Wilhelm Reich believed that the hope for the future of mankind depended upon raising children who were free of chronic armor and thus emotionally healthy. This really requires healthy parents, an ideal circumstance. When this is not possible, effective treatment is needed to prevent armoring from becoming chronic. If this is done, the child can develop in as healthy a way as is possible.

Medical orgone therapy with children is exciting and gratifying because it often moves very quickly and yields dramatic results. This is much more the case than with adults because, in children, the armor is less rigid and less firmly held in place. One can often prevent serious armoring and chronic emotional illness if treatment is begun early enough.

I am here referring to children prior to adolescence. While orgone therapy had much to offer teenagers, it is not recommended that a great deal of biophysical work be done because the adolescent needs armor to withstand the push of puberty and bind the strong emotions that frequently come with this difficult stage of development. It is, however, quite important to provide treatment prior to puberty, before the armor, biophysically and characterologically, becomes firmly set.

Orgone therapy with children can use all the therapeutic modalities available to the classically trained psychiatrist. These include family therapy, play therapy, and behavioral therapy, all in the context of understanding and working with the character and muscular armor of the child. This allows the medical orgonomist to effectively and successfully treat many psychiatric disorders in children. Most emotional conditions in children which are treated pharmacologically by traditional psychiatrists are relieved by the medical orgonomist without resorting to the use of medication. Attention Deficit Hyperactivity Disorder, commonly referred to as ADHD, will be used as one specific example to illustrate this difference.

ADHD has been considered a distinct clinical entity for years. In the past, it has been called minimal brain dysfunction, hyperactive child syndrome, and hyperkinetic reaction of childhood. The concept of ADHD as a disorder hypothesizes a lesion in the brain that leads to "developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity" (1). Theories of causality have considered inborn errors of catecholamine metabolism, neurochemical defects, and functional defects in neuroanatomy (2). The
DSM III R of the American Psychiatric Association lists fourteen different signs and symptoms, but the essential traits of the disorder are seen as impulsiveness, inattention, and hyperactivity.

There are two mainstays in classical treatment for ADHD. The first employs the use of medication. Central nervous system stimulants, such as methylphenidate (Ritalin) and dextroamphetamine (Dexedrine), are the most commonly used drugs. Other medications such as tricyclined antidepressants and clonidine, an anti-hypertensive medication, have also been used.

The more frequently used drugs, such as Ritalin (a psychostimulant), often improve a child's attention and diminish hyperactivity. It should be noted, however, that a "normal" child's attention will also be more focused and his activity level lessened if given such medications. Stimulants suppress growth and weight gain in children, and it is often recommended that children receiving Ritalin be periodically removed from the drug, usually over the summer. Additionally, stimulant treatment does not ameliorate all symptoms of ADHD.

The second classical treatment for ADHD is behavioral therapy. This employs "behavior modification, behavior management training, parent management training, operant conditioning, and contingency-based reinforcement training" (3).

Many orgonomists have had children referred to them who have been described or diagnosed as having ADHD, with the recommendation, made by a school counselor, an educator, a pediatrician, or a psychiatrist, for treatment with Ritalin. These same children, treated with medical orgone therapy, have often had resolution of symptoms with remarkably improved functioning without the use of medication. If ADHD is a disorder that is truly "hard-wired," that is, the result of a lesion in the brain, it would not be possible to achieve such results.

The orgonomic treatment of ADHD focuses on its central pathological feature: the eye block, that is, ocular armor. This block interferes with the ability of the child to perceive, to learn, to maintain attention, and to integrate emotional sensation with motoric coordination and expression. Consequently, as orgonomists, we work directly on the ocular armor. This may include photic stimulation using a moving penlight. We also encourage the child to maintain eye contact with the therapist.

The constant motor movement of the child with diagnosed ADHD is seen as a major defense against making and sustaining contact with the environment and, in therapy, with the therapist. In therapy, we often immobilize the child with gentle holding. This
prevents defensive body movements and results in an emotional discharge from the child, usually anger and crying. Throughout therapy, emotional expression is allowed and encouraged, especially through the eyes. The child begins to see and perceive more clearly. The result, usually over the course of six months to a year, is improvement in behavior and in the child's schoolwork. Interaction with parents and peers improves, as does the child's self-image.

Case Presentations:

Case 1:

Adopted at three weeks of age, B was five years old when he was brought for therapy. His parents complained that he was having problems in school: he simply walked out of the classroom and wandered about the school. Regardless of how many times he was told not to, he continued to wander. He also had difficulty paying attention to schoolwork and frequently talked in class. At home, his parents noted that B seemed to deliberately ignore instructions, always wanted to be in control, had a very short attention span, and often jumped from one activity to another. When he did not get his way, he flew into a tantrum.

The first time I saw B in my office, he impressed me as a charming and energetic child. He moved all about my office, distractedly looking at one thing after another, but never seemed to hold his attention on any one thing long enough to appreciate it or understand it. His eyes had a dreamy quality and he looked "spaced-out." He was easily called back, though only for a moment, after which he went here, there, all over, in apparently chaotic fashion. After letting him look about my office and trying to keep him from creating havoc (he never left anything where it had been before), I told him to get on the couch. He did. However, as if shot from a cannon, he immediately got off the couch and he began to laugh and wiggle. I held him still, which he thought was very funny. The behavior continued over the next two sessions. In the third session, B looked particularly off in his eyes, more dreamy and out of focus than before. He quickly became angry when I wouldn't let him go and began to whine, cry, and then yell loudly at me, screaming the most vile invectives a 5-year-old could think of ("You're a butthead! Poopy breath!") His puckish countenance had changed from that of a bemused little elf to an enraged child. After screaming at me for five minutes or so, he began to relax. His eyes appeared much clearer and his bodily movements were less jerky. After this session, his father called to tell me that now, for the first time, B was coloring inside the lines of drawings in his coloring book. Before, his efforts had a jerky, Etch-a-Sketch gone wild quality and were frequently outside the lines and sloppy.
B's therapy continued in this fashion, with his rages becoming more profound and the attendant relief greater with each session. After one year of weekly therapy, this child's functioning in school was vastly improved. He no longer wandered off and the quality of his work had improved greatly. He also began getting along better with his peers. Before, he had only been able to see himself as being "the boss." He was now more able to tolerate the give-and-take aspect of play with his playmates.

I worked extensively with B's parents, as well, to help them recognize when their son was "off" in his eyes. This allowed them to deal with his resulting difficult behavior more effectively. They learned that when B was "off," it did no good to yell at him. Rather, they often had to simply hold him, which brought out rage and crying. After this, his eyes cleared and he was again accessible to talking.

Now, four years later, the child's school and social functioning indicate he has maintained the gains he made in therapy. He no longer has an attentional problem. No medication was employed in his treatment.

Case 2:

K was brought for therapy at age eight because she was slow in doing her schoolwork. She had trouble finishing tests and labored for hours at home on work that she had been unable to complete in school. Standardized scholastic testing in school was inconsistent: one year she seemed to have deficits in math but not reading, the next year the results were reversed. None of the test results seemed related to her actual school performance, which was good except for her difficulty finishing tests and in-school assignments. Her mother also reported that when shy or anxious, K frequently "froze" in public, her face and eyes blank, her body immobile. There were no automatisms and when removed from the anxiety-causing situation, K loosened up and was herself again.

A pediatrician evaluated K and recommended a trial of Ritalin. K's mother disagreed with this treatment plan and wanted a second opinion.

On presentation, K was a pleasant though dulled-appearing girl, completely lacking in spontaneity or animation. She would say a few words to me, look away, and grimace. She walked rigidly, like a little robot. Despite her mechanical appearance and mannerisms, I felt her sensitivity. When anxious or frightened, she contracted and readily closed down. I saw no evidence of an attentional problem and felt that K's difficulty finishing her schoolwork was caused by anxiety that she might make a
mistake. Her slow completion time resulted from her need, born of anxiety, to check and recheck her work.

During the first four months of K’s therapy, I gradually introduced biophysical work. I applied gentle pressure by tickling her upper thoracic paraspinal muscles. I also encouraged her to make angry faces at me and yell "No!" She enjoyed this immensely, though at first it was difficult for her to get a sound out. She began to accompany her yelling with hitting, striking me through my foam-rubber arm guard as if to beat me up. She began to perk up after sessions, with her eyes sparkling and more alive. Her mother began to notice that K was asserting herself more at home, even showing an overt stubbornness. K’s mother, knowing the importance of her daughter's emotional expression, allowed K to "talk back" within appropriate limits.

By the end of the first year of therapy, K's schoolwork had greatly improved, and she was able to complete most in-school assignments. Her mother reported that K was no longer afraid to play with new children and do new things. She was also performing significantly better on the standardized scholastic tests at school.

K had many features consistent with a diagnosis of catatonic schizophrenia, as defined by orgonomic nosology (a compulsive character with a repressed ocular block) (4). Her previous inability to complete schoolwork was not a problem of attention but rather one of compulsivity and rumination.

In much of the classical literature on ADHD, attentional problems are considered chronic and that they must be adapted to and lived with. The orgonomic approach, in contrast, goes to the root of the disorder. This is possible because of our understanding of armoring and the use of a specific treatment to relieve it. While it is true that psychostimulant medications can provide some relief of symptoms, they interfere with the full release of repressed emotions necessary to effect a cure. Medications, with their attendant side effects, can only relieve symptoms.

Classically, a posited deficit in the brain is seen as the cause of the symptoms of ADHD. The child's poor self-esteem and difficulty with interpersonal relationships are considered to be only a reaction to the personal and social effects of this "brain deficit." Orgonomically, the poor self-esteem and interpersonal difficulties are seen as parts of a whole; the natural functioning of the individual blocked by armor is impaired. Our knowledge of early armoring in infancy and childhood, primarily in the ocular segment (which includes the brain), allows for treatment of the child with ADHD as a totality.
The necessity of prevention must also be mentioned. There are many disorders that can be prevented if children were screened and treated early enough. Unfortunately, children are usually brought to treatment after their problems have existed for some time and are rooted all too firmly in their character structure. Often, only when the child's symptoms become incapacitating and obvious do they come to the attention of an adult, usually a teacher or a parent. By that time, significant damage has already been done. Too often, adults dismiss problems in children with "he's just shy," "she's simply clumsy," "he just has poor concentration," "she's just overly sensitive," or "that's just his temperament." They simply can't or don't want to acknowledge the sickness and misery that is right in front of their eyes.

It is my hope and dream that one day we will be able to provide ergonomic education to parents, physicians, and educators. This would enable them to recognize early childhood armoring and insure timely, appropriate treatment. Such preventative measures will allow children to develop to their full potential.