

The Case of the Broken Heart

A Modern Perspective

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"Heart disease in the United States has reached appalling proportions (Pierrakos, 1974. p.1). Cardiovascular disease, including coronary heart disease (CHD) and essential hypertension (EH) account for one out of even two deaths; 1,563,000 people died of heart disease and 290,000 of cerebrovascular disease in 1984 alone (Wolman, 1988).

The question of why diseases of the heart and circulatory system are of such epidemic proportions "p^{reoccupies} virtually every definable sector of American society, from the federal government to the general practitioner. . . (Pierrakos, 1974. p. 1). According to actuarial profiles, men at middle age. in their 40s and 50s, are particularly susceptible to acute coronary incidents, known as heart attacks. These facts call for a psychosocial approach to heart disease. By exploring psychological factors as well as medical factors, the interrelationship of emotion, belief systems, behavior and physical systems can be understood.

When two cardiologists from Montefiore Hospital of the Albert Einstein Medical School in New York City requested we evaluate a small sample of middle-aged males under their care, eight coronary patients and two angina patients, we w'ere pleased to have the opportunity. The consultation was intended to provide a preliminary investigation of the patients' auras, that is. the energy systems surrounding their bodies. We were asked to determine if their auras indicated disease processes. Our observations are reported at the end of this report and must be considered highly exploratory. Future studies arc planned in this area in connection with referring physicians.

The Human Energy Field

To understand our exploratory investigation of the human energy field, it is necessary to summarize Core Energetic theory as it relates to the heart and circulatory' system. The phenomenon of energy w'as first explored in modem times from a psychosomatic perspective by Wilhelm Reich, the father of energetic psychotherapies. His approach dictated that mental health and mental illness could not be separated from the energetic

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condition of the physical body (Wilner, 1995). Although much research cited in the psychosomatic literature supporting the relationship of psychological stressors to cardiovascular disease and many current studies are cited in the writing, the impact of energy on heart disease specifically and psychosomatics in general is still a concept new to the culture requiring that we "reach beyond known experience"⁷, to understand its role (Pierrakos, 1974, p. 1).

Methods to study energy in the human body have not been validated. The work of healers who use energy, such as Barbara Brennan (1988, 1993) has not been tested empirically to a degree that would be sufficient to conclude its existence. Some exploratory research indicative of the aura's existence will be presented later in this paper. However, there is new empirical research in the areas of psychophysiology and electrophysiology connecting theories of energy and electricity to the human brain and central nervous system. Wang, Begleiter and Porjesz (1994) studied surface energy as it related to the scalp in a sample of 25 subjects and found it a useful method by which to capture cortical spacial properties and other internal mental events. Another study involving the brain and electromagnetic induction (Persinger, 1995) found that all sensory induction is translated into an intrinsic brain specific code which is stimulated through energy in the shape of electromagnetic patterns. Persinger claims that: "Identification of these electromagnetic matrices would allow direct access to the most complex neurocognitive processes associated with the sense of self, human consciousness, and the aggregate of experiential representations that define the individual" (p. 797).

Energy, as an aspect of the life force, makes itself known through the beat of the pulse. The heartbeat is energetic movement. The composition of the blood, chemical secretions and neurological impulses, is infused with energy received from within the body as well as from outside sources. The heart and the circulatory system transmit energetic movement throughout the organism. Therefore heart disease is not only a failure of the tissues, an invasion of hostile microbes, and a strain due to stress, illness or abuse; it also needs to be viewed as a pathological state stemming from an energetic dysfunction.

Later in this article we will review and interpret several large studies of heart disease and in addition, discuss implications stemming from the preliminary investigation of our small sample. In particular, we will utilize Core Energetic analysis to focus on three aspects of cardiovascular illness: psychological manifestations, body structure, and observations of the human energy field. However, first it is necessary to

discuss the heart and its activities.

The Heart, Pulsatory Movement and Emotion

The heart develops from cells of protoplasm which divide and differentiate assuming the special function of maintaining the pulsatory activity of the whole organism (Pierrakos, 1994). "The fully formed heart has four chambers encased in a muscular membrane of fibers-the pericardium-that expands and contracts" (p. 3). The pulsation is regulated by a specific group of cells, the bundle of His, that fire like batteries, creating the rhythmic movement. The inward movement is the systole and the outward movement is the diastole. These rhythms, which are variable depending on what aspect of the heart they represent, can be charted on the electrocardiogram. Under normal circumstances, the heart beats 60 times per minute and never ceases till death.

The main function of the heart is to propel the blood through the arteries and veins. As it moves through the circulatory system, the blood distributes energies and impulses of a biological, electrical, and chemical nature to the arterioles. These are minute blood vessels that connect to the autonomic nervous system and facilitate a connection between emotions and the cardiovascular system. "The cardiovascular network, then, bears the strain of pumping and channeling nourishment . . . and of coping with emotion-related impulses that can...literally break the heart" (Pierrakos, 1974, p. 3). Since 1910 when Cannon did his original research concerning the connection of fear and anger to blood pressure in animals, this has been an important area of study (Pierrakos).

In their study in support of the relationship between emotions and the cardiovascular system, Sinha, Lovallo, and Parsons (1992) confirm the plethora of research findings showing the role of anger and fear in cardiovascular disease. Their goal was to measure the effect of several states of being, such as joy, sadness, physical activity, and neutral imagery, as well as anger and fear, on the cardiovascular system. Twenty-seven male subjects, ages 21-35, who were screened for imaging ability were subjected to imagery induction techniques, and asked to apply specific emotional situations to their personal lives.

The results (Sinha, Lovallo & Parsons, 1992) indicated that anger, rather than fear, had the greatest effect on the cardiovascular system, causing strong increases in both diastolic and systolic blood pressure and increased cardiac output. Sadness produced more moderate increases in diastolic blood pressure, but a decrease in cardiac output. Fear, activity, and joy produced an increase in systolic pressure and left

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diastolic pressure unchanged. According to this study, emotions do impact upon the cardiovascular system, but the results differ depending on the emotion. The researchers predict that anger is most related to heart disease. However, the study did not determine if these effects would be the same for women, poor imaginers, those who have trouble sharing emotions, and middle-aged or older men. In addition, the results conflict with other research which shows that CHD patients exhibit elevations of systolic blood pressure, but not diastolic (Wolman. 1988).

Other feelings associated with cardiovascular disease are depression, isolation, and lack of support. Oxman, Freeman and Manheimer (1995) found that lack of participation in social or community groups and absence of strength and comfort from religion were consistent predictors of mortality after cardiac surgery. Supporting these findings, Jenkins, Staton and Jono (1994) discovered freedom from cardiac symptoms after heart surgery was significantly associated with high levels of self-esteem, well-being, vigor, activities, social participation and social support. Confirming these results, a study investigating college students (Lepore, Allen & Evans, 1993) in a public speaking situation found those who received support experienced smaller increases in systolic blood pressure than others.

Tulen et al (1993) conducted a study which raises questions about the hypothesis that emotions are implicated in heart disease. Subjects were injected with an infusion of epinephrine and norepinephrine, neurotransmitters common to emotional states, and a placebo. Their mood was assessed with the Profile of Mood States and the State-Trait Anxiety Inventory. Impact on the cardiovascular system was observed immediately after the infusions began and for the entire six hour infusion period. Findings showed that psychological parameters and mood did not change at any time during or after the experiment. The study suggests either that the cardiovascular system is not as sensitive to emotion as other studies report, or that external stressors rather than internal energies and neurotransmitters may be the sources of the relationship between the cardiovascular system and emotion. Neutral situations, such as this laboratory' experiment, may not be appropriate for the measurement of emotional impact, even when effects upon the heart are operative.

There is a lack of psychosomatic research which explores the connection of energy to emotion and disease processes. Research studies cited later in this paper will look at the connection between emotion and heart disease. What is missing, however, is an understanding of the role

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that energy plays in psychosomatics. Do energetic principles impact upon the specific organs of the body that become diseased? Research questions must ask whether certain feelings, like anger, are more likely to affect specific parts of the body, such as the heart. How and why do emotions become paired with particular physical sites? Is there an energetic association? Why would one person with repressed anger experience a coronary and another a form of cancer? Empirical research is needed before answers can be entertained. Our exploratory investigation offers a first step by looking at the energy fields of ten heart patients.

Research on the Human Aura

Rhythmic movement, such as that found in the heart, is seen throughout nature in meteorological phenomena in the universe, the migratory route of birds, and the menstrual cycles of women. Rhythmic pulsation can be found in the arterioles, in the cells, and in the building blocks of organic matter, deoxyribonucleic acid. This pulsatory movement can also be seen in the aura. The human form represents the solidification of energy, and the same energy in a less solid form is observed in the aura. The aura or "energy field appears as a pulsatory wave" that glows and "pulsates between fifteen and twenty-five times per minute" (Pierrakos, 1974, p. 4).

Research concerning the aura is scant, mainly clinical, and even those studies that appear somewhat scientific have largely non-replicative results. Clinical observations of clairvoyants report that these people are able to observe the energy patterns of ill people and diagnose the medical problem accurately as affirmed by "normal medical techniques" (Brennan, 1988, p. 32). Describing what they see, healers depict an energy body' surrounding each organ corresponding to its energetic rhythm. When there is pathology the rhythm and the energy field changes. Krippner's psychic research (1976) uses a case study approach to describe and analyze famous healers and their utilization of energy. Mann (1989) reports experiments by Soviet scientists demonstrating psychokinesis, the ability to move small objects by utilizing the body's force field which begins to pulsate.

A study conducted at Drexel University with a clairvoyant showed that a small laser beam could be bent with auric energy. Another study of the energy field during several rolling sessions at the University of California in Los Angeles (UCLA) used electrodes placed on the skin to record electronic signals. A clairvoyant reported the colors of the energy she was seeing at the same time as the data were recorded

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electronically. The mathematical analysis of the wave patterns recorded correlated significantly with the colors the observer recorded. This experiment was repeated with seven other clairvoyants achieving similar results. Hunt perceived her study, still in process, as the "first objective electronic evidence of frequency, amplitude, and time, which validates subjective observations of color discharge" (Brennan, 1988, p. 34). In addition, research at the Neuropsychiatric Institute at UCLA reported that measures by an acoumeter recorded energy given off at acupuncture points, but not at other points in the body.

Even- pulsation, auric and physical, has two phases; these may be called assertive and receptive or expansive and contracted. To illustrate, the heart contracts in order to send blood through the body and expands to allow chambers to fill with blood. Many other examples of expansion and contraction can be found in biology and physiology. When a person is diagnosed with an energetic dysfunction, the assertive and receptive phases are not in harmony. This imbalance seems to be visible to healers through the colors of the aura.

An association is hypothesized between assertive and receptive energies and masculine and feminine principles. Each gender demonstrates both masculine and feminine aspects to a greater or lesser degree (Pierrakos, 1974). Although concepts suggesting that masculine and feminine elements reside in one person are often found in Eastern religions and cultures, current Western psychological research lacks theories, hypotheses and studies concerning this topic. Neither PsycLIT nor Psych First, computer databases of psychology, contain entries in their subject indexes that included relevant data. If spiritual and Eastern models of psychology are to be taken seriously, then empirical research must be conducted along these lines.

To conclude this section, we would like to mention our observations of the aura which depict energy flowing through the torso in the form of a figure eight, crossing at the solar plexus. The energy in the upper portion of the torso seems to reflect feelings associated with love: receiving it, negating it, or feeling deprived of it. The energy in the lower section of the torso seems to reflect feelings associated with sexuality: shame, fear, negation, control, pleasure. Emotions and energetic dysfunction in the chest seem to lead to heart and respiratory disease, whereas energetic dysfunction in the pelvis seems to lead to sexual problems or disease of the uterus or prostate.

This work, these theories, and similar studies are in the early stages of experimentation. The results are highly speculative and most

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likely not replicable. However, it is very important that objective and accurate research methods be developed to ascertain if there is indeed an aura surrounding the body and, if so, what role it might play in the realm of psychology and medicine.

Cardiovascular Disease and Psychosomatics

When scientific medicine was born in the eighteenth century, human illness was considered strictly physical. However, Freud's influence at the turn of the twentieth century marked a turning point (Pierrakos, 1974). Human beings started to be seen as psychosomatic entities: mind and body were either viewed as one or, at least, as symbiotic and complementary. Weiner (1982) defines psychosomatics in terms of "the role that social and psychological factors play in the predisposition to, initiation of, response to, and maintenance of disease processes (p. 31). With the advent of psychosomatic medicine the fundamental causes of most heart diseases have begun to be unearthed (Pierrakos, 1974).

Early research in the domain includes Cannon's finding, in 1910, that fear and anger related to blood pressure. Osier, another pioneer, studied angina pectoris and reported that the disease was responding directly to causes in patients' life situations. Alexander's work in the 1930s uncovered unbounding hostility in heart patients. He characterized this hostility as aggressive, dominating, and overly ambitious. At the same time Dunbar found that emotions related to specific pathologies such as heart disease, and using her findings, she described coronary, arthritic and ulcerative personalities. In this same period, the Menninger brothers established "overwhelming evidence connecting cardiovascular disease with emotional causes" (Pierrakos, 1974, p. 8). Early research in psychosomatics presented a picture of cardiovascular patients caught in a vicious circle between fear and anger, with each emotion damaging the heart and circulatory system.

Currently there are many empirical studies concerning hostility, fear and cardiovascular disease. A study by Mcesters and Smulders (1994) conducted among adult Dutch men who experienced myocardial infarction (MI) questions whether this disease would be associated as strongly with hostility among Dutchmen as in studies involving American men. They also wondered whether they would find an association between age and hostility in men. Their sample consisted of 249 men, 81 heart patients and 168 matched controls between the ages of 35 and 65 who were given the Cook-Medley Hostility Scale and the Buss-Durkee

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Hostility Inventory, and several cardiovascular tests and questionnaires. Personal interviews included a Type A behavior pattern assessment.

The results (Meesters & Smulders, 1994) were interesting and only partially supportive of the hypothesis. Patients gave themselves higher levels of hostility than controls, but differences were only statistically significant in relationship to younger men. Hostility measures confirmed a strong risk of myocardial infarction for men under 50, but not for those over 50. This study supports the results of Suegman et al., Dembroski, and other reports of Type A behavior patterns. Decreasing strength hostility as a risk pattern for heart disease is predicted for older males.

Problems with the study (Meesters & Smulders, 1994) involve its retrospective nature; the hostility could have resulted as a response to heart disease, rather than prior to it. There are questions about the sample since they used a healthy neighborhood control group rather than a group of patients with a different disease. However, the authors are satisfied that these variables did not confound their results.

A large study of 1,532 British men and women suffering from peripheral arterial disease yielded some predictable and some unpredictable results concerning hostility and cardiovascular disease (Deary, Fowkes, Donnan & Housley, 1994). As could be expected, women with peripheral arterial disease, in this cross-sectional, random sample survey, did not have higher hostility scores than the controls. The study, which is important because it is the first large scale study of the relationship between hostility and peripheral arterial disease, found that men with this disease have more negative personality characteristics, a greater tendency to engage in angry confrontations, and a preference for dominance over passivity than the control group. These results were statistically significant but only at the .05 level. In addition, intropunitive and extrapunitive scales showed that the tendency for blame of self or others is not related to peripheral arterial disease.

The data indicate that as the degree of peripheral heart disease increased there were fewer signs of negativity, aggressiveness and Type A behaviors (Deary, et al., 1994). Having no precedent for this result, Deary et al. (1994) suggest that the Bortner Type A/B Inventory may not be an appropriate instrument for their sample which included many older retired people no longer competing in the work world. They also did not include a structured interview' in their methodology which they believe is superior to a questionnaire. On the other hand, they failed to look at age differences in their sample. If they had, they may have found, as did

Meesters and Smulders (1994) that hostility is not significantly related to cardiovascular disease in aging men.

A third study confirming the relationship between hostility and cardiovascular reactivity involved a sample of 60 undergraduate men (Christensen & Smith, 1993). The researchers predicted that hostile individuals would show exaggerated physiological responses to stressors in comparison to nonhostile persons. The investigators engendered hostility by placing their subjects in situations that would call forth suspiciousness and mistrust among hostile individuals. Hostile subjects were asked to disclose personal information to another person, which might lead them to expect mistreatment and create a strong stress response. The Cook-Medley Hostility Scale was used to differentiate high and low hostility subjects. Physiological responses were measured by checking blood pressure and neuroendocrine levels.

The results of the investigation (Christensen & Smith, 1993) were statistically significant, concluding that individuals with hostility who were placed in uncomfortable interpersonal situations will suffer physiological challenges that could make them more vulnerable to disease processes. Weaknesses in the study involved the exclusion of women subjects and the failure to hold other variables constant, such as lowered self-esteem or novelty, which may have led to similar results. In addition, the authors are concerned that their study presents a psychological dilemma for those with high hostility. Do they risk interpersonal situations where they might have to expose themselves, which could lead to medical problems, or do they isolate themselves and risk psychological problems?

Type A Personality and Cardiovascular Disease

Core Energetic therapy works to break the cycle of hostility and fear that develops in people (Pierrakos, 1974). Fear often occurs in reaction to hostility in the sense of "what if someone finds out what an angry, destructive person I am?" Using their knowledge of energy blocks in the body, practitioners work with the person mentally, emotionally, physically, and spiritually to find socially appropriate means to either release or contain emotion, depending on the person and the situation. Men who need specific strategies for release and containment are those who achieve an overdevelopment of assertive energy. According to the assertive and receptive phases discussed earlier, they seem to reflect a strong imbalance with overly aggressive actions and almost no ability to be soft or receptive. Men may unwittingly identify aggression and

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brutality with manhood and independence. "The man's sexual expression may be hard and pornographic... It may turn him into a barroom brawler. Or it may trigger cardiovascular disease" (Pierrakos, 1974, p. 9).

Energetic theory suggests that in cases of male aggression, muscular blocks in the pelvis have forced excess energy into the upper torso and head. An energy overload in the head inflates the ego and reinforces aggression in terms of desire for achievement, power, status, success, and money (Pierrakos, 1974). Energy theory' needs to be studied empirically before these hypotheses can be taken seriously. However, there is a large amount of investigative evidence showing a relationship between aggression, desire for power, overachievement, and heart disease.

Ground breaking research in the early 1960s by Friedman and Rosenman, which was published in 1974, studied 3,500 corporate males. These men fell into two types, Type A and Type B. The Type A personality portrayed motion and struggle, possessiveness and obsession to obtain possessions and power as fast as possible. In comparison, the Type B male led a less pressured life: he was more relaxed and less competitive. Findings showed two to five times more cardiovascular disturbances in the Type A male. Corresponding medical reports showed increased cholesterol and insulin, as well as an excess of norepinephrine in the Type A personality. A follow-up study found that 22 of the 25 men in the sample who died were Type A (Pierrakos, 1974).

Current research on Type A personality and cardiovascular disease shows a strong relationship with hostility. Juhani, Idanpaan- Heikkila, and Sarinen (1993) designed a study to indicate whether there is a relationship between Type A and heart disease, placing an emphasis on the anger-hostility element. They hypothesized that the component of Type A personality most related to cardiovascular problems was hostility. Aware that current studies looking at the relationship between CHD and personality types reported contradictory results, they referred to Ragland and Brand's results indicating that Type B showed significantly higher cardiac mortality than Type A, and to the San Francisco Recurrent Coronary Prevention Project which showed reduction in intensity of Type A behavior followed by a decrease in coronary events. These investigators hoped their study would clear up this confusion.

In an earlier study of Type A behavior, Juhani et al. (1993) found that the Type A patient's level of anxiety was predictive of complications during the first year of recovery. These data correspond to our theory (Pierrakos, 1974) that hostility and fear cycle together in heart disease.

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Results from the current study (Juhani et al.) of 92 patients, 76 men and 16 women, all below age 65, show that those who had a poor prognosis from myocardial infarction were easily aroused and often experienced anger. It made no difference whether the anger was openly expressed or suppressed; the frequency of anger was the important element. The investigators expressed disappointment that mediating mechanisms connecting emotion to the sympathetic nervous system activity are not better understood. This is certainly an area in which more empirical research is needed, particularly in the fields of psychophysiology and energetic dysfunction.

Melamed, Haran and Green (1993) also explored Type A behavior, hostility and cardiovascular reactivity in an all male sample. Using a heavy machinery workshop setting, 123 men were studied in order to measure their reactivity to a noise stressor. Psychological tests differentiated Type A from Type B men. Those in the Type A group were described as extremely competitive, impatient, aggressive, hostile, and exhibiting a sense of urgency. Blood pressure monitoring was used to measure physiological results. The findings showed that Type A experienced a rise in blood pressure in response to the noise stressor. The rise pertained to the diastolic blood pressure, not the systolic.

A final study of Type A behavior (Vitaliano, Russo, Bailey, Young and McCann, 1992), mentioned here, concerns hostility and cardiovascular reactivity. It includes a larger number of women than men, and a larger number of older people than many other studies. The sample consisted of 82 subjects and 78 controls; the average age was 68, and 63 percent were women. Those studied were caregivers to spouses suffering from Alzheimer's disease. The caregivers were subjected to both emotional and cognitive tasks in order to determine the impact of Type A behavior and cardiovascular reactivity on older adults. Hostility was assessed with the State-Trait Anger Scale and the Spielberger Anger Expression Scale, an avoidance scale. The Framingham Type A Behavior Pattern Scale, and a structured interview. The investigation showed that the emotional task was much more arousing than the cognitive task, and that blood pressure was heightened with hostility, criticism and avoidance. Criticism of one's spouse led to higher diastolic blood pressure and heart rate. Individuals rated higher on expressed emotions had higher diastolic blood pressure and heart rate than those whose emotions were more controlled. The investigators suggest that controlled anger may be healthier and expressed and repressed anger less healthy.

In general, men fell into Type A classification in our clinical

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practice. They are accomplished people, with important jobs, of an upper- middle socio-economic class, and socially acceptable. They dominate others through their speech and they dislike sharing authority. However, they are exemplary husbands with their wives, showing much less aggression at home than in the workplace. It is debatable whether they enjoy sex with their wives, and almost all have secret affairs (Pierrakos. 1974).

The developmental history of these clients indicates that as children they felt hostility toward the father, who was either hostile or withdrawn, and fear toward the mother, who was smothering and authoritative. Such a family configuration can set up circumstances leading to heart disease. If children are terrified of superior and controlling parents, they will also feel an underlying hostility toward the parents. The hostility is covered over with the fear that the hostile feelings will be discovered. A dance begins between fear and hostility. This cycle of fear and hostility continues into the person's marriage, for the wife becomes the authority in the house and the marital relationship fosters a hidden dependency. The original hostile reaction toward the parents is transferred onto the wife, but is unexpressed. At home, the husband is gripped between free floating anxiety and hostile impulses (Pierrakos. 1974).

Suppression of Emotion and Cardiovascular Disease

Current empirical research provides evidence that inhibited and unexpressed hostility is connected to cardiovascular problems, although only one study was found to support our theoretical discussion concerning family dynamics as a cause of heart disease. Fcuerstein, Labbe and Kuczmierczyk (1986) reported that pressures emanating from parents and their overdemanding attitudes are characteristics that "lead to the development of competitive and aggressive behavior and Type A personality patterns" (p. 35). Concerning unexpressed hostility, while compiling studies for his review of the psychosomatic aspects of heart disease. Wolman (1988) found that: "Coronary heart disease seems more related to suppressed anger and hostile feelings than to any other emotion" (135). He reports that this finding is related to hypertensive individuals as well.

In related research, Denollet, Sys & Brutsaert (1995) studied 95 men. age 45 to 60, who had recently survived MI. A two-year follow-up showed that those who died had significantly greater distressed personalities than those who lived. The investigators focused on the

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tendency to substantially inhibit emotional expression and found that this reticence could be damaging to the patient's health. The research showed that the interaction of emotional distress and inhibition of feelings is the major factor in the promotion of disease processes. The investigators also suggested that those who inhibited emotion were depressed. They consider their findings preliminary and are currently conducting confirmatory research with a large sample, including women and older patients.

Another study by Miller (1993) examined cardiovascular reactivity in anger-defensive individuals using 40 male undergraduates as subjects and presenting them with four different tasks.

Interestingly, subjects who were tested as defensive, but low on anger, on the Spielberger Anger Expression and Trait Anger questionnaires, exhibited elevated heart rate and systolic blood pressure measures in comparison to other subjects. Although they reported less anger, the researcher found that these subjects had an anger-defensive style that led to elevated cardiovascular activity if stressors that elicit sympathetic nervous system responses were present Miller suggested that: "Anger defensive individuals are likely masking their angry reactions across a range of anger-provoking situations because of a desire to remain and appear unemotional" (p. 83).

Spousal Relationships and Cardiovascular Disease

Since our clinical sample contained married men who experienced hostile impulses but inhibited them in relationship to their wives, we were interested in current research pertaining to marriage and cardiovascular disease. One study, already cited, reported that the spousal caretaker exhibited anger and physiological symptoms under certain conditions, especially when feeling critical of the other spouse (Vitaliano et al., 1993). However, this study was dealing with spouses taking care of Alzheimer patients. Another study found that newlyweds who were given a conflict task in a hospital laboratory setting exhibited hostile and negative behavior at the same time as their blood samples showed increases in their epinephrine and norepinephrine levels (Malarkey, Kiecolt-Glaser, Pearl Glaser, 1994). The investigators concluded that:

Neurohormonal changes related to hostility are thought to provide one of the links between trait hostility and risk for coronary heart disease.

Taken together data on both trait and state

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hostility provide support for the idea that chronically abrasive marital relationships could contribute to the heightened sympathetic tone believed to play an early role in hypertension (p. 49).

Looking at sexual functioning post-myocardial infarction, Rosal, Downing, Littman and Ahem (1994) report that "little progress has been made in identifying the determinants of the sexual dysfunction following MI (p. 655). This is a major problem since the deterioration of the sexual life of a patient with a chronic illness has a negative effect on the quality of life and well-being. In their search for causality, the investigators studied 63 male post MI patients and their spouses, looking at three possible factors: beta-blocker intake, psychological distress, and information about safety of sexual activity. The only variable that showed a statistically significant effect when the results were tabulated was psychological distress. Since it is unclear from the study if psychological distress relates to difficulties in marriage, and since sexual adjustment is such an important area in life, the investigators conclude that more research is necessary

Emotion, Cardiovascular Disease and the Feminine Gender

This paper has emphasized the connection between cardiovascular disease and the male population, because in the past many more men have died of MI and sudden death syndrome than women. Core Energetic analysis observed that historically blockages in female energy tended to effect the pelvis in contrast to the blockage in men which appeared in the chest (Pierrakos, 1974). Just as certain men have been found to display an abnormal amount of aggressiveness, certain women with pelvic blocks have been found to display too much receptiveness. In other words, the fear/hostility cycle expresses itself in the female as extreme submissiveness. Coinciding with this submissiveness, symptoms in the pelvic region have been identified, including: problems with the uterus, fibroid tumors, malignancies, fertility issues, and menstrual problems (Pierrakos). None of these hypotheses have been supported by research, however, since investigations of these matters have not been tackled. There are a large number of psychosomatic investigations concerning illnesses specific to women, but an exploration of these illnesses and their relationship to receptivity and submissiveness are beyond the scope of the present paper.

Not all disease follows a gender pattern with men having heart

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attacks and women diseases of the uterus, ovaries and menstrual cycle. There have been many cases of rheumatic heart disease in women. Core Energetic theory' suggests that the illness originates in puberty when the daughter is affected by the rejection of her father. The parent disengages when he experiences the energy flow between them in a sexual manner. His rejection results in "breaking her heartstrings" (Pierrakos, 1974, p. 10). These patients also succumb to tuberculosis, indicative of an unresolved longing for the father. However, this theory has not been investigated or confirmed.

A different type of woman seems to be affected by cardiovascular problems. In Core Energetic analysis she is considered an aggressive female. This category includes professional women, those gifted in the arts and sciences, competitive women and those amplifying the assertive principle at the expense of the receptive principle. The energy of her heart is contracted and she is unable to give her love to the degree she or others might wish. Underneath the professional mask, the fear-anger syndrome that we see in the male cardiovascular patient is operating. The number of women with cardiovascular disease who fit this picture is rising rapidly (Pierrakos, 1974).

Some of the current research looking at gender, emotion and cardiovascular disease supports this premise and other studies reject it. A study by Powell et al. (1993) which looked at Type A personality factors and behavior in women both contradicted and supported Core Energetic theory. Basing this study on the facts that half the people who die each year from CHD are women, and that "premature CHD death is the second leading cause of death in white women and the leading cause of death in black women" (p. 426), the investigators developed this exploratory study of 83 female subjects who suffered MI, aged 30 to 63, in order to determine the impact of Type A behavior on cardiac recurrences. They found that predictors of death or recurrence involved either being divorced or being employed without a college degree, as well as the reverse Type A behavior, that is, either low time urgency or low emotional arousability.

The authors (Powell et al., 1993) were surprised by their results. They hypothesized that marginal income and subordinate status in jobs have implications for women in terms of their health. In terms of Type A behavior, their research supported previous studies showing an inverse relationship to recurrent MI events in men and women. However, they cannot agree with studies that claim, therefore, that Type B behavior is predictive of recurring MI. Their conclusion, which still needs further

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research, is more in line with one aspect of Core Energetic theory. They write: "More plausible...is the interpretation that the inverse of Type A...are indices of suppression of emotion...In Framingham, suppression of anger predicted first CHD events, particularly in women employed in clerical jobs" (p. 432).

Very different results were reported by Knox and Follman (1993). Looking at gender bias in Type A behavior in relationship to cardiovascular disease, they were skeptical of Framingham data which demonstrated a stronger relationship between Type A, MI and men than between Type A, MI and women. Their sample consisted of 409 twin pairs who were already involved in an ongoing investigation. The ages ranged from 26 to 64 and the median age was 52. They used both the Framingham and Bortner scales to measure Type A. "The Bortner items were added to complement aspects believed to be lacking in the Framingham scale..." (P. 710). Their findings showed that Type A is related to cardiovascular disease for both men and women, but differently. For example, results revealed that Type A women had more alienation and less life satisfaction than Type A men. In addition, high Type A women showed anger along with neuroticism and alienation.

A study that looked specifically at anger expression style, cardiovascular reaction, and gender produced conflicting results. Lai and Linden (1992) investigated the physiological response in a sample of 105 male and female subjects who were harassed during a laboratory experiment in order to determine differences between those who held in anger (unexpressed anger) and those who gave it out (expressed anger). It was predicted that when the anger suppressors and anger expressors were harassed, the expressors would display more rapid cardiovascular recovery. The findings were interesting. The strongest finding was that men react more strongly to tasks performed under anger on all cardiovascular indices. Opportunities to release anger facilitated heart rate recovery in men, and to a lesser degree, diastolic blood pressure recovery, but not in women. Women with unexpressed anger had better systolic blood pressure recovery rates. This study seems to support the theory that unexpressed anger can lead to serious health problems, but only for men. Further studies are needed in order to understand the implications behind lower systolic blood pressure rates in women who suppress anger. This result conflicts with the results of the study (Powell, et al., 1993) previously cited.

The authors looked at both suppressed and expressed hostility. Males with high expressed hostility showed greater diastolic activity and

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also some increased systolic rates. These subjects indicated a readiness to respond to challenging events with anger, and showed a vulnerability to cardiovascular reactivity. In contrast, women with high expressed anger did not have the same physiological reaction, and expressed anger is not considered to be a coronary prone risk for them. Results concerning suppressed hostility were different. Both men and women showed greater diastolic activity, although the systolic rate for them rose as well. The authors suggest that anxiety more than anger is responsible for the physiological response in the suppressed hostility group.

Although current research findings are unclear as to the exact differences between men and women in relationship to expressed versus suppressed hostility and CHD, we believe that health indices are changing in the United States. Where in the past energetic blocks affected men in terms of heart disease and "broken hearts" and women in terms of sexual problems and "broken uteruses," women are now having more cardiovascular problems and men more diseases of the pelvis, including prostate cancer, fertility problems, and sexual impotence.

Preliminary Investigation of Ten Heart Patients

Similarities were apparent in the auras of these men which showed a block at the back of the neck where the energy, a reddish brown color, flew out in a wing-like shape, representing repressed hatred and unexpressed anger. Over the chest, some of the patients exhibited a dark purple and yellow emanation in the form of a cylinder, but in others a yellow brown spiral form was evident with clusters of material hanging from it. Exiting from the chest in this form, the energy demonstrated that it was unable to flow in its normal figure eight format due to blockages in the torso (Pierrakos, 1974).

Although we believe the results of this preliminary investigation are informative, work with the auras must be considered highly speculative until there is more research in this domain. Researchers from around the world who share an interest in psychosomatics, psychophysiological material, electrophysiology, Eastern philosophies, spirituality and quantum physics need to begin to work together to explore methodologies for measurement of auric phenomena and contribute to the knowledge base. "The time has come to broaden the investigation of the energy field not only as a diagnostic but as a predictive instrument" (Pierrakos, 1974, p. 17). In addition, our observations concerning the energetic blockages of these patients, although most likely accurate, cannot be accepted as conclusive or

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generalizable since there was only one observer. It is extremely important that future studies of energetic phenomena utilize a methodology that would insure both reliability and validity. Similarly, our psychological assessment based on Core Energetic, psychoanalytic, object relations and Reichian theory has not been the subject of vigorous analysis.

To conclude, we confirm that an understanding of the medical and the physiological alone are not enough to resolve cardiovascular disease. Psychological and social issues must be explored, particularly those concerning emotions and their effects on different aspects of the physical body. "There is no organic pathology without an emotional disturbance and no emotional disturbance without physiological consequences" (Pierrakos, 1974, p. 17). It is necessary to understand the meaning of the illness for the whole person.

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