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# Ocular Segment Blocking and the Obsessive-Compulsive Character

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It is my impression, substantiated in discussions with other orgonomists, that by far the most commonly diagnosed sub-type of schizophrenia in orgonomic clinical practice is the catatonic. The catatonic is a basically ocular character type (schizophrenic) with a compulsive libidinal structure. And yet, in over a decade of practice, I have seen only one or two patients who I thought were probably pure compulsive characters. Why, on the one hand, is this latter character type seemingly so rare in orgonomic practice, and why, on the other hand, are catatonics relatively so common? And is there a connection between these observations?

According to psychoanalytic theory, the obsessive-compulsive patient, like other neurotics, begins by defending against early oedipal conflicts. To avoid the anxiety associated with genital impulses, the obsessive-compulsive abandons these impulses and *regresses* to the earlier anal-sadistic phase of psychosexual development. The return to this earlier stage is facilitated by fixations (blocks) that have remained from unresolved issues that occurred at the time. As Baker states (1):

> Compulsives are produced by severe toilet training before the child has attained adequate ability to control sphincters; that is, before one and a half to two years of age. This training demand leads to contraction of the whole body musculature in order to conform. Severe anxiety results from the requirement beyond the capacity of the child. The body becomes tight and rigid and heavy armoring results. The patients are walking machines, especially those with affect block. They literally hold back for dear life. This holding back with no release leads to tremendous pressure, which produces rage—which again must be repressed. The compulsive does finally reach the phallic stage, but with much sadistic aggression and bru-

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> tality. It is given up because of the intolerance of the parents and the individual reverts to anality.

Baker also notes that a trait never missing is circumstantial, ruminative thinking: "This ruminating may be an effort to take his mind off forbidden urges and to free himself of the strain of holding back, functioning as an escape or relief."

It is my contention that there is a significant ocular block in most, if not all, compulsives. Thus, in the genesis of the character, I would postulate that regression occurs not only to the anal-sadistic level but to the ocular level as well. This formulation is based on the actual nature of the compulsive symptomotology itself. For example, there is the compulsive's tendency toward circumstantial thinking. Circumstantial thinking is considered to be a mild thought disorder (2), which, orgonomically speaking, signifies some degree of ocular blocking. Likewise, there is obsessive rumination, which also bespeaks an excessive binding up of energy in the brain. In addition, the compulsive is out of contact to a major degree or, as Baker puts it, "Contact is mechanical." This constellation of factors strongly suggests a significant compromising of the ocular segment and raises the question of whether orgonomic nosology might not offer a clearer definition of compulsive disorder, more in keeping with the clinical facts.

In view of the above and what I feel is the comparative rarity of pure compulsives, I wonder if there is overdiagnosing of catatonia and whether a portion of these patients do not fall into another sub-type, one I should like to propose to name the "compulsive with ocular blocking." This category would, of course, have to be differentiated from the catatonic, not always an easy distinction to make. The main criteria, I feel, would be easier accessibility and readier clinical response of the compulsive with ocular blocking, plus the somewhat better level of overall functioning. There is, however, a spectrum of symptom severity where one type would gradually merge into the other.

The following cases illustrate the clinical picture and features of two compulsives with differing degrees of ocular blocking:

A is a 35-year-old, married, white, male, Protestant art historian who has pursued a successful academic career. He came to me with complaints of irrational feelings toward people and insecurity about his career. These complaints were formulated in an extremely vague manner. On examination, his mental status was found to be within normal limits except for an extremely circumstantial, tortuous manner of speaking. After literally waiting ten minutes for answers which never arrived at the point, I had to intervene in his convoluted thinking

and rephrase questions more simply to facilitate answers. There was a great deal of obsessive thinking in his functioning and an over-preoccupation with orderliness.

A was the younger of two children born to middle class parents in the Midwest. His sister, fifteen years older than he, was never an important part of his life, and he was alone in his early development. A was a sensitive, shy, lonely child. His father was passive and dominated by his mother, a rather aggressive, insensitive woman, whose drive for increased social status permeated the household. Her main concerns were family and church. A spent a good deal of time daydreaming and reading, and was considered a "sissy" by his peers. Despite his shyness, he took a strong interest in girls. He had an almost mystical intensity.

Biophysically, A was a well developed man of average height, with an above average energy level. His eyes, although clear and bright, were blank, and their movement was not full. They could not express emotion. The rest of his body was uniformly heavily armored, especially in the neck and the shoulder girdle.

Therapy began with mobilization of the ocular segment together with the chest. A responded quickly and vigorously with rage followed by sobbing. His eyes, however, did not participate. They remained unaffected. I worked more vigorously on the eyes, using a penlight for him to follow with his eyes as I moved it in all directions.

After fifteen sessions of work on the eyes, A became delusional, showing an accentuation of the compulsive, magical thinking. He thought I left subtle messages for him in the environment. If a neighbor left his living room window open the day before therapy, it was a sign that I was signaling him in anticipation. A subway car without graffiti meant that he would be cleansed of his problems. These psychotic manifestations lasted for about ten weeks, never to return, and afterward there was a noticeable improvement in his eyes. It was as though the ocular segment needed to contract even more (causing psychosis) before letting go and improving.

After 150 sessions, there has been improvement in A's functioning. A great deal of his irrationality has abated, and he feels more secure about his career. However, the ocular segment still has not yielded completely—A remains circumstantial, but less so.

B is a 30-year-old,white, married, Jewish architect who came to me with the following complaints: headaches, 3 or 4 weekly, lasting for hours and having features of both tension and migraine types; indigestion of nine years' duration; difficulties in coping with pressure

situations, such as deadlines; competitiveness at work. He felt inadequate and inferior, and avoided situations where his abilities would be "tested." B places a premium on order and meticulousness. His mental status examination was essentially negative with regard to thought disorder, but his manner of presentation was rather affectless and matter-of-fact. There were indications of obsessiveness in his thought process. He would constantly relive events in his mind, over and over again. He was perfectionistic and emotionless.

Infantile amnesia blocks access to most events in B's life prior to the age of 10. He was the second of four children. Father was passive and grim, and had little to do with the children. Mother was perfectionistic and impossible to please. Nothing that B did was good enough for her, and what he did accomplish was undermined by her coldness. In spite of this situation, B did well in school and later was associated successfully with a well-known architectural firm.

Biophysical examination revealed a tall, well-built man. His eyes were bright and moved fairly well. He could not, when requested, express any emotion with his eyes, though, and they showed a look of fear, which he was not in touch with. The rest of him was moderately to heavily armored, and there was a peculiar "bogginess" to his musculature. B was reluctant to come to me; he felt bad about not being able to solve his own problems. This attitude soon developed into one of "doubting." He doubted the premises and efficacy of therapy. He doubted my ability to help him. I felt that B required more character-analytic work than A.

Character analysis was now done with a view to turning the doubts into manifestations of anger, which I encouraged him to express physically. This was not easily accomplished, as he had to overcome a great deal of reluctance and inhibition. His "doubting" intensified, but his expressions of anger became more spontaneous and intense. Concurrently, mobilization of the eyes was effected by having him roll them from side to side. As this process continued, an intensification of the fear expression occurred. Finally, the emotion locked in his eyes broke through into consciousness, and he became frightened during the session. I encouraged him to scream in reaction to his fear. After about seventy sessions, other feelings began to break through. Transferentially, he began to have positive feelings for me. He was grateful for being able to feel so much. He became more aggressive in a rational manner, and, in relationships, he was better able to reciprocate feelings. There was less fear in his eyes.

Pure compulsive characters are rarely diagnosed as such in orgonomic

practice. This, I believe, is because the compulsive, as described classically, usually manifests a significant ocular block. The orgonomist, seeing this, often opts for the diagnosis of catatonia, even where the proposed sub-type "compulsive with ocular blocking" may better befit the clinical picture.

The two cases presented illustrate these options. In the case of A, the ocular block was of such severity that psychosis intervened during therapy. Here one would be justified in making an unequivocal diagnosis of catatonic schizophrenia. In the case of B, a compulsive structure is in evidence, but the ocular block appears to be less severe than in A. Although there is obsessiveness and head blocking, a frank thought disorder is not in evidence. A fair degree of emotional contact, although initially difficult to elicit, was relatively easy to establish.

For just such cases, I am proposing a diagnostic sub-type to be designated "compulsive with ocular blocking." This type would be differentiated from the catatonic by the less severe degree of ocular blocking and absence of thought disorder, and would perhaps reflect more accurately some of the compulsives seen by orgonomists and hitherto possibly diagnosed as catatonic. There would thus be delineated a spectrum of compulsive disorders ranging from the purely neurotic type with relatively intact ego boundaries to the full blown catatonic, a basically ocular character type with compulsive symptomatology.

## REFERENCES

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2. Andreasen, N.C.: "Thought, Language and Communication Disorders," *Archives of General Psychiatry,* 36: No. 12, Nov. 1979.