FROM THE ORGONE AND CANCER RESEARCH LABORATORY

THE CARCINOMATOUS SHRINKING BIOPATHY†

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I. THE BIOPATHIES.

The cancer tumor is no more than a symptom of the cancer disease. Therefore, local treatment of the tumor—be it operation or irradiation with radium or X-ray—affects not the cancer disease as such, but only one of its visible symptoms. Similarly, death from cancer is not due to the presence of one or more tumors. Rather, it is the ultimate expression of the systemic biological disease "cancer" which is based on a disintegrative process in the total organism. Medical literature contains no data concerning the nature of this systemic biological disease. "Cancer disposition" means nothing but the fact that back of the cancer tumor there are at work hitherto unknown processes of a fatal nature. Cancer cachexia, the typical final phase of cancer, must be considered nothing but the ultimate visible phase of this general, as yet unknown process called "cancer."

The term "cancer disposition" is misleading and meaningless. The term cancer biopathy, on the other hand, has a definite meaning. This series of articles will demonstrate the process which is the basis of cancer biopathy.

Under the term biopathies we subsume all those disease processes which take place in the autonomic apparatus. There is a typical basic disturbance of the autonomic apparatus which—once it has started—may express itself in a variety of symptomatic disease pictures. This basic disturbance, the biopathy, may result in a cancer (cancer biopathy) but equally well in an angina pectoris, an asthma, a cardiovascular hypertension, an epilepsy, a catatonic or paranoid schizophrenia, an anxiety neurosis, a multiple sclerosis, a chorea, chronic alcoholism, etc. What determines the development of a biopathy into this or that syndrome, we do not as yet know. What interests us here primarily is that which all of these diseases have in common: a disturbance of the biological function of pulsation in the total organism.

A fracture, an abscess, a pneumonia, yellow fever, rheumatic pericarditis, acute alcohol intoxication, infectious peritonitis, syphilis, etc., are not biopathies. They are not due to a disturbance of the autonomic pulsation of the total vital apparatus; they are circumscribed, and, if they result in a disturbance of the biological pulsation, they do so only secondarily. We shall speak of biopathies only where the disease process begins with a disturbance of the biological pulsation, no matter what secondary disease picture it results in. Thus,
we can distinguish a "schizophrenic biopathy" from a "cardiovascular biopathy," an "epileptic biopathy" or a "cancer biopathy," etc.

This addition to medical terminology is justified by the fact that we cannot comprehend any of the diverse diseases of the autonomic apparatus unless,

1) we distinguish them from the typical infectious diseases and traumatic surgical diseases;

2) we look for and find their common mechanism, the disturbance of biological pulsation;

3) learn to understand their differentiation into the various disease pictures.

The cancer disease lends itself particularly well to a study of the basic mechanisms of biopathy. In it, we find a great number of disturbances that everyday medical practice has to deal with. It shows pathological cell growth; one of its essential manifestations is bacterial intoxication and putrefaction; it is based on chemical as well as bio-electric disturbances in the organism; it has to do with emotional and sexual disturbances; it results in a number of secondary processes—such as anemia—which otherwise form disease entities by themselves; it is a disease in which civilized living plays a decisive role; it is of concern to the dietician as well as to the endocrinologist or virus researcher.

The confusing variety of manifestations presented by the cancer disease only hides a common basic disturbance. The same is true, as we know, of the neuroses and functional psychoses which—in all their variety of form—have one common denominator: sexual stasis.

Sexual stasis represents a fundamental disturbance of biological pulsation. Sexual excitation, as we know, is a primal function of the living plasma system. The sexual function has been shown to be the productive life function per se. Thus, a chronic disturbance of the sexual function must of necessity be synonymous with a biopathy.

The stasis of biosexual excitation may manifest itself, basically, in two ways. It may appear as an emotional disturbance of the psychic apparatus, that is, as a neurosis or psychosis. But it also may manifest itself directly in a malfunctioning of the organs and express itself as organic disease. As far as we know, it cannot produce actual infectious disease.

The central mechanism of biopathy is a disturbance in the discharge of biosexual excitation. This statement calls for the most detailed substantiation. It is not surprising to find that in the biopathy physical and chemical factors are at work as well as emotional factors. The biosexual emotion demonstrates the psychosomatic unity of the total biological system more forcibly than anything else. Thus it is to be expected that disturbances in the discharge of biosexual energy—no matter what their point of manifestation—will result in disturbances of biological functioning, in other words, in a biopathy.

BIOPATHIC SHRINKING

Living functioning in man is basically no different from that in the ameba.1 Its basic criterion is biological pulsation, that is, alternating complete contraction and expansion. In unicellular organisms, it is readily observed in the form of the rhythmical contraction of the vacuoles or the contractions and serpentine movements of the plasma. In the metazoa it is most readily seen in the cardiovascular system; the pulse beat represents the pulsation unequivocally. In the various organs, it takes a different form, according to their structure. In the intestines, it shows itself as a wave of alternating contraction and expansion, as "peristalsis." In the urinary bladder, the biological pulsation functions

1 Cf. W. Reich, "Der Umgangssatz des vegetativen Lebens," 1934.
in response to the mechanical stimulus exerted by the filling of the bladder with urine. It functions in the striped muscles as contraction, in the smooth muscles as a wave-like peristalsis. In the orgasm, the pulsation takes hold of the total organism in the form of the orgasm reflex.

Neither the pulsatory movements of the organs nor their disturbances such as shock, blocking, shrinking, etc., are compatible with the generally accepted notion that the nerves only transmit impulses while they themselves are rigid and immobile. The autonomic movements are comprehensible only under the assumption that the autonomic nervous system itself is mobile. The decisive question as to whether this is a fact can be answered by direct observation. We put small, sufficiently transparent worms under the microscope in such a manner that not only the ganglion but the ganglia fibers are in focus. As the worm is in constant motion, one has to learn to keep an autonomic fiber constantly in focus. Thus one can convince oneself that the autonomic system does indeed expand and contract and is not rigid. The movements of the nerves are serpentine, slow, wave-like, sometimes jerky. They always precede the corresponding movements of the total organism by a fraction of a second: first, the nerve, and its ramifications, contracts, and then the contraction of the musculature follows. The same is true of the expansion. As the worm dies, the nervous system gradually shrinks; with that, the organism bends. The process of gradual shrinking is occasionally interrupted by a contraction. After a shorter or longer period of complete immobility, the rigid contraction ("rigor mortis") subsides, the organism relaxes together with the nerves, and motion does not reappear.

Biopathic shrinking begins with a chronic preponderance of contraction and inhibition of expansion in the autonomic system. This is most clearly manifested in the respiratory disturbance of neurotics and psychotics: the pulsation (alternating expansion and contraction) of lungs and thorax is restricted; the inspiratory attitude predominates. Understandably enough, the general contraction ("sympathicotonia") does not remain restricted to individual organs. It extends to whole organ systems, their tissues, the blood system, the endocrine system as well as the character structure. Depending on the region, it expresses itself in different ways: in the cardiovascular system as high blood pressure and tachycardia, in the blood system as shrinking of the erythrocytes (formation of T-bodies, poikilocytosis, anemia), in the emotional realm as rigidity and character arming, in the intestines as constipation, in the skin as pallor, in the sexual function as orgasmic impotence, etc.

At this point, the careful reader will raise an objection. He will ask how one can speak of "shrinking" if it is only a matter of a chronic contraction of the autonomic system. Is there not the possibility that the contraction will subside and that the function of complete pulsation will be restored? Should one not make a distinction between "chronic contraction" of the autonomic system, on the one hand, and its "shrinking" on the other? Could not the shrinking be a result of the chronic contraction, a gradual and premature dying off of the vital apparatus?

The objection is correct. The biopathic shrinking in cancer is, in fact, the result of a chronic contraction of the autonomic apparatus.

II. VEGETOTHERAPEUTIC CONSIDERATIONS.

The connecting link between sexual function and cancer disease is formed by the following facts with which sex-economic clinical experience has made us familiar:

1. Poor external respiration which in
turn leads to a disturbance of the internal respiration in the tissues.

2. The disturbed function of bio-electrical charge and discharge of the autonomic organs, particularly the sexual organs.

3. The chronic spasms of the musculature.

4. Chronic orgasmic impotence.

Up to now, the connection between disturbances in the discharge of sexual energy and cancer has not been investigated. Experienced gynecologists are well aware of the fact that such a connection exists. Respiratory disturbances and muscular spasms are the immediate result of a fear of sexual excitation (orgastic impotence). Organs with poor respiration, organs which are spastic and insufficiently charged, are biologically weakened; thus, they are highly susceptible to cancer-producing stimuli, whatever they may be. On the other hand, organs which function biologically normally are not affected by these same stimuli. This is a necessary and logical assumption.

These clinically well-established facts—deficient biological charge, muscular spasm and deficient external and internal respiration—give the concept of “cancer disposition” a tangible content. I shall now attempt to show how sex-economic clinical experience led to cancer research.

Sex-economic observation of character neuroses showed again and again the significance of muscular spasms and the resulting devitalization in the organism. Muscular spasm and deficiency in bio-electrical charge are subjectively experienced as “being dead.” Muscular hypertension due to sexual stasis regularly leads to a diminution of vegetative sensations; the extreme degree of this is the sensation of the organ “being dead.” This corresponds to a block of biological activity in the respective organ. For example, the blocking of biosexual excitation in the genital always goes with a spastic tension of the pelvic musculature, as is regularly seen in the uterine spasms of frigid women. Such spasms often result in menstrual disturbances, menstrual pains, polyps and fibromata. The spasm of the uterus has no other function than that of preventing the biosexual energy from making itself felt as vaginal sensation. Spasms representing inhibitions of vegetative currents are seen particularly frequently whenever we find annular musculature, for example, at the throat, at the entrance to and the exit from the stomach, at the anus, etc. These are also places where cancer is found with particular frequency. The disturbance in biological charge of a gland, a region of the skin or a mucous membrane is produced and maintained by a muscular spasm in the neighborhood of the affected site; the spasm prevents biological energy from charging the respective site.

In a woman whom I treated vegetotherapeutically, X-ray showed a beginning cancer of the 4th costal cartilage on the right side. This was due to a chronic spastic contraction of the right pectoralis muscle. This contraction represented a strong holding back in the shoulders because of repressed beating impulses. The woman had never experienced an orgasm and suffered from compulsive flitting.

In vegetotherapy, we see not only character neuroses, but also, of course, schizophrenic, epileptic, Parkinson-like, rheumatic and cancerous disturbances. If an organic disease develops, this may take place during the course of the treatment or afterward; in the latter case, one will remember the signs that foreshadowed the disease. The most frequent finding is spasms in the pelvic musculature in women, resulting, in the majority of cases, in benign tumors of the genital organs.

Vegetotherapeutic clinical observations raise the question as to the fate of the somatic sexual excitation when its normal discharge is barred. We know only that the biosexual excitation can be reduced or
inhibited by chronic muscular tensions. In female patients, these tensions often show in the form of hard lumps in the uterus. The spasm of the uterus usually spreads to the anal sphincter and the vagina, and beyond that, to the adductors of the thigh. The pelvis is always retracted, the sacral spine often stiff and ankylosic. Lumbago and pathological lordosis are typical manifestations of this condition. In the pelvis, any vegetative sensation is absent. During expiration, the wave of excitation is inhibited by the pulled-up chest and the tense abdomen. The excitation of the large abdominal ganglia does not progress to the genital organs and thus a disturbance of biological functioning necessarily results. The genitals are no longer capable of biological excitation.

Many women who suffer from genital tension and vaginal anesthesia complain of a feeling that "something is not as it should be down there." They relate that during puberty they experienced the well-known signs of biosexual excitation; and that later they learned to fight these sensations by way of holding their breath. Later, so they relate in a typical manner, they began to experience in the genitals a sensation of "deadness" or "numbness," which, in turn, frightened them. As the vegetative sensations in the organs are an immediate expression of the actual biological state of the organs, such statements are of extreme importance for an evaluation of somatic processes. (The fact has to be kept in mind that patients are rarely able to comprehend or describe their organ sensations spontaneously; it takes character-analytic exploration to make them able to do so).

The following case illustrates in a singularly simple manner the immediate connection between character armoring, muscular spasm and the onset of a cancer tumor.

A man of 45 came to my laboratory because of a complete obstruction of the esophagus by a cancer tumor. He was unable to take solid food at all; liquid food he soon vomited. Xrays showed a shadow the size of a small fist and a complete obstruction in the middle of the esophagus. The patient was rapidly losing weight and strength; there was a severe anemia and T-bacilli intoxication. The anamnesis revealed the following facts: Several months previous to the onset of the complaints, his son had been drafted for the army. This son was the patient's favorite; he became worried and deeply depressed. (He had always had a tendency to depression.) In the course of a few days, he developed a spasm of the esophagus. He had difficulty in swallowing; this disappeared, however, when he took a drink of water. At the same time, he had a sensation of oppression in the chest. These disturbances kept coming and going for some time, until finally they became stationary. The difficulty in swallowing increased rapidly. He went to see a physician who found the constriction and a small tumor. Treatment by Xray did not help, and in the course of a few months the man got to the point of starving to death. I should like to add that he had suffered since childhood from a severe spasm of his jaw musculature; his face had a hard, rigid expression. Correspondingly, his speech was inhibited; as a result of the tension in his jaw muscles, he talked through his teeth.

The extent of the devastating results of the inhibition of the natural biological rhythm—as it is expressed in respiration and the alternation of sexual tension and gratification—can as yet not even be guessed at. Deficient external respiration must of necessity lead to a deficient internal respiration of the organs, that is, a deficient supply of oxygen and elimination of carbon dioxide.

When, some years back, I began to
comprehend the significance of the respiratory disturbance for emotional disturbances, I remembered the findings of Otto Warburg concerning the metabolism in cancer tissue. Warburg found that all the various cancer-producing stimuli have one thing in common: they produce a local oxygen deficiency as a result of which there is a disturbance of respiration in the respective cells. Thus, the cancer cell is a poorly breathing cell. Warburg considers this oxygen lack in the cells one of the causes of cancer, in the following manner. In certain places, only such cells will develop as are capable of overcoming the respiratory disturbance. The cancer cells originate from such cells. It is a matter of a disturbance in the energy metabolism. The respiratory disturbance is characteristic of all known malignant tumors, including the Rous' sarcoma. The metabolism of cancer cells, thus, has to be regarded as an anoxic condition of normally growing cells. From this correct finding of Warburg we cannot, however, draw the conclusion that the cancer cell is nothing but a normal cell taking on a different mode of growth under the influence of oxygen lack. In reality, the cancer cell is—biologically speaking—basically different from the normal cell. It is nothing but a protozoal formation. (This will be shown in detail elsewhere.)

As stated before, these facts form the connecting link between the autonomic functions and the disease of cancer.

III. FROM THE CASE HISTORY OF A CANCER PATIENT. AN ATTEMPT AT VEGETOTHERAPY.

I shall now give the history of a cancer patient which lends itself particularly well to a demonstration of the nature of the shrinking biopathy.

The patient's brother related that her first complaint was a violent pain in the right hip bone. The pain was constant and "pulling." At this time, her weight was about 125 lbs. Her physician diagnosed a sacro-iliac spasm. She was incapable of rising from the examination table. She was given injections of morphine and atropine, to no avail. The pain continued unabated and the patient was unable to leave her bed, where she lay flat and immobile. Three months after the onset, the patient began to vomit. At about the same time, the pain moved to the region of the fifth cervical vertebra. X-rays showed a collapsed vertebra. An orthopedic surgeon put the patient in a plaster cast. He was the first to find a collapse of the roth dorsal vertebra, a metastasis from a cancer of the left breast. A biopsy confirmed the diagnosis of cancer. The patient was given X-ray treatment of the pelvis and the spine and was sterilized by X-ray. She was constantly in bed. When she left the hospital after the X-ray treatment, the patient weighed 90 lbs.

The hospital case history showed the following data: Four months before admission, there were pains in the right hip which increased with walking and which made it difficult for the patient to sit down. The following is striking: the pains which kept the patient in bed for over two years did not set in originally at the place where the tumor was diagnosed. The pains were in the right hip; the primary tumor, however, was in the left breast, and several metastases were in the spine.

The patient also suffered from vomiting. The record states that she would lie flat in bed and was unable to move on account of her pains. She had no enlarged lymph glands. The tumor of the breast measured about 3 x 2 x 6 cm. Her legs showed limited motility, the sacrum was dislocated and stiff. Most of the spine was painful. The hospital diagnosis was: Carcinoma of the left breast with bone metastases. Four months after the onset of the pains, the

1 Cf., e.g., Biochemische Zeitschr., Bd. 317.
hospital physician pronounced the case hopeless.

Twenty-six months after the discovery of the breast tumor, the patient was brought to my laboratory, hardly able to walk, being supported by two relatives. The color of her skin, particularly of the face, was ashen gray. The pain in the back, sharply localized at the twelfth dorsal vertebra, was violent. The left breast showed a tumor the size of a small apple, hardly movable. Blood examination: Hemoglobin 35%; T-bacilli culture in bouillon strongly positive after 24 hours. There were rot bacteria; the erythrocytes were largely in bionous disintegration and showed T-bodies; there were small nucleated round cells and numerous T-bacilli. The autoclavation test gave predominantly blue bions, but the vesicles were small and showed very little radiation. Inoculation of the bouillon culture on agar resulted in clear-cut T-bacilli growth. These blood findings pointed to an extreme biological debility of the blood system. Xrays showed the following:

The fifth cervical vertebra is collapsed. No significant findings at the other cervical vertebrae.

The dorsal spine shows collapse of the tenth and twelfth vertebrae and a narrowing of the joint space between the third and the fourth vertebra. There is also strong suggestion of a metastatic lesion at the medial third of the right ninth rib.

No lesions are present at the lumbar spine, but there are three round areas of lesser density at the right ilium near the sacro-iliac joint which are very suggestive of metastatic lesions, although they might be gas shadows of the cecum.

Conclusions: Multiple metastatic bone lesions.

On the basis of the Xray pictures, the physician to whom I had sent the patient for a general check-up considered the case hopeless. I was less impressed by the Xray pictures than by the biological debility of the blood. Two physicians, friends of the family, declared that the patient would live hardly more than two weeks, while another physician, on the basis of the information from the hospital, thought it was a matter of at most two months.

The Muscular Armor

The vegetative habitus of the patient, when first seen, was as follows: The chin seemed immobile; the patient talked through her teeth, as if hissing. The jaw muscles were rigid, as was the superficial and deep musculature of the neck. The patient held her head somewhat pulled in and thrust forward, as if she were afraid that something would happen to her neck if she were to move her head. This vegetative attitude of head and neck seemed, at first glance, sufficiently explained by the fact that her fifth cervical vertebra was collapsed. She had been wearing a plaster collar for some time, and there was a good reason for fearing a fracture of the cervical spine with rapid or extreme movements. The patient's neurosis made the best of this situation. As was shown later, the fear of moving the neck had been present long before the collapse of the vertebra.

More than that: this attitude of the neck was part and parcel of a general vegetative attitude which was not a result but the cause of her cancer disease.

The reflexes were normal. Respiration was severely disturbed. The lips were drawn in and the nostrils somewhat distended, as if she had to draw in air through the nose. The thorax was immobile. It did not perceptibly participate in respiration and remained constantly in an inspiratory position. When asked to breathe out deeply, the patient was unable to do so; more than that, she did not seem to understand what she was asked to do. The attempt to get the thorax into the expiratory position, that is, to push it
down, met with a vivid active muscular resistance. It was found that head, neck and shoulders formed a rigid unit, as if any movement in the respective joints were impossible. The patient was able to move her arms only very slowly and with great effort. The handclasp, both left and right, was very weak. The scapular muscles were extremely tense, standing out like taut cords. The muscles between the shoulder blades were sensitive to touch.

The abdominal wall was also tense and reacted to the slightest pressure with a marked resistance. The musculature of the legs seemed thin, as if atrophic, compared with the rest of the musculature. The pelvis was immobilized in a retracted position.

Superficial psychological exploration revealed the following: The patient had been suffering from insomnia for many years previous to the discovery of the cancer. She had been a widow for 12 years. Her marriage, which had lasted two years, had been unhappy. In contradistinction to the many cases of marital misery where the awareness of the unhappiness is absent, the patient had always been fully aware that her marriage was a failure. During the early months of her marriage, she had been much excited sexually and at the same time unsatisfied. Her husband had shown himself to be impotent. When, finally, the sexual act succeeded, he suffered from premature ejaculation, and the patient continued to be unsatisfied. During the first few months, her lack of sexual gratification made her suffer keenly; later, however, she “got used to it.” She had always been fully aware of the necessity of sexual gratification, but had found no way of obtaining it. After the death of her husband, she devoted herself to the education of her child, refused any contact with men and withdrew from social activity. Gradually, her sexual excitation subsided. In its place, she developed anxiety states; these she combatted by way of various phobic mechanisms. At the time when I first saw her, she no longer suffered from anxiety states; she appeared emotionally balanced and somehow reconciled to her sexual abstinence and her personal fate in general. She presented the picture of neurotic resignation with which the character-analyst is so familiar; she no longer had any impulse to change her life situation. I avoided going any deeper into the patient’s latent conflict and concentrated my attention on the organic changes which soon took place.

THE RESULTS OF THE ORGONE EXPERIMENT

A detailed presentation of the technique of orgone therapy will be given elsewhere. Here, I shall mention only the essentials.

Our orgone therapy experiments with cancer patients consist in their sitting in an orgone accumulator. The orgone energy which is concentrated in the accumulator penetrates the naked body and is also taken up by way of respiration. The duration of the individual session depends on the atmospheric orgone tension which is measured electroscopically. I began with sessions of 30 minutes.

During the first session the skin between the shoulder blades became red; this was a region which two months later was to play an important role in the patient’s functional disease. From the second session on, the reactions in general were more distinct and intense. The pain in the region of the tenth dorsal vertebra regularly decreased during the treatment; this improvement usually lasted until the next session. Humid and rainy weather always intensified the pains. During the second session, the redness of the skin spread to the upper part of the back and the chest. When the patient interrupted the irradiation for a few minutes, the redness disappeared, to return as soon as she

1 The technical details of electroscopic measurement of the orgone concentration will be dealt with in a special article.
went back into the box. Beginning with the third session, the patient felt that the air in the box was “closer and heavier.” She said, “I feel as if I were filling up,” “I have a buzzing around the ears from the inside,” “Something clears up in my body.” During the third session, she began to perspire, particularly under the arms; she related that during the past few years she had never perspired.

All these reactions of the organism to the orgone radiation are typical in all cancer patients. In one patient one reaction will predominate, in another a different one. Such phenomena as redness of the skin, lowering of the pulse rate, warm perspiration and the subjective sensations of “something in the body getting loose, filling up, swelling,” etc., admit of only one interpretation: The cancer habitus is determined by a general sympatheticotonia, that is, vegetative contraction. For this reason, we find in most cancer patients rapid pulse, pallor, and dryness of the skin, often with a cyanotic or livid coloration, reduced motility of the organs, constipation, and inhibition of the sweat glands. The orgone radiation has a vagotonic effect, that is, it counteracts the general sympatheticotonic shrinking of the organism. In the accumulator, the pulse will come down from 120 to 90 or from 150 to 110 within twenty minutes; this without any medication. Similarly, there is redness of the skin, and perspiration; the peripheral blood vessels dilate and the blood pressure decreases. Expressed in terms of biological pulsation, this means that the plasma system relinquishes the chronic attitude of contraction and begins to expand vagotonically. This expansion is accompanied by a reduction of the typical cancer pain.

The cancer pains are usually ascribed to local mechanical tissue lesions caused by the tumor. Doubtless this explanation is correct in one or the other case when the tumor presses on a nerve or a sensitive organ. The typical cancer pain, of which I am speaking here, however, has to be strictly distinguished from these local, mechanically caused pains. Let us call it “vegetative shrinking pain.” In order to understand its nature, we have to review a few hitherto generally overlooked facts.

Sex-economy had to give up the view generally held by medicine that the autonomic nerves in metazoa only transmit impulses but are themselves rigid. Such phenomena as the “pulling” pains remain unintelligible unless one realizes that the autonomic nervous system expands and contracts, that, in other words, it is mobile. This is confirmed, as stated before, by direct microscopic observation. We can see the fibers of the autonomic ganglia expand and contract; they move independently of the movements of the total organism; their movements precede those of the total body. The impulses appear first in the movements of the autonomic nervous system and are transmitted secondarily to the mechanical locomotor organs of the organism. This fact sounds revolutionary and strange. Yet it is, really, only a simple conclusion which I had to draw from the functions of pulsation in the organism and which afterward I was able to demonstrate by direct observation. In the metazoon, the contracting and expanding ameba continues to exist in the form of the contracting and expanding autonomic nervous system. This autonomic system is nothing but organized contractile plasma. Thus, the emotional, vegetative, autonomic movement is the immediate expression of the plasma current. The prevalent concept of the rigidity of the autonomic nerves is incompatible with every single phenomenon of biophysical functioning, such as pleasure, anxiety, tension, relaxation, and the sensations of pressure, pulling, pain, etc. On the other hand, the contractility of the autonomic nervous system, which forms a functional and histological unity (“syncytium”), ex-
plains in a simple manner our subjective vegetative sensations. What we experience as pleasure is an expansion of our organism. The autonomic nerves, in pleasure, actually stretch out toward the world; the whole organism is in a state of vagotonic expansion. In anxiety, on the other hand, we feel a crawling-back into the self, a shrinking and tightness. What we experience here is the actual process of contraction in the autonomic nervous system.

The orgasm we experience as an involuntary expansion and contraction; this reflects the actual process of expansion and contraction in the total plasma system. The pain in cancer patients reflects the fact that the autonomic nerves retract from the diseased region and “pull” on the tissues. The expression “pulling” pain describes an actual process. It takes a mechanistically rigid, unalive, unbiological and unpsychological attitude to deny the simple and unequivocal fact that our organ sensations are identical with the actual processes in the autonomic system. Such a mechanistic concept relegates our organ sensations to the realm of metaphysics and cannot do justice to a single aspect of the cancer syndrome.

We understand now the seemingly strange phenomenon that in the orgone accumulator cancer pains regularly diminish or disappear. If the pains are not the expression of a local mechanical lesion but of a general contraction of the autonomic nerves, of a “pulling” at the tissues, then we understand that with the vagotonic expansion of the nerves the pulling, and with that the pain, subsides.

This fact reveals an essential effect of the orgone energy: it charges living tissues and causes an expansion of the autonomic nerves (vagotonia).

The general vitalization of biological functioning by the orgone radiation is also reflected in the blood picture.

Our patient came with a hemoglobin of 35%. Two days later it was 40%; after four days, 51%; after a week, 55%; after two weeks, 75%, and after three weeks, 85%, that is, normal. The patient got up, took her child back to live with her and, after years of being bedridden, began to work again. She was inclined to overdo things; she went shopping, spending hours at a stretch in department stores. She was free from pain, slept well and felt entirely well. She did her housework all by herself. I had to remind the patient of the fact that she was getting over a very serious illness and had to warn her to take it easy. My warnings were justified. After about 6 weeks, the patient began to feel tired, and the hemoglobin dropped to 63%. The pains in the back did not return, but she began to complain about difficulties in breathing and about a “wandering” pain in the ribs, in the diaphragmatic region. She was prescribed bedrest, and the hemoglobin content soon improved, returning to 85% after another week. The weight remained constant at about 124 lbs. After another four weeks, the hemoglobin was still 85%.

The patient was no longer brought to me by car; she came every day by subway. Her relatives and physicians were amazed. As to the physicians, I met with a peculiar attitude which is incomprehensible from a rational point of view, an attitude which appears when, for a change, the case of a cancer patient is not hopeless. They did not ask how the improvement had been brought about. At the beginning, I had sent the patient to a physician who predicted that she would die within a few days. Now, the same patient was up and around and her Xray pictures showed complete ossification in a previously cancerous spine; similarly, the shadows in the pelvic bone had disappeared after two weeks’ treatment. Yet, none of the physicians showed any interest in what was going on.

These Xray pictures showed the healing process unequivocally. They confirmed
what I had seen so often in my cancer experiments with mice: the orgone energy arrests the growth of the tumor and replaces it by a hematoma which—under favorable conditions—is eliminated by connective tissue or, if the tumor is in a bone, by calcification.

**BIOLOGICAL BLOOD TESTS**

I shall give here a brief résumé of what will be presented in detail elsewhere: the orgone energy charges the red blood corpuscles.

Every individual erythrocyte is an independent orgonotic energy vesicle. It follows the same pulsation and function of tension and charge as the total organism and each of its organs. With a magnification of about 3000x, expansion and contraction of the erythrocytes can easily be observed. Under the influence of adrenalin, the erythrocytes shrink, with potassium chloride they expand; that is, they follow the antithesis of pleasure and anxiety.

Our blood tests in cancer patients are done as follows:

1. **Culture test.** A blood sample is tested for bacterial growth in bouillon or in a mixture of 50% bouillon plus 50% KCl (0.1 n). The blood of advanced cancer patients regularly gives a strong growth of T-bacilli (cf. "Bion experiments on the Cancer Problem," 1939).

2. **Biological resistance test.** A few drops of blood in bouillon and KCl are autoclaved for half an hour at a steam pressure of 15 lbs. Healthy blood withstands the autoclavage better than the biologically devitalized blood of cancer patients. Biologically vigorous erythrocytes disintegrate into large blue bion vesicles. Devitalized erythrocytes in cancer blood disintegrate into T-bodies. Depending on the degree of devitalization, the content in T-bodies increases and that of blue bions decreases.

   The orgone treatment charges the erythrocytes. This is shown by the fact that the T-reaction changes into a B-reaction; that is, the blood becomes more resistant to destruction by high temperatures.

3. **Disintegration in physiological salt solution.** A small drop of blood is put on a hanging-drop slide in 0.9% NaCl solution. According to their biological resistance, the erythrocytes disintegrate slowly or rapidly. The more rapidly they disintegrate, and the more rapidly their membrane shrinks and they form bion vesicles on the inside, the lower is their biological resistance. Biologically vigorous erythrocytes can retain their shape for 20 minutes or longer. Disintegration within 1 to 3 minutes indicates extreme biological weakness. In the case of marked anemia, the erythrocytes show the typical T-bodies, i.e., shrinking of the membrane.

4. **Blue orgone margin.** When observed with apochromatic lenses at a magnification of 2-3000x, biologically vigorous erythrocytes show a wide margin of an intense blue color. Devitalized erythrocytes with a tendency to rapid disintegration show a very narrow margin with a weak blue coloration.

In our patient, the blood tests showed a general biological strengthening of the blood. When the patient first came, the blood cultures were strongly positive, that is, they showed intensive growth of T-bacilli. Three weeks later, the cultures were negative and remained so. The erythrocytes no longer showed shrinking and had a wide margin of deep blue. The autoclavage test resulted in 100% bionous disintegration and no longer in a T-reaction. The disintegration in salt solution now took place very slowly and without the formation of T-bodies.

The patient was free from pain and felt generally well, except that she reacted with malaise to rainy weather. She regularly came for her daily orgone treatment. The blood pressure remained constant at about 130/80. The pulse rate was and remained normal. There was only one symptom which not only failed to disappear but became more pronounced. This was a respiratory disturbance which at first was ill-defined.
I shall proceed now to a description of
the cancer biopathy which made its ap-
pearance only after the elimination of the
tumors and the restoration of the normal
blood picture. I did not have the faintest
inkling of what I am going to describe
here; I experienced it at first with utter
amazement and lack of comprehension.
It was difficult to understand the connec-
tion between the two series of phenomena.
What happened was this: After the cure
of the local cancer tumors, a general vege-
tative disease picture appeared which pre-
viously had been hidden and which formed
the actual background of the cancer dis-
case: the shrinking biopathy.
The patient seemed to have regained her
complete physical health. This happy state
of affairs lasted about six weeks and was
objectively confirmed by the blood tests
and the X-ray pictures. The tumors had
disappeared. The blood remained healthy,
the anemia did not recur. The tumor in
the left breast was no longer palpable after
the eighth orgone irradiation. With purely
mechanistic pathological concepts, one
would have proclaimed a “cure” of this
cancer case. At the same time, however,
certain emotional symptoms became more
and more pronounced and kept one from
jumping to premature conclusions.
At the time when the patient first came
she had not felt any sexual desire for a
long time. About four weeks after the
beginning of orgone therapy I observed
in her signs of sexual stasis. Up to that
point, she had been gay and full of hope
for the future; now, a depression began
to set in and she developed signs of stasis
anxiety. She began to withdraw from
people again. As I learned from her, her
attempts to straighten out her sexual situ-
ation had failed. She related that for some
time now she had been suffering from
intense sexual excitation; these excitations
were much more intense than those which
she had experienced 14 years earlier, at
the beginning of her marriage, and which
she had fought then. To judge from her
description, it was a matter of normal vagi-
nal excitations. During the first two
weeks of getting well, she had made a
few attempts to establish sexual contact;
failing in this, she became depressed and
felt physically exhausted. These attempts,
which were entirely healthy, were contin-
ued for several weeks. One day she asked
me whether it would be harmful to have
sexual intercourse “once a month.” The
question had an apprehensive ring to it
and was at variance with her sexual
knowledge. It pointed to an irrational fear:
she began to develop the fear that a dan-
gerous accident would happen to her in
sexual intercourse, since, as she said, “her
spine was demolished in two places.” She
was afraid of what might result from the
violent motions connected with sexual
excitation. It is to be noted that this idea
did not appear until after the failure of
her attempts to find a sexual partner. She
had met a man who proved impotent.
She became furious but fought back her
hatred and disillusionment. When another
attack of anger would come, she would
“swallow her anger.” Now, the patient
presented the complete picture of a stasis
neurosis. The depression became more se-
vere and she suffered from uncontrollable
crying spells; she felt “a dreadful pressure
in her chest—it goes through and through.”
One might have been tempted to ex-
plain this “pressure in the chest” on the
basis of the collapsed 12th dorsal vertebra.
But simple consideration contradicted this
assumption. For six weeks the patient had
had no pain in spite of working hard; it
was inconceivable that a mechanical pres-
sure of the collapsed vertebra on a nerve
should now suddenly become effective
after not having made itself felt for weeks.
What followed showed that the patient
was developing an anxiety hysteria. This
neurosis made use of the spine lesion as a
THE CARCINOMATOUS SHRINKING BIOPATHY

rationalization. It was to be expected that from now on every psychiatrically untrained physician would ascribe all symptoms to the collapsed vertebra, overlooking the fact that this same vertebra had been no less collapsed at the time when the patient was going around without pain for a number of weeks.

After about ten orgone irradiations, the patient had begun to experience sexual excitation. The orgone energy had charged her biosexually, but she was unable to handle the sexual excitation. The anxiety neurosis which she now developed was only a reactivation of old conflicts; in puberty, she had suffered from similar states. The patient now found herself in the tragic situation of waking up to new life, only to be confronted by a nothingness. As long as she was ill, the tumor and the resulting suffering had absorbed all interest. Indeed, her organism had used up great amounts of biological energy in the fight against the cancer. These energies were now free, and in addition were amplified by the orgonotic charge. In a phase of particularly intense depression the patient confessed that she felt herself ruined as a woman, that she felt herself to be ugly and that she did not see how she could suffer this life. She asked me whether the orgone energy could cure her anxiety neurosis also. This, of course, I had to deny, and the patient understood the reason.

Summarizing the sequence of events, we have the following:

1. In the beginning of the marriage, a severe stasis neurosis due to the husband's impotence.
2. Repression of sexual excitation, resignation, depression and a decade of abstinence.
3. The sexual excitations disappear while the cancer disease develops. As we shall see later, the cancer metastases developed exactly in those organs which played a dominant part in the muscular armor which repressed the sexual excitation.
4. Elimination of the tumors by the orgone energy, physical recovery of the patient and reappearance of sexual excitationability.
5. The high-pitched sexual excitation ends in disappointment; the old stasis neurosis reappears.

This constellation then resulted in a general shrinking of the vital apparatus.

One day there occurred a mishap. The patient left the orgone box and began to dress. She bent over to pick up a stocking and suddenly let out a shriek. We found her pale, with a thready pulse, on the point of fainting. We became frightened because we did not know what had happened. We, too, felt the collapsed vertebra to be a Damocles' sword. Nobody knew when the patient might suffer a fracture of the spine. Just because this fear seemed justified, it lent itself so well to a rationalization of the patient's neurosis. When the patient calmed down it was shown that she had only experienced a fright. For a moment she had believed that by her swift movement she had really broken her spine. Actually she had only suffered a slight strain at the shoulderblade; she had made too swift a movement with a hypertonic muscle. During the next few days, the patient felt well, but four days later she complained of heavy "pressure in the chest" and "weakness in the legs." During these days, the reflexes were normal. Three days later she again felt more strength in her legs, but the pressure in the chest persisted. On one of the following days, during a conversation in the treatment room, the patient suddenly cried out and doubled up, so that everybody present immediately thought of a fractured vertebra. Yet, all reflexes were absolutely normal. But now there was a new symptom which kept the patient in bed for many months and which deceived a number of physicians.

When the patient doubled up, she
stopped breathing; she no longer could breathe out properly and kept gasping for air. I had the impression of a spastic contraction of the diaphragm, a diaphragmatic block.

The pain in the lower ribs about which the patient now complained could be ascribed either to this spasm or to the mechanical pressure of the collapsed vertebra on a sensory nerve. The collapsed 12th vertebra corresponded to the costal insertion of the diaphragm. What happened during the ensuing months was essentially a clash of opinions as to which of the two interpretations was correct. I advised the relatives to take the patient to the orthopedic surgeon whom she had consulted previously. The surgeon declared that the spine and the pelvis were free of shadows and metastases and that the patient’s condition was due to a mechanical lesion at the 12th dorsal vertebra. What had made the metastases disappear he did not inquire about. He prescribed bedrest in a plaster cast. The patient’s brother refused to take this advice because he had followed the course of his sister’s disease with great understanding and was convinced of the correctness of my interpretation.

It was during this period that I first began to understand the connection between the lesion of the 12th vertebra and the biopathic contracture of the diaphragm. It could be no accident that the diaphragmatic spasm—a symptom so well known to the vegetotherapist—should appear just at this time. There also seemed to be significance in the fact that one of the main metastases had appeared just at the insertion of the diaphragm. This concurrence of diaphragmatic spasm and lesion of the vertebra complicated the clinical diagnosis considerably; on the other hand, it opened an avenue of approach to the understanding of the extremely important connection between emotional muscle spasm and the localization of metastases. One of the tasks of this series of articles will be to demonstrate the fact that the localization of a cancer tumor is determined by the biological inactivity of the tissues in its immediate neighborhood.

The orgone treatment had to be interrupted because the patient was again bedridden. Renewed examination at a cancer hospital and by private physicians revealed calcification of the defects in the spinal column and the absence of cancer growths. The original breast tumor did not reappear. But nobody could foresee whether or not new cancer growths might appear. I saw the patient repeatedly at her home. She complained of violent pains in her lowermost ribs. The pain was neither constant nor definitely localized; it appeared at various places along the costal margin and could always be eliminated by correcting the breathing. The whole thing looked like a neuralgia with a marked hysterical component. The patient lay flat in bed and gave the impression of being completely unable to move. If one tried to move her arms or legs, she would cry out, become pale and would break out in a cold sweat. A few times I succeeded in getting her out of bed into an easy chair by making her breathe deeply for about 10 minutes. The relatives were amazed that I should be able to eliminate the pain so easily. They had seen the tumors disappear and had had this confirmed by outside physicians. As I worked without drugs or injections, my orgone therapy seemed mysterious. In order to counteract this impression, I tried to explain to the relatives the mechanism of the disturbance. They realized very soon that the pain could not be due to the lesion of the vertebra, otherwise it would have been sharply localized and it could not have been eliminated by improved respiration. At that time, I had as yet no idea of the fact that in reality the patient did not have any pain but a panic-like fear of the onset of pain.

An intercostal injection of an anesthetic
was tried at the point where the pains were most violent. The anesthetic had no effect; shortly after the injection the pains appeared at another rib. The physicians who had been convinced that the pains were the result of the vertebral lesion finally had to admit that they were essentially "functional." But nobody could tell what was the "meaning" of the "functional" symptom. In addition, to most physicians "functional" means "not organic," that is, "not real but imaginary."

One day I found the patient again in violent "pain." She was gasping for air and produced peculiar groaning sounds. The condition seemed serious, but gave way promptly when the patient succeeded in breathing down and when the spasm of the jaw muscles was released. I turned over the work on the respiration to a colleague because I was going away for two months. He reported later that again and again it had been possible to eliminate the pains by the establishment of full expiration.

The patient was taken to a cancer hospital once more. The hospital physician confirmed again the complete absence of metastases in the bones. He doubted that X-ray therapy would eliminate the pains or that a surgical procedure at the nerve of the 12th segment would help. This was 5 months after the initiation of the orgone therapy, and 3½ months after its interruption. When the patient's brother told the hospital physician about the result of the orgone therapy, he became very reserved. He said he could not go into that until it was "recognized by official medicine." He overlooked the fact that he himself was a representative of "official medicine" to which he shifted the responsibility for the recognition of the results of the orgone therapy in this cancer case.

The patient soon returned home and continued to lie flat in bed. The atrophy (of disuse) of her muscles progressed, and the danger of a recurrence of the tumors was considerable. A month later, I saw the patient again. I succeeded again in eliminating the pains by improving respiration. The patient was able to get out of bed but felt very weak. One day, during one of these attempts to stay out of bed, I saw the patient develop severe anxiety; she implored me to be allowed to go back to bed. At that moment, she had no pains. I insisted on her staying up. All of a sudden, she began to tremble violently, was scared, broke out in a cold sweat and turned pale. In other words, she experienced a violent, shock-like reaction of the autonomic system to the standing up. I did not let the patient go back to bed because I noticed that some fear made her want to go back to bed. A few moments later, there were visible convulsions in the upper abdomen, and she gasped for air; the chronic spasm of the diaphragm dissolved itself into clonic convulsions of the abdominal musculature. After this, she felt greatly relieved and was able to move about freely.

Now, I understood a basic feature of biopathy. The biological charging of her organism by the orgone had resulted in sexual excitations; to these, she had reacted with a contracture of the diaphragm. (The repression of sexual excitation by way of a chronic attitude of inspiration is a phenomenon well known to the vegetotherapist.) This contracture of the diaphragm apparently caused the "pressure in the chest" and the pain-like sensations which were ascribed to the collapsed vertebra. The pressure in the chest disappeared every time I succeeded in overcoming the inspiratory spasm and thus in restoring the pulsatory movement of the diaphragm. But it was just these contractions and expansions of the diaphragm which caused violent anxiety which the patient tried to escape by falling back into the inspiratory attitude. As was shown now, the "danger" of a clonic dissolution of the contracture was too great when the patient was stand-
ing up or walking around. The danger consisted in the violent convulsions which threatened to dissolve the diaphragmatic spasm. She did not dare leave her bed because she was very much afraid of these convulsions. It was this fear, then, which kept her in bed, although it was not the exclusive motive for staying in bed.

Doubtless, the diaphragmatic spasm created neuralgic pains in the ribs and at the insertion of the diaphragm. But this spasm accounted only in part for her enormous fear of motion; the more important part was her fear that if she moved she would "collapse" or "break her back."

The involuntary convulsions of the diaphragm which threatened to set in when she got up only seemed to justify this fear. Thus, she really did not suffer from acute pains, but from a tremendous fear of sudden violent pains. This fear was further increased by the experience of a few months before, when "something seemed to crack when she moved too suddenly." In other words, she suffered from a misinterpretation of normal vegetative sensations such as accompany the movement of the diaphragm. Her staying in bed was a strong defense mechanism against the fear of "breaking apart." This fear would arise as soon as the diaphragmatic spasm was about to dissolve itself into clonic movements. This she would counter with an intensification of the diaphragmatic contracture. Of course, this fear and her reaction to it led to the experience of a general muscular tension which was to prevent any motion; the long duration of the consequent immobility led to an atrophy of the musculature. For example, she was hardly able to lift her arms; when she lifted her left arm, she lifted it with the aid of her right. She was unable to lift her legs and hardly able to bend her knees. The head was kept rigid. Passive movement of the head was strongly resisted. The patient was afraid of "breaking her neck." All physicians had warned her against rapid movements because the fifth cervical vertebra was collapsed.

On one of the following days I found the patient in a very bad condition. In spite of a strong urge to defecate, she had not gone to the bathroom for several days, in order not to have to leave her bed. As on previous occasions, the "pains" disappeared when the patient was made to breathe, and she was able to get up. She had an enormous bowel movement without any difficulty.

I told her brother that I would undertake an attempt at vegetotherapy for two weeks (without remuneration), but that I would have to stop if it showed no results. She moved to my neighborhood and for the next few weeks I worked with her for about 2 hours every day. This work disclosed the phobic background of her biopathic condition.

THE CHARACTEROLOGICAL EXPRESSION OF THE SHRINKING BIOPATHY

Six months after the collapse in my laboratory the patient developed a paralysis of the rectum and the bladder. The question was whether this was due to a local mechanical lesion or, as I suspected, to a functional shrinking of the autonomic system. In the first case, emotional motives would be absent and the symptoms would point to a sharply localized lesion. In the second case, one would expect prominent emotional and character disturbances and an inconstancy of the paralytic symptoms.

When I explained to the patient again and again her fear of the pains, she became capable of moving in her bed without any pain. In order to be able to move, however, she always first had to mobilize her respiration and to loosen up the spasms of her jaw musculature. As she put it, she always had first "to get rid of the fear of moving." In the case of mechanical lesion of the nerve, this would not have been possible.

When she succeeded in turning on her
side or her stomach, she always seemed extremely exhausted. We looked for the reason for this peculiar exhaustion and finally found it in an extreme tension of the musculature of the neck and throat. The patient looked as if her head were being pulled into the thorax. It was the same attitude one involuntarily assumes to protect oneself against a sudden blow on the head. This muscular attitude was completely autonomic; the patient could neither control nor consciously loosen it. When this contraction of the musculature of the neck and throat occurred, respiration ceased and the patient's throat rattled as if she were choking. In order to loosen up the spasm, I had her stick her finger down the throat. To this she promptly reacted with a gag reflex which was so violent that she turned blue in the face. After a while she felt "greatly relieved in the throat."

In connection with these throat reflexes, she began to tell me spontaneously about her anxiety dreams. She dreamed every night, with intense anxiety, that she was falling into an abyss; that she was choking or that something was falling on her and she was being destroyed. With such dreams of falling the vegetotherapist is very familiar. They occur typically toward the conclusion of a character-analysis, at a time when pre-orgastic sensations in the abdomen and the genital begin to appear and are suppressed before becoming conscious. These sensations, if anxiety-laden, are experienced as falling. This is based on the following mechanism:

Pre-orgastic excitation is the onset of an involuntary convulsion of the plasma system. If the organism is afraid of this convulsion, it will develop—in the midst of an expansion which should end in a convulsion—a counteracting contraction, in other words, an inhibition of the expansion. This results in a sensation like that which one experiences when an elevator suddenly starts down or an airplane drops rapidly. The sensation of falling is the perception of a contraction of the autonomic system in the process of inhibiting an expansion. The typical falling dreams are often accompanied by a sudden contraction of the total body.

In the case of our patient this means the following: She reacted to vagic sensations of expansion regularly with spastic contractions; her organism became fixated, as it were, in the muscular spasms in the throat and the diaphragm, as if "not to lose hold." The fear of the convulsions diminished considerably when I succeeded in eliminating the spasms by eliciting the gag reflex. Then the movements which she executed in bed no longer resulted in spasms but in pleasurable sensations.

Every plasma current begins with a central contraction (tension) which dissolves itself into a vagic expansion;¹ the vagic expansion goes with the sensation of pleasure; in the case of orgasm anxiety, it is inhibited and results in muscular spasms. We understand now: The patient suffered from a spastic reaction to vagic expansion as the result of orgasm anxiety. Biopathic shrinking begins with a spastic restriction of biological pulsation. It differs from the simple sympatheticotonic stasis neurosis insofar as, here, the impulses to expansion gradually subside, while in the stasis neurosis they maintain their intensity. A sharp distinction, however, cannot be drawn.

This mechanism of spastic reaction to vagotonic impulses of expansion functioned in a different manner in the different muscle systems. For example, when I tried to move the patient's arms passively, she always reacted with a contraction of the shoulder musculature and the flexors of the arms; the reaction was similar to the muscular negativism and rigidity in catatonics. The patient presented the picture of a flaccid paralysis of the arms. When I asked her to hit my arm, she was

¹ This can be directly observed in the ameba limax at a magnification of 2000x.
at first unable to do so. But when I made her imagine that she was now letting out her suppressed anger, she was able, within five minutes, to get rid of the paralysis and to hit quite freely. At the end, she experienced pleasure in the motion and the action. The paralysis seemed to have been eliminated to a considerable extent. Thus, the patient was able to overcome her fear of expansion and of the plasmatic pulsation temporarily. This regularly improved her general condition considerably.

The same thing could be observed when I sat her up passively in bed. She always became frightened, began to gasp for breath, turned pale and repeated several times, with an expression of severe anxiety, "You shouldn't have done that." But when I repeated the procedure several times she even became able to sit up by herself. She was absolutely amazed and said, "It's a miracle how this is possible."

From then on, I had the patient continue to elicit the gag reflex, bite the pillow, hit my arm, etc.; all this in order to produce clonic contractions in the musculature of the throat and the shoulders. I knew from vegetotherapeutic experience that biological energy which is bound in spastically contracted musculature can be released only by clonisms. So it was in this patient. After about half an hour of active production of various reflexes, involuntary clonic spasms began to set in in the musculature of the arms and the shoulders. The legs also began to tremble. This trembling could always be intensified by gentle flexion and extension.

When these spasms appeared for the first time, the patient became very much frightened. She did not know what was going to happen to her. It was the very same fear of involuntary contractions which she avoided by her spastic contractures. After a few minutes, however, she began to enjoy the spasms. Gradually, the musculature of the throat began to participate in the spasms; the patient was afraid she was going to vomit. At one point she looked as if she were going to faint. I asked her to give free rein to the spasms. After a while they became less intense: the biological energy had been discharged. She sank back in the bed exhausted; her face was red, her respiration deep and full. The gag reflex could no longer be elicited, and the patient said, "My throat is peculiarly free—as if a pressure had been taken away." Similarly, the pressure on the chest had disappeared.

On the following day, the patient breathed normally, and I proceeded to relieve the paralysis of the legs by producing clonisms of the leg musculature. This was possible to a certain degree by slowly moving the legs, which were bent at the knees, apart and again together. I had not prepared the patient for the pre-orgastic sensations which are likely to appear with the dissolution of contractures in the leg musculature. All of a sudden, she inhibited her respiration, set her jaw, turned pale and developed a facial expression which I can only describe with the word "dying." The reaction was so violent that I became frightened. There could, however, be no mechanical lesion, for I had moved the legs only very slowly and gently. The patient emitted sounds such as one makes with the most severe pains in the chest. The sounds were a mixture of groaning and rattling. From vegetotherapeutic experience I knew that this was the patient's reaction to vegetative currents in the genital. We know from vegetotherapy that orgastic sensations, when inhibited by orgasm anxiety, are experienced as a fear of dying; "dying" in the sense of falling apart, melting, losing consciousness, dissolving, "nothingness."

The patient groaned heavily, was pale and blue, turned her eyes up and seemed exhausted. Never before had I seen the neurotic reaction of dying so realistically. With all the work on disturbances of the orgasm I had done during twenty years,
I had still underestimated the depth at which the disturbances of the function of biological pulsation are at work. True, my contention had always been that the orgasm is “basic biological functioning per se.” But never before had I seen an organism “die” so realistically as a result of orgasm anxiety. I told the relatives that quite possibly the patient would not survive more than a few days. It was clear to me that the shrinking of her vital system might well continue into actual death. This being the case, I would have relinquished any further efforts had it not been for the fact that seven months earlier, when the patient first came to me, she had also been on the point of dying. There was nothing to be lost by going on and a great many insights into the nature of the shrinking biopathy to be gained.

The following day I was called on the telephone by the relatives who said the patient was actually dying, that she was hardly breathing at all and was unable to have a bowel movement. When I saw the patient, she really seemed to be dying. Her face was blue and sunken, she emitted rattling sounds and whispered, “This is the beginning of the end.” I found her pulse to be rapid but forceful. In the course of about fifteen minutes, I was able to establish a good rapport with the patient. I asked her whether she had—at any time previous to her developing tumors—the feeling that she was going to die. Without any resistance, she related that as a child she had often rolled her eyes up and played at “dying.” The rattling and groaning sounds which she made now were also familiar to her from her childhood. She used to make them when she felt a constriction in her throat; as she put it, “when something pulled together in her throat.” Now it became clear that the localization of one of the cancer metastases at the fifth cervical vertebra was due to a spasm of the musculature of the throat which had been present for decades. The sensation of constriction in the throat, the patient continued, went hand in hand with a pulling in of the shoulders and a tension between the shoulderblades, that is, at exactly the region where later the cancer pains developed.

Now that the patient talked with me wide awake and lively, I made her “play at dying.” Within a few seconds, she succeeded in producing consciously the same picture by which she previously had been overcome involuntarily. She turned her eyes upward so that the lids were closed except for a narrow slit through which the whites of her eyes were just visible, fixed her chest in the inspiratory position and emitted groaning and rattling sounds. It was not easy to bring her back out of this dying attitude; but the more frequently she assumed this attitude consciously, the easier it became for her to give it up again. This was entirely in accord with vegeto-therapeutic experience: by practice, an autonomic function can be made objective and finally subject to conscious control.

I asked the patient whether she thought that she was unconsciously committing suicide. She started to cry and said there was no point in going on living. Her illness had ruined her sexual attractiveness; she could never again be happy; and without happiness she did not want to live. I had the patient again elicit the gag reflex. Promptly, the clonic trembling in the arms and the throat reappeared, though not as strongly as the day before. She even succeeded in sitting up by herself, but her legs failed her. I had the impression that the upper part of her body was functioning while the lower part, from the hips down, failed to function.

For several days after this, the patient felt well and gay. One day, however, she suddenly relapsed into the dying attitude. I saw immediately that it was not playing, but that she was overwhelmed by her biopathic reaction. Her respiration was
shallow and labored, her nose pointed, her cheeks were sunken and her throat rattled heavily. I did not understand why this happened just at this point. She complained of violent pains and was completely unable to move. I succeeded again in restoring normal respiration. Again, intense clonic spasms occurred in the throat and the torso, but the lower extremities remained “dead.” I had her again elicit the gag reflex. After this, the spasms became more intense.

I noticed that the pelvis tended to participate in the spasms but that she held back. The spasms lasted for about ten minutes and then subsided. While previously one had had the impression of suffocation, now the patient showed definite vagotonic reactions: the face was flushed, the skin over the body was no longer pale. The pains due to the diaphragmatic spasm subsided. After a while, the patient began to talk. She was, as she said, afraid that “something was going to happen down there.” She related that up to the time when she came to me for treatment she had occasionally obtained sexual gratification by masturbation. This was a very belated correction of her earlier statement that she had been living in complete abstinence for over 10 years. As early as the first week of the orgone treatment, she had suppressed every impulse to masturbate because of phantasies of sexual intercourse with me. Since then she had not dared to touch her genital. The inhibition of masturbation, together with the fantasy, led to a stasis of sexual excitation, which, furthermore, was intensified by the biological charge by the orgone. The intensification of her sexual needs increased her anxiety. Thus she developed the fantasy that she might break her spine. The straining of the shoulder muscle when she tried to pick up her stocking seemed to confirm this fear, as if she had said to herself, “See, I knew it was going to happen.”

The day after she had told me about her masturbation phantasies, I found her in the best of moods, full of hope and without complaints. The talk of the day before had made it possible for her, for the first time in months, to masturbate again. She had experienced a good deal of satisfaction. She was now able to control her diaphragmatic spasm very well. She was constipated, but felt the urge for defecation; only her fear of motion kept her from going to the bathroom. She moved much more easily in bed. She was even able to sit up all by herself, which amazed and pleased her a good deal. For the first time, she understood the chain of causes and events: fear of spinal fracture → fear of pain → inhibition of respiration by diaphragmatic block → pain in the chest → fear of spinal fracture. Now, however, the inhibition of motion by the fear of pain did not set in so readily. The fear did not appear until the motion required a good deal of effort. We now understood the connection between her fear of spinal fracture and her fear of “motion.”

On the next day, I found the patient again with poor respiration, full of complaints, and assuming the dying attitude. She could not say what had brought this about. The relatives told me that the day before she had felt very well until the evening. Then things had taken a turn for the worse after the following episode. Her boy was in the bathroom adjoining her room. She heard a noise and got terribly frightened. All of a sudden she had the idea that the boy was closed in in a very small space and was going to be smothered. During the night she slept poorly and had a number of severe anxiety dreams, some of them falling dreams. All I could do on this day was to improve her breathing which reduced her complaints about the “pains.”

During the next few days, the patient felt much better, being able to move without pain and to lift her legs. During a treatment hour, she happened to get near
to the edge of the bed, whereupon she became pale, stopped breathing, and cried out. She was afraid of falling out of bed. Her reaction was clearly exaggerated and did not correspond to any real danger. She related spontaneously that the summer before, at the hospital, she had asked to have an additional bed put at each side of her bed, because she was afraid of falling out of bed. I lifted her toward the edge of the bed, and although I held her firmly, she yelled with fear. The fear of falling which was at the basis of her fear of motion was now quite evident.

On the next day she sat up in bed. She had no pain, but developed violent anxiety, broke out into a sweat and hysterical crying. She said she was going to die; that she had been fighting death for so long, but this was the end. She cried for her boy. She asked me for an injection which would make her die so that she did not have to suffer any longer. “I don’t want to get out of bed, I want to stay right here.” After a while, she quieted down and found to her great surprise that she was able to sit up without any effort. But gradually she developed violent clonic spasms all over her body, particularly intense at the shoulders. She was extremely afraid of these spasms; that was the reason for her staying in bed. Whenever she was forced to sit up she felt the spasms coming. She no longer had her fear of falling, but the connection was clear. The violent clonic spasms of her musculature formed the physiological basis of her neurotic fear of falling. During the night, she had nightmares of falling into great depths, of heavy things falling on her, of men attacking and threatening to choke her. Now she remembered that she had suffered from exactly the same anxiety states for a long time in adolescence. She also remembered a phobia she used to have at that age. When she would walk on the street and hear footsteps behind her, she would begin to run, for fear that “somebody was after her.” This fear usually was so intense that her legs “failed her” and she always had the feeling that she was going to fall down. She recognized in this the very same bodily sensation which she experienced when she had to sit up in bed now. Then also, her legs would fail her and she became afraid of falling. With that, she would have the sensation of a spasm of the diaphragm and would be “scared to death.”

All this shows unequivocally that the motor paresis of the legs was caused by a phobia, a phobia which had dominated her as far back as puberty, long before she had developed cancer. The paresis which she now had developed was nothing but an intensification of this old motor weakness in the legs. This old fear of falling now became associated with the idea of the spinal fracture and was thus thoroughly rationalized. The old phobia of falling was the real forerunner of her later paresis.

The next day, the patient was again able
to urinate, but three days later she became unable to control her anal sphincter. The reflexes were normal, but the patient's fear of sitting up returned.

She was again taken to a hospital for a general check-up. X-rays showed the spine, pelvis and legs free from metastases, but there were new metastases in the cranium and in the humerus. That is, the new tumors made their appearance far away from those regions which showed the paresis. Functional biopathy and carcinomatous growth had nothing to do with each other.

The patient remained at the hospital for two weeks. No neurological examination was done. The paresis of the legs was considered a result of the vertebral lesions; none of the physicians discovered its functional nature. They told the relatives that the patient would live for two weeks at best.

As nothing was done for the patient at the hospital except that she was given morphine injections, the relatives took her back home. I saw her on the day of her return. She was very apprehensive about her motions and stressed the fact that the hospital physicians had warned her to be extremely cautious in her motions because "the spinal column was pressing on the nerve and it might break." This admonition on the part of the physicians naturally confirmed and reinforced the patient's phobia. The relatives wished me to undertake another experiment with orgone in order to eliminate the tumors of the cranium. On that day, I was not able to palpate any tumors at the cranium.

I observed the patient for another four weeks at her home. During this time, all reflexes at the legs were normal, the bowels and the bladder functioned normally again. However, the atrophy of the musculature and the bones progressed rapidly. She had developed a putrid bed sore at the buttocks. The legs moved in reaction to painful stimuli, but showed few spontaneous impulses. She continued to have nightmares of men falling into an abyss, of an elephant charging at her and of being "as if paralyzed," unable to move. During the day, also, she felt anxiety in the eyes and in the chest. The pains had completely disappeared, but the fear of motion and of a spinal fracture persisted.

We had a special orgone accumulator built for her bed. The effect of the orgone showed itself in a reduction of the pulse rate from about 130 to between 80 and 90, in a general feeling of well-being and the disappearance of anxiety. The blood picture, which in the past few months had taken a turn for the worse (50% Hb., T-bodies, positive T-cultures, about 50% T on autoclavation) also improved rapidly. The impulses in the legs increased in frequency and intensity.

Then there occurred a sudden and unforeseeable catastrophe which sealed the fate of the patient. One night, as she moved in bed, she fractured her left femur. She had to be taken to a hospital. The physicians were amazed at the thinness of the femur. They could not understand how the breast tumor could have disappeared. The patient was given morphine, declined during the following four weeks and finally died.

The orgone therapy had prolonged her life for about 10 months, had kept her free of cancer tumors and cancer pains for months and had restored the function of her blood system to normal. The interruption of the orgone treatment by the biopathic paralysis interdicts any conjecture as to a possible favorable outcome. What is certain is that in this case the real cause of death was the biopathic shrinking, and not the local tumors.

This case has given us important insights into the emotional and vegetative background of the cancer disease. Now we are confronted by the important question as to what takes place in the blood and the tissues as a result of the biopathic
shrinking; in other words, the question as to how the general shrinking of the autonomic system produces local tumors. I may anticipate: The general result of biopathic shrinking is putrefaction in the blood and the tissues. The cancer tumor is only one of the symptoms of this process of putrefaction. This finding requires extensive clinical and experimental substantiation; this will be given elsewhere.

IV. CONCLUSION.

Let us briefly review our observations. The "dying" of the patient in the biopathic attack did not in the least give the impression of hysteria or simulation. The autonomic system reacted in such fashion that actual death was by no means improbable. The sunken cheeks, the cyanotic color, the faint, rapid pulse, the spasm of the throat, the failure of motility and the general physical debility were dangerous realities.

I venture the statement that each of these attacks was the beginning of an actual cessation of the vital functions. It was possible, by dissolving the spasms and by breaking the diaphragmatic block again and again to interrupt the process of dying. Death was again and again counteracted by vagotonic expansion. This cannot be a matter of suggestion. Suggestion in the usual sense could not possibly penetrate into these depths of the biological apparatus. What was possible, however, was to elicit the biological impulses to expansion in various bodily systems and thus, month after month, to arrest the shrinking process again and again. In order to do this, a good rapport with the patient, as a part of the vegetotherapeutic technique, was, of course, indispensable. Only in this aspect of the procedure might one be justified in speaking of suggestion.

Let us go back to our familiar diagram of psychosomatic functioning and try to find out at which place in the vital apparatus the biopathy (in contrast to a mechanical lesion), as well as the vegetotherapeutic experiment, takes effect:

Every lasting energy stasis in the biological system (a) must of necessity manifest itself in somatic as well as psychic symptoms (b1 and b2). Psychotherapy attacks the psychic symptoms, chemico-physical therapy the somatic symptoms. Vegetotherapy has as its starting point the fact that psyche as well as soma have, from a point of view of bio-energy, the same root in the pulsating plasma system (blood and autonomic system). Vegetotherapy thus influences not the psychophysical function itself, but the common basis of psychic as well as somatic functions; it does this by eliminating the inhibitions of biological functioning, such as the respiratory block, the inhibition of the orgasm reflex, etc. Thus, vegetotherapy is neither a psychic therapy nor a physiological-chemical one; it is biological therapy directed at the disturbances of pulsation in the vital apparatus. Since these disturbances show their effects in all the more superficial layers of the psychosomatic apparatus—for example, as hypertension and cardiac neurosis in the somatic, as phobia in the psychic realm—vegetotherapy, of necessity, reaches these symptoms in the superficial layers also. Vegetotherapy, thus, is the most advanced existing method for the influencing of biopathic disturbances. For the time being, its field is limited to the biopathies.
In the cancer biopathy, the vegetotherapeutic treatment of the disturbances of respiration and of the orgasm is supplemented by the orgone therapy which is directed at the anemia, the T-bacilli in the blood and the local tumors. As succeeding articles will show, we are fully aware of the enormous complexity of the problem as well as of the largely experimental character of this cancer therapy.

According to the prevalent concepts there are only mechanical or chemical lesions of the somatic apparatus on the one hand and functional disturbances of the psychic apparatus on the other. Sex-economic investigation of the cancer shrinking biopathy reveals a third, more deep-reaching disturbance: The disturbance of the plasma pulsation at the common biological basis of soma and psyche. What is fundamentally new here is the finding that the inhibition of the autonomic sexual function can produce a biopathic shrinking of the autonomic nervous system. The question remains whether this etiology can be found in all forms of cancer.

There is a general misconception that the organism is divided into two independent parts: one is the physico-chemical system, “soma,” which is destroyed by such agents as a cancer; the other is the “psyche” which produces hysterical phenomena, so-called conversion symptoms, in the body, and which “wants” or “fears” this or that and has nothing to do with the cancer. This artificial splitting up of the organism is misleading. It is not true that a psychic apparatus “makes use of somatic phenomena”; nor is it true that the somatic apparatus obeys only chemical and physical laws, but does neither “wish” nor “fear.” In reality, the functions of expansion and contraction in the autonomic plasma system represent the unitary apparatus which makes the “soma” live or die. Our patient demonstrated the functional unity of psychic resignation and biopathic shrinking exceedingly well. In her, life began to function poorly; the function of expansion began to fail. To express it psychologically: there was no impulse behind motion, action, decision and struggle. The vital apparatus was, as it were, fixed in the reaction of anxiety; psychologically, this was represented in her fear that motion might result in a fracture somewhere in the body. Now, motion, action, pleasure and expansion appeared to be “a danger to life.” The characterological resignation preceded the shrinking of the vital apparatus.

The motility of the biological plasma system itself is damaged by the biopathic shrinking. The fear of motion has its basis exactly in this vegetative shrinking. The plasma system shrinks, the organism loses its autonomic balance and the self-regulation of locomotion. Finally, a shrinking of the body substance sets in.

The inhibition of plasmic motility by the shrinking fully explains all aspects of the disease picture; it explains neurotic anxiety as well as functional paresis, the fear of falling as well as the muscular atrophy, the spasms as well as the biological disturbance which breaks through as “cancer” and finally ends in general cachexia. For it was possible again and again to make the patient develop new living impulses by vegetotherapeutically correcting her breathing. The diaphragmatic spasm is the central defense mechanism in the biopathic disturbance of the organism: The patient really breathes poorly; she really ventilates her tissues insufficiently; the plasmatic locomotor impulses are actually insufficient for the maintenance of co-ordinated movements; the fear of falling and of suffering damage has a real basis and is not “imaginary”; more than that, the imagined catastrophe of falling has itself a real basis in the restriction of biological motility. The hysterical, functional character of the paresis thus gains a factual biopathological basis. There is a difference only in degree be-
tween hysterical paralysis and paralysis as a result of biopathic shrinking.

In medicine, functional paralyses are usually looked at with some irony; the concept is still prevalent that a functional paralysis is more or less "simulated." I would like to state that functional disturbances of motility are much more serious and far-reaching than are paralyses which result from a mechanical lesion. In the case of the mechanical lesion, the biological functioning of the total organism is not affected. A functional paralysis, on the other hand, is the expression of a total biological disturbance. In this case, the function of plasmatic impulse formation in the biological core of the organism is itself disturbed and may result in a more or less extensive loss of tissue (muscular atrophy, anemia, cachexia, etc.). To say that the mechanical lesion cannot be influenced by suggestion, while the functional disturbance is amenable to suggestion, means nothing. For the "suggestion" which may bring about an improvement in the functional paralysis is in reality nothing but a pleasurable stimulus for the biological system and thus causes it to reach out for new life possibilities and to function again.

The basic disturbance in the functioning of the body plasm, represented by chronic sexual stasis, character rigidity and resignation, and by chronic sympatheticotonia, is to be taken much more seriously than the mechanical lesions. The mechanistic and purely materialistic concepts of medicine of today have to be partly replaced and partly overcome by a functional concept. This functional concept made it possible to make a breach in the wall which hitherto has made the cancer problem inaccessible. Succeeding articles will show to what extent this functional concept is generally applicable. We shall next turn our attention to the local changes in blood and tissues which are caused by the biopathic shrinking.

Concluded February 10, 1942
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.
Texts from the area of Biphysical Orgonomy

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