ENTERING A CASE

A lecture given on
3 July 1950

Dealing with Restimulation

This lecture is about a very important subject. I want to bring all hands up with a short rein on the subject of restimulating people and not picking up engrams.

The danger of restimulation when one is not picking up the cause of the restimulation is not great enough to cause psychosis or even neurosis, but it is certainly great enough to stop a case. Restimulate the case without doing anything further and the file clerk and basic personality will be left waiting, and it may suffice to throw basic personality, the file clerk and the somatic strip out of alignment and out of cooperation with the auditor.

There has been too little attention paid to diagnosis. The idea of restimulating a person just to find out what you can find is a bad one. It is dangerous. It slows therapy and does not accomplish its ends.

The thing to do is to go over everything you get your hands on. The motto should be: Once is never enough. It is the failure to reduce the engram, the failure to properly resolve the case which causes restimulation. If someone is talking continually about his jumping somatics, that case has not been properly handled.

As you grow in experience, your own limits of observation will widen. As you first begin you may have a very sharp eye and a very intuitive feeling for your preclear But your limit of observation is narrow. You have not seen enough of these things manifest themselves to take very many chances. As you become more and more skilled and your observations become wider and wider you will be able to do things which you could not do today at your present state of training.

I bring this to your attention because you may have seen a professional auditor apparently go into a case and rack it all to pieces from one end to the other. Actually that auditor is working on the basis that he is touching things that he knows are not important and will not restimulate. He knows it more or less intuitively, computationally. He has a lot of observation to back up his actions. The instant he touches one that he knows will restimulate, he reduces it.

Therefore this calls upon you as an auditor to be able to differentiate between an incident that has to be reduced and one that doesn't. Any time you put your hands on an experience, much less an engram, reduce it by going over and over it. Any time you find a somatic, flatten it. Any time you find tears, get them wept out. This is very important.

There is a tendency to go into a case, walk around inside it to see what One can find and then leave the case. That is very bad auditing because you may not have recognized, as you were going through the case, that you had touched an incident which might have grave repercussions. It amounts to an auditing crime to leave a person in a state of restimulation, to upset them, and do nothing about it.

You are going to find, as you go into a case, many engrams which will not reduce. The moment you discover one of these, know precisely why it will not reduce.

The first reason is that it has before it a similar engram. If you intend to do something about that non-reductive aspect of the engram, you have to go earlier and find another similar engram. And if that won't reduce, you have to go earlier and find another one. It is simply a process of asking the somatic strip to go to the earlier incident of the same kind and running that.

When you are entering engrams, do not enter them on the basis that you are going to go all the way through them. You only go through the first part of them. Then you will be able to establish whether or not that engram will reduce without restimulating the whole engram.

As you start down a case you may find the phrase “I don’t know.” (It may actually be in the case, sometimes it’s just a remark which is a composite of numerous engramic computations.) But start south on “I don’t know,” getting earlier and earlier and earlier, sticking with “I don’t know.” Don’t go over into the rest of the engram because “I don’t know” is a chain in the case and it will actually reduce only when you get the first “I don’t know,” leaving the case in pretty good shape.

Once you’ve gotten the bottom “I don’t know,” it should erase. Then you can come back up the line. But you would make a mistake if you discovered an “I don’t know” in an engram which erased yet didn’t find the rest of the engram, because now you are way down in the basic areal someplace. So you erase the whole engram. Then you take any other engram in that area that you can lay your hands on and reduce that.

Don’t worry if the patient is not demonstrating a terrific somatic. Don’t worry if he is not convulsing. Don’t worry if he is even protesting he doesn’t feel very much about it. Don’t worry if he says it’s not important. Your judgment is based on the fact that, returned to the moment, the patient is not going to experience a great deal of pain with the engram.

But bring that patient back up to present timer with that engram in restimulation and the patient is going to be very uncomfortable, since the somatic multiplies as it comes up to present time. That is why a migraine headache can be erased at the point it was received on the time track but almost kills a man when experienced in present time. That’s one of the natural mechanisms of engrams.

In order to prevent this restimulation, you should make a proper diagnosis before the case begins. If you are given a patient to put through a two hour session, it isn’t enough to tell the patient to lie down on the bed and just start in, “Close your eyes, now let’s go to the earliest moment,” and so forth. Find out something about this patient.

This may appear tedious, but it will save you and other auditors so much time in the long run that its value is incapable of a proper estimate. It is priceless to do a good diagnosis.

The way you do a diagnosis initially is by having a person sit in a chair, or even lie down, keeping him in present time, and asking him questions. As you ask him more and more questions he will give you more and more information. And at last you have a fairly good idea of what’s wrong with this patient.

Now you want a central computation on this patient that you can resolve, such as: Why is he suffering from what he is suffering?

We had a gentleman who was suffering from Buerger’s disease, which has to do with one’s legs rotting off. The case was merely opened, not diagnosed. Had the case been diagnosed, it would have been discovered rather rapidly that nobody could help him. That was one of the computations, and it would have become apparent the moment work was started on the case because the person would have run in auto. This preclear had a self-control mechanism of “I can handle this myself,” or “I have to handle this myself.”

So he would not have worked well. But you could have discovered this right at the outset by asking him questions in present time about his parents, about what they used to do, what they used to say, what kind of people they were and so on. It must have been a very difficult case to get up and down the track because a case which runs in auto always will be difficult.

The next step that should have been discovered about this case was the reason why his legs had to come off. One would have discovered then the fact that Papa died in a railroad accident

where both his legs had been cut off! The next thing you suspect is a valence shift. What could that be? “Who used to tell you you’re like your father? Why is it necessary to be like your father? Who used to tell you that?”

You will probably get an “I don’t know” at first and a lot of floundering and then all of a sudden this patient comes up with this information: “Well, that must have been my grandmother. She hated my father.”

“Well, who did she say it to?”

“I think she must have said it to me.”

“What would she have said?”

“You grow more like your father every day, and I don’t like it.”

So we run up this piece of information. This must be the top surface computation on the case. It requires wits to do this, but you are looking for something very mechanical and very specific: What is worrying this patient? In this case we have a physical insanity, Buerger’s disease. That’s obvious. We know that’s what is wrong with him. The trouble is in the legs, which must mean something about legs, so we just start asking him about legs. For instance, who was peglegged in his family? Things like that would have turned up this information right away, because it wasn’t outside of his memory that his father died from having his legs cut off. This, in the highest degree of probability, would have matched up with his Buerger’s disease.

You will find people walking around who have bad stomachs, and you say, “Who had a bad stomach?”

And they think for a long time, “Well, my grandmother died of cancer of the stomach.”

Or you say to a person with dermatitis on his hands, “Who had some sort of a hand infection in your family?”

“Oh, nobody.”

“Well now, come on, you can remember it. Now, stay right here in present time for the moment and tell me who.”

“Well, my Aunt Agatha had skin cancer.”

“What kind of skin cancer?”

“Well, it was just skin cancer.-As a matter of fact she died of cancer.”

And you right away peg that down: This person is in Aunt Agatha’s valence. You could be wrong, there might be somebody else who had something wrong with his hands, but you are looking for the people this person approximates.

Having gotten that much, now find out why he has to occupy that valence. Who told him to?

It also happens that if somebody told him to personally, that’s one thing. And if somebody told somebody else in his hearing, for instance prenatally, that’s another. Suppose the husband said to the wife, “You’re just like your father.”

She may have replied, “I like to be like my father. My father was a good fellow. I am like my father. I’m proud of Father. You’re not going to make me like anybody else either. Because I am like my father.” That might be a prenatal argument of family comparisons that is at the bottom of the chain. But, usually if there is a lot of talk of “You are just like. . .” you can get it

on a standard memory circuit. And if you do, you have got that case almost licked, right there 15 minutes after you have put your hands on it. You can actually turn off a psychosomatic illness of the severity of Buerger's disease, Parkinson's disease, dermatitis, sinusitis, bad eyes, and so forth.

It will happen about 20 percent of the time that right there with the diagnosis you can knock the case to flinders if you go at it right. That's worth knowing and it's worth doing because then you will have a case that is running wide open with the person in his own valence. The other 80 percent will have to go at it using the technique outlined here.

Remember that we can divide up physiological and mental aberration. They are both aberrations, only one is physical psychosis or neurosis and the other is mental psychosis or neurosis. In the case of a severe chronic psychosomatic illness, the body has gone crazy. So let's find out why the body had to go crazy.

In the remaining 80 percent of the cases—and these are very rough statistics—you will have to enter the case to discover the sources of these things. But you will have clues by asking: "What did your father used to act like? What did your mother used to act like?"

At first you may get, "My father and mother are very occluded. I don't know anything about them." The heck they don't know anything about them!

You will have to enter the case to discover this computation however, but you know what you are going after. This somatic is chronic. That means that this aberration is chronic and the engram that you are going after is in chronic restimulation. That is the one you want. It may be in the bank 20 times and usually is. But if you get the first one of that chain, you can pull that whole chain out right there. And your patient will get well and be more comfortable.

Those cases which are difficult usually are cases which manifest nothing obvious. These are sometimes quite a puzzler, nothing appears to be wrong with them. In that case go to the last moment of painful emotion in their life and see if it will discharge. It usually will.

If it doesn't, go on down to basic-basic. See if you can get the sperm sequence, see if you can get the first chains of this and that and start working the case right from the bottom, and a lot of times the case will blow! But you can't take a person with a chronic engram in restimulation and do this with him because it would be the most remarkable coincidence that the first engram in the case would be the chronic psychosomatic illness.

That chronic engram had to key in later on in life. So you can go back and find the key-in. You don't even have to put him in reverie to find it usually. It is sitting right in plain sight.

If the person has no psychosomatic illness or aberrations, you are not going to find much of a key-in.

So, do a diagnosis first. Find out everything you can find out about this case, make up your mind what you are going to have to do to this case first, and then enter the case.

You want to find out what point you enter this case, the first engram that you are going to touch. You are going to touch an engram which is, if possible, already restimulated by life, because that thing is normally ready to pull. The one that you run into may be fifth, sixth, tenth, twentieth, fiftieth or eightieth on the chain, but there is always a beginning.

If the patient shows any physical manifestation or agitation as he runs through this engram, be assured that you can reduce it with perfect safety. If he twitches and jumps around on this engram, you can run through it. A lot of these engrams will deintensify. Although they may be in the eighth month of pregnancy, they have still got tension on them. Go back earlier than that and you will find another engram.

Take the tension off these engrams. Take the somatic out of them. If the person is lying there palely, not caring whether you get the engram or not and he isn't agitated about it, that is a case to be leery of because that engram won't particularly deintensify. You have to get early on the chain in order to pick up a good somatic and knock it out.

Judgment has to be used. It all tends toward finding out what is wrong with the patient, knowing that you will be able to reach that somehow, and making up your mind that it must be there in the case. Sometimes you can merely say, "And now we will go to that moment which has been troubling you"—you haven't even made up your mind what it is—and you will get it.

But you can also do a lot of useless work in a case if you don't know the computation that you are going after. Don't think that any case is going to run by rule, although there are some things which you definitely should do, and one of those is that as you enter the case, do your level best not to leave an engram in restimulation once you have it and are flattening it. Don't run a full engram if you don't think it is going to reduce. Run it sectionally.

In the case with Buerger's disease, a late life operation was entered and it was only run once. The emotion was flattened out on one run. The case was then left in a state of restimulation. The auditor should have sat there and run it; he had a late life physical pain engram.

A late life physical pain engram is always dangerous to enter. You may get one into restimulation and after that not be able to get by it. So you let those things lie. They are entirely different than painful emotion engrams. A physical pain engram is one which contains real unconsciousness caused by drugs, anesthetics, injury, or something of that character.

You can touch all the locksl you want which do not in themselves have pain. For instance, someone had a bad case of sinusitis when he was 23 years of age, the real cause of which occurred at birth. You can touch that bad case of sinusitis at 23 years of age and you can get away with it. It is not going to restimulate. The thing that would restimulate it would be to hit birth.
A restimulated somatic is something else, that's a lock, and you can touch all the locks you want to.

But touch a real, honest to goodness physical pain engram that contains ether, injuries, deep unconsciousness where the person was unconscious for a couple of days or even a couple of hours, and you have gotten a bear by the tail and it's pretty hard to let go.

There is only one reason you would ever touch it, and that is if it were enough in restimulation already to hold him on the track. Then you have got to touch it. But in that case, the thing is already restimulated, the person is latched up in it, so you can now enter it with profit because you have got to get him moving on his track.

If the person is in it and it is restimulated, then it is a chronic somatic and can be touched and will be all right. But if it is just lying dormant and he is not held there it cannot.

This also applies to physical pain engrams after the age of $2^{1}/_{2}$ years; leave them alone.

You can do anything you like to a painful emotion engram without particularly upsetting the patient. It is an entirely distinct thing.

The criterion is: You can touch any lock or painful emotion in the case which you care to touch. It will or it won't discharge. It doesn't matter if you have touched it; it doesn't restimulate enough to worry about. But physical pain engrams are the real meat and backbone of aberration. They are the things which cause psychosomatic illnesses.

The painful emotion engram and the lock keep things going. They lock on the physical pain engram somewhere on the chain and you are touching there not a cause agent but an activating agent, which is distinctly different.

You can ask the preclear to go to the time his dog died, and after he has run it maybe once, you find out that it wasn't his dog anyhow. He did feel bad about it but you look at him and there is no agitation about it. He seems to be interiorized, but you can walk off and leave it and nothing is going to happen to it.

Or you can take him to his grandma's death or his grandpa's death or his Aunt Isabel's death, or his mother's death or his father's death, and take him through all the funeral parlors and bring it right straight on up to present time. He will feel sad for a day or so maybe, but that is all that will happen.

But, if you take him back into a real physical pain engram and go through it once, you are liable to have a temporary psychotic on your hands.

You can diagnose the emotional shut-offs just by asking the person questions. You find out that some ally died and that he didn't even cry. You know right away that there is probably an emotional shut-off in this case and you can go back and run him through and confirm it. It's a very good thing to find out quite early.

After a diagnosis, find out whose valence he is in. Find out who else was sick like that. Knock out with straight memory circuits as much as you can possibly knock out of this case in the way of locks.

Now enter the case with age flashes. There are many ways to deliver age flashes, one of which is to say, "How old are you?"

If he has got a built-in circuit that says immediately, "42," if he's 42, he is running on a demon circuit. It's bypassing the file clerk's data. There are cases around which will always say their proper age, although they may be stuck all over the track.

One of the ways to upset this automatic proposition is to start getting automatic flashes on other things. Say, "Repeat a word for every word I give you. Love."

The patient says, "Hate."

"Red."

The patient says, "Green."

"Dogs."

He'll say, "Cats."

"How old are you?"

"Gluh—uh—I'm 42."

"What was the first number?"

"10. But I'm not 10."

"What happened when you were 10 years of age?"

"I don't know."

"What might possibly have happened there?"

"I don't know."

“Now you can remember something of this incident. Were you ever knocked out or injured or operated upon when you were 10?”

“I don’t know.”

“Well, where were you living when you were 10?”

“I guess that was the Badey Street address.”

“How did it look?”

You are building up his memory, and you find that incident and spring him out of it. It may be very difficult to do because he may be in somebody else’s valence, at which moment you would have an emotional shut-off, and sometimes even a pain shut-off.

Now you have to discover where he is held on the track and get him moving and into present time before you work him. Two things can happen with regard to that. The incident in which he is latched up may not be an incident which can be reduced as itself but may be the end of a long chain of incidents. So it isn’t good enough just to keep hammering at 10 years of age. He might be with equal facility at 5 years of age, or 3, or 2, or 2 months after conception on the same chain. He is really all these ages, but the top one is 10. At 10 years of age there was a key-in which really stopped him.

There was a patient recently whose holder, of all things, was “That’s all.” One could regard this person’s whole life as an engram. This person ran into the same phenomenon which you get when you are running an engram and somebody in the engram says, “Well, that’s enough for now,” and the patient stops, although the engram goes on for another hour.

This person’s whole life could be treated in the same way and the last words that ended the life, you might say, were “That’s all.” It ran to the age of 12, when a friend was dying. It certainly took some burrowing with straight memory to find this. The patient was 12 years of age when this friend died, her dearest, closest friend. There was a deathbed scene where she saw the other girl just before death. And what the other girl had said in a moment of very high emotional stress was “I’m going now. I hate to leave you but—that’s all.” So we had a holder at 12 years of age. The rest of life had never been lived as far as the reactive mind was concerned, it was stopped at 12.

So remember, you can find tricky holders or tricky computations. That particular one was painful emotion. In order to get her out of 12, you might have had to have turned on emotion in her case, because you had to get the emotion off that incident in order to get her out of it. You might have also gotten her out of the incident just by straight memory recognition of it, but it is rather doubtful.

The incident in which the person is held may be dependent for its strength upon earlier incidents in the case. One might start in on an appendectomy at the age of 29 and find out that nothing is going to happen with it, and although one hits the right words, it isn’t going to release. Anything one does to that particular engram in which he is stuck isn’t going to hurt him any. He is there anyhow. It is in full play.

Unable to reduce that engram in any way, one would have to go earlier. There is an earlier holder, an earlier nurse, an earlier operation, there is an earlier everything. He will go back from 29 to the earlier holders because they are in a bundle. The appendectomy at 29 is connected to something else earlier, maybe a tonsillectomy, or another ether operation of some sort earlier in the case.

They will be so close together that you can move him earlier on the chain to get an engram to deintensify the 29 year old one. But it’s all stuck in the same operation. Technically there may

be a tonsillectomy and birth hung up, and they finally keyed in at 29. You are not going to have any difficulty with it. Try to send him to other operations and he won't be able to go, but send him to the right one, and he will go. He is not inextricably locked up. You can extricate him from 29 by taking him to an earlier stage of life. But, in a lot of cases, the one in which he is stuck on the track will be independent enough so that you can simply run it through and all of a sudden free him on the track and he's on his way.

But if you don't knock it out, then every time you try to bring him to present time he is going to stop at 29. And if it has got a call-back' in it you may get him to present time and then check him 10 minutes later and find out that although you brought him up to 42 he immediately sagged back to 29, because somebody in that incident is saying, "Come back here." So he does.

The phrase "Let's let it settle down" is also a call-back. It settles down, all right. Or "Lie back down here, dear, be comfortable and relax."

A person can really get stuck. And if he is badly audited, he can get stuck even further, in more and more engrams. But usually they will settle out.

Don't pay any more attention to age flash and flash answers than you can help. They are maybe 50 percent correct. On some patients they seem to be 100 percent correct, but on others they are never right. If the age flash starts working, however, and is fairly reliable on a case, you can go right on using age flash and you will get all sorts of information through.

Then after a while you find the person relying on his age flash mechanism. He wants all manner of numbers which might be quite accurate and it might also be a filtered demon circuit giving him wrong information. You have made him dependent upon a new mechanism he didn't know he had.

That can be knocked out with a straight memory circuit. So, the most reliable method that you can use is to first use age flash and find out whether or not it works. And if you keep asking the person and he says, "42," although you know very well that he is stuck some place early on the track because he has no somatics and can't move around, obviously he is not only stuck in an engram, he is in somebody else's valence.

You may get a flash which will tell you that it's weeks. He may be measuring it postconception, and he may be measuring it postbirth, but usually such flashes are measured postconception. With lots of people, the person's age flash is measured from conception.

If these things don't work, just start probing around to see if you can't discover some portion of the persons life which is fairly occluded from him. Start opening it up on a straight memory circuit. Don't work him on the track. You know he is stuck someplace. Don't charge around in his case taking the engram in which he is stuck early and late with him while he is in the wrong valence. Put your attention on getting him into a state where he can experience his own somatics.

It's actually possible to get that person into the basic area and to get him turned out of the area in which he is held. You will find cases that you absolutely have to work with everything closed off. You are unable to discover exactly where such a case is stuck on the track. It may be that he is stuck in so many places and so thoroughly that a discovery of each and every one of them is almost impossible. But take what you can get, and work toward moving him on the track. Don't work toward clearing his case. There is a definite difference.

This material is formulated on basic observations. You can use these observations pretty well by rote, and don't depart from them too far because it is close to center on what you are trying to do.

Above this level it requires imagination to discover these things. To open up a person's memory, use the formula that a person can be made to remember a small part of the large part you want him to remember; and by making him remember the tiny parts of what he can't remember, you eventually achieve the large section that you want him to remember.

For example, you ask somebody, "Well, you can remember so-and-so." "No, I can't remember people."

"What's my name?"

"Your name's Hubbard."

"Well, you remember me!"

"Well, sure. But I didn't mean that. I mean I can't remember people." "Well now, who is your best friend?"

"This guy named George. George's a nice guy."

"You remember George?"

"Yes."

"Where is the last time you saw George?"

"Oh, I had lunch with him today."

"You know you had lunch with him?"

"Yes."

"He sat right there at the table with you?"

"That's right. We had spaghetti."

"What do you mean you don't remember people. You remember George. You remember me. What about your wife?" Or, "What about your boyfriend?" What about this? What about that?

Soon you are liable to get somebody way back in the early part of life. Actually what you are doing is pulling his file drawers open for him. You start out with remembering a grain of wheat and soon he can remember the whole state of Washington.

You are prying it open, but you can do it using gradients.

For instance, he says, "I don't remember anything my mother ever did." At that moment as he is sitting there, this is, as far as he can tell, true. But now let's ask him some things that a person would have to know about his mother, such as, "Well, where does she live?"

"Oh, she lives in Keokuk."

"I thought you didn't know anything about your mother."

"Well, sure, but I know where she lives!"

"What kind of a place does she live in?"

Soon you are demonstrating to him that he has an astounding amount of information about Mother. And sometimes working in this fashion you will pull it right into the visiol sphere

although the preclear ostensibly has a visio shut-off in that area. You can do, on a straight memory circuit, enough work to put a person clear back down the track into the prenatal area if you want to work at it. They are just gradients.

If you don't use straight memory on this, but persist in working engrams on the track with which he has no real connection and which he himself can't validate, you are going to work a patient that will tell you increasingly, "I don't know where I am, I don't know whether that's true or not, I think that's garbage."

You start to run through an engram, and he goes halfway through it and says, "You know, this is garbage."

So you say, "Keep going," and he will roll it. On the third or fourth recount he yawns. Pretty soon it will die down and he won't be interested in it anymore. You have run an engram, whether it is valid to him or not. But he has to have that engram and the knowledge of it connected up to "I" in order for it to have any real therapeutic value. Try to keep that person connected with reality, and the best way you do that is on a straight memory circuit, on a gradient.

It is true that as you work a patient and knock out engrams, mechanical results will ensue. You may go straight on down the line knocking out incidents and get him into his own valence after which he may remember.

Don't abandon knocking out engrams just because he can't remember whether they are true or false. But don't keep working him forever on the basis that what he is running is so much nonsense or you will be going on and on. I imagine you could spend two or three years working a case like that, giving him maybe three sessions a week.

If he doesn't know whether the data is right or wrong, throw this gradient formula into view and make him remember. If he can't remember, your question is, who wanted him to forget?

He will think that over for a while and he will even come up with the astonishing information about who wanted him to forget. You will discover all sorts of things about a case.

Try and do it on a straight memory basis, or try and get an earlier time. Get the situation oriented, and that all by itself will serve to deintensify the restimulation.

When you have done something wrong in a case and touched on or run head-on into an engram that was not ready to be touched, and you can't get any earlier on it and don't know what to do next, stabilize it. Really work at it before you bring him back up. Take him to a moment of pleasure and you will get the somatic off at that point but don't bring him to present time.

If he can't reach a moment of pleasure and you have to bring him to present time, be sure to stabilize him in present time with the simple process, "Now, let's look at the wall. Now, let's feel the couch under us," using the preclear's present time perceptics.

When the preclear is coming back up the track after you have taken him through an engram that really shouldn't have been hit and which wouldn't reduce, bring the patient up to the time he got well from that incident. Tell the somatic strip to go to that moment. Now you have re-established the fact that he did get well from this engram. Then bring him up to a time shortly afterwards when he was very happy, and stabilize him there. Try to turn on all his perceptics there, and then bring him on up to present time.

There are intermediate steps. If you are unable to discover anything that is pleasant, or his perceptics will not turn on at that spot, try and find a place where they will turn on and he will stabilize. And then finally bring him up. If you can't find any, then try to stabilize him again in present time, but don't leave the patient with that engram in full restimulation.

Something else you can do with a patient is to tell his somatic strip to go anyplace on the track. And if you do not ask him in any way to contact any of the perceptics of his own volition anywhere on the track, but merely tell his somatic strip to go there, you can turn somatics on and off without restimulating him.

You can, for instance, take him to the first moment of the incident by saying, "Now your somatic strip will go to the first moment of the tonsillectomy."

"I don't see anything," he says.

"Well, I'm not asking you to see anything or do anything at this time. I'm just going to run your somatics, that's all. Just lie there, it's okay. This is the first moment of the tonsillectomy. Now one minute passes by. Now two minutes pass by. Now three minutes pass by." And the patient starts gasping. He is being told to take breaths. His somatic strip is reacting, even though he is not seeing anybody or contacting anything.

You can run him through the operation, with swallows, and his hands stiffening up, and when you get him all the way through the operation, tell the somatic strip, "Keep on going," hour by hour then day by day up to the time when he is perfectly well from it. He hasn't contacted a thing, as far as he, "I," is concerned. He may even remark on it. But don't pay any attention to what he remarks, just keep on running him through the incident.

Bring him up to the time when he got well. Now you can start asking him questions about where he is and so on. Let him contact that.

It is what "I" contacts and seeks to perceive, and what is impinged directly upon "I" which is important. In this way, you could take him through an engram which is full of holders, denyers, and other things. "I" isn't asked to contact them, and there is no bouncing, thereb nothing going on there, but the somatic strip is going through and he has got a pain in his shoulder, a pain in his throat, a pain in his head, as it goes on through. And these pains turn off as you march on through the engram down to the end, and then forward to moments when he got well and so on out.

Always take him to the moment when he got well. Don't bring him straight up from an engram to present time. His somatic strip will track with you in the majority of cases.

It is "I" contacting the perception "I" having the perceptics impinged upon it, that restimulates an engram. So you don't run it very far. Find out if it is going to reduce, and find out if there is an earlier moment if it is not going to reduce. In this way you won't leave a case in chronic restimulation, and you will find somewhere on that track an engram that can be reduced. But by your diagnosis you know what you are going after.

Those things are laid down. Know your tools, and by practice coordinate them, and you will see this thing at work. In some cases it may appear very baffling to you, and you are not going to see very smoothly how this thing works out. But don't put it to test on just one case, because it may be your own still unpracticed use of these tools that has caused the thing to bog, not because it isn't workable. So don't stop with just one patient. Work several patients this way, and then come back to the tough ones. By the time you have worked several, there are some of them that are going to respond and you will see the process in operation, then come back to the first one that was so tough, and if somebody else hasn't already knocked the case apart, why, you will normally be able to.

Keep casebooks. You know what is important about this routine, so say how much of it you have done, and what you have discovered. Then each time an auditor takes over a case it saves him the necessity of going all the way through it. Put everything you find in that casebook.

Don't bother to write engrams out word for word, but get some sort of a phrase that the preclear is using chronically. For instance, if Father is always in the habit of saying, "Forget it," note that down.

Make that casebook brief. But make it carry enough information so that a new auditor picking it up can take a look at it and say, "Oh, this is the kind of a son of a gun this person had for a father." Or, "His father and mother were very fine, evidently the trouble lies with his grandparents with whom he was left when his parents went to India. There is probably a mess-up there someplace."

The new auditor can simply scan over two or three pages, know the case, have the feel of it, and go right on with it from there. So make a habit of writing that sort of material down.

What is important is the preclear's chronic psychosomatic illness or his chronic aberration. Whose valence is he most likely to be in? Whose death? Did these deaths have any effect upon him?

Then there is the theory of valences. The person in engrams could be in great pain if he were himself in the engram. So the mechanical proceeding has been evolved by the mind to take a valence for every person who was in the operation, and the person tends to occupy the winning valences of such people.

When a person is not in his own valence, he has a difficult time contacting engrams. For instance, if he is in Mama's valence, he will tell you everything Mama says. But it will appear to him that he is saying the things himself. He is liable to give you Mama's full conversation from beginning to end and never give you Papa's. And yet Papa is part of that engram and Papa is probably the aberrative valence. If he is in Mama's valence and Papa is talking, you may miss all of Papa's words because he insists on running Mama and nothing but Mama.

A valence has a tendency to become sealed by a death. It is as though nature seeks to make a mock-up person to replace the person who is dead.

The term mock-up was used during the war when they shot up mock landing craft built out of plywood. A mock-up hasn't any real body and it has no utility. It's a sort of zombie.

But one of these people is created by the impact of death. The person who is in a valence gets along, and he can get in and out of the valence rather easily through many years. Then all of a sudden the person whose valence it actually is dies, and this puts a sealer on it. It may even lock the person up more or less permanently in that valence. However, there are two ways to get him out of it Dianetically.

One is to find out who, by what remark, put him in it. We used to talk about somebody being off the time track. The way one gets off the time track is by getting into a valence. So, "I can't be myself. It's impossible to be myself. I guess I'll have to pretend to be somebody else," down in the basic area, is a setup to throw a person into some other valence.

More specifically, you will find commands through the bank that settle a person in another valence and hold him there by engramic computation. The engram commands him to be Mama or Papa, or we get allies all along the line saying, "You're just like me, you're just like I used to be. You're your daddy's little boy. You're just like your daddy, yes sir, you've got nice hair just like your daddy," and so on.

It has a tendency to take the child—particularly right at the end of birth you will find these things—and throw him over into that valence. Then let's say Daddy dies. Daddy doesn't have to die to keep him in that valence, but Daddy's death would really put the sealer on it. Now this person goes ahead and suffers with all the psychosomatic illnesses and aberrations of Papa. It's as though life has made a mock-up of the person who is now departed, and intends that mock-up to go along.

A weird philosophy can be evolved around this concept, but all we see here is its mechanical application, its effect.

So the person is commanded to be in a certain valence by something or somebody. It may be a general type of command early in the engram's prenatal area, or it may be a specific command that says, "You now are Mama and you are nobody else but Mama and you're going to be Mama from here on out." This locks him up as Mama.

This is the reactive bank using a native and natural training mechanism of the analytical mind. When you see someone take a bow and arrow in his hand, you can then look at him and take a bow and arrow in your hand. He pulls it back just so and he adjusts his feet just so and you pull the bow back just so and adjust your feet just so. He fires toward the target and you fire toward the target. You are learning. And that is the easiest way to learn.

They discovered with a great deal of shock in the war that the easiest way to teach people was not to have them reading textbooks half the night on how to solder wire, but to send them to the shop to watch somebody solder wire. They could give them the theory behind it, but when they really wanted to teach them and put the finishing touches on it, they had to set it up so that the students could mimic.

Mimicry is a prime method of teaching. This becomes very strange and distorted when it is applied to valences. Mimicry can go a long way. You will find people, especially children, are sometimes in the valence ofa pet; or they were raised with a cocker spaniel, and their mannerisms are cocker spaniel mannerisms. They are in the dog's valence and then, let's say, the dog died. Now there is some part of that person that is being a cocker spaniel!

You can actually see people on the street who are cocker spaniels, bulldogs, mastiffs and so forth. They are locked up in a valence, and the body reconstructs the mannerisms. It is a very interesting study.

Take the little girl who at the age of about 3 had as her constant companion a little dog. This little girl couldn't be persuaded to knock on doors. She would go up to a door, get down on all fours and scratch on the door. That's what the dog did, so she did it that way.

Very often the parents would make comments like, "She is just like the dog, they're inseparable," which shoved the little girl further over into the dog's valence. She would have been there more or less naturally anyway; but now by an engram or by command, or simply by an ally saying, "She and the dog are just inseparable, you can't tell them apart. One after the other they both go out in the mudholes and run around. I expect she will be digging up bones next, " they have made her into a cocker spaniel in some of her mannerisms (because, by computation, allies have to be obeyed). Now let's say the cocker spaniel dies and there is a lot of sorrow about it. You have now got a person who is sewn up in a valence.

It's an odd thing that a person can be in more than one valence simultaneously, and a person can be in more than one engram simultaneously. The engrams can be shifted around on the track. In fact they can all be shifted simultaneously up to present time. If you want to upset somebody badly, use a lot of punishment, hypnosis and so forth, and move it all up into present time. Hypnotists do this sometimes without knowing it: "That's all for the present," a hypnotist might say.

It's the same way with valences. A person can be in several valences simultaneously. He may be in Grandma's valence, Mama's valence, Papa's valence and so on.

Take the luckless individual who has a command that says, "You're just like everybody else. There's no difference between you and anybody else," and it has on top of it, "Why don't you be more like people around you," or "You're like everybody you talk to. I've noticed it." This would be an aberration traveling down the track.

"You talk to so-and-so and you're just like he is, and you think the same things he does. But then you talk to somebody else and you're just like them. You're a different person for everybody you meet. What's wrong with you?" This, lying in the engram bank, has a tendency to do an automatic valence shift for every person to whom the individual talks so that he begins to misidentify himself with everyone. He will see Bill and for an hour he is Bill. And then he sees George and he's George. "Who are you now?" you say to this patient, and he will do a double-take on it and maybe you will get a flash answer that his name is Oscar at this moment. And yet he is apparently perfectly sane.

You get this misidentification with the universe by throwing the mimicry mechanism out of gear with engramic commands. By doing this you get a very upset mind.

Any ability of the analytical mind can be exaggerated and made permanent and be taken out of the control of "I" by engrams. And just by that common law you could derive things that could happen to a person because of engrams.

The phrase "You're two different people" is where such a split could start.

The valence wall is something that is postulated. It is an analogue. The person has been moved over into a valence more or less permanently and then, let's say, some death or grief or sorrow has caused him to be permanently in that engram. Dianetically we have got to take him out. We can take the painful emotion off the top, or we can take the computational engram commands off the bottom. We will get him out either way.

The way we spot this is by psychosomatic illnesses and aberrations: "Who else had this aberration?" The person will tend to have the same physiological structure, the same psychosomatic illnesses, enjoy the same things, have around him the same things as the person in whose valence he is. So we can easily detect the valence.

But in the case of a psychotic person, the valence walls have gotten so tough, they are so strong and sharp, that we can have a psychotic flicking from valence to valence without ever being in contact with "I." We now have nothing but valences. Watch a psychotic and you will see him do this and you can also shift him from valence to valence.

You can say, "Let's be your Papa now." And it's just as though you hear a click as he goes across the valence wall. He's now 100 percent Papa, only he's talking with nothing but Papa's share of the engram or engrams in which he is latched up.

You say, "Now let's be Grandma." So, click, he's over the valence wall and he's now nobody but Grandma. He is out of contact with "I." And we can let him dramatize in this fashion endlessly. But if we can swing him through the valences in the engram and get him to click across the line on it, sooner or later we will deintensify it as a strata of valences.

The place to study valence compartments is in the psychotic, and that can become very fascinating. The gentleman with Buerger's disease has a tough enough valence wall so that he will dramatize at the top of his voice, and a psychotic can really get up there in volume when he starts into these valence walls.

Mr. Blank goes into Papa's valence, and he goes into a screaming fit. Now the engrams and commands are not effective. He can race through them the instant that he is in Papa's valence. But by running him through it several times, in view of the fact that he is slightly in contact with "I," it will deintensify.

But, you are getting none of Mama's commands. To be Mama now we would have to swing him over and say, "Be Mama through this period," and he would go through a full dramatization of Mama. What we are trying to do is get Papa and Mama deintensified, then "I" can start to work. The moment "I" starts to work, the commands that are contained in Papa's

speech, and the commands contained in Mama's speech become effective upon "I" and "I" starts doing the things that these other valences have commanded him to do.

But while he is in Mama's valence, or Papa's valence, he can say, "Go away, go away, don't come near me, get out, get out, I can handle this myself, oh God, what am I going to do? I'm right up against a blank wall, nobody can help me, life is just too horrible to bear, don't touch me, don't touch me, go away, go away, go away, oh, my God, I'm done for," and he can run through all of this because this is just Papa. The instant you get "I" joined up with this and start him through the incident, he says, "I can handle this myself, get out," and up the track he bounces.

But just because he bounced does not mean that that engram isn't in full restimulation. The fact that he bounced demonstrates that it is in restimulation. If we say, "Well, he's bounced out of the engram," that doesn't mean that he's no longer in the engram. He is. But that engram is very active.

So, what we do is deintensify him as Papa and deintensify him as Mama as a valence shift. Just keep him playing it and the records sooner or later will wear out. If he is psychotic you can hope that his records wear out before your ears do.

You can see then as you work a patient whether that patient is psychotic, neurotic or merely normal. You can see these valence walls and it is up to you to find out how he got into them and get him out of them and get those valences deintensified.

But he isn't going to pick up any somatics of his own while he is Papa, he is going to run Papa's somatics. If Papa has a cough and a sore stomach, that is what he is going to have. As himself, in Mama—let's say it's in the prenatal areal—it is probably a crusher somatic, Mama crying or Mama bending over or Mother lifting something, it's something that's impinging itself on the child. And that is his own somatic.

But Mama's somatic may be "Oh dear, I know you have a stomachache, but I have a headache." Well, if he's in Mama's valence at this point, he has got a headache, but that isn't what the child had.

You will find many times that a patient will develop a chronic somatic as you begin to run him. He will begin to have nothing but the somatic which he has. He runs everything with a sore head. He starts to run something and somebody kicks him in the stomach and he has got a sore head. Or he's trying to run Papa's "I don't know, I don't know," because Papa has hurt his foot. And even then although he is running somebody else's somatic he has got a sore head.

That sore head isn't his. It is his someplace on the track, but it is probably a command somatic confirming a somatic of his own. It is not a very good clue as to what the engram is all about. You will find him somewhere on the track with a big groupers like "Everything comes down to this." And there he is stuck on the track in such a case.

You start to run out an engram when he is 5 years of age and he may start off with a slight somatic in his shoulder and then all of a sudden he has got the headache. He has run out of this upper engram and he is now running the upper engram out of the bottom one.

This is what happens when you start to run engrams through other engrams. You are going to get the somatic and the valence of the person in the engram that is chronic, and you are going to be potshooting other engrams without somatics from this one engram. He is apparently moving on his track, but gradually as you run more and more engrams, you are going to have more and more somatics latched up in this same place. The track is going to tangle up more and more, and somebody still have to take the thing apart quickly, otherwise the patient is going to get pretty uncomfortable.

This is not stripping. Stripping is another technique and is a way to handle an engram which won't reduce and in which the patient is so thoroughly fixed that he cannot extricate himself. Let's take a nitrous oxide incident, a late life engram of exodontistry, and we find the patient is giving you an age flash of, let's say, 26 and you know he is 49.

What do we do about it? We try to run the incident at 26, and we find and try to run earlier dentals. If they don't seem to have much effect on it, it is just a tough engram and everything in the lower bank is latched up on it. Everything is in restimulation below it and is pulled up into it. He is in bad shape and you can't get him out of it.

The thing to do in that case is start with the first phrase of the engram. Don't run the whole engram. Try to shoot the holders. Try to shoot the call-backs. If you can't get them out, then start in with the first phrase of the engram and go back to the first time it occurred, all the way back to basic area and erase the engram there. That is stripping. It is a mechanical operation.

Then, run it back up to the top and take the next phrase and go all the way down and find the first time it appeared in the case, and so on through maybe two hours of the nitrous oxide. It may take you weeks to do, it is quite a procedure. But you don't go through the full engram. You try to shoot the holders out of an engram that he is latched up in on the track. If they are going to deintensify and he is going to get out of it, probably the whole engram will deintensify. So run it.

But do sampling on it. Run the first ten phrases of the engram, if you can contact them. Run the first ten phrases two or three times. Find out what they do. Does he develop a somatic? Are you going to be able to deintensify this engram? If he is held up in it, you are going to have to go through the engram and handle it by deintensifying it or by stripping it.

But if you suddenly start out on a late life engram that you know to be dangerous, you know his case is not working well and he is not particularly held up on it, that is when you use stripping. But don't run all the way through it first. That puts the whole thing into restimulation. Just take a section of it and strip that section. Then take the next section and strip that. You are reducing as you go without putting the last half of it into full activation before you have dealt with the first part.

Tell the somatic strip to go to the first phrase in the engram. Count from one to five and snap your fingers on the understanding that the first phrase is going to come through as a flash. The procedure is: "The somatic strip will go to the beginning of this engram. When I count from one to five the first phrase of the engram will flash into your mind. One-two-three-four-five," and you will get the first phrase. It will just move him.

If he doesn't get it, he is not moving; he is held up someplace. So you say, "Give me a yes or a no on any one of the following: Is there a holder here? (snap!)" And he gives you a yes. "All right. The somatic strip will go to the holder. When I count from one to five and snap my fingers, the holder will flash into your mind. One-two-three-four-five (snap!)." This usually works surprisingly fast.

If it isn't working on this you can tell the somatic strip to go to the denyer with the words "Is there a denyer? When I count from one to five and snap my fingers, the denyer will flash into your mind (snap!)," and the preclear gets it.

That doesn't work 100 percent because there may be other things wrong with this engram. But it will work often enough for it to be very interesting as a technique. Remember, the somatic strip will work with you unless somebody has messed the case up. If that has occurred you can free it by going back over the things which have been done to freeze it up and knocking them out as locks, after which the somatic strip will start to comply with you.

Use a straight memory circuit to knock these things out by asking the person to remember this and that, and soon he will be cooperating with you again. Coax him, dare him, do anything you can to him to finally get him to give you something.

He may get mad at you, but that is still all right because you are at least getting a response. You won't get anywhere with an apathy case unless you get the person up to a tone 1. They have to be able to get angry, and you have to take them, sooner or later in the case, through a strata of their being angry. If they can't, they are not getting well. That tone scale works out.

The first thing that an auditor must be able to do is get some kind of a conceptual notion of what the preclear's time track and engrams look like. Actually some auditors see this as a graph. They see where the engrams are entangled. They see what the engrams are like. They know the approximate contents.

By doing a diagnosis on the case you get a pretty good picture of what this person is doing and seeing. Then you can work the case. It acts as your tally. For instance, I could probably draw you a picture on practically any patient I have worked on, after I knew some of the content of the bank and had run the thing through. I either have those pictures on file or I could draw them.

You have to be able to size up your patient. There are two billion human beings alive on earth today, which means there are two billion different engram banks.

Engrams are not filed in a nice, orderly file. They are not set up in such a way as to make it easy for you to reach them.

The difficulty that you have in reaching a person's engrams is the same difficulty his own analytical mind has in reaching these engrams. What you are trying to do in Dianetics is what his analytical mind is trying to do. Only he can't carry it all the way through unassisted. But assisted, he can.

As a consequence there is a parallelism at work. What he can't do in Dianetics, his own analytical mind couldn't do in life. As a result, this parallelism will follow out in diagnosis. What he is unable to do analytically usually works out to be what the people around him were unable to do analytically because of contagion. So you have a model of his engram bank in Papa, in Mama, in Grandma and the other relatives. You want to know what is sitting in his engram bank? Look at the characters of the people with whom he associated from conception onward.

Because of his own perhaps higher dynamic (it works out on a lower dynamic basis too) or because of his own higher analytical power and also because of the accidents of life, these engrams may not have the same character effect upon him that they had on the people he got them from. He may have risen quite superior to these engrams. He may be capable of many more things than the people with whom he is surrounded. Genetically, he may be an entirely different character than they were. There are a lot of variables at work. At the same time if you want to know why this person worries about his stomach all the time, ask him, "Who had a bad stomach?" It works out that neatly.

In Dianetics, we are trying to get the individuality of the patient back into the fullest play and thereby make his mind capable of doing all the things it should do.

The only way we can get it into full play is to get out the things which tell it it should do something else—an interior determinism that was an exterior determinism foisted off on him. So we have got to get him into his own valence. He has got to be himself. The way that we get him into being himself is by taking away the things which force him out of being himself.

As far as the filing system of the engram bank is concerned, it runs on the basis of the earlier you get, the thinner the commands are. When somebody has said, "I hate you," for the 195th time, it's getting very well set, and if you try to blow that out you are going to have a hard time. But let's get the 10th time. That may erase, and although there were 9 times before it you are getting down there where the material is thin.

Therefore you want to work in the basic area as much as you can. You want to get as early in the case as you can, as soon as you can.

This doesn't mean that you can ignore the fact that the person is latched up somewhere in late life on the time track. You have got to do everything you can to free him out of that engram in which he is held in order to get him into his own valence. You will find he will most easily go into his own valence at the moment on the track when he has the least command to be out of it, which is the basic area.

Normally a person will be in his own valence in the sperm sequence unless he is latched up someplace on the track. That is just postulating the way the equation goes. The earlier you get, the thinner the material, the more likelihood there is you cah swing him into his own valence. Also, the earlier you get, the less engram commands are behind him to force him to do things, and the easier it is to work him.

There are two reasons why you can't get early in a lot of cases. One of them is that painful emotion has dropped valence walls down and has occluded various parts of the track, because the painful emotion lies on top of the prenatals, most ordinarily. Whenever you run out a painful emotional engram, you are going to find a physical pain engram right under it, generally quite early. The painful emotion of grief has the aspect of putting a valence wall in that is very solid. It may be very hard to go through that valence wall. But get early enough and you will find the reason he has to be in that valence.

The other reason why a person can't get into the basic area is strictly computational: bouncers. A non-coitus chain occurring in the basic area is the master of this sort of thing. "Leave me alone. Don't come in me." "Get out of here. I don't want to see you ever again. Oh, I would die if you did that to me, I'd just die. Don't touch me. Get it out, pull out."

If the person with such an incident is in the basic area and he is in somebody else's valence, he can dramatize it. But if he goes into the area as "I" he starts to bounce.

Be very sparing, however, in your use of repeater technique. Using repeater technique and nothing but repeater technique on a case can get a case so thoroughly snarled up he won't know whether it's Tuesday or Christmas.

If you have got him in one engram and he is held in that engram and you are trying to free him out of it, you can actually repeat earlier engrams up into the one he is latched up in. You can form a bundle at this spot by giving him all manner of repeater. So try to make your repeater apply to the engram in which he is latched up. And mostly use repeater not as a diagnostic operation but as an actual therapy operation.

If he is running a non-coitus chain, you know very well what will be in it: "Get away from me. Don't come in me. Pull out," and so forth. Feed him these phrases as tests. Ask the file clerk with a snap whether or not these things are there. You will get a yes or no in the majority of cases. Then get him to repeat these things. But you are repeating now for a special incident of which you know the character.

Don't start in at the top of the track using repeater technique. Don't get the preclear into where he is latched up, and don't get him to repeat endlessly anything that comes into your mind, because you would restimulate engrams that shouldn't be restimulated.

Try to discover what the engram is. For example, one preclear was held up in an appendectomy. His mother had had a terrific effect on him in his life, and he was pretty occluded. But here he was at 29 in an appendectomy. So we got the age flash of 29 after working on him for quite a while. And we were fairly well assured of the fact that there was some kind of an operation at 29. His wife knew there was an appendectomy someplace, but she didn't know whether it was 16 or 35.

“I can’t remember anything at 29,” he said.

So we did some pussyfooting around. After all, the analytical mind is faced at that moment with the computation of the fact that it is very unsafe to remember anything in that area. It can’t scan it because there is pain present. The whole year may contain pain. So we got him to remember fragments of what he was doing when he was 29.

“All right. Who were you working for?”

“I don’t know. I don’t remember.”

“Well, were you working inside or outside?”

“Oh, I was working inside.”

Now we have some information. He was working inside.

“Did you like your boss?”

“Aw, he was kind of a dumbbell. No, I didn’t like him very much.”

“Now, where were you working when you were 29?”

“Well, let’s see, I’ve worked for a fellow by the name of Blank. Yeah, that must have been it. Yeah, that’s right, I was working for Blank.”

Then we get the kind of office he was working in. We do not work on an operation. This other material over here is safe to remember. So, you get him to remember this, you get the year, when he was 29, and lay it fairly well open. Then you say, “What did you get sick from?”

“Oh, appendicitis.” This surprises him, as if “I knew this all the time, why didn’t you ask me?”

“Well, who was there? A nurse?”

“I don’t know.”

“Was a doctor saying these things? What’s the holder here? Give us a flash.”

The flash answer may not be working very well. But all of a sudden we find out that the nurse in the appendectomy was an old school chum. And that she’s sitting across the bottom of the bed holding his feet down. Then we find out on further questioning, very nearly on a direct memory circuit, that although we are right in the operation and it is somewhat fogged up and unreal to him as it would be, we get the phrase “Don’t let him move around, you’re liable to open it up.”

And here he has been going around daring everybody to open his case. “Of course if he thrashes around on the bed, the incision is liable to open up,” says the doctor, so the nurse has got to hold him down. So he doesn’t dare have that case opened up because the case is the incision so he can’t be opened up in the case, and that is the computation there at 29.

In order to solve this thing fully we had to go earlier and find other operations. Because this one was so solidly held, it was utterly occluded. But by finding an early operation, all of a sudden we got enough holders out of that so that the later one was released. There were also early denyers which impinged themselves on the later operation. In such a way we got him moving on the time track.

Now, he may not be in his own valence very well. But you can take him down to the basic area and get him into his own valence and then really start running engrams out of this preclear which is the best way we know of at this time.

The smoother you can get a case working right at the beginning, the quicker you are going to get a person released and cleared. If you have got a tough, jumbled, rough case that is messed up right at the beginning and is very difficult to straighten out, keep working it anyway. Keep diagnosing it until you do get the right diagnosis. That is very important.

In order to turn on his sonicl you can take him over pleasure moments, and often by doing so you will actually get him back into his own valence. You have given yesterday reality. This gets him more stabilized and suddenly he may have sonic. It works in a majority of cases. Just taking him up and down the track into pleasure moments and developing those moments, you may get him into his own valence and you may even get him out of the engram in which he is stuck without ever sighting it!

It is always best to find out what he was stuck in and spring it, otherwise he is going to get stuck in it again sooner or later. But if you are faced with a blank, don't suddenly say, "Well, let's start working anything we can get our hands on," and start racing through a lot of engrams. Stabilize the preclear in pleasure.

One of two things will happen eventually as you try to stabilize him in a pleasure moment. You will either go through the same incident over and over until he can smell, taste, see, hear these various things, or you may turn on the moment that makes it impossible for him to approach it, which may be somebody's death or something similar flashing into full view. The man may experience a tremor of fear. At that moment you go straight to the incident that is shutting it off.

But always remember that such a technique depends upon shaking the person out of his chronic valence and out of the engram in which he is stuck. If it won't do those two things it isn't going to work.

So, by approaching the case that way, you have done a diagnosis and found the engram he was stuck in and what the main computation is. Then you want to reduce the engram in which he is stuck and get him moving on the track.

Go over the material, try to get him moving on the track, try to turn on his perceptics and get him out of the incident by running pleasure incidents. If you can't do that, spring him out of the valence he is in by finding out his computational command.

This is not a rote routine. But these are the things that you can do, and as you work with it and go from patient to patient you will find your optimum method of proceeding. But have an optimum method of proceeding that has to do with diagnosis, getting the preclear back into his own valence and running smoothly on the track with his own somatics. That is what you want to do. After that you can start knocking out engrams and you will have a fast case. If you don't do that you are going to have a slow case.

I have no intention of giving you any information that will confuse you. I give you the blunt fundamentals, and as you see patients pass under your eyes, as you work them, you will suddenly find yourself working intuitively. Your tools will become so familiar in your hands that you will know exactly what you are going for, and soon you will be turning off all kinds of somatics by simply having the preclear sitting in front of you looking at you.

Sometimes a preclear thinks his livelihood may be dependent on a manic, but I have never seen a manic knock out without improving a man's ability. If he is going to be the king bee, the manic will make him do things which reduce his stature and reduce his reliability, and as such reduce his ability to command, because he is running on stet data.

Saying that a salesman is only successful when he is a manic type is entirely incorrect. It is something like describing a fine watch by saying, “It keeps perfect time. We call it the watch which has to have its mainspring replaced every 18 months.” Or, “We give it the designation of the watch with a cracked jewel.”

It is an insult. It is giving psychotic classifications to abilities. It is saying, “The reason this fellow is doing all right is because he is crazy.” Did you ever see anybody who was crazy who was doing all right?

Take a manic who goes around shouting at people in his business. He is not going to get cooperation from anyone. Now let’s take his manic away from him. He has still got all that ability and force, only it is now regulatable. The radio no longer has to run wide open. Very often when a radio runs wide open we may say, “That’s a very fine loud radio, but the neighbors won’t like it.” Now let’s fix the radio so its volume can be tuned to as much force as is needed for the occasion to produce the maximum results and we have got the person out of his manic. A manic is worthless.

The psychiatrist has been very prone to classify everybody with a psychiatric classification. They have developed a remarkable theory that the reason the analytical mind worked was because it had 15 or 20 types of insanity. That is just as crazy as it says it is. The cleared analytical mind is capable of reproducing any kind of insanity very easily. You can go into a manic, you can go into a depressive state, you can turn them on and off, and really make them look convincing too.

When an engram is reached in a case and it has a somatic, and it shows any signs whatsoever of being reducible, don’t walk off from it until it is reduced. Knock it flat right there. Take it down to a point where it won’t cause you any more trouble.

You are going to find the following will happen occasionally. You take the preclear back to the time when his mother was giving him an enema when he was 4 years of age, and you start running this enema. At first you get it mildly. Then it gets stronger, and then it gets worse. He has now got it down to the point where he can feel himself getting all swollen when the enema goes in. It would be of harm to the patient if you did not then ask the file clerk to go to the incident before this which would make it possible for us to deintensify this engram. But, by sending him earlier you will find him going to an incident you can run right that minute which releases the upper one that you have thrown into full play.

So, deintensify the lower one, and by doing so you make the case much more comfortable because it will have a tendency to key outl the upper one. Go into the case to a point where something will reduce, and run out anything that shows any signs of reducing at all. If it does not after you have run it—and remember it’s best to run a section—you have gotten one that won’t go into recessions Then you had better go down the track and find out why, and you may wind up in the basic area.

But at the same time get something reduced at that point, otherwise you are going to have this patient in a very bad setup. It is better for you to lay off any slightest thought of artificially restimulating somebody to pick something up.

This procedure requires plenty of experience. If you can go up and down a case looking for something that if knocked out will cause a tremendous change in the patient, you can do this. But right at the present moment you should practice running out engrams and finding out what they do. It may look slower, but it will pay you dividends in the long run.

Pretty soon you will get the feel of these engrams. Then when you start running out an engram, you can say, “This is one that is going to beat into recession.” You have only gone 10 words into it anyhow, so you pull out quickly and go to something else. But test it first, and then go earlier on that same engram chain to knock out what you have got after running a small section

of it about five times to find out if it will reduce. The rule is: As is the whole, so will behave one of the parts.

You ask the file clerk, “Now let’s pick up the incident which we have to reach in order to make this reduce,” and you will get one.

There can be a lot of other computations that are difficult. There’s one on the basis of, “Well, we’ll have to turn him around now,” which is quite common in birth. That is a misdirector,l and you will find the person doing all sorts of weird things at that moment.

So, this is a warning against leading a case into restimulation.