

Somatic Biopathies Part II: The Diaphragmatic Segment

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Classical medicine does not comprehend the medical-historical back-ground of diseases of biopathic origin. Regarding peptic ulcer, for example, Reich wrote, "Obviously, the stomach ulcer with its chemico--physical functions is rooted in a more general functioning principle that is not of a chemico-physical nature" (1).

This wider realm of functioning involves the bioenergetic basis of both psychic and somatic functioning. The general biopathic condition of the organism, as well as the specific segment containing armor, are crucial aspects that have to be considered in the removal of any biopathic illness.

In this section, the question of biopathic differentiation, that is, why individuals with significant armor located in a particular segment develop different somatic biopathies, is investigated.

The choice of organ involvement is related, in part, to the history of armor development, that is, the time and extent of its formation. Obviously, the earlier the armor appears and the greater its severity, the more destructive will be its effects. Other factors include the impulse against which the armor is directed, as well as the defending impulse. In peptic ulcers, for example, there is a great deal of repressed hatred located in the diaphragmatic segment.

This article describes three patients with diaphragmatic armor in whom a somatic biopathy developed in different organs within this segment.

The diaphragmatic segment comprises the diaphragm and all the organs located immediately below it. Armor of this segment may be manifested by epigastric spasm, muscular tension, and tenderness, especially along the xyphoid process, the margin of the lower ribs dorsally to the lumbocostal arches, and a particular respiratory disturbance which consists of a ballooning of the abdomen on expiration indicating that the diaphragm is fixed in the descending position.

The status of armor of this segment may be difficult to evaluate in the earlier stages of therapy. It may have been for this reason that Reich used x-ray fluoroscopy of the diaphragm to determine the biophysical status of this segment. Only when armor in the first four segments is sufficiently eliminated does the true picture of this segment reveal itself. Diaphragmatic armor is characterized by the absence of spontaneous pulsation of this segment (2). With elimination of armor in the upper segments, emotional expression contained in this segment spontaneously surfaces.

An Episode of Diabetes Mellitus

Although every diabetic patient is armored in the diaphragmatic segment - most conspicuously manifested by a ring of fat around the waist - this is not a sufficient condition for the development of this biopathy. Many considerations, including the occurrence of insulin-resistant diabetes, suggest there are other bioenergetic factors at work which are necessary conditions in the pathogenesis of this biopathy. In his discussion of diabetes, Dew focuses on the disturbance in the ability of the various tissues of the body to maintain an adequate organotic charge (3). The importance of the organotic potential (the stronger organotic system attracting the weaker) in the process of absorption, assimilation, and digestion of food substances is clear.¹ Each tissue, based on its level of organotic charge (orgonity) over and above that of the local environment, is capable of drawing off nutrients (chemically broken down food substances) from the bloodstream into the tissue cells. Since nerve tissue (central and peripheral nervous system and the autonomic nervous system) has the highest orgonity, its metabolic requirements are the highest.²

Dew suggests that diabetes mellitus is a form of shrinking biopathy in which the tissues themselves undergo disintegration, that is, massive catabolism melting down into urine.³ The common functioning principle in this biopathy seems to be low tissue charge (tissue anorgonia), and the pathogenesis is the inability of tissues of low organotic charge to draw nutrients from the blood plasma because of a weakening of the organotic potential.

1. The sensation of thirst and hunger can be viewed functionally as the psychic aspect of the organomic potential in living systems.
2. Each organ and organ system has its own organotic capacity level. This, in general, is proportional to its metabolic rate. Regarding the factors involving organ choice in the development of metastasis in the cancer biopathy, the orgonity of the tissue cells containing the primary neoplasia may be crucial. I suggest that metastasis can only form in tissues that have the same or higher orgonity than the tissue containing the primary tumor, never to a lower one. This may be why primary tumors of the CNS never metastasize outside this system. Whereas there are many tumors originating from tissues outside the CNS that form secondary tumors in the brain.
3. Arteus, in the first century A.D., described diabetes mellitus as a melting down of the flesh and limbs into urine. The tissues of the body are literally melting away and being excreted through the kidneys.

The alterations in the basement membrane capillaries in muscles and the renal glomerulus, which occur long before the detection of abnormalities in carbohydrate metabolism, may be the pathological consequence to tissue anorgonia. In contrast to the cancer biopathy, the charge of the vascular system (blood) remains high, hence the absence of the characteristic blood picture (anemia, etc.) found in this biopathy.

Attending to this viewpoint, abnormalities in pancreatic (insulin) function could be considered a reaction to chronic tissue anorgonia. A function of insulin is to facilitate glucose and potassium transport into the cell. It also promotes fat and glycogen synthesis and growth. These functions are identical to a parasympathetic effect on the plasmatic system. Anorgonia of the tissues, especially muscle, signifies that the organotic potential is not sufficiently high. As a result, insulin function is reduced and plasma levels of glucose increase in proportion. This, in a vicious circle, stimulates the pancreas to produce increasingly greater amounts of insulin finally leading to islet cell failure. At this stage of the illness, the patient becomes dependent on exogenous sources of insulin. This view is supported by the clinical observation that symptoms of di-abetes mellitus are often preceded by a phase of hyperinsulinism. At this late stage in the biopathic process, the manifestations of full-blown dia-betes mellitus appear. Since water and orgone charge attract each other, low tissue orgonity leads to tissue dehydration, electrolyte depletion, as well as all the clinical signs and symptoms that are the hallmarks of this biopathy (polyurea, polydypsia, polyphagia, etc.).

From this perspective, the current medical treatment of this biopathy deals only with the most superficial aspects of the disorder. Giving exogenous insulin to diabetic patients may temporarily mask the signs and symptoms of this illness, but it leaves the underlying anorgonotic process, manifested by progressive vascular and neurological symptoms, untouched.

Since both cancer and diabetes involve a shrinking process, the question arises: What distinguishes these biopathic processes from each other? Perhaps the distinction is determined by the locus of the anorgonotic process in the biosystem. In the cancer biopathy, shrinking (anorgonia) progresses to involvement of the vascular component of the plasmatic system, and shrinking takes place at the very core of the biosystem. In diabetes, on the other hand, the anorgonotic process remains more superficial and confined to other tissues (kidneys, muscular apparatus, etc.) while leaving the plasmatic system intact. In the diabetic biopathy, the orgastic disturbance, a disturbance of tissue pulsation in the form of tissue anorgonia, spares the energy charge of the plasmatic system. A reduction in orgonity of tissues other than the plasmatic system, by lowering the energy charge of the organism, may interfere with the capacity for tumor formation, an explanation for the rare occurrence of primary cancer tumors in the presence of diabetes mellitus. Because of a pre-existing anorgonotic process, diabetics may never have the capacity for deep sexual longing which is a frequent clinical finding in patients who go on to develop cancer. There is nothing for the diabetic individual to resign from.

The frequent observation that diabetics seem to be excessively sweet may be based in part on an inability to express strong rage reactions because of an anorgonotic tendency in the skeletal musculature. As defensive maneuvers, they typically express soft feelings, such as longing and sadness. These defensive tendencies are discouraged in therapy. The question arises: To what extent does increased blood glucose levels contribute to the expression of sweetness?

Clinical experience shows this biopathy can only be treated in the earliest stages of illness. Once the disease has progressed to the point of islet cell destruction, the biopathic process is, for all intents and purposes, irreversible. When this occurs, the individual may be dependent on exogenous sources of insulin.

The following case presentation of a patient who developed biochemical manifestations of diabetes during the end-stage of orgone therapy illustrates some of the clinical events encountered in the treatment of this biopathy. It also sheds light on some of the biophysical and characterological aspects of this disorder.

Case Presentation

This 18-year-old, passive-feminine patient had a history of depressive episodes with several serious suicidal attempts. Except for recurrent hemorrhoids, he was in good physical health. Biophysical examination revealed a well-developed, mesomorphic individual. He appeared superficially soft and slightly effeminate. There was severe armoring of the oral segment and moderate armoring throughout the rest of his body. On initial examination, there was no conspicuous armoring of the diaphragmatic segment.

During most of his therapy, considerable amounts of rage, especially from the oral and anal levels, were expressed. As a reaction to discharged rage from every layer of armor, there developed an intensification of his passive-feminine tendencies which were expressed as soft feelings, feelings of weakness, pleading, and helplessness. From a biophysical stand-point, the patient reacted to a sudden increase of charge, accompanying the emergence of intense rage, with a sudden depletion of energy charge (anorgonia). As each layer of armor was eliminated, both the intensity of the rage and the anorgonotic reaction against it increased in severity. These reactions gradually assumed greater significance as therapy progressed. Mobilization of rage from the oral segment, for example, yielded to intolerable sadness and then briefly to hopeless resignation. These anorgonotic biophysical reactions were viewed as being distinct from his passive-feminine defenses, although both acted in the same direction to immobilize the patient and render him helpless. Another emotion, which gradually began to assume greater defensive significance because of its premature appearance, was deep infantile longing for his mother. This emotion, accompanied by preorgastic melting sensations, appeared regularly whenever the strength of his aggressive impulses began to overwhelm him. The expression of these feelings was also treated as defensive.

As noted earlier, there was no indication at the onset of therapy that mobilization of the diaphragmatic segment was going to be difficult. However, as later events clearly revealed, this was not the case at all. In fact, this segment proved to be the most tenacious and was only less difficult to work through than the pelvic segment. The onset of mobilization of this segment was ushered in by a strong intensification of all his passive-feminine defenses, including the emergence of a significant amount of genital anxiety with premature ejaculation and episodes of erectile impotence. This was

evidence that a great deal of energy was being immobilized in this segment. His diaphragm became tense and his abdomen bloated. Pressure on the abdominal muscles produced intense squeezing rage followed by relief with a brief, strong generalized increase in orgonotic charge, manifested also by a lumination of his field. He then experienced stabbing pains in his genitals and began to grovel, pleading with me not to hurt him. Typical signs of orgasm anxiety appeared: He lost all interest in getting well, communications became superficial, and he had thoughts of dying.

With partial mobilization of the diaphragmatic segment, I was able to proceed with pelvic mobilization because the upper four segments remained open.

The sudden, sharp increased charge of his biosystem produced by mobilization of pelvic rage was regularly followed by syncopal attacks (anorgonia). Because of the severity of these biophysical reactions, I became concerned about the possible occurrence of a somatic biopath. This concern was based on the observation that his biosystem was neither able to bind energy in the armor nor to retain a strong orgonotic charge. Instead, his biosystem reacted with collapse (anorgonia). Despite this possibility, it was imperative to take a chance and assist his fight for health.

Deep disappointment at being rejected by his mother surfaced, and he developed suicidal thoughts. Overwhelmed by his misery, he repeatedly became syncopal.

Further mobilization of the diaphragm by pressing along the right costal margin produced gagging followed by strong convulsions of the torso. Pressure over the epigastrium which was exquisitely tender, produced large quantities of murderous rage and a sudden jump in his energy followed by a loss of consciousness for about 8-10 seconds with rotation of the eyes upward and to the right. With repeated exposure to this procedure, he gradually became able to tolerate the build-up of energy resulting from diaphragmatic, abdominal, and pelvic mobilization with no tendency to lose consciousness.

At this point, he developed biochemical signs of diabetes mellitus. Blood studies revealed elevated fasting blood sugar (138) and glucose tolerance curve reaching a maximum value of 155.

This somatic biopathic reaction was accompanied by feelings of resignation and suicidal ideation. A deep fear of death surfaced to which he reacted, not with his typical passive-feminine submissiveness, but with a strong desire to fight and not submit to his fate. Rejecting his entire passive-feminine way of coping with life, he both expressed and tolerated strong outbursts of rage without losing consciousness. This was accompanied by strong sensations of well-being which indicated his organism was restructuring and capable of sustaining a high level of orgonotic charge. This capacity to maintain strong orgonotic charge over a period of time and effectively discharge energy in the genital embrace eliminated both his passive-feminine structure and his diabetic tendency.

The significant biophysical events in this case, in which symptoms of diabetes mellitus appear in the end-stage of therapy, are the following:

1. The presence of a tendency toward anorgonia as a reaction to a sudden increase in organotic charge, particularly following the expression of intense diaphragmatic rage. Anorgonia was accompanied by the premature appearance of melting sensations in the face of undischarged rage from the lower three segments. From a psychic standpoint, there was an intensification of his passive-feminine tendencies.
2. The biochemical appearance of diabetes mellitus was a manifestation of this anorgonotic reaction.
3. The disappearance of this biochemical abnormality followed the elimination of the armor and the anorgonotic reaction from the diaphragmatic and pelvic segments and the biophysical capacity to tolerate charging of the tissues followed by orgastic discharge.

Cholelithiasis and Other Biopathies Involving the Annular Muscles of the Diaphragmatic Segment

Determining which organ or organ system will become diseased in the presence of armoring of a particular segment in part involves understanding which tissues in a given segment are the prime targets in the sympathotonic reaction. Stated differently, what is the response of a given tissue to the effects of chronic sympathetic excitation?

Clinical experience reveals a wide range of individual differences in the susceptibility of various tissues to sympatheticonia.

In the following case, the involved tissue was the annular muscles of the organs of the diaphragmatic segment, specifically the sphincter of Odi, which produced cholelithiasis and resulted in cholecystectomy one year prior to presentation, and the annular muscles of the pylorus and cardia, which resulted in pyloric and esophageal spasms during the course of therapy.

This tendency for the annular muscles to go into spasm may have been the reason that cholesterol nucleated (crystallized) more rapidly in this patient who developed gallstones than in others who do not have this tendency. It is known that, in the pathogenesis of cholelithiasis, dietary factors, excess production of cholesterol by the liver, or decreased production of bile pigment are probably not significant (4). The increased incidence of gallstones in patients who have undergone truncal vagotomy supports the role of chronic sympatheticonia in the pathogenesis of this biopathy.

The generalized, severe sympatheticonia, which was immediately apparent from a biophysical standpoint in this patient, affected the organs under the diaphragm to a degree that resulted in the appearance of overt signs and symptoms of somatic biopathies of the annular muscles of the gut in this segment.

The biophysical basis for these somatic biopathies was a combination of a fairly high energy level and a very low capacity to tolerate expansion, in particular pleasurable impulses.

Case Presentation

This 49-year-old, single, white female came to therapy complaining of being "too old." She stated, "I have no way to live and no way to end it." She also complained of "extreme depression," although this was not evident. Past history revealed she had felt suicidal at age 23 but never attempted to hurt herself. She saw a psychoanalyst at that time for nine years. She married, not out of love for her husband but to please her analyst, and she had two children. While raising her children, she was asymptomatic for about 10 years but trouble started again when her children reached adolescence and she no longer felt needed. She was living in a warm climate during the time she felt asymptomatic, which she felt made a difference in her sense of well-being. As her children grew apart from her, and she felt the need for help, she saw a "Reichian" therapist in California. When he made sexual advances toward her, she left and saw a medical organomist. Although she had a great deal of fantasied revenge against the "Reichian," she never was able to express any hatred openly. Instead, she punched herself in the stomach when she felt anger toward him.⁴

Past medical history revealed she developed pertussis and diphtheria at six years of age. At this time, she felt a distinct change in her personality occurred, and she became a "good girl." One year prior to presentation, she had a cholecystectomy for gallstones. She smoked one to two packs of cigarettes a day.

Biophysical examination revealed an extremely tense, short-statured, haggard-looking, white female who appeared 10-15 years older than her age like a pathetic old woman. Her head appeared to be compressed into her torso and she seemed to have no neck. There was mild depression present and a great deal of bitterness and smoldering rage at how badly she had been treated by others when she allowed them to get close to her. She had an extremely cruel streak which was always self-directed and which had a slightly exhibitionistic flavor to it. She whined and complained incessantly and always belittled herself. Despite her enormous need for warmth and affection, she never allowed anyone to get too close because of a conscious fear of being hurt. She was heavily armored throughout. Her chest was emphysematous and her respiratory excursions were restricted. Her diaphragmatic segment had the appearance of a tight rope around it. The epigastrium was tense and tender, as was the abdomen, and there was a surgical scar over the right upper quadrant. The general biophysical appearance was one of a taut bladder ready to burst. She was unable to shout fully, hitting was held back, and she developed pain in her thighs when asked to kick. Although the occiput was tender and her eyes were distrustful, there was no evidence of a perceptual split. She had a suffering and pained facial expression. When asked to breathe on the couch, a pelvic reflex appeared. She immediately clamped down in the upper segments and felt miserable. My initial diagnostic impression was:

1. Premature iatrogenic pelvic mobilization. 4 This was understood as an attempt to relieve the tension from the solar plexus.
2. Possible masochistic character.
3. Possible depressed manic-depressive character.

The diagnosis of schizophrenia was ruled out, in part, on the basis of her ability to establish strong transference reactions and, in part, despite her muddled thinking, on the absence of perceptual splitting.

My immediate therapeutic objective was to mobilize the expression of anger from the upper segments. This had two goals in mind - one therapeutic and one diagnostic. Therapeutically, mobilizing the ocular segment would produce a generalized parasympathomimetic effect and would help clamp down the pelvis. Diagnostically, this effect would help determine the patient's diagnosis. If she could tolerate the expansive push without reacting masochistically, then the diagnosis of manic-depressive character could be made. This carries a more favorable prognosis than if she reacted masochistically, in which case would most likely be a masochistic character.

In light of her past medical history, the possibility of a recurrence of a somatic biopathy could not be excluded.

Efforts to express rage were followed by brief periods of expansion lasting from a few moments at the early stages of therapy to several days later on. This was invariably followed by fear of being punished and intensification of somatic armoring. These reactions were centered particularly in the diaphragmatic segment and led typically to the appearance of a full-blown masochistic reaction consisting of feelings of hopelessness, self-belittlement, acting provocatively in a stupid or suffering manner, awkwardness, and, later, when she could trust me more fully, in an overtly provocative fashion, testing my patience to the limit. These reactions to therapeutic efforts aimed at providing an expansive effect on her biosystem confirmed the initial diagnostic impression of masochistic character.

Her red thread was that of a spiteful, suffering old woman. She stated in her typical whining and pathetic manner that, in the past, she was told she was "too old" to have what she wanted and, therefore, she had to sacrifice herself for the sake of others, especially her younger siblings and, later, her children. Now, she felt she was "over the hill" to have anyone, especially a man, of her own. As if this kind of morbid self-abuse were not enough, she would then proceed to flagellate herself mercilessly with self-belittling thoughts of being "stinky," "old," "ugly," etc. She would also manipulate others to treat her sadistically. After one such incident, she developed a strong pain over the pylorus. Gentle massage of this area produced deep sobs, which she recognized as a familiar cry when she was disappointed by others. This momentarily relieved the diaphragmatic spasm, and she felt more outgoing and expansive with a brief absence of

masochism. She was able to discuss in a rational manner what her emotional needs were and what she wanted out of life. Kicking helped prolong her expansive reaction but invariably she became terror-stricken and felt bands of contraction around her thighs. This led to masochistic fantasies in which her legs were being beaten by her father because she displeased him.

I continued mobilization of the posterior aspect of the diaphragmatic segment, producing fear in her and clonisms of the torso which again were followed by momentary relief and a brief feeling of clarity in her head. By the following session, she was wallowing in her suffering again. I gradually became impressed by the enormity of her fear of expansion.⁵

She had a recurrent dream: She is taking care of an old woman. She has no life or money to do anything for herself. This dream vividly portrayed her predicament.

Further attempts at liberating diaphragmatic rage again resulted in a brief expansive reaction with a warm feeling centered around the diaphragm and abdomen followed by a return of a spasm in this region. Feeling a constriction around her waist, she had a sense memory of being tightly wrapped around the waist with a diaper and then being force-fed by her mother. She remembered being terrified by her.

Slowly as she began to tolerate biophysical expansion to a greater extent, she began experiencing sexual feelings. She reacted violently to these feelings: "I don't want these feelings; there's no one out there for me; it is no use," were her words.

Her use of anger to keep everyone at a distance so she did not have to be sexually threatened became increasingly clear to both of us.

Accompanying this reaction to sexual feelings, she again clamped down in the diaphragm with pain over the right hypochondrium and substernal area together with an intensification of masochism.

Gentle pressure over these areas again produced gagging and clonisms of the torso. This time she felt fear over the epigastric region and she recognized the diaphragmatic segment as the main source of trouble. She said, "That's where the battle takes place."

Unlike the ordinary neurotic who also has similar fears, this patient felt mortally afraid, as if her life were in danger.⁵ Mortal fear as a reaction to expansion is characteristic of masochistic patients. Unlike the ordinary neurotic, the masochist has no other defenses to rely on.

Because of the severity and duration of this episode of diaphragmatic spasm, I requested that she have a medical evaluation.

The significant results of an esophagram and an upper G.I. series were as follows: Slight narrowing of the distal esophagus (esophageal spasm) and a small degree of

reflux into the esophagus during water siphon testing. There was no evidence of abnormality in the stomach or duodenum.

The results of the esophagram confirmed the clinical impression that armoring of the diaphragmatic segment was extensive and involved organs deep within it. The specific manifestation of armor was in the form of spasms of the annular muscles of the gastrointestinal tract in the region of the diaphragm. A similar constriction most probably resulted in gall bladder abnormalities several years previously, resulting in cholecystitis, cholelithiasis, and removal of the gall bladder.

The diaphragmatic block was central and responsible not only for inhibiting impulses from the vegetative core (solar plexus) so that pleasurable sensations never reached the periphery but also, by extending into the annular musculature of this area, resulted in signs and symptoms of the involved organs.

Duodenitis and Peptic Ulcer

This condition results from the digestive action of acid gastric juice on the mucosal lining of the distal esophagus, stomach (usually lesser curvature), and upper portion of the duodenum. Duodenitis is a non-specific inflammation of the duodenum and represents an early phase of the acid attack on the gastric mucosa. It frequently progresses to peptic ulcer formation. The basic problem and pathophysiologic process is, therefore, peptic ulcer formation.

Etiology

The reason for the failure of the mucosa to withstand acid attack in certain individuals prone to develop peptic ulcer (the predisposition to illness) is, in the vast majority of cases, not understood by classical medicine. Contrary to popular belief, there is no hard evidence that dietary factors cause, perpetuate, or aggravate this condition (5).

Reich showed that chronic sympatheticotonia, with its tendency toward increased acid production in the stomach and spasm of the intestinal wall, is only the somatic aspect of peptic ulcer disease, while repressed hatred is its psychic counterpart. The basis for both the psychic and somatic component of this illness is a chronic energetic contraction of the diaphragmatic segment. This is the biophysical basis for what is commonly referred to as the predisposition to ulcer formation. With armoring of the diaphragmatic segment, the mucosal lining of the organs contained in this segment becomes contracted with a restriction of blood. Vasospasm leads to greater mucosal susceptibility to ulcer formation with the final sequellae of perforation and hemorrhage.

Sympatheticotonia consists of a severe energetic contraction of the diaphragmatic segment. Chronic sympathetic excitation in this illness contains enormous quantities of repressed hatred. Only by expressing hatred from this segment can the "predisposition" for ulcer formation be eliminated.

Case Presentation

This patient, a 23-year-old, single, white male, came to therapy stating he felt he could "get something out of therapy."

Since childhood, he was bothered by a "queer sensation " in his penis and a feeling he was being bodily restrained. These feelings made him restless and he had an urge to squirm. He also felt "numb" in his body, and he knew he could never make up his mind about important issues in his life. Sexual relations with his girlfriend were not satisfying.

Speaking in a flat and confused manner, he said he felt very little. At most he could only feel extremes of feeling. Usually he felt nothing.

He was quick to anger and did not get along well with people, especially those in authority. When angered, he became sarcastic, argumentative, and challenging. This was followed by withdrawal. While at school, he destroyed property and was expelled.

Past history revealed separation from his mother at birth. Prior to adoption at three months of age, he was cared for in a hospital. As a young adult, he took LSD and marijuana for over one year which resulted in paranoid reactions. He was drug-free for one year prior to presentation.

Biophysical examination disclosed a mesomorphic, tense male who gave the appearance of an "angry young man." He glowered and stared menacingly as if ready to attack anyone who threatened him. His eyes were frightened and frozen. His occiput became tense especially when his anger intensified. His right eye was myopic. He looked out of the left but in a suspicious manner. He felt himself "holding back" in his right eye and "watching out" in the left.

There was a severe throat block which came into play as soon as his anger threatened to erupt. During the first part of therapy, this anger originated primarily from the diaphragmatic segment.

On the couch, he seemed ready to explode and barely able to maintain control over the enormous amounts of rage centered in the diaphragm. He seemed to be holding back against expressing this rage as if in one piece. The diagnosis was catatonic schizophrenia.

In the first session, he told me he had to be a "good boy" and ingratiate himself otherwise "people will be hassled" and get back at him. He was clearly terrified underneath his "angry young man" facade. Although his affect block was too strong for him to feel the emotion of rage, shouting itself did provide physical relief. Gradually, he began feeling the enormous anger as he shouted. He felt like belittling and challenging everyone in authority including me. He felt like smashing me for telling him what to do. He asked defiantly why I charged so much for therapy. At the same time, his anger was a source of his fear of others. Expressing this fear of being punished by me if he

became too angry, he gave in to an uncontrollable outburst of rage with shouts and wild swings of his limbs.

This was followed by a bout of anal fantasies and the expression of anal rage. His anger was expressed in the transference as defiance of me for expecting him to behave and feel in accordance with my wishes.

Being relieved of his enormous rage, he found himself to his surprise becoming more sociable. This was followed by the emergence of soft feeling. He began crying and feeling vulnerable in my presence.

This period of well-being was short-lived as his distrust of me and his confusion returned in full force.

I returned to mobilization of the ocular segment and waited to see what would happen next. Gradually the throat block became the primary focus and he felt a painful spasm in the cervical musculature. Shouting produced strong trembling of his torso and gradually strong murderous impulses alternating with periods of contactlessness began to surface. Ocular mobilization cleared the latter and allowed expression of his hatred. This was accompanied by violent clonisms of the torso and a fear of losing control. His pupils dilated with fear. He felt like an angry child ready to have an explosive tantrum. Strong murderous rage then emerged from the diaphragm accompanied by uncontrollable hitting and kicking. These outbursts alternated with periods of intense holding back with arching of his torso. As the outburst of rage increased in intensity, the pelvic reflex began to break through again, alternating with strong pelvic retraction.

Since his volatility, personality type, and the intensity of his rages were not unlike those seen in epilepsy, a neurological examination was requested. An EEG done with hyperventilation and photic stimulation was negative.

With continuous intense outbursts of rage from the diaphragmatic segment, he developed persistent epigastric pain and distress. An upper G.I. series revealed pathological findings consistent with duodenitis and pylorospasm.

Continued expression of hatred from the diaphragmatic segment (he shouted "murder," "kill") relieved the acute contraction of the diaphragmatic segment and the accompanying early manifestations of peptic ulcer disease.

The appearance of the prodromal signs and symptoms of peptic ulcer disease in the patient was a direct consequence of both mobilizing enormous quantities of murderous hatred from the diaphragmatic segment and the intense reaction of holding back against it.

(To be continued)

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