Orgone Therapy: The Application of Functional Thinking in Medical Practice Part XVI: Children and Adolescents

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Children

> If the rigid armoring of the human animal is the basic common principle of all his emotional misery; if it is this armoring which puts him, alone among biological species, beyond the pale of natural functioning, then it follows logically that prevention of rigid armoring is the main and central goal of preventive mental hygiene.
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> Wilhelm Reich (1:16)

There are two aspects of orgonomic neonatology, perinatology, and pediatrics that are essential elements in the training of every medical orgonomist. These are:

- the study of unarmored infants, children, and adolescents including an understanding of the prevention of armoring in the newborn and
- an understanding of the biopathic child including the removal of armor inchildren and adolescents.

Little is known of unarmored humans primarily because conditions in our society make raising healthy children almost impossible. Also, because of structural limitations it is simply not possible for armored human beings to arrive at an accurate understanding of the healthy, unarmored human organism. In contrast, from outside the narrow armored perspective, Reich saw that the newborn child is, first of all, an orgonotic system, a bit of living nature governed by certain bioenergetic laws, and that

social conditions interfere with the lawful processes intrinsic to the development of the healthy child. Armoring of young life and its deleterious, far-reaching consequences for the individual and for society is the result of this interference.

Prevention of chronic armoring is the central goal of orgonomic mental hygiene. Orgone therapy of children and adolescents is thus an essential part of the training of every medical orgonomist. Not only are the manifestations of armor far easier to recognize in children but armor removal is more readily accomplished than in adults. This occurs because in the young child armor has not yet become rigidly fixed. Also, ideation and its defensive function is not fully developed. Hence, ocular armor is not as entrenched as in the adult. Finally, since genitality is not established until the child is about four or five years of age, the goal of treatment is the elimination of any obstacle interfering with natural development toward full genitality. These distinctions notwithstanding, orgone therapy of children is fundamentally no different than that of adults—the removal of armor with the establishment of spontaneous movement. Since character formation is usually not completed until after the oedipal period, removal of armor is almost entirely through somatic interventions rather than through character-analysis.[1] The medical orgonomist, with a history of how the child has functioned and with the findings of the biophysical examination, perceives the overall biophysical picture and focuses therapeutic intervention on the segment containing the major armor.[2] Frequently, the beneficial results are as rapid as they are dramatic.

[1]After the oedipal phase, the character assumes increasing importance in therapy. However, in the rare instance when a child's muscular armor is extreme, character armor may be fully functional before the oedipal phase.

[2]In contrast, traditional child psychiatry, until recently, has relied almost exclusively on a psychological approach to the diagnosis and treatment of childhood and adolescent disorders. With the limitation of this approach, especially in the disorders having their origins during the first year of life before consciousness and language have fully developed, and with no apparent alternative available, the psychiatrist has been increasingly drawn into the pharmacological treatment of childhood disorders.

The precursors of the adult character are found in the typical behaviors of children. Since the young child is in a phase of rapid development, maturational disturbances such as eneuresis, speech and language disorders, and learning disabilities are also encountered. These are often the presenting symptoms when children and adolescents come for therapy. In order to know how to proceed, the medical orgonomist must correctly evaluate the function of childhood behavioral and developmental abnormalities. Because these problems arise or develop within the family milieu, a precise understanding of the child's relationship to the various family members, especially the parents, and his level of development, is essential. This understanding is based in part on a knowledge of the determinants of character formation[3] and of other factors that produce armor in non-erogenous segments.

In evaluating these factors, the therapist determines whether it is the child, the parent(s), or both the child and parent(s) who require treatment. In some cases, the child is accepted for therapy and the parents' contribution to the problem is dealt with by superficial counseling. In other cases, where the parents' involvement in the child's problem is deep-seated, it may be advisable for one or both parents to enter therapy with or without therapy for the child. Sometimes the parents' presentation of the child for therapy is a defensive maneuver on their part, a disguised indication that the parent (or parents) and not the child, needs help. For this reason, the motivation(s) of the parent(s) for bringing the child to therapy must be clearly understood.

Once the child is in therapy, behavioral manifestations may extend to the acting out of conflicts either in relationship to the therapist alone or to both the therapist and the parents. The significance of this behavior must be correctly understood.

There are several other differences which distinguish the orgone therapy of children from that of adults. The child, because of his immaturity, is not expected to be responsible for being in therapy,

[3]Character formation involves armoring of the erogenous zones as discussed in Orgone Therapy: Part V, *Journal of Orgonomy*, 21 (2):223–236, 1987.

in contrast to the adult who has to first commit to the therapeutic process. The presentation of the infant or child for ongoing treatment is the responsibility of the parent. This is another reason that the motivations of the parent(s) for bringing the child to therapy must be clearly understood. Also, because of the child'scontinuous relationship with the parents, essential in the child's development, the transference is not always a major aspect of therapy. As in the case of adults, transference situations may arise when the child's feelings toward a parent or therapist are blocked.

Finally, even though character structure is formed, an accurate diagnosis may be difficult to make because the child's pathology is being manifested behaviorally. In contrast to the orgone therapy of adults, this is not a major therapeutic impediment.

Instead, the therapist is guided by the child's surface behavior manifestations and also by the location and severity of somatic armor. To the well-trained medical orgonomist these signs and symptoms are sufficient to guide the course of therapy.

The Development of Armor in Children

From a functional (energetic) perspective, the infant or child is an expanding orgonotic system undergoing rapid growth and development. Environmental disturbances of this system can occur at any time. The earlier the disturbance, the more profound are its effects. The child's development can be divided into four periods: prenatal, birth, postnatal (up to about age five or six years), and finally, puberty and adolescence. At each period, disturbances can be divided according to whether they arise from the parents, from other exogenous sources, or from a combination of the two.

Prenatal Period

From the moment of conception, the maternal organism undergoes profound biophysical expansion with swelling and orgonotic charging of the tissues. In the human this lasts nine months and prepares for the hours-long birth process, the convulsive (discharge and relaxation) phase of the pulsatory cycle. Thus gestation and

birth are simply two component functions of the pulsatory cycle of expansion and convulsion. In this cycle the single-celled fertilized ovum develops into a highly organized metazoal system by the time of birth. Within this single cycle there are myriad other cycles of shorter duration which govern fetal development both in terms of specialization of function and growth. At birth, the unarmored infant is ready to begin its independent life while still dependent on orgonotic contact with the mother for optimal further development.

Genetic dysfunction reflects a disturbance in the expansive phase early in the pulsatory cycle and results in spontaneous abortion when vital functions are adversely affected during the first trimester. The deleterious, irreversible effects on the developing fetus of alcohol, nicotine, and other drugs ingested by the expectant mother are well-known.

Not so well understood, however, are the effects of a severely contracted armored maternal uterus on fetal pulsation. By impeding pulsation, and hence the growth and development of the fertilized ovum and fetus, this factor can account for the transmission of armor from parent to offspring at any time during gestation. Similarly, since disturbances in genetic functioning are inseparable from the pulsatory function ofcell division, the damaging effects of a contracted uterus can produce a profound delay in, or even an arrest of, fetal development. This accounts for a weakening of the fetal biosystem which may give rise to genetic malformations. This subject will be further elaborated on when the genetic function is discussed in greater detail. Disturbances in uterine pulsation also give rise to specific pulsatory disturbances in the fetus.

Irregularities in fetal respiratory movements, for example, are frequently observed on sonographic examination during the last trimester. This may be evidence of fetal thoracic or diaphragmatic armor and that the process of armor formation occurs in utero.[4]

[4]Some fetuses become agitated during ultrasonography. It is possible that the testing procedure itself is responsible for the respiratory disturbances observed. This observation, therefore, requires further investigation.

Birth

Severe labor pains interrupting the birth of the fetus arise from a disturbance in the convulsive phase of the pulsatory cycle and are a manifestation of pelvic armor. In their origin, they are related to menstrual cramps. Both are a result of intense energetic expansion (with the expulsion of pelvic contents) in the presence of chronic pelvic armor.[5] The organism is stuck in a state of mechanical swelling and energetic charge.

From this energetic perspective, adequate preparation of the mother for delivery attempts to maintain unhindered orgonotic pulsation, contact with herself, and contact with the fetus as much as her bio-physical structure permits. In the ideal situation the mother has little or no armor and there are no external impediments to the process of labor. At the other extreme the mother is so heavily armored in the pelvis or out of touch with somatic sensations that vaginal delivery is contraindicated. Most women are found somewhere in between these two extremes.

Pulsatory disturbances occurring during labor result from the continuing effects of the chronically contracted uterus. The effect of maternal pelvic armor on the fetus is the same throughout all stages of gestation: fetal development is impeded with deposition of armor either in acute or chronic form. It is logical to assume that armoring in the newborn occurs more readily in those segments that are biologically vulnerable. This is the "genetic" factor which consists of a weakening of the fetal pulsatory function at an earlier stage of development.[6]

During the birth process the destructive traumatizing effects of cold inhospitable labor and delivery rooms, the mechanical, impersonal treatment of mother and newborn by the hospital staff,

[5]Chronic pelvic armor must be distinguished from physical inadequacy of the mother's pelvic outlet (cephalo-pelvic disproportion) which is an anatomic (skeletal) limitation to vaginal delivery.

[6]The armored physician and scientist, thinking mechanistically, are structurally unable to recognize and understand the bioenergetic nature of life, and closely related to it, the etiology of human illness in the blocking of energy flow by armor starting in infancy and childhood.

the fluorescent lights and harsh sounds are added to the harmful effects of maternal armor to further damage the newborn. Even the "advances" of modern medicine, such as fetal monitoring and intravenous Pitocin to induce labor, interfere with the natural process of labor and delivery and are associated with higher rates of birth by Cesarean section. Additional damaging trauma comes in the form of isolation of the newborn from the mother, swaddling, constant exposure to harsh fluorescent lighting in the nursery, and circumcision of infant boys. All of these practices are rationalized as being for "the good" of the newborn. Is it any wonder that with this machine-like treatment at the earliest stage of postnatal life many children grow up far short of their biological, emotional potential, and are often described as hyper- or hypoactive, "wired," or unfocused?

Postnatal Period to Age Six

Although Reich formulated his understanding of character formation and its determinants during his psychoanalytic period when the existence of biological orgone energy was unknown, this understanding remains just as valid today. Reich's thinking in functional energetic terms enabled him to understand the dynamics of character formation even before the specific bioenergetic functions underlying them were discovered.

Educating parents and mental health professionals in the fundamentals of orgonomic knowledge can help prevent armoring in infancy and childhood if there is sufficient health in the adult to allow for perception of the significance of these concepts.

At no other time are the biological needs of the infant so inadequately met as at the time of birth. The harsh, inhumane treatment that the newborn experiences goes almost universally unnoticed. Because of their own armor, adults involved in the care of the newborn have no sense of their destructive behaviors. This obliviousness is caused by their own armored character structure and is the physical basis for the transmission of armor from one generation to the next.

The newborn's response to this harsh welcome is to protect itself. Since the solar plexus is the biological core, the organism's

first defense is to inhibit energy flow (emotion) by armoring in the diaphragm. It then armors in the ocular segment against the painful perception of the external world. These defensive maneuvers are just the beginning of a systematic armoring process experienced by virtually every infant. The interruption in ocular development interferes with the child's (and the later adult's) ability to see the world in an undistorted manner and to make rational life decisions. It is also the basis for every kind of political irrationalism.

Deprivation of satisfaction in breast-feeding due to an energetically unresponsive maternal nipple or excessive breast-feeding in an at-tempt to find satisfaction both result in oral armor which manifests in later life in such symptoms as depression, helplessness, mood swings, etc. Another biophysical consequence of disturbed breast- feeding is armoring of the head and neck which gives rise to poor eye-hand–neck coordination, speech disorders of various kinds including stuttering, mutism and laconic speech, eating disturbances, fear of or aversion to kissing, hysterical vomiting, etc.

Somatic manifestations include a predisposition to allergies, weakening of the immunefunction, obesity, malnourishment, etc.

The single most important change in child care that would lead, in one stroke, to a generalized reduction of armor in the human race is to provide for and protect uninterrupted orgonotic contact between mother and infant. By allowing the two energy systems to remain united after birth, as they were during pregnancy, orgonotic contact, the most essential experiential and emotional element in the interrelationship between mother and child, is preserved (1). Practically speaking, this means not only that the infant not be separated from the mother, but that both are allowed the opportunity to make uninterrupted contact with each other in a safe, secure, privacy-ensured environment.

Oral contact with the mother, including breast-feeding, enables the postnatal integration process to continue without interruption. Of course, the mother must be sufficiently contactful herself and emotionally capable of providing for these needs. This prerequisite

for infant and child well-being raises the important but still largely ignored question of maternal responsibility and biophysical health.

In healthy development the young child passes directly from the oral to the genital stage. The anal stage, its characteristics and symptoms, is thus an artifact of our armored society. It is a result of the mother exerting excessive control over the infant and young child, preventing development according to the youngster's own needs.

Usually, maternal control is not centered exclusively around toilet training, but is more ubiquitous and involves many areas in the life of the developing child (e.g., interference with impulses to become more independent, etc.). The end result is a clinging child, afraid of independence, whose impulses to reach out to the world are more or less profoundly inhibited.

Between the ages of about four to six, biophysical integration has progressed to the point that much of the several components of the young organism function as an integrated whole. Now energy begins to concentrate in the genital giving rise to the first puberty. Psychoanalysis refers to this period as the oedipal phase and incorrectly believes that the genital sexual conflict between the child and the parent of the opposite sex is an inborn tendency. This misconception arises because no distinction is made between healthy and neurotic child development. If the child's earlier development and sexuality are allowed expression unhampered by social (parental) prohibition, the oedipal conflict, a result of the blocking and displacement of the child's sexual feelings onto the parent of the opposite sex, does not occur. Rather, sexual interest and focus is directed appropriately to the child's own peer group and genital primacy is soon established. Frustration of these impulses at the time of the first puberty leads to disturbances related to this period—most commonly, the formation of a phallic character structure in boys and a hysterical character structure in girls, a direct result of the oedipal conflict.

The phallic phase is thus another consequence of our armored civilization caused by a thwarting of the child's genital impulses. These genital impulses turn into an urge for revenge, first against the parent and then against all members of the opposite sex.

Concurrently, the child assumes an attitude of subservience toward authority figures of the same sex.

A common child rearing problem originates from uncertainty or confusion regarding the degree to which a given impulse of the infant or child requires gratification. This is the determinant of character formation that Reich called the ratio between gratification and frustration of an impulse. If little or no gratification of an erogenous impulse is allowed for at a particular psychosexual stage of development, then the child develops a severe block in that zone and marked repression is the result. A severe block at the oral stage, for example, leads to an inhibition of oral function with symptoms such as poor eating habits, laconic or under-productive speech, depression, etc. If, on the other hand, impulses are first allowed satisfaction and then undergo blocking, the child is left chronically unsatisfied and strives constantly for satisfaction. In the case of the oral stage, for example, this situation gives rise to overeating, overtalking, etc.

Emotional problems, whether of the repressed or the unsatisfied type, arise because the mother is not in sufficient enough contact with both herself and her child to perceive ("sense") when the child needs satisfaction or has had enough. Questions such as the following are unanswerable even for well-meaning parents because of their own armored structures. When should the mother stop breast-feeding? When should she allow someone else to substitute for her so she can begin to resume living her own life and, by so doing, provide the opportunity for the young child to attain a sense of independence from her? How appropriate is parental nudity in front of the child? How much exhibitionism of the child is natural and when does it become neurotically excessive? To what degree and when is discussion of sexual matters with children necessary?

The answer to questions such as these depends as much on the ability to recognize the quality of the child's needs as on their degree. In our society's present state of overexpansive breakdown, parents tend to err on the side of being too indulgent, which is out of touch with the child's real needs. The end result is an individual with an unsatisfied character structure. Problems that

are caused by excessive, contactless impulse gratification of the child and adolescent include whining, bratty, rebellious, self-centered, "spoiled," demanding attitudes and behaviors, excessive preoccupation with the physical and with material possessions, lack of genuine respect and gratitude for parents and other adults who protect and educate, and lack of a sense of loyalty to rational authority.

To further complicate matters parents actively interfere with the child's growth and development. Spontaneity, natural reactions and sociability fall prey to adult neurotic needs and expectations as the child's "socialization" includes learning mechanical social behaviors and being rewarded for cuteness, "good" behavior, etc. Children also become objects of the parents' secondary, neurotic impulses and needs when they are inappropriately exposed to various aspects of adult life. As a result, children are left anxious, confused, and, in the least, resentful of their parents. Out of touch with their own vital needs and avoidant of painful feelings, some children seek distraction through any form of external stimulation or contactless activity. These behaviors, unmanageable by many of today's parents and educators, are often "overlooked," helplessly ignored, excused, or tolerated as "normal." These childhood and adolescent behavioral disorders, the precursors of adult unsatisfied character pathology, are becoming increasingly more common.

A frequently overlooked source of frustration for the child occurs when its special, innate abilities are not recognized and nurtured by the parents. This often leads to a disturbance in the individual's work function in later life.

Within the context of medical orgonomic understanding, both the parents and the child need to be included in the process of therapy to resolve these problems.

Armoring in a Newborn

This case illustrates the importance of early therapeutic intervention in the removal of armor as well as the effects on the fetus of acute, violent, Pitocin-induced uterine contractions.

Case Presentation

This five-week-old boy was brought to therapy by his thirty-nine-year-old mother because of postpartum difficulties following a precipitous Pitocin-induced delivery.

Pregnancy

The mother became pregnant while still nursing her first child who was five months old. She continued nursing until her fifth month of pregnancy when her obstetrician told her that this could bring about uterine contractions. Her second pregnancy was uneventful but more stressful than the first because the older child still demanded a great deal of attention.

Labor and Delivery

Prior to birth, a small leak of amniotic fluid was noticed by the mother. Her obstetrician confirmed the presence of the leak although a sonogram showed adequate fluid and an apparently healthy fetus. He suggested hospital admission for immediate induction of labor because waiting longer than forty-eight hours carried the increasing risk of amniotic infection, a danger to the baby. The parents were torn between wanting a natural delivery and knowing the consequences of waiting. Hospital admission was decided upon since waiting would only increase the mother's anxiety, which might be more harmful to the baby than induction of labor.

On admission, no active labor or infection was present, but the volume of amniotic fluid was decreased. An intravenous Pitocin drip was started. Intense painful contractions ensued which the mother experienced as hard and unnatural. The fetal monitor began showing deceleration of the baby's heartbeat and an oxygen mask was placed on the mother which increased her terror. To stop the decelerations the obstetrician ordered a saline solution infused into the amniotic sac to replace the lost fluid and "float" the fetus off the umbilical cord. The infusion helped, the contractions increased in frequency, but the pain became unbearable. The extreme fear and the intense pain made it difficult for the mother to maintain contact. Epidural

anesthesia was administered and the pain was relieved. However, all sensation was stopped. Labor progressed rapidly with the birth of the infant soon after.

Post-Partum Course

At birth, the baby had an expression of worry and fear on his face. In fact, he appeared terrified. His forehead had many deep horizontal furrows and his skin was red. In the delivery room he took to the breast after a few moments, but he did more hard biting than sucking. After nursing in the delivery room, the baby was separated from the mother for about one hour. His skin remained hyperemic and the look of fear and worry persisted. His cry was loud and open, but his eyes were out of contact. His respirations were deep but frequently held in inspiration. Movement was decreased. When he cried the lower half of his body looked mottled and felt cool to the touch. These signs indicated that the infant was in a state of severe biophysical contraction (sympatheticotonia).

Alternate breast and bottle feedings were used for the first two to three days. He continued to bite down hard while nursing and seemed to do better with bottle feeding. While attempting to nurse, the mother could feel only limited contact with the baby: holding him en face, the baby focused his eyes just above the face of the observer and tried to push away with his legs. This response continued for many weeks after birth.

Nursing was stopped after four days, but he fed well with bottles and slept soundly. He was quiet and withdrawn most of the time. When it appeared he wanted contact, he cried loudly. When held closely he avoided contact straightening his legs and tightening his buttocks, as if trying to stand. He held continually and strongly in his buttocks, legs, and calves.

Course of Therapy

When first seen he looked like a "little old man."[7] His eyes were brightened and averted upward. His buttocks and legs were in

[7]The look of the "little old man" in infants is a sign of severe biophysical contraction.

severe spasm. I gently massaged his legs and buttocks. He was seen over a period of five months, and gradually the musculature of the lower extremities softened. He stopped avoiding my gaze and I had the impression that he not only recognized me but was happy to see me. I instructed the parents to gently massage the legs on a regular basis. He became more lively and lost his "little old man" look. As he began to crawl his lower extremities softened further. By six months of age he could make good eye contact and enjoyed being held. He appeared bright and happy. Gradually, his underlying aggression surfaced and he was nicknamed "cannonball" because of his determined and basically aggressive nature.

Orgonotic contact between mother and infant increased. He has continued to soften generally and develop normally.

Puberty and Adolescence

Adolescence begins with the sexual push of puberty and ends with the final solidification of the character and personality around the beginning of the third decade. It is the stormiest period of an individual's life. Sexual desire and longing are at their peak. The sexual push of the second puberty may intensify earlier conflicts with the parents and is responsible for the contradictory behavior so often seen in adolescents. On the one hand, they are in open rebellion against authority and, on the other, they crave authority, conformity, and social acceptance. These behavioral tendencies, in an alternating manner, are a direct manifestation of opposing forces in the armor of adolescents that have not become fully structuralized.

The breakdown of social structure, starting around 1960, has had disastrous effects on the ability of adolescents to cope with the sexual push of puberty. In the past, armor bound energy that wasn't discharged sexually. With the reduction in social structure, however, the anxiety of many adolescents has escalated to levels that are intolerable for the individual. This is the major reason for the rise in adolescent drug use, indiscriminate sexual activity, and suicide.

The ability of the adolescent to handle the increase in sexual sensations is dependent on how prepared they are to experience

and tolerate their sexual feelings at earlier stages of development. Children whose environment includes natural expressions of love, where sexuality is affirmed by parents and surrogate parents, have an easier time tolerating their sexual feelings when they reach adolescence. Conversely, children whose environment includes either repressed, ignored, or distorted sexuality have a more difficult time.

How the individual breaks down depends on where earlier blocks occurred in childhood and on the type of armor that was formed. Based on the determinants of armor formation, several outcomes are possible:

Symptom formation with regression to an earlier stage of psychosexual development. Regression to the ocular stage results in excessive fantasizing and learning disturbances. Oral regression may give rise to anorexia or bulimia, etc. Anal regression contributes to adolescent defiance and uncooperativeness with a tendency to tantrums or outbursts of rage. Phobias arise as a result of genital fears. These symptoms are a manifestation of energy being blocked by the armor and pressing for discharge. The block prevents the energy from being discharged in a natural manner. At the same time, these symptoms serve the function of keeping sexual impulses in check.

Symptomatic Behavior

The adolescent's contradictory behavior previously mentioned is the manner in which the blocked sexual energy is partially discharged. Some forms of behavioral contradiction follow. On the one hand, the adolescent is egotistical and self-centered and, on the other, capable of selflessness and great self-sacrifice. The adolescent may suddenly fall turbulently in love and just as quickly lose all interest in the love object.

There may be alternating periods of strict asceticism and unrestrained impulsivity. At certain times, social behavior and interactions may be rude and inconsiderate and at other times. highly sensitive. Intense erotic feelings may oscillate with strong sexual moralism (2:36-44).

If the adolescent does not have a heterosexual outlet, the only possibility for relief of sexual tension is through masturbation. The degree to which sexual satisfaction cannot be obtained determines the degree to which the adolescent is driven to desperate measures in an attempt to obtain relief from intolerable inner tension. In extreme cases, where there is no chance of either satisfying or curbing sexual impulses, the adolescent has little choice but drug abuse, delinquency, homosexuality, or suicide.

Of all the reasons given for why adolescents "go wrong," no one dares mention their genital frustration, even in our age of sexual enlightenment. Furthermore, any discussion of the adolescent problem is complicated by confusing the secondary, destructive drives which lead to drug abuse, homosexuality, promiscuity, etc. with the primary drives which lead to genital union and sexual gratification with a partner of the opposite sex. As always, confusing primary and secondary drives not only evades the essential problem and effectively obstructs arriving at a rational solution to social problems, but often leads to further social irrationalism by asking people to take sides either "for" or "against" a mixed package of primary and secondary impulses. This paralyzing obfuscation makes the plight of children and adolescents inaccessible to any rational intervention.

Therapy of Adolescents

It is not possible to provide adolescents with effective help without an understanding of the importance of adolescent sexuality and how disturbances in their sexual life cause so many of their problems. This has been amply demonstrated by the limited value of past and current treatments that have all but ignored adolescent sexuality. By overlooking the distinction between primary and secondary drives, all those who render treatment remain helpless to deal effectively with the serious problems of adolescence. The result is that the adolescent is often shifted from one therapeutic intervention to another until he or she "grows out of the problem" by forming a stable adult character structure. Of those who fail to do so, some are at risk of becoming chronically maladjusted while others may develop severe character disorders or commit suicide.

The question of adolescent responsibility, as with any other issue of personal and social importance, can only be productively addressed in a functional manner. Moralistic or anti-moralistic attitudes serve no enduring constructive end.

As for responsibility for therapy, the adolescent lies approximately midway between the child and the adult. It is the function of the therapist to decide with the adolescent the capacity of the adolescent to assume responsibility in any given clinical situation.[8] Also, characterological and transferential issues may present fleetingly and are dealt with as they arise. A major difference in the therapy of adolescents and that of children and adults is that adolescent treatment does not require total removal of armor.

Because of the strong sexual push, the adolescent needs much of his armor. The focus of therapy of the adolescent is threefold:

- To provide relief of tension through symptom removal.
- To support his efforts to become independent and responsible, and to tolerate the strong surges of sexual energy within.
- To support his right to seek and secure a satisfying heterosexual relationship.

Case Presentation

A sixteen-year-old female was admitted to a psychiatric hospital because of a suicidal gesture. She made several superficial lacerations on the inside of her wrist after separation from a girlfriend with whom she had become homosexually involved in another psychiatric hospital. She was admitted to that institution from her own home because she was often involved in physically violent arguments with her mother and an older brother. While hospitalized, she had developed homosexual relationships with several other female patients.

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Past History

The patient, who is of Jewish origin, was born in Hungary during the Nazi occupation. Before six months of age, she was separated from her parents and placed in the care of a local family with whom she lived until immediately after the war. Her own parents were incarcerated in concentration camps.

After the war, when she was about five years old, she was reunited with her mother and brother for several months. Because patient and mother were of different nationalities, they could not emigrate together to the United States. She was again separated from her mother, sent to the United States alone, and placed in a series of foster homes for periods varying from several months to one year. During her many of these placements,she was physically abused by her foster parents. At the age of ten, she was finally reunited with her mother and brother. By this time she was exhibiting severe emotional difficulties which manifested in frequent, often physically violent, arguments with her mother and brother. It was after one of these episodes that she was transferred to a psychiatric facility.

Course of Therapy

On initial consultation in the psychiatric hospital, I found that her tough appearance masked her underlying softness and anxiety. Although she felt frightened, her eyes were bright and occasionally seductive, and she made good contact. She was intelligent, clear-headed, and well-motivated to help herself. Her lips were full and her massetter muscles were tight. Her shoulders were large and somewhat stooped and she had large breasts. Diagnostically, she was an oral unsatisfied hysteric. I treated her for four months in the hospital and she continued in therapy with me after discharge.

During the first session she spoke with nostalgia and longing about her early childhood.This was followed by feelings of painful regret about her experiences of constant rejection and emotional abuse in foster homes. She felt the stark contrast between her early happy family life and the later “living hell” being with her own

mother and brother. She felt at a crossroad in her life and needed help to find her way.

The initial phase of therapy was character-analytic. I focused on her fear of men, including her tranferential fear of me, and supported her in her desire to become independent and to have a heterosexual relationship. The defensive nature of her homosexual attachments was identified and understood by her as a substitute for the warmth and affection that her mother was unable to provide. At the same time, she faced her fear of her heterosexual feelings.

Gradually, she was able to give up her homosexual behavior, and by facing her fear ofmen, establish heterosexual relationships. This was accompanied by attaining independence in her work and social functions. She continued her therapy as she reached adulthood.

Conclusion

Because their armor has not yet been consolidated, medical orgone therapy of children and adolescents is less complicated and more straightforward than the therapy of adults. A major difficulty affecting outcome is the pathogenic milieu, specifically, the family relationships and home environment. In treating children, parental cooperation isnecessary. Without the full cooperation and understanding of the parents, one can expect only limited success. In other words, the greater the cooperation of the parents, the more favorable the prognosis. As adolescents approach adulthood, they can generally accept more responsibility and can be treated more as adults. The most difficult cases involve children and adolescents of dysfunctional families. The children and adolescents are usually severely disturbed and full parental cooperation is difficult or impossible to obtain. Of critical importance is the extent to which contactful sex- affirmative expression in the home is tolerated.

References

Reich, W., *Children of the Future.* New York: Farrar Straus Giroux, 1983.

Raknes, 0. "Puberty and its Educational Problems," *The Journal of Orgonomy*, 3(1), 1969.