Functional Diagnostics: Criteria for a Functional Medical Nosology

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The popular and professional medical literature abound with attempts to understand and classify medical, including psychiatric, disorders. They range from those purely mechanistic to those having some semblance of a rational basis. The number of pathological medical conditions satisfactorily understood from an *etiological standpoint,* however, are quite limited. Aside from certain infectious and deficiency diseases, and disorders of traumatic origin, including radiation-induced illness, the origin of most, if not all, pathological conditions, remains a mystery. There is a clear need for a natural scientific nosology of medical disorders.

To arrive at a truly functional nosological system of both medical and psychiatric disorders, the following criteria must be met:

1. The system must have a *comprehensive biological basis* by applying to disease processes on the *widest possible scale* of medical disorders. At the same time, the system must account for the differences (variations) between one form of illness and another; for example, between one biopathy and another, and, within a given biopathy (schizophrenia, for example), between one type and another. Furthermore, since the living is based on *bioenergetic fumctions,* a rational medical nosology must be based on a disturbance of these functions.

2. On whatever level the disturbance is observed, (gross, microscopic, biochemical, etc.), the pathological processes must be

described and defined in strictly *observable* terms. The closer direct observation and description correspond to objective processes, the more accurately and rationally will they be understood. Since the living is essentially an energetic system, the observations must correspond to *energetic,* as well as structural, processes.

3. The observations must lawfully lead, in turn, to a *theoretical framework* for the nosological system. The mutual interaction of clinical observation and theoretical formulation must define disease processes as *deviations* from an objective standard of healthy functioning.

4. This requires an *objective standard of health.* Without a clear-cut standard of health, no natural-scientific nosological system is possible, and therapy is without real orientation, direction, or goal.

Comparing these criteria with mechanistic medicine point by point, this article will demonstrate that medical orgonomy offers the most valid system of medical diagnosis at this time. This article will only deal with the classification of the psychic biopathies. The somatic biopathies will be dealt with later.

A. Degree of Comprehensiveness

Both ergonomic and mechanistic nosology are fully comprehensive, and despite having diametrically opposite views regarding the basic nature of living processes, each covers the entire realm of medicine. Any similarity between the two systems, however, ends here.

Medical orgonomy places bioenergetic *function* at its base and considers material events significant only as material *functions* of primary bioenergetic events.

The gastric hyperacidity present in peptic ulcer disease is significant for medical orgonomy as an indication of chronic and excessive sympathetic excitation (a pulsatory disturbance), itself a function of diaphragmatic armor. That is, an energetic *function* fully explains both

the psychic and somatic aspects of the disease. The presence of elevated gastric acid is totally unexplained in mechanistic thinking.

Similarly, the elevation of uric acid in the blood (hyperuricemia) in the gouty diathesis and the tendency to deposit uric acid crystals in various tissues of the body remain a mystery to mechanistic pathology but can be understood functionally as a manifestation of an energetic contraction of the vascular and smooth muscle components of the plasmatic system with a tendency to deposit solid waste products. This again is symptomatic of a *pulsatory* disturbance of the organism in the diaphragmatic segment.

These examples underscore a basic flaw in the mechanistic approach to medical pathology and diagnosis. Because of its orientation, mechanistic medicine is incapable of going beyond the identification of a pathogenic source (anatomic lesion, infectious agent, etc.). Viewed orgonomically, pathological material findings have significance only in terms of their energetic functions. Mechanism ignores the disturbed bioenergetic *function* (premorbid condition) producing these structural defects simply because it has no basis for understanding them. Without an accurate knowledge of bioenergetic factors, a rational scientific investigation into the nature of disease process is simply not possible.

To mechanistic psychiatry, the significance of the signs and symptoms of emotional disorders does not extend far beyond the descriptive phase of understanding. As a result, the current diagnostic system employed by the American Psychiatric Association (APA), DSM-IIIR, is both complicated and misleading. It lists a diagnostic entity for each and every pathological manifestation that has been clinically identified. From a functional standpoint, all symptoms consist of two antithetical *bioenergetic* components, an impulse striving for expression and a defensive impulse against it. They are internalizations of the original conflict between the organism's striving for gratification and the prohibitions set up against it from the outside world. As a result

every individual with a psychic biopathy using only about two dozen character types.

1 ' See E.F. Baker: *Man in the Trap.* New York: Macmillan, 1968.

These examples illustrate the complete inadequacy of the unifying principle of mechanistic materialism. This principle is based on finding material disturbances in various disease processes. *As* a result, mechanism is at a loss when it comes to diseases where no structural lesion is present. Furthermore, these material changes are a rather crude measure of organismic functioning. Orgonomic functionalism, on the other hand, has proven itself, time and again, to be eminently suited to the investigation, treatment, and classification of these illnesses. In defining disease processes, it recognizes the *order of rank* that must be assigned to the various functional realms and the common functioning principle (CFP) of two mutually interacting variations.

B. Empirical Nature

Both mechanism and functionalism stress the importance of basing diagnostic systems on strict empiricism. However, since orgonomic functionalism has shown that perception is a function of character structure, this criterion is not a safeguard against error. *Consensual validation of a diagnostic system is only possible when the subjective perceptual structure is capable of reflecting objective reality*. This can occur if the physician is relatively *unarmored.* Only under this condition can it be safely assumed that two or more people are observing similarly. Since perception is distorted, any attempt by armored organisms to derive an empirical nosological system based on observation is bound to fail. With armor, observation of facts is obscured by theories about facts at the expense of observation. This has been amply demonstrated in the case of DSM-IIIR. Traditional psychiatry is acutely aware of the problem of validation. Although the APA Task Force on nomenclature and statistics relied on the *same* research evidence, *"Task Force members often differed in their interpretations of these findings"* (1) [italics added].

Orgonomic nosology is based on a wealth of detailed clinical observation, most of which has passed completely unnoticed or is overlooked as insignificant by the mechanistic physician. In fact, it was Reich's capacity for *sustained observation of clinical problems* that allowed him to discover the function of character armor. Therapeutic failures were shown to be a result of *not paying consistent attention* to the function of the patient's character. From this crucial clinical discovery,

Reich found there were certain *types* of characterological expression in armored individuals. Carefully *focusing* on these characterological attitudes provided access to the energy source of the neurosis. These differences provided the basis for a characterological typology. This was extended and developed by E.F. Baker into a comprehensive and theoretically consistent system of psychiatric diagnosis which has no equal.

Orgonomic biopsychiatry has extended the field of physical diagnosis in medicine to include the various biophysical abnormalities accompanying emotional disorders. These physical manifestations, either unobserved or ignored by the mechanistic physician, are as real and tangible as any of the objective signs known in physical diagnosis. Such manifestations as veiled eyes, clenched jaw, stooped posture, retracted pelvis, etc., are full of clinical significance to the medical orgonomist. It is, therefore, mandatory to *observe* the body in the practice of medical orgonomy, and it is for this reason that the patient is partially unclothed. This practice enables the medical orgonomist to *observe* where the pathology is located; that is, where the spontaneous flow of em.rgy is being blocked by the armor. Reich's discovery of somatic armor greatly extended the field of observation of the medical diagnostician and placed the entire branch of medicine known as physical diagnosis on a wider, and more inclusive, basis. [2]

About 1940, Reich discovered the physical energy in the organism that was the basis for its life function . Now, the framework for a diagnostic system could be placed on a firm bioenergetic foundation . It became possible to comprehend both psychic and somatic forms of illness as a consequence of the blocking of the pulsation of bioenergy. The term "biopathy" was defined as a pulsatory disturbance of the plasmatic system. [3] Biopathic diseases ~would have primarily psychic, somatic, or social manifestations. Reich found that energy blocked in a segment containing an *erogenous zone* produced psychic symptoms such as character neurosis. These are the psychic biopathies. Energy

[2] Reich observed that blocks (armor) occurred in the form of rings perpendicular to the long axis of the body much like the segmental armor of lower animals.

[3] The plasmatic system consists of the vascular system and the autonomic nervous system.

blocked in *other* segments resulted in illnesses commonly referred to as psychosomatic diseases. These are the somatic biopathies.

The following are the determinants of psychic biopathies (2):

1) The *time* at which an impulse is frustrated. The earlier the block, the more damaging its effects.

2) The *extent and intensity* of the frustration. The greater the extent, the more severe its effects.

3) *Against which impulse* the frustration is directed. This refers to the psychosexual impulses derived from the various *erogenous zones.*

4) The *ratio* of permission of a given impulse and its frustration . This factor determines the degree to which a given impulse from an erogenous zone is expressed or inhibited. It gives rise to two basic variants within each diagnostic category, the repressed and the unsatisfied types.

5) The *sex* of the main frustrating person. This factor determines the qualitative aspects of the individual's characteristic behavior as it is determined by the parent the individual identifies with.

6) The *contradictions* within the frustrations themselves. Contradictory frustrations have the effect of allowing impulses to build but not permitting complete discharge to occur. This situation gives rise to the development of masochistic tendencies.

Reich always proceeded first by careful observation of the patient and the parts of the organism that were immobilized. What distinguished Reich from other physicians, including psychoanalysts, was

his greater capacity for *sustained detailed observation.* This capacity, lacking in neurotics, and in itself a sign of health, resulted in a greater emphasis being placed on empirical rather than on theoretical considerations in his clinical and laboratory investigations. *From this observational base, a comprehensive functional, diagnostic system spontaneously emerged, satisfactorily accounting for psychiatric, as well as medical, aspects of the patient's illness.* No longer was it necessary to force the patient into an arbitrarily preconceived diagnostic entity. For the first time, it was possible to arrive at a diagnosis *from* the patient who had the illness. Everyday clinical practice demonstrates that the application of the above criteria give rise to a nosological system that can successfully account for an accurate biopsychiatric understanding of most individuals.

Some, however, are difficult to diagnose because their structure contains significant elements from two or more character types. Baker stated that if a diagnosis could not be made in the first seven sessions then it would be made only after various components of the patient's character were resolved in therapy (3). Those elements that remained would give an indication of the underlying character structure. In rare instances, the patient's diagnosis may never be known.

Table I outlines the major diagnostic entities based on two of the above environmental determinants, the *stage* or developmental level at which the major armoring occurred and the fate of the orgonotic impulse. The latter refers to whether or not the affected impulse was completely or partially blocked.

Once an individual has reached the phallic stage and beyond (the hysteric and phallic character types), secondary armor from the pregenital levels can produce traits, either repressed or unsatisfied, from their respective zones.

Table II lists the secondary blocks that may occur in addition to the primary armoring.

TABLE I

FATE OF ORGONOTIC IMPULSE			STAGE OF DEVELOPMENT				
			OCULAR	*ORAL*	*ANAL*	*PHALLIC*	*GENITAL*
REPRESSED		**Predominant Trait**	confusion	depression	restraint caution	moral righteousness	flight or freezing
		Character Type	schizophrenia or epilepsy	oral repressed character	compulsive	repressed phallic	repressed hysteric
UNSATISFIED		**Predominant Trait**	voyeurism	over-indulgence	sub-mission / maso-chism	Don Juanism	nymphomania
		Character Type	voyeur	oral unsatisfied character	passive feminine / maso-chist	unsatisfied phallic	unsatisfied hysteric

TABLE II

	OCULAR	*ORAL*	*ANAL*	*PHALLIC*	*GENITAL*
Hysteric	hysteric with ocular block	hysteric with oral block	hysteric with anal block	hysteric with phallic block	simple hysteric
Phallic	phallic with ocular block	phallic with oral block*	phallic with anal block	simple phallic	

* if the oral block is unstable, the patient is a manic depressive

Baker designated schizophrenia as an ocular character type. He also defined the various schizophrenic subtypes as arising from armoring of erogenous zones other than the ocular, as shown in Table III.

TABLE III

	ORAL	*ANAL*	*PHALLIC*	*GENITAL*
Schizophrenic Subtypes	simple	1) catatonic 2) passive-feminine 3) masochistic	paranoid	hebephrenic

As is the case in schizophrenia, essential epilepsy can be seen in any character type, but the phallic predominates.

C. The Interdependence of Clinical Practice and the Diagnostic System

The biophysical structure of the observer must be included as a natural process in order to agree on the criteria necessary for a nosological system. This is essential because diagnostic criteria cannot be isolated from observation. Since the formulation of a theory is a function of the observer, its validity is determined by the *accuracy of the observer's perceptual apparatus*. This depends, in turn, on how closely the perceptual function of the observer corresponds to natural processes. These processes constitute functions that *both* the observer and the observed realms have in common. When the perceptual apparatus of the observer approximates nature , objective logic spontaneously emerges. Conversely, when the perceptual apparatus is blocked, there is a distortion in observation and a defect in the resultant theory.

DSM-IIIR, for example, is unfortunately nothing more than a summation of descriptions made by an observer with a mechanistic background. It allows the psychiatrist to treat psychiatric symptoms with drug therapy tailored to biochemical disturbances in the brain without understanding their origins in disturbed bioenergetic functioning.

Orgonomic diagnosis connects the theory of therapy with clinical practice. An accurate biopsychiatric diagnosis pinpoints the biopathic disturbance. Without it, a functional therapy is impossible. The clinical course of therapy is determined, each step of the way, by the patient's diagnosis.

Medical orgonomy can relate, in a clinically objective manner, healthy sexual functioning (orgastic potency) and the presence of healthy natural functioning in daily living, on the one hand, and disturbed genital functioning (orgastic impotence) and the existence of biopathic symptoms, on the other. During the transition from biopathic illness to health in successfully treated cases, the following clinical events are observed:

1. As a result of arriving at an accurate biopsychiatric diagnosis, the "red thread" of the patient is uncovered. This is the specific manner in which the patient avoids spontaneous excitation both in therapy and in daily life.

2. Systematic softening of the patient's defenses (armor) results in a gradual increase in spontaneous energy movement in the form of energy charge and discharge. With progressively greater participation of the total organism, there is a correspondingly greater capacity for deeper emotions and sensations.

3. As energy liberated from the armor becomes concentrated in the genital, orgasm anxiety makes its appearance. During the process leading to the final elimination of the armor, manifestations of pathology the patient initially brought to therapy may be re-experienced.

4. With increasing toleration of orgasm anxiety, there is a temporary exacerbation of sexual impotence. Then, the patient begins to assume a different manner of functioning both in his personal and sexual life. This is the final transition-the patient gives up his neurotic structure, with successful resolution of the Oedipal conflict.

Although this state of health is attained in only about 15 percent of the patient population (as much depends on the selection process by the therapist as on the therapist's skill), most patients seen in orgone therapy attains a healthier level of functioning, as structure permits.

In medical orgonomy, a solid correlation is found between the theoretical formulation of what constitutes health, empirical clinical phenomena, the restructuring of the patient, and the establishment of orgastic potency. This is the only form of therapy in which a close relationship exists between clinical practice, the theory of therapy, and the standard by which healthy functioning is defined.

D. The Standard of Health

A complete understanding and classification of medical pathology is impossible without first defining healthy functioning. Central to this definition, and to the establishment of a standard of health, and preceding any formulation of orgonomic nosology, is an understanding of the primary role of genitality in the human organism's energy

economy and its consequent effect on the individual's capacity to love, work, and develop.

Not until Reich focused on the function of an individual's character in relation to the energy economy of the patient did it become possible to distinguish between healthy and armored character *types*. A clear distinction was made between healthy impulses originating from the core and expressed in an unimpeded fashion (primary drives) and those impulses originating from the core but impeded from reaching the surface and expression (secondary drives). This separates those individuals in whom primary drives were expressed without blockage and those in whom this capacity was absent. The former character type corresponded to healthy genital functioning, the latter to armored or biopathic dysfunction.

The goal of orgone therapy is to reestablish spontaneous plasmatic pulsation in the total organism. Biopathic manifestations present in the patient, whether homosexuality, peptic ulcer, schizophrenia, etc., are eliminated *during the course of therapy*. Thus, the goal of therapy is not symptom removal *per se* but the elimination of the *biopathic structure* giving rise to the symptoms. Every type of biopathy constitutes a specific manner in which spontaneous plasmatic pulsation is blocked. This is related to the patient's diagnosis.

Mechanistic psychiatry, on the other hand, focuses on the elimination of the signs and symptoms, ignoring the *biophysical function* they serve. .

Since the signs and symptoms contained in the character disorder disturb the pulsatory orgastic function, the question arises: What function do the signs and symptoms serve in the energy economy of the patient? The answer is: They function to maintain the equilibrium of character armor. Of importance from a *diagnostic* standpoint is not any particular symptomatic expression but *how* the symptom functions in the total energy economy of the patient's orgastic disturbance. It follows that any symptom can occur in *any* diagnostic entity, the symptom being only of secondary importance in ergonomic diagnosis.

In the absence of a strict standard of health, psychiatric nosology can only be based on cataloguing the signs and symptoms of emotional disorders. To mechanistic medicine, the standard of health is defined

materialistically in negative terms as the *absence* of any structural or physiological abnormality. Having abandoned any theoretical attempt to define health, the traditional psychiatrist resorts to adherence to a norm. Whatever behavior society deems acceptable is considered "normal," regardless of how destructive this behavior may be to the individual or to society. When social structure begins to break down, as has happened in the last few decades, it is obvious this standard fails to define an optimum level of functioning. The problem raised by homosexuality is a good example. The American Psychiatric Association (APA) has done a great disservice, both to society and to homosexuals, by proclaiming homosexuality to be "an alternate lifestyle." The homosexual has been officially relieved of having to struggle with his neurosis, and has also been given more egosyntonic defenses. The profound effects of this illness on the homosexual are completely ignored.

It was indicative of Reich's genius that he seized upon crucial observations which held little significance for most people and, then, had the courage to place them in a proper functional perspective. He states that he came to realize the full significance of the genital function and its relation to health by observing one single clinical case (2). This patient's level of functioning waxed and waned in proportion to his degree of genital satisfaction, despite the fact he had not been fully analyzed.

Reich's clinical investigations provided ample evidence that the overwhelming majority of the population suffered from a biopathic disturbance in sexual function, in one form or another. These ideas fit well with his sociological observations. Irrational social behavior, helplessness, work disturbances, neurotic dependency on authority figures, social rebelliousness, etc. , are all based on a ubiquitous sexual disturbaace. *As* his depth of clinical understanding of biological functions increased, so did his ability to define objectively the qualities and characteristics of health and disease.

To be placed in correct historical perspective, it must be borne in mind that the ergonomic classification of medical disorders is limited by the present state of knowledge of living systems. It is likely that deepening our knowledge of the biological effects of oranur and DOR

will bring with it an understanding of disease processes from a wider and more comprehensive biological framework than exists at present. In the oranur experiment, Reich foresaw the possibility of applying orgone energy in its excited state (oranur) to treat biopathic conditions. We can only guess at the wide therapeutic vistas that will accompany our understanding of medical diseases in purely energetic (mass-free) terms.

The objective validity of the functional diagnostic system developed by Reich and E.F. Baker is based on the following considerations:

1. The nosological system is capable of satisfactorily identifying the widest possible range of pathological disorders, both psychiatric and somatic, with the fewest number of diagnostic categories.

2. If structural changes have not resulted in irreversible tissue damage, the system leads directly to a theory of therapy that in many cases can successfully eliminate the original pathogenic factors and bring about a cure based on objective physical standards.

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