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*Love, work and knowledge are the well-
springs of our life. They should also govern it.*

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FROM THE ORGONE AND CANCER RESEARCH LABORATORY

ANORGNIA IN THE CARCINOMATOUS SHRINKING BIOPATHY*

A Contribution to the Problem of Cancer Prevention

By WILHELM REICH, M.D.

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 "un-alive," "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 orgasmic 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 orgasmic 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 orgasmic 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 vegeto-

therapist 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 history¹ 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-

¹ 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 implore 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 anorognia of the lower part of the body was based on this anorognia which had de-

veloped in childhood. That is, the anorognia preceded the cancer disease by some 60 years. The mechanisms of such anorognotic 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 organotic 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 organotically 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, sympathicotonic 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 caused 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 Xrays 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 LEBENSTRIEBE*, 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 organotic 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,

² The following data are taken from Höber, *LEHRBUCH DER PHYSIOLOGIE DES MENSCHEN*, 7th ed., 1934, p. 69ff.

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 alternately 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 alternately 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

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 organotic 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 *organotic* functioning. The bions of the foodstuffs in the intestine are extremely weak organotic systems compared with the organicity of the intestinal wall. This law of organotic 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 organotic 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 organotic 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 organotic 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,³ 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

³ 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 organotic 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 anorgonotic 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 compulsive social moralism or by the armored structure. It is the vigorous natural impulse in the form of an *uncontrollable surge (lumination)* 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 orgasmic 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.

It was again and again the anorognotic 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 orgasmic excitation and plasma stasis. In the fourth case, I succeeded in averting the disaster. The fifth case, to follow, will set the danger of anorognia 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 22 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 inguinal 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 supracerical hysterectomy. The right tube is normal. The right ovary extremely small. Speculum examination shows severe inflammatory changes due to trichomonas 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.