The Concept of Collapse In Psychotherapy and Bioenergetics

Stephen M. Johnson, in his book *Character Styles*, states that all character structures show both a *symptomatic or collapsed self and compensated or false self* in juxtaposition to one another. Each of these two states defends the underlying real-self structure, "which includes the archaic, real, and vulnerable needs of the child."(Johnson, 1994) He also states that this alternating pattern is most obvious in the oral character who often display a pattern of behaviour which fluctuates between these two poles in a cyclic fashion.
In his works, Lowen, uses the word collapse in dealing with a variety of character structures. He uses it to describe the body and energy of the masochist and in his work with the depressive reaction which "invariably follows the collapse of an illusion" (Lowen, 1975). According to Lowen, since "each character structure results from childhood experiences that have to some degree undermined the person's feelings of security and self-acceptance"(ibid) then in each character structure there will be images, illusions or ego ideas to compensate for this injury to the self. The particular illusions and the level of investment of energy in them will be unique to the personality of the individual and his life history. Thus the role of illusions and the concomitant possibility of collapse of the illusions resulting in a depressive reaction may be seen to be present in all character structures.
Although Lowen uses the word *deflated* most often to describe the Oral, the cyclical elation- collapse nature of this structure is vividly portrayed. It is also true that in his book Depression and the Body he states that "people who suffer from depression have unfulfilled oral needs" (ibid) which may determine their character structure. The oral character according to Lowen is not the most common type of neurotic character structure, however oral traits and oral tendencies can be found in almost everyone who presents themselves for analytic therapy.
In the book *Bent Out of Shape* (Michel, 1997) the word collapse is often used to describe various physical manifestations of the oral character. Michel advises that it is important to understand that *collapsed* in this sense is not simply a falling down of the body's structures but a deviation from the alignment which allows our bodies as a whole to stand in the field of the earth's gravity with the least effort.
Given all of the above information it seems pertinent in dealing with collapse to begin with an in depth examination of the oral character structure, its manifestations, etiology and treatment .

In his life the oral presents primarily as a person with unmet dependency needs .The character develops essentially when the longing for the mother is denied before the oral needs are satisfied. The unconscious conflict is between the need on the one hand and the and the fear of repeating the awful disappointment of not having them met on the other. What behaviours, attitudes, and feelings you will see in the person will depend on the severity of the oral issue and on the current effectiveness of the defensive structure. Since we are confronted with adult clients in therapy I will first describe what the adult oral looks and sounds like and then outline the etiology of this character structure as well as how to work with him in the therapeutic context.

Physical Description

To quote Johnson (1985) for the most part the bodily results of character development are a consequence of the self-negation process and to a much lesser extent they may also be reflective of the adjustment process where you present the image of your ego ideal to the world in the form of an adjustment mask. This is especially true of the more developed character structures.

Classic oral characters tend to be tall and thin. There are however oral characters who are rounded and more heavy set. Both Lowen and Michel (1977) , describe them as clinging like a vine which curves around the closest available surface. The oral's spine collapses downward developing exaggerated curves giving in to the force of gravity. Physically, the oral character structure is being pressed down (Michel notes that the derivation of the word depression is from the Latin meaning "pressed down") with more force than it can raise to stand up. They look as if slumping when viewed from the side. This is true particularly in the upper back area which gives the impression that a too heavy burden is being carried. They have thin skin which tends to bruise easily.

The head is thrust forward rather than being held upright. It is used to initiate forward movement instead of starting such movement from the ground. Orals have a strong desire to talk and take great pleasure in speech. This holding of the head in such a misalign position results in chronic muscle tension of the neck and head. Headaches or dizziness may result from any effort which produces a strong flow of energy to the head.

There is a tightness of the throat because of the misalignment of the head, resulting in the limitation for intake of food and air vital to the energy of the body, even though this misalignment actually expresses the longing for nourishment. Occipital tension may be present in the oral due to the need to hold back crying and sucking desires.

The neck itself tends to be long and thin appearing even longer if the shoulders are depressed or rolled forward.

The mouth may either be full as if it needs to suck or tight to defend against the needs. The jaw may be held in a retracted position, thus appearing underdeveloped, or it may be prominent and clenched, if the needs are being defended against. Michael characterizes the head thrust forward, chin pulled back pose as saying "Here I am! Take care of me! But I won't reach out for what I need."

In the oral there is always a strong ring of tension around the shoulder girdle and at the root of the neck. The root of the neck adjoins the upper edges of the scapula and clavicle and cannot be separated from the shoulders functionally.(Michel, 1997)

This results in either a falling of the shoulder ridge, and/or hunching, with both being fairly easy to detect. Michel describes five different ways in which this may occur . There are two important consequences of collapsed shoulders. One is that they clamp down on the upper chest and so prevent full expansion of the upper lungs and contribute to the collapse of the chest. The second is that the arm muscles cannot function with strength, and thus free movement of the whole arm is obstructed. Expression of aggression is inhibited in this way as is reaching out in longing.

The chest and shoulders are fixed in a collapsed position. The collapse of the chest is most visible in the upper part of the chest This collapsed chest affects the energy level of the whole body through limiting breathing. Breathing becomes shallow and does not

supply sufficient energy for the work required to meet the needs of the individual in life. The musculature is weakened by an oxygen supply that is inadequate for vigorous, aggressive movement. Lowen connects the oral's diminished breathing to deprivation in the first year of life. He feels that early deprivation of the breast, which provides both food and contact for the infant, results in a decreased strength of the impulse to suck and good breathing depends in his view upon the ability to suck in air. In therapeutic settings these are the clients who run out of steam quickly when asked to hit or kick. In life in general, they feel a lack of energy and tend to depressive reactions.

In some cases you may even see a client who has a chest so collapsed that there is a depression of the sternum. Although there are various physical explanations for the occurrence of "funnel chest", Michel posits that less severe cases of this deformity may be the result of muscular tensions associated with a collapsed chest during a childhood marked by oral deprivation.

The abdominal area of an oral at first glance may appear to be without much tone and to the touch feel soft and empty. However, chronic tensions here are an important feature of the oral structure. The long muscles which run vertically along the center of the abdomen are tense when palpated. This occurs because the collapsed position of the chest forces these muscles to contract and in chronic holding they become tight. This tension, in preventing the abdomen from moving outward, serves to severely limit breathing with the result that the abdomen becomes "undercharged".

The oral character experiences a lack of sensation in the belly which is often expressed as an inner emptiness.

Lowen (1972) writes: " When feeling is absent [in the belly] it is as if one didn't have any guts when it came to standing on one's own feet and taking a position in life." The oral character out of the "unconscious fear that there is no ground to rest on, nothing or nobody to hold or support him if he lets go"(1972 Lowen) holds tightly in the belly and so is unable to connect the upper and lower parts of the body, leaving the lower body undercharged. This lack of charge increases the feelings of insecurity. It also prevents the oral from letting down into the grief she needs to express over her early losses. The sobbing and screams of rage that the oral gave up, are blocked by muscle tension in the belly and in the chest.

The oral never feels fulfilled, carrying with them this inner sense of emptiness. Lowen points out that "to be fulfilled is to be filled full, and that means a full belly whether of good food or good feelings." (1972)

The oral is described as having a tendency to sway-back with the buttocks and pelvis held forward.. This position puts the back muscles under tension, making the act of standing a fatiguing one. Because the leg muscles of the oral are also weak, the spine muscles must do extra work to keep the body erect. There are tensions in the back between the shoulder blades and lower down at the lumbar vertebrae and the sacrum.

The oral is characterized as spineless. He can use neither the pelvis nor the shoulder girdle for aggression when the spine is weak and misaligned. His tendency will be to run rather than to face an attack . And under stress he will collapse into the helpless and hopeless stance of depression rather than move aggressively to change the source of his stress.

In the oral character, according to Lowen, the pelvis may be smaller than normal and this is a sign of physical immaturity. In women in particular this contributes to a childlike appearance. Once again Michel cites several reasons for this to occur, but she does concur that regardless of the etiology for the underdeveloped looking pelvis, the level of genital excitation will be reduced, especially in the classic case where the forward pelvis position will prevent charge and discharge. Lowen (1958) states that " the muscles of the pelvic girdle are as tightly contracted as those of the shoulder girdle"

In The *Language of the Body*, Lowen describes the legs of the oral character. The oral feels her legs to be weak and unstable. They tire easily when placed under tension, and when asked to do repetitive, forceful actions like kicking. There is a common fear of falling. The legs appear long and spindly. Coordination is below average, so control of movement is poor. This may be accounted for from inadequate usage of muscles during early development in response to a deprived environment, or from genetic or environmentally caused conditions.

The knees are locked in an attempt by the oral to compensate for the weak legs. This provides only pseudostability, making the legs more rigid and sacrificing flexibility of movement.

At the ankles one may observe oral collapse once more. The arches of the feet are usually collapsed into flat feet and the ankles and tops of the feet look as if they are falling toward each other. This is an outer appearance of collapse with chronic tensions in the legs that hold the ankles and the feet in this position. The feet tend to be thin and narrowed and have weak muscles. The weight is often carried on the heels rather than evenly between front and back.

So even though the oral appears to be collapsing toward the ground, the several misalignments in the pelvis, legs and feet actually result in a marked lack of groundedness. This marked lack of groundedness is a hallmark physically and behaviourally of the oral character.

In the oral, the peripheral areas of the body such as the arms, legs, head and genitals are undercharged due to underdeveloped muscles. These muscles in the limbs may feel thin and flabby as opposed to the schizoid's which are thin and stringy. Orals tend to look more rounded and softer than schizoids.

The oral has weak eyes that tend toward myopia. The typical expression in the eyes tends to be describes as needy, sympathetic, soulful even begging. They betray the true neediness of the oral.

Lowen writes (1958):"Energetically the oral structure is in an undercharged state. The energy is not frozen in the core as is the schizoid... it flows out to the periphery of the body, but weakly." The points of contact with the environment are undercharged in the oral and the muscles are weak, so that the core energy is dissipated as it travels along the muscular system. Vigorous body movements emanating from strong core feelings have been rendered impossible Lowen claims, by lack of support for the infant in the first year of life.

The oral character is also described by Lowen (1958)as "an unfilled sac" with enough energy to maintain the vital functions, but insufficient to fully charge the muscular system. This results in a person who does not feel strong desire.
The formation of the oral character is due to an immobilization of the aggressive drive according to Lowen. The infant fears expressing aggression and so does not develop the muscles. The adult oral fears being rejected by others if he reaches out and so rejects his own aggression. The chronic muscle contractions which immobilize any aggressive energy in the oral lack the armouring of the rigid because his need for acceptance and affection are too great .

Psychological Profile

Although not definitional of orality, episodes of depression always occur where there is a significant oral component. Depression may occur in any character structure, but depressions experienced by orals hit harder and are often accompanied by more exhaustion despair and longing than those of other character types. While there are some orals who exhibit only the pole of depression, generally, they show greater fluctuation than the other character types. There may be periods where the oral can sustain normal or even supernormal levels of activity according to Johnson(1985), but sooner or later, they all collapse into deep depression for extended periods of time.
As quoted above from Lowen, the oral is an undercharged organism with depleted life force. The mania is an attempt to deny this and to avoid confronting the underlying despair and longing.
Not having internalized self-caring functions, and depleting their meagre energy resources in periods of mania, orals tend to become ill a great deal. Illness is also a time when it is socially acceptable to receive attention and nurturing.
People with this structure have had to grow up too soon and unconsciously resent having to assume adult responsibilities and consequently have difficulty in sustaining adult adjustments to work, family and personal management. He may force himself to accomplish these adult tasks while secretly wishing to be taken care of.
He has trouble accepting responsibility for his failures, seeing himself as misunderstood, persecuted and unappreciated.
There is weakness in the abilities of the oral to be both assertive and aggressive. He can neither reach out for what he needs nor ask for it on the one hand nor can he refuse to give on the other.
Johnson(1985) sees the oral as a person who longs for life to come to him, but can not go and seize it for himself . He will resent it when it doesn't, but is unable to express his rage at this circumstance. This inability leaves him in a state of hyperirritability.
In *Language of the Body*, Lowen likens the oral to an unripe fruit separated too early from the tree and consequently sour and bitter missing the sweetness that full maturity would have brought to it.
Orals often overwork themselves until they break at their weakest point which physiologically is often the lower back.

Love relationships are problematic for orals. They can lose themselves in relationships when they are not well defended. They can dissolve into symbiosis seeking the perfect caretaking that they lost. In these cases the mate will complain that they feel suffocated, sucked dry and annoyed by the clingingness of the implicit demands for attention.
Because the life force is low sexual problems are common. The oral has a greater need for touching than for genital sexuality. For the oral commitment is equated with symbiosis and symbiosis meaning sameness destroys passion.
Orals fear loneliness and out of this fear may rush into inappropriate relationships.
Jealousy and panic attacks are fuelled by the oral's fear of abandonment, as is her own propensity to abandon others.
This fear of being alone may lead the oral to panic when separated from their primary attachment figure, especially in times when they are not well-compensated. They may be prone to problematic behaviour particularly drug use and dependent behaviour at this time. Johnson explains this by positing that orals have never really achieved the object constancy stage wherein they are secure in the representation of the constancy of the primary attachment figure and so still require transitional objects, especially those that make them feel better. Drugs both recreational such as alcohol, tobacco, cocaine and also caffeine and sugar may serve as these transitional objects.
The well defended oral will present as a superficially effective person whose basic needs are not being met. In denying and projecting his need onto others he will often appear as a nurturing generous and soft person. Or he may displace and overcompensate by the overconsumption of food, alcohol, drink, or drugs to alter the internal experience of loss, emptiness and despair. Or he may displace his need for love from people to a need to be surrounded by material objects, or a need to be the centre of attention, buying into the cultural myth that these will fill up the emptiness within.
The oral may use the defense of reversal transmuting the infantile, bitter narcissistic self into something that receives more support from society, such as exaggerated nurturing or exaggerated responsibility(even though there will still be unconscious demand and unconscious resentment here).
In the case of a well-established and supported false self , the real self may emerge only with a serious illness or injury.
The oral maintains the compromise that is the false self by contracting against his own need and turning against himself the anger that belongs to the abandoning parent. Unlike the schizoid, the oral experiences the self-hate less as an alien force which overcomes him and more as a conscious loathing of the weak and dependent person he feels himself to be.
There are similarities between the issues of the schizoid and the oral as well as a tendency for those with oral issues to have some schizoid and vice versa. Both have primary difficulty in the attachment process and then have difficulty with later attachment.
Both tend to be weaker, more vulnerable and less well nourished than the character types that are created later.
Johnson(1985) feels that in treatment of the oral it will be key to understand the oral's ability to reverse, displace or substitute one object or drive for another. And to understand that the oral's problems tend to be cyclical with a shuttling between COMPENSATION

AND COLLAPSE, neither of which represent the real self but are defenses of it. The oral is attached to his defenses particularly the elated or compensated phase of his mood swing when he is more difficult to reach and help. He is also difficult to reach in the collapsed stage when all feeling has been shut off.
One way or another with the oral we often feel that nothing will ever be enough and that they are truly a bottomless pit.

EXPRESSIONS OF ORALITY

	Collapsed	*Compensated*
Affect:	Depressed or Lonely, despairing and longing	Conscious: Good to elated to manic euphoria Unconscious: Resentful, enraged, despairing and fearful of loss
Behaviour	Withdrawn, self-absorbed, irresponsible, dependent or *Reaching for help	Overly nurturing of others, Takes on more responsibility and independent action than can be sustained Makes plans which are optimistic to grandiose, or unrealistic Charged with ungrounded energy Cares for self poorly- poor diet and sleep habits, overworks plays too hard, excessive drug use
Cognitive	Helpless and victimized or *Motivated to change	Conscious: Optimistic to grandiose Preconscious: "I am sweet, soft, g and entirely giving Unconscious: Self-deprecating, "If I need, I will be despised or abandoned

The asterisks denote the position from which change can be initiated. The collapse into physical illness and depression can occur for the same reasons and is sustained by the same secondary gains or payoffs. In addition Johnson notes(1994) depression also serves the function of defensively suppressing the oral's aggression, hostility and much more intense but real grief at deprivation and consequent loss of the self that she feels. In the oral, both compensation and collapse the task as therapist is to relax the defense and transference so that the hidden feelings are expressed toward their real target. Though simple in formula, this is complex in the execution, due to the resistances in the defenses and the need to work through the interpretative links repeatedly. I will return to this information to discuss the purpose and use of collapse after a presentation of the etiology of the oral structure.

Etiology

We have described the collapsed and compensated features of the oral ,and now will attempt to answer the question of how this structure arises.

Writing at a later date than Lowen, Johnson cites that recent psychoanalytic theorizing emphasizes more the interpersonal relationship and mother-infant attunement as does the developmental research which make the oral label out of date as far as regional specificity implies, but still appropriate if understood metaphorically.(Johnson1994)

Clinicians have found that with those patients who present with problems in the "need constellation" there is a history marked either by a deprivation or unreliability in the need fulfilling capacity of their parents. There is an impression with the severely oral patient that they have never really been thoroughly filled either nutritionally or emotionally, that their needs for nurturance and touch are incompletely met. The defenses used by these individuals are rather primitive from a psychodynamic perspective.

Every human infant needs a single emotionally available caregiver capable of eliciting and maintaining a firm healthy attachment. Orality arises where the infant is initially wanted and an attachment is initially formed, but then the nurturing becomes sporadic producing repeated emotional abandonment or where the primary attachment figure is literally or figuratively lost and never replaced. For many orals there may be a history of depression, alcoholism or extreme circumstances such as disease, economic stress .

Symbiosis is begun but never fulfilled and therefore never really resolved, there is no secure confident expectation established.

According to Bowlby (1973) noted a three stage reaction in studying children separated from their mothers: first there is an acute protest by the infant, next the child falls into deep despair, last there is a superficial adjustment but detachment wherein the child responds to the mother's return either by not recognizing her or retreating from her followed by a period of ambivalence toward her. Johnson(1985) hypothesizes that the infant would find chronic upset too difficult to live with and so finds a compromise, looking for ways to cut off his natural organismic self-expressions and thus stop the pain. Thus the self-negation begins "If I don't need anything then I can't be frustrated." This rather stoic position works in the short term but given the dependent position of the infant is rather unrealistic. Other manoeuvres are necessary to complete the compromise.

Between 6-9 months of age the primary anxiety of the child shifts from fear of annihilation to the fear of the loss of the caregiving object. At this time new defenses beyond denial, projection and introjection become available to him. These new defenses include, identification (the process by which one blurs or eliminates the distinction between the self and others by extending his identity into another, borrowing his identity from another, or fusing identities with another), displacement (the process by which the direction of feeling is transferred from one object to another-the substitution of one object for another as the target of feeling), reversal (in classical analytic theory this is an instinctual vicissitude by which an energetic expression is reversed to its opposite. Through this mechanism hate may change to love, sadism to masochism and longing for an object to rejection of that object. Reaction formation is a defense mechanism that is based on this process) and turning against the self(Another instinctual vicissitude described by Freud[1915] which is used to explain the phenomenon often observed in obsessional

neuroses in which a person directs his hatred inward against himself. The desire to retaliate becomes the propensity to self-torture) (Johnson 1985)
The first step the infant takes to develop his defense against the pain of needs unmet is Denial of the need. The person literally contracts against his own need by limiting his breathing, activity and output of energy. If he puts out less then he needs less. He chooses depression over expression which results in a low level chronic depression that is defintional of the oral character.
It is often the case that while denying his own need there will be attempts to nurture the insufficient caretaker. Johnson cites research that this occurs very early- as early as 10 weeks infants show differential responses to joy, anger, and sadness displayed by the mother and by three months, children respond differentially to another's depression as expressed by facial features and voice cues. By nine months they can demonstrate attunement through crossmodal matching to the mood state of the mother.
Because the needs still exist the infant requires further mechanisms that either bootleg the gratification of the need while denying it, or controlling the natural rage which the chronic frustration has produced. All of the four above defensive functions rely on the individual's ability to substitute one object with another(denial, ident., dis., turning) or to substitute or replace one feeling with another (reversal). Regardless of the defenses chosen to resolve the conflicts, the child moves prematurely to individuation. Talking early and walking early in an effort to gain attention and provide independence from one who cannot give what is really needed are typical of the oral child .
Also, as the child enters the second phase of individuation there is a manic time of natural grandiosity and narcissism that allows for the escape from the despair and sets the stage for the manic defense that characterizes many an oral character.
The oral gets caught between the despair of the unfilled emptiness, and the fear of exposing it and subsequently being abandoned for being too needy and so collapses into depression. In order to exist in the external world, he acts out his fantasies of oral fulfilment by overconsumption of food, drink or drugs as he tries to recapture the sweetness of the nursing experience or he may turn to the fantasy of the good life of security. Because these are illusions, as are all the compromises he tries including finding someone who needs him (this person may eventually grow out of the dependency) he will eventually collapse back into the depression of despair.
This blocking of the need impulse and the ensuing compromises and internalizations that occur will be highly resistant to change due to the fact that they were "forged in the crucible of painful deprivation."(Johnson 1994) The belief under all of this, as for any character structure, is that releasing the block and experiencing the need will lead to repetition of the disappointment and deprivation and unconsciously that failing to meet the needs of others will lead to abandonment.

Working With The Oral

In working with the oral a useful metaphor for the self is to picture a huge cross with grandiosity-inflation and collapse-implosion as the vertical axis and their concept of the all good or all bad self as the horizontal axis. These extremes and paradoxes are all present with this structure as in no other. In Jung's terms the goal of individuation is the ability to hold all of the extremes at once somewhere closer to the middle or balance. this will be the therapist's goal.

This work will be done in stages. In the first phase of therapy the therapist will be the observing self that will eventually be activated within the client. All of the early work will involve the grounding and building of the ego so that it can become the container to allow for the understanding of the history and development of the defenses which in therapy will be experienced as resistances.

In *Depression and The Body* (1972) Lowen states that we must acknowledge that oral needs unsatisfied in childhood cannot be fulfilled in adult life. As an adult the client must be helped to find the security inside himself. We cannot fill what was not filled for the child or reverse the past. To effect and support this both Johnson and Lowen see the need for a change in the person's experience of their body so that the feet and legs are seen to be supportive, and the body as fully able to breathe and relax and let go of chronic tension. We can, through regression, assist the client to feel the depth of his despair and to confront the unconscious infantile fixations and thereby to help him function more fully as an adult. Although Johnson also sees that this is the critical goal for the oral. He recognizes that since the oral person will be threatened by the emergence of his own neediness this will not be the place to begin.

In working with the oral character both Lowen and Johnson agree that the environment must be made as favourable as possible. Johnson (1985) states and Lowen (1958)concurs that the single most valuable response to the oral initially is to hear and acknowledge their pain and frustration and to acknowledge its reality. It is in this way that the abandoned child can be reached affectively. To the extent that there is a serious oral issue, the person has been trying to live an adult life with the emotional maturity of a12-18 month old child. Johnson holds the position that these complaints will eventually grow, in therapy to deep despair at the chronic disappointment of unmet needs. The oral client is typically a very sensitive individual who requires the therapist's attention and sympathy. Lowen also states that the oral character changes to the degree that his adult functioning improves. It is his belief that the character analysis must be done systematically and concurrently work on all of the muscular tension.

Lowen begins with the legs, strengthening them through special exercises bringing more energy down to the feet. He sees this work as primary and continuous throughout the therapy since Bioenergetics is oriented from the ground upward. Next he moves to release the tensions in the shoulders through reaching and hitting. The throat opening needs to be enlarged so that more energy can be taken in through breathing. The ultimate end of all the body work for Lowen is to increase genital feeling and the ability for genital discharge. His belief is that as genital charge increases so too does the charge to the head and thus a better perception of reality is possible.

If the ego is in a state of inflation he believes that it must be gradually deflated. He states that no permanent or substantial change is possible until the client reaches "bedrock".". He stresses the importance of keeping the client in contact with reality in work and love. The analytic process requires that the patient be brought into awareness of his problems and that his own energy be mobilized to effect their solution. He acknowledges that there is no substitute for the analyst's intuitive feeling for each patient.
Lowen feels that it is very important to make a character diagnosis before one treats a neurosis because it gives a knowledge of the total picture and that once a character structure is delineated, the client will recognize and understand his own resistances.

I find Johnson's work to be more accessible and more fully outlined . He states that although there will be great resistance to accessing the deep rage present in the oral, the resentment and irritability are usually readily available and they can be used to eventually uncover the rage. Throughout the release of all of these feelings the oral will experience fear of rejection and abandonment.
The oral must also develop understanding both literally and figuratively which translates into **reducing the chronic tensions in the arms and legs** and working on **grounding** exercises. Strengthening the musculature and accompanying sense of solidity will assist in the growing up process. Grounding **exercises** using a **dowel with** the feet and exercises to **develop and release energy through the ankles (1985, 98-104)** are recommended The typical oral character can spend a good deal of energy and time on the simple **bioenergetic forward position** which will increase his grounding and strength in the legs. Body work in general is extremely useful to the oral in periods of collapse to bring movement and life into the body. A few additional exercises for **grounding and loosening** the typical areas of contraction include:
Standing on One Leg (alternate legs paying attention to the foot's contact with the floor, or vary with the basic bow shifting weight from one leg to the other holding on each leg for as long as possible)
Putting The Foot Down:(Stomping, change angle of foot hitting ground. may add verbalization such as No or I won't!) ,
Squatting against The Wall :(squat with back flat against the wall. Cup your hands behind your head keeping breath full and open. Builds up good charge in the legs. good for self-administration)
Jumping: (in any number of variations, improves grounding and other sensory experiences-like a protesting child, jump high, land flat footed for experience of solid ground; lean back on heels and try to jump-gives idea of pushover position of oral; jump and return lightly from toes to give experience of taking a leap; jumprope or trampoline work)
This grounding and general strengthening will enhance the experience and expression of the natural hostility as well as strengthening the natural and healthy aggression and assertion. As this strengthening occurs a body therapist will then release the various tensions in the lower back, abdomen , shoulder girdle, base of the neck and jaw. As well

there will be work to open the chest,, the breathing, and the energy flow through the throat.
For **loosening chronic tension** Johnson outlines exercises such as the **Windmill (**arms are circled individually forward and backwards), **Reaching Up (**palms turned up with arms out at 45 degree angle, may lead to clenching of fists and bending elbows to pull for anger), **Upper back stretch** (three yoga postures which bring considerable stretch to the longitudinal muscles between the shoulder blades and the neck), **the Roller** (lay with upper back stretched over it and arms extended backward over the head), **the Roll** (similar but using only a rolled up towel or blanket)

Like Lowen, Johnson feels that this work on the body will begin to elicit the suppressed emotion without any other work on the content. With the strengthening , grounding and freeing of the body and the opening of the natural flow of energy through it and the release of the suppressed affects the oral person may begin to emerge and mature.
In terms of attitudes and beliefs it is most evident in the oral that the conscious attitudes and beliefs are the polar opposites of the unconscious attitudes and beliefs. The therapist's job here is to assist the client in identifying this polarity and developing mental, understanding, insight and knowledge about the self. The oral needs to realize that she prematurely contracted against her own infantile nature and developed a compensatory false self that offers others what she did not receive. She needs to see that this is actually psychically an attempt to obtain nurturing either directly or indirectly and consequently is experienced by others as a demand.
She may be helped to see how she creates her own abandonment in relationships and to develop insight into her script decisions (I don't need, I have to do it alone. if I need I will be abandoned.) And just how these play into situations which then justify her defenses. She needs to accept that with her undercharged system her infantile nature eventually asserts itself causing her to collapse into dependency and clinging which will drive others away and to recognize that her unconscious demands for unconditional total acceptance are inappropriate in an adult. These all will lead to the abandonment that is feared. This leads to collapse and then to compensation again and so the cycle continues. It is the role of the therapist to provide insight into this cycle and thus to begin to dismantle the defenses of denial, projection, introjection , reversal, identification, turning against the self and displacement.
For Opening the Need and Longing
This could be done directly after a basic warm up or charge building session. Have client lie down on mat on his back and kick vigorously for a while. Then to slowly breathe deeply, relax and then reach up slowly as if to embrace someone that they imagine, saying the words "I need you". This will arouse resistance and tightening in most orals. You can then have them identify with the resistance .
Usually, if there is no resistance, this will either release feelings or uncover other feelings such as despair at the abandonment, rage or fear of future abandonment. This presents an opportunity for release, remembrance and analysis. The therapist's job is to deepen the release as well as the insight around it. Where resistance is met, the therapist's job is to

help the client identify with the resistance, appreciate its function and ultimately release its grip so that the actual experience can be had.
Johnson feels that with these changes in affect and cognition there will almost naturally be a change in behaviour which can be augmented by a therapist who can do this directly. He offers suggestions for strengthening the transfer of the direct expression of reaching out and asking for help to the person's social relationships by **future pacing,** or actual **assertiveness training.**
Johnson (1994) suggests that the therapist while being ever mindful of the need for continued acceptance and support can explain, challenge, confront, interpret or otherwise undermine the defense system which keeps the cycle going. This is seen as particularly useful during the hypomanic phase of the oral's process if used in combination with physical grounding strategies.
It will be important throughout this process to reaffirm the oral's right to need and to strengthen the identification of the self with those needs. A central cognitive objective will be to affect the ambivalent experience of the self such that the client is aware of his real issues and similarly cognizant of the difficulties with which he must deal.
There is a fundamental solidity in coming from the true ground regardless of how infantile or despairing that ground is. No more energy need be wasted in maintaining an illusion of false hopes that are never reached
The behavioural and social objectives with the oral include helping him to learn self caring behaviours, strengthening his ability to reach out and ask for help or what he needs in all relevant social relationships, developing his aggressive and assertive nature to set his life up in a way that serves him best. He may need to learn strategies for coping with the realistic demands of adult life. These may include sticktoit -ness , mutuality and adult-adult forms of relating which are individuated as opposed to dependent or co-dependent, regulation and conservation of energy cycles, staying in touch with his body, and using direct techniques to experience his real feelings rather than collapsing into illness and depression.
The oral must learn to stop abandoning herself, denying her needs and her natural reaction to needs unmet. She must learn to care for her own abandoned child and stop looking for the lost mother.

A proviso for therapists comes in Characterlogical Transformation (1985) in that to the extent that you are denying your own neediness you will find it difficult to encourage and support the oral in dealing with his neediness By their very nature counselling and psychotherapy are natural draws for compensated orals. In her compensated phase an oral therapist will have difficulty in helping the client to acknowledge and support his own level of neediness, while in the collapsed phase the oral therapist runs the risk of using the client for support and fostering a dependency which will retard the client's adult growth and individuation.
In the early affective work Johnson uses a technique whereby he encourages affective expression while staying tuned for the emotion that seems just below the surface and then guides the flow of the interaction to pull for that affect(1985, 196) being careful to maintain the supportive nature of the therapeutic context. This can be done by gently

calling his attention to that moment or when client's have been in treatment for a while to use more vigorous body therapy techniques. The client could also be asked to identify with the resistance and give voice to that part that resists the recognition and expression of feeling. There is an outline of an alternative process called Schiffman's Hidden Emotion process which has much in common with Gendlin's focusing process, although with a slightly different outcome emphasized (1985, 198-200).Since the oral persistently deceives himself with his feelings to maintain his denial and the believability of the false self this is seen by Johnson to be a particularly useful process. This early affective work can provide both relief and the beginnings of insight for the oral.
Self soothing is a concept that is important for the oral to learn. This can be accomplished both at a conscious level by simply discussing this concept and suggesting or even prescribing self-soothing activities. Here hypnotic skills are seen to be very useful in reprogramming attitudes around this context. Johnson gives three strategies to indirectly suggest self-soothing (1985, 203-205)
The second of these processes he learned in a bioenergetic training experience which he added to in working with a client.
One basic problem for the oral is that he is unable to enjoy nurturing from himself or from others or to relax even during his eventual collapse. He can not let down because there is always guilt associated with getting what he wants, so any manoeuvre that will assist him in really relaxing and enjoying that relaxation will help him a great deal in satisfying the unmet needs and in strengthening him to meet the responsibilities of adult living.
Johnson posits that as safety and relief from collapse are experienced it is common for the grandiosity of the compensated phase of the oral to take over. If a sufficient trust is built up at this point, it will be possible for you to begin to gently deflate the inflated ego. The most ground will be gained if you can assist the client in discovering his pattern for himself. this may be done directly by asking for recall of a time when a similar level of excitement was experienced and then ask him to remember the sequence of events which followed this period of elation. Many orals do have plans that would be realistic for a reasonably functioning individual. The problem is that they do not possess the level of energy necessary to carry them out.. Such goals will become more attainable as the cycles of high and low even out. There may be some unconscious element of setting up a fall here, for though the oral consciously wants to stand on his own two feet, unconsciously he may be afraid to do so for that would mean giving up the hope of ever getting what he missed . Each time he must be encouraged to feel and mourn his real loss and from there to move on to get what is possible. One way to assist with this is to have the client in the manic phase explore the ways in which he might sabotage the positive present. After time this may bring awareness to him .
The manic phase is also a good time to encourage him to use his energy in maintaining his existing commitments to family, work etc. you want to encourage him to understand himself as he is rather than just raining on his parade.
There are many active techniques comprised of simple body exercises that are useful with orals. Whether he is in his compensated phase when he is flying off the ground or collapsed state when he has buried his real feelings he is out of touch with his real feelings

and is ungrounded. You will need to offer support and encouragement to overcome the resistance to the effort and to do whatever you can to produce release and relief for him.

Collapse

When the oral collapses into her need and longing she begins to take responsibility for reaching for help and is then motivated to change. The responsible position , albeit a needy one is the place where real movement can take place.
When the oral character is feeling unable to cope, overwhelmed by responsibilities and beaten down by the circumstances of life, this can be a useful time to encourage collapse. Most oral characters resist collapse while complaining about it. Johnson suggests that you encourage the oral to collapse hypnotically and physically as well as directly and consciously. In fact, encouraging the oral to collapse may constitute a large portion of the therapeutic intervention, lead to core hidden feelings of despair and loss, and ultimately to the oral's acceptance of the original loss. This will help to eliminate the pull to create the past loss in the present
The periods of collapse for the oral are also times to encourage the experience and expression of the resentment felt at having to do what is really too much for the undernourished person. This can be done by a simple interview technique or by using bioenergetic techniques and therapy. After a warm up exercise period or direct work to release the areas of chronic tension have the client, either hit or kick until exhaustion is reached using some simple statement like "It's too much or I won't ". As the process begins to work there will be a complete breakdown , usually into tears followed by a period of deep relaxation. At this time the most helpful response from the therapist is to silently stay with the client and support the collapse despair and the eventual relaxation. Avoid rushing into more cognitive interventions, stay with the feeling for as long as necessary.

Exercises To Encourage Collapse

The Forward Squat Position: Client comes down into a squat posture, have him continue to breathe in as he bends his knees a little and breathe out as he comes up but to stay in the squat position. Hold the position for as long as possible before eventually falling forward. Near the end of the exercise you may ask the client to reach out and to ask or yell for help. Suggest to the client that he says I give up when he collapses. It is useful to make some contact especially in the lower back area but remain silent and just be with the client in his experience

Standing On One Leg: A number of variations are possible. have client standing weight on one leg with it considerably bent. may add reaching out and asking for help. Always end with physical contact as above

Lifting Both legs While Prone: Client lies on back on floor (or on a mattress), lifts both legs in the air as high as possible, pointing the heels at the ceiling. hold until collapse occurs.

Towel Twisting: Client stands in well grounded position and grips towel with both hands and wrings it in front of him with the words "Give it to me". At its most successful, this leads to a collapse into that demand, accessing rage and then despair.

In his panic of loneliness, jealousy and fear of abandonment the oral is actually closer to his core than at during elation, compensation or the coercion of support. In beginning to deal with this issue, which Johnson sees as a variant of the classic separation anxiety, he frequently employs object relations theory and child development as an analogy to explain the situation to the client.(1985, 229).There are many paths that can be used here including to explore the etiology and access the core terror and abreact it using the **persistent problem** exercise(1985 87 -90) in which the client engages in an exclusively internal exploration, or direct bioenergetic or gestalt methods of accessing and releasing held in emotions. Many of the collapse exercises outlined above will be applicable. The oral needs to realize both cognitively and affectively that he is and always has been alone. while there is support available he can never undo what was done nor ever recapture what was lost.
Usually a real, felt collapse into the reality is too painful for this weakened and unsupported organism. He needs to feel sufficiently strong and supported to make this choice.

The final issue is one that must be faced by all character structures, but is more obvious in the oral , that is the integration of the compensated and collapsed selves. One method offered here is a derivative of the **Gestalt "empty chair"** technique and labelled in **NLP** terms as the **"two part reframe"** and relies on the useful fiction of dividing the self into two parts just as does the Oral Collapsed/ Compensated chart presented earlier. The two part reframe begins with the client accessing each of these two parts (often but not necessarily done from an altered state) and developing a complete auditory, visual and kinaesthetic representation of the two parts. The client is asked to picture one part in one chair and the other in the other chair. the client is then asked to become aware of the beneficial intention or purpose of each side of the polarity. Typically, collapse serves a purpose which in the oral is to get the needed rest and to escape the exaggerated demands of the compensated part. At bottom, the collapsed part wants to rest, play and protect the self from the exhaustion and self-denial which is imposed by the compensated part. Finally the collapsed part wants to be taken care of and if this is not available then to express the resentment and rage of the original loss. The compensated part wants to be seen as making it in the world and attract love and admiration.
The client works toward acceptance of each part of the basic intention of the other part and both parts are asked to agree to cooperate on the realization of the mutually accepted

purposes. The parts are then requested to come together and at a point to unite. Last the client is asked to future pace the experience in relevant life situations.
We cannot eliminate parts of ourselves as they express some positive intention and so must be appreciated and integrated.
The healed oral will more and more be able to completely relax and to surrender to his need for collapse and more accepting of his limitations in life. She must experience herself as powerful enough to be vulnerable.
To quote Johnson (1985,242)"In the oral case , perhaps more than in any other healing will with the integration of the key polarities- weak- strong, nurturing-collapsed, and give-take. With this integration accomplished, living a realistically rewarding adult life becomes possible."

Masochist and the Depressive Reaction
I will now briefly deal with collapse as seen in the masochist and in the Depressive reaction
While Orality, according to Lowen, is produced by deprivation and characterized by the unconscious 'I can't", Masochism has its origin in experiences that overwhelm the ego of the child , the aim of which is to have the child become submissive to the mother's superior knowledge and wisdom. It is characterized by an unconscious "I won't". There is a tendency to collapse when inner or outer pressures increase. Lowen sees it as being produced by a mother who is over protective, oversolicitous and overwatchful
There is a failure of the energy pulsations to anchor in the head and genitalia. The genital function is not overdetermined as in the rigid, nor conditional as in the oral, rather it is hesitant as is the whole personality. It is formed by a pattern of advance, retreat, effort and collapse which over time becomes a pattern of repeated failure. There is a fear of self assertion. Lowen believes that most orals will have some degree of masochism and most masochists have some degree of orality. While the ego of the oral is more or less empty, the ego of the masochist is viewed as crushed. Where the oral feels pressure in some situations such as before meeting a situation, the masochist feels under continuous great pressure. The oral will go into a depression that lacks energy, whereas Lowen sees the masochist as falling into inertia or a morass where there is still energy present but blocked. Lowen sees the true masochist as one of the most difficult therapeutic problems because there is so often a relapse into old problems after a superficial improvement, which he calls the "negative therapeutic reaction". He also suggests that the masochist has the greatest degree of negative feeling of all character types. But while masochists tend to be more conscious of negative feelings and to feel and express negativity to a greater degree than other character structures, they also deny how much negativity toward others they express through their complaining. The masochist accepts reality at the same time that he fights it. From Reich's Character Analysis(1972) " the salient emotional and behavioural traits of the masochistic character...." subjectively, a chronic sensation of suffering, which appears objectively as a tendency to complain; chronic tendencies to self-damage and self-depreciation... and a compulsion to torture others which makes the patient suffer no less than the object. All masochistic characters show a specifically awkward, static

behaviour in their manners and in their intercourse with others, often so marked as to give the impression of mental deficiency."
Lowen after quoting the above in Language of the Body(1958)describes the typical heavy set , muscular appearance of the masochist's body.
Michel (Bent Out of Shape, 1997) sees the unifying concept underlying both these emotional/ behavioural characteristics and this body type as the masochist's subjective sense of always being under great pressure. His body is seen as looking as if it is compacted from both above and below. And he expresses emotionally and behaviourally what he feels physically- that he is being pressed upon.
The masochist, unlike the oral, is a high energy character with powerful muscles and plenty of energy . He stays stuck, because he is unable to release this energy in an assertive way. His affect can be aroused, but the charge becomes stuck between antagonistic muscle groups. His limbs both express aggression and inhibit it..
The masochist experiences great anxiety as a consequence of being near to the point of releasing her aggressive impulses, which she experiences as a fear of exploding. In a state of anxiety the muscles contract against each other without relaxing (Valium is actually a muscle relaxant!) The muscles are strong but tightly strained and can lead to real and chronic musculskeletal problems. Michel finds from this alone that it is no wonder that masochists suffer so. She also points out that it is the blocked aggression that prevents the masochist from being able to express his tender feelings as well.
While the oral lacks the ability to work hard, the masochist must work harder than she actually needs to in order to get the task done because she must push against the obstacle of her own musculature in order to get things done.
The masochist's physical appearance even when she stands still possesses a gorilla quality, for the back is usually somewhat rounded, the neck short and thick, the torso broad and the limbs well muscled. There is a shortening of the whole torso as a result of the curve of the upper spine and the contraction of the buttocks, pulling the pelvis forward. There is a subtle folding at the waist which contributes to the heavyset appearance. Even when there is a good deal of fat present the masochist retains a squared off strong shape from different from the pear shaped oral with its collapsed shoulders and chest
The subjective sense of suffering and conflict and the self -destructive behaviour which torment the masochist can be seen to emerge as logical manifestations of their physical structure (Michel, 1997)
Lowen (1958) has a striking image for the masochist's body structure: it looks as if huge pliers have been applied to the two ends of the body where the overcontrol occurred, compressing the body between the neck/shoulder area and the pelvis. Within the two ends of these pliers, the masochist's aggressive drive is bent inward and redirected from the outside to his own self. In the process, his tender erotic feelings are also compressed "between the arms of aggression". When the masochist struggles to release his erotic feelings from this bind, he fails and collapses.. The masochist feels as if he might burst, but it is not possible for him to release his tension in a forthright and satisfying manner. He has developed a strong and harsh superego to keep his hatred and spite from escaping. In order to discharge her own negativity, the masochist must provoke others to anger

through whining and blaming. Only then can she release some of the internal pressure and the tense musculature

The masochist has a strong need for approval by others that has undermined her independence and caused her to adopt a submissive servile attitude, while feeling inside negativity, spitefulness, hostility and superiority to those whose love she is trying to win. She must block out these feelings for fear of exploding violently under the pressure she feels.

Relating the masochist's feelings of humiliation and worthlessness to the physical structure Lowen writes that they lack "backbone feeling" and the feeling that they can stand up for themselves. Again the picture of the pliers is brought to mind , creating difficulty in maintaining an erect posture.

Though at first glance the masochist's body gives an impression of strength the pressure is even greater than she is and she will collapse despite her muscular strength. Without erect posture and "backbone feeling", the masochist functions on an intestinal level and feels unconsciously like a worm or snake that belongs on the ground, unable to stand erect.

The masochist's negativity and spite are expressed from this position of feeling lowly and humiliated. He is stuck in his morass. He feels despair and hopelessness. He always looks to others on the outside to release him from his suffering and so feels helpless. Yet he distrusts both others and himself and his own actions.

The therapeutic approach to the problem of masochism Lowen sees as a many sided one. "At all times the sympathy, understanding and support of the of the analyst must be held out to the masochist the face of his repeated failure, hopelessness, distrust and antagonism to the analytic therapist." While at the same time, one must not allow him to throw the burden and responsibility for his condition onto the therapist."

In this you must balance sympathy and critical analysis.

Next, one must dissolve the spasicity of the muscle system, and free the blocked movement . Then, eliminate the ambivalence between the aggressive and soft feelings and achieve some degree of instinctual fusion.

As Johnson sees it in *Character Styles*, the treatment of choice is to utilize the client's natural human reactions to begin the liberation of his aggressive, spiteful shadow side which may be all that is even potentially available of this person's suppressed life force, exuberance, wilfulness and all other authentic feeling. He acknowledges that this is much easier said than done. You need to welcome the resistance and acknowledge it for it's survival value, as this may be all that is left of the real self.

To be helped, the masochistic character must truly experience a major shift in identity and orientations

.Very briefly you will need to work through the abuse, the intrusion , overpowering and the breaking of the will that the child experienced. Claim, own and aim the resultant anger at the appropriate source and thereby tame it. Here the direct release procedures of Bioenergetics and other expressive therapies can be most useful once there is insight and commitment . IT IS IMPORTANT TO UNDERTAKE THESE STRATEGIES IN A WAY THAT MINIMIZES THE PULL FOR POWER STRUGGLES AND AUTHORITY BATTLES.

Finally, if the masochist is ever to transform, there must be behaviour that is an expression of the hope that has been lost. You must realize that you are either implicitly or explicitly asking this person to trust.
The therapeutic test here is to act differently from the manner in which the client reacted when his ego was being suppressed, and to react differently then how others typically react now.
The therapist must not give up, nor must he act out his anger at the client's self- and therapist defeating behaviour . With this type of client more than any other the therapist's commitment to this process of traversing and interpreting the past to present connection, paired with a relative detachment from the outcome will be necessary to effect any change

In concluding we return to the opening statements of this paper by Stephen M. Johnson, in his book *Character Styles* which contends that all character structures show both a *symptomatic or collapsed self and compensated or false self* in juxtaposition to one another. And that each of these two states defends the underlying real-self structure, "which includes the archaic, real, and vulnerable needs of the child."(Johnson, 1994) According to Lowen, since "each character structure results from childhood experiences that have to some degree undermined the person's feelings of security and self-acceptance"(1975) then in each character structure there will be images, illusions or ego ideas to compensate for this injury to the self. The particular illusions and the level of investment of energy in them will be unique to the personality of the individual and his life history. Thus the role of illusions and the concomitant possibility of collapse of the illusions resulting in a depressive reaction may be seen to be present in all character structures. Lowen states (1972) that we should not be afraid to surrender for we are surrendering our bodies to the earth, to life. We are surrendering to the only force that in the final analysis can sustain us.
Johnson outlines what this could mean in the some of the character structures. He finds collapse a very useful term ,or he states (1994) that it is the individual's *particular* collapse into the underlying emotional reality that reveals the nature of the early developmental injuries and resulting characterlogical issues. He sees the false self compensation as the ego's best adaptation at the time of the original injury to survive, maintain contact, retain love, and formulate the self. When the compensation fails and symptomatic defenses dissolve, the primary anxiety of the developmental period at which the false self was begun will resurface.

For the **schizoid** :this will be literal fear of annilhation. the belief is that if the false self dies the being will die or be killed. The schizoid with an observing adult ego abilities will see the irrationality of this but still will experience the extreme threat to survival
The oral : will in periods of severe depression experience himself as extremely weak, needy and distasteful and fear the desertion of any attachment objects. The core fear is the loss of the love object

The **symbiotic** character:(posited between the oral and the narcissist, called the owned child I am nothing without you) triggers similar fears of loss of love object and concomitantly and frighteningly the loss of the emerging self. Symbiotic knows who she is only in relation it the attachment object
The **narcissistic** loss of false self amounts to the loss of the ability to manipulate the environment and be in control, brings up fear of being humiliated and used again
For the **masochist** the loss of false self reveals his inability to release his energy and the core fear of being overwhelmed.

Collapse can be seen then to serve several purposes for the client and the therapist. For the client, it provides, at times, a rest period from the demands of the compensated self and serves often as the impetus to enter therapy, as well as being the bedrock from which the real work can begin. For the therapist, it provides valuable cues to the underlying nature of the early developmental injuries and resulting characterlogical issues which must be dealt with to help the client to regain his real united self once more.

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