Orgone Therapy*

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This article is specifically addressed to medical orgonomists in training. Only a physician well trained in both psychiatry and medical orgonomy should attempt to use this form of therapy. In untrained hands, disaster can result.

Orgone therapy differs from other disciplines in that it is primarily concerned with an energy concept of functioning, that is, with the movement and blockage of energy in the body. It was developed by Wilhelm Reich, who found that those of his patients who attained health had developed a satisfactory sexual life, while the failures did not. Thus he postulated that, to cure a patient, libido stasis must be overcome and its recurrence prevented by adequate sexual outlet. Reich therefore set about ascertaining just what constituted a satisfactory sexual life. He found that sexual activity in itself did not necessarily achieve this, even where the man had an ejaculation and the woman a clitoral climax. A specific type of capacity for sexual gratification was necessary. Reich called this capacity for gratification "orgastic potency." It entails an absence of holding in the body and a complete giving in to the bodily sensations. The act ends with total involuntary convulsions of the body and a tender, grateful attitude toward the partner. In women, a vaginal, rather than a clitoral, climax occurs.

All this meant that the libido must be more than a psychic concept, as Freud had postulated. It must be a real energy. Reich called it "orgone" energy from "organism" and "orgasm." Energy is constantly being,built up in the body by the intake of food, fluid, and air, and by direct absorption through the skin. It is discharged by activity, excretion, emotional expression, the process of thinking, and conversion into body heat, which radiates to the environment. It is also

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used up in growth. In the usual course of events, more energy is built up than is discharged.

Thus, to maintain a stable energy level, excess energy must be discharged at more or less regular intervals. This is the function of the orgastic convulsion. Reich determined that one who has a truly adequate sexual release cannot maintain a neurosis. Neuroses exist only on repressed excess energy or stasis. Reich thus developed a concept of health based on energy metabolism of charge and discharge, which he called "sex economy."

However, in our society, a child is not permitted to function naturally. Starting from birth, the environment that greets the newborn is mostly unfriendly. The atmosphere is cold compared to the warm uterus, and the baby is treated roughly. It is separated from the mother, whom it continues to need for warmth and contact, placed on regimented feedings from what are frequently the cold, dead nipples of a contactless mother or an inanimate bottle, and subjected to circumcision. Later, the child is subjected to too early toilet training and denied any sexual pleasure. All of this forces the child to hold back his feelings and expressions, which is accomplished by holding the breath and tightening the muscles of his body until, finally, he goes through life with restricted breathing and a rigid body. Reich called this the "armor."

The permissive upbringing that has prevailed in the last few decades produces intense anxiety in the child, a feeling of being unloved and undirected, which ends up with hatred of the parents. It produces an even more malignant condition than the severe regimentation of previous years.

The armor binds energy, making it unavailable for normal functioning. Armor interferes with the free flow of energy through the organism, especially to the pelvis and genital, thus preventing adequate discharge of energy through sexual activity. The individual develops erective impotence, premature ejaculation, sexual anaesthesia, or in some other way is unable to achieve full sexual pleasure. Reich termed this "orgastic impotence." He found that the

majority of individuals, both male and female, suffer from this condition, that their undischarged energy continues to build up, produces stasis, and eventually overflows in the form of neurotic symptoms.

The goal of therapy is to overcome this stasis by freeing the holding (the armor) in the body and reestablishing the free flow of energy. This allows the patient to regain or achieve orgastic potency and, with it, adequate functioning and independence in all areas of life. This is simple in principle, but, in practice, it may be extremely difficult and complex—even at times impossible.

There are three avenues of approach, the priority of each depending on the individual case, although all three are necessary tools in every case. They are:

1. Breathing, which builds up energy and exerts an inner push on the blocks. It may overcome lesser holding and helps to reveal and overcome more severe blocking. The patient is asked to breathe fully, without forcing it, and allow himself to develop a rhythm, which soon becomes easier and freer. Fuller respiration is established. The patient should be allowed to breathe for some time before using any attack on the armor. Breathing may in itself produce considerable emotional release, especially of anger or crying. Usually, sensations are produced (orgastic streaming) that travel down the body until they reach a block. The block can then be seen and removed. Reich said these sensations are even more important to produce than emotional release. Where currents are not produced, but fear and hatred are shown, one may get a paranoid or schizophrenic breakdown when the currents do finally appear. Patients who develop numbness of the arms may go into shock and anorgonia. Marked defensive movements such as opisthotonus and marked depersonalization symptoms may indicate that one is dealing with an underlying catatonia. When the plasmatic currents concentrate in the genital, they may precipitate a catatonic attack in such patients. One should permit the patient to retain the defensive movements until he realizes that he uses them as a defense. They can be stopped. Later, the same defenses can be used to hide

conflicts other than the original one. However, restless patients should be told to stop their movements because they are holding back emotions or plasmatic currents. Defensive movements against the orgasm reflex are usually side-to-side movements.

In dealing with asthma, the patient should forcibly exhale and then quickly inhale to break through being stuck in the vagotonic phase. Sighing out loud while saying "aah" helps to open the throat and produces vibrations in the chest, which tends to break down the holding in the chest. If the jaw is tight, the sound will be "haah" instead of "aah." Only the latter opens the throat. If the patient does not or cannot breathe well, sometimes counting out loud may improve the breathing. One patient who never could breathe adequately got sensations in the legs for the first time when counting. She then said they were uncomfortable, which showed that she did not breathe fully in order to hold down sensation. In all cases where breathing is inadequate, the spinal muscles must be checked. They may be tight and not allow the chest to move. Kicking may improve breathing and get energy moving, as will also exciting the patient by emotional display. The epigastrium may be tight and that, too, will interfere with breathing. Place the hand on the epigastrium and gently but firmly press down. When gurgling is heard, relaxation has occurred. Sometimes, patients do not breathe because something that concerns them is on their mind.

In most cases, breathing will soon produce tingling of the fingers and lips. If breathing continues, the sensation increases to strong and sometimes painful currents, resembling sensations from an electric current. The fingers stiffen, begin to flex, and become immobile. They may continue until the whole arm is involved and eventually the chest and face. At this point, the patient can stop his breathing only with difficulty, and the situation becomes dangerous to life. The contraction must be overcome by stopping the deep breathing and manually mobilizing the fingers and arms. The contraction is a defense against a movement of energy that is beyond the patient's tolerance. Later in therapy, patients may breathe as much as they like

with no contractions. The contractions may reappear, however, after each breakthrough to a new level.

With breathing, trembling frequently occurs. It may start in the thighs and extend to the whole body. The armor is being dissolved as the energy is discharged in the trembling. It is a curative process and greatly to be desired. It should be allowed to continue and stopped only when the patient becomes tired. It usually stops spontaneously. Trembling occurs only in the presence of armoring. It does not occur in the healthy individual.

2. *Directly attacking the spastic muscles to free the contraction.* The contraction of the skeletal muscles can be worked on directly, the muscles of the organs and tissues only indirectly. To mobilize the skeletal muscles, one must first increase the contraction to a point that cannot be maintained. This is done by direct pressure on the muscle with the thumb or by otherwise irritating it. Best results are obtained by pressure near the insertion of the muscle, which is the most sensitive area. Of course, the muscle will only contract again unless the emotion (or idea) that is being held back is released and expressed. For this reason, groups of muscles that form a functional unit in holding back emotions are worked on together. Even this is not enough unless the accompanying anchored history is also released, e.g., drawing away from a forced enema or ducking an expected blow from behind. Where muscles cannot be reached by the hands, other methods must be used, such as gagging to open the throat muscles or mobilizing the eyes and the whole eye segment in order to release contraction in the brain. The latter can be accomplished by having the patient follow a moving finger or penlight with his eyes, while constantly being kept in contact with what he is doing. In gagging, the patient puts his finger down his throat, while continuing to breathe, until the gag reflex is elicited. During breathing, if the patient feels he is choking, have him gag himself.

The therapist feels the patient's armoring as foreign and removes it to get in contact with the patient. One makes a consistently direct attack on the armor only in: 1) hypertensives (the heavily armored),

who are like logs; 2) those who are flaccid and lie quietly. One has to force things out of the latter. Their hypomotility is used as a defense. The chest must be pushed down and the patient asked to pump air in and out.

3. *Maintaining the cooperation of the patient.* This is accomplished by bringing his resistances to therapy and the therapist into the open and overcoming them. This is extremely important because the patient will in every way endeavor to maintain his immobility, trying desperately not to reveal himself. Behind this is an intense fear of expansion and movement. The patient always begins therapy with distrust and suspicion. This resistance is emotional and cannot remain hidden indefinitely. It must be recognized and brought to the surface. Every defense begins with a negative transference. The patient must discuss this freely. A lack of negative transference is due to its being blocked by the therapist's being consistently friendly or otherwise preventing the patient from expressing hostile feelings toward him. The patient may assume an attitude to hide a more important one; for example, he may be laudatory when he wants to criticize. Each time a new resistance is attacked, it reactivates an old one. The therapist focuses his attention on the behavior of the patient and asks himself, "Why does he do it?" One must point out the patient's attitudes to him repeatedly or mimic his behavior. It is necessary to be consistent. The armor protects against stimuli from without and from within. Therapy upsets this equilibrium, which is what the patient resists. He will become talkative, anxious, aggressive, spiteful, affect lame, and so forth. This must be properly pointed out and corrected. The resistance is always attacked from the ego side. The patient understands it better and thus the negative transference is dissolved. We are not concerned with what he wards off but that he does ward off and how. Lastly, *what* he wards off comes out. Remember, patients who intimidate you and make you reluctant to question them fully or say what you think are using their ability to intimidate as a defense. It must be brought out into the open.

No patient is capable of a positive transference at first. A seemingly positive transference is either a compensation for transferred hatred, guilt covering up underlying hatred, or narcissistic expectations of receiving love from the therapist. If this is not recognized, one will eventually run into an extremely difficult or impossible resistance. A real, positive transference is always genital and is met only when one reaches the pelvis. It is dealt with during the end phase of therapy.

It is always important to start right and to be consistent. A general rule is that, if you do not know what to do, do nothing until the situation becomes clear. Don't be afraid to say, "I don't know." Also, let the patient know that you don't expect him to accept anything you say unless he feels it is right.

It is also important to always know where you are in therapy, that is, where the energy is. During the first ten minutes of each session, repeat quickly what you did the previous session. When you are stuck and nothing happens, orient yourself as to what is going on in the patient and let him breathe for a time. If you are still unclear, work on the legs. This frequently starts energy moving and makes the situation clear.

The best and most lasting results have occurred from something I have said rather than somatic work on the armor. I once saw Reich get a patient to give in completely by simply saying, "Now just let go." Learn to trust your feelings as to what to do or say. They are usually right.

When the patient is lying on the couch, the place where he puts his hand on his body is the vulnerable spot; he is trying to protect it.

The patient is advised to make no crucial decisions during therapy such as marriage, divorce, etc., unless it is imperative. If a married patient enters into an affair, he should not tell his mate unless he plans to terminate the marriage. Telling only hurts and never helps. Those who say they wish to be truthful only want revenge.

A chaotic[1] situation can be produced by:

1. Too early an interpretation.

chaotic situation occurs when material from all levels comes up at the same time or when all the therapist can elicit from the patient is spasms.

2. Interpretation in the sequence presented by the patient.
3. Interpreting without first eliminating the resistance.
4. Inconsistent and unsystematic interpretation of resistance.

No interpretation should be made in the presence of resistance. Latent resistance is shown by extreme compliance, stereotyped politeness, affect lameness, or a lack of genuineness, e.g., the inward smile.

Dissolving the armor renders the patient helpless. His potency breaks down from castration anxiety, and he feels his whole character as sick, not just his symptoms. If potency does not break down, therapy has not touched him. One forbids sex only in compulsive sexuality. Sex aids in draining off stasis. Pregenital sexual fantasies during coitus or masturbation should be discouraged.[2]

Always attack the "I can't" rather than "I won't." If this is successful, the "I won't" disappears. In expressing an emotion, the patient does not talk but is allowed to fully experience the emotional outlet. Afterwards, the patient is asked what thoughts or pictures he had. If there are none, ask him if his behavior did not correspond to or remind him of some childhood situation. Sometimes, a pat on the head will facilitate recollections. Where a patient presents a ducking attitude, remember that verbal attacks in childhood are even worse than physical attacks. One can recover from the latter.

When the energy is freed from its anchoring in sadistic, narcissistic, and pregenital fixations, acute anxiety is liberated as energy flows to the genital, reactivating infantile anxiety hysteria with a return of symptoms.

Signs of success in therapy are that the patient can masturbate and fantasy incest without guilt, and that he can experience genital sensations during therapy, which means castration anxiety has been overcome.

Obstacles to success are age, rigidity, and environment. The last factor may present real circumstances over which the therapist has no control. For example, a woman who has several children may be

% a patient practices sexual perversion, this, too, should be stopped; regular sexual activity is desirable and permissible.

married to an impotent man whom she cannot leave for security reasons.

Dangers one may meet are: acute anxiety, depression, and treating new types with which one has had no experience.

Lastly, the genuine, positive transference dissolves as the patient transfers the feelings to an appropriate love object. Difficulties here are: 1) unresolved guilt, with sadistic impulses; 2) a secret hope to attain the therapist; 3) the therapist becomes a protecting mother; 4) a fear of sex and society.

When the patient begins to feel his own restrictions and gains sufficient contact with his organism so he knows he is holding back and wants to free himself, he can be very helpful in therapy. His lack of contact is one of the most difficult problems to overcome. It must be pointed out to him by describing his behavior and the difference between the ideal he sets for himself and the emptiness in which he lives. Dulling and withdrawal in the eyes must be overcome. An inability to make decisions may be an indication that he is afraid to make contact. He cannot commit himself and holds himself above the crowd. When he complains, "Nothing touches me," he is contactless.

Worrying if someone is in the waiting room comes from the patient's not having been allowed to express himself as a child. His rights were not respected. If he cannot express his feelings, have him fantasize the feelings. Later, he may be able to express them.

Patients who are very castrating use this attitude as a defense against feeling. They cannot tolerate sensations. The nearer they come to health, the more intense is their tendency to castrate. Spite also is a defense against intolerable sensations that cause anxiety. We do not allow patients to wallow in their spite; one cannot use his neurosis as an excuse to be nasty. Nor do we allow patients who have been referred by another orgonomist to vent their hate on him. They will give the excuse that you want them to express their feelings. Your answer is yes, but not at the expense of one who doesn't deserve it. Tell them to take it out on the couch. They are, however, allowed to express honest problems they had with a previous therapist. Patients must learn to

behave rationally and decently. Also, they should not gossip about therapy.

Anxiety is the basis for all repression and is behind all contractions. The patient is always trying to control anxiety, and cure is effected by forcing the patient to face his anxiety and express his forbidden feelings. The most important emotion to elicit is rage, and, until this is released, he cannot experience the softer feelings of love and longing. It must be released from every segment.

Through reactions of the body during the process of dissolving the armor, Reich discovered that the body was functionally divided into seven muscular segments, each of which reacts as a unit and is to a certain degree independent of the other segments. The seven segments are the ocular, oral, cervical, thoracic, diaphragmatic, abdominal, and pelvic. They are usually freed in that order, except that the chest is most often mobilized first so fuller breathing can be used to build up energy in the organism and provide additional inner push to help in both revealing and removing other blocks. This does not apply to persons with a high energy. In the high energy types, one must open up a place to drain off the energy to be released from the chest. Usually the legs can be opened up before the chest for this purpose. This does not affect the pelvis, even though the legs are part of the pelvic segment. The energy bypasses the pelvis. (One must not confuse drive with high energy.)

Any one segment may fail to respond completely until further segments are freed. With each release of a segment, armoring in earlier segments may recur and require further attention because the organism is not used to movement and tries to return to its former immobility. It must gradually become accustomed to free mobility. One may have to repeatedly return to earlier segments and free them. A symptom does not clear up until all factors in its origin are dealt with.

One works from the head down, removing the layers of armoring from the superficial to the deep. There are three basic layers in every armored individual:

1. The social fagade, that part which is presented to the world.
2. The secondary or great middle layer where all of the repressions have built up, resulting in destructive forces such as rage, hate, and spite. Here there are usually many subsidiary layers. This is the Freudian unconscious.
3. The healthy core, which expresses itself when all blocking has been removed.

As the organism develops from infancy, it is subjected to repeated restrictions of its natural and even its secondary functioning. Each prohibition becomes part of the character through fear of punishment or rejection and is retained in the armor. There is an increase in inner tension, which produces a harshness that expresses itself as hate. This must again be repressed, so only modified expressions such as contempt or disgust are allowed to come out.

The social fagade takes its structure from the great middle layer which is usually very complex, many sublayers being piled one on top of another until a social adjustment has been reached. The social adjustment presents as the social facade. It may be comparatively stable or unstable depending on the effectiveness of the defenses in the middle layer and the degree of satisfaction the organism can still attain. The social fagade contains one—or possibly more—basic character trait that causes the patient to react the same way to each problem he meets. It becomes the main character defense. Reich called it the ***red thread.*** It must be recognized and understood to properly evaluate the patient. The basic character trait is never dissolved but remains always an integral part of the personality, although it may be modified. It may be socially acceptable, such as shyness, timidity, modesty, or reserve, or socially unacceptable, such as dishonesty, cunning, or cheating.

The three layers are dealt with in each segment as it is mobilized until the final core of unitary vegetative functioning is reached. The depth of the layer on which one is working is recognized by the extent to which the organism is involved in the process and the ability of the

patient to function. If the first four segments are free, one is always working at a deep layer.

With these general considerations, we will now turn to the practical application of this technique.

Prior to any therapy, it is essential to obtain both an adequate history and a physical examination. The history should contain only relevant facts and be short enough to be readily usable and* still contain enough information to give an adequate picture of the patient in both his past and present functioning. The history itself is meaningless. What is important is the patient's reaction to the events that are anchored physiologically in the character structure. These are the things that therapy stirs up. It is important to estimate the stuff the patient is made of. Has he accomplished a great deal against all odds, or has he succumbed to the least frustration? Has he been able to socialize, or has he avoided contact with people? Has he made a good adjustment to the opposite sex or failed in this? When was his first sexual experience and how many partners has he had? What sexual difficulties has he had, and what fantasies does he have? Does he masturbate? When did he start? How does he masturbate and with what fantasies? Is it done out of anxiety or for pleasure? Have there been any homosexual experiences or desires? Homosexual experiences before the age of sixteen are of little significance. Remember that a patient will not tell the whole truth until the end of therapy. One of my married patients early in therapy admitted to one extramarital affair. Later in therapy, he told me he had really had two affairs. When we came to the end phase, he confessed that he had felt guilty over his affairs and could not tell me the whole truth, but he'd really had numerous affairs.

Is the patient willing to make a real effort to get better, or does he want it made easy? I once had a call from a woman in New York City who wanted therapy. She lived four blocks from my office. I could not see her, so I referred her to a medical orgonomist whose office was sixty blocks downtown. She said that was much too far to go. I exploded and told her of my patients' commuting from Boston,

Buffalo, Washington, Richmond, Roanoke, Cleveland, Minneapolis, and even one from Los Angeles. In addition, some had moved to New York from Florida, South Carolina, Texas, California, and Utah in order to have therapy. I suggested she abandon the idea of therapy. No therapist was going to carry his couch over to her place and give her therapy.

The physical examination is important and should be done on every patient either by the examiner, if he wishes, or by the patient's own family doctor. When patients call me for an appointment, I ask them briefly about physical illnesses. Many times, they have an illness or condition that should be attended to even before I see them. It is amazing how physical conditions are neglected. Any physical disease is a complication to therapy and should be corrected if possible. The somatic biopathies, that is, those physical illnesses due primarily to emotional repression, make therapy that much more difficult. They are principally asthma, hay fever, peptic ulcer, spastic colitis, hypertension, and many heart conditions, as well as hemorrhoids, fibroids, ovarian cysts, and even cancer. Also, many skin conditions are biopathic, which usually means that the skin is not capable of holding an adequate energy charge; this may cause a great deal of trouble during the course of therapy. I have found these patients extremely difficult in most cases. The breasts should be checked routinely for growths. The somatic biopathies should be treated also by a suitable specialist, although the patient may protest vigorously and expect orgone therapy alone to handle the condition.

In all cases, watch for physical and emotional emergencies. Have suicidal and impulsive patients promise to call you should they have any suicidal or dangerous impulses. They may call if they only feel panic. Those schizophrenics who may lose contact and become psychotic should be made to promise, in therapy, to stop any action when you ask them to. Therapy is flexible. One is always concerned with the patient and watches his needs.

Treatment requires that the patient lie on the couch with only shorts or panties on, so the therapist can adequately observe and treat

the condition the patient has presented to him. The patient must understand this. Hysterics may not be put on the couch for two or three sessions but allowed to sit up fully clothed, and may even wear their clothes on the couch until they are comfortable enough to undress. They are always suspicious of your intentions and do not trust you. Aggressive patients are handled much more easily if they are lying down.

Some patients will require that their ego be built up, especially those who have a lot of anxiety or a low opinion of themselves. This is done by presenting specific facts, not generalities. For example, you may say, 'You have very nice features, but your expression detracts from them. When your expression changes, you will be pleased with your looks." Or, one may point out what they have accomplished, etc. They will always minimize this. Do not argue with them.

The first step in treatment is the selection of patients. Except for young children and infants, accept only those who request therapy themselves. Do not accept any who come because a husband, wife, parent, or friend pushes them to have therapy. It is difficult enough when the patient earnestly desires help—impossible when it is forced on him. Never accept a patient you do not like. Therapy is too difficult to deal objectively with one you do not like, and it is not fair to either you or the patient. Also, it is advisable to take those you understand the best and can work with the most easily. Criminals and drug addicts are usually not good candidates for therapy, certainly not unless they stop their illegal activities, nor are very religious persons, especially Catholics and orthodox Jews, and, of course, neither red nor black fascists.

The second problem is whether the candidate is ready for therapy. This may not be determined immediately but should be watched for very carefully. The situation is suspect if the patient cannot grasp what is required of him and therapy seems alien and not understandable. Those who grasp it immediately and understand what you are trying to do are usually good candidates. If, however, one says, "I don't know what you want, it doesn't make sense," or "It is all silly," you should be

skeptical of his readiness. He may have to be told to come back in six months or a year to see if he is ready then. Unusual reactions such as blanking out, irrational reactions, turning blue or gray, shock, or extreme weakness make one wary and call for extreme caution. A tendency to develop serious physical symptoms as therapy continues is reason enough to discontinue treatment.

The third necessary requirement is diagnosis. Without an adequate diagnosis, you are always working in the dark and lagging behind the patient, unable to anticipate his reactions. With an adequate diagnosis, you are generally well aware of what lies ahead and can foresee what reactions to look for. One cannot always, and perhaps should not, make a final diagnosis during the initial visit. It may take several sessions and, with some patients, a diagnosis can only be made after continued therapy. I saw one patient who appeared to be a simple stasis anxiety during the first sessions. When I saw him again the next week, he was psychotic.

With the diagnosis, one determines what Reich called the "red thread." This is the way the patient will always react to any progress. For example, the basic red thread of every hysteric is timidity. One has to treat them as one does a wild animal that one wishes to tame. Being timid, they will always run when threatened, just as does a wild deer. Thus one must always be on the lookout for running away during therapy and even actual flight from therapy. This must always be kept in the foreground and pointed out to the patient whenever it arises. Thoughts and feelings toward the therapist should be discussed freely and frequently. A favorite way of running on the part of the hysteric is by flirting and trying to seduce the therapist away from penetrating her problems. If the therapist falls for this, the patient will bitterly accuse him of taking advantage of her and ruining her therapy. She will deny any part in the seduction. Actually, she is unaware of this trait, which must be pointed out to her repeatedly until she can recognize it in herself.

The phallic is usually aggressive and inclined to take over the therapy if allowed. It may be necessary to tell him not to say anything

and merely breathe and be passive until he develops considerable anxiety. He avoids anxiety through his aggression. This is important to recognize. His red thread must be determined. It may differ in each case. The repressed phallic is very righteous and has to become familiar with this tendency and become more tolerant. He, like the inquisitor, would burn his grandmother at the stake to save her soul. This, of course, is a defense against loss of control and se'xual abandon. The need for revenge against the opposite sex must be exposed in all cases, as also the defense against anal surrender.

Depressives must be mobilized actively to get them moving and reverse the shrinking process. They are encouraged to become aggressive and take chances. In fact, all patients must learn to take chances. If the depressive can express bona fide anger that he can feel, his depression usually lifts.

The diagnosis of chronic depressive is often made incorrectly. It is a very specific and rather uncommon condition. Chronic depressives are always very sensitive, have open eyes, and seem to have a strong, wide energy field in spite of low energy. They never have dreams of flying nor of doing things easily. They almost never dream in color.

The compulsive is cautious, heavily armored, and markedly ambivalent. One concentrates on attacking his doubting, which mobilizes his deeply buried hate—first, the anal hate (by squashing, kicking, and expressing meanness) and then the phallic hate (by piercing and stabbing movements). At the same time, one must repeatedly point out his caution.

The passive feminine is usually sneaky behind his nice, cooperative exterior. Aggression is encouraged to force out his anal sadistic rage. A great deal of character work is necessary to bring out the hate and spite behind the overtly compliant, cooperative attitude.

With masochists, it is necessary to turn the masochism back into the sadism from which it started. The patient will retreat back into masochism repeatedly, particularly when orgastic sensations or movements awaken his anxiety. The intense pelvic spasticity must be overcome.

The schizophrenic is always shy, although he may act in a bold and obnoxious manner to cover up this trait. The most important step is to mobilize his eye segment. This may bring out a great deal of anxiety and produce armoring in the rest of the body, which is later dissolved. If his illness pervades all aspects of his life, he is not a candidate for therapy. If only isolated areas are affected, one treats him but proceeds with caution.

The epileptic, like the schizophrenic, is armored primarily in the eye segment. There is usually a history of emotional outbursts. To desensitize him to seizures, have him initiate the convulsion by rolling his eyes upward but stop before the convulsion actually occurs, which can be done by bringing the eyes back into contact.