the journal of Orgonomy

Major articles

US ISSN 0022-3298

Published by Orgonomic Publications, Inc.

Volume 7
Number 1
May, 1973

A Case of Stubbornness

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In clinical practice, the character trait of stubbornness is encountered in a not insignificant number of patients. As with other symptoms, it can occur unimportantly from time to time, or completely dominate the picture with great intensity. The dictionary defines stubborn as "unreasonably or perversely unyielding."

That stubbornness is one of the character traits associated with anal fixation goes back to Freud, who stated that these traits are formed in the conflicts surrounding training for cleanliness. Fenichel (1), elaborating further, stated that "stubbornness is a passive type of aggressiveness developed where activity is impossible . . . [and it] occurs in anal sphincter training." The child, forced to control his sphincter, rebels. His direct anger usually thwarted, he resorts to the passive form of angry rebellion, *i.e.,* withholding his bowel movement. Here the trait of stubbornness is born. Functionally speaking, the somatic aspect of this holding is spasm of the anal sphincter, bowel, and musculature of the lower back, especially the paraspinals. This can lead to chronic constipation and low back pain. Fenichel further states that "there is an oral basis for stubbornness too, although decisively anchored in the anal stage." He comes to this conclusion from the observation that "stubborn persons are filled with narcissistic needs whose gratification is required," implying that these needs are oral in nature.

I feel that there is possibly a form of stubbornness that is oral in origin, or at least in manifestation. What its relationship is to stubbornness caused by anal fixation is conjectural. Is it essentially anal in origin and then orally manifested by regression due to earlier oral blocks, or is it manifested prior to anal fixation, *sui generis?* This oral stubbornness is neurotic (stubborn) pride. The attitude usually expressed is, "I won't give you the satisfaction," the satisfaction being allowing anyone to see ultimately the hurt and misery that the subject feels. Crying is usually held back very obviously or concealed. Physical armoring consists of a fixed, tense jaw and/or a tense occiput. In everyday terms,

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these people are often spoken of as "stiff-necked," "bull-headed," or "pig-headed."

That mothers often battle with little children over feeding is well known. This may be the genesis of neurotic pride (oral stubbornness), just as the battle over sphincter control causes anal stubbornness. Or, if the two types of stubbornness are related, it is probably because a mother battling with a child over feeding would be likely to continue this battle into the realm of toilet training.

Since neurotic pride appears to be an oral block, one might expect other oral symptoms to be present, and, in the case to be discussed, depression is evident. Psychoanalytic theory postulates a relationship between depression and loss of self-esteem (2). One important basis for a healthy feeling of self-esteem is an adequate oral stage of psychosexual development. A healthy feeling of self-esteem might be called natural pride. However, when thwarted in his efforts to protect this self-esteem, the child at this phase manifests defenses (armoring) which result in neurotic pride (oral stubbornness) and somatically, a tight jaw and/or neck.

An interesting manifestation of neurotic pride is the resistance to becoming indebted to anyone. Such people avoid this as it insures that they will not be hurt in the beholden (the infant) position, which they fear. They avoid borrowing money or asking favors. A stereotyped gesture of neurotic pride is raising one's nose up in the air in a haughty manner. Energy is defensively drawn up into the head (orality) in this manner (3).

In the following case, the trait of stubbornness, on both an oral and an anal basis, permeated the character. Diagnostically, the patient was a manic depressive, the depression indicating the dominance of an oral unsatisfied block in someone who had reached the phallic stage of psychosexual development. Also present were ocular and anal blocks. The muscular armoring corresponding to these traits, which one would functionally expect, was found as well.

Mr. L is an extremely intelligent, 33-year-old, married, white businessman. He first came to me with complaints of depression, listlessness and confusion. He also 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, Mr. L had had several months of therapy for depression and again about a year at age 31 with a "behavior therapist." During the latter therapy, he made what was thought to be a suicide attempt by ingesting barbiturates, which necessitated brief hospitalization. In reality, he had taken an accidental over-

dose, and until recently was still using barbiturates from time to time to "numb" his feelings of depression. He refused my request that he stop taking them.

Mr. L was an only child, born unexpectedly to a successful businessman of 47 and his 45-year-old wife. He doubts that he was breast fed, but does remember he was a sickly child. He does not remember toilet training. The family was financially well to do, and Mr. L remembers that he had a nurse when he was little.

The predominant thing Mr. L remembers about his childhood is the alcoholism of his father and the resultant battles between his parents. The father was a weekend alcoholic. He drank himself into a stupor and fought violent battles, mostly verbally vicious, but occasionally physical as well. On occasion, the police were involved. At times, the father had delirium tremens, attesting to his severe and longstanding alcoholism. Mr. L was frightened and anxious throughout all this. Interestingly enough, much of the negative childhood emotional experience was subject to "infantile amnesia," and, when beginning therapy, Mr. L described his childhood as "happy" and not unusual. Mr. L's parents used him as a pawn between them, utilizing emotional blackmail. The mother's method was typical: She would force the child to say things to his father to denigrate him, threatening to withdraw her love if he did not comply. Mr. L's mother subtly undermined his emotional responses as well. If he expressed happiness, his mother would say, "Don't get too happy; you might become disappointed." If sad, "Why are you so unhappy—don't you have enough to be thankful for?" Mr. L remembers that after awhile he stopped responding emotionally to his mother. Indicative of his relationship with her was his conscious fear that she would leave him (he felt this if she was ever late in picking him up at school, etc.) and recurrent dreams of being separated from her. In characterizing his mother, Mr. L surprisingly described her as warm, hospitable, and without malice toward him. Mr. L was overweight as a child. He also remembers being very sad. He always had friends and began to go out with girls at 16.

Mr. L fell in love and married at age 24. A year later, he became very depressed and disillusioned. He realized that he had married someone who was cold and distant, who gave him little, who ignored him. As he states, "I began to irritate her. It was my parents' situation all over again. I got depressed. I didn't feel like getting out of bed. Getting to work was torture."

Biophysical examination revealed an overweight but rather handsome looking man whose eyes were quite open when looking at you, but

quickly "went off" almost immediately on the couch, which has persisted to this day. There is a moderate throat block, and moderate to severe jaw, neck, chest, and paraspinal armoring.

Since the patient was in much distress, work on mobilizing the chest and eyes was started immediately. As the chest armor was quite resistant, manual compression during expiration was necessary. Expressing anger, with hitting and yelling, was also encouraged. This produced some emotional release, with incomplete crying following the anger. However, much of the anger was held back, which I ascribed to a stubbornness, as yet unclear. I encouraged kicking, which I helped mobilize by pressing on the paraspinals. Therapy was quite stormy the first six months. Mr. L felt better from time to time but collapsed quite quickly into his depression, which became even more intense, leading to thoughts of suicide and further ingestion of barbiturates. He spent much time in bed. Some sad thoughts and experiences from the past were recalled. He had initially presented with the usual childhood amnesia, and had insisted that his childhood had been not only not unusual, but indeed, positive. Now, sadness and disappointment were recalled. Fear of his alcoholic father was remembered. Mr. L began to cry quite bitterly, and recalled a childhood friendship that had lasted to adulthood. The camaraderie was close and full of good feeling, but the friend had been killed in an accident four years ago. (Mr. L's mother had been killed the same way the year before.) These recollections were recounted quite reluctantly. In fact, he consciously resisted the welling up of these emotions by holding his breath and going off with his eyes, in spite of my entreating him not to, to allow their expression. He became suicidal soon after this, necessitating emergency sessions and telephone reassurance, but then began to improve after this low point in therapy. I worked constantly on the eyes and on expressions of anger.

Therapy had now taken 50 hours. At this point, a basic pattern emerged, which has persisted to the present. The patient began to feel anger, but mainly in the form of a constant and enduring stubbornness, epitomized by saying, "I won't." At times, he didn't even know what he "wouldn't," but nevertheless the feeling evoked was "I won't," often said defiantly, with arms folded across the chest. This occurs repeatedly, almost every session. I encouraged him to hit and kick while saying "I won't." Often he would clench his jaw and tell me "I won't give you the satisfaction." I tried to push the mandible down to break the holding in the jaw, but could do this only minimally. Using pressure, with the base of both my palms against both jaw joints, sometimes brought the beginning of tears, but he fought them. "I hate you. I hate you; you think

you know it all." At one session, he began to feel pain in his chest. I thought this might be the emotion of longing showing itself. I told him to reach out. He "wouldn't give me the satisfaction," and his jaw clenched, neck stiffened. Seeing this, I got up and reached my arms down to him. He burst into tears, saying, "Please don't be nice to me, please—I can't stand the feeling," alluding to the positive feelings he had, feelings he couldn't tell me about directly because of his inimitable stubbornness. At this point, for the first time in quite a while, the patient recounted that he had enjoyed his summer vacation. Most of his deep depressive feelings had left. He began to feel better towards his wife, and resumed sexual relations.

However, his anger, a major component of which was expressed as stubbornness, persisted. The eyes still "went off." Occasionally, if by persistent, exhausting exhortation I could keep the eyes from going off, an intense feeling of terror would come up, sending him to the verge of panic. This would be followed by crying. This indicated that the function of the eyes' being kept out of contact was to protect him from intense underlying feelings that threatened him too much. The transference during this time was one of deep mistrust and anger. He could never trust me: I would disappoint him—I would hurt him, just like his parents had. In order to "prove" that I was untrustworthy, he began to subject my every utterance to microscopic analysis. Everything I said that could conceivably be interpreted as having a negative tinge was magnified and held up as justifying his attitude of mistrust. I pointed out the function of these maneuvers as keeping him from feeling the fear and misery which underlay his anger. To no avail. On one occasion, a response of mine was tinged with scorn for his neurotic manifestations, which I expressed in order to provoke his anger. I knew immediately afterwards that this was an error. "There, you hurt me, just as I suspected." I had given him something tangible on which to foist his rationalizations. Mr. L arose and announced he was leaving. I tried to redress the error by appealing to his intellect: that emotionally he had a right to feel wounded and angry, as he had with his parents; that he did not express anger fully, but turned it inward, and also modified and muffled it in terms of stubbornness. He believed me, and cried. However, a few incidents such as this one were used at times to justify his not being able to "give in" with me as therapist. I persisted in trying to resolve the stubbornness. I tried to turn it into hot anger, by provoking the patient with my finger in his ribs. I applied pressure along the paraspinals and urged him to kick. Recently, after much work, Mr. L said to me coolly and soberly, "You know I'll never give in; I'll never be hurt

again. I'll never trust you." But Mr. L returns to therapy. After 100 hours, his stubbornness persists, but with differences. He feels much anger welling up in him, which he can express by hitting and kicking. He seldom gets badly depressed, and has more or less given up taking barbiturates. Much sadness is felt now, which he sometimes gives in to by crying. There are signs of some armor loosening. He experiences vegetative currents ("crawly feelings"), and there are some involuntary movements of the body. His basic attitude is still, "I won't," but now he can admit, although with great effort, "I would like to be able to."

A case manifesting extreme stubbornness as a basic character trait has been presented. Stubbornness seems to be manifested in an oral block, as well as in the classical anal blocking. The course of therapy to date shows the difficulties encountered in dealing with a patient whose structure is permeated by this trait.

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