A "Problem" Child

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Reich's discovery of the distinction between primary and secondary drives opened a new avenue of approach to "problem" children and children's problems. From the psychoanalytic view of him as an id- governed "wild beast," the child emerged as basically "good" and "social" from birth, "bad" and destructive only in reaction to the frustration of his natural (primary) impulses. When this destructive- ness is organized psychically and physically in his armor, the child becomes truly a problem child. The "nature vs. nurture" dilemma, as to whether the problem originates in the child or in the adults and their culture, was underscored by Reich's discovery.

Case History

Aaron is a 7-year-old white male child. When he was first seen, he was *AV*2 years old. He had been under evaluation by his day care center for being "moody, depressed, and' aggressive." It was after he threw a chair at another child that he was referred to the clinic where I began seeing him. He was born of an unplanned pregnancy, with a brother one year older and a sister age 8 from his father's previous marriage. His mother reports she felt good during most of the pregnancy but occasionally had worries that she would have a deformed baby, a feeling she had had with the previous pregnancy. She felt guilty about having another child so soon and for having had an abortion before getting married.

Aaron was born with respiratory difficulty and spent the first two weeks in the intensive care unit (the first 10 days on a respirator). She feels the period of nursing (to age one year) was when she had the best contact with him and felt most competent as a mother. Aaron's

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early development was reportedly "normal." He was weaned "without problems" at age one year, "because he was getting too big and aware." Toilet training began about age 18 months, and was accomplished by age two years through the use of shame and comparison with his older brother.

When he was 3 years 3 months Aaron's parents finally separated after more than a year of increasing difficulties and several brief separations. The children saw their father less often than the agreed-on every other weekend. While his mother worked for a period and then decided to go to college, Aaron and his brother spent more and more time with babysitters and in day care centers. When Aaron was seen in the therapeutic nursery at 4 years 6 months, his mother reported feeling that the children had not been "disciplined enough." She was in a relationship with a young man who used a coat-hanger to hit them with "to get their attention" and encouraged her to do the same. She said she felt unable to "get into this," unable to handle them, and guilty that she was not giving them enough attention. At the same time she .felt her "needs were not being met" and that she did not have enough time to do her schoolwork which interfered with her hopes to "make something" of her life. She noted that Aaron and his brother often got into fights and that Aaron had developed enuresis at about age 3V2 (not long after the final separation of the parents). On the positive side, she described him as "lively and curious."

Therapy

My treatment of Aaron has consisted of 25 months of traditional play therapy, followed by 6 months of orgone therapy, with direct biophysical work. The first 21 months were twice a week in a clinic setting, the remaining time once a week privately. The two techniques give us the opportunity to compare them, theoretically and practically.

Play Therapy

When I first saw Aaron he was an attractive young boy who seemed older than his 41/2 years. He had an open endearing quality which gave me the feeling of wanting to cuddle him and do things for him. His behavior was overly self-sufficient. He would not even allow anyone to help him get his coat off. He was bright and curious and explored the playroom, asking many questions. He could make good

eye contact but rarely did so. His color was good but his hands were cold. Physically he had a solid athletic "feet on the ground" appearance.

The first year involved establishing a trusting relationship and handling his resistance to therapy. After only a few sessions he spontaneously although tentatively took hold of my hand while walking to the therapy room. In these early sessions he frequently asked me to build him a house from blocks and gradually allowed me to do more for him.

These early sessions, with the developing strong affection for me, were followed by a one- to two-month period of intense resistance to leaving the nursery for therapy. For several sessions he was dragged by the teachers to the therapy room. When he was prevented from leaving, he became panicky but unable to express it. This problem was then handled by my keeping my appointed time and letting him know I was there to see him. If he refused to come in, I would sit in the nursery while he went about whatever he was doing, which usually involved play with other children. As time went on he interacted more with me. Finally, after increasingly clear signals from him to do so, I began picking him up and carrying him to the therapy room.

As soon as he remained in the playroom long enough for me to feel he could hear what I was saying, I gradually and consistently told him that I thought he was afraid to come to the playroom because he would have strong feelings for me and feared I might leave him like his father did. With each increment of this interpretation he said, "Shut up, don't talk," but would stay longer in the playroom. When the connection with his father's leaving was made, he said, "Shut up, that's not true — how did you know that was true?"

Most of the rest of that academic year involved his asking me to make things for him (usually animals) out of paper or *Play-doh* that he could take home. He began talking more about things that were troubling him, especially missing his father and his bed-wetting. Each of these would only be touched on and, if I pressed to hear more, he would look sad for an instant, then briefly anxious, and quickly become irritated and angry. He also began tentatively asking questions about sex. During this period Aaron's resistance to going to or remaining in the play therapy room was often handled by following his request to go outside, playing games or walking. Often he would ask to be pushed in a small wooden doll carriage he called "the wagon." We would go to the area near the clinic where there were mounds of earth overgrown with weeds, wildflowers, and brambles. He would

be curious and deeply interested in nature, looking at, smelling, and often tasting each new flower or plant, after asking me what it was and if it could be eaten. It was on one of these jaunts that a most touching moment occurred. Aaron had caught a grasshopper and was holding it in his cupped hands and saying he wanted to take it back to the nursery. Then peering at it through a crack between his hands he said, "No, I won't take you back." Delicately taking it by its back between thumb and finger, he tossed it away from him saying, "Go free and enjoy your life."

His mother continued to bring him during the nursery's summer break. This was a period in which he became more immediate and direct, ushering in the second year of therapy which saw a strengthening of our relationship. This allowed us to work more directly with his anger, which was often precipitated by the termination of the sessions and expressed in his "wildly" throwing things off the shelves or attempting to flood the room from the sink. He remained in the therapeutic nursery mornings, while starting regular kindergarten in the afternoon.

At mid-year he was terminated from the nursery because it was decided he no longer needed it. His mother continued to bring him to therapy but was not as consistent as the nursery bus. The clarity of his intellectual awareness was often startling. After several missed sessions when he became hostile and was shooting at me with a gun, I said, "I wonder if you are mad at me for not seeing you several times." He replied, "No, I'm not mad at you, it's my mother that didn't get me here, but I don't let her know I'm mad." I asked, "What do you do with those mad feelings?" He replied, "I eat them and then they go down in my stomach and I throw them up, then they are out on the floor." During this time we began talking more directly about his bed-wetting problem and how it tied in to his anger.

Academically, he performed well in kindergarten. There were few behavior problems, other than occasional minor fights and mischief, until the end of the year, when he was "caught" in two "incidents" of sexual play with girls. The school suddenly decided to do an extensive evaluation and was strongly considering placing Aaron in a special class for behavior problems. I recommended giving him a chance in the regular first-grade class, where his curiosity and obvious intellectual ability could be challenged and in which he should do better with the more structured setting.

When I left the clinic, his mother made the commitment to bring Aaron to me (privately) once a week. There was an initial period of

greater openness and sweetness toward me during which he talked relatively freely and made things for me rather than vice versa. Later, he began hiding from me both literally and emotionally. This coincided with several suspensions from day camp for "incidents" which at the time sounded like defiance of the counselor. At the time we were dealing with his defiance of me. He was also undergoing testing for the evaluation at school. For the most part he refused to talk with me about this saying, "You weren't there so it doesn't have to do with you." When I asked him what he understood about it and why it had been done, he said, "They want to find out if I'm crazy." When I asked, "Why would they want to do that?" he replied, "I'm not crazy but I've been acting a bit crazy there." He then tried to run away and would say nothing more about it.

He began regular first-grade class. It was after several months that he revealed to his mother that the "incidents" for which he had been suspended from day camp were sexual, probably including intercourse with the little girls. She was disturbed on learning this, uncertain how to handle it, and finally gave him a long talk about sex, including the risks of intercourse. She told him it should wait until he was older, but that in the meantime masturbation was all right. He had told her he would not talk with me about it. In the next session, when he asked endless questions about things he knew the answers to, I said, "Often kids ask many questions when they are afraid to ask about something else they want the answer to, like where babies come from or sex." He said, "I'm not afraid of anything" and showed marked contactlessness in his eyes, prompting me to work biophysi- cally on them. When I had him follow my finger with his eyes he stopped breathing. I tickled him to get him breathing, and he ran away across the room. I again had him follow my finger and asked if he knew he went "off" in his eyes. He told me, "Oh yes, I do that whenever I'm about to get in a fight and then they don't know I'm there, and I come out and surprise them and win." Continued mobilization of his eyes quickly brought out "wildness," a frantic, angry response.

Orgone Therapy

His mother jokingly noted the "wildness" in contrast to the sleepiness when she brought him saying, "What did you do to him? I couldn't wake him when we got here." I told her of my work with

his eyes, that there are feelings he was holding back in them, and briefly about orgone therapy. I recommended that I work with him biophysically on the couch. She noted that, when he is upset, he gets a funny look like he is "retreating into himself." She considered my recommendation and agreed.

Biophysical examination showed that his eyes were capable of a wide range of expressions but often looked as if he were about to "get away with something." He also gave the impression that he put his eyes out of contact "intentionally." At these times he showed an "impish" smile but could bring himself back into contact when asked to. (Frequently though he would laugh and roll his eyes all the way up into his head.) When he was willing he could track well with his eyes, although often got "stuck" in the upper quadrants. His forehead showed little movement and when asked to raise it, marked anxiety appeared in his eyes. His occiput was tense and tender, his lips full and pink. He could yell and scream without difficulty when first asked but then refused. His shoulders, back, and intercostals were ticklish but not hard. He held his chest high with little movement. When asked to breathe with his mouth open, he first gave a "silly" grin and then alternately pumped his chest and abdomen up and down without moving much air. He would do this for a few breaths until told to just breathe. He then would settle into a rhythm for a few breaths before holding his chest high again. His pelvis was somewhat stiff both actively and passively. There was little other apparent armor. The overall impression was of a lively, bright, and alert organism.

On the couch I pursued a much more structured approach with him than in play therapy. Initially direct biophysical work consisted of mobilizing his eyes, work on his occiput, and tickling along his ribs to keep him breathing. I had him look at me and bring out the expression in his eyes. The more structured approach quickly brought out his defiance and sneakiness, as shown by his attempts to sneak off the couch and his pretense of following instructions while doing the opposite. I attempted to restrain him from acting on any impulse, until he was fully in contact with it. Initially there were indications of progress with this approach. He began to talk more simply and directly than ever about some of his problems, i.e., how being sneaky would get him into trouble at school and elsewhere, and his fears that he would not have any friends because his brother had told them all that he wets the bed.

He continued to spend much of the sessions fidgeting and trying

to move around on the couch. There would be short periods when he would be calm and cooperate with breathing or with looking at the corners of the room when I called out the numbers he had assigned to them. For the most part, however, he showed little evidence of coordinated emotionally-charged expression. Attempts to work bio- physically on his musculature would lead to increased restlessness and wild or "silly" behavior.

After discussion in supervision it was decided to simplify the approach and work initially only with organizing his breathing and, in a calm, firm manner, stop his disorganized discharge through fidgeting. As he lay on the couch I placed my hands on his chest and instructed him to breathe in through his mouth as I moved my hands up, then out through his mouth as I moved my hands down. Meanwhile I continued to talk to him quietly while trying to establish a rhythm to his breathing. When he fidgeted I calmly restrained him and told him I thought he moved around so much to get away from some feelings he is afraid of, that we need to have him stay still and just breathe, so we can let his feelings develop. In that way we can see what they are and help him get them out, so he does not have to carry them inside. To this he said: "I'm not afraid of anything and if I was it's none of your business." Even so, he established a rhythm in his breathing for four or five breaths, then looked quite serious and a little anxious and asked, "If someone had their eye come out, but it was still hanging on their face, could they still see with it?" and "Could it be put back?" (Not being certain of the origin of this question, I elected to say little about it.)

I continued working on his breathing in the same way. Frequently after merely a few full breaths, he began to cough and developed audible wheezes. Over the next several sessions he initially resisted coming into the treatment room and getting undressed, but with verbal encouragement did so. He began these several sessions by saying "I'm bad," resisted breathing when told to do so but finally began to develop a breathing rhythm. He was told that acting "bad" may be his way of asking for what he wants, such as his mother carrying him into the treatment room, or my holding him on the couch.

The next session he cooperated well, coming into the treatment room and undressing. He sustained a rhythm with his breathing but quickly began to look anxious. When asked if he was aware of looking frightened, he replied, "I'm not afraid of anything." Work with the penlight to mobilize his eyes was immediately followed by his saying,

"Did you see Indiana Jones? The guy in there was not a very good actor because he was afraid to show he was afraid." Continued mobilization of the ocular segment, by having him open his eyes wide and raise his forehead, elicited a progressively clearer expression of fear. Asked to scream, he did so with his silly "getting-away-with-some- thing" look. He was told, "Maybe you are afraid to show you are afraid." He then was able to scream several times which, although restrained, was accompanied by a discharge of real affect. He then began talking about being anxious about going away to overnight camp and that he was having problems wetting the bed again. (His mother had confirmed his report that the bed-wetting had almost entirely stopped for several weeks.) He was reminded of the association we had previously made between his bed-wetting and feeling angry. He spontaneously talked about getting into fights in school in the previous week.

The following week he cooperated well, breathed spontaneously without much prompting, and seemed more serious and "together." He talked about going to camp, his excitement as well as his fear of revealing his fearfulness to the other children. He also said he had stopped wetting the bed, except for the night he spent at his father's. Several attempts to have him talk more about this were answered with, "There's nothing more, it's just what I said."

He returned from camp and a two-week break in therapy. Although cooperatively coming into the treatment room and undressing himself, on the couch he was restless, uncooperative, and defiant. His breathing was again disorganized and lacking spontaneity. I returned to his breathing and pursued his tendency to hide what he thinks and feels, and his acting as if no one would take him seriously. He replied, "Well no one does and besides only sissies show what they feel." He again became restless and, in my attempts to calmly restrain him, he sneaked kicks at my head.

His mother reported that since camp he had been wetting his bed. He also had been very interested in sexual matters. He hid with his brother in her closet, only to come out giggling when she emerged from the shower. She also reported that Aaron unlocked her door to barge in on her with her boyfriend in the sexual embrace, because he said he wanted to "see us moving."

At the present writing I continue to work on his breathing and eye contact and to try to have him express his hostility in a more directed way.

Observations on the Therapy

The work with Aaron is instructive in basic human terms. From the beginning, the simplicity and directness of his expressions were striking. Within a few meetings, he reached out and took my hand. His resistance to therapy was directly expressed by refusing to go to the playroom.

Aaron has the "Emperor's-new-clothes" ability to uncover what is irrational in the behavior of adults, challenging and causing one to question the rationality of some rules. For example, early in treatment he asked to take home a Stegosaurus I had constructed with him from *Play-doh*. I reminded him of the rule that "nothing is to be taken from the playroom." He replied, "You can get more *Play-doh*. I know where they keep it." My own "need" to be "right" was challenged, and I stuck rigidly to the rule. His genuine heartbreak quickly turned to anger as he smashed the Stegosaurus and ran from the room. I realized I had made an error and that it would be important to our relationship to let him know this. Doing so would also serve the broader function of showing him that it is all right to reveal that one can be wrong. (The teachers had noted that he would not do this with other children.) When I told him I had not understood how important it was for him to have the figure and that I had made a mistake in not letting him take it, he replied, "That's all right. You can draw on paper I bring from the nursery, and maybe someday we can make one from *Play-doh*." (A child's ability to forgive is a tribute to his capacity to re-expand and be outgoing again.) Several months later his request for me to make a similar figure accompanied a breakthrough in his therapy.

Aaron's liveliness encouraged me to overcome my own stiff role as "Doctor" and to play again: tag, rolling down hills, drawing, and playing with clay. His absolute faith in my ability to draw or sculpt gave me the courage to try these again.

Many of Aaron's statements and descriptions of his experience are intriguing in biophysical terms, for example, his description, "I eat my anger and then throw it up and it's out on the floor." Also striking was his observation of going out of contact when challenged, so he can then "come out and surprise them and win." His questions about eyes coming out of the head appeared to come from "out of the blue" shortly after he breathed fully for only a brief time. They suggest castration anxiety. Of note, however, in the timing of these questions

is Koopman's observation that, with breathing and organization of their energy fields, patients frequently report a sensation of the energy around their eyes extending out from their heads (1).

Discussion

What causes "a child to become identified as a "problem child"? The child does not come requesting treatment but is brought when some grownup becomes aware of a problem. This can be because the adult recognizes bona fide symptoms from which the child suffers, or because his behavior has become a problem to the adult. In the latter case, it may be because the child's behavior is neurotic, which the adult sees and seeks help to change, or because the child displays healthy behavior which the adult cannot tolerate.

In order to properly treat any problem, we must first diagnose it. The theoretical approach influences the diagnosis. The mechanistic, biochemically-oriented psychiatrist, using DSM-III criteria, might give Aaron a diagnosis of "attention deficit disorder with hyperactivity" (commonly, the "hyperactive child") but could then offer little more than *Ritalin* or other drugs. The psychoanalyst de-emphasizes diagnosis in favor of a "psycho-dynamic formulation" of the patient's unconscious psychological conflicts. My psychoanalytic supervisor felt Aaron's conflicts centered around unresolved issues from his father's separation from the family and unconscious conflicts related to castration anxiety and sibling rivalry.

In orgonomy, diagnosis is functional, having its roots in Freud's early libido-economic theory of psychosexual development, a legacy which Reich always acknowledged. Orgonomic characterology develops the concept much further, since it is based on an understanding of energy movement or its disturbance. In orgonomy, it is the pattern of armoring that establishes the diagnosis. In adults this is defined as a specific character diagnosis. Reich and Baker have noted that a specific character diagnosis cannot be made in children because the character does not become fully set until puberty (2:142). (Baker has said elsewhere that once the child has "resolved" the Oedipal conflict, one can often make a statement of the character diagnosis with some certainty (3).)

Aaron has features suggesting diagnoses from ocular, phallic, or impulsive characters, so no specific diagnosis is yet justified. Even so, the functional energetic theory allows us to establish that his principle

areas of holding are in the ocular, thoracic, and pelvic segments, and that he has significant problems of contactlessness and impulsivity. Since Aaron was treated from the two different theoretical frameworks of psychoanalytic play therapy ("play therapy" from here on) and or- gone therapy, we can compare the theories and their practical implications for treatment.

The goal of play therapy is to help the child alter maladaptive behaviors based on unconscious conflicts, i.e., to help him develop insight and be in control of his behavior rather than driven by it. The method is designed to allow him free expression in the activity that children naturally do (play), while making and reporting to him observations about his activity and its meaning. The relationship with the therapist is considered an essential aspect of the therapy. It provides the child with an experience of being accepted and not punished for what he thinks, feels or does. It also provides a person with whom the child can identify and emulate. Most important, it provides a situation in which the child's automatic behavior in a relationship (the transference) can develop, come to light, and be shown to him. Theoretically, the realm of study and treatment in play therapy is the psychic processes of the child: his ideas, fantasies, and behaviors (4:2648).

The goal of orgone therapy is to achieve unitary, natural functioning of the organism. This implies restoration of plasmatic pulsation and the unimpeded discharge of the orgone energy within the organism, i.e., a healthy sex economy. Therefore, the realm of investigation and treatment in orgone therapy is the child's functioning as a total organism, with emphasis on the interrelationship between psychic and somatic processes. This theoretical difference greatly broadens the practical techniques available to the orgonomist, as compared with those of the psychoanalytic play therapist. All of the techniques available to the play therapist may also be used by the orgonomist.

The transference relationship between patient and therapist is also very important in orgone therapy. The basic tools used by the orgonomist in the treatment of a child are the same as those used in the treatment of adults. These have been well summarized by Baker (2:45; 5) and briefly comprise the following: (1) breathing to increase charge and heighten energy movement through the organism; (2) direct biophysical work on muscular armor to remove blocks to the energy flow; and (3) character analysis.

The distinction in goals between "maladaptive" vs. "adaptive" behavior in play therapy and "natural and healthy" vs. "unnatural and

unhealthy" in orgone therapy has practical implications. If the goal is "adaptation," we become caught in the quagmire of "adaptation to what?" This was pointed up by the recommendation of the psychoanalytic supervisor who suggested seeing Aaron for not more than a year or so after leaving the clinic, as long as he was getting along in school and not wetting the bed. This approach is based largely on the removal of symptoms and adaptation to what is societally normal.

Early in his career, signaling his move beyond psychoanalysis, Reich established two theoretical principles still central to orgonomy: (1) The basis for neurosis goes deeper than the symptoms to the very character of the person; and (2) objective criteria for health can be established. When seen from the perspective of orgone therapy, it becomes immediately obvious that Aaron is far from the goal of treatment, with his muscular armor, disturbed contact, disturbed respiratory function, and disturbed capacity for organized emotional discharge. The criteria of functional health (unimpeded bioenergetic pulsation) — not societal "normality" — is crucial in the orgone therapy of both children and adults. The child who deviates from social norms is, of course, more vulnerable than the adult because of his dependency upon adults.

Throughout his work Reich especially cherished children and saw in them the hope for the prevention of neurosis. He had hoped through the Orgonomic Infant Research Center (6:7) to establish objective criteria for what is inborn, natural, emotional expression and what is secondary expression, coming from distortion by armor. Reich wrote:

> **We do not even know what percentage of children are emotionally deadened soon after birth, or how many retain their inborn agility through their first puberty. We do know that noisiness and biopathic hypermotility are often mistaken for natural behavior. (6:66)**

The emotionally deadened child is not usually identified as a "problem." He will generally be perceived as a "good" child. It is the child who is very much alive that presents as a "problem," because biopathic developments have given rise to "noisiness and hypermotility." The dilemma of distinguishing "biopathic hypermotility" from "natural behavior" and a "genuine" request from a "neurotic" demand in therapy is the same dilemma every parent faces in trying to raise children rationally. Corollary to this is the distinction between responsibly "free" behavior vs. licentious behavior, as discussed by Reich, Baker, and Neill (2:372; 7). The goal is not just to allow the child to express himself, but rather to help him to express himself as much

as possible from the core, while removing the impediments (both internal and external) to his doing so. This case illustrates how difficult it can be to make these distinctions in practical action. Aaron is full of life. Some of his expressions are healthy and come out cleanly, and some are neurotic and come through in a distorted way. Essential to supporting the health in a child is first knowing what it is. Reich's differentiation of primary from secondary drives is a vital theoretical distinction.

It was in part this child's expressiveness which caused him to be identified as a "problem." His referral to the clinic for aggressive behavior (throwing a chair at a classmate) stemmed from the adults' recognition of its neurotic character. On the other hand, his suspension from day camp, the referral for evaluation by his school, and the contemplated placement in a special class were triggered by his sexual behavior. All of this seemed less a recognition of neurotic problems than the adults' intolerance of his natural expressions and their failure to distinguish natural from sick behavior. A recent release of some of Reich's work with children provides insights on this very problem. In order to help children evolve naturally toward genitality, Reich observes:

> **. . . we must agree that a first puberty in children exists; that genital games are the peak of its development; that lack of genital activity is a sign of sickness and not of health, as previously assumed; and that healthy children play genital games of all kinds, which should be encouraged and not hindered. (6:66)**

It is of interest that the mother could tolerate his motor discharge of rage (it was the school which referred him for that), but she became upset and confused by his sexual behavior. Thus she feared he would develop "sexual hangups" like herself and lectured him on the dangers of intercourse, though she knew better intellectually.

This child's problems with "hypermotility" are intimately related to his problems with contact. In retrospect, I felt that my error in the play therapy treatment of this child was in failing to ensure that he was fully in contact, i.e., that he felt what he was expressing, before acting on his impulses. With his contactlessness when we approached his questions about sex and the "wildness" which subsequently emerged, I feared my previous errors had returned to haunt me. I had often had the impression that much of his fidgeting, wild running around, laughter, etc., were in some way sexual. In play therapy there had been times when he would rub his genitals against

objects by straddling them, or would straddle my leg and rock while sitting on my lap. These would be quiet times, following which he would suddenly become giggly, wild, and then begin throwing things. It was as if he discharged some of his sexual energy in his chaotic physical activity. With his activity he has defended himself from and not been in contact with various feelings: sexual excitement, anxiety, anger, and sadness.

In orgone therapy, we have been able to address this problem more directly. This has involved the work to organize his breathing and work on his eyes to improve his contact. It also has involved sufficient inhibition of his impulsive expressions of secondary drives to allow him to come more in contact with the emotions behind them. In this way, the energy of the secondary drives can be adequately discharged in an orderly fashion, rather than partially leaked off in the contact- less, impulsive act.

Summary

This case has given us the opportunity to review several practical and theoretical issues in the treatment and diagnosis of children. Because of the two different treatment modalities we have been able to compare them. We also can appreciate how much can be learned from one child.

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