Observations on a Case of Coronary Occlusion

By Emanuel Levine, M.D.*

A 39-year-old male patient came to treatment because of the following symptoms: constant severe jitters, profuse outbreaks of sweating, much gastric distress and nausea, frequent attacks of diarrhea, chronic fatigue, tightness of the throat, feeling of irritation of the stomach and throat, and depressive moods about once a week. These symptoms were biophysical aspects of a severe general anxiety approaching overwhelming intensity. It did not seem possible to the patient that he could expect to earn a living, and he was taxing himself to the limit to continue his studies in a school of accounting.

Past history revealed mumps and whooping cough as a child. His health, otherwise, had been good until 1937 when there had been indigestion for several months. A general state of ill health began on November 18, 1943, at the age of 34 when the first symptoms of what turned out to be an acute coronary occlusion developed during military service. While doing clerical work, a feeling of “apprehension” developed (“I could not breathe”), it became necessary for him to go outdoors several times “for air,” and then a sensation of pressure girdling the chest appeared, followed by substernal pain and a burning pain on the anterior surfaces of both arms. It was first felt that the diagnosis was indigestion, but in spite of rest and medication the symptoms persisted, and the patient was hospitalized the next day. An electrocardiogram done on November 19, 1943, revealed “a prominent Q-wave in Leads II and III and slurring and widening of the Q-R-S complex and slight elevation of the S-T component in these leads. Impression: Changes, especially the prominent Q-waves, suggestive of myocardial change from coronary artery disease.” The routine physical done at the time of admission to the hospital revealed a blood pressure of 124/80; heart and lungs negative and thorax negative. Laboratory results: X-rays of the heart and lungs were negative, blood count and blood negative, urine negative, cholesterol 259 mgm; and sedimentation rates of 10 to 15 mm. per hour. Serial EKG’s from November 19, 1943, through January 14, 1944, revealed T-wave and Q-wave changes indicating a posterior wall coronary occlusion. Subsequent electrocardiographic studies in army hospitals fully confirmed a diagnosis of a healed posterior wall coronary infarct, and the patient was discharged from Service with this diagnosis on February 28, 1944.

About October, 1946, another acute posterior wall occlusion occurred and the diagnosis was clear both clinically and electrocardiographically. A third attack occurred about two months later. This attack was also confirmed electrocardiographically, but this time the infarct was in an anterior vessel.

My first contact with the patient was on August 25, 1949, in a clinic where I was employed at the time. Two internists had suggested psychiatric treatment though, of course, the treatment had been suggested for the psychic symptoms without the understanding that a single process, a deep biological disturbance (to be discussed later), was responsible for both the coronary occlusion and what they considered to be a psychic disturbance. The patient had been to several private psychiatrists and psychoanalysts but had not been able to find anyone who would accept him as a patient. Because of my oronomic knowledge, I felt keenly the dangers involved in such a case. It was quite possible that an emotional reaction on the couch could result in an unusually severe expansion or contraction, either of which could blow out the old infarct or cause a new one. Coronary artery disease in the younger age group is quite severe. Having had three previous attacks, there was less likelihood of survival of another attack; however, a realistic appraisal of the situation revealed several factors which encouraged me to go ahead.

1. There was, in my opinion, nothing to lose. The patient was at the end of his rope, facing at the best a life of chronic, severely uncomfortable invalidism with a good possibility of another attack of coronary occlusion in the not-too-distant future. The patient also felt that there was nothing to lose, because when I acquainted him fully with the fact that there was danger to life in undergoing therapy he had no hesitation in deciding to go through with it.

2. In studying with Wilhelm Reich and as a result of my own subsequent experiences, I know how true is Reich’s oft-repeated statement that the forces...
for life and natural functioning are very strong and need but a little help to assert themselves in spite of previous tremendous damage.

3. I also knew that Dr. Walter Hoppe had treated cases of organic heart disease with a 20-fold orgone energy accumulator and that the biophysical structure, including the pathological tissue, had stood up under such strong expansive forces.

4. Some feeling of security was also given because I knew what was going on in the patient: that the ultimate basic pathological process was a specific type of disturbance in the flow of orgone energy in the body. The general background of coronary occlusion had been described by Reich. He found that the occlusion resulted from strong expansive movements in the chest which were met by strong contractions in the same area and that because of blocks in the shoulders and diaphragm the vice-like contraction could not find release elsewhere and finally resulted in rupture of a coronary vessel. The first examinations of the patient agreed fully with this description.

I should state at this point that during the year and a half that treatment was done at the clinic only character-analytic technique, modified by my orgonomic knowledge, was used because of the irrational attitude of the clinic toward orgone therapy. Since March 16, 1951, when I left the clinic, the patient has been in orgone therapy and treatment is continuing.

To return to the first examination of the patient, the total picture was one of complete apprehension. The eyes were frightened, restless, awaiting danger and looking for escape. They could not look directly at one. They gave an impression of apprehensive thinking. The rest of the body was apprehensive in a frozen way, the chest held extremely high in inspiration without any discernible movement. There was a slight respiratory movement beginning just below the diaphragm but the pelvis was retracted and immobile in fright. There was a reproachful sadness in the mouth and shoulders, mixed with resignation. These attitudes were later on described by the patient as "why does this happen to me" and "this is my lot." The lower jaw also expressed a mean wild anger, and this area and the neck were strongly armored as was the chest. The armoring in the lower segment of the chest actually overhung the upper abdominal area because of the high position of the diaphragm. The abdominal and pelvic areas were very lightly armored. The posterior aspect of the thighs gave an impression of hard

stubborn anger. From the standpoint of the initial steps in treatment, however, the most important fact was that, except for the eyes, the patient was contactless. He had no real concept of expressing his emotions with his facial expression and felt anxiety only in his eyes. The rest of his symptoms were felt as somatic disturbances. As an interesting corollary of this situation, the patient was able to recognize other people and especially family resemblances only by what he saw in the eyes of other people. The rest of their faces meant nothing to him.

It was clear that the central problem and danger which would determine the feasibility and efficacy of treatment was the complete immobilization of the chest. Here was the basis of the coronary biopathy and the chief block which resulted in the general anxiety. It was felt, as a general principle, that it was extremely necessary for the patient to be in complete contact with everything that was happening to him and also that the treatment should go as slowly as possible without standing still. Therefore, the first few months were devoted to repeated descriptions of the facial expressions and asking the patient to accentuate these expressions in order to bring him into contact with his general emotional status. At the end of that time, the patient had become capable of crying and to a slight extent was able to express himself in anger when environmental situations called for it. Also, there developed the capacity to release anxiety once the attitude of overcautious thinking had been loosened. At this time I advised the patient to discuss his disagreements with his wife more openly because there were acute differences which were a constant source of stress and which had not, until now, been out in the open. This clearly removed the depressive episodes as a disturbing factor.

In the fourth month of treatment there was an attack of anxiety associated with a feeling of severe constriction around the whole chest, of such intensity that a cardiac consultation was obtained to see if another occlusion had taken place, but this was not the case. The symptoms, however, were exactly the same as those associated with the occlusions. It was apparent that the cardiac biopathy was now being brought out into the open. For the next month this syndrome made frequent appearances and the patient became aware that he felt a frustrated anger at such times. Finally, the syndrome began to abate after a particularly severe crying spell which was followed by a marked increase of intensity of genital discharge and violent involuntary movements of the body at time of climax.

After fourteen months had gone by, anger was being felt in greater strength
and there was realization that an express effort was being made to keep anger out of the face and for that reason the patient never looked directly at people. It was at this point that repeated clinical observations were made that the expression of anger relieved chest pain. Also, in this fourteenth month there was a brief attack of genital anxiety. The patient felt for about a day that he was “falling to pieces,” and this was followed by another rise in intensity of genital sensations, and body movements at time of climax were becoming less violent.

In the fifteenth month there was a feeling of “top of head being separated from the rest of the head,” together with pain behind the eyes. This syndrome was gradually relieved by expressions of fright followed by anger, with special attention to the ocular segment. When, subsequently, there was a return of the eye pain, the patient was able to relieve it himself with the ocular expression of fright. In the last week of the fifteenth month a deeper crying again appeared followed by a sensation of “something pushing out in the chest,” and then development of a fuller expression of anger followed by an exhausted feeling lasting three or four days. Then, for the first time, the patient had a feeling which he described as “being free in the chest” and, quite significantly, it was at this time that he was first able to recapitulate emotionally his relationship to a very domineering father who had been extremely repressive to the patient. Wilhelm Reich has shown that the central mechanism for emotional repression is inhibition of the respiratory pulsation. The inhibition of anger and respiration were identical processes resulting from fear in this case.

From a bio-energetic standpoint, a new therapeutic situation now existed. The chest had become mobilized. The sensation of something pressing out indicated that expansive impulses had begun to reach the periphery of the organism and were meeting very little constrictive tendencies in the chest. This was the real beginning of working through the cardiac biopathy.

In the following weeks, as the energy liberated from the chest moved downward, constrictive pains appeared at the level of the diaphragm and gallbladder and then at the level of the kidneys. In each of these cases, hitting the couch in anger relieved the symptoms in dramatic fashion. During the time when there were constrictions in the region of the gallbladder there was a recurrence of gastric distress and pain over the gallbladder area. X-rays revealed a “dyskinesia of the gallbladder.” Clinically, all these symptoms disappeared as previously mentioned.

In the eighteenth month of treatment the patient came into orgone therapy. It became possible to materially increase the mobilization of the chest through work on the armor there and through expressions of snarling rage and anxiety. As the mobilization of the chest increased, the patient began to experience feelings of fullness under his armpits.

I had seen this same symptoms appear in another case where a potential cardiac biopathy existed, and it seemed that the same process was going on in this case: Namely, when the armor in the middle of the chest began to give way, the energy which at times would try to move down toward the pelvis would also move toward the upper segments of the body and, passing the part of the body where the heart was located, would be caught by the block in the shoulders. If this assumption were true, it would indicate that the danger of an occlusion had been materially lessened. This was to some extent borne out a few weeks later when an attack of severe constrictive pain just below the level of the shoulders took place. This pain was described as being more severe than that which had been present during the coronary occlusion attacks. However, the location of the pain was not at the level of the heart and so there was minimal danger of an occlusion developing. This new constrictive tendency is now in the process of abating.

The results of therapy to date are as follows: The patient has reached the point where he feels capable of facing the future and earning a living although it is still no easy matter for him, as his symptoms recur at times, although on a much milder level both in intensity and frequency. His genital functioning has markedly improved. The chest is quite mobile although it, too, at times returns to its former high position, but it can now easily be brought down in therapy. My impression is that the likelihood of further heart attacks has been diminished and that there is a good theoretical basis for feeling that further attacks can be prevented, although it remains to be seen if this can be made a practical reality.

From a medical standpoint, the problem of coronary artery disease was identical with the problem of an immobile chest. When the chest became mobilized and the patient had the sensation of freedom in his breathing, a remark by Myron Sharaf in his review of Northrup’s book, The Meeting of East and West, came to my mind:

For “the physiological freedom to be oneself” remains vague and abstract unless there is added to it the straightforward, orgonomic affirmation of the
genital rights of infants, children, and adolescents, since "physiological freedom" essentially depends upon sexual health.\(^1\)

The phrase "physiological freedom" includes, of course, freedom to breathe as nature intended. The recapturing of the emotional relationship to a domineering father after mobilization of the chest indicated that it was the fear of the father, at least in part, which had caused the chest to freeze. The statement "couldn't breathe," with which the sensations accompanying the first attack of coronary occlusion were described, was a literal expression. This man throughout his lifetime had been afraid to breathe. Breathing would have meant the expression of anger but that emotion was blocked by fear.

The task from the standpoint of preventive medicine is clear. With Wilhelm Reich's finding that coronary artery disease belongs in the realm of the biopathies, a finding for which the foregoing observations are additional evidence, the problem then becomes one of parents being capable of letting their children express themselves emotionally whether it be in crying, anger, or loving. Only thus can coronary occlusions which result from chests and coronary vessels frozen in fear be prevented.

Projeto Arte Org
Redescobrindo e reinterpretando W. Reich

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
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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
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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
06 Charles I. Oller. Orgone Therapy of Frigidity A Case History 1950
Interval 28-33 Pag. 207-216

07 Emanuel Levine & Elizabeth N. J. Treatment of a Hypertensive Biopathy wit the Orgone Energy Accumulator 1951
Interval 14-20 Pag. 23-34

08 Chester M. Raphael. Orgone Treatment During Labor 1951
Interval 17-21 Pag. 90-98

09 N. Wevrick. Physical Orgone Therapy of Diabetes 1951
Interval 27-28 Pag. 110-112

10 A. Allan Cott. Orgonomic Treatment of Ichthyosis 1951
Interval 25-27 Pag. 163-166

11 Philip Gold. Orgonotic Functions in a Manic-Depressive Case 1951
Interval 27-34 Pag. 167-180

12 Emanuel Levine. Observations on a Case of Coronary Occlusion 1952
Interval 24-27 Pag. 44-50

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Orgone Biologics 2. A case History
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01 Eva Reich. Early Diagnosis of cancer of the uterus 1943
Interval 25-28 Pag. 47-53