

# ORGONE TREATMENT DURING LABOR

A Preliminary Report of Two cases  
by  
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By CHESTER M. RAPHAEL, M.D.\*

In studying the prevention of biopathic diseases, it is essential to consider every phase of child development—intrauterine as well as postnatal. Critical periods such as the first formative years and child and adolescent puberty require particular study. There is one period, however, very short in duration, which has been neglected and yet which must have important consequences in the future development of the child. It is the period just before birth—known as labor. This is the time when the oneness with the maternal organism is being severed. What happens in those hours and minutes may have a decisive influence upon the newly born child.

Undoubtedly, certain conditions during the period immediately preceding labor may produce subtle ill effects which later hinder the natural development of the child. It has always been assumed that asphyxia at birth may cause nervous disease later in life. The shock accompanying operative procedures may have a similar effect. A rigid perineum, obstructing the delivery of the head of the infant, or prolonged labor for any reason, must also influence adversely the biophysical state of the infant organism. With each contraction there is some retardation of the maternal blood circulating through the placenta. When labor is protracted, this must have a profound effect on the infant.

My attention was recently drawn to the pathological character of the usual course of labor. It is reasonable to think that, for a healthy organism, labor should be a natural process, "labor" to be sure, but not necessarily so protracted or unbearably painful. This appears to be the pattern among primi-

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tive people. In support of this impression, J. B. DeLee in *PRINCIPLES AND PRACTICE OF OBSTETRICS*, writes:

It is said that some Indian women while the tribe is on the march, feeling the pains of labor coming on, go off to the side in the underbrush, bear the child, and after expressing the after-birth, hurry to catch up with the rest of the train.

Whether or not this is accurate, there is a deep conviction that this should be approximately the case.

In the first of the two cases I am reporting here, labor was abnormally prolonged. In the second, labor appeared to be accelerated. The assistance given both mothers was stimulated by the spontaneous appreciation of the armoring process, which, under these circumstances, represented an acute armoring in response to fear and pain—an appreciation which I have gained from orgonomy and the orgone therapy of chronically armored states.

The first case is that of a twenty-seven-year-old primipara who had been unable to conceive during a period of four years. The studies of the reason for her sterility, including tubal insufflation, semen analysis, vaginal smear study and endometrial biopsy disclosed no positive findings except an endocervical secretion of the type found in chronic endocervicitis. This was felt to be sufficiently severe to block the upward migration of the sperm into the endometrial cavity. For this reason, intrauterine insemination of the husband's semen was attempted but the procedure was not successful. The examining physician found her to be "tense and anxious out of proportion to the situation."

Finally, she conceived. In a letter to me she wrote: "After several attempts at artificial insemination, we decided to take a respite from doctors, thermometers, daily temperature charts, Rubin tests, and regulated intercourse. Result—conception."

Her friends and relatives were oversolicitous because she had had such difficulty in conceiving. She was very tense and unstable during the first months of her pregnancy. She had a few severe attacks of vomiting but then her pregnancy proceeded uneventfully. There was no history of serious illness prior to her conception, and she had the reputation of being a rather stoical person.

The expected date of delivery passed. There was talk of interference, although the mother expressed the feeling that there was no need to meddle. However, when she visited her obstetrician he recommended that labor be

induced. No complications had been anticipated. Her pelvis was ample, there was no undue gain in weight, and her physical condition appeared to be good. A dose of castor oil and an enema were prescribed. Several hours after receiving the castor oil she had a few contractions and was rushed to the hospital. She herself objected that it seemed too early.

Some comments made by the patient on her experiences in the hospital throw some light on the factors which contribute so often to the fear of childbirth. "Until I was admitted to the hospital, I was in excellent spirits. I wasn't particularly afraid. I knew that I would have some pain, but I certainly felt that I would not find it intolerable. When I was taken to the labor room, however, my attitude changed with a suddenness that was startling. I was greeted with blood-curdling screams and pleas for assistance which were coldly disregarded. While speaking to the admitting nurse on the floor, there were two deliveries in progress, every detail of which I heard. Then, while still there, I saw two doctors emerge from the delivery rooms in blood-stained uniforms. The room I was taken to was barren—two beds, a chair and a window that contained mesh wire within the panes of glass, giving the impression of a barren cell. I slowly gained the impression of being in a medieval torture chamber."

For the first five hours she continued to have contractions and then received an intramuscular injection of demerol. She fell asleep. When she awoke a few hours later, the contractions had practically disappeared. She was examined by a resident physician and her obstetrician was notified that the cervix was not dilating. That same afternoon she was still feeling quite well, although somewhat shaken by the tortured screams all around her. That evening contractions resumed and it was suggested to her that she continue to move about to help the process of dilation. In her words: "That night I must have covered about ten miles." Toward morning of the second hospital day, following another sleepless night, the contractions became very strong. No medication was administered at this time for fear that it might again cause an interruption of labor.

Again I should like to return to her description of the proceedings. "I had no idea that I could scream so loudly. When a pain came, I would seek something to press down on until it subsided, a radiator if I happened to be near one, or a table in the hall, anything that I could press down on with all my strength. I was ashamed of myself for screaming so loudly, and when I felt a pain coming on I would head for the bathroom, where I could scream

by myself. I remember apologizing to the girl who shared my room for screaming so much. My room, by the way, was directly across the hall from a sort of supply room and laboratory, and next to the delivery room so that I could hear everything that was going on. During the night, or it must have been Saturday morning, one woman had a stillbirth and I saw the nurses carry a bundle which I presume was a baby, into a room across the hall. All the nurses gathered around and spoke in hushed voices. I was quite disturbed about this. I remember telling my obstetrician that I felt I would go slowly mad, that I couldn't take it much longer and that I had heard of a stillbirth during the night."

At this point, she received another enema and the contractions continued to be severely painful. Then she received three injections of obstetrical pituitrin. The pain became unbearable. The obstetrician, continuing his efforts to hasten matters, ruptured the membranes. Meconium was found in the fluid and the nurses were cautioned to stand by and follow the fetal heart carefully.

At this time I was called and heard that things were going badly. The fetal heart rate was 164 and thready. When I arrived at the hospital the patient had been in labor for more than 40 hours. Her condition seemed desperate. I found her sitting up, supporting herself with her arms held rigidly against the sides of the bed, her face was ashen, her lips cyanotic, her pulse thready, her hands cold and clammy, her shoulders hunched up acutely. With each contraction, occurring at five-minute intervals, she screamed that she could not endure it any longer and wanted to die. Between contractions, her eyes rolled up into her head and her distress was extreme. With each contraction. She held her breath and her body stiffened. The picture was one of acute contraction of the entire organism.

It took considerable effort to make her lower her shoulders. Succeeding in this, I asked her to breathe more deeply, to prolong her expiration. In less than two minutes her body grew tremulous, clonic movements appeared in the lower extremities and extended upward to her lower jaw and teeth, which began to chatter uncontrollably. She clenched her jaws, but I discouraged it immediately and helped her to let her jaw drop. The spasm in her shoulders and intercostal muscles—which were exquisitely tender—was gradually overcome. Her respiration improved. Then she, herself, complained of a block in the region of the diaphragm. Fibrillations appeared in her thighs, strong sensations of current appeared in her hands and fingers.

The severity of the pain of uterine contractions definitely began to subside.

The color returned to her face, her pulse grew fuller and slower, and her respiratory movements now proceeded with an involuntary rhythm. She then began to belch and with this the discomfort in the region of the diaphragm subsided. She grew quieter and began to smile. Very quickly the contractions began to occur at two-minute intervals. There appeared to be relatively little discomfort with each contraction and she was able to rest between them. Despite more than forty hours in labor, a good part of it agonizingly painful, she began to look comfortable and pleased. An important quality of her reaction to pain was a distinct withdrawal in her eyes. When she did this, she appeared to lose all contact. She did not hear me, seemed confused, and it was difficult to bring her back.

"When you arrived," she told me later, "I remember telling you that I could not go on and that I simply could not stand much more. You told me to bend my legs and while pressing down on my chest, told me to breathe regularly and exhale all the way down. You established a rhythm of breathing, while pressing down on my chest, that I tried to keep, but the pains were strong and once again I cried I could not go on. But you persevered and I tried awfully hard until finally we seemed to be having some results. My extremities began to tingle and feel numb. Slowly a drowsy numbness began to envelop me, my legs felt heavy, my gaze would wander. Only when you called me back would I, with a very definite effort, bring my gaze back. It was so easy to go off that I believe you had to call me back quite often. By this time, I was tingling all over. I began to feel warm and relaxed, whereas previously I was chilled and tense. Once when you left the room, the nurse who was standing by commented that she thought you had hypnotized me. The pains were certainly bearable now. You told me that they were coming more frequently although to me it did not seem that way, for in the interval between pains I was able to rest. I can't quite understand it myself. I only know that it helped me tremendously."

I had been with her for about two hours by this time. The fetal heart rate was 179 and it was obvious that something was wrong. The obstetrician was called; he arrived a few minutes later, examined her and found the cervix to be completely dilated although the head was still high. He found the fetus to be in the right occiput posterior position. This position, coupled with the infant's distress, made him decide to deliver the infant immediately with forceps. Working quickly, the mother was now under an anesthetic,

the head was rotated and then delivered, the infant exhibiting three loops of cord around its neck. It was flaccid and pallid; the throat was aspirated immediately, artificial respiration was applied and oxygen administered. The infant responded quickly and was placed immediately in an incubator. Again the mother: "When I finally realized what had happened, I had a feeling of great euphoria and exhilaration, my recuperation was very rapid, I felt well immediately and had no post-delivery despondency which I had been told could be expected."

The second case was that of a twenty-three year old primipara who had been studied during her pregnancy by the Organomic Infant Research Center of the Wilhelm Reich Foundation. The period of gestation had been entirely uneventful and she, in general, appeared to fulfil the criteria for relatively healthy functioning. In this instance the hospital situation was much more favorable. The obstetrician had agreed to refrain from the routine use of medications, anesthesia and routine episiotomy, and even the premonitory spank with which the infant is frequently greeted had been carefully discussed with him and he had agreed to refrain from it as a routine gesture. Plans for immediate contact of the infant with its mother after delivery were made. The entire hospital situation was as favorable as possible, so as to reduce to the minimum the pathological atmosphere and emotional contagion of the labor room.

The patient experienced her first faint contractions at approximately 8 A. M. and continued at about twenty-minute intervals. She arrived at the hospital at 10:30 A. M. Shortly thereafter the contractions practically stopped and she was dubious that she would proceed. The occasional contraction she likened to a menstrual cramp. Her obstetrician estimated that she would not deliver before midnight.

I arrived at the hospital at 4:45 P. M. Contractions were mild, of short duration, and approximately seven to ten minutes apart. She was calm, with a somewhat exaggerated attitude of unconcern. She complained of slight discomfort in her lower back, her face was placid, her jaws relaxed. However, the shoulders and upper chest were held somewhat and breathing was moderately restricted. She complained of some pain in the left groin. The thigh adductors were moderately spastic and while the thighs were held initially, they could be moved easily. I proceeded to help her establish fuller respiration. The almost immediate effect of this was to induce a state of

sleepiness. I encouraged her to rest. About fifteen minutes elapsed when she suddenly experienced a strong and much prolonged contraction. She reacted to this with an inhibition of her breathing for the moment, a facial grimace, a tightening of the abdominal and thigh muscles. I encouraged her and helped her reestablish fuller respiration. The entire organism relaxed again. Within a few minutes, another contraction occurred with the same contraction of the organism in response to pain. Thereafter, the contractions occurred regularly and intensely at two-to-three minute intervals. What appeared most prominently with each contraction was a reaction of withdrawal, particularly noticeable in the eyes. This required almost constant attention until delivery. She felt disinclined to breathe deeply, complaining that it increased the pain. At first, with strong contractions, she felt dizzy and appeared restless and slightly confused. This could be mitigated to a considerable extent by insisting that she "come back" every time she showed any sign of withdrawal. At first, she was reluctant to do so, but as time went on she appreciated its advantage. The pain was less severe when she could achieve it and progress appeared more orderly and effective. Sensations of current appeared in the upper part of the body and to some extent in the lower extremities.

At the spot in the left groin where she complained of pain, a hard, tender cord, running longitudinally, could be palpated. I was not able to overcome this in spite of my efforts. It was not until the cervix had dilated completely and the head of the fetus had passed through the birth canal to the pelvic floor that this painfully tender spot disappeared. Now she began to experience sensations of current in her abdomen and pelvis. She began to belch and finally felt much more comfortable. Then the sensations of pressure on the rectum began to increase and she grew more apprehensive and restless and slightly confused. She felt she wanted to have a bowel movement and wanted to walk to the bathroom, but then decided against this. Her face became flushed and she complained of a feeling of heat throughout her body. Then coldness, a clammy sweat and marked dryness of the mouth occurred. She grew far less cooperative. Her jaws and legs were held stiffly and much more effort had to be exerted to overcome this holding. I had to proceed more energetically to get her to "come back" in her eyes. The vegetative sensations were now very intense. As they began to subside, the process became simply one of voluntary effort with rest, and at times, sleepiness between contractions. The entire process became more rhythmical. Her

respirations increased in amplitude and she was able to bring herself back; at times she was actually able to prevent the withdrawal.

At 6:30 P. M., approximately one and a half hours after my arrival, a slight bulging was observed. The membranes then appeared at the introitus and passed through without rupturing. The obstetrician was called and the patient was removed to the delivery room. At 7:15 P. M. she began to deliver the head of the infant. And now, again, an acute contraction set in. It was more marked than at any time before. I could pry her jaws apart only with the greatest effort and her breathing required considerable attention. She began to tremble, and exclaimed with an expression of terror that it felt like something terrible might happen. She later said that she had the feeling she wanted to push but was afraid she might burst. The infant was delivered at 7:20 P. M., appeared moderately cyanotic but responded immediately, cried lustily and became healthily pink. Two and one quarter hours appeared to be the span of really active labor. A moderate first-degree laceration of the perineum occurred in the delivery of the head and required suturing under an anesthetic.

I have gained the impression from both cases that with the establishment of full respiration, the dissolving of the acute armoring, the overcoming and prevention of the tendency to withdraw and the acute contraction of the total organism, the process of labor and delivery is, in general, very much accelerated. Knowledge of the orgasm reflex and the segmental arrangement of the armoring as discovered and described by Wilhelm Reich excites an immediate appreciation of the problem and technique to be used in rendering assistance during labor. Without this knowledge, the physician must view the problem with bewilderment, helplessness and dismay. His only recourse is to drugs with its attendant danger to both mother and infant; more or less ineffective persuasion to relax; calloused indifference; or meddling interference of one sort or another as, for example, the so-called prophylactic forceps, routine episiotomy, etc. What Reich has said concerning the bodily attitude of the armored organism and the dissolution of this attitude is readily applicable to the acutely contracted organism. Active assistance is necessary for overcoming this "holding back." It is expressed automatically and the individual is unable to comprehend or respond to exhortations to relax, or other such persuasion. The holding back process is so acutely manifest that the obstetrician cannot fail, now and then, to in-

stinctively suggest to the patient to stop holding her breath or to take a deep breath, but he is generally unable to help actively. His assistance is, at best, abortive. He is unable to proceed systematically or consistently. Without the knowledge of the function of pulsation and the armoring process, he is unable to formulate his therapeutic task.

Knowledge of the function of biological pulsation and the armoring process simplifies the task remarkably. It goes without saying that the amount of assistance required in labor is dependent upon the previous state of the organism. The prevention or effective treatment of chronic armoring—prior to pregnancy or before delivery—would facilitate the process of labor. In a primipara, to whom childbirth is new and who approaches it with superstition and trepidation, the shock of the experience can be allayed to some extent by correct education regarding the mechanism of labor. The setting—as was apparent from the first case presented—plays a significant part.

From this preliminary study, it would appear that there are very practical preventive and therapeutic measures, the application of which would alleviate much of the discomfort of labor and many of its dangers. The most important result of such a facilitated process of labor would be the reduction of the danger of injury to the child to the very minimum. It is this result which interests us in this study and encourages its continuation.

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