Energy & Consciousness, International Journal of Core Energetics, 7: 57—60, 1999
ISSN: 1050-5326 print

http://www.coreenergetics.org

Working with Genital Trauma

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R. is a 36-year-old white married foreign-born male in an import- export business who came to the USA seven years ago to enter orgone therapy. His chief complaints were premature ejaculation and “inability to express aggressiveness." He underwent six months of therapy, w hich he experienced as very positive, with sympathetic improvement and some episodes of "catching myself answering back in anger without even thinking what I was doing." This was not an unmixed blessing, since in the process he almost got himself fired from his job and alienated tw o of his closest friends without provocation. Yet. experiencing spontaneity was a definite step forward for him.

When his therapist moved out of state. R. moved to New York City to settle down but could not retain the improvement he had felt during therapy. He again had sexual difficulties, felt depressed, out of contact, emotionally flat, w ith incessant ruminating. After an interval of five years w ithout therapy, he entered treatment with me in October 1990. Because of financial difficulties, sessions have been somew hat sporadic, with a total of 39 at the present w riting.

Mental Status and Biophysical Exam

R. presented as a highly intelligent, soft-spoken individual of average build, appropriately attired. His manner w as pleasing, compliant, cautious and distancing, and eye contact was poor. Affect was flat and restricted: speech rambling and obsessive.

On biophysical exam, his field showed a very "stilled" quality, w ith little movement or charge. His body posture w as one of constraint, with significant armoring in the eyes. jaw. throat and chest. His diaphragm was also held and his pelvis was not moveable. The quality of the armor, however, was not heavily muscular but a combination of stiffness and anorgonia.

Early History

R. is the second son of a middle class provincial family. His brother, four years his senior, was a popular "jock" type, phallic, athletic, socially successful, who spumed R. when he reached out. taunted him cruelly, and called him a girl and a sissy if he cried. There were three

younger sisters, one of whom R. felt close to. The father was distant and emotionally unavailable, a patriarch; the mother limited, unresponsive, too busy to be there for R. or protect him from his brother's teasing.

Despite this, there were happy memories of playing outside with the neighborhood children until age seven w'hen R. underwent a series of operations for an undescended testicle, the last of which also included a totally unnecessary circumcision because "I peed crooked." As later came to light, there were instances of doctors standing over him, laughing and saying his bandaged penis looked like a "little old man." There were painfi.il soakings of the penis in hot camomile in order to soften the big, straw-colored stitches for removal. No attempt w'as made to mitigate the trauma or help him deal with his fear He was not even told his penis would be operated on until he woke up and saw the stitches.

Course of Therapy

Initially, 1 focused on constantly monitoring the transference reaction in order to correct the projections and distortions of reality as much as possible. This was done in a non-pejorative, empathic way which helped built gentle trust between us. Because of the early childhood wounds, this process had to be ongoing, gentile and repetitive, since the patient had suffered greatly. My sense was that the two phallic issues, sex and aggression, were enormously over-determined by the early genital trauma. Therefore, I tried to create the safest, most non-judgmental, nondemanding atmosphere possible and convey to him that he was not alone in his struggle and his pain, and that I was his unconditional ally whether he "produced" or not.

At the same time, because of his "stuckness" energetically, and his depression. 1 worked very vigorously on his body, always with his permission and never forcing anything on him. Also, since the diaphragm is strategically located over the autonomic center. R's autonomic generator of the energy field. I gave him homework of swallowing and regurgitating six glasses of warm tap water every morning in order to mobilize the diaphragm in an effort to counteract the anorgonia and build up his field. He responded positively.

In the initial interview. R . who had been unable to cry for years, surprised both of us by a spontaneous flow of tears. This arose in conjunction with our first retrieval of genital trauma from his surgery. Subsequent sessions have yielded more and more hitherto forgotten pieces of the trauma, which flow ed spontaneously from the combined empathic contact and somatic work. I never tried to channel him toward one affect

more than another, but rather let him be guided by his own energy field. At times some rage would manifest, but the predominant affect appeared to be painful feelings of genital loss. For example, "1 lost my penis," an exclamation which surfaced when he was reliving his age 10 unnecessary circumcision At these times he often reverted to his mother tongue despite his excellent English. Closely allied with these were feelings of utter abandonment and isolation.

Comment

It seems to me that the increasing spotlight on child abuse and its sequelae, as epitomized by the work of Alice Miller, has been helpful in refocusing our attention on the usefulness of recapturing childhood traumas and laying bare their pivotal role in the elaboration of defenses. In *Drama of the Gifted Child* (to me her best work). Miller rightly expands the concept of child abuse to include emotional abuse and emotional starvation, which is really a paraphrase for Reich's early signalling of the devastating effects of what he called "negative bioelectrical conditioning" of infants and children. Miller's point that even "nice," non-abusive parents can be highly damaging in their failure to emotionally resonate with the young organism is what orgonomy has long recognized as the withholding of orgonotic contact.

In the patient presented here, we see a combination of early emotional deprivation by limited, contactless parents and tormenting by a phallic brother who maligned his manhood and deliberately inhibited his emotional expressions. Even given the subsequent genital trauma, if this patient had had what Winnicott calls a warm "holding" environment, he might have survived in a much more intact fashion. But the combination of emotional deprivation, callousness and surgical interventions forced him to elaborate defenses of hiding, distancing, caution, submissiveness, and mtellectualizing as the only way he could survive the devastating genital and psychic pain.

Ultimately, all patients defend against genitahty, which represents the flow of energy toward the world, the capacity for unblocked contact and empathy, creativity and self-activation. How' they defend against genitality often bespeaks deep psychic wounds so painful that trust becomes almost impossible. R. started out with many strikes against him; basically, he is a very decent and highly-endowed individual w ho is now showing signs of opening up and coming more and more in contact with himself and others.

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