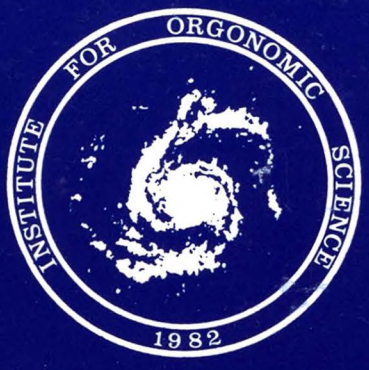
ANNALS

OF THE INSTITUTE FOR ORGONOMIC SCIENCE



Vol. 9 MARCH 1999 No. 1

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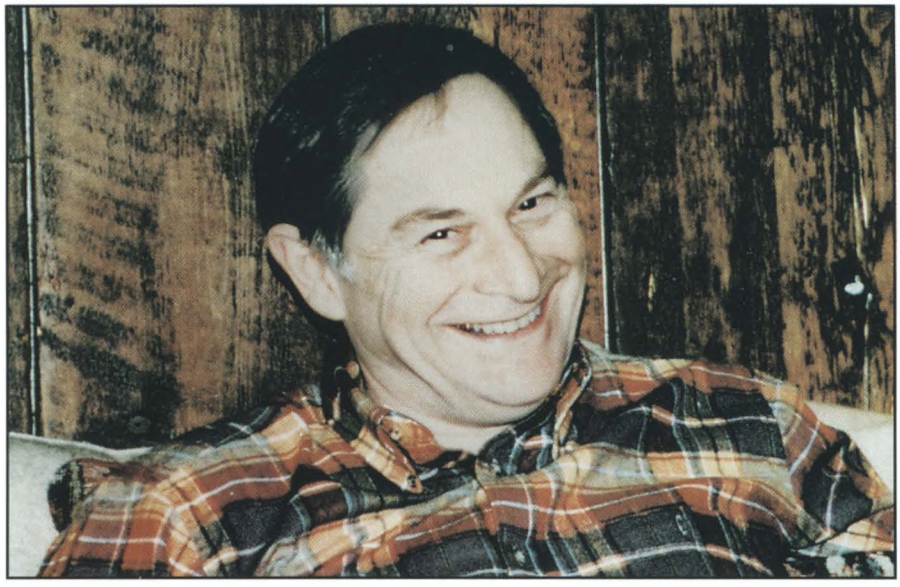
ANNALS
of the Institute for Orgonomic Science

MARCH 1999 VOLUME 9 NUMBER 1

This issue is dedicated to the memory of Robert A. Dew, M.D.

Remembrances

Robert Alan Dew
May 30, 1936 – April 16, 1997



Bob was born in New York City to Elizabeth and Albert Dew. He was raised in an environment that fostered intellectual and artistic pursuits. At the age of four years, he noticed a violin in the window of a music store and said to his mother, "I would like to play that." By the age of five, his talent for the instrument was clear. He was enrolled in the Julliard School of Music at eight; at age nine, he was invited to study at the Curtis Institute of Music in Philadelphia. He won many music competitions and at age twelve appeared with the Philadephia Orchestra as a soloist. Bob spent several summers at the esteemed music camp, Meadowmount, and at the Marlboro Music Festival. Concurrent with his education at Curtis, he graduated from a local high school where his talent for writing emerged.

After graduating from the University of Pennsylvania, he attended the University of Pittsburgh School of Medicine, did his internship at Kings County Hospital in Brooklyn, New York, and completed his residency at the Manhattan Veterans Administration Hospital in 1965. He held a full-time teaching position at Queens General Hospital in New York until called into military service in 1966. He did two years of active duty as a Captain in the Army. Bob became Board Certified in Internal Medicine in 1971.

During his residency, Bob married Jeanette Lupini and enjoyed a 22-year union. Bob and Jan remained close friends throughout his life and she was present the morning of his death.

Bob's interest in Orgonomy began with his own therapy with Dr. Morton Herskowitz at around age twelve. He credited himself for the marriage of Dr. Herskowitz to Karen Tuttle, who was one of Bob's most inspiring teachers at Curtis.

Although Bob was a talented and brilliant diagnostician and clinician, he found the practice of internal medicine unsatisfying and gradually developed a private practice using orgone therapy. He was an active member of The American College of Orgonomy, a founding member of the Institute for Orgonomic Science, and was a regular contributor to those organizations' journals. He was also actively involved in research confirming and expanding Wilhelm Reich's work. As with everything Bob did, his work reflected his enthusiasm, thoughtfulness, curiosity, and creativity.

During the last twelve years of his life, his renewed interest in the violin gave him great pleasure. He played frequently with local chamber musicians and spent a couple of summers at a music camp named "Heaven" in New York State. These were some of his happiest times.

Bob's patients described him as warm, compassionate, a man of integrity, unrelenting in his efforts to help his patients attain a more fulfilling life. They also appreciated his sense of humor throughout the "trials and tribulations" of therapy.

Bob was passionate about classical music and also enjoyed some jazz and popular tunes. His other loves were tennis, movies, good food, Cuban cigars, red wines, Russian vodka, and fast cars. He was an avid reader, an excellent artist, and was one of those people who could figure almost anything out. Bob loved traveling and especially enjoyed the American Southwest and Anguilla.

Then on March 31, 1996, this remarkable, multi-talented, kind and gentle man was diagnosed with a malignant brain tumor (glioblastoma multiforme). Despite the best conventional and alternative medical treatments, he lost the battle after struggling for thirteen months. During this time, he lived with me and was encouraged and supported by loving friends and family. He died at home attended by his best friends and two adoring cats.

Bob is remembered and missed by family, friends, and patients. He is survived by his brother James Dew of Connecticut.

The Editor

ANNALS
OF THE INSTITUTE FOR
ORGONOMIC SCIENCE

SCIENTIFIC ARTICLES

VOL. 9 MARCH 1999 NO. 1

The Metabolism of the Orgone

ROBERT A. DEW, M.D.

This paper was discovered among the effects of Dr. Robert Dew following his death. It is a testament to his searching mind, his intelligence and his care. As Dr. Dew indicates, some of the ideas are purely speculative, but they are speculative with a foundation of reasonability. Every significant scientific discovery was teased into the laboratory by an intuitive thought. There are enough provocative thoughts in Dr. Dew's paper to provide current and future students of orgonomy with years of laboratory studies.

A. Introduction

This paper was originally intended to be a dissertation on a pulmonary biopathy: chronic obstructive pulmonary disease. Quite naturally my thought processes led into the phenomenon of respiration and, further, without any intention I found myself "up to my neck" in the whole problem of metabolism. Metabolism, of course, led to biochemistry and chemistry to the generation of matter itself. This process was exciting and pleasurable and yet also discomforting because of the continual emergence of fresh theoretical problems. I frequently feared things were "getting away from me." I realize that this was an experience in functional thinking. We all have some capacity for thinking in this way: it is our tolerance for following it where it takes us without letting scientific prejudice (or the anxiety from which it stems) interfere.

The experimental work and most of the theoretical concepts on which this paper is based have been presented previously by Reich. In *Cosmic Superimposition* he stressed that he was making a sweeping survey of a vast and unknown territory (man's roots in nature) (1-p.9). He did indeed streak across the landscape from microcosmos to macrocosmos. This is where the superimposition function carried him. It is remarkable that he left as many signposts as he did. He hoped and expected that other workers in orgonomy would "fill in the gaps," but from his own very rich work experience he must have known how slow and painstaking it would be. Orgonomy too has been only slowly recovering from the gap created by his death. Detailed studies of paths he indicated in the wilderness have been slow forthcoming. Much of what was written then was necessarily theoretical and, unfortunately, still is today. So also is a great deal of this dissertation.

I have in the main reviewed or expanded on what Dr. Reich has already suggested and can lay claim to only a few really new ideas. Nevertheless, I take full responsibility for those ideas and for the confusion they might create should they prove invalid. It is my further responsibility to orgonomy to convey to the

reader just what is theory and just what is experimentally proven. If I am remiss in this, my error will undoubtedly be revealed. Where possible I have attempted to provide a basis for various assertions by calling upon experiences from classical physics and chemistry.

It was startling to think through and write this paper, to reread the references below and find how much Reich had already covered and anticipated.

B. The Organization of Matter: Orgonomic Chemistry

A fundamental idea in orgonomy is that *all matter* is ultimately derived from an ocean of free orgone energy (O.E.) (1-p.21). This derivation is the result of the function of superimposition in which two or more independent, free O.E. units mutually approach and condense to form subatomic particles (1). This is functionally identical to fusion in nuclear physics. In the sun, for instance, atoms of "heavy" hydrogen fuse to form helium. Some of the mass involved in this reaction is liberated as energy of tremendous magnitude. A prior corresponding event is presumed to have occurred in mass-free O.E. In the case of nuclear fusion, "unstable" (highly excited) subatomic particles combine to form a very "stable" helium atom. The high energies which result induce the combination of nearby particles to initiate a chain of condensations. Such behavior must have its root in O.E. functions. In sexual superimposition, for example, the mutually approaching organisms undergo ever-increasing excitation culminating in the orgastic convulsion in which energy is discharged and the excitation of the participants precipitously subsides. In the process a surplus of biological energy is discharged. In the superimposition of O.E. units, mass (frozen energy) is postulated to result thus:

(1) O.E. units $\xrightarrow[\text{superimposition}]{}$ subatomic particles + energy (frozen energy)

(2) subatomic particles $\xrightarrow[\text{superimposition}]{}$ atoms + energy

Now in equation (1) the second product (i.e., energy) is entirely presumptive. I am not aware of anything in Reich's writings which suggests this. I have made the assumption that in the superimposition process energy is released *in some form*. In the orgastic discharge energy is expressed in powerful muscular contractions and highly charged coital substances. I thought it not unreasonable to expect an analogous function in the fusion of O.E. units. Actually this is in keeping with what we observe in many chemical reactions. For example:

$$\underset{\text{strong acid}}{HCL} + \underset{\text{strong base}}{Na\,OH} \longrightarrow \underset{\text{salt}}{Na\,Cl} + H_2O + \text{heat energy}$$

Anyone who has performed this experiment in high school chemistry has felt the heat in the beaker. If sexual and chemical superimposition both yield energy, why not the superimposition of O.E. units? One might raise the point that energy need not arise from orgone superimposition because it is all consumed and in pure mass formation, whereas in sexual and chemical superimposition presumably no new mass is being created. I would answer this by recalling that different types of subatomic particles are thought to arise from superimposition, particles which have different electrical charges. Obviously there must be qualitative and quantitative variations in the way that superimposition occurs to account for these differences, possibly in the following fashion:

O.E. units $\xrightarrow[\text{superimposition}]{}$ electrons

O.E. units $\xrightarrow[\text{superimposition}]{}$ protons

O.E. units $\xrightarrow[\text{superimposition}]{}$ neutrons

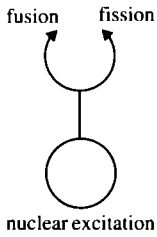
etc.

It is difficult to envision these differences occurring without something being "left over" (i.e., another product). That this something left over is a form of energy—orgone, electri-

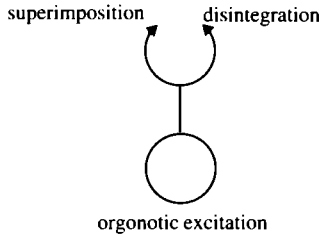
cal, nuclear energy—does not therefore seem unlikely. The reason for pursuing this matter of an energy product from superimposition is not purely academic. I will attempt to show that the form that this surplus takes may be of great significance in our understanding of the metabolism of the orgone in health and disease. First, however, there is a vital concept to make clear before we leave our discussion of superimposition, and that is the antithetical functions of fusion (superimposition) and fission (disintegration).

C. Fission and Fusion: The Interchangeability of Matter and Energy

In nuclear physics the antithetical function to fusion is termed *fission*. In this case, for example, unstable U^{235} atoms mutually excite one another (atomic explosion) to produce a chain reaction from which tremendous energy is liberated and stable elements (e.g., Krypton, etc.) are produced. We see then that out of the function of excitation two antithetical functions derive:



Likewise, for orgone energy units:



An example of the phenomenon of disintegration (fission) in orgone biophysics would be the preparation of bion water. Matter (earth) is autoclaved (excited) and disintegrates, producing bions and free orgone (see the orgonotic potential of bion water—*Cancer Biopathy)* (2-p.54).

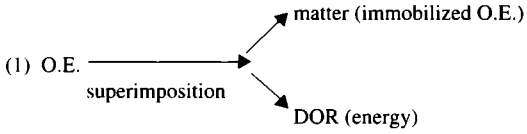
While there are functional identities in the behavior of O.E. units and subatomic particles, there are also some qualitative differences. For one thing, the nuclear reactions are rapid, violent, and involve temperatures of millions of degrees—characteristics consistent with stellar and galactic cataclysms. With orgone energy the reactions are slow, gentle, and relatively cool—features characteristic of biological events. There are also certain similarities:

1) In both cases matter and energy are interchangeable, the important implication being that matter is regularly forming in the orgone as well as disintegrating back into it.

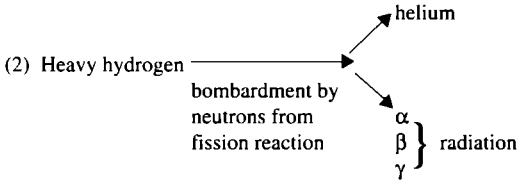
2) In both cases a surplus of energy is liberated and products of greater stability (lower excitation) result.

In the case of the orgonotic superimposition the generation of matter renders the condensed O.E. units relatively immobile (i.e., mass = frozen energy; in matter O.E. excitation is subdued) (1-p.21). The liberation of an energy surplus in orgonotic superimposition has, as we have seen, some theoretical justification from the phenomenon of biological superimposition. However, there is no reason to assume that the energy thus liberated in the superimposition of O.E. units is even orgone. In fact, it is most likely a derivative of the primordial energy. Consider a nuclear reaction, for instance. Fast-moving neutrons initiate and are produced from it, but alpha and beta particles also result. This fact may serve us in attempting to account for the existence of other forms of orgone energy such as DOR. This is particularly intriguing when one recalls that DOR consistently appears when O.E. is *immobilized* in living organisms. It would not be unreasonable therefore to expect that DOR may be an offshoot of O.E. condensation and immobilization in the generation of matter.

Put schematically:

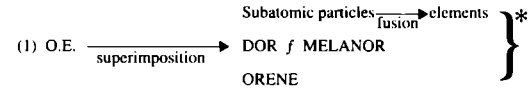


In nuclear fusion:



Before going into the phenomenon of structure it is important to point out that the spontaneous organization of matter from free O.E. is not purely hypothetical. At least two experiments performed by Reich have put this concept on concrete footing. I shall simply report them here but, should the reader wish to explore further, a comprehensive description is available in the references cited below. In the *Cancer Biopathy* an account of Experiment XX is given (2-p.51). In it, bion water (a filtrate of autoclaved earth) is frozen. After thawing, a sediment is formed which on microscopic examination consists of fine amorphous flakes. Over an extended period of observation (weeks to months) these "plasmatic" flakes soften and begin to take on the characteristics of protozoans. With time, the flakes begin to manifest internal motility and external mobility eventually to become free swimming protozoa (orgonomia). This remarkable experiment, in addition to its biological implications, suggested the possibility that matter developed from free orgone energy which had been frozen.

In a pioneer experiment in Oranur chemistry (3-p.29-39) Reich demonstrated the production of a blue-white material from atmospheric O.E. which he termed ORENE. One conclusion to be drawn is that under a variety of conditions free O.E. will form matter. It is pertinent here that Reich postulated that atmospheric DOR under similar circumstances might be the source of MELANOR—a black, noxious, natural material found on rocks and vegetation in areas of desert development. We might further conclude that while the biological properties and effects of O.E. and DOR differ, they share common lawful functions. Thus



D. Biological Structure—A Function of Orgone Energy

Having postulated a functional derivation of matter from energy (and vice versa) we may discuss the derivation of *biological structure* from energy.

1. *The Special Significance of Carbon*

In all living material, at least on this planet, carbon (C) seems to be essential. While hydrogen, oxygen, nitrogen and other elements are of course necessary as well, non-living substances with these elements in the absence of carbon abound, yet no living material lacks carbon. Carbon is literally the backbone of the organic molecule.** This may be intuitively grasped even from the way organic formulas are expressed schematically. For example, C-C-C-C-C-C- is the basic architecture of sugars and alcohols. By substituting "double bonds" it becomes the basis for fats and oils. On more complex materials the carbon chain may form rings. Carbohydrates, fats, proteins, nucleic acids, etc. all represent derivations from this unique arrangement of carbon atoms. This particular function of carbon is of course an expression of lawful behavior which, to our way of thinking, must stem from the superimposition function of the orgone.

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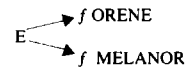
*The functional relationships between ORENE, MELANOR and matter are more fully discussed in references 3 through 6. Reich felt that ORENE was a "preatomic" substance derived from atmospheric O.E.



Preatomic and subatomic are not necessarily identical.

**It has been postulated that in other environments silicon (Si) could conceivably have replaced C in this role.

2. *Atomic Pulsation and Excitation—The Orgonotic Basis of Chemical Reactions*

Let us consider the carbon atom as an orgonotic system. In doing so we hold in abeyance thinking of its placement in the periodic table of elements. Atomic weight and number do not necessarily explain its special function in nature. As an orgonotic system it may possess certain properties in common with living orgonotic systems.

Classical physics has deduced that atoms are planetary systems of subatomic particles. A nucleus of protons, neutrons, etc. is surrounded by concentric shells in which electrons orbit. It is further presumed that the location of the orbit is determined by a balance of centrifugal and centripetal forces. As in other planetary systems the electrons in the inner shells move at greater velocities than those at the periphery. In addition, electrons can shift from one shell to another and when other atoms of different elements collide "bonds" are formed which consist of a transference or mutual "sharing" of these orbiting electrons. (The similarity here to superimposition is clear.) The chemical potential of any atom is thought to be a function of the ease with which it can give up or receive these electrons. A refinement to this idea is that the schematic representation of shells represents only a mathematical probability of where the electron is at any given time. It can be seen at a glance that the movement of the electrons can be viewed as *pendular* motion which in orgonomy we see as an expression of pulsation. Movement from one shell to another constitutes a change in the periodicity of this motion and consequently a change in the amplitude of pulsation. Excitation in this context may be defined as an increase in the amplitude of pulsation. (A change in the period of the pendulum.)

Classical physics is restricted in its view of pulsation, at least to the extent that it finds it difficult to view atoms as pulsatile bodies. Consequently it proposes a mathematically "probable" location for electronic orbits. It follows logically that the nuclear contents behave in a similar fashion; that is, the nucleus is capable of pulsation and excitation. Apparently intranuclear relationships are much more stable than are those between orbiting electron and nucleus, since in ordinary chemical reactions energies of a lower order are required to alter the orbit of an electron (excitation) while tremendous energy is required to disrupt the nucleus.

In summary, it appears likely that atoms are pulsatile and excitable and their propensity for interaction depends upon the ease with which these states can be altered. Carbon may be the backbone of biological chemical systems because its pulsatility and excitability allow both suitable "stability" and "instability" at the order of energies present in *biological* orgonotic systems.

As we have seen, chemical reactions involve the excitability of atoms and molecules, much in the same way as biological orgonotic systems with expansion (e.g., outward migration of electrons, mutual approach) and superimposition (e.g., "sharing" of electrons). To pursue the analogy,* further energy is given off in chemical reactions as heat just as it is in the strong involuntary muscle contractions of the orgasm.

To review:

(1) O.E. units —superimposition→ subatomic particles + energy

(2) subatomic particles (units) —superimposition→ atoms + energy

(3) atoms —superimposition→ molecules + energy

(4) molecules —superimposition→ compounds + energy

We do not wish to imply that these functions must occur sequentially. They may very well occur simultaneously. The important things to note are (1) units on the left side of the equation are in a higher state of excitation than those on the right, (2) superimposition is the common functioning principle in all, and (3) an energy emerges in the production of a relatively stable product (mass).

*We use "analogy" advisedly.

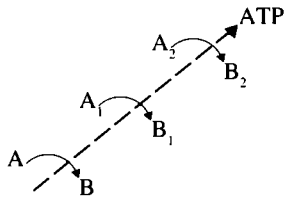
3. *Negative Entropy*

So far we have spoken of reactions involving a net loss of energy, that is, positive entropy. Yet in biological metabolism the organism is able to perform chemical functions against an energy gradient. Classical biochemistry contends that this is accomplished without violating the second law of thermodynamics. For example, energy is "stored" in high energy phosphate bonds (ATP), and is provided to drive reactions against a gradient as follows:

ATP (adenosine triphosphate) ⟷ ADP adenosine + phosphate diphosphate + energy

ATP itself is formed by a number of metabolic pathways whose reactions conform to the second law of thermodynamics (i.e., are exothermic).

The proof for the role of ATP lies in the fact that inactivating *ATPase*, an enzyme vital to the reaction ATP ⟷ ADP, paralyzes the systems which work against the gradients.* From the biochemical point of view the vitality of the responsible tissues depends upon their ability to generate ATP which itself is produced in the metabolism of carbohydrates. Let us examine the basic premise of this view. If all the reactions in this system follow the second law of thermodynamics, then the energy flow for each reaction must be from higher to lower potential, thus:



No matter what chain of reactions we might conceive, the flow of energy could never go from A up to ATP unless energy were *added* at each step. The biochemist answers that such energy *is* added from the combustion of glucose, by a series of reactions in which such small amounts of heat energy are generated as to avoid burning up the organism. But we are still faced with the question then as to *how such high energy gets into biologically produced glucose in the first place*! The traditional explanation is that green plants are the next echelon upward in the energy cascade. The highest of course is the sun. It is presumed that the sun's energy drives the following endothermic reactions in plants:

$$CO_2 + H_2O + \text{sunlight} \xrightarrow[\text{photosynthesis}]{} \underset{\text{carbohydrate}}{CHO} + O_2$$

According to this view, because of the second law of thermodynamics, the first protozoan could not have arrived on the scene unless some form of plant life had preceded it with the capacity of photosynthesis. One would quite naturally deduce then that life originated spontaneously *de novo* only at one point in time (i.e., after the function of photosynthesis). This would also appear to be at variance with the facts of Experiment XX. Furthermore, photosynthesis itself is a life function—how did photosynthesis get started? Classical biochemists look at the living in a particular way and, quite naturally, they see life originating only according to the narrow routes they have elucidated. Orgonomy has open to it a wider range of possibilities. It does not grow frightened when this or that "law" appears to be "violated" by nature. It does not refuse to see something "unlawful." Consequently, while we believe what the biochemist says, we can also conceive that life is being produced continually without the invention of pre-existing life by mechanisms unknown to contemporary biologists. Unhappily, we in orgonomy (even with the advantage of knowing of the orgone and some of its lawful functions) are as abysmally ignorant of the details of these mechanisms as are the classicists.

Nevertheless, there is abundant evidence that the O.E. flows from lower to higher poten-

*An example of this would be the intestinal mucosal cells. When a length of intestine is inverted (turned inside out) and placed in a hypertonic salt solution, water will still cross the mucosa against the osmotic gradient. Physiologists postulate the existence of a "sodium pump" to account for this finding. The mechanism of the pump has never been determined. Presumably the "sodium pump" drives the salt back into the lumen.

tials, unlike the other energies derived from it. Such a property would provide a ready means for driving reactions "uphill" or absorbing against a concentration gradient. Furthermore, Experiment XX illustrates the fact that energies liberated from non-living matter can, with relative rapidity, reorganize into complex molecules expressing the living function. We think superimposition will provide an approach to the comprehension of this phenomenon

$$\text{O.E. units} \xrightarrow[\text{superimposition}]{} \text{C} + \text{energy}$$

in which a surplus of energy is liberated. C represents an orgonotic system of greater potential than the dispersed O.E. units around it. Consequently, O.E. units would tend to be drawn toward the C system. Theoretically, a number of possibilities arise:

(1) Further superimposition with the C atom might actually transmute the C to another element.

(2) The exited O.E. units could form atoms of another element in proximity of C which might combine with C to form compounds.

(3) More C atoms might form in the orgone around the original C atom—much in the manner that dropping a crystal in a saturated salt solution will induce crystallization of the whole.

In view of the results of Experiment XX it is conceivable that all three of these possibilities occur. Particularly with the prejudices of a classical scientific background, one is reluctant to accept these possibilities even if he could allow himself to accept the existence of the orgone in the first place. Nevertheless, to reject Experiment XX would be unscientific. If something "outlandish" can and does happen in nature, its explanation may be equally "outlandish."

Let us return to the point we started to make. The energy required to drive reactions against electro-chemical or osmotic gradients is derived from the superimposition function. Organic materials attract and hold O.E. in the orgone accumulator; biochemical materials, themselves products of superimposition by virtue of their orgonotic charge, tend to draw and hold free O.E. Since this form of superimposition is relatively cool, biochemical systems can build up and reserve relatively high energy levels without the generation of lethal temperatures. Energy is *discharged* in various biological and chemical functions in the manner of *mechanical* potentials (i.e., from higher to lower) (6-p.196).

At this juncture the following questions might occur to the serious reader. For one thing, if the orgone always moves from lower to higher potential, why is it not all used up by superimposition into matter? Why is there any "free" O.E. at all? Secondly, why is it that superimposition produces many discrete atoms? Wouldn't one expect the orgone to form one huge continuously enlarging atom like a snowball rolling down an endless hill? Thirdly, how can organic molecules ever "give up" the energy they accumulate if the energy is held by such a strong orgonotic system?

The answer to all these questions may lie in one concept we have already touched upon, namely, the functional antithesis between superimposition and disintegration or fusion and fission. Consider another orgonotic system, let us say a normal intestinal epithelial cell. It consists of a membrane, cytoplasm, various cytoplasmic inclusions and a nucleus. It has an orgonotic charge which is in a state of dynamic equilibrium; that is, orgone is brought to it via the capillaries and by superimposition forms organic molecules and is partly held free in the cell fluids. The energy is used in performing metabolic activities and cell work. Nevertheless, a surplus of energy accumulates. Excitation of the cell nucleus due to increased O.E. tension induces mitosis. In the cell equivalent of the orgastic convulsion the cell divides and the tension in the two daughter cells is reduced. In short, the orgone energy tension and excitation becomes so great it can no longer be contained within the cell membrane. Now we do not know why or how this form of adaptation (cell fission) to excitation came about, but

it is clear that it exists, that it conserves the energy without destroying the cell and as by-products permits growth and reproduction of *like* cells. Possibly the final size of the cell is a function of the charge and excitation its structure can mechanically contain.* This may constitute at least a partial answer to question number two. Now, anyone who has ever viewed cell division under the microscope—particularly as seen through the technique of stop motion cinephotography—readily appreciates the convulsive aspects of mitosis. Energy is being expended in cell division. Oxygen consumption is much higher in rapidly growing tissues. This further supports the notion that there is energy on both sides of the equation:

$$\text{Orgonotic system} \begin{cases} \text{biological} \\ \text{atomic} \\ \text{chemical} \end{cases} \xrightarrow{\text{excitation}} \text{fission or fusion} \begin{cases} \text{2 cells} \\ \text{atoms} \\ \text{molecules} \end{cases} + \text{Energy}$$

In giving up energy, the system reduces energy tension. We see in this that *all* matter, whether alive or non-living, has a pulsatile function and we appreciate in it the continual interchange of matter and energy. Thus neither is all the energy used up in matter nor does all the matter "decay" into energy. This also touches on the reason that chemical reactions and biological activities "go." They are the inevitable result of the mutual excitation of the participants. It may also be a clue to the action of catalysts and enzymes (i.e., they excite components to the point of disintegration and thereby abet superimposition and reduction of tension).**

4. *Ionization*

Obviously, every chemical reaction involves the antithetical functions of fusion and fission.

We have indicated that the common functioning principle (C.F.P.) is the mutual excitation of interacting chemical orgonotic systems. Consider, however, the following:

$$\underset{\text{silver nitrate}}{Ag\,NO_3} + \underset{\text{sodium chloride}}{Na\,Cl} \longrightarrow \underline{Ag\,Cl} + Na\,NO_3$$

Another reaction familiar to the high school chemistry student. Strictly speaking, the reaction as written would not "go" but,

$$Ag^+ + NO_3^- + Na^+ + Cl^- \longrightarrow \underline{Ag\,Cl} + Na^+ + NO_3^-$$

does. The implication is that in a pure dry state the reaction would not occur. This observation brings us to the concept of *ionization*. Everyone knows that *water* is a necessary medium for many chemical reactions. The classical explanation for this requirement is that H_2O is actually in a continual state of flux, namely:

$$H_2O \rightleftharpoons \underset{\text{ions}}{H^+ + OH^-}$$

In the presence of water

$$Ag\,NO_3 + H^+ - OH^- \longrightarrow Ag^+ - OH^- + H^+ - NO_3^-$$

In other words, although water itself is only "weakly" ionizable, enough "free" hydrogen (H^+) and hydroxyl (OH^-) ions are present to induce the ionization through the mechanism of the attraction of "opposite charges."

For a long time, students have accepted the tenet of "positive" and "negative" charges without question. The idea of atoms floating about with little minuses and pluses attached to them is very real and comforting. But what does it really mean? Well, what do we mean when we say it is eleven o'clock? As children we were taught that it is eleven o'clock when the "small hand" is on the eleven and the "large hand" on the twelve. Most people do not find out until much later that "eleven o'clock" relates to the state of rotation of the earth. Chemists tell us that positive and negative refer to *electrical charge*. Electrochemists—a little more functional—say that which migrates toward the anode and that which migrates toward the cathode in solution are posi-

*This is purely conjectural. We do not know what limits cell size or, for that matter, the finite size of *any* orgonotic system. It seems reasonable to assume that the "stuff" of which the system is made must in part dictate these limits.

**i.e., it is not only a case of providing a surface on which reactants can engage one another.

tive and negative respectively. It fails completely, nevertheless, to convey just what is the essence of positivity and negativity. If we place $AgNO_3$ in pure water, why don't we get

$$Ag^+ NO_3 + H^+ OH^- \longrightarrow \underline{Ag\,OH} + H^+ NO_3^- \quad ?$$

If the explanation is that $AgNO_3$, H^+, OH have identical affinities for one another, then we might well ask why $AgNO_3$ even goes into solution in the first place.

The functional explanation is that water excites the $AgNO_3$ (and the NaCl) into *dissociating* (disintegrating). The reaction "goes" and goes *one way* because an inert (less excitable) substance is formed (AgCl). Chemical or electrical "charge" must signify the relative state of excitation of this or that atom or radical or ion. *Ionization* or ionizability refers to the *capacity* for excitation in a given medium.

Two important questions arise out of this example:

1. What is it about water which endows it with such a broad ability to excite solutes, and
2. What is it about AgCl which renders it inert or inexcitable?

Now the second question must be discussed later in a different context. Although it touches upon the orgonotic nature of the elements and upon their relationship to one another, and although linked to the problem of orgone metabolism, it is not necessary to the present discussion. It *is* important, however, to understand the function of water in these basic considerations in chemistry since our thoughts are leading toward general theory of orgone metabolism in living biosystems.

There is plenty of evidence that life began in water (viz Experiment XX). It is estimated that our bodies are 70 percent water. Obviously the manifestation of the life function of the orgone requires water. We feel strongly that the reason for this is in part related to its aforementioned properties in chemical reactions. Water and orgone are mutually attractive. Reich demonstrated the orgonotic potential of various aqueous solutions (2-p.54). How can we relate its orgonotic potential to water's role in chemical reactions?

We know that water may be loosely bound in the crystalline structure of various compounds (e.g., copper sulphate). We would agree with the classical concept that the water molecules are "trapped" in the interstices of the crystalline lattice of the salt. The situation is thought analogous to a log jam in that the molecules of solute are so numerous that fluid movements are no longer possible. It is not *simply* a log jam because in crystals the molecules of solute and water are not haphazardly oriented. There is an orderly and lawful mutual orientation of all the constituents which suggests a polarity to the constituent molecules themselves.

Let us return for a moment to the ionization of water:

$$HOH \rightleftharpoons H^+ + OH^-$$

Water is a polarized molecule* as is suggested from the different degree of excitation at either end ("positive" and "negative"). Since the hydrogen atoms may be assumed to be identical, it is obvious that the polarization is due to the *oxygen*. We will not go into the obvious structural differences between hydrogen and oxygen, but we must recall the simple fact that animals and plants require oxygen to sustain life. They breathe oxygen.** If the small amount of free hydrogen in respired air were removed, the life process would not be immediately or profoundly affected. Without the oxygen, we would die quickly.

As has been intimated by classical chemistry and here in our theoretical survey, the polarity of the water molecule (presumably due to oxygen) has some bearing on its indispensability in chemical reactions. We would relate oxygen's significance in respiration and in water by proposing that it is an orgone energy *carrier* in both these situations (4-p.5). Clearly in its free molecular state oxygen (O_2) is a more effective, or at least a more labile

*As distinct from, say, the following hydrocarbon: $H_2C = CH_2$

**It does not matter in this context that plants also utilize CO_2

carrier of energy. We cannot breathe water. Just how the association of hydrogen in water affects oxygen's carrying capacity is not understood. Technically, we have no way at present of comparing the orgonotic potential of water with that of pure oxygen. Our theory would predict that the latter should exceed the former. In water, the energy bearing O_2 constitutes a sufficiently strong orgonotic system to excite the solute. It all has a strikingly familiar ring: it is functionally identical to the interaction of bions under the microscope—mutual excitation, lumination, and attraction. Thus the orgonotic potential of, say, salt water is greater than of pure water. It is as if O_2 is to the animal what sunlight is to the plant: water is the "soil" in which animal life grows and develops. Water is thus the catalyst of life.*

E. The Meaning of Metabolism

With the discussion of matter formation (the roles of carbon, water, and oxygen) we have laid the theoretical groundwork for a consideration of metabolism.

In classical biochemistry metabolism is defined as the sum total of the activities of building up and breaking down in the body—anabolism and catabolism; H_2O is the medium in which these activities are conducted. Oxygen is thought to function as the primary electron receptor (oxidizing agent) at the end of a long chain of enzyme mediated reactions which pass along electrons from the cell's interior to the cell's periphery. CO_2 and "metabolic" water are the chemical products. These are carried off via the blood and eliminated by the mechanism of extracellular respiration (breathing).**

Orgonomy does not regard this view of metabolism as incorrect. The scientific tool of orgonomic functionalism simply allows us to look at the facts in another, and hopefully more revealing, way. We feel, for instance, that O_2 not only carries electrons out but brings energy in. Furthermore, we would see water as more than just a passive medium for chemical reactions, but also as a catalytic participant in the interconversion of matter and energy. In short, metabolism would appear to be essentially a transformation of energy within the living organism.

In our theoretical discussion thus far we have gotten the orgone into the body by one of its main routes—respiration of O_2. It now remains to be seen what becomes of the energy once it reaches the tissues.

F. The Fate of the Orgone

We have made a particularly risky proposal in theorizing that O_2 is an orgone carrier, perhaps the main energy carrier in the respiratory function and in biological systems altogether. This is because we have no direct measurements to substantiate it. This idea is partially deductive, and partially intuitive. But in a wilderness, off the beaten path and without a compass, such a risk may be necessary to find our way. It is logical that other atoms or molecules have similar abilities to varying degrees. But, as does carbon in structure, oxygen has a unique role in the life of the organism. Again, it must be peculiarly suitable for this function by virtue of its special properties. There is more than four times as much nitrogen in the atmosphere, yet we can survive without breathing nitrogen. Jumping ahead of ourselves a moment, I can think of no biochemical structure in the anabolic phase* of metabolism that does not have oxygen in it. Thus, oxygen may not be the only energy carrier by any means, but it would appear to be a most significant one in the living.

1. *Hemoglobin—A Step in the Ladder of Rising Energy Potential*

Oxygen gains access to the tissue cells via

*Reich felt that the "water hunger" of DOR might in fact represent a mechanism for the "revival" of DOR to O.E. (4-p.7). In *Contact with Space* (5-p.258) he goes into more detail and shows how the *conversion* of DOR to water regenerates O.E.

**The specific breakdown products of proteins and other biological materials are not pertinent to the present discussion. Thus renal excretory functions will not be discussed here.

*Catabolism of protein produces CO_2 and urea + H_2O. Urea contains no oxygen. Hydrogen appears to be ubiquitous in this context also, but does not appear to be vital in respiration.

the capillaries, diffuses across the cell membranes thus reaching the cell interior. In the vascular compartment most of the O_2 is carried by the hemoglobin of the red cells. Hemoglobin is a remarkable material; among its many peculiarities is its varying affinity for O_2. To all intents and purposes in normal human beings, hemoglobin is 100 percent "saturated" with oxygen.* With varying partial pressures of oxygen the percent saturation of hemoglobin varies. Plotting this relationship produces the well-known hemoglobin-oxygen dissociation curve (Fig. 1 solid line).

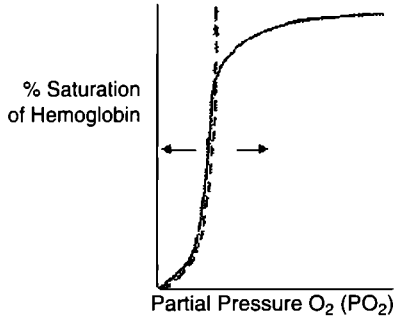


Figure 1. O_2–Hemoglobin Dissociation Curve

This curve may shift left or right depending upon the temperature, acidity, carbon dioxide content, and other conditions of the blood. The *shape* of the curve is not markedly altered in normal physiological circumstances, indicating that the *change* in partial pressure of O_2 (ΔPO_2) always bears the same relationship to Δ percent saturation, regardless of the direction of the shift. As we can see, as hemoglobin becomes more saturated, its avidity for O_2 decreases (top of the curve). While the mutual attraction for O_2 and hemoglobin must have an orgonotic basis, clearly at high saturation it becomes increasingly difficult for O_2 to gain access to binding sites in the heme moiety. If the O_2 binding of hemoglobin were purely on the basis of orgonotic attraction the curve might appear as in Figure 1 (dashed line). Apparently the leveling off of the curve is a mechanical phenomenon. The usual explanation for hemoglobin's giving up its O_2 in the tissues is that O_2 diffuses passively (i.e., from higher concentration in hemoglobin to lower concentration in the tissues). Seen from the orgonomic viewpoint the O_2 is drawn into the tissues with the energy it carries because of the cell's higher orgonotic potential.

*This, of course, refers to systemic, not pulmonic, arterial blood.

2. *The Incorporation of the Orgone into Living Substance*

The actual mechanism by which the orgone is held in the cells is not known. Some is probably free in the cell juices. This may account for the shimmering quality of cell inclusions under phase microscopy. The rest of the energy must be trapped or bound in organic molecules. We encounter here the germ of an idea regarding molecular cohesiveness. In *The Cancer Biopathy* it was pointed out that the low orgone energy tension may account for the friability of tumor tissues and cells (i.e., cohesiveness is a function of charge). In the chemical realm there is a homologous function. Animal starches, for example, are polymers of smaller carbohydrate units (sugars). Glycogen, an animal starch stored in liver and muscles, is regarded as an energy storehouse (e.g., under conditions of stress, glycogen is mobilized and broken down). The cohesiveness of the sugar polymers might be predicated upon the high orgonotic charge therein. As energy is exhausted in the organism through the performance of metabolic and mechanical work, the binding force in the polymer is depleted and *depolymerization* (i.e., glycolysis) occurs.

We are well aware of the efficiency of healthy biological systems. Thus in each step in the breakdown of organic molecules energy is given up all the way to CO_2 and H_2O:

Polymer (starch) → depolymerization (fission or disintegration function) → unit + energy sugar → degradation → $CO_2 + H_2O$ + energy

These features of metabolism are quite revealing.

Anabolism involves building up of complex molecules with the trapping or incorporation of energy. Catabolism involves degrading com-

plex molecules with the liberation of energy. We see at once the antithetical function of superimposition and disintegration here: energy is frozen into matter; energy is liberated in the disintegration of matter. It is reasonable then that, by analogy, orgone energy may be the binding force in chemical molecules. Energy is incorporated into the body substance by virtue of the incorporation of the orgone carrier oxygen into the organic molecules.

G. Biological DOR Removal—CO_2

We have made many theoretical proposals in the previous pages: some to explain the interrelationship of energy and matter; some to explain the interrelationship of different kinds of matter; and lastly, the biological mechanisms for storing and providing energy. At the beginning of our discussion we suggested that the formation of matter from the primordial O.E. might be accompanied by the release of some form of energy. We indicated that one form of this energy might be DOR. Now a word of clarification about the term "DOR" might be in order here. DOR signifies *deadly* orgone. Reich coined the term to characterize a disturbed function of O.E. in the atmosphere. "Deadly" referred to its adverse effects on living and non-living things. A presumption amongst lay persons is that DOR is man-made (i.e., purely the result of armoring of his organism and of the atmosphere itself by his contactless pollution). Reich, however, came to the conclusion that DOR might be a *natural* by-product of O.E. functions in nature, the implication being of course that hampered mechanisms of DOR removal and abnormally increased production underlie its deadliness (4-p.6). In other words, it is a disturbance in DOR economy which makes it harmful. It is immediately apparent then that any abnormality in DOR economy must have an underlying disturbance in O.E. economy since DOR is a function of O.E. What do we know of this?

Reich believed DOR derived from O.E. *stasis*. The whole idea of DOR removal by "cloud busting" is based on relieving stasis. Apparently when O.E. is blocked in its normal functions, it begins to function differently.* If one were to tie up an ordinarily friendly dog, it would eventually become "crazy" or nasty. We feel this is not merely an analogy but actually a real example of the DOR function of O.E. when it is immobilized. Now, if the generation of matter constitutes a form of immobilization of O.E., it is quite possible that some DOR is produced as a consequence. Similarly, the binding of O.E. in organic and other molecules is a form of immobilization. Theoretically then, some DOR may be produced in healthy metabolic processes. This would not be harmful ordinarily because:

1. In health, the energy turnover is brisk. Energy storage and utilization (discharge) go on apace and,
2. The organism normally has an effective means of ridding itself of the DOR.
3. In a healthy, self-regulating atmosphere, DOR situations are spontaneously corrected and the organism does not live in high concentrations of atmospheric DOR.

Let us consider possible normal mechanisms for eliminating DOR:

1. DOR has an extreme avidity for water (one reason for grounding the cloud buster in a large changing water supply). In the maintenance of normal water balance the lungs and kidneys excrete water which might carry out the DOR with it.
2. DOR may be excreted in the feces.
3. DOR may be bound to CO_2 which is expelled by the lungs.
4. DOR may be lost in perspiration.

Some substantiation for the first and fourth mechanisms comes indirectly from the success of the cloud buster. These mechanisms are as yet unproven rigorously. Is there any

*In *Contact with Space* Reich expressed the view with some experimental substantiation that DOR is a function of O.E. when the latter is deprived of water and O_2.

circumstantial evidence that they exist?

a) Why do we experience a feeling of well-being after vigorous exercise and steam baths—hyperventilation and sweating?

b) Why are constipation and malaise so often associated—blockage of DOR elimination in feces?

c) Why are the recoveries from so many renal and non-renal diseases associated with a diuresis?

One could pose an endless list of such questions. But one can only infer from them. They do not constitute rigorous proof. Many can be satisfactorily explained by mechanistic science.

Since we shall, in a future paper, be concerned with respiration, let us pause awhile on the significance of CO_2. We shall have to "backtrack" and introduce some new ideas. If we follow Reich's idea that color is a function of orgonotic excitation it may provide some insights into the significance of CO_2.

Elemental carbon appears in the free state in nature in two forms: crystalline carbon (e.g., diamonds) and coal. Diamonds are bluish-white; coal is black. Diamonds are formed naturally when coal is subjected to great heat and pressure, clearly an endothermic reaction. It follows then that the color of diamonds is a function of the energy "put in." Even if the classicist argues that the color is due to the structural form of the carbon, it is obvious that without the energy the structure would not develop. Thus, these colors of carbon are a function of its energy. One might also conclude that the energy in the coal is in a lower state of excitation, hence it is black. Coal itself is a product of dead, organic material. It is what is left of an organism after the life energy is gone. As we have intimated earlier, it is the structure without the energy. Now DOR is also black and so is MELANOR, which Reich believed to be a derivative of DOR. DOR clouds are black also. The pollutants from automobile exhausts, incinerators and factory chimneys which may contribute so greatly to the DOR infestation of our atmosphere are primarily forms of carbon (e.g., carbon monoxide, hydrocarbons, etc.) We are hinting at a functional relationship between DOR and "dead" carbon, i.e., carbon without Life Energy.

Reich speculated that the dying of the living organism seemed to be "no more than the dying of the Life Energy itself, the change from OR to DOR."(4) Dying also might in turn be construed as inexorable and uncompensated catabolism. As a corollary, catabolic processes in the normal course of events must produce DOR. CO_2 is one of the ultimate products in the catabolism of fats, carbohydrates, and proteins. In other words, it is what is left after the organism has "milked" all the Life Energy from organic compounds. For this reason, the idea that CO_2 is a carrier of DOR is proposed. Thus O_2 brings O.E. into the organism and in its combination with C brings DOR out. We can see then the vital importance of free, unimpeded respiration and the possible consequences of the disturbance of this function.

Summary and Conclusion

Let us summarize our postulations in the metabolism of the orgone.

1. The superimposition function is the common functioning principle (C.F.P.) in the synthesis of subatomic particles from O.E. units, atoms from subatomic particles, molecules from atoms, etc. (i.e., matter is frozen energy). The two are interchangeable and contemporaneous.

2. The capacity for orgonotic excitation is at the root of the antithetical functions of superimposition (fusion) and disintegration (fission) in matter.

3. The cohesiveness of matter is a function of its orgonotic charge.

4. Energy in some form is liberated in both the generation of matter and in its dissolution, although in each process the energy products may differ qualitatively.

5. Atoms and molecules are pulsatile and excitable much in the same way as living orgonotic systems' stability bears an inverse relationship to excitability.
6. Carbon is a C.F.P. in biologic structure and in all organic matter.
7. While chemical reactions follow the law of positive entropy, orgone energy exhibits negative entropy. Thus orgone incorporation by biological structures always involves energy moving from lower to higher potential. This function is at the root of all biological systems' capacity to function against a chemical or electrical or osmotic gradient.
8. Ionization in aqueous solutions suggests that water *actively* promotes the process by exciting and perhaps taking up the energy which binds the molecular components of solutes together.
9. The important role of water in the generation of life derives from its capacity to attract and hold orgone energy and consequently influence the state of matter immersed within it. It also plays a role in the process of deDORization.
10. The capacity of water to attract orgone may be based on its structural oxygen which appears to be a specific biological carrier of orgone energy.
11. Metabolism in the orgonotic sense represents concentration of O.E. toward the higher charge→orgonomic potential from weaker to stronger system→discharge of potential from higher to lower (mechanical work, growth, etc.) and involves the antithetical functions of superimposition and disintegration (anabolism and catabolism).
12. Chains of carbon atoms in the form of organic molecules of varying complexity bind and hold the orgone brought in by the O_2. Conversely the orgone gives these molecules their cohesiveness (i.e., starch, polymers, proteins, and fats).
13. Catabolism is the inevitable result of the depletion of the binding orgone in the performance of work, growth and development, and the orgastic discharge which are expressions of the orgone's "breaking or moving out" and returning to the orgone energy ocean. Thus, movement and structure are antithetical functions deriving from the orgone itself.
14. DOR may be a natural by-product in the synthesis of structure and is certainly a product in biological catabolism. Its deadliness derives only from abnormally increased production and abnormally decreased elimination due to armoring. DOR represents an alternative function of the orgone when its natural behavior is blocked by stasis, dehydration and oxygen deprivation.
15. CO_2 may be the DOR carrier in the respiratory elimination of DOR. The flow of the urine and feces may constitute additional routes for DOR elimination, each with its own specific DOR carrier(s).

With these concepts as a basis our next paper will resume the consideration of the biopathies with that of chronic obstructive pulmonary disease. In it, we shall have to present a functional reinterpretation of the phenomenon of respiration.

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Do Not Touch!

MORTON HERSKOWITZ, D.O., F.A.C.N.

From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact at this time. Of course, a patient who attempts a hug in the last session after seven years of intense, intensive, and successful therapy should probably not be hurled across the room.

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The Physical "Don't Touch"

Reich said, "To touch the truth is the same as to touch the genitals. Therefrom stems the 'touch-it-not' of anything serious, crucial, 'life-saving,' of anything leading toward true self-reliance." In elucidating the symptoms of the emotional plague he repeatedly employed the "don't touch it" metaphor to describe the avoidance of the essence, the heart of the problem.

Although metaphorical "don't touch" has deep biological roots, touch is the most elemental means of making contact. All mammalian mothers meet their babies by touching. Researchers in the study of newborn and infant development emphasize the importance of caretaker-child contact (eye contact, vocal contact, but primarily skin contact) in the service of the healthy growth of the child. In the community at large it is those with significant emotional problems, the psychiatric patient population, who have suffered the largest deficits in this area.

In making the case for the unique way that touch affects the psyche, a report by Oliver Sacks (1) is instructive. It concerns a meeting with the most unusual victim of autism that he had ever encountered, Temple Grandin, Ph.D. in Animal Science, Assistant Professor at Colorado State University, designer of systems for animal management world-wide.

Dr. Grandin's childhood history was typical for the disorder. At six months she stiffened in her mother's arms; clawed her mother at 10 months. At three she was violent, chaotic, and screamed almost continuously. She said that in early childhood sensations were heightened to an unbearable degree. Probably to escape she developed periods of intense, unswerving concentration on what was at hand. The diagnosis of autism was made at three, and the probability of lifelong institutionalization was suggested.

As a little girl she recalled that she had longed for and been terrorized by the thought of being hugged. When hugged by a favorite aunt she was overwhelmed with pleasurable sensation, but was also fearful of being engulfed. At five she dreamed of a hugging machine that was entirely within her control.

Dr. Grandin suffered from the same alienation as other autistics. Concerning her empathy with other humans she described herself as feeling like "an anthropologist on Mars." But because she suffered from the Asperger Syndrome variant of autism she possessed that special "autistic intelligence" which is unorthodox, original and untouched by conventional thinking.

Through the efforts of a devoted mother and a dedicated speech therapist she learned to master the elements of language in early childhood. This provided entrée into the world of non-autistic humans, and she began to penetrate that world, although always as an outsider.

At 15 there was a critical event in her life. She became preoccupied with the squeeze chutes in which cattle were contained (the tactile, hugging theme revisited). From this she was guided to an interest in animals, biology, and ultimately all science. The language of science was readily comprehended, unlike her grasp of human behavior with its incom-

prehensible assumptions. The deep affinity with cows, which has been a motor force in her scientific work, was based on recognition of a similarity of sensitivities. She explains, "The way I would pull away from being touched is the way a wild cow will pull away—getting me used to being touched is very similar to taming a wild cow."

In late adolescence she began to construct models of her fantasized "hug" machine, starting with the model of the cattle chute. She soon had the finished product, capable of exerting the exact pressures she desired, evoking the calmness and pleasure she had dreamed of in childhood. She kept the machine openly in college, enduring the derision of some visitors and the opinions of visiting psychiatrists that it represented "regression" or "fixation." She alleges that she could not have gotten through college without it.

She has systematically studied the effects of deep pressure in autistic persons, animals and college students. The squeeze machine is currently undergoing extensive clinical trials. Sacks observes that, "She feels that the machine opens a door into an otherwise closed emotional world and allows her, almost teaches her, to feel empathy for others."(1)

The reason for this digression into the case of Temple Grandin is that it serves as an almost perfect example of the exception that proves (i.e., tests) the rule. An autistic person, devoid of the common interpersonal sensibilities, discovers out of her own being the healing properties of touch.

The epigraph, repudiating any physical contact more intimate than a handshake between a psychiatrist and a patient, is from an article on the boundaries in clinical psychiatric practice (2). The boundaries elucidated are frequently referred to in the psychiatric community, and are often used as guidelines in practice. They are designed to formulate proper practices and behaviors between the therapist and patient, and to minimize the chances of the therapist being sued.

Boundaries are, of course, necessary in clinical practice. There must be clear definitions of the roles of the therapist and the patient, the time of sessions, the fee, services performed (on both sides of the relationship), language (particularly as it might be used for countertransference purposes), and certainly physical contact. For example, the authors discuss the case of a male therapist who conducted marathon sessions with his hospitalized female patient between 2 a.m. and 6 a.m., which eventually led to an overtly sexual relationship. As a matter of fact, there are some patients (e.g., borderlines) for whom the setting of limits, per se, has therapeutic value. It is in the area of boundaries for physical contact that difficulties arise.

The authors state: "Instead of engaging the patient in a mourning process to deal with the resentment and grief about the deprivations of her childhood, the therapist who hugs a patient is often attempting to provide the physical contact normally offered by a parent. The patient then feels entitled to more demonstrations of caring and assumes that if gratification in the form of hugs is available, other wishes will be granted as well ... When actual physical contact occurs, the crucial psychotherapeutic distinction between the symbolic and the concrete is lost and the patient may feel that powerful infantile longings within will finally be satisfied." In another place they say: "Clearly, a therapist cannot become the 'good mother' or 'good father' in a literal sense and attempt to make up for all the deprivations of childhood."(2)

These admonitions are peculiarly reminiscent of the warnings of "experts" who, in the earlier parts of this century, advised that to pick up a crying baby was tantamount to creating a spoiled child. The implication is that if the patient's need for warmth and touch is satisfied he'll want the world.

There are two sources for the apprehension concerning touching in psychotherapy. First there is a conceptual limitation; it is assumed that whatever is therapeutic is within the reach of talking heads. Despite protestations of a mind-body continuum, therapy is generally conducted at a level above the neck. And de-

spite acknowledgement that much of the most severe emotional trauma occurs in the pregenital stages at a pre-verbal level, that unless the pregenital deficits are shored, work on the following stages must always be incomplete—touch, a language of the earliest times, is proscribed. Friends, even strangers, may in times of extreme pain or stress offer the comfort of touch. But it is outlawed for psychiatrists.

Unfortunately, most psychiatrists have not experienced the patient's crying over today's pain which, when empathic touch is added, changes in quality and moves back in time to a childhood scene, or to the crib. And if many psychiatrists are unpracticed in the comforting and supportive way of touch, all but a very few are unfamiliar with the orgonomic uses of tactile stimuli in dissolving armoring. Not all tactile contact is therapeutic. There is cold touch and hostile touch. There is unfeeling touch, as in "hugging therapy" where patients are hugged coming and going, routinely. And there is sexually provocative touch, which is counterproductive to the process of therapy.

The conceptual limitations are not the primary reasons for declaring most of touch beyond the boundary of proper psychotherapy. The essential problems are sex and litigation. The greater number of malpractice suits instituted against psychiatrists are for reasons of sexual misconduct or alleged sexual misconduct by the psychiatrist. There is no doubt that sexual impropriety occurs between some therapists and their patients, and it has a history going back to the psychoanalytic forefathers. This despite the teaching in every residency training program that a sexual relationship makes a therapeutic relationship impossible, that it is a misuse of the psychiatrist's role, and that it indicates a countertransference gone awry.

Given the fact that sexual misconduct occurs in psychotherapy and that it leads to lawsuits, the answer that occurred to the authors of the "Boundaries" article was to separate the therapist from his/her patient by a no-touching zone. But if it is true that there are unique therapeutic qualities in touch, then its banishment would be of a similar order to banning the performance of hysterectomies because too many gynecologists have removed too many uteri unnecessarily. The patient is ultimately penalized for the therapist's misconduct.

The solution to the problem of the psychiatrist's sexual transgressions is not simple. Reich advised that therapists whose sex lives were unfulfilled should withdraw from conducting therapy on patients who might be sexually attractive. At its root the problem is one of character. Does the therapist have sufficient personal integrity to subserve his/her own temptation to the larger purpose of the implied therapeutic contract with the patient? An absence of touching will not keep a flawed therapist from pursuing his narcissistic purpose. He will be characterologically incapable of sustaining the categorical imperative—no sexual interplay!

As regards the threat of lawsuits—one of the factors emphasized in risk management is that the *absence* of old-fashioned warm, human contact between physician and patient is one of the causes of the phenomenon of litigious patients. Too often patients feel like (and are treated like) bodies with diseases, rather than as persons troubled with ailments. The warm, honest contact of touch emanating from genuine concern for the patient should decrease, rather than increase, the tendency to sue. In the cases of factual sexual malfeasance the vigorous prosecution of transgressors should be supported by the psychiatric community.

The Metaphorical "Don't Touch"

It is difficult to determine where to begin in discussing contemporary psychiatric avoidance of the essential. The problem is made more interesting by the fact that on one hand there have been remarkable advances in psychiatry in recent decades.

The pharmacological discoveries of recent years have revolutionized the symptomatic treatment of depressive and bipolar disorders, schizophrenia, attention-deficit hyperactivity disorder, manic manifestations of organic disorders, obsessive-compulsive disorders, etc.

The psychiatrist must no longer wait for months for the hallucinations of his psychotic patient to diminish. He can be reasonably assured that the intramuscular Haldol will quiet the violent patient, and that in most cases the antidepressant will ameliorate the patient's depression.

Moreover, new imaging techniques have enabled us to visualize the brain areas that are dysfunctional in many of these disordered states. We know a great deal about the anatomy and chemistry of psychopathology that was heretofore unknown. Armed with this knowledge a psychiatric colleague announced, "I no longer treat people; I treat the limbic system." And therein lies the rub.

To a large extent psychiatric treatment has become politicized. As the politician, faced with rampant violent and amoral behavior, thinks in terms of more capital punishment and a vast prison system (an immediate means of quieting the apprehensions of a restive voting public), the psychiatric community is now preoccupied with the quick elimination of troubling symptoms. That symptoms can be expeditiously (relatively) allayed is, in itself, a boon. The qualifier is that an unreal reliance has been placed on their efficacy. Our city streets are peppered with patients who, having been given their "fix" of neuroleptics in their last hospital stay, now take their rest on the warm street vents and hold conversations with the mannequins in the store windows. When they throw stones through the window or threaten the passers-by they will again pass through the revolving doors for the next series of neuroleptic doses to quiet them. Likewise, each attack of the panicky people will be subdued with medications with an increasing tendency to ignore the source of their anxieties.

A recent compilation reveals that at least two-thirds of the Axis I psychiatric diagnoses (the classification of major mental disorders) are accompanied by Axis II diagnoses (the classification of personality disorders). The obvious fact is that the symptomatology of the mental disorders rests upon the substrate of the character disorder, that the character disorder is the soil in which the mental disorder grows. When we address only the symptoms of mental disease we are left with the fouled ground from which the symptoms issue.

To assume that our discoveries of the biochemistry of behavior finally answer the problems of mental disorders is an act of psychiatric denial. No component of the physiologically reactive system is an island. Nerves, blood vessels, muscles, the lymphatic system, enzymes, hormones, neurotransmitters act upon and are acted upon by one another. All are reactive to environmental influences. Although psychiatry has acknowledged the influence of environment on character formation (and its physiologic substrate), there has been a recent tendency to act as if the chemistry were all. Just as in the case of denial in the alcoholic the motivation is to avoid dealing with the troublesome and the difficult, and to pretend that the problem does not exist.

The downplaying of the emotional sources of mental dysfunction evades the need to deal with the hard questions of human unhappiness. If the pills on hand fail to answer the constraints of bodies, thoughts, and actions of an armored human race, the thinking goes, then we must locate more neurotransmitters and new chemicals.

The poet laureate, Rita Dove, speaks of society's tendency to neglect care for the "Interior Condition." She assumes that addressing this need is one of the roles of Poetry. The disregard for and inattention to "Interior Condition" in most of the managed health care systems marks a frightening new turn in psychiatric care in America. The dollar is the determinant of what is treatable. The most acutely troublesome disorders will be fundable for hospital care (for the shortest possible time, i.e., until the patient is quieted). For those patients who do not require hospital care the therapy will be provided at the cheapest possible rate (psychiatrists are often too expensive to provide any function other than writing prescriptions), but only for those symptomatic disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders*, which does not provide names for many of the problems

that confront the hosts of people who suffer "lives of quiet desperation." There are no categories for the inability to establish intimate relationships, for those with devalued self-image, those who cannot tolerate pleasure or energetic expansion, etc. By denying sufficient therapeutic intervention in those cases which do not carry a *DSM-IV*, Axis I diagnosis, the managed care system declares that the patient's internal compass has gone awry and that the patient's symptoms are not equal in significance to the cost of treating them. In one managerial stroke it declares that Freud's discoveries of human behavioral disorders and Reich's revelations of the development of armoring and its effect on a world of "Little Men" are not pertinent to its business, except in the most peripheral sense.

This penny-wise policy not only places a mean value on the depth of a human life, but is pound-foolish. Recent research has shown unequivocally that there is a complex interaction between psychological states, environmental pressures, biological events and health status. The immune system responds to chemicals secreted by the central nervous system. Exposure to chemicals produced by the brain under stress increases susceptibility to disease. Moreover, studies undertaken in psychoneuroimmunology (PNI) reveal that psychosocial and behavioral interventions in patient care have the potential to not only improve the quality of life but to increase survival rates as well as decrease the cost of health care. Saving the penny today may cost many dollars later in life. The mind-body connection apparently goes as deep as Reich knew.

As we continue to keep patients at bay, physically, to rely on medications and withering psychotherapeutic time to treat their wounded spirits we get farther from effective treatment. The current defensive, anemic stance of psychiatry not only fails to address the real needs of our patients, but it stigmatizes the profession. There is no mystery about the fact that American medical students are no longer seeking psychiatric residencies. The profession that once ignited imaginations has become a business, and not a great one at that.

To have gotten so far off the track in addressing real needs is not unique to psychiatry. Penelope Leach has a list of reforms necessary for treatment of children's problems. For example, she writes, "Current debate about daycare is wide-ranging, but it is more about finding solutions to daily cares that dog parents than about finding kinds of care that meet children's needs. A child-centered agenda produces a very different debate.

"Adult society is highly competitive, but children's development is a process, not a race. Children mature faster if parents let them take their own time; farther if parents broaden and share their experiences rather than pushing them down an achievement track.

"Society relies on childhood socialization to produce good citizens but keeps child-apprentices in a separate world from the adults they need to emulate. Instead of learning to do as adults do children are expected to do as adults say. Discipline that is achieved by the exercise of power can never be as effective as self-discipline achieved through influence.

"There are better choices for children available to us. We are not making them because we are not seeing them. We are not seeing them because we are not looking."(3)

Caring for the needs of children and of psychiatric patients are the two ends of the same problem. There is a high price to be paid for avoiding the real problems of people.

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Human Armoring
An Introduction to Psychiatric Orgone Therapy*

MORTON HERSKOWITZ, D.O., F.A.C.N.

Chapter 9
The Therapist

The Taoists have a saying: "When the wrong man uses the right means, the right means works in the wrong way." In accordance with this principle, there is a concerted effort in orgonomy to insure that the "right" man is in charge of the means. In the United States every orgonomist must be a physician. This requirement is established because, although some psychologists are competent to deal with the psychological aspects of therapy, medical training is considered essential to understanding and treating the body as one does in medical orgonomy. Moreover, the aspiring therapist is required to obtain certification in his specialty (usually psychiatry, but certification in internal medicine or obstetrics, for example, is acceptable when the therapist's orgonomic interests lie in these directions). Certification is required to assure classical competence in the field. In addition, the aspiring orgonomist must be trained for several years in didactic course work, laboratory courses, seminars, and supervised therapy before he is considered ready to treat patients.

The therapist must reach an established level of biophysical freedom in his own structure before he is permitted to treat patients orgonomically. The most important prerequisite is the stability of the therapist's character structure and his ability to pulsate freely and to feel and express his full range of emotions without anxiety. He attains this first, through whatever good fortune in childhood kept him relatively alive emotionally, and then through his own therapy, which unties his knots.

In orgonomic work, competence and health vary from time to time. Each of us carries the hidden traces of his sickness. It is presumed that the therapist has reached that state of perception in which he can recognize his sickness if and when it reappears. If it is only mild, he must be aware of it in his dealings with his patients. If it is severe, he should withdraw from professional contact with his patients until he has recovered. I am not speaking here of such sickness as psychotic breakdown, but of the emergence of character traits that do damage to his patients.

If, for example, personal anxiety should temporarily prevent the therapist from being able to admit that in a given situation he is wrong, or from understanding what is going on, then he stands in the way of his patient's growth and development. Or if he fails to confront a patient who is abusing the therapeutic situation, he is failing the patient again.

The patient often attributes magical virtues to the therapist and can be disappointed, sometimes vengeful, when he discovers the therapist's feet of clay. The therapist is supposed to never get sick, to always be happy, to have the perfect family. There is a certain logic to this expectation. The therapist who is constantly sick, who is living in a bored, inert marriage would certainly be suspect; but the perfection that the patient seeks is often unreasonable.

Although the therapist should be energetic enough to keep the treatment alive and mov-

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ing, some days he feels that there is a boiled onion where his brain should be. He does not see what there is to be seen; he feels nothing. On such days he would be a boring companion, let alone therapist. On these days he plods mechanically through his work, rousing himself as much as possible. Something is accomplished at such times by patients who are already moving and no longer depend on his energy. For the others, not much may be achieved except that they learn that sometimes the therapist is as dead as they.

On other days, the therapist's perception crackles. With each succeeding patient, he sees subtle aspects of the body armoring or behavior that he missed for months. These exhilarating days neutralize those times when, after three depressed patients in a row, the therapist feels as if the life has been blotted out of him. On these unusually good days, the contact with patients is mutually enlivening. There are other times when the therapist is especially sensitive to armoring in a particular segment. This is probably a reflection of unusual vitality of that segment of his own body at that time.

In spite of the highs and lows of his energy system, the therapist must have a steady sufficiency of energy over the long period in order to conduct therapy successfully. His energy and stability tide him and his patients over the times when he adds two and two and concludes that the sum is five, when he is grouchy and unreasonable, when he forgets what the patient has already told him, and when he inflicts his enthusiasms and his prejudices onto his patients.

Because the therapeutic technique is potent, it carries the potential for great harm as well as good. There are heady adventurists in the psychotherapeutic professions who, untrained, have "borrowed" from Reich and injured their patients, physically and emotionally. With a technique that can be physically painful, there must be assurance that the therapist has no hidden characterologic reason to inflict hurt. In a therapy involving physical as well as deep emotional contact, in which sexual energies are freed, the patient must be insured against the abuse of the professional relationship. Reich was strict in this matter. He recommended that any therapist who, because of life circumstance, was temporarily unfulfilled sexually should withdraw from conducting therapy with members of the opposite sex until the problem was solved.

The therapist's basic character structure will show in his work with patients. There are "tough" therapists who conduct therapy in a predatory fashion; they are especially helpful to patients with a bag of sneaky tricks. And there are more paternal (or maternal) therapists who establish contact with patients with long histories of abuse. In the course of his own therapy, each therapist should have uncovered enough of his own soft self to be sensitive to the delicate qualities of his patient, and enough of his own aggression to pursue his patients' defenses rigorously.

Contrary to many patients' expectations, the therapist is not a paragon of health. Somewhere there are persons who, by virtue of genetic endowment, rare straight and sensible parents, and smiling fates, have never heard of Reich or orgonomy, but who have achieved a natural level of health beyond that of the therapist. And every experienced therapist knows that some of his patients have achieved a fuller level of health than he. No matter—perfection is not a qualification for conducting useful therapy. A sufficient characterologic restructuring and a comprehensive education in understanding the disease processes are important in helping the orgonomist to be a decent and thoughtful guide to the misguided.

The therapist is obliged to keep his own house in order. If he pussyfoots in any aspect of his life, his work with patients will eventually bear traces of pussyfootedness. Like his patients, he should exercise regularly and provide adequately for play, vacation, and the pursuit of other interests so that he can be continually renewed. He must always be on guard against the reappearance of his own armoring and take adequate measures against it when it occurs. He must maintain his contact with his own nature so that he can distinguish between the real and the assumed.

Clinical Symposia

The Clinical Symposia appears 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.

June 7, 1992

Participants include: Drs. Irmgard Bertelsen, Robert Dew, Karl Fossum, Lynne Hagelin, Morton Herskowitz, Louisa Lance, Arthur Nelson, Carol Stoll

Note: To assure confidentiality, seminar participants have been assigned italicized letters in the discussion that do not correspond to their names.

WHAT WORKS AND WHAT DOESN'T IN ORGONE THERAPY

Dr. A: Last time we discussed aspects of orgonomy that were written about, or that we talked about from "the old days" that may no longer be either pertinent or true or applicable to treatment. We decided to continue the discussion. We spoke about the changing climate in the social arena—the fact that there is a litigious atmosphere, especially with the heightened sensitivity about appropriate boundaries between therapists and patients. Certainly these concerns have an impact on the kind of therapy that we do. So, let's continue our discussion to clarify what still is pertinent to therapy and what is not.

Dr. B: I reread most of *The Function of the Orgasm* and the single thing that struck me more than anything else is how well orgonomy has held up—not how much has fallen by the wayside; but it's hard to put your finger on where we're misdirected.

Dr. A: Yes, I don't think there is much that's "off the wall" in orgonomy. I believe that there were some misdirections, such as the fact that Reich gave very little importance to genetic influences. I think there are corrections to be made in our practice based on essential information that has come out since the time of Reich. But I believe that, essentially, the substance of orgonomy is mostly right on the mark.

Dr. C: I'd like to make an exception to that, Dr. A, and that is—how should I say it without being provocative—the foundation of orgonomy is based on Freudian psychoanalytic theory. I think that the issue of women and their development has been largely distorted by the kind of thinking that considers that the psychological development of men is the standard and that women's development is compared to that standard. Until recently, women's development has been written by men. Now, with all the newer developments in women's psychology, we know that women's development is fundamentally different and cannot be compared to men's.

Dr. A: Can you give us an example?

Dr. C: Well, for one thing, I don't think that women's psychological development is in reaction to not having a penis.

Dr. A: Did Reich say that?

Dr. C: Well, since orgonomy has a psychoanalytical basis, I believe that it is a core assumption. From Reich's writings and his personal history, I don't think that he thought of women as separate entities. So I don't believe that he thought the problems and the developmental issues through, in a way that I think has been done more today—some wrong, some right. Women's psychology is still evolving but we do know that women are different creatures from men. The issues with respect to relationships and relatedness are different depending on gender, and I think the therapy is different with men than with women, although the ener-

getic principles may be the same. Feminist psychology hasn't considered the energetic basis of neurosis, as far as I know. It considers the psychological factors and the relational issues, and it's not psychoanalytically based. As a matter of fact, it is the antithesis to psychoanalysis and penile development. I believe we should try to educate ourselves more about the current feminist thinking in psychology, for I think that it's more true than not because feminist psychology offers a descriptive psychology of how women are "wired."

Dr. D: I agree that a good deal of psychoanalytic thinking is being questioned and that we need to consider new findings and developments. I wasn't here the last time, but I would like to say that I think the profundity of orgonomy, which is based upon the energetic/physical concepts, is still very, very valid. I believe one of the problems, at least in my development and my practice in orgonomy, is how to make the profundity work. What we have not been taught, and which I believe is extremely important, is how to really relate to the patient. You're not going to get to the patient by saying, "Breathe and roll your eyes," as one of our former leaders believed. The question is how to establish genuine contact and effect characterologic change.

Dr. E: Dr. D, I think one of the reasons we don't know how to get to people more effectively is that we don't really have enough of a theoretical understanding as to how energetic processes operate in the development of the human being.

Dr. D: You can't divorce energetics from psychology. How to reach the other person is a question of how deep you can go into yourself vis-a-vis the patient. Character analytic work involves somehow reaching the other person with your own soul. I think with a lot of us in our orgonomic training, character analysis has not been emphasized enough.

Dr. G: I would agree with that. I've seen that, without touching patients, without putting them on the couch, that a systematic approach to the defenses and dealing with resistance can be the approach used by Habib Davanloo. Davanloo comes closest to succeeding in this. It is a much more systematic approach than I was taught. As a matter of fact, I don't recall really being taught a systematic approach. For one thing, we were given a list of character structures—and I think there's validity in some of Reich's ideas about the character structures, although I think it's rather incomplete. But we were never given a way of how to get into any character structure—just a kind of plan of dealing with resistance, regardless of the character structure. Davanloo, it seems to me, has made great advances in that regard.

Dr. F: In the earlier training with Reich, was that dealt with?

Dr. A: You know, one thing that has been promulgated for a long time is that the character types delineated by Reich encompassed all of human character. If you read *Character Analysis* it's very clear that Reich says, "and here are a few clearly delineated character types." I know that Reich thought that most character types could not be pigeonholed. But it has come down through the generations that this is all that exists, and you've got to fit everybody into these types.

Dr. G: That's right—that's exactly the impression that I got!

Dr. B: Our thinking has been based on the stages of psychosexual development and our diagnostic groupings are based on that, as is our whole approach to patients. If that premise turns out to be invalid, you have to go back to square one and start from scratch. I don't know that we have anything to replace it with at this point.

Dr. C: I'm not sure that that's true. I think that if you are sensitive to people, you can tune in to their pain and suffering and deal with things in an organized, empathic way and not go too deep into their character structure until the patient's ready.

Dr. B: It sounds like you are in favor of a more intuitive approach. I still believe it would be helpful to have a more systematic framework to work within. I think the old framework is falling apart.

Dr. E: We don't have a theoretical basis for understanding that person in front of us. Elsworth F. Baker in *Man in the Trap* delineated the character structures in ways we could apply to patients. But over time, we have discovered that the theory is incomplete. In orgonomy, we understand certain fundamental energetic processes, but we don't know how those processes operated to give us the person who presents to us. And I think of Davanloo, and then I don't disagree with anything you all were saying about the way to approach the patient in front of us. Davanloo has a therapeutic approach, but doesn't seem to give a theoretical understanding behind it. That has been my impression.

Dr. H: Actually, Davanloo does address some of that. That's one of the things that Dr. G and I wanted to bring up, to see if people would be interested in having Davanloo conduct some seminars for our group. They do have a systematic approach to character resistance, which I never learned.

Dr. D: By the way, some of the people in the Philadelphia area who studied Davanloo are now interested in AET—Accelerated Empathic Therapy. All the Davanloo people began to share (at least this particular group which is based in Danville, New Jersey) their experiences, and they began to change the Davanloo method because they found that a lot of patients do not respond to his confrontational approach to resistances. As a matter of fact, they become even more resistant. Over a period of years they developed another approach which allows more people to be treated than the original system. These are people who have done the original Davanloo work for eight or 10 years. I've been involved with them, and all I can say is that I've used AET with patients who had been in orgonomy for 20 years, and it really opened them up infinitely more than I accomplished before.

Dr. C: I guess I have a problem constricting my thinking to any one specific discipline. In my psychiatric residency training we learned about everything, some of which seemed ineffective and some of which was profoundly correct. Because we don't have an understanding of the way the brain fits together with the body, I think we're always going to be searching, and there may not be a single theoretical structure. We learned psychopharmacology, psychoanalytic techniques, Jungian analysis, and the different varieties of behavioral therapy. I've probably used them all with different patients in an effort to understand them better. And I'm not sure there's one construct to use with patients unless you go into the biology and the DNA; we're not there yet.

Dr. D: The AET people recognize that. They use elements of Jung, Gestalt, imagery, role playing, etc.

Dr. I: I don't think that those of us who are still students are even familiar with all the techniques that the senior orgonomists use. I would like this seminar to reintroduce actual interviews with patients so we can get some feedback.

Dr. G: I agree. Watching the tapes that people make in the Davanloo seminar is a really tough experience. It's embarrassing because you're sitting there and you can imagine yourself in the doctor's position. You see what everybody's doing wrong, and the guy who runs the seminar is very sharp and he hits on all the instances of what you could have done differently and more effectively.

Dr. H: He also points out the countertransference in the therapist.

Dr. G: Absolutely. It's a major point, the countertransference.

Dr. D: In the New York seminars on orgonomy we never even touched on that.

Dr. G: As a matter of fact, what they seem to be saying is that, aside from sheer ignorance, unawareness of the countertransference can be the most destructive element in treating people, i.e., where treatment goes wrong.

Dr. B: Do they see it in purely negative terms, or do they see its positive aspects?

Dr. G: Dr. H, do you remember if they referred to the positive aspects of the countertransference?

Dr. H: Yes, they discussed that it is often positive. It can reflect what works and what doesn't work and whether therapy has caused change in the patient. Going back to what Dr. A mentioned before, we're seeing many more patients who have been sexually or physically abused—more posttraumatic stress syndromes, and I think we need to consider what our approach to these patients is now.

Dr. B: Did Reich ever talk about that?

Dr. H: No, because then it was still considered mostly the fantasies of hysterics.

Dr. D: Alice Miller addresses that. She's been talking about it for 20 years. But let's go back to what works and what doesn't. A really good way of learning is doing tapes and then watching them.

Dr. E: I remember when you brought a video tape to New York.

Dr. D: 1967—I must have been the first one in psychiatry. I had an original reel-to-reel video tape recorder, and everybody was scared! Elsworth Baker didn't want to do anything with it so it just faded out. It would have been a wonderful way to learn from your mistakes and get input on what you were doing.

Dr. E: Let me bring up another wrench in the gears, and bring it back to the issue of orgonomic contact. How many of us working with patients use our own orgonomic contact in assessing, energetically, where a patient is disturbed and utilize that in the context of a session? I think it should start when the patient first walks in the door.

Dr. J: It takes just a few seconds to clue yourself in to that subtle energy. Orgonomic contact should be used to continuously assess the patient.

Dr. G: If you do something that works, you are affecting the person's energy because nothing can happen in the world without energy. Every movement, whether it be sick or healthy, is an energetic phenomenon, so whatever you use that works, you're dealing with energy.

Dr. J: I was trying to tie together the idea of all these other theories that have been put out, to bring it back to how they relate to orgone energy and orgonomy.

Dr. G: Any good therapy is attempting to get energy moving more effectively.

Dr. H: But also keeping in mind Reich's framework in terms of the direction of the movement of energy, I think that is still extremely valid. Whether you're talking psychologically or orgonomically, you're still working from the top layers down.

Dr. K: Yes, I think that it is important to have a clear theoretical framework because patients will offer a lot of things at once. You do need to know what to proceed with first and what to table for awhile.

Dr. G: Another thing that was really wrong in my training was that I think a lot of people got the idea you could plow right in without giving consideration to the fragility of the patient and what they were ready for. I got the idea that you could put people on the couch right away and start "attacking" the armor.

Dr. E: Maybe that idea came about because we really haven't been taught how to look at the patient. We don't have a theoretical understanding, in energetic terms, of how a child develops. We have the psychoanalytic developmental theory, but we've never taken that

apart energetically and looked at what makes sense and what doesn't. We lack that. We've got this profound understanding and all this experience in working with patients and in our own therapies, that energy really exists, that it is absolutely crucial. It is not understood by the vast majority of people that practice in our field, but orgonomists have never developed an energetic theory of development. All we've got is Reich's description of the armoring process which occurs at certain developmental stages which, I believe, helps us understand neurotic symptoms. But we know nothing about the development of energetically healthy organisms. And I think as a result of not having a good theory, then we don't know the right questions to ask of that patient in front of us. For instance, I believe for most of us who have children, it's very clear that certain aspects of character are inborn. If we knew how to ask the right questions in our initial two or three interviews, or if we could bring the mothers or fathers in, or if we saw video tapes of them as little kids, I think we would get a much more accurate picture of the basic inborn, hardwired character. That would clear up a number of questions about how we should proceed amidst the clutter of "theories" that exists.

Dr. J: I think that's beautifully said. Over the last three years I've seen a lot of abused patients, and one of the things that I ask those patients to do in the first couple of sessions is to bring in their family albums. You get a chance to see a broad range of emotions on the face of that patient when they're one, two, three, four, five years old, and you get a good bit of information from that. You can see terror in the eyes of a baby, you can see that hidden, shrouded eye gaze in a lot of abused children when they're a year and a half or two years old.

Dr. C: I too ask patients to bring in their family albums and we sit together and look through them. It has been a profound experience, especially with people who have been abused. Sometimes it can give clues as to what is genetically determined as opposed to environmental influences.

Dr. J: It may interest you that David Boadella has some very fascinating concepts of energetic development that he ties into embryology, which he calls "maps of character."

Dr. G. Dr. I, when you said you would like to know more about the kind of techniques to use, can you expand on that a little bit? What, as a trainee, do you feel you need to know?

Dr. I: I guess that what occurs to me, having had experience with four different therapists, is that they all treated me a little differently. I tend to fall back on the techniques that were used with me, and I assume that if it were not used with me, or it doesn't occur to me, then I won't use it either.

Dr. G: I've been thinking in terms of what training we're doing and what therapists want to know.

Dr. H: When I started practicing, I thought that my chair should be on the other side of the room because that's where my therapist sat, but I couldn't stand it because I felt too far away from the patient. I think that's what happens—your own person eventually comes through when you start using orgonomic methods according to your own style.

Dr. L: I realize that not just one approach can be applied to each patient. It would be useful to have a demonstration of an initial approach to a patient on the couch and then to discuss how others would have approached it. This would allow us to see how different personalities can apply the various techniques.

Dr. D: I can say something about that. A few years ago I attended a seminar where Davanloo explained how he developed his theories. He said that what started his interest in the technique was the video. He started to tape all psychoanalytic sessions, and he spent thousands of hours viewing taped sessions. He began to catalog what interventions worked and what ones didn't. And he said after looking at literally thousands of hours of sessions,

he finally developed his own way of handling resistances and transference and countertransference.

Dr. K: I think it might be helpful to have the tapes, because when one person presents the case, everything is seen through their eyes. But if we all saw the patient, we might see things a little differently. This would stimulate discussion and perhaps generate new ideas. We could talk about it, we could correct ourselves, or gain new insights. We could observe how the armor is manifested or how the energy is blocked and then we could try to keep those ideas in mind when we actually do therapy.

Dr. I: Dr. A, did you say that Dr. Reich actually brought patients to clinic?

Dr. A: In Forest Hills, there was a regular clinic, and the orgonomists would bring their problem patients. Patients, of course, had consented to be interviewed in front of the whole group—and Reich would examine that patient with all of us present. I remember the thing that was most interesting to me is that I was always impressed by his lucidity and his genius. I think he also made a point of showing what a genius he was. But there's no doubt that it was valuable.

Dr. H: Somebody else pointed this out too, that although we were to see the same patient, people would see different things and probably there would be a wide range of approaches. If people were to bring videotapes, we wouldn't have to feel like there was only one way to do it, that there can be many approaches to a patient, but not necessarily a particular right way. I think there's a reluctance for us to interview patients in front of a group because, although feedback can be constructive, it can also be painful. But, we would learn from it.

Dr. A: I think all of us would like to have a nice formula by which to work, so that we'd be sure of what we are doing and have this little framework that made us comfortable. But life isn't like that!

Dr. H: I agree totally. If there's too much technique, it can also become mechanical. Then you have a recipe, but it may not work.

Dr. A: Yes, and it is just so complicated that sometimes you make what seems to be a mistake, and later it turns out to prove very valuable.

Dr. G: I remember hearing in one of the seminars early in my training, that when you take the history you don't make any kind of comment or intervention. That's wrong, absolutely wrong. Because even if you make an empathic intervention, you get more history. You can get the person to open up more; so that was one bit of didactic material that was wrong, although I guess that being silent is psychoanalytic in origin.

Dr. B: Do the Davanloo people use a fixed duration for each session or are they flexible?

Dr. G: The first session is usually a couple of hours long and then about an hour in length after that. I don't know what they consider a cure. My feeling is that their orientation is if certain goals are established at the beginning—when and if they achieve them, that's it. But I don't think they have the kind of goals that we have in orgonomy, which is to eradicate the tendency to revert to the neurosis by eliminating the deep stasis underneath it. I don't think the Davanloo people have any conception of that.

Dr. D: I think they generally go for symptom removal plus characterological changes so that the patient says, "Gee, I feel I've gotten a lot out of this. I feel like maybe I should stop." And the patient's life has improved and he's more or less content with his life.

Dr. G: Which isn't a bad spot to be in!

Dr. H: So I think everyone is struggling with how to treat patients more effectively.

Dr. D: I think orgonomy, so far in my development, has been the most profound thing I've seen. But it hasn't worked in the way Reich

conceived it. That's why I'm always looking at other modalities.

Dr. H: But don't you think that's because, with any new discipline, adherents don't dare to change things for awhile and stay more doctrinaire? People are probably afraid to introduce new techniques because they may be seen as diluting rather than enhancing. If there is a better way to approach character, I want to learn it. But, if somebody is out of balance biochemically, I'm still going to use an antidepressant. It's all a matter of learning how better to help patients, and it is all basically energy work.

Dr. G: It can't be anything else.

Dr. J: That's what separates orgonomy, really, from the other streams of thought. We're dealing with the energetic basis of life, and what we're talking about is how we can add to the original body of knowledge based on new findings.

Dr. A: Reich implied that at some future time we might be able to work on the physical armoring and avoid talk altogether. But it seemed to be a kind of undefined goal. Maybe he did character analytical work on me, but I don't know how much he had done 10 years before that, because he certainly did a lot of biophysical work, too. I don't know if he was really becoming less interpretive and more biophysical in his work as he was going along or not.

Dr. G: Dr. E said in the last seminar that he didn't consider himself an orgonomist. We talked about it, and I think the way it came out is that he decided he still was an orgonomist but the reason that he thought he wasn't was that the idea of how orgonomy was supposed to be was a rigid idea of what orgonomists do and don't do.

Dr. C: When patients first call and ask, "Are you an orgonomist?" I say that I'm a psychiatrist, that I certainly use some orgonomic techniques, but until I meet you and make a working diagnosis there's no way that I can tell you how you'll be treated. But we'll come up with a plan that we will both agree on. Some people say, "Well, thanks. Bye," because they want a guarantee that they can get on that couch and do things their way. So, therefore, I don't say I'm an orgonomist per se because that seems to imply a sort of rigid doctrine—that no matter what the disease process is you're only put on the couch and treated in a certain kind of way. And I don't adhere to that at all.

Dr. H: But I'm sure even Reich didn't do that.

Dr. J: One of the things Reich said—and I think I can get close to quoting him—is that anything that moves energy is orgonomy, regardless of the technique.

Dr. H: I think he also said that orgonomy was not for everyone.

Dr. J: Whether it's character analytic technique or biophysical work, our orientation is toward moving energy.

Dr. D: Reich also said that if patients wanted to keep the status quo they were not candidates for orgonomy.

Dr. C: But all psychiatrists want to avoid stasis. That's good medicine, isn't it? If a patient's immobilized and depressed, you have to do things—be they biochemical or physical or interpretive—that are going to get them moving.

Dr. J: Clearly the seminars with Elsworth Baker espoused adherence to a rigid doctrine. That's why we're currently struggling with this. We're looking for more theoretical and scientific bases for the techniques we use. The aim is to not be more rigid, but to be more inclusive.

Dr. K: We do want to move energy, but we want to move it in a certain way. We don't want the chaotic movement of energy. I am still awed sometimes by the profundity of Reich's work. And it doesn't mean that I buy everything that he said or that I don't think that there's a lot missing or wrong with it. But there

is something that touches me when he says he goes deeper than a lot of the other therapists who stay superficial. They do move energy, they get patients going a little, but they don't get people really in contact with their innermost, deepest longings. And Reich did that. I don't want to lose that, because that's what drew me to him the first time I ever read him. That's what I would like us to be able to understand better—how to get people in touch with their core feelings.

Dr. C: But maybe it wasn't just orgonomy. It's also who Reich was—and perhaps each of us can do it on a deeper level as we can depending on who we are. And it may be less related to technique, although we certainly have to have knowledge and understanding in order to make a diagnosis and work with people, but maybe it's equally important who we are as individuals. It could be that Reich happened upon this because this was *his* way, and we have to find our own variations of the techniques because of who *we* are.

Dr. E: But that sounds so atheoretical.

Dr. A: Yes, but I think atheoretical is right on the mark also. You know, I tell people that I think essentially psychiatrists are born and not made. I can remember a long time ago, that one of the big shots from the College of Orgonomy was doing his residency at the time, and he came to a seminar with a tape demonstrating the kind of work that he was doing, of which he was very proud. I listened to that tape, and I said to myself, "You will never make it." In my opinion, he hasn't. He was flying high, he was going great in his residency, but he just did not have it! I think what Dr. C said is absolutely true. I think that everybody "does" therapy in his own way. The most profound things that happen in therapy are a result of your own character structure. You can learn techniques and you can see how other people work—which will help—but I think that's not what turns out to be the bottom line.

Dr. E: And what turns out to be the bottom line is ...?

Dr. A: Your own character structure and your own empathy and the depth to which you can feel and recognize the feelings of others.

Dr. F: What I have noticed is that most people are not aware of what we call *contact*—of being in contact or out of contact. It's a state of being in contact with their feelings. Using breathing and eye work seems like a very important technique to begin the process of looking inward to see what's going on in their body, to get them in touch with their feelings. From there, you can proceed with other methods we've evolved. But we do offer a better definite beginning and a distinct differentiation from other modalities.

Dr. H: A lot of people can move energy, but the system Reich describes is moving energy in a specific direction so that, hopefully, things unfold in an orderly way. I think what we have that is the most helpful to patients is once they start to be in contact and the more integrated they are in the head segment, then things are much clearer in general. Then you can start to see some real character changes.

Dr. G: Yes, and the appropriate discharge of the energy is just as important.

Dr. E: I don't disagree with what Reich said about the therapeutic factors and the curative factors. However, if we can't describe it in some way and if we can't study it scientifically in some way, if we can't quantify it in some way, then aren't we just faith healers?

Dr. A: We're not faith healers any more than the doctors who give Prozac are faith healers. I went to a lecture on depression yesterday, and the man was talking about the biology of antidepressants. He went on to prove that we don't really know what is happening. We have this whole class of drugs that all do one thing and they cure depression, but here's another drug that does the opposite and it's also curing depression. He made that point several times. So, despite the fact that we know that Prozac works, and that serotonin and norepinephrine have something to do with it, there still are a lot

of question marks. I think you have to acknowledge that medicine is both a science and an art, and in psychiatry it happens to be a little more art than science. Also, having gone through our own training, we all operate within a framework of a discipline, so we're not just loose cannons. We do something within a framework which involves a great deal of art.

Dr. D: Changing the parameters of the framework might make it more effective.

Dr. H: Psychiatry has changed so much in terms of what physicians and patients know, what patients are looking for, the kinds of problems that they come in with, and the different levels of honesty and depths that they present with. Not only in orgonomy are we questioning what we're doing, but I think all of psychiatry is questioning what they're doing in order to find more effective ways of helping people who have been severely disturbed in their life functioning. Actually, I think orgonomy is going through the least changes in some ways. Analysts are beginning to talk! Can you imagine what that's like? There are some psychiatrists, the chairs of major psychiatric departments in the U.S., who say that psychiatrists should only be giving medications, and that's all!

Dr. J: Leave the therapy to the social worker!

Dr. B: It may be that, in some real way, we are faith healers who tell ourselves we're scientists, and we just pretend to be scientific.

Dr. J: One of the things Reich said had to do with the fact that therapy was the process of interaction of the energy fields between the therapist and the patient, and part of our job as therapists is to use our orgonomic contact in a healing way; and that's part of what it takes to see where patients are stuck. We use our energy field to its capacity in order to generate an energy field to help the patient. Is that not what charismatic faith healers may use?

Dr. H: But you're doing more than that. You're not just laying on hands and moving energy. You have it within a framework.

Dr. K: I think it can be called scientific, because science is observing nature and recording the data and coming to some theoretical framework to interpret what's in front of you and what you're seeing. I've spent some time in Arizona, because my family's over there, and have read some of the Indian lore, and it seems that many of the faith healers have an energetic understanding of phenomena that they work with. They are doing something, and I don't think it's totally nonscientific. It's not scientific in that it's not published in the journals, but if those energetic phenomena are measurable, then it is scientific!

Dr. D: A lot of people, including Bernie Siegel and Norman Cousins, are giving a good deal of credence to the energetic and spiritual phenomena.

Dr. I: You do have to trust your own instincts but there's more to it. Wasn't it Einstein who said, "Life isn't a toss of the dice?" We can talk about things like just following your intuition, but there really is an order to it. We've touched on it once in awhile. Maybe you start with people breathing—that's how energy gets moving. But that's just one "technique" that we use. And it's nice to talk about all this other stuff—charisma or whatever. But that's really not what we're doing. It comes back to having to maintain contact, and to find the most efficient and responsible way to do it. There are techniques that we use. There are basic guideposts along the way that we have to be aware of as effective therapists and we're trying to clarify those guideposts.

Dr. K: We need to understand those guideposts better. There is a variety of therapeutic approaches and a variety of results. It would be more satisfying if our goals were more clearly defined and our therapeutic paradigm more clearly delineated, though we must allow for flexibility within that framework.

Dr. C: But what if the first thing you do is not put the patient on the couch? I don't anymore

and that is not my initial approach. How else do you begin with patients?

Dr. I: I've had all the more established ways of training and making contact with patients, like getting a history, doing a differential diagnosis and all that. I'm looking for orgonomic ways, or what we're calling orgonomic ways, of reaching patients. My life was enhanced and made better by what was called orgonomic treatment, and by therapists who identify themselves as orgonomists. My hope is to be able to take that and give it back to other people. I don't want to have to learn over and over by my own trial and error. I need a structure to work with, so for me these guideposts we're talking about are very important, and how you begin with a patient and what you look for.

Dr. C: Perhaps if we gather enough data from people's personal experience, we may be able to figure out what it is about therapy that works and what doesn't. I think it would be important and informative to survey the patients that we've treated traditionally and orgonomically and who seem to report the same profound experience. I've had patients whom I've treated in both traditional psychotherapy and orgonomically who have thanked me from the bottom of their toes. They have said to me, "Thank you, you have saved my life." Now that's exciting!

Dr. I: It comes down to finding what helps, what is good health. The question that is being asked here is, "What is therapy?" What is it that makes patients want to be in therapy after the initial anxiety or depression is alleviated? They stay in therapy by choice because they feel that there is something more they can get.

Dr. B: I have the impression that there are some people who are exceptionally effective therapists, but if you try to figure out why they are so effective, it's very difficult to put your finger on it. One thing that it seems *not* to be is merely their theoretical orientation. It does suggest that at our current level of understanding there is so much that we don't know that we can't really completely rely on our theory.

Dr. H: But the more you know and have access to, the more effective you can be in terms of deciding what kind of intervention to make.

Dr. B: Except that it may be that some of that is self-delusion—that we only think we know what works—and what we do that really works is sometimes outside our conscious awareness.

Dr. H: What we think we've done is one thing and what the patient takes from it may be different. One of my favorite patients said when she first came to me, that fact that I just listened had helped her and that probably a bus driver could have helped her at that time if he had just listened. That made an impression on me, for that wasn't my perception of what helped her early on.

Dr. L: But I also think that we as trainees are in an unusual situation because we have all come to orgonomy after medical school because we thought there was something unique that orgonomy had to offer. When we finally reach the point of finishing our residency, we don't talk about anything else but orgonomy. That's a very strange position to be in.

Dr. K: That's true. It seems that we're questioning the very things that some of us went to medical school for, which was to become an orgonomist, because at least at that point we believed that orgonomy was the answer.

Dr. C: We came out and didn't question it, but now we are questioning in order to enrich our understanding.

Dr. H: I can certainly understand what you're saying, but I think there's an added benefit to having a group around that isn't following a recipe. No one is throwing out the basic principles of orgonomy but we are asking, what can we do to make our treatment more effective? So you're sort of getting the benefit of our struggles and experience.

Dr. K: And that's exciting, but I think that it would help us at some point to have orgonomic

patients here. For example, if they're lying down, what makes you decide right now, I'm going to sit the patient up? I think that would help, because seeing that and then generating a discussion which might be about contact—that the person was really off in his eyes and not in touch with his feelings or it might be that you saw something else that needed to be worked on—that would help us.

Dr. L: You all have a real solid background and years of experience in orgonomy, so you've had time to question it and to expand and go into a lot of other areas. I think what would be helpful to us is to get something very basic and very practical. It's like someone who is trying to make a really fancy dish and doesn't even know how to go shopping or doesn't know how to boil the potatoes.

Dr. C: But the point is, you're not trainees. You are finished with your residencies, correct? You're not trainees, you're psychiatrists. I think that something in orgonomy made us feel like trainees longer than we were. It made us think that we couldn't trust ourselves, that there was something more theoretical that we had to learn.

Dr. L: But although we are all experienced psychiatrists, we are not all experienced orgonomists.

Dr. J: Dr. L is bringing us back to the beginning of our discussion, which has to do with developing a system that works for us in the context in which we work. That's what you're asking for. Not a recipe, but a systematic approach, which is where we started. That's what we're all struggling with.

Dr. L: I consider myself a psychiatrist. Outside of here, I am a psychiatrist, I can go to the emergency room, I see outpatients, I see inpatients. I feel quite good about it, but when it comes to putting a patient on the couch, which I haven't, I suddenly say, "What am I going to do?" So it's like there's one rotation I haven't had yet.

Dr. G: That's really true. That's why the idea of feeling like a trainee is legitimate because that's the way they feel. I have strong feelings about that because I felt exactly the same way, and I have continued to feel that way even with all the experience I have had. We need a mechanism for giving you what you want to know. I think that, first of all, supervision with patients is probably the most important thing. But something has to be done to make the supervision more effective, that either you take cases with audio or videotapes of what you're doing to a supervisor, or you could sit in with more experienced therapists and their patients.

Dr. K: I think it would help to see how other therapists work, either on tapes or in person because, aside from our own therapy, that's the only other exposure to actual orgonomic treatment.

Clinical Symposia

The Clinical Symposia appears 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.

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Participants include: Drs. Edward Applebaum, Irmgard Bertelsen, Robert Dew, Lynne Hagelin, Morton Herskowitz, Louisa Lance, Stephan Simonian, Carol Stoll, Kristin Van Zant

Note: To assure confidentiality, seminar participants have been assigned italicized letters in the discussion that do not correspond to their names.

PROBLEMS IN CLINICAL PRACTICE

Dr. A: This is a continuation of "Problems in Clinical Practice." For those of you who weren't present at the previous meeting on this subject, we discussed the problems of having patients undress (i.e., remove their outer clothing) given the current legal climate. It has become increasingly a problem. Several therapists said that they are more reticent to ask patients to undress, and they often treat patients for a significant length of time clothed before they ask them to take their clothes off. We also discussed the problem of homosexuality, of the old orgonomic standard of regarding homosexuality as pathologic. We do take homosexual patients, whereas some of the old therapists didn't, and we do not try to convert them into heterosexuals. So we continue with the problems of treating patients.

Dr. C: Perhaps we can also say something more in terms of patient/therapist boundary issues. We are already crossing boundaries by simply touching patients, since according to the APA the only touch acceptable between therapist and patient is a handshake.

Dr. D: If we want to comply with what is customary and ordinarily practiced by the current psychiatric establishment, I think we will not be able to practice orgone therapy. Our efforts would be thwarted by all of the rules and regulations of not touching. Of course, we have to protect ourselves, but how much we must operate within their framework is a question that I have in my mind.

Dr. A: Yes, I am in total agreement with what Dr. D said, and I think the criteria has to be that you, the therapist, have to be very clear in your own mind that what you are doing does not have sexual implications. There has to be a categorical line between what is therapeutic touching and what is sexual touching. I think that if you adhere to that, the very great odds are that you're not going to get into any trouble.

Dr. C: I know that at least since I've been practicing in a hospital-based practice, the kinds of patients that I'm seeing are very different. Originally, the people who came for therapy were sent specifically for orgone therapy. They knew exactly what the treatment consisted of and they wanted orgonomic treatment. We should also talk about the patients who are simply psychotherapy patients. If, when, and how you may want to introduce orgone therapy to other patients should be clarified, and in what kinds of patients orgone therapy would be contraindicated. As you just said, you can have very clear-cut and distinct ideas of what is therapeutic touching and what isn't, but the patient may not—especially when you treat patients who are dissociative. How they may interpret it today and how they may interpret it in a week can be very different. I think we are at risk in this climate because people are litigious and it is our word against the patient's word, in terms of what did go on

in the treatment room. I think that these are important issues to clarify.

Dr. E: I would like to get back for a minute to what Dr. A said about working with people orgonomically and the type of touching that goes on. We have a theoretical basis for touching people in order to facilitate the dissolution of armor and to release emotion. That is different than patting someone on the knee. But I've also found that knowing the theory doesn't make me immune to the countertransference that may come up. I know I have to be even more aware of those feelings, especially with more regressed patients. They may use processes like projective identification which brings up very strong feelings in me that often causes me to pull back some, because there are a number of unconscious processes going back and forth. That gets into what you were saying about those more regressed patients who can really project a lot onto the therapist, and therefore we have to be much more aware and conscious of what we're doing, and of the effects on the patient.

Dr. I: I think that when you're aware of that happening, it is helpful to make it evident to the patient, i.e., that this is what they are projecting or experiencing, and to deal with it on a verbal basis so that it doesn't get out of proportion. And it may be important to reiterate what your ethics are concerning therapeutic boundaries. Sexual feelings do come up in patients and must be dealt with therapeutically, which means the only concern is helping the patient work through his or her feelings.

Dr. A: I believe that the bottom line is the contact of the therapist. I think in therapy you're always flying by the seat of your pants to some extent, and that if you have good contact, you're aware of things that are flying between you and the patient that you never put there, and that you have to deal with. I think that if your contact is good, you deal with these issues, as you said, as they appear. I believe that if you do that, you avoid trouble.

Dr. B: One principle that guides me is to always be aware of and "clean up" the transference. So, as a general technique, whether you're just talking to somebody or whether you're working on their armor, particularly if emotions are stirred up by touching, you have to keep the transference issues clear and in the open. One thing that we do is to ask early on, "How do you feel? What are you feeling now? What do you feel towards me? Do you feel anything towards me?" I've found it very fruitful because, as we all know, people don't generally volunteer that kind of information.

Dr. I: At certain junctures we also ask what their sexual fantasies might be towards us.

Dr. B: Yes. I've found that in most cases you really can't ask them anything like that too early in therapy. You have to have broken down a lot of transferential difficulties and there needs to be a high degree of trust established. If a patient appears too ready to talk about sexual fantasies about the therapist, it is most often a defense.

Dr. E: You mentioned cleaning up the transference. I've had a struggle with that recently with a patient who I think was acting out the transference when she got involved with someone who, in some ways, shared similar characteristics with me, and I was conflicted about what to do in terms of interpreting this. This patient had practically no heterosexual relationships all her life, had been sexually abused, and in some ways was barely holding on. Since this relationship was having positive effects, and she was working on helping the relationship grow, I decided not to bring up the transference issues, even though they were always in the back of my mind. Whenever I had tried to get her in touch with her feelings toward me, there was a good deal of denial. So I just backed away from it. I wanted to clear it up, but it didn't seem like it was going anywhere.

Dr. B: Then it seems to me what you're talking about is what the followers of Habib

Davanloo call "station." There are two stations that you're dealing with—one is with you and the other one is with her boyfriend. Maybe the way to get to the transference is to stay with her feelings about the boyfriend, because the more those feelings come out, the more open she becomes to those feelings, then the more it gets back to you. It might go to the past, too; it might go through her father or something else before it gets to you. But what I got out of what I heard from the Davanloo method, is that you stay with the station which is yielding the most feeling, and you don't try to push them into anything, because as long as the feelings are coming out, you're getting where you want to go. You'll get around to it sooner or later.

Dr. F: I remember reading something from Elsworth Baker that relates to this: that the patient's feelings toward the therapist are really a reflection of the stage of their development that you are working with, and that one anticipates this as therapy progresses. There are feelings that come up from various developmental stages and various levels of armoring and the therapist has to be alert to the differences.

Dr. B: One of the biggest technical errors that Reich cites in either *Character Analysis* or *The Function of the Orgasm* during the seminars in Vienna was handling the transference. That the mishandling of the transference, the error of becoming embroiled in positive transference, leaves a lot of resistances untouched. He did not, if I remember in that material, talk much about countertransference, but I think it really hit home to me how important countertransference is, because the two issues are so closely related; it's where we can go astray. Probably the second biggest technical error is not dealing with countertransference.

Dr. A: Yes, I think they are equally important.

Dr. F: I think sometimes that therapy is really the place where people can learn how to feel in a healthy way, and that the interaction with the therapist can be that microcosm of life where they learn how to deal with somebody, maybe for the first time, who is not abusive and who respects them. And that just being able to take part in a therapeutic process, sometimes just to talk, let alone get on the couch, when you trust this relative stranger, is a way people can test their own boundaries and take what they learn and test their own limits in the world.

Dr. A: I'll tell you an interesting case dealing with transference. A patient had been in analysis for seven years, had had previous orgone therapy and was referred to me by her previous therapist. She was totally preoccupied with her own bodily functions. She was terribly insecure. She had a history going way back to childhood—she was kept in from recess all through grade school because she was afraid to go out to recess and play with the other kids. She had a father who gave her enemas with sexual overtones up until the age of 13. Her father was alcoholic, there was a history of touching. Her mother was a Pollyanna, totally passive. When she came to see me she had been hospitalized twice, once for one month, once for six months. In one of the hospitalizations, she had twelve ECTs. When she first came to therapy she told me she looked forward, on each summer vacation, to being rehospitalized and talked about ECT, even though ECT hadn't worked. But she kept saying, "Let me go back there and get some more shock treatments." That was vacation! She was seasonally employed, barely competent at her work. She regarded the post-vacation resumption of work with dread.

At first, therapy was totally occupied with her somatic symptoms. She had a colorful language for them; she suffers from irritable bowel syndrome; besides that, the only things she ever got were colds and flu, and anxiety. But she had colorful language. For example, she described diarrhea as a "crazy bowel movement," always talked about imploding, etc., etc. So in the beginning her therapy was preoccupied with her coming in with a somatic complaint and wanting to work on the area

concerned with that symptom. She also had weird psychological explanations for every single bout or disorder. In one case, her stomach cramps resulted from looking at the fall leaves too long. She always had an antecedent to match any symptom. So in the beginning she would come in with, say, symptoms of the irritable bowel, and I'd work on that segment concerned with her irritable bowel. I'd treat either her back or her belly, and she'd rave and that's how therapy proceeded for awhile. It took me a long time to realize that we were going nowhere. Also when she came, she had three simultaneous therapists. She was going to a psychologist whom she had gone to for a long time previously, she was seeing a psychiatrist who prescribed medications, and she was coming to me. In the old days I would never permit that. I would always say, "You have to go to only one therapist at a time." I've changed my mind about that, because her dependency issues were such that she needed this team. So, coming to three people at one time and being allowed to hang on to them I thought was necessary in the beginning of therapy.

We proceeded to work on a specific symptom each time she came and, as I say, I gradually realized we were going nowhere. So I changed the rules and I said, "You cannot talk to me about a symptom. These are your symptoms—irritable bowel syndrome, colds, flu, anxiety. They're always the same symptoms. I know you have them; you know you have them. I don't want to hear a word about your symptoms." So, of course, she tried to talk about her symptoms, and I would stop her by saying, "The only subjects you can talk to me about are things that are happening in your life that are troublesome, no symptoms." At that point, of course, she started to express a great deal of hostility toward me which, for the first time, was honest—it wasn't just the empty ravings that we saw on the couch up until that time. And she would come in and say, "I have hostility to all my therapists. I've always had hostility to all my therapists. I could kill them all." She knew all the language. But it was all empty. There was no feeling behind it. But when I wouldn't let her talk about her symptoms, she really got angry at me. She thought I was doing her in, that that's what she was coming to me for, so why can't she talk about her symptoms that have to be dealt with—and that was genuine anger. Then in therapy, instead of going through all these various maneuvers that we had gone through, I did nothing but have her breathe and have her look at me constantly and tell her when her eyes were going off. She made contact with me as she breathed, nothing else. Except one thing, occasionally she would say, "Boy, I'd love to punch you." And I'd let her punch me. That was the only other therapeutic maneuver besides breathing and looking at me. And once we started that kind of therapeutic regimen, things gradually changed. She gave up her outside therapists on her own volition.

When she first came, she dressed like a bag lady, kind of weird costumes, always sloppy, always bulky. She didn't look like somebody who held a responsible job. Her clothes started to change, she started to dress almost fashionably, and at this point, which is about three or four years later, she doesn't dread going back to work after the summer. I'm her only therapist; she even cancels some visits, whereas heretofore she always wanted extra visits. She used to call almost daily, sometimes twice a day. I forbade that; she would always call about symptoms, and now she calls maybe once every three weeks. The whole thing revolves around her red thread. Her red thread was a very, very deep insecurity, which I think we took care of by making contact for almost the entire session. And, denying her defenses, which were getting attention via the symptoms—like not permitting that defense to show its ugly head. Also, getting her able to express genuine hostility to me and knowing that I would not kick her out, since she trusted the relationship. So this is an example of how patients can lead you down some cockeyed trail if you're not aware of what the bottom line is in their trouble.

Dr. D: Dr. A, can you explain from the energy point of view what happened to this patient?

Dr. A: What was happening in therapy before that time was kind of a frittering away of all of her energy, not going in any therapeutic direction. And what I did was concentrate it so that things could begin to flow in a straight line.

Dr. D: Do you think that at the same time the irritable bowel and the explosion or implosion the patient was feeling had an energetic basis, or was that just a defense also?

Dr. A: I think that's a genuine symptom. I think that, given her historical antecedents, she somaticized to some extent, and exhibited psychological symptoms to another extent.

Dr. B: It seems to me that energetically what you did was what we all try to do. That is, by denying a loss of energy through a defense we attempt to make that energy more available in the direction of health. It seems her GI symptom is real, but it is also a form of discharge. It requires getting to know the patient, before it is clear what is real and what is defensive.

Dr. A: Yes, and where it relates to transference—all her talk about hating all her therapists and hating me at the beginning was almost a kind of a play—it was like a rote recitation of what she knew therapists would love to hear, but it had no real meaning. She didn't really feel it deeply, but when she got angry at me for not letting her talk about her symptoms, that was real! What I had done was to unmask the defensive aspects of her complaints, which allowed the energy to go into emotions.

Dr. H: In talking about transference, the way I understand it from residency training is that you always have to talk about transference. You always have to bring it up; you always have to address transference. I think this was a very good example of how you can address transference without talking it away. By simply changing the approach, you changed the transference, and you made something happen without talking it away. I was wondering, with this particular patient, if one had pointed things out to her, whether it would have all gone into defense and she would not have made the real connection, the real contact which she needed to make. So I think that when you talk about transference, one doesn't always have to talk about it, as long as one deals with it.

Dr. C: I think that's true, because obviously she was relating to you the way she related to everyone else in her life. You couldn't really tell her that, because it wouldn't mean anything. What she needed was to change it.

Dr. A: Yes, you know in the old days we always used to say that you have to ask the patient how they feel towards you, and the patient might say, "Well, I know I hate you." But often it was almost like standard routine, and it didn't have emotional implication, on the part of both the therapist and the patient. But the fact is, you know that when they're really getting angry at you, they know it; and if you say, "Boy, look how angry you are," it has a meaning.

Dr. C: I find it interesting that her manner of complaining and of being angry, before you changed the rules, was very much like her irritable bowel syndrome. Her verbal anger took the form of a whining, tight quality, but you never sensed any real feeling.

Dr. A: That's right. It was like her irritable bowel.

Dr. H: Dr. C was covering for Dr. A this summer and, as you all know, she was overburdened—so the people who are most time-consuming were directed to my office. One patient who was directed to me was looking for somebody who could understand her better and who could do something more for her, because she felt dead and stuck in some ways. I thought there was a real manipulative quality to her. Now she had found out that I had not been in orgone therapy practice for very long. So I thought I would simply talk to her. She told me that she thought that I had no leg to stand on at all, and at one point I even offered

her a time but she didn't want it. She was just going to think about it more. There was something very manipulative about it. And then just about the time Dr. A was coming back, she called and she said (before, she had told me that she really didn't think that I was the right therapist for her, she could just tell by the way she would relate to me on the phone) that she had decided she would give it a try and she wanted two or three practice sessions with me to see what would happen. At that point I decided that I had "no leg to stand on" and I would not like to walk around like that, so I would create two legs for myself. I said to her that I was very sorry but that I didn't have any time, that I couldn't give her a session. There was a long silence on the other end and she said "Well, I didn't realize that you were so busy; oh, you must be good." What she was thinking really came out. I just stayed with it and said that if she wanted to call me in a couple of months I could see a few openings and if she wanted to see me a couple of times I would be very happy to see her, but right now I couldn't. And suddenly, I was way up on a pedestal in her eyes. I was totally someone else. I never heard from her again, so something must have pulled together with her. But what I would have addressed with her, if she had come to me, was that I thought that to her the grass was always greener on the other side of the fence. And I would not have put her on the couch. I would have actually talked to her about her manipulations. Anyway, I just had this urge to add this.

Dr. E: This patient seems to have a lot of issues with control and possibly sadistic traits. It brings to my mind problems working with sadomasochistic character types. Especially the ones who are so oppositional and refuse to do what you say—it's not that they can't, it's that they just won't budge. I've been dealing with what to do with problems like that. I had heard that Dr. Reich—when he had his own difficulty dealing with masochistic patients who were just being oppositional—would say, "Hey, the session's over and we'll end it here." That has been one approach, but is there another empathetic way that maybe you could get in and short-circuit things or work with the patient to help him see how what he's doing is really counterproductive? I've been very frustrated. The sadistic part is the really frustrating part.

Dr. D: Reich also said that the patient's inability to cooperate and comply with treatment and to do things is part of his own illness, and it was the therapist's responsibility to help the patient to grow out of it.

Dr. A: When you can.

Dr. E: There are a few limitations, and as therapists we are not superhuman—you can reach a point where you say that this is just not going anywhere. I have one patient who I have tried to refer out because I thought maybe somebody else could help—the patient won't go.

Dr. C: But underneath the urge to torture is the tremendous fear of being hurt. Sometimes if you address it at that level it can sort of short-circuit the top. I agree with you, there are some patients who you feel so frustrated with in not being able to move them, for whatever reason, they have to be referred. Now what do you do with patients who say, "No, I don't want to go"? Well, then I think we still have to be in charge and say, "Well, I can't help you anymore and I will refer you to three other therapists." Sometimes you just have to draw the line; otherwise you are not doing a service to the patient.

Dr. E: What I ended up doing was saying, "We're not having any more sessions for the time being. I want you to call me when you feel you want to come back and work with me." I've done that two or three times with the same patient. We'll work for awhile and then we'll go back and then stop, start ...

Dr. C: I don't agree with that, because the patient ends up feeling blamed, ends up feeling like something's wrong with them, when in fact it may be something wrong with us, that we're just not seeing it at the right level and

can't move the patient off of that spot.

Dr. E: But they tend to identify so much with their defense. They know they will not cooperate. They see that, and there is a strong identification with that and, for some reason, at some part in their life that was necessary and you can be sympathetic to that. But their continual refusal to identify more with the healthy aspects of their functioning has to keep being pointed out to them. So it is frustrating, because they may see that they could be doing something different but the defensive aspects don't change.

Dr. C: What would be her fear of getting hurt? What is underneath her not being able to give it up?

Dr. E: Well, she talks about being hurt many times in the past, but she will not cry, and that's one emotion we're really struggling with trying to get out.

Dr. D: What was she doing that you would not continue the therapy with her?

Dr. E: On the couch she would stop breathing through, she would refuse to maintain contact, she would do a lot of substitute types of behaviors, those types of things.

Dr. D: Why refer her? Just wait and do your work. The only time I refer a patient to someone else is when I feel he or she is bothering me so much that it's out of my control. For example, I have a patient who calls six times a day, suicidal, and I'm not equipped to handle it. I said, "You need to get help from an agency because you need more resources than I can provide." But if the patient's coming and working, I would wait. I know it might not be economically efficient for the patient and that should be pointed out. Sometimes they are stuck so deeply that therapy could take a long time. Maybe you are a little impatient to have results.

Dr. B: May I ask you a question about the detail of the handling of this? You said that she would stop breathing. When all of this stuff would begin—whatever she was doing that was obstructing things—did you ask her at that point what she felt?

Dr. E: The feelings she reports are without affect. When we try to get back to any type of feeling that she had when she'd been hurt before, nothing's there, there's an emptiness in her past—more of a contactlessness.

Dr. B: Does she say, "I don't feel anything?"

Dr. E: Yes, it's more along those lines.

Dr. B: For example, she would stop breathing. You would ask her what she felt, and she said, "I don't feel anything." Did she say she would feel anything before she stopped breathing?

Dr. E: I don't recall that that ever led anywhere.

Dr. C: Sometimes when somebody says that they don't feel anything, I get something if I ask them, "How do you do that? What do you do to *not* feel that?" Because usually they're tightening something up, or else they're going off in their eyes. And if they can become a little more aware of that—

Dr. E: She does go off in her eyes.

Dr. C: Is she aware of it?

Dr. E: Yes, and that's another trait that she's identified with as being good, because she says that that's the only way she can think, and I try to bring her back to the point that we don't want her to think. But for now, she thinks that's fine. It's interesting, even her younger son is pointing out that she stares a lot and that he doesn't like it, so I have an ally.

Dr. C: That's interesting, because you say that's not what *we* want, but that is what *she* wants.

Dr. E. I think she deadens off whatever feelings are behind that.

Dr. B: But it's important to get her to say that. If she can acknowledge that and see that, that isn't being obstructive. I'm really sympathetic to what you're talking about, because it's not that unusual.

Dr. C: But part of it is not just us recognizing it, but the patient has to catch himself doing it; otherwise we become the parent who says, "You're doing it again—stop dissociating, stop going off in your eyes." That's what they hear, until they grow into catching it themselves or whatever it is that is interfering with them getting better. Until *they* feel that they are getting better, we can feel as much as we want; it's not going to help them.

Dr. E: That's a transference issue again, and we have looked at that over and over and we have moved off center of that a little bit. It does seem to happen a lot with the patients who have incorporated that punitive type of mother image.

Dr. B: If the patient wants to keep coming, and keeps coming, and has a good record of coming and paying you, that gives you an idea of what is going on fundamentally. They want to be there, they're serious about being there, so that's your lever. They want to be helped. They may not feel helped, but they still hope that you're going to be able to do it.

Dr. H: What if the patient is there for one hour and it's like they're only socializing?

Dr. B: Then it's a different problem.

Dr. C: But it may also be a necessary part of them getting better. They may use whatever transference they can in that hour, but maybe in two years they'll go out and have coffee with somebody. Just as you were talking about your patient who had qualities like that, I think that's a healthy direction.

Dr. B: So they are learning the process of how to socialize?

Dr. D: I think that the patient who is coming and paying for the session—we have to have confidence in ourselves, that we will make a little improvement in him.

Dr. G: When you were talking about getting a little further with this patient, I was struck with a couple of thoughts, and this led to the idea of who you put on the couch and who's good for orgonomic therapy. When you were talking about how she had ECT in the past and how she was seeing various people and was put on a variety of medications, and we were talking about the degree to which she would somatize, I was wondering—what is her diagnosis? Is this someone who has a major affective disorder or is this someone who has a major personality disorder? Because if I come to the conclusion that this person has either a major affective disorder, or a severe personality disorder, I would feel very reluctant about doing what you did. I mean, it turned out well, but I would have taken a completely different approach; it's probably because I don't deal with any of this. Mainly I deal with patients who are in biological therapies and I give medications.

Dr. A: So what would you have done?

Dr. G: I don't know what I would have done. Knowing that she had had ECT in the past, I would have worried that maybe she did have some major affective disorder.

Dr. A: Did they diagnose her as borderline where you work?

Dr. G: Yes.

Dr. E: That doesn't preclude her having an affective disorder.

Dr. A: She's not that depressed. Her main thrust is somatization, and she can talk at length, because I'm sure so many people have talked "at" her about how she uses it as an attention-getting mechanism, etc., etc.

Dr. G: I still would be concerned about putting a borderline on the couch.

Dr. D: What are you afraid would happen to the patient?

Dr. G: If I was convinced that someone had a borderline personality disorder, that to me is a different ballpark entirely than someone who is higher functioning, who has more intact ego structure, better interpersonal boundaries than someone who is borderline, who has a tendency toward impulsivity, acting out, primitive defenses. Those kinds of things I might want to treat more by meeting with the patient and talking with them, rather than jumping into hands-on types of treatment. I understand that this worked with this patient. It seemed the right thing to do. But in talking in general about what to do with borderline personality structures, I'd be reluctant to put them on the couch.

Dr. A: You do all that in the course of orgone therapy. I can think of another borderline that I presented in the seminar a while ago who was a much more troublesome, wild kind of borderline than this lady. The other one, on her first visit, as she left, threw all my magazines on the floor. A month or two after I started to see her, she had to be hospitalized. In her hospitalization she smeared feces all over the wall because she read that that's what psychotics do. So she was that kind of borderline. She had been hospitalized many times. She also had her own local psychiatrist in her hometown, and everybody was at their wits' end with her. On her initial visit she came with a folder of documents speaking of the mistreatment she'd had at the hands of everybody, including that her son was mistreated by his pediatrician. But I put her on the couch in the beginning and she had an almost psychotic delusional system regarding doctors, etc. We handled that verbally from the very beginning. I told her, "You're crazy, this is crazy, etc." Of course, at first she answered, "*You're* crazy. This is crazy," and a few similar things, but eventually she gave all that up. All of that delusional thinking started to disappear. She did well.

Dr. G: Was it something specific with the couch or was it something specific with having a relationship with her over time? That's the question that I find interesting. For one group of patients, putting them on the couch would be the specific treatment indicated for them. But for another group of patients would some other less specific things—like some cognitive interventions or talking therapy type of things—be more indicated?

Dr. E: I use the couch with patients who are psychotic, and who have recently been psychotic.

Dr. G: I would never do that, never.

Dr. C: What Dr. G is bringing up is something we should really think about because, would you put a borderline on the couch who was a self-mutilator? Would you put them on the couch at all, would you put them on the couch undressed? At what point would you put someone who's chronically suicidal on the couch? Would you put a multiple personality disordered person on the couch, who is actively a multiple? I personally wouldn't. I wouldn't put a person who was psychotic on the couch. I'd make them sit up until they were in contact, because I feel that they're at risk and I'm at risk.

Dr. E: The multiple personality or dissociative is an interesting one, because I think the therapist can really bring about those dissociative states and that can be very scary for both parties involved. The one I'm working with now is dissociative—we just go very slowly and very gingerly. We don't go storming in to get at those emotions and rage that she can't get at. Things are going much better now. We've slowed up.

Dr. F: This brings up some questions in me about the therapist-patient interaction, or choice of therapist and patient. I don't have any answers but the questions I have are—is there a time that the gender of the therapist matters with a particular patient? When do you transfer a patient on? When do you stop therapy and recommend the patient go to somebody else? I think these all have a lot to do with one's feelings about oneself, as well, but I think there

are a number of real therapeutic issues here.

My experience is that I could see and deal with patients that other physicians have disliked and I haven't disliked them. I like borderline patients, and it's almost a funny reputation that I've got. And yet, even in my office in the hospital, where people are just sitting in this ugly vacant room, I work on their eyes and they feel better. Now, is it because I'm working on their eyes or is it because I like them or is it because they like me? Personally, I don't think you can separate any of that, and what I'm hearing today is that you do separate all that, and maybe I'm the one that doesn't have the boundaries as well defined. Because, should it matter who the therapist is, or the gender, or how long you keep them in therapy? And my intuition tells me, yes, it really does. Maybe if you're afraid of a patient (I sure have been afraid of a lot of mine), or if I don't feel I'm doing anything for them, I transfer them on. I don't have to ask anybody's permission to transfer them on if it's in their best interest. If you're not genuinely interested in them, you don't have to treat them yourself and should refer them on.

Dr. H: I think that a patient knows whether a therapist genuinely likes the patient.

Dr. F: Well, I guess a part of the question is, do you have to genuinely like your patients to be able to best treat them? I think it makes a difference. I think you have to like something about them.

Dr. E: There was a study done out of Harvard where they followed half a dozen borderlines over a period of many years, and that was one of the outcome factors whether it turned out well, whether the patient felt the therapist liked them.

Dr. F: I had to write a paper when I was in my residency, and the conclusion I came to is that it's not just the patient you have to like. If you're going to stick it out with them you also have to have tolerance for the way they express their neurosis symptomatically. I also had a patient to whom I finally said, "Please see somebody else. You know, I can't stand these calls all the time, it's getting on my nerves." I had another lady who would call me any hour of the day or night and whine, but I feel this is something that she needs to work through. Somebody else might have the same patient—in fact, the one that I was just speaking of was transferred to a psychologist who thinks she's terrific.

Dr. C: I know what you mean. I've picked up some very difficult patients who are cutters. One woman is a multiple whom I like tremendously, but she is always on the edge of killing herself. I tried to make a contract with her that the two things she can't do are that she can't hurt herself seriously and she can't scare me. Now, can she keep that contract? No, but she tries, and I sincerely like this woman, but would I put her on the couch and undress her? Never.

Dr. F: Would you work on her eyes?

Dr. C: Yes, I'd work on her eyes, as much as she could tolerate, but I'd do it sitting up in a chair.

Dr. F: But isn't that the same thing?

Dr. C: It's not the same thing to her, I don't think, because she even says, "Why do you have that bed in the room?" So I explained it to her. She's a severely abused young woman and I think the idea of her lying down would be too threatening. She is easily triggered into old memories.

Dr. F: Why is it called orgone therapy only when people are lying down, undressed?

Dr. A: It's not.

Dr. C: I think that when you're trained that way you're always using orgonomic points of view, but then it becomes a tremendous matter of judgment as to what you do with a patient, if you do lie them down, if you do undress them, how close you sit to them, the kind of interventions—it becomes a matter of the

therapist's judgment in terms of what they're seeing. I think perhaps, Dr. A, that you take more risks because you have a lot more experience. I know I'm much more conservative.

Dr. E: When you refer to triggers, are you referring to overwhelming emotional experience?

Dr. C: Overwhelming experience, body memories, memories of ritual abuse—

Dr. E: Can she express the terror and the horror that comes associated with them?

Dr. C: No.

Dr. E: I run into that with patients who feel the horror, the terror, and the memories come up. Usually the oral segment is so armored they can't scream, they can't express their emotions, and then we have the danger of actually precipitating a psychotic episode. So now I work to try and soften up that oral area, and this gets into touching, but it's different and it's touching that I was very uncomfortable with when I would read about it. Now I will hold this patient, because it is the only way she could verbally sob when she is crying. If she doesn't do that, then she could become psychotic. So, this gets back to the touching—that was extending my limits and going a little bit further, because the clinical situation seemed to say that was the only thing that was going to work right now.

Dr. A: I think your holding her was exactly what she needed. There are a fair number of patients who need that kind of holding, because they never got it, and they're always looking for it in life. It often comes back to contact. For example, I think of one psychotic patient that I had—I haven't treated too many schizophrenics—who I put on the couch for the first time and did nothing but work on her eyes. (She had been referred by one of our students who was in a residency program. She had come into their clinic, and he referred her to me.) She would say, "Are you Dr. (his name)?" and I'd say, "No, I'm Dr. A." As we went through the session, she kept saying, "Are you Dr. ——?" and I'd say, "No, I'm Dr. A." But after working on her eyes in the first session, she said, "That felt good," which is an indication that what I did was what I should have been doing with her. She did well. It was her first psychotic episode, she was almost forty, so it's not that she had a long schizophrenic history. I see a fair number of patients who have been to many therapies and who haven't gotten anywhere. And so I figure they come to me for orgone therapy and I may get somewhere doing what I do that nobody has ever done before. If I see danger points, of course I back up. You know, the troublesome borderline I referred to before (I treated her in underclothes)—I walked into the treatment room in one session and she was nude. So I said, "Get the h__ up," and we just had a talking session and I gave her "what for." She never did that again. But you handle situations as they come up, and if you handle them properly, I don't think you get into trouble.

Dr. I: Basically, it's nothing really empirical that we go by, like perhaps some other psychiatric disciplines, but a lot of flying by the seat of your pants, of using your didactic knowledge and experience, so what you feel you can handle, you handle; if it's something that you're not too sure of, then you handle it gingerly and get some experience and see how it goes.

Dr. C: You know, I think Dr. I's bringing up another point. The therapist has to know when they are getting into trouble, when it is feeding their own narcissism, when their own ego is too much involved. We all have to recognize those danger points in ourselves in terms of judgment.

Dr. H: That's exactly right. That is where people get into trouble. I don't think many therapists would take a severely abused woman and treat them in their underwear on the couch in the first two or three sessions. But some people would do that. Would we feel comfortable if we were making a mistake or felt uncomfortable with a patient? Would we feel

comfortable bringing it up, for example, with this group? To whom would you talk? Would you say, "You know, I think I'm running into danger with this person?" I think that's an important mechanism to be built in, especially given the current climate, and also because more and more people coming have abuse histories. To whom would we speak? Suppose we were not in therapy with somebody?

Dr. B: It seems to me that there are possibly three problems here. One is that people are not sure what orgone therapy is. The second is a clinical problem—suppose you have somebody who you know you can put on the couch—what kinds of problems come up for you as a therapist? A third problem is whether or not to put somebody on the couch. It seems to me that you have to establish somebody's fragility first before you put them on the couch. You need to know enough about them before you would put them on the couch, and until you're sure—whatever you call yourself—you don't put them on the couch.

Dr. G: If it were me—let's say I knew how to do orgone therapy and I was putting patients on the couch—my framework would be doing a complete diagnostic assessment which might take a long time. I'd evaluate their ego strengths, their defense mechanisms, and do a complete workup. For you, you might feel very comfortable with putting someone on the couch relatively early on.

Dr. A: No. I always take a history, and that history sometimes takes three visits. So I almost never start a patient on the couch. Occasionally I do, if someone is in immediate trouble. I may put them on the couch symptomatically, to relieve them, but I take a history the second visit when they're not in that kind of trouble. So I always do the assessment; it's not that I forego traditional psychotherapeutic procedures because I'm an orgone therapist. Always in my practice there have been people who have come to me and I have said, "I think you need a talking therapist," because I did not believe they were suitable candidates for orgone therapy. But I think that because we own a technique which can do more than other techniques and can accomplish more for the patient, that we should think at least as much in terms of *doing* our therapy with that patient as *refusing* to do our therapy with the patient. I believe we can help people that other therapists can't help, and I think that to refuse doing therapy with that patient is essentially harmful for that patient, if he or she could have gained from having orgone therapy. So I believe that there's a little too much talk about refusing to do therapy or being too careful about putting people on the couch. You have to be careful, but you also have to put people on the couch, because that's why they came to you.

Dr. C: *If* that's why they came to you. But the other side of it—I agree with everything you said, Dr. B, and that Dr. A has been saying about using a technique that we know really helps people—is that recently there are a couple of therapists who have run into problems and at first we weren't aware of it. We meet every month. Why didn't we know this? How can we help our colleagues, how can we help ourselves? Isn't that a purpose of this group?

Dr. E: If we're going to talk about problems of therapy, *this* would be a problem with therapy.

Dr. A: I think that the seminars we've had, dealing with these kinds of transference issues, probably will have some ameliorating effect in the future. We emphasized not overstepping bounds and being very careful about those boundary lines.

Dr. B: You have to think about the individual therapists concerned.

Dr. C: But I think that's what I'm trying to bring up. Within the group, do we not address things that come up that may be problematic in a colleague's character? If they were patients we would say, "Look, you're getting into some trouble here." I don't think it's just like when somebody goes out and murders somebody, but were there things along the way that we

could have picked up to maybe have helped those various individuals? Did we not address it because of who the individuals were? I believe those are things that we have some responsibility for. You know, it would be very painful if somebody came up to me and said, "Dr. C, you're really nuts, you're off the wall, you need to be on Lithium, or your judgment has been off on these three things for the last several months." I think it would be very painful to hear, but somehow I think that we should have that responsibility toward one another.

Dr. E: How do we resolve it?

Dr. C: I don't know, but I think that what we have been talking about (boundaries and transference and countertransference and not doing and doing) has really been generated by the problems that have arisen. It bothers me.

Dr. H: But I think that the format of the meeting here is changing in some ways. I remember that in the beginning I felt the meetings were rather intimidating. I have problems feeling comfortable in a group with people talking, but there was more to it—there was a rigidity to it, and something that was so formal in a way that wasn't really inviting to spell out personal problems.

Dr. C: Why doesn't that get addressed then—that this feels too formal, that this feels too rigid?

Dr. F: But it isn't group therapy.

Dr. C: No, it isn't group therapy, but I think there's much more of an intimacy about the way we talk about cases than you get, for example, in residency training. There's much more involvement of our own; I think we are willing to reveal more about what we really do.

Dr. A: It's clear that the work we do entails problems—with our patients and with ourselves. The problems with ourselves should be exposed so that we can identify them and gain the courage to deal with them.

Imagine a School

ZOE READHEAD-NEILL

Imagine a school ...

- **Where climbing trees and building dens are considered as important as learning decimal fractions.**
- **Where you can shout at the teacher if you want to.**
- **Where the rules governing everyday life are made democratically by the whole community.**
- **Where the children are free to play all day if they want to ...**

Summerhill is such a school.

I am the current Principal of Summerhill, a school founded by my father, A.S. Neill, that has been running for 75 years on the principle of freedom for the individual. Freedom as opposed to license.

My argument against today's educational system and popular child rearing is that they are both full of lies. Parents and teachers lie to children both with words and through their actions. They lecture to pupils, sons and daughters about what they should and should not do. By ignoring their basic right to make choices for themselves they take away their confidence and lower their self-esteem. Many of these parents and teachers will themselves be guilty of using bad language, breaking speed limits, drinking and driving, cheating the tax authorities, having extra-marital affairs, etc. One rule for adults—another for children!

I don't think that anybody is good enough or clever enough to tell another person how to live.

I believe these lies set us apart from one another and are extremely dangerous. A child who has constantly been told "No" will eventually stop listening. In this way, children are taught by our society not to regard the words of adults or authority. If adults live as equals with children and gain respect and love because of the kind of people they are, then their words of warning or advice will be listened to and acted upon much more readily. Children will know that they are being spoken to honestly and that the speaker has a genuine concern for them.

I don't think a parent or teacher has any right to make decisions about a child's personal life. Why should they dictate what clothes to wear or how to have their hair cut? I have heard of cases in England where boys were expelled from school because they had a ponytail.

If adults were treated with the same disrespect as children there would be an outcry. Children in schools all over the world regularly have to do sports or go swimming or learn about subjects they do not like. I wonder what would happen at the average workplace if everybody had to go out and play football or run across country or learn about the mating habits of the moth—and children do not get paid for what they have to do!

This system of rearing and schooling will either produce obedient sheep, or rebellious and angry individuals. If people are suppressed and tyrannized they will live fearfully and harbor huge resentment. We can see and have seen throughout history the appalling results of this. Children reared with respect and self-regulation will never meekly follow a dictator—nor will they have seething anger waiting to erupt whenever the opportunity arises. I believe that the soldiers we see now committing atrocities upon the innocent have all suffered discipline and some form of degradation as children—often, I am sorry to say, in the name of religion.

To safeguard our society we need to rear well-balanced, sociable children to grow into responsible, caring adults. In Summerhill we

are trying to redress the balance. In 75 years we have learned a great deal about children and the way they like to live. We have learned that if you respect children as individuals and give them power to govern their own lives, they will do so with sense and responsibility. This prepares them for adulthood in the best way possible. Only by having real responsibility and practicing it can you learn the true importance of your actions upon others. I think of Summerhill not only as a school but, more importantly, a pattern for life. Our aims could be described as the following:

- To allow children freedom to grow emotionally.
- To give children power over their own lives.
- To give children time to develop naturally.
- To create a happier childhood by removing fear and coercion by adults.

Allowing children freedom helps to develop self-motivation. Emotionally healthy individuals learn better and faster.

Giving children power over their own lives promotes a feeling of self-worth and of responsibility to others. They learn from an early age that what they think is important and that others will listen to what they have to say.

Giving children time to develop means letting them play and play and play for as long as they want to. Only through free, imaginative play can a child develop the skills needed for adulthood. Just as a kitten learns to hunt by chasing leaves and insects, so a child prepares for adult life by playing with other children. Within the group are all the qualities, good and bad, that will be encountered later. By making mistakes the child grows and matures without the need for morals to be taught. Neill constantly stressed the innate goodness of children and urged us to have patience.

Quite naturally the established educationalists are skeptical about a system like this. How can you give children power over their own lives, and the lives of others? Are children to be trusted with this power? Can they really be relied on to make sensible decisions?

The answer is yes. Yes, they can run their own school. Yes, they can make sensible and compassionate decisions. Yes, they can be trusted to govern their own lives. In Summerhill the staff are outnumbered. At any one time the children could outvote us on any issue concerning our daily lives: issues like bullying, bedtimes or smoking—only drugs, alcohol and some safety issues are exceptions.

The reality is that the staff and the pupils are friends. We make decisions together as friends. Because the children are not afraid of us or our power they are able to treat us as equals. If we step out of line we can be fined in the school meetings just the same as the children can.

There have been TV documentaries and many articles in the press about our school. The impression everybody likes to give is that it is an anarchic society full of unkempt, rowdy children with no manners and no thoughts about the feelings of others. Needless to say, this is not true.

On any Friday afternoon you could walk into one of our Tribunals—which are the meetings we have to hear and discuss people's problems within the community—and watch children of all ages listening, deciding and voting on issues such as bullying, stealing or bedtime noise. If you grow up in a system where you are treated with respect and you are aware that your opinion is valued, it naturally follows that you will bring injustices to the school tribunal and also be well prepared to listen to and judge on the troubles of others. It is a system which encourages honesty and openness.

Our community is a group of approximately 80 people, adults and children. We are usually 12 staff and an international group of children. At the present time about a third of the children are from Japan while the rest are divided between England, Germany and Taiwan, with one each from France and Brazil.

We are a self-governing community, which means that all the decisions regarding our daily lives in the school are made by the whole group. An important aspect of this is that the business side—the hiring and firing of staff, intake of pupils, etc.—is not the responsibil-

ity of the children. They are not asked to take on roles which would be inappropriate or difficult for them. Children have a very real interest in what time they go to bed at night but very little in who pays the electric bills!

Our school decision-making process is democratic. Each adult and child has an equal vote. Thus the youngest child, Yuma, age seven, has the same voting power as I have. Not only do the children have equal power in the school meetings, they also vastly outnumber the adults. Most teachers' reaction to this is one of fear.

Imagine what would happen in a conventional school if the pupils outnumbered the staff in a vote? Total anarchy? Loss of all moral codes? Possibly, but in Summerhill, because of the freedom they already have had, most of the pupils are socially responsible and are used to thinking about the needs of the group rather than their own. This does not mean that we never have disputes or disagreements—one of the important things we have learned here is that the needs of children and adults are very different indeed! What is important is that we all recognize these differences and try to negotiate a mutually agreeable solution to any problem, instead of the adults just making up the rules to suit themselves.

A typical meeting case may be this one we had recently. The older children in the school proposed that they could stay up as late as they like provided that they stick to the silence hour which is 10:30 p.m. There was a long discussion about it as many people had things to say on the subject. Eventually the vote was taken and it was carried that they try it for one week to see if it could work. A week or so later there was a special meeting because one of the staff had been awakened several times in the night. The community decided that the older children had lost their chance and should get their bedtimes back again.

Occasionally we get rebellious children who want to break all the school laws and go against the community in whatever way they can. Sometimes such children can whip up enough support to get some of the school laws dropped or changed. Obviously it can be a bit disruptive, but it is a good learning experience and is quickly put right. What better way to learn to be a law-abiding citizen than to try living without laws?

We believe in freedom but not license. This means that you are free to do as you like but you must not interfere with somebody else's freedom. You are free to go to lessons or stay away because that is your own personal business and you can make the choice. But you cannot play your drum kit at four in the morning because that would interfere with the freedom of others.

Within this structure we probably have more laws than any other school in the country—about 190 at the last count! They range from what time you have to be in bed at night to where you are allowed to shoot bows and arrows. Many laws are more or less seasonal and are changed or abolished when not needed. Others carry on year after year:

- Only 12 years and older are allowed sheath knives.
- You must have a working front and back brake on your bicycle.
- You can't ride little childrens' bicycles—even with permission.
- You can't watch TV during lessons or meal times.
- Writing graffiti on any wall—1 pound fined.
- Breaking bedtime laws—1 hour community work.
- Not getting up by 9.30 a.m.—dessert fined.

We hold school meetings twice a week: one on Friday afternoon and one on Saturday evening. The Friday meeting is called Tribunal and is used for people to bring cases against one another. Thus, if I have been riding your bicycle without permission or have broken into your box to steal your money, you will bring me up in the Tribunal.

Chairing the meeting is a difficult task. Although nobody is exactly unruly, it is demanding to keep up to 70 people of different ages

sitting quietly for about an hour at a time. The Chairperson has *ultimate* power! It is a strangely formal occasion and visitors have often remarked how much more ordered it is than the British House of Commons!

Sometimes teachers bring up children for being unruly in class. One such case recently carried the fine that the culprit should be banned from lessons for three days—but the child appealed the fine on the grounds that it was too severe!

Naturally the staff can be brought up, too. It is a very leveling experience to be brought up before the whole community—especially if you have been teaching in the conventional system. Some new staff find it a bit too much and are very embarrassed about it. But I am sure it is a valuable experience for adults to be put in a position where they can be brought up by children and fined accordingly.

All teachers should have the experience of teaching in a school like Summerhill where the children do not have to attend classes. Most teachers spend their entire working career teaching to a captive audience. It is a very sobering experience to teach children who can get up and walk out if they want to.

I would like to finish with a brief word about children living at the school. Because of the potential traumatic effects on children separated too early from their parents to attend boarding schools, there is reasonable apprehension about children living at the school. Boarding schools are no longer in favor and to send your child away is considered bad parenting. While I agree that forcing your child away from home into an often hostile environment is a terrible thing, I must also speak from our experience at Summerhill. Although some children do suffer a little from homesickness during their first term or so, it is usually very mild. After that they positively thrive. The sense of relief they get from living away from home and with a group of other children in a free environment is surprising. Although they love their homes and their parents, they value their independence and guard it jealously.

Summerhill is now 75 years old. Some like to say that it is old-fashioned and the idea is out of date. Perhaps this is true. But until the people of the world begin to understand the true nature of childhood and treat their children with the respect they deserve, Summerhill will continue to be a small beacon in the darkness to show that there is another way.

Self-Regulation in Learning Works!

(or, Everybody is Talking About School Problems—We're Not!)

DOROTHEA FUCKERT, M.D.

Our two sons, Alex (14) and Julio (10), have been pupils at Summerhill—Alex for five years, Julio for two years. We decided they should go there because we were convinced that Summerhill is the best we could give them as far as school and social learning are concerned. Since they were born, we definitely wanted them to grow up in natural self-regulation (not identical with antiauthoritative education and laissez faire). We did not want their liveliness, emotionality, and the natural fun of learning (in other words, their psychosomatic health) to wither in public institutions.

Deeply impressed by A. S. Neill's writings since the 1970s, a lengthy visit to the school in early 1990 finally convinced us that here theory and practice are identical in daily school life and that a positive approach to life is still in practice as Neill envisioned. The cornerstones of education at Summerhill are: (1) social development takes precedence, which means that if children are emotionally stable, balanced and merry, the intellect takes care of itself. Under such conditions, children like to learn and do so on their own initiative. This means that lessons are voluntary, until the last day of school at the age of about 16; (2) children are capable of regulating themselves in a real democratic community. Laws of living together are democratically voted on and can be discussed and voted on anew each week. Everyone can do what they want to do, as long as they do not disturb others and keep to the rules. Summerhill has more rules than most other schools.

Pupils stay at Summerhill for three terms of eleven weeks each (i.e., they stay there for 33 weeks a year) and during the 19 remaining weeks they are at home with their families and some of their old friends. The first two or three days (school as well as home) serve the purpose of reintegration, and sometimes that is not so easy. We visit them during each term for a prolonged weekend. We never need to care about homework and grades, because there are no such things (except for grades in General Certificate in Secondary Education).

Like most children in Summerhill, our sons did not attend lessons for quite a long time. One reason was that during the first grade of regular German school they were compelled to go. Children begin to blossom when, on their own initiative, they choose to begin learning and determine what they want to know—a fact most school systems fail to consider. Neither of our children had any problem during their first year at school in Germany, and the teachers did not see any problem either. But we noticed our sons were getting pale and their natural joy of learning vanished. Therefore, during their first years in Summerhill both had—as most beginners there—better and, for that reason, more important things to do than to spend hours in class. Alex did not attend lessons for more than two years; he just played and played, constructing tree houses, and this and that. We must admit that this sorely tried our convictions about self-regulated learning. We nevertheless stood our ground and consequently set our trust in self-regulation, never mind the odd moments of fear concerning what would become of him. Which means we would let him tell us how he was and what he was doing, but we never dropped a word about lessons and also never tried to persuade him in a more subtle way to learn. At the age of 11, Alex finally started to learn, out of inner motivation, enthusiastically and joyfully. He studied Japanese, computer technique, theater and woodworking, but also a few main subjects. During the last two and a half years he acquired the knowledge for the GCSEC in sci-

ence, which at the moment he is most interested in, and in May 1997, shortly after his 14th birthday, he took these exams. Five of the subjects tested in GCSEC will be acknowledged as German secondary school exams. Among them there has to be one language and one aspect of science. After that, he wants to get his A-levels and go to university. It is not necessary to mention that, apart from this, he lives a full life as a child, with all the joys and pains. The former outweighs the latter.

With Julio it is much the same: he also has not attended lessons for two years, except in art, woodworking and some cooking. But he started taking piano lessons. He likes sports, he plays a lot and gets so much involved that he usually forgets to call us on the set dates. This being the second child, it is much easier for us to trust self-motivated learning. Although he is 10 now he can hardly spell. On the rare occasions that he writes us a postcard, the spelling is sheer horror. However, if he chooses to follow an academic path, we have no doubt that he will succeed. But maybe he wants to become an artist or a craftsman, or all three! The important point is that children can develop at their best, find inner satisfaction, and get some "key qualifications" when it becomes important to them. They learned English within a few weeks through contact alone. Alex is perfect at it, but no less so at his mother tongue.

Both children are happy at Summerhill—they say so, and it is openly visible. There they can develop their potential better than at the usual kind of school. Considering how young they are, they are very mature, self-confident and socially oriented; they are (again) eager to learn, but most importantly they are healthy and bursting with the joy of living. Our relationship is sincere and tender, and it seems almost as if the contact between us is even more openhearted, thanks to Summerhill. Which is not too surprising, because their life in our small family has been broadened and enriched by the democratic community of 65 children and 15 adults. We also have learned through their experience at Summerhill. One of the most profound lessons we have learned is that one day we all have to let our children go, because they do not belong to us. They belong only to themselves.

There has been enough proof in 75 years of practice at Summerhill to deduce safely that former pupils of the school integrate without major problems into secondary education (more than 75 percent), into job training, and into the adult world as a whole. Some skeptics like to think the opposite, so that they can avoid conclusions that would question their own ideas and behaviors. On the other hand, today it is almost common knowledge that many young people leave school crippled in the academic, psychosocial, and creative aspects of their lives.

Our children know that they can come back to Germany for good whenever they want. So far they have decided against it. They are grateful for Summerhill, as we are. In the beginning homesickness was a major problem for Alex, but not for Julio. Most of the time they don't miss us, only sometimes, which they admit. On the contrary, long before the holidays are over they start asking how long it will take until they can return to Summerhill. It is we who feel the pain of parting for a few days, but also, to be honest, some kind of relief. Sometimes we miss them, but much less than we had feared. We see this as some kind of adjustment we constantly make. Fortunately our children are not our only purpose in life. Now we are able to live our relationship more intensely, which does us good and, for that reason, can only be good for our children, too. We devote ourselves more to our work and to other activities and obligations—all in all an improvement in the quality of our lives. Self-regulation does not only work with children!

Does this mean Summerhill is a perfect school? Unfortunately not. Some of the younger teachers don't really know what Summerhill is about and leave soon. The number of pupils from Asia is high compared to European ones. Finances are sparse, because the school is not supported by the state. Meals are quite good compared to usual English food,

but even though there are fruits and vegetables every day, it is still not healthy enough (meat has been eliminated from the diet for some time now). On the other hand, although Summerhill children can choose vegetarian meals, many don't bother about healthy food at all. Teachers receive a relatively low salary and they have little time for themselves. It is rather difficult to be actively involved in the school and have a family life. Large parts of the older buildings have been nicely restored and new ones have been built recently, but some of the older parts still need rebuilding. Although there are pupils from all social classes, it is difficult for many parents to raise the DM 1200 per month (everything included) for a child. For comparison, a German boarding school would cost DM 3000-4000, but nonetheless most parents cannot afford Summerhill.

Fortunately, we manage to raise the money, and even now we see that it is a safe investment from which we all profit. We say this without a guilty conscience, but we regret that unfortunately not all children can attend a school like this. It would be extremely desirable. Julio's last words when he had left German school: "Finally, I am free!"

Information: Dorothea und Manfred Fuckert, Im Braunlesrot 20, D-60429 Waldbrunn, Germany. Phone 06274/5346, FAX 06274/5345. E-mail: fuckert@wwweiss.de Homepage: Http:\\ourworld.compuserve.com/homepages/summerhil (just one "l"; author: Alex Fuckert). Topical literature: A Free Range Childhood—Summerhill and the Principle of Selfregulation, by Mathew Appleton/Summerhill School, 1995, 200 pa., DM 40.

Some Personal Thoughts on My Psychiatric Residency and Orgonomy ... Then and Now

IRMGARD BERTELSEN, M.D.

A while ago, the question arose in a seminar: What was it like to go through a psychiatric residency after having a strong background in orgonomy? The implication: It might have felt like settling for less. It might have been overwhelming or dissatisfying. It might have felt like having to withhold a powerful, yet controversial treatment tool within a generally traditional environment. Most of psychiatry is based on the medical model with symptom relief as its primary treatment goal. Orgonomy, on the other hand, has the potential to touch an individual at the core of his being, and hence can go far beyond symptom relief. I decided to take on the challenge of examining the above question. Of course, this exploration is based entirely on my own personal experience.

Part I: Then

I came across orgonomy long before I started my psychiatric residency. It was in the early sixties, and New York was teeming with young people pursuing their many artistic talents and dreaming about exciting careers. They had come from all over the world, and from many places within this country. And many felt a kinship: They had broken away from restrictive and inhibitory environments, and embarked on this journey in search of personal growth and development, and their own potentialities. I was no exception.

Compared to my own upbringing, where acceptable topics of conversation included food, daily activities, and perhaps a neighbor's misfortune, and where more important issues were silently relegated to a realm of secrecy and nonexistence, life in this huge impersonal city had an almost intimate quality. I began talking about many previously forbidden things among circles of newly found friends and fellow travellers; and when I wanted to explore life on a deeper level, I, too, eventually found my way into a psychotherapist's office. However, as time went on, my enthusiasm and the initial relief I felt as a result of being "verbally" more expressive, gradually gave way to a general sense of disappointment, which was inexplicable to me at first, until I began to realize that my body had remained unaffected in this process. I continued to have numerous somatic symptoms, and relief was always temporary. It seemed that the somatic tension was there to stay no matter how much I "talked."

At some point I heard of a therapist who was "teaching" people to "breathe better," and thought that it might be worth trying. I had no idea what this was all about—but that's when I started orgone therapy. I soon recognized that in this process both mind and body are affected. With its added dimensions in the realm of "emotional" expression, I reached a depth within myself never thought possible. Over time, I also learned what this was all about. I read everything I could about Reich and orgonomy and the effect of human armoring upon all aspects of life. And, of course, I began to regard psychiatric orgone therapy as a "superior" treatment. This attitude prevailed largely because of my own positive response, but also due to my therapist's unique practice setting. By focusing exclusively on orgone therapy, his practice reflected only a very small segment of existing psychopathology. However, this attitude was greatly challenged in my psychiatric residency when I was exposed to the wide range of psychopathology.

Psychiatric inpatient units are temporary dwellings for the most severely decompensated and impaired mentally ill, who need to be sheltered from a world in which they are no longer able to function. They are holding environments for those individuals who have "fallen apart," who have been stripped of their de-

fenses and are helplessly exposed to external or internal stimuli. This is where the wide range of major mental illness is found—from serious mood disturbances, suicidal ideations, and loss of impulse control, to disturbed reality testing, delusions, hallucinations, and functional impairments as severe as the inability to bathe or clothe oneself.

Subsequently, these individuals are often encountered in outpatient psychiatric treatment facilities for maintenance after inpatient stabilization. However, a wide range of less severe psychopathology is found in outpatient treatment settings as well, ranging from less disabling mood disturbances to the full spectrum of anxieties and phobias, personality disorders, and mild to moderate functional limitations. What these individuals have in common is their ability to maintain intact reality testing, although at times ego defenses may become overwhelmed and begin to disintegrate when severe psychosocial stressors bear down upon an individual's life.

I often asked myself whether orgonomy would have a place in these treatment settings.

On an inpatient basis, psychiatry does not differ significantly from other medical specialties. Its primary treatment goal is symptom relief, which involves integration, reconstituting defenses, and restoring an individual to his previous level of functioning in the outside world. Psychopharmacology is the main treatment tool in such crisis interventions, with supportive therapy and education as essential adjuncts to medication treatment. In an environment where individuals are severely decompensated and impaired, with loss of ego boundaries and crumbled defenses, orgone therapy would be contraindicated, as would be any other in-depth therapy.

On an outpatient basis, I would not have considered most patients to be candidates for orgone therapy either. The patient population seen by a psychiatric resident in community mental health centers and large urban clinics can be as skewed as that seen by a psychiatric orgone therapist in private practice with respect to psychopathology, as well as social, economic and educational background. A large percentage of patients were seen at regular intervals for medication maintenance and supportive therapy after stabilization on an inpatient psychiatric unit. Some of them faithfully took their medications, never missed an appointment, and were able to remain out of the hospital for many years. But others were less committed. Poor compliance with medication and treatment was frequently encountered, resulting in decompensation once again, and yet another hospitalization—the "revolving door" syndrome.

In this environment I also learned how truly fragile an individual's ego structure can be. I remember reviewing the history of a middle-aged woman, whose care I had taken over from another resident at the end of her outpatient rotation at this particular clinic. I simply wanted to get to know her better by reviewing her history in detail. But this simple exploratory process was a stimulus beyond her tolerance level, and she began to decompensate. And I, in turn, developed a deep respect for fragile ego boundaries early on in my training. Furthermore, primarily in crisis centers, many patients present with drug and alcohol problems, which can produce temporary organic states and undermine ego defenses. And above all, one is always on the lookout for psychiatric symptoms resulting from underlying organic disease (which are often indistinguishable from those due to mental illness) and require traditional medical intervention.

However, during my training I also came across some patients who wanted to improve their lives and were looking for "therapy." I remember a 29-year-old woman with a history of impaired generational boundaries, who was raising five children by herself on welfare. She came to the clinic because of increased anxiety and a deep dissatisfaction with her life as a "welfare mom." She was determined to change her life around, and gradually pulled herself up by her bootstraps. With the aid of low-dose anxiolytic medication early in treatment, together with psychotherapy and much encouragement and support, she embarked on a demanding vocational training program. At the time I was moving on in my residency, she was

about to graduate and was in the process of applying for a full-time job.

A 48-year-old woman came to the clinic because she had difficulty making an important decision at this stage in her life. She had inherited a small family business after her husband's death, and was vacillating between feeling guilty about selling it and inadequate about running it by herself. We explored her dilemma over several months and when she was ready to make her decision, she moved on.

And then there was a 24-year-old male student who had grown up with alcoholic parents. He had a long history of dysphoric mood, and recently had felt increasingly overwhelmed and unable to concentrate on his schoolwork. He responded well to antidepressant medication, and in response to some cognitive psychotherapy was able to make a few changes in a stressful living situation. Shortly after symptom relief had been achieved, he dropped out of treatment.

All three patients improved with the traditional psychiatric armamentarium. The "welfare mom" was close to getting off welfare and entering the work force. The businesswoman was ready to make an important decision and go on with her life. And the student was able to continue his studies. As for myself, I found a renewed respect for the "verbal" aspect of therapy.

Would these three patients have been candidates for orgone therapy? Theoretically, yes. All three individuals had the ego strength necessary to withstand the rigors of dearmoring, both physically and characterologically. Life can go far beyond survival and symptom relief. Mobilizing the student's energy and affording him emotional release could have effected a change in his basically dysphoric mood and, long-term, his life may have become qualitatively different. But he dropped out of treatment when his crisis was over, and did not look for more. Likewise, the businesswoman was satisfied when she was able to move beyond the impasse in her life, and discontinued therapy. Although feelings of inadequacy had surfaced at other times in her life, her tendency was to push them aside. She did not want to deal with lifelong inhibitions, although orgone therapy may have been able to lessen some of life's constraints. With respect to the "welfare mom," she too would have been a candidate for orgone therapy, but not until she had finished the transition into her "new" working life lest she be too overwhelmed. Right now, she was handling all she could. At the time I was moving on in my residency, she was close to her goal which she had so persistently and single-mindedly pursued. I lost touch with her, but often wondered if she continued to look for more.

Therefore, if orgone therapy had been available as a treatment tool, neither the student nor the businesswoman would have been interested, and we don't know about the "welfare mom." Does this mean that orgonomy does not have a place in a psychiatric residency program? Let's look at some other issues.

The nature of a residency is transiency; it is characterized by constant change. In order to become a competent, well-rounded psychiatrist, a resident must rotate through many different treatment settings. Hence a resident is always moving on, and so is almost every patient, namely to the next resident. This climate is attractive to patients looking for short-term therapy and symptom relief, but may account for the high dropout rate in some outpatient clinics as well. Psychiatric orgone therapy would not have a place in these settings, just as psychoanalysis does not.

Goals and expectations, which are brought into treatment situations by every patient and every therapist, are also important issues. Prior to my residency training, I had not given it much thought. However, while in residency, I was often reminded of a conversation I had during the process of interviewing for a training position. As this particular interviewer perused my application, commenting on my persistence in achieving goals and overcoming obstacles, she suddenly asked, "Can you be satisfied with less in other people?" I hastened to answer in the affirmative, but did not fully grasp the essence of this question until I actually started my psychiatric training. Many patients came from devastating social and eco-

nomic backgrounds, and their human experience vastly differed from mine. To some, personal growth and development were luxuries; they needed all their energy just to survive. And as I learned about the wide range of psychopathology, I also learned about economic and social dilemmas. This world was far removed from my therapist's exclusive practice in New York.

Furthermore, psychiatric orgone therapy is not always a "quiet" therapy. One does notice when someone is sobbing or enraged and, in general, this would be disruptive and alarming in outpatient settings. I remember a relatively quiet afternoon suddenly being interrupted by loud screaming coming from an office further down the hall. Immediately, people "ran to the rescue," including myself, to make sure that everything was all right, that no one was hurt. In this instance, a patient had appropriately raised her voice in anger, and neither the therapist nor the patient had been endangered at any time. However, in outpatient clinic settings safety is almost always an issue. Some patients are highly volatile and can lose control; and a seemingly safe situation can become unsafe in a split second.

In summary, I did not believe that orgonomy would have a place in the various clinical settings I encountered, but this conclusion arose entirely out of my own experience. On inpatient units, most patients need their armoring in the process of reconstituting defenses and regaining baseline functioning. In outpatient facilities, numerous factors make the use of orgone therapy as a treatment tool unsuitable as well. A large percentage of patients present with extremely fragile ego structures unable to withstand any type of in-depth therapy. Although some patients may have had sufficient ego strength to be candidates for orgone therapy, other issues precluded its application. Foremost, the transiency of a residency does not lend itself to long-term, in-depth therapy. Likewise, patients' goals and expectations can differ significantly from those in select private practice settings. Some patients come from such devastating social and economic backgrounds that their whole focus is on basic survival. Furthermore, a therapy which encourages emotional expression would be unsettling and alarming in treatment settings where real emergency situations can arise in an instant.

When I started my psychiatric residency, I entered a world I had not known before. As time went on, my perspective on life began to change, and I gained a new understanding and deep respect for a much wider range of human experience. I never felt that a powerful treatment tool was being withheld, and never felt that I was settling for less. However, I did feel dissatisfied and overwhelmed at times. Constant exposure to high levels of emotional disturbance, in addition to devastating social and economic backgrounds, can be disheartening and gradually distort one's overall view of the world. Above all, the tremendous sleep deprivation endured by every resident put an unforeseen strain on my entire life.

Part II: Now

In the process of examining my residency years, I was amazed how easily I became a resident again in the way I was thinking about and reexperiencing that world. If I were a recent graduate, my paper would end here.

However, after many years of patient contact, it cannot end at this point. I concluded that there would not have been a place for orgonomy in a psychiatric residency. Given time limitations and the severity of psychopathology, in-depth orgone therapy is, of course, not a primary treatment tool, and even contraindicated in certain clinical situations. However, I was wondering why I had rejected the idea so completely, especially since I would reach a different conclusion at this point in my life. My casual statement about "... the tremendous sleep deprivation endured ..." had originally been intended as just another thought-provoking idea with which to end my paper. But as it turns out, it holds the key to my seemingly contradictory conclusions. Chronic sleep deprivation is a tremendous stressor, which can affect the quality of a therapeutic relationship and interfere with the degree of "contact" a therapist has with himself and with his patients. This goes

far beyond factual knowledge.

There is a vast difference between someone who is deeply in contact with himself, and someone who isn't. Whereas the former has a strong sense of belonging in this world and feels comfortable in it, the latter often feels alienated, disconnected, and uncomfortable. A person in touch with himself can deal with issues honestly and directly, without anxieties and fears, and without distortion. There is no hidden agenda, either consciously or unconsciously. His behavior is a true representation of his energetic core impulses. To the degree that he is comfortable with his own feelings, he is also accepting of and at ease with the emotions of others. That is the most important factor entering into every therapeutic relationship, no matter how transient or how permanent it may be. In fact, it is a key factor in every human relationship.

A colleague of mine, who used to spend one afternoon a week at a clinic introducing medical students to the art of eliciting a psychiatric history, relates the following story: He noticed that the conference room was always crowded when he was interviewing a patient. Aside from the medical students, many staff members would attend on a regular basis. Why? Because in almost every interview a profound piece of information not previously revealed emerged from the patient's life, even though the patient often had already been on the inpatient unit for a week and had passed through the whole gamut of intake evaluations and interviews. This interviewer was a distinguished orgone therapist, one of the most contactful persons I have ever known.

Contact invites a patient to unburden himself. He is more likely to disclose feelings that are undesirable to him (such as shame, embarrassment or hostility) when he is looking into warm and accepting eyes. And a chest that moves with rhythmic breathing beckons a rigid chest to be less still. Many patients subjectively sense this contact, and have an immediate response to it. In my practice, I have heard comments like, "I feel I can tell you everything," "I feel you won't judge me," "Now I know I can get things off my chest;" or, "This is a safe place." Of course, all of this is true. But the surprising aspect of these comments is that at times I have heard them from patients in their initial encounter with me, when they have no idea what I am all about. However, contact can also be experienced negatively, even threateningly, by some armored patients who may respond with a great deal of anxiety. Here, misinterpretation is quite common and a patient may need to be assured repeatedly that I am not criticizing or judging him, that I am really "on his side," or that I am not "making fun" of him. Often he gradually begins to open up and become more trusting. Rarely, a patient is clinging so tenaciously to old patterns of thinking and relating that he cannot conceive of a different way of being, and remains a prisoner of his fears. In the extreme case, a patient can be so closed off that he has completely lost his ability to sense or "see" another person. When this happens there is no initial response to even the most contactful therapist.

The degree of contact a therapist has with himself determines the emotional depth a patient can hope to access in the therapeutic process. As a therapist, one needs to be constantly aware of this prerequisite for in-depth therapy, and hence strive toward staying in contact, as much as this is possible in a largely toxic world. As for myself, I am particularly sensitive to immobile chests. For this reason, I rarely return to the rigid environment I have come from for any length of time, simply because it has a very gradual and subtle inhibitory effect on my breathing. However, as soon as I remove myself from that environment, and again seek the presence of lively eyes and a freely-moving chest, my breathing is no longer inhibited, and returns to normal.

Hence, "contact" is not a static state, but subject to many fluctuations. Over the years, I have become keenly aware how seemingly trivial factors such as a poor night's sleep, a nuisance cold, or simply a humid summer day can have an effect on me, like feeling "a little flat" or "not quite myself." These minor fluctuations are part of life; they are short-lived, usually unnoticed by patients, and don't affect the therapeutic process.

On the other hand, major influences such as a protracted illness or prolonged sleep deprivation can have a profound effect on an individual's functioning. During my second year of residency the unthinkable happened—I fell asleep on a patient. I had been on call on a busy night. Now it was mid-afternoon, and I had not slept since I left my home at sunrise the previous day. The patient's speech was monotonal and circumstantial, and despite greatest efforts, I was unable to hang on. When I awoke, he was silent and I was shocked. The patient graciously accepted my apologies, and actually continued to see me for several years after my residency.

However, this incident has left a lasting impression on me. I cannot imagine ever falling asleep on a patient in my practice. When I related the incident to some of my fellow residents, they responded with a sympathetic chuckle, for it could have happened to any one of them. Of all the exciting as well as difficult times in my residency, the chronic sleep deprivation experienced by every intern and resident had by far the greatest impact on my personal as well as my professional life during that time. In retrospect, I marvel at the adaptive capabilities of the human organism when faced with adversity. As lack of water or food signals the body to switch into survival mode, so does lack of sleep—but at what price! It is a purely automatic process, and logically a very positive mechanism to assure the successful survival of the organism. It enabled me to handle a multitude of medical and psychiatric problems at any given time, day or night, and to provide responsible and competent patient care, no matter how tired I was. I often sensed that I had energetically contracted, and that I was not in touch with my real emotional depth. But I did not realize until much later to what degree the continual lack of sleep had overshadowed all aspects of my life. In retrospect, I believe that the diminished contact I had with myself when on "automatic pilot" was a key factor in concluding that orgonomy did not have a place in the transiency of a psychiatric residency.

Just as contactfulness elicits a response, so does lack of contact. One particular psychotherapy demonstration made a lasting impression on me. In this session, a bioenergetically oriented therapist had been invited to interview a patient behind a one-way mirror. The patient was a woman in her mid-forties with a submissive, somewhat helpless disposition, who had difficulty standing up for herself in life. During the interview it became apparent that she was not in touch with any of her repressed angry emotions. To demonstrate how he would go about eliciting her anger, the therapist placed a seat cushion in her lap, and encouraged her to hit it. She obediently complied, hitting with both hands, while the therapist periodically interjected, "You are doing fine," and "Are you feeling it?" The patient eagerly agreed affirmatively, but it was obvious that the hitting was only a mechanical exercise, which did not tap into any real emotions. My fellow residents were untouched, and showed no further interest. As for myself, I remember feeling somewhat disconcerted by this mechanical display, for it had no semblance to what I had experienced in orgone therapy. Contactlessness manifests itself in mechanical processes.

The goal in orgone therapy is always to reestablish the free movement of energy in the organism, as much as that is possible for any given individual, so that life can become less inhibited and qualitatively different. This can range from very minute changes to far-reaching, life-altering transformations. In his "contact" with patients, the therapist's energy has an effect on the patient's energy system, and subtle responses are set in motion. Contactfulness drives the therapeutic process.

In my practice, I am always cognizant of keeping any possible major stressors out of the therapeutic situation. Above all, I am usually wide awake, and in no need of survival modes because of chronic sleep deprivation. This factor alone has changed the quality and depth of my interaction with patients. And from this vantage point, orgonomic principles have a place in any setting where a contactful therapist interacts with a patient, no matter how transient or permanent a situation may be.

Observations of a Psychiatric Resident

LINDA STOCKTON*

In the following essay I would like to share some thoughts and observations from my second year in a four-year psychiatric residency.

I was one of two second-year residents in a program totaling nine residents. Overall, I had little day-to-day contact with the other residents, except for a weekly experiential group, pharmaceutical-sponsored lunches, and a few classes which we shared in common.

In general, the residents seemed to me less emotionally expressive than would be expected. Their eyes were not especially lively, they did not take much interest in self-exploration, and they appeared to have limited insight into themselves.

My observations of the senior class members were that they often complained that they were used or devalued because they had to do history and physicals and discharge summaries. They did not seem to have the courage to speak up about the issues that were upsetting them. I felt their anger had turned to complaining.

For example, one resident was prone to catastrophizing, which was not perceived as such by the other residents. They took this resident at face value and appeared not to recognize his anxiety. When anyone expressed genuine emotions they were usually "cut off" and the topic of conversation changed.

One personal experience during that year of residency has deeply affected me. When a colleague died who had made a profound impact upon my life, I was devastated. My work with my attending psychiatrist became distracted and inefficient. He commented on this and I responded that I had felt distracted ever since Dr. ____ had died. He suggested that perhaps a piece of me had died with him. That hit home and I welled up with tears. He said, "Don't lose it, I can't take it."

*Pseudonym.

Another example is a patient whose three-year-old child drowned. She responded by drinking for the next 20 years. Now she is sober and in therapy. I remarked to my attending physician that it seemed to me she would have to experience, gradually and with support, the grief of her lost child and her guilt over the tragedy as well as the loss of 20 years of her life. The attending responded by becoming upset and warning me that people cannot handle such intense feelings. She was frightened by the patient's deep feeling of loss. So am I. Also, I find that the experience of feeling, and the energetic merging that takes place, is frightening.

From the experiences noted above, one of the most disappointing aspects of the year has been realizing the consequences of the inability to tolerate affect. The physicians often do not seem to tolerate the anxiety they experience when their patients express deep, genuine emotions. I believe they are therefore less effective in helping their patients tolerate anxiety. Patients who are candidates for character-restructuring types of therapy also need to be able to tolerate increasing affect and anxiety. The majority of patients I have seen do not appear to have the ego strength to tolerate the anxiety generated by in-depth psychotherapy. Therefore, they would not be suitable candidates for orgone therapy.

Those patients just mentioned include those who are psychotic, substance abusers, or frequently hospitalized. They have great difficulty establishing meaningful relationships. I have found contact with those patients heartbreaking and I struggle to maintain an optimistic perspective in my profession. I believe that having contactful, meaningful relationships with a loving family could have helped prevent many of their problems. Loving, contactful relationships are fundamental in

making life meaningful. I am grateful for such relationships in my own life.

While performing inpatient and consultation services, I saw a number of patients who attempted suicide, made suicidal gestures, or performed self-mutilating acts (scratching or cutting of the skin to watch the bleeding, or burning the skin). It seems to me that patients who make suicidal gestures and perform self-mutilating acts are attempting to relieve internal pressure rather than attempting to kill themselves. The self-mutilating patients often describe their acts of mutilation as a relief. They will talk about their cutting as painless, or sometimes pleasurable. Sometimes it gives them a "high." Some patients see the mutilation as a substitute for direct sexual stimulation—often these are patients who are sexually unfulfilled. Patients are usually grateful when I show understanding that their acts of mutilation are attempts at relief rather than actual suicide attempts.

The suicidal gestures made for the purpose of relief tend to be more impulsive and the patients almost invariably are grateful that they were not successful, and they express that they acted foolishly. Unfortunately, there are patients who die accidentally from suicidal gestures. The person they believed would find them before they died did not arrive in time. It seems that some people consider suicide as a safety valve—they can escape the misery of their lives by dying. Or they can express anger with a suicide attempt, in effect saying, "I'll kill myself, then won't you be sorry."

Some suicides I have seen this year were people who were cult followers. The power of a cult is impressive—it owns the body, mind and soul. The act of suicide may be the result of the extraordinary power of the mind control of a political or religious cult. Death is the ultimate sacrifice.

I spent several months in a geropsychiatric unit, where I observed that the elderly often suffer a great deal of anxiety. They may develop panic attacks, generalized anxiety or an anxious depression. It is almost as though the lower energy of old age leads to an inability to maintain their defenses and they can become overwhelmed, especially if they are facing a life-threatening illness and must look at their own mortality. The elderly often have a difficult time accepting the aging process and the many losses. On a more encouraging note, I have observed that older people who have loving families and who have spent a lifetime being able to share their feelings are better equipped to handle the challenges of aging, including the loss of loved ones and declining health. I personally feel that aging is the most difficult experience of life.

Some concluding thoughts: I have come to believe that lack of insight and self-exploration on the part of the psychiatrist is one of the major causes for ineffective psychiatric practice. Psychiatry can often be an impotent profession. Patients may not resolve their issues, they may not grow and change. Although certain psychiatric illnesses may require the judicious use of medication, the psychiatrist must not lose perspective of the heart and soul of the patient and the importance of a contactful relationship between physician and patient.

My experiences this past year have again strengthened my belief in the importance of contact and the ability to tolerate feelings. A person does not grow if he does not learn to tolerate feelings. I have learned from orgonomy that the direct experience of and expression of feeling is what is healing and discharges the very energy that is so heavily guarded against and is, in fact, what provides relief. We have a great responsibility to our patients to stay in contact with our own feelings, with our own true nature. We owe it to ourselves and to our patients to travel as far down that difficult but exciting path as each of us can.

Notes from Afield

Notes from Afield is intended as a forum for the presentation 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.

SOME RECOLLECTIONS OF A PSYCHOANALYSIS WITH WILHELM REICH: SEPTEMBER 1929–APRIL 1932*

BY O.S. ENGLISH

Being one of a very few psychiatrists and psychoanalysts in the United States who were analyzed by Dr. Wilhelm Reich in Europe, I have been asked by several people to set down a few of my recollections in regard to Dr. Reich himself and my analytic experience with him.

I will begin by recounting how I arrived in Vienna, Austria in September 1929 and began analysis with Dr. Reich. In 1929, I began a Commonwealth Fellowship of three years' duration which was sponsored by Dr. C. Macfie Campbell, then Professor of Psychiatry of Harvard Medical School and the work being done at the Boston Psychopathic Hospital. After one year, those holding this fellowship were allowed the privilege of spending a year in Europe studying whatever they wished. I had made up my mind that I wished to be psychoanalyzed, if possible, during that time or at least get started with the study of psychoanalysis. When I presented this idea to Dr. Campbell as the type of work I would like to do while on my European visit, he hesitated only momentarily. He looked at the ceiling and leaned back in his chair, reminded himself that I came from Maine, and that a year in Vienna studying psychoanalysis and Freud's theories and principles of practicing psychotherapy would probably be a good blend of New England austerity and the Vienna of that time with its academic life, its culture, and its cafe-life and waltzes. So within five minutes he had told me I had his permission to make the appropriate plans.

I set out for Europe in late August 1929, and after arriving in Hamburg and moving on down through Berlin and Prague, I arrived in Vienna at the time there was a congress of sexual research in session. There I met Dr. M. Ralph Kauffman who was just finishing analysis, and he pointed out some of the analysts to me who were visiting this congress and introduced me to some of them. I did not know one analyst from another and had no preconceived ideas of their particular virtues, and so as he was finishing his work with Dr. Reich and stated that he had found Dr. Reich a most satisfactory person with whom to [sic] his psychoanalysis, I went to see Dr. Reich and rather promptly took Dr. Kauffman's "place on the couch," as it were.

Dr. Reich spoke English quite well and only rarely did he have to ask the meaning of a word or ask for a synonym. He had his office on the fourth floor of one of the older buildings not far from the Allgemeine Krankenhaus. When I began my analysis with him, I expected to spend the entire year in Vienna. However, due to some circumstance, which I do not precisely recall now, Dr. Reich moved after two months to Berlin, Germany. He announced this about a month in advance, and I had no reluctance about accompanying him. I had been a week

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in Berlin, had a few friends there, was perfectly willing to make the change, and it took place uneventfully.

During these two months in Vienna and after about a month in analysis, an incident took place which I feel bears reporting since it tells something about Dr. Reich and his handling of an incident which is probably not too uncommon in analysis, but in this case it was one of those things which occur before any positive transference has become very solidly in force. One evening, as was the custom, I was in a café talking with some of the young analysts who were doing their training there. One of them, upon finding out that I was in analysis with Dr. Reich, showed considerable consternation and warned me very seriously that Dr. Reich was politically a Communist and that if I remained in analysis with him I would naturally end up with the Communist value myself. Not only did he think this was most dangerous and undesirable, but he further pointed out that when I returned to the United States that I, as a result of exposure to him, would not be able to obtain a position in any American university or other institution of learning.

Naturally, this brought about considerable concern on my part, and so I brought it up promptly in my session the next day with Dr. Reich. He listened through the session, and at the end said, "I have the impression considerable time can be wasted on this matter without profit to you, and the time will be spent wastefully quite unnecessarily. I suggest that you go to see one of the educational committee of the Viennese Psychoanalytic Institute, and I will arrange to have you see Dr. Helene Deutch [sic] as soon as possible." He was able to arrange it for the following day between patients of Dr. Deutch.

When I arrived, Dr. Deutch took me in her office, invited me to sit down, and without further ado said something as follows: "Dr. English, we of the Educational Committee of the Viennese Psychoanalytic Institute have complete confidence in Dr. Reich, and we have never seen any evidence that his political views disturb his ability as an analyst for training candidates. Therefore, I advise you to go back and continue your work. Students in the Institute talk too much and they give immature and untried opinions freely among each other, sometimes it is disturbing, and they should not do it. If a psychoanalyst is functioning competently, his political views should not interfere with the necessary objectivity for psychoanalytic work."

This statement by her, given in the manner she gave it, was completely adequate and satisfying, so I thanked her and left. I cannot recall that the subject ever came up in my analysis again, although I would assume that from the emotional impact it made upon me at the time it was said, it *must* have done so. However, the effect must not have been very great thereafter because I cannot recall further discussion of it as part of my resistance to psychoanalysis in general and Dr. Reich in particular. I had plenty of objections about other things, but that of political leanings did not seem to occur after that, to the best of my memory.

Upon moving to Berlin, Dr. Reich for a time took an office in the area of the Psychoanalytic Institute and I too lived in the same vicinity. Later he moved into the suburbs and shared an apartment and a living room with his wife at that time, Dr. Annie Reich, now of New York City.

It was at this time that I recall Dr. Reich utilizing his interest in other than verbal presentations of the personality. For instance, he would frequently call attention to the monotony of my tone of voice as I free associated. He would also call attention to my position on the couch, and I remember particularly that he confronted me with the fact that when I entered and left the office, I made no move to shake hands with him as was the custom in both Austria and Germany. I, of course, defended myself by saying that I came from a part of the world where this was not customary, and he nevertheless replied, "There is a saying you know that when in Rome, one does as the Romans do. This means that if one would

care enough about the people he was associated with, he would as far as possible adopt their manners and customs as an indication that he wanted to be more in harmony with them and their ways." I had to admit that this point of view had merit, and yet, I recall saying at the time that I thought it was a rather useless and unnecessary evidence of amity or friendship. I told him further that in New England, at least that part of New England I came from, we merely said hello and sometimes we didn't even do that. In that territory we merely met with each other and felt fortunate if we did not have anyone turn his back on us at the time.

Possibly due to the fact that my time in Europe was going to be limited or possibly because Dr. Reich felt I was ready, I began, after a certain number of months, to attend the lectures and the seminars in the Berlin Psychoanalytic Institute. Apparently Dr. Reich, after a time of listening to my free associations, felt that I had begun classes and seminars too soon and that I was utilizing these particular data to intensify my resistance to psychoanalytic theory because I would come from the Institute lectures or seminars and take either a patronizing or a critical point of view of the theories I heard expressed or the manner of the man who taught them. Instead of concentrating my affects around him in a utilizable way, I dispersed them widely over various analysts and the concepts being presented. After listening to this a while, Dr. Reich said he felt I was not getting any good from the lectures and seminars and furthermore that they seemed to overload me with too much in the way of theory prematurely and that it would be better for me to withdraw from the classes and deal only with the analytic material itself as it brought itself to the consultation room. In this way, Dr. Reich felt he could better deal with a resistance produced by my own free associations than that which was being added by too many additional activities in relation to analysis.

I can well recall that this nettled me considerably, and while I was not enjoying the classes very much, I nevertheless felt that I were being demoted and took it as a rather painful confrontation of my defect in sincerity. I could see very well his rationale for the suggestion. I followed it, and I have always thought it was a good move on his part because while I had been quite definite back in Boston that I wanted to be psychoanalyzed and to utilize it, I did not realize how much resistance to the system of thought I was going to encounter. Consequently, this rather painful challenge on the part of Dr. Reich did awaken me to do more serious thinking about whether I was going to find the concepts of Freud applicable and useful or not. If they could find a place in my own personality, then it was obvious I could use them effectively. However, if I could not find any application of them or use for them in my own personality, I certainly would not be able to utilize them with any skill or conviction upon anyone else.

One would have thought this confrontation would be adequate to jolt me out of my complacency and a loyalty to the so-called New England "common sense" which New Englanders tend to feel settles all problems in life anyway. However, this confrontation about the Institute lasted for only a certain number of months, and Dr. Reich had finally to confront me one day with a real blockbuster to the effect that I should realize that in addition to the classes and seminars which I was later allowed to re-enter, I nevertheless needed a letter of recommendation from him in order to become a member of the International Psychoanalytic Association. He told me that he would in no sense make any such recommendation if he continued to hear the still present sounds of ridicule about concepts which he and other analysts had found useful in curing people of serious disabling conditions. He pointed out that if I wanted to be this kind of doctor, called a psychoanalyst, who used psychoanalysis to cure difficult mental and emotional conditions, that I could not take part of it and disregard other important parts of it. And, until he felt I had enough of the basic tenets of psychoanalysis to begin work with patients, he would not even recommend me for the supervised work

of the Institute let alone give me a letter eventually recommending me for the International Psychoanalytic Association, which at that time was the organization existent other than the local society and institute in New York City.

This again brought me up with a jolt because I seemed to hear the voice of my father speaking. My father had always insisted upon good preparation and good standards of workmanship, and Dr. Reich was pointing out that I was avoiding the necessary preparation for good workmanship by my attitude and my casual concern about the truth or nontruth of the workings of the unconscious mind as it is revealed in its various ways. So, I responded by looking harder than ever, thinking harder than ever, and merely protested to Dr. Reich that he was a hard taskmaster. This turned out to be the last time that I needed to be confronted so directly and so forcibly about my attention to the value of the material with which I was working. Like so many students of psychoanalysis, I had felt the concepts and theories of the unconscious mind and its forces; the power of affect and imagination and the importance of dreams all rather interesting, but realized while I was in analysis that I had not assumed that they were universally applicable or found to run quite a similar course in every person. A succession of events eventually convinced me they did, and I have always felt a great gratitude that somehow or other I landed in the hands of an analyst who was a non-nonsense [sic], hard-working, meticulous analyst who had a keen ear for the various forms of resistance and a good ability to tolerate the aggression which almost inevitably follows necessary confrontation in subtly concealed or subtly manifested resistance. When I say hard-working, I might recall that on many occasions I went seven days a week. When Dr. Reich proposed this possibility to me, I thought he was being a little too intensive. I thought I was doing pretty well to go six times a week, but while I wasn't objecting on any grounds of religious concern for the use of the Sabbath Day, I thought Dr. Reich was being a little too diligent and he possibly just wanted my money seven days a week. However, he pointed out that a session was a session, and in order for analysis to run its course to a satisfactory point of comprehension, a certain number of hours would have to be put in. Furthermore, he said he believed that during the other 23 hours a day there was plenty of time for the necessary mental, emotional, interactions that would make an hour daily profitable, and since he was willing to see me, I should be willing to see him. There again, Dr. Reich's logic seemed undebateable [sic], so I went. As time went on, and my money ran out anyway because I had to eat and have a place to sleep as well as pay for my analysis, I was glad that he had insisted upon our working on Sundays.

As regards Dr. Reich's handling of aggression, I will recount an incident which has an interesting and mildly amusing climax. One day he called me and asked if I could change an appointment from morning to the afternoon. It so happened that I had a social engagement in the afternoon which conflicted with the time he wished me to come. I told him this, and he asked me whether I felt the social engagement was more important than my session with him for analysis. I replied that I thought it was more important than the analysis and I forget whether he then took me at the original time or whether the appointment had to be cancelled. At any rate, after hanging up the telephone, I became more and more incensed that he should question my schedule or question my right to enjoy myself socially as against the work with him, and the longer I thought about it the angrier I got. When I finally did get to his office, I told him that I previously had kept his schedule from the beginning of analysis and that having made the appointment he should keep his, and that I further thought it was audacious and presumptuous of him to question whether my social engagement was more important than the analysis. And, I went on and on with various other assertions of the justification of my point of view and all that was wrong with his schedule which necessitated calling me. When I had run down on all this, to which he had listened patiently, he

merely said, "You are perfectly right," and this took the wind out of my sails completely, and I was amazingly surprised as I had expected a similar defense of a lengthy expression on his part, and I got none. I had the first and perhaps greatest lesson in my life of the fact that a human being may be self-assertive and be given a right to an opinion and not be criticized for it or have acknowledgment given grudgingly.

Dr. Reich smoked a great deal and, being a nonsmoker myself, I used to frequently object to his smoking. His room was fairly large, but the smoke would be quite profuse, and he would from time to time open the window. I doubt if I was really made uncomfortable by it. It was probably one of the objections I was making in the way that patients make complaints about inconsequential things when they are looking for a greater consideration from some other area of the relationship. He also had fairly frequent telephone calls. They were not of great length, but I used to object to these as well, also on the grounds of his lack of consideration for me.

I rarely ever saw him outside of the analytic hour. This wasn't likely to occur since we travelled in different orbits, but one evening I saw him in a restaurant, and since he had always been an unobstrusive [sic] individual in appearance and demeanor, I was mildly surprised to have him ask me why I didn't come over to him in the restaurant as I left. I told him that I had assumed that he wouldn't have wanted this. He asked, "How did you come to that conclusion?" I said, "You have always been so cold and unfriendly, I didn't think you gave a damn." His comment was, "Well, even though I may have appeared cold and unfriendly in the office, had you felt friendly enough to me to come and speak to me in the social situation, I would have welcomed it." Naturally this made me feel he was a very strange man indeed, because I was obtaining for the first time the idea of the freedom of a person to BE what he wishes to be, while he allows the other person to be himself also. And, everything we learn to regard in a new light we tend to regard it as strange until we become accustomed to it.

Throughout my analytic contact with Dr. Reich, I would describe him as a somewhat taciturn man, a serious man, although not without humor. He was conscientious and dedicated to psychoanalysis and both the training of candidates and treating of patients. One could never miss the fact that he had a sustained interest of considerable intensity in those he treated or worked with. If he disagreed with ideas of his contemporaries, he spoke of the disagreement but did not present any personal animosity toward those who did not agree with his point of view or any of his ideas of technique. As was the custom in Berlin at the time, there were special seminars given by the various teachers, and these were held in their homes away from the Institute. Dr. Otto Fenichel held one; Dr. Muller Braun-schweig [sic] and Dr. Lampel de Groot and Dr. Reich also. Dr. Reich's seminars were on technique, and they were well attended. The students were interested in his approach to difficult problems in the management of a case. He taught with enthusiasm and with intensity, but not impatience. Also, he always listened with respect to the opinions of the students.

After fifteen months of analysis, I was asked by Dr. C. Macfie Campbell to return to the Boston Psychopathic Hospital to conclude my obligations to the Commonwealth Fund Fellowship sponsored by that institution. I had already asked for a three-month extension which he had granted me, but he would go no further, and so I returned. Dr. Reich had been the kind of analyst who paid considerable attention to some definite expression of the analysand's feeling toward the analyst in order to be aware of what the transference feelings were at the time as well as to relate the working relationship to whatever material was presenting itself. I recall that just before I left in December of 1931, he was speaking of my cool detachment still existent at the time and made a remark I did not understand then but which I have pondered since. He said that my difficulty in expressing much positive feeling toward him might result in my developing a

"belly ache." The boat I took back to the United States had a rough voyage throughout, and I was seasick all the way from Southampton to the Statue of Liberty. I always wondered how much of my serious seasickness was all due to the turbulence of La Mer, and how much of it might have been due to my refusal to have come closer to the parental figure that Dr. Reich represented in those fifteen months.

I finished my work for the Commonwealth Fund in another nine months, I believe, or less. In the meantime, I was wondering how I was going to finance further analysis in Berlin, and I recalled an insurance policy my father had taken out for me some years ago. The thought crossed my mind that I might be able to borrow money on it to make the trip. It turned out that I could do this, and I went back to Berlin. I had written Dr. Reich that I was returning, and when I entered his office he had the following conversation with me.

Dr. Reich: "Why have you come back?"
Dr. E.: "Because I wanted to finish my analysis."
Dr. Reich: "Very well, lie down on the couch, please."

And, so the analysis continued. One can see that he was a man who didn't waste words. He was never effusive, but it was hard to find much visible exuberance in him except for his occasional humor and the expenditure of a great deal of energy. Later I learned of other sides to his personality, not revealed to an analysand but which all the same showed a great many interests and a lively interest in many aspects of life.

As I neared the end of my analysis, I became much warmer toward him and during these latter seven months felt emanating from him a greater personal interest and some liking on his part for me. So, I asked him why he did not, as many of the other European analysts were doing at that time, come to America. He replied that since he was so well known all over the world as a person sympathetic to Communistic ideology, he felt quite sure he would not be admitted to the United States. As a Communist, however, he wasn't welcome in Germany at the time. His strongest protest was against authoritarian government of any type. He did mention one day during my last two weeks in analysis that he was aware he was under surveilance [sic] by the Hitler government. He did not say this with bitterness or with any sense of persecution, but just with a rather wry observational affect concerning his own plight.

As I later learned, he departed for Scandinavia very shortly after my last session in analysis. In that area, he was not well received by psychiatrists or any of the medical profession, I have been told. How he was accepted politically, I do not know. He was later to come into the New York area, but I did not know exactly when this occurred and I do not know who sponsored his arrival in the country. I was told that Dr. Theodore B. Wolfe, onetime the husband of H. Flanders Dunbar, had been one of those helpful in his arrival here. How much Dr. Wolfe participated in his transfer to this country, I likewise do not know.

On two occasions, I had correspondence with Dr. Reich, and I believe these are interesting enough to recount. As I neared the end of my analysis in Berlin and my money was running short, he reduced my fee and told me I could send him the money when I had it. After I had been in America a certain amount of time (I would estimate roughly a year), I sent him what I owed him. He replied, thanked me for it, and said that while he had forgotten that I had owed it to him, it came at a very convenient time for him. He wished me success, and at that time I believe did send a letter of recommendation addressed to the International Psychoanalytic Association that he was satisfied with the results of my personal analysis and recommended me to them for membership.

The other correspondence came after he reached this country and had been here some months. I learned where his address was in one of the five boroughs in New York, and said I would like to come to see him. This letter I can no longer find. At any rate, his reply would

seem to indicate that he was already rather oversensitive because without any necessity for it I could detect at the time, said he was glad to hear from me and would see me, but then went on to say that I was not to assume that he was in any need and that I should not trouble to come to see him if it was a gesture of sympathy or because he was in need of any support from those physicians in America he had analyzed in Europe. He said if I came, I should come entirely because I wanted to see him.

While one cannot exactly take exception to this type of letter in a man who was always scrupulously clear in his relation to the analysand and wanted the analysand to be the same with him, it nevertheless seemed to me it did not reflect a great cordiality between a one-time teacher and a student. Rightly or wrongly, I was not able to muster enough enthusiasm after receiving this type of letter to ever make my plans to get over to see him, a fact which I now regret, but which at the time I handled by merely delaying and postponing the visit.

I can cast no light upon the time when Dr. Reich evolved his idea of Orgone or when he began to put it forward as a serious theory. I can only say that I heard nothing about it while I was in analysis with him, and since I never saw him personally afterward, I am at a loss to know when this idea began to develop and he began to work and write in relation to it. My account ends on a rather regrettable note in that our contacts with each other or our relationship was so tenuous that I was not aware that he had been arrested, tried, and spent well over a year in jail, actually in the state of Pennsylvania at Lewisburg, and I even missed the notice of his death there when it appeared in the newspapers.

To offset that regrettable fact, I can perhaps close with a more amusing note. Dr. Reich, after coming to this country, eventually established some kind of summer home and institution of research in the state of Maine which is the state in which I was born. Moreover, the place where he was located for a while had the interesting name of Harmony, Maine. One of my patients whom I was treating about the time this occurred, and who had learned of it somehow, possibly through the newspapers or possibly through some other person interested in psychotherapy—imputed his choice [sic] Maine as the site for his residence (for at least part of the year). As evidence of the triumph of the strength of my personality over his, I, the young man from Maine, went to Vienna to start treatment with Dr. Reich, and the result after several years was that I drew Dr. Reich to Maine after all because of some esoteric influence my personality had exerted over him. To her the location alteration was too significant to be considered only a coincidence.

At any rate, while I heard from time to time of a type of Orgone therapy attributed to him and read of his theories regarding the Orgone, it was to be thirty-four years before I made any effort to learn more about the man who had been of so much help to me through his part in my training.

An account of that goes as follows as written to a friend three weeks thereafter:

"On August 23, I went up to see the Organon [sic] Institute which still is maintained in memory of Dr. Wilhelm Reich and his work. I had always had a curiosity about the place and in the last three weeks there have been two fairly long articles in the Portland Press Herald about him, written by a Mr. Williamson, who gives one of the most dispassionate and fair accounts of Reich I think I have ever read. Upon arrival, we went down to the Institute right away. We had been told by some people in Livermore Falls that his place was about two or three miles beyond the town, so we went out and into the driveway and came to the Institute. There was a chain across the drive to the laboratory and observatory. We learned that the visiting days were Tuesdays and Fridays and we were there on Wednesday.

Ellen had the idea to drive back to a place called the Rangeley Lakes Golf Course at the Sky and Lake Lodge. Any-

how, we went in and had a sandwich and talked with the lady proprietor. When we told her we were interested in the Organon [sic] Institute she called the Chamber of Commerce for us and asked the name of the keeper of the Institute and who cut the grass and kept it in condition for visitors. We learned the name of this man, and when she said she had always had a curiosity about it, we invited her to accompany us. We looked up the man in charge and with a little persuasion from our guest, a local business person there, and me, a one-time student of Dr. Reich's many years ago, he interrupted his grass cutting and gave us a personally conducted tour. It was more interesting than I could possibly have anticipated.

First, Dr. Reich had apparently always had a wish to be buried above ground and not below so there is a crypt of marble about one hundred yards from his former home in which his bones lie above ground and on top of which there is a bust of him which faces out toward the Rangeley Lake region; a most attractive view of water, trees, and low mountains. There is scattered over the place some telescopes and tube-like apparatus which he named a "cloudbuster." There are five of them and they were used to produce rain on a clear day in case a certain area of the state was suffering from drought. I was a bit incredulous at the apparatuses and the effect they were supposed to produce. The man in charge was a man who worked for Dr. Reich ten years before he died, so that means in all about fifteen years ago. He seemed one of those Maine people of considerable integrity, although, of course, when I get to one part of his story you may think it incredible. At any rate, he certainly was not eccentric in manner nor an overenthusiastic devotee, and his wife and daughters are the ones who run the Institute on Tuesdays and Fridays, show people around, and explain what they can. The observatory, so-called, which is where he lived is quite a large house and where he did some of his experiments and where there is still a remarkable library, an organ which he played, and paintings that had been done in his own hand. They show a man very full of color, life, and energy. He has a personally autographed book by Freud done in the latter's most friendly and affectionate manner. In fact, his library would take one to three hours to even begin to get some idea of its scope, magnitude, and profundity of content.

One couldn't say that he lived in grand style, but he did not live in austerity either. His office is large and his desk and the room and view where he worked was very impressive. His classrooms were spacious and contained blackboards and projectors. He had quite a large group there at one time working with him.

Now back to the cloudbusters for another word or two. Apparently, a group of farmers from Hancock County were having a very bad summer with drought and they came over to see him and asked him if he would come and help them bring some rain. He was interested in experimenting, of course, but the distance was great and he had to move a great deal of apparatus, according to Tom, so he said two things. He said he couldn't go for less than $500 and he also said that since his work was experimental he could not promise any results. However, they went and one of the places they set up their apparatus was on Mount Dessert [sic] Island. After two or three tries the rain came (believe it or not) when the weather bureau had not predicted any rain in sight for a week or more. I don't know what credence to give this. The caretaker, Tom Ross by name, seemed very impressed and was on the trip and operated one of the machines. He asked Reich if he could try it in a certain spot; Reich gave him permission, but expressed his doubt as to whether any results would be obtained. But, Tom nevertheless got a little rain all the same and

reports this result with considerable pride. Ross also reports that there were other occasions of successful rainmaking. They were apparently good friends, as much as a farmer and caretaker could be to a man of Reich's interests and background.

There were no Orgone boxes there as they had all been destroyed by the FDA. The article by Williamson in the Portland Press Herald reported that the FDA had burned his books there at the Institute and also burned books in his New York state home and office. I was astonished because I had not thought our agencies were book burners and certainly of all those who might burn books I would not think the FDA would be so totally destructive of the work of one man. I thought book burning had taken place in this century largely in Europe, and not so very long ago, but I didn't know the FDA had been added since.

I never was one to bring forth any special enthusiasm about Reich than any other analyst. I neither renounced him nor did I try to place his contributions above others. I said he analyzed well as far as I could determine for the time I was with him, and many other people substantiate this. I did not follow his work after he left Scandinavia and came to this country. However, it was a little heart-breaking to go there and find that a man's work, whether it derived from a certain kind of insanity or was half-insane or whether there was something of unusual value in it, snatched away from a place he had created and Reich himself forced to spend a year or more in a federal penitentiary and die there. That is a sad end for a person attempting to present a new idea.

I had no idea until recently that Reich was the son of a Polish farmer; hence I went through my two and a half years of analysis with him and didn't know that we were both farmers' sons. That's how much he kept his personal life to himself. I also never knew that he was an organist or that he painted. His paintings would vie with Van Gogh for impact, if I am any judge. Apparently he had some premonition of what was soon to come because he has a pencil sketch of some size on the wall which is entitled "The Hand of Death" and there is no mistaking that the face is that of Reich. The bust of him which was done by Jo West was him looking like a German philosopher with hair sweeping back in a way that I never quite saw it on Reich in my time, although apparently he allowed it to grow longer later. The whole place seems charged with an atmosphere of immense energy. The institution, while not large, represented the outward extension of a tremendously energetic man with his mind flooded with ideas; almost too many ideas for one person to put into action during one lifetime.

I have no idea why he wanted to be buried above ground or why he wished to be buried at all rather than cremated. This is nothing I ever heard him express himself about. It may be in his writings somewhere. I think it has inspired me to read him again and try to see if I can dissect something of the Reich I knew from the Reich who later wrote, and whose ideas took a turn which annoyed or disturbed so many people in the scientific world and outside of it.

Recalling that one of my misgivings when I was beginning analysis was when I was told he was a communist, it might be more correct to say that while he did have communist leanings, it should be born [sic] in mind that he was anti-authoritarian most of his life. Consequently, he was resented and hounded by the Nazis and communists alike. Neither of them liked him because he spoke out against both of them and their ideology when their philosophy affected masses of people. It gives me a certain feeling of sadness that he should have been persecuted and put in prison in this country when he had escaped some of the places in Europe where imprisonment

has been more frequently the punishment for dissenters than in the United States. I am not saying he was insane or that he wasn't. I think I'm just not competent to judge. Time will have to be the judge.

One of his daughters lives in Hancock County and practices medicine there according to Ross and has a little to do with his affairs still. I don't know where the second daughter is living. Reich married again after he and Annie divorced in Europe. His second wife bore him a son and they live part of the year in Maine, although the son is said to be now in the service."

Before closing my narrative and especially since there may appear some unjustified criticism of FDA procedure, I willingly concede that there exists much data I know nothing about. Furthermore, in justice to the government agency's procedure in imprisoning Dr. Reich, I am aware that in looking over his history even before coming to this country, there ran through his actions a red thread of what could be called *daring* if not *rash defiance* of authority which could have been greater than necessary in order to achieve his goals. Put another way, he seemed at times not to have had his sense of self-preservation working to his advantage as well as he might have. Possibly he was one of those people who enjoyed living dangerously. I do know he enjoyed skiing and motorcycle riding for instance. Whether he was a devotee of Russian roulette, I do not know! Also, like many people with ideas they feel have merit, he seemed impatient to the point of inviting retaliation for insisting upon a rapid acceptance of their ideas by the many, forgetting momentarily the fact or ignoring history in its documentation that new ideas permeate the group consciousness slowly.

But all speculations aside, I never regretted my choice of psychoanalyst in choosing Wilhelm Reich, and now at age 74 it is unlikely that I ever shall do so. In fact, I have often felt some uncanny fate directed my footsteps his way in September 1929. An indomitable spirit was existent in this quiet man I came to know so slowly, but it seemed the older he became, and hence a growing awareness of the less time he knew he would have to make his impact upon the world, the faster grew his pace until he crashed to his death against a society he was so eager—possibly overeager—to help with its many problems: social and scientific.

Communications and Notes

A Change in Publishing Policy

Beginning with Volume 9, the *Annals* is being published on an as-needed basis. This will help us to avoid the delays which have occurred in the past between the announcements and mailings. Subscribers who have prepaid for Volumes 9 and 10 will be receiving those issues.

Announcing New Website

We anticipate having a website by spring of 1999. You will be able to access our website at the address www.orgonomicscience.org. You can also find the website by using the search words Orgonomy or Wilhelm Reich.

Report from Morton Herskowitz, D.O.

Since the last issue of the *Annals of the Institute for Orgonomic Science,* Dr. Morton Herskowitz lectured on Psychiatric Orgone Therapy in Germany at the Zentrum für Orgonomie and to the Departments of Psychology and/or Psychiatry at the Universities of Heidelberg, Munich, and Hamburg. The receptions were invariably enthusiastic and cordial.

On the one-hundredth anniversary of Wilhelm Reich's birth (1997), Dr. Herskowitz attended a Congress of followers of Orgonomy including therapists, trainees, and workers in various mind-body techniques. The Congress brought together delegates from all of the countries of South America and was held in Montevideo, Uruguay. Opening ceremonies were held in the large, tiered auditorium of the Montevideo City Hall, which was filled to capacity. Dr. Herskowitz spoke on various orgonomic subjects to an "overwhelming" response. He describes the interest and energy of the participants as "unanticipated and inspiring."

Also in the centennial year of Reich's birth, Dr. Herskowitz spoke on "Remembrances of Reich" at the Orgone Biophysical Research Laboratory in Ashland, Oregon; at the Wilhelm Reich Museum in Rangeley, Maine; and at a convocation of the American College of Orgonomy in Princeton, New Jersey.

Emotional Armoring: An Introduction to Psychiatric Orgone Therapy by Dr. Herskowitz was published by LIT Verlag in translation in Germany in 1996, and is now in second printing there. It was published in the USA in 1998, distributed by Transaction Publishers, New Brunswick, New Jersey.

Report from Edward Applebaum, D.O.

Dr. Applebaum has given the following lectures since publication of the last issue of the *Annals*: In 1992 he spoke on the "Orgonomic Treatment of Psychotic States" at the Wilhelm Reich Museum in Rangeley, Maine. In 1997 he lectured on the "Orgonomic Treatment of Children and Adolescents" at the Orgone Biophysical Research Laboratory in Ashland, Oregon.

Educational Programs

The Institute conducts ongoing training programs for medical students and physicians, and educational programs for the public.

• *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 biogen-

esis 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 resume that includes biographical data, classical and orgonomic training and therapy to the Institute for Orgonomic Science, 205 Knapp Road, Lansdale, PA 19446.

• *Educational Programs for the Public*

The Institute is planning to arrange a discussion group dealing with selected topics on orgonomy in the Philadelphia, PA area beginning in 1999. If you are interested or would like additional information, please contact the Institute for Orgonomic Science, 205 Knapp Road, Lansdale, PA 19446.

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, 205 Knapp Road, Lansdale, PA 19446. 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. Herskowitz, M.: "Human Armoring: An Introduction to Psychiatric Orgone Therapy," *Annals of the Institute of Orgonomic Science*, Vol. 3, No. 1, 1986.
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 5-3/4 to 8-1/2 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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This issue is dedicated to the memory of Robert A. Dew, M.D.