INSTITUTIONAL DIANETICS

A lecture given on
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Observation and Imagination Get Results

Direct memory channels can be used to deintensify some incident of the past. A direct memory channel if opened to some past incident very often serves to knock out a heavy lock, without erasing or reducing the lock by standard Dianetic therapy.

The way one discovers the lock is by asking what is wrong with the patient. His words will express usually, word for word, what he has been told is wrong with him by somebody. It goes down on a channel more or less straight to one of the parents, grandparents, relatives or teachers. That is either a straight circuit in restimulation or it is a circuit via a pseudo-ally. The person, for instance, has married pseudo-Grandmother. Grandmother used to be very nice to the boy, but she used to consider him not too bright. Now he has married a woman who reminds him of Grandmother.

It is only necessary sometimes to get this person to use a direct memory circuit to demonstrate to him that his wife does remind him of his grandmother, and because the upper analytical sphere of the mind is able to differentiate, suddenly this illusion is pulled apart and the identification occurs, whereby wife is wife and Grandmother is definitely Grandmother.

What we are doing here is putting something straight into the computer. The 15-minute technique will take a good percentage of cases (20 to 30 percent) and put them into pretty good shape rather hurriedly.

By the use of this technique one can very often discover what has destroyed a person’s sense of reality, why a person is not progressing properly, what the general diagnosis is, and so on. So, it is a diagnostic technique. But in the application of it, it will sometimes become a therapeutic technique and if you are very rushed for time you will find out that you can use it more or less exclusively as a therapeutic technique.

In its use as a diagnostic technique, you will very often find the person unable to recover and deintensify a lock, or find him sliding straight into an actual engram. If this happens, you can extend the technique to the point of letting him slide right into the engram and then handle that just as you would Dianetic therapy, and bring your patient back up to present time again. Then ask him to remember on a straight memory circuit what he has just gone over and in such a way you will again produce a quick alleviation on a case.

It is actually productive of miracles and is nothing to be slighted, because it has actually triggered out things like Parkinson’s disease and chronic suicide attempts.

You can also handle a pregnant woman in this way and keep her smoothed down about the situation.

In Standard Procedure, if you are suspicious of a case, you should call for a medical examination. On the one hand it will save you a lot of work and on the other it will save you somebody who is beyond recall. However, don’t depend upon such a diagnosis unless the person is very well acquainted with Dianetics, because you will sometimes find a “moron” who will come up very rapidly in IQ and when cleared will be about normal. One can take a lot of “feeble-minded” cases and do things with them, whereas the doctor has a rather definite habit of saying, “It’s probably something organically wrong with this person’s nervous system.”

Nevertheless one should ask for a full physical examination including a Wasserman, blood pressure, urinalysis—the full laboratory examination. You also want the medical opinion of the

case; and it is best to get all that in writing and signed if you are working with a large parade of people. You can tell the doctor, “We are adding to our case records and it would assist a great deal to have your professional opinion on this case before it is entered into therapy.”

The main part of this lecture concerns the treatment of psychotics by Dianetic therapy. This is called Institutional Dianetics. In this subject more than any other the auditor must use imagination, perseverance and nerve, because in the treatment of the psychotic one encounters engrams in the raw. They are right there and in many psychotics all one observes to be there is just the engram. The person has no higher sphere of consciousness working. Therefore efforts to attract his attention, to make him concentrate, to treat him, very often meet with very slow results. But the accessibilityl of the patient must be obtained first and that accessibility is very often denied because the patient is highly restimulated by his environment. He is not called upon to do anything. Whether we observe it or not, the fact that he is behind bars or restrained is very often sufficient to knock out the last small effort to maintain association and reason within himself. In consequence, an auditor who is approaching a patient in an institution or a psychotic in his own office is put straight on his mettle, and quickly. He has to use his head, because you have probably seen what an engram can do in a sane person; and now supposing we had nothing but this engram to work with—that is very often the problem which is posed.

However, it is not as hopeless as it might seem. Consistent effort on any case which is not suffering from actual physiological brain damage will produce results. Sometimes you can produce a result on a psychotic in a matter of minutes, and sometimes it takes days and weeks of patient effort.

There was one case of a manic-depressive who was capable of enormous strength during one of the manic periods, but the remainder of the time was extremely depressed. However, this case was a very strange one since the overall manifestation of the case was a jolly, pleasant old lady. One could look at this case and say, “Well, here’s this hail-fellow-well-met character who doesn’t care about anything,” and so on. But that was just another dramatization, and it was the carry-over dramatization which went along more or less continually.

So when the person would go into this jolly hail-fellow-well-met dramatization, the psychiatrist in charge of the case would pronounce the case “a remission,” and then try to turn the case loose. The next thing that would occur would be one of these enormous physical strength exhibitions while she was in the manic state. Then as soon as this was blocked and she was cowed on that, she would slide back down into a depressive state and sit weeping endlessly.

The way this case worked out actually was all contained within one incident. The jolly person was Grandma who had walked in immediately after an attempted abortion. The person who was crying was Mama who didn’t want to get rid of the baby. The strong person was Papa who, boasting of his strength, was attempting an abortion upon Mother, holding Mama down very forcefully, talking about being the strongest man in the world, how nobody could put anything over him, how he was going to go ahead and do what he pleased, and that nobody but God himself could stop him. And Mama was saying, “Oh no, please, please, please, I want my baby, I would just die, I’ll go crazy, I’ll lose my mind if you take this baby from.me.” A doorbell rings after this altercation—with the baby practically dead by this time—and in walks Grandma, but there is no vestige of the fight. Everything is very hurriedly hush-hush. Then Grandma says, “I’m going to stay for a while and visit with you. I thought I’d come because I was worried about Elsie, but that’s all right, ho, ho, ho. Everything’s going to be fine,” and she’s so happy there’s a baby.

This whole incident was one consecutive dramatization. No part of this dramatization was sanity, but the valence of Grandma appeared to be a sane one. However, if one listened carefully to the patient when she was being very jolly about it, she was very disconnected, since she would dub in more or less rational phrases into Grandma. It was a baffler, because of course one had to get both Grandma’s and Mama’s protective mechanisms out of there before you could touch this manic.

In the first efforts on this case, before we realized what the engram was, in trying to get a case history all we got was the standard psychiatric jargon which had no bearing on the case, except that the patient experienced remissions and had been released many times and had been shortly afterwards returned to the institution. So, on going into it, we knew a dramatization was there that said "strong." Well, there was also a dramatization there that said something to the effect that "I've got to keep it," because as soon as you touched this patient and said, "Give it to me," of course you became Papa. The instant you said, "I've got to keep it," you became Mama, and the moment you were rational to her, you became Grandma.

So the three things that you could do to this patient were to twist her into the three valences present in the engram, and you could do this one after the other merely by assuming other valences. Although this trick is not too new, the mechanisms of it have never been known until Dianetics. One assumes another valence when one hears the patient talking about something or other, and then one gets the rest of the engram because he starts to dramatize that, and in that way one can keep doing a valence shift on it.

That is actually a valid method of diagnosis. It is not a very good therapeutic measure, because pure 100 percent dramatization does not occasion a release. One could keep a person dramatizing ad infinitum and they would still go on being psychotic.

So, here was a case of having to use one's wits. One wrote down what was more or less the engram after about two or three hours of observation. The engram was complicated by the fact that Grandma was a demon circuit to some degree because some of her conversation had set up as a demon circuit which could dub in rationality. Out of the engram, then, were selected all of the holders, bouncers and call-backs.

Next, by very patient, friendly persistence, trying as far as possible to stay out of any of these valences that she had, the auditor tried a new approach of changing tones, just testing them until a tone that he had was finally met more or less lucidly. Then, by repeating the holders, bouncers and call-backs, he could get in maybe 15, 20 minutes of effective work out of every hour with the patient jumping up, running off and going into one of these dramatizations, then coming back and settling down again on persuasion with the most irrational arguments such as, "I'll give you lollipops if you work," and so forth. Because already she was getting unstable in the engram, and more or less clipping into other engrams, so that she would be a little child of about 2 for a moment and then she would be something else. However, there was always a tiny amount of cooperation present even if very slight.

After about three sessions the case was diagnosed, and getting a little fixation we were able to establish a small amount of accessibility, and the patient all of a sudden repeated a bouncer and began to laugh. She repeated the bouncer about 15 times on this basis: "You and I will play a game."

"All right."

"I bet I can say this more times than you can."

"All right, we'll play the game." (Very cheerful for a moment.)

In this case the phrase was "Lie down there and stay down there and don't you ever get up!" So the auditor said, "Lie down there and stay down there and don't you ever get up."

And the patient said, "Lie down there and stay down there and don't you ever get up."

After she had done this about 20 times, all of a sudden the thing started coming loose and she started to laugh about it and get rather hysterical. Then she got up, raced around for a while, sat down and laughed some more, then she became attracted to this mechanism and started repeating it over and over. She must have repeated it about 200 times. Suddenly it no longer interested her, but she had found what she thought was a game.

So now we started on the call-backs and repeated out the call-backs, one at a time. Each time one of these phrases was run out she was more accessible. It was in about the fifth session that she came back up to present time. Now the engram was still there. It had earlier material and so on, but fortunately it had very little ahead of it in terms of the same voices and the same actions. It was more or less the basic on the chain. She then came back up to present time and manifested an entirely different person, that of an extremely tired individual. But after that she was accessible, although you had to be very careful, as you do with all psychotics, not to work her when she was too exhausted, or to work her too long. Because if you work even a normal patient when they are exhausted, you will get a heightened dramatization when they go through an engram. So a patient should be fairly fresh if you can manage it.

The matter of the accessibility of that case was cared for by the inventiveness of the auditor. The very next step on that case was a quiet, orderly effort to get up the last painful emotion that had charged that case into a psychosis. The painful emotion incident worked out rather easily, in spite of the fact that there were countless tears.

There is a motto in this that unfortunately does not always hold true— that a psychotic bleedsl quickly. If you can really put your finger on the charge, you can generally get it off the case, because the case is so far from a normal and operative organism that you are getting a spill of charge rather easily accessible. Unfortunately many psychotics don't bleed quickly. One can get into such a case, and flounder around with painful emotion and so on.

The above example shows the handling of a manic-depressive. An auditor can become very depressed working a manic-depressive because sometimes it appears to be the most thankless task imaginable. Perhaps he isn't getting anything and he isn't sure what he is doing with the case. It may be very closed in, in a deep apathy and he is unable to secure cooperation and so on.

In the case of a paranoid or a paranoiac, he has a lighter task. Prior to Dianetics, people used to throw up their hands in horror about them. But the hard case in Dianetics is the old-time easy case of a manic-depressive. The easy case in Dianetics is the paranoiac.

The manifestations of the paranoid are: "Everybody is out to get me. Western Union Telegraph Company has rigged up special wires to my brain and I can hear those messages going by and they are telling me so-and-so." The case is rigged up on demon circuits, completely aside from Western Union.

Or he says, "I can hear these people whispering in corners all the time. I know what they're going to do to me, and I know why they are going to do it." But he hasn't any idea why they are going to do it. He is working on a demon circuit setup. That is a paranoid.

A paranoiac has been considered a very dangerous fellow because he is more or less intelligent and he has a specific thing that is after him such as "my family." This is sloppy terminology, but it does sum up a certain type of case. The paranoiac has picked out a specific target, and if he has a specific target then that is what the engram is about of course. If someone merely has vague ideas about it, you can be sure that his engrams are very vague about who is after him, who is talking about him and who is trying to get him.

Those two cases however are normally approachable just on the idea of "against me" or "out to get me." One can handle these cases by pronouncing these words with repeater technique, and in this way very often get some very explosive discharges from them. Such material is normally found in the prenatal bank, just by directing the patient from father to mother.

If possible the auditor should get the painful emotion off any psychotic as fast as he can. If he can locate that painful emotion by any means whatsoever and get it relieved off the case he will have accomplished something very definite. Theoretically if one could discharge all the painful emotion in the case one would have a sane person, because you will find in such a case that the

psychosis succeeded some very definite disasters and loss in the person's life. It has not taken place by accident. He was not just walking down the street one day.

We have the data in Dianetics on what makes a psychotic break. One can go back over the case after having brought the person up to a neurotic state at last, and trace back from moment to moment what immediately preceded these breaks, and one will find that it was something shocking, something very heavy on the loss side.

There is another way of treating psychotics by the use of a mechanism known as psychodrama. We are adapting here some of the methods which have been used in institutions over a long period of time.

Psychodrama is merely an effort to get the person to dramatize. If you can start them dramatizing, you can quite often shift them from engram to engram. You are not going to achieve a lot with this shift because it is just dramatization after all. But you can get them into painful incidents; you can tease and wheedle them into them by saying something like, "Oh, I bet you can't possibly tell me about your grandma's case. You wouldn't be able to tell me about that."

"Oh, yes, I could too."

"All right."

"Who do you want me to be?"

"All right, you be Grandma."

"Oh, I couldn't be Grandma because she's dead." (Tears.)

"Well, all right, then be Mama."

"All right, I'll be Mama."

Yakety, yakety, yakety, yakety-yak. The person goes into a full dramatization of what Mama was doing, including all Mama's foolish remarks to the child when the child was disturbed about the death and so on.

"And now let's be the doctor," or "Let's be the undertaker." Or "Let's be somebody else." Just keep running him through these valences. What you are doing is valence shifts on him until you finally get him to run out himself. He will fight around about it a little bit before he will run himself out ordinarily, but you will have gotten him into his own valence!

Now if you can work a psychodrama—and it can be a very noisy affair—on a patient to finally get him into his own valence, the least you will get is the history that is recorded there in the reactive mind. There are other methods, all of them depending upon inventiveness and the discovery of the chronic engram.

In a psychotic, one can pretty well count on the fact that there is one engram which is worse than any of the others which is doing the damage. One can get a patient into this engram in various ways, and get out the bouncers, the holders and the call-backs. The person apparently possesses a reservoir of push to get up into present time, and if you can free him of that engram you can get him up.

Just by repeating the bouncers, holders and call-backs, the person tends to laugh after a while or giggle.

A hebephrenic,[1] however, should be distrusted on that. Giggling may be the psychotic manifestation of some portion of a case and you may think you are getting false fours, but it is

very easy to distinguish once you have seen it, and don't mistake a hebephrenic giggle or hysteria for a false four. In a false four you can hear the sanity. In hebephrenia you can't hear any sanity at all. It is insane. A false four could be described as a good, solid belly laugh.

There are an enormous number of manifestations of psychosis. There are as many manifestations of psychosis as there are engrams, which is quite a number. This was what gave Kraepelin a great deal of trouble. He spent a long time thinking about it, and he finally classified all the manifestations of psychotics. His list is staggering because it finally ended up dumping in the trash bin everything that would not fit into the rest of the categories. He was trying to classify manifestations without the knowledge of what was causing them, and that type of classification is very poor.

But there are some psychiatric classifications which are of some use. There is the manic-depressive. We know that a manic is something that makes a person feel strong and powerful, and that it is probably adjacent to a depressive part of an engram which contains the danger, and the person will fluctuate between the two. So that is a definite and very common aspect of an engram.

Then there is the fellow who thinks that everybody is against him. That's fairly common. There is also the hebephrenic who does nothing but giggle. Then there is the catatonic who is just limp, dead, motionless, and you might include in that category the apathetic case. There is also physiological psychosis whereby the person is simply physiologically a moron. You can tell the difference between a physiological moron and an engramic moron very easily, because the engramic moron is dramatizing (and will dramatize, even though the dramatization consists of being super stupid) whereas the physiological one is just plain dull. This is no real test for an auditor at all. You can look over a few of these patients in a home for the feeble-minded and, even without previous practice, you could simply sort them out into their two respective groups. You would probably have a center group of people who were both dumb and dramatizing, but there would not be very much dramatization. So you would have three categories in which you could put people.

The ones that were strictly engramic would be the ones you would want to do something about. The others you wouldn't care much to do anything about. But regardless of whether a person is a physiological moron or not, remember that engrams are still present, and that there has to be analytical mind machinery in order to express the engram. So if the person is not expressing any of these engrams you can be sure that the machinery is broken down somewhere.

These engramic morons are very often quite cooperative. One is simply dealing with all the manifestations that engrams can take. The very ability of it and man's desire to classify into tight little compartments all of these things has in the past led him astray, and we don't want to be led astray on this. But there are these general classes of manifestations which psychiatrists will point out, and I will take up these classes one by one. Firstly there's the catatonic. There are various ways that you could do something about him, one of which is to set his bed on fire, or other heroic measures. He won't stay there. That is a strange thing and the hypnotist is fully acquainted with this manifestation. This is a similar manifestation to the person who is hypnotized and you tell him you are going to give him a red-hot poker, then you hand him a broomstick. He will take the broomstick and pretend that he is burned and actually the tips of his fingers will sometimes blister. That is the kickback.

Now take the same person, hynotize him, and hand him a red-hot poker telling him, "This is a red-hot poker, take hold of it." He will jump back and say, "Why, you so-and-so!" He is no longer in a hynotic trance.

You can also take a hypnotized person and say, "Now this is a window that is 480 stories above the ground, and you're going to jump out and fall to your death" (which would be as we know in Dianetics one of the foulest things you could do to a man). But he will stand there at the window waiting for the command "Now, open it up and jump out." (Of course the window is just a mock-up.) Then he will step through the window and onto the floor on the other side

and he will go through the whole thing, pretending to jump (being careful not to hurt himself) and screaming as though he is falling, and he will even land with a crunch, sometimes.

But now take him over to a real window which is maybe four or five stories above the ground and say, "All right, open the window and jump out." (Of course you want to be careful on this, because he may have a dramatization which says, "I have to open the window and jump out," and in such a case might do so.) But the usual reaction is that he opens the window and takes a glance outside and says, "Why, you so-and-so, you're trying to kill me," and he will come right out of the trance.

So in a catatonic there is a whole string of rather heroic tricks that can be played on him to make him accessible. One should not indulge too freely in these tricks; one should use quieter and softer methods because we know that the catatonic is sitting squarely in another valence and obeying a "can't move" command.

One of the ways one can take a catatonic and raise his necessity level artificially is to feed him full of Benzedrine—he knows how to open his mouth and swallow—and it will bring up his attention level to a point where you can sometimes work him on engrams. In fact, almost any person who is disassociating badly will present a different aspect when he has been given a stimulant such as Benzedrine.

You are not allowed to give Benzedrine, however. You do that in liaison with a medical doctor. I don't expect anyone who has been certified by the Foundation to have any difficulty whatsoever working with a medical doctor. Doctors will probably be very pleased to work with you.

An obsessive compulsive could be classified as psychotic. Trying to hypnotize such a person would be the first mistake. Mistake number two would be to try to assume any state with the man which was even suggestive of taking command or control of him. Never give a psychotic the idea that you are taking over control of him when it agitates him in any way. Make it out to some degree as though you are merely playing with him a little bit.

Sometimes you will find that he is accessible to your taking control of him. When that is possible it will demonstrate itself rather rapidly, and you can do so, and then you will achieve rather rapid results. But trying to place him in a state before you do something else, and trying to go through any orderly procedure, is of course throwing organization against chaos, and they just don't mix. In consequence you have to catch an obsessive compulsive on the fly. There are certain things they are doing or saying, and you can attract their attention one way or the other and help them.

Just because the person is psychotic is no reason to believe that general human laws have been suspended, which is a sad and serious mistake on the part of anyone trying to treat a psychotic, because part of that person is reasonable. One might not be looking at any part that is reasonable, but part of the person is; and any of the things that will be effective upon a normal patient are equally useful in the treatment of psychotics.

However, one should know quite a bit about Dianetics before one starts working on psychotics. Work a lot of normals and neurotics, and only then take a deep dive into the psychotic end of the picture.

One of the things that makes Institutional Dianetics appear a little bit backwards is that in the institution one has before him mainly psychotics, and as a result a doctor may read the Handbook and say, "Oh, yes," and assume immediately that he knows all about Dianetics, because this dovetails in and he will use parts of Dianetics without organizing at all. He will invariably pick the patient that he couldn't do anything with by any other method and tackle that case with some strange version of Dianetics, and he is very definitely going to have failures on his hands. If he would just content himself with working some accessible patients, handling

people long enough for him to get a good command of auditing, and only then start tackling the tough ones, he could break them. But it is a process of education.

With Dianetics in the public domain we have several factors at work.

We have Preventive Dianetics which is very, very important, because with it one can keep a psychotic from a break.

Neurotics, who ordinarily are confused with psychotics as there are no precise definitions, can be released.

Psychoanalysis will eventually cease to make attempts upon these people. That is not offered as a derogatory statement but as something of which we must take cognizance: Psychoanalysis in practice very often precipitates a severe neurosis or psychosis. In many of these very large clinics it is a byword of the people in the surrounding country that a man goes to the clinic for psychoanalytic treatment, and as long as his money holds, why, they treat him, and then they ship him across the river to the state institution.

The people in the institutions who can be reached rather easily with a cursory knowledge of Dianetics can be freed. Furthermore, people coming in for a very short period can watch the case settle and will know what to expect of it, and they will be able to release what is troubling the case and send him on his way again.

I would say Dianetics would markedly decrease the institutional population of the country.

It will decrease even more swiftly the criminal population of prisons, because the criminal has quite a bit of time on his hands. Very few of these people are inaccessible, and they will do almost anything to get out of prison. As soon as parole boards learn that they can only guarantee an individual on parole after he has attained Dianetic release, there will be a lot of prison Dianetics practiced and our criminal population will decrease markedly.

To return to the subject of psychotics, the psychotic will challenge anyone's ingenuity. One should know his Dianetics thoroughly. He should have had practice on relatively sane people, neurotics and very easily reached psychotics before he starts to graduate up the line and take the cases that could never be touched by anyone. He is then more able, because the tools are easy and familiar in his hands, to use his imagination and to change from one thing to another and work it as an art; because the treatment of a psychotic becomes a fine art. One has to be able to recognize the engram in the raw, see it and know it for what it is, and invent methods instanter to take care of this engram of this particular patient, because there are so many manifestations of psychosis.

The next thing an auditor should know well is the effect of hypnotism and drugs, and he should have observed this actually. In hypnotism one can reach the basic personality, and he can work out the emotional charges certainly from a psychotic case if the case can be hypnotized. So he must be prepared to use hypnotism, he must know how it works, what he should do to make it function, how to regress a person in hypnotism and so on, which is very definitely different from Dianetics in that one produces a trance.

There is a little book by a man by the name of Young written about 1899, which contains in it about as much hypnosis as one ever wants. It is called Twenty-Five Lessons in Hypnotism, published by O. N. Ottenheimer and Company, Baltimore, Maryland. Practically everything in that book works, and clairvoyance, mesmerism and so forth are also delineated.

So there are various methods of hypnotism and someone treating psychotics should know them.

There are a few things that can be added to those techniques, one of which is fixating attention with spinning mirrors and light. This could be reduced much more easily on a technical basis

by having a type of mask tipped over the face that has a spot of light in front of each eye that flashes, producing a trance in the patient. Then there is the proposition of setting up a carrier wave by pounding monotonously on a dishpan with a spoon and saying with each clang, "Sleep," or some such thing, as part of the carrier wave, which will often put a catatonic into hypnotic trance.

It is very difficult to produce hypnosis in a psychotic for the mechanical reason that it is hard to hypnotize anybody who is regressed on his time track. The person should be in present time. Nevertheless you can effect hypnosis at times on psychotics and particularly when the psychotic doesn't happen to be regressed.

It is a very difficult thing to understand, but psychotics will very occasionally settle and you will have short periods when they are quiet and rational. Sometimes a psychotic will run on a time clock. For instance, between the hours of 8 and 10:30 at night any effort to work this patient, although the patient is more or less normal, is quite unavailing. Another patient can't be worked at 2 or 3 o'clock in the morning, as that is the time of the engram and they get quite disturbed on it. In such a way you will find psychotics who are very psychotic during three days of a month in some coincidence with moon periods. So the psychotic, during the monthly phase of the full moon, for instance, may be a raving maniac, and on the remaining twenty-some days he is quite placid and accessible. But because he goes mad every time there is a full moon he is retained in the institution. So you have to work him on the days when he is accessible.

You will find that another psychotic will be more accessible at 2 o'clock in the afternoon than he would be at 10 o'clock in the morning. That is because of the time tab on the engram. So at 2 o'clock in the afternoon this patient who all morning had to lie in a cold pack can be found walking around conversing very cheerily with everyone, but next morning she will be back in the cold pack. Then at 2 o'clock in the afternoon, she will again be quite accessible and seemingly very rational up in present time. This is because there is a call-back at a certain period of the day—a time stimulation. She is restimulated by the hour of the day. Incidentally, you can put a person in a dark room and you will still get the chronometer effect occurring.

It may be that 10:30 at night was when Papa and Mama went to bed and had coitus, and maybe they did that very regularly, so that 10:30 at night was a nonsurvival hour.

I haven't made sufficient observation of working a preclear at such a restimulative time to come to any conclusion, but I have found some preclears were completely unworkable when certain periods of the day came around, usually late evening along about bedtime (which seems to be the pet hour for AAs), and sometimes in the morning around 9:20. For instance, 9 o'clock was when Papa left the house and said goodbye. So at 9:20 Mama said, "Well, I have got to get rid of this baby." Jab! This might have been a standard dramatization of Mama's, and there might be 30, 40 abortion attempts lying around whereby she is throwing herself on the bed or banging herself up against the door or doing something or other that she is very hopeful will get rid of the child. So that at 9:20 in the morning you will find some people in a high state of restimulation, but again, it varies with the engram.

In the matter of drugs, you should be apprised of the relative uselessness of drugs and the danger of their use on the psychotic. It is the favorite stunt in an institution to give sedation to a psychotic. This is very dangerous, and although it is one of these things whereby they think it is better to administer drugs than to do something else, and that it is the lesser of two evils, it is not much less. Here is the situation of a person who is violently disturbed, amid people who are violently disturbed. What would you think of hypnotizing this person and telling him, "Now every word that you hear in your surroundings is going to enter your engram bank"? It does exactly the same thing when a patient is under heavy sedation in an institution.

An auditor will pick up the most fantastic variety of locks when he is finally finishing up a released and cleared psychotic, because the psychotic has nothing around him but high-

powered engrams sufficient to hold up a person on the track, and these are being poured into him while he, although walking around, is still in a suggestible state.

Although I have never cleared an institutionalized psychotic I have brought them up to a point where it was obvious that they were stable and could go on through to clear. When one has removed all the painful emotion from the case then they are stable, but not up to that point. You cannot take out prenatals and clear away a lot of other material and leave the painful emotion in place and not expect something else to happen to the case, because it is liable to collapse at any moment and have a relapse. Unreleased painful emotion is dynamite.

One can be very easily deluded in the administration of soporifics to a psychotic. It appears that the psychotic after the drug has been administered has a return of rationality. You can take sodium amytal and give it to the psychotic who is raving, and within a short period of time find in his place an individual who is fairly rational. So, because he is, one has a tendency not to guard what he says to him, but talk to him as though he were rational. He is not rational in the finest sense. He is in a highly artificial state.

Let us postulate that the charge of engrams breaks down the insulation amongst the memories, and the psychotic would therefore be identifying all the way across the switchboard. Everything is hooked into everything else on the switchboard. As a consequence any stimulus-response, even remote from what we would consider in normal people to be a good reason, will set him off and keep him going. Just the fact of being alive perhaps might be restimulative to him. So, he has what might be termed short circuits all the way through the memory bank and anything will activate his engrams.

Now, by the administration of sodium amytal, sodium pentothal, and many other drugs, we seem to temporarily restore the insulation. We could also use the analogy of an airplane engine which won't start. The reason it won't start is because it is soaking wet and its magneto and spark plugs and wires have all short-circuited. Now we take out the pyrene gun and squirt the engine over with pyrene, drenching the spark plugs, the magneto and the various wires and connections. Then we go back and throw her on, contact, pull the prop through, and the engine is on its way; and because it gets hot it will keep on running because it has dried itself. Unfortunately the analogy doesn't carry all the way through on the administration because the engine in this case doesn't get hot, and the wiring doesn't dry out, but what we have done is restore the insulation amongst the memory banks, temporarily.

Something stated at a moment when a psychotic is under the influence of a soporific is of course received as an insulated and isolated memory. When the drug wears off that is hooked into the circuits too, so that all the dramatizations that he observes while he is under sedation, together with all of the things said to him while he is under treatment, or sedation, become part of the short-circuited pack in his mind.

In the case of an institutionalized patient who has often had a given drug for sedation, if you gave him that drug again, there is some possibility of restimulating the earlier times he was given it; and because it produced the same mechanical effect previously, it will keep on producing it.

The resistance to soporifics on the part of certain human beings has been a subject of great puzzlement to psychiatry for a long time. One person can get drunk on the smell of a glass, and another person doesn't get drunk on a gallon.

The rather careless statement I've overheard amongst psychiatrists of, "Well, anybody can throw it off if he wants to," is not a good, solid scientific statement. It happens that some of the engrams in which the psychotic is existing at the moment carry with them a resistance to drugs and alcohol. The statement "Alcohol doesn't affect me," or "Don't give me any more drugs because they don't do me any good," is good enough in an engram to practically nullify soporifics.

So these people have to be very heavily sedated before they succumb. They will succumb somewhere along the line. They could be 80 years old and almost dead, yet they will stay under the influence of the drug only at the peak, which may be ten minutes to half an hour. So there is a great tendency then, because this person is resisting, willfully and maliciously—and is therefore guilty of mopery and dopery on the institution floor—to keep pumping him full of drugs in an effort to produce an amenable state of mind along the lines of "it does it on some patients therefore it should on others."

I don't know what effect heavy sedation of that character has over long periods of time, but I do know that any of these various types of sedation are poisons. They can control mechanisms of the body, and affect the protein balance, and it is possible that continued sedation over a long period of time in very heavy dosages might bring about a physiological breakdown of the nervous structure.

There is data on this subject which seems to predict the fact that such a breakdown might exist, since I have treated an alcoholic whose brain was "so far gone" that the cellular batteries didn't seem to be able to recharge themselves and he was in a sad state. He had been drunk nearly all of the time for many, many years. It was interesting that he could be worked when he was drunk, and so one got him drunk and worked him, and it went along all right. But he had lowered himself down to a moronic level.

Unfortunately many other things were more pressing at the time and I was unable to make a close observation of him for a long period afterwards. I would have had something more of an answer than I have now on what various drugs can do to the human nervous system the way it is structured. But it is possible that you may encounter in institutions people who have been under sedation so long that the toxic effects of it, plus the fact that engrams are going in there continually, render them almost hopeless as cases due to the enormous volume.

Working a patient with narcosynthesis is not very difficult when the narcosynthesis works, but give a patient narcosynthesis sometimes and you will find he merely goes unconscious. There is no period of accessibility there, or if any it is so fleeting nothing can be done about it. A very good reason for this is that the patient is caught in some sort of an illness or delirium engram which has underlying it enormous layers of unconsciousness.

One patient of which I have a record was in a mumps incident. I finally established this after a couple of sessions. In the engram he had been unconscious for about three days, with Mama and Papa holding him down and pleading with him not to move and thrash about. They did this for three days, telling him they would take care of him, and he was not to worry and so on.

Well, this patient did let them take care of him. His father was a shipping clerk and made a very small amount of money. The boy was not loath to pick up over half of his father's salary and spend it on his own living, and he was 27 years of age, which was rather remarkable. Those parents certainly did themselves proud when they held this boy down for three days—he was still there: "Get back on the bed," "Lie still," and so on. Why they didn't just let him thrash around I don't know, because what he was obviously fighting was them. So whenever he was given sodium amytal, he went right straight into mumps, a high fever turned on, glandular changes took place in his jaws, he became very restless, very wary, frightened, and then would pass through that into straight unconsciousness with no period of accessibility. All it did was turn up the engram.

So, don't depend on narcosynthesis to do anything spectacular for you, and be leery of it because it may do something very, very bad for you. It is possible for you to enter a case with narcosynthesis and start through a late life period of unconsciousness, restimulate it 100 percent, and not lift it or deintensify it because it is right there and it has too much ahead of it. You may not be able to get earlier than that incident because of the extreme weakness of the mind at that moment, and you may succeed in permanently restimulating it, because when the narcosynthesis wears off you haven't approached this thing as you would have in reverie.

In reverie you are trying to get "I" in contact with the reactive mind, and in contact with the standard banks. When you use narcosynthesis you are not working with "I." You are working below the level of "I." So when the narcosynthesis wears off and the bank gets all short-circuited and connected again, you have added with full strength the engram which you have restimulated artificially, and that doesn't wear away or rebalance. So it would be possible for you to enter a case with narcosynthesis and drive a person insane who has not hitherto been insane.

The same analogy can be applied to alcohol. The alcohol, by changing the carbon-oxygen battery setup in the brain, makes it possible for the various memories to stay in their own compartments more or less in an orderly fashion. But when the alcohol has worn away, the whole thing would be short-circuited again.

The reason drunks become worse and worse is because they hang around bars, and people push them around saying such things as, "You bum, get out of here." Insults and arguments go on, yet all this time they could be considered to be under sedation. So they have rendered themselves extremely liable to the receipt of enormous numbers of locks.

I am not warning you on the use of narcosynthesis, merely on the possible consequences in using it. Any use of narcosynthesis that complicates the total knowledge of exactly what engrams are and what they can do is nothing short of irresponsibly adventurous, as many of the past therapies have been—irresponsible in the extreme; because an inspection of the clinical records on the subject of administering narcosynthesis will demonstrate clearly to anyone that a good, sizeable percentage of those cases were much worse afterwards, and stayed worse. It was the fact that narcosynthesis was a variable which made me investigate it.

You will find people who are using narcosynthesis without any knowledge of Dianetics rather anxious to justify themselves in its use. Therefore they will disclaim any responsibility for the patient, with statements like, "He was crazy anyway, narcosynthesis didn't do anything," which tend to bury the actual figures.

What we have to guard against when we treat psychotics is that we do not worsen their condition. It would be possible for a psychotic patient to be in an institution, apparently accessible, and for that patient to be under very heavy sedation of which you would not be apprised. The danger that this poses would be that you start to work a case which is under sedation and slide, whether you want to or not, into a moment of unconsciousness and physical pain late in the person's life. You do not succeed in relieving it, or you accidentally touch it and restimulate it, and the patient doesn't get any better but on the contrary when the sedation wears off is much wilder. Because of the apparent accessibility of a patient under sedation there is an enormous temptation to use it.

If you have to work a patient who is under sedation, work him or her with the full knowledge that the curve of progress is not going to be smooth or all upward. It is going to be a rollycoaster affair, where occasionally the condition of the patient will suddenly seem to be much worse than ever before, and then it will go up again and become better than it had been before. Then right when you think you are winning, down it plunges again. This is a case that you are working under sedation which is actually in amnesia trance, a thing which you might overlook.

The whole operation of amnesia trance is unsatisfactory at best, even when it is done with hypnosis and without drugs, because basic personality's attention units, which we can postulate are down somewhere around the standard banks, have very little force. They find it very difficult to buck into incidents at the beginning of the case. They get more and more powerful as the case goes on, and the more of them that are evidently released, the more the man can do in amnesia trance. But the person has no recollection of what happened when he wakes up.

So there is a definite danger in the treatment of a patient in an institution, and you should be aware of that danger and prepared for the wild emotionalism of the "men of science" in these institutions concerning the changed state of the patient. "The patient has to be under sedation," they say. So, if you want to work the patient, know what you are going to get.

With Benzedrine, you are not running any risks. You could stir the case up as much as you want to. You could take half of an engram and chew it up and maybe not get the other part of it, and leave that and go on to something else, as you will do with a psychotic, and although they may appear pretty wild the following day, a week to ten days later the case will have rebalanced and that cycle can be repeated.

The amount of cooperation which you will get at this time in an institution is slight. The attitude of a gentleman out in Chicago is perhaps representative of this: He was far too busy to look over Dianetics because he had too many psychotics on his hands. He was just going day and night 18 hours a day doing his best for these psychotics. This man was in a bad state. Finally he looked over the basic tenets of Dianetics.

It seems that this person had a bad case of ulcers. He had been free from these ulcers up to a certain moment when he was walking through a corridor of an institution and a gentleman who was somewhat bereft of his wits leaped out of a cell, jumped on him and mauled him a little bit. Didn't hurt him any, but after that for some peculiar reason he had ulcers, and he had had ulcers from that minute right on forward.

The ulcers tell you immediately—one AA. I have never had an ulcer connect with anything else. Ulcers are all caused by AAs as far as I am concerned until I find one which isn't. It is actual pain and injury to the fetus, not a secondhand injury to Mama. The next thing it tells you is that Mama considered Papa a maniac. The next thing it tells you is that Papa jumped Mama about the whole thing and it tells you immediately that the key-inl contains the words "You maniac," or "He's crazy," or "Get him out of here," or something of the sort. There is a shock key-in there. So there is the case lying there nakedly, yet this man was working with and doing things for madmen.

Another thing you must watch for in Institutional Dianetics is the use of positive suggestion during electric shock as practiced by many psychiatrists. They do not call it positive suggestion since they don't recognize it as such. They have never compartmented it. But it is quite ordinary to take a patient immediately after a convulsive shock and tell him, "Well, you're all right here, you will be much better," and "We're your friends," and "People are taking care of you here," and probably "stay here," "don't move," "come back" and all the rest of it. However, it is worse than hypnotism because there is physiological damage going along with it, even if it's just a disturbed electronic balance to the body.

One psychiatrist naively remarked to me that after the patient had been issued forth from the hospital as a remission, the patient very often said that he had a recollection of this touching moment and it had helped him a great deal. I don't know how many of these patients were remitted only because of such a positive suggestion, but if that were the case, the convulsive shockwould have been completely unnecessary in the first place.

To sum this up, people have been working with an enormous number of variables in this area, and there have been a great many learned observations. As a result, when you go into a case you can find almost anything, and probably will. It is not a happy picture. Institutional Dianetics is complicated, not so much by psychosis, but by psychiatric therapy. That is not a bitter statement, I am just asking you to confront this.fact for what it is. You are dealing with patients who are under sedation, patients who are in close contact with people who are going to lay in engrams left and right on them, patients who have been given electric shock therapy with no record of what was said around that patient at all.

You don't know what kind of an engram you are going to suddenly trip into. You may trigger one of these things. You may put the patient right back into the convulsive shock suddenly,

because some psychiatrist as he turned from the machine while the patient was still convulsing said to the nurse, "Come back here a minute. Now wait till I'm through." You just trigger this phrase and the patient goes right into a convulsion. But that electric shock engram, which is after all only an engram, is not susceptible to removal at that moment.

Furthermore, there are freak side effects which you cannot predict, such as the electric shock pulling the whole engram bank up into one place, so that you find yourself working through the chronic somatic of the electric shock, whereby everything you do to this patient takes him into a convulsion.

On the positive side of the ledger, you know what you are looking at. By close observation, you can detail the engram or engrams by the use of your tools and a very good command of them. By using them with great imagination and observation you can produce spectacular results on psychotics. But don't go into the treatment of psychosis, particularly on people who have been institutionalized, with the assurance that you are going to produce positive results in a very short space of time with great ease and with no complications, because the complications are going to be there. You are going to have to work very hard, and sometimes very long to achieve a result. But you will eventually do so, even though you cannot predict how long it is going to take.

If you could just get the person at the time of the psychotic break, and relieve the painful emotion at that time, without the person ever going near an institution, you would have a fine chance of getting a fast release on the case in a few hours of work.

After the patient has been placed in the environment of insanity, under sedation, electric shock, has had psychoanalysis under sedation or narcosynthesis, and maybe years of such an environment have elapsed since the admission of that patient—when you run into this, be pessimistic because you may not want to spend all the time it is going to require to produce a result. But if you are going in because of personal attachment, know that you can fight through this maze and that you can win. However, know also that it may take a lot of time.

Certainly for the first part of your practice in auditing avoid psychotic cases which are institutionalized. You can do quite a bit for somebody who has not yet been institutionalized, but if you go into an institution, you will find yourself dealing with people who have now been deprived of all civil rights, who are wards of the state, who are actually the property of the state, people who by their psychosis are making it possible for other people to be employed. There are economic values being entered in here, and you are not going to get a very pleasant reception.

There is so much work to be done in this field of the mind, there are so many people to be treated, that unless one has a definite personal attachment for an institutionalized case and is going to carry forward just on that line alone, one should leave them alone, because that is a problem into which psychiatry has busily dug itself and they are perfectly satisfied with the problem. I think every effort should be made to keep patients from going into institutions, but once they are there and have received treatment, I think it is up to the psychiatrist. He got them that way, on his head be it. It is all very well to take over the responsibility of all the sins of the world, but it is quite another thing to have enough hours in the day to remedy all things wrong.

I have heard some reports of success in working with electric shock cases, but I have not carried out a long series of test cases and consider it still equivocal. There are many things in the field of man's activities which have not yet been inspected.

In researching Dianetics we take what seem to be the most open and natural manifestations of man first. For instance, we compartment out mysticism and say, "Those are all blue chips with red spots and we're only interested in white ones in this puzzle." So, we compartment out that side of it and we find the other part of it resolves nicely. But we don't disallow mysticism. We say, "That possibly exists, we just don't need it at this time." And so we continue. "Very little

is known about structure, so what do we do about structure? Well, let's just put that aside because we can study function by itself," and we have compartmented it again.

On studying man's behavior, there are more sane men than insane men, or at least they pass for sane. So we get the people who are sane and study them, then we study the neurotics, then we study psychotics and we find out that their minds work in a similar fashion; we are finding the same manifestation on a functional level. And it goes on through.

Now in the studies on that line, we are on very solid ground. But when we start to introduce structure, or anything which alters structure in the mind, then we are not on solid ground. An enormous amount of work has got to be done on this. That is the field of structure.

What has been done physiologically to the mind by an electric shock, by insulin, by metrazol, we don't know. What is done to the mind exactly by a topectomy, a transorbital leukotomy, a prefrontal lobotomy, no one knows. I certainly don't and I know very well no psychiatrist does.

Some experimental psychology could be done on pregnant rats whereby one takes the rat, impregnates it, and kicks the rat in the abdomen afterwards, giving it a good sharp blow and a stimulus. One keeps this up until we get this rat's litter, which is gestating right up through the whole course, giving this litter the same engram over and over and over making it a good tough one. Of course one will achieve the aborting of quite a few litters of rats if one gets too enthusiastic. Then we have control rats of the same strain, raised the same way, but with no blows. Now we take those two categories of rats together, and get them tired in order to key them in. (Of course the rats that didn't have prenatals are not going to key in.) Then we turn them loose in the pen and give them the stimulus and observe what happens to them. You will find that the rats with the engrams are going to be pretty scrawny and extremely depressed. If that experiment works, there is beautiful evidence of Dianetic principles in operation.

The way I have worked it in the past is by comparing mother and child, getting exact recordings from the mother and exact recordings from the child, word for word. Although they might have been relayed conceptually with Mama saying, "Oh, well, you were such a terrible burden to me when you were on the way," and so on, she is not going to (because she is incapable of doing so in present time) give the child a word-for-word account of a moment when Mama was under anesthetic. As a consequence the tapes can be checked and the series of engrams in the child are validated by running Mama through the same incident independently, showing the recordings were there.

Sigmund Freud blew himself a flock of fuses in 1911 when he said all was delusion in childhood because he had found prenatal l He could not account for them, although his tenet of longing for the womb stated clearly that there must be memory connected with them. He got into about as confused a state of mind as any person could get, and suddenly pronounced that all is delusion in childhood, because he discovered seductions by parents. In Dianetics, seductions by parents are so ordinary that you just lose count. Every coitus engram could be translated as a seduction by one parent or the other.

About three years ago, there was a series of eight tapes done checking mothers giving birth against children receiving the birth engram, but since then we have got many more. This is because you treat a young man for a while, and he is getting well, and then all of a sudden Mama gets wind of this, and you are liable to have her as a patient too. You can conduct this experiment any time such a combination shows up. I want to get a pair of identical twins separated at birth some time. Of course their engrams are not going to track 100 percent, because one of them might have been on the outside receiving the injury. There might have been an AA, and only one twin was ever accessible for this AA, and the other one might or might not have recorded such an incident. But you will get on the track there enough engrams in common so that there will be good tapes, running word for word on a lot of engrams. But doing the above using tapes, I have validated it to my satisfaction checking Mama against child.

Many papers have been published on the subject of embryology in the past, which are not well enough known. The work of Hooker is particularly interesting in the field of morphogenesis.

Hooker took an embryo (I don't know how he did this work) and stroked it on the back with a single hair five weeks after conception, causing it to straighten out and then go back into position again in half a second; and he could get this reaction, thus proving nervous muscular control five weeks after conception.

Actually what would be incredible about all this would be if an organism could record nothing or knew nothing until a certain period of life such as two years of age, but up to that moment was not recording, was not doing anything, couldn't think, couldn't act or guide itself in any way; because the most cursory examination of a baby, a few hours old, will demonstrate many abilities, many recordings.

I tested a baby on the subject two weeks after birth to see whether or not an engram could be restimulated in that baby. I didn't do it on purpose, it was an accidental observation. A phrase was uttered loudly in the baby's presence. Many loud phrases had been uttered in the baby's presence, but on this one phrase the baby flung up its arms to protect its face, two weeks after birth.

That was interesting to me; so, guided by science rather than humanity, I promptly threw in with the same intonation many other phrases with no such reaction. I came back to that special phrase, threw it back at the child and got the same reaction again, arms thrown up over the face.

I thought that very curious, so I went back in memory, knowing this child's prenatal background vividly, it being my own child, to the time when that phrase might have been uttered. Mama had fallen at that time and the child had been jarred severely. That was the push button working. It has to be the exact word. For instance, if a man's cough turns on with the word "painted," you can tell him "paint, painter, painting," and you will get no response, but the moment you say "painted," you get a cough. The push button mechanism is very accurate.

Sometimes you get a "delusion" on someone when you are working with them where their present day analytical mind will get back into the prenatal engram and they will start telling you what they thought about it when they were a fetus. Of course they are rationalizing information as it comes up. They can say, "Yes, every time my father came home I used to so-and-so and such-and-such." There is some possibility, by the way, that a child knows quite a bit of language by the time it's born.

I have been looking for something that was scientific enough to be used to act as a means of establishing the character of affinity and the role it plays in raising a child. I have run across several experiments, which, advertisedly, were conducted with the "gravest and greatest scientific care," and on looking at them closely found out that they were just random observations that somebody had optimistically assigned an answer to.

In this lecture I have not told you perhaps with force and precision the exact push button to push in exactly which psychotic, beyond telling you that the rendering of a psychotic accessible without sedation is the most desirable thing that you could do in handling him. It is even possible that some type of metrazol or something of the sort in very light dosages might bring a psychotic into a short period of accessibility. There is some slight evidence to that effect. But as far as electric shock is concerned a look over the field of the insane has not demonstrated much hope for it.

I am always glad to hear of successes in this field, not because it has anything to do with any validation of the work in Dianetics. The day I get interested in my personal reputation ahead of any data of Dianetics is never going to arrive, because this science is as good as it can be applied, and no better. There is an enormous amount of work to be done, enormous numbers

of case histories to be collected in Institutional Dianetics before big, wide statements can be made about it.

But I have treated enough psychotics to know that when I wanted to I could produce a remission in them one way or the other. I have used, in doing that, some very interesting devices. One I learned from a man named Homer Lane in England many years ago. He had some trick of accessibility which he was developing whereby he went into a large institution in England and just said, “Give me the toughest patient you’ve got. I’m going to cure him.”

The superintendent of the institution looked at him aghast and said, “Oh no, besides you’re only a layman, you therefore could know nothing.”

And he said, “Well now, after all the worst patient you have is undoubtedly hopeless, isn’t he?”

The superintendent said, “Yes.”

Then Homer Lane said, “Well, he’s certain to die, isn’t he?”

And the superintendent said, “Yes.”

“Well, then let me have him. What have you got to lose?”

“Well, all right.”

So they pushed Homer Lane into a great, big padded cell where an enormous brute of a man was in raving homicidal fury, and expected Homer Lane to be torn to bits immediately.

Homer Lane said to the madman, “I hear you can help me.”

And the psychotic turned around to him and said, “How did you know?”

Standard Dianetic therapy is administered to normal and neurotic patients. It can be fairly routine, something like repairing a faulty radio set in the home. But treating psychotics could be compared to somebody in a war area who is called upon to re-establish the communication systems of a city that has been bombed into rubble.

The psychotic does not vary greatly in ability or dynamic from the normal or the slightly neurotic, at this time. But I have some evidence that he is essentially a less dynamic individual, and essentially less capable genetically of stability. That does not argue that his stability, such as he has, cannot be restored to him, but it does state that he is not capable of the cooperation which you can expect from a neurotic; because the content in the psychotic bank is not necessarily more than the content in a neurotic or a normal bank. The recalls of the psychotic are not necessarily more occluded. On the contrary, you will find a large percentage of psychotics walking around with emotion, pain, sonic and visio fully turned on, which is an incredible state of affairs, with evidently no greater amount of aberrative content in the bank than a neurotic or a normal person. But the data which has come into the reactive bank of the psychotic has had the effect of laying the town flat, whereas in the neurotic it has had the effect of only knocking off a few blocks of it, and in the normal just deranging a few circuits.

In conclusion, we have treated lots of psychotics, but until several thousand of them are on the books, we won’t have a good, thorough standard procedure whereby even a psychiatrist will be able to treat one successfully.