Armoring in a Newborn Infant

By Wilhelm Reich, M.D.

We assume that in a newborn infant an unwarped highly plastic bio-energy system emerges from the womb, and that from then onward it will be influenced by a multitude of various environmental impacts. The impinging impressions will begin to form the infant's specific type of reaction to pleasure and to sorrow. This is true, provided that no major harm had already been inflicted in the uterus. But let us, for the sake of clarity, separate the prenatal and the postnatal development. They can be kept separated, although a prenatal damage suffered will to a certain degree determine the manner in which postnatal stimuli are absorbed and structuralized.

It seems best to conduct our inquiry along the lines of a concrete case. What matters here is whether or not and in what manner we can apply our base of operation in the concrete single case. What obstacles do we encounter if we decide to "let only the interest of the child determine the course of events and, if at all possible, nothing else?" The "nothing else" is, of course, exaggerated here and not fully applicable in daily social life. We are prepared that for centuries to come thwarted life will infringe upon healthy, newborn life and will cause more or less harm. However, it is crucial for the general line of procedure as well as for the attainment of some degree of success in the one, to learn to judge the obstacles to this undertaking as they arise in daily life.

The mother of the infant to be discussed in the following pages was chosen from among a small group of applicants as one of the "fairly healthy"
mothers. Biologically she appeared outgoing, direct, with no major twists in her character structure. She had been happily married for several years. Special requirements of her husband's job in the Army had prevented them so far from having a baby, which they greatly desired. The mother was a pretty, sexually attractive woman of thirty. The first biophysical examination revealed a strong body, a warm radiating skin, sparkling eyes, full, sensuous lips, well-formed limbs and torso, relaxed and calm behavior.

She could express emotions of any kind freely, which is a major indication of free-flowing bio-energy. She could cut ugly faces, sneer, growl, scream, show anxiety in her eyes, open her eyelids fully, wrinkle her forehead, bite and hit strongly with her fists at an imagined hated object. The gag reflex was fully developed. Her eyes had a deep, serious, penetrating look full of contact like the look of a deer.

The essential point in the examination of a future mother is, of course, her thighs and her pelvis. Not only the mechanical routine functions, such as width of the entrance and exit of the pelvic bone structure, normal position of the uterus, absence of retroversion and prolapse, absence of trichomonas vaginalis, absence of cervical lacerations and erosions, of fibromatous and myomatous growths in the uterus, and regular and painless menstruations are essential. These things are matter of fact to any good obstetrician. **What matters here is whether or not any armoring can be found in the pelvic segment.**

Group A in the OIRC does not accept mothers with armored pelvic segments. The reason for this is obvious. A pelvic armor precludes orgasmic discharge, reduces the vitality of the genital organs and thus impedes full bio-energetic functioning of the fetus; in addition, it renders the total emotional system more vulnerable to strains and stresses of family difficulties, pregnancy disorders and the delivery itself. We did not absolutely refuse mothers with armored pelvises; but we registered them in Group B, that is, with the intention of studying in due time the existence or nonexistence of damage to the fetus growing in a spastic uterus. Little is known about the influence of uterine spasms upon the fetus. The results had to be kept clearly separated, according to our basic distinctions between armored and unarmored organisms. We know from ample clinical evidence that if the pelvis is unarmored the rest of the organism is also free of major immobility; and that if the pelvis is armored there always also exists armoring in other segments of the organism.

To return to our mother: She enjoyed the embrace without fear or restriction. She could “let herself go” completely and had her regular orgasmic discharges; her whole bearing and expression corroborated this conclusion. Only a slight oversensitiveness in her middle abdominal segment could be found; it was easily removed.

In the psychological realm there was an inclination toward an exaggeratedly idealistic attitude regarding motherhood and children. The prospective mother beamed with the expectation of raising a “healthy child,” of raising it to manhood or womanhood in only joy and delight. She seemed not fully aware that bearing and rearing children is a major and often painful task. When this was mentioned to her, she seemed confident, in fact a bit too confident regarding the job ahead. She also seemed to idealize her husband beyond the actual reality. They had, so she said, no conflicts at all, they were most happy together, etc. The examining physicians knew from reports by their chief social worker that not all was or seemed as rosy as the mother preferred to present it. The husband, a kind and handsome fellow, was inclined to verbal pornographic expressions; he had some set ideas about social and cultural matters which were not quite in agreement with his wife’s biological structure. He also seemed to enjoy her idealization too much.

It is essential not to evaluate the parents in “absolute” terms of an “absolute” health with regard to an “absolutely healthy” child; on the contrary, such an attitude of absolute perfectionism does, as will clearly emerge later on, cause much harm not only to the conduct of the parents but, of first importance, to the preventive educational undertaking itself. The ideal of an “absolute” health and an “absolutely healthy” child contradicts the reality in which the child has to grow up. It most probably also contradicts the natural process itself which never is and never can be perfect according to the ideals of man. The setting of absolute ideals in medicine or education precludes proper evaluation of what is and what is not possible to achieve. It will, most likely, break down at the first impact of a major obstacle in the way.

In this particular case, as in other cases, the mother as well as the head social worker in charge of the case were in danger of failure because of this idea of absolute health. It is a general human character trait which we will be kept pondering about for quite some time. We shall later realize in what manner these first impressions of the mother actually began to exert their influence upon the infant in the wrong direction.

The staff which was to take care of the mother consisted of:
One physician, a medical orgonomist; his task was to supervise the emotional status of the mother during pregnancy, to remove any blocking which might have appeared at any time in any part of the organism.

Another medical orgonomist who had specialized in the observation of small children and had had rich experiences with his own son, at that time four years old.

One organonically trained social worker; she was to be in touch with the mother frequently enough to detect any emotional or physical deviation from the physiological.

One obstetrician who was only to deliver the baby; he was willing to cooperate with the one in whatever was felt necessary to secure unimpeded development of the child.

Another medical orgonomist, who had performed a brilliant rescue operation in one special delivery, was to stand by and to take charge in case of delay or complication of delivery.

One mother; she was to learn how much can be taught to other mothers in groups about delivery and nursing.

One may ask at this point: Why this complicated machinery for the delivery of one single baby? The answer is this: Since nothing whatsoever is known about the effects of bio-energetic and emotional disturbances on pregnancy and delivery, it was necessary to have as many skilled workers as possible standing by to make the observations and step in if necessary. It is of little use to have a psychologist who knows nothing about orgonotic streamings and an obstetrician who, merely mechanically oriented, delivers a baby, if that baby is to be studied in regard to its emotional development. It was necessary to have several organonically well-trained specialists pool their knowledge in order to miss as little as possible during the crucial period. It seemed decisive to give the whole project the correct start. Even divergences in opinions of the several observers could be expected to reveal major problems during the prenatal and the postnatal period.

Reports on the behavior of the mother were obtained from different sources. In this manner, what was common observation could be distinguished from what might have been an individual emphasis; and also the reactions of the different workers could be studied at the same time while they were in contact with the mother.

One of the two social workers, for instance, became severely disturbed when, during the first examination, the mother told the examining board that she enjoyed full genital gratification in the embrace. This social worker was at that time in an acute state of frustration, and she broke into crying. Thus we learned how the personal emotional status of a social worker can be affected by certain disclosures in a particular case. Such things of course happen wherever human life is handled medically or educationally. The good physician or social worker knows what goes on subterraneously in such contacts. The rigid and well-armored physician or social worker, on the other hand, does not know it or he discards it as "not belonging"; he may even get angry if such "personal interferences with the job" occur. Accordingly, the literature is bare of any inquiry into the role played by the emotional structures of the specialists involved.

Here is the report of the social worker some six weeks before the actual delivery:

If you are interested in my personal impression of Mrs. L. and how she is carrying the baby, I can say I think it is excellent. Her whole attitude about her baby is remarkable compared to any of my previous experience. Her whole being seems saturated with happiness and contentment. She sits and radiates, and one feels good and close to the living in her presence. I feel very aware of the baby as though it were a member of the group. She doesn't seem anxious about anything. When discomfort or pain connected with childbirth is mentioned, she doesn't seem the least disturbed. When she learned that G's baby had died, she reacted warmly and sympathetically, but with no sign of identification or fear. She looks wonderfully healthy and has had no edema or negative physical symptoms to my knowledge. She appears to have a good understanding of what the Orgonomic Infant Research Center is about and seems wholeheartedly for it.

Here is the report of the chief social worker, fifteen days after delivery:

Baby had its first bath on the 11th day—seems to love it; gurgles and moves in the water. Is startled if taken out of water too quickly (pulss shoulders back).

Very active with head movements, is able to hold head up by itself; when held upright moves head from side to side. Turns head and moves eyes according to sound and movements of people in the room. Appears to focus and coordinate eyes and follows objects as they move.

Has frequent hiccups, practically after every feeding. Also spits up milk; mother said this happens only when having bottle, but it was observed by us to do it also after breast feeding.

Mother relates that at first the baby would eat very frequently (every hour)
from breast. It would go to sleep at breast and start crying as soon as mother tried to put it back in crib. The bottle formula (which is given irregularly) was strengthened and the baby calmed down and seemed to have needed added nourishment. *Mother realized she is tense at times which is influencing the milk flow.* Baby at times sleeps for longer stretches during the night only if mother holds it in her arms. This tires mother out. Mother says baby likes breast better than bottle but takes to the bottle also easily. Baby gained 11 ounces the first week, 10 ½ ounces the second week. *Oral orgasm observed only during the first three days.* Baby still eats at least every three hours, usually more often.

Baby was observed by us while it was lying awake in its crib. Its color and body warmth were good at first; later, extremities seemed pale and cool. It started having hiccups which lasted for quite some time. *Its chest seemed hard ("bird cage"); it would hold it in inspiration: Inhalation long, exhalation short, staccato and irregular.* The baby seemed restless on the whole. When having a bowel movement, the stool was loose and projectile—came out with a terrific force, messing up the crib. Face became contorted, pulled up legs. The father was “playfully” pulling its legs and arms which made baby seem even more uncomfortable. (“You be good or I’ll punch your nose.”)

The second report four days later reads as follows:

**Baby’s age: 19 days:**

Baby had been having a cold for the last two days. The breathing seemed obstructed; it was noisy and shallow and quick. *The breathing has so far only seemed to be reaching the upper chest, but not down to the belly.* The noisy breathing ceased when it was sleeping peacefully in my arm for one half an hour; the chest was moving very rapidly, however.

_Generally the baby seemed restless, fretful and unhappy._ Would be at the breast only for a short time; perspired when sucking. (Often does, according to mother.) Holding it would only satisfy it for a short while, then it would take breast for a short period, then sleep for brief time, etc. Usually its crying was whimperish, rather weak. Only once did it really yell out with any force.

_Baby does not like to lie on belly but does sometimes lie on its side._ At times it seems soothed by lying on its belly over the mother’s knee while having its back stroked.

**Mother uses bottle frequently during the night; however, the baby wants to sleep in mother’s arms all night.**

Mother stated that caring for the baby was far more difficult than she had anticipated. Had some kind of a doll idea. It gives her anxiety and she feels at times at a loss as to what to do to satisfy the baby. Mother says baby often seems more restless at night and will cry, pull legs as if it had cramps (colic??).

*Overall impression:* One difficulty with Mrs. L is that she has a tendency to want to relate everything as “wonderful.” This was noted throughout the pregnancy: _It is an unrealistic, Pollyanish attitude which covers up honest facts._ She will usually only admit difficulties in the past tense. The same holds in her relationship with and perception of her husband. A consequence of this attitude is the fact that the mother now feels surprised and overburdened by the demands of the baby. She admits she resents the amount of time and energy she has to give to the baby, although she says this was only so in the beginning. Furthermore, because everything is not just wonderful right now, we can probably anticipate resentment on her part toward the one because we want the real facts.

Mr. L appears to be somewhat lacking in sensitivity toward the baby. He manipulates its body rather roughly to show it off and is in danger of taxing the baby beyond its limits so that he can prove its “health.” He is also rather aggressive and dominating with his wife who, however, talks very praiseingly about her husband and says she is more in love with him now than ever.

Mrs. L’s mother-in-law continues to be present practically every day and also sleeps there nights, although she does not live with the L’s. According to Mrs. L, she has worked out a very satisfactory arrangement with her mother-in-law who helps her with the housework and shopping. Mrs. L has been urged to handle the baby herself but from some of the things she says, it seems that the mother-in-law takes care of the baby a great deal too. Mrs. L states that she could never have managed everything had it not been for her mother-in-law. Mrs. L seems definitely dependent upon the bottle; will she give up the breast feedings for the bottle?

**Summary:**

Something had gone wrong. The baby was uncomfortable, and nobody seemed to know why. It was only hinted that the mother did not seem to function too well. The job of motherhood appeared to be far more difficult for her than she had anticipated.
Was the mother not as well adjusted to her biological function as we had assumed? Or was there any other, hidden reason for the difficulty?

We know that no such problems usually turn up in medical pediatric work. The child is given its chemical "routine shots." If the mother feels uncomfortable, she is advised to do this or that, to take it easy, to relax, to stick to a schedule, etc. To search for the roots of the evil in a disturbance of the contact between mother and child is rarely thought of. A week later the following report came in from the chief social worker:

I talked today with Dr. M who saw the L's yesterday. He was not satisfied with Mrs. L, felt that she was tense, had anxiety; her eyes seemed dull. Dr. M confirmed the impressions given in earlier reports. When Dr. M questioned her, Mrs. L admitted her difficulties in the past, but said that everything was all right now.

It was then decided to let the parents, together with the infant, travel to Orgonon for a thorough interview and examination of the situation. It is clear that to learn all the details in such a situation in a single family is far more important than doing research superficially with hundreds of babies. For a long time to come, the task must remain on a pilot research level. The further development proved this approach to be correct.

The parents brought the baby to Orgonon when it was five weeks and four days old. These were the basic points of the interview:

Q: Do you (mother) have contact with the baby?
A: Yes, frequently, but sometimes I don't.

Q: How do you know when you do not have contact?
A: I don't seem to be able to be at ease with the baby—I don't seem to hold it the right way, and then the baby does not seem comfortable, it becomes anxious and unhappy.

The mother had contact with the baby most of the time, but she also knew when she had lost contact. Here the first dangerous misconception of "health" manifested itself:

The mother seemed to feel guilty over not being a "healthy" mother, over not fulfilling her task in the OIRC when her contact with the baby was bad. And the baby apparently responded to the lack of contact with discomfort. What then was wrong here? The temporary lack of contact, or the guilty feeling about not having contact? Obviously the latter. It is natural that a mother at times loses contact with her child for a brief period. It is a sign of an alert and alive structure to know when contact is lacking. To have guilty feelings about it does not seem to belong here. Why should a mother feel guilty if she temporarily has no contact? And what do such guilty feelings do to her organism, and through her organism to the baby?

Such questions bother many a mother in many countries. The orgonotic sense of contact, a function of the orgone energy field of both the mother and the child, is unknown to most specialists; however, the old country doctor knows it well.

Orgonotic contact is the most essential experiential and emotional element in the interrelationship between mother and child, particularly prenatally and during the first days and weeks of life. On it, basically, the future fate of the child depends. It seems to be the core of the emotional development of the newborn infant. We know very little about it yet. Let us, therefore, explore it further.

The next problem in the interview was to find out what the disturbed contact did to the child.

Interviewer: It is to be expected that the child will feel uncomfortable if your contact is absent. The important point is that you clearly know when you do not have contact. An armored mother most likely would not know it, and thus could not change the situation. Let me ask you a few questions to find out:

1. Why you lose contact;
2. How you yourself react to the loss of contact, and,
3. What happens to the baby when you lose contact.

How do you know what the baby wants when it cries?

Mother: It cries differently according to what it wants. I have learned how to distinguish it. At times I am not sure; I then try different things until I have found out what it wants.

Interviewer: You are right there. With full contact established, the mother knows what the baby wants. But we must get away from the idea that everything should be perfect, that you should have contact all the time, that the baby must always be happy and healthy. The main thing is not whether or not the child at times feel uncomfortable, but whether or not you know why it suffers and can pull yourself and the baby out of it. Health, in other respects also, does not consist in never being unhappy or always being healthy, but, basically, in whether or not the organism is capable of pulling out of unhappiness and illness. These ideals about an "absolute happiness" and "health"
should be given up outright. They are mystical, no good and cause much harm. It is to your credit as a well-functioning mother that you are aware of your own occasional depressions. Do you know why you get depressed?

Mother: At times I feel strongly that I am bound down, overburdened by caring for the baby. I did not know when I expected the baby that it would mean so much hard work.

Int.: It is quite natural for a young, lively mother to feel the burden and to resent it at times. You cannot go dancing whenever you'd like to, and your time is not quite your own. It is also natural that, in your joyful expectation of having a baby, you overrated the pleasure of having a baby and underestimated the burden you would have to carry. It would be very strange if you did not feel resentment against the baby at times, or if you did not know it and blocked it off. To be unaware of these human attitudes would constitute a serious danger to yourself and to the baby, emotionally. Therefore, do not worry about losing contact at times or disliking the baby off and on. However, I feel that there is more to it. Don't you feel that you do not quite live up to the demand of being a "healthy mother"? Don't you feel that a "healthy" mother should have a "perfect" baby and should never be depressed or distressed?

Mother (her eyes suddenly brightening up and her face, pale before, flushing): Oh, yes, I feel burdened by the obligation to be always healthy and perfect. I feel that I do not comply with the expectations people have in this case with regard to the baby.

Int.: Now this is crucial. In addition to the natural reaction against being bound by the baby, you feel obliged to comply with certain expectations as to health and perfect behavior. This is an unnecessary depression. It is bad for you and bad for the baby. Who expects so much of you?

Mother: Being one of the "healthy mothers" under the care of the one, I feel I must not fail as a mother. This depresses me. My husband always boasts of how healthy a baby we have, and this is not quite true. My baby is not quite healthy, I know it and I do not know why. I do my best and it does not quite work. My baby had a cold when it was two weeks old and since then it is not well although the cold is long gone.

Int.: We shall go into that very soon. First your husband. [To the father]

Do you have contact with the baby? Do you like it?

Father: I love it. . . . The baby always smiles at me; I have good contact . . . [There was a peculiar ring in the father's statement about the smile.]
she assured us, have no influence on the child. Still, it remained a riddle why the mother had not told the truth. We can clearly see that without the connection with the one the mother would have yielded to her parents' expectations and that a severe injury would have been inflicted upon the child.

The question now arose as to whether the parents wanted the child to grow up as a Jew. The mother declared that she would not; she thought it immaterial since those national boundaries were artificial. The father insisted that he was conscious of being a Jew and he could not see any reason why the child should reject the fact that he too was a Jew as he was growing up. He planned to teach the child about his Jewish ancestors and traditions so that he would become a "good Jew," conscious of his heritage from Judaism.

Here a conflict appeared to be developing between the father and the mother with regard to a major question concerning the child's future. It was well known to the interrogators that such conflicts are apt to confuse the child, to cause conflict in its double dependence on father and mother; that the party which would lose out in this fight would resent it and feel subdued by the other. Here, the base of operation in the one was to be tested as to its strength of reasoning and its efficiency. The conflict between the parents, the mother being world-minded and the father being more nationalistically inclined, could only be solved by the "third factor," the common functioning principle, i.e., the interest of the child and nothing but the child. Accordingly, the physician tried to explain the standpoint of the one.

The mother as well as the father had, of course, a full right to their own feelings and opinions. However, the interrogating physician felt that the mother represented the interest of the child more completely than the father. The mother's standpoint still left the opportunity open for the child later to decide whether it wanted to be a Jew or not. The father's view, on the other hand, left the child no choice but would force it right from the beginning, in a phase when it could not defend itself, into a certain cultural and religious pattern which the child, deep down, might resent and want to reject.

Would the father, as fathers were accustomed to do some decades ago and still are wont to do, determine in advance whether the child should become a carpenter or a lawyer? The father said that he would of course never try to do such a thing. Then, why determine right now whether the child should grow up as a Jew? At first the father could not see the point. It seemed to him that being a Jew was different from being a carpenter. He believed that Judaism is somehow inherited, given by birth as it were. The counseling

physician denied this. He said that children were born neither Jews nor carpenters nor anything else; that it was the environment with its preconceived ideas which thought that way. The child was born as nothing more than a plastic bio-energetic system, ready to pick up anything from the environment that was imprinted on its organism with some degree of persistence. This would not serve the child's development to independence and self-regulation which both parents were willing to secure. Just as forced circumcision represents a most violent interference with the inborn freedom of a person, the early determination of what a child should or should not be or become violates the child's rights by forcing it at its most plastic age into a certain preconceived direction. Judaism is all right for whoever wants it. Judaism must be respected as any other belief held by people must be respected. There is nothing wrong with Judaism so long as it does not interfere with the rights of infants and their natural development. If the child, during its later development, tended toward Judaism this would be perfectly all right; it would then be the child's own choice. But not now or during the first five to ten years of its life. It may later want to join the Catholic Church or the Mohammedan Church or worship nature or feel free to just enjoy the world. The father's standpoint had nothing to do with the child's interest which alone should determine its growth. This was the basic policy of the one. No interest in state, culture, religion, nationality, etc. should be permitted to influence the child's development. Even the state gives its citizens the full right to determine themselves where they want their children born and even whether or not they want to be citizens, except, of course, in the lands of the "liberators." Otherwise, the concept and meaning of freedom and self-regulation would be lost and not worth anything right from the start.

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**Beginning of armoring at the age of five weeks**

We have learned in orgonomic medicine that most basic functions of later biopathies begin to develop prenatally and immediately after birth. The psychological approach, including the psychoanalytic, can reach down only to the age where language formed, i.e., to about the third year of life. Beyond this age one must rely on the *expressive, emotional language* and on the *orgonomic contact* one can establish with the living system of the infant.
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The infant under investigation confirmed the fact that one must penetrate deeply enough to get at the source of the armoring. The infant had developed a bronchitis in its second week. Such happenings usually are registered under some heading such as "cold" or "sniffles" which "will pass by in due time with no further consequences." Orgonomy proceeds differently. It asks:

1. Why a cold should develop at all;
2. Whether any bio-energetic functions are involved in the cold;
3. What the possible consequences of such an early cold are for the bio-physical functioning of the infant.

Our infant was pale; its upper chest was "quiet." The breathing was noisy, and the chest did not seem to move properly with respiration. The expiration was shallow and short. Bronchial noises could be heard on auscultation. Generally the infant appeared uncomfortable. Instead of crying loudly, it whimpered. It moved little and looked ill.

First, it was to be established whether this restriction of respiration had immediately followed the cold. The mother confirmed that the child had had these "noises in the chest" ever since the onset of the "cold." It was clear that the chest had never quite relaxed since.

On examination of the chest the intercostal muscles felt hard. The child seemed oversensitive to touch in this region. The chest as a whole had not hardened yet, but it was held in inspiration with the upper part bulging forward. No physician trained only in classical ways would have thought that anything was wrong.

Upon slight stimulation of the intercostal muscles the chest softened. It yielded softly but not fully to pressure downward. The infant immediately began to move vigorously; the breathing cleared up appreciably and the child began to sneeze (bursts of sudden expiration), smiled, then coughed several times vigorously, and finally urinated. The relaxation increased visibly; the back, formerly arched, curved forward and the cheeks reddened. The noisy breathing stopped. The mother was instructed that this first blocking of respiration was not too serious, but that, however, it would recur. She should learn to bring the chest down herself whenever the blocking of respiration occurred, by gentle tickling stimulation of the intercostal chest muscles. The infant was able to relinquish the blocking itself after the "first aid" had been rendered; therefore, the blocking could not be considered chronic at that point. But the parents were told to watch out against the chest rigidity becoming chronic; it should be removed whenever it appeared.

Theoretically this was a major new insight into early armoring in infants. The "cold" itself could be comprehended as the result of a contraction (sympathetic reaction) of the organism due to lack of contact with the mother. Such a contraction necessarily causes paleness, lowering of the peripheral charge and temperature, and, centered in the chest, "bronchitis," i.e., sympathetic irritation of the bronchia with stronger secretion. Thus, a general bio-energetic disturbance is at the source of the local somatic symptom. The latter in turn will increase the bio-energetic contraction and will impede full expiration. This in turn will cause anxiety and nervousness, which in turn will make it more difficult for the baby to establish full contact with the mother. The mother, on her part, burdened with conflict and bad conscience as well as rebellion, will not quite succeed in establishing full contact with the infant. Thus the vicious circle is established which closes the cycle from first contraction, to a "cold," to inability to establish contact, to new colds, to restriction of expiration, to lack of sleep, to annoyance on the part of the mother, to irrational behavior, and so forth. This kind of vicious circle most likely constitutes the core around which later biopathic noxae gather like layers around a shell. It is these layers that we have to peel off later in adult biopat hics.

The single somatic disease symptom now appears merely as a small cog in the big machine called "biopathy." The "cold" has its origin in a bio-energetic, i.e., emotional disturbance of energy equilibrium, and not in innocent "air germs" or unseen viruses. The "cold" in infants is an immediate expression of an irritation of the mucous membranes of the respiratory tract due to disequilibrium of energy metabolism because of lack of orgonotic contact. Later on, chronically irritated mucous membranes may well function independently of any emotional irritation. The bio-energetic disturbance becomes structuralized somatically in a "disposition to colds."

These new insights are of the utmost importance in many ways:

First, we obtain an important weapon with which we can get at the early background of later chronic diseases. What is generally called "disposition to disease," appears now as tangible restrictions of bio-energetic functioning in early infancy.

Second, we have learned that the orgonotic contact between mother and infant are of first-rank importance for an understanding of as well as for coping medically with early mishaps heretofore unrecognized.

Third, we are beginning to learn to read the language of the infant's emo-
tional expression, a most hopeful prospect. Thus we can hope with some
degree of certainty that the fog now surrounding early infant diseases will
slowly dissolve.

It should be plainly stated that this is only a very rude beginning; it will
take many decades and many workers in the field to master the onset of dis-
 ease in early infancy.

The infant was brought back the next day for a demonstration before
some 30 physicians, educators, social workers and laboratory workers. The
rough respiration had returned to some extent. It was quite easy to remove
the blocking this time and the child was able to scream loudly, whereas before
it had whimpered only feebly.

Ten days later the following report was received from our chief social
worker:

The mother related that the baby was "blossoming" since it had been
brought to Orgonon. It had slept peacefully all the way home; formerly it
could sleep only for very brief periods of time. It eats with great
glor and cries heartily. When awake it smiles and "talks" frequently. The
mother now is fully aware of the organic interaction between herself and
the baby. She feels well and confident. She does not suffer from loss of con-
tact, and the baby reacts with great pleasure to the bodily contact. The crying
of the baby is much more forceful than before. It is also much more "demand-
ing." If its needs are not attended to immediately when it cries, however, its
body tenses up and turns red, and it arches its back and holds its breath.

The breathing continues to be noisy, usually when it is actively moving
and kicking, not at all when it is sleeping. The mother tries successfully to stroke
the chest gently downward when the chest gets fixed in an inspiratory posi-
tion, or to tickle gently the intercostal spaces in the sides of the chest. The baby
likes it; the body gives way, it "caves in." But this has no immediate effect on the noisy breathing. In general, the mother believes the chest still is
somewhat high and held in inspiration. At times the breathing still impressed
the social worker as "desperate."

The early blocking of respiration seemed to gain importance rapidly as
more children were observed. Somehow the diaphragmatic region seemed
to respond first and most severely to emotional, bio-energetic discomfort. In
the case of this special infant, the early bronchitis had complicated as well as
helped maintain the respiratory block for an unusually long period of time.
The infant was apparently on its way toward chronic armoring in the
diaphragmatic region. However, it was hoped that continuous vigilance with
regard to the noisy breathing which resulted from the respiratory blocking,
and first aid applied as soon as possible by the mother would in the end re-
move the threat of chronic armoring in the chest completely. With it, a
certain form of "disposition" would be removed.

From that time on, great attention was paid to the early history of armored
small children in order to determine whether or not the respiratory blocking
is a preferred mechanism of early emotional disturbances in infancy. It
seemed entirely possible that a preference for diaphragmatic blocking in early
infancy has some relation to the great emotional excitability of the central
plexus coeliacus which is located in the diaphragmatic segment. Other block-
ings would then have to be expected to spread upward and downward over
the organism. This was now to be carefully studied. This outlook held great
promises for early prevention of biopathic conditions.

Three weeks later the attending medical organonomist reported that the
baby was doing very well. It had doubled its weight and looked rather large
for its age (the parents were of rather small stature). The baby now gave the
impression of round full limbs with a healthy pinkish color. It moved con-
stantly and vigorously. This seemed the outstanding impression. According
to the physician's report, the baby's face seemed to reflect its actions: It con-
tinuously changed its expression from strength, to intensity, to softness, to
smiles, etc. It often made pleasurable sounds and seemed fully aware of what
was going on around it. Generally the baby now appeared vigorous, active
and happy.

But the noisy breathing was still noticeable most of the time. It stopped
only when the baby became less active. The mother had learned to get the
chest down in a playful way, when it became fixed high in inspiration. The
baby seemed to enjoy the mother's help; it "caved in" and showed happiness,
but this had no apparent effect on the noisy breathing. Neither did it seem to
have a lasting effect on the chest as such which after a while returned to its
high position. The abdomen felt slightly hard; it softened only when the
baby was feeding.

However, the baby's sounds and crying were much freer and fuller than
they had been three weeks ago before first aid was rendered. Then, as we
recall, it was whimperish and staccato. The baby also sleeps for long stretches
and eats regularly at about every fourth hour. It eats all kinds of fruit pastes, drinks juices, and takes vitamins. Bowel movement is regular once a day. Sometimes the lips quiver in oral orgasm after feeding. The mother takes the baby into the orgone energy accumulator once or twice daily for three to five minutes. The baby seems to have had enough by then; it becomes restless. Its body flushes strongly in the accumulator, without perspiration. The mother uses the accumulator regularly herself; she has a "sinking, open" feeling in the accumulator and feels that respiration becomes fuller.

Thus the report of the assistant physician. A first substantial result seems to have been obtained: The baby had greatly improved. It remained to be seen how and when the first injury it had suffered would turn up again or become worse. From now on it could be met with a piece of firm knowledge. This bit of knowledge would be extended with further experience. One thing appeared sure by now: No absolutes in terms of "health" could be applied.

Rational infant rearing deals with many big and small troubles which turn up and must be handled skillfully. The armored parent will not sense the trouble, or, sensing it, will be helpless, lacking immediate orgonotic contact. The fairly mobile parent will sense the trouble and in some cases be able to render first aid. In most cases the trouble will remain untouchable because of lack of knowledge. The necessary knowledge in early infant care would have to be acquired bit by bit from many experiences and observations. A long and arduous task, indeed. But the only one that would carry some promise.

The problem still remained unsolved as to how much of these fine and most spontaneous activities in a wordless human interrelationship which resist verbal expression could be taught to mothers, fathers, nurses and doctors at large. This question, too, would eventually, so it was hoped, find its proper answer, provided patience and careful unprejudiced study are maintained. But now, in the end, the admonition appears essential not to create from all this a new ideal of "perfect" orgonotic contact between mother and child. Let mothers just enjoy their babies and the contact will develop spontaneously.

November, 1950
Projeto Arte Org
Redescobrindo e reinterpretando W. Reich

Caro Leitor
Infelizmente, no que se refere a orgonomia, seguir os passos de Wilhelm Reich e de sua equipe de investigadores é uma questão bastante difícil, polêmica e contraditória, cheia de diferentes interpretações que mais confundem do que ajudam.
Por isto, nós decidimos trabalhar com o material bibliográfico presente nos microfilmes (Wilhelm Reich Collected Works Microfilms) em forma de PDF, disponibilizados por Eva Reich que já se encontra circulado pela internet, e que abarca o desenvolvimento da orgonomia de 1941 a 1957.

Dividimos este “material” de acordo com as revistas publicadas pelo instituto de orgonomia do qual o Reich era o diretor.
01- International Journal of Sex Economy and Orgone Research (1942-1945).
02- Orgone Energy Bulletin (1949-1953)
03- CORE Cosmic Orgone Engineering (1954-1956)

E logo dividimos estas revistas de acordo com seus artigos, apresentando-os de forma separada (em PDF), o que facilita a organizá-los por assunto ou temas.
Assim, cada qual pode seguir o rumo de suas leituras de acordo com os temas de seu interesse.
Todo o material estará disponível em inglês na nuvem e poderá ser acessado a partir de nossas páginas Web.

Sendo que nosso intuito aqui é simplesmente divulgar a orgonomia, e as questões que a ela se refere, de acordo com o próprio Reich e seus colaboradores diretos relativos e restritos ao tempo e momento do próprio Reich.
Quanto ao caminho e as postulações de cada um destes colaboradores depois da morte de Reich, já é uma questão que extrapola nossas possibilidades e nossos interesses. Sendo que aqui somente podemos ser responsáveis por nós mesmos e com muitas restrições.

Alguns destes artigos, de acordo com nossas possibilidades e interesse, já estamos traduzindo.
Não somos tradutores especializados e, portanto, pedimos a sua compreensão para possíveis erros que venham a encontrar.

Em nome da comunidade Arte Org.
Textos da área da Orgonomia Biósica.
Texts from the area of Biphysical Orgonomy

International Journal of Sex Economy and Orgone Research

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04 Mary Robert. Shock Therapy as a Subjective Experience 1942
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