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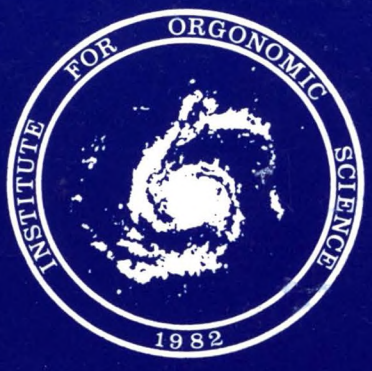


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## of the Institute for Orgonomic Science

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**ANNALS**
**OF THE INSTITUTE FOR ORGONOMIC SCIENCE**

**SCIENTIFIC ARTICLES**

VOL. 8 SEPTEMBER 1991 NO. 1

# Measurements of the Atmospheric Orgone Energy

MANFRED FUCKERT, M.D.

**Abstract**

**The atmospheric orgone energy can be readily monitored by measuring the temperature difference, To-T, between an ORAC and suitable control, and by measuring the electroscope discharge rate. This paper reports numerous examples using both techniques in a large variety of environmental, seasonal, and weather situations.**

## Measurements of Temperature Difference

### *I. Introduction*

The discovery of the temperature difference was reported by Reich in *The Cancer Biopathy* (1). The existence of a temperature difference between an ORAC and environment or suitable control box has been confirmed, as far as I know, by all experimenters, including the work reported in this paper.

This paper is a report of measurements of the atmospheric orgone energy that I have been making more or less continuously since 1976. This includes both the temperature difference between an orgone energy accumulator and environment or control, as well as electroscope discharge measurements. The temperature difference measurements will be discussed first.

### *II. Experimental Setup*

The original technique used to measure the temperature difference was described by Reich in *The Cancer Biopathy* (1). This setup has a fundamental disadvantage: The ORAC has a finite heat capacity so its temperature (To) lags behind that of the environmental temperature (T) when the environmental temperature is changing rapidly. As a result the orgonomic interpretation of the temperature difference is open to many objections. Reich himself recognized this handicap and corrected it, by taking the temperature difference between an ORAC and a control box of the same size and material. Reich apparently made two variations of control box and ORAC, one of which he reported in *The*

*Cancer Biopathy* (p. 114) as well as the booklet on the orgone accumulator (2:20), and the second which I will describe below.

The second variation (shown in Fig. 1) consists of a "cylinder" of four celotex panels, about 20 x 15 cm, and a suitable top with a hole for a thermometer (0.10°C scale), but no bottom. The cylinder stands on a platform which is itself a three-fold ORAC panel with sheet iron on the top (note there is no sheet iron within either cylinder). The control platform has no sheet iron. This device can still be seen at Orgonon. It is functioning perfectly and has been used to take readings for about six years.

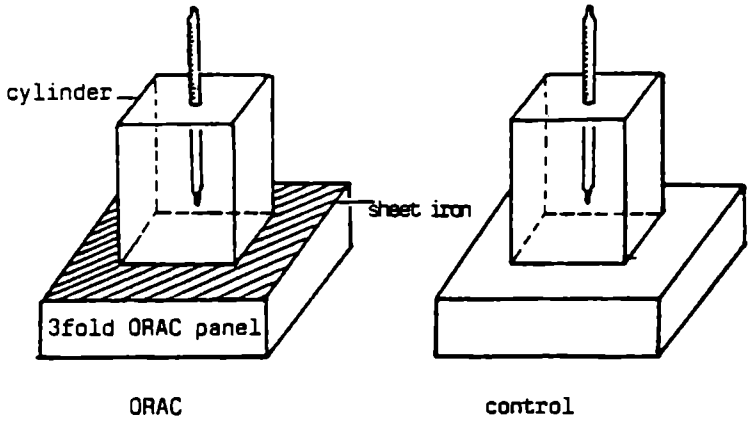


Fig. 1

In my own research on the temperature difference, I have used a simplified version of this device, as shown in Figure 2. Each device is made from four panels of styrofoam (5 cm thick) 20 x 20 cm. A cavity 5 x 5 cm is cut out of the center of two of these panels which are cemented together. Then a 10 x 10 cm piece of aluminum foil is glued in the middle of the bottom panel of the box which functions as a one-fold ORAC. The small mass of the alumi-

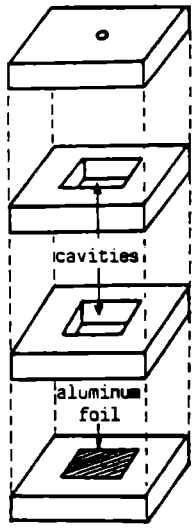


Fig. 2

num foil produces minimal differences in the thermodynamic properties between the ORAC and control (which are otherwise identical). Both boxes were wrapped with white cardboard.

In recent years some variations of this setup have been tested. I have used a four-fold ORAC panel of styrofoam ("Roofmate") 2 cm thick, aluminum foil, and cylinders of cork 2 cm and 4 cm thick (see Figure 2a). The inner cavity has a volume of one liter, with dimensions 10 x 10 x 10 cm. The thermodynamic properties were tested by alternately putting the setup in a refrigerator (4°C) and exposing it to room temperature (22°C). Interestingly, the ORAC made of 4 cm thick cork showed a greater thermodynamic lag behind the control than the 2 cm cork ORAC. I would have expected the contrary, as the mass of the aluminum (which is the only difference between ORAC and control) is exceedingly small compared to the mass of the cork (especially with an increase in the mass of the cork from 2 cm to 4 cm).

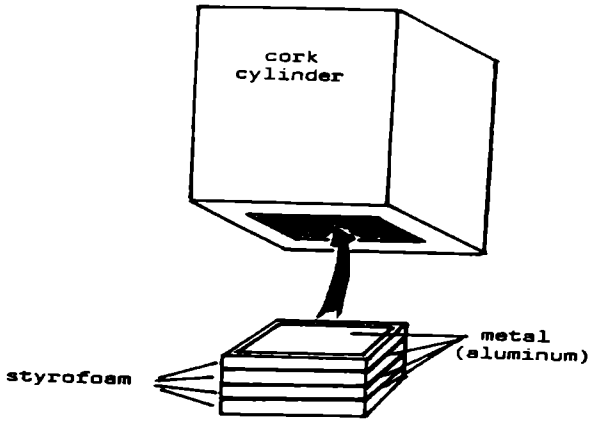


Fig. 2a

This odd property led me to construct another setup using a cylinder thin enough to adjust quickly to changes in environmental temperature but thick enough to retain the heat, using a one liter cup used for freezing (see Figure 2b). I have used this setup continuously for two years. This paper, however, deals only with the setup shown in Figure 2.

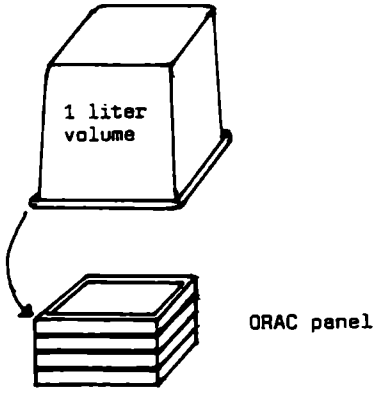


Fig. 2b

The temperatures were measured using both mercury thermometers as well as thermocouples. The thermometers used had a 0.10°C scale, with a range of -2°C to +50°C. A rough calibration in ice water which was allowed to warm up slowly showed no more than a 0.05°C difference between a pair of thermometers. The thermocouples used a copper/constantan junction generating about 43μV/°C. This voltage was measured by a special electronic device which amplified the voltage difference produced between two probes, displayed the voltage and allowed it to be automatically recorded.

The completed setup as described above was not only simple to construct but demonstrated that the ORAC and control had essentially identical thermodynamic properties. An example of readings taken during a sunny day is shown in Figure 3. The graph shows that the two curves (To and T) never intersect despite strong temperature fluctuations, and the temperature difference was always positive. Similar data were obtained when the boxes were placed in a cellar (8°C) or in the sun (20°C). As a result, the basic requirements for a thermodynamically balanced device are thus met (1, 3).

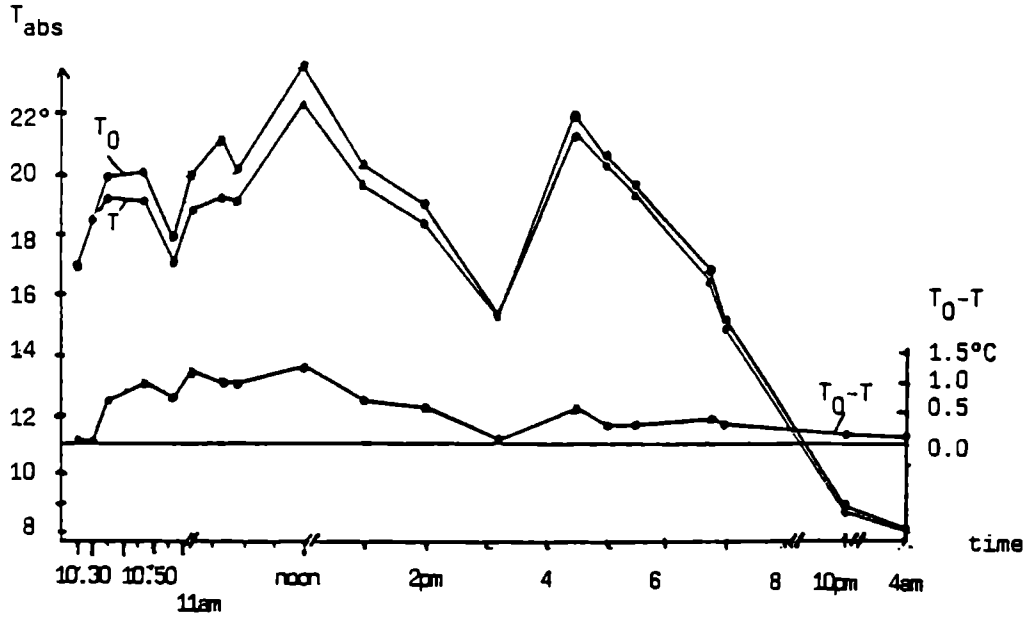


Fig. 3

Now, readings taken during strong temperature fluctuations need no longer be ignored as recommended by Blasband (4) and Rosenblum (3). Rosenblum even discarded temperature fluctuations as low as 1°C/hour. This device can even be exposed to bright sunshine, as long as its position is always corrected so that it directly faces the sun. Whether this is favorable to the evaluation of the atmospheric orgone charge will be discussed below.

The thermodynamic similarity of the ORAC and control means that any temperature differences not due to heat convection are of orgonotic origin. A further advantage is that now an appropriate control box no longer has to be found empirically, which results in an enormous saving in time (3).

Readings were taken at two different locations: the city of Heidelberg, and at two places in Bavaria. They were taken at different times of day and night, different seasons, and in all weather conditions. The electrical thermometer and automatic recorder were of great help; occasional controls showed corresponding readings for both mercury and electrical thermometer. In Heidelberg, the influence of the city climate could not be excluded and was visible in the data, while in Bavaria this disturbing factor could be avoided. Temperature differences due to heat convection could be avoided by putting the boxes closer together (about 10 cm apart). The differences in temperature due to heat convection were evaluated by frequently interchanging the boxes, and this showed that at a favorable position the heat convection contributed no more than 0.10°C. Many readings were taken in the open air, while avoiding exposure to wind.

*III. Summary of Observations*

a) Positive Temperature Differences

Some of the specific findings are described below. In Bavaria the readings were prevailingly positive, but not in Heidelberg. The maximum difference of 4.0°C was obtained with a three-fold ORAC and suitable control on Whitsunday 1979 in Bavaria, in bright sunlight. The styrofoam device described above (used since the fall of 1984) showed a maximum difference of 2.5°C in April 1985 in the sunlight at 0.9°C in shadow. During rain the differences were minimal, zero or even negative (see below).

The highest readings observed were in the open air in direct sunlight. They were considerably lower in the shade (0.9°C) or under the uninsulated roof of the house, where they were also 0.9°C. The further the device was taken into the house, the smaller the temperature differences were. Furthermore, the readings within the house rose and fell similarly to those in the open air, but only after a delay.

The diurnal variation showed an increase in the difference around sunrise, rising to a relatively sharp peak at or shortly after noon, followed by a falling graph, which at sunset passes into a plateau around zero, continuing the whole night. This is illustrated in Figure 4 (which is, of course, an idealized graph). It is observable on sunny, strongly OR-charged days with a low DOR Level. This graph normally also shows a "wave" around sunrise (4), as shown in Figure 5. From personal observations, this wave has also been found to appear at sunset, after a plateau or slight rerise one hour before (shown in Figure 6).

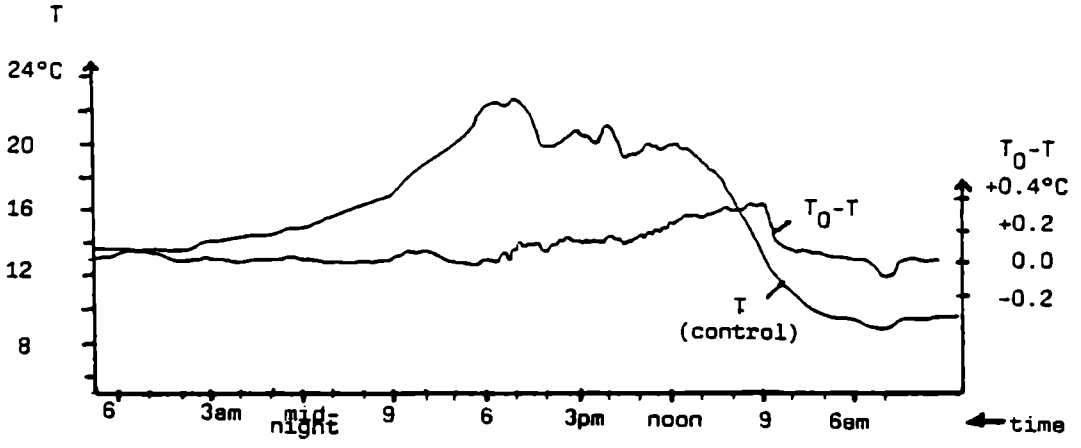


Fig. 4

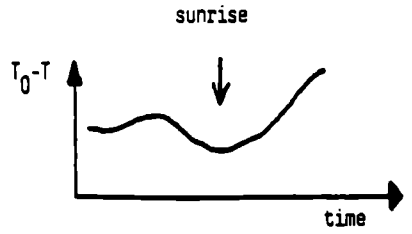


Fig. 5

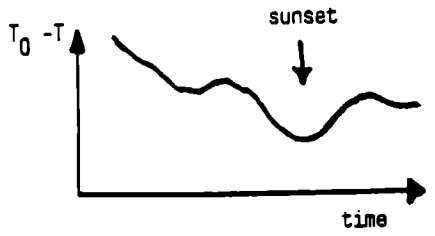


Fig. 6

Another phenomenon may likewise be observed on strongly charged days with rapidly rising temperatures. During the forenoon, the temperature difference graph rises rapidly, slows down and remains at a certain value, then rises again, finally slowing to a stop at a higher value, etc., as shown in Figure 7.

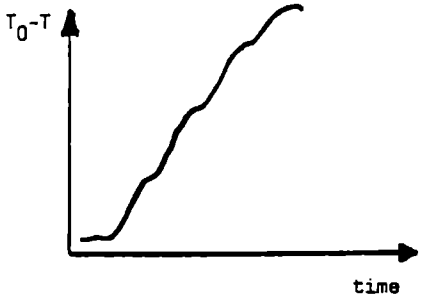


Fig. 7

During overcast weather conditions the temperature difference rarely reached 0.3°C with a maximum of 0.4°C. The daily variation was correspondingly less marked, but still clearly visible.

The drift of clouds, DOR "bands" and wind springing up were correlated with a lowering of the temperature difference, followed by a corresponding re-rise as soon as the sun came out again, the DOR had passed, or the wind abated. Fluctuations of 0.5° to 1.0°C were seen, while in the shade or under the roof they ranged from 0.1° to 0.3°C.

Under conditions of continued bad weather, long-standing fog, rain, or DOR periods (e.g., during November and December) the temperature difference would rarely rise above 0.1°C. For days on end the differences often remained at zero or were even negative. Under these conditions it was impossible to observe any daily variation, although the absolute temperature would still show marked variation.

A seasonal variation in the temperature difference was also observed. The highest values were observed in summer, followed by

spring and fall; during the winter the differences rarely reached 0.3°C (maximum) even on sunny, clear days.

In Figure 4, we see a recording of the absolute temperature of the control box, and the temperature difference, using copper/constantan thermocouples. Note that time is shown moving from right to left. Sunrise (about 5 AM Middle European Summer Time) can be seen, and, somewhat less distinctly, sunset (9 PM). The steep rise in To-T from 8 to 9 AM can often be seen on beautiful, clear, and warm days during the entire forenoon, although on this day To-T had already begun to fall at 9 AM even though the absolute temperature was still rising. This correlated with increasing cloudiness, and an increase in DOR in the atmosphere which was accompanied by a feeling of oppressiveness. At 4 PM the absolute temperature rose further, caused by the arrival of a warm front from the Alps. However, the air carried so much DOR with it that the difference did not rise (which usually happens when the absolute temperature rises), although it was not enough to cause a fall in the difference either. Sunset and the following sunrise can also be seen. Notice that the fluctuations in temperature are much less than those shown in Figure 3.

b) Negative Temperature Differences and DOR

Reich observed negative temperature differences for the first time two days before and during the rainstorm in November 1950 (5). Negative differences have been readily confirmed using the present To-T setup. In fact, only one day after testing the device for thermodynamic stability it showed -0.7°C difference in bright sunshine! At first I thought this was a "failure" of the device, even though I was aware of the many surprises possible when experimenting with orgone energy. The riddle was solved that same evening when a strong thunderstorm came in from the west with heavy rain and wind gusts of up to 15 m/sec. The next day there was sunshine and positive readings returned.

On a number of other occasions I have seen negative differences even in sunshine, when there was strong DOR in the atmosphere.

The obvious influence of DOR on the temperature difference suggested testing the effect of a cloudbuster (8 tubes of 2 cm diameter and 4 m length). This was done on a day when the difference was -0.8°C in the shade; the results are shown in Figure 8. At 1 PM the cloudbuster was pointed at zenith, and in less than one hour the difference rose from -0.8°C to +0.8°C! Then, despite continued drawing, the difference fell to zero and the operation was completed at 2:30 PM. Afterwards the difference fell further, to -1.0°C. I again pointed the cloudbuster to zenith, and the difference rose to 0.6°C and again fell to +0.2°C. At this time I pointed the cloudbuster toward the two DOR clouds in the west; the DOR clouds dissipated and the difference rose to +0.8°C. The operation was then terminated.

I should like at this point to caution the reader about untrained people attempting to perform this experiment; the cloudbuster is a powerful device which can potentially cause destructive heavy rainfall and other dangerous weather changes.

c) Further Observations

There are a number of other interesting observations and experiments worth mentioning here. For example, negative temperature differences are observable when bad weather persists for a long duration, or just before rain or thunderstorm, and often at night. The range of readings is from about -0.1° to -0.2°C.

On another occasion an experimental reading was made using a snow cover. Two holes were cut in the snow cover with a cooking pot,

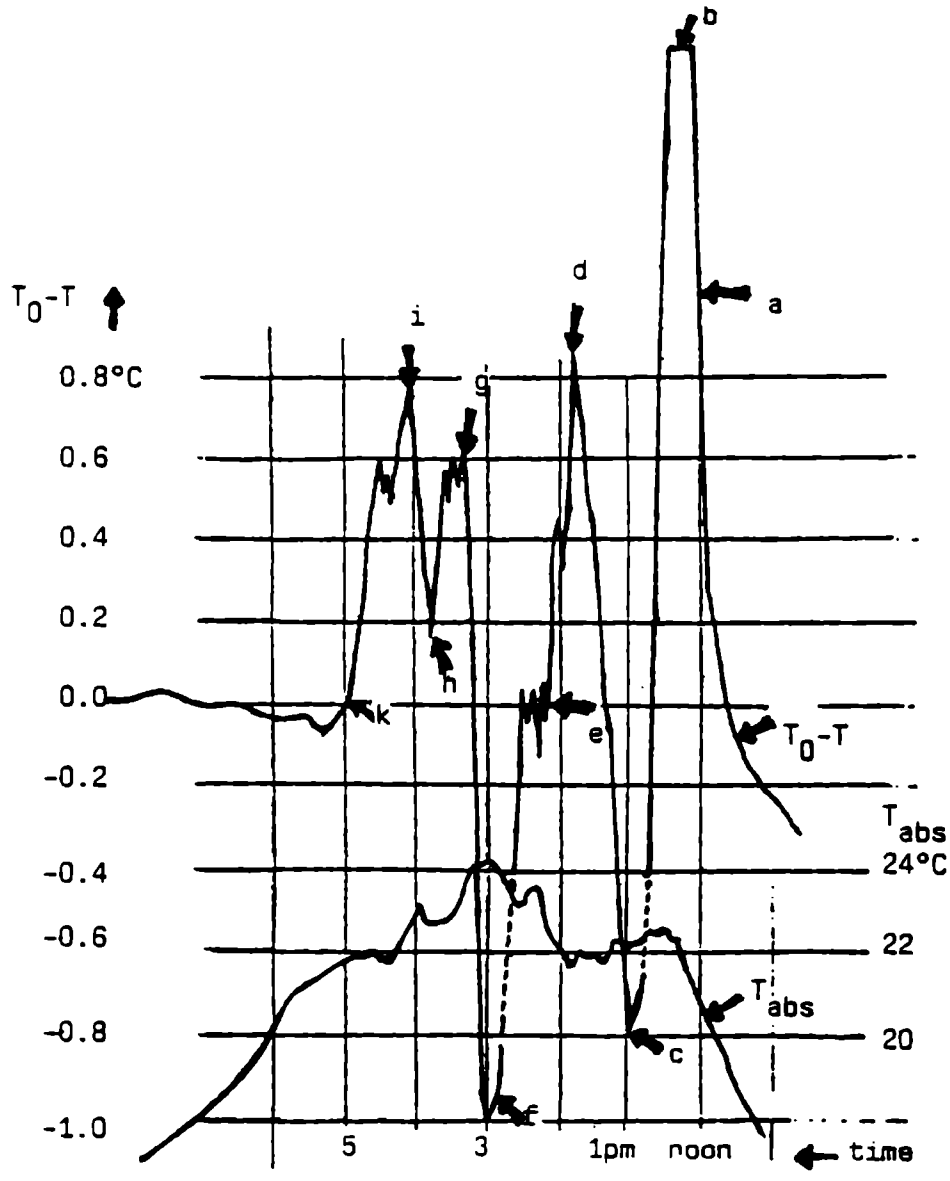


Fig. 8

*a) Sun only on OEA, therefore:*
*b) To-T device in shade*
*c) Difference -.8°C. Start C1B operation.*
*d) Difference rose within 45 minutes to more than .8°C.*
*e) Difference fell, despite using C1B. Operation stop.*
*f) Difference fell further to -1.0°C. Begin C1B operation again.*
*g) Difference rose again, to +.6°C and fell anew on account of DOR clouds.*
*h) C1B pointed toward two DOR clouds.*
*i) Difference rose again. C1B stop.*
*j) Difference evened out at zero.*

and a piece of aluminum foil placed in the bottom of one of the holes (a primitive ORAC). Both holes were then covered with a 1 cm thick styrofoam plate, and thermometers inserted to within 2 cm of the bottoms of the holes. In the shade, this setup gave a temperature difference of -1.5°C, and +0.8°C in full sunshine.

It has been argued that electromagnetic radiation could cause the temperature difference. Blasband (4) dealt with this objection by covering his ORAC with white paper to reflect the electromagnetic radiation, while the control box was made of blue cardboard (which would have absorbed electromagnetic radiation). The experiment showed that the ORAC temperature was not changed, while the control showed a temperature that differed from the environment by +0.15°C to -1.0°C. The temperature difference between ORAC and control was 1.0°C.

In my own work I studied the effect of electromagnetic radiation by exposing the To-T setup directly to EM radiation. In the first experiment, the EM source consisted of a 250 watt infrared bulb placed about 80 cm in front of the device (which in this case had a wall thickness of 1 cm only). Within 30 minutes the absolute temperature rose 4°C, while the difference, however, fell from +0.05°C to -0.15°C. In the cooling-off period after the bulb was turned off, the curves of To and T did not intersect.

In the second experiment, the infrared bulb was replaced by a UV A-lamp, and the distance decreased to 25 cm. In this case there was no change in the temperature of either ORAC or control. The distance was then further decreased to 15 cm, which is the normal distance for cosmetic suntanning, and the intensity of the ultraviolet rays is about seven times as strong as in natural sunlight (6). In this case the absolute temperature rose 2°C within one hour and the temperature difference rose 0.8°C. A pane of glass 3 mm thick inserted between bulb and device reduced the temperature difference to 0.4°C, and a 5 cm thick styrofoam plate reduced it to 0.2°C. Five repetitions of this experiment gave temperature differences of +0.8, +0.3, +0.2, +0.1 and -0.6°C. The variety was most probably due to different weather situations (see Discussion).

## IV. Discussion

I would like to mention a few considerations regarding the use of the temperature difference as proof of orgone energy functioning. First, the experiment should not be limited to winter months, since the temperature difference is often so small that it lies in the range of error due to heat convection. On the contrary, one should take readings when a strong OR charge is to be expected, i.e., on clear, sunny, DOR-free days in spring or summer, in bright sunshine. One need not be afraid of large temperature fluctuations since the ORAC and control in this setup have nearly identical thermodynamic properties (so heat capacity is eliminated as a cause of artificial differences). The objection of heat convection can also be dealt with by frequently interchanging the position of the boxes, or taking the device outside into the open air (where no heat convection from the ceiling can exist, as Einstein and his assistant hypothesized) (1, 7).

The To-T setup can now be used to monitor the energetic state of the atmosphere, and demonstrate variation with rain vs. sun, winter and summer, DOR days and DOR-free days, etc. For example, two succeeding days of blue sky and sunshine may appear superficially similar, but be very different subjectively (and produce different To-T readings). One day will be stimulating, energizing, while the next might be draining and paralyzing. On the first day man and animals are active, the foliage is sparkling, the air is "fragrant," while on the

second living beings are sluggish and lazy, foliage is dull, there is no odor in the air or it stinks (smog). It is amazing how the "subjective" impression agrees with the readings of temperature difference.

Some might object that the subjective feelings are really due to the influence of positive and negative ions in the air. However, the same ions would then have to cause the corresponding temperature difference and I know of no theory which supports this idea. The effect of the cloudbuster further supports the orgonotic source for To-T. The observation of the UV effect does not contradict the orgonotic explanation, since UV as well as other secondary energies may function as a trigger on the orgone.

The daily variation in the temperature difference correlates strikingly with the position of the sun. Obviously the sun functions here as a trigger, exciting the atmospheric orgone energy. The sun effect appears furthermore in the "waves" in the graph at sunrise and sunset. Now, when the thermodynamically balanced device was alternately set up in a cool and warm place (e.g., in a cellar and in the open air) the ORAC needed some time to "warm up." That is: At first its temperature rose more slowly than that of the control, and then more rapidly. Another observation: A device set up in a room showed a sudden rise of the temperature difference of 0.2°C when the curtains were opened in the morning, but then remained at that value when the curtains were closed again! Here we could speak of a "functional inertia" (a well-known phenomenon in the realm of life).

Remarkably, the daily variation is seen on the graph even when the device is completely in the shade. In this case the sun excites the device via the OR energy medium. The trigger function may also explain the observation that some negative temperature differences occurring on a sunny day, but in the shade, became *more* negative when the device was placed in direct sunlight. This reaction resembles the response to radiation by UV rays, when I had the impression that the device was behaving as if it were in the sunlight. Radiation with secondary energy then merely shows the excitability of the OR energy, exciting the already existing OR charge to a point where a higher temperature difference results (and a more negative one with DOR conditions). An important difference between the sun and UV lamp, however, is that the lamp produces a considerable Oranur effect, felt as a buzzing and pulling in the head and face and a tension on the skin surface. DOR was also produced, and it persisted even after the experiment was finished, as evidenced by pressure in the head, tight band around the forehead, pressure on the eyes, vertigo and a desire for air. The Oranur and DOR symptoms could be removed with a medical DOR buster, and with bathing. Before repeating this experiment, however, I would strongly recommend reading the precautions given by Reich (8) and Raphael (9).

A change in the weather can sometimes be anticipated as much as 12, 24, or even more hours (in one case three days) in advance by watching the trend in the temperature difference. The meaning of negative differences accompanying this trend is, however, not quite clear, since the atmospheric changes are not as great as might be expected from the magnitude of the temperature differences (even though DOR is being swept in by weather fronts from the west). Reich reported exclusively positive temperature differences until the storm in November 1950, even though DOR had existed for a long time before, although probably not as severe as that after the Oranur experiment. I suspect that the negative temperature differences are due mostly to the higher levels of atmospheric DOR today. This hypothesis is confirmed by

cloudbusting operations which successfully change negative differences into positive ones. In the cloudbusting operation described above, the total temperature difference change was 1.6°C, representing a tremendous shift in the orgone energy.

A final problem for discussion is that of selecting a suitable location for the setup. If the temperature differences are greatest in the open air, why not put the setup there? One objection is that sun readings reflect both OR charge and excitability, so that if one wants readings which reflect OR charge exclusively, one should place the setup in the shade. A suitably shaded location has the further advantages that the device does not have to be oriented to the sun's position, and is shielded against wind and precipitation. One must take great care that the device is not exposed to wind, otherwise chaotic readings result. The device also needs to be protected against precipitation, since, after wetting, it may take days or even weeks until reliable readings can be obtained. A similar "recovery" is sometimes necessary after long periods of rain, even when the device has been protected from the weather. During this time transitory negative readings may occur, even in good weather and in the sun. In this circumstance the behavior of the device does not seem to correspond to the actual atmospheric orgonotic condition. These kinds of puzzling results emphasize again the living quality of the orgone energy.

V. Outlook

The device which I have described is easy to construct, lightweight, and of small size and thus facilitates its construction and use by others. Ideally readings from a "standardized" setup (preferably Figure 2b) taken at many points on the earth (such as seaside, high mountain regions, polar zones, underground, desert, etc.) could provide new insights into the quality of the atmospheric OR energy.

## Measurements of the Differences in Electroscopic Discharge

I. Experimental Setup

Measurements of the electroscopic discharge were taken during the same period of time that temperature difference readings were made. It was not until 1980, however, that I developed an electroscope that met all my requirements (shown in Figure 9). The electroscope housing was constructed from a glass mason jar (370 ml), oval in cross section. A hole was cut in the lid for an insulating piece (a) made from a plastic garden hose coupling (a special bushing of tetrafluorethylene, which soaks up minimal amounts of humidity, was used). Into the hole of the insulating piece a bolt (b) was inserted and attached by nuts (c); the bolt carries the electroscope plate (d) and the two leaves of the electroscope (e, f). The leaves are suspended from pins inserted into the screw; one leaf is fixed (tin) and the other movable (aluminum foil). A scale was drawn on transparent plastic tape and attached to the inner surface of the glass. It has ten divisions which divide an overall deflection of 90°.

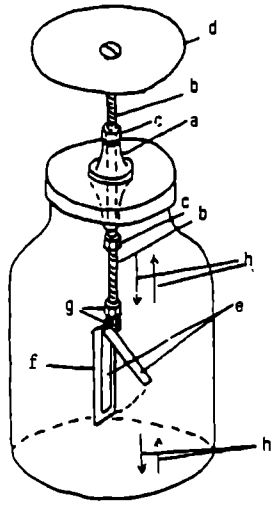


Fig. 9

Reich reported that he used as a base of operation the region between the fifth and third division, with a calibrating voltage of 256 volts (11). However, the present electroscope required 520-600 volts to deflect through this range.

Later a photocell (h) was added, allowing the time of discharge to be read on an electronic stop watch, and thus minimizing errors of reading due to parallax or concussions. Readings were taken within and outside of the ORAC, in all weather conditions, times of the day, and seasons.

## II. Observations

The electroscope discharge time was many times (up to 9x) longer within the ORAC compared to that outside the ORAC. This was most marked in fair weather, while during bad weather and high humidity (>70%) the ratio of discharge times within/without decreased to 1:1.

There was a marked daily variation in the electroscope discharge rate, and a graph of this variation was roughly parallel to that of the temperature difference. However, the maximum temperature difference was about noon, while the maximum discharge time was about 4 PM, about the same time as Reich reported (12).

A graph of the discharge rate also demonstrated a change at sunset, with a re-rise, but about one to three hours later than that of the temperature difference (assuming no change in weather conditions and no stronger OR charge on the following day).

The discharge time was greatly prolonged, up to one hour, on strongly charged OR days. There were also long discharge times seen during snowfall (16 minutes in open air and up to two hours in the ORAC). A lengthy discharge—nearly four hours—was seen within the ORAC during Oranur conditions.

There is only a limited correlation between the discharge rate and the relative humidity. In my data the rates varied greatly over a relative humidity range of 30-70%. As a rule there exists a higher humidity (by 2-3%) in the ORAC than in the surrounding environment, while the discharge time is longer, thus showing an inverse correlation. The discharge times are generally prolonged when the humidity falls below 30%, except in DOR conditions, in which case there are short discharge times even with low humidity. With humidity greater than 60-70% there are, as a rule, very short discharge times. One exception to this is snowfall, where a discharge time of 16 minutes was seen with an RH of 65%.

Rosenblum (13) published a graphical representation of the relationship between electroscope discharge rates and relative humidity, reproduced in Figure 10. It shows an S-shaped area, rather than a distinct linear plot, indicating a correlation but over a wide and variable range.

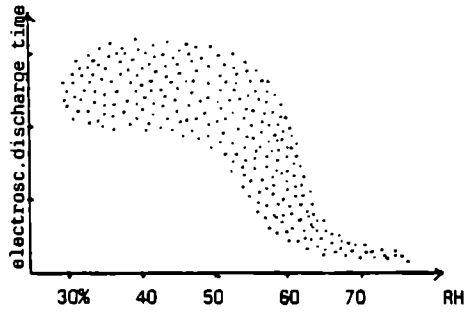


Fig. 10

Before changes in the weather the electroscope showed an accelerated discharge. This observation was made previously by Coulomb in *Dritte Abhandlung uber die Electricitat und den Magnetismus (Third Dissertation on Electricity and Magnetism)* (14). He observed different discharge rates during identi-

cal values for temperature, humidity, and atmospheric pressure. The acceleration phenomenon is observable from hours to a few days before a change in weather, as Reich mentions (12). Conversely, readings taken inside a building react differently, e.g., showing short discharge times for several days after a change from bad to fair weather. Reich believed that the electroscope was the most sensitive instrument for predicting weather changes, compared to the barometer, temperature difference, or vacor tubes (15).

## III. Discussion

One must be careful in making interpretations of electroscope discharge rates. For example, it was recently reported that in overcast weather conditions the discharge inside the ORAC was faster than outside (16). One might attribute this to DOR. On the other hand, a mistake can occur in the interpretation if only one electroscope is used. If readings are taken inside and outside the ORAC alternately, with readings separated by a relatively long period of time (say one half hour), then one might see a slower rate outside the ORAC. This can occur in conditions of rapidly growing orgonotic potential during the forenoon. In this case it is much better to compare the graphs of two nearly identical electroscopes rather than two isolated values obtained from the same electroscope (for an example, see Figure 11).

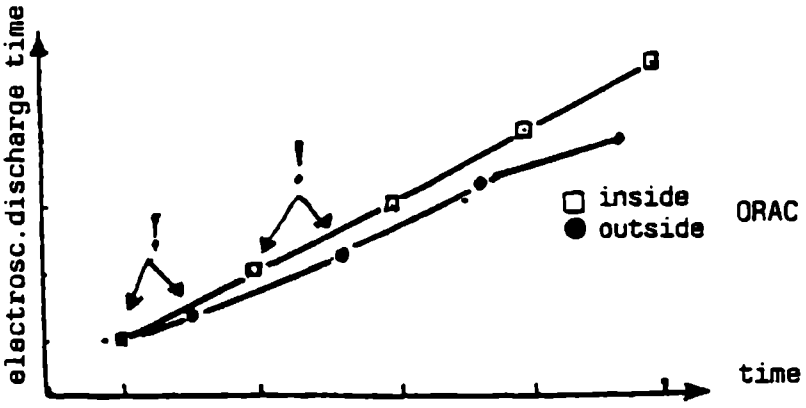


Fig. 11

There is a second phenomenon, however, that also must be considered. It was observed that an electroscope that had been in an OR-charged room for a long time showed a clearly increased discharge time inside the ORAC during overcast weather. This electroscope also showed a more marked daily variation compared with a second electroscope not stored in an OR-charged room. The readings themselves were taken at the same location in an unheated, uncharged room. This phenomenon is understandable when we remember the scheme for OR metabolism (Figure 12).

We can now understand the situation in the

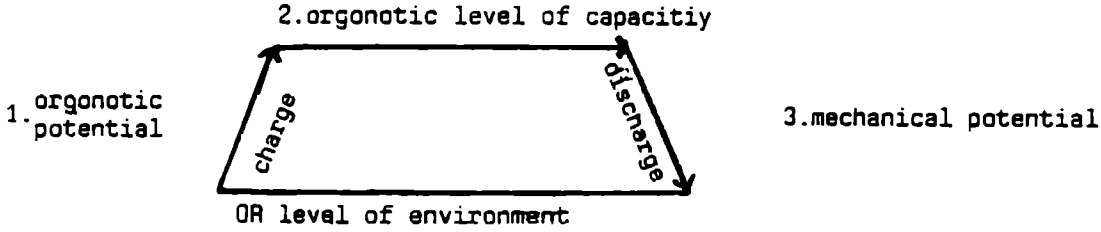


Fig. 12

ORAC where the discharge is slower, by reference to Figure 13. The longer discharge time inside the ORAC arises from the higher OR level of the ORAC: The electroscope is discharging into a more highly charged local atmosphere, so the mechanical potential is reduced. Thus the discharge is slower (Figure 13b). For an electroscope which has been stored in an OR-charged room, it may be that the electroscope itself has an orgone field (6) which then superimposes upon that of the ORAC giving rise to a more strongly charged environment for the electroscope. This is shown schematically in Figure 13c.

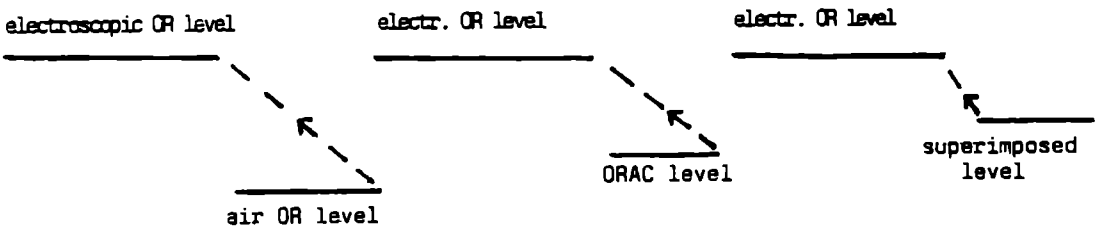


Fig. 13 a b c

In this context, we recall Reich's observation that both GM-counter tubes and fluorescent argon tubes (as well as the vacor tubes) had to "soak up" OR energy before they could show any of the typical orgone effects (17). We find a similar phenomenon in the living realm: A strongly charged person will feel a positive effect in the ORAC even in bad weather (superimposition), while a less charged person won't feel anything. We may hypothesize that the electroscope in an OR-charged room behaves in the same way.

The marked correlation between discharge rates and the relative humidity (when the RH is below 30% or above 70%) is easily explained using functional thinking and by reference to Figure 14.

The atmospheric charge expresses itself in two antithetical functions. In the first condition, energy binds matter; this is manifested

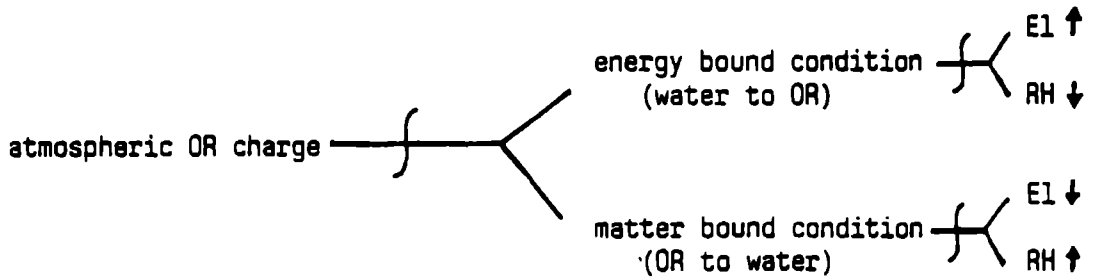


Fig. 14

by long discharge times and low RH. In the second condition, of energy bound to matter, we observe accelerated discharge rates and high RH. This condition exists with precipitation but also with DOR, which is a movement into the direction of matter and immobilization (13).

This method may also explain other influences on the electroscope, e.g., heating, UV light, TV set, Oranur, etc.

One observation, however, contradicts Reich's experiences. Reich observed rapid discharge rates during snowfall (12). My observations have shown slow rates during several snowfalls, despite an RH of 65%. A possible but unconfirmed explanation is that snow today might contain a minimal amount of radioactivity, and the resulting Oranur effect causes a prolonged discharge. A second possibility is that quantities or qualities of charge in snow may vary (cf. To-T experiment in snow).

## IV. Outlook

A useful technical simplification to the electroscope would involve reading the electronic current necessary for holding the electroscope leaf at a certain level. The value of that level consequently would be inversely proportional to the discharge time. If this device were equivalent to the electroscope, important simultaneous readings (e.g., during cloudbuster operations) could be taken. This would also simplify the recording of the daily variation, like that of the temperature difference.

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# Combined Orgone Therapy and Classical Homeopathy

## A Case of Generalized Psoriasis, Dysmenorrhea, and Ovarian Cyst Formation

DOROTHEA FUCKERT, M.D.

### Introduction

Every orgone therapist is regularly confronted with biopathic diseases. He must handle not only character distortions, but also a large variety of long-standing or acutely appearing biophysical reactions which may take the form of well-defined diseases. The American College of Orgonomy recently reported that 45 out of 100 patients already had biopathic disorders upon entering orgone therapy, or develop a biopathy during therapy. Included among these were anorgonic attacks, psychosis, suicidal depression, and incapacitating anxiety (1).

What therapeutic options has the orgone therapist in these cases? At first, he may use orgone energy devices for either charging or discharging the ill organism, or parts of it.* However, the healing effect of this method is often limited by its relatively unspecific nature. A more specific application of orgone energy using a combination of orgone energy devices with acupuncture has been suggested (3). This technique deserves further study. Acupuncture shares with orgonomy the concept that health consists essentially of a unimpeded flow of life energy throughout the organism.

Of course, mechanistic medicine (allopathy) is also a therapeutic option. However, in our view, it suffers from certain serious shortcomings. Mechanistic medicine neither knows of life energy nor does it see the living organism as a functional unity. Its treatment is mainly based on counteracting individual symptoms without any concept of an underlying and generalized disturbance of energetic functioning. This often results in a suppression of the symptoms through which the diseased life energy expresses itself. For example, suppressing a skin eruption with an ointment may not be purely cosmetic, but may also do harm as the energy must then find another, possibly more damaging, mechanism of discharge. In this case, a more serious disease may develop deeper inside the living system, e.g., bronchial asthma. Many patients who have come for orgone therapy have, in our opinion, already suffered harm by these methods of treatment.

Ten years ago it was my good fortune to come to know an entirely different art of healing: classical homeopathy. I had taken a multitude of antibiotics for ten years for a chronic cystitis. Having obtained no relief, I finally discontinued these medications and consulted a homeopathic physician. He prescribed a single remedy. Alarmingly, a high fever and an acute pyelonephritis ensued. I was bedridden for four weeks. Yet without any antibiotics, and with only one further homeopathic remedy, I recovered completely and have not had a single bladder inflamma-

*I have previously reported beneficial results using the ORAC, orgone blanket, funnel, and medical DOR-buster in a variety of disorders (2).

tion in the past ten years.* Psychiatric and physical orgone therapy alone had not been able to cure my cystitis, which had probably been due to an acute pyelonephritis suppressed by antibiotics which I had been given when I was eight years old.

Samuel Hahnemann discovered the principles of the homeopathic method 200 years ago (4,5,6,7). From his observations he concluded that a disturbed "life force" (including that stemming from unsatisfied sexuality) causes disease, and that the disease expresses itself through specific symptoms. By chance, he observed that certain disorders can be cured by remedies which at the same time have the ability to produce a similar disease syndrome in healthy persons. The effects of tobacco poisoning, for example, are cold perspiration, anxiety, and severe nausea with a desire for fresh air. These same symptoms often occur in seasickness. A homeopathic preparation of *Tabacum* may relieve the seasickness if the symptoms are very similar to those of tobacco poisoning. As homeopathic remedies are so highly diluted ("potentized") that they may not contain even a single molecule of the original substance, it would appear that their healing effect must be based on some specific energetic resonance between the remedy and the diseased organism.

Interestingly, homeopathy arrived at the following treatment paradigm which, as can be seen, is not unlike that developed in orgone therapy. In other words, to be successful, the cure of the ill organism must follow certain laws:

1. *From within outward.* Symptoms develop from the "vitals" or deeper layers and spread to "less important" superficial layers. Treatment must therefore deal with the more profound underlying disturbance.

2. *From above downward.* As symptoms abate in the upper part of the body, other symptoms may appear lower down. This diathesis must be anticipated and understood.

3. *The relief of symptoms in the reverse order of their historical development.* The most recent symptoms must disappear first, and the oldest last.

With this scheme, the accuracy of *every* healing method can be proved, be it homeopathy, orgone therapy, or even mechanistic medicine. The similarity to the procedure in psychiatric orgone therapy is obvious. The concept of working from the outer layers of the armoring towards the biological core in orgone therapy is in accordance with the third law of homeopathic healing, as it follows the historical development of the armoring process in reverse. The first homeopathic principle, "from within outwards," is not, as might seem at first glance, contradictory. In orgone therapy one would also have to first treat symptoms from the vital organs, e.g., heart failure, before proceeding to the characterologic symptoms.

## Case Presentation

A striking example of the supplementation of orgone therapy with classical homeopathy (and vice versa) is the case of a 30-year-old married woman who first came into my husband's practice for homeopathic treatment. She had suffered for many years from dysmenorrhea and ovarian cysts. Her first menses appeared at the age of 16 and were always very painful and irregular (delays of up to more than 40 days). A cyst in the right ovary had been diagnosed and operated on (ovariectomy) several years ago. Episodes of cyst formation in the remaining ovary ensued, and these cysts had to be punctured several times.

A number of operations were also undertaken to relieve internal adhesions. She re-

*The editors would point out that in standard medical practice the use of antibiotic therapy is considered mandatory in acute pyelonephritis. This disease is quite dangerous as it is capable, if untreated, of leading to life-threatening kidney damage. Dr. Fuckert took a substantial risk in eschewing the use of antibiotics in this instance.

ceived hormone therapy, whereupon one huge and several small cysts developed in the ovary. This was not yet the end of the unsuccessful allopathic treatment. Further operations and hormone therapy followed. The patient eventually elected to stop these treatments.

The homeopathic anamnesis revealed a friendly and cooperative person. She reported the following main symptoms: fear of fainting, fear of snakes, tight respiration, a sensation of emptiness in the brain, chilliness before menses, and painful and delayed menses (over 40 days). When menstruation occurred, she became free of all these symptoms. There had been an episode of psoriasis on the right knee at the age of 11 which, after treatment with cortisone ointments, erupted on the head! She considered herself sentimental and sensitive. She wept in joyful situations and also during quarrels with her husband; she could also be irritable and railing. In puberty she had often suffered from tonsillitis.

After working out her anamnesis thoroughly according to homeopathic principles, she received a homeopathic remedy (Lachesis C 200 —derived from snake venom). After four months, she felt generally better. The premenstrual pains disappeared, the cycle shortened to 31 days. However, the psoriasis gradually reappeared and spread over her whole body.* This condition lasted over a year and was very hard on the patient, as she suffered tremendously from itching skin. Not only did the psoriatic places itch, but the rest of the skin as well. In retrospect, I believe that it was ultimately to the patient's advantage that no repetition of the Lachesis and none of the several other homeopathic remedies tried improved the skin eruptions (of course, cortisone would have suppressed the itching immediately). Fortunately, the patient was strongly motivated toward regaining her health and remained cooperative. She finally came to me for psychiatric orgone therapy.

When we first met, I had the impression that she had a high organismic charge and a strong energy field surrounding her; unlike that of a psychotic structure, the field seemed cohesive rather than diffuse. Her body, although not fat, gave me an impression of being overly "full," as if stretched to the bursting point. I spontaneously felt sympathy for her, because she also had a fresh, lively, and warmhearted expression. Her open eyes seemed to make contact directly and easily. The skin was generally rosy and warm. There were psoriatic eruptions present on the head, neck, and in every fold of the skin; they were especially severe over the external genitalia. Her lower belly was bloated, resembling a five-month pregnancy. Although sympathetic to her, I also experienced a powerful urgency radiating from her; in her presence I sometimes felt as if I would be pressed against the wall. Her friendliness seemed to be a mixture of both genuine and substitute contact.

A few important details from her history: she was born four years after her brother and was very much "wanted." The birth was reportedly normal, although she was only breast-fed for a few weeks because her mother developed a mammary abscess. She did not know at what age or in what manner she was bowel trained, but she recalled that her mother emphasized that she be clean and well behaved. The mother sometimes used fear as a tool of education, e.g., threatening that she would not love her anymore, or that a black man would come to get her if she did not obey. Nevertheless, the patient described her relationship with her mother as relatively good. She was unable to remember any sexual activities as a child.

In describing her relationship with her father she became visibly agitated. From her early childhood onward, he behaved in a possessive and jealous manner toward her, especially when, later on, she had boyfriends.

*While such a development is understandably shocking and distressing for the patient, the homeopathic physician realizes that it may be a functional sequellum to an appropriate treatment.

After she began puberty, her father started to burden her with constant complaints about how frustrated he was with her mother. He would even drag her out of bed in the middle of the night, tell her to keep quiet, and force her to listen to these bitter tirades against her mother. The patient's psoriasis and recurring tonsillitis had their onset at this time.

My diagnosis was that she had a basically phallic character structure typified by an overcharge of the organism associated with ovarian cysts, dysmenorrhea, and psoriasis.

In the biophysical work her eyes, as noted earlier, appeared open, contact-seeking, and relatively clear and sparkling. I felt, however, a certain lack of warmth in them. She was able to move them rather freely and to express on request distrust, anxiety, sadness, and longing. She could not fully express hate and anger, and her efforts with these caused her anxiety. Yet, direct physical work with the eye segment at this stage did not seem to bring out any "hidden" emotion. I began to call attention to her exaggerated friendliness, which she seemed to turn on and off at will. This resulted in the disappearance of the artificial smile, and her lower face became more relaxed and seemed surprisingly free of armor. In my previous experience I had seldom found so little armoring in the first two segments, especially in the eye segment. In most cases much more extensive work has been necessary there. I began to suspect that something remained concealed and, indeed, this suspicion proved to be correct.

Deep breathing was a bit difficult and expiration was not complete. After breathing a while, she would become excited and then invariably pull up her shoulders with her neck and head drawn in. She also swallowed repeatedly in an anxious manner. Pointing this out to her caused an outburst of long-suppressed emotions. At first she wept, not from sadness, but anxiety. I let her scream it out while at the same time working on the armored muscles of the neck and shoulders. She spontaneously began to shout and hit the couch violently with her fists. Afterwards she was able to breathe more easily and freely, without the anxious swallowing. She felt very much relieved. This sequence of events occurred repeatedly during several sessions. Sometimes it was followed by a brief but deep and tearful sadness. Subjectively, her tension decreased and the near-to-bursting fullness gradually diminished in her body down to the abdomen. The orgasm reflex appeared in the upper body. She began to feel more relaxed at work and in her relationships with others; emotionally she became more spontaneous and honest, and in particular was able to express more of her anger, mainly in a rational way. She was gifted as a kindergarten teacher, and was able to employ self-regulation as an educational principle. I was told by some parents that her competence is very much appreciated and that the children seem to love her. Her husband, who was also in therapy with me, told me that she was always very demanding, especially for more affection and sex. He also described her as being extremely quarrelsome. Although these traits now more often resulted in open fighting, their marriage improved, mainly because of her being more relaxed. She described the genital embrace as joyful, but at the same time she was not sure whether she had ever had an orgasm.*

Orgone therapy had so far lasted one year (about 20 sessions) and she still suffered from the generalized psoriasis, delayed menses (30-35 days) and some premenstrual pain. During the ensuing phase of therapy, no new emotions emerged from the work on the upper body. There was produced, rather, a wave of excitement flowing downward, which was inevitably blocked in the pelvis. Her legs would stiffen, and the patient clearly felt fear of her father. I encouraged her to express this fear and she began to scream, "No, no, don't

*This, of course, indicates that she had most likely not experienced one.

do it, it hurts." After working on the muscular armor of the lower belly and the legs, a memory emerged. She is lying on her back, a little child of about two years, and her father is forcing his finger into her vagina. At first she refused to accept this memory and wanted to believe she had imagined it all. But when the memory kept reappearing in the following sessions, I told her that it really had come out of her own body, that the body does not lie and does not "forget" such bad experiences. I told her that she had repressed this trauma, together with the corresponding emotions, into armoring. At this point I gave her a second dose of the Lachesis in the belief that it might help to free the long-suppressed feelings. We did further work on the muscular armor of the upper legs, and strong impulses started to break through: She kicked violently and struck her pelvis against the couch, shouting loudly, "You asshole, you pig, I will kill you." After experiencing this murderous rage, she felt certain that she had been sexually abused by her father. In the following sessions she repeatedly expressed her hate and rage against him and "killed" him several times. Once in a while she experienced episodes of resignation, but these lasted only a few minutes. More memories came up. It turned out that her father had abused her not only once, but regularly. Interestingly, she now got a hard and hateful look in her eyes. I had long awaited this breakthrough, and had her look directly into my eyes. Distrust and rage came out and she clearly remembered having felt this way towards her mother, while being sexually abused by the father. She had felt "Mama doesn't help me, she must know what's going on, and she doesn't protect me." These emotions, which were expressed with the eyes, could not have come out in the earlier phase of therapy, but only later, in the historical connection with the sexual abuse which was stored in the pelvic armor. Now, the eyes cleared up in the course of three sessions and assumed a warmer look. After having expressed most of the emotions connected with the sexual abuse, she felt tremendously relieved. Meanwhile, the psoriasis had begun to disappear and was gone completely after two years (30 sessions in total!) of combined orgone therapy and classical homeopathy.

The pelvis, lower abdomen, and legs were relaxed to a certain extent at this point. The patient began to feel pleasurable streamings in most parts of her body, but not yet in the genitals. Gradually, the streamings appeared more readily and grew stronger. She also began feeling them during the genital embrace, together with an intense feeling of sweetness and joy, but she could not yet reach a climax. She had no idea what stood in her way. Signs of the developing orgasm reflex have extended to include the lower body. The pelvis, however, still retracts against the impulse. This describes her status in therapy at this point. I do not know if she will develop orgastic potency, although I would judge the prognosis to be rather good. I do not know how long it will take to reach this goal, nor do I know which symptoms may reappear during the end phase of therapy. But I have attempted to show in this case presentation what could be achieved in a relatively short period of time. In three years (40 sessions) with the combined method, the patient was cleared of a generalized psoriasis without any harmful treatment, and her menstrual cycle normalized to 25-30 days and is now unassociated with premenstrual pain. Further, she is free of the irrational fears reported earlier. We do not wish to give the wrong impression; most patients require much more work to achieve this much. This patient certainly seems to have had a strong capacity for health from the outset. Also, classical homeopathy can be difficult, especially with the problems of finding the appropriate homeopathic remedy for the individual patient out of some 1500 possibilities. In this case it was found easily, perhaps because the patient's armor was not too severe. Nevertheless, having had several positive experiences

over the past few years, I am persuaded that supplemental homeopathy can not only help cure biopathic disorders, but may also shorten the course of orgone therapy. The following symptoms and diseases have been cured *without any other medical treatment*: various pains; migraine; common colds; acute and chronic inflammations; disturbed circulation (e.g., low blood pressure); many disorders of the menstrual cycle; various diseases associated with pregnancy, delivery, and breast-feeding including bacterial infections; gall-bladder inflammation; varicosities; all kinds of complications of traumata and surgery; skin diseases; a benign tumor of the breast; several phobias and anxieties. The following diseases have been improved *to such an extent that no other medical treatment was necessary*, and patients became able to cope with their illnesses: bronchial asthma, high blood pressure, diabetes mellitus (reduction from 56 I.E. insulin to 30 I.E.). In some cases lassitude improved so dramatically that a rise in the energy level must be assumed to have occurred as a result of the homeopathic remedy.

Many of our patients have benefited from this combined treatment, at the same time avoiding senseless and harmful medical procedures. In Germany there is an association of classical homeopathic physicians which has fought hard for official acknowledgement. Last year a major breakthrough was achieved. Although homeopathy has long been recognized by the public and the media, the government in Germany has just now legislated that the insurance companies must pay the costs of homeopathic treatment.

## Summary

The particular case which we have described illustrates that orgone therapy combined with classical homeopathy has the following advantages:

1. Classical homeopathy is a life-positive, functional method which may contribute to the healing of serious diseases (biopathies) arising during orgone therapy.

2. Both orgone therapy and homeopathy restore the natural pulsation of orgone energy in the organism in different ways, but apparently in a synergistic manner. For example, the energy level of the organism seems to have been raised following functional principles, i.e., by working through the different layers of the disease structure systematically.

3. Although our experiences are as yet limited, the present case suggests that homeopathic treatment may in some instances have the capacity to shorten the duration of orgone therapy.

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# Human Armoring
# An Introduction to Psychiatric Orgone Therapy*

MORTON HERSKOWITZ, D.O.

# Chapter 8
# Six Patients (Case Histories)

There is a legitimate inclination in outlining case histories to detail one's "cures" as advertisement for one's prowess as a therapist or for the effectiveness of the discipline one practices. In this section I shall rather describe segments of case histories, some single sessions and some longer stretches, that illustrate principles of therapy. I have purposely avoided detailing single case histories from beginning to end because too often patients unwittingly use them as models; and because everyone's therapy is unique they are ultimately more misleading than helpful.

A pale woman in her mid-thirties with a little-girl voice, little-girl body, dead eyes and stiff mouth (I omit reference to the armoring of the lower segments because they are not pertinent to this story) comes for therapy because of the general aimlessness of her life and unhappiness of her marriage. In the initial interview I ask why she had married her husband, and she indicates that she just drifted into it in the same way that she floated into everything.

In therapy, we have already done some work on the eye segment which has increased her liveliness somewhat, and now we are at work on the oral segment. She makes distasteful faces when I suggest that she suck her thumb as she breathes. In the limited thumbsucking session she can only suck mechanically for a few minutes at a time, and she repeatedly makes requests to "do something else." In this session, after an initial demurral when I suggest thumbsucking again, she more easily settles into the pleasure of sucking her thumb, and at one point turns to me to say, "That's not bad." As she continues she gradually loses herself in the sucking and as I watch I note that her respiratory excursions are increasing, which presages a large movement of energy and emotion. She suddenly pulls her thumb from her mouth, coughs several times and erupts into wailing, then sobbing in a bigger voice than I have ever heard from her. When she is finished, she says, "I felt that I wanted M. [her husband] to take care of me completely. You asked me once why I married him and I didn't know; now I know."

In psychiatric orgone therapy the emphasis is on work on the biophysical damage that exists in the present. The biophysical block is always the result of traumata from the past,

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usually from early childhood. We do not engage in long searches into past history. In some cases the history comes to us as the blocks are dissolved. In other cases the armoring yields without the evocation of memories. In some conventional psychotherapies, the patient might have gained an intellectual appreciation of her dependent behavior, but she would not as likely have felt it to her marrow as she did when she permitted herself to become a sucking infant. Having gone this far, the pain of her position struck her full force; then she could stand outside and gain insight into her marriage.

A compulsive middle-aged male patient finds it almost impossible to keep his attention focused on the flashlight I am moving before his eyes. He constantly distracts himself, clearing his throat with a snort, scratching his face, then his belly, then his scrotum, rubbing his eyes, snorting again, then scratching his head, and so forth. I remonstrate with him to stop all his side play and to direct all his attention to following the light. He agrees, follows the light for thirty seconds, and then is off on his wild chase again. This time I begin to mimic him as he goes. When he snorts, I snort; when he scratches, I scratch. He watches me in amusement and says, "I can't keep my mind on the job, heh?" I nod in assent but continue with the imitation. "That's enough," he says, but I persist. "You're a dictator, just like my father," he says in half-anger. "I always have to do what somebody else wants me to do."

There is enough anger generated now for him to be able to focus more efficiently on the work on eye movement. He moves his eyes now with concentration and diligence and permits himself a level of excitement. The session over, he thanks me and leaves in high spirits.

This is a common type of session in which the superficial layer of defense is not given leave to function, forcing the patient to the next deeper level, anger in this case. Permitting some anger to flow mobilizes energy sufficiently so that therapeutic work can be accomplished.

A forty-year-old male complains of constant weariness and lack of sexual drive which has persisted for several years. Though he is sensitive and intelligent he has never made more than a marginal living, working as a store clerk. He is unmarried and has always found occasional sexual partners, but has never had a long-term relationship with a woman. He started to have sexual relationships in early adolescence, with prostitutes. He has visited prostitutes periodically throughout his life; the feeling that he's with a "bad" woman adds spice to these sexual encounters. He masturbates compulsively, even after sexual intercourse. He fantasizes constantly in "lovemaking." His favorite fantasy is of a menage a trois with a lesbian pair. He has a touching compulsion, is often tortured with obsessions and is aware of pleasure from restraining bowel and bladder evacuation (evidences of strong anality). He is obsequious and submissive. Once, in a fight, he beat up his opponent and sustained guilt for a long time thereafter.

He had been in psychotherapy for several years in childhood, and for short periods several times thereafter.

The most notable features of the biophysical examination are dull eyes that convey a look of childlike innocence, a thick, unyielding neck and stiff shoulders, a totally flabby abdomen and a thin pelvis and spindly legs that look as if they were transplanted from a young adolescent body and are totally disproportionate to the thicker torso.

An early characteristic of the therapy is the ease with which tears are elicited. Five or ten

full breaths and the tears start flowing, accompanied by childish whimpering. The eyes are capable of nothing but crying. They cannot look angry, tender, or frightened. The request to make a face is always answered by drawing the muscles toward the center, and crying. The reaction to physical pain is the same—no yell of pain or outrage—only crying. The crying is not full-bodied. It is a step beyond sniveling. Attempts to punch in anger are totally ineffectual. When he tries to kick he tightens his buttocks, stiffens his spine and moves his legs metronomically.

The problem for the therapist at this time is whether to attempt first to elicit the deeper crying, or the anger, both of which are deeply repressed. Since there are no traces of overt anger, whereas there is a constant display of superficial weeping, I elect to enlarge the crying. With work on the ropes of neck musculature and exhortation to increase the volume of sound, the crying penetrates to farther reaches of the throat and chest until the patient is sobbing. His chest and abdomen are heaving and he makes the palms-upward gesture with his hands to indicate that he is helpless in the face of this onslaught. The sobbing continues at home, through the evening. At the next session (the fifth) he says that he had nausea of such severity during the week (the diaphragm is blocking against the tide loosed in the previous visit) that he stayed home from work for several days. The release of sobbing and work on gagging proceeds over the next six weeks. He is clearly more energetic now and unrealistically (but understandably) optimistic about his future. He is forewarned against premature optimism, but ascribes the warning to conservatism on my part. His enthusiasm over the therapy is reflected in his proselytizing fervor amongst his friends. He is also cautioned against this.

He can begin to express some angry affect in his punching now, and makes menacing faces. On the 22nd visit his breathing produces tingling sensations throughout his trunk and down to his abdomen. This is a new experience; he had formerly felt the sensations only in his hands. He is aware of pleasant genital sensations and strong sexual desire during the following week. He has made a date with a girl after a long hiatus.

In the next session (the 24th) he is depressed and drained. He says he feels that the bottom dropped out, for no apparent reason. As if this weren't enough, he was also nauseated again for several days. His eyes are dead and his voice is weak once again. We return to work on the eyes, but he lacks energy for angry display. In two weeks he is back on the track; anger is more effective than ever, depression is gone, and he reports that his girl likes him.

On the 31st visit he appears shaken. He says that during sexual intercourse he became aware of a strong desire to hurt his girl with his penis. This was tremendously stimulating at first, then so frightening that he became impotent. We do not pursue the discussion of his sexual problem. In the following weeks there is again a lack of sexual desire and he breaks off contact with his girl friend.

In the ensuing time I only repeat the accustomed work on segments down to the diaphragm. I am not making any attempt to push on because there has been a little more movement than I would have wished with such a patient.

On the 54th session (approximately one year of therapy) there is the first appearance of diaphragmatic fluttering, a sign that the diaphragmatic block is beginning to give. Sobbing is now even more complete. In recent weeks he has gained in energy, almost to the level of his previous euphoria. On one visit an involuntary spasmodic contraction of the pelvis appears, but I do nothing to encourage its development.

His rage is more potent now. It is reflected in increased independence. He reports pleasant sensations in his pelvis more frequently in therapy (not yet of the tingling variety). He is thinking of starting a small business.

At about the time that he is in therapy for one and a half years he begins to develop abdominal complaints—cramps, occasional diarrhea, etc. At this time he also develops acute anxiety during a session of merely breathing. He had never experienced anxiety before. His status now is a mixture of positive and negative reactions. On one hand he is strong, more confident, able to endure more environmental pressure and cognizant of many areas of symptomatic improvement. For example, he no longer has to "work" to achieve a sexual climax. On the other hand, he has more to endure: gastro-intestinal symptoms and occasional anxiety attacks, interlarded with periods of mild depression.

Over the next nine months there is consistent work on old segments, clearing the debris that remains after each advance. The gastro-intestinal symptoms become milder and eventually disappear. The anxiety attacks increase in frequency and reach a climax when, in the course of several weeks, the patient has a series of critical dreams. The first is a forthright oedipal dream in which he is having sexual intercourse with his mother. The second is a dream about a household dog from his childhood. In the dream the dog is howling in pain and running from room to room with a bleeding penis. This is a difficult period in therapy. His sexual desire drops to zero, which doesn't distress him at all in view of his other problems.

Over the next months, work on the physical armoring is kept to a minimal, restitutive level. He gradually rises from the state of chronic anxiety to a state of ease and peace. His business is moderately prosperous, his relationship has progressed to the point that he is entertaining thoughts of marriage. In his sexual functioning he no longer fantasizes, and concentrates on contact with the woman instead. His sexual drive is strong and the level of his pleasure is high.

We have done no direct work on his pelvic segment, but neither he nor I have much taste for it. After three and a half years of therapy, he suggests discontinuance, and I agree.

In the discussion, I shall forego the analysis of the classical psychiatric features of the patient's disorder, which are beyond the projected range of this book, and concentrate on energetic prospects.

We begin with the physical habitus which is disproportionate below the torso. There is a well-established principle in biology that form follows function. From what we learn in orgonomy, there is an even earlier principle: both form and function follow the energetic flow. The energy moves out and the amoeba's pseudopod follows the energetic flow in reaching out to move or to incorporate food. Wherever a patient shows a disproportionate body part (making allowances for birth injuries and genetic factors) there is always a disturbance of function, but before this, a deficit of energy flow. The people with full bodies and spindly legs, for example, invariably are "unsettled" and unrooted persons, and always have a strong energetic block in the lower extremities.

At the beginning of therapy, the patient is a low-energy, ineffectual specimen with low self-esteem. His sexual energy is at such low ebb that he can only perform with the stimulus of fantasy or the prick of doing a "bad" thing. Even then his energetic discharge is so low that he masturbates afterward. He shows many masochistic features: the pleasure in holding back, then releasing, the simpering, the poor-child look, the obsequious behavior and the low achievement.

The easy tears at the onset of therapy are

worthy of some discussion. Often when the therapist is evaluating the new patient, he asks, "Can you cry?" The patient answers, "Oh, yes, I'm crying all the time." This answer does not indicate that the patient is open to his sadness. It usually signifies that the patient never reaches to the bottom of his sorrow, that his agony stands intact behind a dam wall, constantly spilling over what the bulkhead cannot contain. The early work with this patient demonstrates that the deeply felt crying is submerged beneath the whimpering.

Efforts to uncover his rage and hate precipitate the premature (from the standpoint of where he was in therapy) display of his sexual sadism. In general the discoveries come faster and more furiously than one would have desired with this patient. The probable cause of this prematurity is the lack of charge in the patient. He reacts like a bag of gelatin. Once an impulse is set in motion, it keeps going and cannot be contained. One would have preferred that he react more like a sandbag, so that he could better absorb some "punches."

The flabby abdomen is a case in point. Once an impulse was generated through his diaphragm, it tended to reach the pelvis (which had not been sufficiently prepared) directly. Though his abdomen was not tight, it was armored nonetheless, as evidenced by the development of abdominal gastro-intestinal symptoms. The armoring of hypotonicity (lack of tone) is not as well understood as hypertonic armoring. In some cases the impulse passes through a hypotonic area without any hindrance, as it did in this patient, and sometimes the impulse gets lost in a hypotonic area and cannot get through, which is what happens also with fatty armoring.

Though the patient has far more charge at the end of his therapy, the decision to stop at that point is well considered. Though he has come a long way, he is not the strongest of structures; yet to proceed further might jeopardize the progress he has achieved. The structure is considered too fragile to open the Pandora's box of the pelvic armoring.

Finally, the ebb and flow of the march through therapy, as contraction succeeds each expansion and is succeeded by the next level of expansion, is amply illustrated.

*A single session: working through jaw and cervical resistances*

A woman in her early twenties, typically hysterical in that she is always flirting in whatever she does, lies on the couch exhibiting her casual smile which is part seductive, part "put-on," and withal, a cover for anger. At my request to breathe she takes two or three full breaths, then launches into the following chatter. "What do you think of Mann's book on Reich?" I do not answer. "What time is it?" (This is an oft-repeated question which indicates that time is passing and now we must redouble our efforts to get some meaningful work done.) "I'm a bitch" (which, as an evaluation of the presenting side of her character, is true). "Do you love me?" (asked semi-facetiously). At this juncture I have had enough of this particular defense and I go to work with painful pressure on her armored jaw. She says, "Take off your watch." (The apparent meaning is that as she defends herself against the pressure on her jaw she may break my watch. On a deeper level it is a symbolic invitation to undress.) I continue the painful jaw pressure, but deeper. She begins to cry, but soon changes the crying to laughter (bitchiness victorious). I dig into the jaw again and she repeats the request to take off my watch. Now I pry into her jaw with all my thumb's strength. She says, "Why do you do that when I say, 'Take off your watch'?" I answer angrily, "Because you're using it as an excuse for not sticking to the point." She curls up to me, buries her head in my chest and sobs truly. At the point at which I feel her begin to

stiffen against the sobbing, I forcibly bend her neck back, in the position of surrender. She cries deeply and without resistance for the remainder of the hour. When we stop she says, "I felt like calling 'Mommy'; I never remember calling my mother that."

The simple point of the history of this session is that the array of defenses is attacked by a combination of physical assault on the armoring and unmasking of the maneuvering. In this instance the breach was made by my angry exposition of her tricks, but it could not have succeeded without the physical work which preceded it.

*Another single session*

The patient, in her early forties, is disinclined to work today. Her eyes are a little out of contact so we begin with breathing and work on eye movement. This leads to a limited, held kind of crying. I cradle her and the chest begins to heave, releasing fuller, uninhibited crying. Now she is alive through the cervical segment and I begin work on the armored shoulders. I ask her to sit and yell and she answers, "Getting angry involves pitying yourself." I reply, "No, it involves self-respect." She puts effort into the angry expression now, which makes her eyes come even more alive. She asks if we can stop and talk. Because she is vital and serious now, I say "OK."

She tells me that she was feeling well until she walked into the office, then she could feel herself becoming limp, as if a switch were turned off, and she recognized dependency as a long-standing attention getter in her life story. Beyond this we discover the anger in "You take care of me." Her release of anger threw the whole mechanism into adult perspective.

Later in the day she calls and says, "I finally got the idea; blessed are the strong."

A young college dropout who had worked occasionally as a professional musician complains of "always feeling outside of the action" and of claustrophobia. The first symptom became acute one year ago under the influence of amphetamines; the claustrophobia developed three months later. With the onset of symptoms he also had nightmares of his parents' deaths, of falling in space and of being in a crowd and unable to establish his identity. He feels impelled to be on the move; sitting still makes him nervous. In the past weeks he has been troubled with a steady ringing in his ears. He recognizes a pleasure from scaring people, which he does subtly and sneakily. He always admired the Nazis, but only covertly for fear of social ostracism.

In childhood he was afraid of all kinds of animals and terrified of storms and of his priest whom he regarded as surrogate God and devil. He was often insomniac; he would be kept awake by visions of infinite space at bedtime. He was enuretic till nine or ten. In the family, the mother was the punitive parent and the father was passive. Though he was a "bad" boy, often stealing and indulging in antisocial acts, he identified strongly with Jesus.

He first masturbated at seven or eight with fantasies of pictures he had seen in pornographic books. The experience was physically painful. He made sexual overtures to his sister in early adolescence and was rejected. He recalls one clear oedipal dream from childhood. He has a clear memory of witness to a primal scene (parents in sexual intercourse) in childhood.

The medical history was uneventful, except for a familial history of diabetes.

Though he was a precocious student until he attended high school, he associated with the rebellious boys, and was always involved in mischief. His current relationships are transitory and chaotic.

Examination on the couch reveals typically schizophrenic "far-off" eyes with loose armoring through the rest of the body, excepting the pelvis. Breathing is very shallow.

Free breathing produces the perception of strong currents throughout his body, especially in his head and upper extremities. He becomes frightened with generalized body tremors. He is soon crying, but there are no tears.

On his next visits he has strongly ambivalent feelings about therapy. He is impressed by the dramatic reactions, but he is mightily scared. The effort is concentrated on mobilizing his chest and work on the eyes. He reveals in this time that sometimes inanimate objects appear to him to be breathing and that object size changes from time to time; he and the objects about him alternately shrink and grow.

In one of the early sessions I make a demonic face and instruct him to express fear with his face and eyes. In the course of the session he becomes acutely agitated and reports that he cannot see my face for his childhood priest's face. The priest had repeatedly threatened him with hell fire. In the following session he is afraid of me and finds it impossible to look at me. We practice aggression against me with angry faces and pushing against my person. We have been focusing on enlivening the chest and eyes and releasing anger in the first six months. In this time he has existed by scrounging and by leeching on his friends. I deliver an ultimatum, that within two weeks he must desist from depending on his parents for payment for therapy, or therapy will be discontinued. I assume that now he is capable of self-sufficiency and insist that he employ this potential.

In the following months, he becomes more energetic and expresses increasing involvement with his environment. In his daily life there are occasional instances of spontaneous crying and anger. In our therapeutic work he feels alive through his torso, but feels nothing below the diaphragm. In the work on eye movement there is an increasing block to downward gaze, and he soon discovers a conscious fear of looking at the genital region. In one session we practice focusing on the genitals with the eyes, and this evokes strong fears of homosexuality.

As the ability to tolerate the expression of fear in his eyes increases, he becomes more capable of rage, which is expressed against his father and the priest, and against me as their surrogate. At this time (one year in therapy) he has a dream about the priest in which, rather than be terrorized by him, he puts the priest to shame. We have been working on the eyes consistently from the beginning. He is now able to "go off" in his eyes and bring himself back into focused contact at will.

There has been some work on the mouth segment in recent weeks and he has obtained more and more gratification from sucking. In a revealing session at about one and a half years of therapy, in an angry outburst he yells, "I want everything, and I want it for nothing!" His infantile dependency is showing.

As awareness of his body increases down to his legs he becomes more perceptive of his bodily clumsiness. We institute a program of creeping and crawling at home, based on the work of Doman and Delacato, who theorize that body coordination develops through stages of development corresponding to lower, then higher, brain functions. After practicing these exercises for several weeks he reports a sharpened interest in his environment with (interestingly) more difficulty in walking. With time the walking stability improves.

He is perceiving and enjoying pelvic sensations in therapy now and in one visit he reports that he "raped" his girl friend (he didn't rape her, he merely was far more sexually aggressive than usual) and that they both

enjoyed it tremendously.

At a little past two years of therapy his anxiety level is increasing steadily. In one session there is an orgy of confession in which he reveals that he has recently stolen from his boss, gotten on the welfare rolls though still working, etc. Without comment on my part, he discontinues this stealing activity and therapy proceeds.

He is no longer psychotic, but he still has a considerable distance toward health. The story is terminated at this juncture because after this point it is not particularly instructive.

The main theme in this case is the long and consistent work on the eyes in the treatment of psychosis. The order of the principal lines of defense in the character analysis is interesting; first, the fear, then the rage, and beneath that a layer of submission and dependency which related to yet another fear, that of homosexuality. Of additional interest is the reversion to an old defensive pattern (stealing) when the integrity of the organism is threatened by the developing pelvic anxiety.

# David and Saul (I Samuel 9-20): Expansion and Contraction in a Biblical Narrative

The waxing of David is intimately related to the waning of Saul. Both are chosen, anointed, and willing to serve. Each achieves victories in the name of God, moving Israel towards a permanently unified identity and temporary political power. Both are emphatically fallible and each has his times of weakness and disobedience to God. There is, however, this essential difference between them: David is animated by desire while Saul is constantly constrained by his fears. The tension between the two kings derives from the opposition inherent in this difference in character. The ultimate consequence is the failure of Saul and the success of David.

David eagerly extends himself into the world. Expansive in political power, passionately expressive in song and ritual, intensely connected with other people, he inspires loyalty, even from the least likely corners of the palace. In spite of Saul's achievements, his most enduring impression is that of a sad and shrinking man. He knows that he has been discarded by God because he was ruled by his fear of the people and did not rule over them as he should have. He is, at various times, both attracted to the vital young David and consumed by fear of him.

The account of David's ability to soothe and heal Saul with music (I Samuel 16:23) helps to explain the intensely divided impulses of the king. The ability to control the evil spirits that tormented Saul gave David, at least potentially, enormous power over him. It also implicitly revealed that God favored David over Saul. At first covertly and later openly, Saul attempts to destroy what he cannot tolerate. He is enraged by the adulation given to David. The glorious scene of returning warriors met by women rejoicing in song, ebullient in dance, marks the beginning of Saul's conscious envy (I Samuel 18:5-9). It is that envy, the incapacity of the king to tolerate his energetic and ambitious servant, which devolves into the pathetic suspicion and persecution of David. Saul's animosity precedes his awareness of the gifted shepherd as a rival for kingship (I Samuel 24:20). The sight of this man who wears God's favor so gracefully perpetually reminds Saul of how he himself lost divine patronage. His dark fits of depressive torment seem to emerge directly from the obvious contrast between his own personal and eventually political impotence and the prominent successes of his virile armor bearer. Saul's obsession ultimately destroys him and, ironically, assists in propelling David onto the throne.

Some early indication of the characterological differences between the two men can be seen in the narratives recording their anointings and surrounding events. Both men are described as handsome. Saul's height is his distinctive feature. David's handsomeness consists of a "ruddy" complexion and a beautiful "countenance" (I Samuel 16:13). Stature cannot be attributed to any characterological virtue, but ruddiness may be interpreted as reflecting a vigorous nature and robust style of life. There may be more than a metaphorical relationship between the glowing complexion of the young shepherd and his expansive personality. There is, perhaps, an identity between his physical nature and his personality. A similar distinction can be made when we look at the use of the phrase "of a beautiful countenance" to describe David. Saul is called only "handsome." The word "handsome" alone does not suggest any particular moral or characterological strengths. The word "countenance" does convey a more specific meaning related to expression and bearing. Its use seems to imply an unusual sensitivity and self-confidence in the young shepherd. On the basis of physical appearance alone, David already appears to have an advantage over the older man. This may be the first hint of the charisma that seems intrinsic to

David's nature and is so offensive to Saul.

Neither man is shown to have done anything to deserve his "chosenness." They are both passive at the time of their anointing. Saul's passivity persists in the interval between anointing and installation as king. He does nothing to advance himself or demonstrate worthiness of the gratuitous honor given to him. In fact, when he is called upon to assume the throne he has to be hauled out of hiding from among the baggage. Contrast Saul's timidity with the enthusiasm of David, who ". . . left his baggage in the hand of the keeper of the baggage and ran into the army, and came and greeted his brethren" (I Samuel 17:22).

David's victory over the Philistine giant is often understood to underscore the protection and miraculous prowess God provided to His faithful servant. The extended and detailed mini-epic of David and Goliath also serves to show with great clarity that David is driven by an intense and determined desire to enter the palace and that he makes a calculated effort to join the circle of power. The fact that David's motives are both pious and self-serving is made clear by the triple iteration that David is aware of the reward. He *first* overhears the men of Israel say that the man who kills Goliath will be rewarded: "the king will enrich him with great riches, and will give him his daughter, and make his father's house free in Israel." David *then* asks for confirmation: "What shall be done for the man who killeth this Philistine . . ." and *finally* accepts the Philistine's challenge and rises to the defense of Israel (I Samuel 17:25-27).

The successes following from David's active embrace of life earned him the loyalty of Israel and Judah (I Samuel 18:16). They also provoked the remarkable loves of Jonathan and Michael. It is important to remember that Saul's children loved David *before* Saul had shown his irrational and unjust antipathy towards him. This remarkable, energetic young man generated a magnetism that drew the king's children out of his sphere. The diminution of their loyalty compounded his anxieties, and the increasing virulence of his attacks drove his children further away and closer to David (I Samuel 19:11-17, 20:32,33). Saul began to lose the fealty of his servants in a similar fashion when he ordered them to kill the Lord's priests for their association with David (I Samuel 22:17).

Returning to the early portions of the story, we can see intimations of how each man's characteristic attitude will affect his ability to inspire and sustain loyalties. Samuel anointed Saul privately (I Samuel 9:27, 10:1) and Saul kept the "matter of the kingdom" to himself (I Samuel 10:16). In contrast, Samuel anointed David "in the midst of his brethren" (I Samuel 16:13). Political necessity must surely have dictated that Jesse and his sons also keep their own counsel, but their presence at the ceremony points to the capacity for connection with others characteristic of David, deficient in Saul, and sadly threatening to him. The story of Saul's hiding among the baggage when Samuel called all the tribes of Israel together to give them their king illustrates the loneliness of Saul and his tendency to be withdrawn and isolated. Almost immediately after receiving the crown, Saul is rejected by some of his subjects, apparently in response to his unseemly reticence (I Samuel 10:17-27). The parallel events in David's life, illustrating his magnetism, are the sudden popular success that followed his slaying of Goliath and the love of Saul's children.

The narrative is faithful to the nature of the relationship between these two men when it relates the suffusion of David with the Spirit of the Lord immediately with the exodus of the Spirit from Saul (I Samuel 16:13,14). It almost feels as though the blood is drained from one man, transformed, and transfused into the other.

*Kathleen Mosher*

# 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.**

This symposium was presented at the home at Stephen Nagy, M.D. A clinical case was presented by Dr. B. as a springboard for the discussions of the psychological and energetic mechanisms of phobias, obsessional behavior, and the somatization of emotional disorders. Discussion by the seminar members follows.

## Case Presentation

*History of Chief Complaint*

T.C. was first seen in 1980 upon referral from a psychiatrist at a county community services organization. He was 27 years old and worked bench testing large pumps. He was referred with a diagnosis of agoraphobia associated with symptoms of anxiety, palpitations, difficulty breathing, tightness in the chest, and paraesthesias of the hands. He had not responded to six months of psychotherapy, group therapy, and tranquilizers and was told he might benefit from "body therapy."

T.C.'s difficulties began four years before when he got a teaching job shortly after graduating college with a B.A. in physics. He had a class full of "hyperkinetic" and wildly undisciplined children that he could barely control. At first he experienced palpitations and tightness in his chest in the classroom; then he began to have tingling in his hands on his way to work each day. After a year of this, he took a job with a pump manufacturing firm where he worked with one other man. A brief, temporary improvement followed, but as he became exposed to the various pressures in the new position (e.g., deadlines, technical problems, field trips, and the demands of his superiors) his symptoms returned, intensified, and began to appear in a much wider variety of circumstances. The common antecedent factor was a feeling of "being trapped." Thus, whether caught in a traffic jam, driving over bridges, through tunnels, during a round of golf with friends, at a party, or out to dinner at a restaurant with his wife—virtually any situation from which he felt he could not readily escape—his symptoms would appear. Monday mornings on the way to work were particularly agonizing, frequently requiring his pulling over to the side of the road until the sensations and panic abated. Long trips were almost unbearable unless he could stop, get out of his car and walk around; air travel was out of the question. Actual physical confinement did not necessarily precipitate symptoms; he had no difficulty, for example, in elevators; yet, simply going out to lunch with co-workers was, invariably, a trial.

Despite his symptoms, T.C. rarely missed work. In public he struggled hard to conceal his distress, but he was obsessed with the idea that a heart attack or stroke was imminent. He avoided traveling far from home, where he felt safer, and if he had to go out he was careful to choose routes passing near to hospitals so that he could get to an emergency room if need be. He endured this misery for two years before consulting a physician. Then he saw two cardiologists (he wanted a second opinion) who found no evidence of organic heart disease, although a Holter monitor did show atrial extrasystoles and occasional brief runs of supraventricular tachycardia. Tranquiliz-

ers were prescribed with some benefit, but he resisted using them because the need for these drugs implied to him that he "must be crazy." He was advised to jog—a recommendation which temporarily reassured him—but the symptoms and his obsessive fears about them persisted and he was eventually referred to a psychiatrist.

As the history unfolded, it became evident that his obsessions regarding physical disease had started as early as the sixth grade. He became deeply disturbed after seeing a wrestling teammate knocked unconscious in a match. For some time afterwards he was afraid that if he ventured out into an open space he would lose his equilibrium and fall over, so he took the precaution of walking close to walls. Surprisingly, T.C. was very athletic in junior and senior high school, but at the same time he was tortured with worry over the slightest injury or symptom.

He recalled being consumed with fears of having cancer or kidney disease. Each of these obsessions would eventually fade, only to be replaced by a new one. All the while his family simply dismissed him as a hypochondriac. He felt best in college. He had been socially quite reticent until then; but in college he established enjoyable friendships for the first time in his life and met his wife-to-be. "Believe it or not," he said, "she was drawn to me because I seemed so happy-go-lucky and extraverted!" Since he has become so fearful and reluctant to go out she resents his withdrawal and introversion. "She accepts my difficulty intellectually, but resents it emotionally." He said that despite certain reservations about his job and his marriage, he believed he would be happy except for the physical symptoms which he experienced as an unbearable restriction in his life.

*Medical History*

In the first grade his physical activities were restricted for most of the year because of hay fever allergic symptoms which he seemed to later "outgrow." He has been told that, although his visual acuity is normal, he is "slow adjusting" in shifting focus from near to far.

*Background Information*

The patient is the third of four children; there are two older sisters and one younger brother. Of the siblings, only the brother has a significant medical problem—peptic ulcers. T.C.'s mother had rheumatic heart disease with mitral stenosis and had been warned not to have any children; however, his mother had a rather strict Catholic upbringing. In his third year, T.C. was kept with her in the sickroom where she was confined with congestive heart failure; he was there to "keep her company." She was strict, fastidiously neat and orderly and kept T.C. close. He was never allowed to wander beyond the front yard or to play with the other kids. There were perpetual warnings about his getting dirty or hurt or catching a cold. At the same time, he was restricted in his play inside lest he disturb his mother who was frequently ill. His father and paternal grandmother would often give him huge complicated jigsaw puzzles to keep him quietly occupied; he recalls feeling a torturous compulsion to finish them. The grandmother was a quiet, grimly religious woman who did not engage him. T.C. remembers being frightened by the many predictions of the end of the world and Judgment Day that he heard continuously playing on religious radio programs in the background. His mother was obsessed with the idea that his father, a TV repairman, would have an accident on the way home from work, and T.C., on the rare occasions when his parents would go out together, would become panic-stricken if they were late in returning. When T.C. was 10, his mother suffered a CVA which left her with a speech deficit and a left hemiparesis; she was more or less confined to the house until her death seven years later. He

remembers being called at school and told only that she had gotten worse, but when he saw all the cars in the driveway, he knew she was dead. However, when he saw her body being carried down the stairs, the only feeling he was aware of was annoyance.

His father was cold, distant, and critical but he was not particularly harsh or punitive. T.C. still finds it difficult to communicate with him except on technical and scientific matters. Interestingly, a few years after his mother's stroke, T.C.'s father developed symptoms similar to those of which T.C. now complains.

T.C.'s relationship to his siblings is limited to family gatherings on holidays.

*Social and Sexual History*

T.C. tends to be very polite, correct, and cautious; he is aware of a certain "pushiness" which he keeps hidden within himself out of fear of offending people. When he becomes more familiar with them he is apt to exhibit a bantering, "needling" sarcasm. Amongst his co-workers he feels intimidated by people who seem assertive and is somewhat envious of their ability to be outgoing. His secret strength is his belief that his understanding of mechanical engineering is superior to those around him. He can, for example, take delight in finding faults and "absurdities"—in ripping apart designs submitted to him. When he is assured of his superiority in these situations, he can adopt an outwardly generous attitude in providing help or correcting errors. At the other extreme, if he is insecure or feeling anxious because of his physical symptoms, he has difficulty following discussions, thinking clearly, and focusing his eyes. He can be easily derailed by technical problems in his work which he cannot readily solve; he will then become withdrawn and consumed by obsessive ruminations about the difficulty. He is terribly afraid of being unable to finish projects; his perfectionism often interferes with sensible prioritizing in planning work and he is likely to become stalled in a miasma of detail. At the personal level he is mainly cold and reserved; he has a certain insightfulness about people's behavior and is often quick and accurate in his analyses of their weaknesses and underlying motives. But, to him, the predominant value of this is to allow him to feel superior rather than empathic.

T.C. is married and has three children. His sexual education began in high school with classes in hygiene; sex was not discussed at home. Although he discovered masturbation at age 14, he did not resort to it often and the content of his masturbatory fantasies seems bland. In college he dated a girl for a year but never had intercourse; his feeling was that he would be too embarrassed to go through with it. His wife was also a virgin when they married, and she, a teacher like T.C., is "perfectionistic," compulsively neat and is perpetually making lists of chores which she is sure to complete, no matter how exhausted she may become. She will complain about all she has to do but will not give up any of it. T.C. vacillates between finding her attractive and appealing to feeling no interest in her whatsoever. At one of these "low" points, he once coolly acknowledged that he regarded her as a "hole in which to relieve himself." Yet, one got the impression that deep down he really liked her and that the rise and fall in her stock had more to do with his subjective condition than with her behavior.

*Biophysical Exam and Therapy*

T.C. was almost painfully polite. For the first several sessions he would say "thank you" when I called him in from the waiting room, and he would often say, "Yes, Doctor" in complying with some request I would make. When I brought this behavior up, he was embarrassed and stated that he does this "without thinking" and that in new situations he is "very worried about doing the wrong thing." He talked about himself in a clear

manner with a somewhat monotonous voice and with little affect—like an engineer presenting data. Initially he said that he recalled little of his childhood before his teens, and indeed, most of the history came in piecemeal fashion over the course of many sessions. Very neat and tidy in appearance, he scrupulously folds his clothes on the chair before lying on the couch.

T.C. is about 5 feet, 10 inches tall, slender without any extraneous fat. His legs appear somewhat long for the rest of him. His musculature is well developed but not bulky; his muscle tone is uniformly brick-like. He lies at attention: chin back, neck tense, chest out and pelvis retracted. One could easily slide one's hand under the lumbar lordosis. His face had a stricken, worried look, his eyes open and with a pleading quality; his forehead and scalp were taut with many painful spots, particularly around the occipital area. The expression of his mouth was a finely trembling, subtle pout. The armoring of his jaw, chest, epigastrium, abdomen, and back was strikingly rigid. Respiration was cautious and awkward. His pelvis was only moderately resistant to passive motion; his legs appeared rather dead in repose but with a marked sensitivity in the adductors.

Initially, despite his obvious anxious look, he denied feeling anything. Work on the sensitive occiput induced a somewhat hysterical "cry-baby" sobbing which struck a note of falseness because it ended so abruptly when I let up. He admitted he had wanted me to stop but felt he could not say so. In general, he was very concerned that the physical work would result in damage to some vital structure. Once, when I touched him over the xiphisternum, he jumped. He told me that he had always been afraid that pressure at that point would break off the little bone there and drive it into his heart.

Because of his tendency to do everything on the couch in a dutiful, metronomic fashion, I avoided attempts to elicit emotion through imitation and simply worked in the first two segments and stimulated him by having him kick and yell in any way that he could. I sometimes resorted to pushing the xiphisternal "panic button," although often working on the occiput would cause the panic to emerge also. Afterwards he would appear much more relaxed and expanded. I asked him if he feared dying of a heart attack right there on the couch. He replied that he did not because I was a doctor and would know what to do; in fact, he felt "safest" in my office. I began to question him regularly regarding his feelings about the therapy and at times even suggested that certain things must have seemed strange to him. He finally admitted how crazy the whole process had seemed at first and how he had stuck with it out of desperation. And, he seemed quite genuine when he stated that, although he did not understand how the therapy worked, he was beginning to feel better.

Over the next several months he reported that the physical sensations had diminished and that he had not felt this well since his college days. But now he began to complain that instead of physical symptoms, he was feeling "emotional." He was "depressed" about his job and his marriage, both of which now felt unsatisfying. He was troubled by periods of forgetfulness and confusion. At one point he said almost wistfully that he wished things could be as they were before he first came to me—symptoms and all. We discussed the alternatives available to him in his marital situation; it was clear he was in no way ready to approach another woman and that the only practical avenue open to him was to attempt to revive his relationship with his wife. It was necessary to go into a lot of detail as to what he should do to rekindle her interest in him; he rarely took any initiatives in this direction. Laying it out for him like an operator's manual was something he could readily understand. Now that he felt better, he

began taking her out. He found that he could enjoy sexual bantering and horseplay, and although to some extent she responded, she did not become the sex kitten he had begun to fantasize about of late. I encouraged him to be more aggressive in his work as well. Despite considerable residual anxiety, he was able to widen the scope of his activities. He drove on long field trips for his company and even flew to a plant in Mexico. It seemed that persistent work in the first two segments and increasing his ability to tolerate more excitation on the couch continued to be of benefit to him. Periodically he would reach a certain point and become very frightened of new sensations. The next week he would return and with a doleful and pessimistic expression tell me how many times during the previous seven days he had felt close to dying of a heart attack or stroke. Yet, he rarely called me and never went to an emergency room. He could be reassured by a patient analysis of his symptoms and by my pointing out that they did not resemble those of the conditions he feared having. I gently needled him about his miraculous survival over the past several years and of how he continued to jog without ill effect. Later he would come in and wryly tell me that he had had "three coronaries and two strokes" during the week. I would occasionally play on his fears in a humorous way. Once he quipped that I "must have been out of town when they were teaching bedside manner." Much of his sticky politeness was gone.

In his fifth year of treatment, he felt sufficiently improved to reduce his visits to every other week. His occiput and neck had become quite soft and the earlier sensitivity seemed completely relieved. I continued to work on his jaw and gave more attention to his throat, chest, and upper back. There were spontaneous outbursts of tantrum-like rage. Occasionally bouts of asthma would develop while he was on the couch, but it was the palpitations that would frighten him the most as these would occur outside my office, i.e., at home or work. In a restrained way, he expressed feeling afraid that something inside was broken or that his heart was broken or would rupture. There was nothing maudlin about it; he really felt damaged and afraid to move until things healed. I prescribed Xanax which helped him through the worst of it. More time was spent talking in sessions, particularly about his relationship with his wife. In their daily life he found it difficult to distract her from the multitude of domestic duties in which she embroiled herself. He not only resented her priorities, but also her carping criticism of their son who had confided to T.C. his belief that his mother didn't really care about him. T.C. actually lost patience with her several times and told her off—something he had never done before. He had begun to see himself as "healthier" and less limited.

He has continued to make gains in his overall functioning. He changed to another company, took on a far more responsible position and became much more aggressive in dealing with managers and executives. He said he feared he was "going a little overboard" and becoming a "bit of a prick." He is taking advanced courses at night toward a degree in mechanical engineering and referees soccer matches at his son's school.

Lately the biophysical work has been resumed. He still has palpitations and now sensations are being felt in his abdomen and legs—which produced a transient cancer phobia. He feels like an overcharged "steam boiler"—a lot of energy with no place to go. I have pointed out to him that his phobias and obsessions are a smokescreen to hide his real fears. He had an instant look of "recognition" and surprised me by saying that he thought it had to do with his mother and father.

## Discussion

*Dr. A*: I had a couple of patients with similar kinds of problems and in all of them

there was a religious background, a fastidious mother or grandmother, and a fear that there was something basically "wrong" with them and that something catastrophic would happen to them. In two of my cases, the mother was also ill.

*Dr. B*: When I first mentioned the case to Steve, he immediately asked me, "Was anyone else sick in the family?"

*Dr. E*: In my experience with phobias and panic disorders, there is often a childhood experience with loss due to illness in the family; and, often the child has been in the caretaking position with the sick adult. Four or five cases come to mind with the constellation of early loss and a great deal of repressed rage. Some of the anger arose from always having to be extremely careful with the parent and not to upset him in any way. In one case, the mother had rheumatic heart disease with a bad mitral valve and several episodes of open heart surgery with a gradual downhill course throughout the patient's early childhood and latency period. The patient was put in the position of running the household and of being told constantly "not to upset mother." Another patient's mother had polio and was in an iron lung for two years when the patient was four and five years old.

*Dr. B*: What symptoms were presented?

*Dr. E*: Initially they presented with depression. Soon thereafter, they complained of fears of getting into relationships, and then of panic attacks with hyperventilation, diaphoresis, and feeling as if they were going to faint. One of them had frank agoraphobic symptomatology with fear of going into malls and a fear of driving. At times, both women felt suicidal. One subsequently revealed a history of witnessing the rape of her sister when she was seven years old. There was no abusive history in the other. One thing that seems to connect these patients is the history of something real, not fantasized, happening to them.

*Dr. I*: I don't know if that is always the case, Dr. E., that a real trauma is a necessary antecedent for phobias. The woman that was interviewed last month had not experienced a loss in her early years, but she did have a mother who was terribly concerned about her as in "It's dangerous out there. You have to watch out for this or that. If you ride your bike . . . if you go out in the street . . . etc." Always promoting a fear of expanding out into the environment.

*Dr. B*: My patient was fourteen before his mother said it was okay for him to go down the street and play with his chums.

*Dr. A*: These kinds of precursors are not so uncommon in the general population. What distinguishes the patients with these precursors who do develop phobias from the patients with similar precursors who do not?

*Dr. D*: We do know that a phobia is a partial resolution of conflict and, as such, represents a defense mechanism where the original fear is displaced onto the external world and, as such, becomes ego dystonic, i.e., foreign to the ego. However, these fears mimic the original fears and similarly limit the person's ability to tolerate expansion.

*Dr. B*: At first, I worked on bringing out fear in this man and later I focused on bringing out his aggression. The way in which he handled himself in the world was mirrored in the way in which he presented on the couch. One of my impressions was that he was prone to developing phobias and obsessions because of the time in his life when the conflict occurred, and the powerful repression of feeling afraid and of being fragile.

*Dr. F*: There are many people like him, I'm sure, who live lives of misery and never seek help. I'm wondering how many people have very similar backgrounds with problems of

aggression but who do not develop this complex.

*Dr. D*: There are the additional factors of a sick parent, a parentified child and the early prohibition of expansion.

*Dr. E*: So, they lead constricted lives.

*Dr. D*: And, I found it interesting that when he was given a "how-to manual" to revive the relationship with his wife, he could follow it, but he didn't have the aggression necessary to conceive or initiate it himself. Of course, this could also be his inability to take a risk because of his ambivalence and doubting.

*Dr. C*: I can think of patients who were parentified who don't become phobic.

*Dr. A*: And even people with relatively stronger egos who seem not to develop those kinds of panic attacks until later in their lives, they may develop cardiac phobias in their late thirties or forties and start seeing general practitioners or visiting emergency rooms. They may "suddenly" fear flying, chairing meetings, or other things that had been a part of their normal routine.

*Dr. E*: People who experience panic constantly worry about and are constantly planning for the recurrence of a situation in which they are going to be doomed in some way. Whether or not that happens is secondary to their planning.

*Dr. A*: This patient did have some cardiac abnormalities which he may have, indeed, perceived. Did you ask him, "Did you feel anything in your heart? Did you feel your heart skip a beat?" while he was wearing the Holter monitor?

*Dr. B*: That's what he feels. His heart races or it misses a beat. Yes, the tracings picked up runs of atrial tachycardia and some atrial premature contractions, but this is not uncommon in anxiety, and no organic disease was found.

*Dr. H*: It is documented that a small population of patients with panic attacks have had some kind of chest injury or internal abnormality, and perhaps these patients are simply "tuned in" to that. If that is true, they anticipate the feelings and their lives revolve around this horrible dysphoric state of hyperventilation, sweating, racing heart, etcetera. It is also known that lactate infusion produces panic in some people and not in others. Why some and not others?

*Dr. D*: It is an interesting question as to why some people perceive the missed beat as a heart attack and others experience a missed beat without worry.

*Dr. E*: This patient was raised in an environment in which illness was a major daily event. His reality was constant worry about what was going to happen to his mother and it became a chief focus of his life.

*Dr. A*: That's interesting, because one of my patients didn't develop his cardiac neurosis until after his mother died.

*Dr. B*: And, in this case, after the mother died, the father developed similar symptoms.

*Dr. F*: I wonder how much of it is a reflection of the attitude of the parent towards the illness. One parent might say, "Well, I've got this condition, but I'm going to go out and enjoy myself as best I can." In this case, the attitude of the mother was of continual worry and fear. It sounds like this patient contracted biophysically and emotionally at an early age and was just terrified of reaching out into the world.

*Dr. B*: At one point I was trying to understand the relationship between agoraphobia and claustrophobia, and it seemed to me that claustrophobia was related to a fear of contraction, and that agoraphobia was due to a fear of expansion. In this case, the one relative who really played with him was an uncle who

one day took him out to teach him to catch a ball. Mother was standing in the window shouting, "Don't do it. He's going to get hurt." Sure enough, the kid got hit right in the nose with the baseball. Yet, to his credit, when he got into college, he took up wrestling which helped his self-esteem enormously.

*Dr. H*: But, isn't everyone essentially afraid of expansion?

*Dr. B*: This man was squelched at every turn, not just at selective junctures, so the character takes on a different cast.

*Dr. C*: The psychoanalysts interpret agoraphobia as a specific fear of a sexual encounter. Is there anything in this history that supports that?

*Dr. E*: I have some material about agoraphobia that I could present along those lines. An interesting feature of agoraphobics is that they have an agoraphobic partner, someone with whom they can do almost anything, but not with anyone else, a sort of agoraphobic "twin." I treated a woman, now in her mid-forties and no longer agoraphobic, whose symptoms started around the age of 18. I found it fascinating that her husband called me and asked if I treated phobic disorders. I said, "Yes" and made an appointment. He showed up at the office and it soon became apparent that it was not he who had the disorder, but instead, his wife. He had come to check out the third party. When his wife did come, she had to be driven to the office by him or her daughter. He became increasingly resentful and angry that she was discussing her personal life with me, was not telling about her sessions, and so he decided that he would no longer drive her to the appointments. For a while, she got her daughter, who was very much like her, to drive her, but the daughter soon tired of it, at which point the patient started driving out on her own. It took her a few weeks to master it as she was always afraid she would not make it on time. She lived about 20 minutes from the office. I said, "So, leave five hours early. If you have a panic attack along the way, stop and scream." (She had become used to relieving her fear and anxiety by screaming in the office.) She would often get to the office four and a half hours early and either waited or took a drive around and did things that she had not been able to do before. After about four years, she was able to really see what the agoraphobia meant. Central was the issue of loss. Her mother was her agoraphobic partner. As she got older and went away to college, she became more distant from her mother. In college, she met her husband-to-be and thus found another agoraphobic partner, in return for being his sexual partner. From the beginning, she hated sex with him as he was very demanding of her especially with regards to oral sex, which she disliked. However, she continued to do what he wanted to please him, as she needed him to take her from place to place. He was also well-to-do and could provide for her. As time went on, it became increasingly difficult for her to put up with what she considered his perversities and he became more and more demanding, angry, and nasty. The agoraphobia got worse. At this point, we began looking at the meaning of "the partner" and what her trade-offs were. It was evident to her that she traded a sexual relationship in return for her safety. As the safety got less and less safe because of his demands, she became more symptomatic. When she became less dependent on him, she was able to begin saying "No" to his demands, and her symptoms improved. Interestingly, the marriage has survived even though it has been on difficult turf for the past two years.

*Dr. D*: So, in essence, you are saying that she either had to remain dependent and fulfill the sexual favors, or she had to become more assertive and aggressive.

*Dr. E*: Yes, I saw her sexual conflict as secondary to her fear of any aggression. One

of the crucial things that helped her with her symptoms was the ability to get angry and express it.

*Dr. I*: With typical phobics, there is a characteristic style of operating in the world. I don't think it can be traced to a single traumatic event in most cases, but instead it represents the whole experience of growing up; like in the case presented, the whole world is a dangerous place where bad things happen. Now certainly some bad things happen to everyone, but if the parental atmosphere is pervaded by fears and restrictions both overt and covert, a particular style can emerge. This is, of course, determined by basic personality features, as well as a possible genetic susceptibility.

*Dr. B*: What you said about the style is absolutely on the mark with this man. He can make a fatal disease of a fly crossing the room. What is very clear with him is the identification with the mother. It is like a complete reenactment: His mother had atrial fibrillation, so she had an irregular heart rate, and she developed congestive heart failure; he describes feelings that his heart is going to burst, that it is swelling in his chest. Although he has improved, the style is still there. Now he gets a symptom and says to himself, "Look, you're going to die anyway, so you might as well go out and play golf."

*Dr. C*: I think it is remarkable that patients can change as much as they do in these cases. He probably had 50,000 interactions with his mother where she said, "No, no, don't do that, you'll get sick." And he has seen you for a relatively short time compared to the time he interacted with his mom.

*Dr. J*: All of my patients who have improved have progressed in a similar manner from mainly work on the upper segments, especially the head. This man is just beginning to have some feelings that might tie all this up to a dynamic understanding. So it is interesting to ask why these patients improve with just work on their head segments without necessarily understanding all the developmental phenomenology. That is one question. Then, I also wonder if there aren't different classes of people with panic and phobic disorders—those with a genetic determination and those who manifest the disorder later in life who may not be genetically determined. In two of my patients one had a grandmother, and one a mother, who were very much like this. In one patient, the grandmother had him down on his knees three times a day praying to God to protect him from the devil. The patient was very similar to the one you are presenting. Call it genetic or constitutional, but how does working on the head segment improve the condition?

*Dr. B*: I think that my patient illustrates something we have talked about often. How is it that some people can go through horrendous experiences and come out relatively intact, whereas others are crushed by seemingly minor events? It seems that it has to do with potential, or constitution, where there is enough access to aggression and drive so that, in spite of the restrictions imposed early on, the capacity for expansion is still present.

*Dr. D*: And he could tolerate the expansion that was manifest when his ocular and brain armoring were loosened. It seems clear that wherever there is an obsession, there is ocular/brain armoring.

*Dr. H*: And, if this patient was raised in an environment where the expression of anxiety was intolerable to those around him, the therapist becomes the first person who essentially gives permission for him to feel anxious, or scared, or just to feel awful. I've seen that with a lot of my patients where the family paradigm was to never say anything upsetting or frightening because of its effect on others.

*Dr. J*: The behaviorists have learned to desensitize the cognitive element so that in a relatively short time they can discharge the

energy from the cognitive signal that says "Watch it" so that the patient can learn to deal with the phobic experience. When we work on the eye segment, we are working on the cognitive part.

*Dr. H*: There are many people who have circumscribed phobias who lead relatively normal lives, others where the phobias permeate their entire lives and incapacitate them, and then there are the hypochondriacs, the somatization disorders, whose panic is connected to their bodily sensations and symptoms.

*Dr. J*: From clinical experience, it appears that anyone, regardless of character type, can have a panic attack when the defensive structure is overwhelmed. I've seen people in their 70s and 80s who have suddenly developed panic attacks and I'm convinced that it was because they were becoming senile and thus their ability to maintain their defenses was weakened.

*Dr. D*: It seems that often when we talk about the ocular segment, we are really talking about the sum total of the ego that holds people together, so to speak. It takes energy to maintain the defenses, so that if one's energy level decreases, as in aging or illness, the defenses can't be maintained as well. Or, if there is a sudden increase in energy, or an increase in expansion, the defensive structure may not be able to cope with it. Patients experience a fear of disintegration, or ego disorganization, and lose their ability to cope adequately.

*Dr. E*: One of the problems I have had with patients with panic disorders and phobic disorders is that it has been hard to engage them in treatment, even just medication treatment.

*Dr. F*: Many patients with panic disorders don't associate it with anything psychological and just perceive it on the somatic level. So, it would make sense in those cases that they wouldn't seek psychiatric help.

*Dr. G*: Also, before phobias were really understood, many patients were treated with various medications, including neuroleptics, which produced side effects that added to their somatic preoccupation.

*Dr. I*: And, a lot of these patients have a high degree of magical thinking and come to the psychiatrist looking for that magic. It makes me wonder if they interpret the biophysical work as some kind of magic. I have found that interpreting their symptoms energetically helps them understand their problem, whereas they reject psychological interpretations as "BS."

*Dr. A*: Speaking of medications, which ones have been found to be most helpful in treating panic disorders?

*Dr. G*: There are studies that show that clonazepam has been used successfully in panic disorders as well as the MAO inhibitors. Often it is useful to give medication for a short time to give the patient the opportunity to do the therapeutic work in a panic-free environment. However, being free of the panic can also reduce their motivation for therapy, especially if they are not psychologically minded.

*Dr. D*: Dr. B, you said your patient was on Xanax. What is the status of his medication now?

*Dr. B*: He takes it only occasionally when he has heart palpitations that prevent him from sleeping.

*Dr. J*: From our discussion today, it is clear that these disorders can span the various character types and, whereas different treatment modalities offer varying degrees of patient improvement, no one theory can adequately explain the dynamics of panic disorders and phobias at this point in time.

# 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.**

## Fibromyalgia: A "Newly" Recognized Somatic Biopathy

The mind-body "split," an outgrowth of mechanistic thinking in medicine and psychiatry, has created inestimable difficulties in understanding the relationship between somatic disease and emotional life. Experienced clinicians have long recognized and acknowledged this relationship, but few have a coherent theoretical framework by which they can explain how the "mind" causes the body to be sick. It had been assumed that the major mechanism for this influence involved a central stimulation of autonomic nuclei from certain areas of the cerebral cortex. While this must indeed occur, it leaves much to be desired in attempting to account completely for the specificity of a host of "psychosomatic" syndromes.

With the advent of Reich's concepts of the *vegetative antithesis* and *segmental armoring* with local and focal disturbances in autonomic discharge, we had a much more concrete basis for understanding not only the link to the emotions, but the origin of specific symptoms. Despite its apparent rejection of Reich's work, in the succeeding years mainstream medicine has increasingly accepted a causal relationship between emotional disturbances and somatic diseases which had once been considered to be strictly genetic, inflammatory, mechanical, or neoplastic disorders. Now, stress, through its effect on the immune system, is widely believed to be a causative factor in cancer and other illnesses.

In a recent videotape of a grand-rounds presentation at the Carrier Hospital, Dr. Donald Goldenberg, Associate Professor of Medicine and Rheumatology at the Boston University School of Medicine, discussed the syndrome of *fibromyalgia*. He described it as a relatively new syndrome which, since the middle seventies, has drawn growing interest because of its features, which broadly overlap the disciplines of rheumatology and psychiatry. Most commonly known as *fibrositis*, this condition has also been called *myofascial pain syndrome, psychogenic rheumatism,* or *nonarticular rheumatism.*

### Features

Fibromyalgia is characterized by chronic pain and the uniform finding of *tender points over the musculature*. The pattern of localization of these points is highly consistent from patient to patient. There are also *trigger zones* in which palpation causes distinct autonomic reactions, e.g., tachycardia, sweating, etc. The disorder may occur in both children and the elderly, but is most common between the ages of 20 and 50. Women are afflicted ten

times as often as men. It is rare after 50 years of age and often improves spontaneously as the patients get older or after menopause. The syndrome is at times triggered by systemic illnesses, viral diseases, hypothyroidism, hepatitis, trauma, Raynaud's syndrome, and depression. The average duration of symptoms is five years. Patients have commonly seen several physicians and may have had a host of diagnostic procedures. They present with a history of diffuse pain which lasts all day long. They experience stiffness in the morning which usually abates and is replaced by fatigue in the afternoon. There is a subjective sensation of swelling of the fingers, as well as numbness and paresthesias. Symptoms are improved or worsened by extreme heat, cold, or exercise. "Tension" headaches, irritable bowel syndrome, and sleep disturbances are frequently concurrent. Fibromyalgia is also found in association with rheumatoid arthritis, osteoarthritis, lupus erythematosus, or undifferentiated connective tissue diseases. It is sometimes confused with low back strain, cervical pain syndromes, bursitis or tendonitis. A third of patients exhibit Raynaud's phenomenon, particularly with emotional upsets; 26 percent have dry eyes and mouth (sicca syndrome). There are sleep disturbances which occur in 80 percent of patients. They awaken early feeling "miserable" but not necessarily due to pain.

## Clinical Findings

Most patients look "healthy," i.e., there are rarely signs of chronic degenerative disease, unless the syndrome occurs in an individual with advanced rheumatoid arthritis, connective tissue disease, etc. On physical examination there is usually no gross restriction in the range of motion of the joints. There are some 18 to 20 tender points which occur in symmetrical pairs. In descending order of frequency these locations are: the origin of the extensor muscles at the outside of the elbow, the deltoid muscles, upper sternum, sacral area, inner aspect of knees above the joint, origin of gluteus maximus. The upper neck and occiput may also be tender. Goldenberg points out that tenderness is also commonly found in "normal" people in these same locations(!) While patients complain of nodules in these spots, the physician finds only tight bands. Histologically, tissue samples from these areas are invariably normal and, in fact, blood and x-ray studies are characteristically negative. For these reasons the terms fibrositis or myositis, which imply inflammatory disease, are actually *misnomers*. A small minority of patients have had positive antinuclear antibody tests, a finding often present in autoimmune diseases.

Psychological diagnostic interviews in a large sample of patients reveal that the condition is *not* a somatization disorder. An astounding 71 percent show significant depression which is also present in the first three relatives. In the overwhelming majority the depression antedates the onset of the fibromyalgia. Remarkably, dramatic improvement in most symptoms of fibromyalgia is obtained with antidepressants (e.g., Elavil) in doses so small that for depression alone they would be ineffective. This phenomenon remains a mystery. Unfortunately, the benefit of the long-term use of Elavil appears to wear off after about a year. From the same study, less than 5 percent of patients in a placebo control group enjoyed a remission. Flexeril, a muscle relaxant similar in structure to Elavil, also seems to be beneficial. Sleep laboratory testing reveals a stage 4 sleep disorder characterized by bursts of alpha-wave activity. This is similar to what occurs in depression, rheumatoid arthritis, and chronic pain syndrome. Interestingly, in a study of four healthy symptom-free subjects in which disturbances of

stage 4 sleep were artificially induced, fibromyalgia developed in all four! Quite naturally, this had led some researchers to regard the sleep disorder as the causative factor in fibromyalgia.

A host of therapeutic modalities have been applied including rest, relaxation, aerobic exercise, acupuncture, biofeedback training, and muscle massage. Of course, analgesics, anti-inflammatory and sleep medication as well as procaine injection of the tender points have been tried. While most of these have been helpful to some degree, none has been curative. As Goldenberg says, the condition does not readily "go away." On the other hand, there is no clear evidence that these patients have a predilection to develop rheumatoid arthritis. A few have developed lupus erythematosus.

The considerable investigative effort expended on fibromyalgia has not yet clarified its cause. It has not been linked to any particular virus. No underlying clinical disorder has been discovered to explain any of its manifestations. What *is* clear is its relationship to the emotional life.

## Discussion

What strikes us about this condition is how frequently similar findings are encountered in our patients in orgone therapy. Fibromyalgia seems to encompass a constellation of findings, many of which we routinely find in association with muscular armoring. The tender points, trigger zones, and the association with depression and insomnia have been familiar to medical orgone therapists for at least 50 years. According to Goldenberg, there have been reports of the tender points dating back to the nineteenth century. The fact that laboratory studies are unremarkable is not that surprising, since we know that the armoring process begins early in life and may persist for decades without producing significant changes in conventional tests. What is new and gratifying is that "mainstream" physicians and researchers have taken this syndrome seriously, that they have not dismissed these patients' pain as being "in their heads." They are acknowledging that an emotional state (e.g., depression) has an unquestionable, if obscure, connection to a *real* somatic event (e.g., pain).

Although the concept of the segmental armor provides us with an invaluable tool with which we might unravel the biopathic pathophysiology of fibromyalgia, there are still aspects of the disorder which are not entirely obvious. One can readily relate tender points, trigger zones, and fibrous bands to spastic muscles. One may also understand how the armored state and depression are connected. The study with the four volunteer subjects, however, seems to suggest that the sleep disturbance may be a primary (causative) factor. What is not completely clear is how the sleep disturbance is produced, i.e., if and in what manner it derives from the muscular armor. In the experiment, delta waves were induced by a buzzer sounded during stage 4 sleep (alpha-wave phase).

What is important in this study is that a specific sleep disturbance and fibromyalgia were produced in previously asymptomatic (if not unarmored) subjects. The sleep disturbance *itself* therefore seems capable of inducing the symptoms of fibromyalgia even, presumably, in the absence of depression. It is somewhat more difficult to explain this result than that which we see in our own patients, who are often depressed to some degree. The sleep disturbances we encounter are, of course, not due to buzzers, and do respond favorably to the dissolution of the armor. Furthermore, we find that consistent and systematic biophysical work is also quite effective in eliminating tender spots, trigger zones, unto-

ward autonomic reactions, and other symptoms of the fibromyalgia syndrome in the majority of cases. We are persuaded from this experience that the entire constellation of effects may be a result of the armor and the emotional conflicts surrounding it. Just how these conditions produce alpha waves is as yet unclear.

Lastly, we would like to comment on the frequency of fibromyalgia. Goldenberg says that its actual incidence remains unknown. This is perhaps most likely because the syndrome is simply not reported. Patients are rarely hospitalized and are most likely not referred to facilities where cases would come to be counted. Also, it is probable that most cases are either not diagnosed or are self-treated. Many people endure various "aches and pains" for years, consuming over-the-counter analgesics. They usually do not seek aid from physicians unless their lives are significantly affected. Most of the time even the people who come for medical orgone therapy, who on history and physical exam satisfy the diagnostic criteria for the fibromyalgia syndrome, come for other reasons. We would conclude that this condition and other chronic pain syndromes are extremely common and represent a large part of the host of somatic biopathies which plague armored mankind.

*R. A. Dew, M.D.*

# The Amateur Scientist in Orgonomy

**This column is 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.**

## Orene

COURTNEY F. BAKER, M.D.

### I. Introduction

Orene is a milky-white substance which can be readily demonstrated using simple chemical solutions and apparatus. Reich discovered orene in 1953 during the continuing course of the Oranur experiment (1, 2). It may be obtained by exposing a concentrated solution of NaOH (sodium hydroxide) or NaCl (sodium chloride) to the atmosphere, particularly if DOR is present (3). Within a few days to weeks, the white orene will form above the fluid level and eventually produce large encrustations on the inner and outer surfaces of the fluid-containing dish.

Reich considered orene to be a "pre-atomic substance," that is, a transitional form between mass-free orgone energy and matter. However, it is not the intention of the present experiment to attempt to prove or disprove this hypothesis in any rigorous way. Rather, in this demonstration I will simply describe a technique for generating orene, and make a few basic observations about its formation, behavior, and characteristics.

McCullough (4) outlines a method of obtaining "white orene" using 5N NaOH or 3N NaCl solutions in clear glass jars or clay flowerpots. The procedure, chemicals, and development of orene in our experiment were quite similar to that described by McCullough, although 1N normal solutions were used instead of the more concentrated ones. In addition, one clay pot was filled with distilled water only, as a form of control.

Caution: The NaOH is a caustic material, and the orene itself will become noxious if it is allowed to dry out. Use gloves and safety glasses when working with this material, and be as familiar as possible with the relevant orgonomic literature before starting the experiment.

### II. Apparatus and Supplies

1. Three standard clay flowerpots, five-inch diameter, with three clay dishes. Obtainable at any nursery.

2. Chemicals: sodium hydroxide, sodium chloride (table salt). You will need 20 grams of NaOH, and 29 grams of NaCl. The sodium hydroxide can be obtained from a scientific supply house, such as:

   Fisher Scientific
   711 Forbes Avenue
   Pittsburgh, PA 15219
   or

Thomas Scientific
99 High Hill Road at I-295
P.O. Box 99
Swedesboro, NJ 08085

The NaCl used here was ordinary table salt.

3. Scale for weighing out chemicals.

4. Two gallons of distilled water. Readily available at pharmacies.

5. Miscellaneous glassware for mixing chemical solutions, and dispensing measured amounts of fluid. One beaker or flask holding 500 ml, and several smaller beakers (250 ml). Available at the scientific supply houses listed above.

6. Camera and notebook for making records.

7. One 20-inch piece of enameled copper wire, #20 gauge.

8. Safety glasses and rubber gloves.

## III. Methodology

The location of the experiment is not critical, except that direct exposure to weather should be avoided, and the apparatus placed in a location not accessible to pets or small children, since there will be at least one open dish containing a hazardous concentration of sodium hydroxide solution. In the present case, I arranged the three clay dishes on a wooden table in a back room with open windows providing fresh ventilation throughout the experiment. The experiment must not be attempted under or near fluorescent lighting, and probably not performed near TV sets or other high voltage equipment. It is advisable to place the clay dishes on an impermeable support, such as glass dishes or glass panes, since the clay will become saturated and leak fluid onto the table or surface below.

A five-inch flowerpot is placed in each dish, and will receive 500 ml of solution at the start of the experiment, with lesser amounts of distilled water added thereafter as needed. You are now ready to mix the two solutions. Place a piece of paper on the scale, and (wearing safety glasses!) weigh out 20 grams of solid sodium hydroxide.* The sodium hydroxide is then poured into the large flask containing 500 ml of distilled water. This results in a concentration of 20 grams/500 ml or 40 grams/liter, or a 1.0 Normal solution of NaOH. This is a highly caustic fluid, so use great care in handling the flask, the solid NaOH, and the pouring of the solution, etc.!!!** The sodium hydroxide in the water will not all dissolve immediately; gently swirl the flask (which should be stoppered). You may note some warming of the water as the NaOH dissolves: this is normal. When all of the solid has dissolved, carefully pour all 500 ml into the first flowerpot/dish setup.

Next, prepare the remaining two flowerpots. First, rinse the large flask thoroughly with tap water, and then fill it to 500 ml with distilled water, and pour into the second flowerpot. Refill the flask with another 500 ml of distilled water. Weigh out 29 grams of sodium chloride for the final solution and pour it into the flask. As before, you have made a 1.0 Normal solution of NaCl. It may take a while, and a bit of swirling, for all of the salt to dissolve. After there are no visible solid particles left, pour the salt solution into the final flowerpot.

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*In making these solutions, please note that highly accurate weighing is not necessary.

**Splatters on skin or clothing should be immediately rinsed with water.

## IV. Observations

The setup should now be observed daily, or even more often, over the next few weeks as the orene appears and grows. Make daily notes and take photographs to record significant events. A notation is necessary even though there might be no apparent change from the day before.

When the dish and flowerpot have fluid in the bottom, the sides of the pot will remain moist, and the orene which forms is not toxic. However, do not let the pots dry out! When the water level falls to about one-quarter inch in depth, add more distilled water in measured amounts (and be sure to record the procedure). This is very important because if the material dries out it will become toxic. Similarly, when you are done with the experiment, do not simply abandon it, but thoroughly rinse all the pots and dishes in a sink with hot water until all white residues are gone.

You will probably not see any visible changes for several days other than the slow "wicking" up of the fluid level in the flowerpots. It may take a full 24 hours for the dark moisture line to reach the rims of the flowerpots. In this experiment, the moisture line in the NaOH and NaCl pots rose slightly faster than the distilled water, but all were at the rim at about 30 hours. Then, nothing further was observed until the sixth day, when a very thin white band appeared on the upper surface of the rim of the NaCl pot. Meanwhile, the fluid level in all the dishes was slowly dropping, and 250 ml distilled water was added on the ninth day. By this time, there was a white crust around the entire circumference of the rim of the NaCl pot, and white patches were forming below the rim on the NaOH pot. The photographs in Figure 1 were taken at this time.

By the tenth day, the NaOH pot had heavy encrustations of orene around the whole circumference, mostly below the rim. They were

Fig. 1: Orene Set-Up - Ninth Day

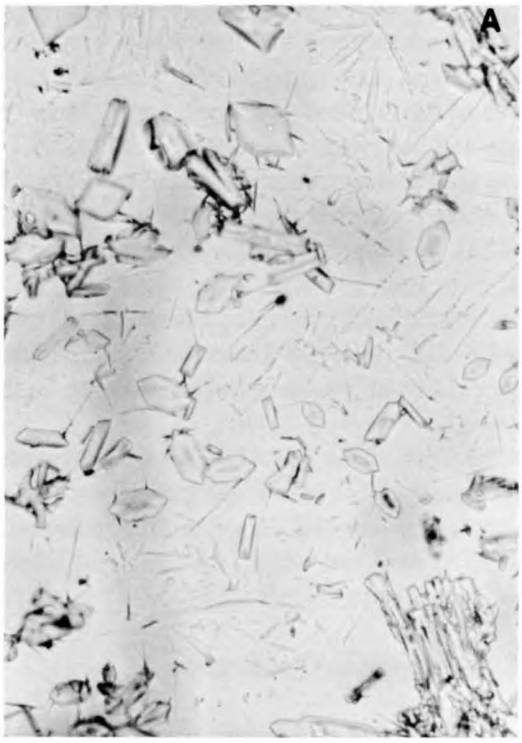
Fig. 2 Microscopic views of orene, all from the same specimen

*a) This photomicrograph, shown here enlarged to 1200x, reveals the variety of structure found in the orene. Bright field, 400x.*

*b) Here is illustrated the "lumpy-bumpy" or "bag" form of orene. The internal structure seems to consist of small vesicles. Bright field, 400x, enlarged to 1200x.*

*c) This view, using the Nomarski DIC technique, shows in finer detail the different forms in orene. The distinct varieties suggest the possibility that the orene is a compound or a mixture. 800x enlarged to 2400x.*

*d) The appearance of the orene after the addition of plain water beneath the coverslip. With much of the crystalline material dissolved, the vesicular structures are more obvious. Bright field 200x, enlarged to 1200x.*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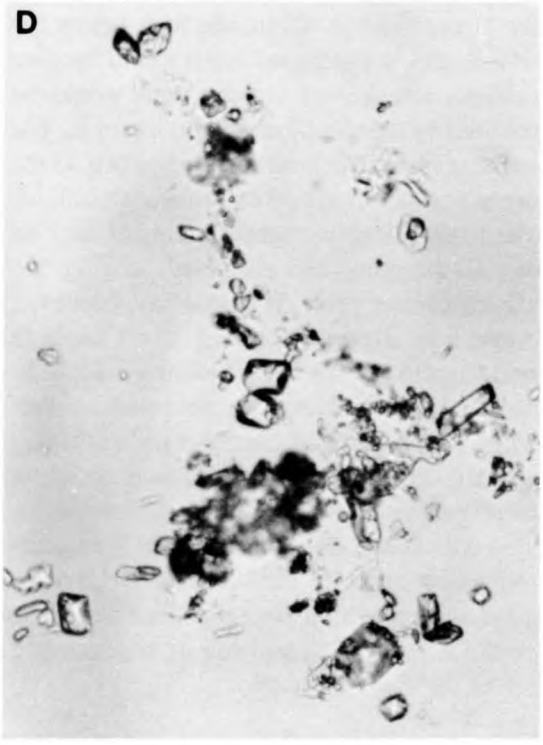
D

heavy enough in places that they appeared to be in the process of flaking off, and, in fact, relatively large flakes were easily removable (and samples sent for analysis). At this time I decided to test the mechanism of formation of the orene. Reich implied that the orene material formed "out of the air," so to speak; that is, as a condensation of mass-free energy into a "pre-atomic" substance. If this is so, then the material would be forming on the wall of the pots from the outside, rather than by deposition from inside the wet clay walls. To test this, I made two thin vertical black marks with a felt-tip pen in a heavy orene patch, expecting the marks to get covered over by material forming on top of them. Over the next two days, the lines became enlarged and blurred, and finally disappeared. It was not clear, however, that they were being covered up; rather, the ink seemed to be diffusing outward. Therefore, on the twelfth day, a piece of #20 enameled copper wire was fastened around the circumference about one inch below the rim. Again, it was hoped that it would become obvious whether or not the wire would be covered by material forming on top of it. For the next several days nothing happened, as the orene formation appeared to have stabilized. Then, inexplicably, on the morning of the 17th day all the orene had dissolved, leaving two glistening-wet pots! Within a day, however, orene was strongly forming again on both pots, especially the NaOH sample. In addition, careful observation revealed several white specks on the copper wire. Under a magnifying glass these proved to be small orene patches growing on the surface of the wire with no visible connection to the underlying clay surface. This seemed to me to be good evidence of the orene's direct formation *on the wire* rather than from its precipitation out of the clay surface.

Remarkably, on the 16th day a very fine white band was observed on the outside surface of the distilled water pot, approximately one-half inch wide and several inches long. It was identical in appearance to the early stages of orene formation on the other two pots.

On the 18th day, almost all of the orene in all pots had spontaneously liquified again, leaving the same glistening appearance. Then again, less than 24 hours later, the orene (especially in the NaOH) was growing back strongly.

The pH of the NaOH solution in the dish measured 10.50, while the pH of an orene sample from the NaOH preparation measured 10.35. These two values are within the tolerance of error of the pH meter.

## V. Microscopic Observation

A small amount of orene was removed and placed in a test tube for microscopic observation. At the laboratory, a small amount was placed on a slide, gently crushed, and observed under low power. A number of different features were observed under the microscope. The larger pieces of orene appeared angular and "rock-like" although most of the margins of the larger clumps were softer than those seen in a crystalline material. The larger pieces had a "lumpy-bumpy" appearance. Possibly this is what Reich refers to as the "bag form" of orene. A number of thin, pencil-shaped, clear, highly fractile, crystalline-like structures were observed. (McCullough mentions filamentous forms of up to two inches in length in his sample obtained with a clay pot collector.) Blue-green bions were seen scattered throughout the field, as well as clusters of bions and bionous breakdown within the confines of some of the larger pieces. With the addition of a few drops of

water (still observing under low power), the material rapidly dissolved, leaving a scattering of small objects, many of them blue-green bions.

In summary, the microscopic picture showed a mixture of crystalline and organic forms, with clear-cut bion formation.

## VI. Discussion

The sequence, growth, and macroscopic appearance of the orene are fully in accord with the description given in the orgonomic literature. However, these observations do not allow us to form any definitive conclusion as to the nature of the material which forms on the clay pot. The formation of orene on the copper wire apart from the clay surface is highly suggestive of material condensing *in situ* (rather than by diffusing outward); this is, however, only one simple observation and needs careful repetition. Also, the microscopic picture suggests life-like properties and argues against a simple crystallization process (e.g., the presence of organic-like forms and bionous formation).

The spontaneous liquefaction was quite unexpected, as it is not mentioned in the literature. There were observed a total of three events which correlated with the weather: two liquefactions followed thunderstorms the night before, and the third occurred on a hot clearing day with high humidity. The most likely explanation at this time would associate the liquefaction with high relative humidity. This can be easily tested in the future.

It was also apparent during the observation period (and before the first liquefaction occurred) that orene was also forming on the distilled water preparation. If this were true, it would again be strong evidence for a process of deposition from the air.

## VII. Going Further

This experiment is rich with possibilities for further exploration. First and foremost would be a refined technique for demonstrating that the orene forms without direct connection to the wet clay surfaces, i.e., by direct deposition. Second, there are unlimited possibilities to experiment with different substances (KOH, KCL, etc.) and in different concentrations. One might also try carefully detailed correlations of orene growth rates with weather changes. Finally, of course, a full, careful chemical analysis of the orene needs to be done.

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1. Reich, W.: *Contact With Space: Oranur, Second Report, 1951-1956.* Core Pilot Press, New York, 1957.

2. Reich, W.: "Orop Desert, Part 1," *CORE*, Vol. VI, Nos. 1-4, 1954.

3. Reich, W.: "Melanor, Orite, Brownite and Orene," *CORE*, Vol. VII, Nos. 1-2, 1955.

4. McCullough, R.: "Preliminary Chemical Analysis," *CORE*, Vol. VII, Nos. 1-2, 1955.

# Communications and Notes

## A Change in Publishing Policy

Beginning with Volume 9, *The Annals* will be published on an as - needed basis. This will help us to avoid the delays which have occurred between the announcements and mailings with recent issues. Advance subscribers will not be affected.

## Reich Tapes

A seminar for physicians entitled *Orgone Therapy's Critical Issues in the Therapeutic Process* was presented at the Wilhelm Reich Museum in Rangeley, Maine, from July 19-21, 1991. The program was based on tape recordings made in 1949 of clinical lectures by Wilhelm Reich. These were lectures only in the generic sense, since there is a constant interplay with the attending physicians—with Reich questioning, prodding, and reproving in his usual clinical manner.

The specific topics presented included "The Theoretical Basis of Orgone Therapy," "Special Characteristics and Dangers of the End Phase," "The Relationship Between Patient and Physician" (with special emphasis on sexual attraction), "Problems of Integration in the Newborn Infant and Their Relation to the Schizophrenic Breakdown and the Question of Consciousness," and "Difficult Problems of New Medicine."

Each of these subjects has pertinence to current practice of psychiatric orgone therapy and there is new information in some of the areas under consideration. As always, the originality of Reich's concepts and the depth and directness of his probing thought still have a remarkably stimulating effect.

Fifteen physicians were in attendance, most of whom were practicing orgonomists; but there were also psychiatrists untrained in orgonomy, a pediatrician, general practitioners—all with an interest to hear and learn from Reich. There was general agreement that, even in audio reproduction, Reich has the power to inspire, to cause one's thoughts and awareness to move in deeper tracks.

## Reich Blood Test

The Institute, in its continuing research on the Reich Blood Test, performs the test free of charge for those individuals recommended by their therapist. For further information please contact: Louisa Lance, M.D., Box 304, Gwynedd Valley, Pa. 19437.

## Educational Programs

The Institute conducts ongoing educational and training programs for medical students, physicians, and laymen, which include:

• *Training Program for Medical Orgonomists*:

Applicants for this program must be undergoing characterologic restructuring with an approved therapist, be interviewed by one or more training therapists, and have completed (or be in the process of completing) their first year of a psychiatric residency. Candidates for training are 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 further information, send a resumé that includes biographical data, classical and orgonomic training, and therapy to: The Institute for Orgonomic Science, c/o Robert A. Dew, M.D., Box 304, Gwynedd Valley, Pa. 19437.

- *Laboratory Course Offerings*:

*Introduction to Scientific Orgonomy:*

For the student without a strong scientific background, a two-day, weekend course in the fundamentals of biogenesis and orgone physics is offered twice a year. The course includes lectures, laboratory work, and demonstrations. Enrollment is limited to 10 students. Course fee: $200. The next course will be offered in May, 1993. If you are interested in taking the course, send a brief resumé to the Institute, including scientific background (if any) and experience in orgonomy.

*Advanced Laboratory Course in Scientific Orgonomy:*

This course is designed primarily for physicians and students with a strong scientific background (it is also open in selected cases to those who have completed the two-day course). It is a more comprehensive, four-day course in biogenesis and orgone physics, with lectures, laboratory work and demonstrations. Enrollment is limited to 12 students.

Course fee: $350. If you are interested in taking the course, send a brief resumé of your scientific background and experience in orgonomy to the Institute.

## Manuscripts

The *Annals* invites the submission of articles on any of the several aspects of 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 copy editing. 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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