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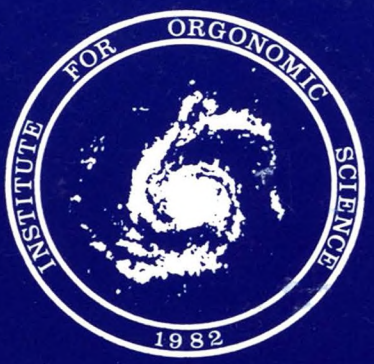

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SCIENTIFIC ARTICLES

VOLUME 5 SEPTEMBER 1988 NUMBER 1

Reich's Bioelectric Experiments: A Review with Recent Data

BYRON BRAID, M.D. AND ROBERT A. DEW, M.D.

Introduction

Reich's bioelectric experiments on human subjects, conducted between 1934 and 1938, represent a bridge between the realms of psychiatry and bioenergetics. Establishing, as they do, a solid connection between subjective psychologic experience and sensation, and objectively recorded electrical changes at the body surface, these studies address the problem of the mind-body dualism with a clarity and impact which, in our opinion, has never again been approached. Moreover, for Reich, they confirmed many important theoretical concepts formulated earlier from his clinical work, and proved to be the gateway to a new and fundamental understanding of biological functioning.

That this work was performed at all was remarkable in itself. Reich had fled the Nazis in Germany and was subsequently forced, in turn, to leave Denmark and Sweden. He finally settled in Norway, where he was able to establish a private practice and a research organization. But, even there, he encountered detractors who launched a public campaign to vilify him and discredit his work. The experiments themselves took considerable courage for all concerned, given the predominance of essentially Victorian values and the emotionally taxing circumstances inherent in the procedure. As far as we know, no attempts to reproduce Reich's results have been published; it is our intention here to review the essentials of this work and present some data of our own.

The Theoretical Background of the Experiments

By 1934, Reich had presented his concept of the orgasm as a *bioelectric* discharge. Until then, sexual tension and its relief with orgasm had been assumed to be strictly mechanical phenomena, i.e., due to the accumulation in and discharge of sexual fluids from the seminal vesicles and spermatic ducts. Reich's argument, based on detailed clinical investigation, was that such an explanation leaves many aspects of sexual functioning unexplained. It would, for example, be difficult to understand the orgastic experience of women, who have no seminal vesicles. Or, where do the reciprocal urges to penetrate and receive completely originate? How would one account for the residual excitation and lack of

satisfaction associated with *coitus interruptus, coitus condomatus,* and orgastic impotence in all of which there is a mechanical release (ejaculation)? If the erotic sensations and sexual excitation in the genitals, etc., were purely a matter of vascular congestion, how would one explain the precipitous drop in excitation after acme, while the hyperemia of the genital declines relatively slowly? Reich discusses at length how these and many other similar questions become readily understandable with reference to the *orgasm formula: mechanical tension—>bioelectric charging—>bioelectric discharging—>mechanical relaxation.* In other words, bioelectric (bioenergetic) events occur in a specific relationship to mechanical tension and relaxation. The experimental evidence needed to prove the orgasm formula was simply to demonstrate charging of the genitalia during sexual excitation.

Another concept which led to these studies was that of the vegetative antithesis of sexuality (pleasure) and anxiety. Reich viewed sexuality and anxiety as functional opposites. In pleasure, the organism expands and, in both the psychic and physical senses, reaches out "toward the world"; in anxiety, it contracts, withdraws "from the world" and, to the extent that it is physically able, tends to assume a spherical shape. Unlike Freud, who had originally believed that the libido energy, when blocked from sexual expression, becomes *converted* to anxiety, Reich postulated that the difference between sexuality and anxiety was essentially a matter of a *change of direction* of the energy. In sexual excitation or pleasure, the energy moves from the center to the periphery of the organism, and in anxiety, from the periphery to the center; everything one experiences or does in these two states is thus a reflection of the overall direction in which energy is moving. Again, to prove this, it would be necessary to demonstrate a rise in bioelectric charge at the skin surface which would correspond to the subjective experience of pleasure, and a fall in potential in "unpleasure" or anxiety.

Reich's Procedures and Results

Reich's arrangement for making these recordings consisted essentially of connecting the subject in series in a circuit including an oscillograph. Non-polarizable 0.1N KCl liquid electrodes or silver electrodes were used. A permanent record was obtained through the inscription of a light beam upon a moving strip of photosensitive paper. This ingenious setup, though perhaps primitive by today's electronic standards, made it possible to take measurements not only from skin but mucus membranes as well. The "indifferent" or reference electrode site was created by abrading an area of skin to the point of producing a serous exudate; the "differential" or exploring electrode was placed upon intact skin or mucus membrane at various sites over the body. The abrasion of the reference site is critical to the question of just what it is one is measuring. With few exceptions, modern research on the electrical properties of the skin has studied *resistance between two superficial points.* With Reich's arrangement, the measurements instead reflected a *potential* between the interior and the surface of the body. As proof of this, he showed that, by abrading the sites of *both* electrodes, the potential between the two points becomes *zero.*

A. The Resting Potential (Figure 1)

Reich discovered the existence of a resting potential of approximately minus 20 millivolts in nonerogenous zones. Long recording strips revealed little oscillation in this potential. Its presence indicates that the skin surface carries a uniform electrical charge originating from within the organism (1:82).

Fig. 1. Resting potential in a nonerogenous zone (axilla) (after Reich; 1:132).

B. The Wandering Potential (Figure 2)

The wandering potential was found by measuring the resting potential of the sexually excitable (erogenous) zones of the body. Its characteristics are quite different from those of the nonerogenous areas. It tends to rise and fall in magnitude in a gradual, meandering fashion and exhibits a far wider range of extremes. Reich, in fact, observed deflections of up to plus 200 millivolts. Increases in this potential seemed to occur only in association with erotic or other pleasurable sensations. The surface of the erect penis, for example, regardless of its state of engorgement, would show no rise in potential unless a pleasurable erotic sensation was simultaneously experienced by the subject. Reich was also able to demonstrate that the amount of excitation, and hence the change in potential, does not correspond to the intensity of the stimulus but, rather, to the organ's state of *readiness*. He believed that the wandering potential represented a *preorgastic* flowing excitation and showed that it would vary with changes in mood, an effect which is clearly evident from the tracings below.

C. The Response to Tickling (Figure 3)

Up to this point, Reich had performed no experiments involving intentional stimulation. Because he wished to explore the relationship between the subjective perception of sensation and the objective measurement of electrical charge, it became necessary to measure the responses of his subjects to specific external stimuli. Reich characterized gentle tickling as the mildest form of sexual excitation; it induces the impulse to rub or scratch - actions which he thought were related to sexual friction. He regarded muscular motor activity and rhythmic friction as the most basic biological manifestations of sexuality, and sought to establish a connection between the subjective awareness of pleasure from friction by way of electrical changes at the sites of sensation. He began a series of experiments utilizing tickling and pressure stimuli. Pressure consistently produced a negative deflection of 15 to 20 millivolts; tickling resulted in positive deflections in an inverse relationship to the intensity of the

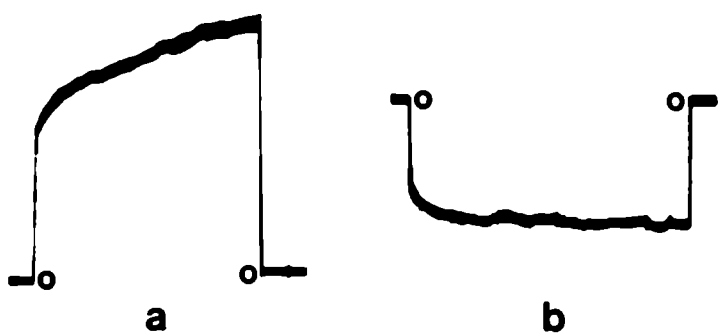


Fig. 2. (a) Wandering potential from anal mucosa of a woman in a state of pleasurable excitation. (b) The same in a state of premenstrual depression (after Reich; 1:136, 137).

stimulus, i.e., the gentler the stimulus the greater the deflection. An example of different responses to tickling and pressure is shown in Figure 3.

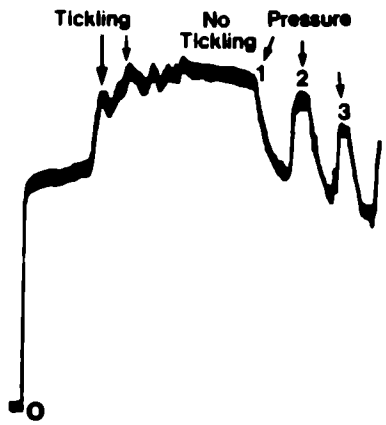


Fig. 3. Responses to tickling and pressure stimuli in the palm of the hand (after Reich; 1:141).

In another related experiment, the subjects were connected to the recording equipment in a separate room by means of long wires. They were asked to describe the type of deflection being produced on the oscillograph based on their sensations. With the gentler stimuli, these individuals were able to say with remarkable accuracy what the apparatus was doing. Not surprisingly, the success of this experiment depended on the contactfulness and openness of the subjects. It shows dramatically the functional identity between the objective measurement of potential and the accompanying subjective sensation.

D. The Vegetative Antithesis (Figure 4 and Figure 5)

Reich next tackled the problem of the relationship of anxiety and pleasure. His review of the contemporary literature on "psychogalvanic" phenomena revealed that, from an electrical standpoint, no distinction was made or even anticipated to exist between these two states. From his clinical experience, however, he seriously doubted the correctness of this view. His own bioelectric studies, indeed, showed unequivocally and consistently that pleasurable stimuli produced an increased charge at the periphery, while unpleasurable or anxiety-provoking stimulation resulted in a negative deflection. In an experiment with a female subject in which readings were being taken from the labia majora, he observed that a sharp decrease in potential coincided with her accidental spilling of a drop of KCl on this sensitive location. It became clear that, with strongly negative stimuli, the experience of annoyance is accompanied by a decreasing electrical charge, and that this accounts for the dramatic decrease in sexual excitability. In other words, with "unpleasure," the periphery becomes discharged.

Further evidence of this kind is found in the sugar-salt experiment (Figure 4). Here, cotton wads were soaked either with concentrated solutions of sugar or salt, and the subject was asked, without knowing which solution had been applied, to suck on the cotton (which was connected to one of the electrodes). The sugar produced a distinct and powerful positive deflection while the salt resulted in a negative one. Additional experimentation demonstrated the electrical concommitants of *disappointment* and *habituation*. If the tongue was initially stimulated with salt, subsequent attempts to elicit a positive reaction with sugar resulted in a further negative deflection. If, on the other hand, the tongue was first exposed to sugar and then salt, it was found that the salt did not produce as dramatic a negative deflection nor did a following re-exposure to sugar result in as significant a rise in potential. In

fact, with each additional stimulus in sequence, the reaction became less in either direction. It is of extreme interest that, upon returning to the experiment in which salt was administered first, further attempts to obtain a positive deflection with sugar revealed that the tongue remained refractory to stimulation for over 30 minutes.

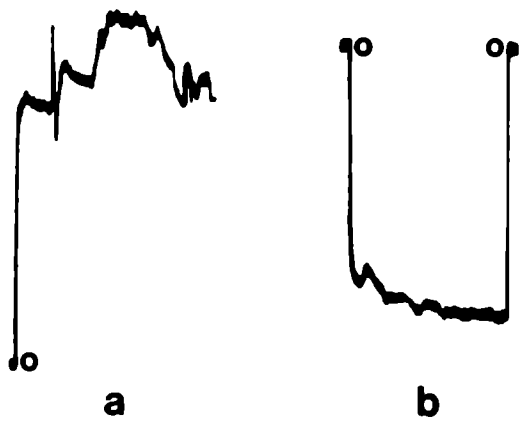


Fig. 4. The effect of sugar (a) and salt (b) on the tongue (after Reich 1:148, 149).

Apart from the obvious and dramatic confirmation of this conception of the vegetative antithesis, Reich drew from these experiments several important inferences in regard to sexuality itself:

1. Sexual reactivity is more related to the state of *readiness* of the organ than to the stimulus.

2. Noxious stimuli produce an overall decrease in liveliness; an organ which has been "disappointed" will respond sluggishly and "cautiously" to pleasurable stimuli.

3. Habituation to a stimulus produces diminished *reactions* bioelectrically whether they are positive or negative.

Reich also studied the pleasure reaction per se in an attempt to identify what bioelectric events accompany the motor actions which seem to intensify the subjective experience of pleasure. He cited the phenomenon of *sexual friction*, e.g., the alternating penetration and withdrawal of the penis in the vagina, and the pumping action in suckling, as representative examples. As noted above, he regarded the tickling stimulus and sugar-licking tongue as analogous. In these, the tracings showed alternating peaks and valleys in the potential. A subsequent recording from a kissing couple illustrates this dramatically. Moreover, it can be seen that, with each frictional movement, the subsequent rise in voltage would exceed the one which preceded it (Figure 5). This corresponded to the overall increase in excitement experienced by the couple.

Fig. 5. The excitation curve during a kiss (after Reich; 1:157).

Reich postulates that the motor action (friction) itself, as well as the rise in potential at the periphery, are the results of *central tension.* This central tension arises from the overall increase in peripheral charge. Thus, the total expansion and rise to acme in the sexual experience are the result of a series of stepwise surges in excitation, each preceded by a measure of contraction. Reich likens this to the tiger's crouching before leaping. The contractions correspond to the falls in potential ("valleys"); each succeeding rise, in turn,

corresponds to a further expansion and an intensification of the pleasurable experience. *Central tension as a result of peripheral charge* is, therefore, one of the four types of negative bioelectric reaction which may be manifest at the periphery. The other three are:

1. Peripheral orgastic discharge: the charge falls below the resting potential and rebounds to zero.

2. Anxiety: the tension remains at the core.

3. Death: the source of the tension is extinguished. As the tissue dies, it becomes negatively charged.

E. The Vegetative Center

With the bioelectric confirmation of the vegetative antithesis, the question arose as to where the energy actually retreats in the case of anxiety. Reich hypothesized that the ganglia plexuses of the autonomic nervous system - primarily the coeliac, hypogastric, and pelvic - were the probable sites. To prove this, he showed that during inhalation, with the Valsalva maneuver or direct pressure over the epigastrium, the usual resting potential of that area falls steadily by 10 to 20 millivolts. Upon exhalation or with relief of mechanical pressure, the potential again rises to its original value. Reich's explanation for these fluctuations was that the act of respiration alternately compresses and relieves pressure on the abdominal contents and, thus, the underlying ganglia. Pressure, as was demonstrated in the erogenous zones, evidently also inhibits the charge emanating from the plexus. He noted that, in patients with diaphragmatic armoring and inhibited respiration, the bioelectric changes were of much less magnitude and clarity. In anxiety states, the pressure is exaggerated and not completely relieved on expiration - hence, the pulsation in bioelectric activity is also inhibited. This study thus corroborated both his theory and, later, an important clinical finding: as the armoring was dissolved and the anxiety relieved, his patients began to experience pleasurable streaming sensations in the chest, abdomen, and pelvis, which were felt most intensely on exhaling.

At the time Reich completed these bioelectric investigations, he had, as yet, no idea of the existence of the orgone energy. In a footnote written in 1945, he emphasizes that "In reality the processes involved [in these studies] are orgonotic and not electrical" (1:171). In other words, the millivolts of electricity detected by the oscillograph reflect only a small fraction of total orgone energy underlying the function. Nevertheless, from the point of view of dynamics, the conclusions to be drawn from these experiments remain the same:

1. The resting potential confirms the presence of a continuous charge at the skin surface generated from within the body. The source of the potential appears to be primarily the vegetative ganglia of the abdomen and pelvis (the vegetative center).

2. In the erogenous zones, a higher potential corresponds to a more intense state of excitation experienced subjectively. Passive mechanical congestion alone does not produce an increase in charge, and it must be accompanied by charging for the sensation to be experienced as erotically pleasurable. The intensity of the excitation is directly related to the quantity of the charge. These findings constitute a confirmation of the tension-charge portion of the orgasm formula.

3. Sexual excitation is functionally identical

to energetic charging of the erogenous zones, or, more generally, pleasure represents a movement of energy from center to periphery. Anxiety (or "unpleasure") is functionally identical to a withdrawal of charge from the periphery toward the center. Thus, the theory of the vegetative antithesis of sexuality and anxiety is confirmed experimentally. Reich further concluded that the sexual process is identical to the "biological-productive energy process per se" since vegetative sensations of pleasure are the only experiences associated with an increase in charge at the periphery. Anxiety, in contrast, is related to the process of dying in that it is characterized by a withdrawal of energy from the periphery.

4. These experiments are of great importance to the problem of the mind-body relationship. They demonstrate a concrete correlation between psychic experience and vegetative excitation which has its roots in the movement of energy between the interior and the periphery.

The Recent Studies

A. Materials and Methods*

In these experiments, a Houston Instruments Strip Chart Recorder (Model D-5000) and a High-Precision Variable Span Input Adapter (A-9-A) were used with Sensormedics pure silver skin electrodes. A "homemade" electrode paste consisting of four grams of K-Y Jelly®, 3 cc of plain water, and 0.5 grams of crystalline KCl were employed for the recordings reproduced below. This mixture is somewhat irritating on abraded areas of the skin and cannot be used at all on mucus membranes; and due to the unavailability of KCl liquid electrodes, such as those used by Reich, we were restricted to measurements of the skin surface.

The seven subjects were men and women between the ages of 30 and 50. They were prepared with a brief discussion of the nature of the experiments and assurances that no significant pain would be involved. They were also counseled to dispel, as far as possible, the notion that their participation was in any way a "test" in which a performance was required of them. In most cases, the subjects rested, fully clothed, in a comfortable reclining chair. Despite these precautions, several minutes were usually required for them to settle down. Also, the electrodes themselves seem to require some time to stabilize; the abraded reference electrode site, for example, produces a *current of injury* which may persist for 45 minutes or longer. Thus, tracings taken immediately after electrode placement may exhibit a very gradual and steady baseline "drift" in either an upward or downward direction.* That this is of biological origin is proven by the absolutely flat recording obtained with the electrodes connected to a fixed voltage source, e.g., a battery.

The "indifferent," or reference, electrode site (RE) was, except for certain controls, the same in every case: about half way down the volar aspect of the left forearm. It is prepared by abrading a circular area of skin, one-eighth inch in diameter, until a serous exudate is obtained. A conical grinding stone, mounted in a hand-held Dremel Moto-Tool®, is convenient for this purpose. One may instead

*See Appendix for further details.

*Customarily, we have begun taking measurements without waiting for the injury current to dissipate fully. The changes in potential seen with mechanical stimulation, for example, occur in a time period and at an amplitude that cannot be confused in any way with the course of an injury current.

scrape the skin with the rounded edge of a No. 10 scalpel blade. It is not necessary to cause bleeding; however, should this occur, the site is still usable. The other permanent electrode is the ground electrode; this is applied over intact skin at the middle of the left leg, just medial to the tibia. The "differential," or *exploring* electrode (EX) is, of course, applied to various sites all over the body. The skin under the EX electrode was not usually abraded or broken except in the case of a special control experiment which is described below.

The model D-5000 recorder offers a wide range of chart speeds. For the processes illustrated below, we have found 2.5 cm per minute to be most convenient; this speed permits an accurate indexing of events and mechanical stimuli. For most purposes, the voltage input range can be set at 100mV. With the A-9-A input adapter dial at 6.50, a 10mV signal will produce a pen deflection of 10mm.*

The recorder is situated so that the subject is unable to see the tracing in progress. The operator questions the subject regarding sensations, thoughts, emotions, etc., and the record is marked accordingly. A second operator is sometimes required to apply the various stimuli. Generally, there has been little difficulty in obtaining a precisely timed annotation of the recording with the stimuli and subjective experiences of the subject.

B. Results

1. Controls

A variety of controls were devised to explore different categories of possible effects. These included:

1. Electrode connections on the polarity of the deflections.

2. Ground and RE electrode position.

3. Physical movement: a) by the subject b) of the electrode wires.

4. Simultaneous abrasions of both reference (RE) and exploring (EX) electrode sites.

5. No abrasions of either the RE or EX sites.

As expected, interchanging the RE and EX leads simply inverts the tracings "image." We elected to follow Reich's convention and use the "negative" electrode for exploring; this results in upward (left) deflections with increases in charge, and downward (right) deflections with decreases in charge at the skin surface. The placement of the ground and RE electrodes on the subject seems immaterial as long as the skin under the RE is abraded.* Generally, physical movements produced little or no deflection, even when a limb to which an electrode was attached was raised and lowered. The EX electrode is somewhat sensitive to muscular activity; with the EX in the right palm, for example, wiggling the right thumb or raising the right leg produces roughly equivalent upward deflections. These have a jagged contour, with a sharp rise and rapid recovery, and the onset of the potential rise follows the physical action with scarcely any delay. They are usually far overshadowed in amplitude by deflections associated with sensations or alterations in emotional state which also have a slower rise,

*See Appendix

*Our conclusion is based on trials with four variations. Obviously all possible combinations were not tested. There also seemed to be no point in tests with the ground electrode on an abraded site.

a rounded peak, and a slower recovery. These latter types of deflections often seem to anticipate or lag behind the onset of physical actions or mechanical stimuli. In short, the two types of deflection are easily distinguished. Deflections due to wiggling of electrode wires are, like those of muscular movement, small, jagged, and generally only seen with the EX electrode.

Tests with both electrode sites abraded, unlike the foregoing controls, were not so clearly in agreement with Reich who, in this case, obtained a zero potential. We measured three locations along the left upper extremity and in the right palm with the following results:

EX LOCATION	DISTANCE FROM RE	INITIAL POTENTIAL	POTENTIAL AFTER 45 MIN.
left forearm	3 cm	+ 3.6mV	-16mV
left mid-biceps	17 cm	+ 6.0mV	-16mV
left deltoid	35 cm	+ 5.2mV	-16mV
right palm	150 cm	+18.0mV	0

It is unclear whether the distance between the electrodes is of any consequence. The declining potentials from the four sites are highly suggestive of currents of injury. At about one hour, the voltages from the left arm had started to rise, but the recording had to be discontinued because of the subject's fatigue. We, therefore, cannot say at what level the potential finally stabilized. One notes that the highest initial value is from the palm, i.e., the erogenous zone, and that this did stabilize at the zero line. Reich does not say at what sites he made his measurements nor does he mention a protracted decline in potential. In tracing 6a, in which both electrode sites (left forearm and right palm) were abraded, we see that the EX site has been rendered almost completely unreactive.*

*Not shown in this tracing is the same lack of reactivity observed at the RE site.

Results with both sites unabraded brought out clear differences between the nonerogenous and erogenous zones. At seven locations up the left arm and across to the right shoulder and forearm, minute or immeasurable potentials were obtained. There was a general unresponsiveness to pressure on the electrodes and to other stimuli. The palms of the hands, in contrast, exhibited potentials as high as 30mV. Muscular activity, tickling, and stroking all produced upward deflections, although these were reduced in amplitude compared to those obtained with the RE site abraded. In 6b, we see the responses to electrode pressure. Generally, with neither site abraded, pressure on the RE results in an upward deflection while that from pressure on the EX is downward. If one presses on *both* electrodes simultaneously, one obtains a summation of the two, i.e., they, in fact, "cancel" each other. The reason for these opposite effects is not entirely obvious, but it would appear to have something to do with polarity. More puzzling is that the phenomenon should be inconsistent. In 6c, pressure on *either* electrode produced a downward deflection, and at the third stimulus, no response at all.

Despite some of the oddities that have turned up in the abraded and unabraded controls, these tests do illustrate a number of pertinent points:

1. The intact skin confers bioelectrical responsiveness upon the electrode site; destruction of the epidermis eliminates reactivity to stimulation.

2. The observed electrical reactions to stimulation have little to do with mechanical disturbances of the electrodes or their wires, but would appear to be the result of alterations in charge in the skin itself.

3. The reactivity of the skin varies over the surface of the body. Certain zones, such as the volar aspects of the forearms, in fact, approach electrical "neutrality" both at rest and in response to stimulation. Others, such as the palms, may exhibit an innately higher charge at rest and a greater sensitivity and responsiveness to stimulation by objective measurement.

4. Potentials at the EX site, regardless of their direction, are increased in amplitude by abrading the skin beneath the RE electrode. The fact that *any* site may serve as an RE site (so long as it is abraded) without a substantial effect on the results at the EX site supports Reich's contention that the observed potentials are the result of a difference in charge between the "interior" and the skin surface (periphery).

II. The resting potential (RP) in nonerogenous zones

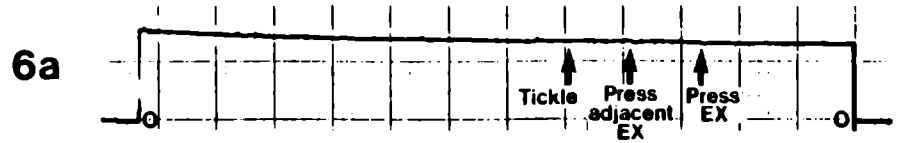
Tracing 7a shows RPs taken from the axillary regions of a female subject at the level of the fifth intercostal space. They are not quite as ruler flat as those obtained by Reich; however, this was probably due to a failure to allow sufficient time for electrode stabilization. They do show the characteristic lack of oscillation. Unlike Reich, who found an RP of -18mV, we recorded +3mV. Reich reported that in a given subject there was very little variation in the values obtained from a particular nonerogenous zone with repeated measurements. He further observed that, in comparable zones of different subjects, the range of variation in RP between individuals was much narrower than RPs from the erogenous zones. At the present time, we do not have enough data to verify this.

One notes, in tracing 7b, the lack of response to stimuli at other areas and to the axilla itself; a rather muted response to painfully deep pressure at the EX electrode is also shown. Similar tests, in a male subject, showed slight bioelectric responses to local and distant stimulation. Obviously, one should not be surprised to find some measure of reactivity in the nonerogenous zones. However, as we shall see, it is of a far lower order than that of the erogenous areas.

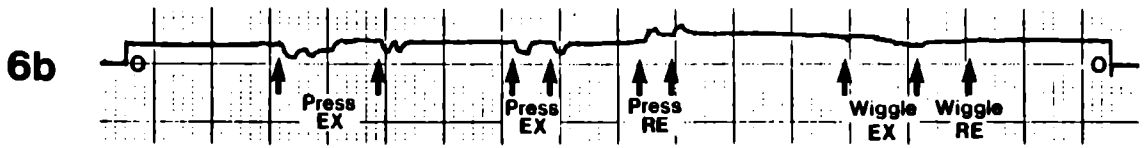
III. The erogenous zones

a) resting and wandering potentials (WP)

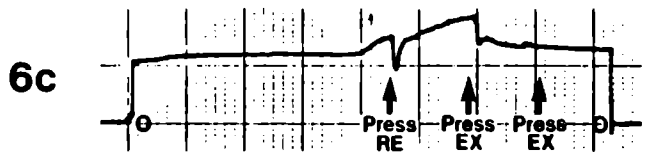
As did Reich, we encountered a wide range of variation in the RP of the erogenous zones. The variability takes a number of forms. Even with the subject in a quiescent state, the tracing is rarely perfectly horizontal; it either rises or declines very gradually. Consequently, on closing the circuit while measuring a particular zone, the amplitude of the deflection will vary greatly from one trial to the next. In one male subject, the initial potential as measured in the right palm varied between 34 and 74mV (6 trials). Thus far, none of these potentials have been "negative"; and, in the longest continuous recording (15 minutes), the voltage did not stray below the zero line. Since, on this point, our experience differs from Reich, further investigation will be required. In agreement with Reich is the finding that RPs in the erogenous zones may range far higher than any of those from any of the nonerogenous areas. We also found, in one intellectual subject, a resting potential of over 85mV at the forehead; this exceeded the values in any other erogenous zone tested including the palms, lips, epigastrium, and glans penis. Another form of the variability in the RP are minute oscillations which occur continually throughout its course.



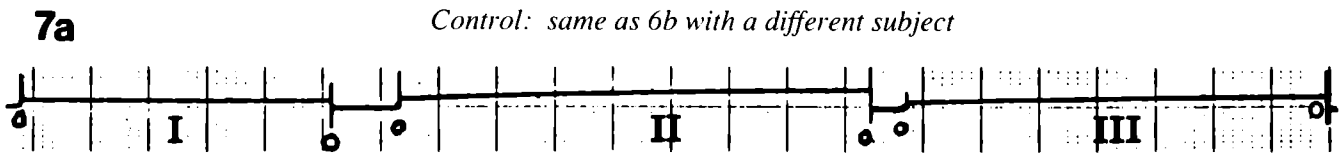
Control: both RE (left forearm) and EX (right palm) electrode sites abraded, showing loss of reactivity to stimulation



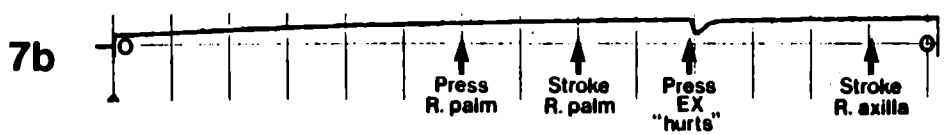
Control: both RE and EX electrode sites unabraded showing reactivity to stimulation



Control: same as 6b with a different subject



Resting potentials in nonerogenous zones: I. Left posterior axillary line; II. Left posterior axillary line; III. Right mid-axillary line



Same subject as 7a; right mid-axillary line showing reaction to stimuli

A typical example of an RP, taken from the palm of a female subject, is seen in 8a. It exhibits a gradual downward drift with small undulations. Subjectively, there was no sense of excitation or erotic streamings. Compare this to 8b taken a few moments later, in anticipation of having her palm tickled with a wisp of cotton. In the first 40 seconds, her palm had not yet been touched, but as she experienced an increasingly intense sensation of "itching," the potential wandered upward. Next, a series of four step-wise waves followed corresponding to gales of laughter.

b) tickling and stroking

As the tracing 8b continued, we see the effect of actually tickling a subject's palm while she kept her eyes closed. These stimuli produced downward deflections. She simultaneously reported that the sensation was "strange." Immediately afterward, her lower right forearm was gently stroked with the cotton; this felt "nice" and was associated with a small upward deflection. The subject was then left undisturbed for about two and a half minutes. Her palm was again stroked gently with a back and forth motion which she described as "pleasant." This time a series of ascending, rounded, saw-tooth deflections resulted which are strikingly similar to those obtained by Reich (Figure 3 above).

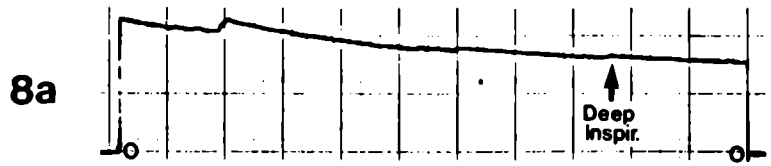
Deflections are also recorded from an erogenous zone when other, remote erogenous zones are simultaneously stimulated. Tracing 8c is a portion of a recording, again taken from the right palm. At the second arrow, the right thigh was stroked; two minutes later, the left breast was stroked, producing an even higher rise. The subject then pinched herself in the left thigh (using her left hand) which resulted in a downward deflection. A second pinch, 10 seconds later, had hardly any effect. These tracings clearly show the relationship between the quality of the subjective experience and the change in charge at the skin surface. Moreover, the reactions in the palm from stimulation elsewhere demonstrate the unitary functioning of the entire plasmatic system, i.e., the *overall* movement of energy toward or away from the periphery (in pleasure or unpleasure).

c) pressure

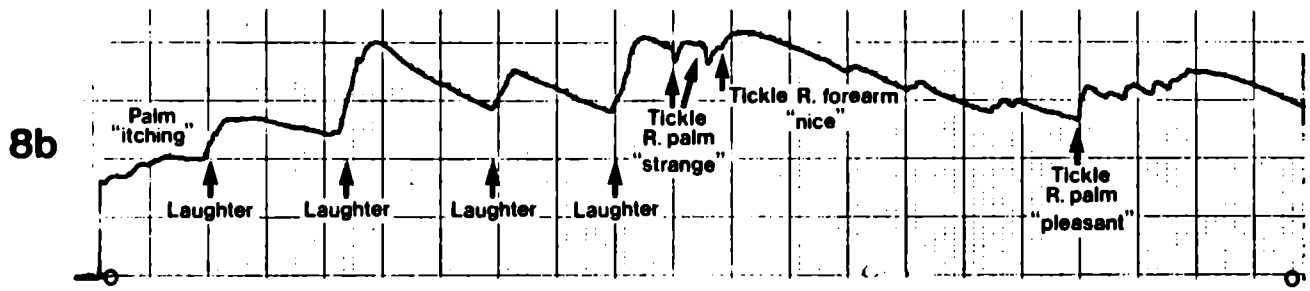
Tracing 8d shows the effects of pressure as measured in the right palm. The first deflection is of interest in that it embodies a combination of two effects. One sees an upward deflection containing a downward spike. In this case, the subject saw that pressure was about to be applied to the electrode. As a consequence, she tensed the muscles of the hand and forearm. From the control studies, we recall that voluntary muscle tension typically produces upward deflections. What seems to have happened here is that the characteristic electrical reaction to pressure (seen in the next two deflections) was "embedded" in the reaction to muscle tensing. The second and third arrows indicate the effect of pressure adjacent to (two centimeters away) and directly upon the EX electrode.

d) respiration: the vegetative center

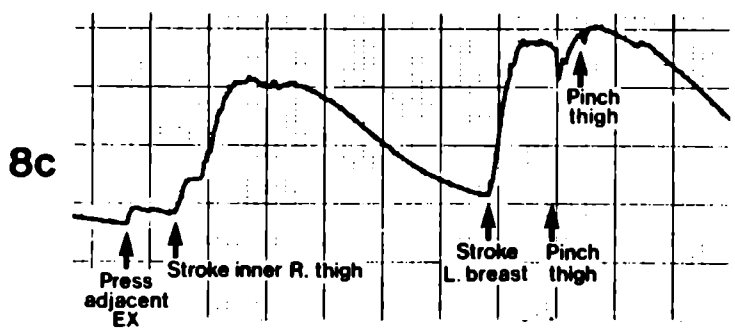
Before proceeding to measurements directly over the region of the solar plexus, we first explored the possibility of a bioelectric reaction to respiration in other zones. Ordinary quiet respiration did not result in visible deflections in any of the various locations tested. *Deep inspiration and sighing expiration* sometimes did produce recognizable waves. Examples of these, taken from the palms of two different subjects, are shown in 9a and 9b. What is noteworthy, is that the rise in potential is delayed - by as long as six



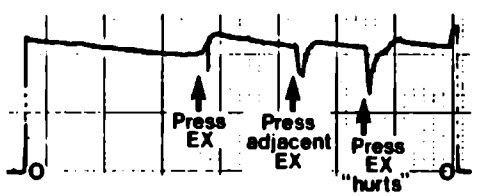
Resting potential from the right palm



Wandering potential from the right palm showing response to tickling



Responses in the right palm from stimuli in other erogenous zones



Responses (right palm) to pressure

seconds - after the physical onset of inspiration, and that the return to the baseline begins before actual expiration. While the reason for an increase in charge following inspiration is unclear, the temporal relationships between the mechanical actions of deep breathing and its bioelectrical manifestations suggest the passage of a wave of excitation which has been generated elsewhere and takes time to reach the palm. The order of events is also familiar:

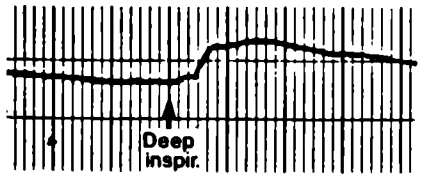
> Inspiration (mechanical tension)—>increase in potential at the palm (energetic charging)—>return of voltage to the baseline (energetic discharging)—>expiration (mechanical relaxation).

In other words, this finding might be interpreted as an indication of a total organismic pulsatile function, associated with respiration, which is manifested at the skin surface. The wave may also be related to the subjective sensation of streaming which waxes and wanes with each respiratory cycle.

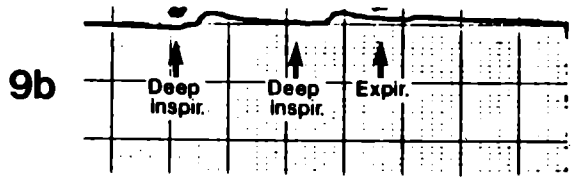
The recordings from over the epigastrium itself (9c) were somewhat disappointing. The subject, whose palmar tracing is shown in 9a, felt "tense, full, and uncomfortable" in the abdomen. The initial voltage (+32mV), unlike that obtained by Reich, was "positive." The course of the record was typical for an RP from an erogenous zone; however, deep inspiration and sighing, and the Valsalva maneuver caused no deflections. Deep pressure adjacent to the electrode resulted in a small dip of about 3mV. We note that the same relationships between the mechanical and electrical events seen with respiration in 9b seem to apply here. By itself, this recording does not entirely confirm Reich's conclusions regarding a vegetative center. It should be pointed out, however, that the deflections do not resemble those due to pressure seen elsewhere (8d). The fall in potential occurs with a distinct delay after the application of pressure to the abdomen; the wave has a rounded bottom and the slow return to the baseline precedes the release of pressure. These differences may indicate a different *process* which, after all, might have some connection to the underlying ganglia of the solar plexus. Because of the possibility that the subject's armoring in the region may have affected the results, we repeated the experiment with a woman who, clinically, exhibited much less restriction in this segment. The results, however, were identical. Further trials are obviously needed to clear this up.

e) pain and fright

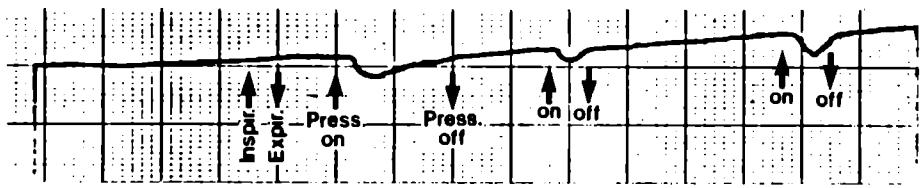
The bioelectric responses to negative stimuli such as pain and fright have been somewhat inconsistent. That is, these stimuli, at different times, resulted in either negative or positive deflections. Some of the inconsistencies may be more apparent than real, the subjects being more entertained than alarmed at our attempts to surprise them. Nevertheless, there were instances in which they reported being genuinely frightened and, yet, an upward deflection had been inscribed. Another possibility is the effect of muscle reaction; both pain and fright have been accompanied by the sudden, powerful withdrawal of a limb or an overall tensing of the body. It may be that the positive deflections associated with these actions overrides and obscures opposite electrical reactions. Clearly, a careful and systematic approach to this problem is needed to determine what actually transpires energetically. In very anxious subjects, recordings from erogenous zones tend to appear flat or show inapparent, vague, or even paradoxical reactions to stimuli. Of course, this in itself seems highly significant; clinical experience reminds us that in states of contraction reac-



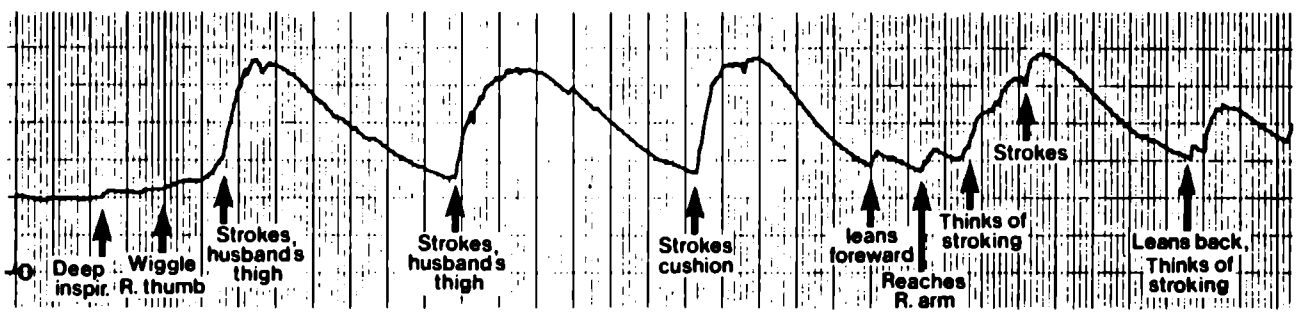
The effect of deep inspiration in the right palm showing a delay between the muscular and bioelectric events (Chart speed 5cm/min.)



The effect of deep inspiration in the right palm again showing the delay phenomenon. The potential also begins to return to the baseline before actual expiration.



The effects of pressure over the epigastrium showing similar delay and recovery characteristics as in 9b.



The effects of sexual excitation in an erogenous zone (right palm)

tions may be inhibited or distorted. It may be that armor or anxiety also causes the skin of the erogenous zones to function more like that of the nonerogenous zones. In any case, there seems to be sufficient data in the present study to confirm Reich's assertions regarding the vegetative antithesis.

f) sexual excitement in an erogenous zone

Tracing 10 is a continuous 16 minute recording from the right palm of a female subject. The circumstances were fortuitous. Her husband stood close by. The subject was lively and excitable; she had an excellent understanding of the experiment, and was not so inhibited in the situation as to be prevented from feeling and taking action spontaneously. The first 60 seconds is a typical RP for this area. At the first and second arrows, she had taken a deep breath and wiggled her right thumb. At the third, without informing us in advance, she had reached forward and stroked her husband's thigh. One notes that the rise in potential began *before* the physical act was initiated. The oscillations at the apex of this wave correspond to the gentle back and forth motions of her finger tips on his thigh. She then leaned back, and for the next two minutes, we observed a gradual decline in potential. The second time she stroked his thigh (arrow four), she did so at our request, although she reported that she still felt aroused. As a "control," we then had her stroke a cushion in the same manner (arrow five), but, in this case, without leaning forward in the chair. To ascertain more exactly the contribution of voluntary muscular movement to the potential, we had her, in succession, lean forward (arrow six), and stretch out her right hand (arrow seven). At arrow eight, she had simply begun to *imagine* stroking her husband and then actually did so (arrow nine). The final arrow shows the effect of her again lying back and thinking of touching him.

This remarkable recording vividly illustrates a number of cardinal points. First, it demonstrates the charging of the periphery as a consequence of sexual excitation; the apices of the five major waves seen in the tracing all corresponded to the subject's experience of heightened erotic excitement. Second, the rise in potential *before* any actual physical movement, and even in its absence ("imagining") relates the charging process strictly to psychic activity and somatic sensation. Third, the "readiness" for excitation is suggested by the reaction to stroking the cushion; significantly, the subject felt distinct streamings in her arms before doing so. If one draws a line through all the lowest points on the record, one sees an upward trend of 10mV - a rising "base" for all the deflections - which is consistent with the subject's overall rise in excitement and manifest increase in responsiveness to stimulation. Clearly, what we see here are not "action potentials" in the classic electrophysiologic sense; these are characterized by spikes and waves which are measured in fractions of seconds. This and the previous tracings show mostly slowly rising and falling waves lasting in some cases for over two minutes.

C. Discussion

In the absence of KCl liquid electrodes, we have been unable to repeat all of Reich's experiments and controls; and the lack of sufficient numbers of trials with different subjects has prevented us from verifying certain of his observations. Despite these limitations, however, the present study has confirmed several of his findings; qualitatively, i.e., from the point of view of dynamics, our results are in close agreement. His description of resting and wandering potentials in nonerogenous and erogenous zones, the various responses to tickling, pressure and other stimuli, and the overall relationship between vegeta-

tive excitation, psychic experience, and fluctuations in charge at the skin surface have been clearly corroborated. We have also confirmed the validity of *indirect* measurements by showing that changes in potential may be recorded at one site while stimuli are applied simultaneously to another, remote site. In addition, some of our own experiments have brought out phenomena not mentioned by Reich. The changes in skin potential with voluntary muscular movement and in the palm of the hand with deep respiration are cases in point.

In general, the differences between Reich's results and ours appear to be quantitative. Voltages obtained in nonerogenous zones, for example, did not correspond to his. This may, of course, resolve itself with further experimentation. Of somewhat more concern, is the absence of "negative" potentials in our measurements. We do not refer here to the *direction of change* of potential, but rather to the registration of any potential *below* the zero line. It is not yet clear whether this discrepancy is a result merely of chance or due to differences in circuit design between Reich's apparatus and ours. In any case, the results, thus far, very much encourage us to clear up these technical matters, as well as those involved in obtaining recordings from mucus membranes. As indicated earlier, there are certain inconsistencies, in the reactions to fright, for example, which require elucidation. More data is necessary to establish a clearer relationship between the resting potential in the erogenous zones and the overall mood of the subject. Most importantly, manifestations of the tension charge phenomena of erectile tissue during sexual excitation remain to be investigated.

Summary

1. The essentials of Reich's bioelectric study of sexuality and anxiety are reviewed.
2. Recent data is presented which confirm several of his observations and conclusions. Certain of the results obtained in the present work differ from Reich's. The bases of these differences, which are mainly quantitative in nature, remain to be clarified. Additional trials with more subjects may resolve some of these discrepancies. The possible role of differences in the equipment used is mentioned.
3. A new finding, not reported by Reich, is the deflection obtained from the palm of the hand upon deep inspiration and sighing. This phenomenon may point to an overall organismic pulsation related to respiration. The pattern of mechanical and energetic events recalls the orgasm formula, and the wave of increased potential may bear some connection to the subjective sensation of "streaming" experienced with deep breathing.

References

1. Reich, W.R.: *The Bioelectric Investigation of Sexuality and Anxiety*, Higgins and Raphael, editors, Farrar, Straus and Giroux: New York, 1982.

Appendix

Technical Notes on the Use of the Recorder and Accessories

A. Electrode Pastes and Jellies

The electrode medium must satisfy two major criteria: it has to be adequately conductive, electrically stable, and at the same time be non-irritating to intact skin, abraded skin, and mucus membranes. None of the preparations tried satisfied both. The Upjohn Pharmaceuticals paste was the least irritating to

abraded skin, but is unsuitable for use on mucus membranes. When it became temporarily unavailable, the "homemade" mixture previously described was tried. This was electrically satisfactory, but proved irritating to abraded skin. An electrode jelly from the TECA Corporation had the same drawback and is contraindicated for use on mucosal surfaces. No qualitative or obvious quantitative differences were found in the results using either preparation. Tests were conducted to determine if changes in the electrolyte concentration would have any effect. We found that once a voltage became obtainable with a given concentration, further increases made no differences except to cause more irritation at the abraded sight.

B. The Variable Span Input Adapter

The purpose of this accessory is to enable one to record the full range of voltages which occur experimentally with a single setting of the input selector switch on the strip chart recorder. This feature becomes important when swings in potential are found to drive the pen off the chart. If, in this case, one simply changes the position of the selector switch to the next higher impedance, the amplitude of the deflections will be reduced by a factor of 10. This may result in some deflections becoming too small to evaluate. The adapter, which is essentially a variable potentiometer, allows one to create an "in-between" range which maintains the large deflections well within the width of the chart paper, reasonably close to the centered "zero" line, while at the same time permitting the smaller changes to be seen clearly. This is made possible at the lower impedance setting of the selector switch by dialing the control knob of the adapter to the proper setting. By putting a source of known voltage, such as a battery, across the electrodes (using the electrode jelly between the contact points), one may calibrate the device to produce a deflection of the desired size for a given potential. The A-9-A adapter has a vernier scale which can be tuned to the nearest 1/100th unit. For these experiments, a setting of 6.50 was used. This results in a 10mm deflection with 10mV of potential with the input selector switch at 100mV full range. We hoped in this way to obtain deflections on the same scale as Reich's so that quantitative comparisons could be readily made.

For certain tests, the adapter was not used and the electrodes were connected directly to the terminal strip on the recorder. With everything else the same, each centimeter of deflection then represents 4mV. In this mode, the zero line had to be moved close to one edge of the chart paper to accommodate deflections approaching 100mV. Moreover, the contour of the tracing, then, has superimposed upon it a multitude of small (1-3mV), irregular, jagged deflections which neither correspond to the subjects' heart rates nor to the usual pattern of 60 cycle "noise." These are, oddly enough, absent in tracings from nonerogenous zones. Their significance is unclear.

These particulars are presented, in part, to alert the reader to the possibility that our equipment and that of Reich may not be exactly comparable in their electrical characteristics. Reich's oscillograph, for example, employed vacuum tubes; our recorder has transistors. Lacking a more detailed knowledge of Reich's apparatus prevents us from determining its *sensitivity*. This question may have a bearing on the quantitative differences in the results.

Human Armoring
An Introduction to Psychiatric Orgone Therapy*

MORTON HERSKOWITZ, D.O.

Chapter 5
The Physical Dissolution of Armoring

A chapter on the techniques for reducing armoring should be introduced with a warning that the methods to be described are intended neither as a do-it-yourself, self-improvement program, nor as procedures with which psychotherapists untrained in orgonomy should experiment. Many of the techniques demand that the therapist be open and unarmored in the particular segment upon which he is working. An armored therapist using a particular technique in cookbook fashion would, in most cases, be ineffective. Or, he might even increase the armoring that he is seeking to remove. The worst possibility is that he might be effective and create problems that he is not prepared to deal with.

Another aspect of the use of these techniques as a therapeutic recipe is that they are not things in themselves but are used by the practicing orgonomist at a certain time, according to a particular intuition, and with a particular deviation from the way in which they have been described in writing. If the practice of medicine is an art as well as a science, the practice of orgonomy is that art carried to an exponential power. From this, it follows that there is no finite body of therapeutic maneuvers. One is always improvising, creating, and working in accordance with one's own structure and energy at that time. The critics and writers who have described the physical maneuvers of orgonomy as manipulation or massage are completely off the mark.

The Eye Segment

The physical approach to the eye segment is determined by *what* is being repressed, *where* in the segment the block is located, and *how* it is being held. For example, we may note in a patient with constant apprehension and frequent headaches that the eyebrows and forehead are chronically held raised in a low-level expression of fear and worry. We might then apprise the patient of what we see and ask him to consciously exaggerate this expression so that he may feel what he is doing. Work on wide-eyed fear over many sessions might eventually put him in touch with an acute fear that had been repressed and forgotten. Or, direct work on the fear in the eyes may be too threatening for him to deal with at that time

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and he may resist with angry determination, revealed in increasing spasticity of his jaws. We might then shift our focus to the angry jaw temporarily and confront the anger before resuming the work on the fear in the eyes.

Tension in the scalp is revealed directly on palpation. More subtle tension is uncovered by hypersensitivity to pressure, usually in the temporal, parietal, and suboccipital areas. To elicit the emotion that is bound by the tension, one would knead these areas until the anger, fear or crying, is expressed.

Hey, don't do that; what are you trying to do, break my head? I know there's something wrong in there, otherwise I wouldn't be here (giggle). How long do you intend to keep that up?!.....You having fun? Go ahead if that's how you get your kicks.....Man, are you some kind of sadist?.....That's enough, stop it (pseudo quiet determination).....Aw, come on, stop it (whine).....Well, what do you want me to do?.....Ow, that hurts (a little whine, but more honest expression of pain). Stop it (a little anger).....Shit, stop it! That's enough!! (Now the anger is true. His face is unmasked, his voice is serious and we continue with his expression of honest rage.)

There are a number of possible maneuvers to correct tension in the orbital muscles revealed in the inability to follow movements in the visual field with dexterity. The patient may roll his eyes as quickly as possible, moving them in a circle around the walls. The object is to attain the maximum speed without the sacrifice of particulate sight. This technique and the several to follow are essentially exercises in concentration and in permitting the eyes to be excited. They are difficult to perform, as is any exercise that demands undivided concentration.

An alternative maneuver is to have the patient follow random movements of a finger or a flashlight within the visual field. The flashlight is more commonly used in therapy because the photic stimulation of the electric light seems to add to visual excitement. Dr. Barbara Goldenberg Koopman has done fascinating work in this area.* In all of these visual motor activities, the therapist is an active participant, concentrating himself to pick up flagging patient concentration, goading the patient to greater speed and focus. It is not merely a matter of setting the patient in motion and sitting back comfortably to watch the performance. The inability of some individuals to participate in these moving-seeing exercises for more than a few seconds would seem astonishing to many. The existence of dissociative processes in people is often uncovered with these techniques.

"That's strange, I start out determined to really follow the light. I know it's a simple thing to do. But then, I don't know when it happens; I'm suddenly thinking about something altogether different, or else I'm thinking about doing it, instead of actually doing it."

Perceptive patients describe the effort of following a darting object as trying to pull the eyes around against the resistance of strong rubber bands. The continued exertion often results in gradually decreased muscular tension and a new visual clarity.

The focused endeavor to move the eyes and see over a long period of time uncovers frustration and rage. In those yet unable to rage, the frustration may lead to crying. For those patients who early in childhood learned the trick of dealing with life's difficulties by going off in the eyes, either into a fantasy

*Baker, Elsworth F.: *Man in the Trap*. The MacMillan Co., N.Y., 1967, pp. 50-52.

reverie, or else into a state of utter blankness, there is a mountain of arduous work to unhinge this automatic mechanism. The patient is instructed to go into the eyes-off state voluntarily and then to suddenly pull his eyes back into focused contact. This is a maneuver that requires the utmost concentration in individuals unused to concentrating. It is used in conjunction with the work in eye-tracking.

Once patients have discovered their tendency to separate themselves from the environment by going off in their eyes, and have learned how the performance of eye movements can help bring them back into contact with their environment, they can use this knowledge when they are faced with loss of concentration. Students, for example, learn that, after hours at their books, when they are beginning to reread each sentence, they must take a brief vacation from the print, move their eyes quickly around the room, apprehending as many visual details as possible. After several concentrated minutes of this work, they can return to their books once more and understand each sentence as they read it.

For those who need it, work on eye comprehension is not restricted to the treatment hour. Patients are instructed to pass store windows grasping as much detail as possible, and then to return to see what they have missed. They must pick out details of color, design, and texture in the clothing of people in the street, peculiarities of gait, facial expressions, etc. To people who have never looked, the revelation of the emotions on the faces of their fellows always comes as a surprise.

From the therapeutic standpoint, these are not merely mechanical exercises. The patient with a large emotional stake in deadened eyes will resist strongly. As the dead eyes learn once again to see, there will be a concomitant rise in experienced anxiety which must be dealt with. Occasionally, there will be a strong breakthrough in eye armoring with precipitation of acute anxiety and need for immediate care.

In the course of therapy, the patient with armored eyes must become capable of the expression of all emotions in his eyes. He must be able to look and feel tenderly in his eyes, to look violently angry, terrified, deeply sad, etc. In eliciting these eye emotions, the therapist interacts with the patient, feeling and expressing these things in his own face and eyes.

After many hours of work and fifteen defensive ploys, a patient arrives at the point where she and the therapist are looking at one another openly, warmly, without subterfuge. The patient's face is transfigured; it is not her (old) face. She says, "You know, I never made a place for love in my life."

A schizophrenic patient who is having great difficulty with eye tenderness says, "When I let my eyes go soft and look at you, I feel as if you're going to come at me and beat me up; when I keep my eyes the usual way, I'm not scared of you."

A young man attempting to express eye rage throws his head around as if it were almost independent of his body. The therapist explains that he throws the head about in this fashion to disclaim responsibility for his anger, as if the anger were independent of him. When he attempts to "take charge" of his anger by coordinating head and body, he can no longer express the anger.

A patient succeeds finally in expressing anger with his eyes. His face is flushed, contorted with rage, sneering, bitter. Afterwards he says, "I really started to hate you; I felt like tearing your eyes out. How can that happen, because I really like you?"

Another patient accomplishes letting the

tenderness through her eyes and she says, "I recognized that I never looked at any men, not even Larry (her mate), and I suddenly wanted to hit you. You became my father and I knew I was afraid of being seduced. I couldn't look at men because of him."

Working temporarily on another segment, the therapist asks a patient to try to feel the pleasure of breathing down without resistance. The patient tries for a while, then interrupts himself. He says (correctly), "Doc, how can I feel pleasure? I can't even look you in the eyes yet!"

One of the most terrifying procedures, especially for individuals with a palpable level of anxiety, is to open the eyes widely, raise the forehead, emphasize the inspiratory phase of respiration (as in actual fright), and permit fear to come into the eyes. If the patient can muster the courage, the experience often precipitates an anxiety attack. And often, in the throes of the fear, the memory of fearsome events that eventuated in armoring rise to the surface in three-dimensional vision.

Moving the eyes to their lateral limits and looking through them in this position simulates the suspicious gaze of the paranoid as he examines his environment for signs of danger. This sidelong glance is used in therapy to help make patients more aware of their suspiciousness.

As with all the segments to be described, one repeats the same maneuvers time after time in therapy. Having experienced a hint of the feeling of suspicion on one occasion, at some farther point in therapy the technique is tried again. This time the patient feels suspicious to the point of paranoia. Or, at one time the patient may have experienced deep rage in his eyes, but at some subsequent repetition, he comes upon a layer of rage more consuming than he thought possible.

In addition to the commonly used techniques for dealing with the armoring of a particular segment, every therapist adds his own variations or borrows from his life experience or his medical knowledge to bring something new to his practice.

For example, a patient with a severe eye block also complained of a chronic pain in one ear. Direct work on the eyes and the affected ear area did little to relieve the pain. On one occasion, when the patient described the difficulty she was having with reading, transposing letters and syllables, the therapist inquired into her handedness. The inquiry led to the discovery that she was ambidextrous, that she had been born left-handed, but that handedness had been switched in childhood. She was instructed to put a patch over one eye for increasing periods daily and to begin retraining her left hand in writing. Within a week of conscientious practice of dominance-training, the ear pain that resisted the assault of direct work on the armoring from without, diminished. The problem was not completely solved because the patient still complained that the ear felt "closed" (though her hearing was adequate), but she was relieved of the pain.

Eye armoring is dissolved to some extent when brain functions are improved through conventional means. The exposure of irrational thought processes to reasonable scrutiny and the attainment of a deeply experienced insight clears the knotted brain, bringing more clarity to the eyes. The formerly chaotic backward patients who, with conditioning techniques, have learned to eat with utensils without slopping themselves are, to a small degree, less eye-armored for the experience.

In the heyday of the drug culture, one heard of the profound insights gained with the use of

this or that drug. Despite the overblown claims of benefit, it seems that certain drugs have the potential for loosening brain armoring and, in rare instances, of bestowing new and valid insight on their users. However, taken all in all, the end result of such processes is far more often harmful rather than helpful. Armoring released in the eye segment can not be therapeutically useful when it is loosed against an otherwise heavily armored body. As a matter of fact, one often observes that the eye segment is more heavily armored after the immediate effects of smoking marihuana have "worn off." The expansion that follows loosening of brain armoring by the drug is succeeded by a reactive contraction, and the result is a net loss so far as emotional health is concerned. Chaos could result from the clash of the idea of grace in a graceless corpus; and these are the drug takers who require hospitalization. In most cases, the armored body will gradually smother the enlivened brain, and the individual will continue in his life as dead as ever, with eyes devoid of luminosity.

Deadness in the eye segment often elicits spontaneous efforts to "get something moving up there" and individuals poke their scalps, rub their eyes, and, in the case of severely armored children, bang their heads.

A patient with eyes sorely out of contact is subjected to the therapist's painfully prodding fingers in the parietal area. He says, "I know it hurts, but I don't even feel like yelling; in a way it even feels good. Does that mean that I like to suffer?"

To be free of armoring in the eye segment implies that the mind acts in conjunction with natural emotions and is not used to provide "rational" defenses against them. Unarmored eyes, informed, attain insight. The husband with armored eyes sees his anxious, harried, distraught, coping wife and makes jokes about her behavior. The husband with unarmored eyes sees that she is distracted and that she copes, but he senses the terror from which she flees and is not jocular.

The Oral Segment

In dealing with the armoring of the oral segment, which involves a considerable part of the facial musculature, the use of a mirror, either the actual glass or the mirror of imitation, is helpful. To help the patient become aware of his pouty, or angry, or scared, or overbright face, he must see it as we see it. We mold our face as he molds his to reveal him to himself. Sometimes the anger which his overbright face conceals is elicited as we persist in our imitation. Sometimes he cries childishly, the next step inward, as we pout back to his pout.

Patients must learn to express all emotions in their faces. Free breathing aids in providing energy for this task and sometimes the addition of the appropriate uses of other segments, e.g., clawing hands or pounding fists in anger, help in the procedure. Emotional involvement is a *sine qua non* in this process; it alone provides authenticity. In patients who have been trained to bland affect, the work is arduous.

A patient whose constant face as she lies on the couch is a mask, with lips slightly pursed and eyes firmly glued to a spot in the ceiling, works on making a pleasant face that feels nice. For the better part of an hour, she tries, and it is all mechanical; but at one point, and for the first time since the therapist has known her, her face eases into a genuine open smile. When the session is over she says, "I feel as if I've been through a wringer."

For the facial muscles to convey an emotion in its full force, it is necessary for the eye

segment to have been at least partially mobilized, because the expression in the eyes is integral to any meaningful facial expression. Contrariwise, when working on the transmission of emotions in the eyes, we are already doing preliminary work on the facial muscles.

To deal with the anger contained in a jaw held tightly, there are two principal therapeutic maneuvers. The therapist prods the musculature with his fingers (this is usually a painful procedure) and the patient bites as forcefully as possible, feeling his anger as he bites. Where the jaw armoring is chronic and heavy, patients are often instructed to practice biting on cloth or leather in their spare time at home.

A young woman in whom jaw armoring had been dealt with in the past, and whose therapy had proceeded through the abdominal segment, developed intense rearmoring in the jaw segment, with tooth-gnashing at night, and intense clamping of the jaw by day to the point of pain. She was advised to do lots of towel-biting as homework.

On the following visit, she reported, "I've been practicing the biting, and one day I suddenly knew what I wanted to hold on to. I was biting my father's finger, and I've read enough to know what that means. And then the back of my throat opened, and then muscles on the inside of my thigh that had always been tight before."

The sucking function of the oral segment is dealt with by thumbsucking. This is often extremely distasteful to those individuals in whose childhood weaning was a traumatic process, or those who sucked their thumbs and were shamed for it. In some, the lips are so sensitized that they cannot bear having their lips touched, and constantly avert their heads. Others cannot put their thumb to their lips without gagging.

As the result of emotional breakthroughs in other segments, one often sees involuntary tremors occurring in the muscles of the mouth and lips. As the tremors develop, they sometimes are revealed as a last ditch effort of the mouth to suppress crying. More often, when the free play of these apparently random twitchings is encouraged, they gradually take shape as infantile sucking movements and are associated with recovery of infantile memories and feeling states.

Where sucking has been interfered with in childhood, there is an inability to suck softly with pleasure; the sucking is either mechanical or avaricious. Sometimes, when pleasure begins to be perceived in sucking, there is almost simultaneous pleasure perceived in the pelvis. In this case, the pelvic anxiety interferes with the ability to indulge in the oral satisfaction.

The patient, who had sucked her thumb to age 9 and broken herself of the act through rigid self-discipline, lies crying and yelling. There is a childish coloration in her vocalization. Suddenly, she is quiet and her eyes open wide. She stays this way for several moments, perturbed, but absorbed. Her lips begin to move in a distorted sucking pattern, then she sobs in huge, heartbroken waves. When she is again quiet, the therapists asks, "What did you see?" "A huge breast filled with sour milk," she replies.

The vocal function of the oral segment is realized in the vocal expression of rage - yelling and screaming, sadness, crying, screaming in fear, and in the subtle modulations of the voice in expressing the gentler feelings. The therapist works not only on the intensity of the vocal expression, but on its quality also. There is a natural timbre and range to each voice, governed by the same physical laws that determine the sound of the flugelhorn and the oboe, the nature of the

material, the shape and size of the instrument, etc. Any constraint on these natural notes of speech are sensed by a sensitive listener. Anyone can identify the broader trespasses on the natural voice - the whisperers, the bellowers, the whiners, etc.

A big, robust man who conducts his life so that he's liked by everyone, has a large resonant voice which he rarely uses. In a previous session, he had sung for the therapist, who found the quality of the voice to be glorious. But now he lies on the couch sighing through a squeezed, tight throat, and his chin is tense. He is directed to make a bigger, more open sound; but as the volume increases, so does the strain.

The therapist describes his resonant natural voice and its relationship to problems of character. "That big voice commits you," he says, "It makes you a target. It's deep and important. It says, 'This is not a good nice guy; it's me.' You can use it when you sing because that doesn't commit you; you are only singing. That's probably one of the reasons you enjoy singing so much; you can be your deep, big self without putting yourself on the line. You're like the stutterer; he can sing without stuttering."

To which the patient replies, "Oh wow, I'm so fucking good on the stage and I know it. I see how it works. If I spoke like that in a bar somebody might pick a fight."

The natural quality of the voice cannot be elicited until the emotions entrapped in the armored musculature, e.g., the crying or the screaming, have been released. It is not simply a matter of vocal training. In some cases, the emotion cannot be released until the throat has been loosened in gagging. One threads one's way from emotional block to emotional block.

A patient attempting to scream is going through an obviously traumatic experience. There is the quality of tantrum in her expression. She stops and breathes for a while, then goes into the screaming again, but this time the performance is much wilder and piercing. When it is over she asks, "You want to know what happened?" She says, "The first time I was having a tantrum on the street when I was a little girl walking with my parents, and that actually happened. The second time, I decided to make it come out better, and I was yelling so loud that I'd attract the attention of a policeman and he'd come and take me away from my parents. That never happened, but I wish it had."

The muscles under the chin are often instrumental in holding crying, and just as one watches for swallowing as a way of keeping from crying, one keeps an eye on the submental muscles. When they are taut, they are subjected to painful finger pressure until the cry is released.

A discussion of handling the voice in therapy would be incomplete without a discourse on the subject of the patient's communications. As so much of human activity is a camouflage for significant action, so much of human expression is a flight from feeling, thinking, and saying something of seriousness and import. As armoring in the eye segment converts the brain from an organ that provides intelligent solution of a body's problems to an organ that provides rationalizations for the body to continue to perform in its crippled fashion, armoring in the oral segment acts as the verbal courier of the "cockeyed" brain. Consequently, it is not uncommon that the therapist's comment at the end of the patient's recitation is the unseemly and indecorous one, "Bullshit!" One does not permit the patient to crowd the treatment room with verbal garbage any more than one permits the patient's defen-

sive smile to go unchallenged. Patients who are masters at the defense of the verbal barrage are made to shut up. On the other hand, thoughtful, deeply felt discussions are welcomed in their appropriate time. True, serious words are no less significant conveyors of deep feeling than more dramatic expressions such as crying and screaming.

The patient, a man in his early forties, who was raised in a fundamentalist church, is requested to yell the vilest, most obscene words at the top of his voice. After repeated demurrals, he consents, beginning with "shucks" and "darn," and progressing to expressions that would be credible in a navy barracks. But he is only saying, not shouting them. He is prodded to scream them at the top of his lungs. He finally does, and they come pouring forth with affect. He stops suddenly. His eyes are raised apprehensively to the ceiling. He is waiting for God's thunderbolt.

Certain aspects of oral armoring are treated as problems of character as well as specific physical problems. The most dependent persons, for example, make their way through life looking for sustaining nipples. In therapy, this would be worked through on both the behavioral and physical levels.

The Cervical Segment

Treatment of armoring in the cervical segment involves handling problems of the lower reaches of the throat, the deep cervical musculature, the superficial posterior cervical musculature, and further work on gagging. Ordinarily, most of the painfully taut cervical muscles lie in the posterolateral and posterior area of the neck.

Crying, screaming, yelling and raging, and tender sighing are elicited to enable the patient to express whichever of these emotions has been problematic. It is interesting to note that on occasion the repeated utterance of deep, satisfied ahh sounds with a fully opened throat serves to eliminate the wheeze in an asthmatic attack of mild to moderate severity.

Stubbornness is dealt with on both a characterological and physical level. The stubborn muscles lie posteriorly and they are attacked by painful pressure to the point of evoking the rage that lies behind the stubborn defiance. To become acquainted with the muscles of stubbornness, patients are requested to stiffen their necks and experience the resistance in its fullness. Later, they are encouraged to shake their heads from side to side while yelling words like "no" or "I won't." Sometimes, the forcible dorsi-flexion of the neck to a point where the mouth lies in a plane with the throat succeeds in releasing deep sobbing held back by a tight ring of cervical armoring.

In those individuals in whom cervical armoring represents the fear of being struck, the emphasis is on the expression of the fear, then the fury in reaction.

To counter the stiffness in motion and the anxiety that free-wheeling neck movements engender in those with cervical armoring, patients perform free-swinging neck, shoulder, and arm movements as in dancing. The anxiety that such loose cervical motion elicits is often surprising in its intensity. To those unaware of the general fear of surrender in the neck, it would be instructive to perform the following experiment. In the supine position, raise a healthy, happy infant by providing a fulcrum in the area between the shoulders or by lifting the body by supporting the extended arms. The healthy infant will permit his back to be raised without resistance and, as his chest rises, his head and neck fall backward gracefully. Now repeat the same maneuver with

adults and note how, in most cases, the head and neck rise rigidly as the chest is raised. To surrender in one's neck is to be undefended, a dangerous posture in a hostile world.

The Thoracic Segment

Work on thoracic armoring involves several separate functions. There is the breathing activity, which not only sustains life but regulates the energy level of the body. Then there is the aggressive and defensive function of the upper limbs, the surrender of the lower chest bordering on the diaphragm, the holding-back function of the dorsal spinal region, the protective function of the shoulders turtled to cover the neck, and the longing for union of outstretched arms.

Breathing is encouraged by the therapist's exhortations and by vigilance for any insidious decline of respiration. Sometimes, patients are instructed to place their hands on their chests to encourage tactile awareness of chest movement in breathing, in contradistinction to moving the abdomen and holding the chest in respiration. It is sometimes necessary for the therapist to place his hands over the sternum and push forcefully with each expiration until the chest begins to move spontaneously.

Sometimes, despite this forced aid, the chest will still not move until one has dealt with the armored intercostal muscles. Painful pressure (it need only be marginally painful) in the axillary or lower rib or dorsal area may get at held emotions and, subsequently, the chest moves freely and continues spontaneously. Where there is muscular hypersensitivity, tickling, or sometimes the softest stroking, may have the same effect.

Just as there is a natural timbre and range for each voice, there is a natural respiratory rate above which the organism is energized and below which one merely maintains life functions. Patients sometimes inadvertently discover that when they breathe at a certain rate nothing frightening will happen and they attempt to hold their breathing to this rate. The therapist must be aware of this fact and encourage them to breathe faster. Contrariwise, some patients attempt to huff like a steam engine in an attempt to precipitate some dramatic effect. This unnatural mechanical exercise must also be discouraged.

In encouraging breathing, the therapist must be aware of the patient's general energetic status and tolerance. In an organism tight to the bursting point, a sudden increase in energy generated in the chest could conceivably precipitate a psychotic episode or a cardiac accident.

A bright, energetic, relatively new young patient lies breathing, savoring the experience. The therapist cautions her to slow down, but she reassures him that this experience is too pleasant to diminish. As she continues, it is apparent that she is becoming uncomfortable and, just at the point that the therapist decides to tell her to stop all activity, she begins to scream. The screaming continues for minutes, and now her pupils are saucer-wide and her palms drenched with cold sweat. He cuddles her and the screams subside gradually. She is all atremble and continues in soft moans. Later, when she has recovered, she says, "It just happened suddenly. I got scared and I thought I was going crazy."

The aggressive and hateful uses of the upper extremities are exercised in a variety of ways. Patients pound on a couch and occasionally on a rug-covered wall (though the latter is not encouraged). In punching, it is all important that the patient put his entire force into the blow, that no energy be lost in the play

of inhibitory muscles, and that strong emotion accompanies the effort. Females are permitted to punch the therapist's arm in the padded deltoid area, unless it begins to hurt. Sometimes the sheet is shaped into head size, and patients visualize pounding the face of their momentary enemy.

Impulses to throttle are gratified by encircling the therapist's forearm and squeezing with all one's might. Scratching and pinching are vented on the couch mattress. Occasionally, patients are granted the pleasure of ripping the sheet to shreds.

The importance of the muscular discharge of energy through the hands is attested to by many natural phenomena: the tremor of the outstretched hands of the anxiety-ridden, the pan-cultural habit of wringing hands, drummings fingers, rubbing fingers, counting beads for distraction, etc. In the physical release of rage, one must know one's patient. Where there is doubt about ego control, one moves slowly. And, as in all of the rest of life, there are times when one takes calculated risks.

A meek and mild borderline psychotic in her early thirties has been working on the repressed aggression in her shoulders and arms. Throughout therapy, she has been voicing dissatisfaction with her husband to whom she is tied in a dependency-hate relationship. He has been the target of all her hostile outpourings. On the day that her rage finally erupts in therapy, she is seized with reactive anxiety and says that she fears that now she might kill her husband. The therapist reassures her that she has sufficient control to keep from doing such a thing.

In the middle of the night the therapist is awakened by the ringing phone. The patient is on the line and she says that after her husband fell asleep she arose from bed, went to the kitchen, returned with a knife, and cut his wrist. Then she woke him, told him what she had done, and hastened to bandage his wound.

The therapist asked to speak to the husband. The husband (who had been cooperative throughout the course of treatment) could hardly speak for laughing. "The nick is so small," he said, "I don't see how it could have bled at all."

The symbolic murder marked a turning point in the therapy and in the marital relationship.

The release of shoulder girdle hostility is augmented when there is simultaneous hateful eye contact. This is the time when patients recognize that they harbor murderous impulses toward the therapist which had been totally hidden from consciousness. Patients are often at a loss to account for the fact that they would wish to kill, or at least hurt, someone who has been helpful and considerate. The therapist explains at this point that he is the extant representative of humanity, that the rage is not against his person but the species which he represents.

In several decades of practice, there has been only one patient who, at the point of expressing his rage, stirred in me feelings of apprehension for my safety. He was a huge hulk of a man who once, in a bar room brawl, had beaten-up his adversary and then turned the juke-box over his fallen foe.

Patients who learn to express their rage violently in therapy do not go about thereafter beating up their families, friends, and neighbors. They are, however, less prone to suffer aggression passively, and they tend to function more aggressively (but not hostilely) in all aspects of their life. In my experience, there was one brief exception to this generalization.

The patient had rioted and raged for the

first time on the couch and, having been submissive for most of his life, he relished the experience and left the session in high spirit. When he returned on his next visit, he told the following story:

"When I left your office," he said, "I was feeling wonderful. And as I walked toward the subway station, I had the feeling that I wanted to get into a fight. When I was a kid, I used to run away from fights and now, when I got to the subway station, the impulse was really strong. I started talking to some dude on the platform, and I knew that I was deliberately edging him. Well, finally he had a neckful of me and we got into it. I gave him a couple of good ones and knocked him down. Then I helped him to get up and apologized to him and told him he could give me a couple, but he didn't want to. He must have thought I was out of my mind."

A variant technique for eliciting upper extremity aggression along with the aggressive uses of other segments of the body consists of the therapist's pinning the patient's arms to the couch above his head and instructing the patient to attempt to throw the therapist off and free his arms using any means except biting. The weak, hopeless struggles of some patients, and the concentrated, energetic battle of others are not only a gauge of the available aggressive energies of the patient, but the dispatch with which some thinly muscled ladies can unburden themselves of the therapist's oppression attests to the power of focused energy and purpose.

In eliciting the tender uses of the upper extremities, the patient reaches with outstretched arms while sighing with longing. Because of the cultural mold, this is particularly difficult for many men to do. It flies in the face of the "macho" model in which little boys have often been set. Consequently, it is males who often have the strongest emotional breakthroughs in the performance of this act.

The soft-touching uses of the hands are practiced by having the patient enclose his hand on the therapist's, perceiving warm tactile contact. Or, the patient may touch the therapist's face, maintaining warm eye contact. Tender touching suffers from the same cultural abnegation as reaching out. It is instructive in watching films of the stone-age Tasaday of the Phillipines or of premodern Eskimos to recognize how much of human communication is transmitted by touch in those less armored societies.

The therapist asks a wooden patient to hold his hand in hers. She cannot bear to close her fingers around his hand, and when she finally does, she must close her eyes.

For the shoulders that rise in defense of the neck, the patient must be ever watchful and learn, particularly in times of stress, to proceed with loose, lowered shoulders. There is a reciprocal relationship between the aggressive and defensive uses of the shoulder girdle. The more the individual becomes capable of aggressive activity, the less the tendency to automatic defense, and the less the shoulders tend to rise.

The spite that is held in tightened bands of paraspinal muscles between the scapulae are treated with firm, probing pressure that releases the rage that lies under the spite.

The Diaphragmatic Segment

The force of the work on the diaphragmatic armoring is centered on destroying the impedance function of the armored diaphragm so that impulses of excitation can proceed through this area unhindered. The practice of gagging while breathing in and out freely is one of the chief techniques employed. Those

with a strong diaphragmatic block are encouraged to gag upon arising. Another mechanical aid is the practice of the movements and sounds of "belly" laughter or convulsive sobbing, assuming that whatever blocks that might have existed in the throat have been eradicated.

The armoring may be approached externally by tickling the hypersensitive muscles in the diaphragmatic region, taking care that the laugh that is elicited is released freely and openly.

When one has succeeded in relieving the diaphragmatic block, permitting the patient to breathe through, the greatest barrier between the pleasurable impulse source and the target genital excitation has often been removed. Consequently, there is sometimes a surge of sexual fantasy and sexual dream material at this point. On the other hand, if there is almost total blocking in the pelvis, the diaphragmatic breakthrough may appear as violent rage.

In the preceding week's session, the patient had succeeded in breathing through for the first time. At his next session, he told the following story: "Last Wednesday, I was trying to breathe and let my chest go when suddenly the same thing happened that happened here last week and everything seemed to melt all the way down to my pelvis. Then I went into a fantasy; it just came over me that I was having intercourse with my mother. Then I remembered that, when I was about thirteen, I dreamed that I was having intercourse with my mother and that was the last wet dream I ever had. But, when I woke from that dream I felt so miserable and guilty that I couldn't stand it. I guess that's why I didn't think about it till this happened."

When the diaphragmatic block has been removed, the attempt to gag and vomit is accomplished easily. In the therapeutic work, a physical wave runs down the abdomen at this point which the patient may not only observe, but may perceive subjectively.

The Abdominal Segment

The dissolution of abdominal armoring is usually a fairly straightforward matter. One of the commonest techniques is the pressure of a finger placed in the midline between the xiphoid process and the umbilicus. With each expiration, the therapist presses fairly gently, and this often suffices to soften the taut musculature sufficiently to permit the abdominal wave to proceed. In other cases, more severe pressure laterally along the margins of the rectus abdominis is necessary. Occasionally, after one has relaxed the musculature in the upper abdomen, there is a residue of tension in the low abdomen, especially above the pubic area. Spite that is represented in the armored lumbar muscles is released by pressure on them. It is sometimes advantageous for the patient to bang his belly against the couch repeatedly to get at abdominal rage.

Reich indicated in his writing that, when one had freed armoring above the abdominal segment, the work on the abdomen offered no difficulties and proceeded easily. In my experience, this has often been so, but there have also been instances where the progress of therapy has been held up for months at the abdominal segment. It may be that, in this latter case, the abdominal armoring represents the last line of defense for a not too heavily armored pelvis.

After months of consistent attack, the abdominal armoring of a young male patient finally gave way. Spontaneously, he remarked on how tense his arms and buttocks felt at this point. When he voluntarily relaxed them he found himself walking in a new way.

These events that occurred in the pelvic segment were almost like a follow-through to the dissolution of the abdominal armoring.

The Pelvic Segment

The patient with an armored pelvis who attempts to move his pelvis usually moves thighs, pelvis, and abdomen in one piece, as if they were cast together. Independent pelvic movement is difficult when the muscles in and around the pelvis are tense.

The regions that tend to greatest tension are the pelvic floor, the buttocks and perianal area, the thigh adductors, and posterior thigh musculature.

There is no segment where work on the armoring is so intimately connected to precipitation of anxiety as the pelvic segment. There is no anxiety that is so deep as this anxiety. It is for this reason that work on the pelvic armoring is left for the last in therapy. Only when the armoring in all other segments has been dealt with and the organism has gained a certain solidity does one embark on treating the pelvic segment. And one proceeds cautiously.

The simple act of breathing down and permitting the thighs to open gently on expiration is sufficient to occasion anxiety in some patients, especially females.

A young woman who had performed this simple exercise for the first time in her therapy session reported at her next visit: "I knew when I was doing it that it was upsetting me, but I didn't know how much. Every night last week I had dreams of horrible punishment and it got to the point where I was afraid to go to sleep. All that from opening my legs a little bit."

Another patient performing the same exercise says, "I have to keep telling myself that I'm not trying to seduce my father, and I'm afraid of what will happen when that wall comes down."

The almost universal armoring of the adductors of the thighs is observed as the patient lies breathing with her thighs apart. In some, there is an observable periodic spasm as the thighs fight to close together; in others, the armoring is only recognized upon palpation of the taut adductors. Reich facetiously dubbed these adductors the "morality muscles." Both the superficial and deep adductors are treated also by painful pressure, both on the muscular belly and above their point of insertion. The pain increases awareness of the armoring and often elicits the story of the affect buried in the armoring. The same procedures are employed in dealing with the posterior thigh muscles, chiefly the biceps femoris.

After the armoring of the thigh musculature has been dealt with, one proceeds to the tension in the sacral and buttock areas. The patient is made aware of the tension in the buttocks by voluntarily tightening and releasing this musculature and by the application of painful pressure to these taut muscles.

This having been accomplished, the tension of the anal sphincters is treated by instructing the patient to tighten the sphincters with inspiration and to let them go with expiration. An alternative is to instruct the patient to tighten the sphincters and to maintain the tension for as long as possible while breathing.

A patient reports: "You know, I noticed that every time I put my foot on the brake, I tighten my anus. Now that's really weird. That must mean that anytime I go to stop anything I automatically tighten my ass."

Once patients have mastered the armoring about the anal sphincter, they frequently report a change in bowel habits that had per-

sisted until that time. Disorders such as constipation usually disappear, and patients experience a new pleasure in bowel functions.

With the elimination of armoring, an awareness of the connection of the pelvic segment with the rest of the body develops.

In order to deal with the pelvic armoring, the patient must first perceive that it is there. The absence of awareness that a muscle group is held in a state of constant contraction is most true of the muscles of the pelvic floor. Often, as the patient breathes, the scrotum can be observed to rise with each breath, as the pelvic floor muscles contract; the patient lies breathing, assuming he is totally relaxed. (There is no comparable external sign for females.) To apprise the patient of this contraction, he is instructed to voluntarily contract the pelvic floor musculature for as long as he can possibly hold it and then to let go. For the first time, he recognizes what relaxed musculature in this area feels like. An alternative method is to instruct the patient to tighten the muscles with inspiration and to relax them with expiration. Then he is instructed to develop awareness of the state of contraction or relaxation of these muscles as he proceeds with his ordinary activities during the week.

When some of the armoring has been loosened, the patient is in a position to practice the voluntary movement of the pelvis with breathing. The pelvis must move independent of thighs and abdomen, and it is here that acute anxiety is often experienced. At this juncture in therapy, patients who had enjoyed a relatively satisfying sex life often report a sudden cessation of all sexual desire, or a sudden difficulty with sexual performance - frigidity, impotence, anesthesia - that had never occurred before. This difficulty is always temporary and coincides with the new layer of sexual anxiety that has been plumbed. Almost invariably, the sexual experience, once this difficulty is passed, rises to new, and heretofore unexperienced heights.

The voluntary pelvic movement is not designed as practice for sexual performance but as a means of eradicating the pelvic stiffness which prohibits the appearance of involuntary pelvic movement, the orgasm reflex.

The appearance of the orgasm reflex always comes as a surprise to the patient the first time it occurs. One patient said, "It feels like a magnet making your pelvis move, and you have nothing to do with it." In the beginning, it is always experienced with at least a modicum of anxiety, no matter how much sexual anxiety has already been cleared.

While the work is proceeding on the pelvic armoring, patients report increasingly on new sensations perceived in the genital area. Females describe warmth, tingling, melting sensations deep in the vagina and males report on similar feelings in the penis, often accompanied by erections. With time, the sensations perceived in the therapeutic hour become incorporated in the sexual performance at home. Generally, the patient is several years out of therapy by the time new sexual freedom is totally integrated into his actual sex life.

A final note: It has been mentioned, but because of the damage we see that has been wrought on patients in "neo-Reichian" therapies, it bears reemphasis: The pelvic segment must be approached only after armoring has been cleared in the upper segments. When the pelvic segment is approached prematurely, the body attempts to deal with the overwhelming anxiety by increasing the blocking at higher levels. Sometimes this last ditch, desperate attempt to hold back energy from reaching the pelvis creates armoring of such intensity that it is no longer amenable to therapeutic efforts.

To be continued.

The Management of a Case of Substitute Contact

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Introduction

The following discussion continues a case report which was published four years ago in the *Annals*. The patient, a white, single, 48-year-old male had developed problems that were related to his three year course of "Reichian" therapy conducted by a social worker. Therapy was sought with the author, as the previous treatment had resulted in an "impasse." We shall begin by quoting from the original description of him (1).

> *He was moderately armored in all segments except for the neck, where armoring was extremely pronounced. On the couch, he talked endlessly and repetitively, with his eyes squeezed tight or fixed on the ceiling. After a few breaths, he would writhe dramatically, kicking and hitting the couch, with his eyes tightly closed and his teeth clenched. This was accompanied by angry, forced crying. Having spent himself in this activity, he resumed the compulsive talking, using psychological terms in a confused manner to describe his feelings, current experiences, and early family interactions. This behavior, precipitated by only minimal breathing, gave evidence of an inability to tolerate energetic expansion.*
>
> *Dynamically, the following was occurring: First, biological charging produced some emotional movement. This led to the thrashing about, which permitted the leaking off of some charge while simultaneously intensifying the blocking at the eye segment. The patient's intellectualizing was the result of an increase in brain activity, while his compulsive talking aided in dissipating further excitement and reducing his anxiety level.*
>
> *On the level of personal interactions, much the same thing was taking place. As an executive officer, he was solely charged with the development of new business for his firm. He attained superb results by virtue of a frantic schedule of social and civil "public relations" activities. The tremendous energy expended in these pursuits exhausted him until he developed a general weakness with colds and flu-like symptoms. He ran from the closeness of a sustained love relationship with the same desperation that characterized his professional life. In both areas, he was driven and unsatisfied but unable to deepen his emotional contact.*
>
> *The therapeutic errors in the previous treatment that led to this plight were in accepting the dramatic display as if it were a clear emotional expression rather than an inability to hold a charge, and in permitting the loquacious psychologizing to run on unchecked (1).*

History

The family relationships, as he described them in his early sessions, are of crucial importance in grasping the origins of his charac-

ter defenses.

His father was a warm, emotionally demonstrative, socially extroverted, somewhat disorganized but accomplished painter and musician. He was gregarious and usually the center of attention, particularly from women at parties where he entertained by playing and singing. A congenital spinal deformity forced him to walk with a limp and generally impaired his mobility. The patient felt his father exploited his physical disability by encouraging people to feel protective. The father was not a financial success and the lack of money was always felt. The patient identified strongly with him.

Contrastingly, the patient's mother was described as cold, highly organized, and emotionally detached. She cared for her children competently but with what the patient experienced as a lack of warmth, nurturing, and physical closeness. Doing what was expected and being quietly well behaved was the approach most certain to garner her approval.

During his pre-teen years, both parents were active in leftist social causes and groups, much of which activity occurred in their home. Accompanying these activities was a conspiratorial and covert atmosphere. Concerns about F.B.I. surveillance, fear of established authority, caution regarding neighbors, with the attendant sense of being different, produced in the patient a heightened level of anxiety, with feelings of isolation and insecurity.

He has two younger brothers. As they were growing up, he assumed the role of peacemaker between them.

Course of Treatment

The task of overriding importance in this man's treatment was twofold. The first was to help him overcome his intolerance of energetic movement. The second was to establish an avenue for its expression that would permit a determination of which genuine emotions lay beneath his substitute expressions, i.e., the dramatic displays and compulsive psychological verbal flow. The first effort in this direction was the technically appropriate one of shutting him up. While that did result in less verbiage, it occasioned, after only three or four deep breaths, a corresponding increase in the thrashing about, kicking, and general turmoil. Inquiring as to his thoughts or feelings during these outbursts disclosed very little content except for some tension felt in the chest. For a time, I attempted to stop these displays as well. This proved difficult, but could be accomplished by gently restraining him physically while quietly and firmly directing him to stop and to establish eye contact. Proceeding in this manner left the patient somewhat more uncomfortable than before, for he no longer got the physical relief that the previous eruptions provided. During each interval provided by this restraining approach, I again pressed him for concurrent sensations and associations. After many efforts to decipher them, he was able to identify fear associated with a feeling of being left alone and unresolvable aching and terrifying loss. Soon after, he felt that the fear was also related to his feeling threatened by confrontations in which he was obliged to say no to a request or discipline or dismiss an employee. So, even though the restraining intervention increased his sense of physical tension and heightened his anxiety, it provided us with a method of examining his functioning on an ego level as he began to integrate the material experienced in the sessions with those of his life. For example, it was in this phase of treatment that he felt his major character defenses to be artificial. Foremost among them were the

efforts he took to be accepted and liked. He employed any maneuver with which he might ingratiate himself, accommodate, or please. A panoply of behaviors which derived from identification with his father was clearly apparent. The patient had appropriated from his father the disorganized style, the air of being unable to cope with the world, and a gregarious, boyish charm with women, all of which invited attention, protective responses, acceptance, and affection. Over the next several months, the focus was on his character defenses, accompanied by an attack on the holding in his neck and jaw as he was encouraged to express the now clearly felt fear and longing in his chest and throat. Proceeding in this way, particularly with emphasis on maintaining eye contact, he began to feel a furious rage against his mother. Although the origin of his anger toward her initially seemed related to her lack of warmth and nurturing, the anger and the fear and loneliness with which it seemed associated persisted unabated. As a by-product of expressing this anger, however, he started to handle confrontational situations better and was more effective in negotiations, feeling significantly less threatened.

A pivotal memory with its emotional components occurred following a recent talk with his mother. At three years of age, he and his brother were placed in a nursery for three weeks just prior to and subsequent to his youngest brother's birth. Apparently this was done on the advice of the mother's doctor in order to lighten her responsibilities during this time. The patient was separated from his brother in this institutional setting, although when allowed outside they could see each other through a fence. During the stay there, his parents made three visits. The patient recalled, with sobs, how he felt a nearly intolerable longing for his brother and a profound feeling of having been abandoned by his mother. He recalled pleading with her, saying, "Please mommy, take me home. I'll be good. I won't make trouble." He was so plaintive and pitiful, she told him during their current conversation, that both she and his father cried upon leaving him. Over several sessions, he experienced, with both physical and emotional relief, the mix of rage at his mother and the fear of abandonment as retribution.

At the present time, the rampant psychological verbal fog has cleared. He has become increasingly able to breathe deeply for longer periods on the couch and tolerate the buildup of energy and sensation. His neck has softened, his eyes are focused and show emotion, and his chest moves freely. Emotional content in sessions mirrors current concerns and is felt directly without a contrived obligatory dive into a well of childhood trauma. As to work, he described increased aggressiveness in expanding his company's business and greater ease in disagreeing with clients without worry about his nice guy image. Socially, he has reduced the behavior engineered to elicit admiration and love from everyone to a more realistic search for a woman with whom he can, as an equal, have a love relationship. With a reduction in the forced schedule of activities, he now rarely gets ill as in the past with cold and flu-like symptoms. These results were achieved in 170 sessions over a four year period.

Discussion

The improvement in this case depended in large part on the eradication of substitute contact that had been developed and reinforced in a previous therapeutic setting and subsequently utilized as a defense. In those patients who are more able to stand energetic movement, stopping substitute contact per-

mits anxiety to develop. At that point, the energetic expansion induced by the treatment process is accompanied by the emergence of genuine emotional expression. In this case, energetic expansion was immediately converted (short-circuited) to physical discharge. To deal with this, a greater amount of substitute contact than usual was permitted expression but always combined with specific attention to the ocular segment. In this way, over a period of time, the patient's organism little by little became able to tolerate an increasing amount of emotional tone - that is, to hold a charge. Helpful in this regard was a concurrent and continual focus in every session on his present life without historic psychodynamic linkage. The purpose of this approach was to reduce thinking (brain activity) and thus his avoidance of feeling. As he developed energetic tolerance, the critical events of his past that were actually related to his pathology became available to him and were genuinely felt.

In summary, I believe his improvement was fundamentally a function of three interrelated factors. The first was the clearing of his eye block. The second was the relief from the always present underlying terror of childhood abandonment. With this disturbing and constantly intervening element eliminated, he felt his emotions clearly and developed a sense of security based on the core contact that had been lost in childhood. And thirdly, some inherent strength permitted him to accept the strong emotional excitation, new to his organism, and to experience his true feelings without distortion.

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A Case of Longstanding Borderline to Mild Hypertension

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In his article on Benign Essential Hypertension (BEH), Dew (1) summarized by stating: "a) BEH, like all somatic biopathies, represents an adaptation to an intolerable excitation in the energy economy of the neurosis as the neurotic defenses are breached. In this case, the surplus energy is absorbed in powerful discharges by the sympathetic apparatus of the cardiovascular system. b) The bioenergetic and biophysical structures in BEH include a vigorous, highly excitable core combined with a severe pelvic block, chronic orgastic impotence, and a resultant powerful expansion into the upper segments. This upward expansion is contained by a comparably powerful contraction in the chest and neck segments which produces most of the physiological and symptomological disturbances found in the disease." He stated earlier that "a logical assumption is that cases of ... mild BEH will be the most responsive to orgone therapy." As pointed out by Dew, little has been reported on BEH in the orgonomic literature. Other than the above mentioned pattern of armoring, there is no indication that any generalizations can be made concerning any relationship between BEH and character structure. Are the BEH characters phallic-narcissistic types with the dynamic of genital revenge? This appears to be the character type most resembled by the "type A" individual as described in the conventional literature as prone to hypertension. In the case to be presented, this was not so; however, the armor pattern was that described by Dew. (One should keep in mind that many patients with this pattern do not develop BEH!)

The patient, H., was a 40-year-old, separated, white male, professor and chairman of the Political Science Department at a prestigious university near Washington, D.C. He consulted me with the chief complaint of severe anxiety about his loss of erective potency. He had recently separated from his wife, and these difficulties had begun with a new girlfriend. The patient had been in intensive psychoanalysis (three to four sessions per week) for the past several months. He had found the process fascinating, but it had not changed his functioning, which he found extremely distressing. H. also complained of not feeling "vital" and of being slightly depressed when he was alone. He admitted to "spacing out," of being shy, and of having difficulty expressing his feelings, especially with women.

The patient was the youngest of four children born to aspiring, middle class, "WASP" parents. He described his father as "emotionally remote, a workaholic, but the parent who did spend time with me." He loved his father, but was sad because there had not been more contact. Mother was "active, restless, and irrational." He was afraid of her, and his emotional attitude towards her was one of compliance. From fairly early on, he remembers his parents quarrelling. He was, however, the favored child, and as the youngest had the attention of everyone in the family. He was encouraged and expected to excel intellectually, which he did. He achieved extraordinary academic achievement in record time.

His father died when H. was a young adolescent. H. remembers how shy and frightened of girls he himself was at that time.

He presented as a slightly pudgy (5'10"; 176 lbs.), but well-developed male, likeable, with a "boyish" quality.

His low but modulated voice bespoke of a significant block in the throat. There was no other discernible pathology elicited on examination of his mental status.

His medical history revealed borderline hypertension since the age of twenty five. The systolic pressures ranged from 160-170mm; the diastolic pressures from 85-90mm. Aldomet had been prescribed because of his young age, but it was discontinued after three years due to concern about the long-term effects of the drug, and since his response to it had not been dramatic. His hypertension continued to be followed by his internist; his blood pressures averaged 150/90 when he presented for therapy with me.

On the couch, he presented a picture of severe anxiety and looked somewhat like a trapped animal. His chest was held high in the inspiratory position, his oral and cervical segments were extremely tight, and his eyes were dull, with widely dilated pupils. My preliminary diagnosis of H. was that of an ocular repressed character type.

I explained to H. what was expected of him in therapy and began work by asking him to breathe while focusing around the room with his eyes. With mobilization of his eyes, he experienced a great deal of fear. Often his eyes would glaze over, as his ocular defenses struggled to contain the emerging feelings, mainly fear followed by anger. I instructed him to look at me in order to counter the tendency to go out of contact. Having him look at me out of the extreme corners of his eyes was very effective in eliciting fear. I encouraged him to scream fearfully, but this was difficult because of the severe throat-blocking. Strongly inhibited crying broke through from time to time. I worked physically on the armor of the upper segments including the muscles of the occiput, jaw, and neck. I also assisted his exhaling by gentle pressure on his chest. Childhood memories often returned, mainly involving his mother and a sister he had been close to. During this phase of therapy, his dreams contained repetitive themes of mother and anger. Strikingly, and rather surprisingly, the armor in his chest gave way quickly and easily. This was quite an unusual occurrence considering the high inspiratory position of his chest on presentation, which I had assumed to be chronic. After only three or four sessions, the chest moved freely. One possible explanation, which I have seen in a small minority of patients, is that for some reason, or reasons, the chest is held high without the muscles becoming unduly contracted. Since the tone of his tissues was soft on inspection and palpation ("pudgy"), the yielding of the armor was relatively easy despite its longstanding presence. Concurrent with the changes in his chest, he also lost a great deal of his ocular holding as much of the dullness left his eyes, and his pupils returned to normal size. During each session there were many vegetative signs: prodigious diaphoresis, "gooseflesh," tingling, etc. Subjectively, he felt less anxious. His erective potency returned, and he felt much more comfortable in general.

After his fourth session with me, his internist was amazed to find his blood pressure 130/75. Believing this to be a fluke of some sort, he had H. return for follow-ups over the next few weeks. The blood pressure readings remained essentially the same and continued to be in that range over the following eighteen months. His internist can not understand the change.

Within the first 3-4 months of therapy, H. spontaneously lost 25 pounds. This was with no real effort on his part, and I attribute it to the yielding of his oral holding. He has been seen for approximately 100 sessions, and it appears that his BEH is a thing of the past. Therapy will continue on the usual course of working systematically and methodically on the armor in order to restore a unitary state of functioning.

A case of longstanding benign essential hypertension has been presented. This condition, as predicted by Dew, responded in a gratifying and rapid manner to orgone therapy.

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Considerations in the Treatment of Ocular Armoring

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Abstract

Wilhelm Reich developed his technique of character analysis over 50 years ago. Since then, Reich and his followers have discovered the importance of the eyes in emotional life and learned a great deal about armor of the ocular segment. Simultaneously, traditional psychiatry has learned much about pre-oedipal psychopathology. These parallel developments suggest the necessity of a modification of Reich's technique in the initial phases of therapy with patients who have serious ocular blocks. A change in the orgonomist's observing position, empathic contact, gratification of the patient's primary needs, and a temporary de-emphasis of the negative transference are discussed. Finally, some potential problems associated with this therapeutic approach are considered.

Theoretical Background

Each patient's armor is a shell which protects him from the outside world but at the same time restricts his freedom. The goal of orgone therapy is to break down this armor so that the patient may face and overcome his conflicts, thereby increasing his freedom through more natural pulsation. In parts I and II of *Character Analysis* (1), Reich describes his technique of verbal psychotherapy, specifically developed to efficiently break down the patient's defensive blocks.

Before *Character Analysis* was published, psychiatrists recognized that patients resisted therapy by using various defense mechanisms, but these were analyzed in an inconsistent and unsystematic way. Reich was the first to see that the defenses are organized into a layered and cohesive system. He argued that each individual's defensive apparatus has a "cardinal character resistance," which is the key to the whole system. The orgonomist must identify this "constant attitude" and then, systematically and consistently, bring it to the patient's attention. Steadfast pursuit of the cardinal resistance will lead the therapist and patient vertically down through the layers of the shell to the person hidden within. This is akin to following a "red thread" to the center of a labyrinth.

But, when the armor breaks down, underlying emotional conflicts are exposed; this frightens the patient, so he sees the therapist as an antagonist or "dangerous enemy." This helps to foster the development of a negative transference, consisting of feelings of fear or anger toward the therapist. Further, this negative transference may be disguised in the patient's behavior. For instance, hatred may be hidden in excessive politeness. Reich taught that this negative transference must be unmasked.

Thus, patients marshal considerable forces against the therapist's efforts and these forces tend to be subtly disguised. To be effective.

the orgonomist must become an expert observer, carefully studying the patient's every gesture, tone, and mannerism to detect clues relevant to the cardinal resistance, the underlying conflicts, and the latent negative transference. The therapist's observing position is *outside* the patient where he can carefully study him. Observation reveals the shell's weakest point and character analytic comments are made to exert pressure at that spot.

Reich stated that his character analytic technique is not indicated for every patient. He warned that "it is a far heavier burden for the patient," that it "mobilizes violent affects," and "results in a temporary condition of helplessness." Clearly, there are times when the "systematic and consistent emphasis on the character resistance" and the "consistent interpretation of the latent negative transference" are contra-indicated.

In Chapter V of *Character Analysis,* Reich argued that "work on the character defense is not necessary in the early stages" of therapy with acutely anxious patients because the anxiety "indicates that the armoring has broken down on a wide front." Acute depression is a second condition in which character analysis is generally not the treatment of choice early in therapy. Reich cautioned that patience is required until the patient's "initial apprehensiveness and insecurity" have been overcome. Finally, he wrote, "character analysis is very difficult in patients who represent a new type with which one is unacquainted."

Today, 55 years after the original publication of *Character Analysis,* parallel developments in orgonomy and in traditional psychiatry have enabled us to understand much more about patients who present with "initial apprehensiveness and insecurity." Elsworth Baker was the first to classify the ocular segment as a major erogenous zone. He and later orgonomists have increasingly recognized the importance of the eyes, and the orgonomic literature contains articles, case presentations, and clinical seminars discussing the ocular segment in great detail. Many orgonomists have noted the great number of patients who present with major armoring in this segment including hysterics with serious eye blocks, weak phallics with little aggression and prominent ocular symptoms, and various ocular characters where eye segment pathology is primary.

At the same time, traditional psychiatry has greatly increased our knowledge of pre-oedipal, developmental psychopathology. Work in ego psychology, object-relations theory, and "self" psychology highlight how the psyche can be significantly impaired *prior* to the oedipal phase. Psychologic development is a maturational process comprised of many stages. Later stages supercede and integrate previous phases; deficits in one stage will interfere with the ensuing ones. The result can be developmental fixations or lags in any of the major psychologic areas such as ego functions, interpersonal relationships, and self-concept.

In general, pre-oedipal psychopathology and the degree of ocular armoring correlate with one another. That is, serious pre-oedipal psychologic problems are usually seen in patients with more severe ocular armoring; patients with less ocularity tend to show less pathology in ego functions, object relations, and the "self." One must be very careful here in making generalizations. It is not possible to draw hard and fast distinctions or classifications. All patients present with some armoring in the eye segment. This may range from the more severe primary ocular blocking to the milder, secondary ocular armor. Similarly, virtually all patients have some oedipal conflicts and some pre-oedipal developmental blocks. Again, there is a spectrum from primary oedipal conflicts toward primary pre-

oedipal developmental fixations. In general, these spectra run parallel to one another; this is exactly what we would expect from Reich's resolution of the psychosomatic relationship. Somatic ocular segment armoring and early, developmental psychopathology are functionally related. They are antithetical to one another because the psyche and soma are two different realms, but they are also identical to one another in that both are expressions of blocked orgone energy which occurred early in the individual's life.

One can formulate a tentative, incomplete, but clinically useful hypothesis explaining the origin of these parallel findings. During the first four years of life, a loving, contactful, and empathic relationship between mother and child fosters the integration of sensation and perception in the ocular segment; this is the biologic core of the personality. "Good enough" parenting enables the child to develop a perceptual framework which is flexible and capable of normal pulsation during new experiences. Important psychologic developments occur simultaneously. Basic trust, object constancy, a cohesive concept of "self," and essential ego functions such as defense formation, adaptive capacity, and drive modulation are established. All these psychologic functions are crucial aspects of complete ocular integration; the result is a coordinated, integrated, and undistorted perception of oneself and of the world, which becomes the biologic foundation for behavioral freedom. This is the pre-condition for optimal learning and further development. For the future neurotic character, this precondition is mostly fulfilled, and problems develop later when oedipal conflicts arise.

But, for the individual with significant ocular segment armoring and accompanying psychopathology, there is no secure basis for exploring the world. There is functional brain damage in that the perceptual framework is not integrated and flexible; rather, it is primitive, incomplete, and inflexible. Without full integration, the child ventures into the world cautiously and without much confidence. He is ill-prepared for the ensuing stressful experiences, so learning is compromised. Much of his emotional energy must be used to avoid stimulation which might threaten his precarious balance; he may not be able to tolerate full expansion.

Whereas neurotic characters struggle *primarily* with oedipal conflicts, patients with major ocular blocks suffer *primarily* from developmental impairments in perceptual integration and diverse psychologic functions. This difference in pathology requires a modification of Reich's character analysis. The "detective" orgonomist, pursuing the patient from *outside,* probing the constant attitude and negative transference in order to break through the armor, is most effective with neurotic patients. On the other hand, to help patients with developmental lags and major ocular armoring, the orgonomist must provide a sustaining emotional environment which fosters cohesion and ocular integration and helps to overcome the developmental blocks. To do so, the therapist moves from *outside* to *within t*he patient where he can make use of empathy.

Empathy

Empathy is the capacity to experience the sensations, feelings or thoughts of another individual from that person's standpoint. It is a partial identification in that we "enter" the other person and understand his experience from his unique perspective; this may be very different from, "what I would feel if I were in his place."

Establishing empathy is difficult because it demands emotional involvement. An empathic therapist must pay close attention to the

patient and push all that is unique and particular to himself into the background. This temporary suspension of individuality is necessary in order to assume the perspective of the patient, that is, to perceive things from *within* his skin.

When it can be established, empathic contact generates emotions, ideas, fantasies, and pictures of the patient's world that are vibrant and immediate. There are many signs that empathy has been established. The orgonomist may note that his breathing pattern has fallen in line with the patient's. When fear is expressed, the therapist is wide-eyed or he clenches his jaw when the patient is holding back anger. The ability to complete the patient's sentences is a measure of cognitive empathy.

Leston Havens has distinguished between active and passive empathy(2). In active empathy, the therapist uses his own emotional power to express in gestures, words, or feelings what his intuition tells him the patient is feeling. Using affective language the therapist says, "You seem worried," "It's puzzling," or, "You feel two ways about it." This can touch, stir, and mobilize rigid characters who are heavily armored against their feelings or ocular characters who are dissociated from their affects.

For example, an ocular character who very much loved his children began a session by stating that his 25-year-old daughter had suddenly announced she was moving out of state. He looked sad but said he was "happy for her" because the move would offer new occupational opportunities. Once on the couch, and after breathing to build up a charge, the sad look intensified, but subjectively the patient still could not feel it. Gently and quietly, I said, "It hurts." The patient's eyes flashed recognition, then his lips quivered, and his chin trembled. I added, "It's sad to see her leave after so many years together"; the patient broke into deep and prolonged sobbing. Afterward, he talked at length about his life with his daughter and his hopes for her future.

Havens describes passive empathy as "a waiting, sentient attitude, echoing some of the patient's statements and, above all, supporting and reflecting his emotions" (2:17). This is a particularly useful technique with any new patients, before we know them well, and with any patient who is moving deeper into a previously unexplored area. The therapist relies heavily in these uncharted waters on his own orgonotic sensations. All the patient's affects are "contagious" to a contactful therapist.

For example, a new patient was explaining her reasons for coming to therapy. She explained that she wanted to be independent of her parents but said that "It's always been a struggle." Later in the initial interview, she said, "I'm afraid I'll lose my job because I'm so nervous that I'm making a lot of mistakes." I nodded, and the patient went on to describe the occupational situation in greater detail. Then I said, "No wonder you're afraid of losing the job; if you did, you would be more dependent on your parents." She looked relieved and noticeably relaxed. The nod is an empathic gesture, my use of "afraid" reflects the patient's affect, and linking the possible job loss to her earlier expressed concerns about independence conveys both support and understanding. The patient will now feel safer to express more of her situation. Passive empathy is also the preferred technique with suspicious or paranoid individuals where one must protect against appearing able to "read the mind" of the patient.

Havens also describes tests of successful empathy, the most important being the stimulation and deepening of the patient's narrative flow. When working on the couch, success is measured by the extent to which the

orgonomist's efforts enable the patient to experience and express his or her emotions.

Effective treatment of patients with serious ocular problems depends upon the therapist establishing an empathic relationship with the patient. This is very different from the character analytic technique developed by Reich in Parts I and II of *Character Analysis*. Interestingly, Reich elegantly illustrates the empathic technique later in the same book when he describes his treatment of a schizophrenic woman, which indicates his intuitive understanding that a different approach was required for ocular characters.

How Empathy Promotes Integration

Because of the impaired development, adults with serious pre-oedipal problems are really children confronted by adult challenges, threats, and responsibilities. It is no wonder they are terrified, and it is also very understandable that instead of exploring life's opportunities, they are preoccupied with avoiding overwhelming anxiety. These patients are simply too ill-equipped to expand and risk new experiences. The empathic therapist, observing from within the frightened patient, is an ally enabling the patient to face what can not be faced alone. Havens provides an excellent example of how empathic exploration enables one to share a patient's despair.

Patient: *I did want to die.*
Havens: *It may still be what you want.*
P. *I don't know.*
H: *The pain continues.*
P: *I feel so terrible.*
H: *It may not be possible to imagine any time free of it.*
P: *I thought if I died it would stop.*
H: *That might be the only time.*
P: *No, now I feel I will be better.*

(The patient's mood lightens, and she goes on to discuss several positive aspects of her world (2:68).)

Havens speaks from within the patient and his emotional investment enables the patient to express more and to risk some expansive optimism. Such exchanges promote openness and, over time, build a secure therapeutic relationship. The patient, beset by threatening situations and unpredictable or absent relationships, now has one safe haven. This security, which the patient feels because someone is now sharing his burden, is the first step toward integration of the personality.

Notice that Havens avoids questioning the patient. Interrogation comes from an observing position outside the patient, so questions tend to increase the patient's aloneness. Also, patients tend to feel they are "supposed" to know the answers to questions, so when they can not answer the therapist, they are apt to feel more inadequate and incompetent. Finally, Havens points out that questions are often judgmental: for instance, "Why didn't you call?" If, instead, he says, "You must have had some good reason for not calling," he puts himself with the patient and fosters a more open, less defensive exploration of the situation.

The following example will show more specifically how empathic contact was established with a particular patient of mine and how this fostered ocular integration. A. was a 39-year-old woman who presented with confusion, anxiety, and depression. She complained that her husband, a physician, was demanding and controlling by nature and was constantly belittling her. She had originally married him because he was sensitive, did not scare her, and she expected he would protect her. The early years of the marriage were "fine," but it deteriorated when the kids began

school. She said, "I wanted more of a life of my own." She claimed he belittled and resisted all of her efforts to be more active in the community. "I'm frustrated trying to prove myself so he'll acknowledge me; he's like a parent." She began to withdraw from him, occasionally lashing out with cold, nasty, cutting remarks. This marital pattern continued until she developed the presenting symptoms.

She described her childhood as "unhappy" because she was a shy, quiet "reader" in a loud, argumentative family. Her life was dominated by an aggressive, dictatorial mother who "distrusted and hated men." The father, "more like me," was "passive." He left home when A. was eight years old. A sister, 11 years older, was a "bully." A. was a loner during much of her adolescence and did not date until she met her future husband.

On the couch, she constantly squinted, blinked, and knit her brow. Her temples were very tender and the occiput and scalp were tight. She "hissed" most words through a tight jaw, and her voice was quiet and weak. She could not make a loud sound. Respiration was shallow. She was suspicious, restless, and fidgety. When building up a charge, she became more restless, touched or scratched her face, and then used her arms to cover her head and face. At this point, she would become sarcastic toward me.

I diagnosed her as an ocular character, and it was clear that the ocular segment required immediate attention. In the next ten sessions, I tried to get her to relax on the couch and to tolerate charging. But as soon as her face flushed she would "go off" and become silly or very wordy with intellectualization. If I stopped this behavior, she became restless, fidgety, and covered-up again. She criticized herself for "messing up" on the couch, but I suspected some pleasure at frustrating me. Work on her temples and occiput led to weak tears but no real crying. I tried to get some fear expressed before she "went off," but she did not feel anything. Increased charging led to repetition of the above pattern.

Thus, simple, straightforward requests were unsuccessful in eliciting the patient's cooperation in the charging process. Character analytic work was therefore necessary; several defensive patterns were apparent. First, she habitually withdrew, to her room when she was a child, later from her husband, and now on the couch. Second, I could address her anger which was evident in her cutting, sarcastic remarks to her husband and to me. Another possibility would be to focus on her suspiciousness and distrust. If A. was simply neurotic, one of these defense interpretations could have been chosen.

All of these interventions are accurate, and in time A. must face and grapple with each of these defenses, but any of the above interventions would be nonempathic and counterproductive at this time. Any comment on the patient's defense apparatus would be made from an observing position outside the patient; it would probably make her feel more alone and less safe no matter how accurate it was. Her already fragile self-esteem might be depleted further, and she might very well feel shame at learning that she withdrew, was angry, or was mistrustful in addition to "my other faults." A.'s energy stasis would have gotten worse if her sarcasm was questioned, because it was the only expression of aggression available to her. She had overcome considerable distrust in coming to see me; if I had pointed out her mistrust, she would have felt defeated and her motivation for therapy would have been compromised. Any defense comment, therefore, would probably have produced iatrogenic defensiveness, increased aloneness, and may have weakened the patient's self-esteem and motivation.

Taking an observing position within the patient enabled me to see different possible interventions. This woman had been a timid, passive girl who felt overwhelmed by a dictatorial mother and "bully" sister. She identified more closely with her father, but he had abandoned her. As a frightened young woman, she chose a husband who would protect her, but she came to resent *his* controlling her. Now she had come to me for help, and *I* was telling her what to do on the couch; I was yet another dictator. I said, "How frustrating this must be to have me telling you what to do." She replied that it did feel like "giving in," but that it scared her not to go along because she needed my help. I simply acknowledged the "bind" she was in and gently asked her to breathe and roll her eyes. She relaxed more than ever before on the couch, tolerated more of a charge, and then spoke at length about the "bind" of her marriage. She left the session feeling better, and her eyes were brighter and more contactful.

Once established, this empathic foothold was returned to many times over the ensuing months. Each time I brought up A.'s "bind" of needing to "give in" in order to receive help or protection, it was possible to explore more deeply her feelings of vulnerability and weakness, her lack of self-confidence and low self-esteem, and her shame and frustration at "needing so much help." She trusted me more and was able to tolerate charging so that we could work biophysically on the ocular segment. The use of defense analysis early in therapy from an outside observing position tends to weaken patients who are poorly integrated. If the orgonomist can reach "behind and beneath" those defenses and see the situation from the patient's viewpoint, integration will be enhanced by approprite empathic comments and interventions.

Therapeutic Gratification of Primary Needs

Empathic interventions give patients an ally and hope. But, individuals with serious eye segment pathology will still doubt that anyone can understand or approve of them; their self-esteem is so low and their previous relationships so ungratifying that they can not believe they will be accepted. To promote integration and to overcome deficits in the "self" and in relationships, the orgonomist must next provide a stable relationship in which the primary needs of recognition, understanding, acceptance, and approval are gratified. This is a prerequisite for the patient to risk a more expansive approach toward the outside world. The therapist, providing interest and approval as a concerned parent would, offers the patient a second chance at overcoming the impaired development.

For example, A. hesitantly and with considerable anxiety, returned to college despite criticism from both her husband and her mother. I was an appreciative audience to her academic successes and validated the "impossibility" of mastering complex economic theories while adolescent children are nagging you for money to go to the video store. We talked at length about raising children and I was understanding and accepting of the many dilemmas of living with adolescents. I praised her commitment to her children's well-being.

Another brief case history will further demonstrate how gratification of primary needs helped a patient grapple with several pre-oedipal problems. S. was a 35-year-old woman who had had three previously unsuccessful experiences in therapy. She presented a great deal of mistrust and suspiciousness and disclosed very little. She claimed the earlier

therapeutic efforts had failed because "the psychiatrists were quiet as stones" and they had "accused me" of not trusting them. Pointedly, she told me this was "the last chance"; she had given me the burden of carrying the profession's banner! My early interventions consisted of first passive and later more active empathic statements. On the couch, we worked on the ocular segment, and I had her make suspicious expressions.

As she trusted me more, the following history emerged. S.'s parents were cold, distant, and undemonstrative; she couldn't remember ever being hugged or having seen her parents kiss. There was no joy or enthusiasm in the house, and S.'s parents could not be gratified by her accomplishments or nurture her self-esteem; she did not remember receiving any compliments.

During this initial phase of therapy, she frequently noted that she felt ineffective and inadequate—"Things I do don't help, they never do any good." As she began to trust me, her expectations of me increased and a very demanding sense of entitlement characterized her attitude. She demanded to know my middle name, wanted longer sessions, and complained that I forced her to do all the work on the couch while I sat back "resting." She complained that my quietness was like her parents' and it made her wonder if I cared at all; she sincerely doubted my concern and wanted me to do something "to prove" myself to her.

S. was demanding attention and reassurance that I cared for her and was interested in her. Such behavior in a neurotic individual might be narcissistic defenses which the orgonomist would confront from an observing position outside the patient. The sense of entitlement, the excessive and unreasonable expectations, and the stubborn demandingness would be repeatedly confronted to break down the defensive armor and allow the expression of underlying feelings, possibly rage.

But, S.'s difficulties are pre-oedipal, and this defense analysis from "outside" would probably intensify her aloneness, crush her fragile self-esteem, undermine her developing trust, and might create overwhelming anxiety. It is true that S.'s demanding expectations are seriously compromising her current relationships, and she will have to face this problem in therapy. If the therapist did not help her to do so, he would be guilty of overidentification and of colluding with her defenses. But, first, perceptual integration must be established, and her self-esteem must be strengthened. She will be more able and willing to examine her demandingness once she likes herself better and believes more in herself.

This is accomplished by again taking an observing position within the patient. From this vantage point, the patient's behavior is seen in a much "softer," more positive light. First, I realized that, in demanding so much from me, she was trusting me in a way she had never trusted her other therapists; she was letting herself be known, and exposing herself to rejection and humiliation in an attempt to gain my recognition, acceptance, and approval. Second, I remembered her self-image as ineffective and realized her demandingness was rooted in a lack of conviction that she could do anything to help herself; therefore, she was convinced someone else *must* do it for her.

Therefore, my interventions with S. avoided her character resistance and addressed her underlying emotional needs. I repeatedly told her that I understood and appreciated how much she wanted and needed my aid and assistance. I praised her for trusting me and for taking the risk of asking for my help. I accepted and appreciated her disap-

pointment that our sessions could not be longer and that I could not do more to help. I carefully explained the realistic limitations of what I could do for her, but pointed out that I knew she felt my efforts were insufficient. Frequently, I reassured her that I respected her courage and commitment to therapy, and that I was concerned about her and cared for her.

It is important to recognize that reassurance and gratification of the patient's emotional needs are essential to the success of therapy with many patients since earlier relationships have not given them the opportunity to learn how one's own actions influence the treatment one receives, and how that treatment shapes self-concept. This gratification can promote further expansion. Rather than confront S.'s resistant demandingness, I acknowledged it as a step forward from distrust and accepted it as an expression of need for help since she felt so ineffective. I made no interpretation of its resistant component and did not focus on her anger toward me.

I adopted this empathic technique several years ago after seeing the potential adverse consequences of employing Reich's original character analytic technique while treating a patient with serious ocular segment pathology (3:41). Early in therapy, this patient claimed he needed a "mentor" or "guide" to help him make decisions since he was indecisive and "unable to make the tough calls." I failed to appreciate how overwhelmed and inept he felt and interpreted his request for help as a defensive effort to have me do the work of therapy. In my efforts to provoke the anger he must have felt toward me for not gratifying his wishes, I suggested he call me "coach."

He quite correctly complained that I didn't understand him, but at the time I saw this as another layer of resistance. He felt more alone and isolated. I tried to mobilize his anger, but he could not express it because ocular integration had not proceeded far enough for him to feel safe with his anger, and because he did not yet trust that he could get angry at me without losing my help. Therefore, the blocked anger resulted in greater anxiety and deepening depression. His fragile self-esteem suffered another blow since he was "not doing well in therapy, either."

Confronting this patient's dependency and passivity was a mistake. It reinforced the shame he already felt about his dependence on others. After reading the Kohutian self psychologists, I was able to empathically appreciate this patient's need for guidance and help him move toward integration and independence. I did not and could not provide all the direction he was asking for, but, by understanding and accepting his perceived need and avoiding defense analysis, I was able to share his emotional state, and this gave him enough support that he was able to rely on his own resources to make some difficult decisions and to risk new behaviors.

The Transference

Every patient cathects the orgonomist with both positive and negative transference feelings. In *Character Analysis*, Reich taught how important it is to seek out the negative transference reactions in the treatment of neurotic patients. Later, he emphasized that rage is the most important feeling to elicit and that this must precede softer feelings.

My work with the above patient indicates that Reich's principles may not be applicable to the early stages of therapy with many patients. Anger is a powerful and potentially overwhelming affect for many patients with pre-oedipal pathology, and feeling it may cause anxiety, which results in intensification of the ocular block. Their primary need is for a trusted ally and they fear they may lose that

ally if they become angry at the therapist.

By the time I had begun work with A., I had learned this lesson. When she became angry at her "bossy" mother and husband, I made no attempt to extend her anger to me, the latest dictator in her life. It was important for the developing therapeutic relationship that I remain in a positive light. Later, when she did become mildly angry at me, I accepted the feeling without attempting to bring out more forceful rage. She became angry during a session on the couch and bitterly told me, "This is like a game of 'Simon says' and I'm sick of always taking orders." A response of "gushing" approval would have been patronizing and reinforced her feelings of inferiority within our relationship; instead, I simply offered an understanding and accepting nod. At the next session, she told me she was surprised and relieved that she had not gotten "in trouble" for her outburst. Slowly, she began to face "powerful" people in her life more directly and she resorted less often to withdrawal.

S., the previously described patient who was so demanding was often spontaneously angry at me for not living up to her expectations. But, I did not actively pursue any hidden or disguised negative feelings toward me. I empathically appreciated her anger and encouraged her to vent her fury on the couch. Afterward, I reassured her that I accepted her anger and explained that it did not change my interest in her or commitment to her. I frequently re-explained the practical limitations of what I could do for her, and I avoided any transference interpretations.

The therapist should not be cool, aloof, or impersonal with people who have developmental lags, because such behaviors create distance and the patient might feel more alone. The purpose of being aloof is to give the patient's unconscious an opportunity to express repressed conflicts through the fantasies he attaches to the therapist. Again, this is often useful with neurotics but contraindicated in more serious cases because, for several reasons, we do not want to promote fantasy. First, fantasy increases energy in the head, thereby intensifying the sensory-perceptive split. Second, many patients will fantasize the therapist as omnipotent and omniscient; this weakens their own self-concept by comparison and inclines them to turn the responsibility for their therapy over to the God-like therapist. Some ocular characters, such as S., learn early in life that the recognition, acceptance and appreciation of others is not attainable; they will tend to project the same rejecting attitude onto an impersonaltherapist. Finally, many patients respond to a therapist's silence by becoming frightened and anxious, the very thing we seek to alleviate. In all these instances, aloofness by the therapist increases the patients' "apprehensiveness and insecurity" and thereby decreases their ability to risk expansion.

The techniques of empathic contact, gratification of primary needs, and de-emphasis of the negative transference, all tend to foster a positive transference. During the early phases of therapy, these patients are usually dependent upon the orgonomist; this is necessary if the problem in perceptual integration is to be overcome. But, the dependence is temporary. Ocular integration enables the patient to make contact with his core needs and it promotes the self-confidence necessary to pursue those needs out in the "real world" beyond therapy. Once the developmental blocks are overcome, the patient recognizes that the therapist is not sufficient to meet his or her primary needs, just as the developing child recognizes that the world offers exciting opportunities and spon-

taneously moves beyond his parents to explore it. Both the child and the patient naturally progress beyond the stage of seeking the parent's or therapist's praise and approval to pursue their own individual destinies. The burgeoning field of developmental psychiatry confirms this inherent tendency toward expansion, mastery, and maturation. Therefore, to withhold acceptance, appreciation, and approval from a patient because he may become dependent on therapy makes no more sense than it would to withhold those qualities from a developing child because he might become dependent on his nuclear family and not venture into the world. The orgonomist remains alert to the possible dangers of the positive transference. If the sessions become boring and circular, or if the patient's life outside therapy becomes stagnant, then the latent negative transference must be examined.

Potential Problems

There are potential pitfalls in taking an observing position within the patient. One is that it is difficult to identify feelings amidst the chaos of the patient's lack of cohesion. In attempting to integrate and mobilize a patient's emotional expression, we translate a vague reference into a specific feeling. For instance, a patient may be describing an absence of hugging, kissing, and touching within his nuclear family. We note the detached, non-emotional way in which the information is relayed and respond, "It hurt." Perhaps the lack of physical contact had actually made the patient more angry than hurt. If he can correct us, no harm has been done; actually, therapy is probably advanced because the patient is now emotionally in touch. But, some patients may adopt the feelings that we assume they have, thereby misleading us. On the other hand, if the therapist protects against misidentifying an affect by being overly cautious in translating feelings, he may reinforce any image the patient has that he is unfeeling or aloof. Concerning this dilemma, Havens says,

> *It is like hunting; the hunter must make sufficient noise to flush the quarry, but not so much that he frightens it into paralysis or fresh concealment* (2:49).

The second potential problem of the internal observing position is that our understanding of the patient may become as fragmented and as disorganized as is his personality; empathy always entails the possibility of becoming lost in what we are trying to understand by intimate experience. If this happens, we fail to lead or guide the patient and simply become a fellow traveller who is little more than an echo. The protection against this nontherapeutic eventuality is found in our theoretical knowledge. First, empathy enables us to experience a certain feeling, thought, or perception the patient has. Then we "remove" ourselves from the patient and resume our observing position outside the patient. Now, our knowledge of the biologic laws of the orgone and the principles of psychodynamics enables us to understand the meaning of what we just experienced "within" the patient.

The joint use of empathy and knowledge protects against another problem. By definition, ocular armoring causes distorted perceptions and this often results in distortions in the empathic pictures the orgonomist gathers. At best, these pictures are incomplete and often they are erroneous in fundamental ways; to accept them at face value is to collude with the patient's defensive misperceptions. There-

fore, what the therapist empathically experiences must be processed cognitively into a richer and deeper understanding of the patient. Empathy without the knowledge gathered by orgonomy and traditional psychiatry will, ultimately, be disappointing as a therapeutic technique.

Some humanistic psychologists have made a fundamental error in their use of empathy. They have promoted the notion that the empathic therapist must like the patient and must get the patient to like him. Psychotherapy should not become a popularity contest where the emphasis is on being "nice," "human," and "supportive." A patient's fear of intimacy, expectation of being hurt, and many other reasons often cause him to behave antagonistically or to be detached. Therapists will be unable to help such patients if they work primarily toward getting the patient to like them. Rather, they will iatrogenically increase the patient's armor and defensiveness. The needs of the treatment (i.e., the promotion of integration), rather than the therapist's concern about what the patient will think of him, should determine the type of intervention.

Finally, it must be noted that the empathic relationship alone is not sufficient for the successful treatment of any patient, including ocular characters. Rather, empathy is the foundation on which the therapeutic process is built. It provides the patient with an ally, with a sense of safety, and with feelings of being accepted and understood. Once this is established, much more needs to be accomplished if the patient is to reach his optimal level of freedom and independence. This will require the use of traditional character analytic techniques, including the examination of the negative transference and confrontation of the cardinal resistance. These interventions will increase the patient's anxiety and sense of isolation. But, the patient will be better able to tolerate the resulting internal tension because the empathic relationship has promoted ocular integration and has helped to overcome pre-oedipal developmental lags.

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Clinical Symposia

The Clinical Symposia will appear as a regular feature of the *Annals of the Institute for Orgonomic Science*. The edited material from the training seminars of the Institute presented in the Clinical Symposia is intended to provide the readership with information regarding the theory and practice of orgone therapy.

SOMATIC BIOPATHIES

The following seminar was held at the home of Louisa Lance, M.D., during 1986. The purpose was to focus specifically on those biopathic illnesses with primary somatic expression, rather than on the more often discussed biopathies that express themselves as neuroses.

Robert Dew, M.D.: There are some major points about somatic biopathies that I think should be discussed and clarified. The first is what effect the specific biopathies have on people that would influence their suitability for treatment and, therefore, our willingness or reluctance to treat them. Then, considering all factors in the case and the body of knowledge that we have, how does treatment differ for the various somatic biopathies? In connection with that, does the presence of a somatic biopathy have a special significance with regard to the patient, over and above the fact that he has a neurosis? And, what is it about the patient's psychosexual history and development that may predispose him to one or another of the somatic biopathies?

Courtney Baker, M.D.: Well, the first issue to consider, then, has to be treatability.

Dr. Dew: The biopathy that seems to present the greatest problem with regard to treatability is cancer. Should patients with a history of cancer, past or present, be treated? Personally, I have no objection to treating a patient who comes with a history of cancer but is currently in reasonably good shape. I have a lot of reservations about treating people who present with cancers.

Morton Herskowitz, D.O.: What about someone who has had a breast cancer and a lumpectomy?

Dr. Dew: I might consider treating that patient, but I would emphasize strongly that orgone therapy might not be the best thing for her. That is, we would have to watch her progress very carefully to be sure that the treatment doesn't produce stresses that could worsen the condition. Also, I would insist on her being followed medically and with conventional treatment for her condition.

Louisa Lance, M.D.: Generally I agree with that approach, but we also have to consider that by increasing their energy level and freeing up some of the blocks, we are attempting to provide healthier ways to discharge that energy. If some of the contraction can be overcome, their condition may improve. Otherwise, we would be saying that once someone has a cancer potential, they are not treatable.

Arthur Nelson, M.D.: Well, it seems certain that these patients are in a high risk category.

Dr. Dew: Yes, and I think we have to make the patient aware of that.

Michael Ganz, M.D.: Why is the question of cancer different from any of the other biopathies? Someone who has hypertension, or any other biopathy, has developed it, not instantaneously, but as a result of a long historical course, also.

Dr. Dew: Except, in the case of hypertension, we have other methods of treating it, and we can easily monitor the effect of orgone

therapy on the blood pressure. In the patient with cancer, the parameters for checking on the progression or regression of the process are not so simple.

Dr. Baker: There is something much more fundamental to consider here. Cancer represents a much more primitive way of discharging energy, than say, hypertension. In cancer, the tissue integrity is actually compromised and is breaking down. That is what disturbs us. I don't think it's just a question of not being able to follow the process; you could follow it. But, it is not so cut and dry. In practice, we have seen a few people with a tissue diagnosis of cancer who have had normal Reich Blood Tests, and we have seen people with less serious biopathies who have had poor tests.

Karl Fossum, M.D.: Are these reservations about treating cancer patients based more on experience or more on theoretical reservations? Have you treated cancer patients and had bad results?

Dr. Dew: No, it isn't based on experience in my case. In fact, I have yet to see anyone who has had an active tumor who hasn't shied away from therapy.

Dr. Baker: I've seen that also.

Dr. Fossum: Is it possible that happens because of our caution? That, directly or indirectly, we tell them that they are bad risks?

Dr. Herskowitz: I have two patients with breast cancer who had relatively normal Reich Blood Tests, and both are very good patients.

Dr. Lance: The tumor can be a local expression of disease without having affected the total energetic system of the patient.

Dr. Dew: Yes, Reich specifies in *The Cancer Biopathy* that there can be tumor without the shrinking biopathy.

Dr. Nelson: What's the opinion about skin cancers? Would they be considered local or general processes? I've had two patients with basal cell carcinomas. One patient had had recurrences about every six months for several years before he entered therapy. After a couple of years of treatment, the recurrences diminished to about one every two years. So, it seemed that perhaps therapy had some effect on the process.

Dr. Dew: Basal cell is one of the lowest orders of malignancies. I'd be less cautious about that, than about a patient with malignant melanoma.

Dr. Ganz: Are you saying that melanoma would not be a good example of a local tumor?

Dr. Dew: The relationship between how malignant a tumor is and whether or not it's localized, and the patient's prognosis is not entirely clear. We do know that melanoma can be extremely malignant.

Dr. Baker: Melanomas also have one of the highest rates of spontaneous remissions.

Byron Braid, M.D.: True, but they also have a history of recurring with extensive metastases ten or fifteen years later.

Dr. Nelson: That happens also with post-mastectomy patients. Ten years later, they can present with metastases.

Dr. Baker: How do we know that those are remissions? Maybe they actually get better, and then break down again later.

Dr. Braid: I don't know the answer to that, but I do know that when a melanoma recurs, it is extremely virulent and difficult to treat.

Dr. Nelson: I have had a few patients with histories of ulcerative colitis, as teenagers, who had been asymptomatic for ten years, but as therapy began to reach them, they began to have attacks again.

Ruth Lamdan, M.D.: It's well documented that people who develop ulcerative colitis, as teenagers, have a very different course from those who develop the disease as adults. And, about 80% of children with ulcerative colitis develop carcinoma.

Dr. Braid: I saw an interesting thing in a

female patient who, as a teenager, had toxic megacolon with her ulcerative colitis. She has a real passive-aggressive streak and constantly undermines every diet given to her. As therapy progressed, her colitis attacks diminished, but she developed a pyoderma on her leg. I felt strongly that this was an external manifestation of her colitis. A gastroenterologist confirmed that these things are seen with ulcerative colitis patients and put her on steroids to clear up the leg ulcer. I thought it was an interesting and curious twist as to how therapy had affected the colitis pattern.

Dr. Lamdan: Let's get back to the problem of treating cancer patients, because it occurs to me that perhaps our own fears make it difficult for us to evaluate their suitability for therapy. First of all, we are scared of the disease because there is no treatment, except for surgery, that is good enough. If we can get beyond that, why can't we then evaluate them like we evaluate any other patient in terms of their basic health? What is their tissue potential for holding a charge? How much can they understand? If they are very ill, they probably won't be interested in seeking psychiatric treatment anyway. Cancer is a defense. So what is the difference in treating them from treating someone who has another kind of character defense?

Dr. Dew: Chances are that a lot more people develop cancers and get over them without anyone ever knowing it.

Dr. Lamdan: That brings up another interesting observation. With so many routine mammograms being done, more microscopic tumors are picked up and more surgical procedures are performed. The incidence of bilateral tumors seems to be so much greater now, but maybe that is because, before mammography, the body's normal defense mechanisms have taken care of the tumor before it became clinically apparent. It may not represent a systemic biopathy, but simply a local breakdown.

Dr. Ganz: A former patient of mine had surgery for a leiomyosarcoma. She called me a week ago and said they had discovered some metastases. I asked her how she was feeling, and she said, "Great. I had my first chemotherapy. I'm going to work everyday and keeping up with my social life. I don't feel it yet." She had felt well prior to the diagnosis, also. Here's another case of cancer in a very energetic woman.

Dr. Lance: It can't be that all cancers are due to resignation. People live longer nowadays, and in a very different atmosphere of toxins and stresses. And, there are substances that are carcinogens. Given the right circumstances, even an otherwise healthy organism could be overwhelmed.

Dr. Fossum: Then, do we assume that the toxins affect the quality of the tissues, and, therefore, set up the conditions for cancer to develop? Or, do they produce the cancer in another way? My guess would be that the carcinogens have a direct effect on the integrity of the tissue.

Dr. Dew: The current thinking in traditional cancer research is that we all carry oncogenes that may be "turned on" by some event and cause cells to become cancerous. This is very reminiscent of what Reich said in the first place: that the cancer potential is there in virtually everyone. So, if we all have oncogenes, and one out of four people develop cancer, what is different about the people who don't get cancer?

Dr. Baker: If you had a patient with a history of cancer, what would you do differently? Dr. Herskowitz, were you more cautious?

Dr. Herskowitz: Generally, I didn't do anything different except when their systems were more fragile during chemotherapy or radiotherapy. During those times, I was more cautious.

Dr. Ganz: If the development of the disease lies outside the emotional realm, do we influence the disease by treating them with a therapy that's directed primarily towards improving their emotional functioning?

Dr. Dew: That's making the assumption that it doesn't arise out of the emotional realm.

Dr. Herskowitz: Dr. Ganz, if we think in terms of energy, we have more of a right to be in there. There must be some energetic phenomenon operating in cases of metastatic carcinomas that spontaneously undergo remission. And, since we are involved with a therapy that moves energy, we do have a place in these cases.

Dr. Ganz: Of course, when I use the term "emotional" in this company, I mean energetic, based on the movement of energy. However, there is evidence that there are other determinants which may be the cause of cancer, and so just because someone presents with a tumor, it can't be simply assumed that they have an energetic shrinking which is manifesting as that disease. We don't have to defend the idea that we treat cancer patients, but we really don't know if we influence the course of that illness in either direction. So far, the theory that we have used for the cancer model has not been proven, and we are not in a position to be able to prove it at this time.

Dr. Lance: Either overtly or covertly, patients believe that therapy will protect them from cancer. There is a general cancer phobia in this country, and patients who have read Reich have a notion that once they are in therapy, they won't get it.

Dr. Baker: I've had patients verbalize that they thought therapy would protect them from cancer. I want to go back to the idea of energetic patients and cancer. It isn't just a matter of how much energy someone has. Most important is how they handle the energy that they do have. For example, I treated a woman who was quite energetic but developed uterine cancer. Her Reich Blood Test was normal. Following surgery, she made some rather important changes in her life in terms of her work and got much more involved and interested in what she was doing. Although she did not look resigned, she had a significant characterologic problem. In her life, she had difficulty facing things and was a big avoider. On the couch, she was unable to hold a charge. This was a woman who appeared to have a lot of energy but could not hold on to it. Anything that was stirred up in therapy was immediately discharged.

Dr. Nelson: Another thing is that we are all being subjected to carcinogens and toxic substances. But, some people may be a little resigned, and those could be the ones with a greater potential for carcinomatous breakdown. Maybe the resignation is the extra straw that breaks the camel's back, so to speak.

Dr. Herskowitz: That sounds reasonable, but you also see a lot of resigned people who don't have cancer.

Dr. Lamdan: Characterologic resignation is also easier to spot than the more subtle resignation that may be occurring on the tissue level.

Dr. Baker: My experience with this one particular woman impressed me with the subtlety of the resignation. I did not see it clearly, early on, because superficially she presented herself as lively and energetic.

Dr. Braid: My experience has been that often the resignation is very difficult to see because it is so subtle.

Dr. Ganz: Perhaps it is those people who can overcome the breakdowns that occur. Then, there is still the observation of those patients who are obviously and profoundly resigned, and don't have cancer. Losses are often related to the development of cancer. My patient with the leiomyosarcoma had been diagnosed with essential hypertension about

four years before the tumor appeared. About a year and a half before the tumor was found, she got divorced. The divorce was reasonable for both her and her husband, and actually improved the quality of her life. Still, it was a terrifically stormy and emotional period. Time after time, I've either seen or heard of patients who have developed cancer after significant losses.

Dr. Lamdan: That's a short time for a tumor to develop. One would guess that the process had been going on, and the loss served to facilitate or enhance it.

Dr. Baker: There's more to it. Studies have shown that these people often have a history of a loss very early in their lives, sometimes within the first couple of years. The theory is that they never fully recover from it and are, therefore, more vulnerable to subsequent losses.

Dr. Braid: The incidence of a tumor arising after a severe loss is somewhere around five times higher than in the general population, where there is no loss.

Dr. Dew: It just occurred to me that when a patient builds up a charge and can't maintain it, he is actually resigning the charge. Even if the characterologic resignation isn't so obvious, the biophysical manifestation of resigning the charge may be. It is as if the cancer patient can't handle the excitation and discharges it at the cellular level. The production of cancer cells and T-bacilli may be a form of discharge for him.

Dr. Baker: My patient showed both. What she did characterologically mirrored the biophysical manifestations.

Dr. Nelson: Maybe the fact that the tissues can't hold a charge has nothing to do with character. How can we explain the finding that breast cancer is much higher among first-degree relatives of breast cancer patients? It could be that they are genetically predisposed to being unable to handle the charge. This might also explain how high energy people get cancer.

Dr. Lance: Isn't it also possible that these people with high energy who can't hold the charge have that much more energy to put into tumor formation? They could get a more ferocious form of cancer.

Dr. Lamdan: Premenopausal women with breast cancer die off much faster than postmenopausal women. The tumors have a different biology.

Dr. Fossum : Is it that cancers that are determined by emotional factors are different diseases than cancers that are not? Having a different etiology results in a very different disease.

Dr. Nelson: My point is that there may be a lot of cancers produced by factors that have nothing to do with character.

Dr. Fossum: Clearly, yes, it's possible. But, another question is, if you have someone who has a toxin-induced cancer, are you also likely to find a shrinking biopathy with characterologic findings?

Dr. Nelson: What about the asbestos workers who have an unusually high rate of mesotheliomas? You can't assume that the industry attracts people with poor tissues.

Dr. Baker: But, how come they don't all get it?

Dr. Dew: There are some other interesting models. If you shave the backs of mice and paint them with coal tar, they'll develop cancer. You can overwhelm an otherwise healthy organism, and I think that eventually that process itself can cause a shrinking biopathy. If the organism is flooded with breakdown products, cells, and T-bacilli, eventually it will shrink.

Dr. Ganz: Given everything we have said, I can't see any contraindication to treating cancer patients.

Dr. Nelson: Except that some patients break down and get worse.

Dr. Ganz: But, you don't know that hap-

pens because of the treatment.

Dr. Lance: Would it make a difference if they got cancer because of resignation, rather than their resigning because of the cancer? Someone with a serious illness could have a resultant depression and a shrinking that could be reversed.

Dr. Ganz: Sure, you would want to treat the depression.

Dr. Lance: Then you are also treating the shrinking process.

Stephen Nagy, M.D.: A finding not surprizing to us is that, in studies done on hospitalized cancer patients, it has been well documented that the ones that were the most aggressive and difficult to get along with live the longest. So, it's not a given that, if you get cancer, you must also be miserably depressed. Some patients will be just as spunky and as much of a pain in the neck after they get cancer as they were before.

Dr. Braid: Have we ever compared the results of the Reich Blood Test to tissue diagnosis? Are there increasingly negative RBTs with increasingly severe tissue diagnoses?

Dr. Baker: I can tell you without a doubt, there is no simple correlation.

Dr. Braid: The reason it occurred to me was that, in looking at bion preparations, we've always said that structure is related to charge; i.e., the greater the charge, the more structure. And in cancer, the more fulminant forms have cell types that show a great loss of surface adhesiveness, which enables them to invade a lot easier. Those are the cells that have a more protozoal kind of appearance. Just to continue my thinking out loud for a minute, I wonder if that lack of cohesiveness and structure has anything to do with how we might think about treatability.

Dr. Baker: I don't think so. We have to remember that patients can have reactions to acute situations and get over it. They are not doomed. We had one woman with an undiagnosed breast lump who looked bad biophysically, and who also had a very poor Reich Blood Test. When the lump was removed, it was benign. The following year, her Reich Blood Test was normal. Here is a case that was probably precarcinomatous. Whether or not the surgery or some improvement in her life "cured" her, we can not say. It does show that people can have acute, severe reactions and breakdown, but also have the potential to get better.

Dr. Dew: We should also keep in mind that the Reich Blood Test doesn't represent the illness; it represents what that individual does with that illness. So, I think it would be difficult to try to show a correlation between histological tumor type and what the Reich Blood Test shows.

Dr. Braid: Well, I was just using it as an illustration in my thinking for comparing structure and cohesiveness.

Dr. Baker: There are other biopathies to consider which we probably see a lot more often than cancer. The more common ones seem to be hypertension, asthma, and ulcerative colitis.

Dr. Dew: Let's look at hypertension. I'm always interested to know if other therapists take blood pressures before, during, and after sessions with hypertensive patients, and what the results are.

Dr. Nelson: I have treated a 30-year-old man who had a history of borderline hypertension for ten years. His systolic pressure ranged from 140-160; the diastolic from 90-100. He reacted beautifully to therapy and really had a good understanding of it. He spontaneously lost twenty pounds, and his blood pressures were consistent at 120/70. After about four months of therapy, he was seen by his internist who said, "What happened to you? You don't have hypertension anymore."

Dr. Ganz: Is he on any medication?

Dr. Nelson: Nothing at all.

Dr. Dew: Hypertension is one biopathy where it is very clear what's going on. Numerous studies have shown that these people have an absolute increase in catecholamine output. In clinical work, beta blockers have become the treatment of choice. So, the mechanism is very clear as to how orgone therapy helps.

Dr. Baker: Yes, it is a very rewarding biopathy to treat because it responds so well. It may take awhile, but you can get them off medication and down to normal pressures.

Dr. Dew: Another rewarding one is acne.

Dr. Nelson: What about asthma?

Dr. Baker: Asthmatics respond fairly well, too.

Dr. Braid: I think I've caused it as often as I've helped it.

Dr. Baker: That happens. Probably we've all had that experience.

Dr. Dew: I have noticed that people who have had asthma as children and outgrew it by their teens will generally become symptomatic again at various times in therapy. It is also odd that the same therapeutic techniques that abort an attack in one patient can induce the attack in another.

Dr. Braid: I have a question. Would you say that getting them scared brings it on, and that getting them to express that fear makes it go away?

Dr. Dew: It might break the attack, but at other times, it can also increase their symptoms.

Dr. Ganz: I go very slow with asthmatics. You have to titrate them. Get them to feel their anxiety a little bit at a time.

Dr. Baker: I treated a teenager once who had such severe bronchoconstriction that I kept a syringe of adrenalin nearby.

Dr. Dew: If they use any inhalation medication, you should absolutely have it on hand in case of an emergency. One of my patients, a real easy-going charmer who is liked by everyone, will start wheezing just by talking about certain issues. It is confusing at times because it is not always crystal clear as to what emotion is being hidden. But, if you are accurate in eliciting the right emotion, you have a good chance of aborting an attack. The big problem is that, if their level of excitation increases and there is no avenue of discharge, they can squeeze down with even greater intensity.

Dr. Nelson: You mean it could be any emotion that is being hidden.

Dr. Dew: Any emotion. The asthma symptoms are just the patient's way of handling it.

Dr. Baker: Asthmatics have a rather significant mother-dependency. I've seen attacks triggered when that topic gets broached. So, if you want to recreate symptoms, that will often do it.

Dr. Nelson: There is another group of patients who present with purely somatic complaints, and who are terribly out of contact with their emotional life. There is no particular biopathy, just a variety of somatic complaints. I have found them to be very poor candidates for therapy.

Dr. Braid: Their medical charts can be weighed in kilograms! It seems like their only currency is to talk about this pain or that pain.

Dr. Dew: The clue here is their lack of emotional contact. So, the approach to these problems has to be on the level of contact, which means working on the eye segment.

Dr. Nelson: Yes, a lot of them are ocular characters, often schizophrenics.

Dr. Dew: The somatization is probably their only means of discharge.

Dr. Braid: Actually, this is a well studied group, especially in community mental health centers and in teaching hospitals where they represent the majority of patients seen in medicine clinics. It is difficult to get them to talk about anything emotional, or even to en-

tertain that there might be an emotional component to their various symptoms. Interestingly enough, it has been found that the best treatment for them is to just let them talk about their complaints.

Dr. Lamdan: In some places, that has actually been instituted and formalized. There are clinics for pain-prone patients where they just come in and "kvetch" for a specified length of time.

Dr. Nelson: Most of my experience has been with men who are probably schizophrenic.

Dr. Nagy: I've seen it in a lot of women whom I wouldn't call schizophrenic, but who are terribly infantile and often times give histories of having been badly treated. Many of the patients in this category have been put on all sorts of pills and have secondary iatrogenic addictions.

Dr. Dew: Let's go back to Dr. Baker's question. Is there a specific way, from the point of view of orgone therapy, of handling a particular biopathy?

Dr. Baker: Personally, I would be alerted to the degree of difficulty that the patients have tolerating the anxiety. And, especially the particular tendency they have to secrete away that anxiety. That would be the signal to me as to how I should focus on bringing their anxiety to the surface in order to work with it.

Dr. Ganz: More than with any other patient?

Dr. Baker: Yes, because the degree of difficulty they have in handling the anxiety is different in patients with biopathies. They are particularly intolerant of it.

Dr. Braid: Do you mean that if there was something special about the way they handle their anxiety, by hiding it, you would go after that?

Dr. Baker: No. Dr. Dew asked what I'd do differently, and part of the answer to that is that I would be more alerted to the fact that I had a more difficult problem on my hands with a reference to the anxiety. In other words, my index of suspicion that something potent is lurking in there and that I should pursue it would be higher. I might be more patient with someone else.

Dr. Ganz: So, you would be more aggressive in these cases.

Dr. Baker: That's right. Be aggressive in trying to uncover it, but also be sensitive to how they react.

Dr. Fossum: Is it necessary to deal specifically with secondary gains in patients with longstanding somatic problems? If you focus only on the level of emotional expression, are you likely to see a temporary improvement, or perhaps a symptom substitution which could even create a worse situation since it satisfies the dependency needs?

Dr. Braid: That's a very interesting question. One patient, a brittle diabetic, would end up periodically in severe ketoacidosis. After a couple of these episodes, a pattern became clear. She would have dinner out with friends and forget her insulin. As a result, her sister would run to rescue her. At first, she presented this as if she had no control over what had happened. When I confronted her with the facts that not only was she endangering her life, but that she also had set it up to get rescued by her sister, and thus mobilize everyone in her family to help her, she stopped the behavior. So, you do have to address the secondary gains very directly.

Dr. Baker: I have an ulcerative colitis patient where the issue of secondary gain is just beginning to emerge. He is starting to realize that he is using his attacks, and his concomitant need to always be near a bathroom, to avoid going out in the world and actually facing things.

Dr. Ganz: Dr. Dew, when you introduced this topic, you mentioned three things: treatability, mechanism, and whether there is some

difference in the biopathies over and above the neuroses. Why do some people with similar constellations develop a biopathy, and others do not?

Dr. Dew: I don't have a definitive answer, but my assumption has been that the disease is a mechanism for discharge of energy which isn't discharged by neurotic behavior or by any healthy behavior. Whatever portion of their energetic excitation is not discharged by neurotic action or healthy action is discharged by the autonomic nervous system so that it affects the viscera. Why it is so specific, I don't know.

Dr. Ganz: Do you mean the predilection for a specific system or organ?

Dr. Dew: Yes. The diaphragmatic segment contains a whole host of organs. So, why does someone get gall stones, another gets ulcers, and still another gets pancreatic disease?

Dr. Nelson: What about the familial influence, the genetic factors?

Dr. Ganz: And, how would that relate to the energetic concept?

Dr. Dew: If the organ is compromised by a genetic predisposition, then it would probably be more selectively affected by a disturbed energy system.

Dr. Herskowitz: In other words, there are some offspring of diabetics and hypertensives who get the disease and others who do not.

Dr. Dew: And, even if both parents are diabetic, not every offspring of the pair will have diabetes.

Dr. Ganz: I'm still curious about the issue of secondary gain. Is that behavior really secondary to the illness, or is it just another manifestation of the basic characterology? If the person didn't have that particular illness, would that same behavior show up anyway?

Dr. Braid: I think so. The style of the behavior related to the secondary gain is determined by the character.

Dr. Ganz: This reminds me of another point that didn't come up in our seminar on countertransference. It is something worth considering, because our response to a patient's illness, instead of being therapeutic, could support or even subtly encourage the secondary gain. For example, sometimes we might be seduced into ignoring the manipulative aspects of the patient because we get too wrapped up focusing on the illness itself.

Dr. Fossum: There could be circumstances when therapy touches the patient's neurosis in such a way that he feels he is on the verge of losing something very important to him, and, for a time, he actually gets worse. This sort of exacerbation might be related to secondary gain.

Dr. Ganz: That makes sense.

Dr. Dew: When people's lives have been so severely affected by illness, it is very important to emphasize the positive aspects of what they are able to do in spite of the illness. The point is not to sit around and groan about what your shortcomings and deficiencies are. They are factors, but to make use of what you have is more important. We have to avoid the trap of being too sympathetic.

Dr. Ganz: That's really what I was alluding to. You can really feel for them on a very human level.

Dr. Lance: There is another way in which countertransference might influence the treatment process. Whereas one therapist may see a set of options available for a particular case, another might see a different range of possibilities. I don't mean that both could not be helpful, but it does depend, to some degree, on the therapist's own experience and character.

Dr. Braid: Countertransference issues are easy to see in physicians who work with dying patients. Most of the oncologists I have known have been terribly depressed or practical jokers. It also becomes a tremendous issue for

people working in emergency and trauma units, or on medical wards where there are a lot of terminal cases.

Dr. Nagy: I have seen another style in oncologists, and that is to become severely obsessive. They try to keep their anxiety down by nailing down every little detail of the case. You know, where the patient is chart perfect, but dies.

Dr. Nelson: Another interesting thing about biopathies is how the incidence of the various diseases changes over the years. This influences what we see more or less of in our offices. For instance, in the last five or ten years, the incidence of coronary artery disease has dropped dramatically. Of course, you know that the most common cancer in women is lung cancer. More women are getting peptic ulcers. Why is there less CAD?

Dr. Herskowitz: Probably dietary change is a big factor.

Dr. Dew: That's certainly a factor. It is also interesting to note that coronary artery disease is becoming more prevalent in younger people.

Dr. Nagy: Yes, it is not so unusual to see heart attacks in the thirty- and forty-year-old age groups.

Dr. Ganz: That reminds me of something I saw, a few years ago, at a CME seminar at Bryn Mawr. They showed an angiogram of a bypass vessel, which is a vein. The study was six or seven months post-op, and the patient was experiencing angina again. The angiogram clearly showed the vessel in spasm. To me, this was evidence that the chest segment contracted and that the vessel, with no nervous supply, was responding to that contraction.

Dr. Braid: How did they explain it?

Dr. Ganz: They didn't. Listen, that's not unusual. Recently, I met a man who was chief of nephrology at a major teaching institution, who told me that he had just found out he was hypertensive. I asked him about it, and he ran through the customary list of possible causes. When I asked him about the emotional aspect, he said, "Oh, there's no question that there is an emotional component." So, I asked him what happens when he gets pissed off. He said, "I don't get pissed off." When I went further and asked him if he ever felt like screaming, he asked me what I meant and wondered where one would do that. I said, "In your room or your car. You know, just to get it off your chest." He said, "Boy, I never heard of an idea like that." He had never made the connection in any real way.

Dr. Braid: I treated a hypertensive patient, blood pressure 180/120, who was on several medications. When he came to therapy, there had been very little change in his pressure, despite the medication, so I took him off everything with the consent of his family practitioner, and put him to work on the couch. After about two and one-half months, his blood pressure normalized, but the price he paid was increasing anxiety. He began to question whether or not he was willing to deal with all the anxiety. So, I said to him, "Well, it is a trade-off. You've had uncontrollable hypertension for a couple of years, and now your blood pressure is 130/70 on no medications. Now you have to decide if you can face up to the anxiety." He left therapy.

Dr. Ganz: You wonder what happens to these patients. Will his blood pressure go up again, or will he manifest another illness? The increased anxiety is going to go somewhere.

Dr. Dew: I know of one case where the blood pressure went down, the man left therapy, and three months later had a massive coronary.

Dr. Ganz: The source of the anxiety may be exclusively internal, or as the result of some external situation. If the patient is incapable of changing or modifying either of these conditions, then therapy can actually make him

worse. How can you determine when the person is capable of biting the bullet, so to speak?

Dr. Dew: It is all well and good to get a patient excited, but there has to be an outlet for discharge and change.

Dr. Baker: That's a very good point. You cannot leave them feeling helpless in their environment. In practice, we actually spend some considerable time with certain patients going over all the ways they can influence the course of events around them. Many patients who feel victimized and helpless don't recognize that their inaction is a major cause of their difficulties.

Dr. Ganz: That's terrific, if it can be done.

Dr. Baker: Well, you explore situations to see what options are open to them, and if there are no real options available, they can leave the situation.

Dr. Ganz: It's probably a good thing to do routinely, early on in therapy.

Dr. Lamdan: They may not be able to see all their options at that point in time.

Dr. Ganz: That's true, but I think it's our responsibility to try to put them in a position where they can begin to consider the various possibilities open to them in any given situation.

Dr. Baker: It's hard, because they literally can not see clearly. When they begin to see more clearly, literally and figuratively, it does change what options and actions are available to them. Many patients will see it on their own, spontaneously. Unfortunately, we are running out of time for this meeting. Our discussion has wandered a bit from the biopathies, so we will have to continue to struggle with that topic at another time.

To be continued.

Notes From Afield

Notes from Afield is intended as a forum for the presentation—in brief synoptic form—of findings from other sciences that bear more or less directly on any aspect of orgonomy. Readers are invited to contribute such material, citing the author, title, source, and date of publication. In the case of books or excerpts from books, the name of the publisher should be included. Contributors may also, if they wish, provide a commentary indicating the relevance of the information to orgonomy. The editors reserve the right to alter, revise, or add to such contributions as they deem necessary.

BÉCHAMP: A DISCOVERER OF THE BION VESICLE

In previous pages of Notes From Afield, we have presented evidence in support of Reich's work from modern research. Recently, a book has been bought to our attention* which reveals the remarkable work of a man who preceded Reich. The book, *Béchamp or Pasteur?: A Lost Chapter in the History of Biology* by Ethel Douglas Hume, concerns the life and research of Pierre Jacques Antoine Béchamp, a contemporary of Pasteur, who lived from 1816 to 1908. Béchamp was a man of impressive credentials which included Doctor of Science, Doctor of Medicine, and Master of Pharmacy. He was Professor of Medical Chemistry at the University of Montpellier, Professor of Biological Chemistry, and Dean of the Faculty of Medicine at Lille, and a Fellow and Professor of Physics and of Toxicology at the School of Pharmacy in Strasbourg. His research in the natural sciences, including daily work in the laboratory, continued until his 83rd year. He was extremely prolific, authoring over 30 books and papers on a wide range of subjects. Though classically trained, he seems, like Reich, to have been capable of dissolving and transcending the artificial barriers between the various disciplines in his work and thought. The thrust of the book is mainly that of establishing Béchamp's priority in discoveries which, conventionally, have been attributed to Pasteur and others. The contention with Pasteur is dealt with in particular detail. Pasteur is depicted as a mediocre scientist who, unlike Béchamp, knew how to put himself in the limelight and was even unscrupulous in doing so. He was opportunistic, ruthless and, according to the author, caught in at least one outright plagarism of Béchamp's work. Hume carefully documents these accusations from Pasteur's own letters and from records of the proceedings of the French Academy of Science. In this respect alone, the book makes fascinating reading.

The magnitude of Béchamp's contribution, particularly as it related to the later work of Reich, is perhaps more fully appreciated if it is seen in the scientific context of the period. At the time, a great deal of the debate in biology pivoted around theories on the origin and properties of living matter, i.e., "protoplasm." The major battle lines had already been drawn the century before. The *Spontaparists* believed that organized life is continually emerging from inanimate matter while the *Panspermists* contended that all life ultimately derived from pre-existing *germs* of life which came into being at some remote time in the earth's history. Closely related to this argument was the debate over *fermenta-*

*Our thanks to Ira Bauer for providing us with this book and the articles on pleomorphism which follow.

tion. The latter group maintained that the agents which bring about fermentation (including "rotting" or "spoilage" of all manner of foodstuffs) are living organisms which derive from the air. Oddly enough, Pasteur, who identified the lactobacillus in souring milk, then attributed the bacteria's origin to the protein in the milk! Béchamp, using simple sugar solutions had shown conclusively that exposure to the air was a prerequisite for fermentation, that protein was not even necessary, and that the fermentation was a by-product of the metabolism of the medium by the organism. Of course, Pasteur subsequently reversed field and, without acknowledging Béchamp's priority, took credit for the elucidation of fermentation. But, it is obvious from Humes' comparison of both men's statements on the subject that Béchamp's understanding of the process was clear, detailed, and accurate, while Pasteur was somewhat hyperbolic and confused. Pasteur went on to pursue the matter of aerial contamination and consequently set the stage for the unqualified acceptance of the germ theory of both life and disease. Béchamp, on the other hand, despite his earlier work on fermentation, was reluctant to believe that there was a germ for every bacterium and that every infectious disease was the result of such germs gaining access to the interior of the body from the outside. His objections read like those of Reich written nearly 100 years later. He considered it preposterous that everyone seemed prepared to assume without proof that a multitude of germs filled the atmosphere. He continued his work on fermentation.

In his earlier research, Béchamp had noted, on microscopic examination, the presence of minute vesicles in the protoplasm of various cells. Other workers had seen these previously, and had called them "molecular granulations" or "scintillating corpuscles." Henle, as early as 1841, regarded these particles as the elementary units of cellular structure. But, Béchamp was the first to demonstrate that the cells' capacity to ferment resided in these "little bodies." Later, he found similar bodies in strata of limestone millions of years old; much to his surprise, these too exhibited fermentative activity. He coined for them the term *microzyma* (little ferments).* He recognized a vibration in them which he could distinguish from "Brownian" movement; under the right conditions, they would multiply. Béchamp found the vesicles in the cells of virtually every plant or animal he examined, as well as in milk and blood. Those in plant tissue were discovered to have a particular predilection to turn into bacteria if the cells are injured or killed, and the appearance of rot bacteria is the direct result of this process. He was able to demonstrate that these same bacteria, under certain circumstances, will revert to microzymas which in turn may organize into true mold cells.

Béchamp spent some 20 years studying the microzymas from a multitude of sources. From a massive accumulation of laboratory and clinical research, he developed a general microzyma theory or "doctrine" which linked microbiology, physiology, and pathology. In the light of Reich's work, what Béchamp says about these vesicles is remarkable indeed. A few of the major points are as follows:

1. The microzyma is the fundamental structural element of the living. It gives life to the organism and is the repository of that life after the organism dies. The microzyma itself

*Béchamp was, in 1864, the first to employ the term "zymase" for the soluble ferments he obtained from yeasts and molds. However, Buchner was the one who got credit for its invention in 1897!

is, therefore, in a sense non-transitory or "immortal."

2. The microzyma may become harmful through a change in function within the cell and, thereby, be the starting point of a disease.

3. The cause of disease is autogenous, i.e., "disease is born of us and in us."

4. The microzymas may evolve into bacteria within the body without necessarily becoming diseased; however, *in a diseased body, a change of function in the microzymas may lead to a harmful type of bacterial evolution.*

5. Diseased microzymas may be found in air, earth, and water, and in the excrement or remains of diseased organisms; however, *germs* of disease cannot exist primarily in the air we breathe since they arise in diseased bodies. The "disease germs" are, therefore, either the diseased microzymas themselves or the bacterial forms which they have assumed in the sick organism, and susceptibility to them is mainly a function of the state of health of the organism.

From the information in Humes' book, it is not entirely clear what constitutes Béchamp's conception of "health," but it is obvious that he believed it had to do with an internal environment which fosters normal functions in the vesicles.*

Béchamp's views, interestingly, placed him in opposition to both the spontaparists and panspermists. He is characterized as one who was led by nature in his experimentation rather than by attempts to prove or disprove a given theory. This adds to his credibility as a scientist because this attitude allowed him to see the truth (and weakness) in both schools of thought without embracing either dogmatically. He was not given to broad speculation but, instead, backed up most of what he said with well conceived and precisely executed experiments.

The relationship of Béchamp's work to Reich's is clear. Their objections to the air germ theory are very much the same, as are their convictions about autogenous disease and some of its mechanisms. Béchamp appears to have recognized may of the features and functions of what Reich called bion vesicles and was, as was Reich, prepared to accept the phenomenon of *pleomorphism*, e.g., the capacity of one kind of microorganism to change into another. As we shall see, the idea of pleomorphism has, in itself, been a source of heated controversy amongst microbiologists for over a century.

R. A. Dew, M.D.

*This is, of course, where Reich's work fills many gaps.

References

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PLEOMORPHISM

Pleomorphism is defined in biology as the simultaneous occurrence of independent forms or types of structure of the same organism. In microbiology, this concept has been extended to the consideration that the multitude of bacterial genera are simply multiple forms of essentially a few basic species. This means, literally, that depending upon conditions in the environment, one type may change into another. This is in contradistinction to the current view which, instead, holds that while these multitudes may have evolved from a few types over the millennia, they continue to breed true to form. While it is generally conceded that through spontaneous mutation or exposure to chemicals, e.g., antibiotics, bacteria may undergo certain alterations in structure or metabolism, their form in nature remains basically the same. Thus, a coccus is always a coccus and a bacillus always a bacillus. This is the concept of *monomorphism* which, of course, also presupposes that each and every kind of infectious disease has its origin from a specific germ or spore. So, the idea that a coccus might change into a bacillus, or any bacterium into a virus (and back again), would be pure "heresy" by contemporary standards.

From an investigational standpoint, the dispute between the proponents of monomorphism and pleomorphism revolves principally around the existence of "filterable" forms of bacteria. The filters most commonly used are made of porcelain or cellulose of such a pore size that all bacteria will be trapped, or held back, while smaller particles such as viruses will pass through freely (thus, viruses are said to be *filterable*). The advocates of pleomorphism contend that most, or all, bacteria also have a filter-passing or viral stage or form, and that, with appropriate techniques, the conversion of bacterial to viral forms and vice-versa is demonstrable. Because of this phenomenon, they further believe that these interconversions occur spontaneously within host organisms, i.e., man and animals. The conventional view is, of course, that ontologically speaking, viruses and bacteria are unrelated. An important aspect of this debate is the matter of the growth media themselves. According to the monomorphists, viruses typically reproduce only in *living* tissue cultures, unlike bacteria which will grow readily in *dead* extracts of plant and animal tissues which contain little or no complete protein. The pleomorphists (or "filtrationists" as they are sometimes called) argue that with special media and growth environments not only can both forms coexist in the same culture, but also the conversion in either direction of one to the other can be induced at will.

As we have seen, as early as the 1860's, Béchamp's work challenged the theory of monomorphism even before it had quite become "holy writ." Actually, since the late 19th century, a large body of research has accumulated which documents the phenomenon of pleomorphism, and it is worth mentioning that many of the hundreds of papers and articles on the subject were written, not by revolutionaries, but by highly respected workers in bacteriology and infectious disease. Nevertheless, in 1931, Hadley et. al., had this to say:

> *. . . the significance of these mutually confirmatory reports has, for the most part, remained unappreciated by the majority of bacteriologists. Against the view of the existence of special filterable forms of bacteria and spirochetes have been urged many and diverse arguments by writers who have never taken the trouble seriously to study the question or who have not applied the proper methods.* (4:p.6)

and,

> *Moreover, it has come about in these days that to express convictions that differ from the* consensus gentium *becomes almost professional foolhardiness; it brings down the strictures of one's friends and enemies alike.* (4:p.4)

This state of affairs may sound familiar to the student of Reich. The very idea of pleomorphism obviously touches a raw nerve and has evinced irrational attacks. The consequences of this bias were not lost to Hadley, who discusses what the recognition and acceptance of pleomorphism would mean:

> *. . . it might yield an entirely new picture of the extent of the distribution of pathogenic microbes through the organs, blood and tissues . . . and thus permit deeper insight into certain problems of pathology. Finally, such proof* [of pleomorphism] *might afford a new basis for the study of the still obscure etiology of several important communicable diseases that at present appear to be caused by filter-passing microorganism.* (4:p.5)

Obviously, the proof of pleomorphism has rested to a large degree on the experimental demonstration that viral or filterable particles may be derived from bacteria and/or the reverse, i.e., that these same particles can be induced to give rise to bacteria. Such work was done as early as 1894 and, as will be seen, has been repeated with a host of different organisms and viruses over the years. Also, in the course of this type of investigation, evidence has been gathered to show interconversions between different types of bacteria (often with an intermediate filterable stage). In 1914, Rosenow (1), a brilliant and highly respected bacteriologist, had already concluded that bacteria, by themselves, are not necessarily dangerous, but are capable of rapid modification in response to changes in the environment. Bacteria may then become a threat as a *result* of alterations of conditions within the host. Rosenow is not speaking here of a loss of *resistance* in the usual strict immunologic sense, but refers, rather, to antecedent changes in the host environment which promote actual *in vivo* pathogenic pleomorphic transformations.* The idea of the autogenous origin of disease is thus a logical consequence of the phenomenon of pleomorphism. We can cite here only a few examples of the experiments documenting pleomorphism, but these should suffice to illustrate the kinship and relevance to Reich's work.

Of particular interest are the findings of Rosenow and Wheeler (2), who recovered the identical coccus from the brains and spinal cords in 16 of 17 victims of lethal poliomyeletis. Depending on the mode of cultivation, the organism was found to assume the form of either a hemolytic streptococcus or a pneumococcus. Under anaerobic conditions, the bacteria were found to disintegrate into smaller and smaller lancet-shaped microdiplococci which became filterable. Cultures of the filtrate, when injected into animals, produced the characteristic syndrome and histopathologic lesions of poliomyelitis. In addition, it was found that sera from humans who had recovered from polio exhibited antibodies against the very coccus from which this viral particle had developed. In 1942, Rosenow (3) was able to identify the micrococci in both filtrates of naturally occurring polio virus and the virus he had obtained artificially from the bacteria 25 years before. Evans, in 1927 (4), demonstrated the opposite phenomenon when she cultivated virulent streptococci and a

*This view is very much in agreement with that of Béchamp and Reich.

spore-forming bacillus from pure filtrates of herpes and encephalitis viruses. Hadley et. al. (5), in an extensive and intricate study, demonstrated a filterable stage of the shiga dysentery bacillus (and for at least 10 other bacterial species). Moreover, it was possible to cause the filterable particles to revert back to the bacillus. Interestingly, the authors point out that, while the bacillus itself was difficult to maintain alive in culture, the filterable form, though sealed in glass ampules for over two years without air or nutrition remained capable of reversion to the living bacillus.*

Kendall (6), using a culture medium of his own invention ("K" medium), obtained reversible conversions of influenza viruses and diplococci. In the same study, filterable forms were obtained from *Bacillus typhosus* and *Leptospira icteroides*. Kendall also succeeded in converting staphylococcal bacteriophage into staphylococci. In all cases, the filterable particles were initially incapable of growth on ordinary bacterial growth media but, after several passages through the K medium, typical bacterial colonies grew out on conventional media and the resultant organisms gave positive results with stains and immunologic tests. Kendall describes the microscopic changes in the bacteria as filterable forms developed from them. In *B. typhosus*, for example, the bacilli, though still mobile, became ghost-like outlines containing tiny granules. Eventually, the bacilli disappeared altogether, leaving only the highly active granules which were just discernable as bright pin-points of light on dark field examination.

Kendall is also of interest because of his association with Royal Raymond Rife. Rife (whose work is dealt with elsewhere in this issue of the *Annals*) was the inventor of a light microscope of unusual design and with unprecedented powers of magnification and resolution. Unlike the electron microscope, Rife's instrument permitted the examination of material in the living state. With conventional light microscopes, the filterable stages of bacteria are either invisible, or just at the limits of visibility, using the dark field technique. Kendall took his cultures to Rife with whose microscope he was able to identify the virus from the *B. typhosus* at 8000x (7). Through Kendall, Rosenow was also able to view the polio virus he had obtained from cocci on Rife's instrument (8). Rife himself had been studying different kinds of cancer tissue since 1920 in an effort to isolate a causative micro-organism (9). When efforts to isolate and cultivate an organism proved futile, he became convinced that what he was seeking must be a filterable particle. From earlier observations of bacteria, Rife came to believe that all the pathogenic types fall into 10 individual groups, and that any member of a particular group, with subtle alterations in the growth medium, may be caused to change into any other member of the same group. A pure culture of *E. coli*, for example, may be transformed into *B. typhosus* or *M. tuberculosis*, etc., and again back to *E. coli*. All of these organisms can be induced to develop filterable viruses which produce specific viral syndromes when inoculated into animals. When Kendall's K medium became available to Rife, he was successful in isolating and culturing a filterable particle from human breast cancer; when injected into albino rats, this "virus" produced tumors consistently in 100 trials. Not only was this virus recoverable from these animals but, also, with appropriate adjustments in the growth media, it proved to have three unfilterable pleomorphic forms: cocci, *E. coli*, and a fungus. Rife theorized that cancer virus can arise in humans as a result of a pleomorphic change in a normally

*This is a vivid confirmation of Béchamp's point about the apparently "immortal" quality of the "microzymas."

harmless commensal - in this case, *E. coli* from the intestine. He postulated that this comes about because of predisposing chemical abnormalities which first must develop in the patient.

As the reader may appreciate, there are a number of aspects to this research which bear heavily on Reich's work. Reich frequently encountered pleomorphic phenomena in his studies of the bion vesicle, cancer, and finally, in Experiment XX. A recurring finding is that tissue cells will disintegrate into bion vesicles which, in turn, disintegrate into smaller and smaller bacterial forms. These ultimately give rise to the T bacillus which is described as being at the limits of microscopic visibility and most readily detected with dark field examination. As we have seen, this corresponds very closely to the experience of Rosenow and Kendall. Rife's cancer work bears striking similarities to Reich's (albeit Rife's was more restricted in scope). Rife and Reich each obtained a virus or T bacillus from breast tumors; both isolated and cultured the particles and injected them into rodents and obtained tumors. Rife's microscope allowed him to determine the size of his cancer virus to be precisely 1/15 micron; Reich, using a conventional microscope, estimated the size of the T bacillus as between 1/4 to 4/10 micron. While there are some significant differences in emphasis with regard to the origin of the particles, there is no contradiction *in principle* between the two; both men believed that disturbances in the internal milieu of the host antedate and predispose the organism toward the spontaneous production of a cancer-inciting agent.* Our small sampling of papers makes clear the role of definite, if artificial, chemical and physical changes in illustrating pleomorphism *in vitro*. Reich's concept of disease, as a disturbance in charging and a loss of orgonotic potency of the tissues, fills a major gap in understanding the mechanism of origin of analogous changes *in vivo*. It remains to be seen if some common functioning principle may be drawn from the various and unusual culture techniques employed in all these experiments.

R. A. Dew, M.D.

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* It seems a pity that neither man appears to have known of the other's work, particularly since they were studying the same problem at almost the same time. There are indications that Rife, apart from articles about his microscope, was unable to get any of his own experiments published. He and his coworkers eventually got into a great deal of trouble because of efforts to put a treatment for cancer into practice.

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GROWING INTEREST IN CIRCUMCISION AND ITS EFFECTS

Orgonomy has long recognized that circumcision of male neonates, for either ritual or sanitary reasons, constitutes an unnecessary assault on the genital and contributes to the emotional withdrawal of the infant at a time when the free flow of energy is of vital, life-long importance. Reich stated, "Circumcision is one of the worst treatments of children. You just look at them. They just cry. What they do is shrink. They contract, get away into the inside, away from that ugly world."(1)

1. *The Journal of the American Medical Association,* March 11, 1988, reported a study conducted by the Department of Pediatrics, Group Health, Inc. (Drs. Stang, Snellman, and Condon) and the University of Minnesota, Institute of Child Development (Gunther and Kestenbaum) entitled "Local Anaesthesia for Neonatal Circumcision: Effects on Distress and Cortisol Response." The results of this study, and of others cited by the authors, clearly demonstrate the correctness of Reich's views and of those still held by orgonomy.

The article cites the fact that "...routine, nonritual circumcision is both controversial" and, according to the American College of Obstetrics and Gynecology, Washington, D.C., that "...there is no absolute medical indication for routine circumcision of the newborn" (p.1507).

In their study, Stang, et.al., report: "A controlled, double blind investigation was conducted to determine whether the dorsal penile nerve block, using lidocaine hydrochloride without epinephrine, would effectively reduce behavioral distress and adrenocortical responses to routine neonatal circumcision." Sixty subjects were randomized into three groups of equal size as follows: (a) members of Group 1 were circumcised after dorsal penile nerve block (DPNB) using 1% lidocaine HCl without epinephrine (lidocaine group), (b) members of Group 2 were circumcised after injection with normal saline to control for the effects of injection and of fluid volume compression on penile sensation (saline group), and (c) members of Group 3 were circumcised without any injection (no injection group). All manipulations known to trigger the adrenocortical axis were avoided. Each baby was undressed from the waist down and strapped on a standard circumcision restraint (Circumstraint) board for five minutes before the first clamp was applied. It was during this period that infants in the lidocaine and saline groups were injected using the DPNB technique. Following this five minute period, the circumcision was performed on all groups. Behavioral states were recorded every 30 seconds during the injection and circumcision period. All babies were given pacifiers and were continuously soothed by the attendant. (These procedures are known to reduce crying, but not to alter adrenocortical response to circumcision.) The subjects in all three groups were comparable for birth weight, test weight, age at circumcision, maternal age, prandial time at circumcision, and behavioral state before testing.

The results of the study are summarized as follows: (1) Behavioral data: No significant differences in the percent of time crying were noted among patient groups for any period except during circumcision. Injection alone (saline and lidocaine groups) did not increase crying over the crying caused by the restraint apparatus. A significant difference was obtained for the circumcision period, with newborns in the lidocaine group crying less than newborns in the saline and no injection groups. Babies in the lidocaine group cried 23% of the time, while babies in the saline and

control groups cried 68% and 71% respectively, during circumcision (p.1509). (2) Cortisol data: Overall, lidocaine attenuated the adrenocortical response to circumcision, as compared with the response noted in either control group. There was no significant difference in the mean cortisol concentrations of the no injection and saline injection groups.

The authors of this study propose the use of the DPNB as a safe and easy to use technique for reducing the traumatic effects of circumcision on the newborn. They contend that if circumcision must be done, it should be done as humanely as possible. Although DPNB reduced crying and physiologic stress responses, there is still discomfort and stress associated with circumcision, and the authors, thus, endorse educational efforts to decrease the rate of routine circumcisions (p.1510). They also point out that the rate of circumcisions at the study hospital was 69%, and that the rate had not changed greatly in the last five years.

Citing a report by Gunnan, Fisch, Korsvik, et.al., *NEJM*, 1987: "There is no doubt that circumcision is painful for the baby. Indeed, circumcision has become a model for the analysis of pain and stress responses in the newborn." Referring to two other studies, they state: "Not only does the unanaesthetized newborn cry vigorously, tremble, and, in some cases, become mildly cyanotic, but post-stress related physiologic reactions have been demonstrated, including dramatic changes in heart and respiratory rates and subcutaneous oxygen and plasma levels." They point out, "It has now been shown that the absence of crying following circumcision is the result of the operation of the pain- or stress-coping mechanisms, not a lack of post-operative pain. Newborn response is different from that of older infant's response to pain in that there is a decrease in REM sleep, along with increased irritability after being aroused from sleep, as well as lethargy and difficulty in arousal, apparently indicating a profound autonomic effect" (p.1510).

The authors further point out that even research animals cannot, by law, be subject to surgery without anaesthesia, but that we do it to infants routinely without anaesthesia. Physicians have been slow to extend the same consideration to human babies as that required by law for experimental animals. Circumcision of the newborn remains the only elective surgical procedure performed without anaesthesia.

2. *U.S. News and World Report,* May 30, 1988, reviews a study by Dr. Aaron Fink, a California urologist who "successfully prodded the California Medical Association to endorse circumcision as a public health measure" (p.68). Stating that: "For the first time, we have medical knowledge that the benefits (of circumcision) extend beyond cultural practice..." Dr. Fink refers to a study done by Thomas Wiswill, M.D., at Walter Reed Army Institute of Research, showing a dramatic decrease in urinary tract infections in infants who have been circumcised. His study of 220,000 infants, over a 10 year period, published in the March 1987 issue of *Pediatrics*, showed that infections occur in fewer than one percent of circumcised boys. The rate is ten times higher for uncircumcised babies. The *U.S. News and World Report* article indicates that these data have successfully prodded the medical world to reconsider old evidence that also considers there to be a connection between penile cancer and lack of circumcision. In 1975, the American Academy of Pediatrics stated that: "Optimal hygiene confers as much, or nearly as much, protection as does circumcision." Another topic under reconsideration is the lack of circumcision being related to the possible increased spread of

sexually transmitted diseases, such as syphillis and gonorrhea, as well as AIDS.

The point, however, being missed by the study is the relative effect of circumcision without anaesthesia as compared to the biophysical effects of a urinary tract infection. A urinary tract infection, while a serious matter, does not compare with the assault on the genital of a newborn. Further, the presence of a urinary tract infection, especially in the age of effective antibiotic therapy, justifies only the accurate diagnosis and treatment of the medical condition, and does not constitute an excuse for the circumcisional assault on the penis. Reich's comments are appropriate: "Then, the Jews introduced something about six or seven thousand years ago. And that is circumcision. I don't know why they introduced it. It's still a riddle. Take that poor penis. Take a knife - right? And start cutting. And everybody says, 'No, it doesn't hurt.' Get it? That's an excuse, of course, a subterfuge. They say that the sheathes of the nerves are not yet developed. Therefore the child doesn't feel a thing. Now, that's murder."(2)

*Reginald Hilig**

*Pseudonym.

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APPRECIATING REICH AS AN ARTIST

"WR: Functions of the Artist," is the title of a four page article by Carl Little in the prestigious magazine, *Art In America*, March, 1988. The article was inspired by Little's visit to Orgonon, during the summer of 1987, where he saw an exhibition of 45 of Reich's oils. Little says, "... hung together in a gallery-like arrangement, they make for an impressive example of the scientist turned artist." The article begins with a brief biographical note and uses photographs of five of Reich's paintings as a framework for Little's commentary.

Little describes the five works vividly, and with an understanding of the connections they have to Reich's life and work. He points out the strong Expressionist influence on his style. Also interesting is the inclusion of a photograph of Reich and some colleagues standing by a cloudbuster, which Little sees as sculpture. He points out that, "Reich was intrigued by the idea of scientist / artist. In my opinion, Reich came closest to achieving a reconciliation of these opposite impulses in the 'cloudbuster'." Little's appreciation of Reich is most evident when he says, "... Reich's paintings add another dimension to an already fascinating man, and merit further appraisal on aesthetic as well as psychological grounds."

Louisa Lance, M.D.

The Amateur Scientist in Orgonomy

This column in intended to encourage "hands-on" experience with various aspects of Reich's biological and physical laboratory findings, particularly for interested readers with limited means or access to sophisticated equipment. Each issue will feature an experimental research project that illustrates basic orgonomic findings using only modest equipment and expertise. Readers are encouraged to submit their own projects, including a brief theoretical background, a detailed practical description, references for further reading, and relevant diagrams or charts. It must be a project actually carried out as described rather than a theoretical design.

To-T

COURTNEY F. BAKER, M.D. and
PATRICIA S. BURLINGAME

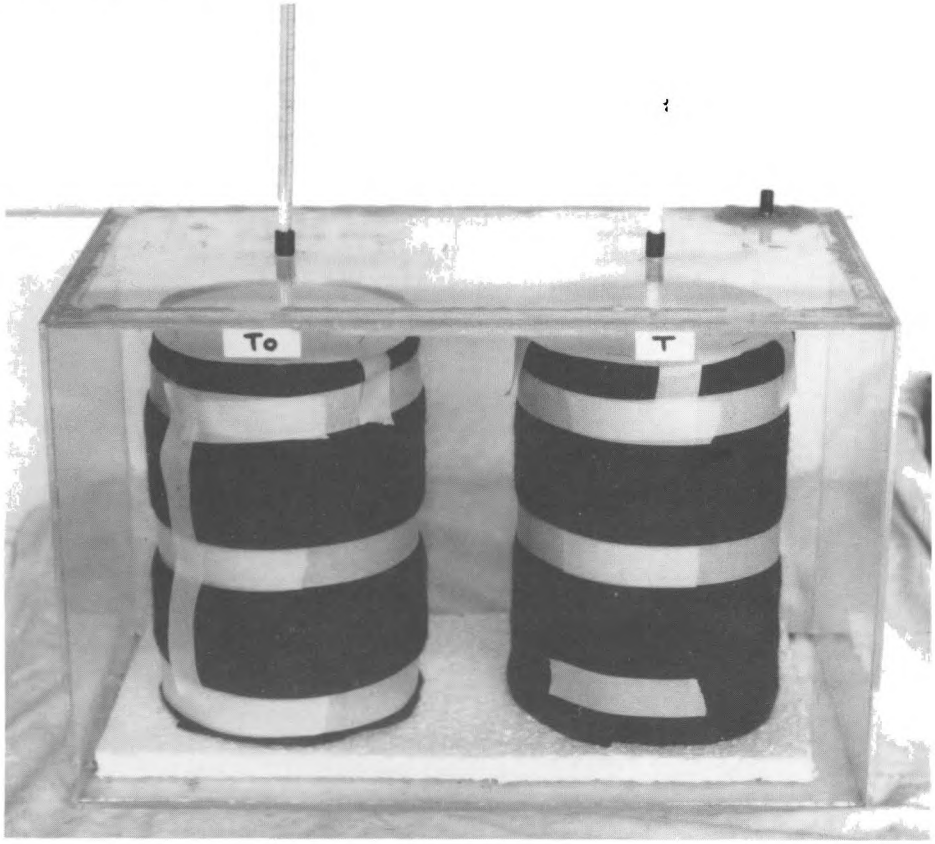
I. Background

In the course of his work with the orgone accumulator (ORAC), Reich noticed a distinct warmth and tingling sensation within the confines of the box. He was later able to objectify this observation by placing a thermometer within the ORAC and demonstrating a higher temperature within the box, compared to the air. This temperature difference between the ORAC (To) and the air (T) is designated To-T. It arises because the ORAC accumulates an energy level above that of the environment, and some of this energy is transformed into heat, which can be readily measured. The temperature difference, To-T, fluctuates with time, due mostly to changing weather conditions.

In practice, however, the direct comparison of air temperature with the ORAC temperature is prone to serious errors, since the air thermometer can respond much more rapidly to air currents and rapidly rising or falling ambient temperature, compared to the ORAC. This will lead to serious distortions in the value of the temperature difference, i.e., differences not due to orgone energy but, rather, ordinary heating effects. Consequently, the experimental design has been modified since Reich's description of it in *The Cancer Biopathy*, such that the internal ORAC temperature is usually compared with the internal temperature of a suitably constructed control box (whose temperature is also designated T), which is designed not to accumulate energy, but to respond to environmental temperature changes in the same way as the ORAC does.

Thus, in order to ensure that the temperature difference To-T is measuring orgone energy heating effects only, we must construct a control box such that it has thermal properties similar to the ORAC. To do this, we need to construct a box of size, shape, and weight similar to the ORAC, so that when the environmental temperature is rising or falling, both the ORAC and control box will respond by heating or cooling at the same rate. If the ORAC and control are suitably balanced, then any temperature difference between them can be due only to orgone energy.

In this experiment, we describe the construction of an accumulator and suitable control, which will be balanced if the construction plans are carefully followed. A state of balance can be readily ascertained by graphing hourly readings of the internal temperature of the two boxes; when they are balanced, the



The completed To-T set-up

curves are parallel to each other when the environmental temperature is both rising and (later) falling. Careful attention to the details of construction is therefore strongly advised. In addition, the two boxes are housed in a plexiglas container to shield them from the effects of air currents. This set-up has been successfully used outdoors on a shaded porch to monitor To-T as it varies during the day and with various weather changes.

In his early work with To-T, Reich found that the ORAC was always warmer than the environment, except before and during rain, when the two temperatures came together. Since then, however, a number of researchers have discovered that some ORACS will register consistently negative temperature differences (that is, the ORAC is consistently cooler than the control). The reason for this phenomenon is unknown, but has been found to be related to DOR in the atmosphere, and, in some cases, location. In the present experiment, the readings of To-T were found to be consistently negative (except during a thunderstorm). It is important to note that negative To-T readings are, from a theoretical standpoint, just as significant as positive ones, since any consistent temperature difference between the ORAC and control is evidence of orgone energy effects.

We would be interested in hearing from any readers who build the boxes described below, especially with regard to the To-T readings in various weather conditions.

II. Construction

Equipment

1. One 46 oz. juice can, 7" high, 4-1/4" in diameter.
2. A sheet of heavy construction paper or light cardboard, at least 16" square.
3. Wool felt, 5' long and at least 14" wide.
4. A piece of 1/8" plexiglas, 4' x 14", available in hardware stores and home improvement centers.
5. Two rolls of 000 steel wool.
6. Plexiglas cutting tool.
7. Plexiglas adhesive and syringe or glass eye dropper.
8. Two thermometers covering the 10-40° C range in 0.1° C increments. These can be purchased from a scientific supply company. Thermometers of this caliber are relatively expensive, but are necessary for this experiment, as the temperature differences are usually quite small. They are also fragile, and should be stored in a safe place when not in use.
9. A one-pound coffee can with a plastic lid.
10. A 1/2" thick slab of styrofoam, about 7" x 13".
11. Tools: scissors, stapler, masking tape, ruler, protractor, china marker, drill with a 1/4" bit, and a few sheets of newspaper.

Building the ORAC and the Control: It is suggested that this be done on a very nice day with low humidity, clear blue skies, and lots of cumulus clouds, as some people think that there is a correlation between the weather on the day an ORAC is made and its ability to accumulate orgone energy. Thus, an ORAC put together on a rainy day may be permanently weaker than one whose "birthday" was clear and sunny.

Remove the top and paper label from the juice can. Wash, then dry thoroughly. From the piece of felt, cut two identical strips, each 5' long and 7" wide, and eight discs the same diameter as the can. Cut a 1/4" hole in the center of four of these discs. Cut out the following pieces of construction paper: one 7"x16" strip, two discs the diameter of the can, and two discs 4-3/4" in diameter. Cut 1/4" holes in the centers of the larger pair of discs.

Place two of the felt discs with holes on each of the two larger paper discs, then line up the holes and fasten together by stapling around the edges. Stack and staple the two sets of intact discs. Next, wrap the strip of paper snugly around the can. Slide it about one inch off the end of the can and staple the edges together. Slide it off another inch and staple again. Do the same with the other end and then pull out the can. You now have a paper cylinder the same size as the can, which will be used as the foundation of the control.

Fasten the intact stacks of discs, paper side out, to the bottoms of the can and paper cylinder, using short strips of masking tape. Tape one end of a long felt strip to the cylinder, then wind it snugly around the cylinder. Fasten with three long strips of masking tape, wrapped around the whole circumference. Fasten the second felt strip to the side of the can, and wrap once around the can. Unroll a package of steel wool and gently tug at the edges until it is 7" wide. Lay the can on its side with the free end of the felt flat on the table. Place the steel wool on the felt and snugly wrap them together around the can until you reach the end of the roll. Using the second roll of steel wool, continue to wrap until you come to the end of the felt. Cut off the exposed steel wool even with the end of the felt, as you want the outermost layer to be felt. Fasten with three lengths of masking tape.

Center the felt/paper discs with holes over the tops of the can and cylinder. The felt should sit inside the rim. Fasten with six short strips of tape. Your control and ORAC are now complete.

Building the Housing: Plexiglas comes covered with a protective layer of paper or thin plastic, which should be left in place until all pieces have been cut. This will prevent scratching. Mark a point on each long edge of the plexiglas 7-1/2" from one end; then draw a line between the points. Lay a ruler along the line and scribe three or four times with the cutting tool. Place the sheet on a firm, flat surface, such as a sturdy table or kitchen counter, with the scribed line up and just at the edge of the table. While firmly holding the sheet in place, push down sharply on the protruding edge. The plexiglas should break cleanly with a snapping sound. (Note: You may want to practice on a scrap piece a few times to master the technique. Also, it is easier to hold down the main section of the plexiglas and snap off the smaller, measured piece.) Using the above method, measure and cut the following: another 7-1/2" x 14" piece, two 9" x 14" pieces, and two 7-1/4" x 9" pieces. Now remove the protective covering.

Cover a flat surface with several layers of newspaper, and place one of the 7-1/2" x 14" pieces on the newspaper. Take the four 9" high sections and stand them on their edges over the horizontal piece, making a box 9" high, 14" long, and 7-1/2" wide. This step is a bit tricky; you may want to temporarily support the pieces with small boxes or stacks of books. Hold the pieces together with masking tape. (Don't use scotch tape; it will be very difficult to remove.) When you are satisfied that the sides are perfectly vertical and the edges match squarely, you are ready to apply the adhesive. Using a syringe or eye dropper, dribble a small amount of adhesive along all the seams. It will flow into the cracks, and any missed areas will be clearly visible. Let the box sit undisturbed overnight; then remove the masking tape.

The remaining 7-1/2" x 14" piece will serve as the lid, and must have two holes drilled in it to receive the thermometers. Using the china marker, draw a line lengthwise down the center and mark a point 3-1/2" from each end. Drill a 1/4" hole at each point. If you wish, you may cut out several narrow strips of plexiglas and fasten them on the under side of the lid to keep the lid from sliding. These should be attached slightly more than 1/8" from each edge of the lid.

Thermometer Calibration: Since you will be making precise measurements, you will need to establish that the thermometers always record the same temperature, or if not, by how much they differ. First, label the thermometers A and B. Drill or punch two 1/4" holes in the coffee can lid, approximately 1/2" apart, and place the lid on the can. Put the can in the plexiglas housing, and move to a shaded spot outdoors. Wrap several layers of tape around each thermometer, about one third of the way from the bottom, then insert them side by side into the can. They should protrude several inches into the can, vertical and parallel, without touching the bottom of the can.

Take readings hourly during the day as the outdoor temperature rises and falls, recording the values from each thermometer separately. You will no doubt find that there is a slight difference between them. (In the experiment performed as background for this article, we found that thermometer B was consistently 0.05°C higher than thermometer A.) Note this difference, which you will later use as a correction factor when calculating To-T.

Final Assembly: Put the slab of styrofoam in the housing; then insert the ORAC and control. Arrange them so that their holes will be beneath the holes in the lid. Place the lid on the housing and carefully insert the thermometers through the lid and into the ORAC and con-

trol. The thermometers should protrude several inches into their respective containers, leaving exposed above the lid that part of the scale corresponding to the expected temperature range. Very carefully carry the housing to a protected, shady spot outdoors. If that is not practical, set it near an open north-facing window.

III. Taking Readings

You are now ready to start taking readings. The apparatus that you have constructed will not only demonstrate the existence of orgone energy, but is a useful research tool for monitoring variations in orgone functioning in the atmosphere. Since there are many things which can potentially affect the value of To-T (some of them well understood, and some of them not), it is important to record all pertinent information in a notebook. You will need to record location, weather, time, and any other potentially important influences (such as proximity to power lines, TV sets, etc.).

Mark the following column headings: Time, To, T, T', To-T, and Weather. T is the uncorrected reading of the control temperature; T' is the final value after the correction factor found during thermometer calibration is added or subtracted. It is important to be explicit in making the correction since it is very easy to become uncertain later on, i.e., asking yourself if you made the correction or not. You will want to take readings approximately hourly, and record the weather with each reading. The thermometers are graduated to 0.1°C (the smallest black lines) but you may, as a generally accepted scientific practice, estimate the reading to half this value, i.e., 0.05°C. This will take some practice and patience; it is important to read the height of the mercury level straight on to avoid parallax errors.

IV. Graphing

It is usually rewarding and highly instructive to graph the data that you have taken. Time intervals will be marked off on the horizontal axis, and temperature readings on the vertical axis. It is strongly recommended, at least initially, that you make at least one graph of To and T together, to satisfy yourself that the two curves are parallel. An example of data from this experiment is shown in Graph I, showing two clearly parallel curves while the temperature rises and falls during the day. The parallel curves are an indication of good thermal balance between the two boxes.

Once you are satisfied that the boxes are balanced, you may want to simply graph the value of To-T itself against time. This is shown, for example, in Graph II. Note the symbolic representation of weather at the top, and the steadily decreasing magnitude of To-T as a local thunderstorm is building. Generally speaking, the magnitude of To-T rises and falls during the day in a natural diurnal cycle, peaking in the late afternoon during clear sunny weather.

V. Projects

As mentioned above, a number of factors affect the ability of the ORAC to concentrate energy, and thus raise (or lower) the temperature of the enclosed air. The following is a list of parameters that would be worth correlating with To-T, as well as some of the things that you are likely to see.

(1) Time of Day: With stable weather, To-T should increase until early afternoon, then fall off again toward evening.

(2) Weather: High readings are most often found on clear, dry days, and lower or inverted readings during rainy weather.

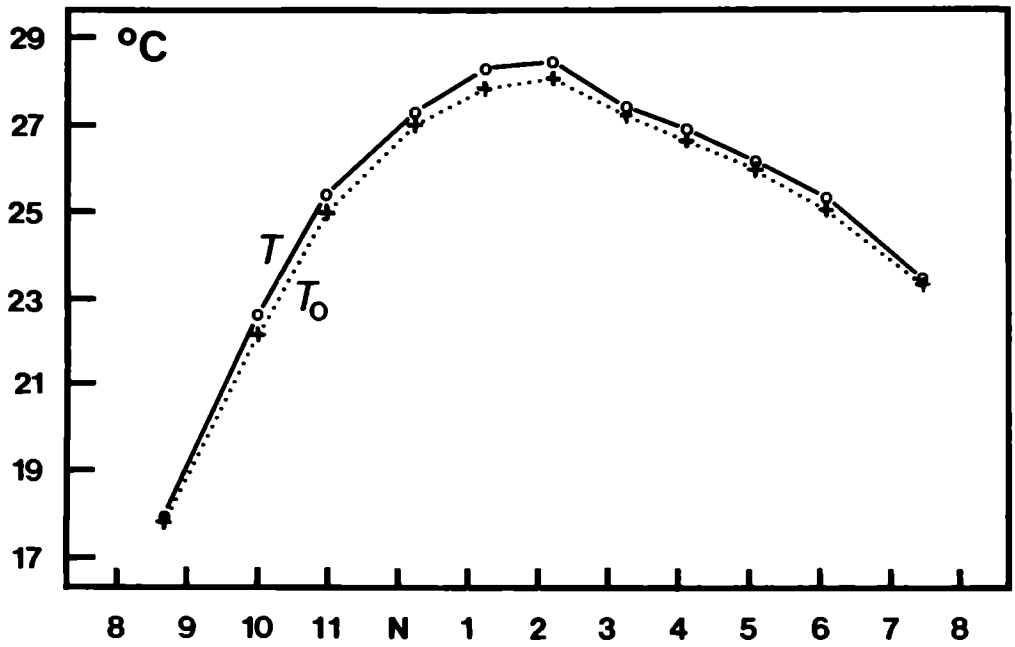


Fig. 1 To and T graphed over time, showing two parallel curves, indicating balance.

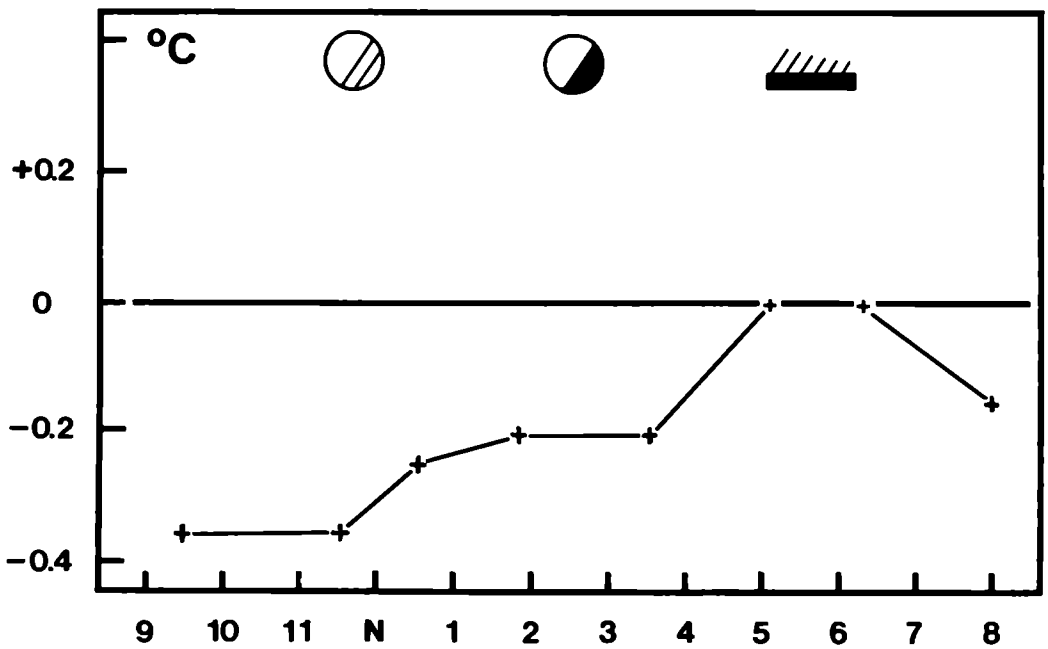


Fig 2. To-T graphed over time, showing a fall in magnitude of To-T as a thunderstorm builds.

(3) Location: Move the housing to various locations, both indoors and out, and see if To-T changes significantly. Remember to allow at least an hour before taking a reading in the new location, as it takes a while for the system to adjust to its new environment. When moving from indoors to out, or vice versa, an overnight acclimation is advised. For reasons that are not always clear, it may be found that some areas will give higher To-T values than others. Experiment with different influences, such as sources of oranur (television set, fluorescent lights) and negative ions (waterfall, ion generators).

(4) Electroscope Readings: Take readings at the same time and in the same place as To-T is read. Graph both sets of values. Are the curves roughly parallel, and does the rise in one curve precede the rise in the other, or is there no correlation?

(5) Refer to "A Home-Made Electroscope" in the Amateur Scientist column of *The Annals*, Volume 2 (September, 1985) for further ideas, as many experiments with the electroscope can also be performed with To-T.

Wilhelm Reich in Hell

by ROBERT ANTON WILSON

Falcon Press, 1987, $9.95

In this review, because there are separate issues involved, each of the forewords and the author's introduction will be discussed first, and then the play "Wilhelm Reich in Hell" will be examined.

The book is dedicated to "all political prisoners, where ever they may be." On the reverse side of the dedication page is the admonition, "If you would like to read further on the New Age Conspiracy to elevate Human Consciousness on this Planet and elsewhere" demand that your book dealer order the following titles. Then follows a long list of book titles among which are: *Undoing Yourself with Energized Meditation and Other Devices, Zen without Zen Masters*, etc. There is a last minute notice that Timothy Leary has joined the Falcon Press stable.

In the Christopher E. Hyatt Foreword, Hyatt writes of his mentor, Dr. Israel Regardie. In the summer of 1956, Dr. Regardie wrote to Reich asking permission "to quote at some length from various of his (Reich's) writings." There was no answer. In the spring of 1957, another request to Reich was answered several weeks later by Dr. Eva Reich informing Dr. Regardie of the government's injunction against Reich , and she advised against publishing anything pertaining to Reich's work. Dr. Regardie refrained from publishing his book entitled *Wilhelm Reich, His Theory and Technique*. However, the book is to be updated and edited by Dr. Hyatt, who "was certified by Dr. Regardie in Regardie's adaptation of Reich's non-verbal therapy (now called Chakratherapy) and Robert Anton Wilson, the author of this book." "For reference purposes, neither Dr. Hyatt, Holmes, nor Wilson are Orgonomists or Reichian therapists." "Each has his own views on Orgonomy and Dr. Reich, which I might add, are respectful."

He quotes from Dr. Regardie's introduction to his book, "It must be emphasized that I am not a partisan of any cause. I do not favor by any means the cruel and malicious opposition that dismisses Reich's contributions as delusional and he himself a paranoid. Nor, on the other hand, do I adhere unequivocally to the current Reich viewpoints."

After the receipt of Dr. Eva Reich's letter, Dr. Regardie proceeded with the revision of his manuscript. The news that Reich died in jail came in the fall of 1957.

Regardie writes, "This was indeed a great shock. I think we are the losers here. Reich was a great innovator as well as a creative and experimental clinician. It is a blot against the intellectual climate of society that he has been denied the freedom of expressing and disseminating his ideas whatever they were. It is an even greater crime against freedom of academic thought that he was imprisoned - regardless of the fact that he had violated a legal injunction and then refused adequately to defend himself. He felt no court of law was fit to adjudge scientific discovery and progress."

Hyatt writes that he was introduced to Dr. Regardie's adaptation of Reich's work, "which included kundalini yoga pranayama and some Kabbalistic rituals," in 1970-71. When Hyatt received a check from "one of the official Reichian organizations" for a copy of the book, he and the staff of Falcon Press became "paranoid," thinking that the Reichians had ordered the book to determine if Dr. Wilson was slandering Dr. Reich.

He notes that Regardie "was concerned about the law suit since he was both a chiropractor and a mystic; neither of which sits well with orthodox Reichians." Regardie couldn't comprehend Reich's dislike of mysticism and would sometimes hypothesize that Reich was a "reincarnation" of an Eastern Yoga Master.

Hyatt recounts his first "run-in" with a patient in orgone therapy. The patient accused Dr. Regardie of quackery and indicated that people like Regardie and Hyatt were dangerous and destructive. In consulting with Regardie concerning this incident, Regardie said that, "Reich would have been displeased about that type of behavior although Reich at times insisted that only medical doctors should practice any form of his therapy."

Hyatt cites other "run-ins," one involving his colleague, who was a licensed psychotherapist, a chiropractor, held a masters degree in bio-chemistry, and a masters degree in psychology, and had worked with Regardie for over four years at the time. In this instance, the orgonomist who confronted his colleague appeared to "have taken on the role of an unofficial regulatory agency."

To Hyatt, the attitudes of orgonomists and patients in orgonomy toward him, his teacher, and his colleagues smacked of victims turned prosecutors and inquisitors. He says, "The irrational behavior experienced was no different than that experienced by Reich, except that the Orgonomists had no state powers to arrest or burn the books of Dr. Regardie, myself and other non-orgonomists."

He elucidates the dynamics: it is simply-identifying with the accuser. [You] "develop your own group with arbitrarily defined rules and then do everything in your power to protect yourself from dangerous outsiders."

He continues, "I believe that Reich and Reichians in general, have a deep regard for individual differences and have genuine concern for the plight of man. However, they have been so wounded that they fire their cannons in all directions hoping not to harm but to protect themselves from further humiliation and persecution. They have developed similar prejudices, catch phrases and slogans which similar groups have used to recognize friends and foes. However, this form of self in-breeding leads to a staleness, because the perspective is not changed by new information which more frequently than not is carried by a heretic, someone who is a friend but not a 'true believer'."

Reich cautioned that every argument, even one that is essentially incorrect, may contain some tiny germ of truth. So, we shall deal first with the germ of truth in Christopher Hyatt's argument.

It is true that there is an inclination in human affairs for those who possess power to appropriate more power and to strive to exclude the dispossessed. Professional power is attained by passing the rigors of initiation and examination (as in attaining an academic degree), by gaining expertise (as in dismantling and assembling motors until one understands motors), or by conducting and repeating the experiment (until one is certain of the findings). These are the rational means of attaining power, and the only ones which we shall consider in this argument. Having attained power, the bearer may expand its range beyond that of his legitimate expertise. He may use his power to decry the findings of those who conduct arguments in his field that are beyond his area of competence (as the psychoanalytic community rendered opinions on Reich's work in vegetotherapy). He may use his power to downplay the work performed in his field by those who lack the acknowledged credentials in that area (the monk, Gregor Mendel, experimenting on heredity). He may use his power, though his competence has languished, as addicted physicians do. So, from voluminous evidence, there is reason to be

wary of the abuse of power that is attested by academic degrees and by certification of expertise.

On the other hand, there is a reality to the knowledge attained in academic pursuit, in conducting rigorous work, and in setting standards of performance. Though they do not guarantee continuous excellence in professional work, they at least attest to a level of competence agreed upon by those who work at that task. In orgonomy, because we are aware of the powerful tool with which we work, and because we recognize the skill required to use it well, we have set exacting standards for our practitioners. We have not done this because Reich was sent to jail, but because we set a high value on what Reich has discovered.

Dr. Hyatt is properly disturbed by Reich's persecution by government agencies. Wilson, the playwright, is the author of an international proclamation which "deplores governmental condemnation of those guilty of no crimes except creative thought." Yet, Hyatt is upset when orgonomists set standards to maintain the purity of Reich's thought and keep it free of contamination. He is not concerned to examine the standards to which his trainer was held when he came to practice his "adaptation of Reich's non-verbal therapy." He is more preoccupied with Reich the victim than with the power of Reich's discoveries. In his failure to examine the rigor of Reich's thought, he expresses his devaluation of Reich. One wonders whether he would select his brain surgeon using the same cavalier abandon with which he chose his therapist and mentor.

The foreword by Dr. Holmes is brief and breezy. It recognizes, in passing, the governmental intrusion into Reich's life and work, but the reference is used as a case in point of the kind of interference Holmes has experienced for expressing *his* ideas. His psychiatric text was banned in Spain (he says he knows not why), and he was fired from his academic post for urging that the use of marijuana be decriminalized. As he sees it, humanity in the childhood of its development fears all new ideas. He uses the larger space of his foreword to advertise his book, *The Sapiens System*, which espouses a method of dealing with this fear of novelty by (if I read him correctly) offering rewards for exposure to new ideas.

The introduction by Robert Wilson deals with some disparate themes. He speaks first of his dismay at the burning of Reich's books. He describes himself as a Jeffersonian libertarian who takes the U.S. Constitution at its word when it promises that there shall be no abridgement of free speech. To the governmental role in clearly abridging Reich's freedom to speak, he adds the injury of the scientific community in assuming an inquisitorial function. He decries their ability to destroy work and careers not on the basis of logic or experiment, but simply with their heavily weighted *ad hominem* arguments.

He professes, as a philosopher, to be open to entertain all ideas. He is sympathetic to Reich's description of sick humans and sick societies, and is able to comprehend Reich's idea of emotional plague. He is, however, apprehensive that the concept of emotional plague includes the potential for sealing-off those who make the diagnosis from those regarded as plague sufferers. Any criticism of the diagnosticians, he says, can be regarded merely as more symptomatology. Thus, he fears a new class of inquisitors may be created, insulated from winds of change, and unable to evolve.

Wilson describes a common error which occurs in phenomenological sociology. It is the result of uncritical inference, and it is called "gloss." Thus, he says, if he uses Marxist terminology in a statement, it is quite likely that someone will assume "Wilson is a

Marxist." This is gloss; it is an untrue inference based on an invalid logical leap. In arriving at his conclusions about self-sealing orgonomists, Wilson is himself culpable of dealing in considerable gloss. He has never entertained the possibility that orgonomists have already considered his "danger," and they have, therefore, laid down very specific criteria for the diagnosis of the emotional plague character. To not love Reich, or orgonomy, or orgonomists is not one of the criteria for the diagnosis. With a more charitable view, Wilson might have been aware that orgonomists are as sensitive to the possibilities of interpersonal mischief as he is, and even in some cases, are more ready to diagnose it in themselves than he.

And, what of the Wilson gloss that assumes that orgonomists regard Reich's words as holy writ. Reich was never misled by such an illusion. If going through the process of therapy destroys the ability to think critically, then it is not a therapy, but a brainwashing technique. If Wilson were as cognizant of what is happening in orgonomy as he assumes he is, he would be aware that there is constant elucidation and modification of Reich's work in accordance with our own experience.

To indicate the extent to which Wilson misses the mark of what orgonomy represents, the following quotation from the introduction is repeated without comment.

"The quickest way to experience something of what Reich meant by orgone is to smoke one marijuana cigarette . . . I have often wondered in this connection, if the anti-grass hysteria might not be described like the burning of Reich's books, as the defensive maneuver of a heavily armored culture against any intrusion of an unarmored life style; but I will leave that thought in the form of a speculation."

There is an interesting discussion on whether the "New Holistic Paradigm" that Reich evolved in *Cosmic Superimposition*, relating the geometry of galaxies, the spiral vortices of hurricanes, the evolution of living forms, and the tenderness of orgasmic sharing is valid as poetic metaphor or as science.

Wilson's preference is to include as many "reality tunnels" (ways of looking at how the world works) as possible into our awareness. He thinks that we should entertain them to the extent that they enhance our personal growth. He preaches agnostic libertarianism, but recognizes that all views do not have equal value, and that those which fail to profit us should be abandoned. He does not rate these views as true or false, but on a relative scale based both on their ability to help us deal with our world, and the body of proof which supports them. The theory of character armor he rates 8-9; emotional plague as metaphor rates 9. Emotional plague as a concrete illness he rates 2-3, and prefers to think of it as a description of the imperfections occasioned by our recent evolution as a species. Reich's cosmology he rates at 3-4.

He is outraged that Reich's writings, which illuminated the failure of people to take responsibility for their lives, a critical message for our times, were burned.

Wilson is bright, writes entertainingly, and is sympathetic to many of Reich's ideas. The problem is that when he fails to understand, his misconceptions are so egregious that they convey a false impression of what Reich is about. The endorsement of Reich by Wilson and his colleagues in the areas in which they are improperly informed carries the same weight as the affirmation of a new theory in astrophysics by a council of astrologers.

The Play

Claiming no competence as a drama critic, the play will be reviewed as by an interested reader who knows something of Reich.

The cast includes, among others, two acrobats, two jugglers, one magician, two Playboy Bunnies, two female members of the Anti-Sex League, Wilhelm Reich, the Marquis deSade, the American Medical Association (four punk rock singers), Ronald Reagan, a hip California psychiatrist, a radical lesbian, Marilyn Monroe, etc.

Wilson describes the play as a punk rock opera. The atmosphere is of circus and farce. There are low comic goings-on, crude, lewd jokes. The ringmaster is the judge. He is also Satan. The prosecutors are the Marquis de-Sade and Baron Von Sacher Masoch, who are also clowns.

As in life, Reich recognizes the court for what it is, a gathering to rule on the letter of the law, rather than for what it pretends to be, a means of achieving justice.

Reich: *I refuse to take this circus seriously!* (To the Ringmaster): *Everything relevant will be ruled irrelevant. Everything material will be ruled immaterial.*

The theatrical device of staging the trial in a circus-music-hall setting is clever and telling. The fact that Reich and some few demeaned witnesses speak simple and powerful truths while clownishness and pomposity prevail around them, serves to increase the impact of their words. Unfortunately, misinformation is disseminated in some of the testimony. For example, in the examination of the AMA:

> *Specifics, please. Dr. Reich's claim that cancer and schizophrenia are two forms of the same disease, the so-called Emotional Plague?*

The AMA answers:

> *Whackery, whackery! Total quackery! etc.*

(In this instance the author reveals a confusion of biopathic disorders with emotional plague).

In another section, speaking of Reich, the examiner says,

> *His claim that the Emotional Plague and muscular tension began with organized religion, was exacerbated by early capitalism and imperialism with the racial myths they invented to justify looting other peoples, and has now reached its most virulent form in the modern totalitarianism both so-called Capitalist and so-called Socialist?*

(Here the author borrows from Reich's hypothesis on the origin of armoring and from the *Mass Psychology of Fascism* to attack two of his favorite whipping objects - organized religion and totalitarian systems. Reich recognized the harmful aspects of organized religion, but he also was cognizant of the fact that it served a function in the lives of armored humans. In simplifying the message, the playwright disavows the subtlety of Reich's thinking and uses it for his own purpose.)

There are lines that are poignant in spite of the farcical atmosphere:

Sade: *What would he [unarmored man] see that the rest of us do not see?*

Reich: *That our own civilization is a circus, a clown show. That it is governed by magical rituals like all savage societies, that it uses the rituals to rationalize its addiction to sadism and masochism.*

Ringmaster: *I think the defendant is sailing dangerously close to contempt of court again.*

Sade (smoothly): *If your almightiness please, I think Dr. Reich should be given some leeway. He is not intentionally insulting this Court. He is describing the world as it actually appears to him, due to his mental illness.*

There is an interesting array of witnesses called by Reich. He examines a hip California psychiatrist who testifies that some of the therapeutic techniques instituted by Reich have now been quietly incorporated into conventional psychiatric practice. Marilyn Monroe tells how her audience was disturbed when she attempted to alter her image as a sex-object into that of an intelligent, sentient woman. Prince Peter Ouspensky reveals how he awakened to the teachings of Gurjieff (that most human behavior is robotic) when he witnessed lorries full of wooden legs on their way to the Russian front. Ouspensky is dragged out of court as a subversive.

The play ends by calling attention to the thin line between art and life. Each of the players, removing his costume, announces his real-life name. Reich, momentarily confused by this sudden shift, hesitates when they invite him to a pub for a drink, then prepares to join them.

As a device for revealing the deep injustice that was visited upon Reich by an anesthetized beaurocracy, the play succeeds. It is essentially a morality play, except that, in place of the conflict between virtue and evil, the opposition is between the victimized seer and insensate prosecutors. The form illuminates the message but limits the characters' dimensionality. One is particularly sensitive to this lack of roundness and depth in a portrayal of Reich who was such a rich and fascinating human being.

Morton Herskowitz, D.O.

The Cancer Cure That Worked

by BARRY LYNES with JOHN CRANE

Marcus Books, Box 327, Queensville, Ontario L0G 1R0, Canada, 1987, 167 pp., $8.95

The Cancer Cure That Worked by Barry Lynes is a fascinating account of the work of Royal Raymond Rife - a man whose driving curiosity and genius led him to discover what he believed to be the causative agent and a cure for cancer. By challenging and overcoming the theoretical and practical limitations of the conventional light microscope, Rife was able to explore the microbial universe in a way no one had ever done before, providing us with provocative new ideas about the etiology and treatment of disease. The author captivates both layman and scientist as he guides us through this intriguing story, which tragically ends with Rife's demise at the hands of the organized Emotional Plague - an unfortunately familiar scenario whose consequence may have been the needless suffering of untold numbers of people.

Lynes does not give us a great deal of personal information about Rife, but then again, this is not a biography; it is the story of a man's work which, as in the case of Reich, often tells more about the person than the individual details of his life. We learn that Rife was a multi-talented man whose primary passions were in the fields of microscopy, bacteriology, and electronics. Additionally, he trained to become a highly skilled machinist in order to sculpt his ideas into a functioning reality. His close friends and acquaintances described him as a gentle and humble man, happily married, whose intense desire to better the world was only exceeded by his creative genius.

In 1913, Rife, originally from Nebraska, moved from New York to San Diego and, with the help of roller-bearing magnate Henry Timken, began his career. Believing that microscopic pathogens were responsible for most diseases (especially cancer), Rife spent years studying the chemical constituents and electrical properties of microbes and came to the conclusion that each of them possessed a specific, individualized resonance - something like an electromagnetic fingerprint. He then reasoned that, if he could make a machine that could tune, or loop, into those oscillations, he might be able to devitalize the pathogens by blowing them apart, in much the same way that a glass can be shattered by a human voice.

Rife's initial experiments with guinea pigs (which were given tuberculosis) showed great promise. With his newly invented radio-frequency instrument, he was successful in destroying the tuberculin bacillus, but not without certain complications; some of the animals developed toxic poisoning and died. It took years for Rife to deduce that perhaps he was releasing some form of viral disease at the

same time that he was destroying the bacillus. Since viruses are much smaller than bacteria and thereby unobservable in the living state with an ordinary microscope, Rife was faced with something of a dilemma: how could he be certain of destroying an organism he could not possibly see?

The Rife Microscope

At this point in his research, Rife took what Lynes refers to as an "intuitive leap" in the world of optics and set standards which have yet to be met with conventional microscopes.

The Rife Microscope had several outstanding features. Among them was its capacity to reach extraordinarily high magnification and resolution with living specimens; another, and perhaps its most arresting feature, was the unique ability of the illumination system to "stain" microorganisms with their own specific frequency of light. Magnifications reached as high as 50,000x, compared to the ordinary microscope whose useful magnification is generally limited to 2,000x. Resolution, which is the capacity of a microscope to discern individual components of a specimen clearly, went as high as 31,000 diameters, roughly the equivalent of 20 times the resolving power of an ordinary light microscope. The only other device capable of such high magnification and resolution is the electron microscope (which magnifies and resolves even higher), but the specimens, by necessity, must be killed. This eliminates the possibility of observing movement, which, as Reich points out, is crucial to the comprehension of the living.

The optical system of the Rife Microscope consisted of fourteen lenses and prisms that were made of block crystal quartz. This allowed for the passage of ultraviolet and infrared light from the invisible parts of the light spectrum, which was necessary for the observation of particular specimens. Only five microscopes were ever built, the largest and most versatile of which was the Universal Model. It consisted of 5,682 parts with "separate substage condenser units for transmitted and monochromatic beam, dark-field, polarized, and slit-ultra illumination, including also a special device for crystallography."

One of the important factors that influences magnification and resolution concerns the passage of light through a medium. After a certain distance, light rays have a tendency to converge and cross each other, which results in distortion and a loss of magnification. Rife overcame this by spacing specially designed prisms at frequent intervals in the microscope. This allowed him to place three pairs of matched oculars strategically in the body of the microscope and achieve extremely high magnification that was free of distortion and aberration.

As mentioned before, the most important feature of the Rife Microscope was its unusual illumination system. With the use of a patented lamp and a special control that rotated two round, wedge-shaped quartz prisms, Rife was able to polarize the light and produce a monochromatic beam from any part of the light spectrum. So refined was the system that he could illuminate a specimen with a ray as narrow as *one* frequency of light. Whenever he hit upon a frequency that would resonate with the specimen's chemical constituents (much like tuning a radio), the organism under view would light up brilliantly and emit a color specific to itself. Repeated trials demonstrated that each microorganism had its own consistent frequency. In this way, Rife was able to "stain" the specimens without the use of a chemical dye, which normally would kill them. Equally important was his discovery that certain microorganisms could be revealed only when excited by ultraviolet light, which comes from the invisible portion of the spec-

trum. This demonstrated that, in addition to high magnification and resolution, a key factor in the observation of living specimens was the *control of illumination.*

Pleomorphism vs. Monomorphism

Early in the book, Lynes presents the concept of pleomorphism, which is essential to the comprehension of Rife's discoveries. It concerns a mid-19th century conflict between Louis Pasteur and his little-known contemporary, Antoine Béchamp. The issue centered around the question of whether a bacterium (or any microorganism) had the ability to assume more than one distinct form in its life cycle - a concept referred to as *pleomorphism*, as opposed to *monomorphism.*

Pasteur contended that pleomorphism was impossible and came to the conclusion that most diseases were initiated by specific "germs" which came from the air. Béchamp, however, argued that not only could bacteria change their form, but they could also "devolve" into smaller pathogens (depending on the chemical balance of their host) and "re-evolve" if conditions returned to normal; this led him to profess that diseases were autogenic by nature and that germs originated in the body.

Lynes informs us that, in part, because of Pasteur's powerful political influence, the orthodox scientific community embraced his theories and allowed them to become the cornerstone of the medical diagnosis and treatment of infectious disease, while those of Bèchamp were ignored.

In the 1920's, the debate was rekindled, but this time with an added twist. The two schools of thought that clashed were the "filtrationists" and the "non-filtrationists." The filtrationists upheld the theory of pleomorphism and contended that "devolved" forms of bacteria could pass through the finest filters, while the non-filtrationists held fast to a belief in monomorphism and claimed that whatever passed through the filters was not bacterium but, rather, a separate and distinct entity known as a "virus."

Once again, the orthodox community, in the face of tangible proof to the contrary, sided with the non-filtrationists. Lynes makes the crucial observation that the largest viruses range in size up to 300 millimicrons, which happens to be the limit of resolution of the conventional light microscope and is also the diameter of the pores in biological filters used to separate bacteria from viruses. In other words, bacteria and viruses were differentiated solely on the basis of passage through the filters, and not whether they were visible under the microscope.

In 1926, however, a qualitative difference between bacteria and viruses *was* established by Dr. Thomas Rivers of the Rockefeller Institute. Rivers claimed that viruses required a living host to reproduce, while bacteria did not. As Lynes points out, this helped to establish virology as a separate and distinct subspecialty in microbiology. Today, further distinctions have been made, a most important one being that viruses contain only one nucleic acid (either RNA or DNA), while bacteria contain both.

In 1931, Rife began his collaboration with Dr. Arthur Isaac Kendall, who greatly helped him in his quest to discover the cancer microorganism. Kendall was the head of medical research at Northwestern University Medical School and claimed to have developed a protein-rich, peptone-free culture medium (known as the "K" medium) which supported the growth of filter-passing forms of the bacterium *Bacillus typhosis.* This was in direct opposition to Rivers' claim that filter-passing forms (viruses) could not reproduce outside the host. In his medium, Kendall was able to observe tiny, highly motile granules;

but without adequate magnification, he was not able to discern anything of their individual structure. Having heard of Rife's extraordinary microscope, he contacted him to see what could be found.

Using Rife's microscope, they made a series of remarkable discoveries. By observing the culture at various intervals, Rife and Kendall were able to see 1) the original typhoid bacillus (practically colorless) in its unchanged state; 2) other bacilli in the intermediate stage between their filterable and non-filterable forms (slightly blue in color) with bluish granules still attached to them; and 3) the final filterable bacillus forms, which were the small, active, motile granules with a distinctive turquoise-blue color. That is to say, all the forms of the organism were present at the same time and in the same field of view. Equally exciting was their observation that when these filterable forms were transplanted into a standard broth medium, they "re-evolved" into the original bacillus!

The impact of these findings was that they 1) proved the concept of pleomorphism; 2) disproved the idea that a virus is the only form capable of passing through a filter and that filterable forms are incapable of reproducing outside a host; 3) raised the possibility that viruses may be pleomorphic forms of bacteria; and 4) lent support to the contention that certain diseases may be autogenic.

One would think that the medical authorities would have welcomed Kendall's and Rife's findings, but such was not the case. Rivers, with the power of the Rockefeller Institute behind him, lashed out at Kendall, publicly calling him a liar and claiming that his experiments were not reproducible, while never having access to a Rife microscope himself in order to back up his so-called "negative findings."

Even today, despite the fact that there is an enormous body of evidence in support of pleomorphism, the orthodox medical community holds fast to its position. As Lynes points out, "the medical moguls wouldn't even listen to one of their own." In 1911, Peyton Rous, a member of the Rockefeller Institute, demonstrated that a virus could cause cancer in animals, but the powers that be still clung to the theory that cancer was a "somatic mutation" and had nothing to do with an infectious agent. Eventually, however, Rous was proven right and, in 1966, was awarded the Nobel Prize. Moreover, Lida Mattman reported in her 1974 book, *Cell Wall Deficient Forms*, that in 1948 Dr. Eleanor Jackson was able to prove that the Rous "virus" was actually, by definition, a classical bacterium, i.e., it was capable of producing both RNA and DNA! Another study, done in 1975 at the Memorial Sloan Kettering Cancer Center in New York City, showed that the filterable form of the Rife cancer microbe was found in *every* blood culture that was performed on cancer patients. Was it then acknowledged that such an organism was associated with cancer? No. Rather, the findings were explained away as being due to contamination, and the study was ignored.

Discovery of the Cancer Microbe

In the six years before his meeting with Kendall, Rife and his colleagues had examined more than 20,000 laboratory cultures of carcinoma in an effort to isolate the filter-passing form of cancer; but they had no success. Then, in 1932, in much the same way that Reich found the orgone energy in his SAPA bions, Rife made a serendipitous discovery that led to a breakthrough. He had placed a test tube containing sections of a cancerous, ulcerated breast mass (in "K" medium) into an argon-filled glass loop charged with 5,000 volts of electricity, a device that he had been experimenting with for use in his radio-frequency instrument. The

culture was left in the loop for twenty-four hours, after which Rife noticed a cloudiness in the medium. Careful analysis revealed that the material had been ionized and, in order to counteract that, Rife placed the culture in a water bath with two inches of vacuum and kept it at body temperature for twenty-four hours - his reasoning being that by oxidizing the culture he could counteract the ionization. When he reexamined the culture at 20,000x, he discovered it was teeming with active, motile forms (1/20 by 1/15 of a micron) that had a distinct, purplish-red color; Rife had finally isolated his filter-passing cancer microbe, which he termed Bacillus X (BX). As he later would write, "This method of ionization and oxidation brought the chemical refraction of BX out of the ultraviolet and into the visible part of the spectrum. Owing to the fact that the test-tube specimens had gone through so many trials, we again started from scratch and repeated this method 104 consecutive times with identical results."

Further investigation with this newly discovered cancer microbe revealed that it was pleomorphic by nature and capable of taking five different forms dependent on the chemical nature of the medium. The first was the BX; the second, somewhat larger, was called BY; the third transformation was a coccus found in the monocytes of cancer patients; the fourth form was a fungus arising from the coccus; and the fifth, a *Bacillus coli* evolving from the fungus. The purplish-red color remained a constant throughout all of the stages except that of the *Bacillus coli*, which had its own characteristic mahogany color.

Animal and Human Experimentation

Rife's next step was to prove that the BX forms could consistently produce cancer. Following Koch's postulates, the accepted procedure for proving such matters, Rife injected the BX into 426 albino rats, producing tumors "with all the characteristics of neoplastic tissue" in every animal. From tumors surgically removed from the rats, he consistently recovered the BX form. In addition, Rife was able to cure all of the animals by destroying the BX with his radio frequency instrument.

After his success with animals, Rife was ready to begin testing on human subjects. In the summer of 1934, the first clinical trials were performed on 16 patients who were diagnosed as terminally ill with cancer and considered hopeless. The study was supervised by Dr. Milbank Johnson, who was the head of a special research committee at the University of Southern California. Over a four-month period, using Rife's Frequency Instrument, Johnson's committee of five physicians had declared all of the cases clinically cured! Particularly significant was the fact that the treatment's effect was *specific* to the cancer microbe and caused no damage to any other tissue; in addition, it was non-invasive, painless, and needed to be administered only every third day for a period of three minutes.

When these results became known, other clinics were set up by highly reputable physicians who reported extraordinary success in the treatment of cancer, tuberculosis, sarcoma, streptococcus and staphylococcus infections, typhoid, leprosy, syphilis, gonorrhea, and many other diseases.

Rife and the Emotional Plague

Just as Reich was hounded by Mildred Brady and the FDA, so too did Rife have a nemesis who led to his eventual downfall. He was Morris Fishbein, who at the time was head of the American Medical Association. In 1939, Fishbein had heard of Rife's success in the treatment of cancer and other maladies and

tried to "buy in" on the cure. When he was rejected by Rife and other members of Beam Ray (Rife's company), Fishbein acted like a man possessed in his efforts to discredit him. Using his influence, he threatened to have revoked the medical license of any physician who continued to use Rife's Frequency Instruments. In addition - although it is not possible to substantiate his involvement - laboratories were broken into, equipment was vandalized, and records were destroyed.

The final blow to Rife came from an unexpected source, and whether Fishbein had a hand in this, too, Lynes can only speculate. There was a Judas in Rife's midst - an electrical engineer named Phillip Hoyland, who helped Rife with the later models of his frequency generator. Having worked so closely with Rife, Hoyland felt he deserved a greater share in the company than the other members of Beam Ray. When he was denied this, he dragged Rife into court in the hopes of gaining control of the company and perhaps negotiating directly with Fishbein.

Unlike Reich, Rife won his trial, but the process took a tremendous toll. Unprepared for the scathing attack on his work and his character, he became so nervous during the trial that his hands shook and he could hardly put a sentence together. Both his smoking and his drinking escalated, and before long, Rife became an alcoholic. After years of treatment in a clinic, he made a brief effort to rekindle his once exciting and promising career, but it was too late. Not only was he a broken man, but, as Lynes put it, he became an "invisible" person to the medical community; even people who later confirmed his work were careful not to mention his name. Royal Raymond Rife died in 1971.

Reich and Rife

Although some reference is made to Reich in the preface to Lynes' book, no detailed comparison is made between him and Rife. A review of their respective works, however, reveals a significant number of parallels and shows their discoveries to be unusually complimentary.

As to the similarities, both men were well aware of the need to study live specimens to comprehend function as opposed to using dead stained material which shows only structure; and in this connection, they each appreciated the need for higher magnification in microscopy. Both came to the conclusion that the air-germ theory is severely flawed and both recognized the phenomenon of pleomorphism. Reich postulated that the bion vesicles represented a transitional form between the nonliving and the living; Rife, with the tremendous powers of magnification available to him, found in living cells an infrastructure of vesicular bodies which, in turn, were composed of yet smaller vesicular bodies. This would appear to support the concept of bions as the building blocks of living structures.

Rife's and Reich's discoveries are intriguingly complementary in the area of cancer; each regarded it as a disease of the entire organism, viewing the tumor as only a local manifestation. Rife, who never claimed to have understood the underlying cause of cancer, mainly demonstrated *in vitro* chemical changes which could initiate a pleomorphic cycle culminating in the development of a cancer-causing microbe. He postulated that, by some unknown mechanism, corresponding changes in the living host might trigger a similar cycle. Reich, on the other hand, had a very definite idea about the mechanism of the disease: that the development of the T-bacillus and cancer cell was the result of the bionous disintegration of energetically deficient tissue. He saw the compromised energy metabolism, i.e., the generalized T-reaction, as both the source of the tumor initiating T-bacillus and the tissue's susceptibility to it. It

may be that Rife's BX "virus" and Reich's T-bacillus are one and the same or at least related agents; the chemical changes of which Rife speaks would seem plausible in the energetic environment described by Reich. If so, this would represent a truly remarkable and satisfying convergence of their work.

Besides the possibility of mutual confirmation in the work of these two men, there are also possible practical implications for orgonomy in Rife's research. Unquestionably, a microscope with the capability of the Universal would be extremely useful; and some of his culturing techniques might have application in bion research. If his findings concerning reversibly pleomorphic, filterable forms are correct, his methods might be employed in a systematic investigation of the phenomenon from an energetic viewpoint.* And, if his treatment of cancer is as effective as is claimed, our thinking regarding the application of orgone energy to this and other diseases might take a new direction.

The Cancer Cure That Worked is an excellent book. Lynes conveys that Rife was a serious, brilliant scientist and a mechanical genius. From a scientific viewpoint, it may seem a bit tantalizing in that it leaves one craving more detail; however, it is obvious that the book is not intended as a scientific treatise, but rather as a comprehensive overview. Clearly, Rife's is a highly significant and revolutionary body of work which has been all but lost through deliberate suppression, ignorance, and neglect. One hopes that responsible researchers will give it the attention and careful consideration it deserves.

Ira Bauer, B.A.

*Rife's studies in this area reinforce the idea that bion vesicles carry "genetic" information, a possibility suggested also by Reich's observations.

"Self Psychology from the Perspective of Evolutionary Biology: Toward a Biological Foundation of Self Psycholgy"

by DANIEL KRIEGMAN, in *Frontiers in Self-Psychology,* Chapter 13, Volume 3

Hillsdale, NJ: The Analytic Press, 1988

Psychiatrists from varied theoretical backgrounds are rebelling against physiologically and biochemically oriented psychiatrists who have kidnapped the label "biologic psychiatry." This is biology in the narrow sense - the reductionistic study of the physical substrate of life phenomena. Biology, more comprehensively, is "the study of life," and today many researchers and clinicians are trying to understand human emotional and psychologic phenomena in the light of broad, nonreductionist biologic principles. Reich, and later other orgonomists, pioneered in this pursuit with their efforts to understand psychic functions as expressions of orgone energy.

Daniel Kriegman and Malcolm Slavin have written a series of articles applying the principles of evolutionary biology, the study of how life was shaped by natural selection, to psychology. They believe that mental structures and behavior patterns are shaped through evolution and that their survival value and adaptive function can be studied. In the paper under consideration, Kriegman analyzes *altruism.*

Freud's drive theory described man as self-serving, pleasure-seeking, and innately destructive. He believed altruism and compassion to be *secondary,* culturally learned behaviors, a "thin sugar coating" on a darker, animalistic core. Freud's ideas are grounded in Darwin's concept of "survival of the fittest." Kriegman is a self psychologist so he compares Freud's view with that of Kohut, who saw man as having *primary* motivational forces toward cooperative, altruistic behavior. Kohut's ideas are compatible with Reich's view that man's core is naturally decent, compassionate, and socially concerned. But, where is the evolutionary evidence to support Kohut or Reich? According to Kriegman, the traditional theory asserts that evolution is driven by "survival of the fittest," not "survival of the most compassionate and altruistic." If a gene suddenly appeared which caused the organism to act "for the good of the species," it would quickly be outcompeted by organisms with selfish genes that would take advantage of this altruistic gene's aid to the species. This is the evolutionary problem of altruism.

Kriegman begins his solution by stating that the principle underlying all evolutionary thought is that life can be understood in terms of an innate push toward reproductive success for the genetic material contained within the organism. Altruism is defined as behavior which "increases the fitness of another organism while decreasing the fitness of the altruistically behaving organism" (p. 262). Thus, altruistic behavior would survive the pressures of natural selection if the altruism maximized the genetic advantage to individual organisms. Kriegman next uses William Hamilton's concept of "inclusive fitness":

> *The overall inclusive fitness of an organism is not based on the individual organism's self-survival (personal fitness), but, rather, the survival of copies of an organism's genes in other individuals and in the resultant future gene pool for the species (p. 264).*

Devoted parental behavior that benefits the child, but often at considerable cost to the parent, has adaptive value; the parent's reduced *personal* fitness is balanced by an increase in his or her *inclusive* fitness because nurturing the child promotes the parent's genetic self-interest. Thus, altruism is selective when applied to one's children, but what about non-kin altruism? Kriegman answers this question by using the concept of "reciprocal altruism" developed by Robert Trivers.

This theory stems from the idea that an altruistic act can, at some later time, be returned to the altruistically behaving organism. In effect, altruism becomes a form of cooperation. Trivers uses the example of host and cleaner fishes found along coral reefs in the tropics. The cleaner fishes remove ectoparasites from the mouths of the host fish; the host loses a parasite as the cleaner gains a meal. Hosts sometimes act altruistically toward their cleaners, warning them of danger. When a grouper fish has a cleaner in its mouth and is attacked by a predator, it doesn't swallow the cleaner and flee. Instead, it warns the cleaner to exit, the cleaner exits, and then the grouper flees. There is good evidence that individual hosts and cleaners often return to one another and insofar as the host gains from dealing with a particular cleaner (for example, ease of location), the host may be selected to watch out for the cleaner's welfare. This is reciprocal altruism.

Another example of non-kin cooperation occurs when a baboon helps another baboon in a fight. The individual who is helped is more likely to return and aid the helper in the future. Recent monkey experiments have indicated that it was the capacity to cooperate which enabled early primates to protect themselves against predators such as leopards. This reciprocal altruism was probably what allowed monkeys to leave the trees and live primarily on the ground; these primates, of course, were the ancestors of *Homo sapiens*.

Trivers has shown that altruistic behavior confers a powerful adaptive advantage on the altruist. Primate research has demonstrated that cooperative social behavior existed early in the evolution of mankind; altruism existed prior to sophisticated intelligence, consciousness, language, and civilization. These adaptive tendencies enabled the individual to participate in a developing social order, and thus to garner the optimal advantages of the successful trading of altruistic acts.

Of course, this sharply disputes the traditional view of conflict psychologists who see altruistic behavior as a recent development brought into being after the requirements of civilization forced a restriction of instinctual behavior. In this Freudian view, heightened cognitive capacities predate altruism and are, in fact, used to control the self-serving sexual and aggressive drives.

Reich's clinical experience, his observations of children, and his study of primitive cultures all led him to appreciate a deep wellspring of natural decency, compassion, and social concern at the core of the human character. Kohut later recognized these energetic expressions as conflict-free motivational sources of the human tendency toward empathic union with others. Kriegman's article suggests that there is a solid biologic basis for this optimistic view of mankind and that there is no inevitable, irreconcilable conflict between the needs of the individual and the needs of civilization.

David Schwendeman, M.D.

Communications and Notes

For the Record

In the September, 1985 issue of the *Annals of the Institute for Orgonomic Science*, we published an article entitled "The Mystique of Health." The article dealt with a common tendency among patients as well as some therapists to idealize health, orgonomy, and therapy. In it, we addressed some of the common distortions, idealizations, and unrealistic expectations that we have encountered and tried to paint a more realistic picture of health.

In particular, while we clearly emphasized the importance of orgastic potency as the end point of therapy, we also pointed out that healthy individuals are not clones of each other, and that the health in each individual is expressed in individual ways. This was to counter the common notion that there is some sort of idealized genital character who is always rational, reasonable, functional, and glowing with emotional and physical health.

Then, in the September, 1987 issue of the *Journal of Orgonomy*, an article entitled "Genitality: Myth or Reality?" authored by Richard Blasband, appeared. The article had nothing new to offer to the understanding of genitality, and consisted mainly of a highly distorted and intellectually dishonest attack on our article, and a number of quotations from Reich and E.F. Baker.

In response, in the late winter of 1988, we wrote a letter to the editor of the *Journal of Orgonomy* regarding this article, asking for it to be published in full. The letter was neither published nor its receipt even acknowledged, so we are publishing it here in its entirety.

The letter is self-explanatory.

February 26, 1988

To The Editor
Journal of Orgonomy

Dear Sir:

We wish to comment on a recent (*JO* 21, No. 2, pp. 154-158) article by Richard Blasband, "Genitality: Myth or Reality?"

The article appears to have been motivated in part as a response to our article "The Mystique of Health," as Blasband offers nothing new about genitality other than rounding up the usual suspects (sexologists, "body therapists" and Lowen), and a restating of Reich and E.F. Baker on genitality. Otherwise, what Blasband has to say is a seriously distorted, out-of-context attack on our article.

It is difficult to understand how Blasband missed the focus of our article. Even a cursory reading of the article makes it clear that genitality is the goal of therapy and nowhere in it do we imply that there are no shared qualities in genital characters; those are givens. As we clearly stated beginning with the first sentence in our article:

> *Health in orgonomic terms refers to the ability of the organism to regulate its energetic household in accordance with sex-economic principles... The goal of orgone therapy is to remove the impediments to the natural pulsation, and to restore the free flow of energy which can then be discharged in a self-regulatory way appropriate to the age and developmental stage of the individual. The genital orgasm is the most effective regulator of the biologic energy and is necessary in order to maintain physical and emotional health.*

The context and intent of our article is clear: a critique of the tendency to idealize and mysticize health and genitality, with an attempt to demystify the notions too often parroted by orgonomists and laymen alike, concerning health. As we stated, in part:

> *There is no absolute model for health; no absolute 'right' way of being; no rules*

or recipes to follow to manifest genitality. If there were, then all therapeutic successes would be clones of each other. This is not the way nature functions. While it is true that all maple trees bear a number of striking resemblances to each other, and are quite different from oaks, the number of nuances and variations in each are limitless. So it is with health. As two very dissimilar character types improve in therapy and become closer to health, they will express the health in them in very individual ways. The health in them will distinguish them from the neurotic, but it will be an individualized expression determined by the totality of their personalty.

Out of this context, Blasband lifted the single sentence, "...it will be an individual expression determined by the totality of the personality," and concluded: "This is a meaningless and pragmatically useless definition of health." This is a remarkably dishonest use of an out-of-context quote to draw a conclusion not even vaguely intended by the original text.

One gets the impression from some patients and therapists - and Blasband's article has done nothing to dispel this idea - that there is a sort of perfect, ideal, generic genital character who always acts rationally, thinks functionally, and that, in any given decision-making situation, there is a single "right" decision that the genital character would make. This idea amounts to a mystification and idealization that is destructive to what we do know of actual genital individuals. For example, Blasband quotes from E.F. Baker, who says (in part):

He (the genital character) knows what others want and can accept their needs. Never dogmatic, he thinks functionally and objectively; his motives are rational, undisguised, and directed toward self-improvement and social improvement...His skin is warm and radiating, the eyes sparkling, the lips full and sensuous, and the limbs and torso well formed. He is relaxed and his behavior calm...There is no extraneous fat.

The fact is, the genital character is NOT defined by a collection of traits, even though real genital characters may have many of these traits. A genital character is one who functions at the genital level, and can obtain complete and satisfying energetic discharge in the orgasm. It is quite true that the genital character is qualitatively different from the neurotic; it is also true - which was the point of our article - that genital characters are as individual in their personalities as anyone else.

Blasband's article, which consists largely of an attack on our article and a re-stating of Reich and Baker, continues a disturbing trend. The world has, indeed, been quite hostile to genitality, often by ignoring or distorting or minimizing it. However, mystifying genitality can be just as, or more, destructive, as it transforms the genital character into the God-Man, unreachable by ordinary humans. It is this tendency to mystify and idealize genitality that is perhaps even more destructive than simply ignoring it.

Obviously and unfortunately, Blasband believed what he wrote, which is both defamatory and inflammatory; and for what purpose? He has certainly not enlightened or educated his readers. His maligning of our article is, at best, ignorant, and at worst, dishonest. We would suggest that the *Journal of Orgonomy* reprint our article in its entirety to correct the record.

Sincerely,

Courtney Baker, M.D.
Louisa Lance, M.D.

Letters to the Editor

The following letter was received in the fall of 1987, too late for publication in the September, 1987 issue, so we are publishing it now.

September 14, 1987

Annals of the Institute for Orgonomic Science
Gwynedd Valley, PA

To the Editor:

Your review of *Notes from the Workshop of Applied Orgonometry* (Baker: *Annals*, 3:71, 1986) blatantly attacks my work and tries to obfuscate the real significance of the new publication. But even more important, it unwittingly diminishes the significance of orgonometry itself in a number of subtle ways. For example, right at the beginning (in the third sentence) the reviewer, Courtney F. Baker, M.D., *narrowly* and mechanically defines orgonometry as "a notation system...." without considering how Reich expanded it or without assimilating what I have accomplished. Further, Baker is characterologically driven to insert the adjective "preliminary" in his reference to "Basic Orgonometry," when the correct qualification should be "introductory." "Basic Orgonometry" is entirely derived from Wilhelm Reich's original paper and one wonders whether Baker would categorize Reich's paper as "preliminary." Of course Baker does not want to be obvious about his underlying resentment of my demonstrated knowledge of orgonometry (a knowledge that is not presently open to him), so he concludes his review with a mystical assertion about 'Reich's Orgonometry' offset by a nasty, contemptuous and inappropriate description of my work. In this way he arranges a false setting in which he can take on the role of an authority in a matter that he has not mastered. "An authority is the one who *knows* what he is dealing with and not the one who has never learned what he thinks he already knows." (Reich: Rules to Follow in Basic Research)

Baker dismisses my knowledge of science as "amateur" (used to express contempt) without pausing to think of what this means with respect to those who have written for his own journal under the heading "The Amateur Scientist." Nor does he realize that the root meaning of the term is "lover," which makes "amateur" one of the sweetest titles a person could be given - especially in orgonomy. If we could eliminate the expression of contempt that is so frequently associated with this word, I would be very happy to be called an "amateur" since I love the work I work at.

The example that Baker gives as evidence that I am an "amateur" can be completely turned around and used to deflate *his* superior attitude. Among his many past errors, I could not wish to find a better sample than this feeble attempt to deny the content of my text. Remember that we are speaking of functional thinking, of functions and processes, and not about mechanistic *explanations*. He rehashes the standard mechanistic explanation (out of physical chemistry) of stored energy by calling it the "bonding energy," as if the label implies that this *quality* was something well understood. But what does "bonding energy" mean? Does it mean energy trapped in a structured environment, or energy that has become more structuralized, i.e., part of the

structure? And what is the nature of Matter itself - "frozen energy" (Reich). From a functional viewpoint it is clear that Matter is a secondary expression of Energy (i.e., Energy expresses Matter), and that the function of the *secondary* energy of the bonding continues to express the role of its *primary* source, orgone. Accordingly, I feel confident about what I wrote and that the energy locked in the bond is not "stored" but "materialized." The energy in a storage battery, despite its name, is not really stored but part of the structure of an unstable (over a long term) compound. Quite frankly, after six years of working with the new way of thinking I have ceased being impressed with the fundamental views of standard physics.

It seems appropriate to note here that the above error of thinking is not an isolated instance - a temporary lapse. A number of similar errors have appeared in Baker's published works and since they are recorded they can easily be reviewed and assessed. He might counter any examination of his errors with "we cannot proceed without error," which is what I say and practice. But I have yet to see any such acknowledgement by Baker, even though Reich said: "Do not try to hide your mistakes, speak about them frankly, and be proud of knowing your mistakes." (Rules to Follow in Basic Research)

For example, more than 10 years ago I noted a series of errors that appeared in an article by Baker, and since some of them concerned the subject of Musical Physics about which I have a very developed knowledge, I wrote him a friendly but serious letter stating the correct facts and discussing how and why they are often misinterpreted. Nothing further happened. No public correction was ever made, nor did I receive any personal or private acknowledgement of any kind. The errors are still there - printed witnesses to what I have noted about Baker and his weakness with respect to errors.

Let me say forthrightly that *Notes from the Workshop of Applied Orgonometry* does not aim to be "perfect" or "well balanced," but to reflect the operations of a process - an ongoing process - in which thoughts, feelings, and observations are integrated according to the functioning principles incorporated into orgonometry. The process is itself "cyclic," shifting back and forth (—> and <—) with respect to the direction of *development*. This repeated change of direction is also expressed in the practical development of temporary *errors* followed by *correct* realignments. Thus, Baker's criticism of what he perceives to be a "tedious" style is *partly right*. However, it takes time to assimilate a new "language" and initially, it makes sense to exercise it fully so that others may follow the process as well as the meaning. For this reason and for personal practice, I will continue to present the full process despite the appearance of repetition. Furthermore, as a long time admirer of Gertrude Stein's creative prose, I have developed a taste for the stately forward flowing of a content that is embedded in a spirally constructed sequence of closely related sentences.

Sincerely,

Jacob Meyerowitz
Editor

Dr. Baker replies:

The bulk of Mr. Meyerowitz's letter consists of personally abusive statements regarding my character, "resentment," "superior attitude," past errors, etc. etc. This response is offensive and inappropriate, and avoids dealing in a straightforward fashion with the content of my critique. It deserves no further comment.

Meyerowitz does, however, address the factual content of one of the issues raised in my review. Concerning statements made about the conversion of secondary energy into matter, he states, in part:

"But what does bonding energy mean? Does it mean energy trapped in a structured environment, ...it is clear that Matter is a secondary expression of Energy (i.e., Energy expresses Matter), and that the function of the secondary energy of the bonding continues to express the role of its primary source, orgone. Accordingly, I feel confident about what I wrote and that the energy locked in the bond is not 'stored' but 'materialized'."

Now it is all well and good to talk about bonding energy and what it may mean, but this is just so much verbal tap-dancing because it is NOT what Meyerowitz said. What he said, quite simply, was:

"We have evidence of heat-storing chemical reactions that lock energy into a compound structure. There is the living process of photosynthesis that converts light energy into plant and food structures. As a further example, we apply the energy of electricity to move particles from one material to another thereby altering the structure of both. We do not doubt in some way, SECONDARY ENERGY is converted into MATTER."

And this conclusion is, quite simply, WRONG.

Regarding Mr. Meyerowitz's style, of course he has the right to choose any style or format he wishes. However, I fail to see how being tedious or obtuse serves any legitimate function of scientific enlightenment.

Courtney F. Baker, M.D.

Announcement

After publishing 15 issues, almost singlehandedly, Lois Wyvell has turned over the editorship of "Offshoots of Orgonomy" to Marjorie Grubb. "Offshoots" was a natural outgrowth of Ms. Wyvell's long association with orgonomy and was, in part, created to fill the need of making orgonomic concepts and issues more available to laymen. Her historical perspective and her clear understanding of orgonomy have been invaluable to the readership. She will continue as Editor Emeritus of "Offshoots," serving an important advisory role.

Educational Programs

Laboratory Course Offerings

Introduction to Scientific Orgonomy : A two-day weekend course in the fundamentals of biogenesis and orgone physics is offered twice a year. This course includes lectures, demonstrations and laboratory work, and is designed for the student without a scientific background. Enrollment is limited to 10 students; course fee is $200. The next course will be offered May, 1989. For additional information write: The Institute for Orgonomic Science, c/o Courtney F. Baker, M.D., Box 304, Gwynedd Valley, Pa. 19437. With your application for the course, please include a brief resume.

Advanced Laboratory Course in Scientific Orgonomy : Although this course is designed for students with a strong scientific background, it is open to selected students who have completed the two-day course. This is a more comprehensive, four-day course which includes intensive laboratory work supplemented by lectures, films and demonstrattions. Enrollment is limited to 12 students; course fee is $ 350. To apply, write: The Institute for Orgonomic Science, c/o Courtney F. Baker, M.D., Box 304, Gwynedd Valley, Pa. 19437. Include a brief resume of your scientific background and experience in orgonomy.

Somatic and Psychic Biopathies Course: Designed to enhance the student's classical understanding of disease processes through an in-depth exploration of Reich's pioneering work in these areas, this course is offered to third- and fourth-year medical or osteopathic students and physicians. It is not limited to students interested in becoming medical orgonomists. Applicants must be undergoing characterologic restructuring and be recommended by their therapist. For further information, write: The Institute for Orgonomic Science, c/o Louisa Lance, M.D.., Box 304, Gwynedd Valley, Pa. 19437.

The Institute's Training Program for Medical Orgonomists: The Institute for Orgonomic Science sponsors a comprehensive program for qualified candidates seeking to become medical orgonomists. Applicants must have completed (or be in the process of completing) their first year of psychiatric residency and be undergoing characterologic restructuring with an approved therapist. He or she will be interviewed by one or more training therapists and, if accepted, will be required to complete the biopathies course, advanced laboratory course in biogenesis and orgone physics, and the clinical didactic course. Training then continues with the monthly clinical seminar given by the Institute and with individual case supervision.

For additional information, send a complete resume that includes biographical data, classical and orgonomic training, and therapy to: The Institute for Orgonomic Science, c/o Louisa Lance, M.D., Box 304, Gwynedd Valley, Pa. 19437.

Research

The Reich Blood Test: The Institute offers the Reich Blood Test, free of charge, as part of an on-going research project to individuals recommended by their therapist. Requests for the test should be made through the patient's therapist to: The Institute for Orgonomic Science, c/o Louisa Lance, M.D., Box 304, Gwynedd Valley, Pa. 19437.

Errata Volume 4

The description of Fig. 5d on page 43 should read: "...This same species was discovered in a single uninoculated rice infusion..."

In The Amateur Scientist in Orgonomy, at the bottom of page 116, the sentence should read: "The objectives recommended—all achromats—have some degree of correction for both.

Chapter 4 of Dr. Herskowitz's book, *Human Armoring: An Introduction to Psychiatric Orgone Therapy* was presented in its entirety in the *Annals*, Vol. 4, No. 1, Sept. 1987.

Manuscripts

The *Annals* invites the submission of articles on any of the several aspects or orgonomy. Manuscripts must be sent in triplicate (the original and two copies) to the *Annals of the Institute for Orgonomic Science,* Box 304, Gwynedd Valley, PA 19437. They should be typed on one side of white paper, double spaced, with margins of no less than one inch. A letter should be included indicating the category of the paper and should provide the name, address and telephone number of the author. The title page must include the following information about the author(s): first name, middle initial, and last name; academic degree(s), occupation, and institutional affiliation (if any). An abstract of 150 words or less—also double spaced—is requested, stating what was done, the results obtained, and conclusions reached. References should include only those actually cited in the paper and are to be listed and numbered in the order of citation. Within the article itself, references are indicated numerically in parentheses on the line of typing. Journal references should include the author(s), title, name of the journal, volume, page numbers, and year. In the case of books, the name(s) of the author(s) and editor(s), number of the edition, name of the publisher, city of publication, and year are required. The format indicated below should be followed:

1. Baker, C.F., Dew, R.A., Ganz, M., Lance, L.: "The Reich Blood Test," *Journal of Orgonomy,* 15: 184-218, 1981.
2. Reich, W.: *Character Analysis,* 3rd edition. New York: Orgone Institute Press, 1949

Tables should be typed double spaced. Figures and graphs should be scaled to fit within a 5¾ x 8½ inch format. All should be clearly labeled. Manuscripts accepted for publication are subject to copyediting. They become the property of the Institute for Orgonomic Science and may not be reproduced without the consent of the authors and the Institute.

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