
HOW TO CONTROL YOUR BRAIN AT WILL

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The first part of this work is a new, revised and updated edition of Dr. Roger Vittoz's "Treatment Of Psycho-Neuroses Through Re-Education of Cerebral Control." The preface was written by Dr. David Halimi. The sections on practical applications are by Christian H. Godefroy.

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Preface

Preface by Dr. David Halimi

In today's modern world, most human societies are rapidly evolving. This evolution goes hand in hand with scientific discoveries being made in the areas of technology, sociology, human behavior, and... medicine.

An unfortunate side effect of all this progress is a marked increase in the level of STRESS. Stress has almost become a dirty word nowadays! Hans Selye, who coined the term, used it to describe the psychological reactions of an organism when adapting to all forms of aggression. He hardly imagined the importance of his discovery. Present day societies are both the authors and hostages of their own evolution, which has become an inexhaustible source of mental destabilization. Worry, fear, anxiety, anguish, depression, discomfort - in short a host of forms of physical and mental suffering - are directly related to stress.

At the same time as concepts like New Age, New Medicine, New World Order, New Man, and so on are being invented, we must admit that whole sections of the edifice of classic socio-psychology have been shaken and even destroyed.

But since the dawn of humanity, we have been posing the same anguished questions about our origins, and the purpose of our lives. We are exposed to them every day, in the course of our normal day to day exchanges. We are constantly being heckled and battered by the

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same doubts, the same anxieties, the same sufferings and the same hopes. We are therefore the inheritors of an immense emotional and energetic deficiency, which binds us to our past, and to our fellow man. And most of us remain more or less unconscious of the programming we have been conditioned with!

By reuniting us with the primary elements of our material being - i.e. the functions and mechanisms of our own brain - the method developed by my colleague, Dr. Roger Vittoz offers a collection of practical exercises aimed precisely at re-establishing that fundamental and existential equilibrium which we have lost.

Our understanding of neuro-physiological processes has increased dramatically over the last ten years. Far from contradicting these insights, the advice offered by Dr. Vittoz, when skillfully and intelligently applied, provides us with the keys for achieving mental control. The mind is difficult to define, situated as it is on the border between the psyche and the body, the organic, the functional and the existential. Based on his day to day therapeutic practice, Dr. R. Vittoz is able to enlighten us by presenting his theories in a comprehensible way, stripped of any arduous intellectualizations, while remaining completely integral and accurate.

Feeling good about yourself, being yourself, knowing how to assert yourself, fulfilling your own potential, respecting yourself, staying healthy... these are some of the fundamental themes covered by my colleague.

Conscious, subconscious, will, desire, imagination, body structure, relationship dynamics... all represent a kind of interface between how we relate to others, how we would like to be ourselves, and how we finally achieve self fulfillment.

Dr. Vittoz's book has been completely updated, and presents a body of important information in the form of practical exercises, making it accessible to the greatest number of readers. Even if we do not agree with all the conclusions he has drawn, we must admit that modern neuro-physiology does seem to back them up.

We are convinced that anyone who puts these theories into practice, and who perseveres, will be able to overcome any of the psycho-behavioral or organic disorders they are suffering from. And curing physical and mental suffering without having to rely on medication is the challenge which the author of this method has taken on... for the health and happiness of his fellow beings.

Dr. David Halimi

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Introduction

Over the last few years, a number of works of this kind have appeared, and my adding a stone to the edifice was above all a response to the needs of my patients; I also wished to enlighten people as to the cause of these nervous disorders, known under various names such as neurasthenia, psychoneurosis or psychasthenia; and finally to develop my personal point of view on the subject of treatment.

So it is above all the patients, suffering from these disorders, whom I am addressing, and that is why I tried, as much as possible, to simplify anything in this study which seemed too abstract. My primary objective is to show you, as best I can, why people get sick, and how they can be cured.

This training method, if I may be permitted to call it that, is based on the certainty that all psychasthenic disorders are caused by a malfunction in the brain, and that it is in the brain, and nowhere else, that we must look for solutions.

What causes the malfunction? What is it really? How can it be changed? These are the questions we will try to answer.

The title of this work gives you a good idea of its contents: by studying what is termed a patient's patterns of 'cerebral control' we will be able to identify his or her particular dysfunction.

We consider a lack of cerebral control to be the psychological cause of these disorders. And it is by identifying this lack that we are able to

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determine the form and rationale of any effective treatment.

We realize that certain facts included here would, under other circumstances, merit more detailed explanation, but we must remind you that this book is simply meant to express, in terms which are as concrete as possible, the work we are doing.

As for the results we have obtained, I cite the cases of patients I have already treated, and call on my colleagues to patiently and sincerely attempt to apply to their own patients what I have been able to do with mine.

If patients who are suffering from what I term insufficient mental control, are able, through the simple explanations offered in this method, to find a direction, an indication, or even a hope of recovery, then I feel I will have achieved the goal I set for myself.

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Chapter 1

Cerebral Control

The duality of the brain

Before beginning our study of cerebral control, it is very important that you understand how the brain functions, as far as perception, developing ideas, sensations and actions are concerned.

There are a number of modern theories, but let's look at the simplest one, which accepts the existence of two different functional centers, called the conscious or objective brain, and the unconscious or subjective brain.

We will use the former terms, with the understanding that neither provides a perfect definition. Given the existence of two centers, we see that the unconscious brain is, in a general way, the originator of ideas and sensations, and that the conscious brain acts as a kind of regulator, i.e. it is the conscious brain that is responsible for reason, judgment and willpower.

This theory of two distinct centers may seem hypothetical, but it is not really so. Whether we call them centers, or groups of nerve cells is only a question of semantics. The fact is certain, however, that a "conscious self" and an "unconscious self" are present in the sense we have described above, and although it is true that their exact ana-

tomical location is not yet known, they must really exist. Proof of this assertion is furnished through hypnosis, whose influence suspends the conscious functioning of the brain. If something can be suspended temporarily, then it must exist.

The unconscious self is the primitive, primary brain; the conscious self evolved from this primary self and led to the formation of reason, judgment, in short of all conscious faculties. Therefore, the subconscious can be called the primary center, and the conscious brain the secondary, or evolved centre.

There is nothing arbitrary or hypothetical about attributing conscious activity to certain groups of cells or nerves.

And we must accept this duality in order to understand what we call cerebral control.

This division is hardly perceptible in normal persons, since an idea or a perceived sensation is the result of the work effected by both centers; people are usually not aware of the particular processes being carried out by each center.

But in cases which fall into the class of nervous disorders, this duality is accentuated, and patients generally become more or less aware of the distinction.

There has been an attempt to associate certain psychoneuroses with the subconscious brain; but it seems to me to that we are more likely to find a cause in the imbalance and disharmony between the two parts of the brain; it is the link between them which creates a healthy, normal person, and the more or less pronounced separation

between the conscious and subconscious brains which leads to disease.

At first glance, it may appear that a perfect balance of the conscious and subconscious minds depends on the equilibrium of each of the parts, but in reality this is not very important.

A perfectly balanced individual may have a preponderance for one or the other part of the brain. Nervous persons in particular are often observed to place more emphasis on the subconscious brain, without necessarily becoming ill. All he or she has to do is learn to control it.

Definition of cerebral control

We can define cerebral control as an inherent faculty of normal persons to balance the functions of the conscious and subconscious parts of the brain. By normal cerebral balance we mean that each sensation, impression or idea can be controlled by reason, judgment and willpower, i.e. that it can be judged, modified or rejected.

This faculty is partly unconscious in normal persons; they may well have the feeling of being in control, but the mechanism whereby this control is exercised is completely ignored. Persons who are ill have a more accurate perception of what is going on, since they feel that they are lacking something, and this “something” is cerebral control.

So the function of the faculty of cerebral control is to “regulate” each idea, each sensation that we experience. In some cases it acts as a brake, in others as a regulator, adjusting our psychological functions, and even (as we will see later on) the physiological functions of

our brain: it influences action just as much as it influences ideas. In normal persons, control is automatic - it intervenes on its own, without the person having to make any conscious effort of will. In addition, it develops progressively in accordance with age and education. We can thus conclude that it is a natural and inherent part of every balanced human being.

This faculty dominates an individual's entire life, and we could even state that any person who lacks control is "sick" (of course we are not referring to cases where control is momentarily not exercised, as for example when persons become angry).

So this is our definition of what control should be. It will now be easier for you to understand what happens when an individual completely loses his or her faculty of control.

Absence of control

Imagine a patient without this regulating faculty: a brain without a brake, without direction, in a state of total anarchy. Carried away by every impulse, vulnerable to all kinds of phobias, unable to reason or judge, forced to accept all the impressions received by the subconscious mind... such a person would be no more than a miserable wreck, living a life of constant suffering. Fortunately, complete lack of control is an extreme case which is rarely encountered in the patients we treat; what we usually find in cases of psychoneurosis is an insufficiency or instability of control.

Insufficiency or instability of control

In cases of insufficiency, control exists as a faculty, but either it has not reached full development, or it is defective in some way, or its

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influence is not adequate. In such cases we can see that some of the ideas or impressions experienced by the patient do not pass through the filter of the conscious brain.

These persons may be able to reason or judge in a normal way, yet remain dominated by ideas or impressions which they know are absurd or exaggerated, but over which their willpower has no control. This is the situation of a typical psychasthenic patient.

In cases of unstable control, the situation is basically the same: here patients shift from a normal state to a diseased state, for no apparent reason. Symptoms appear and disappear in more or less close succession. A period of critical depression may be followed by a period of gaiety, and all aspects of the personality are subject to change - it can affect patients' physical health, their character, or their thought processes.

There are an infinite number of degrees between a total absence and an insufficiency of control, giving each case its particular character.

These differences are of interest when diagnosing and prognosing an illness, but it would be useless to describe them all here since, in practical terms, it is enough to determine whether control is sufficient or insufficient.

Effect of insufficient control on ideas, sensations and actions

Now let's try to determine what effect insufficient control has on ideas, sensations and actions.

To do this, we must look at what happens in an individual's brain to mix up ideas and controlled or uncontrolled sensations.

It seems that even if the insufficiency is only slight, patients feel a vague sense of unease that some of their ideas are escaping them, or cannot be sufficiently defined. They are also often troubled by a feeling of being only half awake, as if they were living in a kind of semi-dream state which they cannot break out of, a condition which can cause significant anxiety.

If the insufficiency is more serious, symptoms will increase proportionally; patients no longer suffer from a vague sense of unease, but rather from a very pronounced sense of confusion, where ideas become all mixed up, and have no logical sequence or direction.

An uncontrolled idea is always less defined, less precise; left to itself, it can repeat itself indefinitely, or become fixed in the brain (in other words it can become an obsession) to the point where willpower has no effect on it whatsoever.

In other cases, ideas can undergo veritable distortions; they become exaggerated, are modified or transformed, without the individual being aware of it.

So the major effects of insufficient control are a lack of precision or clarity, and exaggeration or distortion of ideas.

As for sensations, we find the same symptoms; they are rarely clear, often bizarre, and tend to be grossly out of proportion.

Actions suffer from the same defects. Patients are undecided, and their actions are rarely thought out or may even be partly uncon-

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scious. Since the idea preceding an action is too confused, patients forget what they wanted to do, or are incapable of completing something they started.

All these effects of insufficient control on ideas, sensations and actions are not clearly perceived by patients, who accept them without realizing that they are the basis of the most severe symptoms associated with their illness.

Despite their importance, we will only outline these symptoms briefly here, since we will be encountering them at every step of the way in the course of this study.

Influence of insufficient control on the organs

We said earlier that cerebral control dominates an individual's psychology, and also his or her physiology.

This statement is supported by the fact that neurasthenics suffer from all kinds of organic problems, which demonstrates that the superior (or cerebral) functions directly influence so-called psychosomatic pathologies.

It is quite natural to accept the fact that organic and cerebral equilibrium are united, or that they are at least interdependent.

It is also certain that a mechanism exists which controls the organs, assuring their regular function, just as a mechanism of cerebral control exists, and that both are subject to the same laws, governed by the same causes, and produce the same effects in their respective areas.

Therefore, any defect in cerebral control will have repercussions on the organic level; at times, the organic symptom will even replace the psychological symptom as the primary indication of illness, and the psychological symptoms will become of secondary importance, or even go completely unnoticed.

An insufficiency can therefore affect a particular organ like the stomach or intestines for example (nervous dyspepsia, enteritis, etc.) or an entire system (vascular, nervous, muscular, etc.).

In almost all cases, the vascular and nervous systems are affected to some degree: every psychasthenic patient suffers from vasculo-motor problems and some pain.

The sense organs are also affected; troubles with hearing and vision are frequent.

And the genital organs often exhibit tenacious symptoms as well.

As soon as an organ is affected and modified by insufficient control, the purely psychological symptoms seem to diminish, and patients tend to transfer the cause of their problem to the organ in question. In reality, easing of the psychological symptoms is illusory, since they are only being hidden by the more obvious organic symptoms - they will reappear with equal intensity as soon as there is any improvement on the organic level.

Cerebral control and psychoneurosis

We have determined what we mean by cerebral control, how it can be defective, and the results produced by insufficient control.

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We will now apply this information to the treatment of psychoneurosis.

If we are reserving our application to include only this class of illness, it is because the various forms of psychoneurosis seem to exemplify what happens when there is insufficient cerebral control, since these cases respond better than any other form of illness to the process of re-education.

We can, in effect, assume that in psychasthenic patients the conscious and subconscious parts of the brain are normal and have not undergone any organic alterations, conditions which are indispensable for complete re-education.

In all purely mental illnesses, there is more than an absence or insufficiency of control - there is always some alteration of the conscious mind. In cases of hysteria, for example, which is certainly characterized by obvious modifications of this kind, we would not know how to tell whether or not the disorder was uniquely a problem of mental control. Its nature is so complex that it would be difficult to accept the instability of mental equilibrium as its absolute cause.

In psychasthenic cases, on the other hand, even the most inexperienced observer can recognize in each symptom and each step in its development, an obvious insufficiency, so that it would be hard to refute the fact that "all cases of psychasthenia are caused by a lack or an insufficiency of mental control."

This conclusion may seem somewhat hastily drawn, but we will attempt to prove it by analyzing the psychological symptoms found in all cases of psychoneurosis.

Chapter 2

Psychoneurosis

We cannot, nor do we wish to provide a detailed description here of all the forms and symptoms of psychoneurosis; attempting to do so would be much too involved, and would exceed our objectives as stated in the introduction to this work. What we do want is, above all, to study psychoneurosis from the point of view of cerebral control, researching its etiology, its development, and the symptoms which are related to, and can be explained by, insufficient control.

Etiological causes

These can be divided into:

1. Primary cause
2. Secondary causes

Primary cause

We are referring here to heredity since, in almost all cases, we find the same problems or nervous symptoms in a patient's progenitors, to a more or less pronounced degree.

Note that heredity, above all, creates an environment propitious for the development of the disease, rather than creating the disease itself.

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From a cerebral point of view, we can say that the effect of heredity is either to inhibit the progressive development of cerebral control, which would otherwise occur completely naturally starting at a certain age, or to instill patients with a kind of instability or insecurity.

Secondary causes

Among the secondary causes, the most important is some kind of psychological or moral shock, which suddenly suspends cerebral control, followed by more long-term causes which gradually wear patients down: a personal tragedy followed by a long period of worry, for example, or being constantly overworked, or the aftermath of medical surgery, or any other kind of trauma.

Forms of psychoneurosis

These can be divided into:

1. Essential forms
2. Accidental forms
3. We can also include a periodic or intermittent form, which is nevertheless well defined.

Essential form

This form begins at a very young age, and is characterized by a progressive development, with occasional slight remissions, until it establishes itself as a general state of being, usually when the patient reaches adulthood.

It is therefore characterized by an insidious, rather slow beginning, followed by progressive development.

Accidental form

Here the onset of the illness occurs suddenly: patients who appear in perfect health suddenly become completely prostrate. The transformation can take place overnight, or at least in a very short period of time.

There is no progressive development; often the most severe symptoms are immediately apparent.

This form of neurosis is often the result of some emotional or moral shock, which is why it appears so suddenly. When caused by overwork, it may take a little longer to develop.

Intermittent or periodic form

We are including this third form because it is relatively common.

The onset of the disorder occurs fairly rapidly; in just a few weeks, and for no apparent reason, patients exhibit serious symptoms which last for weeks or months. Then, suddenly, the symptoms disappear and patients think they are cured. They go back to work, and resume a normal lifestyle.

This period of remission may last for several months, or even years; then once again, patients undergo another crisis, with little or no warning beforehand. Or the illness may be periodic, in which case patients usually suffer through a crisis stage once or twice a year.

The sudden return to health, so convincing to patients and the people close to them, is more apparent than real since, when carefully examining patients during their periods of remission, I have

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always observed them to be mentally overexcited, a state which cannot last indefinitely and which must, sooner or later, depending on its intensity, bring on another relapse.

The prognosis for such intermittent cases, despite their return to health, is no better than for patients suffering from the essential form of the disorder.

These three forms, so different in terms of their causes, beginnings and development, are not really so dissimilar if they are considered from the point of view of defective control.

In its essential form, we clearly find the presence of an inhibition of the development of this faculty.

In other cases, the problem is the instability of control. Therefore, the three forms are the result of nothing more than varying degrees of insufficient control.

As for their prognosis, it is obvious that total inhibition of the development of control makes a cure much more difficult to achieve. No longer is it a question of rediscovering a faculty which has been suspended by shock or fatigue. The faculty must, in a sense, be created from scratch, and this requires long months of struggle and perseverance on the part of patients and their therapists.

Instability in its intermittent form should be easier to cure; but here another factor comes into play - patients do not willingly submit to rigorous treatment since they know that they will recover without making any effort, if they just wait long enough. However, what they are not aware of is that their recovery is only artificial, and a relapse can be very dangerous, and even fatal.

Chapter 3

Psychological Symptoms

Psychological symptoms can be grouped into two main classes: the first includes initial symptoms which appear during the latent phase of the disorder, when cerebral control is already insufficient, but not permanently so.

The second class includes those symptoms which appear when the disorder reaches its active phase, and the insufficiency is more stabilized and complete.

Symptoms during the latent phase

During the latent period, symptoms are not pathognomonic (pathognostic); they are therefore often difficult to detect.

Doctors have little opportunity to observe them, since patients hardly have anything to complain about, nor do they seek treatment. They are only potentially psychasthenic, and since this period may last for years without becoming aggravated, it is very rare for them to be in the care of medical professionals.

However, it is of the utmost importance that patients at this stage be treated, since insufficient control is much easier to cure when discovered in its early stages; if detected early, it is easier to prevent the

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onset of complete insufficiency. At this stage, the role of education is primordial, and if doctors had more opportunity to intervene, they could at least detect the symptoms, warn the patients' parents, and save many an unfortunate child from years of suffering.

Although the individual symptoms do not have any obviously distinguishing characteristics, hardly differing from those observed in cases of simple nervous disorders, when taken as a whole, they become easily identifiable to even to the inexperienced observer.

The first symptom is exaggerated impressionability: its distinguishing characteristic is that it is not permanent, as in cases of simple nervousness - the patient's character is unstable, sometimes gay, sometimes morose, sometimes gregarious and outgoing, sometimes totally self-centered, and all this for no apparent reason. Interrogate a patient and s/he will not be able to explain the condition, ascribing it to a lack of morale, or some indefinite vague fear, or even to a loss of memory.

Such patients often let themselves fall into a kind of dreamlike semi-conscious state, which they do not find unpleasant, but whose dangers they do not recognize, and which they will be hard put to get out of later on. The longer this state lasts, the more pronounced the symptoms become: apathy, fatigue, and a general disinterest in life soon take hold and refuse to let go.

In cases where such daydreaming does not occur, patients will at least show a marked instability in their thought processes: they can never seem to concentrate, and suffer from a condition which we call mental wandering.

This form of the disorder does not represent a major inconve-

nience, and may persist for a very long time without becoming aggravated. However, it is just as characteristic of unstable mental control as the dream state is.

Cerebral instability, however temporary, results in mental fatigue, and eventually leads to an inability to make decisions, and a lack of self confidence.

Patients ponder over everything they do, endlessly deliberating, without ever being able to reach any definite and practical solutions. They hardly exist in the present; their thoughts come and go, and their minds are either lost in reveries about the past, or are consumed with worry about the future.

Remember that all these phenomena are temporary - they may occur twenty times a day, but patients revert to normal between bouts, which is characteristic of unstable cerebral control. They also occur when the disorder has reached its active phase, with the difference that they cause patients real suffering, and there is no period of remission.

We have said that the latency period does not have any specific duration; it can persist for years, and then suddenly, because of some moral or emotional shock, even one which is relatively minor, progress to the active phase of the disorder.

Symptoms during the active phase

It is easy to understand how, during the active phase, one symptom leads to another, this being nothing more than the result of the progression of unstable control towards permanent insufficiency. There is, in addition, an added phenomenon, one which differenti-

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ates the first phase from the second, which is that patients become more and more aware of their mental state; the feeling, which is often hard to define, causes patients to exhibit very characteristic signs of fear and anxiety. This phenomenon is also a symptom which, while tolerable during the first phase, becomes unbearably frightening in the second.

This explains how even insignificant facts or events take on enormous importance, and often result in a crisis of severe depression or despair - patients lose sight of their real, objective point of view, and are only concerned with their insufficiency of control.

When considered from this angle, all the symptoms exhibited by psychasthenics can be explained and easily understood. These are no imaginary symptoms: they are quite "real" and are the result of an abnormal functioning of the brain.

We can therefore say that all symptoms which occur during the active phase of psychasthenia are partly the result of unstable control, and partly the result of how the patient feels about his/her instability.

Now let's take a look at what aggravates symptoms during the latent phase.

Take patients in the dream state, who live in a kind of semi-consciousness. There's nothing harmful about this in itself, since everyone drifts off into a daydream from time to time - it's the brain's way of relaxing. But in normal persons the state is voluntary - they can choose whether to dream or not to dream. At the beginning of the latent phase, this is also true of psychasthenics, but little by little, because of mental laziness, they get into the habit, they seek out the

dream state, and are soon unable to get out of it, reluctant even to try since the effort becomes so difficult. They start living more and more inside themselves, distancing themselves from the outside world; and this results in a kind of unhealthy, self-centered egoism, which affects their entire behavior, and makes them such a burden on other people. They lose all contact with the people and things around them, they cannot see farther than the thick veil which clouds their minds; they have no sense of “self,” and often end up hating themselves, without being able to escape from their own mental prison.

We have said that they will suffer as they attempt to break out of this negative state, and their suffering is very real; the return to normalcy can only be achieved after a kind of painful rupture has taken place, and patients are fearful of the process. On the other hand, they are also aware that this dream state cannot go on indefinitely, and that it leads inevitably to despair, depression and anxiety; they are torn between the two alternatives, lacking willpower, lacking strength, lacking courage.

The inability to concentrate their thoughts, which we have called mental wandering, does not represent a major inconvenience at the outset of the disorder, except as far as work is concerned. But as the state persists and eventually becomes permanent, things soon change. The incessant effort of trying to concentrate tires patients out; the multitude of thoughts going round and round in their head obsesses them day and night, and results in terrible anxiety.

They no longer feel in control, they are like a boat being tossed around in a storm without a rudder. Because they are so numerous, and also because of fatigue, thoughts lose any value and clarity; confusion sets in, and is soon followed by panic.

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The mental excitation which we found in the first phase also become proportionally worse, and produces fits of anger or bouts of despair, with no apparent cause. These are usually followed by periods of sadness, hopelessness and depression.

Being aware of this uncontrolled state produces a series of diverse sensations which we will now quickly review.

Sensation of fatigue

Neurasthenic fatigue is the first result of the lack of cerebral control. This is because the mind is constantly active, with no rest or respite. It is also symptomatic for cerebral activity to be more intense in the morning than at night, when hyperactive thinking is replaced by the sensation of being overexcited, which is less severe. This does not mean that the brain is less tired, but it does indicate at least some degree of control.

Proof that the sensation of fatigue is caused by a lack of cerebral control lies in the fact that the fatigue always disappears during periods of normal control.

Fatigue is sometimes the condition's predominant symptom; in such cases, patients refuse to partake in any kind of activity, including making any mental effort; they only want to rest, not because resting makes them less tired, but because they feel less guilty about their inactivity while in a state of semi-consciousness. These people make ideal customers for institutions offering "rest cures" and will register for sessions over and over again, without finding any lasting solution.

Feelings of inferiority

Patients lose their self confidence; they feel they inept, unable to handle important tasks, and sometimes even to engage in conversation; they avoid people as much as possible. The slightest change in their habits, or the simplest thing they are asked to do, can bring on a crisis of anxiety, because they feel inferior and incapable of coping.

Anxiety

A direct result of feeling inferior is continual anxiety. The state is very hard on patients, and has the same cause as feeling inferior - patients see their lives as a series of tragedies. They are never calm, never happy; they live in continual fear of the present and of the future.

When things are going relatively well, they still feel worried and agitated; they don't know what they want, nor what they should do. If they do something, they regret it, and if they do nothing, they feel even worse.

Anguish

It's only a short step from constant anxiety to a state of total anguish or depression, which is one of the most typical symptoms of non-control. It is also the most violent, and can have very extreme results, often for no apparent reason. This may take the form of physical pain and/or mental suffering, the specifics of which differ from case to case. On a mental level, patients may suffer because they feel inadequate, and incapable of attaining what they desire, which in turn both terrifies and depresses them. This kind of suffering can

destroy the strongest mind - it is the kind of pain the mind fears the most, and is least able to deal with.

Some patients transfer the problem to an organ, and the disorder becomes psychosomatic; anxiety can affect the precordium, stomach, intestines, etc. The pain is not acute but dull, and creates the strangest sensations, which vary from case to case.

Abulia

We can say that all psychasthenic patients suffer from abulia, and in fact there is a large grey area between what can be considered simple indecision and complete abulia.

However, as we will see later on, the absence of willpower is more apparent than real, and is due rather to its misguided application. Be that as it may, the result is the same. Every thought or idea, every act requiring some measure of willpower, will evoke feelings of fear in these persons' minds; they are incapable of making any effort, and are paralyzed by doubt. Abulia is really a fear of wanting anything, since patients believe that making any kind of effort is painful, and every action results in anxiety.

Phobias and obsessions

These symptoms are constantly present during the disorder's active phase. Fear of a certain word or thought or object becomes obsessive, and always results a belief that the word or object in question is not under their control - patients feel defenseless and at the same time unable to escape.

Physiological (organic) symptoms resulting from insufficient control

Aside from the psychological symptoms we have described above, patients can develop a whole range of physiological symptoms, which are the direct result of the lack of cerebral control. It could be said that the affected organ often mirrors the state of the brain so well that it develops its own phobias, anxieties and abulia.

We will not attempt to describe all possible symptoms which can affect the various organs, since they are not uniquely caused by non-control, but can also be the result of a malfunction of the organ itself.

This malfunction of a given organ originates in the nervous system, which is directly affected by all abnormalities in cerebral control.

The vascular system, it seems, is the one which exhibits the most typical reactions: vaso-motor nerves cause the system to become anemic or congested, and to either increase or diminish secretions in accordance with the slightest psychological imbalance.

All systems can be affected: however, the digestive and genito-urinary system (in men especially) are most frequently influenced.

The sense organs exhibit certain peculiarities which merit our attention here.

Vision

All abnormalities related to vision are aggravated in cases of non-control; like thoughts, images can be less clear, confused, and this

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without any physical alteration of the organ itself. It has often been noted that images seem to hit the retina without being transmitted to the brain; psychologically speaking, it is as if patients were looking without seeing or, listening without hearing.

Hearing

Unlike vision, which is obscured, hearing is usually intensified. Patients become overexcited, and overly sensitive to the least noise, which often results in insomnia.

Touch

Sensation in the hands seems accurate, but somehow gets erased before it reaches the brain, so that patients are not conscious of what they are touching, or of what they are doing.

This is precisely the mental process we are attempting to emphasize, since, although the physiological symptoms which we have just described are of little importance in themselves, understanding their psychological origin is essential if they are to be treated with any success.

Chapter 4

Necessity for re-educating cerebral control

We have seen in the preceding chapters that the essential cause of most cases of psychoneurosis is an instability or insufficiency of what we call cerebral control.

We feel we have sufficient evidence to be able to use this information as a basis for treating psychasthenia.

Except in cases of emergency, drugs are of little help in recovering a lost cerebral faculty, or of completing a faculty that is underdeveloped; in such cases, we must turn to psychotherapeutic methods for results.

We will take a quick look at the various forms of treatment, not because we intend to criticize them, but rather to show how they led up to the formation of a therapeutic method which we call the "training."

Hypnosis/Suggestion

This method, practiced by experienced doctors, has resulted in too many amazing cures for its effectiveness to be denied. I have wit-

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nessed some of its marvelous powers, for example in calming patients down, eliminating symptoms (like constipation, digestive problems, etc.) or, from a psychological point of view, instilling patients with hope, courage, confidence, etc.

However, as far as re-education of cerebral control during the hypnotic trance state is concerned, I have only seen very temporary results, the problem being that patients tend to rely more on the hypnotist than on themselves, and prefer obeying easy suggestions to struggling to overcome the problem themselves.

In addition, hypnosis only affects the subconscious mind, and has little effect on insufficient control; in certain cases, it can make patients even more passive, and aggravate the negative aspects of their personalities.

This form of treatment is therefore more palliative than curative, and cannot be recommended except in cases of instability, where patients are able to regain their mental equilibrium themselves.

As for other methods of pure psychotherapy, such as the re-education of the will developed by Dr. Dubois, they have the same aim as our own method, and have opened new horizons in the treatment of these disorders, providing results beyond all expectations. Given the successes obtained with these treatments, why then should we look for something else - what are the advantages or the necessity of another form of treatment?

We can answer this question with a statement made by a number of patients who were treated and not cured. What they said was this: "Everything you're telling me I know already, I sincerely want to do what you tell me to do, but I cannot; show me how I can..."

This statement expresses a truth which cannot be denied: it is not always enough to tell patients what they should do - you have to show them how to do it. And that is the aim of this training method.

Any treatment that is based only on reasoning with patients, or trying to persuade them to do the right thing, cannot replace a program of re-education. This becomes obvious as soon as patients acquire some degree of control. As for rest cures and disintoxication programs, they only address the problems of fatigue and digestion, but do nothing to modify the cause of these problems.

We have to remember that patients who lack control are like children who no longer know how to walk; they have to be shown how to take their first steps, and supported while they try; correcting their errors comes later.

Abnormal cerebral control is not simply a question of false ideas which can be modified through reasoning. There is more to it than that: the various changes we observe, which are the result of insufficient control, force us to admit that it is not only ideas which are modified, but the cerebral functions themselves - there is something abnormal about the way the organ itself is functioning. This abnormal functioning cannot be corrected through reasoning alone, but requires "training."

How to control the brain

In demonstrating the necessity for the re-training of cerebral control, we said that patients must be shown what to do. How to achieve this is, in fact, the tricky part of the problem, and will be of special interest to physicians who are directly involved in treatment. However, before beginning our study of the training itself, we should ex-

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plain the procedure we will be using, i.e. how we will show patients precisely what they should do.

Direct control of the brain, at the present stage of scientific development, is beyond our control. This means that there are few means at our disposal to verify what patients report in terms of what is actually happening in the brain.

Struck by this gap in our scientific knowledge, I tried to find some simple method of verification.

It seemed to me to be quite amazing that symptoms which are sometimes extremely intense could not be perceived (i.e. verified) objectively. The cerebral pulse (electroencephalograph) provided some indication of what was going on, but was not practical enough, and required the use of highly sensitive instruments.

My own personal experience showed me that, contrary to current opinion, the hand, when placed on the forehead of a patient, and when sufficiently trained, can provide a fairly accurate indication of what is happening in the brain.

It is very likely that the entire body vibrates in unison with the brain, a sensation which is clearly felt by persons suffering from certain disorders. This vibration is not limited to the forehead, but is more perceptible in that region. It is completely different from the cerebral pulse, and is caused by a contraction of the skin and skin muscles. The intensity of the contraction corresponds to the patient's intensity of concentration.

Therefore, perceiving this vibration is not a question of having some kind of special gift or having especially sensitive hands; for years,

many patients have been able to perceive it just as well as I can.

I am well aware of how skeptical people will be about this, because it is difficult to admit that the brain's activity can be detected through the skull; I cannot explain how it works - all I can say is that there is an exterior effect, and this effect can be felt by the hand; it appears as a series of repeated shocks, creating the sensation of a wave or particular kind of vibration.

For those who wish to try it, here's how to proceed:

Ask someone to concentrate on the ticking of a metronome, or better still to mentally repeat the ticking sound. Place your hand on the person's forehead, either flat or cupped, and you will feel a subtle shock or beating which is more perceptible on either the right or left side, depending on where the metronome needle is.

If you increase the metronome's speed, the beating will become more rapid; decrease the speed and the beating slows down accordingly.

If the subject is distracted, you will not feel any beats - the sensation in your hand will change, or stop altogether. There is, therefore, a correlation between what the subject is thinking and the sensation you experience in your hand.

It is possible that your sensation will not be precise enough the first time you try the experiment, but if you are patient, the sensation gradually becomes clear.

We are presenting this phenomenon as a simple hypothesis, although later on we will provide more complete and scientific proof

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of its accuracy.

For the moment, let us assume that the sensation which is perceived does relate to cerebral activity, and that it is modified according to the state the brain is in. It then becomes easy to perceive the difference between a calm brain and one which is agitated, as well as the difference between a controlled idea or thought, and one which isn't. This phenomenon is a powerful diagnostic tool, allowing doctors to verify how patients are thinking or behaving.

We are in no way suggesting that we can determine what a patient is thinking with this technique. All we can do is verify his/her level of control.

With a little practice, you can begin to recognize certain different sensations, perceived through the hands, which correspond to different states of the brain. We will try to describe them, and give names to the various vibrations or waves which are perceived.

Abnormal states of the brain

In the context of non-control, we find three main types of abnormalities:

1. State of torpor
2. State of hyperactivity
3. State of tension

1. The state of torpor is characterized by a reduction of sensation perceived by the hand; reactions are slower and more irregular; it feels as if the brain is less active, heavy, and lacking energy.

2. The state of hyperactivity, on the other hand, is accompanied by very strong, but disorganized sensations, which differ from normal agitation which always present a certain regularity of vibration.

3. The state of tension almost always causes pain, either piercing pain in the nape of the neck, or pressure on the temples. Patients feel as if their brain is “blocked or contracted.” At first, the phenomenon is caused by a natural defense against anxiety, or simply because patients become more or less conscious that they are not in control of their own brain. It is therefore constantly present in all neurasthenics. The initial temporary symptom can, in certain cases, become persistent, and create a particular type of disorder.

This particular type, although it occurs relatively frequently, seems to have been ignored by most authors. It is characterized by three symptoms:

Irritability

Pain

Fatigue

Irritability is the result of the hypersensitivity of the brain in a state of constant tension, and since this state is permanent, it is quite natural for persons to become irritated and upset about almost anything.

Pain varies in intensity and form: patients sometimes feel as if they are about to explode - the skull feels too small to contain the pressure; or they may feel as if a steel band were being progressively tightened around their head. One patient described it as feeling like a violin string which has been tuned too tightly, and which vibrates with pain.

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Fatigue is a perfectly normal result, considering the extreme tension; this cannot go on indefinitely, and when it stops patients experience intense fatigue, which they end up fearing as much as the pain itself.

The tension or feeling of contraction is not limited to the brain, but can be felt throughout the body.

In the first place, muscles become more or less contracted, and sometimes painful; walking becomes difficult, and sometimes impossible; balance is unstable. Patients may also suffer from contractions of the esophagus, stomach or intestines.

These muscular symptoms often lead to an erroneous diagnosis, especially when they are limited to a single arm or leg. They may be mistakenly attributed to hysterical contractions and, when more generalized, to lesions of the encephalon or spinal cord.

It is easy to detect this kind of cerebral tension through direct examination: the vibrations are very tense, like a wire vibrating very quickly; waves have hardly any amplitude, and are so faint they are hardly perceptible.

Normal or abnormal vibrations

As we have just seen, different abnormal states of the brain produce different sensations, which can be detected through hand contact. To make this more clear, let's look at the most typical kinds of vibrations we are likely to encounter - this will make it easier for those who wish to try the experiment themselves.

First, let's look at the vibrations produced by a normal brain.

In these cases, you will perceive a kind of pulsing, which varies in speed, depending on the state of the brain, from between 5 and 100 beats per minute.

The slower the vibration, the calmer the brain; the faster the vibration, the more animated the brain is. There are also differences in amplitude and strength. Also, as soon as willpower comes into play, it is easy to detect an immediate increase in vibratory speed and/or amplitude.

Despite these variations, all normal vibrations are fairly rhythmic and regular; this is what differentiates them from abnormal vibrations, which are always irregular.

If you examine a neurasthenic's brain, even during periods when s/he feels perfectly normal, you will never detect very regular vibrations.

They may appear to be normal at first, since you can perceive a few rhythmic beats, but suddenly they change, and you feel a series of disorganized beats, after which they become regular for awhile, only to change again a little later on. If you question the patient, s/he may tell you that the change was due to a thought or a distraction, or s/he may not have been conscious of the change at all. The examining physician can conclude with certainty that the change was due to an interruption of cerebral control.

As soon as patients become obsessed with an idea, or simply over-excited, the pulse becomes very rapid - too fast to count. You may also perceive a violent pulse, followed by a series of very rapid, fluttering vibrations, which are hardly perceptible; in addition, rarely do

subsequent series of vibrations exhibit the same amplitude or intensity.

The state of anxiety is simply an increase in patients' already over-excited cerebral activity; beats are even more intense and more disorganized, and create a feeling of terror or panic.

The state of tension mentioned earlier represents a fourth form of abnormality, presenting the same irregularities as those described above.

These various modalities constitute the major forms of the state of cerebral non-control; as soon as they are detected, a physician may proceed with the training program we referred to earlier on.

How to modify an abnormal vibration

If we accept the fact that abnormal vibrations, which correspond to particular states of cerebral non-control, exist, then we can conclude that any insufficiency modifies brain function. When treating neurasthenia, we will have to take this new element into account, since it guides us towards the development of an effective training program: the re-education of cerebral control cannot be considered complete until the abnormal brain function has been replaced, and abnormal vibrations are replaced by normal vibrations.

The first question we have to ask then is how can we change the vibrations?

To do this we first have to discover what causes them. We already know the answer - they are caused either by an instability, or an insufficiency of cerebral control. But these very general causes do not

give us enough of an indication upon which to base a training or re-education program. Therefore, there are other factors which we must consider carefully, and which can provide us with keys to the puzzle.

When examining a patient's skull, it very often happens that we feel a change in the abnormal vibration; it resumes a regular rhythm, and resembles vibrations characteristic of cerebral control.

What causes this sudden change in abnormal vibration? Here are the three main reasons:

1. If the case is one of simple instability, it is enough for the patient to become more aware of what s/he is doing and thinking.

2. When there is some degree of insufficiency, awareness alone is not enough; the patient must be able to concentrate on what s/he is thinking or doing.

3. The third factor, and the most important, can replace the previous two: it involves bringing willpower into play. The patient must make the thought or act voluntary, in other words the thought or act is subject to his/her will.

Therefore, normal cerebral control depends on these three factors - awareness, concentration and willpower - being present.

Patients have to be sufficiently conscious, concentrated, and able to exercise willpower, in order to modify an abnormal vibration.

Chapter 5:

Treatment

As we begin our discussion of treatment, we should keep in mind what we learned in the preceding chapters, and consider the cure of psychasthenia from two aspects:

1. Functional
2. Psychological

We will therefore have two well-defined objectives:

1. Modify the cerebral mechanism through functional re-education.
2. Modify the mental state through psychological re-education.

These two objectives are actually inseparable, and we are only making the distinction for the sake of clarity.

Functional treatment

We have stated that all cases of instability or insufficiency of control are characterized not only by psychological modifications, but also by functional changes. It is therefore quite natural to try and adjust the brain's abnormal functioning, just as we try to adjust a patient's

abnormal thinking.

Patients find this material approach to their illness very useful: they need some kind of concrete representation, something more tangible than simply dealing with thought processes, since they know that these are already out of their control to a large extent. Through functional treatment, we teach patients how to modify an abnormal vibration by providing them with the qualities they lack. In other words, they are shown how cerebral control should operate, and how to replace their own non-control.

The mental exercises we offer here are designed to re-establish the essential qualities of cerebral control; their aim, therefore, is to help patients acquire willpower, concentration and an awareness of their defects. They also correspond to the various types of normal vibrations, so that by practising them, patients are led towards the objective (functional and psychological healing).

Insufficient control is not simply a question of thoughts and mental processes, but also affects even the simplest actions, and all forms of sensation.

We will therefore begin our program of re-education by teaching patients how to control their ordinary actions and sensations, before moving on to the control of thoughts and ideas.

Chapter 6:

Controlling actions

Learning to control actions is the first step in re-educating the brain; it the simplest way to achieve this and, although it may often seem almost childish at first, it does provide appreciable results.

If we observe the way psychasthenic patients carry out their daily activities, we notice a remarkable lack of clarity and precision. It is as if their thoughts were elsewhere most of the time, or they were incapable of thinking about what they are doing while doing it. This makes their actions hesitant - you get the feeling they lack any kind of determination.

Let's look at an example: A psychasthenic wants to get something from his room, but by the time he gets to his room, he often forgets what it was he came for; if the object is in a locked drawer, he will take it out and then forget to close the drawer, or lock it, and so on.

All actions are carried out in an altered state of consciousness, without purpose or determined will; the patient is not able to retain the initial impulse, which was to retrieve such and such an object, and see it through to the end.

You can imagine how inconvenient this is in everyday life; in addition, all these semi-conscious acts have repercussions on the brain;

the mind tires of trying to remember what it is supposed to be doing; the constant uncertainty troubles the patient, and leads to a loss of self confidence.

We do not begin by asking patients to control all their daily activities - this would be impossible - but simply to perform a certain number of predetermined actions every hour. In a relatively short time, the constant repetition of predetermined, controlled actions creates a kind of cerebral pattern which patients find very useful.

Before we proceed to the re-education of actions, we must first understand what it is we are asking of patients.

A controlled action must be “conscious,” which means that patients must be absolutely present and concentrated on what they are doing. This should exclude all distractions from interfering. That is the first point.

The second important point is the following: during a conscious act, the brain must be uniquely receptive; its function is to record precisely what is taking place; the brain must “feel” the action and not think it. This distinction between feeling and thinking clearly distinguishes a controlled, conscious act from a non-controlled one. Thinking an act means emitting energy, while feeling it means receiving energy.

By developing this receptivity, sensations become accurate instead of distorted, as is often the case with neurasthenic patients. Patients must get into the habit of looking clearly at what they’re seeing, of listening to what they hear, and of feeling what they do.

Here is how to proceed:

Vision

Vision becomes conscious when you simply allow the vibrations of the object you are looking at to penetrate your eyes. You should feel as if you are absorbing the object without making any effort to do so, without having to stare hard at it. You are not looking for details; your mind should grasp the object in its entirety, and create an image which becomes very clear with a little practice.

Hearing

The same goes for hearing: you have to allow the sound you're listening to to penetrate you, and learn to open your ears without making any forced effort. You could listen to the ticking of a clock for a moment, or the noise of a moving tram, to reinforce your awareness of hearing.

Perceiving sounds in this way makes patients less irritable, since they can become indifferent even to unpleasant noises, when they perceive them consciously. This simple procedure works very well when treating noise-related phobias.

Touch

The first sensation which is perceived, whether cold or hot, hard or soft, will be the most conscious.

The object presented to the patient should not be analyzed. Patients should only be asked to report their initial sensation. Other

senses (taste, smell) are treated in the same way.

Movement control

Every action become conscious if the movement involved in the act is perceived in its totality. For example, to lock a drawer, you have to realize that turning the key completes the action; or if you put a coin into your wallet, you have to understand that it is really there.

True awareness excludes all uncertainty: you know that the drawer is locked, or that your wallet really contains the coin.

Thinking alone, without conscious awareness, will always open the door to doubt and all its consequences.

When re-educating the mind to be more conscious, it is useless to try and work with complicated actions; the best actions are those which are carried out most frequently, and on a day to day basis. By using such actions, patients can stop their thought process for an instant and become totally conscious of what they are doing, which calms the mind and allows it to rest.

Walking

Walking merits special attention because it allows for the frequent application of conscious activity, despite the complexity of the movement involved.

Conscious walking usually creates an impression of suppleness and certainty; it does not occur until coordination of the various sensations involved in the act of walking has been achieved by the brain.

To do this, you must proceed in successive stages.

First instruct patients to perceive the sensation of their foot touching the ground, then the movement of the leg, and finally that of the entire body.

Breathing is also involved, and should be adapted to the movement. Also don't forget that vision and hearing are a part of walking as well.

Conscious walking can make patients less tired, and dispel dizziness in some cases. It has been successfully used in the treatment of agoraphobia.

Voluntary acts

We consider voluntary acts as a special class, slightly apart from other actions, and very useful as far as training is concerned. We naturally agree that all conscious acts are at the same time voluntary, since they are carried out by choice, but we do make the following distinction.

When we ask patients to perform an act consciously, we are asking them to simply concentrate on the sensations produced by the act, for example the sensation of bending an arm or touching a light switch. In acts which are qualified as voluntary, patients concentrate more on the feeling of their desire to perform the action - i.e. they feel they want to bend their arm, or raise it to close a light switch.

Getting a patient to stand up as a conscious act can be translated into the following verbalization: "I feel myself getting up." If the act is voluntary, the patient will verbalize it this way: "I feel myself want-

ing to get up.” Making this distinction may seem overly subtle, but it does have its uses, since it is the first step in re-educating the faculty of willpower.

And there is a difference in cerebral vibration which can be detected when using the technique of hand application. The waves will be stronger for voluntary acts than for conscious acts. So patients should be taught to perform various voluntary acts during the course of the day, and learn to distinguish them from purely conscious ones.

When they awaken in the morning, they should get up voluntarily, and go to bed in the same way; they should leave their dwelling place because they want to go out, and so on.

Physical effect of controlling actions

Now let’s look at how controlled action affects psychasthenics. At first, it may seem as if this constant effort to concentrate and act attentively is completely abnormal, placing an added strain on patients and adding yet another unhealthy symptom to the list.

However, what may be true for a balanced mind is not necessarily true for a non-controlled mind. Psychasthenic patients, therefore, can develop very useful habits through voluntary action. If their actions are carried out properly, they feel more in control, become calmer and weigh their actions more carefully. With their brain constantly occupied with something concrete, they experience less and less anxiety. Their self confidence is given a boost, and they get into the habit of controlling what they think and do.

The more patients are made to perform precise conscious or voluntary acts, the faster they will find that the effort and concentration

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required, which is somewhat difficult at first, soon diminishes; conscious action will no longer be work, but a practical habit, which becomes progressively more natural and normal.

Also, conscious or voluntary actions make a deeper impression on the brain; patients can more easily remember what they did, and this, in turn, serves to gradually strengthen the faculty of memory which was completely lacking beforehand.

A common error for beginners is to make too much of an effort to make actions conscious. On the contrary, controlled actions should be relaxing, since the brain has to concentrate on only a single idea or sensation - that of the action being carried out.

To summarize, controlled movement results in:

1. Patients being fully conscious of the action they are performing;
2. Clarity of thoughts associated with the action;
3. The feeling that the act is desired or voluntary.

In addition, patients are obliged to concentrate on the present moment, which relaxes the brain and allows it to rest.

As far as sensations are concerned, control teaches patients to receive impressions as they are, without distorting them by thinking too much; it heightens receptivity, and in so doing helps patients exteriorize more easily.

Chapter 7:

Controlling thoughts

Once the ability to control actions is acquired, we can move on to the control of thoughts. Here again, there are three essential conditions:

1. The thought must be conscious.
2. The patient must be able to concentrate on the thought.
3. The thought must be subject to the patient's will.

The thought must be conscious

This means that patients must be aware of their thoughts; awareness, which is so natural in normal minds, is only partial in cases of non-control. It must be remembered that psychasthenics suffer from mental confusion most of the time; thoughts are unconnected, and occur so rapidly that patients simply cannot be aware of everything that goes through their mind. Thoughts are rarely clear and precise, and are expressed only with great difficulty.

This state of cerebral unawareness varies considerably; it is sometimes so weak the patient doesn't know it's there; in other instances, it can be extremely intense and debilitating.

Obviously, we cannot ask patients to judge, rationalize or differ-

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entiate between thoughts which they are unaware of. So the first step is to teach patients to be aware of what they are thinking, and to do this we have to determine the state of consciousness of their brain.

State of consciousness

To help patients get used to being conscious of their own thought processes, we ask them to perform a quick examination of everything they are feeling and thinking, of any ideas they might have, a number of times a day. This self examination may be carried out mentally or, in some cases, written down so that it can be analyzed by the treating physician. A written report has the added advantage of forcing patients to formulate their thoughts more precisely.

Awareness is equivalent to the “*gnoti seauton*” of ancient philosophy; more than anyone, psychasthenics must learn to “know themselves” in order to arrive at an understanding of what is positive and what is negative about the functioning of their own brain. They must understand the way their mind works, and become aware of the abnormal ways in which they modify certain thoughts and impressions; they must also learn what thoughts or ideas provoke anxiety. They will learn that having uncontrolled thoughts is like being in a car with no driver - the vehicle has no direction, often heading toward a destination which is completely different from the one intended, and usually ending in disaster. They will learn that some thoughts must be avoided altogether, if they want to stop suffering; that certain ideas produce certain symptoms, and that fear of pain will almost surely bring on the pain.

If this analysis is carried out properly, it will give patients a field of experience on which to base further thoughts and actions; after a number of attempts, they will finally understand that certain thoughts

are to be avoided, and that this can only be achieved through controlling thoughts and impressions.

Physicians have a very important role to play - they must show patients their errors, and also what to look for; they will also discover a host of indications for further treatment.

What patients should not be permitted to do is concentrate on all their little pains and anxieties, which is what they are usually preoccupied with, but rather shown how to look for the causes of their particular problem. This is quite different from the more traditional technique which requires patients to make notes of all their minor problems in a little black book, and which we believe is an ineffective treatment. Our analysis is designed to be useful and interesting. Instead of noting problems, patients keep track of the progress they are making, and see results in a relatively short time.

To achieve a more or less complete state of consciousness, patients must first look at the state of their brain.

State of the brain

From a control point of view, we can distinguish two primary states of the brain:

1. Active state
2. Passive state

Active state

By this we mean the brain in its normal state, which can also exist in psychasthenics. A hand, placed on a patient's forehead, will detect

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a regular, rhythmic vibration without bursts or lulls of activity; psychologically speaking, this state represents the brain in its conscious and controlled state, subject to the person's will.

We can also call this the positive state: patients have better comprehension; they are aware of what they are thinking and doing, and know what they want to do; the brain is not burdened by anxiety, fear, or any abnormal ideas.

Passive state

The passive state refers to all varieties of cerebral non-control. The mind may be conscious, but it is never voluntary, i.e. it is not directed by the person's will. Psychologically speaking, this state is characterized by extreme receptivity, as if the mind were exposed to all kinds of deficiencies, obsessions and phobias. These psychological symptoms only arise in the passive state, which is therefore perfectly representative of a pathological state of the mind. To give patients an idea of what the passive state is, we can describe the main forms it assumes, starting with the one closest to the active state:

1. Semi-conscious dreaming and fatigue
2. Wandering mind
3. Excess excitability
4. Confusion
5. Anxiety
6. Depression
7. Anguish

Each case represents a special type - one person will suffer more from excess excitation or confusion, while another will succumb to depression or anxiety. But almost all will experience some degree of

all the symptoms associated with the passive state.

Each variety has its particular vibration, which can be easily distinguished through hand contact. An experienced therapist will be able to differentiate the dream state from excess excitability, or simple wandering of the mind from real anxiety.

This classification aims to facilitate our understanding of the passive state which, once it is recognized, can then be modified. We are convinced that the greatest difficulty in curing psychasthenia consists of the fact that patients do not know what is wrong with them - they do not understand the problem, or even if they do, they don't know how to go about changing it. Therefore, it is up to us to provide them with the tools they need - i.e. regaining awareness through re-education - so that they can cure themselves.

Chapter 8:

Concentration

Now that we have defined the states of conscious thought and action, let's move on to the second essential quality of control - concentration.

Definition

Concentration is the faculty of being able to fix thoughts on a given point, to develop an idea without getting distracted, to be able to lose oneself in a book, in some kind of work, etc. The faculty is completely lacking in neurasthenic patients.

We will now outline the exercises we use to help patients acquire the ability to concentrate.

Exercise No. 1

At first, trying to concentrate on an idea is too difficult. So the first exercise consists of mentally following a curved line, for example a figure eight or the geometric sign of infinity.

It is hard to imagine that such a simple exercise can present any problems, yet many patients are incapable of doing it correctly.

If the exercise is carried out properly, a double regular wave pattern will be felt through hand contact; if done incorrectly, you will feel interruptions in the wave pattern, almost always occurring as the patient reaches the outer edges of the curves.

Patients will become aware of this themselves with a little effort.

Exercise No. 2

Ask your patient to follow the swinging pendulum of a metronome, while mentally repeating the ticking sound. Start with 10 to 15 repetitions, and then progressively increase the duration of the exercise.

Exercise No. 3

Train your patients to try and retain the impressions they perceive when touching an object for a certain time.

In these three exercise, we are trying to help patients develop mental concentration related to sight, hearing and touch.

Exercise No. 4

Concentration on a point in the body: in this exercise, patients are asked to mentally determine the exact sensations they are experiencing, first in their right hand, then the left hand, then the right foot, left foot, and so on. When this becomes fairly easy, move on to the elbows, knees, ears, various fingers, etc.

What happens is that in order to specify the various sensations

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coming from different parts of the body, patients are forced to concentrate on those points. The advantage of this exercise is that the patients themselves know if they are concentrating correctly or not. After a few days, concentrating on a given part of the body will produce a particular sensation which patients can easily recognize, for example a feeling of pins and needles, or a slight shock, or the feeling that blood is flowing into the designated area.

Hand application will show more accentuated vibrations on the right side of the forehead when patients concentrate on their right hand or foot, and on the left side when concentrating on the left hand, foot, elbow, etc.

Exercise No. 5

The doctor places his/her finger on any muscle, and asks the patient to concentrate on that point. If the patient is able to concentrate, the doctor will feel a slight muscular contraction under his finger. Note that it is often necessary to wait a few seconds before getting results.

The exercises we have just described are easy, and can be improvised on to form infinite variations; we have only given the basic forms here - the rest is up to you.

Exercise No. 6

Concentrating on the number 1: this exercise often presents real difficulties, and we have seen many patients take weeks before being able to do it correctly, although at first it seems quite simple.

The exercise consists of writing and mentally saying the number

1, three times in succession, without allowing any other thoughts to interfere. In addition, between each written and mental repetition, there should be a pause of between half a second and a second. For example:

1 pause 1 pause 1 pause

It is not necessary to maintain a mental image of the number 1 during each pause.

In this way, patients have to concentrate on sight, words, and mental hearing (since the word is heard in the mind as it is spoken in the mind) as well as on the act of writing, which also occupies the brain.

As soon as a patient is able to do the exercise correctly, increase the number of repetitions to 4, 5, 6, 7 etc. A patient who can do seven successive repetitions is able to concentrate sufficiently.

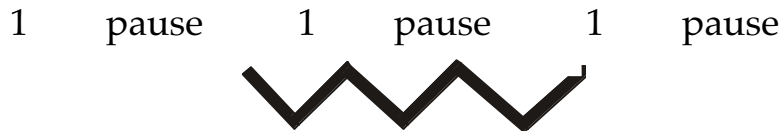
Let's look at what happens in the brain, functionally speaking. To start with, it must make an effort of will to suspend all other cerebral activity, then it performs the voluntary act of writing the number 1, speaks it mentally, and listens to it mentally at the same time.

Then everything stops for a second, after which the process is repeated. The patient must therefore concentrate a number of times in a row. It should be noted that without the pause the exercise becomes much easier, but at the same time loses much of its value.

The exercise forces patients to be fully in control of their brain; that is why it is so difficult.

The presence of a controlling physician is indispensable at the outset, since patients are hardly aware of the errors they make.

A curve representing good concentration would look like this:



Each 1 produces a clear impulse, followed by a period of relaxation.

When incorrectly done, the following curve is produced:



We should not place too much emphasis on visualization of the number 1: some patients never succeed in doing it. The effort to visualize can be useful at first, but it can be dropped later on, and replaced by concentrating on the sensation of writing, mentally speaking and hearing.

Of course, any other number can be used, as well as grammatical symbols like dashes or periods. We chose the number 1 because it gets patients used to the idea of concentrating, which, in fact, means fixing the mind on one single thought or action.

Patients will then make the transition more easily from this form of concentration, which is more or less mechanical, to real psychological concentration. As a means of transition, we suggest that patients try to gather all their thoughts and concentrate on the number 1. In other words, patients are told to mentally repeat the number 1 when they feel they have succeeded in gathering all their thoughts

into a single, larger thought (which is really the concept of thought itself).

An image of the above would be a circle whose rays (separate thoughts) all converge on the number 1 at the center.

Every patient has his or her particular concept for achieving this result: some imagine that they are shrinking their head until there only room for one thought or idea; others try to eliminate all thoughts except the thought of 1.

If patients persevere, they will gradually become convinced that they are able to concentrate for a set period of time, no matter how short. Once this conviction is acquired, it becomes a precious aid in their struggle. But it is not enough - patients must eventually learn to concentrate whenever, and on whatever they want.

This is certainly more difficult to achieve; patients should practice ignoring distractions, at first in solitude, and finally when surrounded by people, noise, etc. In this way, they gain confidence in their ability to concentrate at will. This ability becomes complete when they are able, through concentration, to put a stop to anxiety, or overcome a phobia.

Now let's assume that our patients have acquired this ability: the next step is to ask them to concentrate on an idea.

Concentrating on ideas

In this exercise, patients are asked to develop an idea in their minds. For example, they may try to resolve a problem, or prepare a written summary of something they read, or listen to a conversation or lecture for a predetermined period of time, without allowing them-

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selves to get distracted. To do this they must instantly stop all other thoughts from entering their mind, except those which are directly related to the subject at hand.

Patients will start to see practical results only gradually, after a number of failures. The allotted time period should be very short at first, so as not to discourage them, and the activity should be treated as a simple exercise and not some kind of test.

The most common error patients make at the beginning is to wonder if they are really concentrating properly during the exercise. This self verification naturally interrupts their concentration, and patients start worrying if they are able to concentrate at all. It should be explained that they will not be really concentrated unless they approach the exercise as simply as possible.

This series of exercises cannot be directly controlled by the attending physician (except the one which involves concentrated reading, where hand application will produce a series of regular wave vibrations). For the rest, we have to depend on what patients tell us, and leave them to judge their own progress.

However, there are a number of other exercises which can be verified through hand application, since the curves obtained from them are very characteristic.

One example is "Concentration on Tranquility."

We ask patients to try and establish a sensation of mental calm, of psychological and physical tranquility in their minds. To do this, they will mentally evoke an idea or thought which represents those feelings. For example, one person might think of a peaceful landscape,

another of a particularly soothing piece of music, another of some elevated moral concept like compassion, or a prayer, etc. Once the feeling of tranquility is attained, patients must try to maintain it for as long as possible, through an effort of willpower. The image should become more defined the longer it is held in the mind. Objective verification is simple - as soon as the sensation of tranquility is established in the brain, the hand perceives a modification of vibrations, which become slower and stronger.

Concentrating on the idea of energy

This is done using the same method as in the above exercise. Patients are asked to try and feel the energy and strength pulsing through their own body, by remembering occasions when they were really energetic.

They will try to fathom what “energy” really is, or might be. And with a little perseverance, the sensation will become engraved in their brain.

During the exercise, hand application will detect a series of more accentuated, voluntary vibrations.

Concentration on the idea of control

This exercise is the natural progression of the two preceding ones, and requires a simple process of deduction. In fact, as soon as patients are able to remain calm or summon their energy at will, they are capable of self control. They will, therefore, not have much difficulty in defining the sensation of control.

They simply have to be persuaded that, during those moments of

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voluntary tranquility or energy, they really are in control, in order for them to gradually develop the faculty of real control which is so essential to their well being.

The vibration associated with control is stronger than the usual vibrations - rather than the series of short impulses produced by voluntary energy, these vibrations are slower, stronger and very regular.

At first, patients only have to experience the sensation of tranquility, energy or control for a few seconds; as they develop the habit, the duration will increase. Patients should therefore do the exercises a number of times per day, under varied circumstances.

Soon the sensations will become engraved in their brain, so that they are able to produce them instantaneously, which is extremely useful.

The same method can, of course, be used to establish other sensations, depending on what we want to change in the patient's behavior, and on each individual patient's characteristics.

Physiological effects of concentration

The ultimate aim of concentration is to regularize what we call "cerebral emissions" which are continually disturbed in the non-controlled state. Regular cerebral emissions are necessary to concentrate thoughts on a given object, and to digest or classify that object; without regular emissions, no useful work can be done, since the mind wanders aimlessly, and is disturbed by all kinds of distractions. Concentration directs the thought process, and is the antidote for fighting obsessions and phobias.

The effects of concentration are not limited to the mind, since it can act on the physical body. The physiological effects of concentration are worth mentioning here.

To understand these effects, it must be assumed that concentrating on any fixed point results in an influx of nervous energy, originating at that point. This nervous influx is proof that concentration does produce cerebral emissions which have a very special regularizing and healing effect, which we will now look at in light of a few sample cases.

Mrs. V, 45 years old, suffered from almost complete paralysis of her lower limbs for close to ten years. She could stand up for a moment, but could not walk; as soon as she tried, she felt as if her legs were collapsing; she had no conscious control of the muscles in her legs, although she could move her upper body and arms normally. She had no problems with perception, nor did she complain of any particular pains. But she did experience a sensation of intense fatigue, which her immobility only aggravated. Aside from these primary symptoms, she clearly exhibited symptoms of cerebral instability, although these she all but ignored, preoccupied as she was with her paralysis. She was obsessed with the fear that she would never recover, since all treatments up to that point (electric shock, showers, massage, injections, etc.) had had no effect.

It was not difficult to prove to this woman that her pseudo-paralysis was the result of her brain not sending adequate nervous emissions to her lower limbs, and that prescribing appropriate exercises would soon alleviate the condition.

This case was relatively easy, since a diagnostic error was hardly possible. However, when patients suffer from contractures, it is some-

times difficult to be certain of the results. The following case, on the other hand, proves that we should never give up hope unless a lesion has been absolutely identified as the cause of the disorder.

Mrs. W was bedridden for 14 years because of generalized contractures. All the doctors she consulted agreed the problem was caused by an incurable disorder of the medulla. I was only called in to provide some relief, since the contractures were very painful. The patient seemed to be resigned to her condition, and only asked for some relief from her pain.

My cerebral examination provided signs of excessive tension. This led me to hope that the cause of the problem was not a lesion of the medulla, but a defect in her motor mechanism. She agreed to let me treat her, and to my great joy she recovered completely in six weeks time, and has remained healthy for a number of years since.

The heart also responds very well to these exercises. Here are two very revealing cases:

Mrs. X came to see me about her angina attacks; she had suffered from acute dilation of the heart (muscle), accompanied by generalized edema and cyanosis. Her treating physician had concluded that cause of the disorder was an organic lesion, complicated by nervous problems. When she first came to see me her attacks were frequent, and she was under constant care, day and night. Her slightest movement brought on dyspnea and palpitations. In my opinion, the nervous problem was the major cause of her disorder. I advised her to give up all medication, and prescribed a number of exercises. Fifteen days later she went home, completely cured.

The second case concerned Mrs. Y, who had been bedridden since

catching the flu, which was not serious in itself, but after her convalescence dragged on for weeks, her doctor concluded that her heart was in bad condition, that she was suffering from asthenia and palpitations, during which she tended to faint at the slightest movement.

She spent two months in this condition, during which time I didn't see her. She finally wrote me, asking if there was a possibility her disorder was of nervous origin. I wrote back, advising her to try certain exercises, and to verify any results with her treating physician. And in fact, a few days later her symptoms disappeared.

The digestive system is susceptible to a host of nervous reactions, among them contractions of the oesophagus, stomach or intestines, hyperchlorhydria, constipation, ulcers, etc. Here too, emission of nervous currents through concentration can perform wonders.

An example: Miss X had been suffering from attacks of hyperchlorhydria and vomiting for a number of years. Her condition worsened, and she ended up having an operation (for gastro-enteritis). Unfortunately, this had no effect. Her pains and nausea persisted, and prevented her from eating anything. She was in this miserable condition when I began my treatment. With no medication, and no specific diet, her symptoms soon improved, and eventually disappeared.

If we had enough space, we could cite many more such cases whose origins appeared to be organic, but which were cured through re-education. However, since space is limited, we will conclude this chapter with a description of how nervous currents affect pain.

Pain

Pain is a common symptom of neurasthenia, and can be easily

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influenced by nervous currents. We might conclude, at first, that it would seem inappropriate to call a patient's attention to his or her pain. But this view is mistaken, since concentration, directed at the point of pain, results in a normal nervous influx which neutralizes and modifies the current of pain perceived by the brain.

This can be proved by the following simple experiment:

Pinch a person's body hard, and ask the person to concentrate on the painful point: if the person can concentrate well, the pinching sensation will clearly disappear as soon as the current is directed at the point in question. Of course, the subject must concentrate on the area of the body, and not on the pain itself.

This phenomenon is not a case of self hypnosis, since it is easy to see that the cessation of pain does not happen until the nervous current is created, and this in an incontestable manner.

Mr. X had been suffering from intense pain in his right thigh for months. The pain would come in the form of attacks. His doctor diagnosed the cause as ataxia (loss of motor coordination due to a lesion of the central nervous system). Analgesics and injections of morphine could only partially alleviate the pain. Attacks usually lasted for a period of about three weeks. With my procedure, the pains stopped completely after only two sessions.

However, results do not always come so quickly, and sometimes require a relatively lengthy training period to succeed. Nevertheless, my experience proves that many cases of pain due to nervous disorders can be cured with this simple procedure.

Chapter 9

Elimination, de-concentration

We teach patients how to concentrate and how they should centre their thoughts or ideas. We also teach them how to do the opposite, i.e. how to get a thought out of their mind.

The usual way to do this would simply be to think of something else. However, what seems simple to normal people is all but impossible for neurasthenics. All they seem to be able to do is concentrate even more on the undesired thought. They must be taught to eliminate such thoughts, by attacking them directly.

Experiment 1

The simplest training procedure is the following:

Patients choose 3 to 5 objects and place them on a white sheet of paper. After studying the objects, they are asked to eliminate one by taking it off the paper and putting it aside. They are then told to close their eyes and to make sure they can mentally eliminate the object in question. This is the main part of the exercise.

A second and third object are eliminated in turn, until all objects are gone. If the exercise was done correctly, the patient will be left with a mental image of a blank sheet of paper, devoid of objects.

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Although this exercise may seem infantile, it is effective. After a number of repetitions, the brain becomes accustomed to eliminating unwanted objects (or thoughts) from its mental image, an ability which is very useful.

Experiment 2

Patients are asked to write 2 or three numbers down in their mind. They must then erase each number successively until their mental image is empty.

Experiment 3

Offer a patient two objects and tell him/her to mentally choose one and eliminate the other. The same thing can be done with two numbers, letters, words, phrases. etc.

You can verify whether or not patients are doing the exercise correctly from the vibrations felt by placing your hand on their forehead. If you ask a patient to mentally write the numbers 3 and 5, for example, you will feel a vibration on the left side when s/he writes the first number, 3 (since people write from left to right) and a vibration on the right side when s/he writes the number 5. Then ask the patient to eliminate one number. If s/he chooses the 3 and keeps the 5, for example, you will feel a vibration on the right side (and vice versa for the 3).

The same occurs for objects - the object to the right of the patient will be inscribed on the right side, an object to the left on the left. It is interesting to note that nervous persons do the opposite of what they are supposed to do and, at the beginning of their training, it is always

the object or number which they want to eliminate that they fix in their brain.

Once patients can eliminate numbers, they move on to letters, then to words, and finally to sentences. Words are first erased letter by letter, then as whole words. Sentences are first erased as words, then as whole sentences.

After a short period of training, patients succeed in eliminating obsessive ideas and phobias, temporarily at first, and then more and more permanently.

We use another procedure of elimination which we call “de-concentration.” This, in fact, is the opposite of the concentration exercise. In this exercise, patients first concentrate on the number in question. They must then voluntarily and gradually eliminate the number. We insist on this point since, under no circumstances, should the number disappear without the patient’s consent.

Here’s how to proceed:

1. Patients can mentally write the number in smaller and smaller characters, until it disappears completely.
2. They can also imagine that the number is getting farther and farther away, until it becomes invisible.
3. Instead of making the number move farther away, patients progressively increase the interval of rest between efforts to concentrate on it. An initial rest period of 1 second is lengthened to 2, 3, 4 seconds; during these intervals, patients must eliminate all thought of the number.

4. After initially concentrating on the number, patients are told to relax their brain for as long as possible. As soon as a thought arises, they concentrate on the number again, and so on.

These last two techniques have the advantage of getting the brain used to relaxing. If the state of relaxation is long enough, it leads to sleep, and is therefore the best way to cure insomnia.

Chapter 10:

Willpower

Willpower is the crucial point of the training, since it is the force which will allow neurasthenic patients to regain the faculties which their illness has caused them to lose.

The first thing we notice is that a kind of intrinsic willpower exists as a force in all individuals, whether normal or neurasthenic, and even in persons suffering from abulia. Therefore, it is not actually willpower that these people lack, but the ability and knowledge to use it correctly.

We will first define what willpower is, and to do so we will base our definition on what happens in the brain when willpower is brought into play.

Here's what we observed: as soon as a person wants to want or decides to want, energy is released in the brain, and cerebral vibrations double or triple in intensity, depending on the force of the person's willpower. In graph form, willpower looks like this:



The increase in vibrations may last for some time or not, depending on the individual's state of mind, but it is always apparent when

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willpower is brought into play.

With this constant in mind, we can define willpower as a separate force, a special energy existing in each individual, independent of any thought or idea, which manifests itself under certain conditions which we will specify in a moment. This force exists in every individual, and remains intact as long as that individual exists. Used in a normal way, it increases during intense periods of cerebral or physical activity, and diminishes during periods of inactivity. However, like all forces, it has its limits, and also needs periods of rest.

Therefore, this force is latent: it does not manifest itself as an increase in vibration unless a person wants to want something, and this process of activating the faculty of willpower is what we call...

The effort of will

The effort of will, which can also be called an expansion of willpower, can be compared to opening the tap of an energy reserve; the energy that flows out can be applied to an action, or to a thought or feeling. This is the simplest way of describing how willpower works.

The force of willpower acts like a whip. It is temporary, but can be renewed. Its intensity is regulated by a normal individual's need at the moment it is brought into play, since an individual can control his/her emission of willpower, just as s/he can control all other aspects of cerebral activity.

In cases of insufficient control, we have to work not only on the faculty of willpower, which is weakened by inaction, but also on the way it is used, which is always defective. The reservoir of energy may have some leaks, or a patient may not know how to use the en-

ergy reserve at all.

What conditions are necessary for bringing willpower into play? They are, of course, the same in for persons suffering from insufficient control as they are for normal persons, and can be considered from two points of view.

First let's look at the phenomenon of willpower from a mechanical point of view, which is the less important of the two, but which should be understood.

This is what happens whenever willpower is used:

1. An effort of will is never possible when persons are exhaling. It always happens during the pause after inhaling, as if the brain were looking for a physical point of reference in the air contained in the chest cavity.

2. There is a more or less pronounced increase in pulse rate, and accelerated cerebral circulation.

3. An effort of will is almost always accompanied by a muscular contraction.

These three points describe the mechanical side of the effort of willpower.

To get patients to reproduce the same conditions, we make them do the following exercise:

They are told to inhale, and then hold their breath for 2 to 4 seconds while mentally repeating the phrase "I want" and clenching their fists.

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This fulfils the mechanical requirements for making an effort of will: retaining air in the chest cavity, which also increases pulse rate and circulation; repeating “I want” in relation to an act or decision that has to be made (or simply saying “I want to want...”).

Too much emphasis should not be placed on the importance of this little scenario. All that is required is that patients become familiar with the process through repetition, until it becomes almost unconscious.

Now let’s look at the psychological conditions, without which there is no emission of willpower. These are three in number:

1. Knowing what you want.
2. The possibility of getting what you want.
3. The sincerity and truth of wanting.

Knowing what you want

No effort of will is possible without definitive thought. We have to be precise about the nature and the goal of wanting. We often believe we know what we want, without realizing that the idea we have in mind is too vague and imprecise. In such cases, the mind cannot concentrate on the idea, which has no substance, and nothing is achieved. We must get into the habit of accurately formulating exactly what we want, in a clear sentence. We often realize how vague our desires are when we try to formulate them clearly. This indicates that we often really don’t know what it is we want.

Possibility of wanting

This second factor is easily understood - it is futile to want what

is impossible. The mind knows when this is the case, and will not make any real effort to achieve what it knows is impossible.

Sincerity and truth of wanting

Of the three psychological conditions involved in making an effort of will, it is most often this last which is defective, and I believe I am not exaggerating when I say that it is due to a lack of sincerity that most efforts of will fail.

The causes are numerous: first there is paralyzing doubt, the fear of making any kind of effort, which can even be seen as a form of self-imposed suffering for daring to want something. Then we have the class of persons (and there are many) who lie to themselves, some unconsciously, others quite knowingly, but who because of weakness or moral cowardice, eventually expose themselves. Persons who do this unconsciously usually give up after “trying to want” which means that although they think they may want something, they cannot make the decision to actually want it. This can be easily corrected when patients are made aware of their mistake.

Results are more difficult to obtain with the former group; it's very hard to get people to admit that they don't really want what they say they want, since they can easily hide behind all sorts of problems, some of them real, which will prevent them from making an effort of will.

So the first thing to aim for is sincerity - getting these people to be honest with themselves - and then the effort of willpower will achieve the desired results.

However, we must also recognize that, aside from persons who

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fool themselves more or less consciously, there are those in whom the notion of making an effort of will has been entirely extinguished, especially if they have been ill since childhood. We must understand that during their long years of illness, any attempt to exert an effort of will was nothing more than a futile struggle.

These repeated failures, where trying to exert their willpower was synonymous with fatigue and anxiety, eventually annihilated any vestiges of willpower they might have originally had, to the point where these people cannot even comprehend its existence in other people.

Such people do not know how to want, but always in the sense that they don't know how to use their willpower.

These are the three main factors concerning the emission of willpower. Now let's look at how we can use them to re-educate the faculty in problem cases.

Re-educating willpower

The first step consists of getting patients to experience the actual sensation of making an effort of will. To do this, we take the simplest kind of action, one which requires a minimum of movement and expenditure of energy, for example wanting to get up, walk, bend an arm, etc.

As in the exercises on control, patients must be made aware that it is really their own willpower which sets off the impulse to get up, or to walk. This point must be firmly established, since however feeble the emission of will is, it still constitutes a real effort.

Next, we gradually and methodically increase the expenditure of energy patients are required to make. At first we only ask them to perform a simple action for only a few seconds, i.e. almost simultaneously with the effort of will itself.

Little by little, we increase the level of difficulty by asking patients to do things which take more energy, and for longer periods, for example writing a letter, or even making a decision and carrying it out within a given time. Patients should be reminded that in the beginning of the re-education process, their willpower is a very temporary force, and should be taken advantage of while it is there. Also, any decisions they make should be carried through, otherwise they will lose all self confidence.

The physician's role is to make sure that any voluntary act or decision a patient makes is within the limits of his or her capabilities. It would not be prudent to attack a harmful symptom, for example, until a patient is confident in his/her ability to make an effort of willpower. Generally, patients quickly learn to evaluate their efforts at exercising willpower, and can determine whether the effort was well directed by feeling the energy it generates in them.

In all doubtful cases, or in cases where a patient experiences some difficulty, the physician should proceed in the following manner:

The first question patients should ask themselves is:

a. Do I want to try to want? (such and such an object, such and such an action, etc.)

If patients are sincere, and their thoughts precisely defined, the effort of will becomes easy. They will not have to fight against doubt,

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nor worry about success, since they will initially be asked to do only very simple things.

Second question:

b. Can I want? (This determines possibility.)

Third question:

c. Do I want to want (or will I decide to want) - this is the natural progression from establishing possibility - it affirms the decision to want and constitutes the completed effort of will.

For patients, these three questions involve a real examination of their conscious ability to make an effort of will, and can thus be very useful. An attending physician will often observe the following initial results: trying to want is generally successful, while establishing the possibility is doubtful, and the “wanting to want” stage is not there.

After some training, the possibility stage becomes established, but the “wanting to want” stage is still difficult to achieve.

Efforts of will should not only be directed at actions, but also at modifying ideas, sensations and feelings. Patients must therefore get used to making more abstract efforts of will, formulating statements like: “I want to be my own master!” or “I want to be more energetic!” or “I want to want!” in order to awaken the sensation of wanting itself.

In certain cases, as an additional measure, it’s a good idea to look through a patient’s past in order to find instances where s/he did

exert some measure of willpower, i.e. where s/he can remember experiencing what can be termed an “expression of will.” It is curious to note how each individual experiences his or her willpower in a different way. Some find it better to work with abstract ideas, others prefer a definite act or task they must accomplish, while others prefer to work on their emotions.

People have affinities for different things (as the saying goes: Different strokes for different folks!). An orator will find satisfaction in making a moving speech, while a businessman will enjoy working out a difficult deal. It all depends on the temperament and habits of the individual patient.

Errors

In describing the major factors involved in making an effort of will, we have already inferred some of the errors patients tend to make, such as a lack of sincerity, expressing ideas which are not well defined, not realizing the impossibility of a given desire, and so on.

We must draw our patients’ attention to the frequent confusion between willpower on the one hand, and desire, impulsiveness and intention on the other.

Desire

The difference between desire and real willpower is particularly subtle, since for many persons desire is the only reason for wanting something. This confusion is so deeply ingrained that patients often object to the distinction, saying something like: “Well how do you expect me to want something if I don’t desire it!”

This confusion usually prevents patients from making an effort of will. However, it can be avoided by making them aware of the difference between desire and willpower.

Only willpower is an active form of energy, and only willpower expresses freedom of choice; desire is passive, subjecting persons to blind attraction/repulsion reflexes.

If, as often occurs, we can reasonably want what we desire, it is only after desire has been tempered by judgment and freedom of choice. However, we should not wait for a desire to arise before wanting something, since this would mean giving up our freedom of choice.

Impulsiveness is the same as desire, but exerts an even stronger influence. It is a powerful form of mental energy, but it is also disorganized, with no built-in braking mechanism, and therefore not an expression of freedom.

Impulsiveness is even more dangerous than pure desire because it is less rational, and can dominate an individual's mind more completely.

Once again, patients who cannot differentiate between willpower and impulsiveness believe that they want what they impulsively decide to want, without realizing that they are, in fact, slaves to their own impulses.

Intention

Intention, even more than desire, misleads patients. Isn't intending to do the right thing enough? Well, no it isn't, since almost all intentions remain just that - an intention -instead being transformed

into action. Persons who rely on this false conception of willpower quickly run out of steam and rarely achieve their objectives. Intention is all the more dangerous in that it satisfies a person's conscience to some extent - people are content with defining an objective, but do not make any real effort to attain it. Intention, although an illusory form of energy, can possess a certain amount of force, just like feeling sincere about the intention to do good can create the illusion of honesty.

However, with a little training, it is not difficult to differentiate between intention and willpower.

Only willpower can completely satisfy a person's conscience; your conscience knows when a decision has been made - it is no longer preoccupied with finding an objective, nor with defining what it wants. When an outlet for its energy has been found, your conscience becomes calm. When only the intention is there, the energy is only encapsulated and not actually used - you always get the feeling that something is missing, that your intention is only half true.

Physicians will have no problem differentiating between intention and willpower, since a patient's desire will not lead to an exercise of willpower, but only to a greater degree of inner tension.

Patients can be helped to recognize this purely physical difference in sensation, and will eventually be able to tell if there is a real emission of energy (in the form of willpower) or simply an increase in tension (intention).

We will now attempt to explain why patients, when faced with two choices, cannot make up their minds to want one or the other option.

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The error patients make here is to try and see too many of the consequences involved in choosing one or the other option. The major issues are obscured behind a host of secondary considerations, which in turn prevent patients from exercising any kind of clear and objective judgment. They can no longer find sufficient reason for choosing one option over the other.

Patients must be taught to “go with their feelings” since the primal, instinctive choice is usually the right one, encompassing as it does the most important elements of both options. This is what patients should base their decisions on, and this is what will give them the right to want whatever it is they decide.

Generally speaking, patients should get used to making rapid decisions as soon as the idea of what is wanted is clearly defined. The more they hesitate, the more objections they find, until they lose themselves in secondary considerations and end up not knowing what they want at all.

The role of willpower in treating insufficient control

Willpower plays a capital role in the re-education of cerebral control. When used properly, it can make all the difference. The exercise of willpower instills patients with a sense of self mastery, and forces their subconscious to remain within normal limits. It inspires confidence and courage. In short, almost anything can be accomplished through a concentrated effort of will, including the re-establishment of cerebral control.

Psychologically speaking, all passive and uncontrolled thoughts become active when they are controlled by an exterior force or influ-

ence. All mental symptoms of illness disappear as soon as the influence of willpower becomes possible. Anxiety which is produced voluntarily cannot last; even the strongest phobias make no impression against an effort of will.

We could therefore say that a patient who is able to exercise his or her willpower is all but cured.

As soon as patients get used to exercising their willpower, the faculty becomes almost automatic, especially in instances of insufficient control, and constitutes what we call Mental Recovery.

It would be hard for psychasthenic patients to recover if they had to make a real mental effort every time they tended to act passively, without sufficient control.

Fortunately, this is not the case. A well trained brain makes the effort on its own, with hardly any conscious participation on the part of the patient. By simply being aware that s/he is falling, the patient will make the necessary adjustments to remain upright, without any conscious effort - balance is recovered so to speak. Although unconscious, this mental recovery is the result of an effort of will, and can be monitored in the intensity of vibrations felt through hand contact.

For some patients, mental recovery feels like a mechanical effort. One will find the sensation stimulating, another disturbing. What is curious to note is that these patients do not think they are exercising willpower, and see the change as simply a defense against passivity.

When mental recovery assumes this mechanical quality, it may not last very long. There is a danger that such patients will resume their old bad habits. Real mental recovery, on the other hand, is a guarantee that control is stable, and that the habit of exercising control is firmly established.

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Chapter 11:

Psychological treatment

Re-education the faculty of willpower completes the functional, mechanical part of the process of retraining the brain. Patients now have the tools to heal themselves. They know how to modify an abnormal vibration. They can concentrate, and they can exercise their willpower. All they have to do now is create new mental habits by keeping an eye on their level of control. And they can be assured that they will regain their mental equilibrium simply by applying the procedures they have already learned.

In many simple cases, treatment can be limited to the functional level. In more complicated cases, it is sometimes necessary to complement functional re-education with a more psychologically oriented training process.

This second part of the training is concerned with ideas, with the way thoughts are conceived, and with the various modifications patients make in their minds which distort ordinary facts, thoughts and feelings.

We are not going to talk about generalities here, but instead maintain a therapeutic point of view, and we must remind the reader of our stated intention to keep this work as simple and practical as possible, so that it can be used by patients as well as doctors. We will

therefore limit ourselves to mentioning certain facts, certain anomalies which are useful to know about, since they arise in almost all cases of psychasthenia.

These modifications can be easily detected by physicians and patients during the functional treatment stage, by analyzing the various determining causes of recurring symptoms. For example, fear of a certain kind of pain can immediately bring on the pain. Patients can usually understand that the thought precedes and determines the symptom, but are often completely ignorant of the psychological cause of the thought. It is this search for the psychological origin of symptoms that physicians must carefully help patients carry out, since once they become aware of the psychological causes, they can defend themselves and prevent symptoms from developing before they actually appear.

As we have said, the various psychological causes are not difficult to determine. However, therapists must sometimes look to the past, to their patients' memories, for answers.

In the next chapter we'll be looking at some of these causes in order to emphasize their importance.

Clichés

All psychasthenic patients exhibit, at some time or other, certain symptoms which appear suddenly, under certain conditions, and which seem, at first to be completely inexplicable. The symptom may take the form of general discomfort, fear or anxiety, or be more physical - pain, dizziness, nausea, palpitations, etc.

The inexplicable cause of such a symptom is actually an ancient

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impression, crystallized in the brain so to speak, which always produces the same symptom through an unconscious mechanism. Patients are therefore almost always unaware of this mechanism or, if they do know about it, do not connect it to the symptom. We call this the “cliché mechanism” because of its persistence.

Here are a few examples:

1. Mrs. N... suffered for ten years from a stomach disorder characterized by vomiting at mealtimes. She had no organic illness, and could not find any plausible reason for the symptom herself. After a minute scrutiny of her past, she remembered suffering from a violent emotional shock ten years before, just as she sat down to a meal. It was this incident, buried in her subconscious, that was causing her nausea: once the cliché was identified, the symptom disappeared.

2. In addition to the usual symptoms associated with psychasthenia, a certain Mr. B... presented the following behavior: after twenty minutes of walking, he would always start sweating profusely, his legs would start trembling, and he would have to sit down and rest for some time before continuing. This had been going on for seven years, and was probably the result of a severe flu he had once contracted, which had kept him in bed for three weeks. The first time he took a walk after recovering, he developed the symptoms, which persisted, although there was no organic reason. However, as soon as he became aware of the cliché, the symptoms ceased.

3. Another case concerns Mr. L... who suffered for a number of years from palpitations, brought on by the slightest effort. We identified the cause as a medical consultation during which the physician told him to be careful about his heart. The palpitations disappeared as soon as Mr. L became aware of their origin.

We could cite many more examples, since almost all patients have a certain number of cliché symptoms which are more or less pronounced.

In addition to symptoms like vomiting, diarrhea etc. a cliché can cause psychological symptoms, particularly fear, depression and anxiety. Identifying a cliché usually happens in the patient's subconscious memory of the original event, without there being any obvious connection between the event and the symptoms as they continue to arise - at least it is impossible to determine through what process of deduction the brain connects the two. However, in some cases the connection can be identified, as we will see from the following:

One of my patients could not stand seeing or hearing the number 3, which always caused her to experience violent feelings of anxiety. We found the key by accident: a relative, to whom she felt very close, had had a serious accident a number of years before, on the third day of the month. The patient had completely forgotten about the cause, but still exhibited the symptom - a subconscious aversion for the number three.

The cliché symptom will usually disappear as soon as patients become aware that it is only a reaction to a past impression, and has no relation to the present moment. However, in some cases the cliché is so strong that it cannot be gotten rid of so easily.

In these cases, patients must make a voluntary effort to remember the event, until the brain is under control. When the cliché is consciously and voluntarily recalled, it does not produce any psychological or physical symptom.

It is therefore important to look for these clichés and make them

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conscious again, so that patients can modify them by exercising their judgment and willpower.

Abnormal thoughts -abnormal cerebral functions

In this section, we will try to determine what constitutes an abnormal vibration from a psychological point of view, i.e. what peculiarities can be associated with thoughts, sensations and emotions emitted in a non-controlled or passive state.

We call these thoughts, sensations and emotions abnormal, in the same sense that we call the functioning of a non-controlled or insufficiently conscious brain abnormal.

There are no thoughts which are uniquely the result of a passive state. Therefore, there is nothing abnormal about a particular thought itself, despite the fact that it is always erroneous in some way. The same goes for sensations and feelings.

We should find the same causes here as we do for other abnormal vibrations:

1. Lack of awareness

Thoughts are almost always vague and imprecise, which easily leads to an erroneous mental appreciation.

2. Lack of concentration

This makes thoughts unstable; patients have difficulty thinking things through, and are always distracted by other thoughts. Consequently, they often achieve exactly the opposite of what they intended.

In addition, multiplicity of thoughts leads to mental confusion.

3. Lack of willpower

Thoughts are not tempered by willpower, and therefore tend to be exaggerated, resulting in obsessive behavior.

4. Lack of judgment and rationality

A lack of judgment results in patients finding what would normally be considered absurd and completely unreasonable behavior acceptable.

5. Lack of compassion

In the passive state, patients are usually preoccupied with their own sensations, and don't give much thought to others. The state brings on a kind of inertia, with thoughts being limited to the past and future (and which therefore do not require any immediate action).

The feeling of non-control also creates a sense of inferiority, which distances patients from their peers, so that they separate themselves more and more from the life going on around them, perceiving people and events through a veil of self-centered anxiety. Everything seems unreal, since they are not in contact with ordinary day to day life.

As you can see, the modifications created by the passive state are very numerous.

One abnormal thought process found in many neurasthenics concerns maintaining certain "misgivings" whose origins can be easily

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determined. In their subconscious mind, these people never have complete confidence in their thoughts, actions and intentions, and always interpret them to their own disadvantage. For example, a neurasthenic will not admit to making a mistake; instead s/he will form doubts which seem perfectly reasonable, but which are actually an unconscious defense against possible error.

The treatment for this problem would consist of showing patients that people with normal cerebral control, i.e. in the active state, do not experience such misgivings. They must accept the fact that having constant doubts is an illness, and therefore wrong, and that the only way to understand this is to exercise cerebral control.

Generally speaking, we can assume that any thought or idea which contains a suggestion that can mislead an individual is abnormal, and becomes what we call a “dominating idea” which, in its extreme form, becomes obsessive. Patients can easily recognize their own obsessive behavior, and usually try to combat it.

However, thoughts or ideas which are dominant, but which have not reached the obsessive stage, often go unnoticed. Patients do not fear such thoughts, since they seem reasonable and even logical. There’s nothing abnormal about the thought itself; what is abnormal is the fact that little by little it, because of its intensity, the thought supplants cerebral control and relegates it to a secondary role. Such dominant thoughts are usually also rather morbid. They flourish because patients are unaware of them, and therefore do nothing to defend themselves against them.

The feeling of guilt or responsibility, for example, can easily become a dominating idea, and can turn someone’s life into a veritable hell.

Any thought, word or action, even the most innocent, can become an incessant cause of anxiety through a specious reasoning process which patients do not realize is absurd, since it is based on what they perceive as a real or possible fact. For example, a patient drops a banana peel on the sidewalk one afternoon, and at night is still thinking about it, feeling responsible for all the possible accidents it may have caused. Next morning, the guilt is still there, as the patient is sure s/he was the author of all sorts of broken bones, concussions, and even deaths. A few days later, the patient remembers seeing a piece of crumpled paper in the street, and is convinced s/he should have picked it up, that in so doing s/he could have prevented all kinds of fantastic, and disastrous consequences.

These unfortunate people spend their lives worrying about hypothetical disasters that they caused. But they never actually go back and pick up the banana peel or the piece of paper, or whatever the cause of their anxiety happens to be.

In the same way sensations, like ideas, can become abnormal. They are just as bizarre and just as ill defined as abnormal thoughts; like thoughts, they become increasingly exaggerated and persist for no reason, in widely varied forms.

Dominant feelings are even less predictable; they may become very intense, but usually don't last very long; in most cases they become obscured and forgotten, since patients are indifferent towards anything that doesn't directly concern them. A mother suddenly stops loving her children, a lover wakes up one morning having lost all feelings of love for his partner; even religious beliefs, which are the most important thing neurasthenics have to hold on to, disappear. However, we must hasten to add that all these can be regained as a patient's illness is cured.

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Abnormal cerebral function

Thoughts are rarely sustained and carried through to their logical conclusion; instead, patients get caught up in any thought that arises; these supplant the original thought, and are in turn supplanted by new distractions, and so on. The original thought or idea is completely forgotten, or recalled with difficulty.

Normal persons can easily follow the progression of their thoughts. In the non-controlled state, a part of the mind is usually unconscious, and patients draw conclusions which are opposite to what they intended. I am not exaggerating when I say that a neuros-thenic patient can come up with a statement like, "I am in perfect health, therefore I'm sick!" and this with the total assurance of being logical and correct. All we have to do to understand what they mean is to add the patient's unconscious deductions. "I am in perfect health, but I may get sick" may be what they mean. Or "What if I get sick..." or "I'm afraid of getting sick..." or simply "I am sick..."

Patients only recall that in their minds they followed a plausible progression of ideas, so their conclusion must be correct.

It would be impossible to explain how patients manage to produce certain symptoms if this fact were not taken into account.

Another abnormal cerebral function is the constant analysis patients perform in their minds.

Every thought is dissected, scrutinized and weighed to the point where patients invariably become lost in a labyrinth of deductions and doubts. They cannot reach any satisfactory conclusions which would be capable of dispelling their doubts and calming their minds,

nor can they accept any proof that a given idea is valid. They end up doubting everything, including their own sensations and feelings, as well as their thoughts.

You can understand the extent of the mental torture such persons undergo. Unfortunately, the intervention of another person only seems to aggravate things.

Patients think it is their superior intelligence which enables them to analyze their thoughts and feelings so extensively, and cannot accept things any other way.

They do not realize that this involuntary, unconscious analysis deprives their mind of being able to perceive any valid sensations or emotions, which they immediately distort instead of accepting as they are. They do not see that what they take for reason and judgment are really faculties which are not controlled by their “superior self” and that the doubts they entertain are only proof of their own blindness.

A succession of non-controlled ideas, which is the result of abnormal cerebral function, also leads to characteristic states of morbidity and depression.

It begins with a sensation that may be normal and not exaggerated. Then a painful memory, or some kind of fear or sad thought - in fact almost anything - becomes a pretext for developing this form of harmful thinking. The state is characterized by the following behavior: the painful memory (or whatever the pretext is) spreads progressively and indefinitely to everything the patient remembers, instead of remaining limited to the specific event which caused it in the first place.

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Mr. X is a typical example: One day, during a discussion with one of his friends, something was said that hurt him. There's nothing unusual about that. However this friend happened to be wearing a blue jacket, and since that time all blue jackets produced the same sensation of hurt, until eventually the color blue became enough to trigger the unpleasant reaction. And that's not all: the discussion took place on a Friday, and that day became etched in Mr. X's mind as a fateful day, on which he refused to travel, or undertake any kind of activity. The Friday in question also happened to be the ninth day of the month, so the number nine was also to be avoided at all cost. He would not get on a bus that had the number nine, and was very careful never to place nine objects on his dressing table.

This uncontrolled association of ideas persisted and all but ruined Mr. X's life, since he spent all his time trying to avoid anything that might remind him of the original unpleasant experience.

All such anomalies must be sought out in the course of psychological treatment. We have to open patients' eyes and make them understand how these mental defects work, and teach them to accord little or no importance to all passive thoughts or sensations. Patients who become aware of the process can correct it. It is only ignorance that gives passive thoughts and sensations their power.

A whole range of thoughts and feelings can be called intrinsically passive or non-controlled, although they are not abnormal per se. Fear, envy, hate, jealousy etc. are all non-controlled; other feelings, like remorse can be either controlled or non-controlled, active or passive. In active remorse, a person recognizes his or her fault and tries to correct it; passive remorse, on the other hand, can destroy a person as s/he cannot forgive the error, nor struggle to correct it. Passive sadness is a blend of egoism and indifference, while active sadness

can be healthy and beneficial.

The difference between the two is of enormous importance, both from a moral and psychological point of view. A host of destructive consequences could be avoided by an awareness of this distinction.

Any passive thought is a sign of trouble, of a psychological or even physical disorder, which acts as a real toxin on the organism.

We could mention many other ways in which patients develop false attitudes towards life, how they refuse to accept obvious facts and remain slaves to their passive thoughts and feelings, but this would go beyond the scope of the present work.

What we have to do is teach patients to be on their guard against exterior impressions. Such incidents are not caused by abnormal cerebral function, but rather by a reduction, or even total absence, of the brain's reactive faculties.

Reduction of reactive faculties

In normal persons, the brain is constructed in a way that allows it to react against any exterior influences that may disturb its functioning. Psychasthenic persons, on the other hand, are exaggeratedly impressionable. This condition is, relatively speaking, more pronounced when dealing with minor external influences than with major ones. We have, in fact, observed that these people seem able to bear the brunt of an intense psychological trauma, while becoming completely unbalanced by some minor incident. This can be explained by the fact that an intense disturbance is strong enough to awaken their reactive faculties, while a minor one is not, and therefore leaves them defenseless.

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All the little incidents that occur during the course of a normal day, including changes in the weather and atmospheric pressure, be they hot, cold, wet or dry (each patients has his or her specialty) has a detrimental effect on both the mind and body. A slight problem assumes tragic proportions, a minor setback becomes a disaster.

This seems absurd to persons who react with normal cerebral control; their brain tends to automatically get rid any harmful influences, like a rubber ball that bounces back to its original form after absorbing the shock of a disturbance. In patients with insufficient control, the opposite occurs - even a minor disturbance results in a very strong impression that tends to remain fixed in the brain.

How can this exaggerated impressionability be modified and a normal reactive faculty re-established? That is what patients must learn to do.

First of all, they must be conditioned to accept the following axiom: "No exterior influence has an absolute effect on the brain." This means that although we naturally perceive outside influences, both strong and weak, we must always consider ourselves capable of controlling our reactions and overcoming them.

It would be useless to talk about control if this were not true. And as absolute as this axiom may seem to patients, they must use it as a basis for defending themselves. This is the only way they can awaken their normal reactive faculties, increase their resistance and self confidence, and cease being a slave of all and any exterior impressions.

If patients refuse to accept this truth, they will be sure to suffer a relapse. They will never be able to defend themselves, since they believe that the sensations and symptoms they experience, although

caused by exterior influences, are logical and cannot be combated.

They would be true if exterior influences affected normal persons in the same way, but their error lies in the fact that it doesn't - it has no effect unless a person's brain is passive, and therefore incapable of reacting properly.

We ask patients to verify for themselves what we are proposing, through numerous experiments. When their attitude has been modified in a positive sense, they will be convinced that we are right. In most cases, exterior influences cannot produce harmful effects unless the brain is in a passive state. In its active state, the brain is always capable of reacting. If warned in time, and if they possess the ability to modify brain activity from previous training, patients soon learn to defend themselves. Relapses are insidious, usually stemming from a patient's inability to differentiate between normal and nervous reactions. The following case history is a clear example:

Mr. C left the treatment center fully confident that he was cured. On the trip home, he caught a slight cold. His doctor, who considered him to have a weak constitution, advised him to be careful and stay in bed for awhile. The patient gradually became depressed. He developed a persistent headache, and feelings of fatigue and lassitude grew until any activity became difficult, and all the symptoms of his neurasthenia reappeared. The patient placed all the blame on the fact that he'd caught a cold, and it didn't even occur to him to react. He wrote me a month later and asked for my advice. As soon as I wrote back and explained his error, all his symptoms disappeared.

We could cite a host of similar relapses, some due to even more absurd causes like a bout of anger or some extremely minor, everyday incident like breaking a pair of glasses. We always find the same

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error - the patient does not react, thinking that any attempt to do so would be futile.

Causes of relapse

The preceding section called attention to the kinds of errors we should look for as being the main causes of relapse, based on what we have observed in our patients.

We are not referring to relapses which occur in patients who are not completely cured, since these are not real relapses, but only to those which occur in patients who have re-established normal control. The disappearance of symptoms may be temporary, and cannot be considered as absolute proof of recovery. We can see how, in cases of intermittent psychasthenia, the brain remains overexcited to a degree, despite the appearance of health.

Patients may suffer a relapse for two main reasons:

1. The mechanism of concentration is not well established.
2. Psychological causes.

Faulty mechanism

Most patients who come back to us have not fully recovered because they have not fully integrated the laws of control into their lives. Treatment usually stops when symptoms have disappeared, or when patients feel able to control them. But this is not enough for a complete cure. Awareness, concentration and the exercise of willpower must become habitual. This does not always happen during the few weeks of therapy. Patients must therefore remain attentive and con-

tinue the work on their own, until such time as normal control is fully established. Usually, concentration and willpower are fairly easy to maintain, while awareness of reactions breaks down. In such cases, it is usually enough to resume simple “conscious action” exercises to attain a definitive cure.

In less frequent cases, a “cliché” which has not been fully eliminated takes hold of the patient once again. This type of relapse is also not serious, and can be quickly overcome by doing some more work on eliminating the clichéd response pattern.

Psychological causes

Intense emotional shocks are not as often a cause of relapse as might be expected. Generally speaking, patients react well to such situations. Although they may become sad or depressed, they do not fall back into their old defeatist state. However, post operative shock due to narcosis can easily lead to a relapse which, however, usually doesn't last very long.

A more common cause is lassitude: patients who have constantly to struggle against various kinds of problems may give up the fight, and sometimes voluntarily decide to suffer a relapse, since all they want is rest, hoping to escape the burden of life's vicissitudes. We must understand these people, and try to help them.

In all forms of relapse, previous treatment still has an effect, so that improvement occurs rapidly, however weak the patient's motivation may be. Nevertheless, some motivation is necessary - patients must want to get better. We sometimes observe patients who, at the last moment, step back and do not dare take the step that will free them from their illness.

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Why does this happen? The possible causes are numerous, and patients rarely acknowledge them. It may be a real fear of resuming a normal life and the responsibilities that go along with it; in other cases, patients might want to stop suffering, but are unwilling to give up their negative habits; still others get some kind of absurd pleasure from complaining, and wish to continue doing so.

Unfortunately, such cases are not unusual, even among patients who seem to want to get better, since it must be realized that deep down they may be afraid of being cured. Although very frustrating for treating physicians, these people should not be abandoned, for the simple reason that they are still sick.

This brings to an end our study of the re-education of cerebral control. We have dealt with those areas which we consider most useful to patients, and which will give practitioners an insight into our methods.

The section on psychology has been condensed a minimum, since our treatment in this area does not differ from traditional psychotherapeutic methods, which have already been amply described by authors more qualified than ourselves.

The following sections will deal with insomnia, and the specifics of the treatment we use.

Chapter 12:

Insomnia

Insomnia is one of the most persistent and depressing symptoms of psychasthenia. Patients suffer through sleepless nights, followed by bad days, and are so tired they don't have the courage or will to react - their constant fatigue gives them an excuse to succumb to their illness. They place so much importance on sleep, and especially on how long they sleep, that sleep itself often becomes the main symptom of their disease. We've heard so many patients say, "If only I could sleep, I'd get better."

This belief is more illusory than real. Certainly insomnia does make patients less capable of defending themselves, and more passive. But many patients sleep 10 or 12 hours a day, and still remain ill!

We must accept the fact that getting rid of insomnia, as difficult as it is to put up with, does not guarantee a cure, and that it is the quality of sleep, more than the quantity, that is the essential point.

Sleep returns naturally as soon as there is some degree of improvement of other symptoms. However, since general improvement is sometimes slow in coming, we must look for ways to restore this essential function as soon as possible, in order to help patients to a more speedy recovery.

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We will therefore explore the causes and describe the various forms of insomnia, and indicate possible forms of treatment.

Causes of insomnia

The basic, primordial cause is most often insufficient control, which takes on different aspects. Some patients can't stop the flow of their thoughts; others suffer from some kind of phobia, for example an exaggerated sensitivity to noise, or even a fear of not being able to sleep.

Clichés are also a common cause. These do not prevent patients from falling asleep, but instead wake them up in the middle of the night, interrupting their sleep. We have seen patients suffer attacks of palpitations at the same hour every night. Sometimes, the memory of having been awakened on a previous night will repeat itself and keep them awake for hours.

All these causes can be corrected through re-education. We can distinguish two main forms of insomnia:

1. Partial insomnia.
2. Complete Insomnia.

Partial insomnia

Partial insomnia is characterized by a kind of light somnolence which unfortunately does not give patients the feeling that have slept well.

In such cases, we advise patients to wake up completely, even a few times a night if necessary, and then to try and fall into true, deep

sleep by practicing the exercises we will describe a little later on.

Another form of partial insomnia is when patients sleep deeply for one or more hours, but then wake up suddenly for no reason, and remain awake for a certain time. This is almost always due to a cliché, which must first be discovered, after which patients can concentrate before falling asleep in order to mentally set a more reasonable waking hour. When patients succeed in doing this, their insomnia is all but cured.

Hypersensitive hearing or phobias about noise interrupt sleep, but patients usually fall back to sleep as soon as the noise stops. In some cases, however, the phobia is strong enough to prevent patients from sleeping at all - they are so anxious about being awakened they can't get to sleep in the first place.

The most radical treatment for this consists of desensitizing patients to noise. There is another method: patients are instructed to concentrate on the source of noise as soon as they wake up. Such voluntary concentration will eventually cause the phobia to disappear.

Complete insomnia

This is very often caused by a fear of not being able to sleep. This fear is so strong it can remain impervious to the most powerful sleeping pills.

The best method we have found may seem a little strange, but it does produce results. It consists of getting patients to promise that they will resist falling asleep for a set period of time. They soon become aware that if this instruction is really carried out, their anxiety

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disappears, and they feel they can sleep.

It is essential that patients keep their promise for the set time period, and that they fight to stay awake. If their phobia reappears when they try to get to sleep, they must start again. Results will not be long in coming, and they will soon regain their ability to sleep peacefully.

I have seen patients struggle with this method, not sleeping for one or two entire nights in a row. It takes quite some effort, but will always lead to success if they are sincere.

Another form of complete insomnia is when patients do not sleep because they aren't tired; they are not suffering from any phobias or clichés, their brain is calm but very awake, and they can rest without actually sleeping. This form is quite rare, and the exercises we suggest have hardly any effect, hypnosis being the treatment of choice in such cases.

We will not be talking about cases of insomnia caused by various organic problems, or by physical pain, since insufficient control does not affect these types.

We can now move on the exercises most appropriate for regaining the ability to sleep. All the exercises are effective, since they all work to calm the mind and re-establish cerebral control. Some, however, are designed for specific types of insomnia.

The procedure we have termed "de-concentration" almost always leads to sleep, as soon as patients are capable of producing a state of rest for a certain period of time. Patients concentrate on the number 1, then try to suspend their thoughts for as long as possible while progressively distancing themselves from the number 1. Any distrac-

tion or new thought is stopped by resuming concentration on the number 1.

Concentrating on the concept of calm and rest is also effective.

A simple method is to concentrate on breathing, making it regular and pretending to snore a little, as if asleep.

Visualizing the symbol of infinity (see page —) growing larger and larger works well for some patients.

A determined effort of will to fall asleep is sometimes effective, if patients can dispel their doubts.

To get results, these exercises require some training - obviously, if patients are unable to concentrate, they will not be able to put them into practice.

As for sleeping pills, we try to void them as much as possible. We are rarely forced to resort to them, and when we do it is only during the initial phase of the treatment. The great disadvantage of narcotics is that patients are invariably in a passive state the following day, not to mention the dangers of addiction and harmful side effects.

Chapter 13:

Treatment summary

In this chapter we will present readers with a general view of the way in which we treat patients. We will try to make our description as concise as possible.

Case histories must be carefully studied, of course, even though this may be time consuming, since it helps physicians determine special areas of treatment, for example by finding various clichés, and by classifying patients into one of the two following categories:

1. Predominantly psychological cases.
2. Predominantly organic cases.

In the first group, symptoms affect only the brain, and re-education of control can be started immediately.

The second group includes patients who attribute their illness to some organic disorder of the heart, stomach, intestines, and so on.

Before beginning the training, a minute examination of the organ in question must be carried out, and if there is any kind of lesion, or even the slightest indication that medication or some special diet is required, it is preferable to postpone the training until these have been taken care of.

Ultimately, we ask patients to rely only on themselves, and not on some medication, so it would be futile to administer two diametrically opposed types of therapy at the same time.

Patients need to understand what is wrong

At the outset of treatment, patients need to know and understand what is wrong with them. They will only have confidence in the treatment if they can be shown why they are sick, what the causes of their symptoms are, and how they can be cured. This is not the usual kind of diagnosis, limited to a vague explanation like “It’s a nervous disorder” which has so often discouraged them in the past. Patients feel very encouraged when they are helped to understand what they could not figure out for themselves.

We could not carry out a program of re-education if patients were ignorant of the causes of their illness. And it usually isn’t difficult to pinpoint the faults in their cerebral mechanism, and the way insufficient control affects their behavior.

So we begin by explaining passivity in its different forms, and then go on to the treatment - conscious and voluntary actions.

These actions must be repeated as frequently as possible during the course of the day. They constitute an effective training program, and are an excellent way to develop discipline.

At the same time, we begin with the first concentration exercises:

1. Concentrating on different parts of the body.
2. Concentrating on an infinity curve.
3. Concentrating on the number 1.

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These exercises should be done for an average of ten minutes, every two hours.

As soon as patients are able to do these exercises well enough, we proceed with the re-education of willpower, as described in Chapter 10.

These stages constitute the first part of the treatment. When they are completed, i.e. when patients are able to modify their cerebral functions through the exercise of willpower, concentration and/or conscious action, the real struggle begins. They must now attempt to modify all passive states using these techniques, in order to reduce or eliminate all their symptoms.

All results, whether positive or negative, must be noted and analyzed, since it is this personal experience that will enable their confidence to grow. Patients have to convince themselves that they can get better - the treatment is based on what they do, and not on what they are told.

Despite the best intentions, patients will rarely make regular, steady progress. They should be warned that there will always be periods of relapse which, however, can be very useful, since it is during these periods that they learn to use the tools they have been given, and gain valuable experience.

As a follow-up to the initial concentration exercises, we proceed with the various exercises on elimination and de-concentration, and then on concentrating on the concept of thought itself.

Lastly, we search for abnormal thoughts, abnormal cerebral functions, and clichés. This gives you a general idea of the treatment pro-

cedure, which can be modified according to the specific needs of individual patients.

Length of treatment

The length of treatment varies, of course, but we estimate that two or three months are sufficient to teach patients to carry on by themselves.

Less serious cases may require only three to six weeks, while in more serious cases it is preferable to check up on patients after a few months, in order to see how far they have come on their own. This follow-up treatment is meant to rectify errors which patients can develop during the course of their struggle, and usually lasts for a short time.

Results of treatment

The more progress we make, the more we are convinced that insufficient control can, and must be cured, even in cases which seem hopeless, and even for people who have been sick for years.

It would be difficult to come up with valid statistics concerning the number of cases who are completely cured, since we would have to see all our patients one or two years after their treatment ended, which rarely happens.

In any case, the results we do know about have far exceeded our expectations, and are ample reward for our efforts.

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Practical exercises

Dr. Vittoz left a prodigious quantity of notes on his exercises, which are an inexhaustible source of information about achieving self control and re-educating cerebral control. Here is a summary of those notes, with comments by Christian Godefroy, author and conference leader, and a specialist on the subjects of mental control and personal development.

How to make the Vittoz method a part of your daily life

The exercises that comprise the Vittoz method should be practiced while sitting down on a comfortable chair or couch, with your back towards the light source, and your eyes closed. However, you must not allow yourself to doze off, and good muscle tone must be maintained.

Close your eyes.

Ideally, two sessions of twenty minutes each will enable you to benefit fully from the method. But if you don't have the time, remember that three minutes of exercise done properly is worth ten minutes of exercise done in haste, and that two or three minutes during the course of a day is better than nothing at all.

After a few sessions, the mental attitudes prescribed by the Vittoz method will begin to affect your daily life. You will transform tasks that have become too mechanical into conscious actions. You will become tuned in to your own sensations. You will sincerely want and attain whatever you decide to undertake. And you will take control

of your life, instead of being controlled by it.

How to know if you are making progress

The saying “Too much is not enough” applies here - if you use too much salt when you cook, you ruin the meal. If you do too many exercises, or do them badly, you may not attain your objective, or you may even produce results which are opposite to what your intended. There are two negative signs, and one positive sign, to which you should pay particular attention:

1. Fatigue

If the exercises make you tired, stop. Read this book again, and resume the exercises at a later date. If necessary, consult your therapist or doctor. You should feel better after a session than you did before.

Fatigue can be a sign that you are doing the exercises incorrectly, or that you have some kind of psychological resistance to them.

2. Headaches

Even the concentration exercises should not give you a headache. If they do, you are probably taking them too seriously. Treat them like a game - do your best, without putting in too much effort.

Dr. Vittoz often used to remind his patients of the three S's:

Supple
Simple
Sincere

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Supple

Making too much of an effort may generate inner tension. The Vittoz method aims for the opposite effect - suppleness and agility of the brain. By improving perception, your brain can better adapt to new and varied situations. Think of these exercises as a kind of mental yoga or T'ai Chi, and not as strenuous gymnastics.

Simple

The main advantage of the Vittoz method - and the main complaint made by intellectuals who seem to enjoy complicating things - is that it is so simple.

The exercises are simple. The philosophy is simple. The images and designs it uses are simple.

The more you practice this method, the simpler your life will become. You reduce complicated issues to their essential simplicity. Due to your improved perception, you discern the truth behind appearances.

You will be able to accept criticism without having to justify yourself, and stop attributing responsibility for what happens to you to exterior events and the people around you.

Sincere

You are not doing these exercises to please me or anyone else, but for yourself. No one but you knows what is going on in your brain. Therefore, it is essential that you be sincere with yourself.

Don't cheat during the exercises. Don't take short cuts. Do them sincerely, and they will work for you.

The more sincere you are with yourself, the more you will be sincere with others. And you'll soon realize that sincerity makes for much more solid and true relationships than those based on lies and attempts at pretending to be what you are not.

3. The joy of living

An accurate measure of your progress is simply the way you feel about life. You may suffer setbacks or relapses during your treatment, but on the whole you should feel better and better about yourself and about life in general.

What does "joy of living" mean? A text found in an old Baltimore church in 1692 may shed some light on the question:

"In addition to maintaining a healthy discipline, you have to be gentle with yourself. You are a child of the universe, no less than the trees and the stars; you have the right to be here, and whether it is clear to you or not, the universe is no doubt unfolding exactly as it should.

"Be at peace with God, whatever your conception of God may be. And whatever your accomplishments or dreams, make sure to maintain peace and tranquility in your soul, amidst the chaos of life.

"Develop your ability to feel your oneness (with God), and you will overcome useless fears and fantasies. This will lead you back to the joy of living."

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Control of actions

Read Chapter 6 over again. These exercises must be “conscious” and not “thought.” Thinking is emissive, while consciousness is receptive.

Sight

Your eyes receive waves. Let the waves simply penetrate your consciousness. Instead of focusing your gaze and moving from one point to another, embrace the totality of an object, with all its nuances and colors. Then close your eyes.

Visualize the image in your mind, but without thinking about it. Recall just the image, the visual impression it made on your retina. Then start again.

Look at a detail, a fragment of the object. Then close your eyes and visualize it, this time making it grow larger and larger, as if you were looking at it through a magnifying glass.

Practice developing instantaneous and total perception of images, in all their detail, like a still camera as it snaps a picture instead of like a video camera which pans across the scene, centering on one point after another.

Hearing

Clink a glass (crystal if possible) or ring a chime or a bell. Instead of listening with your thoughts, let the sound waves pass through your body without stopping them. Vibrate in unison with the sound.

Perceive the sound as it continues, until it becomes almost imperceptible.

Listen to other sounds, like the ticking of a clock or the regular purring of a motor. Try to perceive all the nuances of sound, without anticipating them (as if you were hearing them for the first time).

Instead of tensing up and feeling your muscles quiver whenever an unpleasant or sudden sound reaches your eardrums, accept it. Welcome it, as you perceive each vibration. Suppress all inner dialogue as you listen to the sounds around you.

Touch

Find someone to assist you, and ask them to place an object in your right hand, while you keep your eyes closed. Keep them closed throughout the exercise, in order to concentrate on your sense of touch.

Perceive the whole range of sensations you experience through touching: first, hot or cold, hard or soft, moist or dry; then the texture of the material - smooth, rough, soft, etc. Don't try to attach words to what you feel. Don't try to determine what the object is.

- Next, do the same exercise using your left hand.

- Become aware of everything you touch and everything that touches you while sitting on your couch: all the points of contact between your body and the chair, the texture of the materials touching you, all the objects (jewelry, glasses etc.) or articles of clothing that you're wearing.

- Next, become aware of your own body. Concentrate on perceiv-

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ing your body from head to foot. Feel the vibrations, the pulsing in each part of your body, radiating from the surface of your skin.

Taste

You may have heard the story about the two writers who were able to procure a can of sardines for themselves during the second world war, an occurrence which was extremely rare at the time. They opened it, began feasting on the fish, and started talking excitedly.

Suddenly, one of them cried, "My God! I swallowed without tasting it!" Caught up in the discussion, he had swallowed his portion without even feeling what he was doing.

This is exactly what you should not do.

Take some food that is salty or sweet, bitter or acidic, and savor it without trying to transform your sensations into words.

Smell

Do the same thing with various perfumes, or foods that give off a strong odor.

Control of movement and perceptions

Dr. Vittoz recommended doing exercises on movement control throughout the course of a normal day. For example:

- Instead of thinking about something else while brushing your teeth, feel the effect of the bristles as they brush over your gums and teeth.

- When you take a shower, concentrate on the water pouring down, on its temperature, how the droplets feel as they hit your skin, the sensation of soap sliding over your body. and so on.

- When you open a door, feel the cold metal of the doorknob, the resistance of the spring or hinges, the way the lock clicks open and shut, the way the handle turns the lock, and so on.

- When you shake someone's hand, feel the contact - is the grasp firm or gentle, the skin dry or moist, rough or smooth, warm or cold? Feel the energy flowing from hand to hand, be aware of the duration of the handshake, the rapidity or slowness with which your hands separate...

- When you drive your car, be aware of all your movements: how you hold the wheel, how you shift gears, how you sit in your seat... You will quickly become aware of any useless tension in your body. The aim of Dr. Vittoz's method is economy and simplicity of movement - both of which help you conserve your energy.

- As you eat, feel the weight of the food on your fork, the muscles you bring into play to carry the food to your mouth, the movement of your jaws, the consistency of the food you're eating...

- When you engage in some sport, like tennis for example, feel the movements of your body, the contact of the racket as it hits the ball, the way it vibrates, and so on.

- When you apply the Vittoz method as you are making love, you will experience a reawakening of your sensitivity, which has been weakened by habit and by being too "emissive." Each caress, each gesture, each movement is an occasion for conscious feeling. Even

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your emotions - the love you feel for the other person, the love s/he feels for you, your pleasure and the intensity of your orgasm, can be heightened by being conscious and relaxed. Many people claim to have been cured of frigidity or impotence by practicing the Vittoz method.

- Every one of your daily actions can be an occasion to practice the Vittoz method of conscious movement: opening a letter, picking up a telephone, talking, holding a pen, washing something, cooking, cleaning, doing repairs, or even reading.

One exercise merits special attention. Although it is very complex, you can do it frequently. The exercise we're talking about is conscious walking.

1. Conscious walking

Start the exercise by concentrating on your right foot, the way it touches the ground, the sensation you feel as it supports your weight.

Then do the same with your left foot.

Become aware of your ankles, your knees, your thighs, your hips, the way your spine moves, the way your arms swing and balance, the way you hold your head. Feel your entire body in perfect balance and control. Feel the amazing mechanism that is your body as it moves in perfect harmony, on a simple command from your brain. As you concentrate on your walking, you will be so flooded with sensations that it will be impossible for your mind to wander.

This is an extraordinary exercise for calming yourself down, regaining a sense of harmony, and getting rid of fatigue.

Compare your mental state before doing the exercise, and after a few minutes of conscious walking. You will be sure to feel the difference.

Whenever you're under a lot of stress, when you get some bad news, or suffer a serious setback, one or two minutes of conscious walking is enough to re-establish your sense of inner calm.

Set yourself a daily route, and practice conscious walking regularly. It can be a short distance, from the garage to the car for example, or up the stairs to your office or apartment.

When you are used to doing the exercise, you can make it even more effective by adding conscious breathing.

2. Conscious breathing

Whenever you feel stressed or start thinking negative thoughts, your respiratory rhythm changes; you take shorter breaths, leaving some of the tainted air in your lungs, thus providing your body with less oxygen, which in turn makes you even more tense. As you can see, the effect is very much a vicious circle.

By becoming conscious of your breathing, you can control your respiration and free yourself from this harmful cycle, so that your lungs expand more fully and remain more flexible.

Concentrate and feel the air flowing up through your nostrils to the back of your throat, then down your trachea and into your lungs. Feel the cool fresh air entering your body and regenerating you.

Synchronize your rate of respiration with the conscious walking exercise (one deep breathe - inhaling and exhaling - per step).

You can also do a few minutes of conscious breathing at a predetermined rhythm. Dr. Vittoz recommends the following sequence:

INHALE for 10 seconds: HOLD for 5 seconds: EXHALE for 10 seconds and start again.

3. Voluntary acts

“I just can’t go on. It’s too much for me!”

Have you ever felt like that? Chances are you have. You may even go through periods where you feel you have absolutely no willpower left, and can’t seem to deal with anything at all.

Willpower can be re-educated. Dr. Vittoz advises practicing control on little everyday activities. “If these activities are really well done, patients will feel more in control, calmer and more rational. Since the brain is always occupied with something definite, persons become progressively less anxious. Their self confidence grows, and they get into the habit of being in control.”

Too often we confuse desire with willpower. Many people would like to speak a foreign language, be rich, have a better job or a more attractive companion, but how many of them have the willpower to go out and get the things they say they desire? The reason for this is that they don’t really WANT them.

Dr. Vittoz explains it by setting 5 conditions for having strong, healthy willpower:

1. Unity
2. Concentration
3. Definite objective
4. Possibility
5. Sincerity

1. *Unity*

The preceding exercises aim to restore your sense of unity, which your mental wandering or “dispersion” has eroded.

Feeling at one with yourself opens the door to all kinds of possibilities, and prevents you from hiding behind excuses and irresolute thinking. If you are at one with yourself, your will belongs to you, and is not imposed on you from outside.

Many people believe they have willpower, but in reality they have simply assumed the will of their parents, teachers, peers etc. All these influences stifle their own willpower and prevent any real voluntary behavior. This is not willpower as Dr. Vittoz understands it. The concentration exercises on the number 1, which we will look at a little later on, can restore this sense of unity, which modern life tends to erode.

2. Concentration

Concentration is the cornerstone of the Vittoz method. It is trained and developed in a series of exercises that we will review later on.

3. Definite object

You have to know what you want. Instead of saying, “I have to...” or “I should...” say “I want...”

Exercise:

1. Every time you have to do something you don't want to do, every time you feel under an obligation, take some time to think and find the reasons why you WANT to do whatever it is you think you should do. There are always reasons why you want to do something, and if there aren't, you'd better not do it. Ask yourself the question Why?

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2. Define what you want precisely rather than in general terms:

What?

When?

Where?

How?

How much?

With whom?

4. Possibility

It would be futile to mobilize your willpower if what you want is impossible. Knowing yourself and your capabilities, and also generating confidence in those abilities, are essential stages in the process (of getting what you want). Ask yourself, “Can I do this?” and try to feel the answer in the depths of your being. A yes or a no will condition your future commitment.

5. Sincerity

Before committing yourself to a voluntary act, ask yourself one last question: “Am I really sincere?”

There may be hundreds of reasons for undertaking something that you don’t really want to do: pleasing someone else, keeping up appearances, staying on top of the corporate ladder, trying to be perfect, etc. Answering the question “Am I really sincere?” will prevent you from doing things for the wrong reasons.

Some possible applications

Start with very simple actions like drinking a glass of water, getting out of bed, arranging the objects in a room, getting the mail, turning the TV on or off, phoning someone, paying a bill, etc.

Then move on to more complex actions like preparing a project, going out, meeting people and so on.

Finally, set goals for yourself and use the same process to achieve them.

Dr. Vittoz recommended performing twenty such voluntary actions every day.

4. Concentration: First series of graphic exercises

These concentration exercises are mental. You will have to reproduce the following graphic figures in your mind - in other words you will have to “visualize” them. You can create a mental support for yourself in the form of a blackboard on which you write with chalk, or a computer screen or a TV screen, or any other device which will make visualizing easier.

If you find visualizing too difficult, don't persist. Remember that these exercises should be treated like games - they are not meant to make you tense or add to your stress.

If necessary, start by actually drawing the figures on a piece of paper.

Then redraw them in your mind, with your eyes closed.

1. A continuous broken line



2. Waves



3. The infinity symbol



Don't try to draw it perfectly - the aim here is concentration, not artistic skill!

Practice drawing the infinity symbol in various positions.

4. Spirals



5. Straight lines



Randomly place two points on your mental screen, and then join them with a straight line.

Keep all the lines you have already drawn fixed in your mind throughout the session.

7. Ladders

Start with the two vertical lines, and then add the steps, one after the other:



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5. Second series of graphic exercises

In this second series, you draw two lines simultaneously, as if you were using both hands.

1. Spirals
2. Hooks
3. Zigzags
4. Rose motifs
5. Calligraphy exercises

When you start becoming adept at visualizing lines, you can practice mentally reproducing these kinds of figures:

Elimination and de-concentration

As Dr. Vittoz put it, the aim of the exercises is to teach the brain to first set aside troublesome thoughts, and then to eliminate them completely.

This will prevent you from being overwhelmed by worries, and help you eliminate negative thoughts or obsessions.

Exercise #1 : Eliminating objects

Place 3 to 5 objects on an empty table. Observe them carefully, then close your eyes and draw a mental image of them.

Now open your eyes and remove one of the objects from the table. Look at the empty space, then close your eyes and once again create a mental picture of the table, this time without the missing object.

Open your eyes, remove another object, and so on. Repeat the

exercise until there is no remnant of any of the objects in your visualization.

Exercise #2 : Mental elimination of objects

Repeat the above exercise, only this time do not physically remove the objects from the table. Imagine that you are removing them, and visualize them disappearing. The physical objects, however, remain on the table.



Make sure you terminate the exercise by imagining the table covered by a white tablecloth, devoid of any objects.

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Exercise #3 : Eliminating numbers

Visualize three numbers in your mind, for example:

3 2 1

Now eliminate one number...

3 2

And a second number...

3

And the last number.

If you have trouble with this exercise, you can cross out the numbers instead of completely eliminating them, using 4 or 5 numbers instead of three:

3 2 1 6 9

~~**3 2 1 6 9**~~

Exercise #4 : Eliminating graphics

First choose a drawing:



Then eliminate parts of the drawing one after the other. For example:



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Exercise # 5 : Eliminating letters

Visualize a series of letters that have no special significance. Write them on your mental screen, then erase the last letter, the next to last letter, and so on.

A S D F G H J K L

A S D F G H J K

A S D F G H J

A S D F G H

A S D F G

A S D F

A S D

A S

A

This is an example. You can start with upper case letters, and then use lower case ones.

a s d f g h j k l

a s d f g h j k

a s d f g h j

a s d f g h

a s d f g

a s d f

a s d

a s

a

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Do the exercise again, after changing the order in which you eliminate the letters.

A S D F G H J K L

A S F G H J K L

A S F G H K L

A S F G H K

S F G H K

S F G H

S F H

S F

F

Exercise # 6 : Eliminating words

Instead of using random letters, choose a series of words which do not have any special significance for you:

New York

Paris

London

dog

cow

mountain

car

etc.

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Exercise # 7 : Eliminating opposites

This time, use pairs of opposites:

war - peace

hard - soft

dark - light

cold - hot

stress - relaxation

noise - silence

etc.

Eliminate only one of the words in each pair, and repeat the one that remains.

Exercise # 8 :

Now use words that are meaningful - that represent negative thoughts which you wish to eliminate. For example:

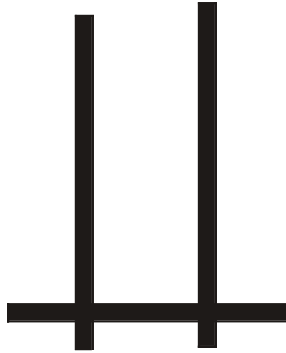
F A I L U R E

or

W O R R I E S

Exercise # 9 :

- In your mind, draw two vertical lines, and one horizontal line:



- Between the borders of the lines, write a series of the number 1, making each smaller than the one before it.

- As you write each number 1 in decreasing size, erase the number before it. The last number 1 should be so small you can hardly see it. Then erase that too.

Exercise # 10 :

A very effective combination: add a word that carries some negative connotation to the number 1 in the preceding exercise.

As you erase the numbers, you erase the negative word as well.

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Exercise # 11 : Transforming negative into positive

This is the final phase of this series of exercises. Not only are you going to eliminate a word with negative connotations, you will also replace it with its opposite. For example:

LOVE of my mother

HATE

Another example:

CONFIDENCE I feel for the men in my life

FEAR

Variations:

You can imagine that you're using chalk to write the words down on a blackboard, and then erase them with a piece of cloth. Or you can type them onto a mental computer screen, and use the "DELETE" command to erase them.



Exercise #12 : Eliminating noises

Imagine a very loud noise (aero plane, motorcycle, car, siren, saw, gun, etc.) moving farther and farther away from you until it disappears.

Exercise #13 : Graphic distancing

Draw these graphics in your mind, moving from the largest elements to the smallest.

Concentrating on ideas

Dr. Vittoz recommends doing concentration exercises, in particular on the three following ideas:

CALM

ENERGY

CONTROL

Louise Bron-Velay, author of “A Practical Guide To The Vittoz Method” (Levain Publications, 1979) suggests doing the exercises in the following manner:

“After writing the word CALM in your mind, underline it with a curved line:

CALM
~~~~~

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Now try and remember a time when you felt agitated, hurried, pressured, etc. Experience the feelings of tension this situation produced in you. Write the word “agitation” under the arc of the curved line:

Now erase the word “agitation” and reject the feelings associated with it completely. Recall the state of calm, and make it your own through concentration and assimilation of the feelings associated with it.

Reject the negative idea. Recall the state of calm and possess it.”

You can now use the same procedure for the other two positive concepts:

Energy - Inertia

Control - Impotence

### *Concentrating on a sentence*

Choose one of the sentences in Appendix 1. It doesn't have to apply to your particular situation. In fact, you will probably make better progress with a sentence that you find somewhat disturbing at first.

Concentrate on its meaning - don't memorize the sentence exactly as it is written.

Then move on to other sentences which you find personally inspiring.

## *Concentrating on the number 1*

This is one of the most difficult exercises in the Vittoz Method, which is why we saved it for last.

Write and repeat the number 1 in your mind three times in succession, without thinking of anything else. Empty your mind for a moment before each repetition.

If you find this difficult, start by actually writing the number 1 three times on a piece of paper, with your eyes open.

Use a lead pencil if necessary, so that you can erase the numbers afterwards.

With some practice, you will be able to do this exercise under any circumstances. It only takes a few seconds, and is an effective way to regain control and re-establish your sense of inner unity.

## *Conclusion*

After a few weeks of practicing these exercises, you will find you have developed a powerful tool for maintaining cerebral control, which you can use under any circumstances.

Stress, problems, setbacks, and many kinds of psychosomatic illnesses will no longer affect you. Don't stop halfway - even if some of the exercises seem very simple at first, they are designed to mobilize extremely powerful inner forces, and their simplicity in no way alters their effectiveness.

When you have attained perfect cerebral control, you can share your discovery with your family and friends. Even your children will be receptive to, and benefit from the Vittoz Method. There is no age limit - anyone can obtain the desired results.

I hope your training is fruitful, and helps make your life more fulfilling and joyous.

Christian H. Godefroy

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