The Function of Independence

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Dr. E.F. Baker once emphasized to his trainees that patients should achieve at minimum two things - independence and responsibility (1). The cases presented below illustrate that independence is the direct expression of natural biophysical functions. Each of these cases also illustrates an unexpectedly positive outcome which was primarily the result of increased independence.

Case 1

A 25-year-old, white female presented to her community mental health center seeking medication treatment for chronic symptoms of paranoia and auditory hallucinations. She met the classical psychiatric criteria for a diagnosis of paranoid schizophrenia and this was also her characterological diagnosis. Functionally, she lived on government disability payments and led an isolated existence in a small apartment in a bad neighborhood. She had almost no social contact with others, and her primary interest was in television evangelists to whom she sent a substantial portion of her money. Her dress and grooming were poor, and she was unable to carry on a sustained conversation. Neuroleptic medication (when she took it) relieved her psychotic symptoms but did nothing to improve her apathy and isolation. She had been hospitalized many times.

This patient's disability payments were discontinued. Social workers who worked with the patient expressed their belief that this was part of a general tendency in the area to make the criteria for Psychiatric disability more strict in order to save money. It was predicted that the patient would be unable to survive without her disability payments and would decompensate rapidly. Efforts were set in motion to obtain legal services for this patient to appeal the government's decision.

Within a month after the discontinuation of payments, the patient had an acute psychotic breakdown and was hospitalized for a period of approximately two weeks. Following her discharge from the hospital, she did not continue to decompensate as predicted. Instead she sought work as a sales person in a local store. She made intense efforts to improve her dress, grooming, and social skills, and was able to get and keep this job. She became more responsible in taking her medication and when she appeared for her sessions she was able to converse about events in her daily life. Her social contacts markedly increased.

Her religiosity continued but she transferred her interest from television evangelists to making contact with a more traditional local church. The church members helped her with transportation and with developing her social and work skills. According to the patient, they emphasized her making efforts to help herself. This was in contrast to her previous religious interests which centered on sending money and praying in hopes of receiving "gifts" from God.

Although she had some difficulties, her progress continued for approximately one year. She moved to a better apartment, had over half of the money she needed to buy a used car and automobile insurance, and continued to hold down her job.

Legal efforts to 'help' her with the disability authorities continued. Eventually the original decision was overturned, and the patient's disability status was reinstated. She quit her job and went back on disability.

Over the next six months, she lost, one after the other, all the gains she had made. Her appearance, conversation, and social functioning returned to what they had been before.

Case 2

This forty-year-old, white, male office manager presented for orgone therapy complaining of chronic feelings of anxiety, anger, and dissatisfaction with his life. Functionally, he was successful at work, had a wide circle of friends, and had been married for several years. His marriage was pathological. He was intensely dependent on his wife, even though she treated him poorly. She engaged in a number of activities outside the home which were very damaging both to their relationship and to their finances.

There was a strong sadomasochistic component to their marriage. This consisted of her constantly whining and complaining to him until she provoked him into becoming verbally abusive toward her. This was followed by intense scenes where she would remonstrate him about how hurt she was. He then felt guilty and would beg her to forgive him.

As therapy progressed, he became increasingly aware of how dissatisfied he was with the relationship. He gave his wife ultimatums to stop her destructive behavior (or he would leave), but he had no ability to carry them out. His increasing awareness of his dissatisfaction only worsened his condition and for the first time he became physically as well as verbally abusive.

At this point, he decided to stop therapy. He stated that he was aware that his main problem was dependency on his wife. He also stated his intention to work on this outside of therapy. I did not expect to hear from him again.

Two years later, this patient returned to therapy. In the interim, he had focused his intentions and efforts on becoming more independent of his wife. This culminated in his becoming ready to leave her. She then stopped her destructive activities and the marriage improved markedly. Although the patient had not had therapy in the intervening two years, he appeared much healthier than he had previously, as if he had had more years of treatment.

He was now able to work with me to overcome many of his problems. He stopped responding to his wife's provocations, and the provocations eventually stopped as well. He gave up a number of self defeating behaviors. He was able to focus on developing an increased capacity to tolerate an energetic charge. He spontaneously lost interest in a number of pregenital sex activities that had been important to him before.

Case 3

This 19-year-old, Hispanic male presented for orgone therapy in hopes of developing his artistic capacities. Although I had some questions as to his capacity to benefit from therapy, I accepted him because he expressed strong motivation. He had never used drugs.

Although he denied having emotional or psychiatric problems, he was psychotic much of the time. He suffered from a number of paranoid and grandiose delusions. He had never had hallucinations. His speech consisted primarily of bizarre descriptions of his somatic sensations. For example, he would say that his stomach cancer was fighting with his atherosclerosis.

His functioning was minimal. He was a college student who was supported by his parents but was making questionable progress toward a degree. He was not studying anything that would enable him to earn a living, nor was he focusing on his artistic activities in a way that would produce any results. He had almost no contact with other people, who were frankly frightened by his bizarre mannerisms and speech. He longed for a girlfriend but could not find one. When women avoided him, he would say, "they just can't tolerate my orgastic potency."

His parents were very sick themselves. There had been a great deal of emotional and even sexual pathology between them and the patient. He almost never saw them in person (they lived hundreds of miles away), but showed me a number of destructive letters that had passed between them.

He did not appear to respond well to therapy. The only result was increasing feelings of bitterness and rage toward his parents. There was even the possibility of violence. Eventually, he announced his desire to drop out of school and cut

himself off completely from his parents. While I recognized his need for independence, I was afraid he would be completely unable to function without their financial support. He had never been able to hold a job. I expected that he would become homeless and destitute.

His grandiose delusions insulated him from any such fears. He detached himself from his parents and quickly found that he was unable to support himself. He drifted to a large city and joined the ranks of the homeless. I did not hear from him for several weeks. He phoned once to tell me that he was now unable to pay for therapy.

Shortly thereafter, he called me and said that he had scraped together enough money for one appointment. He appeared unwashed and in rags. I had fully expected him to decompensate psychiatrically. However, this was not the case. All of his delusions and bizarre mannerisms were gone.

He spoke in a moving and contactful way of the difficulties of life on the street. He described his efforts (sometimes unsuccessful) to avoid physical assault. He stated, movingly, "Dr. Harman, I'm scared."

He came for sessions once every month or two, which was all he could afford. He made steady progress in putting his life together, moving from panhandling to part-time, odd jobs to more regular employment. Eventually, he was able to move from the city to a more suburban area. When I last heard from him, he had his own apartment, a car, a steady job, and a girlfriend. He had begun attending college in hopes of obtaining a degree which would enable him to earn a better living.

The relief of this patient's psychotic symptoms was one of the most dramatic things I have seen in my career. It can only be attributed to his increased independence (refusing financial assistance from his parents).

Case 4

This 30-year-old painter presented for therapy complaining that he had always been emotionally unhealthy and that this limited his functioning in all areas of his life, including his creative work and his relationships with women. He suffered from a strong tendency toward intellectualization and suspicion.

Functionally, he was able to earn a living as an artist and had a steady girlfriend. However, he was dissatisfied with both. Characterologically, he was a high functioning paranoid schizophrenic.

He appeared to do well initially in therapy. He discharged a great deal of anxiety by screaming. His suspicions of me were covered up by a tendency to idealize both the therapy and myself. After several months, his regress came to a halt. I did not know the cause of this and questioned him as to the details of his life. It turned out that he was experiencing financial difficulties which he attributed to the cost of therapy. His income was not sufficient to pay for both therapy and his living expenses. He had gone into debt to pay for therapy and was going further into debt. He requested that I reduce my fee to what he could "afford" - and was bitter at my refusal to do so.

I told him that he should not go into debt for further therapy and that I would only see him when he was actually earning the money to pay for therapy. Although he had been willing to go into debt for therapy, the thought of earning that amount of money brought out many of his negative feelings and suspicions.

He insisted he was willing to continue going into debt for therapy, but I told him this was not a good idea. First, he should earn the money for therapy, then he could benefit from it. He expressed anger before he left. I did not know whether or not I would ever see him again.

About a year later, he returned. He had been able to develop his career (in ways he had felt helpless to do before), and was now earning enough to pay for therapy on a regular basis. In addition, he had paid off all his debts and established some savings.

When he appeared for his first sessions, he described what he had been through in the intervening months. He spoke of each emotional difficulty he had experienced and how he had surmounted it. He stated: "I made a lot of progress. It's as if I was still in therapy the whole time." He was quite correct about this.

Case 5

This 35-year-old, white, unemployed laborer presented requesting therapy to help him overcome his incapacity to work and to establish a relationship with a woman.

Initially, there were three things that were striking about him. First, he talked incessantly in a contactless and intellectualized way. Second, he had a number of infantile expectations that others would take care of him and a tendency to blame his problems on others and on the system. Third, he had a tendency toward extreme ambivalence. His initial diagnosis was unclear; the most likely possibilities were catatonic schizophrenia, manic-depression, or an oral (unsatisfied) character.

I found his excessive talking and feelings of entitlement annoying. I had serious doubts as to whether he would respond to therapy. Matters were further complicated by his unwillingness to pay my fee. He insisted that he be seen for next to nothing and that once therapy had "improved him," he would then be able to pay.

I gently but firmly told him that he was putting the cart before the horse and that he could never get anywhere that way. He initially felt this was another example of "the system" being against him, but was willing to listen when I told him that he would be stuck forever in his problems until he could take responsibility for overcoming them. He was acting as if the responsibility for overcoming his difficulties was mine, not his; in truth, it was exactly the opposite.

He continued therapy, and his feelings of entitlement quickly disappeared. to my surprise, his constant and contactless talking also improved with no further intervention on my part. I believe one reason he talked so much is that it never occurred to him that he actually needed to do something. Within a few sessions, his characterological structure became much clearer. His constant ambivalence and doubting (which served the function of binding his anxiety) was the predominant manifestation. His diagnosis was established as catatonia.

Discussion

Each of these cases illustrates the importance of independence. The profound effect that establishing independence had in each of these cases shows that it is the immediate expression of deep and powerful biophysical forces.

We see this in nature. Every living thing strives to develop its capacity to take care of itself and takes a great deal of pleasure in doing so. In babies and animals, this tendency is virtually "unstoppable." It wanes only as a result of being repeatedly thwarted over a long period of time or as a result of severe contactlessness and irresponsibility from parents. Such contactlessness can take the form either of overt neglect or overt indulgence. This is often well rationalized as being for the child's own good.

E.F. Baker pointed out that independence is a function of contact with the self (2:67). This is because independence requires a capacity for a certain level of integration. In the development of the infant, integration of the different parts of the body results in greater and greater independence (1).

What about the process where one person helps another? This is a function of responsibility. Feelings of responsibility result from contact with the immediate environment (2:68). Examples of this include a mother caring for an infant or someone helping a sick friend. Efforts to "help" others without such a relationship

constitute a form of substitute contact made in an effort to relieve neurotic anxiety. The destructive results of such "efforts to help" reveal that the "good intentions" of the "helpers" are rationalizations. As Case 1 illustrates, the independence of the "beneficiaries" of such efforts is, in fact, damaged. Such cases show that intolerance of the independence of others is the motivating factor.

In the case of therapy, the patient and the therapist form a functional pair whose common functioning principle is the therapy itself. They make contact through this common functioning principle and such contact forms the basis for their respective responsibilities. The patient has a responsibility to be a patient and the therapist has a responsibility to accept the patient. To discharge his responsibility of accepting the patient, the therapist must understand the patient (which requires years of prior training), must overcome his own problems so that they do not intrude in the therapy, and must make the patient's needs the primary focus of the therapy. The therapist must not let considerations of social acceptability, convenience, anxiety over confrontation, etc., override any of these necessary conditions. If he allows them to, he will completely fail to discharge his responsibility. For his part, the patient needs to take the responsibility of being a patient. This includes meeting the essential details of therapy, paying the therapist, accepting the therapist's help, and accepting responsibility for the outcome.

Several factors can interfere with the patient's capacity to discharge his responsibility. For example, conservative characters can act as if they are excessively independent: they present a rigid facade of not needing help rather than making contact with what is required for help. Liberal characters show disturbances in the opposite direction: this can include feelings of entitlement, lack of acknowledgment of their responsibility to pay their own way (with feelings of resentment), and expecting the therapist to perform services not necessary for therapy. Endless talking that goes nowhere is a prime example of failure to be a patient. If the patient took responsibility for the outcome of therapy, he could not do this. I devote more space to the liberal manifestations because they can be more difficult to recognize and deal with. This is partly because they have become anchored in our social institutions; the system of "third-party payment" in all of its various forms is the most prominent manifestation of this.

In several of the cases above, it turns out that establishing independence without therapy was more therapeutic than therapy without independence. In some of these cases, therapy was conducted when the necessary degree of independence was lacking. The result was many wasted and, indeed, counterproductive sessions. This suggests that dependence on others to meet one's physical (including financial) needs is a strong relative contraindication to orgone therapy.

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