Hakomi Forum
A publication of the Hakomi Institute
Issue 13, Summer 1999

Editorial Policy: Hakomi Forum welcomes a wide range of contributions for possible publication. In addition to articles that address the theory and/or practice of Hakomi Therapy, pieces are encouraged that establish dialogue with related fields and foster the principles Hakomi Therapy is based on - that of unity, organicity, mind-body holism, mindfulness, non-violence. Manuscripts may be short or long, academically written with footnotes or more experiential and poetic. Annotated verbatims of actual psychotherapy sessions, applications to different client groups and settings, and interfaces with other complimentary approaches to healing are all encouraged as well as more theoretical contributions. Hakomi Forum is a publication of the Hakomi Institute, Box 1873, Boulder, CO 80306 (Telephone : 303/499-6699, Email: hakomihq@aol.com), a non-profit educational corporation for the teaching of Hakomi Therapy. Manuscripts should be typed, double spaced with two copies and SASE provided. Permission to reprint text from this publication must be obtained in writing. Permission will be granted contingent upon decision by the author.

Hakomi is a Hopi Indian word meaning “How do you stand in relation to these many realms,” which is their way of saying, “Who are you?”

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Contents

Training Psychotherapists in the Almost Impossible Task of Just Paying Attention
by Deepesh Faucheaux and Halko Weiss

Key Words for Unlocking Our Unconscious
by Jerome Liss, M.D.

Applying Hakomi Principles and Techniques to Mainstream Psychodynamic, Behavioral and Systemic Couples Psychotherapy
by Rob Fisher, MA, MFCC and Jaci Hull, MA, CHT

“Far Beyond Psychoanalysis”: Freud’s Repetition Compulsion
by Greg Johanson

Lightbody Consciousness in Hakomi
by Wolfgang Ronnefeldt, MA

Glossary of Hakomi Therapy Terms

Cedar Barstow And Greg Johanson

Introductory Note: The main teaching manual of the Hakomi Institute which explains the structure and process of the work is Hakomi Therapy by Ron Kurtz available through the institute in Boulder.

The following glossary is provided as a convenience to the Forum reader who might not be familiar with all the terms used in the articles.

ACCESSING: The process of turning a person's awareness inward toward present experience in a mindful or witnessing state of consciousness.

BARRIERS: Beliefs which block the normal organic process of attaining sensitivity and satisfaction. Insight barriers block clarity about what is needed. Response barriers block effective action to attain what is needed. Nourishment barriers block the experience of satisfaction when something is attained. Completion barriers block the relaxation which functions to savor the need attained, release tensions, and to give further clarity about what other need the organism is now ready to reorient around. (See chart on page 24).

CHARACTER: A chronic disposition in people, influenced by metabolic, psycho-social, and structural factors, to both experience and express themselves in a rigid way unaware of or unable to make use of a wider range of choices.

CHARACTER STRATEGY: The patterns, habits, approaches to the world a person has developed to achieve pleasure and satisfaction, given the nature of their particular core organizing beliefs about the world.

CHARACTER PROCESS: Any one of a number of characterological ways of being in the world that have been delineated in Hakomi and general psychological literature as having identifiable, predictable components. (See 'character' above). Referred to in Hakomi literature by both descriptive and classic terms: Sensitive/Analytie—Schizoid, Dependent/Endearing—Oral, Self-reliant— Compensated Oral, Tough/Generous=Psychopath I, Charming/ Seductive=Psychopath II, Burdened/Enduring—Masochist, Industrious/Overfocused=Phallic, Expressive/Clinging—Hysteric.'

THE CHILD: A state of consciousness in which a person is aware of their current adult status and at the same time is experiencing the memories, feelings, thought modes, and speech patterns of childhood.

CONTACT: The first stage of the general therapeutic process in which the therapist is in touch with the immediate experience of the client and able to communicate it to the client in a way they affirm. T: “A little sad, huh?” C: “Yah.”

CORE BELIEFS: The level of consciousness, normally influenced by early childhood beliefs and decisions, that organizes and mobilizes experience and response before experience and response happen; the program that is running the computer: the level of creative imagination or filtering that makes reality available to consciousness.

DEEPENING: The process of helping a person stay with present experience in a mindful or witnessing state of consciousness long enough for it to lead to information about core organizing beliefs; how reality is being structured or limited.

HIERARCHY OF EXPERIENCE: A common shift in the course of the deepening process is from thoughts and ideas, to sensations and tensions, to feelings and emotions, to memories and images, to meanings and beliefs.

JUMPING OUT OF THE SYSTEM (JOOTS): Going from being in some automatic form of habitual behavior, to noticing the pattern, to the freedom to step outside the normal reactions.

MAGICAL STRANGER: The therapist as a compassionate adult who appears as if by magic when the client is experiencing a traumatic childhood memory, to support the child through the painful and confusing event.

THE METHOD: Refers to Hakomi Therapy as a specific form of psychotherapy with accompanying notions about character, therapeutic approaches, techniques, etc.

MIND-BODY HOLISM: One of the Principles which maintains that mind and body interact and influence each other. Beliefs originating in the cortex influence posture, body structure, gesture, facial expression, emotions, etc. through the voluntary musculature, hormone system, etc. Feedback from chronic bodily mobilizations confirm and reinforce belief systems. HT constantly explores the mind-body interface.

MINDFULNESS: A witnessing state of consciousness characterized by awareness turned inward toward live present experience with an exploratory, open focus that allows one to observe the reality of inner processes without being automatically mobilized by them. Also, a principle of the work that maintains the value of being able to step out of the habits and routines that

normally control consciousness and observe the reality and organization of experience without being caught up in it, so that choices and change become possibilities.

NON- VIOLENCE: One of the principles of the work that respects the wisdom of living organic systems to know what is needful for themselves. A way of working that favors going with the flow, accepting what is, paying attention to the way things “want” to go, supporting rather than confronting defenses, and providing a safe setting in which clients will feel free to explore what is most urgent from their own perspective.

ORDINARY CONSCIOUSNESS: Normal, everyday, outwardly oriented, goal directed, narrowly focused awareness ruled by habits and routines in space and time.

ORGANICITY: One of the principles: the perception that organic systems have a “mind” of their own and have the capacity to be self-directing and self-correcting when all the parts are communicating within the whole. Hakomi Therapy assumes and nurtures these capacities as central to the healing process.

ORGANIZATION OF EXPERIENCE: The creative way in which the mind or imagination filters, structures, or transforms the givens of reality to control conscious and unconscious experience and expression in the individual.

THE PRINCIPLES: The basic, foundational assumptions of Hakomi Therapy concerning living systems in general and therapy in particular, taken from contemporary philosophy of science and ancient religious traditions. They are mindfulness, non-violence, organicity, mind-body holism, and unity.

PROBE: A Hakomi technique in which a verbal and/or non-verbal experiment is undertaken with the client invited to witness in mindfulness whatever spontaneous responses they become aware of. The usual form for a probe is, “What do you experience when I say . . .” or “What do you become aware of when I do

THE PROCESS: Refers to the general stages Hakomi Therapy sessions normally progress through - making contact, accessing, processing, transforming around new beliefs, integrating and completing.

RIDING THE RAPIDS: A state of consciousness characterized by the loss of mindfulness, uncontrollable emotional release, spontaneous movements and tensions, waves of memory and feeling, and the use of tension and posture to control the flow of feeling.

SENSITIVITY CYCLE: Stages in the continuing flow of increasingly efficient functioning. Clarity leads to the possibility of effective action which sets up the possibility of organismic satisfaction which may lead to relaxation of tensions mobilized around the original need and the chance for greater clarity about what the next need may be that the system is ready to orient around.

TAKING OVER: A Hakomi technique in which the therapist takes over or does something as precisely as possible (that the client is already doing for themself). Taking over can be physical (taking over the holding in of shoulders), verbal (taking over a voice a client hears inside themself, “Don’t let others get close”), active (taking over the holding back of an angry punch), or passive (taking over a reaching movement with the arms). The technique is normally an experiment done while inviting mindfulness in the client except during riding the rapids when it is simply used to support spontaneous behavior.

TRACKING: The therapist paying close attention to spontaneous or habitual physical signs and changes that may reflect present feeling or meaning in the client at each stage of the process.

UNITY: The most inclusive of all the principles that maintains everything exists within a complex web of interdependent relationships with everything else and that there is a force in life often called “negentropy” which strives to bring about greater wholeness and harmony from component parts and disorganization.

THE WITNESS: That part of mindful consciousness that can simply stand back and observe inner experience without being caught up in it.

About the Hakomi Method of Therapy
and Ron Kurtz, the Founder and Director

On the method . .

Hakomi founder, Ron Kurtz, influenced by the techniques of the body-centered therapies (Gestalt, Bioenergetics, Feldenkrais, etc.) by the intellectual breakthroughs of modem systems theory, and by the timeless spiritual principles of Taoism and Buddhism, has created a synthesis that has a special relevance for the 1980's.

What has evolved in the course of these trainings and in the practice of Hakomi for more than a decade is an approach to psychotherapy that can effectively heal the wounded spirit of an epoch.

Like the art of Aikido, Hakomi offers no resistance, but gently follows the flow of the client's energy to the completion of its momentum. More of a dance than a contest, this cooperative exploration of the client's core belief structures is conducted in an environment of safety and acceptance. The aim for the therapist is to help the client arrive at a state of mindfulness in which the two of them can explore those formative, often self-limiting beliefs, which are locked in the body, and to begin experimenting with more creative options.

Ron Kurtz, born 1934 in Brooklyn, NY., is a nationally acclaimed psychotherapist whose work is having an increasingly profound effect on both traditional and non-traditional modes of experiential therapy. After working in computer electronics as a writer and a teacher, Kurtz returned to school at Indiana University to study psychology. He later taught psychology there and at San Francisco State College. He was at one time the resident body-mind therapist at Esalen Institute, was in private practice for eight years and has lectured and led workshops through the US. and abroad. He is the co-author of THE BODY REVEALS, an illustrated guide to the psychology of the body.

In the years since Esalen he has developed the Hakomi Method of Body-Mind Therapy, created workshops, trainings, and authored a manual for teaching this method, HAKOMI THERAPY. He is the Founder of the Hakomi Institute.

"What are we trying to get at when we do core psychotherapy? We are trying to get at beliefs, images, memories, decisions about who We are and what kind of world we're part of - pieces of the long ago that established patterns of perception, behavior and systemic experience and still control what can be experienced, felt, thought and expressed, to this day."

—Ron Kurtz

BODY-CENTERED PSYCHOTHERAPY
The Hakomi Method
by Ron Kurtz

Hakomi is a Hopi Indian word which means “How do you stand in relation to these many realms?” A more modem translation is, “Who are you?” Hakomi was developed by Ron Kurtz, co-author of The Body Reveals. Some of the origins of Hakomi stem from Buddhism and Taoism, especially concepts like gentleness, compassion, mindfulness and going with the grain. Other influences come from general systems theory, which incorporates the idea of respect for the wisdom of each individual as a living organic system that spontaneously organizes matter and energy and selects from the environment what it needs in a way that maintains its goals, programs and identity. Hakomi also draws from modern body-centered psychotherapies such as Reichian work, Bioenergetics, Gestalt, Psychomotor, Feldenkrais, Structural Bodywork, Ericksonian Hypnosis, Focusing and Neurolinguistic Programming. Hakomi is really a synthesis of philosophies, techniques, and approaches that has its own unique artistry, form and organic process.

“This book is an absolute must. Ron Kurtz is a healing transformation looking for a place to happen. Hakomi is the absolute ‘cutting edge’ in moden therapeutic technique. Kurtz belongs to the masters Perls Berne, would certainly call him brother.”
me, Owen, Bandler and Grinder
—John Bradshaw, author of Bradshaw on the Family, book and TV series

“In Body-Centered Psychotherapy: The Hakomi Method, Ron Kurtz explains how he developed this unique approach and how and why is works. I find it a beautiful expression of the partnership model: a way of healing that recognizes not only the essential partnership between body and mind but between therapist and client; that shows that inclusion, empowerment and nonviolence make it possible to listen to ourselves and move to new levels of consciousness.”
—Riane Eisler, author of The Chalice and the Blade

“Ron Kurtz’s Hakomi Therapy is a highly original new amalgam of some of the best aspects of earlier therapies An unusual combination of elegance and delicacy, its essence is the use of touch-the gentle, wise, caring and healing touching of the body and spirit as well as thinking mind. It is also uniquely in touch with the psyche of our time and the new century into which we are moving,”
—David Lowe, author of The Sphinx and the Rainbow: Brain, Mind and Future Vision

“An extraordinary book that skillfully looks into the therapy process. Ron is a master therapist and a brilliant and sensitive teacher who is able to pass on his skills to others. The simplicity, clarity and humor of his writing enables the reader to easily absorb his profound insights into what makes a therapist truly effective. This book is a breakthrough in integrating principles of meditation and holism into psychotherapy and in offering many new and exciting techniques. The innovative approach offered here is far ahead of other therapies in enabling the client to discover and set aside defensive postures and self-imposed limitations.”
—Swami Ajaya, Ph. D., author of Creative Use of Emotion

TRAINING PSYCHOTHERAPISTS IN THE ALMOST IMPOSSIBLE TASK OF JUST PAYING ATTENTION

by Deepesh Faucheaux and Halko Weiss

Deepesh Faucheaux, M.Ed., CHT, is a Certified Hakomi Therapist and Trainer. He has been a counselor/therapist since 1971, working with individuals, couples, families and groups. During this same 27 years, he has also pursued other passions, including college and secondary teaching, carpentry, freelance writing, performing Shakespeare, and intentional community building. Having lived, practiced or studied in monasteries, ashrams and zendoes around the world, Deepesh has a special interest in therapeutic methods which complement and deepen spiritual practice. For the last seven years, he has concentrated on teaching Hakomi and training Hakomi therapists. He can be reached at 4396 Snowberry Ct. Boulder, CO 80304 Ph: (303) 440-9072 ; Fax: 443-6232; e-mail: dpeshpriya@aol.com

Halko Weiss is a licensed Clinical Psychologist, Founding Trainer, and International Director of the Hakomi Institute. Halko started working as a psychotherapist in 1973 and taught at the University of Hamburg. He is co-author of the book "To the Core of Your Experience", and other publications. He facilitates workshops and trainings in Europe, North America, New Zealand and Australia. Halko also spends a lot of time in Hawaii, where he tends his garden and writes. He can be reached by email at: halkohd@aol.com

A subtext of controversy underlies the question, "How do we train psychotherapists?" Or, the question, "What is psychotherapy?" The sad fact is, both answers depend upon whom you ask.

The latter statement takes us into a socio-political context. Further, it brings up the important distinctions between psychology and psychotherapy so clearly articulated by Dr. Jan Resnick's in the May issue of Psychotherapy in Australia. We could not hope to say it more thoroughly, or gracefully than he, although if pressed, we would repeat many of the same points.

Nevertheless, we will refer briefly to the perennial debate that has continued in the West at least since Socrates: the question hinges upon what Charles Tart (Waking Up) calls "consensus reality", i.e. are we to assume that the dominant paradigm is the measure of truth, or is it no more nor less than the thought form which for various historical, economic, sociological reasons happens to control or primarily influence what is officially defined as valid, respectable, legal, "true"? Tart and others go so far as to call "consensus reality" a "trance".

Currently the dominant paradigm in psychology/psychotherapy is characterized by (or at least enamoured with) the term “scientific”. The most recent manifestation of the “scientific” approach is represented predominantly by the behavioral/cognitive schools, the adherents of which maintain a firm grip on our universities, our professional associations, and our licensing agencies, apparently in Australia, clearly in America and Europe.

The non-dominant or “alternative” side might argue that our emulation of materialist, empirical science has only served to cripple and dehumanize the field of psychology (once the study of the soul), repel some of our brightest and most creative spirits, spawn a whole world of new, ex-academia therapies (many well-supported by public demand), and often scandalize and confuse the novice seeking therapy. Judging from the psychology (and sociology) curricula of the larger universities, (and most of the smaller ones) with their emphases on empirical thinking, measurement, and research, we have a long way to go before we escape the “physics envy” that marks the dominant paradigm.

The definers of consensus reality, who loyally guard and protect the scientific approach in psychology, counter with the argument that we have to maintain rigor, academic discipline, and control. Otherwise we will have chaos. Principles, methodology, and teachings must be solidly supported by empirical evidence. Candidates must be carefully screened, standards maintained, licensing procedures in place to protect an unsuspecting public from charlatans, incompetents, and lechers. Anyone can set out a shingle and do “therapy. “ We have to have laws which ensure that therapists are coming from a solid, scientific foundation and can meet approved professional standards of competency. (In America and Europe, third party compensation may depend upon compliance with these standards.)

(Incidentally, there is no support in the literature to date, including the regularly published complaints and procedures from the medical grievance board in some states in America, that credentials and licensure are any guarantee of protection from charlatans, incompetents, and lechers in the fields of medicine and psychology. We await a thorough study.)

Dr. Resnick skillfully mediates the conflict by differentiating “productive” from “practical” sciences, psychology possibly belonging to the former, psychotherapy to the latter. Psychotherapy, like art, is “a way of being” which involves “a very personal way of knowing that should not be formulated into a system, “ he offers. I could not agree more. This way of thinking makes an inspiring contribution to a peaceful delineation of boundaries between the two types of science. Would that Resnick’s highly civilized line of reasoning find its way into academic and

professional circles on a large scale! If so, “artists” like Ron Kurtz in America and George Sweet in New Zealand would receive their due recognition.

The people will, anyway, find what they really need despite the cautionary labels put forth by the powers that be. A parallel phenomenon is happening in medicine, as an overly intrusive, cumbersome and expensive allopathic model competes with lower-costing, more holistic, alternative approaches like homeopathy, Chinese and naturopathic medicines, chiropractic, and other, older healing traditions. In many countries of Europe, and to a large degree in America, a substantial percentage of the population relies exclusively or partly on alternative medical modalities.

The numbers involved and the intractable inroads already made indicate that this movement is more than a fad or a brief trend. Twenty-five years ago, an American intellectual critic (and prophet), Ivan Illich, predicted that society would “deschool” itself. It would cease to believe that we need the structure and authority of an established school or university to teach us what is true, relevant and useful. People would vote with their dollars, he argued, and create new “learning webs” outside of the traditional structures so often ruthlessly dominated by one school or mode of thought.

Moreover, the centuries-old town/gown dispute, which once grew out of the avant-garde nature of university thinking versus the conservative nature of the populace, has produced a reversal of roles. In many fields, Universities have become museums of outmoded ideas. With reverse snobbery, a new, media-savvy urban avant-garde sneers at academic credentials. And the information highway, especially via the internet, perhaps the ultimate deep democratization of learning, is only in its infancy. It does not take a Nostradamus to predict that the university, like the Medieval Church, stands to lose its monopoly on the truth, even its intellectual hegemony, especially if it continues to be a de facto closed system.

Judging from the proliferation of new therapies, institutes, private trainings and faculties, completely and avowedly off-campus, it is safe to say that Illich was right. And not only in the field of psychology. Deschooling is as much a reality as the multi-billion-dollar alternative medicine industry.

The validity debate continues in various forms even within academic circles, where voices of moderation who advocate a more democratic and open-minded investigation of the best of the new therapies, are often labeled “flaky” by their more conservative colleagues. In fact, it may be a stretch to call it a “debate”; one of the characteristics of a dominant thought form is a refusal to allow scrutiny of commonly held assumptions, despite lip-service to academic freedom. To

veterans of more than twenty years of therapeutic practice in various settings, academic, clinical and alternative, Dr. Resnick's well-considered distinctions between psychology and psychotherapy come as a clean breath of hope for more than mere peaceful coexistence; perhaps we might even hope for mutual appreciation and cross-pollination.

Shifting more directly to the topic at hand, the question of what makes a good psychotherapist becomes more pointed when we consider, for example, the evidence on efficacy research as reported by Michael J. Mahoney in Human Change Processes:

"In four major research projects at the University of Pittsburgh, Johns Hopkins University, the Veterans Administration in Pennsylvania, and McGill University, for example, the therapeutic impact attributable to the psychotherapist was eight times greater than that associated with the treatment techniques. The 'person' of the therapist, and the 'therapeutic alliances' she or he is capable of encouraging and co-creating, are much more central to the quality and effectiveness of professional services than are the specific techniques, explicit interpretations, and theoretical scaffoldings for structuring and enacting the experience of psychotherapy. "

In another work, Healers on Healing, dozens of renowned therapists, doctors, spiritual teachers, healers of all types are asked to summarize what heals. The most often repeated word, and perhaps the theme of the book, is "resonance". If there is a magic ingredient, it is the resonance created in the healing relationship: one human being meeting another in a space of safety, mutual acceptance, respect and—dare I say it?—love! Ron Kurtz, the developer of Hakomi Therapy, calls this work, "developing loving presence, " after the quality most desirable, most efficacious in the being of the therapist.

In short, experience, wisdom, humanness and personal development matter far more than the fanciest or most scientifically valid techniques. Qualities like cleverness, rigor, and thoroughness, so highly valued in academic and professional disciplines, may not be useful in this almost sacred process; they may, in fact, interfere with our ability to be there, to be truly present with the other person.

Kurtz reports his own change of perspective in this way:

I had to shift my attitude from wanting to make something happen for the client, or making things better, to being perfectly okay if nothing happened. I realized that my agendas were getting in the way of the client's power to direct his or her own growth." (p. 18)

On the other side of the planet, George Sweet, a New Zealander who is a long-time counsellor and teacher of counsellors, refers to the art of paying a certain kind of attention:

“I do not even need to know what the problem is. It is a distraction from how the client is, now, with me. And from how the client moves in relation to the problem. I may get so caught up in ‘what’ is being said that I fail to pay attention to the life-changing ‘how’ it is being said. If I do not approach the problem with the flaming attention of choiceless awareness I will seek a solution from outside the person—from my conditioning and needs, training, prejudices and values.” (p. 52)

Paying attention, in this sense, is not the same narrowly focused concentration so elevated in scientific thinking. Multi-faceted, it is an attention that includes internal as well as external experience. It is more spacious and relaxed, though no less alert. Like the discipline of meditation, it must continually return to the here and now, to the client, and the therapist’s own, present experience.

The 19th-century Hindu mystic, Ramakrishna, and more recently Ramana Maharshi, after decades of studying different spiritual systems, taught that to gain control of the attention is the sole aim of all spiritual exercises and disciplines. Following this theme, Russian mystic and teacher, George Gurdjieff, added that the value of spiritual disciplines lies in their ability “to reach and study an attention which can transform, an attention which can link a man with his deepest aspiration and the power to resist the automatism of flight in the face of suffering. … “ (Fremantle, pp. 50-51.)

In our psychotherapeutic work, we call this skill by various names: “being with”, “non-doing”, “listening to the storyteller not the story. “ It seems simple enough, but it goes against a deep and pervasive conditioning we Westerners have (which, undoubtedly, has served us well in other contexts) to be busy, to do, to change what needs changing, to fix what seems broken. How do we reconcile “non-doing” with the simple fact that a client comes to therapy in the first place because something is not working?

Clearly, there is a paradox here, captured best perhaps in the Taoist notion of “action through inaction”. The new counsellor-in-training, eager to fix and change, may be “not yet sufficiently disciplined to be spontaneous, “ (to add another potentially frustrating Taoist expression to the chemistry) and need to learn the fine art of waiting.

Consider, too, Martin Buber’s words:

“What do we expect when we are in despair and yet go to a man? Surely a presence by means of which we are told (emphasis mine) that nevertheless there is meaning. “

If Buber, Kurtz, Sweet, and Resnick are all on track, we are faced with a realization at once consoling and disturbing: perhaps all of the teachable aspects of psychotherapy do not make effective psychotherapists, while all of the things that matter most are next to impossible to teach. You can teach technique, you can create good technicians, but can you teach art? The art of being human? Perhaps the great ones, Jung, Satir, Erickson, and Rogers carry an extra ingredient we can emulate but should not try to imitate. At best they can inspire us to find a way to awaken something similar in ourselves, our own unique version of the human alchemy. Our conviction is that we all have it; we already have loving presence, compassion, wisdom, insight. At least the seeds. The Buddhists refer to this “basic goodness, “ as our very nature. The seeds rest, awaiting nurturance, in the fertile ground of our consciousness. In that sense, Plato was right, and the education of psychotherapists is essentially a process of “remembering”. The function of therapy itself, furthermore, is to help clients remember their own basic goodness and their self-compassion, what Buddhism calls “maitri”, or “loving kindness to the self. “

Before there was any such entity bearing the name “therapist, “ there were elders, priests, shamans, grandfathers, wise women, saints, mentors, and inspired teachers. What the good ones had (and still have) may be able to be caught, but can it be taught? Because so many of the structures which once made these people generally available are now gone, “debunked” by science, or relegated to unreachable fringes, we have tried to replace their functions in the roles of psychologist, and therapist. And many have forgotten that “mentoring” includes much more than teaching; it includes modeling , inspiration, and compassion, or “suffering with “.

In any training, student expectations may also get in the way. Trainees often expect that they will learn the work as if it were a craft. They may know that personal development is a big part of the process, and yet still find it difficult to understand, or even to see, their own character limitations. There is often a readiness to deal with the “how to do it” of therapy and much less readiness to face the difficult personal issues which may be painful to face and to work with, consciously and publicly, that is, in full view of their fellow trainees. The simple truth is that our cutting edge is always in the realm of the not-yet-known; the psychotherapy student, (like Einstein’s fish, which is the last to discover water) may be the last one to see what is getting in the way of learning. It may feel safer not to attend too well to the client within:

Because I am much more like my clients than different from them, I hear myself when I truly hear them. (Sweet, p. 78; emphasis mine).

Clearly then, there are two levels to a psychotherapy training: the “mechanics” of learning theory, skills, and methodology, and this more foundational piece we refer to as the personhood of the therapist. Mechanics can be learned to varying degrees of mastery depending on intelligence, motivation, and perseverance. The personhood of the therapist is another matter. Like the artist, some will have natural gifts and excel almost effortlessly; others will try too hard and somehow miss the point. The majority of the students who take our trainings have already earned a psychology degree, and/or have been working with clients in a therapeutic setting. If this is not the case, they have a lot of fundamental information to put in place. If it is the case, they may have a lot of “unlearning” to do in order to make way for a different set of emotional and intellectual attitudes. Our work is, after all, a shift into a new paradigm.

Some brief mention of the nature of our work might serve to clarify. The Hakomi approach to psychotherapy facilitates the creation of certain attitudes intrinsically related to the notion of personhood. The system is based on a set of five interrelated humanistic principles derived to a large extent from Taoist and Buddhist psychology. Those principles, which constitute a philosophical as well as methodological base, are : Mindfulness, Unity, Non-Violence, Organicity and (Body/Mind)Wholism.

These principles philosophically circumscribe, and have the potential pragmatically to create (or evoke) within the trainee (as well as the client) a certain attitude of gentle, non-critical self-study, self-acceptance, connectedness to the “larger selves” (i.e. other people, society, the planet), and a trust in the built-in natural order of things, especially living systems (the Tao). These principles can be explored and taught philosophically, but in order to make full, holographic sense they must be grounded in experience, must be grasped in the context of exercises which access and make conscious the real feelings, bodily involvement, thought processes of the student/client, (what we refer to as the organization of experience).

The methodology based upon these principles is as teachable as any other method. The difference is that we do not teach method and skills by themselves or for their own sake; in teaching the skills we also, but indirectly, teach the “untrainable” or attitudinal factors.

For example, a student may be clumsy with the method but be working well “within the principles” as we call it . Conversely, a trainee may be highly skillful in the use of technique and still be “Violent” or “not Mindful” or “out of Unity” and

therefore off-track in terms of learning the more fundamental and crucial attitudes necessary to become the kind of “Presence” we have been describing.

The point here is that technique, methodology, even overall theory are always in service of attitude. Our object is not to impose, for example , a theory of the self upon our clients, or even to base our procedure unequivocally on a certain school of thought or set of meanings about the self. In psychotherapy, there is no one “Meaning”. The client, after all, has a very personal set of meanings within which s/he lives and moves and has his/her being. As Resnick points out:

These theoretical notions or myths of therapy are neither true nor false but enable the psychotherapeutic process to move. In a way it doesn’t really matter if the theory is true or not if it succeeds in giving form and meaning to a client’s discourse—in a way that works for them.

One recalls William James notion of useful beliefs, the first principle of pragmatism. In Hakomi, we go for a set of therapeutic attitudes that we know will allow a client’s process to unfold organically and non-violently; we name those attitudes; we train them. For the sake of structure and form, which are necessary for linear thinking and teaching to proceed, we call them by names: “uncritical awareness”; “loving presence”; “mindfulness”; “heartfulness”; “beingness vs. doingness”; “curiosity” vs. “a desire to change someone”; “experimental attitude”. We even describe the qualities of those attitudes, but we don’t pretend to be able to teach them directly.

Although a great deal of cognitive material is presented through lectures and written texts, the training is primarily experiential. We trust experience, in Francisco Varela’s words:

“The only real way to do a science of mind is to accept the hard and solid fact that the realm of experience is ontologically irreducible. . . Explanations that do not allow me to link up with my experience are ipso facto discarded. . . (as) bad explanations. . . bad science. . . because they leave a big chunk of the world out.” (quoted in Davis, p. 31.)

Part of the essence of our approach is “experience evoked in mindfulness”; therefore, the emphasis is on “felt sense” learning. The process recalls the etymology of the word “educate”: i.e. e/ducere, to lead toward. Exercises are designed to access in the student or to lead them toward awareness of how they stand in relation to the material being explored. In other words, the question is not, “Do you agree or disagree?” but more, “What does this bring up for you and how do you notice that? Does something happen in your body? In your feelings? Or in your mind?” The ultimate point of focus is not on the individual experience

but on the student's (and client's) relationship to experience itself. The distinction is at first subtle and elusive, but in the end, potentially life-altering, like a Zen Koan.

How, in fact, do you stand in relation to what is happening, right now, to and for the client? Here we would honor George Sweet's injunctions about the "client within", for no therapist, in our view, is inseparable from their client's process. From this perspective, therapy is "a mutual co-arising", to use a transpersonal term. To use a scientific concept, no phenomenon is inseparable from the observer of that phenomenon; the observer is part of the equation. Transference, therefore, is potentially harmful only to the degree it is unconscious. The neverending journey of therapy is one of self-discovery, every step of the way, and not just for the client. Called by many names, the attitude of self-remembering is the key:

"Less and less do I give energy to the doing of counselling. Now I seek stillness, to pay attention, be there - the almost impossible which, when it occurs, produces a miracle, and a celebration." (Sweet, p. 6)

The ancient practice of mindfulness, adapted to use in the therapeutic setting, is the cornerstone technique in Hakomi therapy. Each student learns personally to use as well as to teach this practice to his or her client. The intense self-study fostered by this powerful tool is an inescapably transformational process, one that has given rise to the notion of "therapy as spiritual practice". Mindfulness, together with the conscious practice of loving presence or compassion, puts this training solidly in the realm of the transpersonal, although we do not align ourselves with any particular religion. The practices we have named, although inspired by Buddhism and Taoism, are deeply rooted in all of the major spiritual traditions.

The changes a student undergoes are not always easy. For that reason it is strongly recommended, and in some cases required that trainees receive regular sessions of therapy during the training, preferably, though not exclusively, Hakomi therapy. By regularly changing roles, the trainees stay in touch with both sides of the relationship. Frequent, supervised practice, after as well as during the training, is essential.

A typical training exercise may serve to illustrate the principle of mutual co-arising in its practical manifestation. In a triad practice exercise, one student works as "therapist" with another student as "client"; a third student is "observer. "A staff person oversees. The "therapist" works until s/he gets stuck. The staff person then takes over and works with the stuck "therapist" while the observer completes the session with the original "client. " The staff person, in working with

the original “therapist” precisely at the point where s/he stumbles or freezes, is often able to uncover, in a gentle and non-critical way, exactly how the student’s mostly unconscious, personal process is entering into the dynamics of the therapy session or the healing relationship.

Every session, indeed every relationship, is a dance, a two-part system. Normally we are blind to our part in the system. Throughout the training, practice in mindfulness and “jumping out of the system” enable the trainee to become more and more aware of how s/he is affecting the therapy. This highly developed self-knowledge enables the therapist to get out of his/her own way when necessary, and to use the relationship more consciously when that is what is needed, in short, to refine the use of oneself as an instrument.

Our aim is always to empower the student as well as the client, principally through the refinement of a greater awareness of who and how they are. We teach them a powerful set of tools, but more importantly, we try to impart a sense of the purpose and overview that gives meaning and direction to their journey. In this respect, George Sweet, once again, makes the point very well:

“We counsel in a day when people are taking back their lives from specialists. We can be in the forefront of this change as people seek wholeness through meeting a whole counsellor. People are ready for a still counsellor, with the Empty Mind, who seeks for Choiceless Awareness, who opens people to themselves.” (p. 7)

What could be more worth doing?

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KEY WORDS FOR UNLOCKING OUR UNCONSCIOUS

by Jerome Liss, M.D.

Editor's note: This is a nice example of a self-contained technique that you can put into practice right away.

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THE KEY WORD IS LIKE A KEY

The door of the unconscious is locked. Key Words unlock the door.

When I am distressed and unhappy, I know something: "I am distressed and unhappy!" But why, how come, from what? Maybe a thought recurs again and again: "I shouldn't have done it!" "I am sad!" "It's the end of the world!" "Empty, nothing!" or "Take that, you bastards!"

These are all the key words of my unhappiness. They are the top surface of my awareness, the top of the iceberg, and there is a Hell underneath, but I can't get to it yet. And I'm afraid to get to it, or I just don't know how!

THE KEY WORD OPENS THE DOOR TO THE UNCONSCIOUS

Through the Cellar-Bin or Out the Window

So my therapist-companion says, "Say it again!" And I begin to repeat my key phrases, stronger and stronger, to unbar the door, open the portholes, perhaps to open the cellar-bin of fears or just take a flying leap through my mental window. All to know better what is happening...inside.

"Just repeat the key words, Dr. Liss? That's enough? But I thought that the therapist should do much more: interpret, probe, penetrate and cut through the resistences with a knife."

Dr. Liss: "If I become your patient, please don't use your knife on me!"

"Stay With What Is"

So I am talking about a therapeutic approach that is very profound and yet that does not use the knife. It is respectful and safe.

When I use the key words — whether I am patient or therapist — I am going deeper, but in the Gestalt sense, that is, with “what is.”

Although any therapist can use Key Words, it is especially useful for the body-oriented psychotherapist. I’ll go back to that in a moment.

Negative Interpretations Diminish The Patient’s Self-Esteem

Let me give some background. When I lead various Body-Oriented Psychotherapy Training Groups, as guest trainer, I am always impressed by the skills and intuitions of the student therapists in terms of their conducting the body work: Helping patients reach deeper emotions with “just right contact,” creating rapport and safety with body empathy, supporting the patient’s newly found expressive freedom with mutual play, and so on.

On the other hand, when it comes to the verbal aspects of the work, the students frequently show a certain amount of vagueness, confusion and even contradictoriness, using “negative interpretations” to reach repressed infantile traumas, but re-stimulating that very same trauma — the sense of self-negativity and self-defeat — that their therapeutic interventions are trying to overcome.

For this reason I will undertaking, in this article, to clarify a methodology for “use of language in psychotherapy” that has the advantages of clarity, precision and, I propose, therapeutic effectiveness. The model is called, “the Key Word” and the “Key Word” can also mean the “key phrase.” The work deepens and advances while the therapist keeps in mind several maps of personal evolution: deepening emotions that are already present, moving from problem to solution, favoring sympathetic-parasympathetic alternance, and moving ahead with one’s thinking.

Part I: Deepening With Key Words

What is the “Key Word”?

The Key Word or key phrase means the hot word or hot phrase. They are coloured red, for passion, or black, for despair, or white and yellow for hope and radiance, or orange for the taste of sweet oranges. Technically, the Key Word and key phrase refer to those special words embedded within the patient’s verbal communications that carry a special emotional charge and that reveal an important aspect of the patient’s experience. Everytime we hear the key word we can see lights blinking, vibrations shimmering and flesh needing to tremble: emotion, charge, impulse and force! Or else the flower petals of vulnerability.

A simple example: “Today I am not feeling very well. In fact, to tell you the truth, I am feeling like shit! Key word: Like shit!
Other examples: “When I woke up this morning, I had a repeated thought: ‘You’re a mess! Your life is all botched up!’ Key words: Mess! Botched up!

“I was thinking of how my mother looked in that photo. Something in her expression, her eyes... Can it be true? Is she really crazy? Something about her... an absence...” Key words: Crazy? Absence... Perhaps eyes...

“My husband was never a big talker. But now when he comes home, he plops himself in the front of the television, and for the whole evening doesn’t say a word, no, not a word, not a Goddanned word! (pause) It makes me feel... lonely... What can I do? What should I do? (looking at the therapist)
Key words: Not a Goddamned word! (sympathetic anger charge) Then lonely... (rebound to parasympathetic vulnerability). Which Key Word will the therapist pick up? Clinical intuition and experience will lead the clinician to a very rapid decision: Lonely if he wants to favor, for the moment, the deepening of vulnerable and hurt feelings, Not a damned word! if he senses it is preferable, at that moment, to deepen and elaborate the sympathetic anger.1 Whatever the decision, it is the Key Word that will unlatch the lock.

One last point: Not everyone will agree, in a particular case, as to which word (or phrase, or part of the phrase) represents the Key Word. But that is fine. We can never know for sure the inner life of our patient or, for that matter, of anyone, aside from oneself, as R.D. Laing so poignantly points out in The Politics of Experience.2 So we must acknowledge that every intuition we make, when attempting to select from the patient’s total statement the most pungent Key Words, remains, epistemologically speaking, a hypothesis, not a truth.3

Repeating the Key Word

And how does the therapist use the patient’s Key Word? By repeating it! Not only by repeating the Key Word itself, but by repeating it with an intonation and rhythm close to the client’s. For that reason I wrote the above Key Words, like “...loneliness...” and “Doesn’t say a damned word!” along with their various grammatical signs, since the intonation and rhythm of the verbal expression are integral parts of the Key Word, but the reader cannot hear the sounds written on the page.

The Body Therapist’s Opportunity: To Use Key Words Deepened By Body Interventions

Question: “Dr. Liss, I suppose that there is more to this therapeutic approach than just repeating the Key Word.” “That’s right.” “But before you come to that, why did you say beforehand that the Key Word approach is especially interesting for body psychotherapists?”

Response: First, let me say, as a preamble, that I love body psychotherapy. I hope that this is not dangerous to say in Energy and Character. And I say this because I think that body-oriented psychotherapy is a most incredible tool for helping people explore their problems and come to vital solutions. The point is that when Key Word methods are applied WITH body psychotherapy interventions, that is, at the very same moment, we have an extraordinary way to help people open their unconscious and unearth its hidden resources. Thus, while Freud used “free association” of words as the Royal Road to the Unconsciouus, and while some body psychotherapists use, too exclusively, in my opinion, only body contact and body mobilization to travel down the same road, the Key Word method proposes, “Let us use words and the body in one blow!” And that means very strong winds sometimes. Or, at other moments, deep fertile rest.

To Repeat the Key Word Creates an Echo Chamber of Experience

Before I develop the possible methods with examples, I’d like to explain a bit of the phenomenology, that is, the experiential impact of the therapist’s repeating the patient’s Key Words: When I say, for example, “I’m depressed”, and my Helper says, “M-m-m, depressed,” (and I think, at this moment, of Hakomi therapy’s originator, Ron Kurtz, for I saw him in one brief and touching moment at Trimurti in France using this rhythmic echo), I am creating an echo chamber, not only of the word, but of the experience. Depressed. This gives the patient time... time to absorb his own experience of “depressed, and also time to absorb the therapist’s absorbtion of his depressed experience. The point is that when the patient absorbs the empathic introject of the therapist, this is already a major step in therapy.3A

What happens when we are in the position of the patient? Whenever our therapist simply repeats our Key Word or phrase, with an empathic attitude, we benefit from two immediate effects: First, we feel the echo of our experience through the therapist’s words and thus we can maintain our consciousness on what we had said: “Stay with it.”

Second, we can feel directly our therapist’s closeness and support. As suggested in the article, “The Self, the Impulse and the Other,”4 the Impulse is reinforced, the Other is empathic and the Self becomes more self-accepting.

If therapy is like crossing the river, at this point the patient is remaining on the same rock, almost crouching and digging his heels in. Not very much? The opposite! This is a great deal! “We have to become what we are in order to change!”, a beautiful Gestalt and meditation phrase. This is a method for arriving there... where we are.

CROUCHING ON THE ROCK

“Express the Key Word with Your Body! I’ll Do It With You!”

How can the therapist combine Key Words with body intervention? By suggesting to the patient that he express both impulses together: the word and the body. To illustrate this point, let us return to one of the initial examples:

“When I woke up this morning, I had a repeated thought: ‘You’re a mess! Your life is all botched up!’ (Key words: Mess! Botched up!)

It’s the sixth session. So the patient, Louise, already knows the ropes, the rules of the game. And, of course, she has given her consent to work in this way of expressing more fully her Key Words by using her whole body.4A

Therapist: “Mess! All botched up!” There, in the bed... waking up... can you tell me more?

Patient: Since my husband is away, I was able to think about the situation while I was lying in bed this morning. It doesn’t work out — I mean, the marriage — but we have the two children. The attraction to my colleague, Frank, doesn’t help. It’s not that I want to leave Jeff (the husband) and run into Frank’s arms. The problems have been going on for too long, years, even before I ever knew or heard of Frank. So what am I going to do?!

Therapist: Do!... Yes, do. But is it all right if we go back to “feel”? Then later, to “do”?

Patient: Yes, of course...

Therapist: Feel... “Botched up. A mess.” Can you say it several times, let it come out, so we can see it better, feel it better...

Patient: “Botched up... A mess!” The therapist accompanies Louise’s words as well as her new gestures that rise up spontaneously. This is called Body Empathy.5 And what happens? Louise’s arms, shoulders and face begin to writhe and twist like swollen intestines in blocked peristalsis — and she has had abdomenal problems for more than two years — and as her words are repeated

with more and more force, the therapist repeating with her the words and gestures to create body-voice empathy, she half closes her eyes and ends up with vigorous expressions that are between rage and crying. (She is stuck between sympathetic rage and parasympathetic crying.)

At a certain moment she raises both arms as if on the verge of declaring something important (a sympathetic-mesodermal gesture), but the words get blocked, and her arms drop in defeat (rebound to the parasympathetic, “I can’t”).

Therapist: (gently, firmly) Louise, can you bring your arms up there again, just for a moment, and he gently lifts one arm to the position he means, slightly above her head. She moves both arms to the position above her head, he holds both there as support, and asks her to repeat the same Key Words in that tonic body position: “Botched up... A mess!” And they say it together three times, her arms moving in rhythm with the sounds and... Louise drops in a collapse! She suddenly keels over, drops her arms, bends her whole back over, until her face is almost in her own lap, and a deep and painful cry gushes out, followed by streams of tears. The therapist encourages her to repeat the same words, or to say any other words that come to mind, and with pain and despair she repeats, “Botched up... A mess!” And then changes it to just repeat, “Botched up!”, with the therapist saying it with her (at the very same time, in the same tone and rhythm). Thus the endodermal-mesodermal6 “knot” words are repeated by both the patient and therapist together, with the result that the patient’s crying remains abundant until it gives full release.7

Deepening the Feeling of Relief and Liberation

“I’ve got to solve it!” is the next phrase that spontaneously appears. (A “doing” mesodermal phrase) So therapist and patient begin to repeat this phrase again and again together. And as she repeats it, Louise’s energy becomes more “clear,” her breathing wider, her position returns to almost sitting up with the back erect (but now with the elbows crooked on her knees, as if she is ready to contemplate something), the eyes lucent, not just from crying but also from relief, and the Problem phase is now ready to pass on to the Solution-Construction phase.5A It is not that the emotional relief is total, as I would have preferred, but her insistence on “What to do”, already said two times, means that she needs to consider some first steps in order for the therapy (that is, her life) to advance. See the article, “From Negative to Positive,” previously cited.

The point of this example is that the focus on the Key Words, without the introduction of any extraneous Key Words of interpretation, association, understanding or whatever else the therapist might want to interject, allowed the patient to focus on both her situational dilemma and her deep emotions. If the

therapist introduces too many of his own Key Words, the intensity of the patient's emotional-cognitive experience can become diluted. And what about the body interventions? Key Word work connected to just right endodermal-mesodermal body interventions7 also adds intensity to the therapeutic work, and that means a deepening and transformation of the patient's experience. The clouds of anxiety and depression dissipate as the emotions unravel and find release.

Objection: Dr. Liss, I see a contradiction. You said that the therapist restricts his language to the Key Words that come from patient. But in this example, the therapist added many other words.

Dr. Liss: That is correct. But if you look at the therapist's words — "Can you say it several times?" "Can you let it come out?" "I can say it with you!" "Let's try it louder and louder!" "Can we do that movement together?" — we see that these are not Key Words with emotional impact. These are "directional words" that indicate what the therapeutic direction is: To say the word with greater force, expressivity and whole body movement, and for the therapist to support the patient by doing it as well, We will see in a later section, "The Rigor of Key Word Selection," how the therapist can often add "directional indications" to suggest a direction of psychological attention: "What is the image?", "What is the feeling?" "Do other words come to mind?"

These are "directional questions" that follow the logic of an experiential map containing three channels: image, emotion and thought.

Part II: Going from Problem to Solution Using Key Words

"Coming Down to Brass Tacks"

"Next-step" Solution work can also move ahead with Key Words. In the example of Louise, she came up with the Key Words "breathing space". Therefore, we focused the work on determining what concrete actions Louise could initiate in order to create "breathing space", at least partially, in the near future.8 Her idea was to take advantage of her husband's 10-day absence for business reasons in order to take some "breathing space" for herself: And what were the concrete hypotheses?

An evening with her two best women friends, with whom she decided to confide more deeply about her distress and confusion, asking them to promise confidentiality.

An evening by herself to go to the movies in order to taste that free “breathing space” she will have more conclusively should she decide to effect the separation.

And a day alone with the children in the open air (“breathing space”) in order to reinforce and explore the single-parent relationship that may become more habitual for their future.

Once again, all this “concrete next step”9 taking was accompanied by the words, “Breathing space,” the open arm hands in the air, open breathing gestures (to maintain the appropriate body vitality while formulating and imagining10 these next steps), and the therapist’s accompanying body-voice empathy.

The Rigor of Key Word Selection: Problem Material vs. Solution Formulations

There are “advantages and disadvantages” in every therapeutic intervention. The therapist, for example, will often orient the exploratory work with open-ended questions, such as, “What comes to mind?”, or else, “Is there an image, or another important thought?”, all of which can help unlatch the door to unconscious associations.

On the other hand, the therapist will often intervene with greater specificity by selecting Key Words that correspond to the patient’s stage of emotional work: “Explore the problem” or “Formulate the solution.” Thus, in our previous example, the therapist chose solution work connected to the Key Word, “breathing space.” What guided his choice? First, the patient was alreading beginning to breathe more fully and this was associated with a general sense of “positive force” coming from her body (body tone, posture, gestures) and also from her facial expression. In other words, her overall state corresponded to the “relief” experience which gives the sign to change from Problem Exploration to Solution Work. Second, Louise had expressed, at the very beginning of the session, the question, “What can I do?” Therefore to neglect that basic question would indicate that her therapist was not listening to her needs.

There was another consideration: In an earlier session, greater time was spent on deepening the patient’s distressful emotions connected to her Problem-oriented Key Words: “confused,” “a dead end,” “a knot that cannot be untied,” etc. These Key Words had led Louise to the associated memory of being fed by her mother food that she could not stomach, and after that to other memories of her difficulty in extricating herself from her mother’s forced and invasive interventions. Finally, in the previous session based on “problem exploration,” Louise linked these unhappy Key Word feelings of “confused” and “dead end” to

more recent situations involving her husband. Example: When he expressed “words and attitudes” (and she gave examaples) that she “could not swollow.”

The point is that Key Word work focuses with precision and rigor on the patient’s emotionally charged language. To bring out their significance and force, the body-oriented psychotherapist selects the Key Words pertinent to the Problem Elaboration or Solution Creating Stage of the work and, at the very same moment, asks for mind-body intensification.
How can we better understand this process? Let us imagine how a microscope hones in on cell structures, sometimes pathological, sometimes healthy. In just the same way, the meanings, associations, images and passions embedded within the Key Word cellular structures become problem-based or solution-generating organelles magnified into consciousness.

Perhaps a number of full-blown examples are needed to better illustrate the potential of using Key Words. But for the moment, I would like to limit myself to just outlining a series of frequent interventions that the body-oriented therapist can use in order to combine body and mind in an effective therapeutic strategy: In other words, how can we use this two-forked road to the Unconscious — the body pathway by means of intensification, the mind pathway through repeating Key Words — in order to deepen and work through the patient’s psychological distress? In the following section we will examine the richness of methods that can both inspire the therapist’s interest and advance the patient’s emotional growth.

Returning to the metaphor: If we call upon the image of the patient standing on the first rock as he crosses the river, let us call this next section, “Jumping on the Rock.”

“Jumping on the Rock”

“Jumping on the Rock” means intensifying the emotional work by merely repeating the Key Word or key phrase. “I feel stuck!” Therapist and Patient (together): “Stuck! Stuck! Stuck!” Said with increasing loudness.

An even more incisive “directional question” offered by the therapist — and I hope the reader will not underestimate its value because of its simplicity — is the phrase, “Can you show it with your whole body?” (The tone of the phrase is as important as its content, as is the case for all directional indications that seek to make Key Words and phrases shiver and vibrate in their fresh, red-blooded vitality, or else their murmuring parasympathetic delicateness and vulnerability.)

Words like “stuck,” “afraid,” “miserable” and “pissed off” are spewed out during the Problem Stage of emotional work, since they express the patient’s experience of his life difficulties. After that a totally different series of Key Words crop up and we know that we have reached the Solution Phase: “free,” “liberated,” “clear” or “secure.” As clarified in the article, “From Problem to Solution: Guiding Emotional Work with Deepening Followed by Construction,”11 the therapist’s capacity to discern the patient’s emotional movement within these two phases of Problem and Solution work becomes an important sign of his growing competence. That is because pulling out from the stream of language the particular Key Words that conform to the patient’s emotional state — distress in the Problem Phase, positive force in the Solution phase — is an essential element of the Key Word strategy.11 It is like pulling out the right word-fish that jump out of the stream of consciousness. To be a poor fisherman, pulling out the wrong words, can block therapeutic progress and may even create a harmful impact.

JUMPING ON THE ROCK

Let us take another example of Key Word deepening in the Solution Stage. The patient says, “Now I feel free!” The therapist proposes, “Can I say that with you?”, thinking of the motto, “It takes two to tango!” At that point therapist and patient begin to repeat in unison the phrase, “Now I feel free!”, with ever increasing vigor. During this intensification, they might get onto their feet, start waving their arms in the air, laughing and giggling like two playful children, and then end up jumping up and down as they sing out, “I feel free! I feel free. Absolutely free!” And at that moment it cannot be denied that they are actively ‘jumping on the rock’!

“Crouching on the Rock”

What does it mean when we say, the patient began to “crouch on the rock.” This means that the patient’s Key Word and total body energy represent a parasympathetic “inward” state. So simple logic tells us that this is the right moment to use body intensification methods that help the patient reach down into his parasympathetic depths of distressful feelings — pain, hurt, fear, sadness, shame — benefiting from spontaneous movements, for example, that involve turning the shoulders inward, letting the head sag downwards, bending over the back, putting one or both hands on the belly or chest in the mid-line area — that’s where the vulnerable emotions are usually strongest — and bending the knees to assume a somewhat crouched position. The patient’s Key Words or phrase usually involve a sense of vulnerability and impotence: “I feel abandonned.” “There’s nothing I can do.” “I feel depressed.” “I want to hide from the world.” Etc. In other words, to repeat such Key Words and phrases with the crouched up and bent over position is another psycho-physical intensification. Whether we are

‘jumping up and down’ or ‘taking a crouched up position’ on the rock, it means that no new Key Words have been added by the patient. We are not yet advancing on the level of thoughts. We are merely distinguishing, with great sensitivity, sympathetic-mesodermal states from parasympathetic-endodermal states, and guiding the alternance between these two emotional modalities with dexterity, so as to help the patient untie his emotional knots.12

Part III. Moving Ahead with Key Words

Advancing: “Stepping from Rock to Rock”

I find that the elegance of the Key Word approach becomes especially apparent when we advance from thought to thought, as if we are stepping from rock to rock, in crossing the river of personal exploration.

And where does the next thought come from? From the patient! No interpretations, no leading, no pushing from the therapist’s side. The therapist merely says, after a moment of mind-body intensification using the Key Word, (Jumping or Crouching on the Rock), “Does anything come to mind now?” (or: “What are you feeling?” “Does another thought come?” “Is there an image? And if not, a particular sensation?”) These are “directional phrases,” not Keywords. And very often the therapist says nothing. When the sympathetic-parasympathetic rebound is obtained, there is usually a change of the emotional state toward deepening or toward emotional relief.

This moment becomes especially productive if the previous mind-body intensification involved a strong sympathetic-aggressive thrust. We bounded up the mountain with our mesodermal force, almost to the very top! And then? And then... A moment of silence. The patient is in his deeper self... a deeper feeling, soft, delicate, precious, can emerge. “And deep inside now?”, says the therapist, softly. Perhaps it’s a crying feeling. Perhaps it’s an unburied hurt. “It feels like a swollen wound inside.” Therapist: “Swollen wound...” And we go on with Key Words. What has happened is that the intensified body dynamic has permitted us to reach the “parasympathetic rebound”13 (rebound from the sympathetic to the parasympathetic), and this moment reveals the deeper self.

ADVANCING FROM ROCK TO ROCK

As the patient continues to respond to the therapist’s “directional question,” new Key Words may come up: “It makes me so mad.” “I won’t give up.” “I’m falling into a deep hole.” “It feels so empty inside.” And these key words then become stepping off points for new intensifications and step-wise advances.

Some Neurological Considerations: Plunging Into the Deeper Brain Substance

Language processes are most clearly related to neurological functions around Broca's area in the cerebral cortex, as numerous studies have verified for more than a century.14 But we know that a neurological center does not "contain" all aspects of a function like a car that contains all parts of its engine under the hood. The brain is a vast network and its genius comes from the vast interrelationship among all its parts.

This "network" model of the brain permits us to speculate as to how Key Words and phrases reveal a special emotional charge. And our hypothesis? That the Key Word, related to Broca area functioning, has important but dormant connections with brain areas especially concerned with emotion: the hippocampus and the amygdala, two important sub-cortical centers that constitute the limbic system, also known as the "emotional brain." The hippocampus, which is the site of benzodiazepine action — benzodiazepine being a tranquillizer that acts against anxiety — is also intimately connected to the temporal lobe, the important "memory storage" sector of the brain. But connections between the higher up cortical Broca's area and the lower down hippocampus-temporal lobe region are not of high density. Neuronal messages between these two areas must pass through the entorhinal cortex and the cingular gyrus, two subcortical structures that function as a filter. Therefore, a language pattern can have some relationship to an emotional state, but the two functions are not always intimately related.

Therefore, how can we enhance the connection between the cortical Broca language area and the sub-cortical limbic system emotions?

From clinical experience, we find that repeating Key Words and phrases, increasing the sound intensity, permitting different "emotionally expressive" intonations of the sound, and adding to this our full body power using our arms, legs, trunk and facial expressions, all seem to "wake up" the dormant connections between emotion and language. We can imagine that these integrated body-vocal expressions, repeated and intensified, awaken a great number of brain neurons and also their somatic connections (muscular, visceral, hormonal, etc.), profiting thereby from a somatic "recharging" feedback to the discharging brain neurons. Thus, our work stirs up countless central-brain / periphral-somatic circuits firing together in positive feedback loops. Perhaps more can be said about which neural pathways and centers constitute these particular feedback loops. But for our purposes, it is sufficient to imagine a general schema of the brain functioning at a multiplicity of levels: the conscious cortex, the emotional centers of the limbic system, and the lower vitality centers, to follow Paul MacLean's scheme of the Three-Level Brain.15 The Key Word repetition and verbal associations awaken cortical association areas,16 while the "whole body intensification" awakens lower brain vitality centers. Thus, the

emotional brain limbic system receives cortical inputs from above and vitality center inputs from below,17 all of which catalyzes limbic-based emotional intensification and transformation.

To summarize, our mind-body method of repeating Key Words and phrases with high vitality levels can awaken our Word-Emotion neurological connections and in this way help us explore our emotional problems, as well as formulate our emotional solutions,

Using Key Words to Open New Experiential Channels

To return to our clinical work, the previously illustrated examples of body-mind intensification are not the only way to use Key Phrases. A more gradual approach involves the careful use of “directional questions” (as mentioned before) that merely ask for something more on a verbal level. (This is one of the most frequent types of psychotherapeutic intervention.)

Let’s say the patient simply says, “I feel anxious.”

Therapist: Anxious... (and then adds)

“How...?”

“In what way...?”

“Do you feel anxious IN YOUR BODY right now? What is it like?”

“Can you describe WHAT’S HAPPENING INSIDE in that moment you say, ‘I feel anxious’?”

“Perhaps you know something about THE SITUATIONS that make you feel anxious. What happens in those situations?”

The therapist, therefore, can ask for associations, sometimes by indicating a particular experiential channel — sensation, emotion, thought, image, situation, even space or time (these are channels or domains of consciousness that are part of the experiential map)18 — or sometimes by maintaining a general direction: What comes to mind? What’s happening inside?

The upshot is that we are crossing the river, going from rock to rock, step by step, following the patient’s pace as we deepen together our awareness of the problem. Evidently, these are methods and questions that we are already using in our therapeutic sessions. The Key Word strategy only says this: Avoid

extraneous language. Don't add your probing associations. Let the patient's own resources of awareness and psychological disposition lead this delicate work.

Planting the Seed: The Therapist Is Discrete When Using His Intuitions

As a final word, the principle, "The therapist does not add any extraneous Key Words," is not absolute. After mastering the above Key Word - body vitalisation methods, the therapist now takes certain opportunities to add new Key Words. But this has to be done judiciously and with great respect for the patient's psychological disposition.

To illustrate this final point, let us return to the above example of the patient saying the simple phrase, "I'm feeling anxious." If the therapist feels that the advantages of slow and patient exploration, as illustrated in the above section, "Using Key Words to Open New Experiential Channels," can be outweighed by a verbal approach that more specifically searches out cognitive connections and associations to real-life situations, he can "plant the seed" of concrete association by suggesting, in a humble way, one or two possibilities that sprout up from his own intuition. This is a most complicated terrain, but I will offer just several indications to show what is possible.

Light Planting: The Therapist Offers Several General Examples

In seeding the patient's psychic ground by light planting, the therapist seeks nothing more than go to the next concrete level of situational associations:

Therapist: Anxious... Is it something around work? Or your home situation?

Therapist: Feeling anxious... Is it connected to being afraid of criticism, or in some way of being refused by people?

Therapist: Saying 'I'm feeling anxious,' is there something about coming here, our way of trying to face your emotions, or something about my presence, that brings on this anxiety?19

Therapist: I imagine that the sensation, 'I'm feeling anxious,' crops up at particular moments. When you talked about that difficulty of talking with your colleagues the other day, I was wondering if that could have created the same type of feeling of 'I feel anxious.' (Notice that the Key Phrase is repeated in all of these "planting the seed" proposals, so that the echo chamber potential of the therapist's words is exploited as often as possible.)

Deeper Planting: The Therapist Offers a Few Probing Intuitions and then Stops!

Here, a more concrete situation is offered for the patient's consideration, not because the therapist believes that he is correct, but only to stimulate the mental level of "concrete associations."

Therapist: "For example, when your husband starts criticising your older son, as you mentioned the last time, and you disagree with your husband's attitude, but, as I remember you said, you don't want to contradict him in front of the children, does this make you anxious?

Patient: No, it's not that... But when he suddenly gets into one of those irritable moods, slams the door saying he's going out, and I know he'll probably get drunk again, that's what makes me so anxious!

We see that the therapist's Planting the Seed by offering concrete associations, either at a "light" or "deep" level, means that the therapist can, on occasion, introduce new Key Words and concrete situations from his own intuitive framework. In fact, it may be said that this is almost the same as "offering interpretations." However, there are several differences or, at least, precautions: First, the initiative of "planting seeds" should not be taken up by the therapist too frequently, for this creates slight ruptures in the patient's own associative mental processes. Second, this is the work that the client should be doing for himself, and therefore the therapist's "associative interventions" are mainly offered to catalyze, almost "enzymatically," the client's coming to similar "thought deepeners" on his own two feet. Third, the tone of the therapist is extremely modest: His attitude shows clearly that he has no interest in being found "correct" in his intuitive contribution, but that his only wish is to help the client find his own associative material.20 Fourth, every offering is connected to the Key Words or phrases that the therapist is also repeating, so that the work of stepping from rock to rock goes on unimpeded.

Conclusion

I propose that three fundamental maps are necessary (and sometimes almost sufficient) conditions for conducting therapeutic sessions that explore and transform emotional disturbance. 1) The map of Sympathetic-Muscular Emotions in alternanace with Parasympathetic-Visceral Emotions, 2) The map of Problem to Solution, 3) The map of Abstraction to Concreteness.

To follow the emotional-cognitive process acccording to these three maps can give the patient a therapeutic structure that allows a deepening and exploring of distressful emotions as well as a projecting forward to possible solutions for the future.

And the Key Word? This is the key to unlatch these unconscious processes. The therapist follows the patient step by step, as he explores, first, the cellar of his darker unconscious, and then as he constructs new possibilities on the upper floors where there is sunlight.

Footnotes

1. Parsympathetic “vulnerable” feelings and sympathetic “aggressive and asseertive” feelings are discussed in Liss, J., “The Autonomic Nervous System and the Emotions,” in Free to Feel, London, Wildwood House Pub., 1974.

2. R.D. Laing points out that we can see one another’s behavior, but not one another’s inner experience, which remains invisible and private to everyone except to the person who owns the experience. That means our statements about one another’s inner life — like interpretations — must always be couched as hypotheses. To declare with certainty the nature of the other’s inner life — his emotions, his thoughts, his intentions — is to transgress this essential difference between persons and therefore becomes a sign of invasion and disrespect. See Laing R.D., The Politics of Experience,, London, Penguin Books, 1969, Chapter I, “Persons and Experience,” (esp. pp. 18-20).

3. The special task of trying to intuit with competence which is the patient’s Key Word may be given as an exercise in a Training Group, and if a certain disagreement crops up among student therapists regarding which word or series of words represents the Key Word or phrase, then the question can be posed to the student therapist who is role-playing the client. The final judge, in any situation, as to what constitutes the Key Word, is the person who uttered the phrase.

3A. Laing, R.D., Phillipson, H. and Lee, A.R., Interpersonal Perception, London, Tavistock Pubs., 1966.

4. This article proposes that there are three fundamental theories in psychoanalysis: Self Theory is developed by Fairbairn, Mahler, Jacobsen and Kohut. Impulse Theory is developed by Freud and Melanie Klein. Object Relations Theory is developed by Fairbairn, Gunthrip and Winnicott. These three theories are chosen as the basis for psychological work because they correspond, taken as a whole, to the grammatical form “Subject, Verb and Object,” which represents the basis of linguistic structure in Occidental languages. See Liss, Jerome, “The Self, The Impulse and The Other,” in Energy and Character, (Editor: David Boadella), Sept., 1992 and April, 1993.

4A. When the client refuses this approach — and to my mind this is not resistence, but just another expectation regarding therapy — then we can turn to other possibilities.

5. The concept of body empathy was first suggested and developed by Dr. Maurizio Stupiggia in Chapter 2, “Empathy,” of La Terapia Biosistemica, (edited by Jerome Liss and Maurizio Stupiggia, Milan, Ed. Franco Angeli, 1995).
5a. See the article, “From Problem to Solution: Guiding Emotional Work With Deepening Followed by Construction.” (Jerome Liss, unpublished, 1998)

6. For more details about the transition “from Problem to Release to Solution,” see the above article.

7. To understand the terms “endodermal” and “mesodermal,” which correspond to “parasympathetic” and “sympathetic,” see Lifestreams, by David Boadella, (London, Routledge and Kegan Paul, 1987) and also the article by Jerome Liss, “Muscles and Guts: The Boadella-Liss Model as a Scientific Progect,” in Energy and Character, Vol. 28, No. 1, April, 1997.

8. The fact that some therapists finish their work with these general orientations, “I want to take more breath space...”, rather than come down to brass tacks, creates an important limit, I believe, for the client’s growth. The therapeutic work of defining “what? when? and with whom?” in concrete terms is essential for the patient’s evolution at some stages of the work.

9. This particular therapeutic phase is called “Concrete Solution Work” and, although not discussed often in “depth psychology” treatises, is a powerful lever for making real life changes and, when there is self-sabotage, for provoking new “depth work” in subsequent sessions. See the article, “From Negative to Positive,” (already cited) for a more complete elaboration.

10. See Rossi, Ernest, The Psychology of Mind-Body Healing, (New York, W.W. Norton Pubs.) on physical-dependent memory and mental associations, which he calls “state-dependent memory.”

11. Key Words are also slected according to their muscular-sympathetic or visceral-parasympathetic significance. For example, “I know what I want to do!” (said with a tonic movement of the arms and shoulders) is a “muscular-sympathetic” Key phrase. In contrast, “Now I have this warm and soft bubbly feeling,” (said with a soft voice and round movements of one hand on the abdomen) shows that the person’s state is “visceral-parasympathetic.” See the article, “Muscles and Guts” (cited earlier) for a full case illustration. Also, see the

video film, “Father I Want to See You!,” for a blow-by-blow demonstration of visceral-muscular interactions between patient and therapist. (video film for professionals only)

12. See Liss, Jerome, “The Autonomic Nervous System and Our Emotions” in Free to Feel, already cited.

13. Liss, Jerome, “Vertical Grounding, Horizontal Grounding and the Sympathetic-Parasympathetic Rebound,” Energy and Character, Vol. 20, No. 1, April, 1989, pp. 21-44.

14. Pinker, Steven, The Language Instinct, The New Science of Language and Mind, London, Penguin Books, 1994, esp. pp. 307-314.

15. See the classic article by Paul MacLean: “Psychosomatic Disease and the Visceral Brain, Recent Developments Bearing on the Papez Theory of Emotions,” Psychosomatic Medicine, 1948, Vol. 11, pp. 338-353.

16. For an exposition of how stress disrupts cortical association functions, and how the resumption of cortical association area interaction can help return the person to a state of equilibrium, see the interesting research based on EEG studies by Quarti, C. and Renaud, J., Neurophysiologie de la Douleur, Paris, Hermann, 1972.

17. Visceral inputs reach the limbic system by a tortuous route: Starting with the vagus nerve, the visceral sensory input enters the brain at the level of the Solitary Nucleus, then climbs up the pons through a series of short fibers to reach the trigeminal region and central gray matter, and from there the message is relayed further upward to the limbic system. This once again indicates “indirect connections” that need to be reinforced, such as by Key Word repetition and intensification, in order to integrate visceral emotional input with emotional experience. See Nauta, Walle, “The Central Visceromotor System: A General Survey,” (pp. 21-39) in Hockman, Charles H. (Editor), Limbic system Mechanisms and Autonomic Functions, Springfield, Ill., Charles C. Thomas Pub., 1972.

18. For examples of “experiential maps” that are used to guide the psychotherapeutic process:
a. Liss, Jerome, Free to Feel, (cited previously), “Excitement, Flexibility, Clarity and Complexity,” (pp. 102-103) for a map of consciousness based on these criteria.

b. Bandler, Richard and Grinder, John, Frogs Into Princes, Neurolinguistic Programing, Moab, Utah, Real People Press, 1979, for the model of body, word-thought and image dimensions of consciousness.
c. Gendlen, Eugene, Focusing, New York, Everest House, 1978. for a map that emphasizes the interaction between body sensation, word and image.
d. Downing, George, Il Corpo e La Parola, (The Body and the Word), Roma, Astrolabio Pubs., 1996, (also in German and Swedish editions), for a presentation of word, image and body domains of consciousness, with the body domain containing position, gesture, sensation and movement.

19. Although the language here is not particularly charged with material from the patient's history, and in this way represents "light planting," the fact that it deals with the here-and-now relationship between patient and therapist, i.e., the so-called "transference," can justify it being re-categorized as a "Deep Planting."

20. How can the patient sense that the therapist is not interested in imposing his personal ideas but only in stimulating the patient's own intuitions? Here are two signs: First, when the therapist's tone of voice, while offering new ideas, is not one of certainty, but rather, one of "offering hypotheses" that the patient must evaluate himself. Second, when the patient says "no" to the therapist's intutition, then gives the correct alternative, and the therapist shows immediate acceptance and appreciation for this correction.

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Applying Hakomi Principles and Techniques to Mainstream Psychodynamic, Behavioral and Systemic Couples Psychotherapy

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Introduction

Hakomi Therapy has been influenced by many therapeutic approaches. Adding mindfulness and a body-centered focus to the more traditional approaches, Hakomi Body Centered Psychotherapy (originated by Ron Kurtz) has attempted to "humanize" what had become a pathologizing and disengaged practice of psychotherapy. However, there are current theoretical orientations from the psychotherapeutic mainstream that can be integrated into Hakomi knowledge and practice which can actually increase the depth and wisdom of assessment as well as the effectiveness of interventions. This is particularly true in couples and family therapy where the therapist must be more influential with the system rather than solely with the individual. At the same time, we believe these other therapies have much to benefit from the Hakomi Method in applying their theories to actual therapeutic interactions. As therapists, we greatly

appreciate Hakomi in its ability to enliven and deepen therapy by working with present experience.

In this article we will: 1) describe in English (as opposed to "psychologese") important concepts from a number of traditional psychotherapeutic approaches, such as: Psychoanalytic, Bowenian, Structural, Strategic, Behavioral, Cognitive Behavioral and Narrative therapy, 2) provide vignettes of what these concepts look like in an actual session, and 3) demonstrate how they can be used experientially by Hakomi therapists who are working with couples. Our descriptions of each theory do not attempt to be comprehensive. They are intended only as an encouragement to the therapist to explore the effectiveness of taking traditional theory into present experience.

Psychoanalytic Theory

Some important concepts from the object relations school of psychoanalytic theory that are particularly useful in couples therapy include: object representations, transference, projective identification, projection, defenses, splitting, repetition compulsion, and counter-transference.

Object Representations: An object representation is an emotionally laden internal image of another person that functions as a map from which the individual predicts and expects what will happen interpersonally. People organize their character around these images. For example, if you had an absent father, you will tend to see intimate partners in this light, and organize characterologically around this expectation, for instance, by defending yourself with anger or exaggerated self reliance.

Character strategies develop as a result of the way in which the individual organizes him or herself in relation to their early experiences. For example, if you were abused or threatened whenever you were loud, you would eventually develop an internal map of human relations that predicts the worst if you speak up. You would start to contain your energy, your voice and your power in order to be safe. Eventually you would generalize this view of the world from your original family of five to the world of five billion. The strategy of containment would then become automatic, somatic and unconscious. The strategy is founded on the image of another as unsafe and intolerant of power or expansiveness.

In couples therapy the therapist attends to the images each partner holds of the other and how each person organizes around the image. In one

couple I (RF) see, Helen sees Jack as rejecting and unavailable. She feels hurt and then flies into a rage which alienates him further. From my position as a therapist it appeared that Jack really was interested in her, but struggled with his own issues of autonomy and independence causing him to distance from her. I asked her to allow the feeling of being rejected to be present in her body and notice what else came up. She had a memory or not fitting in with the girls in the neighborhood which led to her core belief: "Why would anyone be interested in me" that got triggered every time Jack distanced from her. Rather than discussing her belief in a mental fashion I asked her to listen to it as it occurred inside. I set up an experiment in which her husband opposed the belief, not to try to convince her out of it, but so that she could explore it more deeply. I asked him to say "I'm happy to see you" so that she could notice how she processed it. She learned that she was in the grips of this belief and actively prevented it from changing by rejecting any information to the contrary.

Each character strategy is formed by internalizing particular images of the self and others in relationship. For instance, in the contained or schizoid strategy, the image of the self is fragile in relationship to an un-welcoming other. In the conserving or oral strategy, the self is seen as weak in relationship with a depriving other.

In couples therapy we are interested in discovering how the two character strategies in a relationship interact, based on their core organizing beliefs, and in helping those interactions become more flexible and conscious to the couple. We set up opportunities in the session to explore in mindfulness and in the present how the character strategies and defensive systems interact.

Object relations theory focuses on internalized images while Hakomi character theory focuses on missing nourishment and core beliefs. Using object relations we can name the internal images, core beliefs and strategies. We can provide opportunities in session for couples to explore how they resist taking in these missing experiences.

Transference: Transference is the inclination that we all have to superimpose emotionally laden images from the past unto present people, in particular, those with whom we are most intimate. In individual psychoanalytic therapy, the transference towards the therapist is used experientially as a way of uncovering and exploring unconscious material.

In couple’s therapy, the focus of the transference is sideways, between the partners.

A client of mine, (RF) Maddy, was crying when suddenly she opened her eyes and found that Jon, her partner, was not looking at her. She interpreted this, according to her past relationships, as "he isn’t listening and doesn’t care". She felt about him the way she felt in her family which always discounted her feelings. This was a superimposition of an emotional relationship from the past unto the present as well as a major injury from her childhood which was being reenacted. As she became increasingly angry at him he withdrew further. It is important to remember that the present time characterological organization often helps sustain the old beliefs and feelings in the present. To counteract this I asked her to study the image of him turning away from her (since this is what was being enacted between them). She was immediately transported back to the feelings of her childhood. He was much more sympathetic once out from under her attack and reached out to her emotionally.

Projective Identification: Projective identification is the process in which you project the image of a person from your past onto a person in the present, and then, as if that weren’t enough, you try to get them to identify with it and act it out with you. Of course, it is your partner who does this and not you, however!

For instance, a client of mine (RF) tended to see her husband as unusually cruel, just like her step-father. Following the principle of riding the horse in the direction it is already going, I asked her to see him this way on purpose and study it internally. I asked him if he would be willing to take on this image (which he was doing anyway) and study how he related to it, or would prefer to see it only in other people. I had simply asked them to perform in mindfulness what they were already doing unconsciously. In this way he was able to own his own cruel side, and she was able to begin to explore the meaning of this image and to begin to disassociate it from the image of her stepfather. He became more sympathetic to the injuries she had incurred early in life and she began to see that her vision of her husband was colored by the ghosts of the past.

I (JH) often become suspicious that projective identification is taking place when I hear one partner say to the other something like "I bet you hate me" or "You just wanted to get away from me, didn’t you?"

Projection: Projection is the tendency to assign behaviors, feelings, cognitions and intentions to others which we don’t allow in ourselves. (Of

course this only applies to clients and not to therapists who never project!) If, for instance, you don't want to think of yourself as an angry person, you will tend to project the feeling of anger onto the screen of your partner and then accuse them of being angry.

This principle can be used in therapy by saying, "You are seeing her as angry right now and condemning her for it. Why don't you take a moment inside to notice what happens if I say to you, 'Its o.k. for you to be angry".

Projections are often maintained by the belief that the part of the individual that is projected is unacceptable. Therefore, challenging the belief in a way that pulls for integration of the disowned part will help undo the projection. By saying this to the client, they will either begin the integration or become conscious of the process of projection and the exportation of their anger.

Counter-transference: Counter-transference has two definitions: 1) The personal, unresolved material that comes up for the therapist in response to their client's characterological organization, feelings, beliefs and behavior, and 2) the natural response that anyone would have to a client with a particular characterological organization. If you are experiencing the first type, it is important to receive consultation or therapy on the issue. This is not a black mark against your professional skill, but an inevitable and ongoing process. In the second type, your response is diagnostic and can be use to great benefit. Often both types of counter-transference occur simultaneously.

For instance you may feel paternal or maternal when interacting with an dependent strategy, impatient with a masochistic one, overwhelmed with histrionics and exhausted in the presence of a manic rush into action. These internal, experiential responses provide you with a clue as to what strategies you are encountering.

In individual therapy counter-transference happens directly between you and the client. In couples therapy it is still happening between you and each client, but it is also happening between them. You can use your personal reactions to each partner as a possible indication as to what one partner is experiencing with the other. Your counter-transference points you in the direction of working with each person's character strategy as well as exploring how the two interact.

For instance, I (JH) work with a couple where the husband draws largely from a sensitive/analytic strategy and the wife draws largely from an expressive/clinging strategy. My counter-transference with her, which makes me want to quell her loud and frantic pleas, informs me that she feels ignored by his silence. My counter-transference with him, which makes me want to get him to stand up for himself, informs me that he feels frightened and overwhelmed by her impassioned expression. At that point I can create an exercise in which the couple slows down their interaction enough to "hear" one another rather than simply react to the other.

I, (RF) saw a couple in which she had been trying to get him to marry her for over a decade. He had been resisting her, and true to his character strategy also resisted me in the session. Towards the end of the session I started to feel frustrated at him. Having just taught the Enduring Strategy in the Responding to Life Training I was reminded that I was having the appropriate Countertransference to the strategy. At this point he said, "I just don't want to be owned". I sat on the edge of my seat, and with the intensity borne of understanding this strategy from the inside said, " I will fight for your right to not be owned in this or any other relationship." The next session he came in and said, "I don't know what happened in the last session, but I went home and asked he to marry me."

Defenses: Defenses are the ways in which individuals consciously or unconsciously protect themselves from any kind of damage or threat to the self, both real and perceived. Defenses can be witnessed not only in what the individual says but also in how he or she holds tensions in his or her body. Sam might say in a session that he doesn't care what happens in the relationship while he closes his shoulders in and around his chest. His words indicate that he can't be hurt by the outcome while his body indicates a need to protect his heart.

The way in which people defend themselves often proves to be a major factor in triggering their partner in attacking them. In the case mentioned above, Sam's tough exterior left his wife feeling left out, angry at him and more likely to attack him.

In working experientially, one can study defenses in mindfulness. The therapist may even take over the defense while the spouse offers nourishment. It is critical that the therapist not oppose the defense, or he will lose the client's cooperation.

For instance, Tom reported feeling "a wall or armor" around himself in relationship with Kitty. I (RF) asked him if it was keeping something in or out. He studied it in mindfulness (a state of self-observation) and said it protected others from his anger and protected his spirit, but also kept it it from soaring. I asked what his spirit had to say about that. It said "I want to be free". Then I asked what his wall wanted to say, and it said, "No way, its too dangerous for you." I then took over the defense (the voice of the wall), whispering to him "No way, its too dangerous for you." while Kitty cheerleaded for his spirit. He finally said "I don't want to fight with the wall anymore" and established, at least for the moment, a deeper and more vulnerable level of contact with her.

Splitting: Splitting is the tendency to see yourself, life and others in black or white terms. In other words, during a conflict a man may think of his wife as "the hysterical maniac" and forget the times when he loves her and thinks she is the most wise, compassionate and sexy saint around. When someone is splitting, they cannot keep both the positive and negative images in mind simultaneously. This is often present in couples' arguments where each partner regards the other as the demon from hell who was sent to personally torture them with their meanness and insanity. Splitting is not just the province of borderlines and narcissists. The more threatened one feels, the more likely one is to split.

In working with couples the therapist might contact this phenomenon by saying, "Right now you are seeing her as irrational and purposely trying to misunderstanding you. Can you remember a time when you felt like she was on your side? What happens inside as you switch back and forth between these images?" The purpose of this exercise is to begin to build an integrated image of the partner that includes the positive as well as the shadow, and, most importantly, to explore any disinclination to integrate them.

Repetition Compulsion: Freud postulated that people are compelled to reenact patterns of relationships and emotional wounding in an effort to master them. I (RF) would add to this that people organize themselves characterologically in ways to which others will respond predictably, and the response is often a repetition of the original wounding relationship. Paul Watzlowick, a strategic therapist, believes that the way in which people attempt to solve their problems often creates and maintains them.

For instance, Brad favored a masochistic strategy, in which he would resist Kathy whenever she would want to do something new. His characterological resistance tended to engender her pushing, which was

the very thing he was organized to avoid (an incursion into his sense of autonomy). I (RF) encouraged him to actively resist and study the internal feelings and memories surrounding this action, as well as the systemic effect it had on Kathy - thus, "riding the horse in the direction it was going". I also had him experiment to see what happened if he resisted a tiny bit less. In this way he would have a visceral experience of the phenomenon, rather than a concept such as "Its probably because my mother pushed me , so I hate it when my wife does." He would have an experience of how he evokes pressure from Kathy.

Bowen Theory

Two of Bowen's important contributions which we would like to include here are genograms and the concept of differentiation..

Differentiation: Differentiation is the ability to separate what is you from what is not you. It is your psychological immune system. It is the ability to notice and act on your own values, desires, impulses, thoughts, feelings and sensations while maintaining contact with others. It is the ability and willingness to declare oneself even if that means loss of contact. It is the ability to tolerate the anxiety of fully being oneself, being truly intimate, as well as the risk of aloneness that goes with this territory and is one of the most important skills an individual needs in a relationship. Differentiation is the willingness to fully embody one's uniqueness.

Jim would tend to hold back his anger in his relationship with Mary because Mary would escalate so quickly into anger herself. He would be reluctant to state his needs because they met with such intense negative responses. This pattern of relating can be tracked and then contacted in couples therapy: The therapist might say: "Jim, I notice you started to say something and then stopped yourself. Would it be O.K. if we take a look at how you do that". The therapist may then look for ways to take over Jim's tendency to give himself up in favor of Mary. This would assist him in becoming more in touch with his desire to differentiate.

Genograms: A genogram is a diagram of a family tree that records information about family members and their relationships over a number of generations. Made up of connecting lines and descriptive symbols, genograms provide the therapist with a quick gestalt of a family's history and how the two histories of a couple's family intersect. It allows the therapist to keep in mind certain interactional and intergenerational patterns as well events which may have recurring influence on the

individual, couple or family. It also helps the therapist detoxify, normalize and reframe current emotionally laden issues for the client(s).

Devi Records, a Hakomi senior trainer, believed that individuals carry an internalized experience of their family's history in their bodies and psyche, and that that experience can be accessed in mindfulness. Instead of, or along with, a regular genogram, she would ask her client(s) to create a genogram "from the right side of the brain". She would ask them to go into a state of mindfulness, imagine being with their family and then produce a picture of their family history using colors, images, movements, human sculptures, symbols, photos, collage, words, etc. that they feel would depict the emotional, relational and eventful quality of their lineage tracing beliefs, characterological organization and patterns across the generations. Again, this process allows the couple to get more of a somatic feel for the kinds of issues and unfolding legacies, both hidden and obvious, which their partners are trying to resolve.

I (JH) find genograms particularly helpful when working with issues such as affairs, addiction and emotional cutoff. Often, we can look back and see how these behaviors have been repeating themselves throughout the generations as the result of modeling, loyalty and characterological training. Clients experience some relief when they see that they are acting out behaviors that have become deeply entrained in the family psyche. Consequently, they often are more willing to move in a new direction.

Structural Therapy

Structural therapists believe that problems in families and couples are maintained by dysfunctional interactional structures. By structure we are referring to the way in which a family or couple organizes its boundaries, hierarchies and subsystems. With boundaries we are looking at how rigid or how loose are the interactional patterns between family members. In hierarchy we are looking at how the family determines what is important. In subsystems we are looking at the kinds of affiliations within the family context and how they affect family functioning.

For instance, in a relationship with overly permeable boundaries (too loose) we might find instances where one partner answers for the other and there is little sense of individuality or autonomy. One such couple came into my (RF) office and practically sat on each other with their arms and legs entwined. He said, "The reason we are here is that she is taking

antidepressant medication and that means I am a bad husband. This is called enmeshment.

Conversely, in a relationship with overly rigid boundaries (too tight) we might find a disengaged couple who avoids conflict and resultant closeness by avoiding contact and living parallel lives. The therapist's job is to help the couple tighten or loosen boundaries to a level that is more functional for them by having them experiment with new approaches to one another in mindfulness.

In one disengaged couple, I (JH) experimentally changed the structure of their interaction by having them turn towards each other, hold one another hands tightly while one or both discussed what was problematic for them. The angriest or most emotional person could hold their partners hands as tight as their emotions were being felt. The tight hand holding allowed them to express their anger without hurting the other. They found this helpful as it allowed them to stay connected while dealing with difficult issues. Changing the structure of their boundaries helped them assume a more functional way of relating to them.

What I've described above is a structural tool known as an enactment. Enactments are the reproduction in a session of behavioral sequences that occur in outside life. We recommend performing them in mindfulness so that something can be learned and options explored. Couples can enact negative behaviors as well as positive behaviors. This usually helps them make more informed choices about their interactions.

An opportunity for an enactment came up when a couple I (JH) was seeing was having difficulty around connecting. A focal point of the problem was when Tom came home from work. His wife, Shelly, reported that Tom would come into the house, give a brief greeting to her and go straight for the mail, newspaper and the t.v. "He never stops. I'm afraid he'll get sick, not to mention how I feel unimportant." I had them enact that moment in my office with Tom going outside and then re-entering while Shelly stood at the "sink" preparing dinner. At first I had them do it the way it usually happened with Tom coming in, greeting and moving on to the mail and t.v. After acknowledging that this was indeed how it would go at home, I had him go out of the office and come in again, this time stopping to acknowledge Shelly. Tom embellished this experiment by walking over to kiss her. As he approached Shelly, she found herself backing away, red-faced. Suddenly, another issue between them, and for

Shelly in particular, had now surfaced. This enactment allowed me to approach their "connection" problems more precisely.

I (RF) saw a couple in which the man's parents were interfering in the couples relationship to an extraordinary degree. The mother did not want to lose her son to this new woman. This is an example of an unclear demarcation between the parental and couple's subsystem. I had the couple draw a circle around them that excluded the parent and for the man to explore inside how this felt. He was subsequently able to refuse to answer questions his mother asked about his relationship and to ask her not to give him advice anymore that was adversarial to his relationship with his fiancee.

In Hakomi, we ask family members to study the structure of their relationship in mindfulness. They can shuttle back and forth from functional structures to dysfunctional structures to get a good bodily felt sense of both, identify any other experiences that went with each and then make their own choice about what felt best.

General Systems Theory

Circular self-reinforcing patterns: A concept that appears in much of systemic thought under different names is "mutually self-reinforcing interactive sensitivities". In other words, each partner comes to the relationship with sensitivities developed from experiences in their past. These sensitivities tend to become triggered by their partner's behavior which was in turn triggered, by the first person's sensitivity.

In the diagram on the following page, one partner has sustained injuries of abandonment and the other injuries of intrusion in early childhood. They each defend themselves from recreation of these injuries through use of characerterological strategies such as pursuit and distancing. Unfortunately, these strategies work systemically in such a way as to insure the reenactment of the injuries.

For instance, Ellen had a rageful father and cannot tolerate any kind of anger in her partner. Harry had a withdrawn mother and it is hard for him to tolerate Ellen's need for space. These are their sensitivities based on past injuries. They interact in such a way as to exacerbate each other. The angrier Harry becomes, the more withdrawn Ellen becomes thereby inviting more anger from him which invites more withdrawal from her. The pattern is circular with roots in each person's individual psychology.

In Hakomi, this can be studied through the use of couples sculptures in which the partners physicalize this interaction. They make a real life sculpture of their stances in relation to each other and then explore how these interact as well as the personal history encoded in the postures. They can also amplify or decrease their part in the interaction and study what happens to their partner as they do this. For instance, Harry could soften and see what gets elicited from Ellen and she could come forward more and see what gets elicited from Harry.

The Function of the Symptom: Peggy Papp saw symptoms as an attempt by the couple or family to maintain a certain regulation in their interactions. If the symptom is removed, then the interaction will become unregulated causing increased anxiety. In a systemic approach one recognizes that to solve one problem may create another problem in "the larger ecology". Many times parents have returned to therapy after a symptom in their child has disappeared and report that their marriage in now in jeopardy. In treating a symptom, the therapeutic question is "What will happen if this symptom is eliminated?" How will this couple function without it? Is it worth it to change? Will the price of change be too high?" The job of the therapist is not to solve the problem presented by the client(s) but to set up experiments through which the dilemma can be explored and the deeper meaning of its presence discovered.

One couple complained that there sex life lacked passion and intimacy. They both wanted more and blamed the other for the lack. Giving them the probe:"Its o.k. to be vulnerable" brought up for her the decision to never allow herself to be vulnerable again in the way she was with her humiliating, critical father, and brought up his fear of appearing weak. Becoming more vulnerable, even though it sounded attractive, was what they each resisted most. Curing the problem would put them face to face with their fears of intimacy and the vulnerability that goes with it.

As another example, one couple presented with an affair. As the crises was reduced and the underlying issues began to emerge, it became apparent to me (JH) that this couple had little experience and/or comfort with intimacy. Their awkwardness, defensive joking and subtle blaming and even the affair were all in service of keeping them from entering territory for which they had little skill or modeling. The (affair) symptom served the function of protecting them. The focus of the therapy, therefore, was to help the couple learn to tolerate intimacy by exploring expressions of support, listening, disclosing and other aspects of intimacy that had been so foreign to them in the past.

Narrative Therapy

One important concept in narrative therapy is "unique outcomes".

Unique Outcomes: A unique outcome is the exception to the rule. In couples' interactions, this means the time when they do not fall into the same self-reinforcing pattern that they habitually recreate. In narrative language, this is the time when they do not come under its influence, or they do not accept its invitation.

For example, generally Martha complains about Don who defends himself. This tends to escalate reciprocally with Martha feeling unheard, and Don feeling under attack. One time, however, stepping out of the pattern, Don said, "Oh, that must make you feel really bad." Martha was surprised at this break in the pattern, but felt relieved and heard for once, so she let it drop. This is a unique outcome, and the therapist should, according to this theory, pay great attention to exploring it..

A Hakomi approach to this style would be to ask the couple to create the unique outcome in front of you: "Lets say you go home and you have this same fight, except, this once it turns out well, what would each of you do differently to arrive at a more satisfactory conclusion. Why don't you act it out right now and lets explore how it feels to each of you."" This gives the couple an opportunity to experientially expand their repertoire and to explore any resistances that might come up to discourage them. Each person can direct the play as they see fit providing new roles for both of them and then acting them out in mindfulness.

In Narrative Therapy one attributes negative intentions to the pattern, not the individual. A therapist might say,"Tell me about a time when you did not come under the influence of the pursuer/distancer pattern and did not accept its invitation to pursue him (or distance from her)"

I (JH) tried another approach to access unique outcomes recently: I asked a burdened couple to teach each other their dance of joy. They were mired in lifelessness together mostly because they were embarrassed about showing their happiness to each other. I wanted to provide an opportunity for them to experience something other than their usual weightiness. Performing this exercise, helped them connect with each other in an uncharacteristic way that immediately bright more aliveness to their relationship and enabled to explore their predisposition to stuckness as well as a pathway to more aliveness.

A simple technique that provides an opportunity for a unique outcome is to ask an adversarial couple to look at each other experimentally through kind eyes and see what comes up. For the more shy couple, you can ask them to look into each others eyes and try to name the exact colors or color of the iris. Often, this leads the couple to taking a closer "look" at the other.

It is important in creating opportunities for unique outcomes that one is not doing violence to the current form of organization. It is best framed as an opportunity to try something different, like trying on a new coat to see if it fits, as well as a time to explore their reluctance to the new organization rather than a "better way of doing it".

Strategic Therapy

Problem Maintaining Solutions: Strategic therapy postulates that people maintain their problems by their methods for solving them. As Geneen Roth says, "For every diet there is an equal and opposite binge". The attempt at losing weight (the solution) actually maintains the problem (being overweight) by resetting the metabolism and leaving a person with so much deprivation that the body compensates by bingeing.

Taken in the context of couples interactions, Jill tends to feel lonely, and feeling lonely tries to solve the problem logically by reaching out to her husband Alan, who tends to feel suffocated and pulls back to solve his problem (Jill's pursuit). Jill's attempt to solve her loneliness fails, and actually exacerbates her problem, because it elicits withdrawal from her husband. In the same fashion, Alan's attempt to solve the problem of intrusion results in more intrusion on an ongoing basis.

In Hakomi, this perspective could be used by asking Jill to engage in her usual problem solving behavior (pursuit), and notice what happens to Alan when she does it. She can then also explore in mindfulness how she is organized around maintaining contact and the feelings and beliefs that arise when she is more alone. The therapist might ask Alan to move his head a bit to the side while Jill studies the effect internally. She could then also explore what would happen if she tries other approaches to Alan. Jill's reach can also be used as a probe for Alan who can study internally what happens when she reaches towards him, and how he organizes around intimacy.

Cognitive Behavioral Therapy

ABC Formula: One useful concept from the Cognitive/Behavioral world is the ABC Formula. This formula views couples interactions in the following manner: An action ("A) takes place which is interpreted ("B") along the lines of a person's core beliefs. Their interpretation then generates a reaction ("C") such as a feeling or a behavior. The interpretation is the critical factor in this formula. Reactions do not simply follow actions, but are oriented in certain directions by the interpretations, which are in turn based on core beliefs (a concept familiar to Hakomi).

When Sam comes home from work he is tired and does not say hello to his partner Roger ("A"- the action). Roger interprets ("B"- the interpretation) this as meaning that Sam is not interested in him and then acts accordingly, by closing down and pouting for the evening ("C"" - the reaction).

This can be used in Hakomi couple therapy in a number of ways. Looking for these interpretations provides the therapist with information about core beliefs. These can be explored with probes and taking over. The partner can offer the potentially nourishing experience that is the opposite of the core belief. In the example above, Roger has a core belief that people don't really care about him. Sam could say as a probe, "I care about you." As the resistances to this come up in Roger, the therapist can take them over. For instance, Roger may hear a voice inside saying, "Don't trust him." The therapist can then take this over while Sam continues to say, "I care about you." The therapist can also look for what happens once the interpretation is made. Does the interpreter get angry, withdraw, collapse, dig in, move into action, etc.? How are they organized around the interpretation? This organization can be studied in mindfulness.

Behavioral Theory

Some useful concepts in a behavioral approach to couples therapy are 1) the overuse of aversive conditioning, 2) communication training, and 3) care days.

Aversive Conditioning: Aversive conditioning is a method for shaping behavior through the use of unpleasant consequences for undesirable behavior.

A typical way in which this is commonly used with couples is as follows: When Dawn is not interested in Jack, he calls her "frigid". However, rather than decreasing the unwanted behavior (rejection of his sexual advances),

it tends to produce more of the same since Dawn does not like her sexuality criticized, and the reason she is not interested is not being discussed (his affair with Sylvia).

One of the problems in couples interactions, according to behaviorists is the overuse of aversive conditioning.

When a member of a couple uses aversive conditioning, instead of rebuking them for their bad form, a therapist might have them study in mindfulness what the effect is on the partner and where the aversive approach originates in the one who is using it. It may come, for instance, from a sense of frustration about the communication, or perhaps it can be an attempt to voice a need without being vulnerable, or an attempt to keep the level of intimacy at as low level.

I (JH) will often use the metaphor of the "relationship bank account " to illustrate the value of positive reinforcement in a relationship. Each member must remember to make regular deposits of affection, kindness, acknowledgement, favors etc. to tide them over during times of stress or solitude when they might not be able to be as generous.

Communication Training: Training people in communication methods has been popular for some time, although it is somewhat ineffective.We believe this is largely because intentions must be embodied to become automatic. Training includes teaching couples such techniques as making "I" statements, not using "always" and "never", speaking about one's feelings rather than the character flaws of the partner, referring to distinct, observable events as opposed to evaluations or judgments, reflective listening without interrupting, checking out assumptions with their partner, etc. Unfortunately when people are angry and don't feel understood, their first tendency is to violate all these rules.

Applying Hakomi to this, a therapist might suggest the couple try a communication first according to their impulses, and then according to the "rules" while tracking their internal responses as well as their partners' to each method. They can study what comes up internally that pushes them to violate the "rules"

Care Days: Care days is a behavioral homework assignment in which the partners in a couple write out lists of what would make them feel cared about. This is followed by an exchange of some of these caring behaviors.

In suggesting an assignment like this, it is helpful to have the clients track internally what in them objects and what supports providing these caring behaviors to their partner as well as what happens inside when they are the recipient of nourishment by their partner. Exchanging these behaviors tends to begin a self-reinforcing cycle of good will.

Conclusion

We have selected concepts from a number of important schools of couples psychotherapy to demonstrate how they can be used and integrated into couples psychotherapy using Hakomi principles. Many of these techniques also apply to individual therapy as well. Our contention is that these interventions and assessment procedures can be used experientially in mindfulness while providing helpful maps of the territory of couple's interactions. There are of course, many other such concepts as well as other important theoretical orientations. We hope that you will drink deeply from their wisdom and integrate them with the power of experience that is the hallmark of Hakomi.

"FAR BEYOND PSYCHOANALYSIS":
Freud's Repetition Compulsion

By Greg Johanson

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Editor's note: This is an article that attempts to build a bridge between the Hakomi Method and our roots in psychodynamic theory.

INTRODUCTION

Every brand of psychology and psychotherapy has a theory about human nature. What are people like? How do they get in trouble? How, if possible, can they move beyond their predicaments? Though it was never highlighted overmuch, Freud's conception of the repetition compulsion can be viewed as the Grandparent or paradigm version of many subsequent attempts to make sense out of human psychological bondage. It is dealt with here as one way of entering into dialogue with the broad Psychoanalytic tradition which Hakomi Therapy has benefited from and subsequently built upon.

The repetition compulsion also embodies fundamental assumptions for Freudianism itself. The significance of early childhood experiences is that the child learns certain patterns of reacting which it will be disposed to repeat over and over again in latter life. The significance of the unconscious is that repressed elements continue to affect a person's behavior in compulsive, repetitive ways that can be observed. The importance of knowing there are fundamental sexual and aggressive drives in the Id is that the expression and control of these drives are attached to habitual compulsions to repeat behaviors which can be observed by therapists, brought into awareness, and modified.

It is valuable to investigate and keep in the foreground what Freud had to say about the repetition compulsion. Like other psychoanalytic concepts, subsequent theorists have played fast and loose with the repetition compulsion in the years

following Freud, though it actually has been dealt with relatively little. Likewise, most secondary opinions about what Freud meant by the repetition compulsion are less satisfactory than his own treatment of the subject. Therefore, the main part of this paper, preceding the discussion section, will follow an historical, exegetical approach that stays as close to the primary text as possible, quoting Freud himself extensively.

An additional benefit of tracing the development of the repetition compulsion in Freud is that it serves as a foil for distinguishing Freud the clinician from Freud the philosopher. All therapy is value-based, a mix of experience and art with conscious or unconscious philosophical understandings from science, religion, and history (Johanson, 1985). It is good that we learn more about this interplay from those who have gone before us, and become as self-conscious of our own presuppositions as possible.

HISTORICAL EXPLORATION OF THE PRIMARY TEXTS

Without using the name, Freud recognized and described the repetition compulsion as early as the Studies on Hysteria with Breuer (SE: Vol II, 1893-95). In a footnote in the “Frau Emmy von N.” case (p. 105) Freud notes that Emmy’s hysterical pattern had been present for many years. Her “performance” had been compulsively repeated with many doctors besides Freud. 1) Her condition would become bad (though she still ran a household and a business). 2) Hypnotic treatment would lead to a remarkable recovery. 3) A quarrel with the doctor would suddenly erupt. 4) Treatment would be terminated. 5) The illness would be reinstated.

In a footnote (p. xxi) the editors note that the concepts of the pleasure principle and the compulsion to repeat, both in the service of the principle of constancy (which seeks to keep excitation low and/or even) represent a continuity in Freud from the Studies in Hysteria through Beyond the Pleasure Principle.

In his paper on “Jokes and the Unconscious” (SE: Vol VIII, 1905) Freud observed that young children like to repeat words when they are learning to talk. They discover that there is a relationship between pleasure and constancy.

In doing so they come across pleasurable effects, which arise from a repetition of what is similar, a rediscovery of what is familiar, similarity of sound, etc., and which are to be explained as unsuspected economies in psychical expenditure. (p. 128)

Freud suggests here that the organism strives for efficiency, the simplest, most economic way to accomplish something. Children also like stories repeated to

them precisely over and over again. Familiarity seems to be of high value to the developing organism.

It was in his paper “Remembering, Repeating and Working-Through” (SE: Vol XII, 1911-13) that Freud first used the terms of “compulsion to repeat” and “working-through.” Here the compulsion to repeat is associated with acting out in which the patient is unconscious of what is repressed.

He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating it.…For instance, the patient does not say that he remembers that he used to be defiant and critical towards his parent’s authority; instead he behaves in that way to the doctor. (p. 150)

This compulsion to repeat past experiences in the context of the relationship with the doctor is the essence of the transference which is always present early in treatment; is inescapable; is hopefully less intense and automatic at the end of treatment; and can be understood as the patient’s route to remembering.

The transference of the forgotten but present past to the doctor is just one instance of the patient’s habitual way of experiencing and relating to the total current situation.(p. 150) The greater the resistance of the patient to the treatment “the more extensively will acting out (repetition) replace remembering.” (p. 151)

Freud initially experimented with hypnosis to get around the resistances. By the time he writes this paper he is centering his efforts at working-through transference material. He notes that memories are unearthed easier under a mild, positive transference.
If the transference becomes hostile there is immediate repression and resistance, and the patient brings out an armory of past weapons to defend himself against the progress of the treatment. These, says Freud, the therapist must “wrest from him one by one.” The patient can’t be allowed to forever repeat instead of remember. What does the patient repeat in his or her acting out?

Everything that has already made its way from the sources of the repressed into his manifest personality—his inhibitions and unserviceable attitudes and his pathological character-traits. He repeats all his symptoms in the course of the treatment. (p. 151)

An important implication of this observation is that “we must treat his illness, not as an event of the past, but as a present day force.” (p. 151) Therapy is present centered for Freud, as many newer therapies strive to emphasize.

Since repressed material is stirred up and acted out in the present, Freud assumes that it is unavoidable that patients will deteriorate during treatment. He recommends that they understand their illness as an enemy. They can be consoled by pointing out that “one cannot overcome an enemy who is absent or not within range.” (p. 152) An ever present danger is that they will unconsciously choose a life circumstance which will confirm their deepest fears that their way of constantly and repetitively relating to life is true and necessary, and that therefore, there is no way out.

Though Freud does not think that total remembering is possible through his present techniques, he says the doctor must be prepared for perpetual struggle with patients to “keep in the psychical sphere all the impulses which the patient would like to direct to the motor sphere.”

If the transference is workable, then the most important repetitive actions can be prevented through utilizing “his intention to do so as material for therapeutic work.” (p. 153) The patient can also be protected through eliciting a promise that he not make any major life decisions while in treatment, though Freud does not mention any time period here. (Freud initially thought an analysis might take six months to three years. He was not considering here a fifteen year analysis.)

On the other hand it is important to allow the patient as much freedom as possible to make his own mistakes, because it is “through his own experience and mishaps that a person learns sense.” (p. 153) Reflecting on one’s experience can make the repetitive patterns clearer.

A major way the repetition compulsion is curbed for Freud is through the transference itself. “We render the compulsion harmless, and indeed useful, by giving it the right to assert itself in a definite field.” (p. 154) The transference within the analysis becomes a playground where there is freedom to experience and explore pathogenic instincts. Symptoms are given a transference meaning. The patient’s ordinary neurosis is converted into a “transference neurosis” which has the advantage of being an artificial-though-real experience which is immediately present and therefore “accessible to intervention” and cure. “The transference thus creates an intermediate region between illness and real life through which the transition from the one to the other is made.” (p. 154)

From the repetitive reactions which are exhibited in the transference we are led along the familiar paths to the awakening of the memories, which appear without difficulty, as it were, after the resistance has been overcome. (p. 154)

Of course, overcoming the resistance is no small matter. Working through resistance is an “arduous task for the subject of the analysis and a trial of

patience for the analyst." (p. 155) The patient never recognizes his own resistance. The doctor must uncover it and acquaint "him with it." Pointing out resistance doesn't change it and sometimes reinforces it. Analysts may easily feel like failures. Freud says this is often an illusion. He counsels analysts to be patient and give the patient time to work through it, to overcome it, by continuing, in defiance of it, the analytic work according to the fundamental rule of analysis …a course which cannot be avoided nor always hastened." (p. 155)

When the patient's repressed impulses are finally brought into consciousness, he will be convinced by the authority of his own experience.

In "Observations on Transference Love" (SE: Vol. XII, 1911-1913) Freud cautions against giving into and returning the love of a patient. If the analyst does so the patient "would have succeeded in acting out, in repeating in real life, what she ought only to have remembered." (p. 166) All transference love should be interpreted as a repetition of old patterns. The analyst who is "proof against every temptation" provides safety for the patient to bring forth the "preconditions for loving", to work through the infantile roots of loving and come out at a place of greater maturity and capacity for authentic love.

In his discussion of "A Case of Paranoia" (SE: Vol. XIV, 1914-1916) Freud describes certain trends within the patient anxious to preserve the symptoms which conflict with other parts striving to remove them. Jung, he says, would attribute this to psychical inertia which opposes change and progress. Freud's own hunch is that there is an early linkage between instincts, impressions, and the objects involved in those impressions, and therefore, Jung's psychical inertia is no different than a fixation. Later in his 1926 paper "Inhibitions, Symptoms, and Anxiety" he would attribute the phenomenon to the compulsion to repeat. In this discussion the flirtation is seen between clinical and philosophical concepts, with the balance still being tipped toward the clinical.

In his paper "The Sense of Symptoms" (SE: Vol. XVI, 1916-1917) Freud lays more groundwork for his eventual philosophical speculation. He notes that most symptoms are connected with a patient's past experience. There is normally some "past situation in which the idea was justified and the action served a purpose." (p. 270) This is true of individual symptoms. The connection is usually with early childhood experience, but some can come from later adult experience. (p. 263) But there is also a tendency to repeat not just individual but typical symptoms. These typical symptoms, which are common to great numbers of patients, tend "to resist any easy historical derivation." (p. 270)

It remains possible that the typical symptoms may go back to an experience which is itself typical—common to all human beings. (p. 271)

Here there is a foreshadowing of a discussion of the universal experience of death, and the death instinct Freud would eventually posit.

The relation of the repetition compulsion to the pleasure principle, instincts, and the sense of the demonic is broached in Freud's paper "The Uncanny." (SE: Vol. XVII, 1917-1919) Here he argues that the close connection in linguistic usage between das Heimliche (homely) and its opposite das Unheimliche (unhomely or uncanny) is because "the uncanny proceeds from (a repetition of) something familiar which has been repressed." (p. 247) In literature also, it is this "factor of the repetition of the same thing" (features, character traits, crimes, numbers, etc.: p. 236) that evokes the sense of the uncanny. In a summary statement Freud notes,

It is possible to recognize the dominance in the unconscious mind of a 'compulsion to repeat' proceeding from the instinctual impulses and probably inherent in the very nature of the instincts—a compulsion powerful enough to overrule the pleasure principle, lending to certain aspects of the mind their demonic character, and still very clearly expressed in the impulses of small children; a compulsion, too, which is responsible for a part of the course taken by the analysis of neurotic patients. All these considerations prepare us for the discovery that whatever reminds us of the inner 'compulsion to repeat' is perceived as uncanny. (p. 238)

In Beyond the Pleasure Principle Freud expands this summary statement from "The Uncanny" and no longer holds back from revealing the philosophical speculations his clinical work has been leading him to.

He begins by lining up evidence that the compulsion to repeat sometimes seems to operate over against the pleasure principle.

There are the "mysterious masochistic trends of the ego" (p. 8) which could lead one to posit a primary as opposed to secondary masochism.

There is a child who plays a game of "fort" (gone) and "da" (there) in which the distressing experience of his mother leaving is continually repeated. (p. 8ff)

In therapy patients repeat painful, past relationships with the analyst that could have never produced any pleasure. (p. 15) No lessons are learned from instinctually derived behaviors that continually lead to painful, unsatisfying results. (p. 15) This is even more remarkable in supposedly passive cases such as a woman marrying three husbands in a row who end up needing nursing on their death-beds. (p. 16)

There are also dreams which arise from traumatic incidences that one would like to be able to forget. (p. 17)

In general the compulsion to repeat cannot be assigned to the secondary resistance of the ego but must "be ascribed to the unconscious repressed." (p. 14) It has to do with the primitive necessity of binding energy as opposed to letting it run free. Though there can be a lot of debate over these phenomena and whether they are in fact not paradoxical expressions of attempts to find pleasure, enough is left unexplained to justify the hypothesis of a compulsion to repeat—something that seems more primitive, more elementary, more instinctual than the pleasure principle which it over-rides. (p. 17)

Before going further with the implications of this finding Freud prepares the reader by saying "What follows is speculation, often far-fetched speculation." (p. 18) His following discussion centers around the instinctual character of the compulsion to repeat which gives the "appearance of some 'demonic' force at work" when it operates in opposition to the pleasure principle.

But how is the predicate of being 'instinctual' related to the compulsion to repeat? At this point we cannot escape a suspicion that we may have come upon the track of a universal attribute of instincts and perhaps of organic life in general which has not hitherto been clearly recognized or at least not explicitly stressed. It seems, then, that an instinct is an urge inherent in organic life to restore an earlier state of things. (p. 30)

If it is assumed that instincts are "an expression of the conservative nature of living substances," (p. 30) then it follows that the phenomena of organic development must be attributed to external disturbing and diverting influences. The elementary living entity would from its beginning have had no wish to change; if conditions remained the same, it would do no more than constantly repeat the same course of life…Instincts are therefore, bound to give a deceptive appearance of being forces tending towards change and progress, whilst in fact they are merely seeking to reach an ancient goal by paths alike old and new. Moreover it is possible to specify this final goal of all organic striving….If we are to take it as a truth that knows no exception that everything living dies for internal reasons—becomes inorganic once again—then we shall be compelled to say that "the aim of all life is death" and, looking backwards, that "inanimate things existed before living ones." (p. 32)

At some primordial time then, life was "evoked in inanimate matter by the action of a force whose nature we can form no conception." "The tension which then arose in what had hitherto been an inanimate substance endeavored to cancel

itself out. In this way the first instinct came into being: the instinct to return to the inanimate state." (p. 32)

With the death instinct firmly established, Freud then moves to debate its possible relationships with sexual, life promoting instincts. For awhile he plays with the possibility of a dualistic theory of life which would contrast with Jung's monistic theory of libido. In this view sexual instincts are made the exception of the death instincts which seek to restore an earlier state of things. (p. 35)

For Freud, there is no necessity of assuming an instinct toward higher development or perfection. What is meant by higher is merely a matter of opinion anyway. "The efforts of Eros to combine organic substances into ever larger unities probably provide a substitute for this 'instinct toward perfection' whose existence we cannot admit." (p. 36-37) Life then develops out of the colossal collision of these two fundamental powers of Eros and Death.

Freud is still unsatisfied with the theory however, because the sexual instincts cannot be reconciled with the repetition compulsion which has been so fundamental to his overall thought. Schopenhauer has already suggested that life and death are fundamentally intertwined. But Freud thinks the best solution may be in following the poet-philosopher Plato in assuming that living substance at the time of its coming to life was torn apart into small particles, which have ever since endeavored to reunite through the sexual instincts. (p. 52)

In this view the sexual instincts are seen as compulsively trying to repeat or reunite with a state of primary oneness. This would tip the scales in favor of the death instinct as most fundamental. It also suggests a form of oneness mysticism that Freud is quick to deny.

Freud does not see himself as doing philosophy. He grants that philosophers can have correct intuitions that can later be confirmed by research. For Freud, the compulsion to repeat represents observable facts which make his speculation scientific. But at the end of the essay he says he has not yet totally convinced himself, though he thinks it is valid to think through a possible hypothesis out of scientific curiosity to see where it might lead. (p. 53)

In his "Remarks on the Theory and Practice of Dream Interpretation" (SE: Vol. XIX, 1923) Freud refers back to Beyond the Pleasure Principle and how he dealt with the matter of distressing, infantile experiences overcoming the repression of the pleasure principle to compulsively repeat some pattern. Here he notes that this reproduction can be grist for the mill of analysis if there is enough positive transference that an alliance can be formed against the pleasure principle in the

service of the reality principle. Here he is writing as Freud the clinician with no references to a death instinct.

However in his “An Autobiographical Study” (SE: Vol. XX, 1925-1926) he freely admits in the following summary paragraph that

In the works of my later years …I have given free rein to the inclination, which I kept down for so long, to speculation, and I have also contemplated a new solution to the problem of instincts. I have combined the instincts for self-preservation and for the preservation of the species under the concept of Eros and have contrasted with it an instinct of death or destruction which works in silence. Instinct in general is regarded as…an impulsion towards the restoration of a situation which once existed but was brought to an end by some external circumstance. This essentially conservative character of instincts is exemplified by the phenomena of the compulsion to repeat. The picture which life presents to us is the result of the concurrent and mutually opposing action of Eros and the death instinct. It remains to be seen whether this construction will turn out to be serviceable.…It goes far beyond psycho-analysis. (p. 57)

In his essay “Inhibitions Symptoms and Anxiety” (SE: Vol. XX, 1925-1926) Freud adds some clinical nuances that would later be important to object-relations theory (cf. Horner, 1979), but also produces some confusions of language.

He notes that once the ego represses some instinctual impulse because of a danger in reality, the impulse then becomes an outlaw, “excluded from the great organization of the ego and is subject only to the laws which govern the realm of the unconscious.”

This is demonstrated whenever the danger situation in reality is changed, so that theoretically the instinctual impulse no longer needs to be repressed. Even though the ego no longer has any need to fend it off, “the new impulse will run its course under an automatic influence—or, as I should prefer to say, under the compulsion to repeat. It will follow the same path as the earlier, repressed impulse, as though the danger situation that had been overcome still existed.” The repetition compulsion is formed by a deeper level of organization than is controlled by the conscious ego. (p. 153)

The ego is rarely able to “break down the barriers of repression which it has itself put up.” (p. 153) This is true “even after the ego has decided to relinquish its resistances.” (“Addenda” SE: Vol. XX, 1925-1926 p. 159) There still must be “the period of strenuous effort which follows after its praiseworthy decision, the phase of ‘working-through.’” Again, this is because of the “attraction exerted by the unconscious prototype” which forms the compulsion to repeat. Freud remarks,

“There is nothing to be said against describing this factor as the resistance of the unconscious.” (p. 160)

What is confusing, however, is that Freud has previously said that the unconscious does not offer resistance (Freud, 1961, p. 13). That is the function of the ego. So it is not clear whether the unconscious Id is more organized than previously thought or whether it is a now unconscious part of the ego that controls the compulsion.

But, in either case, the main point is clear. The repetition compulsion has to do with an unconscious level of organization that organizes perception and expression before they actually occur and is not subject to logical, rational input. In Piaget’s terms, the repetition compulsion assimilates data into what it already knows and reacts according to the old patterns as opposed to accommodating and expanding to include new data and allowing new behaviors.

The aim of psychotherapy also is clear. Therapy is an attempt to help the unconscious part of the ego (id?) update the files in such a way that it is given assistance which is able to put it in a position to lift its repressions, it recovers its power over the repressed id and can allow the instinctual impulses to run their course as though the old situations of danger no longer existed. (“Inhibitions, Symptoms, and Anxiety” p. 154)

It should be noted that the above is only true if the clinical interpretation sympathetic to object-relations theory is maintained.

If Freud is taken to mean that the repressed instincts of id are not merely organized according to previous experience but that they are acting according to their instinctual nature to return to previous modes of being, ultimately death, then therapy is untenable. The therapist would be in the position of either trying to get the person to act against their deepest biological nature and wishes, or of trying to facilitate the quickest possible route to the patient’s chosen mode of death in accordance with their wishes.

In “Civilization and Its Discontents” (SE: Vol. XXI, 1927-1931) Freud is back into a self-conscious philosophical mode. He says that the tentative proposals of Beyond the Pleasure Principle are now firm in his thinking. Contra the monistic thrust of Jung who would “make libido coincide with instinctual energy in general,” (p. 118) Freud is convinced that life is better explained by the “concurrent or mutually opposing action of these two instincts,” Eros and Death (or Thanatos). (p. 119) Additionally, the two kinds of instincts seldom—perhaps never—appear in isolation from each other, but are allowed with each other in

varying and very different proportions and so become unrecognizable to our judgment. (p. 119)

In his chapter on “Anxiety and Instinctual Life” in New Introductory Lectures Freud once again invokes the repetition compulsion in support for the death instinct. Here he makes the case that the dynamics of being outwardly destructive toward others is a defense against the more primary “impulse to self-destruction.” (p. 94) In this essay he also adds support for the repetition compulsion from a wider field.

Thus, the whole of embryology is an example of the ‘compulsion to repeat’ . . . power of regenerating lost organs . . . instincts for recovery . . . the spawning migrations of fishes, the migratory flights of birds, and possibly all that we describe as manifestations of instincts in animals, take place under the order of the compulsion to repeat, which expresses the conservative nature of the instincts. (p. 94)

Freud wavers a little about how much primacy he gives to the conservative, death promoting aspects of his theory. He says “we are not asserting that death is the only aim of life.” “We recognize two basic instincts and give each of these its own aim.” (p. 95) However, he then goes on to list some unanswered questions and tasks that must be left to future research. One is how the two instincts mingle and serve each other’s purposes. Another is whether the conservative character may not belong to all instincts without exception, whether the erotic instincts as well may not be seeking to bring back an earlier state of things when they strive to bring about a synthesis of living things into greater unities. (pp. 95-96)

Here is another reflection of Freud’s drive to provide a primary, foundational, explanatory principle that would extend to all of life, a drive that was characteristic of the intellectual milieu of which he was a product (cf. Olsen and Koppe, 1988, Part I.).

In his chapter on “Femininity,” also in New Introductory Lectures, Freud writes of the possibility that though a woman may rebel against her mother for a good part of her life, that when she herself becomes a mother, she may then switch to identifying with her mother. Then, through the compulsion to repeat which is now viewed on a wider scale, she may proceed to reproduce the same unhappy marriage of her parents. Here Freud anticipates the work of Boszormenyi-Nagy (1973) on intergenerational loyalties.

In “Moses and Monotheism” (SE: Vol. XXIII, 1937-1939), the last of Freud’s essays to be considered in this historical overview, Freud goes into the repetition compulsion again, especially as it relates to character formation.

He argues that the effect of early, infantile traumas, normally inaccessible to memory, “are of two kinds, positive and negative.” Here is a hint of how Eros and Death might interact.

On what Freud terms the positive side there is a force moving the organism “to remember the forgotten experience or, better still, to make it real, to experience a repetition of it anew” in analogous relationships (p. 75) This is a fixation to the trauma that colors character formation and character traits, and becomes accessible material for therapeutic working-through.

On the negative side seen in defensive reactions, avoidances, inhibitions, and phobias under the sway of the pleasure principle, there are opposite aims “that nothing of the forgotten traumas shall be remembered and nothing repeated.” (p. 76) These aims likewise represent fixation to the early traumas and contribute powerfully to the stamping of character.

Paradoxically, Freud is suggesting here that the repetition compulsion under the sway of the instinct toward death gives the patient the greatest positive hope and means for growth. The negative avoidance of repeating past pains under the sway of the pleasure principle tends towards the repression of possible avenues of growth.

Freud notes again that both positive and negative phenomena are compulsively instinctual in quality and remain in the unconscious unaffected by changes in the external world observed by the ego.

They are, one might say a State within a State, an inaccessible party, with which co-operation is impossible, but which may succeed in overcoming what is known as the normal party and forcing it into its service. (p. 76)

DISCUSSION

Contemporary Impact: The historical exercise of tracing the thread of Freud’s concept of the repetition compulsion throughout his works has touched upon a number of fundamental points for the Freudian understanding of human beings, psychopathology, and psychotherapy.

Whether the repetition compulsion was ever studied or credited directly by subsequent theorists, the essence of its meaning can be said to have been

incorporated into all systems of therapy since Freud that claim in any way to be Neo-Freudian, to do depth psychotherapy, to transform people at the level of character.

The substantive shadow of Freud today is enormous. The following points drawn directly from this historical review are more or less standard, non-controversial assumptions, and starting places for contemporary depth psychotherapies.

1. People compulsively, habitually repeat certain patterns of behavior which are an objective, recognizable part of their characteristic way of being in the world.

2. These repetitions can be quite maladaptive to the person's life in the world when they do not correspond to a consensus view of how the external world is currently meeting him.

3. These repetitive patterns generally have roots in early childhood experiences, though subsequent experiences can also be a factor.

4. They are rooted in the unconscious. They organize perception and motor expressions before they consciously happen. They are often totally unaffected by objective changes in the external world open to the conscious awareness of the ego.

5. The power of repetition compulsions derive from fundamental, instinctual energies related to fear, sex, and aggression.

6. The initial form a repetition compulsion took made sense and served a purpose given the person's experience of danger at the time.

7. Some repetitive patterns come not so much out of individual idiosyncratic experience, but out of common human experiences.

8. The compulsion to repeat archaic modes of relating is transferred onto the therapist in the treatment situation as well as onto other important aspects of the current situation.

9. Therapy is always present-centered in that past experiences are affecting immediate behavior within the treatment setting.

10. Working through this experience of transference can be a vehicle for bringing into conscious awareness the pattern of the repetition, and the early memories it was based on.

11. Working through is most successfully done when there is a mild positive transference in which the patient feels safe and supported enough to form an alliance with the therapist in the service of the reality principle, which facilitates facing the pain the pleasure principle is trying to avoid.

12. Whenever the patient goes beyond a certain level of threat and fear, he or she will resist by defending against the progress of the therapy.

13. The more they resist, the more they will compulsively, automatically repeat or act out old patterns as opposed to remembering.

14. Clients are fundamentally ambivalent. There are strong desires which want to change existing next to normally stronger desires to keep the status quo.

15. The job of the therapist is to encourage introspective awareness of impulses to act out in such a way that encourages remembering of the archaic experiences on which the impulses were founded.

16. The therapist must avoid mutuality in the relationship, because the client will automatically try to live out old patterns with the therapist instead of remembering them.

17. A lot of the therapy happens outside the consulting room as the person experiments with new ways of being in the world.

18. Transformation has taken place when the person is able to recognize that a new situation has emerged in which their defensive repetitions are no longer necessary, and they are able to allow their impulses to flow in a new way, appropriate to the new situation.

19. Patients should be encouraged not to make major life decisions in the midst of major uncovering and reorienting aspects of the therapy.

Criticism: Clinical: It is not especially useful to criticize Freud in himself. He was a pioneer who went beyond the normal fields of his day and broke new ground. In so doing he eventually developed his own orthodoxy to which he perhaps became captive, but this seems inevitable for any mortal thinker. Most of the criticisms that can be directed at Freud come from hindsight and from the vantage point of research that he prompted but was not the beneficiary of.

However, it is helpful to criticize Freud for the sake of those who come after and especially for those who make Freud into an “ism”; those who would presume an orthodoxy with strict boundaries, and not continue developing Freud’s work

according to the best that was in his inquisitive, honest spirit, even when this means modifying or contradicting him.

Jones (1961) says one should be careful in differentiating the clinical and philosophical aspects of Freud's work. That is well taken. However, Freud himself put them in close proximity through his desire to speculate from a unified scientific base. The following criticisms may cross categories at places.

An array of criticisms can be made from the perspective of American, pragmatic psychotherapy, whose main concern is the healing of the patient at the level of technique as a therapist strives to work through repetition compulsions with clients.

Psychoanalysis itself has been driven to develop beyond a narrow Freudianism and has flourished into new areas and schools of thought documented in numerous works such as Wyss and Buirski. Some of the recent work in the psychoanalytic community which embodies particular affinities with Hakomi Therapy are Peterfreund, Stolorow, and Bromberg.

Freud gave up trying to get directly back to early memories of traumatic events. There are now improved techniques for doing so. The therapist sitting in silence, attempting to stir up transference reactions while generating summary interpretations from free associations is no longer our only or primary option.

The inner child work of Hakomi, the Internal Family Systems parts work of Richard Schwartz, and the Psycho-Motor Movement Therapy of Pesso-Boison are three powerful ways, among others, to access early memories through contemplative states of consciousness which move beyond free association.

Pat Ogden and her Hakomi Integrative Somatics team have been doing special work in the area of accessing early dissociated memories based on the literal, physiologically-based trauma of feeling one's life threatened.

Freud's practice of giving every symptom a transference meaning that can only be dealt with interpersonally is now seen as arbitrary, and can subvert the necessary spontaneity of the therapeutic process.

Likewise, therapists such as Gendlin, Kurtz, Pesso and others have realized that the use of silence should always be a therapeutic choice. Generally speaking, the transference is so powerful that the client will live it out whether the therapist is friendly or formal, more active or more passive, or whatever.

And, the transference manifested as their habitual, compulsive ways of relating to the world will also show up in the totality of the ways persons negotiate their lives. Their body structure or movement, their way of anticipating a job interview tomorrow, or dealing with the rejection of a proposal for a date earlier this morning, will present in live, present, experiential ways. They can all be used to lead back to early, characterologically significant memories, just as the person's manner of relating to the therapist can.

At some points in the therapy the relationship with the therapist will be urgent and primary and at other times, other aspects of the person's experience will take precedence.

Stolorow has written convincingly of how transference is simply a way of talking about how people creatively organize their experience, driven by the basic human need to make meaning of their lives. "People" for Stolorow includes therapists, who can never do enough self-analysis to consider themselves objective, which is why all therapeutic treatment must be viewed now in an intersubjective framework.

David Feinstein has written about a number of options here-and-now therapists can employ for relating to a person's transference. Posture, movement, gestures, feelings, breathing, sensations, hopes, dreams, relationships, and more can all be used as royal roads to the unconscious.

Being silent and promoting free associations were initiated by Freud for the valuable purpose of allowing a client's reality to emerge while not interfering with it. They can still serve that function when artfully done. In Hakomi we have learned that it is also possible for the therapist to call attention to certain words, memories, movements, changes in breathing, feelings, etc. and encourage the person to slow down and witness these realities in a mindful state of consciousness.

This contemplative approach to mindfulness of the mind broadly conceived (including sensations, feelings, memories, and more) can help persons get curious and discover more about themselves, which often leads them spontaneously back to deeper core material and memories.

Here the emphasis is put on empowering the person's capacity to witness his experience and learn from it by staying with it in a disciplined way, not allowing the mind to wander indiscriminately. It provides a concrete method for encouraging the process of discovery that Peterfreund terms the essence of psychoanalytic work, and takes the therapist out of the position of having to

argue the correctness of interpretations. People themselves discover and thereby claim their own modes of organization.

Of course it is a fine clinical art to skillfully enter into someone's train of associations in such a way that they are not derailed, or re-railed onto a track that they would not have spontaneously taken.

Contemporary work is also beginning to empower people through accessing and mobilizing what could be called a core self, heart self, ontological self, or higher self on behalf of their healing. As William Schmidt has documented in his historical review, Freud did not really have a theory of the self.

Psychoanalysis has only recently come to remedy this through Kohut's development of self psychology, and even there, the self is considered constituted by introjects from significant interpersonal relationships. Thus, a poor history of interpersonal relationships necessarily implies a defective self, and the necessity of introjecting a good one from a therapist through a long term process.

More recently, theorists such as Almass, Schwartz, Kurtz and others have demonstrated clinically that consciousness not only contains hurt, vulnerable, exiled inner children, managerial and attacking parts, all created in interaction with the external world; which together can be considered to comprise the ego.

There is also the capacity for a passive witness or observing ego that many have noted before, even if they did not know how to bring it into play.

Additionally, there is a center of awareness which can actively bring essential qualities of wisdom, compassion, and curiosity to bear on various aspects of ego-organization when they become activated. This is the Self with a large "S" although the total self would include all aspects of consciousness. Thus, clinical work has also propelled the field into considering aspects of transpersonal psychology as outlined by Cortright and others, a consideration Freud was not sympathetic to.

Throughout all therapeutic processes safety needs are primary as Freud suggests in his discussion of the necessity of positive transference. We have certainly confirmed this in Hakomi where it has become obvious that people cannot turn their awareness inward on their felt present experience if they have to keep one eye wearily out for what a therapist might be up to.

However, when fear, tensing and negativity appear, these can become the precise vehicles for furthering the therapeutic process if they are attended to mindfully. Although, in opposition to Freud, our experience in Hakomi is that the

process works best if the “resistance” is not approached as an enemy, but befriended and honored as a normal aspect of organic process, and a useful expression of the psychic economy.

Working with barriers is the essence of therapeutic work, which Freud would affirm. It is possible he would have applauded the clinical efficacy we have developed in Hakomi of Taoistically using “taking over” techniques which support resistances in a paradoxical way that allows them to be released.

The repetition compulsion which fed into therapists and clients becoming intertwined in rigid systems of predictable responses led Freud and others after him to write articles on interminable therapy which had difficulty getting beyond the systems in play.

Another contribution from Kurtz which addresses this phenomenon is the jumping out of the system or JOOTs technique. Whenever a therapist realizes that she and a client are locked into a system which is reinforcing rigid, characterological ways of relating, the system needs to be jumped out of by being consciously named. What is different here from Freud is that this naming needs to be done in such a way that it is not an interpretation in an ordinary state of consciousness.

The power and effect of JOOTS lies in the clinicians ability to manage a mindful state of consciousness in the client. Here their awareness is turned inward toward their felt present experience, and they witness the effect of the words which lead them into a deeper, open, non-linear exploration of the wisdom of their inner knowing where they will confirm or modify the hypothesis. The system caught in simply becomes grist for the mill of furthering therapeutic curiosity.

Throughout this kind of process, we have also found it is more clinically efficacious to assume a force toward health and growth, as opposed to death, though fears, aggressions, etc. can never be minimized or skipped over. The science of living organic systems, which heavily informed Kurtz’s development of Hakomi, clearly indicates that an organism is made up of parts which negentropically come together to make a greater whole. This is the Eros of Freud, which was only scientifically confirmed years after his death by Prigogine.

Along the same line, Gregory Bateson tells us that what makes a system organic is not just that it has parts, but that the parts communicate within the whole. When they are communicating the system is self-organizing, self-directing, and self-correcting. In Hakomi we have clinically confirmed Ken Wilber’s (1979) view of therapy as addressing splits within the organism; helping one part of the mind talk to another, the mind talk to the body, the whole self communicate with the environment, etc.

Much more could be said of the clinical implications of current philosophy of science, but the issue of improved technique since Freud is the subject of multiple books, and again, he should be held in gratitude as the fountainhead of massive research and developments that came after him.

Criticism: Philosophical: On the philosophical level, Freud's dualistic theory of life and death struggling together have interesting implications and a body of precedent in such thinkers as Schopenhauer, Nietzche, and Goethe. His more monistic theory of the all powerful death instinct is more controversial.

In any case, his efforts to support his speculation from clinical findings is problematic today. Even in his own day, anyone with less prestige than Freud from his pioneering psychological work would never have been given as serious a hearing.

Looking back from the comfortable distance of 1999, all the clinical data Freud brings forth to support an all pervasive death instinct seems forced. Everything has simpler, more economical explanations. The compulsion to repeat certain patterns does not demonstrate so much the conservative character of instincts as it does their habitual character.

Attributing instinctual character to the repetition compulsion in the first place does not seem helpful or necessary. Certainly, as Gregory Zilboorg notes in his introduction to Beyond the Pleasure Principle, "there is nothing instinctual about dying, even though the end is inevitable." (p. xv)

In his own paper "Fixation—the Unconscious" (SE: Vol. XVI, 1916-1917) Freud gives a plausible reason himself why people would have traumatic dreams, memories, etc. "It is as though these patients had not finished with the traumatic situation, as though they were still faced by it as an immediate task which has not been dealt with." (p. 275)

This is the notion of "unfinished business" that Fritz Perls picked up from Freud. It emphasizes the importance of people organizing their world in such a way that it makes sense, as object relations theorist such as Horner argue.

People with masochistic dispositions surely push therapists to the limit through all the ways they have of subverting therapy. However, Lowen's research into the masochistic predicament has proven highly useful on a clinical level where he suggests that such clients are best responded to as dealing with a very painful conflict between closeness and freedom.

They feel they have to give up their freedom, who they are, what they like and don't like, as the price for having closeness and affection. If they choose the freedom of expressing who they are, they are convinced people will not tolerate it. They will end up free, but also painfully alone and shut out from significant relationships.

Of course, they have corresponding surpressed rage that emotional closeness must be bought at such a devastating, blackmailing price. They are not happy about it. But since they don't believe the relationship can tolerate their negativity, they can't risk expressing their unhappiness.

They are forced to find myriad ways to express the unhappiness and rage passive-aggressively without having to take responsibility for it or even be aware of it.

This includes frustrating the therapist, whom they also organize as one who only likes them when they behave, when they perform as a good client. The end result is frustrating the therapy itself, even though it is theoretically in their best interests not to. The destructiveness of such actions do not need a death instinct to explain them.

Nor do the demonic aspects of repetition compulsions which seem to work against the pleasure principle require such a death hypothesis. Kurtz notes that the shuttle box experiments with dogs of Solomon and Wynn (Journal of Experimental Psychology, 1952) give a viable explanation in terms of avoidance conditioning.

Dogs learn in one or two trials to jump to the other side of a shuttle box once a yellow warning light is flashed, followed by an electric shock through the floor. This is unremarkable.

What is relevant is that when the researchers turned off the shock and continued the trials to see how long it would take the dogs to learn that there was no longer any shock following the light, they had to close down the experiment after hundreds of trials.

The dogs never learned. Whenever the light went on, strong, internal, visceral, primitive, fight-flee-or get frozen brain alarms would signal to the dog that there was danger. The dog would be in demonstrable anxiety and fear until the jump was made to the other side. Then the dog would visibly relax with the dog-brain knowledge that it had saved itself once again. It never learned it was saving itself from nothing, from an illusion.

What is most insidious is that every escape by the dog was a full-body, cognitive and physiological reinforcement of its earliest, but now out of date way of organizing its experience and response.

While the jump from animal studies to humans is problematic in many ways, it takes little imagination to make the analogy to people with schizoid dispositions who constantly withdraw from supposedly friendly contact with others, or to people with oral dispositions who constantly seek out but doubt the reality of support they actually receive from others, and so forth through all the characterological dispositions. They can't experience a new situation as new.

Freud seems invested in denying any possible instinct toward higher levels of development and states the meaning of the word "higher" is completely relative.

Wilber (1980) makes a case that precise meanings of the word higher can be derived from a study of the developmental psychologies of both Western and Eastern traditions. As noted above, Ilya Prigogine won the Nobel Prize for demonstrating that there was indeed a force within organic systems that moves parts to combine into greater wholes. There is not only the entropy in the world that Freud was familiar with through Newtonian physics. There is also negentropy. Wilber (1995) assembles the consensus of the scientific world of today in twenty tenants which describe evolution toward higher degrees of complexity and consciousness.

It is hard to make a case that all movements toward increasing development in life are simply sneaky, subtle attempts to bring about death.

Certainly all the research on curiosity and exploratory behavior (Johanson, 1988) flatly contradict the notion that organisms attempt to keep stimulation down or constant.

Learning happens on the borderline of creation and chaos. If life is too chaotic and strange the organism retreats in search of security. If it is too constant and common, boredom sets in, and the organism seeks stimulation, even in preference to other choices for food or sex. Yankelovich and Barrett offer the following summary statement.

Does it seem at all plausible that the extraordinary process of organic evolution that developed the more complex and higher nervous systems took place merely to find a more elaborate means of escaping stimuli? If Freud had pursued the evolutionary point of view that he had borrowed from Darwin, Haeckel, and others, and explored in connection with the instincts, he would certainly have questioned this Nirvana-like view of the nervous system. Does it not seem that

the more complex and higher nervous system of man may even be involved in a restless search for stimuli? It is by means of this complex nervous system that man, unlike the other animals, breaks out of his biological habitat, creates new environments for himself, and now soars restlessly into space. It would seem that Pascal spoke more acutely of human nervousness, when he described man's condition as one of perpetual "inconstancy and restlessness." Human mobility and restlessness are blazoned on the pages of history, and it is hard to see how they could be the product of a nervous system whose essential function is to diminish stimuli, and if possible to eliminate them altogether. (p. 43)

Certainly, one does not need to lose Freud's insights into fundamental sexual and aggressive instinctual forces within a person, if his concept of the death instinct is not wholehearted embraced. It does seem less paradoxical to hold that humans are violent and kill because they have fundamental self-protective fears and aggressions instead of doing so out of a defense against a core self-aggression.

Contemporary Dialogue: Theoretically, the repetition compulsion raises a myriad of questions about the nature of consciousness, human development, therapy, and other issues that would provide grist for the mill of ongoing research and dialogue with Freud.

However, subsequent work in the field has mainly chosen other Freudian concepts to explore. There are at least two possible reasons for this. 1) The concept of the repetition compulsion is so basic and foundational that it can easily be assumed without question. 2) It has been so closely tied with Freud's more philosophical speculation about the death drive that researcher's would rather not be associated with it.

Jones notes that from the very beginning the death drive received a mixed reception within psychoanalytic circles. "A few, including Alexander, Eitingon, and Ferenczi, accepted them (the new theories) at once. So far as I know, the only analysts, e.g., Melanie Klein, Karl Menninger, and Hermann Nunberg, who still employ the term 'death instinct' do so in a purely clinical sense which is remote from Freud's original theory." (p. 407) Fuller also makes the case that there is a large social, historical, cultural factor that tends to make Europeans more pessimistic about the unconscious than their American counterparts.

In any case, such standard texts as Fromm-Reichmann, Saul, Wyss, Kohut, and Chessick do not even index or mention the compulsion to repeat. Other texts such as Olsen and Koppe, MacKinnon and Michels, Menninger, and Malan give it brief, passing mention as a clinical phenomenon only, without developing it in any way.

Ricoeur's treatment is the most insightful and stays closest to Freud's own development of it. Ricoeur also adds the insight that taking Freud seriously about the notion that what fights against death is not something internal to the organism, makes the desire for "the Other" fundamental for life. "It is always with another that the living substance fights against death." (p. 291) In terms of Freud's ambivalent bouncing back and forth between dualistic and monistic views of life, Ricoeur's final judgment is that for Freud "pleasure and death are both on the same side." (p. 319)

Laplanche is another French author who attempts to take Freud seriously on his own terms. He follows the repetition compulsion and Freud's arguments to the place of affirming "the death drive does not possess its own energy. Its energy is libido. Or, better put, the death drive is the very soul, the constitutive principle, of libidinal circulation," (p. 124) a riddle, he believes, Freud's successors are just beginning to decipher.

Most of the recent articles listed in psychoanalytic indexes as dealing with the repetition compulsion such as Anzieu, Kogan, Horowitz, and Shengold also simply mention it in passing as a clinical phenomenon without further attempts to develop it.

The articles of Anzieu and Horowitz actually tend to use the concept as a justification for why an analyst and patient get caught in acting out a compulsively repetitive system together and are not able to extricate themselves from it, so that lack of insight and interminable analysis result.

Kogan's article did expand on Freud's belief in the necessity of a mild, positive transference for working through destructive, repetitive patterns. She develops the notion of a holding environment in analysis in which "the analyst's representation as an emotionally adequate container, a 'second skin'" (p. 259) helps hold together the different aspects of the client's personality as they are progressing toward greater integration. This is consistent with the author's research (Johanson, 1991).

A search of the international index of PsycLIT, which corresponds to the printed Psychological Abstracts from 1974 to 1992, yielded three articles dealing specifically with the repetition compulsion.

Wallace argues that the roots of the repetition compulsion are mainly non-cognitive ones in Freud's own neurotic psychodynamics that he was not able to work through.

Shapiro works to deepen an understanding of how the compulsion to repeat develops through reference to separation-individuation processes.

Juda likewise takes the concept seriously and seeks to demystify its supposedly demonic aspects. He argues the repetition compulsion is a healthy feature of a cohesive self, a way of making sense of the world, and a good therapeutic ally for promoting change when it becomes maladaptive.

SUMMARY

In summary, Freud's compulsion to repeat is a rich concept that interfaces with other fundamental Freudian concepts, though it has received relatively little attention over the years.

It is good concept for any beginning therapist to trace as a way of getting at the basics of Freudian psychoanalysis.

The concept goes "far beyond psychoanalysis" in at least two ways. One, it has had widespread, if unsung, influence on all approaches to depth psychotherapy which follow Freud. Two, it led Freud into philosophical speculation about a death instinct which does not have a clear place in clinical practice, but which has evoked much interesting debate over the nature of human life.

In terms of Hakomi, I think it would be helpful to take the repetition compulsion far beyond psychoanalysis and make it a central talking point for communicating with not only psychoanalysts, but other therapists as well. Virtually every therapy from behavioral to psychoanalytic to humanistic to family systems recognizes the clinical phenomenon of compulsively repetitive patterns, and seeks to address them. It could be a productive point to share what we have all been learning in our various camps.

Also, the Hakomi community can be glad that Kurtz has put the method squarely in the midst of the best, cutting edge, contemporary sciences of complexity. One of our best features is that our methods and techniques flow with high congruence from our theory. Our clinical work and philosophy form a unified whole.

However, this was the same thing Freud was striving for. Looking over his material is a good lesson in humility. It cautions us to be ever-reflective of our work, noting places where clinical experience does not seem to confirm our theory, watching when it seems effortful to force data into a certain conceptual frame; always remaining open to new developments. In this arena, perhaps Ken Wilber (1982) has said it best: "We are not faced with several errors and one

truth, but with several partial truths, and how to fit them together is the supreme puzzle." (p. 61)

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LIGHTBODY CONSCIOUSNESS IN HAKOMI

by Wolfgang Ronnefeldt, MA

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Editor's Note: This is an experiential report on a topic which has been an area of dialogue and inquiry among Hakomi therapists for several years: essence.

The lightbody consciousness enables us to experience the unity principle, our sense of connection with ourselves and the world around us. It is associated most closely with the energy of the heart and the soul.

The soul's motivation is towards unity, towards the merging with "all that is." When the lightbody consciousness is present, then a physical sense of connection and relaxation will be present. Emotionally there is a sense of safety and acceptance of life as it exists, as well as a feeling of hopefulness. Mentally there is greater clarity and imagination; options in life become apparent. It is more a state of being-ness than of doing. The individual experiences the qualities of spaciousness, expansion, peace and compassion, and a neutral curiosity about life. The sense of tranquillity allows us to observe a situation as it is, rather than being pulled by emotions into limiting judgments and evaluations.

In contrast to the expansion of consciousness, mental rigidity is a state where core beliefs do not allow vision and flexibility. Strong emotions like fear create a sense of separation and limits (fight or flight syndrome). Frustration and anger can also severely close down the aperture of possible options.

The lightbody consciousness has some similarities with " the magical stranger." It is the aspect of ourselves that wants us to be in our full potential, and it encourages other aspects to arise for deeper integration.

The lightbody consciousness, like mindfulness, the "rapids", and the child consciousness, is its own separate state. Initially I noticed clients experiencing the lightbody consciousness at the end of a session, when the turmoil of the process was completed and the client moved into an expanded state of integration, where spaciousness, safety, compassion, and an awareness of possibilities are more apt to be present.

The lightbody consciousness is a very versatile state and lends itself to a multitude of purposes. The initial state of relaxation and expansion is very nurturing. Savoring and relaxing into this sense of expansion is of great benefit for the regeneration of all aspects of the being. People often feel a lightness; the heaviness of the body is replaced by a buoyancy. Very rarely do we actually feel that weightlessness that comes from the experience of energetic support by the planet. This sense of support means that we feel that we are not alone in our journey, and we are able to let go of some of our burdens, as if we are floating comfortably in warm salt water.

All physical objects have a fight body or aura; thus when we consciously merge our own lightbody with the lightbody of a rock, plant, animal, or landscape, magic can emerge. Being the landscape can be a step towards mystical union. I offer nature workshops in the lightbody consciousness. When people move into the expanded state with sense of wonder and love about a tree, for instance, amazing experiences may occur. People might tune into the plant spirit and bring forth great insights about healing aspects of trees or about our human relationships with the plant world. The options are limitless.

How to move into the lightbody consciousness

Anybody who is capable of practicing mindfulness and stilling the mind can move into this state, although people who have a lot of control issues and find it difficult to let go might need some extra help to shift consciousness. As I saw clients experiencing the expansion of consciousness at the integrative phase near the end of the session, I began to look for avenues to get more quickly into this state. I experimented with different visualizations, such as calming images of nature. I soon simplified the imagery to the color of golden light. Looking at the light of a burning candle, a light bulb, headlights, light striking a piece of yellow glass are all ways of stimulating the visualization.

All colors have their own qualities of feelings and vibrations (as do sounds).

Green tends to have aspects of calmness, growth, transformation and healing. Gold brings tranquillity, expansion, safety, softness and a gentle loving detachment. When a client is particularly confused and in a state of chaos, I encourage them to go into nature and study the different hues of green in a landscape. If someone has a narrow vision in an area of life (inside barriers) it is helpful to look at the blue in the sky to open up.

The re-focusing of the mind on a visualization with the color gold disconnects an individual from linear thoughts and concerns. It acts like an elevator, shifting us to another level of being. The lightbody consciousness emerges from the energy of

the heart, so we start by visualizing the chest and heart space in golden light. Then we extend the image of the light throughout the body, and finally six inches beyond. The light cocoon creates a feeling of safety, protection and detachment.

When I used the visualization by itself, without deep breathing, I noticed that people tended to move out of the state of expanded consciousness fairly easily, through mind chatter or through abrupt jerking on the part of the body, such as that which occurs in the state between waking and sleeping. It took a while to reestablish the sense of relaxation and spaciousness. I realized that in order to support the expansion, and integrate the physical with the spiritual experience, it is essential to encourage the client to breathe deeply. This conscious deep breathing requires a conscious relationship between spirit, mind and body. I experimented with different forms of breath, which proved mostly distracting to the process. Deep relaxed rhythmic breathing through the nose has proven to be most effective.

Once the shift in consciousness has occurred, it is important to deepen the process by establishing various landmarks, such as lightness, safety, spaciousness. Different landmarks present themselves for different people. They might experience a sense of warmth, a roundness as if a balloon of light supports them; they might see colors behind their eyes, especially gold and blue hues. There might be a feeling of pulsations and energy surges.

It is important to maintain communication with the client throughout the process, so we can track how it is unfolding. If the client shows any traces of criticism, fear, or judgment, then we know that the lightbody awareness is not present and we need to manage and deepen the state. The guide needs to emphasize safety, relaxation, and a sense of inner calmness, since a busy mind can easily erode the expansiveness. The more mindfulness is present, the deeper can be the exploration of this state of consciousness.

It is vital to stress all along that we are interested in blending the lightbody with the physical body. When people focus only on the lightbody itself, without bringing it into the physical arena, the temptation to disassociate becomes great, and it is much harder to integrate the experience into our daily lives. Taking the awareness outside of the body and the light cocoon, and looking down on the body lying below, deepens the process, particularly enabling detached and neutral observation. At this point some of the psychic senses can contribute to the unfolding process and greater insight can be reached. For example, someone may be able to get in touch with the causes of an illness and may be able to perceive the cure. Where there are unresolved issues with another person (parent, child, or partner for instance), introducing the image or memory

of that person into the light bubble will provide new perspectives on the relationship.

So we see that once the lightbody consciousness has been established, it is available as an expanded therapeutic workspace. Elements of compassion, neutrality and deeper understanding become a resource. In this state it is possible to investigate limiting core beliefs, and expand and update them.

Examples of working with the lightbody in therapy

I have worked in the local county jail offering a program in stress management. There were opportunities to move into the lightbody consciousness with inmates.

Relaxation expansion was emphasized as a tool to move away from the stresses of prison life. On occasion I would give an individual session. Here is an example: through a series of unfortunate coincidences and poor choices, “Peter” spent four weeks in the county jail. He was homeless, as was his wife with two children, and his girlfriend was pregnant. His whole life seemed hopeless and depressive. Fear and anger against himself and the world were diminishing his life spark and creativity. Using the lightbody consciousness, Peter was able to look at his life and dysfunctional relationships from an expanded perspective, from his core, with a deep sense of compassion and love. At this point a profound change occurred instantaneously. He realized how much love was available within him and for him, and for the people in his life. He realized how deeply connected he was to his larger family. The despair and hopelessness left. He was able to be more conscious and present for his life, and to make choices that would create more satisfying results for himself and the people around him.

Most people in jail are there on some drug-related issue. A major resource of drug addicts is their ability to move with facility into different states of consciousness, such as the lightbody awareness. The potential for drug rehabilitation by using this ability is yet to be explored.

Recently I have offered lightbody classes, working specifically with self-worth issues, the critical inner judge, guilt, and time anxieties — the challenges of our lives. It is useful to establish the source and motivation of these patterns; generally they are based more on socialization and its limiting effects. Moving into the lightbody consciousness presents an opportunity to unburden and expand with remarkably quick results. People with physical health problems can look with greater ease at the issues involved, such as the attachment and secondary benefits that an illness offers. Any issues in life where we feel a sense of limitation gain from the expansion: health, emotional stress, inner burdens, relationships, clarity about goals in life or the desire for greater creativity. First the

client is able to immediately recognize the thwarting effects of limiting beliefs and the decisions that arise out of that narrow perspective, and then the client is able to shift into a different perspective, which gives a new basis for action. There is less guesswork in finding solutions and cures. If nothing else, it creates greater spaciousness and relaxation, and a reprieve from fears and discomforts.

The lightbody consciousness is the awareness of unity, thus placing childhood hurts into the larger context of safety and connectedness. Because of the added neutrality and safety created by the golden light experience, the edge of trauma is not so close at hand. However, if the fear level of the client rises rapidly, the state is lost. The lightbody consciousness needs to be managed as carefully as all the other states.

Integration

It is important to help the client to integrate the larger picture into his or her life, and this is really the challenge of this work. Sometimes the lightbody consciousness can have a dreamlike quality and is easily forgotten or dismissed; therefore translating the experience into everyday awareness is essential. Within the lightbody, the client might realize the view from the top of the mountain of her life, which is quite different from the struggles of the valley floor, but the further she moves away from the vision and sense of unity, the more unreal that view may become. Drawing the experience in colors or shapes, writing and talking are all useful. Homework and practices that support the expanded realization are vital. In an individual session it is much easier to maintain a sense of integration because of the uninterrupted communication with the therapist.

The lightbody consciousness can be experienced by almost anyone. Mindfulness is an important key. It is easiest to work with the lightbody at the end of a Hakomi session, when the major emotions have been addressed and people are more relaxed. Starting at the beginning of the session, the client needs more guidance, and consciousness needs to be carefully managed. Including lightbody work in a processing group can rapidly increase the safety and depth of which the group is capable.

Because it involves the integration of the spirit with the body and mind, the options available to us through this work are vast. In a situation where the spiritual dimension includes the body and mind, we have a limitless container. It is as though we have been working in black and white, and now suddenly we are presented with a huge range of colors.