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A Case of Homosexual Panic

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This case is being presented for two reasons. The first is that it is an example of a successful treatment that lends itself well to illustrating how psychiatric orgone therapy, by eliminating blocks to the free, natural movement of energy within the organism, is able to bring about reexpansion in a contracted individual. The case shows how symptoms, such as panic decompensation, were relieved, and how the gradual induction of characterological modification enabled the individual to continue emotional growth and maturation. The second reason for this presentation is that, from the outset, the case has been an intriguing diagnostic challenge. The case will be discussed first, and the problem of the differential diagnosis will be taken up at the conclusion.

Anamnesis

P., a 24-year-old single Jewish male, came for therapy because of mounting anxiety, confusion, and physical tension. He was becoming increasingly frightened and ashamed of his homosexual feelings and frantic from trying to please everyone he knew. Tightness and pressure in his head, and tension in his neck, shoulders, and back, were becoming unbearable. At times he feared he might "go crazy."

P.'s greatest confusion was about his sexuality. Although he had always regarded himself as heterosexual, and wanted to be, he was terribly disturbed by having sexual fantasies involving men as well as women. At times his preoccupation with "nude men of a strong and virile type" amounted to an obsession. Mostly the fantasies were of pleasing and serving these men. At times, he felt sexual excitation in the presence of male coworkers or friends and feared he might act out on these feelings, but he never had. He had heard the term *latent homosexuality* applied to people who had homosexual feelings and fantasies, but did not function as homosexuals. This term frightened

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him. Did it mean that he really was a homosexual and the homosexuality was becoming overt? Although he had always had a strong revulsion toward homosexuality, which accounted for his tremendous shame and embarrassment, he was starting to wonder if he should try to become homosexual or bisexual.

P. stated that for a long time he had felt cut off from people and was "just going through the motions, not knowing how to act." He was able to form relationships, but, dreading closeness, had to keep them superficial. He had "muddled through" college (actually doing very well) by turning off all his emotions, feeling miserable, and wishing for some kind of help, but he was too frightened and embarrassed to obtain it.

P. was the youngest of four children, with three older sisters. The family, educated and middle class, lacked love and warmth. P. was a precocious and bright child. His mother was overprotective, and P. said he had always sensed that her oversolicitous clinging and hovering compensated for her real inability to love. His father was overly critical and disapproving of him. When P. was a teenager, his father made known his strong disappointment in not having the athlete he wanted in a son, at the same time minimizing P.'s intelligence and ridiculing his strong interest in music, art, the theatre, and politics. P. tried desperately to get along with his father. But as he entered high school, his father became more outspoken in his demeaning remarks, frequently calling him a "sissy." P. was very jealous of his father's affection for one of his friends who was athletic. When all attempts at gaining acceptance had failed, P. fought back. He and his father argued constantly. P. often wished that his mother would step in, but to no avail. She would never say anything against P.'s father. Her only way of trying to compensate him was by "babying" him even more. Although it was a rather rigid and distant family, there had never been a history of major emotional illness in any of its members.

P. said that he had been a basically happy child, who, although individualistic and selective, had the ability to make and keep friends. After puberty, he found himself becoming anxious in the presence of girls, a source of great frustration to him. He wanted strongly to be sexual with them, but could not stop worrying about what they thought of him. The problem also persisted into his adult years, although to a lesser degree.

About the time of P.'s graduation from high school, his father, then in his early 50s, became ill with cancer and succumbed within a year. As the illness became terminal, with progressive weakness

and incapacitation, P. and the other family members witnessed a side of their father's personality they had never been permitted to know. Unable to sustain his defenses in the face of his failing energy, his prideful, stubborn, and critical nature gave way to a "softness and mellowness," a very striking contrast. He became more pleasant, more "human," and easier to understand and relate to. He was actually able to reciprocate some warm and tender feelings. But the depressed and "pathetic" side of him was also revealed, which was less pleasant, evoking feelings of sadness and remorse in P. and the other family members. Seeing his father fail, while experiencing an intense mixture of anger, resentment, joy, sorrow, and guilt, made the last few months of his father's life a period of extreme anguish for P.

Masturbation had begun at the age of 12 or 13, with the above mentioned bisexual tendency in his fantasies present from the outset. At age 13 or 14, P. a few times engaged in mutual masturbation with other boys. This activity lasted for a few months and was easily given up, but it has continued to cause a great deal of worry and guilt. P. first began having intercourse in his early college years. Aside from his difficulty in initially approaching girls, P. said there were no problems in his actual sexual functioning.

There had never been any serious medical problems in P.'s life, the only problem of any concern had been a tendency to a "lazy" right eye when he was younger. An operation for this condition was considered when P. was about 10, but never done, because the condition began to improve, possibly as a result of eye exercises that were recommended. P. had always believed that there was a strong emotional factor in his eye problem: that it represented a going out of contact, losing visual focus, at times when he was nervous or upset. In adolescence, he became myopic and needed glasses, but had no other eye problems.

Biophysical Examination

P. was a very pleasant, intelligent, and serious young man, with some tendency to be reserved and proper. He was obviously very troubled by his symptoms and very eager for help. He had read some writings of Reich and other orgonomists and had a good degree of understanding. He was well-built, nice looking, and had a healthy appearance. In the initial biophysical examination, P. proved to be in basically good contact, very cooperative, and somewhat overattentive to my directives. He breathed well, with a full natural sounding sigh, a spontaneous falling forward of the shoulders, and slight for-

ward motion of the pelvis at the end of expiration. His eyes appeared clear and in good contact. He was able to move them well, to focus on and track my moving finger, and to express basic emotions through them, such as fear, sadness, and rage. The pupils were slightly dilated, an indication of anxiety.

After breathing for a short time, he became aware of a tight feeling in his forehead. He said it expressed a "cautious alertness," a feeling he said had played all too great a role in his life. His musculature was well developed throughout with a moderate amount of armoring present in the occiput, the muscles of the neck, the shoulders, the back, and the legs. The chest and diaphragmatic segments were not seriously armored. The abdomen was soft. The pelvis was not fixated; it could be moved against a moderate resistance, appearing to be held mostly by the legs.

I asked P. to yell, to hit the couch, and to kick, and was struck by the tremendous force employed by this outwardly rather mild-mannered individual. Kicking, in particular, was continued for several minutes without stopping; it was an expression of unrestrained fury. Afterward, P. said he had felt anger toward his father. He felt very relieved at the end of that session. His forehead in particular felt freer and his eyes more open and "looser deep inside." P. said that he had never been aware of any tightness or discomfort of any kind in his eyes before this first therapy session.

I had several first impressions. An inescapable one was that there was indeed a great deal of life in this young man. Another was that, despite his problem, from which he suffered greatly, he basically had a good degree of contact with himself. Despite his complaint of confusion, I felt strongly that he was a rather intact person. Muscular armoring was present only to a moderate degree. His energy level was obviously good. He had a strong motivation to get well and an eagerness to be helped. His basic solidity, his motivation, and his natural grasp of the therapeutic process made him seem to me a very good candidate for treatment.

Course of Therapy

The early sessions proceeded smoothly and productively, paralleling the pattern seen in the initial examination. Breathing would lead after a time to a pronounced feeling of anxiety or anger, which P. was usually able to identify and then express. When indicated, I worked manually on the points of muscular armoring in his occiput, neck, or back, to help crystallize and release whatever emotion was starting to take form. Usually this was when I sensed that armoring

was holding back the full expression of an emotion. Occasionally, the patient was able to direct my attention to an area of tightness which I was then able to release, allowing the fuller expression to take place. The expression of anxiety was also aided by having the patient focus on my finger or look at me and scream while showing a frightened expression in his eyes. The expression of anger was also facilitated by having him get up on his knees and punch the couch or stand on the floor, slamming the couch with a plastic whiffle-bat. The punching, pounding, and slamming released muscular holding of the arms, shoulders, and back, often obviating the need to work on the muscles directly. Because the amount of muscular armoring in the patient was moderate, these techniques were used to a limited degree and largely confined to a number of sessions at the beginning of treatment. Once a general "loosening up" had been achieved in the initial stage, breathing alone provided sufficient impulse to the therapeutic process. It was as if "the pump had been primed." I did feel that P.'s expressions were often somewhat overdramatized, out of a need to please me. However, he appeared to release considerable tension and did feel quite well at the end of the sessions, so I chose not to interpret the resistance aspect (his conciliatory attitude) at this stage, and the dramatic quality lessened of its own accord.

P. began to report a decrease in his anxiety and confusion and a conviction that his held-back anger (directed mainly at his father and a few other authority figures) was his most immediate problem. He now felt stronger contact with his rage and a desire to "get it out." As the process of opening up affect and releasing it was proceeding spontaneously (i.e., without resistance at this point), very little active intervention on my part was necessary. My role was to "let it happen." My basic interest in the process and the permission implied by my presence were sufficient catalysts at this time.

After a time, however, certain aspects of the transference came conspicuously to the fore, necessitating my greater activity, in exploring, encouraging, and clarifying the resistance. P. began to express distrust of me for a variety of reasons. I encouraged the airing of his latent hostility toward me. He said that I was too "reserved," too "Freudian," "not directive enough." I lived in a large house and must be rich and therefore "must be more interested in money than in helping my patients," etc. As he continued to express his negative thoughts in session after session, the feeling of anger toward me developed and gradually became intense. In one session, P. told me he felt like punching me. I had him hit the couch, which he did for a long time with tremendous vigor, again, typically, experiencing

great relief. A few sessions later, he told me of a dream in which I was scolding him for not being honest. It sounded like he felt less afraid of me, but had still more things to tell me and was unable to do so. Again, I encouraged him not to hide his feelings, but to continue to tell me all his doubts about me. P. obviously was relieved and grateful; he thanked me for my concern and my willingness to accept him and tolerate him as he was. In the following session, he was able to tell me that he had had homosexual fantasies about me. He had begun to believe that I thought he was a homosexual, but then had come to realize that I did not categorize him in this way. His ability to recognize his own transference distortions and to communicate them to me were extremely therapeutic. It marked a turning point in his therapy and in his life.

P. had a quick grasp of the therapeutic process, so that it required only little clarification on my part to help him realize that he was transferring to me at this time the fear, distrust, and anger he had experienced toward earlier figures in his life, chiefly, of course, his father. His understanding of this was aided by a dream he had in which he was hiding and trying to escape from a man who bore a resemblance to his father, the action taking place, however, in the neighborhood of my office. In addition to seeing, again, the parallel in his attitude toward his father and me, P.'s attention also became focused on his tendency to withdraw, to hide, and to run away from things he could not deal with. He was familiar with the defensive maneuver of "running away" in some of the case histories he had read and now experienced keenly the importance that it played in his own life. This proved another valuable insight for him.

P. was now reporting feeling more secure and less confused about his relationships with males. He was able to see them and understand his feelings about them more objectively. He was by now feeling less distrustful of me and began to feel that he had blamed his father too much. He realized that his father was not a "bad" man, but that he had simply not known how to relate to his son. He felt slightly sorry for him.

Later Phase of Therapy

Experiencing himself now, and less mistrustful and frightened of other people, he reported finding it easier to be truthful, and, if the occasion demanded, more self-assertive. He terminated a somewhat sticky relationship with a girlfriend, recognizing that he was constantly angered by a "bossy" quality she had. He now experienced

his hanging on to her as a kind of self-punishment. P. also reported that he was more in contact with his childhood feelings. For example, he remembered his mother catching him and a friend playing "peeing games." He remembered vividly her frozen, expressionless look, and her lack of any communication, which left him puzzled and terrified. He was scared to death that she would tell his father, and he slept very poorly for some time. He also remembered that his father had once actually called him a "homosexual," and he now was able to reexperience the devastating and bewildering impact his father's statement had had on him. His perceptions were becoming clearer, and less confused, and he was able to reestablish contact with the memory of the traumatic event. (Armoring contains the repressed emotion as well as the history of its own onset. Each time a new layer of armoring is eliminated, the previously repressed emotions can be reexperienced, and, in some cases, the memory of the actual traumatic event will return to full consciousness.) In this instance, it was his father calling him a "homosexual," an experience which undoubtedly had been too painful and disconcerting for him to tolerate.

P. now brought in a dream in which he was "kidnapped" by friends of his father and taken to a place where his father had often taken him as a child. His mother and sisters rescued him by paying the ransom. P. then felt sorry that they did, and was very sad that he could not stay there. This dream he understood immediately, saying that he had become much more aware of how dependent he had been on his mother, and also on his older sisters, and how his dependency crippled him. He recognized that it had been for the sake of his mother, who needed him. Now it occurred to him that all forms of dependency on his mother kept him from becoming fully a man. Thus, though now a graduate student, he obtained a part-time job so as to make himself financially independent of her. She was very upset by this, and it required some reassurance on P.'s part to persuade her that his action indicated only his desire to become independent and did not imply a rejection or abandonment of her. He was even able to tell his mother to "stop babying" him and let him "grow up." Completing his studies and making every effort to achieve a high professional competence so as to have a good income now became a more clearly defined goal.

In one treatment session during this period, a sense of being quite alone built up gradually as he was breathing and grew into severe anxiety. I encouraged him to give expression to his fear. He screamed several minutes with a chilling intensity, which gave no doubt of its reality. A great feeling of relief followed, accompanied with a few

gentle sobs, and then an awareness of warmth flowing through his body, especially through his abdomen and into his legs. P. said that the frightened feeling of being alone had started as he was telling me that he felt stronger and "more like an individual," and then kept intensifying as he breathed. He said that with my encouragement the anxiety had "come out easily," and that the anxiety was "the negative side of being independent." The exciting warmth he was now able to feel within him corresponded to the "positive side," which was the "optimism and excitement" he felt about his life. The anxiety, he said, was like an obstacle. It built up and became more disturbing, like a foreign body "that had to come out." When it did, he was able to feel his strength more fully. It had been a powerful, instructive, and inspiring session.

Being in the business world and working with more aggressive and competitive male coworkers and superiors was a new experience for P., and he was pleased with his newfound ability to do this. He had tended to "latch onto" and "hide behind" that kind of male. He despised his behavior around them, but had been powerless to stop it. Homosexual feelings did come up from time to time, but he understood them better and was no longer frightened by them. He never did have any desire to be a homosexual and realized that the presence of these feelings did not mean that he was one or would become one. He no longer felt that it was necessary to "do anything"; or that he would lose control and "do something." There were some dreams with homosexual overtones at this time. In one of them, P. was about to perform fellatio on one of the bosses in the office where he was now employed, a man who tended to be aloof and subtly demeaning. In the dream he first felt "like a servant," but the feeling changed; P. began to feel sorry for him. The idea of the fellatio started to disgust him, and he realized that "it wasn't necessary," and stopped. While telling me the dream, he realized that in the dream the man had also looked somewhat like his father.

Therapy sessions were now proceeding more smoothly, as was P.'s life on the outside. He was able to tolerate breathing for the full session. Some anxiety or anger occasionally came to the surface; it was easily recognized, expressed directly and verbally, and understood in perspective. The soft, natural movement of the shoulders and pelvis that accompanied breathing, which had tended to disappear during periods of internal tension, had returned and were even more pronounced. Often P. said he felt "like a baby," "softer and more natural" with pleasant currents flowing through his whole body and into his buttocks and legs, adding that he was feeling that way

not only on the couch but also in his life. He no longer had to be always "on guard," or conscious of having to prove himself. There was more fun and satisfaction, with less strain.

I made a note, summarizing the progress and accomplishments of therapy up to that point. The armoring of the ocular segment had been worked through. Complaints of tightness of the eyes, the forehead, and the scalp, and the bothersome confusion, which had been a strong presenting complaint, had not been present since the earliest phase of therapy. He had become able to freely express his anxiety and rage, and this had greatly relieved his internal tension. The moderate degree of muscular armoring he had, had been significantly reduced. As a result, his organism had come to function in a more unitary way, and he had become able to feel the energy movements throughout his body which built up as he breathed. In his own words, it was a "dramatic breakthrough of waves of energy throughout my body, which prior to therapy I had never felt in my life, or at least not in my memory." Also, and of special importance to P., he had learned the meaning of avoiding or "running away" from a problem or an unpleasant feeling, the unfavorable consequences that running had for his character, and he had largely overcome the tendency to do it. As a result, he felt more "real," more relaxed, and more secure. "It feels good to be me," as P. put it.

The emotional dilemma which developed during P.'s early twenties, seriously impairing his ability to function and threatening his whole future, had been stopped. The dilemma clearly represented a culmination of certain key factors, i.e., the expectations of full adulthood were impinging upon the characterological problems acquired in childhood. Although at this point in treatment, P.'s characterological problems had not been fully eliminated, they had been much reduced, allowing his development toward further independence and maturity. P. had been "opened up" again. Since that writing, marriage, fatherhood, and important professional advancement have followed in a natural way without the reappearance of old problems or the development of new ones.

I was surprised when suddenly, in one session, P. announced to me that he was seriously thinking of discontinuing therapy. He had been married for some time. His wife was expecting their first child, and they were buying a home. Although he was by now doing quite well professionally, a certain apprehension about the expenses which would very soon be upon him was understandable. He had done quite well in therapy and was grateful. He was clearly "out of the woods" and feeling secure and optimistic about his life. On the surface, at least, his intention of stopping appeared plausible. But I was struck

by the way in which his intentions were made known to me. He had always given me the impression that he had a strong commitment to getting well completely. He was a thoughtful, sensitive, and decent person, who always had, I felt, a good capacity to be open with me even when it was painful. Thus, it was out of character for P. to present his intentions to discontinue therapy in an ultimatum-like fashion. Since that earlier stage of therapy, where his negative transference was actively dealt with, P.'s characterological tendency to conceal the expression of distrust and anger behind a facade of being a "nice guy" and a "good patient" (and a successful case!) had been kept in sharp focus. Since that phase, no new resistance or negative attitude had become apparent. But I felt that P.'s wanting to stop now was nothing but a resistance to further expansion. I explained all this to P. I told him that his stopping would probably no longer be disastrous as it once might have been, but that, in my opinion, it would be very unfortunate. He would be letting himself down, cheating himself of the full benefit that he could get from therapy, and giving up the realization of his full potential, which was considerable. I said that, as far as I was concerned, this would be an irrational decision motivated by fear. His therapy had, on the whole, run smoothly, perhaps *too smoothly*, this now being the first time that his resistance had expressed itself so strongly. And I saw him again, typically, running away. I suggested that he keep the matter open for several sessions before making a decision. This he readily agreed to do.

At the next session, P. was much more insightful. He had thought about it a great deal. The things I had said seemed right to him. He realized that stopping would be unhealthy and wrong, and he would not stop. He became curious about what he was trying to run away from. He said that he was no longer afraid of me, but had come to like me and would have indeed missed seeing me. Even though he was feeling much more comfortable with male figures, including his father, he had not yet dealt with his feelings about his mother, and therefore, about women in general. "Maybe it's my feeling about women and sex that I'm running from." I told him that his thinking now sounded clearer to me and that continuing therapy would eventually reveal to us what he did not want to face. P. was still worried about money but said that he could afford to come every two weeks, which he has done since then. At this writing, approximately two years have elapsed. P.'s treatment is still in progress. His decision to stay in therapy proved a psychological boost for him, increasing his self-esteem. "I realize that I have a right to my health at all costs, and I don't have to abandon it."

P. tolerates breathing well for the greater part of the sessions. Spontaneous trembling of the legs at the point of complete expiration has been present for some time and is increasing. Sometimes the trembling begins to involve the pelvis, which is gradually becoming more mobile and "alive." The observation made in my initial biophysical examination—that the pelvis seemed held mainly by leg armoring—is borne out by the fact that as the leg armoring lets go, the pelvis is quite free to move. P. has a greater awareness of his pelvis as a distinct part of his body, with soft pleasurable feelings, which are also felt in his thighs and at times in the genital.

At the same time that he is feeling more "solid," P. also reports feeling "softer." He has less need to defend himself or "fight back" in the inevitable give and take of life. Anxiety or anger, when present, is better tolerated or can be expressed in a natural way without having to be hidden. He has much less tendency to be tense, ill-at-ease, or irritable, a fact which has been appreciated and communicated to him by others. He no longer feels crippled or inferior, but rather on a par with others, with whom he can now empathize more readily and deeply. During sessions, sad feelings, longing, and pleasurable excitement are experienced, whereas earlier in therapy, he was more apt to experience anxiety or anger. When the harder emotions of anxiety and rage have been released, the softer emotions of sadness, longing, love, etc., can be experienced and well tolerated.

P. is no longer intimidated by males, but feels closer to them and more empathic. Recently, P. reported a dream in which he was the parent carrying the child, his father, and feeling very tender toward him. P. recognized the tenderness as a feeling that could previously have only been felt as a homosexual feeling. It was a simple longing for closeness, distorted by the hard emotions of fear and hate, which were held in place by armoring. Homosexual feelings and fantasies are occasionally still present—at least in their formal content, but with very little emotional charge behind them; they no longer play any significant role in P.'s life. His sexual functioning has remained good; he reports a gradually increasing feeling of security and a deepening of sexual enjoyment.

Summary of Therapy

Because of the relatively moderate degree of muscular armoring in this patient, it has not been necessary to do as much direct physical work as in some cases. Consistent direct work on muscles was largely limited to the very earliest phase of treatment. The good degree of energetic expansion brought about by the patient's breathing during

the sessions and his ability to express his feelings when they arise have kept the therapy moving productively. Dealing with characterological problems, on the other hand, i.e., the use of *character analysis* in dealing with the patient's *character armor*, has been extremely important throughout treatment. Character analytic techniques included the interpretation and clarification of his negative transference reactions early in therapy and the direct interpretation of his resistance to therapy in the crisis about discontinuing. The "softer" aspects of psychotherapy, such as giving permission, sympathetic understanding, support, encouragement, etc., were, of course, utilized constantly. The character analytic work continues to be necessary even though therapy has been going well. For example, continuing vigilance with regard to negative reactions and manifestations of resistance is indicated even though tenderness has replaced fear and anger in P.'s dreams about his father. It is altogether possible that his new attitudes may still contain elements of repressed rage. To the degree that we can elicit the rage, further strengthening of his integration and functioning can be expected.

Differential Diagnosis

The first problem in diagnosis was the striking contrast presented by the fact that, although the patient's history and biophysical examination revealed a relatively strong and intact individual, he was nevertheless in a state of very severe distress when he first came for treatment. The other problem was a differential diagnostic one—a much more common dilemma. The patient presented features strongly suggestive of two different character types: schizophrenia and passive-feminine character. Since all patients present with mixed features, it is the task of the well-trained therapist in every case to keep all diagnostic possibilities in mind, while proceeding carefully and observantly with treatment, gradually amassing further data and ultimately arriving at the correct diagnosis.

Initially, and for some time, a diagnosis of passive-feminine character was entertained. Several clinical features pointed strongly to that disorder—an overprotective mother and a domineering, hypercritical father, his pronounced characterological tendency to fear strong males and ingratiate himself to them, his passive homosexual feelings and fantasies, and the biophysical findings of good breathing and moderate muscular armoring.

Yet, there were other features of the case which were at variance with that diagnosis. The patient had presented with panic, a severe degree of anxiety. He complained again and again of "confusion,"

even though he did not appear obviously confused. He felt as if he really did not know who he was; was he heterosexual or homosexual? Splitting, panic, and confusion were thus present, which, taken together, strongly suggest a schizophrenic process. His panic was over the fact that his defenses against homosexuality were failing: He felt threatened by the fear of succumbing to his own strongly rejected tendencies. It was thus a true homosexual panic. I felt that this would have been uncharacteristic of a passive-feminine, in whom one would rather expect the homosexual strivings to be more ego-syntonic or certainly not disowned with such vehemence. Severe, acute anxiety itself would seem unlikely in the passive-feminine due to his greater degree of armor. Another feature that would militate against the passive-feminine diagnosis and be more compatible with schizophrenia, was the patient's style of relating. Despite severe discomfort and his above-mentioned reserve, he was basically friendly. He was very honest, cooperative, eager for help, and seemed to possess a great deal of decency. They were the qualities that made him a very likable person from the first meeting, and that has not changed throughout the course of therapy. Features regularly encountered in the passive-feminine, such as truculence or obsequiousness, slyness, overt or covert hostility, abusiveness, contempt, and spite, have not been encountered, whereas the features that made him likable have steadily increased.

The biophysical examination, as well, was suggestive of schizophrenia. The moderate degree of muscular armoring coupled with some degree of initial pelvic reflex are biophysical features frequently seen in schizophrenic patients. P. almost immediately experienced "an opening" of his eyes and forehead, even though he had not been aware of any constriction in this area before therapy. (But, of course, a major presenting complaint had been "tightness and pressure in the head.")

Problems with the schizophrenic diagnosis were the patient's good breathing and the lack of an obvious throat block. As already noticed, this patient, despite his problems, appeared to be a basically strong and intact individual—a fact that in itself makes for some difficulty in diagnosing. (It is easier to diagnose more severely compromised patients than relatively healthy ones.) The patient's relatively open throat and good breathing must be adjudged from that perspective. Whatever his character type, he had simply not been that severely damaged.

Although so many features of the case suggested that this patient was a schizophrenic individual who was in the process of decompensation, I was still puzzled by the family configuration so typical of

the passive-feminine, but not especially typical of the families of schizophrenics. Accumulating data gradually permitted a critical reassessment of P.'s parents. P.'s mother was, upon closer inspection, a basically weak individual, very dependent upon her son, exploiting him for her own needs and support. P. had, in reality, not been coddled and overprotected, but leaned upon and used, forced to take care of a somewhat helpless and childlike mother. The effect of this type of mother-child relationship, much more typically seen in the history of schizophrenics, was a paralyzing one. The child, P., ever mindful of the needs of his mother, prevented from the expression of angry, aggressive, and rebellious feelings, burdened with guilt, needing to be ever on guard, proper, "good," etc., was actually deprived of the opportunity of being a child. Genuine contact was lacking.

Reexamination of the personality of P.'s father also led to a picture quite different from that originally presented. P.'s father became ill with cancer to which he succumbed at a relatively early age. This fact alone, without additional information, suggests that he was a basically weak, resigned figure, making it likely that his domineering and critical tendencies were a narcissistic compensation—an expression of his facade. In reality, he was an insecure, highly conflicted man with very poor self-esteem. When he became seriously ill, "mellowed," "depressed," and "pathetic," P. was permitted to experience directly, for the first time, the true essence of his father. Throughout his childhood, he had sensed a frustrated tenderness in his father and had tried to relate to him accordingly, but his father's inability to give expression to his softer feelings left P. unable to experience his own softness. Thus, P. did not have a father who was truly strong and domineering, but rather one who, like the mother, gave out confusing and frustrating messages. P.'s recent dream of tenderness toward his father, now the child, becomes completely understandable in this light. P. recently told me that he often saw his father as "desperate," "extremely stubborn," and, on occasion, "almost crazy."

The reevaluation of the personalities of both parents shed considerable light upon the diagnosis, and also permitted a clearer understanding of what had happened in his life that caused him to seek therapy. The family constellation which would have been conducive to the development of a passive-feminine male offspring was only an apparent one; upon scrutiny, the parents could no longer be seen as simply an overattentive, overprotective mother, or a tough, domineering father. Actually, both of them projected highly confusing images, a feature very common in the family histories of schizophrenics, making the diagnosis of schizophrenia the more likely one.

The ability to make this diagnosis made clear another important fact of the case. The panic—homosexual panic—with which P. presented was a manifestation of (schizophrenic) decompensation. P. felt that he was falling apart and was afraid that he would "go crazy." He was in the grip of something that was happening to him. He had not always been as anxious and confused as when he first presented for therapy, but had shown considerable stability in the past. Despite his problems, he had consistently done well. He was a good student in high school. In his last year of high school, he did active battle with his father. ("We fought like cats and dogs.") In college, even though he "muddled through by turning off all emotions," he nevertheless did quite well, finishing with a very good academic record. Thus, evaluating not exclusively from the presenting clinical picture, but also making use of the historical data to reconstruct a patient's premorbid personality, and establishing a comparison between the two, is frequently of inestimable value in making or confirming the diagnosis, as in this case.

Recognizing his obvious strength, his ability to keep plowing through, in spite of internal conflict and anxiety, provided further clarity as to the type of schizophrenia. The diagnosis of schizophrenia, passive-feminine type, was considered a possibility for a time, in addition to that of passive-feminine character. However, the patient had always seemed to me somewhat different, most important, *stronger*, than those cases of passive-feminine schizophrenia originally described by Konia. The "miserable," "helpless," and "pleading" qualities Konia described were definitely not present, nor did it appear that they had ever been in P.'s life. Nor was his homosexuality in any way ego-syntonic, but was strongly defended against. These differential-diagnostic considerations strongly suggest that the most accurate diagnosis is schizophrenia, catatonic type. This diagnosis fits well with all the facts of the case. It also explains P.'s very favorable response to treatment as well as the fortuitous course his life has taken since treatment was begun. According to E. F. Baker, the prognosis in schizophrenia is, generally speaking, the most favorable in the catatonic type, thanks to the greater amount of armoring present in these patients.

A further, noteworthy, aspect of this case, indicated by Baker, is the considerable degree of health present in a patient with a diagnosis of catatonic schizophrenia. However, even this category, according to Baker, can present with a broad spectrum of degrees of severity, ranging from relative intactness to extreme impairment. Our patient, then, exemplifies the healthier end of the spectrum, a fact further buttressed by the gratifying outcome of his therapy.

REFERENCES

1. Reich, W.: *Character Analysis*. New York: Orgone Institute Press, 1949.
2. Baker, E. F.: *Man in the Trap*. New York: Macmillan Co., 1967.
3. Arieti, S.: "The Psychodynamics of Schizophrenia," *The American Handbook of Psychiatry*, 468-475. New York: Basic Books, Inc., 1959.
4. Konia, C.: "A Case of Homosexuality," *Journal of Orgonomy*, 11:195-207, 1977.
5. Konia, C.: "The Passive-Feminine Schizophrenic," *Journal of Orgonomy*, 7:220-233, 1973.