

Manic-depressive Character and the Ocular Segment

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Baker (1) lists the manic-depressive among the phallic group of character types and defines this type as a phallic with an oral unsatisfied block. He does not state whether this implies the existence of psychosis. Manic-depressive illness, in the classical literature, is considered a "psychotic" illness. According to the Diagnostic and Statistical Manual of the American Psychiatric Association (2), the term "psychotic" is applied "when [the patients'] mental functioning is sufficiently impaired to interfere grossly with their capacity to meet the ordinary demands of life. The impairment may result from a serious distortion in their capacity to recognize reality . . . and alterations of mood may be so profound that the patients' capacity to respond appropriately is grossly impaired."

Let us focus on these two factors as delineating psychosis: a) serious distortions of reality, and b) profound alterations of mood. Orgonomically, we know that disturbances in the ocular segment bespeak disturbance in contact. This may vary from minimal in neurotic illness to the gross and bizarre disturbances (e.g., delusions and hallucinations.) in a psychotic illness such as schizophrenia(3). Even neurotic structures may at times become psychotic, here an ocular block is significant and sufficient stress to the organism is present (4). Thus defining psychosis as "serious distortions of reality" is fully compatible with the orgonomic view if the orgonomic concept of the biophysical disturbance of the ocular segment is added. One wonders whether the second factor, "profound alterations of mood" per se (an oral segment disturbance) can be considered to cause psychosis. In theory, probably not. However, in practice, the question becomes whether these profound alterations in mood, e.g., a patient so severely depressed as to be nonfunctional, exist without concomitant severe ocular segment damage (albeit in the brain parenchyma only). In severe cases of manic -depressive illness. there seems to be a concomitant ocular segment disturbance, and I suggest that the presence of the latter determines the "psychosis."

Manic-depressives without significant ocular segment disturbance do not appear to become psychotic, as will be illustrated below.

There are two main types of maniac-depressive illness—the depressive type and the circular type. A third, the manic type, is rarer. The depressed type is defined by the Diagnostic and Statistical Manual as "consisting of depressive episodes." It continues:

These episodes are characterized b), severely depressed mood and by mental and motor retardation, progressing occasionally to stupor. Uneasiness, apprehension, perplexity, and agitation may, also be present. When illusions, hallucinations, and delusions (usually of guilt, or of hypochondriacal or paranoid ideas) occur, they are attributable to the dominant mood disorder. . . .

The manic type "consists of manic episodes . . . characterized by excessive elation, irritability, talkativeness, flight of ideas, and accelerated speech and motor activity. . . ."

The circular type is "distinguished by at least one attack of both a depressive and a manic episode.

For those patients who exhibit milder, obviously nonpsychotic forms of the above, the classical diagnosis, "cyclothymic personality" is provided: "This behavior pattern is manifested by recurring and alternating periods of depression and elation. Periods of elation may be marked by ambition, warmth, enthusiasm, optimism and high energy. Periods of depression may be marked by worry, pessimism, low energy and a sense of futility . . ." (2) . That the latter might be, classically at least, a forme fruste of manic-depressive illness is acknowledged in current thinking (5).

Orgonotic clinical experience has indicated to me that there are "mild" cases of manic-depressive character who have never been psychotic, and who under average conditions of life probably never would become so. The ocular segment is not significantly disturbed. However, many of the moderate-to-severe cases of manic-depressive illness have presented with a concomitant significant ocular block. This, to my mind, would account for the proclivity to psychosis under stress and/or contraction.

In the or organomic nosology, an interesting clinical contrast exists between the phallic with a dominant oral unsatisfied block (manic-depressive) and the phallic with an oral repressed block (chronic depressive) (1). The latter rarely presents with a significant ocular disturbance and though capable of becoming severely depressed, rarely becomes psychotic, in contradistinction to the manic-depressive.

As to the manic phase of manic-depressive illness, Baker (1) accounts for it by "a sudden yielding of the (oral unsatisfied) block . . . creating ... a manic phase. The body is unused to handling the increase of energy and, with the armoring present, the organism responds in a jerky, disorganized way."

To account for the psychotic aspects of the manic phase, I would suggest that, with the yielding of the oral block, the biosystem goes on overload and fires off spasmodically in an attempt to discharge the excess energy. The head area may be especially vulnerable to the over-expansion-perhaps because of its proximity to the oral segment and the flooding of energy upward into an already damaged ocular segment. This, in turn, causes a further clamping down of the head armor, giving rise to delusions, hallucinations, flight of ideas, and other psychotic manifestations.

In the case of psychosis in the depressive phase, I am postulating that the severe general contraction of the organism inherent in severe depression also involves an already vulnerable ocular segment sufficiently to result in "psychotic" manifestations.

The following three cases all were diagnosed organomically as manic depressive, and they illustrate the spectrum of manic-depressive illness, with and without psychosis, as discussed above.

C., a married sales executive in his late forties, came to therapy because of periods of marked depression. Questioning also revealed that there were many periods where he became euphoric, optimistic, expansive, and active. His depressions were never severe enough to render him dysfunctional or psychotic, nor did his "highs" lead to irrational behavior. C. also complained of inability to hold a job. It appeared obvious that he resented the necessity of working. This attitude concealed a strong feelings, of deprivation and a conviction that "the world owed him a living," which was quite close to the surface.

He was the oldest of three children and had two younger sisters. He described the home situation as miserable. His father had had his own small business but barely eked out a living. The parents hated each other. Mother was described as weak and helpless; she died relatively young of cancer. Father had a violent temper, which burst out against the mother. This alienated C. from his father, whom he saw as cruel and martinet-like. He was also very frightened of his father. It became obvious that C. had identified with the mother, and that she had shown a thinly disguised seductiveness towards him. She called him her "little man," took him places while excluding the daughters, and, in his teens, wanted him to escort her to concerts. His childhood feelings were basically disappointment and loneliness. As an adolescent, he suffered from severe headaches and nausea (probably depressive "equivalents") (6) which he connected with feelings of helplessness.

C. had had at least 200 sessions of therapy first with an orgonomist and later with a "bioenergetic" therapist twelve years before consulting me. He had been helped to the extent of being able to mobilize himself and to persevere in a career. He still became periodically de-pressed, but noticed his "highs" became less frequent. He came to me in a depressive phase, with subjective feelings of dejectedness, disappointment in life, and lack of energy.

Biophysically, C. was tall and rotund, his body giving an impression of flabbiness. The ocular segment was relatively unarmored. The oral segment showed a mild to moderate throat block with armoring of the jaw. The chest and diaphragm were moderately armored. Although orgonomically the diagnosis here was manic-depressive, classically he might have been called a cyclothymic personality.

Work consisted of mobilizing rage. He could move his eyes quite easily and express emotions with his eyes and face. I encouraged him to strike the couch and roar at the same time. There was a raspy quality to his voice, denoting in part his oral block. After the expression of rage, he would begin to sob spontaneously. This sequence was repeated during several sessions, with concomitant physical interventions at the jaw, submental, and trapezium muscles. C. began to feel better. His tiredness abated, and his mood improved. However, he declined to continue further, as he was satisfied, for the time being, with having been "mobilized."

L. is an extremely intelligent 33-year-old married businessman. He first came to me with complaints of depression, listlessness, and confusion. He wanted to obtain a divorce

from his wife, as she was withdrawn, unaffectionate, and ungiving, but he was afraid he would "fall apart" if he made this move. At age 25, L. had had several months of therapy with a "behavior therapist." During that therapy, he made what was thought to be a suicide attempt by ingesting barbiturates, which necessitated brief hospitalization. He had, in fact, taken an overdose, which he claimed was accidental, and was still using barbiturates from time to time to "numb" his feelings of depression. He refused to comply with my request that he stop taking them.

He was an only child and had been conceived unexpectedly when his parents were in their forties. His father was a successful businessman, his mother a housewife. They were well off, and L. remembers that there was a nursemaid when he was small. He does not remember any toilet training and doubts that he was breast fed. Uppermost in his childhood were the memories of vicious battles between his parents. His father was a weekend alcoholic, drinking himself into a stupor eventually but not before violent (mostly verbal) battles occurred, usually involving the police to restore order. He recalls his father's contorted face coming at him, terrifying him, making him hide under the covers. The father's alcoholism was severe enough to cause delirium tremens. Interestingly, many of these negative experiences were subject to "infantile amnesia," and, at the start of therapy, L. had described his childhood as happy and not at all unusual.

L.'s parents used him as a pawn, asking him in effect to choose between them. He remembers being so undermined by his mother that after a while he stopped responding emotionally to her. Retrospectively, he now recalls that he would go "off" with his eyes at an early age, effectively numbing himself emotionally. L. was overweight as a child. He remembers being very sad.

Biophysical examination revealed a rotund, overweight, but handsome man of average height. There was a moderate ocular block manifested by the eyes going "off" frequently and at times becoming totally "glazed," especially when threatened with the breakthrough of significant emotions. The eye block, however, was capable of being released, and, at those times, the eyes were clear, bright, and open. There was a moderate throat block with moderate-to-severe jaw, neck, chest, and paraspinal armoring.

What is pertinent to this discussion is L.'s periodic outbursts of borderline behavior. One could not call it outright psychotic, but it had a marked paranoid flavor. This behavior has occurred during therapeutic sessions, as well as in his ordinary life; in the latter, mainly during depression. In therapy, irrational behavior would occur when his eyes were "glazed" (ocular blocking). Extrapolation dictates that it probably occurred in life under similar circumstances of ocular blocking. An example of this behavior in therapy follows:

Trust became an issue at one point. He felt trusting anyone was fraught with danger, as it had been with his parents. When he had "opened up" to them, he was often humiliated and made to suffer. During a session when I had comforted him, putting my

hand on his during a particularly poignant moment of misery, he suddenly went into a "frenzy." "Don't touch me," he shouted, his eyes glazed, his body violently jerking away. "You're tricking me, you're tricking me! I won't let you. I won't let you!" Retrospectively, when his eyes had cleared, he recognized that he had been quite irrational that he had felt overwhelmed and in great danger, and he had realized he was going out of contact.

From the past, he remembers similar instances, especially when he was badly depressed; he would go into a "frenzy" (agitation) and think what he realized were irrational thoughts, viz., this or that person was going to hurt him, they deliberately wanted to make him feel bad, etc.

P. was a 32-year-old, married, Negro woman with three children, who came to therapy with complaints of sexual unfulfillment. She also revealed that she had had two "nervous breakdowns," the second of which necessitated three weeks' hospitalization. The latter had been characterized by hyperactivity and an inability to sleep, leading to exhaustion, "racing" thoughts, and "funny" ideas. After discharge from the hospital on major tranquilizers, she became extremely depressed (but apparently not psychotic). She had been off tranquilizers for one year, but she now felt "empty and not in touch."

P. was the youngest of twelve children, born to a lower middle class, black, Southern family. Her father had a minor position in the church. Her mother, an extremely harrassed woman, had all she could do to shop, cook, and wash for all the children. P. barely recalls seeing her father, and her mother was too busy to pay any attention to her. She felt lonely and deprived as a child. The only interaction was with an older sister who treated her cruelly.

P. always had mood swings but predominantly characterized herself as "high." She was a gregarious, outgoing person who had close friends. Within the last three years, the "high" had become a psychotic manic attack necessitating hospitalization.

Biophysically, P. was rotund, overweight and of average height. There was severe armoring of the ocular, oral, and chest segments. At this time, there was no evidence of a thinking disorder or other schizophrenic stigmata.

Therapy was begun with mobilization of respiration and exclusive work, on the ocular segment. This work was extremely difficult, as the armor was massive and rigid. The eyes rotated with difficulty, and a penlight was used to facilitate work with the eyes. P. followed the light with difficulty. The chest moved with difficulty, and I resorted to manual compression. P. began to feel subjectively worse as therapy progressed. She complained of depression and sexual frustration. After about 25 sessions no inroad had been made in the ocular block. However, her behavior began to change dramatically. I noticed that she began to be cheerful and more energetic. I did not take this seriously until she called me two days before her next session, asking for sleep medication as she had hardly slept for the past three days. Her mind was "racing." She had "a million things to do." She showed up for her next session extremely energetic, talking rapidly, refusing to disrobe, and wanting to talk. Her eyes looked "wild." She looked at me

knowingly, glanced around, and stated that I had succeeded-that I had given her a sexually euphoric feeling, that my "testing" of her had "succeeded." She stated also that we were destined for each other" and that she was in love with me, adding cryptically, "You know exactly what you are doing." P. was obviously in a manic, psychotic (delusional) state. She refused to work biophysically, so I resorted to prescribing a major tranquilizer. I called her husband, instructing him to watch her carefully as she might have to be hospitalized. Because of her physical exhaustion, hospitalization was necessary.

Three cases of manic-depressive illness of increasing severity, with concomitant increased involvement of the ocular segment, have been presented. In the case of C., diagnosed as manic-depressive, circular type, there was little or no ocular involvement, and oral armoring was less than in the other two cases. No psychotic or irrational behavior was observed historically or during treatment. Patient L., diagnosed as manic-depressive, depressed, demonstrated more severe armoring orally, and a significant ocular segment involvement. Borderline behavior was noteworthy in his life and during the course of therapy. Patient P., diagnosed manic-depressive, circular type, had the most severe armoring orally and ocularly, and she became frankly psychotic. I have also treated a case of manic-depressive, depressed, who, like the latter patient, decompensated into frank psychosis and showed significant pre-morbid ocular involvement as well.

The severity of the ocular segment armor appears in this small clinical sampling to vary directly with the severity of oral segment disturbance. This would appear to explain psychotic symptoms when severe depression or mania occurs.

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