The Treatment of Two Patients with Obsessive-Compulsive Symptoms

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A current interest of contemporary biologic psychiatry, obsessive-compulsive symptomatology, reflects its perspective; behavior and symptoms explained on the basis of excessive or deficient neurohormonal influence on neuronal cells and their synaptic membrane "receptors" in specific areas of the brain. This perspective, based in part on the efffect of pharmacologic agents in ameliorating target symptoms, is a satisfying reality to the general psychiatrist, the psychopharmacologist, and the patient with emotionally uncomfortable or disabling symptoms usually resistant to other conventional treatments.

Although psychopharmacology may be included in the management of these patients, discussion of anxiety or aggression in the context of character and its defensive structure is usually absent from the literature. Also absent is any mention of the "affect-block", emotional lameness caused by the dissociation of emotions from ideas. It is a central characteristic found to varying degrees in neurotic individuals but particularly prominent in those with typical obsessive-compulsive symptoms, including a tendency toward rumination and repetitive, ego-dystonic ideas and impulses. Because the affect block is rooted in the characterologic and muscular armor, only a treatment based on a functional understanding of character can provide an effective means of breaking through this tenacious defense. How these disturbing symptoms become accessible to treatment is illustrated in the following cases.

Case 1: Stephen's Fellatio Fantasies

Stephen R is a 36-year-old, married, asthmatic cardiologist and father of three children. His presenting complaint was a severe anxious depression of four months' duration. To avoid his mother's fate, a lifelong pattern of "useless" psychiatric care and hospitalization for recurrent depression, he felt it necessary to kill himself. His current condition, the result of increasingly frequent intrusive thoughts of performing fellatio and having semen on his face, made him feel as if he were going crazy. Although he was no stranger to obsessional, repetitive thoughts, having had occasional episodes lasting up to several weeks during his adult years, previous episodes had never before been so all-consuming, so ego-dystonic ("foreign"), threatening (homosexual content), and intensely anxiety-provoking. The current episode he traced to a male patient voicing his concerns about sexual impotence, which intensified his own worries about erectile function. These worries escalated into preoccupying ruminations which, on one occasion,

interfered with marital, sexual intimacy. Shortly thereafter, the intrusive thoughts of fellatio ensued.

Initial biophysical examination on the couch revealed a stocky, well-armored man with a grimly held jaw, a barely moving chest, and eyes that were either frightened or stared straight ahead. His voice was flat and monotonous. When asked to kick, he did so in a forceful yet plodding, mechanical fashion. A diagnosis of catatonic schizophrenia was made.

Therapy sessions had a typical structure. His weekly "review" was followed by kicking and breathing for several minutes with stretching of his face and jaw. Pressing along the calf muscles then elicited yelling, a characteristic, desperate, and pleading, "ow, ow," accompanied by hitting his right fist into the couch. The yelling became angrier, although still desperate, and usually ended in a fit of coughing. Occasionally, I asked him to roll his eyes in wide circles, and sessions were often terminated with this activity. Spontaneously emerging after the biophysical work, which lasted approximately 5 to10 minutes, (two to three times per session), was an un-peeling, layer by layer of characterologic defenses with release of emotion and recall of historical material, i.e., the hallmarks of a classical character analysis.

His initial anxiety and shame about seeing a psychiatrist were rooted in memories of his mother's emotional illness, his disgust with her doctors for their ineffective ministrations, and feelings of helplessness about her; if only "she tried harder," "controlled herself." Concerns for his own sanity were related to intense anxiety, fears of his being homosexual, and the "mindlessness" of his troubling thoughts; they occurred without apparent rhyme or reason in all spheres of his life.

Gradually, after several sessions, he began to feel he was using the distress over his thoughts to avoid anxiety-provoking activities and situations much as he had emphasized minor physical ailments for the same purpose throughout his school years. He became more aware of other ways he avoided or blocked anxiety, with each week's session bringing new accounts from the distant to the recent past; social withdrawal and masturbation in adolescence (anxiety and fear of females), ritualized behaviors (performance anxiety), angry irritability (social and professional anxieties), routinized sexual intercourse with his wife (reassurance against fears of sexual inadequacy), higher detailed projects around the house (parental and marital anxieties), etc. A major means of maintaining contactlessness was his drive for "perfection" (a husband, father, doctor, son should/should not feel this/that). He recalled feeling this way his entire life, immediately thinking of his father's furious and terrifying reaction to one episode of hooky-playing in the fifth grade.

With continued, consistent attention to his characterologic defenses and direct biophysical work opening up his chest and throat, anger began to surface more freely. He came to see in clearer perspective his increasing passivity over the previous several years. Situations of greatest anxiety, he realized, were those in which he was angriest, yet said or did nothing. A senior colleague dumped clinical responsibilities on him, was ever critical, and never had an appreciative word about his work. He gave into his wife's "practical sense," buying a modest car (instead of the one he really wanted), going on modest vacations often staying with relatives (instead of going to exciting places he really wanted to visit), allowing her to make decisions about their children (even though he disagreed with her). He remembered, with anger, his mother always taking sick just before the family's vacations.

As he more openly faced and tolerated his anxiety, more openly felt and expressed his anger, more effectively asserted himself, his disturbing thoughts of fellatio receded and all but disappeared. Therapy to date: 33 weekly sessions.

Case 2: Carla's Face-Picking

Carla T. is a 39-year-old textile designer with a chief complaint of "depression, I want to die." At the time of initial consultation, she had just ended therapy with a psychologist-analyst who, while continually berating her over the course of a two-year treatment, most recently pressured her to "dig deeper, try harder." Feeling increasingly frustrated and immobilized, she was angry with him for insisting on a third weekly session she could not afford. She had a previous ten-year therapy for "depression" terminated by her therapist's death. An only child, she suffered continual parental beatings and emotional abuse and wished her mother dead. She described herself as being aware of her feelings but was unable to explain why she continued a decades-long practice of compulsively picking at pimples on her face, leaving scars.

Biophysically, she was gaunt-faced and thin-lipped with a pear-shaped body (narrower on top, wider on bottom). Numerous pock-marked scars were apparent on both cheeks. Her jaw was particularly grim and tightly held and her eyes were dull and watery. Her breathing, even with encouragement, was literally unnoticeable as she lay completely immobile on the couch. She was able to kick, though without enthusiasm, and she was unable to scream. A diagnosis of oral-repressed hysteria with masochism was made.

Early on, Carla spoke tearfully and despairingly of her recent six months of increasingly severe hopelessness and depression, alluding to "pain" in her childhood at the hands of "sick" parents. This gave way to frustration and anger toward her former analyst as she recounted his impatient berating of her

throughout treatment. Her description of an off-the-mark, intellectualized analysis, I felt to be essentially accurate, and ventilation was encouraged with supportive listening and simple comments aimed at removing impediments to expression. Self-doubt and abnegation were temporarily neutralized by siding with her, "Why shouldn't you feel angry?" or, "What does all his training and credentials matter, if he does things that aggravate you?" She expressed mistrust of therapy and therapists, myself included, wondering how two therapists could be so completely different. "He always found my anger "inappropriate," you're saying it's O.K." Inquiring about additional mistrust of me, she wondered what "this therapy was all about," was fearful of the "physicality" and intensity of emotional expression on the couch.

Based on her testy, defensive reaction to several innocuous or even supportive comments, I told he she expected me to criticize her, a further indication of mistrust. This was met by an angry outburst: How could she trust anybody with her emotionally and physically abusive parents, her sick, sick mother; she never felt any support. Tearfully, with great pain, she described continual criticism during childhood; she was never right. Hounded by both parents, she was attacked for any display of emotion, particularly anger. She then added: "O.K., so I know this, I knew this before, it doesn't change the pain in my life, and I still pick at my face!"

In a subsequent session, she again expressed her life's futility and hopelessness, raising the problem of her facial picking. Examining the circumstances of this compulsive behavior, of which she seemed to have no understanding or control, clearly established, at least intellectually, its association with unexpressed frustration and anger with others. I encouraged her to refrain from picking and to try to tolerate whatever feelings emerged. She could not do this, and she again retreated into immobilization and self-recrimination.

Despite her continued fear of me, I felt it necessary to attempt direct biophysical mobilization. Requests to breathe deeper were ineffective, and kicking had little effect; she simply could not move her chest. I began to press gently on her calf muscles, which were exquisitely tender to touch, and elicited haunting, pitiful sobs from deep within her chest. As she tolerated increased pressure, heart-wrenching cries broke through the armor in the throat. Thoracic mobility was immediately improved. Over subsequent weeks, direct biophysical work once or twice per session continued to elicit the same response with increasing amounts of anger as she pulled her legs from my grasp. Characterologically, her tendency to lament life's inequities gave way to unhappy, suffering accounts of her own victimization by the callous and insensitive around her. As her masochistic plaints were unmasked, her fears of speaking and standing up for herself emerged. Intolerant of her own anger and fearful of others, she retreated into being a "good girl," "spiritual," superior (seeking "inner peace", the absence of anger), or most

frequent, merciless emotional picking at herself. As these characterologic defenses were systematically addressed and as the muscular armor of the chest and throat yielded to the biophysical work on her calves, she became more vocal, managing people and situations more effectively. In therapy, she accused me of being "cold," of speaking in monosyllables, of not being "spiritual" enough for her, of having a dark office. In her daily life, she was less likely to tolerate being pushed around and said, "I can't believe I'm saying these things!" Consequent with her newfound assertiveness, facial picking diminished. The way to resolution of this vexing compulsive symptom has become clear. Treatment continues after 15 weekly sessions.

Discussion

The sine qua non of the catatonic, the compulsive character with ocular repression, is holding back. There is constant fear that self-control may be lost, and caution is the characterologic watchword. The ruminations, obsessive thinking, and compulsive behaviors are defensive manifestations of the character, binding anxiety and aggression as well as distracting from "real" life. They find their complement in the somatic armor with chronic muscular rigidity throughout the body. Armor, in general, decreases vegetative excitability and affective intensity and interferes with emotional expression. The affect block, in varying degrees, represents the effectiveness of the organism's armor in the form of sensations and perceptions of unacceptable emotions and impulses. This success is not without cost. As Reich points out in Character Analysis, "It (the affect block) is by no means the passive attitude of the ego it appears to be" (1:197). Enormous energy, derived from aggression, is required to maintain the emotional blandness of the affect block and the individual's character and life is saddled by caution, rigidity, and the need for order. This was amply demonstrated by the tenuous equilibrium maintained by the catatonic cardiologist between the emotional demands of his daily functioning and the elaboration of obsessive-compulsive symptoms or "tics," as he called them. At first more-or-less equal to the task, years of seeming passivity and acquiescence ("perfection") in the face of increasing quantities of contained rage, stretched his defensive capacities to their limit. This limit was reached after a conversation with a patient about sexual impotence, with his own resultant ruminations and erectile dysfunction. A major bulwark in his defensive armamentarium (compulsive sexual relations with his wife) gave way, and he was soon flooded with thoughts of fellatio (representing both rage from his oral segment and his "passive" defense).

Treatment focused on increasing his awareness of his emotional contactlessness and how it was maintained. This was accomplished through both characteranalytic attention to his emotional holding and direct biophysical work on its somatic correlate on the surface, his hypertrophic, tender calf muscles.

Work there mobilized aggression from his upper segments and eased armoring in his chest, throat, and jaw. As he tolerated more anxiety and his emotional contact improved, he felt increasingly angry and became more assertive in his relationships. His obsessive-compulsive "tics" decreased, and his thoughts of fellatio all but disappeared.

In the oral-repressed hysteric, oral rage is held back in the various components of the oral and contiguous segments (jaw, throat, chest) because of anxiety, fear of punishment or loss of love. Depression is a frequent concomitant because of the oral holding and may accentuate whenever unacceptable angry impulses are intensified. The dysphoria of the oral-repressed textile designer was also significantly exacerbated by her characterologic, masochistic, emotional self-flagellation. This was clearly and concretely demonstrated by her facial "picking" which, although compulsive, irresistible and ego-dystonic or "foreign", was more fundamentally directed against herself. As such, it was not only an expression of oral rage, [Footnote 1] but also represented her use of masochistic behavior and resultant self-recriminations (moral masochism) to run from her oral aggression. Her former therapist, pushing and berating her, not only provoked her anger but also helped block its discharge by intensifying her masochistic defenses. He made her feel both guilty and neurotic for her anger both inside and outside therapy. The charateranalytic focus of treatment supported her expression of anger, unmasked her masochistic plaints and emotional "picking" and encouraged her to face her mistrust. Direct biophysical work on the surface, her exquisitely tender calf muscles, eased holding there and mobilized her upper segments with expression of oral rage. Thoracic mobility was immediately improved and armoring of the throat and jaw was relieved. She tolerated more aggression and managed her daily affairs more effectively. Her depression was relieved, and her facial "picking" decreased.

In both cases, the importance of understanding the significance of a symptom within the context of a correct characterologic diagnosis was demonstrated. The importance of relieving armoring of the throat and contiguous segments in the dissolution of a patient’s affect block was also demonstrated.

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Footnotes

1. Trichotillomania (hair pulling) is another behavioral expression of rage from the oral segment (2). back to text

REFERENCES

1. Reich, W.: Character Analysis. New York: Orgone Institute Press, 1949.

2. Koopman, Barbara G.: "A Case of Trichotillomania in a Two-Year Old," The Journal of Orgonomy, 1:1, 1967.