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Hazards of Body Therapies: Three Case Studies

By CHARLES KONIA, M.D.*

Regarding the question of lay therapy, Baker states:

> I am opposed to lay therapists, particularly those who practice body-oriented techniques. This is not just a personal bias nor one to eliminate competition. A lay therapist cannot possibly have the necessary respect for the body that one fully acquainted with anatomy, physiology, pathology, and the various illnesses, physical and emotional, learns to have after years of studying medicine. Psychologists do have some knowledge of psychiatry but lack the necessary medical background a physician has acquired. This is bad enough, but today we have completely untrained, uneducated persons assuming the responsibility for patients with emotional problems. It seems that everyone believes he is capable of treating these conditions and that this in itself justifies his becoming an instant professional meriting large financial returns. Many assume the title of doctor, and the unsuspecting patient finds himself in wholly incompetent hands. Behind this attitude is utter contempt for human misery. It is a wonder that disaster is not more frequent. To successfully treat emotional problems is difficult even for the most experienced. To recognize physical or emotional emergencies is never easy. This is not a task for the poorly trained or inexperienced, not even for the best of lay therapists. Emotional disorders belong in the realm of disease, and disease should be treated by a fully trained physician (1).

Despite these exhortations made by Dr. Baker over three years ago, so-called body-oriented lay therapists continue to abound and the trained medical orgonomist sees a sampling of these unfortunate patients on a fairly regular basis. Even when really disastrous results do not occur, therapies performed by either lay therapists or untrained physicians inevitably become bogged down very soon after the initial stages. The disorderly management of therapeutic material necessarily

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results in a chaotic situation. At the very least, little if any lasting improvement can be expected. In these hapless cases, not only are the patient's time and money wasted, but any hope for a permanent cure or improvement is thwarted. Most cases are not so fortunate, however. They lie somewhere between these two extreme possibilities. That is, they are worse off than they could have been had "nothing happened," but better off than those patients who succumb to the disastrous consequences mentioned above.

Based on the experience of treating dozens of patients who were first seen by inexperienced therapists (both lay and medical) and subsequently came to me, the following general statements can be made: In some cases, considerable time was required for the patients to rearmor and attain some degree of equilibrium before they could function at their pretherapy level. Many were in such poor biophysical condition that little if anything could be done to improve their situation or alleviate their chronic distress. Others had developed a hook, which, in most cases, proved to be untreatable. In none of the patients that I can recall did any permanent benefit result from their previous therapy. Where orgone therapy was still possible, it was necessary in every case to go right to the beginning and start systematically to dissolve the armor from the ocular segment.

In this article, five of the most recent cases in this group will be described in sufficient detail to demonstrate the inevitable consequences that can be expected from the haphazard mismangement of human biophysical structure. Two cases in which the patients had seen a lay primal therapist will be discussed.[1] This will be followed by three additional cases in which the patients saw "Reichian" therapists.[2]

Case 1

The patient was a 34-year-old machinist who came to therapy after having seen a primal therapist for six years. His chief complaint had been and still was a moderate to severe degree of depression. He had felt better at the time when the lay therapist used "Reichian" techniques, that is, when the therapist worked on his muscular armor. Because therapy was done in an inconsistent manner, however, no real progress was made, and the patient became dissatisfied. The only benefit was a learned ability to express anger verbally (which he had never allowed

[1] See "The Body Therapies" by Dr. M. Herskowitz in the *Journal of Orgonomy,* Vol. 13 No. 1, May 1979.

[2] Aside from a few groups such as those mentioned in this article, most of the body therapists refer to themselves as "Reichian" or "neo-Reichian."

himself to do before), but this was not of much help. In social situations, he was quite demanding of others and, when his expectations were not met, he became frustrated and depressed. He felt cold and distant towards women. On one occasion, he attempted sexual contact but was left feeling dissatisfied. His tendency towards depression had continued unchanged by the primal therapy.

Biophysical examination showed that the eyes were sad, but he was able to make good contact. He had no ability to express anger in his face or eyes. He whined and complained a great deal. When close to becoming angry, he either laughed or appeared ready to cry. His jaw was tight, the throat was heavily armored, and he was unable to shout. The most severely armored segment was the chest. The sternum was hard and not compressable. Respiratory excursions were severely constricted. Manual attempts to lower the thorax were unsuccessful, and he had a moderate degree of pectus excavatum.

My diagnosis was a depressed manic character with a moderate degree of depression. My impression was that no consistent work had been done in his previous therapy, either characterologically or biophysically, and in particular, no mobilization of the chest segment. This was confirmed by the patient. It was clear that, unless the severe armoring in the oral, cervical, and chest segments could be eliminated, his tendency to depression would not be alleviated. I therefore directed my efforts to helping him express anger and attempting to raise his energy level by mobilizing the chest. The patient reacted by becoming spiteful, which indicated that he was terrified of his anger. Biophysically, he developed a flu-like syndrome manifested by fever, pharyngitis, cervical adenopathy, and depression lasting for several days. The biophysical intolerance to expansion was typical and recurred frequently. Therapy was difficult, but, gradually, his organism began to respond. He began to tolerate a greater level of emotional charge without collapsing biophysically. This was accompanied by a gradual reduction of his tendency towards depression.

The crucial therapeutic considerations were the necessity to focus on his inability to express rage and, at the same time, to understand the limitations of his biosystem to withstand a build-up of energy and thus to release the rage in a gradual and consistant manner.

Case 2

The patient was a 35-year-old dietician who had seen a primal therapist in California for four-and-a-half years and had stopped when she reached a plateau. Subsequently, she moved to the East Coast in an ef-

fort to obtain therapy with a qualified medical orgonomist. Her complaints were vague. She stated that she wanted to "become healthier," "feel better," "open up more," etc. These statements were the exact same as those offered in her first therapy. They indicated from a biophysical standpoint that she was in as poor contact with her emotions now as she had been at the onset of her therapy almost five years ago.

She could be somewhat more specific regarding her difficulties with men. She always seemed to form a relationship with the wrong type of man. Her relationships were "physically oriented" and without any real emotional contact. When these relationships soured, she had difficulty in breaking them off. She had no understanding of why she behaved this way.

Biophysical examination revealed a petite, attractive female who appeared and acted like a little girl. The eyes revealed a drooping of the upper lid, indicating a great deal of anxiety. Despite being in such poor contact with her emotions, she was in good contact superficially with others and was able to flirt easily. There was moderate armoring in the oral, cervical, and thoracic segments, and the rest of the biophysical examination was unremarkable. When asked to do anything, such as opening her eyes wide or breathing, she became spiteful. She pouted and began whining and complaining, expressing a "nothing helps" attitude. The diagnosis was simple hysteria, complicated by a considerable amount of masochism.

From her biophysical and characterological appearance on the initial visit, it was difficult to imagine that any real improvement had been achieved during her previous therapy. On the contrary, because of her inordinate anxiety and spite, I got the impression that she had been pushed to the limit and had become too frightened to cooperate in therapy, for one does not typically observe such an intense degree of spite in new patients. She had not been allowed to unarmor in accord with her own ability.

Despite the fact that her most prominent expression was the anxiety that showed in her eyes, it was clear that no attention had been paid to this emotion during her previous therapy. This was confirmed by the patient. When asked if any work was done on this expression, she at first did not even realize that she was anxious. Pointing out in a consistant manner the expression in her eyes gradually made her aware of her anxiety. This made it possible for her to cooperate with my efforts to eliminate it, and, gradually, her spitefulness subsided. This is exactly what had not been done in her previous therapy. As she came into better contact with herself, her masochistic behavior was more apparent

and, therefore, could be handled. Following this, her relationship with men began to improve.

The following three patients were seen by a pair of lay "Reichian" therapists practicing in Oregon. Their treatment consisted of a combination of a form of group therapy called "The Long Class" and individual therapy conducted on the couch.

Case 3

This patient was in group and individual therapy for several years. Her original complaints were feelings of hopelessness, poor sex drive, and a great deal of free-floating anxiety. With men whom she saw as authority figures, she would flirt in an almost compulsive manner. Aside from feeling less hopeless, there was little change in her status now compared to the time when she first went to a "Reichian."

On the initial visit, there was no indication that her basic problem, her ocular armor, had been dealt with at all. Despite several years of therapy, her eyes appeared immobile and suspicious. They oscillated between being clear and being glazed. When her eyes felt hazy, she had difficulty thinking. When her eyes felt clear, everything seemed easy. She was easily distracted. Her occiput was quite tender. Having little ability to hold an emotional charge in the ocular segment, she either became panicky and confused with the slightest build-up of energy or she looked hurt and cried. The patient had a great deal of spite, the function of which was not only to protect herself from her own uncontrollable impulses, but probably also, in part, to protect her against the onslaught of the therapist. This assumption was suggested to me when, early in the course of therapy, the patient expressed relief that, contrary to the procedure of her previous therapist who constantly pushed and prodded her, I allowed her to proceed at her own pace. That the clinical situation in this case was iatrogenic was evident from the fact that this patient responded extremely well to the systematic dissolution of her armor and made unusually rapid progress. She was discharged from therapy after ninety-one sessions.

Case 4

The patient in this case had also been in group and individual "Reichian" therapy for several years. A paranoid schizophrenic, he exhibited a severe block in the ocular segment. His eyes were suspicious. Strabismus was present in the right eye. He developed headaches when tense. The patient had a high energy level and was quickly overwhelmed by sudden rushes of energy into his head, which resulted in

confusion. This reaction was accompanied by rapid blinking. In his daily life, these episodes, which were provoked by anger, would severely incapacitate him, as, at these times, his emotions threatened to run wild. To avoid losing control, he would have to walk away from these threatening situations. He was spiteful, bristly, and prone to quick outbursts of anger. With females, he tended to use his sexuality as a weapon.

It was again clear on the initial visit that the basic problems, both biophysical and characterological, were essentially untouched by the previous therapy. Even though the patient claimed to be in somewhat better contact with himself, his difficulties in social situations and his sexual functioning remained unchanged. Unlike the previous case, however, on initial examination, this patient was flooded with anxiety. This alternated with sudden outbursts of rage which, occasionally and for no apparent reason, became directed at the therapist. He would jump off the couch and look down at me menacingly, then meekly lie down again.

By focussing consistantly on his main source of armor (the ocular segment), this patient has made considerable progress thus far in orgone therapy. He is more rational in his work and sexual functioning and able to handle troublesome interpersonal situations with greater ease. It is highly unlikely that his basic problems would have responded without a clear-cut understanding of the manifestations and functioning of the ocular block.

Case 5

The patient in the following case was not as fortunate. An unusually gifted artist, he sought out a "Reichian" therapist following a break-up with his girl friend. His father, toward whom he was ambivalent, was also a successful artist, and the patient grew up in the shadow of his father's reputation. He felt confused about his emotions and had problems regarding his identity. Shortly after starting "Reichian" therapy, he felt himself becoming hardened and losing touch with his feelings. He became embittered, left therapy, and wandered aimlessly about the country, finally ending up on the East Coast. He again sought help, and this time contacted a qualified orgone therapist who referred the patient to me. When I first saw him, he stated that his identity problems, confusion, and difficulty in ordering life had intensified. He assumed different personalities in different social situations and complained that he did not know who he really was. At times, he felt "crazy." As he

spoke, his speech gradually became disorganized, and he exhibited a loosening of associations.

He stated that he went to Oregon to start "Reichian" therapy. Early in that therapy, he experienced an acute contraction deep in the occipital area, which terrified him. At this time, he experienced a sudden opening of his pelvis, following which he was flooded with more or less constant anxiety. He felt that he was going to die of a heart attack. He also found that he was becoming more spiteful in his daily life. Socially, he found that he was unable to reach out as much as he had done in the past. He became distrustful and had an idea that his mind was being controlled by the therapist. He saw the whole setup in Oregon as cultist. He began to hate it and left. Since that time, he had been unable to maintain steady employment and had wandered aimlessly around the country, hitchhiking, living like a hermit, and eating out of garbage cans. Prior to the "Reichian" therapy, he had been a successful commercial artist. Now, because of his severe anxiety, he was unable to maintain sustained functioning in any area of his life.

On biophysical examination, the patient's eyes and face were found to be stiff and the occipital muscles extremely tight. He was visibly anxious. He felt this particularly strongly in his chest. He gave the impression of being ready to explode in this region. The rest of the biophysical examination revealed light armoring except for tension in the lower extremities.

Unfortunately, this patient came for only two sessions. It was my impression that the high degree of anxiety he was experiencing, together with his basic distrust of therapy (which was not entirely unwarranted), made it impossible for him to continue. If this patient had been allowed to unarmor in an orderly fashion, the therapeutic outcome would probably have been entirely different.

Discussion

From the initial biophysical picture presented by these cases, it is obvious that, in every instance, there was absolutely no evidence that these untrained therapists knew what they were doing. It was apparent that the patients' major problems were not even touched, to say nothing of being dealt with in a consistant and orderly fashion.

These statements are not meant to imply that problems never arise for the trained medical orgonomist. Two of them are as follows:

1. *An acute biopsychiatric emergency:* Both characterological and biophysical signs and symptoms arise regularly during the course of

orgone therapy. It often takes all the diagnostic skills of the therapist to determine if the problem is transitory or if it requires immediate medical or surgical attention. It is frightening to realize that these conditions arise and go unattended in the hands of inexperienced therapists.

2. *A problem in therapeutic technique:* Only with sufficient experience and training is it possible to recognize a difficult therapeutic situation, as well as one's own limitations in technique. It is then possible to take appropriate action—to determine whether a given problem is beyond one's own capabilities or beyond the present capabilities of the therapy itself. In the former case, the problem can be presented at a training seminar or the patient can be referred to another, more experienced therapist. If the problem lies beyond the scope of therapy, the situation is frankly discussed with the patient with the recommendation that, in the interests of the patient, therapy be discontinued.

In this connection, I recall being told by another orgonomist of a life-threatening situation that arose during the course of therapy. The patient regularly developed recurrent episodes of renal failure whenever a certain point in therapy was reached. The therapist told the patient that he should discontinue therapy and that under no circumstances should he consider risking therapy with someone else, since it would probably kill him. The patient subsequently consulted a bioenergetic therapist in New York City, who assured him that there was really nothing to be concerned about and that he could cure him. The orgonomist was later informed of the death of the patient shortly after he began bioenergetic treatment.

The behavior of unqualified, inexperienced therapists is more than irresponsible. Unfortunately, there are no laws to safeguard the unwary patient from such practices. With the implementation recently of a more liberalized ethical standard by the AMA, the flood gates have opened for every kind of charlatan and psychopath to enter medical practice.

An independent check on the therapeutic work of these lay therapists can be made by comparing these patients with the initial clinical picture of patients referred by qualified medical orgonomists. When a specific problem is encountered in therapy, patients may be referred to another orgone therapist. The appearance of these patients are typically in marked contrast to those cases described above. Here the therapist reached an impasse and knew it. *These cases were handled correctly up to the point where the specific problem arose.* It was evident that armor had been removed in a systematic manner. This is based on the following criteria:

1. Work was performed on the upper segments *before* the lower ones.
2. Work was done from the surface (periphery) *inward* into the core.
3. Work was done on historically later sources of armor *before earlier* ones.

These criteria, which are strictly followed by every qualified medical orgonomist, insure that each case is properly managed.

Conclusion

These case histories represent typical examples of what can be expected from inexperienced therapists. Several important conclusions can be drawn:

1. In none of these cases was there any evidence that the armoring was dealt with in a systematic manner based on an understanding of the individual patient's structure and an accurate psychiatric diagnosis.
2. In the absence of this comprehension, therapy was done in a haphazard manner depending on the personal whim and inclination of the therapist.
3. We can assume that, under these circumstances, therapy would become bogged down sooner or later when the unsystematic dissolution of the armor had progressed to a sufficient degree. This would be manifested by the following situations:

a. Complaints by the patient that therapy was not going anywhere.
b. Increase in the manifest resistance to therapy by the patient (the appearance of spite, negative therapeutic reaction, repetition compulsion, etc.).
c. In cases where the patient did not armor against the onslaught of the therapist, one would observe either manifestations of intense anxiety or disastrous reactions such as psychosis, suicide, or breakdown into organic illness.

What makes people like the "Primal," "Reichian," and bioenergetic therapists believe that they are capable of doing this most arduous therapy without the rigorous preparation required from every orgone therapist? Most of these self-proclaimed healers lack even the minimum requirement for working in this field: a medical degree, Board certification in either psychiatry or internal medicine, supervised training in orgone therapy, plus a healthy character structure.[3] In place of these

[3] For a more detailed list of requirements, see the *Journal of Orgonomy,* Nov. 1977, p. 276.

criteria, they rely on a mixture of gall plus their own belief in their special powers of healing. These attitudes betray not only arrogance and grandiosity but also contempt for hard, persistent work, not to mention contempt for the patient himself. One wishes, for the sake of the patient, that therapy was as easy as they make it out to be. From the cases described above, however, it is clear that this is a dangerously mistaken attitude indeed.

REFERENCE

1. Baker, E. F.: "Lay Therapists," *Journal of Orgonomy,* 11: 62-67, 1977.