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## Wilhelm Reich 1897-1997 Commemorative Issue

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# Procrastination as a Symptom of Catatonic Schizophrenia

*Robert Harman, M.D.*

This case history presents one woman's struggle for health against great odds. It illustrates important features in the character structure of schizophrenia. There are significant differences between this type of structure and that of the neurotic. The course of this patient's treatment demonstrates some of these differences and shows how understanding their bioenergetic basis is essential for the proper conduct of therapy.

## Case Presentation

C sought therapy with me shortly after she was discharged by Dr. R, her previous therapist, because of her inability to come on time for sessions. She was thirty-two years old and was barely supporting herself working part-time in the family business. Prior to this she had lost almost every job she held due to persistent tardiness. This occurred despite the high quality of her work when on the job. Members of her extended family had taken her in, fixing up a small bedroom for her in the basement of their office building so she could not only have a place to live but also be available to do odd jobs for the company. Since she lived on the premises, her tardiness was less of an issue.

She had read some of Reich's books and began therapy with Dr. R, a physician who held himself forth as one "trained in the techniques of Wilhelm Reich." He felt she needed to kick and scream and brought this about by pressing hard on the armored muscles of her neck and back. Initially, this produced periods of intense subjective feelings of well-being lasting several days. However, these apparent "break-throughs" were not accompanied by any improvement in her ability to function. In fact, her timidity increased. She began appearing later and later for appointments, eventually arriving only for the last twenty

minutes of each session. Dr. R decided she was late because she could not tolerate a full session, that her “unconscious mind” was making her late, and that the solution was to “bypass her resistance and communicate directly with her unconscious” by scheduling her for shorter visits.

She experienced this as punishment and became increasingly discouraged and withdrawn. Her self-esteem, which was already low, diminished even further and her work and social functioning deteriorated. She became confused. In this state she fell under the sway of an eccentric older man who coerced her into sexual activities that were repugnant to her. She also began showing up five minutes before the end of her scheduled sessions or sometimes even after the end of her scheduled time. Dr. R dismissed her from therapy and she sought treatment with me.

When C walked into my office she literally looked like a little, trembling mouse. At times she was so frozen with fear that she was hardly able to think, speak or move. At other times her thought process became disorganized, and she spoke in unrelated phrases before coming to a complete halt. When asked what had made her late for work and therapy she said only, “There isn’t a reason. I have no excuse. It’s just me.”

There were moments when her immobilization gave way to excitement and she was able to speak clearly for a minute or so. At these times she talked about her own limitations or some aspect of human life with a sparkle in her eyes, common sense and a delightful, low-key sense of humor. After each of these “outbursts,” as she called them, she became embarrassed and self-deprecating; she thought that now I knew how “mixed up” she was. When I told her this was not the case and that I enjoyed hearing what she had to say, she was genuinely appreciative of my “kindness” but profoundly doubtful that I really meant what I said. When I persisted, the sparkle came back in her eyes and she said, with good-natured skepticism, “Oh yeah...sure!”

C denied any history of delusions, hallucinations, suicidality, obsessions or compulsions. (Months later she was able to describe obsessional thought patterns and compulsive behavior occurring at home.) She also avoided looking at me. Her voice was pleasant but meek. Both her voice and facial expression revealed little emotion

(affect block). She gave the impression of being fearful, not by direct emotional expression, but by her immobilization and timidity. Her eyes were bright but eye movements were stiff, especially when she attempted to follow a moving penlight. Respiration was diminished and she appeared to not breathe at all. The musculature of her forehead, jaw, occiput, chest and legs was stiff; her paraspinal muscles were especially rigid. When she lay on the couch she appeared quite rigid and when asked to kick, hit, or vocalize she was completely unable to do so.

### Course of Treatment

C was motivated to cooperate but consistently arrived late for appointments. However, she never blamed others or made excuses (even though she overcame more reality-based obstacles in getting to sessions than any other patient in my practice). From the beginning she recognized that her lateness was her own problem and insisted that she pay for the time that had been set aside for her. Therapy meant a great deal to her and she appreciated it, no matter how short her session.

Therapy focused on helping C to form a clear and accurate picture of her actions and how they related to her emotions. After many weeks the circumstances surrounding her tardiness became clearer: She would make plans to start out early for the three hour trip to my office. However, when the time came to leave her home, she unexpectedly realized she "wasn't ready" to go until, for example, she washed the dishes. When she started to wash the dishes she realized she "wasn't ready" to wash them until she scoured the sink, and so on until she finally made it out the door, late. These actions seemed inevitable to her and she was unaware of any emotions that accompanied them.

Session after session we went through the process of trying to have her focus long enough to get some of the details of what had happened when she tried to leave for that day's appointment. I saw how hard this was for her and how tenaciously she persisted in her efforts to cooperate with me.

After several months of therapy the traumatic details of her childhood began to emerge. Her parents were missionaries who had gone

to South Korea at the end of World War II. When the North Koreans invaded, the family suffered terribly. C was born and spent the first four years of her life living amidst the devastations caused by the war. When C was six the family came to the United States. They lived in a poor neighborhood of a large Midwestern city where her father started an unsuccessful business. Although highly regarded in the community, C's mother and father were brutally sadistic at home. Her mother would devise different tortures for C and her siblings and often beat C about the head. After severe beatings, when she bled profusely, C was taken to a physician, her father's friend. C recalled that he treated her kindly but wondered why he covered up what her parents were doing. C could not understand the expression of sadistic pleasure she saw in her mother's face when she hurt the children. The discrepancy between her parents' public personae and the way they abused her behind closed doors made C despair of ever being understood or believed.

After years of her mother's beatings C became timid and unable to defend herself. Then she was sexually molested by an acquaintance of the family and remembers feeling, even then, that "people who do things like that know how to pick out children who look like they can't fight back or speak up." Now, as an adult, she felt that her inability to fight back or speak out made her less of a person and unworthy of participating in or enjoying what life had to offer.

By the thirtieth session her thinking had become clearer and she was able to give a detailed account of the events of her morning ordeal to leave her home. She always concluded, "I wasn't ready." I began asking, "And what would happen, what would you feel, if you walked out the door even if you weren't ready?" The question made no apparent sense to her; and although she had no answer, each time it was asked, she became more animated. After several months, something "clicked" and she said, "I would be scared."

Now it was possible, each time with a great effort on her part, to bring her in contact with her fear and how her reactions to it caused her difficulties. For example, she could not communicate her thoughts in a clear way: Her thinking became blocked, or she changed the subject, or ruminated on a minor detail until the point she was trying to make was completely lost. This often occurred because, as she began to get to the point, she became afraid I would disagree with

her. She imagined this would lead to her showing anger, then to my getting angry in return, and finally to her exploding with rage for which I would punish and never forgive her. She recalled that, during her childhood, her mother responded with a sadistic outburst to any expression of C's anger.

As she communicated more in therapy she became better able to feel and to tolerate the fear and annoyance that resulted from the scenarios her imagination conjured up. With each increase in her ability to tolerate her emotions, she became able to communicate her thoughts more clearly. At last she could take the chance of saying what she felt. When she spoke up she was greatly reassured because she saw that no permanent misunderstanding or disruption of our relationship occurred. She reported, "I left the session and said to myself, 'Nothing happened to you, that's great!'"

But her reassurance was not complete or lasting because of her doubts. There was always a lingering uncertainty that I really didn't understand her or that I was hiding some resentment or had a low opinion of her and of what she said. The doubt was even stronger if her communication had a great deal of depth and clarity. Every movement forward became stalled in doubt. Doubting was, in fact, the central mechanism of her characterological defense. She recalled a poem she first read in adolescence, which she had often recited to herself, never sharing it with anyone:

He who doubts of what he sees,  
Will ne'er believe, do what you please.  
If the sun and moon should doubt,  
They'd immediately go out.

This was in accord with her character diagnosis of catatonic schizophrenia.<sup>1</sup> Her symptoms of social isolation, thought blocking, affect

<sup>1</sup>The organomic criteria for the character diagnosis of schizophrenia differ from those used by other psychiatrists. The diagnosis of schizophrenia, as found in the fourth revision of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-4)(1), is based on the appearance of a specific constellation of symptoms, including hallucinations or bizarre delusions. This patient did not manifest all of these symptoms and therefore would have been diagnosed as having a complicated mixture of disorders such as, "Mixed Personality Disorder with Avoidant and Schizoid Features," "Obsessive Compulsive Disorder," "Anxiety Disorder Not Otherwise Specified," etc. (Continued on the next page.)

block and tardiness were all manifestations of catatonic immobilization in response to excitation.

The task of therapy was to help C tolerate greater and greater levels of excitation without contracting and becoming catatonic. She was able to do this by:

- Taking the chance of doing those things that excited her (which for her were all constructive activities) and not allowing her doubts to immobilize her.
- Persistently fighting to stay in contact with her feelings.
- Allowing herself to become excited in therapy and seeing that I could tolerate her excitation. This always produced a feeling of reassurance followed by doubts as to whether or not what she saw in my reaction was “real.”
- Actually eliminating her doubts by looking clearly at a situation, in spite of her anxiety, and thinking clearly about it until she was able, without ambivalence, to believe what she saw in front of her.

Over the next few years, she made slow but steady progress and allowed herself to strive for lifelong ambitions: to get a high school diploma, to learn how to drive, and to have her own car.

There were now periods when she came on time for sessions. With each improvement in her functioning, however, the tardiness reappeared. The tenacity of this symptom was striking. But even more impressive was her determined effort to overcome this problem. No matter how many setbacks she had, no matter how long it took, no matter how hopeless things appeared, her basic persistence never wavered.

She discussed episodes from her childhood that made it clear there was a relationship between the tenacity of her symptoms and her natural healthy tendency to persist despite all setbacks. As a child she felt the need to defend herself against her parents' sadism. If she

(Continued from previous page) The medical orgonomist does not arrive at a diagnosis based solely on symptoms, which can be inconsistent and do not always reflect the underlying cause of the illness. Rather, he determines the patient's characterologic structure and distribution of significant muscular armoring. In schizophrenia a split is observed between perception and excitation. Thus, intolerance of excitation in the schizophrenic individual causes disturbances in perception. It is this bioenergetic derangement that produces symptoms characteristic of schizophrenia. An accurate understanding of this permits the therapist to address the root cause of the illness.

opposed them directly the punishments became more brutal, so she withdrew emotionally but tenaciously held on to the thought, "What they're doing is not right. This is not the way things are supposed to be." In this way she was able to fight to keep them from extinguishing her feeling for life and her hope for the future. However, the onslaught from her parents as well as society's acceptance of them as "normal" made it difficult for her to maintain her own point of view. The only way she could do so was by immobilizing her thoughts and she did this by adopting an attitude of doubt towards everything around her. In this way her persistence, which was her greatest strength, turned against her and became a basis for her symptoms.

This persistence was clearly a core quality, an essential element of her nature. The perseverance of tardiness which others interpreted as stubbornness and which had led family, friends, and Dr. R to give up on her, was only a secondary, distorted expression of a deeply rooted, healthy trait. Her basic core persistence was deeper and stronger than her symptoms, and years of therapy had proven her capable of expressing this core quality. I therefore had confidence, which she, of course, doubted, that there would be continuing improvement.

For example, it took more than five years for her to obtain a driver's license. Progress was exceedingly slow but her persistence never wavered. She prevailed despite her own doubts, many setbacks, and negative comments from family.

Obstacles slowed her forward momentum but did not stop her progress. The family business relocated to a city hundreds of miles away and she had to move with it. The trip to my office was now much more difficult; complicated transportation arrangements became necessary, creating new situations in which her doubts could sabotage her efforts to come to sessions on time. Even on the occasions when she left home so late that she was sure to miss the entire session, she completed the trip and made valuable use of the few minutes of encouragement and perspective I was able to give her. Occasionally she would arrive after I had left my office. When this happened, she would use the trip home as a therapeutic exercise, overcoming her anxiety and starting conversations with other passengers on the bus and the train. She discussed her experiences and observations with me by phone the next day.

Eventually the family business closed. C needed to find a place to live and a job that she could hold without any support from her family. She faced this challenge beautifully, finding a new job and an apartment. With her independence, however, came new financial responsibilities that made it impossible for her to see me. She maintains contact with me through brief phone sessions and is building a life for herself. Now she is saving money, advancing in her new career, forming social connections, and refining her skills in the activities of day-to-day life.

Looking back, she describes her therapy as follows:

As far as being still I always had an excess of that, for hours and days I could stay still...the more something was happening, the more I would freeze up. The more they asked me, the more I froze up. Now, I understand about the energy thing: How I couldn't handle the excitement, how I cut out whenever there was a charge.... One day in therapy it just hit me—"I believe that he believes me," then I felt good. Now, the pressure was off and I didn't feel I had to perform and do things.... Now, I know there's a light at the end of the tunnel, even though I don't know exactly how to get there. When I need to get moving but I'm not sure I'm doing the right thing I tell myself "just go through it and do it and one day you'll know from the results if it's right or not right.... My first thing before was always to sit and stay still in one spot. Now, I don't think as much as I used to. I'm working more physically and getting more used to moving. Now, I'm always doing things.

C is building up the material basis of her life by developing her career, earning more money, saving for a better car, etc. She is coming closer to the time when she can resume therapy in person.

## Discussion

Reich discovered through his clinical and social research that basic human emotional structure is divided into three layers:

Extensive and conscientious therapeutic work on the human character has taught me that, in judging human reactions, we have to take into account three different layers of the biopsychic structure.... In the superficial layer, the average individual is restrained, polite, compassionate and conscientious. There would

be no social tragedy of the animal, man, if this superficial layer were in immediate contact with his deep natural core. His tragedy is that such is not the case. The superficial layer of social cooperation is not in contact with the biological core of the person, but separated from it by a second, intermediary character layer consisting of cruel, sadistic, lascivious, predatory and envious impulses. This is the Freudian “unconscious” or “repressed”; in sex-economic language, it is the sum total of the “secondary impulses.” Orgone biophysics has shown that the Freudian unconscious, the antisocial element in the human structure, is a secondary result of the repression of primary biological impulses. If one penetrates through this second, perverse and antisocial layer, one arrives regularly at a third, the deepest layer, which we call the biological core. In this deepest layer, man, under favorable social conditions, is an honest, industrious, cooperative animal capable of love and also of rational hatred. In character-analytic work, one cannot penetrate to this deep, promising layer without first eliminating the false, sham-social surface. [2:vii]

The way in which these three layers interact with each other and with the outside world differs depending on whether the patient has a neurotic or a schizophrenic character structure:

The schizophrenic world mingles into one experience what is kept painstakingly separated in the homo normalis [i.e., the neurotic]<sup>2</sup>. The “well-adjusted” homo normalis is composed of exactly the same type of experiences as the schizophrenic. Depth psychiatry leaves no doubt about this. Homo normalis differs from the schizophrenic only in that these functions are differently arranged. He is a well-adjusted, “socially minded” merchant or clerk during the day; he is orderly on the surface.... Homo normalis [whose deepest beliefs in God are an expression of his biological core] does not believe in God when he does some tricky business [an expression of his secondary layer], a fact which is reprimanded as “sinful” by the priests in Sunday sermons. Homo normalis does not believe in the Devil [a product of his secondary layer] when he promotes some cause of science; he has no perversions when he is the supporter of his family; and he forgets his wife and children when he lets the Devil go free in a brothel. [3:399]

<sup>2</sup>In this paragraph all brackets and their content are authored by Dr. Harman.

In the schizophrenic the separation between the three layers breaks down:

Homo normalis blocks off entirely the perception of basic organotic functioning by means of rigid armoring; in the schizophrenic, on the other hand, the armoring practically breaks down and thus the biosystem is flooded with deep experiences from the biophysical core with which it cannot cope. [3:401]

In contrast to the well-adjusted neurotic who is “orderly on the surface” in his conscious thought and social interaction, the schizophrenic has an incomplete and sometimes disorganized surface layer. In C this was manifested by limited social contact, work disturbance and, at times, disorganized speech.

Contact with the therapist enables the schizophrenic patient to develop a more intact and organized social facade (superficial layer). With many neurotic patients, in contrast, the therapist often may need to keep conversation about superficial matters to a minimum in order to break down elements of the social facade that interfere with genuine contact. With the schizophrenic, discussions of the superficial details of life can be very therapeutic by building up the social facade. This facilitates more contact with others.

The contrast between the schizophrenic and the neurotic character is best understood by comparing their functioning to that of the genital (healthy) character. In the three types—genital, neurotic and schizophrenic—the relationship between the deepest layer (the core) and the outside world is very different.

The *genital* character lives directly from his core. His contact with the outside world comes directly from this deepest layer of his structure and is accompanied by a full capacity for accurate perception of internal and external events. Thus his thoughts, feelings and actions are fully integrated with reality in a rational and objective way. One reason the genital character can function from his core, and still withstand the vicissitudes of life, is his capacity to avoid or to voluntarily armor himself against harmful external events:

[T]he ego of the genital character also has an armor, but it has the armor at its command instead of being at its mercy. This armor is pliable enough to allow adaptation to the various situations of

life.... The pliability as well as the solidity of his armor are shown in the fact that he can open up to the world as intensely in one case as he can shut himself off from it in another. [3:168-169]

In the *neurotic* character, contact from the core is always indirect, because it is weakened and filtered as it passes through his chronic, involuntary armor. This protects him, but limits the depth of his contact. Whatever he sees or hears reaches his perception only after passing through the armor. As a consequence he is limited in how much it can affect him in a deep way.

The *schizophrenic* represents the contradiction between genital functioning and neurotically armored functioning—he has contact with his core but at times suffers a loss of perception. He lacks both the integration and the voluntary, protective armor of the healthy organism. He also does not have the same kind of chronic armoring as does the “homo normalis.” Thus he cannot function in the “well-adjusted” (but limited) way that the neurotic does. This is seen even in the very high functioning schizophrenic. He may be a great physician, philosopher, scientist or artist, but those around him sense that he is “eccentric,” “different,” or somehow not “well-adjusted.” He never quite fits into the mainstream of human life.

Practically speaking, the schizophrenic’s core contact and lack of armor has a profound effect on how the organomist must relate to him. Whatever the therapist says or does in relation to the schizophrenic will be taken very much “to heart,” i.e., will go to his core. It will affect him very deeply, and his intolerance of the resulting excitation may cause him to perceive what was said in a distorted way.

However, it must be remembered that the fact that the schizophrenic is deeply affected by everything the therapist says and does has positive as well as negative implications. Traditionally trained therapists are sometimes taught that their interactions with schizophrenic patients are best limited to “supportive” contact, because such patients are considered “fragile.” This is a misunderstanding based on a lack of knowledge of deep biophysical functions. The schizophrenic patient is not necessarily fragile; in fact, he can be quite robust. This was the case with C, who was a very strong person. The fact that everything around her affected her so deeply was a blessing as well as a curse. With C, a word of encouragement or a bit of common

sense advice from me always penetrated to her core and could therefore have a profound therapeutic effect.

Schizophrenic patients are much more able than neurotics to respond intensely and positively to such “superficial” interventions. For example, if a schizophrenic has developed good contact with the therapist and expresses concern about whether or not he will be able to overcome a problem, it is often appropriate to provide reassurance. He will be deeply touched by this and, as a result, may be able to tell the therapist of any distortions, such as doubts or suspicions, that he has about the reassurance. This brings about improvement in his capacity to function. With a neurotic (before the end phase of therapy) the effect could be the opposite—the phallic might dismiss the reassurance as a display of the therapist’s weakness and inability to do anything more effective; the hysteric may respond as if the therapist’s reassurance were a cue to shift into a superficial conversation; the passive-feminine will take it as an indulgence of his passivity.

Reich pointed out another important difference between the neurotic and the schizophrenic:

[I]t is understandable that armored homo normalis develops anxiety when he feels threatened by the findings of orgonomy, whereas the schizoid [i.e., schizophrenic] character understands them instantly and easily, and feels drawn toward them. [3:401]

C is a good example in that she was strongly drawn to Reich’s work. However, because of her perceptual limitations, she idealized Dr. R and was unable to fully defend herself from him. She once had the thought that he was a “con man” and tentatively expressed this to him in the form of a humorous remark. She was deeply frightened by the hostility in his voice when he responded. However, she could not tolerate the fear she felt in that brief interaction and replaced her suspicion of him with doubt about herself and believed that her own remark had been “stupid.” Schizophrenics, more so than other character types, are at risk of injury in the hands of therapists who have not had their own character armor addressed. Because the schizophrenic longs so deeply to form a connection between his core and the outside world and has a keen sense of energetic functioning, he is especially vulnerable to sociopaths who claim that their work is connected with Reich’s.

The schizophrenic's longing for deep contact and his instinctive attraction to orgonomy do not necessarily make him an individual who will benefit from medical orgone therapy. C's case illustrates an additional requirement: the capacity to accept responsibility for one's own problems. Furthermore, C had a strong desire to take care of her own material needs, i.e., to become more independent. A sense of the importance of independence and responsibility, on the part of the patient, is an essential prerequisite for treatment and, without it, little lasting benefit can be expected(4).

### Conclusion

The medical orgonomist has at his disposal both verbal characteranalytic and direct biophysical methods of treatment. The decision when to use each varies from patient to patient. This patient did not require direct work on muscular armoring but responded to character-analysis based on an understanding of her biophysical structure and functional needs.

C's case illustrates the importance of the orgonomist recognizing and allying himself with the healthy elements of the patient's emotional structure. Distinguishing the healthy elements that came from her emotional core and supporting these elements proved, at times, more valuable than addressing her apparent resistances to therapy, such as her tardiness. This "supportive" contact with the therapist enabled the patient's confusion (ocular armoring) to improve. It then became possible to characteranalytically address her central defense—doubting.

This patient made progress by overcoming great obstacles. Faced with similar difficulties, many people in today's society might have gone on welfare. C chose instead to do what was necessary to preserve her independence and to discharge her responsibilities. Despite the terrible misfortunes suffered in childhood she never developed a sense of entitlement, nor did she lose contact with her basic decency and the strength of life within her. Individuals such as this give us hope for the future of humankind.

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