The Chronic Depressive Character

Charles Konia, M.D.

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The chronic depressive can be one of the most difficult patients to understand and diagnose correctly (1). Although he has a phallic structure, he is quite timid, and his phallic traits (except for his strong drive) are not conspicuous. This is especially true when the oral block is strong. In fact, any well-defined phallic behavior rules out the diagnosis of a chronic depressive. To further complicate things, although he has an oral repressed block, depression may be relatively mild. Because of these difficulties, the diagnosis may either be missed completely or it may be confused with other character types. Nevertheless, the chronic depressive has a specific constellation of symptoms that, when clearly seen, makes the diagnosis unmistakable.

Baker (1) has differentiated the chronic depressive from the compulsive and schizophrenic characters. Other character types for which the chronic depressive may be mistaken are the manic depressive, depressed (the depressed manic) and the phallic with an oral repressed block.

The depressed manic may be confused with the chronic depressive, especially when his drive is fairly strong, as he then approaches the phallic. Biophysically, both have their major armor in the oral and chest segments. The depressed manic, however, usually has a strong ocular block as well. Ocular blocking in manic depressive characters has been noted by Nelson (2). Characterologically, minor differentiating features are that the depressed manic maintains an unstable phallic position. He is not as well integrated as the chronic depressive. This is shown by a tendency to be unreliable, have a relatively poor drive, and inconsistent work habits. When depressed, he may exhibit psychomotor retardation and a proneness to suicide, for which hospitalization may be necessary. The depression of the depressed manic is deeper and typically cyclic. In therapy, he may respond by becoming manic. He alternatively blames himself and others for his plight. He is typically demanding and feels that the world owes him something. His inability to tolerate anxiety makes him volatile.

In contrast, the chronic depressive has the strong drive of a phallic. He is an efficient worker with a strong sense of responsibility. Undemanding of others, he works in a selfless manner. When depressed, he may become immobilized, but not to the point of psychomotor retardation. He rarely, if ever, attempts suicide, although he may contemplate it. According to Baker, he never has dreams of flying. His plodding existence never allows him to get off the ground. Reflecting the drabness of his life, the setting of his dreams is usually night, and the dreams are almost never in color. His depression may vary in severity according to the external situation, but it is not cyclic. He blames himself rather than others for his situation. He is in good contact with his anxiety and never becomes manic.

This brings us to another differentiating feature, the state of armoring of the ocular segment. As stated earlier, the depressed manic typically has an ocular block that when severe, makes him prone to psychosis (for example, psychotic depression). The ocular block gives rise to the poor contact, bad judgment and the tendency to displace his rage onto the environment that is typically seen in these cases.

In contrast, the chronic depressive has a relatively open ocular segment. In fact, without this provision, the diagnosis cannot be made. He displays good contact and excellent judgment. He has no tendency to displace his rage. It is directed at frustrating situations in his present life and is expressed only as a last resort. Despite his good contact, however, he has a great deal of guilt and blames himself for his problems even when there is no reason to. His clearheadedness is probably not related to his low energy level since this characteristic is also possessed by individuals with fairly high energy levels. **1** Occasionally, the phallic with an oral repressed block may be confused with the chronic depressive. Like the chronic depressive, these patients have a strong sense of responsibility with stable functioning. The main distinguishing feature is the presence of well-developed phallic characteristics. The oral repressed block is not severe enough to prevent the expression of overt phallic impulses. Any amount of mobile phallic aggression points to the diagnosis of a phallic, not a chronic depressive. Also typical of the phallic is the tendency to blame others instead of himself.

Case Presentation

The following case illustrates the chronic depressive character. In addition, certain observations regarding the biophysical picture will be presented.

The patient, a 32-year-old, white, female, married business manager came to therapy because she was "getting unhappier as the years go by." She had no children. Her marriage of ten years' duration was becoming increasingly more intolerable. Her husband was a tyrant and a bully, who not only constantly ordered her about, but also incessantly picked on her. Her typical way of dealing with his behavior was to be silently tolerant until pushed to the limit. She would then explode, and they would have screaming matches in which nothing ever became resolved.

In giving her history, she remembered that, when she was seven, a neighbor gave her more physical attention than she received from her own family. She enjoyed school and made one friend, the first close friend she ever had. When she was 12, her family moved to another town. By this time, she was taller than all the other children her age, very thin, and had undeveloped breasts. She was teased constantly at school and at home by her older brother, whom she hated for the teas-ing, so they had constant fights. Since he was very poor scholastically, she attributed his picking on her to his stupidity, although that did not make his remarks hurt any the less. The teasing made her feel inferior to those around her, and she was hesitant in making friends or taking part in social activities. She was a good student and always liked school, although she was too embarrassed to answer questions in class, since she did not want to draw attention to herself. In high school, she joined the swimming team and did very well in

the meets, as well as in other sports. At this time, she made a close friend, which enabled her to become less afraid of making social contacts with people her own age. She had good relationships with others but was never asked out on dates, which did not lessen her feelings of insecurity. She seemed to be someone to talk to and be friendly with, but not someone to take out on a date. During her last year of high school, her family moved again, and she found adjusting to the new social situation very difficult. She was very good at selling herself short and felt that no one would want to be her friend.

When she entered business school, she made many close friends, felt socially more accepted and wanted than at any other time in her life. She found that she was able to talk and relate very freely and easily. Being of help to others made her feel more comfortable and self-confident. She became dating, but was very afraid of sex, mainly because of the way it was treated at home. There was never any sex education; she was only told that you did not "do it" unless you were married because you would become pregnant. Of course, she knew better than that by this time, but the idea that one somehow was doing something unacceptable, bad, or immoral was always there.

After finishing school, she moved to New York and met the man she was to marry, an engineer, shortly thereafter. She liked him immediately. He had a good sense of humor and was very handsome but demanding and infantile. The sexual relationship was enjoyable, but it also produced a great deal of guilt. When he moved in with her, she had all the responsibilities for homemaking on her shoulders. Sexually, he expected her to continue with orogenital foreplay until he reached a climax. Although this was frustrating, she nevertheless went along with his wishes. Shortly after the marriage, they moved overseas, and the physical and mental abuse became a way of life. He would yell and pick on her, stating that she was not good enough for him. This would lead to some sort of physical violence. When they went out with others, he would regularly proposition some woman he considered attractive, and always made sure to disparage his wife's appearance at the same time. When he began having a few affairs, she looked upon this as being her own fault because she was not good enough. The self-confidence that she had managed to gain before her marriage slowly dissolved, and, once more, she felt like the ugly duckling whom no one would want to have for a friend.

Returning to the States, she began working again, which gave her some feeling of selfworth. As she was an extremely efficient and responsible worker, her boss frequently commented on how indispensable she was. At work, she was establishing good relationships with people and realized that she had something to offer. She generally was outgoing and opened her eyes enough to see that people actually liked her and respected her for what she was. Gradually, she began to recognize the many flaws in her marriage but did not know whether or not she still loved her husband. She was allowing herself to slowly shrink away to nothing in a relationship where she was giving all she could and receiving only abuse in return. This angered her, but, when she began fighting back, the abuse and destructive arguments only worsened. Then she began to get depressed, since she didn't see any solution to her marital situation other

than leaving her husband and she was too frightened to do that. At this point, she started therapy.

Biophysical examination revealed a somewhat thin, pale, white female who appeared cooperative and sincere. Although serious, she had a good sense of humor. Her eyes were mobile and in good contact but lacked luster. They appeared both sad and frightened. The most striking aspect of her face, however, was her extremely tight jaw. She spoke little, through partially clenched teeth, and had difficulty opening her mouth wide when asked to. One had the impression that she wanted to be understood with as little explanation on her part as possible. Her face was stiff and the occipital muscles, especially in the oral segment, were tender. Her throat was constricted and she found it difficult to shout fully. She had a cough, probably secondary to chronic bronchitis due to cigarettes. Her arms were held stiffly by her side. The lower segments, including the pelvis, were not particularly armored. While she was lying on the couch, I suddenly became aware that she gave the appearance of a corpse. She impressed me as having a low energy level associated with a major armoring in the oral and, to a lesser extent, the chest segments. At the same time, she appeared both decent and likable, and it was my impression that she could be attractive if her jaw were open and she had some sparkle to her.

She needed every bit of energy she could get. I therefore took im-mediate measures to increase her energy level by immobilizing her mouth and chest. Pressing on the massetters resulted in strong shouting. She was able to breathe more deeply, and this produced a strong, trembling of the lower segments accompanied by a highly visible lumination of her orgone energy field, particularly in the lower segments. This strong, wide field reaction, which occurred regularly in her therapy as an accompaniment to emotional discharge, was in marked contrast to her generally low energy level.

This energy push produced a feeling of well-being during the early part of the following week, but when her husband began picking on her again, she clamped down. I therefore focused on her marriage. She stated that her response to her husband's bullying was to hold back her rage as long as possible, which she did because of her fear of physical violence (to be discussed later). When it finally became impossible to contain herself, she went into a screaming battle. One had the feeling that, because she was in good contact, whatever she said was objectively correct. Later, a joint session with her husband corroborated the picture she gave of the marital situation. She nevertheless felt partially to blame for the problem. When I asked her to be specific she was unable to. It was obvious that her tendency to blame herself kept her from handling herself better, which was her pathological contribution to making the marriage. She seemed intent on making the marriage work at all costs. Discussion of her marriage problems enabled her to be a bit more aggressive.

I continued to mobilize her jaw and increase her energy level. She typically gave in to angry crying. Her lower body gave in to clonic movements with deep breathing. This procedure occasionally resulted in clamping down in the chest when the intensity of the

energy push became too strong. During these early sessions, no memories accompanied the emotional discharge.

She then had this dream: Her blouse had been torn down. She goes outside to find something but feels lost and naked. This dream indicated that her organism was responding to therapy (her blouse being torn down represents breakdown of armoring.) However, she felt lost and out of touch with her real needs (when she goes out to find something she is lost and vulnerable).

Further attempts to raise her energy level produced stronger anger. Her head shook from side to side as she shouted, and gradually she vocalized, "No." This resulted in a stronger expansion of her biosystem. Her entire body, including the vagina felt warm. She became relaxed, and her field luminated strongly.

As the intensity of the rage increased, she became increasingly frightened of what was inside her. She felt terror in her chest and abdomen and thought that someone was strangling her. During the following week, her husband, in order to control her, actually attempted to strangle her during one of their arguments. This reinforced all of her fears: If she spoke up for her rights and was not intimidated by her husband, he would strangle her. In the session following this episode she felt very frightened, weak, and unable to do very much. It was clear that the rage she felt towards him was so great that, rather than risk the consequences of a confrontation, she chose to capitulate.

During the following week, she appeared sad and depressed. Her sleep was disturbed by early morning awakening and she reported feeling tired. She stated that she was very angry with her husband and was not now pushing it into the back of her mind.

I resumed mobilization of her biosystem as before. Gradually, she began responding once again. We discussed her fear of getting angry, but she was not in touch with what was behind this fear. I decided to do a Reich Blood Test because I was concerned with the possibility of shrinking biopathy: Her organism typically responded to frustration by becoming depressed.

The blood test revealed the following: Microscopically, the red blood cells had a strong, wide orgone energy field. Disintegration began late (within 15 minutes) and was slow. Bions formed peripherally and were medium sized. This is a "B" reaction, indicating a strongly expansive biosystem. On autoclavation, however, the supernatant fluid was turbid instead of clear. When the fluid was agitated, the clot was quite friable, breaking into numerous small flakes with prolonged settling time. Microscopic examination of this fluid revealed the presence of T-bodies. This indicates a "T" reaction, reflecting a low energy level.

The blood test posed the same contradiction that I had observed clinically: This was a patient with a wide orgone energy field and low energy level. The possibility of shrinking could not be ruled out, although she did not seem in any immediate danger. As her depression subsided, she began to realize more vividly that her relationship with her

husband was based for the most part on her acceptance of his bullying and her feeling needed by him. She began having memories of her parents and recalled that, although they loved her, no love or affection were ever shown. They were both cold and reserved. She began having feelings of wanting to hold and love someone.

With further mobilization of her biosystem, her rage became intensified. Her voice became stronger as she repeatedly shouted, "No!" She again became very frightened. She had a dream in which people were breaking into her house. She tried to shout for her husband, but no sound came out. This indicated that although she was still afraid of shouting, on a deeper level she was facing her fear of separation from her husband. She was shouting out for him (holding on), yet she made no sound.

Further focusing on her feelings of guilt and intimidation enabled her to become more self-assertive, and she found her marriage more intolerable. Again, strong anger directed at her husband was followed by her becoming frightened. For the first time, she was able to identify this fear. Contemplating being totally separate from him, she asked, "What am I going to do?"

Facing this fear enabled her to temporarily put a stop to his bullying. As she got into better touch with her anger, she began making threats to leave. She expressed frustration at living "half a life" and questioned whether or not she really loved her husband. I told her she deserved more than she had and asked her why she tolerated being abused. She was very moved by my concern.

She began having sexual dreams but felt unexcited by her husband. She then contracted once again in her chest. She expressed dissatisfaction with herself and felt that her body was full of knots. She curled up into a ball.

I focused on her inappropriate attitude of kindness toward her husband. Despite his abusiveness, she invariably behaved kindly toward him. This attitude in effect was an invitation to be further bullied by him. On the couch, she gave in to more angry shouting. Suddenly, she stopped and stated that she had a feeling of well-being, that she had stopped feeling sorry for herself, which had made all of her aches and pains disappear. For the moment, she felt that she could take on anything.

She felt well during the following week, especially in her mouth and chest. She was handling her husband better. This gradually led to an uncovering of a deeper layer in her structure, her frustrated and unfulfilled longing for life. She hesitantly began reaching with her arms. When encouraged, she expressed fear of reaching or touching anyone because she felt inhibited. She felt alone and lost and recalled always being "picked on" as a child. One could feel her deep sadness, as well as her fear, when she said that no one could see or understand her desire to reach out.

The following autobiographical excerpt from a letter she recently wrote to me is a good indication, not only of her course of therapy, but of her present functioning:

I have in the last two years become confident enough to realize my rights and stand up for them at all costs. Unfortunately, at times I have been battered around in doing it, but I at least know it is the only way I can live from now on. My husband has improved his treatment of me, but still will take any opening if he can manage it to bully me. At this point, I feel if we continue to work at it, there is still a chance to save our marriage, but my main concern now has to be to save myself-something I've been avoiding all my life.... I have never felt so confident or alive in all my life, and I still have such a long way to go. The most important thing I can recognize from my childhood at this time is the lack of physical affection — holding, hugging, kissing. I want so much to show physical affection, but am afraid of being shunned. I'm getting closer and have been able to do so on occasions, and it has been an exhilarating feeling.

The past few months, friends have been telling me how much better I look. They say I have put a little weight on my face and don't look so drawn. I think what has actually happened is, since I'm not holding in so much my jaw, my face has loosened and I'm allowing expressions and feelings to show.

I'm beginning to feel alive and healthy and good about myself. I finally realize that I don't have to worry about what other people may think of me.... In the past, I always took the burden of others' poor actions as my own worthlessness. Now, I am able to understand that anyone else's poor behavior is not a reflection on me personality or actions. I am responsible only for my own actions. It's a good feeling and makes living a pleasure rather than a burden of guilt. Although my life is partly gone, I feel I have my whole life to look forward to as long as I continue to rid myself of my guilt.... Before I started orgonomy, my life was passing before my eyes, becoming increasingly unpleasant and depressing, and I was resigned to the fact that it would continue in the same manner without any real love or pleasure. I knew what was happening and was allowing it to go on and get worse. I still feel very frightened and desperate at times and burdened with guilt for what I do not know - but at least I understand now this does not have to be a way of life and, if I can just let go of what I'm holding onto so desperately, I will be able to give and receive love fully and express my emotion in an appropriate manner.

Discussion

In the chronic depressive, a severe oral repressed block occurs very early in life. Despite this, however, he reaches the phallic state and desperately clings to it. Since he received no gratification at all from the mother, he spends his entire life striving for his frustrated oral needs, which is expressed as a need for closeness and security. In the male, this is manifested as a strong dependency on the spouse, who replaces the frustrating mother. In fantasy, it is the wife who now will provide the long-sought oral gratification. He is forever trying to win the love and approval of the mother. This is why he must blame himself rather than his mate. He can suffer any punishment rather than loss of love. This forms the basis for his extreme dependency and need for security at all costs. Needless to say, there can never be any real love under such circumstances.

In the female, as illustrated by this patient, there arises a partial identification with the frustrating mother on an oral level. In later life, her relationship with men is based on providing them with the she was never given. She picks men, who will be strongly dependent on her, thereby ensuring the secure continuation of the relationship.

This patient illustrates some of the features of the chronic depressive. She was an efficient, responsible decent individual who had a feeling of hopelessness and futility about her life. Superficially, she gave the impression of being untroubled, yet she suffered from a deep sense of inadequacy. She was dedicated both in her work and in her marriage. She chose a mate not only because she loved him but also because he "needed" her. She was tolerant of and perpetuated the most extreme kind of abuse by partly blaming herself for her marital difficulties. Because of her deep fear of genuine independence, she was afraid of fully facing her rage and the need for separation from her husband.

The characteristics of the chronic depressive depend on:

1. A desperate but successful attempt to cling to a basic phallic structure despite the strong pull of an oral repressed block.

2. A relatively open ocular segment.

3. A strong, wide orgone energy field, which may exist even with a low energy level.

The inclusion of orgone energy field characteristics as part of the biophysical picture--specifically, the correlation between a wide orgone energy field and the absence of ocular armoring is speculative. In contrast. the schizophrenic has a weak, diffuse field, and this is directly related to the ocular block. Little work has been done on the orgone energy field, either in its natural healthy state or in various diseased states.2 From a purely neurophysiologic standpoint, the brain, which constitutes the greatest mass of the central nervous system, has the highest metabolic rate. This must be related to the greater capacity of nervous tissue to hold an orgonotic charge. (One recalls that the autonomic nervous system is the center of and contains the highly energetic impulses of the vital apparatus.)

From a clinical standpoint, Koopman (4) has observed that, along with mobilization of the ocular segment and the increase in the patient's ability to hold an emotional charge in this segment, there occurs an expansion of the orgone energy field. Baker (5) has also observed a wide field in the chronic depressive (who characteristically shows minimal ocular blocking).

These findings suggest that it is not the strength of the energy level of the organism that determines the width and strength of the orgone energy field, but rather the degree of openness of the ocular segment. Further investigation of field properties is necessary to conclusively determine if this is correct and if the proposed bioenergetic basis for this phenomenon is accurate.

* Medical Orgonomist. Easton, PA Diplomate in Psychiatry. American Board of Psychiatry and Neurology.

Footnotes

1. The chronic depressive presented in Man in the Trap (1) had a high energy level.

2. A notable exception is the work of Kilner (3).

References

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5. Baker, E.F.: "My Eleven Years With Wilhelm Reich (Part III)," Journal of Orgonomy, 11:155, 1977.