The Acute Schizophrenic Psychosis

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In the orgone therapy of schizophrenia, all degrees of anxiety, from the oldest form (as ambulatory cases) to full-blown panic, are encountered. The significance of this panic in the schizophrenic is that a clamping down of the ocular segment leads to an increased disruption of the unitary biophysical functioning and to psychosis. In dealing with the schizophrenic patient, it is therefore necessary that the therapist understand the limits of each individual's capacity to tolerate anxiety and know exactly what to do in cases where a psychotic episode (which constitutes a biopsychiatric emergency) does occur.

In general, the extent of preexisting bodily injury (exclusive of the ocular segment) determines how successfully the schizophrenic can defend against a psychotic breakdown. The acute schizophrenic has a better prognosis and is easier to treat than chronic cases. **1** With each successive psychotic attack, biophysical deterioration may occur. This is because breakdown of armor in the lower segments is accompanied by an intensification of ocular armor which is needed to deal with the increase in anxiety. Therefore, unless armoring of the lower segments occurs spontaneously in untreated cases, therapy becomes increasingly difficult depending on the length of time this process of deterioration has continued. Reich felt that this impairment actually involved shrinkage of the brain itself.

The differential diagnosis of the acute schizophrenic psychosis consists of psychosis due to other causes: organic syndromes, drug and alcohol psychosis (alcoholic hallucinosis **2**), epileptic furor, and the so-called functional psychoses including manic depressive psychosis.

The organic psychosis can be ruled out by taking a careful history, testing for organicity in the mental status, and performing appropriate medical tests. In cases of drug or alcohol abuse, one elicits a history of ingestion. The diagnosis of manic depressive psychosis and epileptic furor (which can be mistaken for catatonic excitement) is more difficult during the acute psychotic attack. Once the psychosis is eliminated, however, and the underlying premorbid personality emerges, one can usually differentiate these cases. A positive EEG is helpful in diagnosing epilepsy. An important differentiating feature in the premorbid makeup of the manic depressive is that he is basically extroverted. Similarly, there is no disturbance in thinking in the nonpsychotic manic depressive.

Three cases of paranoid schizophrenia will be presented. All three cases dealt with the patients' first psychotic episode. The first two will deal only with the acute psychotic phase. In the third case, a detailed description of the onset of an acute psychotic attack that occurred during the end stage of therapy will be given to provide a deeper understanding of the origin of the psychotic attack.

Case 1: Acute Psychosis Accompanied by Homicidal Impulses

The patient was a 37-year-old, single, white, male policeman who came to therapy because of severe anxiety attacks and restlessness accompanied by almost uncontrollable homicidal urges. These were primarily directed towards his girl friend and had intensified in the past month. His anxiety first began after several heavy bouts of drinking hard liquor. He was given tranquilizers, which gave him moderate relief. Although he had been very conscientious and had high goals in life, he began feeling totally alienated from society and gradually lost all his ideals. Continued heavy drinking brought out his paranoia and made him belligerent and socially obnoxious. Sexually, he behaved like an extreme Don Juan but was becoming threatened by fears of erective impotence. He began smoking marijuana to relieve his anxiety and help his sex drive. Potency was vital to him, and he attempted to over-come feelings of inadequacy by behaving sadistically toward his sexual partners with either fantasied or actual beatings. He realized that underneath his apparent toughness there was a great deal of anxiety.

One month prior to my seeing him, his anxiety attacks, as well as his sadistic urges during sex, suddenly increased in both intensity and frequency. One night, after heavy drinking, he began retching violently. This was the onset of a further intensification of his sadistic impulses and he had insomnia and constant nightmares **3** . He could not concentrate, was afraid of strangling his girl friend, and felt that he was going insane. He consulted a psychiatrist who gave him tranquilizers and recommended that he be hospitalized because of his homicidal tendencies.

It was at this time that I first saw him. On the initial interview, he appeared extremely tense and frightened. Biophysical examination revealed that he was athletic in build and had a very high energy level. The musculature of the face, scalp, and head was severely contracted. His occiput, especially the deep musculature was very tender, and his face was pale. Subjectively, the patient felt a generalized tightness in his head, which was especially severe on the left side. He complained that his forehead and eyes felt numb. Little armor was present in the lower segments including his pelvis, however, and he had a very strong pelvic reflex. **4**

He had difficulty thinking clearly. His past history was unremarkable except that he had had surgery for strabismus in the left eye as a child. He was amblyopic in this eye.

On the couch, he appeared terrified, tense, and ready to explode. When I asked him what he thought of me, he became bristly and antagonistic, immediately venting his negative criticism. He saw me as being "authoritarian." He thought I was "cold" and "businesslike." This gradually led to a violent outburst of rage with hitting and kicking the couch. He strangled a towel and shouted at an imaginary authority figure, and then at his mother and sister. This rage produced momentary relief and alternated with a feeling of pressure and clamping down in his head.

My impression was that this patient was on the verge of psychosis because of the emergence of uncontrollable sadistic impulses to over-come his deep fears regarding his sexual potency. Despite the severity of his illness, I felt that his prognosis was good because of his strong phallic structure and the easy accessibility of his intensely sadistic impulses, provided, of course, that he could confine his outbursts to the therapeutic situation. Another reason for a favorable prognosis was that he was in good contact with his fears and distrust of therapy. This enabled him to have an objective attitude and cooperate with my therapeutic efforts. I emphasized that it was crucial to restrict his murderous impulses to therapy and told him that I could agree to treat him only if he assured me that he would contact me immediately if he could not control these impulses. He agreed. I also told him to continue taking tranquilizers whenever he felt homicidal or in danger of losing control.

By the second session, he appeared somewhat quieter. He reported an improvement in potency. Mobilization of his tense occiput produced deep breathing. He "saw" his mother's hand coming to pick him up. Then his father's face became superimposed on hers. He became acutely fearful that he might be a homosexual. His pelvis began to writhe. In an attempt to overcome these feelings, a strong outburst of sadistic impulses followed. He shouted "Stop it!" as he hit his head and pelvis violently on the couch.

By the fourth session, his eyes felt clearer and he was feeling better generally. Further mobilization of the occiput revived the memory of a recurrent childhood nightmare: There are two glass telephone booths. He is boxed in one of them. His mother has a choice of going into either booth, and she chooses the empty one, which leads him to feel abandoned and terrified. This dream illustrates not only the extreme fragility of his armor (he is enclosed in a glass cage), but also his intense terror of maternal abandonment. I asked him to breathe. He felt the walls of the room closing in on him, and he became acutely belligerent. I therefore told him to stop and relax. Later in the session, he reported feeling generalized, pleasurable tingling, "like after sex."

I continued to mobilize his eyes and focused on his expressing anger. My object was to enable him to express increasing intensities of anger to the point of losing control in order to relieve the severe ocular armor and panic. Expressing anger with his eyes open regularly produced feelings of well-being and reduced his fears. He expressed intense sadistic impulses, fantasizing all kinds of sexually sadistic acts towards everyone in his life for entire sessions at a time. Anger that was not expressed through the eyes, however, resulted in a further clamping of the head. I, therefore, discouraged any expression unless it was shown in the eyes as well. Another situation that produced a clamping down of his head was when he behaved in a sexually sadistic way with his girl friend. Typically, pressure would develop in his head, together with an intensification of his fears of insanity. This sadistic acting out also had to be constantly discouraged.

Providing an outlet for his intense sadistic impulses in therapy eliminated his homicidal impulses and produced an improvement in his sexual functioning and in his general well-being. He was gradually able to taper off tranquilizers and finally stopped taking them entirely. Very slowly, as the tightness he felt in his head was relieved, it became

possible to reach progressively deeper layers of armor. He began tolerating soft feelings for women and felt more genuinely sexual. Accompanying these changes, he became able to think more clearly and was more rational in dealings with people and his work. At this time, his amblyopia was eliminated.

Case 2: Acute Psychosis Accompanied by Homosexual Panic

This 23-year-old, white, male, married factory worker came to therapy because of feelings of insecurity at work and progressively severe anxiety.

Several months before, he had developed ideas of reference and began having accusatory auditory hallucinations. This occurred when he attempted to control his anxiety at work. He heard voices calling him a homosexual.

He found it increasingly difficult to cope with his work situation, to deal with his relationship with his boss and his coworkers, and he began experiencing sexual difficulties (impotence) with his wife. Auditory hallucinations began following a period of intense anxiety accompanied by an "inner shakiness." These symptoms were triggered by anxiety-producing work situations.

During the initial interview, the patient appeared tense and anxious. There was no thinking disorder on this occasion, and he spoke relevantly and coherently. He stated that his problem began when various union officials began to exert pressure on him to slow down on his work. He acquiesced even though he was typically a hard worker. He felt intimidated by them and had fears of being a homosexual. He felt this especially when he saw these men scratching their crotch area, which made him think they were interested in him sexually. He attempted to overcome his passive homosexual feelings by becoming bristly, but this only further alienated him from his coworkers.

Biophysical examination revealed that the eyes were proptotic, and they appeared frightened and suspicious. When asked to move them, he could do so only by moving his head as well. The occipital muscles were extremely tense and tender. His face was stiff and the jaw tightly clenched. His neck was armored, and his chest was held high in inspiration. The rest of his body appeared to be relatively free of armoring. Since his terror was close to the surface, as indicated by the frightened expression in his eyes, I asked him to open his eyes wide and express his fear through screaming. This produced considerable relief. In addition, I pressed on the tense occipital muscles and asked him to scream when he felt frightened. This produced a fear so intense that he felt his head was about to come off. This led immediately to feelings of anger, which I encouraged him to express as well.

By the fourth session, the hallucinations had diminished, and he began to feel calmer. I asked him to roll his eyes from side to side and look out of the corners to elicit feelings of suspiciousness. This intensified his fears of being a homosexual, and he discussed the homosexual feelings he'd felt from talking to the union leader.

By the sixth session, the patient appeared more aggressive and less frightened. He reported that the hallucinations were becoming less derogatory. At this time, I was able to mobilize more terror from his chest. Deep breathing produced a feeling of tightness under the sternum. Manual pressure to relieve the tension produced terrified screaming. This was immediately followed by a complete disappearance of the hallucinations. He felt a tingling and pulsation of the face, eyes, and occiput. During the following week, he felt more relaxed in dealing with people.

By the twelfth session, the auditory hallucination had been eliminated. Within the next few months, he regained his confidence and lively sense of humor that had been present prior to his illness, and he became more effective in dealing with others. He stated that for years he had had to bend backwards to accommodate others. Now, he is finding alternate ways of handling people. As his sexual sensations increased, his heterosexual functioning markedly improved, and his fears of being a homosexual disappeared. Although this patient had not achieved orgastic potency when discharged (over six years ago), he has retained his inroads in health and has been functioning satisfactorily since then.

Case 3: Acute Psychosis Occurring During Orgone Therapy

In contrast to the previous two cases, where the acute psychosis was the presenting symptom, this case shows the importance of adequately preparing the patient to express deep emotions by careful and thorough mobilization of the ocular segment. It illustrates the biophysical basis for her tendency to psychosis and the management of this reaction.

This 20-year-old, single, white, female lab assistant was referred by another therapist whom she had been seeing for about one year. Original complaints at that time were that she had been feeling hopeless, she had a poor sex drive, and her life was filled with anxiety. Her current complaints included the following: She was easily distracted. When her eyes felt hazy, she had difficulty thinking. At times, when her eyes felt clear, everything seemed easy. She stated that spite was her biggest enemy. She could not tolerate skin contact. It made her skin itch and made her feel anxious. Biophysical examination revealed that, when her eyes were clear, she was in good contact. At other times, they appeared either fuzzy or suspicious. She was intelligent, perceptive, and sensitive. Despite the fact that she gave a superficial appearance of confidence, closer observation revealed that she was quite fragile, and one had the feeling that she could become psychotic. Her eyes were moderately immobile, and her occiput was tender. Her throat was armored, her chest appeared soft, and respiratory excursions were shallow. The rest of the biophysical picture was unremarkable.

My therapeutic formulation was that, because of her fragility, one had to proceed cautiously and allow her organism, especially the ocular segment to tolerate increasing amounts of energy charge, and to watch carefully for any signs of psychotic decompensation.

In order to ascertain her capacity for emotional expression, I asked her to shout. She was able to shout angrily, but her eyes did not participate. This was followed by some "hurt" crying. I proceeded to mobilize the occipital muscles. She became panicky and confused and felt anger towards me but could not express it. This led to her typical spite reaction. I therefore had her kick, not only to express her spite, but also to draw energy out of her head. This momentarily relieved her panic and she felt somewhat better.

In the following session, when I asked her to move her face, she became angry at me for telling her what to do and also for knowing what she felt. She stated that she felt vulnerable and did not want to have her defenses taken away. As she expressed her feelings to me, I gained her cooperation, and she was able to roll her eyes briefly, which gave her a feeling of well-being. During the following week, feelings of sexuality alternated with feelings of fright. By the next session, she had clamped down in the oral segment and had developed gingivitis. I asked her to breathe, which made her feel anxious, and her skin began to itch. She expressed a fear that I would not accept her sexual feelings yet she was pleased that unlike her previous therapist, I left her alone to get well at her own pace.

Mobilization of her face produced more anger. She shouted "No!" in disgust while pushing something away with her hands. She related that "No!" to not wanting to take food. Again, a brief period of expansion was followed by contraction. Her face paled, she felt a strong pressure in her chest. She stated that she felt "too open" and as if she were "falling apart. She gave in to this anger by squeezing from her legs and pelvis, and by arching her back and digging her buttocks into the bed. She felt spiteful and vengeful towards men. She shouted angrily, "You won't get it!" referring to the idea of giving pleasure to men.

These feelings of spite and vindictiveness gradually resulted in an increased capacity to tolerate sexual sensation, but also intensified her fear of disintegration. She became overwhelmed by her sexuality and wanted to become promiscuous so as to destroy her relationship with her boyfriend. She began having fantasies of castrating men.

Discussion of these fantasies revealed that they were based on her feelings as an adolescent towards her father who never permitted her to enjoy a relationship with a boy. He would barge in on them and take her away. As a result, she had to be constantly on her guard. She recalled, further, that she was beaten by her parents as a child when-ever they suspected her of having sexual feelings. In this way, her sexuality became associated with destructive impulses and formed the basis for her sadomasochistic tendencies in later life.

She developed a tightness in the back of her neck accompanied by a feeling of suspiciousness. Looking around the room intensified her anger and, for the first time, she had spiteful and taunting thoughts directed at me. This was expressed as not wanting to give me the satisfaction in getting her well. This resulted in strong rushes of energy into her head. She felt dizzy and frightened, and she had to fight against losing contact and becoming psychotic.

During the following week, she had a feeling of well-being and an intense sexual experience with her boyfriend. Once more, she felt frightened and was reluctant to continue therapy. She did not want to undress in front of me, since she felt I would not accept her sexuality. She had nightmares and felt masochistic and suicidal. She expressed a great deal of anal spite. For example, she felt as though she was sitting on the potty and was expected to defecate. This was followed by more taunting and teasing expressed as not wanting to give me any credit for her improvement. The following dream illustrates the admixture of elements from anal and phallic levels: She is going to her wedding, but also is being coaxed to go by her friends. She wants to go but, at the same time, is angry at being told what to do. She ends up fighting with everyone.

On the couch, she gave in to disgusting grunts and made anal gestures, movements as if straining at stool, and wiped her hands on her body in order to erase her feelings, all of which only further intensified her bodily sensations and terror.

At this time, her early sexual fears were revived. She had dreams of being impregnated without sex and also dreams of violence and castration. The following dream is an example of the latter: Her dog dies, but she cannot feel for it because its genitals are cut off.

On the couch, she quickly developed pelvic clonisms. She was frightened and raised her knees to protect her genitals. Her eyes became dull, and her head contracted. In order to prevent a psychotic attack, I kept vigorously mobilizing her eyes and had her express her terror.

During the following week, she had stabbing dreams. She was very angry with men, including me. She felt again that she did not want to give them anything. Expression of this anger made her feel more integrated. This alternated with an intensification of her sexual feelings, but this time they were for older men. She recalled her sexual experiences as a late adolescent and how she seduced older married men and fantasied getting even with their wives.

Further mobilization of her pelvic rage followed. She developed violent pelvic thrusts, and, accompanying this, she fantasied that she was expelling a penis from her vagina. Expression of this rage produced feelings of wild sexual abandon similar to that which she had felt as an adolescent.

This ushered in her oedipal conflict in full force, as illustrated by the following dream: She is with a man whom she wants to touch sexually. Suddenly, the man turns into a disgusting woman and the wife enters, rebuking the patient for attempting to steal her husband.

Breathing produced immediate itching and pelvic clonisms. She felt a burning in her abdomen accompanied by a very deep hatred of me. She shouted spitefully: "I don't want these feelings! I don't want to be well!" She became frightened, since she believed

that I would not accept this amount of anger. I encouraged her to allow herself to express whatever she felt. She cried and said she felt that she had given up a great deal as a child and that she wanted it all back.

She was beginning to tolerate a great energy charge and remained expanded longer than before. For the first time, she felt her paraspinal (spite) muscles relax and could feel her back touching the couch. Now she was able to discuss her oedipal attachments more fully. She recalled that, as an adolescent, she wanted her father completely to herself. She attempted to achieve this by doing everything that she felt would please him. At the same time, she resented him for preventing her from being with boys. In later life, this attitude carried over to other older men whom she respected. Either in reality or in fantasy, she sexualized these relationships and then took revenge on the men by denying herself to them.

I asked her if she felt that she had to please me in this way also. At first, this question terrified her, but then she gave in to a strong outburst of rage directed at me. She stood up in front of me and taunted me spitefully: "No! I won't do it! You can't have me!"

During the following week, she had a wealth of castration dreams. When I saw her, her head was severely contracted. She was frightened of lying down because this made her dizzy; she became disoriented and felt she was losing hold of reality. Gradually, she was able to lie on her back and breathe. When she felt she was losing hold of herself, I asked her to scream her terror.

Then she went on vacation for two months, during which time she felt very sexual and had regular gratifying sexual experiences.

Prior to the following session, she had this dream: She is dressed as a bride. Her father is the groom and her mother is in the background. She has a secret that she is concealing from them. If she tells this secret, her parents will fall in love with each other. I stated that by keeping her secret she was holding onto her father. This angered her, since she did not want to hear or face this, but she did not express it. As her eye block became intensified, she came close to a psychosis; that is, she felt disoriented and her vision became flat. She recalled a dream in which her feelings were unacceptable to me. In order to relieve her ocular block, I asked her to kick. She became dizzy, and her fear intensified into panic. Then she became frankly psychotic. She sat up. Her eyes were dull, and her head appeared pale and contracted. She felt herself receding, leaving the therapy room and going to her car in the parking lot several hundred feet away. I was able to clear the ocular block and the psychotic attack by mobilizing her occiput. Later, she told me that she was terrified of expressing intensely sadistic impulses to me since she felt I would not accept them. (See previous dream.) She wanted to order me around and render me sexually submissive but felt I would find this amount of sexual anger (sadism) unacceptable.

During the following week, she was very anxious and uninterested in sex, yet she was able to perform well in her work. In her relationships at work, she was making a strong

effort to be direct and honest with men and to curb her neurotic attitude toward them. I examined her occiput, which was loose; but, when she lay down on the couch, she became dizzy, and her eyes became cloudy. I was very concerned about a possible recurrence of the psychotic attack of the previous session. I, therefore, asked her to sit up and look at me. This produced very strong sexual taunting. She stood up, looked at me provocatively, began ordering me about, exposed herself, and boasted, "You can't have it!" etc. After expressing this rage, she felt calm and her eyes became clear. But she was left with the feeling that she had displeased me. I would no longer like her because she had shown me her deepest emotions. She recalled how, as an adolescent, she had to hide her sexuality from her father in order to strengthen her emotional ties with him.

This led to a spasm in her neck. She verbalized anger at me for expecting her to grow up, accept her boyfriend in a mature way, and flirting with other men. Then she admitted that she fantasied punishing me by seducing me. In that way, I would get close enough to her so that she could destroy me.

In the next session, she was capable of expressing a great deal of anger, verbally and motorically, but I noticed that any expression of anger in her face was absent. I encouraged her to make angry faces by making these faces myself. She became frightened at these faces and screamed: "Don't look that way!" She recalled how any expression of anger toward her by her father was terrifying. It meant that he was not pleased with her. She realized that because of this she could never tolerate any man being angry with her. When, as an adult, she behaved provocatively and angered men, she would literally fall to their feet and beg them to stop being angry with her. Her ability to see the expression of anger on my face and not shrink from it made a considerable difference in her ability to tolerate feelings. She stated that she felt better than she ever had in her life.

She became capable of tolerating strong sexual pleasure and her capacity for genital discharge increased dramatically. She lost her promiscuous tendency and began having dreams of giving up her father. She became closer to her mother and wanted to be more like her. Her eyes retained their clarity as she gradually restructured into health.

Therapeutic Considerations

The schizophrenic attack (psychosis) is triggered by a specific emotional upheaval corresponding to a sudden, sharp increase of energy (affect or sensation) within the ocular segment. Sensations become intolerable and panic ensues followed by psychosis.

The sequence of intolerance to panic leading to psychosis was clearl illustrated in Case 2. The acute psychotic attack consisting of derogatory auditory hallucinations began when the patient attempted to control his anxiety and visible tremulousness. This resulted in an "inner shakiness" and the onset of hallucinations.

In each of the three cases discussed above, the acute psychosis involved the breakdown of the major defensive structure of the patient, which was at the phallic level. This is not always the case, however.

A cardinal technical principle is that the therapist must focus on the most immediate situation presented by the patient. For example, which particular emotion is closest to the surface, and exactly how does the patient defend himself against its expression? Therapy is highly individualized, and the therapist is constantly guided by the needs of the patients.

Since the acute psychotic attack represents an intensification of the ocular armoring as a reaction to an emotional push, the primary therapeutic task is to help the patient tolerate this increase of emotion in the ocular segment. As sensations reach the critical point of becoming intolerable, the schizophrenic patient shows unmistakable clinical signs and symptoms of anxiety. If he is in contact with himself at the time, he will report feeling anxious. Otherwise, he may become confused and restless, go off in his eyes, and stare into space in order to remove himself from the situation. If the underlying emotion is not expressed, panic increases, with manifestations of frank psychotic reactions such as delusions and hallucinations, disorientation, etc. It is essential that the therapist recognize this situation so that he can assist the patient to deal with this unaccustomed buildup of energy. At this point, the patient may be instructed to scream to relieve the underlying panic or to express whatever emotion is being held back. With this discharge of the specific emotion, the psychotic episode regularly clears up. This process gradually enables the patient to build up his emotional tolerance to increasing amounts of energy. In the acute schizophrenic, this produces a remission of psychotic symptoms and eventually leads to a restitution of the premorbid personality.

The spontaneous mobilization of the pelvis that occurs during therapy while armor is still present in the upper segments may trigger a psychotic reaction. In this event, the therapist can use neuroleptic medication as indicated in conjunction with orgone therapy.

The first two cases were described to the point where the psychosis was relieved. The systematic removal of armoring from the most superficial character defenses through the secondary layer which contains the sadistic, destructive (Freudian unconscious) impulses and finally the successful resolution of the oedipal complex, is the same in schizophrenia as it is in neurotic patients.

The pelvic segment is the most difficult to work through in any patient because pelvic mobilization results in a sudden increase in the total energy level of the organism. It is for this reason that the upper segments must be consistently and thoroughly mobilized to withstand the greater intensity of emotions before the pelvic armoring is touched. If this is not done, one cannot expect to produce full orgastic potency. However, the difference with schizophrenics is that the patient must first be given a sufficiently strengthened ego through intensive mobilization of the ocular segment before his neurotic defenses (armor) can safely be removed. This was illustrated by the third case.

Even with intensive mobilization of the ocular segment, there occurred psychotic attacks during the end stage of therapy. Activation of the highly charged impulses of the pelvic segment accompanying the working through of oedipal material overwhelmed this patient's capacity to withstand energy in the ocular segment and produced transient psychotic episodes. Expression of these intense emotions was essential for building up a tolerance for these feelings in the ocular segment. Thus her tendency to resort to psychotic mechanisms in order to deal with her panic was eliminated. This was an indispensable step on her road to health.

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Footnotes

1. Hebephrenia is an exception to this rule. In these cases, the prognosis is unfavorable even at the onset of any manifest symptomology

2. Alcoholic hallucinosis is probably an acute paranoid psychosis that is triggered by alcohol.

3. Gagging spontaneously mobilized the armor in the lower segments and increased the energy push from below

4. Pelvic armoring binds great quantities of energy. Schizophrenics typically have light pelvic armoring. However, this absence of armor does not imply the presence of orgastic potency since the energy is not available for genital discharge