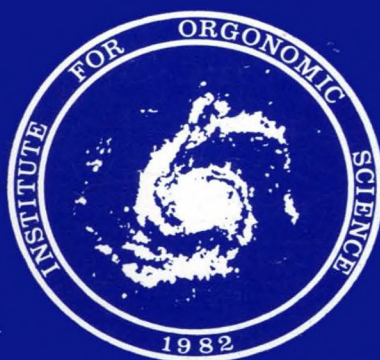


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The Reich Blood Test: Clinical Correlation

COURTNEY F. BAKER, M.D. ROBERT A. DEW, M.D.

BYRON BRAID, M.D. LOUISA LANCE, M.D.

Abstract

This report correlates the numerical evaluation of the Reich Blood Test with a number of disease states and several normal conditions. The former range from benign tumors and dysplasia to ulcerative colitis, inflammatory diseases, lymphomas, and carcinomas. Typical test results are given, illustrating change as the disease progresses or with various treatment regimens. Included is a discussion of the GMA and delta-49 as early, sensitive indicators of pathology.

Introduction

In the usual course of doing a Reich Blood Test, one is presented with a patient of known diagnosis, and the test is used to determine the existing energy level. The qualitative and quantitative results can then be contrasted with the clinical condition, i.e., as a measure of how well the organism is maintaining its energy level despite the disease. In this paper, we will examine typical values for the 1% time, delta-49, and GMA (to be defined below; see 1,2) as they have been observed in a number of different disease states. These values then give a general idea of what to expect under certain pathological conditions.

GMA Evaluation

The Gross, Microscopic, and Autoclave (GMA) portion of the Reich Blood Test is the most sensitive indicator of pathology, and the microscopic portion of the examination is by far the most important part of the GMA. The GMA is scored by starting with a value of ten and subtracting points for each abnormality observed, as shown in Table I.

TABLE I: GMA Scoring

Gross Appearance:	
Slight tendency of droplet to spread:	1
Droplet spreads quickly over finger:	2
Microscopic Appearance:	
Moderate variation in size or shape:	- 1
Marked variation in size or shape:	- 2
Flat appearance or loss of 3-D quality:	1
Reduced internal pulsation:	- 2
Occasional collapsed cell:	- 1
Many collapsed cells with central bions:	- 2
Autoclave Appearance:	
Poor clot cohesion:	- 1
Turbid or cloudy fluid:	- 2

The gross observation of the initial drop must be done with care, since wet fingers will produce artifactual spreading of the droplet, although non-artifactual rapid spreading is a serious, though rare, sign. In addition, the autoclave portion has not yet been quantified satisfactorily to give dependable results. In any case, the features scored as -2 are always pathological. Healthy subjects have GMA scores in the range of 8-10; however, some individuals with serious pathology may occasionally show GMA scores in this range also.

The microscopic appearance of the cells must be assessed throughout the period of bionous breakdown; the cells may look normal at first but then proceed to develop severe abnormalities as the test progresses. A GMA score of 7 or less is associated with mild to severe pathology in 98% of the cases. The GMA scores of seven or less from 128 tests are shown tabulated with the diagnosis, 1% time, and delta-49 in Table II.

TABLE II

Diagnosis	GMA	1% Time	Delta-49
Normal	7/10	12/50	45/59
Benign Tumor	7	72	30
Benign Tumor	5	- 30	107
Breast Injury	6	41	117
Class II Pap	7/7	29/50	78/91
Elevated Sed Rate	6/7	14/18	69/87
	6.4	28	83
Thyroid CA	6	- 20	44
Lymphoma	5	- 53	106
Lymphoma	6	- 41	131
Lymphoma	6	- 14	76
Lymphoma	3	- 33	99
Lymphoma	5	- 31	117
Ulcerative Colitis	1	- 112	208
Ulcerative Colitis	6	- 41	146
Crohns Disease	6	- 38	137
Uterine CA	6	24	36
Ulcerative Colitis	6	- 39	81
Mesothelioma	5	1	35
Epithelioma	5	40	27
Mesothelioma	3	- 48	112
Ulcerative Colitis	7/7	18/19	67/70
Mesothelioma	5	- 15	130
Breast CA	6/7	9/53	33/59
Sarcoidosis	6	24	46
Lymphoma	4/7	6/21	51/56
Erythema Nodosum	6	- 13	80
Malignant Melanoma	7	- 3	89
	5.5	- 12	85

In Table II, average values are shown at the bottom of each column; double values are from simultaneous "side-by-side" testing on the same drop of blood. The table shows one normal test, several instances of mild pathology, and the remainder severe pathology.

Table II substantiates the reliability of low GMA scores. Only one normal showed a GMA as low as seven (while a simultaneous side-by-side test gave a ten). One half (17 of 35 tests) gave borderline or negative 1% times. Evidently qualitative changes in cell morphology or functioning often precede

measurable energy loss. This is to be compared with 35 tests of individuals with mild to severe pathology but with GMA scores from 8-10: In this case, only 8 tests gave borderline or negative 1% times.

In summary, a GMA value of seven or less is a strong indicator of pathology, whatever the other test scores or the apparent clinical condition. While GMA scores of 8-10 may be found in cases of severe pathology, they are infrequently associated with abnormal 1% times. The microscopic evaluation is an early indicator of energetic changes which may often precede a measurable decrease in the energy level as determined by the 1% time.

Evaluation of the Delta-49

The delta-49 and 1% time are both mathematically determined numbers derived from the curve of percent bionous breakdown graphed against time. The best linear or exponential curve fitting the data is extrapolated backwards to the point at which 1% of the cells have formed bions; this is defined as the 1% time. The delta-49 is the time, in minutes, from 1% breakdown to 50% breakdown. In a previous paper (2), we have shown that the delta-49 is a measure of the variability of the energy levels of the individual cells, and is actually proportional to the standard deviation of the distribution. A large delta-49 signifies a large variation in energy level among the cells and is associated with pathology. It is a useful parameter in that it often shows abnormal values even when the 1% time is still in the normal range.

The average value of the delta-49 for normal individuals is 42, and for borderline tests, the average is 68. Table II shows that the average value for the five cases of mild pathology is 83, or clearly in the abnormal range, even when the 1% times are (with one exception) in the normal range. In this set of cases, then, both the GMA and delta-49 show abnormal values despite normal 1% times. In other cases, an abnormally prolonged delta-49 may be the only indication of energetic dysfunction.

All tests in the study were examined, and by inspection it appeared that the value of 76 represented a significant cut-off value. There were 31 tests with delta-49 values greater than this; of these only three were of normal individuals, while the majority represented severe pathology. In addition, there were 16 negative 1% times and three borderline values. This confirmed the impression that 76 is a useful cut-off value; 90% of tests with a delta-49 greater than this are associated with pathology.

Evaluation of the 1% Time

The Reich Blood Test is formally classified as normal, borderline, or abnormal based on the values of the 1% time; the defining limits are shown below:

Normal	greater than 9
Borderline	from 8 to -2.5
Abnormal	less than -3

In addition, two cases (below) showed abnormally large 1% times, which were both associated with benign tumors and interpreted tentatively as representing overcharge. The data contained a total of 29 tests with borderline or negative 1% times, of which four tests were from normal individuals, two tests associated with mild pathology, and the remainder with severe pathology. Abnormal or borderline 1% times are thus reliably associated with pathology in the majority of cases.

We will now examine specific types of pathology to study the 1% times associated with individual cases.

(1) Normal Infants and Children: 8 cases

The 1% times of eight children from two months to eleven years in age are shown below:

Age	Date	1% Time
6 Mo.	10-24-82	25
5 Yr.	11-28-82	34
2 Mo.	2-6-83	58
7 Mo.	6-26-83	12/-3
7 Mo.	11-8-83	25
8 Yr.	10-16-83	26
11 Yr.	10-16-83	8
6 Mo.	1-29-84	18

One infant fell into the negative region on one side-by-side test; he was suffering from a recent vaccination reaction. It is clear that infants and children have 1% times in the normal (for adults) region.

(2) Lowest Normals: Adults and Children: 4 cases

The lowest values recorded for normal adults and children, with comments and their usual values, is shown below:

Subj	Date	1% Time	Comment	Usual 1% Time
Adult	4-10-83	18/11	3 weeks of Flu	30,30,39
Adult	4-10-83	2/9	viral illness	12,46,48,42
Child	6-26-83	12/-3	vaccination	26
Child	10-16-83	8		

One value fell slightly into the pathological region and two fell into the borderline region. As can be seen from the comments, these low values reflect concurrent mild disease. Therefore, in the absence of any disease or untoward reaction, the 1% time falls regularly in the normal region for healthy adults and children. This is taken from a total of 39 tests on normal adults and children.

(3) Normal Pregnancy: 6 tests on 2 individuals

Case	Date	1% Time	Comments
#1	10-8-83	24/35	31-34 weeks
#2	11-6-83	9/15	28 weeks
	11-20-83	28/22	30 weeks

In this limited sample, the 1% times all fall into the normal range.

(4) Benign Tumors: 4 cases

Case	Date	1% Time	Comments
#1	10-3-81	-30	Breast mass
	8-13-82	54	Post Surgery
#2	1-20-80	72	neck mass
#3	5-27-82	114	neck mass
#4	10-30-82	19	abdominal tumor

In case #1, the breast mass was found to be benign at surgery, although the clearly abnormal 1% time as well as a GMA of 5 and delta-49 of 107 have raised the possibility that the mass was ultimately pre-malignant.

In addition, the two cases of masses in the neck showed abnormally long 1% times, suggesting overcharge in these individuals (and possibly the mass representing the organism's attempt at discharge).

(5) Radiation Effects: 4 cases

Four cases of individuals receiving radiotherapy for a lymphoma or carcinoma were followed; however, interpretation of the changes is complicated by the fact that cases #3 and #4 also underwent surgery prior to the start of the radiation treatment.

Case	Pre-Radiation	Post-Radiation	Post-Radiation
#1	9-9-79 - 53	11-4-79 - 143	7-27-80 - 14
#2	8-3-83 9	9-28-83 25	11-9-83 35
#3	11-13-83 0	1-29-84 51	
#4	4-27-83 8/-10	8-7-83 40	

These 1% times clearly show the expansive effect of radiation therapy; in all cases, radiation produced marked improvement in the values. It should be noted that, in two of the cases that have been followed over a long period of time, the improvement was temporary (cases #1 and #2).

(6) Transfusion Effects: 2 cases

Two instances of patients receiving blood transfusions during surgery were followed, as shown below.

Case	Pre-transfusion	Post-transfusion	Post-transfusion
#1	10-8-83 24	1-29-84 14	
#2		6-16-83 1	8-3-83 9

In this sample, one case had no pre-transfusion value, although the rising value for the 1% time several weeks later is instructive. Lower 1% times following transfusion is a logical expectation, since transfused blood contains red cells that have already been aged and damaged.

(7) Mononucleosis: 1 case

Only one case of mononucleosis was followed, but was nevertheless useful in demonstrating subtle changes as the patient's condition improved.

Date	1%	D49	GMA	Comments
8-18-82	14	120	9	Weak, tires easily
9-1-82	29	32	9	feeling better
1-23-83	24-28	28-33	10	90% recovered

The initial test shows a low normal 1% time and grossly abnormal delta-49; the patient was quite symptomatic. Test results improved to normal values thereafter as her condition improved.

(8) Pap Tests and Cervical Dysplasia: 5 cases

In the table below, case #5 had an initial pre-biopsy diagnosis of dysplasia, which was reduced in degree to simply "atypical cells" when the biopsy specimen was examined.

Case	Diagnosis	Date	1% Time
#1	Cerv. Dysplasia	12-9-79	23
#2	Class II Pap	8-14-83	23
#3	Cerv. Dysplasia	7-26-84	32
#4	Class II Pap	9-23-84	29.50
#5	Cerv. Dysplasia	6-2-85	10
	"atypical cells"	6-5-85	- 17
		6-12-85	83
		6-26-85	46

These 1% times are all in the normal range, except for the - 17 reading, possibly due to the severe anxiety and contracted state of the patient the day the test was done. Even so, the highly variable 1% times for this individual over such a short period of time are very unusual and difficult to explain.

(9) Collagen Vascular and Inflammatory Disease: 8 cases

Eight cases of various inflammatory or collagen vascular diseases are shown together in the table below.

Case	Diagnosis	Date	1%	D49	GMA
#1	Periarteritis Nod.	1-17-82	5	156	9
#2	Arthritis	8-29-82	31	76	9
#3	Bursitis	9-13-82	26	60	9
#4	Diverticulitis	4-17-83	49	11	8
#5	Arthritis	9-23-84	3 18	103	10
#6	Sarcoidosis	11-11-84	24	46	6
#7	Erythema Nodosum	5-2-84	- 13	80	6
#8	Oral Hyperkeratosis	10-14-84	16	39	10

Most of these tests indicate that the patients maintain their energy level in a normal range despite the disease. However, severe abnor-

malities of the delta-49 and GMA are recorded in several cases, indicating qualitative red cell changes.

(10) Ulcerative Colitis: 6 cases

Several cases of ulcerative colitis of greatly varying severity and duration are shown in the table below.

Case	Date	1% Time	Comments
#1	4-25-81	- 41	active symptoms
#2	8-14-83	23	three year history
#3	4-15-84	19/18	
#4	5-16-81	- 38	severe case with colectomy
#5	7-11-81	23	mild symptomatology
#6	3-29-81	- 112	severe symptomatology
	2-24-82	- 39	improving
	8-29-82	- 3	feels and looks improved
	10-30-83	22/29	feels better than in years

These test results indicate severe lowering of the energy level in many cases, which appears to correlate with the severity of the symptoms. Dramatic change is also evident in case #6, who steadily improved over the course of two and a half years.

(11) Lymphomas: 5 cases

Five cases of lymphomas (mostly Hodgkins disease) were studied; they varied in duration from a 13 year course (case #2) to a diagnosis made only two months before the test (case #5).

Case	Date	1% Time	Comments
#1	9-9-79	- 53	Pre-radiation
	11-4-79	- 143	Post-radiation
	7-27-80	- 14	radiation and chemotherapy
	8-31-80	- 33	chemotherapy
	11-1-80	- 31	chemotherapy
	12-2-84	6/21	last treatment in 1981
	7-27-85	- 18	Increasing symptoms with fever
#2	3-30-80	34	in remission; 13 year course
#3	7-27-80	- 41	"in remission"
#4	7-25-81	48	Post-radiation and chemotherapy
#5	10-24-82	27	recent diagnosis; feels well

Again the results show severe energy loss in many cases, but with normal values in some

treated individuals or early in the disease. Case #1 also clearly shows the beneficial effects of the treatment. In this disease, the test is valuable in showing whether the patient is truly "in remission" (from an energetic standpoint) or not (see for example case #3).

(12) Carcinomas: 8 cases

In five of eight cases of various types of carcinoma there was the opportunity to do testing before and after various types of treatment were applied.

Case	Diagnosis	Date	1% Time	Comments
#1	Thyroid Ca.	11-4-79	- 20	Post surgery. rad
#2	Uterine Ca.	5-23-81	24	recent diagnosis
		7-3-83	15	2 year post surg
#3	Epithelioma	4-27-83	8 - 10	
		8-7-83	40	post surg and rad
#4	Mesothelioma	6-16-83	1	Post surgery
		8-3-83	9	Post surgery
		8-28-83	25	6 radiation Rx
		11-9-83	35	18 radiation Rx
		1-15-84	27	short of breath
		3-15-84	- 48	died 10 wks later
#5	Breast Ca.	11-13-83	0	
		1-29-84	51	post surg and rad
#6	Mesothelioma	7-22-84	- 15	
#7	Breast Ca.	11-4-84	9/53	Post surgery
#8	Malig. Melanoma	6-30-85	- 3	Tumor on lower leg
		8-4-85	21/13	Post surgery

The most striking result seen in the data is the dramatic improvement in the 1% times following treatment using surgery, radiation, and chemotherapy. However, these cases must be followed for a longer period of time to determine if a lasting improvement has taken place.

Conclusion

The data demonstrates a number of striking features about the test results and various disease states:

- (1) Test results for normal, healthy individuals are uniformly in the normal numerical ranges, with few, minor exceptions;
- (2) Striking improvements in the 1% time are regularly seen following treatment for lymphomas and carcinomas, at least on a short term basis (a few years);

- (3) A few individuals with severe symptomatology and highly abnormal test results have shown a remarkable ability to recover to normal values, concurrent with clinical improvement;
- (4) The GMA and delta-49, especially at their respective cut-off values of seven and 76, are reliable indicators of pathology even with normal 1% times;
- (5) Finally, the highly variable relationship between serious diagnoses and 1% time (such as carcinoma with normal 1% values) emphasizes that the organism can maintain a normal energy level for years despite the onset of a shrinking biopathy.

These results are impressive in demonstrating the ability of the organism to maintain its energy level and recover despite serious disease. Under these circumstances, the Reich Blood Test functions as an extremely useful tool in revealing the actual state of energetic health in the individual.

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Wound-Healing in Mice: Part II

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Abstract

In this paper, we present the results of seven years of experiments using orgonotic devices to influence the rate of wound-healing in mice. Our findings demonstrate that the healing rate is regularly increased by both the orgone accumulator and medical dor-buster; the results are significant at the level of $P < 0.002$ or better. Included is a discussion of our methodology and the development of device modifications and their relative effectiveness, as well as seasonal patterns in the action of the devices. We believe this study represents the first statistically rigorous demonstration of the biological activity of orgone energy devices.

Introduction

In Part I of this report (1), the general design and methods of the wound-healing experiments were explained. The presentation of findings, limited to those of the control animals, revealed hitherto unknown aspects of the normal healing process in mice. First, it was found that, in the initial four days of wound closure, the wound periphery exhibits an alternating contraction and dilatation, *i.e.*, pulsation, occurring two or more times before the final and generally recognized phase of consistent (linear) contraction and tissue regeneration. Second, another form of pulsation was observed; namely, an annual pattern in the rate of early wound closure with a maximum magnitude of variation of 21% between the first four and last four months of the year. We are now ready to consider the data obtained from treating wounds with various devices designed to alter the orgonotic milieu of the test subjects; that is, to demonstrate a biological effect of these devices on healing as we have defined it.

In a study of this scope and complexity, a considerable mass of information inevitably accrues. To present all the details as they emerged in their precise temporal relationships would, more than making our report overlong, risk lessening the impact of the

essential findings. Nevertheless, an understanding of how this project evolved seems to us invaluable for reasons other than the obvious one of orientation:

1. Rather than an arbitrary design, the ultimate or C-protocol will be seen as the outgrowth of logical steps dictated by experimental results.
2. The early work yielded highly significant fundamental information, as well as providing relevant data which stands on its own.
3. The succession of experiments shows the validity of the wound-healing experimental model as a biological indicator of the energetic activity of the devices.
4. The project suggests important avenues for further study.
5. The project demonstrates vividly how easily one might be led astray, be discouraged, or jump to the wrong conclusions on the basis of a few experimental trials. Working with orgone energy—precisely because *it* pulsates and underlies all forms of pulsation—requires extended, multiple observations to discover trends and lawful variation. Without this approach, not only might the seasonal variation in healing have been missed, but some of the effects of the treatment devices might have been

lost, dismissed, or have remained totally incomprehensible.

Synopsis

This project was undertaken with the following principal aims in mind:

1. *To demonstrate that various organotic devices have a definite biological effect. A high priority in this connection was repeatability of results.*
2. *To demonstrate that the biological effects are life-positive or at least to determine when and under what conditions the effects are positive. This, of course, touches on the possibility of enhancing the effects.*
3. *To determine the mechanism of action of the devices.*

The work of the study falls into two periods. The first stage (approximately 4 years) was mainly concerned with discovering how to make optimum use of the wound healing model so as to address the above tasks, *i.e.*, developing and perfecting a satisfactory protocol. The second stage (3 years) was principally a period of data accumulation, simply by repetition of a rigorously defined procedure—designated as the “C” protocol—without significant changes. These last 18 studies have therefore provided much of the material for our statistical analysis and conclusions.

The experiments began in December of 1976 with the first of 27 “A-Series” runs, entailing a small number of mice and a few simple devices. During this period, the experimental groups were treated several times a day for up to 15 days. It soon became apparent (by run A-5) that most of the change in wound-healing occurred in the first few days, and therefore the end point of the run was defined as the time taken for the wound to reduce to 50% of its initial size. This was generally reached between three and five days. Later, by run A-10, a more objective end-point was defined: the percent healed at 96 hours after the initial wound measurement. As a consequence, the length of the period of observation was shortened to exactly four days.

As the work evolved, other changes were made. The frequency of treatments and their duration were reduced until in the sole B protocol treatment consisted of a single dose on the first day, delivered immediately after wounding. This change marked the beginning of the “C-Series.” In addition, a number of modifications were made in the construction of the dor-buster and orgone accumulators (ORAC) in an attempt to increase the strength and consistency of the devices as well as understand the relative importance and functioning of the device components.

The effectiveness of each device was determined by comparing the end-point of the controls with that of each experimental group. This procedure generated a number called the “therapeutic index.” It was calculated by dividing the percent healed (at 96 hours) of the experimental group by the corresponding value for the controls:

$$\text{Therapeutic Index (T.I.)} = \frac{\% \text{ healed at 96 hours (test group)}}{\% \text{ healed at 96 hours (controls)}}$$

Thus, if a particular test group healed faster than the controls, its value at 96 hours would be larger than that of the controls, and the therapeutic index would be greater than 1.00. This was called a “positive” therapeutic index. A therapeutic index less than 1.00 was termed “negative.” This numerical data could then be used for graphing and statistical work.

Historically, all the devices used in organomic treatment of humans and animals, whether for clinical reasons or with experimental models, have been some variant of the orgone accumulator (ORAC) or Medical Dor-Buster (MDBO). It was therefore natural to begin with them in their basic configurations. Treatment with the orgone accumulator was accomplished using two basic approaches: (1) placing the mice (3 to 5 animals) inside a cylindrical ORAC for the exposure time, or (2) confining the group in a metal container with a conical ORAC on top (*i.e.*, irradiating the mice from above rather than all sides) for the duration of the exposure time. The ORACs used consisted in strength of three to four folds, constructed of sheet iron or steel wool

for the metallic layers, and foam, plastic, or fiberglass for the non-metallic layer.

The basic experimental setup from which variations of the medical dor-buster were derived is shown in Figure 1. The medical dor-buster consists of three basic components: (a) a metal "head" constructed from a hollow box or cylinder of copper with 6 to 17 eight- to ten-inch brass or copper tubes projecting from holes in its side; this is connected to an orgone accumulator by means of a length of flexible vinyl-coated cable sheathing (Weatherfield or SEAL-TITE) that makes contact with the innermost metal wall of the ORAC by means of standard connecting fittings; (b) a three- to four-fold accumulator; and (c) grounding of the accumulator into water by means of three lengths of the same sheathing extending from the opposite metallic wall, the ends of which are placed in a plastic bucket containing at least two gallons of water.

The control animals were always treated first, by placing them for seven minutes in a glass container above which was suspended a wooden "dummy" dor-buster head. In this way, the controls were handled in exactly the same fashion as the treated groups, and were not exposed to any residual or distant effects from the treatment devices. Each treatment group was similarly confined for its treatment period (which varied from 30 seconds to seven minutes) with the metal head suspended vertically a fixed distance above (Figure 4). The dor-buster device was activated by placing the grounding tubes in the water. After the treatment, the device was deactivated until the next group was ready.

The first several runs included only the MDBO and MDB (the dor-buster head grounded by cable in standing water without an ORAC in series) with suitable controls since it was anticipated that the dor-buster might quickly emerge as an effective device. ORAC-treated groups were soon added and became part of almost all of the subsequent runs. Appendix I provides a complete list of the devices and controls utilized over the seven-year period.

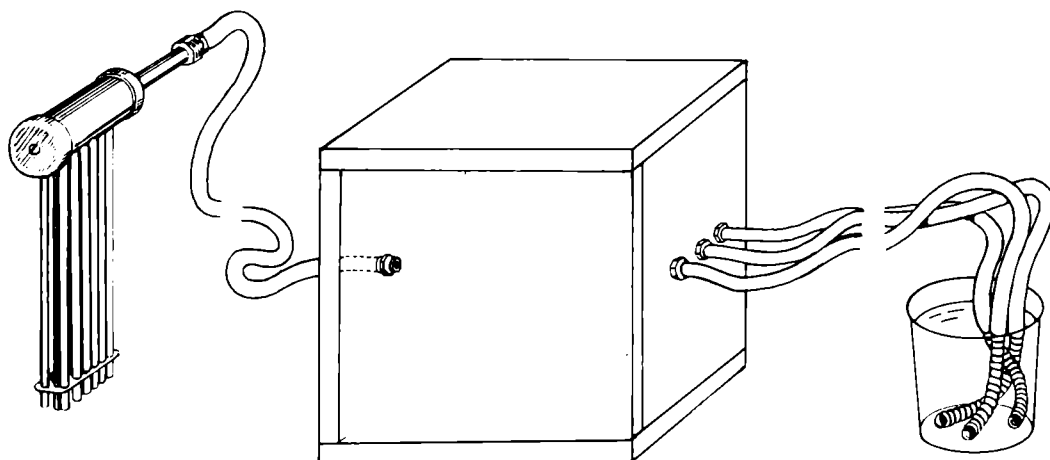
Initial Dor-Buster Modifications

In an effort to "dissect" out the function of the individual components of the dor-buster, different groups of animals were treated with five separate variations of dor-buster design. These, of course, were compared to results from concurrent testing using controls exposed to the wooden dor-buster mock-up. A major variation derived from Reich's observation that the cloud-buster* appeared to work better if its grounding cables were led into *running water* (e.g., a stream); we elected to test this effect with both the MDBO and MDB. The new arrangement, designated by the prefix R, consisted of having the grounding cables led into a bucket which was continuously overflowing from a running faucet. In addition to the controls, the early protocols thus included the following groups:

1. MDB: Dor-buster head grounded directly into standing water (Figure 2a).
2. RMDB: Dor-buster head grounded directly into running water (Figure 2b).
3. MDBO: Dor-buster head connected to an ORAC which is grounded in standing water (Figure 2c).
4. RMDBO: Dor-buster head connected to an ORAC grounded in running water (Figure 2d).
5. MDB-Shooter: Dor-buster head connected to an ungrounded ORAC (Figure 1 e.)
6. ORAC: Cylindrical type.

After 13 runs using these groups, some clear differences emerged. First, the importance of running water was confirmed, as the RMDBO proved to be the most consistent and strongest device, showing a 20% improvement over the controls. The MDB showed the weakest positive and often negative effects, while the MDBO and RMDB yielded intermediate results. The latter two groups were then dropped from the protocol (so that the best and worst dor-buster designs could undergo further study). Both the MDB-

*A device used in weather modification having a design similar to the MDBO.



Head

MDB

A1-16, 8, 20-24

RMDB

A7-9

MDB Shooter

A2, 5-8, 13-16

Head Only

A14-16, 18, 20-27

Water Head

B
C1-9

ORAC

Rotator

A25-27

Water Head

High Voltage

ORAC

C13-18

Ground

Standing Water

A1-9

Running Water

A7-18, 20-27
B
C3-18

Agitator

A14-16, 23-24

Water Head

Fin

C10-12

Fig. 1 The basic dor-buster design is shown with the component modifications listed beneath. In italics, are those studies in which the modifications were tested.

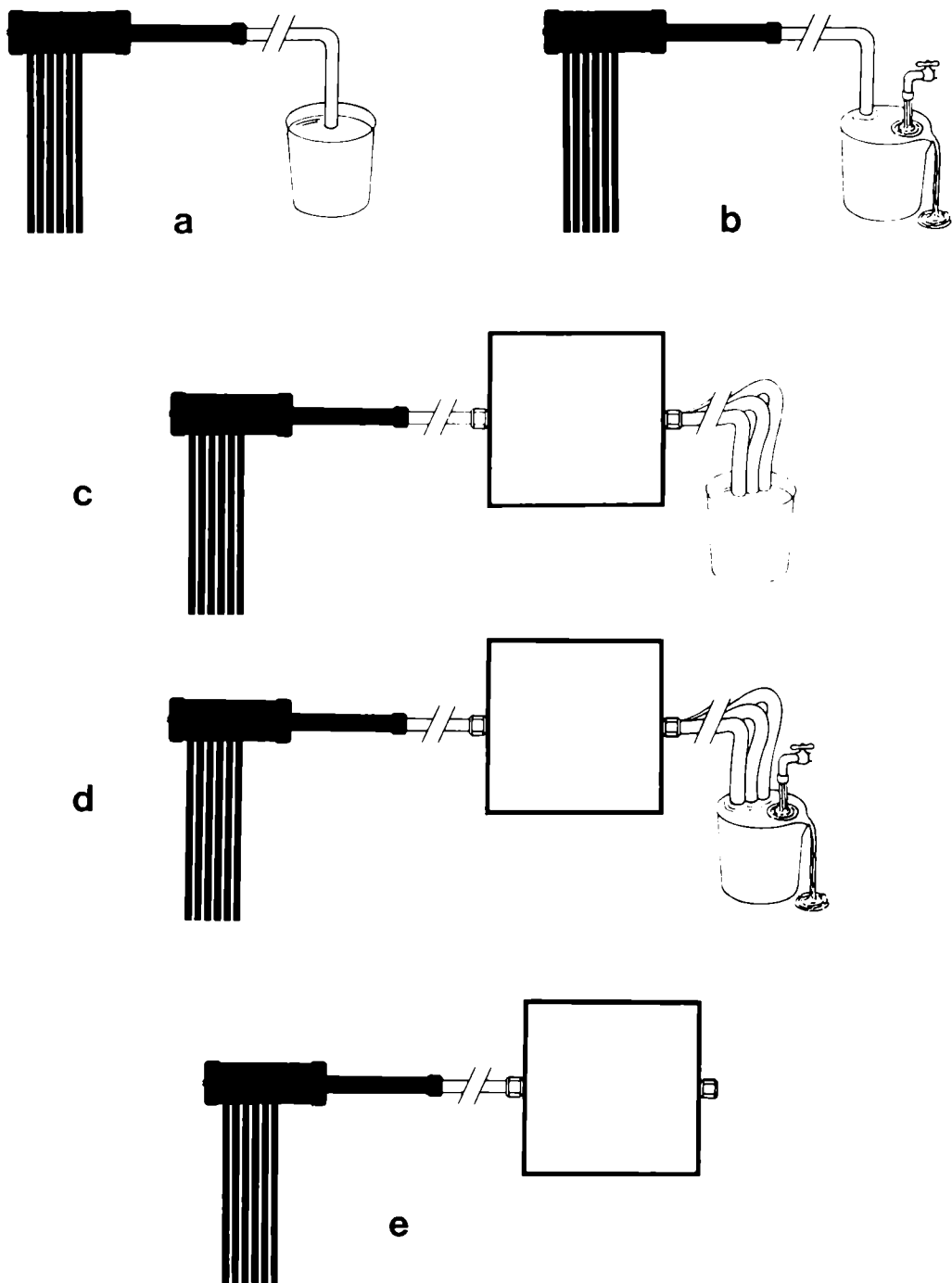


Fig. 2. The initial dor-buster component testing arrangements shown schematically.

shooter and cylindrical ORAC were discontinued soon afterwards, as they produced highly erratic results.

The Problem of Enhancement

Efforts to improve the performance of the devices fell into one of the following categories of modifications (Figure 4):

1. Enhancement of water-grounding

Experimental confirmation of the benefit of running water-grounding led to a number of design modifications based on the observation that water *in motion* over the grounding element improved the efficacy of the MDBO. It was hypothesized that, by carrying the energy off the grounding cables more efficiently, moving water increased the potential between the dor-buster head (lower) and the ground (higher), thus increasing the drawing capacity of the device. The designs tried were:

a) MDBO-Agitator (Figure 3d). In this setup, the usual 2-gallon water reservoir was replaced by a large cylindrical plastic tub. Extra long lengths of one inch (inner diameter) plastic-coated metal cable sheathing were led from the ORAC into the reservoir where they were bolted in spiral coils to the inner wall of the tub. In the center, a high-output submersible pump was placed with its outflow so directed as to swirl the water vigorously over the cables in a circular current. In this arrangement, the water is not continuously replaced as it is in the RMDBO. We hoped that the more powerful flow of water over a larger surface area of cable would improve the grounding function. In 5 trials, the net performance of this device was not as good as the RMDBO, which had been tested concurrently.

b) MDBO-“Water head” (Figure 3e) (shown in Results as “Water”). Similar in principle to the agitator, the water head, however, incorporated major design changes. A newly con-

structed ORAC was mounted directly above the large plastic water reservoir. Instead of bare cable sheaths, the grounding element now consisted of an array of 4 one-foot sections of baseboard heating units (aluminum fins on copper pipe) which led from the ORAC into the water below. The submersible pump was used as before; but, in addition, a loop line of over 100 feet of plastic tubing (inner diameter $\frac{3}{16}$ ") coming off the pump outlet was led back into the ORAC through 13 loops of cable shielding coiled within. From there, the tubing passed into the dor-buster head in which it was coiled 60 times before returning by the same route back to the reservoir. This arrangement allowed water to circulate through all the components of the device. This feature, plus the very large surface area of the grounding element and the agitation of the reservoir water, were hoped to remedy the disappointing results with the agitator. Such was not the case. Although it produced some remarkable T.I.s (highest 1.59; lowest 0.63), on average (9 studies), it was not more effective than the RMDBO and less effective than the ORAC.

- c) MDBO-“Fin” (shown in Results as “Fin”). This was simply the water head apparatus with all internal tubing and cables removed. The fin grounding array and water pump agitation were retained. Essentially, we hoped it would prove a more efficient version of the original agitator. Unfortunately, only two studies were completed with this device; there is insufficient data from which to draw any conclusions.
2. Enhancement by excitation of the ORAC component of the RMDBO

While experiments with new grounding designs were in progress, other modifications of the RMDBO were being simultaneously tested. These were directed at

exciting the ORAC in series with the dor-buster head. The premise was that a stimulated ORAC would increase the potential gradient and hence the drawing capability of the whole device. Two designs were built:

a) RMDBO-“Rotator” (Figure 3b). In this modification, a small four-fold ORAC was rotated on a “lazy susan” bearing mounted inside a specially constructed ORAC between head and ground. Rotation was imparted by a small electric motor suspended beneath the larger accumulator. A long plastic drive shaft linked motor and turntable. We hypothesized that the fields of the internally rotating ORAC and the one enclosing it would be mutually excited. While this may have been the case, no clear evidence of it was registered in the mice. In contrast, simultaneous trials with the conventional RMDBO showed T.I.s 18-20% in excess of the controls.

b) RMDBO-High Voltage (Figure 3c) (shown in Results as “HV”). The ORAC in this case differed in having a pair of parallel metal plates suspended from the top panel into its interior. Insulated from the metal lining, the plates were wired by long leads to a remote high voltage source; when turned on, a potential of 1000 volts was placed on the plates. We hoped that a mild oranur reaction might increase the potential of the ORAC. Six studies with this modification produced an average T.I. only slightly greater than 1.00.

3. Enhancement of the ORAC as an individual treatment device

As has been noted, results in previous work with the ORAC have been erratic. A number of ORAC types were tried in an attempt to produce more consistent effects.

a) ORAC “Charger.” It was suggested that, by bringing the field of the ORAC

as close as possible to that of the test animal, we might improve its effectiveness. Instead of simply treating all the ORAC treatment group mice together in the same chamber, individual mouse-sized ORACs with interior chambers of steel pipe were used. In 5 studies, these ORACs produced nil or negative results, while simultaneous groups run with the large cylindrical and “cone” ORACs showed positive T.I.s. It may be that the fear generated in the animal from its close individual confinement more than offset any expansion induced by the ORAC.

b) ORAC - “Cone-type,” Two-fold (Figure 3a). With this arrangement, the technique of treating all the mice together in the same chamber was resumed. The animals were placed in a plain steel can, the open top of which was covered by the cone ORAC. This method, over a period of 18 studies, yielded highly significant elevations of the T.I.—almost on a par with the RMDBO. Whether or not the cone configuration is a critical factor is not entirely clear, but the *biological effectiveness* of this ORAC was conclusively confirmed.

4. Enhancement by alterations in dosage

Dosage procedures had to be approached empirically. However, in keeping with anecdotal reports in humans that superficial injuries respond best if treated promptly, we began by treating the mice as soon after wounding as possible. The following dosages were used initially (Studies A-1 to A-27):

a) Dor-buster devices: 5-7 minutes, two to four times daily

b) ORAC groups: 15 minutes, twice daily

This regimen was applied every day for the full duration of the study, *e.g.*, up to 15 days. When it became clear that the noticeable effects of the therapy occurred mainly within the first 4 days, treatments

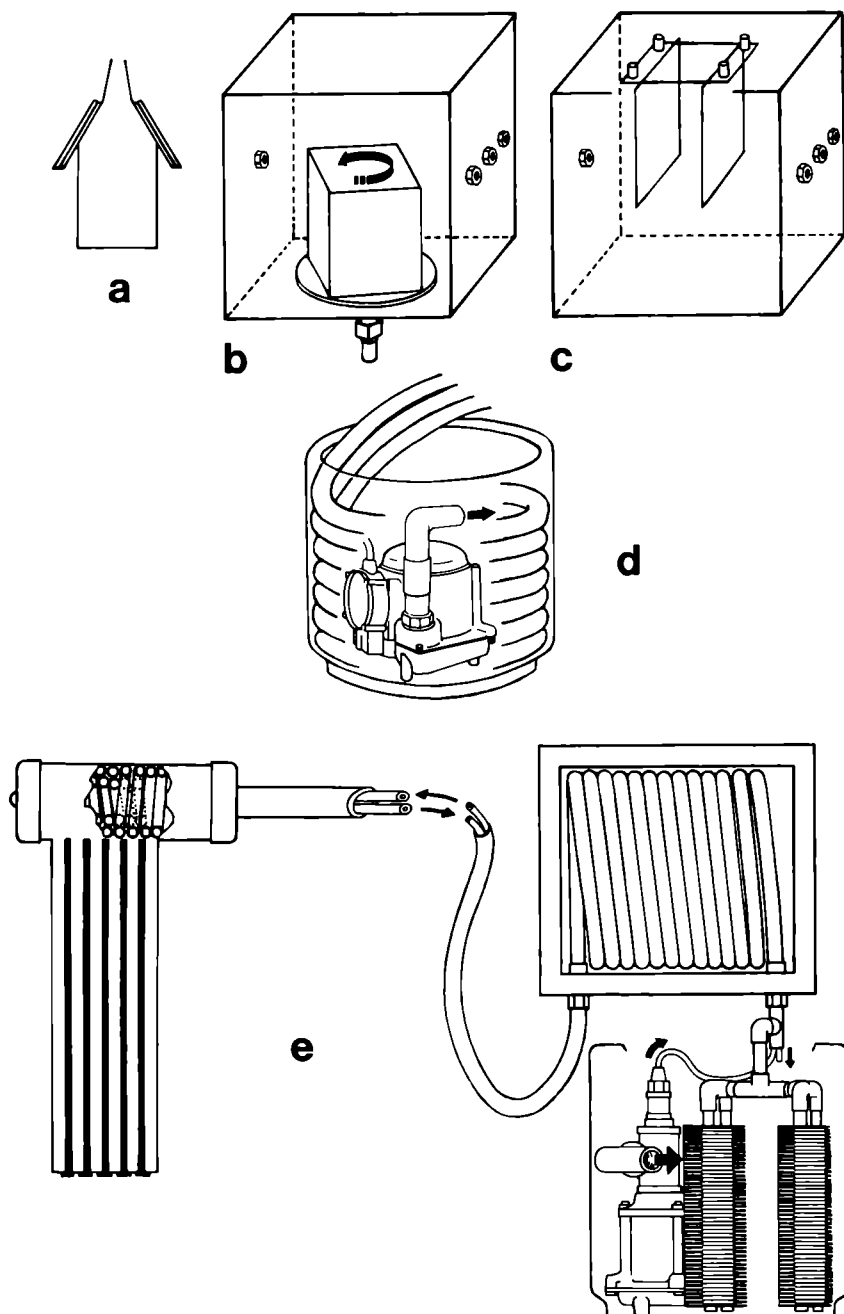


Fig. 3 The principle design modifications for enhanced effects are illustrated: a) Cone ORAC, b) Rotator ORAC, c) High voltage ORAC, d) Agitator, e) Water-head RMDBO. Note that the head is shown to larger scale for clarity.

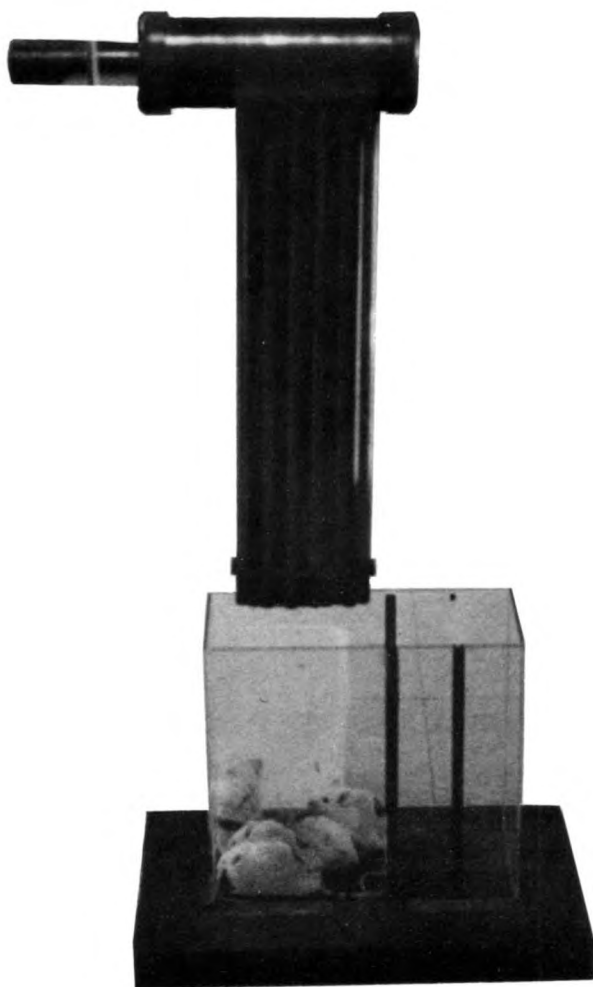


Fig. 4. Method of application of the dor-buster.

were no longer applied beyond 96 hours. As the data accumulated, we found that *every device tested, at some time or another, produced negative therapeutic indices*. Only later did we realize that the effects of the devices themselves had distinct seasonal patterns. At the time, we simply believed—as it proved, correctly—that the dosages were in these circumstances sometimes excessive for the mice. By the 29th run, it was apparent that *a single treatment given immediately after wounding* produced the most consistent result. Our decision to define more exactly an optimum dosage led to the variable dose regimens—the “C-Series”—in which single dosages ranging from 30 seconds to 30 minutes were tested.

5. Controls

In this project, nine types of controls were employed. Some of them were necessary because of changes in procedure; others were used in connection with device modifications; and still others were necessary to insure the validity of the standard control as a true basis of comparison for most of the test groups. By “standard controls,” we refer to animals handled in identical fashion to all the dor-buster groups with the sole exception that they were “treated” with a solid *wooden* dummy dor-buster head. These controls were included in all the experiments and were always run before any of the treatment groups. This was to minimize artifacts due to remote or residual influences from any of the treatment devices. The timing and dosages of the mock treatments were kept consistent with the experimental groups at all times. Other controls utilized were:

- 1) ORAC controls: Treatment in a paste-board cylinder comparable to the cylindrical ORAC in size and shape.
- 2) Distant controls: Identical in every respect to the standard controls, these groups were handled entirely in a

remote (6 miles) location. They were designed to rule out residual effects of the devices on the standard controls, e.g., “charging up” the laboratory.

- 3) Extra anaesthesia controls were introduced to determine whether or not a second anaesthesia would effect wound closure.
- 4) ORAC “Charger” controls: These animals were treated in acrylic mouse-sized cubicles or styrene cylinders as a control for the ORAC charger experiments.

The above four types of controls all behaved comparably to the standard controls, proving the adequacy of the standard control in most situations.

There were two control groups whose behavior was remarkable and unexpected:

- 5) “Head Only” controls: As part of the program to test the components of the dor-buster individually, 12 groups of mice were exposed to the copper dor-buster head with no other connections except the camera tripod on which it was mounted. To our surprise, this “control” had considerable effect on healing: mostly negative—sometimes remarkably so. This was in sharp distinction to the same head mounted in the same way but connected in series to an ORAC and water ground (RMDBO). Heads of other metals were not tested.
- 6) The High Voltage ORAC control (HVC): This consisted simply of the RMDBO-HV described earlier used without the voltage applied. It was intended to serve two purposes:
 - a) As a control against which to compare the performance of the high voltage apparatus *with* the voltage applied.
 - b) As a comparison against the RMDBO, whose construction is similar except for the plates suspended within the ORAC.

It was in the second respect that the HVC proved unusual. The six studies concerning the HVC averaged a negative T.I. (*i. e.*, .91) compared to the RMDBO, which produced an average T.I. of 1.10. Instead of performing similarly as expected, they behaved like different devices with no pattern of relationship between them. We have no explanation for this. One wonders if even subtle differences in construction could cause such divergent behavior. In another context, other research has shown that two ORACs of identical construction may simultaneously exhibit distinct *thermal* characteristics. Of course, one plausible hypothesis is that, once the plates *had* been charged, the characteristics of the ORAC, and hence the functioning of the entire system, were permanently altered, *e.g.*, a process of organization.

In any case, these differences between otherwise similar ORACs can be seen as a vital area of investigation inasmuch as the ORAC plays such a pivotal role in physical and biological research. Obviously, if we are to build devices and instruments of higher predictability, a better understanding of the relationship between the accumulator's construction and its behavior is indispensable. Another matter requiring clarification in this connection is the link—if any—between its thermal properties and its biological effects.

The C Protocol

The C Protocol marks the beginning of the consistent use of a true "0-hour" reference photograph. With the 96-hour follow-up picture, the biological effect may be optimally documented. The protocol also includes for the first time the study of a dose-effect relationship in the use of the dor-buster and orgone accumulator (C3-C18). The first of the series was begun in April 1981, the last,

C18, being concluded in March 1984. The composition of the series is shown in Table I.

1. Procedure: C Series

In all cases, the animals were treated *once only* for the prescribed period immediately after the 0-hour photograph. The interval between wounding and photography was quite constant, and the time from wounding to treatment, 30 minutes or less. The mice were ether anaesthetized for the surgery, allowed to recover, and then reanaesthetized for the initial picture. The sequence for handling the groups was always the same: The controls came first, before any device was applied or "turned on," followed by the RMDBO and ORAC. Special treatment groups, such as the water head or high voltage types, were always last. All running water or agitation devices were run for a full minute before placing the mice beneath the dor-buster head, at which point the timing of the treatment was begun. The devices were then dismantled, water reservoirs drained, and cables and ORACs were removed for storage outside of the laboratory. At 96 hours from the time of wounding, each animal was photographed in exactly the same order (*i.e.*, as in wounding and the initial photograph) but without anaesthesia. The manner of wounding, photography, and data extraction has been described in Part One of this report.

Results

A number of useful, unexpected, and in some cases statistically significant findings emerged from the seven years of work on wound-healing. Foremost among our goals was to devise a protocol, modifying the devices as necessary, which could demonstrate a statistically solid biological action of the devices. Hopefully, the action would be both life-positive and consistent. In several cases, we appear to have come close to this goal.

The statistical evaluation was hampered by the many protocol changes, making certain comparisons statistically unsound; in other cases, insufficient data was available for some groups to allow meaningful comparisons. A major problem was the great deal of natural variation within each group; this was true of the controls as well as the experimental groups. Consequently, a large amount of data was necessary in order to demonstrate statistical significance, even in groups where the results were clearly positive. The latter point should be kept in mind in the discussions that follow regarding those groups that entailed only a few runs. In these groups, the lack of statistical significance is very likely due to insufficient data alone, since for some dosages the results are clearly positive. Nevertheless, a great deal of reliable and useful data was produced during the C-series, consisting of 18 runs of approximately 42 mice per run. The various groups

and treatment schedules for the C-series are shown summarized in Table I. The numbers following each letter represent the time, in minutes, for which the mice were exposed to the device.

The most significant data derived from a comparison of five groups (controls plus the groups listed in Table II) using an Analysis Of Variance, which was applied to 381 values for the percent healed at 96 hours. The differences among the groups was significant at the level of $P < 0.002$. A further evaluation compared each group's performance with the controls; the results are shown in Table II:

TABLE II: C-Series ANOVA

Group	Stat. Sig.	T.I.
RMDBO-1	$P < 0.0018$	1.12
RMDBO-7	$P < 0.0008$	1.10
ORAC-7	P Not Sig.	1.01
ORAC-30	$P < 0.0023$	1.12

Three of the four treatment groups show highly significant statistical probabilities.

TABLE I: C-Series Summary

G	Date	Con	R.5	R-1	R-3	R-7	O-1	O-7	O-30	W.5	W-1	W-7
C-1	Apr-4-1981	43				1.14			0.89			0.63
C-2	Jun-6-1981	52				0.9			1.19			0.98
C-3	Aug-8-1981	38		1.11	1.08	1.12		1.35	1.24		1.12	1.57
C-4	Sep-30-1981	45		1.43	1.19	1.38		1.37	1.12		1.22	1.06
C-5	Nov-14-1981	30	1.01	1.58		1.34		0.85	0.89	1.21		0.90
C-6	Dec-9-1981	45	0.93	1.23		0.91		0.61	1.09	1.23		1.01
C-7	Feb-6-1982	39	1.10	1.15		1.25	1.10	0.85		1.22	1.03	0.97
C-8	Apr-28-1982	37	1.09	0.97		1.05	1.12	1.35		0.95	0.50	1.37
C-9	Jul-21-1982	42	1.16	1.25		1.06	0.97	0.92		0.88	1.02	0.38
G	Date	Con		R-1	R-2	R-7	O-1	O-7		F.5	F-1	
C-10	Oct-27-1982	44		.85	.96	1.04	1.16	1.11		1.14	1.39	
C-11	Dec-1-1982	42		0.97	1.25	1.11	1.05	0.47		0.99	0.94	
C-12	Feb-13-1983	42		1.13	1.20							
G	Date	Con		R-1	R-2	R-7	O-2	O-7	O-30	HVC7	HV2	HV7
C-13	Apr-17-1983	49		1.11	0.82	1.12	0.93	0.95		1.04	0.78	0.38
C-14	Jul-7-1983	48		0.96	1.16	1.19			1.07	0.88	1.07	0.72
C-15	Aug-17-1983	51		1.07	1.10	1.09			1.05	0.97	0.98	0.97
C-16	Oct-26-1983	54		1.17	1.09	1.03			1.04	1.02	1.14	1.06
C-17	Dec-18-1983	44		0.97	0.78	1.17			0.96	0.88	0.89	1.00
C-18	Mar-7-1984	35		1.24	0.66	0.98			1.29	0.68	0.91	1.13

with average healing rates from 10-12% in excess of the controls. These results represent perhaps the first rigorous demonstration of the biological activity of organotic devices such as the ORAC and medical dor-buster.

Analysis Of Variance was also applied to two other sets of data, namely (1) the controls and four RMDBO-water head groups (W-5, W-1, W-7 in Table I), and (2) the three RMDBO-high voltage groups (HVC and HV groups in Table I). Neither of these groups showed statistical significance, although three of the groups (W-0.5, W-1 and HV-2) showed positive average therapeutic indexes.

A. Dose Relationship

The values for the average therapeutic index for each device (excluding the Fin group due to insufficient data) at various dose levels are shown in Table III below:

TABLE III: DOSE RELATIONSHIP

Group	T.I.
RMDBO-0.5	1.08
RMDBO-1	1.12
RMDBO-2&3	1.05
RMDMO-7	1.10
ORAC-1	1.01
ORAC-7	1.01
ORAC-30	1.12
Water-0.5	1.10
Water-1	1.02
Water-7	0.96
HV-2	1.03
HV-7	0.98

It is clear that the RMDBO is effective at all the dose ranges used, although no correlation between dose and therapeutic index is apparent. Evidently the RMDBO is effective at promoting healing over the dose ranges used. The ORAC treatment, on the other hand, has little effect at short treatment durations, but gives 12% improvement with thirty minutes exposure. For the other two groups, the data demonstrates a positive effect at low dosage, but a reduced or even detrimental effect with more prolonged exposure. This is consistent with the conclusion that these devices were, as intended, stronger than the RMDBO, and hence show positive effects at low dosage

but toxic effects at higher dosage. Although the mechanism of the toxic effect is not immediately clear, the results indicate the care that must be exercised in using these devices.

It is instructive to look at the variation that occurs within each dose range, since this information is obscured by the group average. This data, shown in Table IV, is taken from Table I and summarizes minimum and maximum T.I. observed and the computed range.

This table illustrates the variability inherent in these devices, and in particular the data is instructive regarding consistency. We have generally found that more powerful devices are also more inconsistent, showing large excursions above and below the 1.00 therapeutic index level. By contrast, the ORAC-30 and RMDBO-7, two of the most consistent devices in terms of average T.I., also show less extreme values, despite that fact that there are more data for these devices (and hence more chance for large statistical fluctuations). The table also includes data for the MDB, obtained from runs A-7 through A-24. This device showed a great deal of variability but little net positive effect; its average therapeutic index was only 1.01.

TABLE IV: VARIATION IN T.I.

Group	Min.	Max.	Range	% Positive
RMDBO-0.5	0.93	1.16	0.23	80
RMDBO-1	0.85	1.58	0.73	69
RMDBO-2/3	0.66	1.25	0.59	64
RMDBO-7	0.90	1.38	0.48	82
ORAC-1	0.93	1.16	0.23	67
ORAC-7	0.47	1.37	0.90	40
ORAC-30	0.89	1.29	0.40	73
Water-0.5	0.88	1.23	0.35	60
Water-1	0.50	1.22	0.72	80
Water-7	0.38	1.57	1.19	44
HVC	0.68	1.04	0.36	33
HV-2	0.78	1.14	0.36	33
HV-7	0.38	1.13	0.75	50
MDB	0.77	1.75	0.98	47

This problem of variability is one of the most serious difficulties facing the researcher working with organotic devices; it was encountered by Reich early in his work and has

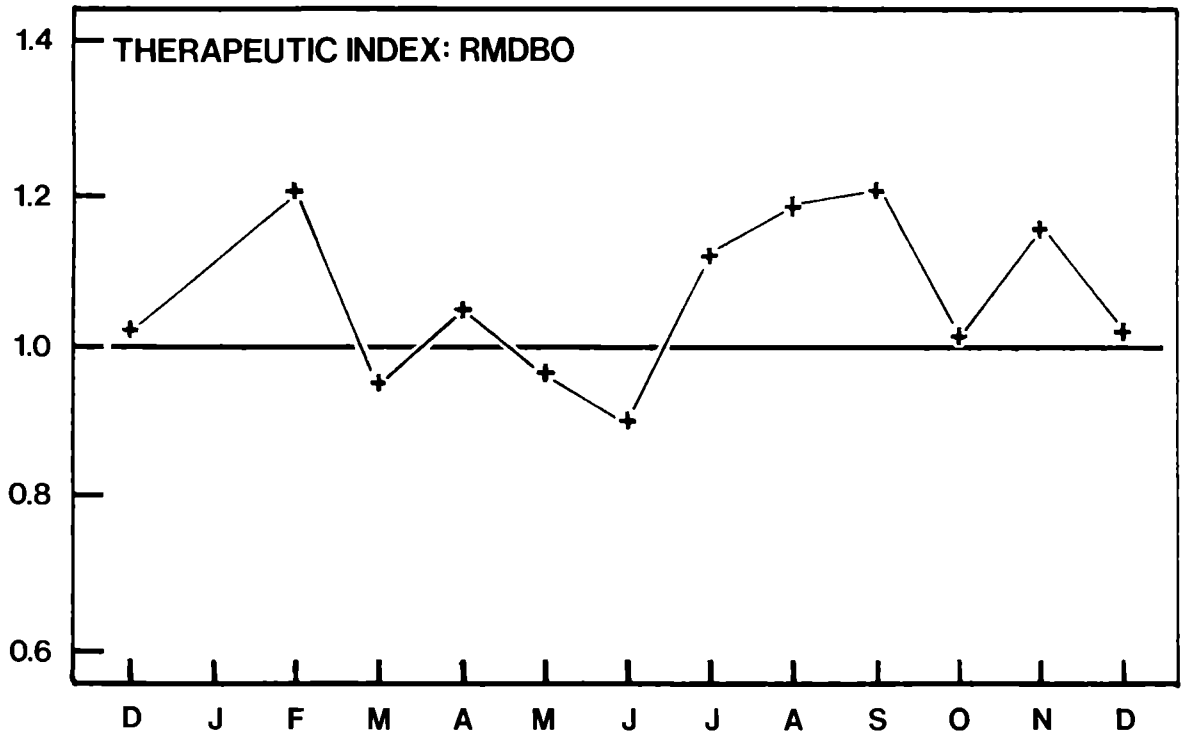


Fig. 1: Seasonal variation in the therapeutic index of the RMDBO devices, from runs A-7 through C-18.

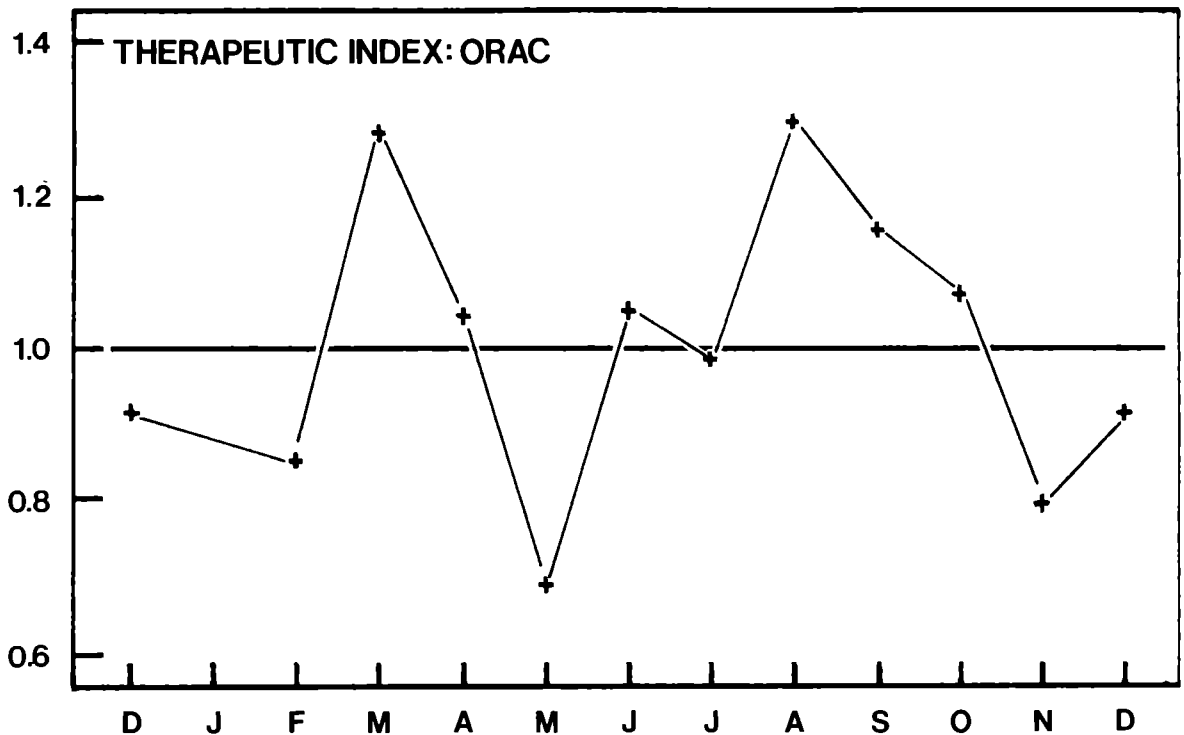


Fig. 2: Seasonal variation in the therapeutic index of the ORAC devices, from runs A-7 through C-18.

been a recurrent problem since then. In an overly simplified manner, the problem may be summarized in two parts:

(1) Orgonotic devices frequently exhibit a high degree of variability and even unpredictability;

(2) The variation often increases with power of the device, i.e., making the device stronger does not necessarily make it more consistent but rather may increase the magnitude of swings above and below baseline.

B. Seasonal Variation

A clear seasonal variation in the wound-healing rate in the controls was found (presented in Part I), and it is therefore not surprising to discover annual changes in the experimental devices. The seasonal variation in therapeutic index for all RMDBO and all ORAC devices from run A-7 through C-18 is shown in Figures 1 and 2. In addition, the data was broken into four-month groups and averaged, shown below in Table V:

TABLE V: SEASONAL VARIATION

Period	RMDBO	ORAC
JFMA	1.10	1.01
MJJA	1.10	1.09
SOND	1.07	0.98

Although these differences are not statistically significant, some useful information can be surmised from the graphs and data. The RMDBO maintains a positive therapeutic index for most months of the year, falling slightly below the 1.00 line on only three months. The ORAC, on the other hand, shows somewhat larger fluctuations throughout the year. Even so, a common pattern is still evident in the two graphs: a peak early in the year, followed by falling values and then a second peak. This is to be contrasted with the controls, which show a pronounced dip in the early part of the year, followed by a peak at the end of the year.

C. Weather Variation

The time at which wounding began, as well as the prevailing weather during the run, was recorded starting with C-3 and is shown in Table VI below:

TABLE VI: WEATHER VARIATION

Grp	Date	Time	Weather	R-1	R-7	0-7	0-30
C1	4-4-81	5:00	*	*	1.14	*	0.89
C2	6-6-81	4:00	*		0.90	*	1.19
C3	8-8-81	5:30	Fine Drizzle & Overcast	1.11	1.12	1.35	1.24
C4	9-30-81	5:45	Overcast	1.43	1.38	1.37	1.12
C5	11-14-81	5:30	Overcast	1.58	1.34	0.85	0.89
C6	12-9-81	2:50	Overcast & Windy	1.23	0.91	0.61	1.09
C7	2-6-82	5:15	Thin Overcast	1.15	1.25	0.85	*
C8	4-28-82	3:25	Mostly Clear	0.97	1.05	1.35	*
C9	7-21-82	1:30	Clear	1.25	1.06	0.92	*
C10	10-27-82	2:00	Clear & Pleasant	0.85	1.04	1.11	
C11	12-1-82	2:00	Steady Rain & Fog	0.97	1.11	0.47	
C12	2-13-83	2:20	Clear	1.13	*	*	
C13	4-17-83	2:30	Clear & Pleasant	1.11	1.12	0.95	*
C14	7-7-83	2:00	Partial Overcast	0.96	1.19	*	1.07
C15	8-17-83	1:55	Clear	1.07	1.09		1.05
C16	10-26-83	1:25	Overcast & Breezy	1.17	1.03	*	1.04
C17	12-18-83	1:15	Milky Overcast	0.97	1.17	*	0.96
C18	3-7-84	1:00	Stratocumulus	1.24	0.98	*	1.29

The data from Table VI was analyzed to compare the ORAC and RMDBO in three weather states: rain, overcast, and clear. The results are shown in Table VII:

Table VII: WEATHER ANALYSIS

Weather	ORAC	RMDBO
Clear	1.07	1.07
Overcast	1.01	1.19
Rain	1.02	1.08

These differences were not significant by ANOVA, although the RMDBO data reached near significance ($P < 0.09$). However, they are nevertheless useful in attempting to understand the functioning of the two devices. Specifically, the T.I. values are very much in accord with previous data for the ORAC (such as To-T), namely, that the accumulator functioning is strongest in clear, sunny weather. The RMDBO, on the other hand, appears to function in all weather states but clearly stronger during overcast. This can be understood as follows: during overcast, energy is moving from the atmosphere at large into clouds (water), and this movement is being mirrored in the RMDBO. Specifically, energy is being drawn from the air (and the mice) into the device and ultimately into the running water.

The understanding is somewhat complicated by the fact that the RMDBO also contains a functioning ORAC. However, this may very well be a major element in the consistency of the RMDBO since, as the

weather pulsates between clear, cloudy, and rainy states, either the ORAC or the water-drawing process will be active a majority of the time. Indeed, it is further likely that the sum is greater than the parts, *i.e.*, the simultaneous presence of the ORAC and water enhance, as well as modulate, the behavior of the system, producing a new, functionally different device than either alone.

D. Conclusion

Seven years of work encompassing 42 experimental runs testing wound healing in mice was successful in demonstrating that various organotic devices could be carefully evaluated and modified to eventually produce a consistent biological effect. The large number of alterations and protocol changes highlighted the difficulties in working with highly variable, nonmechanical energetic devices such as the ORAC and medical dor-buster. From this work, we can draw the following conclusions:

- (1) A great deal of data is necessary to draw firm statistical conclusions, due to natural biological variation as well as the unpredictability inherent in the devices themselves.
- (2) It is necessary to stay with the experiment for a long period of time in order to develop a refined sense of the nature of the variation and develop ways of dealing with it.
- (3) It is also necessary to consider and take into account many unusual variables in working with organotic devices, such as the weather, season, and energetic state of the laboratory.
- (4) The data showed that the most consistent device for promoting wound healing was the medical dor-buster grounded in running water, for dosage periods ranging from one to seven minutes. The orgone accumulator was found to be ineffective at low dosages (one to seven minutes) but clearly effective with thirty minutes exposure.
- (5) The effects of the other devices was found to be less consistent although very useful in clarifying the mechanism of action of these type of devices.
- (6) The wound margin behaves like a contractile ring in the early stages, exhibiting pulses of contraction and expansion. The effects of treatment are mainly apparent within 96 hours of wounding; it is postulated that the devices exert their influence on this pulsatory function.
- (7) With some devices, a clear relationship was apparent between dose and effect.
- (8) A seasonal pattern of variation in rates of spontaneous healing was evident in the controls; seasonal patterns in the efficacy of two of the devices was also observed.
- (9) Grounding of the medical dor-buster in running water clearly enhanced its effectiveness. The dynamism of this device can be appreciated from the magnitude and consistency of the response to a single, brief (one minute) treatment exposure.
- (10) The data suggested a relationship between the effectiveness of the orgone accumulator and medical dor-buster and the weather. This information is very useful in elaborating the mechanism of action of the devices.

Appendix I

Devices and Controls

Description	Studies Involved	Remarks
A. Controls		
1. Standard	A1-C18	Wooden dummy dor-buster head
2. Orac	A1-A9	All cardboard dummy ORAC
3. Distant	A18-A22	Standard controls run in distant location
4. Extra Anaesthesia	A21	Repeat anaesthesia: effect on healing
5. Extra Pictures	A23	Mice (untreated) photographed every 12 hours
6. ORAC Charger	A24-A28	Acrylic cubicles, individual mouse-sized
7. Head Only	A14-A16, A18 A20-A27	Unattached dor-buster head (metal)
8. High Voltage	C13-C18	High voltage set-up operated without current
B. MDBO Variants		
1. MDBO	A1-A9	Standing water grounding
2. RMDBO	A7-A-18, A20-A27, B, C1-C18	Running water grounding
3. Agitator	A14-A16, A23-A24	Grounding water reservoir with submersible pump
4. Rotator	A25-A27	Small rotating ORAC with main ORAC
5. Water Head	B, C1-C9	Fin array in grounding reservoir with agitation; internal water circulation
6. Fin	C10-C11	Same as 5 but without internal tubing and water circulation
7. RMDBO-HV	C13-C18	New smaller ORAC with internally suspended metal plates for high voltage excitation
8. RMDBO-HVC	C13-C18	Same as 7 but without high voltage applied
C. MDB Variants		
1. MDB	A1-A16, A18, A20-A24	Dorbuster head with cable direct to standing water grounding
2. MDBR	A7-A9	Dorbuster head with cable direct to running water grounding
3. MDB-Shooter	A2, A5-A8, A13-A16	Dorbuster head with cable to ORAC without grounding
D. ORAC Variants (ORAC for direct treatment)		
1. Cylindrical	A7-A9, A13-A18, A20-A27	—
2. Charger	A24-A28	Individual mouse-sized metal-lined chambers
3. Cone	A28, B, C1-C18	Two-fold (steel and foam)
4. Rotator-Shooter	A28	Single fold cone applicator connected to the underground Rotator ORAC.

Appendix II

A Note on the Device Modifications

As we have seen, highly significant results have been obtained with the 30 minute ORAC and the 1 and 7 minute RMDBO treatments. Running water-grounding has proven to be the most enhancing physical modification overall. It would be, however, a hasty and unwarranted conclusion to discard some of the other device designs as "ineffective." The question of their value is far from closed. One must remember that one major thrust of the work was to isolate a design and mode of application that would produce a positive effect most consistently—which in fact is what was achieved. This priority, however, might tend to obscure the fact that other designs, though erratic, did produce powerful effects that were, in some cases, more highly positive or negative than either the ORAC or RMDBO. Furthermore, in the present context, a negative (as distinct from *nil*) effect has as much significance and—even though we may not yet fully understand how—must have serious theoretical and practical implications. We should consider, then, how the evaluation of these other modifications might have been improved upon.

First, there is the question of the number of trials. Thirteen studies were required to prove the efficacy of the RMDBO. Overall, 40 studies were conducted with it. In contrast, our experiences with other designs were relatively limited:

Agitator	- 6 studies
Rotator	- 3 studies
ORAC Charger	- 4 studies
Water Head	- 20 studies
Fin-grounding	- 2 studies
High Voltage	- 6 studies

It is clear that there may be insufficient data to characterize the effects of these devices themselves other than their simultaneous performance in comparison to the RMDBO and ORAC.

Second, some of these designs were not tested with the variable dose protocol.

Thirdly, despite the proven advantages of running water-grounding, unlike the RMDBO, the agitator, water head, and fin-grounding systems for practical reasons did not have a continuous flow of fresh water in and out of the ground water reservoir during use. That is, water was circulated and/or agitated, but *not exchanged*. This may have been a critical factor in their functioning as they did. What is suggested here is the

possibility that the grounding water may become "saturated" with the energy.

In any case, the problem of enhancement is not settled, but we have learned a great deal about how it should be attacked.

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Atmospheric Pulsation: Air and Water

COURTNEY F. BAKER, M.D.

Abstract:

The atmospheric pulsation of the orgone energy can be measured in many ways. In this paper, the results of several different techniques using the electroscope and ORAC temperature difference as monitoring parameters are presented, as well as confirmatory findings from the wound-healing experiment.* The data is consistent in finding an antithesis between the movement of energy between air and water, demonstrated both in the atmosphere and by various experimental devices such as the orgone accumulator and medical dor-buster.

Introduction:

The findings presented in this analysis combine the data derived from atmospheric measurements over several years, as well as data from the wound-healing experiment. The data was studied in an attempt to understand the movement of energy in the atmosphere between air (the atmosphere as a whole) and water (clouds) during the normal functions of weather formation. Additional confirmatory data was obtained from the results of the study of the orgone accumulator (ORAC) and medical dor-buster used in the wound-healing experiment during various weather states; this data helps clarify the functioning of these devices as well.

Experimental Arrangement:

A series of regular atmospheric observations and measurements was begun in August of 1975 in eastern Pennsylvania and continued through January of 1977. Readings were taken 10-15 times daily from 8:30 A.M. to 11:30 P.M. and consisted of the following:

Date, Time

Electroscope: Initial and Final readings

To-T

Barometer, Relative Humidity,

Temperature

Weather Observations: clouds,

precipitation, wind

The instruments were placed on a porch, which was shielded from the elements but allowed free circulation of air to the outside. The ORAC temperature difference, $T_o - T$ was taken from a three-fold ORAC and a control that were thermodynamically matched according to a method described previously (1). The two boxes were buried underground together in a double plywood enclosure, and the actual temperature measurement was made indoors via an electronic thermometer utilizing carefully calibrated commercial thermistors. The electroscope setup, to be described below, was placed on a table on the porch next to the other weather instruments.

Electroscope readings were made via a unique high-voltage setup that allowed more rapid and sophisticated measurements than those produced by the discharge rate method used by Reich (2). In this setup, the electroscope was charged indirectly by induction via a high voltage negative DC potential (-980 volts) connected to the inner metal wall of a three-fold ORAC (see Figure 1). This voltage produced an induced charge on a metal plate that was suspended within the ORAC and connected to the electroscope. The high voltage was turned on only when readings were being made, and resulted in two readings of electroscope deflection, as follows: When the voltage was activated, the electroscope leaf rose to a certain deflection,

*See the article on page 7 of this issue. All reference to the wound healing experiment pertain to that article.

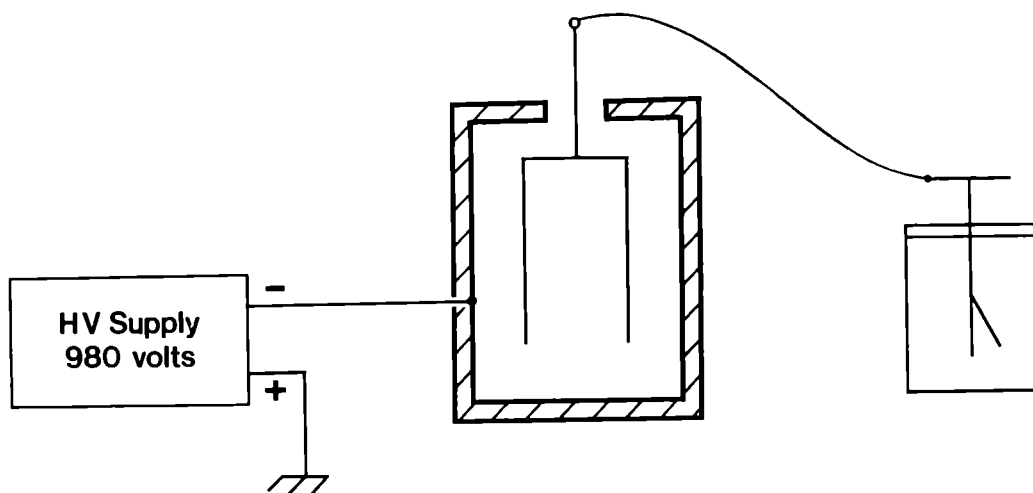


Fig. 1: High voltage electroscope setup, using air as the inter-electrode medium.

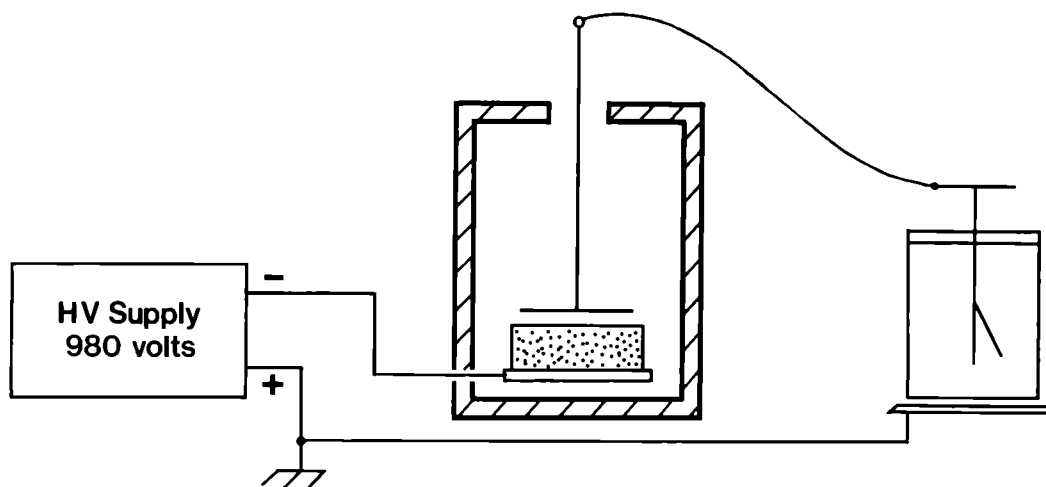


Fig. 2.: High voltage electroscope setup, using water as the inter-electrode medium.

called the "initial" reading, within the first three seconds. Then, thirty seconds later, a second measurement of the leaf deflection was made, giving the "final" deflection value. The second value would be the same, greater, or lesser than the initial value depending on the prevailing energetic state of the atmosphere. In this way, a rapid assessment of the atmosphere could be made. Final readings greater than the initial readings were found to correlate with "charging" states in the atmosphere (such as cumulus cloud formation), and the reverse occurred in "discharge" states (such as during rain). The difference between the two readings (i.e., Final-Initial) could be used as an index of the direction of energy movement in the atmosphere as a whole. A discussion of these findings was presented in a previous paper (3).

A second set of similar measurements were taken from October 1982 through March 1984, with regular readings also from 8:30 A.M. through 11:30 P.M. In this case, a major modification was made in the electro-scope setup (shown in Figure 2). Here, the high voltage potential was applied to a circular metal plate placed under a plastic container holding water to a depth of one inch; this arrangement induced a charge on a metal plate suspended above the water and connected to the electro-scope. The whole setup was placed in a three-fold ORAC located outdoors but shielded from the elements. Readings were otherwise taken as before, except for the ORAC and its control, which were located outdoors but not buried.

The values from Table I are shown graphically in Figure 3. A remarkable correlation with the various weather states and between the two curves is apparent. Both curves show their largest excursions (largest difference between initial and final readings) during rain, and less excursion for snow, which represents discharge (precipitation), as well as charge (snow is highly charged). However, of greatest interest to the present study is the fact that the curves are mirror images of each other, demonstrating oppositely directed ex-

cursions for each weather state. Thus, both electro-scope setups react similarly to the various weather states, but do so in opposite directions (i.e., the magnitude of the changes are similar but the polarity of the changes opposite).

Several different but related energetic changes take place in the atmosphere during the developmental sequence from clear skies to cloudiness and then precipitation. First, the barometer steadily falls, with the lowest average readings being found during snow-fall. The barometric reading is interpreted as indicating the overall degree of expansion or contraction in the atmosphere; thus, clear skies represent expansive weather, and rain, snow, and storms represent the most contracted state. As this sequence from expansion toward contraction takes place, the distribution of both energy and water changes. The homogenous distribution of both energy and water in clear states is disturbed, leading to discrete areas of higher energy concentration which build according to the organotic potential (flow from low energy concentration toward high concentration). Meanwhile, moisture may be drawn into these areas as well, leading to the formation of clouds; this process continues until a plateau is reached (the "capacity level" of the atmosphere) and building ceases. The direction of movement may then reverse, with both energy and water being discharged from the clouds as precipitation, lightning, or energetic rain.

It is obvious that the two different electro-scope arrangements entail significant differences, as well as similarities. Both setups induce charging within the concentrated orgone energy environment of the ORAC, which serves to amplify pulsation taking place in the atmosphere as a whole. On the other hand, the first arrangement entails induction through an air space, while in the second, the interelectrode medium is water, which is a strong absorber of the energy. Both setups can thus be expected to accurately reflect atmospheric changes while at the same time exhibiting differences due to the two different mediums.

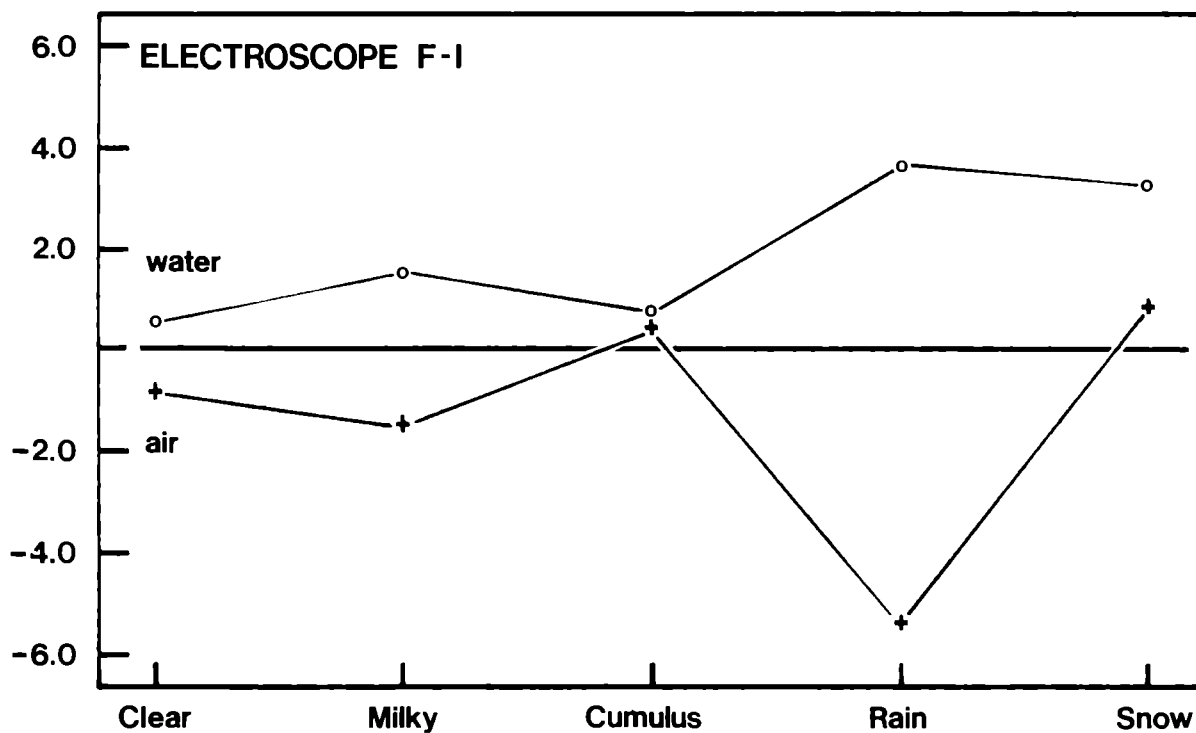


Fig. 3. Comparison of electrostatic readings in various weather states using air vs. water as the inter-electrode medium, showing inverse relationship.

The third set of data came from the wound-healing results from the runs C-3 (August 1981) through C-18 (March 1984). This data consisted of a comparison of the healing effect of the medical dor-buster applied for one (R-1) and seven (R-7) minutes, and the ORAC applied for seven (O-7) and thirty (O-30) minutes. The parameter used for comparison was the therapeutic index, since this number indicated the degree of measurable biologic effect of each device and therefore can be used as a rough measure of the energetic strength of the device during the run.

The wound-healing results compare two fundamentally different devices, the ORAC and medical dor-buster, whose functional differences are also based on air vs. water. In the ORAC, energy is concentrated within an air space, while in the dor-buster, energy is drawn into water. These differences allow another source of data comparing the energetic differences between energy moving relative to air and water.

Results:

The two sets of electroscope data were subjected to a computer sorting routine, which sorted the values according to five different weather states. An average of the initial and final readings for each state was computed and the differences subtracted; the results are shown in Table 1 below:

TABLE 1: Electroscope Data

Weather	F-I (Air)	F-I (Water)
Clear	- 0.70	+ 0.50
Milky	- 1.40	+ 1.60
Cumulus	+ 0.50	+ 0.67
Rain	- 5.30	+ 3.67
Snow	- 1.00	+ 3.27

The weather state of "milky" consists of diffuse patches of white in the sky, representing moisture in the atmosphere which has not yet formed discrete clouds. In Table 1 above, the various states were arranged in a logical progression in that clear skies may develop cloudiness leading to rain or snow. Furthermore, average values of the barometer for each of the weather states also shows a progressively lower barometric reading going

from clear to snow (see Table 2 for the values from the second electroscope setup).

Thus, the basic sequence is a movement of diffuse energy in the air (atmosphere as a whole) toward concentration in clouds (the water both attracts and binds the energy). The sequence may then reverse. It is also possible to observe this pulsation on a smaller scale over a period of minutes to hours on a clear day when fair weather cumulus are building. Very commonly, the cumulus clouds will go through several sequences of building and dissolution during an afternoon. These sequences represent pulsation of energy in the atmosphere, and energetic changes are indicated by the changing values of electroscope leaf deflection, since the ORAC, electroscope, and water container are all imbedded in the changing energy medium.

A more complete listing of average weather state values taken with the second (water) electroscope setup is shown in Table 2.

TABLE 2: Weather State Averages

State	I.	F.	F-I	To-T	Bar	N
Clear	27.8	28.3	0.50	- 0.038	29.91	569
Milky	28.7	30.3	1.60	- 0.074	29.87	162
Cumulus	29.6	30.3	0.67	- 0.128	29.74	237
Rain	29.6	33.2	3.67	- 0.028	29.63	219
Snow	26.7	30.0	3.27	- 0.013	29.58	46

In Table 2 above, T_o-T is the temperature difference in degrees Centigrade; the barometer is given in inches of mercury; and N is the number of readings in the average.

The difference (F-I) in the electroscope readings and T_o-T values are shown graphically in Figure 4, which demonstrates parallel curves; here the electroscope readings from the water type are parallel to T_o-T from an ORAC that runs consistently negative.

The final set of electroscope data, from the air-electroscope setup and with positive values of T_o-T (1975-77), is shown in Table 3 below:

TABLE 3: Air-Electroscope

State	F-I	T_o-T
Clear	0.54	0.75
Milky	0.22	0.04
Cumulus	1.67	0.64
Rain	- 1.75	- 0.72
Snow	0.58	- 0.77

This data is shown graphically in Figure 5.

Both Figures 4 and 5 show sets of parallel curves between the electroscope readings and T_o-T . That is, readings from the water-electroscope are in phase with an ORAC that gives consistent negative T_o-T , while readings from the air-electroscope are in phase with an ORAC giving consistent positive T_o-T . It is noteworthy that the two figures are rough mirror-images of each other, *i.e.*, both curves in Figure 4 rise with cumulus but both curves in Figure 5 are depressed with cumulus.

The data shown in Figures 4 and 5 suggests, as has been discussed elsewhere (4), the negative T_o-T does not simply represent less energy in the ORAC (compared to a positive T_o-T), but a different functional state, and further, that this difference in functional states has some relationship to the air/water antithesis function.

The final set of data relevant to the present study came from the wound-healing experiment. Table 4 shows the average therapeutic indexes for the RMDO and ORAC in three different weather states:

TABLE 4: Wound-Healing Data

	Clear	Cloudy	Rain
RMDBO	1.07	1.19	1.08
ORAC	1.08	1.01	1.02

The air/water function is clearly apparent in the data: the RMDBO is noticeably more effective at healing (and therefore presumably stronger) during cloudy weather, *i.e.*, when energy is moving into water. This atmospheric function obviously parallels the functioning of the device itself, which acts by drawing energy into water. On the other hand, the ORAC is more effective in clear weather when energy is moving into the air, including the airspace within the ORAC itself.

Discussion

The data presented above demonstrates orgone energy pulsation in the atmosphere over periods ranging from hours to days. The

pulsation consists of an alteration between diffuse, homogeneous energy distribution and an inhomogeneous, concentrated distribution, represented by areas of higher orgonotic potential associated with observable weather phenomena. These changes are reflected in instruments sensitive to orgone tension and concentration, and show the following characteristics:

(1) In the high voltage setup, the charge induced on the electroscope depends on the intervening interelectrode medium in the ORAC. The electroscope readings in different weather states are oppositely directed for air vs. water as the medium, suggesting an antithetical relationship of these two media relative to orgone energy.

(2) Variations in T_o-T in various weather states are parallel to the electroscope readings, demonstrating similar variations in atmospheric orgone concentration (ORAC) and tension (electroscope). This parallel relationship was noted by Reich in his work with T_o-T and electroscope discharge rates (2). A new finding in this study is that a continuously negative T_o-T is parallel to the water-electroscope readings, confirming again that an important functional difference exists between positive and negative T_o-T .

(3) The energy-shifting is further demonstrated in the biological activity of the ORAC and dor-buster, whose strength varies in harmony with atmospheric movements of energy between air and water. This finding is of some practical significance in the use of these devices.

This atmospheric pulsation may also be viewed as an alteration between stasis and movement. In expansive weather (high barometer, clear, sunny skies) the energy is homogeneously distributed, while in contracted weather (low pressure systems with storms) directed motion of energy occurs toward the storm center or cloud system. Higher T_o-T readings occur with clear weather, representing conversion of orgone energy into heat. Directed energy flow, on the other hand, represents potential work. These ele-

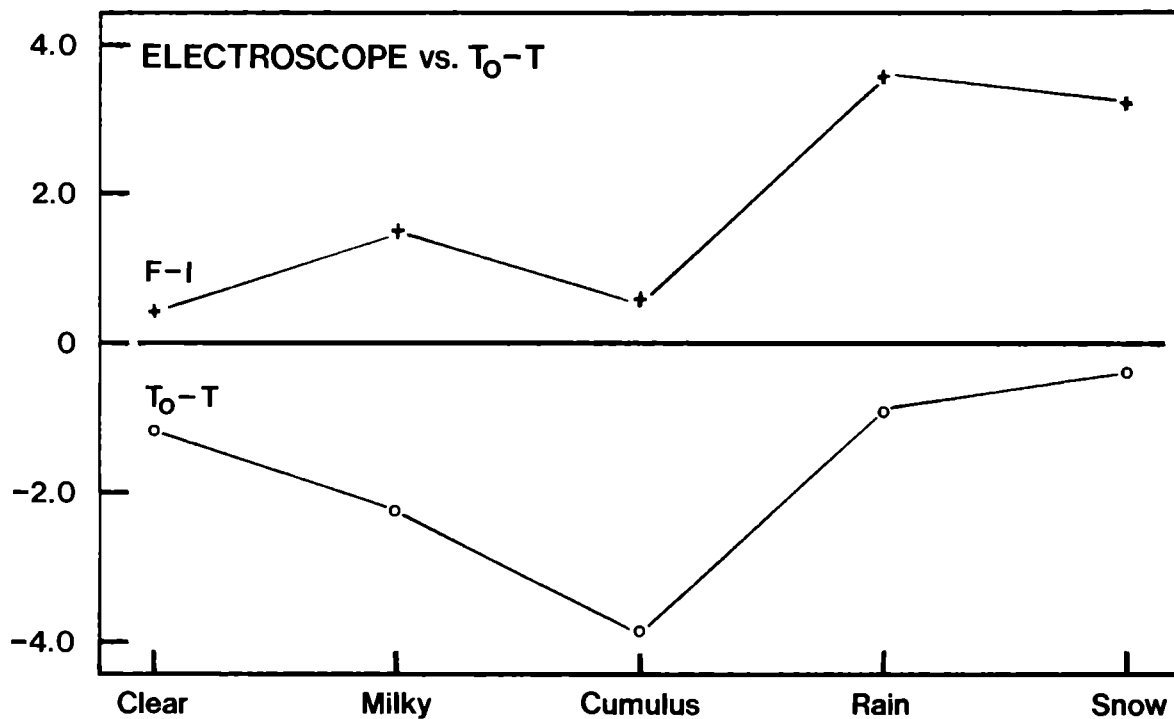


Fig. 4: Comparison of water-electroscope readings in various weather states vs. continuously negative T_0-T , showing parallel curves.

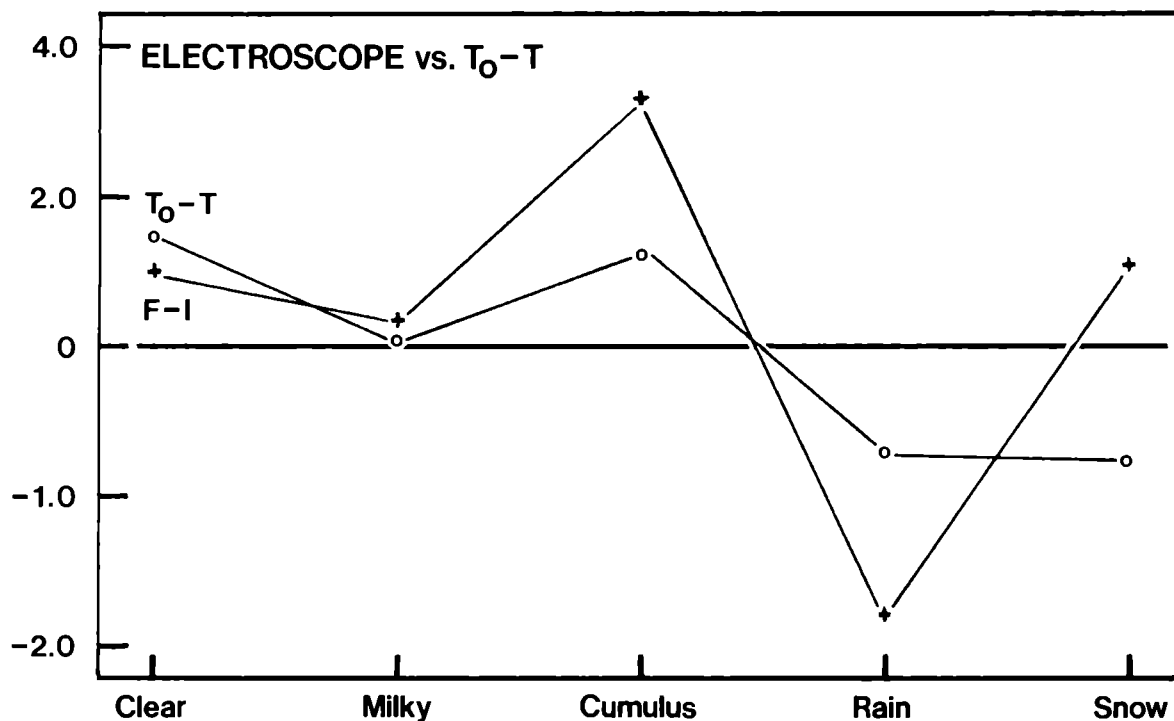


Fig. 5: Comparison of air-electroscope readings in various weather states vs. generally positive T_0-T , showing parallel curves.

ments can be understood functionally as follows:

Stasis	Movement
Random Motion	Directed Motion
Expansion	Contraction
Heat	Work
$T_o - T$	MDB Flow
Air	Water

Conclusion:

Experimental measurements from several different devices demonstrated orgone energy pulsation in the atmosphere, which has been characterized as a shifting of energy between air and water. This information is of theoretical significance in understanding or-

gone energy functions, as well as practically useful in using various orgonotic devices such as the ORAC and medical dor-buster.

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The Mystique of Health

COURTNEY F. BAKER, M.D. LOUISA LANCE, M.D.

Health in orgonomic terms refers to the ability of an organism to regulate its energetic household in accordance with sex-economic principles. When the basic pulsatory nature of the organism is intact, excess energy is not dammed up in chronic character or muscular armoring so that the conditions for biopathic illness do not exist. The goal of orgone therapy is to remove the impediments to the natural pulsation and to restore the free flow of energy, which can then be discharged in a self-regulatory way appropriate to the age and developmental stage of the individual. The genital orgasm is the most effective regulator of the biologic energy and is necessary in order to maintain physical and emotional health. The aim is always to protect and promote the individual's development towards genitality.

Orgonomy attracts people to it because of the basic and powerful truths that it embraces. These truths evoke a deep longing for a natural, spontaneous way of being, for the pulsation and core contact, which was once felt but which is now inaccessible because of the armor. It is this deep longing as perceived through the armor that often causes people to mystify orgonomy and to become cultish about it. It is as if they have found a piece of the truth that will solve all their problems, protect them from illness, guarantee them happiness, and give them membership in an exclusive, elite group that is superior to all others.

These attitudes are fairly common among patients who are new to therapy. They become proseletyzers, try to discuss everything in orgonomic terms, and become critical of all things that they judge not to be "functional" or "contactful." Old friends are sometimes rejected because they are not in orgone therapy and therefore are not "healthy"; others are accused of being

"plaguey." Longstanding relationships may be severely damaged and sometimes forever lost. The enthusiasm and excitement they feel is distorted by their armor and not tolerated by their energetic structure, so they run around like misguided missiles talking and acting like they "think" healthy people would. Energetically, it represents a form of contactlessness and may be a kind of "flight into health" on a very superficial level.

At various stages of therapy, and transcending all character types, clinically one sees the tendency of the patient to idealize the therapist and his way of life. This may be expressed overtly and covertly. A common misconception is that there exists a sort of *generic genital character*, which all orgonomic physicians embody by virtue of their positions as orgone therapists. First, it is assumed that the therapist is absolutely healthy and that this is reflected in everything he says and does. Often it is also assumed that the therapist was always healthy, or perhaps went to his own therapist for a very short time and then mostly because it was a required part of his training, rather than for his neurosis. Some patients express surprise if the therapist gets a common cold or looks tired one day. Certainly therapists are assumed never to contract major illnesses.

Anecdotes from patients and therapists (who it should be remembered *were* once on the treatment couch themselves) abound with misconceptions about "health." Therapists are supposedly never anxious and are always at ease; no matter what the situation is, they are calm, contactful, and know just what to say and do. With friends, they have only deep and meaningful conversations. Their friends are either other therapists, have completed therapy, or are naturally healthy. The therapists are never

silly, and certainly never irrational. Major life decisions are made easily and without any of the agony that patients must go through. They are all brilliant. *Man in the Trap* describes the genital character in idealistic terms with his sparkling eyes, radiant skin, well developed body, no extraneous fat, his full lips, natural, resilient affect, and so on. (These are formidable beings!) Patients express concern about meeting the therapist in a situation other than a therapeutic one. What would they say? What would they think of the therapist? Maybe they are different "outside." A male patient bumped into his female therapist in a restaurant and said, "I always thought you were very tall." Another patient had the occasion to be at his therapist's home for a meeting and was shocked to see a group of organomists eating hamburgers for lunch. Not only does the myth presume that therapists are larger than life, but also that they eat only such things as bean sprouts, tofu, and yogurt, drink only herbal teas and mineral water, and certainly never use tobacco or alcohol. Patients have questioned female therapists' use of cosmetics; if one is healthy, doesn't the natural beauty just shine through? And then, why do some organomists have thin lips, or saggy neck skin, or carry a few extra pounds? If they don't fit the ideal does this mean that they don't know what they are doing? In election years, because the conservative socio-political character type is described as the closest to health, patients often ask to be told for whom to vote. Does it mean that one is not healthy if one takes a position other than the conservative one on all issues? Above all, the therapists all have a picture-perfect love life, with each sexual embrace providing a peak orgasmic experience for both partners. And the children of organomists are by definition self-regulating and never have any of the problems normally associated with growing up. The basic belief is that therapy will provide us with this ideal, anxiety free, problemless life. The therapist will show us the "right" way to live.

Illustrative of this sort of magical expectation is the case of a youngster born with a serious heart defect, who was running on the beach with her mother after recovery from open heart surgery. The child fell and suffered a superficial cut that bled and was quite painful. With surprise and some indignation, the five-year-old turned to the mother, saying that she had thought the operation was supposed to make her impervious to this sort of thing. In other words, her expectation was that the surgery should have made her into a superwoman! So it is with patients in therapy.

Patients will often compare "notes" as to how their therapist treats them. They wonder with whom he is more friendly; which of them knows the most about the therapist; which of them is "further along" in therapy? This competitiveness and vying for attention in order to be the favorite recreates the original strivings of sibling rivalries and infantile narcissism. They are not to be taken at face value. Instead, the underlying dynamics must be unmasked in order for the associated emotions to be revealed and released from their libidinal cathexes.

Reich clearly states that *there is no absolute health* and that the descriptions of the genital and neurotic character types represent the *ideal*; real people are mixed types, and whether libido economy is possible or not depends on the degree of the admixture. The descriptions of the genital character, while valid, are nonetheless generalizations. Patients coming into therapy read the descriptions of the various character types and are surprised to find that they have characteristics of several of the types including the genital character. This is not surprising since all but the most infantile of characters have at least reached the phallic stage of development even though they may have subsequently retreated from it. And, except for rare cases, there is some degree of health in everyone, even though it may be distorted in their current functioning. What does not seem to be understood or underscored enough is that

health is not a static, set way of being. There is no absolute model of health; no absolute "right" way of being; no rules or recipes to follow to manifest genitality. If there were, then all therapeutic successes would be clones of each other. This is not the way nature functions. While it is true that all maple trees bear a number of striking resemblances to each other, and are quite different from oaks, the number of nuances and variations in each are limitless. So it is with health. As two very dissimilar character types improve in therapy and become closer to health, they will express the health in them in very individual ways. The health in them will distinguish them from the neurotic, but it will be an individualized expression determined by the totality of their personality.

When an individual is cut off from his core impulses, he searches for formulae by which to live in order to decrease his anxiety and sense of isolation. There is a pleading for someone to provide the answers so one's own sense of inadequacy and impotence does not invade the consciousness. Patients want the therapist to "do it for them." The situation is analogous to being a child who is told how to think and act and feel. The parent is the protector, is perfect, and has all the right answers, while the child is vulnerable, small, and inexperienced. When the therapist is cast into the role of "perfect," the patient is substituting the transference neurosis for the original neurosis. If it is not recognized and dealt with, it will create the same disastrous outcome as did the original neurosis and mire the individual deeper in his armor, thereby rendering him even more incapable of satisfaction. The therapist needs to be aware of the various manifestations of the transference neurosis and the level of the individual's structure from which it arises.

The therapist is a legitimate role model in one essential way. He, too, has been a patient, and therapy has enabled him to largely solve his infantile conflicts and has restored his natural pulsatory nature so that he functions mainly without major pregenital

blocks. He may feel anxiety but, because of the orderly libido economy, he does not behave in a neurotic fashion. Being out of contact is experienced as alien and distressing, so he will work to overcome it. It should be emphasized that there is no generic genital character and that it would not be an expression of healthy functioning for the therapist to set himself up as all-knowing or to convey to the patient that his way is the "only and right way." Here the flexibility of the therapist is of vital importance, for he must be able to recognize healthy functioning and expressions of health that may not be part of his own structure, or he will run the risk of condemning behaviour as infantile or irrational simply because he does not agree with it. For this, the therapist needs to have intact organotic senses.

In the process of character restructuring, some identification with, not idealization of, the therapist is essential and necessary for the therapeutic process. In the best of situations, the patient will recognize the health in the therapist and will want "to grow up to be like him." Assuming that the therapist has no infantile narcissistic needs of his own, he will understand this identification and use it in order to encourage the patient's expression of his own personality. Often in the process of loosening some of the armor, the patient may feel ill-equipped to deal with the world as his old defenses start to feel alien to him. Here the therapist can assist the patient in taking risks and in using his own judgment so that his successes belong to him and not to the therapist.

An important component of an individual's functioning that is relevant in this context is the function of *choice*. In the course of therapy, patients may make choices partially on the basis of infantile needs; these are not necessarily "wrong" but may be the best the individual can do given his present state of functioning. It is just as irrational to choose something that one is not ready to handle energetically as it is to make a neurotic choice. The patient should feel free to make

choices of his own without agonizing over whether it is "healthy" or not; what is important is whether it is the right choice for him. In addition, actively making decisions is a vital aspect of getting better, since taking responsibility for one's life is a critical aspect of the road to health. Thus, therapist and patient alike must learn to tolerate the making of bad decisions without seeing this as a major "failure." The ability to take risks and recover from bad choices is an important lesson: no one always makes wise choices.

In adults, when a successful orgonomic restructuring takes place, the patient is freed of his chronic muscular and characterologic armor and the greater part of his energy is available for genital discharge in the orgasm. Preenatal residues that may remain can be naturally discharged in foreplay preceding the genital embrace. The orgasmic discharge regulates his energy economy so that chronic tension and armor do not reappear as long as satisfaction remains possible. This allows him to function as a genital character, and energetically he is said to be healthy. This does not mean that there is no armor in a healthy person, nor does it mean that circumstances might not arise to challenge his health or perhaps even push him back into neurotic functioning. Reich states that the "ego of the genital character has an armor, but it has the armor at its command rather than being at its mercy" (3: p. 169).

This means the genital character can react appropriately to a situation by relaxing or reinforcing his protective mechanisms. Reich also points out that this armor can be pliable or solid depending on the circumstances. It is not a rigidly fixed armor rooted in infantile conflicts. The genital character has the *choice* of loving fully and hating intensely, of completely opening up to the world or withdrawing from it. The neurotic character has little choice but to act as his character dictates.

We would emphasize that the distinction between the genital and neurotic character types is based on the extent of genital satisfaction versus libido stasis. There are many

transitional types between the two extremes. The quantity and quality of armoring and the libidinal stage of the individual determine to what extent a healthy libido economy and social adaptation can be maintained. Although relatively healthy individuals may have some pregenital residues, if they are largely freed of their infantile cathexes, the major portion of the energy will be free to excite the genitals. The closer an individual is to health, the more the total personality is able to participate in life.

The mystique that life only exists for the genital character and that everything else pales by comparison would certainly be a depressing thought. One's life is not put on hold because one is neurotic and/or in therapy. Therapy emphasizes that the individual on the road to health should try to participate in his life as fully as possible, and that, in the course of therapy, as new satisfactions become available through character restructuring and education, the more primitive and neurotic satisfactions are given up just as they are in the developing child as he passes through one libidinal stage to the next. One does not judge an infant for infantile behavior; it is what he is capable of, and it provides him satisfaction. The infant is assisted in his development towards genitality by guarding his natural pulsation. Neurotics should not be judged for their neurotic behavior; it is what they are capable of, and it provides some satisfaction to them. In therapeutic restructuring, the individual is assisted in freeing the energy from the pregenital zones in order to restore the natural pulsation so that he becomes *free* to make his own choices and to participate in his life more fully, and to have access to more satisfaction in all areas. He may never like tofu, will still bleed if he is cut, and may be devastated temporarily by real life stresses. But, if his organism is basically healthy, he will recover and be able to enjoy his life to his fullest capacity and in a way that expresses the health and the uniqueness of his own individuality.

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How Fantasy Robs the Genital: A Case History

MICHAEL GANZ, M.D.

The senior partner of a successful accounting firm presented himself on his first visit as highly competent, intellectually bright, aggressive, and hard-working. He held public office, was respected in his suburban community, had received honors and awards, and at age 33 had one son and an attractive wife. His initial reasons for seeking treatment were as follows: First, he described himself as bored with his personal life and his profession. Unable to share intimacy or to feel a part of any relationship, he felt alone and isolated. He complained of an inner emptiness that no success was able to fill. Frustrated in his aspirations as a poet and painter, he characterized life as a meaningless farce. Next, he stated that his wife, changing as a result of her psychiatric therapy, was demanding greater emotional involvement. He felt that if he failed to improve in that regard, she would leave him. Finally, he admitted that he suffered from erectile impotence. He was able to overcome it to some degree and obtain limited genital feeling by the use of a specific fantasy. In it, a woman, immobilized so that she could not free herself, was subjected to feet-tickling to such an extent that he characterized it as torture.

Appearance and Biophysical Examination

In the initial interview, the patient strode in "hail fellow," using his and my first names with the forced heartiness of a conventioner. Upon my pointing out the inappropriateness of his familiarity and swagger, he dropped the false self-possession and became subdued, acknowledging considerable anxiety.

He was well proportioned, and 5 feet 10 inches in height with no excess fat. His eyes showed apprehension and vigilance but were lively and bright. He was cynical, not only in his manner of speech, but also in facial

expression, with a half-smile, half-leer, that, at times, looked like he was snickering. His neck, chest, paraspinals, and abdomen were moderately armored. Touching any of these segments caused him to tighten up; he lay on the couch as if "at attention." His voice had a slight whine, giving what he said a peevish quality. He spoke in a clear, organized, analytical way with irony and wit directed against himself.

Family Relationships

The patient was an only child. His mother was a professional dancer whom he described as a strikingly beautiful woman. As a child, he admired her on the stage but felt small, frail, weak, and undeserving in her presence. He claimed to have experienced no loving contact with her at any time. She told him the following: As a nursing infant, he would pull away, trying to look into her eyes. When she pushed his head toward her breast, he resisted strenuously by stiffening his neck. He characterized her as an emotional cripple dependent entirely on his father. Throughout his college years, he carried a picture of her in his wallet, showing it with pride.

His father, a courthouse functionary and political ward heeler, disliked both the patient and his mother. His father spent his time with card-playing cronies or at political meetings and, when at home, slept on the couch. His treatment of the patient was described as sadistic and abusive. In playing catch, his father laughed at him while throwing the ball repeatedly with such force that the patient's hand became painful. He beat the patient regularly, for very minor infractions or accidents, using a strap across his buttocks and mechanically counting the strokes. Later, he frequently punched him about the head and neck which resulted in a 20% hearing loss

in one ear. It was typical for his father to intimidate him by using a cold and threatening stare. On his trips with his mother to a nearby city, the boy often fantasized that his father would be dead on their return and that he and his mother would be free. Throughout his life, people spoke of his parents as the ideal couple and his family as perfect.

He perceived his wife as demanding, while blaming and rejecting him for his lack of emotional responsiveness. He resented her inability to reach a climax during intercourse, maintaining that he had satisfied others by performing mechanically with the aid of his perverse fantasies. Discouraged by failing to meet her expectations and doubtful that he could function sexually without the fantasies, he regretted his marriage and its demands. At the same time, he missed his wife and child whenever they were apart, and he did not pursue other women.

Treatment

During the initial six months of therapy, he was unable to stand the sensations of energetic movement produced by deep breathing. Attempts to work directly on his musculature made him very fearful, resulting in general stiffening and a derisive imperturbability. Therefore, in this phase, treatment proceeded character analytically, focussing on his utilization of that defensive attitude. As a result, he acquired some understanding of his need to be in control and aloof, both with his wife and his professional contacts. Gradually, he began to tolerate more sensation from breathing in the sessions, although there was a tendency for his eyes to lose contact. At these moments, he described vivid childhood memories. His earliest was the following:

He was a small baby in his carriage, in an alcove off a public sidewalk. A large man came down a flight of stairs carrying a violin case. A feeling of loss (being left alone) and insecurity pervaded the experience. It seemed to the patient that, at the time, he *felt* the questions, "Why am I alone? Where

is my mother?" Two events that occurred later in his life were recalled and are pertinent. The first was a conversation that took place between himself (at age six to eight), his mother, and the man who carried the violin case, a family friend. The patient asked what was meant by the expression "They died with their boots on." The man replied that, when Indians slaughtered white men, they removed their boots and tickled their feet to see if they were dead. The patient sensed his mother's laughter as being decidedly embarrassed during this exchange. The second occurred when he was slightly older. He witnessed his father tickling his mother's feet as she lay on the bed. While she acted annoyed and told him to stop, the patient remembered laughing and feeling sexually excited.

As therapy progressed, his attention wandered less frequently. He developed better contact by moving his eyes while focussing on objects in the room. In this period of treatment, he discussed his sense of inadequacy. People, he thought, were disappointed in him, his appearance put them off, he made a bad first impression, etc. Calling himself a carbon-copy person, he claimed his primary motivation was money, "piles and barrels of it." However, he viewed that desire with ambivalence, feeling that it was uncreative.

In an attempt to drain energy from the head and thus reduce pressure on the eye segment, I directed him to kick the couch while lying on his back. He did so, smirking and ridiculing the treatment method. After several such sessions, I tried having him yell while kicking with his eyes widely opened. He managed a few weak croaks. I encouraged him to continue despite his protests that it was "no use, I just can't let anything go." Upon giving one loud scream, he became terribly frightened and recalled that, at age 5, he had fallen backward out of a window to the ground two floors below when a screen gave way. He regained consciousness sometime later in an emergency room. This first appearance of uncontrolled

emotion after 34 sessions in a period of 15 months initiated a gradual lessening of his cocky, self-assured, derisive defense.

Over the next 18 months, he was able to allow increasingly stronger emotions to develop. He tolerated direct work on the musculature of his forehead, neck, jaw, and chest. Expressions of misery with sobbing were frequent. As these emotions began to be felt and expressed, he gradually became emotionally more accessible to his family. Socially, he felt less remote, more accepted, and relied less on formalities. He felt considerably more vulnerable as a result, but was able to enjoy the change nonetheless. The tickling fantasies decreased and erections were better maintained as he started to experience sexual pleasure in his genital. His wife responded strongly to these changes, and they began to find intercourse mutually more satisfying.

During the next six months of treatment, he again had visual images, which usually followed kicking and work on his occiput. For example, on one occasion, he saw a human skeleton shining against a dark background; on another, he saw himself in church where a dead body lay on the altar piece, which was embroidered with a skull and cross-bones. These images and several others were accompanied by intense feelings of fear, after which he obtained relief from crying strongly. He thought the images came from his very early childhood. In one such session, he had a powerful memory of his mother and grandmother holding him down while they administered an enema. His struggles against them were futile. At this, he began to grimace but couldn't identify the facial expression until I held up a mirror. It was a look of vicious spite, which, when exaggerated, became furious rage expressed verbally as hatred of his father, principally for his brutal mistreatment. These emotions, later directed against his mother, were expressed repeatedly in the ensuing sessions and again were followed by deep sobbing and relief. Following this, at his own instiga-

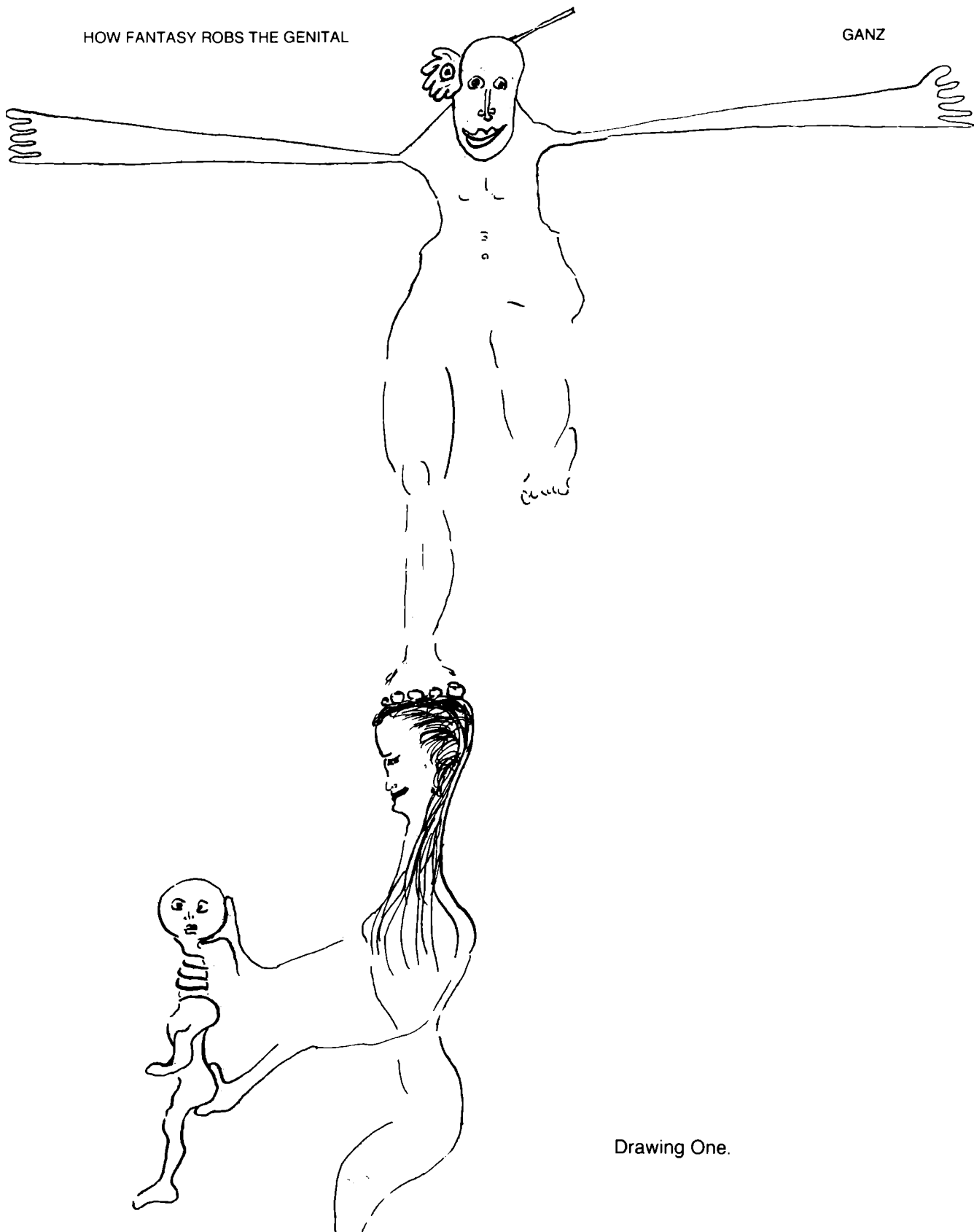
tion during a session, he began banging the back of his head against the couch, uttering a forceful MA sound. He became completely terrified, screaming pleadingly, with arms outstretched, "Wait! Oh no, please. I know what happened." Requiring considerable reassurance and comforting, he said he felt himself as an infant, abandoned in his crib with no one responsive to his cries. He was pale, shaken, and amazed by the intensity of his feelings, stating, "It actually happened. It was me!"

The last three months of therapy were used to clarify the ways in which his feelings of abandonment, rage, and longing for maternal contact had influenced his development and adult functioning. In behavior and speech, he became less mechanical, was spontaneously outgoing, less suspicious of people, and his humor lost its hostile edge. All the tickling fantasies had stopped, there was no loss of erections, and he and his wife were capable of deeply felt orgasmic pleasure together.

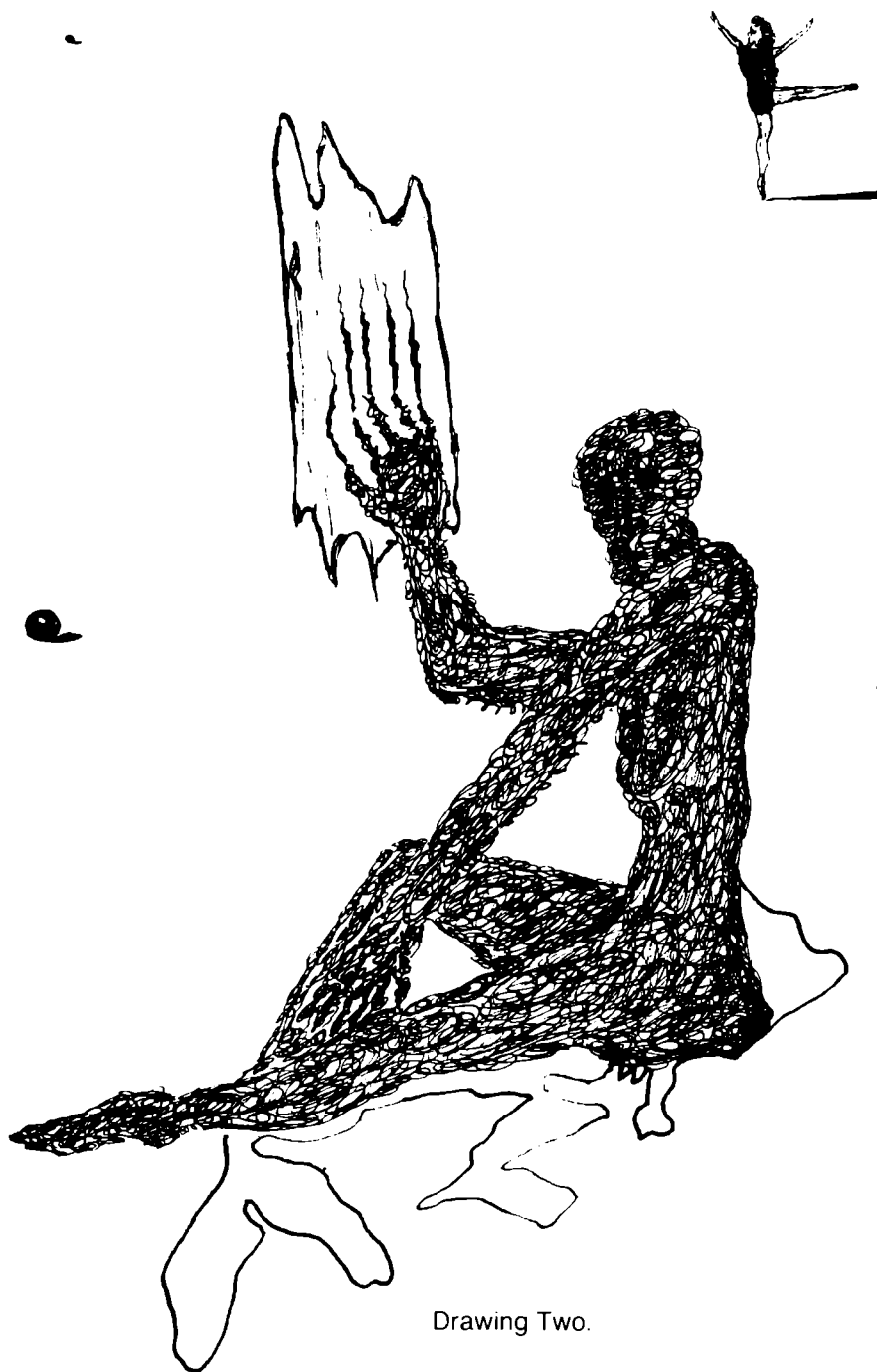
Discussion

The patient was diagnosed as a phallic character with repressed ocular and anal blocking. Ocular holding was evidenced by his vigilant suspiciousness, tendency to go out of contact on the couch, and the degree to which fantasy pervaded his functioning. The quality of the fantasies, *i.e.*, sadistic torture, his preoccupation with money, the aesthetic compensation inherent in his view of himself as artist and poet, and the mechanical quality of his social contact, were all aspects derived from the anal holding. Both areas of armoring prevented energy from fully reaching the genital, resulting in loss of erection and the dependence on fantasy to stimulate excitement to the extent that it could.

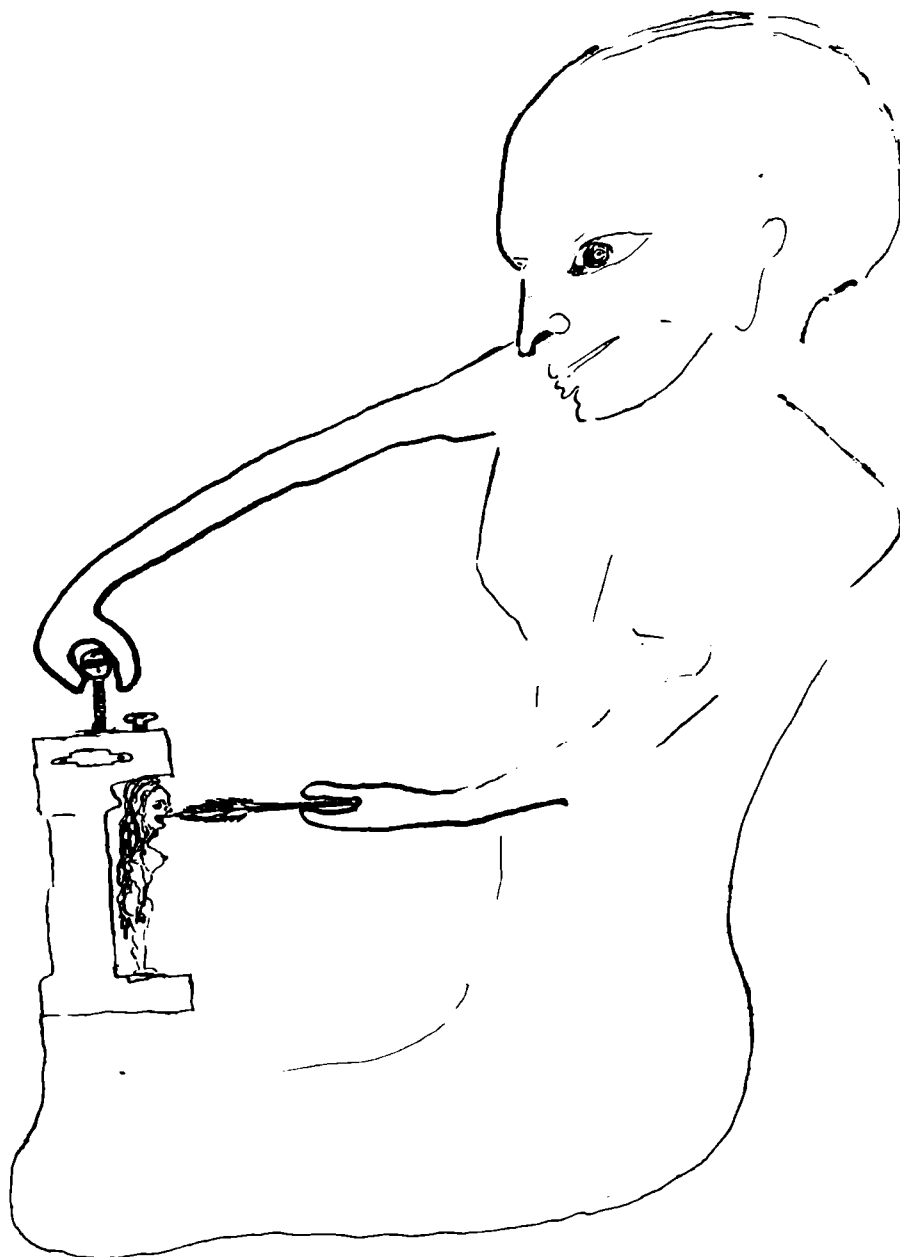
The origin and form of the torture fantasy derived from several sources. Beaten by his father for any trivial mistake or accident, the patient appropriately became extremely cautious and controlled against the emergence of



Drawing One.



Drawing Two.



Drawing Three.

any behavior that might be viewed as an infraction. Excitement and loss of control became states to be feared. His mother and chief caretaker, subjugated as she was by her husband, was seen as unable to protect him from his father. These feelings were grafted onto a series of early memories in which he experienced abandonment, loss, and vulnerability to sadistic treatment. As rage against his father came through in the course of therapy, it became felt, in equal measure, toward his mother. Her passive acquiescence allied her with his father in the patient's mind. Although the father was obviously more brutal toward the patient physically, the mother's combined seductiveness and repression had its impact on the patient's emotional structure. Over the course of his upbringing, his mother was, for that reason, the main source of frustration. The first and second drawings by the patient reveal his view of the family dynamics and his relationship with his mother. In drawing number one, his mother is seen as passing through his father's subjugation, cruelly twisting his neck and grasping him by his occiput and buttocks, the principal segments armored in the course of his development. The hidden fury against his mother shown in drawing number two was present in another form, that of sadistic squeezing rage with the sexual component (the tickling) as seen in drawing number three. It is his mother in the vise. Viewing

the woman as the victim of torture permitted him a sense of mastery, overcoming his feelings of insignificance while diminishing his sexual excitation to a safer level. Placing the woman of his fantasy (all representing his mother) in a completely submissive position allowed the patient to identify with her and by that identification reduce to some degree his fear of abandonment. The choice of tickling seems to have been derived from a condensation of events in which tickling played a part at times when the patient felt forbidden sexual impulses. That highly charged associative connection, *i.e.*, tickling, was then utilized as an acceptable substitute for those impulses.*

Most of the dynamics underlying the pathology in this case were understood intellectually by the patient from the beginning. Only when the main areas of physical holding, together with their associated character defenses, were influenced was the patient able to experience some sexual pleasure. His eventual ability to live without sadistic fantasies and without the need to maintain restrictive control over himself was the result of further dissolution of his armoring. As a consequence, a lifetime of terror and sadism was left behind.

* In drawing number three, the sexual component is less disguised than in the foot-tickling fantasy, as it depicts a fellatio impulse. The patient was of Italian origin. "*Penna*" (feather) and "*pene*" (penis) have an obvious similarity.

Clinical Symposia

The Clinical Symposia will appear as a regular feature of the *Annals of the Institute for Organomic 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.

THE OCULAR SEGMENT, PART II

The following seminars took place February 5, 1984 and March 8, 1984.

Michael Ganz, M.D.: Would it be useful to discuss what the block in the eye segment looks like? We're discussing its treatment and perhaps something could be derived from describing the ways in which it manifests itself when you simply observe it.

Stephen S. Nagy, M.D.: Go back to the first phone call. When someone calls for an appointment and is confused or unclear about what they are asking for, this immediately suggests the existence of an eye block.

Robert A. Dew, M.D.: The first thing to look for when the patient is physically present is whether they are looking at you or not. It's also important to note whether they are looking at you as if drilling holes, as in substitute contact. I've been fooled a lot by eyes that look bright, shiny, and twinkly, and usually the reason why I miss the armoring is that I haven't yet put them to the test, and that the armoring is a lot deeper. It also means that the blocking is deeper and that not everyone with eye-armoring has dull or lackluster eyes. Pupillary reaction is important. You look at the differences between the pupils, what size they are, and what emotion the patient is showing. If, for example, somebody is carrying on furiously, while their pupils are dilated, you should begin to wonder whether there's a discrepancy, because in rage the pupils ought to be constricted. Other things that we worry about are how mobile the skin of the forehead is, how expressive the forehead is, whether the skin is shiny, the color and feel of the skin, how well the eyes move. Also, whether they

complain of anything to do with tears, or of not being able to cry. The list is very long.

Louisa Lance, M.D.: There are some people who actually cry with no tears. What do you make of that?

Dr. Dew: Almost every gland in the body has both sympathetic and parasympathetic innervation. If a person does not produce tears, then I think it is a sign—unless they have scleroderma or Sjogren's syndrome—reflecting sympatheticotonia of the eye segment and lacrimal glands.

Carol Stoll, M.D.: Is it possible that it could be a substitute contact, that they are taking cues from the therapist, who may want them to cry, and that they may be pretty good actors? Perhaps they're giving you something they really aren't feeling?

Dr. Dew: I think that any discrepancy between what the eyes look like and what the rest of the person looks like is of great importance.

Dr. Ganz: That's not easy to see. You're saying, "What is the emotion in the eyes?"

Dr. Dew: You're right, but it really hits you sometimes with people. It will be the one thing that really catches you, if something is amiss there, or, for example, you see a cold look in their eyes when they are being some other way, maybe affable or sociable.

Arthur Nelson, M.D.: What I'm impressed by, is how extremely rare it is to see really expressive eyes. It's easy to lose a reference point with patients. You say "Well, this eye doesn't look so bad." But then it really hits you when you see tremendously expressive eyes.

Byron Braid, M.D.: What's your explanation for those people that look bright-eyed,

have a sparkle, look you right in the eye, and yet are badly blocked?

Dr. Dew: Well, it could mean that the block is deeper. I suppose it's like good color in the cheeks. It can signify either a malarial episode or good health. I haven't thought through how a disease state could produce brightness in the eyes, but I know that you just cannot go by bright-looking eyes and assume that those eyes are healthy. It may mean the block is deeper and that they haven't been challenged. You also have to go around back to the subocciput, which is a real nest of material. You should be able to press back there pretty hard without it being too uncomfortable. There are many little spots with individual reactions. With one patient, if I get her in a certain position on the right side, she gets terrified, and if I go to the symmetrical position on the other side, she becomes furious. The occiput doesn't always feel like a brick; it can feel a number of ways. It can feel boggy. It can feel soft all over until you find one of those little spots, and working on that will stir up a lot of feeling. Working around the eyes can also stir up feeling over the rest of the body, for example an upset stomach. In one case, I've had a patient tell me that, after work on the occiput, he had to go to the bathroom to urinate, feeling a strong sense of urgency.

Dr. Ganz: Something else worth noting is the color of the skin around the eyes. There are sometimes very subtle differences, but at times you can see distinct black coloration around the eyes that dissipates after you work on them. Also observe how much bagginess there is under the eyes; this doesn't go away so fast. Both usually signify stasis in the segment.

Dr. Braid: How about the appearance of the sclera under the pupils as an indication of severe fear?

Courtney F. Baker, M.D.: More often that is due to the eyes not being centered and already partially rolled up into the head. It's as though they are already halfway off. What was said earlier about testing it out refers to

a patient undergoing some kind of emotional upheaval, when you charge them up and can see how much real capacity they have for holding a charge with the eyes. They can look really good until intensely charged up. The other thing in assessing that eye block is that you are going to notice it in how much they are in contact or how confused they are. One thing I have seen, particularly in hysterics, is that they have very bright, clear and focussed eyes, and yet the eye block is maintained by their being very glib and quick to argue with you. They don't let anything get through—it just bounces off. So, when you do get through, you can expect the fear to emerge.

Dr. Lance: In a way, you would rather see that. Most eyes resemble what you see in a catatonic, and at least there is some indication that they've got another place to put the feeling. Prognostically, it's better.

Dr. Baker: I'm not so sure about that. I'd rather see sick eyes than these bright, clever little people. I've seen bright people with fairly clear eyes who are very clever and very glib, and they are a lot of work. It takes a long time to break through that.

Dr. Lance: Yes, but you're talking from our point of view as a therapist, and I'm talking about the point of view of the patient. Isn't it prognostically better to know that they are not just holding it in their head?

Dr. Baker: I suppose technically that's true. The thing is that the spaced out and confused person can be more gratifying to work with because you can do marvelous things in a relatively short period of time.

Dr. Dew: That's the "shining" armor you're talking about. I have hit it in an hysteric patient who happens to be very smart and manipulative, and, I'll tell you, I have succeeded very rarely in breaking through that. It's very, very tough.

Dr. Nelson: I have seen this kind of brightness in schizophrenic patients as being faceted, that is, sparkling from different facets as in a diamond, a very strange look. Further along in therapy, these patients will complain

of pain above the superciliary foramen when they clamp down in a session. They complain of the pain being deep down and in the brain itself, so my feeling is that they are perceiving a real clamping down in the brain itself. Kicking can sometimes relieve it.

Dr. Dew: It's worth repeating the general principle that you don't know what a segment is really like until you've challenged it. One way of looking at it is that, if you get energy moving, then you tend to bring out blocks. Another way of looking at it is to see how a patient handles what real emotion is produced.

Douglas Levinson, M.D.: We have discussed the different presentations of the eye segment. I have become uncomfortable with my own assumption that every facet of a person's armor is a function of the details of their early experience. I would like to raise another hypothesis. My own sense, first as a parent and then as a child psychiatrist, is that people have different innate vulnerabilities as to where they are going to block when distressed. My own belief is that some people are innately more prone to withdraw in the eyes, whereas others are not.

Dr. Ganz: How do you make that determination?

Dr. Levinson: This is a sort of how-much-do-we-know question. It's difficult to determine what part of our armoring is innate and what part is one's own personal experience. I don't know how to tell.

Dr. Ganz: That's a very pertinent question. What led you to conceive of that as an innate quality?

Dr. Levinson: There are several things. One, the evidence for a genetic basis in hardcore Kraepelian schizophrenia is pretty solid, and if a biological factor can produce something that looks to us like the worst armor you've ever seen, there must be innate factors that can do it. Secondly, there is evidence that when identical twins are reared separately and then are met by researchers 20, 30, or 40 years later, they look extraordinarily similar in their personalities and presentation, despite having had different

mothering from infancy. That indicates that some of the aspects of character formation that we identify as developmental are really innate, what the person brings to the world. How they interact with the world may determine how happy or unhappy, how blocked or unblocked they are, but maybe not the specific kind of armor. The third thing is having more than one child and seeing one of them that by age three has already started to use the eyes as a means of withdrawing and another child in no way does it; they've had equally good experiences, and yet they have very different styles of dealing with anxiety and stress.

Dr. Ganz: I came to the same tentative question from watching my son. At between a year-and-a-half and two, he has had no toilet training, and he evidences behavior that in an adult would be seen as compulsive; that is, before he goes to bed, he wants his cars and trucks lined up a certain and very particular way. And he's not emotionally crippled, compulsive, or restrained. It isn't sucking up a lot of energy that he could put anywhere else. And, not knowing that, 20 years later, a therapist would see him and say . . .

Dr. Braid: "What did your daddy do to you?"

Dr. Nelson: In agreement with Dr. Levinson, I recall a story going back to when Reich was involved with infant research and following the development of several infants. They followed one, who, up to the age of three, was considered to be in excellent shape. The bottom line was that the child developed schizophrenia as an adolescent and killed himself. Also significant is a statement pertinent to this question made by Dr. Elsworth Baker at New York University. He said, "We're all born with a certain tendency. All life does is push you in that direction or not."

Dr. Levinson: That was always his answer when I raised these questions to him, also. If you're going to be what you're going to be, then therapy may help you be it better or worse, but—you are going to be that way.

So, it's not that you've been ruined, it's that you came out that way.

Dr. Nelson: I am impressed by the literature—as well as in my own experience—that indicates there is a genetic factor in schizophrenia. I know a family with two children. The first child was a girl who turned out to be a soft hysteric, the second was a boy. The mother, soon after birth, when they presented this child to her, said, "There's something wrong with this child." And the child turned out to be a catatonic. The mother knew it the day after birth.

Dr. Ganz: What do you mean by genetic? How do you explain a patient whom we have diagnosed as schizophrenic, or who may be schizophrenic with a psychotic break, whom we treat successfully, and who then never has another break and functions better than the general population?

Dr. Nelson: I think that in the population we call schizophrenic, there are many soft rules. There are different kinds of schizophrenia, some are so-called structural, and some are purely emotional. In other words, I think there are many subgroups.

Dr. Baker: There is another side to it. Arieti kept hearing from his schizophrenic patients how bad their mothers were, so he went and interviewed the mothers and found that they weren't so bad, only about 25% of the mothers had rejecting personalities. What it comes down to is that they tend to see everything in a bad light. So, whatever the mother's got that's negative is all that they see. They react less to any positive stimuli. If they do something that is a positive achievement, it rolls right off, but the negative thing has 100 times more impact on them. From the beginning, they see the world in negative tones.

Dr. Nelson: Appropos of what we are talking about is an ongoing study of temperamental differences in children, conducted by Stella Chess at New York University. The study has many implications for what we do.

Dr. Levinson: Unfortunately, the sample had so few children who turned out to have

serious problems that they did not gather much data about the kinds of things we see. I think that Dr. Ganz's question is pertinent. I think that the range of things that, organomically, are called schizophrenia have not been studied in the genetic studies of schizophrenia, so all the genetic studies can say is that, if a person is a true hospitalizable, recurrently psychotic subtype of schizophrenia, that person probably has an excess of schizophrenia in his family. Those people who have more subtle eye blocks, or who have eye blocks without overt symptomatology, have never been studied. There is another group in psychiatry who have asserted that, if you remove from the schizophrenic group those patients who have affective symptoms or who are lithium responders, there is no increased family incidence of schizophrenia.

Dr. Baker: It is true that many times you can dig and dig, and not find a history that is appropriate to the particular character type, whereas, if a person brings to that stage a certain predisposition—for example, some children drive their parents crazy from the beginning, they evoke rejection and hostility.

Dr. Nelson: That is what Chess says in the study on temperamental differences, that there are some children whose tendency to be difficult becomes a self-destructive process.

Dr. Dew: The supposition seems to be that if the child comes from you, you've got to hit it off. But the fact is, I've seen mothers and sons who simply irritate one another just the same as two people meeting from opposite ends of the country may irritate one another.

Dr. Ganz: Does that really happen from the word go? I'm a little bit more suspect of that.

Dr. Baker: Let's bring it back to the ocular block. I want to comment that there are many kinds of ocular blocks, as many kinds as there are brain functions. First, that of the schizophrenic, who may be paradoxically very alive and perceptive in contrast to many neurotics who are out of contact and dull in

every area. I had a catatonic patient who also had narcolepsy, which is a motor disorder, or type of seizure disorder, suggesting a particular type of brain armoring. I had another patient who had temporal lobe epilepsy, who, after having a seizure, would come to therapy with a memory loss and would ask if she had a session the week before; she was that confused. Another type that you see are the patients who have migraine headaches. In several instances I have seen a severe degree of contactlessness. I think it's important to think of the ocular block as a very diverse collection of features and perceptions, and to think of it as brain armoring. The other day, I saw something I had never seen before. I was working with a patient who has migraines. I was working on her occiput, and she suddenly exclaimed that she had gotten a very severe pain in her head; when I asked her to point to it, she said that it was in the inside. My feeling is that something contracted inside her head.

Dr. Dew: Apart from the way it may affect one's approach characterologically, have you found that you do anything differently when somebody has a memory block as contrasted with someone who has narcolepsy?

Dr. Baker: The answer to that is characterologic. As an illustration, I had a patient with very severe migraine headaches to the point that he would be paralyzed on one side of his body for three days at a time. He was a supervisor in a factory, and he looked like an ordinary neurotic, with nothing loose or vague about him. But, he had an across-the-board contactlessness, with no insight, and a quality of blandness, complicated by explosive outbursts. One time, when he was working on something, he threw a wrench through the window of his garage and explained it as his blowing his stack "a little bit," and he didn't connect it to anything. The only way to handle that is to work characterologically, besides working on the eyes. That's a severe eye block, yet you wouldn't say that he is confused or loose.

Dr. Dew: Another variant I have seen in a schizophrenic was a kind of dyslexia. She would mix up word order. It would come out backwards. She has become aware of it, and it seems to be occurring less and less.

Dr. Braid: I have a patient who does that when she gets a migraine headache. She describes herself as feeling flooded or full in the head and eyes. She is fully aware that there is something wrong. Her situation is further compounded by the fact that her migraines have been accompanied by episodes of blindness, in fact, a bitemporal hemianopsia, on neurologic evaluation. She actually did not notice it until she went to punch her time card at work and missed by six inches. At the time, she was working in a neurosurgical intensive care unit, surrounded by neurologists who wanted to do an arteriogram immediately. She knew what the problem was, came immediately out to my place for a session, pointed to her occiput, and said that she thought she was having a spasm there. Interestingly, it was the opposite side from her hemianopsia. I saw her daily for three days with gradual improvement in each session, but what was striking was her ability to perceive the contraction at the base of her skull.

Dr. Baker: You can abort these things, either a migraine or a seizure, if you get them early enough. There is a point at which you can't stop it, however.

Dr. Braid: I want to mention a patient whom I've been treating for 3 years, whose chief complaint at the beginning was depression. I first saw him as a depressed manic, and have come to see him as catatonic. He has intense armoring in the eye segment and jaw. It's taken quite a long time to mobilize much energy movement in him, and over the last 8 months, he has been more able to tolerate some movement in his head and has been able to cry a little bit, which is probably the first time since his early adolescence that he's been able to cry. When I work on his eye segment, he begins to gag. When I first began to work on him biophysically, it would

have taken a jackhammer to mobilize anything at all, and now it takes very little work on his head to get him to gag. About two months ago, we had a session when I worked a little on his eye segment, and he gagged and vomited a little. Three days later, he called me up to tell me that he had developed blindness in the right eye. He went right to the ophthalmologist, who hospitalized him right away and told him that he had a thinning of the retina in both eyes, which was a consequence of his severe myopia. I'm mentioning it now because I wondered whether his condition was basically a result of having so much spasm and so much holding over his entire life. I told him to tell the ophthalmologist about the session with the gagging, to see if there was some connection; but according to the patient, the ophthalmologist said there was no connection.

Morton Herskowitz, M.D.: I'll tell a story about caution in working on the eyes. I saw a woman in her 50s, and in the first session, we spent most of the time taking a history. Then, at the end, I put her on the couch just for an evaluation, had her roll her eyes for about five minutes to four spots, and she got up totally disoriented. I saw that she was out of it, so I had her sit in the waiting room through the next patient, and through the next patient, for two hours. I told her to read magazines, but she couldn't. At the end of two hours, she said, "I think I'm all right." I looked at her, she seemed much better, and I sent her home, telling her to be careful when she drives, since she had come a distance. On subsequent visits, she always got lost coming into the city. I drew a map for her, and she invariably ended up in southwest Philadelphia. And she demonstrates word confusion and dyslexia. In the second session, she said, "I know I was here, but what happened?" With older patients especially, you have to be very wary, for the tiniest bit of work on the eyes can be very disorienting. She's now at the point where she can come directly to my office without getting lost.

Dr. Braid: I can think of a patient or two, speaking of first visits and eyes, whom I've had sitting in a chair for most of the time, and at the end, when it was time to do a biophysical examination, and I've asked them to lie down, it was as though just asking them to recline was enough to make the eyes wide with fright. By the time they were on the couch, their eyes were off. It's interesting to see how sitting erect holds them together.

Dr. Baker: I had a patient similar to Dr. Herskowitz's who turned out to be an hysteric. She had seen several other therapists before I saw her. In the first two months that I saw her, she missed about half the sessions. Once, she took the train to Trenton; on other occasions, she totally forgot. She'd come halfway to the appointment and forget where she was going. This is a bright girl, who has a responsible position. Her eyes got a lot better in the first six months, but getting to the office on a regular basis should not seem to be a major feat.

Dr. Nelson: The selectivity of the ocular segment has always fascinated me. For instance, some schizophrenics can function brilliantly. They can manipulate the most complex mathematical concepts, yet can be confused and "out of it."

Dr. Lance: Along those lines, I have seen artistically creative people with eye blocks, who worry that if they get better, if that head loosens up, will they lose their creative abilities.

Dr. Dew: There's no reason to assume that the brain is like a pound of butter, that one corner is like any other corner. There are a lot of forces in its development, currents of energy moving, in which its embryology governs its formation, and that kind of movement of energy probably continues even after the brain is fully developed. The question is, why, if that is true, one area gets blocked and another does not. We are probably dealing with a subsegmental microarmoring.

Dr. Herskowitz: The fact that a person can be both schizophrenic and brilliant is really not so surprising because the essential func-

tioning of the armoring is between the brain and the real world. You know, some paranoid delusions are gorgeous, so complicated and so smart within their own logic that it's not surprising that some schizophrenics can maintain some lucidity as long as it doesn't involve functioning in the world. I can't think of anybody, except a comedian, who lost his talent in the course of therapy. This person was a very, very sad guy; when it became clear to him that the comedy was a defense against perceiving how sad he was, he really lost that talent. I ruined that career, but he's very happy, doing social work with kids.

Dr. Dew: That is interesting, because Richard Pryor said the same thing. He said that he was less funny than he used to be before he was injured and came back down to earth. He admits that he is not the same anymore.

Dr. Herskowitz: I think that comedians as a group are so obviously defending against something, that talent you can ruin, but with other artistic or intellectually talented people, though they may change their styles, I've never seen one lose his talent.

David L. Schwendeman, M.D.: What is the theory about those people who develop severe ocular armoring but are not schizophrenic? Is it that they develop the armor at a later time in their development? Is that why they are not schizophrenic?

Dr. Baker: That's the way I look at it. There is a period in the first year of life, maybe in the first six months, where the infant has to differentiate his internal from external sensations, continuity of existence, cause and effect, so that any disturbance at that time has a very profound effect on the whole process of integration. The earlier it is, the more profoundly the integrative function is disturbed. Maybe that's what explains the neurotics who have across-the-board contactlessness without their basic integration being disturbed.

Dr. Nagy: I wonder if we might say something about acute ocular blocking. I am thinking back to a patient whom I saw last

week who functions at a fairly high level of responsibility but tends to be out of touch with his feelings most of the time. He had a fight with his wife and came to treatment in a confused state. This had happened to him once before, which led to his being hospitalized for a period of months, when he was placed on Navane. He had the fight an hour or two before the session. I worked on his eyes and occiput, and it cleared up rather dramatically.

Dr. Dew: What did you do?

Dr. Nagy: I worked around his eyes, on his occiput, as well as his scalp. He has male-pattern baldness, and his forehead is like polished glass. He peeked up and said that it was like taking a veil away from his eyes. Most of the time, his sight is not very clear.

Dr. Dew: I have a slightly different subject, but I don't want to forget to mention it, I've noticed one thing common to many people who come in with acute migraines. They're often very pale; this has happened enough times that I think it's meaningful. If, in your treatment, you can produce a flushing of the skin of the face, neck, and shoulders, that may be a prognostic indication that you've aborted the headache. What I have seen is that, about an hour later, the headache stops. I don't think this is fortuitous, because the headache may have been there for days.

Dr. Levinson: I can confirm that for you in traditional biofeedback research. The biofeedback treatment of migraines is an attempt to raise skin temperature, usually by warming the hands.

Dr. Braid: I have another thought about eye blocks on the heels of what Dr. Ganz said before. I was thinking about iatrogenic eye blocks as a consequence of misdirected therapy. Recently, I started seeing a woman who had been in treatment for several years with someone who had become interested in EST and along the way, had persuaded my patient to go to it. Then this person decided not to do individual therapy any more, as she was going to devote herself to EST full time; so she dismissed the patient from

treatment. This was perceived by the patient as a crushing event, because she had been depressed for a long time and had felt she was beginning to make some progress. She resumed therapy, this time with a psychiatrist, who immediately put her on an antidepressant, and whose chief tactic seemed to be to challenge all of her perceptions, giving her alternative judgments about almost anything she would say. This persisted for 5 or 6 months, during which time she became increasingly depressed, anxious, and finally suicidal. She happens to be someone whom I know, and I was amazed, on her first visit, to see that she looked practically psychotic. I started working on her eyes immediately. I told her it appeared to me she had been having some perceptions that were seemingly accurate, that nobody believed them, and that the people in whom she had placed some trust did not understand them and, instead, challenged her. She happens to be such a good little girl that she was willing to question her own judgment instead of marshalling some aggressive reaction to the challenges. The end result appears to have been an acute ocular contraction, for which I have been seeing her three times a week for three weeks. She's finally beginning to come down to earth.

Dr. Baker: Did she have parents who did the same thing to her? You said the psychiatrist reinterpreted her perceptions. That sounds a lot like what parents do: You don't really feel that, or you're not really this. I wonder if she had a replay of what she had already been programmed with.

Dr. Braid: I suspect you are right. My sense is that she felt no permission to express any feeling in that setting.

Dr. Lance: What about treating an individual with an eyeblock who comes to you on a major tranquilizer? What's the effect of that on the eye block? I've found that I don't get anywhere as long as they're on medication.

Dr. Braid: I've seen a lot of patients on medication by virtue of the fact that much

of my work is hospital based. I consider the medication to be an external armoring device, and in those patients who have continued on orgone therapy, I generally wean them from the medication over a couple of months, and in that time, making an attempt to get them used to working in the eye segment appears to help. In fact, they seem to take to it right away and have tended to express some gratitude for the relief. One patient, a classic catatonic, was in the slow learning class throughout her elementary and secondary schooling. Once she started to feel a bit more clear, she spontaneously theorized that the reason for her slow learning was a combination of her "not seeing" and shallow breathing. She felt that she was seeing in a different way within weeks of working on the eye segment. She was able to stop medication quickly and has not needed it for three years.

Dr. Nelson: Does anyone have experience with manic-depressives and weaning them off lithium?

Dr. Braid: None of the patients that I've taken off lithium have had prolonged manic episodes. Most of them were, by and large, depressed. My gut reaction, not based on a large number of observations, is that those people who predominantly have manic episodes have a greater requirement to stay on medication, because, it seems to me, they are more susceptible to cycles. The other thing operating with manics is that not many stick around for a reasonable length of time, because, when they settle down, their emptiness becomes more apparent and they claim that they need their mania to give them some feeling. I've had better experiences with the depressed patients.

Dr. Nagy: I wanted to follow up on your comment about major tranquilizers functioning as an external armoring device. If you look at the treatment goals of the psychopharmacologists, in fact they are looking for dystonic side effects as evidence of sufficient basal ganglia and thalamic blockade. What you see, in fact, is that people do become

very rigid and stiff in the peripheral musculature. It is a way of creating armoring and, at the same time, armoring their energy level.

Dr. Braid: The contention is made, in psychopharmacology, that the major tranquilizers have a direct effect on the thinking process. Not just that they tranquilize in a somatopsychic mode, but that there is some recognition that they are affecting the thinking process.

Dr. Dew: Along those lines, I've had a feeling that even casual use of marijuana makes it very hard to get at the patient. No amount of work that you do seems to be enough to really get past that. Does anybody else notice this?

Dr. Nagy: Yes, and some recent research speaks to that. A study was done in California where a researcher advertised for people who had graduated in mathematics, and he gave them a very difficult math problem. The people who could do it were offered entrance into the study, which was to smoke one joint three times a week for three months and then try to do the math problem again. None of them could do the problem and in a five-year followup, none has yet been able to do the problem again.

Dr. Nelson: The ironic and horrible thing is that they all have that illusion that they can do the work.

Dr. Herskowitz: How about if we talk about wide-eyed fear? I think it comes up pretty often. I don't know if this is conventional knowledge, but it has recently dawned on me that it can be much more effective, especially if the patient is close to the fear but is not quite able to really feel it, to scare the hell out of them by making a loud noise or lunging at their necks. Then they feel it. Do you people do that?

Dr. Dew: It works sometimes, and other times it falls flat. My alternative to that is not terribly sensational; it requires that you gradually find ways of getting them more and more excited until there's enough push so they start to get scared, and you can do

that by having them kick, open their eyes, and scream. I think one of the reasons we tend to have trouble getting out wide-eyed fear is that the patient is just not mobilized enough.

Dr. Baker: Sometimes it's a matter, specifically, of what you're doing; you may be working on the forehead and occiput and on rolling the eyes, but then you may have the eyes dart from side to side, and that specific thing gets the fear going. Then you can lunge at them and make an impact. Having them keep their eyes open when they scream is very important, as well.

Dr. Lance: Also, have them close their eyes when they inhale and open wide when they exhale, and you show them the mirror suddenly when they're afraid. That can help bring out the fear.

Dr. Dew: It makes me think of something else, too. That is, when you wonder whether what you are seeing is a substitute kind of contact. If you have the patient open his eyes and the emotion stops, it's a good indication that it is a substitute emotion. My impression is that if a person is experiencing a strong, genuine feeling, then, you can't joke it away and you can't make it stop by having him open his eyes. If it's deeply felt, there's little you can do to make it go away. As a matter of fact, I've found that when I make a joke when something is really felt, the patient can get very upset with me.

Dr. Nelson: How about pupillary dilation?

Dr. Braid: In observing my children when they were infants, I found that, when breastfeeding, their pupils pulsate. They don't just dilate, but really expand and contract in a very steady beat, with pleasure. I think that is something that you rarely see in adults until they get excited.

Dr. Herskowitz: I think it's a reaction to the excitement. I've read that it's an old trick of the Arab traders. They would look for dilation of the pupil to figure if the customer was really interested in a particular thing.

Dr. Dew: Along the lines of wide-eyed fear, one question that I am frequently asking

in the course of a session is , "What do you feel?" Many times people will say they feel anxious, and an important thing about evaluating the eye segment is whether or not the anxiety shows in the eyes. And, that's worth pointing out to the patient. "You say you're anxious but it doesn't show in your eyes." That is the *entré* to get them to open their eyes.

Dr. Nagy: Does anyone here have a sense about what makes the difference between someone who is mildly schizophrenic and essentially functional and doing well versus someone who is much more debilitated? What makes the difference beyond the obvious redundancy of saying that one may have a more severe eye block?

Dr. Dew: One thing, and this is nothing new, is how much armoring they have elsewhere. If the pelvis is well armored, or if they have some holding below the eye segment, that may be enough to hold down the excitement, and then they may not be as deeply blocked in the eyes. That, for example, is usually the case in the catatonic.

Dr. Baker: There is something else that is important, and I'm not sure that "genetic" is the right word, but people are very different right from the beginning. Some are strong and survive, and despite whatever neurotic problems they have, there's real strength underneath; others are mushy, and though

they may not lead such a terrible life, or be overloaded with armor, they don't do very well. It isn't all what happens to a person; it's also who it happens to. I think in general that this is a very important thing to assess. We always talk about pathology, but it's secondary to who this person is that's got it.

Dr. Nagy: And their strength.

Dr. Baker: If they've got strength, they can have all kinds of pathology and function responsibly.

Dr. Dew: I want to bring up something that I thought of at the beginning, and this has to do with how you approach the treatment of any segment. The systematic approach to the eye segment is that you do what is possible at a given level of excitation, and then you have to move on to raise the level of excitation, even by moving into a lower segment, which invariably leads you back up again to retackle the eye segment. Maybe something new emerges, something old comes back up, but you're constantly having to deal with the eye segment as long as you are working on the patient. And, even when you get down into the pelvis, which may raise the level of excitation in the whole organism, you may bring out something in the eyes again, and you have to go right back up to it. One is constantly returning to the eye segment throughout the entire course of therapy.

Notes from Afield

Notes from Afield is intended as a forum for the presentation—in brief synoptic form—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.

A NATIONAL CONFERENCE ON PARENTING

This conference was held in Allentown, Pa., November 16-17, 1984; the faculty included nationally renowned psychiatrists and pediatricians. Despite areas of disagreement and controversy, there was a consensus on certain major issues, many of which support Reich's ideas on infants and child-rearing. Two types of research were highlighted. Annie Bergman, Ph.D., explained Margaret Mahler's pioneering observations of mothers and their infants in a natural setting, unseen observers studying the dyad in home-like play areas. Stella Chess, M.D., described the New York Longitudinal Study, a remarkable prospective study in which a cohort of 133 children has been followed since birth for over a quarter of a century.

The speakers agreed that we're just beginning to understand the emotional needs of children and that, so far, little is scientifically established about the parent's role in the growth and development of their children. However, certain striking themes emerged:

1. Children are more distinctive and individualistic than was previously realized; also, each particular parent-child dyadic relationship is unique. Henri Parens, M.D., a veteran of many years, said, "Each child is such a unique individual. I sometimes despair of generalization." This individuality has immense research implications.
2. Emotional contact between the mothering figure and infant is essential for healthy

development. Virtually every speaker noted how the mutual and reciprocal excitation between mother and child formed the foundation for the infant's exploration of the world. Stanley Greenspan, M.D., showed a film that vividly emphasized the central importance of eye contact. Others stressed the need for stimulation of all the senses, and Greenspan used his film to illustrate how the observation of the baby's posture and movements can be used to detect early problems. (No one, however, noted the early respiratory inhibition described by Reich.)

3. Effective parenting is greatly aided by education. Parents tend to be defensive, so instructors must be careful to avoid a judgmental approach. Many parents are also anxious and, in their fear, fail to accurately assess situations. Parens found that if he could decrease their anxiety, many parents were able to recognize the difficulty and help their youngsters with sound, common-sense interventions.*

*Parens's parent groups have particularly wanted help with thumb-sucking, sexuality, aggression, "limit-setting," ambivalent feelings toward the child, and appropriate amounts of holding and nurturance.

Sally Provence, M.D., urged that teaching not be theoretical, but practical, on-the-spot, and directed specifically at the child's behavior and the parent's emotional and behavioral response. Rather than teaching specific techniques to "handle kids," Provence focuses on the parents' basic attitude toward

their children. She stresses empathy by helping parents to feel their children's view of events and by observing the child's face and behavior.

Greenspan echoed this theme. "Since we now know how different kids are from one another we must teach parents how to understand their own child so they don't fall back on . . . formulas which are supposed to be appropriate to all children." Both Provence and Greenspan said parental education should be an on-going process. As a child progresses through the developmental stages, parents are confronted by new challenges and conflicts. Trouble occurs in the dyadic relationship when the child's behavior activates areas of conflict in the mother. For instance, mothers who tend toward dependence handle infants effectively but may struggle angrily with a defiant toddler. Thus parenthood is a developmental process which requires great flexibility of character.

4. Several speakers confirmed Reich's findings that early contactful intervention can be both helpful and enduring. Both Provence and Greenspan have documented long-range positive outcome from early treatment. Greenspan more in cognitive improvement, Provence more in the emotional realm. Parens confirms that responsible, educated parents can greatly aid their children; he's shown, on film, how even "gross disturbances" in children can change with patient, practical, non-judgmental teaching.

Commentary:

These themes confirm Reich's earlier insights (see his *Children of the Future*). That the conference, apparently the first of its kind, was even held reaffirms that "the fate of the human race will be shaped by the character structures of the Children of the Future" (1:5). Reich predated current researchers in recognizing that emotional health cannot be understood through studying neurotic adults; 35 years ago he called for prospective studies such as those mentioned

above. Although the speakers didn't understand the full energetic implications of emotional contact, it was gratifying to hear how consistently they confirmed the central importance of multi-sensory, reciprocal stimulation between mother and child. It was exciting to see the mutual, joyful gazes between mother and child in Greenspan's film after he had taught the mother to hold the infant in a manner that allowed eye contact.

The experiences of the speakers support Reich's assertion that parents, in some cases, can be taught to help children disentangle themselves from emotional problems. Greenspan and Provence address a central issue of parental education—the myriad of "how-to" and "what-to-do-if" books cannot be consistently relied upon because every child is unique. Parens's and Provence's suggestions seem helpful in promoting a more contactful approach. Anecdotally, Reich showed that early intervention could have enduring positive effects on developing children. Parens, Provence, and Greenspan have now all verified this in well-documented studies.

I have one reservation about the current research on children. None of the speakers mentioned the role of the investigator in the research process, that scientists are armored, cut off from their own emotional depths, and that this will inevitably result in distortions in the research. Thus, we must be cautious in assessing the new data.

Reich, W.: *Children of the Future*, New York: Farrar, Straus, and Giroux, 1983.

D.L. Schwendeman, M.D.

THE ROLE OF JAW TENSION IN OVER-ALL MUSCULAR COORDINATION

A January 1985 article in the *Washington Post Magazine* describes the work of two Washington area dentists who have developed mouthpieces that help relax the jaw and produce documented improvement in the performance of professional athletes. Dr. Peter Chorbajian of Bethesda, Md., has created a plastic "Tru-Grid" device; his

theory is that it reduces malocclusion, which would normally give rise to increased tension, diverting energy from the body's other muscles. He has shown success in improving the performance of professional football players, who become more controlled and relaxed. Dr. Lowell Weiner of Silver Springs, Md., uses several different appliances with athletes, noting that the devices do not make one stronger, just more efficient.

This work developed out of the doctors' observation that, when people tense, one of the first things they do is clench their teeth; the mouthpiece helps to relax the jaw muscle. Regarding the mechanism of action, they admit, "It may be that some other neurological system or reflex mechanism that has a relationship with the jaw is involved."

These observations confirm the importance of armoring and localized muscle tension in disrupting the functional integration of the body as a whole, i.e., jaw tension interferes with the overall coordination of muscle groups far removed from the head. They emphasize, again, Reich's view of the healthy organism as an integrated, functional unit, that is not simply the sum of its parts.

C.F. Baker, M.D.

ORIGIN OF LIFE: PROTEINOID MICROSPHERES

For more than two decades, Sidney W. Fox, Ph.D. has been investigating the properties of proteinoid microspheres, or cell precursors, at the Institute for Molecular and Cellular Evolution at the University of Miami in Coral Gables. The microspheres are formed by heating a mixture of amino acids, which spontaneously form long polymers. Dr. Fox refers to these polymers as "proteinoid," since they share several properties of protein, including limited heterogeneity, reaction to color test, a range of solubilities, salting-in and salting-out properties, some optical activity, susceptibility to proteolytic enzymes, a number of "enzymelike" activities, inactivatability of catalytic power by heating in aqueous buffer, a tendency to

assemble selectively into nucleoproteinoid microparticles, and others (1). Boiling sodium chloride solution is added to the hot proteinoid, resulting in the spontaneous formation of spheres a few microns in diameter, characterized by a two-layer membrane with some residual material trapped inside. These proteinoid microspheres have a number of properties similar to living cells, including stability (on standing, during centrifugation, and sectioning), variability of shape, uniformity of size, stainability, producibility as Gram-negative or Gram-positive, a tendency to shrink or swell in atonic solution, a boundaried structure, selectivity of passage of molecules through the boundary, ultrastructure visible with the electron microscope, patterns of association, budding and fission; the ability to propagate through budding, growth by accretion, and the ability to form junctions and to transfer informational molecules (2). Recent experiments have indicated that these also show spontaneous electrical activity, with light as the principal energy source for these spontaneously-forming, excitable microspheres.

Dr. Fox and a collaborator, Dr. Klaus Dose, record many of their findings in a book first published in 1972 and later revised in 1977, *Molecular Evolution and the Origin of Life*. In this book, they place these findings in the context of their own "constructionistic" approach to a comprehensive theory of biology, attempting to work with components that assemble into precursors of life. In contrast, contemporary research has primarily pursued a "reductionistic" approach, in which living systems are disassembled into their components, which are then studied. The prevailing theory regarding the origin of life, therefore, centers on the need for nucleic acids as cell regulators, despite their complex structure. In contrast, Dr. Fox makes a compelling argument that, at the beginning of life, molecules organized themselves into amino acids, subsequently into preproteins, with some order and some enzyme-like activities, then into protocells with some

membrane activity, metabolism, and primitive reproduction, and then into contemporary cells. He discusses fossil and extraterrestrial evidence (from meteorites and moon rock) which supports these theories.

The significance of these experiments for students of orgonomy is that Dr. Fox appears to be working with bion cultures created through heating, adding moisture to, and swelling of amino acids. He places the notion of biologically active cell precursors on a rigorous footing within the conceptual tradition of classical biochemistry and organic chemistry. What is missing from the book is any mention of the work of Wilhelm Reich, M.D., specifically his *The Bion Experiments on the Origin of Life*. However, for those who are interested in experimental work with bions, Dr. Fox's book may provide ideas for future research, as well as references to articles on the origin of life that might otherwise remain buried in the technical literature.

1. Fox, S.W. and Dose, K.: *Molecular Evolution and the Origin of Life*, Revised Edition. New York: Marcel Dekker Inc., 1977, 178.
2. *Ibid.*, 237.

S. S. Nagy, M.D.

EYE MOVEMENT DISORDERS

While impaired smooth pursuit eye movement in schizophrenic patients was first noted in the psychiatric literature in 1908 (1), significant further investigation has not occurred until approximately the last decade. In brief, subjects are asked to follow a moving object while their eye movements are recorded. These can be smooth or saccadic. Smooth eye movements are more or less automatic or nonvoluntary in the presence of a moving target (2), and stabilize moving images on the retina. Saccadic movements are more or less voluntary and bring objects at the periphery of the visual field onto the fovea by a high velocity shift in eye position (3,4). Individuals who are unable to follow a moving target smoothly, who show a de-

crease in velocity while the target is moving, or who exhibit saccadic movements, are said to exhibit a movement dysfunction, which has been recorded and scored by many investigators in number of different ways.

Investigation has shown that eye-tracking dysfunction is present in 50% to 85% of schizophrenic patients, 40% of manic-depressive patients, and 8% of the normal population. In addition, other studies have shown that 34% of parents of schizophrenics and 10% of parents of manic-depressives show a similar dysfunction (5). In schizophrenics, this dysfunction is not due to medication, age, inattention, or poor motivation (6), although conditions designed to distract attention produced abnormal tracking movements in 24 matched controls that were indistinguishable from those observed in 24 chronic schizophrenic patients (7). Other studies have shown that impaired smooth pursuit eye movement may be associated with social introversion and related psychopathology in a nonpsychiatric population (8). In the absence of neurologic disease, this impairment of nonvoluntary attention has been attributed to a central nervous system dysfunction located above the brainstem that is considered a genetic marker for vulnerability to psychosis and schizophrenia (9,10).

What these studies are recording in detail, of course, is the effect of ocular armoring, which can be present in varying degrees of severity and chronicity. This disorder can be shown to be a physical symptom, not a genetic marker, by the change in smooth pursuit patterns following orgone therapy. Unfortunately, to date, no quantitative studies have been done by orgonomists that demonstrate these changes. It is interesting to note that the current theories that explain these findings are not inconsistent with the theory proposed by Dr. Reich in *Character Analysis*: "There is good reason to believe that in the schizophrenic process parts of the brain, most probably the base with its nerve roots, become immobilized . . . (11)."

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S.S. Nagy, M.D.

The Amateur Scientist in Orgonomy

This column is intended to encourage "hands-on" experience with various aspects of Reich's biological and physical laboratory findings, particularly for interested readers with limited means or access to sophisticated equipment. Each issue will feature an experimental research project that illustrates basic orgonomic findings using only modest equipment and expertise. Readers are encouraged to submit their own projects, including a brief theoretical background, a detailed practical description, references for further reading, and relevant diagrams or charts. It must be a project actually carried out as described rather than a theoretical design.

Electroscope Theory

The metal pole of the electroscope may be charged with either electrical particles or orgone energy, depending on the source of the charge. Traditional electrostatic theory, which recognizes only charged particles, requires a conducting path for the charge to leak off. This conducting path is provided, according to mechanistic theory, by ionized particles in the air which result from natural radioactive bombardment. Thus, the discharge rate is interpreted as an indirect measure of air ionization.

Orgone energy, on the other hand, is mass-free and, furthermore, a charged electroscope sits imbedded in a continuous orgone energy medium. The discharge rate thus is understood as a measure of the rate of energy flow from the more highly charged metal pole to the lower ambient energy level. Reich thought of this process at first in terms of the gradient, i.e., a steeper potential difference between the two energy levels would result in a faster discharge. Later, he thought of the discharge process more in terms of the qualitative energy state, i.e., the electroscope discharges more slowly in clear sunny weather because of the expansive energy environment; the electroscope "feels better" and holds its charge longer. In any case, an orgonotically charged electroscope can be readily used to monitor the environmental orgone energy tension.

A HOME-MADE ELECTROSCOPE

PATRICIA S. BURLINGAME*

The electroscope is a useful instrument for measuring electrostatic charge but, as many of you know who have looked into the purchase of a commercial instrument, they are both expensive and difficult to obtain. Here, I will describe an easy-to-make, inexpensive version that may be constructed in a few hours, using readily obtainable materials. This home-made electroscope works as well as the expensive needle types, and its relatively long discharge time, due to the virtual weightlessness of the gold leaf, is advantageous in measuring subtle changes in the energetic condition of the atmosphere.

I. BACKGROUND

The electroscope consists of a glass housing containing a vertical metal strip to which is attached a section of gold leaf. The top of the metal strip is connected to a metal post that extends upward through a hole in the top of the housing. On the outside back wall of the housing is a scale that is used to measure the angle of deflection of the leaf relative to the metal strip. When a source of electrostatic charge is applied to the post, the leaf will rise up away from the strip, then slowly fall back to the original vertical position. The speed with which the leaf falls (the

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discharge time), measured in minutes or seconds, reflects the atmospheric orgone energy tension, which varies with the weather, the location, the time of day, and the season of the year. The higher the tension, the longer will be the discharge time. In addition, the nearby presence of an orgone energy accumulator, which is surrounded by an energy field that is higher than that of the atmosphere, will cause a longer discharge time, while the presence of a source of high voltage or ionizing radiation will bring about a decrease in the discharge time.

In the experiments that follow, you will be charging the electroscope to a standard height, then measuring the time it takes for the leaf to fall a set number of degrees. The maximum initial degree of deflection will not be taken into consideration, as there are many variables that prevent this measurement from being consistently useful.

II. CONSTRUCTION

While the construction of the electroscope is fairly simple and straightforward, some trial and error is involved, and you may find that certain steps will have to be repeated a few times. A cardboard mock-up of the vertical metal strip and gold leaf serves to minimize the amount of this repetition with the final materials, although more than one attempt is usually necessary to obtain a usable leaf. Only relative measurements are presented, as the size of both the leaf and the metal strip are proportional to the size and shape of the jar.

Equipment:

1. A clear glass jar with threaded plastic cap, either round or oval in cross section, with good optical properties, at least 3" wide and 6" tall. An instant coffee jar works well.
2. Copper strip, 1/2" wide and approximately 1" shorter than the height of the jar. Sheet copper is sold in hardware stores as "flashing."
3. Gold leaf. A package of many sheets costs

only a few dollars, and is available in craft and art supply stores. Note: Never touch gold leaf with your fingers. It crumbles easily, and will pick up oil from your skin, which may cause it to adhere to the copper strip.

4. Brass bolt, 1/8" in diameter and 1 1/2 to 2" long, with 2 washers and a nut.
5. Light cardboard, the weight of an index card.
6. Grounding material (optional): aluminum foil, small plastic dish, 10' of light wire.
7. Tools: scissors, ruler, lead pencil, wax pencil, cellophane tape, pliers, screwdriver, tin snips, fine sandpaper or an emery board, drill with 1/8" bit, straight pin, model glue, and a protractor the approximate size of the leaf.
8. Accessories: plastic comb or rod, notebook, graph paper, stopwatch, weather gauge (temperature-humidity-barometer).

Preparation: Remove the cardboard liner from the cap. Wash the cap and jar, making sure to remove any traces of glue from the glass. Rinse well, using distilled water if your tap water is hard, then set aside to air dry. When completely dry, check the clarity of the glass by laying the jar on a printed page and seeing how well you are able to read the words through the bottom half of the jar. If there is more than slight distortion, obtain another jar, as eyestrain will result from long periods of time spent trying to line up the leaf with the scale through wavy glass.

Place the cap on the jar and tighten to just beyond the point where the cap turns freely; overtightening will crack the plastic. Observe the vertical mold marks on the sides of the jar. Using a grease pencil, extend these lines up the sides of the cap, then connect them by marking a line across the top of the cap. On this line, drill a 1/8" hole in the cap, about 1/3 of the way in from the edge. This is most easily done from the inside, with the cap placed on a wooden board to protect both table and drill bit.

Cardboard Mock-up: Measure the height of the jar, from the top of the threads to the bottom of the smooth area. Cut out a $\frac{1}{2}$ " wide strip of light cardboard equal to this height; this will represent the copper strip. Form a tab by folding the strip $\frac{1}{2}$ " from the end, then poke a hole in the center of the tab. Next, measure the inside diameter of the jar, about half way up. If the jar is not round, measure the narrowest diameter. Cut out another strip of cardboard, $\frac{1}{2}$ " wide and one half the inside diameter of the jar, and fold over a $\frac{1}{4}$ " tab. This shorter strip will represent the gold leaf. Lay the shorter strip on top of the longer one and line up the unfolded ends. Tape the tab of the leaf strip to the longer strip. Extend the leaf strip to form a 90° angle to the longer strip, then tape the tab of the longer strip to the inside of the cap, with holes lined up and the cardboard leaf parallel to the line on the top of the cap, and facing the farthest side of the jar.

Place the cap on the jar and tighten as before. Observe the leaf strip as you are turning the cap, and see if the end is at least $\frac{1}{8}$ " from the glass in all positions. If the cardboard leaf touches the glass at any time, trim a bit off the end, and a corresponding amount off the end of the longer strip. (This step is important, because at times the gold leaf will not rise nicely to the side, but instead will flip over and become attracted to the front or rear wall of the jar. If contact with the glass is possible, the leaf may actually become stuck to the glass.) Also note how clearly you can see the position of the leaf. If it appears blurry, replace the jar.

Copper strip: Remove the cardboard strip and leaf from the cap and carefully separate the two pieces. Flatten the tabs. Place the longer piece on the sheet of copper and outline with a lead pencil. Using tin snips, cut out the strip, keeping the edges as straight and perpendicular as possible. With sandpaper or an emery board, smooth the edges, then polish one face until very shiny and smooth. Draw a pencil line across the strip, $\frac{1}{2}$ " from the end, then drill a $\frac{1}{8}$ " hole in the center of the

resulting square. Fold the strip along the line, toward the polished side, forming a tab at a 90° angle. Even out any irregularities in the strip by placing it on a smooth metal surface and hitting it with a hammer until perfectly flat. Repolish if needed. Place the cardboard leaf on the smooth side of the copper strip, with the tabless ends together. Make a pencil mark on the copper along the line of the fold of the cardboard leaf.

Gold leaf: The making of the leaf and the final assembly of the electroscope should be done on a clear, dry day, both to facilitate the testing of the instrument and to avoid trapping moisture within the jar. Work with the gold leaf in a draft-free area, as the leaf is so light, the slightest puff of air will send it sailing away.

Remove a sheet of gold leaf from the package, keeping the protective papers in place. Lay it on a flat surface, and place the cardboard leaf on the top paper. Very lightly trace the outline of the cardboard leaf with a sharp pencil. Cut out the leaf, being careful to keep both papers in place. If using scissors, try to cut each side with a single stroke, as this will give you a cleaner, straighter edge than several smaller snips. Alternatively, an x-acto knife or a single-edge razor may be used, with the aid of a straight-edged ruler. Lay the paper-enclosed leaf on a flat table, with one end near the edge of the table. Carefully remove the top paper with a slightly moistened finger tip, remembering not to breathe on the leaf. Using a pin, draw a fine straight line of glue on the polished side of the copper strip, just above the pencil line. Holding the strip by the tab end, turn it over and position it just above the gold leaf, with the tab end extending over the edge of the table. Line up the far ends of the leaf and the strip, then very gently press the strip onto the leaf. If too much force is used, the gold will turn to dust. Turn the strip over and set aside for the glue to dry.

Examine the leaf to make sure its edges are even with the edges of the copper strip. If too large, it is possible to trim off the

excess, but you will probably find it easier to just start over with a new leaf. Next, hold the copper strip in a vertical position, and slowly tilt it until it is horizontal and the gold leaf is hanging below. A well-made leaf will hang straight, with a sharp line of attachment to the strip, and no large wrinkles or folds. If only slight irregularities are present, consider the operation a success and proceed to the next step. If not, remove the leaf with the edge of a dull knife, sand to remove any remaining glue, and try again. If you get a usable leaf on the second try, you've done very well!

Assembly: Place a washer on the bolt. While holding the copper strip vertically, with the tab uppermost and your fingers above the leaf, insert the bolt up through the hole in the tab, then up through the hole in the cap. Place another washer and a nut on the bolt, and tighten just enough to hold the strip in place. Turn the strip until the bend is perpendicular to the line on the cap, and the leaf is facing the most distant wall of the jar. Tighten the nut firmly, making sure the strip does not move in the process. Place the cap on the jar and slowly tighten.

Examine the copper strip and determine if it hangs vertically. If not, remove the cap and adjust the angle of bend at the tab, handling the strip as close to the top as possible. Replace the cap and tilt the jar to the leaf side. Note how the leaf hangs, how clearly it is visible, and whether or not it clears the glass. If using an oval jar, it is important that the leaf rises parallel to the long axis of the jar. Make any necessary adjustments. See figure 1.

Your electroscope is now ready for the final test. Run a clean comb through your hair, then gently touch it to the post. If the weather is favorable, the leaf will rise to a horizontal position. Check for any irregularities and correct.

Scale: Cut out a square of light cardboard about 1" larger than the length of the leaf. Draw a horizontal line, as long as the free length of the leaf, $\frac{1}{2}$ " down from the top of

the square. Starting from the left end of this line, draw a vertical line of the same length. Place a protractor on the square, with the straight edge even with the vertical line, and the horizontal line passing through the 90° mark. Draw an arc between the two lines, then, using a pencil, lightly mark off every 5° along the arc. Remove the protractor. Line up a ruler with the first mark and the point where the two lines meet. Draw a short line through and perpendicular to the arc. Do the same with each mark, making the 10° lines somewhat longer. Label the 0° line (the bottom end of the vertical line), and each 10° increment.

Place the electroscope on a level surface and charge to 90°, or as high as possible. (Repeated applications of a charged comb may be necessary if weather conditions are less than ideal.) With the electroscope at eye level and the leaf extending to the right, place the scale on the outside of the rear wall of the jar. Adjust the position of the scale until the following are lined up: the edge of the copper strip with the vertical line of the scale; the juncture of the leaf and strip with the point where the two lines of the scale join; the leaf with the horizontal line, when the electroscope is fully charged. When satisfied with the placement, attach the scale with cellophane tape.

Grounding (optional): The housing of the electroscope tends to build up a surface charge with repeated use. This can in part be removed by touching the glass with your hands between readings. Grounding of the instrument, on the other hand, will reduce this buildup and thus give you more relevant readings.

Obtain a small plastic dish or food-container lid that fits snugly on the bottom of the jar. Line the dish with aluminum foil and tape or glue the foil in place. Tape one end of the 10' light wire to the foil. Place the electroscope on the dish, and tape the dish in place. Ground by attaching the other end of the wire to a metal stake driven into the earth or by attaching it to the middle screw

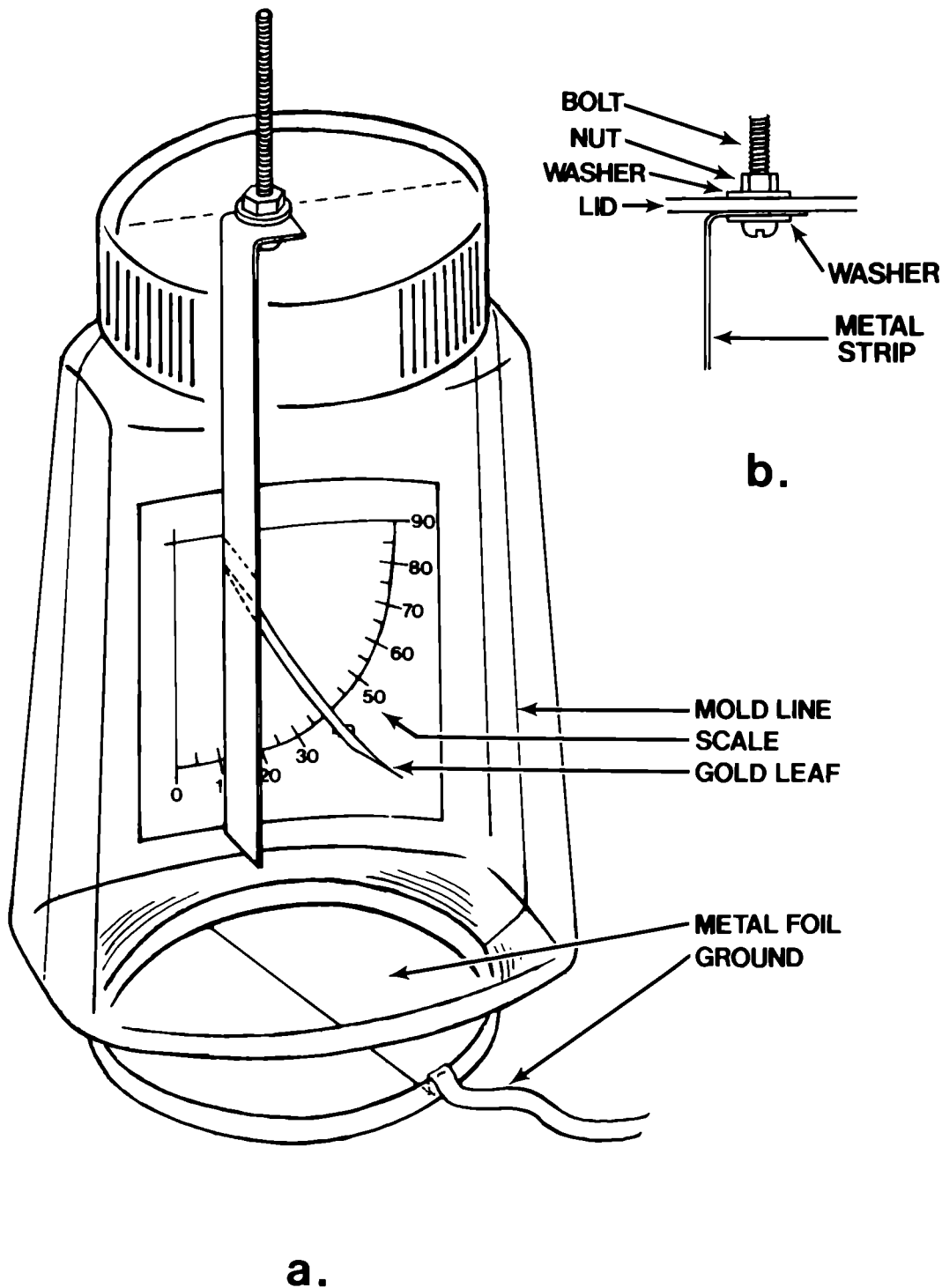


FIG. 1:(a) The completed electrostatic deflection apparatus.
(b) Detail of metal strip attachment.

of a wall socket plate. **CAUTION:** Do not insert the wire into the socket, not even into the grounding outlet!

III. HOW TO USE

Charging: Run a plastic comb or rod gently through your hair, then touch it to the post by lowering your hand directly from above. If approached from the side, the leaf may be pulled toward the comb, causing wrinkles to form and possibly even tearing the leaf at its point of attachment. If the leaf does not rise high enough, stroke the comb through your hair several times, then leave it in contact with the post for a few seconds, or gently stroke it across the top of the post. On humid days, several rapid applications of a freshly charged comb may be needed to raise the leaf high enough to obtain a reading. Damp or oily hair will prevent proper charging, as will an oily comb, so be sure both are clean and dry. Other sources of charge you might want to try are rubber or glass rods rubbed on fur or silk.

After taking a reading, draw off any remaining charge by touching the post with your finger. If the instrument is not grounded, run your hand over the glass to remove any surface charge. Then let the electroscope rest for a few minutes. If this is not done, each successive charging may yield a progressively longer discharge time. If you are interested in doing careful measurements of the atmospheric orgone energy tension, it is advisable to wait at least 10 minutes between readings. This is particularly important after moving the instrument to a new area, as it takes a while for it to become acclimated to its new environment.

Reading the scale: Place the electroscope at a height at which it is comfortable for you to observe the position of the leaf. Apply a charged comb to the post and note where the deflected leaf crosses the scale. It is important to be consistent in the way this is done, as a slight change in the angle of view will cause a large variation in the reading. First,

line up the copper strip with the vertical line of the scale, then move your head up or down until the leaf appears as a thin line. If a minor misalignment prevents you from observing the leaf this way, read the location of either the leading or trailing edge of the leaf. Remember, these measurements are meaningful only in *relative* terms; the absolute value obtained is not important. Thus, the actual method used to read the scale is not critical, as long as it is consistent. So decide on the most convenient, comfortable system and stick with it for all your readings.

Taking a reading: You will be measuring the rate of discharge of the electroscope, which is done by observing the time it takes for the leaf to fall a certain number of degrees from a standard height. As it is often not possible to charge the electroscope to 90°, a range somewhere in the middle of the scale will be used. Consistency is again important, as the discharge rate is not linear. The leaf will fall rapidly at first, then slow its descent. The speed at which it falls at any point on the arc will be the same whether the instrument is charged fully or to just above the desired height. To obtain accurate comparative readings, always time the fall of the leaf between the same two points.

I have found that measuring the time it takes the leaf to fall from 60° to 40° is a good compromise, as it is usually possible to raise the leaf above 60°. If it won't go that high, the discharge time will probably be too rapid to measure accurately. The only drawback is that, on nice, expansive days, the leaf may leap up to 90° and stay there. You will then have a long wait until it falls to 60° so you can begin timing!

With stopwatch in hand, charge the electroscope to a point above 60°. Begin timing when the leaf has fallen back to 60°, and measure the time it takes for the leaf to drop to 40°. This time is the *discharge time*. It will vary with the tension of the atmospheric orgone energy, increasing (slowly falling leaf) with an increase in tension, as on a

clear, dry day, and decreasing (rapidly falling leaf) with a lowering of the tension, such as at night or in humid weather.

IV. PROJECTS

Presented below are examples of some of the parameters that affect the discharge time, along with suggestions on how to study each one independently. Although you will surely be eager to begin taking readings with your new electroscope right away, it is important, if you wish to accrue any meaningful data, to have an idea of what you wish to study and how you will go about doing so.

The first and most important step is to obtain a large, bound notebook with lined paper and a sturdy cover. Draw columns down the first page and head with the following: date, time (the time the leaf reaches the initial height, not the time of charging), humidity, discharge time (DT), weather, and comments. Additional headings that you may find useful are temperature, barometric pressure, precipitation, wind, and which electroscope you are using, if you have made more than one. I find it convenient to enter data only on the right-hand pages, leaving the left ones free for additional comments or discussions on the location, the goals of the study, subjective observations, etc. With a little experience, you will find that certain factors are of greater import or interest than others, and later pages may be modified to suit the needs of your work.

Time of Day—The Daily Pulsation: On a day that is predicted to be dry, sunny, and stable, take a reading every hour over the course of the day, from just after sunrise until evening, when the electroscope will no longer charge. Locate your instrument where it may be left undisturbed, preferably out of doors. If this is not practical, placing it in an open window will suffice, although the energetic condition of the building will modify the readings, as compared to those obtained outside.

Charge the electroscope and watch the progress of the leaf. If it looks like it will

take a few minutes to reach the initial degree mark, use this time to make entries in your notebook on the weather. Record the humidity and an abbreviated description of the sky color and the nature of the clouds. If the leaf is falling rapidly, wait until you have completed the reading to make these entries. Record the time you began the reading. When the leaf has fallen the designated number of degrees, record the discharge time. Complete the discharge by touching the post with your finger. Repeat this process hourly until the leaf either will not rise, or falls too rapidly to measure.

When you have collected a day's worth of readings, plot the data on graph paper. Designate the horizontal axis "Time of Day", and mark off this axis, in hourly increments (or minutes if you have been ambitious and taken more frequent readings). Label the vertical axis "Discharge Time," and mark with the appropriate time units. Enter the readings on the graph, then connect the points with a ruler. If the weather has indeed been stable, with no major changes in the clouds, and no fronts moving through, you will have a curve similar to that shown in Figure 2. This graph shows the discharge time, in minutes, over the course of a day in early August, 1985, with readings taken every 20 minutes in an open window. Early in the morning, the electroscope charged feebly, or not at all. As the day progressed, the discharge time became increasingly longer as the atmospheric orgone energy tension increased, reaching a peak in the early afternoon. It then began to shorten again, with a sharp drop occurring a few minutes before sunset. Note how the readings grow farther apart as the discharge time increases; at this time of day, 15 to 20 minutes would pass before the leaf dropped to 60° and the readings could begin.

Time of Day—The Weather: Choose a day of unstable weather, with a forecast of changeable skies and a slight chance of showers. Take hourly readings as before. In addition

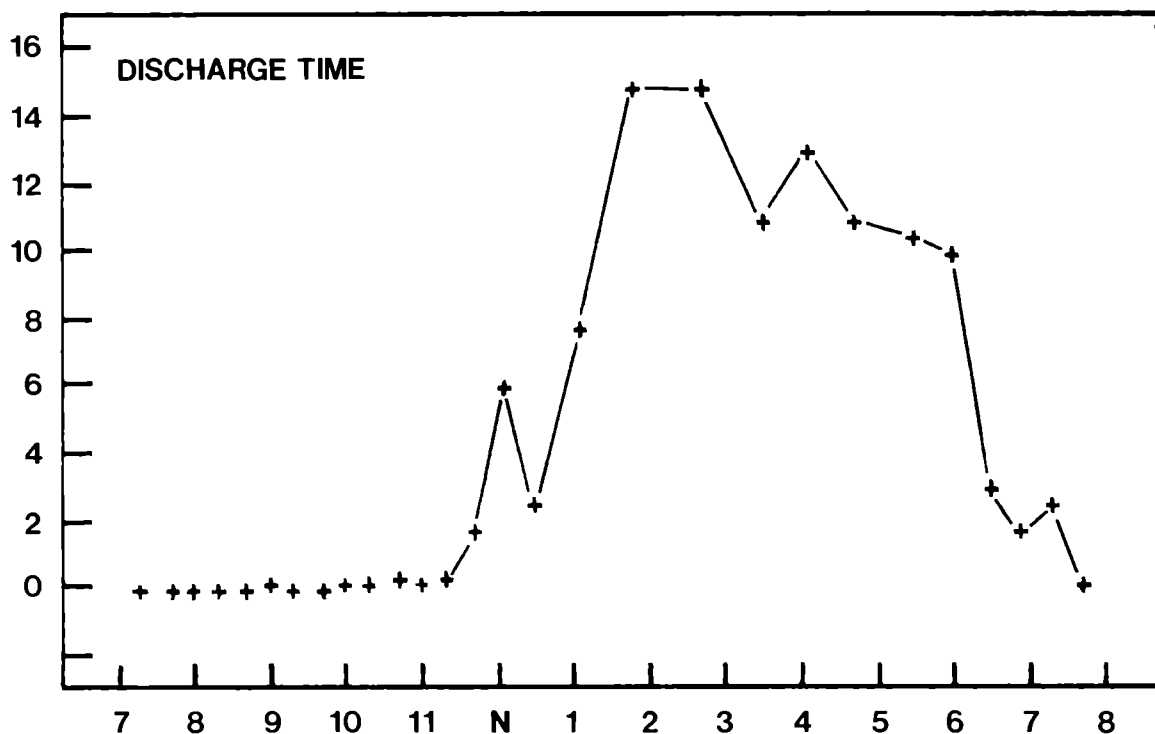


FIG. 2: Electrostatic discharge time, showing diurnal variation.

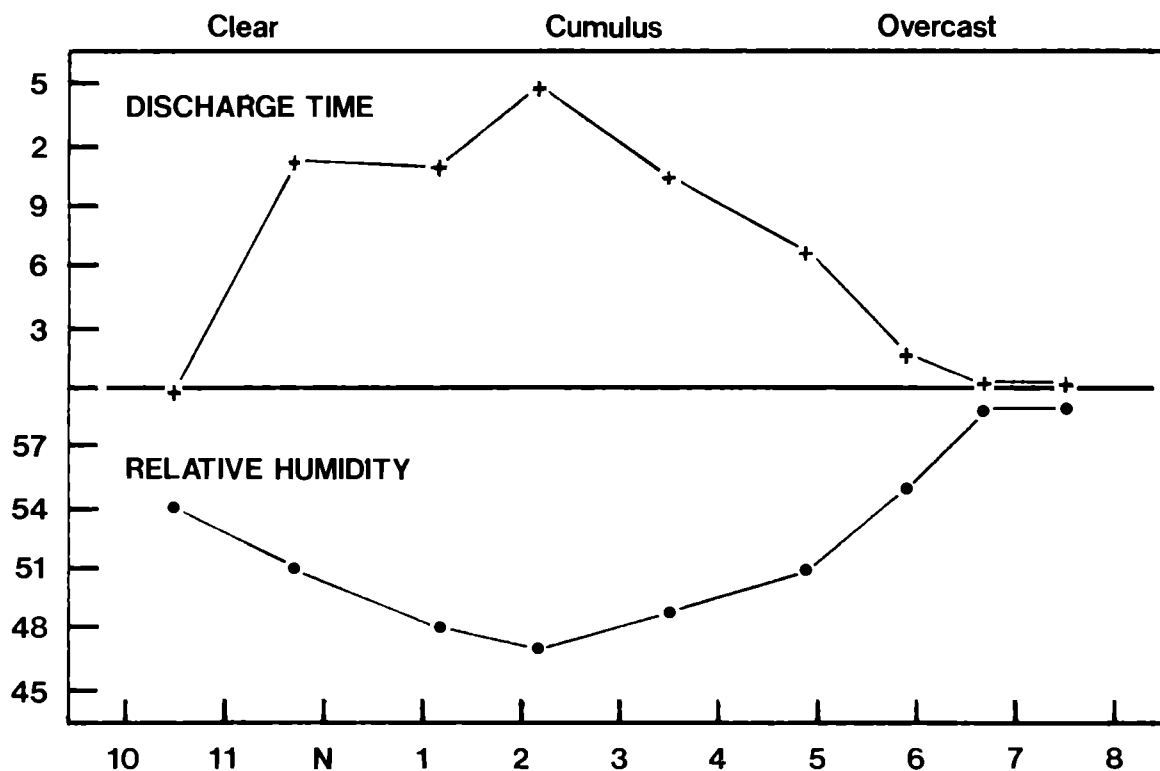


FIG 3: Electrostatic discharge time, with changes in relative humidity and cloud formation.

to humidity and clouds, include in your notes the nature of any precipitation. Be sure to look for orgone rain, which appears as a fine drizzle, but contains no water. This phenomenon is often seen in the late afternoon or early evening, especially on still, cloudy days.

Graph your day's worth of data as before, then draw a second curve for the humidity readings, either above or beneath the Discharge Time curve. Symbols or abbreviations for clouds may also be added along the Time of Day line.

You will find that the discharge time curve will be more irregular than that obtained during stable weather, with the time shortening as the humidity rises and the cloud cover increases. The example given in Figure 3 shows the relative humidity and type of clouds present, along with the discharge time, measured outdoors in July, 1985. Note how the discharge time is longer in the presence of cumulus clouds, which are a sign of high tension, and shorter as the sky becomes overcast and the humidity rises. You may sometimes find that the discharge time changes an hour or so before any change in clouds or humidity are evident. This may be interpreted as evidence of a causal relationship between the atmospheric orgone energy tension and the weather.

Day-to-Day Variation—The Weather: Take readings daily for a month, at the same time of day and with the electroscope in the same location. Plot the discharge time against the humidity, and include information on clouds and precipitation. Having eliminated the influence of the daily pulsation from your data, you will have an even stronger correlation between the weather and the discharge time, and thus the energy tension.

Seasonal Variation: For one month of each season of the year, take daily readings as above. Graph each month's data separately

and compare. Are there any differences in the curves that cannot be explained by the weather? Average all of the discharge times for each month and compare. Again see if there are any significant differences in the times.

Location: Take readings in various locations, such as different rooms of your home, remembering to give the electroscope time to adjust to each new environment. If you have made two instruments, simultaneous readings will be even better. Note any differences in the discharge times. Determine the influence, if any, of a nearby television set, ionizing smoke detector, or orgone energy accumulator. Are these effects different, and if so, how?

There are many other ways the electroscope can be used to study the manifestations of orgone energy. As you gain experience, ideas for new projects will develop, and perhaps one will lead to the discovery of an as yet unknown organotic function. For more information on this subject, refer to the sources listed below.

I wish to thank Dr. Courtney F. Baker for both technical and theoretical advice, and Dr. Robert A. Dew for the illustrations.

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The Secret Life of the Unborn Child

by THOMAS VERNY, M.D. with JOHN KELLY.

Dell Publishing Co., New York, 1981. 253pp., \$7.95

Recalling the recent decades when the most modern knowledge of newborns emanated from the halls of psychoanalysis, when according to Freud, the newborn was regarded as an insensate creature until the appearance of the reactive smile (at about the 12th week postpartum), we are struck by our former teachers' failure of observation and by the immense fund of knowledge that we have gained since that time. In the past half-century we have learned more about newborns' perception and "wiring" than had been accumulated in all the history of our species. Unfortunately, the practical uses of this knowledge are yet hardly perceived by the medical community, which proceeds according to its own laws of inertia. Whatever changes have been effected in the delivery rooms and nurseries have been the result of pressures exerted by sensitive, educated mothers and a few exceptional physicians.

The books under review are both written for laymen. They are an attempt to make mothers aware, in one case, of the sentient life of the fetus in the womb, and in the other, of the possibilities of a birthing experience that is as close to nature, as free of medical interference, as is safely possible.

The Secret Life of the Unborn Child is gratifying for the many studies the authors have assembled that reveal the sensitivity and liveliness of the growing fetus. Sometimes, however, it is annoying, and occasionally it is maddening, when it proposes theses that are based on nothing more substantial than unreasoned conjecture. Although most of the material is presented in anecdotal form, there is a decent index of source studies for those inclined to a more detailed exploration of the topic.

Some of the material in the book will be familiar even to lay readers. There are the

old studies of the effect of broadcasting the mother's heartbeat in the newborn's nursery. In the heart-sound nursery, the infants ate more, gained more weight, slept better, breathed more fully, cried less, and had fewer complications than had their control peers in quiet nurseries. Of course, the message of this study is that mothers and infants should not be separated.

Another old study that is cited concerns the transmittance of maternal catecholamines across the placental barrier, so that, when the mother is anxious, the infant is anxious. There are studies indicating that short-lived acute maternal stress has no long-term effect on the baby. Chronic stress for which there is no resolution tended to produce children with a heightened incidence of physical and emotional disorders in most studies. There is some evidence that strong maternal love and desire are mediated by neurohormones, implying that the fetus perceives the mother's feelings. In a study of two thousand mothers followed through pregnancy, delivery, and up until the child was four or five years of age, the maternal attitude toward the unborn child was the most critical factor influencing the child's physical and emotional health. One wonders about the care with which such studies were performed. Notwithstanding the importance of the maternal love and desire for her unborn child, it seems that the factors that interfere with bonding once the child is born must be of equal, if not greater, significance.

Aside from the effects of maternal drug or alcohol consumption, studies on maternal deprivation during pregnancy reveal interesting hormonal effects. For example, a study of Dutch mothers who suffered from famine in World War II revealed an unusual incidence of obesity in their progeny. This was particu-

larly pronounced when the hunger occurred in the first four or five months of gestation. It indicates a relationship between maternal hunger and an inappropriate setting of the infants' hypothalamic appetite gauge.

In tests to find if the fetus is responsive to conditioning, loud noises elicit a kicking response at six months. If a vibratory stimulus was associated with the loud noise, the fetus could be conditioned to kick when presented with the vibratory sensation.

The anecdotal material on intrauterine memory is fascinating: A conductor notes that the cello lines of a particular score leap out at him. He discovers later that his cellist mother practiced these passages during her pregnancy. An autistic child of French-speaking parents is put at ease when English is spoken. His mother worked in a store in which English was spoken during the pregnancy. Recent studies (not cited in the book) indicate that infants show a preference for stories that are regularly read aloud daily from the seventh month of pregnancy.

The correlation of sensory discrimination and fetal development has been documented. At four to five months, the addition of saccharine to the amniotic fluid doubles the swallowing rate. After four months, shining a bright light on the mother's abdomen causes a startle response or aversion of the fetus's head. From the seventh to eighth month, the EEG reveals the pattern of REM in the fetus. In adults, REM sleep indicates a time of dreaming. What might it signify in a fetus?

Other studies show that smoking lowers the oxygen content of maternal blood and causes an increased heart rate in the fetus. One study indicates that the fetal heart rate increases when the mother *thinks* of smoking. Apparently, the depth of this symbiotic relationship extends to realms beyond our knowledge. A Finnish study of women whose husbands died during pregnancy or after delivery reveals a marked increase in psychiatric disorders in their children. In those whose husbands had died during pregnancy, the incidence of schizophrenia in the off-

spring was particularly high. In general, there is a positive correlation between mothers who are chronically anxious and children with low birth weight, gastrointestinal disorders, reading difficulties, and behavioral problems.

The authors make a case for prenatal bonding, citing one in which animal studies such as chicks hatched in a brooder were found to be less responsive to their mother's call and to make a slower adjustment to their environment than chicks hatched by their mothers.

An interesting study of schizophrenic mothers is cited. First, there is a higher rate of birth complications in schizophrenic mothers, which is not unexpected. But of the 170 children of schizophrenic mothers studied, 20 had developed symptoms of the disorder, and 70% of these suffered one or more complications during pregnancy or birth. Only 13% of the remainder were reported to have complications.

To illustrate the loose thinking that one encounters in this book, consider the following:

1. In a study of 400 mothers who, during their pregnancy, feared the responsibility of parenthood or the possibility of a defective child, there was an increased incidence of spontaneous abortion. Rather than consider the possibilities of attitudes translated into chemical effects, the authors attribute the results to the fetus's ESP.
2. The intensive craving for physical contact in those born by Caesarian section is attributed not to the separation of mother and child at birth, but to the sensual deprivation of a vaginal birth.
3. The authors' observation that those born prematurely tend to feel rushed and hurried throughout their lives.
4. Among the birth memories of several subjects, one remembered his mother being scared and concluded, "I'll have to do it all by myself." Another describes his mother's Caesarian section: "I could

- feel her terror as the knife began cutting across her stomach."
5. The fascination with tricks of magic, such as of pulling rabbits out of a hat, is explained as follows: "This symbolic recreation of man's magic emergence from the womb is why magic had such a powerful tug on the human imagination."
 6. Those who have aversion to head coverings and neckwear suffered from bad birth experiences.
 7. The mode of passage through the birth canal is said to govern adult sexual practices and preferences. For example, those born by Caesarian birth fail to gain the sensory experience that conveys the extent of their bodies; hence they are clumsy in lovemaking.
 8. Phallic males who make an endless round or sexual conquests "attempt to recapture the serenity of the womb."

The later chapters—on the choice of an obstetrician, a comparison of the prenatal instruction methods of Lamaze, Bradley, and Dick-Read, maternal bonding, child development in the first year, the implications of abortion, surrogate-motherhood, and test-tube babies—are essentially reasonable. The need for humanizing obstetrical practice and the dangers of neonate I.C.U.s are among topics reviewed in the final chapter.

Birth Reborn

by MICHAEL ODENT M.D.

Random House, Inc., New York and Canada, Toronto, 1984, 123 pp. \$14.95

Whereas Dr. Verny and his coauthor are prone to hyperbole, slightly sensational conclusions, and purple prose (they describe a hospital delivery as "a group of strangers who clutch, probe and pull at the baby"), Dr. Odent, the author of *Birth Reborn*, offers only conservative, cautious and carefully considered opinions in describing how he found his way to his unique methods of conducting the birth of babies. If, when we hear rumors of this obstetrician, who delivers babies under water and lets the infants swim to the surface, we prejudge the procedure as a crackpot scheme to exceed Leboyer and his birthing bath, we would be wrong.

Dr. Odent was trained in general surgery with a speciality in orthopedic surgery. He is credited with devising helpful, innovative techniques in orthopedic practice. He was appointed chief of surgery at a community hospital in the French Village of Pithiviers. That position included the care of the obstetrical patients, an area in which Dr. Odent had no special training.

Perhaps because he had no intensive obstetrical training, and hence no strong medically-modeled prejudices in the field, the more he witnessed conventional obstetrical practice, the more he became convinced that it was perverse. What should be a natural process was turned into a medical procedure. His historical research revealed that what had been a procedure conducted by knowledgeable women became a medical specialty in France in the 17th century when the forceps were invented and applied by physicians. Until that time, women were usually delivered in the squatting position by midwives. The introduction of forceps forced the delivery into the supine position, and there it has stayed, despite the obvious fact that the supine position is unphysiologic since the baby must descend.

What struck Odent most forcibly was that modern obstetrical practice drained the sexuality from the childbirth experience.

His introduction to Leboyer's consideration for the sensibilities of the newborn was

a powerful learning experience. "Leboyer created a language new to most doctors—a language that spoke to our sensitivity and emotions as well as to our intellect. He showed us the newborn not as an object unable to see, hear or feel but rather as a human creature in need of warmth and nurture. In short, Leboyer was the first doctor to express what many women intuitively know about their babies." That Odent was unaware that Reich had expressed concerns for the sensitive newborn decades before Leboyer, and far more comprehensively, is an unfortunate fact, but understandable. To his credit, he correctly criticized Leboyer for controlling the birth process and excluding the mother.

With the sensibilities of a competent orthopedist (or a good plumber), Odent set about correcting the unphysiological features of obstetrical deliveries as they were conventionally performed. He noted, for example, that delivery in the supine position not only contradicts the uses of gravity, but that it compresses the major blood vessels that supply the placenta, decreasing oxygenation to the fetus.

Operating not from the premise of one who knows all the answers, but as one who seeks to learn, he discovered that, as he gradually left delivering mothers to find their own ways, new usages evolved. The dorsal position on the delivery table was replaced by a low platform with bright pillows in a room with cheerful colors on the walls. It was "more like a place to make love than a hospital room." The woman could do exactly as she liked. There were well-trained, friendly midwives to aid and assist her. Childbirth was being given back to women.

In the early stages of labor, the women walk about in the woods and hospital paths, with the midwives, their husband, or children, and do whatever they wish. In this climate, Odent noted that, when seized with uterine contractions, the women altered their positions in physiologically efficient manners and often made unselfconscious sounds and movements.

There is no training for delivery, no breathing methods are espoused, nor instructions in utilization of contractions or recovery from pain. During pregnancy, the expectant mother becomes at home with the hospital surroundings, the personnel, women who have already given birth and come back to visit, and the other expectant mothers. Once labor sets in, there are no techniques for the mother except to forget any preconceptions and do whatever she wishes—to give in to herself. In the last moments of labor, women often stand and flex their knees, supported by their mate.

As the first stage of labor advances, the mother moves into a comfortable, soothing, dimly lit room. She removes her clothing, resting on someone or on the furniture. Some lie curled on their side or stand asymmetrically because the baby makes a spiral descent. The women are supplied with fluids and calories *ad lib*. The woman's demands are responded to, not anticipated.

If her contractions stop, she is placed in a warm bath. Here she is weightless; her muscles relax, and the relaxation aids cervical dilation. Many mothers say they feel drawn to water.

At the end of the first stage of labor, many women have a distant look, repeat single words or simple sentences, and appear to have withdrawn into themselves. This Odent considers to be the desirable state. He determines the second stage of labor not by vaginal examination but by noting the mother's tendency to flex her knees during contractions and her urgent need to grasp someone or something. If she is squatting with support, her legs spread apart and the vulva opens wide. At this point, she may lose sphincter control. Most women deliver in this squatting position with support. Infants are only born in the water when the mother has sought relief in the pool, and the last stages of delivery occur there. There is no danger to the child when this occurs because infants take their first breath only in air.

Following the birth, the infant is placed in the prone position between the mother's knees, with its head turned to the side to prevent any fluid from gravitating to the lungs. It often takes only seconds until the child coughs or sneezes, cries, and "pinks up." It is then placed at breast. There is no clock in the room; contact takes its own time.

In the early days of Odent's obstetrical practice, babies were swaddled according to the French mode. Odent soon recognized that the swaddled babies took longer to suck because they were not free to touch their mother's skin.

Odent assumes that women permitted to assume the natural play of vaginal delivery enjoy the free flow of their own oxytocin (which induces uterine contractions and defends against pain), and their own endorphins (which quiet pain and possibly aid in forgetting previous pains), and a decrease in epinephrine. Pain-killing drugs and synthetic oxytocin destroy the natural hormonal play. He notes that the longer and more difficult the labor, the higher is the endorphin level. There are connections between endorphins, oxytocin, and prolactin. Breast-feeding seems to raise the endorphin level, and endorphins promote "grooming" behavior (which suggests there may be a hormonal basis for bonding).

He is aware of the risks entailed in employing these methods. But the process that returns childbirth to the mother is also the safest. The best perinatal mortality rates in industrial societies are 10/1000, and the Caesarian rate is up to 20. In the U.S., the mortality rate is 18/1000 and the Caesarian rate is 19%. Odent's mortality rate is 10/1000, and his Caesarian rate is 6-7%.

He curtails the use of ultrasound, amniocentesis, and forced bedrest when there is risk of premature birth. Most European countries have a prematurity incidence of 6%-7%. His prematurity incidence was 4.9% of 1000 births before December 1973, and 2.5% of the 1000 births from 1973 to December 1980.

While giving all of these statistics, I would emphasize that Odent's is not a skewed population. All who come to his hospital are admitted, and some come in serious trouble.

There is a far lower incidence of postpartum depression at Pithivier than is usually recorded. Though incubators are provided for premature births, most premature babies spend most of the time outside the incubator, with the mother. Of forty-five babies under 5.5 pounds born at Pithivier, not one has had to be hospitalized subsequently.

Odent does not rupture membranes to hasten the delivery, believing that this increases the risk of maternal infection. He assumes that, when indicated, he can determine the color of the amniotic fluid (fecal coloration indicates oxygen deprivation in the fetus) by leaving the membranes intact and employing an amnioscope. Rupture of membranes is only performed in cases of marginal placenta praevia or when contractions cease with the cervix fully dilated. Pitocin is employed in fewer than 1/100 cases of difficult fetal descent. "Lumbar reflex therapy" (the intradermal injection of water in the lumbar area) is used when contractions are causing severe low back-pains and when cervical dilation has stopped at about 5 cm. The afferent stimulus from the skin seems to inhibit the deep pain. Forceps have not been employed since 1963, but a vacuum extractor is used in about 6% of deliveries. Episiotomies are performed in only 7%. He believes natural tears that are not extensive heal more readily than incised wounds.

Odent has discovered (or rediscovered) the virtues of "self-regulation" in the birthing process. He has restored the birth process to mothers and given the lie to the fiction that a mother delivering her baby is a patient. He is the best of physicians — one who uses his medical knowledge to assist nature.

*Morton Herskowitz, D.O.
Philadelphia, Pa.*

Communications and Notes

- Elsworth F. Baker, M.D. died June 2, 1985 after a long illness. Dr. Baker was the founder and President of the American College of Orgonomy, editor-in-chief of the *Journal of Orgonomy*, author of *Man in the Trap* and author of numerous clinical articles and articles pertinent to the history of orgonomy. Dr. Baker was a practicing medical organomist from 1946 to 1985. He was 82.

- We wish to thank Irmgard Bertelsen, M.D. for her work in translating some of the reference material for the wound-healing experiment.

- A two-day weekend laboratory course was held at the laboratory of the Institute for Orgonomic Science in Gwynedd Valley in October 1984.

- An advanced four-day laboratory course was held at the laboratory on May 16 through May 19, 1985.

Microscope Fund Update

In the spring of 1985, the Institute for Orgonomic Science instituted an appeal for funds to purchase a Zeiss Universal microscope, which had become an essential need in the biological research. We are pleased to report that the fund-raising was an unqualified success due to the large number of generous contributions. The Institute is currently in the process of purchasing the instrument and expects to begin using it in the next few months.

Educational Programs

The Institute conducts ongoing educational and training programs for medical students, physicians, and laymen which include:

- *Somatic and Psychic Biopathies:*

This course is offered to third- and fourth-year medical or osteopathic students and physicians. It is designed to enhance the student's classical understanding of disease processes through an in-depth exploration of

Reich's pioneering work in these areas. This course is not limited to students interested in becoming medical organomists. Applicants must be undergoing characterologic restructuring and be recommended by their therapist.

For further information, write: The Institute for Orgonomic Science, c/o Robert A. Dew, M.D., Box 304, Gwynedd Valley, Pa. 19437.

- *Training Program for Medical Organomists:*

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 biogenesis 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, c/o Robert A. Dew, M.D., Box 304, Gwynedd Valley, Pa. 19437.

- *Laboratory Course Offerings:*

Introduction to Scientific Orgonomy: For the student without a strong scientific background, a two-day, weekend course in the fundamentals of biogenesis and orgone physics is offered twice a year. The course includes lectures, laboratory work, and demonstrations. Enrollment is limited to 10 students. Course fee: \$200. The next course will be offered in May 1986. If you are interested in taking the course, send a brief resume to the Institute, including scientific background (if any) and experience in orgonomy.

Advanced Laboratory Course in Scientific Orgonomy: This Course is designed primarily for physicians and students with a strong scientific background (it is also open in selected cases to those who have completed the two-day course). It is a more comprehensive, four-day course in biogenesis and or-

gone physics, with lectures, laboratory work and demonstrations. Enrollment is limited to 12 students. Course fee: \$350. If you are interested in taking the course, send a brief resumé of your scientific background and experience in orgonomy to the Institute.

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