

New therapeutic intervention and assessment tools: GSR, sexual dysfunction and the Peptide Assisted Therapy method—an applied therapy and mathematical metric of healing.

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Abstract:

This adjunct to our previous work (Norman and Conte et al. 2016, 2016a) will apply the proposed methodology within a specific clinical paradigm in order to aid the ever increasing population afflicted with sexual dysfunction and more subtle relationship issues. As has been previously supported, GSR is a noninvasive alternative to other measures which is capable of reaching into the deepest unconscious layers of the human mind. We will propose a specific series of tests and treatments which may allow risk-free aid to be disseminated to needful populations and treatment efficacy evaluated in precise mathematical terms supported by known trustworthy psychological measures. We may thereby develop and substantiate from several fronts at once, both a new therapeutic approach specifically aimed at a large target population in present need of care, and also, the methods of mathematical evaluation applied. The Peptide Assisted Therapy (PAT) method utilizes the known fact of oxytocin induced hippocampal mnemonic plasticity within a neuropsychanalytic context, to reshape basic attachment structure dynamics in order to ameliorate active pathology. A detailed protocol is presented relating the previously articulated methodology to the current theoretic construct and its applicability. In this way we will suggest new avenues of approach, analysis, theoretic substantiation and treatment which may directly help those afflicted with a common condition.

Qualification and importance: It must be qualified that the proposed treatment is new, safe, non-toxic and remains to be assessed. Although it is unlikely that those patients and couples with deeply entrenched libidinal imbalance will benefit from this therapeutic approach outside of a greater and more extensive therapeutic context, those whose condition is less severe may well receive substantial benefit. With ~30% of all men and ~40% of all women displaying some level of sexually dysfunctional symptomatology, (ASRM fact sheets 2008, 2015) over a complex distribution (Simons and Carey 2001), we may rightly conclude that this safe and inexpensive treatment could help millions, and so, should be closely investigated and quantitatively assessed.

General justification of treatment approach:

Outside of substantive physiological pathology sexual dysfunction is attributable to mental factors. Curiously, there is a very limited amount of cogent neuroscientific information concerning the common basis of the problem: *guilt* as it is expressed across the circuitry and active anatomy of the brain. This fundamental aspect of neurosis, social control and sexual expression so deeply intertwined with the very basis of affect regulation itself, seems to be absent in neuroscientific literature and review. We have derived the missing information from many sources, and may now present a method of treatment based on the results. A sound scientific basis will be rigorously ensured via supporting analysis, particular tests, mathematics and essential protocols.

Transference theory:

The psychological notion of ‘transference’ is most clearly seen in the artificial therapeutic situation of psychoanalysis as the familiar transference neurosis. However transference phenomenon are most assuredly not limited to this case of artificial functional pathology, but are responsible for the healthy and unhealthy qualitative aspects of perception and experience itself (Norman 2011, 2013*a*, 2015, 2016). Just as the neurotic in proper psychoanalytic therapy displays the repetition compulsion and his fixations in an artificially induced neurosis which defines their reality within therapy, so does the healthy case from his more fluid memory and experience project outward his or her definition of the world and experience, in a flexible, dynamic, associative, non linear process (Norman 2011, 2013*b*, 2015).

This transference which binds current perception to associated qualitative valence as an affective distributional function of memory, is available to observe in its foundational anatomical formative innervations and their resultant allocational functions as stemming from circuit architecture created in the first 18 months of life (Norman 2013, 2013*a*, 2014, 2016*a*). During this initial period of development the groundwork is laid for the core of affective expression and restriction throughout later life. This represents primary human unconscious autonomically interdigitated regulatory functionality, as extending from the foundational innervations of Schore’s dopaminergic "sympathetic ventral tegmental limbic" circuit, and also, the noradrenergic "parasympathetic lateral limbic" circuit, which act in tandem to opposite effects (Schore, as cited in Kaplan-Solms & Solms, 2002, pp. 234-235, 237). These two circuits span the limbic and Orbito-Frontal regions to imbue experience with basic valence, and delegate or perhaps restrict positive dopaminergic affective expression in response to social cues, meaning shame and then guilt. This oppositional circuit balance, over all, creates either a foundational basis of repression which is associated with amygdala activation, Corticotrophin Releasing Factor and stress, or, if balanced differently toward predominant activity of the sympathetic circuit, to permit feelings of elation and explorational behavior (Kaplan-Solms & Solms, 2002; Panksepp 1998; Norman 2014, 2016*a*). These two circuits then are the foundational basis of expressed guilt, social control, sexual expression, health and happiness and, are mediated by social cues, meaning: *conditional regard*.

It is now thought that mirror neurons are the neural substrate of empathy. This is incorrect. Mirror neurons signify mere imitation, as distinct from empathy as can be seen in cases of catatonics who display echopraxia, which is based in mirror neuronal response (Bengston 2015; Rizzolatti et al., 2008). A catatonic is not empathizing with the attending physician to reflexively imitate his motions, although imitation is an obvious sub-function under a primary empathy. Empathy is akin to identification proper, and is first evidenced in the indistinct pre-individuated period characteristic of initial circuit innervation, not of the expression of the sympathetic circuitry mentioned, but in its primary innervation (Norman 2013, 2014, 2016a). This is the basis of empathy: a primary identification with the world and each other. This in turn, is the very foundation of subsequent energetic circuit expression. It is this which is so sharply curtailed in the painful guilt of conditional regard: *the very basis of energetic expression, and empathetic connection*. Clearly, these are the exact basis malformations responsible for sexual dysfunction and lack of caring within human relationships.

The curtailment of energetic expression as a function of super-ego, affective restriction due to what we may colloquially refer to as conscience, is the basis of modern morality stemming from primary conditional regard. It may clearly be seen from this vantage that such moral restriction is opposed to empathetic expression, and is instead aligned with *obedience to external authority*. This is a sure basis of modern afflictions such as neurosis. Modern man is controlled through, and suffers of, a permanent low-grade homeostatic imbalance created via improper and unhealthy energetic circuit allocations: Guilt. This is the locus of the problem, and it is this which the therapy will adjust.

The context of guilty expression is Oedipal. Rights to caring, love, sexual contact and life itself in male and female cases, were traditionally ascribed to the authority of the father, and now phylogenetic and epigenetic underpinnings of patriarchal threat enforce pathology from unconscious sources (Norman 2011, 2013, 2013a, 2014, 2015b,c,d,e; Dodds 1973). This pathology stands in opposition to permission and rights to the caring of the mother, which once formed the initial basis relationship in both male and female cases. We will use our knowledge of symbolism and the process of circuit innervation, to derive a treatment to reallocate the predominant basis of the damaged attachment relations which underlie pathology. This will change the transference which allocates valence to the relationship, and its sexual component expression. We will restore 'permission' to love.

The feeling of human dissociation and anxious threat engendered by super-ego and authority, may be replaced with a feeling of empathy and safety, warmth and relaxation. Health may replace the source of illness. Please recall: *the transference responsible for qualitative experiential valence, is a function of associative memory*. Therefore, to gain the desired effect memory must be influenced.

The initial early impressions of dyadic exchange between the mother and infant are fundamental, life sustaining for the infant, and distant (Norman 2013, 2016a; Spitz in Bowlby, 1980; Panksepp, 1998, p. 262). The impression we have of the mother has undergone many, many deep and irrevocable transformations since our first 18 months of

life. Therefore, we must use the language of the intraconnected mental system, *symbolism*, to create resonance to the early initial impression of circuit innervation (Norman 2013, 2016a). The mind expresses its deepest hidden unconscious wishes as symbols in dreams, and all the visible world is also given its very most essential quality as a function of the same (Norman 2015, 2016). To access the old memory and augment it, we will use symbolism to affect memory.

Peptide Assisted Therapy treatment, a basic component outline:

Next, we will articulate the components of the treatment method. Think analogously of the transference forming human ontogenetic ontology as an experiential template with topographic organization which distributes affective valence [appendix 1]. Memories and elements of greater energy are analogous to those higher in topographic position, and contribute more to the outcome, and also influence what phylogenetic and so, epigenetic expressions underlie the effects. We will seek to substitute healthy mnemonic aspects for pathogenic contributors by way of adding cathexis (energy) to healthy impressions associated with dopaminergic sympathetic circuit innervation through using symbolic resonance (Norman 2015a, 2016a). The process will be aided in the addition of a neuropeptide, oxytocin, which promotes attachment bonds and encourages plasticity in hippocampal memory (Panksepp, 1998; Garcia-Segura 2009; Leuner et al., 2012; Monks et al., 2003; Lin et al., 2012). This will provide/augment the sense of security necessary for subsequent energetic libidinal expression, and perhaps reduce the number of treatments needed to gain demonstrable therapeutic effects. Ideally: Pathogenic conditional regard stemming at the lowest levels from deeply inculcated threat may have security, abundant energy and empathetic expression placed in its stead.

As permission to the care, love and empathy extending from the initial maternal nurturance are to be supplemented in their expression via a sort of “semi-regressive resonance,” symbolism must be derived which will connect current experience with past memory corresponding to formative nurturance and hence, initial circuit innervation (Norman 2015a, 2016a). Such present mnemonic additions must correspond symbolically to the initial impression so as to resonate with, and supplement it. As the reader will soon see in the following section, the entire of the treatment process is structured to elicit commonalities with the formative impressions on many levels. Here is a brief but salient explanation, and the basic symbolism pertaining to the formative innervation of the sympathetic limbic/OFC circuitry which will be placed into a proper working therapeutic/scientific framework suitable for mathematical assessment and analysis in the next section:

Why access memory with symbolism, and what would such a symbol associated with primary dopaminergic circuitry be?

Affective regulatory analysis:

Schore has discovered two circuits which are primary in development, and function in opposition to each other: the dopaminergically modulated sympathetic ventral tegmental limbic circuit, and the noradrenergically modulated lateral parasympathetic tegmental

limbic circuit (Schore as cited in Kaplan-Solms & Solms, 2002, p. 234-235). The sympathetic circuit, which we propose underlies intersubjective Alpha Function (Brown, 2011; Norman 2013, Norman 2014) is formed, much as Bion had supposed, as a function of the dyadic exchange between infant and mother of glance and gaze, and we will add an inference which is quite obvious and easily supported (Keverene, et al., 1989; Montagu, 1978; Panksepp, 1998, p.272) as infants engaged in the exchange of maternal glances are usually being held, that *maternal touch* and the subsequent addition of neuropeptides/endorphins also have a part to play in creating the result.

"It is hypothesized that maternal regulated high intensity socioaffective stimulation provided in the ontogenetic niche, specifically occurring in dyadic psychobiologically attuned, arousal amplifying, face to face reciprocal gaze transactions, generates and sustains positive affect in the dyad. These transactions induce particular neuroendocrine changes which facilitate the expansive innervation of deep sights in orbitofrontal areas, especially in the early maturing visuospatial right hemisphere, of ascending subcortical axons of a neurochemical circuit of the limbic system—the sympathetic ventral tegmental limbic circuit." [Schore as cited in Kaplan-Solms & Solms, 2002, p. 234]

The famous studies from the 1940's conducted by Spitz (Spitz in Bowlby, 1980; Panksepp, 1998, p. 262) may well imply the primacy of this developmentally innervated brain circuitry extends to include the most basic dependence: that of life itself. Specifically: if deprived of maternal touch and gaze, the infant may well die. The sympathetic tegmental limbic circuit is dopaminergically modulated, and can rightly be thought of as a primary manifestation of libidinal excitation and discharge (Kaplan-Solms & Solms, 2002, p. 237). It should be noted that the dopaminergic and opioid systems and circuitry which respond to create the good feelings which reinforce socially mediated behavior, both involve many of the same areas, such as the ventral tegmental area, where the A-10 meso-limbic dopamine cells are located (Panksepp, 1998, p. 118). Neuropeptides such as the endogenous opioids including beta-endorphin which is triggered by social cues and touch, have a primary role in creating social bonds, quelling pain, both physical and mental, are key in alleviating separation distress, creating sexual reward, and addictive reinforcement (Panksepp, 1998, p. 255, 264). So we can see here, in the formation of the sympathetic ventral limbic circuit triggered by maternal exchanges of glance, sight and touch, a source of libido, an energetic dopaminergic circuit which up-mediate arousal and shapes behavior, formed presumably by way of allocating both endorphins, and those neuroendocrine functions involved with encouraging the substantial innervations of dopaminergic projections into orbitofrontal areas. Here, in the activity of the completed circuit, along with the peptide systems, dopamine and opioids serve their reward and motivational functions as social and energetic contributors.

The contrary circuit, the parasympathetic lateral limbic circuit, is to be thought of as a balance, a cut off, a competing inhibitory system to counter the rewarding energetic expression of the sympathetic circuit (Kaplan-Solms & Solms, 2002 p. 237). This circuit functions to stop our energetic libidinal expression: functional, conditional, affect regulation in response to social cues (Kaplan-Solms & Solms, 2002, pp. 234-238) and so, can best be understood as the physiological structure triggered by social disapproval: *by*

shame and guilt. Both of these circuits are innervated into the orbitofrontal areas, which mediate social cues and functioning, just as one would expect.

As we have stated, we propose the improper excessive repressive/parasympathetic balance between these two circuits, may well have a fundamental and in some degree causative influence in creating pathology. Ergo: pathology may well be lessened to adjust that balance. We will attempt, to reshape that result, via symbolic access to pertinent hippocampal attachment memory, aided by neuropeptide induced mnemonic plasticity. This will change the circuit balance.

The alpha function key:

As the infant progresses through the initial 18 month period during which the sympathetic and parasympathetic limbic circuits are fully formed, the infant masters several stages of differentiation. It is now accepted through the work of Klein (1952) and empirical demonstration, that a developmental/behavioral correlation at the age of four months, exists between infants categorized as attachment secure or disorganized, "dis-coordinated" [disorganized in the sense of being unable to properly integrate the intermeshed and exclusive psychical manifestations of separation RAGE and FEAR as they conflict and inhibit SEEKING and CARE] (Hopkins, 2013, p. 47). The infant at this stage singles out the mother as a separate object which is essential for CARE, and that this fact is then made evident by the manifestations of separation-RAGE and stranger-FEAR, which become manifest at 7-8 months of age (Hopkins, 2013, p. 47). To observe firsthand, the interactions between mother and infant, the effect is obvious to casual observation: *the mother's face is the infant's entire world*, once indistinct as an object, now, *once engaged in the exchange of gaze, touch and glance, only semi-distinct from himself*, her face responds to his affects *and anticipates as if part of himself, as if the world itself were a loving extension of the infant*, a responsive and inclusive extension of himself. Here, we see the essence of empathy: *identification with the world*. Note that we make no mention of the less important distinction of identification with mankind, which is a small and far less important embedded sub-aspect associated with mirror neurons, a sub-aspect of this most vital and needful result, identification with the entire of the world—*Empathy* (Norman, 2013; 2014; 2016a). It is this which we will substitute for the pathogenic content.

Next please recall that all the world is given its quality and definition by way of symbolism (Norman 2015; 2016). Remember also, that symbolism is the mind's intra-systemic means of communication, ie., the unconscious becomes available to consciousness once symbolized in dreams (Freud, 1900). The mother, has undergone much additional layering in her symbolic meaning and impression since we were 18 months old! For this reason, to imagine her face involved in the infantile exchange of maternal gaze and glance is ineffective, as she means many things now symbolically beyond the early formative impression. The solution is to craft a symbolic image which is directly resonant to the *initial* impression of the circuitry's formative process. To engage the circuitry, *the following symbolic image must be formed in the mind's eye, and,*

entered into as if a dream. We will use video to achieve subject emersion as detailed in the next section. The result is a peaceful, safe, content state indicative of beta endorphin activity, created by manually engaging the formative aspects of the sympathetic circuitry which connects the orbito-frontal areas with the limbic. We should observe that as beta endorphin activity is increased, pain response is decreased, and other empirically testable responses will be found, like a characteristic EEG associated with secure low stress states, rather than the easily defined activity of mentation associated with fear, and anxious stress. Here is the symbolic key, symbolized from the source formative impression which caused initial innervation. [The first paragraph is hypnotic introduction, the image is below. This is abbreviated.]:

"Please relax, hear, the water, and listen to my voice. There is a meadow, within the forest, surrounded by trees, stirring, a distant breeze. The day is still and quiet. Listen to the shining brook, spilling itself, over smooth rock and sand, listen, as it splashes, so near the meadow.

The sun is pouring down upon your face, shining and warm, golden and loving is this light, a light you are folded into, and have created, shining, pouring back up into the arch of heaven, spilling up from your glad face, and again down to fill you, the trees nodding as you dream them, the sky golden and warm as you have poured it—and back around—for it has dreamt you...now as the world, of the world, nourished and warmed, the circle complete, a round of golden warmth and light, spilling into the world and returning again, unto you, and again, you unto it...and all the world is eternal, safe, nourished and nourishing, a circle of happiness, pouring down and returning, warm and sweet, the circle glowing, life spilled round into warmth—and golden light."

Treatment protocol and relation to taxonomic and dynamic analysis with primary and secondary variables:

As has been demonstrated in (Norman and Conte et al., 2016, 2016a) it is essential to embed any such treatment program in firm scientific grounding and assessment. GSR as a primary variable, coupled with HR and HRV as secondary variables (perhaps in conjunction with EEG) within a conservative/dissipative signal analysis, will provide that grounding once interpreted via linear and nonlinear parameters as previously specified. These new methods themselves will then be proven valid as tools with rapid, deep and trustworthy analytic potential in the addition of more cumbersome traditional tests. In this way, a new treatment targeted at a needy population and a new and efficient analytic mathematics of human affect may both be proven and made practically available to aid in the treatment and diagnosis of this highly individual pathology. The method is designed to provide practical results within a simple framework and technique of analysis which can be directly validated in comparison to a known metric. Once proven thus, the method of treatment and mathematical tools will stand on firm ground, and be ready to begin doing vital work for physicians serving the general population.

The protocol establishes a pair of baseline readings, from which patient progress

contextualized within the relationship, and, the physiological and psychological profile of the subject can be derived. In this way, unconscious drives, repressions and their expression within the context of the current relationship may be best categorized. The simultaneous administration of known and accepted tests, will prove out the new mathematical theory, and treatment.

As has been established in (Norman and Conte et al., 2016, 2016a) the physiological and psychological profile of the subject may be derived via signal assessment of GSR and secondary variables under conditions of controlled stimuli. Drive elements can be introduced in explicit material, and reactions and repressions observed, and hence, the subject may be categorized as to their unconscious and repressive constituency. This baseline knowledge over the long term, will prove of great value in outlining the specifics of dysfunctional pathology. However, it is also of great importance to critically and quantitatively assess the affective state of the subjects as expressed within the context of the relationship in question. This will provide utterly vital and primary information for measuring treatment efficacy. We will *measure healing itself* and this metric, stemming from the deepest recesses of the mind, will serve us well. The treatment itself then, will have its effects evidenced in any alteration in basic drive structure, and its substantive sublimated expression within the real relationship will be detailed also. We can predict a lessening of depression along with increases energetic expression, and an adjustment in positive valence in response to contextualized relationship cues.

The order of tests is important, as repressions are created in a sort of sexual cuing or tuning as is evidenced in (Costa and Esteves 2008). Therefore, *explicit sexual content is likely to affect pathology*, and will affect any subsequent contextualized relationship cues presented. Therefore, the personality profile and drive elements will be tested for AFTER the contextualized cues. Contextual cues will provide a baseline for the state of the relationship so as to judge functional improvement, tests as delineated under the profile will provide a measure of internal drive structures. Confirmation and interpretation will be assured through a second layer of vetted tests.

General Protocol:

1. Couples are gathered who wish to participate in a study of sexual dysfunction within human relationships. They are asked to self-assess the level of difficulty and honestly answer a checklist of possible problems.
2. A standardized battery of tests is administered including the aspects: personality inventory, depression, neuroticism and anxiety.
3. GSR/HR/HRV are recorded to measure response as scenes of sublimated sexuality such as landscapes, and photos of couples expressing different aspects of courtship and intimacy are shown.
4. GSR/HR/HRV are recorded to measure response as scenes of explicit sexual activity corresponding to drive elements are shown. The basics of the therapy are explained. It is

explained that therapy will be given at three day intervals.

5. On another day once rested, the couple is given Peptide Assisted Therapy while monitored and their responses silently recorded:

- a. Oxytocin is administered via nasal spray 45 minutes before therapy begins (Gossen et al., 2012). The therapy is again explained.
- b. The couple is seated in a comfortable semi-reclined position in physical contact so as to imitate the initial situation of contact in primary nurturance. A ~30/40 minute video has been prepared with the symbolism narrated to corresponding scenes of tranquil beauty and soothing music. The couple watches and relaxes to encourage a safe hypnotic state.
- c. The couple is gently encouraged to enjoy the day and each other, and return in three days for further treatment.
- d. Each 4 sessions the relationship cues and basic test battery are repeated after therapy to judge functional progress without raising defenses or affecting outcome.
- e. After 10-15 sessions the therapy is concluded, and the test battery in full including the profile of drive elements is again repeated in the specified order.
- f. Complete hippocampal mnemonic consolidation requires 30 or more repetitions (Panksepp, 1998; Norman, 2013a, 2016a) and may well be aided with the addition of oxytocin. A CD copy of the video and over the counter ration of oxytocin are provided to the couple so the therapy may be continued at home, to full result.

In this way, the persistence of memory itself will aid in altering the transference structure at a near causal level to ameliorate pathology, and, the process can be measured, and those measurements confirmed.

This stepwise approach may yield two things of benefit: 1. a new therapy which is inexpensive, non invasive, non toxic and can be made widely available to benefit a specific and substantial population, and 2. a new substantiated and less subjective mathematical approach and metric which will delineate therapeutic progress and internal affective dynamics without need for recourse to cumbersome written tests prone to subjective influence. Autonomic measures are less subject to conscious influence.

Conclusion:

Sexual dysfunction is one of the most common of all pathologies and affects millions of individuals, couples and relationships. GSR and other variables once interpreted in a suitable non linear and linear analysis, may allow accurate, objective and noninvasive

taxonomic and dynamic analyses of this pathology, and treatments affecting the same. The PAT method, has the potential to help a great many in need of aid without making recourse to invasive, lengthy, costly, or toxic treatments. The PAT method and the mathematics to evaluate it will articulate the human drives creating the transference itself, and might best be brought to specific fruition using the above methodology, to the benefit of mankind.

Appendix

1.

It will be helpful to create a working analogy, a schematic model for ego processes, which can be functionally ascribed to neuroanatomical coordinations extending systemic connectivity associated with the Default Mode Network (Carhart-Harris & Friston, 2010). Think of psychoanalysis and the role of ego as a stimulus barrier which mediates both internal and externally derived cathexis (Freud, 1923). We wish to suggest at this juncture the simple and correct idea that the combinative functionality of ego/super-ego in distributing and restricting the expression of unconscious affect, the forming of affective repressions and affective/libidinal distributions, may be usefully reduced to the idea of a non-commutative topographic experiential template. On the simplest level, imagine a stratified structure allocating resistance where height in vertical location corresponds to the strength of that element's dynamic contributions to the qualitative unconscious transference forming ontological reality. On a more nuanced level of analogy, please think of an associative neuronal attractor network, perhaps with epigenetic underpinnings, which defines perceived objects and situations—the attractor—in a nonlinear process of displaced affective valence akin to theories of quantum perception and collapse (Norman, 2015), where elements closer to the surface in the associative chain, those of greater energetic cathexis are greater contributors. Increased quanta of energetic cathexis, is akin in its effect, to raising the element up in the associative chain. [Think of quantitative energetic cathexis in terms of Freud's economic/quantitative factor (Freud, 1914-1916)]. The precise role of each typological participant in the formative unconscious transference *must* be quantitatively articulated if psychology is ever to claim its rightful place as hard science and place a real etiologically sound basis under this pluralistic discipline (Norman, 2016), and in addition, a clear relation must be established to phylogenetic epigenetics (Norman, 2015*b,c,d,e*). However, this simple starting point, will soon prove itself a useful gateway.

The designation *non-commutative* refers to the notion that the order of topographic assembly and relation is a functional contributor to manifest outcome. Ego often carries out the repressions of super-ego, and is therefore structured so as to mediate resistance to, and distributions of, affect. As the process of mnemonic re-polarization (Norman, 2013*a*) takes place, we can learn much by examining the particulars of the process. Firstly, it is to be noted that although even one or two regressions are therapeutically demonstrable in the amelioration of pathology to some substantial degree, 30 or more regressions are needed for the full effect to become solid. A full mnemonic re-consolidation then, simply by looking at those familiar numbers, is likely a function of hippocampal mnemonic

instantiation, and subsequent hippocampal–neocortical consolidation (Panksepp, 1998, p. 157; Stickgold et al., 2001). The effect of such a complete mnemonic re-consolidation, is to alter the non-commutative template structure. Once altered, the pathogenic contributors are reduced to lower levels of less reactivity in distributional and repressive mediation, and, the new memories are allotted a predominant place. *The basic circuit balance is thereby altered.* So in re-polarization, effective pathological amelioration is accomplished by way of therapeutically inculcated variance in non-commutative topography via regression, via dynamic hippocampal plasticity, and then, neocortical consolidation. Clearly, hippocampal plasticity and mnemonic functioning are key to the secondary neocortical consolidation, and, demonstrated plasticity is insufficient to gain ground with less than an unrealistic number of difficult regressive therapeutic interventions.

We wish to suggest a new method whereby the "experiential template" may be topographically re-defined and pathology lessened, without need for direct regressions, drugs, or the direct access to unconscious repressed material. A process of substitutive mnemonic alteration by partial regressive augmentation is implied. This may well allow some great measure of healing, by more closely approaching the cause.

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