Medical Orgone Therapy of a Post-Traumatic Stress Disorder

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Nightmares, shaking, lingering fears, physical sensations of anxiety, guilt, and phobic responses as the aftermath of traumatic events has been known for generations and described in the great works of literature from the Greek tragedies to Shakespeare and Dickens.

Psychiatry, over the years, has given the clinical picture many names and attributed it to various causes. During the American Civil War soldiers with palpitations and chest pains were felt to have a functional cardiac disturbance called "soldier's heart" or "effect syndrome." Anxiety symptoms in World War I soldiers were labeled "shell shock" and were thought to be caused by central nervous system lesions.

In the early 1900's, under the influence of psychoanalytic theories, psychological etiologies were proposed and the term "traumatic neurosis" came into use. Unconscious childhood traumas were emphasized, with the stressor seen as the triggering event that brought dormant conflicts to the surface, but was insufficient in and of itself to cause a neurosis. The horrors of World War II, not just among combatants but among civilian survivors of prisoner of war camps, Nazi death camps, and atomic bombings of Japan, brought to the fore an awareness of the significant impact if emotional trauma in apparently "normal" individuals, not just those predisposed by unconscious conflicts.

Recognition of traumatic war neuroses in World War II veterans led to inclusion of the category "gross stress reaction" in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in 1952. The 1968 second edition, DSM-II, dropped this category. However, the third edition, DMS-III, in 1980, attempted to describe it phenomenologically and introduced the currently popular designation "post-traumatic stress disorder" (PTSD), defining it among the anxiety disorders.

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience. The characteristic symptoms involve re-experiencing the traumatic event: numbing of responsiveness to, or reduced involvement with, the external world and a variety of autonomic, dysphoric or cognitive symptoms (Reference 1).

Subsequent editions, DSM-III-R and DSM-IV, made some changes in the emphasis of the symptoms, but describe the disorder with the same essential features (Reference 2). The traditional psychiatric understanding of the history, etiology, and treatment of this disorder is well reviewed by Kinzie (Reference 3).

Presented here is a case of PTSD treated initially with character analysis and subsequently with the full range of medical orgone therapeutic techniques.

Case Presentation

Mrs. A presented for evaluation two months after a serious automobile accident. At age fifty-five she had been in good health and had no psychiatric history or treatment prior to the accident. In the car involved in the accident she was a rear seat passenger, her brother drove, and her mother sat up front. They were on their way to dinner traveling approximately 45 mph on a divided surface street when a drunken driver traveling at a high rate of speed crossed the divider and collided head-on with them. Her mother and brother were killed instantly, a fact she was unaware of when she was taken to the hospital and treated for multiple fractures.

She made a good recovery from her physical injuries, but her physician was concerned about her anxiety and depression associated with recurrent worries, guilt, nightmares, flashbacks of the accident, and exaggerated startle response to any sudden sound or movement. On my initial evaluation she related her account of what had happened in a flat indifferent tone. With some probing she revealed her recurrent nightmares, but most disturbing to her were intrusive images of headlights coming straight at her. At these times she felt her heart racing and that she would suffocate. She also had intrusive images of the hours when she lay in the hospital emergency room wondering how her mother and brother were.

By the time I saw Mrs. A she had recovered physically. One of her daughters lived in the area and had been helpful with physical and emotional support. With her daughter's urging and encouragement she returned to driving, but because of fearfulness she limited the scope of her travel. (The 12-mile trip to my office was the longest excursion she had made since the accident.) Her emotional symptoms also limited her life at home; anxiety and intrusive thoughts interfered with her ability to concentrate on and perform everyday activities.

Mrs. A arrived for her initial evaluation session perfumed, properly appointed with jewelry, and fashionably dressed in a mink coat. She related to me in a friendly and engaging manner as if talking over tea. Every subject received equal emotional weight. She described her mood as depressed and anxious at times, but had very little apparent concern about this; "I'm just not my usual lively, life-of-the-party self." Her affect had an animated but superficial quality until I asked about her feelings concerning the accident. She initially showed some emotion but struggled to control it. She quickly exhibited a calm bland demeanor and

distracted herself with some superficial aspect of what had happened. For example, when I said, "Tell me what you recall feeling when you were in the emergency room," she responded, "I was worried sick about my mother and brother." She developed a frightened look and her eyes filled with tears. She quickly wiped them away with a tissue, composed herself, cleared her throat, and continued, "The nurses wouldn't tell me anything about them, but you know they were wonderfully supportive and tried to calm me down and got me to think about other things. You know a funny thing happened just the other day. I ran into a woman in the supermarket who obviously knew me and called me by name. I couldn't for the life of me figure out where she knew me from, but it turned out she was my ER nurse. We had a good talk and I caught her up on what has happened since the accident." As she talked, Mrs. A gradually developed a cheerful expression on her face and a chatty voice so that none of the initial fear was evident. In a similar fashion she became circumstantial every time and emotional subject came up. There was, however, no evidence of a more serious formal thought disorder. Her thoughts continually returned to themes and preoccupations concerning superficial aspects of the accident. "I can't stop thinking about the fact that I had on one of my favorite coats and they cut it off me in the emergency room. Then I feel guilty that I am thinking about that when I should be thinking about what happened to my mother and brother."

If even the slightest emotion surfaced about the accident she became easily distracted and could not concentrate. Otherwise her attention and concentration were good. Her immediate recall and short-term memory were intact. Her long-term memory was complete except for a period on the night of the accident. She had clear memories of driving to dinner and then fleeting but disconnected images, rather than a true memory, of headlights coming at them. The next thing she was able to recall was being in the emergency room, realizing her coat had just been cut away, and someone was trying to calm her. Except for these specific disturbances in attention, concentration, and memory related to the accident, her cognitive functions were normal. She was clearly intelligent. Her insight was good to the extent that she knew she was not her usual self and that there was something wrong. However, she tended to gloss over the extent of the problem with an attitude conveyed by the comment, "These things just take time to get over."

Biophysically she was a well-developed and well-proportioned woman who, despite appearing frozen in terror, continued to move with a certain fluidity and grace. Her eyes initially darted about the room, but in a short while she looked at and engaged me with her eyes. If we looked at each other for more than several seconds, however, she began to show fear in her eyes and looked away. This was especially true if there was even the slightest emotion in what she was saying. At these times the anxiety in her eyes belied the cheerful and charming expression on her face. In general, she spoke easily but her jaw was somewhat clenched. Her voice then became soft, choked, and hesitant. She held her head

with "proper" quality. Her breathing was shallow with occasional deep "burdened" sighs.

My overall impression was that of a vital energetic woman who was terrified, with only an inkling of just how frightened she truly was. My diagnostic assessment was that Mrs. A had a hysterical character with which she had functioned relatively well through most of her life, but now suffered from a severe acute contraction in response to this horribly traumatic accident. She exhibited all of the features of post-traumatic stress disorder as outlined in DSM-IV (Reference 4).

Course of Therapy

I began seeing her in weekly face-to-face character-analytic sessions. It was horrifying to hear her recount the story of the accident even though she spoke with little emotion. It struck me that we would need to proceed slowly so that she could become accustomed to the intensity of the repressed emotions associated with the accident. Over the next several sessions she gradually opened up and revealed that she constantly replayed the day of the accident in her mind. She was plagued by thoughts such as, "What if I had gotten in to mother's house sooner and we had left a little earlier? Or a little later? What if I had offered to drive instead of my brother?" She tormented herself with thoughts such as, "Why am I alive instead of them? I don't deserve to live any more than they. I should have died, not them? She was initially reluctant and uneasy when she talked about having such thoughts, but now she told me they ran around and around in her mind preventing her from concentrating on the everyday things she needed to get done.

Initially she felt some relief at overcoming her anxiety about telling me these thoughts and seeing that I did not think she was crazy for having them. It became evident that she could run in circles in the sessions by reporting innumerable inconsequential details. When she did so she related in a characteristic bland unemotional manner. Also, for the most part, her thoughts remained focused on the period prior to or following the accident. The fleeting moments when she lit on an image from the accident itself brought on extreme anxiety accompanied by palpitations and shortness of breath. At these times she suddenly appeared disconnected from her intense emotions and exhibited a bland affect. It was as if emotionally she was "in another world." Later she revealed that she had an intense desire to run away and hide whenever this happened.

It was evident that her basic character mechanism was to run from intense emotions. This showed itself in various forms: distracting her focus from the source of her fear; talking about things rather than feeling them; running from the devastating grief over the loss of her family members by remaining stuck in the less intense emotion of guilt. Running from anxiety served as a protective mechanism which prevented her from being overwhelmed and incapacitated.

This protection, however, exacted a great toll. She had become emotionally dulled.

Focus on the details of the accident was the thread that needed to be followed to bring her into contact with her terror. The intensity of her feelings and her limited tolerance of them made it essential for me to regulate the amount of fear and anxiety she faced in each session. This amount was increased gradually so that she would not be overwhelmed. After one month of weekly therapy sessions she reported feeling more fear. Putting her anxieties into words allowed her to come into better contact with her emotions. At this point she needed an emotional outlet more intense than words could provide and I recommended, and she agreed to, biophysical treatment on the couch.

I began by having her breathe for a few minutes without talking. I then had her close her eyes, imagine arriving at her mother's house the night of the accident, and sequentially describe the subsequent events. Each time as she got closer to the scene of the accident she became anxious and agitated and said, "I just want to run away from all of this." I encouraged her to feel, to stay with the fear, and to kick her legs on the couch as if she were running away. I also had her open her eyes at the point that she felt afraid and encouraged her to show the fear in her eyes. She was reluctant to do so and I felt she was becoming angry with me for having caused her to re-experience these very disturbing feelings. I asked her to tell me what she felt toward me. She said, "I don't like to feel these things, but I'm not angry. I know you are trying to help me." I said, "You're not angry at all?" "Well, maybe a little irritated at times." To this I observed, "You gloss over your negative feelings and try to act nice and cooperative on the surface." She said nothing but appeared to feel understood and relieved that I accepted her irritation without holding it against her.

She was gradually able to proceed closer and closer to thoughts and images of the accident itself while remaining in contact with her emotions. When she was able to relate the details of her experience in the accident accompanied by her emotional reactions I encouraged her to scream out the fear. She was inhibited by embarrassment about being so overtly emotional. I encouraged her to go ahead even though she felt embarrassed.

Frequently, we were confronted with her reluctance to feel the emotions related to the accident. At these times I again had her express her feelings toward me. She usually said little more than that she was "a bit irritated" that I was having her feel these things, but even this minimal expression of her negative feelings allowed her to move on. She became able to scream with some relief, but still reflexively choked off the expression in her throat. The expression of fear brought to the surface sadness and deep grief at the loss of her mother and brother, a grief that she had never been able to express. (She had thought there was something wrong with her and felt guilty for not having cried much after their deaths.) She began to talk more about the driver of the other car. Her initial

attitude and expressed feeling was to pity him. Although she still denied any other feeling toward him, it was not long before she began to express some anger at his irresponsibility. Gradually she began to express outrage that he had escaped with only minor injuries while her mother and brother were dead and she was injured.

The discharge of her fear, grief, and anger brought her relief and she had a gradual resolution of the nightmares. Her sleeping improved as did her ability to concentrate. She was also more lively in general and more emotionally expressive. It was only after she had discharged her pent-up emotions that she was able to tell me, "You know, I really did hate you for bringing up all of those things that I didn't want to think about or feel. I was too afraid to tell you how angry I really felt. I guess I needed you too much to risk telling you." By the fourth month of therapy she began taking longer excursions in her car and was able to visit her daughter some 60 miles away.

Her functioning was much improved, but there still remained a tendency to be emotionally superficial. When this tendency in her relationship with me was identified she realized it was also true of her relationships with her daughter and friends. Five months into therapy she continued to have a tendency to choke back the full intensity of her emotions. This became the focus of still-needed work.

She missed her next session, which had not happened previously without a call to cancel or reschedule. An hour after the appointed time her daughter called to tell me that her mother had been in an auto accident. The daughter said, "I don't fully understand the message, but my mother said she knows you will. She wants me to tell you only two things: that she was not hurt physically and that she was able to scream full out."

The accident reactivated some of her earlier fears and symptoms and served to bring them to the surface. In the next two or three sessions she was able to let out her fear with full-throated screams. It was also my impression, in retrospect, that the second accident serves the function of lessening her fear of driving. She now realized that it was possible to survive an accident without serious injury. She was able to continue to drive and carry on with all of her usual activities.

The next two months of therapy focused on helping her to discharge more of her fear and grief. This was accomplished by pointing out her consistent tendency to become superficial and flighty whenever emotional intensity became great. For example, she talked with great feelings of grief about the deaths of her family members and then suddenly changed the subject with a comment such as, "Oh by the way, did I tell you my other daughter wants me to visit in California? We have had good times playing cards together as a family." There were times when she could stay with one subject only for moments.

After first experiencing in the therapy sessions that she ran from her emotions, she now became increasingly aware of how she ran. She saw that while running away protected from the overwhelming emotions of the trauma, it also interfered with her resolving it. When she saw how she avoided emotional contact and intensity in her relationship with me, she spontaneously began to realize that these typical ways of reacting were also how she engaged in relationships with men, especially in her marriage with her ex-husband. She saw that her problem expressing her negative feelings toward me was identical to her experience with her husband and that this difficulty caused her to withdraw and relate more superficially.

After seven months of therapy she no longer needed treatment to help her express her emotions; she was able to discharge them on her own. Her symptoms of panic, flashbacks, nightmares, and startle reaction were fully resolved. She was also now able to drive past the site of the accident without feeling panicky.

She was discharged from therapy with the understanding that the door was open to her if she wanted to pursue deeper characterological issues. I also asked her to let me know how she was doing. The total course of therapy was 24 sessions.

Approximately six months after her discharge from therapy she called to report that she was continuing to do well and that her awareness of her character problems had actually helped her to avoid falling into the pattern of running from her emotions. She wanted me to know that the post-traumatic symptoms had not returned. She also felt that even though she had some desire to work on her other problems, at this time it was most important for her to just live her life. She was planning to go to California to live with her other daughter for a year and then decide what she would do from there. About a year later she called again to say that she had returned from California. She was still doing well and occasionally thought about returning to therapy, but just wanted to let me know she was fine and was appreciative of my help.

Discussion

Mrs. A's accident resulted in severe anxiety accompanied by nightmares, flashbacks, and physical symptoms of palpitations and constriction of breathing. Even a marked intensification of her usual hysterical defenses of dissociation, superficiality, and flightiness failed to adequately contain her overwhelming anxiety.

The immediate goal of treatment was to help Mrs. A overcome her acute emotional stasis. In this regard, a bioenergetic understanding of anxiety and its management was invaluable in relieving her debilitating symptoms. She did not heed to analyze or rationally understand the events she had experienced. She only needed to remember them and feel her intense emotional reactions so that

she could physically discharge them. Until she was confident that she could safely express her feelings it was in fact rational for her to avoid coming into emotional contact with her tragedy. It is significant that there were no long-term sequelae of the second accident because she was able to scream effectively right there.

Mrs. A's character was not significantly restructured. A relatively brief course of medical orgone therapy not only resolved her acute symptoms but also allowed her greater emotional flexibility and improved her overall functioning, especially giving her greater satisfaction in family relationships.

Conclusion

With severe trauma a combination of intensified character armor and break-throughs of emotion dues to a failure of both muscular and character armor produces the basic features of PTSD. Diagnostically it is a "clinical entity" (Reference 5) which may occur with any character diagnosis.

The central role of anxiety in this disorder was well-illustrated by the case presentation and is supported by traditional psychiatry's placement of PTSD among the anxiety disorders (Reference 6). To determine whether PTSD has a specific bioenergetic mechanism or is merely an extreme example of the clinical picture seen with any severe contraction will require further clinical investigation.

References

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