

Essential Hypertension

Three Cases Discussed from an Ergonomic Perspective

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Arterial hypertension is defined as a medical condition characterized by a persistent elevation of blood pressure over 140 mmHg for the systolic and over 90 mmHg for the diastolic pressure.¹ The term "essential hypertension" refers to those cases of arterial hypertension (95%) whose etiology or origin is unknown, in contrast to those of valvular, renal, or endocrinological origin (5%). Essential hypertension is believed to be caused by "heterogeneous genetic and environmental causes..., which despite relentless research efforts... remain incompletely understood" (Staessen, page 1629). It is present in 25-35% of the adult population and in 60-70% of people older than 70. It is the major cause of coronary heart disease and stroke.

Increased vasomotor tone and augmented sodium-water retention are thought to be the cause of increased *peripheral arterial resistance*, the "hallmark of essential hypertension" (ibid., page 1632). "Psychological" factors such as depression (Sakuragi) as well as somatic factors such as *insufficient breathing* (Andersen) have been researched and new techniques of respiratory exercise have been proposed (Meles). Nevertheless, classic, standard treatment is mostly limited to lifestyle interventions (dieting, quitting smoking and exercising) and taking medication.

As described by Wilhelm Reich, the cardiovascular *biopathies*² are the direct consequence of armoring of the thoracic segment, which at a physiological level determines a *chronic contraction of the peripheral blood vessels* with consequent resistance against the work of the heart (Reich 1948, page 283) and a diminution of the fullness of its free

1. The systolic pressure is obtained during the contraction of the heart while the diastolic or resting pressure is obtained during the relaxation of the heart with the Riva-Rocci technique.

2. The term biopathy describes a variety of somatic as well as psychic diseases such as cancer and schizophrenia determined by a "*pulsatory disturbance of the plasmatic system*" (Konia, p. 224).

pulsatory capacity. The inability of the armored individual to express emotions such as "raving rage" or to engage in "heart-breaking crying" because of his typical characterological traits of inaccessibility and superiority represents the psychic counterpart of this condition (Reich 1933, pages 376-7). Dew (1976) summarizes the organomic literature on the subject adding an interesting observation of arterial hypertension as "*a defense at the vascular-autonomic level.*" Konia (1989) integrates these observations related to the different levels of the depth of the disorder in the statement that essential arterial hypertension is the result of a "*chronic sympathicotonia of the thoracic segment...* [which] *holds a great deal of suppressed rage*" (Konia, pages 226-7).

Consequently, organomic treatment focuses on loosening the thoracic segment by freeing the repressed emotions, mostly sobbing and/or rage, held in it.

Case 1

Martha was a 70-year-old woman who suffered from mild hypertension for two years. A medical evaluation failed to find any organic cause, and drug treatment was initiated. The patient, a repressed phallic character, had always been afflicted with mild panic attacks. Biophysical examination revealed superficial breathing, with the chest held in an inspiratory position, and a psychic attitude or demeanor of superiority. She was subsequently counselled to do deep-breathing exercises for ten minutes every day. Once she started these exercises there was an evident reduction of her blood pressure, which became consistent after one month. As a result, Martha was able to reduce her medication dosage by 50%. This improvement, and her daily exercises, have continued for the past three years.

Case 2

Basil was a 50-year-old business man who sought help for recurrent panic attacks, occurring for more than a year (Foglia). A oral unsatisfied phallic character, he showed a remarkable thoracic block with very superficial respiratory excursions, noticeable tenderness of

the intercostal muscles, and vague, precordial spasms and pains. The chronic muscular contraction was accompanied by a character attitude of "toughness," which had helped Tiim tolerate deep feelings of misery and hatred during his childhood. In his 20's he was diagnosed with essential hypertension with average values of 160/100 mmHg. He was treated with beta-blockers for the two years prior to therapy. In therapy, mobilization of his chest aroused tremendously intense feelings of misery with progressive release of uncontrolled crying and sobbing. After 50 sessions, the patient was able to cry spontaneously. Rage, expressed by yelling and hitting, began to surface. His chest appeared softer and his respiratory excursions were greater. His high blood pressure decreased, and he was able to stop medication without relapse. Now sixty, he continues with orgone therapy sessions on a monthly basis during which he discharges rage from his chest. His blood pressure has remained consistently normal for the past ten years.

Case 3

Claudio was a 47-year-old patient who came for treatment because of severe anxiety, social phobia and a pervasive sense of inadequacy that had burdened his life. He was unable to express any emotion and approached life with a disabling attitude of negativism, which he called, "My steely No."

Therapy systematically and consistently worked on his characterological "steely" attitude, and his concomitant "steely" muscular armor³, without any sign of success. The chest, like his body overall, was held in a chronic attitude of resistance. This was accompanied by chronic hypertension since his 20's. A cardiologic evaluation at that time diagnosed essential hypertension with average values of diastolic pressure of 100-105 mmHg. After 400 sessions, during which he attempted to yell and shout mechanically, no improvement was evident. Any attempt to directly overcome his thoracic block failed and his hypertension never showed any amelioration, as confirmed by regular medical evaluation.

Correspondingly, for many years there were no signs that Claudio was in contact with the underlying emotions. Suddenly, after more than 14 years of therapy and more than 400 sessions, his attitude changed: He began to feel tremendous pressure in his chest with shortness of breath and exhaustion. He related this condition to his intolerance of physical and psychic effort and consequently to his severe work disturbance. Sessions were mostly dedicated to tolerating this crippling sensation and an intensely violent (and "universal," as he described it) "No" began to appear. After 20 more sessions the patient complained of anxiety and panic attacks, with a sense of constriction in his chest, a feeling he never had before, one that frightened him. On the couch he began to make completely new, aggressive facial expressions, his "No" became extremely violent, and he began to see himself differently: much more aggressive, intolerant and impulsive. The violent discharges in therapy were able to relieve his anxiety and resolve his panic attacks in just a few sessions. At the same time and for the first time in 14 years, to our mutual amazement, his blood pressure was normal (125/80 mmHg). Since then blood pressure measurements have continued to be normal. Hope remains that his psychological and social functioning will also improve consistently.

Discussion

Three cases of essential hypertension have been presented from the privileged perspective of the medical ergonomist, who sees this condition as the result of thoracic armoring. Armoring determines a lack of contact with intolerable emotions held in the chest such as rage, sadness, and anxiety. This informs the medical orgone therapy of such patients who are helped to make contact with these emotions and body attitudes, the prerequisite for discharging them.⁴

Classical mechanistic medicine has begun to recognize the importance of the thoracic segment in essential hypertension and is introducing new treatments to improve chest movement, for example deep respiration or laughing therapy (Sakuragi, Andersen, Meles).

However, the inability to comprehend and integrate the somatic expression of the chest armor with its psychic (emotional) content limits the understanding of these new discoveries, reducing them to isolated findings. Consequently, the classic approach to essential hypertension remains superficial and mechanistic, with the addition of respiratory exercises.

The organomist understands that decreasing muscular tension in the chest area is not the same as freeing the patient's chest from its armoring. The latter allows for the free bioenergetic pulsation of the segment which leads to the resolution of the local sympatheticotonia and the chronic vascular contraction.

The first patient showed an amelioration of her condition following an intervention that helped her move her chest better. However, this amelioration is not definitive and needs to be supported by daily breathing exercises. In contrast, the second patient was able to free his chest armor early in therapy and was basically cured of his longstanding arterial hypertension. The third patient wasn't able to come into contact with his deep-seated emotions and impulses of violent hatred for many years and, consequently, there was no apparent amelioration of either his psychic or somatic condition. His hypertension did not improve because, although patiently and consistently addressed, his powerful resistance, a character attitude of negativism together with its somatic counterpart of tenacious chronic muscular contraction, couldn't be loosened for many years. Once he came into contact with the emotions literally held in his chest, he quickly discharged them in therapy with a tremendous gain in perspective and awareness of his crippling character attitude of "No." Concomitantly, for the first time since his youth, his blood pressure diminished from an average diastolic pressure of 100-110 mmHg to 80-85 mmHg, as reported by frequent measurement.

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