Somatic Biopathies: Part I

Charles Konia, M.D.

Reprinted from the *Journal of Orgonomy* Vol. 23 No. 2
The American College of Orgonomy

Introduction

This series of articles will demonstrate clinically Wilhelm Reich's postulate that all the various disease forms encompassed by the somatic biopathies have as their common functioning principle (CFP) a pulsatory disturbance of the plasmatic system and that orgone therapy can eliminate both the somatic biopathic symptoms, as well as the underlying pulsatory disturbance. A somatic biopathy manifests itself primarily in the somatic realm and includes the psychosomatic diseases of classical medicine. The term "psychosomatic" however, is a misnomer for the following reasons:

1. It fails to correctly define the disease processes in questions.

2. It is not sufficiently inclusive. Idiopathic Parkinsonism, multiple sclerosis, etc. (examples of somatic biopathy) are not, at the present time, clearly recognized as having both a psychic and a somatic component.

3. Strictly speaking, every biopathy, including a psychic one (i.e., character disorder), has both a psychic and a somatic component.

In contrast, the orgonomic term "biopathy" focuses on the pathogenesis of these diseases. All biopathies arise from an underlying disturbance of orgonotic pulsation involving the plasmatic system (autonomic nervous system and vascular system).(1) This disturbance is itself caused by orgastic impotence.

A psychic biopathy arises when the pulsatory disturbance of the organism involves a segment containing an erogenous zone (1). A somatic biopathy, on the other hand can arise from armoring of any segment. All somatic biopathies develop within the milieu of a pre-existing, underlying psychic biopathy. In these cases, therapy is determined not only by the patient's character structure, but also by the segment containing the somatic biopathy.

A somatic biopathy arises when the muscular armor is unsuccessful in immobilizing energy, which then overflows into the plasmatic system, in particular, the autonomic nervous system and the target organs innervated by it. The symptoms of the somatic biopathy are nothing more than undischarged somatic excitation being expressed by the autonomic division of the plasmatic system. The process is comparable to the anxiety of psychic biopathies. Both situations result from a failure of armoring.

Shrinking biopathies (i.e., the cancer biopathy) develop an increased vascularity, which supplies large quantities of energy for tumor growth. The vascular component of the plasmatic system is, thus, the source of energy discharge. In all other biopathies,

however, in which shrinking does not occur, the autonomic nervous system is the primary source of energy discharge. In both cases, the patient has more energy than that contained in the armor. Somatic biopathies can be divided into high energy states where energy is discharged via the autonomic nervous system and the low energy states where energy discharge occurs by way of the vascular system. In the latter case, the shrinking biopathy has been preceded by decades of chronic sympatheticotonia (chronic excitation of the sympathetic nervous system), a primary manifestation of the biopathy prior to tumor formation. After decades of sympatheticotonia, autonomic excitation is finally extinguished with psychological resignation of the organism. At this point, the vascular division of the plasmatic system becomes the primary outlet. Malignant tumor formation can occur, accompanied by the proliferation of vascular tissue to it. This further depletes the host organism of energy and accelerates the shrinking process. (2)

Benign tumor formation may represent an intermediate state between those somatic biopathies exclusively involving the autonomic nervous system and those in which shrinking is present. If this is correct, then benign tumors would involve activity of both components of the plasmatic system. It is known that benign tumors can develop in high-energy biopathies and these, under certain conditions, can degenerate into malignant tumors.

When energy overflows into the autonomic nervous system, the result is chronic sympatheticotonia. In certain biopathic diseases there may be, in addition, a superimposed parasympathetic reaction to it. This can occur either simultaneous with sympathetic excitation, as is the case of asthma and mucous colitis, or alternatingly, as in the case of Raynaud's disease and migraine.

Typically, biopathic symptoms wax and wane with the emotional state of the individual. When autonomic discharge becomes chronic and fixed, irreversible structural damage to the tissues may result. Because the symptoms of the biopathy originate from undischarged sexual excitation resulting from orgastic impotence, orgone therapy remains the only means of permanently eliminating a somatic biopathy.

During the course of orgone therapy, somatic biopathies may appear and disappear. Their manifestations may vary in intensity and can become sufficiently prominent to warrant a classical medical diagnosis. Others are too subtle for medical identification. Depending on the type and severity of the somatic reaction, the management of a biopathic symptom may require medical or surgical intervention. As in the case of a psychic biopathy, the earlier a somatic biopathy develops in the patient's life, the more severe will be its consequences. The following series of case presentations show well-known examples of biopathic disorders. It will focus primarily on the clinical manifestations of somatic biopathies and not on the process of systematic dissolution of the armor, as is customary. They will be presented up to the point at which the biopathies were eliminated. (3)

Cardio-Vascular Hypertension (Essential Hypertension)

Etiology.

In this condition, the most common form of hypertension seen in clinical practice, the thoracic segment is primarily affected. There is chronic sympatheticotonia involving the cardiovascular system. The excess sympathetic excitation may also result in disturbances of the rate and regularity of the heartbeat. Biophysically, the patient appears under a great deal of tension, and the chest is held in an inspiratory attitude. There may or may not be awareness of a sense of oppression or tension in the chest, depending on the degree of contact the patient has with himself. Great quantities of suppressed rage are held in the thoracic segment. If the condition becomes chronic, it predisposes to the development of arteriosclerotic heart disease, cerebrovascular strokes, as well as renal disease.

Case Presentations

1. Hypertension as a Presenting Symptom.

This 56-year-old, married, white male accountant came to therapy because of vascular hypertension of 10 years' duration. Approximately four and a half years prior to therapy, an internist found the patient's blood pressure to be 240/150. His physical examination was otherwise unremarkable, while blood studies, urinalysis, EEG, and chest films were all within normal limits. He was placed on diuretics, anti-hypertensive medication, and a minor tranquilizer. Follow-up visits revealed a blood pressure stabilized around 180/110. He was told by his physician that this amount of reduction as all he could expect.

When first seen in consultation, he complained of occasional headaches but no dizziness. He felt a numbness in his right arm when upset. He dated the onset of his hypertension to his wife's refusal to have sexual relations. He later learned she had taken a lover. When he confronted her, he did so without expressing any emotion but stated in a rational manner that she was jeopardizing the marriage. His voice, restrained to this point, suddenly became stronger. He stated that he never expressed anger toward anyone. He just sulked and withdrew, ending up feeling stupid. He acknowledged feeling stupid for not doing anything about his marital problem.

Biophysical examination revealed a well-developed tense, white male. He was myopic and had difficulty moving his eyes. He spoke in a timid, restrained fashion. His occiput was tight and his face and neck stiff. His chest appeared particularly tense and was held in an inspiratory position. Both the thoracic and diaphragmatic segments were heavily armored. There was generalized tenderness along the subcostal margin. The rest of the biophysical examination was unremarkable. Characterologically, he had a marked affect block and exhibited doubting when sensitive issues were broached. For example, despite the clear association of the onset of his hypertension with his wife's sexual rebuff, he doubted the important of sexuality in his life. His characterological diagnosis was catatonic schizophrenia.

Because of the severity of his hypertension (ranging between 160/110 and 150/100), the primary therapeutic focus was facilitating the expression of pent-up feelings from the patient's chest. The thoracic segment was mobilized by prodding the intercostal muscles and encouraging him to shout. His blood pressure immediately dropped to 140/90 and on one occasion was as low as 130/80. He felt generally less tense. His wife, who often complained of the patient's failure to socialize, found him becoming more social. He also began speaking regularly to his children, for him an unusual event.

Relieving his physical tension resulted in a greater degree of contact. He felt more buoyant and saw how his selfish attitude toward his children was the result of having an overindulgent mother.

With continued mobilization of the chest segment, his blood pressure remained at normal levels and he was instructed to reduce the dosage of anti-hypertensive medication. Because of the stresses encountered both at home and at work, his blood pressure was elevated at the onset of each session. After expressing rage from the chest, his blood pressure typically returned to normal levels.

As his emotional contact improved, he began fighting with both his wife and his mother. He blew up at his wife for nagging him and decided he did not care if his marriage survived. He saw the poor quality of his marital relationship and concluded he had nothing to lose if it broke up. During this period, his anger became deeper and involved the diaphragmatic segment. Violent gagging followed the expression of rage from the thorax. After shouting, his body vibrated and throbbed down to his thighs. He felt more self-confident and told his wife in a fit of rage she could leave if she wanted to. He became more relaxed, his blood pressure remained normal, and the antero-posterior diameter of his chest decreased. He developed a loud, booming voice.

At this point, all anti-hypertensive medication was eliminated. He was able to remain normotensive so long as he expressed rage from his chest and diaphragm. His entire body would go into intense clonisms, and he left the sessions feeling limp and relaxed.

After one such episode, his anal sphincter tightened. After shouting, his diastolic pressure did not drop below 100. During the following weeks, his blood pressure continued to remain elevated.(4) He began to hold back his resentment toward his wife while expressing a desire to remain in the marriage. In his typically ambivalent manner, he stated the marriage to be "80% good and 20% bad," the latter due to the sexual problem, which he minimized. Despite the rapid progress made to this point (therapy consisted of 31 sessions), he decided to remain in the marriage rather than fight for his life, and he quit therapy. Six years later, I learned from a relative he died from complications of his hypertensive biopathy.

2. Hypertension Occurring during Orgone Therapy.

This 28-year-old, single, white female came to therapy because she was out of touch with her feelings and was bored with life. She was unemployed for almost two years and

socially isolated. Biophysically, she was approximately 50 lbs. Overweight and was heavily armored throughout. Her forehead appeared flat and unexpressive. She stared frequently and her eyes were distrustful and contactless. Her face was immobile. She was able to hit and shout mechanically. Her lower extremities were exquisitely sensitive to touch. There was no history of hypertension or other significant medical illness. Her diagnosis was paranoid schizophrenia.

After several years of therapy, when the first three segments were sufficiently mobilized, the patient developed a sensation of fullness in her chest. Pressure on the thoracic paraspinals and shoulders resulted in an intense anxiety felt in her chest. During the following week, the patient developed dizziness, headache, ocular pain, and other visual symptoms. An internist found her blood pressure to be 155/105. ECG and chest x-rays revealed slight left ventricular hypertrophy. Ocular examination revealed oritis and conjunctival hemorrhage of the right eye. Blood and urine examinations were normal. She was placed on anti-hypertensive medication and advised to lose weight.

When seen the following week, her blood pressure was 150/100. With manual pressure on her chest, she gave in to shouting with fear and rage followed by gagging. Her blood pressure dropped to 124/90. She described seeing better and her head felt clearer. She was instructed to stop the anti-hypertensive medication. During subsequent sessions, screaming continued to relieve terror and rage centered primarily in her chest and she was free of paranoia. With pressure on the sternum, she felt sensations of terror spreading outward from the center of her chest to the periphery (arms and shoulders). Hitting the couch elicited intense frustrated anger directed at a family member with whom she was currently having a great deal of difficulty. During the next few weeks, mobilization of her chest continued with monitoring of blood pressure before and after each session. Typically both systolic and diastolic pressures decreased by 10mm Hg after expression of fear and anger from her chest. She was instructed to scream outside of therapy, as well. Gradually she felt a breaking up of the tension in her chest.

During this phase of therapy, anxiety shifted between her thoracic and ocular segments. When she felt anxious or tense in her chest, she was hypertensive but free of paranoia. When she was normotensive, her ocular segment clamped down and she became withdrawn and paranoid. Continued screaming terror relieved both conditions.

Following this, feelings of sadness began to surface, and she was able to express great misery and longing from her chest. With dieting, she gradually lost most of her excess weight. As her armor shifted downward and her weight loss was maintained, her blood pressure stabilized at normotensive levels. This phase of her therapy lasted 31 sessions.

Asthma

Bronchial asthma is a somatic biopathy involving the thoracic segment manifested by a characteristic form of wheezing, dyspnea, and expectoration of thick sputum. It can occur with intervals of relative comfort but can also assume a mild continuous form with

exacerbations. In rare instances, the acute attack may persist for days or weeks as life-threatening status asthmaticus (3).

Etiology.

In the asthmatic, parasympatheticotonia occurs in reaction to an underlying sympathetic excitation. The parasympathetic nervous system contracts the bronchioles and stimulates mucous production, thereby interfering with expiration (1). Although many cases of asthma are associated with external allergens or infection the underlying cause is, indeed, biopathic. This is demonstrated by the clinical observation that with elimination of the biopathy, external agents are no longer capable of inducing an asthmatic attack.

Since hypertension and asthma both involve the thoracic segment, the question arises: What factors determine the formation of which biopathy? In hypertension, sympatheticotonia predominates and the chest appears tense and hard. In asthma, there is an overlying parasympathetic excitation and the chest appears softer. Crying, regularly seen in the mobilization of the asthmatic chest, may be the emotional manifestation of clonic parasympathetic excitation of the respiratory system.

Case Presentation.

This patient, a 21-year-old, single, white, female office manager, had a history of allergy to ragweed and first developed asthma as a young child. Her asthmatic attacks subsided at puberty but then returned in late adolescence. Even during asthma-free periods, she always felt as if she had cotton in her chest. Characterologically, she tended to be agreeable and engaging. These traits concealed her fear of revealing her true feelings. She became contemptuous and angry in the transference, thinking me stupid for revealing my innermost feelings for everyone to see. Behind this was her fear of being vulnerable and in my power. Still, she knew emotional honesty was necessary if she wanted to get well. Facing her fears, she expressed more contempt of me. She acknowledged reading my published clinical articles in order to find weaknesses in them. While expression of intense negative feelings produced strong generalized tremors, her rage was nonetheless centered in her mouth and vagina, both of which felt like bear traps. She had the urge to throw temper tantrums but was too frightened (she felt partially held in the back of her chest). She risked speaking up with her boyfriend, a self-acknowledged milestone.

She then experienced a constriction in her chest followed by intense nasty rage toward her father. Unable to tolerate these feelings, she began to overeat. More contempt and ridicule of me followed. This time, however, it served a defensive function, stifling intolerable sensations of vulnerability. Expressing this hatred allowed her misery to surface – she was getting in touch with feelings of rejection by her father. As an adolescent, she played golf with him, not out of enjoyment of the game, but because of a desire to be agreeable and pleasing. On the golf course, her father paraded her around, controlling their walking together by holding her firmly by the back of her neck.

She felt them to be like a couple more than father and daughter. These feelings were intensified by her parents initiating divorce proceedings. In session, she had the distinct feeling a golf club was lodged in her throat. (5) As she experienced this, she felt nausea rising from her abdomen. She became terrified and cried in panic. Dyspnea followed and she felt on the verge of an asthmatic attack. She realized being agreeable and living up to her father's expectations allowed her to lose touch with her genuine feelings. After this episode, she began having glimpses of what being well was like.

She then had the following dream: While in a session with me, I leave and transfer her to another (female) therapist. The patient behaves in a cavalier fashion, although upon awakening, she felt unbearably sad and cried. She related the dream to her deep sadness at being rejected by her father. Both in therapy and her daily life, she gave in to deep sobbing and felt the back of her neck and chest temporarily yield. She resisted, however, reaching out fully.

During intercourse, she felt her throat close. She identified this spasm with her incapacity for genital satisfaction. In session, she felt her throat armor. I mobilized the occiput and the deep muscles at the base of her neck eliciting terror in her chest and throat.

A deeper and stronger murderous rage toward her father surfaced for his cold and insensitive treatment of her. After expressing this rage, she felt movement in her vagina and gave in to deep sobbing. She recalled her father's intolerance to any emotional display – "What is this nonsense?" he would say contemptuously. She then felt a ring-shaped sensation of terror around her cervical segment, re-experiencing her father grabbing the back of her neck while going out onto the golf course with him.

Because her father treated her like a boy, she acted like one and could not be soft, feminine or delicate. She viewed all men in the same threatening way, crying as she expressed her fear of me and admitting she had to "shape up" before coming to every session. She felt I disliked her and that she was literally hanging on by her fingernails, because I could disapprove of and dismiss her at a moment's notice. This is why she had to be constantly agreeable and anticipate every move I made. Her agreeable manner protected her from rejection and, on a deeper layer, from castration. Expressing these fears produced a strong sense of well being. In session, however, she was still frightened with the same tightness being felt in the back of her chest. She then became angry with me for "controlling" her and had the urge to stab people in the back. "Stabbing" the bed while on her knees resulted in a strong sense of exhilaration.

Focusing more on her pleasing attitude brought her into better contact with being in her father's grip. She recalled that, before her parents' divorce, she slept in the same bed with her father. During this period, she felt as if they were lovers.

Experiencing these feelings was accompanied by a tightening with subsequent cold shivers traveling up and down her back. While her sexuality increased briefly, she began to wheeze. Pressure on the interscapular region proved to be too much. She

became frozen with fear and felt nothing. This was followed by an intensification of her asthma. She felt caught between her asthma, on the one hand, and her fear of crying in my presence, on the other. She then felt a terror of dying centered deep in her throat, recalling how she was always too embarrassed to cry as a child. Instead, she developed asthma. As she faced her fear of crying, she was able gradually to reach out to me, giving in to deep sobs. This was followed by a strong sensation of heat in the interscapular region. She was deeply shaken. During the intervening week, her asthma intensified until the next session, when deep heartbreaking sobs were expressed. Her asthma then subsided.

Again her asthma returned. She had the following dream. A Nazi puts his hand around her throat and threatens to imprison her forever. This she saw as expressing her fear of speaking up in therapy and an associated cantankerous nastiness. She said she did not want to say anything to me or hear what I had to say because she knew she would automatically agree with whatever I said. She was simply terrified of being herself in my presence. She then had a strong impulse to reach out but became very frightened of doing so. Gradually, she gave in to deep uncontrollable sobs. She felt great relief and was amazed she could express these feelings in my presence. More deep sobbing followed as she felt the lack of her father's love. This alternated with terror from the back of her chest expressed in a typical scream, a mixture of fear combined with rage. (6)

She felt the importance of crying to relieve her asthma. Crying reversed the tendency of her lungs to fill with fluid. She recalled, as a child, being taken to the doctor for antibiotic injections when she had a cold to prevent a recurrence of her asthma and being told she should not cry because this would make her asthma worse. Her mother would bribe her, telling her, if she did not cry, she could have the biggest candy bar she could find in the store. More deep sobs followed. The feeling of having cotton in her lungs gradually became less intense. The entire asthmatic process seemed to be reversing itself as she relived the earliest experiences of her illness.

Her asthmatic tendency was thus eliminated. She was able to express deep longing from her chest and feelings of love. At this time, she developed a pruritic rash (seborrheic dermatitis) over her scalp, face, and shoulders, as well as the back of her neck. (7) Her biopathic tendency seemed to be moving outward, from the center to the periphery of the thoracic segment. Therapy up to this point consisted of 180 sessions.

Spastic Colitis (Irritable Bowel Syndrome)

In this biopathy, the patient experiences periodic attacks of abdominal pain, gas, and diarrhea or constipation. The condition is characterized by an abnormal irritability of the bowel with resultant abdominal distress. In most cases, the syndrome causes frequent but not debilitating discomfort. In a minority of cases, however, it causes severe enough pain to dominate the patient's life. It is a fairly common illness, accounting for as many as 40% of all visits to gastroenterologists. In one study, it was estimated as much as 15-17% of the general population has symptoms related to this biopathy (4). The symptoms vary in severity from fullness and discomfort induced by the ingestion of food or drink to

severe, cramp-like abdominal pain. This tends to be generalized over the abdomen, may shift from point to point, and usually is more noticeable in the lower than the upper abdomen.

Etiology.

The symptoms are based on a parasympathetic reaction to an underlying sympathetic excitation of the nerves serving the intestine, primarily the colon (1). Emotional stress or certain specific foods may trigger the appearance of symptoms.

Case Presentation.

This 60-year-old, married, white businessman had a history of mucous colitis for 15 years. The frequency of attacks of abdominal pain, flatulence, and diarrhea had increased in recent years to the point of restricting his travel, rendering him dependent on the availability of toilet facilities. The attack consisted of an acute onset of abdominal pain and diarrhea following the ingestion of certain foods, especially milk products, and was aggravated by long trips. Because of this, he carefully planned his travels and did so only when it was absolutely necessary.

On initial examination, the patient appeared dejected, depressed, and older than his stated age. He was also severely out of contact with his feelings. He spoke in a slow, drawn-out, controlled manner inclined to put the listener to sleep. He had the appearance of an undertaker, there was slight psychomotor retardation. Biophysically, his eyes appeared teary and sad, and he was moderately armored throughout.

Although appearing depressed, the patient denied feeling sad. His life was dull and routinized, consisting of monotonous work by day and a boring marriage by night.

Because the patient was a depressed manic-depressive, my primary aim was to increase his energy level by any means possible. His low energy level made it permissible even to mobilize his pelvis whenever it was biophysically indicated. The presence of the somatic biopathy required drawing energy from the lower extremities both manually and through kicking, the latter limited by leg spasms and hip pain. Chest mobilization, shouting, kicking, and hitting regularly produced an expansive biophysical reaction and a sensation of currents throughout his body.

Because of severe contactlessness, he was unaware of feeling anxious when he developed bowel symptoms. It was necessary to continually focus on his emotional reaction asking him what, if anything, he felt. I also pointed out his character defenses, telling him he destroyed all spontaneity and liveliness by speaking and looking like an undertaker. Furthermore, he did not listen to others, behaving like a guru and expecting everyone to listen to his pronouncements. In addition, he subtly denigrated others and was unaware how this alienated people from him. At the same time, he behaved in an overly responsible and paternalistic manner, tending to ignore his own emotional needs.

This was expressed in the following dream: He feels drained because he has to give blood to many people; he wishes there were an easier way to give blood.

Much of each session was spent doing biophysical work on the lower extremities including the pelvis. I worked intensively on his hamstrings, buttocks, adductors and abductors of the thighs, producing a strong biophysical expansion with generalized currents throughout his body. Gradually, he became more lively with better contact, and abdominal symptoms began to subside. He was still restricted in his travels, however, and was still unaware of the underlying anxiety related to his bowel symptoms.

I focused on how he used his overly serious and critical attitude to squelch his wife's excitement. He suddenly became angry with me but just as suddenly lost it and began speaking in a conciliatory manner. I intensified the biophysical mobilization of anger by working on his shoulders and legs, eliciting strong, angry shouts. For the first time, he felt a sense of strength and power as anger rose from his diaphragm and abdomen. This was accompanied by strong genital sensations. Following this, he took a long automobile trip without developing bowel symptoms but instead felt the underlying anxiety as claustrophobia. From this time forward (after 84 sessions), he remained free of abdomen symptoms and was able to eat any type of food and travel without trouble. He exercised more daring with the extent and duration of his travels and became quite excited at the prospect of sightseeing in foreign countries. He was told by his daughter and others that he looked younger and more lively, and he developed a sense of humor.

(To be continued)

REFERENCES

1. Baker, E.F.: Man in the Trap. New York: Macmillan, 1967.

2. Reich, W.: The Discovery of the Orgone, Volume Two: The Cancer Biopathy. New York: Orgone Institute Press, 1948.

3. Wyngaarden, J.B., Smith, L.H. (eds.): Cecil Textbook of Medicine, 16th Ed. Philadelphia: W. B. Saunders Co., 1982.

4. New York Times, February 2, 1988.