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Orgone Therapy: Part VII
The Application of Functional Thinking in Medical Practice

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The presence of *trust* between patient and therapist is an essential prerequisite for the successful progress of therapy. The patient's ability to trust depends directly on the degree of orgonotic contact tolerated both with himself and with the therapist. Trust, in turn, leads to cooperation in the therapeutic process. Without trust, the patient cannot feel completely free to relinquish armor by facing internalized prohibitions and exposing innermost feelings, especially the dreaded orgasm anxiety. Treatment progresses fastest with those individuals capable of developing strong, immediate trust, placing themselves by degrees in the flow of the therapeutic process.[1] Based on disturbances of contact, pathological distortions of genuine trust are seen in blind trust (mysticism, idealization of the therapist) or chronic, irrational distrust. The latter stems from an underlying wish to trust and an inability to do so because of underlying fear and anger. A further impediment to the development of trust is a lack of contact with the therapist. This problem must be dealt with first by establishing contact. Only after the completion of therapy, when orgastic potency is achieved, can full trust be expected from a patient. Until then the therapist remains a threat, in varying degrees, to the patient's narcissistic integrity.

Past Development and Present Structure

A problem common to every type of mechano-mystical therapy is whether the therapist should focus on the patient's current neurotic sit-

[1] Often the breakthrough into a deeper layer is preceded by a greater degree of trust in the therapist.

uation or on past events leading to present conditions. Certain therapies, such as behaviorism, focus exclusively on present-day issues, while others, notably psychoanalysis, delve into historical antecedents. Freud's original hypothesis of the therapeutic process stated that once unconscious material from the past was made conscious ("remembered"), the neurotic symptom would disappear. The physical basis for this putative therapeutic effect remained obscure. In reality, therapeutic success resulting from recall of past events was, and has always been, a matter of chance.

Because so much of the individual's past trauma resulted not from single incidents but from chronic life negative attitudes and because events occurring prior to the age of one year could not be reexperienced in the same manner as later ones (consciousness is not fully developed early in life), the criterion of making the unconscious conscious gradually lost significance as a therapeutic goal.

Reich, moreover, addressed this crucial issue very early in his career. He found, through careful clinical observation, that improvement was related not so much to the conscious remembering (often simply an intellectual process) but to the *affective reexperiencing* of past traumatic events. In fact, the stronger the energy *charge* contained in the affective expression, the greater the therapeutic effect. Once the energy contained in the past event was fully experienced emotionally, it could then be reintegrated within the total organism. For relief and clinical improvement to occur, conscious recall of past events seemed irrelevant. The memory contained in the traumatic event was therapeutically significant only if it was experienced *after* the emotional expression.

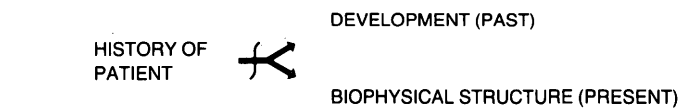
Only later was this important clinical observation placed in its proper functional perspective. This came with Reich's discovery of the biological orgone energy and his formulation of a specific thought technique found to be essential for the therapist's understanding of the complicated nature of biologic armor. In this connection, Reich states:

> The antithetical-functional unity of instinct and defense made it possible to comprehend the present-day and infantile experiences between the historical and the contemporaneous. *The whole experiential world of the past was alive in the present in the form of character attitudes. The makeup of a person is the functional sum total of his past experiences.* (1)

In a previous section, it was stated that armor has a definite structure with the earliest events of an individual's life found in the deepest layers

and later events deposited more superficially. *The direction of therapy, therefore, must proceed from the present to the past.*

According to orgonomic functionalism, healthy human development is not possible without complete fluidity of all part functions (2). It does not tolerate rigid, fixed structure. Development turns to structure when orgone energy movement *freezes*. This occurs either naturally during the process of ontogenic development or as a result of armoring. Structure, and with it, past history, is frozen movement. An individual's past history can be reconstructed from analysis of the character structure. Development and structure thus form a functional pair with the common functioning principle of history:

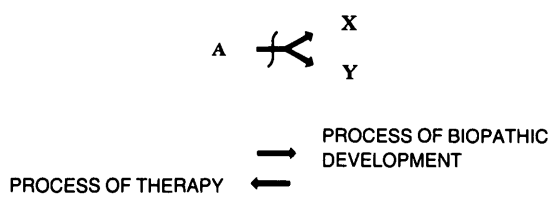


In the process of armor removal, it is essential that the patient's various characterological and biophysical attitudes be accurately grasped by the therapist and described to the patient. The functional principle that armor is frozen energy is illustrated in the following clinical episodes:

1. The most prominent biophysical feature of this oral repressed hysteric was the disproportion between the upper and lower halves of her body: Above her midsection, she was underdeveloped and appeared immature like a preadolescent girl; below, she had the physique of a fully developed woman. In addition, her facial expression appeared *frozen* in a "baby face." At a certain point in therapy, she looked like an infant lying in a crib with her hands raised above her shoulders. She grimaced as her head began turning from side to side. *She then began crying in a high-pitched and infantile voice.* After expressing this very early cry, her face suddenly and dramatically lost its frozen "baby face" appearance, as if her armor had melted. Subjectively, this was accompanied by a strong sense of relief. Objectively, her face became more attractive and she appeared biophysically more integrated in the two halves of her body.
2. Although capable of superficial facial expressions, this patient was unable to sustain contact with his deep misery. This state of contactlessness was maintained by a specific mechanism: Whenever misery began to surface, he had an uncontrollable urge to laugh. This was

accompanied by a feeling of puffiness in his cheeks. Although serving a powerful defensive function, it was not possible to eliminate the tendency to laugh until, one day, when close to crying, he associated the puffiness in his cheeks with the facial expression of the puppet "Howdy Doody." He then recalled, as a child, being mercilessly taunted by neighborhood children who dubbed him "Howdy Doody." It became clear that by freezing the muscles of his face into the expression of the puppet, he armored, in the past, against the pain and humiliation he experienced then and against feelings of misery threatening to emerge in the present. I massaged his cheeks and asked if he could imitate the puppet's expression. His face gradually assumed, with an uncanny resemblance, *the hard wooden features of the puppet's face*. He began laughing in a mechanical, puppet-like fashion. This turned into deep uncontrollable sobbing which soon overtook his entire body.

In orgone therapy, investigation of the character structure of a patient can proceed in two directions. Either the therapist proceeds *from* the basic character structure (CFP) *to* the particular neurotic variations that originate from it. In this case, we investigate the process of *development* of the biopathy. The therapist investigates the functional energetic significance and consequences of a particular symptom in relation to a given character structure (the direction from left to right in the following diagram). Proceeding in the same direction, we begin our investigation into the structure of the patient by examining the patient's signs and symptoms. Taking these as the CFP we may proceed toward an understanding of the *effect* these disturbances have on the individual's life. We may find, for example, that logorrhea leads to social alienation or that a chest held high in inspiration leads to hypertension. Or, the therapist can proceed in the reverse direction *from* the present-day neurotic character attitudes *to* the biological core. In this case, we proceed toward the patient's structuralized past history (right to left in the diagram below):



This is the direction that the therapist takes *when arriving at a characterological diagnosis*. It is also the direction that every correctly handled therapy follows in the process of *systematic* armor removal.

Replacing physical functions for the abstract symbols in the equation above, we have the following:

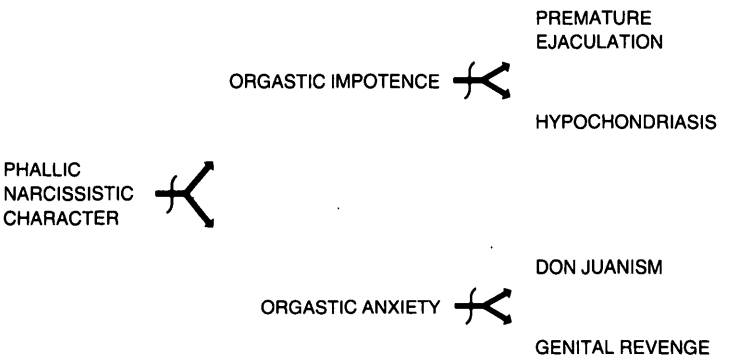
In every biopathy, the two paired variants (X, Y) of the biological armor (A) are orgastic impotence (*somatic* function) and orgasm anxiety (*psychic* function). These two functional variations are always present clinically at the *end stage* of every successful therapy, that is, when pelvic armor is being mobilized.

The therapist proceeds stepwise from superficial to deep, from the present situation to the past, until the CFP of orgastic potency is reached. Understanding the main character trait of the patient (the "red thread") and its present function leads directly to the past oedipal conflict which is resolved by establishing genitality.

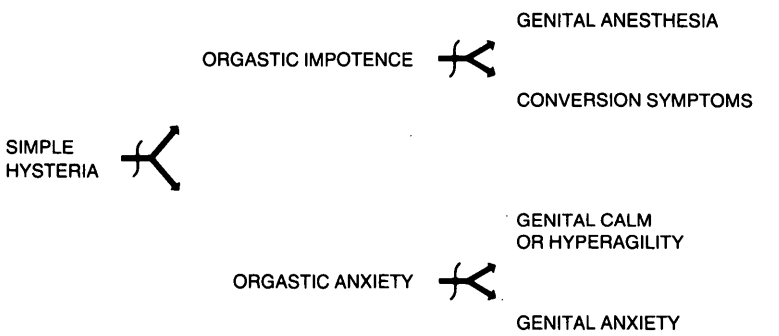
Some Specific Functional Examples[2]

1. The Psychic Biopathies. In phallic patients, a predominant symptom may be Don Juanism. This behavior is always accompanied by feelings of genital revenge. Don Juanism and genital revenge are viewed as paired functions, the CFP of which is orgastic anxiety. Since orgastic impotence is a paired function of orgastic anxiety, the question arises: What are the paired functions of orgastic impotence in a phallic patient? Asking the question in this form reveals the two functions as *premature ejaculation* and *hypochondriasis*. Premature ejaculation is an immediate result of orgastic impotence, while hypochondriacal pains originate from inadequate genital discharge, a consequence of orgastic impotence. Written as a functional equation, we have the following:

[2] These equations apply only to pure types.

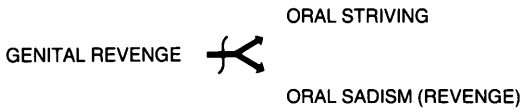


Similarly, we can write the following functional equation for the hysterical character. Genital hyperagility or genital calm are paired with genital anxiety. Both of these are variants of the CFP of orgastic anxiety. Genital anesthesia and conversion symptoms are paired functions of orgastic impotence. Accordingly, for the simple hysteric, we have the following functional equation:



The phallic and the hysteric are the least complicated neurotic characters. Functionally speaking, they have the fewest neurotic variations. However, the same functional equations can be written for more complicated character types as well. In these cases, more biopathic variations are present *to the right* of the characterological equation. The manic-depressive, for example, is a phallic with an oral unstable block. He is similar to the phallic in every respect, except one. In this case, genital

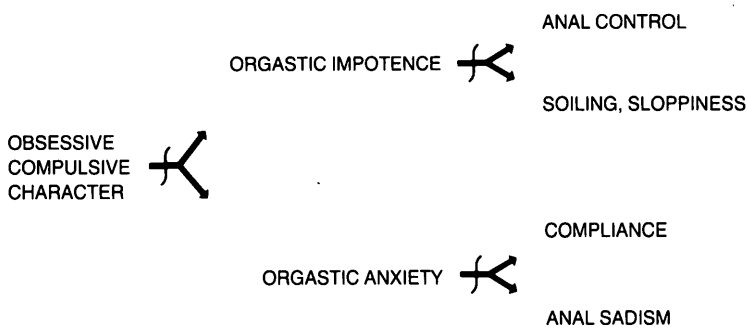
revenge is *masked* by oral strivings. The paired function of oral striving is oral sadism. Both traits represent an expansive (unsatisfied) impulse from the oral segment. This can be written in the following manner:



The rest of the equation for this character type is the same as for the phallic individual.[3] In the therapy of the manic depressive, the oral unsatisfied symptoms are treated first. Once these are sufficiently eliminated, powerful impulses of genital revenge toward the opposite sex begin to surface.

In the phallic with a repressed oral block, genital revenge is *inhibited* to the degree that the repressed oral block is present. In the chronic depressive, these impulses are totally inhibited. This does not mean, however, that they cease to exist. Since these individuals are basically phallic characters, the success of treatment depends in good measure on whether they are capable of fully expressing the impulses of genital revenge.

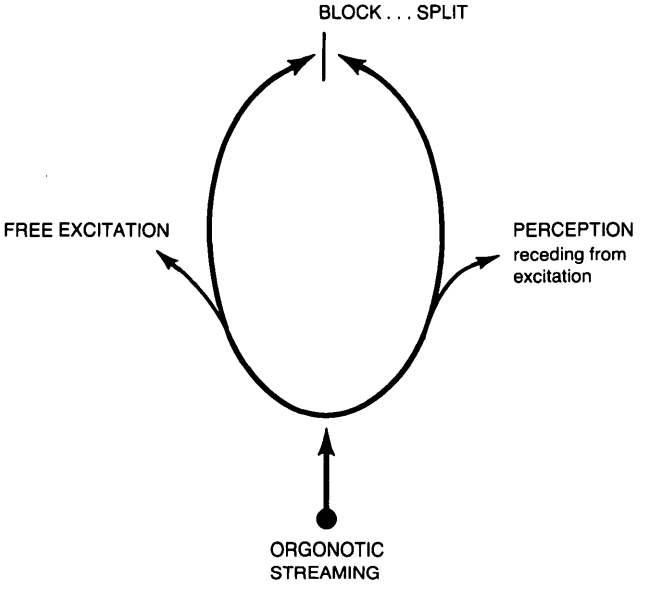
Anal characters, on the other hand, have reached but given up the phallic level for anality. In the compulsive (anal repressed) character, for example, phallic revenge is given up for anal sadism. Once therapy has eliminated the anal traits and the patient is again brought to the phallic level, he is then treated like an ordinary phallic. The following is the functional equation defining the compulsive character at the onset of therapy.



[3] The same equation describes the phallic with an oral unsatisfied block.

The same equation describes the passive feminine (anal unsatisfied) character. Here, genital revenge is given up for anal submission. The difference between these two anal types is determined by which variation is the defending impulse and which is the impulse striving for expression. In the passive feminine character, for example, *at the anal level*, anal sadism (nastiness, etc.) can be a defending impulse against compliance or anal surrender, or conversely, compliance can be a defense against anal sadism. In the compulsive, anal control defends against soiling (loss of control).

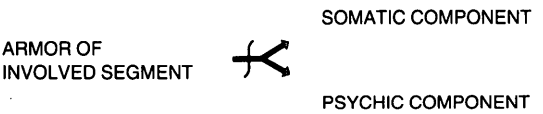
In schizophrenia, the *sensory-perceptual split*, pathognomonic for this disorder, occurs *before* complete development of psychic and somatic functions (either in utero or during the early post-natal period). Therefore, the functional equations describing this biopathy precede the variations to the right of the equation for neurotic characters described above. More specifically, the biophysical armor of the ocular segment produces the split, and this is the CFP of every psychic, as well as somatic, manifestation of this illness (3):



Most schizophrenics do not remain completely arrested at this early stage but continue to develop. As they do so, character traits similar to the neurotic character types appear, producing the schizophrenic subtypes.

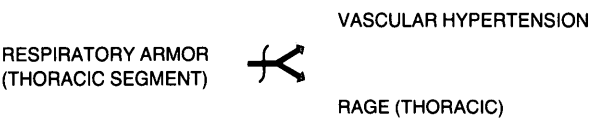
2. The Somatic Biopathies. Unlike the psychic biopathies, which always originate from segments containing an erogenous zone, somatic biopathies can originate from any segment. Therefore, any somatic biopathy can occur in any character type. In the case of somatic biopathies, the armor of the involved segment assumes primary importance as it fails to bind energy. Excess energy spills over into autonomic innervation with untoward consequences.

The general form of the equation for somatic biopathies is the following:



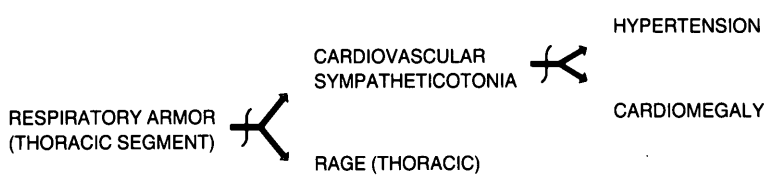
Some specific examples:

a. Systemic hypertension



If the biopathy progresses to the development of cardiomegaly, we have:

b. Hypertension with cardiomegaly



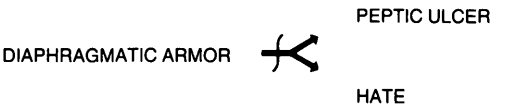
Cardiomegaly can involve either the left or right ventricle, depending on whether the systemic or pulmonary vasculature is involved. As the biopathy progresses, more variations (complications) develop to the right of the equation. These equations do not consider the function of *rank* with regard to the hypertensive biopathy, such as the pathological changes in the endothelium, etc. Other functional equations, beyond the scope of this discussion, are required to describe them. In any event,

hypertension is reversed when the rage in the thoracic segment is fully expressed.

Similarly, in bronchial asthma, the respiratory block also determines the clinical picture. The difference between these two somatic biopathies has to do, in part, with the *fate* of the unbound autonomic excitation in the armored thoracic segment. In hypertension, the excess sympathetic excitation is directly expressed as vasoconstriction. In bronchial asthma, parasympathetic overexcitation of the smooth muscles of the bronchial system, with excess mucous production, occurs *as a reaction against* an underlying sympathetic excitation. The reasons for the protoplasmic variability between individuals producing different biopathic conditions are based on deeper biological functions requiring careful investigation.

c. Peptic ulcer

In the case of peptic ulcer, the armor in the diaphragmatic segment determines the disease.



These examples illustrate functionalism's view that somatic, pathological symptoms are variations of a deeper bioenergetic disturbance in which segments of the body assume significance because of the failure of armor to function adequately. It focuses on both the psychic and somatic variations of medical disease, as well as the underlying bioenergetic disturbance as their CFP. In this way, the entire realm of psychosomatic diseases is placed on a firm, natural scientific foundation.

The manner in which the armor functions is identified by a correct biophysical diagnosis, the CFP on the left of these equations. It contains every type of pathological variation appearing to the right. The development of the character takes place from left to right. The reverse direction — from right to left — reveals the sum total of the *structuralized* processes that emerge layer by layer during the course of orgone therapy. In principle, at least, the process of armor formation is reversible to the extent that degenerative organic changes have not occurred. If the armor contains memories of a circumscribed traumatic event, expressing the related emotions may allow the memory to become conscious. Proceeding from recent events to the patient's past also corresponds, in general, to the deposition of armor from upper to lower segments and from more

superficial layers to those contained in the biologic core. Proceeding from the surface to the depths may bring childhood illnesses, such as eczema, asthma, etc., to the fore.

In general, a lawful sequence of material unfolds as therapy progresses. In the initial stages, the patient usually speaks about problems and individuals in present life. In the later stages, the patient discusses individuals from the past. Transference issues may become more intense as each new level is reached. This includes the final stage of therapy. Similarly, as deeper strata are encountered, memories of past events become richer and more vivid, approaching the intensity of original childhood experiences. In better emotional contact, the patient is now able to use his intellect *in the service of* experiencing emotions. This contrasts with other forms of therapy, including psychoanalysis, in which the patient, even at the outset, is usually encouraged to delve into his early life in a purely intellectual manner. Psychoanalysis and analytically oriented therapies mechanically and arbitrarily focus on the patient's past and ignore present-day character formations developed from these very same historical situations. Orgonomic functionalism retrieves the past with full affective intensity precisely through its consistent focus on the *present* character structure of the patient.

Dealing with past events and issues before "working through" present ones is a grave technical error. Anxiety and guilt are intensified by not allowing for or facilitating expressions of emotion, particularly anger. Ocular armor is also biophysically intensified by intellectualizing the therapeutic process. The unfortunate consequence is a therapeutic impasse. The patient becomes increasingly deadened to all emotions, including anxiety and guilt, and this is mistaken for a cure.

A frequent question is whether other clinical material should be dealt with before or after neurotic situations occurring outside of therapy. The answer is straightforward. A patient's functioning at any given time is determined by a particular layer of armor. From this perspective, both therapeutic and daily events are an expression of the same bioenergetic layer. Since both functioning on the couch and day-to-day behavior are governed by the same biophysical conditions, they surface together and must be dealt with as soon as they appear. Frequently, egosyntonic pathological behavior, not manifested in the clinical situation but expressed in daily life, escapes detection, despite the therapist's consistent vigilence for these hidden defensive strongholds. These pathological attitudes and behaviors are difficult to detect, powerful, and usually signal signif-

icant contactlessness. Patients may successfully, albeit unwittingly, elude the therapist's efforts.

In contrast, the armor of the schizophrenic fails to adequately bind energy. Flooded with anxiety, these patients become disoriented and have difficulty separating the present from the past. Relationships with individuals in present-day situations may assume the same emotional intensity as those in earlier life. These patients are in great need of perspective. The therapist must actively help them to separate current situations from past memories and experiences. They must also be helped to armor.

(To be continued)

REFERENCES

1. Reich, W.: *Function of the Orgasm*. New York: Orgone Institute Press, 1948.
2. Reich, W.: "Orgonomic Functionalism; Part II," *Orgone Energy Bulletin*, Vol 2:4(175), 1950.
3. Reich, W.: *Character Analysis*. New York: Farrar, Straus & Cudahy, 1961.