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**TOWARD A PATIENT-CENTERED UNDERSTANDING  
OF ORGONOMIC (REICHIAN) THERAPY**

by  
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## Abstract

THIS STUDY EXPLORES the experience of patients who have been treated with orgonomic (Reichian) therapy. The purpose of this study is to shed light on the experience of undergoing this therapy from the perspective of patients who benefited from it. A brief history of Reich and his theory and practice of orgonomic therapy is chronicled along with clinical and autobiographical accounts of treatment cases. Seven current or former patients who have been treated with and benefited from orgonomic therapy were interviewed using a qualitative, heuristic method yielding rich experience-near descriptions of the subjective experience, conscious and unconscious meanings, and functions/experience of orgonomic therapy. Interview data were inductively coded producing individual depictions for each research participant, a composite depiction, and six core themes of the experience: (a) entry into orgonomic therapy, (b) orgonomic therapist attributes, (c) orgonomic biopsychotherapy, (d) experience of the therapeutic process, (e) therapeutic results, (f) thoughts and feelings about orgonomic therapy. The results are consistent with Reich's theory and practice of orgonomic therapy and provide a broader, deeper, and richer understanding of the patient experience directly from the aggregate voices of those who have experienced and benefited from it first-hand. The results also indicate that patients who are treated with and benefit from orgonomic therapy feel innately and intuitively drawn to it. Clinical implications are offered along with recommendations for future study.

# Contents

ABSTRACT .....	III
INTRODUCTION .....	1
REVIEW OF THE LITERATURE .....	4
Understanding Reich: His Personal History .....	4
Reich's Theory.....	9
What is Character? .....	10
Unity of the Body and Mind: Armoring.....	12
Discovery of the Orgone .....	14
What is Orgonomic (Reichian) Therapy? .....	15
Character Analysis .....	16
Biopsychotherapy.....	17
Goals of Orgonomic (Reichian) Therapy .....	17
Dissolving Armor .....	17
Orgastic Potency.....	17
Genitality .....	18
Application in Clinical Practice .....	19
A Note on Touch .....	21
The Patient's Experience: What We Know So Far .....	22
Therapists' Single-Case Accounts.....	23
Therapists' Multi-Case Accounts.....	24
Patients' Autobiographical Accounts.....	24
Moving Toward a Patient-Centered Understanding.....	26
RESEARCH METHOD .....	27
Design .....	27
Qualitative Research Design and Methodology .....	27
Heuristic Research Design and Methodology .....	29
Participants .....	31
Sampling Strategy .....	31
Recruiting Procedures .....	32
Demographics .....	33
Instrumentation .....	34
Data Collection .....	34
Data Analysis.....	36
Thematic Coding and Analysis .....	36
Verification Procedures.....	38

## CONTENTS

RESULTS .....	40
Introduction to the Individual Depictions.....	40
Individual Depiction 1.....	40
Individual Depiction 2.....	44
Individual Depiction 3.....	48
Individual Depiction 4.....	51
Individual Depiction 5.....	54
Individual Depiction 6.....	58
Individual Depiction 7.....	62
Introduction to the Composite Depiction .....	65
Composite Depiction.....	66
Core Themes of the Experience.....	72
DISCUSSION .....	73
Theme 1: Entry Into Orgonomic Therapy .....	74
Theme 2: Orgonomic Therapist Attributes.....	77
Theme 3: Orgonomic Biopsychotherapy.....	81
Theme 4: Experience of the Therapeutic Process.....	86
Theme 5: Therapeutic Results .....	89
Theme 6: Thoughts and Feelings About Orgonomic Therapy .....	96
CONCLUSION.....	98
Clinical Implications.....	98
Limitations of Current Study and Suggestions for Future Research .....	99
Final Reflections .....	101
REFERENCES.....	102
APPENDIX A: INTRODUCTION LETTER TO RESEARCHER’S COMMUNITY .....	108
APPENDIX B: INTRODUCTION LETTER TO PROSPECTIVE ORGONOMIC THERAPISTS.....	110
APPENDIX C: INTRODUCTION LETTER TO PROSPECTIVE RESEARCH PARTICIPANTS .....	112
APPENDIX D: INFORMED CONSENT FOR RESEARCH PARTICIPANTS .....	114
APPENDIX E: BILL OF RIGHTS FOR RESEARCH PARTICIPANTS .....	117
APPENDIX F: DEMOGRAPHIC FORM FOR RESEARCH PARTICIPANTS .....	118
APPENDIX G: SEMI-STRUCTURED INTERVIEW QUESTIONS .....	119
ABOUT THE AUTHOR .....	120

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## INTRODUCTION

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Soul and body, as it seems to me, are affected sympathetically by one another: on the one hand, an alteration of the state of the soul produces an alteration in the form of the body, and contrariwise an alteration in bodily form produces an alteration in the state of the soul. (Aristotle, 350 B.C./1913, I:808<sup>b</sup>)

PERPETUALLY STEEPED IN CONTROVERSY, Wilhelm Reich is both idolized and reviled for his unique contributions to the field of psychology. As the founder and leading pioneer of somatic psychology and body-oriented psychotherapy, Reich holds a special place in the development of psychology yet remains largely an unsung hero (Fadiman and Frager, 1994). With the possible exception of somatically-oriented programs, most mental health practitioners will complete their education without hearing Reich's name. Yet, as Fadiman and Frager noted, his enduring contributions to psychology include his focus on the unity of body and mind long before it became fashionable (particularly in the west) and his innovations in character analysis and the unique physical manifestations of character (body armor) in each of us.

Orgonomic (Reichian) therapy is unique and very different from other therapies. Orgonomic therapists, as an example, treat their patients with physical, hands-on touch in addition to intervening with words. Whereas most psychotherapies privilege the mind, orgonomic therapy privileges the person. Patients in orgonomic therapy are treated as a whole, with verbal character analysis and biopsychotherapy seamlessly integrated. Biopsychotherapy, in the Reichian context, refers to therapy in which the patient lies down on a couch, mat, or mattress while the therapist physically and directly intervenes on the patient's muscles, assists the patient with his or her breathing, and asks the patient to vocalize and express emotion in a variety of ways. In addition to cognitive, affective, and perceptual changes, patients in orgonomic therapy often experience profound and sometimes sudden physical and behavioral changes.

## INTRODUCTION

Relatively little is known and even less is taught about orgonomic therapy, yet it is on the cutting edge of the emerging emphasis and focus on mind/body unity. Barnes, Bloom, and Nahin (2008) found that almost 4 out of 10 adults and approximately 1 in 9 children used what is termed complementary and alternative medicine (CAM) in the 12 months prior to publishing their study. CAM refers to “a heterogeneous spectrum of ancient to new-age approaches that purport to prevent or treat disease” (Barnes et al., p. 1), composed of alternative medical systems, biologically-based therapies, manipulative and body-based therapies, and mind/body therapies. Orgonomic therapy shares common features with CAM therapies, most notably a holistic approach and recognition of the integral relationship between mind and body. It differs, as well, in that it emerged from Reich’s psychoanalytic ideas and theory, unlike CAM therapies, which do not have a similar foundational base. Although Barnes et al. found that patients increasingly seek certain types of integrated mind/body therapies, recent trends (as exemplified in DSM-IV-TR) have pointed away from holistic and characterological understanding toward a reductionistic, atheoretical, and symptomatic description of patients. These trajectories exemplify two opposing trends in contemporary psychotherapy: piecemeal, symptom-reduction approaches based on DSM-IV-TR and the medical model, and holistic approaches that recognize the unity of mind and body.

This study sought to explore the question “what is it like to be a patient who has experienced and benefited from orgonomic (Reichian) therapy?” Although case studies exist, these are largely described in the voice of and from the perspective of the practitioner. Autobiographical accounts, in the patient’s voice and from his or her perspective, provide only singular data points with poor reliability and validity that lose meaning and comparability across accounts. There is a dearth of research that aggregates the experiences of patients in orgonomic therapy.

It is necessary to hear from patients to inform and deepen this conversation. Patients need to be included in the discourse. Orgonomic theory has historically been the primary driver in application and clinical practice; the patient’s

## INTRODUCTION

experience, *from his or her perspective*, has not. Many industries, health care in particular, have been moving toward patient-centered (or customer-centered) design and delivery of products and services for some time. Schoenbaum (2002) described this as “a health care system that is...designed from the patient’s perspective” (p. 4). Yet, simply hearing the voices of those patients is not enough. A rigorous research method and analysis are required in order to extract valid and reliable information from those voices.

Through experience-near descriptions from patients who have been treated with and benefited from orgonomic (Reichian) therapy, the subjective experience, conscious and unconscious meanings, and functions/experience of this type of therapy were explored in this research. This included seeking to understand (a) the basic elements in this transformative therapy, (b) the way in which the patient experienced deep and difficult character restructuring and allowed it to occur, and (c) the patient’s personal myths and what orgonomic therapy has meant in the course of their lives.

A review of the literature will provide an understanding of Reich’s personal history and the formation of his theory. Special attention will be given to describing orgonomic therapy, including specifics of how it is practiced. Lastly, a review of case accounts will be provided, illuminating individual, non-aggregated experiences from the perspective of the therapist or patient.

This study employed an analysis of verbatim transcripts obtained from individual semi-structured, in-depth conversational interviews with those who currently are or have been a patient in orgonomic (Reichian) therapy and have benefited from it. This analysis revealed common themes across individual accounts. All of this, of course, was uncovered and explored from a patient-centered perspective, ultimately arriving at a deep and rich understanding of the phenomenon, process, and experience of being a patient who has experienced and benefited from orgonomic therapy.

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## REVIEW OF THE LITERATURE

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### **Understanding Reich: His Personal History**

EVEN DECADES AFTER HIS DEATH, controversy continues to swirl around Wilhelm Reich, his ideas, and theories. Rarely do figures persist in attracting such abject admiration and caustic, unbridled derision and scorn. Reich felt this during his life and foresaw it following his death, stipulating in his will that his unpublished papers be kept secure and safe from destruction and falsification until a full 50 years after his death (Sharaf, 1983).

Although Reich's book *Character Analysis* "is generally acknowledged as a classic by many different branches of psychotherapy, most seem to have studiously ignored many other implications of this work" (Young, 2008, pp. 6-7). His subsequent and later works were, likewise, studiously ignored (Young). Cornell (2009) noted that Reich's ideas were "effectively undiscussable in the mainstream psychoanalytic literature" (p. 79). Baker (1986) more directly stated that Reich "has been incredibly misunderstood and maligned, and almost everything he has written has been misinterpreted" (p. 175). Reich's very name ultimately became "associated with unacceptable, repellant practices" (Cornell, p. 79). In referring to a patient's autobiographical account of orgonomic therapy, Neill (1971) stated "this book will be met with the scorn and hate of so many Reich enemies who dismiss him as a madman" (p. viii).

Shapiro (2002) wrote that Reich's works, particularly *Character Analysis*, "while very influential, have not been thoroughly exploited in psychoanalysis and psychotherapy" (p. 338). Shapiro reexamined Reich's work, which he characterized as "aimed particularly at producing genuine change rather than mere intellectual understanding" (p. 338). The fact that Reich's ideas had been neglected, and even reviled, left Shapiro believing that "a serious weakness of the psychoanalytic method" (p. 339) had not been fully addressed and corrected.

## REVIEW OF THE LITERATURE

“This neglect has meant a serious loss for psychoanalysis and psychotherapy” (p. 339).

Reich belonged to a middle generation of Freud’s critics, sandwiched between Jung and Adler on one side and Fromm, Horney, Sullivan, and Erikson on the other (Robinson, 1969). Although initially members of Freud’s inner circle (Cornell, 2009), this middle generation, including Ferenczi and Rank, made their most significant contributions to psychoanalysis in the 1920s and had a major falling out and split with Freud in the early 1930s (Fadiman and Frager, 1994; Robinson). Concerned with the post-WWI pessimism about psychoanalysis, Reich, Ferenczi, and Rank responded by examining and dramatically altering the traditional “talking cure” technique. Ferenczi and Reich, in particular, were “perhaps the two most prominent and ultimately most reviled apostates” (Cornell, p. 79).

Reich’s lesser-known status is due, in part, to the tremendous controversy that seemed to follow him everywhere he went. This controversy arose not only from building his career largely on studies of sexual functioning and the orgasm, but also his own personality; both left him vulnerable to moralistic and personal attacks. More specifically, Neill (1958/1974), a very close friend of Reich’s from their first meeting in 1936 up until the time of Reich’s death in 1957, believed that the enormous persecution of Reich was primarily due to the fact that Reich was the first to claim “that the adolescent had the right to a full sex life” (p. 379). Whatever the reason, the controversy over Reich’s work continues to this day.

Reich has been described as courageous, stubborn, tough-minded, extremely honest and even brutally direct (Fadiman and Frager, 1994), as well as aggressive, charming, vivacious, tenacious, patient, open, and unconventional (Raknes, 1971). Klee (2005) portrayed him as charismatic, controversial, and energetic. Several (Conger, 1988; Cornell, 2009; Fadiman and Frager; Klee) described Reich simply as brilliant. Waal (1958/1974), who trained with Reich at the Berlin Institute of Psychoanalysis in the early 1930s found Reich to be “an extremely dynamic personality with great intuition and imagination combined with thorough training and an active, creative mind,” as well as “temperamental and

## REVIEW OF THE LITERATURE

dominating” (p. 354). Placzek (1981), who prepared for publication over 20 years of letters between Reich and his dear friend, A. S. Neill, characterized Reich as “highly educated, enormously gifted, and of driving energy, who moved, thought, and worked always in high gear” (p. v). Placzek added that Reich was like a magnet, attracting a host of disciples and sycophants, none of whom could keep up with “his single-minded intensity or follow his leaping shifts to ever new areas of exploration” (p. vi).

Reich was a prolific researcher and writer with approximately 20 books, 100 papers, and 100,000 pages of manuscript (Baker, 1971). Cornell (2009) considered Reich to be “one of the more generative...figures in psychoanalytic history” (p. 79). Much of his later work remained unavailable to anyone, including scholars, until 2007, due to a condition in Reich’s will stipulating that his unpublished papers be kept secure and safe from destruction and falsification until 50 years after his death, as already mentioned.

As with all theorists, Reich’s personal history had a profound impact on shaping his own character, his world view, and his ideas and theory. Born in 1897 in a German-Ukrainian area of Austria, Reich lived on his family’s prosperous and large farm of approximately 1,000 acres. Both Raknes (1971) and Robinson (1969) indicated that Reich’s initial interest in biology and sexual functioning was nurtured in this bucolic setting. Although he was of Jewish origin, he never received any Jewish religious instruction and did not even consider himself Jewish or an adherent to any particular religious faith, especially later in life (Raknes). Any interest in religion, for Reich, was strictly from a scientific standpoint.

By all accounts, Reich’s father was jealous, authoritative, and domineering. His father insisted that only German be spoken at home, which resulted in Reich being isolated from both the local Ukrainian- and Yiddish-speaking children (Fadiman and Frager, 1994). Reich idolized his mother, who committed suicide when Reich was just 14. Her suicide was precipitated by Reich, himself, after having told his father of his mother’s affair with his tutor. This information is notably absent from several accounts of Reich’s life (Boadella, 1974; Raknes,

## REVIEW OF THE LITERATURE

1971; Robinson, 1969), underscoring the vast differences in how Reich is viewed and remembered as well as the allegiances and schisms present in the early years of psychoanalytic society that continue to persist today. Elsa Lindenberg, Reich's second wife, reported that well into his thirties Reich would sometimes wake in the night overwhelmed with the thought that he had killed his mother (Conger, 1988). Reich's father died just three years after his mother's suicide, when Reich was 17, and Reich's only brother died when Reich was 26 (Fadiman and Frager).

Reich received his medical degree at the age of 25, having already been a member of Freud's Vienna Psychoanalytic Society for three years (Fadiman and Frager, 1994; Raknes, 1971). Like Freud, Reich was very concerned with the role of society in creating instinctual inhibitions in the individual, especially as that relates to sexuality (Fadiman and Frager). This interest led Reich to become very politically active with the socialist and communist parties in his early 30s and to spearhead the development of highly controversial sex clinics that would still be considered forward-thinking and radical by today's standards. His sex clinics, for instance, provided intensive education on birth control and sexually-transmitted diseases, and distributed free contraceptives to anyone who wanted them. They also advocated for the complete legalization of abortion and "the right of every woman to her own body" (Boadella, 1974, p. 70), the abolition of any legal distinction between the married and unmarried, freedom of divorce, treatment (rather than punishment) for sexual offenses, and, according to Raknes, the abolition of laws against homosexuality and sex education, and sex counseling and nurseries in factories and businesses.

Reich's strong and radical views contributed to a life punctuated by stormy, broken relationships. Although considered by many to be "Freud's pet" (Sharaf, 1983, p. 5), Reich parted ways with Freud over theoretical differences when Reich was 30. In 1930 Reich left Vienna for Berlin, and then escaped to Denmark upon almost being imprisoned by the Nazis during Hitler's rise to power. He was subsequently expelled from Denmark and then Sweden, where he had later moved, because of his controversial theory. He was also expelled from the German Communist Party when he was 36 and expelled from the International

## REVIEW OF THE LITERATURE

Psychoanalytical Association when he was 37, though the latter was erroneously characterized by the Association as a resignation (Boadella, 1974). In essence, Reich's psychoanalytic leanings left him disenfranchised from the political organizations in which he took part, and his political leanings left him disenfranchised from the prevailing psychoanalytic movement, which wanted little or nothing to do with larger-scale political or societal change. After this, he renounced politics, seeing it as more committed to simple ideology than human possibility. He finally moved to Norway with his second wife, where he lived rather peacefully for five years until he was, once again, the target of controversy. This hastened his move to New York, alone now and separated from his second wife, where he had been offered an associate professor position. Reich had three different wives during his life, further adding to his strings of broken relationships.

In 1954 the U.S. Food and Drug Administration (FDA) obtained an injunction against the use and distribution of orgone accumulators (also known as orgone boxes), one of Reich's controversial inventions intended to channel cosmic orgone energy into a person sitting inside the box (Klee, 2005). The FDA pronounced Reich's claims about the accumulators to be unfounded and actively sought experts who would denounce his work. Upon being contacted, the American Psychiatric Association referred the FDA to Robert Spitzer, a premedical student in his last year at Cornell University who had recently conducted some experiments on Reich's theories of orgone energy (Spitzer, 2005). Reich was conducting research in Arizona when one of his assistants in New York violated the FDA's injunction, eventually landing Reich in a federal prison with a two year sentence. Spitzer was never called as an "expert witness." During this time the FDA went so far as to burn his books and publications that referenced orgone accumulators, which included a very large quantity of his work. Reich died in prison of massive heart failure, in 1957, at the age of 60. His death produced little fanfare or attention. In fact, not one scientific or psychiatric journal even mentioned Reich's death (Sharaf, 1983). Shapiro (2002) described Reich's rise and fall this way:

## REVIEW OF THE LITERATURE

He [Reich] had held a place in the psychoanalytic world that was more than promising; as a young man he had already made important and recognized contributions. By the time of his death he had become alienated from virtually all professional and personal contacts, apart from a few followers, and was occupied with fantastic and grandiose pseudo-biological and cosmological theories. (p. 338)

Shapiro was not alone in alluding to Reich possibly suffering from delusional thinking, especially toward the end of his life. Raknes (1971), a friend of Reich's, also referred to this, noting that Reich "liked to trust the people he liked, [yet] was too prone to distrust them as soon as they disappointed him in any way" (p.68). Raknes further stated that "however much he had reason to feel persecuted, this feeling sometimes would be exaggerated and even misplaced" (p. 69). Furthermore, "in his [Reich's] judgment of people his very perspicacity might lead him to exaggerate certain traits, both favorable and unfavorable, so that the total picture might be distorted" (Raknes, p. 69).

### **Reich's Theory**

Reich's concepts and theory have as their foundation classic psychoanalytic drive theory, meaning that his underlying framework for understanding human psychology is rooted in the concept that energetic impulse seeks discharge, and when thwarted results in some sort of defensive pathology. The nature of the drive, discharge, and pathway to pathology sets Reich's concepts and theory apart from others. In Reich's theory impulse is rooted in the biologically-oriented sexual drive, discharge is the orgasm, and pathology is manifested in what Reich called body armor.

Although Reich's theory has roots in drive theory, his ideas do not fit neatly into either just the biologically-oriented (nature) or culturally-oriented (nurture) schools of thought. "Reich was among the first to recognize the importance of social factors in psychic development," yet he also "pushed psychoanalysis to the utmost biological extreme, reducing all of psychic life to a manifestation of bodily streamings and spasms" (Robinson, 1969, p. 60).

## REVIEW OF THE LITERATURE

Reich believed sexual repression by society and culture to be the primary source of neurosis (Fadiman and Frager, 1994). He claimed that many people become trapped in unsatisfying marriages primarily because of the economic ties, moralistic demands, and habitual function that the legal and religious arrangement fosters, yet are not sexually fulfilled. Certainly not a huge proponent of traditional marriage and society's prohibitions on sex outside of marriage, he went so far as to say that all of this "results in the wretchedness of marriage" (Reich, 1942/1973, p. 202).

Over time, the application of Reich's theory evolved from more traditional analysis, relying solely on talk, to an increasingly greater focus on analysis of both the physical and psychological aspects of character and associated character armor (Fadiman and Frager, 1994). Reich was a pioneer in moving from behind the couch, which was customary therapeutic practice at the time, to facing the patient directly. Though Reich never relinquished talking altogether in favor of working strictly on the body, he did increasingly rely on communications from the somatic expressive language of the patient. These findings paved the way for his groundbreaking exploration into somatic psychology.

### ***What is Character?***

Although Freud discussed the concept of character, it was Reich who first formulated a coherent theory of it (Fadiman and Frager, 1994). Reich arrived at this by initially noticing that it was often not simply a patient's particular symptom or small piece of conscious or unconscious material that affected the analytic process, but instead the patient's general style or whole character structure (Robinson, 1969). *How* patients said something was more important than *what* they said; the expression was more important than the content (Raknes, 1971). Although this may sound mundane today, it was considered quite revolutionary at the time that Reich presented it, akin to Freud's discovery and illumination of parapraxes (Robinson).

Alongside the "what" of the old Freudian technique, I placed the "how." I already knew that the "how," i.e., the form of the behavior and of the communications, was far more important than

## REVIEW OF THE LITERATURE

what the patient told the analyst. Words can lie. The expression never lies. Although people are unaware of it, it is the immediate manifestation of the character. I learned in the course of time to comprehend the form of the communications themselves as direct expressions of the unconscious. (Reich, 1942/1973, p. 171)

This meant treating patients not just by analyzing their symptoms, but instead by analyzing their whole character (Raknes, 1971). What is the difference? Reich (1933/1945) viewed neuroses with circumscribed symptoms as *symptom neuroses*, whereas neuroses without them he viewed as *character neuroses*. Reich believed that symptom neuroses were always rooted, and derivative of, neurotic character. Because of this, character analysis became the main clinical focus of attention. Two important distinctions surface between symptom and character neuroses. First, in character neuroses, insight into the neurosis is poor or even nonexistent. Unlike neurotic *symptoms* which are typically ego-dystonic and experienced as alien to the individual, neurotic *character traits* are ego-syntonic and experienced as integral parts of who one really is (Fadiman and Frager, 1994; Josephs, 1994). Simply put “lack of insight points to a neurotic character trait” (Reich, 1933/1945, p. 46). Second, in character neuroses, rationalization plays a major role in minimizing or vanquishing any perception of pathology or senselessness. Neurotic character traits and even what are considered simple bad habits are generally passed off by the individual as “that’s just the way I am.” Josephs noted that when a person “is made aware of possessing a distinctive character style, it is conceived as a normal, rational, and adaptive manner of conducting oneself that need not be questioned or examined, for it is not a problem” (pp. 42-43). Furthermore, Josephs noted that even if it were a problem for the person it would be seen as immutable and “simply the way one is, always has been, and always will be” (p. 43). Extreme orderliness, shyness, or appeasement are examples. Reich pointed out, as well, that symptoms have a much simpler structure than character traits. “Whereas the symptom corresponds solely to one definite experience or one circumscribed desire, the character, i.e., the person’s specific mode of existence, represents an expression of the person’s entire past” (Reich, 1933/1945, p. 48).

Character, more specifically the ego's "chronic, automatically functioning mode of reaction," is formed when the ego is "continually subjected to the same or similar conflicts between need and a fear-inducing outer world" (Reich, 1933/1945, p. 338). The ego is forced to undergo a change, becomes rigid, and a hard shell develops "to deflect and weaken the blows of the outer world as well as the clamoring of the inner needs" (Reich, p. 338). This serves a dual function: the person becomes less sensitive to unpleasure, but is also increasingly restricted in libidinal and aggressive motility, effectively reducing capacity for achievement and pleasure (Reich).

Reich defined character as "a person's habitual attitudes and pattern of responses to various situations" (Fadiman and Frager, 1994, p. 224), much as the concept of personality is often defined today. Unlike personality, however, character also includes "psychological attitudes and values, style of behavior (shyness, aggressiveness, and so forth), and physical attitudes (posture, habits of holding and moving the body)" (Fadiman and Frager, p. 224-225). Josephs (1994) further clarified that character "is not reducible to any single personality trait alone but rather refers to the superordinate organization of one's personality as an overall strategy of defense, a sort of philosophy or style of living that provides protection against any conceivable situation of danger" (p. 42).

### ***Unity of the Body and Mind: Armoring***

Reich showed how these physical attitudes were not just *part* of the individual's character, but came to embody the character itself in physical form. According to Reich, different character traits work together and become dependent on one another, forming an integrated, unitary defense that he called character armor. This character armor is the actual physical manifestation of the individual's character made up of "both the repressed emotions and the embodied tensions" (Young, 2008, p. 8). Reich (1942/1973) clarified:

Character armorings were now seen to be functionally identical with muscular hypertonia. The concept, "functional identity," which I had to introduce, means nothing more than that muscular attitudes and character attitudes have the same function in the

## REVIEW OF THE LITERATURE

psychic mechanism: they can replace one another and can be influenced by one another. Basically, they cannot be separated. They are identical in their function. (pp. 270-271)

“Physiologically,” Reich (1933/1945) stated, “the muscular armor fulfills the same function that contactlessness and superficiality fulfill psychically” (p. 350). He further clarified the relationship between the physiological and psychic apparatus not “as one of mutual dependency but as one of functional identity” (p. 305). Baker (1967) concurred in reiterating Reich’s view that character armor is “functionally identical with muscular armor” (p. xxxi). “The basic theory – that character is based on movement and blocking of energy in the body – effectively removes the dichotomy of mind-body functioning” according to Baker (p. xviii).

Character armor is formed when the energy associated with an impulse or drive becomes split when denied satisfaction, with one part of the energy suppressing the other part (Raknes, 1971). This character armor is physically manifested in the body in the form of chronic tensions and contractions, or muscular armoring, which Reich (1933/1945) viewed as one in the same. According to Reich, natural or temporary armoring is a muscular contraction related to being threatened whereas character armor is a permanent or chronic contraction without choice. Reich’s theory holds that an individual’s character structure, and associated muscular armoring, forms as a defense against anxieties “over intense sexual feelings and the accompanying fear of punishment” (Fadiman and Frager, 1994, p. 225). This character armor includes all defenses which eventually form a coherent pattern that each of us experiences not only as an integral part of our personality, but as our personality itself, as who we know ourselves to be.

The presence of armoring distorts, inhibits, and destroys natural feeling, especially feeling strong emotions, and prevents the free flow of energy in the body. This inhibition is particularly true, according to Reich (1933/1945), of sexual feelings which prevents complete and fulfilling orgasm. “This characterological armoring is the basis of isolation, indigence, craving for authority, fear of responsibility, mystic longing, sexual misery, and neurotically

impotent rebelliousness, as well as pathological tolerance” (Reich, 1942/1973, p. 7). As Fadiman and Frager (1994) stated, only by feeling these strong emotions can one become free of them. Feeling these emotions is facilitated through “attacking the neuroses from the bodily side, partly by calling the patient’s attention to the chronic tensions, partly by making him feel them by direct manipulation” (Raknes, 1971, p. 23). According to Raknes, in addition to feeling repressed emotions during therapy, Reich also noticed that his patients sometimes felt unusual and unexpected streamings in the body with the loosening of chronically rigid and tense muscles. Raknes explained:

These new and unexpected experiences were feelings of streaming in the patient’s body, streamings that to most of the patients were formerly unknown and which to most of those who knew them had been of little or no significance. Such streamings were pleasurable, usually soft and rather weak, but occasionally so strong that the person felt that they overflowed him. In such latter cases, and sometimes even when they were of moderate strength, they would make the patient afraid, as of some unknown danger.  
(p. 23)

Observing these energy streamings in his patients precipitated Reich’s discovery of orgone energy.

### ***Discovery of the Orgone***

Reich (1933/1945) asserted that these streaming sensations, which he observed in patients and explored in extensive laboratory experiments, resulted from the movement of freed biological energy. According to Baker (2010), Reich called this energy orgone (from “organism” and “orgasm”) and believed it to be the basic life energy that is present in all living organisms and the force behind Freud’s concept of libido. DeMeo (1999) defined it as “cosmic life energy, the fundamental creative force long known to people in touch with nature, and speculated about by natural scientists” (p. 11).

Freud initially believed libido to be a real and potentially measurable energy, but later recanted (Fadiman and Frager, 1994). Freud would say, for instance, that an infant’s fingers, toes, and mouth are highly cathected with libido, or more

accurately that the psychic representatives are. Reich, however, would say that the infant's fingers, toes, and mouth are highly cathected with libido, or orgone energy, and that this energy is actually present there, stored there; it more than just exists in the psychic realm. Reich (1942/1973) made clear that orgone is a real, physical energy that can be seen, measured, and photographed.

Reich's experiments led him to define major properties associated with orgone energy, some of which contradict established and accepted theories and laws of physics and biology (Fadiman and Frager, 1994). His bold creativity and imagination, fueled and inspired from surprising sources, also left him bored with replicating his experimental findings, contrary to accepted western scientific methods. His lack of experimental replication further added to the mountains of criticism and controversy that he encountered during his life and that his concepts and theory still draw today. Partly because of the controversy that swirled around Reich's theory and work, Fadiman and Frager stated that no reputable scientific inquiry or critique had ever been conducted to prove or disprove it. Blasband (2000) and DeMeo (1999), however, later substantiated aspects of Reich's theoretical and experimental work. According to Boadella (1974), "no negative evidence or clinical refutation of Reich's work in orgone energy has ever been published" (p. 270) and his "psychiatric, biophysical, and physical findings...[have never been]...seriously challenged by reports in the mainstream literature" (Blasband, p. 199). Heuer (2002) concurred.

### **What is Orgonomic (Reichian) Therapy?**

Reich's approach to therapy departed from the prevailing psychoanalytic standard of the day, namely free association. Reich (1933/1945) found that most patients, though directed to do so, had difficulty following the fundamental rule, i.e., to free associate, to completely open to the therapist, and to verbalize all feelings and all thoughts that randomly pass through the mind. Character armor, of course, inhibited this, which was precisely why the patient (usually unbeknownst to him or her) came to therapy in the first place. Because of difficulties with free association and the patient's chronic character armor and

integrated defense structure Reich favored more confrontational interventions which he ultimately called character analysis. He later integrated somatic interventions (biopschotherapy) into his armamentarium, ultimately arriving at what is now known as orgonomic therapy. This therapy, according to Lowen (1974), is unique in that it involves the body analytically, expressively, and energetically simultaneously.

### *Character Analysis*

Reich's foray into his orgonomic therapy began with character analysis, "the prototype of active and confrontational approaches to the analysis of defense and resistance" (Josephs, 1994, p. 41). Reich criticized the interpretation of the patient's manifest content because the patient's resistance makes those interpretations ineffective and essentially meaningless for the patient. "These are the interpretations that fail to produce a genuine emotional response and therefore fail to effect any therapeutic change" (Shapiro, 2002, p. 339). Shapiro noted that "Reich's attention was drawn to the patient's attitude...and therefore to the patient himself" (p. 339).

In character analysis Reich would regularly and repeatedly refer to the patient's overall attitude, increasingly seeking to expose the patient's seeming compliance with therapy for what it actually was: the patient's characteristic form of defense. Reich lectured extensively on patients who were, for example, (a) overly-friendly, excessively trusting, and idealizing, (b) conventional and formal, (c) calm and unemotional, even in the presence of disturbing ideas or interventions, and (d) disingenuous in their demeanor, with an inward, smug smile, suggesting nothing could really touch them (Boadella, 1974). His approach for making the therapy more tolerable for the patient included (a) the establishment of a therapeutic alliance with the patient, and (b) working from the surface to depth in analyzing resistance (Josephs, 1994).

### ***Biopsychotherapy***

To his character analytic approach Reich seamlessly paired work on the patient's body armor. Because character and muscular armor are functionally identical, these two seemingly different types of work with the patient are, in fact, equivalent and cannot be artificially separated. Work on the patient's body armor will be described in detail below.

### ***Goals of Orgonomic (Reichian) Therapy***

Reich's orgonomic therapy is a therapy fully informed by theory, and every theory explains what constitutes normal, healthy functioning. For Reich, healthy functioning, characterized by genitality, is a result of dissolving the body armor and achieving what he called orgasmic potency. "Reich's dissatisfaction with psychoanalysis was that it frequently failed to do that, and instead provided only intellectual understanding" (Shapiro, 2002, p. 339). McNeely (1987) stated that "intellectual recognition of complexes without the emotional experience does not activate movement at the level of the archetypes [referring to Jung], which are always plugged into instinctual, feeling processes" (p. 69). Schwartzman (1986) succinctly stated the goal of treatment as being "the removal of armor and the establishment of genitality with the realization of orgasmic potency" (p. 245).

#### *Dissolving Armor*

Reich (1933/1945) viewed therapy as the process of dissolving muscular armoring in order to allow the free flow of energy throughout the body. Dissolving psychological and physical armoring, which as mentioned earlier is one in the same, is one goal of therapy according to Reich. By doing so, individuals become naturally orgasmically potent.

#### *Orgasmic Potency*

Reich believed orgasmic potency to be the ultimate goal of therapy and the hallmark of mental health (Raknes, 1971). He described this as "the capacity to surrender to the flow of biological energy, free of any inhibitions; the capacity to discharge completely the dammed-up sexual excitation through involuntary,

pleasurable convulsions of the body” (Reich, 1942/1973, p. 102). Full orgasm means the ability to relate to one’s partner without any of the blockages in emotional contact that neurotic problems can impart (Boadella, 1974). If this energy is not completely discharged through orgasm, it will feed secondary drives that are responsible for neuroses (Raknes, 1971). Reich believed, therefore, that complete and “free expression of sexual and emotional feelings within a mature, loving relationship” that satisfies the natural or primary drives is the goal (Fadiman and Frager, 1994, p. 224).

Reich described his views on the function of orgasm as more than simply for purposes of procreation: this function, he said, is to regulate bioenergy (later termed orgone energy) “by the discharge of that part of the energy that is not consumed in the other activities of the human being” as well as to provide “the well-being and the pleasure that make life enjoyable and worth living” (Raknes, 1971, p. 27). “Reich viewed pleasure as a movement of energy from the core of the organism toward the periphery and the external world; anxiety is represented as a retraction of energy, or movement away from the external world” (Fadiman and Frager, 1994, p. 221).

### *Genitality*

Orgastic potency is the natural result of relinquishing body armor, and along with it comes a spontaneous capacity for what Reich called self-regulation. Natural and effortless self-regulation operates in place of rigid, neurotic controls. Self-regulated individuals are naturally, rather than compulsively, moral. They are aware of and guided by their own inner inclinations and feelings rather than simply following external rules and ways of being (Fadiman and Frager, 1994).

Reich applied the term *genital character*, following Freud’s term for the final level of psychosexual development, to those individuals who were orgasmically potent and “spontaneously decent” (Boadella, 1974, p. 44). Genital characters are able to selectively don their armor and dispense with it at will, in accordance with the nature of the environment in which they find themselves. In other words, they are in control of their armor, not the other way around. According to Reich,

genital characters have worked through the oedipal complex so that the superego has become affirmative of sex and in harmony with the id (Fadiman and Frager, 1994). The genital character is able to freely experience sexual orgasm, with a complete, involuntary, and uninhibited discharge of all excess libido without the force or violence more characteristic of the armored individual (Fadiman and Frager). Reich (1942/1973) described it this way:

The unification of the orgasm reflex also restores the sensations of depth and seriousness. The patients remember the time in their early childhood when the unity of their body sensation was not disturbed. Seized with emotion, they tell of the time as children when they felt at one with nature, with everything that surrounded them, of the time they felt “alive,” and how finally all of this had been shattered and crushed by their education. (pp. 357-358)

Reich had a rather pessimistic view of achieving his defined state of mental health. He believed that “few, if any, who pass through the mill of our education and society will ever attain this goal [of genitality and orgasmic potency] completely” (Raknes, 1971, p. 28).

### *Application in Clinical Practice*

Clinical application of Reich’s theory involves character analysis and manipulation of the body armoring. The nature of analytic work is widely understood to involve talking. The nature of work on the muscular armoring is, however, less known.

Dissolving the body armor involves three tools: “building up energy in the body through deep breathing, directly attacking the chronically tense muscles (through pressure, pinching, and so on) to loosen them, and maintaining the cooperation of the patient by dealing openly with whatever resistances or emotional restrictions arise” (Fadiman and Frager, 1994, p. 228). This hands-on manipulation of the body armor by the therapist is not massage and is often experienced by the patient as quite painful. The therapist might pinch, poke, or prod at muscles while directing the patient to breathe in and out in certain ways, roll eyes, grimace, makes noises, kick legs, pound fists, or perform other specific

## REVIEW OF THE LITERATURE

movements. All of this is usually done on a mat or couch, with the patient laying on their back or prone.

Reich also employed such techniques as imitating and exaggerating a patient's characteristic gestures, postures, and body movements or having his patients do the same (Fadiman and Frager, 1994). This may sound reminiscent of more popular gestalt therapies, later developed by Fritz Perls, and that is most certainly in part because Perls himself was in analysis with and a student of Reich's.

Muscular armoring is physically organized into seven segments, roughly forming seven horizontal rings at right angles to the spine and torso. These rings are centered in the eyes, mouth, neck, chest, diaphragm, abdomen, and pelvis and roughly correspond to the seven chakras of kundalini yoga. Reich (1933/1945) found that the most significant armoring in most individuals was in the pelvis and that therapy was considered complete once this segment was open and energized with the patient in full contact. Therapy, therefore, progresses from the eyes to the pelvis, in a direction opposite to that in most yogic traditions.

This therapy requires some modicum of ego strength and is often perceived by patients as quite confrontational and aggressive. According to Baker (1967) three things occur in the patient during the process of removing armor: anxiety, emotional release, followed by a sense of relief. "When Reich, instead of interpreting the material which patients brought him, began to call their attention to the way they brought it and to their general manner of behavior, it was felt by them as an attack upon their personalities and very often as a shock" (Raknes, 1971, p. 21). Josephs (1994) noted that character analysis could be experienced by the patient as character assassination. Raknes described how patients experienced orgonomic therapy as quite different from classical analysis and as "something going much deeper, to the very core of their personalities" (pp. 21-22).

Clinical application of Reich's work has sometimes been reduced to what is called the ventilationist approach to therapy (Berkowitz as cited in Fadiman and Frager, 1994). The encouragement of expressing repressed emotions, according

## REVIEW OF THE LITERATURE

to this view and behavior and learning theory, rewards that behavior and encourages more of it in the future. Thus, the expression of rage encourages more rage; the expression of sadness encourages more sadness. Fadiman and Frager claimed this to be a “shallow understanding of Reich’s work, in which emotional release is never simply encouraged for its own sake” (p. 235). Reich (1933/1945) repeatedly emphasized that the therapeutic technique should be focused on dissolving the armor that prevented the full release of held emotion. Reich contended that emotional expression is a result of the process of breaking down armor; it is not the process itself.

### *A Note on Touch*

Because the orgonomic therapist must easily and accurately view the patient’s bodily movements and breathing and also gain physical access to and work on the muscular armoring, the patient typically wears minimal clothing during the therapy. Ethical considerations become paramount because of the physical touching that occurs in this form of therapy. Early controversy swirled around the very thought of touching the patient, which during Reich’s time was considered “a horrible offence [*sic*]” (Waal, 1958/1974, p. 356). In many ways it still is today, perhaps even more so, given the litigious environment in which we live. Cornell (2009) noted that “any systematic discussion or empirical evaluation of the therapeutic role of touch has been nearly nonexistent in the psychoanalytic literature” (p. 82). Further, “there has been no systematic theorization in the psychoanalytic literature of the potential functions of touch and/or bodily movement on the part of the analyst. It is rather difficult to think systematically about something that one is simply not supposed to do” (Cornell, p. 82).

Reich (1933/1945) was firm in stating that beyond technique, an orgonomic therapist must also engage in his or her own personal growth. This is especially necessary around sexual issues because of the “overtly sexual sounds” and “orgastic streamings” (Fadiman and Frager, 1994, p. 234) that are often produced by patients during treatment. Boadella (1974) echoed this, stating

the indispensable prerequisite for whatever methods the therapist uses to release the emotions held in the musculature is that he is in touch with his own sensations and able to empathise [*sic*] fully with the patient and to feel in his own body the effect of particular constrictions on the patient's energies. (p 120)

### **The Patient's Experience: What We Know So Far**

Many single-case accounts of therapist and patient experiences exist, as case studies are commonly used as teaching and communication tools for therapists. Fewer accounts, however, exist of patients who have experienced integrated verbal and biophysical therapy. Fewer, still, exist from a purely orgonomic perspective in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated. Painter (1987), for example, recounted numerous examples of biophysical work with clients, yet all using an integration of techniques, not a purely orgonomic approach. Josephs (1994) offered a compelling case of character analysis, but without a biophysical component. Still others (Lowen, 1983; McNeely, 1987; Wiener, 1999) offered numerous examples of cases involving integrated verbal and biophysical work using various specific technical approaches, but none from a purely orgonomic perspective.

Furthermore, the literature provides very little *aggregate* information about the actual experience of patients in orgonomic therapy. More specifically, nothing exists in the literature, apart from anecdotal, biographical accounts, that describes the experience from the patient's perspective. Feiss (1979) provided summary descriptions of a wide variety of body therapies, but nowhere is the voice of the patient to be found. Likewise, Smith (1985) offered an integrated approach to addressing the body in psychotherapy, but excluded the voice of the patient. To date there has been no cohesive, systematic study examining common, phenomenological themes of experience among patients in orgonomic therapy nor among patients who have benefited from orgonomic therapy. Given the absence of empirical data related to the topic of the current study, the literature that chronicles the cases of patients who have been treated with

ergonomic therapy will provide a place from which to begin. This literature includes single- and multiple-case accounts written by therapists and patients' autobiographical accounts.

### *Therapists' Single-Case Accounts*

The point of reference, or perspective, from which most look at ergonomic therapy is through the eyes and experience of the practitioner. And with rare exception, this viewpoint is typically further constrained to the clinical arena and the patient's pathology. Only infrequently will something of the patient's experience, perspective, or voice emerge. Mentioning this is not meant to fault any author for this omission, but to highlight the dearth of patient perspective to be found. The historical precedent and guidelines for writing and presenting cases do not focus on such information.

Both Konia (1990, 1995) and Foglia (1995) provided compelling accounts of patients, ages 3 to 14, in ergonomic therapy, but included nothing of the patient's voice or perspective in any of them, not even a brief quote or patient utterance. This may be due in part, of course, to the ages of the patients profiled.

Baker (1984), Dew (1975), Heller (1995), and Konia (1977) offered just a bit of the patient in their accounts. Each of them included at least one quote or patient utterance in their case presentation. These utterances, however, consisted of something that the therapist heard from the patient during an actual session. The broader patient perspective of life outside of the treatment room was lost.

Andrews (1990), Baker (1972), Crist (1994a), Harman (1992a), and Konia (1975) provided a bit more of the patient in each of their accounts. Each of them, for example, offered several quotes from the patient, again all gleaned during actual sessions. However, apart from the therapist's interpretation of those utterances, the reader was left only to surmise what the patient's experience was. No deeper analysis beyond case conceptualization from the therapist's viewpoint was provided. Baker (1967), Herskowitz (1997), and Reich (1933/1945) also provided numerous accounts in their books, but all with the same shortcomings (as pertains to the current study) already mentioned.

### ***Therapists' Multi-Case Accounts***

Several multi-case accounts of patients in orgonomic therapy exist. These cases are presented together by each author either because they share a common diagnosis (Chavis, 1991; Harman, 1995; Nelson, 1976), similar approaches to treatment (Schwartzman, 1986), illustrate a clinical construct (Crist, 1994b; Harman, 1992b), or simply for convenience (Wright, 1982). All of these are written by therapists with an orgonomic approach and theoretical orientation, inherently limiting the perspective and presentation to that paradigm. Many of these cases, like the single-case accounts already mentioned, bear the stamp of the devotee of orgonomic therapy.

Each of these multi-case accounts are limited, vis-à-vis the current study, in the same ways that the single-case accounts were. In addition, only very limited integration of findings across cases was presented, usually amounting to just one or two sentences. Of these integrated findings, nothing pertained to the experience of the patient.

### ***Patients' Autobiographical Accounts***

Fewer accounts are available from the patient's perspective. Of these, all are strictly anecdotal, autobiographical accounts. Nevertheless, each of them provides a glimpse into what it is like to be a patient in orgonomic therapy, a priceless place from which to enter the current study.

Orson Bean, a television, movie, and theater actor since the 1950s, wrote a detailed account of his orgonomic therapy with Elsworth Baker in his book *Me and The Orgone*. In it, he provided a rich description of his budding awareness of his previously unconscious armoring, the changes in his senses, attitudes, and behaviors as a result of his therapy, and his experiences during the therapy itself. He stated that the value of his book lay "in its being the only account of Reichian therapy written from a patient's-eye-view" (Bean, 1971, pp. 121-122). Neill (1971) echoed Bean's statement noting that "Orson's descriptions are valuable mainly for this reason – that so far books about the method have been written by practitioners, not by patients" (p. vii). This was true at the time of his writing, but

## REVIEW OF THE LITERATURE

thankfully English (1977) later provided his own, albeit abridged, account of therapy with Reich. Raknes (1971) and Neill also provided some glimpses into their own therapy with Reich. Apart from these accounts or the occasional small statement buried in writing primarily devoted to something other than patient experience, very little exists to tell us what it is like to be a patient in orgonomic therapy.

Bean's (1971) account made clear the power of the therapy for him and the profound changes that he experienced. After his first session he wrote: "It seemed as though all my senses were heightened. I was perceiving everything with greater clarity. I walked home feeling exhilarated and bursting with energy" (p. 21). But not all of his experiences held the same exhilaration. He also wrote of the terror in the work, referring to the therapy in general he stated:

As each new area of armoring was broken down, the patient would feel elated at first and then absolutely terrified. It was as though the armoring had become part of the personality and as *it* went, he felt that *he* was going. Patients told him [Reich] they literally felt they were going to die, that they were coming apart, that they had nothing to hold onto. (p. 12)

As therapy proceeded Bean began to recognize the tenacious quality of armor and the resistance he would mount against its dissolution:

I realized it was going to take all the courage I could muster to de-armor myself. I knew I would fight Dr. Baker every step of the way but I also remembered how I had felt for that thirty-six hours or so after my first treatment and I wanted it more than anything else in the world. (p. 30)

Bean later described his understanding of health:

The healthy, unarmored person, aware of the rhythmic, pleasurable pulsations within himself, feels a oneness with the farthest star and the nearest katydid because both he and they beat to the same rhythm. The armored person, having lost the ability to perceive his streamings, can only hypothesize intellectually about the unity of nature and his connection with it. (p. 38)

Later in his therapy Bean began to make contact with what he had been missing:

The feeling of hopelessness stems from the frustration of the deep cosmic yearning for merger, union and oneness which can only be

obtained through the unarmored, healthy capacity to melt into a loved one in full orgasm, lost forever to armored man. (p. 41)

Neill (1971) noted that Bean's experience mirrored his own, stating: "Orson had an experience similar to my own. I had more emotional reaction after six weeks on Reich's couch than I had after years in 'talking' analysis" (p. vii). Reading Bean's account "brought back memories of when I lay naked on a couch and old Reich made me squirm when he attacked my stiff muscles" (p. vii).

English (1977) provided a more clinical and pragmatic description of therapy with Reich, probably because English was a psychiatrist and psychoanalyst himself. His account offered insight into Reich's character analytic approach with details of what he remembered Reich saying that effected profound change in him.

Similarly, Raknes (1971), also a psychoanalyst, provided personal reflections on therapy and training with Reich. Raknes's account was limited, vis-à-vis the current study, in that it tended less toward a detailed description of therapy with Reich and more toward an understanding of Reich's history and theory.

### ***Moving Toward a Patient-Centered Understanding***

If we accept the notion of a dynamic, intersubjective, relational field between therapist and patient then it is vital to know the patient's perspective to help inform clinical application. The voices of the theorist and practitioners are well-integrated into orgonomic therapy. It is time now to hear from and integrate the patient's experience. Through rich, deep qualitative understanding (not just statistics and numbers), the present study explored the much-needed perspective of the patient who has experienced and benefited from orgonomic therapy. In addition, the critical analysis across accounts that had been missing was addressed.

Psychological research is increasingly migrating from the position of researcher as neutral, observing expert to more relational and intersubjective approaches. This study continued that trajectory and moved us closer to a patient-centered understanding of orgonomic therapy.

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## RESEARCH METHOD

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### **Design**

THIS STUDY SOUGHT TO EXPLORE THE QUESTION “what is it like to be a patient who has experienced and benefited from orgonomic (Reichian) therapy?” Creswell (1998) stated that qualitative designs are often indicated when the research question begins with *how* or *what*. Furthermore, Creswell encouraged qualitative designs when a topic “needs to be *explored*” and a “*detailed view*” is needed (p. 17). Merriam (2002) advised the use of qualitative designs when understanding and making sense of phenomena from the participant’s perspective defined the area of interest.

This research, like orgonomic therapy itself, sought to explore and understand the whole, not the parts. Discretely isolating and quantifying variables, and then examining them through a deductive approach, was inappropriate here. This research gracefully lent itself to a qualitative method, seeking a rich and deep study of the individual experience of the patient and allowing flexibility in exploring that experience more naturally. Among the many choices of scholarly research designs, this study utilized a qualitative, heuristic design due in part to the nature of the research question: *what is the patient’s experience in orgonomic therapy?*

### ***Qualitative Research Design and Methodology***

“The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world” (Merriam, 2002, p. 3). This meaning is not a fixed, single, agreed upon, or measurable phenomenon, but constructions and interpretations that change and flux over time (Merriam). This study was interested in those individual constructions and interpretations of being a patient in orgonomic therapy.

## RESEARCH METHOD

Although qualitative methods vary widely, authors frequently distill just a few salient features that are common among them. Three common fundamental assumptions shared among all qualitative methodologies according to Patton (1990) are: (a) a holistic view in which the whole is greater than the sum of its parts, (b) an inductive approach with a movement from specific observations to general patterns, and (c) naturalistic inquiry through which phenomena are understood in their naturally occurring state. The inductive approach, in particular, encourages the researcher to suspend any imposition of an organizing structure prior to data collection.

Merriam (2002) described four key characteristics of qualitative research: (a) the researcher strives “to *understand the meaning* people have constructed about their world and their experiences” (pp. 4-5), (b) the researcher is the primary instrument for data collection and analysis, (c) the process is inductive, and (d) the resulting product is richly descriptive.

Creswell (1998) stated that leading authors generally agree that qualitative research is conducted “in a natural setting where the researcher is an instrument of data collection who gathers words or pictures, analyzes them inductively, focuses on the meaning of participants, and describes a process that is expressive and persuasive in language” (p. 14). Creswell (1998) and Rudestam and Newton (2001) further emphasized that qualitative researchers work with few cases and many variables for a relatively long period of time, unlike quantitative studies, which work with many cases and few variables for a relatively short period of time. This study adhered to all of the characteristics just mentioned.

Many have discussed the increasing importance of qualitative research, particularly for the social sciences. The trend in research has been “away from a rational objectivism, which asserts that scientific knowledge is founded on objective empirical truths, and toward the conception of a more relativistic universe and ‘poststructuralist’ epistemologies” (Rudestam and Newton, 2001, p. 24). Kazdin (2003) highlighted the increasing importance of qualitative research due to its unique ability to yield information that is “not likely to emerge from quantitative studies” (p. 329) and to offer complex, detailed, multilayered,

and rich descriptions of experience. Qualitative studies, Kazdin noted, “are an excellent way to begin to understand a phenomenon of interest...and to develop hypotheses” (p. 329-330).

Qualitative methods are indicated when data are in the form of words, rather than numbers (Rudestam and Newton, 2001). The emphasis in the research is on description and discovery rather than hypothesis testing and verification (Rudestam and Newton).

### ***Heuristic Research Design and Methodology***

Among the many qualitative research traditions, this study employed a heuristic design and methodology, which is a form of phenomenological inquiry. Phenomenology is a unique and discrete research tradition, sometimes erroneously viewed as synonymous with qualitative methods in general, yet actually quite specific in its approach. Phenomenological approaches, first used and developed by Edmund Husserl and later expanded by Amedeo Giorgi, seek to answer the question “what is the structure and essence of experience of this phenomenon for these people?” (Patton, 1990, p. 69). Phenomenological approaches answer this question by exploring “how people describe things and experience them *through their senses* [italics added]” (Patton, p. 69). In addition, phenomenological research designs mandate that the researcher *bracket* out the world, a term coined by Husserl (1913/1931), essentially denuding the data of presuppositions and extraneous intrusions. Lastly, phenomenological approaches assume and search for commonalities among human experience; simply describing unique views is inadequate.

The heuristic approach shares some features with phenomenology and differs in other respects. Most importantly, heuristic research, according to Moustakas (1990), requires that the researcher has “had a direct, personal, encounter [and intimate experience] with the phenomenon being investigated” (p. 14). VandenBorn (1982) believed that “in order to be subject to inquiry, a topic cannot be something wholly unfamiliar; it must be enclosed in a kind of pre-understanding” (p. 115). Whereas phenomenological research strives for

## RESEARCH METHOD

detachment on the part of the researcher, heuristic research is a personal journey, a process of internal search and creativity that allows for the “I” of the researcher yet also involves a suspension of pre-existing beliefs. Not only is knowledge extended as a result, but “the self of the researcher is illuminated” (Moustakas, p.11). Heuristic research involves “self-search, self-dialogue, and self-discovery; the research question and the methodology flow out of [the researcher’s] inner awareness, meaning, and inspiration” (Moustakas, p.11). This means that the self of the researcher will be present throughout the project due to having undergone the experience of organomic therapy in a complete, vital, and direct way himself.

Moustakas (1990) suggested six phases in heuristic research: (a) initial engagement, (b) immersion, (c) incubation, (d) illumination, (e) explication, and (f) creative synthesis.

*Initial engagement* involves a willingness to allow intuition free reign as an intense interest and passionate concern begins to form and create the vague theme of the emerging research question. VandenBorn (1982) described it this way:

A topic for inquiry comes into being for the prospective researcher most constructively when a powerful but clouded portion of his or her lived experience generates a vague outline of coherence. Because there is a connection to important commitments in such experiences, the vague outline is necessarily invested with an attractive force, drawing the researcher nearer and nearer. (p. 115)

During this phase the researcher comes into contact with the context from which the research question emerges and takes on significance.

*Immersion* is an intentional process of living with the question as it increasingly becomes crystallized. During this phase everything in the researcher’s life becomes involved with, encompassed by, and in relation to the question of interest. Everything becomes a possibility for further illuminating and refining the area of interest.

*Incubation* offers a retreat from the intense involvement with the question through less conscious involvement. In this phase the researcher essentially “takes a break” from direct contact with the area of interest and allows intuition and tacit understanding to evolve. During this phase understanding on levels

outside of immediate awareness develops and dreams may provide insights and clues.

*Illumination* is a somewhat quantum breakthrough into consciousness that serves to organize material, reorient the researcher, or correct previous distortions. This phase allows for expanding awareness through “a modification of an old understanding, a synthesis of fragmented knowledge, or an altogether new discovery of something that has been present for some time yet beyond immediate awareness” (Moustakas, 1990, p. 30).

*Explication* involves description and explanation to capture the experience of participants in the study. It is essential during this phase, according to Moustakas (1990), that the researcher attend to his own awarenesses, feelings, thoughts, beliefs, and judgments while focusing, indwelling and self-searching. The result of this phase is an explication of the major components of the phenomenon of interest, ready to be combined into a holistic depiction.

*Creative synthesis* enables the researcher to synthesize and bring together as a whole the participant’s lived experience. This may take the form of a narrative using verbatim material, a poem, story, drawing, or other creative work that generates a coherent, meaningful depiction of the experience being explored.

### **Participants**

#### ***Sampling Strategy***

Random sampling from a general population of psychotherapy patients would have likely yielded inadequate numbers of participants for this study because of the relatively small number of therapists who treat patients with orgonomic therapy. Participants for this study were, instead, sought through purposive, criterion sampling; that is by “selecting participants who closely match the criteria of the study” (Rudestam and Newton, 2001, p. 92) and “for whom the processes being studied are most likely to occur” (Denzin and Lincoln, 2000, p. 370). These criteria of the study and processes being studied formed the inclusion and exclusion criteria for participants in the study. Participants in this study were (a)

## RESEARCH METHOD

currently or previously a patient in orgonomic (Reichian) therapy with the same licensed therapist for at least two years, and (b) 18 years or older. *Orgonomic (Reichian) therapy* means therapy in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated. *Orgonomic biopsychotherapy* means therapy in which the patient lies down on a couch, mat, or mattress while the therapist physically and directly intervenes on the patient's muscles, assists the patient with his or her breathing, and asks the patient to vocalize and express emotion in a variety of ways. Participants whose therapy was with a therapist who integrated verbal and somatic work, but who did not identify their approach as orgonomic or Reichian were excluded. No more than one patient from any given therapist was included in the study and all participants resided in the United States.

Sampling in qualitative studies is done with the intention of saturating the area of interest (Rudestam and Newton, 2001) rather than generating a statistically-valid sample, as in quantitative studies. Saturation refers to the process of proceeding until no new relevant data are uncovered (Auerbach and Silverstein, 2003; Josselson and Lieblich, 2003; Rudestam and Newton). As already mentioned, this includes working deeply for a relatively long period of time with few cases. Rudestam and Newton quantified this, noting that most “studies engage a relatively small number of participants (10 might be appropriate) for a relatively long period of time (at least 2 hours)” (p. 93). Because saturation is the criterion that determined when completion of sampling occurred, it was inappropriate, in fact impossible, to specify an exact number of research participants a priori. This study initially targeted between 6 and 12 participants, and then proceeded with more participants in the event that saturation had not occurred.

### ***Recruiting Procedures***

Participants were recruited through two channels: (a) emails sent to the researcher's community of those known to be interested or somehow involved in orgonomic work (Appendix A), and (b) telephone calls to licensed therapists

## RESEARCH METHOD

known or considered to be ergonomic therapists. The researcher confirmed all inclusion and exclusion criteria with a prospective therapist on the telephone and then mailed or emailed an introduction letter (Appendix B). Prospective participants, referred from these two channels, contacted the researcher directly by email or telephone. In some cases, the participant authorized the referring therapist to provide their contact information to the researcher. In these cases the researcher contacted the participant directly. Once contacted, the researcher confirmed all inclusion and exclusion criteria with the prospective participant on the telephone, determined appropriateness for inclusion in the study, and scheduled the first of two informal, semi-structured, conversational interviews. The researcher then emailed the participant an introduction letter (Appendix C), informed consent (Appendix D), bill of rights (Appendix E), and demographic form (Appendix F). Participants reconfirmed all inclusion and exclusion criteria as part of signing the informed consent. No incentive or compensation was offered to participants.

### *Demographics*

Participants in this research project were not meant to be representative of all patients who receive or have received ergonomic therapy, although a diverse sample was desired. Seven participants, four women and three men, were ultimately involved in this study. Ages ranged from 38 to 74 ( $M = 54.86$ ,  $SD = 12.02$ ). All participants lived on the east or west coasts of the United States. Three participants identified as Caucasian, two as White, and two as Irish. Four participants identified as heterosexual, two as straight, and one as questioning. All participants indicated that their primary language was English. Three participants identified their socioeconomic/class background as middle, one as lower middle, one as upper middle, and two did not provide an answer. Participant annual gross income ranged from 35,000 to 200,000 dollars ( $M = 76,166.67$ ,  $SD = 62,049.71$ ). One participant did not provide income information. Three participants reported their relationship status as married, two as divorced, one as separated, and one did not provide an answer. Four

## RESEARCH METHOD

participants indicated they had received a masters degree, two indicated some college, and one did not provide an answer. Three participants indicated their therapist's credential as M.D., three as Ph.D., and one as D.O. All but one participant was still in treatment with their therapist, with length of treatment ranging from 2.5 to 26 years ( $M = 9.86, SD = 8.67$ ).

### **Instrumentation**

Consistent with Creswell's (1998) and Merriam's (2002) common characteristics of qualitative research, the researcher was the primary instrument for data collection and analysis for this study. Each participant, as well, was an additional instrument for this study. Because of this, the focus was on improving the human observer and utilizing the participants in verification. The stories that participants told depended as much on the researcher as listener as on each participant as narrator.

### **Data Collection**

This research and data collection were conducted in accordance with the *Ethical Principles of Psychologists and Code of Conduct* (American Psychological Association, 2002). Data were collected during two informal, semi-structured, one-on-one conversational interviews during a nine-week period in fall 2010. Nuttall (2006) suggested that the results produced by heuristic inquiry are largely a product of the quality of the relationship between researcher and participant. Because of this and as recommended by Moustakas (1990), the researcher, at times, judiciously self-disclosed details of his own experience in organomic therapy in order to further elicit disclosure from each participant.

First interviews lasted between 62 and 103 minutes ( $M = 71.00, SD = 14.38$ ) and second interviews lasted between 31 and 109 minutes ( $M = 71.29, SD = 27.16$ ). Both interviews were audio recorded. First interviews were transcribed for analysis; second interviews were not. Both interviews with five of the seven participants were conducted by telephone and both interviews with the remaining

## RESEARCH METHOD

two participants were conducted in person at a mutually-agreed upon time and location. Transcriptions of the audio recordings of the first interviews as well as the researcher's naturalistic observations formed the pool of data for subsequent analysis.

What data were actually collected? Rather than equate the experiential with the authentic, assuming that "interview responses index some external reality" (Silverman, 2000, p. 823), what Silverman called the *realist* approach, the researcher instead treated responses as "potentially 'true' pictures of 'reality'" (p. 823) that allow the creation of "plausible accounts of the world" (p. 823).

During the first interview the researcher began by providing a contextual frame for the research and interview and then "broke the ice" by starting with general questions and gradually moving on to more specific ones, as Fontana and Frey (2000) recommended. In addition, the researcher also, as inconspicuously as possible, asked questions intended to check the veracity of the participant's statements. Some or all of the questions in Appendix G were used as a device to focus discussion on the area of interest. These questions, as well as the contextual frame for the interview, were informed by the literature review, the researcher's own personal experience with the phenomenon of interest, and Moustakas (2001). Each question was designed to be open-ended and nondirective.

During the first interview the researcher invited the participant to talk about his or her experience as a patient in organomic therapy and asked some or all of the specific questions of research interest listed in Appendix G. Participants were also invited to share personal journals, letters, poems, or artwork that they had used to record and understand their experience. During the second interview, subsequent to initial analysis of the data, the researcher reviewed a summary of the participant's responses with them and asked for their feedback. Responses were spontaneously and collaboratively edited based on participant feedback until participants felt that their pool of data accurately represented their experience in organomic therapy. As previously mentioned, data collection continued with additional participants until theoretical saturation had occurred.

### **Data Analysis**

According to Patton (1990) “there is typically not a precise point at which data collection ends and analysis begins” (p. 377). Although this study employed inductive content analysis, a process described by Patton of “identifying, coding, and categorizing the primary patterns in the data” (p. 381), Janesick (2000) advised against becoming overly-enamored with methods and strategies. Janesick stated that “there is no one best system for analysis. The researcher may follow rigorous guidelines described in the literature...but the ultimate decisions about the narrative reside with the researcher” (p. 389). According to Janesick “staying close to the data is the most powerful means of telling the story” (p. 389). Although Moustakas’s (1990) approach to data analysis offered the primary guidance for analyzing the data in this study, these general principles were also kept in mind.

#### ***Thematic Coding and Analysis***

Moustakas’s (1990) eight-step process for coding and analyzing heuristic data was followed for this study, with two exceptions, to be noted. Moustakas’s first step involved gathering the data from one participant. This included transcription of the audio recordings by someone other than the researcher after each first interview. Subsequently, the researcher entered into the material by listening to the audio-recorded interview while simultaneously reading the transcript to ensure transcription accuracy and to become immersed in the participant’s experience as a whole and in detail. This was Moustakas’s second step. The researcher approached each interview with as little interference from preconceptions as possible to ensure that what was being heard was what the interviewees genuinely had to say. Bracketing, a process in which the researcher became aware of and attempted to set aside individual preconceptions, and the researcher’s personal statement helped to facilitate this. The goal was to become more conscious and explicit about personal positions in order to avoid interpretive bias during coding and analysis.

## RESEARCH METHOD

In the third step, the data were set aside, allowing an interval of rest so that the data may be re-approached with fresh energy and perspective. The data were then reviewed again. This time the researcher took notes and began to identify themes. Ryan and Bernard (2000) stated that themes are abstract, fuzzy constructs that are identified before, during, and after data collection. Furthermore, literature reviews and the researcher's own experiences can serve as sources for these themes. The interview text, however, is the primary source from which themes are induced, and congruent with Moustakas's (1990) approach, was the primary source for this study. These themes constitute what Moustakas called an "individual depiction." This individual depiction of the experience was the culminating piece of this third step. The individual depiction retained the language of the participant and included examples.

Moustakas (1990) did not provide clear guidance on the development of themes. To be clear, the researcher used the following method called open coding. Open coding means developing the coding scheme or the code book as coding proceeds rather than being constrained by looking for any pre-existing list of codes, characteristics, or theoretical guidelines. The researcher highlighted phrases, sentences, and whole utterances that seemed to speak to the research question while reading each transcript and listening to each interview. As codes were developed, category coding began and occurred concurrently with continued open coding. Category coding is a process of grouping open codes together into broader categories that make sense in answering the research question. In qualitative research, coding and analysis cannot be artificially separated. Ryan and Bernard (2000) noted, for example, that by the time the researcher codes, identifies salient themes, and is ready to apply them to an entire body of texts, much of the interpretive analysis has already been completed.

In the fourth step the individual depiction was provided to and discussed with the participant during the second interview. During this interview the participant was asked how he or she felt about the analysis and how well the results explicated their own experience. Feedback obtained was instantly and collaboratively incorporated into the individual depiction as a means of ensuring

validity of the data. Results were edited until the participant felt that their individual depiction accurately represented their experience in ergonomic therapy.

Moustakas's (1990) fifth step was simply to repeat the first four steps for each individual participant. Once this was complete the individual depictions were gathered together and the researcher once again entered a period of immersion, but this time with the depictions of all participants together as a whole. Where considerable consensus across interviews existed, a common narrative was created. Where there was a lack of consensus discernable patterns were described. This constituted the sixth step, culminating in a composite depiction that encompassed the core themes in the experience and generally reflected the experience of all individual participants. This composite depiction should be "vivid, accurate, alive, and clear" (Moustakas, p. 52), but not an "endless description" (p. 391) as Janesick (2000) warned. "Analysis and interpretation effectively balance description" in constructing a powerful narrative (Janesick, p. 391).

Moustakas's seventh step specified the creation of two or three "individual portraits," based on two or three participants who clearly exemplify the group as a whole. The eighth step included the development of a "creative synthesis" of the experience. These two steps were not completed as part of this study, consistent with Echenhofer's (as cited in Pehle, 2003) recommendations and modifications to Moustakas's guidelines.

### ***Verification Procedures***

Moustakas (1990) made the distinction that the question of validity in heuristic research is one of meaning: "does the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching and from the explications of others present comprehensively, vividly, and accurately the meanings and essences of the experience" (p. 32)? This judgment, according to Moustakas, is made by the researcher.

## RESEARCH METHOD

In order to increase the validity of this study, the researcher returned again and again to the data “to check the depictions of the experience to determine whether the qualities or constituents that have been derived from the data embrace the necessary and sufficient meanings,” as recommended by Moustakas (1990, p. 33). Creswell (2003) and Rudestam and Newton (2001) referred to this as “triangulation.” In addition, as already mentioned once the initial coding and beginning analysis was completed (step three) the individual depiction was provided to and discussed with the participant during the second interview (step four) and feedback obtained. This is what Creswell and Rudestam and Newton called “member-checking,” and was the primary means of ensuring validity of the data.

Creswell (2003) also recommended using rich, thick descriptions, which this study employed, as a means of transporting readers to the setting and giving the discussion an element of shared experiences. In addition, the researcher clarified the bias that he brought to the study through a written personal statement (Creswell). Lastly, negative or discrepant information that ran counter to themes was presented to add credibility (Creswell). All of these are Creswell’s recommendations for increasing validity in qualitative studies.

Regarding generalizability, Denzin and Lincoln (2000) wrote that “to study the particular is to study the general. For this reason, any case will necessarily bear the traces of the universal” (p. 370). Nevertheless, no one case or small collection of cases can be held as representative of all cases, though the collection from this study shares similarities with them. While making no claim of generalizability to the entire population of patients who have experienced and benefited from ergonomic therapy, this study instead attempted to offer findings of relevance from the perspective of the reader. “The researcher assumes that the readers will be able...to generalize subjectively from the case in question to their own personal experiences” (Denzin and Lincoln, p. 370).

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## RESULTS

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### **Introduction to the Individual Depictions**

A TOTAL OF 933 INDIVIDUAL PARAGRAPHS, comments, and phrases from the seven participants were analyzed, ranging from 85 to 208 individual paragraphs, comments, and phrases per participant ( $M = 133.29$ ,  $SD = 45.08$ ). This analysis and subsequent verification with each participant during the second interview resulted in a total of 270 open codes, ranging from 34 to 49 open codes per participant ( $M = 38.57$ ,  $SD = 5.41$ ). The open codes associated with a single participant constitute the individual depiction for that participant.

In the individual depictions presented here, an open code preceded with an asterisk indicates that the research participant considered that open code to be critical, essential, or extremely important. The number in parentheses following each open code indicates the total number of paragraphs, comments, or phrases associated with that code.

Individual depictions are in the words of each research participant, with the exception of words contained in brackets, which are those of the researcher. In some individual depictions the pronouns referring to the therapist have been changed from male to female or vice-versa to further preserve the confidentiality of the research participants. Identifying information for each research participant is excluded for the same reason.

#### ***Individual Depiction 1***

1. Every once in a while my therapist will reveal something personal about himself (2)
2. I had never heard of ergonomic therapy before I started it (1)
3. It was some time into therapy before I started the bodywork; I needed enough time being clean and sober first (3)

## RESULTS

4. \*My existence/life was very tiny, getting smaller and smaller, and I was in danger of losing my job; I had no idea of what was possible for me; I couldn't even dream or imagine this (4)
5. \*Therapist was very forthright, straight, and persistently called me on my b.s. and held me accountable/responsible; I couldn't do a snow job on him; it was initially unpleasant and painful (9)
6. \*This is the first time I told the truth, I learned to be honest, even about little things; therapist wouldn't let me just sweep it under the rug; as time evolved I became more aware and that allowed me to be more honest (10)
7. \*I was able to take responsibility for my actions in the past (1)
8. I gave up cocaine just so I could work with therapist; I was afraid he wouldn't take me as a patient if I didn't (1)
9. \*Therapist supported me and gave concrete suggestions and guidance without telling me what to do, but gave me things to work with (e.g. book and retreat recommendations, suggestions for getting out of debt, options for reporting others' illegal behavior) (13)
10. Therapist told me to stop smiling in the beginning because it was a cover-up; now I smile more authentically and I can tell the difference (1)
11. \*I would get really angry and pissed-off at therapist; he would allow me to get angry, it was OK, and he didn't take it personally; sometimes it would make me more angry that he didn't take it personally (6)
12. \*Therapist pushes me; I need and want it now, but in the beginning I didn't know; it means he won't give up on me and that's important (11)
13. In later sessions I found my therapist to be excessively aggressive, but I now realize that was my own defensiveness (1)
14. I was ready to stop and thought "I don't need (want) this hogwash/baloney/b.s.!" I now realize this came from my own defensiveness, it [the therapy] was pushing too many buttons (1)
15. At the first session my therapist said "I can help you" (1)
16. It's a process, a long-term commitment, but therapist didn't overwhelm me by telling me how long it would take (3)

## RESULTS

17. \*My gratitude for this work is endless; it's been life-saving, the best investment of my life; it's given me a whole new life; it's amazing; it's good; I haven't found anything else as powerful (9)
18. What am I getting into?!? This therapy is bizarre stuff; Reich is not mainstream and all this stuff about being sexually aware! (3)
19. My therapist introduced things slowly at a rate I could digest it (1)
20. \*I really trust my therapist and have great faith in what he's doing, but it took time for that trust to grow and it's still growing; that has allowed me to go deeper (2)
21. \*I can feel, talk about, and deal with my emotions/feelings and needs (3)
22. \*I know how to deal with certain situations instead of operating out of my character defenses; I'm more aware of my character defenses and what I do to keep myself safe; I'm able to observe myself; I'm no longer clueless (5)
23. I've gone to levels in this therapy, talking about what goes on innermost (1)
24. My therapist would ask questions that would make me uncomfortable and really make me stop and think and go deeper; sometimes going deeper wouldn't occur until after and outside of a session; it could be subtle or a big breakthrough (2)
25. Sometimes my therapist would say things that I heard but couldn't understand until later (1)
26. \*I don't understand how the therapy and bodywork works, but I don't need to because I trust in my therapist; some of this work is unknown, but I know it works and there have been changes; the bodywork, in general, is very important (4)
27. Bodywork is incredibly intense, just remembering it is intense (2)
28. For a long time I was so self-conscious in doing the bodywork and it made me feel very vulnerable, it was very private; it still does and that's OK to feel vulnerable (4)
29. I couldn't figure it out [the bodywork] and it took a long time before I could let go and breathe (1)

## RESULTS

30. I couldn't not feel emotions! The bodywork has a life of its own and I wasn't in control and that was very scary; my body would just take me, there would be reactions in my body that I couldn't control; but, I was aware of it at the same time; it's a very bizarre feeling; it allows you to get out of the way (6)
31. It amazes me how quick it is; it's almost immediate (2)
32. It's terrifying to have feelings during bodywork, it's really very uncomfortable and I was afraid to let go a lot (5)
33. Part of it is a process of breaking down barriers to let this work work (2)
34. The most powerful thing was when I was finally able to really cry, it was like waves of release, and it just kept going; it was really good, but it hurts at the same time (1)
35. It was hard to stay with emotions, I would shut down; therapist would say things or provide eye contact to bring me back from an unknown and alone place that was too deep for me to deal with alone (5)
36. Even though I trust my therapist I was aware of closing down when it was too much (I wasn't there, "the lights are on, but nobody's home"), but it's weird because I had awareness of it at the same time (11)
37. I needed help coming back to the present and therapist would bring me back with eye contact and directing me to look at him; that got me back to safety; I am able to go deeper because I know my therapist will bring me back, he would reconnect me, I could trust in him and that allows me to go wherever it takes me; I knew it was OK to go wherever I went, that I was safe (3)
38. Therapist can read me and it's as if it's another language; I'm aware of him being very present at that time; I'm really grateful for this! (4)
39. Therapist knows when to push and when to hold back a little; he's patient with me; he's a coach who encourages me to express emotion [during bodywork], otherwise I couldn't (2)
40. \*Biggest change is I'm alive - I wasn't alive - I was a zombie; I see things in a different light; I have a better quality of life; it's wonderful! (5)
41. \*Therapy has given me the world, friends; I used to isolate and only relate on a purely, very superficial level; I'm no longer afraid of reaching out to people and exposing myself, but with good boundaries (9)

## RESULTS

42. \*I've been able to change relationally and learn to live on my own (with my therapist's support), to stand on my own two feet; to be my own person; it's a really good feeling (15)
43. \*I've changed my health; I eat healthier and exercise (1)
44. \*Mat work doesn't happen every time; afterward I can just start to feel, there's a definite release, but it's hard to explain, something's been lifted and it's permanently gone (5)
45. Early on, approaching the mat was like having to take medicine: you know it's good for you but it tastes yucky; it's changed over time and now I want to do it, but it's still hard to get started with the first few breaths (5)
46. I'd like to keep my jaw! (3)
47. When it hurts it's working and I'm letting loose crying or whatever; that's when I get those waves of emotion (2)
48. In the beginning I felt like I must not be doing it good [the bodywork] (1)
49. \*Through talking about inappropriate sex, I remembered long-forgotten and repressed memories and allowed me to process what I'd never processed and understand things I'd done in the past in a clear way; it freed me to look at my sexual activity in a straightforward manner (not false bravado) (17)

### *Individual Depiction 2*

1. \*I heard people talk about armor, that little word made a lot of sense to me, and the sex-emotional core of people that was armored and hard in people; basic sensations, emotional and orgasmic/sexual feelings, that I remembered from childhood and teen years were triggered when I heard about orgonomy and Reich's basic writings about armor and emotional movement in the body; I wondered "what happened to that?" that's what brought me to orgonomy (5)
2. The particular combination of the physical with sensation of emotions in orgasm and health just felt intuitively and instinctually right; it drew me/urged me to orgone therapy; I knew this therapy was onto something; it felt instinctual, meaning the core emotional impulses (2)

## RESULTS

3. My psyche is a reflection of my overall core, biophysical, system's condition; my psyche and biophysical structure are not separable, they're inseparable (1)
4. I was never drawn to other therapies; they felt superficial and cognitive (1)
5. I'm trying to free myself, to make my life better, to break through to feeling (2)
6. It makes sense; I was drawn to orgonomy because I just "knew" it makes sense and feel that (1)
7. Orgonomy's kind of a lonely field (1)
8. At a certain point in therapy I started to feel what integrity was instinctually, on a deeper level, not just intellectually; I began to feel what's integrated (1)
9. Sessions [with first orgonomic therapist] were more calm/static with a lot of talking and there was less anxiety; it wasn't that dynamic; the feeling was of having someone to talk to who understood me (2)
10. At first I didn't think the therapy [with my first therapist] had much of an effect on me, but a few years after ending I realized that therapy had bolstered me in being more awake, alert, integrated, and in contact with my environment, people, and things happening in my life, even on a physical level, especially visually; but, it was subtle and didn't really alter my sexual or relationship functioning (3)
11. Therapy has allowed me to remember whole years and long periods of time when I had a sense of the reality of ocular armoring, when visual contact with the world was more closed down and shy and withdrawn; I realized I was "away" (1)
12. Now there's more opening up and awakening of visual contact; I can express more spontaneously without conflict or struggle; I'm more alert, conscious, and awake in the world visually (1)
13. Sessions [with my current therapist] start with breathing as an energetic bellows to build up a biophysical charge; I feel the benefits of this; I get the most benefit from working with my current therapist (4)
14. \*I felt the effects of sessions very subtly over months and years, rather than days or weeks (4)

## RESULTS

15. Deep, genuine crying or anger comes out in session every once in awhile; a lot comes out in session (1)
16. I get stimulated to let down armoring, very incrementally, very slowly by being poked and prodded; it feels organic, not mechanistic (1)
17. \*The effects [of therapy] are more freedom and spontaneous/dynamic behavior in relationships, ability to express, sexual behavior, ability to aggress, clarity of thought, at work, everything, in a lot of different ways; generous feelings of well-being on a day-to-day basis; my capacity to enjoy on a day-to-day basis has increased (3)
18. Integrity (my ability to relate to myself and others) comes up a lot in terms of what therapy is doing to me; integrity of my humanness, my sex-emotion and orgasmic functioning (1)
19. \*It's a healing of the soul, not in a mystical sense, but in the sex-emotional function, which is the soul of a person; the soul to me is not a mystical concept, but a feeling of the deepest integrity, the deepest substantialness of my humanness; feeling content, happy, and more pleasurable; well-being (1)
20. Over time, building energy charge during session steamrollers over anxiety and counteracts shrinking back, weakness, uncomfortableness, and fear; and over time I have feelings of well-being, ready to take on the world (1)
21. Low levels of anxiety during sessions doesn't feel as helpful (1)
22. I could no longer fool myself into believing that I was living a substantial life that I wanted to live (1)
23. \*The effects of therapy in life can make things excruciating and bring up anxiety, churning, and disruption; why would anyone do that? it's like an instinct; I instinctually go to a place of expansion; that's why I go; I've had feelings of expansion, too (4)
24. Therapy and life look to me like contracting and expanding: the pulsatile nature of a person; it's hard to tolerate the contraction, but I know there is expansion, too (5)
25. Therapy has allowed me to energetically expand out of what was a very difficult relationship breakup (2)
26. As the armor has come off I've had spontaneous levels of sexual pleasure increase, not just intercourse, but all kinds of sexual behavior; the

## RESULTS

euphoria, pleasure, and contentment dwarf the secondary pleasures in life; it's a dramatic feeling of change; the things I enjoy are much more simple now (2)

27. \*I find sexual behaviors come out of me spontaneously, naturally, and easily; the level of euphoria and pleasure is heightened and intense; this can occur in the hours after sessions (8)
28. In the lifting feeling where there's more freedom and spontaneity, I realize the nature of armoring in myself; I can't sense my armor until I've shifted a little bit; if I'm completely armored there's an anesthetic quality to it that prevents me from recognizing it; the changes allow awareness and consciousness of the armoring; I wasn't aware of it before the changes (4)
29. I couldn't release myself from my armor without Reich's tools; the only way out, unfortunately, is long-term orgone therapy unless I would have had some phenomenal event in my life that shook me up maybe and made some change (1)
30. I have a pleasurable visual alertness (a combination of the eyes, brain, and energy of my whole organism) right after sessions; but, I notice a substantial core shift and change in my visual alertness more over months and years; I've become more contactful visually over the years and realized that there really is visual armoring (6)
31. I notice eye contact and armoring in others (e.g., at markets and with different ethnic/socioeconomic groups) (5)
32. Over time I've had character change that has allowed me to be more contentious, honestly expressive, and able to loosely and spontaneously confront things directly which I feel are wrong, oppressive, or unfair (e.g., unhealthy authoritarianism); I haven't become a fighting person, I'm just more able to clearly see what's wrong (7)
33. I feel waves of expansion and contraction physically in the therapeutic process; I feel looser over months or years (1)
34. During expansion I feel more happy and fulfilled with life; during contraction I can better tolerate and understand ways to help myself expand out of them (1)

## RESULTS

### *Individual Depiction 3*

1. As a young person I was really shut down and there was a lot of anger, but I knew; I didn't want the medical model; I wanted somebody who was right for me (2)
2. \*I went to a group in which people were emoting and expressing and I thought "Oh my God! This is for me!" (1)
3. I was doing Reichian therapy with a previous therapist and now I'm doing organomic therapy; I got a lot out of the Reichian therapy, but the organomic therapy is like shifting from 1st to 10th gear (11)
4. Medical doctors and others kept saying I was fine "Oh, you look so good, you can do anything you want, you're bright;" I had a lot of energy and smoked pot to deal with that and bring me "down to earth," to calm me down and deal with huge amounts of loneliness; inside I was lost and traumatized (6)
5. As my head has gotten clearer through the therapy I can look back and realize that it wasn't clear on the pot (3)
6. \*I didn't have contact with anybody or the world; nobody gave me contact; there was a lot of abandonment; I was a very sensitive child; all that is very sad for me (4)
7. When I started with my therapist I was having tons of anxiety and I couldn't find my self, my center, I had no place to rest (3)
8. It's only been in the last six months of therapy that I've really realized what is happening (1)
9. My therapist doesn't volunteer unnecessary information (1)
10. I love that my therapist talks very little unlike in previous therapies; she just shares key words and his perceptions (3)
11. \*My therapist guides and gently modulates me; I love that she doesn't try to fix me; I'm accepted and validated (e.g., she'll say "that's fair to feel") (2)
12. I had a previous therapist who tried to fix me and it made me really mad; I just wanted to get my feelings out (1)
13. My therapist articulates what I'm trying to communicate better than I can and that is extremely relieving and helpful (2)

## RESULTS

14. My therapist watches my eyes, my movements, my face, hears voice inflections, and she can see me going from my emotions to my mind (1)
15. \*Every session is like magic; it's magical!; it's been fascinating; really amazing; it's incredible; I love it!; this is the most amazing work on this planet (11)
16. Now I have no resistance when I go to sessions because I know how magical it is; I go into sessions curious about what's going to happen today; I'm excited on days I have sessions (2)
17. I go in feeling fine and something deep emerges (1)
18. Often times when I am re-experiencing something during session it's like I am absolutely there at that moment in time; I happens out in the world, too, but it's not so intense or clarified; I'm able to have deep emotional experience and be present with it; I'm in contact with it and I love it [re-experiencing] (3)
19. \*My therapist's contact with me through her shining, open eyes creates safety and trust for me; this is part of what allows me to have deep emotional experience and be present with it (1)
20. My therapist is very compassionate, caring, and contactful; it fills me up; the genuine contact was like a life force for me; it allowed me to find myself; it saved me from a lifetime of periodic anxiety; it made me whole and integrated parts of myself I couldn't find before; it's in the relationship that it happens; it's so much my relationship with my therapist (6)
21. I started the biophysical work immediately (2)
22. The first six months was a floodgate of emotions and memories (1)
23. \*My therapist has shared with me extremely potent and powerful images from her own mind about me and that has deeply affected me (e.g., young woman in Viet Nam war with both arms blown off, running and screaming from the trauma); it made me feel seen and recognized; it was healing to be acknowledged (2)
24. I'm so thankful and grateful to my therapist for giving me the opportunity to feel and re-experience what's inside of me that needed an outlet, healing, and acknowledgment at that depth (3)

## RESULTS

25. My therapist would strategically say something that made me feel understood that would let the floodgates go off my emotions! this floodgate of energy would move out of me because I felt understood; there's less of a floodgate of stuff needing to come through now (3)
26. My therapist is the good mother that I never, ever had (1)
27. I've noticed that my head is quieter and settling down and my energy is more in my body as a result of therapy; my dreams show this; I'm getting more connected; I notice it in my eyes; I'm more at peace, calmer (4)
28. I have more orgone energy (1)
29. I'm more patient and compassionate, but also able to tell the truth more, instantly; I have more power and I see people's stuff, armor, games, their pain more clearly now (1)
30. I'm more self-sufficient; I'm not seeking something outside of myself as much (1)
31. I've had big changes and shifts; I'm warmer and more affectionate; others have noticed the changes in me (2)
32. This therapy feels like a PhD program, whereas other therapies feel like high school or college (1)
33. What I do in the sessions doesn't seem like enough to make all this difference, but somehow it does; my therapist is really just present, has the energy of connection and care; I don't do that much intense physical work myself (2)
34. After recognizing and acknowledging the initial floodgate of stuff, most of the work has been getting me open and grounded in my eyes (2)
35. After I leave a session everything is literally clearer, greener, brighter, outside is fresher, there's more life; my vision is better; what else is there?!? (4)
36. \*A couple of times after sessions I felt intensely compassionate and deep and whole and was seeing things in others more clearly (e.g., another person's painful distancing) and was able to be wholly, behaviorally different; I had expanded awareness and contact; it lasted all evening long, not just 30 minutes; the defensive and critical me was gone; it was a magical and awesome experience of my self; I wish I could live there! it was a great gift; like seeing God (9)

## RESULTS

37. My progress is integrated and my behavior more natural so I don't see it as dramatically anymore; I'm more "my natural being" (3)
38. This therapy is my destiny; this is what I'm here to do; this is my heart's desire (1)

### *Individual Depiction 4*

1. I didn't think I would ever go to therapy; my brother expressed concern about how I was living, especially relationally, and what I was subjecting myself to; my parents were already involved in Reichian work and something "hit home" and I started therapy (6)
2. I don't see my therapist as frequently or have as much time to just be and to just feel as I'd like since I had kids (3)
3. I've been in therapy 17 years, but it doesn't seem that long; it feels like there will be no end because there does not need to be an end (2)
4. I don't have specific goals in therapy and I'm fine with that; it's part of why we [my therapist and I] work so well together; it's more a constant dealing with life as it comes; maybe my agenda is different than other patients or this isn't a traditional organomic approach (6)
5. I have a unique vantage point, being the child of two therapists (2)
6. When I go to therapy now it feels like I've had a tune-up and an oil change; all the dust is wiped off and there's so much more clarity; I'm back on both feet for awhile (3)
7. Half the time, my therapist says only six words the whole session; my life is filled with chatter and talking and screaming so therapy is a sort of sanctuary; during one especially intense and helpful session I don't think he [my therapist] said practically one word to me (3)
8. My therapist's voice, those six words, are enough to put me really, really inside myself where, especially as a mother, I've had precious little time like that; my therapist just nods or says "mmhmm" until I get to the crux of what I'm feeling or dealing with (2)
9. It feels like a missed opportunity if I go to my therapist's city and am unable to have a session (1)
10. \*Therapy allows me to just lay there, breathe, feel, and stop thinking; it gets me out of my mind; I get to step back from seeing the world psychologically and that's a relief; it gives me perspective so that I can

## RESULTS

see what isn't working in my life that didn't necessarily look like that before; it allows me to live for myself, not others (4)

11. It takes 10 to 15 minutes of talking in the beginning of a session just to get to the point where I can stop talking; it feels like such a waste, but I have no choice! it's part of the process; there's movement from thinking and talking to feeling and breathing; it takes some talking to get to a deeper emotional space (4)
12. I talk less at the beginning if I've been doing my therapy consistently or if I'm going through something incredibly intense (e.g., death, birth); then everything sort of bursts out of me (5)
13. There's a familiar smell and serenity just when I walk into my therapist's office; it's a palpable comfort, a very memorable part of my childhood; I remember it from when I was a child and my family would take my stepbrother went there; the whole environment sets the mood as a whole reflection of my therapist (2)
14. \*My therapist is a very unique person (1)
15. There's something very mysterious about orgonomic therapy because there's so little talking (1)
16. We'll do some breathing; my therapist will often instruct me in breathing (e.g., "take some deep breaths"); it's all about breathing (2)
17. My therapist often has me track a flashlight with my eyes; it helps me to emotionally look at a situation or myself and my feelings; it connects my waking self to my inner self; I get larger, clearer, and bigger; after doing that I feel more connected to whatever it is that I'm feeling (3)
18. My therapist may just put his hand on my shoulder and that connects some energy to my breathing; it allows me to express my feelings and breathe; I think this is different than how he might work with other patients (3)
19. My therapist will guide me deeper into whatever I'm connected to; or give me time to express whatever I'm feeling (e.g., sadness, anger, crying, bawling) (2)
20. My therapist has encouraged me to feel free to safely hit the bed if I'm feeling angry; sometimes I yell, but not often (3)
21. I remember three particularly intense and helpful sessions; all involved breathing; my therapist's energy and touch allowed me to be with myself

## RESULTS

and for myself so that I processed eight months of grief in a healthy, pure way in one hour (1)

22. Just a simple question that my therapist might ask (e.g., “do you remember ever first having that feeling of...?”) will force me to search my body emotionally in terms of feelings and not just a catalog of memories; something will come up, something really simple, that will just click and bring me to a new level of understanding; I can’t say exactly what it is (1)
23. \*The environment of incredible trust and safety allows me to have spontaneous physical reactions and feelings that I don’t usually have time for in my regular life; to connect physical memory with emotional and psychological memory; heart, openness, and energy, which is Reichian; like a meditative state; everything connects at the same time; it’s a different emotional plane (5)
24. \*Regular talk therapies can’t reach this level of depth because the physical, emotional, and psychological memories are cut off from each other (1)
25. Therapy is to train me to be able to connect between regular life and feeling; to be more in touch with my feelings; to fall into myself deeply and quickly, but this is difficult for me, partly because of day-to-day life activities and pressures (3)
26. I can cry for an hour during session (1)
27. It’s hard, after session, to maintain the state that I experienced during session; everything around me is kind of bombarding; I feel like the second I stand up [from laying down] it’s a different reality; to try to keep what I just experienced in myself is hard to maintain (3)
28. Talking about this makes me realize I need to go see my therapist more frequently (1)
29. Therapy has helped me get some healthy emotional distance from the culture I received as a child and to integrate it in a way that is right for me, so that it has become mine; I’ve been able to own things in my own way (6)
30. \*I’ve become more clear about what’s mine and what’s not mine, what was put on me and what was not put on me, who I am and who I’m not, what I want and what I don’t want to be me; I feel like choices (e.g., choosing my husband, given his cultural background) are mine; I’m more

## RESULTS

able to see when things are being over-analyzed and judged and to create space from that and to let go of that (8)

31. My self-esteem has improved (1)
32. I'm able to "see things" as they are, clearly, and I'm grateful for that (1)
33. After a session I need time alone to breathe (10 to 15 minutes), to just be; I might not go to the train immediately, but aimlessly walk for awhile instead; the breathing helps continue my state from the session (4)
34. \*My eyes are big to the world after a session; I can safely take more in than usual and see; there's a visual openness that's connected to everything inside; my breath is connected to my eyes (6)
35. My whole body feels connected after a session (1)

### *Individual Depiction 5*

1. \*I packed a lot inside, but now it's opening up and I can explode very quickly; especially if I feel backed into a corner; I'm no longer willing to stuff it; I don't want to go back to where I was; I let it out if it's relatively safe (6)
2. Before doing orgonomic therapy I had been in therapy a long time, maybe 20 years (but not continuously), and I had worked with a transpersonal therapist who sometimes employed something body-oriented on the side; I was helped, but it did not feel like I was really going anywhere (4)
3. \*My therapy before orgonomic therapy was as though I had hacked my way out of a jungle with a machete (a jungle that I had been going and growling through my whole life), only to find myself in an opening and standing in front of a thick wall that went as high and to the left and right as I could see; I didn't know what was on the other side; I hacked at it and banged my head against it, but nothing really happened; that's what I felt like in my previous therapy; the machete was all that the previous therapy offered against the wall (4)
4. \*I was somewhat familiar with the orgonomic work because I talked to a trusted friend who had been doing it; my friend recommended my orgonomic therapist upon hearing my story of standing in front of that wall; so I called her; all my previous work was leading me here to this (4)
5. I continued seeing my old therapist and my orgonomic therapist for maybe a year until my orgonomic therapist confronted me and I had to

## RESULTS

choose; I was going in two different directions; the choice was clear: my [previous transpersonal] therapist offered me only a machete against a huge wall and it just didn't feel like it would produce the results I wanted; my organomic therapist was an unknown, a gamble, a leap of faith, but held possibility (10)

6. I didn't know what I wanted out of therapy, but I just knew I was not myself; I had yearnings and energy I wanted to move (a push from inside), but I was held, being in a straitjacket, held back; I was unhappy (8)
7. My memory of the beginning [of therapy] is affected by what's happening to me now (it's a strange state); I see visions like flashes of my therapist from that time; it's hard to describe this in a connected way because I didn't know what was going on then; I can't create an exact coherent picture of it (3)
8. I would go there, take my clothes off, lie down on the mat, and probably breathe; I remember being worked on physically, but not having hardly any conversation with my therapist (2)
9. I remember being very blocked in the beginning; I was very protective and held physically; not trusting, not knowing (4)
10. In my previous [more traditional] therapy we would talk back and forth and I tried to hide everything from my therapist (my modus operandi); I don't remember doing that [talking, conversation] in the organomic therapy, but the hiding was still happening in a different way (2)
11. \*I thought about quitting therapy many times when, as a result of the therapy, I felt excited (meaning angry, unhappy) and would feel faced with something; I would think "What's the point? I'm not getting anything out of this! What the fuck? What is this? What are we doing here? Why are you [my therapist] finishing early? It's a lot of money, what's the purpose? Nothing's really happening;" On top of everything, now I'm angry!" I now know this was my defense (9)
12. My old character pattern was to try to squoosh my energies to prevent movement, so I'd be still, because only there I can control and feel safe (2)
13. I was scared of things happening naturally because I didn't know what would come as a result (2)
14. \*The therapy disrupted my attempts to keep my energy still and from moving, it would challenge that; my energy would start moving as a

## RESULTS

result of breathing and expressing anger and stuckness by hitting and yelling; I'd try to squash it and I'd become angry; it was unpleasant and made me question why the fuck am I doing this [the therapy]?! (3)

15. If I could stop things from moving, I'd be OK and wouldn't feel the need to quit therapy (2)
16. As a result of therapy I can see this [stopping energy movement] in other people now (3)
17. \*I stay in therapy because there at least is a possibility that I won't remain alone and hidden (like I always am); if I leave what would I have? nothing; I'll have my state, as it is, stuck in a trap, with no possibility of getting out of it, no possibility for anything; back to where I was (7)
18. \*I initially approached therapy from a very defended place; I was defended against anything and everything including what was happening in the therapy, including my therapist (8)
19. \*Now it's transformed and changed; but it was really gradual, probably because I was and still am (to a lesser degree) defended; it's difficult to describe how that happened, but somehow, suddenly, I realized something was happening [in session], something that actually benefits me, something that gets me to that place that I yearn for, something better (1)
20. \*At first my mindset was "My therapist will be doing something to me;" over time I began to realize that something is happening and if I do my part by being active and present I can make it happen faster and more effectively; now I realize my therapist is facilitating something and what is actually happening is that I am doing something; it's a team now; feeling that I am a team with my therapist really helped me to continue opening up (3)
21. I look back and can see that I perceived my therapist and what happened during session as an attack on me; I took offense; but it wasn't, that was just how I was perceiving it; I looked at everything in my life as an attack on me; my life is not like that anymore (4)
22. \*What really helped was finally bringing my anger to session and embodying my anger during session instead of "showing a face;" screaming, banging arms, yelling, giving words to it; feeling safe enough to express hate; at first it was very difficult to do that, even with my therapist's encouragement; all of these things have helped me to be more in touch with my anger and own it more (9)

## RESULTS

23. I think I've expressed anger at my therapist, but not so much anymore; it was difficult to express anger at my therapist because how can I dump on my therapist who is there to help me? (9)
24. A lot of my memories of therapy revolve around explosions and expressions of anger and allowing that to be; that happened in many sessions (2)
25. After sessions I feel spent, but energized for a few hours; then I crash and have little energy and feel sleepy; I feel expanded for a half a day or so, but toward the end of the day and after waking the next morning I feel contracted (10)
26. The transition from expanded to contracted is so stark and unpleasant (2)
27. \*As a result of therapy I'm less attacking toward others; I'm less defended (3)
28. \*As a result of therapy I maintain my presence longer with other people, without collapsing inside or hiding or shutting myself out (3)
29. \*As a result of therapy I function better, including financially and occupationally; I never could have done this without the therapy (6)
30. \*As a result of therapy I'm calmer; I'm more in touch with my self; I feel expanded, more alive, more my self, more connected; there's very little anxiety or mental soup, I'm just there; (5)
31. It used to be like both of my hands and feet were tied up or part of me was moving forward and part of me was pulling me back; my functioning was low because I was too compressed (2)
32. \*Therapy allowed me to be present in life and allow good changes, expansion, movement and to make things happen; to not squash it out of fear that something unsafe will be created, but to allow it to happen; the feelings inside to allow this are stronger and clearer (5)
33. Orgonomic therapy addresses the underlying issue which is in my body somewhere, other therapies don't; there is no chance to be well without addressing this; orgonomic therapy is much, much deeper and goes to root cause; a lot deeper; it provides healing, other therapies just provide relief; orgonomic therapy treats me like everything is connected and integrated, unlike other therapies; it seems natural and logical to me (9)
34. My experience is that my neurosis is stuck in my body; it's present as a real thing, a holding place where energy is stuck; I remember drawing it

## RESULTS

as a very dark, very dense black steel ball in my gut; it's not in my head, but in my body (3)

### *Individual Depiction 6*

1. I'm frustrated that such a profound philosophy [orgonomic therapy] may be dying and orgonomic therapists are so few and far between (1)
2. When I sought this work I wanted it so much that I had actually considered seeing a therapist who was a 12 hour drive away; I was very grateful when my therapist moved to my area so I could have Reichian work without traveling for hours (5)
3. I had heard about Reich in my 30s from a therapist at the VA who practiced bioenergetics; I was just drawn to it; it made sense to me; it speaks to me; I felt Reich was really grounded in science; I'd read that Reich worked with a guy who saw prostitutes and after the work he got into a loving relationship and I thought "oh, my God, that's what I want!" that stuck in my psyche (8)
4. \*I began to read [Alexander] Lowen [father of bioenergetics, heavily influenced by Reich] and was powerfully influenced by him; his words touched my gut, they spoke to me, I fell in love with his verbiage; it wasn't a head thing, his words go to my heart; I was like "oh yes! yes!" it was like he's written that book to me; it felt like there was a way out (7)
5. \*I found the bioenergetics good at first (screaming, crying, getting a release), but it didn't last; I wanted to find somebody who knew what they were doing; everybody I ran into was doing neo-Reichian and it was just a little too intense and didn't analyze character; plus, people treating others may have had a few years of therapy themselves, but weren't really trained to do it; it just wasn't quite clicking more deeply; it was mechanical; it wasn't good, solid work where you change over time; I wasn't seeing change or progress; it didn't feel right (27)
6. In the early bioenergetic group work I found it hard to be open; the closeness of the group was a bit too much for me (2)
7. I was looking for something; I didn't know what it was or what changes I wanted in myself, but I knew I'll know it when I find it; as I begin to inhabit my body more I'm beginning to understand what I'm looking for (2)
8. I was in full-blown addiction and on a lot of anti-depressants; it took me a few years to get clean; I knew, I just knew I didn't need that stuff [the

## RESULTS

psychotropic medications]; neurophysiological feedback helped me get off that and then it ran its course (3)

9. I intuitively knew something about myself, and that was that I couldn't feel; I felt nothing; I could think it, but couldn't feel it (3)
10. I believe Reich was a genius and ahead of his time (3)
11. The first couple years we did a lot of eye work and we still are, trying to establish feeling there (4)
12. I went on the mat fairly early in my therapy (1)
13. \*Even after four years of this I'm still a little nervous every time I go to a session; I don't want to do the [mat] work (part of me would rather sit there and talk for 45 minutes); the [mat] work is difficult for me; I'm apprehensive and nervous every time (8)
14. \*I manage the nervousness before sessions by numbing out by making phone calls or I'll have a session in the car myself, to get ready (on the drive to sessions); I also always come late to sessions (5)
15. Every time I'm done [with mat work] I feel better [as a result of having done it] (3)
16. \*I've realized that for me the work has to go slow; my therapist went really slow with me; I think that was a wise decision; it enabled me to talk about things and for movement and change to happen (2)
17. \*My therapist will encourage me to stay with difficult feelings (e.g., feeling fear and breathing hard), and I want to back away (and maybe talk); it's difficult for me to stay there (1)
18. \*I ask myself why I keep doing this; I have hope, based upon actual experience, that I'm working through a process here; that what keeps me going through this; I wouldn't be able to continue without hope; my therapist says I'm going in the right direction and making progress and I feel that myself, but my own actual experience is the key component (i.e., I notice movement and change) (4)
19. \*I don't know what the outcome will be; I'm sure it will probably be different than I imagine it; I have no idea when I'll be done, but I guess I'll know it when the time comes (2)

## RESULTS

20. I've moved from twice a month, to once a week, to twice a week; I decided that in consultation with my therapist; I've recently thought about increasing to three times a week (4)
21. I don't have a real tight relationship with my therapist, but I feel that he knows what he's doing; it's kind of disconcerting; I realize I'm not there to become friends, but I would like there to be more of a community around him; that would give me more of an opportunity to interact with my therapist outside of therapy (6)
22. \*The third year or so we started talking more; we hadn't done much of that prior to that; that became an important component; it's given me a much better understanding of myself; I'd never had that in any of the other work that I'd done; sometimes [now] we don't do any biophysical mat work (5)
23. \*We spend a lot of time talking about [one of] my core addictions and my early childhood; the [talk/verbal] therapy changed my way of thinking about and understanding that (3)
24. I remember establishing being able to feel angry in my eyes and face; that took quite a while; getting there was a real milestone; as we've moved into working with fear it feels very crucial and I feel afraid (1)
25. \*When I started I didn't feel anything in my body, but today there's all kinds of stuff going on in my body (2)
26. Being able to feel anything is a big change for me; it excites me to be able to feel; now I can feel feelings in my body that I'd never felt before; wow! (5)
27. \*My therapist's ability to listen to what I said and to feed that back to me (with his perspective and thoughts, but without saying I'm wrong) somehow just got by all of my filters; I didn't like it, but I couldn't deny it; I don't know why this therapist is able to do that and others [before him] weren't; my therapist just enabled me; I'd never had this kind of movement or change with any other therapist (5)
28. \*Doing this work does not match any idea of what I thought it would be like; reading about it is just bullshit; I imagined dramatic breakthroughs and being very open, but it's been a very slow process for me (4)
29. I left other therapists after about a year because it didn't feel like a lot of change or movement; the same thing happened with my current therapist, but...she's just kind of special, she has a way that I just can't put into words (2)

## RESULTS

30. My therapist doesn't talk a lot; she's a good listener; when she does have something to say it's pertinent and to the point (2)
31. I realize now that I can over-talk to defensively avoid my feelings (1)
32. After a session I can feel like I've had a cardio workout, I may be sweating, I feel pleasantly tired; I always feel much more relaxed, my body is more relaxed; I feel more open; more in touch with me; things are a little clearer; my desire to smoke is decreased; all that will last for a couple hours, maybe (2)
33. Making eye contact with my therapist is very difficult for me; I'll twitch and squirm, my body will move (1)
34. I can now say that I expand and I contract; I can physically feel more expansive, I'm more open; I'm more attuned to myself and able to feel subtleties, to feel the subtle ebb and flow in my body; I didn't know that three years ago (5)
35. As a result of therapy I now know that I have a face I wear when I'm not happy; I can feel my face; I can feel when I have a dead face or when I have emotion in my face (4)
36. As a result of therapy I've had three episodes of sexual sobriety for months each time; that was profound; they happened out of a cognitive shift as to why I'm doing this; I haven't resolved this completely yet, but I have a much better understanding; but there's also something in the body that is driving this that I haven't touched yet; it's saying "what about me? what about me?" (7)
37. \*As a result of therapy I've learned that I can go to my wife and express my feelings (e.g., anger, fear); this sounds like something everybody should know, but I had to learn it (1)
38. I feel grateful that I've been able to experience this work (1)
39. Reichian therapy, for me, is a form of waking up, like Buddhism; I think Reich was a Buddha, trying to wake humanity up in a very profound way (4)
40. People and therapists who do other types of therapy don't seem to have that feeling that "this is just right" (2)

## RESULTS

41. Now I understand why emotional focusing didn't work for me - it was asking me to feel a felt sense, but I couldn't feel! And it was too cognitive (6)
42. Reich's work was very, very serious and very deep, profound (3)

### *Individual Depiction 7*

1. I consider my orgonomic therapy equivalent to an analysis, as in the traditional analytic model, even though it was a once a week experience (4)
2. I was very impressed with the thoroughness of the initial interview/intake [with my therapist] and that was the beginning of developing trust; that was important to me because I am a clinician as well (1)
3. I didn't know [from my friend] that you take off your clothes; doing that the first time was an act of courage on my part! I remember that first time (3)
4. When I asked my therapist about what I might read, my therapist said "don't read anything! don't go into your head!"; that allowed for me to have therapy be experiential, to be immersed in it as one might be immersed in water (if one wasn't too afraid) (3)
5. I had done a great deal of insight/talk therapy when my previous marriage was crumbling and found it to be very, very helpful; I felt good about that (5)
6. A friend who lived with us, who was also a dancer and dance teacher, moved across the country to do Reichian therapy with the person who was to become my therapist; it was evident to me that the Reichian work meant so much to her and she was invested in it; that inspired me to check it out; I also knew another woman who had done tons of talk therapy and was doing Reichian therapy (4)
7. I was drawn to this therapy because of the physical nature of it; I was very damaged from a previous marriage: I had stopped dancing, I had stopped singing, I wanted to swim freely in the deep end/I wanted to be free in the water, and I wanted to address these three issues through the Reichian experience (1)
8. I think a lot of people are drawn to Reichian work because of the emphasis on one's sexuality; this wasn't key for me initially; I had sex very compartmentalized in what I thought was a good place; later during therapy I discovered that there can be a darker side to sexuality; I also

## RESULTS

realized that being sexually molested was more than just a fact, it was something I wanted to explore (2)

9. The first time on the couch my therapist had me start breathing, coaching and encouraging me to give my breath a voice; I don't remember exactly what happened, I think it was tears, whatever it was - it was powerful (1)
10. After this first appointment on the couch a friend noticed that my face looked very different, wondering what had happened (had I had a facial?); it was very affirming for me that a perceptive friend noticed a change in me; that made going back more interesting; it made me think "this might be legitimate!" (6)
11. I felt good, lighter, freer after the first session on the couch; I wanted to go back [for more sessions] (2)
12. I didn't know what to expect, because I hadn't read about it, but I thought "I'll keep trying this;" I took it on faith (1)
13. As I talk about it I'm kind of re-experiencing it, visually and the feeling; I feel very emotional talking about some of this (1)
14. It was very important to me that my therapist was grounded, grounded in a theoretical orientation or structure, not flaky, not misusing people; my therapist was and is very grounded and professional (1)
15. My therapist has such a presence; he's present (not detached - not glomming onto me); he's present emotionally and physically; his eyes were with me; I could feel his presence; it didn't take long for me to have absolute trust in him; I trusted my therapist and I still do (8)
16. It often hurt when my therapist touched me [during biophysical work], but only because he was trying to help me release; it didn't hurt afterwards; the hurt was gone like deep tissue massage (2)
17. My therapist was the father I never had, but wanted; that was very healing (4)
18. My therapist was very compassionate and caring; would get mad at me, provoke me, but he was always there; my therapist never left me; I feel very emotional about that (2)
19. I remember having a vision during the first year of work in which all the insights from the previous talk therapy about myself and my family became very vivid and were brought together, the insights and the physical work came together, they became one, in a nonverbal way; I

## RESULTS

actually felt I had re-lived this very early, early childhood; it happened without words, without cognition; it felt preverbal; it was a really powerful experience; I don't remember the content now exactly, but I remember the feeling of it; it would be like being able to jump into the deep end of the pool and not be afraid (if I could do that, but I can't do that, and I never did address that in my therapy) (5)

20. I had fantasies of getting my therapist to go to a swimming pool with me to help me be able to jump into the deep end (1)
21. Another experience that happened more than once, was like being in the womb, or the birth canal coming out of the womb; it was very, very, very early and very primitive; very important; that experience affirmed for me that the previous insight work had been so significant, and that those were truths; and that I didn't need to question them anymore, in any way; it was amazing, it bypassed cognition; it was almost like I was a baby (4)
22. It's almost indescribable, but very powerful and stays with me today (1)
23. I was a very insightful and knowing child and young person; I was very deep at a young age, yet I also felt that I led my whole early life in a performance (smiling, being friendly and outgoing) (4)
24. I had a hard time expressing anger; my therapist would tell me to hit him and when I couldn't, my therapist would hit me; it was odd, but also seemed ok; I deeply knew he was trying to help me; I realized there was a problem that I wouldn't hit back or stop someone from trying to hit me; my therapist got me to get angry after a while (6)
25. My therapist would, at just the right time, scoop me into his arms and hold me close; this would comfort me and make me feel safe (1)
26. Sometimes I would just talk with my therapist and sometimes my therapist would tell me to stop talking and to get on the couch; he knew which would be more beneficial for me (2)
27. I trusted my therapist partly because my therapist has intuition and I have a lot of respect for that (I have it, too); his intuition helps him to have good timing and I trusted that (2)
28. My therapist seemed to know where to go, what was next, the direction to take (1)
29. I was very guarded about telling people that I did Reichian therapy because I wanted to be "acceptable" to the mainstream psychotherapy

## RESULTS

community (though my intimates knew); I didn't want to be perceived as a flake; I wanted to protect myself (4)

30. I knew there was an authentic "me" in there and through the therapy I was able to embrace my authenticity (1)
31. Through the therapy I was able to embrace my differences (1)
32. Through the therapy I was able to open my heart more in all my relationships; I'm softer, more malleable; I would not ever have been able to let my current husband into my heart had I not done this work (3)
33. Through the therapy my eyes became unblocked (1)
34. Through the therapy my better self was affirmed and realized (my intuition, my compassion, my genuine concern and my respect for others) (3)
35. I think my daughter suffers from my having been armored; I didn't recognize that at the time of my early parenting; therapy helped me begin to change that (1)
36. I felt my therapist never fully understood my issues about learning; I felt like he would be dismissive about them (though he probably wouldn't be if I worked with him on this now); so I learned to not go there; but I still wish I could get over this anxiety about learning (9)
37. My therapist and I are colleagues now; we respect each other; we really love each other (2)
38. I wish my Reichian therapy had taken me into the deep end of the pool; I'm sorry I never got that far (3)

### **Introduction to the Composite Depiction**

Analysis of the 270 open codes across all individual depictions resulted in a total of 47 category codes. Of these, 31 exhibited considerable consensus across interviews. These 31 category codes provided the basis for the composite depiction that distills the experience of all participants into a comprehensive narrative.

Considerable consensus, for the purpose of this study, was defined as any category code which included (a) recurring open codes from three or more

## RESULTS

participants (29 category codes met this criterion), or (b) two or more open codes considered to be critical, essential, or extremely important by two or more participants (2 category codes met this criterion). This liberal definition was employed so that the widest variety of detailed experiences could be included in the composite depiction without unduly compromising the overall integrity and generalizability of the narrative across all participants. The 16 category codes which did not exhibit considerable consensus, but yielded discernable patterns, will be explored in the next chapter.

Although the composite depiction is a rich and complex distillation of the qualities and essences that permeate the experience for the entire group of participants as a whole it is not meant to be representative of any single participant nor of all patients in organomic therapy in general. *Bodywork* and *mat work* were used interchangeably by participants to mean biopsychotherapy, the somatic component of organomic therapy, but *bodywork* was used most often by participants and will be used here. The following composite depiction, written in the first person as is each individual depiction, illuminates the essential qualities of what it is like to be a patient in organomic therapy for this group of research participants.

### ***Composite Depiction***

I suppose patients first hear about organomic therapy in a variety of ways, maybe from a trusted person or just by chance, but what struck me most was that something immediately resonated inside of me upon hearing about this unique form of therapy. Something inside of me said “Yes! Yes! This is for me! I want that!” I feel that this therapy just makes intuitive sense. It somehow speaks to me and just feels right. Organomic therapy seems different from other types of therapy; it feels like it is really onto something. I am just naturally and intuitively drawn to it, especially because of the focus on the functional integration of the mind and body as well as the prospect for real emotional expression and movement. I am reminded of a time in my childhood when I was less armored, when I could feel emotional and sexual energy movement in my body. I have a

## RESULTS

memory of that. I wonder what happened to that energy movement. I also feel angry at its loss, at being shut down, and I feel a strong desire to regain it.

I have a strong desire to receive organomic therapy and I am willing to go to great lengths to engage in it. I have given up highly addictive drugs and am willing to travel great distances just to work with an organomic therapist. I feel a keen loss if I miss an opportunity for therapy. At times I have realized that I want therapy more frequently than I am getting it. It is painful to miss an opportunity for therapy.

I entered therapy with a sense that my life was small and compressed and that something was wrong inside. There wasn't a lot of deep feeling, yet there could be a lot of anxiety. I had a sense of holding back, of being tied up, of not being myself. There came a point when I could no longer fool myself into believing that I was living the substantial life that I wanted to live. I didn't feel like myself and couldn't find my center. Life sometimes felt like a performance. There was a desire to break through to authentic, deeper feeling and not just think or talk about it.

In session I quickly realized that my therapist doesn't talk very much. This can feel like a relief from the chatter of day-to-day life and also highlights the importance of anything that my therapist does say. It also means I can't defensively hide behind my own talking. When my therapist does have something to say it is pertinent, key, and to the point. The brevity of my therapist's words is enough to put me inside of myself. My therapist is a good listener.

Brevity does not mean vague, however. I find my therapist to be very strong, direct, and forthright. My therapist calls me on my b.s., holds me accountable, pushes me, provokes me, and sometimes gives me concrete advice. Difficult material, including sexual material, is examined directly in a straightforward manner. All of this gives me a sense that my therapist won't give up on me, no matter what. My therapist is somehow able to say things to me that get by all of my filters; some of it can be difficult to hear, but it gets in. My therapist seems to have a special knack for being able to do this.

## RESULTS

My therapist is intuitive and has a great ability to “read” me in a variety of ways. For instance, my therapist notices and makes sense of subtle movements in my body and subtle voice inflections. I have a sense that my therapist can discern when I go from the emotions in my body to my mind. Sometimes it feels like we are using another shared language. My therapist has good pacing and timing and doesn’t overwhelm me with too much material or information. My therapist knows when to push, when to hold back, and when to say exactly the right thing. This contactful attunement engenders trust in me and allows me to go deeper into the experience. I trust my therapist, but it took time for that trust to grow.

I started bodywork fairly quickly with breathing and building an energy charge. Much of the work has been on my eyes, getting me open, grounded, and establishing feeling there. The eye work helps me connect to whatever it is that I’m feeling.

Bodywork is incredibly intense and powerful and it takes courage to do it. I didn’t know before starting it, for instance, that you take off some of your clothes to do it. Just remembering it is intense. As I talk about it I kind of re-experience it emotionally and visually, with visions like flashes. It’s very emotional to talk about. And it’s very hard to describe. It’s almost indescribable. I can’t create an exact coherent picture of it, yet it’s very powerful and it stays with me to this day. It’s a very important part of my therapy.

I feel very vulnerable doing the bodywork. It can be very scary, even terrifying, and difficult, largely because I am afraid of what might come up. It’s almost as if the bodywork has a mind of its own and my body would just take me with spontaneous physical reactions and feelings I couldn’t control. I never know what it might bring up in me and I can’t control it the way I can control things sitting up and just talking. Even after years of doing bodywork, I can still feel nervous about it, uncomfortable, and afraid to let go in a natural way and just let things happen naturally. I just don’t know what will come up.

The bodywork is very difficult. It’s hard to let go during the bodywork and to stay with the experience. It’s hard to just breathe. Over time it’s gotten somewhat easier, but it’s still hard to get started with those first few breaths. My

## RESULTS

therapist would encourage me to stay with difficult feelings, like fear or anger, but I'd want to back away. It was difficult to stay there. I'd shut down and go away in a variety of ways: maybe I'd start talking or maybe I'd just go far, far away in my own mind or maybe I'd stop breathing and stop the energy movement. I didn't do it on purpose, it would just happen. It was my defenses. I was very blocked and defended and started to realize that through the bodywork. I could even begin to recognize it and feel it in my body. I was very held, physically, but I wanted to break out of that.

Through the bodywork I'm able to experience powerful waves of deep, genuine emotional release: really deeply crying, getting angry, or expressing any other sort of emotion, sometimes for a long time. Sometimes I couldn't *not* feel emotions! And the energy movement can happen very quickly. It can burst out of me like a floodgate of emotions and memories.

A real turning point came when I was able to embody and express my anger and hate, even at my therapist, with my therapist's encouragement. It was very difficult because I kept thinking "my therapist is here to help me," but it was a real milestone in my therapy when I could do it. My therapist didn't take it personally and would allow me to get angry. It has helped me be more in touch with my own anger and to own it more, rather than disavow it and pretend it doesn't exist.

Even though the bodywork is difficult I know it's good for me, kind of like taking medicine and I want it. It can physically hurt (I mean sometimes it can *really* physically hurt!), but I know it works. Although the bodywork is difficult, I always feel better after doing it. It helps me get out of my own way. There is a sense that the hurt is gone...for good.

I don't really understand how the bodywork works, but it does. My trust in my therapist helps to allow it to happen. I do know that it happens naturally and organically, not mechanically. When I do the bodywork it feels like everything connects up at the same time. Sometimes it feels like a meditative state or a different emotional plane. I don't really need to know how it works. Some of this

## RESULTS

is just unknown. Over time, I've come to realize that my neurosis is stuck in my body as a real thing. My psyche and my biophysical structure are inseparable.

This is difficult therapy. I have asked myself "why do I do this difficult work?" What keeps me going is hope, hope based on actual experience that I'm working through something here. I've noticed changes and others have noticed changes in me, changes that I like and I never could have imagined before starting therapy. I don't know exactly what to expect or what the outcome will be, but I have faith in the process and I like what is happening.

There have been many, many changes in me as a result of my therapy. I feel more clear. I can see things in myself and others more easily and more clearly. This could be noticing how I stop energy movement in myself or realizing that I've kept something compartmentalized all my life that really needs exploring. It's like waking up in a very profound way. I'm awake and more present to what is happening with me and others. I have better contact with myself, others, and the environment so I know and can make sense of what's really going on.

I feel more integrated, connected, and at peace with myself. I'm calmer. I've begun to feel, on a deeper level, what integrity is. My head is quieter and I'm able to settle down, not just in my head, but in my body too. My energy is more down in my body, not just up in my head. My whole body feels more connected and integrated.

I can simply feel, in my body, and this is huge for me. This is no simple statement; it's a feeling of being alive, of having a life. It's the difference between being alive and being a zombie. I have more energy, there are all sorts of feelings in my body, and I'm more free and spontaneous with them. It's very exciting to be able to feel!

I can feel the natural pulsation of expansion and contraction in myself now. Sometimes I feel very expanded after a session. Expansion feels wonderful, even magical. It can be hard to maintain, but I'm more able to do it now. I also notice the contraction, but I'm better able to get myself out of it now. I can better tolerate the natural pulsatile nature of being human.

## RESULTS

I very much feel like I am more my authentic, natural, and real self. I am better at knowing what's mine and what's not mine, who I am and who I am not, what I want and what I don't want. I feel more in touch with me. I understand who I am. I'm just there.

Part of this comes from being more aware of my character defenses and realizing the nature of armoring in myself. I'm better able to observe myself and notice when my defenses are in play. With my armor, I can't really recognize it until after there has been a shift in it. Then, only in hindsight, can I recognize it for what it was. Armoring has an anesthetic quality to it that prevents me from recognizing it until after I've experienced that shift or movement. A lot has become more readily apparent to me as I look back from where I am now. Back then I couldn't see what I can now see as character defense and armor in myself.

I'm more real with people as a result of my therapy, and my relationships have changed. I can more easily and clearly see and confront what feels wrong, oppressive, or unfair, but I'm also warmer, softer, and more affectionate. I don't stuff things inside anymore, but am more able to freely and spontaneously express myself in my relationships. This ability to express includes sexual expression as well as naturally aggressing in the world to get my needs met. For example, I'm more able to reach out to others now. I'm more honestly expressive and able to confront things that are wrong more directly. I feel like I have more power. At the same time, I'm less attacking and less defended in relationships.

There have been physical changes in me as a result of my therapy, most notably my actual, literal visual functioning has improved. I'm more alert, conscious, and awake in the world visually. I'm more "here," in contrast to when I was more armored in my eyes and was "away." I've come to realize that visual armoring is a real thing because I've had a shift in it. My eyes have become unblocked and "big" to the world. It's very pleasurable. My therapy has helped me in very concrete ways as well, with everyday functioning. I function better financially and occupationally because I am more expanded. I even eat better and have improved my physical health and exercise habits.

## RESULTS

When I reflect on my experience in organomic therapy, other therapies feel superficial and overly cognitive to me. Organomic therapy goes much, much deeper, to root cause. It provides more than just symptom relief, it provides real healing. It's certainly more intense, but, for me, it's the only way out. I just don't see any way to heal without addressing what's in the body.

Organomic therapy is one of the best things I've ever done and I feel enormously grateful for it. It is really amazing, powerful work. It is unfortunate that there are so few practitioners, though. It's a bit of a lonely field, even for patients. I wish it was more acceptable in the mainstream and that there was more of an organomic community to engage in.

### **Core Themes of the Experience**

The core themes constitute the highest level abstraction of the interview data. These core themes describe the highest level elements of the experience of being a patient in organomic therapy for this group of research participants. Every category code, consisting of several open codes, fits under one of these core themes. In the course of each interview every participant spontaneously spoke to each of the following core themes, to be explored in-depth in the next chapter. The number in parentheses following each core theme indicates the total number of category codes associated with that core theme:

1. Entry Into Organomic Therapy (4)
2. Organomic Therapist Attributes (9)
3. Organomic Biopsychotherapy (9)
4. Experience of the Therapeutic Process (10)
5. Therapeutic Results (12)
6. Thoughts and Feelings About Organomic Therapy (3)

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## DISCUSSION

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RESULTS TAKE ON DEEPER MEANING when explored in relation to the research question. This study specifically sought to explore the question “what is it like to be a patient who has experienced and benefited from organomic therapy?” This included seeking to understand (a) the basic elements in this transformative therapy, (b) the way in which the patient experienced deep and difficult character restructuring and allowed it to occur, and (c) the patient’s personal myths and what organomic therapy has meant in the course of their lives. The present chapter explicates the results of the study in relation to this research question as well as in relation to Reich’s theory and the practice of organomic therapy.

In the course of each interview, every participant spoke to the same basic experiential elements of being a patient in organomic therapy: entry into organomic therapy, perceptions about the therapist, the lived experience of bodywork and the therapeutic process, changes resulting from the therapy, and overall thoughts and feelings about organomic therapy. Each of these basic thematic elements of the participants’ experiential process will be investigated in this chapter. A common experience among participants very often emerged, as already illustrated in the previously-presented composite depiction, yet differences in experience also arose. In addition to delving into what was common and shared among participants, discernable and differing patterns of experience will also be detailed and explored here. In some cases the pronouns referring to the participant, the therapist, or others have been changed from male to female or vice-versa to further preserve the confidentiality of the research participants. In addition, some content has been omitted in quotations (as indicated by ellipses) or slightly changed (as indicated in brackets) for the same reason.

### **Theme 1: Entry Into Orgonomic Therapy**

*Entry Into Orgonomic Therapy* refers to the ways in which patients first encounter orgonomic therapy and what leads them to begin their own orgonomic treatment. One participant discovered orgonomic therapy by chance through interviewing several therapists, one of whom turned out to be an orgonomist. All other participants first heard about orgonomic therapy from a trusted person in their life, and often furthered their understanding with subsequent reading on orgonomic therapy. For them, this trusted person was someone who the participant saw as worthy of emulating and trusting due to that person's own work in orgonomic therapy or the influential position that the person held in the patient's life. One participant described the sacrifices that this trusted person made in order to engage in orgonomic therapy:

It was who he was and that this [orgonomic therapy] meant so much to him and that he had come across the country [from the west coast to the east coast] to invest in this...He had come specifically to work with [my future orgonomic therapist]. That's why he had come back [to the east coast].

It was these sacrifices and the investment that this person made, in part, that inspired this participant to investigate the possibility of orgonomic therapy for himself.

Willingness to make sacrifices is a common expression of the desire to engage in orgonomic therapy. One participant in this study ended addictive drug use in order to work with an orgonomist: "I actually stopped doing cocaine right then. I had done it two days before [my first session with my therapist] and I stopped because I was afraid he wouldn't take me [if I continued using]." Others pondered traveling great distances to work with an orgonomist: "In desperation I tell myself 'oh, I'll do the travel' and then when the reality sets in it's like, wow [the therapist's location] is 12 hours [away]...there's a big commitment."

Most notable among the participants is an intuitive sense that orgonomic therapy, among the countless options, is "right" for them, especially due to the functional focus on mind/body unity. As these two participants indicated:

## DISCUSSION

This therapy is onto something. I was never drawn to any other kind of psychotherapy or Freudian-type stuff. It was the particulars of the physical aspect...of orgone therapy and the connection to sensation of emotions in orgasm and health. Those things put together the urge [for me] to go to orgone therapy. That's why I went to it. That's why I was drawn to it...like an instinct...It feels like home...It makes sense.

I've heard of this work since my 30s...and just was drawn to it...It touched something in my gut. It wasn't a head thing, it was a gut thing...I remember reading [about Reich's work] somewhere...and that stuck in my psyche. "Oh my God, that's what I want!" This speaks to me, it just speaks to me...When I talk to people that aren't familiar with Reich or other therapists they just don't have that feeling.

The literature does not specifically address this intuitive pull toward orgonomic therapy, this feeling of rightness, and of the therapy making natural sense to the patient. This is an important, and heretofore, uncovered part of the patient's experience.

How is it that these participants, self-admittedly armored, are able to know or feel that orgonomic therapy is intuitively right for them? In a sense they need to enter therapy with some modicum of ego strength and some minimal amount of contact with themselves in order to know that orgonomic therapy is indeed the path for them. This usually comes from a memory of having been more alive and less armored at some point in time along with recognizing and feeling the unpleasantness of the loss of that. As one participant described:

[I remember] breakthroughs of feelings that I had had earlier in my life. I had orgasmic feelings, sexual feelings that were deep enough that when I heard these things about orgonomy and Reich's basic writings about armor and emotional movement in the body and the unarmored orgasm [it made sense]. It was the basic sensation that I remembered from childhood and teen years. These basic emotional feelings and sexual feelings that put two and two together...Without those I don't think I would have gone to orgonomy...If you're alienated from those...then you're not going to go to [orgonomic] therapy.

Other participants remembered being "a very insightful and knowing child and young person...very deep...at a very young age" or "very armored, very shut

## DISCUSSION

down, but wise...very sensitive...very aware...and [I] ‘knew.’” Reich (1942/1973) specifically referred to this sort of memory and described it this way:

The patients remember the time in their early childhood when the unity of their body sensation was not disturbed. Seized with emotion, they tell of the time as children when they felt at one with nature, with everything that surrounded them, of the time they felt “alive.” (p. 357)

Baker (1967) characterized lack of aliveness as “lack of contact, ‘deadness’” (p. xxxi), which several participants referred to in the course of the interviews. It is clear, from these participants, that some minimal level of contact with the self is necessary in order to enter this work. This presents a bit of a conundrum, however: whereas awareness of a loss of aliveness and contact is a somewhat necessary propellant for entry into organomic therapy, awareness of the same is also a goal of treatment while being somewhat hidden from the patient. It appears that an optimal balance is necessary and that the patient needs to come to therapy somewhat ready, with some degree of ego strength along with a strong internal motivation.

All of the participants in this study described experiencing an overall sense of contraction, smallness, and lack of contact in life before entering therapy: “My life was getting smaller and smaller. I’d reached pretty much a low...I had no clue of what was possible [for me]. I couldn’t envision it. My existence was very tiny.” For some participants this contraction and smallness was obvious to others, for some participants it was hidden:

Everybody’s [saying]: “Oh, you look so good! You can do anything you want! You’re bright! You’re smart! You look good! Oh, you can do anything you want!” But, inside was this lost [woman]...I was suffocating in this lack of contact with the world...Nobody gave me contact.

Another participant iterated something similar, stating that “I led my whole early life in a performance, but in another way there was this private life I had that was not a performance at all and was very deep.” One participant described an intimate awareness of feeling contracted along with a desire to break through to authentic, deeper feeling:

## DISCUSSION

It was just too compressed. I knew that I am not myself. It seems like I have some yearnings. I have energy I want to move somewhere and I am held...the sense was I'm strapped to something, I'm really held back. I want to move. I'm not quite sure what, but...there is clearly, from inside, a yearning, there is a push...that there is something better.

Another participant echoed this desire, stating: "And that's why I went to therapy...It's just as simple as that. It's like to break through to feeling." Yet another participant described his life before therapy this way: "One thing I kind of intuitively knew about myself was that I don't feel. I could watch a torture scene and feel nothing. I just was aware that I didn't feel much."

This anesthetic and contracted lack of feeling coupled with a vague awareness "that there is something better" reflects Reich's theory of the formation of character armor. Reich (1933/1945) stated that character armor develops, like a hard shell, "to deflect and weaken the blows of the outer world as well as the clamoring of the inner needs" (p. 338). As previously mentioned, this serves a dual function of deadening the person to unpleasure (difficult feelings), while simultaneously reducing the capacity for achievement and pleasure (Reich). Baker (1967) succinctly stated that "character is based on movement and blocking of energy in the body" (p. xviii). One participant summarized the experience concisely in stating that one could no longer "fool yourself into believing that you're living a substantial [life], and...living the life that you want to live."

### **Theme 2: Orgonomic Therapist Attributes**

Every participant spontaneously spoke at length about what their therapist is like, yet no other theme exhibited as much disparity in opinion as this one. Of the nine category codes in this theme only three exhibited considerable consensus. This is not surprising, given that the person of the therapist plays a significant role in shaping the type of therapist that one is. In addition, orgonomic therapists, while not alone in this, do not provide a "one size fits all" therapy, but instead focus on what is functionally required to effect therapeutic change. Nevertheless,

## DISCUSSION

the participants in this study identified several areas of commonality in therapist attributes.

Most of the participants noted that their therapist does not talk very much. Congruent with Reich's progression toward less focus on what the patient says and a greater focus on the body, some participants mentioned that their therapist sometimes barely spoke at all. One participant made clear that "half the time [my therapist] says maybe six words the whole session" and in recalling one particular session stated "I don't think he [my therapist] said practically one word to me." Participants experience this as relieving, therapeutic, and, for some, difficult and challenging. One participant stated that "his [my therapist's] voice, his six words, is enough to put me...really, really, really inside myself. My life is filled with chatter and talking and screaming and...it's just this sort of sanctuary." Another succinctly stated that "what I totally loved about [my therapist] is that she talks very little...and she doesn't volunteer unnecessary information." For others, the minimal talking produces anxiety and increased awareness of the desire to defensively over-talk. Participants also realized that when their therapist does say something it feels significant and important, not frivolous: "When he [my therapist] does have something to say it's pertinent, to the point...my therapist doesn't over-talk." Interestingly, participants used very few words in the interviews to describe this important aspect of their therapist.

Reich favored more direct and confrontational interventions and it is clear from these participants that their therapists do as well. Most of the participants shared that their therapist is very strong, direct, and forthright with them and could not be easily fooled. One participant stated that "she [my therapist] was someone that would call me on my b.s....she'll be straight...she'll call me on my shit." This same participant had interviewed another non-orgonomic therapist and felt "I could do a snow job so easy [on this other non-orgonomic therapist]." This direct and straightforward approach helps participants to explore their own material in a similar direct and straightforward way. Two participants mentioned that exploration of deeper, sexual material was facilitated in this way. Another

## DISCUSSION

described how his therapist's ability to feed back what he said in a direct way somehow got by all of his "filters:"

I dealt with these issues in the past with other therapists and never, ever had any kind of movement or change. [My ergonomic therapist's] ability to listen to what I said and to feed that back to me, saying "this is what you said and this is...what I see or think about that"...just got by all of my filters...Although I didn't like it, I couldn't deny it...I don't know why he was able to do that. I had seen a number of therapists over the course of my life, and...never experienced anything quite like that.

Participants felt that this contactful directness and strength on the part of their therapist gives them a sense that their therapist will not give up on them, no matter what. One participant stated:

She [my therapist] was compassionate and she was caring and she would get mad at me...she would provoke me, but...she was still always there. She never left me. I feel very emotional when I say it. She never left me.

Four of the participants described experiencing their therapist as having a great ability to read them, especially during bodywork, sometimes in an almost uncanny way. Descriptions of this experience tended to be vague, seemingly as though the participants had difficulty putting this into words. One participant noted that "it's as if it's another language." When asked how their therapist was able to read them, most said "I don't know, I don't know how she [my therapist] knew." Another participant, deeply intuitive herself and highly respectful of intuition in general, noted that "he [my therapist] always knew the right time to comfort me or just make me feel safe...I just felt he had intuition...I thought he had great intuition or great judgment about timing." Participants indicated that right timing was part of what gave them the sense that their therapist could read and deeply understand them. One participant stated "I trusted his [my therapist's] timing." Another participant remarked that her therapist has an ability to know exactly "when to push and when...to hold back." Another said that her therapist would say "something so strategic [it would] let the floodgates go off my emotions, that I was understood...and this floodgate...of energy would move out of me. That's happened many times." Yet another participant recounted the

## DISCUSSION

incredible safety that her therapist offered in knowing that she needed help in “coming back into the present” during bodywork. Participants reported that this ability to read them engendered trust in the therapist over time. Notably, this experience was divided along gender lines in that all four participants who spoke to this experience of feeling read were women. Not one of the three male participants directly referred to this phenomenon.

Beyond being trained to be in deep contact with their patients, Reich believed that orgonomic therapists must engage in their own personal growth in order to, as Boadella (1974) stated, “empathise [*sic*] fully with the patient and to feel in his own body the effect of particular constrictions on the patient’s energies” (p. 120). It may be personal growth work that allows these therapists to remain so tuned to their patients and to read them so well.

Two participants further described this attunement as a relational presence that they could feel from their therapist. Though not exhibiting considerable consensus across all participants, this discernable pattern nevertheless describes an important aspect of the patient’s experience: the relational and contactful presence of the therapist. This felt presence allows patients to deepen their emotional experience and to remain present to it as described by this participant:

My therapist’s contact with me through her shining, open eyes creates safety and trust for me. This is part of what allows me to have deep emotional experience and be present with it...I think it’s the relationship...it’s so much my relationship with [my therapist]...and her being there...[my therapist is] present with me and [has] the energy of connection and care and insight.

Another participant described this felt presence and the trust that resulted from it this way:

[My therapist] was such a presence and it didn’t take very long for me to just kind of have absolute trust in him...he wasn’t detached, but he wasn’t glomming onto me either. He was very, I use this phrase a lot, he was just present. He was just present emotionally, he was present physically...his eyes were with me...he was present...I could feel his presence.

Other discernable patterns include participants describing their therapist as a unique and special person, mentioning that this is difficult to put into words: “[my

## DISCUSSION

therapist is] just kind of special, he has a way that I can't put into words." Some participants felt that their therapist was the mother or father that they wanted, but never had. Still others felt that, over time, their relationship with their therapist became more of "a team."

Though not exhibiting considerable consensus, one last discernable pattern expressed by several participants concerned "flaky" or minimally-trained "therapists" who purport to do orgonomic work. Some had previous experience with these so-called "therapists." Their worries about these "therapists" contrast with the solidity they felt with their orgonomic therapists, as one participant stated:

It's very important to me that people who do psychological things...that they're grounded, that they're not flaky, that they're not misusing people. That's really important to me. So it was important to me that [my therapist] was so professional...I was very impressed with the thoroughness of the [initial] interview.

### **Theme 3: Orgonomic Biopsychotherapy**

*Orgonomic Biopsychotherapy* refers to the patient's experience of the somatic component of orgonomic therapy. Other than themes 1 and 6, which both exhibited complete consensus across all category codes, no other theme showed as much commonality of experience as this one: eight of the nine category codes in this theme exhibited considerable consensus. This commonality of experience may be due, in part, to the fact that this work bypasses cognition and manifest content, going instead directly to fundamental, shared, and more universal, core feelings in the body. In addition to analysis of character, this is one of the primary differentiators between orgonomic therapy and other therapies. Once again, "biopsychotherapy," "bodywork," and "mat work" will be used interchangeably here to mean the somatic component of orgonomic therapy.

Most participants started bodywork immediately or fairly quickly after beginning therapy. Among the participants in this study, bodywork was delayed only if a period of sobriety from substance use was first necessary. Participants generally found bodywork to be incredibly intense, powerful, and difficult to

## DISCUSSION

describe. For some, simply remembering the bodywork and talking about it was intense. One participant exemplified this in stating “just this morning...thinking about it [the bodywork] was very intense for me...it’s incredibly intense.” Another noted that “I’m really kind of re-experiencing that feeling [of the bodywork] as I tell you about it...it’s almost indescribable, but it certainly was powerful and it stays with me today, that whole experience.” Two participants described memories of the bodywork as being very visual, as one participant illustrates here:

I remember [my therapist’s] office that I described, I see myself there...I see views, visions of [my therapist] from that time...it’s like flashes...I’m not sure I can describe [it] in a connected way...I cannot bring in the exact coherent picture...of it.

Much of the bodywork has been on each patient’s ocular segment, specifically the eyes. Participants in the study frequently spoke about eye contact, biophysical work on their eyes, noticing others’ eyes, and experiencing increased feeling in and awareness of their own eyes. One participant described the experience of this eye work as allowing her to be “more connected to whatever it is that I’m feeling.”

Participants often felt vulnerable in doing the bodywork and recognized that it takes courage to engage in this therapy, just as Bean (1971) shared in the autobiographical account of his own experience in orgonomic therapy. The bodywork can feel scary and uncomfortable at times. Most of the fear stems from not knowing what might emerge during the bodywork or from simply having feelings to which the patient is unaccustomed. One participant stated that “I would be scared of things happening naturally because then I don’t know what could come...it’s scary!” Another mentioned that he felt very self-conscious engaging in the bodywork, that it “felt very private and it felt very vulnerable, extremely vulnerable” and that “it was terrifying, it was actually terrifying for me to have those feelings...any feeling!” One participant revealed that:

Even today, after [several] years of this, every time I go to a session I’m a little nervous...almost every time I feel that way [not

## DISCUSSION

wanting to do mat work]...there's this part of me that just, I'd just as soon sit there and talk for 45 minutes.

This fear of allowing something to happen and emerge naturally is at the heart of Reich's understanding of the armored orgasm. He described unarmored orgasmic potency as "the capacity to surrender to the flow of biological energy, free of any inhibitions; the capacity to discharge completely the dammed-up sexual excitation through *involuntary* [italics added], pleasurable convulsions of the body" (Reich, 1942/1973, p. 102). It is involuntary, natural bodily reactions, including emotions, that patients fear in the bodywork.

This fear is understandable as well, given the organic, non-mechanical nature of the bodywork and the physical pain that can sometimes accompany the work. This physical pain is a result of the patient's muscular hypertonia, or character armor, not undue pressure or physical manipulation on the part of the therapist. Participants describe the bodywork as having "a life of its own." One participant stated:

I can't not feel emotion!...There would be reactions in my body...my body would physically take me to where I would want to curl up in a fetal position...I really couldn't control it. But...I was aware of it at the same time. It's a very bizarre feeling...My body wants the bodywork because it wants to go to those emotional things. It wants to feel it...it's like "ok, we're ready!" It's a strange thing.

Several participants mentioned the uncomfortable physical sensations in the bodywork. For example, one participant stated "it often hurt when my therapist touched me during the biophysical work, but only because he was trying to help me release something." Other participants described the quick nature of the bodywork, noting "what amazes me is how quickly...I can just do a couple of those...breaths and I'm...right in that space...it's almost immediate." Another participant described the spontaneous, organic quality of the bodywork this way:

[I] can physically, emotionally be open in a way that is...in touch with [my] physical memory as it's attached to [my] emotional and psychological memory...in this sort of meditative state...which is energy, which is Reichian, which is all of it, and...lets it spontaneously come out...in a different emotional plane...it allows

## DISCUSSION

[my] body to connect to [my] mind and [my] heart and everything at the same time. And it...allows this openness of a connection between all of it.

Even though the bodywork can be intense, scary, and difficult, patients see it as enormously beneficial and a very important aspect of the treatment. The participants in this study described breaking through their armor and into deeper feeling, along with experiencing a permanent letting go: “it’s gone...you don’t feel it afterwards...it doesn’t stay hurt.” One participant described the breaking through this way:

All of a sudden...it’s [the bodywork is] doing it’s work! Because, oh my God, I’m letting loose crying or whatever...that’s when I get those waves of emotion...one of the most powerful things for me was when I was actually...just really able to cry...being able to cry was probably the most powerful. After that was just...waves of release...the crying...just kept going and it was really good to cry...it’s good and it hurts at the same time...it’s painful, but it’s really powerful.

One participant described her reticence about approaching the bodywork and her feelings after having done it this way: “I don’t want to do it [the bodywork] and I do it and I feel better...every time I’m done I also feel better...when I’m done I feel, I feel much better...I always feel much more relaxed.” One participant summarized it as similar to “having to take medicine: you know it’s good for you, but it tastes yucky.”

The initial feelings of vulnerability that these participants experienced, followed by waves of emotional release, and then feeling better perfectly mirrors Baker’s (1967) explanation of what occurs in patients during the removal of armor. He stated that the following three things occur in the patient during the process of removing armor: anxiety, emotional release, followed by a sense of relief.

Although this is descriptive of the overall process of removing armor, it does not imply that it is somehow easy for the patient to simply allow this to happen. On the contrary, even though bodywork at its best can take on a life of its own, participants frequently found it difficult to let go during the bodywork and to stay

## DISCUSSION

with difficult emotions. One participant stated that it “took a considerable amount of time before I could begin to let go...and breathe.” Patients iterated that the action of their therapist to encourage them to stay with difficult emotions helped here:

My eyes are wide open and I’m feeling fear and I’m breathing hard and he’ll urge me to stay there with that, and I want to back away, so he encourages me to stay with what’s happening and it’s sometimes difficult to do that. I want to stop or I want to talk or whatever.

Part of the difficulty in allowing and letting go comes from the patient’s own defensive character structure. Here again is a conundrum: the therapy is aimed, with the assistance of creating an energetic charge, at penetrating and dissolving that character structure, yet it is the character structure itself that can prevent a charge from developing. How then, can a therapeutic effect begin? The character armor must become conscious and ego-dystonic for the patient, either through verbal or biophysical intervention. One participant described how over time he began to somatically and experientially become more consciously aware of part of his defensive character structure through the bodywork:

I would want to squash my energies so that there is no movement, so that I am still, because only there I can control, I can feel safe...I was very blocked...very protective...held physically...not trusting, not knowing...really from a defended place in me...against what’s happening, anything, [including] what was happening in the therapy.

He began to realize that this defensive position was habitual and without choice, exactly as Baker (1967) and Feiss (1979) described character armor: whereas natural or temporary armoring is a muscular contraction related to being threatened, character armor is a permanent or chronic contraction without choice.

Through the bodywork, the research participants realized an understanding of the non-dual nature of mind and body. Just as Baker (1967) reiterated Reich’s view that character armor is “functionally identical with muscular armor” (p. xxi), the participants in this study came to the same conclusion experientially. One participant described this realization:

## DISCUSSION

It [neurosis] gets stuck in the body. It's in the body. It's actually present as a real thing...a holding place and a place where energy is stuck...my sense was that there is this black steel ball, very dense, very dark, very dense, right there in the middle of my gut. It was just very clear...it's not in my head.

Another participant simply stated “the psyche...it's kind of like a reflection of the overall core biophysical system's condition...so they're not separable, they're inseparable.”

### **Theme 4: Experience of the Therapeutic Process**

In addition to the specifics of biopsychotherapy just explored, participants spoke generally, as well, about the experience of the overall therapeutic process. Most significant here is the experience of expressing anger in session. Several participants experienced a turning point in their therapy when they were able to embody and express anger and even hate at their therapist or in general, with their therapist's encouragement. One participant described her experience of stepping into this challenging arena:

I think the biggest part of that is finally feeling ok to bring my anger there [to session] and embody it as fully as I can...For a long time that was very difficult...because when I go out from my apartment...I cannot show my anger like that...I need to show...a face...So leaving [my apartment] involves basically...hiding anger. And even in therapy, for a long time...I was invited to...show my anger...but the end result was that I would come into the therapy and I would not embody my anger. I would have a difficult time doing that there. Even though...this is a good place to do it, right?! And it's a safe place to do it...As I began to feel ok about bringing it out there, in the session, now I feel more ok to actually kind of be in touch with it and own it more, even outside...I cannot remember whether it [my anger and hate] was actually directed at him [my therapist] anytime, but I'm sure [it] was...I would find it very difficult to act on, because I would think “how can I dump or do bad or do something not nice to someone who is there to help me?”

Another participant shared his evolution from mostly disavowing his anger to being able to express it in a healthier, more natural, and useful way:

## DISCUSSION

I was supposed to...always be friendly and outgoing to people...In a way I feel I led my whole early life in a performance...[My previous therapist] used to say..."you don't have to smile all the time!"...I didn't know that I could be angry. We weren't allowed to be angry in my family. I didn't know about anger. [My organomic therapist] would have me sit on the couch and say "hit me!" I'd say "no! I don't have any reason to hit you! Why would I want to hit you?" So he'd start hitting me!...But he got me to get angry after awhile. It was odd! It was odd, but it seemed ok...I don't know how to explain it except that I felt he was trying to help me...And that was something I had to do, something I had to somehow get through, because obviously there's something a little askew that you wouldn't hit somebody back if they hit you...[if I hadn't done that therapeutic work] I probably would still be smiling...I used to lie on the couch and bang and kick and scream and do all that at the same time.

To many therapists this would not only seem unorthodox, but downright unethical heresy. Yet the participants in this study described significant benefits in encountering and working with their own anger, even in unorthodox ways.

Another participant described his trajectory with anger in therapy this way:

I had kept so much in for so, so long...she [my therapist] was somebody that actually allowed me to be angry in a safe environment...I would get angry at her [my therapist]!...I would just get really pissed off at her because for the first time it was ok to get pissed off, and she didn't take it personal [*sic*].

Reich (1933/1945) stated that character serves an insidious dual function of reducing the person's sensitivity to unpleasure, but also restricting libidinal and aggressive motility, effectively crippling the person's capacity for achievement and pleasure. Without healthy, natural aggression these patients are unable to fully achieve, experience pleasure, and get their needs met in a healthy way.

Every participant remarked that deep, genuine feelings regularly come out in session and that, over time, this becomes more comfortable and natural. One participant remarked that "I can cry for an hour during session." Another noted that "in the actual session I had a lot more stuff come out...in terms of movement and deeper, genuine crying or anger." As previously mentioned, the presence of armoring distorts, inhibits, and destroys natural feeling, especially feeling strong

## DISCUSSION

emotions, and prevents the free flow of energy in the body. Breaking down armor allows the movement of these emotions, as these participants experienced.

This is difficult therapy. Participants would sometimes question their involvement in it and struggle with wanting to quit. Some participants found this therapy to be utterly bizarre and mysterious. And is it any wonder given the physical and emotional discomfort involved, the sometimes thorny relationships with strong, confrontational therapists, along with strong feelings of anxiety, vulnerability, fear, and anger? Beyond ego strength, participants are able to rely on memories of what it was like for them before engaging in this unique therapy as well as the knowledge that changes have resulted from the therapy. One participant described how remembering what he was like before therapy keeps him going:

I think back...[to] why I kept doing it...when I actually started looking at that possibility of leaving I started looking at what would be the alternative...and then I became faced with the fact that I would be hidden...like I always am. But now, in therapy, at least there is a possibility that something could happen...but if I do actually leave, then what would I have? Nothing. I'll have my state as it is with no possibility of getting out of it...then what? Back to where I was? Completely stuck in my trap?...I know where that leads. So, I guess I found strength, I found a way to stay with that [the therapy].

Another participant described the hope he feels based on actual experience and change:

Why am I still seeing this guy [my therapist]?...I have hope based upon actual experience that I'm working through a process here. I have hope. I think that's probably what's kept me going through it...without that I would not continue on...and...the experience itself...is the key component. I would give that a good bit of the weight...I mean, if I wasn't noticing movement or change I wouldn't be there...there's got to be some actual proof along the way, too.

Participants have faith in this therapy even if they do not fully understand it or know what the outcomes will be. One participant stated "I thought 'I think I'll keep trying this, see what happens.' And I didn't really know what to expect because I hadn't read and nobody had really told me, but I just took it on faith."

## DISCUSSION

Reading about orgonomic therapy may not have shed much light on the experience of being a patient anyway. As one participant stated: “This work that I’ve done...does not match any idea that I had of what this would be like. None. Reading about it, in retrospect, is just bullshit...Books capture moments in time and not the whole process.”

Though not exhibiting considerable consensus across all participants, two participants described their experience of moving from thinking and talking to feeling and breathing. They described how the therapy can sometimes bypass cognition. One participant shared an intense experience in therapy that bypassed cognition and allowed for deep insight:

I don’t remember if I was crying or not, but there was intense work going on. And I had this vision, literally a vision, of being in a tunnel, a dark tunnel, but there was some light around it. I felt like all the insights I’d had about myself, about my family, became very vivid and were brought together. The insights and the physical work came together, they became one, in a nonverbal way. I actually felt I had relived this very early, early childhood. It happened without words, without cognition. It felt preverbal. It was a really powerful experience. I don’t remember the content now exactly, but I remember the feeling of it.

### **Theme 5: Therapeutic Results**

*Therapeutic Results* refers to the changes that the participants in this study experienced through engaging in orgonomic therapy. The results that they experienced and shared focused exclusively on changes in global ways of being, not at all on circumscribed symptom reduction. This is not surprising given the clear goals of orgonomic therapy, namely the removal of armor allowing for the free flow of energy, full orgasmic potency, and genitality. In effect, the participants were describing changes in their character, congruent with orgonomy’s approach of targeting character neuroses, not symptom neuroses, as the focus of treatment.

This theme encompasses a wide variety of deep, characterological changes, yet significant consensus emerged across 9 of the 12 category codes in this theme. Patients differ in myriad ways, as do therapists, yet the final therapeutic results

## DISCUSSION

exhibit a great deal of confluence, pointing to a shared understanding of treatment goals among orgonomic therapists. This is likely due to Reich's specificity, clarity, and consistency in delineating the goals of treatment.

Participants in this study overwhelmingly described feeling more clear and present as a result of orgonomic therapy. Bean (1971) described a similar experience immediately after his first session, noting "I was perceiving everything with greater clarity." For the participants in this study, this clarity was most-often noticed in being able to be present to and see, or make sense of, what is really happening in oneself and others. One participant described this as:

A tune-up and an oil change...all the dust is wiped off and there's so much more clarity...Once you've been through this...once you've kind of embraced this way of seeing things in life it's very difficult not to see things that way.

Another described his ability to see how others stop energy movement in themselves: "As I progressed in the therapy I could see that [stopping energy movement] in people. It's interesting. Now that I look at a person I can see those things." One participant stated that she can now "notice visual armor in other people, too." Another participant described this clarity from orgonomic therapy as a form of waking up:

If the term *Buddha* means to be one who is awake then I could see Reichian therapy as a form of waking up...Reich, in my opinion, was a Buddha. He was somebody who was trying to wake humanity up in a very profound way.

This clarity extends to awareness of one's character defenses and armor as well. All but one participant specifically spoke about gaining deep, experiential understanding of their defensive structure and armor through the therapy. These participants no longer saw these defensive aspects of themselves as simply just the way they are. In effect, their defenses and armor became ego-dystonic, unpleasant, and foreign during the course of therapy. One described a budding awareness of his defensive rebelliousness this way: "I'm able to observe whereas I would have been clueless before...recognizing that I was rebellious...that's progress that I'm actually cognizant of that." This same participant described his

## DISCUSSION

ability to observe his armored dissociation during bodywork: “Lights on, but nobody’s home...I literally was like so distant, and it’s weird because at the same time...there was a little part of me that could observe myself not being there.” Participants described multiple experiences of becoming aware of varied defenses and armoring ranging from consistently arriving late for sessions to over-talking to perceiving everything in life as an attack on the self. In hindsight participants gained an understanding of what one participant called the “anesthetic quality” of armor: until there is energy movement or penetration of the armor it is difficult to see it for what it is. This initial lack of awareness and ego-syntonic nature of the experience once again points to character neurosis.

One of the most concrete results that patients experienced was an actual improvement in visual functioning. Although associated with and extending the concept of clarity, this experience transcends the psychic realm; for some it is literal. Participants noted an increased alertness in their eyes. They felt more conscious and awake in the world visually. This change occurred over time as well as immediately after sessions, as described by this participant: “Almost always after the session...everything’s brighter when I leave the session. Clearer, greener, brighter, outside is fresher, there’s more life. Literally!...What else is there?!?” Another participant shared the changes she noticed in her eyes after a session: “There’s a difference, an openness, visually which is connected to [my] self, everything inside...my eyes are big to the world after a session...[I can] safely see and feel and take in.” These changes in visual functioning ushered in an awareness for these participants that ocular armoring is real:

I can look back in my memory and I can sense years or time periods where the visual contact with the world was more closed down and shy and withdrawn...I can definitely...get a sense of the reality of visual ocular armoring.

Overall, participants describe these visual changes as “very pleasurable.”

As a result of orgonomic therapy participants reported feeling more integrated, connected, calmer, and at peace. Examples of this integration, very much in alignment with the non-dual nature of mind and body in orgonomic

## DISCUSSION

therapy, have already been given, but one participant more specifically spoke to this phenomenon: “[I] start to feel this sense of what’s integrated...it’s having integrity...that is a word that has come up a lot in terms of...what therapy’s doing to me.” Another participant described this integration as: “I think it’s that [my] breath is connected to [my] eyes and so it was just...[my] whole body...that is where I notice a difference...it does feel all connected at the same time.” Another participant noticed that her “head was quiet and my energy was all in my body...my energy’s been more in my body...my ‘mental’ is calming down...and my eyes are getting connected...my head is settling down...I’m more at peace, I’m calmer...I’m more integrated.”

Armor inhibits the natural pulsation of an organism’s expansion and contraction along with destroying natural feeling, resulting in a profound lack of aliveness. Participants in this study heartily reported feeling much more alive, energetic, and able to feel. Participants found this to be a very important and critical therapeutic result. Participants were exuberant in expressing their joy in simply being able to feel a variety of emotions and sensations deeply and clearly. One participant described her migration from being a “zombie” to being alive: “The most significant change? It’s very simple: I wasn’t alive, I was like a zombie. [Now] I’m glad I’m alive! I’m glad I’m alive!...I was...dead.” Another participant described his migration from not feeling anything to having a variety of feelings:

When I started I didn’t feel anything in my body. And today there’s all kinds of stuff going on...being able to feel anything is a big change for me...this part kind of excites me, well not “kind of,” it excites me!...[I remember] the first time driving in a car and I hit a little slick spot on the road and I felt something funny in my back and realized I was feeling fear and I’d never felt that before. Or watching a scary movie and somebody jumps out and I feel this tingling in my back and my legs and go “oh my God! That’s fear!” I didn’t know what that was initially.

This participant further illuminated his experience in beginning to feel during session:

## DISCUSSION

With the mat work, if we work with my eyes...I could feel something in my calves...it felt like energy, I don't know how to describe it. And then it moved up to my thighs and then it moves to my pelvis and was kind of stuck right around the ass. And then it moved up into the stomach and the chest, and when I take a deep breath I feel this "oh my God!" this "wow!" and I'd never felt that before.

This account matches Raknes's (1971) description of the unusual and unexpected streamings that patients sometimes experience in organomic therapy:

These new and unexpected experiences were feelings of streaming in the patient's body, streamings that to most of the patients were formerly unknown and which to most of those who knew them had been of little or no significance. Such streamings were pleasurable, usually soft and rather weak, but occasionally so strong that the person felt that they overflowed him. In such latter cases, and sometimes even when they were of moderate strength, they would make the patient afraid, as of some unknown danger. (p. 23)

This ability to feel is so profound for participants that it is difficult to limit the number of vivid depictions that could be shared here.

Along with being able to feel more deeply, participants also realized a greater ability to express themselves more freely and spontaneously as a result of the therapy. This, along with a strong sense of being more authentic and natural aided these participants in being more real with people. All of the participants experienced the therapy as helping them to understand and be who they really are: their real self. One participant described this differentiation and awareness of real self this way:

It felt even kind of stickier for me to get away from that, to have some perspective of my own childhood...To be clear about what was mine and what was not mine, what was put on me and what was not put on me, and who was me and who was not me, and what I want and what I don't want to be me.

Another described an easy and more sustained contact with the self:

I seem to be more in touch with my self, more connected...there's very little anxiety, very little mental soup going on. I'm just there...I'm more alive, I feel more my self...it feels to me that I am in a more expanded space.

## DISCUSSION

One participant described a regaining of his authentic “me:”

There was always a part of me that was very authentic, but [through the therapy] I was able to embrace my authenticity...and my differences...My better self was affirmed and realized: my intuition, my compassion, my genuine concern for others, my genuine respect for others.

Others simply describe this as “it’s given me a much better understanding of my self” or “I’m more my natural being.”

This contact with the self altered how these participants engaged with others and their environment. Participants expressed a sense of being more real with the people in their lives and more able to easily and clearly see and confront what feels wrong, oppressive, or unfair. Several described having a lower threshold for accommodating “people’s shit” and less willingness to “stuff it” when they are having natural and justifiable feelings in relation to people or society and culture in general. These participants welcomed and enjoyed this newfound experience of mobilizing their healthy aggression. One participant described her increased aggressive motility this way:

[Therapy has made me] more contentious...more honest...there’s more tendency for me to confront directly things...which I feel are wrong or oppressive or unfair...things I would describe as authoritarian in a bad way...The therapy makes me able to spontaneously confront that kind of thing. It does make me more contentious a character, but only because of the context [society and culture]...that’s around us...it doesn’t make me a more angry character. It makes me more loose, the ability to confront, which is more loose, spontaneously.

At the same time, several participants described increased access to a depth of warmth and softness in themselves that they were able to bring to their relationships. One participant exemplified this in stating:

I was able to open my heart more in all my relationships. It felt very much that it [the therapy] had changed me. I felt that I would not have ever been able to let him [my husband] into my heart had I not...done this work...I feel like I’m even softer...that’s part of the Reichian thing for me: malleability.

## DISCUSSION

Participants noted that they are less attacking toward others, more able to express and share their feelings with others, and better able reach out to others.

Reich (1942/1973) wrote at length about the natural pulsatile nature of organisms between pleasure (expansion) and anxiety (contraction). Participants spoke to this same phenomenon often using these same monikers. Many simply stated that they had developed awareness of and ability to better tolerate the expansion and contraction in their being as a result of being in therapy. The participants noticed that they frequently felt expanded after a session, but had difficulty maintaining it, as described by this participant:

It's very easy to lose sense of that [expansion]. I walked out of the office and I'm back on a [city] street in the middle of the day with my big sunglasses because I've been crying, usually, for an hour...it's very hard to maintain that sense [of expansion]...you're bombarded with everything around you...it's very hard. I feel like the second I stand up [from the couch] it's a different reality. I try to keep some of that in [me]...[it's] a real test, a hard thing to maintain...that's why the breathing [helps]...it all comes back to breathing...within this newly created space, to try to maintain that.

Another participant described this difficulty this way:

I expand and I contract...physically I can feel after a session I'm more expansive, I'm more open, my body is more relaxed...Later on in the day I have an argument with my wife or whatever, I can feel myself close down. I can feel my face change, my body tighten...I can feel that ebb and flow...I didn't know this [several] years ago. I didn't know that I expanded and contracted.

Feelings of expansion, especially after a session, are felt as “awesome,” “a great gift,” “magical,” and as “a fulfilled and happy life.” Contraction, in stark contrast, is even more unpleasant in relation, yet participants reported greater ability to move themselves out of contracted states as a result of therapy.

Participants also felt that their therapy helped them with everyday functioning. Several noted better financial and occupational functioning that they attributed to the results of their therapy, namely being more expanded.

Discernable patterns that did not exhibit considerable consensus included: (a) increased levels of honesty, responsibility, and self-sufficiency, (b) diminished cravings for substances, and (c) increased spontaneous sexual pleasure.

### **Theme 6: Thoughts and Feelings About Orgonomic Therapy**

Participants expressed very strong feelings about orgonomic therapy compared to other treatment modalities. With the exception of one participant, every participant felt that other therapies were superficial and cognitive, lacking the depth that they experienced in orgonomic therapy. There was a strong sense that orgonomic therapy penetrates much, much deeper, directly to root cause and that it is, in a sense, the only way out. Other therapies, these participants contended, just offer relief whereas orgonomic therapy provides true healing. One participant compared her experience in orgonomic therapy to her previous experience with a therapist who was primarily transpersonal in orientation and who also incorporated body-oriented interventions:

The imagery...I had at the time: It's like all my life I was going through the jungle...with [a] machete...and I'm hacking and hacking, I'm slowly moving and...I hacked my way out of the jungle [with my transpersonal therapy]. I'm in some kind of an opening. But then I see a wall that goes as far high as I can see, as far left, to the right as I can see. [A] thick wall...and all I have in my hand is a machete. So I hack at it...I bang my head against it. Nothing really happens. That was my therapy at the time. I did not see [it] progressing to the winning end...The machete is the modality that [my old therapist] offered, which I did not feel was going to go anywhere...it did not feel like it's going to produce the results that I really wanted.

She continues on, expressing her understanding of orgonomic therapy, borne out of her experience with it:

Orgonomic therapy addresses the underlying issue, question, which is in the body somewhere, which really was not happening [in my previous therapy]...without addressing it there is no chance in hell to be well from this condition...From my experience everything's connected, we are integrated...it seems natural, seems logical. Orgonomic is much deeper, much deeper...it goes to root causes, a lot deeper...[other therapies provide] a little relief, but not the healing.

Another participant echoed these sentiments, comparing bioenergetics, a body-based therapy with lineage from Reich's theories, with his experience in orgonomic therapy:

## DISCUSSION

[Bioenergetics got] me to scream and cry and get a release. That was it. It felt good at first, [but] didn't last...where are you going with this?...It just wasn't enough for me...[Nobody was] analyzing character...it just wasn't quite clicking...[it was] mechanical...it just wasn't good solid work where you change over time...it didn't click more deeply...it really wasn't working long-term.

One participant compared orgonomic therapy to “a Ph.D. program, whereas other therapies feel like high school or college...[it's like] shifting from 1<sup>st</sup> to 10<sup>th</sup> gear.” Another participant noted that “regular talk therapies can't reach this level of depth because the physical, emotional, and psychological memories are cut off from each other.”

These sentiments match Reich's eventual dissatisfaction with psychoanalysis, finding, as Shapiro (2002) stated, that it “provided only intellectual understanding” (p. 339). These experiences also mirror Raknes's (1971) claim that orgonomic therapy differs from classical analysis as “something going much deeper, to the very core of their [the patients'] personalities” (pp. 21-22).

Participants expressed fierce excitement about this work, almost with religious fervor. Several claimed that orgonomic therapy is one of the best things that they have ever done. Many felt enormously grateful for it. In some ways their experience seemed more of a spiritual journey than just psychotherapy. They expressed very little negativity about the therapy, in fact, almost nothing at all. One patient noted that he wished his orgonomic therapy had taken him further into an unexplored realm, but this was expressed as more of a longing than a criticism of the therapeutic work that he had done.

Several participants expressed concern that orgonomy is a lonely field for both patients and, they assumed, practitioners. There was a desire for a larger orgonomic community and for the therapy to be more acceptable in mainstream psychotherapeutic circles.

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## CONCLUSION

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THE FINDINGS OF THIS STUDY are consistent with Reich's theory and practice of orgonomic therapy. The experiences of the participants in this study mirror Reich's, and others', understanding of what it is like to be a patient in this unique form of therapy. The benefits of this study are in its ability to provide a broader, deeper, and richer understanding of that experience directly from the aggregate voices of those who have experienced and benefited from it first-hand. Nothing in the literature heretofore has offered that. Nor has anything in the literature, heretofore, referred to the innate and intuitive draw that these patients feel toward orgonomic therapy.

### **Clinical Implications**

The participants in this study described great benefit from experiencing genuine and deep emotions in therapy. Orgonomic therapists must be willing and prepared to tolerate, bear, stay present with, and even welcome a wide variety of these emotional experiences from their patients. This can range from abject adulation to unbridled hate and scorn. Reich (1933/1945) implored therapists to remember that all transference is negative transference, no matter how positive and benign it may appear, until the very end of treatment. What "the analyst usually regarded as a positive transference," he wrote "was merely secret, concealed, and repressed hate" (pp. 289-290). Working with the patient's latent negative transference and anger, as the participants in this study described, is healing and necessary. Orgonomic therapists must be prepared for this, partly through engaging in their own personal growth.

The difficult and demanding nature of this therapy for patients calls for special attention to this fact on the part of the orgonomic therapist. Patients should be carefully assessed for the ego strength, readiness, and motivation to do this work. Those deemed unsuitable should be referred to others or treated by

## CONCLUSION

different means. Being in contact with oneself, which aids in deep, resonant contact with the patient, is a necessary start, but organomic therapists must also keep in mind that patients may have difficulty engaging in the work even though they want to do so. When defensive character structure and armor is in the way, the organomic therapist must encourage his patient to stay with difficult emotions, sensations, and experiences, just as the participants in this study described. This can be scary therapy for patients. Encouragement as well as direction is sometimes needed from the organomic therapist.

Organomic therapists are well-advised to remember that most of the patients in this study came to this unique therapy with a strong intuitive sense that this therapy was right for them. Patients can experience a numinous quality in the very concept of organomic therapy. Heretofore, this finding has not been described in the literature. This understanding can greatly aid the organomic therapist in helping the patient to remember what initially brought them to therapy when thoughts of quitting arise. In addition, patients can be reminded of the trap they were in before beginning therapy.

### **Limitations of Current Study and Suggestions for Future Research**

Qualitative research methods, as already mentioned, are inherently limited in generalizability. This study, however, never purported to provide findings that would be generalizable to the entire population of patients in organomic therapy. Instead, this study attempted to provide a description that, as Denzin and Lincoln (2000) wrote “will necessarily bear the traces of the universal” (p. 370). Measures were taken to mitigate limitations on generalizability, reliability, and validity, however, as already described.

The design and structure of this study, nevertheless, has several limitations, some of which provide intriguing guidance for future study. The sampling and recruiting strategy, for example, allowed organomic therapists to choose which of their patients they might refer for inclusion in the study. Far from a random sample, this introduced an additional confounding variable, allowing for the presence of significant bias on the part of each referring organomic therapist. The

## CONCLUSION

referring ergonomic therapists, for example, may have been more likely to refer patients who made favorable therapeutic progress or who the therapist believed may report a favorable account of their experience in therapy.

If, instead, each ergonomic therapist simply made information about this study available to all of their current and former patients a more random sample could have been obtained. This sampling strategy, of course, presents difficulties that might adversely impact current or previous therapeutic relationships, which is incompatible with ethical psychological research. Future research that was able to generate a more random sample of participants could provide an even more reliable glimpse into the experience of the patient in ergonomic therapy.

Although a diverse participant sample was desired, the participants in this study, as a group, lacked diversity in some areas. A variety of cultural factors that may influence a patient's experience in ergonomic therapy may have been missed because of this. This resulted in little emphasis on the cultural aspects of ergonomic therapy, an area rich for investigation given the increasingly diverse world in which we live. Future research that addresses this void is warranted.

It is very likely that a patient's particular character diagnosis has a great impact on their experience in ergonomic therapy. Patient experience depends on, and is confounded by, the patient's character type. Certain character types may experience ergonomic therapy as more nurturing or more confrontational, more direct or more confusing, more refreshing or more provocative, depending on their character diagnosis. In addition, interventions appropriate for one character type may be completely inappropriate for another, further confounding patients' explanations of their experience. Character diagnosis is a variable that is not accounted for in this study, but could easily be explored in future research.

While this study sought to provide rich and vivid descriptions of the patient's experience in ergonomic therapy, the researcher stayed close to the hard data expressed through the open and category codes, congruent with Janesick's (2000) admonition that "staying close to the data is the most powerful means of telling the story" (p. 389). These codes, while accurate and useful for this study, lost some of the nuance and inexplicable quality of each patient's experience. As one

## CONCLUSION

participant said while reviewing her individual depiction: “There’s something about seeing my experience broken down into [a certain number of] points that misses ‘me,’ feels too scientific, and doesn’t appeal to me.” She has a point. Even the best of research cannot fully describe a patient’s experience. That is likely best left to great authors and other works of art.

### **Final Reflections**

One participant in this study stated: “This work that I’ve done...does not match any idea that I had of what this would be like. None. Reading about it, in retrospect, is just bullshit...Books capture moments in time and not the whole process.” I hope that this study has succeeded in capturing more than just a moment in time.

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## APPENDIX A: Introduction Letter to Researcher's Community

I am a doctoral candidate in clinical psychology at California Institute of Integral Studies in San Francisco. I am currently seeking participants for a dissertation research study entitled *Toward a Patient-Centered Understanding of Orgonomic (Reichian) Therapy*. I am seeking participants who are interested in sharing their experience of being a patient in orgonomic (Reichian) therapy.

As a patient in orgonomic therapy myself for the past six years, and now as a therapist providing orgonomic therapy, I am greatly intrigued by my own experience as a patient as well as what other patients have experienced in this form of therapy. My dissertation research is one of the first studies aimed at understanding what it is like to be a patient in this unique and often misunderstood form of therapy.

I am contacting you because I know you are interested or somehow involved in orgonomic work. I need your help in identifying orgonomic (Reichian) therapists, current or former patients, and/or others who may know of these people.

Therapists must be licensed orgonomic (Reichian) therapists and identify as such.

Participants (patients) should meet the following criteria:

- Currently or previously a patient in orgonomic (Reichian) therapy with the same therapist for at least two years.

*Orgonomic (Reichian) therapy* means therapy in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated.

*Orgonomic biopsychotherapy* means therapy in which the patient lies down on a couch, mat, or mattress while the therapist physically and directly intervenes on the patient's muscles, assists the patient with his or her breathing, and asks the patient to vocalize and express emotion in a variety of ways.

- Be 18 years or older.

Participation in this study consists of two informal, semi-structured, conversational interviews during a one- to two-month period. Each interview will be approximately 75 to 90 minutes. These two interviews will take place either by telephone or in person at a mutually-agreed upon time (and in the case of in-

## APPENDIX A: INTRODUCTION LETTER TO RESEARCHER'S COMMUNITY

person interviews at a mutually agreed-upon location). During the first interview I will invite the participant to talk about his or her experience as a patient in organomic (Reichian) therapy and will ask specific questions of research interest. Participants may also share personal journals, letters, poems, or artwork that they have used to record and understand their experience. During the second interview, I will review a summary of their responses with them and ask for their feedback. No prior preparation is required for any part of either interview although spending some time self-reflecting on their experience as a patient in organomic therapy may be useful prior to the interviews. In some cases I may need to contact a participant after either interview to clarify certain responses or ask additional questions.

### **Here's how you can help:**

Please provide my contact information (below) to anyone in your network of contacts who fit the criteria that I listed above. Encourage them to contact me directly by email or telephone, and I will do the rest. If you prefer, you can call or email me with names and I will contact your referral(s) directly. Lastly, if you know of anyone who may not have received this and is interested or somehow involved in organomic work, please feel free to forward this email to them.

If you have any questions or concerns, please feel free to contact me.

With gratitude,

Neil Schierholz, M.S., M.A.  
3237 Sacramento Street  
San Francisco, CA 94115  
(415) 821-2345  
NeilSchierholzMA@aol.com

## APPENDIX B:

### Introduction Letter to Prospective Orgonomic Therapists

I am a doctoral candidate in clinical psychology at California Institute of Integral Studies in San Francisco. I am currently seeking participants for a dissertation research study entitled *Toward a Patient-Centered Understanding of Orgonomic (Reichian) Therapy*. I am seeking participants who are interested in sharing their experience of being a patient in orgonomic (Reichian) therapy.

As a patient in orgonomic therapy myself for the past six years, and now as a therapist providing orgonomic therapy, I am greatly intrigued by my own experience as a patient as well as what other patients have experienced in this form of therapy. My dissertation research is one of the first studies aimed at understanding what it is like to be a patient in this unique and often misunderstood form of therapy.

I am contacting you because I understand that you are a licensed orgonomic (Reichian) therapist and identify as such. If this is you, please keep reading.

I am hoping that you will consider encouraging your current or former patients to contact me for participation in this study.

Participants should meet the following criteria:

- Currently or previously a patient in orgonomic (Reichian) therapy with you, their therapist, for at least two years.

*Orgonomic (Reichian) therapy* means therapy in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated.

*Orgonomic biopsychotherapy* means therapy in which the patient lies down on a couch, mat, or mattress while you, as the therapist, physically and directly intervene on the patient's muscles, assist the patient with his or her breathing, and ask the patient to vocalize and express emotion in a variety of ways.

- Be 18 years or older.

Participation in this study consists of two informal, semi-structured, conversational interviews during a one- to two-month period. Each interview will be approximately 75 to 90 minutes. These two interviews will take place either by telephone or in person at a mutually-agreed upon time (and in the case of in-

person interviews at a mutually agreed-upon location). During the first interview I will invite the participant to talk about his or her experience as a patient in orgonomic (Reichian) therapy and will ask specific questions of research interest. Participants may also share personal journals, letters, poems, or artwork that they have used to record and understand their experience. During the second interview, I will review a summary of their responses with them and ask for their feedback. No prior preparation is required for any part of either interview although spending some time self-reflecting on their experience as a patient in orgonomic therapy may be useful prior to the interviews. In some cases I may need to contact a participant after either interview to clarify certain responses or ask additional questions.

**Here's how you can help:**

Please provide my contact information (below) to your current or former patients who you believe would be appropriate for this study. Encourage them to contact me directly by email or telephone, and I will do the rest.

If you know other orgonomic therapists who may be interested in referring patients for this study, please feel free to notify me or forward this information to them directly and ask them to contact me. Lastly, if you have any questions or concerns, please feel free to contact me.

With gratitude,

Neil Schierholz, M.S., M.A.  
3237 Sacramento Street  
San Francisco, CA 94115  
(415) 821-2345  
NeilSchierholzMA@aol.com

## APPENDIX C: Introduction Letter to Prospective Research Participants

I am a doctoral candidate in clinical psychology at California Institute of Integral Studies in San Francisco. I am currently seeking participants for a dissertation research study entitled *Toward a Patient-Centered Understanding of Orgonomic (Reichian) Therapy*. I am seeking participants who are interested in sharing their experience of being a patient in orgonomic (Reichian) therapy.

As a patient in orgonomic therapy myself for the past six years, and now as a therapist providing orgonomic therapy, I am greatly intrigued by my own experience as a patient as well as what other patients have experienced in this form of therapy. My dissertation research is one of the first studies aimed at understanding what it is like to be a patient in this unique and often misunderstood form of therapy.

If you meet the following criteria, please continue reading:

- You currently are or have been a patient in orgonomic (Reichian) therapy with the same licensed therapist for at least two years.

*Orgonomic (Reichian) therapy* means therapy in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated.

*Orgonomic biopsychotherapy* means therapy in which you lie down on a couch, mat, or mattress while your therapist physically and directly intervenes on your muscles, assists you with your breathing, and asks you to vocalize and express emotion in a variety of ways.

- You are 18 years or older.
- Your therapist is a licensed orgonomic (Reichian) therapist and identifies as such.

Participation in this study consists of two informal, semi-structured, conversational interviews during a one- to two-month period. Each interview will be approximately 75 to 90 minutes. These two interviews will take place either by telephone or in person at a mutually-agreed upon time (and in the case of in-person interviews at a mutually agreed-upon location). During the first interview I will invite you to talk about your experience as a patient in orgonomic (Reichian) therapy and will ask specific questions of research interest. You may also share personal journals, letters, poems, or artwork that you have used to

## APPENDIX C: INTRODUCTION LETTER TO PROSPECTIVE RESEARCH PARTICIPANTS

record and understand your experience. During the second interview, I will review a summary of your responses with you and ask for your feedback. No prior preparation is required for any part of either interview although spending some time self-reflecting on your experience as a patient in ergonomic therapy may be useful prior to the interviews. In some cases I may need to contact you after either interview to clarify certain responses or ask additional questions.

I am honored that you are interested in this research and deeply appreciate your commitment in time and energy. Please complete the following forms, included in this packet and bring them with you to your first interview (if being conducted in-person) or mail them back to me at the address below (if being conducted via telephone):

- Informed Consent for Research Participants
- Demographic Form for Research Participants

The *Bill of Rights for Research Participants* is for your reference and for you to keep.

If you know others who may be interested in this study, please feel free to notify me or forward this information to them directly and ask them to contact me. Lastly, if you have any questions or concerns before your first interview, please feel free to contact me.

With gratitude,

Neil Schierholz, M.S., M.A.  
3237 Sacramento Street  
San Francisco, CA 94115  
(415) 821-2345  
NeilSchierholzMA@aol.com

## APPENDIX D: Informed Consent for Research Participants

I, \_\_\_\_\_ (Participant), voluntarily consent to participate in a research study being conducted by Neil Schierholz, M.S., M.A. (Researcher), a doctoral candidate in clinical psychology at the California Institute of Integral Studies, Clinical Psychology Doctoral Program, in San Francisco. This study is being conducted under the supervision of Kaisa Puhakka, Ph.D., dissertation chair, and follows the guidelines of the American Psychological Association Ethical Principles for research with human subjects.

The purpose of this study is to explore and further understand the experiences of patients who are being or have been treated with orgonomic (Reichian) therapy *from the patient's perspective*. I have been asked to participate in this study because I meet the following criteria:

- I currently am or have been a patient in orgonomic (Reichian) therapy with the same therapist for at least two years. *Orgonomic (Reichian) therapy* means therapy in which verbal character analysis and orgonomic biopsychotherapy (both based on the work of Wilhelm Reich) are seamlessly integrated. *Orgonomic biopsychotherapy* means therapy in which I am lying down on a couch, mat, or mattress while my therapist physically and directly intervenes on my muscles, assists me with my breathing, and asks me to vocalize and express emotion in a variety of ways.
- I am 18 years or older.

I understand that my participation in this study consists of two informal, semi-structured, conversational interviews during a one- to two-month period. Each interview will be approximately 75 to 90 minutes. These two interviews will take place either by telephone or in person at a mutually-agreed upon time (and in the case of in-person interviews at a mutually agreed-upon location). During the first interview Neil Schierholz, M.S., M.A. (Researcher) will invite me to talk about my experience as a patient in orgonomic (Reichian) therapy and will ask specific questions of research interest. I may also share personal journals, letters, poems, or artwork that I have used to record and understand my experience. During the second interview, the Researcher will review with me a summary of my responses and ask for my feedback. No prior preparation on my part is required for any part of either interview although spending some time self-reflecting on my experience as a patient in orgonomic therapy may be useful prior to the interviews. I also understand that it may be necessary for the Researcher to contact me after either

## APPENDIX D: INFORMED CONSENT FOR RESEARCH PARTICIPANTS

interview to clarify certain responses or ask additional questions and I agree to be available for this.

I understand that there is no offer or guarantee of direct monetary, emotional, or scholastic benefit to me from my participation in this study. Nevertheless, I may find the process interesting and thought-provoking. The information I provide may benefit others in understanding and treating patients with organomic (Reichian) therapy.

I understand that the interview questions may touch sensitive areas for me; I may experience some discomfort from discussing a situation or therapeutic experience that might have been personally challenging or intense. I realize my participation in this study is completely voluntary and I am free to refuse to answer any question(s) or to end my participation in the study at any time without penalty or prejudice. Neil Schierholz, M.S., M.A. (Researcher) will be available before, during, or after the interviewing process to talk with me about my concerns. He can be contacted at (415) 821-2345 or NeilSchierholzMA@aol.com. I also understand that I can contact the Researcher for a referral to a local psychotherapist or counseling center, if desired. In addition, I understand that the Researcher reserves the right to either end my participation in the study or to not utilize my data.

All information I contribute will be held in strict confidence in accordance with the American Psychological Association Ethical Principles and within the limits of the law. There are circumstances, however, in which Neil Schierholz, M.S., M.A. is required by law to reveal information, usually for the protection of a research participant or others. A report to a police department or to the appropriate protective agency is required in the following cases:

- If, in the Researcher's judgment, a research participant becomes dangerous to himself or herself or others (or their property), and revealing the information is necessary to prevent the danger.
- If child abuse is suspected, in other words if a child under 16 has been a victim of a crime or neglect.
- If elder abuse is suspected, in other words if a woman or man age 60 or older has been victim of a crime or neglect.

I understand that this interview will be audio recorded and subsequently transcribed by someone other than the Researcher. Access to audio recordings will be limited to the Researcher and, for a short time during transcription, the transcriber. After transcription, audio recordings and transcripts will be kept in a safe, locked file or on a finger-scan and multiple password-protected, non-networked computer to which only the Researcher has access. Audio recordings and transcripts will be identified by numbers only and will not have my name or

APPENDIX D: INFORMED CONSENT FOR RESEARCH PARTICIPANTS

any identifying information in them to maintain my confidentiality. Likewise, this consent form with my name will be kept separate from my audio recording and transcript for the same reason.

I understand that the data obtained in this study will be used for research purposes only. Any publication which might result from this study will not identify me by name. I further understand that the Researcher will ask me to refer to anyone I talk about during the interview by pseudonym or to refrain from naming him or her at all. I understand that all identifying data of any sort will be deleted from any publication. In addition, I may request that specific details I provide be omitted from any publication and that this will be honored. All transcripts and audio recordings will be permanently destroyed within five years of collection.

I understand that if I have any questions regarding this research, I may contact Neil Schierholz, M.S., M.A. at (415) 821-2345 or NeilSchierholzMA@aol.com. If I have further questions, I may also contact Kaisa Puhakka, Ph.D., dissertation chair, at (415) 575-6103 or kpuhakka@ciis.edu. I understand that if I in any way feel that I have been put at risk, experience an injury, or have any questions about my rights as a research participant, I may contact the Chair of the Human Research Review Committee (anonymously if I wish) at:

Human Research Review Committee  
California Institute of Integral Studies  
1453 Mission Street  
San Francisco, CA 94103  
(415) 575-6114  
bduchmann@ciis.edu

I have read the above *Informed Consent for Research Participants* and am aware of the nature, requirements, and potential benefits and risks of this study to me. I realize my participation in this study is completely voluntary and I am free to refuse to answer any question(s) or to end my participation in the study at any time without penalty or prejudice. In signing this I am not waiving any legal rights, claims, or remedies. By signing below I acknowledge that I have read, understand, and have received a copy of this *Informed Consent for Research Participants* and the *Bill of Rights for Research Participants*.

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Participant's Name (Printed)

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Participant's Signature

Date: \_\_\_\_\_

## APPENDIX E: Bill of Rights for Research Participants

You have the right to:

- Be treated with dignity and respect.
- Be given a clear description of the purpose of the study and what is expected of you as a participant.
- Be told of any benefits or risks to you that can be expected from participating in the study.
- Know the researcher's training and experience.
- Ask any questions you may have about the study.
- Decide to participate or not without any pressure from the researcher.
- Have your privacy protected within the limits of the law.
- Refuse to answer any research question, refuse to participate in any part of the study, or withdraw from the study at any time without any negative effects to you.
- Be given a description of the overall results of the study upon request.
- Discuss any concerns or file a complaint about the study with the Human Research Review Committee, California Institute of Integral Studies, 1453 Mission Street, San Francisco, California 94103.

**APPENDIX F:**  
**Demographic Form for Research Participants**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male     Female     MTF     FTM     Intersex     Other

Racial/Ethnic Identity: \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Other Language(s): \_\_\_\_\_

Language(s) spoken at home (in order of most to least used): \_\_\_\_\_

Disabled?     Yes     No

Type of Disability: \_\_\_\_\_

Family socioeconomic/class background: \_\_\_\_\_

Current relationship status: \_\_\_\_\_

Education and credentials: \_\_\_\_\_

Source of income: \_\_\_\_\_

Gross income (before taxes): \$ \_\_\_\_\_ per year

Orgonomic (Reichian) therapist's name, credentials (M.D., Ph.D, Psy.D, MFT, etc.), and license number: \_\_\_\_\_

Date you began therapy with the above-named therapist: \_\_\_\_\_

Date you ended therapy with the above-named therapist (if applicable): \_\_\_\_\_

## APPENDIX G: Semi-Structured Interview Questions

### Contextual Frame

In our conversation today I hope to understand what it's like for you as a patient in organomic therapy.

I'm going to ask you a few questions about your experiences, but they are really only a guide and you shouldn't feel restricted by them. Feel free to talk as much or as little as you want about your experiences and what you want me to know about what it's like for you as a patient in organomic therapy.

Also, if you brought personal journals, letters, poems, or artwork about your experience feel free to share that with me.

The information you share with me will be held in strict confidence in accordance with the American Psychological Association Ethical Principles and within the limits of the law, as described in the consent that you signed.

One last thing, please refer to anyone you talk about during the interview by a fake name or you can just not name them at all.

### Questions

- What brought you to organomic therapy? What led you to move from more conventional talk therapies to organomic therapy (or back)?
- What's your experience in organomic therapy? Describe it as fully as you can. Go ahead and tell me whatever you like.
- What's your most vivid and significant experience in organomic therapy? What qualities or aspects of the experience stand out for you? What is your interpretation of it?
- What's the most significant change that you've experienced? Describe it as fully as you can. How did it come about? What was it like for you?
- What's your experience in the hours and days after you do the work?
- How has your experience affected you and your life?
- What would you ask that I didn't ask? What else do you think we should talk about?

## About the Author

Neil Schierholz PsyD is a licensed psychologist who provides character analytic orgone therapy in private practice in Los Angeles and San Francisco, California. He trained with Drs Richard Blasband and Patricia Frisch for over four years and has received an additional two and a half years of continuous clinical consultation from Dr Richard Blasband. Dr Schierholz's previous experience includes a long career in providing organizational psychology consulting services to more than 45 organizations worldwide.

Dr Schierholz has PsyD and MA degrees in Clinical Psychology from the California Institute of Integral Studies as well as an MS in Industrial & Organizational Psychology from the University of Central Florida. His BS degree is in Chemical Engineering (with minors in Russian Literature and Physical Chemistry) from the University of California, San Diego. Dr Schierholz is a full member of the American Psychological Association (APA), the California Psychological Association, the Lesbian and Gay Psychotherapy Association, and the Marin County Psychological Association. He became a guest of the Institute for Organomic Science (IOS) in 2011.

Dr Schierholz may be reached at (310) 866-0440 in Los Angeles, at (415) 821-2345 in San Francisco, or at [DrSchierholz@DrSchierholz.com](mailto:DrSchierholz@DrSchierholz.com)