Six Clinical Cases

By Victor M. Soby, M.D.*

As students of Wilhelm Reich at the Orgone Institute, we learned the sex-economic concept that the somatic anchoring of repressed memories is reflected in pathological attitudes and reflexes. These attitudes and reflexes, when loosened up correctly either by psychic influencing or by the dissolution of muscular rigidity, not only liberate bio-energy but also bring back into memory the very infantile situation in which the repression had taken place.

The energy which holds the armor together consists mostly of destructiveness which has become bound during the process of armoring. This is proven by the fact that destructiveness is set free as soon as the armor begins to crack. Reich showed how this destructiveness which is bound up in the character is nothing more than anger caused by frustration in general and by denial of sexual gratification in particular. This fact is, of course, in direct opposition to Freud's later theories of anxiety and basic impulses. These Freudian concepts are now used in the treatment of patients and in the rearing of children. For example, Dr. Franz Alexander in an article in the New York Times of May 15, 1949, states that "the child is born with impulses (instincts) which he tends to carry into action at once; but under parental influences the impulses—basically destructive and sexual—become domesticated." Reich found that vital energies, under natural conditions, could regulate themselves spontaneously without compulsive duty or compulsive morality; but when the orgasm reflex (mechanical tension → orgonotic charge → orgonotic discharge → mechanical relaxation) which governs all life, was interrupted by unnatural conditions of our anti-life and sex-negating culture, secondary manifestations of destruction and anti-life attitudes set in.

The following clinical experiences bear out the sex-economic concepts of Reich. The first case is that of a 22-year-old male, suffering from stuttering, anxiety, inability to concentrate and fear of possessing homosexual tendencies. The most striking body attitude of this patient was a pronounced sardonic grin on the face, below the eyes. All of his activities conformed to this body attitude. He had only contempt for anyone else's ability and believed he could seduce any girl if he pursued her. However, deep down he felt a longing and crying which he could not express, either verbally or physically. The patient's laugh was a good imitation of a baby suppressing a cry, but this was covered up by a grin. When he would stutter severely, he complained of choking sensations in the throat and a nauseated feeling in the lower chest. I was able to get the patient to vocally express rage and to physically express rage by hitting the couch, but for a long time the patient could not cry. He felt the sensation of crying several times in his eyes and throat but each time this impulse was warded off by the grin. Finally, after several months, he began to complain of tension around his eyes. He stated that he also developed a feeling that something was going to hit him in the eyes and therefore he had to keep his eyes closed as much as possible. This latter expression was maintained constantly during the session. I told the patient to open his eyes, which he did, but nothing happened until I suddenly and without warning pulled down his lower lids, whereupon he began to cry freely and angrily. After this release of affect, the patient related that he felt a wonderful warm feeling flow down his cheeks, neck and chest. He smiled warmly at me and all he said was that he wanted to enjoy this feeling.

He then was able to bring back into memory, without any difficulty whatsoever, the very infantile situation in which the repression had taken place. He recalled that when he was about four or five years old, his father, who was extremely self-centered, selfish and rigid in his approach to children, would become annoyed by the patient's eating habits. Some mornings the patient would not want to eat his cereal first or would not eat it at all. The patient, like any child, and I quote Neill's The Problem Family, "if left to itself, will evolve its own timetable, which means that a baby has the capacity for self-regulation, not only in milk feeding, but later on in solid feeding," was not angry with his father but was simply trying to satisfy his own desires at that moment. The child's feeding activities on one particular morning infuriated the father to such an extent that without any warning, he took the dish of oatmeal and shoved it full force into the boy's...
face. The child cried immediately and was commanded to stop. He continued to cry and the father slapped him, whereupon the boy stopped crying. For some reason this made the father angrier and he slapped the boy harder. This time the patient did not cry. He choked his crying to the pain by swallowing and tensing the neck muscles and then he grinned. The boy received a great deal of satisfaction from this act; he felt he had finally mastered his father. Later on he devised many tricks to outwit his father. He recalled that at night he would go upstairs to bed but instead of retiring would crawl out of the window, down the ledge, and hide behind the stoop. His parents, before retiring, would look into the boy's room and when they saw he was missing, they would become panicky and search for him. He, in turn, would watch these proceedings with a sadistic grin and then quietly sneak back to his room. These acts would occasionally result in the boy receiving a beating, but he would never cry. Immediately after this emotional breakthrough the patient's stuttering stopped almost completely; he felt a tremendous release; his eyes cleared up and he was eager to continue. I warned him that this improvement could only be temporary, and with the appearance of genital anxiety the stuttering did return. The parents, who were always against therapy “because he can snap out of it himself,” finally pressed him into discontinuing treatment. Incidentally, if one thinks that the behavior of this father would be repellent to most parents in our culture, one has only to recall the startling success of Clifton Webb as a baby sitter who “disciplines unruly tots by coolly emptying bowls full of cereal over their pretty little heads” in the motion picture Sitting Pretty, to see that such behavior or the desire to behave in such a manner is much more prevalent than one thinks.

The next case is that of a girl, 26 years old, suffering from cyclic depressive episodes and feelings of stupidity, who complained of feeling ugly, even though she was pretty and sexually attractive. The patient stated that for the most part she had good contact with her body feelings and that she often had pleasurable feelings in the pelvis and vagina. She would desire a man but the thought would frighten her and she would kill the desire by saying, “No man would want me—I'm too ugly.” The outstanding expression I could see in her face was an anxious anticipatory attitude of the forehead which was held raised in a deeply furrowed manner. She was always smiling but occasionally she would clench her teeth and depress the lower jaw as though she were trying to prevent an impulse from breaking through. The sterno-cleido-mastoid muscles were very tense. I could barely move her neck from side to side. With the initial breathing, the smile disappeared and sobbing broke through. As this expression was analyzed and dissolved, the forehead became very tense; finally she came in one session and complained that she had had a severe headache all week. The headache was located in the back of the neck and over the forehead. She said that all week long she felt that she wanted to scream but could not do so because of a frightened feeling. The stronger the impulse became, the more she would clench her teeth and hold her neck stiffly and then the headache would become worse. I told her to give in to this feeling, but the fright was too much for her to overcome. Finally I stimulated the muscles in the occipital region; the eyes looked panicky; she began to scream horribly and then to yell and bite. As the reaction subsided she began to curse an Uncle Adolph in a hysterical manner. After the reaction stopped, the respirations gave in freely down to the pelvis for the first time; the thighs began to quiver, and she sighed in relief. The eyes cleared and the frightened look and the muscular tensions with the headache all disappeared. She was able to reconstruct the repressed content of this armor, as follows. This same incident occurred several times when the patient was about ten years old. About once a week she would stay overnight at her uncle's home. When both aunt and uncle were present, the uncle, who was considered a very religious and moralistic person, would act the good uncle. However, when the aunt would occasionally visit friends for the evening, Uncle Adolph would tell the patient to get into her pajamas, would then remove the top of the pajamas, and would play with her breasts and put his head to her breasts. The girl became terrified and wanted to scream and push and kick him away but could never get herself to do it. At the same time, she became sexually excited. Somehow she could never tell anyone what had happened. Later, when the patient masturbated, she would fantasize an older man playing with her who had lived down the block (Uncle Adolph). It took many sessions to completely dissolve this armor. Each time the same reactions would take place and more memories dealing directly with early sexual impulses, which had been blocked from expression, were elicited. Whenever the feelings would become too strong in the pelvis, she would tighten her mouth, hold her neck, raise her forehead, and subsequently stop the reflex. However, she became able to
tolerate this increased energy level, felt it as pleasure and now has sexual relations with a boy friend.

This is the case of a 32-year-old married accountant who complained of loneliness, fear of people, "a vacuum-like feeling inside," total lack of interest in his work although he held a rather high-paying responsible job, and inability to look at people. He was fearful that everything was going to close in on him and felt as though he would have to run away from everyone. The patient had had these feelings for about seven years. Biophysically he presented all the signs of chronic sympathicotonia. The pupils were chronically dilated, reacted to light but snapped right back to full dilation. The eyes were always dry and the patient complained that a veil seemed to be over them. The mouth was excessively dry; the lips always looked parched. His body was bathed in a cold oily sweat. The patient's face and chest were covered with acne infections interspaced with numerous old acne scars. The abdomen was rigid and reacted stiffly to the slightest pressure. The penis was flaccid, blue and cold. The patient held his chest in a chronic inspiratory phase. His pelvis was held in a chronically retracted position. He held the buttocks stiffly as though he were afraid he would have a bowel movement. He was terrified afraid to relax even after some show of affect, such as crying or anger. I noticed that if the respirations in the chest relaxed, he would tighten up in the buttocks. It was quite obvious that there was generalized fear throughout the entire body. The repressed energy seemed to be concentrated in his eyes and buttocks. I proceeded to point out to the patient the tensions in his eyes and buttocks. At first he could not feel these tensions. When I made him exaggerate the tension in his buttocks and then relax them as well as he could, he stated that he was not aware of this tension. While he could not feel the tension in his eyes, he was able to express it psychologically as "I am afraid to look at people," etc. I had the patient imitate fear and at the same time I stimulated his buttock muscles. These muscles began to twitch and convulse; his eyes opened wider in fright and soon he broke through with a terrifying fit of crying. He held his hands in the air as though he were pleading for someone to pick him up. When he finished this emotional breakthrough, the respiration relaxed. There was no doubt that this was a real vegetative release of muscular tension. The immediate effect of this release was perceived physically by the patient, who described it as "pleasurable, warm and good—let's do it over again." This breakthrough opened up a Pandora's box of early childhood memories. Some were photographic reproductions and others were feelings from very early infancy. The patient stated that the first thing he remembered experiencing was a feeling that he was reaching for his mother's breasts but couldn't get to them. Then he saw himself lying in the crib, crying and longing for someone to come to him. This latter feeling, he said, seemed to have been with him all his life. He then told me that as a child of three or four years, he saw his younger brother feeding at his mother's breast. The patient would observe this feeding and would ask to be also fed at the breast. The mother would hold out her breast and tell him to come to her, but as the patient went to the breast, she would pull it away and make fun of him. He felt terribly let down and soon after he began to have bowel movement accidents. The scolding for and retraining of this regression were given over to an older sister, since the mother was busy with the younger boy. The patient said he was severely scolded by his sister, so much so that any anal sensation was painfully held back. He mechanically reinforced this holding back later on by kneeling and then pressing his heel against the rectum. Soon, he stated, he derived some pleasurable sensations from this holding back of his feces, as well as satisfactorily preventing the soiling. The boy soon became so constipated that he began to develop a distention of the bowel. All household activities stopped. The mother took him to the doctor. The patient said, "I had her to myself." He was taken to the hospital for a possible operation because the doctor believed the patient had a kink in the bowel, but the distention was released by enemas. The doctor, however, thought there were some pathological foci in the body that were responsible for this condition and removed the tonsils and circumcized the penis. The patient remarked to me, "If the doctor had only asked me what was causing the trouble, I could have been spared a lot of cutting."

A married woman 32 years old came to treatment because she was "confused, didn't know what life was all about, because men got all the breaks in this world." Even though she felt sexual feelings in her pelvis and desired intercourse, she could never adequately achieve sexual gratification. She stated that she was always able to entice and attract men, but "somehow they always wanted one thing—intercourse." She constantly looked at me through the side of her eyes with eyelids half closed and maintained
a soft coquettish smile. The gait was characterized by a swinging of the hips which was obviously sexual in its meaning. These statements, in combination with her rather agile sexual body movements, were the outstanding characteristics in this patient.

The early sessions demonstrated these characteristics very clearly. She flirted with me constantly, discussed the difficulties that she had with men because "all they want is sex," but at the same time she had no contact with her sexually provocative mannerisms. She reacted to stimulation by crying and displaying temper tantrums; however, the patient did not seem to make any contact with these outbursts of affect. Soon, after several sessions, a rather apprehensive expression appeared in the eyes and forehead. At first she did not understand this expression although she felt the tension. Finally during one session she was able to bring out very strongly fright and apprehension by imitating my expression of a raised forehead with eyes opened-wide in fright. Her respiration increased in depth and frequency. She began to toss her head about as though she were trying to escape from an attack. Then she screamed, bit her nails and finally threw her legs up in the air. These actions were repeated several times. When she finally stopped, she felt calmer. She experienced this emotional release as fear and immediately recalled that she had done this several times as a child when she was threatened by her father. She added that from the first time she had intercourse she always threw her legs up in the air when she seemed close to attaining an orgasm, but never understood why she did this. The patient went on to say that as a child her father threatened to whip her many times with a strap, but only on one occasion did he actually do it. She recalled this episode quite clearly. One day she was being pursued by her father for "having done something wrong." The patient tripped and fell on her back. The father swung the strap and the patient immediately threw her legs up in the air and was hit on the buttocks. I questioned the patient as to why she did this maneuver. She immediately replied, "to protect myself." I then asked her, "to protect what?" For a second she could not answer this question. Then an earlier memory accompanied with a release of crying came to consciousness. The patient's bedroom was next to the master bedroom. At night she would hear the heavy breathing and groans of her mother during intercourse coming from the parents' room. Once or twice she peeked through the crack of the door to see what was happening. She became frightened by what she saw and interpreted the sexual embrace as a sadistic act of the male injuring the female genital; but at the same time she became sexually excited by the situation. The patient stated that after this her feelings toward the sexual embrace and her father were mixed with fear and desire for intercourse with the father. The sexual meaning of this whole infantile episode became clear to the patient. To her, the beating was equivalent to a sexual attack by her father and in order to protect herself from the fear of having her genitals injured she threw her legs up in the air. Subsequently, any sexual behavior on the patient's part which seemed close to attaining its goal threw the patient into a panic or retreat. The next time the patient had intercourse, she did not throw her legs up in the air, for she did not have as much fear of the excitement.

The next case is that of a 26-year-old married woman who came to treatment because of constant headaches, anxiety states, inferiority feelings. She was not happy in her marriage, did not enjoy sexual relations, complained that her husband was much too sexually aggressive for her. She suffered from repeated episodes of depression. The patient was attractive but appeared sad and depressed. It was difficult for her to look at the therapist. The forehead was taut and held in an apprehensive expression. The upper lip was held rather stiffly and the edges of her mouth were drawn down as though she were going to cry.

When asked to smile, she could only do so weakly. When the smiling was exaggerated she cried freely; tears flowed copiously, but all she could say in connection with this release of emotion was, "I am lonely." For the next two or three sessions all I had her do was exaggerate the crying, and stimulated the masseters and neck muscles. Biting and anger with hitting of the hands appeared but would be abruptly terminated by a terrific feeling of fear in her whole body, especially in her eyes and forehead. Therefore I proceeded to work on the forehead segment. She was able to perceive this segmental tension as fear. Suddenly I could see stark terror in her eyes. The patient tried to put her hands in the air as though she wanted something. I helped her do this. She, for a moment, reached out eagerly and then quickly brought her arms down to the couch. At the same time, the upper lip which had relaxed into a sucking attitude, reverted back to the tightly held attitude. I repeated the arm-raising episode several times and each time she would repeat the same thing. Finally the movements
stopped but she continued to sob and would not look at me. It was obvious that she was holding back some embarrassing content. After much reassurance on my part the patient was able to describe the meaning of this episode. She stated that at first she felt like a baby, frightened and alone. She wanted to reach for something and she tried to reach out with her arms. She felt as though she were reaching for her mother's breast, but as she went to suck with her lips all she could think of was her husband's penis and this frightened her. Then she was able to relate with much shame that she practiced fellatio with her husband. This entire session, however, did not give the patient any great release but rather increased her anxiety and apprehension and this persisted for several weeks. Each session brought out more fear from the eyes in particular and the body in general; each time a specific real or fantasy sexual situation would be produced. She told me that on the subway she found herself looking at the genital region of men, wanting to be seduced by them and then feeling frightened about the whole idea. This brought to memory a situation which occurred when she was sixteen. An uncle about whom the girl had been warned because of his rather roué tendencies led this patient into a situation where he passionately kissed her and then tried to seduce her. After a number of sessions the patient was able to bring out her fantasies toward me which she had felt all along—that I wanted to seduce her and as a result she was fearful of me. She was not able to produce any memories which might indicate a real or fantasied attack by her father against her. I am sure, however, that most of the armor of this segment has been dissolved because of the fact that the fright in her eyes disappeared and the respiration had improved.

The next case demonstrates how the understanding of body expression and attitude can overcome acute distressing symptoms of patients in an emergency situation. A man, 38 years of age, single, had been going to an internist for repeated mild asthmatic attacks. These mild attacks had been ushered in by a status asthmaticus attack seven months previously. Before that attack, the patient had never suffered from asthmatic symptoms. During the original status asthmaticus seizure the patient was given repeated injections of adrenalin, penicillin and other anti-asthmatic drugs, to no avail. He was finally hospitalized and released after one week. The attack more or less ran its course. The patient continued with the internist who gave the patient symptomatic drug relief. At the same time, the internist recommended that the patient seek psychiatric help because he felt that there was an emotional etiology present. The patient received psychotherapy with very little benefit. About seven months after the original status attack, the patient developed another severe status asthmaticus attack. The internist intensively treated the patient with adrenalin, etc., for three days but the intensity of the attack could not be abated. Finally, in desperation, the patient came to me for help. I studied the patient. The wheezy breathing could readily be heard. Physical examination showed râles which were dry, musical and evenly distributed. All the accessory muscles of respiration were in action. However, an orgone therapist has to investigate further and ask himself, "What does this body attitude express?" The accessory muscles of respiration and muscles of the neck showed a tautness which resembled the neck of a wrestler before he lets go of his aggression in a contest. The jaws were closed tightly; the eyes showed anger; the hands were clenched tightly as though the patient were going to strike out. It was obvious to me that anger was being held back from expression.

At first I tried to establish better breathing but was unsuccessful. I then stimulated the upper thoracic muscles and the patient went into a rage reaction which involved the whole body. Within two minutes the whole episode was over—the status attack was terminated. Upon questioning the patient about any episodes of repressed aggression, he was able to recall a recent incident which happened the day before the attack had occurred when he almost killed a man in an argument which resulted from a card game. He added that it seemed as though he was being "choked with anger." The patient was amazed and could not understand what had just taken place and when he left the treatment room he immediately told his internist what had happened. The reaction of the latter reminded me of the answer Reich received from a physicist who had seen the illumination in a fluorescent tube which had been excited by an orgone-charged rod of insulating material. The physicist answered, "Oh, it is the gas," and did not in the least explain why the gas was able to illuminate. The internist, when asked for an explanation by the patient, replied, "Oh, I know what happened. He just made you mad and caused adrenalin to flow." However, the good doctor apparently forgot that for three days he gave the patient not only countless shots of adrenalin but other anti-asthmatic drugs as well, to no avail.
Summarizing these six cases, we again have clinical proof of Reich's concept that in individuals with character-neurotic structures there exist constant and varying muscular spasms which bind the spontaneous flowing movements of the body. In order to remove these spasms it is necessary to make the patient consciously experience what is happening in his body, what he is doing, and what is occurring spontaneously. This can be done by various methods, as described by Reich and others. If these body attitudes are properly understood, forgotten and half-forgotten memories often clearly related to the muscular spasms are remembered; the discharge of affect is assured and the muscular spasm is properly dissolved. Each time this discharge of energy occurs the patient feels more bio-energetically alive and will often express this feeling in terms of motion, as “I feel a warm feeling running down my face and chest” or “my headache just seemed to dissolve and my head expanded so freely.” This is nothing more than the objective perception of plasmatic motion in cells and fluids which have been freed from their rigidity.

The conclusion I wish to draw from these cases is that in none of the patients was there a destructive impulse at the time the traumatic episode occurred which had caused the need for “domestication” but it was the demands of a sadistic father, a pathetic sexually frustrated Uncle Adolph, and a selfish, rejecting mother, which forced these children to suppress their impulses into neurotic channels of expression. The acts of these adults toward the children seemed to be a method of “domesticating” destructive impulses in our children. Funk and Wagnalls define “domesticate” as “to train, reclaim, tame.” “Tame” is defined as “docile, subdued or subjugated, spiritless, lacking in effectiveness, uninteresting, dull, flat, insipid.” Incidentally, how does one tame or domesticate the sexual instinct? Sublimate it?

Each time I release a patient from the effects of the emotional anguish of a barbaric circumcision ritual, the frustrating mechanics of bottle feeding, sadistic anal bowel training, and the pitiful suffering due to repressed masturbation and to the denial of heterosexual relationships to adolescents, I hear and see all too clearly the millions of young children undergoing the tortures of this “domestication” process. It then becomes clearer to me that the task of the orgone therapist lies not only in the treatment room but also in our society, by working towards the abolition of “nursery kennels” where children are “domesticated,” by exposing the sadistic sur-
Projeto Arte Org
Redescobrindo e reinterpretando W. Reich

Caro Leitor
Infelizmente, no que se refere a orgonomia, seguir os passos de Wilhelm Reich e de sua equipe de investigadores é uma questão bastante difícil, polêmica e contraditória, cheia de diferentes interpretações que mais confundem do que ajudam.
Por isto, nós decidimos trabalhar com o material bibliográfico presente nos microfilmes (Wilhelm Reich Collected Works Microfilms) em forma de PDF, disponibilizados por Eva Reich que já se encontra circulado pela internet, e que abarca o desenvolvimento da orgonomia de 1941 a 1957.

Dividimos este “material” de acordo com as revistas publicadas pelo instituto de orgonomia do qual o Reich era o diretor.
01- International Journal of Sex Economy and Orgone Research (1942-1945).
02- Orgone Energy Bulletin (1949-1953)
03- CORE Cosmic Orgone Engineering (1954-1956)

E logo dividimos estas revistas de acordo com seus artigos, apresentando-os de forma separada (em PDF), o que facilita a organizá-los por assunto ou temas.
Assim, cada qual pode seguir o rumo de suas leituras de acordo com os temas de seu interesse.
Todo o material estará disponível em inglês na nuvem e poderá ser acessado a partir de nossas páginas Web.

Sendo que nosso intuito aqui é simplesmente divulgar a orgonomia, e as questões que a ela se refere, de acordo com o próprio Reich e seus colaboradores diretos relativos e restritos ao tempo e momento do próprio Reich.
Quanto ao caminho e as postulações de cada um destes colaboradores depois da morte de Reich, já é uma questão que extrapola nossas possibilidades e nossos interesses. Sendo que aqui somente podemos ser responsáveis por nós mesmos e com muitas restrições.

Alguns destes artigos, de acordo com nossas possibilidades e interesse, já estamos traduzindo.
Não somos tradutores especializados e, portanto, pedimos a sua compreensão para possíveis erros que venham a encontrar.

Em nome da comunidade Arte Org.
Textos da área da Orgonomia Bifísica. Casos clínicos.
Texts from the area of Biphysical Orgonomy. Clinical cases.
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International Journal of Sex Economy and Orgone Research
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Orgone Biologics 2. A case History
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01 Wilhelm Reich. The Orgasm Reflex. A case History 1942.
International Journal of Sex Economy and Orgone Research Volume 1 Number 1 1942
Interval 60-69 Pag. 55-64

02 Carl Arnold. The Treatment of a Depression. 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 2 1942
Interval 69-76 Pag.163-170

03 Wilhelm Reich. The Mosochistic Character (1933)
International Journal of Sex Economy and Orgone Research Volume 3 Number 1 1944
Interval 43-66 Pag.38-61

04 Walter Hoppe. My First Experiences the Orgone Accumulator 1945
International Journal of Sex Economy and Orgone Research Volume 4 Numbers 2 3 1945
Interval 78-79 Pag. 200-201

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Orgone Energy Bulletin
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01 Simeon J. Tropp. The Treatment of a Mediastinal Malignaney with the Orgone Accumulator 1949
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02 Ola Raknes. A short Treatment with Orgone Therapy 1950
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06 Charles I. Oller. Orgone Therapy of Frigidity A Case History 1950
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09 N. Wevrick. Physical Orgone Therapy of Diabetes 1951
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10 A. Allan Cott. Orgonomic Treatment of Ichthyosis 1951
Interval 25-27 Pag. 163-166

11 Philip Gold. Orgonotic Functions in a Manic-Depressive Case 1951
Interval 27-34 Pag. 167-180

12 Emanuel Levine. Observations on a Case of Coronary Occlusion 1952
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Eva Reich. Early Diagnosis of cancer of the uterus 1943
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