

Trilogy Integration & Baker-Miller Pink (Joe Shafer)

First, I am not talking about raw receptor information, unless you are referring to the fact that all perception must have some underlying reception. What we are examining is the higher-level integration of the trilogy proprioception, interoception, and exteroception (PIE) and what happens when this system breaks down.

The fact that proprioceptive, interoceptive, and exteroceptive streams must be integrated for the brain to construct a coherent sense of safety is well-researched across neuroscience, predictive processing, and clinical psychology[1–5]. While much of the foundational work has focused specifically on interoception a breakdown in sensory integration heavily disrupts interoceptive prediction errors[6–9].

When multimodal integration fails, hyperactivation or dysregulated functional connectivity within the insula-ACC-brainstem circuit prevents the proper suppression of false alarm signals. This directly correlates with clinical presentations of panic, hypervigilance, and persistent survival-circuit activation[10]. In fact, survival circuits do not just become activated by integration failure; they actively participate in driving and sustaining 'ception' dysintegration. When the central nervous system registers a state of sensory ambiguity, it immediately triggers threat-monitoring pathways.

Anatomically, tactile, deep musculoskeletal (proprioception), and visceral (interoceptive) inputs converge through spinal pathways and the reticular formation (RF) to the thalamus. Synchronous, coherent multimodal integration is required to maintain a calm baseline "sense of self"[11, 12]. This relies on an integrated topography across the insula that maps how interoceptive, exteroceptive, and emotional awareness intersect within shared neural architectures[13]. This includes high functional integration across interoceptive, exteroceptive-proprioceptive, and mental layers of self-awareness[14], coordination between bottom-up and top-down cognitive and emotional control. Interoceptive training impacts the neural circuit, and specific coupling between the anterior insular cortex and somatosensory/proprioceptive areas[15].

The Baker-Miller Pink Connection

As for Baker-Miller Pink (BM pink), historical research has primarily focused on its effects regarding aggression reduction in institutional settings. Schauss himself discussed this with me in the 1980s: brief exposures ranging from 15 minutes up to a short holding period successfully curbed aggressive outbursts, lowered heart rates, and temporarily pacified incoming detainees without requiring staff intervention.

However, when facilities attempted to leave inmates inside solid pink-painted holding cells for extended hours, the physiological and psychological impact inverted. Rather than remaining docile, the confined inmates experienced acute frustration and agitation, sometimes using their fingernails to scratch the pink paint off the cell walls[16].

In the late 1970s, Alexander Schauss (director of the American Institute for Biosocial Research) investigated how light and color wavelengths trigger changes in endocrine and cardiovascular systems. His early experiments concluded that short-term exposure (roughly 15 minutes) could temporarily suppress feelings of aggression, lower pulse rates, and even cause muscle strength changes. Other studies and replication attempts yielded mixed results; while initial tests showed calming trends, later applications in facilities like the Santa Clara County Jail or broader institutional trials indicated that the calming effect was often short-lived and that prolonged exposure occasionally caused frustration, agitation, or increased behavioral incidents. (Even University of Iowa football coach Hayden Fry famously tried painting the opposing team's visitor locker room with Baker-Miller Pink to reduce opponent aggression, though they eventually made him stop).

Schauss reported this color to me in 1984–1985 in Denmark. At the time, I thought it was interesting but of little clinical use—until November 2025, when a Brain Recovery (BR) student with multiple TBI incidents was wearing glasses reminiscent of that pink tone. She had been prescribed them by a neuro-optometrist to help calm her stress load, prompting me to jokingly refer to it as "looking at the world through rose-coloured glasses."

When I followed up and tested her while she wore them, I was amazed at what I found. Further investigation revealed that when abnormal, the extensors stayed strong, but when normal, they inhibited. It took further clinical trials and Therapy Localization (TL) to begin understanding what was happening: while in normal BR extensor inhibition is typically undesirable, under Baker-Miller pink conditions, extensor inhibition is normal.

For example, in conditions like PTSD, OCD, and hyperactive disorders, proper inhibition fails to occur. Restoring normal inhibition through BR protocols leaves the patient feeling calmer and more relaxed. Notably, the TL frequently localizes to the area of the corpus callosum around the frontal region.

Aside from historical studies regarding aggression in prisons, Baker-Miller pink has been very little studied and has virtually no clinical precedent. Naturally, this makes it subject to the "dubious eye" of the scientific community and prone to rejection rather than acceptance. To date, the clinical findings and applications are entirely my own, yet the results witnessed by Geert and others utilizing this approach border on the incredible.

Prior to discovering its application here, Brain Recovery outcomes were often hampered by our inability to access and assess precisely how these threat circuits were influencing recovery. We still have a vast amount of work ahead of us, but the clinical indications directly target emotional survival and threat circuitry. For instance, the changes observed in Heart Rate Variability (HRV) following therapeutic intervention are remarkable, and patients who were previously resistant to recovery are beginning to turn a corner and heal.

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