Treatment of a Hypertensive Biopathy with the Orgone Energy Accumulator.*

By Emanuel Levine, M.D., Elizabeth, N. J.1

This is the case of a 64-year-old woman who has used the orgone accumulator for 14 months for the treatment of a hypertensive biopathy. The patient was known to have had an elevated pressure for 10 years prior to the use of the accumulator. The symptoms which developed when the hypertension was first noticed were headaches, dizziness, and feelings of hot flashes. The blood pressure at that time was 180/94. During the ensuing years and prior to the use of the accumulator, the pressure ranged from 180 to 220 systolic over 96 to 106 diastolic and the general state of health was gradually becoming worse. Just before the patient began to use the accumulator, she was feeling weak and unable to do her housework; had frequent dizzy spells; began to develop gastric distress whenever certain foods were eaten; complained of frequent dysuria, attacks of diarrhea with certain foods, excessive salivation, choking sensations; and hair was beginning to fall out rapidly. She was going downhill at a rather fast pace and the prognosis seemed poor.

To understand the further presentation of this case—the development of the disease and the therapeutic process with its difficulties—it would be well at this point to present a brief description of the basic functional disturbance in the hypertensive biopathy as discovered by Wilhelm Reich. In his book, The Function of the Orgasm, there is the following discussion of cardiovascular hypertension as one of the typical psychosomatic diseases based on a chronic sympatheticotonia, resulting from orgasm anxiety:

* Read at the Second International Orgonomic Convention, Orgonon, Rangeley, Maine, on August 24th, 1950.
1 Practicing medical orgonomist. Formerly Staff Psychiatrist at the Vermont State Hospital for the Insane, Waterbury, Vt. Graduate of the Veterans Administration Resident Psychiatric Training Program.
The peripheral blood vessels are chronically contracted and their amplitude of expansion and contraction is limited; thus, having to move the blood through rigid blood vessels, the heart has continually an excessive task to fulfil.2

Since this book was published, vascular hypertension has been more specifically delineated by Reich in terms of the disturbed biosexual energy dynamics. It is for this reason that I have not used the clinical medical term, "essential hypertension," for this condition. The term "essential" was used to indicate basically that one did not know what the cause was, but Reich's discovery of orgone energy and the laws governing its function in the living organism enabled him to describe the hypertensive biopathy in terms of a specific type of disturbance of the movement of orgone energy in the body. He found that individuals with hypertension have a structure in which the decisive armorring blocks the movement of energy as it approaches the genital. The energy thus blocked moves freely into the upper segments of the body, and the continual force of expansion in the chest, neck, and head gives rise to high blood pressure. Evidence of this process can be seen in the fact that the hypertensive generally has a ruddy face but the lower segments of the body are pale.

Now to return to the patient: She is the third oldest of 7 children, was the third girl in a row to be born, and "my father wanted to throw me out." It is not known how much of this resentment the father carried out in his relations to the child. The details of her early life are quite vague and the following is an approximation on her part: Breast feeding went on for at least a year. During the first 3 months of life, her body was tightly bound from the shoulders down with the hands tucked in. Until the age of a year, the lower half of the body continued to be tightly bound. Nothing is known concerning the bowel training. There was enuresis until the age of 7. In the patient's opinion, the family life was congenial; she always felt well treated. At the age of 12 she had pneumonia and typhoid. She started work as a teacher at the age of 14, and in her 17th year was the full support of her mother and 3 siblings. Her life from then on seemed to her a constant struggle for existence; but, for the most part, she felt equal to the tasks before her. At about the age of 17, she had what was felt to be a nervous breakdown, lasting for 3 months. She had been away from home and had come under the mistaken impression that her mother was seriously ill. She rushed back and found her well but then became extremely overactive in all respects and was advised to discontinue her teaching duties for the 3-month period. The patient herself said that at no time before or since had she ever felt so well in her life, was happy, felt vigorous and capable of consistent application to tasks. The attack terminated in the following manner: An acquaintance told her that what she needed was to get married. For some reason, this angered her and she determined "to get hold" of herself. With this determination the attack subsided. From her early twenties on, she has had a specific fear of "fainting or losing control" (i.e., not be able to hold on) of herself. For this reason, she was always afraid to be alone or to travel any distance from her family. Upon closer questioning, it seemed that being alone or in the company of strangers intensified the fear of "fainting and losing control" of herself. (It might be noted, in addition, that recently the use of an elevator also precipitated fear of fainting.)

The patient was very vague about her earliest sexual experiences, but most of her contacts until she was in her late teens had been genital play with other girls. Heterosexual experiences began at the age of 21 and were frequent from then on. Coitus interruptus was always practiced and satisfaction was achieved through clitoral stimulation; she was able to reach a climax in 3 to 4 minutes and always felt relaxed afterwards. Her earliest heterosexual contacts were associated with fear of being found out, but the patient's general attitude appeared to be more on the sex-positive side. She was married at the age of 28 and had 5 children. Her husband, who was two years younger than she, died of cancer when he was 50. She has continued up to the present time to achieve sexual satisfaction through self-gratification.

Before and after marriage she had always been a vigorous worker and assumed much responsibility as in adolescence. An outstanding characteristic which manifested itself during her married life was the choking back of crying whenever difficulties arose. She would set her jaws, swallow, and then start working about the house to "work off" her troubles. Within the past 15 years, there have been about 4 or 5 anginal attacks, lasting from 2 to 5 minutes. During these attacks there was a severe sense of constriction across the entire precordium. At the age of 52, there were 3 large vaginal hemmorhages in the space of a few months' time; and these were treated with curettage. There was spotty bleeding thereafter for 6 years; and at the age of 58 a large cervical polyp was removed. There was no bleeding after this operation, but a mild leucorrhea persisted. Just prior to the use of the ac-

cumulator, the patient was examined by an internist; other than the hypertension, physical examination was negative.

The patient gave a general impression of being apprehensive. This characteristic was especially manifest in the eyes, and there was an anxious furrowing of the forehead. The head and neck presented an active holding-on attitude, and there was little mobility in this area during walking. A superficial impression gained was one of sturdiness, with the jaw set in a determined way and the head held erect. But behind what appeared to be a determined jaw, one could sense a strong expression of anger. There was a reddish color to the face. The sternornastoids were particularly heavily armored. Shoulders were retracted; chest, in a slightly inspiratory position. Respiratory movement of the topmost portion of the chest was very limited; but from the precordium down to the pelvis, movement was free and of good amplitude. When the patient laughed, it was noted that her body, including the pelvis, shook. The arming of the pelvis was most apparent posteriorly and there was slight retraction. The legs were pale and spindly and gave the impression of being one unbending unit, especially in walking; steps were quick and awkward. The adductors were moderately armored.

The first 3 months of treatment were with a 3-layer accumulator; and from then on, a 5-layer accumulator was used. The accumulator was used daily, and the treatment would be discontinued when a mild sweat appeared. During the first month, patient felt much warmth in the accumulator; and after she came out felt as though "I could put my arms around the whole world." It was noted that fatigue was quickly relieved. The urinary symptoms disappeared at the end of 3 months. At this time the blood pressure ranged from 150 to 160 over 90, and since then has remained within a systolic range of 140 to 160 over a diastolic range of 84 to 90, with brief transient elevations to previous levels. The only psychiatric orgone therapy done was to advise the patient to let herself cry whenever the impulse was present. This advice she was able to follow on several occasions. At the end of a year's therapy, hair roots began to turn black, and her hair which had been white became dark gray. Skin texture was softer; there was more tone to the musculature. Gastrointestinal symptoms decreased markedly in intensity to the point where they were no longer considered annoying. The same was true of choking sensations. There was a marked growth of black hair in the genital area. During the entire treatment period, there was a greatly increased capacity for work; and from the emotional standpoint, the patient bore up well under some very trying situations. The most reliable clinical indicator of excessive use of the accumulator was insomnia. Whenever this symptom appeared, orgone energy irradiation was omitted for a day or two and then gradually resumed with whatever decreased daily exposure was necessary to avoid the insomnia. All through the year there were transient dizzy spells, and in the 13th month there was a momentary attack of unseens of footing. In the following days, there was an alternation of markedly increased vigor, with days of marked weakness. About this time, the patient developed what she considered a cold and used the accumulator much more intensively than had been her custom.

At the beginning of the 14th month, the patient felt very unsteady one morning. She was alone in her apartment and went to a neighbor and told her she did not feel well, then fainted. The neighbor caught her and called me. The patient's expression as she fainted was described by the neighbor as one of "dying," and by this she meant the way in which the eyes turned up. I saw the patient within three-quarters of an hour after the fainting attack. She was cold, clammy, and confused; could not remember what had happened in the two hours prior to the attack; and asked the same questions over and over again, not realizing she had just asked them. When she became aware that she could not remember the events prior to the fainting attack, she cried rather piteously, saying, "I don't remember, I don't remember." There was panic in this crying, and it was my impression that this was a psychological representation of the fact that this lifelong feared loss of control had finally occurred. There were two attacks of this crying within the space of about half an hour. It was realized that it would be inadvisable to open the armor any more than was absolutely necessary and also that a massive dissolution of armor was possible, which would be catastrophic; therefore, the crying which was there at the surface and was being fought back was let out, and then the patient allowed to rest. The blood pressure when the patient was in the cold, clammy sweat was 200/80, and the pulse was 20. Two hours after the attack, the blood pressure was down to 140/80; the body was very warm; and the pulse was 80 and had a slow undulatory peaceful quality to it. The whole body, however, was excessively relaxed. There was no pain. It should also be mentioned that during the first few hours after the attack the patient reverted to her adolescence, talked about the fact that she had taken heavy responsibilities at an early age; that she had never felt, in spite of opinions of others to the contrary, that she had...
been able to work quite to the limit of her abilities. It always seemed to her that she was capable of doing better work than she was doing. Physical examination by an internist, including neurological, was entirely negative.

The following day there were two attacks of the same pattern but much milder and over in a few minutes. The attacks were followed by nausea and a brief period of frightened crying. There still was slight confusion present, evidenced by the repeated asking of the same questions. The second night after the attack, there was a strip of coldness about 3 inches wide across the upper chest during a mild attack of panic. At that time the blood pressure was down to 110/70; the rest of the body appeared warm; the pulse was around 60. The next morning this same chest area was specifically warmer than the rest of the body. On the third day, the patient was still weak but was up and about and improving, taking sips of wine. On the fourth day, there was a feeling of something pleasurable moving from the upper abdomen down to and coming out of the vagina. This sensation, the patient reported, was exactly the same as the ones she had had during her vaginal hemorrhages; in fact, she thought she was bleeding and looked down to see if any blood was present and was surprised to see that none had come out. On the fifth and sixth days, the patient was much stronger and up and about most of the time. By the ninth day vigor and strength were coming back. Blood pressure remained between 130 and 140 systolic: over 80 diastolic. During the next few weeks there were frequent daily attacks of severe anxiety. During them, the patient felt that she was going to collapse and expressed the idea that "one could go into the next world during such a thing." These attacks were aborted by small amounts of whisky. The patient noted that she would urinate after each attack and there was a change in the character of her bowel movement. Usually she would have to, as she described it, "get the bowel movement down from high up," but now "it seems to be right down there ready to get out."

The accumulator was discontinued from the time of the first attack but remained in the apartment. The patient reported that just prior to her acute illness she had begun to see "sparks of lightning" moving in her lateral fields of vision. At the same time, she also saw black spots moving in front of her. The "lightning sparks" disappeared seven days after the accumulator was discontinued; but when the patient looked into the closet where the accumulator was kept, she could still see "the sparks," and this state of affairs lasted into the fourth week after her fainting attack. At this time, it was felt that it would be advisable to take the accumulator out of the apartment because the attacks were continuing, and the apartment seemed to be quite charged. The last serious attack took place at the beginning of this fourth week. The patient had again developed symptoms of a cold and, on her own initiative, used the accumulator for about 20 minutes. The attack occurred just as she came out of the accumulator. The blood pressure was checked quite closely and was found to be 180/94 during the acute anxiety, and an hour later was 110/70. The elevated pressure was associated with paleness and the lower pressures with what appeared to be a good red color. Within two days after the accumulator was taken out of the apartment, the attacks began to diminish in frequency and intensity. Sparks were no longer seen anywhere by the patient. The weak sick look which she had had was gone, and she now looked quite healthy and began taking walks, though mild attacks of anxiety continued. These consisted of palpitation, associated with what the patient described as a feeling of "something not being right in the upper abdomen"; at times, with the feeling that "something was pushing up" inside her head. Sometimes there would be only palpitations; sometimes, just this feeling of "things not being right" in the upper abdomen.

The patient always described herself as being "anxious" at these times. The blood pressure during this period remained in the vicinity of 180/80 but in subsequent weeks dropped to around 150/80. Now, instead of a general paleness with an elevated blood pressure, the face appeared flushed. There was a slight tendency to cry, but the patient was not able to get it out by herself and was not urged to do so. She felt, in general, that she was improving but still felt that she had to tell herself "to hold on." By the tenth week, the patient had resumed all her household activities although attacks of anxiety, some fairly severe, continued. By the twelfth week, there was a continued lessening of anxiety. Patient began to have days during which she was entirely free from anxiety. The blood pressure was in the vicinity of 150/80.

Six months after the first severe fainting attack the blood pressure level was between 140 and 150 systolic over 80 to 86 diastolic. The patient was able to function in her daily tasks, although a mild amount of discomfort in the form of anxiety was often present. The use of the accumulator was discontinued because, as Wolfe suggested, the blood pressure level could be used as a good criterion of whether orgone energy irradiation was necessary or not. Also, for a time, the patient developed an intense fear of the accumu-
latter which gradually subsided. About this time there occurred a strong outburst of angry crying. In an irrational way, the patient blamed herself for a certain situation. She was being carried away by this reaction and was practically out of control. It was feared that a psychotic depression could occur were she allowed to continue. Very forcefully the patient was told to stop. She had enough control to do as she was told although an hour later when she regained her equilibrium there was no memory of what she had been through nor could she remember what had happened about half an hour before the attack, although she had behaved at that time in her usual manner. She was again somewhat confused, asked the same questions over and over, and it was about 3 hours before she was completely clear.

The blood pressure level the moment the reaction stopped was 200 over 94. Two hours later it had dropped to 144 over 86. The point has been made earlier in this paper that the blood pressure level dropped after an emotional reaction. For the sake of completeness, it should be added that it was the surge of energy, that is, the emotion, prior to the breakthrough which pushed the pressure up. During the attack, it was also noted that there was a hard redness in the face. This facial appearance ran parallel with the blood pressure level and was due to the strong upward rush of energy. The whole episode was a clinical confirmation of Reich's elaboration of the biophysical structure of the hypertensive. The next 48 hours were the best she had had in several years, but in the following few days several new symptoms appeared. A feeling of fullness developed in the chest which was most intense high in the axillae. This chest syndrome alternated with attacks of diarrhea. The energy would move upward from the pelvis and be largely blocked by the holding attitude in the shoulders and then move back down to the pelvis and cause diarrhea. At times during the chest fullness, there were sharp pains over the precordial region. It will be remembered that in previous years this patient had had 4 or 5 attacks of anginal pain. The feeling of fullness was felt by the patient as though something inside her chest was pressing to get out. In subsequent days, this sensation changed into a feeling which the patient described as similar to milk coming into her breasts.

It has now been two years since treatment with the accumulator was begun and the use of the accumulator is being resumed although very slowly and carefully. Mild symptoms of anxiety persist, and these symptoms are associated with feelings of fullness in the head, quiverings in the stomach, and unsteadiness of the legs. The hypertension as a problem no longer exists.
response to treatment with the orgone energy accumulator is based partially on the fact that the accumulator has a vagotonic effect which counteracts the general sympathethicotonin in the hypertensive. This expansive effect, as evidenced by the patient's statement upon leaving the accumulator—"I feel as if I could put my arms around the world"—is responsible for the lowering of blood pressure and general relief of symptoms.

The production of symptoms leads to trying to understand the process of aging in the armored individual. The patient's condition prior to the use of the accumulator indicated the armor was giving way. This was apparent in the tightness of the throat, tendencies to dizziness, gastrointestinal disturbances, and dysuria; that is, the equilibrium between energy production in the core, absorption in the armor, and discharge in work and sexuality was being disrupted. The armor had reached the limit of absorption and energy was breaking through to give rise to local and general symptoms and, eventually, mechanical defects in organ functioning. Keeping in mind that chronic armoring is a dynamic obstruction to the natural movements of expansion of orgone energy, then the relief of symptoms by the accumulator can be, in part, attributed to the fact that there is a lessening of constricrive tendencies in the organism, with allowance for more natural total expansion instead of small isolated breakthroughs of energy in a pathological way. However, as Reich has said, armor of any kind, from a certain standpoint, serves a function. When the energy held in the armoring of the cardiovascular system was released and the pressure reduced, the situation from which the armoring protected the individual, that is, pre-genital and genital anxiety, made its appearance. The feeling of something moving from the upper abdomen down through the genital was a breakthrough of energy into the genital. When this happened, the hypersensitive structure was broken through; and the patient's reaction of syncope, associated with intense paleness and a blood pressure of 200/80, indicated that there was now a total contraction of the organism against expansion of the core. The base of the elevated pressure at this point was now the core instead of the block in the pelvis. In time, the organism returned to its previous hypertensive structure. Here there was movement of energy from the block in the pelvis directly up into the shoulders and face in the form of anger, and the face was quite red. The pressure was again elevated, by this time with a higher diastolic. It can be seen that two different clinical pictures and two different types of elevated blood pressure resulted from two separate, though functionally connected bio-energetic situations. That the patient developed a feeling that the milk was coming into her breasts during the time when her chest felt full indicated that energy was moving into her breasts; and when this happened, the chest was more at ease. The breasts seemed to act as safety valves for the chest pressure. Further observations will be necessary to see if this happening has any connection with the fact that coronary occlusion is much less frequent in the hypertensive female than in the hypertensive male. The improving color of the legs and the earlier climax during self-gratification is indicative that increasing amounts of energy are pressing toward and breaking through to the genital and this, in turn, is the basis for the continuing anxiety.

The experience with this case has impressed me with the multiplicity and depth of problems one faces in dealing with a biopathic structure of many years' duration. There has been the hypertension and when this gave way, the pre-genital and genital anxiety, the anginal syndrome, and a tendency toward a psychotic depression. It is a medical fact of the first magnitude that the orgone energy accumulator for a long period of time decisively influenced such a structure in the direction of health.

Dr. Walter Hoppe, in his article "My Experiences with the Orgone Accumulator," reported marked clinical improvement and a drop in blood pressure level from 210 to 190 systolic in a 52-year-old patient who used the accumulator for 3 months. There have been many similar experiences with hypertension which are, as yet, unpublished. That the accumulator has this effect in hypertension, one of the most common biopathies of our time, is another confirmation of Wolfe's statement in his pamphlet, EMOTIONAL PLAQUE VERSUS ORGONE BIOPHYSICS:

THE ORGONE ACCUMULATOR IS THE MOST IMPORTANT SINGLE DISCOVERY IN THE HISTORY OF MEDICINE, BAR NONE.4

This is a factual statement of tremendous medical importance which can bear repetition. Another fact demonstrated is that the physician who pre-

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4 Theodore P. Wolfe, EMOTIONAL PLAQUE VERSUS ORGONE BIOPHYSICS, Orgone Institute Press, 1948, p. 44.
scribes the accumulator is responsible for understanding and following deep-seated biological changes and must observe the patient closely.

A few words might be said about the psychiatric aspect of handling this case. In general, as previously stated, the patient was advised to let out crying whenever she felt like it, and this she was able to accomplish. Whenever it became necessary to do specific psychiatric orgone therapy, I always did a little less than seemed necessary because an organism which has been biopathic for 64 years can tolerate changes in structure very poorly. It was felt that if the reaction had been inadequate during one treatment session that one could always go back later and obtain a more complete reaction if it became necessary.

The problems involved in treating a 64-year-old hypertensive have been presented. From a functional standpoint the problems are identical with the biopathies of the earlier years; the only difference is they have existed for a much longer period of time. The term "diseases of old age" is misleading. Actually, what we are seeing are old diseases spawned in the life-negating frustrations of infancy, childhood, and adolescence.

*All the profound thoughts of hygiene and the art of healing are like the efforts of a mechanic, who having stopped all the valves of an overheated engine should invent something to prevent this engine from bursting.*

—Leo Tolstoy
Caro Leitor
Infelizmente, no que se refere a orgonomia, seguir os passos de Wilhelm Reich e de sua equipe de investigadores é uma questão bastante difícil, polêmica e contraditória, cheia de diferentes interpretações que mais confundem do que ajudam. Por isto, nós decidimos trabalhar com o material bibliográfico presente nos microfilmes (Wilhelm Reich Collected Works Microfilms) em forma de PDF, disponibilizados por Eva Reich que já se encontra circulado pela internet, e que abarca o desenvolvimento da orgonomia de 1941 a 1957.

Dividimos este “material” de acordo com as revistas publicadas pelo instituto de orgonomia do qual o Reich era o diretor.
01- International Journal of Sex Economy and Orgone Research (1942-1945).
02- Orgone Energy Bulletin (1949-1953)
03- CORE Cosmic Orgone Engineering (1954-1956)

E logo dividimos estas revistas de acordo com seus artigos, apresentando-os de forma separada (em PDF), o que facilita a organizá-los por assunto ou temas.
Assim, cada qual pode seguir o rumo de suas leituras de acordo com os temas de seu interesse.
Todo o material estará disponível em inglês na nuvem e poderá ser acessado a partir de nossas páginas Web.

Sendo que nosso intuito aqui é simplesmente divulgar a orgonomia, e as questões que a ela se refere, de acordo com o próprio Reich e seus colaboradores diretos relativos e restritos ao tempo e momento do próprio Reich.
Quanto ao caminho e as postulações de cada um destes colaboradores depois da morte de Reich, já é uma questão que extrapola nossas possibilidades e nossos interesses. Sendo que aqui somente podemos ser responsáveis por nós mesmos e com muitas restrições.

Alguns destes artigos, de acordo com nossas possibilidades e interesse, já estamos traduzindo.
Não somos tradutores especializados e, portanto, pedimos a sua compreensão para possíveis erros que venham a encontrar.

Em nome da comunidade Arte Org.
Textos da área da Orgonomia Bifísica. Casos clínicos.
Texts from the area of Biphysical Orgonomy. Clinical cases.

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International Journal of Sex Economy and Orgone Research
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Orgone Biologics 2. A case History

01 Wilhelm Reich. The Orgasm Reflex. A case History 1942.
International Journal of Sex Economy and Orgone Research Volume 1 Number 1 1942
Interval 60-69 Pag. 55-64

02 Carl Arnold. The Treatment of a Depression. 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 2 1942
Interval 69-76 Pag. 163-170

03 Wilhelm Reich. The Mosochistic Character (1933)
International Journal of Sex Economy and Orgone Research Volume 3 Number 1 1944
Interval 43-66 Pag. 38-61

04 Walter Hoppe. My First Experiences the Orgone Accumulator 1945
International Journal of Sex Economy and Orgone Research Volume 4 Numbers 2 3 1945
Interval 78-79 Pag. 200-201

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Orgone Energy Bulletin

01 Simeon J. Tropp. The Treatment of a Mediastinal Malignaney with the Orgone Accumulator 1949
Interval 5-10 Pag. 100-109

02 Ola Raknes. A short Treatment with Orgone Therapy 1950
Interval 14-18 Pag. 22-31

03 Victor M. Sobey. Six Clinical Cases 1950
Interval 19-24 Pag. 32-43

04 William A. Anderson. Orgone Therapy in Reumatic Fever 1950
Interval 14-15 Pag. 71-73

05 Simeon J. Tropp. Therapy of an Early Breast Cancer 1950