SHOCK THERAPY AS A SUBJECTIVE EXPERIENCE†

By Mary Robert,* M.D.

Editor's note: The literature on shock therapy is so voluminous that it would be useless to add still another article unless it had something special to contribute to the problem. This is what the following article does. Most articles on the subject are concerned only with the statistical results of the treatment and with the nature and incidence of complications such as bone fractures during the shock. Only very rarely is the question discussed, “What is the curative factor, in other words, the rationale of the treatment?” As it stands, shock therapy is a purely empirical procedure and there is no knowledge of the curative mechanism. The theories that have been advanced are unconvincing or patently erroneous.

The present article is remarkable for two reasons. First, it shows the rationale of shock therapy and, with that, its inevitable limitations. Second, the author, in order to obtain first-hand knowledge, underwent a shock herself and thus became able to describe the subjective experiences of the shock. Thus, although this article was written some two years ago, it is still far ahead of the present-day literature on the subject.

The problem of shock therapy, its results, indications and dangers, is the subject of lively discussions in medical periodicals. There are two opposing viewpoints in the question. One group of observers maintains that shock therapy, in particular the cardiazol shock, cures certain types of schizophrenia, if they have not lasted too long, in 30-40% of the cases, while depressive states are cured in 60-70%. The other group maintains that cure takes place only in patients who would have had a spontaneous remission, i.e., who would have gotten well anyhow, without treatment. They concede that the treatment may bring about a rapid improvement, but point out that such an artificial improvement means little. To judge from the literature, this objection is contradicted by the fact that “cures” take place in many patients who, up to the time of the shock treatment, showed no tendencies whatsoever for spontaneous remission. According to my own observations, this is particularly true in depressive states. However, the period of observation is so short and the statistical material so little evaluated, that we have as yet no sufficient material to compare treated and untreated cases. For this reason, I shall not try any such differentiation.

The most astonishing aspect of the whole discussion is the fact that very seldom is the question raised as to what it is that brings about the cure or improvement. Some observers ascribe the effect to an action upon the midbrain, the thalamus or other subcortical centers. Others, in a more popular vein, speak of the psychic experience of the shock as the therapeutic agent, and think one might just as well use any other shock experience, such as treatment with sulfosine or carbon dioxide. What they have in mind is the “therapia

† Translated by the Editor.
* This is a pseudonym. Present conditions force us, unfortunately, to withhold the names of our European co-workers.
SHOCK THERAPY

Remarkably enough, any basic concept as to what really takes place is rarely found.

Meduna as well as many others have given detailed descriptions of the seizure. In spite of certain differences, there are many similarities between the cardiazol shock and the less well-known benzidine treatment. To mention only a few of the main points: A few minutes after the injection of cardiazol the patient gets red in the face, begins to clear his throat and to cough; that is, he gets a dry throat; looks confused and usually lets out more or less frightened shrieks; then there are clonic spasms with loss of consciousness, and marked cyanosis; after this, the spasms become tonic, pulse and respiration seem to stop; often there is incontinence of urine and flatus; after about half a minute to a minute, the spasms become again clonic and respiration returns. There is, typically, deep, snoring, complete expiration, often followed by sleep. The color becomes again natural. The pulse, which right after the seizure was rapid, gradually returns to normal, and the whole musculature—except perhaps localized parts—become atonic (relaxed). Immediately after the seizure, the patient has no recollection of it and appears cheerful, like slightly intoxicated. Sexual activities, masturbation and amorous behavior are common. To mention only a few of the statements made by patients: Every time before the shock occurs, Mrs. N. calls to the physician, “Come to your girl, if you want to have me. You can have me, but I don’t want to die for it.” And before she loses consciousness, “Say, it itches so down there.” Miss K. tries every time to bare her genitals and talks in a confused way about Bill who will come and take her. Miss R. says, “Put out all these girls. You may stay here and take me, but we must be by ourselves.” Many interpret the injection as sexual penetration. Miss S. wrote a long letter about the “smut psychiatry” we did with her in order to arouse her sensual desires. Mrs. P. wrote her husband, imploring him to take her home, saying we were accusing her of adultery; this letter was also full of folksy expressions. Some of these patients had constantly been talking about sexual activities even before the shock treatment. But no other form of treatment had provoked any acute sexual symbolization; the injection resulted in a very marked increase in sexual phantasy life. In other patients, this was an entirely new phenomenon. We know that the syringe as such has the unconscious significance of the sexual act, of impregnation, etc., but with the shock syringe this is true to a far greater extent. No other form of treatment provoked that outspoken amorous behavior which is typical in so many patients right after the shock. A demented and completely mutistic girl of 17, after the shock called for her mother and tried to embrace those around her. These examples are not meant to show that the affective expressions and the energy discharges are in all cases of a localized sexual nature; they do show, however, that in all cases the affective and vegetative discharges become more lively. Where the shock treatment is at all effective there is always an attempt on the part of the patient to establish contact. There seems to be a general activation of all primitive reactions in those patients who react to the shock. In popular language, one might say that the “animal,” the “flesh,” gets away from the inhibition by the “spirit.” This is difficult to bring about in any other way, because the inhibitions, “morality,” prevent it.

As far as the pupillary reactions are concerned which have been described—marked dilatation with the seizures and marked constriction afterwards—I find in my material a great variation from case to case. There is either dilatation without constriction after the seizure, or no or only little dilatation but marked con-
striction; in most cases one finds both reactions. My material seems to indicate that the best results are obtained in those cases which show the most outspoken pupillary reactions.

My material consisted of 35 women; three of these I did not observe long enough, so that I am considering only 32. They fall into four groups:

**Group I:** 10 of these 32 patients were so much improved that they have been discharged or are going to be discharged soon. 9 out of these 10 showed dilatation of the pupils with the seizures and constriction afterwards. One of them showed dilatation with the seizures but little constriction afterwards; she belongs to the least improved in this group. None of the 10 showed any noticeable change in character.

**Group II:** 13 patients showed a noticeable improvement although they still present definite signs of their psychosis. The best results in this group compare with those in Group I, the poorer results with those in Group III. These 13 showed less uniformity in their pupillary reactions. The most frequently observed reaction was dilatation with the seizures (increased sympathicotonia) but little or no constriction after the seizure, or even dilatation after a temporary constriction.

**Group III:** 7 patients showed practically no improvement at all. These showed a very variable pupillary reaction; either dilatation but no constriction, or very labile pupils.

**Group IV:** 2 patients have to be considered separately. They showed considerable improvement after one course of treatment, but had a complete relapse when they were transferred to the open ward. A second course of treatment did some good, but did not approach the result of the first. These two patients, during the first course of treatment, showed dilatation of the pupils with the seizures and constriction afterwards. During the second course of treatment, there was some dilatation, little constriction; or occasionally, no reaction at all with the seizures but dilatation afterwards; in other words, a completely paradoxical reaction.

It would be interesting if it could be shown that the refractory cases (i.e., those who show no improvement from shock therapy) are those in which there are no or only slight vegetative reactions with the seizure. The material is still too small to state definitely that this is the case. It would explain the fact that the cases of long standing respond least to the treatment, because in them the pathological ways of functioning have become well established in the organism. The substantiation of this concept that the extent of the vegetative reactions is the essential element for improvement requires more vegetative tests and examinations than I had the opportunity to make. Nevertheless, the vegetative reactions were so definite as to justify this concept.

Many observers have mentioned the fear of the treatment which the patients develop after having undergone one seizure. However, the literature contains neither a description of this fear nor an explanation for it. Particularly in female patients, but also to a lesser degree in men, the anxiety after a few treatments is so intense that the patients feel as if they were going to be drowned or otherwise threatened with sudden death. (This is highly reminiscent of the pre-orgastic anxiety which one observes during vegetotherapy.1) The patients say that they not only feel as if they were going to die, but that they are convinced every time that they will die. In reality, it is the fear that the inhibitions will "die" or that one is going to "lose oneself," "lose control." (Orgasm anxiety as observed during vegetotherapy always shows the same connection; but there also, patients express it as a fear of death.) This

---

anxiety is by far too intense to be "justified" on the basis of actual danger in the form of various complications of the treatment, like the fracture of a vertebra, etc. If such an accident happens, it becomes of course known in the wards; but there can be no doubt to anyone who has talked to these patients and has tried to calm them down, that this anxiety is based on certain physiological processes and a definite subjective experience.

In order to get a clearer picture of this subjective experience, the writer submitted to a shock treatment. A few seconds after the injection there was a pronounced feeling of tickling in the throat like a beginning cough; it felt as if the precordial region and the region over the sternum were being constricted; that is, there was the typical physical correlate of anxiety, like a claw gripping at the throat and the chest. Immediately afterwards there was a towering gray shadow in front of the eyes, a slight confusion and a buzzing sensation in the top of the head. It felt like the beginning of a narcosis or of a faint but was more unpleasant. It was a feeling of being grabbed by a wave and being carried away. When consciousness returned, there was absolute amnesia, i.e., no recollection of what had happened. The other physicians were absolutely unable to convince me that I had gone through a shock. My disbelief was so strong that I insisted on going on with my work in the ward and thought the whole thing was a practical joke on their part. According to the description, I behaved like an intoxicated and slightly manic person. My body felt light, as if I were walking on air. The only thing that forced me after a while to go to bed was a weakness in my knees and an increasing nausea. As is often the case with intoxicated people, I saw the world in a rosy light and felt extremely affectionate toward everybody. During the day I developed a violent headache, and bit by bit the memory came back. It was a typical retrograde amnesia, i.e., that which was experienced last also came back last. It took a whole day before I remembered the time immediately previous to the shock. The lameness of the musculature lasted a whole week and the ability to remember everyday happenings was reduced for a long time. (Forgetfulness and confusion are typical manifestations during shock treatment.)

In contradistinction to the patients, I did not experience any anxiety at the moment of losing consciousness, nor did I show any objective signs of anxiety. In this regard, it must be pointed out that the physical phenomena described here are experienced as anxiety by most people. It is different, however, if, first, one knows the rational explanation of these phenomena. Second, and more important, these phenomena also occur in the course of vegetotherapy, accompanied by a great deal of anxiety. Inasmuch as I had undergone vegetotherapy, the anxiety had been experienced at the time when these phenomena occurred; thus they were known to me. This intense anxiety occurs in all patients toward the conclusion of the vegetotherapeutic treatment, and in connection with similar physical phenomena. It is what Reich called pre-orgastic anxiety.

If I have described these phenomena in some detail, it was in order to point out the interesting fact that most of these phenomena—in a less acute manner—occur in the course of the vegetotherapeutic treatment. In shock therapy, the shift from an artificially increased sympatheticotonia to a relative vagotonic (parasympatheticotonic) relaxation is brought about abruptly, is being repeated with every new shock and ceases in between shocks; in the course of vegetotherapy, this change takes place gradually, almost imperceptibly. Our neurotic patients suffer from a chronic vegetative disequilibrium, essentially in the form of a predominance of sympatheticotonic reactions, but also in
the form of more or less localized sympa-
theticotonic and vagotonic reactions, that
is, a disturbance of the harmonious inter-
play between the two antagonists. During
shock therapy, one observes an acute and
extreme change in respiration, particularly
the occurrence of deep expiration; how-
ever, this does not last. In vegetotherapy,
on the other hand, one makes a deliberate
and sustained effort to establish the ability
for deep expiration, that is, the ability to
breathe with both chest and abdomen; the
average person uses one or the other, or
both, of these mechanisms, only incom-
pletely. Thus, observations derived from
shock therapy confirm the fundamental
value of vegetotherapy.

To form an opinion as to the value of
shock therapy for the treatment of mental
disease is a different matter. Here, I will
have to point out the differences between
shock therapy and vegetotherapy. First of
all, it goes without saying that shock
therapy is used in a different kind of
cases. Shock therapy is used mainly in
psychotic or borderline cases. Vegeto-
therapy, on the other hand, is used mainly
in neuroses, and cannot be used where
the patient's conscious processes cannot
be utilized in the procedure. Neverthe-
less, the comparison of the two methods
will in part explain why, in my opinion,
shock therapy alone cannot produce a cure
(in our sense of full cure). The main
point is that the shock treatment takes
place independently of the patient's con-
sciousness; that will say that all the con-
scious or unconscious pathological reac-
tions which result in or from conflicts in
the patient's life and environment are
completely left out of consideration in
shock therapy.

From a sex-economic point of view,
energies are being set free which are dis-
charged only partly. I have mentioned,
for example, the sexual reactions occurring
in the course of shock treatment. Quite
plainly, these are the expressions of a
liberated sexual need, and it goes without
saying that such a need cannot possibly
be satisfied in any adequate way in a
mental hospital. It cannot be satisfied for
such reasons as that men and women are
separated, that husband or wife are out-
side of the hospital, etc. But, in addition,
sexual activities, such as masturbation,
which would give partial gratification or
rather a substitute gratification, meet with
the customary concepts of the condemna-
ble character of such activities. One only
has to see the expression of horror on the
faces of the nurses when they see patients'
sexual manifestations in connection with
the shock. When such things as baring
the genitals or masturbation occur, they
are immediately stopped by the nursing
personnel. But even if one were not
prejudiced, it would be difficult to give
these things free rein. Even other forms
of energy, such as anger, unrest and
anxiety, have to be suppressed in the inter-
est of hospital routine. For the same rea-
son, one is almost forced to prevent dis-
charges of aggressive energies or other
actions which may influence the condition
of other patients. Almost imperceptibly,
the social living in the hospital makes one
judge the patients' behavior moralistically;
befor e being aware of it, one has said,
"he is bad" or "she is nice" and thus gets
away from a scientific comprehension of
the patients' structure. It is wholly incon-
sistent to liberate affective energies with
the treatment, and then immediately to
suppress them again. The shock treatment
requires much greater possibilities for
individual therapy than a mental hospital
can offer today.

The same holds for occupational therapy. When the patients, as it were, become
alive and show interest in doing some-
thing, the opportunities one has to offer
them are extremely limited. In the first
place, it is mainly a matter of manual
work, such as knitting, weaving, or out-
doors activities; but this does not liberate
energies according to the patients’ pleasure needs. One lacks the facilities for more varied forms of motion and for artistic work. In this field there are enormous possibilities, but they are limited first of all by lack of funds and personnel, but also by the point of view from which the work is considered. Namely, the point of view that if the patient works that is in itself a moral victory; the fact is overlooked that the work should be a source of pleasure.

Most therapists will realize that any improvement in a patient must be utilized by immediately moving him to an open ward and putting him to work. But, as I have already pointed out, circumstances do not allow to do this to a sufficient degree. On the whole, then, one must say that the energies that are liberated by the treatment and the needs that develop with the improvement are not satisfied; I repeat that this depends more on the routine and the economic circumstances of the hospital than on the individual director’s concepts.

Many psychiatrists are also aware of the shortcoming which lies in the fact that psychotherapy is not combined with the shock treatment. They point out that psychotherapy is necessary before, during, and especially after the shock therapy. However, exactly what kind of psychotherapy should be instituted is not stated, and on the whole the problem is largely neglected.

From a vegetotherapeutic point of view, one might say that the shock treatment is a kind of mechanical gymnastics of the vegetative nervous system and the autonomic functions; thus it liberates vegetative energies. Where this liberation succeeds, there is considerable improvement. But since the treatment is purely mechanical, since it does not take in the whole personality, it will never really change the personality. This is clearly demonstrated in the patients who were discharged as cured after shock therapy.

Mrs. N., 52 years old, had all her adult life been an apprehensive and pedantic person. Two years ago she became depressed, suicidal and completely apathetic. Hospitalized 1½ years ago, she showed no signs of improvement, was completely isolated, mute and deeply depressed. Shock therapy 3 months ago. After the seventh shock there was some animation; her husband noticed the difference. After 15 shocks there was a definite improvement: she began to talk, became more lively, somewhat more natural, and started to work. Began to develop insight into her illness. Was discharged as cured and remained well; her environment considers her well. At the time of discharge, she had retained a somewhat circumstantial, “school-marm” behaviour, very “refined,” somewhat stiff in her motions, although considerably less so than before shock therapy. The pupillary changes from dilated to constricted were marked after every shock. There was also a lasting change in the pupils, in that after the treatment the pupils, under ordinary light conditions, were of a smaller diameter than before the treatment. A vegetotherapist would say that the patient became a socially adequate though neurotic personality, somewhat unnatural, formal and pedantic. The family, however, were so happy over her “cure” that they seemed quite willing to adjust themselves to this personality.

I could cite many such examples. Generally speaking, one can say that the patients turn from psychotic individuals into neurotic personalities with socially acceptable behavior. Where the environment can adjust itself to this personality, it may be assumed that the “cure” will last; where this is not the case, a relapse is to be expected. People in an advanced age will come up against fewer sexual conflicts and will therefore manage better.

As far as the mental hospital is concerned, it is quite obvious that hospital life cannot possibly be elastic enough to utilize fully the possibilities of expansion which the patient derives from the shock
treatment. The obstacles are both economic and administrative.

As vegetotherapist, one might think that the shock therapy would make many patients accessible to vegetotherapy who otherwise are unapproachable because of their rigidity. From a social point of view, one must say that, as things are now, shock therapy in the mental hospital gives certain definite results even though the improvement may be of short duration. It gives the patient and the relatives some hope and some possibility for better adjustment. From an economic as well as from the patient’s subjective point of view, it is a great improvement even if nothing more is achieved than that the patient becomes capable of living outside an institution.

However, shock therapy will have no real significance until such time as its mechanism is understood and until we know what kind of aftertreatment is necessary. At any rate, it should give food for thought to the extreme constitutionalists in psychiatry. It seems unlikely that such a drug treatment would appreciably influence a purely endogenous condition.

One has to ask oneself how the vegetative deadness came about in the first place, and why it can be influenced or eliminated by vegetative means. One has to ask whether much could not be done prophylactically if children were brought up in a manner which would allow the biological functions to take a more natural course than is the case now. This would entail a complete reorientation with regard to human attitudes. Certainly, vegetotherapeutic experience points to the necessity, from a social preventive point of view, of a reorientation and a more natural form of living for the adolescent. The course of the shock therapy should open everybody’s eyes to the fact that—inside and outside the hospital—the liberated vegetative energies should have possibilities for an outlet. If these were given, it is quite possible that many cases who are now negative would turn out positive. As they are not given now, shock therapy is in danger of meeting the same fate as many other new therapeutic methods which promise much but perform little and finally disappear. If this happens to shock therapy, it will be because one does not draw the consequences from the vegetative changes in the patient.
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

-------------
International Journal of Sex Economy and Orgone Research
-------------

Orgone Biologics
-------------

01 Walter Frank. Vegetoterapy 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 1 1942
Interval 70-92 Pag. 65-87

02 Wilhelm Reich. The Discovery of the Orgone 1941
International Journal of Sex Economy and Orgone Research Volume 1 Number 2 1942
Interval 12-36 Pag. 108-130

03 Wilhelm Reich. The Carcinomatous Shrinking Biopathy 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 2 1942
Interval 37-61 Pag. 131-155

04 Mary Robert. Shock Therapy as a Subjective Experience 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 2 1942
Interval 62-68 Pag. 156-162

05 Wilhelm Reich. The Natural Organization of Protozoa from Orgone Energy Vesicles (Bions) 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 3 1942
Interval 1-33 Pag. 193-255

06 William F. Thorburn. Mechanistic Medicine and the Biopathies 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 3 1942
Interval 65-66 Pag. 257-258

07 Theodore P. Wolfe. A Sex-Economic Note on Academic Sexology 1942
International Journal of Sex Economy and Orgone Research Volume 1 Number 3 1942
Interval 67-73 Pag. 259-265

08 Wilhelm Reich. Experimental Orgone Therapy of the Cancer Biopathy (1932-1943)
International Journal of Sex Economy and Orgone Research Volume 2 Number 1 1943
Interval 6-96 Pag. 1-92

09 Lucille Bellamy. Vegetotherapeutic Gymnastics 1943
10 Theodore P. Wolfe. Mis Conceptions of Sex-Economy as Evidenced in Book Reviews 1943
International Journal of Sex Economy and Orgone Research Volume 2 Numbers 2 3 1943
Interval 49-55 Pag. 141-147

11 Carl Arnold. A Theory of Living Functioning 1944
International Journal of Sex Economy and Orgone Research Volume 3 Number 1 1944
Interval 22-42 Pag. 17-37

12 Notes Editorial. Rational and Irrational Discussion of Orgone Biophysics 1944
International Journal of Sex Economy and Orgone Research Volume 3 Number 1 1944
Interval 79-84 Pag. 74-79

13 Theodore P. Wolfe. The Stumbling Block in Medicine and Psychiatry 1942
International Journal of Sex Economy and Orgone Research Volume 3 Numbers 2 3 1944
Interval 69-91 Pag. 175-187

14 Wilhelm Reich. Anorgonia in the Carcinomatous Shering Biopathy 1944
International Journal of Sex Economy and Orgone Research Volume 4 Number 1 1945
Interval 3-35 Pag. 1-33

15 Notes Editorial. Cold Facts. Orgone Accumulator 1945
International Journal of Sex Economy and Orgone Research Volume 4 Number 1 1945
Interval 102-102 Pag. 100-100

16 Notes Editorial. Free Love 1945
International Journal of Sex Economy and Orgone Research Volume 4 Numbers 2 3 1945
Interval 81-82 Pag. 203-204

18 Wilhelm Reich. From the History of Orgone Biophysics 1947
McF 207 Annals of the Orgone Institute, Number 1. 1947
Interval 58-67 Pag. 108-126

--------------------------------
Orgone Energy Bulletin
--------------------------------
01 James A. Willie. The use a Male Dummy in Medical Orgone Therapy
Interval 9-13 Pag. 61-69

02 Notes. A Psychoanalytic Dilema and Bionous Disintegration in Wood 1940
Interval 21-23 Pag. 85-88

03 Editorial. Public Responsability in the Early Diagnosis of Cancer 1949
Interval 11-14 Pag. 110-116

04 M. S Reviews. Harper & Brothers 1949
Interval 26-27 Pag. 141-142

05 Walter Hoppe. Further Experiences with the Orgone Accumulator 1950
Interval 11-13 Pag. 16-21

06 Helen E. McDonald. Wilhelm Reichs concept Cancer Biopathy I 1950
Interval 25-27 Pag. 139-142

08 On The Record. Wilhelm Reichs Priority in Cancer Test 1950
Interval 35-37 Pag. 220-221

09 Reviews. Correction Regarding a Control of Reichs Cancer Experiments 1950
Interval 36-37 Pag. 222-224

10 Wilhelm Reich Cancer Ceells in Experiment XX 1950
Interval 3-4 Pag. 1-3

11 Orgone Biologics. Ruler to Follow in Basic Research 1951
Interval 34-35 Pag. 63-64

12 Wilhelm Reich The Leukemia Problem Approach 1950
Interval 10-12 Pag. 76-80

13 Simeon J. Tropp. Limeted Surgery in Orgonomic Cancer Therapy 1950
14 On The record. Life in Russia, Cancer Research and Stromy Social Weather 1951
Interval 28-29 Pag. 112-115

15 Wilhelm Reich Armoring in a Newborn Infant 1950
Interval 3-13 Pag. 121-138

16 Archives of Orgone Institute. Wilhelm Reich on the Road to Biogenesis (1935-1939)
Interval 17-25 Pag. 146-162

17 Michael Silvert. On the Medical Use of Orgone Energy 1952
Interval 27-29 Pag. 51-54

18 Elsworth F. Baker. Genital Anxiety in Nursing Mothers. 1952
Interval 11-17 Pag. 19-31

19 Arthur Steig. Orgone Energy Metabolism 1952
Interval 29-31 Pag. 54-58

20 Wilhelm Reich Orgonomic Diagnosis of Cancer Biopathy 1952
Interval 2-34 Pag. 65-128

21 Ola Raknes. Letter to Reich (1950) 1952
Interval 21-25 Pag. 207-214

22 On the Record. Clarifications 1952
Orgone and energy in the Brain, Emotionally Positive and Promise Cancer Cure
Interval 26-28 Pag. 217-221

23 Elsworth F. Baker. A Grave Therapeitic Problem 1953
Interval 32-37 Pag. 60-70

24 Kenneth M. Bremer. Medical Effects of Orgone Energy 1953
Interval 37-44 Pag. 71-84

-------------------------------
-------------------------------
---------
CORE.
01 Robert A. McCullough. Antibiotics Cloudseeding and Life Energy 1955
Interval 22-25 Pag. 40-46

02 Eva Reich. Early Diagnosis of cancer of the uterus 1943
Interval 25-28 Pag. 47-53

03 Bernard Grad. Willelm Reichs Experiment XX 1955
Interval 19-25 Pag. 130-143