DIAGNOSTIC PROCEDURE

A lecture given on
14 June 1950

Indicators

This a short dissertation on diagnosis.

A formal diagnosis should be made on a patient. I shall go through the diagnostic procedures. Each person should have a casebook containing various headings which form the outline the auditor follows. An auditor will be able to tell then at a glance about how far the case has progressed. It is not absolutely vital that an auditor know what state the case is in, but this casebook gives him material for which he can search.

The first thing we want to know in any interview is whether or not a person has a foreign language background. The following is a demonstration of a case diagnosis, and I want you to take particular note of the headings.

LRH: Do you have a foreign language background of any kind?

PC: Possibly German, a very slight possibility. As far as I know, no. However, the possibility exists.

LRH: All right. (LRH is writing as he talks)

PC: It would be German if there is.

LRH: Yeah, it would be German. All right. Now have you ever had any shock therapy?

PC: No.

LRH: No shock therapy. By shock therapy I mean metrazole, insulin, electroshock machines. You've had none of these?

PC: None of those.

LRH: None of them? All right. The next one is hypnotism. Have you ever been hypnotized?

PC: No. It's been tried but it's been unsuccessful.

LRH: Hypnotism—tried but unsuccessful. Now, have you ever had a psychosis that you know of?

PC: No.

LRH: Have you ever had a severe neurosis that anyone has ever labeled?

PC: No.

LRH: All right, no neurosis. Have you ever been psychoanalyzed?

PC: No.

LRH: Have you any psychosomatic disorders?

PC: Yes.

LRH: What are your psychosomatic disorders?

PC: They appear to be a thyroid misfunction.

LRH: A thyroid misfunction?

PC: It has always reacted to standard thyroid treatment.

LRH: Uh-huh. Well, what else about your thyroid or glandular setup?

PC: As far as I know, that's all.

LRH: You're wearing glasses, what is your eyesight?

PC: I'm myopic in my right eye, slight astigmatism in the left. Right eye is 22/100.

LRH: 22/100?

PC: Yeah.

LRH: The right?

PC: Right.

LRH: And what's the left?

PC: It's probably something like about 20/30.

LRH: 20/30. And now what is your weight at the present time?

PC: About 145 lbs.

LRH: Your weight's 145 lbs. Your height?

PC: About fiue, seven and a half.

LRH: Height, 5 foot $7^{1}/_{2}$ inches. All right. Now, this is a very peculiar thing to ask you, but do you ever have any dramatizations? That is to say, do you ever get mad?

PC: Yes, quite frequently.

LRH: You get mad. All right. And what do you say when you get mad?

PC: Usually I can't think of anything to say.

LRH: All right. We note that data: "Usually I can't think of anything to say." You get speechless with anger as I understand it?

PC: Yes.

LRH: All right. Now, I want you to tell me what operations you have had.

PC: I had a tonsillectomy.

LRH: Tonsillectomy. What age?

PC: 5.

LRH: Okay. What else?

PC: Circumcision at 7.

LRH: Circumcision. Most people get embarassed about that. About 7?

PC: 7.

LRH: What else?

PC: Tooth extraction under gas.

LRH: Nitrous?

PC: I asked at the time and they just kind of smiled and didn't say anything.

LRH: Which tooth?

PC: Two wisdom teeth.

LRH: Two wisdom teeth.

PC: That's all under gas.

In various psychotherapies a person may have amytal. A person will ordinarily tell you yes or no, "I didn't have psychoanalysis, but I spent ten months under constant sodium amytal."

In actuality, a person who has had sodium amytal treatment day after day, three or four times a week, is rather heavily drugged, consistently. With a person who has an amytal background (that is to say, amytal massively), you can expect that what the therapist said to him is very liable to be lying there in the bank restimulating very, very thoroughly those hypnotic suggestions. Anything that is said to the person in narcosynthesis is very aberrative. A person gets delusions, there is a complication with it. So that is amytal.

PC: I've never had that.

LRH: Okay. Any others? How old were you when you had these two wisdom teeth extracted?

PC: That was just this summer. I was 24.

LRH: 24 years?

PC: 23, rather.

LRH: Okay. And what else have you had in the way of operations?

PC: No other operation.

LRH: No other operations that you know of?

PC: Let's see, I can guarantee that I....

LRH: You think you can guarantee it. Okay. Now what childhood illnesses have you had?

PC: Well, I had a severe illness lasting several months, it was a combination of whooping cough and chicken pox. Also about 5.

LRH: What was that? Whooping cough and what?

PC: Chicken pox.

LRH: Okay. Whooping cough, and chicken pox, 5 or 6. It surprised your Mama. How old were you?

PC: About 5.

LRH: In years?

PC: I was in kindergarten at the time.

LRH: Hm-hm. Was that before or after the tonsillectomy?

PC: That I don't know.

LRH: All right. Have you had anything like scarlet fever?

PC: No.

LRH: Measles?

PC: I've had measles. I've had every kind of measles and I've had some of them more than once.

LRH: Measles many times.

PC: I was never very severely sick.

LRH: All right. And what about scarlet fever?

PC: No scarlet fever. Pneumonia.

LRH: Pneumonia?

PC: Had a light attack of pneumonia, about 8.

LRH: Pneumonia, 8 years. What else?

PC: That's all, except for the flu occasionally or a light case of the grippe.

LRH: Now we'll take up accidents. What kind of accidents have you been in? Major accidents.

PC: I can't think of a single major accident.

LRH: No major accident, huh?

PC: No major accident.

LRH: And at the present time in therapy, how is your audio? (Make a list of these recalls.)

PC: How about war service?

LRH: Did you have any accidents in the war?

PC: No.

LRH: Okay. (All war service comes under terms of accidents.) Now let's make a list of these perceptics. Audio, how is your audio?

PC: I don't exactly know how to describe it. I have perceptions of what is being said but none of them have been clear.

LRH: Partial perception?

PC: Partial perception. Similar with visio.

LRH: Visio, partial.

PC: Varies a lot.

LRH: Pain?

PC: Practically nonexistent. I haven't had a really good solid somatic yet.

LRH: (pause) How about feeling? Tactile?

PC: Tactile? No tactile.

LRH: All right. Olfactory?

PC: I think as far as it exists, I haven't run across it in therapy yet.

LRH: Taste? Do you taste things in therapy?

PC: I haven't tasted them in—yes, I have. I tasted the iodine in something. It's fairly acute.

LRH: Has tasted iodine. Well, now, you say it's fairly acute, you mean you've tasted it more than once?

PC: I mean in therapy.

LRH: In therapy you tasted that iodine more than once?

PC: I've tasted—well, they swabbed my throat first with iodine and then with something that was different.

LRH: How old are you?

PC: (pause) 5. (laughs)

LRH: All right. There we've got the tonsillectomy.

PC: I was thinking about that at the time though.

LRH: (chuckles)

PC: All right.

LRH: (He's latched up.) Okay. The next is kinesthesia.

PC: That seems to be very acute.

LRH: Acute, huh? How about emotion? Emotion. Spilled any?

PC: Nope.

LRH: Okay. No. All right, time track mobility, are you moving on the track?

PC: I'm stuck right now.

LRH: How have you been moving on the track?

PC: Fairly well.

LRH: Fairly well. Exteriorization? Do you see any exteriors?

PC: What do you mean, see myself?

LRH: Yeah.

PC: Nope.

LRH: You're inside yourself?

PC: Yep.

LRH: (Exteriorization, that is to say, does he see himself in the scene or is he in himself.) Do you have prenatal visio?

PC: No, I have no prenatal visio.

LRH: How about occluded characters? Do you see everybody? Everybody that you've ever known?

PC: Well, yah.

LRH: You see Grandma, Grandpa?

PC: Yah.

LRH: You see everybody?

PC: There's a possible occlusion on a great-aunt.

LRH: Uh-huh. Possible occlusion, great-aunt. Okay.

Now the general observations of the case come after this, including the obituary, which is very important in a case. It is also very important when you are working a case to note in the patient's casebook when the thing was erased or reduced because it immediately tells the state of the case. A release of painful emotion in a case is utterly vital because painful emotion on a case must be released before you can say a person is a release. The primary way to get a release is by releasing painful emotion off a case. Releasing real painful emotion may produce some smiles, but there is seldom any false four, because that follows fear. So we follow this obituary very closely.

LRH: The first thing we want to know in the obituary is: Is your father alive?

PC: Yes.

LRH: (You write down "Father alive.") Mother?

PC: Mother's dead.

LRH: Mother's dead. Grandfather, maternal?

PC: Both grandfathers are alive. My paternal grandmother's dead.

LRH: Paternal?

PC: Paternal grandmother is dead.

LRH: Paternal grandmother is dead. Okay.

PC: My other grandmother's still living.

LRH: Is there charge on it?

PC: I (pause) I would expect so.

LRH: Anybody ever try to release it?

PC: Nope. How did you spot that?

LRH: What?

PC: What made you think there was charge on that?

LRH: I watched your eyes.

That's the value of a diagnosis. The auditor must observe the physical manifestations of the patient at all times. I mentioned father—no response. Paternal grandmother—automatic response. One can tell at once whether a person is agitated or not.

LRH: The next thing that we want to know is: Any aunts that are dead?

PC: No. Except the great-aunt.

LRH: Aunts, great-aunt. Anybody in the

PC: (coughing) I'm waiting for my greatgrandmothers.

LRH: We'll get to that in a moment. Any uncles who are dead?

PC: Yes.

LRH: What uncles?

PC: My paternal uncle.

LRH: Paternal.

PC: Died during the war.

LRH: Okay. Now your great-grandfather, maternal? Any great-grandfather?

PC: Three of my great-grandmothers were alive when I was born, and the other one died just shortly before I was born.

LRH: Three great-grandmothers . . .

PC: Alive when I was born. My greatgrandfathers....

LRH: I.. alive when you were born!

PC: Yeah.

LRH: Gee! (pause) And one died just before you were bom?

PC: One died just before I was born.

LRH: Oh, brother. Which one was that?

PC: That was my great-grandmother Harrison, maternal maternal.

LRH: That's maternal?

PC: Yes.

Watch those maternal grandmothers, because the maternal grandparents were the allies of Mama, ordinarily. Whereas Mama's mother was probably a villain, Mama's grandmother was a heroine as far as she was concerned. This is the ordinary course of events involving the skip of a generation. After all, this is not Grandmother's baby. Grandmother didn't have to go and deliver this baby. Grandmother may have been hell on wheels when she was a mother, but now she's old and feels placid and it's fine, and the children are lovely, particularly when somebody else has to take care of them most of the time. So she can come around to countermand Mama's orders and do a lot of things. At some point the little boy may be frightened and restimulated by his mother, and here is an ally, particularly where Grandmother or a greatgrandparent has been present rather consistently in illnesses.

The aberrative factors must occur in illnesses. We.don't care what she did as long as the child was feeling frisky and running around and enjoying life. She could have spoiled him, given him things, robbed him of his independence, done almost anything to him; but if she was present during those periods of illness, particularly if she was present at those times when Mama had decided the pregnancy should be no more, saying, "Please don't get rid of it. You shouldn't get rid of it, honest, Agnes, you mustn't get rid of it. Just give me your word you won't try to get rid of it anymore," you get the case running fairly well and all of a sudden one day he can't get rid of any engrams, which becomes very confusing. That type of sympathy engram is quite common and it very often stops the patient in his tracks.

PC: Double-check my paternal grandmother then, because she was a bedside consoler.

LRH: Okay. And one died just before birth.

Great-grandparents are usually very hard to find in the case because the great-grandparent is the ally of the parents, and if the child asks whether or not he ever knew his great-grandparents he is liable to be told, "Oh no, that was long before you were born." There is occlusion there and the parents misplace the death in time and so on. Of course, great-grandparents have a habit of dying off fairly early in the person's life. The death is actually occluded. The parent often doesn't remember when it is.

LRH: How about school and so forth?

PC: (mutters)

LRH: Okay. How about brothers and sisters?

PC: (murmurs response)

LRH: Any of them alive?

PC: All of them are.

LRH: Sisters and brothers all alive.

Now we come to pets. (Some of the doggonedest emotional releases I've ever gotten are off pets where the person is about 15 years old and the dog suddenly dies.)

The matter then is to locate the number of deaths you can find in the case.

That completes the interview with a patient, after which we start running the case in therapy.

What I have said in this lecture about reaching the painful emotion does not invalidate the statement made in earlier lectures that when one finds a patient very badly occluded, try to find the incident he is locked up in. Having gotten that incident, get him moving on his track freely. That is clever Dianetics; because you can keep on pounding the patient, getting him to give you more and more incidents of a painful nature, until you have just stacked his track up with "can't reduce" incidents and he will get more and more occluded.

One has to be particularly careful in handling a psychotic. It is very difficult to work a psychotic because there is not much rationality there to handle. They will work with you as far as they are able to do so, with as much as they have available to cooperate with you.

That doesn't invalidate getting the man to present time. Get him to present time at least, using everything you can lay your hands on.

In some cases you will find it necessary to tackle birth head-on. If birth is right there and waiting, you have got to run it from beginning to end, and keep on running it, and that birth will deintensify.

Here is an individual in the womb, and it is nice and warm, and everything is going along fine. Then suddenly the earth quakes and there are cramps and screams and things are happening and he gets knocked out, and he is ejected out into colder air—wet, warm, dry, cold. Simultaneously he has mucus in the nose and throat, and it is thought that this single engram is the genesis of most common colds. At least most people who have had birth deintensified, not erased but just completely deintensified leaving the prenatal bank untouched, don't have colds. It is probably bacteriological as well but the engram predisposes the person and lowers his resistance. Then we get the condition of a person who takes a warm shower, steps out into the cold, and thereby restimulates his birth.

In opening a case and testing someone for pain shut-offs, you may be running along very nicely with the preclear at the age of 21 where he has a cut finger and suddenly have him stall, at which point you can say, "Now let's go to the moment which makes it hard to reach this incident. The file clerk will give us the moment," and sometimes he will hand up birth. That birth is ready to be deintensified, after which the case will fly. The file clerk won't give you anything it can't deintensify.

When the mind returns down the track it gets a big shutdown. Part of the analyzer is hooked in with that engram at that moment, and the engram has a little tab on it that says "analyzer shut-off."

So we return the patient down the track and then the patient starts to "reason." Of course the moment he starts to think, he is thinking straight out of the engram he is in.

It is not true that a person in present time, wide awake, such as you are now, is talking out of his engrams, or that every one of his phrases will be an engramic phrase. That process of

tasking a person with this unsettles him a great deal. The patient will finally get furious and try to explain, “All right. So I’ve got no words of my own. All I was trying to tell you is I’m tired. I am extremely fatigued. I have a great deal of lassitude,” and he starts putting it up into high-class words in order to convince you that he is not talking out of an engram. He wants to quit because he is worn out, or he is really trying to communicate something. A good auditor does not snap a patient out. He lets him talk even though he knows he is talking out of an engram.

The first thing in auditing is use your wits and discretion. Any time you find it necessary to violate anything but the Auditor’s Code, by all means do so.

An engram very often will be tapped and have a bouncer, and when you try to go back against a bouncer the person doesn’t bounce; but in about ten days that engram half reduced will have settled, and will then be more or less back in place. Anything approached in reverie if touched will settle eventually, and go back into a condition whereby it is unaberrative.

But if it was contacted in deep hypnosis or, through psychiatry, trying to reach a patient with narcosynthesis, anything hit in the case is going to go into restimulation, and when the narcosynthesis or deep hypnosis is over, something will be left in permanent restimulation.

If you don’t like someone, don’t try to give him a new engram, just throw him down below the level of awareness and restimulate what he already has, such as moments of unconsciousness. Those will stir up and stay stirred up. They do not settle. But using just plain Dianetic reverie, one merely tells the person to close his eyes, and go back down the track and find something. One can run a half hour, and even mess it up any way you want to and there would not be any future aberration out of it.

Sometime or other you are going to have a patient who will work in no other way but in deep trances. He closes his eyes and is instantly out of contact in deep trance, one of these natural hypnotic subjects.

Terminology can be handled very neatly with a patient who doesn’t know Dianetics by saying to him, “Give me something that would make you stay in one place,” for a holder; or, “Give me a set of words that would make you run away or go,” for a bouncer, and you would get an answer from him.

I have even seen little children of 5 and 6 do something about it. I have worked on a little boy of 4, and I got quite an emotional blow-off too. His father had paddled him the week before, and he felt sad about the whole thing. We got rid of this and he felt a lot better—he told me so.

Normally if you look at the size of a reactive bank and the amount of content, and then you expect a child of even 10 or 12 years of age to handle that, the answer is no. When a man who is grown and fairly well developed with high analytical power can’t touch this thing, and suddenly we take this little child with his case wide open, with full recalls, not heavily restimulated, and take him back down the track, it is just the same as throwing him out into the Roman arena.

A person’s analytical power keeps on growing in a case evidently up to maybe his 20s.

I have done the following with children, and you can too. They fall down and get a bump, so you teach them the trick of returning over the area (which they will learn in a hurry). You only have to do this to them a couple of times. One little girl, for instance, had been returned over an area when she had been bumped a few times. Later her Papa gave her a little switching around the legs and she was overheard out on the back porch rubbing her legs and swearing quietly to herself and then going back over the engram again picking it up!

In this way you can clear out minor emotional charges. If the child has suffered a great deal of restimulation such as a recent death on the case, and you know that the emotional content of the prenatal bank is very heavy, you could try to get that death out. But you are liable to find

yourself back in the prenatal area, into material that the child can't handle. The best thing to do is just keep a child from getting restimulated. Limit therapy on a child to picking up little odds and ends. Make them happy, give it to them when you think they need it, stay as late in the case as possible, and above all don't get the case stirred up to a point where it will swamp the child with anything you suspect may be there.

Any prenatal bank is full of infamy. It is extremely embarrassing to try to run some little girl back into the coitus chain who doesn't know what on earth is going on. She only knows that she is uncomfortable. The words and actions are a complete mystery to her. She is flabbergasted. She will get it off by syllables. One particular little girl was going around asking people and wondering, "What on earth.... Now where have I been? What's been happening to me?" Seduction by father.

The patient who is in somebody else's valence should be returned to the earliest possible moment on the track to find an incident, and then told to get into their own valence. In other words just shift valences. Let them run out the dramatization of Mama's valence and Papa's valence in the early moments of the track which form the basic area—before the first missed period is the basic area—and shift them over to their own valence, deintensifying it, and they will run it then as themselves. After that it becomes increasingly easy to do so.

The other method of attack on this is to take the patient back to the moment when he is in valence as himself. A patient will go into these valences probably during therapy, but one will be very confounded sometimes to find a patient who has been working fine with sonic and visio and so forth who then goes into a restimulative environment. He comes in for therapy and you keep on working without checking his perception. Then one fine day you say, "Well, let's take a look at it," or, "Let's take a good close look."

"I can't."

"Well, when did your visio turn off?"

"Oh, it's been off for about two weeks." (They tend to get the idea that you are inside there with them looking and that you automatically know this.)

I worked one patient whose case was very wide open, and turned on the prenatal area with full sonic merely by saying, "Well, why don't you take a good listen."

So these are case openings, and diagnoses, and what to do about it.

Never come off an engram just because a person doesn't have full perceptics. Keep coaxing the person through an engram until you get another perceptic out of it somehow with phrases like, "Now let's see if we can get a tactile on this while running it," and so on. All of a sudden the engram may build up and, despite himself, the person may find himself with full recalls. That has happened. You can take a birth apart that way, and run out each perceptic at a time. So there is no excuse to leave a lot of the engram there, but you will have to sometimes.

An auditing error can sometimes occur because the auditor sees the preclear back along the track discharging the painful emotion, with the case going like wildfire, and out go the auditor's basics. It's all an auditor can do to keep up with it. He doesn't have to use his wits, he just has to sit there and ride.

Then all of a sudden the auditor gets a case which is badly occluded. Things are not too clear, and he will sit and watch one of these sad cases. The fact of the matter is that although it may take a while, it nevertheless opens. It may take 20 hours just to come down the line with any certainty and get the somatic run out and the engram reduced.

It is interesting how a violation can take place of the very best technique, such as the auditor repeating things that the preclear has said conversationally. It is quite all right if the preclear says, “I’m caught,” you know he is going to have an engram that says, “I’m caught, I’m caught, oh God, I’m caught, I’m trapped, what do I do now?” And way afterwards the auditor says, “All right. Repeat, ‘I’m caught, I’m trapped, oh, my God, what do I do now?’ “ That is quite correct. The person is going toward the engram. It is deintensifying, he is looking for it, and they have both more or less agreed on the subject. But in another instance the preclear thinks that he is using his own mind and he says, “I can’t remember.”

“Oh, well, come on, let’s see if we can try.”

“I can’t remember,” the preclear says plaintively.

“Well, let’s just see if we can get something.”

“Well, I can’t remember.”

“All right. You can’t remember.”

If you do that, you will have the case explode right there, because you have repeated something that obviously is appearing in the bank. Only it is appearing in an engram which you are not going to have the capacity to handle, and it will key him in. It is part of his engram, but it isn’t necessary for you to tell him so at that point. Therefore don’t use it at best.

Many wives have developed a trick, and so have many husbands, particularly where there is a very unhappy relationship, of repeating back everything that the other person says. There is no surer method of driving a person off his hinges because, by repeating these things back, one is breaking the dramatization and restimulating the engram. He is driving the person out of a habitable valence.

For instance, let’s say the man is being Papa now, “I am the boss around here, I’m going to lay down the law. You’re going to do what I tell you.”

And his wife says, “Yes dear, yes dear. All right.”

But supposing she says, “All right. You’re the boss. All right. You’re the boss. You’re the boss. All right. You’re going to do everything around here,
you’re going to have the say around here, huh? You’re the boss. Okay. Okay. Okay. You’re the boss.” She is driving him straight out of this valence.

Now he may try to be Mama. “You have no business talking to me that way,” he says tearfully. But Mama is the secondary valence and as such is not quite survival.

So supposing this horrible thing happens to him. She says, “All right. You can’t talk to me that way.”

“All right. So I can’t talk to you that way, so I can’t talk to you that way,” he shouts antagonistically, descending into Baby’s valence now. And, boy, it was not safe to be a baby when that engram was going on. The first thing you know, this fellow has somehow or another gotten lumbago or sciatica, or a few other minor ailments, because one has ticked the engram while the analytical mind is attenuated.

This is not hypnotism by a long shot, although hypnotism is to a large degree based upon this mechanical plan. It is used entirely differently. But he goes back. The analyzer is shut down. Therefore its ejector mechanism of evaluating and throwing out material content is to some slight degree lowered.

If the person is looking for an incident, he knows this is a phrase out of the engram, and the preclear and the auditor have agreed that it is a phrase out of an engram, so they try to get to the engram. The auditor can help the preclear repeat himself back into the engram by repeating it. But he must not engage in conversation about it thereby slapping a lock on top of it, because that would be against the preclear. Auditor plus preclear going against an engram is different.

However, the auditor should not act as the memory of the preclean Let patients remember their own pains. Another point is not to bait a person. It is not fair to take an engram out of the bank and then say, “Oh, you say that to me all the time. Now you see, you had an engram about it. I told you all the time you had an engram about it. But you didn’t believe me, but you did and there it was.” It will be impossible to get another engram out of this case until you have cleared that up. A case can really be slowed down by bad breaks in those areas.

The other crime that could be committed is when a husband and wife are working each other and he sends her back to dinner last night; and he knows very well that last night it was Joe Zilch who was sitting across the table and she keeps coming up with the fact that it was Mr. Smith. After they are all through he says, “You know, we’ve got to do something about your dub-in. You kept seeing Mr. Smith there and it was actually Zilch.”

Husbands and wives do not make the best auditing teams. If you have any doubts about carrying on a husband and wife team, don’t. But you should also know that many husbands and wives have carried each other successfully all the way through Dianetics.

That concludes this dissertation on diagnostic procedure, and its importance in the opening of cases.