A Case of Manic-Depressive Character

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The manic depressive character is fundamentally a phallic structure modified by an oral unsatisfied block. Depending on the strength of the pregenital inhibition, the underlying genital revenge may be more or less masked by the oral traits. Unlike the repressed oral fixation, the manic depressive vacillates between depression and a breaking through of oral strivings associated with excitation, heightened, usually disorganized, activity and euphoria. Baker (Reference 1: p.122) has summarized the salient features of this structure:

Characteristically, this type is rotund, with a tendency to breadth rather than height but he is agile, impatient, and intolerant. The body gives an impression of flabbiness and poor substance; the more the depressive characteristics dominate, the less rotund it is.

Usually manic depressives are talkative and energetic, but changeable and with poor ability to persist at one task. The more manic they become the more restless, flighty, jerky, and pushy is their behavior, with increasing excitability and loud boisterous, and boastful speech, frequently rude and vulgar. Their judgment is poor and their insight at best is only fleeting. They seem to have been wound up and let go without guidance.

This condition may suddenly change to a hopeless, reproachful depression. All activity then becomes slowed, including speech, and the face appears sad and hopeless, the body seems to shrink, and the shoulders droop. This may increase to the point of immobility and total neglect of all bodily needs. In the manic phase, eating, drinking, and talking are excessive; in the depressive, they may all be stopped completely. Compulsive symptoms may be present especially when neither phase is too marked. One sees all degrees, from slight variations from normal to the extreme where hospitalization is necessary. In some individuals the depressive side dominates, in others the manic; while in still others the two alternate quite regularly. As the years pass variations tend to become more marked and longer in duration.

The following case is noteworthy for its "classic" features.

C.S. is a 32-year-old, white, male psychology consultant for a large business firm, who presented with the following complaints: He felt unable to reveal his real feelings to people. In any encounter in which he detected the merest hint of

rejection or aggression, he would become withdrawn. Cautious and shy, he found it difficult to establish close relationships. At work, while his performance was more than adequate, he'd become withdrawn if bested intellectually by some coworker and feel that he'd be regarded with contempt.

He described himself as a "manic-depressive" during the initial interview, having experienced wide swings of mood with highs and lows lasting months at a time since the age of 19. During the "highs," he may be quite gregarious and well organized. In college, for example, he rated in the top ten of his class scholastically, was very popular as a freshman, became a leading class officer, and was "rushed" by the fraternities. Then, for reasons which he never understood, he became depressed. His formerly clever and enthusiastic conversation would become slow and plodding, he'd lost interest in everything, have difficulty reading or studying, become forgetful and prone to falling asleep in class, his grades would slip, and he'd finally isolate himself completely. During these periods, he'd have fantasies of suicide although he never made an actual gesture.

He felt his swings of mood had prevented his realizing his full potential and had given him a continual sense of jeopardy. During one of his "ups," for instance, he single-handedly organized a drug abuse program, cornered a vice president of the company, berated him for not contributing sufficiently to the program, and so antagonized him that he had the patient transferred to another office in the company. Shortly thereafter, he began to feel that the responsibility for the program was too much for him. He "lost interest," and it collapsed. Thus, he felt that at either extreme he sabotaged himself. He regards himself as very systematic ordinarily - very good at starting things rolling - but has great difficulty in carrying things through to completion. His performance is erratic.

C.S. initially did not mention any sexual symptoms, but, as therapy went on, his considerable problems emerged. In his family, sexual matters had never been openly discussed only giggled about. His brother, 3 years older, made overtures to the patient (who was then 13) regarding anal intercourse in which the patient was to play the passive role. The patient refused. He denies ever having had a homosexual relationship, but, sometimes during masturbation, he'd have to stimulate himself anally with fantasies of being penetrated to achieve climax. Most masturbatory fantasies consisted of intercourse with a woman, entering her from behind. His first intercourse was at age 15. He is frequently, troubled with premature ejaculation - within seconds of penetration. A common pattern of intercourse is that he has a premature ejaculation in the face to face position, shortly regains his erection and enters from behind with a more normal endurance before climax. He is unaware of any fantasies during intercourse and denied feeling anxiety; however, he has also reported that the more exciting his partner the more prone he is toward premature ejaculation. In general, he seems to choose aggressive, feminist women and maintain relationships with them for

one or two years. In at least one of these there was a formal verbal understanding in which both partners were free to have other partners, with the other's knowledge. Thus the patient was entertaining and having sexual relationships with two or three women simultaneously. Despite this apparent surfeit, he gained little satisfaction from it. He felt he couldn't really love anyone. His affairs would usually terminate because the women got "fed up" with his depressions, silences, and withdrawal. The premature ejaculation would worsen as they became more critical of him. In the same way, his marriage of three years ended in divorce.

Background

The patient was bright, normally developed, and lively until the age of 9 when his father died of a bleeding peptic ulcer. He recalls nothing of him except that by all accounts he was very much admired and regarded as a real leader, albeit quiet and reserved. The mother had been very dependent on her husband and took his loss very hard, attempting suicide on two or three occasions. Apparently his health had been so precarious, they were advised against taking on the stress and responsibility of having children. In the first years after his death, she threw this up to the two sons repeatedly, i.e., if it weren't for them, he'd still be alive. She berated them hysterically and rigidly dominated their lives. When C.S. was 16, his mother suffered a near fatal medical illness which hospitalized her for nine months. During this period, the patient and his brother - who had assumed authority - managed at home by themselves. The patient never liked him because of his cruelty and bullying. At the same time, he dreaded the return of his mother. C.S. became increasingly withdrawn and was brought to a psychiatrist, whom he saw for six months. When he was 19, he had his first "high" as a freshman in college and experienced cyclic swings in mood over the next few years. At 22, he consulted a psychiatrist. After two years of therapy, he felt he hadn’t changed substantially. Despite his erratic performance, he completed college in four years and obtained his Master’s degree. On the other hand, his behavior - particularly in reference to "authority figures" - cost him a number of jobs.

In recent years, he has been simultaneously involved in encounter groups, transcendental meditation, and transactional analysis. He meditates daily, sitting in a clothes closet, and periodically attends meditational retreats. He feels this has benefited him to a certain degree - he has "smoothed out" quite a bit - e.g., he has held down the same job for two years and his regular visits to his mother are no longer the occasion for their customary violent arguments. It is of interest that his brother once required hospitalization for three months because of a manic-depressive episode.

Medical history reveals a predilection toward "tension headaches," but otherwise the patient rarely catches cold and is seldom ill from other causes. There is a history of hemorrhoids and constipation.

Biophysical

The patient is tall, gaunt, and aesthenic. He is well dressed in a very neat, conservative style. The impression is of a John Carradine physically or the stereotype of an undertaker. His stride, though broad, was at the same time cautious and tentative, with the shoulders up and the neck pulled in. the eyes flicked about in a covert manner. His speech was voluble, glib, and professional, very analytical and liberally sprinkled with Freudian and psychological jargon. He said outright he was a manic depressive. He was fully prepared with a copious collection of notes about his complaints to read to me (which I asked him to put aside). Though he spoke of depression, he looked not depressed but excited and frightened. The eyes shone unnaturally like those of a zealot. He sat with an elaborately expansive posture, legs crossed, fingers laced in front of his knee. He smiled tightly when asked to undress.

On the couch, he appeared quite anxious; he lay very still, barely breathing, with a frozen half smile, and eyes straight ahead.

The Eye Segment

Examination revealed frontal baldness with brows arched, forehead furrowed in a fixed expression of superciliousness. The brows, forehead, and the temporal and occipital regions were quite tense and tender, and he became frightened with the palpation. The eyes appeared bright and motile, the pupils dilated.

Oral Segment

The jaw was long, prognathous, and only slightly armored. The lips were fairly full and sensuous, and the face mobile in a mechanical way.

Cervical Segment

Examination of the anterior neck elicited retraction of the chin and a ticklish titter. The attitude of the neck was as if in anticipation of a blow from behind. His voice was deep and monotonous in quality.

Thoracic Segment

The chest appeared depressed, extremely rigid, and it barely moved with respiration. The anterior and posterior musculature of the shoulder girdle was very tight and tender, the intercostal and posterior paraspinals extremely ticklish, again evoking a childish giggle which seemed eerie in contrast to his usual professional manner. Punching was fairly powerful but still and robot-like, accompanied by a staring expression and rigid neck.

Diaphragmatic Segment

The epigastrium was very tense, sensitive and painful and bulged prominently with inspiration.

Abdominal Segment

Flanks were very ticklish and tense.

Pelvis

The pelvis seemed moderately armored but he allowed the thighs to fall loosely apart. Kicking was strong but also robot-like.

Therapy

At the beginning of therapy, he asked if he could continue transactional analysis and group therapy simultaneously with orgone therapy. I pointed out that this really constituted running- an evasion- and that he had to make up his mind what he wanted and stick to the one thing. He appeared to understand the importance of this and, as far as I know, discontinued everything else. However, he still retires to his closet to meditate in the belief that it helps to control his erratic behavior.

Biophysically, the immediate aims in therapy appeared to be to:

1. Mobilize the thoracic segment while simultaneously.
2. Bringing out his terror by working intensively on the ocular seg-ment.

Characteristically, the patient sits on the edge of the couch after undressing, intending to read a written résumé of his week, including his dreams. I forbid him to do this; I have continually to remind him to 1ie down as soon as he has undressed. On the couch, he would at first cross his legs and lie with his hands folded across his abdomen or behind his head. I insisted that he uncross his legs and bring his arms down. He'd become very sti11 and quiet, breathing cautiously with his belly, and staring straight up while occasionally sneaking glances in my direction. I'd have him breathe, sigh, and roll his eyes, which would shortly evoke the insipid smile and a low-pitched guffaw. Should I rise from my chair to approach him, he becomes very apprehensive. He is "ticklish" all over, cannot bear any degree of pain, squirms all over the couch, and literally climbs the wall or slides to the floor to evade me. He never fights back or loses his temper but literally begs for mercy. He cries "Help, help, help me, help me," but in a curiously unemotional voice with blank face and eyes. It is difficult to elicit real emotion. He is compliant but robot-like in everything he does, and, while he becomes a frightened little boy when I work on him physically, he doesn't seem able to fully feel or express terror. I am most successful with a low key approach; just having him breathe and sigh while looking about fearfully and slowly rolling his head from side to side. I keep pointing out the multitude of ways he runs from his fear: the fleeing "manic" behavior, and the superficial, contactless relationships and sexual affairs. At the end of the sessions, he appears much more serious, and his skin is warm, ruddy, and sweating; but at each succeeding session, its' as if we had to start from scratch.

Discussion

While many of the historic details which might document the genesis of the oral unsatisfied block are as yet unavailable to this patient, certain factors in the generation of his structure seem clear. The identification with the mother at the phallic level is readily inferred from the anamnesis. As in all phallics, the traits of genital revenge may be modified or weakened by the presence of pregenital blocks - in this case, oral and anal. Our patient does indeed demonstrate a rather tenuous hold at the phallic level:

1. He is shy and easily intimated, tending to become passive (anal dragback) in the presence of more aggressive persons-male or female.

2. His frantic sexual behavior represents an unconscious, desperate effort to regain contact with the phallus, i.e., he's not really sure it's there.

3. Deep anxiety, deriving from phallic aggression, produces his premature ejaculation and a tendency, toward the expression of pregenital, anal sexual impulses.

4. The fairly, long duration of his relationship with women has mainly an oral, dependent basis, since at the genital level he fears contact.

A most important aspect of this case is the mechanism by which the syndrome of genital revenge has been modified.

The significance of any pregenital block or hook is that it binds energy that would otherwise flow to the genital. Another way of thinking of it is that genital functioning implies an unrestricted (and tolerated) flow into the genital, and the essential characteristics of the genital character are an expression of this. This is also true of the phallic: Everything that makes him a phallic is an expression of this energy, again reaching the genital but without discharge (being bound up in infantile sexual functioning, i.e., phallic narcissism). The energy bound up in the pregenital blocks is thus diverted from the genital, thereby deemphasizing its characteristic expression and lending the flavor of the particular block to the structure. Thus it can be said that the more substantial the pregenital block the weaker will be the hold at the genital level. With this in mind, we might better understand the be-havior of the patient when the oral block yields and when it clamps down. In the present instance, with release of the block, not only is there a flood of oral activity but also a flooding of the entire organism with energy; since some of this reaches the pelvis, the patient may, function more like a phallic. When the oral block clamps down, the phallic traits become subdued and the dragback to the oral level activates anal features. It is as if the energy in being withdrawn from the genital becomes stalled at the anal level. Thinking of the characterologic in terms of energy also explains why meditation has helped the patient. The meditation has the function of reducing excitation by inhibiting respiration which, being intolerable to the patient, would otherwise produce chaos in him. At the present time, this is the situation: He is neither manic nor depressed. He has also had a resurgence of premature ejaculation and one by one has given up all but one of his sexual partners, a girl who is rather kindly but "not very exciting." All this would indicate a withdrawal of energy from the genital. At the same time, he is better organized at work and was recently promoted (somewhat to his dismay!).

Biophysically, the basis of this functioning is reduced excitation by virtue of the thoracic armoring. This is most striking. The chest is obviously contracted and rigid, a not infrequent finding in the phallic; yet is held in expiration and barely moves, more like that found in schizophrenia. This plus the bizarre behavior on the couch at first made me think of schizophrenia, despite all the evidence for a manic-depressive diagnosis (including the patient’s own affidavit). This might also account for the absence of significant depression of clamping down in the jaw. It would appear that our patient has achieved an equilibrium between manic

euphoria and depression, not only by anal holding, but by reducing excitation through a thoracic block. The picture is analogous to the compensated schizophrenic in which respiratory inhibition and pelvic block produce a degree of stability. One might say our patient is literally afraid to breathe. Clearly, the immediate biophysical therapeutic problem is to mobilize the chest without producing an iatrogenic euphoria or depression. In many cases of this nature, there is also a danger of suicide as the patient goes into or emerges from depression. Much of the emphasis must be character analytic. Once mobilization of the chest is tolerated without rearmoring in the oral segment, the phallic structure may be attacked.

REFERENCE

1. Baker, E.F.: Man in the Trap. New York: The Macmillan Co., 1967.