of the true nature of their health difficulties, which explains why a minor complaint of indigestion sometimes ends up with immediate open heart surgery. While patients generally expect relief without delay, they are rather slow, and often simply refuse, to change the lifestyles and habits which are at the root of their pathologic condition. These helped them survive. After all, smoking, drinking, over-eating, gambling, rebelling or compulsively conforming, and a myriad of others, are all so popular because they are effective in lessening anxiety, and "the push away from fear and dread supersedes everything" (Bar-Levav, 1988, p. 324). Patients win another chance for life by losing the battles to keep such pathological modes of existence. Competent and ethical therapists do not serve their own power interests when they take an authoritative stand. They serve as representatives of reality and they speak in its name in the hard struggles against irrationality. Patients are the beneficiaries when such therapists prevail, and they lose.

#### THE FOUR PARTS OF SEPARATION-INDIVIDUATION

The theories of Darwin and Freud which literally changed our world were both based on evidence that today would be dismissed as anecdotal. Many of their observations could not be and never were duplicated independently, but the sheer volume and variety of their observations were of such a magnitude, and they corresponded so well with common knowledge of people everywhere, that their conclusions could not easily be overlooked or rejected.

The same is true now. The behavior and inner workings of human beings still cannot be quantified in the same way that we measure chemical reactions, and even though nose counters continue to dismiss other types of observations as non-scientific, the long-standing clinical research efforts of the group with which I work (Ronald Hook, M.S.W.; Pamela Torracco, M.S.W.; Leora Bar-Levav, M.D.; David Fogel, M.D.; John Rierson, M.Div.; and Charles R. Kelley, Ph.D., have been especially helpful with these observations) make it possible now to summarize succinctly the main features that must be present when the process of Separation-Individuation is essentially completed, which is how we define a successful outcome of psychotherapy. Open-minded, independent clinical research will challenge or confirm these observations, but in fact they can be validated and invalidated more directly than many of Einstein's theories that are yet to be confirmed.

By now we have an almost endless accumulation of observed and recorded data about people who are emotionally stable and on others who are not. And

leaving psychoanalytic and other metapsychologic speculations and philosophizing aside, reliable judgments about success and failure in psychotherapy can be rendered more reliably, based on how much of the following continuum has been completed:

1. The patient's physical body is no longer governed by long-past, early life experiences, nor is conscious attention unreasonably concerned with uncontrollable future happenings. Behavior and physical reactions are directly related, and proportional, to the type and strength of stimuli in the present. As a result, bodily functions are generally not under stress, and the body's musculature is generally not unrealistically tense.

2. Feelings, which are the emotional residues of a person's total life experiences, have been sufficiently calibrated by meticulous working-through, and thus mostly drained of their excessive, titanic force, the result mostly of accumulations from early preverbal frustrations and from over-indulgence in the first few years of childhood.

3. Thus attenuated, feelings influence, but no longer dominate, all behavior, thinking and action, as before. Objective, critical thinking, out of the shadow of feelings, is now possible, thus enabling the person to consider alternatives and to live rationally and thoughtfully.

4. In the relative absence of the pressures of confusion and irrationality, the person is literally able to rest in peace while still alive. Such brief rest periods are frequently present even in the midst of a working day, they are emotionally as well as physically invigorating and restorative, and they markedly increase productivity, sensitivity, creativity and the capacity for joy. The interferences of the physiologic character structure, dominated by preverbal hunger and rage, have been markedly minimized.

In general, explaining, clarifying, interpreting and reconstructing are useful only as additives, when they occur within a real relationship between patient and therapist in which the former experiences so much physiologic safety that powerful, primitive, irrational affects repeatedly rise to the surface, and they are effective only in conjunction with such expressions. The more intense the affective expressions and the shorter the time between them and the explanations and clarifications, the better. The *body* thus slowly learns that its past knowledge of what is safe and what is not, based on a reality long gone, is no longer valid, and it slowly is altered. Not being under the control of the cortex, the body is a slow learner, which explains why achieving successful results in psychotherapy takes such a long time. Increased understanding and insight, in themselves, are irrelevant to this process. Much more than changing memories or cognitive perception of one's past is required to cure depression and to eliminate the confusion of irrationality.

Joel was in his 50s when he finally reached such a state after trying for almost ten years to overcome his inner ghosts. A child of an outwardly intact family,

he nonetheless always felt all alone, an odd kid in school, a tense daydreamer at home, without peers, siblings or relatives to confide in or to get support from. Like Van Gogh, he too expressed his fears and yearnings by incessantly sketching and drawing, not by talking. Living as a grown-up in a city with hardly any public transportation, he had never learned to drive a car, barely made a living, was unmarried and existed alone and apart from others. Though he was not really autistic, he almost appeared that way.

His earlier isolation and confusion were gone near the end of therapy, his body and face were visibly relaxed and he was able to think critically and clearly. These internal changes have given him the freedom to change his external life. He became the proud owner of his own house and he drove his own car, taught art in a prestigious high school and had a broadening circle of real friends. "Finally," he told his therapist one day, "at long last, I really fit. My inner image fits my outer one, and that of other people too. Finally they see me as I really am, while nobody used to see me at all before. My life is not always easy even now, but it is so much richer and so much less painful. One day soon I'll be leaving, but although I won't see you, I won't be gone."

This, finally, is an unambiguous story of success.

#### WHAT SPECIFIC MECHANISM BRINGS ABOUT CHANGE IN THE PSYCHE?

How did Joel go from point A to point B? In addition to the usual work and to some other less common interventions (physical touch [Bar-Levav, 1998] and dredging for affect [Bar-Levav, 1977]), we have increasingly used, and can now describe more fully, one more active ingredient whose exact nature is in general still poorly understood. This mechanism turns out to generally be of central importance in effecting real changes in the psyche, and although used for many years, only now can we explain the reasons for its effectiveness. This then is a first attempt to focus not on the goal, but on the mechanism, of change within the psyche.

The respiratory apparatus is the key. *It* must be activated to permanently change the physical reactions to what people (erroneously) perceive as dangerous, frightening or hurtful. (This is the opposite of "political correctness," which is a futile attempt to change external reality to fit pathologic and unrealistically low inner tolerances for hurt.) *Two voluntary muscle groups must repeatedly be activated by the will of the conscious patient as he or she is in the midst of re-experiencing storms of fear, hurt, rage and love* within the therapeutic setting. These muscle groups are (1) the facial muscles which open and shut the mouth by lowering and raising the mandible, and (2) the diaphragm (and other muscle groups related to respiration).

These two muscle groups are the ones directly involved in increasing the amplitude of inhaling and exhaling, and their condition at any one moment

can be directly observed. The jaw is sufficiently unlocked when the temporal-mandibular joint (at each side of the face) is activated, and the movements of the diaphragm can be seen by observing the rise and fall of the thoracic wall and abdomen.

We practice "talking" psychotherapy, not direct body-work. (Useful as the latter is, it does not normally include intense-enough transference and symbolic involvement over time, and in itself it thus mainly provides important emotional release, not permanent physiologic change.) Psychoanalysts and other doubting psychotherapists who aim at increasing insight and understanding will obviously wonder how such an unusual formulation about the respiratory apparatus fits with any type of "talking" psychotherapy, and on what clinical observations it is based.

The respiratory apparatus changes immediately by swelling emotions. For instance, breathing becomes shallow or fast in fear, and it deepens and slows without it. Selye (1956) observed correctly that both animals and humans fight or resort to flight when they sense danger, but what happens to them when neither of these two possibilities exists? A deer that is suddenly caught in the glare of a car's headlights normally freezes in whatever position it is in, as do all other creatures, such as spiders or ants, under similar circumstances. Motionlessness is a natural reaction under such circumstances, since it attracts less attention. This, *the third alternative*, is commonly used by all living things when fight and flight are judged to be impossible, in an effort to survive in situations perceived as extremely dangerous.

But how does the deer cope physiologically in those few seconds when, frozen, it senses the immediacy of a life-endangering threat? It becomes relatively motionless also inside. We can conclude this from what we know about humans caught in extreme danger without the possibility of escape: they either mobilize extraordinary power for a few brief moments to extricate themselves, or else they become paralyzed by panic and temporarily lose their ability to think clearly and to reason. This explains why living creatures generally use poor judgment at such moments (soldiers have run towards enemy lines, not away from them), a temporary state of going "out of mind," cognitive fainting which enables the organism to tolerate that which is subjectively experienced as intolerable.

A desperate fish, like a person in panic, throws caution to the wind in the pursuit of relief. It is easy to see why any creature would overlook hidden hooks in bait while in the midst of a hurried and compulsive escape, [and we humans have] devised ingenious traps using this principle, even for the largest and most powerful animals. But [we] also get trapped when [our judgment is overwhelmed by fear.] (Bar-Levav, 1988, p. 123)

All newborns and every young baby often exist in the third alternative during the first year of life, physically unable either to fight or to flee. In the darkness and emptiness of normal autism, the sharp and sudden pain of hunger pangs, for instance, cannot but be experienced as we would feel a knife stab, and its real

nature, like anything else, is totally unknown. The only possible response available to young human organisms then is to scream and to endure the horror. As with the deer, the body soon becomes still (as if it knows that survival demands battenning down of the hatches), the musculature tenses in response, and the extreme fear itself is repressed. The diaphragm, being an especially prominent muscle, also becomes relatively still, as can be judged from a baby's shallow breathing at such moments.

Such patterns of reaction remain the normal response to extreme danger throughout life, although in adulthood we adopt behavioral camouflages to try hiding our vulnerability. Underneath, we commonly find a silent body and frozen emotions, the physiologic characteristics resulting from repeated series of maladaptive responses, beginning very long ago.

We must reverse this process to effect lasting change in psychotherapy. The voluntary musculature must be activated in the midst of, or as soon as possible after, the re-experience of the storms of old fear or hurt that bubble up in the safe environment of the therapeutic setting (storms of anger, and the swelling up of love and tender yearnings, affect mostly the throat, but the working-through process is essentially the same). No amount of reasoning and insight has the power to overcome panic, but grown humans who possess the ability to observe what they experience in such an environment can increasingly refrain from bolting in response, and instead they are able to reactivate their somewhat still and underactive respiratory apparatus.

But still and all, *how* does breathing affect the psyche and what are the specific connectors that bind physiology and psychology to each other?

A rapidly growing number of well-constructed scientific research projects increasingly confirm what used to be no more than speculation, that the mind and body are so intricately intertwined that they can no longer be considered separate entities. The two are one. Solid scientific validation showing that effective psychotherapy changes the biology of the body has been lacking until recently, but late advances in the field of psychoneuroimmunology now demonstrate that a sophisticated mind-body network relays "emotional information" throughout the body (Ruff et al., 1985). We now have more and more evidence which documents that core centers of the brain are part of an all-inclusive network of chemical messengers and receivers of information, connecting all parts of the body with each other. These messengers, called neuropeptides, are literally molecules of emotion travelling from brain to body (where they are decoded), and from the body (which produces them also) to central subcortical centers in the brain (Pert et al., 1998).

During healthy times, these molecules of emotion travel freely in both directions, relaying necessary information. But sometimes the body becomes frozen and silent for the exact purpose of blocking the transfer of such molecules. *It* must therefore be reactivated to make the sluggish and poorly functioning transportation system more efficient, and thus it is a prerequisite for emotional health. Clinical research and many years of experience clearly show again and

again that such repair of the neuropeptide transport system is best achieved by repeatedly activating the respiratory apparatus. Increasingly fuller exhalations through a wide-open mouth make room for deeper inhalations, which bring about maximal movement of the diaphragm.

## MY PERSONAL JOURNEY AS A PSYCHOTHERAPIST

Wishing to be a Freudian analyst when I first decided to become a psychiatrist, I soon practiced psychoanalytic psychotherapy almost exclusively. But before long I realized that although my patients were doing better, they never got well. They understood more and could explain their troubles, but physically they continued to react to anxiety and to stress just as before. So, I added twice-a-week group psychotherapy and introduced once- or twice-a-year marathons into my practice, hoping that good contact and the increased frequency would intensify the transference and help build a solid real-relationship. But I worried. Probably I was not blank enough of a screen to foster emotional dependency (obviously not actual dependency), and perhaps my patients would therefore not develop the transference neuroses necessary for working-through.

Instead, and to my total surprise and delight, all was very well. And regardless of the presenting symptom, powerful yearnings to be taken care of, to be seen, welcomed, even to be touched physically, were soon powerfully and repeatedly expressed in almost every case. The hunger for good mothering was apparently universal, I discovered. This my teachers did not warn me of, and at first I was perplexed and frightened.

Naturally, I would not touch patients then, and never gratified such "regressive" wishes. Gratification of infantile wishes was, and still is, a taboo and damaging, but I did not understand then that the open expression of such normally embarrassing yearnings was, in itself, an indication of how physiologically safe these patients felt. I worried that perhaps the *yearnings* for mothering were also wrong, a contamination resulting from my wandering away, and eventually leaving behind, some of the basic rules believed to be necessary for the development of transference.

I know better now. Transference is unavoidable in any close, long-term relationship, and powerful transference neuroses (and unfortunately psychoses) develop spontaneously, as can be seen in almost every marriage, and elsewhere. This is the source of most interpersonal conflict everywhere, and always. The powerful yearnings for perfect mothering indeed resulted from my *not* being a blank screen, but instead, from my making good human contact regularly. I attempt to be a real person with my patients, in committed I-thou relationships, for as long as they need me, provided that they do not act out. This brought up all those yearnings. It is sort of crazy for adults to want to be mothered like babies, but in dependable, long-term relationships (e.g., marriages) such unresolved wishes from the distant past always bubble up, instead of remaining in shameful hiding. And here the relationship was also sane, reliable, responsible, accepting and

decent, which intensified the old wishes. But only in psychotherapy can such yearnings be worked-through, and resolved.

At first I could also not understand or explain why patients lying on my psychoanalytic couch (now used not for free association but to facilitate deep breathing) would sometimes begin to tear spontaneously, or even wail and weep with sounds normally heard only in the newborn nurseries of hospitals. I only treat adults. Some patients would physically shake in fear so powerfully in a session, and for so long, that the leather couch turned completely wet from their sweat. Slowly it became clear that all that was required for patients to experience such seemingly strange happenings was a genuine welcome and a little help to settle themselves and their racing thoughts—achievable by taking a few deliberate, deep breaths in a safe environment.

Previously unknown emotions and sounds quickly rise to the surface when patients feel safe enough, resulting in a form of nonverbal free association emanating from the body itself. These are not explosive eruptions but gradual and controlled openings for emotions which normally remain hidden below and behind the spoken words, primitive residues of experiences from a distant and unknowable period, well concealed deep inside our unconscious and typically so embarrassing and unacceptable to the adult that people generally deny their existence for as long as they can. (What made some drug trips “bad” for many people was the sudden, uncontrolled breaking through of such residues. After the “trip” it was generally impossible to push the previously unseen oceans of fear back into hiding again.)

I felt rather guilty when I first mentioned to someone that dreams were *not* the royal road to the unconscious. It reveals its secrets much more quickly, more accurately and more directly through the language of the body. But now we actually know that indeed “cell receptors which are spread throughout the body are directly involved in the storage of information in the cell” (Pert, 1997).

What used to be mere speculation is fast being confirmed by hard and valid research. What psychotherapists and body-workers have believed for decades, based on their clinical observations, is really true: a system of interconnectedness exists between mind and body, and this knowledge outdates the long-held view of ourselves as a hard-wired set of central brain connections with nerve fibers descending and controlling our bodies, like a master puppeteer.

The pre-memories of irrational, early fear and hurt are unavoidably stored in everyone’s body, and symptoms develop or we come down with a clinical illness when the holding capacity becomes overloaded by the addition of present-day stress and fear. The solace obtained from mothering (in its many forms) is the best known and the most eagerly sought antidote against the torture, which is why falling in love has such enormous magical power while it lasts. But both the irrational fear and the yearnings for someone to “take the pain away” are better treated in psychotherapy, where realistic resolution can occur. With the aid of our more specific understanding of the respiratory apparatus as a central

mechanism for character reorganization, successful outcomes of psychotherapy are much more likely.

And when will this search for better psychotherapy end? Hopefully never. Turning around a crippled or endangered life is truly a miracle-like achievement, but the process takes too long, is often tedious and painful, and is very costly too. But as everyone knows, it is and has always been very difficult and dangerous to scale a high mountain in an attempt to conquer its top. The effort is made tolerable by the enormous joy of discovery, as previously unseen, new peaks always reveal themselves when we reach higher. Fresh and unsuspected landscapes, not seen from below, always lie ahead as a challenge. The same here. Climbing mountains requires stamina, perseverance and courage, which explains why relatively few have ever scaled Mt. Everest, and it also explains, without condemning, why many psychotherapists and the psychoanalytic establishment essentially still tread on the meadows first discovered by Freud almost 100 years ago, and why so little venturing forth occurs.

But new vistas do exist, and as healers it is our duty to minimize pain and suffering. The search must continue.

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#### REFERENCES

- Bar-Levav, R. (1977). The treatment of preverbal hunger and rage in a group. *International Journal of Group Psychotherapy*, 27(4), 457-469.
- Bar-Levav, R. (1988). *Thinking in the shadow of feelings*. New York: Simon and Schuster.
- Bar-Levav, R. (1998). In E. Smith, P. Clance, & S. Imes, *Touch in psychotherapy*. New York: Guilford Press.
- Pert, C. (1997). *The molecules of emotion: Why we feel the way we feel*. New York: Scribner.
- Pert, C., Dreher, H., Ruff, M. (1998). The psychosomatic network: Foundations of mind-body medicine. *Alternative Therapies*, 4(4), 30-41.
- Ruff, M., Weaver, R., Herkenharm, M. (1985). Neuropeptides and their receptors: A psychosomatic network. *Journal of Immunology*, 35(2), 820s-826s.
- Selye, H. (1956). *The stress of life*. New York: McGraw Hill.