A Case of Manic-Depressive Character With Dissociation

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C.R. is an overweight, 53-year-old, white, Protestant, married woman. She presents as sad, emotionally, labile, and intelligent. She lives with her 55-year-old husband and one of her three children, a 23-year-old daughter.
C. has been followed at Central Hospital for four years with eight admissions and outpatient care. At the time I first met her (July 1986), she was one of many "medication" patients being treated with lithium and phenelzine, an anti-depressant. After seeing her every 2-3 weeks for 20-minute sessions for four months, it became apparent her depression and labile mood were worsening. She complained that I was not helping with the typical questions about sleep, eating, suicidal thoughts, etc., and that medication was a joke.
She gave a history, consistent with manic-depressive illness, but her behavior seemed somewhat atypical for that diagnosis. She reported cycling from depression to mania every two months for eight years, but she seemed to change drastically almost every time I saw her; either non-verbal and sad, or very self-confident, bragging, and quite casual (feet up on the chair in front of her).
In October 1986, I decided to offer weekly sessions of 45 minutes, since the medication and brief superficial sessions were of no help. When offered, she immediately said, "Why should I trust you, you'll be gone in a few months." I gave a commitment of weekly sessions until June of 1988 and had to reassure her constantly of this.

Symptoms in October 1986, included mood swings (equally divided between mania and depression), erratic sleep, off and on suicidal thoughts, and poor concentration. No hallucinations or delusional thoughts were noted, but she was occasionally grandiose. She admitted feeling angry but showed no outward sign of it. She never cried nor was any other emotion shown, except for a devil-may-care attitude when she appeared manic.
Her eye segment showed significant blocking while either manic or depressed, but she was not overtly psychotic. When depressed, she appeared and acted like a frightened little girl and, when manic, was boastful, arrogant, and intrusive. Throughout all this, I felt she was likable. She looked as if she were at the end of her rope, swinging between a helpless, frightened little girl and a raucous, "carefree" but contactless woman.

C. is the eldest of three children, with one sister (chronically depressed) and one brother (manic-depressive). She was born in Canada. After her father died in an accident, her mother brought her to the U. S. at eight months of age. Her mother, whom she describes as cold and cruel, beat her as a child because she would

not stop crying. Her mother remarried and had one son and one daughter. C. was sexually abused by a maternal uncle from the age of 8 to 12. She ran away from home and tried to prostitute herself at the age of 13. C. had few friends as a child and was an average student who graduated from high school. She married her husband at 20, after becoming pregnant (a marriage of necessity). She attended college for one year but stopped, because she could not concentrate. C. has worked as a nurse's aide sporadically.

From early childhood to adult life, she has felt angry but has been too afraid to show her anger. The only exception to this is when she appears manic (since the age of 38).

C. sought treatment for depression at the age of 31. Her first three years of treatment with an analyst were of "no benefit - He just sat there and said nothing." Her first hospitalization for depression was at age 34. She was treated with imipramine and lithium with a fair response. Since age 34, she has had 24 hospitalizations, including two series of electroconvulsive therapy which helped significantly. C. has been admitted for both depressive and, since age 38, manic episodes. There was one suicide attempt in 1982 with a drug overdose. Suffering depression only until age 38, she then had mood swings of equal duration (mania and depression) with two-month cycles. There was no history of hallucinations until March, 1987, when C. experienced visual and tactile hallucinations of spiders crawling all over her. There have been no paranoid delusions but occasional grandiosity while manic. Past therapists are described by C. as not caring about her, losing their patience, and discharging her. C. sought hypnotherapy at age 36 to stop smoking but, when hypnotized, became acutely terrified.

C. has been very guarded about her sexuality, revealing only the sexual abuse by her maternal uncle from the ages of 8-12 and describing herself during adolescence as "sexually promiscuous." Recently, she has asked questions about why her husband cannot take "no" seriously. Since the birth of her third child, she has not felt sexually aroused except when manic and, then, flirts with strangers, usually in a bar, but never lets them "get" her.
C. has no allergies. She had kidney stones removed surgically in 1965 and has had pyelonephritis and multiple urinary tract infections. Additional history revealed sclerosing adenoma of the left breast (1970), rectocoele and cystocoele repair 20 years ago, a hiatal hernia, migraine headaches, and tonic/clonic seizures in 1972 after having bacterial meningitis which was treated with antibiotics and phenobarbital for two years. C. has smoked since the age of 15. She has had occasional left--sided chest pain but workup proved negative. Two of her three children were delivered vaginally, one by Cesarean section. There is no history of drug abuse, but she drinks alcohol when manic. She reports overeating when manic or depressed. Her bowel habits are normal.

C. is obese, with most of her weight in her torso and thighs. Her eyes, when open, appear childlike with eye contact brief and poor. She has difficulty looking to the left. Her face is sad with tightness in the oral segment, primarily in the jaw. The cervical segment has poor mobility (the patient complains of tightness at the base of the neck, posteriorly and medially). The thoracic segment shows large breasts and a large chest cavity. Armoring appears minimal in respiration. Her abdomen is obese and dead, and her pelvis stiff. The overall energy level is low but can be excited, especially in the ocular, oral, and thoracic segments. C.'s manner is of a sad lump. When eye contact is made, she looks either childlike or sad. Her attitude has changed from "no one can help me" to "I don't know who I am now" and "I can't deal with all my anger." Currently, her anger has become more focused on me.

Initially, C. was either sad and non-verbal, as if to test my patience, or casual, nonchalant, and arrogant. Sessions lasted 45 minutes. For almost one month, the only subject was C.'s mistrust of me: "Why are you, a psychiatrist?" "Why are you interested in helping me?" "You won't be able to see me after June." Her primary resistance when sad wasn't looking and not talking. When animated, she could make better eye contact but still avoided energetic contact by, her arrogance and casual attitude. The day of her ninth session, it was snowing and I canceled the appointment. When I saw her three days later, she was openly angry with me for the first time, "Maybe it will snow again so you won't have to see me." She again became sad and withdrawn at the next visit. I had her breathe while looking at me. She tolerated a modest charge and then said, "This is what the hypnotist did; it makes me feel like I'm losing control." The next session she was biting, arrogant, and unreachable. She angrily said, "Why were you so mean to her last week?" This was the first appearance of a second personality in our work together.

Historical material concerning her two personas, her experiencing sexual abuse, and her promiscuity now began surfacing by way of notes she would leave me. When C. spoke of historical material without affect, I redirected her to the present which created improved contact with her current anxiety. She did reveal that she had felt like two people since the age of 10 or earlier but had never told anyone else, allowing them (former psychiatrists) to assume her changing presentations were due to her manic-depressive illness. Some notes written by her depressed persona described the other as a "dirty tramp who only uses men." Notes written by the arrogant one described her depressed persona as useless, suicidal, and doomed to destroy "both of us," as well as being weak. She was starting to present more consistently as depressed and withdrawn.

Work on her eyes and breathing partially mobilized these segments while generally increasing her charge. Spontaneous feelings of nausea and the need to vomit appeared at home but were actively resisted. She described the feeling of

being choked and having trouble breathing when nauseated. I suggested she induce vomiting by gagging on her finger when nauseated. She did so the next day and was surprised at how good it felt. She wondered how I knew it could help, appearing suspicious and fearful. Work on eye movements, looking at me, and breathing continued as tolerated; sometimes she refused to do anything but sit like a lump. Her character resistances of silence, stubbornness, projection, gas well as the dissociative defense manifested by the two personas, were pointed out to her repeatedly until March 1987, when she spontaneously said, "I feel like screaming." She was told to scream into a pillow at home while keeping her eyes wide open. She got relief from this, experiencing a feeling of being more comfortable with herself.

From mid-March until June, there was no mention of two personae and she presented consistently as depressed. Her respirations were deeper and she experienced "tingling" in her face, eyes, arms, and hands after rolling her eyes and breathing. Again, she was curious about how eye motion and breathing could make her feel like this. She was afraid, but at the same time was clearly making energetic contact between her eyes and hands. I felt, for the first time in therapy, she was in contact with deeper layers of anger and fear.
By the end of June, she said while looking at me, "I feel I have no defenses, I don't know who I am. She is not here anymore to help me with my anger." Since presenting her case in seminar, I have pointed out to her that she defends and hides herself from me by holding her hands over her face and head, avoiding eye contact with me, and by her silence. She has responded by remaining in a depressed mood but is becoming intolerant of her withdrawn position. Flashes of anger with outbursts of "shut up, Goddamn it, shut up," accompanied by improved eye contact have become more frequent.

In December 1987, C. began to complain that nothing had changed, and she felt more miserable than ever. She appeared in better contact with her own misery and anger, but terrified of moving (although she complained openly of not making progress quickly enough). At this point, C. openly would say "No" to me with increased intensity and started to criticize me in a more focused manner, while maintaining eye contact for the first time. She told me she had never shown any overt negative feelings to any of her former psychiatrists.

Discussion

C.'s diagnosis of manic-depressive character is well-supported by the following: (1) chief complaint; (2) body type; and (3) armoring pattern, specifically oral unsatisfied block with a phallic structure. Her eye block, while never manifesting in overt psychosis, was evident in her self-perceptual split of identity into two personas. Consistent attention and work on looking at me and eye movement while breathing has integrated her structure, at least on the superficial level. Her

eye block, while still Present, is less severe so that she is more tolerant of expressing anger at me. C.'s general functioning has improved, although she has remained depressed. She is socially more active without going off in her eyes or becoming more manic as she had in the past.

Orthodox psychiatry acknowledges only two separate symptom complexes in this case: manic-depressive illness and multiple personality disorder. Orgone therapy allows the understanding of character and mus-cular armoring as manifested in resistance and the layering of both categories of defenses. In this case, the character is manic-depressive accompanied by a severe eye block, presenting with splitting of self-perception and defended by projection. Character analysis has allowed this patient to crystallize out and make contact with her resistances while, at the same time, biophysical work on breathing and eye contact has allowed greater charge to move in those segments previously defended by character armor.

Although this patient's self-perception appears better integrated on the surface, a deeper holding and tendency to dissociate may occur as deeper layers are worked with. Her therapy is proceeding cautiously and is regulated by her ability to tolerate an increased charge safely. Sessions continue weekly.

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