Fall/Winter 2007
volume 41 • number 2

# The Journal of Orgonomy

## Commemorative Issue: Wilhelm Reich's Legacy


- Introduction to the 2007 ACO Annual Conference
  Dale Rosin, D.O.
- The Decline and Fall of Modern Psychiatry
  Charles Konia, M.D.
- The History of the Development of Medical Orgone Therapy
  Edward Chastka, M.D.
- Sigmund Freud, Wilhelm Reich and Elsworth Baker
  Robert A. Harman, M.D.
- A Case of Recurrent Psychosis
  Alberto Foglia, M.D.
- Can Migraine Headache be Treated Without Medication?
  Peter A. Crist, M.D.
- Reich's Mind-Body Approach: First Aid in a General Medical Hospital
  Howard J. Chavis, M.D.
- Wilhelm Reich's Legacy: Bombshells in Science
  Peter A. Crist, M.D.


The American College of Orgonomy

www.orgonomy.org • USSN/ISSN 0022-3298 • Published by the ACO Press

**ORGONOMY** is the science of orgone energy. Discovered by Wilhelm Reich, M.D., in biological organisms in 1934 and in the atmosphere in 1940, orgone is the primary energetic foundation of all of nature.

*THE JOURNAL OF ORGONOMY* is published semiannually, in spring and fall, by the American College of Orgonomy Press.



**Manuscripts** should be sent to the American College of Orgonomy Press, P.O. Box 490, Princeton, NJ 08542. They should be typed on 8.5 x 11 inch paper in dark print, submitted in triplicate, and accompanied by disk. If articles have been published elsewhere, or submitted for publication consideration by others, then this information should be provided in the cover letter. Accepted manuscripts are subject to copyediting. They become the permanent property of *THE JOURNAL OF ORGONOMY* and may not be reprinted without permission from both the author and the *JOURNAL*.

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> Raknes, O. 1995. The Orgonomic Concept of Health and Its Social Consequences. ***Orgonomic Medicine*** 1:106-120.

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The American College of Orgonomy

# Editorial

*Charles Konia, M.D.*

There are few days in one's life that are remembered with particular vividness. Sunday, December 7, 1941, the day that the Japanese attacked Pearl Harbor, and Tuesday, September 11, 2001, the day that the World Trade Center and the Pentagon were attacked are two of those days.

Sunday, November 3, 1957 was another such day for me. Late that afternoon I had returned home from a swim at a nearby quarry and I remember thinking, because it was getting late in the fall, it would be the last time I went there that year. The phone rang. It was a friend. Wilhelm Reich had died in prison.

Although I was in emotional shock, my mind remained unusually clear. I knew that the course of my life had changed forever. I would never have the opportunity to know Reich or to learn from him. I remember feeling regret at not having made an attempt to meet him the previous year when he was residing in Washington, D.C. Even though I had been a second-year medical student living in that city, I had no reason to meet with Reich. It would have been premature and also a bother to him during that stressful time when he was engaged in a court battle. My only course of action was to continue my medical studies, become a physician and study medical orgonomy with Elsworth Baker, M.D. Baker was the one person that Reich had thought most highly of, and he had appointed him to be in charge of training medical orgonomists.

That was 50 years ago. When I began seeing Baker upon my graduation, I understood what Reich must have known all along: That of all practicing medical orgonomists, and I had been in contact with many, Baker was the one individual most qualified to carry the knowledge of the science of orgonomy into the future. Because of Baker's tireless dedication to transmitting Reich's knowledge to the

next generation of therapists, the orgonomic sciences have survived intact.

This year marks the 50th anniversary of Reich's death and we are observing it with this commemorative issue of the *Journal.* Also, the College's Annual Conference on Sunday, November 4th will be largely devoted to presentations on Reich's remarkable therapy.

I am certain that Reich and Baker would have been both proud of, and grateful to, the many individuals who have not only carried the science of orgonomy forward into the future without distortion, but who have also advanced orgonomic knowledge and understanding.

The last 50 years have been devoted to continuing Reich's struggle to secure a beachhead of sanity in this troubled, emotional plague-ridden world. The American College of Orgonomy has always been at the forefront in keeping the science of orgonomy alive and well. What will happen in the future remains to be seen.

# Introduction to the 2007 Annual Conference of the American College of Orgonomy

*Dale Rosin, D.O.*

Good morning. I am Dr. Dale Rosin and on behalf of the American College of Orgonomy let me welcome you to our Annual Conference.

This conference is special because of its date. Today is November 4, 2007. Fifty years ago yesterday, on November 3, 1957, Dr. Wilhelm Reich died of "myocardial insufficiency with sudden heart failure," a heart attack. He died alone, in a cell, in a federal penitentiary in Lewisburg, Pennsylvania. He was 60 years old.

On that day, his 13-year-old son, Peter, lost his father. Dr. Reich's wife, Aurora Karrer, lost her beloved husband. A group of dedicated physicians studying with Dr. Reich lost their inspiring leader and mentor.

And the world lost a man who was one of the greatest natural scientists ever to have lived.

The world lost a man who had dedicated his life to solving the mystery of mankind's misery and who, in the process, discovered the life energy, orgone energy, discovered how life itself develops and also discovered the scourge of life which he called the emotional plague. As we look back on the events of Dr. Reich's life and death, we see now that, in fact, he was murdered by the very emotional plague he was the first to identify.

Eighteen months before Dr. Reich's death, on May 7, 1956, he was convicted of violating a 1954 Federal Decree of Injunction. This injunction had banned the interstate shipment of orgone energy accumulators by Reich himself or by the Wilhelm Reich Foundation, which included any of Reich's literature containing any statements, representations or suggestions that "the alleged orgone energy exists."

On June 26, 1956, the U.S. Food and Drug Administration, the FDA, burned a quantity of Reich's books at Orgonon.

On August 23, 1956, more than 6 tons of Reich's writings, his books and publications, were burned at the direction of the FDA in a New York City Department of Sanitation garbage incinerator. We have to stop and realize this: A book burning, in the United States, in 1956. And on March 17, 1960, again, more of Reich's books, kept in storage at Orgonon, now the Wilhelm Reich Museum, in Rangely, Maine, were burned. 1960.

Dr. Reich's work spanned from medicine and psychiatry to biology, sociology, physics, cosmology and more. Today, we will focus on his work in medicine and psychiatry and how his discoveries in these fields are vital—as well as how their exclusion from mainstream psychiatry has, ultimately, led to the present deplorable state of psychiatry in the world.

So, it's a good day to remember and honor this man, Wilhelm Reich. Many people in this room and around the world have had their lives changed dramatically for the better because of the therapy he developed and pioneered. Many people in this room and around the world have been moved by his seminal discoveries and their horizons broadened because of his work.

Some in this room today and around the world continue to strive, against great odds, to carry on this work, to further develop and increase the public's awareness and understanding of Reich's work.

Today's conference will examine Wilhelm Reich's legacy to psychiatry and medicine. We will hear about the effect on present-day psychiatry of this legacy being scorned or, worse yet, ignored. We will look at Reich's life and the evolution of his work. We will hear how he passed the mantle of leadership to Dr. Elsworth Baker, who, with others, founded the American College of Orgonomy. We will hear presentations of clinical cases that will show how Dr. Reich's therapy is being used around the world today to lessen human suffering.

We should remember this man who some revered, some hated, but who no one felt lukewarm about. We should remember the courageous

way he lived his life and feel grateful that he did. And we must continue to examine and learn from the enormous body of research and understanding of life and the human condition that he elucidated, lest it be lost to the ages.

As you are listening to the presentations given here today, think of this brilliant man, Dr. Wilhelm Reich, who died so prematurely and tragically, fifty years ago yesterday, after giving the world so much.

Today's conference is dedicated to the memory of Dr. Wilhelm Reich.

From the History of Orgonomy

# The Decline and Fall of Modern Psychiatry

*Charles Konia, M.D.*

## Introduction

Psychiatry is not the only branch of medicine that has declined in stature. The entire medical profession and the whole of society have suffered degradation. However, today I will focus only on the decline of psychiatry.

## Psychiatry in 1960 and Psychiatry Today

In 1960, when I started my psychiatric training in a psychoanalytically oriented residency program, the psychiatric profession was at its zenith. Psychiatrists were highly respected members of the medical community. Rightly or wrongly, they were considered the exclusive authority by all on matters of mental health and illness. The organization of mental health professionals was seemingly well ordered. Psychiatrists were in charge of treating psychiatric patients, clinical psychologists dealt primarily with psychological testing, while social workers mainly handled matters of patient disposition to psychiatric and non-psychiatric facilities.

Contrast that situation with the current state of psychiatry. Psychiatrists who have been in practice for many decades watch with amazement and alarm at the steady decline in the social standing of the psychiatrist and the quality of psychiatric care. Today, the understanding and treatment of psychiatric patients has been degraded into a mindless, cookbook approach to patient care. Psychiatric hospitalization is largely devoted to medicating and releasing patients in assembly-line fashion. The practice of prescribing medication for children's emotional disorders, unthinkable in past

generations, is a matter of daily routine and to make matters worse, there is little or no attempt made at understanding the underlying source of the patient's condition. For example, the number of children and adolescents treated for bipolar disorder, a catch-all phrase applied to almost any explosive, aggressive child, has increased 40-fold from 1994 to 2003. After children are classified, they are treated with powerful psychiatric drugs that have few proven benefits and potentially serious side effects like rapid weight gain (New York Times).

Finally, the psychiatrist is no longer the primary caretaker. He is now trained in a mechanical fashion to dispense psychotropic drugs that seek to eliminate the patient's symptoms. This approach, erroneously called biological psychiatry, is his exclusive function. The primary therapist in charge of the patient's emotional and mental care are now psychologists and social workers.

The traditional physician-patient relationship, where the psychiatrist is the one in charge of the well-being of the patient, has become a thing of the past. To further complicate the situation, insurance companies have become responsible for paying for a large part or all of the patient's treatment. As a result, the psychiatrist has come under the direct control of insurance companies and is, in effect, working for *them.* Big business now dictates treatment by watching over the psychiatrist's work, offering alternative "low cost" options, pushing medication as the treatment of choice and establishing "guidelines" for the type and duration of treatment. As a result, *the rational authority* of the psychiatrist has been eroded to the point of being non-existent.

Before looking at the ways to alter this course, it is first necessary to understand how this degradation occurred.

## What happened?

Around 1960, the most prestigious psychiatric residency programs, like the one I was trained in, placed a strong emphasis on Freud's ideas, and the various schools that had splintered off from psychoanalysis. Despite its strictly Freudian emphasis, the residents in my training program were expected to have more than a passing

understanding of the various schools of psychiatric thought other than psychoanalysis. This acceptance of eclecticism was the rule, with one notable exception: Except for the first part of his book, *Character Analysis*, Wilhelm Reich and his ideas were considered off-limits in every psychiatric residency program. In my psychiatric training, not only was any discussion of Reich's ideas not tolerated, but there were several occasions when I heard his name smeared by members of the psychoanalytic teaching staff. Entire lectures were devoted to slandering Reich and his work with the sole purpose of making sure that no resident even thought of looking seriously into his psychiatric contributions. The chairman of psychiatry, who himself had been analyzed by Reich in Europe, once said that if he ever heard any resident mention Reich's name that person would be dismissed from the program. Since I had started my training in medical orgone therapy shortly before, I kept my mouth shut and simply learned as much traditional psychiatry as I could. Later, when the residency director offered me a position on that hospital's staff, I declined, knowing that I would not be able to practice psychiatry the way I wanted to.

The reason I mention these events now is that it will help to clarify later developments in psychiatry. I will show that the exclusion of Reich's contributions to psychiatry and sociology from the main body of psychiatric knowledge were *the pivotal factors* that resulted in the degradation of psychiatry during the following decades. It prevented psychiatry from being placed on a natural scientific, biological foundation. Instead it is based on sterile, mechanistic principles.

Even in the early 1960s, however, there were signs indicating that the façade of psychiatry was cracking and conditions were not as robust as they appeared. For one thing, there were many psychiatric disorders such as psychoses and depression that were not amenable to psychoanalytic treatment. Another was the discovery of drugs that could be used to suppress the symptoms of anxiety and panic resulting from psychiatric disorders. These drugs were effective in eliminating the distressing psychiatric symptoms, but they certainly could not be

considered a cure and, moreover, they had disturbing, sometimes life-threatening, side effects. Nevertheless, the practical advantage of these medications was that in many cases the length of psychiatric hospitalization could be reduced dramatically with great overall savings. The effectiveness of drugs on symptom reduction, although doing nothing to alleviate the underlying emotional problem, was a welcome alternative to psychiatrists with a mechanistic orientation. Psychoanalysis could not stand up to the symptomatic benefits of medication therapy.

Slowly, within departments of psychiatry a separate division focusing on psychopharmacology began to appear. By the late 1970s, the replacement of the psychotherapist by the psychopharmacologist in the departments of psychiatry across the United States was well underway. It was then a small step for the psychiatric profession to be taken over by big business in the form of the pharmaceutical and insurance industries.

Psychiatry thus came under the domination of the mechanistic approach of molecular medicine and brain research. By mistakenly equating the mind exclusively with the brain, and not with the whole body *which includes the brain*, the new generation of psychiatrists hoped to find a cure for psychiatric illnesses through an understanding of brain physiology. No longer did the psychiatrist have to understand the patient and look into his life's story that was giving rise to the particular symptom such as anxiety, depression, overeating, headache, insomnia, and so on. Instead, the patient was subjected to diagnosis by symptom checklist and given the appropriate medication. If that did not work, the patient was referred to the appropriate eating disorder, headache or insomnia clinic and put in the hands of the "expert" who dealt with these particular symptoms.

## How Did it Happen?

The advent of psychopharmacology and an interest in brain research were not the major reasons for the collapse of traditional psychiatry, however. There were other factors having to do with fundamental

weakness in the body of psychiatric, including, in particular psychoanalytic, knowledge and practice. These deficiencies were concealed just beneath the surface and they were far more serious.

The most important of these was the absence of an in-depth understanding of emotional functions and their relationship to psychiatric illness. From this lack of clinical understanding grew a diagnostic system that was inconsistent and often inaccurate. Psychiatrists from different schools of thought often came away with different diagnoses for the same patient.

Related to this lack of diagnostic consensus was insufficient understanding of the biological, bioenergetic principles underlying psychiatric illness. For example, what exactly does a symptom consist of and what is its function? What is the relationship of the symptom to the patient's illness? What is an emotion? Where do ideas originate from? What does a cure consist of? Combined with a lack of diagnostic reliability, failure to ask, much less answer, these questions led to confusion and uncertainty as to the correct course of therapy.

Finally, there was confusion as to an objective standard of emotional health and, as a result, the goal of psychiatric therapy was left vague and vulnerable to attack by the mechanistically oriented psychiatrist. Another consequence of this confusion was that it permitted every kind of deviant and indecent behavior to be tolerated and considered "normal," regardless of its destructive effect on the individual and on society. To further add to the confusion, this behavior was consistently supported by political activists, often arguing for protection under the First Amendment. Now, homosexual activists, for example, could argue that homosexuality was not a pathological condition but just a different sexual "orientation." This politically correct attitude and pressure from gay rights activists led the American Psychiatric Association to put the issue *to a vote.* With less than one-third of its members voting, a majority elected to remove homosexuality from its official listing of mental disorders, a decision based on politics, not on the merits of actual scientific evidence.

These gaps in psychiatric knowledge eroded the rational authority of the psychiatrist and helped to usher in *the emotional plague* in full force during the latter half of the twentieth century. Almost every kind of deviant or indecent human activity, regardless of its harmfulness, was normalized. People felt free to do almost anything they wanted and personal responsibility was thrown to the wind. It was at this time that the phrase "different strokes for different folks" entered the vernacular. Freedom peddlers of every variety, such as free speech activists, argued that these offensive forms of behavior were not pathological but just different individual life style "choices."

These shortcomings in diagnosis and treatment and the decline in moral standards were the underlying reasons responsible for the degradation of psychiatry that we see today. They were part of a more fundamental social phenomenon: the breakdown and transformation of the structure of society from an authoritarian to an anti-authoritarian form. This transformation had a biological foundation. It was based on the widespread breakdown of muscular armor along with intensification of ocular armor in the general population, manifested by impulsive and psychopathic behavior that was often exacerbated by drug use. Hatred and destructive impulses broke through and were primarily directed toward authority figures in every area of social life, as a benumbed public stood by and watched helplessly. The resultant social chaos was referred to by some as "the sexual revolution."

Because the emotional plague underlying the breakdown was not recognized, it could not be understood and addressed. Every social institution—the Establishment—was challenged, from the government, military, and police, to schools and universities. Under the relentless assault of public opinion dominated by the politics and policies of the political left, many parents of adolescents fell victim to the emotional plague and lost the will to assert their rational parental authority. Thus, the degradation of psychiatry was part and parcel of the generalized breakdown and transformation of the authoritarian social order.

In psychiatry, the hatred was directed most strongly against the authority of the father of modern psychiatry, Sigmund Freud, his teachings and his followers. This antipathy ultimately turned toward all psychiatrists. In the intervening decades, one book after another appeared attacking Freud and his theories, sometimes even written by psychoanalysts themselves.

The central psychoanalytic premise consistently attacked and rejected was that conflicts originate from *within* the individual, and that these unresolved conflicts are responsible for people's psychiatric symptoms and illness. Instead of looking at the underlying sickness in the individual, at the disturbances in the person's *character* that determine neurotic behavior, the focus was turned outward toward authority figures in the real world. In effect, people's hostility was projected outward onto society in general and authority figures in particular. Nothing productive, certainly no advances in understanding the cause and treatment of psychiatric illness, ever came out of these attacks.

In the absence of a coherent, unifying understanding of the origin of psychiatric illness, the psychiatric profession turned its attention and focus to the patient's symptoms, to the endless variety of human suffering that emotional disorders can manifest. It was hoped that this would make possible a more satisfactory system of diagnosis. By standardizing definitions and providing a clear set of criteria for each and every psychiatric disorder and condition, it was believed that this new descriptive way of classifying mental illness would solve the problem of diagnostic reliability, that different psychiatrists would be able to arrive at the same diagnosis. This resulted in the development of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which remains the official listing of all mental disorders recognized by the American Psychiatric Association.

First published in 1952, the *DSM* originally listed 106 categories of mental disorder and was 130 pages long. In the following decades the list has grown and the most recent revision, *DSM-IV* published in 1994, contains 297 categories and is 886 pages long. This attempt at

standardization, by simply adding every conceivable symptom to the list, produced many new diagnoses, such as academic skills disorder, pathological gambling and pre-menstrual dysphoric disorder. These additions only complicated matters and served to further mechanize the diagnostic process. As could have been expected, the degree of reliability and agreement using this symptom-based set of criteria in clinical practice proved to be no better than the old, and in most cases was worse. Furthermore, the new diagnostic criteria in effect threw out the significance of psychosexual developmental factors in the causation of psychiatric illness, knowledge that had been painstakingly gained through many decades of clinical work and research. This paved the way for the triumph of a mechanistic-behaviorist approach to psychiatric treatment, to treat human beings as if they are a machine. By effectively negating the importance of the emotional life and of psychosexual factors, it was a triumph of the emotional plague.

Commenting on some of the defects in the current use of the *DSM* classification, the editor in a recent issue of the *American Journal of Psychiatry* wrote:

> One, we have lost the patient and his or her story with this process; two, the diagnosis, not the patient, often gets treated; three, surprisingly, the study of psychopathology is almost non-existent; and four, the strict focus on diagnosis has made psychiatry boring. This never seemed to be a problem in our field before. (Tucker)

Further destructive consequences followed necessarily born of this shift to a symptom-based method of diagnosis. It led to the "pharmacologization" of psychiatric practice: Each symptom has a recommended drug that is purported to eliminate it. Psychiatrists were often mandated to follow these diagnostic and therapeutic guidelines. By focusing on symptoms, and not on the underlying emotional condition of the patient, most psychiatrists and eventually the vast majority of those in the mental health field accepted the idea that pharmaceuticals targeting the brain was the correct method of treatment for psychiatric disorders.

## Why Did it Happen?

Was this degradation inevitable or could it have been prevented? Was it simply a matter of ignorance on the part of psychiatrists, or was it due to a flaw in the psychiatrists themselves? The answer: If the psychiatric discoveries of Wilhelm Reich had been utilized, the degradation of psychiatry could have been prevented. Reich's discoveries were available to be applied, but they were not. Not only were they not used, but they were avoided "like the plague."

We can trace the origin of this reaction to the fateful event that occurred at the 13th International Psychoanalytic Congress in 1934 in Lucerne, Switzerland. The significance of this event went unnoticed by almost all, at the time and since. At that Congress, Wilhelm Reich was expelled from the International Psychoanalytic Association (IPA). Reich had been a highly respected psychoanalyst who made many valuable contributions to psychoanalytic theory and technique: But he went much farther than that—and *that was the problem.* He provided a *biological* basis for Freud's psychoanalytic theories and the world of psychiatry was not prepared to accept that.

Among Reich's important contributions to psychiatry are the following:

- The discovery of a real energy that lawfully governs biological functioning, including psychic (emotional) functioning. This gigantic discovery placed Freud's libido concept on a solid physical foundation.
- The discovery of armor. Armor is defined as the typical characterological and muscular attitudes that an individual develops as a block against the breakthrough of emotion, in particular, anxiety, rage and sexual excitation. It results in bodily rigidity and lack of emotional contact. Armor interferes with the spontaneous movement of bioenergy. All the signs and symptoms known in psychiatry depend on the location and severity of armor, and the time of its formation during infant and child psychosexual development.

- The discovery that the therapeutic removal of armor restores the spontaneous movement of bioenergy and makes possible the capacity for pleasurable work and the establishment of a gratifying sexual life. By eliminating character neurosis, armor removal eliminates the energy source of psychiatric symptoms and this is an objective indication of an individual's progress toward health.

Thus, Wilhelm Reich succeeded in placing psychiatry on a bioenergetically, not chemically, based biological foundation. He showed that the biochemical alterations accompanying disease are themselves the result and not the ultimate cause of illness.

Tragically, neither Freud, his followers nor the overwhelming majority of psychiatrists could grasp the crucial importance of these fundamental discoveries. They continued to remain stuck in the more superficial psychological realm. Unable to follow him, many psychoanalysts turned against Reich and began a vicious emotional plague attack against him, starting rumors that he had gone mad or was a psychopath.

One example of their limitation was their inability to grasp the fact that more important than the patient's symptoms are the disturbances of character, since the energy of the neurosis is held in the character armor. The symptom is simply a partial discharge of energy through the character armor. Effective treatment requires an understanding of the *bioenergetic,* as well as the psychological, *functions* of character.

With this understanding of character, Reich went further and showed that it is not only the individual who is sick. He concluded from his clinical studies that since everyone suffers from a character neurosis, society as a whole is sick. He was the first to emphasize that the source of the sickness in both individuals and society is the way children are raised from the very beginning of their lives. Therefore, there have to be fundamental changes in childrearing practices. This was another revolutionary idea that was unacceptable to Freud and the other psychoanalysts who believed that the individual had to be made to conform to society's rigid authoritarian standards.

Thus, the exclusion of Reich and his contributions from mainstream psychiatric thought was not based on rational considerations but rather was a manifestation of the emotional plague, the destructive social behavior of people. This reaction has had a lasting destructive effect on the practice of psychiatry. Instead of having an effective diagnostic system and a practical technique of therapy to access the underlying bioenergetic disturbance of the patient's neurotic character and restore natural functioning, psychoanalysis and all subsequent therapies are today largely psychologically oriented and separated from the physical, biological body.

The consequences of this emotional plague attack on Reich's good name and his work have been devastating for psychiatry and the public. Power and influence in the profession has been polarized between the mechanistic biologists (psychopharmacologists) who believe that "chemical imbalance" is the cause of mental disease and the mystics who believe that these illnesses are primarily a result of environmental (psychological/sociological) influences. Neither group will ever be able to provide a satisfactory understanding of and a solution to the problem of mental illness.

Without the insights given to us by Reich of the origin of emotional disorders from chronic armoring, there can be no functional bridge to integrate these divergent views, or the mind-body duality, or to provide any possibility of prevention.

Thus, the current problems and limitations confronting modern psychiatry can be directly traced to the past and present-day consequences of the psychoanalytic community's rejection of Reich and his pivotal contributions to psychiatry, that began back in 1934. These ideas were rejected because the psychoanalysts and the psychiatrists at large were and still are, themselves, unable to comprehend and utilize them in their clinical practice. Their personal limitations set in motion an emotional plague campaign whose destructive social consequences are being felt to this day. The destruction is in the form of a tyranny of the masses where everyone's medical opinion and brand of therapy is as good as anyone else's.

Some 50 years after Reich's death, almost all in the scientific community, like their predecessors, have failed to understand and continue to ignore the deep significance of his bioenergetic discoveries. Incredibly, overt plague attacks against Reich's reputation and work are still heard from time to time.

Once thing is certain. Before psychiatry can regain the stature that it must have in order to survive as a natural scientific discipline, it must first recognize and address the emotional plague campaign against Reich's crucial discoveries. This step consists of exposing the existence and the operation of the emotional plague, and its use of distortions and slander to silence public interest in his work.

In conclusion, the emotional plague's effective destruction of Reich's good name and work has been the underlying reason that the psychiatric profession has been turned into an emotional desert. The members of the American College of Orgonomy and the faculty of its training programs in medical and social orgonomy are dedicated to opposing the emotional plague by training qualified therapists and by insuring that the knowledge given to us by Wilhelm Reich is established as the biological foundation of a living psychiatry and sociology.

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# The History of the Development of Medical Orgone Therapy

*Edward Chastka, M.D.*

The history of the development of medical orgone therapy is one filled with drama, punctuated by important scientific discoveries, and fueled by the genius of Wilhelm Reich, M.D. In his scientific "narrative," *The Function of the Orgasm* (the first volume of *The Discovery of the Orgone*), Reich tells us that "No preconceived idea determined the development of my views. It should not be assumed that here is an individual with a peculiar personal history, who, isolated from 'good society' and as a result of 'complexes,' is trying to foist his fantasies about life upon other people." Instead, Reich tells us that over the course of many years, "one problem and its solution led to another;" and that each of his discoveries owes its existence to this "peculiar course of scientific logic." What follows is a brief history of one part of that "peculiar course," the development of the technique of medical orgone therapy. The content of this article is drawn entirely from Reich's published works. My only contribution is to summarize them in a way that I hope provides the reader with a clear, concise exposition of the development of Reich's thinking and work.

## The Early Years

Wilhelm Reich was born in 1897 in Galicia, a part of the Austro-Hungarian Empire. His father was a prosperous farmer, and Reich spent his early years on the family's farm. He was well educated in the formal sense, but in later years always stressed the importance of growing up close to nature. By the age of 17 he had lost both of his parents and was running the farm on his own. A year later, Eastern Europe was engulfed by World War I. Reich barely escaped with his life, fleeing the family homestead just before it was overrun by the invading Soviet army. Galicia became part of Rumania, and Reich

never saw his home again. He joined the Austrian army, and served on the Italian front. After the war, uprooted and penniless, Reich entered the medical school of the University of Vienna. It was during his years there that Reich's interest in sexuality led him to Sigmund Freud and psychoanalysis.

### From Psychoanalysis to Character Analysis

During his second year at the University (1919), Reich was elected the leader of the Viennese Medical Student Seminar of Sexology. Reich, along with his fellow seminar members, started the seminar because they felt that the medical curriculum ignored this important subject and they decided to take responsibility for researching and presenting different aspects of sexology. When Reich presented a paper on psychoanalysis, he took the initiative to visit Freud in his office to ask for direction. His first meeting with Freud made a lasting impression on him. He recalled that "Freud spoke to me like an ordinary human being. He had piercingly intelligent eyes; they did not try to penetrate the listener's eyes in a visionary pose; they simply looked into the world, straight and honest."

Reich was a precocious student and by the following year (1920) he was admitted to membership in the Vienna Psychoanalytic Society. By the time he received his medical degree in 1922, Reich was already a practicing psychoanalyst. The years between 1922 and 1930 were a period of extraordinary productivity for Reich. During this brief span he published 10 books and numerous articles in the field of psychoanalysis. He was a member of the teaching staff of the Psychoanalytic Institute in Vienna, and in 1924 he was appointed Director of the Seminar for Psychoanalytic Therapy, a position he held until 1930. This gave him an important role in the training of new analysts.

Reich relates that there were two aspects of Freud's work that he found particularly attractive: The first was Freud's belief that adult sexuality did not suddenly arise at puberty, but developed out of infantile sexual drives; the second was that the sexual drive was the manifestation of a deeper, instinctual energy or libido. It was also

Freud's understanding that neurosis develops out of childhood inhibitions; that is, as children develop, their instincts, and in particular their sexual instincts, come into conflict with the rules of society, enforced primarily by their parents. The child comes to fear these feelings and hides or represses them. Although repressed, the feelings remain active internally, causing anxiety and neurotic symptoms such as panic attacks, compulsions or social anxiety.

Central to psychoanalytic technique was the patient's capacity to free associate, to say anything that came to mind. Reich recognized that this was one of the chief difficulties with psychoanalysis. Patients did not always say everything that came to mind. In fact, it was the rare patient who could be fully honest about his or her thoughts and feelings, particularly when it came to aggression and sexuality. Instead, patients hid their true feelings by putting on a false front, or tried to please the analyst by telling him what they thought he wanted to hear. Many patients developed an intellectual understanding of their condition without showing any improvement in their symptoms. Patients who made no progress were labeled "resistant" and their therapy was terminated. Reich began to focus on analyzing resistances, a technique he named *resistance analysis.* He recognized that it was this very tendency for patients to hide the truth about themselves, their *resistance,* that had to be unmasked first, before the repressed memories and feelings could surface.

The next important contribution Reich made to psychoanalytic theory was the realization that the main resistance to analysis was revealed not by what the patient said or did, but by the manner in which he or she said or did it. Not the "what," but the "how" was the most important manifestation of resistance. This discovery led directly to Reich's third contribution to psychoanalytic theory: Once you begin to talk about how someone acts, you are no longer talking about what they think, you are talking about their *character.*

Freud and others had demonstrated that individual character traits have their origin in the stages of infantile psychosexual development. Reich was the first to formulate a coherent theory of

character. He showed that the different character traits are dependent one upon the other and that they work together to form a unitary resistance, or defense, against all emotions that are felt or perceived to be dangerous. Reich named this unitary defense *character armor.* These three discoveries became the basis for the technique of *character analysis.*

## Sex Economy

In 1923, after three years of study on the subject, Reich presented a paper to his psychoanalytic colleagues asserting that the disturbance of genitality was the most important symptom of patients' neurosis and had prognostic significance. The "icy" response by some psychoanalysts, insisting that they knew numerous neurotics with a healthy sex life, led Reich to investigate in greater detail his patients' experience of the sexual act. He wrote in *The Function of the Orgasm,* "The more exactly I had my patients describe their behavior and sensations in the sexual act, the firmer became my clinical conviction that all of them, *without exception,* suffered from a *severe* disturbance of genitality." (italics in the original)

His findings led to his elucidation of the difference between erective and ejaculative potency in the male and clitoral orgasm in the female and *orgastic potency*—the capacity for surrender to the flow of biological energy without any inhibition, the capacity for complete discharge of all dammed-up sexual excitation through involuntary pleasurable contractions of the body, with momentary loss of consciousness.

Reich also found that patients refractory to treatment, as well as those who relapsed, had one important feature in common, which distinguished them from patients who had successful therapy: The former never established a satisfactory, pleasurable, genital sex life. He, therefore, concluded that the disturbance of genitality is the energy source of the neurosis and neurotic symptoms, and that the function of the orgasm is to discharge energy as the ultimate regulator of the individual's energy economy (sex-economy). Thus the goal of therapy is the establishment of orgastic potency.

## Character-Analytic Vegetotherapy

Striking changes became apparent in patients who were treated with Reich's new technique of character analysis. Patients who became conscious of their character attitudes, whose character armor softened, spontaneously began to express emotions that had often been repressed since childhood, emotions that they had never been able to express, or sometimes even to feel. Along with this emotional expression, Reich observed a spontaneous change in bodily attitude and behavior. It became clear that the physical attitude of the body, composed of muscular spasms and tensions, is how impulses and emotions are repressed, and that these spasms and tensions contain within them, as if frozen, the repressed emotions and impulses. Reich called this physical mechanism of repression *muscular armor.*

Reich now began addressing the neuroses from the body side, partly by calling the patient's attention to the chronic tensions, and partly by direct physical manipulation. He found that by loosening up the muscular holdings and tensions, repressed emotions and memories came to the surface. In addition, patients reported new and unexpected feelings of "streaming" in the body. These were pleasurable and usually soft, but occasionally so strong that they were perceived as overflowing. Reich felt that they came from the vegetative or autonomic nervous system and he called them *vegetative streamings.*

Character-analytic vegetotherapy, the name he gave to this new advance in therapeutic technique, represented a substantial step forward for the young science of psychoanalysis. Reich was generally recognized as one of the bright young minds, perhaps the brightest, of the younger group of analysts. While Reich's other contributions to psychoanalytic theory brought him acclaim, his contributions to the theory of the cause of neurosis were controversial. You will recall that Reich was first attracted to psychoanalysis by Freud's discovery of infantile and childhood sexuality (the psychosexual stages of development), by Freud's belief that neurosis was caused by the frustration of the child's natural sexual drive, and by Freud's psychic energy concept of *libido.* Freud, and the majority of psychoanalysts,

gradually abandoned the libido theory in favor of the concepts of ego psychology. Reich was one of the few who remained convinced of the importance of the libido theory and he began to apply this belief in his social and political actions.

## Sociopolitical Work

Reich's therapeutic work made him ever more conscious of the immensity of human suffering, while his theoretical and scientific work made him ever more conscious of its causes. Quite early in his career, Reich became involved in attempts to help the poor benefit from the insights of psychoanalysis. In 1924 he became an assistant at the Psychoanalytic Polyclinic in Vienna, and from 1928 until 1930 (when he moved to Berlin), Reich was actively involved in establishing mental hygiene consultation centers for the poor in Vienna.

Reich recognized early on that psychoanalytic therapy could never solve the problem of the suffering of the masses. There were too few analysts, and the poor couldn't afford therapy. Reich, along with a number of the younger psychoanalysts, looked for allies among the Socialist and Communist political parties that were powerful in Austria and Germany at the time. Reich felt that his understanding of the role of sexual repression in making people unhappy, and in reducing their capacity for work and rational living, was the ideal accompaniment to the economic reforms proposed by the Socialists and Communists. He started a movement called the *Sex-Pol Bewegung*, or sex political movement, to promote social reforms to reduce people's sexual misery. The political platform anticipated many liberal programs we see today including: government subsidized housing; abolition of laws against abortion, birth control and homosexuality; distribution of contraceptives; sexual education and counseling; and childcare at businesses and factories.

The Sex-Pol movement was well received by the public, and particularly by young people. Meetings drew members of all political parties, conservative and fascist as well as the Socialists and Communists, and despite its lack of central organization, the sex-pol

movement grew rapidly into a network of groups with a membership of some 500,000 people. Sex-pol, however, was not popular with the leaders of the Socialist or Communist parties. Reich's growing following made them afraid that he would turn the attention of the young away from socialism and its purely economic class conflict view of society. Reich tried to convince them that sex economy was the psychological foundation that Marxist economic theory needed, but they rejected his ideas and he was expelled from party membership, first in Austria from the Socialist party, and later in Germany from the Communist Party. With the rise of Hitler, Reich was no longer safe in Germany, and in 1933 he escaped to Denmark.

Reich also tried to arouse the interest of the other psychoanalysts in addressing the social basis of the neuroses. He was not alone in this, many of the younger analysts wanted to translate what they had learned in psychoanalysis into social action. However, Reich's outspoken social and political activism frightened the leadership of the International Psychoanalytic Association. The leaders of the IPA hoped to coexist with the Nazis by remaining outside of politics. Their policy was to appease the Nazis by suppressing any aspect of psychoanalysis which the fascists might have found objectionable. They put pressure on Reich to stop all of his political activities and discontinue his writing. Reich refused, and in 1934 he was expelled from the IPA.

I'd like you to reflect at this point on Reich's achievements. From his arrival in Vienna in 1918 to his escape to Denmark in 1933, Reich completed medical school and classical postgraduate medical education; completed his training as a psychoanalyst; was accepted into the Psychoanalytic Association; and developed a successful private practice in psychoanalysis. He rose to a leadership role in the Psychoanalytic Polyclinic in Vienna, and was appointed as the leader of the seminar responsible for the training of analysts. He became famous for his many contributions to psychoanalytic theory and published a prodigious amount of work. He was instrumental in founding psychoanalytic clinics for the poor; and developed a political

movement and platform that inspired hundreds of thousands of people. He was expelled from political parties and by the International Psychoanalytic Association in which he had once been so prominent. He was forced to flee Germany, his adopted country, under threat of arrest and certain death. He was just 37 years old.

## Breakthrough into the Biological

By the autumn of 1934, Reich had managed to get a temporary permit of residence in Oslo, Norway, where he was to reside until 1939. He quickly attracted a talented group of people interested in receiving therapy from him or in training with him in his new technique of character-analytic vegetotherapy. He also found the means to start experimental research in physiology and biology. During these years in Norway, he made some of his most important discoveries.

Impressed by patients' reports of bodily currents and streaming, trying to understand what accounts for the flow of anxiety, anger and pleasure, and thinking about "sexual friction," the contact between the mucosal membrane of the penis and the vagina, and the muscular contractions during orgasm, Reich concluded that "bioelectricity" was the "unknown something," the energy, he was searching for.

Between 1934 and 1936, he conducted a series of experiments measuring changes of electrical potential at the skin's surface. Utilizing a vacuum tube amplifier and an oscillograph, the technology of the day, he demonstrated that when the human test subject experienced pleasure, there was a positive deflection measured, and that when the subject experienced anxiety, there was a deflection in the opposite direction. Furthermore, the greater the subjective intensity of emotion experienced, the greater the deflection measured.

The data provided experimental evidence for his 1934 discovery, "the basic antithesis of vegetative life;" that is, in pleasure something moves "towards the world, out of the self" and in anxiety, that something moves "away from the world, back into the self." Furthermore, he had also concluded that, from the perspective of the

total organism, pleasure is associated with excitation of the parasympathetic branch of the autonomic nervous system, and that anxiety is associated with excitation of the sympathetic branch.

This latter observation, Reich concluded, is important for two reasons. The first is that it is the inhibition of pleasure, the inability to experience sexual pleasure fully, that forms the core of the neurotic illness. Thus the goal of therapy is the removal of the inhibitions that interfere with the natural process of free emotional and physical expansion and contraction, or pulsation, of the patient. The second reason is that for the first time psychosomatic medicine had a natural scientific foundation, a demonstrated mechanism, the autonomic nervous system, by which emotion could affect the physical state of the body. Many physical illnesses, high blood pressure being one of the most common, can be understood as arising from a disturbance of expansion and contraction in the autonomic nervous system of the individual.

In his bioelectric experiments, Reich saw that the actual size of the change in electrical potential measured was small, and he felt that it was unlikely that this could be the driving force of the emotions. If the biological force was not electricity, then what was it? Again, impressed by patients' reports of bodily currents and streaming and recalling Freud's description more than 10 years earlier that libido flowed like the pseudopods of ameba, Reich began to look at ameba. Wanting to see for himself where they came from, he prepared the usual infusion of grass and water and observed meticulously for days on end. He saw that the cells at the margins of the grass swelled and disintegrated into vesicles, which then clumped together, developed a membrane and finally moved off into the fluid as an ameba. Heating accelerated the process.

He then began experimenting with other substances, including non-living materials such as sand and coal dust, heating them to very high temperatures and then plunging them into a sterile nutrient broth. When he observed these solutions with a microscope, he found small, spherical vesicles that glimmered with a blue color. He called

these vesicles "bions." While observing the bions microscopically, Reich developed an eye inflammation, but only in the eye that was looking through the microscope. If he looked with the other eye, inflammation developed there. He was able to culture bions and observed that bion cultures fogged protected photographic paper. Reich concluded then that the bions emitted some form of radiation that was "present everywhere." From these observations and experiments and others, Reich concluded that an energy exists that had not been previously described by science.

Reich was initially frightened and then extraordinarily excited by this new discovery, and suspected it might be the answer to his search for the biological force that he had always felt and thought must exist. Unfortunately, while Reich was conducting his investigations, including the origins of life, a social and political storm was arising around him. As had happened in Austria and Germany, Reich's work aroused considerable, generally positive public interest, although hostility appeared from the medical profession. These hostile elements began publishing articles in the Oslo newspapers that characterized Reich's work as unscientific and pornographic. The attacks on him, more than one hundred articles over a year's time, ultimately interfered with his social relationships and the viability of Norway as home for his work. He also recognized the rising threat of Nazi Germany to Norway and to all of Europe, and in 1939 he accepted an invitation to teach at the New School for Social Research in New York.

## Orgonomy

In America, Reich quickly resumed his efforts to identify and characterize the new energy he had discovered. He built a Faraday cage, a device designed to block out any electromagnetic radiation. While sitting in this enclosure in the dark, Reich observed that after a period of time he could see blue-gray clouds or "fog-like" vapors drifting inside the cage. He also observed small dots of light moving in a characteristic pattern. At first he thought that these might be subjective impressions, like the afterimages we see after looking at a

bright light, so he observed them through a magnifying glass. The magnifying glass made the clouds and small moving dots appear larger, and thus proved that they could not be subjective. Reich made several other experiments and observations to find out whether other living organisms emitted the same kind of energy that he had discovered in the bions, and he found this to be the case. When it came to human beings, he found that the energy emitted varied with the degree of free, natural liveliness or with greater or lesser freedom from neurotic inhibitions. Reich called this new energy "Life Energy" or "orgone." Later he observed the same kind of energy in the atmosphere as well, and he arrived at the conclusion that orgone was ubiquitous. Over the course of the next several years, he was able to demonstrate its effects visually, thermally, electroscopically and microscopically.

With the discovery of the orgone, it was clear to Reich that this was the bioenergy he had been searching for since the beginning of his career. He now recognized that the therapeutic technique he had developed resulted in the liberation of orgone energy from its inhibitions in both the body and the character. In his study of the orgasm, Reich had postulated a four-beat formula to describe what he thought was an electrical discharge during orgasm: **mechanical tension → electrical charge → electrical discharge → mechanical relaxation**. Reich now realized that this was the *life formula*, and that it described the build-up and discharge of orgone energy in all life processes in living organisms: **Tension → Charge → Discharge → Relaxation**.

He called this latest evolution of treatment medical orgone therapy. Medical orgone therapy continues to use the techniques of character analysis and vegetotherapy to dissolve the characterological and muscular armor. In addition, medical orgone therapy recognizes the importance of natural, unrestricted breathing in building up the body's energy charge, as well as the importance of pleasurable sexual discharge.

The discovery of the orgone opened new avenues of research in every branch of science. In the ensuing years Reich made advances in sociology, medicine, biology, physics and even meteorology and

cosmology. He called this new science orgonomy because it is the study of the functions and manifestations of orgone energy.

Throughout his career, Reich often met with criticism that he went from one subject to another without taking the time to fully develop his discoveries, and without enough experimental evidence to fully prove his conclusions. People could not understand how he could work simultaneously in the realms of psychology, medicine, biology, and physics. Reich began to focus more attention on the question of how he was able to work the way he did, and how he was able to make so many groundbreaking discoveries. When he looked back on his experiences, he felt as if he were being led logically from one observation to the next, from one discovery to another. Toward the end of his life he began formulating the principles which had, at first unconsciously, led him to his momentous discoveries. He gave this work the name *orgonomic functionalism*, thinking in the way nature functions. It is described in *Ether, God and Devil*, published in 1949, the second volume of *The Discovery of the Orgone.*

Reich never completed the third volume. A sensationalistic smear article by leftist Mildred Brady in *The New Republic* implied Reich was running a sex racket, and prompted the U.S. Food and Drug Administration (FDA) to begin an investigation. Instead of appearing in court to contest the FDA request for an injunction against him, Reich sent a letter appealing directly to the judge in the case, stating that the courts was not the place to settle matters of basic natural scientific research. Unfortunately, the court granted the FDA a broad-reaching injunction against him by default. Scientific books, journals and materials were burned or destroyed, about six tons in total. In 1956, Reich was convicted of contempt of court as a result of a colleague's violation of the injunction. He was imprisoned in the federal penitentiary at Lewisburg, Pennsylvania and died there on November 3, 1957.

# Sigmund Freud, Wilhelm Reich and Elsworth Baker

*Robert A. Harman, M.D.*

## Introduction

Dr. Elsworth Baker played the primary role in keeping Reich's work alive after Reich's death. The essence of the relationship between Reich and Baker is that each of them possessed the ability to think functionally and was therefore able to take on the responsibility for the future of important scientific knowledge. Functional thinking, independent from mechanistic or mystical thinking, was established in a rudimentary form by Freud in the period 1887-1897. Freud, however, was unable to develop it thereafter, although his discovery had the potential to change all of science and to alter the direction of human life. Reich took on full responsibility for this discovery and thereby established the science of orgonomy.

Functional thinking differs from mechanistic or mystical thinking in that it deals with natural functions rather than abstractions. In other words, functional thinking makes *direct* contact with nature. The essential qualities of a function include spontaneous motion and self-organization. Reich and Baker faced tremendous challenges because individual and social armoring constantly interfere with the practice, implementation, and teaching of any science based on functional thinking. Their overcoming of this interference is one of the pivotal events in the history of mankind.

Baker took responsibility for the future of Reich's work just as Reich took responsibility for the future of Freud's work. Baker, like Reich and Freud before him, was able to think functionally. The capacity to think functionally, and not the incidental features of his character or the details of his personal relationship with Reich, was responsible for Baker's ability to bring Reich's work into the future intact and without distortion.

## Wilhelm Reich and Sigmund Freud

This paper was written on the occasion of the 50th anniversary (November 3, 2007) of the death of Wilhelm Reich, M.D. Therefore, it starts by showing Reich's place in history. The paper also centers around the theme of the conference at which it was given, *The Decline and Fall of Modern Psychiatry,* held by the American College of Orgonomy. This must, necessarily, include showing what happened to Reich's work in the generation after his death and how the work that Reich started remained alive as a major force for the future of mankind. Elsworth F. Baker, M.D. played the primary role in that part of the history of orgonomy.

A proper understanding of history requires accurate observation and thus can only be formulated if those who live through great events, as we have, are aware of the greatness of what they have witnessed and can put their observations into perspective. History is usually presented in a skewed way. Far too often, wars or political events are considered to be the milestones of history. Reich argued that the most important part of history is the history of science, which he describes as follows:

> The history of science is a long chain of continuation and elaboration, shaping and reshaping, creation and criticism, renewed shaping and reshaping, and new creation. It is a hard, long road, and we are only at the beginning of this history. Including long empty spaces, it stretches over only about 2000 years. It always goes ahead, and fundamentally, never backwards. The pace of life becomes accelerated, and life becomes more complicated. Honest scientific pioneer work has always been its leader and always will be. Aside from this, everything *is hostile to life.* This places an obligation upon us. (Reich 1942, pages 18-19)

Reich began his scientific work in 1919 as a loyal follower of Sigmund Freud, M.D. Freud had made a series of revolutionary discoveries during a ten-year period starting around 1887, but had made no fundamental progress after that period.[1] Reich took

[1]This statement may seem extreme to students of psychoanalysis, where emphasis is placed on Freud's later discoveries. However, as will be shown in the pages that follow, Freud laid the foundations of all his future work by 1897 or so. His later work dealt with important practical details of psychodynamics and specific applications of his earlier discoveries to the clinical and social sciences.

responsibility for continuing what Freud had started, so it is worth reviewing Freud's original discoveries.

Freud started out as a neurologist at a very exciting time in the history of science. By 1874, Broca and Wernicke, who had been studying patients with brain damage, felt confident that they had localized certain mental functions in specific areas of the brain. They were trying to find out the exact location where certain functions of speech take place. Neurologists believed that the process of dealing with words could be broken down into steps, each of which occurred in a specific region of the brain; for example, hearing the sounds of a word occurred in one area of the brain and recognizing that the sounds were a specific word occurred in an adjacent area. They believed they were putting together a puzzle with six or seven pieces and they were sure they had found at least four of them.

Like many other neurologists, Freud was working on this puzzle, and was very excited about it. Let me explain why this area of research was so exciting. It would be a major leap forward for mechanistic science if a specific mental, that is psychic, function could be localized to specific areas of the brain in the same way that chemical processes of digestion could be broken down into component parts and localized to the stomach, pancreas and gall bladder, or in the same way that pumping functions can be broken down and localized to the valves, muscles and chambers of the heart. It would mean that the ancient problem of the relationship between psyche and soma could be solved.

In his efforts to solve this fundamental problem, Freud discovered something even more amazing. When he analyzed the data in great detail, he was able to prove that the four available pieces of the puzzle, so to speak, could never fit together. Applying incisive logic to a large amount of clinical observation, Freud constructed a brilliant proof that language functions can not be localized to specific areas of the brain, and can only be understood as functional states.

This is not the only time in the history of science that new observations have shown the impossibility of a traditional theory. What

Freud did with aphasia is similar to Einstein later proving that it is impossible for a rocket to propel matter faster than the speed of light, or to Heisenberg proving that it is impossible to determine simultaneously both the wavelength and the position of a particle.

Freud discovered the functional, non-mechanical nature of language functions in the late 1880s and, although he did not realize it at the time, it was one of the great turning points in the history of science. What Freud discovered is that there are observable processes, in this case small observable details of the language process, that *can* be studied scientifically, but can *never* be understood mechanistically. *Freud had found a part of the universe that can only be understood functionally, never mechanically.* The thrust of science up to that point had been mechanistic. Scientists regarded the universe as an infinitely enormous and infinitely complicated machine, and believed that this great machine could one day be explained by a few simple, mechanical laws. In the mechanistic view, the galaxy is one type of machine and the atom is another type of machine; the solar system is a machine and a jellyfish is a machine and the human mind is the most amazing machine of all. That is what the very best scientific minds thought in 1886, and then, without fully realizing what he had done, Sigmund Freud demonstrated that the universe is *not* a machine. He thereby overturned all previously existing science and made it necessary for science to be re-established on a new basis. The concept of mechanism had been meant to define *all* of physical reality, so once it was proven that *any* scientifically observable part of the universe is not a machine, then the old definition of physical reality no longer held. There may be some things that function as machines, but they no longer define or set the limits on the overall functioning of the universe.

In addition, Freud understood that language functions in the mind had to involve a physical energy process in which brain cells are energetically excited and that the effects of brain damage are due to interference with the cells' capacity to become spontaneously excited or to be excited by other cells. This meant there had to be a physical energy process that is functional, not mechanical.

Thus, by 1887, objective scientific research had begun to establish two facts that would change science forever:

- **The universe is not a machine.**
- **There must be a physical energy process that is functional, not mechanical.**

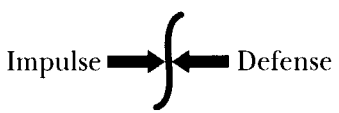
If the universe is not a machine, and a functional energy is a reality, then we must alter our entire way of studying the universe, not just speech functions and neurological diseases, but psychology and psychiatry; and not just psychiatry, but sociology and biology, and even physics.

Freud, of course, back in 1887 was in no position to imagine all of the future developments that would come from his discovery. Quite properly, he was focused on the job in front of him, as a neurologist, which was to further develop and use this new discovery to treat the sick people who came to him for help. Back in those days, there was no effective treatment for emotional illness, so many patients simply suffered until they were driven to the point of developing numbness, paralysis and other neurological symptoms. Josef Breuer, a well-known internist who was a friend of Freud, had discovered that such cases often involved conflicts between impulses and fears arising from traumatic family events. Breuer found that when the buried feelings could be vocalized, and the original emotions could be relived and expressed, then the patient got better. Starting around 1889, Freud was able to continue Breuer's work from the perspective that such treatment could be conducted functionally and that the repressed impulses and fears could be treated as physical realities, as energy functions, not just ideas. This led him to discover the unconscious mind, where conflicts about forbidden sexual impulses were always present. Further observation showed that sexual repression is at the root of emotional illness, and that lack of sexual gratification causes anxiety disorders. By the time Reich was born in 1897, Freud had solidly established all of this as scientific fact.

So far, I've used the term "functional" several times without defining what it means, other than that it's the opposite of

"mechanical." Freud actually did use the term "functional" back in 1887, and what he meant is that a functional understanding of a part of nature involves observing what that part of nature actually *does*, rather than trying to understand things second hand as manifestations of some underlying mechanism. Freud's definition of "functional" is essentially correct, because to say that a part of nature *does* something implies spontaneous motion. This is a direct contradiction of mechanistic dogma which maintains that every action is "caused" by another action.

Nowadays, we say that functional thinking means to think as nature functions. To give an example from Freud's early work, we can say that a forbidden impulse is a function that is trying to express itself and that the defense that represses the impulse is also a function.




This is depicted in the diagram above, which we now call an orgonometric equation. Freud had no knowledge of such equations but he was able to observe impulses and defenses in great detail and was able to see how they operated and what the interrelationship was between an impulse and its corresponding defense. Today, because of Reich's work and the work done in the fifty years since he died, we have a much clearer understanding than was possible 120 years ago of what a function is and of what is meant by functional thinking. I'll save that for later in the story, after I tell you more about Wilhelm Reich.

Freud's work had immediate sociological implications. He demonstrated that everyone in society has both conscious and unconscious forbidden sexual urges. In addition, there are murderous impulses. These very powerful sexual and murderous impulses are held in check by equally powerful repressions. Freud's breakthrough into functional thinking unlocked the secret to understanding psychology and the emotions. At the bottom of it all is sexuality, which

is biology on the deepest level. In addition, Freud had found what would later become the key to sociology, because sexual conflicts determined the functioning of everyone in society, not just those with psychiatric problems, and because the powerful repressions he discovered originated from and were constantly maintained by interpersonal, that is social, interactions. Because Freud had a resigned belief that armored civilization was the natural state of the human animal, he was unable to accurately grasp the sociological truth he had touched upon. It was left to Reich to describe, later, the correct relationship between biology and sociology:

> The average human being of today has lost contact with his real nature, with his biological core, and experiences it as hostile and alien. He must of necessity hate anyone who tries to bring him into contact with it. (Reich 1942)

This relationship forms the basis of the orgonomic sociology of the emotional plague. Much of the history of Freud, Reich and Baker can be said to revolve around two facts:

- Scientific progress must, of necessity, bring armored man in greater contact with his biological core.
- Anyone whose work brings armored man in contact with his biological core finds himself the object of hatred from all corners of society.

This means the scientist will not only be exposed to danger, but will encounter continuous resistance, indifference and hostility from the world, as well as repeated and unexpected disloyalty and disappointment from his co-workers. The lives of all three, Freud, Reich and Baker, must be understood from the perspective of how they were able to continue forward despite such obstacles.

Freud was very tenacious and, more importantly, he had an ability to think functionally, which enabled him to remain true to his initial discovery for decades. Unlike most people, who are intolerant to the mobility of thought, Freud was intolerant of the tricks people use to *immobilize* thought. He was very encouraging to Reich when Reich

began to work on the answers to the fundamental unanswered questions at the heart of psychoanalytic theory and practice.

Of course, the world was completely unwilling to recognize or deal with the facts that Freud had uncovered, just as it was later unwilling to deal with what Reich discovered. Armored human life is immobilized and will do whatever it takes to remain immobilized. However, there were two brief periods in the 20th century when society had an unusual, albeit temporary, willingness to deal with uncomfortable facts. This happened for a ten-year period after World War I and again after World War II.

Wilhelm Reich began his work with Freud in 1919, immediately after World War I. There were many talented physicians in the psychoanalytic movement, but Reich quickly became a leader because he was unique in his ability to recognize the full value of Freud's discoveries. Others saw the value of this or that isolated piece of Freud's work, but Reich was the only one to "get" the whole picture, and the only one to take responsibility for the future of Freud's original discoveries. He describes the situation in the 1920s as follows:

> Unlimited devotion to a cause is the best prerequisite for intellectual independence. In those years of severe struggle for Freud's theory, I saw many characters appear upon the stage and vanish again. Some of them were like comets, seeming to promise much, but performing actually nothing. Others were like moles, working themselves through difficult problems of the unconscious, without ever having the vision of Freud. Others tried to compete with Freud, without grasping the fact that Freud differed from orthodox academic science in that he was maintaining an adherence to the subject of "sexuality." Still others quickly appropriated some piece of psychoanalytic theory and made a profession of it.
>
> But it was not a matter of competing or of inventing a profession. It was a matter not only of adding details to what was already known, but it was, primarily, a matter of *giving a foundation to the libido theory through biological experimentation.* It was a matter of taking the responsibility for a piece of important knowledge;

> knowledge which had to face a world which made everything platitudinous and formalistic. (Reich 1942, page 18)

A Technical Seminar was set up by the analysts in Vienna for the purpose of understanding how psychoanalytic technique could be based on rational theory. For this to be done successfully, it was necessary to address the original unanswered questions from the 1890s, questions about how psychological functioning was based on energetic functions in sociology, biology and physics. Reich quickly became the leader of this seminar because he was the only one capable of moving forward to make the discoveries in these new realms, discoveries that were necessary to solve the practical and theoretical problems raised by Freud's early work.

It was obvious to Reich that repressed ideas could not possibly bind the amounts of energy necessary to cause psychiatric illness. He discovered that much greater quantities of energy are held in character attitudes, inhibition of breathing, and muscular tension or armor. He discovered much about the qualities of biological energy as well. In particular, that the energy is primarily a genital energy which, when functioning naturally, is organized according to the principles of orgastic potency, and that emotional illness consists of disturbances in the capacity for genital functioning. These disturbances are rooted, ultimately, in what Reich called orgastic impotence, which consists of an incapacity to love and an incapacity to work. Reich described this as follows:

> Psychic health depends upon *orgastic potency*, that is, on the capacity for surrender in the acme of sexual excitation in the natural sexual act. Its basis is the un-neurotic character attitude of capacity for love. Mental illness is a result of a disturbance in the natural capacity for love. In the case of orgastic impotence, from which a vast majority of humans are suffering, biological energy is dammed up, thus becoming the source of all kinds of irrational behavior. The cure of psychic disturbances requires in the first place the establishment of the natural capacity for love. It depends as much upon social as upon psychic conditions. (Reich 1942, pages xxii-xxiii)

Life is hard for suffering human beings and, because of the helplessness caused by armoring, it seems more tolerable to *not know* the truth about oneself, to believe instead that problems are caused by mental "conflicts," or by "chemical imbalances," or by "lack of spiritual harmony," all of which can be analyzed, medicated, or meditated away. It is painful to look at oneself in the mirror and say to oneself, "My life is unhappy because I do not have the capacity to love." Even highly motivated patients find it easy to forget that their limitations are rooted in the incapacity to love and work, and most everything in modern society functions to distract people from this one essential truth. This tendency is rooted in the fear of living and creates a strong incentive for the psychiatric profession to support the evasion of the essential. This is one reason why psychiatry excluded Reich and his work in 1934, and why modern psychiatry declined and fell so quickly thereafter. We can readily imagine how strong the forces are that cause the practice of therapy to deteriorate into platitudes and formalisms, and the temptations to let therapy go stale that Freud, Reich and Baker had to face over the years.

## A Definition of Function and of Functional Thinking

Freud and Reich (and, later, Baker) were able to avoid participating in the decline and fall of modern psychiatry to the extent that they were able to think functionally, and because they understood nature in terms of its functions. So now is a good time to explain more about what a function is and what "functional thinking" means. The term function, both as a noun and a verb, is often used in orgonomy but never satisfactorily defined. I have long wondered about this state of affairs and have spent the last ten years trying to come up with a good definition of what a "function" is. The definition I'm going to give you is a preliminary working definition that comes out of the experience of teaching orgonomists, in the College's orgonometry seminar, to use functional thinking to improve the quality of medical orgone therapy. Everything in this definition traces back to Reich's observations of the characteristics of orgone energy.

## Working Definition of Function, Functioning Principle, and Functional Thinking

A **function**, which is just another name for a **functioning principle**, always has the following characteristics (otherwise it is not a function or functioning principle):

- The essence of a function is **spontaneous motion**. Its motion is not the result of any outside force, but *originates* from the function itself.
- The spontaneous motion of a function includes **self-organization**. A function organizes itself, its organization is not externally imposed.
- A function is capable of **causing matter** (non-living matter, as well as the bodies of living organisms including humans, and human social organizations) **to move** and capable of exciting mass-containing energy.[2] This excitation of matter is a secondary result of the function's operation and is the means by which we can objectively observe the operation of the function.
- A function has the **potential to develop** into a pair of variations.
- A function **governs** the operation of itself and its variations.

**Functional thinking** is "thinking as nature functions" and includes identifying spontaneous motion (functions) and observing what nature does, while aligning the thought process with the function (spontaneous motion, principle) being observed. Functional thinking has a spontaneous motion of its own and is intolerant or indifferent to distractions and to mystical or mechanical thinking. The purpose of distractions and of mechanomystical thinking is to *immobilize* thought.

If there is one term in the English language that best captures that nature of a function (functioning principle), it is "spontaneous motion." The dictionary definition of "spontaneous" contains some distortions, but also describes some of the essential characteristics of spontaneous motion (i.e., of functions):

> adj. 1. **Happening or arising without apparent external cause; self-generated** 2. Voluntary and impulsive, **unpremeditated**;

[2] "Mass-containing energy," such as electrical, chemical, and mechanical energy, is energy that does not move spontaneously or organize itself. Its action and organization occurs as a secondary effect of the action and organization of primary mass-free (orgone) energy functions.

> *spontaneous applause* 3. Unconstrained and unstudied in manner or behavior. ...Synonyms: *spontaneous, impulsive, instinctive, involuntary, automatic.* These adjectives describe response, in actions or words, either uninfluenced by forethought or seemingly so. *Spontaneous* applies to **what comes naturally** to a person by reason of temperament or **native tendency**, and not from constraint or external stimulus. *Impulsive* refers to action prompted by a sudden urge not governed by reason and sometimes contrary to reason. *Instinctive* implies behavior **guided not by one's reason but by natural consequence** of being a member of a given species. Usually the term suggests behavior that promotes one's welfare or that traces to reflex action. *Involuntary* refers to what is not subject to the control of the will, as does *automatic.* The latter also suggests unvarying, mechanical response. (Morris 1981, page 1248. Italics in original; boldface added by this author [RAH] to emphasize the characteristics of functions)

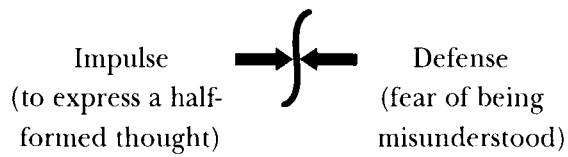
Spontaneous is also listed as a synonym of voluntary (as well as involuntary):

> *Spontaneous* refers to behavior that seems wholly unpremeditated, a **natural response and a true reflection** of one's feelings. (Ibid., page 1436)

Although it is off the subject of my talk, it will be helpful for those of you who read Dr. Konia's new book, *The Emotional Plague: The Root of Human Evil* to remember these qualities of functions when you encounter some of the orgonometric equations in the book. When you appreciate the spontaneous motion and organization of the functions that Konia describes, they become living realities with their own unique, ever-changing qualities, rather than the cold abstractions of the equations you learned about in school.

Let me give an example of a pair of functions, namely an impulse and a defense encountered in a patient in therapy. A patient suffering from paranoid schizophrenia is beginning to expand and to trust the therapist, so he has an impulse to reach out by expressing some thought that seems important to him, which he would not normally do. On the other hand, his fear of being misunderstood interferes with his ability to put his half-formed thought into words and causes him to

complicate what he says and makes it laborious for the therapist to understand him.




The opposition of the impulse and defense is shown here. This formulation is not useful, however, unless we understand each element of the pair *as a function.* Otherwise, it is merely a formula that doesn't tell us anything we don't already know, and doesn't help us treat the patient more effectively. It is necessary to understand that the impulse and the defense each move spontaneously and each follows its own laws of self-organization and functioning. Neither one is "caused" by anything else. Most importantly, the impulse must, by its very nature, be different than any other impulse that the therapist has ever had to deal with before and the defense must be different from any other defense[3], even though both have characteristics consistent with the patient's character type and characterological red thread. An appreciation of the spontaneous, self-organizing motility of these two functions would prevent most of the blunders that therapists are prone to make in a situation like this, such as reacting with annoyance, contempt, indifference, or picking apart the content or style of the patient's expression. Because he was able to think functionally, Baker, for example, would never mishandle a situation like this. Baker's legendary "kindness" and "understanding" were not *moral* virtues, but expressions of his capacity to grasp human nature in a functional way.

With this simple example in mind, I want to go back to one of Reich's most famous quotes, which is, to this day, one of the cornerstones of the training program of the American College of

[3]Here we use the term "defense" to refer to an ever-changing spontaneous and autonomously functioning inhibition that the orgonomist must deal with in the course of a therapy session. If the defense is removed by therapy, it ceases permanently to exist. The term defense is also used to refer to a stereotyped and persistent type of defense, such as not speaking up in a characteristic way. These distinctions are important for the practice of medical orgone therapy, but need not concern the general reader here.

Orgonomy. It is Reich's description of the setup of the Vienna Technical Seminar more than eighty years ago.

> ...there was wide divergence of opinion even with regard to everyday problems of analytic practice. If, for example, a certain resistance situation is presented in the Seminar, one analyst will say it calls for this measure, a second, another, and a third, still another. If the analyst then, provided with all this advice, again approaches his case, there appear innumerable other possibilities, and the confusion often is worse than before. And yet, one must assume that one definite analytic situation—given certain conditions and situations—admits of only one optimal technique, that there is one definite procedure which in this situation is better than any other. This applies not only to an individual situation, but to analytic therapy as a whole. We have to find out, therefore, what characterizes this one correct technique, and how one arrives at it.
>
> It took a long time before it became clear what is the crux of the matter: *to derive the situation technique from each respective analytic situation itself by way of an exact analysis of its details.* (Reich 1949a, pages 5-6)

To put the matter severely, there are 1,000 possible ways to handle a therapeutic situation, 999 of which are wrong, and the correct one is one the therapist has never thought of before, and must ad lib at the last moment. Such a standard of therapeutic expertise would be impossibly strict were it not for the fact that we are dealing with spontaneously moving, self-organizing functions that can be observed and responded to using the tools of functional thinking. Functional thinking is able to respond appropriately because it is itself spontaneously moving and self-organizing. This perspective shows clearly, once and for all, how impossible it is to treat effectively using a mechanical approach.

Reich's capacity to think functionally was apparent in all of his work. If you have ever heard recordings of Reich working with students, he is very patient with the limitations of his students but he always gravitates toward the living, mobile aspects of any subject under discussion, and is very much aware of when a line of thought drifts away from where the spontaneous motion lies.

## Baker's Place in History

When people who knew Dr. Baker discuss him, they often mention that he was "a great man" and what a privilege it was to know him. Those who never met him will often ask, "What was so great about him?" The answers that are given are usually imprecise and unsatisfying, something on the order of "Well, when you met him you just felt like he could see right into the bottom of your soul." Such comments are understandable if we remember that Baker, like Reich, had what is called a magnetic personality. Because of this, and because, like Reich, he was deeply responsible, Baker instantly inspired trust and confidence. It is also true that Baker had extraordinary steadiness, patience, perseverance and kindness. However, these qualities are not sufficient to make a person "a great man," nor are they sufficient to explain how Baker succeeded in keeping orgonomy alive, when no one else could have.

In the course of reviewing everything I could find that had been written about Baker, I found nothing that satisfied me as to an understanding of what constituted Dr. Baker's greatness. My own conclusion is that Dr. Baker was a genius, of the type that occurs in fewer than one in a million people. Not on the same level as Reich, who was a genius of the "once every thousand years" type, but still a genius of a very high order. Because of this, Baker was the one who best understood Reich's work, even though there were some areas in which Baker made errors. It is worth exploring just what Baker's genius consisted of, not least because his genius included certain qualities of thought and action that are invaluable in the furtherance of Reich's work—qualities that orgonomists must possess if they wish to fulfill their responsibilities to their patients, to Reich's work, and to the world's future. And, as I've already said, Baker's genius was very much related to the ways in which he maintained his capacity to think functionally.

Konia points out that Baker "brought the science of orgonomy into the future, intact, without distortion" (Konia 2008, page v). He recalls how Baker "quickly had a deep understanding of *anything.*

Once, I discussed violins with him and you could tell from what he said that he had, right away, a deep understanding of them" (Konia 2007).

One thing very characteristic of Baker as a therapist was his ability to say something in ten words or less that would change a patient's life forever. I've treated a number of his former patients and many describe such experiences; some of these patients I saw while Baker was still alive and had the benefit of his advice. He had a way of saying things in words that had a life of their own. It is easy to understand why Wilhelm Reich chose Baker to be the therapist for members of Reich's own family.

Baker's ability to describe things in this way was the result of functional thinking, of identifying the spontaneous motion of some function in the patient's structure and observing how that function moved and organized itself. Baker's ability to come up with memorable formulations had nothing to do with cleverness, and Baker had no patience for the use of cleverness to concoct convincing-sounding and memorable formulas on an artificial basis.

In seminars, students came up with all kinds of ideas, but Baker was completely unmoved until the discussion hit upon a vital point that reflected the real-life functioning of the real-life patient. He had, like Freud and Reich, an admirable ability to tolerate unsolved questions and to stick to a discovery that he knew to be in alignment with natural functions even if it had loose ends and apparent contradictions.

This is the case with his two most famous discoveries: the ocular character types and sociopolitical characterology. These discoveries have been so useful and have stood the test of time so well that there can be no doubt as to their value. On the other hand, there are elements in them that never quite added up.[4] This combination of obvious value and important unanswered questions has been a motivation for research in these fields for decades. Even Baker's

[4]We now know that the sociopolitical character types must be redefined using our understanding of how the relationships between sensation and emotion form the basis for thought and of the relationship between percipient and excitant in the social realm. A full understanding of the ocular character types requires a knowledge of the interrelationship between pulsation and spinning wave functions and between perception and excitation. (Konia 2000a and 2000b) These are all discoveries that came after Baker's death in 1985.

biggest mistakes were productive because of the functional elements in his theories. Just as important was Baker's refusal to make his students more comfortable by smoothing out the rough spots with plausible-sounding speculations or formulas.

The achievement for which Baker is best remembered is the formulation of a system of character diagnosis for medical orgone therapy. Almost everyone underestimates the magnitude of this achievement. Baker completed an extremely difficult task which Reich had left undone. Reich had described an excellent system of diagnosis for character analysis and, no doubt, would have been able to formulate diagnosis for medical orgone therapy better than Baker did. However, the demands of Reich's research in biology, physics and sociology, the ordeal of defending himself from the prosecution that eventually murdered him, and his premature death made this impossible.

Diagnosis for medical orgone therapy requires the following:

- Diagnosis must encompass the conscious and unconscious basis of character development, rooted in the Oedipal complex, producing a character which is disturbed, in highly specific ways, in its psychic functioning.
- Diagnosis must encompass the segmental muscular armoring that binds energy, in a specific pattern, for each patient.
- Diagnosis must be based on neither the psychic nor the somatic alone, but on the overall character "attitude" and the "way of functioning" that characterize the patient, which is a manifestation of libidinal functioning[5], and is simultaneously both psychic and somatic.
- Each patient must have one and only one diagnosis, the set of possible diagnoses must be small (5 or 6 diagnoses encompass 99% of patients), yet the diagnosis can never *in any case* contradict the patient's red thread.

[5]When we say that the armored character attitude is a "manifestation of libidinal functioning" we mean that it is not merely a psychic or somatic habit, nor is it an inert residue of past conflicts. The character attitude contain the impulse and defense both of which are active forms of sexual (libidinal) gratification. A full description of this is beyond the scope of this paper, but Baker stressed that this (perverse) libidinal gratification can generally be categorized as some form of revenge. Libidinal functioning and emotional organization in the genital character take a different form.

There is no way to mechanically create a set of "criteria" or a theory that satisfies these requirements. One cannot, for example, say that "character is defined by the segment where the primary blocking occurs, for example an ocular character is one whose primary blocking is in the ocular segment." Such a "method" breaks down into absurdity when applied to the anal character or the phallic character, since there *is no such thing* as an anal segment or a phallic segment.

Learning how to make and to safely use an orgonomic biopsychiatric diagnosis requires decades of work on the part of the physician. The set of diagnoses described by Baker are functional enough to contain several lifetimes worth of knowledge.

### Baker Contrasted with Reich and Freud

Baker had a fundamentally different task than did Reich. Reich was required to complete the foundations for the complete re-establishment of science on a functional basis, foundations which Freud had only begun. Baker, on the other hand, took responsibility for a science whose foundations were mostly sketched out.

Just as Freud focused on a single task, the elaboration of the unconscious mind, Baker focused primarily on the task of establishing medical orgone therapy as a scientific discipline so that it could be handed down to future generations. Unlike Freud, Baker was able to remain true to the great scientific work until the end of his life.

### Illustrations of Functional Thinking from Freud, Reich and Baker, Showing the Unique Features of Each

Functional thinking, because it springs from the basic operations of nature, expresses both freedom (variability) and lawfulness to a high degree. A comparison of the functional thinking of specific individuals, such as Reich, Freud and Baker, will thus show unifying similarities (from the depth at which the thinking originates) as well as infinite variation. A set of quotations from Reich, Freud and Baker demonstrates this clearly. The passages chosen all deal with the same underlying problem: the difficulties caused by mysticism, coupled with

armored man's contempt for basic life functions as being inferior to ("below") his armored thinking, which, whether it be mechanical or mystical, is held up as something superior. Every effort of the human race to use armored thinking to escape from the trap of armoring inevitably fails.

The passage from Freud was written originally in German, in 1914, at the time of Jung's defection from psychoanalysis and his attempt to abandon the sexual basis of neurosis and to replace it with a new system of mystical thinking, and deals specifically with that event. Freud was already, in 1914, struggling against the incipient decline and fall of modern psychiatry. Freud's description of the deterioration in medical and scientific practice applies perfectly to much of what occurs in the 21st century. The passage from Reich, written by him in English in 1949, deals with humanity's helplessness on the deepest, biophysical and also cosmic, levels. The passage from Baker attempts to describe the problem in basic common sense terms to the ordinary reader. Reich and Baker have access to a solution to the problem and therefore have an advantage over Freud.

All three passages capture the contrast between the spontaneous mobility of basic life functions as opposed to armored immobility. All three passages describe the futility of armored man's attempts to solve human problems by moving his focus away from the genital and up into the complications and distortions of the armored brain. By doing so, man tries to reach life by moving upward and away from life. Both Freud and Baker express themselves briefly, with a sense of longing and irony, but Baker is much more emotional and direct; Baker did not share Freud's love of words. Reich's thought presents constant, irresistible movement, powerfully encompassing and integrating the deep and the superficial. I hope that the reader will feel the presence of these three men and sense the uniqueness of each.

A patient once asked Baker why he had a picture of Reich in his office, and Baker replied, "We do his work." To the extent that we do the work of Reich and Freud and Baker, they live on with us and will live forever.

## Freud

[In Jung] a new religio-ethical system has been created...bound to re-interpret, distort or jettison the factual findings of analysis. The truth is that these people have picked out a few cultural overtones from the symphony of life and have once more failed to hear the mighty and primordial melody of the instincts....

The form taken by the Neo-Zurich therapy under these influences can be conveyed in the words of a patient who experienced it himself: "...not a trace of attention was given to ... the transference... The moral instruction was very fine and I followed it faithfully, but I did not advance a step. ... Instead of freeing me by analysis, every day brought fresh tremendous demands on me, which had to be fulfilled if the neurosis was to be conquered—...inward concentration by means of introversion, religious meditation, resuming life with my wife in loving devotion, etc. It was almost beyond one's strength; it was aiming at a radical transformation of one's whole inner nature. I left the [Jungian] analysis as a poor sinner...in utter discouragement. Any clergyman would have advised what he recommended, but where was I to find the strength."...

[Jung's] view that the sexual representation of 'higher' thoughts in dreams and neurosis is nothing but an archaic mode of expression is of course irreconcilable with the fact that in neurosis these sexual complexes prove to be the bearers of quantities of libido which have been withdrawn from utilization in real life. If it were merely a question of a sexual 'jargon,' the economy of the libido could not have been altered in any way by [properly conducted therapy]...This can never be achieved, however, by directing the patient away from [his libidinal impulses and blocks] and urging him to sublimate...The first piece of reality which the patient must deal with is his illness. Efforts to spare him that task point to the physician's incapacity to help him to overcome his resistances, or else to the physician's dread of the results of the work...

Men are strong so long as they represent a strong idea; they become powerless when they oppose it. Psycho-analysis will survive [the defection of Jung and his followers] and gain new adherents in place of these. In conclusion, I can only express a wish that

fortune may grant an agreeable upward journey to all those who have found their stay in the underworld of psycho-analysis too uncomfortable for their taste. The rest of us, I hope, will be permitted without hindrance to carry through to their conclusion our labors in the depths. (Freud 1914, pages 62-66)

## Reich

...there are great truths in ... religious teachings, even if they have been distorted by the armored human animal.

The "Devil" meant the absolute "Evil," personified in the well-known creation of Hell in Christian thinking ... Man has felt the "Evil" as tempting. Why, we must ask, did he not think of *God* as "tempting"? If the Devil represents distorted nature and God original, true nature, why does man feel so much more drawn to the Devil than to God? Why the great, eternally frustrating effort to redeem man from "sin" (i.e., from the temptation of the Devil), if the beauty, harmony, life-enhancing power of God is so obvious and so convincingly postulated?

The answer is again the same as before: The Devil is tempting and so easy to follow, God is so boring and distant because the Devil represents the secondary drives which are easily accessible and because God represents the core of life which is inaccessible to the majority because of the armoring. Therefore, God is the great unreachable goal and the Devil is omnipresent, engulfing reality. In order to make God a living reality, the armoring must be destroyed and the identity of God and primal life, of Devil and distorted life, firmly and practically established. Unfortunately, God and the living functioning which is nowhere so clearly expressed as in the orgastic discharge, are identical. Once this approach to God was blocked, only the Devil could reign. And how he reigned! How tragic, how colossal this error of man, this endless search for the inaccessible experience of God, with the fatefully irrevocable landing in the Devil's realm!

...Orgonomy succeeded in going beyond the realm of the Devil, not because of a special inspiration or supernatural sense but solely because of the faithful and conscientious study of the function of the orgasm; this function has its roots in cosmic orgonomic laws and, therefore, not only governs the whole of the

living realm far beyond man but in addition represents exactly what the truly religious man called his "unreachable God." Orgonomy succeeded in going beyond the "Devil" because it learned to master the terrifying obstacles which are piled up in the way of every single individual who transcends the realm of the Devil, i.e., the realm of the unconscious secondary drives. Once one has found rock-bottom under one's feet in the natural orgonomic function which is represented in the biosystem as the orgastic convulsion; once one has mastered the sharp distinction between the deep biophysical functioning and the distortion of life in the realm of the armoring, the Devil begins to lose most of his horrible aspects. We then look at the Devil "from below" as well as from beyond and not "from above," e.g., from the standpoint of a national or ecclesiastical interest... (Reich 1949b, pages 110 and 109)

### Baker

Functional ideas have been developed in the past, only to be stifled by the application of an absolute, an immobility. Normal urges were killed and themselves became killers because of this great terror, orgastic anxiety. Neurotic man cannot stand natural movement and fights bitterly against it wherever he finds it; his consistent source of error is in this fight against nature which results from armoring and orgasm anxiety. What terror to make contact with the cosmos and feel the pulsating eternity around him! So man has never accepted a continuum of moving, luminating energy in which all atoms, planets, suns, and galaxies are included in the pulsation and react vibrantly to each other's charge. He quiets himself and so egotistically quiets the universe.

Yet stillness is not satisfying and never can be, for deep within man is a stirring always calling for expression. He longs for the freedom he once felt ("heaven lies about us in our infancy") and promises himself he will find it again when he dies. God will give it back to him when the spirit is free of the armored body. Even here on earth he strives for that freedom, but unfortunately he does not know what he seeks. (Baker 1967, page xxiii)

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# A Case of Recurrent Psychosis

*Alberto Foglia, M.D.*

Elena is a 40-year-old gym teacher, married and the mother of two girls. She came to me in 2003 because she wanted to be treated with medical orgone therapy for recurrent psychotic attacks. (Psychosis refers to episodes of severe mental disorder with derangement of personality and loss of contact with reality.) She had suffered these attacks every September since the age of 19. Except for two occasions when she had to be hospitalized for a few weeks, she was treated every year with psychoactive drugs, which gave her a sense of deadness and marked drowsiness. Regularly, one to two months after the attacks, Elena stopped the medication.

The attacks presented in the form of paranoid ideas and delusions about people she knew, relatives or friends, starting one to two weeks before the actual attack. She thought these people were hurting her, in her words: "taking away my energy" or "putting me down in a mean way." This was experienced with escalating terror and hatred, and ultimately expressed in explosions of rage and disconnected outbursts of shouting, cursing and physical violence against physical objects. At the same time, she also experienced visual hallucinations, usually seeing a skull, which she connected with her dead mother. The actual crisis lasted one day and was expressed in a sort of detachment, "a trance-like state," very similar to the "possessed paroxysms of certain movies," as she described it. The day after the crisis, Elena woke up from this "trance-like state" with a sense of lightness and relief but with the fear of being insane. The psychiatrists in charge of her diagnosed an "Acute psychotic episode in a Borderline Personality Disorder." Luckily, the drugs they gave her were effective in controlling the attacks; in fact, without the medication Elena would have been hospitalized much more frequently and for longer periods. In the last

two years, however, the attacks were becoming more intense and more frequent than in the past, appearing at different times of the year, not only in September. The psychiatrists advised her to take medication for the rest of her life to avoid relapses.

An orphan, Elena vaguely remembers that she saw her mother die of a heart attack when she was eight years old. She was adopted by a professional couple with two children and grew up in a caring environment. An athletic girl, she was a good student and graduated from high school before becoming a gym teacher. For 15 years she taught in a private institution with success and satisfaction. Her two daughters, Livia and Sara, were born in 2001 and 2005, and she is a happy mother.

During our first telephone contact on October 3, 2003, Elena told me that one of her attacks was imminent. She didn't know what to do and asked me for advice. She agreed to take a major (anti-psychotic) tranquilizer to stop her crisis and, given how far away she lived, to come to see me as soon as she could in the following days. At our first encounter, I found a tall, somewhat masculine-looking woman with a rigid, immobile posture. She spoke rarely, and was shy and reserved. Her eyes were mobile with a guarded quality, her mouth was contracted, her voice whispery, and her chest was held rigidly with minimal respiratory excursion. I couldn't evaluate armoring of her pelvis because she was sitting at the desk in front of me. I asked her to roll her eyes, which she did with a look of suspiciousness. I sensed some insecurity and worry, and I told her this. She explained to me that she was feeling fragile, was afraid of exploding, and that this was exactly the kind of attack she had for years. She also explained to me that her crisis had begun some two weeks before in the form of anxiety, fear and emotional withdrawal, followed by rage and unjustified hatred, this time toward her husband. Luckily, the early administration of medication prevented the real explosion of psychosis. I reassured her, let her express her anxiety, and explained to her how orgone therapy works. She already knew something from reading about Reich and asked me many questions about the couch,

the release of emotions, the indications and the contraindications of this therapy. Her questions were logical and appropriate, and my responses reassured her. At the second session, Elena presented herself in a more open way; she was less timid and fearful. My general impression was of more solidity and control, and together we discussed her beginning to work on the couch in the next session.

At the third session, Elena lay down on the couch and seemed to want to take what belonged to her: She yelled, hit, insulted and menaced anyone she thought was commanding her, including me. She felt much better after that and explained to me that this violence was closely related to her old crises as well as to her well-being thereafter. This time, however, she was not afraid of being crazy. She asked me for permission to stop the medication, which I gave her, sensing that she was able to discharge an enormous amount of dammed-up energy and was able to do so while still keeping contact with reality.

At the fourth session, Elena still looked guarded and suspicious but was able to express her feelings. She was able to maintain good contact with me: if I told her to stop, she followed me; if I asked her to look at me she did, and her eyes expressed correctly the feeling of the moment. All-in-all she was there, present and oriented. In addition, her pelvis looked firm and rigid, which is always a good sign in patients with a history of psychotic episodes. In fact, the cessation of the medication had brought only a slight increase of intensity in her emotional discharge on the couch. From this time on, Elena never had to take any more psychoactive drugs.

Progressively, Elena's therapy sessions adopted a pattern, a recurrent theme that mirrored her way of being: guarded at first, aggressive and rigid later. This was nothing other than her character defense, which Reich called *armor* and described as the characteristic way an individual defends him or herself from unbearable feelings. On a deeper level, character armor is a specific way of blocking the free flow of energy in the body. Elena used suspicion and rebelliousness. My intervention progressively concentrated on pointing out to her these character traits, to which she reacted by intensifying her

rebelliousness, vehemently yelling "No, no, I don't want to, I don't want to!" These outbursts were followed by states of affect block and rigidity—she barely breathed and was unable to emit a sound. She felt blocked and impotent. Many sessions were spent with this immobility and unpleasant feeling of impotence, which were slowly replaced by sudden jerks of her head and neck followed by whimpering sounds. She felt she couldn't move her legs and her arms; she felt she was paralyzed. She began to see herself as an eight-year-old child trying to pull her mother out of the bathtub, too weak to manage the weight of an adult, impotent and desperate. She yelled "No, no, I don't want to see, I don't want to, I don't want to!"

"Negativity dissolves by expressing it," Reich once wrote. The more Elena expressed her refusal to see, the more she saw and looked: she saw her mother dead, herself trying to save her; she was alone, nobody was around. She desperately cried for help and was even angry at her mother, demanding, "Why do you smoke so much?" At the 15th session, Elena for the first time expressed disgust and vomited. She writhed and rebelled, yelling, "No, no, I don't want to, I don't want to see, I don't want to look!" She was disgusted by her mother's blood; her mother was soaking in water and blood, there was blood everywhere. "Disgusting!" she yelled. Elena reported to me that she had nightmares for months after the death of her mother, often waking up in the middle of the night yelling and screaming, "I don't want, I don't want you to die!" During the session Elena cried, calling for her mother, longing to see her, and not wanting people to tear her away.

In the summer of 2004 Elena became pregnant for the second time and decided to interrupt her therapy. Little Sara was born in March 2005, and Elena called me in April, wanting to resume therapy because she was having anxiety and negative feelings, but also "strange ideas" toward her husband. On the couch again, she unburdened herself of an enormous amount of violence as she had done in the first session one year before. She felt that somebody wanted to hurt her, she was very little and had the clear impression that a bad man was hitting her forcefully. She expressed rage, fear and disgust and

after that, despite the dramatic nature of her recollections, she felt immensely relieved.

We resumed our sessions on a monthly basis again. The emotional discharge of the first session after her delivery had completely dissolved the postpartum anxiety she had been experiencing. Elena was starting again from where she had left off: disgust at the sight of her mother's blood, alternating with violent whimpers and screams, "I don't want to, I don't want to see, I don't want to look!" This always brought great relief and the clear feeling that we were working exactly on her specific life problem—her recurrent, past psychotic attacks. Similar attacks presented regularly during sessions. This time, however, they began to have a sense. Elena recognized the feelings and sensations that had been hidden within them and, with that, their meaning and their very origin in a dramatic, traumatic past event.

However, there was still a certain holding back, a resistance to an even more powerful discharge of feelings and energy. Elena was somehow detached, slightly "off," contactless, disconnected from me, herself and also her past. Moreover, she continued to keep her eyes closed. I persistently pointed this out to her, and she exploded in her typical rebellious rage, "I don't want to, I don't want to, I don't want to see!" Who could blame her or not understand? She saw, she saw better and better, and it was an awful torment. She saw her mother rigid, bluish, naked, too heavy for her to lift, wet with water and blood, there was blood everywhere. Elena screamed, she wanted to rescue her, she called her, she begged her not to die, she called for help, but nobody was there. Mother was not dying from a heart attack, she had killed herself. The blood came from her wrists that she had cut while in the hot bath.

Elena cried for a long time on the couch. She finally saw clearly and it was awful. She recalled and told me that people finally rushed in, tore her off her mother and took her to another room, where she stayed silent, completely paralyzed. She recalled with pain and sorrow the nights spent with her new adoptive family, crying, alone and desperate. In all these years she had completely repressed these memories.

This was Elena's 37th therapy session, and since then she has gained bit by bit more fragments of the puzzle of her tragic past. During every session, she discharges rage, pain and despair, always accompanied by her typical stubborn whimper, "I don't want to, I don't want to see." I assist and share at these sessions, sympathetic and moved.

Today, after 50 sessions, Elena is a much more open and happy person than when she first came to see me in 2003. She hasn't had any further psychotic attacks, nor has she taken any psychoactive drugs since her third session. During therapy she hasn't re-experienced additional feelings or images related to earlier traumatic episodes prior to the death of her mother, such as the clear feeling of being forcefully hit by a man. It is as if her sessions have become more ordered without mixing feelings and memories of different episodes from her past. She continues to express stubbornness and rebelliousness in therapy, but in her outside life she has become much less guarded and shy. The reason for the timing of her attacks in September has not yet been solved, but I am confident that a rational explanation will be found.

Modern psychiatry is not able to cope with such disorders. It makes faulty diagnoses that have no emotional or physiological meaning, its ignorance and contactlessness blinding it to the very object of its investigation. Its treatments are limited to the administration of psychoactive drugs. Luckily, these are able to control and contain the worst signs and symptoms of psychosis in millions of people. Without psychoactive drugs, psychiatry would be exactly where it was in the early 1950s, when chlorpromazine, the first neuroleptic drug, was discovered. Within a few years, two-thirds of all psychiatric hospitals in the United States and worldwide were definitively closed down. Since then, new psychoactive drugs have been developed, having fewer adverse side effects and less sedation. But this is all. From the standpoint of psychotherapy, despite the plethora of psychoanalytic, behavioral, cognitive and body-centered therapies, substantial improvements haven't been made. In the 1990s, "Eye

Movement Desensitization," was developed, superficially similar to orgonomic biophysical work on the ocular segment. It appears to be effective in the reawakening of painful memories of old traumas. Later on this technique was highly standardized and mechanically regulated and today has lost much of its attractiveness.

The medical orgone therapy of Wilhelm Reich, on the other hand, aims at restoring the patient's natural energy metabolism through the process of dissolving somatic blocks (muscular armor) and loosening characterological defenses (character armor), thus allowing the unitary, integrated, free flow of emotions and energy. In Elena, the progressive loosening of her somatic blocks, mainly in the ocular and oral segments, as well as the dissolution of her major character traits of suspiciousness and rebelliousness, enabled the liberation of enormous quantities of held-back, dammed-up emotions, which until then could only be discharged through painful and disabling psychotic attacks. Through medical orgone therapy, Elena's recurrent attacks of derangement have been transformed into rational emotional discharge, improved contact with herself, and a deeper comprehension of the cause and meaning of her past psychosis.

# Can Migraine Headache be Treated Without Medication?

*Peter A. Crist, M.D.*

## Introduction

The chief complaint or problem in most of the cases presented so far at the 2007 ACO Annual Conference have been emotional symptoms. However, many physical problems for which people seek traditional medical treatment can also be helped by medical orgone therapy. This is because some of these physical problems have their roots directly in emotional disturbances. We must often repeat the obvious: Orgonomic psychiatry is a biological psychiatry that is rooted physically because we understand that emotions are physically in the body.

The essential point is that when an individual cannot tolerate certain emotions he or she tenses up, in effect armoring, against them. This chronic tension has physical effects, as the emotions are held in the body. What is needed to relieve this situation is to help the individual to stand these emotions so that they can be expressed in a way that can be tolerated, and then the individual will no longer need to armor against them. At the same time the therapist must also help change the typical ways in which emotions are handled so that there is no longer a need to block them.

Modern psychiatry has abdicated its proper place in the understanding and treatment of emotions and emotional disorders. As a result, it has also failed in the realm of emotionally connected physical disorders, the so-called "psychosomatic illnesses."

As orgonomists, we understand that the natural, primary domain of psychiatry is emotions, not biochemistry or psychopharmacology. The increasing emphasis on a mechanistic treatment of specific symptoms with specific pharmacological agents entirely overlooks essential emotional factors. Often the only connection that today's psychiatry and medicine make between psyche and soma is to acknowledge the

fact that drugs, which may affect psychiatric symptoms, also often affect physical symptoms such as pain and inflammation.

The physical disorders and their various symptoms that are amenable to medical orgone therapy are innumerable and could easily take up several conferences. Today, I want only to introduce this subject by presenting a single case and discussing the orgonomic understanding and treatment of headaches.

For those interested in a more in-depth description and analysis of the functional basis of headaches, and their various types, I refer you to the "headache issue" of the *Journal of Orgonomy* which contains a republished article by Dr. Robert Dew (2005, pages 34-47) and an accompanying article about migraine headaches by Dr. Ian Livingstone (pages 48-56), as well as articles by Dr. Charles Konia (pages 57-66) and a republished article by Dr. Arthur Nelson (pages 67-76).

Headaches are one of the most common physical disorders. They result in significant economic loss with decreased productivity, absence from work and lost wages, and certainly in loss of enjoyment in life. They also account for billions of dollars in sales of over-the-counter pain-killers.

While modern psychiatry and medicine have virtually lost touch with the emotional component of headaches, the general public still widely recognizes that they are associated with "stress." In fact, for years, even a common over-the-counter medication was advertised by portraying a stressful situation and then calling it "Excedrin Headache Number X." The clear message was that emotional factors, under the generic term "stress," caused the headache.

More recently this has changed. The increasingly mechanistic approach of modern medicine is reflected in how the advertising industry currently promotes over-the-counter headache remedies. Instead of those "Excedrin Headache" ads, we now see ads for Excedrin divided into specific symptom categories so that it is sold as: Extra Strength Excedrin, Excedrin Tension Headache, Excedrin Migraine, or Excedrin PM. Specific consumers are "targeted" to generate more sales.

Let us now look at what can be done therapeutically without relying on such medication.

## Case

Katie was 16 years old when a neurologist who was treating her for headaches referred her to me. He felt there was an underlying problem with how she handled anxiety. At the time of referral she said she had had almost constant headaches for eight months, which had been diagnosed as "transform migraines:" the typical episodic acute migraine had "transformed" into a constant headache. By the time I saw her the migraine-type headaches were superimposed on "muscle tension" headaches.

When I first saw Katie she also had emotional complaints. A few days earlier she had an anxiety/panic attack severe enough that her parents took her to the local hospital emergency room to make sure that she didn't have a heart problem. She also described feeling considerable stress at school since starting high school the year before.

Since entering adolescence she had, as is so common, many worries and at times she described feeling "down." Her big concern was how she looked; she was afraid it was never good enough. She was also afraid to get into confrontations, especially with anyone in authority.

At her initial evaluation, although she presented as an attractive, slightly overweight young woman who was quite lively, serious and earnest, she was also very anxious, and had ruminative, worried thinking. Her mood was mildly depressed. There was no evidence of formal thought disorder or psychosis and history revealed no suicidality, drug or alcohol use.

In the very first session, as I encouraged her to talk about herself and what was going on in her life, she started to cry. She told me how miserable she was with feeling so uncomfortable at school and how unhappy she was with having headaches. Expressing these feelings gave her considerable relief from her anxiety. In the second session, when she started to cry, frustration also came to the surface and I suggested that she lay down on the couch to see if this could help her

get her emotions out. By hitting the couch and shouting out, she was able to relieve some of the frustration.

The next week she came in and said that she had been without headaches for two days. This was remarkable! She had suffered for an eight-month period with constant headaches of one form or another, and now she had two days without a single one—this without direct biophysical work on her armor. At the same time, however, she felt *more* anxious than she had felt before; not an attack of anxiety, but nearly constant anxiety throughout the day that was almost unbearable.

Both Katie and her mother were concerned about the level of her anxiety. I discussed with them whether Katie should be on medication to bring the level of the anxiety down. With Katie, I encouraged her to just stand feeling the anxiety, see how it was, and to call me if it *really* became intolerable. With her mother, I told her Katie needed to increase her capacity to function in the face of anxiety and encouraged her to stand seeing her daughter in distress and not immediately try to relieve her of it. How different this approach is: The traditional psychiatrist would have prescribed medication to relieve the symptoms.

I told Katie that I thought she was tougher than she believed herself to be and that she could handle it. Here I was addressing her characteristic tendency to run away rather than face difficulty. With the mother, I also told her that I thought Katie was tougher than she looked. Here I was addressing the mother's tendency to baby her daughter, which reinforced Katie's tendency to run from her feelings into childish behavior with her mother. I persuaded both of them to see how things went.

Fortunately, within a couple of days, Katie's anxiety subsided. In the next weekly session she was able to let out a lot more frustration by hitting, kicking and shouting. By that time virtually all of her depressive feelings had resolved. By the fourth session the headaches had diminished even further. She started expressing more of the fears that she had and more of the frustrations, which produced more significant relief. By the end of the fifth session she said she had been

without a headache for a full week, no longer felt depressed and felt good about going back to school.

I told her that there were other issues to work on, especially her difficulty confronting authority figures. She said she wanted to do that but I think her mother wasn't ready for her daughter to confront authority, namely her. The mother responded, "She is doing better. We will call you if she has any more trouble." Katie's mother called me eight months later only because there was a problem with a medical insurance form she needed my help in resolving. She said her daughter was doing very well, no longer had migraine headaches, and only had occasional muscle tension headaches that were easily relieved. She said that once the headaches were gone both she and Katie realized how much Katie had withdrawn from life during the months that she had them. Now she was much happier, more social and able to face people at school, and was less concerned about what people thought of her. Katie just seemed to be "back to her old self" and enjoying everything again. It's been several years now and I haven't heard anything from them since.

## Discussion

This was one of the most satisfying cases in all my years of practice. It was remarkable how in *five sessions* a condition was resolved that appeared certain to become chronic—and all without medication of any kind or extensive neurological testing (CT scan, MRI). My patient had complete resolution of eight months of constant headache *and* of her symptoms of disabling anxiety. She did have some continuing anxiety but it did not interfere with her functioning. This case demonstrates how an orgonomic approach can yield dramatic benefits when patients are treated early in the course of their difficulties. This can spare them a dependence on drugs to manage physical and emotional symptoms.

Fortunately, some cases proceed as simply as this one, but of course others are more complicated and don't respond as quickly. Why did therapy help Katie's headaches so quickly? Undoubtedly the

most important factor was that the problems that led to the headaches were addressed *very early* in their course. The headaches had not really become set as a part of her typical way of handling her life's stresses. And also, because they were still very disturbing to her, they had not become part of her characteristic way of responding to stress.

In addition, the point at which someone finds emotions so intolerable that they shut down on them and develop headaches is undoubtedly quite significant. Katie did not develop headaches until age sixteen, which is much later than with some children I have seen where the condition has become chronic. Another factor was that Katie was very excitable and lively. Just sitting down and talking with me immediately brought her emotions to the surface, and more importantly, she was able to express them. She was also very motivated. Her symptoms were bothering her greatly and she had the drive to try to change her situation. Fortunately, neither she nor her mother wanted to use medication, and both wanted to find out what else could be done.

In my experience treating people with headaches, especially young people, there is a tendency for them, for whatever reason, to have a lot of energy in the head: They are thinkers. If the energy doesn't have an outlet, it gets stuck. With Katie, she worried. One of the things I encouraged her to do to clear her head was follow through on her interest in trying out for the swim team, despite her anxieties about what she looked like in a bathing suit. I told her, "Whatever you look like, do the swimming." When I spoke with her mother eight months after Katie stopped therapy, she told me Katie had in fact joined the swim team. Anything that draws the energy down out of the head will definitely help.

## Summary

As a result of its drug-oriented, mechanistic approach, psychiatry has abdicated its vital role in addressing the importance of emotions in such physical conditions—a glaring example of the failure of modern psychiatry.

Katie's therapy shows how quickly severe problems such as migraine can resolve with medical orgone therapy. How many more people, especially young people, could be saved from long-term reliance on medications that have detrimental physical effects and adversely impact the individual's emotional health? This is especially important to avoid during the vital period of emotional development in childhood. Unfortunately, today's mechanistic approach focuses solely on symptoms and uses medications to block anxiety and other disturbing emotions. It seems we are living in a world that is increasingly intolerant of natural emotions. The medical profession *and* the general public have a tendency to medicate any emotion as if it is a symptom.

If only more neurologists and primary care physicians, as well as the general public, saw the larger picture of the role emotions play in physical illness and physical symptoms, and knew that there are ways to treat them other than with medication, especially when addressed early. We at the American College of Orgonomy are doing what we can to see that this happens.

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# Reich's Mind-Body Approach: First Aid in a General Medical Hospital

*Howard J. Chavis, M.D.*

There are several reasons for my selecting this topic for presentation. The first is that the cases I will describe are, I believe, fascinating from anyone's perspective. It is also an opportunity to see firsthand how a seemingly esoteric therapy, at least in its name, medical orgone therapy, can be applied to clinical situations that occur on the medical services of a busy city hospital. It is also an opportunity to see by concrete example what was and remains lost to psychiatry and medicine when psychoanalysts rejected most of Reich's discoveries in the 1930s and thereafter. The most significant destructive consequence was the lost opportunity to place depth psychology on a comprehensive, natural scientific, biological foundation, one that is neither mechanistic nor mystical. It is a foundation that erases the mind-body split and recognizes this artificial duality as a clinical phenomenon found in people who are cut off from contact with their own internal sensations and emotions.

Integral to my discussion is the recognition and understanding of muscular armor, which is readily observable in most everyone. In everyday language, people are described as uptight, as stiff-necked, tight-assed, having a stiff upper lip, and so on.

In its acute form, it is a natural, somatic, physical defensive reaction, even sometimes seen in very young infants—we all tense up our muscles in stressful situations and hold our breath, but we then relax and "let go" when the situation passes. When muscular armoring becomes chronic, however, it interferes with natural emotional and physical motility. Reich showed that muscular armor laid down in the various erogenous zones during childhood psychosexual development forms the somatic basis of the various neurotic character types. For example, premature toilet training, before the infant is

developmentally ready, before natural neuromuscular control of the anal sphincter has developed, can only succeed with contraction of the muscles of the pelvic floor, the buttocks and thighs, aided by retraction of the pelvis and inhibition of respiration. This provides the somatic basis of the obsessive-compulsive character in some and obsessive-compulsive symptoms in others.

Reich came to this understanding when he observed that individuals with rigid character attitudes, what he called character armor, also had muscular rigidity and hypertrophy and that, in general, the greater the character rigidity the greater the muscular rigidity. When the patient's character defenses yielded to character analysis, the approach Reich developed to dissolve character armor, the chronic muscular rigidity also softened. He saw with one particular patient with a stiff-necked attitude toward the world that when the defense finally let go, the patient experienced dramatic, rapidly shifting physical changes in the face and neck. Reich concluded then that the chronic character attitude and the patient's chronic muscular rigidity were functionally identical—both contained and held back vegetative energies, sensations and emotions. This is how Reich came to discover muscular armor and its defensive function, which led him to include direct work on patients' tense muscles in their therapy.

Reich described the segmental anatomical distribution of human skeletal musculature and its arrangement perpendicular to the long axis of the body—much like the annular segments of a snake or worm. There are seven segments: ocular, oral, cervical, thoracic, diaphragmatic, abdominal, and pelvic. Clinical experience reveals that muscular armoring is laid down in these segments in a functional distribution; that is, according to where it is needed, as I described in the case of premature toilet training.

Muscular armor is readily identified. Some common examples include: How emotionally expressive is the face? How expressive are the eyes? Can they show the full range of human emotion? Are they dull? Is the chest held in an inspiratory position? Is the voice caught in the throat? Does it sound forced? And so on.

This now brings us to the topic of orgonomic first aid. It is a treatment whose goal is to relieve distressing or disturbing symptoms and suffering by reversing bioemotional, biophysical contraction. This state of contraction can be visualized by thinking of a single-celled ameba being pricked with a needle—it literally contracts. The human organism, with its billions of cells, also contracts in response to trauma. With its more complex organization, contraction manifests through acute muscular tension (armoring), inhibition of respiration, and increased discharge of the sympathetic division of the autonomic nervous system. In reversing this contraction, orgonomic first aid seeks to restore a previous level of functioning. It does not attempt character restructuring, although in some cases aspects of the patient's character may be addressed. It is utilized only after a careful evaluation and assessment of the patient's history, clinical condition, and biophysical status, the patient's armor and emotional state.

In the following cases we will see how "simple" observations of somatic armoring and recognition of the armor's significance within the characterological context of the individual allowed for effective treatment with prompt relief of acute symptoms and restoration of a previous level of functioning, by definition orgonomic first aid.

## The Case of Maria

Maria is a 22-year-old, Filipino nurse admitted to the neurology service for evaluation of episodes of "dizziness' and "falling down." The episodes of dizziness were transient, lasting only for a few minutes, were not accompanied by loss of consciousness or involuntary motor activity, and usually occurred when she was alone, sometimes in potentially dangerous circumstances, such as while driving. Several times, and recently with increasing frequency, she fell to the ground while dizzy but could not explain what had happened other than to say she felt "weak." These symptoms started a week or two after the accidental death of an older sister several months prior to admission. Although no specific connection with her sister's death could be ascertained, either by herself or the neurologist, the time of onset of

her symptoms certainly seemed more than coincidental. Neurological evaluation, furthermore, including CT scan and electroencephalogram (routine and sleep-deprived), was within normal limits. A psychiatric consultation was requested.

On initial evaluation, the patient was in bed—her activities were restricted because of the danger of falling. She was dressed in a "nightie," was shapely though slight of build, looked younger than her chronological age, and acted in a coquettish manner despite appearing mildly depressed. When expressing anxiety about the possibility of having a brain tumor, dulling of her eyes and restriction of her breathing were apparent. Responding to open-ended questions, she recounted her personal history as the youngest daughter in a large family living in the Philippines, as a student attending Catholic schools staffed by nuns, and of her secret internal rebellion with, and outward conformity to, the rigidities of family and social expectations. Her family's move to the United States, in her early teens, was a welcome change for her.

Several times I pointed out her tendency to hold her breath and explained how this helped suppress feeling. Over subsequent sessions, I asked her to breathe more fully. She readily went "off" in her eyes, which I also pointed out to her. Breathing, in contact, gradually elicited sobbing and crying. She described how, hearing an awful thud, she fearfully went into the bathroom to find her sister, blood-spattered, unconscious in the bathtub, bleeding profusely from the wound where she had struck her head, and how the family stood vigil at the hospital until her sister was pronounced dead several days later. Continued breathing, with good contact, elicited increasing anger and rage and the rest of the story.

The dead sister had been involved with drugs and alcohol for years, and for years, Maria had been assigned by their parents the task of keeping her sister out of trouble. Outwardly, she accepted this assignment—she was, after all, a "good" daughter and sister. Inwardly, she felt growing resentment over the responsibility, especially since

her sister never accepted limit-setting or advice. Finally, Maria asserted her independence and decided, several days prior to the tragedy, to no longer watch over her older sister. The night of her accident, the sister came home staggering drunk and announced her intention to take a shower. Maria, aware of the danger, nonetheless stuck by her decision—other family members were at home—and she allowed her sister to proceed with tragic consequences.

Maria's anger, initially directed at her sister for the present tragedy and past self-destructive behaviors, soon turned to bitter rage at her parents for assigning to her permanent responsibility for her sister's welfare. Over several subsequent sessions, she angrily recounted other incidents involving assigned responsibility, including the suicide by hanging of a depressed male friend several years before. He, too, had refused her advice to seek professional help. Maria was seen for five in-hospital sessions. As the treatment unfolded, her episodes of dizziness and falling disappeared, and, at last follow-up a year after treatment, she remained symptom-free and had plans to marry.

Characterologically, Maria is a simple hysteric. In the hysteric, as in other character types, if there are pre-genital blocks, armor, symptoms referable to the armored segments are seen—with an anal block, obsessive-compulsive symptoms; with an oral block, depression, overeating, talkativeness etc. Maria's defenses, as a simple hysteric, were simple—she could only resort to holding her breath and going off in her eyes. When I addressed these physical, somatic defenses she came into contact with and re-experienced and expressed the held-back intense and intolerable emotions with the associated historical material. Dizziness, as a symptom, is often seen with intense emotion in the presence of inadequate somatic and characterological armor; that is, when the armor is not strong enough to bind the intensity of emotion. With effective emotional discharge, Maria's dizziness was relieved.

The following two cases describe orgonomic first aid in the treatment of neurological disaster. Again, "simple" observations of the patients' armor and an understanding of what to do with these observations were essential to successful treatment.

## The Cases of Valerie and Myra

Valerie is a 39-year-old, unmarried, photographer's assistant, admitted to the psychiatric ward because of confusion and "catatonic" immobility. She was soon transferred to neurology when a CT scan revealed massive central pontine myelinolysis. This uncommon condition—a disintegration of the white matter in an area of the midbrain called the pons—is now known to be caused by a too-rapid hospital emergency room correction of severely disturbed blood electrolyte levels. Valerie's electrolyte disturbance was caused by a strict, month-long, "juice-only" diet (designed to remove "toxins" from the body) combined with excess fluid and mineral loss from an ileostomy (she had severe colitis in her twenties). She was started on L-dopa, an anti-Parkinson's medication, and baclofen, a muscle relaxant, with only slight improvement in her immobility. Her behavior, regressed and infantile from the time of admission, deteriorated further despite correction of her electrolyte imbalance, with depression, anorexia, increased withdrawal and helpless dependency. After six weeks of hospitalization, a psychiatric consultation was requested.

On initial examination, Valerie was small, greasy-looking, cachectic, childlike, and bedridden, only weakly able to move her arms and legs. Her face was "frozen," wide-eyed and terrified. Her voice was peculiarly thin and croaked, as if stuck in her throat, and her speech was flat and robot-like. Her chest and neck were also "frozen," and with her face, appeared to be cast as a single unit.

Armed with these biophysical observations and a report of a few isolated words of near-normal speech, I felt hopeful her clinical presentation could not be explained solely on the basis of her primary pontine disaster. As such, and despite a despairing neurological consensus regarding her recovery, I proceeded to tell her softly how terrified she looked—"scared stiff"—and how expressing her feelings, perhaps with assistance, might provide some relief. I encouraged her first to breath while opening her eyes wide and stretching her jaw, and then to scream. In subsequent daily sessions, I pressed on her jaw

muscles, the masseters, and occciput and had her gag and bite on a cloth. Initially, she cooperated mechanically and for only the briefest moments. She was clearly terrified of any sensation, tolerating only five- or ten-minute sessions before asking me to leave her room. Acutely aware of her limits, I complied, only to return patiently persistent the following day. Therapeutic efforts, both somatic and characteranalytical, elicited more intense expressions of fear followed by increasingly stronger vocal negative reactions. This culminated in her firing me for being "too traditional!" Her psychiatric symptoms and croaking voice returned in full force, however, over a four-day period, and I was asked to resume treatment. In subsequent weeks, as more and more emotion was expressed more strongly, her appetite and caloric intake improved, and her voice softened in tone and sounded more spontaneous—much to everyone's surprise. Over several more weeks her hostility and aggressivity in demanding attention intensified, until an entire day was spent screaming and raging at anyone who came near. The following day she reported feeling much better, was in good emotional contact, and saw most clearly how her pre-morbid, and a significant part of her in-hospital, behavior reflected a characteristic use of dependency to avoid emotional responsibility. She was now determined to be more independent and was subsequently transferred to an intensive rehabilitation unit where she worked diligently, cried more fully, both in and out of treatment, was tapered off of all medications, and, with a cane, walked out of the hospital.

Myra is a 29-year-old, unmarried woman whose life was tragically and permanently disrupted when she was 15. Following several days of crushing, unremitting headache, she underwent major neurosurgery for a possible tumor of the brain (unknown type). Her postoperative course was disastrous—she never fully awoke from anesthesia, and a cerebral ventricular-jugular shunt was placed to reduce internal brain pressure. She also received radiotherapy. She remained in a vegetative, helpless state for several years necessitating around-the-clock, custodial care provided primarily by her mother.

Over the ensuing years, Myra gradually regained consciousness and some limited personal and social function. Although unable to dress or bathe herself, comb her hair or prepare her own meals, she was included in family relationships and even managed to volunteer several hours a week filing forms in a protected environment at a local hospital. During her mid-twenties, however, a favorite aunt was attacked and murdered by an arsonist. Within several weeks, Myra, inexplicably, lost her hearing. Some two years later, over a week's time, she began having difficulty with continuity and volume of her speech and became mute. Several months after losing her voice, she developed problems maintaining her upright balance and appeared increasingly confused. Because two similar, although shorter episodes occurring during her prolonged convalescence were attributed to ventricular shunt malfunction and treated with neurosurgical shunt repositioning, the family was wary of further iatrogenic trauma to the brain. A different neurologist was consulted and she was admitted to the neurology service. Aware of the clinical complexities and the family's concern, a psychiatric consultation was requested.

On initial contact, Myra was sitting silently in bed. She had an amblyopic right eye ("walleye") and a paste-colored, expressionless, immobile face. A palpable tension hung in the air and was dissipated only when her mother, hovering aggressively and anxiously nearby, reluctantly complied when I asked her to leave the room. Left alone, Myra appeared as if "in another world." There was no eye contact or apparent excursions of her chest, and she moved very slowly in an eerily detached, seemingly aimless fashion, first touching the covers, then her sleeve. She failed to acknowledge or respond to simple spoken then written questions placed patiently before her. After a few additional minutes, I left, telling her with a note written in large letters that I would return the following day.

On the second visit, Myra, alone and mute, still appeared somewhat "other-worldly," although now obviously aware of my presence, as her head jerkily, slowly, and somewhat belatedly followed my movements. I was again impressed by the biophysical immobility of

her chest and upper segments despite her bizarre, seemingly demented presentation of the day before. I encouraged her in writing and by gesture to exercise, separately and then simultaneously, two basic components of speech—opening her mouth and breathing. This day she was able to comply, albeit weakly and mechanically, and only for a minute at a time. Heartened by this small but significantly improved capacity for engagement, I cocked my head quizzically to one side, cupped my hand behind my ear, and waited. An expression of puzzlement, tinged with a barely discernible quality of "dumbness" soon appeared on her face. Struck by the "dumbness," to me, a subtle characterological trait, I repeated my pantomime with greater facial exaggeration and an ever-dumber "Eh? Eh?" to match her own increasing intensity of expression. A silent but clearly formed "What?" appeared on her lips and, as I energetically gestured for her to breathe, a word, for the first time in over two months, was heard cracking and breaking in her throat—"What?"

In the third session, Myra appeared significantly more "down-to-earth." Silently but expectantly, she waited for me to sit down. I again coached her on breathing, and her response was stronger and more sustained than before. I exaggerated my breathing by moving my shoulders, arms and chest up and down more dramatically. Although she followed suit, her puzzlement appeared again, as did my "hearing-impaired" pantomime. "What?" broke weakly in her throat but then was repeated more distinctly. I wrote, "I can't hear you," even when her voice became a bit clearer. She "tsk"-ed at me in frustration. I wrote, "You clucked your tongue at me!" and continued to indicate I couldn't hear her. With increasing frustration, as color rose in her face, she gave me a dirty look and said loudly, "What do you want?"

Myra was discharged about ten days later. She was speaking spontaneously, clearly, and without confusion. She also walked without assistance. A complete neurological evaluation revealed normal ventricular shunt function and, in comparison with her most recent, previous workup, no essential change in her neurological parameters.

Over several subsequent years of on-going therapy, recurrences of mutism, confusion, and gait instability were clearly related to intolerable rage at her mother and were immediately relieved by biophysical intervention. As the rage was expressed, the full story of her convalescence emerged. Her mother's intense caring, so essential during recuperation, evolved into an all-consuming protectiveness, lest any mishap compound the damage already done and for which she had irrationally accepted full responsibility. Any initiative on Myra's part was stifled, any anxiety reinforced by her mother's aggravated fear. The result was years of enforced invalidism, intense anxiety, and repressed rage. The separation from her mother at the initial psychiatric consultation in the hospital was the first time Myra was without her mother's presence in almost 15 years. At last contact, some years ago, she was living with her parents but was considerably more independent and daring within the boundaries of her functional capacities.

The basic clinical perspective of neurology is derived from a mechanical understanding of the neuroanatomical complexities of the central nervous system. The limitations of this perspective were clearly demonstrated by an appreciation of somatic armoring and character structure and the effective use of biophysical observation in arriving at a coherent understanding of complex "neurological" symptoms. This truly functional, orgonomic approach allowed for treatment, without medication, in the form of orgonomic first aid. Using both physical, somatic and characteranalytical modalities, severe local armoring was effectively relieved. This permitted not only emotional catharsis and reversal of severe organismic contraction, but also an increased sense of integration and a significant step forward in recuperation from neurological disaster.

## The Cases of Selma, Donna and Hilde

The following cases describe orgonomic first aid for eating disturbances in medical illness. By way of introduction let me say that for most physicians, illness causes problems with eating because patients "don't feel well," are "depressed," or have some mechanical or

physiological dysfunction created by the disease process itself. While these "reasons" may have validity, they often fail to provide more than a superficial, mechanistic explanation of symptoms derived from the acute local and systemic effects of, and reactions to, illness on armoring and the energetic state of the organism. The following cases demonstrate how a functional, energetic, an orgonomic, approach allows not only for a comprehensive understanding of the disturbance of a basic biological function, but also for its treatment.

Selma is an 80-year-old, retired office manager, admitted to the hospital five months previous with fever and lower abdominal pain—symptoms of diverticulitis, an inflammatory disorder of the large intestine. In the course of her diagnostic evaluation and treatment, she had major intra-abdominal surgery and suffered multiple complications and setbacks, including infection, heart attack and a mild stroke. She spent countless weeks in intensive care and was finally transferred to a regular medical service where a new problem arose—so-called "failure to thrive." Because of great difficulty swallowing, she was unable to eat and saliva pooled in her mouth. Over a six-week period, she lost more than 25 pounds and was increasingly withdrawn and lethargic.

The medical staff, after an exhaustive (and for Selma, exhausting) evaluation including ciné-radiographic studies of the pharynx and esophagus, still could not explain her disordered swallowing, and a psychiatric consultation was requested. Immediately apparent was the "cowed" expression in Selma's eyes ("What are you going to do to me now?!") and the saliva drooling from her mouth as she spoke through jaws that barely opened. She could only separate her teeth the width of a small finger and literally could not swallow. After a brief explanation and with her cooperation, I elicited gagging with a tongue blade and then began gently but firmly pushing her mandible forward by pressing on the angle of the jaw. This was painful and tolerated only for seconds at a time, but elicited misery and crying. In subsequent brief sessions, gagging was repeated as much as tolerated and work on the mandible was expanded to include massaging the masseters and

having Selma bite on a cloth. These efforts produced greater expressions of misery related to the experiences she endured during the endless months of hospitalization and her hopelessness about ever being discharged alive. In subsequent sessions, as she allowed more vigorous and sustained physical work, her misery gave way to resentment and anger—she told me, "I could kill you," as she punched at my arms. This deepened into rage for everything that had gone wrong during her hospital stay and for all the indignities she had suffered. After only a few sessions, Selma was again able to swallow. She began to eat and saliva no longer pooled in her mouth. She became more sociable and lively with the hospital staff and with her boyfriend. She was discharged home two weeks after initial consultation.

Donna is a 27-year-old waitress and part-time model with known epilepsy secondary to head trauma in childhood. She was admitted to the neurology service because of an increase in seizure frequency. Laboratory testing determined blood levels of anti-seizure medication to be below therapeutic range, and over a week's time adjustments in dosage were made. Donna, however, reported continued seizures preceded by her familiar aura—a "feeling" in her stomach—and the type of medication itself was also changed. Persistent, distressing nausea with occasional enervating vomiting and diarrhea started about five days after admission and was variously thought to be "flu" or drug side effect. Eating exacerbated the problem. She was treated with intravenous fluids to maintain hydration, and an anti-emetic, an anti-nausea medication, was given without consistent effect.

These developments were followed firsthand—a psychiatric consultation was requested within the first several days of admission once the medical staff learned of a history of physical and emotional abuse in childhood and adolescence. On initial contact, Donna was a thin, attractive, anxious, young woman with a look of misery on her face. Her eyes occasionally showed fear and her voice was flat with a grinding, whining quality. Accounts of abuse by her mother and foster family, as well as details of more recent unhappy incidents, were presented almost as a litany. Her anxiety she related to her intention

of ending a live-in relationship with a man 25 years her senior. Little apparent headway was made beyond recounting the above history as subsequent daily sessions were soon focused on, and limited by, her nausea, weakness, and physical distress. Her neurological evaluation, meanwhile, confirmed the presence of an irritable, epileptic focus in the right hemisphere of the brain but also determined some of her "seizures" to be motor activity without concomitant electrical discharge in the central nervous system (so-called "pseudo-" or psychogenic seizures). She anticipated this finding by asking if some of her seizures could be "emotional." Although she still suffered nausea, I began to work with her biophysically. Having her breathe while opening her eyes wide produced a lump in her throat, which was relieved by vigorous gagging. The next session she complained of pains in her stomach. I palpated, firmly massaged, and "dissolved" a small, painful, firm mass in the right upper abdominal quadrant which produced an outpouring of crying misery and angry memories of her mother making her eat from a bowl on the floor with the family dog. She looked and felt enormously relieved with complete resolution of her nausea. The following day she complained of pains in her legs that had plagued her intermittently for years. I pressed on her calves and the lower, outer aspect of her thighs with similar results—memories of abuse and a painful outpouring of misery and anger, the emotions that had been absent from her litany. She was discharged shortly thereafter, eating well and seizure-free.

Hilde is an independent 80-year-old, retired bookkeeper admitted to the hospital confused and disoriented after falling and striking her head. A CT scan found a localized collection of blood just under the dura, the membrane covering the brain, and a subdural hematoma was diagnosed. She was effectively treated over several weeks with steroids, and although no longer confused, she refused to eat or drink. A psychiatric consultation was requested. During the initial visit, this frail, elderly, seemingly hearing-impaired, apathetic, depressed-looking woman said she "wanted to die" but also, on questioning, reported feeling a lump in her throat. Prominent biophysically was the

limited mobility of her jaw, depressed respirations, and a "lost" expression in her eyes. Treatment began with gagging induced by a cotton-tipped applicator followed by pushing her mandible forward. This last therapeutic maneuver elicited sobbing cries of "Momma, momma." After this brief session, she asked for a drink of water and later that evening ate her first meal in weeks. Daily, brief sessions using gagging, breathing while stretching the jaw, and pushing the mandible forward elicited misery, despair, and small but significant amounts of anger. Her eyes soon appeared more focused, and her hearing, surprisingly, returned to normal. She became more vocal in her complaints about life in the hospital and more interactive with the nursing staff. Her appetite continued to improve but she also told her doctors that she was "too heavy" on admission, felt more comfortable having lost 15 pounds, and would eat only enough to maintain her current weight. She thanked me at the end of each session, obviously looked forward to seeing me again, but was also able to tell me she didn't like the physical work I did with her. She was soon transferred to a rehabilitation program in a nursing home, hopefully an interim step preparing her for return to her own apartment.

In conclusion, I reiterate what I said in my introductory comments. Presenting these cases of orgonomic first aid in a big-city general medical hospital is an opportunity to see by concrete example what was lost to medicine and psychiatry when psychoanalysts rejected most of Reich's discoveries in the 1930s and thereafter. The most significant destructive consequence was the lost opportunity to place depth psychology on a comprehensive, natural scientific, biological foundation. Instead, we have a symptom-based, descriptive menu of psychiatric diagnoses. Paraphrasing Dr. H.M. van Praag, a world-renowned psychopharmacological researcher, speaking on the occasion of his departure as Chairman of Psychiatry at the Albert Einstein College of Medicine, "There is good news and bad news regarding the *DSM*, the psychiatric *Diagnostic and Statistical Manual of Mental Disorders*. The good news is that it brings some degree of uniformity to psychiatric diagnosis. The bad news is that there is no

theoretical framework that underlies or connects any of the diagnoses." How's that for honesty?

In response, I am convinced that without an orgonomic understanding of how the human organism functions emotionally and biophysically and how this functioning is impaired by armoring, these patients could not have been helped, certainly not in the effective way demonstrated by the brevity of their treatment and the degree of their recovery.

# Wilhelm Reich's Legacy: Bombshells in Science

**Peter A. Crist, M.D.**

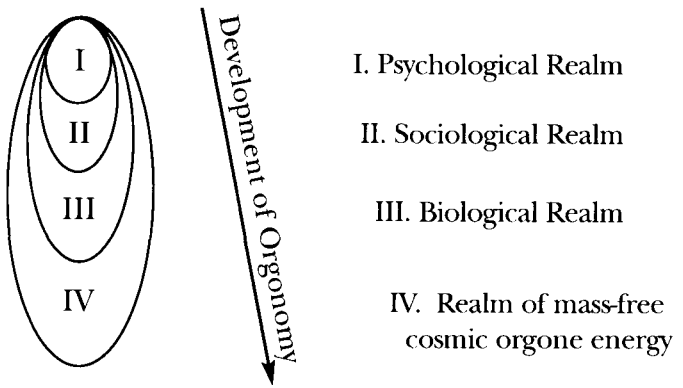
*The following remarks were made by Peter A. Crist, M.D., President of the American College of Orgonomy, at the ACO Annual Dinner on November 3, 2007. The dinner was held at the Wyndham Princeton Forrestal Hotel and Conference Center, Plainsboro, NJ.*

On our invitation to this dinner we wrote that we were: "Celebrating the Life, Honoring the Work, Continuing the Legacy of Wilhelm Reich on the Fiftieth Anniversary of his Death."

Fifty years ago today Wilhelm Reich, the greatest natural scientist in history, died of a heart attack, alone, in a cell in the Lewisburg Federal Penitentiary. The loss to his loved ones was tremendous, the loss to the world immeasurable. We are here because of the remarkable body of work he accomplished, and the legacy he gave to the world, in the 60 years of his short life. We are here, however, not to mourn his loss but to celebrate his life and continue the work he pioneered.

His professional life began in psychoanalysis, as a star student of Sigmund Freud, in the realm of unconscious emotions; however, his work led him into progressively deeper and broader realms as he investigated social problems, and then biology. In 1940, with his discovery of the atmospheric orgone, he entered the deepest and broadest realm: the physics of mass-free cosmic energy.

The following is a diagram of the realms of Reich's work modified from the one found in his book *Ether, God and Devil* (1949):




Early in 1941 he arranged a meeting with the most well-known physicist of the day, Albert Einstein. After describing to Einstein that the temperature in an orgone energy accumulator was consistently higher than that of the surrounding free air, Einstein said, "That is impossible. Should it be true, it would be a great bombshell."

Reich's legacy was a series of "great bombshells" in each of the great realms that he worked: psychoanalysis, sociology, biology and physics.

We can't possibly cover them all tonight. That is one of the problems with Reich's work as he himself was all too aware. In the opening pages of *Ether, God and Devil,* Reich writes:

> The greatest difficulty in grasping the orgone theory lies in the fact that the discovery of the orgone has solved *too many* and *too great* problems all at once: the biological basis of psychic diseases, biogenesis and with that the cancer biopathy, the ether, the cosmic yearnings of the human animal, a new physical energy, etc... No one has felt the TOO-MUCHNESS as painfully as myself. ...many, very many facts of great significance were lost... Still the vital point and basic principle in the discovery of the orgone energy seem firmly established and so arranged that others can continue to work on the structure I could not complete. (1949, page 6)

He goes on to write:

> In reality, I have made only one single discovery: *the function of orgastic plasma pulsation.* It represents the coastal stretch from which all else developed. (1973, page 5)

From the very beginning of his work with Freud in the early 1920s, Reich made observations that led to his discovery that the function of the orgasm is the regulator of the organism's bioenergy. This first major contribution to psychiatry, published in *The Function of the Orgasm* in 1927, was his first bombshell.

As we heard in Reich's own words, this early discovery was the bombshell in psychiatry that presaged each of the subsequent realms he studied. It showed that emotional health is deeper than conscious thought and will; that the biological basis for neurosis is libido stasis. The understanding of the function of the orgasm also begged the question, "Where does energy stasis and neurosis come from?" This led Reich to the realization that society itself is sick, especially regarding sexuality. This is still a bombshell for most people who see themselves as paragons of normalcy.

In his investigation of society Reich discovered another bombshell, the mass psychology of fascism: One individual can control the masses by tapping into their simultaneous longing for freedom and their fear of it. One cannot free a people merely by eliminating their despotic ruler. Just look at the former Soviet Union and Iraq.

Freud became uneasy with Reich's mixing of social issues and politics with psychoanalysis, and their friendship began to cool. Ultimately, Freud sanctioned his expulsion from the International Psychoanalytic Association in 1934.

As Reich the man who cared deeply about human suffering tried to help the masses of people with their sexual disturbance, Reich the scientist continued to investigate the function of the orgasm. If libido stasis causes biological effects then the libido must be a real energy.

He wanted to investigate more deeply what moves out toward the world in sexuality and away from the world in anxiety. At first believing he was dealing with a known energy, electricity, he devised the

bioelectric experiments. He found that the deflection measured by an instrument in a room away from the test subject could accurately describe the subjective experience of the subject, and vice versa: a bombshell that bridges the gap between psychology and biology. For the first time, a subjective impression could be objectified. Clearly there is a real "something" that moves in the body that is perceived as pleasure or anxiety.

Reich wanted to observe more directly what was moving and to observe the "streamings" reported by patients who had overcome their neurotic armoring. Recalling his own observations of ameba as a young student and being aware of Freud's analogy of connections between people being like an ameba sending out pseudopods, Reich decided to observe these protozoa under the microscope.

Wanting to make his own preparations of ameba rather than having to order them from the laboratory, he asked where ameba come from. He was told to put grass in water and wait several weeks, and sure enough they appeared. Not satisfied with the explanation that they came from "air germs," he decided to make direct observations of the grass. He discovered that over time the grass in the water gradually disintegrates and heaps of vesicles spontaneously develop a membrane and organize into protozoa.

This observation was a bombshell in biology. How so? By late in the 19th century, Pasteur and biological doctrine had thrown out the idea of spontaneous generation and the doctrine of *omne vivum ex ovo* ("All life [is] from [an] egg.") had taken hold. A demonstration that protozoa form spontaneously out of decaying living matter goes against this established doctrine.

Reich's laboratory work continued in a logical progression from here. From some of these experiments he developed cultures of the vesicles, which he called "bions," described as the elemental particle of life. In 1939, he discovered the radiation of a previously unknown energy from some of these cultures. He called this energy "orgone."

In 1940, Reich observed and discovered the orgone in the atmosphere. As I've said, he was now working in the physical realm of

a mass-free cosmic energy. That energy spontaneously moves from an area of lower energy charge to an area of higher energy charge, as he demonstrated in his famous temperature ($T_O$ - T) experiments with the orgone accumulator, the very data he described to Einstein.

So we have come full circle in our brief tour of some of Reich's bombshells. Did you notice the theme that runs through so many of Reich's "bombshells"? They are discoveries of something spontaneous: spontaneous development, spontaneous movement.

Reich concluded that spontaneous movement is a basic quality of orgone energy. This fact alone is a bombshell that violates mechanistic physics' second law of thermodynamics, the basic law of the universe, not to mention sending shock waves through the ubiquitous immobility of armored human rigidity.

I have only brought you to the discovery of the orgone. But the number of fields in which Reich set off bombshells is truly amazing. And in this all too brief outline, I have not even mentioned so many of his concepts and discoveries: the importance of mother-infant contact and healthy childrearing, work democracy, the discovery of muscular armor, somatic biopathies and the cancer problem, and all those that came after the discovery of the orgone, the orgone accumulator, Experiment XX, the Reich Blood Test, the emotional plague, the vacor tube, the orgone motor, Oranur, DOR, preatomic chemistry, the medical Dor-buster, orgonometry, theories of weather and galaxy formation, as well as gravity, and the list goes on.

Reich devoted his life to helping Man leap the gap between his healthy core and the superficial and destructive way he lives his everyday life. I want to end with one image:

Kari Berggrav

Wilhelm Reich working on "Man Leaping the Gap"

## References

Reich, W. 1949. *Ether, God and Devil.* Rangeley, ME: Orgone Institute Press.

———. 1973. *Ether, God and Devil: Cosmic Superimposition.* New York, NY: Farrar, Straus and Giroux.

# Questions and Answers

### Question

Is there a deep-rooted need in humans, especially males, to be violent?

### Answer

There is no deep-rooted, intrinsic need in humans, male or female, to be violent. The origin of violent behavior is found in early infantile and childhood development when natural emotional needs, which are benign and non-destructive, are *not met* and are instead chronically frustrated and thwarted by people in the environment, especially the parents. The reaching out, the emotions of the infant and child, turn into rage which manifests as disordered behavior and violence. Although the form of violence is often different in men and women, the violence of males is typically physical whereas the violence of females is typically emotional, the destructive effect is the same.

Children whose emotional needs *are met* during their development, from birth through adolescence, will not become violence-prone no matter how much violence they are exposed to. Conversely, children whose emotional needs are frustrated during their development will always be prone to destructive behavior in one form or another, even if they have never been exposed to violent scenes in the media. Their destructive behavior will be passed on to their own offspring through the same kind of emotional abuse that was visited upon them. This is how human destructiveness perpetuates itself from generation to generation.

This material is discussed in detail in my book *The Emotional Plague: The Root of Human Evil.*

### Question

A lot of moms do not allow their kids to watch, for example, "Hannah Montana" or "High School Musical" or see "Spider Man" or "Harry Potter" because they feel they condone violence/bad values (such as talking back to your parents, lying, cheating, etc.). Can watching these shows/movies be a bad influence on younger children (under 10) and hurt their development and play a factor in how they will deal with society as they grow older?

### Answer

The problem is not this or that TV show or movie. Children need a role model, and if the parents and other significant adults in the child's world (grandparents, aunts, uncles, etc.) do not have genuine emotional contact with the child, then he or she will necessarily resort to substitute measures such as television programs, movies, the internet and video games for learning modes of behavior. A healthy relationship, however, between the child and parent, or parent substitute, provides the means for children to differentiate what is shown on TV and elsewhere and what is considered appropriate behavior in the real world. Certainly, viewing gratuitous violence, bad values and obscenity is not desirable, but in many instances these depictions can provide a contactful opening to discuss issues that the child is wondering about and give the parent an opportunity to explain why the anti-social behavior is not acceptable.

*Charles Konia, M.D.*

# Communications and Notes

## Announcements

*The Emotional Plague: The Root of Human Evil*, by Charles Konia, M.D., has been selected out of 15,000 applicants as a finalist for the Eric Hoffer Award and the Montaigne Medal. The book was published by the ACO Press in 2008.

Howard Chavis, M.D. gave a Department of Psychiatry Grand Rounds presentation, "The Somatic Basis of Character," at Harlem Hospital Medical Center, New York, NY, on March 12, 2008.

Howard Chavis, M.D. gave a presentation, "The Dying Patient, or You're Not Dead Yet," at the Faculty Group and Family Therapy Conference, Department of Psychiatry, Mount Sinai School of Medicine, New York, NY, on January 10, 2008.

Peter A. Crist, M.D., as part of a series of social orgonomy public presentations held at the ACO headquarters, spoke on "What is the Emotional Plague? An Introduction." This talk, given to a standing-room-only audience on February 2, 2008, was repeated on March 1, 2008.

Additional social orgonomy lectures planned for 2008 are: "The Many Faces of Evil: Current Examples of the Emotional Plague," (Drs. Dee Apple, Peter Crist, and Virginia Whitener), on April 5, 2008; "The Faces of Evil: Examples from History," (Virginia Whitener, Ph.D.), on June 7, 2008; and "Politics and the Emotional Plague: An Open Forum," with Dr. Charles Konia (author of *The Emotional Plague: The Root of Human Evil*), and Drs. Dee Apple, Edward Chastka, Peter Crist, and Virginia Whitener, on October 4, 2008.

David Holbrook, M.D. gave a talk, "Wilhelm Reich and Orgonomy," to the Child Psychiatry fellows at The University of Medicine and Dentistry of New Jersey in Piscataway, NJ, on October 23, 2007.

Project Protozoa was announced at the ACO 2007 Annual Dinner. In Reich's laboratory research in the 1930s, he observed and filmed protozoa forming spontaneously from the breakdown of vegetable matter. This was a bombshell in science that went against all accepted biological doctrine. Steve Dunlap, the ACO lab technician, will try to reproduce and film the technically demanding and tedious process involved in making these observations. Mr. and Mrs. Jack and Jean Sargent led the fundraising effort with a matching grant for Phase I of Project Protozoa, the purchase of the necessary equipment. There is still opportunity for more people to share the excitement of supporting this groundbreaking project.

## Available to the Public

### Therapy Referral Service

The referral service provides qualified therapists for individuals seeking treatment. For more information contact the College by telephone, fax, or e-mail.

### Seminar in Orgonometry

The American College of Orgonomy Seminar in Orgonometry, formerly restricted to physicians, is now accepting applications from qualified members of the general public. Requirements include being recommended by a medical orgonomist affiliated with the College and a personal interview. Orgonometry is the science of functional thinking using a form of mathematics that incorporates qualities as well as quantities. Specialized mathematical training is not required. The seminar meets six times a year, on a Saturday afternoon for about two hours. Arrangements can be made for students who are not able to attend all six sessions. Tuition is $600 a year plus a $120 materials fee. There is a $100 application fee. Students may begin the seminar at any time. Those interested should contact the ACO at (732) 821-1144.

## Invitational Lectures, Seminars and Workshops

The American College of Orgonomy periodically presents lectures and seminars at its headquarters in Princeton as well as onsite at other locations. Individuals or organizations interested in having a presentation on a specific topic should contact Peter Crist, M.D. at the College.

## Website

The American College of Orgonomy has a website, currently undergoing extensive redesign, to introduce the science of orgonomy and the American College of Orgonomy to the world. A wide variety of articles selected from the *Journal of Orgonomy* are presented in their entirety including many case histories illustrating the theory and method of medical orgone therapy. Also available at this site is a news section and information about the College and its programs. The A.C.O. website address is www.orgonomy.org.

## Introductory Laboratory Workshop in Orgonomic Science

This two-day workshop is offered periodically. It is given so that interested individuals with or without scientific training can have the opportunity to observe orgonomic phenomena through hands-on use of the microscope and other laboratory apparatus. The educational approach includes demonstrations, lectures, and film. The workshop includes the microscopic study of bions, the natural organization of protozoa from grass, and an introduction to the Reich Blood Test. Atmospheric orgone is observed and measured thermically and electroscopically. The effects of the orgone energy accumulator are observed and its principles demonstrated. Orgonomic principles of weather formation and cosmology are elucidated.

The workshop is organized under the direction of Dee Apple, Ph.D. The teaching staff includes Drs. Dee Apple, Howard Chavis, and Peter Crist, Mr. Steven Dunlap, Drs. Robert Harman and Raymond Mero. The fee for the introductory course is $400. Application forms are available from the College.

## The Advanced Laboratory Workshop in Orgonomic Science

This four-day advanced workshop allows the student to more thoroughly explore orgonomic biology and physics through direct experience and experiment. It is reserved for those with medical or other scientific training. This course is a prerequisite for certification by the American Board of Medical Orgonomy.

The workshop includes in-depth microscopic study of bions, the natural organization of protozoa from grass, the development of life from mass-free orgone energy, an introduction to the Reich Blood Test, and the study of blood and tissue of cancer mice. The atmospheric orgone is observed and measured thermically and electroscopically. The effects of the orgone energy accumulator are observed and its principles elucidated. Time is allowed for individual research projects which are presented in brief on the fourth day.

The workshop is organized under the direction of Dr. Peter Crist. Dr. Charles Konia contributes his long experience in orgonomic research to discussion of the individual projects. The fee for the advanced course is $800. Application forms are available from the College.

## Reich Blood Test

The Reich Blood Test for the evaluation of bioenergetic charge is available by physician request and is performed at the Elsworth F. Baker Oranur Research Laboratory in Princeton, NJ. For more information contact Howard Chavis, M.D. at the College.

## College Subscription Sponsorship Program

The American College of Orgonomy accepts sponsorship from individuals interested in offering in-print issues of the *Journal of Orgonomy* (volume 11 to current) to an alma mater or university library. The cost is only $75. A subscription to the *Journal of Orgonomy* will then commence at the standard subscription rate. If you are interested in sharing advances in orgonomic science with others, please contact the College.

## Available to Professionals

The American Board of Medical Orgonomy is an authoritative and responsible body of physicians whose primary function is the setting of standards and testing for qualification to practice orgonomic psychiatry and medicine. Board certification in medical orgonomy requires that candidates have graduate training in psychiatry, pass the specialty board examination in that discipline, undergo characterological and biophysical restructuring by a qualified medical orgonomist, receive at least three years of didactic, clinical, and laboratory instruction by qualified instructors in medical orgone therapy, and pass written and oral examinations in orgonomic theory and practice.

## Training in Medical Orgonomy for Physicians

The American College of Orgonomy offers training in medical orgonomy to qualified physicians in the fundamentals of orgonomic medical science, clinical assessment of character structure, character analysis, and psychiatric orgone therapy. Training consists of personal characteranalytic and biophysical restructuring, laboratory workshops in orgone biology and biophysics, didactic and clinical seminars, and clinical case supervision. The program was originally designed and directed by Elsworth F. Baker, M.D., who was appointed by Dr. Reich in 1950. It is now under the direction of Charles Konia, M.D., Chairman of the Committee on Training and Education. Members of the Committee include Peter Crist, M.D. and Richard Schwartzman, D.O. All interested applicants can request an application form from Charles Konia, M.D., Director of the Medical Orgonomy Training Program, at the College.

### The seminars include:

- **Didactic Training Seminar:** This seminar, which meets eight times a year, is a prerequisite for individuals accepted into the training program. It is designed to provide an understanding of emotional illness and its treatment based upon characteranalytic and functional energetic theory and principles. The three-year

course is under the direction of Dr. Peter Crist.

- **Principles of Characteranalytic Technique:** A monthly continuing case seminar for physicians on the use of characteranalytic technique, under the direction of Dr. Peter Crist.
- **Orgone Therapy—Beginning Phases:** A monthly seminar that focuses on diagnosis based upon characteranalytic and orgonomic theory, under the direction of Dr. Charles Konia.
- **The Elsworth F. Baker Advanced Technical Seminar:** A monthly seminar that focuses on case management and medical orgone therapy technique, under the direction of Dr. Richard Schwartzman.

## Social Orgonomy Training Program

The Social Orgonomy Training Program of the American College of Orgonomy (ACO) offers training in the application of orgonomic principles within the social realm.

We accept application from candidates in two categories:

1. Social orgonomy therapists are individuals engaged in clinically oriented work in fields that address interpersonal dynamics and problems within social structures, including work with individuals, families, and work organizations. The requirements for training in this category include character-restructuring with an approved medical orgonomist on the training faculty, completion of or active enrollment in an advanced degree program in an appropriate field of social intervention such as psychology, social work, nursing, marital and family therapy, or organizational development.
2. Other individuals who are not engaged in providing therapy but may apply the knowledge of social orgonomy in a wide range of fields such as those who work as teachers, administrators, politicians, writers, businessmen, attorneys, managers, etc. The requirements for training in this category include character-

restructuring with an approved medical orgonomist and at least a bachelor's degree.

The curriculum focuses on the application of bioenergetic principles to interactions in the social realm and begins with the Didactic Training Seminar. This is followed by an advanced social orgonomy didactic seminar, ongoing case seminars, and individual supervision.

Following recommendation by the candidate's therapist the process of enrollment begins with a written application, which is provided by the ACO upon request. This is followed by a personal interview with the Social Orgonomy Training Subcommittee and ACO Training Committee who together approve candidates for training.

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