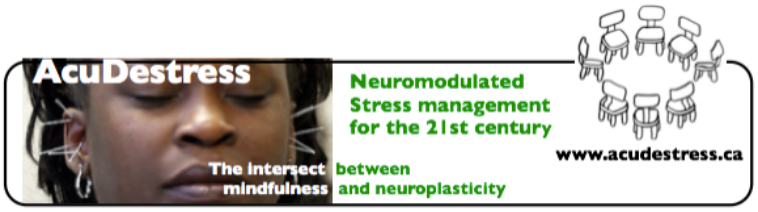

The Territory Beyond Talk Therapy

by Brian C. Bailey M.D.

A MANUAL FOR PRACTITIONERS OF ACUDESTRESS

Chapter 5; Phenomena Make The Brain Over
(The Brain That Changes Itself)

This chapter, leading on from the last, offers an explanation of what is really happening when persons with intractable mental /emotional illness are treated wth ***5-point ear acupuncture***. Throughout the whole of Chapter 4 I laid out out the events of my early learning curve without a manual. For lack of a manual, I had to devise a strategy to get the best from what was available, and I put it to you that the same challenge will apply to you. If you duck the challenge, you will still get 60% results as I got over my first half year, during which the majority of the 75% of all those we treated in the early going who attended our optional evening invitational events, also sallied through the individual appointments which followed, as each of you did too. But I knew that Dr. Smith was getting 85% results, and I knew that Dr. Wen had observed that 100% of those with substance addicted would get some matter of result if the received 15 treatments within a month. Whatever else I knew I knew that we could improve on 60%.

So, you might say "If these are patients who were not getting any results (we have had several patients who have had the upwards of thirty years of psychotherapy and have almost nothing happen) maybe 60% is good enough. If you're content with what you can get from merely putting the pins in, so be it, but don't bother reading further, do your thing, and please don't call it AcuDestress.

If not, what I'd like you to do here is replicate my initial thinking to create a set of presuppositions you'll use to bring your result more in line with Smith's lofty figures of 85%. Let's go over it and let me run through one patient I treated totally myself, talking with him throughout his 15 pinnings due to the fact that his anxiety was so high, his job was at stake, and he was on the verge of being under arrest. Add that I had the two *Borderline* patients who were so well that i'd been able to totally discharge them from treatment, my own personal experience with Nancy of having a fight which turned into a transformation over time, that 15 of the first 20 patients we'd treated showed up at an optional two month evening, in great shape, sort themselves out into 3 groups of people who had similar dynamics without the slightest word of instruction, then all do well afterwards. I had one more experience which influenced me, which introduced me to ***phenomena*** which I have to add as well.

The Emergence of Potentiating *"Phenomena"*[12]

Below I quote verbatim from material I wrote over 20 years ago for my second book, **The Magic of AcuDetox Part 2** [13], which was written for people who had just completed their session and might have

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[12] **Phenomenon:** phe·nom·e·non fəˈnämәˌnän, noun: **phenomenon**; plural noun: **phenomena**

1. 1. a fact or situation that is observed to exist or happen, especially one whose cause or explanation is in question."glaciers are unique and interesting natural phenomena" synonyms: occurrence, event, happening, fact, situation, circumstance, experience, case, incident, episode "a rare phenomenon"
    - a remarkable person, thing, or event.
    - *synonyms: marvel, sensation, wonder, prodigy, miracle, rarity, nonpareil; More informal humdinger, phenom, stunner, doozy, ripsnorter "the band was a pop phenomenon" 2.*
    - *PHILOSOPHY*
      the object of a person's perception; what the senses or the mind notice

[13] Bailey, Brian: The Magic of AcuDetox Part 2, Chapter 13 p. 83-4 (patient-only, password protected)

encountered points where they needed to refresh their sense of what was needed to continue on, on their own. I include add-on boxes in blue which add in what I have learned in the intervening 20 years. We never sit still. We have now completed 122 groups. Each builds on what we've learned from the last. The case was not actually the fifth patient I treated, probably the tenth, but he was Patient #5 i've reported on. In those days I didn't talk to patients during their pinning so Patient # 5 the only patient in that group I actually talked to and still honoured Smith's dictum of "No talk therapy"

Patient #5 The story I want to tell you here is of a a **s**maller-than-the-world THINKING-predominant man - whose **RED** side emerged in treatment and whose process has a lot to teach us as providers and as recipients about what to look for as a result of 5-point ear acupuncture. You've been through the sessions, and you know enough about being RED, BLUE or GOLD from your own experience, but after this story , later in this chapter and then, even later in Chapter 6 I'll come back to this topic in detail. For now, read him as **RED**.

Gordon (not real name)

Gordon, a 53-year-old high school teacher, showed up with a complaint I had never heard before and had no understanding. He'd found himself becoming a compulsive Peeping Tom, peering in the window of a previous girlfriend, even though he had moved on and found a new girlfriend following their breakup. Because he was known to me before coming to see me, I went to visit him at his apartment, where he showed me how his ex- girlfriend's house was visible from his bathroom window. While there, I experienced him compulsively walking by the window frequently, and he told me that the whole thing started when he happened to see that his old girlfriend was entertaining somebody new in her backyard, and that gradually he had been pulled into watching for every time the new boyfriend appeared. Gradually his curiosity had grown, and he had started by hiding in the backyard between their two houses late at night. His watching escalated and soon he was peering in the window. He had been caught twice, once by his former girlfriend and once by a neighbour, and was in jeopardy of losing his job had they reported him to the police. He was still at it.

Gordon was not really the type to come for psychotherapy - worldly, somewhat pompous and a touch disdainful and I was, at the time, still dabbling with **AcuDetox** so first I tried a psychotherapeutic session which pulled in his many friends - several of whom were anxious to help - particularly those who didn't know him very well. A few of his closer friends found themselves disgusted, and urged him to just stop what he was doing forthwith. That was not going to work. Regardless of his tearful appearance at the event, and regardless of the support it garnered for him, it didn't produce any results. And he needed results - yesterday - not next week not next year. He was welded *(into)* the process, and I was wondering what to do next. Enter **AcuDetox**! Like anything else which was new, I wasn't sure at the time which things it would work for and which things it wouldn't. I was also just twigging to the idea of the **Resource Types** *(i.e. the three colours)*.

Gordon agreed to **AcuDetox,** and as I was still only using it occasionally, he came as an individual patient. I spent the hour he had the pins in with him each day. It was a

The term "*Peeping Tom*" is the well-known vernacular descriptive of the diagnostic category of Voyeurism, described in the literature as a sexual perversion:

- recurrent, intensely sexually arousing behaviour over a period of six months
- behaviour involving obsessive observation of unsuspecting persons who are lightly dressed, undressing, or naked
- the creation of fantasies while observing
- significant distress caused by the onset of sexual urges brought on by the act of voyeurism

The literature in somewhat vague about whether conventional treatment is successful. As it reads like an addiction, it seems likely that talk therapy would not find it easy to break through with it.

I didn't know what to expect for more reasons than one. Firstly, I had already given conventional talk therapy my best shot with Gordon and it had utterly failed. Secondly, I had agreed not to combine ear acupuncture within talk therapy so i didn't know what I should be doing with the hour and had to make it up. Also, i had never treated voyeurism previously as such patients rarely preset themselves for therapy. So this was different. to say the least. It was kind of the blind leading the blind.

curious process throughout, as I didn't know what to expect. He didn't know what to expect either and so he began to compose voluminous notes about his childhood and his unsatisfactory relationship with his mother. He began to develop a theory that this all had happened because his mother had not given him enough attention growing up. I was kind of amused at his note-writing, as I knew that it was not going to be because of insight if **AcuDetox** worked for him. I did note that everything he said was self-referential - things that happened to *him - caused by others*, misfortune directed towards *him*, negligent mothering of *him - and finally his recurrent complaint that his ex-girlfriend had done him in by declining to be with him for no good reason. He just could not understand it, and it made him miserable*.

Then his last day of **AcuDetox** came. He told me that he had an odd incident to relate. The night before he had been at his new girlfriend's house, and she had been rushing around to get ready for an employment interview. She was washing and ironing her clothes, and suddenly it came to him to ask her if she wanted any help. He told *(her)* that he was a good ironer. She accepted and he found himself standing at the ironing board with the odd feeling that he had never done anything like this before - i.e that he had never looked outside of himself and assessed somebody else's need, then done something about it. Everything before had been self-referential. While he had been anxious to tell me the story, it was not because it had delivered any insight - only that it he found it odd. On my side I could see that he was having an experience of *reading* somebody else for the first time in his 53 years. I told him what I saw in this, and he broke down crying, realizing for the first time that his old girlfriend had feelings which he could now appreciate. This was the missing factor in his Peeping Tomism - a notion of the peepee being a feeling human being.

The next day he tearfully apologized to his ex-girlfriend, and never once engaged in this compulsion again.

This sequence of events taught me a great deal in my early days of AcuDetox. Firstly it was my first real view of a result in a **FEELING RESOURCE person.** Secondly, I learned that such people are so self-referenced that they simply don't experience feelings in another person. There's no sense being angry with them, even if their behaviour is atrocious - as they are simply missing a badly-needed skill - and don't have a clue it's missing. I also learned that even though they may have experiences of breakthrough in which they do see other people's feelings, they usually don't have insight at the time. You've already seen that on some occasions, the experience they are looking for is actually so disliked by them, because they associate it with vulnerability, that they can be mad at you as the person they hold responsible for evoking these feelings. Thus you must work with them, and you'd better have thick skin. And if you're a FEELING RESOURCE person and you're reading this, my advice is to make sure you're working with someone who really understands what it takes to evoke the full sensory response which comes with AcuDetox.

Here we see what occurred more commonly later when I gave shrift to it, a "breakthrough" event occurring spontaneously, out of the blue, as it were, which changes the narrative, giving rise to needed change, usually in the form of some extrasensory perception of another person, who may be close by or at a distance. Change is profound, and lasting, and the experience feels "natural" even if it is odd and non-linear. It is notable that it occurs without the involvement of insight.

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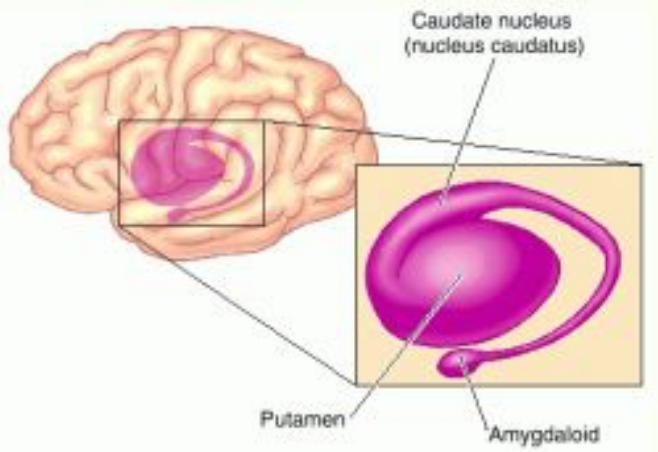
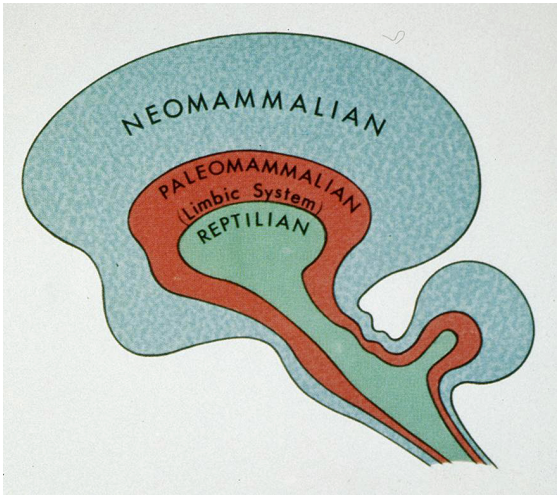
Most people who come for treatment get something that pleases them and works for them. REDs, who have spent their lives trying to control life, wake up to realize that what they get is NOT what they had in mind, that it is laced with far more lack of control than they bargained for. I have had such patients threaten to sue me, holding me responsible for something needed but unwelcome. Gordon was not one of these. He was very relieved not to have lost his job over this. He thanked me for what he deemed to be the

Phenomena such as we see in the story of Gordon, are the direct opposite of those referred to in scientific *phenomenology*, in that in our use it connotes something positive and expansive beyond our normal capacity, as in the synonyms included in the dictionary definition of *phenomenon* : *marvel, sensation, wonder, prodigy, miracle, rarity,* (see definition three [pages back) **Indeed, phenomena read as moments of intuition.**



In an article titled: ***Intuition May Reveal Where Expertise Resides in the Brain : Our ability to provide rapid, accurate answers engages a small area in the brain's basal ganglia, a hub for learning and automatic behaviour***,[14] by Christof Koch on May 1, 2015 in Scientific American Koch concludes:

"....It appears that the site of fast, automatic, unconscious cognitive operations—from where a solution materializes all of a sudden—lies in the basal ganglia, linked to but apart from the cortex. These studies provide a telling hint of what happens when the brain brings the output of unconscious processing into awareness. What remains unclear is why furious activity in the caudate should remain unconscious while exertions in some part of the cortex give rise to conscious sensation. Finding an answer may illuminate the central challenge—why excitable matter produces feelings at all."



Interestingly enough, the ***caudate nucleus***[15] is the head of a basal ganglion structure attached to the infamous ***amygdala***, to which most researchers attribute the generation of ***intuition***. *Phenomena*, in our parlance, then, are spontaneous responses to our desire to know something we currently do not know - and lack the capacity for knowing. So, are the conditions for intuitive knowing a willing state of not-knowing? In my metaphorical depiction of the brain, consistent with Paul MacLean's *Triune Brain* model (left) and Stephen Porges' *Polyvagal Theory*[16] - intuition in the RED brain would be "as if" **the feeling (or limbic brain)** were to approach (attach to) the two brain layers already active in the underlying personality (as depicted on the right.) Pushing the metaphor further, and assuming now that we are talking about the formation of personality, we can further see how this would link with Bowlby's *attachment theory*[17] in people like Gordon and others.

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[14]Koch C.: https://www.scientificamerican.com/article/intuition-may-reveal-where-expertise-resides-in-the-brain/

[15] The basal ganglia (including the **caudate nucleus**, the putamen, the globus pallidus, and the substantia nigra) lie over and to the sides of the **limbic system**, and are tightly connected with the cortex above them. They are responsible for repetitive behaviours, reward experiences, and focusing attention.

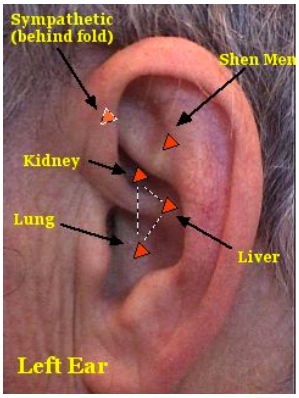
Porges, Stephen: *The polyvagal theory: New insights into adaptive reactions of the autonomic nervous system*: Cleve Clin J Med. 2009 Apr; 76(Suppl 2): S86–S90 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3108032/

[17] Bretherton, Inge: *The origins of attachment theory; John Bowlby and Mary Ainsworth*; http://www.psychology.sunysb.edu/attachment/online/inge_origins.pdf

Gordon was a participant in our very first after-session evenings, described above, and as you can imagine from his story he participated in the **RED FEELING conversation…**

"They are not people who find their way easily to psychotherapy of any kind, as they are independent, brash, and highly extroverted. So, the piece they gain from 5-point ear acupuncture is their sudden ability to sense feelings. While slow to understand themselves, once released they're an emotional house-on-fire. These are people are often sent to treatment - like anger management - or are assigned to come to me by managers who don't know what to do with them. One they get their RED piece they're the life of the party. " *(Brian C. Bailey M.D. 5 pages back)*

We cannot make too much of the fact that Gordon, in his moment of **intuition**, saw the woman in the room with him, as she actually was, for the first time ever. I'm inclined to call this *dissociation* - and what happened to him as *"sociation" (the normalization of dissociation.)* Prior to that he could only see himself - and not very accurately at that. **Dr. H.L. Wen**, the original discoverer of the transformative power of the ear acupuncture protocol, was a neurosurgeon, doing prefrontal lobotomies on failed treatment cases of substance addiction. He was using only the three points **kidney-liver-lung**[18] *(which, by the way, do not refer at all to the organs after which they are named)* The two upper points were added by Dr. M.O. Smith to add an anxiety-quelling dimension. In 1970, Wen was conducting a practice run for using the three points to perform a prefrontal lobotomy on a very difficult opium abuser, who habit went back 30 years. The reason for using acupuncture anesthesia, was to have the patient awake during the procedure, as the results of lobotomies is immediate, and the decision as to how much brain tissue is removed is individual. So, this patient had his practice session, and noted how relaxed he felt. But the next day, everything had shifted. He came running back into Dr. Wen's office, cancelling his surgery and describing how "free" he felt. Indeed, he was uncannily accurate, never relapsed and his mood soared.



Dr. H.L. Wen M.D.

Does this sound a lot like Gordon? The patient sensed that his freedom was not just a *"flash in the pan"* but something lasting, and he was right. **Dr. Wen** sensed it too, even though he'd never seen it before and followed that patient for years afterwards. But Wen's focus was substance addiction, and for his intents and purposes, the acupuncture had done its work. But he was seeing patients every day with serious addiction problems. There weren't patients like his one-treatment-cure very often, so, being fully trained in traditional Chinese acupuncture he took 5 years to determine how many treatments and at what time interval would assure that all of his patients would get the effect. Smith learned that Wen advised **15 treatments in 21 days,** but admitted that this was an ideal, often impossible to reach with outpatient (often street) substance addicts, so he was lenient about the frequency but not the number.

When Dr. Smith brought Wen's formula to the methadone clinic at the *Lincoln Hospita*l in New York City in 1974, he had immediate success. Treatment time was cut drastically, and those who used it were still allowed their methadone. This was also a tough time for AcuDetox. The addiction community, those who relied on being paid to treat addiction, were threatened, and did everything in their power to sabotage his efforts. Smith had to be thick-skinned (he was, I can tell you.) He related to me how he then had to be careful to which colleagues to introduce his protocol. If the person he was speaking to about it had a method of their own, and if it worked, even weakly, he knew that AcuDetox use would never get off the drawing board. *I was to find this myself in short order, but didn't quite realize what was happening until I decided to become a recipient myself. When one does psychotherapy, one has a lot of one's own personality invested in it. It is hard to "change horses in midstream."*So, Smith found a very receptive audience in members of the judiciary in the **Miami Drug Court** who were charged with sending felons to jail who were, at the same time, substance addicted. Few did well. The rate for returning to crime on discharge was 44%. But when a group of volunteer inmates did a pilot project of sitting in a circle with the pins in every day for 3 weeks left prison, they had a recidivism rate of 2%. Something more than substance addiction cure was transpiring. **Gordon** was not substance-addicted, but he was "addicted" to rejecting everything he saw outside of him as related to him. It was as if, really, there was no one else out there, that everyone else was just a reflection of him. When he recovered, he saw others for what they are. He was immediately able to see that the old girlfriend he was "peeping" on was a human being with feelings off her own. He was not just better. He was changed. And he stayed changed!

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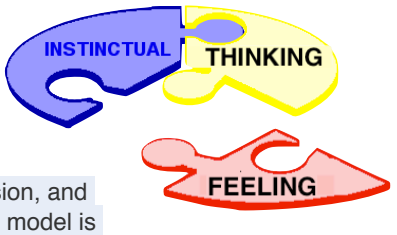
[18] Bailey, Brian: Acudestress web site; Clinician section: https://www.acudestress.ca/clinician/Ear_acupuncture_points.html If reproduced, please acknowledge source

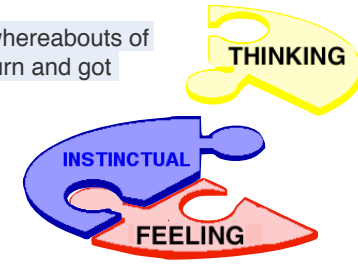
Had I been a student of **Bowlby's attachment theory**[19] in 1995 I'd have looked there. But I have more recently.

Secure attachment (55-65% in non-clinical populations)[20]In the Strange Situation (SS[21]), the infants used the mom as a secure base from which to explore. The infants noticed when mom left the room and protested. When mother returned, the infant went straight to the mother to be held, was easily reassured, and quickly returned to play. In the home, these parents were emotionally available, perceptive, and responsive to infant's needs and mental states. The internal working model of these infants is likely to be one that expects that their needs will be known and met, that they will be attuned to and emotionally regulated, and that they can freely explore their environment in safety. *(the placement of personality models below is mine)*

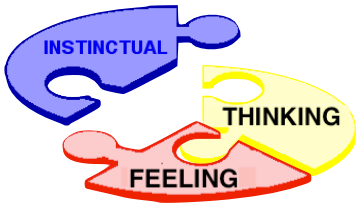
Avoidant attachment (20-30% in low risk samples) In the SS, the infants did not use the mom much as a secure base from which to explore. When the mother began to leave the room, the infant might move toward her, but often did not. When the mother returned, the infant acted like she was not even there and just continued playing. In the home, these parents were seen to be emotionally unavailable, imperceptive, unresponsive, and rejecting. Some were responsive in many non-emotional interactions, but were very dismissive and non-responsive when the infant was emotionally needy, frustrated, or angry. These infants often expressed random aggression, and were more clingy and demanding in the home then securely attached infants. The internal working model is likely, "mom does not respond to my emotions, especially when I am needy or angry, so I will shut down my needs and try to become independent." The infants then protect themselves from this difficult situation by dissociating from contact with their normal need for connection, and repress their emotions more generally. This is a "deactivating" strategy with respect to attachment. In **Gordon's** case, metaphorically speaking, ***avoidable attachment*** happens when the 2 brain layers which form the child's personality don't attach firmly to each other, making it harder for the child to get a feeling for the emotions of the (m)other, and thus sees the other as a projection of his own feelings. Ear acupuncture activates the limbic brain. It comes on line, repairing the *avoidable attachment*, i.e. seeing there is an "*intersubjective"* entity out there that is not me. **Intersubjectivity** *is defined as information processing performed by cognitive systems that serve interaction or communication between persons or interactants within and even between species.*



Ambivalent attachment (5-15% of low risk samples) In the SS, these infants were more alert of the whereabouts of mother while playing. They were very upset when she left the room, immediately went to her upon return and got very clingy. Their behaviour upon reunion alternated between outbursts of anger and going limp, and in either case the infant was not soothed by the presence of the caregiver even if the mother was seen to be caring and emotionally available. In these homes, the mother was inconsistently available for the infant, and when she was available she was often pre-occupied and un-attuned to the infant in her responses. These infants were the most anxious, clingy, and demanding at home. The likely internal working model here is "even if mom is available physically, she will likely not be able to soothe me." These infants respond by "over-activating" their attachment system.



Disorganized attachment (20-40% in non-clinical populations?? And up to 80% in situations of abuse. This is not used as a primary classification, but rather an additional descriptor.) This was not an original classification in the SS, but later studies showed some infants who got disorganized when their mothers left the room, and also expressed disorganized patterns of behaviour on return (move towards mother, then away; freeze; go into a corner). They were not soothed if they made contact with the mother. The homes of these infants often had physical or sexual abuse histories, psychologically disturbed parents, and/or parents with substance abuse. Their inner working model of this relationship is not functional, and is one where the "supposed" source of soothing is also the source of danger — a situation of "fright without solution" — leaving their mind state and behaviour very disorganized. *(This is what we call dissociation, but perhaps the others are as well?)*



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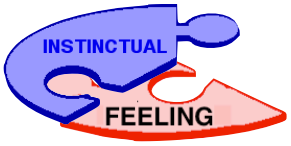
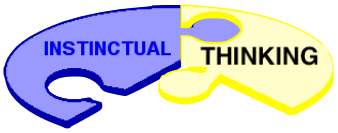
[19] John Bowlby: The Making and Breaking of Affectional Bonds: I. Aetiology and Psychopathology in the Light of Attachment Theory: The British Journal of Psychiatry: Volume 130, Issue 3 March 1977 , pp. 201-210

[20] Forms of Attachment http://www.essentialparenting.com/2010/05/22/the-forms-of-attachment/

[21] testing attachment in infants and their mothers is done by watching how the infant responds to what us called the Strange Situation. The mother leaves the room, with a surrogate in her place. The baby is observe during her absence and when she returns. The way the baby relates to her allows a "diagnosis" of attachment typing.

One thing I haven't done above is extend the metaphor to showing what "secure attachment" might look like. I think it would mean that the two brain layers which are genetically available to children are (rendered) more functional if they are closely associate with each other, versus being dissociated as is particularly seen in the withdrawing (thinking/ feeling personality types. Perhaps all chronic emotional pathology is due to *dissociation* of the two layers determined by inheritance, and modified by early life experiences. So we see three possible forms of personality based stability:





Cathy Hurley and Theodorre Donson, have studied the three distinct personality variations which were described by psychoanalyst, Karen Horney six decades ago. Rather than seeing eperseonality structures are pathological or not, personality typing applies to everyone, such that everyone would fit one of the three groupings, as Horney predicted.Their book calls the three variations on the theme INTROSPECTIVES, RESPONDERS and GO-GETTERS

Qualities of Introspectives

1. Original approach.

2. Insightful perception of issues.

3. Enlightened solutions.

4. Appreciate intricacy and understand complicated issues.

5. Strive to understand a project thoroughly before moving forward.

6. Weakness: can spend so much time researching and planning a project that it never gets off the drawing board.

Qualities of Responders

1. Attentive to detail.

2. Dedicated and responsible.

3. Strive to create harmonious group dynamics.

4. Anticipate problems and set up procedure that can circumvent them.

5. Value and attempt to establish clear lines of communication and authority.

6. Weakness: can become so consumed by details and communication that other team members lose both interest in and enthusiasm for the project.

Qualities of Go-getters

1. Visionary.

2. Achieve results.

3. Use humor that diffuses potentially tense or difficult situations.

4. Undeterred by obstacles, which they perceive as challenges or opportunities.

5. Create optimism and inspire enthusiasm.

6. Weakness: can move too quickly and sidestep building team unity through clear communication.

To go over the *secure attachment* model one more time:

> **The internal working model of these infants is likely to be one that expects that their needs will be known and met, that they will be attuned to and emotionally regulated, and that they can freely explore their environment in safety.** [22]

Since none of the *insecure attachment* types is seen to be free to explore their environment in safety, it stands to reason that what secure attachment leads to *trait mindfulness* but that this looks differently from personality to personality. But personality difference can also obscure what we therapists are dealing with. For example, *"Why doesn't everyone dissociate when stress is magnified beyond tolerance?"* Well, perhaps everyone does but it's just more subtle. The mindful child can safely take a position outside off themselves, often called the "position of the witness" to objectively appraise the situation. In the article seen below, it is established that trait mindfulness is associated with activating the brain's **insula**, when a stimulus from the environment is observed and responded to.

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[22] Forms of Attachment http://www.essentialparenting.com/2010/05/22/the-forms-of-attachment/

Soc Cogn Affect Neurosci. 2013 Jan; 8(1): 56–64.

Psychological and neural mechanisms of trait mindfulness in reducing depression vulnerability

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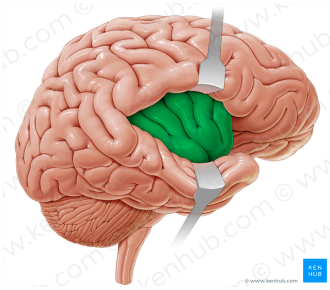
Mindfulness-based interventions are effective for reducing depressive symptoms. However, the psychological and neural mechanisms are unclear. This study examined which facets of trait mindfulness offer protection against negative bias and rumination, which are key risk factors for depression. Nineteen male volunteers completed a 2-day functional magnetic resonance imaging study. One day utilized a stress-induction task and the other day utilized a mindful breathing task. An emotional inhibition task was used to measure neural and behavioral changes related to state negative bias, defined by poorer performance in inhibiting negative relative to neutral stimuli. Associations among trait mindfulness [measured by the Five Facet Mindfulness Questionnaire (FFMQ)], **trait rumination**, and **negative bias** were examined. Non-reactivity scores on the FFMQ correlated negatively with rumination and negative bias following the stress induction. **Non-reactivity was inversely correlated with insula activation during inhibition to negative stimuli after the mindful breathing task**. Our results suggest non-reactivity to inner experience is the key facet of mindfulness that protects individuals from psychological risk for depression. Based on these results, mindfulness could reduce vulnerability to depression in at least two ways: (i) by buffering against trait rumination and negative bias and (ii) by reducing automatic emotional responding via the **insula**.



How AcuDestress Morphed Into Neuromodulated Transpersonal Psychotherapy

In 1995, when I finally got started, after getting over the procrastination I suffered. I was critical of myself for not being able to solve every problem with *talk therapy, but once I got started (with exactly the patients I needed to find an answer for) I had success from the first patient on*. Clearly, it wasn't me that got the results, it was the pins, but so what? But it does help to get oneself out of the way. I did follow the rules Dr. Smith had set, and that was the hardest. No one else was staying this in the way that **Bessel van der Kolk** says it now. It was just one man telling me that he had something which would address my failed therapy patients, and that part of the solution was to give up *talk therapy*. I wasn't yet tuned into **Norman Doidge**'s brain, whose treatise on **neuroplasticity** T*he Brain That Changes Itself* showed me clearly what was happening in my patients. That was in 2007. By being acupuncture-savvy , from the start, I'd learned to expect the unexpected. Miracles always happened there. And eventually, by becoming a **5-point ear acupuncture** recipient myself, I really understood. So, it was not hard for me to extrapolate from my experience of seeing a migraine go away in 30 seconds. But I'd never seen the mind/brain do it. I was treated, within 2 months to the realization that this was an **intersubjectivity** phenomenon, the mysterious space between individuals. This changed everything. After I read Doidge, I realized that after twelve years of silence during the treatment, and applying my intuition afterwards, to gently nudge the patients in the right direction, I also realized that they could probably now respond to *talk therapy* finally. But why would they want to? They'd discovered that the best authority on the self is the (expanded) Self. Of course, conventional psychology and psychiatry are oriented to pathology and do not have a notion of an expanded self. But **William James** did. And if **Norman Doidge** didn't, he does now.

Those receiving **5-point ear acupuncture**, even if they don't respond as fast as a BPD patient, develop *mindfulness* in one week of pinning. After a week and a half they can perform *neuroplasticity*. But all along, from the first session on, people report *phenomena. These interim transcendent states, are both brief and spontaneous. Are they mini-***out-of-body-expertences***?** When spoken of, the rich articulateness of the words uttered suggest this is not ordinary. An element of learned agency occurs. So, *transpersonal psychotherapy (TP)* has been chosen by most clinicians. That's because unlike conventional therapy, anything that can be read as criticism will throw a wrench in the works. Transpersonal psychotherapy (which I'll elaborate on in Chapter 6) just lets it happen.

The nature and conduct of *Transpersonal Psychotherapy* as it applies to the three different personality types its the topic of Chapter 6. It has has some auspicious proponents, starting with Dr. William James, proceeding to **Dr. Roberto Assagioli**[23], Dr. Maurice Nichol, Abraham Maslow. More recently, Stanislas Grof and A.H. Almaas (from whom I learned the most hands-on.) Mostly, its the realization of a reality beyond mundane existence that opens the door.

Dr. Roberto Assagioli

If this were all there was to it, we should have 100% results. We have very high results - but not 100%. It is all there is to it - in some cases, but we all know that serious mental illness is often

[23] Bailey, Brian: Doctor-to-doctor; https://www.acudestress.ca/clinician/Doctor-to-Doctor.html

complex if there are significant co-morbidities. Take *Borderline Personality Disorder* and *Complex PTSD*, and even add in *Narcissistic Personality Disorder.* This is a more complex situation and it's not going to get better in one fell swoop. Like the following case…

Case #4 Susan is an attractive, and sometimes zany single woman in her late 40's, who showed up at her summertime intake appointment covered in a huge floppy hat, turtleneck sweater, and a winter coat. She took none of her outerwear off, as if to make a statement that she was free to get up an leave at any moment. She had already missed an intake appointment. She admitted that she was ambivalent about coming, suggesting to me that she wasn't really sure she deserved to get better. She's been in therapy since her teens and was diagnosed by several different psychiatrists as comorbid *Borderline Personality Disorder* and *Narcissistic Personality Disorder*. She did not smile, nor look me in the eye.

She was involved in illegal action against a physician, but she was reluctant to talk about it, saying it wasn't going well. I tried to establish a rapport with her, as is usual, but by the end of our session she decided not to continue. I suggested that she come to a group *Information Session* to see if that would change her mind.

Susan had been in psychotherapy for long time, almost 30 years, and none of it had turned out very well for her. At one point in her teens her therapist convinced her to stay away from her mother, and although that didn't happen right away, she told me that she had not talked to her mother in over 10 years. She came to the *Information Night*, at which time I got to introduce her to one of my assistants, who is also a former *Borderline Personality.* We've had 25 to 30 people (in 22 years) mimic Dr. Wen's first patient, having a complete change after a single ear acupuncture treatment. I saw that Susan had the right preconditions, and she had a sample acupuncture treatment in the group. The next morning everything had changed for her. She signed on immediately for the next session, and began pestering me with email questions about why all of her negativity had suddenly melted away. Of course I don't know all the answers, but because I use *transpersonal psychotherapy,* my answers focus on the good things that are happening, and on the ownership of the person can take in making them happen. **Dr.Roberto Assagioli**, one of the pioneers of *transpersonal psychotherapy* and founder of *Psychosynthesis*, had his patients consult their "wise old person" within, to come up with answers to their existential questions. Clearly he was evoking intuition.

Dr. Roberto Assagioli

It was not "all over" for Susan, who still had her *Narcissistic Personality Disorder*, and her PTSD in tow. But she was now motivated - very motivated in fact. Her questions gradually diminished, as she found answers for herself, but she always wanted to be reassured, even when she was right. That this was no different than the woman 20 years ago, who wanted someone or some people as a sounding board for her new ideas. Then came an exercise in the middle of the session, where she found herself sitting beside someone who became very panicky. She put her hand on the woman's shoulder, and it was exactly the right thing to do. But when debriefing with me afterwards, she found herself feeling shame. Why? I saw it was clearly the other woman's shame which she was feeling. She would not be reassured that she had done the right thing. But a few days later, having reconnected with the woman, who'd had a good result in the end, we saw Susan smile for the first time. She'd not been very confident in her sense of what was going on with others (she lacked a *self*), but now she was clearly *" throwing it out there"* to see what would stick.

With some successes under her belt, she was ready to take on her PTSD. She had a memory of being 3 years old *(which is almost unheard of, but not, by any means, impossible)* of having a doll, *Lulu*, whom she related to like a security blanket. Her memory was that her mother engaged her sexually, and that when she pulled away, her mother took her doll away and never gave it back. That was the memory, and the question that it left her with was *"Where did Lulu go?"* It was a tragic question for three-year-old, but a woman in her 40s could answer it. So I suggested she answer it. She'd asked me to sit with her through facing this dissociated memory, but after that she could do it on her own. Shortly after, I introduced her to another woman who had also had BPD go into remission. I asked them them whether they might be interested in developing their intuition as *"partners in crime."* By this time, Susan was smiling a lot, and although she knew that she wasn't nearly ready for a romantic relationship, the friendship did appeal to her greatly, and the two women have made great strides in supporting each other's *embodiment* phase of their therapy.

Susan responds below to what I wrote above by adding her memory of what happened to her. She is now able to work on her own (actually I paired her up with another BPD patient to work together on enhancing intuition) with only rare need for us to talk. I see her as BPD-free, PTSD-free and working on her NPD. I comment in the BLUE boxes.

A Hard Nut To Crack (by Susan X)

I *(Susan - not her real name)* am a complex patient (bpd, npd, ptsd) and over the years some serious efforts have been put forth for my wellness. Unfortunately, in the end I was devastated. Discouraged to participate in any further therapy because after 28 years, at a minimum of once a week, I was more bewildered than ever and not interested in being a further burden to anyone anymore. To say that I was at the end of my rope would be an understatement.

Jane *(a program assistant who is three years free of BPD)* called and our conversation gave me hope and the motivation to try one last time. There was no talking required for acudestress and that was very enticing. The day after the first *Intro Session* I woke with a new sense of certainty and it was very encouraging.

When the group started I was guarded but as time went on I was coming to terms with all sorts of things; the good, the bad and the very ugly. Being a willing participant is an essential part of the process but it got easier as time went on. I was able to face my truths while managing the emotions associated (shame, guilt, sadness) more mindfully and with a better understanding.

I recall one day during the morning session responding to Dr Bailey's comment about having returned to group after a difficult *(individual)* session, "*I think its been established that I'm a clusterfuck. That's the point isn't it?!*" Owning it. Breaking down barriers one session at a time. It was rough at times but the benefits were tremendous. My anxiety had diminished and ruminating was a thing of the past. A sense of self was building in me and for the first time, in what seemed like ever, I started to feel like my life actually mattered. That taking on everything that I was or had been led to the freedom of getting past it... Without talking about. What a concept! Of course, private sessions were available for *guidance* to work through any difficulties. Ultimately, knowing what to do came from within.

Nearing the end of the program, I was managing the waves of shame with ease and even levity at times. Sharing more in hopes of encouraging others and offering support when it seemed fitting.

I found myself compartmentalizing throughout the program because I had a lot to process but by the end my spirits had lifted with a sense of ease that was unfamiliar but a very welcome change. In my follow-up session, I was ready to share a part of me and an early trauma with Dr Bailey and Jane. *I knew* it was time and necessary. Afterwards, I felt like a 'rockstar!' Worthy and truly accomplished for what seemed like the first time in my life.

My 47 year journey has been *very* colourful. Full of all kinds of crazy that seemed insurmountable. Not any more. I am now more open to the possibility of what could be and able to manage what was with understanding and ease. There is no more getting caught up in life's idiosyncrasies. I am able to process things without drama or rumination. I am taking on new things with optimism minus the over-analysis.

Acudestress isn't a 'cake-walk' for people like me but the end result is nothing short of a miracle. The program works. AcuDestress saved my life. Susan

Dr. Smith had written, not as a formal study, but anecdotally, as early as 1990, that his alcohol-addicted patients with BPD gift better from both, but because talk therapy was not involved, I now doubt he realized that it was as early as after the first session. Thus by the time patients come to the group they are already moving beyond symptoms and know it.

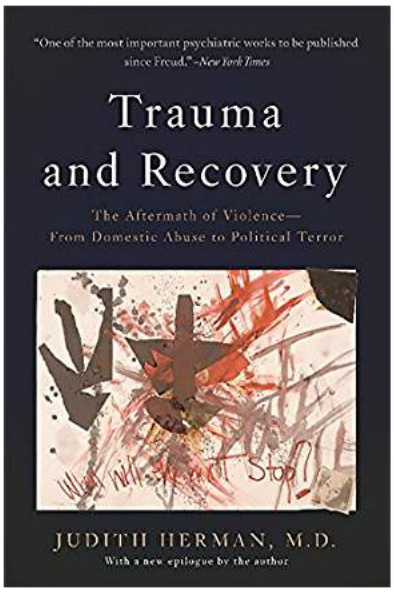
The slang term Susan uses is in common parlance today and stems from the earthy description of a military operation gone terribly astray. It actually describes her situation surprizing ly well.The term **"clusterfuck"** is often replaced in military communication by the NATO phonetic acronym "**Charlie Foxtrot**." While vulgar, it says it all! Is this insight, or what?

Notice that she has come to sees the process being more important than the content of her thinking. Does this mean that once she adopts a processing style that works for her, the past will be of lesser interest?

People like Gordon and Susan would be among the "happy campers" at the kind of post-session group gathering, described above, from 1995, which we held experimentally in the first year of operations. Gordon actually was there in that early going. With him, I was struck at the time of his therapy with the awe and wonder of improbable success that drove him forward. After springing free, he no no further need for therapy. Susan, we'll come back to later, watching her work on her own after her sdession to have the good life she has missed out on her whole life. The important thing is that she has little or no need to work with a therapist.

It's all very well for you as aspiring AcuDestress principals to hear the stories of what happened that shaped the course of my design, and my progressively upgraded design going forward. But the question, now, is, if the early events had happened to you and you were in charge of design, what would you have presupposed and how, then, would you have proceeded, at this point? I ask you this because soon you will be juggling the lives 12 people in a group, and each will resemble, to some extent, the people you've just learned about. Every day you'll gave to gather in everything you've learned, to help them.

I considered the way we were seeing people recover, largely from PTSD (we now know that 40-70% of people who attend our groups are alexithymic, almost all of whom are suffering from early life trauma) delightfully odd. It left them (and me) tingling with pleasure to see people without drugs and without talk therapy suddenly get better.



This was 1995. I was awed. As an inveterate reader, I sought out the barn-burner of that time for answers, Judith Herman's 1992 *Trauma and Recovery* where I saw her say, over and over, that there was a path to recovery which repeated itself over and over in each survivor of trauma. *" Because the traumatic syndromes have basic features in common, the recovery process also follows a common pathway. The fundamental stages of recovery are establishing safety, reconstructing the trauma story, and restoring the connection between survivors and their community."*

Yes, but with 5-point ear acupuncture's post-session attendees it was all too obviously happening in the reverse order, with all of the steps intact, each step a necessity. Just as Herman predicted, people who had not been able to talk themselves out of their dilemma had found each other, created a virtual community and in finding each other, they had gained the resilience to face the "real" story of their trauma, to take charge of insisting that they see these thangs, and only then knew (as they often entered not knowing) what was required to assure their safety. And you know this from following this sequence, yourself.

Frankly, it was the fact that, with other than the few patients wth whom I had minimally interacted with the early going, there was no *talk therapy* from their first pinning to the moment the people who'd finished their therapy came to the "aftermath" group, that came to the forefront of my attention. *I'd simply trusted Dr. Smith that no talk therapy would work. So,* I couldn't see what was transpiring during most treatment. Gordon was the exception. I was still on the cusp of deciding whether I was a *talk therapist (which I'd tried, at first, wth Gordon)* or in search of an understanding of the territory beyond *talk therapy.* Seeing Gordon "solve" his own voyeurism problem spoke to me. But seeing him function so well in a group of people he 'd never met before, all of whom were, like him, solving their own problems, got me hooked.

The reader may recall that Gordon, after some pinning, spontaneously saw his present girlfriend as a real person, and from this experience was able, in the same way, to see accurately the woman who'd been his former girlfriend, to whom he'd become a voyeur. He did require (I thought at the time) a brief interaction with me, during which I supplies the mentalizing interpretation he was still lacking (i.e. a typical brief transpersonal intervention) but he was able to summon up his own when it came to suddenly being able to correctly mentalize away his reason for his voyeurism towards her. And he did, afterwards, with no help from me, take up "cleaning up" his relationship with his former wife and teenage kids (also a mystery to him). It was just like Dr, Smith had said. *"He was relearning how to learn."* After he was released from this voyeuristic compulsion, he was also able to tell me how it had happened in the first place. To my delight I even got to meet his old girlfriend after his apology and his explaining my role in the matter.

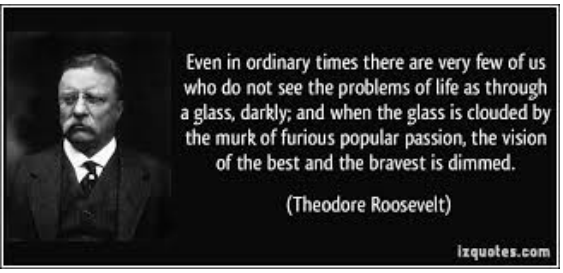
His former girlfriend wasn't the same personality type he was. His inborn temperament was ***aggressive***, whereas hers was ***withdrawing***. He was (now) a **RED** and she was potentially a BLUE (like Susan) and so she'd been a mystery to him. Gordon, as a schooled-in-the-world high school teacher, and was very popular with his students. His brash, impulse-driven swashbuckling a**ggressive** style was wildly similar to behaviour we in young underdeveloped prefrontal cortices from ages about 16 to 24. But he was divorced, and with two shared teenage kids they'd raised together, and he still lacked the slightest idea of what made his ex-wife or his own kids tick. He was lost! In a couple of explanatory words, he was *intersubjectively naive*. Does this mean dissociated? His voyeurism wasn't sexual at all. His ex-girlfriend had dumped him. He felt maltreated. And he was partially right. He'd let things be until she took a new lover, and could see them together from his bathroom window. When I visited him at home, I saw, every time he passed the bathroom door his glancing out the window at her nearby house. He was addicted. Yet he'd moved on to another girlfriend. What was going on? As he was a hair's breadth from losing his job I'd suggested **5-point ear acupuncture.**

But once he was free, he was able to tell me that he'd come to feel compelled to watch her interact with someone else (and not necessarily sexually) so he could come to understand why she'd dumped him.

This, in turn, explained to me why the "graduates" who gathered for the after-session were so keenly involved. Like Gordon, they had up-regulated to a state of *advanced intersubjectivity, as explained by Nobel Prize winner -* ***Ilya Prigogine****, whom you met during the session and will meet again further below.* The reader who is on the way to providing AcuDestress may want to read more about *intersubjectivity.* It has been explored more within the field of philosophy (by Edmund Husserl) but I will additionally suggest a neuroimaging **treatise on it by Marchetti and Koster**[24] *(neuroimaging being the way we will come to understand things in the future)* which suggests how we gain understanding of another individual, saying:

"...the specific way whereby neural self-other representations co-occur and exert influence on each other in order to promote higher-order functions necessary for social functioning remains largely unclear. We propose that the philosophical theory of *intersubjectivity* (Hegel, 1807/1977) could integrate neuroscience findings and, in turn, shed new light on the self-other dynamics at neurocognitive level.... How may Hegelian *intersubjectivity* inform our knowledge of the brain and, in turn, account for our social functioning? *Intersubjectivity* could shed light on recent neuroimaging findings by integrating two of the most active research lines in neuroscience, the **Mirror Neurons System (MNS)** and the **Default Mode Network (DMN).** "

As a result of my subsequent attraction to advancing *intersubjectivity*, using it as my explanation of the phenomenon of my patients rising to a level of higher brain/mind complexity, I was, in 1999-2000, able to apply my adult design to an *intersubjectivity-based* program for 10-19 year olds, which allowed them to understand each other in a way their immature prefrontal lobes couldn't yet do, which I named the *Young Canadian Leadership Challenge.* Seventy five percent of the young people who participated in it were able to enter a state of *intersubjectivity* by which their interactions with each other soared.



Gordon, in his evolved state, no longer was seeing life *"as through a glass darkly."* As was the promise in Chapter 4 , and as it had become the case for Theodore Roosevelt, it now was a matter of *"(Then) I (knew) in part; but (now) I … know (you) even as I am also known."*

[24] Marchetti I, Koster E: Brain and intersubjectivity: a Hegelian hypothesis on the self-other neurodynamics; Front Hum Neurosci. 2014; 8: 11. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3901003/