An Anxious Preadolescent Boy

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Abstract

In this case of an eleven-year-old boy suffering from chronic anxiety, treatment with medical orgone therapy reversed the direction of emotional energetic movement from chronic contraction (depression, masochism) to expansion (rage, pleasurable physical movement). This functional approach allowed for complete resolution of the presenting symptom.

Introduction

Michael, an eleven-year-old boy, was brought for treatment by his parents because of anxiety and depression for the past eight months. He insisted on sleeping in bed with them every night and his anxiety and fearfulness could be alleviated only if he was allowed to do so. They soon came to resent Michael's intrusion into their marital relationship. They tried to limit his behavior but soon gave up because of his crying and very real distress if put back into his own bed. Michael was unable to provide any explanation for his anxiety. He could only say that he *needed* to sleep with his parents.

Outside the home, Michael was also having problems: He was afraid to go to school and felt harassed and ridiculed by his schoolmates. He also believed he wasn't liked by his teachers, who, he claimed, always treated him badly and didn't support him when he was taken advantage of by his fellow students.

History

Michael was a wanted child and mother's pregnancy with him was uneventful. The birth was difficult, however, and vacuum extraction was required. Despite this complication, at birth Michael appeared to

be in good shape, was lively, and cried strongly. A medical condition, hypospadia, was immediately diagnosed. It is a malformation of the tip of the penis with an abnormal displacement of the urethra, the opening of the urinary tract, to the underside of the penis.

Michael appeared to develop normally in all respects and was breastfed for four or five months. He slept well. At the age of three years he was hospitalized for surgical correction of the hypospadia. The procedure was performed without medical complication, but Michael's separation from mother was very traumatic for both of them. His mother told me that every night she was required to leave him alone, and desperate, in the hospital—it was a wrenching experience and she herself felt desperate and guilty.

When Michael entered kindergarten he reacted with intense fear and despair. Many children react in this way during the first days of separation, but they are soon able to adjust to the new environment. Michael, however, remained in a corner of the classroom for several weeks, waiting for mother to take him home. This traumatic episode in his young life was completely forgotten until it was recalled in the course of therapy.

Course of Treatment

At the first appointment, Michael was accompanied by his father. He appeared as a strikingly small, shy and cautious boy. However, he was eager to come to see me as he was moved by a strong desire to get well. I explained to him and his father that medical orgone therapy views symptoms, such as anxiety and fear, as a manifestation of blocked and forgotten emotions, and it employs various physical methods to help the patient discover and express these buried emotions. Both agreed to this approach and Michael, in this first session, lay down on the couch, his father still in the room. I asked him to look around the room, which he did but warily, and then, after a while, I asked him to make faces and to yell out loudly. He did this fairly well, although with some inhibition. His neck, on palpation, was tense and tender to my light touch, and his jaw was rigidly held. His breathing was very

superficial, with only the slightest excursion of his chest, and the intercostals, the muscles between the ribs, were tender and ticklish to touch. The abdomen was soft and he was able to kick well when asked to do so, but his pelvis was stiffly held.

I was able to engage him and excite his energy by playing at fighting, which he enjoyed. However, he held back striking out with his fists and yelling at me, and he tired very quickly. Importantly, he was unable to sustain eye contact with me while fighting. This behavior alternated with smiling and shouting silly jokes that were inappropriate and out of context. The use of inappropriate humor, evidence of contactlessness and a form of substitute contact, was identical to that of his father. Father's jokes and "humor" were often directed toward his son, particularly when either he or Michael was anxious. This clearly was an attempt to alleviate his own nervousness as well as his son's. The stress of this first session and Michael being on the couch had understandably brought up anxiety in both. Most importantly, the stress revealed their characteristic way of dealing with anxiety and this was valuable for me to see.

Over the next twelve sessions, over six months, a pattern emerged. Michael engaged eagerly in play fighting with me as he wanted to be strong and unafraid and fight anyone who harassed him at school. This relieved much of the pent-up rage held in his chest and arms, but he remained blocked in his neck, jaw and head. Only when we were well engaged in the therapeutic process did I point out how much his voice was held back, preventing him from yelling loudly, and also how much his blows and kicking were not as forceful as they could be. As a result of this constant pointing out of inhibitions, Michael was better able to feel his rage and to fight with force and shout at full volume. His blows became stronger and instead of trying to defend himself from my playful feints and attacks while laying down on the couch, as he had done in the first months of therapy, he was now able to stand up and hit and kick the pillow I used to protect myself. He was even able to push me against the wall. Michael's defensive, fearful withdrawal was being reversed and he was feeling more solid and

assertive. Coming into contact with his rage and expressing it with full emotion also brought him more confidence.

In the course of the 23rd to the 26th session, however, a new attitude appeared: He began to display a defiance I had not previously seen. During our fights he pinned me against the wall, not letting me break loose. When I told him to let me go and then added that he should stop sleeping with his parents, he answered, "*I* will decide when I'll stop this habit, and *you* can't tell me what to do!"

This young boy's inhibited, shy and cautious demeanor had given way and he became rigid, stubborn and authoritative. This transformation was greeted with enthusiasm by his parents, who thanked me for my help and said they could now recognize their son again. They knew, they said, that under his depression and suffering, he had strength. They also came to see the stubbornness that had emerged as a positive sign and trusted that continued treatment would address this difficult aspect of their son's behavior.

With continuing treatment, Michael's social life improved greatly. He was able to defend himself against the school bully, was no longer harassed, and had made new friends. We discussed his inappropriate "humor" and his acting like a buffoon, and he came to see that he acted this way both to get attention and to relieve anxiety. Slowly he became able to control himself, and this greatly helped all of his relationships. However, these improvements, significant as they were, did not alleviate Michael's presenting problematic behavior. Although no longer anxious and depressed, he was now aggressive and stubborn and these newly emerged attitudes allowed him to continue as he had before: demanding to sleep in his parent's bed. I realized that I was faced with Michael's " No, you won't tell me what to do," and that such a deeply rooted trait in a child of his age would not readily yield to character analysis or other verbal exchange. I decided to meet with the parents and they agreed with my advice that a firm, authoritarian intervention was needed. Michael was no longer to sleep in their bed with them, but he would be allowed to sleep on a camp bed in their room. Some days

later, the parents reported that he had accepted their decision and was now sleeping quietly in his own bed in their room.

At this time, my therapeutic approach was also changing. I asked Michael to look around the office and focus and see to reduce his thinking and to help him to come in better contact with his feelings. Although he often felt bored, he nonetheless complied. Other times, he exploded with rage, which in turn, led to whining. This was a valuable turn of events as I was now able to point out that his whining and suffering occurred because he was still unable to fully express his rage.

This new-found understanding of his symptoms of anxiety and fear, and now suffering, combined with his willingness to express rage on the couch, gave him great emotional relief and Michael now began to follow my directions without opposition.

In the 29th session he told me triumphantly that his symptoms had disappeared, that he now slept in his own bed in his bedroom and was no longer anxious. In the session his rage had a more "evil" quality and for the first time, looking directly in my eyes, he cursed at me, yelling "Fuck you!" In the subsequent seven sessions, Michael followed my directions to look around the room to see and to breath. This led to more discharge of rage—mostly directed against me.

At this point I met with his parents, who were satisfied with the outcome, but also willing for Michael to continue therapy. I explained to them the recent developments: True, he was no longer weak and anxious, but now he had become stubborn and controlling. It was clear that a new therapeutic strategy was called for. It was therefore necessary to take over control again but in a different way, in order to bring Michael to a deeper understanding of his behavior and its function.

It is not always the case that a definitive diagnosis can be made before adolescence, but with Michael this was not so. His structure, biophysically and characterologically, was clearly that of a phallic type, and as such, he was avoiding anxiety and feelings of weakness by being and acting strong. I told him he had be aware of his pushy, demanding behavior everywhere—and stop it! I also told him that he

had to do as I directed in his therapy sessions. Michael's answer to this was clear and straightforward: "I am like that because I am afraid that if I follow your orders, you will control me and make a fool out of me." This revealed his latent mistrust and gave further confirmation as to his character defences. Since that time, therapy has proceeded smoothly, a blend of emotional release, character analysis and support. It is bringing this young man to a significantly better level of functioning.

One thing remains the same: We like each other and we enjoy working together very much. Because we succeeded in eliminating Michael's long-standing sleeping problem, I feel confident he will continue to make steady progress that will allow him to enjoy life much more fully.

Discussion

This case demonstrates some typical aspects of the phallic character type and their relationship to symptom formation. In his seminal work *Character Analysis,* Wilhelm Reich, M.D. describes the role of character and muscular armor in its function to bind anxiety and, with it, energy. Michael developed a complaining attitude that made him appear weak and silly. He was trying to rein in his anxiety, which he couldn't do fully, but underneath was repressed rage. His functioning deteriorated and he needed an external support: sleeping with his parents. Once this was pointed out he could no longer continue in the same way and his aggression surfaced. With the release of rage, his symptom disappeared. Before he was weak and depressed, but now he became strong and stubborn. This pushy attitude, in turn, also had its defensive function, that of warding off yet deeper feelings of mistrust and fear, issues that will have to be dealt with in the future.

Reich explained the disappearance of neurotic symptoms in the course of character analysis as the result of a reduction of the energetic push behind them. When an energetic charge can no longer both sustain a symptom and the corresponding muscular component, then the symptom disappears.

It is not surprising that neither Michael nor I could clearly see the causation hidden behind his symptom. In fact, it may never be known for sure what underlay his motivation for sleeping with his parents. Assumptions can be made, such as the unconscious reactivation of the hospital and kindergarten traumas. Also, the demands of the oedipal complex or the need to cling to his parents to avoid a deeper rage can also be postulated. But, in fact, these are only intellectual speculations. Sometimes in the course of medical orgone therapy the actual history of a symptom appears with the re-experiencing of repressed emotions on the couch. However, this may not occur and it is possible that Michael will be free of his symptoms well into the future without ever knowing *why* they had appeared.

Treating this young man has been a moving experience for both of us. Therapeutically, there is more that can be done and Michael appears willing to go forward. Reich's discovery of biological orgone energy, armoring, and the method of treating emotional disturbances holds hope for this and future generations.

References

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