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Orgone Therapy: The Application of Functional Thinking in Medical Practice

Part XV: The Relationship Between the Diagnosis and the Red Thread

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Many studies in the psychiatric literature conclude that various forms of psychotherapy do not differ in their effectiveness. One important reason for this finding is that in all these psychotherapies a functional biopsychiatric diagnosis is lacking. Without an accurate biopsychiatric diagnosis the therapist is unable to see the patient's behaviors and symptoms from a functional characterological perspective, is unable to anticipate the patient's characteristic reactions, and consequently works in the dark. In effect, treatment is superficial (symptom-focused), haphazard, or there is no treatment.

Closely related to the diagnosis, the red thread is the basic character trait by means of which the patient meets the world. It is the trait that presents itself when the patient first meets the therapist and is the characteristic manner in which the patient reacts to situations encountered in therapy. It will invariably become the main resistance that presents itself throughout the course of therapy. This predominant character trait or red thread must be differentiated from all other character traits of the patient. It distinguishes itself by its prominence in the patient's life, its presence in all layers of his character structure, and its specific relationship to the orgastic disturbance of the individual in the end phase of therapy.

The red thread can often be described as a specific character trait such as friendliness, frankness, modesty, seriousness, reserve, pushiness, nastiness, etc. Or sometimes it can be more accurately typified as a certain type of person or professional. Some examples taken from clinical practice are "Priest", "Rabbi", "Gestapo Agent", etc. Alternatively, it may be best described as a specific personality such as "Samson", "Shirley Temple", "Alice in Wonderland", "Hitler", etc.

Another useful category is a particular kind of animal such as "turtle", "bulldog", "mouse", etc. It does not matter how the red thread is described so long as it is both accurate and *specific* to the patient(1).

For therapy to proceed optimally both the diagnosis and the red thread require correct identification and their relationship to one another understood during the course of therapy. The therapist seeks information that bears on these two aspects of the patient. Information related to the patient's diagnosis is more general while that pertaining to the red thread is specific to the individual. Important information contained in the patient's diagnosis will also be found in the red thread, but in less detail. The red thread is ever-present and contains the most powerful resistance to energy movement. However it may be given up for brief periods. At these times the patient experiences intense bursts of energy. Because of its integral position in the patient's structure it is never completely eliminated, even when therapy is completed.

While the accurate diagnosis pinpoints the primary block in the character structure of the patient, the red thread reveals *how* the individual with this particular diagnosis functions. For example, all paranoid schizophrenics have as their main defense distrust of others. However, the *manner* in which distrust is manifested may be different in each individual paranoid schizophrenic. The following two clinical examples illustrate that identification of this manner, which is the red thread, is essential if the therapist is to focus effectively on the patient's paranoid defenses.

1. The red thread of a paranoid schizophrenic patient was severe criticism and vicious belittlement of herself. These attitudes, coupled with her terrified demeanor, tended to elicit a compassionate gentle response from the therapist. With her acute sensitivity she accurately perceived that this response was not quite genuine. This justified her wariness of the therapist. Her frightened facade in effect served as a test of others to see if they would behave falsely toward her. Only when her testing terrified demeanor, her red thread, was repeatedly related to her basic mistrust was her suspicion of the therapist effectively addressed.

2. The red thread in another paranoid schizophrenic patient was a blasé, happy-go-lucky attitude and a facade of friendliness. These attitudes concealed not only her deep feelings of mortification and terror of being emotionally exposed in social situations but also her distrust. This could not be effectively addressed until her red thread was understood. In effect her red thread served the function of denying her own vital needs which she dared not reveal. In her relationships she assumed the role of a sympathetic listener and nurturer. Beneath this was her absolute mistrust of reaching out to others and her fury at everyone for never paying any attention to her needs. "What about me!" was her enraged expression that she could never reveal. Once the function of her red thread became clear it was possible to focus on her suspicion and the rage behind it. Her friendly blasé facade not only concealed her rage but also prevented anyone from getting close to her. Repeatedly having her look at the therapist in a sustained way filled her with terror, but this gradually allowed her to become aware of and feel the enormity of her mistrust. Underneath this was her terror of expressing murderous rage followed by her intense longing to be held and nurtured.

The following case illustrates how treating a patient without knowledge of the red thread results in a therapeutic impasse.

The patient, a depressive character with a phallic structure, had been treated previously in medical orgone therapy with temporary relief of his depressive tendencies through mobilization of rage. However, minimal attention was given to his character and he had little understanding of the basis for his tendency toward depression. In his therapy with me I focused on the most predominant aspect of his demeanor which was one of earnest seriousness. He immediately recognized how this trait was the manner in which he approached every situation in his life. It served to attenuate every emotional reaction that he felt. This included, as he came to see later in treatment, his negative feelings toward both parents. It served to keep his anger at his father for his sarcasm in check and at the same time it was a rebuke directed at his mother for her chronic superficial attitude. In his present life his seriousness was a severe handicap. It made him take every bit of criticism from his girlfriend "to heart" which led to his depressive episodes. His seriousness interfered with his ability to

recognize that his girlfriend's criticisms of him were actually an attack, a way to keep him at a distance. By the therapist focusing consistently on his seriousness, the patient soon realized that this was a chronic rigid attitude. (He saw that he even walked in a serious manner.) Recognizing the function of his red thread led to a sense of hopefulness and lightheartedness that he had never felt before.

These examples illustrate the necessity of recognizing the patient's red thread and the threat to the therapeutic course and outcome if it is not.

From another perspective the red thread can be viewed as originating from the intrinsic strengths of the patient. Because a strength is used defensively, however, it turns into an exaggeration of normal functioning. For example, a naturally aggressive person becomes pushy or obnoxious, etc.

Although there is only one red thread, as deeper layers of the patient's structure are penetrated and dealt with in treatment many characteristics related to the red thread can appear in their exact opposite form. Some paired examples are: muzzled bulldog–aggressive bulldog, righteous rabbi–masochistic rabbi, defiant bad boy–compliant good boy, devil–priest, hateful misanthrope–good fellow, wimp–obnoxious bully. Whatever their form, these traits have the same defensive function as the red thread.

The red thread reappears as each layer of armor is uncovered. Addressing the red thread in a consistent manner effects the breakdown of successive layers of armor and leads directly into deeper layers of the patient's structure. Addressing the red thread consistently also helps to separate out the underlying core impulses from the secondary destructive ones. When this happens, when distinctions are made between the healthy and the pathological, the patient feels understood, comes into better contact, and is more cooperative.

The Relationship Between Symptom and Diagnosis

Because mechanistic psychiatry has no understanding of the underlying significance of symptoms it cannot penetrate beyond the personality or the surface of the patient's biophysical structure. For the

same reason manifestations of character which arise from layers of the biopsychic apparatus deeper than the personality are also beyond its comprehension. Confined by these limitations mechanistic psychiatry's perspective can only focus on the patient's symptoms and aspects of personality.

For the medical orgonomist, however, *the significance of every symptom is derived entirely from its relationship to the patient's biopsychiatric diagnosis.*[1]

Some Clinical Illustrations

1. The tendency to doubt, a prominent symptom of the compulsive character and the catatonic schizophrenic, is seen regularly in other character types. Whenever a particular phallic narcissistic patient was confronted with having to emotionally commit himself to a woman he "doubted" whether he loved her. Since he was a phallic his doubt was actually a covert manifestation of genital revenge toward women rather than an example of passive indecision more typically found in anal characters.

2. Doubting in a manic-depressive patient surfaced whenever there was an occasion to express his core drives. His doubt was actually self-denial, a manifestation of his extremely harsh superego (armor) mercilessly directed against his ego. Although superficially resembling compulsive doubting, this trait had an entirely different function: it effectively undermined his sense of self-worth. Any achievement which would have normally produced a feeling of pride was regularly met with laughter at himself, a form of self-belittlement. By consistently pointing out how his doubt was directed against strivings and accomplishments in time he became aware of the function of this self-destructive trait. When this occurred he was gripped by a cold fear. Yielding to deep sobs, his armor softened.

3. Both the catatonic schizophrenic and the compulsive character manifest prominent obsessive-compulsive symptomatology. However, the true compulsive character is a rare entity. Because the traditional

[1] Excluding this fundamental relationship explains the failure of the current exclusively symptom-based psychiatric nosology vis-a-vis understanding etiology and deriving treatment from it.

psychiatrist focuses exclusively on symptoms the catatonic schizophrenic is often incorrectly diagnosed and is instead treated as any other patient with obsessive-compulsive symptoms. The failure to recognize or appreciate the ocular pathology and armoring of the brain of the catatonic has unfortunate and profoundly negative therapeutic consequences. Instead of addressing the primary problem, which is the catatonic's ocular armor and the underlying terror of losing control, treatment is directed solely at alleviation of obsessive-compulsive symptoms.

4. The symptom of voyeurism has an entirely different significance when it occurs in the voyeur, the compulsive, or the passive-feminine character. In the first instance it replaces heterosexual activity; in the second it is a compulsive behavior; and in the last case it is a manifestation of the patient's characterological passivity, sneakiness, and tendency to hide. To be sure, in all cases the symptom prevents anxiety from being experienced, but this in itself tells nothing about how to *specifically* deal with the symptom. This can only follow from an accurate characterological diagnosis.

5. The significance of homosexual behavior varies with the individual's character structure. In the female hysteric homosexuality is a relatively superficial symptom, a flight from a fear of genitality. In the passive feminine male homosexuality is a deep defense against aggressive impulses of genital revenge.

These examples illustrate the importance of determining an accurate biopsychiatric diagnosis rather than focusing solely on the patient's symptoms. This permits genuine understanding and allows for a rational process of biophysical restructuring.

REFERENCES

1. Baker, E.F., In a personal communication.