

The Significance and Treatment of Anxiety in Orgone Therapy: Presentation of a Case

Vittorio Nicola, M.D.

An armored organism defends itself from anxiety in ways that are determined by its character structure and the pattern of its muscular armor. These defensive reactions sometimes prove inadequate, and the individual may experience the unpleasant feeling of anxiety and its physical manifestations of motor restlessness, gastrointestinal sensations, tightness in the chest, dry mouth, etc. If the symptoms are severe enough psychiatric consultation may be sought.

In contradistinction to other forms of treatment medical orgone therapy does not attempt to eliminate anxiety with medication, analyze its origins, or “strengthen the ego.” Rather, the medical orgonomist facilitates, in session, the expression and discharge of those emotions, conscious or otherwise, which press for release. In this manner rapid relief of symptomatology is often possible. The medical orgonomist also encourages the patient to tolerate the anxiety which inevitably emerges with the dissolution of each layer of muscular or characterological armor. As a matter of course the organism tries to defend itself against these sensations and does so with all the means at its disposal (psychic and somatic defenses). The success of the therapy depends on the outcome of the constant struggle between the patient’s inclination to restore his neurotic equilibrium (armor) and the strength of his desire for health. The nature of this relationship varies greatly from one person to another, but the most significant factor is the “cloth” someone is made of. That is, how determined is he to fight for his life? Also of crucial importance is the ability of the therapist to introduce therapeutic interventions in a sensitive timely manner, to maintain emotional

contact with the patient, to appreciate how much anxiety the patient is able to tolerate, and to know when somatic or characterological work is required. This is only possible if the therapist comprehends the structure of the patient. This, in turn, requires a correct characterological diagnosis. These important aspects of medical orgone therapy are illustrated in the following case presentation.

Case Presentation

M, a 30-year-old single Catholic resident in obstetrics and gynecology presented for therapy with a chief complaint of severe bulimia or daily episodes of binge-eating followed by provoked vomiting. She also consumed alcohol and tranquilizers (benzodiazepines) in large quantities and was taking a tricyclic antidepressant to combat her feelings of desperation and hopelessness. Her emotional state caused extreme limitations in her professional and social life.

The bulimia began when M was 16 years old. Feeling that she was obese, she then weighed 121 pounds and was 5'4" tall, she began a weight loss diet. The discovery that she was able to vomit when she had barely eaten gave her a gratifying feeling of having control over her weight. In a short time, the situation was out of control as the bulimic behavior gained the upper hand in her life. At the age of twenty, timid and uncomfortable in the presence of others, she began using alcohol and tranquilizers as a "strategy" to deal with anxiety-causing situations such as parties or dates with men. However, as time went on, her capacity to tolerate anxiety decreased still further until she was drinking and taking pills even when faced with the usual tasks of everyday life.

Despite this situation M graduated from medical school and began her residency in obstetrics and gynecology. With the evident worsening of her overall functioning, her productivity during her residency was very low. She barely passed the first-year exams, initially failed the second-year exams, but subsequently passed them with a minimal grade at the end of her third year of residency. Her personal life was always "chaotic" and punctuated

by numerous unsatisfying relationships. Medical history, past and present, was non-contributory.

Childhood history revealed parental abandonment with profound emotional deprivation starting a little after M's birth until she was two years of age. Shortly after giving birth to M, her mother's time and attention was focused on helping a psychotic brother as well as her own gravely ill mother, while M's father was consumed with his professional career. M said, "He noticed that I existed when I was three years old." From then on, perhaps to compensate for their absence during the first years of her life, both parents assumed an attitude of overprotectiveness toward M, present to this day. Her father, however, was only able to express tenderness and understanding when M appeared infantile, was unable to take responsibility for herself, or when she was ill. He also tried to sabotage her attempts at independence by undermining her confidence as a person and as a physician with sarcastic comments, or more profoundly sadistic, by responding to her with total emotional detachment.

About one year ago the patient started psychoanalytic psychotherapy which she stopped after four months. A careful discussion with M revealed that the classically trained psychiatrist was triggering intense, emotionally intolerable, aggressive reactions with his attitudes and with his premature psychoanalytic interpretations. She felt increasingly frustrated, and her symptoms remained unchanged.

On initial presentation, M was thin, about 5'4" tall, had long brown hair, and was well groomed. Her big brown eyes looked like those of an abandoned puppy, and with her forehead said, "Someone please take care of me." Evident behind her abandoned puppy expression was a seductive attitude which manifested as a theatrical exhibition of her suffering and self-pity. She talked in a whining voice. Her gait was that of someone who, while not intoxicated, was unsteady on their feet.

Biophysical examination showed light armoring throughout with more serious armoring of the ocular and oral segments. Her eyes had a hazy expression and often appeared absent, blank, or

“off.” The masseter muscles were hypertrophic, the jaw was held, and her tendency was to barely open her mouth when speaking. Her pelvic segment was armored.

Despite her thin body habitus, unusual for this character type, my initial diagnosis was of an oral unsatisfied hysteric. This was supported by the history of the illness, the clinical symptoms, and the character defenses. The diagnosis of ocular repressed character (schizophrenia) was also considered. However, the absence of the central aspect and other features of this character type¹ allowed me to exclude this diagnosis.

Course of Therapy

Initial treatment focused on her character attitudes. Attention was drawn to her acting like an abandoned puppy, her self-pity, the theatrical display of her misery, and her attitude of extreme “goodness”. Biophysical work focused on the first (ocular) segment. For several sessions she was asked to track the penlight. The poor-little-abandoned-puppy expression on her forehead was consistently pointed out to her. Mimicking these defensive attitudes triggered spontaneous laughter with the comment, “Don’t make me laugh, Doctor. I am suffering a lot.” Occasionally she reacted with frustrated anger. After some time, this reaction changed into intense explosions of genuine rage. Concomitantly, her cooperation was secured in stopping the use of alcohol and medications, and in controlling her bulimia. Only in this way could she learn to tolerate the anxiety that her substance abuse and bulimia were covering up.

Slowly, the patient showed significant changes. At the present time, after about sixty sessions, the abandoned puppy attitude appears only rarely, as does her theatricality. Her eyes are also brighter, her gaze more assertive, and her gait is more self-confident. As for her self-pity, as soon as it is pointed out, she reacts with explosive rage accompanied by an intense urge to bite that she discharges by biting

¹Reich identifies ocular splitting as the central feature of schizophrenia. This permits acute sensation, but its perception is “split off” and distorted. A soft chest, absence of observable breathing, a rigid throat block, and a diffuse energy field are other features.

on a towel. In the beginning this rage was unfocused, but it is now expressed more directly toward her father.

It has also been several months since M has stopped drinking alcohol and using tranquilizers. There are episodes of bulimia, about two per month, and they are always related to conflicts with her parents. Her working capacity has improved, and she now undertakes more responsibility. Her social life has improved, and she is dating a boyfriend who is well-liked by her parents. At the same time problems remain. For example, her aggressive attitude, initially covered over by self-pity and submissiveness, is becoming a defense against deeper feelings of despair and abandonment. These feelings are related to early childhood experiences. She protects herself from them with an attitude of defiance and spite, especially evident during the sessions. However, the correct diagnosis, the deep understanding of her characterological structure, and her sincere desire for health allow a prediction of positive results in support of the long and strenuous work ahead.

Conclusion

A central feature of a successful orgone therapy is the ability of the patient to tolerate the anxiety which inevitably arises in the course of treatment. In the case presented, the patient's pattern of armoring, specifically the presence and adequacy of her pelvic armoring, allowed for resolution of the pre-genital conflicts contained in the holding of the upper segments without the risk of early emergence of genital sensations and accompanying anxiety.