Motivation for Therapy: Two Cases

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Some individuals come to therapy motivated by a desire to overcome character problems and others want the therapist to relieve symptoms such as anxiety, depression, embarrassment, or guilt. Still others may become motivated through therapy to address the deeper characterological problems that underlie their symptoms. While a relatively brief course of medical orgone therapy can accomplish symptomatic relief in many cases, it is also true that the deeper the emotions an individual is able to contact the more he can be in touch with what it is that prevents him from experiencing life fully. Often he will then be motivated to face these problems in therapy, even when the initial symptoms have been alleviated. Regardless the depth to which the patient goes in therapy, the therapist's knowledge of the patient's character diagnosis and specific typical character reactions are invaluable basic therapeutic tools. The following two case presentations are illustrative.

Patient One

Mr. A, a 55-year-old married father of three and district manager of an international company, presented for therapy with a complaint of an "inability to be my usual cheerful assertive self at work." He also reported feeling mildly to moderately depressed for some time and this had worsened over the previous two months. In the initial session he related to me in a friendly cooperative manner doing his best to bravely tell me his story. His range of emotional expression was constricted and mostly sad, but he had a smile and made an effort at cheerfulness. He continually returned to themes about how he was depressed and how hard it was for him to keep up his cheerful front. He answered questions directly and there was no evidence of a thought disorder. His attention, concentration, memory, and other cognitive functions were normal. He was intelligent and his judgment and insight were good.

On biophysical examination he was stocky and moderately overweight. He moved with a bear-like quality which gave the impression of his being heavy yet also quick and energetic. His eyes were clear and direct. His lips were full and he spoke easily until emotion over-came him. At these times he became choked up but continued speaking with a brave effort at being matter-of-fact. His jaw appeared tight. His chest was held somewhat stiffly in inspiration. He also gave the impression of having generalized moderate tension by the stiff way he walked and sat in the chair.

He elaborated on his situation saying, "I have a lot to be happy about. My wife and I love each other very much and have been married 25 years. Our three grown children are all living away from home and doing well in their personal and professional lives." In passing he mentioned his wife had a ten year history of diabetes, but he quickly returned to his problems at work: "I'm usually very effective with people because I'm so cheerful and a nice guy. They all like me and do what I ask because I get them motivated. They don't want to disappoint me. Lately, though, I've been irritable and feeling sad and don't really want to face my employees. I never get angry with them. In fact, I don't like to get mad because there's no point to it. You know the old saying, 'You catch more flies with honey than vinegar.' That's my motto. The problem is I've felt like such an old sourpuss lately and I'm afraid they're going to see it."

As we spoke, a primary resistance that appeared was his tendency to overlook negative things and to focus on the positive. When I pointed this out, he responded by saying, "That's how I've always kept in charge of my life. It's a sign of weakness to show those other feelings." He said this with a slight frown of worry, a subtle grimace around his mouth, and a look of anxiety in his eyes. When I pointed out that he looked anxious, he acknowledged it but bravely went on with what he had to say. He revealed more about his wife's situation and his feelings about it. Her health had gradually deteriorated since developing diabetes, but the decline had accelerated in the previous two years. In the past year she had become nearly blind from diabetic retinopathy. Also, her walking was so affected by peripheral vascular disease that she was now nearly house-bound.

As he spoke of this some sadness began to show through his cheerful facade. In his typical way, he quickly controlled himself and focused on the positive side of things - how much he loved her and how glad he was that he could do so much for her. He had gradually assumed one task after another and was now taking care of most of the house-hold chores as well as almost all of his wife's needs. Whenever he returned to his "look on the bright side" attitude, it was pointed out to him. He typically replied, "There's no point in getting into all the other stuff." He said that he was "afraid to feel those things." When encouraged to express his fears he said, "I could just get stuck in them. Not only would it not help, it would make things worse because there is nothing I can do to change my wife’s situation."

His need to "do" something was pointed out to which he responded, "I've always handled bad times in my life by getting busy. That's why I'm so effective at work. If there's a problem I just get busy and fix it. Now, how am I going to fix my wife's problems?" A tone of frustration immediately appeared. He was told that one of the things he could "do" was let his emotions out. He was also told, "It won't change your wife's condition, but it could change how you feel by bringing you some relief. Isn't there value in your feeling better?" His eyes immediately filled

with tears and he allowed himself a few sobs before regain-ing composure. Then he said he felt irritable in the same way that he felt at work. With some encouragement he finally said, with irritation, "I hate having those feelings of sadness. They just don't accomplish anything." He felt relieved and calmer having expressed his irritation.

Over the next few sessions he said that he felt very frustrated with his wife's situation and often found himself angry with her. "I know it's not fair because she's doing the best she can and I know she didn't get sick on purpose. I'm glad I can do so much for her, but underneath I know I'm just angry that I have to do all the cooking and cleaning. With all the college expenses for the kids that we're paying off and all her medical bills, we can't afford to hire someone. I know it's petty but I never in my life thought I'd be vacuuming. There's no point in getting mad at her about all this." I replied, "By letting those feelings out here you may get enough relief to allow you to let her know you are frustrated by the whole situation. It might be a relief to her because she probably knows you are aggravated and it would give her an opportunity to express some frustration that she also feels."

In the next session he said that he often sat at home in the living room reading to his wife and would suddenly feel overwhelmed with an impulse to shake her and say, "Damn it, why don't you see like you used to, read like you used to." He continued. "I know these feelings aren't fair. So to keep them from her I get up and go busy myself with something that needs to be done in the house." He felt guilty for being angry when she couldn't help her situation and then even more guilty that he left her alone when she wanted him to read the paper to her.

After three months of weekly therapy sessions he reported he was feeling much better and had a better understanding of his problems. In the past two months he had felt in a better mood. This particular week someone at work remarked that he seemed his "usual old cheerful self again." "I think you've cured me, Doc. I don't think I need to come here anymore."

I had also been aware that his mood had been gradually improving, but this sudden brightening and liveliness took me a bit by surprise. I asked him to tell me what had happened and how he currently saw things. "Now I'm aware that I always felt I could tackle anything that came my way. I was doing fine with all the problems my wife had until a couple of months before I came here. At that time she almost started a fire trying to heat some water to make tea. She can be so strong--willed that even as blind as she was she wasn't going to quit doing things on her own. I think that incident scared the hell out of both of us, but we didn't talk about it or even acknowledge it. I didn't even think to tell you about it before. She did her usual stoic thing and I did too. I got busy trying to fix the problem. I tried to be around the house as much as I could to do things for her. I avoided taking any extra time at work, which is unusual for me. I began to resent it because work is the one place I always know just what to do. But I couldn't tell her any of this.

At home I couldn't be everywhere at once and I started to feel impotent in the face of the enormity of all the ways my wife could get into trouble. Now impotence is not a feeling I like or am used to because before I always found a way to do whatever needed to be done ... You know, I finally started to hear what you've been saying, that one of the things to do is express my feelings. Over the weekend I finally told her I was frustrated by the situation and wondered what she thought we could do. Almost just like you said, she poured out a flood of how frustrated she's been but didn't want to burden me with it. Then we both told each other how terrified we had been when she almost started the fire. You know Doc, that fire incident was the start of my getting really depressed. On Sunday we both just held each other and had a good cry together. I never would have thought that possible or helpful, but I'm sure that's why I'm finally back to my usual self."

In that session I mostly just listened and accepted what he said. I told him I was glad he was feeling better and recommended that we meet again to make sure that the changes in his mood were sustained and to evaluate where things stood with his therapy and where to go from there. Although the changes appeared genuine, I was concerned that they might be temporary and merely covering over and defending against the pain that had surfaced. In our next meeting he continued to report feeling well and described how he and his wife had opened up to each other in a way they had not been able to do for a long time. He said this was a great relief. I told him that it was good that he had come out of his depression and that he was back to his usual self. I said, "We are at a crossroads in your therapy. We could stop at this point or we could explore the problems that underlie your depression." He said, "I know what you're talking about, but I'm feeling good now and think I should probably leave well enough alone rather than stir up stuff that will be unpleasant." I told him, "This is your usual approach of keeping everything positive. It depends on how well you can live with what is there and how much it is costing you. Don't make a decision now. I want you to think about it and we'll meet next week to discuss it."

He returned the next week and said that things were continuing to go as well as they could at home and at work. He also continued to be in a good mood. He said, "I've given a lot of thought to what you said about my choices and whether I want to delve deeper into my emotions. I know now it does cost me to put aside what I always thought were just negative emotions. It came to me that the choice you presented is very simple: do I want to learn to live with the dragon in me or to slay it? I just don't have it in me to try to slay it. I know I want to stop now while I'm feeling better. Maybe I just don't want to deal with what would come up."

We talked some about his feeling good with his wife and at work. Through a local association for the blind he found someone who could train her in how to manage everyday life. He thanked me for my help. I wished him well and told him he should feel free to call me in the future. This was the last time I heard from him.

Discussion

My characterological diagnosis of Mr. A was an oral unsatisfied phallic character. Typically such individuals defend against anxiety by taking action, here evidenced especially in Mr. A's take charge manner at work and at home. His pushy phallic qualities were modified by the oral unsatisfied block which also manifested in his tendency to overeact, a loquaciousness, and a "hail fellow well met" attitude. These individuals underneath want to be cared for, but because they need to be in charge and in control they often become the caretaker of others. The prominent features of his facade were his cheerful nice guy attitude and his tendency to emphasize the positive side of things. These attitudes derived from his deeper defense against "weakness." The combination of his phallic need to push and the oral unsatisfied strivings to keep expanded caused his depression to be all the more painful.

With a focus on his defensive attitudes underlying anxiety surfaced. He tolerated this anxiety and expressed some of his deeper feelings. This in turn drained off some energy held in the secondary layer allowing him to be more accepting of himself. With the relief of symptoms he was satisfied and chose to leave well enough alone.

Patient Two

A patient may come to therapy with only a desire to eliminate symptoms but then develop the desire to go further and ultimately make deep character changes. Mr. B, a 35-year-old married father of three and a computer programmer, came to therapy because "things have gotten out of control and I don't know why I do some of the things I do." He went on reluctantly, "I made a pass at one of my female employees." With considerable embarrassment and shame he revealed that he had been having persistent sexual fantasies about one of his female coworkers and went on to describe the incident that caused him to seek treatment. He had fantasized about a sexual relationship with this woman for months, but held back acting upon his impulses because he knew they were inappropriate and also because he was married. Finally, alone with her in a work meeting, he reached across the table and took her hand. He said nothing to her. He knew though that his immediate embarrassment and flustered reaction revealed to her the intensity of his feelings. He told me, "This little act revealed a crack in my professional decorum."

In this initial consultation he was casually dressed. He had a round, boyish, cherubic face with a studious intellectual appearance. His manner was formal and inhibited but with a subtle hint of wit and irony. His eyes revealed frozen anxiety and his expressions were muted, especially when emotionally charged subjects were raised. He had an ironic "knowing" smile and used polysyllabic words in a clever erudite fashion. He was brief and direct with good attention and concentration when factual answers to questions were required. With emotionally charged answers, however, he became circumstantial, sometimes tangential, and experienced thought blocking. Cognitive functions and memory were

otherwise normal. He was intelligent and tried to understand the cause of his emotional problems, "I know there must be psychological reasons why I did what I did." He was also quite disturbed by his actions and had a sense that there were forces at work beyond his ability to understand.

He moved in a self-conscious but paradoxically bouncy manner. He avoided eye contact and tended to stare. His voice was soft and hesitant with little emotional expression. The overall impression was that of someone who was emotional, sensitive, and easily hurt doing what he could to freeze and stiffen against any painful feelings.

He was initially seen in twice-a-week character-analytic psychotherapy which focused on his anxiety and embarrassment about the incident with the coworker. In the first sessions he spoke in a logical intellectual manner about what had happened and in fact consistently avoided looking at or thinking about anything that would affect him emotionally. We later came to call this his typical "out of sight, out of mind" approach to his emotions. After a number of sessions he said with genuine feeling, "I don't want to delve into all this emotional stuff. I just want you to fix me so I don't do such a stupid thing again."

In these first several sessions he was often almost unable to talk. He felt stuck between the feeling that he should talk, because that's what one does with a psychiatrist, and the anxiety that he would reveal something that would cause him embarrassment. His repeated reactions of doubting and "clamming up" were pointed out. By encouraging him to express both his doubts and what made him not want to speak he gradually became able to experience and tolerate the anxiety that these reactions avoided. He was then able to express what he had been holding back. He revealed that there were significant problems in his marriage and that he was frustrated by his wife's lack of sexual interest.

Aware of his tendency to avoid anxiety-provoking topics in therapy, he also came to see the same behavior as a problem at work. He realized that holding back his emotions caused a buildup in their intensity until he was unable to restrain himself with his "professional decorum." He saw that he lacked judgment about expressing his feelings.

As he became more aware of his holding back and its function he became aware of tension in his body. This was taken as a signal that the treatment could now include direct biophysical work on his muscular armor. A complete biophysical examination on the treatment couch revealed considerable holding throughout his body with significant armoring in the ocular, oral, and cervical segments. On the couch he looked quite anxious but said he felt calm. When on request he opened his eyes wide, he felt "weird." Although his mouth was dry, his chest felt constricted, and his heart pounded, he felt nothing emo-tionally. Having him look in a mirror and open his eyes wide made him aware of his fear. Asking him to feel this and kick the couch gave him some relief but produced an unexpected

reaction: he froze with the innocent look of a choirboy. This was his typical reaction to any intense perception of anxiety and was the red thread of his character [Reference 1].

Character-analytic work continued to focus on his tendency to avoid or cover up his embarrassment. After several months he was less inhibited by embarrassment and experienced significant emotional relief and physical relaxation by screaming out his anxiety and fear. Through his new-found awareness that he fended off emotions we were able to focus on how he did so. All of his many reactions could be generally understood as reflecting either his lack of awareness of emotional thoughts and feelings or his tendency to hold back when he was aware of them. His therapy addressed both by encouraging him to verbally express any do doubts and negative feelings and by having him kick and shout to discharge his emotions on the treatment couch.

He gradually took more chances to express himself in therapy and in his outside life. He took risks at work and spoke up at staff meetings. When he was promoted to division manager he was brought face-to-face with his long-standing need to please. Because this was inappropriate in his new position he was forced to tolerate and manage conflict with colleagues and coworkers. This made him emotionally stronger at work and at home. He felt more confident and talked with his wife about their relationship and his dissatisfaction. He was thus able to address the marital and characterological problems that underlay the incident which brought him to therapy.

Discussion

My characterological diagnosis of Mr. B was catatonic schizophrenia. His therapy was directed at overcoming the catatonic's characteristic emotional and physical immobility by encouraging expression of doubt and negative feeling verbally and by having him discharge emotion physically on the couch. As his initial symptoms were alleviated he recognized that they were based on as yet unresolved deeper problems and he became motivated to continue in treatment.

Both Mr. A and Mr. B wanted relief from symptoms that arose when their usual character defenses proved inadequate to handle specific life situations. Mr. B, however, came to therapy more directly in contact with deeper feelings. His initial symptoms included anxiety resulting from a breakthrough of deep longing. Mr. A's initial complaints, on the other hand, resulted from the secondary effects of depression which served as a defense against anxiety. [Footnote 1]

With both patients an essential therapeutic task was to overcome contactlessness [Reference 3]. This required each patient to be willing and able to tolerate anxiety. Mr. A, his presenting complaints eliminated, chose not to face his deeper fears. Mr. B, on the other hand, showed both a desire and an ability to feel more deeply.

Conclusion

The goal of orgone therapy is to restore natural bioenergetic pulsation and establish orgastic potency. While not every patient reaches this goal, orgone therapy can be of value by dissolving enough armor to relieve symptoms and to effect positive changes in a patient's disturbed bioenergetic functioning.

Mr. A's symptoms were relieved and he left treatment satisfied but far short of the potential benefit he might have obtained. Mr. B, though also far short of the endpoint, experienced and tolerated deeper emotional contact in therapy and decided to continue in treatment to achieve more profound character change. While each patient had different motivations for treatment, orgone therapy's systematic and comprehensive approach afforded the flexibility to help each achieve his own goals.

Footnotes

1. Baker noted that depression often functions as a defense against anxiety [Reference 2]. As a state of contraction depression reduces excitation and thus decreases anxiety.

References

1. Baker, E. F. Man in the Trap. New York: The Macmillan Co., 1967, 62-63.

2. Ibid.,121.

3. Reich, W. Character Analysis. New York: Noonday Press, 1949, 316-327.