



Sensomotorische Körpertherapie
nach Dr. Pohl®

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Is everything psychosomatic ?

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Summary: *"Psychosomatic illness" is the most common medical diagnosis in modern-day Germany. Unfortunately, this is no more than an exclusive diagnosis, declaring simply that no medical explanation for the complaint could be determined. The patient affected often feels totally misunderstood, since the complaint from which he suffers is a reality and is experienced physically.*

The solution in such cases is a new way of considering physical and psychological processes. Contrary to perceived wisdom, in the case of psychosomatic illnesses there is also a physical diagnosis to be made. It is simply not to be found where it is sought by conventional medicine and psychology, but rather in the musculature and connective tissue directly under the skin. Sensory Motor Body Therapy according to Dr. Pohl® consistently approaches so-called "psychosomatic" complaints with physical treatment, resulting in the simultaneous disappearance of both condition-related anxieties and depression.

Prevalent psychosomatic theories

Recently it was said in a newspaper that “psychosomatic illness” was by now the most frequent medical diagnosis in Germany. “Nice”, says the enlightened contemporary, “Finally medicine is beginning to take into consideration what a large role psychic factors play in the development of physical illnesses.” “Not nice at all,” think the patients who receive this diagnosis. Each of them experiences his or her complaints as completely and really physical. For example, one person has back pains: he feels very precisely that his back hurts and not his soul! The next person writhes with abdominal pains and feels ridiculed if she is told that it all only psychic. Another is so dizzy that he can hardly stand upright. Is he only imagining all this? That cannot be; there must be a physical reason for the complaints.

That also is exactly how people react who have urinary retention or an exaggerated urge to urinate; who have a lump in their throat or heart pains, head-ache or sleeping disorder, etc, etc.. There must be a physical illness behind it and probably a very bad one, because otherwise they would never have such massive complaints. The current doctor has just not yet found the illness, so in desperation one turns to the next one. Thus begins – seen from outside – “doctor hopping” and – seen from inside – a spiral of fear, despair, rage and feeling misunderstood. It leads to an odyssey of doctors and clinics, which at some point ends at a healing practitioner’s office or in esoteric circles (with which, however, the complaints usually do not end).

The reaction to the diagnosis “psychosomatic” is so typical that in the ICD, the official diagnostic glossary, it was already named the diagnostic criterium of the “somatoform illnesses”; this has meanwhile become the official term for psychosomatic illnesses without somatic findings. There, we read: “Characteristic of somatoform disorders is the repeated description of physical symptoms in connection with stubborn demands for medical examinations despite repeated negative results and the assurance of the doctors that the symptoms cannot be explained physically.” Furthermore, it says: “...the patient usually resists attempts to discuss the possibility of a psychic cause; this can even hold true for obvious symptoms of depression and anxiety.”

Under the heading “somatic disorder” and “diagnostic guidelines” the second point is the criterion “stubborn refusal to accept the counsel or assurance of several physicians that no physical explanation can be found for the symptoms.”

The patient’s rejection of the diagnosis in this case becomes the diagnostic evidence. Such a conclusion can, however, also be considered perfidious and as a sign of medical arrogance, especially if the “diagnosis” is accompanied by statements such as: “There isn’t anything there.” “That cannot be painful.” “Now don’t carry on like that.” “Are you going through a midlife-crisis?” or if the patient is directly referred to a psychiatrist.

Let us look at how such a diagnosis comes about: One examines the patient with all the modern equipment and laboratory techniques of current medicine. If no finding is made which differs from the “normal” or “healthy”, one concludes razor-sharp that the complaints cannot have a physical cause. But because the patients insist that they are suffering from these or those complaints, one declares “the psyche” to be the cause, as nothing else is there. However, one has not examined “the psyche” and determined that something is wrong with it (because a healthy “psyche” does not cause physical disorders). Neither does one doubt that every physical process can be detected with current equipment and laboratory techniques. To be precise, the medical information would have to be: “I cannot find anything with my equipment”.

Thus, the diagnosis “psychosomatic illness” can usually be translated with “I just don’t know what is wrong with you” and demonstrates the helplessness of current medicine.

If the diagnosis “psychosomatic illness” is to be more than just an excuse or makeshift diagnosis, the psychic side would have to be considered. That is the domain of psychologists and especially of psychoanalysts. Here it is said that the affected person “somatisizes”, i.e. he has a psychic problem which he doesn’t see, doesn’t want to acknowledge, and which therefore manifests itself physically. There are various theoretic models regarding how somatisizing happens. First, the model of

“conversion” came from Freud. Here, the psychic energy is transformed into physical energy, and the unconscious conflict in the domain of sexuality is represented symbolically with the body. But how the jump from one system to another is supposed to take place – from the immaterial psyche to the material body – neither Freud’s model nor the following models explain. Neither “projection” nor “two-phased suppression” nor “alexithymie” can explain this jump.

Nonetheless, the psychoanalytic concept of “somatization” has become enormously popular, particularly the symbolic representation of psychic problems in the body, which has least held up to empirical verification.

One is of the opinion that one can draw conclusions from a certain illness (whether with or without classical medical findings) to a certain personality or a certain psychic problem. Every single thing is given significance.

Just as dream books, where one could look up the meaning of every dream content, used to be in fashion; nowadays one can read in books such as “Illness as symbol” by DAHLKE what significance a disease is supposed to have, what this illness wants to “tell” us, and what we should change in our psychic life.

Under the heading athlete’s foot e.g. we can read:

“The contact to mother/earth/woman/world is not clean. A forgotten conflict regarding one’s own steadfastness wants to return to consciousness and be resolved. Too weak to defend one’s skin (weak defenses); the own border defenses (skin) and weapons (claws) are occupied by foreign invasion troops which then sponge upon them...”

The instructions on what to do against athlete’s foot are included: “Action: Reduce defenses regarding one’s own points of view; become more willing to make compromises and cooperate and to take foreign impulses seriously; open one’s own unused, lifeless, devitalized domains for foreign life impulses; clear the question of one’s own parasitism: ‘Where do I talk my way through?’”

Especially in esoteric circles, it is typical of fanatical lay psychology to give every illness and unwellness a symbolic significance.

That of course is all nonsense, because biological processes do not conform to symbolizations. We people add the latter. For example, someone simply made up the above symbolizations; they do not correspond to the experience of the affected persons. Nobody nowadays considers his toe nails as weapon arsenals. The fact that athlete's foot is scientifically counted among the parasites has nothing at all to do with whether we experience it as such. It can not at all be concluded that persons are more prone to be affected who themselves – in a figurative sense – have a parasitic style of life. It doesn't make any difference to the athlete's foot whether they are aware of such a way of life or not. Also, the defense against athlete's foot does not improve thereby.

Analytical psychosomatics has long ago departed from such wild symbolizations and strives for connections which are closer to experience. One seeks to elicit them in individual cases together with the patient. But also the psychosomatic models of psychoanalysis almost completely neglect the pathophysiological aspects (excepting ALEXANDER, whose conflict-specific reaction of the sympathetic versus the parasympathetic system, however, could not be verified; and excepting Wilhelm REICH, who did observe muscle contractions in psychosomatic illnesses, but attributed these to an unprovable damming up of sexual energy. Moreover, since his expulsion from the Psychoanalytic Association in 1934, REICH has been ignored in psychoanalytical circles). Psychoanalysis is generally indifferent to the real body with its sensations and functions. If at all, it is interested in the image which that individual has of his body.

This, however, leads to a duplication of reality. If abdominal pains are supposed to be psychosomatic, where, I ask you, does the affected person have pain? In his soul? In the image he has of his body? In a psychic body that exists next to the actual body? In a body pattern in the brain? (hardly possible, because there are no pain receptors in the brain). Are they phantom pains? Is the affected person hallucinating? – This should not be the case, but where then is the pain, and how does the perception of pain come about?

This question can not be answered in the classic psychosomatic model, as it originates from false premises, namely the separation of body and soul, and the

assumption of (usually one-sidedly directed) cause and effect relation between the two, and that only in the case of a disorder. No one can answer the question, how the immaterial psyche can attack the material body and elicit distress in this body.

Learning theoretical models, e.g. “shaping”, also cannot explain how the pain gets into the belly and stays there, as pain is an unpleasant sensation which should automatically lead to avoidance behavior.

The assertion that the advantages of the role of the patient outweigh the negative experience of pain, and thereby maintain the pain seems extremely cynical considering the seriousness of the patient’s suffering.

With psychosomatic complaints there are also physical findings

If all the psychosomatic models do not help, and we can neither talk the patient out of his physical distress nor give him a reasonable explanation for it; nothing else remains but to give up the idea of a separation of “body” and “soul”, which is also reflected in the separation of medicine and psychology, and devote ourselves to the patient as a living organism. Only the patient can give valid information about what feels how in his body. He is the only specialist in this world for the sensations of his body.

Thus, we will ask him: “Please show me where you feel the complaints, and describe how it feels”. Then the patient will show a certain place on his belly (or head or back or wherever) and will give descriptions such as “Well, it is a very strong, stabbing pain that appears here like lightning.” Or: “It is like an iron ring around the rib cage here which hardly lets me breathe” – “It is a twinging pain which goes from the right shoulder to the head. When it gets really bad the ear also hurts.”-“With that dizziness everything turns in front of my eyes. It always happens when I turn my head.”-“It isn’t really a pain, but it aches very unpleasantly from the kidneys to the groin” etc., etc. We will hear somewhat different complaints from every patient. In contrast to what we are used to from medical diagnoses, there are evidently completely diverse abdominal, back or head pains or other complaints.

If we inquire further, we usually also hear about other complaints than those which led to the consultation, and this again differs from patient to patient. One has an imperative urinary urge; and at the same time or alternately he has pressure on his stomach, and points to the triangle in his upper abdomen between the costal arches, directly under the sternum. Perhaps he also grinds his teeth at night. The next patient has incredible menstruation complaints which tie her to her bed for several days. She points to the area where she thinks her ovaries are but where in reality the psoas muscles are located. Sometimes she also has a head ache which runs from the back of her neck to behind her eyes. Furthermore, she is often suddenly so tired that her eyes fall shut.

The combination of complaints differs from one patient to another, and cannot be linked as an overall diagnosis. A specialist will naturally not hear this, because one comes to him due to the bladder, or the stomach, due to the specific complaints in his field, and he wants to make a diagnosis related to his field. However, if we listen to the patient without bias, we hear individual complaints which are also individually linked with other complaints. One or the other is in the foreground. We are miles away from a typical diagnosis according to the pattern "rash, diarrhea, fever, this and that bacillus evident in the blood, together equals the illness X".

As an alternative to a diagnosis, I suggest taking everything the patient says very seriously and literally. If one has the patient show exactly the spot or spots where the complaints occur, and presses these spots experimentally, one will feel hardened places in the muscle and/or connective tissue. Furthermore, the patient will cry out in pain from the pressure reaches a certain intensity. "Yes," he says, "that is it exactly! It is as if you were sticking a knife in there". "That is exactly my menstruation pain." "Yes, exactly, my back hurts there" "My nausea comes precisely from there."

If we continue the examination, we can even see or hear the complaints from outside. One can see how the aching belly does not move along with the breathing; or, the belly moves with the breathing, but exactly the spot where the patient feels an iron ring around the rib cage does not move. Or we see that when the patient walks, the aching back does not move along but is held stiff. We can hear that the breathing

through the nose obviously can only be done noisily with much effort; or we can hear and see that it only occurs in the upper rib cage and much too rapidly. If one passes a hand over the body parts where these complaints are felt, one can often feel that they are colder than the rest of the body.

When the patient stands, one can see that he is inclined forward. It is evident that the abdominal and thoracic musculature are shortened, and one can test this by touching the musculature (it feels hard and is sensitive to pressure). Or one sees that the patient is standing with a swayed back and can feel that his erector spinae muscles are hard and also sensitive to pressure. This whole diagnosis can be done without apparatus and laboratory. It is a communication from one human organism's sensory organs to another.

As the result of such communication we can conclude that the pain or functional disorder evidently always originates with tense musculature and/or hardened subcutaneous connective tissue, however diverse the localization may be. Tense, hard tissue no longer moves or hardly moves any longer, as it always remains in the same condition of contraction. Movement, however, results from the rhythmic interchange of contraction and relaxation. If the concerned persons try to move the hard spots by stretching them, the pain becomes acutely aggravated, because they are now pulling on contracted tissue which does not yield, as would normally be the case. For example, if one bends the torso forward, the back muscles normally must yield and become longer. But if they are chronically contracted and do not give way, one cannot bend forward as far as previously possible and feels pain. If, vice versa, the abdominal musculature is contracted, one walks bent forward, and standing straight or even bending backward is impeded. Even if there are no acute complaints, that is visible and palpable.

The body perception is very precise regarding the localization of the disorder. If one lets the patient show the place on his body where his complaints occur, he will point very exactly to the area where hardened spots can be felt from outside. This can be single points, so-called myogeloses or trigger points, or a more or less extensive area. Even if the patient thinks he does not know it so exactly, he will point to the spot

very precisely, because pointing is controlled more by the sensory motor memory than by the frontal brain where verbal knowledge is located.

The perception of outside as inside

Only in one point is the otherwise so precise body perception deceptive: We often perceive outer occurrences which take place on the periphery as inner ones. With a head-ache we think, e.g., the skull will burst from inside. Another pain is perceived deep inside a joint, e.g. in a knee, elbow, or shoulder. But if one presses on the muscle insertions at the back of the head, on the knee, elbow or shoulder, the concerned person will say: yes, yes, that is the pain! Also the lump in the throat which is perceived as pressure or a foreign object at a certain spot inside the throat comes from hardened tissue in the connective tissue on the outside of the throat.

Also, when we think we feel an “inner” or “psychic” tension, we are actually perceiving tensions in muscles and connective tissue. Even with so-called stomach pain or pressure on the stomach, which is usually shown in the epigastrium, i.e. in the upper abdomen between the costal arches, one can find hard connective tissue and muscle at exactly this spot on the outside. (By the way, the stomach is not even located at this spot but further to the left; the affected person has merely learned to call it stomach pain. Also “kidney pain” often originates from contracted back musculature in the area of the kidneys. The same holds true for many bladder and heart complaints. Then, nothing remains but to ask the patient: „Please show me from the outside where it hurts inside.“ If one releases the outer tensions at all these spots, the complaints also disappear “inside”.

The biological sense of this deviation in body perception is not clear to me up to now. In any case, through this phenomenon we do not perceive ourselves as hollow, also not in places where organs which we cannot feel are located, like the brain or liver, as these organs possess no sensory cells. If nonetheless “liver pains” are described, the painful spots are naturally on the abdominal wall.

Much of our not always correct thinking regarding our organism may be due to the perception of outside as inside, especially the higher value give to the inside. If we

allow the soul a place at all in our body and do not consider it purely immaterial, then we localize it inside ourselves. It usually dwells in our chest where we perceive our feelings. We say, e.g.: “How it looks deep inside of me is nobody’s business.” Or: “we turn our innermost inside out”, when we disclose our most secret feelings to others. To attribute the soul to sensations of the skeletal musculature seems too profane or even blasphemous. It may be that the shift of body perception toward the inside has also led to the fixation of medicine (including psychosomatic medicine) on the internal organs.

Muscles and connective tissue, the sensory motor system, the neuromuscular system, is considered as *quantité négligeable* in applied medicine, although it accounts for the largest part of our body mass. There is no specialist doctor for it, because even the orthopedist is primarily concerned with the inner parts, namely the bones. The psychologist speaks abstractly of behavior which is determined by inner motivations without realizing that every behavior is an activity of our neuromuscular system. Whether we walk or crawl, write or look around, speak or eat, have a fit of rage or hold it back; whether we caress or hit someone, whether we sneeze or cough; whatever we do, we do it with our muscles. Even when we form an opinion of someone’s character, we can only do this based on behavior which this person has carried out with his neuromuscular system.

The most important and vital movement is without doubt that of breathing. If this movement stops we are dead within minutes, because all other functions of our organism depend on it. It is not executed from inside by the lungs but rather from outside by the skeletal musculature.

Psychosomatic processes in ill as well as healthy persons

If we ask the patients: “What have you observed; when and under what conditions to the complaints get better or worse?”, we hear statements like: “Well, when the weather changes it is very bad, especially when it gets humid-cold”; “During the day it’s bearable, but at night it gets so bad that I can’t sleep.”; “In the morning it is worst until I have moved a little and taken a warm shower.”; “After my divorce it got better

all at once”; “After stress at work I feel particularly poorly.” “Recently, I was to have a discussion with my boss the next day, and then it was especially bad.”; “When I have my little grandchild with me and caress him and play with him, I feel better.”; “Whenever I bend down and make exactly this movement, it is unbearable.”; “If I smell something very bad it gets worse.” etc..

As the result of our verbal communication we note that there are evidently very heterogeneous triggers which worsen or improve the condition of muscle contraction. Cold, immobility at night, atmospheric disturbances, sudden movement against the contracted musculature; the organism evidently reacts to all these with stronger contraction, whereas it lets up in affectionate body contact and playful movement.

But what about the condition “bad smell”? Isn’t that nonsense? What about the conditions “stress at work”; “expected discussion with the boss”; “after the divorce”? Isn’t that psychosomatic? Yes and no. No, according to the traditional understanding of psychosomatics, because the complaints do not at all only occur in the head or psyche of the affected person; rather, they are just as physical as those triggered by physical stimuli. Yes, if with the term psychosomatic one really means the organism as a whole.

Then, we can see that the organism contracts with all negative things that it experiences via the sensory organs or even only expects to experience; whereas it relaxes and expands with all positive experiences. That we perceive something at all as positive or negative is due to the perceived muscular contraction. The patients’ complaints thus get better or worse under exactly the same conditions under which all of us also normally can observe a greater relaxation or contraction of our own musculature. One becomes rigid with fright or fear; one trembles with rage; one sets oneself under performance pressure by contracting the muscles harder than necessary to accomplish a task and thereby prevents relaxation in the movement. Vice versa, the musculature loosens with joy, faith, love, hope, trust. That is how we think we are floating on pink clouds when we are in love. Vice versa, it is not possible to utter a declaration of love with contracted lip, jaw and voice musculature.

All positively experienced sensory impressions like warmth, light, melodious sounds, fragrance, good food, soft touch, harmonious movement are connected with relaxation and well-being, and this also holds true for the expectation of positive experiences. The latter probably serves to explain the placebo effect. In the reverse case, we arm ourselves with our musculature against all unpleasant things which we experience, i.e. perceive with our sensory organs: injury, strong pressure, pain, noise, cold, great heat, bright light, a gruesome sight, disgusting smells and tastes, and even already the expectation, the imagination of such sensory perceptions. A good example for the latter is the visit to the dentist: long before the painful injection stings, before the awful drilling noise can be heard, we sit totally tense in the dentist's chair and grip the armrests with our hands, sometimes so hard that our knuckles turn white. But also when we pass the door of the "nasty" neighbor we will note, if we observe ourselves closely, that we tense up in our whole body.

The imagination – this paler sister of sensory perception – activates the contraction patterns of the neuromuscular system and thus gives an emotional presentiment of that which is to come. The neurologist DAMASIO even thinks that we make (cognitive) decisions on the basis of such physical sensations. The decision "Shall I go to Aunt Ida or not" thus depends not only on the rational reasons I have for or against it ("haven't been there in a long time") but also on the sensations I have in my body when I imagine visiting her.

Our intentions for action also take place in the neuromuscular system, i.e. one needs only to want to lift an arm, before even lifting it at all, and already there is a small but measurable tension in the arm. Every action connected with "I would like" is automatically carried out with looser, more relaxed and more harmonious movements than actions combined with one's own attitude, though often taken over from outside, of "You must!" or "Exert yourself" or "Pull yourself together!"; in the latter we create a muscular resistance which is noticeable in the movements. One can imagine what physical consequences it has when, as usual under stress, one constantly thinks one has to do everything at once.

Contraction as retreat, armor for self-defense, connected with an unpleasant feeling; and relaxation as becoming wide, opening and devoting oneself, connected with a positive feeling; these processes do not only occur in humans, they are basic

mechanisms of life. One can observe them e.g. in domestic animals. Thus, a cat is soft and cuddly when it purrs and obviously feels comfortable; but it becomes hard and resistant when confronted with another dominant cat. A snail is soft and extended as long as it is crawling or eating. It becomes hard and contracted as soon as one pokes its antennae. Even in the world of plants it seems to be no different. A daisy contracts inwardly and closes up when the sky clouds over and wetness and cold come. It opens up again and stretches toward the light and warmth when the sun shines again. Even in single cell organisms like amoebae we can observe the same process. When the amoeba perceives the environmental stimuli as somehow unpleasant it contracts and retreats from the stimulus; whereas it extends itself when stimuli seem to be pleasant, and it moves toward them.

Each of these organisms evidently already has the rudiments of feelings, i.e. it has a sensory and a motor system which can tell it whether certain stimuli are advantageous to it or not, and what it therefore should do. The organism must feel something so as to be able to classify stimuli as pleasant or unpleasant. The more differentiated the organism, the more different its emotional reactions will also be. In cats and dogs e.g. one can perceive a whole variety of different emotional reactions. We perceive them as diverse tension and movement patterns in the body.

We do the same with our contemporaries and ourselves, and understand the expression of emotions directly. From the sound of a voice (which is generated by contractions of the thoracic and cervical musculature) whether a person is angry, depressed, or in a good mood. From the facial expressions, gestures, body posture, and movements, we can gauge a person's mood. We don't have to learn this; it is mostly congenital. Even if we don't know certain things explicitly, expressions like "someone jumps for sorrow" or "he hangs his head in joy" would seem absurd. We know exactly that this cannot be correct.

In ourselves we can also register different contraction patterns as feelings. Our body perception is generally far less trained and therefore conscious, differentiated and articulated than the perception through our other senses, particularly the eyes. More subtle sensations than pain or hunger easily escape our conscious perception, as we

can hardly name them, and it is often not clear to us that they are physical sensations. We disregard physical sensations much more than we overlook with our eyes. Thus, in daily life we use food or alcohol to reduce tension. But usually we realize it only after training our self-perception.

The psychosomatics of fear and depression

Science has told us for years that our feelings only take place in our brain. But if we ask someone: "Where do you feel it, when you are afraid?", everyone, in trying to imagine it, will point to the front of his torso. Often this will be close to the heart, sometimes also the belly, more seldom the neck, sometimes the whole front of the body. That is exactly where the main tensions are located, when a person tends toward anxiety attacks. Nobody feels fear in his lower back, in his knee or little finger; also not in his head, although he may say that anxious thoughts are racing through his head. But he does not feel the actual anxiety there. Thus, feelings are something that we feel in our body; it is not possible anywhere else. The brain certainly participates in the generation and recognition of feelings, but we cannot feel anything there, because the brain itself has no sensory cells. It communicates with the sensory cells which are distributed throughout the body. As for the perception of feelings, we also need the brain for visual perception; but without eyes we would be as blind as we would be lacking in feelings without sensory cells in the body.

In depression, also, the central feeling, namely that of being depressed, is shown on the front side of the body; usually the front of the upper rib cage is the center. That is why on old engravings depicting nightmares, the hobgoblin always sits on that spot. It never sits on the cheek or the leg.

All the same, one feels anxiety and depression in the whole body, because the entire flexion musculature is contracted. This is sometimes palpable and visible as far as the fingers and toes. The extension musculature, mainly in the back and neck, has to contract additionally in order to keep us upright in gravity. Moreover, anxiety and depression can lead to further distress and malfunctions, because of a change in breathing. Due to contraction of the front part of the body, in both disorders the

volume of respiration is restricted. In anxiety, respiration is too rapid and due to hyperventilation (with the simultaneous feeling of not getting enough air) vasomotor disorders occur: heart racing, knee trembling, dizziness, cold, damp and trembling hands, a blackout in the brain, etc. Everybody who has had an acute anxiety attack will confirm that anxiety is an eminently physical occurrence. Some persons do not even recognize the episode as anxiety; rather, they only experience an extremely threatening physical occurrence.

In depression the respiratory volume is also constricted. But in this case the breathing is too slow and shallow, altogether much too little. The muscles are thereby so undersupplied with oxygen that every movement, every enterprise becomes infinitely strenuous. All limbs are heavy as lead, so that getting out of bed already becomes a huge effort. Thinking is just as slow, difficult and uncreative as all movements.

It is immediately clear the anxiety and depressions occur relatively often in connection with “psychosomatic” illnesses, as both are based on tensions. In no case are the physical complaints only “symptom” of an “underlying” depression or “equivalents” of an anxiety attack.

Our front side, especially the front of the thorax, can be considered the center of our emotional life. Here is where we point to when we mean “I”. In this area we do not only feel anxiety, depression, lover’s grief, joylessness in contraction; but also joy, love, happiness and relief in relaxation. Hence expressions like “I feel light of heart” (when the tension there suddenly abates). On the whole, feelings or the soul are often set in this area. The Greek word “psyche” actually means “breath”. The Greeks assumed the diaphragm to be the location of the psyche. Later, the heart was considered the center of psychic and emotional life, probably because people have always felt that the heart beat changes according to emotional state (and naturally because outside is perceived as inside).

Only rage, disgust, contempt, performance pressure, standing at attention, holding one’s ground, forced self-assertion mainly lead to a contraction of the back

musculature. Always, however, we perceive emotions via our torso (and therefore respiratory) musculature and not via our extremities, although sometimes we could stamp our feet in rage. Therefore, if someone feels a pressure, pain or numbness e.g. in a knee or hand, they will not primarily feel affected psychically.

The immaterialization of the soul

As it is always our whole organism which acts and reacts (one can note this not only according to the muscular tension but at the same time according to many different physiological variables), it is nonsense to say that someone is “somatisizing”. This would be as if the feelings and the imagination of the “normal” or healthy person would not be manifested physically but only “psychically”. It would mean that they float along immaterially and that this would be desirable of “mature” behavior.

For a change of thinking in psychosomatics it is necessary to no longer see the “psyche” as entity; rather, it should be broken up into various functions of the organism, as, for instance, FELDENKRAIS has done. Every condition of a person, as long as he is alive, therefore has at least four aspects: perception, movement, feeling, and thinking. These do not cause one another; rather they are different sides of the same coin. For instance, if the organism is in a happy mood, the perception has a happy tint, as do movement, feeling, and thinking.

Feeling could be subsumed as a form of sensory perception, whereas perception is a sensory perception with cognition. Often, feeling, movement and condition are complimented by imagination. Imagination is a living picture which has developed in our sensory perception and which we can still change in our mind. Thus, we can imagine how something looks, sounds, feels, how something smells or tastes, and we react with our whole body accordingly. The organism prepares to encompass the pleasant stimulus (e.g. when we imagine a tasty meal, saliva gathers in our mouth; whereas when we imagine a good smell we widen our nostrils and breathe slowly and deeply. Vice versa, when we imagine an unpleasant sensory experience: The body armors and closes itself against taking in these stimuli (“I already feel nauseous just thinking about it!”).

Our largest and most varied sensory organ, but also the one we pay least conscious attention to, is not located in the eyes, ears or mouth; it is in the form of sensory cells in our muscles, bones, tendons, skin, and connective tissue. These are sensory cells which register differences in pressure, pull, and temperature, which in part occur through outside stimuli; for the other part, they are caused by movements of our sensory motor system which are accompanied by certain thoughts, phantasies, intentions, and perceptions through other sensory organs.

The sensory cells in our sensory motor system transmit the message “pleasant” or “unpleasant” or also “easy”, “strenuous”, difficult, etc.

It is evident that the sensory organs interact with one another. When we are frightened – whether by a sudden loud noise, a threatening sight, or a sudden injury – we always flinch with our whole body. We cannot say whether the fright is a physical or psychic occurrence, because we feel it in our entire organism. It is not the frightening event itself which is unpleasant, but the sudden contraction of musculature makes us feel unpleasant within ourselves.

As little as we perceive feelings in our brain, just as little do we feel all the hormones and transmitter substances which accompany our feelings. It is not the adrenaline itself which for example causes us to feel excited: rather, we sense the acceleration of our physical functions and the movements in our body.

If one considers movements as processes of oscillation, one can say: we feel uncomfortable when the amplitude of the movement is limited, when the muscles are contracted so much that they can only move in a limited way. On the other hand, we feel comfortable when our muscles are relaxed and we can move freely (particularly when we can breathe without constriction, even when we do not otherwise move). A further characteristic of movement is the frequency. In terms of experience, we perceive an increase in frequency as a stronger arousal. Depending on the combination of these two factors – amplitude and frequency – there are at least two kinds of well-being or distress: In a state of relaxation and weak arousal we feel inner peace, serenity, resting within ourselves up to a pleasurable fatigue. In a state of relaxation and strong arousal we feel joy, cheerfulness, energy and a desire for

action. On the other hand, in a state of tension and weak arousal we feel leaden fatigue, exhaustion, depression. Tension with strong arousal is perceived as fear, upset, nervousness, or as feeling as though we are going to burst. The sensory motor system of the head's sensory organs is synchronized with the sensory motor system of the body regarding amplitude, frequency, and rhythm. Therefore, when we are frightened, e.g., not only our eyes are rigid, but also the whole body; we hold our breath with fright and are speechless.

All these emotions are not merely the expression of our inner condition; this condition would not exist without the movement. Thus, stress does not cause muscular tension in our body, just as fear does not. Rather, we can only feel stress or fear when a certain tension pattern of our musculature is present. The tension can be so strong that we are no longer able to feel joy. Feeling and movement are two sides of the same life process: without movement there is no feeling, without feeling not movement. With all our sensory organs we can only perceive changes. These changes and differences result from movement. Even when seeing static objects, e.g., the eye is continually in movement, to scan the single points and contours. "Sentio – ergo sum", that is the answer of the evolutionary biologist HUMPHREY to DESCARTES "Cogito - ergo sum"; with "sentio" he means an active process, the unity of feeling and movement. The question, whether the chicken or the egg came first, is superfluous.

By nature, we evidently react especially to stimulus constellations or audible, visible or palpable movements which originate with representatives of our own species, i.e. other people. Therefore, we immediately feel better when someone gives us a smile. Involuntarily, we smile back; and this calls forth in us a relaxed sense of well-being. MALMO, a research pioneer of correlations between neuromuscular processes and mood, instructed the person conducting the experiment to praise the test person at the end of the experiment. As a result, the test person's muscles relaxed. Subsequently, the experiment conductor's muscle tone was measured and noted to have decreased. Naturally, we react conversely with a contraction of our musculature when someone yells at us, hit us, or shows us a face distorted by rage. After a certain amount of experience, these inter-human interactions also function already in

expectation or imagination, even though we are often not aware of these processes. We can also communicate well emotionally with animals, which act and react similarly to us. Thus, we not only understand anthropoid apes, but we also react psychosomatically to the growling or the joyful jumping of a dog, or the hissing, purring, or smooching of a cat. This explains why in the USA it has been very successful to prescribe keeping pets for people with hypertension and heart and circulatory disorders.

Subtle and purely psychic processes are in reality also psychosomatic, e.g. identification. From an identification figure, we take over not only opinions and standpoints but also mimicry, gestures, and posture. This usually happens involuntarily. For instance, if we see someone being injured, we flinch as though to instinctively protect ourselves against such an injury. We often unconsciously take over movement and emotional patterns. For instance, it is nearly impossible not to hurry on a Saturday in Germany in a pedestrian zone and not to have the corresponding feeling, as one can hardly avoid doing the same as the other people. On the contrary, in a Greek village it is easy to stroll along slowly and in a relaxed manner and to feel that way, too. Such a vacation is really restful!

The origin and effect of continual contractions

If in fact “body” and “soul” always are a unit and therefore do not cause each other, then what distinguishes a person who has distress from someone who can live in a carefree way?

The answer is very simple: the difference is in the duration and the variation of intensity. Feelings and physical sensations including pain are perceived tension patterns of musculature and connective tissue. They are generally ephemeral and temporary. They pertain to moments of danger or advantage, and pass by with these. They have the effect, e.g., that we do not blindly run headlong to our ruin; rather, we already sense before what could be dangerous for us. They make us immediately stop in our normal activity, interrupt the ongoing movement, and cause us to take up a new movement which is adapted to the changed circumstances. Thus, e.g., the

increase of breathing frequency and the contraction of flexor musculature in fear is the best prerequisite for fleeing or running away (that's why professional sprinters start from a crouching position). Whereas, in rage, the contraction of extensor muscles in the back and leg as well as arm and finger flexors is the best prerequisite for fighting, i.e. for yelling and hitting.

If the danger signals which cause us to turn rigid are very intense and/or do not cease, or the prepared movement (e.g. escape or attack) does not take place, we cannot help keeping the musculature continually contracted. Certain body parts become completely or partly rigid, and the movement ceases. As a consequence, the blood and lymph circulation in these body parts is not as thorough, and they are not as well nourished nor cleansed of metabolic waste products. This process of becoming rigid and hardening can affect the musculature as well as the connective tissue. A hardening of the connective tissue also leads to the immobility of the musculature lying beneath it.

Continual contractions often develop in the aftermath of injuries and operations (which the organism naturally also registers as massive injuries). They often become noticeable only months or years later, as the tissue becomes progressively harder and more impermeable. Among such injuries are not only open wounds (e.g., gunshot injuries in the war regularly caused subsequent continual contractions) but also bruises, fractures (where besides the bone, the soft parts are also always injured), whip-lash trauma, rape, and other abuse.

The second possibility for the development of continual contractions is through bad posture. As we have seen above, they can develop from emotional causes. If, e.g., we are continually in fearful expectation, we will ultimately always be inclined forward, keep our shoulders raised and our head pulled forward and into our shoulders. This can lead to neck pain, stomach and abdominal complaints, but also (via limited breathing) to weakness and depressive feelings. The same can be achieved by "stupid" habits. Currently most widespread is the stupid habit of setting the computer screen so low that one sits hunched in front of it all day. A further very widespread example is raising the shoulder as soon as one wants to do something with one's

hand. (playing tennis, writing, playing a music instrument, etc.) This first leads to shoulder pain and later often also to complaints in the arms and hands.

“Chest out – belly in” is by far the most stupid and unhealthy of all habits. The causes of such posture-induced complaints can also be perceived by simple observation of one’s self and others (they do not show up in X-rays or childhood anamnesis).

The third possibility for the development of continual contractions is through lack of exercise. Not only does our muscle mass diminish when we exercise less (fitness studios profit from this fact); the musculature also stiffens, which is much worse in terms of health. This is evident in limbs which have been in a cast for a lengthy period. Here, one very regularly finds stiff, hardened (albeit atrophied) muscles and hardened connective tissue. Due to the injury-induced bad posture, the continual contraction continues throughout the rest of the body (see above). Therefore, all kinds of braces, corsets, and “Schanz” collars are the worst thing one can do to oneself for the treatment of pain and movement limitations. But also the normal life of a couch-potato at some point will lead to stiffness, pain, poor general condition and bad mood, as well as all kinds of little complaints which can develop into massive problems.

Biochemical factors such as bacterial toxins, nutritional substances (the most well-known example is lack of magnesium), and hormones also influence the tension of musculature and connective tissue. If continual contractions already exist, the addition of these factors surpasses the pain threshold. This makes itself felt, e.g. in pains in the limbs during influenza, nocturnal cramps in the calf, or menstrual pains; the latter can be localized in various spots – depending on where the tension is.

The problem is that these – how so ever developed – continual contractions have a tendency towards overreaction and spreading. The continually contracted tissue reacts hypersensitively to all the afore-mentioned negatively felt sensory perceptions. We have already heard that the affected persons cry out as soon as the tactile pressure surpasses a certain proportion which they do not feel at all unpleasant in other spots of the body. I.e., the tissue is now hypersensitive to pressure as well as

other factors which we perceive as unpleasant: cold, noise, performance pressure, certain odors and slight variations of taste, aggressive sounds and movements, etc.

The hypersensitivity of the tissue can be understood as learning. Small negative stimuli are enough to provoke strong contractions and pain reactions in spots where negative experiences have taken place. That is why the affected spots hurt when one presses them, whereas one only feels pressure in tissue which has not had such negative experiences.

Depending on the location of the sensitive spot, one person will get abdominal pain during stress whereas another will react with a head-ache. Thus, if the back of the neck is already damaged by continual fearful expectation, by whiplash injury, or by a wrong working posture, and is in continual contraction, it will react all the more sensitively to a draft, a change of weather, anger, etc. It will hurt all the more severely and contract all the more strongly. This can be considered as a kind of body memory for negative experiences.

Because many medical doctors do not know about such processes, they lack the understanding in treating patients with such a history of previous damage. If a doctor, e.g., does a bladder examination of a patient who has pain from contraction of the lower abdominal and pelvic floor musculature, he will only be able to insert the device with difficulty due to the muscular tension. The patient will react with severe pain, all the more the more often the examination is done, as every examination reinforces the distress. The examining doctor however believes that the patient is carrying on, not being cooperative, reacting hysterically, etc.; such an intervention could not hurt (because it doesn't hurt other patients who do not have this problem.)

The tendency to extend the continual contractions and thus the distress results from the following: every pain, every malsensation causes us to contract, not only at the directly affected spot but also around this spot, combined with a more or less pronounced spreading in the whole body. This means that a continual pain automatically leads to an increased muscle tone and diminished mobility in the entire body. As the entire torso musculature, i.e. the respiratory musculature, is always

thereby affected, with severe continual pain – no matter from which source - one inevitably becomes depressive.

Furthermore, pain and distress over a lengthy time periods always also result in a protective posture. This means that we twist our body so that we can best bear it. As children of gravity, however, our weight can only be borne by our skeletons, while our muscles are freed from this job, if our posture is totally upright. Every deviation from this posture, thus also every protective posture, leads to abuse of our muscles to carry our weight so that we don't fall over. In this way, new continual contractions develop which affect the whole body and lead to new complaints. This again causes doctors to doubt the good will and common sense of the patient; a twinge here, an ache there, a proper diagnosis cannot be made. Nothing helps, the patient gradually becomes annoying. Thus, the whole thing is surely psychic. The medical specialist may then make the (wrong) diagnosis "larvate depression".

The only alternative can be to take all the patient's complaints seriously and try to understand their functional context in exactly this individual case. There are no psychosomatic illnesses without somatic finding. There is also no difference between an organic and a psychosomatic pain. Every pain is transmitted through pain receptors and the nervous system and every pain is correlated to damage in the body tissue.

All functional illnesses at first probably affect the sensory motor system. Only in an advanced state do malfunctions and ultimately structural changes of the inner organs occur. A pressure or pain in the stomach can develop into gastritis, and this can lead to an ulcer and ultimately stomach cancer if a series of other factors also play a role. Muscle tensions are considered harmless, but this is not at all true. Hardly anything can cause worse pain and distress than muscle tensions, and they can be the starting point of chronic illnesses. Muscular tensions can lead to asthma, heart rhythm disorders, colitis, haemorrhoidal ailments, and a multitude of other illnesses.

With a hundred percent regularity, in such disorders a muscular malfunction is also detected in the outer surroundings. This does not only develop, as according to

medical opinion, only reflexively from inside to out, but also as a result of the organ damage (as due to an inner spasm, caused e.g. by a gallstone, the abdominal musculature is contracted); rather, the muscular malfunction usually precedes the organ damage. The inner organs are not independent from what happens outside. Thus, e.g. at each respiratory movement, which is carried out via the skeletal musculature, not only the lungs but all the inner organs are moved. The organs are not rigidly attached to a point in the body; they are continually on a journey, continually in motion, and apparently they need this movement for their smooth functioning.

Thus, e.g. the intestinal peristalsis is dependent on the movement of the diaphragm. Without a hard belly (which prevents abdominal and downward diaphragmatic breathing) no constipation occurs. SMITH and SMITH even thought that all the inner organs only become active at the command of the neuromuscular system; that the neuromuscular system controls the function of the inner organs. This process can easily be observed in muscle, respiratory, and cardiac activity. In jogging, e.g., more energy must be produced in the mitochondria of the muscle cells, for which oxygen is needed. Therefore we breathe all the more the faster we move. As the volume and frequency of respiration increase, the volume and frequency of the heartbeat increase; more oxygen is pumped into the bloodstream and ultimately arrives in the muscle mitochondria. Vice-versa, it is easy to decrease the pulse frequency by slowing one's breathing; one thereby generally feels calmer. From such a point of view, the differences between psychosomatic, functional, and organic illnesses disappear, because almost all illnesses (notwithstanding massive hereditary diseases or congenital defects) begin as functional illnesses. Perhaps it would be better to speak of tension or rigidity illnesses, or sensory motor disorders.

This is evident, e.g., in back trouble. Here also patients are usually divided into those with organic findings and those without. As we already know, the latter group does not exist, because the finding can be detected in the neuromuscular system. But how about the first group? Here "organic" mutations like slipped discs, dislocated vertebrae, or curvatures of the spine can be detected in X-rays or computer tomography. Are these patients sick in a different way than the others? No, it is only

an advanced stage, because the muscles which are shortened by continual contraction and press on the spine ultimately wear out the intervertebral discs, pull the spine crooked, and, if there is both sides are unequal, they pull single vertebrae more to one side. The pain however – what people suffer from – stems in both cases from contracted musculature and not from what one sees on the X-ray. Pain as well as vertebrae damage result from contracted musculature. In hip arthrosis it is no different: it is due to continual contractions of the hip musculature (e.g. with sideways inclination of the body as a result of previous injuries). Even organically detectable heart damage is preceded by a long history of insufficient breathing due to contractions of chest and abdominal musculature. This, however, cannot be seen on X-rays or any other imaging process; it can only be observed in live human beings. The list of sequential illnesses could be continued at length.

Thus, like every healthy behavior, every illness also has a psychosomatic aspect. I.e., every illness influences the thinking, feeling, imagination, and actions of a person; just as his thinking, feeling, imagination, and actions have an influence on the illness. As psychoneuroendocrinology and also daily experience show, we are more likely to catch a common cold when we are not “in good shape”, i.e. when we are tense. The statement that a certain illness is a psychosomatic disorder becomes a tautologism, because every illness attacks a living, moving, animated body; only corpses no longer get illnesses.

What one can do against tension illnesses

Because nearly all illnesses are connected with the functioning of the sensory motor system, it is also possible to influence them all positively through the same processes. Therefore, we repeatedly find studies which prove that exercise has a positive effect, whether prophylactic, healing, or in prevention of relapses. This is true for illnesses of the locomotor system, the circulatory system (e.g. hypertension, cardiac infarct, and stroke), for internal illnesses such as diabetes, even for cancer, and naturally – last not least – for fear, depression, and (in the sense of classical medicine) “psychosomatic” illnesses.

Rhythmic movements of the whole body which get the circulation going and loosen the musculature have proven to be particularly suitable, e.g. jogging, swimming, mountain hiking, dancing, cross-country skiing. These rapid, rhythmic movements have a relaxing and activating effect. Sports which tend towards tension rather than relaxation are unsuitable, like competitive sports, most kinds of heavy athletics, and bodybuilding. But also the above-mentioned endurance sports are unsuitable if the movements are executed in a jerky, strained, or violent manner; this is often visible in the tense and distorted facial expression.

In recommending sports the following must be considered: It is true that we soon feel better when we exercise more – and when we feel better we feel more like exercising. But the contrary is also true: when do not feel well, we do not feel like exercising. The muscles are so tired and lacking of oxygen that it takes a lot of willpower to get moving. The “inner demon” is to be found in the musculature. That is why, when one is depressive, one preferably sits in a corner and broods or would prefer to stay in bed, because even getting up is too much of an effort. Such behavior, however, is in reality a depression promotion program. If, in this state, one forces one’s self to go on a mountain tour, or to go swimming or jogging, one soon feels better. (Considered under the aspect of lack of exercise one can say that common psychiatric clinics breed depressions).

Besides endurance sports, laughing, crying, and singing, even just speaking, are very well suited to especially release the emotional musculature from rigidity. Also all the gentle, slow, careful forms of movement like Tai-Chi, Chi-Gong, Feldenkrais “Awareness through movement” are good ways to emerge from tension back into the flow of movement and thereby to well-being. These slow, rhythmic movements are experienced as relaxing and calming. The regulation of tension and excitation in daily life takes place in varied ways, as especially THAYER has pointed out. Then it is best to rest, go for a walk or rock our child (which acts soothingly on both parties).

These natural and simple processes often do not suffice, because they are very unspecific. It is possible for the person to move and to still hold the regions, which are centrally contracted, in excessive tension without noticing it. In this case he will be reinforcing his malposture. The pain is often so severe that these movements cannot

be carried out. In these cases one must work with a more precise therapeutic focus.

As we have seen, sensory perception, movement, thinking, and imagination are only various sides of the same process; we can work therapeutically on any of these sides. Naturally, we can utilize traditional verbal psychotherapy as heretofore, which mainly applies thinking and imagination with the intention to influence feelings and movement. A certain alleviation and improvement will often already come through the explaining what the matter of the complaints is. Thus, one helps the patient to exit the spiral of fear that he has a grave illness, preventing him from getting more and more tense and aggravating his distress. The statement "There is nothing there" usually does not help, because the affected person senses very precisely that this is not correct.

One can also try to influence the sensory organs directly in order to induce a relaxation reaction in the body: e.g. with light therapy, music and sound therapy, with fragrances or with warmth application. In directing one's attention to positive sensory impressions an – at least momentary – reduction of tension and excitation takes place, not only in the area of the sensory organ but in the whole body. One utilizes this e.g. in meditation or breast-feeding. In everyday life we take a warm bath or visit the sauna, go out for a good meal, embrace somebody, listen to music, etc. Also, all psychological diversionary maneuvers, e.g. in therapy against pain, make use of this effect. However, if one concentrates on negative sensory impressions, e.g. the pain, these are reinforced.

Since the sensory motor system, as we know, can also be influenced via the imagination, one can also work with autogenous training, visualization exercises, catatym imaging, NLP, and practicing movements in the imagination. In everyday life daydreaming corresponds to these methods.

According to my experience, however, the most effective are body therapies which are applied directly to the muscles, fascia, and subcutaneous connective tissue, in order to loosen and restore movement to them; these therapies direct attention to the perception of the whole body and all its single parts and functions. Once the

blockages are removed, the natural self-organization of the organism takes over again, it learns another way of moving, another way of dealing with itself; more body awareness develops so that in future it notices by itself what is good and what is bad for it. Here, too, there are a series of methods: Feldenkrais' Functional Integration, Rolfing, Alexander Technique, Trager Work, Bodymind-Balancing, breathing therapies, certain massage techniques, etc. They all work directly with the body and do not consider its single parts symbolically; neither are they concerned with catharsis through the disposal of psychic energy (whatever that is supposed to be). All these methods lead to a significant reduction of tension, whereby the muscle tone can sink under the threshold of pain or complaint perception.

Especially in chronic cases, however, the basic hypertension and hypersensitivity of the tissue does not disappear therewith. Unfavorable circumstances can lead to renewed increases of tension which surpass the pain threshold, i.e. relapses can occur. I myself therefore prefer my "Body therapy according to Dr. Pohl", a combination of Hanna Somatics (a further development of the Feldenkrais method, named after Thomas HANNA) and gelosis treatments which I have further developed; the original form of the gelosis treatments was already described in German-speaking areas in the 1920s and 30s by LANGE.

With the method Hanna Somatics I have the patient – similarly to JACOBSON's Progressive Muscle Relaxation – first contract tense muscles even more and then – in deviation from JACOBSON – to very slowly relax them, with exact sensory motor feedback from the therapist; i.e. the therapist with his own muscles gives a counter-pressure which he also slowly and gradually reduces. With this method one goes through the entire individual contraction pattern (one treats not only the spots where already acute complaints are evident). Thereby, at least the actual heightened tension is released and the patient already feels considerably better.

If, after this precise, active, functional relaxation, hard spots in the tissue are still perceptible (which usually is the case), this means that chronic structural changes in musculature and/or subcutaneous connective tissue have developed. These so-called myogeloses and fibrogeloses can be felt as hard spots that are extremely

painful under pressure, usually in areas of muscle insertions. With purposeful, precisely adapted and shifting pressure, one can release these hard spots. The basic excessive tension is thereby permanently released and the hypersensitivity disappears. Momentary stimuli such as pressure, cold, weather changes, threatening situations then no longer provoke exaggerated reactions and ailments.

Moreover, the patients learn somatic exercises which they can carry out at home to keep themselves flexible. Also, changes of posture and movement in daily life take place whereby the patients learn to feel and observe themselves and acquire new, more pleasant everyday movements. In this way the therapeutic success is stabilized. The patients can maintain their body awareness and mobility and avoid the development of new continual contractions. The therapeutic success is visible and perceptible for the patients as well as for the therapist. The pain or other complaints cease, the tissue becomes softer, the mobility of the concerned body parts increases in active as well as passive movement, the respiration becomes calmer and deeper, the whole look is healthier (through better circulation one again gets ruddy cheeks, whereas pain patients in the beginning typically look gray in the face). The whole person becomes more relaxed and cheerful, he moves more and differently. Through removal of the functional blockades the natural healthy self organization again takes over. I used to be a psychoanalyst for many years. Today I would never again treat anyone in this way. Body therapy is much more successful, also and especially for “psychic” and “psychosomatic” disorders.

What about the early childhood experiences that are supposed to be the cause of all subsequent “psychic” and “psychosomatic” disorders? Can one treat someone without getting to the bottom of this cause? One can!

It can be that someone has already his musculature contracted in childhood, for whatever reason. Sometimes patients can directly remember this or they discover it on old photos. But, as Wolfgang Loch, a known German psychoanalyst, once said: we cannot change what has been done to the ego, we can only change what the ego

has done with it. This statement is valid for all psychotherapy and also if one replaces the word “ego” with the word “organism”.

The early childhood experiences are not “the cause” of the current complaints. They may have triggered continual contractions that are linked to certain thoughts and feelings which still exist today and probably have been reinforced during the life’s course. It can just as well be, however, that they only developed later in life. Nobody can remove a patient’s early childhood experiences; but one can release the continual contractions on which his current complaints are based, no matter when they may have developed. Thereby, the feelings and motivations change. A patient who originally consulted me due to testicle pain and abdominal cramps (it soon became evident, however, that he also suffered from constriction of the heart, sleeping disorders and depressions) described it thus at the end of therapy: “My mood is much better. Now it is a pleasant restlessness: I still want to do this and that. Previously, it was: I still have to do this and that and that. The work load is the same, but on the positive side.”

If somebody had told me 20 years ago that he could heal depressions, anxiety, and “psychosomatic” disorders by pressing certain spots on the affected persons and having them do certain movements and that this was very successful – I surely would have declared him to be crazy.

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