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Biosocial Basis of Family and Couples Therapy

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Editor's Note: *The practical application of orgonometry to solve important problems in the social realm may well become the most important scientific development of the 21st century. "The Biosocial Basis of Family and Couples Therapy," originally published in 27(2), 1993, was an important early milestone in that development, and remains useful to this day.*

The universal cause of human misery is the orgastic impotence of armored man. What we are dealing with is simply the incapacity to love. This expresses itself everywhere in human life, but most strongly in its effect on marital happiness, and especially in the sexual difficulties and progressive estrangement that all too often develop in a marriage as the years go by.

Society has gone through, and continues to go through, major changes in its attitude to this problem. Fifty years ago it was assumed that sexual misery in marriage was simply an inescapable part of the human condition, and that one must resign oneself to it in the interest of social stability and for the sake of the children. After the 1960s, the opposite attitude became fashionable and it was believed that the solution was simply to change partners, with minimal regard for the consequences. In recent years, experience has shown that divorce is more damaging to children than had been thought and that divorced individuals typically take their problems with them to their next relationship. In the current social environment, those who care deeply about life have become increasingly concerned about preserving and improving the family. More and more often the chief complaint of the individual seeking medical orgone therapy is concern about the quality of marital and family life.

Thus, it is essential that every medical orgone therapist have a clear understanding of orgonomic sociology and know how to use that understanding to help patients address marital and family problems. This is just as true in the practice of individual therapy as it is for couples therapy. [Robert A. Harman, M.D.]

Introduction

Reich began to study the social realm seven decades ago. In the 1920s, he made a revolutionary breakthrough in understanding the human condition when he focused on the role of the neurotic character of society in the etiology of neurosis. His work with impulsive characters led him to see that the neurosis was more than the person's symptoms: it was in his character and in how he lived. This was in contrast to the prevailing view that the neurosis was a circumscribed symptomatic condition in an otherwise healthy individual. At the same time, Reich realized that the character of the typical upper middle class, Viennese, inhibited and repressed, psychoanalytic patient was also neurotic. The fact that this character was both the norm *and* socially acceptable helped convince Reich that society itself was neurotic. It had become clear to Reich that neurosis did not derive from an inborn death instinct as postulated by Freud, but rather from the deeply ingrained anti-sexual, anti-life attitudes of society as propagated through the authoritarian, repressive, patriarchal family. These theories and conclusions are presented in his major sociological work, *The Mass Psychology of Fascism* (1946). At the time, he was also investigating broader social issues and had initiated the sexual hygiene movement.

Reich's view, as distinguished from those prevailing in psychoanalysis at the time, was that man's emotional and psychic life—both in health and disease—was the product of more than internal intrapsychic processes. He understood that they were the result of a dynamic interplay between intrapsychic and social factors (1974). This "obvious" fact, now accepted and taught world-wide in every school of sociology, was first elucidated by Reich. It was, in part, this pursuit and emphasis on social issues that led to his separation from the psychoanalytic movement.

Reich's subsequent disappointment with the failure of mass social programs to effect change came at the time when he had begun to explore the biological roots of neurosis in the somatic armor. He turned away from sociopolitical approaches to the human condition because the integration of psychic, biological, and social discoveries

led him to the inescapable conclusion: armored man was *incapable* of tolerating freedom (1943). Later, in the work of the Orgonomic Infant Research Center, he returned to social issues within the family armed with the deeper perspective of problems of bioenergetic contact between mother and infant (1983).

Baker further developed Reich's groundbreaking work by delineating the major sociopolitical character types and identifying their armor patterns and typical emotional defenses (1967). Since that time, the primary focus of social orgonomy has been on the way in which the individual—as a liberal, a conservative, one of their subtypes or an emotional plague character—expresses himself in the sociopolitical arena (Baker, Matthews, Konia).

More recently, Goldberg's contributions are the first to expand the focus of social orgonomy by emphasizing the interaction *between* individuals (1989). Based on his work as an organizational business consultant, he views work organizations as unitary energy systems. Within these systems, the interpersonal dynamics form a realm distinct from the internal emotional dynamics of the individual. His profound insights into this social realm have important theoretical and practical applications, including the description of distinct character types of work organizations.

Utilizing this foundation of social orgonomy and clinical observations, we now examine the principles of health and sickness in families and the basis for treating them.

Definition of the Family

Everyone has a family, either as a parent or as a child. Families are a universal human social unit. *The primary natural function of the family is expression and discharge of love. A dysfunctional or neurotic family is one in which the expression of love is chronically blocked.* The purpose of family therapy is to help overcome and eliminate blocks in the social system of the family and, if successful, to restore loving relationships. We know that when the love in a family dies, the family will dissolve unless

it is secondarily, i.e., neurotically, bound. Love is the primary organizing principle of the family.

By "love," I mean an emotional and physical expression and discharge of the biological energy, not a metaphysical concept of love. Mutual energetic contact and excitation experienced in the body is sexual. In this way, the term "sexual" is used in its broadest sense. One of Freud's most important contributions was his observation that man's sexuality is much broader than "genital" sexuality. He came to see that infants and children have a sexual life, qualitatively different than adult sexuality, but a sexuality nevertheless. The love in a family has many aspects and relationships within which to show and express itself. Adult genital sexual love between mates forms the *core* of the healthy family while other healthy sexual/love expressions within the family are also vital, including for example: the ocular contact, eye contact, an infant reaches out for and receives from those around him, as well as the oral contact an infant has with the mother's breast during nursing. In a disturbed family, such *natural needs* and their expression will be inhibited and distorted by the *neurotic needs* of the family members. Such reactions include a mother's or father's intolerance of the child's excitement. This may manifest as an inability to stand the child's shrieks of joy or an intolerance of the excitement between the other parent and the child. This may occur out of jealousy—a spouse interrupts a child's cuddling with the other parent or a father interferes with nursing.

A major impediment to the forthright discussion of these issues is the squeamishness we have about acknowledging the sexual nature of everyday relationships. To overcome this problem, we must first deal with the rational basis for this attitude: the average individual does not make a distinction between primary healthy sexuality in family relationships and secondary, pathological, neurotic sexuality. We are indebted to Reich for making the distinction between the primary healthy and the secondary neurotic drives. The examples above of everyday neurotic family behaviors illustrate one of his conclusions: neurotic family life is found almost universally in our culture.

Development of Theory and Practice

Clinical experience with families, as well as investigation of orgonomic theories about individual and group character (Reich 1946, Reich 1983, Baker, Goldberg), led to the understanding that families form natural energy systems in the *social* realm with the natural healthy function of expression and discharge of *biological* love. In disturbed families, these expressions are blocked from satisfaction with recognizable mechanisms in typical patterns. Such formulations indicate that the underlying basis of any successful family therapy is *biosocial.*[1]

They also have important theoretical and practical implications for understanding family dynamics and for working with families and their individual members. The ability to distinguish healthy features from those that are pathological makes it possible to develop treatment to overcome neurotic patterns and return the family system to its natural functioning.

Suzy, an only child, was four years old when brought to me by her parents. They had read much of the orgonomic literature and wanted to raise her to be perfectly healthy. They told me that she had "trouble with anger and was blocked." They said that she seemed to have trouble expressing herself but was also stubborn and when told to do things, occasionally threw tantrums.

On biophysical examination, she had significant armor in her ocular segment, going "off' in her eyes, staring off or looking at me with no apparent emotional connection. She also had significant armoring in all other segments, but especially in the paraspinal muscles of her neck and back. She was a sensitive child and reacted to anxiety by withdrawing. Her verbal communications were vague and unfocused.

I began by meeting with her for a number of visits, focusing on establishing a relationship and making emotional contact. Soon I felt the need to know more about her emotional environment and recommended to both parents that we meet in order to learn about their life at home. At this first meeting, they were afraid that I would

[1]Here, the "bio" of biosocial refers to bioenergetic, not the biochemical of contemporary psychiatry.

pass judgement on them for not being the perfect "orgonomic" parents. Their shame and guilt at not being ideal parents interfered with their ability to look at the actual situation in the home. Humor and recounting a few of my own experiences and struggles being a parent relieved some of the mystical expectations that they had of me and of themselves. They thought that somehow a knowledge of orgonomy made one capable of raising a perfectly healthy child without problems or struggles in the process. It was apparent from this first meeting with the parents that significant problems interfered with their ability to work together in raising their child. Their alliance as parents was blocked. Specifically, this manifested as divergent attitudes and responses to Suzy's behavior. I realized that the child's confusion and lack of clarity was set off by confusion in the family resulting from the contradictions between her parents. Her stubbornness and refusal to move allowed her time to gain some clarity in a confusing environment. Her negativity was a rational response given her predicament, but it irritated her parents causing each to respond in their own typical fashion.

The mother, raised in a harsh authoritarian family, did not want to treat her own child in the same way and tended to be outwardly lenient about expectations while putting silent pressure on her daughter at the same time. For instance, wanting to avoid compulsory cleanliness, she felt that Suzy didn't have to clean up her room on schedule, but she was silently irritable if Suzy's room was a mess. Suzy's father, on the other hand, had clear expectations, but because of his own inhibitions about asserting himself, said nothing or held back until furious. He then came down on Suzy with a righteous attitude and an intensity out of proportion to the situation. Suzy responded by getting her back up and being stubborn. It made perfect sense that her paraspinal muscles were tense and contracted. The neurotic pattern came full circle when her father, feeling contrite and guilty, tried to be lenient just the way his wife had insisted he be, allowing Suzy to express herself in a stubborn, spiteful manner.

This tense and conflicted home environment reinforced Suzy's tendency to go off in her eyes and to handle the confusion by holding back. Her stubbornness irritated the parents, exaggerating their typical responses in a repetitive cycle. If my treatment of Suzy was to have any lasting effect, I knew there had to be a change in her emotional environment and in the family dynamics.

I was faced with these clinical issues when the biosocial therapy of work groups was being developed by Goldberg (1989-91, 1993). I applied some of his principles to the problems in dealing with Suzy's parents.

My focus was pragmatic: they had trouble *working together* as parents and I, therefore, needed to focus on their relationship. In other words, a recurring pattern in their interaction inhibited genuine contact and communication about how to raise Suzy. We came to see that the mother's tendency to withdraw from involvement and to be lenient with Suzy irritated the father. He responded with short-tempered outbursts triggered by his sense of what was right. This, in turn, made the mother feel even more inhibited about expressing herself. Her lack of response made him angrier still, causing her to retreat even further. In this cycle of withdrawal, anger, further withdrawal, further anger, we could now identify the elements of a dynamic pattern that interfered with their communication. At times, the cycle was temporarily broken when roles were switched: the mother's resentment might build to the point where she finally exploded in fury or the father gave up and withdrew "in a huff." This blew off some steam between them but they soon returned to their usual stance, feeling all the more reluctant to touch explosive issues. In our sessions, we looked nonjudgmentally at their interactions to see how their behavior interfered with contact. The focus was *how* they interacted rather than its *content.*

My interest in work organizations (Goldberg) directed my attention to Reich's formulation of the relationship between work and sexuality (Reich 1976) (Figure 1).

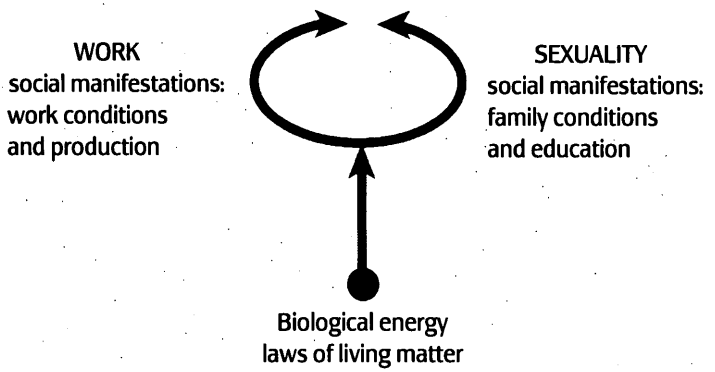

Figure 1

Adapted from Wilhelm Reich. 1976. *People in Trouble.* Farrar, Straus, Giroux, page 71.

As shown, he identified important aspects of the basic difference between work and sexuality. It was the awareness of this differentiation that provided a better understanding of the interaction between Suzy's parents. I was looking at their problem as a block in their parental *working* relationship. However, as this was not a "pure" working relationship, it suggested that their problems had roots in their love relationship. It was clear that there were underlying frustrations in making contact as mates. Although their work together as parents was not the primary function of their relationship, this function was blocked because it became the focus of their underlying love/sexual conflicts. Blocks to the expression of love between parents will interfere with the natural need for them to work together in parenting. Clarification of these different functions led to important developments in the theoretical basis of family therapy.

Another conclusion drawn from the formulation that the natural healthy function of the family is to express and discharge love is that a determination of the level of health in a family is not based on any specific family structure or behavior. At any particular time, each individual within the family system has his or her own needs for the expression of love. In addition, each family has consistent patterns of contact and communication that either support or interfere with adequate discharge of members' needs within and outside the family

system. The relative degree of health or neurosis in any particular social system, as a whole, is determined by the balance between the satisfaction of those needs and the strength of chronic blocks to their satisfaction. This determination must be *functional* and cannot be based on any particular family structure or behavior.

Review of Family Therapy: Traditional Theories and Historical Development

The understanding of the core family function as the biological expression and discharge of love energy distinguishes the biosocial approach from other treatment approaches. It determines the goal of therapy, even if only partially realized, and guides the choice of specific technique from among the myriad which have developed in the field of family therapy. Gurman and Kniskern review in detail the development of family therapy from disparate traditions, disciplines, professions, and movements: social work, social psychiatry, sexology, family life education, marriage counselling, conjoint marital therapy within psychoanalysis, family therapy, and sex therapy (1981). Many treatment approaches have come from these diverse groups but all fall within a useful definition given by Glick:

> Family therapy might broadly be thought of as any type of psychosocial intervention utilizing a conceptual framework that gives primary emphasis to the family system and which, in its therapeutic strategies, aims for an impact on the entire family structure. Thus any psychotherapeutic approach that attempts to understand or to intervene in a family system might fittingly be called "family therapy" (1987).

Lansky summarizes well the major approaches in traditional family therapy showing the broad range of theoretical models and their attendant views of normality, pathology, and goals of therapy (1989).

Distinct Realms of Family and Individual Therapy: Their Differences and Interrelationship

Individual psychiatric orgone therapy focuses on the realm of the individual organism's psychic and emotional bioenergetic functioning

and is *biopsychic* or *bioemotional* therapy. In contrast, as previously stated, biosocial family and couples therapy focuses on the realm of the bioenergetic functioning within the family social system. These distinct realms dictate that the goal of therapy for each will also be different. For individual medical orgone therapy, it is to overcome the individual's chronic armoring; for family therapy, to overcome chronic, rigid, dysfunctional patterns of contact and communication in the family social unit. The distinct realms of individual and social systems are also mutually interrelated (Figure 2). For individual therapy to be most beneficial, it must help the person to be able to discharge energy out into the world in work and love. The individual's therapist cannot overlook social functioning. Likewise, the family therapist cannot overlook individual neurotic character structure when working with a family.

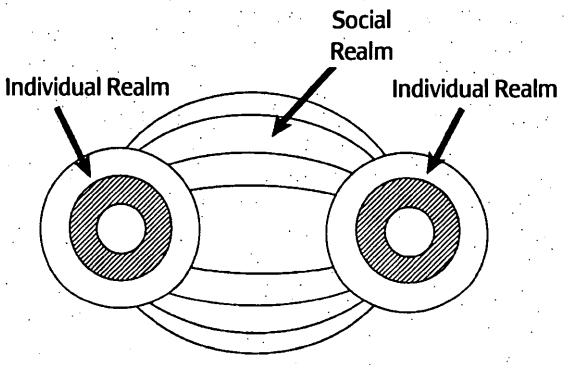

Figure 2

It is essential for the therapist to be clear as to the realm at hand at any particular moment in his work with patients. The task is to be aware of both individual character structure *and* its effects in social relationships. One potential pitfall of individual therapy is that an exclusive focus on internal blocks can result in the patient expressing himself only in the "safety" of the therapy session, with little improvement in his ability to function socially in the rest of his life. Conversely, family therapists who identify pathology as exclusively the result of social system dysfunction commit a (mystical) error in

thinking that denies the obvious fact that the energy source of the health and sickness within a social system resides in the individual and his character. (In the social realm, there are no relationships or blocks without individual characters to manifest them.)

Traditional training in individual psychotherapy teaches that the therapist must not take sides in the patient's neurotic conflicts. While the medical orgone therapist tries to avoid supporting or being partial to any particular side in the patient's *neurotic conflicts* (e.g., ambivalences or doubts), he certainly *does take sides with the health* in the patient by actively supporting and allying himself with it. Likewise, traditional training in family or marital therapy advises against taking sides with any particular member of the family or relationship.[2] The biosocial perspective demands that the family therapist not take sides in the *neurotic* conflicts between family members but *must* ally himself with the health in the *relationships* of the *social system.*

The pervasive moralistic tendency to look for someone to blame sometimes causes a therapist to take sides or to tell a patient, overtly or covertly, that he or she would be better off with a different partner, not adequately taking into account the part the patient himself plays in the neurotic relationship. The desire to take sides stems from an anxious need on the part of the therapist to take *some* action. Or, this tendency is held in check by a therapeutic rule of neutrality so absolute that the therapist may fail to point out any problems. A biosocial perspective that helps identify how the neurotic problems manifest in the relationship also helps the therapist point out who is responsible for each part of a particular neurotic problem at each point in time so that he or she can address them.

Such a perspective also shows us that there are even times when it is necessary and therapeutic to advise a couple to end their relationship. This advice is based on what would most support the love functions of each partner and would not originate from the desire to place blame.

[2]If couple or family therapy is needed for a patient engaged in individual treatment, it is sometimes better that another therapist undertake the marital or family treatment. It is important that both therapists communicate to remain clear about issues that involve transference.

Most people come to therapy with a fear that they will be moralistically judged. Recently, the father of a family I am treating described this quite simply: "I was reluctant to come here because I thought you would have my wife and I each report our problems with one another. I thought you would then point a finger and assign guilt. Instead, you had us look at what was good between us and then tried to see what is blocking us from being that way together now."

A fundamental rule of treatment is to let the problems, capabilities, and needs of the social system and the individuals within it determine what must be done therapeutically. Mechanical approaches with a set procedure are not helpful. For example, even when individuals present with marital problems, couples therapy is not always advisable.

Mr. and Mrs. Smith both came for individual therapy, each presenting with complaints of marital difficulties. The husband had impulsively made a pass at a coworker and felt guilty about this, as well as about a previous affair. The wife felt that they were not communicating well and that his impulsive act might indicate serious problems in the marriage. She had a great deal of unexpressed feeling about his previous affair. They both resisted meeting together, fearing that opening that "can of worms" would blow them apart and destroy their marriage. I believed they were right in having these fears since previous attempts to express these intense emotions led to greater emotional estrangement. At the time, the ability of each to communicate intense feelings, without immediately retreating, was not yet strong enough to allow meeting them together. Working with each one individually helped to significantly strengthen their tolerance for conflict, anger, and anxiety. Due to their inhibitions and the intensity of accumulated resentment, however, they remained both unable and reluctant to work *together* on the marital problems. Their reluctance was further reinforced by mutual concern about their two young children.

There are other instances when both parties are willing to come together, but family therapy is best accomplished by meeting

individually. I saw seven-year-old Billy for therapy because he was "acting out" and inattentive at home and at school. In my first meeting with his parents, it was clear they had difficulty in working together raising their son. Within minutes after sitting down together, they engaged in a screaming match with mutual recrimination about the other's failures in raising Billy. In subsequent meetings, this volatility repeated itself regardless of the subject. I had the impulse to see them separately, but this went against my traditional training that a relationship problem should be treated with the people physically together, if they are amenable. These parents did, in fact, first come to my office together, but after several explosive incidents, the father, a busy executive, could no longer find time for the appointments. I continued to work with the mother individually, focusing on overall family functioning and on ways to handle various family situations in a more effective and satisfying way.

In the case of Billy's parents, talking to each other interfered with their making contact and working on Billy's problems. In order to improve the possibility of the couple making contact with Billy and with each other, it was necessary to have the couple *not* talk with each other in the therapy setting, at that time.

It is the biosocial viewpoint that defines family therapy so that a therapist can work with one individual and still do family therapy. Conversely, it is the perspective of the individual character and armoring that defines individual therapy so that a therapist can do individual therapy using the support, viewpoints, and assistance of people other than the patient. This is often the purpose of conjoint therapy,[3] as described by Karpf (1994).

Communication and Its Disruption

One of the cornerstones of family therapy is to identify and resolve or remove the impediments to communication. In this task, it is important to make the distinction between "self-expression" and "communication." Failure to distinguish between the two is at the root

[3]Conjoint therapy grew out of the psychoanalytic tradition and is a descriptive term meaning meeting together with one or more people related to a patient.

of many of our communication problems. Before our expressions can be the basis of communication, there must be common ground.[4] This requires bioenergetic contact. For the fullest range of communication, a couple must be able to see eye to eye, talk heart to heart, and be mutually excited by physical contact. In fact, blocks in any of these areas of communication must be dealt with in that particular order, just as individual therapy must address internal blocks in systematic fashion. Energetic contact between two people, in each of the areas of communication, is the basis for the "common ground." All too often, one person reacts as if the other thinks and feels as he does. In a situation such as this, substitute contact and the appearance of communication predominate.

Blocks in relationships occur when there are fixed patterns of expression without contact and true communication. Blocks result from expression either being held back or from expressions made without contact. Under these circumstances, communications are incomplete and not satisfying. The chronic *patterns of miscommunication* form the neurotic structure that must be dealt with in marital and family therapy. Such patterns are found in all relationships and result from the difficulty individuals have in finding the common ground necessary for communication.

In working with couples, we find that the very qualities that first excited the partners are usually those, in distorted or exaggerated form, about which they complain and which form an essential part of the dynamic block between them. For example, when Suzy's parents first met, he was attracted to her quiet self assurance and she was attracted to his forthright immediacy. Each time their relationship was troubled, her quiet self assurance became a silent self-righteousness, and his forthright immediacy became a quickness to criticize. These reactions then formed the specific elements of the neurotic cycle of miscommunication and lack of contact: His criticism caused her to retreat into a silent, self-righteous stance which caused him to become more critical, and so forth.

[4]Communication, from its word root, means literally to "hold in common."

Such disturbances in the pleasurable excitement between people underlie the neurotic patterns in relationships. Contact between people raises the level of emotional excitement, whether pleasurable or unpleasurable, and may exceed tolerable intensities. External traumatic events may also stir up stronger emotions than either partner can tolerate. The couple often reduce the emotional intensity by pulling away from each other. Looking for and identifying such energy dynamics must be part of the evaluation of family problems when undertaking family therapy.

Diagnostic Evaluation of Families and Love Relationships

Diagnosis is essential for successful treatment. Diagnostic evaluation of families has been discussed at length in the traditional family therapy literature (Howells), and, therefore, I will focus here on some basic aspects pertinent to the biosocial approach.

Knowing the individual character diagnoses of the members of a family may be helpful in understanding the emotional/energetic tolerances and tendencies of each. However, a *biosocial diagnosis* is based on an understanding of the immediate present behaviors and their energetic *function* within the social system. These are the elements that form the dynamic blocks, as previously described with Suzy's parents.

Initially, several sessions are devoted to evaluating the couple or family. Each person is asked to describe the problems they see, and then to respond to the other's description. This begins the process of gaining perspective by developing a viewpoint of the relationship larger than each individual's own thoughts and feelings and helps identify the role each partner plays in the development of problems. The saying, "It takes two to tango," describes this reality and is vividly portrayed and illustrated by Eileen McCann and Douglas Shannon in *The Two-Step, the Dance Toward Intimacy* (1985).

It is important to identify mutual neurotic patterns, but it is also important to identify the elements of the deeper healthy core of mutual excitement that originally drew the two individuals together.

This is evaluated in the first few sessions by asking each partner to tell about how they met and what excited them about the other at that time. It is this core excitement which stimulates the emotional layers of each individual resulting in a relationship with aspects of three basic types of love: a superficial love including appearance—façade, a neurotic love—secondary layer, and a deep abiding love—core (Figure 3). The presence of core excitement at the beginning does not necessarily mean the relationship can be "saved." Experience suggests that the natural course of some includes dissolution. The magnitude of the neurotic patterns that have developed can so outweigh the core excitement that it may be impossible to recover its initial intensity, or one partner may grow, often through therapy, so that his or her needs can no longer be met.

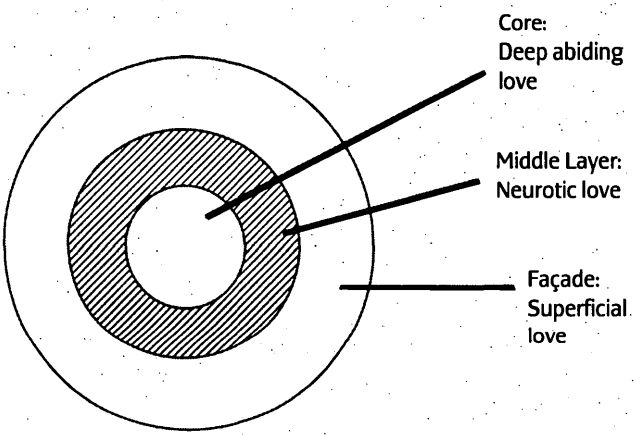

Figure 3

Work with couples has shown that each love relationship has qualities that give it a characteristic stamp. In addition, they can generally be differentiated into one of two types.[5]

One type is quiet and stable, the other is volatile and unstable. This latter type is changeable in its moment-to-moment manifestations, but it may demonstrate a long-standing dynamic instability much as an individual's unsatisfied block is a "stable" instability. Of the cases previously discussed, the quiet type was

[5]These appear to be energetic types within the social realm that are the energetic equivalent of repressed and unsatisfied types of individual characters, as first specifically named by Baker (1967).

illustrated by the Smiths, while Billy's parents are a classic example of the volatile type.

Just as the individual neurotic character isolates the individual from the world, the neurotic family structures isolate the family from the rest of the world. The diagnosis of an individual's character type is essential for the conduct of individual therapy. Can we formulate a character diagnosis of the energy system of the family itself? We know from Goldberg's observations that in the social realm specific biosocial diagnoses can be made of the entire energy system of *work* organizations (1990a, 1990b, 1993). I have the impression that there may be an equivalent range of *family* character types that are identified by the specific way that they isolate themselves from the world, but we do not yet have sufficient observations to identify them all. One example, though, is a family that functions as a unit in a "paranoid" fashion, isolated from the reality of the rest of the world. In such a family, anyone outside the unit is suspect and the behaviors and internal functioning of the family are determined by a need to see the world as a threat. Other examples include rigid authoritarian families or those that are disorganized and permissive. There are also families that are quiet and "repressed," and others that are volatile and "unsatisfied." Everybody has a particular character, one that describes how expressions are handled within and outside the family.

Love and Work in Families

Reich identified love and work as primary life expressions each of which manifest in the social realm. They are discrete, but not rigidly separate, mutually interrelated functions sharing the common principle of bioenergy discharge in the social realm (Figure 4). Every relationship has both work and sexual/love aspects. The energy oscillates between the two with one or the other as the primary basis for any particular relationship. Two basic types of social structure form to support the expression of these functions: business organizations with the primary function of work, and families with the primary function of love (Figure 5). The underlying common principles in the social realm have allowed therapeutic techniques which were

developed to address work organization problems (Goldberg) to be used in families, as mentioned above.

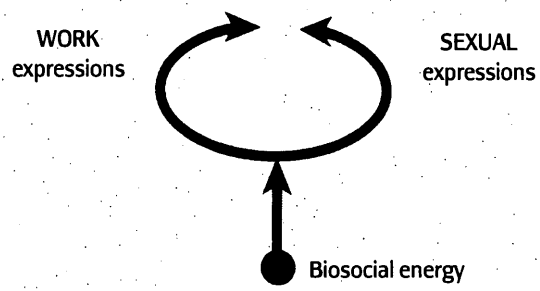

Figure 4

How many find that there is work involved in maintaining a love relationship? Or that there is a special excitement in working with a particular co-worker? In a healthy work organization, the sexuality, broadly defined as the mutual excitement of simply being in contact with another, supports the discharge of the work function. In the healthy family, the work, broadly defined as any effort expended, supports the discharge of the love/sexual function.

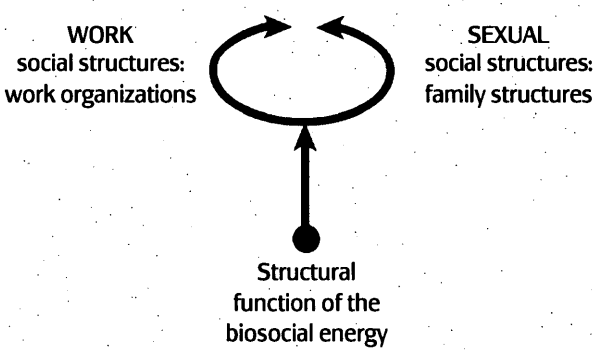

Figure 5

The goal of a work relationship is a product. In a work organization, the best product results from well-focused work in the organization. The goal of a sexual/love relationship is mutual excitement and sexual discharge. In the most obvious sense, a child is

the product of the love between parents. In a family, the best product, a healthy child, results from well-focused love. By well-focused love, we mean that the biological love needs of the child must be clearly seen and met at each stage of development. What meets the needs of the child at one stage of development, may thwart them at another. To successfully raise a child requires flexibility on the part of the parents and an understanding of the various sexual needs within the family.

The Differing Sexual Needs of Family Members

Genital sexual contact between mates supports the core function of the family and is appropriate. Between a parent and child, it is inappropriate and destructive because it creates terrible confusion and fixates the child's sexual excitement and interest on the parent. This inhibits the child's development of sexual independence by interfering with finding sexual satisfaction outside the family, and, thus, severely undermines the long-term function of the family. The sexual needs of the child at each stage of development—ocular, oral, anal, phallic, and genital—must be met in a manner that is appropriate for the child's age and level of development. It is appropriate for an infant to have oral contact with his mother's breast, but inappropriate for a grown child to do so. Given the world-wide patriarchal culture we live in, it is often necessary for the child to repress genital sexual impulses until he or she is able to find a socially appropriate outlet. The desire to allow children inappropriate sexual "freedom" is often the result of misinterpreting orgonomic knowledge.

I began seeing Ann at age two-and-a-half years because her parents thought she should be evaluated by an orgonomist, although they were not sure there was anything wrong. She was lively and a bit of a tiger. I detected some oral holding and a subtle tendency to go off in her eyes. It was necessary to see her only every four to six months. I worked on her jaw which allowed her to discharge significant rage and sadness resulting in her being more emotionally present, calmer, and more open to soft, warm contact with her parents. At age four,

however, her parents expressed concern because she had become sexually provocative with her father. She occasionally came up to him and rubbed her genital against him while he was sitting on the sofa. They wanted to raise a "healthy child" and, although both were uncomfortable with Ann's behavior, they were reluctant to stop it because they "did not want to repress her sexually." Through discussion, it became clear that, in general, she failed to make eye contact or say directly that she wanted her father's attention. In response to her sexual behavior, he tried to act as if everything was fine, but it made him intensely uncomfortable which she apparently sensed. I urged the father to gently tell Ann to stop rubbing against him and to encourage her to make eye contact and speak up for what she wanted. I reassured the parents that this gentle repression of her genital impulses was necessary. When the father handled Ann's sexual behavior in this way, it quickly stopped. She calmed down and became more focused in general and was able to look at her father and engage him in a range of everyday play activities by saying, "Watch me do this, Daddy."

With Ann, her inability to make ocular contact and to speak up for herself needed to be addressed and alleviated. This case demonstrates that genital excitation can lead to confusion and chaos unless sexual impulses from segments other than the genital (ocular contact, oral expression, heartfelt feelings, etc.) are adequately expressed and integrated. It also shows the importance of keeping in mind the long-term needs of the child in making decisions about handling children's behavior within the family. In this case, genital repression, which might be viewed negatively, was necessary in the short-run in order to help the child's ocular integration and to support the long-term development of her sexual independence without genital fixation on her father.

Positions, Roles and Functions Within Families

Within families, just as in work organizations, individuals have one or more positions, roles, and functions. Traditional family therapy (in

particular, the structural model) discusses positions and roles in the family. An understanding of the underlying energy functions, however, allows us to put the roles and positions in perspective.

The positions in a family are mostly superficial and are clearly defined: father, mother, only child, oldest child, middle child, youngest child, grandmother, etc. Each of these positions may have many different roles which will discharge various core energy functions. These roles can serve neurotic or healthy energetic functions defined by how the role is used and not by the role itself. For example, a father may have the role of disciplinarian. As disciplinarian, he could punish his five-year-old daughter for engaging in sexual play with the five-year-old boy next door. The energetic consequence may be fixation of the daughter's sexual interest on the father and inhibition of her reaching out into the world in an age-appropriate way. On the other hand, a father could discipline his jealous five-year-old daughter to prevent her from interfering with her baby brother nursing at the mother's breast. In this case, as disciplinarian, he serves rational healthy functions by insuring that the oral love needs of the baby are met and that the daughter is prevented from the neurotic discharge of energy in destructive acting out.

The appropriate healthy roles for a particular position are generally not fixed and change over time. For example, the role of the mother must be different with an infant than it is with a teenager. When he is five, the role of a child in relation to his parents will be very different than when he is grown and has children of his own. Understanding the underlying energetic basis of the healthy family system means that the various roles can be defined in terms of how these functions are discharged. Each position can then be evaluated as to how well the individual discharges his role (bioenergetically). The wide range of neurotic problems is evidence of the failure to change roles over time. A grown man may be a "mama's boy" or a grown woman may be "daddy's little girl."

Neurotic family situations are also characterized by confusion in positions, roles, and functions. For example, in our modern permissive

social environment, a child is often allowed or encouraged to either take on parental roles or those that are discordant with his rational function in the family. This confusion of positions and roles is an increasing problem in our society. In many ways, parents are abdicating the rational roles of their parental positions (i.e., trying to be "buddies" to their children). This creates confusion, anxiety, and stasis in the family system. The rational family function of the parent is delegated to other organizations such as the schools. Teachers are forced to become surrogate parents which, in turn, interferes with their rational work function of teaching. One of the features of a successful family therapy process is that each member of the family assumes or reassumes the roles appropriate to his positions within the family in ways that discharge the underlying sexual/love impulses appropriate to that position.

One family I worked with consisted of father, mother, four-year-old girl, and 17-month-old boy. The parents were having trouble making contact with each other, which included overt sexual difficulties. Each was frustrated with the other. On occasion, this erupted as bickering or with the wife expressing anger and the husband retreating into defensive angry silence. They were both often overwhelmed with "trying to give both children the love and contact they need." Difficulties intensified after their son was about a year old. The parents' interactions followed a pattern in which the wife responded to anxiety by "coming on strong" verbally, her husband then withdrew into quiet contemplation, causing the wife to come on even stronger, and the husband to withdraw even more. The four-year-old daughter was a sweet, sensitive, feminine, caring child. The 17-month-old boy was a live wire who came on like a Mack truck—getting into everything. The daughter was often asked by the parents to watch out for him and frequently took that responsibility upon herself without having been asked. The parents reported that when they fought, the daughter often stood between them trying to stop the fighting.

My work with this family included a series of individual sessions with the wife, which led to couples sessions, some individual sessions

with the husband, and finally, a brief series of individual sessions with each child. After approximately a year-and-a-half, both parents reported that things were better between them and at home: "There is a lot more love in the house." At this point, the daughter had several episodes of rage especially directed at the mother. The parents were puzzled because everything seemed to be going so well and they couldn't find anything that was upsetting her.

I felt that the situation reflected a shift in the dynamics of the entire family. The daughter had previously taken on (and had been supported in) an almost adult role of caretaker for her brother, but more significantly, she had the role of peacemaker in the family. As the parents were more able to express their anger with each other, to resolve the conflicts between them, and to genuinely relate more out of their love for each other, she no longer had to maintain the peacemaker role and *could finally express her own rage at being in a role that was not rationally hers.* My assessment of the situation rang true to the parents. It helped them to accept and tolerate the entire range of emotions in the family, including rage. It also helped them to face an unrealistic, all-encompassing family attitude that everything had to be "loving," with no fear or rage. Awareness of this "loving" attitude expectation helped them acknowledge underlying anxiety and frustration in the family. This acknowledgement gave them temporary relief, which allowed underlying deeper feelings of love to emerge. More importantly though, it opened an avenue to face the problems in the family and to find more satisfying solutions to them.

Comparison of Neurotic and Healthy Family Functions

No family is perfectly healthy or ideal. Given our social structure, most are examples of the Oedipal family. Its essence is the fixation of the child's genital sexual needs on the parent of the opposite sex. This occurs and is possible because the child's satisfactory genital play with an age-appropriate playmate is usually discouraged or prevented. This outlet is certainly not something for which most parents and society are ready.

We must recall that natural healthy structures and relationships, positions, roles, and functions cannot be clearly defined because they have not yet been adequately studied. Some of the research of anthropologists, however, may give us some clues. The natural core of the family is mother-centered. This is clearly supported by the anthropological evidence from cultures with little neurosis such as the Trobriand Islanders studied by Bronislaw Malinowski (1929). That human families are mother-centered at the core, regardless of the neurotic character that overlays it, is shown in the deep truths revealed in the humor, jokes, and clichés about mothers of virtually all ethnicities.

Figure 6 diagrammatically shows that the natural core of the human family is mother-centered (matrist). The expression of this natural core is typically inhibited and/or suppressed by a harsh patriarchy. Over this, any number of façades are possible. These may include a thin veneer which is little more than a direct expression of the brutal patriarchy, or a reactive, father-centered façade of chivalry, or a reactive, harsh, mother-centered façade of matriarchy or feminism.

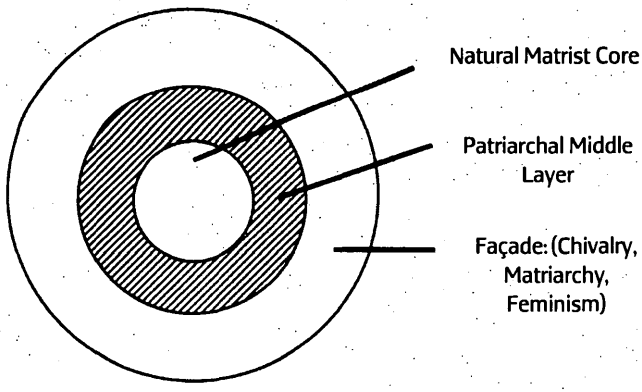

Figure 6

Some of the family functions and, therefore, roles are defined by biology. The infant's oral sexual love needs can only be fully met through nursing, a function that can be discharged only by the

mother. This is a biological reality true of all mammals. The basic social unit of all highly social mammals is mother-centered. This is true for a wide range of species from chimpanzees to whales to elephants. Humans are animals in which the female not only gives birth, but also provides, through nursing, the major psychosexual contact for the first year of development. This biological fact defines certain functions for male and female. When social roles and the individuals in them allow for the full and direct discharge of the energy of biological functions, healthy energy metabolism in the system is ensured.

The Basic Orgone Energy Function of Spontaneous Movement at Work in Family Therapy

One intrinsic characteristic of orgone energy is spontaneous movement. Unlike a machine, it does not need to be *made* to move. A family also does not need to be made to move and change. Both respond in a similar fashion if blocks to movement are removed. Like a log jam, which cannot be pushed, removal of a key block allows the rest to move on their own. Many aspects of the social realm are often much more fluid than the individual psychic or somatic realms. For this reason, very little intervention may produce significant movement in a relationship or family system.

The Social Realm Can Be the Locus of Neurosis

Sometimes, therapists who have referred couples to me report that after only a relatively few sessions in couple or family therapy, patients have made sudden surprising progress in their individual treatment. Often, it is those patients who have already been doing well and progressing steadily. Such reports have reconfirmed the impression that a tremendous amount of energy can be tied up in a person's relationships. This energy is discharged in fruitless, unsatisfying expressions and is unavailable for satisfying pleasurable experiences.

An individual in orgone therapy may have largely overcome his internal blocks to energy movement, but until he unravels the neurotic fabric of his everyday love and work relationships, he cannot

make full use of the progress he has made. It appears that at times the person's relationships are, in fact, the major locus of his or her neurosis. Acted out in this way, the patient's neurotic problems may be, to a greater or lesser degree, inaccessible to treatment in individual therapy. It is a common mechano-mystical idea that the patient becomes well "magically" by the removal of armor. Simultaneous awareness of the internal biopathic structure of man and his neurotic social environment provides the perspective required to help him out of the emotional trap so vividly described by Wilhelm Reich and Elsworth Baker.

Conclusion

Families are social energy systems formed around the biological, sexual love function. This biosocial basis of families and the treatment of their problems is the central understanding presented here. It provides avenues to explore families in health and tools for treating them in sickness. The implications for this work are broad, but most importantly, it helps support the deepest love between a man and a woman so that there is an environment in which the children of the present and of the future can thrive.

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