CASE FACTORS

A lecture given on
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Paralleling the Mind

We have to have some quick method of handling inaccessible institutionalized cases which doesn't hang around the neck of the auditor. One of the reasons I'm cautioning you against the very impractical, strange case of the psychotic as any kind of a steady diet is the fact that the probability is that the problem will eventually be solved. Meanwhile there is no reason to take any beating on the subject.

Narcosynthesis is not a good answer because one is liable to restimulate late moments of unconsciousness and worsen the psychosis, which is not too hard to do. But sometimes an effort to hypnotize the patient, even a neurotic patient, will bird dog right to the engram in which he is. One is trying to press him down toward this engram, not to.hypnotize him, and all of a sudden, bang! the engram is there in full view. You can use a flashing light, a Charcot mirrors or something similar to produce the same effect on a patient.

Nitrous oxide has a restimulative factor whenever there have been nitrous oxide operations. It is very restimulative to people, and it has a slightly sweetish odor which the body recognizes instantly. In using nitrous oxide, if they used a different type of face mask it might be less restimulative, because the odor is the smell of stale rubber, and that odor is more restimulative than the odor of the gas.

The series I ran on nitrous oxide cases and the use of nitrous oxide was only three, and was all on normals, so I don't call it a series or even a test. But I did find that in each case it was restimulative.

Leave soporifics strictly alone. That includes phenobarbital or any such substance. If you get a headache, Bromo-Seltzer isn't too bad, it wears off rather rapidly. We do know that it will shut down some of the headache, but just the same the headache is still there. Aspirin would be better, but to turn down the analytical level and then go ahead and audit is a very bad idea, and the soporific has a tendency to do just that.

With a so-called hypnotic its possible action is to disconnect some of the more or less "permanent" actions in the mind so that differentiation is therefore better, and the person can evidently think a little better. But he pays for it heavily in that it permits locks to be received by himself in the form of other people's engrams. He could get more thoroughly restimulated in trying to come off a soporific. I know because I made myself a guinea pig on one of those experiments, and trying to get off the soporific was a tough job. Completely aside from the physiological reaction, when one suddenly ceases to take phenobarbital one gets the kick-in of the locks. It is like hypnotizing a person, and giving him a positive suggestion, then waking him up. Here he has been listening for ten hours a day to engrams, engrams, engrams, and for a few days he doesn't know whether he's going or coming or walking around the block. That's pretty gruesome.

If you have to grab hold of anything, grab hold of Benzedrine, if you feel the energy skipping. Benzedrine doesn't shut down the analyzer. Just what it does we are not quite sure, but it seems to have the opposite effect, and if you are a very smart auditor you will not throw away the advantages of the power of suggestion completely.

Suggestion does have its uses when it is controlled and one knows what one is doing. I am not now talking about hypnotic suggestion, I am talking about just the simple matter of cheering somebody up and a good bedside manner and so on.

It is said in the Handbook that as a stimulant Benzedrine helps blow emotional charges. This is true. But from Smith, Kline and French you can get Benzedrine blanks which look exactly like the Benzedrine tablet, more or less triangular, with a crease down the center. Give the patient a Benzedrine run. If you feel that it doesn't produce any marked effect on him the first time you give him a run with it, there is no reason to have him in a physiological state of nervousness because of the reaction of it. If he says, "Oh, I need Benzedrine, Benzedrine will blow that charge," and he believes this will take place, feed him the blanks, and give him runs on blanks. You will very often get better results than if you were actually feeding him the drug.

This sometimes handles fibrillations of the muscles when one hasn't got the faintest idea of what is causing them, because actually they could be a neurological derangement of some sort. It could be some physiological factor, and not enough work has been done at this time to separate out which is which.

There are certainly some physiological manifestations which are not psychosomatic in the field of fibrillations alone. We don't know. So it's better to take a cheerful attitude about it and say, "Well, if it's psychosomatic, it's psychosomatic and we'll get rid of it. But if it's not psychosomatic, why, it's not psychosomatic. But we'll get rid of a lot of engrams and that will make you feel better anyway. So what are you worrying about?"

Another attitude is one of calm with regard to a patient. If he sees you start worrying, he is liable to go way off the level. Some patients, even today, will give me a tremendous jolt if they suddenly explode (after sitting there very calmly running something in a highly orderly fashion) and fly off the couch onto the floor and roll around manifesting a convulsion.

It still gets my eyes going a bit wide and I say, "Well, now, that's fine, now let's go over it again," meanwhile I'm thinking, "I hope this thing isn't in the middle of the bank, I hope I can deintensify it. I don't know what I'll do to get my hands on this thing, and whether we can pick up anything."

However, my experience has been that I could always deintensify an incident regardless of where it was, and anything that violent will discharge.

You get someone going through an incident where he was actually in a convulsive state, an epileptiform seizure, and that person will be in the foulest shape that a man can possibly be in. Run it. And just keep running it. The thing will settle one way or the other. It will deintensify.

Don't do what a poor gentleman's girlfriend is currently doing to him. She is putting him back into a convulsive incident. There are no words there. She is not trying to guess any words there. She is not using any repeater technique. He is running on non-sonic, and all she has done is start him in at the beginning of the incident and then let him have a convulsion. Then after he has had a few convulsions, why, she brings him up to present time. Of course he keeps on having these convulsions. That is not going to deintensify. He isn't getting any perceptic out of it at all, and he said, "I am beginning to feel very irritable with people."

Well, what could be in the girl's mind? He also said to me, "What good would it do to just do teamwork in the Foundation? I might as well do it at home." Here he is being punished to within an inch of his life practically every time he goes into therapy, yet at the Foundation his case will be handled, his auditor will be trained, and supervised with relationship to his case particularly, and the thing will be gotten running. He will learn what to do about these things. But there we have two babes in the woods where Dianetics is concerned.

Don't ever do that. If you run someone into an engram where they are shaking all over, make them get the content out of the thing, hammer in when you get these quivers and convulsions. I have never had one of these cases fail to deintensify. Somewhere down in the early area the case should start to break on the unconsciousness. Then after a few more convulsions in the early area, these should just cease to exist on the rest of the case. In a migraine headache band you may have 200 incidents and you get off maybe 15 of them in the early part of the basic

area, after which the person just gets a slight headache, and the headaches get slighter and slighter as you go on. Convulsions can be a standard engramic pattern. After all, there are five kinds of orgasms a woman has and she might have a very convulsive type of orgasm, quite in addition to the fact that the shivers and shakes which she would then transmit might be very heavily laid in with verbal content; together with the fact that the preclear himself might have an engram at that point.

You will notice that as you watch people, those things with which they become most concerned in therapy are those things which you will generally find lie closest to the surface.

Dianetics improves when it parallels the mind closely in its actions. For example, if a man is worried, if his whole manifestation is "I am not sure and I don't know," it may sound like a dirty trick and just an effort to invalidate his doubt or skepticism, but if you have worked a few of these cases, you will suddenly find yourself slugging into a bank wherein Mama or Papa was never sure.

So go into the case for what it is manifesting, not for an aberration or a psychosomatic illness, although a chronic psychosomatic illness may lead you straight to the sympathy engram because it is held there by the real factor of sympathy.

Most sympathy engrams have a foundation in the prenatal area. Somebody felt sorry for the baby in the prenatal area, not just for Mama. It is highly personalized. The worst case that you can imagine, of course, would be one where Grandma was living with the parents, and Grandma saved the baby's life. It was because of Grandma that the baby got born, and Grandma had many rows with Mama concerning how much care she was to take of this baby. The baby was in pain, and both Mama and Papa were hostile to the baby. Then, postnatally, Grandma has some kind of a "you'll forget it" mechanism. Then every time she kisses the little boy after he hurts his head or gets sick she has a lot of supersympathy going into him with highly engramic content.

When this case eventually turns up in your hands, it will have a terrible set of psychosomatics. You can depend on it. It is not necessarily true that the case which has bad psychosomatics is always this case, but if this engram pattern exists you can be certain of it. You may get it in conscious recall from the person to some degree.

So that if a person has lots of psychosomatic illnesses and in answer to the question "How much do you remember of your youth?" he counts back and can remember 12 incidents up to the age of 16, start searching around to find out who was around him. It is usually one of these big, super ally computations together with antagonistic parents who didn't want the child. It goes clear on down to the bottom of the prenatal bank, so the despair charges on that case are just like exploding firecrackers when you finally get them running. They are all up and down the case.

Such a case as I demonstrated in a previous lecture where the person was very argumentative, very skeptical, he could not believe, and so forth, whose eyes were all twisted inwards, who had the prenatal hunch to his shoulders, and who is traveling along in a chronic manic—that man is an incipient psychotic.

I was a little bit disturbed that they screened him through onto the course. But apparently it was one of these jerry-rig affairs whereby his colleague, who is going to work for a psychoanalyst practicing Dianetics in New York, wanted a partner for the course and somehow they argued it in.

I did not really let my eye light on that case until last night, at which moment I realized that his presence in the five teams that will make up his section is going to cause a contagion. He is likely to catch somebody just after he has come up to present time and is still a little bit groggy, having just been through hell and high water, and he's going to start pounding him with this

and that and hammering away. He is talking straight out of engrams himself, so he is going to restimulate the cases around.

You could look at a case like that and say, "Aha! Probably two grandmothers and one grandfather and a couple of aunts and great-aunts, and Papa and Mama AAing like mad, with maybe a mother's lover in the case, and just strictly a mess from beginning to end."

To handle such a case, I would put him on Benzedrine, and go back over the case and start picking up the deaths and emotional discharges; and I would start knocking out allies and try, watching his manifestations, to pick up and blow the content of his chronic manic. Because it would have to be done, rapidly, at which point his false stature would go down and then as it came back up again it would be more rational.

The way to ease a chronic manic would be by looking at what the patient considers himself pretty good at, that he talks a lot about and brags about, his relationships and so on. He would use certain phrases, describing himself. You will find out that one or two of those phrases will trickle out, and you will be able to pick out, just by observation, the number of times he is using the phrase "I'm the strongest man in the world," or "I'm the brightest man in the world." Or he will use the phrase surreptitiously, such as, "Well, somebody thinks he's the brightest man in the world." It would be along in that line. So you finally isolate it and say, "He is probably the brightest man in the world," and this will be a big compliment.

The underlying engram would be something on the order of Mama has been AAing him and he is all full of holes, and Grandma comes in and says, "You know you shouldn't touch that dear little child that you have got inside of you; after all, it's a part of you," which misidentifies him instantly. Then she carries on, "He might grow up to be the brightest man in the world," and establishes the manic right there.

But hold the case down and keep knocking it full of holes. It is very dangerous when a case is in a high gear situation. Unload the painful emotion off the case before you tackle that manic. The major problem in handling such a case is that he is held in a manic. You are going to be operating every incident you get your hands on out of that manic in which he is. So it is a complex attitude that the case is manifesting. You are liable to upset the case to a point where he won't work with you, because you are going after his heart's blood, and it will probably have in it something like, "You can't get rid of it, you don't dare get rid of this. After all, I would just die with shame." If a person is caught in an engram, remember that the engram has such a link (and although this is supported by scientific observation it may not be the whole theory by a long ways).

For instance, here is someone who has nitrous oxide, and the dentist has been very nice to him and the nurse has been highly complimentary to him, but the other technician has been highly antagonistic toward him, and this is the technician that has been working on him. So on one hand there are people standing up for him and saying nice things about him, but on the other hand this one person doesn't believe it.

Now, as the thing travels along as an engram, there is a part of it which is a manic: "Oh, he's a strong fellow," etc. But he is in this engram, and it says, "I have to come back here," or some such call-back. As soon as the engram gets restimulated, he will come back into this manic. He is never quite out of it. But it has moments in it of great depression. "He's no good, he'll never amount to anything."

"What do you mean, he won't amount to anything? No, he's a strong guy!" So he flips valences.

Now, as the world snaps his valences, he is thrown into his own valence under the hands of the antagonistic technician, and he accepts it. But then he never quite gets there. However, he can be thrown around into the valence of the doctor defending him in this operation, and any person he is confronting is more or less the technician who disagrees with him.

Now, something rotates his valence, and he becomes the nurse listening to the doctor and so forth which is a friendly valence. So now he is in a friendly valence being praised. This valence shift proposition is extremely interesting.

We had a case here the other day who had a very nasty case of Mama's morning sickness. He was up in present time and he.was gripping his stomach convulsively, so I said, "Why don't you shift into your father's valence. How does he feel about it?" So he immediately straightened up, and I said, "How do you feel?"

"Fine."

"Well," I said, "let's be your mother for a moment," and he doubled up in pain again. Then I said, "Well, let's be your father."

"My God," he said, "what are you doing to me?" Because these savage pains would turn on in his abdomen the second that he went into Mother's valence. You could stand there wide awake and just slap him from valence to valence, back and forth as often as you wanted to. In one, he was speaking with a deep voice, rather self-confident and polite, and in Mama's valence it would be high-pitched and frantic.

People can be shifted in these valences. So much so that you get this idea that the person is different to everybody he meets. He meets somebody, he matches up an engramic valence with the person he is meeting, so at that moment he is smooth and suave, but with the next person he meets he is highly irritable. That is the phenomenon of valence shift. I would like to know a great deal about this subject, but it certainly does enter change.

Take, for instance, a manic-depressive who is in a manic valence, such as, "He's a great guy, he's strong," and so forth but which has a depressive end to it. Now, for some reason or other, the manic is less and less activated, and the depressive is more and more activated as his own physiological level begins to approach the physiological tone level of the engram. The psychosomatic illness gets worse because physiologically he is less able to resist it. So he becomes more and more himself, his own valence, he feels, yet trying to get out into these other valences, and now he is suffering. Then he swings back into the less and less friendly valences and finally he comes back to himself. When he gets into himself he is practically done for, because there he is in pain and misery actually sitting in a dentist's chair, but walking around.

There are various factors that enter the picture.

For instance, there is the man whose wife threatened to leave him. She threatened to leave him over a period of five or six years, and finally he came up to the point where he left her. He was having a bad time with her before that. The odd part of it is that all the time she was agitating about leaving, he was sick from 10:30 in the morning until 2 in the afternoon. He would go to a hamburger stand and the hamburger would look terrible, but the rest of the day he was perfectly well and unworried by the whole thing.

He had lying under this his mother and her-lover worrying about getting rid of him. They started in at 10:30 in the morning, with four or five rows in progress about leaving each other and so on, and at 2 o'clock the doctor had to be called. So from 10:30 until 2 he was in the hands of a couple of demons on the subject of leaving each other, and for the rest of the day he was in good hands. He was just idling between these two factors.

You can handle this if you know what the valence is or what was restimulated back there, but it is very hard to handle a person after they have gotten very solidly into the engram, they just keep tearing to pieces the engram as the closest thing.

The valence is not sealed. For instance, a person has an ally valence which he has occupied happily for years and years, and all of a sudden that person dies. How wrong can you get? You can certainly be no more wrong than to get into the valence of somebody who dies. That's really being wrong. So, the painful emotion floods that whole channel, and at that moment it is made very serious. I have found lots of patients who had emotional charge on the ally going away for even a weekend. That is in the line of loss; because loss of a business, loss of a car, these things can all mean emotional charge.

A good auditor knows when the somatic turns on. He knows when the patient has it, and he can repeat him into the place where he is going. But he isn't asking him to do anything. If he is getting yawns off the case, he recognizes that he is getting unconsciousness off.

Some cases are so nervous that as you send them back down the time track they may try to get out of something. They think it's too hot, so you just have to coax them into it.

Don't ever give a patient two directions simultaneously, or tell him to do one thing and before he has a chance to do that tell him to do something else. If he shows an inclination to run something the instant he starts down the track, it is very bad Dianetics to pull him off it.

If the patient thinks it is dub-in, then his sense of reality on it is very high. He is the person who is supposed to do the evaluation. If he thinks it is dub-in, that's fine, but go over it a few more times and if it really is dub-in, it will come out straight.

A real dub-in case, however, is quite different. You get him back to the prenatal area, and he goes for the first train wreck, he goes for the second train wreck, and then he gets to the fifth train wreck, and then all of a sudden a fire truck comes up just as they are taking him out of this train wreck and runs over him and breaks his spine. That is one kind of a dub-in; the other one is going through dream sequences continually.

So, there are various case factors that come up in auditing, and in this lecture I have covered some of the ways they can be handled.