

Orgonomic First Aid in the Prevention of Post-Traumatic Stress Disorder: A Clinical Case

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Abstract

A case of emotional/psychic trauma treated with medical orgone therapy is presented. The anxiety reaction of the traumatic event was dissolved in a few sessions, preventing the development of Post-Traumatic Stress Disorder (PTSD). Making an accurate character diagnosis and the specific orgonomic technique of addressing and working with emotional as well as muscular blocks (armoring) were essential in achieving this clinical result.

Introduction

In 10 to 30% of cases, PTSD (Post-Traumatic Stress Disorder) can be the lasting pathological consequence of a psychic trauma, a traumatic event outside the range of ordinary human experience, which impacts the individual. The psychic trauma can be directly experienced (e.g., war, violence, accident) or indirectly (observing injury to or the unnatural death of others; learning about similar experiences from others). Reactions to the event include feelings of intense fear and helplessness, resulting in the persistent re-experiencing of the traumatic event (e.g., intrusive thoughts, distressing dreams, flashbacks, dissociative states), persistent avoidance of stimuli associated with the trauma, and a numbing of general responsiveness¹ (*Diagnostic and Statistical Manual of Mental Disorders*). If these symptoms appear during the first days or weeks after the trauma they are considered normal. If they persist for a month they are classified as Acute Stress Disorder (ASD). If they are still present after one month, the diagnosis of PTSD is made. (For the orgonomic treatment of PTSD, see Crist.)

¹In orgonomic terms this is described as contactlessness, a state of energetic lack of movement. (Baker, page 69)

A significant panic-like response, pronounced distress, dissociative reactions, and a past history of anxiety and depression are considered risk factors for the development of PTSD. (Zohar et al., page 45)

In cases of acute psychic trauma, psychology and psychiatry primarily use superficial cognitive interventions, such as encouraging patients to return to full activity, regain emotional control, and avoid emotional withdrawal, etc. Another technique that has been used by psychiatrists is so-called "psychological debriefing," i.e., an early intervention after exposure to the trauma ("the golden hour") providing emotional and practical support to prevent the development of chronic symptoms. Many experts today advise against any intervention that enhances the memory of the traumatic event, this based on studies that show a statistically significant symptomatic deterioration particularly if used in the immediate aftermath of the traumatic event. (For a review, see Zohar et al.) This curious statement unmasks the contradiction of mechano-mystical psychiatry: on the one hand, there is a vague understanding of some emotional phenomena occurring after trauma and the need to get rid of it; on the other, there is insufficient understanding about the nature of this phenomena (emotional and energetic stasis, damming up) and therefore an inability to deal with it. This renders the "golden hour" off-limits.

Orgonomic first aid deals with emotional reactions to traumatic events from the functional point of view, based on the role of character and muscular armor and its economic significance for the energy metabolism of the individual (Chavis). A traumatic event causes an immediate contraction of the bioplasmatic system of the organism, which can potentially become chronic. This means that the individual organism is no longer able to re-expand and resume its pre-traumatic state of pulsation. Orgonomic first aid by definition tries to restore the pre-existing level of functioning (organismic energy level and pulsation) by using biophysical and characterological interventions intended to reverse the state of acute contraction and prevent the development of chronic symptoms.

Clinical case

On a Sunday evening in January 2006, I was called to an emergency during my obligatory on-call service as a psychiatrist in my hometown. The call for help regarded the wife of a middle-aged man who had just committed suicide by shooting himself in the head.

When I arrived at the scene, I saw the deceased lying on the living room couch, a hole in his right temporal area, the gun still in his right hand. The house was full of police and Crime Scene Investigation personnel. In another room I found his 49-year-old wife. She was crying, agitated and confused, and had to be assisted by a policeman. The soft-looking, slightly overweight, scared woman accepted my help and began to talk and breathe, in an agitated and shaky manner, unable to discharge any emotion. I asked the policeman to leave us alone. Once alone I asked the patient to tell me what she was feeling. Surprisingly, she told me that she was angry and didn't know why, nor could she tolerate having this feeling in front of her deceased husband. I asked her if she was able to yell. She tried and began to yell and scream with enormous force. Three policemen came into the room to check on us. They left reassured after seeing that I had control of the situation.

At first she continued to shout out with rage, then she cried and later she raged again. In the interim she explained to me that she had wanted to leave her husband and that he had threatened to commit suicide if she were to leave him. When she told him she had made up her mind, he made good on his promise. She was mad at him over this but also felt terribly guilty. After 30 minutes of crying, discharging guilt and rage, she felt relief. She then agreed to come to see me in my office. We scheduled an appointment for three days later.

At the first appointment she was anxious, over-talkative and slightly confused. She felt guilty and sad. I told her to lie down on the couch and asked her what she was feeling. She was again surprised to feel anger. I encouraged her to shout and again she yelled out the same feelings as she had at our first encounter: rage and guilt. This pattern continued for three weekly sessions with a sense of relief that

lasted 3 to 4 days. Slowly the rage she felt against her husband was transformed into rage against her parents, who made her into an over-anxious, always supportive, helpful woman, incapable of enjoying life and being more assertive in meeting her own needs. With her husband, she realized, she had built a relationship similar to that which she had with her parents: being maternal, supportive and caring while denying her own needs, feelings and desires. This realization allowed the discharge of stronger rage through forceful yelling and hitting, which brought stronger and lasting relief. She felt better and better over the course of another three sessions. She then decided to continue her sessions on a monthly basis. After one year, she decided to quit therapy and she expressed her gratitude. She had overcome her trauma in a satisfactory way. She was in love again, this time it was not as a caretaker, but in an adult relationship of love and physical attraction. This patient was seen for a total of sixteen sessions over 13 months.

Discussion

The clinical picture at presentation gave no doubt that this patient was at serious risk for developing PTSD. Her history, indeed, included past episodes of anxiety, depression and mild dissociative states under stress. From a characteranalytical standpoint we know that these symptoms can be typical of the hysterical character. Hysterical features were present at initial contact and were resolved with a combination of bioemotional discharge and reassurance and directives to face her anxiety. The aim was stopping her from running away from emotion with consequent emotional and energetic stasis. In fact, she was running away from rage by using several defenses, such as dissociation² and confusion, chaotic emotional expression and hysterical fit. Relief was not difficult to obtain once she had been helped to face the intolerable feelings of rage against her dead husband.

Mechanistic psychiatry and psychology grasp the importance of remembering and discharging memories immediately following the

²Dissociation, to be distinguished from the schizophrenic split, relates to the hysterical disconnection between ideas and their associated emotions.

trauma, "the golden hour," but they are unaware of the biophysical necessity of emotional discharge. In fact, intervening psychologists and psychiatrists, fearing emotional, visceral, physical discharge, end up enhancing the memory of the traumatic event in victims by not encouraging, sometimes even blocking, the emotional discharge. This is reflected in the statistically reported worsening of anxiety, with consequent development of PTSD.

References

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