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The American College of Orgonomy

A Hysteric's Running About Even in Therapy

Virginia Whitener, Ph.D.

An awareness of dissatisfaction can be an impetus toward change. It can motivate attempts to ameliorate the situation, to improve one's health and enjoyment of life, and is often the first step that leads to therapy. A person's statement of dissatisfaction may be the very first utterance in the initial consultation. Certainly, it tells the therapist what is bothering the patient. Listening to complaints also attunes the therapist to the patient's unfulfilled desires, conflicts, and ways of looking at, approaching and reacting to problems. This along with observing how the patient expresses herself allows the orgonomist to see the patient's character defenses and reach a character diagnosis.

When a patient complains of a boss, mate, parent or a child bullying or harassing them,[1] for example, this is taken seriously. A patient in therapy may articulate a problem, identify solutions and think through appropriate and effective behaviors. They may become aware of obstacles to solutions and effective responses, including their own anxiety, which can lead to finding ways to conquer those obstacles, including facing anxiety.

Therapy can help increase perception, clarify thinking about a situation and improve the patient's ability to look at her feelings, attitudes and behavior objectively. It can also increase the capacity to face and tolerate the anxiety of expressing feelings and to speak up. Seeing situations more clearly, taking effective action, and getting out of the victim role are important results of talking about problems in therapy. However, there may come a time when talking about problems, complaining about them, serves a different function.

Sue was 45 years old, the mother of three children, and employed when she sought therapy. She was separating from her husband, had

[1]Indeed, in this day and age it may be a child, underage or adult, who is attacking the parent. In past authoritarian society, it most commonly was the parent who was attacking the child.

incurred debts and feared for the safety of herself and her children. She reported a history of anxiety and mild depression and had taken antidepressant medication for several years. At initial presentation, Sue was visibly upset. She talked with her eyes tensely closed as if it was difficult and painful for her to look at her problems and relate them to the therapist. Her breathing was short, quick and shallow. At the same time, her manner otherwise appropriate to the therapy setting, her articulate discussion of her problems, her fluency in languages, and her employment status indicated intelligence and competency. There was no indication of a thought disorder or a major problem of mood. Based on her reported history and by observation one had the impression that Sue was variably lively, active and engaged in life, and avoidant with periods of anxiety and feelings of worthlessness.

With therapy focusing supportively on her feelings and her taking responsibility for them and what she could do for herself, Sue expressed her anxiety, was better able to assess her situation and problem solve, and proceeded with separation and divorce. Her fear of her husband was not unwarranted, as he claimed. She tried to leave before but had not been able to do so out of fear of his reactions, because of her own anxiety, and because of the financial difficulties of being divorced. Her hesitation and vacillation intensified when her husband promised to change his behavior, offered more financial help, or made her feel she was being irrational for considering leaving. Second-guessing her own decisions, she ended up anxious and depressed when she returned to him, only to again use stop-gap measures and last minute safety plans that invariably cost her money and left her in debt. She needed to keep herself safe and take measures to be independent, not only for her physical safety but also for her emotional well-being. Once Sue was finally able to leave for good, not allow boundary violations, and divorced, she was less anxious, more relaxed, and had a more positive view of the future. She discontinued the antidepressant medication as she had no need for it. As therapy continued, Sue became less scattered and more efficient at her work, took on more responsibilities and advanced in her field.

In time Sue became interested in finding a new romantic relationship. In her pursuit, a pattern in relation to men came to light. She was at first overly solicitous and obsequious, doing chores for a man, hoping to draw him into a relationship. Once her attentions were not reciprocated and the relationship did not turn out to have much substance or to be the kind she wanted, she became strongly disappointed and passively angry. She seemed to act on the basis of fantasy, imagining who a man might be without seeing who he really was, who it was she would get if she got him. As she moved toward establishing a relationship, her anxiety-driven behavior blindly failed to include much consideration of the man's response or the necessity for her to face her feelings about what was occurring. This pattern allowed her to avoid or have no need to face her feelings about having an actual relationship. Therapy continued to help her get out more anxiety, increase her awareness, and attend to the reality of her relationships and feelings, including anger and anxiety. In particular, it focused on more considered, selective behavior with better self-care and self-respect. Sue began to choose higher functioning men who were more respectful.

After several years and several aborted relationships, Sue met a decent man whom she wanted to marry. Although their styles and interests were different and he was not without frustration for Sue, he was a stable, competent man who cared about her. She was determined to marry him and pushed for prompt marriage without delay. Eventually, therapy sessions became a repetition of complaints about this man, now her husband. Sue also complained about him to others outside of therapy and said things about her family members to him that inevitably turned her husband against them. She then complained about this.

In the course of Sue's complaining, several layers appeared. In the first, Sue, was a dark cloud, angry but held in, lips and jaw tight, full of feeling. Expressing her anger in therapy and facing her anxiety over having or expressing aggressive feelings moved her through the dark

cloud. Next, she was the “victimized” wife who complained. However, she was not actually resigned and passive in this role, as even then she could be, as she called it, “manipulative,” working to get things from her husband indirectly. Amidst her complaints of victimization, one still felt her determined and annoyed liveliness. However, as the “victim,” there were “reasons” why nothing could be done. She was trapped but off the hook: she did not have to say or do anything. She did not have to face any further anxiety that asserting herself and trying to work things out with her husband might stir up. In exploring the part played by this victim role, we both started to laugh. Having gone to extremes to portray the role, Sue eventually chuckled over her efforts and the unreality of her position, as it came to light that she got a great deal out of her marital relationship and was in possibly the best living situation in her life.

Next, there was the “wet blanket” layer. First, Sue became aware that it was as if a wet blanket, a repressive, restrictive, inhibitory atmosphere and effect, was thrown over situations she was in. She recognized that she felt lifeless and became “flat” in her thinking and manner. She then saw that it was she herself who threw the wet blanket and that she threw it over herself. She acknowledged damping down, flattening her excitations out of fear, particularly in contact with and in relationships with men. This realization was profound. Living through these layers, experiencing and expressing deeper, more intense anxiety and anger enlivened her: her countenance was like sunshine. She saw that much of her behavior was anxiety-driven and often resulted in further distress and problems for herself. This left her determined to recognize and not fly off into them.

Baker characterizes the hysterical character as genitality with anxiety (page 104). The hysteric’s main, in some cases only defense is to run.[2] Baker states:

> Hysteria has been known since ancient times and was the first emotional disorder to be recognized as having a sexual connotation... It is still common but the marked manifestations earlier writers described, such as fugues, fits, and paralyses, are

[2]There may be secondary blocks which “color” the character. In such cases, the individual runs away into these blocks; e.g., oral symptoms may develop.

> comparatively rare today... . Today we see earlier cases and also milder cases because of the widespread acceptance of therapy. However, except that symptoms are less marked, hysteria possesses the same characteristics it has always had, and Reich's description is as accurate today as it was thirty years ago.
>
> The hysterical character, usually female, has reached the genital level but with anxiety. Thus there is genitality, but genitality which cannot be accepted. There is a constant push toward genital contact with a simultaneous flight from it, so that one finds a constant approaching and running, even during the sexual act. Complete sexual satisfaction is not possible, so there is never a complete discharge of energy. This leads to stasis, which only increases the turmoil and results in an organism which is alive, but restless and flighty. (pages 104-105)

Thus it is important and useful to know and observe that the hysterical character does not simply run *away* from problems or conflicts. Running only away as a defense would make for and result from a less lively character. The hysteric instead runs toward and away from life by showing indifference, being calm, not reacting, or, to the contrary, exaggerating their emotional reaction, being dramatic or hysterical, for example. They may exhibit this running in regard to feelings, a cathected object, a source of their anxiety—a person or situation including therapy, and, fundamentally, sexuality and sexual sensations.

The result of Sue's repetitive complaining was typical of the defensive nature of hysterics, avoidance of her feelings. She effectively avoided the anxiety of acknowledging her deeper feelings. By complaining about one person to another, she avoided the anxiety of speaking up to the person who had offended, bothered, or upset her. Then, by the sustained, particular nature of her complaints, she cast doubt on and neutralized the power of the male, reducing her fear of and contact with sexuality and intimacy. With her complaining behavior she could show, even prove that she was not interested in the male. She could also gain an ally in others who listened (family and unwitting therapist), further reducing her sense of threat and danger.[3]

[3]This perceived danger was a neurotic one based on her hysterical character structure and the arousal of incest fear, and not on any actual physical threat or harm.

This occurred without Sue being aware of or acknowledging her feelings of desire and fear. Thus, the back and forth movement of going toward and away from feelings and from her sexuality and a sexual relationship was sustained.

As therapy continued, Sue became more tolerant of her feelings and sensations. She could accept them, be excited by them, and, at times, enjoy them. She better saw that her behavior frequently was anxiety-driven. There was less need for her to project her bioenergetic, emotional intolerance onto her husband and others. She became more able to speak to her husband about things that bothered her, and some things that had bothered her no longer did. She reported with delight that she was enjoying her husband and they were having a good time. More therapeutic work and time will reveal to what degree she can continue to sustain her contact with her feelings and decrease her flight and running.

References

Baker, E. 1967. *Man in the Trap*. New York: Macmillan Publishing Co.