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Treatment of A Catatonic Schizophrenic

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Reich describes three layers of the human neurotic ("armored") character structure: the social façade, the middle (secondary) layer which is made up of many subsidiary layers, and the healthy biologic core (1:xi-xii). Medical orgone therapy attempts to dissolve the armor in the first two layers until "the final core of unitary vegetative functioning is reached." (2:63) The goal is to relieve the chronic contractions (muscular spasms and defensive attitudes) which interfere with and block the free flow of energy in the organism. This restores the individual's natural functioning and results in the expression of "rational self-regulating protoplasmic movement and excitation." (2:61) In order to establish health the practicing orgonomist, in arriving at a diagnosis and conducting therapy, must distinguish the façade from the underlying secondary layer and core. The orgonomist must be able to perceive the layer from which expressed impulses originate.

The façade is the surface layer, the layer a person most readily presents to the world. The quality of the façade may be positive or negative, socially acceptable or unacceptable, likable or unlikable, but it "works" for the individual and allows sufficient interaction with the world for the individual's social survival. The appearance of the façade does not necessarily indicate much about the overall health of the individual. The "good," quiet kindergartner is seldom referred for evaluation, certainly less often than is the hyperactive or antagonistic child, even though the former may be suffering from more severe pathology, e.g., autism. Underneath the façade lie deeper secondary layer repressions and impulses, mostly of rage and fear. These neurotic impulses may be contained, held back, or facilitated in their expression by the façade. If one looks only at surface "adjustment" without seeing and appreciating its defensive function, underlying pathologic processes will not be recognized.

Severe pathology can exist in any character type.[1] However, the schizophrenic's disturbance is formed earliest and particularly affects the individual's ability to perceive. The primary armor is located at the base of the brain. Reich described this as the basis of the schizophrenic's split between excitation and perception (the disruption of unitary functioning) which leads to a lack of perspective, confusion, biophysical disorganization and, ultimately, in the worse case, to a deterioration in consciousness of psychotic proportion. Schizophrenia is a deep-seated disturbance. There is, however, a belief commonly held by the public and even some mental health practitioners that schizophrenia manifests only in dramatic, bizarre, highly visible symptoms and as a readily identifiable, incurable condition. This is not necessarily the case.[2]

The following paper describes the therapy of a catatonic schizophrenic[3] adolescent whose suffering and seriously compromised and disrupted functioning was concealed by a well-developed, normal appearing, socially acceptable façade. It chronicles his treatment as he moved into adulthood and illustrates a process of intervention at this developmental stage (the transition from adolescence).

Case Study

P was a fifteen-year-old high school sophomore who sought treatment on the recommendation and with the support of his mother. Presenting

[1] Degree of illness is not related to diagnosis. A severely ill hysteric (genital character) is much more impaired in functioning than a mildly ill schizophrenic (ocular character).

[2] The orgonomist frequently sees in consultation or for therapy schizophrenics who have previously been diagnosed by classically trained psychiatrists as cases of depression and/or obsessive-compulsive disorder. The orgonomic understanding of the energetic disturbance in schizophrenia provides a basis for accurate diagnosis and a method of treatment which can help reverse the pathological schizophrenic process and reestablish unitary functioning.

[3] Harman states, "The orgonomic criteria for the character diagnosis of schizophrenia differ from those used by other psychiatrists....The medical orgonomist...determines the patient's characterologic structure and distribution of significant muscular armoring."(3:73-74) Like Harman's patient, this patient did not manifest all of the symptoms listed for the diagnosis of schizophrenia in the current Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-4). He had no hallucinations or delusions. However, he exhibited the basic bioenergetic split between perception and excitation that causes the distortions in perception seen in schizophrenia.

complaints were vague, but one clear concern he and his mother shared was his academic performance. He said his poor, inconsistent grades depressed him, yet he waited until the week before an examination to study. P was involved in extracurricular activities and had friends. He had never had a girlfriend.

Early development as reported by his mother was generally unproblematic. Birth was natural with a prolonged last stage of labor. He was not breast-fed. He was a physically active infant, vigorously turning and twisting in his early weeks. He walked and talked by nine months of age. The family environment was stable though his mother was known to be intermittently overanxious, oblivious and/or demanding. His father's emotional expression was limited, but on occasion he was explosively hostile. He once kicked the boy. P was an only child with a large extended family. There had been no prior psychiatric or psychological treatment. He suffered from allergies, asthma, and scoliosis. His mother thought the latter could reflect emotional stress.

In appearance and manner P was polite, pleasant, cooperative, nice-looking, slightly clumsy, disorganized and likeable. After the initial consultation with his mother, in his first session by himself, P walked into the office without knocking, not in a rude but rather in an oblivious manner. He tripped and dropped his book bag and then placed his coat where I had to walk. He spoke in generalities of his life and was curious about the office and therapy.

In the second session, on the couch, P had a sprawling appearance and gave an impression of vagueness. He reported no sensations and said he felt nothing emotionally. His emotional flatness, physical paleness, lack of anxiety and little sign of excitation or tension indicated a low bioenergetic charge. Biophysical examination revealed severe armor in the first three segments. He was unable to visually follow a moving object; his eyes did not focus on my moving finger and wandered off although he made an effort to look at the object. He occasionally made fleeting, unfocused eye contact with me. There was an underlying earnestness. His mouth smiled in a friendly but contactless way. He could not make a frightened face. Breathing was minimal and chest movement was imperceptible. His legs and pelvis were "floppy" and somewhat restless, suggestive of less armor. In this second session P stated that he wished to come to therapy every other week.

He said that his breathing was "sort of labored lately" but this was the only problem he could think of. Later he added that he was bothered by a feeling of not wanting to do things he needed to do. Doubt was evident in the way he qualified his description of both of these experiences. Word usage was awkward and convoluted. He often expressed himself in the negative; that is, he said what he did not feel or did not want. His were cautious statements. Encouraging him to look about the room led to deeper breathing.

In the third session I directed P to move his eyes and look around. After doing this for several minutes he became dizzy and his legs felt uncomfortable. Having him kick stopped his dizziness, but he felt slightly nauseated. By the fourth session it was apparent that when P was on the couch, if I did not engage, talk to or direct him to do something, his attention wandered, his thinking and speech became vague, and on occasion his eyes rolled up into his head. He seemed far away. When I asked what was going on with him, he said he felt "tired." (This tiredness was a reflection of his low bioenergetic charge.) Again I mobilized his eyes[4] and had him kick; he felt less tired and was more focused. In these sessions we talked of P's interests and daily activities; this encouraged his self-observation and expression and built rapport.

Biophysical mobilization of P's ocular segment[5] continued over the next several sessions along with discussion of his functioning. P developed greater self-awareness and noted that he copied his peers' behavior in an attempt to fit in. This copying behavior, combined with his flat, contactless exterior, gave him a certain superficial, false portrayal of confidence and well-being; he, in fact, did not feel much at all. After his school year ended, he observed that he stayed in the

[4] As Baker describes, having a schizophrenic open their eyes "leads to panic from movement of energy and from a flood of sensations. The panic starts breathing."(2:146) Treatment of the schizophrenic is in part a matter of titrating energy increase, desensitizing the person to stimuli from the ocular segment and building tolerance to the organismic sensations; this promotes greater integration.

[5] Baker states, "This is the first segment and is concerned with all contact at a distance (except field reactions). It includes sight, hearing, and smell. Armoring consists of a contraction and immobilization of the greater part or all of the muscles around the eye, eyelids, forehead, and tear glands, as well as the deep muscles at the base of the occiput—involving even the brain itself. I believe that the brain...if adequately mobilized enables the rest of the organism to tolerate expansion and movement. Contraction seems largely in the vegetative centers."(2:48) The eyes "are an extension of the brain and our only means of mobilizing the brain."(2:52)

house most of the time and was "just vegetating." He said he "could not" read. He was becoming more aware of his difficulty sustaining integrated visual and cognitive focus. P began reporting dreams. He stated what his dreams "did not mean" and laughed nervously, indications of negativism and anxiety.

For several months P continued to report confusion and tiredness. I persistently mobilized his eyes. This sometimes led to an initial increase in his sense of confusion. With kicking, however, he experienced relief and felt clearer in his head. He reported two dreams. In one there were cave men, some of whom had guns; he had difficulty fighting them or moving with an oar, which was what he had. In a second dream he could not hit a ball. Asked if he had frustrations in his daily life, he said he was frustrated about "everything." He said his parents were fighting, yelling, bickering over unimportant things and he was disgusted by it. He was distressed about an upcoming competition. His complaints stood in contrast to his initial presentation when he reported almost no problems. P entered one session looking quite sluggish. He reported a dream of "half animal" people. They had his face. I told him to breathe fully and make some sound; he yelled and screamed with an angry, red face and afterwards looked and felt livelier.

After six months of therapy P was showing more feeling in response to situations, and at the sixteenth session he said with a laugh he had had a terrible weekend. He described frustration and defeat: he "got shot down" in an academic tournament, his sports team lost a game, and his hat was stolen off his head. Also, all day long he had the experience that things were happening that had been in his dreams, as if he were prescient. When he was on the couch I had him move his forehead, worked on his occiput and encouraged him to breathe deeply. His eyes closed and his breathing became so shallow as to be imperceptible. He looked as if he were sleeping. When asked where he went, he couldn't remember. We called these lapses his "mental holidays" to draw his attention to them. There was then much yawning. I encouraged him to stay with his sensations. He felt tingling in his arms and hands and a sense of aliveness in his body. His eyes looked brighter. This greater liveliness often developed in sessions and persisted for a while afterwards, though generally within

an hour or so he returned to his prior flatness and tiredness.

In sessions, attempting to visually follow a moving object, P's eyes sped ahead—he tended to think and anticipate what he thought was going to happen rather than look at what was before him. This paralleled his tendency to skip over his anxiety. However, when he was directed to look and focus his eyes and he actually did so, internal excitation occurred and he felt dizzy. Now with continued mobilization of his ocular segment, P's eyes slowed down from their quick anticipation and he was able to track and focus. As his eyes relaxed, his ocular segment opened and he was able to think more clearly. He started earning good grades in school. He was also elected to a school office.

P continued reporting dreams; they seemed to identify problems that he was not otherwise able to bring up. Dreams at this stage were used in therapy simply to return to daily experiences and any feelings he could discern. He dreamt that he jumped off a dock, someone grabbed him, he couldn't scream for help. He said he often dreamt that he couldn't scream or breathe. I asked P if he expressed himself in his daily life. He acknowledged difficulty and said that his common response to peers was, "I don't know." Also, though confused about material being discussed in his different classes, he didn't and couldn't ask questions. His statements, "I forget" and "I can't remember," and the attitudes contained therein reflected the biophysical reality of his severe ocular armor. (The difficulty he had expressing himself was also related to his throat block and fear of exposure.) With continued biophysical work on his ocular segment, his eyes and thought process became more mobile, breathing increased, his legs quivered, and his face became warm and showed good color.

Eight months into therapy P talked of sexuality; he expressed confusion and uncertainty because a girl made sexual overtures toward him. After some discussion he jokingly and sarcastically called his situation a "teenage crisis" and "stupid," dismissing his concerns and his feelings. When I then worked on his eyes and chest, he screamed out with a look of fear and felt he had released something.

Encouraged to voice negative feelings about the therapist, P, in the twenty-fourth session, said, "You're kind of commanding but it's no big thing." Dislike of control, growth in his capacity to verbalize fledgling

negative feelings, doubt and equivocation (saying something, then taking it back) were evidenced in his statements.

P reported a dream that his sports team was badly beaten in a game. He gave this association: he was feeling futile in his life—with school, girls and his future. He laughed in an anxious manner, indirectly objecting to the therapist's intrusion when I suggested he ask a girl out on a date.

In the twenty-seventh session P drifted off several times. Asked what was going on, he said that he had spent the previous evening necking and petting with a girlfriend; he spoke of fear of being discovered. He was less emotionally flat after discussing his anxiety. For several months his interest in and relationships with girls came to the fore. I acknowledged his fear and encouraged him in facing it. During this time P became more aware of his eyes; he noticed when they were not focusing and that he felt pain in looking at the lower corners.

In a subsequent session P spoke of cruelties he saw in a cousin, saying they were similar to those of his uncle and his father (thereby criticizing his cousin, uncle and father). No sooner did he say this, than he took it back. Talking of these family matters led P to acknowledge that he had borrowed his cousin's ski jacket, met some friends, neglected to bring the coat home, and now the coat was lost. P's need to go along with the plans of friends had kept him from being responsible. He feared asserting himself against the flow of external social activity. He needed to appear casual, like everyone else, not daring to do or say anything different. He complained in his tangential but accurate manner that this also made his conversations with people trivial.

A year after he was initially sent for therapy by his mother, P came to sessions on his own, was interested in treatment and looked forward to coming in. Therapy focused on his doubt and how he stopped himself from initiating or following through with things. P's mother complained that P was messy and not getting things done. P denied any disorder and complained that his mother thought he had things to do (that he was not doing) and had shown up at his friend's house, unannounced, to take him home. He saw this as unreasonable and was angry. He said he wanted to yell and break something. I told him to show on his face what he felt and to do (in the session) what he felt like doing. Much hitting, constricted (due to his throat block)

yelling and kicking followed. He then felt relaxed, "easier" in his chest and "connected." His previous look of removed indifference was gone.

Toward the end of his junior year, thirteen months after beginning therapy, P said that he was failing a subject. Though his concentration had improved, he was still having difficulty completing a report. It was also revealed that no accomplishment—not even all A's—would be enough for him. With great reluctance he acknowledged that he wanted prestige and to impress and be above others. He felt "down" because he wanted to win a writing contest but had not done the work necessary to enter. He had "nothing to write." I pointed out his self-negating attitudes and stringent, rigid expectations: "They defeat you even before you get started." I also pointed out that his attempts to look like everyone else limited his initiative and creativity. He said he thought he had to go to Harvard to "make it" and was torturing himself with this idea. Asking him where his heroes went to school made him laugh and gave him a broader perspective. P saw that hiding his lack of understanding made it hard to learn. His self-doubt blocked the success he wanted.

In the next session P was upset with feedback he had received from a teacher about how to improve a project he was working on. As he discussed this he experienced much tension in his shoulders, arms and legs; I asked him what impulse he felt was in the tension. This led to his vigorously kicking and hitting the couch. In his next session he reported this dream: he had a fight with his mother and hit her; he felt badly when he realized he had hurt her. In the session he expressed animosity regarding her intrusions and wanted to tell her to leave him alone. He screamed out and his face "opened" (the muscles simultaneously relaxed and became more mobile, and more feeling showed through). This led him to feel fear in his eyes and he remembered that it was difficult for him to look at people, especially men, as it felt too intimate and sexual.

P was becoming angrier in his daily life. He kicked a long-time friend during a game. The friend broke off their relationship, saying that P did not support him and was not doing his part in clubs they were in. P admitted some irresponsibility, was upset by what he felt to be false accusations, but let the friend go. His life now felt "strange" without this friend around. The event revealed how extensively P had

followed this friend, done more or less as he directed, and relied on the friend to provide structure and impetus for his life. On the couch P began to make squeezing motions with his hands; asked if there was anyone he would like to do this to, he replied, yes, his friend. This gave his squeezing, angry gestures more focus. After this aggressive expression P became frightened and felt alone or thought that he would be alone.

In subsequent sessions, pointing out the impersonal manner with which P spoke about his life led him to reveal more about his self-image, his concern with how others viewed him and his need to hide himself. He felt terribly awkward, embarrassed and anxious asking girls out; so much so that, whenever he did, he resolved never to do it again. Trying to make frightened faces to get at the fear behind his doubt, P squirmed as if wishing to get away from even thinking about the dreaded feeling.

P graduated from high school with excellent grades and was accepted to a prestigious college. He had had two years and two months of therapy, approximately fifty sessions. After graduation he continued therapy through the summer. He talked about his frustration and confusion over love and sex. Each time he did so, he reported tightness in his chest and such pain that discussion could not proceed. When I then briefly pressed on his chest, wheezing developed with a deeper awareness of his anxiety about these topics. (As he tolerated this anxiety his wheezing resolved and over time no longer appeared.)

Over the next four years sessions were infrequent and sporadic. Therapy basically helped P maintain or regain functioning he had recently attained; there was not the consistency nor frequency needed for much new progress to occur. Despite the infrequency of sessions, P took therapy seriously. At the end of his first year of college P said he felt "not quite real." He knew that he was "not being himself" at school and felt a "cloudiness" and constriction in his head. He tended to stare through or past people. The staring lessened his connection with people and the intensity of sensations he experienced when around others; this decreased his anxiety but heightened his ocular immobility. The increased stimulation of his new environment had likely stimulated this defensive reaction. Biophysical work with his face, eyes and occiput continued. Having him kick and make sound

resulted in grimaces, holding his breath and contracting his muscles against outward, visible movement, and then an explosion of more vigorous, aggressive expression. This resulted in a lessening of his catatonic withdrawal. He appeared more alive and related with awe[6] that his eyes were "open." He said they and he "had not been here" (he had been closed off and withdrawn). During this time, although he spoke of his social relations, he hedged and watered down his statements, unable to openly criticize others or state his frustrations. I pointed out that he stopped himself in speaking and that this took away from what he felt. He added that he spoke to his girlfriend out of obligation, saying what he thought he was supposed to say and not speaking directly to her for fear that she would think badly of him. He once felt he was exploiting her and did not want to feel like "a biological animal" or look like a typical "macho" male.

After graduating college P returned home. He had had no therapy for a year (and little for the prior three). His forehead, neck and occipital region were tight and sensitive to touch; he said his eyes were "trashed." He was uncertain and confused about his future. Vigorous biophysical work on his occiput, forehead and the muscles of his face led to more feeling and expression in his eyes.

Two weeks later P first said he was "okay," then acknowledged he was miserable. He hated feeling weak and ineffectual—he had no work and no plans for his life, yet felt he shouldn't be aggressive. He said he was raised to be "special" but also not to express himself in ways that would stand out. He quietly held all his misery inside. He felt "caught" and unable to move.[7] He said he wanted love but felt angry, and he saw everyone as fighting and so frightened, terrified or otherwise disturbed that they turned away from engaging. With biophysical work he let out much angry sound, protest and some tearless crying. He thought of his father's contempt for his mother and said that both sides (of the dyad) were in him.

P continued unemployed with no idea how he was going to support

[6] This may also happen with neurotics but catatonics often report a profoundly greater sense of clarity as their ocular armor is dissolved.

[7] Catatonic schizophrenics often behave as does a person sitting on a fence who can't get off either side. With intellectualism and doubt they have "reasons" why they can not and facts which reinforce why they must not proceed in either direction. Hence they are immobilized or "stuck."

himself. I focused on his uncertainty and his ambivalence. He was reluctant to ask for work because of his fear of presenting himself and being assertive, and he expressed acute and distressing ambivalence about a girlfriend. He voiced resentment and frustration regarding women, which generalized to include me and a feeling of not wanting to come to therapy. In a confused manner he seemed to be seeing himself and his relationships in a negative light. Thinking that others would see him negatively (a projection of his own hostility), he wanted to avoid the anticipated ill will and possible exposure of his own animosity (of which he was frightened). P saw that he reacted to his frustration as his mother would—by becoming scattered and confused, not keeping track of things and not tackling work. When his girlfriend broke off their relationship, he felt "not good enough." In therapy he talked of similarities between his mother and girlfriend, especially their intolerance of his anger. He then expressed intense anger toward his girlfriend and his family. Afterwards he felt "changed" and was amazed at how "different" (in a positive way) he felt.

For months in therapy P continued discharging frustration and examining what work he would like to do and what obstacles stood in his way. A year after graduation, feeling better but still unemployed, he moved with some friends to a city to find work. Returning several months later for a therapy appointment, he said he was having a difficult time. He was self-doubting, lonely, had no girlfriend, no job and no money. Biophysical pressure on his paraspinals and occiput led to expressions of anger and sobs of sadness. He then complained more clearly that his main problem in the city had been that he felt "dead," felt "nothing" in his body.

Several months later, all resources exhausted, P gave up on the city and returned to live in his parents' home. He was riddled by doubt and had fallen into a pattern of getting up late and not doing things he knew would help him get going. Encouraged to look at what he might like to do as a career, he considered the field of music but said he was not motivated or structured enough to work without a teacher. We focused on immediate employment, the first step toward independence, and his characterological objections. He said jobs were not easy to come by, he was afraid he would be "trapped" and found

the jobs that were available humiliating. I told him getting any job would help him get moving, feel better and do other things he wanted to do. He then came up with a number of extraneous things he needed to do first, including visiting relatives, and said, "I hate to put these things off." He laughed, and I with him, on hearing himself say this and his mood lightened.

P's explicit homework to "look for a job" led, by his next session, to his working in a no-pay training position with a promise of a less than minimum wage job. Discussing this situation led to his acknowledgement of a fear of the commitment he assumed a better job would require. He feared having to stay in a job that he did not like and feared being controlled and unable to do what he wanted. Biophysical work with his eyes, jaw and chest led to the release of much sound accompanied by movement (grunting, yelling, grimaces, bodily contortions, twisting of his torso, squeezing and hitting with his hands and kicking) and afterwards to a more vigorous sense of himself. With this came less fear of others' control.

P started working, became busy with other activities, felt better about his decisions and was not frantic about them as he had been in the past. He felt that they were not something imposed on him and he was able to feel some pride in his accomplishments. We continued to discuss what stood in the way of long-term career plans. He said that nobody would be interested in him and he thought he had to prepare a full repertoire in order to apply to music schools. These expectations overwhelmed and immobilized him and kept him from facing his fear of presenting himself.

P began a subsequent therapy session with a long, philosophical soliloquy regarding possibilities he saw for himself and their unimportance. I told him his speech would get an "A" for its excellent quality (it was interesting and well delivered) but was still an expression of doubt and a camouflaged way to stop his life. He laughed in good humor and self-recognition. He used the phrase "there's no point" several times. I had by now realized that P spoke in an abstract, tangential way when there was something quite specific bothering him. Intuiting that there was a girl he was interested in, I asked who she was, and, in keeping with his philosophical bent, said that if there was an antithesis ("no point"), there must be a thesis ("point"). He

laughed. It turned out he had met someone, wanted to ask her out, but stopped himself, saying, "There's no point." With biophysical work he expressed angry yelling, arching his back and twisting his torso. He looked as if he were fighting for his life and said he felt like he was in jail in his own body.

P decided he wanted to study music, but he procrastinated and had not submitted the necessary applications. He completed one task then told himself, "Well, now you can watch TV," and "numbed out." He said his family chose activities that helped them to be vague in their thinking and passive in their behavior (like watching TV). He said he took lessons from them in how to not take life seriously and not respond in an excited, assertive way. Biophysical work led to graphic expressions and discharge of emotional ambivalence: first anger, then pulling back, holding in, twisting and turning, then pushing his arms and legs out violently and expressing anger again. So intense was his struggle, he looked as if he were fighting against visible restraints.

Over the next several weeks P became more aware of the degree to which procrastination stopped his pleasure and prevented him from moving toward what he wanted. He saw a similarity with his mother. He felt how much he held back and said it seemed it was "just him" almost as if he had no choice. He was in better contact with himself.

Several weeks later P noted that his eyes were unfocused and that he was feeling vague frustration. Asked at whom, he said at himself. He said it would really be frightening if he got as angry toward others as he did with himself. I pointed out that by turning anger against himself he avoided anxiety. He then spoke of his frustration with his family and their fighting and hitting each other; he felt embarrassment and shame. As his negative feelings came out, his eyes lost their diffuse quality. In the next session his self-negativity decreased further as he expressed more frustration with his family's situation. One problem now seemed to be his living in his parents' home. He was separating more from them, but at home he blunted his emotional reactions and returned to his quieter, superficial, "what-me-worry" manner. He was supportive of his mother and cheered her up, but by putting his needs aside and avoiding confrontation he promoted his

own emotional disconnection and hiding.

It was now possible to focus on his negative feelings toward the therapist. When asked what he didn't like about therapy or me, P after some protest said that he didn't know me and that I didn't understand how he felt. That I even asked what he didn't like showed my lack of understanding. He wondered what the goal of therapy was. After brief discussion he said that he wished to be more confident. He then stated he was "wary" of using the word "goal." His statements reflected his anxiety about the apparent self-directedness of therapy and the challenge to his passivity. This interaction and expression of negativity seemed to mark another transition in the transference from where he started (something that his mother had set up and something to which he passively related). He was facing the anxiety of stating his own opinions. His face and eyes had by now become more mobile and he looked directly at me, but his chest was tight and he looked frozen with anxiety as he spoke of these things.

Observing that he was not able to simultaneously tolerate the intensity of feeling that being close to others aroused and stay in contact with his own perceptions and emotions, I had P look at me while making some sound. I encouraged him to make any sound including yelling but only to the point that his eyes could stay focused. He felt fear. He was afraid that he would lose himself, be manipulated, be told what to do. In subsequent sessions, as I continued to work with his emotional hiding and fear of looking and talking to others, P realized that rather than relating directly to others, he "strategized" with people—he planned ahead of time what he would say and how he should behave with others, partly to avoid conflict. He wished to be able to say, "Here I am. If you don't like it, good-bye." With biophysical work P twisted and turned; his back and forth body movements, contortions and writhings seemed to express ambivalence and an agonized "No."

Over the next several months P took more initiative and found enjoyment in attending to practical matters of daily living. He was positive in attitude and enjoyed what he described as the "nothing extraordinary" contact with himself. During his sessions he was biophysically more able to let go. Between sessions he could feel that his head "tightened up." In therapy he expressed muffled then angry

sounds; he would alternately yell out and then clench his jaw which cut off vocal expression. Pressure on his masseters and directing his attention to this clenching allowed him to relax these muscles and to continue to discharge anger. Aware of his timidity, he feared being cut off from life.

Though feeling better, P struggled. He questioned himself, "What is the point? What am I trying to do?" He knew he turned away from really looking at or feeling things. Also he did not notice or did not give himself credit for small successes. His doubt came up in convoluted ways. For example, he felt guilty for "not feeling attracted to" a coworker who made sexual advances toward him. His questioning of himself seemed to allow him to be easily manipulated, at least on a superficial level. After biophysical intervention and more expression of his negativity, P was more aware of his feelings and said he had never said "no" forcefully and directly in his life.

P made more realistic, preparatory plans for a career in music. He decided to go to a university for a degree in this field. He had a new girlfriend and felt serious about their relationship. But he also felt uneasy and anxious about the changes on the horizon. This renewed his self-doubt. I encouraged him to show feeling on his face and in his eyes. He expressed poignant fear of doing this and also frustration regarding his difficulty doing so. He felt sad and his eyes looked anxious. Moving the muscles of his face especially those around his eyes, he felt the anxiety and was able to discharge it by expressing it in his eyes and yelling out. This gave way to constricted crying. He felt relief and was appreciative.

Preparing to leave for the university stirred up more fear and doubt in P, and he felt tension between his shoulder blades. Biophysical work in this area helped him breathe more fully which resulted in an increase in charge that he was able to handle. His eyes focused and tracked without "wandering." He said with a laugh that he felt terrified; this laugh reflected his excitement about being able to feel this emotion and also deflected the intensity of his fear.

Through the next year P returned for therapy every several months and had one or two sessions each visit. He said that living on his own, he was learning much about life and was feeling grown up, "real" and more independent of his mother. He found it odd that at the same

time he valued her opinion more. He said he felt a desire to move with spontaneity, but doubt and fear stopped him. He also said that vagueness and indecision strangled him, that he made decisions "by forfeit," and that almost anything could sidetrack him. He described living in a hovel—a dirty basement room without a door. These were conditions with which he had been comfortable in the past, but now he couldn't relax there. He said the comprehensive motto of his life had been "Not" and "To not have."

More than doubt, P now felt anxiety. He also said that he felt a defense that was bigger than his vagueness: "a great smashing down" against any emotion or impulse that came up in himself. He came to one session looking quite gray and said he felt an unidentifiable terror that he knew was out of proportion to any situation. Biophysical work helped him express this terror and he felt much relief. Subsequent sessions continued to focus on the release of anxiety. He expressed fear of "being" without trying to please another person, without having a plan, without relying on social roles. He lamented that he felt pressed "to be all things," that in composing music he should do so in the style of all eras. This kept him from getting started on anything.

P received a degree from the university and he and his girlfriend decided to marry. However, with these gains came indecision, procrastination and other symptoms of his clamping down in this time of transition. He kicked himself for his lack of discipline and for not maintaining the productivity he had while in school. He feared being "no good" musically and, despite several part-time jobs, felt he was not making enough money. In therapy, with mobilization of his occiput, he expressed anxiety, his head and throat loosened, and he felt clearer and more emotionally positive.

For the next year P commuted to therapy from some distance. He related his lack of confidence and indecisiveness to the role he assumed growing up in his family. He diffused family conflict by being mild, innocuous, cheerful, placating and without problems or needs. This, he said, meant he had to forego anything that was hard to do, anything that did not come easily. Not only could he not be aggressive, but struggle and any accompanying discomfort were perceived as dangerous. Contracting the muscles in his jaw, throat and chest helped him to keep mild-mannered and silent. In therapy, moving his

eyes and face elicited fear. Direct work on the muscles around his jaw led to the release of agonized sounds. With encouragement he sustained expression of these sounds and let this agony out. He writhed with his whole body twisting and turning.

P continued to address his interest in and fears regarding pursuing a career. He applied and was accepted to a special overseas school of music and was offered a large grant. He requested therapy with his wife at this time to help sort out matters related to the possible move—she herself had received a major job promotion and they were considering living apart temporarily. In his individual therapy session talk gave way to tears, halting, heart-felt sobs and emotional pain. Sobs trying to come out were stopped by his constricted throat, chest and head and by his attitude that he shouldn't cry, that he should be independent. Crying, he said, was embarrassing and shameful. He then expressed contempt for himself for not having a better sense of self and said that during a recent public performance he had felt cynical, exhausted, disconnected and "pulled" to conform to others' style of playing. He said that he had glimpses of the depths that he wanted for his music but ended up avoidant and contactless. In a following session he arrived anxious and reported that while playing music he had become afraid of the intensity he felt. He realized he feared pleasure and success as well as failure. Hitting and yelling, he expressed fear and anger, was more open and exclaimed, "Oh, my God," in amazement at his sensations. He then felt like crying. Tears came out and he felt relieved.

P discussed in more detail his interactions with his wife. He made erroneous assumptions about her that were projections of his own doubt and negativity. He responded by withholding his participation and expression of his reactions. He said he had an impulse to first say "No" whenever his wife asked for anything. Also, he never communicated to her nor articulated to himself what he wanted. This made for difficulties in the household. With biophysical work he expressed deeper fear and anger. He was stunned by the intensity of his feelings.

P returned for a series of sessions twice over the next two years of his post-graduate schooling. He reported that he was having a profitable experience: he was growing musically and learning how to market

his skills and search out employment opportunities. Also, instead of speculating about what would be inconvenient for his wife, he faced his fear of her possible negative reactions and brought up subjects for discussion. They talked more openly and more satisfying plans were made between them. He was encouraged. Biophysical work during this time continued mobilizing his occiput and increasing his energy level. Frustration and fear came out although he sounded choked at times and in much emotional pain. After kicking aggressively he felt relief with the discharge and experienced sensation moving within his body. His thinking was clearer, he was more relaxed and his eyes were bright—he remarked how bright the room looked.

After completing his specialized schooling P obtained a good position and returned with his wife to live in a nearby area. Though managing practical aspects of his life well during the last year, he said he had suppressed his feelings and his emotional reactions in order to "get through" his academic program. He now felt frightened and unable to let go. He said he didn't know why as he knew "nothing" (no external problem) was the "real" reason. I encouraged him to let his chest relax and to breathe and move his eyes. He was able to do so and felt well.

P now came to therapy more often. He had his first professional job and was pleased. He noted, however, a recurrence of old patterns though of a milder intensity—when he found himself behind in his work, he felt overwhelmed, stuck and frozen as if he couldn't do anything. It helped him to remember that in the past he had felt he couldn't make decisions and had doubted his ability but that he had in fact persevered and handled matters anyway. I also reminded him of his Mr. Nice Guy role—focusing on what others were doing and going along with them while passing over what he needed to do. He said he also had an angry, mean, spiteful streak: he didn't *want* to do what was needed. He put things off, then didn't want to do them, then "wouldn't" do them and then was angry that he had to do them. In the session he first made contact with and expressed fear, then yelled out repeatedly, "I don't want to!" In his expression was a mixture of cringing fear and negativity he did not want to face. He said he was embarrassed, didn't like feeling embarrassed, felt awful and "on the edge of anger." In his daily life he began feeling more aggressive,

although he was uneasy about it.

Over the next several months mobilization of his occiput and the paraspinals around his scoliosis led to further crying, anger and more aggressive kicking. He used his eyes purposefully, felt sharper, more integrated, focused and "in the moment." Now more tolerant of sensations, P no longer twisted and contorted when there was an increase in energetic charge. He reported that for the first time ever he could feel his face. He said he was usually "in his head" thinking and that he thought so much he thought without even knowing what he was thinking.

By the end of the nine months of therapy since completion of his post-graduate program P, enjoying his work and projects, met job and career choices with curiosity and in the end made decisions with conviction. He articulated professional goals which he felt able to achieve and which came out of interests that had abided over time. His certitude and clarity and the ease with which he made commitments were new.

Summary

P is employed, creative, professionally involved, married and planning a family. He experiences gratification with his wife and from his work and surroundings. He is more in contact with his feelings and able to expand, make decisions and assert himself. He continues in therapy. As he has solved practical problems of living and can come to therapy on a regular basis, and as he has moved beyond adolescence, treatment focuses more vigorously on biophysical work. This helps him increase charge, stay integrated, be of "one piece" and maintain contact with his emotions. He continues vulnerable to periods of low charge and contactless emotional deadness. (Perception of emotion is dependent upon energetic excitation at an intensity above a certain threshold.) At this point, because of remaining armor, without continued therapy he is at risk of withdrawing and withholding in order to defend against his fear and indirectly act out his deep-seated rage. As his tolerance for excitation increases, the risk of withdrawal will decrease.

Discussion

P's red thread[8] is his easygoing affability. It so dominated his façade that on initial presentation he appeared to fit moderately well into adolescent culture—he could look superficial, casual, untroubled, friendly and willing to go along with whatever came up. However, P exhibited an underlying shyness and aloof, emotional detachment—hallmarks of the schizophrenic, energetically withdrawn into himself, as described by Baker (4:36). On the couch P's body tended to spread out in a sprawling manner, indicative of the general lack of cohesiveness to which Baker refers (2:145). In addition the vacant look in P's eyes, his soft (almost hoarse) voice,[9] flat affect, frequent confusion, disorganization, procrastination, doubt and fluctuating degrees of loss of sense of self were pathognomonic of catatonic schizophrenia.

As is often the case in schizophrenia, P's energy level was low.[10] His withdrawal and depression functioned as defenses against the anxiety and excitation that social involvement and active behavior would elicit. Also typical of schizophrenia, P's symptoms were first noticed in adolescence. (They appeared again in an intensified form on the brink of adulthood, after graduation from college, when P's extreme difficulty functioning in the absence of external structure became apparent.) P's problems were not highly visible prior to initial presentation in part because the repression that often occurs with anal armor

[8] Baker states, "The social façade contains one (sometimes more) basic character trait as its means of meeting the environment. This trait...causes the patient to react consistently in the same way to each problem he meets. It becomes the main character defense. Reich calls this trait the *red thread* and it must be recognized to understand and evaluate the individual. The basic character trait is never dissolved..., although it may be modified."(2:62-63)

[9] The soft voice results from a severe throat block, one of the basic characteristics essential to the diagnosis of schizophrenia as outlined by Baker(2:145).

[10] Low charge is not unusual in schizophrenia. It results in part from limited respiration. Baker states, "The contraction that holds energy from the eyes is the major armoring of the schizophrenic. It lowers stimuli from the vegetative centers in this area [the base of the brain], from the hypothalamic and pituitary functions and particularly from the respiratory center. Thus breathing is minimal."(2:146) Minimal breathing reduces not only charge but also conscious sensation including anxiety.

during the latency period from which he was emerging[11] temporarily muted the apparent severity of his problems.

The socially pleasant and adaptive qualities of P's red thread are not accidental. In the catatonic character caution predominates and holds back repressed phallic sadistic impulses. P's façade was an expression of that caution and also obfuscated it. Baker describes the accompanying affective weakness (including a sense of inferiority) which develops with anal repression and leads to reaction formations (2:124-126). One can see the reaction formations in P's case in his superficial ease, likability, accessibility, affability and look of bumbling, non-offensive confidence. The underlying inferiority also shows through and is visible in P's self-doubt.

P had an expansive façade and an underlying catatonic contraction. His somatic biopathies also seemed to express opposition between expansion and contraction, at times intensely so. Both biopathies were in the thoracic segment. Baker states that asthma is

> a parasympathetic over-excitation to overcome sympathetic contraction. The patient assumes a calm and brave façade to cover up his deep anxiety. In other words, he refuses to be anxious. Deep rage is behind this façade, a rage caused by an inability to show anxiety; behind the rage is a deeper level of anxiety. Thus, we have a calm façade, superficial anxiety, rage, deep anxiety. (2:56)

The contraction that arrested growth in P's skeletal system causing his scoliosis[12] may have resulted from an intolerance of the increased bioenergetic excitation and expansion of adolescence. It is likely that it, like armor in general, defended against emotional intensity and expression and in particular intolerable bioenergetic excitation which

[11] Baker states in reference to the anal character, "A progressive flattening occurs, so the compulsive looks like a model adolescent. The patient, however, feels an inner emptiness and a desire to start life anew and may attempt to do so repeatedly."(2:126) Although the locus of P's primary armoring was ocular, his anal holding was second in significance. His energetic charge was so low that starting life anew was mainly a mental exercise with little overt activity.

[12] Brenner in his article, "Adolescent Idiopathic Scoliosis," postulates scoliosis "as a manifestation of interrupted orgone energy flow posteriorly, and that its form is specifically determined by the energetic characteristics of the dorsal structures..."(5:193)

could have easily overwhelmed a significantly contracted ocular segment and an already compromised ego. Total organismic functioning and equilibrium were thus preserved but at a cost.

This case study demonstrates Baker's description of the essentials of treatment for any patient:

> (1) increasing the inner push on the organism by building up its energy through breathing, (2) directly attacking the spastic muscles to free the contraction, and (3) maintaining the cooperation of the patient by bringing into the open and overcoming his resistances to the therapy and the therapist. (4:37-38)

Typical of the orgonomic treatment of the schizophrenic, most biophysical work focused on the ocular and cervical segments. It was the loosening and dissolution of P's ocular armor that led to the marked improvement in P's functioning. Although P frequently spoke of the immediate, positive biophysical effects of energetic expansion in his head and described the sensation as one of "lightness," dissolution of ocular armor had a deeper, more comprehensive effect—allowing his perception, thinking, emotional contact, self expression and aggression to develop.

Also important in the treatment of schizophrenia are encouraging patients in their efforts to get well and helping them sort out their thinking. The latter intervention addresses, identifies for the patient, and possibly even loosens the ocular armor. It may also help the patient avoid dangerous situations or disaster by reconsidering or stopping planned actions based on distorted thinking.

P's past affability and capacity to copy other people's behavior helped him to hold back his own emotions and impulses and to hide his affect block, contraction, and inability to assert himself. His affable "sociality" thereby lessened his anxiety. Superficially, this anxiety was related to his fear of showing his anxiety and revealing his lack of aggression. Deeper anxiety was related to making contact with the world and letting go and expressing phallic, sadistic impulses. His sociality helped defend against both layers of anxiety.

P's current improved degree of biophysical mobility and integration allows increased bioenergetic movement which insures a greater capacity to move out toward and make contact with his environment.

With increased contact and sensation and with less ocular armor, he perceives and processes more "information" more accurately and thus has an improved capacity to make rational decisions. He is less vulnerable to confusion and catatonic withdrawal and is more able to rely on himself to make decisions and initiate activity. Consequently, he has less need to follow others and less need to use camaraderie as a defense against his rage and terror of letting go.

An understanding of the layering of human emotional structure is essential in order to make an accurate character diagnosis. A character diagnosis is invaluable in aiding the orgonomist in efforts to focus on and consistently address the significant armor and defensive traits of the patient. In P's case, observing and differentiating superficial functioning from what lay beneath his façade led to a characterological diagnosis of catatonic schizophrenia and effective treatment of his ocular armor, immobilization, and doubt. Had only the façade been observed and a characterological diagnosis not been made treatment crucial to this adolescent's transition into adulthood would not have occurred.

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