the journal of Orgonomy

Major articles

USN ISSN 0022-3298

Published by Orgonomic Publications, Inc.

Volume 13
Number 2
November 1979

Schizophrenia and the Oral Unsatisfied Block

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Few individuals have undisturbed ocular segments. The diagnosis of schizophrenia is made orgonomically when the *major* blocking of energy is found to occur in the ocular segment. Reich thought that the eye block, which characterizes schizophrenia, occurs in the first ten days of life. In spite of this early blocking, development to higher levels of psychosexual functioning occurs, and the type of schizophrenia that occurs is determined by the usual vicissitudes of character formation. The types of schizophrenia delineated in orgonomy are (1):

hebephrenic—hysteric character with a repressed ocular block
paranoid—phallic character with a repressed ocular block
catatonic—compulsive character with a repressed ocular block
simple—oral character with a repressed ocular block

Dr. C. Konia has elucidated two other sub-types, the passive feminine and masochistic schizophrenics (2, 3).

Oral blocking and cervical blocking are prominent in schizophrenia. (Oral blocks invariably have an associated cervical block (4).) It would appear that, in most cases, the oral block is of the oral *repressed* type.

The oral-cervical blocking in itself can account for some of the symptomology in schizophrenia. Some features of the oral repressed block are exemplified in the oral *repressed* character, *e.g.* (1): "He is quiet, laconic, and speaks with an unusually low voice . . . (this last may be the result of the associated cervical block); . . . [He] easily retreats into his shell of inaccessibility"; and "He is very sensitive and easily slighted."

In my clinical experience, there are a small minority of schizophrenic patients who exhibit, besides their primary schizophrenic symptoms, those symptoms that can only be attributed to an oral *unsatisfied,* in

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contrast to the more usual oral *repressed,* block. The more prominent of these include garrulousness, energetic behavior (liveliness) and above average interest in eating, drinking, and/or smoking. At times, depression dominates the picture. The pattern has been recognized in classical psychiatry and given the name schizo-affective schizophrenia.

The Diagnostic and Statistical Manual of the American Psychiatric Association defines schizo-affective type schizophrenia as follows: "This category is for patients showing a mixture of schizophrenic symptoms and pronounced elation or depression. . . ."

Schizo-affective schizophrenia can thus be viewed, orgonomically speaking, as schizophrenia with a significant oral *unsatisfied* block instead of the usual oral repression. There are pitfalls in making the diagnosis. It must be differentiated from manic-depressive illness where the manic depressive has a significant ocular block. I can envision cases where this might be extremely difficult. This differentiation is not only of academic significance but is practical as well, since the untreated manic-depressive usually has a better prognosis than the untreated schizo-affective. The main differentiating feature is usually the more profound ocular disturbance in the schizophrenic, with confusion a prominent aspect. Also, the schizophrenic shows more disorganization and less accomplishment. The manic depressive usually has accomplished more, is better integrated, and often complains about his moods.

The following two cases are examples of schizophrenia with significant oral unsatisfied blocking (schizo-affective schizophrenia).

Patient B is a 35-year-old, married, Irish Catholic male, who came to therapy with the chief complaint of being "out of it" and confused. He was one of three children born to a lower middle class family where there was an inordinate neglect of the children. "My parents just didn't care for us," he explained. "They would go away for periods of time and leave us with neighbors or relatives." He remembers that as a child he was in a "complete daze" at school. He neither understood the work nor what was expected of him. He eventually dropped out and learned some elementary carpentry, at which he intermittently eked out a living. His adult life was chaotic. He became a drug addict and an alcoholic, drifting for a time in a skid-row environment. At times, he would feel so "cut off" that he would find himself engaged in something somewhere without quite knowing how he got there. He eventually married an extremely dependent, limited woman, who catered to him and created some stability in his life. With her help, he started a modest neighborhood carpentry business. At this point, he sought therapy.

B is garrulous, lively, and giddy to the point of hypomania. There is

a euphoric optimism about him, but it is easily shattered, and depression ensues. Because of his liveliness and talkativeness, B can relate well superficially in his interactions with people, but underneath he feels lonely, shy, and completely cut off. Except for some concrete thinking at times, his mental status is otherwise within normal limits.

Biophysically, B is a good-looking, tall, blonde man of mesomorphic proportions. His eyes are open, but glazed and dull, with a hint of fright. He is heavily and uniformly armored in his other segments. Though he does present some compulsive traits, they are overshadowed by the manifestations of oral unsatisfaction.

I have seen this patient for 98 sessions, and work has been primarily on the ocular segment. He is asked to move his eyes and to try to express feeling with them. At times, I ask him to follow my finger and focus his eyes. He feels nothing with his eyes, his predominant feeling being a generalized detachment. He often makes small talk with inappropriate jocularity. In spite of this, he claims he feels nothing about me or the therapeutic process. On a few rare, momentary occasions, he has expressed genuine emotion; otherwise, the outward indifference and detachment persist. At times, I have told him to shout, in an attempt to elicit anger. This results in spasms of the throat and chest. Kicking has no effect. The ocular segment has recalcitrantly resisted any loosening to date, and the prognosis remains guarded in this difficult case.

Patient A is a 30-year-old, white, Jewish housewife with three children, who had married directly after her high school graduation. She was the younger of two children born to a fairly well-to-do family living in suburban southern California. Her brother was ten years her senior, and she felt that effectively, she was an only child, as he was totally outside of her life.

The patient feels that her parents ignored her. Her mother spent much of her time shopping, leaving A in the custody of various maids who cared nothing for her. The father, a driven, withdrawn, morose individual, spent most of this time in business pursuits. A felt extremely lonely at home. In school, she was well liked, as she was lively and winsome. She had difficulty in learning, because of confusion. She had a strong interest in boys and had her first intercourse at the age of 16.

This patient initially presented herself for therapy with the chief complaints of anxiety and confusion. A thought disorder was immediately apparent. A's complaints were presented in such an extremely convoluted and circumstantial manner as to defy all attempts to follow her logically. Probing would produce more tangential talk, within an extremely intellectual framework. She complained that there "is some-

thing missing" from her marriage and that she has vague "stirrings" she cannot identify—feelings that she feels "cut off" from. She related that, as an adolescent, she "couldn't communicate" or integrate her thoughts; she would go off on tangents and get lost. The patient was extremely talkative, with a lively affect—almost hypomanic—and very energetic. She said she smoked and was interested in good food. She also reported mood swings, cyclical in nature; the rest of the mental status was within normal limits.

Biophysical examination revealed a slender, well developed woman of average height. Her eyes were fairly open but lacked much expression. She was unable to move them fully and often felt as if there were "fuzz" in front of them.

I have seen A for 18 sessions. Therapeutic work has focused exclusively on the ocular segment, with ancillary use of a penlight to facilitate movement of the eyes. A has difficulty in following the light. Often there is anticipatory rather than following movement. She frequently stares. Occasionally, she has even momentarily fallen asleep. There have been moments when she has felt some feeling in her eyes—particularly longing and sadness. But mostly there has been a heightened awarenes of how out of contact she is, which, paradoxically, may indicate more contact. Transferentially, she feels positive feelings for me. Therapy continues with the initial and most important goal—that of releasing the main block, the ocular segment.

Summary

Orgonomic nosology has originally differentiated four subtypes of schizophrenia, all of which are determined by a repressed block at one or another libidinal level. In addition, I should like to propose another sub-type of schizophrenia based on an *unsatisfied,* rather than a *repressed* block, at the oral libidinal level. In this type of schizophrenia, in addition to the primary ocular blocking, there appears an oral unsatisfied block as the second major symptom-producing block. These cases would correspond to the schizo-affective category of classical psychiatry and may be differentiated from the ocularly blocked manic depressive by criteria presented above.

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