A Schizophrenic Child with Learning Disorder

Charles Konia, M.D.

Reprinted from the *Journal of Orgonomy* Vol. 29 No. 2
The American College of Orgonomy

Developmental disturbances such as learning disorders are a common occurrence in childhood. The traditional psychiatrist is often not aware of the etiology or the treatment of such conditions. Orgonomic theory is able to satisfactorily understand learning disorders as arising from a disturbance in the development of ocular functioning in childhood. This formulation is based on the close functional relationship that exists between ocular and cognitive development. The following case presentation illustrates how an improvement in ocular functioning as a result of medical orgone therapy was followed by an increase in the capacity to learn.

Case Presentation

B, a six year old boy, was brought to therapy because of learning difficulties in school. His major problem was comprehending what he was trying to read. He also had difficulty processing new instructions and, according to the father, tended to get stuck "hyperfocusing" on a subject. In contrast, his ability in mathematics was a grade level above his chronological age. In the social sphere he exhibited hostile behavior toward a younger sibling (eighteen months his junior) and fought constantly with his schoolmates. He also found losing in any competitive sports activity intolerable. It was as if his very life depended on winning.

History

His mother's pregnancy with B was uneventful. However, labor lasted eighteen hours and was extremely difficult. After deceleration of the fetal heart rate and discovery of cephalopelvic disproportion an emergency Cesarean section was performed. B was cyanotic at birth but his eyes were reported to be "open and clear." He was described as a "quiet, good, happy" baby. He slept well and was breast-fed for one year.

At eighteen months, following the birth of his younger brother, there was an abrupt change in his "good" disposition. He became hostile, acted aggressively toward the baby, and had tantrums. He became headstrong, negativistic, was difficult to be with, and exhibited head banging. Speech development was delayed and he did not begin speaking until after age two.

By age four he was becoming shy, withdrawn, and lacking in self-confidence. Toilet training occurred spontaneously about this time but he had occasional periods of enuresis that continued to the time of presentation. When B was five he started playing soccer in school. Because he was an excellent athlete he dominated the game but could not tolerate losing or not scoring. He also teased and bullied his younger brother incessantly. When his hostile behavior was curbed by his parents he had a tantrum. They responded by putting him in his room where he screamed, kicked, and threw

things about. This was followed by crying which yielded to deep sobbing. He would then fall asleep for several hours.

B was exceedingly strong-willed. His frustration with himself for not winning a game or not scoring goals was intense. He reacted either by becoming angry with himself or simply not trying. Occasionally, he stubbornly sat down on the playing field and refused to leave. At half-time he stayed to himself away from his teammates and the coach. It soon became evident that he was incapable of controlling his behavior. He could not stand to lose. The following incident is illustrative:

While playing the position of goalie in a hockey game, he blocked the puck with his head and injured himself. When asked why he did not duck, he answered that if he had then the opposing team would have scored a goal.

On entering first grade, it was noticed by the school psychologist that B had a "learning problem." He was referred to a private school for learning-disturbed children and it was at this time that he came for treatment.

Biophysical Examination

Biophysical examination revealed prominent armor in the ocular segment. His forehead was pale and immobile and his face was inexpressive. His eyes were dull and unfocused and he was unable sustain eye contact. The musculature of the occiput was very tender. He could not shout out loudly and his throat (cervical segment) was constricted. He could kick and punch when asked to. Except for the diaphragm there was little armor below the cervical segment, including the pelvis. Beneath his dull facade, he appeared quite alive and sensitive.

History

From a characterological and biophysical standpoint B's initial presentation was the same as that of his father, a paranoid schizophrenic. Years before, B's father had presented with hostile tendencies including homicidal impulses. Biophysically, there was severe armoring of the ocular segment with a pale, constricted forehead. The eyes were immobile and expressed suspicion. The occiput was very tight and there was little armor of the lower segments particularly of the pelvis. Like his son, he was headstrong and had impulses to smash with his head. In childhood, he also had a learning disorder and was left back several times. The qualitative aspects of his learning disorder (difficulty processing information) was identical to that of the child. The mother's psychiatric history was non-contributory.

Course of Therapy

Because both parents had been patients in medical orgone therapy they understood the process of therapy and therefore gaining B's cooperation occurred without difficulty. I began treatment by directing his attention to the expression of anger and his underlying

fear of it. Mobilization of his occiput produced angry shouts, following which he looked relieved. At the end of the first session I asked him how he felt and he said, "Happy."

In subsequent sessions, although he was reluctant, B allowed me to continue to relieve the chronic spasm in the muscles of the back of his neck and occiput. This resulted in more angry shouts accompanied by angry kicking and punching the couch. It was not long before he himself became aware of the spasm and tension in the muscles of his head and neck. His subjective recognition of what I observed clinically enabled me to further gain B's cooperation. A therapeutic alliance was thus formed which allowed for increasingly intensive work. More release of anger with relief followed. After each session he reported that his head felt "loose" in those areas where I had re-lieved his muscular tightness. I also worked on mobilization of the eyes and forehead.

By the sixth session the occipital muscles felt softer. However, he continued to drift away in his eyes after only moments when I tried to have him stay focused in the present. As his occiput continued to soften, a painful muscle cord could be palpated on each side of his neck. Pressure on these muscles produced more rage and increased both his alertness and attention span. The more intense the anger he expressed, the more relief he felt. Direct expressions of anger were now occurring at home. The father, because of his understanding of similar feelings in his own therapy, was of considerable help during these episodes. After his son's angry outbursts he would massage B's neck and scalp and make eye contact with him.

By the sixteenth session the father noticed a marked improvement in B's ability to be more aware of his surroundings, although he continued to be somewhat absent-minded. He also reported that B was doing better at school and did his homework unsupervised. He learned to read and particularly enjoyed problems in mathematics. In session, he appeared more alert. He expressed curiosity and was able to initiate conversations with me. His eye movements were now much improved. This included his being able to look around the room in a more sustained manner.

The bioenergetic disturbance underlying his learning problem be-came clear as therapy progressed. His inability to keep his eyes focused and "present" for sustained periods of time during a task (for example, tracking a pattern of objects in the room) was the biophysical basis of his inability to think sequentially or to concentrate on a sequence of ideas. The major thrust of B's therapy was to continue releasing energy held by the predominant blocks in his ocular and oral segments which gave rise to the signs and symptoms of impaired natural functioning.

Gradually, as the expression of anger intensified, an admixture of sadness appeared with it in the form of angry crying. As physical mobilization extended to the muscles of the face, neck and shoulders, the emotional expression changed to misery. This phase of therapy was accompanied by an ability to tolerate softer feelings and with it to better accept losing in sports. His relationship with his mother became closer and he was better able to accept her love. His learning ability continued to improve as well. Now, the primary therapeutic task was to enable him to express the full intensity of his misery.

Pressing on the muscles around the scapulas (supra and infraspinatus) produced deep sobbing. His body began to participate more fully in this expression and he sounded more and more like an infant in distress.

At this time B entered a period of overt negativism, both in therapy and at home. He became less cooperative and resisted coming for treatment. This reaction was a defense against rage toward his father which he had begun to express directly. His anger at home intensified with frequent tantrums and outbursts against his younger brother. His father continued to be helpful by confining him to his room during these episodes and by comforting him afterwards. This allowed B to express his misery. In his sessions, I encouraged the expression of anger directed at me by having him kick and punch the couch. He left the sessions smiling, alert, and grateful.

B's treatment was then interrupted for one year because of the father's financial difficulties. During this time the family moved and B was transferred to a regular public school. He continued to improve academically. Upon his return to therapy I observed that the improvements he had made earlier had been sustained. I resumed mobilization of his misery as before which he could now express for entire sessions at a time. In addition, there were indications that his pelvis was beginning to armor. This included occasional arching of his spine and retraction of his pelvis. At present B is ten years old and has had one hundred forty-four sessions.

In one of his most recent sessions, he proudly showed me his report card from school his grades were mostly "A's" with a few "B's." His father describes B as being more in control of himself, studying and doing homework by himself without prompting from his parents, and practicing clarinet because he enjoys it. In soccer his behavior is much improved but he still has some problems losing or not feeling successful. His father further describes B as being "sensitive and caring." He loves animals and plays with his dog for long periods. He takes a parent's hand while walking through the mall, wants a kiss and says, "Love you" at bedtime each night. He is liked by his teachers who say he tries very hard. He and his younger brother continue to be very close although bullying and fighting, while less intense, are still problems.

The focus of therapy will continue to be freeing the ocular segment of its remaining armor. This will stabilize the progress he has made as well as effect further improvement in his functioning.

Discussion

Orgonomic diagnostic criteria include direct observation of the patient's pattern of armor and the history of disturbances in the functioning. This information directs the medical orgonomist to the segment containing the major block to the organism's energy flow and it is here that the therapeutic intervention begins. This child's signs and symptoms indicated that the primary site of involvement was the ocular segment.

It is probable that the vicissitudes of B's birth (trauma to the head and the difficulty of his mother's labor) laid the foundation for the formation of his particular biophysical structure which contributed to the development of his learning disorder.

From a diagnostic standpoint, the child was an ocular character, most likely a paranoid schizophrenic. **1** His headstrong behavior and early head banging were attempts at relieving holding (tension) in his head. His learning problem was a direct manifestation of his ocular armor. Specifically, ocular armor resulted in his inability to focus and be "present" in his eyes. This in turn resulted in a diminished capacity for concentration and an inability to think sequentially or follow a sequence of ideas. These manifestations of ocular armor constituted B's learning disorder. The severe contraction of the ocular segment responded well to orgone therapy following which his learning problem was largely eliminated. With continued focus on the ocular segment this child's clinical improvement is proceeding smoothly.

This case illustrates the importance of parental cooperation and early intervention in order to obtain the best therapeutic results.

Footnotes

1 The father's history of paranoid schizophrenia was a genetic predisposing factor. Although we use the term "genetic predisposing factor" it must be emphasized that at this time we understand nothing about the energetic functions involved.