ANORGONIA IN THE CARCINOMATOUS SHRINKING BIOPATHY*

A Contribution to the Problem of Cancer Prevention

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The term anorgonia refers to those biopathic conditions which are characterized by a block in plasma motility. This disturbance of plasmatic functioning is unknown in orthodox pathology, though it is well known to the practising physician. The reason why this disturbance remained unknown to a mechanistic pathology is that it does not consist primarily in structural tissue changes or nerve tract lesions but in a reduction of the total energy function of the organism. Everyday language describes the condition in various terms. They refer to the emotional expression of an organism, such as "unalive," "dead," "stiff," "contactless," "cold," etc. (in contrast to "alive," "sparkling," "warm," "having immediate contact," etc.), and render the immediate impression which another person makes on us. However, the concept of "anorgonia" which is here introduced for the first time means more than mere "contactlessness" or "unaliveness." It refers to a well-defined, heretofore unknown disease picture which I have found most outspoken in patients with cancer or with a cancer disposition.

Before describing the anorgonia in cancer shrinking biopathy, I must go back to a well-known finding of clinical sex-economy, the significance of which can be comprehended today much more deeply than before the discovery of the orgone. I am referring to the undisturbed plasmatic functioning of the healthy organism and its counterpart, biopathic falling anxiety (fear of falling). Let us set out by summarizing what we have learned thus far about the falling anxiety in biopathic diseases:

Falling anxiety makes its appearance in every case of character neurosis or somatic biopathy at a time when the armoring is dissolved and orgastic sensations begin to break through. The "orgonotic sensation" is nothing but the subjective perception of the objective "plasmatic excitation" which, heretofore, in a mechanistic manner, we termed "vegetative current." The appearance of falling anxiety indicates with certainty that plasmatic excitations and orgastic sensations are beginning to function in the total organism. The signs of falling anxiety are various: dizziness, "sinking feelings," falling dreams, feelings of oppression in the gastric region, nausea. These and similar symptoms characterize the breakdown of the armor, which is accompanied by orgastic sensations, involuntary muscular spasms, hot flushes, tremors, itching sensations, etc. These biological symptoms are psychically represented as a generalized anxiousness and insecurity. Roughly speaking, then, the therapeutic process has to pass through the following stages: loosening of the armor, orgonotic sensa-

* Translated from the manuscript by the Editor.
tions, breakdown of the armor, clonisms, falling anxiety, increased plasmatic excitation, orgasmic sensations in the genital apparatus.

If we proceed correctly in dissolving the armorings, the unpleasurable sensations gradually give way to a pleasurable perception of the body. Patients, after having gone through a series of clonisms, often state that "they never felt so well before." If, on the other hand, one does not correctly dissolve the armorings, layer by layer; if rigid armorings remain; if one lets the orgonotic excitations break through too immediately so that they hit on the still undissolved layers of the armor; then the patient is apt to react with a complete withdrawal into his old armoring. Afraid of the plasmatic excitations (pleasure anxiety), he increases his biopathic rigidity. Overwhelmed by increased quantities of mobile biological energy, the patient may experience states of disorientation, panic and even suicidal impulses. That much about the known clinical manifestations.

The falling anxiety may express itself more in the somatic or more in the psychic realm; usually, it is a combination of both. At any rate, the appearance of symptoms of falling anxiety indicates a biopsychic crisis, the first step in the direction of health in the sense of orgasmic potency. If the vegetotherapist knows the structure of the case, these striking symptoms of falling anxiety need not cause him any alarm.

However, the falling anxiety is harmless only in pure character neuroses. A number of experiences in patients with cancer or cancer disposition show that falling anxiety may be the symptom of a fatal process. In these cases, it indicates a complete failure of the plasma function in the biological core of the orgonotic system. Obviously, it depends on the depth of the biopathic disturbance. The vegetotherapist must know whether he is dealing with a superficial disorientation of the organism occurring with the transition from rigid to freely mobile functioning, as in pure character neuroses, or with an oscillation of the total plasma function between pulsation and non-pulsation, as in the cancer shrinking biopathy. As always, these distinctions are not sharp; there are fluid transitions. It is important for the therapist to develop a feeling precisely for these transitions from the light to the severe syndrome of falling anxiety. Really, the cancer shrinking biopathy is nothing but a particularly severe form of character neurosis if, as we must, we mean by "character" the biophysical mode of reaction of an organism. The attitude of resignation can progress from superficial to deep layers of the biosystem and thus extend to the cell plasma function itself.

We shall now examine the biophysical mechanism of falling anxiety in the cancer biopathy. The attentive reader of an earlier case history will have been struck by the great role played by the biopathic falling anxiety. That patient could have maintained the health which she had recovered had it not been for the tremendous falling anxiety which came with her sexual excitations. The patient had actually collapsed in my laboratory a short time after she had become free of cancer, symptomatologically speaking. Her legs had suddenly failed. From then on, she remained in bed. She developed a phobic fear of getting up, thus made further orgone therapy impossible and kept shrinking until her death a few months later. Basically, I did not understand her falling anxiety; all I knew was that it had been provoked by the sexual excitation. The experimental cancer cases I have seen since (1941 to 1944) all showed this falling anxiety with the same typical mani-

Cf. The carcinomatous shrinking biopathy. This Journal 1, 1942, 131ff.
festations. As time went on, I recognized the manifestations more easily and began to understand them better. It was to be expected that further study of the falling anxiety would lead to therapeutic measures; this expectation was confirmed in two cases of cancer biopathy which came to treatment at a relatively early stage. All in all—besides in pure character neuroses—I studied the falling anxiety in 6 cancer cases and, in the phase of first development, in an infant of 4 weeks of age. These observations provided sufficient material to justify this publication. I shall not present any complete case histories but only those parts which refer to the diagnosis and to the falling anxiety. The falling anxiety observed in the infant will provide the key to the problem.

Falling anxiety as the expression of plasmatic immobility

I shall first summarize the findings which make the biopathic falling anxiety comprehensible as the expression of plasmatic immobility. The cancer patients observed had the following symptoms of plasmatic immobility in common:

1. General physical debility: slowing of all motion, tendency to avoid motion and tendency to remain lying in bed. It should be noted that the disturbance of plasmatic motility had, in every one of these cases, existed long before there were the slightest signs of cancer. In 3 out of the 6 cases, a slowing of speech and of all motions had existed since early infancy.

One patient (cf. footnote, p. 2) had the phobia in adolescence that "somebody was after her" in the street. *Her legs would fail her and she felt she was going to fall down.* Later, in her shrinking biopathy, the legs were first to show marked atrophy; her fear of walking was based mainly on the weakness of her legs. There was a transitory paralysis of the anal and urinary sphincters. It was a fracture of the *femur* (thigh bone) which finally led to the fatal outcome. (The local cancer growths were at the 10th, 11th and 12th dorsal vertebrae and the 5th, 6th and 7th cervical vertebrae).

The patient gave as the reason for her keeping to her bed the danger of breaking her spine; I was able to demonstrate the fact that it was not a matter of a mechanically caused pain in the vertebrae but a matter of *falling anxiety*. It was possible to make the patient walk. During her good period she had walked around a good deal, in spite of the fact that the deformation of the spine was irreversible. Later, she was unable to move her legs and was afraid that if she were to move, some part of her body would break apart.

2. In all cases, falling anxiety is accompanied by a disturbed sense of equilibrium. This same phenomenon was observed in the case of the infant during the period of falling anxiety. The connection between the two phenomena is probably this: *The disturbance of the sense of equilibrium determines the falling anxiety, and not vice versa.* The falling anxiety is a rational expression of a biopathic disturbance in innervation, and not its cause. In several cases, it was indirectly fatal in that it prevented the continuation of the orgone therapy, encouraged the atrophy of muscles and the development of bed sores which contributed to the fatal outcome.

One of the 6 cancer patients—with a carcinoma of the prostate—was for some time, as a result of orgone therapy, free from local symptoms (urine clear, free of cancer cells and T-bacilli, no local pain, etc.), but the legs became atrophic and he developed a *functional abasia* (inability to walk). In this case, too, the motor reflexes were normal. I treated this patient with orgone therapy and a simplified vegetotherapy daily during 4 months each during the summers of 1942 and 1943; thus I had ample opportunity to ac-
quaint myself with the peculiarities of the paralysis. After the elimination of the local tumor of the prostate, the patient walked around and seemed to get better and better. He had no pains, his appetite was excellent, he gained seven pounds within a few weeks, was hopeful and even started to work. In the midst of all this progress, he suddenly collapsed in the knees one day and fell down. His knees had suddenly failed him “as if life had suddenly left the legs.” From then on, he was unable to move his legs, he had to keep to his bed and soon there was a progressive atrophy of the muscles in both legs. Two months later, he lost control of the urinary and anal sphincters. There was a blunting of sensation in the legs and the perineum. There was no disturbance of tactile sensation, but the perception of pain stimuli was reduced. The urinary sphincter was spastic, the anal sphincter paralytic. He was unable to urinate and unable to retain his feces. The sensory disturbance was not sharply defined, that is, it did not correspond to a definite spinal segment. That it was not a matter of a central lesion in the spinal cord but of a biopathic paralysis of the plasma periphery was not only shown by the irregularity of the disturbance but even more by the fact that it was possible to reduce and finally to eliminate the paralysis. Only in the course of the vegetotherapeutic treatment of the immobility, that is, with the return of the ability to sit up and to move the legs, did the biopathic character of the paralysis become evident; only then did the falling anxiety and the disturbance of equilibrium make their appearance.

Before entering upon this, I have to counter some possible objections: One might have assumed that the disturbance was of a mechanical nature. This seems highly unlikely, for a lesion in the spinal cord, say, a tumor, would have led to a progressive increase of the disturbance; the elimination of the disturbance by vegetotherapeutic means would have been impossible. A peripheral paralysis of the nerve was out of the question; true, there were pains similar to those seen in neuritis, but they could be eliminated by purely vegetotherapeutic measures. In addition, neuritis itself would have to be explained as a symptom. In the case of a mechanical lesion, either central or peripheral, it also would not have been possible to influence the disturbance of anal control. The disturbance fluctuated, however, with the total biopsychic condition of the patient. If he was in a good mood and hopeful, he was able to move his legs much more easily and extensively than at times when he felt hopeless.

The localization of the tumor in the prostate was immediately caused by 8 years of sexual abstinence. The later spasm of the urinary sphincter and the paralysis of the rectum were of a sympatheticotonic nature; it was the immediate basis of the carcinomatous degeneration of the tissue. From this center at the perineum, the biopathic paralysis extended to the legs. Thanks to the orgone therapy, the patient had not developed any metastases. The upper part of the body and the arms remained mobile and strong until the last. There was no cachexia except in the legs. One had to assume, then, that the location of the paralysis in the legs must have its specific reason.

During the summer of 1943, I worked with the patient daily in an attempt to mobilize his legs. At first, I loosened the spasms of the ankle musculature by passive motions, gradually extending the work to new parts. This procedure was very painful, but soon the patient became able to move his toes, ankles and knee joints. Then I proceeded to the musculature of the thighs and finally to the hips. After about 4 weeks of vegetotherapy, he was able to move his knees and hip joints. Soon after, he was able to sit up in bed.
This gave him new courage and increased his cooperation.

Now I suggested his moving from bed to an easy chair. His reaction was peculiar: He seemed very enthusiastic, but when he was supposed really to do it, he became evasive: he wanted to wait a while, etc. There was no doubt that he was perfectly capable of sitting in the easy chair, since he was able to sit up in bed without any difficulty. Plainly, he was afraid of the transition from bed to chair, although he knew that he would be assisted by two strong individuals and that really nothing could happen to him. As a transitional measure, I suggested sitting on the edge of the bed. He showed some hesitation about this. We helped him and supported him; but as soon as his legs swung freely, he experienced violent anxiety, became pale and broke into a cold sweat. It should be noted that he did not have pain of any kind but merely anxiety. After half a minute he implored us to be allowed to lie down again.

This was exactly what I had witnessed in my first cancer patient. I asked him to give me an exact description of the sensations which caused him to imploring us so pitifully to be allowed to lie down again. He said he had a great feeling of insecurity, that his body, from the hips down, felt numb, "as if it didn't belong to him," as if "it might break any moment." He had a deadly fear that he might fall or that we might drop him, and then his body would break. In this connection, he remembered a peculiar condition from which he had suffered between the ages of 6 and 18: It often happened, when he was working in the woods, that his knees and thighs failed him suddenly so that he collapsed or had to sit down suddenly. No physician was able to interpret these states of weakness.

Now we understood that the later anorgonia of the lower part of the body was based on this anorgonia which had developed in childhood. That is, the anorgonia preceded the cancer disease by some 60 years. The mechanisms of such anorgonotic attacks of weakness is obscure. It may be relevant to mention the fact that the patient's mother had died shortly after his birth; he was brought up by foster parents who showed him little if any love and made him work hard even as a child.

The dulling of sensations in the lower part of the body had been eliminated by vegetotherapy except for a spot of about two square inches at the penis root. All stimuli were perceived. There was no pain with movement; lying on his back in bed, he could move all joints without pain and often even made dance-like movements with his legs. All the more baffling, therefore, was his violent anxiety which occurred with sitting up and having his legs dangle over the edge of the bed.

Now I had him practice sitting on the edge of the bed for a minute or two several times a day. This helped. After a week of this, his falling anxiety had been sufficiently reduced so that we could get him into a wheelchair and take him outside. The falling anxiety seemed to have been overcome. By lying in bed for months, and as a result of the atrophy in the legs, he had lost the feeling of his body, and with that the feeling of equilibrium, but had partly regained it by getting used to sitting up, so that the falling anxiety disappeared.

If we translate the process into the language of orgone biophysics, we may say the following: The biopathic shrinking process had almost extinguished orgonotic motility and, with that, the organ perception. This allows the conclusion that the organ perception is an immediate expression of the motility of the organ plasma. The loss of organ perception results logically in the sensation that the body is something alien, and in the fear of
falling and "breaking." The sensation of numbness in the presence of sensory-motor reactions admits of only one interpretation: The numbness is the subjective perception of objective orgone immobility in the affected parts. It is accompanied by a sensation similar to that in an arm or leg which "has gone to sleep" and that of "ants crawling" over the limb. The anorgonia of our patient differed from an acute numbness only in its duration and its biopathic background. Otherwise, the symptoms were the same.

The question arises: Does anorgonia consist in a decreased orgone content in the tissues, or in an immobility of the tissue orgone without a change in quantity, that is, a reduction of orgonotic pulsation? We shall postpone the answer to this question.

The patient felt well for several months, even regaining rectal control. Then, with bad weather, he experienced violent pains. A physician gave him injections of snake venom to combat the pains, and a few days later the patient died. Probably, he would have died anyhow, for the carcinomatous shrinking had been deep-reaching. However, it goes without saying that orgonotically weak tissue poorly tolerates poisonous drugs. For this reason, we have come to regard drugs with a sympathicotonic effect or which damage the tissue as contraindicated, even though they may alleviate pain. Instead of eliminating the anorgonia, they increase it.

I shall proceed to the description of another cancer patient who also died subsequently. The tumor, histologically a sarcoma, had developed in the right shoulder (deltoid muscle). The tumor receded under Xray treatment; this also resulted in a third degree burn of about 8 inches square. This was bad prognostically. The general biopathic condition was also alarming. The skin all over the body was pale and clammy. The legs were cold and showed a condition which we now know as anorgonotic: livid coloration, clamminess, no perceptible orgone field. The patient was a quiet, resigned character. He felt that he had missed his chances in life and had achieved nothing. He was particularly worried about his pelvis which he felt to be "numb, like dead." As long ago as a year before the appearance of the tumor he had considered coming to me for vegetotherapy, but because of the rumor spread by some psychoanalysts that I was crazy he had refrained from doing so. When, later on, the appearance of the tumor confirmed his old apprehensions, he decided to come to me for orgone therapy after all. It is difficult to say whether in this case the irresponsible talk of rumor-mongers has cost a human life; but it is more than possible that a year earlier the patient could have been saved.

In the course of four months of orgone therapy and vegetotherapy, the patient made good progress. Gradually, he became less reserved and even became able to break out in anger which he had never been able to do. Under the influence of the orgone, the Xray burn healed rapidly. The patient gained weight, improved his neurotically complicated family situation and rapidly approached the point where the orgasm reflex was to appear.

It was clear why the tumor had become localized at the right shoulder. Ever since he could remember, his right arm had been "weak." He felt that the impulses in the right arm never had really come through. The right shoulder blade was pulled back more than the left. In the 12th session, violent beating impulses in the right arm broke through; but it took a long time before he could really let himself go and hit. As soon as a beating impulse began to break through, the patient developed a severe spasm of the glottis. The voice and the breath were cut off, the patient looked as if he were going to choke. His face assumed a dying
expression. The eyeballs were turned up, the skin became pale and livid, respiration shallow, and the pulse thin.

This syndrome had heretofore remained hidden; vegetotherapy had brought it to the surface. In a milder form, these manifestations had been present for decades. The patient recognized that his resignation was in part due to the fact that as a small boy he had never succeeded in holding his own in fights with other boys. As soon as he tried to defend himself and to start hitting, he became short of breath and felt choked in his throat. This rendered him impotent and cowardly. Naturally, this injured his pride and he soon resigned. He became cowardly, submissive, evasive, and ashamed of himself for this reason.

Let us keep this biopathic reaction of our patient in mind. We shall meet it again at the end of his life and shall understand the gigantic significance of the biophysical structure for life and death. The fact should be emphasized that this patient does not represent any extraordinary case but a typical one.

The glottis spasm and the dying attitude turned into the patient’s typical reaction to any progress in the treatment. His pelvis, as he said, was “dead” when he came to treatment. Gradually, the orgasm reflex developed, but it was mechanical, without orgonotic sensations in the pelvis. With the working through of the infantile masturbation anxiety, there was some improvement, but the anorgonia of the pelvis remained. We both had the impression that this pelvis had never been “alive,” as if it were “hopelessly dead.” It was not without reason that, for many years, it had been his most serious concern. When he first heard of vegetotherapy, he knew immediately that it applied to his case.

After several weeks of sustained effort to mobilize the pelvis, a spontaneous pelvic movement forward with strong orgonotic sensations suddenly occurred one day. That is, in the depth the orgonotic motility was still alive. But the patient’s reaction was so violent that suddenly I understood the depth of the anorgonia.

After the pelvic contraction, he immediately fell back into the “dying attitude.” The glottis spasm now was so severe that he could hardly get his breath. Several days later, several spots on his shoulder, in the region of the X-ray burn, began to swell.

The vegetotherapist is quite familiar with spastic reactions to newly mobilized plasma current. It cannot be expected that the orgasm reflex should develop without spasms. On the contrary, every new advance to plasmatic streaming in the biological core provokes ever deeper anxiety reactions, sympathetico-tonic states at the place of the breakthrough, the return of previously dissolved muscle spasms, etc. This we count on in every case.

In the cancer shrinking biopathy, this process is more complicated. Here—in contrast to other biopathies—the anorgonia works in the biological core and therefore can lead to a complete block of pulsation. Clinical experience leaves no doubt about this. Thus, one is never far from a cessation of the life functions. The problem, then, is whether and how quickly one can play the function of expansion against the anorgonia. The cases yet to be described will bring some clarity here.

To return to our case: Repeated blood tests showed that his biological progress continued. When he came to treatment, his blood was extremely orgone-weak: 70% hemoglobin, 99% T-reaction, disintegration of the erythrocytes in seconds, etc. After 6 weeks of orgone therapy, the blood was normal: 84% hemoglobin, almost 100% B-reaction, disintegration of erythrocytes in 30 minutes, full orgone margin of the red blood cells.
The complex nature of the cancer biopathy is again shown in the fact that neither the surgical removal of the tumor nor the re-establishment of the full orgonity of the blood were sufficient to halt the shrinking of the autonomic life apparatus. Nor could the prevention of the cachexia, the loss of body substance, which succeeded by orgone therapy, prevent the fatal process. The patient died without cachexia and with healthy blood. An authority in the field of mechanistic cancer pathology found this to be true, to his great amazement.

The reader will understand why, in my presentations of experimental orgone therapy, I keep repeating that, though we are on the way to an elimination of the cancer scourge, there still are many, and deep-lying, disease mechanisms still to be understood and mastered. In view of this complex nature of the cancer biopathy, it is strange to read in newspapers and magazines, about once every week, about a new chemical which promises to cure cancer. Radical cancer therapy is going to be much more difficult than that.

All the more peculiar is the attitude of traditional pathology which not only approaches cancer with erroneous premises, not only gets stuck in the local symptom, but which, in addition, seems to be so enmeshed in hopelessness that it seems not to take cognizance of the fruitful efforts of orgone biophysics. I repeat: seems to. It may be that its silence about sex-economic cancer research is just an attitude of waiting. In other aspects of our work, too, we often feel as if we were speaking in a large empty hall the walls of which are full of ears but without speech. This should not discourage the friends of orgone biophysics: One day what orgone biophysics promises today will be distinctly heard.

The therapeutic situation of our patient was the following: His anorgonia was marked; in his character, he had a strong tendency to resignation; at the time of treatment, he had no tumors, but his plasmatic motility, which alone could save him, was greatly reduced; it had just, for the first time, reappeared to any appreciable degree; to this, he had reacted with severe orgasm anxiety, in particular, with a violent glottis spasm.

He took lessons in vegetotherapeutic gymnastics in order to liberate his body motility. One day, he slightly wrenched a muscle in his left buttocks. Three weeks later, a small tumor appeared at this spot which gradually, in the course of another three weeks, grew to the size of a child’s head. He could still walk, but now his tendency to lie in bed appeared again. He stayed in bed until his death. While the tumor at the left hip ceased to grow, the small swelling at the right shoulder began to grow again.

One day, there were difficulties in urinating, and, exactly as in the patient described above, the perineum and the root of the penis became “numb.” An X-ray series of the whole body revealed that—apart from the two tumors just mentioned—there were no metastases in any of the inner organs. This is an astounding finding in the case of lymphosarcoma. There were some swollen glands in the right inguinal region and in both axillae. The right shoulder became more and more threatening. The attacks of glottis spasm became more frequent. An edema developed over the whole right arm, up to the first rib. The voice became hoarse, and there was an increasing danger of death through suffocation as a result of glottis edema. The surgeons had no suggestion to make with regard to the edema. Puncture of the tumor at the hip revealed malignant small cells.

The numbness in the genital region could again and again be eliminated, so that the use of a catheter could be avoided. One day the patient developed a con-
tinuing glottis spasm which led to his death by suffocation.

Like the other cancer patients, this patient also did not die from the local tumor, from weakness, heart failure or cachexia. The immediate cause of death was the glottis spasm which the patient had developed decades before the appearance of the tumor. The location of the tumor, and the later edema, at the right arm was unequivocally determined by a chronic biopathic impulse inhibition in the right shoulder.

We understand the immediate cause of death, and the development and function of the glottis spasm in connection with his genital anorgonia which had cause the patient so much concern. We also understand the rapid relapse as a reaction against the first intense plasmatic currents. What remains to be understood is the biopathic mechanism in the tissues of the right shoulder which resulted in the edema. The X-rays showed the tumor at the right clavicle to be the size of a small apple. That is, the edematous swelling of arm and shoulder were not due to the tumor growth. “Clogging of the lymph passages” may explain the edema formation in part, but certainly not in full. One can assume that the edema of the tissues impeded the flow of the tissue fluids as well as the opposite, that a clogging of the lymph passages with tumor substance caused the edema.

In the place of a purely mechanical interpretation of the edema in cancer patients, I would like to attempt a biophysical interpretation: this, I believe, is more in accord with cancer biopathy than the simple mechanics of the “clogging of passages.” There are a sufficient number of ramifications and secondary passages to allow the flow of the fluid from the tissues. There must be something else at play here.

There is edema in starvation. Certainly, there are no “clogged lymph passages” in this case. Nevertheless, there is edema. There is edema of the gums in the case of toothaches. Here, again, there are no clogged lymph passages, and yet, there is the edema. There is edema of the legs in pregnancy. If this edema were mechanically caused, then all pregnant women would show this edema, which is far from being the case. There is edema in burns and inflammations, where there is no clogging of passages.

Hoff writes, in L. R. Müller, Lebensnerven und Lebenstrieben, 3rd ed., p. 753f.:

In all cases of paraplegia of long standing one finds edema in the legs, due mostly to the impairment of circulation resulting from the lack of motion. In two cases, however, Böwing found, immediately after the spinal injury, such an extensive edema of the legs that one had to assume the existence of a trophic damage to the vessels. Marburg and Rance made similar observations in patients with bullet injuries of the spine. In hemiplegia, we have seen an edema of one side of the face appear together with a paralysis of the facial nerve. These observations also help to understand the angioneurotic edemas described by Quincke. We do not yet understand in detail how, in these cases, a disturbance in vegetative vascular innervation leads to edema [italics mine, W.R.]. According to the findings of Ascher and his school, however, it is probable that the vegetative nerves can influence the permeability of the membranes and with that of the walls of the capillaries... Unilateral edemas on the side opposite to the brain lesion are not rare where the lack of motion alone is not sufficient as an explanation. Böwing observed the formation of vesicles on the skin, thinning of the skin with a shiny appearance, changes in the nails and increased growth of hair on the paralyzed side. In psychotic patients with organic brain changes, Reichard often found trophic skin lesions, in particular, ulcers, which could be explained neither by emaciation nor by injury through pressure.
To return to the edema in cancer. Observations in cancer patients, taken together with the above-mentioned non-carcinomatous edemas, permit the assumption of a functional, biophysical causation of the edema. The movement of body fluids is not a mere mechanical function. It cannot be assumed that the lymph glands and lymph vessels are rigid, that, in other words, the motion of the lymph takes place purely passively and mechanically. Rather, one must assume that all organs, including nerves, vessels, lymph passages and tissue cells, are contractile, that, though in different rhythms, they pulsate.

The life functions of the various organs are based on their pulsation. We must be consistent in the application of our functional concepts. Each organ, independently of the total organism, forms a living unit, having perception and the ability to react to stimuli. This has been demonstrated unequivocally in extirpated organs, such as heart, intestine, bladder, etc. We must assume, then, that each organ reacts to injury and disturbances of function in the same way in which the total organism reacts to disturbing stimuli: The living reaction to disturbances in function consists either in an intensification of the specific function, for the purpose of destroying the disturbing stimulus, or else a withdrawal from the diseased organ. Examples of the first mode of reaction are: processes of regeneration and of inflammation, increased blood temperature, etc., as well as the formation of PA bions and cancer cells as a defense against cancerous tissue disintegration (cf. "Experimental orgone therapy of the cancer biopathy," This Journal 2, 1943, iff.), and the destructive anger reaction.

Anorgonia belongs to the second mode of reaction to disturbances of function. While the first reaction is one of fight against the injury, the second is one of resignation, or, in different terms, one of isolating the injured part from the still healthy organs. The isolation of diseased parts is known in pathology in the form of sequestration, i.e., the expulsion of a diseased bone part. In the animal world, one knows the elimination of a diseased member, for example, a leg, by biting it off. The counterpart of biophysical isolation of diseased parts is inflammation with regeneration. Where regeneration, that is, plasmatic growth reaction, is no longer possible, isolation takes place.

This isolation of the diseased organ is readily observable in cancer patients. It is characterized chiefly by a withdrawal of the autonomic nerves and a cessation of their pulsation. This explains in a simple and logical manner a number of secondary symptoms: the local anemia, the numbness, the excess of CO₂, and, finally, the atrophy of the cell substance. We see severe ascites occur in cancer of the stomach or the ovary where one cannot speak of a mechanical clogging of drainage. This leads to general disturbances of function such as intestinal paralysis and thus accelerates the fatal course. I believe that the main factor in inhibiting the movement of body fluids in the region of the diseased organs is the anorgonotic block of motility in the autonomic nerves. With that, the edema is explained functionally. In edema and similar anorgonotic conditions, we are dealing not with mechanical, chemical or physical functions, but with specific orgonotic life functions.

Are there experimental proofs for this orgone-physical assumption? To begin with, vegetotherapeutic and orgone-therapeutic experience shows that anorgonotic conditions can be alleviated or eliminated. Since these two therapeutic methods are based on the premise that the autonomic nervous system is contractile, their practical results confirm the correctness of the assumption.

Furthermore, there are a great number of phenomena in classical physiology...
which remain incomprehensible without a knowledge of the orgone-physical functions. One of these, for example, is the normal function of resorption in the intestines. The course of an edema which was caused by local anorgonia depends on whether or not the fluid of the edema can be resorbed. This in turn depends on the orgonotic potency and the pulsation of the respective tissues. Let us summarize the known processes of intestinal resorption:

The nature of resorption is an important and, according to the physiologists, a completely obscure problem of mechanistic physiology. The problem is this: Does the resorbing membrane of the intestinal wall act like a dead membrane or do the cells do active work? The processes in living tissue often contradict the purely physico-chemical processes in semi-permeable membranes. The resorption of food through the intestinal wall cannot be ascribed to osmosis. Heidenheim² made the following experiment: He took blood from a dog, opened his abdomen and introduced the dog's own blood serum into an empty intestinal loop which was closed off at both ends. It was shown that the dog resorbed his own serum. Since, in this experiment, there is no difference in concentration between intestinal content and tissue fluid, the purely mechanical processes of diffusion and osmosis cannot have a part in the process of resorption. The physiologists then tried to explain resorption—which cannot be explained by the principle of osmosis or that of diffusion—by the work done by the intestinal muscles. They assumed that in this experiment the intestinal muscles, which can exert a pressure on the intestinal contents from all sides, pressed the serum mechanically into the blood; they made it filter through the intestinal membrane, as it were. Relevant experiments showed that this assumption was erroneous. Reid used as diaphragm pieces of small intestine taken from a freshly killed rabbit. He separated two spaces which were filled with the same kind of salt solution, that is, isotonic spaces. It was shown that these pieces of intestine transported the solution for some time from the mucosa side to the serosa side. In the words of Höber, then, the intestinal wall itself did the work: “It sucks or presses the solution through itself.” Höber adds:

After some time, apparently when the intestinal wall dies, but also when one chloroforms it, it fails; this proves that it depends on the viability of its cells [italics mine, W.R.]. How is this to be explained? A logical hypothesis is the following: The intestinal villi contain smooth muscle fibers which shorten them; furthermore, the lymph spaces in the sub-epithelial reticular connective tissue open into a central chyle vessel which leads into the deeper, larger lymph vessels which carry chyle, that is, intestinal lymph. Since the villi are alternatingly erected and shortened by the periodic activity of the muscles, a sucking and pumping effect comes about; for the villi do not get thicker when they shorten, so that the space of the central chyle vessel becomes alternatingly smaller and larger . . . If this mechanism of a “villus pump” actually operates, then we understand the puzzling experiment of Reid's. In this case, we have to admit unequivocally that vital activities take part in the process of resorption; but the problem which then remains to be solved is none other than that with which any muscle contraction confronts us.

As we have seen, the mechanistic interpretation of the function of resorption, of the movement of fluid through the intestinal wall, fails. The mechanical functions of osmosis and diffusion fail in the explanation of living phenomena. After

²The following data are taken from Höber, Lehrbuch der Physiologie des Menschen, 7th ed., 1934, p. 69ff.
having tried in vain to uphold the mechanistic viewpoint, Höber continues:

But there are also observations which are strictly at variance with what one would expect according to the laws of osmosis and diffusion. O. Cohnheim, for example, showed that when a cephalopod intestine filled with sodium iodide is suspended in ocean water, all NaI is expelled into the surrounding solution. In dogs it can also be shown that, under certain conditions, the NaCl content of a solution in the intestine becomes less during resorption than that of the blood plasma, that, in other words, the NaCl does not wander according to the potential of concentration. [The NaCl, then, does not wander, as one would expect, from the higher to the lower concentration, but from the lower to the higher concentration! W.R.] This is an achievement comparable to that of bringing a gas from a lower concentration, that is, from a lower pressure, to a higher one. This is an achievement which also takes place in other organs; for the achievement of concentration is typical of many glands ... This proves again that the living cells take an active part in resorption.

This admission contributes nothing to the solution of the problem which was correctly formulated by mechanistic physiology. Mechanistic physiology leaves us in the lurch when it comes to understand in what manner and according to what energy laws the living cells perform their work which is at variance with the mechanistic laws of potential drop. The known laws of mechanics do not apply here. Does orgone physics give a better answer? It is the following:

1. According to the law of orgone physics, the stronger orgonotic system always attracts the weaker system. It follows that the intestinal wall can absorb the intestinal contents, but not conversely, the intestinal contents the fluids of the intestinal wall. The movement of the fluids in one direction and only that direction, then, is determined by the law of orgonotic functioning. The bions of the foodstuffs in the intestine are extremely weak orgonotic systems compared with the orgonity of the intestinal wall. This law of orgonotic functioning was derived from direct observation, and not by any means thought up for the explanation of biological phenomena. Only after it had been discovered at the orgone accumulator was it, secondarily, and successfully, applied to biological processes. The attraction of the weaker by the stronger orgonotic system applies in the living as well as the non-living realm of functioning.

2. The circulation of the blood and the body fluids depends on the intensity of the function of pulsation in the organs. The more "alive," that is, the more active an organism is, the more intensive its orgonotic pulsation is, the more rapid and complete is the metabolism of the body fluids. Increase and decrease of metabolism are vegetative life functions which are immediately dependent on the general pulsatory activity of the organs. A "decrease in vitality" is orgone-biophysically understandable as a decrease of orgonotic motility which may go as far as complete anorgonia. Seen from this standpoint, the edema with a toothache, in starvation, in nerve injury or in burns, in many pregnancies and in circumscribed cancer tumors, develops for one essential reason:

The pulsatory activity of the respective organ or region is decreased; this results in a slowing of the movement of the body fluids. In the region with decreased pulsation an accumulation of fluid takes place; more fluid flows into the diseased region than flows from it.

The pulsatory activity of an organ depends, first of all, on the activity of the autonomic nerves. Thus, the immobilization of autonomic nerves in any part of
The body must result in a cessation of the movement of body fluids. This makes readily understandable the formation of fluid-filled vesicles in the case of burns, as well as the formation of various kinds of edemas.

To return to our cancer patient: Since childhood, he had suffered from an inhibited motility in his right arm and in his speech organs. This inhibition of motility, together with the corresponding spasms and local anorgonia of the tissues, had led to the local tumor in the right deltoid muscle. Back of this local anorgonia was his general character trait of resignation which had reference particularly to the pelvis and the genital. To this corresponded the local anorgonia of the genital apparatus which toward the end led to a paralysis of the bladder function. In these two anorgonotic regions there developed edemas due to the blocked motility of the autonomic nerves. Death took place through suffocation due to glottis spasm.

We shall now proceed to another case which demonstrated the anorgonotic paralysis particularly clearly. As a child, the patient suffered from a sore throat (suspected diphtheria) which was followed by a slight cardiac weakness. Menstruation began at the age of 12 and was normal in the beginning; later, there were always, on the first day, violent cramplike pains in the region of the left ovary. Neither hot compresses nor drugs helped. The left side of the lower abdomen remained a "weak spot" in which violent pains kept recurring. At the age of 16, the patient started working in an X-ray laboratory. Three months later, she felt poorly, suffered from nausea, palpitations and loss of hair. A physician prescribed arsenic which, however, she tolerated poorly. The cardiac complaints became worse. At the age of 17, she was found to suffer from severe anemia, swelling of the breasts and disease of the ovaries. The pains in the region of the left ovary kept getting worse. Different physicians made different diagnoses, such as "inflammation of the ovary," "spasm of the uterus," etc. All medication was of no avail. Two years later the patient found that her left leg tired very easily, and a phlebitis appeared. Every year, the patient suffered three or four times from "grippe," at which time the weakness in the leg and the "phlebitis" always increased. Soon, there were pains in the lower abdomen. After the delivery of a child the swelling in the left leg became worse and her whole body became sensitive to pressure. Her physician found anemia: 3.2 millions of erythrocytes and 56% hemoglobin. Different kinds of treatment were tried, to no avail. The case history shows that the many physicians who were consulted conflicted with each other both as to diagnosis and therapy. At various times, the patient had been treated with diathermy, liver injections, heat treatments, and evipan.

Blood examination.

The orgone-physical examination of the blood revealed a peculiar picture which I had never seen before: Hemoglobin was 95% while at the same time the blood culture was strongly positive and the T-reaction almost 100%, as shown in the autoclavation test and in the Gram stain of the blood colloid. Microscopically, the following was striking:

Although the autoclavation test pointed to an extreme orgone weakness of the erythrocytes, they showed, microscopically, no shrinking and no premature bionous disintegration (disintegration in 20 minutes); on the contrary, they showed a wide, strongly radiating orgone margin. What was particularly striking was that some erythrocytes were far larger than normal. In every field there were numerous large cells with smooth plasm, resembling macrophages. It was observed that the erythrocytes grouped themselves about
these large plasmatic cells at a certain distance, that is, without contact of the membranes; however, they formed strong orgone bridges. After a few minutes' observation, I had the impression as if the erythrocytes were tremendously overcharged. To this overcharge, which expressed itself in the color and size of the erythrocytes, corresponded their extremely slow disintegration in physiological salt solution: while normally the first bion vesicles appear in the erythrocytes after about 3 to 5 minutes, the erythrocytes of this patient showed no bionous disintegration even after 15 minutes. When it finally occurred, the resulting energy vesicles were extremely large and strongly radiating.

I shall summarize the peculiarities of the blood picture in this patient in such a manner as to make it understandable why I made the diagnosis of a latent leukemia.

In my article on the experimental orgone therapy of the cancer biopathy, I expressed the assumption that leukemia is not a disease of the white blood corpuscles, but of the erythrocyte system. My assumption was that the erythrocytes undergo a process of disintegration or putrefaction, and that then the white corpuscles increase in exactly the same manner as when there are bacteria or other foreign bodies in the blood stream. The "foreign body" in leukemia is the disintegrating erythrocyte itself.

The patient's blood picture showed the following contradiction: Microscopically, the erythrocytes were overcharged, radiating abnormally strongly. Autoclavation, on the other hand, showed inner putrefaction, that is, almost 100% T-reaction. It is difficult to harmonize the orgonotic over-radiation with the simultaneous process of putrefaction in the erythrocyte. However, we know many processes in the organism which consist in an exaggeration of normal biological functions and which occur when the defense against pathological processes in the same organ requires this additional effort. The patient, then, suffered from a chronic, latent tendency to putrefaction in the erythrocytes. To this putrefaction of the erythrocytes the organism reacted with an increase in white blood corpuscles, with the development of large, macrophage-like white cells, and with temperature rises, that is, with frequent lumination of the blood system, to overcome the orgonotic weakness.

As always, orgone therapy became the touchstone of my hypothesis. If my hypothesis was correct, the application of orgone energy would eliminate the tendency to putrefaction in the erythrocytes and the corresponding manifestations. My expectation was confirmed. As early as one week after the beginning of orgone therapy, the blood culture was negative. The erythrocytes were smaller than before and there were fewer white blood cells in the field. The disintegration of the erythrocytes began after 3 to 5 minutes, and this time there were also T-spikes.

Two weeks after the beginning of the orgone therapy, the large cells with smooth plasm had disappeared, and after another three weeks the T-spikes and the over-radiation. Three weeks later, the T-reaction after autoclavation—which on first examination had been almost 100% positive—was only 10-20% positive. The blood picture was almost normal. In the course of the following year, blood tests were made about once a month. The culture reaction remained negative, the over-radiation and the increase in white cells did not recur. But the T-reaction after autoclavation continued, in the form of a greenish discoloration of the colloid and

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8 A diagnosis on the basis of a stained smear is not possible in these cases. What matters here is not the name or the structure of the various kinds of white blood corpuscles, but the living function of the grouping of red cells around white ones, and the orgonotic constitution of the living and the disintegrated blood cell.
in the form of disintegration into T-bodies. In the course of this year, the culture reaction in bouillon was once positive; this happened after the application of drugs by another physician.

The fever attacks from which our patient had suffered for so long had to be understood as a reaction of the blood system to its own tendency to putrefaction. The blood had reacted toward its own orgonotic weakness as it would react toward a toxicosis. The proof of this lies in the fact that the fever attacks disappeared together with the hyporgonia and the T-reaction of the blood. It remains for further investigations to determine whether what is called “functional or cryptogenic fever” always is due to a lumination of the blood cell system, that is, a defense reaction against the disturbance of vegetative functions. In this case, the blood system reacted precisely as it does in the case of an infection with bacteria.

The father of this patient had died of leukemia. For some time, the patient had suffered from a suspicious leukocytosis. At certain times of her functional fever, she had a leukocytosis up to 14,000. Her physician, too, had suspected some kind of latent leukemia, although the customary methods of examination provided nothing to substantiate this suspicion. Our blood tests left no doubt about the cancerous character of the blood picture. True, there were no circumscribed malignant tumors, but numerous precursors such as tumors of the ovaries, putrefaction of the uterus, etc.

Personally, I have no doubt that the patient would have died of leukemia if the orgone therapy had not been successful.

There was, then, a latent hyporgonia of the erythrocytes. The course of the orgone therapy showed how deeply rooted this hyporgonia was, for it gave way only very gradually and there was a great tendency to relapse. In other words, the coherence of the plasma in the erythrocytes was weak, and the tendency to putrefaction correspondingly great.

The attacks of weakness did not cease with the re-establishment of the normal blood reaction, although they became much less frequent, of shorter duration, and did not force the patient to keep to her bed for months. The anorgonia, then, could not be ascribed exclusively to the bio-energetic weakness of the blood system. Apparently, the anorgonia can affect special organs and organ groups and thus create disturbances in the respective organ functions and give rise to local malignant growths. But, as this case shows, the anorgonia may also exist without tissue disturbances, that is, in a purely functional manner.

Our patient was able to eliminate every attack of weakness by using the orgone accumulator. Nevertheless, the tendency to anorgonia persisted for over two years after she had become well.

We are dealing here apparently with a disturbance of the functioning of the total body orgone, independent of any mechanical or physiological organ disturbances which may accompany the anorgonia. It is necessary to assume the existence of such a total and independent anorgonia.

Anorgonia is not identical with the condition of plasmatic contraction which we find in vascular hypertension; true, it may accompany or follow muscular and vascular hypertension, but it may also appear without hypertension.

Anorgonia is not identical with the carcinomatous shrinking process, either; although the shrinking, in the last analysis, always leads to anorgonia and death, anorgonia does not necessarily lead to the shrinking. I have observed anorgenotic conditions in cases where there was no question of shrinking of the autonomic life apparatus.

The hypertonia of the life apparatus has
to be thought of as a biophysical contraction which fights against vigorous impulses originating from the biological nucleus. Shrinking biopathy is accompanied by a decrease in the impulses from the nucleus; there is a gradual slackening of the pulsatory impulse functions.

In anorgonia, on the other hand, we are dealing with a sudden failure of motility, as in fright paralysis which most likely represents acute anorgonia in the purest form. All the cases described so far showed the acute anorgonia alongside the gradual shrinking process: Our first cancer patient collapsed in the laboratory at a time when she was getting well and was gaining weight. The patient with the cancer of the prostate also collapsed one day during the period of getting better. Our third case, too, was suddenly overcome by anorgonia at a time when he was visibly improving.

Fright paralysis and vegetative shock suggest what we are dealing with: It is a matter of a sudden cessation of the plasmatic functioning of the total organism. If the acute anorgonia includes the cardiovascular system, death occurs.

Our patient disclosed a part of the mechanism which is the basis of the block of plasmatic motility. She came to vegetotherapy for the elimination of the biopathic background of her latent leukemia. For several months she made excellent progress so that she almost forgot about her illness. Then one day, suddenly, the old disease picture returned in its full strength, as if nothing had been achieved in the meantime. This was precipitated by the occurrence of vigorous but strongly warded-off genital impulses. At the moment when these impulses announced themselves in the form of sensations of streaming in the vagina, there was orgasm anxiety and with that an anorgonotic state which lasted about 10 days and appeared quite alarming. This time, however, I was not hopelessly surprised. My earlier experiences with cancer patients had prepared me for this occurrence and I was able to take the appropriate measures. In concentrated vegetotherapeutic work—the patient came daily—I tried to eliminate the acute anxiety reactions which made the patient shrink from the full experiencing of her genital sensations and which made it impossible for her to let the orgasm reflex take its course. A wealth of infantile experiences which now were remembered showed that her mother had threatened dire punishment for any activity which might cause genital excitation, such as dancing, and had called such behavior that of a "whore."

I would like to stress this connection. It forms the key to an understanding not only of the biopathies in general, but to that of the shock-like anorgonia in especial. Needless to say, it is not a matter of the word "whore," but of everything which it represents socially, psychically, structurally and biophysically: Slight genital impulses which can always be controlled and repressed are not considered "whore-like," either by compulsory social moralism or by the armored structure. It is the vigorous natural impulse in the form of an uncontrollable surge (illumination) of the body plasma which is officially designated as immoral, criminal or "whore-like" and which is subjectively experienced as "loss of self-control."

This fact has far-reaching social and biopsychiatric consequences. The terms "pleasure anxiety" or "orgasm anxiety" are too weak and narrow to designate the bio-energetic storms which take place in an organism which is still armored and yet experiences the full orgasmic plasma excitation. The consequences of this conflict between armoring and plasmatic orgastic excitation are extremely serious. They are a matter of life and death, far from being harmless "clinical problems." I hope I shall succeed in conveying the full seriousness of this fact.
ANORGONIA IN THE CARCINOMATOUS SHRINKING BIOPATHY

It was again and again the anorgonotic paralysis which killed my cancer patients who were already on their way to health. The three first-described patients all died at a time when they came up against the natural orgastic excitation and plasma stasis. In the fourth case, I succeeded in averting the disaster. The fifth case, to follow, will set the danger of anorgonia into even sharper focus.

In this patient, the first signs of the disease began between the ages of 12 and 14, that is, in early puberty. The first sign was a pulling pain in the left hip which, intermittently, lasted for several years. Somewhat later, there were attacks of pain in the chest which recurred at very frequent intervals for about 10 years. The diagnosis was "pleuritis." An X-ray of the lungs taken at the age of 13 showed "healed tuberculosis." At the age of about 13, generalized "rheumatic and neuritic pains" set in which, also intermittently, lasted for about 15 years. At the age of 12, a tonsil operation was done for "tonsillar infection." At the age of 15, there was an inflammation of the salivary gland (parotitis). At the same time, the patient suffered from violent pains in her big toes which often took on a livid discoloration; apparently, a matter of angiospastic attacks. The patient had suffered from severe anxiety states since early childhood; at the age of about 19, these increased to acute attacks of violent palpitation. At the age of 15, she had an "infection" of the jaw and the roots of her teeth, as a result of which a large part of the lower jaw, with 9 teeth, was resected. Now, the diagnosis was "osteomyelitis." Between the age of 16 and 20, there were various intestinal complaints, diarrhea alternating with constipation; also febrile periods and a general weakness and fatiguability which continued up to the beginning of vegetotherapy.

At the age of 19, there was such an increase in the pain in both inginal regions that she was operated on, this time for "appendicitis." After the operation, she suffered continuously from high temperatures which were accompanied by "diarrhea." The attacks of diarrhea went with cold shivers. The condition ended in a "nervous breakdown."

Between the ages of 21 and 26, she underwent a second tonsil operation because of "inflammation and infection"; also a diagnostic laparotomy "in order to find out what caused the pains." The febrile temperatures continued. The diagnosis, again and again, was "infection." Between the ages of 24 and 27, the findings of "anemia" and "enlarged liver" were made. For a time, there were intestinal hemorrhages with every act of defecation. Two years later, a hospital diagnosed "amebic dysentery" and she was operated on for "hemorrhoids." At the age of 30, a third tonsil operation was done because of "pus." A year later, the patient developed an increased urge to urinate. She was again operated on, this time because of "multiple benign tumors," the body of the uterus and one ovary with a cyst were removed. Soon after this operation, "gastric ulcers" were diagnosed. Two years before the beginning of vegetotherapy, a pus-producing fistula opened in the middle of the abdomen.

The gynecological findings were as follows: Two finger introitus. Urethra, Bartholin's and Skene's glands free. Cervix in axis. Uterine stump freely movable, no stump exudate. Left adnexa cannot be felt, have apparently been extirpated at the time of the supracervical hysterectomy. The right tube is normal. The right ovary extremely small. Speculum examination shows severe inflammatory changes due to trichomonias infection in an atrophic vaginal mucosa. Of other physical signs I mention only the cystic mastitis.

The diagnosis of the gynecologist was "dysfunction of the endocrine glands" as the cause of the many infections.
Let us not go into the tragicomedy of this history of suffering. There is an infinite number of patients who, all their lives, go from physician to physician with their acute organic diseases, without being hypochondriac neurasthenics. Such patients receive not only different diagnoses on the basis of their different symptoms; also, different physicians treat one and the same symptom in various manners on the basis of different diagnoses. The mechanistic disaster in internal medicine is characterized by the fact that medical understanding has given way to diagnostic slogans, among which two stand out: “infection” and “dysfunction of the glands.” Whether the knife or vitamins are used, the basis of the misery is always the use of mechanistic slogans. The bacillus “in the air” has become an imp no less than the chemical stuff in the endocrine gland. The knife in particular represents the extreme in the disastrous mechanistic view of the organism. One does not ask why it is that the ligaments in the parametrium become shortened, why it is that tumors develop in the uterus, why it is that “air bacilli” can settle in all kinds of organs; one blithely assumes an infection of the vagina with protozoa, although no such protozoa can be demonstrated “in the air”; in brief, the great medical discoveries concerning infection, internal secretion, etc., have been degraded into a ready-made scheme which not only blocks the way to new problems but which also destroys innumerable human lives. Is it reasonable to assume that this patient suffered from a dozen diseases? Certainly not. In reality, she suffered from one single disturbance, a disturbance of the function of plasmatic pulsation. The individual diagnoses are not important here. When the body plasma as a whole does not properly function, then there will be organs which are poorly charged, so that bacteria can settle in them; then the glands of internal secretion will function poorly; then muscles will become chronically contracted so that they pull on ligaments; then the vaginal mucosa will undergo atrophy, etc.

Imagine a building contractor who, in the course of 20 years, makes the following findings in a house which was built on sand: cracks in the chimney and ceilings, warped floor, injury of a child by a falling lamp, break in a water pipe, and seepage of water through the walls. What would be done with a contractor to whom it would not occur that the house is built on unsafe ground and that this is the reason for all the disturbances? Yet, the mechanistic splitting up in the diagnosis of somatic diseases is in no way different from the procedure of this contractor. Mechanistic slogans like “infection,” “grippe,” etc., disguise the fact that the causative agent is neither known nor demonstrable. If, as a vegetotherapist, one sees colds, rheumatic pains, or pains in the pleura develop as soon as the respective part of the body becomes contracted, one must needs think of the possibility that infections may be the results of biopathic disturbances of function. This is an obscure field in which everything remains to be done. We will have to learn to consider the orgonity of the organism as at least as important in epidemics of cholera, typhoid, poliomyelitis, etc., as the specific micro-organism. Since it has been established as a fact that specific micro-organisms can develop autogenously, through degeneration of body cells, the “bacillus” takes its place in the general disease process as its result as well as its cause.

The tumors of the genital apparatus which necessitated the hysterectomy, and the tendency to tissue destruction through putrefaction, make this case similar to case 4. The attacks of fever and weakness point to a severe disturbance of the bio-
logical energy equilibrium. True, with the exception of the genital tumors, the precancerous symptoms were slight; nevertheless, they were marked enough to justify the contention that the patient would have died of full-blown carcinoma. Just as the psychiatric vegetotherapist assumes the development of a psychoneurosis when he sees acute anxiety attacks, so, in cancer pathology, can one foresee the development of a cancer biopathy when its precursors make their appearance. It will be one of the tasks of cancer prevention to recognize the precursors of the disease as early as possible and to eliminate them. This is possible by orgone therapy and vegetotherapy.

I shall now proceed to the patient's reactions in vegetotherapy: The thorax was immobile in the typical manner, respiration was shallow, the musculature of the neck tense, the spine lordotic, and the pelvis "dead." The facial expression was that of a grimace-like, stiff smile; it was not difficult to see a deep depression and impulses to cry behind this mask. The dissolution of the superficial inhibition of respiration immediately resulted in body impulses composed of violently jerky, pushing motions. This pushing soon assumed the form of a hateful defense against a sexual attack, the face being distorted with hatred: the orgasm reflex had assumed the function of expressing hatred of sexual motions. Between the ages of 6 and 16, the patient had often been sexually abused by her older brothers. On these occasions, she had been excited and defensive at one and the same time. The excitation forced her again and again to allow it; the defense had become somatically anchored in the "pushing away." In this way, her orgasm reflex had assumed its special form.

I shall pass over the many details of the infantile history and confine myself to the anorgonia. It is unimportant what early experiences caused the anorgonia, since there are no specific experiences which do so. Anorgonia is a purely biological reaction to a chronic block of the orgasm function. What is likely to be specific in anorgonia is the conflict between very vigorous natural genital impulses and equally vigorous disruptions in the course of the orgasm reflex. I would like to venture the assumption that children who do not develop a particularly strong genital orgonity will also tend less to anorgonotic states; this assumption, I would like to emphasize, is very tentative. But to return to our patient.

As long as the body contractions had a hateful character, the work proceeded in the usual manner. This changed, however, when the contractions became softer, more "giving in," and consequently pleasurable. To the extent to which the expression of hatred disappeared and the motions became pleasurable, the movement of the pelvis changed its direction. Previously, the pelvis would move backwards during the contraction, would "push away." Now, forward movements appeared in the pelvis. As was to be expected, preorgastic sensations soon appeared in the pelvic floor. At the same time the inflammation of the vaginal mucosa receded; microscopic examination of the vaginal secretion showed a reduction of the trichomonas parasites, most of which were immobile or even disintegrating. From then on I could see over a period of months how genital coldness went with an increased formation of protozoa, while, conversely, genital excitation went with a decrease in protozoa formation. This is fully in accord with the orgone-biophysical contention that protozoa form in the organism only in the case of orgonotic weakness in the respective organs, and that they disappear with strong orgonity. Since the trichomonas
protozoa develop from bionously disintegrating vaginal or cervix epithelium, the relationship with the orgonotic potency of the tissue is understandable.

As long as the plasmatic currents in the vagina were weak, the course of treatment did not differ from the average. This changed, however, when the patient felt the first strong surge of sexual excitation. One day, she gave in more than usual, and a strong wave of excitation appeared in the lower part of the body. Suddenly, she was unable to move or to talk; she did not answer when spoken to; she was unable to get up; there was a flaccid paralysis of the limbs. The picture as a whole was alarming: The skin of the neck and the upper body was bluish and patchy as in vegetative shock. The body did not react to such stimuli as pinching. However, the patient was not unconscious; after the anorgonotic attack she related that everything around her had been "black," that suddenly she no longer felt her body and had thought she was "dying."

The attack corresponded to acute anorgonia. The reflexes, as well as tactile and pain perception, were present, but motility was lost. The anorgonia lasted for about 40 minutes. I helped the patient to sit up, but she sank back helplessly. After an hour she was able to get up by herself, with considerable effort; but when she did, her knees collapsed. After another hour of rest, she was finally able to go home by herself.

During the next session, the patient was again armored very strongly. When the armoring was loosened, the anorgonia recurred; this time, however, it was less intense and did not last so long. The patient described the attack as "fading out." From then on I was able to produce the anorgonia at will; it was sufficient, for example, to move the head to the side or backwards to produce it.

It is important to note that these attacks were not accompanied by anxiety. Gradually, the connection between anorgonia and vegetative current became clear. One of the patient's defense mechanisms was that of a superficial jocularity which served to ward off serious feelings. Another mechanism was that of "going dead" when her emotions became too strong. The anorgonotic attack, then, represented a third mechanism.

The superficiality in the character and the affect-lameness represented the superficial armoring; the real depth mechanism was the anorgonia. In the course of the ensuing months, it became clear that the anorgonia had always been functioning, though subterraneously; it had resulted in the attacks of weakness as well as in the diverse suppurative processes. The anorgonia failed to occur when the patient let herself experience sexual excitation, and it recurred immediately when the excitation was not allowed full swing, when, in other words, it was arrested while increasing.

The anorgonia was accompanied by dizziness and falling anxiety. It would either develop "superficially," stretched out over days, as it were, or else "deeply," that is, acutely and in full force. As in case 4, the use of the orgone accumulator usually eliminated the attacks of weakness. The bringing about of the orgasm reflex, also, relieved it.

The mechanism of anorgonia in this case is completely in accord with that of the cases described earlier: The organism reacts to a strong and unaccustomed plasma excitation with a block in motility which expresses itself in "weakness," "collapsing," "fading out," disturbance of equilibrium and falling anxiety. It is as if the orgonotic expansion would start but would not be able to take

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4 The organization of Trichomonas vaginalis from the vaginal epithelium has been demonstrated microscopically and recorded on movie film.
its full course, as if the impulse to expansion became suddenly extinguished.

In the course of the treatment, the patient remembered a number of childhood situations in which such attacks of weakness had occurred. For example, when she had the impulse to show her father affection, she would feel “as if paralyzed.” The exploration of the details of this situation left no doubt that what paralyzed her was an extremely strong sexual excitation which started to break through. The father was a hard, cold person, which seemed to make the sensation of sexual currents in his presence a horrendous occurrence. Her paralysis expressed the helplessness of the child which wanted to express love without being able to prevent the physical sensation which accompanies the expression of love. The result was a block in motility and an attack of weakness.

It was even possible to localize the block of motility: When the orgasm reflex became more intense and spread from the thorax to the abdomen, the patient developed a peculiar reflex action: She literally collapsed below the umbilicus; the legs were pulled up rapidly, the upper part of the body jerked forward; both hands grabbed for the lower abdomen as if in pain. Gradually it became clear—and palpation of the abdomen confirmed it—that the wave of orgonotic excitation, on its way to the genital, became stopped by a spasm of the intestines. This took place precisely at the place where the suspensive fistula had broken through the abdominal wall. (The fistula had healed in the meantime under orgone treatment). It is clear, then, that the abdominal organs became spastic as soon as waves of excitation moved toward the genital. This is how her abdominal pains, her colics, diarrhea and constipation had originated. What is less clear is the histological mechanism by which such spasms produce tumors in the uterus or the intestines.

However, the causation of benign genital tumors by spastic conditions of the abdominal organs cannot be doubted.

In the course of two weeks of hard work on this block in the lower abdomen, the condition ceased. The orgasm reflex was no longer jerky but became soft; soon there occurred the typical “melting” sensations of current in the lower abdomen and the patient, for the first time in her life, experienced preorgastic sensations of current in the genital during the sexual act. With the elimination of the block in motility, the acute anorgonotic attacks disappeared also, though the mild, stretched-out states of weakness continued to persist.

In this way, therapy confirmed the concept of anorgonia.

The anorgonotic paralysis is now satisfactorily defined, symptomatically and dynamically. It comprises those conditions which heretofore led a Cinderella existence in pathology under the name of “functional paralyses.” They now become understandable as disturbances in the functioning of a concrete biological energy, instead of as “hysterical” or mechanical lesions of the nerve tracts.

What is more difficult is the differentiation of the anorgonia which results from gradual plasmatic shrinking from the anorgonia which sets in acutely. Does anorgonia consist in a loss of organismic orgone, or merely in a block of motility of undiminished orgone? Mild anorgonomic states of weakness are easily distinguished from acute attacks of anorgonia. The principle must be assumed to be the same in either case. We must assume that anorgonia of the type of acute attacks can develop into a chronic shrinking process; and that, conversely, chronic anorgonia can end in acute functional paralysis. The organism may resign and finally shrink if its impulses to expansion cannot function; and it can cease to expand when the organism is subjected to gradual orgone
loss. The common denominator is, biophysically speaking, the inhibition of the function of expansion, or, psychologically speaking, the inhibition of the pleasure experience.

The next question is the following: How far back does this disturbance reach in the developmental history of the organism? In all 5 cases we were able to find traces of anorgonia, slight and transitory attacks, as far back as early childhood. The origin of anorgonia cannot be set at too early a period. It is likely that the functions of the body orgone acquire their characteristics in the course of fetal development. This does not by any means imply "heredity"; it simply shifts the problem to the period before and shortly after birth. It is important to remember that the constitution of an organism results from a development, that it does not exist, "ready-made"; furthermore, it has to be assumed that the development of the biophysical constitution lasts beyond birth to about the end of the first year of life.

Just as the prevention of disease cannot be started early enough, so must the study of the biophysical constitution go back as far as to the formation of the embryo. This is made possible, in principle, by our knowledge of many functions of the orgone.

Scientific progress is based on the reduction of empirical facts to primary causes and on the progressive unification of these causes. Freud's psychopathology considerably reduced the importance of the imp, "heredity," by his discovery of early infantile libidinal development. The findings of psychoanalysis are based on observations of children up to the age of about two.

Orgone research goes beyond this. Vegetotherapy of schizophrenic characters leaves no doubt that the central mechanisms of a later schizophrenia are established within the first few weeks of life.

To learn more about this is of vital importance. The language of motility, the organ language and the language of emotional expression used in vegetotherapy is, phylogenetically and ontogenetically, older than the language of the word and of the idea which forms the tool of depth psychology. Unlike the language of the word and the idea, the language of bodily expression does not begin at a certain age and is not restricted to the human animal. The language of bodily expression is a function of the animal world in general, even though we have not yet learned to understand it. In this way, living functioning becomes accessible to orgone physics before the first year of life in the human, and in the animal generally, for emotion and motor expression are based on plasma pulsation.

I shall postpone an exposition of the results of experimental vegetotherapy in schizophrenics until another time, and shall conclude this report on anorgonia with a description of the expressive language of a newborn child. It will be shown that the early beginnings of anorgonia are in fact to be looked for in the period before and after birth.

Falling anxiety in an infant of 3 weeks

Recently, I had an occasion to observe the development of falling anxiety in an infant of 3 weeks. This observation filled a gap which the study of cancer biopathy had left open.

This infant was born into an environment in which the expressive language of the organism is professionally understood and handled. For this reason, it was all the more baffling that the parents felt helpless in the face of the infant's gesture language; during the first few weeks, they felt that one knows practically nothing about the emotional life of the newborn. Purely mechanical care, it goes without saying, does in no way satisfy the emotional needs of the infant. He pos-
sesses only one form of expressing needs, that is, crying. This one form covers innumerable small and great needs, from the pressure of a diaper crease to colic. The expressive language of the infant finds no response in the environment.

I shall not go into any of those injurious methods of infant care which modern education has effaced, or is still trying to efface, from the earth: rigid allotment of food quantity and of feeding time as instituted by Pirquet, violent extension of the legs by tight swaddling, as was customary some 30 years ago, denial of the breast during the first 24 hours, as still practised in many hospitals, overheating of the nurseries, the mechanical routine handling of infants in large institutions, the “letting them cry themselves out,” etc. Such measures of force are the expression of a life-inimical attitude on the part of parents and physicians. They do lasting damage to the biological self-regulation of the organism shortly after birth and lay the basis for a later psycho-neurosis which is then misinterpreted as hereditary. All these things are already common knowledge today although not yet common practice in infant care.

I shall confine myself here to one definite harmful influence during the first few weeks of life which has hitherto been neglected: The lack of orgonotic contact between mother and infant. This lack of contact may be of a direct physical or it may be of a psychic nature. It goes without saying that the infant’s language of emotional expression will be the better understood the fuller the orgonotic contact.

The pre-eminent place of contact of the infant’s body is the bio-energetically highly charged mouth and throat. This organ immediately reaches out for gratification. If, now, the mother’s nipple reacts to the sucking movements in the proper biophysical manner with pleasure sensations, it becomes vigorously erect, and the orgonotic excitation of the nipple combines into a unit with that of the infant’s mouth, just as in the orgasmic sexual act male and female genital luminate and fuse orgonotically. There is nothing “peculiar” or “repulsive” in this. Every healthy mother experiences the sucking pleasurably and gives herself over to the experience.

There is the other fact, however, that about 80% of all women suffer from vaginal anesthesia and frigidity. Corresponding to this fact, their nipples are either anorgonotic, that is, “dead,” or the mother reacts to the pleasurable sensations which the sucking arouses in the breast with anxiety or disgust. This is the reason why so many women refuse to nurse their own babies. This situation has further consequences. An anorgonotic breast functions poorly physiologically, that is, the milk production is disturbed. As a result, the excited mouth of the infant either meets a “dead” nipple so that he fails to get satisfaction, or the mother, because of her phobia of nursing, relegates the infant to the non-excitable rubber nipple of the bottle.

The emotional disturbances of the vegetative currents in the mouth, neck and shoulder regions which one finds in the biopathies leave no doubt that these defects on the part of the mother result in a severe damage to the orgonity of head and neck. Speech disturbances, emptiness of emotional expression, eating disturbances, spastic hysterical vomiting, fear of kissing, depression, stuttering, mutism and similar disturbances are an expression of the poor orgonotic function of the mouth and throat.

So much about the first physiological contact of the infant with the world.

We shall proceed now to the emotional contact, which is determined directly by the orgonotic contact. The infant has no other means of expression than the various forms of motion (grimaces, move-
ments of arms, legs and torso, expression of eyes) and the crying. The contact of the mother with the infant is governed not by language but by the motor expression: the adult perceives the infant’s motor expression through orgonotic contact (psychologically speaking, by identification). If the adult’s own motor expression functions well, he will also comprehend the infant’s expression. If, on the other hand, he is armored, hard in his character, pleasure-shy or otherwise inhibited, then his understanding of the infant is severely limited, which will inevitably impair the emotional development of the child in various ways. The need of the infant can be satisfied only if one understands the infant’s expression. It is not always easy to know immediately what the infant wants.

Every newborn has its own characteristics, its own basic trait; without understanding this one cannot understand its individual emotional reactions. The infant in question was characterized by an “earnest looking.” This “looking expression” was fully developed a few minutes after birth: the newborn baby looked with his eyes wide open and with the expression of seeing. He took to the breast immediately and sucked vigorously. In the first week, he cried very little. In the second week he cried much, and the people around him were unable to understand the reason for the crying. The pacifier did not always pacify. I often had the impression that the child wanted something definite but I did not know what. Only two weeks later did I understand that what he wanted was bodily contact. This I will have to explain in some detail.

During the few hours in which the baby was awake he would follow with his eyes the red, moving lines painted on the wall of his room. He distinctly preferred the red to the blue or green color: his gaze would remain longer on the red, and the expression of looking was more intense.

At the age of two weeks, the infant had his first orgasmic excitation of the mouth region. This occurred while he was nursing: the eyeballs turned upwards and sidewise, the mouth began to tremble, as did the tongue; the contractions spread over the whole face; they took about 10 seconds, after which the musculature of the face relaxed. To the parents, this manifestation seemed only natural. But we know from practice that many parents get frightened when the mouth orgasm occurs in their child. During the next four weeks, this orgasm of the facial musculature occurred several times more.

At the end of the third week of life, there was an acute falling anxiety. It occurred when the child was taken out of the bath and put on his back on the table. It was not immediately clear whether the motion of laying him down had been too fast, or whether the cooling of the skin had precipitated the falling anxiety. At any rate, the child began to cry violently, pulled back his arms as if to gain support, tried to bring his head forward, showed intense anxiety in his eyes and could not be calmed down. It was necessary to take him up again. At the next attempt to put him down, the falling anxiety appeared again, in the same intensity. Only when taken up did he again calm down.

During the next day, the right shoulder blade and the right arm were found to be pulled back and less mobile than the left arm. There was a definite contraction in the musculature of the right shoulder. The connection between this contraction and the falling anxiety was clear: During the anxiety attack, the child had pulled back both shoulders, as if to gain a hold. This muscular attitude persisted now even in the periods free of anxiety.

I believe this happening to be of great
significance. In trying to explain it, we must first exclude several things:

It could not be a matter of genital orgasm anxiety as in patients after puberty. Neither could it be a rational fear, for an infant of three weeks' age has no concept of "falling," of "high and deep." Nor could it be a psychoneurotic falling anxiety, for before the development of word language there are no concepts, and without concepts there can be no phobia.

The psychoanalytic explanation of "instinct anxiety" which is used in such cases is unsatisfactory, for we would have to ask which kind of an instinct was warded off? There is at this age no moral ego, and, according to psychoanalytic theory, there can be no instinct anxiety unless there is a moral defense present. The anxiety cannot be a "danger signal of the ego" because there is no "ego."

Rationalistic as well as psychological interpretations, then, leave us in the lurch. How can an acute anxiety attack come about in a child three weeks of age if there is neither a consciousness of a danger of falling nor a defensive anxiety signal of the ego? We certainly will not take recourse to the assumption of an "archaic, inborn instinct anxiety"; that would be too easy and would not mean anything. An anxiety attack is a functional disturbance and can be understood only from the orgonotic body functions.

Let us attempt a biophysical interpretation: If it is not a matter either of a fear of danger or a defense against an instinct, there remains nothing but the pleasure-anxiety mechanism of the orgonotic body system, a mechanism which, as we know, begins to function with the first plasmatic motion. In my monograph, *Psychischer Kontakt und Vegetative Strömung* (1934) I assumed that the sensation of falling comes about purely biophysically through a sudden withdrawal of the biological energy to the vegetative center. It is a matter of a kinesthetic organ sensation as it occurs with actual falling, in fright and with sudden inhibition of orgasmic expansion. As I have shown clinically, orgasm anxiety is always based on falling anxiety; the rapid and extreme pulsation in the orgasm is experienced as falling if the pulsation cannot take its course freely. In contrast, the free, uninhibited orgasmic contraction conveys the sensation of floating or flying.

Now, the withdrawal of bio-energy from the body periphery means an anorgonia of the extremities; the anorgonia of the supporting organs goes with loss of the feeling of equilibrium.

Falling anxiety, thus, is not a "psychic formation" but the simple expression of a sudden anorgonia in those organs which maintain the body equilibrium by opposing the force of gravitation. Whether falling anxiety and anorgonia are precipitated by sudden orgasm anxiety, by actual falling or by a fright contraction, the mechanism is always the same: loss of peripheral plasma motility, and with that loss of the feeling of equilibrium and of equilibrium itself. The experience of anxiety is an automatic biophysical result of the sudden contraction of the plasma system. However, the orgonotic contraction goes with loss of plasma motility in the periphery, and for this reason expresses itself as fear of falling.

The effect is, of course, the same whether the immobilization takes place as a result of a secondary pleasure block or as a result of a primary anxiety contraction; the sensation of falling is the immediate inner perception of the immobility of the body periphery, of the loss of equilibrium. It follows that the equilibrium of a body in the field of gravitation is a function of the full orgonotic pulsation in the periphery of the orgonotic system.
At this point, I must mention an observation which supports this interpretation: A boy whom I knew had caught a squirrel which he held in his hand. I was struck by the fact that the squirrel lay there in the hand completely flaccid; it did not move, or fight or bite: it was paralyzed with fright, it had an acute anorgonotic attack. After a few minutes, the boy put it down on the ground. At first, it continued to lie there immobile, as if dead. Then it tried to get up, but fell down again; in terms of physics, it was not able to overcome the pull of gravity. These attempts to get on its legs were continued for about 15 minutes, without success. It was not injured, for later on it was perfectly able to run and climb. The disturbance of equilibrium and the continued falling down increased the anxiety, which in turn led to further falling down. For some minutes, the whole body convulsed in sudden contractions which were so violent that it was thrown into the air as high as several inches. Finally it recovered from the attack and retreated to some bushes; after having rested there for a long time, it ran off.

But to return to our infant. Can we surmise the cause of the anorgonotic attack? I think we can.

As I mentioned before, for a period of about two weeks the organotic contact of the mother with the baby was poor; apparently, the baby had strong impulses toward contact which remained ungratified. Then occurred the orgasm of the mouth region, in other words, a perfectly natural discharge took place of the high-pitched excitation of the head and throat region. This increased the need for contact even further. The lack of contact led to a contraction, to a withdrawal of biological energy as a result of unsuccessful attempts to establish contact. If it were permissible to use psychological terms here, one would say that the child "resigned," that it was "frustrated." The "biological resignation" led to anorgonia and with that to falling anxiety. I may remind the reader of case 5, in which the same mechanism governed the biopathy.

My attempts to master the falling anxiety in the infant were successful. If my conclusions were correct, three things were required:

1. The child had to be taken up and held when he cried. This helped. After three more weeks, the falling anxiety no longer occurred. With the falling anxiety, a fear of strange people had also appeared. Before the first attack of falling anxiety, the child had always liked to be taken up by strangers; after the attack, he would become anxious and would cry when somebody tried to take him up. He also had once reacted with anxiety to a dog which appeared unexpectedly.

2. The shoulders had to be brought gently forward out of their backward fixation in order to eliminate this first beginning of a characterological armoring in the shoulders. Playfully, with laughter and sounds which the baby loved, I moved both shoulder blades forward; this was done daily for about 2 months, always in a playful manner.

3. It was necessary actually to "let the child fall" in order to accustom him to the sensation of falling. This also was successful. Holding the child under the armpits, I would lift him and then lower him, slowly at first, then increasingly quickly. At first, the child reacted with crying but soon he began to enjoy it. He even developed a kind of game from it: he made "walking" movements with his legs. He leaned against my chest and looked up toward my head. I understood what he wanted: to crawl up on me; arrived above my head, he would squeal with pleasure. In the succeeding weeks, the climbing up and "falling" became a much-beloved game.

The first biopathic reaction had happily
been overcome. During the ensuing 6 months, no trace of falling anxiety could be detected.

It is important to follow the development of this infant over a terrain which has an immediate connection with biopathic shrinking: If the carcinomatous shrinking of the adult organism has its roots in a chronic contraction and resignation acquired at an early time, it follows that the prevention of the shrinking biopathy is a matter of an undisturbed development of the life impulses during the first few months of life. True, it would be simpler and more acceptable if a drug could be discovered against the carcinomatous shrinking process. Since this is not possible, the problem is and remains that of a sex-economic upbringing of infants. There is, as far as I can see, no other way. As we know, this has serious social consequences.

Our starting point was the lack of understanding on the part of the adults for the expressive language of the newborn. This lack is deep and quite general. The parents of our infant believed themselves to be very understanding when they let their child determine himself when he should be fed and how much he should get. As early as the fourth week of life, they noticed that the child was restless, which expressed itself in frequent crying. At first, they did not understand. Gradually, the simple insight dawned on them that it is indeed extremely boring to lie in a crib or carriage alone, many hours each day, for months on end, with high walls to the crib on both sides, and a roof above.

The aliveness of the newborn requires aliveness of the environment. I mean aliveness not only in the expressive language of the adult, but movement in the strict sense of the word. The infant prefers alive colors to dull ones, and moving objects to stationary ones. If the infant is placed in a higher position so that the walls of the carriage do not obstruct the view and if one removes the roof, the infant can observe his environment; he will show glowing interest in people who pass by, in trees, shrubs, posts, walls, etc.

The concept of the “autism of the infant,” of his “being withdrawn into himself,” is widespread. Nevertheless, it is erroneous: the autism of the infant is an artifact resulting from the behavior of the adults; it is artificially produced by the strict isolation of the infant and by the character armoring of the persons who take care of the child as well as of the theorists of nursing. It is understandable that the infant will not reach out toward the world if the environment does not meet him with alive warmth but only with rigid rules and spurious behavior.

It is true that today most newborn infants are quiet and withdraw. But is lordosis or anxiety neurosis natural merely because it is so widespread in occurrence?

As long as parents, physicians and educators approach infants with spurious, stiff behavior and rigid concepts, with dignity and condescension instead of with organotic contact, so long will infants be quiet, withdrawn, apathetic, “autistic,” “queer,” and will they later be “wild little animals” which the cultivated ones feel, must be “tamed.”

All the political talk notwithstanding, this world will not change as long as the adults cannot cease to let their own deadness take effect on the still unspoiled plasma system of the infant.

An infant does not respond with any expression either to sweetish “baby talk” or to the strict language of the adult. He responds only to an intonation of the voice, to the pitch of a voice and to a language which corresponds to his own nature, things with which he can establish a connection through his expressive language. It is possible to evoke in an infant of a few weeks vivid pleasure and lively
responses if one talks to him in his guttural sounds, if one makes his motions, if one has, above all, a lively contact oneself. Spurious behavior on the part of the adult inevitably forces the child back into himself. The fact cannot be emphasized enough that in this respect 90% of the people in general are still deaf and blind, thus creating biopathic constitutions day in and day out.

Disturbances of inner secretion and of the so interesting enzyme functions are results and symptoms, and not the causes of the later diseases of the biosystem. This must be correct if the mechanico-chemical standpoint of biology is incorrect—and it is incorrect. That is proved by the deplorable state of general health everywhere on our planet.

We should not be too surprised at the East-Indian, Japanese or any other kind of Asiatic authoritarian upbringing of small children. In fact, with us, in the "cultured West," it does not look much better. Only the methods of "taming the wild little animals" are different. The old-spinster spirit which does not tolerate anything alive around it is the same. In another 20 or 50 years it will be a matter of course that those who take care of children experience love themselves, and that their organism must know the orgasmic sensation and contraction if they are to understand an infant. Today, this may still sound exaggerated; that does not alter the truth of the everyday observation that orgastically impotent educators form the greatest danger for the development of the child's organism.

The "autism" of the infant, then, his quietness, pallor, his being withdrawn, are an artifact of education, a product of his total social misery. Soon, it will be realized that such disturbances as diarrhea, whooping cough, etc., also belong here. This is not far-fetched: if the intestinal function is of a vegetative nature—and it is—then the emotional, that is, orgone-

biophysical faulty development of the infant must play a decisive role also in such things as diarrhea, pallor, anemia and so on. It would be senseless to object here by pointing to the "social misery," for this social misery itself, in the last analysis, is a result of the rigidity of the animal, man, of a world which has ample resources for wars, but never sufficient resources—even amounting to a minimal fraction of what is expended in the war in one day—for the securing of living functioning. That is so because these shipwrecked, rigid human beings have no understanding of living functioning, only fear of it. In addition, no other kind of social misery can compare with the misery suffered by infants of biopathic parents.

It is a widespread misbelief that such functions as grasping, crawling and walking "are suddenly there," ready-made as if fallen from the sky. It is assumed that the child "simply" starts to grasp at the age of x weeks, to crawl at y weeks, and to walk at z weeks. One must marvel that the pediatricians have not yet worked out a schedule of the number of steps a child has to take every day, in the manner in which they worked out the number of daily calories. An alive, erogenously functioning nipple, a warm, contactful embrace of the infant beats any chemical prescription in stimulating digestion and the total body functioning. If there is contact between the infant and an understanding, warm, environment, then—and only then—can one observe natural processes, instead of artificial products of a pathological upbringing. Not until the educators are sexually healthy will the scientific statements about children be correct. A day should, and will, come when a statement will be judged according to the character structure of him who makes it just as today it is judged according to the elegance of the style or as a surgeon is judged by the technical skill of his hand.
As I just said, the framework for correct observations has first to be created:

If the organonotic contact is present, one sees the various functions appear in the infant long before their "goal" is present. The eye, for example, establishes contact with the moving fist; the motions of closing the hand develop long before the child really grasps an object. This has nothing to do with "grasping reflexes" thought of in a mechanical way. The goal-conscious grasping develops gradually through the coordination of many diverse functions, that is, a coordination of the motions of previously uncoordinated organs. It is the contact of the eye movement with a pleasurable movement in the environment which gives rise to goal-directed seeing. Once the act of seeing is established, the function, which now is already complicated, seeks new pleasurable objects. Unpleasurable stimuli, which lead to contraction, do not form an act of seeing. It is all the unpleasure and anxiety which our infants experience which later lead to "dull eyes," "myopia," spasm of the lids and with that to a "dead" expression in the eyes.

What, in the face of these facts, is one to think of the mechanistic misconception that "seeing is the answer of the retina to a light ray"? Undoubtedly, it is that; but the reaction of the retina is merely a vehicle, a means of seeing. Is the dancing of a child "merely" the contact of the feet with the floor or "merely" such and such a succession of muscular contractions? Such questions disclose the emptiness of all mechanistic explanations of life.

The child looks at one in a different way when one smiles at him, and differently when one frowns at him. What matters, then, is the motor expression of the plasma action, and not individual stimuli, reactions or muscle contractions. The light ray which hits the retina always represents the same process of definite wave lengths. Nevertheless, the infant's eyes may be dull or shiny. This depends on the turgor of the tissue, which is increased by pleasure and decreased by anxiety.

If one has good contact with the infant one can develop the functions. At the age of about 14 weeks, the infant in question would make motions of walking, in a lying position, when I came near him, indicating that he wanted to "walk." He would shout with joy when I held him under the arms, letting him put down his feet rhythmically on the floor, so that he was "moving along." During this, he would look along the walls or the ceiling as if to convince himself that "locomotion" really took place, that is, that the objects moved past him.

Infants go through a phase of development characterized by vigorous activity of the voice musculature. The pleasure in shouting and the formation of various sounds is regarded as a pathological aggressivity by a great many parents. Accordingly, the infants are admonished to be "quiet," not to shout, etc. With that, the impulses of the voice apparatus are inhibited, its muscles become chronically contracted, and the child becomes quiet, "well-behaved" and withdrawn. The results of such mistreatment soon become obvious in the form of eating disturbances, general apathy, pallor of the face, etc. We must assume that retardation of speech and speech disturbances are caused in this manner. In the adult, we find the result of such mistreatment in the form of spasms of the throat. What seems particularly typical is the automatic constriction of the glottis and the deep muscles of the throat, a contraction which inhibits the aggressive impulses in head and neck. Clinical experience demonstrates that one must let children "cry themselves out" when the shouting is a pleasurable activity. Many parents will find this inconvenient. But in deciding problems of education our concern must be exclusively
the interests of the child and not those of the adults.

I trust to make it clear where I see the problem of the prevention of biopathic shrinking processes: In the dependency of psychic and physico-chemical functions on the bio-emotional activity of the organism in the earliest phases of development. Here, and only here, will one also have to look for a solution, and not in drugs or cultural theories of sublimation.

I emphasized the dependency of the psychosomatic functions on the bio-energetic functions of plasma pulsation. Lively pulsatory activity from birth is the only conceivable means against chronic contraction and premature shrinking.

Bio-energetic pulsation is a function which depends entirely on the stimuli from and the contacts with the environment. The character structures of the parents form the main part of this environment from the moment of birth. In particular, the maternal organism plays the role of environment from the formation of the embryo until birth.

I should like to talk now about the insights we have into the prenatal development of the organism. They are meager and not decisive. Much more has to be learned before we can make a breach into the obscure problem of heredity. But the notes to follow are at least a beginning which may lead to further observations.

If we assume the beginning of a shrinking biopathy to take place in the phase of embryonic development, the first question is that of the influence on the fetus of the maternal blood, of the orgonity of her organism and in particular the bio-energetic state of the maternal genital organs.

The contractions of the chicken embryo as they have been demonstrated on movie film confirm the clonic-pulsatory nature of embryonic growth. The vitality of an embryo is expressed in these contractions. The bladder form itself indicates that what is at work here are the typical bio-energetic functions of protoplasmic protrusion as they are most easily studied in flowing amebae. We must assume that a freely contractile uterus which is capable of contractions represents a far more favorable environment for the embryo than a spastic and anorgonotic uterus. Not only is the circulation of blood and body fluids more complete, and with that, the energy metabolism more rapid in a strongly orgonotic uterus; the chargeability of the maternal tissue is transferred to that of the embryo, which, after all, forms only a functional part of the uterine mucosa.

Thus it becomes understandable why the children of orgastically potent women are so much more vital than those of frigid and armored women, a fact which is corroborated by everyday observation. What is customarily called “heredity of temperament” is essentially nothing but the effect of the maternal tissue on the embryo. In this manner, we gain for the first time access to a corner of the gigantic problem of the “heredity of character.”

Since the emotional functions are determined by the orgonotic energy function, it follows that the basic character is, to begin with, only a greater or lesser energy activity; in other words, the temperament is an expression of the degree of pulsatory activity of the orgonotic body system.

The “heredity factor,” then, becomes: tangible, in principle, as a quantitative energy factor. Naturally, a system rich in energy will not as easily resign as one poor in energy. It follows that the energy weakness of an embryo is determined by the energy weakness of the maternal genital organs. Energy weakness may be thought of quantitatively as a decrease in orgonity, or functionally as a decreased pulsatory activity of the plasma. It must be assumed that the decrease in plasma pulsation in the embryo can secondarily lead to anorgonia. That is, the embryo need not be
originally anorgonotic, even though the parents may suffer from a decreased orgone energy metabolism. We must assume both possibilities: original anorgonia in the embryo, or secondary anorgonia as a result of anorgonia in the maternal genital apparatus.

Let us follow this train of thought further. It remains, of course, for concrete observations to correct or amplify what is obscure here.

The embryo participates in the orgastic contraction of the uterus during the sexual act of the parents. The physiological and anatomical situation being what it is, this cannot be otherwise. The maternal orgasm during pregnancy extends to the embryo in the form of contractions. Before birth there are growth contractions which, bioenergetically, cannot be distinguished from orgastic contractions. To these are added the orgastic contractions which are aroused by the maternal orgasm. If there is, in addition, a high orgonity of the maternal organism before pregnancy, we have a picture of favorable bioenergetic conditions for the orgonity of the embryo. Hand in hand with this goes the genital character structure of the parents which later continues to develop, in the realm of psychic development, what the bioenergetic function has established in the embryo and continues to maintain later on. After birth, there is an independent orgasm of the head and neck regions in the newborn.

Since high orgonity causes vigorous expansive instinctual activity, a prevention of anorgonia is established. The development of a cancer shrinking biopathy or of anorgonia has become unlikely even though not impossible; for unfortunate experiences in later life may force even the most vigorous life apparatus into resignation and shrinking.

To return to our infant: The movements of the embryo were extraordinarily vigorous beginning from the fifth month of pregnancy; so vigorous as to cause the mother pain quite frequently. The obstetrician also noted that the heart sounds were extraordinarily strong. In spite of a difficult delivery (first pregnancy, premature rupture of the bag of waters, 20 hours of labor) there was no asphyxia at birth. To the end of the pregnancy, the blood of the mother was strongly orgonotic and completely free of T-bacilli.

To summarize: High orgonity and orgastic potency of the parents, absence of anorgonia of the uterus, absence of T-bacilli and CO2-excess in the blood—these are the biosocial prerequisites for a strong orgonity of the child in the embryonic stage.

Conversely, orgastic impotence of the parents, anorgonia of the uterus, disturbed tissue respiration, T-bacilli in the blood, hyporgonia of the blood, and vegetative armoring—these are the disturbances of functioning which have now become tangible as causing a later anorgonia in the child.

With that, the mechanistic and mystical theory of heredity has lost another piece of its ground to functional pathology. It is no longer a matter of a "hereditary disposition to cancer" which is beyond our control; it is a matter of life functions which can be influenced, a matter of energy quantities and of disturbances of pulsation. These disturbances, it is true, create a tendency to anorgonia, but this tendency must not of necessity develop; favorable circumstances in later life may render the original damage innocuous. The living is very adaptable; it adapts to favorable as well as to poor conditions of life.

Orgone biophysics considers the period from the formation of the embryo to about the end of the first year of life the "critical period" in which the "constitution of the system of orgonotic functioning" is established. The core of this "con-
stitution" is determined by the amount of orgonity and of the ability of the tissues to pulsate; these factors determine the extent of vegetative impulse motility.

If we see the termination of embryonic development not at birth but at the time when all biological functions become coordinated into a unitary biosystem, at the age of about 10 to 12 months, we have before us the critical span which determines the later bio-energetic functioning. The critical period of "psychic" development lies between the third and fifth year of life; its outcome is largely determined by the outcome of the biophysically critical earlier period. This biophysically critical period contains the solution to the riddle that, in every vegetotherapeutic treatment, after the working through of the pathological mechanisms, an intangible something remains; an unalterable hopelessness in general life activity, a resigned quietness, an irritability, in one word, what classical psychiatry calls "inborn disposition."

Many aspects of falling anxiety and anorgonia remain obscure. Neither anxiety nor anger are pathological manifestations of the life system. It is only natural that a child should experience anxiety when it falls or is attacked by a dog; only natural that the infant should express anger when its needs are not satisfied. But falling anxiety is more than a fear of danger. It can occur long before there is any consciousness of danger. It is connected with rapid contractions of the life apparatus, is, in fact, produced by them. Just as actual falling causes biological contraction, so does contraction, conversely, cause the sensation of falling. We understand now why a contraction with orgastic expansion results in falling anxiety, and why falling anxiety appears when the muscular armor is broken down and the first plasmatic currents make themselves felt. A contraction in the course of a plasmatic expansion disturbs the sensation of equilibrium. But something remains unexplained. Let us try to define it, even though we cannot find a solution.

A basic function of the living orgonotic system is that it must oppose and overcome the pull of gravitation. The dead stalk of a plant is completely subject to the force of gravitation. The living stalk grows in a direction opposite to gravitation. (It goes without saying that this cannot be due to mechanical tension alone, for a dead stalk, even if full of water, remains lying, does not become erect). The flight of birds is based on the overcoming of gravitation. The erect gait of man requires a tremendous amount of balance against the pull of gravitation. We know that this balance fails when the unitary character of the motor functions is somehow disturbed. This motor disturbance may be of a purely mechanical nature as in the case of an injury to a leg or in tabes (locomotor ataxia); but it may also be of a functional nature. Anorgonia of the total body or of essential body organs means a disturbance of balance, and with that a tendency to fall and corresponding falling anxiety. Up to this point, it is clear. But the expression of falling anxiety in an infant of three weeks, precipitated by a cooling of the skin, remains somehow obscure. True, there is the function of rapid vascular contraction, but the experience of falling is lacking. Whence the expression of the falling anxiety? Recourse to a "phylogenetic experience" does not explain anything, for the phylogenetic experience must become effective in some actual anchoring. There is no memory function without an actual mechanism.

Here we have to renounce the ambition to understand everything about anorgonia and falling anxiety. For the time being, we shall be satisfied with the understanding of the connection between the block of orgonotic pulsation on the one hand and the loss of the feeling of the organs and of equilibrium on the other. The connec-
tion between orgonity and anorgonia on the one hand and gravitation on the other hand is obvious. In a state of anorgonia, the members are “heavy,” motion takes place only with great effort. In the state of high orgonity, on the other hand, one feels “light,” as if “floating.” Such linguistic expressions are to be taken literally and seriously. In anorgonia, less biological energy is free and active; the inert mass of the organism becomes greater, that is, heavier, in relation to the active energy which has to move the body. In a state of high orgonity, more bio-energy is free and active, and in relation to it the mass of the organism becomes lighter. We are dealing with a genuine, alterable relationship between mass and energy in the biosystem.

This is as far as we can go at the present—unless we were again to take recourse to the metaphysical imp which is alleged to act, think, feel and react in the background of living functioning. That would lead nowhere. Let us wait for a better opportunity to finally comprehend this obscure remainder. For the time being, it is sufficient to have comprehended how early and in what orgonotic functions the carcinomatous shrinking process with its anorgonia has its beginnings.

Concluded October 1944
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 Bífisica.
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