Genital Anxiety in Nursing Mothers*

By ELSWORTH F. BAKER, M.D.†

Wilhelm Reich has shown how vital contact between mother and infant is for the healthy development of the latter. Loss of contact creates anxiety, that is contraction, primarily at the diaphragmatic segment, resulting in respiratory blocking. A continuation of this state may be expected to result in extension of the armoring upward and downward laying the foundation for future biopathies.

This paper presents some of the problems encountered when contact was lost because of genital anxiety in the mother. The baby was planned with the expectation to "let only the interests of the child determine the course of events, and, if at all possible, nothing else."

Many features in this setting were very favorable for such a project. The mother, age twenty-eight, had essentially completed psychiatric orgone therapy. The father, one year older, patient, understanding and kind, had solved most of his problems by the same means. The grandmother with whom the parents were closely associated was in therapy and a sister each of the mother and father had been in treatment. All were intelligent, well educated, had read orgonomic literature extensively and were well acquainted and in complete agreement with the principles of sex-economic self-regulation. All were warm, likable people.

There was one child, a boy four years of age, who although born prior to the parents' acquaintance with orgonomy was nearly healthy with good sexual expression and evidence of only fleeting, occasional armoring. I saw

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†Member of the Board of Trustees of The Wilhelm Reich Foundation, Director of the Orgone Energy Clinic, Forest Hills, New York. Formerly, Chief of the Women's Service, Marlboro State Hospital, New Jersey.
him a few times for minor difficulties. He had been circumcised at one month. His birth had been easy and uncomplicated.

Although the mother was freed of armor and the orgasm reflex had been established, she continued to be somewhat anxious and flighty and chattered in a repetitive manner with endless, anxious questioning. She had never been able to consistently accept her genital feelings and when they were particularly strong she would control their intensity by holding her breath. She enjoyed the genital embrace, experienced real pleasure but could never let herself go completely and at the acme would hold her breath and either lie still or retract her pelvis—all of this with a conscious feeling of anxiety. She was quite aware of her genital anxiety which she could not solve, and survived by occasional therapeutic sessions. She had been quite eager to become pregnant for some time as she wanted another baby. However, in view of her continuing anxiety, I consistently suggested waiting until she had had more opportunity to attain genital potency. She was so determined that eventually she proceeded in spite of my objections.

She was observed by me throughout her pregnancy and was seen every two weeks. Her pregnancy presented no problems, was free of nausea and other symptoms except for continuing anxiety. She frequently held back in her upper chest whenever genital feelings became strong and held back at the climax by holding her breath. It was always very simple to get her to move and breathe through, taking but a few minutes.

She was quite willing and eager to be accepted as a research project and determined to bring the baby up in the concept of sex-economic self-regulation.

Arrangements were made with an organically oriented obstetrician and nurse and rooming-in was arranged at the hospital. She used the orgone energy accumulator throughout her pregnancy. She felt life at a little under four months and the baby's movements were always vigorous and active but never violent. Three weeks before the expected date of delivery she woke at two o'clock in the morning with some mild cramps and showed. The pains rapidly increased in severity and frequency and she went to the hospital. At 3:30 A.M. she delivered a 5 pound 5½ ounce girl, without anesthesia. Labor was uneventful and uncomplicated. She breathed down throughout. At the point of delivery she became frightened but remembered not to hold her breath and screamed in order to breathe.

The baby was born with the cord around the neck and the face was blue but became pink in a few seconds after the cord was removed. No artificial respiration or resuscitative methods were necessary. Because the weight was below 5 pounds 8 ounces the baby was placed in an incubator. This was a strict hospital rule. However, the hospital which had never had rooming-in before allowed the incubator to be placed in the room with the mother and the special nurse. The mother could have the baby with her whenever she wished. No interference on the part of the hospital was met. No silver nitrate or other solution was placed in the baby's eyes, no mucus was noted in her throat.

Shortly after birth the baby was placed at the breast, when sucking movements were noticed. She suckled vigorously, but the mother did not believe there was any milk. I saw the baby at 1 P.M. which was the time of the second nursing.

At this time the mother and baby both looked very well. The mother reported she had felt pleasurable streamings through her body and thighs during labor, but she developed considerable anxiety at the point of delivery. She screamed to prevent holding her breath. Pain was not intense and she refused anesthesia. Up to the time of the second nursing she had felt no streaming in her breasts. This appeared shortly after, accompanied by a profuse flow of milk which oozed out of her nipples. Streamings were felt in the uterus, pelvis and thighs. The uterus was well contracted but not hard and spastic such as one is accustomed to feeling on obstetric wards.

The baby was rosy pink and warm throughout, with full breathing showing the reflex. Her cry when hungry was full and angry. She showed strong sucking movements and smacking of lips and nursed vigorously. I observed an oral orgasm during nursing at this time. The hospital shirt which the baby wore had the ends of the sleeves sewed up to prevent the babies from scratching their faces. Since this hampered the movement of her hands I asked the nurse to cut the sleeves, which was done. The baby was lively, alert and reacted quickly to touch. One felt that she focused momentarily when looking at you, which I was convinced of on my second visit. No evidence of cyanosis or trauma from the cord could be found, her neck was soft, chest free, breathing full, abdomen soft and warm and her feet and hands were warm. She could move about freely, turning from side to side, and by the third day she could turn completely over.

I saw her on the second occasion two days later together with a second organonist trained in infant research. At this time the mother was up and
about having been up since the first twenty-four hours. The mother had
streamings in her breasts and uterus when nursing, with some pain at times
when sensations became strong. There was much flow of milk.

The baby, still in the incubator, now weighed 5 pounds 5 1/4 ounces which
was only 1/2 of an ounce under the birth weight in contrast to the usual
marked loss of weight. It is probable that under ideal conditions there
would be no loss or even a progressive gain. She was warm all over, nursed vigoro-
ously and had a strong cry when she was hungry. However, she seldom cried
and was amazed to the nurses on the ward as the only baby who
never seemed to cry. She definitely focused her eyes and followed persons
about her. She could turn over quite freely. While nursing she was seen to
have an oral orgasm again and the mother reported she had noticed others.
The other organism suggested removing the beads from the baby’s neck.

The uterus could not be palpated abdominally. She reported having several
days. The baby had regurgitated slightly and appeared uncomfortable. The
social worker had also reported the stools were watery and forceful. A funnel
accumulator was applied for three or four minutes. The baby vomited and
returned home on the fifth day.

On the fifth and seventh days the baby was seen by our organismic social
worker. She reported the abdomen appeared distended and hard on both
days. The baby had regurgitated slightly and appeared uncomfortable. The
social worker had also reported the stools were watery and forceful. A funnel
accumulator was applied for three or four minutes. The baby vomited and
seemed relieved.

I saw the baby again eight days after birth together with the second
organismist. No evidence was found at this time of distention of the abdomen.
One stool was somewhat watery but mostly well formed. Oral orgasms con-
tinued. The baby was warm, breathed well and no blocks could be seen.
She was sleeping peacefully when first seen, awoke gradually and pleasantly
and nursed. She was very alive and alert and one was drawn to her spon-
taneously. She was able to hold her head up very well.

At this time I examined the mother, who showed no armor. She felt well.
The uterus could not be palpated abdominally. She reported having several
exciting sexual dreams.

I do not believe that in her first ten days this baby had any serious
traumatizing experience.

I continued to keep in contact with the mother by telephone who reported
that the baby had shown no problems. However, on the twenty-second day,
while I was away, the baby developed a marked regurgitation and diarrhea.
Her stools were greenish in color, twelve to fourteen a day. The mother be-
came quite concerned, tried to locate me and finally called the second
organismist. She remained under his care until I returned. I saw her on her
twenty-fifth day. The baby had continued very fretful, crying almost con-
stantly, slept very little at night and would be only momentarily relieved
after nursing. Her chest was not moving, her breathing was abdominal and
crying was not full. On questioning the mother I found she herself had been
very anxious previously, having felt strong genital feelings which she had
been unable to tolerate or fulfill. She developed considerable resentment and
became anxious. She found herself withdrawing from the baby, could not
stand her near her, held her stiffly and even felt hostile toward her older
child. She was angry at herself for this attitude. She felt that such behavior
was not acceptable from the standpoint of being a “healthy mother” and
presented considerable guilt. I spent quite some time explaining the mechanism
of her feelings which had arisen out of genital anxiety, and helped free
the baby from her blocks.

The baby appeared in distress, miserable and pale. I mobilized her chest
and she began to cry an angry cry which was still inhibited in her throat.
After making her gag, stimulating the muscles in the back of her neck and
the spinal muscles, her voice became more free. Her face flushed, she looked
angry and cried a free angry cry. Immediately after this, she went to sleep
and rested peacefully with her chest moving.

I saw the baby next on her twenty-eighth day. The mother reported that
the baby had continued free for two days following my last treatment three
days previously. She had slept well at night and seemed satisfied after eating,
although the mother herself had continued anxious, guilty and had no
contact with the baby. When I examined the baby her chest was pale, the
abdomen and legs were bluish, there was a slight discharge from the left
eye and some lack of contact in the eyes. Her chest again was not moving,
diarrhea was still present but to a lesser degree. I again mobilized the chest.

The babycried angrily and her body became a bright pink down to the
middle of her abdomen. Afterward she seemed more alert and restful. I also
examined the mother who presented some stasis. I succeeded in mobilizing
her energy, discussed in some detail her resentment toward lack of sexual
fulfillment, her resentment towards the baby because of this, and the result-

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while
On her thirty-second day the baby was definitely better. Her cry was lusty, her chest was moving but not freely, and a general tendency towards holding back was seen. Her spinal muscles and the back of her neck were quite spastic. The abdomen and legs still had a slight bluish tinge. She had continued to cry and the mother developed the attitude of nursing her more and more frequently in the hope of quieting the baby. I explained that the baby accepted nursing so frequently because of anxiety and not hunger, that the anxiety was an outcome of lack of contact, and that as the mother found it impossible to supply the contact the baby needed, she should let the grandmother or father attempt to supply it. She had noticed that the baby was much better when being taken care of by either of them than she was with her. I again released the spastic muscles and the baby seemed much better. Diarrhea had practically subsided.

Five days later her color was good, all the blueness having disappeared. Her body was warm, chest was moving though not fully and the spinal muscles were again spastic. Her abdomen was quite tense and she had had no movement in twenty-four hours. I again freed her chest and suggested that the mother use the funnel accumulator over the abdomen for short periods.

On the forty-sixth day, when I next saw the baby, the mother reported she had been crying almost constantly, did not sleep at night, demanded half hour nursing and had irregular bowel movements. During the first few days of the past two weeks the mother said she had enjoyed the sexual embrace with initial full pleasure resulting in anxiety at the acme. Following this period she had developed "terrific anxiety and became sexually disinterested." Quite obviously she had run from genitality to the tedious care of constant attention to the baby. At the time of my examination, the baby presented a surprisingly healthy picture. Her chest was moving, she was warm, was not crying and her body was quite soft. I decided that certainly now the difficulty was not with the baby but entirely with the mother. I explained that she had set up too much of an ideal which she had been unable to follow and that from now on she was going to be an ordinary mother. I explained also that she would put the baby on a feeding schedule during which she would not feed her more often than every two or three hours, that she was not going to walk the floor all night because the baby cried, and that after investigating and finding that the baby was not suffering she would simply let her cry. I made these suggestions to release the mother of the burden she had made of the baby and hoped she would thus regain contact.

She called me two days later saying that although the baby had cried a great deal the first night she had by the second day been content to nurse every four hours and had slept the majority of the night. The mother felt quite relieved.

When I next saw her on the fifty-third day, the mother reported the baby had continued very well during most of the week but on the last day or two she had lost contact with the baby, did not know what the baby wanted when she cried, and the baby had started crying again. However, during my examination she was smiling, her body was soft including the abdomen and her chest was moving freely. I found nothing to require working on the baby. For three weeks she continued very well. The mother said the baby had been happy, awoke smiling, ate regularly every four hours and slept through the night. The mother herself felt happy and relaxed.

A month then elapsed during which I did not see the mother or baby but kept in contact by telephone. During this interval the family bought a house and moved into their own home. During the period of readjustment the mother developed considerable anxiety and became afraid to stay at home alone with the children. The baby reacted also with anxiety, crying and with some disturbances in its sleeping and eating habits.

When I next saw the baby, the mother reported that although the baby had not been crying she would sleep for only short intervals, sucked her thumb a great deal when she woke up at night, and had not been gaining any weight until recently when the mother gave her a bottle. She drank the bottle avidly. She had two to three bowel movements a day. She was not constipated but tended to strain at stool. Her color was quite good, she looked well nourished, she was warm, but she presented a rather shocking picture of very typical and almost total holding back. Her chest was high, moved only slightly, she held her arms and the only noticeable movement was a rather vigorous kicking of her legs. Her shoulders were pulled back, thighs were quite spastic, and her spinal muscles were also very spastic. Mobilization was quite a problem and I did not succeed in completely freeing her shoulders. Her cry which had been markedly restricted became fairly full with a still noticeable block in her throat. I planned on seeing her again the following week but during this time she developed an illness diagnosed by her pediatrician as rose fever with which she developed a high tempera-
live for two days then broke out in bright red blotches over her body. Her temperature fell but she showed a marked irritability. Two weeks therefore elapsed before I again saw her.

The mother had this to report: During the past week she had had to stop nursing the baby because she could not stand the sensation in her breasts and wanted to cry. However, these sensations had continued in spite of this action. She had consistently avoided the genital embrace, had withdrawn from her husband and son, and developed a "love for her baby which was more than she could stand." She was quite aware of her complete withdrawal from genitality.

The baby had accepted the bottle very well, sucked vigorously and seemed to have a strong oral need. She would grab everything and put it into her mouth eagerly. She seldom cried but continued to wake frequently at night and suck her thumb. No evidence of genital play has been observed. She enjoyed her bath immensely and loved being lifted and allowed to fall with the mother's arms, but the mother frequently felt too much anxiety in this play to do her part. The baby has not been able to tolerate the accumulator more than half a minute at a time, becoming restless and pulling toward the window until the mother took her out. The mother noticed that the baby's bowel movements depended almost entirely on her own anxiety.

The mother's anxiety was almost constant with occasional short periods of feeling very well and alive. These periods would last perhaps an hour or two. Her anxiety usually disappeared when holding the baby, but at times increased. The mother said, "Because I was afraid of my love—it was so strong," I expected to find a similar picture in the baby as that seen on the last visit. I must say I was very much surprised. The baby looked very well. She was smiling and, although a slight gurgle in her throat was noticeable, her chest movements were quite full with the impulse going well down into the pelvis. She had an occasional tilting forward of the pelvis at the end of expiration. There was no picture of the holding back seen on the last occasion. The baby was quite alive and happy and weighed 15 pounds.

Somehow the mother seemed to have established some contact in spite of her anxiety. But we may add at what cost—her complete rejection of her own genitality.

(After this visit, the mother's genital feeling returned and she accepted the genital embrace, but continued to react with anxiety at the climax.)

During the period that I have observed this baby I found it necessary to

The discussion after Dr. Baker's paper was chairmaned by Wilhelm Reich.

Educator: "Dr. Baker quoted the mother as saying that the love she felt for her baby was 'more than she could stand,' after her genital anxiety made her withdraw from her husband and from genitality. What kind of love was this?"

Chairman: "Yes, what was behind this love?"
Dr. Baker: "Hate."
Chairman: "Yes, basically, but let's get the exact mechanisms. You described the case very well, but the mechanisms didn't quite come through. First, the mother accepted genitality; then she became terrified of it; anxiety developed with subsequent rejection of the family, and then a new kind of 'love' for the baby developed. Here we see clearly that you can't operate with a static concept of genitality. It constantly fluctuates. The level of genitality before pregnancy and delivery the mother could tolerate pretty well. Then the sucking on the breast increased the streamings and the genital desire. This she could not tolerate."

Physician: "You frequently see in women after delivery that strange things develop—psychoses, terrific increases in weight, etc."
Chairman: "Yes. But this process comes about not only through delivery and breast feeding; in carrying the child, too, the whole organism softens up. The thought came to me right now that the fetus acts like a stove; it is another energy system in the mother and it energizes the mother's whole being. In one case it will enhance the genitality and the mother can accept the increase. In another, it may bring about a psychoses in the mother; in still another, the mother may react against the rise in the bio-energetic level with a complete killing of genitality."

"Now, we see how our clinical findings work back again and help the social worker in her task. She will have to prepare the mother for a likely rise in genitality in connection with pregnancy, delivery and the nursing period. Pay attention to that. Prepare the mother to watch out for it."

Social Worker: "I still don't see how you can take care of that energy condition. If the mother can't tolerate it, she can't tolerate it. What are you going to do?"
Chairman: "True, it's an energy condition, but you are dealing with a bio-apparatus in which the psyche has its influence, too. Of course, you don't eliminate the problem by preparing the mother, but at least her ego will be better prepared to accept the rather sudden intensification of genitality. It won't come as a surprise to the organism."

Educator: "What about some spontaneous kind of orgasmic discharge after delivery and before the embrace can be had again?"
Educator: "I recall spontaneous orgasm after my child was born."
Chairman: "Orgasm is not the word for that. The orgasmic experience requires a certain set of circumstances, and we should be very careful in using that word: it has a very special meaning. What you experienced were waves of discharge. However, it is true that there are other means of discharge besides the embrace which could be used after delivery, and I hope that one day we will have a case described in which this is gone into. And we won't be embarrassed, I hope, about doing it."

Physician: "I think the rose fever this child suffered from was connected with the mother's withdrawal."
Chairman: "Yes, we should distinguish between two sets of problems in an infant: (1) Those immediately induced by the mother or other adult in contact with the infant, and (2) those problems that already belong to child pathology where the pathology, though originally brought about by the social situation, has acquired a functional autonomy, so to speak. The rose fever in the case Dr. Baker presented clearly belongs under (1)."

"One point about children's diseases: They all at first present a similar picture—vomiting, temperature, rash, diarrhea. We can picture the infant as a trunk of order or disorder. The child flows freely and the trunk is in order; it contracts and then disorder is total. Later, the child blocks (armor) locally and where these local blocks set in, the local diseases appear. We are faced with the logical question: How far are infectious diseases the results of local organ armorings?"

Physician: "I notice in the hospital where I work that diphtheria seems first to be preceded by a high chest and disturbed breathing."
Chairman: "That may be, but I wouldn't advise running ahead into fixed ideas at this point. Very careful, continuous clinical observation is needed. All I wanted to convey now was the picture of a trunk of order or disorder, and then later various branches of order or disorder developing."

Following the discussion, Dr. A. Allan Cott presented a brief, informal talk on his experiences as a medical organismist in attendance at deliveries. A brief summary of this talk is here presented:

"The chief problem I met in the two mothers whose deliveries I assisted at was the ideal of being a perfect mother. One mother had a terrific fear of hurting her child because she had been told her structure prevented her from being in Group A. Both these mothers were frightened by the hospital routine. One during delivery had a great fear of something being torn. In both these mothers there was complete withdrawal in the ocular segment,
as though they were dying. A major problem for the medical organonist in attendance is to prevent the mother's going off in the eyes, and to establish respiration.

"As has been mentioned earlier, the hospital routine was in line with and strengthened the inner holding attitude of the mother. The mothers were encouraged by the nurses to take a deep breath and hold it. They were told to grab onto the rails attached to the table and hold tight. Both mothers were severely stuck when I got to them. In both cases I encouraged them to make noise and scream, kept them from going off in the eyes, and helped them to establish full respiration. In one mother, dilation began one and one-half hours after I came, in the other four hours after my arrival. One of the major tasks, I believe, is to prepare the mother to expect that she may very likely experience pain and that she should not feel ashamed to scream. This ideal that the 'healthy mother doesn't experience pain' is very deep-rooted and very dangerous."

Chairman: "Do you have the same feeling I have—that water is pouring in and that we haven't got the barrels arranged to catch it all? The method is not quite worked out, and I would advise you to work more and better on method. Of course, the mothers should be prepared to feel pain and to scream. A list of all the things the mother may expect should be drawn up."

Physician: "In connection with what Dr. Cott said about the withdrawal in the ocular segment, I am impressed by the number of post-partem psychoses."

Chairman: "Yes. The eyes go off with the fear of the sensations, the death anxiety, if you will, that sets in. Now, the key psychotic mechanism is precisely this going off in the ocular segment and then the mother may really go into psychoses."

Physician: "I saw a psychotic moment in a mother when her baby was brought to her. 'It's alive,' she said, 'it's moving,' and she was terrified. 'I can't stand it.' I put the baby near the mother and told the mother to just feel it. She came through and was able to nurse the baby. Now I am frequently called in on such cases, even though the nurses still look askance at me."

Dr. Cott: "I may add in this connection that when I first appeared on the scene when one of the mothers was in terrible difficulties, the nurse and I were more or less working against each other. Then I asked the nurse if she would leave us alone for a while. Later, when she came back and saw the improvement that had come about, she wanted to just watch. After the delivery, she asked if she could observe my work with other cases. And the next time I worked in the same hospital, I met with greater interest all around."

Chairman: "Exactly, and that is the way to win over a whole hospital—not through proselytizing, but through superior skill and knowledge."

Educator: "I think that it is most important to arrange for a decent delivery table and for sympathetic nurses."

Chairman: "That's much too rationalistic! Of course, if one could get all those things, then there would be no problem. But our concern here is basically not with technical arrangements, not with nurses, not with the bed, not with the hospital routine, but with what underlies all these things—the hatred of moving, living life. That is our real problem here—the fear and terror of living life. It is very wrong in the sense of being very superficial to concentrate on beds, routines, nurses, etc. This thinking would destroy the Organonomic Infant Research Center, would divert its attention from the common functioning principle, the terror of life, and shift it to all the variations."

Physician: "You find that if you question hospital rules, you arouse hatred."

Chairman: "Exactly. Their rules stem from their characters, their rules are themselves. So it is not a question of giving 'courses for nurses,' or any other such superficial approach. The task is research, and keeping the focus on that common functioning principle, the terror of life, in the workers of the OIRC and the mothers, as well as in the hospital. We must always explain the superficial things, the variations, by the main thing, the common functioning principle, and not vice versa."
Progetto 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.
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