

A Difficult Diagnostic Problem

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Introduction

The following case illustrates some problems encountered in the early treatment of a patient whose symptoms obscure her diagnosis. Because of this, she was presented to a training seminar at the American College of Orgonomy, and the patient's course illustrates how medical orgonomic training is conducted.

Background

Reich describes the situation that prevailed when he took over the Vienna Technical Seminar for psychoanalysts more than sixty years ago:

There was a wide divergence of opinion even with regard to everyday problems of analytic practice. If, for example, a certain resistance situation is presented in the Seminar, one analyst will say it calls for this measure, a second, another, and a third, still another. If the analyst then, provided with all this advice, again approaches the case, there appear innumerable other possibilities, and the confusion often is worse than before. And yet, one must assume that one definite [therapeutic] situation, given certain conditions and situations, admits of only one optimal technical procedure, that there is one definite procedure which in this situation is better than any other. This applies not only to an individual situation but to [the] therapy as a whole. We have to find out, therefore, what characterizes this one correct technique, and how one arrives at it. (1:5-6)

Reich's insistence on there being one and only one correct technique in a given situation was not merely theoretical; it is a clinical reality experienced repeatedly during properly conducted orgonomic training and therapy. Initially in discussing a case, there is a wide variety of opinions, many of which seem valid and helpful at the time. One may feel he is getting many useful tools to work with.

Eventually, however, it is possible to arrive at the essential feature of the particular situation. At this point, all the previous suggestions appear secondary at best. From this vantage point, it is clear what is going on (i.e., the most essential resistance) and what needs to be done to clear it up. It is also clear that unless the essential resistance is dealt with properly, no real progress can be made and that all other measures merely delay or complicate the situation

unnecessarily. All of this is a palpable reality that one experiences in the case itself.

Presentation of Case

A is a 38-year-old Sicilian-born housewife who came to therapy with a chief complaint of "I'm very depressed." This began two months before when her mother-in-law began to mistreat her. She experienced tearfulness, anhedonia, loss of appetite with fifteen-pound weight loss, sleep disturbance, and mild suicidal ideation without intent or plan.

The patient's father abandoned the family when she was an infant, and her mother was cold and unemotional. She came to the United States as a teenager. She herself is a good housewife and a hard worker.

On initial exam, the patient was severely depressed with tearfulness, hopelessness, and psychomotor retardation. She spoke in a baby voice and asked me for advice in a childish manner. I had a clear sense that she would desperately plead for guidance and then, without fail, go ahead and do what she felt was right, taking no account of anyone else's opinion. She tended to place her hands behind her head in a commanding position, in marked contrast to her pleading voice (although some members of a group of ergonomists who examined her in consultation felt that the gesture was seductive). She was heavily armored in her jaw and chest. I felt she was in fairly good contact. She followed a flashlight well, but had trouble rolling her eyes on her own.

I considered her initial depression to be a biophysical emergency. This responded well to eliciting rage by working biophysically on her jaw and upper chest. Within two months, her major depressive symptoms were relieved. On the basis of my own understanding of her, and suggestions from my consultants, I then addressed her attitude of dependency and helplessness as well as the babyish voice, and attempted to get her to be more specific when she would refer to an emotionally charged situation in a vague way. I also attempted to bring her into contact with the fact that her bland dependent attitude toward me was a wall against contact and what the consequences of this were for her. She initially responded with "what do you think I should do?"

With more consistent work on her attitude of helplessness, she became angry and experienced relief and gratitude and even began functioning better at home. Pointing out her childish voice several times each session had the same effect. Still, there was no significant change in her character attitude. Moreover, her diagnosis, which had been initially deferred because her depression masked her character structure, was no clearer than it had been at the beginning. My initial differential included manic depression, paranoid schizophrenia, and hysteria, and

I felt a convincing case could be made for any of them based on what was visible when she first presented.

At this point, her red thread was evident; a good, babyish, little girl. Her diagnosis was more difficult. Manic depression was considered unlikely because there was no previous history of mood fluctuations, she lacked the typical somatotype of the manic depressive, and she had no history of oral unsatisfied symptoms (even her dependency did not have a particularly oral unsatisfied feel; it appeared more likely to be either seductive or a way of making substitute contact despite anxiety and suspicion). Both hysteria and paranoid schizophrenia were consistent with the clinical picture. Even upon reexamination of the patient by the members of the seminar, the two could not be differentiated.

The seminar participants remarked to the presenting therapist that he should not feel bad, that it was a difficult differential, and that there were some patients in whom even the most experienced organomists were unable to diagnose with certainty. It was also pointed out that one must not focus on the diagnosis and lose sight of the patient. Any construct, such as a diagnosis, no matter how useful, is secondary to the needs of the patient.

This is true, but the situation with this patient was unsatisfactory: without a diagnosis one is never secure in treating the patient and has little or no idea what lies ahead. Also, what exactly prevents us from understanding her better? What is the cardinal resistance at this particular moment in therapy and the one best technique for dealing with it?

Close examination of the details of the patient's behavior showed that the baby voice was the most salient manifestation of her character that it was called into play by her at every turn of the therapy. Here was an obviously infantile trait so intense that it blocked any further understanding of her. Pointing it out several times a session (mixed in with other interventions) was not adequate to loosen it. It was concluded that this trait should not be allowed to pass unchallenged even once, letting it pass simply reinforced it. It was predicted that when the babyish voice started to dissolve, the patient would either become more openly seductive or confused. The diagnosis could then be made on the basis of which of these two traits appeared.

In the following session, I did precisely that, pointing out the babyish voice again and again every time it appeared and ignoring other issues that presented themselves. The babyish voice persisted and so did I until finally the patient began to speak in a more natural voice, at which point she also began staring out into space and rubbing her forehead. Her appearance was that of the typical high-functioning paranoid schizophrenic. I asked her what she felt and she

replied, "I feel confused." The confusion cleared quickly with kicking, biophysical work on her calf muscles, following a penlight, and rolling her eyes.

Before this, it had been clear that, like all patients, she had an eye block, but its extent was unclear. Furthermore, previous work to relieve the eye block (kicking, rolling her eyes, etc.) had produced no change at all. In previous sessions, she would giggle when I pressed on her calves and could roll her eyes for long periods saying, "I've never been any good at this, no matter how much I do it, I still can't do it any better." In the next sessions, pressing on her calves produced screams of fear, and rolling her eyes resulted in release of emotions (anxiety and frustration) and clearing of her eyes. Her babyish voice was pointed out whenever it occurred.

Discussion

This case illustrates several points:

Most important is the necessity of identifying the cardinal resistance and focusing on it consistently. As Reich says: "It is important to undermine the neurosis from the cardinal resistance, from a definite strong-point, as it were, instead of focusing one's attention on detail resistances, that is, attacking the neurosis at many different points which have no immediate connection. If one deploys the resistances and the analytic material consistently from the strong point of the first transference resistance, one never loses sight of the total situation, past and present" (1:36)

To understand why we fail to accomplish this, we remember that character analysis is not merely resistance analysis. Reich felt that its most essential feature was its understanding of genitality. Therapy loses the ability to identify the cardinal resistance when the organomist misunderstands the nature of genital functioning or relinquishes genitality as the goal.

For example, the patient's infantile voice might be attractive or appealing to many people in our culture, it superficially enables her to function better in certain social or occupational situations, it masks anxiety (and the underlying excitation) that she and people around her find hard to tolerate. To the extent that the therapist shares these perspectives, he is relinquishing genitality as the goal and will become, to some degree, deaf to the patient's voice. Similarly, the therapist may gravitate toward some part of genitality: e.g., independence, ability to think rationally, open-mindedness, liveliness, ability to sustain contact, etc. Experience shows the result will be that he can get close to identifying the cardinal resistance, but will always be a little "off target." This is illustrated in all of the ineffective interventions suggested before what Reich called the "strong point" was seen clearly.

Here we can see why, even in a high-functioning patient, the mechanical term "ocular repressed character" is inadequate. The babyish voice is analogous to the inappropriate smile one often sees in schizophrenics and, like it, is a manifestation of the split that is characteristic of schizophrenia (ocular repression with panic and splitting). The vacant stare and the confusion that appeared are also manifestations of the split which results from armoring at the base of the brain. This is why we call this character type schizophrenia (from the Greek for "split mind").

The babyish voice in this particular patient could be appealing, it drew people in a way that did not threaten her, thus it provided enough substitute contact to reduce her anxiety. This "drawing people out" could be mistaken for hysterical seductiveness. The paranoid schizophrenic and the hysteric are similar in that both appear lively, unarmored, and can draw the therapist out and move him emotionally. To summarize some of the differences that distinguish them:

The hysteric uses sexuality to draw people out while running away from herself. To do this she uses flirtatiousness, physical softness, anti-sexual calm, sexualization of her body and of situations, etc., all manifestations of genitality with anxiety. This provides enough substitute contact to avoid intolerable feeling (especially rage) and unmask men as dangerous and disappointing. The results of her behavior are used to reinforce her chronic attitudes of disappointment and apprehension that function as armor by preventing contact and movement.

The paranoid schizophrenic draws people out while remaining in the safety of his shell. He does this with an infantile (more common in women) or artificially friendly or aggressive voice, superficial smile, non-threatening "open" appearance (consistent with his diffuse energy field), physical softness, superficial calm, etc. Underlying these defensive attitudes is panic and a tendency to split perception from excitation. The attitudes themselves provide enough substitute contact to avoid feeling anxiety and also function to gather "evidence" covertly about other people without being seen. He saves this to use later on to support an attitude of suspicion and distorted perceptions that function as armor by preventing immediate vegetative contact.

Conclusion

A knowledge of the functioning of the different diagnostic types is invaluable in knowing what to expect and in understanding unexpected occurrences. We cannot use this knowledge mechanistically as "criteria" to understand or treat our patients. Correct treatment can only be done functionally: by functioning as therapists in a way that makes the structure of the patient's character unmistakable.