skiing occasionally — all things she'd given up because her husband couldn't or wouldn't participate.

For Marilyn, awareness didn't lead to life changes but let her observe herself in action. This helped her make choices within the situation, and these choices saved her from resentment, guilt, anger, and self-pity.

The Primary Scenario is one of the most important things in Integrative Body Psychotherapy. We start here and end here, continually referring back to it throughout therapy. Although we can describe the Scenario in simple terms, any one in particular has many more facets than are first apparent. New subtleties of the relationships unfold as the Scenario is repeated over and over in life and again when it is reenacted in the therapeutic process. New clues emerge in the body work that expand our knowledge of the Primary Scenario. The more we know about the source of the holding patterns in a person's body, the more able we are to help him give them up.

The work goes on, always playing the patterns in a person's current life against the source of those patterns. Therapy is a healing process, but healing is easier and quicker when we know what is to be healed and how. Knowing a client's Primary Scenario and his character structure, we can diagnose what type of body work would be most effective for him and how best to proceed. The Primary Scenario is a powerful diagnostic tool, one that is continually validated by our work with clients.

Chapter 4

Looking In: Contraction and Expansion

We described the Primary Scenario as, among other things, a diagnostic map that guides us in the therapeutic process. From it we have some clues as to the sorts of injuries a person may have suffered in his childhood. By putting these clues together with what he tells us about his current relationships, we can make a preliminary diagnosis about the type of body work that will be the most effective and acceptable. Then we go to the body to learn more and to begin to heal the old injuries.

To illustrate how we use the materials from the Primary Scenario to get the most out of the body work and how we use the body work to alleviate problems that arose in the Primary Scenario, we start with Sara's description.

Sara was an agreeable free-lance artist in her forties. She was strong, healthy, cheerful, capable, motherly, and above all, agreeable. In fact, it was her very agreeableness that brought her into therapy.

"First I agreed to do this little task," she said, "and then I agreed to do that. Then I admitted I might have time for the third job, and finally, just before I collapsed, I sandwiched in a three-week vacation with my boyfriend. All I need is a three-ply week and I'll do fine. Imagine — three days running simultaneously. I ought to be able to take care of everybody then."

She went through the beginning sessions of therapy doing the nutritional intake, physical history, and gathering the Primary Scenario. Then she had her first body session and described it thusly:

"I had seen Helen, my therapist, for a few months and gotten to know and trust her while she took my physical history and found out about my terrible eating habits. When she gathered my Primary Scenario, I told her the usual tale of my life. I've always been proud of what a happy, untroubled childhood and adolescence I had. My mother and I had always been good friends, even through my teens. I did well in school and have always had good, responsible men around me. Amazing, considering that my handsome father had been a womanizer, breaking my mother's heart and then bruising her body when she complained. I told Helen how happy my mother was to have me because I was such a good baby. I slept a lot, woke up smiling, and never cried. My brother, on the other hand, was a hellion, a hyperkinetic kid born before they had any idea of what to do with his symptoms. He had cried twenty out of every twenty-four hours and my mother followed the belief of the day and didn't pick him up except at four-hour intervals, so he cried a lot, and then scowled all his life, and finally drank himself to death. But lucky me. Mother had decided to feed her next baby when she felt like it, so I never needed to cry. No wonder I turned out so well.

"I felt that I had 'accomplished' my Primary Scenario quite well. I'd been through conventional therapy before and had my history down pat. I blamed any little problems I did have on my father and knew there was nothing my mother ever did wrong. From the time I was small she gave me the respect one would give an adult. She trusted my judgment, admired my intellect, and built up my self-confidence. I was reluctant to explore anything too deeply, though, because I didn't want to find that she wasn't the wonderfully charming, humorous, considerate person I had always thought. What if I dug up something awful, like she beat me daily and locked me in the closet — such a discovery would undermine my foundations. But I wasn't too afraid this would happen. My other therapist had dug and poked around a lot and my mother's image remained unscathed.

"Nevertheless, I came to the session with considerable trepidation and determination. I wasn't used to expressing anything but my pleasant emotions and I didn't want to. I never had; how could I start now? I'd heard about body work and releasing emotions and it scared and disgusted me, just the thought of crying or gagging in front of anyone. God forbid, what if I regressed and sucked my thumb — I'd never be comfortable with the therapist again. But in the midst of this fear, I reassured myself that it probably wouldn't happen anyway. For one thing, I thought I had enough control so

that I could face up to a submerged emotion with dignity, without funny noises or unpleasant scenes. For another thing — and I really comforted myself with this thought — I didn't think I had very many nasty emotions, at least not repressed ones. I habitually swore at bad drivers and kicked machines that didn't work, but those were open and unrepressed, so maybe I had nothing to fear at all. God knows I was considered cheerful, happy, serene, calm, and confident by the people who knew me. 'So maybe nothing lurks underneath,' I told myself. 'Won't Helen be surprised,' and I went to that fateful session with the same smug confidence I had always taken to examinations in school.

"I had worn a snug fitting tank top and tights because Helen had said it was important for her to see as much of my body's movements and coloring as she could. I was used to very light clothing but this morning, sitting in the waiting room that was always too warm, I was chilly. I was even colder in Helen's office where it was probably five degrees warmer, but I refused to admit that I might be tense. 'Not me, I'm easy; I'll do just as I'm told,' I thought, as she told me to lie down on the massage table.

"'Lie on your back,' she told me, 'and bring your knees up. Now place your feet about as far apart as your hips and put your arms at your side.' I complied, 'Now put your legs a little farther apart,' she said. I squirmed my feet over a bit. 'And now your knees,' she said patiently. I looked at my knees; they were clamped tight together like a pair of magnets. I pulled them apart and watched them snap back together. 'That's okay,' said Helen, 'just relax a little bit and they'll come around as we work. Now look at me,' she said. Her voice was low and vibrant. There was an aliveness to it that made me constantly aware that she was 'all there' and more attentive to my words and feelings than I was myself. I had learned to trust her, so I obeyed, frightened though I was.

"I looked in her eyes, at her pleasant, friendly expression, and hoped earnestly that I wouldn't disappoint her. 'Are you here?' she asked. 'Are you ready to work?' My affirmative answers sounded like a strangled squeak. 'What do you feel?' she asked. I was uncomfortable because I didn't feel much, but I described the sensation of my arms on the table, the tautness where my knees bent, the hardness of the table against my head. 'That's it?' she asked. 'Yes, that's it,' I apologized.

"'I want you to breathe now,' she told me. 'Breathe through your mouth and breathe into *here* — do you mind if I touch you?' she asked, indicating a spot not much below my collar bone. I didn't

know my lungs were up that high, but I did as I was told. Or I thought I did, but she said, 'Now see if you can make your chest move.' I tried again with a big deep breath, pushing my shoulders back as far as I could against the firm table. That time even I could see that nothing much moved. She put her hand on my upper chest, and pressed firmly. 'Now breathe,' she said, 'and push against my hand.' We did that several times until I began to have the feeling that I could, indeed move her hand. Then she released the pressure suddenly and my chest expanded. 'Good, now keep it moving that much,' she said, and I tried. It was hard work.

"'What do you feel?' she asked. This time I could tell her something. My mouth was dry from the breathing, my chest felt a bit frantic, making me think of coronaries, and my fingers were tingling. Not altogether pleasant, but I was pleased to produce some feelings for her.

"I kept on breathing deeply, watching my chest rise and fall. When Helen said to breathe faster, I did so, although I felt as though I'd had quite enough air for the next month. 'What do you feel now?' she asked again, and I told her that I felt as though I were ready to go, that I was poised for action somehow. My lower arms, my thighs, and my calves seemed to be outlined in tingles and my feet were eager to bear my weight even while they felt completely relaxed. 'Are you warmer now?' she asked. I said I was, but then I began to tremble. My knees, which had finally relaxed to a comfortable distance, were knocking against each other. My ribs were moving sporadically in and out while a convulsive wave sped from my belly to my neck, back down, and then up again. It barely passed through my mind that I might be getting sick, but I was too caught up in trying not to tremble so violently to worry.

"'You can let some sound out as you breathe,' offered Helen. I wondered why she thought I might like to, but decided to try. First I emitted a small squeak, then a faint wheeze, then a timid croak. 'Good,' said Helen, sounding like a mother praising an inept but earnest child. 'Try some more.' I tried, but suddenly I didn't have to try. The trembling in my body, the convulsive wave I was afraid was nausea must have reminded me unconsciously of the noise I needed to make and I began to sob. 'There!' said Helen, sounding so satisfied I didn't even feel apologetic about losing my dignity. It felt so wonderful to cry, to sob like a baby, though why I wanted to just because I'd been breathing hard, I couldn't fathom.

"Helen's voice came through my sobs. 'What do you feel like?' 'Like a little girl,' I sobbed. 'Can you picture that little girl?' she asked. I

could. She was that sweet little toddler playing by the lake that I knew so well from our family movies. Around her bald head was tied a blue ribbon and she wore the apple-cheeked smile she always wore. Cute happy little kid.

"'Now what would you like to do with her?' asked Helen. Dumb question. The kid was perfectly happy picking flowers, so why disturb her, but to my surprise I burst out, 'I want to hold her.'

"'So hold her,' said Helen, as though it were only reasonable. I scooped her up in my arms and she only struggled a little bit. 'You can hold yourself, too, you know,' offered Helen, and she helped me wrap my arms around my shoulders the way you do when you're alone and *must* hug yourself in joy or sorrow.

"It was the strangest thing. I had imagined hugging a sweet child who obviously didn't need a thing, but I knew at the same time that that sunny little girl was the same as the grown-up lady sobbing uncontrollably. And putting my arms around the baby in my imagination was the same as hugging myself and trying to console *me* for whatever sadness was hidden there underneath my ribs.

"Helen had me roll over onto my side and I curled easily into a fetal position. 'You can hold that little girl any time you want to, you know,' she said. 'Your mother had a lot of worries. She must have felt bad when your brother cried and your father hurt her. She counted on you to be her good girl. It must have been awful never to be able to cry or disobey.' I had never thought of myself as being anything but naturally docile, but the continuing sobs, coming straight from my gut, agreed with Helen that it had, indeed, been awful.

"'Babies cry and get dirty and throw up and break things,' she went on. 'It's normal. You can help that little girl inside you grow up. Just comfort her whenever she feels bad and let her know *you* love her even when she's not the perfect, smiling baby her mother loved. Tell her that her bad feelings are just as acceptable as her good ones and you'll always love her.'

"I cried a while longer, then rolled onto my back. 'Notice the feeling in your body,' said Helen, and this time it was a pleasure to take inventory. I wasn't tingling, but I could feel my body, every inch of it, even the calloused soles of my feet. At the very same time I felt wondrously relaxed and full of life. I could have slept soundly or gone dancing. 'Look at your face,' said Helen, handing me a mirror. 'See how easy the lines are around your eyes and how open your expression is.' She was right. My jaw looked smoother, too. I looked the way I look when I'm in love or serenely happy, eyes wide open and unguarded."

Sara's experience followed the classical pattern we depict in Figure 9, when we tell about the breathing work and developing a charge. Because she was physically active and had a healthy awareness in her body, she learned more from her first session than would a person who was less aware and more defended.

And she learned a great deal. Her fears that she would find out terrible things about her mother didn't come true. The injury her mother had inflicted was in not seeing or accepting the normal, negative side of Sara's nature. Punishment was in showing her disappointment, and by gently chiding, "Oh Sally, how could you?" The gentleness was insidious, for it made Sara stifle any impulses that might lead to her mother's disappointment.

"To this day," says Sara, "whenever I do something clumsy or forget some dumb thing, I call myself by my baby name in exactly the same patiently irritated voice 'Oh Sally . . .' "

Yet the injury, inconsequential though it was from a grown-up's vantage point, made Sara grow up afraid of disappointing people. She couldn't stand the disappointment in her mother's eyes, and as she grew older she learned how to avoid provoking disappointment in other relationships. She became eternally agreeable. Her friends liked her and a lot of people took advantage of her, but other people thought she lacked spice and asked, "Don't you ever have opinions or objections?"

"I don't," she said. "I honestly don't usually care where we have lunch or which side of the bed I sleep on." This is consistent with her fear of disappointing people. She learned to suspend strong feelings and wait until she found out what other people wanted. She wasn't, however, totally without opinions and preferences, but she generally kept these to herself. Eventually, it all backfired. She couldn't please everybody, and in trying to do so, she began disappointing them. This was so hard on her that she hunted up a new therapist and began looking at her life.

She was surprised that her feelings came out so quickly, for she had kept them well hidden from her previous therapist. Of course he hadn't taken her Primary Scenario nor thought to look for the repeating patterns in her life. And she had breathed normally in her sessions, which meant that she had barely breathed. She hadn't inveigled her body into giving up its secrets by infusing it with oxygen in a way designed to do just that. She just sat there, talking. *And just talking won't do it.*

Basic Concepts of Body Therapy

We owe a great deal to Wilhelm Reich for his pioneering work in bringing the body into psychotherapy. Freud didn't believe in looking at his clients, let alone touching their bodies, and generations of psychotherapists followed his example. Reich came along and changed that. He believed in contact, so he sat facing his clients, looking into their eyes, and occasionally touching them. In *Character Analysis*, he addressed the issue of "contactlessness":

> Whenever natural, adequate, instinctual impulses are denied direct relationship to objects of the world the result is anxiety, as the expression of a crawling into oneself, and the development of a wall of contactlessness.[1]

He went further than superficial contact, though, and his work with the body is the foundation and core of most "body therapies." His theories deeply influenced Fritz Perls, developer of Gestalt therapy.

Reich believed, as did Freud, that the cause of neurosis was repressed sexual energy. Reich also believed that the ultimate goal of therapy was to restore free, natural energy flow. This would establish "full orgastic potency," the ability to build up and release full energy in orgasm. The way to restore the energy flow was to dissolve the neurotic character structure that restricted it. He said that the energy was restricted by way of "armoring" in the form of fixed muscular attitudes. "It is as if," he states in *Character Analysis*, "the affective personality put on an armor, a rigid shell on which the knocks from the outer world as well as the inner demand rebound. This armor makes the individual less sensitive to unpleasure, but it also reduces his libidinal and aggressive mobility and, with that, his capacity for pleasure and achievement."[2]

Reich's formulation of a muscular theory of repression was a major paradigm shift in psychological circles and has effected much change in therapeutic methods.

When people are in a state of repression — that is, when they try to keep an idea or impulse from consciousness — they experience tension, or muscular contraction. If a waiter, for instance, has to carry out his duties politely no matter how boorish the customers, he must repress any urge he has to spill coffee in their laps. If it's a long night of boorish customers he will probably go home with a headache or a stiff neck or a muscle spasm somewhere. When this contraction is severe and chronic, it becomes armoring; the muscles

are fixed into patterns and cannot readily expand. Reich called this armoring "the freezing of emotions." It results in deadness. The body shrinks or contracts to avoid pain and thereby cuts off pleasure as well, since muscular expansion is associated with pleasurable sensations.

The natural diversion of energy to a muscle is functional, but when the work is done, the muscle should relax or expand, and release the energy. If the energy remains bound up in the muscle and the muscle remains contracted and ready for work, the flow of energy is cut off and the natural functioning of the body becomes blocked. If the body remains in this state, sexual excitement and orgasm, among other things, are inhibited. The aim of Reich's therapy was to relieve this inhibition by ridding the body of chronic muscular armoring and allowing the release of repressed emotions until the free flow of energy is reestablished in the body.

We don't identify with any current body therapy practices, despite our common foundation in Reichian theory, because of some important differences. The major difference is in the goal of therapy, or the purpose. To Reich, the goal was to dissolve all the armoring in the body to release the bound energy. This would establish "full orgastic potency" or the ability to build up and release full energy in orgasm.

In Integrative Body Psychotherapy we believe that the aliveness in the body, the flow of energy, is the sense of Self. The Self is a non-verbal sense of well-being, continuity, and identity in the body, plus the verbal structure and cognitive process one learns. Our goal in therapy is to find that sense. Although we have built on Reich's theory and methods, we have an expanded theory regarding the energy in the body. That is, we see greater use for the energy of the soul and the Self than simply its full release in orgasm.

Cathartic Release

In many current body therapies, cathartic release occurs without a contact-full relationship between client and therapist, and therein lies their flaw. The value of cathartic release is lost if the client isn't in emotional contact with the therapist during the releasing. It is the contact in the relationship that provides the healing factor, grounds the experience, and makes it real. We've seen many people who have undergone "expressive release" forms of therapy, but they typically don't remember the releases. They feel better afterwards but the sense of well-being doesn't last long. Although many people

get hooked on "venting," they are getting only symptom relief. The repeated discharges of emotion, without any deeper awareness, don't contact the underlying injury. The armor is softened only temporarily and reforms when the person goes out into the world, because the underlying cause of the armor hasn't been touched.

Had Sara done the breathing part of her session alone, she might have broken down into great sobs and felt much better for it, but she would never have known why she was crying. Had Helen not been there, armed with information from the Primary Scenario, to help her see that the tears might belong to herself as a child, Sara might have thought they were caused only by the unusual breathing. After all, our bodies have been hiding secrets from us for many years and won't relinquish them easily. We repressed these secret emotions to spare ourselves pain and will continue to do so. It is only in a situation of trust that we can begin to confront the pain. And in order to make that confrontation a valuable learning experience, we need the therapist to connect the body experience to the emotional one. This is the beginning of the process of integration, of connecting the cognitive, verbal Self to the more primitive physical and emotional Self.

We're reminded of one case in particular in which the client, Stewart, had had several years of release-oriented therapy before he came to IBP. In all those years he had never developed a relationship with the therapist. He would simply lie down and breathe, neither looking at nor speaking with him. When his muscles would begin to contract, he would break through the tension by outbursts of emotion, primarily crying. He had a great sense of relief after each session, and came to IBP expecting a similar process. In the first session it was clear that the previous emotional releases that he had experienced had been of temporary value and had not removed his rigid armoring. His face was mask-like, his neck was extremely rigid, and his body was very thin and tightly muscled. He was a severely armored person, completely unable to maintain contact or to interact with the therapist. His eyes were vacant, and it was difficult to feel his presence. When asked to close his eyes, he was unable to do so completely, and they remained neither closed nor open, in a semiguarded expression. It was clear that therapy could not progress without dealing with the lack of contact. This condition was reflected in his life by his inability to form or maintain relationships. The tragedy was that this client had worked very hard in his previous therapy, enduring gut-wrenching emotional experiences, which were ultimately futile because he was never really touched emotionally.

In IBP the goal isn't release but the discovery of the Self and identity through exploration of the origin of the blocks. Learning to understand the function of the armoring is a major part of the therapy process. Once this awareness develops, release may occur as a conscious choice by the client. In this way, too, he can choose to let go of obsolete behavior patterns and incorporate new responses to the unchanged context of his life. Therefore, our first goal is not to remove defensive character armor, but to use awareness of it and of its function as a base from which to do psychological exploration.

The armor, or block, is a chronic muscular contraction that occurred originally as a protective mechanism, and it signifies that a person is holding onto an unfinished situation. In the therapeutic relationship, the client reenacts this unfinished situation in the present. This lets the therapist see the repetitious nature of the process, relate it to the Primary Scenario, and intervene. Sometimes the therapist will refrain from intervening when the client confronts a block. This can be frustrating for the client, but we use the frustration as a tool to show a person how he interrupts his energy flow and to point out how he does this in his life as well as in a therapy session. We want to show him how he is cutting off his aliveness and his sense of Self.

We want the client to feel safe during the painful process of melting the armor, so we tailor the therapy individually, basing the kind of work we do on our initial assessment and the information we have from the Primary Scenario. Some people tolerate fairly invasive techniques and others must proceed slowly. When the therapist remains in contact with the client and maintains their relationship, the client can eventually take responsibility for participating in the giving up of his defenses. If the therapist does the releasing — that is, if he uses some technique such as massage or movement to release the tension held in a muscle — the client can become dependent upon the therapist. That is why the therapist depends primarily on the relationship to heal the client and give him the strength and courage to drop his defenses. It's similar to the way a parent tries to teach a child how to be responsible because he won't always be there to take care of him.

A person's defenses are important and we respect them. For this reason we seldom use invasive muscular manipulative techniques such as deep tissue massage and stress movement patterns. One danger in doing so is that the client simply withdraws, moving his defenses to a deeper level. It's like pursuing someone with such a fearful weapon that he can only run deeper into the forest.

This door you might not open, and you did;
So enter now, and see for what slight thing
You are betrayed. . . Here is no treasure hid,
No cauldron, no clear crystal mirroring
The sought-for Truth, no heads of women slain
For greed like yours, no writhings of distress;
But only what you see. . . Look yet again:
An empty room, cobwebbed and comfortless.
Yet this alone out of my life I kept
Unto myself, lest any know me quite;
And you did so profane me when you crept
Unto the threshold of this room tonight
That I must never more behold your face.
This now is yours. I seek another place.

Edna St. Vincent Millay

In IBP we find that it is possible and preferable to draw a person out with tenderness and compassion. However, there are situations in which the use of muscular release techniques is of value. For example, when the muscular contractions are so chronic that it is virtually impossible for the person to release himself without outside help, then we may assist with physical releasing techniques.

As the armor is being dissolved, it is important to replace the released painful experiences with "positive introjects." These are not so much images or voices as they are good feelings such as a good parent might instill in a child with a smile, a hug, a look of approval, or some assurance of acceptance and unconditional love. It was the opposite of this that caused the original injuries, and the old injury is healed by the positive introject. This value of the therapeutic transference is that the therapist temporarily provides this ideal parental support until the client has developed a sense of Self in his body and internalized this positive parent. This is what happened to Sara when she wanted to hold the child that was herself. Her therapist let her know that she could give that little child the unconditional loving it needed and she could do it in the present. She helped her replace the chronic tension in her muscles with a positive introject.

The aim is not to eliminate defenses entirely. They will surface when needed in threatening situations, but when the danger has passed, the healthy body can relax. This differs from chronic armoring, which is inflexible and cannot be relaxed. The aim of therapy, then, is to create flexibility and choice. We in IBP see it as

replacing defensive, rigid characterological and muscular boundaries with Self boundaries which express the individual's sense of identity and are flexible.

Reich's Notion of Orgastic Potency

Reich came to the conclusion that emotional health was related to the capacity for full surrender in the sexual act, or what he called orgastic potency. Energy bound in chronic muscular tensions prevents that energy from being available for sexual release; thus his concern with dissolving those tensions. It is important to understand that Reich defined orgasm not as an ejaculation or a climax, but as an involuntary response of the total body, manifested in rhythmic, convulsive movements. This same type of movement can occur in a session when the breathing is completely free and a person surrenders to his body.

The release of sexual energy normally comes at the end of the orgastic reflex. Theoretically, a person whose body is free enough to have this reflex during the therapy session would also be able to experience the full orgasm in intercourse and would be considered healthy by Reich's standards.

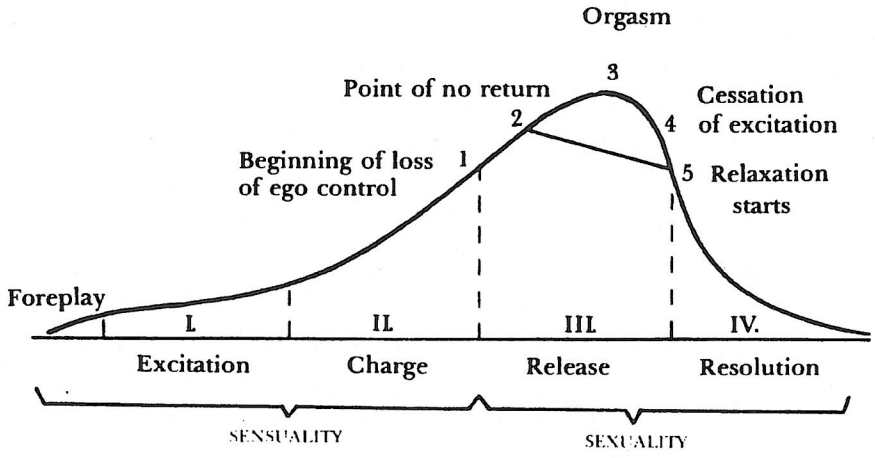
This is where we depart from Reich, for we believe that therapy continues well beyond the achievement of the full orgastic reflex. The reflex indicates that the body has been opened up to the strong energy currents within, allowing them to pass through it without blocks. With the orgastic release, the person experiences a loss of normal ego awareness, a profound feeling of peace, and a sense of integration and connectedness wth the Self. This altered state of consciouness then becomes the foundation for moving into the transpersonal or spiritual aspects of the therapy. It is as though the orgastic reflex forms the first half of a cycle of energy waves through the body. We now work to move the energy back through the unblocked body in order to achieve a fuller choice of the expression of this energy. While Reich formulated the idea of the life force in the form of orgone energy, he never fully realized the potential of this concept. We will discuss the transpersonal aspects of IBP in chapter 9.

The Charging Process

Reich's orgasm formula described the cycle of tension, charge, discharge, and relaxation. The Reichian breathing moves a client

through this cycle. The reason we devote so much space to the orgasm cycle is that it parallels a typical breathing session in IBP.

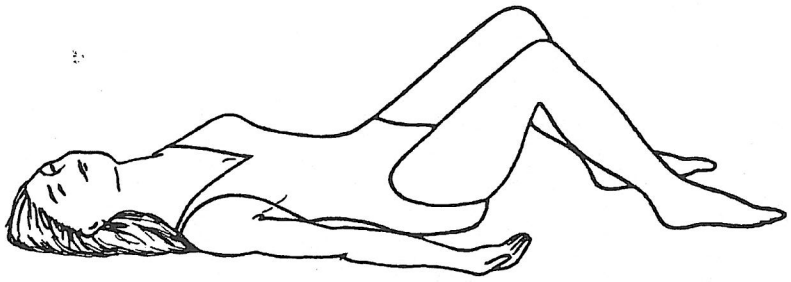
Figure 9
Charge/Discharge Cycle *



* This diagram closely typifies the male sexual response. See page 240 for the typical female response patterns.

If we look at this graph in terms of a therapy session, we see a build-up of charge that occurs through the breathing process. The person lies on a firm surface such as a hard mattress, knees raised, feet flat (equal amount of pressure on heel and toe), and approximately pelvic width apart. Since we are paying close attention to subtle changes in the body, it is necessary to see as much of it as is comfortable for both the client and therapist. It is more important for the chest and legs to be uncovered, but it rarely is necessary for the client to be completely nude.

Figure 10
Breathing Position



In IBP, intensification and expansion of the excitement in the body are encouraged and are referred to as "charging." A convenient way to look at the level of charge is on a scale of one to ten. We try to work at a charge level of six or seven. One of the first signs of physiological changes is the tingling of the skin, caused by an increase in circulation.

Another sign of charge on the physical level is change in skin coloration. Areas of charge will turn red or mottled because of increased blood flow to the capillaries close to the surface of the skin. Blocked, or uncharged, areas will turn white where constriction occurs. The lines of demarcation between the red, charged areas and the white, constricted areas are often as obvious as the bathing suit lines on somebody who is sunburned.

Another indication is change in skin temperature. Even in a cold room, a person doing the breathing work will feel warm as a result of the increased circulation. But where a person's fixed muscular patterns inhibit the increased circulation, the skin will feel cool to the touch.

Think of this expansion and contraction of the body in terms of a balloon responding to pressure from inside. Think, in particular, of a balloon that was partially blown up, then had a picture painted on

it. When it's blown up farther, it resists expansion where it was painted because the paint won't allow the rubber to stretch. Similarly, the body (the balloon) expands in response to the charge (the pressure), remaining constricted where it has muscular blocks, corresponding to the paint on the balloon.

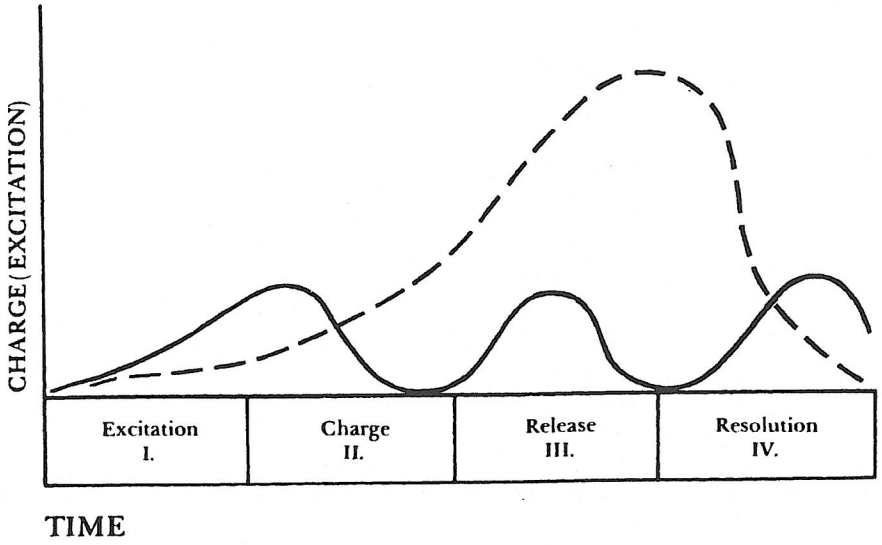
Progress in charging seems to be in steps or levels. A person will periodically reach a plateau, and then there will be a sudden breakthrough, and the person will move on from there. The problem is in trying to go too fast. It is important not to go beyond the body's level of tolerance for the increased feelings that come with deep breathing and "letting go." A person's body must be given time to overcome old patterns. Many people "push" themselves in the therapy. The therapist can let them see how they also push themseves in their lives, in their work, in their sexual orgasms. He can connect this pattern to the repetitive patterns in their Primary Scenarios.

In the first part of the charge-building, the excitation phase, we often find that people cannot tolerate the feeling of the charge. We see exactly the same thing on the sexual level. Splitting off is frequently the way in which people avoid their excitement in sex, in everyday activities, and in the therapy session.

During the excitation phase (Phase I), people will interrupt the building of a charge by both physical and psychological means (giggling, for instance, or splitting off). During this phase, we maintain contact to keep the person present so that excitement can build. In the charge phase (Phase II), we see interruptions that are usually more of a psychological nature, such as the client experiencing regressive states which are basically reliving early painful experiences. It is in this phase that healing occurs and the positive introject is introduced. In Phase III we usually see more transpersonal experiences, such as out-of-body states, or in-body states of a very profound nature, such as archetypical experiences (see chapter 9). In the resolution phase we see relaxation beginning. We ask the person to put his legs down, and a hyperparasympathetic state begins, which is a profound sense of well-being and a sense of Self.

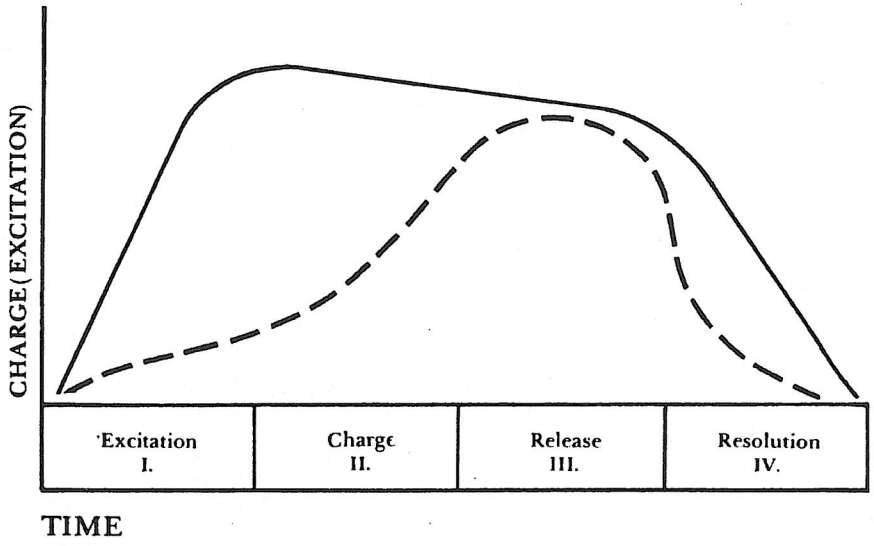
We focus here on the excitation phase by looking at the charge-discharge cycles as a body experience. Now we will describe the breathing process. Ideally, as breathing increases, energy builds in the body, reaches a peak of excitation, and is released or discharged (see Figure on p. 101). In actuality, each person's process of excitation and release is different. (see Figures 11, 12, and 13).

Figure 11
Lack of Tolerance for Excitement and Rapid Discharge



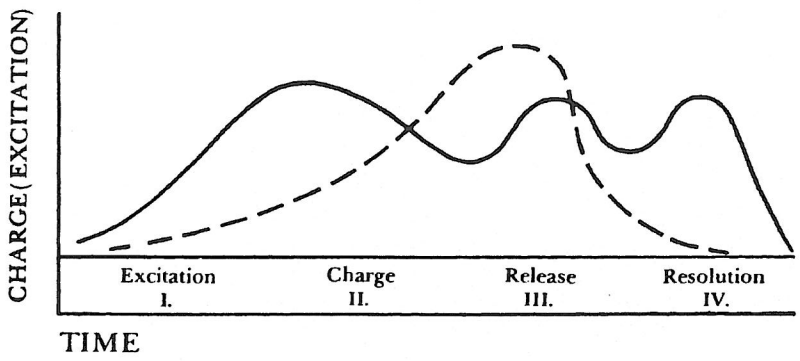
This person cannot tolerate increased excitement and discharges rapidly. Consequently, low levels of charge are reached and quickly released. On a psychological level, this can be seen as an inability to tolerate pleasurable feelings. On a sexual level, premature ejaculation is an example of this. Focus should be on learning to contain and build a charge (excitement/pleasure).

Figure 12
Inability to Release



This person builds a high charge quickly but cannot release it. May have minimal orgasm but release and resolution stages are protracted. Focus should be on maintaining contact, grounding, and paying attention to release impulses that are being avoided. On a psychological level, this indicates splitting off from the situation so that excitement is not experienced and greater and greater levels of stimulation do not bring release. Sexually, this is very common in preorgastic women who seem to need a great deal of stimulation for release, or in retarded ejaculation in men. In life, this can be seen in people who seek constant stimulation, often dangerous, in order to make them feel alive.

Figure 13
Flexible Charge and Release Pattern



This person develops a high charge and can sustain excitement, maintain contact, and reach orgasm easily with minimal tension. This can be seen on a lifestyle level — this person has ups and downs, but moves from one event to the next, enjoying his or her life. This charge-discharge curve is similar to a multi-orgastic pattern.

The Breathing Process

A charge can be built up by altering a person's normal breathing pattern. To promote this excitement, he fires up the sympathetic nervous system by breathing into his upper chest (as opposed to diaphragmatic or belly breathing). Increasing the level of excitement increases the level of energy. Breathing is the most basic function of the body and is directly related to emotion. Any emotional response one has will immediately change one's breathing pattern. Conversely, by consciously changing one's breathing, it is possible to alter emotions and feelings.

A person should respond to an increase in excitement or charge

by increasing his rate of breathing. Instead, many people are uncomfortable with the charge and they attempt to control their excitement so they can stay "calm, cool, and collected." They do this by curtailing their breathing. The reason that they do this is that breathing deeply and fully amplifies their awareness of feelings. Many of the feelings that emerge with the deep breathing are uncomfortable ones, so most people avoid awareness by restricting their breathing. Unfortunately, while restricting the breathing to repress uncomfortable feelings, they restrict feelings of pleasure as well. This is not just a reaction we see in therapy, but a common pattern of the average man-on-the-street. Most people breathe with only a portion of their lung capacity during the normal day and then hold their breath when they get tense or frightened. In order to continue this discussion of the breathing process, we must now talk about the effects of breathing on the autonomic nervous system.

Autonomic Nervous System

Reich's initial system of therapy, which grew out of character analysis, was called "vegeto-therapy," after the vegetative responses of the autonomic nervous system. The mobilization of feeling through breathing and movement of the musculature activates the vegetative centers (the ganglia of the autonomic nervous system) and thus liberates vegetative energy. The body has two nervous systems: the central nervous system, or the voluntary nervous system, and the autonomic nervous system, which is considered involuntary. The central nervous system controls muscular movement and voluntary responses; the autonomic nervous system controls the functions of organs, emotions (through the endocrine system), respiration, and is also concerned with sexual response (through the endocrine and circulatory systems). Reichian therapy is primarily concerned with the autonomic nervous system, Reich's theory being that the character resistances (armoring) are "automatic," and therefore locked into the autonomic nervous system.

The autonomic nervous system has two components: the sympathetic and the parasympathetic. The sympathetic nervous system (sometimes called the "fight or flight" system) serves to protect the person by mobilizing his resources: increasing adrenalin, heart rate, and respiration rate, and by readying muscles for action. This can be seen as a state of contraction. (See Chart 6.) In this state, the person has increased energy to meet the stress.

The parasympathetic side is the subtler, relaxed side that mediates

pleasure and free-flowing feelings. It can be seen as a state of expansion. Ideally, there is a balance between the two systems, and this can be achieved by changing a person's breathing pattern. If, for example, a person is tense and fearful, moving the breathing to the diaphragm and/or belly and slowing it will activate the parasympathetic system, and calm the person.

If a person has a toneless, apathetic personality and body, a goal would be to energize the sympathetic side by having him breathe from the upper chest, because this builds a charge that activates the sympathetic side. Breathing bridges the voluntary and involuntary nervous system; it is both a voluntary and involuntary activity. By voluntarily manipulating or controlling his breathing, a person can affect his involuntary responses.

The goal is balance. If a person is under psychological stress, the sympathetic nervous system of the body reacts as if he were in actual physical danger. This continued reaction can cause symptoms of stress and "diseases of adaptation," as Hans Selye calls it in *The Stress of Life*.[3] A person can be taught techniques to release the tension by learning to activate the parasympathetic nervous system, bringing it into balance with the sympathetic side.

Interruptions

Many people have difficulty building a charge. Muscular interruptions to the charge tend to occur during Phase I (excitation) (see Figure 9). They may take the form of thinking, dizziness and/or nausea (usually a sign of anxiety), splitting off, "spacing-out," fidgeting, scratching, squirming, yawning, falling asleep, muscle spasm, cramping, ear ringing, urge to urinate, talking, laughing, and a number of other responses that dissipate the intensity of the charge. Since the increased charge of energy in the body induces feelings of excitation and pleasure, we want to help the client tolerate these intensifed feelings of pleasure and increased amounts of energy without interruption. Rather than seeing interruptions as difficulties, we see them as expressions of resistance, and as indicators of where or at what point the therapy should be done. They are signs of blocks the client has. Because we are alert to his unconscious attempts to avoid painful impasses, we ask him to stay with the block, to experience the discomfort of the holding rather than changing or releasing it immediately.

For example, during Sara's session at the beginning of the chapter, she reached a point in her feelings where she wanted to cry,

Figure 14
The Nervous System

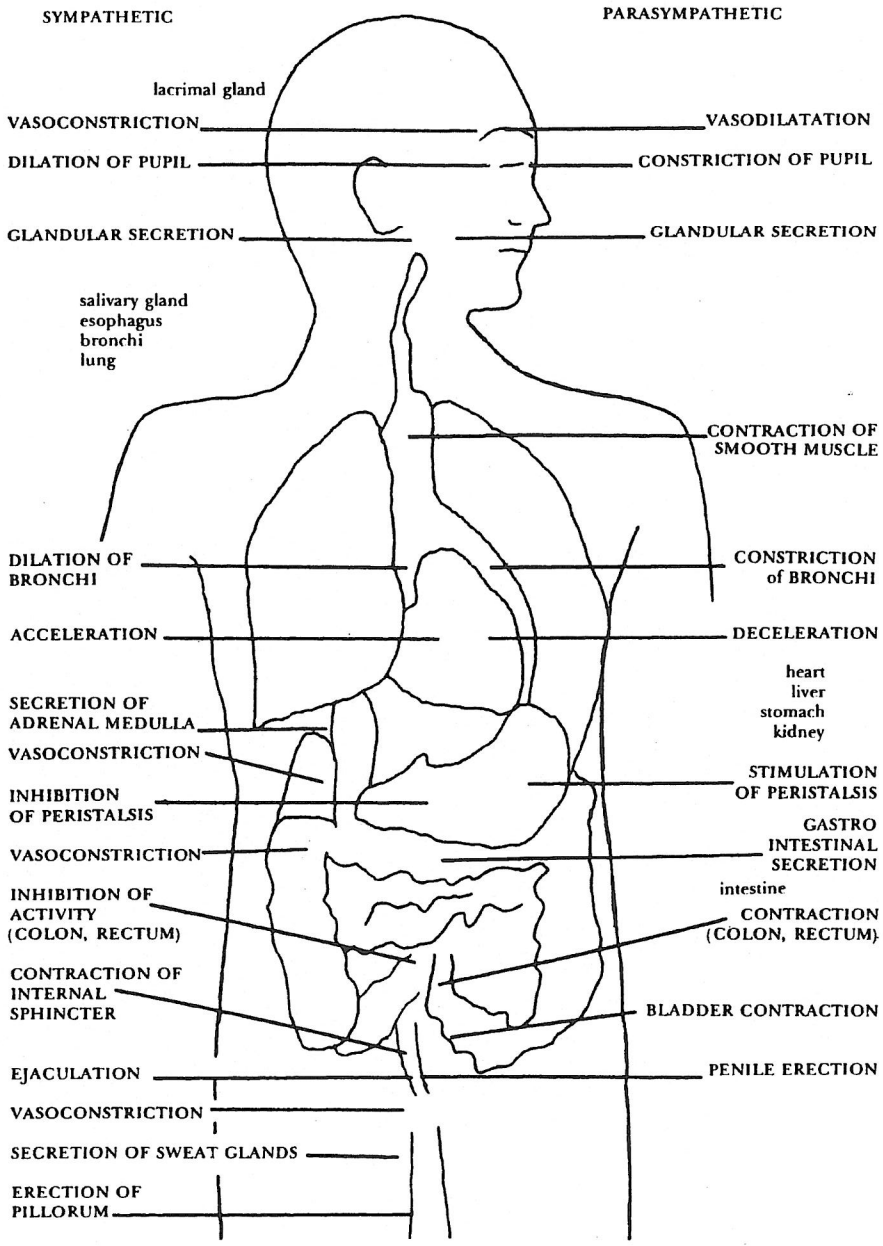


Figure 15: Functioning of the Autonomic Nervous System

Sympathetic Effect	Organ	Parasympathetic Effect
Inhibition of the m. sphincter pupillae; *dilated pupils*	Musculature of the iris	Stimulation of the m. sphincter pupillae: *narrowing of the pupils.*
Inhibition of the lachrymal glands: "dry eyes." Depression	Lachrymal glands	Stimulation of the lachrymal glands: "glowing eyes." Joy
Inhibition of the salivary glands: "parched mouth"	Salivary glands	Stimulation and increased secretion of the salivary glands: "making mouth water"
Stimulation of the sweat glands in face and body: "skin is moist and cold"	Sweat glands	Inhibition of the sweat glands in face and body: "skin is dry"
Contraction of the arteries: "Cold sweat, " pallor, anxiety	Arteries	Dilation of the arteries: "freshness and flushing of skin, increased turgor without perspiration"
Musculature of hair follicle is stimulated: hair bristles, "goose pimples," chills	Arrectores pilorum	Inhibition of arrectores pilorum: skin becomes smooth and warm
Inhibition of the contractive musculater: bronchi are relaxed	Bronchial musculature	Stimulates the contraction of the bronchial musculature: bronchi are narrowed
Stimulates cardiac action: palpitation, rapid heart beat	Heart	Slows cardiac action: quiet heart, slower pulse
Inhibits peristalsis: reduces secretion of digestive glands	Digestive tract; liver, pancreas, kidneys, all digestive glands	Stimulates peristalsis: increases secretion of digestive glands
Increases adrenal secretion: anxiety reaction	Supradrenal gland	Reduces adrenal secretion: pleasure reaction
Inhibits musculature of the bladder, stimulates urinary sphincter: inhibits micturition	Urinary bladder	Stimulates musculature of the bladder, inhibits the sphincter: stimulates micturition
Tightening of the smooth musculature, reduces secretion of all glands, decrease of blood supply, dry vagina: reduction of sexual feeling	Female sex organs	Relaxation of the smooth musculature, stimulates all gland functions, increases blood flow, moist vagina: increase of sexual feeling
Tightening of the smooth musculature of the scrotum, reduction of gland functions, decrease of blood supply, flaccid penis: "diminished sexual desire."	Male sex organs	Relaxation of the smooth musculature of the scrotum, increases all secretions, increases blood flow, erection: "intensified sexual desire"

but she'd built up her armor against crying, so she resisted the feeling. The interruption came in the form of violent trembling and shaking. At this point her therapist could have either taken the course that was described — let her cry and talk about the feelings afterward — or the therapist would have had her confront the block. She could have done the latter by asking, "Can you feel anything? What's happening? What do you feel in your chest? Your throat? How are you feeling about the shaking?" She would have helped her see where the tension was — the tightness in her chest, the taut diaphragm, the clenched jaw, and the tightly constricted muscles around the eyes — then she would have asked Sara to concentrate on how she was blocking her feelings. The therapist might then have empathized, saying, "It must be terribly painful for you to be so close to your feelings and not be able to let them go."

The value in the second approach is that many people aren't aware that they are blocking. If the therapist lets them release their tears or their anger, the emotion dissipates, and the lesson is lost. This is like the cathartic release therapies: it brings temporary elation and relaxation but it is not the learning and relearning process that we strive for.

As any school child knows, lessons learned under conditions of emotional excitement are the lessons remembered the longest. Who ever forgets his first love, his most embarrassing moment, or the things he learned from an inspired teacher? This is why the therapist gets so much mileage out of the interruptions to the breathing process. When a client is right up against strong emotions that are too painful for him to feel, he is extremely receptive. He is also vulnerable. The therapist must tread gently and not go any faster or deeper than the client can support. He must think of himself as a *guide*, assisting the client but not directing him. He *allows* the client to proceed but doesn't push, because even though his protective blocks are obsolete, they are part of his character structure and identity and mustn't be removed before he is ready. In fact, the therapist prefers to give him the responsibility for giving them up, rather as you let a child dive into the water when he is ready instead of pushing him before he gets over his fear.

Some interruptions are physiological in nature. They occur occasionally among clients in the early stages of body work. The rapid stimulation from the deep breathing changes the blood chemistry, leading to a decrease in calcium levels. This causes nerve symptoms such as numbness and tingling in the fingers and around the mouth and, sometimes, muscle spasm or cramping (tetanae). It may cause

reduction in blood flow to the brain, which may result in lightheadedness (dizziness) and in extreme cases, brief spells of unconsciousness, fainting, or syncope.

Once the body becomes used to high levels of oxygenation and the corresponding sense of aliveness throughout, these reactions seldom occur.

These symptoms are temporary and not dangerous, so they can be ignored if the client isn't distracted. However, if he is, the therapist should define what is happening and put it into perspective so the client can cope with the sensations of hyperventilation. Also, slowing or stopping the exaggerated breathing will correct the imbalance that is causing it almost immediately.

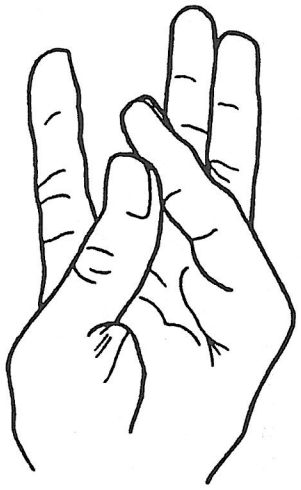
Muscular interruptions, or tetanae, may cause discomfort and some degree of loss of control. Pain or numbness are minor examples of this condition and feelings of paralysis or of the hands rising off the mat are more extreme. Spasm, or tetanae of the hand (Figure 3) and tightening of the sphincter muscles (eyes, mouth, vagina, anus) may occur, causing moderate fright to a client. This can be a valuable experience to people who have never allowed themselves to lose control.

For example, Ruth was a gifted cellist, a beautiful young woman with long blond hair and a perennially soulful expression. During her first breathing session, her hands went into spasm and she was terrified. "My God," she cried, "I'll never play again — I can't move my hands!" Her fear was real and intense and she came to realize as she talked about it that it was a chronic fear, not a sudden fear evoked by the spasm. "I dream about things happening to my hands," she said. "I always have, since I first knew I was good. The night before my first solo I woke up screaming because I dreamed that I was in Turkey and stole some food and had my right hand cut off as punishment. It came from a story I'd just read and I knew it was a far worse punishment than being put to death." Ruth hadn't known consciously how much tension she carried in her hands and how much fear was behind that tension, but her new awareness allowed her to give it up. The spasm that so frightened her not only didn't prevent her playing but ultimately allowed her to play even better.

Tetanae of the hand can be relieved in several ways: by simultaneous use of the energetic pressure points in the web of the hand and in the elbows (see Figure 19), by having the client slap his hands on the mat or table, or by having him massage them or rub them together.

Another interruption to the breathing process is *muscle vibration.*

Figure 16
Spasm or Tetanae of the Hand



This happens when a muscle begins to let go of its fixed pattern of tension, and it is similar to muscle fatigue, such as Sara's experience. The vibration may begin as gross jerking of the muscle, which eventually smooths out into a pleasurable sensation. It is as though the fixed muscular pattern is shaken or melted, and as this happens, a sense of muscle aliveness begins. The muscles that are held most tightly will start to vibrate first, and we encourage this vibration to let the muscle relax.

Once the physical interruptions have been focused on and released and the charge proceeds, involuntary movements and pleasurable sensations will occur in the person's body. His energy field will be expanded and he will seem to glow. His whole body may vibrate. These sensations are from the energy flowing through the body. Reich called it *streaming*. Although the involuntary movements are

called the "orgasm reflex," it isn't a true orgasm but something that can occur when the breathing is completely free and a person surrenders to the energy or the charge in his body.

The ability to be flexible enough to expand muscularly and to sustain one's charge is called *containment*. To go back to the balloon analogy, imagine a balloon with a tiny hole in it. It can be blown up, but it won't stay that way because the pressure is released in a thin stream from the pinhole. Some people release the charge the same way, letting it dissipate before it's even fully built up. Containment is an important ability to develop in this early stage of the work because maintaining a sense of well-being is necessary to facilitate and sustain the therapeutic relationship.

Emotional interruptions may occur in Phase II when a client is flooded with the emotions triggered by the release of old, fixed patterns. It is important to stay with the emotion until it subsides, allowing it full expression without cutting it off prematurely.

The physical and emotional interruptions are different expressions of the same inability to tolerate the excitement and pleasure of the charge. We discuss them separately to aid in recognition, but they may occur simultaneously and for the same purpose.

As the client begins to develop the capacity to tolerate higher levels of excitation and oxygenation through deeper breathing, the tingling of the charge tends to diminish, leaving only a charge of energy. This is a feeling of excitement and pleasure, a sense of vitality not unlike the feeling that follows an orgasm. The pleasure is in a profound sense of Self and well-being, and this can support a more intensified exploration of emotions. When a client has this sense of well-being deep within his body, he can begin to grow, to move forward both in therapy and in his life. Without this, he won't be able to sustain the changes he makes.

[1] Wilhelm Reich, *Character Analysis* (New York: Farrar, Straus & Giroux, Inc., 1949, 1961).
[2] Reich, *Character Analysis*.
[3] Hans Selye, *The Stress of Life* (New York: McGraw-Hill, 1956).

Chapter 5
Looking at the Body

Energy flows in the body from head to feet and feet to head. When that energy flow is blocked by fixed muscular patterns, it is called armoring. Muscular armoring runs laterally across the body and divides the body into segments. Each of the segments represents areas of the body where blockages of energy can occur.

The Segments

Reich organized the body into seven lateral segments as follows:

1. Ocular (eyes, brows, and forehead)
2. Oral (mouth and chin)
3. Cervical (neck, throat, and upper shoulders)
4. Thoracic (chest and back)
5. Diaphragmatic (lower chest and diaphragm)
6. Abdominal
7. Pelvic

In addition to Reich's seven segments, we divide the ocular, oral, and part of the cervical segments into four bands (see Figure 8).

It is interesting to note that in Hindu and other mystical traditions, the body is seen as seven energy centers, which correspond to these segments. We will discuss the possible implications of these similarities in the Transpersonal chapter.

All these segments are connected with varying degrees of interdependence. In a chronic state, armoring usually involves more