CULTURAL AND BIOENERGETIC APPLICATIONS IN INDIVIDUALS WITH HEART DISEASE

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For centuries, psychosocial and behavioral factors have been known to influence disease. Psychosocial characteristics may reflect one's personality and individuality. One's individual history is expressed in one's body. Cultural influences may also affect bodily characteristics and attitudes. Fear, for instance, contributes to rigidity and rigidity can be scrutinized on individual and cultural levels. Therefore, health and illness may be expressed individually or collectively as an extension of a culture. Mind, body and heart are connected. To be in touch with the self is to be aware of the body and its feelings (1). To be out of touch and totally unaware have serious cardiovascular consequences. Every illness has psychosomatic element or every psycho-somatic illness seems to represent a particular element of unventilated affect which eventually takes its toll on the body and its physiological it' in. In simple terms this is called disease. In the setting of coronary heart disease, the repressed emotions of anger, sadness and hostility are present. The cardinal repressed emotion and the topic of this discussion is HEARTBREAK. But how does repressed emotion such as heartbreak contribute to heart disease? And what is the impact of culture on heartbreak? And are culture and heartbreak related?

Cultural patterns, values or motives are dominant in various societies. There appears, for instance, to be a positive correlation between need for achievement as a cultural index and the mortality rate of arteriosclerotic and degenerative heart disease (2). In other words, if a nation is achievement oriented, the incidence of coronary heart disease is higher. Culture affects character, and character is a manifestation of one's personality and body. Clinical observations have demonstrated a typical personality profile of the coronary patient. Such profiles have included statements concerning overachievement, overperformance, and overcontrol. Behaviourally, the coronary-prone patient seems to strive without satisfaction or fulfilment. Typically, these individuals seem to invest more in their image as opposed to their true self. The coronary personality is driven by achievement and

performance with the ultimate goal of success. They suppress and restrain inner feelings and imagination instead of acting them out. They frequently have an overcommitment to work and have a profound sense of time urgency and impatience. They project a polarity of positive self-image and success. The reality of poor self-esteem, depression and various forms of sexual inadequacy are frequently hidden from the outside world. Where does this behavior come from? And how does it manifest itself on a cultural level? As an American, perhaps I can use myself as a patient model exhibiting coronary prone behavior.

As a man in my mid-thirties, aggressive, and successful, the reality of my own mortality was suddenly revealed to me through my patients. Traditional cardiovascular risk factors, such as cigarette smoking, hypertension, obesity, and diabetes as frequently were not found in victims of heart attack. Typically, it was one's behavior that became the fulcrum of the disease process. As a clinical cardiologist, I became aware of patterns of destructive behavior in my own patients, which lashed individuals "prone to developing coronary heart disease". What I didn't expect to discover was that I was wearing that label myself. This awareness was absolutely horrifying.

My search sent me backward, to my childhood, and a recognizable pattern developed. I was the third child in my family. When I was 4 years old, my sister was born, and around that time I started on a course of multiple childhood diseases and accidents. Were these incidents a maladaptive way to achieve contact and love from a mother who must have had her hands full with a newborn baby and a growing family? Through the years I can still feel that yearning for my mother's attention and soothing. I know that it was then that I felt my first heart-break. I began to armor myself, trading the soft vulnerability which caused me such pain for rigidity is a rigid character structure. I know my mother loved me dearly, but at that young age I was unable understand her needs and focused on my own. I sought her approval and love and hoped that by being a "good boy", a good student, an athlete and achiever, I would gain them. Success would bring me love, I thought. I developed this false connection between the two, which carried through to adulthood. This connection influenced the process of Type A behaviorr which coult ultimately result in my demise.

After medical school I went through an internship in psychiatry and medicine, 2 years of residency in medicine and 2 years of specialized training in cardiology. I became a highly trained technical invasive cardiologist and felt extremely competent in what I was doing. During the first few years of my practice, I became a workaholic and had tremendous self-esteem. My job in essence had given me a place in the universe. I enjoyed immensely what I was doing.

Over a short period of time, however, in the midst of this success I felt myself burning out. I was in an internal struggle to achieve and perform at the expense of my feelings. I denied my fatigue and pain; something I had done in adolescence to prove myself a good student and athlete. In this pursuit of success and achievement, was I really seeking approval and love? Was I trying to prove myself worthy of approval and love? I had carried this need through the years, and saw it again and again in many of my patients. Many chased this need to heart disease and death. The challenge I now gave myself was to alter this self-destructive, coronaryprone behavior pattern. Over the next few years, I attended many self-awareness seminars. I hosted stress and illness workshops utilizing a Gestalt therapeutic technique in teaching susceptible individuals how to cope with life. Group awareness training had a tremendous impact on healing, particularly when individuals "saw themselves" in other people. After being involved in several workshops and publishing data in the medical literature, I knew I wanted to pursue

specialized training in the field of psychotherapy. The connection between mind, emotion and heart was absolutely clear to me.

During my training in Gestalt psychotherapy in Hardford, Connecticut, one of the books on the reading list was "Bioenergetics" by Alexander Lowen. After reading his book and realizing the impact of uniter structure, muscular rigidity and suppressed emotions on the body, I wanted to meet the author. My first live exposure to Dr. Lowen is a moment I shall never forget.

In one of the international workshops in New York City I saw before me a man who was energized and vibrant. He mobilized integrative psychiatry, analysis, gestalt and bioenergetic technique in a course of minutes. He was able to determine the history of a person from looking at the body. He could determine where tension was located and energy blocked, keeping people from experiencing their full potential of aliveness. He utilized various techniques and exercises that charge and discharge the body, releasing the blocked energy. It was incredibly exciting, and I approached Dr. Lowen and asked him to be one of my teachers. Through his guidance and his therapy, I entered another training program in bioenergetic analysis in Cambridge, Massachusetts.

During this training period or "renaissance" in my own life I became aware of my own feeling, or should I say "absence of feelings"? The fatigue, exhaustion and occasional despair that I had as a young medical student pushing myself to excel while denying my own feelings came back to haunt me. I was doing the same thing now in my cardiology practice, becoming more cerebral, performing in a machine-like effective way, but denying my own feelings. Now, after being exposed to bioenergetic analysis, I ached for softness and true, deep feelings. It was a beginning. What has been exciting in my own growth and development is the utilization of bioenergetic analysis and psychotherapy in the treatment of heart disease. It has been a long, sometimes painful, sometimes joyous journey, and one which continues. The training of a psychotherapist and clinical cardiologist has enabled me to gain a greater insight into understanding the disease process. Disease is a process that just doesn't happen. It is frequently the result of unconscious – conscious feelings. What has been exciting in my life has been a transition and awakening of the embodiment of bioenergetic therapy in the healing process.

One can see in this short autobiography a central theme of my characterological drive in achievement at the expense of feeling and success at the expense of self. This attitude was learned early in my life and represents a typical pattern in American society. Moreover, in the Puritanic cultures of northern Europe, similarities in child-rearing occur. As in America, there is also an increased incidence of heart disease in this area. Late-Victorian attitudes and overcrowding in the United Kingdom sacrificed the expression of emotion. Anger and sadness were frowned upon. Approval was based on performance, first at home, then at school, and later in the workplace. Children of such reserved parents fail to learn emotional spontaneity. As in my personal history, there was a failure to receive unconditional love. If the child is not loved as he or she is, but rather for what he or she does, the child sees himself as unlovable. In order to become lovable, he senses the need to achieve, strive and perform. He believes that success will buy love. If this false message is propagated by a fast-moving and achievement-oriented society, the seeds of coronary-prone behavior are planted. This failure to receive unconditional love results in a poor self-esteem. The ultimate narcissistic injury to the child is experienced in the body as heartbreak. The memory will be repressed but the body will reveal the unless" of the somatic expression. If the child closes his heart to avoid subsequent rejection and and heartbreak, he pays the price of loneliness and love. Loneliness results from the fear of loving. New connections are not made and there is an avoidance of intimacy and commitment. The heart becomes

closed and vulnerable. The connection between heartbreak in childhood and the fear of love result in a typical personality and character structure that ultimately leads to the development of coronary heart disease. This, perhaps, can be exemplified in the following case study:

A 34-year-old male experienced a near-fatal myocardial infarction. He was a non-smoker, had a cholesterol level and told me that he had a negative family history of heart disease. He spoke in a soft manner. He did not interrupt my sentences. He appeared not to be hostile and he did not have any of the typical Type A coronary-prone characteristics. At one point of my interview, I was confused as to why he had heart disease. I again asked him about his family history. He told me his mother was alive and well. It was only after he told me that his father died when he was 3 years old that I was to see the sadness in his eyes. This patient experienced shock and loss at age 3. The heartbreak in this case was one of threat to survival and deep shock at the loss of a significant other. This man's character structure was one of rigidity; that is, a highly inflated chest with very little mobility. His heart was "broken" at an early age and he managed to protect himself with muscular armoring. Although he had many relationships, he never married. He was afraid to become intimate, committed and reach out for love. Such a closed heart becomes easily vulnerable to subsequent heart disease. Characterologically, therefore, rigidity in itself seems to be a risk factor. Other character types vulnerable to heart disease include variations of rigid narcissistic characters. If there is an exaggerated involvement in one's image at the expense of oneself, one loses the capacity to feel. If feeling is denied without a solid sense of self, one becomes vulnerable in pushing and striving beyond normal expectations. The result can be the sudden, unexpected occurrence of heart disease. The lack of feeling, the denial of feeling, or suppression of feeling all contribute to cardiovascular risk. In the masochistic character type, it is held-in feeling that is hazardous to one's health. Masochistic types are prone to heart disease in that they hold in feeling. Holding in sadness, rade, anger, and hostility can have serious consequences on the cardiovascular system. Being stuck in one's body without movement or experiential feeling renders the myocardium vulnerable to explosion. So, it appears that the narcissistic and masochistic character types develop heart disease. Can characterological type be protective? As a clinical cardiologist I have rarely seen structural heart disease in both schizoid and oral types. The oral character will give in and collapse and not push beyond exaggerated expectations. This surrender and giving in is protective to the myocardium. So it seems that character and heart disease are related. But how does culture affect character and how are heartbreak and culture connected?

We have seen in a previous analysis that driving and achieving can be a way of life in a culture. Drive creates rigidity and rigidity creates drive. Coronary-prone behavior is prevalent in societies where achievement and accomplishment are placed in high esteem. In Freudian term«, the pleasure principle is suppressed and replaced by reality principle. Although coronary heart disease is prevalent in many cultures, some cultures are protected. The countries of Northern Europe, Australia and North America are highly industrialized and urbanized. In these societies, coronary heart disease is the most prevalent in the world.

Japan, however, also urbanized and highly industrialized, has one of the lowest incidences, of heart disease in the world. Why is Japan protected or how does Japan protect against the "somatic distress of culture"? Several studies in their literature (3 - 5) seem to indicate that family tradition and prolonged exposure to Japanese culture during childhood appears to protect against coronary heart disease in adulthood. However, if a Japanese leaves Japan and migrate to Hawaii, their incidence of coronary heart disease is significantly higher. Moreover, if a Japanese migrate to California, their incidence of coronary heart disease is even higher and very similar to the incidence of heart disease in

North America. The data seem to indicate that a closely-knit family with tradition and support assuages stress and tension. Loss of roots at an early age result in traumatic loss of social support. This in itself creates heartbreak and lends further testimony to the heartbreak theme in heart disease.

The cohesive families of the Mediterranean such as found in southern Italy, Greece and Yugoslavia all demonstrate protection from coronary heart disease (6, 7). Thus, the importance of family support and tradition seem to be of considerable importance in group orientation with emphasis on group welfare and family, rather than individualism and competitiveness. This nuclear family structure provides important social and psychological support which may have substantial protective effects on health and disease.

This concept is further exemplified in the 16-country study (6). Crete, for instance, over a 10-year period had no occurrences of myocardial infarction death. Although the average cholesterol in Crete was over 200, the lifestyle was slower paced, sunny and less stressful. However, quiet conversation and male-to-male contact with sharing of oneself may be perhaps a better predictor in enhancing tranquillity and assuaging stress and tension. In an International Conference discussion, I was told (8), for instance, that men in Crete sit with one another at lunch tables and talk about their feelings in cooperative, noncoercive, noncombative ways. The social support of this type of exchange and data opens the heart with subsequent flowing of feeling and energy. Thus, it seems that social support, family support, and tradition seem to be major factors in reducing coronary heart disease.

Some cultures, therefore, "protect" their inhabitants in a way that is beneficial to their hearts and health. How societies regard aggression, emotion, and child-rearing are likewise important. For instance, if children are raised in cultures where expression of emotion is permitted, this will allow for emotional spontaneity which is protective for one's heart. On the other hand, if children are raised in cultures and families with rigid hierarchies, defensive taboos, and sexual guilt, then one can say that the heart can be at risk. In simple terms, simple things are good for the heart. Emotional spontaneity in itself is protective to the myocardium.

Emotional feeling frequently allows for Increased breathing which enhances oxygen delivery. Breathing and laughing are certainly good ways to free up muscular rigidity. If one laughs hard enough, one may begin to cry. Crying, next to love, is perhaps the most healing activity for the heart. Crying frees the heart up of muscular tension and rigidity. Sobbing also enhances oxygen delivery. Man is the only primate able to weep for emotional reasons. Why are tears so copious during emotion? Tennyson wrote:

"Home May Brought Her Warrior Dead.
She Nor Swooned Nor Utter'd Cry;
All Her Maidens Watching Said,
"She Must Weep or She Will Die ..."

Crying is necessary to release the pain of heartbreak. Crying is necessary if heartbreak is not to lead to heart disease. Of all the emotions, however, it is perhaps love that is the most healing to one's heart. This has been seen in studies of survivors of myocardial infarction who have come home to pets. These people show considerably higher survival rates than individuals who come home to judgmental spouses, children or significant others. Love enhances healing. Fear of love contributes to heart disease.

Throughout life we are constantly making new connections, deeply to some, less deeply to others. Every break of a connection, whether between friends or lovers, entails pain. The deeper and

more intimate the connection, the greater the pain. However, not to make a vital connection with another person leads to an unbearable loneliness that could be deadly. To put it in another way is to say that a life without love is empty and meaningless. Loneliness is endemic in our culture, as many writers have pointed out, and perhaps for that reason heart disease is equally endemic.

The causes for loneliness have to be sought on two levels, one social, the other personal. Socially, the cause of loneliness can be found in the breakdown of community living and the disruption of family life consequent upon the heightened mobility of individuals. On a personal level, loneliness results from fear of loving. The avoidance of intimacy and commitment is characteristic of today's superficial relationships and can only be explained by a fear of heartbreak that would be experienced if a deep connection is broken (9). Heartbreak can make hearts break. Love heals the heart and sets it free!

As adults, most of us establish the deep connection of love with another person through the sexual act which is called making love. In a recent workshop with cardiac patients, it was apparent that an unsatisfactory love life was a significant aspect in all their histories. Opening up the energy in the pelvis via the sexual act discharges the energy in the chest. Like crying, sexuality frees the chest wall and heart of muscular rigidity and tension. In working with cardiac patients, it is important to emphasis the healing aspects of the above entities. Breathing, laughing, crying, and sexuality combined with love cannot be overemphasized. Since heartbreak is a major repressed feeling in these patients, it is useful to work bioenergetically with them in releasing this suppressed affect.

In many of the cardiac patients I have worked with it appears that the throat is constricted and the voice cannot break through. The pain of reopening the heart with subsequent release of feeling is perhaps the greatest resistance the patient can offer. He does not really want to examine the pain. He does not want to get in touch with the feelings of heartbreak that he experienced as a child. As a child he experienced the feeling that he could die. To re-examine such feelings presents the patient in almost a life-threatening situation (10). The somatic expression is of contraction, both in the pelvis and neck with rigidification of the chest wall. Techniques and interventions to release such physical tensions in these areas are extremely helpful. Interventions may facilitate the affective side of the work, thereby brining into focus transference and counter-transference. Opening up the throat with occasional light pressure on the diaphragm may also be a useful therapeutic manoeuvre. Since fear is inherent also in every patient with cardiac disease, working with soft touch, particularly with the hands and arms, may also be helpful. The utilization of soft touch in synchrony with one's breathing may also facilitate the energy to flow from the chest. Many cardiac patients hold in feeling, the expression of any affect is extremely therapeutic.

Since coronary heart disease is rapidly progressing into a behavioral disorder, the role of psychotherapist and particularly the bioenergetic therapist will be extremely useful in the treatment of these patients. Bioenergetic analysis with particular emphasis upon the affective side of the work will enhance feeling and free up muscular rigidity and tension. The attenuation of coronary-prone behavior through bioenergetic analysis allows the patient to experience spontaneity of feeling and aliveness. Within the therapeutic framework of bioenergetic analysis, the patient can gain emotional and physical well-being and regain lost health and once again sense the feeling of truly being alive.

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Résumé par B. BAILLEUX et B. DOHMEN

APPLICATIONS CULTURELLES ET BIOENERGETIQUES CHEZ DES PERSONNES MALADES DU COEUR

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Être en contact avec son Moi, c'est être conscient de son corps et de ses sensations, L'absence de ce contact peut conduire à la maladie, chaque problème psychosomatique semble relié à un affect bloqué qui fait payer son tribu au corps, cuis les problèmes coronariens, on va trouver, comme émotions réprimées, la colère, la tristesse, mais aussi et surtout une histoire de "coeur brisé".

La culture aussi va marquer l'individu au niveau de son caractère, de sa personnalité et de m corps. Certaines cultures favorisent les maladies coronariennes et cardiaques : ce sont les cultures qui poussent à la performance et à la réussite. Cependant, certaines de ces cultures, industrialisées, urbanisées et compétitives, comme le Japon, n'ont pas ce problème. Ce sont des cultures qui gardent, parallèlement à leur industrialisation, une tradition familiale unie et un soutien social de l'enfant. Les individus "à risque" surinvestissent leur travail, sont impatients, projettent une image d'eux-mêmes faite de succès et camouflent tout ce qui les limite (dépression, faible estime de soi, problèmes sexuels, ...).

En termes d'histoire individuelle, ce fonctionnement "coronarien" trouve son origine dans l'échec de l'enfant à recevoir un amour inconditionnel. Cette blessure narcissique profonde lui brise le coeur. Cet enfant ferme son cœur, a peur d'aimer et va éviter de nouveaux liens, un nouvel engagement, afin de ne pas revivre un rejet et une nouvelle déception. L'enfant qui se sent non-aimable peut établir un lien entre amour et succès et chercher à devenir super performant. Il deviendra, par la même occasion, sujet à risque pour ce type de maladie.

L'auteur constate que les caractères rigides, masochistes et narcissiques présentent un risque accru pour ce type de maladie. Par contre, les structures schizoïdes et orales y sont moins sujettes. La

peur de l'amour contribue à la maladie, car elle conduit à une solitude qui peut être insupportable pour le coeur. La peur de l'engagement dans une relation s'explique par la peur d'avoir son cœur brisé si cette relation profonde est rompue.

Dans la thérapie, le patient peut éprouver beaucoup de résistances à réouvrir son cœur, à rentrer dans la souffrance d'enfant du cœur brisé, au point d'avoir la sensation qu'il peut en mourir. Dans le travail bioénergétique, il faut développer le côté affectif du travail, mais aussi relâcher les tensions physiques de ces régions corporelles, où les affects sont bloqués. Le patient doit apprendre à respirer, rire, pleurer, vivre les émotions avec spontanéité, aimer, vivre la sexualité. Cela lui apportera un bien-être, la santé perdue et le sentiment d'être vraiment vivant.

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