Fall 2014/Winter 2015
volume 48 • number 2

# The Journal of Orgonomy

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The American College of Orgonomy

# Depression and Antidepressants: Life Without Medication

*Dale Rosin, D.O.*

**Abstract**

*This article describes the case history of a woman who, for 25 years of her life, had been on antidepressant medication for treatment of depression despite multiple attempts through the years to discontinue them. The patient began medical orgone therapy specifically to try one last time to stop the medication. With treatment, as her characterological and muscular armor was dissolved, she was increasingly able to experience and express her long held-back emotions. She was then able to tolerate the gradual tapering of medication to the point where it was stopped completely.*

Sue, a 51-year-old woman, wanted to try, one last time, to discontinue her antidepressant medication. When she first presented for treatment, she matter-of-factly stated, "I want to get off this Effexor. I've been on it for 7 years and I feel like an automated robot: push the button, start and repeat the same cycle. I'm not feeling sad but I'm not feeling content or happy either. I have no sex drive and I can't have an orgasm."

Sue was a tall, muscular woman with an imposing bearing. She looked directly at me from behind her glasses with a subtly challenging air. Despite this, I could see an expression of sadness in her eyes. She was a psychiatric nurse and I could see her as an effective nurse manager. She came across as tough and in control. With an evident smirk, she described her life to me in efficient, curt bullet points of information. There was a profoundly stoic expression to her mouth, with lips pursed so tightly together that one could barely discern the vermillion border

of her lips. The sides of her mouth were pulled downward giving her face an appearance of disapproval and disappointment.

Feeling that commenting on how sad her eyes looked might be taken as criticism or simply be too emotionally intense for her, I lowered my voice and asked when she had last cried. For a moment the question seemed to surprise her. Then she told me, with little expression, that it had been years ago and that, in fact, she found herself now unable to cry. Sue said that she occasionally felt like crying "...but it wouldn't come out." She shrugged her shoulders as if to minimize what she was telling me, her lips pursing tighter.

I asked her to tell me the last time she got angry. "Oh, I don't get angry, I'm a New England WASP. We don't get angry," she said with her smirk, looking as if she were laughing it all off.

Rather blithely she told me how she'd gotten married at age 22 and divorced at 28. In the year before the divorce she had her first bout of depression. Finally, she wound up being hospitalized for two weeks. This was the first time she'd been placed on antidepressant medication.

She presented this information to me in a dispassionate manner, as if she were describing someone else. Despite her manner of talking, I had the impression that just telling me was a lot for her and I decided not to press her for more details in that first session.

I did say that in order to possibly discontinue her medication it was essential to start dealing with some of the emotional reasons that had made medication necessary in the first place. I further said that I would not be taking her off medication right away and that her therapy would require some time.

A slight look of irritation came over her face. "OK, you're the doctor. I haven't been able to do it myself so I guess I'll have to do it your way," she said. I gently told her I had the impression that she didn't like me having any control in the session. Smiling at me, as if she were laughing things off, she acknowledged that she always liked to be in control of all situations. "Well," I said sympathetically, "You know, you might have to give up some control here." "Yeah, I know. Sure," she said, with a jaunty smile.

Then, clearly taking control of the situation, Sue looked at her watch, got up and walked to the door with a bit of a swagger. "I'll see you next week," she said. But she didn't just leave. Rather, she paused slightly at the door, her hand on the knob. This moment only lasted a few seconds but at that moment she looked right at me. I could see she knew exactly what she was doing and that she knew I knew. In those few seconds, though not stated out loud, it felt as if a question, her question, hung in the air: "Look, Buster, this is really tough for me so are you going to pin me down or are you going to work with me?" Looking back at her with a slight reassuring smile and a small nod of my head, I told her that I would see her next week. She nodded her head, almost imperceptibly, opened the door and left.

Sue began the second session by walking into the treatment room and saying, as if we were friends or colleagues, "Hi, how are you?" She sat down, chatting about her job, her cats, her friends. After ten minutes I said quietly, "So, how come you always have to be in control?" She stopped talking for a moment, looked away and took a deep breath and exhaled. Then she told me that her ex-husband, Tony, used to wrestle with her which always ended up with him holding her down, refusing to let her up. He kept her pinned and she hated that. She told him she hated it and he said his brother used to do it to him all the time. And he kept doing it to her.

As she remembered this interaction with her ex-husband, Sue stopped talking again, looking deep in thought. I waited. She finally looked at me as if suddenly aware that I was in the room with her and told me, softly, that she really didn't trust men. She looked away again.

I nodded my head, accepting what she was telling me. I thought to myself that despite what she had just said she trusted me a great deal by just saying it. I asked, "Then tell me, please, how do you feel having a male therapist like me?" Sue looked up, smiled that smirk, looked me in the eye and said, "Oh, I'm not worried with you. You come highly recommended. Besides, I can protect myself. I could definitely beat the tar out of you if I had to." She smiled, looking cocky, as if

she'd retaken the high ground. I smiled back at her and said, "Yes, I think you could." Sue said, "You bet I could."

I noted to myself how, at 5'8", she came across as much larger and imposing. I thought how she was rather like a cat whose fur stands up when it's scared or threatened. That said, I felt she had courageously put her "cards on the table" and this small interaction allowed her to more freely share details of her life with me from that point on.

In the first two months of therapy Sue talked more about her family and childhood. She spoke with overt contempt for her father, describing him as a "wimp," whom she did not respect. On the other hand, Sue spoke admiringly and respectfully of her mother. She saw her as strong, unafraid and not ruled by emotions, as her father was apt to be.

Sometimes in sessions she talked about her mistrust of men and we'd both nod, smiling and remembering as she had stated before, "I could definitely beat the tar out of you." That she had said this to me and I hadn't challenged her became a point of connection for us in the therapy.

At the beginning of the third month of treatment, Sue began her session by telling me that she had a dream about Tony, her ex-husband. She was astonished by this, noting that for many years she had very few thoughts of him. After saying this, shaking her head, she grimaced in her stoic, corners-of-the-mouth-turned-down way.

I asked her what she was feeling at the moment. "Oh, nothing really," she said blandly, again pursing her lips. I asked her if she was aware that she had grimaced with her mouth after she talked about Tony. She looked at me questioningly, cocking her head to the right. I showed her with my mouth what the grimace looked like.

"Oh, did I? I guess I did," she said. She appeared to shrug this off, raising her shoulders and then letting them fall. I watched as her eyes started to look sadder, perhaps even a little bit tearful. I asked if she knew that her eyes looked sad. "I don't feel sad," she said, grimacing again. "You just did it again," I told her softly.

Suddenly, perhaps for the first time, she was aware of this expression she made with her mouth. Looking away from me she grimaced and let it go, grimaced and let it go, over and over, trying it out with a new awareness. Then she turned back to me and said, "Interesting," and shrugged, grimacing again.

Following that session, to her surprise, she came in with more dreams about Tony. "In one of the dreams I was missing him. Can you believe that?" Again, I pointed out how she was grimacing and told her how sad she looked. She shrugged my comments off but without the usual energy. Seeing her masseter muscles flex on both sides of her jaw, I asked how her jaw felt. She moved it about a bit and agreed it was very tight. She said that, in fact, she ground her teeth at night and that the back of her neck was tight, too. As quickly as she admitted these things to me, it appeared that such openness was a bit threatening to her. She regained control of matters by sitting up straight and saying, "By the way, when are we going to lower my meds? It's been four months."

I asked her how long she'd been on this medication and she told me she had been taking it for seven years. "Well," I told her, "We'll get there... but not yet. You've started and stopped and started and stopped this medication and you've done this for years with many other antidepressants, too. Right?"

She agreed and remembered how she'd stop them and then the depression would start again with sleeplessness always the first sign. Looking sad she said, "It was awful. And I had to function. I was afraid of not functioning. So, I'd go back on."

"Okay, then," I told her, " Let's be clear, the goal here is not just to get you off the medication but to help you change emotionally so you can stay off it, come what may, for the rest of your life."

"For the rest of my life?" I nodded my head. Sue thought this over, nodding her head solemnly. Then, as she'd said once before at the beginning of her therapy, she smiled and said, "Okay, you're the doctor!" we both laughed with the unsaid acknowledgement between us of how she grudgingly let me be in charge of her treatment.

At the start of the fifth month of therapy Sue again recounted a dream she had about Tony. As she did so, she told me how terribly hurt she was by the divorce. She immediately became aware of how her jaw and neck were tightening up just talking about it.

"What are you feeling?" I asked. "Maybe a little sad," she said. "Actually, I sort of feel like I'd like to sort of cry, maybe, but (the grimace) I can't."

I asked her if I could palpate the back of her neck and head and perhaps press a bit on her tight jaw muscles as it looked like there was emotion held there.

"Well," she said, "I remember you talking about this muscular armor stuff and it made sense so, yeah, go ahead." When Sue said this she sounded cavalier, albeit a bit anxious. I got up slowly, walked over to where she was sitting, placed one hand on her forehead and with the other began to gently press on the muscles at the back of her head and upper neck.

"Ouch!" and then the grimace. I told her to go ahead and let out a sound. She yelled, ''Ouch!" a little more as I gently worked on her tight muscles. I could see her eyes welling up with tears. I slowly sat down and looked at her, pausing. I could see her eyes filling with tears and said, "It's all right."

She started to cry, and then quickly stopped herself, with that grimace. Then she sucked in through her nose as if she had to pull any crying back. "I want to cry but I feel myself holding it back. I'm embarrassed." "It may be easier for you to give in to your crying more fully if you sit or lie on the couch," I replied.

Giving me a quick look that said, "Remember, I can beat you up," she got up from her chair, walked over to the couch and sat on it for a moment. She looked around, laid down on her stomach and began slowly, and then more fully, to cry and then to sob. Sue sobbed for, perhaps, three minutes. This was loud, deep sobbing, her shoulders heaving up and down as she gulped for air in between sobs. Then it stopped as quickly as it had begun. She lay on the couch breathing for some moments and then sat up, wiping the tears from her eyes.

I could see that her grimace, though still present, was less evident and her eyes looked softer and showed more sadness. Her respiration was less held. I asked what she felt.

"Oh, I guess relieved," she said. "I can't believe I cried." "Well, you needed to," I told her. I could see this was a startling new idea for Sue—that she actually might need to cry.

With each subsequent session Sue opened up further, telling me more about her life. Each session culminated with her laying down and crying, always giving her a feeling of relief. After several months of this, when her ability for this degree of emotional expression was established and integrated into her emotional functioning, we began lowering the medication, albeit very slowly.

With each session more memories and then crying came out. As this happened, she let me see still more of herself by going further into her history. She began to describe her mother in a different light. She said, "My mother did not tolerate any type of emotion from us. I remember crying about something and she said, 'If you want to cry, I'll give you something to cry about.' I went to my room, played my records and eventually I stopped crying. I don't remember crying again for several years, and when I did, I had learned to go to my room and cry, by myself, and never show my tears to anybody."

After a few more months of sessions with much crying and the medication being lowered even more, Sue told me, "My mother basically wanted us kids to be quiet, do the right thing, not get into any trouble and stay out of her way. She was not interested in us at all."

Sue also began to describe her father differently than she had initially. As she was able to feel more sadness and to cry it out she remembered him in another light. "He was the sweetest man I ever knew. I often felt angry at him for not being able to stand up to my mother and help us out at times, but I also knew he would have a price to pay if he ever did that."

It was good that she began to see her father more clearly because about two years into her therapy his health began to slowly deteriorate. She was able to be with him many times, taking care of him in various

ways, telling him, even as he became increasingly demented and debilitated, that she loved him.

After two and a half years of therapy Sue stopped the antidepressant medication completely. She told me that while she was not having any withdrawal symptoms, she was afraid of relapse, another hospitalization, and an inability to face life.

She reminded me of major losses that were coming soon: her father's death was imminent, one of her best friends was slowly dying of breast cancer and another was in the final stages of multiple sclerosis.

She also said, "I've been on this stuff for so long and now that I'm off it I am really afraid." I told her that as long as she was able to cry she'd make it through. She replied, "Yeah, but I'm becoming a wimp, all this crying." I asked, "You mean you're not so tough?" "No," she said, tears welling up in her eyes. "I'm actually like a marshmallow inside." And she cried more fully than ever before.

Over the next year Sue weathered her father's death, her best friend's death, the death of a beloved cat, as well as losing a long-held job she loved. Despite her fears she did not become depressed again. She cried at home and she cried heavily in her therapy sessions, always getting much needed relief.

As she softened, that is, becoming what she called a "wimp," she realized that she avoided becoming genuinely close to others by always being "the strong one" and taking care of everyone. She began to look at all her relationships differently.

And she let me see still more of herself, recounting more of her childhood. She said, "There were no demonstrative emotions ever shown in our family. Nobody ever said they loved anybody. There were no hugs, no hand holding, no anything. When we went to our grandmother's house we were told very strictly to keep our hands behind our back and not to touch anything. We could look but not touch. 'Mustn't touch!' I always whispered under my breath as I put my arms behind my back, clenching my hands together." She described saying this even today when she catches herself doing the same thing, and bringing her arms out in front of her feels extremely alien. With

evident sadness she said, "I have always felt I had to watch life from afar like this."

In medical orgone therapy, as armor is dissolved, the individual's held back emotions surface and are expressed in a lawful order, much like the layers of an onion. Throughout the five years of Sue's therapy, as various emotions surfaced, I remembered how she first told me, "Oh, I never get angry." Although I sometimes wondered, "When will her anger come out?" it was clear to me that she first needed to cry and cry and cry.

A month or so ago, she told me, "I had another dream about Tony and I was crying, but I was angry, too." This was a first. I waited. She lay down on the couch, just breathing for a few minutes. I could feel tension building in the room. Sue got up, matter-of-factly walked over to a baseball bat in the corner of the room, picked it up, walked with deliberation back to the couch, heaved the bat over her head and began beating the couch, screaming with rage, "You bastard! You bastard!"

She did this for a few minutes, although it seemed longer. When she finally tired she stopped, bat in midair, and turned and looked at me with an expression of amazement. Then she made a Cheshire cat, teeth-baring smile at me and raised the bat a little in my direction. She then put it down and smiled warmly. I smiled, too.

I knew that Tony was Sue's first love and that he'd broken her heart. However, I did not know how that fit in with the rest of her life. Now, after this explosion of rage in the session, I found out. The woman who had at first been reluctant to tell me much about herself now found her words pouring out.

She referred back to her emotionally bleak childhood, which she then contrasted with how Tony was with her when they met. He was demonstrative, warm and he liked her. He put his arms around her but, not knowing what to do with such an expression, she froze. She remembered now, astonished, that at fifteen years of age she had never been hugged before. Soon after, he told her that he loved her and she could only reply awkwardly, "No you don't."

She began to recall how wonderful Tony's family was. They were warm, accepting, and demonstrative, the polar opposite of her own family and what she had so much longed for. "After a while," she said, "they even told me they loved me." Sue felt that she had been adopted by a loving family. She gave her own parents funny Mother's Day and Father's Day cards but gave Tony's parents cards that expressed her great affection for them. She felt that Tony's parents filled in many of the gaps that her parents hadn't and could not. She told me, with tears in her eyes, "I felt alive, important and special around them. I mattered." Tony's mother told Sue she was the daughter she never had. "So, you see," she said, "I lost a lot more than Tony with the divorce."

"Tony and I were in marriage counseling for almost three years. He adamantly denied he was having an affair but my gut feeling was telling me otherwise. I worked a lot of overtime during the evening hours and the night shift as well and that was when he had his affairs. I felt betrayed and used, and I felt like a real sucker! I tried to make the marriage work but all my efforts counted for nothing. I started to be unable to sleep, eat, or concentrate at work, and didn't know if I could keep going. I went into the hospital for two weeks and came out on antidepressants."

"After I got out of the hospital, Tony and I then agreed to 'give our marriage a try,' as he put it. Six months later I found a love note to another woman in his jeans when I was doing the wash and I became even more depressed and was prescribed more antidepressants."

Like Sue, a lot of people get placed on antidepressants like Prozac, Zoloft or Effexor, to name a few. I don't want to suggest that these drugs are bad or shouldn't be used. However, I have met many patients who were told that they must stay on these medications for the rest of their life, or, like Sue, have tried repeatedly to discontinue them. Unfortunately, because of the re-emergence of depression, symptoms of withdrawal or both, they have not been able to stay off them.

Without effective therapy to address the emotions and resolve conflicts covered up by the medication, symptoms will simply reappear as the dosage is lowered.

Despite having had multiple losses in the last two years, Sue has remained off of antidepressant medication. She notes that now she can feel angry at her ex-husband, angry at her mother for being emotionally unavailable and angry about being on antidepressants for 25 years of her life.

Sue now feels and knows she is a sensitive, loving and caring person and that she doesn't have to hide that part of herself anymore. She told me recently, "I am actively participating in life now rather than just passively watching from afar with my hands behind my back!"

## Further Commentary on the Case by Peter Crist, M.D.

Sue came to therapy wanting to discontinue antidepressant medication because of unwanted side effects. Her case illustrates many aspects of the medical orgone therapy of a patient with depression and the effects of antidepressants on that process. Her treatment also shows that the character forms from layer upon layer of specific emotion bound up by armor that the therapist helps the patient face and handle in more constructive and satisfying ways. The process must start carefully with the most superficial layer of emotion. Therapy then proceeds one layer at a time to uncover the more charged, more defended against and less conscious deeper emotions. With each successive step the patient no longer needs to maintain a defensive state of contraction to its original degree and extent, and can live with more expansiveness in life.

Dr. Rosin approached Sue by first evaluating the function of her depression and where her use of medication fit into that. He informed her that before anything could be done with her medication, the emotional reasons that made them necessary would have to be addressed. He then set about assessing her defenses and character structure to determine the underlying emotional basis of her depression. On the surface, she presented a stoic, tough, in-control attitude. She laughed things off rather than feel the underlying pain that might risk making her cry. Dr. Rosin did not immediately

challenge her in-control attitude but pointed it out to her. They could then work together on how hard it was for her to let go of control. With this step-by-step approach, she began to trust him enough to gradually let go of her need for control and allow him to use his knowledge and skill as she let him take charge of the therapy.

In the early months of Sue's therapy Dr. Rosin used character analysis, a basic tool of medical orgone therapy, to improve her capacity for self-perception and to maintain her cooperation with him. Her clarity and ability for accurate self-perception also allowed him to use rational discussion to engage her, for example, when after four months she pushed him to begin lowering the dose of her medication. After having Sue review her overall history with medication and the circumstances of her numerous failed attempts to discontinue them, Dr. Rosin told her the crux of her situation:

> The goal here is not just to get you off the medication but to help you change emotionally so you can stay off it, come what may, for the rest of your life.

To achieve this Dr. Rosin focused on Sue's defensive stoicism rather than trying to encourage her to feel and express blocked emotions. As a result of this approach, her underlying sadness emerged spontaneously in a dream about her ex-husband.

At that point he addressed a specific physical attitude—a grimace Sue made with her mouth that appeared to keep her sadness at bay. Again, by first focusing on the defense rather than the underlying emotion, he was in a position to draw attention to the sadness expressed in her eyes, of which she was unaware. She then spontaneously developed more contact with her sadness.

After several years working to improve her ability to tolerate experiencing her sadness, it became evident that the sadness, in turn, fended off intense rage. Psychologically, depression is often thought of as anger turned inward, but applying that formula in a mechanical way would have led to problems in Sue's treatment. Understanding the layers and structure of Sue's character meant that Dr. Rosin could help her gradually increase her tolerance of emotions in a manner she

could handle. Initially, she could not tolerate feeling and expressing sadness, but her sorrow, nonetheless, was closer to the surface and more tolerable for her to connect with than her underlying rage.

Dr. Rosin's emotional contact, his connection with Sue, allowed him to anticipate the order of emotions that needed to be expressed. He knew "crying her eyes out" was essential before touching the anger. If he had encouraged her anger before she had discharged enough of the sadness, she might have felt overwhelmed, become withdrawn or stuck in misery (a mixture of sadness and anger) rather than being able to fully feel the anger and express it.

Five months into therapy, Sue perceived her sadness more clearly but physical muscular tension, somatic armor, blocked its expression. At this point, Dr. Rosin used another basic tool of medical orgone therapy and worked directly on the tight muscles in her neck, scalp and jaw to release the tension. This intervention allowed Sue to give in fully to her emotional impulse and cry with relief. Here, too, his emotional contact with the patient helped ensure a beneficial effect because the timing was exactly right.

Once Sue could cry regularly and her ability for emotional expression had become established and integrated into her day-to-day functioning, her medication could be slowly reduced. No longer suppressed by her defenses and dulled by the medication, painful emotions and memories from her childhood came to the surface. Now, however, she had a place to express them safely.

Entirely new aspects of Sue emerged. She became more fully alive with an emotional, vulnerable side now accessible. Under her tough, stoic façade lay a tender, vulnerable, caring human being. Quite significantly, she managed to weather several major very emotional losses without becoming depressed and without needing medication to help her through them.

Dr. Rosin describes a vivid example of how breathing, the third tool used in medical orgone therapy, increases excitation in a way that can overcome a block. He reports that in a recent session Sue breathed for a while with the excitation building to the point that she

spontaneously felt and expressed anger by hitting the treatment couch with a bat.

With this breakthrough of anger, Sue and Dr. Rosin unearthed a new layer of emotion. They now have the opportunity to free up even more of her buried emotions and vitality. With well-conducted therapy, a patient could essentially stop at any point and enjoy improved functioning. In this way both therapist and patient can be in control of the process to weigh and decide whether to live with the gains already made or to continue dissolving armor and in the process add more to the patient's life.

As is so often the case, Sue's major defense is an expression of her underlying health. Her stoic, in-control, tough attitude is an expression of strength that allowed her to survive the traumas in childhood. Nothing was going to get her down, she was going on no matter what. Her ability to "get it together," be tough and in control also served her well in a profession requiring organization and ability to face intensely emotional situations without impairment of function.

By working through the emotions she previously had to suppress with antidepressants, Sue has weathered a number of significant losses without requiring medication. She notes several key changes in herself and her life. She feels that it is acceptable to feel and experience the normal human emotions of sadness and anger, and she accepts that she can be vulnerable as a sensitive, loving and caring person without having to hide. She feels alive and actively participates in life again.