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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

EXPERIMENTAL ORGONE THERAPY OF THE CANCER BIOPATHY (1937-1943)*

By WILHELM REICH, M.D.

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* Translated from the manuscript by Theodore P. Wolfe, M.D. Third article in a series on the cancer problem. *Cf.* I. "The carcinomatous shrinking biopathy," *Internat. J. of Sex-economy and Orgone-Research,* 1, 1942, 131-155, and II. "The natural organization of protozoa from orgone energy vesicles (bions)," *ibid.,* 1942, 193-225.

INTRODUCTION

In the following pages I shall show the ways in which the orgone therapy experiments of today developed in the course of seven years of experimental work in cancer. To the unprepared reader, the orgone therapy experiments may seem like hocus-pocus. Orgone energy is taken from the air. The cancer patients sit in a simple cabinet made of an outer wall of organic material and an inner wall of metal. There are no complicated contraptions, no wires, no buttons to press, no whirring motors. The orgone energy, with all its far-reaching effects on the shrinking biopathy, does not cost any money. More than that, our Institute has taken steps to prevent any profiteering with this energy. This may sound surprising, "too simple," and "too good to be true." This simplicity, together with the quackery and profiteering going on all around us, will make the reader inclined to strong disbelief. It is imperative, therefore, to give a thorough account. It is impossible here to enter upon every question and every doubt. The reader who has questions which he does not find answered in this article may send his queries to the Editor of the "International Journal of Sex-economy and Orgone-Research." They will be answered to the best of our knowledge. The connections between our findings and those of traditional cancer research are discussed in a separate, as yet unpublished article.

I. THE SEX-STARVATION OF THE ORGANISM IN CHRONIC ABSTINENCE. ILLUSTRATED BY A CASE OF SHRINKING BIOPATHY WITHOUT TUMOR.

In my article, "The carcinomatous shrinking biopathy" (*See* footnote, page 1), I showed that the local tumor is not itself the cancer disease. The process behind the tumor is a shrinking of the autonomic life apparatus. The patient described in that article had been freed of her local tumors by the orgone therapy; nevertheless, she died of this shrinking of the life apparatus which was the result of a severe sexual disturbance.

Recently, I had occasion to observe another case of carcinomatous shrinking biopathy which confirms and amplifies the earlier observations. This case, like the first, clearly demonstrates the social and sexual background of the carcinomatous shrinking biopathy. At the same time it shows the possibilities which the orgone therapy of this disease opens to the physician and the educator. The responsibilities which the sexual biopathies impose on the sex-economist and psychiatrist are tremendous. Unavoidably, the knowledge of the nature of the biopathies can be gained only bit by bit, from case to case. One case will leave questions unanswered which the next case will answer, while it, in turn, opens up new questions. All these problems are accessible only to the psychiatrist who thinks in terms of sex-economy. To the mechanistic pathologist they are and will remain a closed book.

A sex-economist, an outstanding coworker of our Institute, had treated a woman with a severe character neurosis and had brought about a striking change in her within a few months. An acquaintance of hers noticed this change. She knew of a thirty-year-old woman who for two years had suffered from a disease which no physician seemed to be able to explain. In this way, the patient came to my laboratory.

The first impression I gained of her was this: She had a facial expression which could be described only with the word "death mask." The skin of the face was pale and somewhat livid. The cheeks were sunken so that the jawbones protruded sharply. The eyes had a tired, veiled, hopeless expression. The corners of her mouth were drawn down, expressing deep resignation and depression. The body was thin; ribs and vertebrae stood out. The muscu-

lature all over the body was so thin that there could not be any doubt about the presence of an atrophic process. Movements were tired, slow, somewhat dragging. The patient spoke slowly, as if with great effort, without facial expression. The voice was monotonous and without force. It looked as if all activity were held back, as if there were not sufficient energy behind the impulses. The bones of the pelvis also stood out. Hands and feet were cold, pale and clammy. The patient seemed to want to establish contact with me without being able to come through.

Her weight was 90 lbs. During the previous 4 weeks, she had lost 10 lbs. Two years previously, her weight had been 120 lbs. She had always been rather thin since the age of 5; up to that age she is said to have been rather fat. After that, she grew rapidly and became thin. Ever since, her weight had been below average. As a child she had had measles and whooping-cough. She had frequent "colds," up to now, and had an adenoid operation. Menstruation began at the age of 14 and was regular, every four weeks, but always lasted a week or longer and was very painful.

Five years ago, she went to a psychiatrist in an attempt to straighten out her sexual difficulties. Since the age of puberty she had been convinced that "she was not all right sexually." She often had to interrupt school in order to "build up her health." She often felt weak, tired easily and could not keep up with the school work. The simplest task seemed tremendous. She suffered from severe depressions and chronic lack of vitality. Her resignation gradually turned into complete inactivity.

Her mother had undergone a total extirpation of the uterus for cancer, but died later of bone metastases. According to the patient, the mother was a very quiet person, very much devoted to her children. She died as resignedly as she had lived.

The patient's education with regard to sexuality had been very strict and ascetic. She had never had sexual intercourse. She was never allowed to go to dances. During puberty, she had for a time the urge to become acquainted with men, but her attempts failed. Her strictly religious family tolerated no situation which might have become "dangerous." In trying to break through these external barriers, she found that she was suffering from insuperable *internal* barriers which made it impossible for her to approach a man. This condition had set in in late puberty and had persisted to date. It was the main reason for her depressions and her withdrawn way of living. In spite of the fact that she was pretty, men seemed to avoid her. A few times it seemed that a friendship might develop. But none of them had a chance to develop, because at the mere thought of physical intimacy, a *spasm of the genital organs* would inevitably set in. As time went on, she developed a fear of these painful spasms and avoided anything which might possibly lead to sexual activity. She knew that this was pathological but she saw no way out. She did not dare ask a physician's advice or talk to anybody else about it. In brief, she resigned herself. She had never masturbated although her genital excitation made her suffer. She only used to keep her hands at her genital at night. Unlike similar cases of sexual abstinence, she had good insight into her disturbance. She was little inclined to camouflage her disturbance with ascetic ideologies. Her suffering, therefore, was all the more intense. She expressed herself rather uninhibitedly about it during the first interviews. I shall interrupt the description of her abstinence here and come back to it later.

The serious condition of the patient required a thorough physical examination. The result was highly surprising. The physician who examined her prescribed

a diet but found nothing wrong with her physically. His report was as follows: "This is to certify that I have given Miss X a complete physical examination, including blood and urine examination, and find her to be in good health." This finding contradicted the patient's appearance so much that at first I did not understand it. After all, the patient had lost 10 lbs. in 4 weeks; her weight, although she was tall, was only 90 lbs.; for two years, she had been incapable of working, had been lying around at home, feeling weak and incapable of any social contact. To overlook the biopathy resulting from abstinence was only usual, but the loss of weight was hard to overlook, and so was the general impression given by the patient. Such an oversight is possible only because physicians are trained exclusively for mechanical and chemical examinations. They overlook a severe biopathic picture very frequently, simply because they have not learned to pay any attention to the *bodily expression* and to the *mode of sexual living*.

The patient had a tumor the size of a bean at the outer margin of the right breast. I asked her whether the physician had noticed it. He had. But since this tumor alternately grew bigger and again smaller, he had made the diagnosis of a harmless glandular enlargement, apparently on the assumption that a malignant tumor would keep on growing and would not spontaneously recede. This small tumor had been present for about a year, without ever growing beyond its present size. In order not to frighten the patient, I refrained from having a biopsy done. Since the patient wished to undergo the orgone therapy experiment, there was no reason why I should not wait to see whether the tumor would disappear after a few irradiations. If it would disappear *rapidly*, it would have been a malignant tumor. If it took many weeks or even months to disappear, or if it neither receded nor grew, it would have shown itself to be a harmless glandular enlargement. In addition, we had our cancer tests to aid us in arriving at a definite diagnosis.

All of these tests[1] were *positive*. The examination of the rate of disintegration of the erythrocytes showed bionous disintegration and the formation of T-spikes in about one minute. The orgone margin of the erythrocytes was narrow and only slightly blue. The hemoglobin content was normal. The culture test showed cloudiness of the bouillon after 24 hours. Inoculation on agar and Gram stain revealed the typical growth of T-bacilli. The autoclavation test of the blood showed a strong T-reaction of the erythrocytes (about 60%).

These results of the cancer tests, together with the vegetative condition of the patient, definitely established the diagnosis of an *advanced* carcinomatous shrinking biopathy. Whether the tumor in the right breast was carcinomatous or not was of small significance. I felt that the patient would not live beyond another year.

I notified a near relative whom I had give me a written statement to the effect that the diagnosis was cancer and that I could not promise any cure. I warned the relatives that, if the orgone therapy experiment should fail, rapid deterioration and early death were to be expected. I knew that no physician could deduce cancer from the present disease picture and with the customary methods. But even if a physician, on the basis of the poor general condition, had suspected cancer, there would not have been any method of treatment except the orgone, for there were no local tumors which, with customary diagnostic methods, could be diagnosed as cancer.

The patient started with daily orgone irradiations in my laboratory. Later she ordered an orgone accumulator and took

[1] *Cf. Internat. J. of Sex-economy and Orgone-Research*, 1, 1942, 141 ff.

two daily irradiations of half an hour each; one in the early morning, after the bath, and one in the evening before retiring. The result of this treatment, in the course of the next 8 weeks, was as follows:

Weight: After one week, no increase, still 90 lbs., but not any further loss either. After two weeks, 91 lbs.; after four weeks, 92 lbs.; after six weeks, 95 lbs.; after 3 months, 100 lbs.; after 4 months, 102 lbs. In other words, the shrinking process had not only been arrested, but the increase in weight became progressively more rapid.

Growth of T-bacilli in blood medium: After five weeks, bouillon as well as agar cultures were *negative,* and remained so.

Autoclavation test: After three weeks, no improvement; still about 50% T-reaction. The blood bion solution did not have the character of a pure colloid, but showed, as is usual in advanced cancer, a blue-green discoloration.

Tumor of the breast: After 10 days of orgone irradiation, the tumor was no longer palpable. (Observation of earlier cases had shown that orgone therapy eliminates breast tumors of medium size in a space of two to three weeks).

These observations were of signal importance for the orgone therapy experiment. They showed that an advanced carcinomatous condition can exist in the absence of any conspicuous *local* manifestation. This confirmed my earlier conviction that the essence of the cancer disease is a general shrinking of the vital apparatus; that the local tumor is not the disease, but only one of the symptoms. These observations showed further that customary medical training does *not* enable the physician to diagnose cancer until *conspicuous local manifestations* make their appearance. They proved, furthermore, the usefulness of our biological blood bion tests in cases where the usual methods of examination do not yet reveal cancer. Even if a surgeon had suspected the tumor of the breast to be cancer and had operated, the general shrinking biopathy would have, nevertheless, persisted, and the patient would have died from it. In any case, it is inconceivable that this very small tumor, without metastases in the axillary glands, could have been the *cause* of the poor general condition. The tumor was of a more recent date than the general shrinking condition. The existence of a "carcinomatous shrinking biopathy *without* tumor" is an established fact. It remains to be seen how frequent such cases are. At any rate, the possibility of orgone therapy divests the disease of much of its horror, no matter how many detail problems remain to be worked out. In this case, the therapeutic orgone experiment was successful. It has the right to be tested and developed on a large scale. This aspect of the problem will be discussed elsewhere.

Before turning to the main subject of this article—the principle of the orgone therapy experiments, the problem of the development of the cancer cells and the processes in the tissues—I shall have to say more about this patient.

When the first number of the INTERNATIONAL JOURNAL OF SEX-ECONOMY AND ORGONE-RESEARCH appeared, a well-meaning physician said that sex-economy was very important and quite correct, but "what on earth did it have to do with cancer?" He thought it a mistake to talk about cancer in the first number of the Journal; that would only prejudice people against sex-economy, he reasoned. Many others show astonishment and incredulity when I call cancer a sexual biopathy or a sex-starvation scourge. These reactions show that the central point of our work has not been grasped:

The diseases resulting from sexual stasis are severe biopathic diseases of the organism. Cancer biopathy is one of the diseases in which the chronic disturbances of the sexual economy express themselves. Cancer is a sexual biopathy or sex-starvation dis-

ease. Therefore, sex-economy and cancer research are inseparable. "Character-analysis," "vegetotherapy" and "orgone therapy" may appear as different therapeutic methods, but they are, basically, *one and the same biotherapy,* working in a *unitary* organism. They have a common root in the biosystem. Their superficial differentiation corresponds to the superficial differentiation of the total organism into biophysical, characterological and physiological functions.

I had the patient examined by a gynecologist. This examination confirmed my diagnosis of vegetative shrinking: The uterus was very small, the ovaries could not be palpated on rectal examination. The breast glands seemed to be completely undeveloped. Whether we are dealing here with an atrophy or a primary underdevelopment of the sexual organs is, of course, difficult to say. The gynecologist thought it was a matter of primary hypofunction of the ovaries. Our theoretical concepts do not admit of the assumption of such a primary and isolated ovarian disturbance. For the ovaries do not function independently, but are a part of the total functional system of the autonomic life apparatus and dependent on it. On the basis of the sexual history of the patient, I am inclined, therefore, to consider the underdevelopment of her breasts and genital organs an *atrophy of disuse.* The question as to what extent endocrine glands may play a primary role or to what extent they are only executive organs of the total plasm function cannot be definitely answered at this time.

In addition to the orgone therapy, I treated the patient vegetotherapeutically. Very soon, the patient began asking a series of questions: "Does sexual intercourse hurt?" "When are you going to rape me?" (Like so many other chronically abstinent people, this patient suffered from intense rape phantasies. She was convinced that a woman could not stay alone in a room with a man without being raped). "Does the man move the penis in the vagina? Wouldn't that hurt?" "What does one do when one gets too many children?" (She knew nothing about contraception.) "Does a woman have to give in to a man if he wants satisfaction? I dread it." The patient was ignorant with regard to the most primitive questions of sex life. As a child she had kept asking her mother questions but had been rebuffed, had stopped asking anybody such questions and now believed that one was not supposed to know "such things." She had developed a strong fixation to her father. He was a strict authoritarian disciplinarian and moralist who had immediately suppressed the first adolescent impulses in the girl. Soon after that, she had developed perverse phantasies which made her suffer a great deal. The main content of these phantasies was brutal violation. This led to panicky fear whenever a boy came near her. Even then, at puberty, this anxiety was accompanied by spasms of the genital apparatus. Later on, they became a chronic complaint. More and more, she avoided men and became increasingly lonely.

She had absorbed the usual distorted concepts of sexuality and had anchored them characterologically: Sex is evil, a terrible sin against God. One has sexual intercourse only in marriage, and even then only in order to have children. (Of course, everything she saw all around her contradicted this.) The man violates girls in order to "still his lust." Women have no sexual desires, they only bear children. They have sexual intercourse only because the man "needs that sort of thing." If one masturbates, one becomes a cripple, an idiot. (Therefore, she never really masturbated, only always kept her hand at the genital at night, in a stereotyped manner.) Man is different from the animals in that he is not sexual. Everything sexual is animal-like and has to be fought. One

must cultivate "higher values" and must not have "bad thoughts."

Of course, she did have "bad thoughts," felt guilty about them, tried to repress them, and developed "worse" thoughts. Even as a child she developed brutal sadistic phantasies which scared her, so that she tried to suppress them. She had impulses to bite men's penises off or to tear them off. At puberty, when she was about to dance with a boy, the impulse to choke him would break through into her consciousness. This made her withdraw still more. Her father warned her against venereal diseases, making her believe that sexual intercourse would inevitably result in venereal disease. He did not mention how one could protect oneself against it. Thus she was, helpless, left to her own devices, torn between longing for love and fear of it. This led her into dangerous situations. Her curiosity made her approach completely strange men and indulge in various sexual practices only to flee in a panic and withdraw completely for months at a time. That it was her anxiety which led her into dangerous situations is easily understandable. She had the urge to find out whether what she had been told was true. This anxiety was an expression of her urge for sexual gratification. This only confirms what sex-economy has always contended: *Compulsive morality and abstinence create the exact opposite of what they are intended to create: they create sexual criminality and perversions.*

She did not know the anatomy of her genital. Since her genital made her suffer so much, the thought of how it was built and how it worked was with her almost constantly. It would come to her during perfectly harmless conversations with male or female acquaintances. And so she had again to take flight and withdraw. Only once, at the age of 20, had she felt more deeply for a boy and attempted to break through. But she soon gave up. She "went to pieces." The genital excitation became so intense, and the genital spasm became momentarily so violent that she wanted to commit suicide. She could not conceive of the sexual act as other than a brutal violation.

As early as puberty, her tremendous sexual stasis impaired her working capacity. Whenever she became interested in her work, compulsive sexual thoughts would intrude. Apparently, the emotional stimulus of the work simultaneously stirred up the dread sexual excitation. *Sexual stasis is the most important cause of work disturbances in puberty.* As time went on, her working capacity kept decreasing, until the patient reached a stage of complete emotional emptiness. During the past two years or so, the emotional emptiness had developed into somatic shrinking.

In these first attempts to treat a shrinking biopathy vegetotherapeutically I started out from the following premises: Carcinomatous shrinking as well as the cardiovascular biopathy, the "stasis neurosis," are based on sexual stasis.[2] Nevertheless, there must be an essential difference between the carcinomatous and the cardiovascular biopathy. Cancer characters show predominantly mild emotions and characterological resignation. Hypertensives, on the other hand, people who suffer from chronic vascular contraction, are "emotionally labile," more or less explosive, characters. This is expressed in their acute anxiety attacks; on the other hand, I have never seen cancer patients with violent emotions, explosions of anger, etc. In spite of their common basis, sexual stasis, these two biopathies show essential differences. The decisive factor here is *how the organism reacts to the sexual stasis* once it has come about.

In exploring new connections, we are

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[2] Cancer and cardiovascular disease are the most frequent causes of death. *Cf.* Thorburn, Wm. F., "Mechanistic Medicine and the Biopathies." *Internat. J. of Sex-economy and Orgone-Research,* 1, 1942, 257.

again and again forced to make certain assumptions which the disease pictures impress on us, without being able to say with certainty that these assumptions are correct. We have to leave it to further experiences to confirm or refute our assumption. The clinical comparison of cancer biopathy and cardiovascular hypertension necessitated the assumption of a basically different energy process in the two:

In the cardiovascular biopathy (stasis neuroses due to abstinence) *the sexual excitation remains alive,* biologically, physiologically and emotionally. That is, the biological core of the organism, the autonomic vital apparatus, continues to produce energy to the fullest extent. The organism, in its state of contraction, reacts to this with outbreaks of anxiety or anger and with somatic symptoms such as hyperthyroidism, diarrhea, tachycardia, etc.

In cancer, on the other hand, the biological core reduces its energy production. Thus, as time goes on, the excitations and emotions become weaker and weaker. Here, the energy household is disturbed far more severely than in such neuroses as hysteria, in spite of the much more conspicuous symptoms of the latter. Functionally speaking, an eruption of anxiety or anger is still a *discharge* of energy, pathological as it may be. *Chronic emotional calm, on the other hand, must correspond to a depletion of energy in the cell and plasma system.*

Though with some hesitation, I cannot help speaking here of *"suffocation of the cell energy system."* Character resignation must correspond to a gradual cessation of the energy functions of the vital apparatus. I would like to illustrate by an analogy:

In a running brook, the water changes constantly. This makes possible the so-called self-purification of the water; dirt is soon dissolved—a process which is as yet not understood. In *stagnant* water, on the other hand, processes of putrefaction are not only not eliminated, but furthered. Amebae and other protozoa grow poorly or not at all in running water, but copiously in stagnant water. We still do not know what this "suffocation" in stagnant water, or in the stagnant energy system of the organism, consists in; but we have every reason to assume the existence of such a process. It can be no accident that cancer cells develop so readily in organisms in which the energy no longer flows freely. Apparently, the cancer biopathy—in contradistinction to other biopathies—begins with this calm in sexual and emotional life. While the previous history of cancer patients frequently shows numerous symptoms of stasis anxiety, they are very rare in the *mature,* or cancer stage. There seems to be a sharp reduction of the *biological energy metabolism* which in the healthy person is so vividly reflected in the function of the orgasm. These assumptions seem very important and deserve thorough investigation.

It should not be assumed that the organism accepts the gradual extinction of the energy system without a fight. At a time when the orgonotic excitation of the total system decreases, the excitation may still be intense in individual cells or cell systems, just as a suffocating organism defends itself against the final relaxation by clonisms. That is, even at a time when the *total* organism has lost its capacity for excitation and for energy metabolism, *individual cells may still show orgonotic overexcitation.* It goes without saying that such isolated excitations, which no longer take place in connection with the excitations of the total organism, can no longer be physiologically normal. They must exert a harmful influence on the cell *structure.*

I shall interrupt this discussion here in order to go back to our patient. At any rate, orgone physics promises to provide important insights into the affective function of the cells and its relation to orgone

energy metabolism. For example, the orgonotic lumination of bions reveals important connections with the phenomena of cell lumination and cell excitation in the organism.

The affective and energy behavior of our patient fully corresponded to the assumptions just described. She kept asking about sexual matters, but there was no urge or excitation behind the questions. A patient with anxiety hysteria, for example, would have asked the same questions with the greatest excitation, or she would have repressed them and developed anxiety; the *emotional* significance of the questions would have been immediately evident. Not so in our patient. Everything she said or asked about was *flat,* as if devoid of interest, in spite of the fact that these things filled her life. Her phantasies were cruel, but she herself seemed untouched by them and superficial. Soon she began to complain herself about this superficiality, about the "corpse-like" quality of her way of experiencing things. She felt that she was unable to establish genuine contact with anything or anybody. This emotional calm of the cancer character is entirely different from the coldness and contactlessness of the compulsive character; in the latter, strong energy impulses are inhibited by the emotional block, while in the former the energy is simply lacking.

Precise observation of the patient's behavior contradicted the assumption that there were repressed affects in the biological depth. Not only where there no affects on the surface; *there were no affects in the depth either.* The breakthrough to the orgasm reflex succeeded with surprising ease; but again, there was hardly any affect connected with it. *Affects are the expression of biological cell excitation.* If, in the case of a patient with stasis neurosis and anxiety, one breaks through the respiratory inhibition, strong excitations inevitably and immediately appear. But this was by no means the case in our patient. Though the correction of her respiration over a period of two months resulted in spontaneous vegetative movements, it produced no strong affects. While the stasis-neurotic patient develops an intense fear of the orgasm reflex, our patient was not afraid of it because there was so little energy behind it. In other words, the affective debility reached far down into the biological system.

I was confronted by the question whether it would be possible to dissolve spasms of the genital apparatus in the absence of strong excitations. For it was clear that she could get well only if her sexuality would begin to function strongly. After only two weeks, she began to develop vegetative currents in the genital, though they were weak. With that, the genital spasms became milder and the pain disappeared. But the excitation was so weak that the patient did not develop the usual fear, and the excitation failed to increase. This was an extraordinary finding, and in contrast to the usual observations in neuroses. It confirmed the assumption that in the shrinking biopathy the sources of excitation in the autonomic vital system gradually become extinguished. The extent to which dwindling energy functions can again be revived by orgone therapy and vegetotherapy remains to be investigated.

Resignation without open or latent protest against the frustration of happy functioning, then, must be regarded as one of the essential causes of the shrinking biopathy. *The biopathic shrinking is the continuation, in the realm of cell functioning, of chronic characterological resignation.*

Let us think of the biological, physiological and psychological functions in terms of a wide circle with a center ("core"). The shrinking of the circle periphery then would correspond to the characterological and emotional resignation. The center, the core, is as yet untouched. But the process progresses to-

ward the center, the "biological core." This biological core is nothing but the sum total of all plasmatic cell functions. When the shrinking process reaches this core, then *the plasma itself begins to shrink*. This coincides with the process of weight loss. But long before the plasma function is directly disturbed, the peripheral physiological and character functions are disturbed: first the ability to establish social contact, to enjoy life and pleasure, the ability to work, and then vegetative excitation and pulsation.

The vital apparatus works in layers around the biological core; the biosystem consists of superficial and deeper layers. Such a layering was first found in the character.[3] Correspondingly, there are superficial and deep disturbances of bodily functioning. An *acute* respiratory disturbance will not affect the biosystem. A *chronic* respiratory disturbance, in the form of a chronic inspiratory attitude, will create chronic anxiety; but it will not affect the biological cell plasma function as long as the energy functions of the cells continue, that is, as long as the organism continues to produce strong impulses. When, however, the peripheral character resignation has progressed to the biological core, when, thus, *the production of impulses in the cells itself is affected,* we are dealing with the process of biopathic shrinking. This process will have to be further investigated in schizophrenia, especially the hebephrenic form.

That this process is specific in cancer is now an established fact. The real carcinomatous process is essentially like the protozoal life in a pool where there is no movement of water but ample growth of protozoa. Unfortunately, these processes in cancer can only be deduced and not directly observed microscopically. Thus there is a gap without *immediate* observation between characterological and biological affective debility and that carcinomatous process in the cell plasma which—in the form of vesicular, bionous disintegration—we can observe microscopically.

We shall now turn to these pathological processes in the cells and the tissues. In so doing, we shall remember an important fact which is overlooked by orthodox cancer research: No simple scar, wart, injury or chronic irritation can lead to cancer *unless* there are already present basic disturbances of vital functioning in the core of the biological system which then, secondarily, take hold of the local injury. The question is: *how does this take place?*

II. THE RIDDLE OF THE DEVELOPMENT OF THE CANCER CELL. THE DEVELOPMENT OF PROTOZOA: THE KEY TO THE UNDERSTANDING OF THE CANCER CELL.

Among the many unsolved problems presented by the cancer scourge hardly any has excited as much curiosity, among physicians and laymen alike, as the question of the origin of the cancer cell. Healthy tissue is "at rest," that is, the individual cells live together in an organic harmony and collectively fulfill the functions of the respective organs, such as taking up food, digestion, excretion, respiration, sexual excitation and gratification, etc. In brief, the cells are subordinated to the organ functions; they function in the sense of guaranteeing the vital functions of the total organism. Cancer tissue develops from *seemingly* healthy tissues. Its chief characteristic—according to traditional concepts—is this: one or more cells which were at rest begin to get "restless"; they divide rapidly, become rampant and grow into large heaps, thus forming the "cancer tumor." In contrast to healthy tissue cells, cancer cells are mobile. Dividing rapidly, they grow into the surrounding tissues, thus destroying them. They are rightly called "infiltrating" and "destructive." Let us concentrate first

[3] *Cf.* Wilhelm Reich, CHARAKTER-ANALYSE. 1933.