Symptomatic Relief of Adolescent Depression

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This clinical case illustrates how a few sessions of medical orgone therapy can relieve a state of severe depression. Indeed, this case was chosen for presentation because of the unexpected and remarkable improvement obtained by the patient and as an example of how medical orgone therapy can be effectively used in a psychiatric hospital setting.

For a medical orgonomist, working in a hospital is both frustrating and challenging. It is frustrating because of the often economically determined, usually short duration of hospitalization and the fact that the hospital staff is not familiar with orgonomic concepts and techniques. It is challenging because of the opportunity to use medical orgone therapy in the presence of severe psychopathology.

Case Presentation

In the hospital one Monday morning, the nurse in charge of the adolescent ward reported to me that one of the adolescent girls had been observed participating and being more talkative during group activities. She was less sad and was taking care of her personal appearance by wearing some make-up and dressing in bright colored clothes for the first time since her arrival a week earlier.

These changes surprised the hospital staff who had frequent contact and interactions with this girl. She had, in fact, been very depressed and refractory to all attempts made to help her during the course of her hospitalization. As the attending physician, I too was surprised. I wondered if the antidepressant medication that I had prescribed a few days earlier could have brought about such a dramatic improvement. Such an early response would have been unusual.

I considered the possibility that this patient was becoming hypomanic or even manic. However, this did not appear to be the case as the girl was not euphoric or elated. Furthermore, she didn't exhibit

pressured speech or racing thoughts and she was cooperative and appropriate in her behavior.

The patient, a 12-year-old girl whom I will call Stephanie, had been hospitalized because of suicidal ideation and auditory hallucinations. I was familiar with Stephanie from a prior hospitalization a month earlier. At that time she was also depressed, had suicidal thoughts and was hearing voices. During that hospitalization, the medications I had prescribed were only somewhat helpful, as evidenced by the disappearance of her suicidal thoughts. Otherwise, her depression was only slightly improved. Ultimately, I had discharged Stephanie with the intent that she continue outpatient treatment in a partial hospitalization program. Unfortunately, Stephanie did not do well in that program and required hospitalization again.

During this second hospitalization, Stephanie's clinical condition appeared worse. When I met her, she looked sad and hopeless. She spoke only a few words and could not interact with me. There was a feeling of heaviness around her and it appeared that life had come almost to a standstill within her.

Her face was immobilized with an expression of misery; her eyes were empty and lacked any sparkle. As she sat in the chair in front of me, she kept her eyes downcast and her shoulders hunched. She spoke slowly and in a weak voice. Her movements were slow. She was unkempt and dressed in dark, neutral colored clothes. Energetically, she was in a state of contraction which resulted primarily in immobilization and, secondarily, in deep depression.

Stephanie told me that she had become suicidal after some of her peers at school had made fun of her. I realized she had little insight, indeed no way of comprehending, that the return of her hopelessness and hallucinations resulted from a severe contraction that followed being ridiculed by her classmates. After evaluating Stephanie, I placed her on medications. One week went by, but she showed no improvement. She continued to appear sad, avoiding interaction with her peers and spending most of her time alone in her room. She remained unkempt and poorly groomed. The sense of hopelessness remained deep and was spreading to those around her—nurses, therapists and mental health

workers in daily contact with her. I understood the energetic basis of Stephanie's clinical condition and knew that she needed a more active intervention than just medication.

One Friday afternoon I made time for a session with Stephanie in my office. I briefly talked to her and then asked her to breathe deeply and unwind. She had to make considerable effort to inhale and exhale deeply. It seemed as if she had a bandage wrapped tightly around her chest and was breathing against a strong resistance.

This inhibition of respiratory movement is present in all depressed patients. It is a sign of armoring of the chest. When it is present, there is a decrease in the energy level of the entire organism, with resulting immobilization. From this observation, it follows that one of the most important interventions in the treatment of a depressed patient is the reestablishment of full respiration as soon as possible.

Stephanie was able to cooperate with my efforts. Here, I need to point out that cooperation with treatment is a very positive factor in determining the patient's prognosis. Most often the adolescents admitted to a psychiatric hospital are very angry, defiant and rebellious, particularly toward authority figures. This attitude can make it more difficult for the psychiatrist to reach the patient and be of help.

With Stephanie it was clear that she was willing to make the effort to participate. She recognized her suffering, wanted to be helped, and was reaching out from the depths of her depression.

Because Stephanie's face was mask-like, with dull eyes and a sad expression, I decided to focus first on mobilizing her face with the intention of relaxing the facial muscles and reducing the state of energetic contraction. I asked her to make faces and to try moving her forehead. After some initial reluctance, she began to move her face but she could not move her forehead. (The inability to move the forehead was a sign that she was more armored in her ocular segment.) In an attempt to mobilize the ocular segment and her face, I asked Stephanie to open her eyes as wide as she could and then to close them tightly while at the same time breathing deeply. She could do this only with great difficulty. I noticed that when she closed her eyes a crying

expression appeared. She did not, however, perceive this or any associated emotion. The energetic immobilization, i.e., the lack of energy movement, results in a lack of excitation as well as perception.

On the positive side, Stephanie could roll her eyes and look around the room, and also focus on my finger and follow it as I moved it back and forth in front of her eyes. These interventions did much to loosen her up.

When I felt that some emotional excitation, albeit small, was present, I told Stephanie to open her eyes wide and to yell out. She emitted a high pitched scream, yet she could not at the same time keep her eyes open wide. (This was an indication that she had difficulty tolerating the intensity of emotion brought about by this intervention.) When I felt Stephanie had done enough, I told her to stop and rest. A few minutes later I asked her how she felt. She said she felt calmer. This was the single therapy session which had preceded the sudden, unexplained, marked change in Stephanie's mood and behavior described earlier.

Encouraged by Stephanie's dramatic improvement, I saw her again for another session three days later on Monday afternoon. Stephanie reported that she was feeling better and that the first session had relaxed her. I worked again with her as I had during the previous session asking her to breathe deeply and make faces. This time it was easier for Stephanie to breathe. She could also move her face with greater ease and was in better contact with what I was asking her to do. Throughout the session I maintained constant emotional contact with Stephanie by talking to her, focusing her attention on what she was feeling and continually asking her to look at me.

This is a point that needs to be stressed. The patient has to be in emotional contact as much as possible with the therapist, with what he or she, the patient, is feeling at that moment and with his or her surroundings. In the absence of this contact the above described interventions become mechanical and meaningless. By making contact with the therapist, patients acquire again the capacity to make contact with themselves. This point cannot be overemphasized.

In this second session, instead of a high pitched scream, Stephanie was able to yell out loudly with more intensity and emotional involvement than the first time. I saw again the crying expression on her face when she closed her eyes, but she was still not in contact with this. At the end of the session, I told Stephanie that she would be going home the following day and I wished her good luck.

The next day I saw Stephanie as she was leaving the hospital. She was wearing a red shirt and her hair had been carefully combed and styled. She looked brighter and for the first time I saw Stephanie smile.

Discussion

Stephanie's sudden and marked improvement shows how beneficial medical orgone therapy can be. Just two sessions were able to provide effective first aid in a clinical emergency manifesting as a state of immobilization and deep depression. Stephanie's clinical improvement is more significant if one considers that such an improvement had not been present during the first hospitalization when she was not provided this type of therapy. Stephanie's case also demonstrates that it is possible to provide medical orgone therapy within the setting of an essentially pharmacologically-oriented psychiatric hospital.