SOUND AND ABERRATION

A lecture given on
15 June 1950

Carrier Waves

There have been some very interesting witch doctoring practices whereby the witch doctor chants and screams at the person phrases like, "You (scream) are (scream) a (scream) fox. You (scream) must (scream) be (scream) a (scream) fox," and so forth, with the finishing sentence, "You are now a fox and will always be a fox." Then he walks around the fellow, scatters some powder on his head, does some magical rigamarole and the person suddenly gets down on all fours and gives a "bark!" But the audience watching at an enormous distance away hasn't caught any of the implant words. That the person now gets down on his hands and knees and barks and runs off into the woods is proof enough he has been cursed by medicine.

I was very interested in this mechanism that appeared in some of the Hudson's Bay journals early in the 18th century. I also ran into some of this material in the West, where I met an old man who could scream so loudly he practically tore my ears off. I practiced it a few times.

Now that is merely an experiment on carrier waves. One has a wave occurring and then the word, and then a wave and the word, a wave and the word, which really affects the person on the receiving end.

Now when it comes to all of this material which is impinged upon the reactive mind by the volume of noise we find in this modern society, it is an interesting angle.

A person's level of health also affects his analyticall level. With bad health, the analytical level shuts down.

When you are working a psychotic, you will find that you are very often working with enormous sound volume. The sound volume that a psychotic, particularly a manic-depressive in full swing, can pick up is almost unbelievable. One wouldn't think that a human voice could make such a racket. If you haven't run into such a case, take even an incipient psychotic and you will understand what I mean.

If the person's analytical level is pretty low and you take them back to an incident, you will find them going through the valences in the incident. Now they are Mama, and now they are Papa, and you will find them talking in the voices of Mama and Papa too. You may also find that if you run into such a thing as birth, the psychotic will be screaming Mama's screams, with enormous volume. This to an auditor is very, very uncomfortable. The case can be further complicated by this.

Let us say this auditor has his own birth still in place, he is now hearing a woman's screams of birth. Possibly his own birth contained screams. As a result he gets a full blast, containing not only the analytical shutdown effect of the carrier wave, but also the restimulation of his own birth engram, and he can just about be knocked apart at the seams.

Further, there seems to be a strange phenomenon with regard to the impact of emotion. Without getting supernatural, it's almost as if there is an actual radiation occurring, although there is no real proof of this. Some of these things are merely observations. But it is as though you get waves of terror emotion coming off people quite in addition to the restimulation involved in the engrams. That, too, can serve to shake a man up. Therefore it is inadvisable to handle a screaming psychotic until one is very well on the road to clear. Even at this time, I myself will not take on a psychotic when I can possibly avoid it who is of the loud volume type, because I find out that I have to sit down and run myself through the session afterwards to turn my analyzer back on.

The words will be caught up in the midst of the screams and the yells. It is nothing, of course, when you are working on a psychotic for him to suddenly spring up or hit you or startle you. So you are always on the qui vive. You have got tension toward this psychotic and although he may work very quietly for a while he may suddenly switch into another valence and leap up.

The auditor's awareness wearies. It is not true that attention would do so, but the tension has his endocrine system set up so that it could be triggered. He is continually ready to be scared and to rebuff this patient's attack on him.

However, if the auditor is clever with a psychotic, he can switch him into valence, rapidly. Just repeat what the psychotic is saying in some other valence and the psychotic will switch over to a wilder one. Repeat what he is saying in the wild valence, and the person will sometimes go over to a mild valence. Then such a person will also make irrational requests of the auditor such as, "Now if you'll say 'I want you to,' I will do it." And the auditor of course says, "Yes, I want you to repeat this." On the working of psychotics, you just agree with them. You are extremely agreeable about the whole thing. One keeps on working calmly and mildly. About 10 minutes out of an hour is effective with a psychotic. If you are working a nymphomaniac, she may be all over you, and you just get her back on the couch and get a few more repeats.

The only advantage to a psychotic usually is that he or she is talking exclusively out of the engrams in which he or she is held. He or she is going through the same valences.

So, all the auditor has to do is make a list of the phrases that the psychotic is uttering, and take those phrases he has uttered which are holders, or which are things that would press him back down the track, and just have him repeat them, because he is already there. But psychotics are not good people to work, and don't try to work them under sedation when you can use stimulants such as coffee, or Benzedrine.

I am referring to institutionalized psychotics here, but I am telling you because sooner or later in your auditing career somebody is going to take you by the nape of the neck and have you come over and see Aunt Bessie. You are going to walk into the back bedroom, and there you are going to find Aunt Bessie who is a screaming psychotic. Or at least she appears so the instant you start her back down the track. The person is so close to going off that they go off during therapy.

The reason I'm telling you about carrier waves and analytical shutdowns is to help you in the first stages of your auditing to keep people from restimulating to a greater degree. When your case is first opened, and you still have a great deal in the bank, be a little bit careful on the subject of loud cases and you will get along. That doesn't mean that you are not going to work people who have loud engrams; however, the volume is nowhere like that of a psychotic. Psychotics should be left until you are very well along both in clearing and in auditing experience, because they are dynamite. But you know how to detect a tough case.

Now if you as an auditor get too restimulated by a case before you are clear—and it just seems to be the moment there, not an earlier moment on the track, just the session—keep working with a team partner and this session will deintensify fairly rapidly. You can clip it out as a lock. But this is only when they are very severe, and you can't immediately find their source. You have gotten one keyed in—key it out. As far as the usual run of neurotic patients is concerned, you are going to get plenty of restimulators. In auditing even normal people you will get restimulated. There are a lot of so-called normal people who are expressing enormous amounts of shut-off.

So this matter of restimulation in Dianetics is technically solvable. It wasn't in psychoanalysis, psychology or psychiatry because they were not getting at the cause. They were getting things restimulated, and the mechanism was relatively unknown. As a result you had the unhappy picture of many people working in the field of the mind who would eventually wind up in institutions themselves.

There is another caution about auditing psychotics. Don't audit them when you are tired, or if you are exhausted, or feel a little sick. That will be hard to do sometimes because somebody will be hanging around your neck saying, "Well, I just know that I finally contacted that ally," and so on. But it doesn't work. Start auditing people at 2 and 3 o'clock in the morning, and two things are going to happen:

1. You yourself will be tired and will have analytical shut-offs. Stop at 9:30 or 10.

2. You are liable to get the patient into a spot where, due to his own weariness, he has insufficient energy to overcome the engramic commands and he may go straight into a flat spin. He may get to a point where he is exhausted and will sit in the engram out of present time, and two or three days will have to elapse before this thing wears off on him. You are not going to hurt him any by this, but it should be avoided if possible.

Another factor that an auditor should be very well aware of is that when a psychotic is very weary, an added psychosis can enter in which will give a very wild state of affairs. So, if possible, he should be worked when he is well rested. Furthermore, on the subject of working patients you may find that working a patient at 8 o'clock may be much better than working him at 10 o'clock. Or it may be very easy to audit a patient in the afternoon, but very difficult to audit him in the morning.

If the patient has one of these time mechanisms he gets upset at certain times of the day, such as 10:30 at night, and you can occasionally detect that Papa and Mama went to bed around that time. So the time clock on the coitus engram or on the mutual AA engram which occurred at 10:30 very definitely states, "Oh, this is a bad time of day." If you throw the patient into an engram which agrees with the time and he is upset about it, this is of no great therapeutic value.

Most people have a low period about 2 o'clock in the morning according to some opinions I have read, and as far as I'm concerned these opinions are scientifically unsound. I have also heard the opinion that more people die at 2 o'clock in the morning than any other time of the day. There may be some truth in it. I have never tested it or seen any statistics.

I have found that at 2 and 3 o'clock in the morning, a patient can very often be thrown into a very bad engram which may be good, but it also may be bad. It all depends on how much of a risk you want to take with this patient. If you want to work him at 2 or 3 o'clock in the morning when he is pretty tired and his physical energy is low, in the hope of breaking his manic, you possibly may be able to accomplish something. However, it isn't a method that I would recommend.

The road from psychotic to neurotic is usually very short compared to the road from neurotic to normal.

Usually a release is up above a normal and has all the painful emotion off the case. But just pegging normal roughly and loosely at that release line, we can take off from there and go to clear.

Clear is actually a very fantastic height. It is utterly unappreciated. This is no sales talk, it is something you have to know. The number of engrams that a human being can contain in his reactive bank and still stay sane gives one nothing but the most profound admiration for the ability of the human mind's fundamental state. It is enormous. You can count on 200-400 prenatals in a neurotic subject. Afterwards in life there are just scores and scores of incidents, lots of them hidden. It is unfortunate that there is such a problem, and that the physical structure of the zygote, embryo and fetus is so tender that injury is evidently very easy to receive.

At the beginning of the case you are going to be lucky if you are able to do anything very thorough with it. But as the case progresses you will find you are getting maybe two or three

incidents which were hitherto out of sight. When the case gets on up to the normal level, you can hit four or five or six incidents, and when you get him about halfway between normal and clear you will be able to start running incidents at the rate of fifteen, twenty, thirty, and so on. Now, the distance from normal up to the point I've just made is not a short one.

As the case progresses and you have got basic-basic out and the case is behaving properly and you are getting all the perceptics in engrams, incidents will start to erase on one recounting. For instance, you say, "Now contact the next earliest moment of pain."

"Yes."

"Is there an emotional charge?"

"Well, yes, I lost my dog."

And you remember working this thing for two full days, at the beginning of the case, when it was really sealed in, with the patient saying, "Yes, I lost my dog, gee, I felt bad." And the doctor was saying; "Well, he'll never come back, poor dog," and sympathizing with the little boy and so on. Now you go back over the incident again, and he says, "What dog?" Incidents disappear as you come up the home stretch to clear.

One doesn't try to do it by rote, but you will find that a patient will start to run a scale on you. Let's take the words "My mind is unhinged." Well, this thing has been missing out of every engram that has ever appeared up and down the whole case for a matter of a thousand hours (and you can count on a bad, stuck case taking a thousand hours to clear). The person is just coming in toward clear and all of a sudden the most remarkable thing happens. You start to get a situation where a phrase appearing in a late nitrous oxide dental incident which you thought you had erased reappears such as, "He won't unhinge his jaw." The word "unhinge" is sticky. One can bat it down, but it comes back up again three days later; and you find that the word "unhinge" goes all the way down to the bottom of the bank in the basic area where it has been omitted because it was locked up in this nitrous oxide incident up at the top. Going over this, you find "unhinged," "My mind is unhinged," "You are unhinging my mind," and so forth. By running a scale on the word "unhinged" all the way up through the bank with the phrases that go with it, you will find out that you are clipping engrams which you have clipped before and are going through engrams that you thought were erased. But they were not erased, they were merely phrased with the word "hinge." It will take you about two sessions to run such a scale as it may appear in the bank a couple of hundred times.

The engram bank is a very nasty, tangled mess whereby all of the engrams are interlaced, and cross one another like a big log jam. What you are looking for at the beginning of the case is the key log. When you finally put your hands on that and give it a yank, the jam untangles and can be run off. Now you have to look for the next few, and soon you have got it to a point where all you have got to do is just take a preview back over the logs and they roll easily. But you have still got to look, and there is no predicting, at least by any method I know of at this time, whether it is going to be easy or not.

Basic-basic will always erase if you get your hands on it, always. Get a person in the basic area, flip him into his own valence, make sure he is in his own valence, and he will get sonic, tactile, and everything else. If it was supposed to be basic-basic, and getting the unconsciousness off didn't erase it, it means that there is an earlier basic which is interlocked with it someplace. Go on and erase the case, and one fine day he will suddenly find an engram that just doesn't blow. Start looking for why this one doesn't lift, and one comes up with a new basic-basic all the way down at the bottom. This time you can start to get unconsciousness off the case.

Most of our researches right in present time are directed toward taking the glue out of such incidents. If we could take the glue out biochemically, it would simplify things.

There is glue in there that glues down the engrams and if the glue can be shaken on a biochemical basis, pulling up engrams, it would still require art; but you might be able to erase a case just exactly as if you were running the scale, and you would know what you were looking at. Then you could say, "Give me the subject," and get it right then.

The glue in the case is unconsciousness. This is the business and art of Dianetic auditing, the art of application.

Clear goes a very long distance. You are going to be absolutely amazed sometimes at how long it is going to take. You might as well face it. There is no predicting what is in the bank. Even when a person starts to feel a lot better, he still worries about his therapy occasionally. But just keep him going. It's something like beating the altitude record about every 20 days.

I introduce this for two reasons:

1. You are going to get growls. Allow for the fact that the fellow has come to see you for five days and is not clear, and he may snarl about this.

2. A patient never looks back at the pain in the incident that is gone. You may have someone in therapy for three months. At the end of that three months he looks fine. He is doing well and he has erased many engrams. And you say, "Let's look back at last August. How do you feel about that now?"

"Well, let's take a look. Yes, as a matter of fact I couldn't work, dead most of the time and so forth. But you know, I think we ought to be getting back to these flu engrams. I've been worried about that. I'm sure that is the reason why...." You just cannot get him interested in his past improvement, because it is on the basis of negative gain.

He may mention it some day, and say, "Well, I haven't had any ache in my shoulders for the last six to eight months since you deintensified birth, and I am very grateful for that. By the way, I have a leg pain." Negative gains—because the aberration and the worry about the pain in his shoulder have gone simultaneously, creating an illusion to the effect that it wasn't there. The locks are removed.

Another thing you will notice is that you will have a very hard time carrying very many patients through to clear. You just haven't got the time. Therefore you should content yourself with a psychotic to boost him to a neurotic state, someplace above normal, and then turn him loose. He will have transferred ordinarily for the first many hours of therapy. You get the phenomenon of transference in Dianetics.

When a person starts to stand on his own two feet (I always use that as a rough rule of thumb), this person is a release. He is no longer calling you up at 2 o'clock in the morning to ask you whether or not he should blow his nose. He is making decisions by himself, not because he has been told to, but because he is now becoming more and more self-determined. That is the side nature of recovery—the self-determined characteristic.

That is a very rough rule of thumb test, because you will also run up against patients who have a neglect mechanism at work. Don't ever mistake self-determinism for a good neglect mechanism. You may have patients who just will not confront the fact that they should get rid of their psoriasis and their boils and so on. "Oh, well, I've been getting along all right," they say, while in actual fact they are getting fired every two weeks from another job and their child is unhappy and the wife is in bad shape and so on. All of these things still don't demonstrate to them that their life is a long way from happy. There you have a tough case because you can't interest this case in his own difficulties, and there is no reason to try to foist off these difficulties on him either.

In the field you will find men who are trying to work their wives. Women, I have found, have more neglect attitudes than men do on the whole, although that is a generality which is very dangerous to assume.

You will find some man who wants to get along in life. You treat him and he feels fine. He is thinking on all 12 cylinders and his life is looking a lot brighter to him and so on. The only trouble that he is running into is his wife. He will suddenly insist that his wife has some treatment. He may not feel qualified to treat her, and there may be lots of reasons why he should not, such as the fact that they quarrel a lot.

You will find yourself, whether you like it or not, with some of these neglect cases on your hands. They are sloppy to work, but with patience they too can be cleared.