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Symptoms, Feelings, and Inner Movements

Reaching out, turning away – primary and secondary feelings, feelings taken over from another, and meta-feelings

By Dr. Ursula Franke, Munich, Germany

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In searching for the relevant events and individuals in a family system, we look closely at the connection between symptoms and the psychic structures and track two contrasting movements for diagnostic clues. These are the movements of reaching out and of turning away. These movements reflect structures we learn usually very early in life in contact with others, as well as the coping mechanisms that we have developed for dealing with those contacts, both within the framework of our family and subsequently in the course of our life. They have utmost importance for our capabilities for being in the world. These movements engender and influence feelings, which have a reciprocal effect. We can ask clients at the very beginning of a therapy, even during the first description of the presenting problem, which movement is more typical for them and what inner movements they are prepared to make.

A reaching-out movement can be understood as an interest in the world, turning towards life and openness as an unconscious or intentionally adopted attitude. This reaching-out movement can be described as a primary movements directed towards contact with other people and objects. It has the function, essential to life and survival, of establishing and maintaining contact. The patterns of reaching-out movements reflect so-called primary

feelings and the physical state is marked by relaxation, flexibility, and spontaneous reactions appropriate to the situation. The basic attitude is one of interest and agreement and basically says 'yes' to the world. In this sense it is strengthening, life-bringing, and guides us further along our path.

A turning away movement can be understood as a kind of withdrawal, pulling back and closing up. This serves primarily to protect us in situations that cannot be met and mastered any other way. It is physically recognizable in chronic tension, and cognitively in fantasies and concepts of how things should be, rather than reflecting the actual situation. There is often a pattern of refusal, rejection and defense, or a constant readiness for a row. This is understandable as a more or less active strategy to set external boundaries for the personal area. Secondary feelings round out the picture. The general attitude says 'no'. This attitude or pattern of withdrawal is usually the result of experiences at an early age, unless there has been some massive trauma later, after the early childhood formative phases, that has changed and damaged the original basic structure of saying yes to life.

From developmental psychology, we know that a child begins to communicate at a very early age immediately following birth, or possibly even before. The formative phase, during which a child is open to influences on basic structures, has already come to an end by the age of three, according to Bowlby (cf. Trautner 1978). The patterns laid down during the first three years of life are stable but not irreversible. A psychotherapeutic treatment can support learning more functional, more appropriate, more meaningful, and more helpful patterns.

As students on a course in developmental psychology, we were shown a film of the well-known "still face" experiments by Brazelton. The communication between a mother and her child were shown in sequences. (Brazelton and Cramer 1986). The camera is directed at an infant of several months lying propped up in a baby seat. There is a mirror nearby in which we can see the mother's face, so that the viewer can see both faces at once. As the film begins, the mother approaches the baby who then laughs. In the first trial, the mother reacts and laughs back, turning and touching the baby. The baby is delighted, and laughs and gurgles with pleasure. In the second trial, the mother approaches the baby, who again laughs. This time, however, the mother has been instructed not to respond. She looks expressionlessly at the baby with no friendly recognition (with a still face). The baby laughs and reaches out to its mother, but she doesn't respond. The child tries again and begins to look distressed. The mother still doesn't react and the baby becomes visibly more tense and restless. Finally the baby gives its mother a questioning glance, looks away and goes limp, or begins to scream and cry. These film sequences lasted only a few minutes each. Further

examination showed that the relationship between the baby and mother quickly returned to normal when the mother met her baby with constant attention and a friendly manner. After the first mistrustful moment, the child soon turned openly to its mother again. If a mother's rejection of her child is a continuous pattern, the child remains in a state of tension and resignation. In such cases, further investigation has shown that the mother's behavior has its roots in her experience with her own mother,

Symptoms are right

The symptoms and problems that clients complain of, their inappropriate behavior, and the puzzling emotions that cause such a disturbance, can all be regarded as meaningful symbols. They are "right" and in the right context it is understandable why a person behaves or feels this way. We see the negative, as in a bronze casting of a relief, and extrapolate what the positive must have looked like. In this sense, the symptoms are the key to the missing data.

Symptoms are distressing and weigh on our clients, who feel responsible for them and are self-critical when they can't get themselves under control. It is an enormous relief when these symptoms finally make sense, or take on meaning through a systemic understanding.

When a symptom or feeling that has been taken over from the family system appears in an another situation, we assume that it is "right" in its quality and quantity, but it is not in the right form or time frame. It seems as if it belongs to another person. The important questions towards a new understanding of the symptoms are: How is it to be interpreted? In what context does it make sense? What situation and person in the family system does it fit with?

Example:

> Ms. Kramer was a 25-year-old student preparing to take her final examinations. She reported having nightmares that had to do with war, from which she awoke terrified and bathed in sweat. As we looked at her family system for structures where these feelings and images would have meaning, we found that both her father and her grandfather had had traumatic war experiences, since they had both been soldiers on the front. It was as though Ms. K was re-living the terror and feelings of her father and grandfather.

Primary feelings and inner reaching-out movements

A central goal in therapy is to support the client in primary feelings. We regard these as original feelings, connected to a movement of turning towards. They are identifiable through the following characteristics: Primary feelings give strength. They express an inner reaching-out movement and are appropriate to the situation. They may express affection or a deep love, but could also include anger in response to an injustice or fear in a threatening situation. A primary feeling runs through a predictable sequence beginning with the first appearance, followed by a building up, then receding and coming to an end. We can experience primary feelings with ours eyes open and still remain in contact with the outside world. This is something that is not possible with secondary feelings. Primary feelings produce a resonance in us as therapists and we can accompany our clients through their process with understanding, patience and empathy.

When a child is born, the baby's expression and communication comprise a complete reaching-out movement. We assume that this inner reaching-out movement arises out of a need to belong. Perhaps we still have the echoes of the ancient mammalian instinct of needing to belong to the herd, which gives us protection and security and provides for what we need for survival. If we are excluded or too far astray, the predators will devour us.

As Ivan Boszormenyi-Nagy describes it, we can prompt others to give us something by giving them something ourselves (Boszormenyi-Nagy et al. 1973, 1986; Franke 1996). If parents are available for their children and aren't dominated by their own needs, the children feel safe and secure. Their physical and emotional needs are met and they feel satisfied. Everything that is essential for life is learned as a child in a family, above all the difference between right and wrong, i.e. what has to be done and what must be tolerated in order to belong to this family.

Those who are able to feel their primary feelings and live in a reaching-out movement generally don't come into therapy. They are able to seek out contact and exchange with others and in this way create satisfying relationships. We usually see those people whose open access has been denied because of their history and experiences. They suffer from inner boundaries which they cannot cross by themselves using the means currently at their disposal. We assume, as a working hypothesis, that the problems or undesirable symptoms that the client presents are not a result of primary movements, but instead, that possibly we are dealing with secondary feelings or feelings taken over from someone else.

Secondary feelings, inner turning-away movements and interrupted reaching-out movements

For a child, the entire world is initially comprised of the relationship to his or her parents or caretaker. Being recognized, cared for and touched, and having a feeling of belonging all contribute to a healthy development. The child lives within these relationships and exchanges, and experiences the assurance that his or her needs will be met when they are expressed, and that affection and attention are forthcoming.

When a child's movements towards relationship are not responded to, and when attempts at closeness lead repeatedly to rejection or helplessness, the child takes that to mean that the environment cannot be relied on to provide what is needed at the moment. As in the trials described above, even a child not yet capable of speech becomes physically distressed and turns away when this occurs. This can be understood as a basic pattern of secondary feelings. If it continues as a pattern through life, we describe it, in Bert Hellinger's terms, as an interrupted reaching-out movement.

If the disruption in the relationship occurs frequently and over long periods of time, a limit is clearly reached where resignation takes over and the child ceases to make any more attempts at contact. It is as if the child comes to the decision to never again submit to such a painful experience that results in that physical state, and never again to try to establish a close, deep relationship, but rather to do everything alone.

Particularly underlying depression and resignation, it is often clear that a person has been repeatedly subjected to situations and the associated feelings in which the reaching-out movement found no responding recipient. What this experience means for a young child is that no actions will have an effect on others. It is as if the child suspects that at the bottom line, he or she is helpless, and at the mercy of death itself. In therapy, as clients come closer to the primary feelings underlying the secondary coping strategies, they often describe feelings of fear, or general anxiety, deep dread, panic, fear of death, horror, indescribable outrage, existential danger, and the feeling, or the fear, that they will come apart, disintegrate, or disappear.

In practice, we can identify the pattern of an interrupted reaching-out movement when the child's contact with an important caretaker was interrupted, e.g. when the father or mother was unreachable due to illness, travel, or war, or when the child was isolated in a hospital, or was sent away from home for a period of time.

When clients report an early, lengthy separation, they often comment that their parents later reported that the child had behaved very well during the absence. We take that to mean that the child adapted to the situation in hopelessness. The child bowed to the

external structure and ceased trying to have an effect on the environment.

Often, clients have experienced such interruptions when their parents were entangled in their own system or life experiences. For example, if a mother had lost her own mother when she was young, or if a father was a soldier, away at war, then presumably neither would have been emotionally available for their child, our client.

In the same way, it seems that any massive event which results in trauma, has the effect that "the soul pulls back", as Hunter Beaumont has described it. This could apply to a difficult birth that endangered the life of the child or the mother, serious, life-threatening accidents, or even when someone has experienced a life-threatening situation or death of another person. It is as if the entire organism, physical and psychic, freezes in the experience and can't find a way back to normality alone.

Example:

> Mrs. Gloss, aged 32, came in a deeply depressed state. She felt driven and didn't know which way to turn. She lived her life in despair, feeling incapable of taking charge of things or creating anything for herself. Ever since childhood she had been plagued by images which pulled her away from reality. She imagined her own death in various ways, which made her very fearful. Relating her family history, she reported that when she was five years old she had seen her cousin fall from a tree. She thought at the time that he was dead, and that night he appeared to her in a dream, demanding her favorite shoes. In total panic, she had refused him. Only later did she find out that he had survived practically untouched. At that point her trance-like states began, lively daydreams full of horror and distress. None of the numerous psychologists or medical treatments had helped.
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> As she haltingly described this scene, she was trembling and crying. I suggested that she imagine her cousin sitting opposite her, and that she look him in the eye. She wasn't able to do this because he wouldn't look at her. Her despair broke out and she sobbed. I told her my suspicion that a part of her had got stuck with him. She nodded wordlessly and became calmer. I suggested that she bring that episode to closure through a ritual, "something appropriate to the significance of the situation." She nodded in agreement. Together, we thought about what she could do. Since she was raised as a Catholic, she decided to put a large candle in her church for her cousin. Then she pictured her cousin standing opposite her, symbolized by a piece of paper on the floor. She bowed to him silently. Whatever this ritual did, the inner

images which had tortured her and the distress she had felt were gone by the time she came to the next session a few weeks later. The symptoms of depression had let up and she was able to cope with them with a behavior therapy treatment (cf. Peter Levine's writing about healing traumas, which describes similar processes of working through and change).

Recognizing secondary feelings in the therapeutic process

Just as primary feelings represent a reaching-out movement, secondary feelings move away. There are particular qualities, which make these feelings easily recognizable in the therapeutic process. The strength of secondary feelings is usually not appropriate to the situation, even if the feelings themselves fit. They serve as coping mechanisms to protect, limit, and decrease tension. Since secondary feelings and the accompanying physical states feed inner images and earlier experiences rather than the actual present situation, clients tends to interrupt contact with the therapist, or to close their eyes. Since it is impossible to be in the past and present at the same time, secondary feelings can be easily interrupted by having the client look the therapist directly in the eye and come back into the present.

Secondary feelings are chronic, with no concrete beginning and no clear end. Like primary feelings, these secondary feelings also run a predictable course. They persist and appear repeatedly in session after session. As therapists, we then also react with secondary feeling patterns and close off. We experience the client's feelings as false, and feel impatient, aggressive or bored. A sense of disbelief sets in and sometimes even indignation, in any case not empathic responses.

Secondary feelings and movements distract from the primary feelings, which are appropriate to the situation. They weaken because they are not connected to a personal goal. The client wastes time and energy with symptoms, which do not lead forward on life's path. Usually the person has a clear sense of this and is angry or sad about it without being able to identify the connections.

Although secondary feelings don't seem to make sense in the context of the client's actual life, we still assume that the feelings and awareness are correct in some way and begin the search for an appropriate context. The pattern may have been in operation for the person's entire life. In current, similar situations, old feelings are stimulated by memories and awakened. For example, when a someone describes their relationship with their mother or father, precisely the same feelings and physical reactions appear, even though some of the events being described may have occurred decades in the past.

If a person's relationship with his or her parents is or was difficult, the pattern will probably still be active in the present. To examine relationship problems in the present, we look at the client's learned patterns of relationship from the past, primarily the relationship with his or her parents.

The reactivated symptoms present a complex picture of a condition in the past. We can draw conclusions from the particulars of the traumatic event, but above all, from the time of the occurrence, about what needs the client had back then and what is needed in the present in order to resolve this old traumatic situation.

Secondary feelings and patterns of turning away stem from old learned patterns and conditioning and are connected with old injuries and experiences. They are usually resistant to any therapy that does not address the original situation with the intent to change the picture and allow the client to move into the present with a different experience and perspective. Expressing and acting out secondary feelings leads to short-term relief, but doesn't alter anything long-term. The symptom is a continual reminder of a situation or event that had an unsatisfactory outcome for the client's inner reality, and that has not been resolved. By asking how the story should have ended, and how it should proceed now, we get some idea of what this client needs in order to be able to let go of the past.

In a therapeutic process we often find a correspondence between learned secondary feelings, movements and behavior patterns and the physical and emotional state of the child when the learning or trauma occurred. A client who has been subjected to a high degree of stress at an early age was limited in reacting to the situation at that time by the constraints of physical development. Now, this adult person sitting in front of us exhibits the somatization: a chronic non-localized muscle tension that affects the entire body, an all-encompassing sense of discomfort, and specific breathing patterns. Some people may react to difficult topics or situations in a session with a kind of 'play dead' reflex which cannot be dealt with cognitively. Sometimes the symptoms present themselves in a very vague way, and the client has only got a feeling about a body reaction or a continual discomfort, without being able to describe precisely what it is actually about. These are all indications of a coping strategy developed at an age when the client was not capable of dealing with something cognitively.

With maturity and a more robust ego-structure, the secondary feelings and coping strategies take on different qualities of expression. When a child has enough inner stability to manage it, he or she will he or she will externalize with aggression, stubbornness, or temper tantrums, and be less apt to fall into helplessness and depression. Rage is a

stimulating feeling, which activates the body and allows the child to avoid the feeling of helplessness in difficult situations. Instead, the physical awareness and sensations divert the child from the inner pain. Such symptoms help keep the child occupied until the body tension has tapered off.

Later, the developing person introduces cognition and explanation to understand and control the surrounding world. Other coping strategies include fantasy and dream worlds, blocking, fuzzy thinking, or even shutting everything out completely through a blackout. A client may experience any of these symptoms as problematic when they are not subject to intentional control.

These things may occur intensively in a session when a discussion or constellation touches on critical inner places and the client reacts with old patterns. The symptoms are important clues about the client's structures and about the time at which he or she was called on to take an inner stance in relation to the world. The patterns at a body level are described by Lowen as character amour. (Lowen 1981), and by Freud as early childhood fixations (Freud 1910).

In planning a course of therapy, the critical question is what the client feels and experiences when he or she doesn't resort to the old familiar coping strategies.